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MA000100

DRAFT DETERMINATION

Fair Work Act 2009
s.156 - 4 yearly review of modern awards

4 YEARLY REVIEW OF MODERN AWARDS – SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

(AM2018/26)

XXXX
XXXX
XXXX

XXXX, XX XXXX 201X

4 yearly review of modern awards – Social, Community, Home Care and Disability Services Industry Award 2010.

A. Further to the decision issued on XXX in AM2018/26 ([201X] FWCFB XXXX), the above award is varied as follows:

1. By deleting clause 25.1 and inserting in lieu thereof:

25.1 Ordinary hours of work

(a) The ordinary hours of work will be 38 hours per week or an average of 38 hours per week over the employee's roster period, up to a maximum of four weeks.

(b) Subject to clause 25.1(c), the maximum ordinary hours that can be worked per shift is 8.

(c) By agreement between an employer and an individual employee, ordinary hours may be worked up to 10 hours per shift.

2. By deleting the words 'or period of work' in clause 25.4(a).

3. By deleting clause 25.5(d)(ii) and inserting in lieu thereof:

(ii) However, a roster may be altered at any time:

A. by agreement between the employer and relevant employee, provided the agreement is recorded in writing;

B. to enable the service of the organisation to be carried out where another employee is absent from work on account of personal/carer's leave,

compassionate leave, community service leave, ceremonial leave, leave to deal with family and domestic violence, or in an emergency; or

C. where the change involves the mutually agreed addition of hours for a part-time employee to be worked in such a way that the part-time employee still has four rostered days off in that fortnight or eight rostered days off in a 28 day roster cycle.

4. By deleting clause 25.5(f) and inserting in lieu thereof:

(f) Client cancellation

(i) This clause applies where a client cancels or changes a scheduled home care or disability service which a full-time or part-time employee was rostered to provide.

(ii) Where a service is cancelled by a client under clause 25.5(f)(i), the employer may either:

A. direct the employee to perform other work during those hours in which they were rostered; or

B. cancel the rostered shift.

(iii) Where clause 25.5(f)(ii)(A) applies, the employee will be paid the amount payable had the employee performed the cancelled service or the amount payable in respect of the work actually performed, whichever is the greater.

(iv) Where clause 25.5(f)(ii)(B) applies, the employer must either:

A. pay the employee the amount they would have received had the shift not been cancelled; or

B. subject to clause 25.5(f)(v), provide the employee with make up time in accordance with clause 25.5(f)(vi).

(v) The make up time arrangement cannot be utilised where the employee was notified of the cancelled shift after arriving at the relevant place of work to perform the shift. In these cases, clause 25.5(f)(iv)(B) applies.

(vi) Where the employer elects to provide make up time:

A. the make up time must be rostered in accordance with clause 25.5(a);

B. the make up time must be rostered to be performed within 3 months of the date of the cancelled shift;

C. the employer must consult with the employee in accordance with clause 8A regarding when the make up time is to be worked prior to rostering the make up time; and

D. the make up shift can include work with other clients or in other areas of the employer's business provided the employee has the skill and competence to perform the work.

5. By deleting clause 20.9 and inserting in lieu thereof:

20.9 On call allowance

An employee required by the employer to be on call (i.e. available for recall to duty at the employer's or client's premises and/or for remote response duties) will be paid an allowance of:

(i) $17.96 for any 24 hour period or part thereof during the period from the time of finishing ordinary duty on Monday to the time of finishing ordinary duty on Friday; or

(ii) $35.56 in respect of any other 24 hour period or part thereof on a Saturday, Sunday, or public holiday.

6. By inserting new clause 20.10 as follows:

20.10 Remote response

(a) In this award, remote response duties means the performance of the following activities by an employee outside of hours at the direction of, or with the authorisation of, their employer:

(i) responding to phone calls, messages or emails;

(ii) providing advice ('phone fixes');

(iii) arranging call out/rosters of other employees; and

(iv) remotely monitoring and/or addressing issues by remote telephone and/or computer access,

in circumstances where the employee is not required to attend their employer's premises, or any other particular place of work, and at a time when the employee is either on call or has not otherwise been rostered to work.

(b) Subject to clause 20.10(f), where an employee is directed or authorised by their employer to perform remote response duties between 6.00am and 10.00pm, the employee will be paid at the applicable rate of pay specified in this Award for

any such work performed between these hours, with a minimum payment of 15 minutes.

(c) Where an employee undertakes multiple separate instances of remote response duties during a particular period referred to in clause 20.10(b), and the total time spent performing such duties does not exceed 15 minutes, only one minimum payment is payable.

(d) Subject to clause 20.10(f), where an employee is directed or authorised to perform remote response duties between 10.00pm and 6.00am the employee will be paid at the applicable rate of pay specified in this Award for any such work performed between these times, with a minimum payment of one hour. Where such work exceeds one hour, payment will be made at the applicable rate for the duration of the work.

(e) Where an employee undertakes multiple separate instances of remote response duties during a particular period referred to in clause 20.10(d), and the total time spent performing duties does not exceed one hour, only one minimum payment is payable.

(f) Subject to clause 20.10(g), an employee who performs remote response duties must maintain and provide to their employer a time sheet specifying the time at which they commenced and concluded performing any remote response duty and a description of the work that was undertaken. This record must be provided to the employer prior to the end of the next full pay period or in accordance with any other arrangement as agreed between the employer and the employee.

(g) An employer may implement an alternate method or system for the recording and notification of the details referred to in clause 20.10(f).

(h) An employer is not required to pay an employee for any time spent performing remote duties if the employee does not comply with the requirements of clause 20.10(f) or any alternate method or system pursuant implemented under clause 20.10(g).

(i) For the purposes of this clause, remote response duties do not include employees undertaking administrative tasks such as (but not limited to) reviewing or inquiring about their roster or seeking changes to their roster.

(j) Clause 28.3 does not apply where an employee performs remote response work in accordance with this clause.

7. By deleting clause 28.4 and inserting in lieu thereof:

28.4 Recall to work overtime at the employer's or client's premises

An employee recalled to work overtime after leaving their place of work to attend at a premises where work is performed will be paid for a minimum of two hours' work at the appropriate rate for each time recalled. If the work required is completed in less than two hours the employee will be released from duty. This clause does not apply to an employee performing remote response duties in accordance with clause 20.10 of this Award.

B. This determination comes into operation from XX XXXX 201X. In accordance with s.165(3) of the Fair Work Act 2009 these items do not take effect until the start of the first full pay period that starts on or after XX XXXX 201X.

[Insert the Seal of the Fair Work Commission]

XXXX

Fair Work Commission: 4 yearly Review of modern awards

REPLY SUBMISSION

4 YEARLY REVIEW OF MODERN AWARDS: (AM2018/26) SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010 - SUBSTANTIVE ISSUES

AUSTRALIAN BUSINESS INDUSTRIAL

- and -

THE NSW BUSINESS CHAMBER LTD

5 APRIL 2019

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1. BACKGROUND

1.1 This reply submission is made on behalf of:

(a) Australian Business Industrial (**ABI**);

(b) the New South Wales Business Chamber Ltd (**NSWBC**);

(c) Aged & Community Services Australia (**ACSA**); and

(d) Leading Age Services Australia Limited (**LASA**),

collectively, '**our clients**'.

1.2 This reply submission is filed in accordance with the Amended Directions of the Fair Work Commission (the **Commission**) issued on 4 February 2019 in respect of the *Social, Community, Home Care and Disability Services Industry Award 2010* (the **Award**).

1.3 This reply submission addresses those claims of the Health Services Union (the **HSU**), the United Voice, and the Australian Services Union (the **ASU**) that were identified during a mention on 3 April 2019 before the President, Ross J, as being scheduled to be dealt with during the hearing listed for 12 April 2019.

1.4 Those claims are identified as follows:

(a) S44A – Deletion to the 24 hour care clause (United Voice);

(b) S47 – Variation to the excursions clause (United Voice);

(c) S51 – Variation to the overtime clause (United Voice);

(d) S57 – Variation to the public holidays clause (United Voice);

(e) S40 – Consequential amendment to the sleepover clause (United Voice);

(f) S48 – Rates or pay for casuals on weekends and public holidays (HSU);

(g) S43 – Deletion of 24 hour care clause (HSU);

(h) S19 – First aid certificate renewal (HSU); and

(i) S6 – Community language skills (ASU).

1.5 This reply submission addresses the above claims, as pursued by the respective unions in their submissions as follows:

(a) the submission of the HSU dated 15 February 2019 (**HSU Submission**);

(b) the submission of the United Voice dated 15 February 2019 (**UV Submission**) and

(c) the submission of the ASU dated 18 February 2019 (**ASU Submission**).

Our clients

1.6 ABI is a registered organisation under the *Fair Work (Registered Organisations) Act 2009* and has in excess of 4,000 members. ABI represents the interests of businesses in a variety of industries including the social, community, home care and disability services industry. Its primary role is to develop workplace policy and to shape debate on major workplace relations issues.

1.7 NSWBC is a recognised State registered association pursuant to Schedule 2 of the *Fair Work (Registered Organisation) Act 2009* and has some 18,000 members. NSWBC is the State's peak business organisation and represents all businesses from small enterprises to large corporations across a variety of industries including the social, community, home care and disability services industry.

1.8 ACSA is the leading peak body supporting church, charitable, other not-for-profit and government providers of residential care services, community care services and retirement living for older people in Australia.

1.9 LASA is the national peak body representing and supporting providers of age services across residential care, home care and retirement living. LASA's membership base is made up of private, not-for-profit, faith-based and government operated organisations providing care, support and services to older Australians.

2. LEGISLATIVE FRAMEWORK APPLICABLE TO 4 YEARLY REVIEW

2.1 The legislative framework applicable to the 4 Yearly Review has been considered in detail in *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 (***Preliminary Issues Decision***), and *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 (***Penalty Rates Decision***).

2.2 More recently, the legislative framework applicable to the 4 Yearly Review was considered in *4 yearly review of modern awards – plain language re-drafting – standard clauses* [2018] FWCFB 4177 issued on 18 July 2018[1] and summarised in the *4 yearly review of modern awards – Alpine Resorts Award* [2018] FWCFB 4984. The main propositions may be summarised as follows:

(a) section 156(2) provides that the Commission must review all modern awards and may, among other things, make determinations varying modern awards;

(b) the term "review" has its ordinary and natural meaning of "survey, inspect, re-examine or look back upon";[2]

(c) the discretion in s 156(2)(b)(i) to make determinations varying modern awards in a review, is expressed in general, unqualified, terms, but the breadth of the discretion is constrained by other provisions of the *Fair Work Act 2009 (Cth)* (**FW Act**) relevant to the conduct of the review;

(d) in particular the Modern Awards Objective in s 134 applies to the review;

(e) the Modern Awards Objective is very broadly expressed,[3] and is a composite expression which requires that modern awards, together with the NES, provide "a fair and relevant minimum safety net of terms and conditions", taking into account the matters in ss 134(1)(a)–(h);[4]

(f) fairness in this context is to be assessed from the perspective of the employees and employers covered by the modern award in question;[5]

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[1] [2018] FWCFB 4177 at [3]-[13]
[2] *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161 at [38]
[3] *Shop, Distributive and Allied Employees Association v National Retail Association (No 2)* (2012) 205 FCR 227 at [35]
[4] [2017] FWCFB 1001 at [128]; *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161 at [41]–[44]
[5] [2018] FWCFB 3500 at [21]-[24]

(g) the obligation to take into account the s 134 considerations means that each of these matters, insofar as they are relevant, must be treated as a matter of significance in the decision-making process;[6]

(h) no particular primacy is attached to any of the s 134 considerations and not all of the matters identified will necessarily be relevant in the context of a particular proposal to vary a modern award;[7]

(i) it is not necessary to make a finding that the award fails to satisfy one or more of the s 134 considerations as a prerequisite to the variation of a modern award;[8]

(j) the s 134 considerations do not set a particular standard against which a modern award can be evaluated; many of them may be characterised as broad social objectives;[9]

(k) in giving effect to the Modern Awards Objective the Commission is performing an evaluative function taking into account the matters in ss 134(1)(a)–(h) and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance;

(l) what is necessary is for the Commission to review a particular modern award and, by reference to the s 134 considerations and any other consideration consistent with the purpose of the objective, come to an evaluative judgment about the objective and what terms should be included only to the extent necessary to achieve the objective of a fair and relevant minimum safety net;[10]

(m) the matters which may be taken into account are not confined to the s 134 considerations;[11]

(n) section 138, in providing that a modern award may include terms that it is permitted to include, and must include terms that it is required to include, qualifies that power to be exercised "only to the extent necessary to achieve the Modern Awards Objective and (to the extent applicable) the minimum wages objective", and

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[6] *Edwards v Giudice* (1999) 94 FCR 561 at [5]; *Australian Competition and Consumer Commission v Leelee Pty Ltd* [1999] FCA 1121 at [81]-[84]; *National Retail Association v Fair Work Commission* (2014) 225 FCR 154 at [56]

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

[8] *National Retail Association v Fair Work Commission* (2014) 225 FCR 154 at [105]-[106]

[9] See *National Retail Association v Fair Work Commission* (2014) 225 FCR 154 at [109]-[110]; albeit the Court was considering a different statutory context, this observation is applicable to the Commission's task in the Review

[10] As above at [28]-[29]

[11] *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161 at [48]

emphasises the fact it is the minimum safety net and minimum wages objective to which the modern awards are directed;[12]

(o) what is necessary to achieve the Modern Awards Objective in a particular case is a value judgment, taking into account the s 134 considerations to the extent that they are relevant having regard to the context, including the circumstances pertaining to the particular modern award, the terms of any proposed variation and the submissions and evidence;[13] and

(p) where an interested party applies for a variation to a modern award as part of the 4 yearly review, the task is not to address a jurisdictional fact about the need for change, but to review the award and evaluate whether the posited terms with a variation meet the objective.[14]

2.3 When considering the merit basis to make variations, the *Preliminary Issues Decision* held that:

(a) there may be cases where the need for an award variation is self-evident. In such circumstances, proposed variations can be determined with little formality;[15] and

(b) where significant award changes are proposed, they must be supported by submissions which address the legislative provisions and be accompanied by probative evidence properly directed to demonstrating the facts supporting the proposed variation.[16]

2.4 Lastly, the Commission should proceed on the basis that *prima facie* the modern award achieved the modern awards objective at the time it was made.

[12] *CFMEU v Anglo American Metallurgical Coal Pty Ltd* [2017] FCAFC 123 at [23]; cited with approval in *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161 at [45]
[13] See generally: *Shop, Distributive and Allied Employees Association v National Retail Association (No.2)* (2012) 205 FCR 227
[14] As above at [46]
[15] Ibid at [23] and [60]
[16] Ibid

3. THE SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY

3.1 The social, community, home care and disability services industry is undergoing unprecedented structural change by reason of the significant reforms that have recently been (and continue to be) implemented across the country.

3.2 The two main reforms which are having a significant impact on the operating environment are the National Disability Insurance Scheme (the NDIS) and the introduction of 'Consumer-Directed Care' for home care packages. Other similar reforms are also taking place in respect of State and Territory funding models. Broadly speaking, these reforms involve a move away from a block funding model to an individualised funding model.

3.3 These reforms all have a shared focus: empowering individuals to exercise a greater level of choice and control over the delivery of their support services. The reforms aim to empower individuals to exercise more choice and control in their lives by having a greater ability to determine what services are provided to them, and when, where, how and by whom those services are delivered.

3.4 However, the reforms also represent a major challenge for employers in the industry, and require businesses to rapidly transform the structure and nature of their workforces in order to remain viable.

Consumer-directed care in the home care sector

3.5 The aged care reform agenda places older Australians at the centre of the system (consumer directed care) and is predicated on four principles :

(a) ageing in place - based on the preferences of older people to age at home;

(b) consumer choice - care recipients are empowered to choose who provides the age services that best meet their changing needs and preferences;

(c) market based competition - as a mechanism to drive value for money and ensure diversity in care providers to meet consumer choices; and

(d) consumer contributions - where recipients of care and services contribute to the cost of their care, commensurate with their ability to do so.

3.6 Australia's aged care system supports more than 1.3 million older Australians annually, the majority of whom are supported at home in line with their clear preference to remain at home.

3.7 The aged care industry is comprised of residential aged care (which is covered by the Aged Care Award 2010) and home care, which is covered by the SCHCDS Award. In the non-residential aged care sector, there are two main programs under which services are delivered: the Commonwealth Home Support Program (CHSP), and the Home Care Packages (HCP) Program. Entry to the system is though My Aged Care operated by the Federal Government. The system is designed, regulated and funded by the Federal Government.

3.8 In the home care sector, the Federal Government announced reforms in 2012 creating Consumer Directed Care. Consumer Directed Care (CDC) is a model of service delivery designed to give more choice and flexibility to consumers, by allowing individuals to have more control over the types of care and services they access and the delivery of those services (including who delivers the services and when).

3.9 CDC was first piloted as a model of care within the HCP Program in 2010-11. Following the success of the pilot, all newly released Home Care Packages from August 2013 were required to be delivered on a CDC basis. From July 2015, all Home Care Packages must be delivered in a CDC basis.

3.10 Home Care Packages are generally available to older persons who need coordinated services to help them to stay in their home, and to younger persons with a disability, dementia or other special care needs that are not met through other specialist services.

3.11 Prior to the introduction of CDC, Home Care Packages in Australia were provided as a bundled set of services relatively tightly-specified by government. Availability of Commonwealth funding for these services had been capped by the allocation of funded "places" to a limited group of approved providers (as provided for in the Aged Care Act 1997), by the funding levels prescribed and by a cap on consumer fees. This created a market characterised by:

(a) limited supply;

(b) lack of price competition;

(c) limited scope for competition on quality; and

(d) limited product differentiation.

3.12 Previously, a set planning ratio dictated the number of "home care places" which were allocated to approved providers for specific geographic regions – meaning that supply was constrained both in total levels and in location.

3.13 However, the recent reforms have shifted the dynamic in the sector to a more market based system – in the old model, providers selected consumers to receive care; in the new model, consumers select suppliers.

3.14 Under the reforms, consumers' needs dictate the allocation of services. Providers, meanwhile, can provide services to (approved and prioritised) consumers wherever they are located – as long as providers have an attractive service offering. However for providers, it also brings the challenge of no longer having a guaranteed number of places and therefore income. This issue is addressed in more detail at paragraphs 4.6-4.10 below.

The National Disability Insurance Scheme

3.15 The NDIS was established under the National Disability Insurance Scheme Act 2013 (Cth), with the objectives of:

(a) supporting the independence and social and economic participation of people with disability;

(b) providing reasonable and necessary supports, including early intervention supports, for participants;

(c) enabling people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports;

(d) facilitating the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability; and

(e) promoting the provision of high quality and innovative supports to people with disability.

3.16 The NDIS supports people under the age of 65 who have a permanent and significant disability. Under the NDIS, individual consumers (eligible 'participants') have greater choice and control over how their services are delivered, which includes control over what services are provided to them, when those services are provided, where those services are provided, and by whom those services are provided. Participants have the ability to choose their service providers, and to terminate their service arrangements at their discretion.

3.17 Each participant's supports are set out in a 'NDIS Plan' which is developed by the National Disability Insurance Authority (NDIA) in consultation with the individual participant. Service providers do not have any control over, or input into, the NDIS Plans. NDIS Plans specify a 'global' funding amount for different categories of 'fixed' and/or 'flexible' supports, but typically do not specify details of how or when those supports are to be provided.

3.18 Participants then typically enter into a service agreement with one or more service providers for the delivery of services outlined in their NDIS Plan.

3.19 The transition to an individualised funding model has meant that employers have had to be more flexible and responsive in the delivery of their services in order to meet the goals of the individuals to whom they are established to support. This has led to a number of challenges, including:

(a) a reduction in the stability or predictability of demand, as individual participants are now free to terminate their service arrangements at any time;

(b) a fragmentation of working patterns, as the employer is no longer able to organise the work in a manner that is most efficient to it;

(c) an increase in cancellations and requests for changes to services by participants; and

(d) an increase in requests for services to be delivered by particular support workers.

3.20 The above challenges have also been accompanied by diminishing profitability and viability of providing some types of services due to the inadequacies of the NDIS pricing model, which is addressed at paragraphs 4.11-4.14 below.

4. FUNDING CONSTRAINTS

4.1 For many decades, prior to the introduction of the NDIS and the CDC reforms, there was a high degree of certainty and stability around the funding for organisations in this industry. However, as the markets have moved to a more decentralised, dynamic, market-based model, employers have had to be responsive to the needs and desires of individual consumers, resulting in significant financial stress. This is particularly so in the disability sector where prices are fixed by the NDIA, and so employers are in many cases unable to recoup an amount sufficient to meet their costs for particular services.

4.2 There are two distinct features of businesses operating in the SCHCDS industry which should be recognised.

4.3 Firstly, the prices that can be charged for most services are regulated and in some cases fixed by the Government (or otherwise businesses are limited by the funding that is provided to deliver certain services).

4.4 Secondly, many employers in the SCHCDS industry are not-for-profit organisations with a deeply-embedded mission to support the community. This fact means that these businesses are not driven by the same imperatives or motivations as most other commercial businesses.

4.5 The above two factors lead to a dynamic whereby many service providers in the SCHCDS industry, if/when faced with the choice, will elect to provide services to consumers at a loss in order to meet the organisation's mission rather than not provide the service by reason of it being unprofitable.

Financial position of the home care sector

4.6 The home care sector is under significant financial strain.

4.7 The data provided by the *StewartBrown Aged Care Financial Performance Survey* is the most contemporaneous information on the financial performance of the sector. These quarterly surveys are the largest benchmark within the aged care sector and incorporate detailed financial and supporting data from some 25,000 home care packages across Australia.

4.8 According to this data, the average profit per client per day for home care providers fell 48 percent over the two year period between the December quarter of 2016 and the December quarter of 2018, from $6.40 to $3.33 per client per day.[17]

4.9 Its most recent report, the *Aged Care Financial Performance Survey; Sector Report (Six months ended December 2018)*, contains financial data based on over 27,164 home care packages (503 home care programs) across Australia. The Report indicates that:

(a) the HCP segment experienced "a significant decline in profitability in FY18 with revenue and overall EBT per client per day declining";[18]

(b) while there had been seasonal improvement in results since the end of the financial year in 2018, the underlying year-on-year results indicate declining financial performance;[19]

(c) there was a financial performance decline in the 2018 financial year, seeing revenues reduce by an average of 6.1 per cent resulting in an overall reduction in profitability of 29.8 per cent;[20]

(d) the number of providers have increased by 80.6 per cent since June 2016, however the number of home care funding packages has only increased by 43.4 per cent in the same period;[21] and

[17] EBT per client per day.
[18] StewartBrown, *Aged Care Financial Performance Survey; Sector Report (Six months ended December 2018),* 2019, p.27
[19] Ibid, p.5
[20] Ibid, p.6

(e) there has been a decline in Level 4 (high care) packages, with a decline in return from $24.80 per client per day in July 2015 to $5.92 per client per day, representing a return on revenue of 5.3 percent which is described as "bordering on being unsustainable".[22]

4.10 This decline in profitability likely reflects a range of factors including input costs increasing at above the rate of indexation, increased competition driving lower prices or more attractive service offerings to maintain or grow market share, and reduction in the level of package utilisation.

Financial position of the disability sector

4.11 A regular complaint of service providers in the disability services sector is the inadequacy of the NDIS pricing system. In certain areas, there are signs of market failure.

4.12 The legitimacy of this concern has been borne out in a range of studies, including most comprehensively in the Final Report of the Independent Pricing Review commissioned by the NDIA and published by McKinsey & Company dated February 2018.[23]

4.13 Amongst a range of findings, the Independent Pricing Review found:[24]

(a) "signals that concerning" in the attendant care market, including a "significant proportion of providers that currently have unprofitable operating models"; and

(b) while some providers have operating models that are profitable at the current price points, "many are struggling, particularly traditional providers delivering attendant care supports", which is attributable to a combination of factors, including:

(i) higher overheads;

(ii) challenges in adapting to unit pricing and NDIA systems improvement opportunities;

(iii) lower utilisation of workers; and

(iv) higher labour costs.

4.14 The findings of the Independent Pricing Review are consistent with the feedback from service providers that has been received over the past few years, which is summarised in the

[21] StewartBrown, *Aged Care Financial Performance Survey; Sector Report (Six months ended December 2018),* 2019, p.6
[22] Ibid, p.29
[23] McKinsey & Company, *Independent Pricing Review: National Disability Insurance Agency* (Final Report, February 2018)
[24] Ibid, p.5

Independent Pricing Review and a range of other surveys and publications, including the *State of the Disability Sector Report 2018* published by National Disability Services (NDS). This feedback includes that:

(a) current loadings for complex participants do not fully reflect the additional costs of serving those participants;[25]

(b) travel allowances do not adequately cover the costs of provider travel and participant transport in regional areas and isolated communities;[26]

(c) in attendant care, existing providers are struggling to adjust their business models to operate under the NDIS unit-funding model and the current level of price caps;[27]

(d) a very large number of service providers ranked the NDIS pricing as their top concern, and believed they would not be able to provide NDIS services at their current prices; [28]

(e) many service providers are not making a profit/surplus;[29] and

(f) the inadequacy in pricing has resulted in some providers discontinuing services to some participants.[30]

[25] McKinsey & Company, *Independent Pricing Review: National Disability Insurance Agency* (Final Report, February 2018), p.4
[26] Ibid
[27] Ibid
[28] National Disability Services, *State of the Disability Sector Report 2018*, p.9-10
[29] Ibid, p.18
[30] Ibid, p.27

5. THE UNIONS' CLAIMS

5.1 The Unions' claims must be considered against the backdrop of the significant structural reforms that have been implemented over the last five years, and the significant financial and operational pressure currently being experienced by businesses as they struggle to transition to a radically new system of service delivery.

5.2 Our clients do not have any philosophical objection to the Award providing a 'fair and relevant' minimum safety net of terms and conditions. However, the task before the Commission ultimately requires a balancing exercise whereby the needs and interests of employees are balanced with the needs of employers in order to ensure a fair, sustainable and viable industry.

5.3 From the perspective of service providers in this industry, yhe reality is that any variation to the Award which results in increased labour costs will inevitably have a material adverse impact on employers in the industry and will threaten the viability of their operations and their ability to continue providing certain services, unless there is some equivalent increase to the funding received by the business.

5.4 Equally, any variation that adversely affects employers' operational flexibilities will also have a material adverse impact on the businesses' ability to deliver quality services to some of the most vulnerable members of the community.

5.5 By way of summary, our clients oppose the following variations sought by the Unions:

(a) S44A – Deletion to the 24 hour care clause (United Voice);

(b) S47 – Variation to the excursions clause (United Voice);

(c) S51 – Variation to the overtime clause (United Voice);

(d) S57 – Variation to the public holidays clause (United Voice);

(e) S40 – Consequential amendment to the sleepover clause (United Voice);

(f) S48 – Rates or pay for casuals on weekends and public holidays (HSU);

(g) S43 – Deletion of 24 hour care clause (HSU);

(h) S19 – First aid certificate renewal (HSU); and

(i) S6 – Community language skills (ASU).

5.6 Each of these claims is addressed in detail below.

6. CLAIMS RELATING TO 24 HOUR CARE CLAUSE (S43, S44A AND S40)

The HSU and United Voice claims

6.1 The HSU and United Voice both seek the deletion of clause 25.8 of the Award, which deals with 24 hour care. The current clause provides:

> ***25.8 24 hour care***
>
> *This clause only applies to home care employees.*
>
> *(a) A 24 hour care shift requires an employee to be available for duty in a client's home for a 24 hour period. During this period, the employee is required to provide the client with the services specified in the care plan. The employee is required to provide a total of no more than eight hours of care during this period.*
>
> *(b) The employee will normally have the opportunity to sleep during a 24 hour care shift and, where appropriate, a bed in a private room will be provided for the employee.*
>
> *(c) The employee engaged will be paid eight hours work at 155% of their appropriate rate for each 24 hour period.*

6.2 The United Voice also seek a consequential amendment to remove certain wording in clause 25.7(a),[31] which will be an uncontroversial amendment if the 24 hour care clause is removed from the Award.

6.3 While the United Voice have articulated their concerns about the 24 hour care clause in some detail in their written submissions, the HSU have advanced a whole three paragraphs in support of the proposed deletion of clause 25.8.

6.4 A range of submissions are advanced in support of the deletion of clause 25.8, including that:

(a) the clause is unclear, in that it provides no certainty regarding the hours or work of an employee or the sleeping arrangements to be applied; [32]

(b) the clause is rarely used;[33]

(c) the entire engagement is 'work' and should be remunerated as such;[34]

[31] This is described as claim S40.
[32] HSU Submission at [64]-[65]; United Voice Submission at [18]
[33] Ibid

(d) the clause does not adequately compensate employees, or provides for remuneration at a "discounted rate", for the time they are required to be available for work;[35]

(e) the clause may breach section 323 of the FW Act because it permits an employer to require an employee to work for a 24 hour period but does not require the employer to pay the employee in full for that work;[36]

(f) the clause creates situations where an employee is effectively liable to work in excess of the notional hours attributed to the engagement, and the hours that such engagements will 'require' the employee to work are not foreseeable;[37] and

(g) leaving employees for lengthy periods on duty dealing with complex interpersonal matters is problematic.[38]

6.5 We address firstly the history and rationale for the current 24 hour care clause, and then turn to each of the above arguments in detail below.

History of the 24 hour care clause

6.6 Provisions relating to 24 hour care have been a common and important feature of industrial regulation in the SCHCDS industry for many years.

6.7 Numerous pre-reform awards contained 24 hour care provisions, including:

(a) the *Charitable Sector, Aged and Disability Care Services (State) Award 2003*;[39]

(b) the *Charitable, Aged and Disability Care Services (State) Award*;[40]

(c) the *Community Services (Home Care Service of New South Wales) Care Workers Award 2002*;[41]

(d) the *Community Services (Home Care) (ACT) Award 2002*;[42]

(e) the *Disabilities Services Award*;[43]

(f) the *Disability Support Workers Award - State 2003*;[44]

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[34] United Voice Submission at [24]
[35] Ibid at [65]-[66]
[36] United Voice Submission at [30]
[37] United Voice Submission at [20]
[38] United Voice Submission at [34]
[39] AN120117
[40] AN120118
[41] AP815060
[42] AP816351
[43] AN150046

(g) the *Home and Community Care Award 2001*;[45]

(h) the *Miscellaneous Workers Home Care Industry (State) Award* [NAPSA – NSW];[46] and

(i) the *Social and Community Services Employees (State) Award*.[47]

6.8 These pre-reform awards covered a very large number of employees across the home care and disability services sectors throughout the majority of States and Territories.

6.9 During the Award Modernisation process which led to the making of the current Award, the AIRC published an Exposure Draft on 25 September 2009 contained a 24 hour care provision at clause 24.8.

6.10 Following the publication of the Exposure Draft, parties were given the opportunity to file submissions in respect of the Exposure Draft. Notwithstanding that the unions raised a number of concerns about the terms of the Exposure Draft, it is notable that the union parties did not raise any issue with the proposed 24 hour care clause. For example, no issue was raised with the 24 hour care clause in the following submissions of the unions:

(a) the submission of the ASU dated 16 October 2009;

(b) the submission of the HSU dated 16 October 2009;

(c) the submission of the ACTU dated 16 October 2009; and

(d) the submission of the AWU (Queensland Branch) dated 16 October 2009.

6.11 In contrast, the employer parties did raise issue with the Exposure Draft provision. For example:

(a) In its submission of 16 October 2009, AFEI raised concerns with the clause and submitted that the clause may result in severe operational difficulties for employers providing this type of service and may ultimately cause such a service to become unviable. AFEI then submitted that clause 5 of the *Miscellaneous Workers – Home Care Industry (State) Award* should be adopted;[48]

(b) In its submission of 19 October 2009, ABI raised concerns with aspects of the clause, including that the wording in the Exposure Draft failed to contemplate the situation whereby an employee is required to provide care for a client outside of the client's

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[44] AN140093
[45] AP806214
[46] AN120341
[47] AN120505
[48] At [24]-[27]

home. The ABI submission also enclosed a marked-up version of the Exposure Draft which included the specific amendments sought;[49] and

(c) In its submission of 19 October 2009, the Aged Care Employers raised the same concern as ABI about the clause being limited to the provision of care within a client's home, and proposed an amendment to that effect.[50]

6.12 In response to the above submissions, the ASU filed a submission on 5 November 2009 in which it rejected "as a standard award condition across the whole industry" the proposition of the employers that the clause be amended to allow for the provision of care outside the client's home.[51] Notably, the ASU then, in response to the proposal for the insertion of a "Live-In employees" provision as per the *Miscellaneous Workers – Home Care Industry (State) Award*, stated:

> *The ASU supports the Full Bench decision to insert the 24 hour care provisions as a standard and submits that the existence of a "Live In" care provision in one New South Wales award is not a proper basis for inclusion of such a condition in the Modern Award.* [emphasis added]

6.13 The ASU submission of 5 November 2009 then attached a 'comparison table' summarising the various positions of the interested parties. The table records, in respect of the 24 hour care clause, that each of the "ASU, HSU, AWU, LHMU, ACTU" ... "support" the ED.[52]

6.14 No other written submission was made by any union concerning the 24 hour care clause in the Exposure Draft. Nor have we been able to identify any specific discussion about the clause during the hearings held between October and November 2009.[53]

6.15 Given the lack of dispute between the main interested parties in respect of the clause, the AIRC unsurprisingly retained the clause unaltered when it made the modern award on 4 December 2009.[54]

6.16 Subsequent to the Award Modernisation process, the Award has contained a 24 hour care clause since it was created in 2010.

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[49] At [51]-[53]
[50] At [11]
[51] At [16]
[52] See page 2 of comparison table attached to submission.
[53] See transcripts of 26-30 October 2009 and 4-5 November 2009.
[54] [2009] AIRCFB 945

6.17 Aside from a variation to the clause following an application by the ASU in 2012 to clarify that it only applies to home care employees,[55] the clause has otherwise operated without any controversy until these proceedings.

The rationale for, and importance of, the 24 hour care clause

6.18 The Unions' support for the inclusion of the 24 hour care clause during the Award Modernisation process reflects the fact that these provisions were common features of the pre-reform industrial relations system, and represents an acknowledgement of the importance of the Award facilitating 24 hour care arrangements.

6.19 While the 24 hour care clause is not used on a daily basis by most service providers, it facilitates the provision of a valuable service to elderly Australians who are in receipt of home care services. By way of example, where a family has an elderly family member in their care and the family wishes to take a holiday, the 24 hour care clause allows them to arrange for a home care worker to attend their home and provide care to the elderly family member in his/her own home, without the need to organise respite care in an out-of-home setting. These arrangements are consistent with the aims of the CDC model of encouraging individuals to stay at home for as long as possible and to give consumers choice about how they are cared for. The Award should continue to facilitate the delivery of such a service.

Response to the Union contentions

6.20 Before turning to the issues raised by the unions, we make the following observations about the current clause:

(a) first, the operation of the clause is limited to employees working in the home care stream, and so the clause must be viewed in that context and consideration must be given to the peculiar characteristics pertaining to that sector;

(b) second, while the clause requires an employee to be available for duty in a client's home for a 24 hour period, it explicitly requires them to provide "no more than eight hours of care"; and

(c) third, the clause provides for a loading of 155% of the appropriate rate of pay for the 8 hours of work performed.

6.21 We now address each of the unions' submissions.

[55] Fair Work Commission; PR531544

Alleged ambiguity or lack of clarity

6.22 Concerns have been raised by both the HSU and the United Voice about the lack of clarity in the clause. The matters complained of appear to be confined to:

(a) first, that the clause is silent as to what happens when an employee is required to perform more than 8 hours' work;[56]

(b) second, that the clause provides no certainty regarding the hours or work of an employee, creates situations where an employee is effectively liable to work in excess of the notional hours attributed to the engagement, and the hours that such engagements will 'require' the employee to work are not foreseeable;[57] and

(c) third, that the clause is unclear regarding aspects relating to sleeping.[58]

6.23 We respond to these matters as follows.

6.24 As to the first matter, it is correct that the clause does not specify what happens where an employee is required to perform more than 8 hours' work during a 24 hour care shift. Our clients accept that there is a degree of tension within the clause given that it states, on the one hand, that an employee is required to be "available for duty ... for a 24 hour period", and then on the other hand states that the employee "is required to provide a total of no more than eight hours of care during this period".

6.25 Our clients' view is that the intent of the clause is that employees are not required to perform any more than 8 hours' work, however there may be occasions where additional work may be required (for example, in the event of a medical emergency). While the employer may not be able to require the employee to perform more than 8 hours' work, the employee can agree to perform additional work and, where that occurs, such work will amount to work that is additional to their rostered hours and will be regulated by the overtime provisions at clause 28.

6.26 In our submission, the above position is the logical conclusion and reflects the proper construction of the current Award having regard to the principles of interpretation of industrial instruments.[59]

6.27 In relation to the second matter, we reject the suggestion that the clause provides "no certainty" concerning the hours or work of an employee.[60] To the contrary, clause 25.8(a)

[56] HSU Submission at [65]
[57] United Voice Submission at [20]
[58] HSU Submission at [65]
[59] See *AMWU v Berri Pty Limited* [2017] FWCFB 3005

expressly provides that "The employee is required to provide a total of no more than eight hours of care during this period". In practice, there is likely to be some flexibility as to precisely when the 8 hours of work are to be performed over the 24 hour period, as is required given the nature of the work. However, ultimately the span of the engagement (being 24 hours) is clearly known to the employee.

6.28 In relation to the third matter, an issue is raised with the alleged lack of clarity around the phrase "...where appropriate, a bed in a private room will be provided for the employee". Specifically, the HSU complain that the clause is ambiguous as to whether the employee will be provided with "a safe and clean space to sleep". It is of course accepted that the current clause does not expressly provide that employees will be provided with "a safe and clean space to sleep", however we are not aware that the absence of any such wording has caused an issue before in the 9 years the clause has been in operation. There is certainly no evidence of any issue before the Commission upon which a finding could be made that the clause is not operating sensibly.

6.29 Ultimately, if the Commission forms the view that one or more aspects of the clause are ambiguous or would benefit from clarification, our clients would not be opposed to the clause being varied to resolve any such ambiguity provided the substance of the clause is not altered. This would of course be consistent with s 134(1)(g) of the FW Act.

6.30 However, it must be stressed that a finding of ambiguity in the clause's operation does not necessitate or warrant the wholesale deletion of the clause.

Prevalence of use of the 24 hour care clause

6.31 Importantly, the HSU do not assert that the clause is *not* used. Rather, the HSU assert that the 24 hour care clause is "rarely used".

6.32 While our clients do not dispute that the clause may not be used frequently by all employers, the clause is utilised by a number of employers throughout Australia.

6.33 Indeed, a quick internet search for "24 hour home care" returns a lengthy list of providers who offer 24 hour care in the home care sector. Further, there are a large number of enterprise agreements in operation in the home care sector that contain 24 hour care provisions.[61]

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[60] United Voice Submission at [18]

[61] See for example, *Fresh Hope Care Home Care Enterprise Agreement 2017* (AG2018/1325); *Regis Aged Care Pty Ltd, ANMF & HWU Enterprise Agreement – Victoria 2017* (AG2018/5594); *Jubilee Community Care Enterprise Agreement 2016* (AG2016/3888); *Just Better Care Northern Rivers Enterprise Agreement 2018* (AG

An allegation that the entire 24 hour period is "work"

6.34 The thrust of the unions' submissions is that where an employee is required by their employer to stand in readiness for work, or is otherwise not free to engage in leisure activities, the time should be treated as time worked and paid as such.

6.35 At a theoretical level, the proposition is sound. However, the modern award system contains a range of provisions dealing with situations where employees are required to be on-call, on stand-by in readiness for work, or otherwise available to perform work. These situations and provisions are not unusual, and clause 25.8 of the Award is no different to other clauses in a large number of other modern awards that require employees to be on stand-by or otherwise on-call whilst not performing "work". The various modern awards deal with those situations differently, and provide for different compensation mechanisms, having regard to the specific obligation imposed on employees and the particular circumstances applying in that industry.[62]

Remuneration applying to 24 hour care shifts

6.36 As stated above, clause 25.8 entitles employees to 8 hours' pay at 155% of the appropriate rate of pay.

6.37 The unions argue that the remuneration provided by clause 25.8 is inadequate when one considers the requirements imposed on employees. However, the unions do not provide any indication as to what level of remuneration they consider would be adequate. They simply assert that the entitlements provided by the Award are inadequate.

6.38 There is no evidence before the Commission as to the value of the work that would justify any change to the amounts payable for the work. In the absence of any evidence regarding the disutility associated with the performance of 24 hour care shifts, the Commission should

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2018/7264); *Just Better Care Multi Enterprise Agreement 2018* (AG 2018/1456); *Australian Unity Home Care Enterprise Agreement 2017* (AG2017/6064); *Australian Unity Home Care EA 2017*; *Flexi Care Inc Care Providers Enterprise Agreement 2017* (AG2017/5995); *Thompson Health Care, NSWNMA, ANMF NSW Branch and HSU New South Wales Branch Enterprise Agreement 2017*; *Flexi Care Inc Care Providers Enterprise Agreement 2017; JBC Brisbane North Enterprise Agreement 2015* (AG2015/6180); *Amana Living Home Care Enterprise Agreement 2015* (AG2015/4566); *SYC Specialised Residential Care Workers Enterprise Agreement 2014-2016* (AG2014/6402); *Envigor Home Care Enterprise Agreement 2014* (AG 2015/143); *Southern Cross Care (Victoria) Community Services Enterprise Agreement 2014* (AG2015/412); *Multicultural Aged Care Services Geelong Inc, Community and Home Care Employees, Enterprise Agreement 2013* (AG2013/2499); *SOS Home Carers' Agreement 2013* (AG2013/2282); *Jewish Care Victoria Inc – Social, Community, Home Care, Disability, Health Professionals & Support Services Enterprise Agreement 2011-2014* (AG2012/5038); *After-Care (A'sia) Pty Ltd Enterprise Agreement 2010* (AG 2011/14915)

[62] See for example, clause 26.6 of the *Electrical, Electronic and Communications Contracting Award 2010*; clause 21.8 of the *Telecommunications Services Award 2010*.

not depart from the prima facie position that the 155% loading provides appropriate compensation for the work undertaken and any disutility associated with the engagement.

Alleged arguable contravention of section 323 of the FW Act

6.39 We do not consider that clause 25.8 contravenes section 323 of the FW Act.

6.40 The chief submission advanced by the United Voice appears to be that clause 25.8 "may" breach s 323 of the FW Act because it "permits an employer to require an employee to work for a 24 hour period but does not require the employer to pay the employee in full for the performance of the work".[63]

6.41 That submission should be rejected. As stated in paragraph 6.27 above, the clause explicitly does *not* require an employee to undertake more than eight hours' work. Further, as stated in paragraph 6.35 above, the notion of employees standing in readiness to perform work (but not actually performing any work at that time) is not a novel or unusual feature of the modern award system.

Fatigue concerns

6.42 The United Voice assert that "leaving one employee for long periods of time to deal with complex interpersonal matters is problematic".[64] The submission is not developed any further than that single sentence, and is unsupported by any evidence.

6.43 As previously stated, the clause requires employees to provide no more than 8 hours' care, and provides for the opportunity to sleep. Given the lack of further detail or evidence in support of the assertion, it should be given no weight and disregarded.

Conclusion

6.44 None of the matters complained of by the unions warrant the clause being deleted from the Award. That is a significant step which would have adverse implications for the elderly and disabled members of the community who receive care in their home under this clause.

6.45 The claim should be dismissed.

[63] UV Submission at [30]
[64] Ibid at [34]

7. UNITED VOICE CLAIM RELATING TO EXCURSIONS (S47)

The United Voice claim

7.1 The United Voice seek a variation to clause 25.9(a) to alter the way in which TOIL is calculated or accrued where employees agree to supervise clients in excursion activities involving overnight stays away from home during the week (i.e. between Monday and Friday).

7.2 Clause 25.9(a) currently provides that where employees undertake 'excursion' work during the week, they will be paid at the ordinary rate of pay for time worked between the hours of 8.00am and 6.00pm up to a maximum of 10 hours per day, and that the employer and employee may agree to accrual of time instead of overtime payment for all other hours.

7.3 The United Voice propose that where an employer and employee agree to TOIL instead of overtime, the time accrued will be calculated at the overtime rate. By that we understand that the intention is that where TOIL is agreed, an employee would be required to be given the equivalent amount of time off work based on the applicable rate of pay that would have otherwise been payable (i.e. the employee would take 1.5 hours or 2 hours off work for each hour of overtime worked, depending on the overtime rate that would have applied). This is described as the 'time for penalty' approach, rather than the 'time for time' approach.

7.4 The United Voice also propose a consequential amendment to clause 25.7, which is uncontroversial if their claim in respect of clause 25.9 was to be successful.

7.5 In support of the claim, the United Voice assert that the existing clause is ambiguous as to whether the accrual of time would be equivalent to the normal hourly rate or the overtime rate.[65] Further, they submit that:

(a) unless their variation (or interpretation) was to be accepted, the clause would not meet the modern awards objective as employees would not be compensated for working overtime;[66]

(b) it is unfair for the Award to provide for TOIL on an 'hour for hour' basis, as the arrangement does not reflect the "true value of the work";[67] and

[65] United Voice Submission at [44]
[66] Ibid at [45]
[67] Ibid at [46]

(c) the clause "allows employers to apply pressure" on employees to accept accrual of time at an 'hour for hour' rate instead of paying overtime, given the "power imbalance" that exists between employer and employee.[68]

7.6 We address each of these contentions as follows.

Alleged ambiguity of the clause

7.7 Contrary to the United Voice assertion, there is no ambiguity in the existing clause as to the 'rate' of accrual of TOIL.

7.8 Having regard to the principles as to the proper interpretation of industrial instruments[69], it should be uncontroversial that the TOIL process in clause 25.9 operates on a 'time for time' basis. That has been the prevailing or default position since the *Family Leave Test Case*[70] in 1994, and so if the drafters of the Award intended for a different approach to be taken, they would have explicitly stated that.

7.9 Further, the main TOIL provision in the Award, clause 28.2, expressly states at clause 28.2(c) that the period of time off that an employee is entitled to take is the same as the number of overtime hours worked. Given that express provision, certainly the framers of the Award would have expressly specified in clause 25.9 if a different arrangement was intended to apply.

7.10 Lastly, it should be noted that the current Award position regarding the rate of TOIL reflects the position in two of the main pre-reform awards upon which the modern award was based, namely the *Social and Community Services (ACT) Award 2001* and the *Social and Community Services (State) Award* (NSW).

7.11 For the reasons outlined above, there is no substance to the United Voice claim that clause 25.9 is ambiguous. However, and in any event, to the extent that the Commission was minded to make the clause abundantly clear, our clients would not oppose the insertion of wording in clause 25.9 to specify that TOIL is to be taken on a 'time for time' basis.

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[68] United Voice Submission at [46]

[69] See for example *Automotive, Food, Metals, Engineering, Printing and Kindred Industries Union' known as the Australian Manufacturing Workers Union (AMWU) v Berri Pty Limited* [2017] FWCFB 3005

[70] *Family Leave Test Case - November 1994* (1994) 57 IR 121; *Family Leave Test Case, Supplementary Decision* (1995) AILR 3-060

Response to other submissions

7.12 As to the other matters raised by the United Voice as summarised in paragraph 7.5 above, we respond as follows.

7.13 In response to paragraph (a), that assertion must be rejected. Contrary to the United Voice submission, the existing clause and Award *does* compensate employees for working overtime. The only circumstance where an employee would not receive overtime payments is where the employee has elected to take TOIL in lieu of the overtime payment.

7.14 In respect of paragraph (b), the Award as presently constructed ultimately allows individual employees to determine how they wish to "value" the work they have performed: they can choose to be paid at overtime rates, which is the default position, or they can reach agreement with their employer to take TOIL. That "value" judgement is something that individual employees will assess differently and make their own individual decisions about.

7.15 In respect of paragraph (c), the suggestion that employers are able to "apply pressure" on employees to take TOIL rather than receive overtime payments is unsupported by any evidence at all, and should be disregarded.

The Award Flexibility decisions

7.16 The United Voice have conveniently ignored the various Full Bench decisions in the common issues Award Flexibility proceedings, which recently considered in detail the issue of TOIL in the modern award system.

7.17 In those proceedings, the Commission considered a number of claims to vary certain modern awards in respect of make up time and TOIL. In the July 2015 decision[71], the Full Bench expressed certain provisional views about the type of model TOIL term to be inserted into 113 modern awards, of which the SCHCDS Award was one.

7.18 Relevant to the issue of the 'rate' of TOIL, the Full Bench held at [255]:

> *We have had regard to these contextual differences in our consideration of the Family Leave Test Case. Despite the differences in the statutory framework we have concluded that some aspects of the Family Leave Test Case TOIL provision retain their cogency in the current statutory context. <u>In particular, we see no reason to depart from the test case standard regarding the calculation of time for the purpose</u>*

[71] [2015] FWCFB 4466

> *of TOIL, that is at the ordinary rate (i.e. time for time) rather than the overtime rate (i.e. time for penalty).* [emphasis added]

7.19 The Full Bench then outlined a provisional model term which included the following:

> *Overtime taken as time off during ordinary time hours shall be taken at the ordinary time rate; that is, an hour for each hour worked.*[72]

7.20 A subsequent Full Bench decision of 8 July 2016 then affirmed the provisional view that the model TOIL term should provide for TOIL on a 'time for time' basis.[73]

7.21 The decisions of the Full Bench in the Award Flexibility proceedings are centrally relevant to the current United Voice claim here, and only serve to reinforce that the United Voice claim should be dismissed.

7.22 The United Voice have failed to articulate any basis for the Commission departing from the decisions of the Award Flexibility Full Bench.

[72] Ibid at [267]
[73] [2016] FWCFB 4258

8. ASU CLAIM RELATING TO COMMUNITY LANGUAGE ALLOWANCE (S6)

The ASU claim

8.1 The ASU seek the introduction of an allowance titled "Community Language and Signing Work" into clause 20 of the Award.

8.2 Under the proposed clause, employees using a community language in addition to their normal duties to provide services to persons who speak other languages or those with hearing difficulties, will receive an allowance.

8.3 The quantum of the allowance will be determined by how often an employee uses the community language skill. If an employee uses the language occasionally to meet demands, they will be paid $45.00 per week. If an employee provides regular assistance with their community language, they will be entitled to $68.00 per week.

8.4 The proposed clause is set out in full below:

20.10 Community Language and Signing Work

20.10.1 Employees using a community language skill as an adjunct to their normal duties to provide services to speakers of a language other than English, or to provide signing services to those with hearing difficulties, shall be paid an allowance in addition to their weekly rate of pay.

20.10.2 A base level allowance shall be paid to staff members who language skills are required to meet occasional demands for one-to-one language assistance. Occasional demand means that there is no regular pattern of demand that necessitates the use of the staff members language skills. The base level rate shall be paid as a weekly all purposes allowance of $45.00.

20.10.3 The higher level allowance is paid to staff members who use their language skills for one-to-one language assistance on a regular basis according to when the skills are used. The higher level rate shall be paid as a weekly all purposes allowance of $68.00.

20.10.4 Such work involves an employee acting as a first point of contact for non-English speaking service users or service users with hearing difficulty. The employee identifies the resident's area of inquiry and provides basic assistance, which may include face-to-face discussion and/or telephone inquiry.

20.10.5 *Such employees convey straightforward information relating to services provided by the employer, to the best of their ability. They do not replace or substitute for the role of a professional interpreter or translator.*

20.10.6 *Such employees shall record their use of community language skills.*

20.10.7 *Where an employee is required by the employer to use community language skills in the performance of their duties*

a) *the employer shall provide the employee with accreditation from a language/signing aide agency*

b) *The employee shall be prepared to be identified as possessing the additional skill(s)*

c) *The employee shall be available to use the additional skill(s) as required by the employer.*

20.10.8 *The amounts at 2.10.2 and 2.10.3 will be adjusted in accordance with increases in expense related allowances as determined by the Fair Work Commission.*

8.5 By way of summary, the grounds relied upon by the ASU in support of this variation consist of the following:

(a) an assertion that the ability to communicate in more than one language is a skill that is highly sought after in potential employees in the social and community sector; [74]

(b) a submission that the use of language skills is not contemplated by the classifications in the Award and therefore not taken into account for the purposes of the base rates of pay; [75]

(c) an assertion that the value of bilingual workers in the community sector is recognised as providing a superior professional service to clients;[76] and

(d) an assertion that community organisations make extensive use of professional interpreters and translators to assist people who find themselves unable to communicate effectively with essential community services.[77]

[74] ASU Submission at [39]
[75] ASU Submission at [39]
[76] ASU Submission at [42]
[77] ASU Submission at [43]

Response to the claim

Preliminary issue

8.6 As a threshold issue, in order for the claim to succeed, the Commission must be satisfied that the existing wage structure does not already contemplate employees exercising a 'community language skill'.[78]

8.7 While it is accepted that the current classification structures in the Award do not explicitly refer to "language" skills or proficiency, that fact does not establish that the Award classifications and rates of pay do not take into account these capabilities. The capabilities which are the subject of the application (i.e. an ability to speak a language other than English) are not new capabilities, and may indeed have been taken into account in the determination of wages in the industry. Certainly, the evidence falls short of establishing that there has been some proliferation of the requirement to use these skills in the industry.

8.8 To the extent that the above threshold issue can be satisfied, the claim for a new allowance essentially involves the proposition that employees should be compensated for being required to utilise a particular skill that is not otherwise compensated for in the Award.

8.9 Although s 156(3) does not apply to this claim, the principles applicable to such claims are relevant here as guiding principles. In the present case, there is no explanation as to how the ASU have reached the quantum of the allowances sought, nor sufficient evidence that would allow the Commission to make a proper assessment as to the value of the "skill".

Merit basis for variation

8.10 Turning to the general rationale for the variation, it is not disputed that *certain* employers will value the ability of an employee or prospective employee to speak a community language other than English. That is an uncontroversial proposition, and is not one that is unique to the SCHCDS industry.

8.11 Nor is it uncontroversial that employers will value a range of other competencies. Employers in the SCHCDS industry value a whole range of different life skills, experiences and attributes held by employees that may not be an inherent part of the particular role. For example, in the home care and disability sectors where personal care is provided to individuals, employers actively seek to match support workers with consumers who have shared experiences or interests.

[78] See s 139(1)(g)(ii) FW Act.

8.12 Employees in this sector demonstrate an ability to build rapport with consumers, and therefore become highly valued employees, in a range of different ways. These attributes make them more desirable employees in the sector. A community language skill is just one of a number of life skills that employees may possess.

8.13 For the Commission to insert the proposed allowance into the Award, it must be satisfied that the claim does not offend section 138. In our submission, the evidence before the Commission does not permit the Commission to reach that conclusion.

8.14 While there may be certain sections of the industry for which a community language is required to be used, we do not consider that the issue arises across the industry, or even in a large part of the industry. It strikes us that a community language allowance is something that is better left to be dealt with at the enterprise level, rather than on an industry basis.[79]

8.15 We turn now to some of the other issue that must be considered in the context of the ASU claim.

Ambiguity of the proposed variation

8.16 The proposed variation is unclear in a number of respects. For example:

(a) clause 20.10.1 introduces the term "community language skill" but does not define the term;

(b) the purpose and effect of the words "according to when the skills are used" in clause 20.10.3 are unclear;

(c) clause 20.10.4 commences by stating "Such work...", however it is not clear whether the "work" being referred to is the work contemplated by clause 20.10.3, 20.10.2 or 20.10.1;

(d) equally, clause 20.10.5 commences with "Such employees...", however it is not clear to which employees the clause is referring (i.e. does the clause refer to employees caught by clause 20.10.3, employees caught by clause 20.10.2, or is it a broader reference to clause 20.10.1?);

(e) it is not clear what the purposes of clauses 20.10.4 and 20.10.5 are. Are they intended to be definitions of "community language skill", or do they have some other purpose?; and

[79] See s 134(1)(b) of the FW Act.

(f) clause 20.10.1 is an operative provision imposing an obligation on employers to pay an allowance (see *"shall be paid"*), the quantum of which is referable to clauses 20.10.2 and 20.10.3. However, the clause does not state that an allowance is only payable where the employee is "required by their employer" to use the skill. The variation should not be made without such a precondition.

8.17 While some of the above issues may be able to be rectified, the proposed variation suffers from further issues which are less easily resolved.

8.18 First, the proposed allowance is expressed to apply to employees using a community language skill "as an adjunct to their normal duties". The term "adjunct" is defined as:

> *noun* 1. something added to another thing but not essentially a part of it.
>
> 2. a person joined to another in some duty or service; an assistant.
>
> 3. *Grammar* a modifying form, word, phrase, etc., depending on some other form, word, phrase, etc.
>
> 4. *Logic* a non-essential attribute.
>
> –*adjective* 5. joined to a thing or person, especially subordinately; associated; auxiliary.

8.19 The proposed variation would therefore require employers and employees to make an assessment as to whether a person's language skills are utilised as an "adjunct" to their normal duties, or whether it is used as a core part of their work. Such a distinction is likely to be difficult to draw in many cases.

8.20 Second, there is then a lack of clarity as to which allowance is payable. The language in clauses 20.10.2 and 20.10.3 requires an assessment as to the frequency of use (i.e. whether there is "no regular pattern" of use or whether the usage is on a "regular basis").

8.21 Third, there is also a lack of clarity as to when the allowance is payable, or how it is to be calculated. For example, if an employee is, from the commencement of their employment, required to *occasionally* use a community language skill as an adjunct to their normal duties, is the obligation to pay the allowance triggered immediately and payable on an ongoing basis given that there is some expectation that in the future they may need to use their language on an occasional basis? Or is the allowance only payable in respect of pay periods where the skill is actually utilised? Does the clause require employers to make that assessment at the conclusion of each pay period? If so, over what period is the assessment made?

8.22 Fourth, what happens when the level of usage fluctuates over time between occasional and regular? How often must a review and assessment be made?

Accreditation

8.23 The proposed variation should properly include a requirement for employees to have their community language skill accredited by an appropriate body as a precondition of receiving the allowance. However, as currently drafted, the proposed variation does not do this.

8.24 Clause 20.10.7(a) does not operate as a precondition to the obligation to pay at clauses 20.10.1, 20.10.2 and 20.10.3.

8.25 Further, clause 20.10.7(a) imposes an obligation on employers to "provide the employee" with accreditation if their purported skill is required. There is no sound basis for the burden of accreditation to be placed on employers. It should operate as a precondition of payment, but should be something that is obtained by the relevant employee. For example, it would be unfair for employers to incur costs in respect of sending an employee to obtain accreditation for a skill in circumstances where an employee has represented that they have a certain language proficiency for which the employer is not in a position to assess. The claim does not meet the modern awards objective in that respect.

Implications of the ASU claim

Cost to employers

8.26 Given that the ASU claim proposes to insert a new monetary entitlement in the form of an allowance payable in certain circumstances, the variation will undoubtedly have an adverse impact on employment costs for a number of employers.[80] The extent of the cost imposition cannot be measured, given the lack of evidence before the Commission as to the number of employees who possess community language skills, the proportion of those who use them as an adjunct to their role, and how frequently the skill is used (or required to be used).

8.27 It would also involve an up-front cost in respect of having to cover the costs of employee accreditation.

Administrative burden

8.28 The proposed variation, if properly understood, creates a significant administrative burden on employers. This burden arises from the need to maintain a new suite of records regarding the language proficiency of certain employees and their usage of that language skill.

[80] Fair Work Act 2009 (Cth), s.134(1)(f)

8.29 It will also impose administrative complexity in processing the proposed allowance. As stated at paragraph 8.21 above, it is unclear how the payment obligation is to be determined or paid.

Conclusion

8.30 The claim is inconsistent with section 138 and should be dismissed.

9. UNITED VOICE CLAIM RELATING TO PUBLIC HOLIDAYS (S57)

The United Voice claim

9.1 The United Voice seek the introduction of a new clause, to be numbered clause 34.2(c), that would prohibit employers altering rosters for the purpose of avoiding public holiday entitlements under the Award or the NES.

9.2 The argument advanced by the United Voice in support of this variation is a bald assertion, unsupported by evidence, to the effect that "there are some employers who are altering the rosters of part-time employees to avoid the payment of public holiday rates".[81]

Response to United Voice claim

9.3 The claim is a novel one.

9.4 Contrary to the generic assertion proffered by the United Voice, the Award as presently formulated does not permit an employer to alter a part-time employee's roster at a whim. Rather, the Award contains numerous conditions on such an exercise, including:

(a) chiefly, the requirement at clause 10.3(c) that employers reach agreement in writing with part-time employees on a set pattern of work, which can then only be varied by agreement with the individual employee (and recorded in writing);

(b) second, employers must provide 7 days' notice of roster changes in accordance with clause 25.5(d), subject to certain exceptions; and

(c) third, the consultation obligations at clause 8A would apply.

9.5 The effect of clause 10.3(c) is that an employer could not lawfully engage in the practice complained of unless the employee agrees to the variation (which must be recording in writing in accordance with clause 10.3(e)), and the other applicable provisions of the Award are satisfied.

9.6 This claim should be dismissed.

[81] United Voice Submission at [166]

10. HSU CLAIM TO VARY RATES OF PAY FOR CASUALS ON WEEKENDS AND PUBLIC HOLIDAYS (S13 AND S48)

The HSU claim

10.1 The HSU seek to increase the rates of pay payable to casual employees when working on weekends and public holidays.

10.2 They seek to do this by having the Award varied to provide that the casual loading is payable in addition to the penalty rates provided for in clauses 26 and 34.2.

10.3 The relevant current Award provisions are set out below:

> ***26. Saturday and Sunday work***
>
> *Employees whose ordinary working hours include work on a Saturday and/or Sunday will be paid for ordinary hours worked between midnight on Friday and midnight on Saturday at the rate of time and a half, and for ordinary hours worked between midnight on Saturday and midnight on Sunday at the rate of double time. These extra rates will be in substitution for and not cumulative upon the shift premiums prescribed in clause 29—Shiftwork and the casual loading prescribed in clause 10.4(b), and are not applicable to overtime hours worked on a Saturday or a Sunday.*
>
> *...*
>
> ***34.2 Payment for working on a public holiday***
>
> *(a) An employee required to work on a public holiday will be paid double time and a half of their ordinary rate of pay for all time worked.*
>
> *(b) Payments under this clause are instead of any additional rate for shift or weekend work which would otherwise be payable had the shift not been a public holiday.*

10.4 The bases for the proposed variations consist of the following contentions:

(a) a general assertion that the casual loading should be paid in addition to any overtime, weekend and/or public holiday penalty, given the function of the casual loading;[82]

(b) a submission that the proposed variation is consistent with the 'default approach' discussed by the Full Bench in the *Penalty Rates Decision*;[83] and

[82] HSU Submission at [48]

(c) a submission to the effect that it is unfair for other penalties to operate to subsume the casual loading.[84]

10.5 We address these two proposed variations as follows.

Threshold issue – work value considerations

10.6 There is a threshold question as to whether s 156(3) applies to this claim.

10.7 Section 135 of the FW Act relevantly provides that:

(1) Modern award minimum wages cannot be varied under this Part except as follows:

(a) modern award minimum wages can be varied if the FWC is satisfied that the variation is justified by work value reasons (see subsections 156(3) and 157(2));

10.8 Section 156(3) provides:

In a 4 yearly review of modern awards, the FWC may make a determination varying modern award minimum wages only if the FWC is satisfied that the variation of modern award minimum wages is justified by work value reasons. [emphasis added]

10.9 Section 284(3) provides the definition for 'modern award minimum wages', which is expressed as follows:

(3) Modern award minimum wages are the rates of minimum wages in modern awards, including:

(a) wage rates for junior employees, employees to whom training arrangements apply and employees with a disability; and

(b) casual loadings; and

(c) piece rates. [emphasis added]

10.10 Given that the effect of the HSU claim would be to increase the amount payable to casual employees when working on weekends and public holidays, there is a reasonable basis to conclude that the claim represents a proposal to vary "modern award minimum wages". On the basis, the claim can only succeed if it is justified by "work value reasons".

10.11 The HSU have failed to meet the requirements of s 156(3).

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[83] HSU Submission at [48]
[84] Ibid at [52]

Background to clause 26 of the Award and previous decisions

10.12 In putting their position, the HSU conveniently ignore the relevant historical background to clause 26 of the Award and the previous decisions (including a Full Bench decision) which involved a detailed consideration of the rationale for the current Award position.

10.13 The issue of rates of pay for casuals on weekends has been considered in detail by the Commission on at least two occasions since the Award was made:

(a) Firstly, by VP Watson in the course of the 2 yearly review of the Award;[85] and

(b) Secondly, by a Full Bench of the Commission in the context of an appeal against the decision of VP Watson.[86]

10.14 The relevant background to this matter is set out as follows.

10.15 When the Award was first made on 4 December 2009, clause 26 provided that:

> *26. Saturday and Sunday work*
>
> *26.1 Employees whose ordinary working hours include work on a Saturday and/or Sunday, will be paid for ordinary hours worked between midnight on Friday and midnight on Saturday at the rate of time and a half, and for ordinary hours worked between midnight on Saturday and midnight on Sunday at the rate of double time. These extra rates will be in substitution for and not cumulative upon the shift premiums prescribed in clause 29—Shiftwork.*
>
> *26.2 Casual employees who work less than 38 hours per week will not be entitled to payment in addition to any casual loading in respect of their employment between midnight on Friday and midnight on Sunday.*[87]

10.16 This clause remained unchanged until the transitional review of the Award. As part of the 2 yearly review of the Award, the ASU sought to delete clause 26.2, which would have had the effect of entitling casual employees to the same penalties as provided for full-time and part-time employees when working on weekends.

10.17 In a decision of 27 June 2013, VP Watson determined to vary clause 26 to provide for casual employees to receive the applicable weekend penalties in lieu of the casual loading when working on weekends (the **VP Watson Decision**).[88]

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[85] *Australian Municipal, Administrative, Clerical and Services Union* [2013] FWC 4141
[86] *Australian Municipal, Administrative, Clerical and Services Union* [2014] FWCFB 379
[87] See PR991066

10.18 In reaching the conclusion, VP Watson had regard to both the history of the provision and the approach taken by a Full Bench in modifying an identical provision in the *Aged Care Award 2010*.[89]

10.19 The ASU then appealed against the VP Watson Decision in respect of the findings in relation to, inter alia, the issue of weekend penalty rates for casual employees.

10.20 In the appeal decision[90] (the **Appeal Decision**), a Full Bench upheld the findings in of VP Watson in respect of the issue of weekend penalty rates for casual employees. In dismissing this aspect of the appeal, the Full Bench held:

> *[29] In paragraph [33] of the Decision, it is reasonably apparent that Vice President Watson intended that that casual employees should be entitled to the weekend penalty rates for ordinary time work specified in clause 26.1, but that consistent with the approach taken by the Full Bench in paragraph [59] of the Aged Care Award 2010 decision, those weekend penalty rates should be in substitution for and not in addition to the casual loading. This meant that his Honour intended that the total loading for casual employees should be increased from 25% to 50% for Saturdays and from 25% to 100% for Sundays.*
>
> *[30] We do not consider that the ASU has succeeded in demonstrating any error in his Honour's consideration of that part of its claim which concerned the working of ordinary hours by casual employees on weekends. Although in paragraphs [30]-[33] of the Decision his Honour did not make an explicit finding concerning the weight of regulation in pre-existing awards and instruments, we consider that it is implicit in his Honour's reference to and reliance upon the approach taken in the Aged Care Award 2010 decision that he recognised the weight of the pre-existing position but considered that the increase in the casual loading should be regarded as an offsetting factor.*
>
> *[31] We accept that the ASU was able to demonstrate convincingly that the predominant position in the pre-existing awards and instruments was that casual employees were entitled to penalty rates for working ordinary hours on weekends of the same quantum as those applying to full-time and part-time employees in addition to payment of a casual loading. To the extent that the respondents took*

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[88] *Australian Municipal, Administrative, Clerical and Services Union* [2013] FWC 4141 at [31]-[33]
[89] Ibid at [33]
[90] *Australian Municipal, Administrative, Clerical and Services Union* [2014] FWCFB 379

issue with the ASU's analysis in this respect, it was largely at the margins and did not serve to alter the main conclusion to be drawn from the analysis. However, it is equally clear that as a result of the adoption of a standard 25% loading for casual employees in modern awards, a large majority of casual employees will upon the completion of the operation of the SCHCDS Award's transitional provisions have received an increase in their casual loading. In the majority of pre-existing awards and instruments, the casual loading had been 20% or less, so that many casual employees will receive a reasonably substantial increase in their ordinary rate of pay (leaving aside weekend penalties) under the SCHCDS Award. In rectifying the omission of weekend penalty rates, we consider that it was open to Vice President Watson, as it was to the Full Bench in the Aged Care Award 2010 decision, to take that matter into account and to award weekend penalty rates that operated to the exclusion of the casual loading. We do not consider that in taking this course, his Honour fell into error in any of the respects identified in paragraph 2.3 of the ASU's appeal notice. [emphasis added]

10.21 The above passage discloses a sound rationale for the current Award position. That is, the introduction of the Award effectively led to an increase to the quantum of the casual loading for many casual employees, and so that fact was quite properly taken into account in determining the appropriate level of remuneration to be payable to casual employees when working on weekends.

10.22 Other than pointing to the observations of the Full Bench in the Penalty Rates decision as to the 'default approach' to determining penalty rates for casual employees and asking the Commission to adopt that approach, the HSU have failed to recognise or engage with the particular factors that were unique to the SCHCDS industry and which led the Commission to set the current entitlements for casuals working on weekends in the way that they did.

10.23 The HSU have not advanced any persuasive argument that would warrant the Commission revisiting or departing from the conclusion of the Full Bench in the Appeal Decision.

Public holiday entitlements

10.24 While the issue of public holiday rates of pay for casual employees was not the subject of consideration by VP Watson during the 2 yearly review, the observations of the Full Bench in the Appeal Decision are equally applicable. That is, introduction of the Award resulted in an increase to the quantum of the casual loading for many casual employees. Accordingly, we submit that, consistent with the decision of VP Watson as affirmed by the Full Bench in the

Appeal Decision, that fact is relevant and should be taken into account when considering the HSU claim for a further increase to amounts payable to casual employees when working on public holidays. The HSU proposal should not be adopted without a proper consideration and assessment of this background.

Conclusion

10.25 The HSU claims should be dismissed.

11. UNITED VOICE CLAIM RELATING TO OVERTIME RATES FOR CASUALS (S51)

The claim

11.1 The United Voice seek a variation to clause 28.1(b)(iv) of the Award to provide that casual employees are entitled to the casual loading when working overtime.

11.2 The current clause provides:

> *(iv) Overtime rates payable under this clause will be in substitution for and not cumulative upon:*
>
> *(A) the shift premiums prescribed in clause 29—Shiftwork; and*
>
> *(B) the casual loading prescribed in clause 10.4(b),*
>
> *and are not applicable to ordinary hours worked on a Saturday or a Sunday.*

11.3 The United Voice seek to remove clause 28.1(b)(iv)(B) such that clause 28.1(b)(iv) will be read as follows:

> *(iv) Overtime rates payable under this clause will be substitution for and not cumulative upon the shift premiums prescribed in clause 29 - Shiftwork and are not applicable to ordinary hours worked on a Saturday or a Sunday.*

11.4 The rationale for the claim is an assertion that casual employees do not receive an amount in respect of casual loading when working overtime.

11.5 The United Voice assert that the 'default approach', as referenced in the *Penalty Rates Decision*, should be adopted unless there is some 'cogent industry or sector specific reason'.[91] The United Voice relies on passages from the Penalty Rates Decision in support of this claim, and argue that the casual loading and overtime rates serve different functions and so should therefore both be payable.

Threshold issue – work value considerations

11.6 There is a threshold question as to whether s 156(3) applies to this claim. The submissions contained in paragraphs 10.6-10.11 above are equally applicable to this claim.

11.7 Given that the effect of the HSU claim would be to increase the amount payable to casual employees when working overtime, there is a reasonable basis to conclude that the claim represents a proposal to vary "modern award minimum wages". On the basis, the claim can only succeed if it is justified by work value reasons.

[91] United Voice Submission at [164]

11.8 The United Voice have failed to meet the requirements of s 156(3).

Background to clause 28.1(b) of the Award and previous Full Bench decision

11.9 The UV submission does not address the relevant historical background to clause 28.1 of the Award. Notably, this issue (and this exact claim) was previously the subject of an unsuccessful application to vary the Award by the ASU during the 2 yearly review of the Award.

11.10 We outline some of the relevant background to this claim as follows.

11.11 When the Award was first made, it did not contain any overtime entitlement for casual employees.[92]

11.12 During the 2 yearly review of the Award, the ASU made an application to vary the Award to provide for casual employees to receive overtime payments, which were sought to be payable in addition to the casual loading.

11.13 The application was one of a number that was dealt with by VP Watson, the findings of which are contained in his decision of 27 June 2013 (described above as the **VP Watson Decision**). In that first instance decision, VP Watson declined the application.[93]

11.14 The ASU subsequently appealed this aspect of the VP Watson decision.

11.15 On appeal, the Full Bench overturned the aspect of the VP Watson Decision dealing with overtime entitlements for casuals[94], and then re-determined the claim.

11.16 The Full Bench concluded that the absence of overtime provisions applicable to casual employees in the Award was an "oversight"[95], and observed that there was no sound rationale for casual employees being excluded from overtime penalty rates in circumstances where they apply to full-time and part-time employees.

11.17 Turning then to the specific variation to be made, the Full Bench determined that the overtime entitlements for casual employees should be in substitution for the payment of the casual loading.[96] In reaching that conclusion, the Bench took into account:

(a) the "somewhat mixed" position which applied in the pre-existing awards and instruments in respect of the overtime rates payable;[97] and

[92] See clause 28.1 of Award as made on 4 December 2009
[93] *Application by Australian Municipal, Administrative, Clerical and Services Union* [2013] FWC 4141 at [34]-[36]
[94] Ibid at [36]
[95] Ibid at [38]
[96] Ibid at [44]

(b) that the provision of overtime penalty rates for casual employees, even without the addition of the casual loading, will be a significant benefit for those casuals who work overtime, and will equalise the overtime cost of full-time, part-time and casual employees.

11.18 The Bench then specifically noted that their decision did not intend to foreclose further consideration in the four yearly review process as to whether, under the SCHCDS Award, the casual loading should be payable in addition to weekend and overtime penalty rates.[98]

Response to the United Voice's submissions

11.19 As outlined above, a Full Bench of the Commission has already considered and determined the manner in which overtime rates are to be payable to casual employees. Accordingly, as a starting point the Commission should not depart from that previous Full Bench decision unless there are cogent reasons for doing so.

11.20 That said, it is acknowledged that the Full Bench, when determining that overtime rates for casual employees should be in substitution of the casual loading, also expressly referred to the potential for further consideration of the issue during the 4 yearly review of the Award. In that context, it is acknowledged that the principle of the Commission generally following previous Full Bench decisions unless there are cogent reasons for not doing so, must be viewed in that light.

11.21 Again, we submit that the Commission should take into account the observations of the Full Bench in the Appeal Decision to the effect that the making of the Award resulted in an increase to the quantum of the casual loading for many casual employees. In our submission, that provides a basis for the Commission not applying the 'default' position as referred to in the *Penalty Rates Decision*.

Conclusion

11.22 The United Voice claim should be dismissed.

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[97] Ibid at [42]
[98] Ibid at [45]

12. HSU CLAIM RELATING TO FIRST AID CERTIFICATION

The HSU claim

12.1 Clause 20.4 of the Award currently provides for payment of a first aid allowance to full-time, part-time and casual employees where they:

(a) are required by the employer to hold a current first aid certificate; and

(b) are required to perform first aid at their workplace or, in the case of home care employees, are required to be responsible for the provision of first aid to employees employed by the employer.

12.2 The quantum of the first aid allowance is currently:

(a) $16.03 per week for full-time employees; or

(b) a pro rata amount of the above for part-time and casual employees based on their ordinary weekly hours of work.

12.3 The HSU seek the introduction of a new and further entitlement in respect of the costs and time associated with an employee maintaining a first aid certification. Specifically, they seek the insertion of the following provision to supplement the existing clause 20.4:

First aid refresher

(i) Where an employee is required to maintain first aid certification, the employer will pay the full cost of the employee updating their first aid certification by:

a. reimbursing the employee's registration and attendance expenses; or

b. paying the registration and attendance costs.

(ii) Attendance at first aid refresher courses will be work time and paid as such.

12.4 In support of this variation, the HSU submit that:

(a) many employees engaged in disability support or home care roles are required to hold a current first aid certificate in the performance of their roles;[99]

(b) even where the employer does not require an employee to possess first aid certification, the qualification is likely to be beneficial for the employer; and

[99] HSU Submission at [63]

(c) where an employee is required to maintain their first aid certification, they should be entitled to be reimbursed for the costs of maintaining that certification.

12.5 In considering these submissions, it is necessary to first consider the history of the existing first aid allowance clause, the scope of its operation and the rationale for the current provision.

History of the clause

12.6 The first aid allowance clause has undergone a couple of variations since the Award was first introduced.

12.7 Initially, when the Award was first made the clause read as follows:

> *19.4 First aid allowance*
>
> *An employee who holds a current first aid certificate issued by St John Ambulance or Australian Red Cross Society or equivalent qualification, and who is required by their employer to perform first aid duty at their workplace, will be paid an allowance of 1.67% of the standard rate per week.*

12.8 However, three applications were subsequently made in 2010 which sought to vary the clause.[100] Those applications were dealt with together by VP Watson. In broad terms, the applications raised two issues:

(a) Firstly, that the clause contained an ambiguity or error in respect of home care employees, given that:

(i) the phrase "at their workplace" created ambiguity in relation to employees in the home care stream, given the nature of the work;

(ii) the intent of the clause was to apply to situations where employees were required to provide first aid to fellow employees (rather than to customers or clients);

(iii) the pre-reform awards covering home care employees did not provide entitlements to a first aid allowance; and

(iv) a first aid certificate is an inherent requirement for the role of a home care employee, is part of the certificate III qualification, and so is already contemplated as part of the classification structure; and

[100] Matters AM2010/77, AM2010/109, AM2010/112

(b) secondly, that the clause did not deal with the issue of pro rata entitlements for part-time and casual employees.[101]

12.9 On 3 August 2010, VP Watson held that the clause contained ambiguities in respect of the two issues referred to above, and indicated that he was inclined to grant the applications and adopt the wording sought by VECCI, however directed the parties to confer in relation to the precise terms of the variation to be made.

12.10 After hearing further form the parties on 21 September 2010 and considering two alternative formulations, VP Watson decided to make the variation in the terms proposed by VECCI.[102]

12.11 The subsequent Determination varied the clause so as to read:

19.4 First aid allowance

(a) First aid allowance—full-time employees

A weekly first aid allowance of 1.67% of the standard rate per week will be paid to a full-time employee where:

(i) an employee is required by the employer to hold a current first aid certificate; and

(ii) an employee is required by the employer to be, in a given week, responsible for the provision of first aid to employees employed by the employer.

(b) First aid allowance—casual and part-time employees

The first aid allowance is payable at 1/38th of the full-time allowance per hour for part-time and casual employees where:

(i) an employee is required by the employer to hold a current first aid certificate; and

(ii) an employee is required by the employer to be responsible for the provision of first aid to employees employed by the employer.[103]

12.12 The decision of VP Watson was then the subject of an appeal brought by the ASU.

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[101] See Transcript of AM2010/77, AM2010/109, AM2010/112, 3 August 2010
[102] Transcript of AM2010/77, AM2010/109, AM2010/112, 21 September 2010 at [94]-[95]
[103] See PR500495

12.13 In the appeal proceedings, the parties were encouraged by the Full Bench to have discussions to endeavour to resolve the issues between them regarding the clause, and this led to a consent position being reached regarding an award variation which resolved the various parties' concerns with the clause.

12.14 In light of that agreed position, on 23 December 2010 the Full Bench allowed the appeal by consent, set aside the variation made on 21 September 2010, and varied the Award to include the first aid provision as agreed between the parties.[104]

12.15 The clause read as follows:

(a) First aid allowance - full - time employees

A weekly first aid allowance of 1.67% of the standard rate per week will be paid to a full-time employee where:

(i) an employee is required by the employer to hold a current first aid certificate; and

(ii) an employee, other than a home care employee, is required by their employer to perform first aid at their workplace; or

(iii) a home care employee is required by the employer to be, in a given week, responsible for the provision of first aid to employees employed by the employer.

(b) First aid allowance - casual and part - time employees

The first aid allowance in 19.4(a) will apply to eligible part time and casual employees on a pro rata basis on the basis that the ordinary weekly hours of work for full - time employees are 38.

Rationale for the current Award position

12.16 A number of observations can be made from the above background to the current first aid allowance entitlement.

12.17 Firstly, the clear intent of the existing first aid allowance at clause 20.4 is that it applies only to those employees who are designated as first aid officers in a particular workplace and who may be called on to render first aid to colleagues in the event of an illness or injury. The allowance does not apply to employees who might be required to hold a certification as

[104] See [2010] FWAFB 9880.

an inherent requirement for their position or where the role might involve rendering first aid assistance to a client (e.g. support workers in the home care and disability services streams).

12.18 Secondly, the rationale for the Award not providing first aid allowance entitlements to employees who provide support and care to clients (e.g. home care and disability services employees) is due to the very nature of the work undertaken by those employees.

12.19 This rationale is sound, and was ventilated during the hearing before VP Watson, as demonstrated by the following exchange between the Vice President and Mr Nucifora for the ASU on 21 September 2010 at PN36-PN42:

> *THE VICE PRESIDENT: Just about every one of the employees would be required to perform first aid if there's someone injured in a basic sense, because the clients are incapable of administering basic first aid to themselves.*
>
> *MR NUCIFORA: Yes, your Honour, and we would say that there is no recognition in the classification structure for first aid qualifications. It is - - -*
>
> *THE VICE PRESIDENT: Isn't it inherent in the nature of the work and the nature of the certificates they hold at various levels? I haven't looked at the detail of the certificate courses that employees in this sector commonly hold. They are quite skilled in dealing with everything that's required for the care of their clients.*
>
> *MR NUCIFORA: I was just distinguishing them from, say, the Nurses Award and those that provide medical attention.*
>
> *THE VICE PRESIDENT: Yes, and for example the house with those suffering epilepsy, a lot of those employees are former nurses that have come from an institution where the services are provided to a house in the community but they are - they have nursing experience and, to a point, qualifications.*
>
> *MR NUCIFORA: We would suggest, your Honour, that it might have been an issue that was dealt with at the review, and that certainly there'd be discussions between the parties about how some of the new sectors that have been picked up by the modern award - because clearly it didn't come up or we're not aware that it came up under the previous underpinning awards, and I'm talking about the SACS awards in particular, but there certainly was a practice where they were required to provide first aid to service users outside the traditional workplace.*
>
> *THE VICE PRESIDENT: Or even in their traditional workplace. The argument against you is that for many employees in this sector, it's part and parcel of their job to*

administer basic first aid, and to hold certain qualifications to perform those basic duties, and it is encompassed within the classification structure. That's the argument against you.

12.20 That is why the Award clause was varied in the manner it was by VP Watson at first instance and then through the consent position of the parties endorsed by the Full Bench on appeal.

Response to the HSU claim

12.21 For the same reasons that underpin the scope of the existing clause 20.4, the Award should not be varied to require employers to reimburse employees for maintaining their ability to perform the inherent requirements of their position.

12.22 The HSU claim is not limited to employees who fall within the scope of clause 20.4. Rather, the claim seeks to provide an entitlement to all employees who are required to maintain first aid certification, regardless of whether they are designated first aid officers at their workplace to provide first aid to their fellow employees.

12.23 That being the case, the claim will capture a huge number of employees in the industry, by reason of the very nature of the work undertaken by the vast majority of them.

12.24 The HSU claim should be dismissed for the following reasons:

(a) first, the proposed variation is inconsistent with the modern awards system;

(b) second, the proposed variation allows for employees with more than one job in the industry to receive reimbursement from multiple employers for the single cost; and

(c) third, if granted the variation will impose significant costs on employers in circumstances where (in many cases) the employer will not be able to pass the additional cost onto customers.

<u>Inconsistency with modern awards system</u>

12.25 The modern award system does not typically provide for allowances in respect of costs borne by employees in maintaining their ability to perform the inherent requirements of their position. To provide some relevant examples:

(a) the *Nurses Award 2010* does not require employers to reimburse employees for the costs associated with maintaining their registration with the Nursing and Midwifery Board of Australia;

(b) the *Health Professionals and Support Services Award 2010* does not require employers to reimburse employees for the costs associated with maintaining their registration with the relevant health profession Board;[105]

(c) neither the *Passenger Vehicle Transportation Award 2010*, nor the other two road transport industry awards[106], require employers to reimburse employees for the costs associated with maintaining the applicable heavy vehicle licences; and

(d) the *Legal Services Award 2010* does not require employers to reimburse certain employees for the costs associated with maintaining their professional certifications (e.g. practising certificates).

12.26 As another example, many Award-covered employees across the award system are required to hold and maintain a valid driver's license as a necessary (and inherent) requirement for their position, and yet modern awards do not contain allowances in respect of the costs incurred in holding and maintaining a driver's license. Many awards do of course provide a motor vehicle allowance in respect of employees required to use their vehicles in the course of their duties. However, that is a different proposition to compensating employees for the costs associated with holding and maintaining a driver's license in order to allow them to perform the inherent aspects of their role.

Potential for reimbursement from multiple employers

12.27 The evidence in these proceedings is that secondary employment within the industry (i.e. individuals holding more than one job in the industry with multiple employers) is not uncommon.[107]

12.28 As presently drafted, there would be nothing preventing an employee from claiming back the costs of first aid certification from multiple employers at the same time, and obtaining a windfall gain that is in excess of the costs incurred by the employee. A clause which allows for such practices or outcomes does not lead to the Award meeting the modern awards objective of providing a 'fair and relevant' minimum safety net.

12.29 Even if such a mechanism was to be inserted into the proposed clause preventing employees from claiming back the cost from multiple employers, there is still a question about which employer would be required to pay, and how that question would be determined.

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[105] See Australian Health Practitioner Regulation Agency

[106] The *Road Transport and Distribution Award 2010* and the *Road Transport (Long Distance Operations) Award 2010*

[107] Statement of Bernie Lobert at [1]; United Voice Submission at [133]

Cost implications for businesses

12.30 Lastly, the costs associated with this claim should not be underestimated. As stated above (and acknowledged by Vice President Watson in 2010), a very large number of employees in this industry are required, as an inherent requirement of their position, to hold a first aid certificate. The Award has never before contained a term requiring employers to cover those costs. For large employers in the industry, the costs would be significant.

12.31 Further, in many cases those costs will not be able to be passed onto customers, given the regulated nature of the industry, meaning that the variation will have a direct adverse impact on the viability of the industry.

Conclusion

12.32 For the reasons outlined above, the HSU claim should be dismissed.

12.33 In the alternative, to the extent that the Commission is minded to introduce a provision into the Award to require employers to reimburse employees for the time and cost associated with maintaining their first aid certification, such a clause should be limited to those employees to whom the existing clause 20.4 applies. That is, the clause should only apply to employees who are designated as first aid officers to provide first aid to fellow employees at their workplace.

13. CONCLUSION

13.1 For the reasons outlined in this submission, the claims should be dismissed.

AUSTRALIAN BUSINESS LAWYERS & ADVISORS

On behalf of Australian Business Industrial and the New South Wales Business Chamber Ltd

5 April 2019

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Fair Work Commission: 4 yearly Review of modern awards

SUBMISSION

4 YEARLY REVIEW OF MODERN AWARDS: (AM2018/26) SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010 - SUBSTANTIVE ISSUES

FILED ON BEHALF OF:

- **AUSTRALIAN BUSINESS INDUSTRIAL**
- **THE NSW BUSINESS CHAMBER LTD**
- **AGED & COMMUNITY SERVICES AUSTRALIA**
- **LEADING AGE SERVICES AUSTRALIA**

2 JULY 2019

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1. INTRODUCTION

1.1 This submission is made on behalf of:

(a) Australian Business Industrial (**ABI**);

(b) the New South Wales Business Chamber Ltd (**NSWBC**);

(c) Aged & Community Services Australia (**ACSA**); and

(d) Leading Age Services Australia Limited (**LASA**),

collectively, '**our clients**'.

1.2 ABI is a registered organisation under the *Fair Work (Registered Organisations) Act 2009* and has in excess of 4,000 members. ABI represents the interests of businesses in a variety of industries including the social, community, home care and disability services industry. Its primary role is to develop workplace policy and to shape debate on major workplace relations issues.

1.3 NSWBC is a recognised State registered association pursuant to Schedule 2 of the *Fair Work (Registered Organisation) Act 2009* and has some 18,000 members. NSWBC is the State's peak business organisation and represents all businesses from small enterprises to large corporations across a variety of industries including the social, community, home care and disability services industry.

1.4 ACSA is the leading peak body supporting church, charitable, other not-for-profit and government providers of residential care services, community care services and retirement living for older people in Australia.

1.5 LASA is the national peak body representing and supporting providers of age services across residential care, home care and retirement living. LASA's membership base is made up of private, not-for-profit, faith-based and government operated organisations providing care, support and services to older Australians.

1.6 This submission is filed in accordance with the Amended Directions of the Fair Work Commission (**Commission**) issued on 7 June 2019. This submission is made in support of the proposed variations advanced by our clients, as recorded in a Draft Determination filed on 2 April 2019 (**Draft Determination**).

1.7 By way of summary, our clients are seeking three categories of variations to the *Social, Community, Home Care and Disability Services Industry Award 2010* (the **Award**):

(a) a variation to clause 25.5(f) of the Award dealing with client cancellation, to extend the scope of the clause to all types of disability services, and to provide a more structured and balanced regime for employees working make-up time;

(b) a proposal to introduce a 'remote response' allowance to provide a fair and relevant compensation regime for employees performing remote response duties outside of their normal working hours; and

(c) a variation to clause 25 of the Award dealing with hours of work and rostering, to remove unnecessary prescription around when ordinary hour are to be worked, and to clarify when a roster may be altered under clause 25.5(d)(ii).

1.8 These submissions are supported by witness statement and other documentary evidence, as well as other material that has been filed in these proceedings which goes towards the nature of the operating environment in the industry.

2. LEGISLATIVE FRAMEWORK OF THE FOUR YEARLY REVIEW

2.1 The legislative framework applicable to the 4 Yearly Review has been considered in detail in *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 (**Preliminary Issues Decision**), and *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 (**Penalty Rates Decision**).

2.2 More recently, the legislative framework applicable to the 4 Yearly Review was considered in *4 yearly review of modern awards – plain language re-drafting – standard clauses* [2018] FWCFB 4177 issued on 18 July 2018[1] and summarised in *4 yearly review of modern awards – Alpine Resorts Award* [2018] FWCFB 4984.

2.3 We rely on the summary of the applicable legal principles as set out in the reply submissions filed by our clients in this matter on 5 April 2019.[2]

2.4 We also refer to, and agree with, the summary contained in the document titled 'Legislative framework relevant to the Review' published by the Commission in this matter on 12 April 2019.[3]

[1] [2018] FWCFB 4177 at [3]-[13].
[2] See [2.1]-[2.4].
[3] Published pursuant to a Statement issued on 12 April 2019 ([2019] FWCFB 2514).

3. OPERATING ENVIRONMENT IN WHICH THESE VARIATIONS ARE SOUGHT

3.1 There is considerable material before the Commission going to the challenges currently facing service providers in the industry and, in particular, the disability services and home care sectors.

3.2 Broadly speaking, the reforms in both the disability sector and the aged care / home care sectors have involved a deregulation of the markets through a move away from the traditional 'block funding' approach to a 'consumer-directed care' approach whereby individual consumers receive a tailored, individualised care plan (with individualised funding), under which consumers have a far greater ability to choose how care services are provided to them (including what, when, where, and by whom those services are provided).

3.3 These reforms are significant, with many describing the introduction of the National Disability Insurance Scheme for example as the most significant social policy reform in Australia since the introduction of Medicare.

3.4 The key features of the National Disability Insurance Scheme (the **NDIS**) and the similar reforms in the home care sector have been detailed in materials filed in the course of the review of this Award, including in:

(a) the Reply Submission filed by our clients on 5 April 2019;[4]

(b) the Reply Submission filed by Ai Group on 8 April 2019;[5]

(c) the Productivity Commission Position Paper 'National Disability Insurance Scheme (NDIS) Costs' published in June 2017;[6]

(d) the Productivity Commission Study Paper 'National Disability Insurance Scheme (NDIS) Costs' published in October 2017;[7]

(e) the 'Independent Pricing Review: National Disability Insurance Agency' Final Report published in February 2018 by McKinsey & Company;[8]

(f) the 'Australian Disability Workforce Report' published in February 2018 by National Disability Services;[9]

[4] At paragraphs 3.1-3.19.
[5] At pages 39-69.
[6] Filed by the ASU, 18 February 2019.
[7] Filed by the HSU, 15 February 2019.
[8] Filed by the HSU, 15 February 2019.
[9] Filed by the HSU, 15 February 2019.

(g) the 'State of the Disability Sector Report' published by National Disability Services in 2018;[10]

(h) the publication 'Australia's Welfare 2017', published by the Australian Institute of Health and Welfare;[11]

(i) the report 'Reasonable, necessary and valued: Pricing disability services for quality support and decent jobs', by the Social Policy Research Centre of the UNSW;[12] and

(j) the article 'Wage theft, underpayment and unpaid work in marketised social care', by Fiona Macdonald, Eleanor Bentham and Jenny Malone, The Economic and Labour Relations Review 2018, Vol. 29(1) 80–96.[13]

3.5 While these consumer-directed-care reforms are widely supported by all stakeholders (including by our clients and their respective memberships), their implementation has (perhaps unsurprisingly) caused significant uncertainty and disruption to the operations of service providers. One of the major areas of change for service providers (and one of the major challenges) has been in the area of workforce management and, in particular, rostering.

3.6 At the workplace level, the consumer-directed-care reforms have caused employers to lose a degree of control over the organisation of work, by reason of consumers having more control over the delivery of their services. This has led to the disaggregation of working patterns, and challenges around organising a series of discrete (and often short) customer engagements into a block of work for a particular employee. For example, service providers are required to coordinate three or four (or more) short customer engagements (e.g. 30 minute home care services) and turn it into a shift for an employee. This involves having regard to factors such as:

(a) the geographical location of the work (i.e. organising the work in an efficient manner having regard to the locations of the clients, while also trying to meet the clients' preferences around times of services);

(b) the timing of each of the separate customer services so the work can be done in an efficient manner so as to minimise the unproductive time and ensure a 'utilisation' rate that is viable; and

[10] Filed by the HSU, 15 February 2019.
[11] At pages 175-180 (in respect of home care/aged care) and pages 301-310 (in respect of the disability services sector).
[12] Filed by the HSU, 15 February 2019.
[13] Attachment 'FM2' to the Statement of Dr Fiona Macdonald, filed by the HSU on 15 February 2019.

(c) matching employees and clients based on factors such as client needs, employee capability, and also client preference.

3.7 This is particularly challenging in rural and remote areas where the demand is less consistent, the volumes are lower and distances between clients greater.

3.8 The above challenges around workforce flexibility have then been compounded by funding constraints, which have also been well publicised. Many of the reports referenced at paragraph 3.4 above detail the funding inadequacies in various areas of the system and the consequential pressures being felt by service providers. The reports referred to above have also been supplemented by other materials filed in these proceedings, including:

(a) The StewartBrown 'Aged Care Financial Performance; Survey Sector Report (2018 Financial Year)', published in 2018; and

(b) the StewartBrown 'Aged Care Financial Performance; Survey Sector Report (Six months ended December 2018', published in 2019.

3.9 Those publications were summarised at part 4 of our clients' Reply Submission of 5 April 2019.

3.10 The state of the operating environment, as outlined above, is critically relevant, at least contextually, to the Commission's review of the Award.

3.11 Our clients (and their memberships) support the proposition that the Award should provide a fair and relevant minimum safety net of terms and conditions. However, such terms must operate in harmony (or at the very least not in direct conflict) with the regulatory and funding environment.

3.12 It is in this context that our clients pursue the following variations to the Award.

4. PROPOSED VARIATION TO HOURS OF WORK AND ROSTERING CLAUSES

4.1 Our clients propose some relatively minor amendments to the hours of work and roster provisions in the Award. The proposed variations are designed to achieve the following:

(a) remove unnecessary prescription around the structuring of hours of work; and

(b) clarify the operation of clause 25.5(d)(ii).

Proposed variation to clause 25.1

4.2 Clause 25.1 sets out the ordinary hours of work. Under that clause, the ordinary hours of work are expressed to be 38 hours per week or an average of 38 hours per week.

4.3 Clause 25.1(a) then continues by prescribing how those ordinary hours are to be worked. It expressly prescribes that the hours "will be worked" in one of three different ways as set out in items (i), (ii) and (iii) of clause 25.1(a).

4.4 The effect of items (i), (ii) and (iii) of clause 25.1(a) is to require ordinary hours to be worked in a particular way. The main element of these clauses is to prohibit shifts exceeding 8 hours each.

4.5 However, when one considers clause 25.3 of the Award, it is unclear what other work items (i), (ii) and (iii) of clause 25.1(a) have to do.

4.6 This is because clause 25.3 provides that employees, other than casuals, will be free from duty for not less than two full days in each week or four full days in each fortnight or eight full days in each 28 day cycle.

4.7 Our clients propose a simplified clause 25.1, that retains all of the key elements of the existing provision, but which removes unnecessary and superfluous prescription which does not actually have any operative effect.

4.8 Our clients propose a new clause 25.1 in the following terms:

25.1 Ordinary hours of work

(a) The ordinary hours of work will be 38 hours per week or an average of 38 hours per week over the employee's roster period, up to a maximum of four weeks.

(b) Subject to clause 25.1(c), the maximum ordinary hours that can be worked per shift is 8.

(c) By agreement between an employer and an individual employee, ordinary hours may be worked up to 10 hours per shift.

4.9 This variation is more in the nature of a minor or technical variation rather than a substantive amendment. However, in our submission, the variation has the benefit of being simpler and easier to understand, without reducing employees' entitlements in any way.

Proposed variation to clause 25.4(a)

4.10 Equally, our clients propose the deletion of the words 'or period of work' in clause 25.4(a) as a minor and technical variation rather than any substantive amendment. The words "period of work" do not appear to have any work to do, and seem to be an unnecessary duplication of the concept of "shift". That phrase is not used throughout the rest of the Award, and is unnecessary as any "period of work" that falls outside the bounds of a "shift" is addressed separately in clause 28, which deals with rest breaks after overtime.

Proposed variation to clause 25.5(d)

4.11 Clause 25.5 deals with rostering for permanent employees. Under clause 25.5(a) ordinary hours of work of full-time and part-time employees are required to be displayed on a fortnightly roster which is to be posted at least two weeks before the commencement of the roster period.

4.12 Under clause 25.5(d), an employee's roster can only be changed in certain specified circumstances. Clause 25.5(d)(ii) provides that:

> However, a roster may be altered at any time to enable the service of the organisation to be carried on where another employee is absent from duty on account of illness, or in an emergency.

4.13 Our clients propose a relatively minor variation to clause 25.5(d)(ii) to:

(a) permit rosters to be altered at any time by agreement between the employer and the relevant employee (provided the agreement is recorded in writing); and

(b) clarify the operation of the existing provision allowing for roster changes in the event of another employee being absent from duty on account of "illness".

4.14 The wording proposed is consistent with the Full Bench decision in 4 yearly review of modern awards - *Nurses Award 2010* [2018] FWCFB 7347.

5. PROPOSED VARIATION TO CLIENT CANCELLATION CLAUSE

Background

5.1 Our clients propose that the scope of the client cancellation clause at 25.5(f) of the Award be expanded to capture the provision of disability services in the community (for example, care services provided in the community to people with a disability).

5.2 The current client cancellation clause already applies to a significant part of the disability services sector, as it applies to services provided to people with a disability *in their home*. However, there is no reason for distinguishing between supports provided to persons with a disability in their home and services provided in the community.

5.3 Other than the location, there are clear similarities between care services provided by support workers in the home and care services provided in the community, including that:

(a) community-based services are just as susceptible to client cancellation as in-home care services;

(b) community-based services are subject to the same cancellation rules under the NDIS as attendant care in the home; and

(c) the nature of the work is the same or very similar.

5.4 There is no good reason why the Award should provide a regime for dealing with client cancellations of rostered "home care" services, but not provide any such regime for client cancellations of attendant care services in the community for people with a disability.

The current position

5.5 Clause 25.5(f) of the Award permits employers to change an employee's roster where a rostered "home care service" is cancelled or changed by a client.

5.6 It also provides that where a roster is changed, an employer is not obliged to make a payment to the employee where the requisite notice was given to the employee (being by 5pm on the day prior to the rostered shift in question).

5.7 The clause also entitles employers to direct employees to make-up time equivalent to the cancelled time in that fortnight or during the subsequent fortnight.

5.8 The phrase "home care service" is not defined in the Award. The phrase is only found once in the Award, at clause 25.5(f). However, the phrase "home care service" is most likely intended to mirror the scope of the "home care sector", which is one of four defined sectors which the Award is expressed to cover.

5.9 The term "home care sector" is defined at clause 3.1 to mean the "provision of personal care, domestic assistance or home maintenance to an aged person or a person with a disability in a private residence" [emphasis added].

5.10 It is clear from that definition that the home care sector encompasses the provision of services to persons with a disability.

Funding arrangements for client cancellations

5.11 NDIS service providers are bound by a price cap. They are also bound to comply with rules relating to client cancellations.

5.12 Under those cancellation rules, service providers are prohibited from charging clients for cancelled services where the participant provides notice of cancellation prior to 3pm the day before the scheduled service (regardless of the reason for the cancellation).

5.13 Where a 'short-notice' cancellation (being a cancellation after 3pm on the day before the scheduled service or a 'no show' on the day), service providers are permitted to charge up to 90% of the agreed price. For personal care and community access supports, the fee may be charged against a participant plan up to 8 times per year. Beyond this threshold, the NDIS will require the provider to demonstrate they are taking steps to actively manage cancellations.

5.14 While the intention behind the NDIS cancellation rules is to attempt to strike a balance between the interests of service providers and participants, the reality is that the cancellation rules place service providers in a very difficult position.

5.15 Unless there is an ability to cancel the rostered shift (without being required to pay the employee), or redeploy the rostered employee to other available work, service providers will incur costs regardless of the scheduled service having been cancelled, yet will not derive any revenue.

The disconnect between the NDIS rules and the Award regarding cancellations

5.16 There is a clear disconnect between the terms of the Award and the funding arrangements under the NDIS when it comes to client cancellations. This disconnect is having a materially adverse impact on the viability of businesses operating in this sector.

5.17 Our clients acknowledge the desire of many employees in having job security, stability in income, and reasonably predictable hours of work. However, those interests need to be balanced against the interests of employers in being responsive to client needs.

5.18 Where it is not feasible to redeploy a permanent employee to other work in the event of a client cancellation event, the employer should have the ability to cancel the employee's rostered shift and offer them make-up time at a later date.

5.19 This type of regime is not new in the home care sector, including in situations where the in-home service is provided to a person with a disability. However, it should be extended to the broader disability sector where supports are provided in the community.

5.20 Under our clients' proposal, the make-up-time regime in the existing clause 25.5(f) would be replaced with a more robust and comprehensive clause, which allows for the make-up-time to be worked over a 3 month period rather than within a fortnight under the existing clause.

6. PROPOSAL FOR REMOTE RESPONSE WORK CLAUSE

Background

6.1 One of the issues raised during the review of this Award is how the Award operates in circumstances where an employee, who is not 'at work' or otherwise rostered to work or performing work at a particular time, is contacted and required to undertake certain functions remotely without having to physically attend the employer's premises (such as providing information to the employer over the telephone).

6.2 This issue was raised by a number of parties at the commencement of the review process, including by:

(a) Jobs Australia, which questioned whether the 'recall to work overtime' provision at clause 28.4 of the Award might apply to circumstances where an employee is not required to physically return to the workplace (e.g. where an employee takes a phone call while on-call);[14]

(b) AFEI, which proposed an amendment to clarify what constitutes a recall to duty to perform overtime, to ensure that employees (whether on-call or not) who answer telephone calls or respond to text messages are not deemed to have been recalled and thus entitled to two hours minimum pay at overtime, or alternatively to create a regime within the Award to accommodate employees receiving phone calls;[15] and

(c) the HSU, which had flagged pursuing a variation to provide for an "on-call penalty payment" when an employee is telephoned while not receiving an on-call allowance.[16]

6.3 It was also raised by our clients at that time, who flagged proposals to clarify the operation of the 'recall to work overtime' provision at clause 28.4,[17] as well as to introduce a "Telephone Advice Payment" where employees provide telephone advice outside of their rostered ordinary hours of work.[18]

6.4 There are now two competing proposals advanced on this subject in the current proceedings:

(a) a proposal advanced by our clients; and

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[14] Submission of Jobs Australia, 2 March 2015, at page 5.
[15] Submission of AFEI, 5 March 2015, at page 3.
[16] Submission of HSU, 2 March 2015, at page 5.
[17] Submission of ABI and NSWBC, 2 March 2015, at page 2.
[18] Submission of Aged Care Employers (which consisted of ACSA and LASA), 1 March 2015, at page 2.

(b) a proposal advanced by the HSU.

The HSU proposal

6.5 The HSU have proposed that clause 28.4 be varied to include a new sub-clause dealing with circumstances where an employee is required to perform work from home after leaving the employer's or client's premises. Under the HSU proposal, the employee would be entitled to a minimum of one hours' pay at overtime rates "for each time recalled".[19]

Our clients' proposal

6.6 In contrast, our clients' claim involves a proposed new clause 20.10, as well as consequential amendments to clauses 20.9 and 28.4. Under the proposed new clause 20.10, employees would be entitled to payment for performing remote response duties, with the quantum of such payment and the relevant minimum payment dependent on when the remote response duties are performed. Specifically, it is proposed that employees be paid:

(a) at the applicable rate of pay for work performed between 6.00am and 10.00pm, with a minimum payment of 15 minutes; and

(b) at the applicable rate of pay for work performed between 10.00pm and 6.00am, with a minimum payment of one hour.

6.7 While there is a large degree of overlap between the competing proposals, the key difference between the proposals relates to the scheme of remuneration to be applied when employees perform remote response work.

Our clients' proposal

6.8 The intention of our clients' proposal is to provide a scheme of remuneration for situations where an employee is required, outside of their working hours, to provide advice or assistance remotely.

6.9 This is not a novel claim or provision. Similar types of provisions appear in:

(a) the *Local Government Award 2010* (at clauses 24.4(d) and 24.6(d));

(b) the *Local Government (State) Award 2014* (NSW) (at clause 19E);

(c) the *Water Industry Award 2010* (at clauses 26.4(d) and 26.6(d));

(d) the *Business Equipment Award 2010* (at clauses 30.6(d) and 30.7); and

(e) the *Contract Call Centres Award 2010* (at clauses 26.4(d), 26.6(d) and 26.7).

[19] See [16] of Amended Draft Determination of HSU, filed 15 February 2019.

The disutility associated with performing remote response work

6.10 If the Commission was minded to insert such a provision into the Award, the Commission's task is to determine what an appropriate monetary entitlement is for this type of work.

6.11 In the scheme of a minimum safety net instrument, this task involves an assessment of the value of the work and the extent of disutility associated with the time at which the work is performed. In the Penalty Rates Decision, the Full Bench observed at [202]:

> A central consideration in this regard is whether a particular penalty rate provides employees with 'fair and relevant' compensation for the disutility associated with working at the particular time(s) to which the penalty attaches.

6.12 Unlike being physically recalled to the workplace in the traditional sense (or being on call to be recalled to work), the level of disutility associated with employees performing remote response work is significantly less, as employees are not required to:

(a) stay in the vicinity of the workplace while on-call;

(b) keep themselves, their work clothes and transport in a state of readiness while on-call for a possible recall to work;

(c) spend time travelling to or from the workplace if recalled to work; or

(d) incur additional travelling expenses (such as public transport fares, petrol or road tolls) if recalled to work.

6.13 An employee can be on-call remotely from anywhere. They do not need to remain static at a particular location, be in readiness to attend work or be in (or change into) work clothing to perform the work.

6.14 Our clients' proposal provides a fair and relevant minimum safety net payment regime for this type of remote work, which is proportionate to the lower level of disutility associated with remote work.

7. CONCLUSION

7.1 For the reasons outlined above, our clients' proposed variations should be granted.

AUSTRALIAN BUSINESS LAWYERS & ADVISORS

On behalf of:

- **AUSTRALIAN BUSINESS INDUSTRIAL**
- **THE NSW BUSINESS CHAMBER LTD**
- **AGED & COMMUNITY SERVICES AUSTRALIA**
- **LEADING AGE SERVICES AUSTRALIA**

2 July 2019

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Fair Work Commission: 4 yearly Review of modern awards

REPLY SUBMISSION

4 YEARLY REVIEW OF MODERN AWARDS: (AM2018/26) SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010 - SUBSTANTIVE ISSUES

FILED ON BEHALF OF:

- AUSTRALIAN BUSINESS INDUSTRIAL
- THE NSW BUSINESS CHAMBER LTD
- AGED & COMMUNITY SERVICES AUSTRALIA
- LEADING AGE SERVICES AUSTRALIA

12 JULY 2019

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1. INTRODUCTION

1.1 This reply submission is made on behalf of:

(a) Australian Business Industrial (**ABI**);

(b) the New South Wales Business Chamber Ltd (**NSWBC**);

(c) Aged & Community Services Australia (**ACSA**); and

(d) Leading Age Services Australia Limited (**LASA**),

collectively, '**our clients**'.

1.2 Our clients have a material interest in the review of the *Social, Community, Home Care and Disability Services Industry Award 2010* (the **Award**).

1.3 This reply submission is filed in accordance with the Amended Directions of the Fair Work Commission (the **Commission**) issued on 28 June 2019 (the **Amended Directions**).

1.4 This reply submission addresses the outstanding union claims as listed in Attachment C to the Amended Directions, being claims advanced by the Health Services Union (the **HSU**), the United Voice and the Australian Services Union (the **ASU**), save that it does not address the claims relating to travel time by reason of the variation made to the Amended Directions on 11 July 2019.

2. OUR CLIENTS

2.1 ABI is a registered organisation under the *Fair Work (Registered Organisations) Act 2009* and has in excess of 4,000 members. ABI represents the interests of businesses in a variety of industries including the social, community, home care and disability services industry. Its primary role is to develop workplace policy and to shape debate on major workplace relations issues.

2.2 NSWBC is a recognised State registered association pursuant to Schedule 2 of the *Fair Work (Registered Organisation) Act 2009* and has some 18,000 members. NSWBC is the State's peak business organisation and represents all businesses from small enterprises to large corporations across a variety of industries including the social, community, home care and disability services industry.

2.3 ACSA is the leading peak body supporting church, charitable, other not-for-profit and government providers of residential care services, community care services and retirement living for older people in Australia.

2.4 LASA is the national peak body representing and supporting providers of age services across residential care, home care and retirement living. LASA's membership base is made up of private, not-for-profit, faith-based and government operated organisations providing care, support and services to older Australians.

3. LEGISLATIVE FRAMEWORK OF THE FOUR YEARLY REVIEW

3.1 The legislative framework applicable to the 4 Yearly Review has been considered in detail in *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 (**Preliminary Issues Decision**), and *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 (**Penalty Rates Decision**).

3.2 More recently, the legislative framework applicable to the 4 Yearly Review was also considered in *4 yearly review of modern awards – plain language re-drafting – standard clauses* [2018] FWCFB 4177 issued on 18 July 2018[1] and summarised in *4 yearly review of modern awards – Alpine Resorts Award* [2018] FWCFB 4984.

3.3 We rely on the summary of the applicable legal principles as set out in the reply submissions filed by our clients in this matter on 5 April 2019.[2]

3.4 We also refer to, and agree with, the summary contained in the document titled 'Legislative framework relevant to the Review' published by the Commission in this matter on 12 April 2019.[3]

[1] [2018] FWCFB 4177 at [3]-[13].
[2] See [2.1]-[2.4].
[3] Published pursuant to a Statement issued on 12 April 2019 ([2019] FWCFB 2514).

4. THE SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY

4.1 Our clients have previously addressed in a range of submissions the nature of the SCHCDS industry and the unprecedented change and structural reforms which various parts of the industry are currently undergoing. By way of example, we refer to:

(a) Part 3 of our reply submissions filed on 5 April 2019; and

(b) Part 3 of our submissions filed on 2 July 2019 in support of the claims being advanced by our clients in these proceedings.

4.2 We refer to and rely on those aspects of our previous written submissions in respect of the nature of the industry generally.

4.3 The SCHCDS industry is a diverse industry, both in relation to the functions of the organisations regulated by the Award and in relation to the characteristics of the work and working patterns that are required to undertake those functions.

4.4 Given the diversity of work that is regulated by the Award, it is unsurprising that there is diversity in the characteristics of the work and the working patterns that are required to deliver the various services.

4.5 In broad terms, the work arrangements regulated by the Award can be divided into two categories of work:

(a) the first type is work that is stable, consistent and certain, and where employees generally perform the work in the one work location (their primary place of work), and have relatively fixed working patterns (such as a working pattern of five days of 7.6 hour shifts performed at the same work location); and

(b) the second type is where the nature of the work, including the location, the time and the duration, is dynamic, variable and difficult to predict with any degree of certainty due to the client-driven factors that cause the working arrangements to be subject to regular change.

4.6 The first category of work can be described as the more 'centralised' areas of service provision where the particular service is made available by the business at a particular location and during specified operating hours that are determined by the business. Examples of this type of work include:

(a) community services that are provided from a fixed location - for example: community legal centres, family counselling centres, migrant support centres, health

and mental health referral centres, indigenous support centres, tenancy support centres, homelessness support centres, drug and alcohol rehabilitation support centres, social policy and advocacy centres, etc.);

(b) institutional, residential or group home services - for example: group homes that are established to provide 24 hour care to residents, with support workers employed to provide home-based care to those residents; and

(c) other services which are provided at a particular time that is determined by the service provider (i.e. the employer) - for example: a community transport service which runs to a fixed timetable or a schedule determined by the employer.

4.7 For the above types of services, the nature of the service is such that the employer can, subject to the usual commercial and market considerations, largely determine when, where and how the service is provided. Further, the nature of the work is such that the work can be organised by the employer into regular, predictable and lengthier segments of work.

4.8 As to the second category of work, this work includes the provision of individualised, customer-centric services in a non-institutional setting such as home care services or disability support services in the community.

4.9 In the disability service and home care service areas, businesses historically had a far greater level of control as to when, where and how these services were delivered. However, as a result of the NDIS and other reforms, the individual consumers (i.e. the customers, clients or 'participants') now have a greater level of choice and control over how these services are delivered to them.

4.10 To provide an example: where an employee with a disability was eligible to receive personal care services to assist him/her to get ready in the morning. Prior to the reforms, a service provider that was contracted to deliver that service would determine when the service was to be provided, and could therefore schedule that service in an efficient manner having regard to other operational factors. However, now under the NDIS or other reforms, the consumer is able to advocate for and request a time that is most suitable to him/her, which in many cases will be operationally less efficient for the service provider. This leads to the service provider having to make the following decision: provide the service at a time which is not operationally efficient for it, or decide not to provide the service.

4.11 While some of the work in the home care and disability services areas will continue to have a degree (or a large degree) of regularity and stability (e.g. a client who requires personal care

assistance in getting showered and dressed in the morning), there will still be occasions where those services will be changed or cancelled to meet the various needs of the individual.

4.12 And then there are the more variable items of support. For example, an individual with a disability who is eligible under the NDIS to receive a prescribed number of hours of support to facilitate his/her independent living skills is able to determine when they might wish to utilise those supports, which may be dependent on what they wish to do and when a particular event is on. For example, the consumer might wish to attend a football game one week on a Friday night which starts at 7pm, while the following week the football game may be on the Sunday afternoon at 2.30pm. Service providers are therefore required to be sufficiently agile to meet the needs of customers and deliver these services.

4.13 Further, the nature of this work is also often characterised by short segments of work, given that:

(a) the services provided (e.g. personal care) typically only take a short period of time to provide; and

(b) consumers tend to request shorter periods of service (to get more perceived "value" in terms of the support services they can receive).

4.14 While this is, in many respects, the typical market environment in which many businesses and industries operate, there are two significant differences in the SCHCDS industry:

(a) firstly, the prices that can be charged for certain services are in many cases regulated and fixed by the Government (or otherwise businesses are limited by the funding that is provided to deliver certain services); and

(b) secondly, most businesses in the SCHCDS industry are not-for-profit businesses with a deeply-embedded mission to support vulnerable members of the community, and so are not driven by the same commercial imperatives or motivations as other private sector businesses.

4.15 The above two factors lead to a dynamic whereby many service providers in the SCHCDS industry, when faced with the choice, will elect to provide services to consumers at a loss in order to meet the organisation's mission rather than not provide the service.

4.16 Given the diversity in the nature of the work across the industry, and the other unique characteristics of the industry, the task of striking the right balance and providing a fair and

relevant minimum safety net of terms and conditions for all Award-covered employees is no easy feat.

4.17 However, it ultimately requires a balancing exercise whereby the needs and interests of employees are balanced with the needs of employers in order to ensure a fair, sustainable and viable industry.

4.18 In this regard, it is critical that the Commission have regard to the impacts on service providers that any variation to the Award would have. There is considerable material before the Commission demonstrating that the industry is under significant financial pressure, and so any variation that is likely to further exacerbate these issues must be implemented in a way that minimises these adverse impacts.

4.19 To synthesise these observations into factual findings that the Commission is invited to make, our clients submit that the following uncontroversial findings can be made:

(a) since the Award was first introduced in 2010, the industry (or parts of it) have undergone significant and unprecedented structural change;

(b) the consumer-directed-care reforms have led to individual consumers having more choice and control over the delivery of services to them, including what, when, where, how and by whom those services are delivered;

(c) many of the care services provided to consumers in the home care and disability services sectors are for short periods of time, including for less than one hour;

(d) employers in the industry are predominantly not-for profit, mission-based businesses which are not driven by the same commercial imperatives or motivations of other private sector businesses, which leads them to make decisions based on community need rather than profitability;

(e) employers in the industry are often reliant on government funding and subject to price regulation, for which there is evidence of inadequacy of such funding in particular areas; and

(f) many service providers and the industry generally is under significant financial pressure arising from the decentralisation of the funding arrangements and the aggressive pricing models (for example, under the NDIS).

5. SUMMARY OF OUR CLIENTS' POSITION IN RELATION TO THE UNIONS' CLAIMS

5.1 The Unions' claims, if granted, would represent a truly significant alteration to the current safety net instrument.

5.2 If implemented, the changes sought by the Unions will have a significant deleterious impact on the viability of most businesses in the sector, which are already under significant pressure due to the inadequacy of the current funding models and the major structural reforms that have occurred over the last five years.

5.3 Already, many businesses are unable or barely able to sustain themselves and cover their operating costs.

5.4 Our clients do not have any philosophical objection to the Award providing for a 'fair and relevant' minimum safety net of terms and conditions. In this context, our clients have taken a reasonable approach to these proceedings and have either not opposed a number of claims (or aspects of certain claims), or have proffered alternative variations which rectify the particular mischief complained of by the Unions without damaging the sustainability of businesses.

5.5 The reality is that if the Award is varied in such a way that results in the labour costs of employers increasing, that variation will have a material adverse impact on employers and will threaten their sustainability and viability, unless there is some equivalent increase to the funding received by the business.

5.6 Equally, if the Award is varied in such a way that adversely affects employers' operational flexibilities, this change is likely to have a material adverse impact on the businesses' ability to deliver services to vulnerable members of the community. This will then undermine the objectives of the NDIS and other consumer-directed-care reforms and have a tangible adverse impact on the community.

5.7 While our clients oppose the vast majority of the variations that have been sought by the Unions, we acknowledge that there is a need to vary the Award in a number of areas to ensure that it meets the modern awards objective.[4]

5.8 For convenience, we set out a summary of our clients' position in relation to the Unions' claims. The reasons for these views are set out in further detail in separate sections of this submission below. However, by way of summary, our clients' position is as follows.

[4] Among the necessary variations are those that our respective clients are pursuing.

Minimum engagements

5.9 In respect of proposed changes to minimum engagements, our clients:

(a) are opposed to any change to the existing minimum engagements for casual employees;

(b) are opposed to the proposed introduction of any minimum engagement for full-time employees; and

(c) are opposed to the introduction of a uniform 3 hour minimum for all part-time employees.

5.10 However, our clients are not opposed to the introduction of minimum engagements for part-time employees, provided that:

(a) they are consistent with the existing minimum engagement periods for casual employees; and

(b) attendances for the purpose of staff meetings and training / professional development are subject to a minimum engagement of one hour.

Broken shifts

5.11 In respect of proposed changes to the broken shifts clause, our clients are opposed to the Unions' claims, save that our clients do not oppose:

(a) the introduction of a requirement that broken shifts only be worked where there is mutual agreement between the employer and individual employee; and

(b) that the existing payment under clause 25.6(b) be varied such that the applicable shift allowances be determined by either the starting time or the finishing time of the broken shift, whichever is the greater.

Overtime for part-time employees

5.12 Our clients are opposed to the proposed introduction of additional overtime entitlements for part-time employees when working agreed additional hours or when working more than 8 hours in a day.

5.13 However, our clients are not opposed to a variation that would provide a mechanism for reviewing and adjusting a part-time employee's hours of work where they are regularly working more than their guaranteed minimum number of hours. Further details of this proposition are outlined in paragraphs 8.26 to 8.29 below.

Overtime for casual employees

5.14 Our clients are opposed to the proposed changes to overtime for casual employees.

Phone allowance

5.15 Our clients are opposed to the proposed variation to the telephone allowance clause.

Clothing and uniform allowance and reimbursement

5.16 Our clients are opposed to the proposed variations in respect of clothing and uniform allowances.

Client cancellation

5.17 Our clients are opposed to the HSU's proposed variation to the client cancellation clause, and have proposed a separate variation to the client cancellation clause which we consider should be made.

Recall to work

5.18 Our clients are opposed to the proposed variation to the recall to work overtime clause, and have advanced a separate proposal to introduce a remote response duties compensation regime.

Roster changes

5.19 Our clients are opposed to the United Voice proposal in respect of roster changes.

5.20 However, our clients consider that the rostering provisions of the Award (particularly for part-time employees) require consideration to ensure they provide an appropriate balance between the interests of employees in having have sufficient certainty around working patterns, and the interests of employers in being able to continue to utilise part-time employment as a viable form of employment under the current operating environment.

5.21 This requires a consideration of the interaction between clauses 25.5(d) and 10.3(c), with a focus on ensuring that part-time employment is appropriately flexible to meet the needs of employers to prevent those terms acting as a bar to employing people on a part-time basis, and leading to a casualisation of the workforce.

6. CLAIM FOR CHANGES TO MINIMUM ENGAGEMENT PROVISIONS (S10)

The HSU claim

6.1 The HSU seek the introduction of uniform 3 hour minimum engagements into the Award for all classes of employee (full-time, part-time and casual). When considered across the various categories of employment, the claim involves:

(a) in respect of full-time employees, the introduction of a 3 hour minimum engagement in circumstances where the Award does not currently contain any minimum engagement;

(b) in respect of part-time employees, the introduction of a 3 hour minimum engagement for part-time employees, in circumstances where the Award does not currently contain any minimum engagement;

(c) in respect of casual employees working in the home care sector, an increase to the existing minimum engagement from 1 hour to 3 hours;

(d) in respect of casual employees undertaking disability services work, an increase to the existing minimum engagement from 2 hours to 3 hours;

(e) in respect of casual employees working in the crisis assistance and supported housing sector, an increase to the existing minimum engagement from 2 hours to 3 hours; and

(f) in respect of casual employees working in the family day care scheme sector, an increase to the existing minimum engagement from 2 hours to 3 hours.

6.2 The only area of the existing Award which the HSU do not seek to disturb is in relation to casual employees in the social and community services sector who do not perform disability services work. Otherwise the claim impacts every other category of employee.

6.3 In support of the variation, the HSU note that the Award does not presently contain any minimum engagements for part-time employees.

6.4 The submissions advanced in support of the variation are summarised as follows:

(a) first, the HSU submit that the existing protection for part-time employees at clause 10.3(c) is inadequate, has "little relevance", and is not "observed" or "honoured";[5]

[5] HSU submission at [26]

(b) second, where employees (such as disability support workers and home care workers) perform work at different or various locations on any given day (or throughout the course of the day), those employees make a "greater investment of time and effort" for the performance of each shift;[6]

(c) third, it is commonplace within the industry that employees are rostered to perform very short shifts;[7]

(d) fourth, it is commonplace that those very short shifts are interspersed with unpaid breaks in which employees are required to travel between clients;[8] and

(e) fifth, the majority of workers in the industry are employed on Award rates only.[9]

6.5 We address this claim below.

Recent consideration of minimum engagements: The Casual and Part Time Employment decision

6.6 Minimum engagement provisions across the modern awards system were recently the subject of detailed consideration by a Full Bench of the Commission as part of the common issues Casual and Part-Time Employment proceedings.[10]

6.7 Those proceedings primarily concerned a claim by the ACTU for the introduction of, *inter alia*, uniform 4 hour minimum engagements for both part-time and casual employees in approximately 108 modern awards. The SCHCDS Award was one of the awards covered by the ACTU claim.

6.8 In its decision of 5 July 2017 (the ***Casual and Part Time Employment Decision***)[11], the Full Bench rejected the ACTU claim in relation to 4 hour minimum engagements.[12] However, the Bench formed the provisional view that a 2 hour minimum engagement provision should be introduced for casual employees in respect of modern awards that contained no minimum engagement period for casual employees.[13] The Bench rejected the ACTU claim altogether in respect of minimum engagements for part-time employees.

[6] Ibid at [28]
[7] Ibid at [29]
[8] Ibid
[9] Ibid at [30]
[10] AM2014/196 and AM2014/197
[11] [2017] FWCFB 3541
[12] Ibid, at [407]
[13] Ibid, at [408]

6.9 Given that the SCHCDS Award already contained minimum engagement provisions for casual employees, the *Casual and Part Time Employment Decision* did not impact the SCHCDS Award in respect of minimum engagements.

6.10 Notwithstanding the above, the reasoning in the *Casual and Part Time Employment Decision* remains relevant. In their decision, the Full Bench considered the history and case law authorities on award minimum engagements, and made the following observations:

(a) modern awards contain a range of different minimum daily engagement periods for casual and part-time employees;[14]

(b) minimum engagement periods in awards have developed in an ad hoc fashion rather than having any clear founding in a set of general principles;[15]

(c) the issue of minimum engagements did not receive any systematic consideration during the award modernisation process which led to the establishment of the modern awards;[16]

(d) the award modernisation process largely preserved the predominant provisions concerning minimum engagements contained in pre-reform awards;[17]

(e) existing award minimum engagement provisions generally derive from provisions in pre-reform awards which were in most cases likely formulated by the agreement of the award parties;[18]

(f) where such pre-reform award minimum engagement provisions were derived by agreement of the award parties, it can be presumed that in doing so the parties took into account the circumstances of the industries in which they operated that prevailed at the time;[19] and

(g) in particular modern awards, it is clear that that the minimum engagement periods were intended to meet the peculiar circumstances of special types of work or workers. [20]

[14] At [404]
[15] At [399]
[16] At [346]
[17] At [402]
[18] At [404]
[19] Ibid
[20] Ibid

6.11 As to the rationale of minimum engagement provisions, the Full Bench observed at [399]:

> ...their fundamental rationale has essentially been to ensure that the employee receives a sufficient amount of work, and income, for each attendance at the workplace to justify the expense and inconvenience associated with that attendance by way of transport time and cost, work clothing expenses, childcare expenses and the like. An employment arrangement may become exploitative if the income provided for the employee's labour is, because of very short engagement periods, rendered negligible by the time and cost required to attend the employment. Minimum engagement periods are also important in respect of the incentives for persons to enter the labour market to take advantage of casual and part-time employment opportunities (and thus engage the consideration in paragraph (c) of the modern awards objective in s.134).

6.12 However, the Full Bench then observed that there are a number of "important countervailing considerations" that need to be taken into account in establishing award minimum engagement requirements, namely:

(a) longer minimum engagement periods may prejudice those persons who wish to and can only work for short periods of time because of family, study or other commitments, or because they have a disability;

(b) the need for and length of a minimum engagement period may vary from industry to industry, having regard to differences such as in rostering practices and whether there are broken shifts;

(c) an excessive minimum engagement period may cause employers to determine that it is not commercially viable to offer casual engagements or part-time work, which may prejudice those who desire or need such work; and

(d) a minimum daily engagement period for part-time employees might not need to be as long as for casual employees, because part-time employees are likely to enjoy the greater security of a guaranteed number of weekly hours of work.[21]

6.13 The considerations outlined above should be taken into account and applied when dealing with the present claim.

[21] At [403]

6.14 The ultimate conclusions of the Full Bench in respect of the ACTU's claim for model 4 hour minimum engagement provisions for part-time and casual employees appears at paragraphs [407]-[408], the relevant aspects of which are extracted as follows:

> *[407] While a 4 hour minimum daily engagement might under some awards represent an appropriate balancing of the competing considerations to which have earlier referred, we do not consider that it can be adopted on the across-the-board basis proposed by the ACTU. That would not in all awards meet the modern awards objective in s.134, because we consider that it might have the counter-productive result of reducing workforce participation and social inclusion, and also because under some awards it may inhibit flexible modern work practices and the efficient and productive performance of work. The ACTU's claim for a standard 4 hour minimum engagement for casual and part-time employees is therefore rejected.*
>
> *[408] However, we do consider, having regard to those same competing considerations, that it is necessary for modern awards to contain some form of minimum engagement period for casual employees in order to avoid their exploitation in order to meet the modern awards objective. The modern awards listed in Attachment G contain no minimum engagement period at all. We have reached the provisional view that such awards should be varied to include a 2 hour minimum engagement period for casuals. However we will provide interested parties an opportunity to provide further submissions concerning this proposition.*

6.15 While the *Casual and Part Time Employment Decision* is of course relevant to the current proceedings, that decision does make it clear that ultimately the task of considering minimum engagements in modern awards needs to be undertaken having regard to the particular characteristics of the industry covered by the award.

6.16 We now turn to an award-specific consideration of minimum engagement provisions for the SCHCDS industry.

Background to minimum engagements in the SCHCDS industry

6.17 While there may not have been a systematic consideration of minimum engagement periods during the award modernisation process, the issue certainly was considered in detail during the course of the AIRC making of the SCHCDS Award.

6.18 During that process, a number of party draft Awards were submitted to the AIRC for consideration. For example:

(a) Jobs Australia submitted a draft *Social, Community and Employment Services Award 2010* on 24 July 2009 which was proposed to have a broader coverage including the labour market assistance industry, and which proposed a four hour minimum engagement for full-time employees and a two hour minimum engagement for part-time, casual and sessional employees;[22]

(b) AFEI submitted a draft *Social and Community Services Employees Award 2010* which proposed a two hour minimum engagement for part-time and casual employees, and no minimum engagement for full-time employees;[23] and

(c) the ASU submitted a draft *Social, Community, Disability and Employment Services Industry Award 2010* which proposed a three hour minimum engagement for casual employees, and no minimum engagement for full-time or part-time employees.[24]

6.19 When the Exposure Draft was published on 25 September 2009, it contained a three hour minimum engagement for casual employees, and no minimum engagement for the other categories of employment.[25]

6.20 Following the publication of the Exposure Draft, a considerable volume of submissions was then received by the AIRC which addressed the proposed three hour minimum engagement for casual employees. Put simply, employers and employer parties forcefully objected to a proposed three hour minimum engagement, particularly in relation to the home care and disability sectors.

6.21 For example, the Aged Care Employers (consisting of our clients, ACSA and LASA) submitted that the casual minimum engagement should be reduced from three hours to one hour in respect of home care employees.[26] The Aged Care Employers submitted:

> [9] The concept of a three hour minimum payment to a casual employee is foreign to many home and community care projects and services. It will be unfunded.
>
> [10] It will also be contrary to client needs and schedules. In many cases clients only require less than one hours assistance with medication administration, or early morning or evening care/assistance. The flow-on effect of a three hour minimum payment is that employers will be forced to juggle and change client schedules (against client wishes) so as to ensure the full three hour payment is allocated to a

[22] See clause 21.7.
[23] See clauses 10.2 and 10.3.
[24] See clause 10.4(c).
[25] See 10.4(c) of the Exposure Draft, published 25 September 2009.
[26] Submission of Aged Care Employers, 19 October 2009 at [2].

client and/or working time. Given that the home and community care industry relies so heavily on achieving client satisfaction as a measure of its effectiveness, it is wholly inappropriate to impose three hour minimum starts on both providers and their clients. A one hour minimum is consistent with sector and client needs and Clause 10.4(c) must be amended accordingly. Such an outcome has already been determined in respect of homecare employees under the Aged Care Award.

6.22 ABI also lodged a submission raising similar concerns in its submission of 19 October 2009:

> 24. Sub-clause 10.4 provides for a minimum start of three hours for casuals. This condition creates an impediment to the flexibility demanded by the industry, and is problematic for the reasons that follow.
>
> 25. Many of the services provided by this industry, including but not limited to, respite and home-care services, are carried out by casual employees. The flexibility associated with casual work is a critical feature attracting many employees to the industry.
>
> 26. The nature of the services provided vary. However, there is typically strong demand for assistance at the beginning and end of the day. For example, many clients require assistance getting ready before school and/ or work and preparing for bed in the evenings. The nature of this care would not typically require three hours.
>
> 27. Nor, in most cases, can the same employee provide this type of home assistance to more than one (or perhaps two clients who are geographically close) because clients cannot be left unable to start (or finish) their day well into the morning (or night).
>
> 28. Further, the three hour minimum requirement contained in the Exposure Draft is inconsistent with a number of programmes common to the industry. These include (but are not limited to):
>
> - Attendant Care - support provided to people with a physical disability to meet the requirements of their personal care needs. This is limited to a maximum of 35 hours per week and divided roughly into 5 hours per day - usually 2-3 hours in the morning with either 2 x 1 hour shifts at other times of the day or 1x 2 hour shift in the evening;

- Veterans Homecare - provision of a maximum of 6 hours per week in personal care, with domestic assistance and respite that is usually provided in 1 or 2 hours shifts;
- Commonwealth Respite for Carer's - allocation of regular 1 to 2 hours shifts to support a family member who is the primary carer for someone elderly or with a disability;
- HomeCare NSW - provision of 1 and 2 hours shifts to provide domestic assistance, personal care or respite for the frail elderly or those with a disability.

29. The ABI draft [consisting of a one hour minimum engagement for casual employees] restores the necessary flexibility with respect to casual employment.

6.23 A flood of other submissions were received which also raised the same or similar concerns with a proposed three hour casual minimum engagement. Without being exhaustive, these included submissions from the following interests:

(a) AFEI;[27]

(b) Business SA;[28]

(c) the Attendant Care Industry Association of NSW Inc;[29]

(d) the Disability Trust;[30]

(e) the Hills District Nursing Service;[31]

(f) Mamre Association Inc;[32]

(g) the Queensland Community Services Employers' Association (QCSEA) Inc;[33]

(h) Interchange Respite Care (NSW) Inc;[34]

(i) Spinal Cord Injuries Australia;[35]

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[27] Submission dated 16 October 2009
[28] Submission dated 16 October 2009.
[29] Submission dated 14 October 2009.
[30] Submission of 15 October 2009; further submission of 16 November 2009.
[31] Submission dated 16 October 2009.
[32] See http://www.airc.gov.au/AIRISYS/isysquery/0fcad409-7bbd-4587-b3de-251415418e46/21/doc/Mamre_social_ED.pdf#xml=http://www.airc.gov.au/AIRISYS/isysquery/0fcad409-7bbd-4587-b3de-251415418e46/21/hilite/
[33] Submission of 16 October 2009.
[34] Submission of 15 October 2009.

(j) WorkAbility;[36]

(k) the Catholic Commission for Employment Relations;[37]

(l) the Victorian Hospitals' Industrial Association;[38]

(m) Lifeline Community Care Queensland;[39] and

(n) Disability Alliance.[40]

6.24 The issue of minimum engagements for casual employees was also subject to further consideration and oral submissions during a Full Bench hearing on 5 November 2009, as recorded on transcript.

6.25 Finally, there is clear evidence that the issue of minimum engagement periods for casual employees was specifically considered at the time the Award was made. In the decision of *Award Modernisation* [2009] AIRCFB 945, the Full Bench specifically referred to minimum engagement provisions for casual employees, and observed at [83] that:

> [83] The minimum period of engagement for casuals has been altered to take into account the different sectors of this industry...

6.26 While there is an absence of detailed reasoning in *Award Modernisation* [2009] AIRCFB 945 behind the Full Bench's decision to set the casual minimum engagements in the manner they did, the only rational conclusion available is that the Full Bench was persuaded by the submissions put by the employer parties.

6.27 Ultimately, the reasons which were advanced by employer parties during the award modernisation process in support of short minimum engagement periods remain just as relevant today, if not more so following the implementation of consumer directed care reforms. We rely on the matters raised in those submissions.

6.28 There is no proper basis to depart from the conclusions reached by the Full Bench when the Award was made.

6.29 We now address the HSU's proposal in respect of full-time and part-time employees.

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[35] Submission dated 14 October 2009.
[36] Submission dated 13 October 2009.
[37] Submission of 16 October 2009.
[38] Submission of 16 October 2009.
[39] Submission dated 19 October 2009.
[40] Submission of 15 October 2009.

Proposal for a 3 hour minimum engagement for part-time employees

6.30 When the Award was made, the AIRC decided not to provide minimum engagements for part-time employees. This is despite, as addressed above, the fact that the issue of minimum engagements received considerable focus during the making of the Award.

6.31 The issue of minimum engagements for part-time employees (or lack thereof) was then the subject of re-consideration by the Commission during the 2 yearly review of the Award. In those proceedings, the ASU sought the introduction of a 3 hour minimum engagement for part-time employees across all streams of the Award.

6.32 In support of their application, the ASU submitted that the absence of a minimum engagement period for part-time employees was at odds with both the "critical mass" of relevant pre-reform awards as well as the position provided for other employees under the Award.

6.33 However, in the Commission's decision of 27 June 2013[41], VP Watson dismissed the application and relevantly held that:

> [19] It is clear that in common with many other awards, the AIRC deliberately did not insert a minimum engagement period for part-timers in this award. It was obviously influenced by the variable position under predecessor awards. In my view the introduction of a minimum engagement period for part-time employees as part of this review would require a strong case that evaluated the impacts on employees and employers across the various sectors covered by the award. The application fails to meet this standard.

6.34 The above aspect of the VP Watson Decision was not challenged by the ASU on appeal.

6.35 While the Commission rejected the application for minimum engagements for part-time employees during the 2 yearly review process, it is relevant that the Commission decided to grant another of the ASU's claims relating to part-time employees.

6.36 VP Watson granted the ASU's claim for the insertion of a provision that is now clause 10.3(c) of the Award, which imposes an obligation on employers to agree with part-time employees in writing on an agreed pattern of work (including number of hours to be worked, the days on which work is to be performed, and the starting and finishing times on each day) which can then only be varied by written agreement.

[41] [2013] FWC 4141

6.37 In granting that variation, VP Watson considered the absence of minimum engagement provisions as a particularly influential factor leading to his decision. In the decision, VP Watson held:

> [20] That part of the application seeking a requirement that part-time arrangements be agreed in writing prior to commencing employment is a common award provision. It requires employees to be given clear information as to the basis of their employment when they are engaged. I consider that the case for such a clause is strong, <u>especially when there is no award minimum engagement period</u>. In my view the concerns of the employers can be allayed by standard procedures that comply with the clause, such as those that have been developed for employers covered by similar provisions in other awards. I will make this change prospective to allow employers to prepare for the change. <u>If significant practical problems emerge an appropriate variation can be sought</u>. I will insert the clause sought by the ASU with effect from 1 August 2013. [emphasis added]

6.38 It follows from the reasoning of VP Watson that if minimum engagements for part-time employees were to be inserted into the Award, the case for maintaining clause 10.3(c) is weakened, and should be reconsidered.

6.39 This is the case now, particularly given the submissions that have been advanced by the HSU as to the operation of clause 10.3(c).[42] For example, the HSU assert that clause 10.3(c) "appears to have little relevance", despite the HSU opposing a claim advanced by some of our clients in the Casual and Part-Time Employment proceedings to vary clause 10.3(c) for that very reason.

6.40 In our submission, any proposal to introduce a minimum engagement for part-time employees should not occur without a contemporaneous review and reconsideration of clause 10.3(c).

6.41 Another matter should also be noted. To the extent that the Commission is minded to introduce minimum engagements for part-time employees, the observation of the Full Bench in the *Casual and Part Time Employment Decision* at [403] is relevant. There, the Full Bench observed:

[42] See HSU submission at [26].

a minimum daily engagement period for part-time employees might not need to be as long as for casual employees, because part-time employees are likely to enjoy the greater security of a guaranteed number of weekly hours of work.

6.42 This observation is of course applicable to the SCHCDS Award, where part-time employees have the security of permanent employment, guaranteed hours, and a pre-agreed pattern of work as per clause 10.3(c).

Our clients' position in relation to minimum engagements for part-time employees

6.43 It is notable that the HSU acknowledge that it is "commonplace within the industry that employees are rostered to perform very short shifts".[43] This is of course true. Indeed, it is a fundamental feature of the industry, brought about by the fact that customers (particularly in the home care and disability services sectors) require care services of a short duration to assist them to undertake basic activities such as showering, cooking, medication prompting, getting dressed, etc.

6.44 Given that many of these services involve a short engagement of anywhere between 30 minutes and 2 hours, employers are required to effectively bundle a series of different customer service engagements together in order to 'build' a longer shift for employees. It is of course in the employer's interest to build a shift that is attractive to those employees who do not require or desire the flexibility of shorter shifts (as some employees do).

6.45 This is particularly challenging in regional and rural and remote areas where there is a lack of scale or where clients are geographical dispersed. The reality is that in some cases, it is simply not possible to bundle multiple separate customer engagements together to create a three hour shift.

6.46 This fundamental feature of the industry is precisely the reason why the Commission should not introduce a three hour minimum engagement. If a three hour minimum engagement was to be implemented, it would have a very significant adverse impact on employers. It will also seriously disadvantage members of the community who access services from these employers, as employers would not be prepared to continue delivering support services of a short duration, which is contrary to the objectives of the NDIS and other consumer directed care initiatives. It will also adversely affect employees who prefer short shifts to accommodate their other family, caring or study commitments.

[43] Ibid at [29]

6.47 In summary, our clients are not opposed to the introduction of minimum engagement provisions for part-time employees, subject to two conditions:

(a) they reflect the existing minimum engagements for casual employees; and

(b) there be a one hour minimum engagement applied for casual and part-time employees where they are required to attend staff meetings and training / professional development.

6.48 That is, our clients would not be opposed to:

(a) a one hour minimum engagement for part-time home care employees;

(b) a two hour minimum engagement for part-time employees undertaking disability services work;

(c) a two hour minimum engagement for part-time employees in the crisis assistance and supported housing sector; and

(d) a two hour minimum engagement for part-time employees in the family day care scheme sector; and

(e) a three hour minimum engagement for part-time employees in the SACS sector (excluding disability services).

6.49 We now turn to full-time employees.

Proposal for a 3 hour minimum engagement for full-time employees

6.50 Put simply, there is no merit basis for the introduction of a minimum engagement period in respect of full-time employees.

6.51 Under the current terms of the Award, full-time employees must be engaged to work 38 hours per week or an average of 38 hours per week, and the way in which those hours can be worked are conditioned by a range of requirements, including that:

(a) shifts must not exceed eight hours each, or up to 10 hours by agreement;

(b) the employee must be free from duty for not less than two full days in each week or four full days in each fortnight or eight full days in each 28 day cycle; and

(c) the employee must be given a break of not less than 10 hours between the end of one shift or period of work and the start of another.

6.52 That being the case, the prospect of full-time employees performing shifts of a short duration would be very remote, and there is certainly no evidence at all before the

Commission that would support a finding that full-time employees are affected by unreasonably short shifts.

6.53 Further, even if there was such evidence (which is denied), the fact of the employee having a guarantee of 38 hours' work and pay per week eliminates or satisfactorily ameliorates any adverse impact.

6.54 The claim should be dismissed.

7. CLAIMS TO VARY THE BROKEN SHIFTS PROVISION (S35, S36, S37)

7.1 There are various claims on foot in respect of clause 25.6 of the Award.

7.2 While there is a degree of overlap between the three Union claims, each of the Union claims is different, as summarised below.

The HSU claim (S35)

7.3 The HSU seek to materially vary the broken shifts provision (clause 25.6) of the Award. The proposal involves varying the existing clause in at least six respects:

(a) firstly, they seek to limit the clause to part-time and casual employees, thereby preventing full-time employees from being permitted to work broken shifts;

(b) secondly, they seek to impose a limit of one break per broken shift;

(c) thirdly, they seek to introduce a requirement that broken shifts only be worked where there is mutual agreement between the employer and individual employee

(d) fourth, they seek to introduce a requirement that each portion of a broken shift be subject to the proposed 3 hour minimum engagement;

(e) fifth, they seek that travel time between broken shifts be treated as time worked and be paid at the appropriate rate; and

(f) sixth, they propose that the shift allowances be determined by either the starting time or the finishing time of the broken shift, whichever is the greater.

7.4 This reply submission does not deal with the travel time aspects of the HSU's claim.

The United Voice claim (S37)

7.5 The United Voice seek a different variation to clause 25.6, which involves two main components:

(a) firstly, they seek to impose a limit of two portions to a broken shift; and

(b) secondly, they seek a variation to the way in which the existing loading is determined.

The ASU claim (S36)

7.6 The ASU seek the introduction of a 15 percent loading to be paid when employees work a broken shift. The loading is expressed to be payable not in respect of each hour worked during a broken shift, but in respect of the entire duration of the broken shift from

commencement of the first portion of work to the cessation of the final portion of work (inclusive of breaks).

7.7 Further, the loading is proposed to be payable in addition to the existing requirement that penalty rates and shift allowances in accordance with clause 29 be payable, with shift allowances being determined by the finishing time of the broken shift.

Grounds relied upon by the Unions in support of the proposed variations

7.8 In relation to the HSU claim, the grounds relied upon in support of the variations are summarised as follows:

(a) firstly, the HSU assert that the broken shifts provision is "manifestly open to exploitation" in the absence of appropriate minimum engagement provisions;[44]

(b) secondly, the capacity for multiple breaks during a broken shift can result in:

(i) employees having to undertake work on a non-consecutive basis over an extended period of time in order to generate a reasonable amount of earnings;[45]

(ii) employees being paid only for a proportion of the time that is expended in performing the work required by the employer;[46] and

(iii) employees can endure stretches of "dead" time waiting time during the course of the day.[47]

7.9 In relation to the United Voice claim, the grounds relied upon in support of their claim include:

(a) that it is common for employers to only provide employees with a few paid hours of work in several broken shifts over a long span of hours;[48]

(b) that the impact of broken shifts on employees is compounded by other "issues" within the Award, including the lack of minimum engagements for part-time employees, and the practice of some employers requiring employees to travel to the next work location during unpaid break periods;[49]

[44] HSU submission at [36]
[45] Ibid at [37]
[46] Ibid
[47] Ibid
[48] United Voice submission at [114]
[49] Ibid at [115]

(c) a submission that broken shifts are disruptive to the lives of employees;[50] and

(d) a submission that the current method of calculating shift premiums is anomalous and results in employees not receiving adequate additional remuneration for working shifts.[51]

7.10 In relation to the ASU claim, the rationale for the proposed 15 percent loading is said to be to compensate employees for the "disutility" or "disability" associated with working broken shifts.[52] The ASU also submit that:

(a) the existing clause provides employers with "exceptional" rostering flexibility without significant restriction or compensation;[53]

(b) other features of the Award contribute to provide for significant rostering flexibility with little restriction;[54]

(c) the broken shifts provision in the Award is out of sync with broken shift provisions in other Awards.[55]

7.11 Our clients' response to these Union claims is set out as follows.

Background to the broken shifts clause

7.12 Under the current Award, clause 25.6 provides for certain types of work[56] to be undertaken on a non-consecutive basis.

7.13 Clause 25.6(b) currently provides for broken shifts to be paid at "ordinary pay with penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the finishing time of the broken shift".

7.14 The effect of clause 25.6(b) is that employees working broken shifts are shiftworkers for the purposes of the Award and receive the applicable shift loading in respect of the broken shift.

7.15 There is a very clear and compelling basis for the Award to permit the working of broken shifts. Due to the nature of the work being undertaken by support workers, there is a very clear pattern of service/labour demand whereby customers wish to receive services for a

[50] United Voice submission at [126]
[51] Ibid at [147] to [148]
[52] ASU submission at [18]
[53] Ibid at
[54] Ibid at [23]
[55] Ibid at [31] to [32]
[56] Clause 25.6 only applies to employees in the home care stream and employees in the social and community services stream when undertaking disability services work.

short period of time in the morning, and then again for a short period in the evening. There is also evidence that supports a third peak in demand around midday.

7.16 Accordingly, the broken shifts clause allows employees to provide services on a non-continuous basis to meet customer demand. Absent such a provision, employees would not be able to be given the same number of hours' work, or alternatively employers will not be able to meet customer needs, which is inconsistent with the consumer directed care reform agenda.

Consideration of the broken shifts clause during the 2 yearly review

7.17 The broken shifts provision was considered during the 2 yearly review. In that matter, the ASU sought to vary clause 25.6 to remove the availability of broken shifts in the disability services sector. In the alternative, the ASU sought the introduction of a broken shift allowance.

7.18 In that review process, Vice President Watson concluded that he was not satisfied that a case had been made out to modify the existing arrangements.

7.19 Ultimately, the unions (and particularly the ASU) are simply seeking to re-litigate a matter which had previously been advanced and rejected.

7.20 That said, we respond to the contentions advanced in support of the claims.

Other changes can remedy any concern that may exist with the broken shifts provision

7.21 Our clients accept that the current Award requires amendment to ensure that employees are not exposed to practices which do not provide them with a fair and relevant safety net of terms and conditions. However, our clients do not accept that there is any need to materially alter the broken shifts provision.

7.22 Rather, our clients consider that the issues identified by the unions can be properly addressed and rectified by:

(a) making some modest adjustments to the broken shifts provision (as detailed below);

(b) addressing the concerns around travel time; and

(c) by introducing appropriate minimum engagements for part-time employees in the form suggested in paragraphs 6.47 and 6.48 above.

7.23 This approach is at least in part acknowledged by United Voice, who contend in their written submissions that "the impact of broken shifts on employees is compounded by other 'issues' within the Award, including the lack of minimum engagements for part-time employees, and

the practice of some employers "requiring employees to travel to the next work location during unpaid break periods".[57]

7.24 We now turn to the specific claims advanced by the unions and our position with respect to same.

Response to the Union claims

Response to the HSU claims

7.25 Firstly, in respect of the HSU proposal to limit the application of the broken shifts clause to part-time and casual employees, the basis for that proposal is not clear. The HSU submissions do not appear to address this issue at all.

7.26 In respect of the proposal to impose a limit of one break per broken shift such that a broken shift cannot consist of more than two portions of work, our clients are opposed to this claim for a number of reasons. Firstly, such a variation would reduce operational flexibility and prevent employers from having employees work a broken pattern of work across the course of a day to meet customer needs. Secondly, the variation would likely have the effect of reducing the number of hours that employers can offer to employees, thereby reducing their hours of work and take home pay.

7.27 That said, to the extent that the Commission was minded to impose a restriction on the number of portions of a broken shift, our clients would not oppose a variation to the Award that would only permit a broken shift of more than two portions of work to be worked by agreement with an individual employee.

7.28 Our clients are not opposed to the proposal to introduce a requirement that broken shifts only be worked where there is mutual agreement between the employer and individual employee.

7.29 In relation to the proposal that a three hour minimum engagement be applied to each portion of a broken shift, our clients oppose that variation. The minimum engagement applicable to a broken shift should be considered in the context of the recent findings in the *Casual and Part Time Employment Decision* and the previous authorities considered in that decision. For example, the notion of a "daily" minimum engagement had effectively developed to ensure employees received a sufficient level of remuneration to justify their attendance at work. On that logic, if the Commission has determined an appropriate minimum daily engagement, it is unclear why that period would apply twice if a broken shift

[57] United Voice submission at [124]

is work. This is particularly so given that the broken shifts provision of the Award already provides for a shift loading.

7.30 In relation to the proposal that the shift allowances be determined by either the starting time or the finishing time of the broken shift, whichever is the greater, our clients do not oppose this variation.

Response to the United Voice claim

7.31 In respect of the proposal to impose a limit of one break per broken shift such that a broken shift cannot consist of more than two portions of work, we refer to paragraphs 7.26 and 7.27 above.

7.32 In relation to the proposal that the shift allowances be determined by either the starting time or the finishing time of the broken shift, whichever is the greater, our clients do not oppose this variation (as stated in paragraph 7.30 above).

Response to the ASU claim

7.33 Our clients are opposed to the introduction of a 15 percent loading to be paid when employees work a broken shift.

7.34 While our clients do not cavil with the contention that there is likely to be a degree of disutility associated with working a broken shift for some employees, it is not appropriate that a 15 percent loading be applied *in addition* to the existing penalty rates and shift allowances.

7.35 Further, it is not fair or reasonable that the 15 percent loading be payable in respect of the entire duration of the broken shift from commencement of the first portion of work to the cessation of the final portion of work (inclusive of breaks and unpaid non-working time). This is plainly unreasonable.

7.36 By way of illustration, a common working pattern is for employees to perform a 2-3 hour shift in the morning, and then have a large break from work until the afternoon or evening where a further period of work is performed. The gap between the two portions of the broken shift may in many cases be in the range of 6-8 hours, which provides an ample period of time for employees to engage in leisure activities, go home, rest, or in some cases perform work in secondary employment. It is not fair or reasonable for an employer to be required to pay a 15 percent loading in respect of a 12 hour span, in circumstances where up to 8 hours of that period the employee was not at work.

7.37 In respect of part-time employees, the alleged 'disutility' of working broken shifts needs to be assessed against the requirement at clause 10.3(c) that their pattern of work be agreed in writing on commencement of employment. In light of that existing protection, any disutility arising from a broken shift is largely mitigated by the employee having agreed on commencement of employment to the pattern of work and by having advanced notice of that fixed pattern of work.

7.38 Lastly, there is no merit basis for casual employees to receive an additional loading for working broken shifts. Casual employees receive a casual loading which compensates for working irregular hours. Further, casual employees are under no obligation to accept shifts that they do not wish to take on.

8. HSU CLAIM RELATING TO OVERTIME FOR PART-TIME AND CASUAL EMPLOYEES (S50)

The HSU claim

8.1 The HSU seek the introduction of new overtime benefits for part-time and causal employees. Under the proposed variation:

(a) part-time employees would be entitled to overtime when working in excess of their rostered hours; and

(b) both part-time and casual employees will be entitled to overtime when working in excess of 8 hours per day.

8.2 Under the current Award, no overtime is payable where part-time employees agree to work additional hours (i.e. additional to their rostered hours), save for where they work in excess of 10 hours per day, 38 hours in any week or 76 hours in any fortnight.[58] In respect of casual employees, the current Award provides for overtime where they work in excess of 10 hours per day, 38 hours in any week or 76 hours in any fortnight.[59]

8.3 The grounds relied on by the HSU in support of the variation consist of the following:

(a) the absence of overtime rates for part-time employees working additional hours creates a "structural incentive" on the part of employers to underestimate the number of hours of work required of the employee[60] and utilise part-time workers like a pool of casual employees[61];

(b) work performed by carers in private homes and in the community providing personal or domestic assistance is both physically and mentally taxing;[62]

(c) the taxing nature of the work is compounded by the (often unpaid) travel involved;[63] and

(d) during long shifts, there may be little opportunity, or appropriate facility, for proper rest breaks.[64]

Response to the HSU claim

8.4 It is difficult to understand the rationale for this claim.

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[58] See clauses 28.1(b) (i), (ii) and (iii)
[59] See clauses 28.1(b) (i) and (ii)
[60] HSU submission at [46]
[61] Ibid
[62] Ibid at [47]
[63] Ibid
[64] Ibid

8.5 Many of the concerns raised by the Unions in these proceedings revolve around underemployment and their members having to work a particular pattern of work that is too short, or not efficiently allocated, or where their members are not able to secure as many hours of work as they would like. There is also evidence of employees being engaged in secondary employment in order to secure a sufficient amount of work. By way of example, the Unions assert that:

(a) there are high levels of underemployment within the sector, necessitating secondary employment;[65]

(b) since the commencement of the Award, there has been an increase in the proportion of care workers employed for fewer hours;[66] and

(c) there is a need for employees to work additional hours to maximise their incomes.[67]

8.6 The HSU claim runs counter to the above concerns.

8.7 The proposed variation will do nothing to address the above concerns, and will only have an adverse affect on both employees and employers.

8.8 The claim should be dismissed for the following reasons:

(a) the claim for overtime entitlements for hours worked in excess of 8 hours per day is inconsistent with the overall modern awards system and the position in other comparable modern awards;

(b) a case has not been made out on the evidence that would justify the introduction of overtime after 8 hours (rather than the existing position which is 10 hours);

(c) a very likely consequence of the variation would be a reduction in the working hours of part-time and casual employees, as employers will adopt rostering practices in order to avoid triggering overtime entitlements; and

(d) the mischief which the claim intends to seek to largely address can be more effectively dealt with in a more appropriate way by implementing certain safeguards to prevent employers from artificially underestimating the number of hours of work that can be given to part-time employees.

8.9 These matters are expanded on as follows.

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[65] See United Voice submission at [133]
[66] See HSU submission at [15]
[67] See ASU submission at [27]

Proposal to introduce overtime for work in excess of 8 hours in a day

8.10 The proposal to introduce overtime rates for work performed in excess of 8 hours in a day is inconsistent with the current modern awards system, and does not accord with the position in comparable modern awards. By way of example:

(a) the *Nurses Award 2010*, under which caring work of a similar nature is performed, provides for 10 hours to be worked before overtime rates are payable;[68]

(b) the *Health Professionals and Support Services Award 2010,* under which caring work of a similar nature is performed, provides for 10 hours to be worked before overtime rates are payable;[69]

(c) the *Supported Employment Services Award 2010,* under which employees responsible for the supervision of employees with a disability are employed, provides for 10 hours to be worked before overtime rates are payable;[70]

(d) the *Aged Care Award 2010*, under which caring work of a similar nature is performed, provides for 10 hours to be worked before overtime rates are payable;[71] and

(e) the *Local Government Industry Award 2010* provides for between 10 and 12 hours to be worked before overtime rates are payable.[72]

8.11 The current Award position cannot be said to be inconsistent or out of sync with other comparable awards such as those set out above. Further, while the work of many employees covered by the Award may well be physically or mentally challenging, it cannot fairly be said to be any more taxing than the work of nurses, health professionals, employees supervising supported employees, and the work of other employees doing comparable work.

8.12 Significantly, it should be noted that the *Local Government Industry Award 2010* covers employees of local government employers who perform community care work, which is essentially the same work as that regulated by the SCHCDS Award.

8.13 It is also notable that other inherently dangerous industries such as the road transport industry permit a greater number of hours to be worked before overtime rates are triggered.[73]

[68] Clause 21.2
[69] Clause 23.3
[70] Clause 21.5
[71] Clause 25.1
[72] Clause 21.5.

8.14 No persuasive evidentiary case has been advanced which would support a conclusion that the current Award position is inadequate.

Proposal to introduce overtime for agreed additional hours by part-time employees

8.15 The proposal to introduce overtime entitlements for part-time employees working additional hours is a significant claim, and is a significant departure from the current Award position.

8.16 Since its introduction in 2010, the Award has allowed for part-time workers to work hours that are in excess of their rostered hours, by agreement. Where there is such an agreement, no overtime is payable in respect of those hours.

8.17 This has been a longstanding and well-established arrangement in the SCHCDS industry.

8.18 This well-entrenched industrial standard recognises the lack of certainty in demand for labour and the variability in working hours that naturally occurs when providing care services to individuals whose circumstances are subject to change.

8.19 It also provides a mechanism for employees to be given additional hours without the structural disincentive of triggering overtime payments. The simple reality is that employers would not readily offer employees additional hours if it would trigger an additional cost.

Implications of the proposed variations

8.20 Giving the funding constraints plaguing the industry, employers do currently and will continue to actively seek to avoid or minimise the number of overtime hours that are worked/paid.

8.21 As an example, the NDIS pricing system does not factor in overtime rates of pay, which means that if employers are required to pay overtime rates for particular hours of work, they cannot recover that cost from the participant or the NDIA. The effect of this would very likely be that the particular service is rendered unprofitable and cost accreting for the employer.

8.22 There is no reasonable basis for the imposition of overtime penalties for work in excess of 8 hours in a day, or where part-time employees agree to work additional hours, when one properly considers both:

(a) the obvious adverse implications for employers; and

(b) the very likely adverse implications for employees (as detailed below).

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[73] *Road Transport (Long Distance Operations) Award 2010*, clause 20.2(b)(ii).

8.23 The very likely implication of this claim for most Award-covered businesses in the SCHCDS industry would be that employers would take all available steps to ensure that part-time and casual employees never work more than 8 hours in a day. For those employees who are currently receiving shifts of more than 8 hours' duration, the employer will look at alternative options regarding the arrangement of work in order to avoid triggering overtime payments. This is borne out in the evidence of service providers filed in these proceedings.

8.24 Equally, employers would have no choice but to dramatically adjust their business models to avoid part-time employees triggering overtime payments for agreed additional hours.

8.25 In our submission, to the extent that the Commission considers that a variation is necessary in this regard, there are more effective ways to remedy the issues raised by the union which will not create chaos for a large part of the industry. This is addressed below.

Addressing the HSU's concerns around part-time employee hours

8.26 To the extent that the Commission forms the view that the Award contains any 'structural incentive' to set part-time employees' hours of work at artificially low levels, one approach to addressing that issue might be to introduce a mechanism for reviewing employees' hours upon request and adjusting their guaranteed hours to a more realistic reflection of their actual working patterns, subject to an ability for employers to refuse on reasonable business grounds.

8.27 This approach has been adopted in the context of enterprise bargaining in this sector. For example, we are aware of a number of enterprise agreements in the aged care and home care sector that contain a clause in the following form (or similar):[74]

Review of part time hours

(a) At the request of an employee, the hours worked by the employee will be reviewed annually. Where the employee is regularly working more than their guaranteed minimum number of hours then such hours shall be adjusted by the employer, and recorded in writing to reflect the hours regularly worked.

(i) The hours worked in the following circumstances will not be incorporated in the adjustment:

[74] For example; The Presbyterian Aged Care, NSWNMA and HSU NSW Enterprise Agreement 2017-2020; BaptistCare NSW & ACT Aged Care Enterprise Agreement 2017; McLean Care Ltd (NSW), NSWNMA and HSU NSW Enterprise Agreement 2017-2020; The Lutheran Aged Care Albury NSWNMA and HSU NSW Enterprise Agreement 2017-2020 and Diocese of Lismore Care Services, NSWNMA and HSU NSW Enterprise Agreement 2017-2020.

A. If the increase in hours is as a direct result of an employee being absent on leave, such as for example, annual leave, long service leave, parental leave, workers compensation; and

B. if the increase in hours is due to a temporary increase in hours, for example, due to the specific needs of a resident or client.

(ii) In addition to those matters covered in sub-clause x.x(a)(i) changes to hours for Home Care employees may be affected by:

A. continuity of funding;

B. client numbers; and

C. client preferences for services including their ability to choose particular care workers.

(iii) The employer will not unreasonably refuse to change the hours of a Home Care employee based on the circumstances in subclause x.x(a)(ii) unless there is an imminent change to any of those circumstances.

8.28 The above mechanism provides an opportunity for employees who regularly work in excess of their contracted hours to request that their hours be reviewed and increased on an annual basis, and employers cannot unreasonably refuse.

8.29 In our submission, such an approach would remedy the concerns raised by the HSU.

9. CLAIMS RELATING TO THE TELEPHONE ALLOWANCE (S21)

9.1 Two separate claims have been advanced by the unions in respect of clause 20.6 of the Award.

The HSU claim (S21)

9.2 The HSU seek a variation to the telephone allowance at clause 20.6 of the Award. The stated purpose of the variation is to effectively modernise the provision which is currently expressed to apply only to situations where an employee is required to install and/or maintain a landline telephone for the purpose of being on call.

9.3 The HSU propose to extend both the operation of the provision and the quantum of the entitlement.

9.4 In respect of the operation of the provision, the HSU propose that the entitlement apply:

(a) where an employee is required to use a mobile phone rather than a landline telephone; and

(b) where the employee is required to use the phone for "any work related purpose" rather than only where employees are required to be "on-call".

9.5 Further, the HSU seek to alter the substance of the entitlement. The HSU propose that where the clause is triggered, employees be entitled to either:

(a) the provision of a mobile phone that is fit for purpose *and* reimbursement of the cost of "any subsequent charges"; or

(b) be refunded for the "cost of purchase" and "subsequent usage charges" on production of receipts.

9.6 The grounds advanced by the HSU in support of the variation include:

(a) that the current telephone allowance clause is "outdated" because it refers to a landline telephone and does not deal with mobile phones;[75]

(b) that the vast bulk of employees now have mobile phones which are available to them during the course of their work;[76]

(c) that employers "frequently require or expect" care workers to be contactable by mobile phone when performing their duties;[77]

[75] HSU Submission at [59]
[76] Ibid

(d) that employees who are required to use their phones for work purposes should receive a telephone allowance "that reflects the cost of maintaining and using such mobile phone";[78] and

(e) that employees required to use a smart phone should be reimbursed for the cost of purchasing one "if such purchase is necessary".[79]

The United Voice claim (S21)

9.7 The United Voice advances a similar claim to the HSU claim.

9.8 The variation sought by the United Voice is expressed in different terms:

> *Where the employer requires an employee to install and/or maintain a telephone or mobile phone for the purpose of being on call, for the performance of work duties or to access work related information, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts.*

9.9 As can be seen from the above drafting, the United Voice claim differs from the HSU claim in the following respects:

(a) the allowance is payable on three specific occasions, being when an employee needs a phone for:

(i) the purpose of being on call;

(ii) the performance of work duties; or

(iii) the purpose of accessing work related information.

(b) the employer is required to refund the installation costs, but not to 'provide a mobile phone'.

9.10 The grounds advanced by the United Voice in support of their claim are summarised as follows:

(a) the Award contains no clear allowance or mechanism for an employee who is required to purchase and maintain a mobile phone for work purposes to receive any reimbursement of costs associated with the work related use of the phone;[80]

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[77] HSU Submission [60]
[78] HSU Submission [60]
[79] HSU Submission [60]
[80] United Voice Submission at [82]

(b) the Award contains classifications where work takes place outside a conventional workplace office and an assertion that employees therefore perform a significant amount of work away from the workplace;[81]

(c) a general assertion that a mobile phone has the "status" of a tool of trade and that where a mobile phone has become a tool of the trade and an employee is directed to use one for work, the employee should be reimbursed;[82]

(d) a reference to an apparently "established principle" of the modern awards system "generally" providing some form of compensation where an employer directs an employee to use a particular "tool of trade";[83]and

(e) that the telephone allowance in the Award is anachronistic, does not reflect the current ubiquity of mobile 'smart' phone use and their status as work tools.[84]

Failure to adduce relevant evidence in support of the claim

9.11 While there is evidence of widespread mobile phone and smart phone ownership throughout Australia and evidence from some employees within the industry, the Unions have failed to adduce any evidence of:

(a) the proportion of employees in the industry who are required to use mobile phones in the course of their employment; and

(b) the proportion of work-related versus non-work-related usage by employees of mobile phones.

9.12 Nor is there any evidence before the Commission of:

(a) any Award-covered employer requiring prospective employees, as a condition of employment, to own a mobile phone; or

(b) any Award-covered employer directing or otherwise requiring existing employees to purchase a mobile phone.

9.13 Indeed, the evidence on smart phone and mobile phone ownership in Australia recently relied upon in the review of the *Aged Care Award 2010* suggested that such scenarios would be very rare – for example:

(a) approximately 83 per cent, or 15.97 million Australian adults, already have a smart

[81] United Voice Submission at [83]
[82] United Voice Submission at [90]
[83] Ibid
[84] Ibid at [101]

(b) phone; and

(c) approximately 96 per cent, or 18.57 million Australian adults, own a mobile phone.[85]

9.14 When one takes into consideration the fact that elderly adults are less likely to have a mobile phone, the data suggests that it would be highly unusual for someone of working age to not own a smart phone, let alone a mobile phone.

9.15 In line with the above, the evidence from United Voice is that the employees already have their own mobile phone, and that upon commencement of employment, the employee is asked for their mobile number so that the employer can communicate with the employee with regard to rosters.[86]

9.16 Evidence from the HSU suggests that some employers provide mobile phones[87], and others have employees use their own mobile phone which they already own.[88]

Response to Unions' claims

9.17 There are a range of issues with the drafting of the proposed claims.

9.18 Firstly, the submissions appear to be advanced in respect of "care workers".[89] However, the application of both clauses is not confined in such a manner. Rather, it is expressed to apply to all employees covered by the Award. This would extend to managerial staff and other very senior employees who do not work as carers or support workers.

9.19 Secondly, the HSU clause requires an employer to either "provide" a mobile phone, or refund the "cost of purchase" of a mobile phone, where one is required to be used for specified purposes. However, there is no exemption in circumstances where an employee already owns a mobile phone. There is nothing to prevent an employee who already owns a mobile phone from purchasing a new one, simply in order to obtain the reimbursement for it.

9.20 Thirdly, there is nothing to prevent an employee from seeking reimbursement of the purchase costs of a mobile phone that was purchased years before the employer required the employee to use it for work purposes, provided the employee can produce "receipted

[85] Australian Communications and Media Authority, Communications Report 2017-2018, p. 33. (30 November 2018)
[86] Statement of Trish Stewart at [21], Statement of Deon Fleming at [28], Statement of Belinda Sinclair at [16], Statement of
[87] Statement of Thelma Thames at [22], Statement of Heather Waddell at [31], Statement of Pamela Wilcock at [19]
[88] Statement of Bernie Lobert at [18]
[89] See HSU submission at [60] and United Voice Submission at [83]

accounts". This would result in the employer bearing the costs of a depreciated asset and subsidising the employee's personal use of the device.

9.21 Fourth, in relation to both Union claims, there is no limitation on the costs which are required to be borne by the employer.

9.22 There is no reference to refunding the "reasonable" purchase costs or "reasonable" subsequent charges. There is also no mechanism in the clause for the employer to have any control or oversight at all over the type of device or service arrangement that employees might purchase or enter into. It appears that the employee would be free to decide what device to purchase and what service arrangement they wish to obtain.

9.23 The evidence tendered during the hearing in relation to the review of the *Aged Care Award 2010* demonstrated that the costs of mobile phones (both up-front costs and ongoing usage costs) vary wildly depending on:

(a) The type of device purchased;

(b) The type of usage 'plan' or fee arrangement that is in place;

(c) The amount of 'data' provided for use under the plan; and

(d) The extent of usage by the employee (in relation to calls, texts and 'data').

9.24 Fifth, both clauses fail to link the monetary entitlement to the type of device that an employer requires an employee to use. For example, an employer may only require an employee to have a basic mobile device that allows them to make and receive phone calls and text messages, yet unless the employer physically provides the device, the employer would be obliged to cover the purchase costs of whatever device the employee chooses to purchase (which may not be the basic device required by the employer). There is nothing to prevent an employee from purchasing a smart phone even though the employer only requires a more basic device.

9.25 Sixth, and most importantly, the clauses do not require an employer to reimburse or refund an employee for only the work-related costs associated with the use of a mobile phone. It requires the employer to cover all costs, both up-front costs and "subsequent charges". This is plainly unreasonable.

9.26 In practice, if the claim was to be successful, an employee could be required by their employer to use their mobile phone once per week to check their work roster, and the employer would automatically be obliged to cover both the purchase costs of the mobile device and the subsequent charges relating to the device. There would be nothing

preventing the employee from taking out the most expensive mobile phone plan, using it virtually exclusively for personal use, and requiring the employer to foot the bill.

9.27 In relation to the United Voice claim specifically, the drafting uses the same wording that was used for the home phone telephone allowance that exists within the Award already. This means that there is reference to 'installation costs' being refunded. A mobile phone does not need to be installed and there would be no costs associated with that. It is therefore not clear if this is intended to entitle employees to be refunded the cost of purchase (as is the case with the HSU claim), or if the reference to installation is irrelevant in respect of mobile phones.

Implications of the Unions' claim

9.28 The Unions' claim would undoubtedly have a considerable adverse impact on employment costs for employers.[90] More importantly, it would impose an unreasonable cost on employers, given the issues identified above.

9.29 There has been no attempt by the Unions to limit the cost imposition on employers to only those expenses which are directly attributable to the work-related use. This does nothing to achieve a "fair and relevant" minimum safety net.

9.30 Of significant concern is the fact that the cost to be borne by employers under the proposal will be disproportionate to any benefits that an employer would derive, given that they will be subsidising an employee's (potentially significant) personal use. It is not difficult to imagine situations where an employee inadvertently incurs a huge mobile phone bill because they or a family member streams movies through a mobile device while travelling on a family holiday. On the drafting proposed by the Unions, the employer will be required to reimburse the employee for these costs.

9.31 It is difficult to understand how an employer can reasonably be expected to reimburse an employee for the up-front and ongoing costs of their mobile phone in circumstances where the employee already owned a mobile phone prior to commencing work with the employer, and primarily uses it for personal use.

9.32 The Unions' claim also fails to recognise that where an employee incurs a work-related expense, the applicable income tax legislation entitles the employee to claim a tax deduction, which has the effect of reducing the individual's taxable income (and thereby

[90] *Fair Work Act 2009* (Cth), s. 134(1)(f)

reduces the amount of income tax required to be paid). This is a fundamental and well-established feature of the income tax system in Australia.

9.33 One of the rationales for the current system of tax deductibility of work-related expenses is that it generates consumption benefits and stimulates the economy. Another important rationale is that certain cost items tend to have mixed uses or mixed functions (i.e. certain costs are partly work-related and partly non-work related). For example, employees incur a range of expenses which are partly work-related and partly for personal use. Common expenses include motor vehicle expenses, telephone expenses, home internet, laundry expenses, home office expenses, etc.

9.34 The vast majority of costs borne by employees through the purchase, use and maintenance of their mobile phone will almost certainly be related to their personal use of the device (rather than work-related use). We would expect that for most employees, their work-related usage would be only a small proportion of their overall usage, and as such the work-related costs would be a small proportion of the overall costs.

9.35 In light of the anticipated breakdown of the source of cost, in our submission the current tax deductibility system is the appropriate mechanism for this usage to be dealt with.

Conclusion

9.36 Our clients are opposed to the Unions' claims for the reasons outlined above. A merit basis for the claim has not been made out. No mischief or problem has been properly identified which would warrant the intervention of the Commission. The claim will pass an unreasonable cost onto employers, which is in no way equivalent to the usage of mobile phones for work-purposes. The claim would effectively require employers to subsidy employees' personal usage of a personal device, for which employers have no way of controlling or maintaining. This is plainly unreasonable, and is inconsistent with the notion of creating a fair and relevant minimum safety net of terms and conditions. The proposed Award term will result in the Award not meeting the modern awards objective. The proposed term offends section 138 of the FW Act.

9.37 The Unions' claims should be dismissed.

10. CLAIMS RELATING TO CLOTHING AND UNIFORMS (S20, S2A, S20A)

The HSU claim (S20A)

10.1 The HSU seek the introduction of a new clause in the Award (to be numbered clause 20.3) to provide for a "damaged clothing allowance".

10.2 Under the proposed clause, employers would be required to compensate employees, to the amount of the "reasonable replacement value", for any damage to, or soiling of, any clothing or other personal effects (excluding hosiery) which are damaged in the course of the employee's employment.

10.3 The grounds relied upon by the HSU in support of this variation consist of the following:

(a) an assertion that many employees, particularly support workers in home care and disability services, wear their own clothes to work and are not provided with a uniform;[91]

(b) a submission that employees' clothes are at risk of being soiled or damaged in the course of their duties;[92] and

(c) an assertion that employees' clothes "will frequently become damaged, soiled or worn" given the nature of the work they do.[93]

Response to the HSU claim

10.4 The Award already contains an allowance at clause 20.2 for uniforms and their laundering. That provision is expressed as follows:

(a) Employees required by the employer to wear uniforms will be supplied with an adequate number of uniforms appropriate to the occupation free of cost to employees. Such items are to remain the property of the employer and be laundered and maintained by the employer free of cost to the employee.

(b) Instead of the provision of such uniforms, the employer may, by agreement with the employee, pay such employee a uniform allowance at the rate of $1.23 per shift or part thereof on duty or $6.24 per week, whichever is the lesser amount. Where such employee's uniforms are not laundered by or at the expense of the employer, the employee will be paid a laundry allowance of $0.32 per shift or part thereof on duty or $1.49 per week, whichever is the lesser amount.

[91] HSU submission at [61]
[92] Ibid
[93] Ibid at [62]

10.5 If an employer does not provide the employee with a uniform (as is the case with the two witnesses that provide evidence in support of the HSU claim), the employee is entitled to receive a uniform allowance. This uniform allowance can be used to purchase clothes to wear to work, and, if those clothes become damaged in the course of their employment, to replace them. The alternative is that the employer provides a uniform, and if it is damaged, the employer replaces the uniform.

10.6 The primary concern with this variation is that the Award already provides an allowance for employees who are not issued with a uniform.

10.7 There are also both drafting and practical issues with the clause., given the lack of precision around how the replacement value of clothing is to be calculated and the phrase "suffers any damage".

10.8 For example, it is not clear how an employer should determine what the "reasonable replacement value" is, and whether the employer would be required to replace a second-hand piece of clothing with a new piece of clothing.

The United Voice claim (S2A, S20)

10.9 United Voice seek the introduction of a new clause 20.2(b) in the Award to insert additional wording in relation to the requirement that an "adequate number of uniforms" be provided to an employee.

10.10 Under the proposed clause, employers would be required to provide employees with enough uniforms to allow employees to go the full week without needing to launder their work uniforms more than once per week.

10.11 Our clients do not accept the contention advanced by United Voice that "the decision as to what constitutes an 'adequate' amount of uniforms is often made solely by the employer".[94] The Award terms are clear, and the obligation requires an objective assessment as to the adequacy of the number of uniforms to be provided, having regard to the particular circumstances.

10.12 If there is any dispute about the number of uniforms provided by a particular employer, the matter can be resolved through the application of the dispute resolution procedure provided for in the Award including, if necessary, the involvement of the Commission.

10.13 We do not consider that a sufficient case has been made out for this variation.

[94] United Voice submission at [50]

11. CLAIM RELATING TO RECALL TO WORK (S22)

The HSU claim

11.1 The HSU seek a variation to clause 28.4 to introduce a regime for compensation where employees are required to perform work remotely outside of working hours, without having to physically be recalled to work.

11.2 Under the HSU proposal, the employee would be entitled to a minimum of one hour's pay at overtime rates "for each time recalled".

11.3 The HSU have not advanced any submission as to why the minimum payment of one hour's pay should be adopted, other than to point out that the "work should be compensated appropriately".[95]

11.4 There is no specific submission which addresses why a minimum payment of one hour is appropriate, or why such a payment provides employees with 'fair and relevant' compensation for the disutility associated with working at the particular time(s) to which the penalty attaches.[96]

11.5 Our clients are opposed to the HSU claim.

Our clients' competing proposal

11.6 Our clients have a competing claim in respect to this issue.

11.7 Our clients' claim involves a proposed new clause 20.10, as well as consequential amendments to clauses 20.9 and 28.4. Under the proposed new clause 20.10, employees would be entitled to payment for performing remote response duties, with the quantum of such payment and the relevant minimum payment dependent on when the remote response duties are performed.

11.8 Specifically, it is proposed that employees be paid:

(a) at the applicable rate of pay for work performed between 6.00am and 10.00pm, with a minimum payment of 15 minutes; and

(b) at the applicable rate of pay for work performed between 10.00pm and 6.00am, with a minimum payment of one hour.

[95] HSU Submission of 15 February 2019, at [71].
[96] See Penalty Rates Decision at [202].

11.9 While there is a large degree of overlap between the competing proposals, the key difference between the proposals relates to the scheme of remuneration to be applied when employees perform remote response work.

11.10 We refer to our submissions dated 2 July 2019 as to the reasons why our clients' proposal is to be favoured and should be adopted.

12. CLAIM RELATING TO CLIENT CANCELLATION PROVISION (S29)

The HSU claim

12.1 The HSU seek a variation to the client cancellation provision at clause 25.5(f) to increase the amount of notice required to be given by employers to employees in the home care stream of a cancellation of, or change to, a rostered home care service in order to avoid the obligation to pay the employee for the cancelled shift.

12.2 Under the HSU proposal, where an employer fails to provide the employee with 48 hours' notice of a cancelled shift, the employer would be required to pay the employee for their minimum specified hours on that day.

Our clients' position on the HSU claim

12.3 Our clients are opposed to the HSU's claim. The reality is that most cancellations or changes to rostered home care services by customers are made in the 24 hours prior to the commencement of the scheduled service. The evidence before the Commission will overwhelmingly support this.

12.4 That being the case, the HSU variation would effectively nullify the utility of this clause for employers, which is more important than ever in the context of the consumer-directed-care reforms that have recently been implemented.

Our clients' competing proposal

12.5 Our clients recognise that the current client cancellation clause requires review and amendment to ensure:

(a) it provides a fair and balanced framework for dealing with client cancellation events;

(b) its scope is extended to disability services work; and

(c) it operates harmoniously with other Award provisions concerning roster changes.[97]

12.6 Our clients are pursuing a separate variation to this clause, which is set out in a Draft Determination filed on 2 April 2019, and supported by submissions filed on 2 July 2019.

12.7 It is critical that the current client cancellation clause be extended to the disability services sector, and that it operates harmoniously with the NDIS rules and pricing arrangements dealing with client cancellations. We refer to paragraphs 5.1 to 5.20 of our submissions filed on 2 July 2019.

[97] The clause as currently drafted is arguably inconsistent with clause 10.3(c) in respect of part-time employees.

13. CLAIM RELATING TO THE SLEEPOVER CLAUSE (S38)

The HSU claim

13.1 The HSU seek to vary clause 25.7(c) of the Award which relates to sleepovers. In essence, the HSU propose to vary the items required to be provided to employees when performing a sleepover.

13.2 The current Award clause provides:

(c) The span for a sleepover will be a continuous period of eight hours. Employees will be provided with a separate room with a bed, use of appropriate facilities (including staff facilities where these exist) and free board and lodging for each night when the employee sleeps over.

13.3 Under the variation proposed by the HSU, employers would be required to provide the following:

(a) "a separate and securely lockable room with a peephole or similar in the door, a bed and a telephone connection in the room";

(b) "suitable sleeping requirements such as a lamp and clean linen";

(c) use of appropriate facilities (including staff facilities where these exist); and

(d) free board and lodging for each night when the employee sleeps over.

13.4 Items (a) and (b) above represent variations to the current Award provision.

13.5 In support of this claim, the HSU have filed written submissions totalling two paragraphs, one of which does not deal with the specific variation that has been sought.[98] The submissions advanced in support of the variation are limited to:

(a) a submission that the Award should be varied "to ensure appropriate facilities are provided" to employees when undertaking a sleepover; and

(b) an opinion that sleepover shifts are "compensated modestly".[99]

Response to the HSU claim

13.6 As to the first ground relied on in support of the variation, the HSU have failed to articulate why it is that they consider the current clause to be deficient. Put simply, the basis for the variation is unclear. The application is not accompanied by sufficient evidence going

[98] HSU submission at [74]
[99] Ibid at [73]

towards demonstrating that there is any problem with the current clause, or that the variation proposed will rectify any such problems.

13.7 As to the second ground, the HSU's opinion as to the adequacy of the sleepover allowance does not appear to have any relevance to the variation sought. The variation proposed does not have any relevance to payment.

13.8 Turning to the specific terms of the variation sought, the proposed variation relates to the specific items that are required to be provided by an employer during a sleepover. The current Award clause refers to providing employees with "use of appropriate facilities". We consider that formulation to be sensible, as it is sufficiently flexible to apply to a broad range of circumstances. Ultimately, what is "appropriate" will vary depending on the circumstances of a particular situation, having regard to a range of factors.

13.9 Given that the Award is an industry-wide minimum safety net instrument covering employers operating in a diverse range of sectors and catering to a broad customer base, we do not consider that it is appropriate to prescribe in any greater detail the specific items that must be provided to every Award-covered employee across Australia performing sleepover shifts.

13.10 For example, it cannot be said that it is necessary or appropriate to require employers in all circumstances to ensure employees are provided with a room that is "securely lockable", and that the door has a "peephole or similar". Nor can it be said that it is necessary or appropriate to require employers in all circumstances to ensure every room used by employees for sleepovers has "a telephone connection in the room". While these types of facilities may well be "appropriate" in some circumstances, it is not the case that such requirements are necessary or appropriate in all situations.

13.11 There is insufficient evidence before the Commission of instances where employers have not provided suitable facilities for employees performing sleepover shifts, and so insufficient evidence of the current clause not operating unsatisfactorily.

13.12 It cannot be said that the variation is self-evident. Therefore, in the absence of any probative evidence substantiating the issues that the HSU seek to address, the claim should be dismissed.

14. CLAIM RELATING TO ROSTERS (S3)

The United Voice claim

14.1 The United Voice seek a variation to clause 25.5(d)(i) to provide that full-time and part-time employees will be entitled to the payment of overtime for roster changes where seven days' notice is not provided.

Our response

14.2 Roster changes are a significant issue in many parts of the SCHCDS industry, and the rostering arrangements in the Award require consideration.

14.3 This proposed variation is reflective of the issues currently facing the SCHCDS industry. United Voice note at [71] of their submissions that:

> This needs to be considered in the context of a sector in which there are constant and unpredictable shift changes. Our witnesses all indicate that there are frequent changes to their rosters and a significant variability in hours from week to week.

14.4 The challenges facing employers in this industry with respect of rostering appear to be well accepted from both employer and union parties. The reality is that employers do not change rosters for fun. Where employers seek to change an employee's roster, it is for a legitimate operational reason and generally in order to meet the needs of the vulnerable customers which the organisation is providing care services to.

14.5 Employer parties have been vocal about the challenges around rostering since the commencement of the four yearly review. This has particularly been an issue in the disability services sector as a result of the introduction of the NDIS. Two of our clients, ABI and NSWBC, sought a variation to clause 10.3(c) of the Award as part of the Casual and Part-Time Employment common issues matter in order to specifically address this challenge. The variation sought in that proceeding was to remove some of the restrictions on the rostering of part-time employees to meet the needs of industry, and to ensure that the part-time employment category continue to be fit-for-purpose so as to prevent the casualisation of the workforce.

14.6 The union parties opposed the variation sought by ABI and NSWBC in that matter, and advanced evidence from witnesses who were support workers who almost exclusively worked in group homes in a bid to demonstrate that the hours of part-time employees were reasonably predictable and not subject to change.

14.7 In the current proceeding, we now have union parties advancing evidence from part-time employees working outside of a group home setting, for whom employers struggle to provide reasonably predictable hours of work.

14.8 Ultimately, if the Award is varied to make it even more difficult for employers to utilise part-time employees in the current dynamic operating environment (for example, by imposing overtime payment obligations where a part-time employee's roster is changed), employers will transition towards a workforce composition with a greater proportion of casual employees.

14.9 Contrary to the assertion of the United Voice, the Award currently does not provide "a significant level of flexibility in rostering".

14.10 Although the 'change in roster' provision at clause 25.5(d)(i) purports, at first glance, to provide the employer with the ability to change the roster of an employee on 7 days' notice, the reality is that this right is limited in two ways:

(a) Firstly, the employer must consult with the employee (and his/her representative, if any) regarding the proposed roster change in accordance with clause 8A, which involves:

(i) providing information about the proposed change;

(ii) inviting the employee (and their representative) to give their views about the impact of the proposed change on them; and

(iii) considering the views expressed by the employee and their representative (if any),

prior to implementing the roster change under clause 25.5(d)(i); and

(b) Secondly, where the employer wishes to change the roster of a part-time employee, clause 10.3(c) operates so as to prevent the employer from utilising the right conferred on it under clause 25.5(d)(i) unless the employee agrees in writing to the change.

14.11 The first limitation outlined in paragraph 14.10(a) above is not cavilled with.

14.12 However, the second limitation materially diminishes the right under clause 25.5(d) to change a part-time employee's roster.

14.13 In our clients' submission, the rostering provisions in the Award (particularly for part-time employees) require consideration to ensure they provide an appropriate balance between

the interests of employees in having have sufficient certainty around working patterns, and the interests of employers in being able to continue to utilise part-time employment as a viable form of employment under the current operating environment.

AUSTRALIAN BUSINESS LAWYERS & ADVISORS

On behalf of:

- **AUSTRALIAN BUSINESS INDUSTRIAL**
- **THE NSW BUSINESS CHAMBER LTD**
- **AGED & COMMUNITY SERVICES AUSTRALIA**
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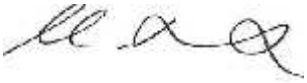

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12 July 2019

Fair Work Commission: 4 yearly Review of modern awards

SUBMISSION IN REPLY

4 YEARLY REVIEW OF MODERN AWARDS: (AM2018/26) SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010 - SUBSTANTIVE ISSUES

FILED ON BEHALF OF:

- **AUSTRALIAN BUSINESS INDUSTRIAL**
- **THE NSW BUSINESS CHAMBER LTD**
- **AGED & COMMUNITY SERVICES AUSTRALIA**
- **LEADING AGE SERVICES AUSTRALIA**

13 SEPTEMBER 2019

PART A: BACKGROUND

1. INTRODUCTION

1.1 This submission in reply is made on behalf of:

(a) Australian Business Industrial (**ABI**);

(b) the New South Wales Business Chamber Ltd (**NSWBC**);

(c) Aged & Community Services Australia (**ACSA**); and

(d) Leading Age Services Australia Limited (**LASA**),

collectively, '**our clients**'.

1.2 ABI is a registered organisation under the *Fair Work (Registered Organisations) Act 2009* and has in excess of 4,000 members. ABI represents the interests of businesses in a variety of industries including the social, community, home care and disability services industry. Its primary role is to develop workplace policy and to shape debate on major workplace relations issues.

1.3 NSWBC is a recognised State registered association pursuant to Schedule 2 of the *Fair Work (Registered Organisation) Act 2009* and has some 18,000 members. NSWBC is the State's peak business organisation and represents all businesses from small enterprises to large corporations across a variety of industries including the social, community, home care and disability services industry.

1.4 ACSA is the leading peak body supporting church, charitable, other not-for-profit and government providers of residential care services, community care services and retirement living for older people in Australia.

1.5 LASA is the national peak body representing and supporting providers of age services across residential care, home care and retirement living. LASA's membership base is made up of private, not-for-profit, faith-based and government operated organisations providing care, support and services to older Australians.

1.6 Collectively, our clients represent a significant proportion of employers in the industries covered by the *Social, Community, Home Care and Disability Services Industry Award 2010* (the **Award**).

2. SCOPE OF THIS REPLY SUBMISSION

2.1 This reply submission is filed in accordance with the Amended Directions of the Fair Work Commission (**Commission**) issued on 2 September 2019. This reply submission addresses each of the union claims relating to travel time, which consists of:

(a) a claim by the HSU to vary clause 25.6 of the Award (the **HSU Travel Time Claim**);

(b) a claim by the United Voice to introduce a new clause 25.7 into the Award (the **UV Travel Time Claim**); and

(c) a claim by the HSU to vary clause 20.5(a) of the Award (the **HSU Travel Allowance Claim**);

collectively referred to as the **Travel Claims**.

2.2 The HSU claims are recorded in an amended Draft Determination filed on 15 February 2019.

2.3 The United Voice claim is recorded in a Draft Determination filed on 1 April 2019.

3. LEGISLATIVE FRAMEWORK OF THE FOUR YEARLY REVIEW

3.1 The legislative framework applicable to the 4 Yearly Review has been considered in detail in *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 (**Preliminary Issues Decision**), and *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 (**Penalty Rates Decision**).

3.2 More recently, the legislative framework applicable to the 4 Yearly Review was considered in *4 yearly review of modern awards – plain language re-drafting – standard clauses* [2018] FWCFB 4177 issued on 18 July 2018[1] and summarised in *4 yearly review of modern awards – Alpine Resorts Award* [2018] FWCFB 4984.

3.3 We rely on the summary of the applicable legal principles as set out in the reply submissions filed by our clients in this matter on 5 April 2019.[2]

3.4 We also refer to, and agree with, the summary contained in the document titled 'Legislative framework relevant to the Review' published by the Commission in this matter on 12 April 2019.[3]

[1] [2018] FWCFB 4177 at [3]-[13].
[2] See [2.1]-[2.4].
[3] Published pursuant to a Statement issued on 12 April 2019 ([2019] FWCFB 2514).

PART B: UNION CLAIMS

4. HSU TRAVEL TIME CLAIM

4.1 The HSU seek a variation to clause 25.6 of the Award, which deals with broken shifts.

4.2 Specifically, the HSU seek a new sub-clause 25.6(d), to provide that:

> *(d) Where an employee works a broken shift, they shall be paid at the appropriate rate for the reasonable time of travel from the location of their last client before the break to their first client after the break, and such time shall be treated as time worked. The travel allowance in clause 20.5 also applies.*

4.3 This is one aspect of a broader proposal by the HSU to substantially vary the broken shifts clause. Our clients responded to the non-travel related aspects of the HSU claim to vary clause 25.6 in our Reply Submission filed on 12 July 2019.

4.4 We confine these submissions to the proposed new clause 25.6(d).

4.5 The current clause 25.6 does not contain any provision similar to that sought by the HSU.

4.6 Currently, clause 25.6 permits home care stream employees as well as employees in the social and community services stream who are undertaking disability services work to work 'broken shifts'.

4.7 A 'broken shift' is defined at clause 25.6(a) as 'a shift worked by an employee that includes one or more breaks (other than a meal break) and where the span of hours is not more than 12 hours'.

4.8 Accordingly, clause 25.6 permits specified classes of employees to work hours on a non-consecutive basis, in the sense that they can work shifts which are split into two or more portions of work, with intervening periods of unpaid non-work time.

4.9 Employees who work broken shifts are entitled to shift allowances in accordance with clause 25.6(b).

4.10 Under the current Award, employees are not entitled to any payment in respect of the non-work time which falls between the portions of work time in a broken shift.

4.11 The HSU claim proposes to materially alter that position.

4.12 Under the HSU claim, employees will be entitled to "be paid at the appropriate rate" for the "reasonable time of travel" from the location of their last client before the break to their first

client after the break", and appears to deem the time as "time worked" ("such time shall be treated as time worked").

4.13 In support of this variation, the HSU submit that:

(a) firstly, the broken shifts provision is "manifestly open to exploitation" in the absence of appropriate minimum engagement provisions;[4] and

(b) secondly, the capacity for multiple breaks during a broken shift can result in:

(i) employees having to undertake work on a non-consecutive basis over an extended period of time in order to generate a reasonable amount of earnings;[5]

(ii) employees being paid only for a proportion of the time that is expended in performing the work required by the employer; and

(iii) employees enduring stretches of "dead" time waiting time during the course of the day.

4.14 We note that the first ground outlined above is sought to be addressed by a proposed variation to the minimum engagement periods in the Award.

4.15 As to the second category of grounds advanced in support of the claim, we note that there are multiple claims being advanced by union parties that are designed to rectify these alleged issues. For example, the ASU claim for a 15% loading to be applied to broken shifts appears designed to address the issues outlined above, which are relied on by the HSU in support of its proposed variation.

5. THE UNITED VOICE TRAVEL TIME CLAIM

5.1 United Voice seeks the introduction of a new clause 25.7 into the Award. The proposed new clause is in the following terms:

25.7 Travel time

(a) Where an employee is required to work at different locations they shall be paid at the appropriate rate for reasonable time of travel from the location of the preceding client to the location of the next client, and such time shall be treated as time worked. The travel allowance in clause 20.5 also applies.

[4] HSU submission at [36]
[5] Ibid at [37]

(b) This clause does not apply to travel from the employee's home to the location of the first client nor does it apply to travel from the location of the last client to the employee's home.

5.2 There is considerable similarity between the UV Travel Time Claim and the HSU Travel Time Claim. However, the two claims also vary in two respects. These are:

(a) First, the HSU claim only applies in relation to broken shifts, whereas the UV claim applies to all forms of shifts and working arrangements; and

(b) Second, the HSU claim only applies to employees in the home care and disability services streams, whereas the UV claim applies to all streams of work and categories of employees covered by the Award.

5.3 The grounds relied upon by United Voice in support of the UV Travel Time Claim are summarised as follows:

(a) the time spent travelling between the homes of clients is "essential" to perform the duties of the job;[6]

(b) the current terms and conditions of the Award lend themselves to inappropriate and unsustainable work patterns;[7]

(c) there is little or no incentive for employers in what is an increasingly competitive and diverse sector to structure work efficiently;[8] and

(d) the cost of poor rostering decisions and taking on work which is geographically remote or at different times of the day are able to be shifted onto employees.[9]

6. HSU TRAVEL ALLOWANCE CLAIM

6.1 Separately, the HSU seek an additional variation relating to travel.

6.2 The HSU also seek to amend the existing clause 20.5(a), which provides a travel allowance/ reimbursement of $0.78 per kilometre for employees required and authorised by their employer to use their motor vehicle in the course of their duties.

[6] Supplementary submission of United Voice at [4]
[7] Ibid at [9]
[8] Ibid
[9] Ibid

6.3 The HSU propose a new clause 20.5(a) as follows:

(a) Where an employee is required and authorised by their employer to use their motor vehicle in the course of their duties, the employee is entitled to be reimbursed at the rate of $0.78 per kilometre.

Disability support workers and home care workers shall be entitled to be so reimbursed in respect of all travel:

(i) from their place of residence to the location of any client appointment;

(ii) to their place of residence from the location of any client appointment;

(iii) between the locations of any client appointments on the basis of the most direct available route.

6.4 While the HSU claim does not seek to disturb the existing travel allowance / reimbursement of $0.78 per kilometre, it seeks to extend the application of that entitlement so that it applies where certain specified classes of employee travel from their place of residence to their first working location prior to the commencement of work, and from their last working location to their place of residence after the cessation of work.

6.5 For clarity, our clients consider that the activities described in:

(a) items (i) and (ii) of the HSU proposed drafting represent an extension to the existing Award position; and

(b) item (iii) of the HSU proposed drafting does not depart from the existing Award position, in that the activity described in item (iii) is already captured by the existing clause 20.5(a).

6.6 The grounds relied upon by the HSU in support of the Travel Allowance Claim are summarised as follows:

(a) firstly, that disability support workers and home care workers are as a matter of course required to travel considerable distances during the course of their working days in order for them to perform their work for their employers;[10] and

(b) secondly, the travel to the first client and from the final client of the day:

(i) is a fundamental part of the duties performed by those workers;

(ii) is necessary in order to perform the principal caring duties; and

[10] HSU Submission at [41]

(iii) well exceeds the usual travel engaged in by employees to and from their workplaces.[11]

[11] Ibid.

PART C: OUR CLIENTS' POSITION IN RELATION TO THE UNIONS' TRAVEL CLAIMS

7. SUMMARY OF POSITION

7.1 Our clients do not have any objection to the notion that employees should receive reasonable compensation for time spent travelling in the course of their duties.

7.2 However, our clients do not consider that employees should be compensated for the time or cost in travelling to and from their place of residence to attend work or to return home from work at the conclusion of their shift.

7.3 The Award already provides compensation to employees when travelling in the course of their work, as the time spent travelling will fall within their working hours and will be paid as such.

7.4 The only circumstance where an employee might not receive remuneration for travelling in the course of their duties is when working a broken shift, and where an employee is expected to travel from one client's residence to another client's residence during the unpaid break (i.e. the gap) between two portions of work in a broken shift.

7.5 There are very clear, longstanding and compelling merit and policy reasons for the Award to permit the working of non-consecutive working hours or 'broken shifts', given the nature of the work undertaken by support workers and the patterns of service/labour demand.[12] Broken shifts are a fundamental and necessary part of the home care and disability services sectors.

7.6 To the extent that clause 25.6 is capable of being applied in a manner that does not appropriately compensate employees for time spent travelling between clients' residences when working broken shifts, our clients are not opposed to that issue being rectified.

7.7 However, we make the following observations in respect of addressing this issue:

(a) First, the Travel Claims advanced by the union parties do not address the issue in a satisfactory or workable manner;

(b) Second, there are government-imposed limitations on the charges that employers can pass onto consumers in respect of travel costs in the disability services sector, and these limitations should be taken into account; and

(c) Third, the industry must be given a reasonable period of time to prepare for any variation (in the form of a delayed commencement date of any variation).

[12] See paragraphs 7.15-7.16 of our Reply Submission, 12 July 2019.

7.8 Each of the above issues is addressed in more detail in Section 8 below.

7.9 In light of our clients' position as set out in paragraphs 7.6 and 7.7 above, we propose an alternative variation for the Commission's consideration which our clients consider address any issue with the existing broken shifts provision, but which does not suffer from the problems with the Union proposals which we consider are significant and insurmountable, as detailed below.

7.10 Details of the alternative variation proposed by our clients are set out in Section 9 below.

7.11 Our clients are not opposed to the introduction of the alternative formulation, subject to there being an appropriate delay to its implementation to provide the industry with time to prepare for its implementation.

8. ISSUES WITH THE SPECIFIC PROPOSALS

Issues with the HSU Travel Time Claim

8.1 Under the HSU's proposed clause 25.6(b), a 'broken shift' is defined to be a shift that includes 'a break (other than a meal break)'. This formulation is consistent with the general notion of a broken shift; that is, a broken shift is a shift which involves two or more portions of work which are broken by periods of non-work time. See for example the existing definition of 'broken shift' at clause 25.6(a) of the Award.

8.2 However, their proposed clause 25.6(d) then appears to 'deem' certain periods of non-work time (that is, certain time falling during the break between the portions of work) as 'time worked':

> *Where an employee works a broken shift, they shall be paid at the appropriate rate for the reasonable time of travel from the location of their last client before the break to their first client after the break, and such time shall be treated as time worked. The travel allowance in clause 20.5 also applies.*

8.3 Clause 25.6 appears to have the effect of deeming certain unpaid non-work time (i.e. time falling in the break period between two portions of work) as 'time worked'.

8.4 On the ordinary words of the proposal, it is unclear whether the time spent travelling *is* time worked or whether it is simply *treated* as time worked. This is particularly the case given the wording in the proposed clause 25.6(b).

8.5 If it is the former, the proposed drafting does not appear to achieve that objective. There would also be an apparent inconsistency between the proposed new clause 25.6(d) and the proposed clause 25.6(b).

8.6 Given the drafting, we have assumed that the intention is to *treat* certain unpaid non-work time as 'time worked'. This appears to be reinforced by the HSU submission of 15 February 2019, which states at [39] that:

> *"The relevant restrictions should be ... that the employee is paid, as if working, for the time necessary to travel between clients required to be undertaken during any break in the shift".*

8.7 While it is clear that the HSU seek that the 'reasonable time of travel' occurring during the break of a broken shift be 'paid at the appropriate rate', it is not clear whether that time is intended to be recognised as 'time worked' for all purposes under the Award.

Is the reasonable time of travel 'time worked' for all purposes?

8.8 If the 'reasonable time of travel' undertaken during breaks between portions of work in a broken shift time is intended to be *time worked* for all purposes, this will have significant implications and flow-on impacts in respect of:

(a) ordinary hours of work at clause 25.1(a) of the Award;

(b) the maximum shift lengths at clauses 25.1(a)(i)-(iii) and 25.1(b) of the Award;

(c) meal break entitlements under clause 27.1 of the Award;

(d) tea break entitlements under clause 27.2 of the Award;

(e) overtime entitlements under clause 28.1 of the Award;

(f) the operation of minimum engagement provisions in the Award;

(g) rostering requirements under clause 25.5;

(h) leave entitlements;

(i) superannuation contribution obligations;

(j) the requirement at clause 10.3(c) of the Award to agree in writing on a regular pattern of work; and

(k) the requirement under clause 8A of the Award to consult about changes to hours of work.

8.9 By way of example, if it is proposed that the 'reasonable time of travel' be time worked for the purposes of 'ordinary hours of work', clause 25.5 would require that the time be displayed on the roster.

8.10 It would also require the time be included in the written agreement made with each part-time employee under clause 10.3(c). It is not clear whether the 'actual time' would need to be specified in this agreement, or the 'reasonable time'.

8.11 It would also appear that any changes to the 'reasonable time of travel' would need to be the subject of consultation under clause 8A of the Award.

'Reasonable time of travel'

8.12 The HSU proposal would require that employees be paid for the 'reasonable time of travel'.

8.13 This drafting is unclear and ambiguous.

8.14 It is not clear whether the provision would require employees to be paid for the *actual* time spent travelling, or whether it requires employers and employees to reach agreement on a nominated 'agreed' period of time.

8.15 There is a distinct lack of precision as to what this phrase means or how it is intended to apply in practice.

Identifying which 'time' is the 'time worked'

8.16 Due to the nature of the home care and disability services sectors, there are many occasions where employees work broken shifts that involve providing support to clients for a relatively short portion of time in the morning, and then providing further support to clients for a relatively short periods of time in the evening. For example, the work may involve assisting elderly clients with showering and getting ready for the day in the morning, and then further assistance with the preparation of meals in the evening.

8.17 The effect of this is that quite often, a broken shift will involve a break of some 6 or more hours between the two portions of work.

8.18 The break time often significantly exceeds the time that would be involved in travelling between client's residences.

8.19 Under the HSU proposal, there will be situations where the 'reasonable time of travel' may be 30 minutes, but the period of non-work time between the two portions of work in the broken shift may be 6 hours.

8.20 Under those scenarios, if the 'reasonable time of travel' is 'time worked' for the purposes of the Award, the 'time' will need to be capable of being identified.

8.21 Our clients consider that there are real difficulties with the notion of declaring the 'reasonable time of travel' (whatever that phrase may mean) as 'time worked' in the type of scenario referred to above. For example, based on the above scenario, it is unclear which 30 minute period of the 6 hour break is the 'time worked'. It is also unclear how that is to be determined, and by whom.

8.22 For example:

(a) Does an employee decide when within the 6 hour period they are going to undertake the travel, or does the employer dictate when the travel is to be undertaken?

(b) What happens if the employee engages in misconduct during the 6 hour span? Is the employee 'at work' at the relevant time?

(c) What happens if the employee is injured during the 6 hour span? Is the employee 'at work' at the relevant time?

(d) Is the employer able to direct the employee when to undertake the travel, given it is time worked?

(e) What happens if the employee elects not to comply with an employer's directions about when to undertake the travel?

(f) What happens if the employee chooses to take a less direct route, which results in the travel time taking more than 30 minutes? If the travel takes 60 minutes, what part of the time spent travelling is work, and what part is not work?

8.23 If a period of time is to be declared time worked, it is important that employers and employees are able to clearly identify and distinguish between working time and non-working time. This will be relevant for all of the matters listed at paragraph 8.8 above, and will also be relevant for matters such as work, health and safety obligations.

8.24 Our clients acknowledge that the above issues do not arise to the same extent where the employee is undertaking 'direct' travel between locations in order to perform work, where the gap between the portions of work in the broken shift is equal to the time taken to travel between locations.

8.25 However, where the travel is undertaken during a larger break between engagements, a whole raft of issues arise.

Issues with the UV Travel Time Claim

8.26 The United Voice Travel Time Claim is in similar terms to the HSU claim, and so unsurprisingly suffers from the same problems outlined in paragraphs 8.1 to 8.25 above. The submissions above are equally applicable to the UV Travel Time Claim.

8.27 However, the United Voice claim has the following additional issues.

8.28 First, its application is not limited to broken shifts, and instead applies generally to all forms of shifts and work, and across all streams covered by the Award. This is unnecessary, given that the only circumstance where an employee could be required to travel between clients in the course of their duties and would not be entitled to be paid for that time would be when the travel time falls in the gaps between portions of work in a broken shift.

8.29 The broad and generalised nature of the proposed variation is also unnecessarily broad given that:

(a) the variation is clearly targeted at home care workers and disability support workers who undertake support work at various locations (principally clients' residences);[13]

(b) the evidence and submissions filed in support of the variation relate to employees working broken shifts; and

(c) the United Voice acknowledge in their submissions that the claim is 'interrelated' to their proposal to vary the broken shifts provision.[14]

8.30 Notwithstanding the breadth of application of the proposed clause, the drafting of the proposed variation is also problematic. On the one hand, the clause refers to employees who are required to work at 'different locations'. However, in the following sentence it then refers to the location of 'clients'. That is, the clause presumes that the relevant location is the location of 'a client'.

8.31 While that will be the case for support workers in the home care and disability services streams, it cannot be assumed that other employees covered by the Award are always visiting 'clients' when travelling in the course of their duties.

8.32 For the avoidance of doubt, the UV Travel Time Claim also suffers from issues relating to:

(a) the lack of clarity around whether it deems the 'reasonable time of travel' as 'time worked' for other purposes of the Award;

[13] See Supplementary Submission of United Voice, 1 April 2019, at [4].
[14] Ibid at [8].

(b) the ambiguity surrounding the phrase 'reasonable time of travel'; and

(c) the difficulties with identifying which 'time' is 'time worked' and the raft of issues that creates.

Response to the HSU Travel Allowance Claim

8.33 The HSU Travel Allowance Claim proposes to extend the entitlement to the travel allowance at clause 20.5 of the Award to the travel undertaken by disability support workers and home care workers in attending work from their place of residence, and in returning home from work after the conclusion of their shift.

8.34 Our clients are opposed to this claim.

8.35 The HSU Travel Allowance Claim is inconsistent with the overall system of modern award regulation, and is an outlier in the context of the award system of minimum entitlements. It does not achieve a 'fair and relevant' minimum safety net, and offends section 138 of the FW Act in that the proposal goes well beyond the extent necessary to achieve the modern awards objective.

8.36 The HSU Travel Allowance Claim should be dismissed.

9. ALTERNATIVE FORMULATION TO ADDRESS THE TRAVEL ISSUE

9.1 In light of the issues with the unions' Travel Claims which are articulated above, and for which no party has been able to come up with a satisfactory solution, the unions' Travel Claims must be dismissed.

9.2 However, to the extent that the Commission finds that the existing broken shifts clause does not meet the modern awards objective of providing a fair and relevant minimum safety net of conditions, our clients consider that an appropriate way of dealing with the issue of unpaid travel time in the gaps between portions of work in a broken shift is to introduce payment mechanism into the Award in the form of an allowance. This avoids the complexities which arise if the time was to be 'time worked'.

9.3 We note that a number of pre-reform awards dealt with this issue in this way.

9.4 For example, clause 29(ii) of the *Miscellaneous Workers Home Care Industry (State) Award* (AN120341) provided for a payment at the rate of 3% of the ordinary hourly rate per kilometre travelled where employees were rostered to work with consecutive clients. The clause provided:

(ii) Where employees are rostered to work with consecutive clients they shall be paid for the time taken to travel between locations at the rate of three per cent of the ordinary hourly rate per kilometre travelled, excluding travel from the employee's home to the first place of work and return to home at the cessation of his or her duties; provided that this payment shall not be made if the employee is being otherwise paid under this award.

9.5 Similarly, clause 20.4.2 of the *Community Services (Home Care) (ACT) Award 2002* (AP816351CRA) had a substantially similarly worded provision. It provided:

> *Where employees are rostered to work with consecutive clients they shall be paid for the time taken to travel between locations at the rate of 3% of the ordinary hourly rate per kilometre travelled, excluding travel from the employee's home to the first place of work and return to home at the cessation of his/her duties.*

9.6 An allowance such as those mentioned above would appear to be a sensible way of compensating employees for time spent travelling during periods that are expressed in clause 25.6(a) as not being work time.

9.7 Such an allowance appears to meet the objectives of the Unions in terms of compensating employees for travel time, without any of the complex implications outlined in paragraphs 8.8 to 8.11 above.

9.8 An allowance of this type would also appear to more readily meet the modern awards objective, in the sense that it:

(a) provides additional remuneration for employees working broken shifts;

(b) provides an entitlement that is simpler and easier to understand than the Unions' proposals;

(c) addresses the relative living standards and the needs of the low paid;

(d) provides a floor entitlement from which parties can collectively bargain;

(e) does not prevent the utilisation of broken shifts (see the 'need to promote flexible modern work practices and the efficient and productive performance of work');

(f) does not impose an unreasonable regulatory burden on business (notwithstanding it representing a significant new cost imposition on employers).

9.9 As stated at paragraph 7.11 above, our clients are not opposed to the introduction of a form of allowance, subject to there being an appropriate delay to its implementation to provide

the industry with time to prepare for its implementation. In this respect, we address this issue as follows.

10. FUNDING LIMITATIONS AND IMPLEMENTATION OF ANY CHANGE

10.1 In certain parts of the industry, there are government-imposed limitations on the charges that employers can pass onto consumers in respect of travel costs. For example, the disability services sector is regulated by the NDIS rules and regulations, and prices are effectively capped in that sector.

10.2 Under the NDIS Price Guide providers can only claim travel costs from participants in certain circumstances, being:

(a) the Support Catalogue indicates that providers can claim travel for the particular support item;

(b) the participant agrees in advance; and

(c) the provider is required to pay the worker for the time spent travelling.

10.3 If those requirements are satisfied, the maximum amount of travel time that can be claimed is 30 minutes for some areas, and 60 minutes for others.[15]

10.4 While our clients acknowledge that government-based funding limitations do not operate as a barrier to the Commission varying modern awards, the operating environment must be taken into account in the assessment of a 'fair and relevant' minimum safety net of conditions, and issues such as funding and the overall profitability or viability of the industry are relevant to many of the considerations in section 134(1).

10.5 These issues should also be taken into account in the context of the proposed implementation of any variation to the Award.

10.6 Given that any variation will impose a new cost on employers, the implementation of any such variation should involve a delayed commencement date so the industry has an appropriate period of time to prepare for the change.

AUSTRALIAN BUSINESS LAWYERS & ADVISORS

13 September 2019

[15] NDIS Price Guide 2019-2020, Billing for non-direct services, p.14.

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Filed on behalf of:

- **Australian Business Industrial**
- **the New South Wales Business Chamber Ltd**
- **Aged & Community Services Australia**
- **Leading Age Services Australia Limited**

FAIR WORK COMMISSION
4 Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award 2010
Matter: AM2018/26

STATEMENT OF GRAHAM SHANAHAN

I, Graham Shanahan, of [redacted], affirm as follows:

MY BACKGROUND

1. I am the General Manager of Coffs Coast Health & Community Care Pty Ltd trading as NSW Home Support Services (**the Company**).

2. I am based at Coffs Harbour.

3. I have been employed with the Company since around March 2013.

4. My role involves overseeing the daily operations of the business and I also head the finance department as the financial controller.

5. Prior to working with the Company, I was employed in finance as an Accountant and Manager in an Accountancy/Tax Practice. I have over 20 years' experience in the accountancy profession.

6. I am a Fellow of the Association of Chartered Certified Accountants (FCCA), I hold a Chartered Tax Advisor (CTA) membership status with The Tax Institute of Australia and also hold a Bachelor of Commerce majoring in Economics from the University College Cork, Ireland.

INFORMATION ABOUT THE BUSINESS

7. The Company is a privately owned company that has been in operation since around 1991.

8. The Company operates in the home care sector and predominantly provides services through the Commonwealth Home Support Program, Home Care Packages and the Department of Veteran Affairs. This is where the majority of the Company's funding comes from.

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9. The Company provides home care to enable people to remain in their homes as long as possible without going into residential care. The Company's objectives are to:

   (a) support people who are frail aged to remain in their home;

   (b) support family or other primary care givers in their role;

   (c) operate the organisation in an effective, efficient and accountable manner; and

   (d) maximise flexibility to respond to the expressed preferences of consumers.

10. The Company provides a range of services to frail aged people and their carers in the surrounding regions of three local government areas, being Coffs Harbour, Bellingen and Nambucca.

11. The services that the Company provides include:

   (a) DVA Community Nursing;

   (b) Veteran's Home Care Program;

   (c) Home Care Packages; and

   (d) Flexible Respite programs, funded by the Department of Health.

12. The Company's service portfolio also includes brokerage and private clients, although both are currently very small components of the services the Company provides.

13. The Company operates under three separate funding schemes. They are:

   (a) Department of Veteran Affairs;

   (b) Commonwealth Home Support Program; and

   (c) Home Care Packages.

14. The home care industry introduced Consumer Directed Care in 2011, however this was a pilot scheme and it has developed significantly since then and in particular since de-regulation of the Home Care Package environment in February 2017. The clients we provide care to are in control of how they spend their money and what provider they use, and following de-regulation, competition has increased significantly. Prior to de-regulation providers were required to tender each year for additional Home Care Packages.

15. In the aged care industry, there is a shortage of packages. I am aware of people having waited in the queue for over 12 months for home care packages.

THE COMPANY'S WORKFORCE

16. The Company currently employs approximately 70 employees. The Company's workforce consists of 6 full-time employees, approximately 31 part-time employees, approximately 33 casual employees and approximately 10 independent contractors.

17. The Company has a high level of part-time and casual employees because we are not able to offer enough consistent work to engage a high number of full-time employees due to the unpredictability in the industry (resulting from cancellations due to hospitalisations etc). The full-time employees we engage are our Community Services Manager, two Case Managers, two Rostering Co-ordinators and myself as General Manager.

18. The Company offered all regular casual employees to convert to part-time employment, however of the approximately 20 employees who were offered to convert, only six employees wanted to move to permanency and they were transferred to part-time employees. This took place in May 2019.

19. The *Social, Community, Home Care and Disability Services Industry Award 2010* (**the Award**) is the principal industrial instrument applying to the Company's employees. The Company does not have an enterprise agreement but does have a Collective Agreement. Coffs Coast Health & Community Care Pty Ltd Employee Collective Agreement 2009-2011 is still in place, however the Company typically pays Award rates of pay.

CLIENT CANCELLATION ISSUES

20. The Company experiences client cancellations on a regular basis. The Company prepares a monthly report of the cancellations and the reasons for the cancellations. The reports for the months of March, April and May 2019 are attached and marked **Attachment 'A'**.

21. Each of the funding schemes that we operate under, as set out at paragraph 13, have different terms in respect of cancellations.

22. Some of the reasons why a client cancels their scheduled services include that the client is ill, the client is in hospital, the client has had a fall, the client's family are visiting and they do not require the care, the client has passed away, or the client has been moved into permanent residential care.

23. When a client cancels a scheduled service, the Company tries to place the employee who was supposed to work that shift, with another client. For example, if another employee is sick, the employee who has had their client cancel would be moved to cover the sick employee's shift. If the Company cannot find alternative work, the Company sends the employee home and pays them for one hour.

24. The amount of notice that is typically given by clients when they cancel a scheduled service is on the day a client goes into hospital, permanent care or when they pass away. It is almost impossible to plan for such events and even more difficult to replace the loss of work or hours for the employees that are affected.

25. The Company is able to charge the client for the cancellation in certain circumstances. The maximum amount that the Company is able to charge is for one hour under the Department of Veteran Affairs Home Program. Under the Department of Veteran Affairs Home Program, if the client cancels within 24 hours of the booking, we are able to claim one hour from the client. This is irrespective of the duration of the booking. This means that an employee could be rostered to work three hours with a client, and if they cancel with no notice, we are only able to claim one hour. If the client does give notice of at least 24 hours, we are not able to claim any monetary compensation from the client.

26. If the Company was required to pay the employee for the full rostered shift following a client cancellation with less than 48 hours' notice, the Company would become insolvent and the existence of the Company would be threatened. If the Company ceased to exist, 70 people would lose their jobs.

27. The Company has a policy in place which states that we will only charge one hour for our clients under all funding arrangements. The reason the Company introduced this policy was to remain competitive in the market.

28. While the Department of Veteran Affairs Home Program provides a limit of one hour, I am aware that larger organisations operating in the home care industry charge more than one hour for

cancellations if the required notice is not given for other schemes. The large organisations are able to do this under the Commonwealth Home Support Program and Home Care Packages. However, as we are a smaller organisation operating in a regional area, we need to be mindful of the community. If we were to charge the clients more like the large organisations do, we would lose clients.

PART-TIME EMPLOYEES

29. The Company offers part-time employees work in excess of their minimum contracted hours regularly. This is because of the unpredictable nature of the industry and the clients' demands.

30. In the month of May 2019 we offered 902 additional extra hours to our part-time workforce.

31. If the Company was required to pay overtime to part-time employees who work in excess of their contracted hours, we would be hesitant to employ part-time employees. The economic impact of paying part-time employees overtime for work in excess of their contracted hours would mean, for example, that in the month of May 2019, we would have had an extra cost of $17,400. If the Company were to have that cost every month for a year, that would equate to $205,200 over the 12 month period. This would simply make this organisation insolvent and thus 70 jobs would be lost.

32. If the Company was required to pay overtime for that work, our business model would not be workable. Ultimately it would mean that we would employ less part-time employees.

MINIMUM ENGAGEMENTS

33. The Company's work is based on client demands and therefore rostering takes place around the preferred times of our clients.

34. If the Company does not provide services in the requested time period the clients will leave and go to another service provider. We have had a lot of clients transfer to us who have left other service providers because they were not being provided with what they requested. For example some clients only want 30 minute visits and some providers charge a minimum engagement of one hour. We however cater to the needs and demands of the client as the client is at the centre of all decisions and we have therefore had a number of clients come to us from other providers to accommodate these 30 minute visits.

35. In respect of morning visits especially for medication prompting and personal care, visits shorter than one hour are common. Approximately 80 per cent of all visits are less than one hour.

36. The Company provides services in blocks as small as 30 minute slots and one hour slots and up to longer lengths if they are requested by a client.

37. It is common for services to be required in the morning and the evening. The reason for this is that clients require showers in the morning and assistance with their meals, and then in the evening they require another meal and preparation for bed. Because of this demand, we often have, for example, shifts rostered from 6.00pm to 8.00pm to accommodate dinner time and showers as requested by clients.

38. It is common for an employee to be rostered to work four 30 minute blocks to form a two hour shift. This is usually due to client demand. We often allocate one employee a 5.00pm to 7.00pm shift, and another employee a 6.00pm to 8.00pm shift. If we were required to provide a three hour minimum engagement, it would not only mean that one employee would lose their shift, but we also wouldn't be able to cover the client demand that falls in the overlap period of 6.00pm to 7.00pm.

39. It is difficult to provide some employees with shifts longer than 2 hours because many clients demand certain employees, and threaten to leave if they do not have that particular employee. This makes rostering difficult if there is a client demanding a particular employee for half an hour of an afternoon, but we do not have any other work, or very minimal work to give them, surrounding the requested time.

40. If the Company was required to provide a three hour minimum shift to all employees there would be a significant financial strain on the business. There is a real chance that if we retained the same number of employees, and were required to provide 3 hour minimum shifts, that the business would not survive.

[redacted]

Signed by **Graham Shanahan BComm FCCA CTA**

28 June 2019

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'A'

'Enabling your lifestyle'

Bellingen Dorrigo Nambucca Heads Macksville Coffs Harbour Woolgoolga

nswhomesupportservices.com.au

Monetary Cost of Cancelation of Hours (not within 24 hours)

Month	# of Hours	Monetary Cost/Loss
March 19	**64**	**$2,624**
April 19	**62**	**$2,542**
May 19	**58**	**$2,378**
Total	**184**	**$7,544**

FAIR WORK COMMISSION
4 Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award 2010
Matter: AM2018/26

STATEMENT OF SCOTT HARVEY

I, Scott Harvey, [redacted], affirm as follows:

MY BACKGROUND

1. I am employed by ConnectAbility Australia Limited (**ConnectAbility**) in the role of Operations Manager, based at the organisation's head office in Warabrook, NSW.

2. I have been employed with ConnectAbility since around September 1996.

3. My role involves operational oversight of:

   (a) the ConnectAbility Community Disabilities business stream (this includes NDIS service delivery in Community Supports, Supported Independent Living, Support Coordination); and

   (b) Community Program development at the Jesmond Neighbourhood Centre.

4. Team Leaders, Rostering Officers, Support Coordinators and the Community Centre Coordinator report directly to me. I oversee the direct supervision of the frontline staff by the Team Leaders.

5. I hold a Bachelor of Arts with a Major in Psychology.

THIS STATEMENT

6. The information in this statement is based on my experience and observations from either working at ConnectAbility or from my experience generally working in the social, community, home care and disability services industry, and is true to the best of my knowledge.

7. Where I depose particular conversations, I provide either the exact words used or the substance of the conversation to the best of my recollections.

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8. Where I comment on matters that I did not personally observe, I identify the source of that information in this affidavit.

INFORMATION ABOUT CONNECTABILITY

9. ConnectAbility was established in September 1992 by a group of community members and families to meet the needs of people with significant disabilities to provide opportunities to access community based resources, facilities and services.

10. ConnectAbility is a not for profit Company limited by guarantee, and is registered as a gift deductible recipient with tax charity concessions. We are governed by a Board consisting of volunteer community and consumer representatives.

11. ConnectAbility operates in the social, community, home care and disability services industry.

12. ConnectAbility provides service to over 600 customers across the Hunter Region and Central Coast Regions of NSW. ConnectAbility provides a broad range of personalised supports to people with a disability, older community members, children and young people.

13. ConnectAbility provides direct service delivery in the following areas:

    (a) NDIS Disability support including Community Social and Civic Support, Daily Activities, Supported Independent Living and Support Coordination;

    (b) Department of Health and Ageing 65+ supports - These are community based supports to people with disability aged 65+ who were not eligible for access to the NDIS scheme on its implementation on 1 July 2013;

    (c) Aged Care 'Home Care Packages' (**HCP**) and 'Commonwealth Home Support Packages' (**CHSP**) services;

    (d) Community Programs through Jesmond Neighbourhood Centre; and

    (e) Adolescent and Family Counselling.

14. ConnectAbility assists people with in-home personal care and domestic assistance, shopping and meal preparation, assistance with medication management and social supports both in-home, and in the community.

15. ConnectAbility is an accredited provider of supports through various government bodies, including:

    (a) the National Disability Insurance Scheme (**NDIS**);

    (b) the Department of Family and Community Services; and

    (c) Department of Health, Ageing and Aged Care.

16. ConnectAbility is a registered service provider with the National Disability Insurance Authority.

17. I have considerable knowledge and experience in managing the delivery of services to individuals under these government schemes.

CONNECTABILITY'S WORKFORCE

18. ConnectAbility currently employs approximately 270 employees, in a range of roles including:

    (a) frontline care workers (for example, Community Support Worker, Residential Support Workers, Caseworkers, Domestic Support Workers, Adolescent and Family Counsellors);

    (b) team leaders, coordinators and managers (for example, Disability Team Leaders, Support Coordinators, SIL Team Leader, SIL Coordinator, Accommodation Manager, Centre Coordinator, Aged Care Manager); and

    (c) administration and senior management (for example, CEO, CFO, Operations Manager, Executive Officer, People and Culture Manager, finance administration, quality and compliance, Roster Officer).

19. The *Social, Community, Home Care and Disability Services Award 2010* (the **SCHADS Award**) is the principal industrial instrument applying to ConnectAbility's workforce. ConnectAbility does not use an Enterprise Agreement in engaging staff. The Company typically pays Award rates of pay.

20. ConnectAbility has a large proportion of front line community support staff engaged in part-time employment (approximately 69%). No direct support workers in the community support workforce are employed on a full-time basis. Currently 30% of the frontline community supports workgroup are employed as casual support workers.

21. Currently 17% of casual support workers are engaged to work permanent scheduled supports with customers each week. It is the nature of engagement from customers that the same support workers are engaged with customers for the same scheduled supports each week. This is to ensure continuity of supports to customers with complex physical and behavioural support needs.

THE NATIONAL DISABILITY INSURANCE SCHEME

22. ConnectAbility is a registered service provider with the National Disability Insurance Authority.

23. The NDIS incorporates approximately 93% of business revenue across its operations.

24. ConnectAbility currently has 358 NDIS customers who receive Core Support funding through the NDIS Scheme. These services can be broken down into the following categories:

    (a) 73% of NDIS customers are funded for Community Social and Civic participation (of this group, 11% are children aged 13 and under); and

    (b) 27% of customers are provided Supported Independent Living supports which is care in the home.

25. The major impact of the NDIS for ConnectAbility is the increased administration requirements to meet the NDIS Terms of Business. The introduction of the NDIS service provider portal and customer support claiming has required an increase of administrative staffing resources to fulfil claims process to ensure cash flow and quality safeguards are in place.

26. The NDIS Portal system has been plagued with problems leading to inefficiencies to ConnectAbility as a service provider. These overhead costs attributed to deployment of extra resources and extra time invested by Disability management staff has not been recognised by the NDIA quickly enough and incorporated into the pricing framework for Core Support delivery.

27. ConnectAbility implemented a rostering team in its Community Disability operations in December 2017. Initially a Full Time role was introduced. This has increased to a 1.6 FTE operation specifically for Community supports. Prior to the introduction of the rostering team, the Community supports Team Leaders were responsible for customer rostering.

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28. The model of Rostering for customers has generally not changed but with the introduction of the NDIS it offered opportunities for customers to select supports outside of business hours and on weekends/public holidays. The scope of rostering increased significantly due to this. Currently ConnectAbility is investigating the continued viability of providing weekend/public holiday supports under the current pricing framework. There is potential that the weekend/public holiday model of service delivery will be withdrawn if new pricing framework to be delivered by the NDIA does not sustainably match the actual costs for services provided.

29. The NDIS has led to increased organic growth for delivery of community support services. Community support Team Leader portfolios currently range from 56 – 68 customers across the team. The Disability support team initially employed 4 FTE team leaders with portfolio sizes ranging from 40-45 customers. Due to the current pricing framework for Core Supports service delivery and Team Leader roles being non-billable under the NDIS, the Team Leader group has reduced to 3 FTE.

30. The Team Leader group were supported by a Level 3 Support worker team to assist in rostering, NDIS administrative tasks and as a communication conduit with the frontline support worker group. However, this role and two positions were made redundant in September 2017. This role was unbillable in the NDIS service delivery model and staff members in the role were not generating income. This role was deemed financially unsustainable and ConnectAbility made an operational decision to reduce administration wage overhead costs to improve the viability and sustainability of the Community Supports program.

31. ConnectAbility roster staff to match customer needs, and acknowledge the choice and control of the customer in who they engage.

CLIENT CANCELLATION ISSUES

32. ConnectAbility experiences client cancellations on a daily basis.

33. ConnectAbility has implemented data collection of client cancellations for services provided under Community Social and Civic supports. This data is collected monthly from our Hunter Region community support customers.

34. Data collected from the 2018 Financial Year (1 July 2017 - 30 June 2018) recorded that:

(a) there was a total of 1,134 customer cancellations;

(b) 72% of those total cancellations were "late notice" cancellations or "no shows" from customers/families;

(c) 13% of total cancellations were provided within the notice period by customers/families; and

(d) 15% of total cancellations were made by ConnectAbility.

35. The definition used for "late notice" cancellations was adopted from the SCHADS Award, and the terms for how cancellations are dealt with are clearly outlined in ConnectAbility's NDIS Customer Service Agreement. A copy of the template NDIS Customer Service Agreement is attached and marked **'A'**.

36. The data recorded shows that 75% of cancellations are made within 24 hours or not provided at all by the customer. The most common cancellation is communicated on the day of the scheduled support. While the data collected does not drilldown into this level of detail, I would estimate that between 80-85% of cancellations would occur on the day of scheduled community supports and within 3 hours of support scheduled to commence.

37. There are a wide variety of reasons provided by customers as to why they cancel their scheduled services. Some of these reasons include:

(a) the customer cancelling due to ill health;

(b) the customer being hospitalised;

(c) the customer taking holidays with family members;

(d) the customer cancelling due to complex behavioural needs;

(e) the customer cancelling due to poor weather;

(f) the customer electing not to have supports on the scheduled support time and day; or

(g) a customer "no-show" (the customer not attending a scheduled support, or not being home at the scheduled time).

38. There are also occasions where ConnectAbility cancels a scheduled support due to not having the appropriate staff resources available at the time.

39. When a client cancels a scheduled service, the Company will attempt to first re-deploy the staff member with another customer/s who may require support. However, this is not always a straightforward process, as it requires the staff member to have been inducted to provide supports to that particular customer, unless they are working alongside another staff member who can assist with mentoring inducting the staff member. This is usually the case where a support gap has occurred due to a staff member being absent from work on the corresponding day or is taking approved leave.

40. Staff members have been re-deployed to be supernumerary in a community or centre based group support activity, but this option is no longer operationally approved as the support costs for this supernumerary engagement cannot be billed against the customer, therefore there are unrecoverable wage costs incurred by ConnectAbility.

41. Staff members are redeployed to be inducted to work with a customer with complex support needs they have not worked with before. This assists build staffing resources for customers who have limited staffing resources attached. The NDIS buddy shift component in the customers plan is limiting with only 6 hours per plan allocated for staff buddy shifts. This again incurs unrecoverable wage costs for ConnectAbility.

42. ConnectAbility attempts to re-engage the customer to have service provided at another available time. This proves difficult to match with customer and staff member and ensuring the same rostered hours can be completed.

43. Where no redeployment opportunities are available staff members are provided alternative duties within the CSW position description and unrecoverable wage costs are incurred. If staff decline alternative duties they are offered the opportunity to use Annual Leave provision or take time as leave without pay (LWOP). For weekend support late notice cancellations where redeployment or alternative duties are not possible staff are paid rostered wages in full.

44. Changes to the NDIS Pricing Framework from 1 February 2019 only allow for 90% of the billable support item price to be claimed back for short notice cancellations. Short notice cancellations have a cap per customer as determined by the NDIS terms of business and

service providers are currently unable to claim for short notice cancellations after the first 12 short notice cancellations.

45. In the new 2019/2020 NDIS Pricing Guide the limit has been abolished and providers are only able to claim for short notice cancellations in very specific circumstances. A cancellation is a short notice cancellation (or no show) if the participant has given less than 2 clear business days' notice for a support that is less than 8 hours continuous duration and worth less than $1000, and less than 5 clear business days' notice for any other support.

46. There is no limit on the number of short notice cancellations (or no shows) that a provider can claim in respect of a client in the 2019/2020 NDIS Pricing Guide, but providers have a duty of care to their clients and if a client has an unusual number of cancellations then the provider should seek to understand why they are occurring and report it to the NDIA.

47. Client short notice cancellations equate to 2,647 support hours not able to be billed. In total revenue based on the pricing framework for the 17/18 FY this is equivalent to $104,786 across the financial year.

48. If ConnectAbility was required to pay employees for the rostered shift where the client cancels with less than 48 hours' notice, our wage overhead costs would increase by approximately 65% on top of the amount referred to in paragraph 47 above.

PART-TIME EMPLOYEES

49. The Company employs part-time employees in a variety of roles, including as community support workers, residential support workers, adolescent and family counsellors, and support coordinators.

50. The Company offers part-time employees work in excess of their contracted hours. Part time employees are provided minimum contract hours depending on each person's availability and rostered supports. All part time community support workers and residential support workers are engaged to work above contract hours stated in employment contract. Due to fluctuating support requirements of customers and changing needs of customers we have found it impossible to provide staff with rostered hours that directly match contract hours. Customer

control and choice has dictated this in the way part time contract hours are calculated for each individual staff member.

51. If the Award was varied to require ConnectAbility to pay overtime to part-time employees who agree to work in excess of their contracted hours, ConnectAbility would be forced to reduce part time employment opportunities and casualisation of the workgroup would be required.

52. Wage overhead costs due to overtime wages has been identified as not financially viable given the set NDIS pricing framework and unsustainable for ConnectAbility to continue as a provider of community participation supports under a part time model involving payment of overtime for hours in excess of contracted hours.

MINIMUM ENGAGEMENTS

53. Our work is based on client demands and therefore rostering takes place around the preferred times of our clients. This has always been the case for ConnectAbility even prior to the NDIS model. Customers engage ConnectAbility as a service provider due to the flexible nature of support provided and different support models offered as a community or centre based model either 1:1 or shared supports 1:2, 1:3; 1:4, etc. Customer/family control and choice has always existed and driven when service is to be delivered.

54. The NDIS has increased the number of customers requiring supports, and many people who are eligible to receive services under the Scheme are receiving low levels of community participation funding. We have received many referrals for short increments of community participation support (for example, 2 hours per week each Friday; or 1 hour weekly to provide transport).

55. Delivery of such services is not viable for ConnectAbility. It is not financially viable to engage customers for small increments of support under the NDIS pricing framework and in some instances where the requests do not meet current SCHADS Award minimum engagement.

56. ConnectAbility will not take on customers for periods of service that do not meet minimum engagement as per the Award (i.e. less than 2 hours). We have also established minimum engagement benchmarks for community participation supports, which is set at 8 hours per week. In other words, we do not take on customers who are wanting less than 8 hours of

services per week, as the costs in establishing those arrangements outweighs any commercial benefit (i.e. profit) that is derived from the delivery of the service. These costs include administrative costs in preparing service agreements, time spent liaising with the customer and his/her family/carers, undertaking plan reviews, staff training, quality and compliance obligations, liaising with other client stakeholders/service providers assisting the client, claims invoicing and reconciliation.

57. ConnectAbility has approximately 20 staff members who are engaged for small increments of support (for example, 2 hours). However, wherever possible these supports are rostered to back on to other roster supports of similar durations. This is particularly the case for a cohort of 40+ customers currently supported by ConnectAbility from Hunter Residences Stockton. This is a large residential facility for people with disability. ConnectAbility has two modified wheelchair accessible vehicles housed on site at the facility. Staff engaged may support 2-3 customers back to back from the facility. This enables staff to be engaged to provide support to customers who only require small increments of support due to their complex presentations and support requirements in the community. This also creates a 6-8 hour working day for support workers making it an attractive work engagement for staff.

58. Other scenarios where small 2 hour support shifts are provided is when a customer requires in-home support and then the staff member is engaged to support another customer/s for a larger block of time. This roster model is set where travel between customers is minimal (for example, 15 minutes travel time between customers). This also provides a more attractive work day for staff and assists to retain support worker staff.

59. ConnectAbility does not provide morning/afternoon supports or before/after school supports unless the customer commits to having a minimum of 8 hours of service per week in accordance with our minimum weekly engagement benchmark.

60. If ConnectAbility was required to provide a three hour minimum shift to all employees, this may affect customers' ability to maintain current service levels depending on their NDIS Core support package funding. For example, if a person is funded for 8 hours of support and is provided with 2 hours of support 4 days per week, a 3 hour minimum engagement will impact

the organisation's ability to provide that service, and will thereby reduce time in the community or supports provided in-home for the individual.

RECALL TO WORK

61. ConnectAbility has an on-call team for its community supports service provision. This role is currently provided by Team Leaders and Rostering staff. Community support workers are not engaged to provide on-call responsibilities as part of their role.

62. ConnectAbility also has an on-call team for supported independent living (SIL) operations. This role is currently provided by accommodation coordinators and managers. Residential support workers are not engaged to provide on-call responsibilities as part of their role.

63. The on-call process is implemented to ensure Direct Support staff members have access to emergency support and advice after hours. The on call role is to provide advice to minimise any risk, ensure compliance with legislative requirements and policy and procedure and to provide support to staff experiencing critical issues.

[redacted]

Signed by **Scott Harvey**

2 July 2019

A

Agreement No: 1
Customer NDIS No:
DOB:

ConnectAbility NDIS Service Agreement

Service Agreement with ConnectAbility

Thank you for choosing ConnectAbility Australia (ConnectAbility) as your Service Provider. This service agreement sets out agreed expectations around how the Service will be delivered by ConnectAbility to you. It outlines each party's responsibilities and obligations, and how to resolve any problems should they arise.

This service agreement is made between: **[insert name]** and ConnectAbility.

Description of Services

ConnectAbility agrees to provide you with Core Supports, Supported Independent Living (SIL), Specialist Disability Accommodation (SDA) services and/or Support Coordination services. The supports are listed in the Support Schedule, along with any arrangements needed to make sure the supports can be provided to you.

This Agreement will commence on **[insert date]** and will conclude on **[insert date]**

The types and duration of supports will continue unless a review is initiated earlier by either party. ConnectAbility would respect notice periods in relation to any changes in the type or duration of supports in the event of a review of your NDIS plan occurring. Where pricing changes are implemented by the NDIA, ConnectAbility will apply the new benchmark price levels for services delivered from the start date of the newly implemented NSW NDIS Price Guide.

Access to your National Disability Insurance Agency Plan:

By making this Agreement with ConnectAbility you agree to provide a copy of, or provide access to, a current copy of your NDIS Plan. This may require interaction with the NDIS Portal or representatives.

Participant's responsibilities: By entering this Service Agreement, you agree to:

- Work with ConnectAbility to ensure that the services meet your needs, and is also in accordance with all applicable legislation
- Have the right to be treated with dignity and respect and to have my choices and aspirations supported as far as is reasonably possible
- Try to solve any problems with our service by talking with us; if this is unsuccessful, there are other agencies that can help you with your complaint
- Treat staff and other customers with courtesy and consideration at all times

- Advise ConnectAbility with reasonable notice where unable to attend the services as planned.
- Keep ConnectAbility informed of any changes to my situation that I expect will have an impact on this Agreement;
- Pay for your services under the terms of this agreement.
- Be respectful of ConnectAbility's property, as you may be responsible for the costs of any deliberate damage caused
- Provide ConnectAbility the required notice if you need to end the Service Agreement (see 'Ending this Service Agreement' below for more information); and
- Let ConnectAbility know immediately if your NDIS plan is suspended or replaced by a new NDIS plan or you stop being a participant in the NDIS.

Responsibilities of ConnectAbility

In agreeing to provide this support arrangement ConnectAbility will:

- Provide the supports and services that are outlined in this Agreement
- Work cooperatively with the customer and in line with the principle of least restrictive alternative with the person and the activities they have chosen to undertake.
- Respect the rights of the customer to determine the range and types of activities they wish to participate in.
- Treat the customer and their family/carer with dignity, courtesy and respect.
- Communicate openly and honestly and in a timely manner and explain things clearly and in a way that you can understand
- Listen to the customer's feedback and work to resolve problems quickly.
- Be responsible for the management, reporting and documentation of supports, payment requests and allocated plan funding.
- Make sure your information is correct, up to date, stored carefully and kept private
- Will provide invoices and statements for your supports and services if requested by you and/or your representative in line with NDIS rules and relevant consumer laws
- At all times comply with all the rules and laws that apply - this includes the National Disability Insurance Scheme Act 2013 and the National Disability Insurance Scheme Terms of Business
- Immediately notify your family/carer or other significant stakeholders of any significant incidents or accidents involving yourself
- Ensure staff involved in your supports are provided with the required training and supervision
- Induct and complete all probity requirements on all employees employed by ConnectAbility.
- Will provide the customer with four (4) weeks notice of intention to cease service provision.
- Assist you to contact your Coordinator of Supports and/or NDIA should you wish to move out of ConnectAbility supports.

Ending this Agreement

Should either party want this agreement to end, both parties agree to give four weeks written notice. If extenuating circumstances present or either party seriously breaches any terms of this Agreement then the requirement of notice will be waived. This will be at the discretion of ConnectAbility.

Conflict of interest & relationships

We acknowledge the potential for a conflict of interest as ConnectAbility provides a range of disability services, including Specialist Disability Accommodation (SDA), Support Independent Living (SIL), Support Coordination and NDIS Core Supports. ConnectAbility will act in the best interests of people receiving service, ensuring they are informed, empowered and able to maximise choice and control. ConnectAbility will not (by act or omission) constrain, influence or direct decision making by a person and/or their family so as to limit that person's access to information, opportunities and choice and control over supports provided.

ConnectAbility will proactively manage perceived and actual conflicts of interest by:

- ensuring organisational or ethical values do not impede a customer's right to choice and control
- managing, documenting and reporting on individual conflicts as they arise, and
- ensuring that advice to a customer about support options is transparent and promotes choice and control.

In the case of this agreement, ConnectAbility is the provider for:

☐ **NDIS Core Supports** ☐ **Support Coordination** ☐ **SIL** ☐ **SDA**

Recording of Supports Provided

ConnectAbility agrees to keep full and accurate accounts and financial records of the supports delivered to you, along with records of service agreements, service care plans, house hold expenses and any complaints which they have received for seven years from the date each record is received.

ConnectAbility confirms that the way they hold these records complies with the NDIS Terms of Business, all relevant statutes, regulations, by-laws and requirements of any Commonwealth, State, Territory or Local Authority.

If you would like to view the records held by ConnectAbility, you can make contact with your Team Leader on 4962 1000.

Cancellation of Supports and 'No-shows':

ConnectAbility reserves the right to claim against your Plan for cancellations and "no shows" as outlined in NDIS pricing rules. To avoid cancellation fees, customer's, or their person responsible must provide notice prior to 3.00p.m the day before the scheduled service (Monday to Friday). This applies Monday to Sunday inclusive.

This must be by phone to 02 4962 1000 Monday – Friday 7am-5pm or weekends to ConnectAbility On-Call (0484 571 929). If ConnectAbility does not receive such notice, as per the NDIS Terms of Business, then ConnectAbility will classify this as a late notice cancellation or late notice change to supports.
In the event of a cancellation of support there will be no charges raised for travel/transport.

Any late notice cancellation or "no show" that is charged will be according to the terms set out in this service agreement between the customer and ConnectAbility and following the NDIA Terms of Business. Where cancellation is received within the specified timeframe no payment request will be made to NDIA.

For further information please see cancellations-policy [insert link] or ask for a copy.

Payment for Services

By signing this Service Agreement, you agree that the services provided will be paid with your NDIS funding, by you or your agent.

Process:

ConnectAbility will first lodge a Service Booking with the NDIA through the NDIA Provider Portal which sets out the services agreed to be delivered in line with your Schedule of Supports. Once services are delivered ConnectAbility will create an invoice and make a claim for payment through the NDIA Portal.

ConnectAbility seeks payment for services after the services are delivered directly from the National Disability Insurance Agency (NDIA), a Plan Manager or from a customer self-managing their NDIS funds.

For customers who have a nominated Plan Manager to manage payments for supports delivered an invoice will be directly provided to the Plan Manager nominated by the customer. Payment must be received from the Plan Manager within 14 days.

For self-managing customers an invoice will be directly provided to the customer. Payment must be received from the customer within 14 days.

Non-payment of Invoices

If payment is not made, ConnectAbility will contact the customer or their Plan Manager to discuss why this has occurred, agree to resolve any dispute you may have as per the Feedback, Complaints and Disputes section and make a limited extended time arrangement and/or a payment plan to pay the debt.

If the customer or their Plan Manager does not comply with any debt payment arrangement or plan negotiated with ConnectAbility, the debt may be handed to a collection agency where collection fees may apply. Delivery of service may also be withdrawn until settlement of the matter.

Goods and Services Tax (GST)

If you receive supports as detailed in an NDIS plan, for the purposes of GST legislation, the Parties confirm that:

- a supply of supports under this Service Agreement is a supply of one or more of the reasonable and necessary supports specified in the statement included, under subsection 33(2) of the *National Disability Insurance Scheme Act 2013* (NDIS Act)
- in the customer t's NDIS plan currently in effect under section 37 of the NDIS Act
- You and/or your representative will immediately notify the Service Provider if your NDIS Plan is replaced by a new plan or you stop being an eligible participant in the NDIS.

Protecting your personal information and privacy

While working with you, we may gain access to personal information about you as a client. We will take all reasonable steps to protect your information and safeguard it from unauthorised disclosure or loss. We will not divulge any information whatsoever relating to you, except in the circumstances where:

- it is within the public domain,
- where disclosure is required by law, or
- if you have given us your consent to do so.

To view the ConnectAbility Privacy Policy (and Easy Read Privacy Policy) please see our Privacy Policy or ask for a copy.

Quality Safeguards

Your records may be viewed by a third party auditor to ensure that ConnectAbility is complying with all funding standards, legislation, and Acts pertaining to disability services.

☐ I do not want my records to be viewed by a third party.

Feedback, Complaint, Disputes

Feedback is an important part of the way we review and assess ourselves and our services, and we take it very seriously. There are several ways you can provide feedback. You can talk to any member of ConnectAbility Staff, or you can provide it in writing and email it to contact@connectabilityaus.org.au ConnectAbility is committed to resolving complaints fairly, equitably and as quickly as possible.

If you wish to make a complaint or have a dispute, you can:

- Talk to the relevant staff member directly; or
- Talk to their manager directly (ask for details), or
- Provide details of your Complaint in writing to contact@connectabilityaus.org.au or in person.

For more details, see our Complaints and Compliments Policy, or ask for a copy. 3. If ConnectAbility cannot fix the matter, then you may contact:

NDIS Quality & Safeguards Commission	NSW Fair Trading	Intellectual Disability Rights Service	National Disability Insurance Agency
Phone: 1800 035 544	Phone: 13 32 20	Phone: 4926 5643	Phone: 1800 800 110
Website: www.ndiscommission.gov.au	Website: www.fairtrading.nsw.gov.au	Website: www.idrs.org.au	Website: www.ndis.gov.au

Entire Agreement

This agreement sets out all of the terms of your supports and services with ConnectAbility Australia. This agreement supersedes and replaces all prior representations, contracts and agreements (whether oral or in writing) detailing your supports and services with ConnectAbility. ConnectAbility advises that there may be requirement to amend this document to reflect changes to the scheme as a result of policy change by the Federal Government.

Once you sign this agreement, you are confirming it is complete and no agreed terms are missing. If this agreement is not returned signed ConnectAbility acknowledges this as a working agreement.

Customer or Customer Representative		ConnectAbility representative
Print Full Name:		Print Full Name:
Signature:		Signature:
Phone:	Email:	Position Title: Team Leader
Date:		Date:

Agreement No: 1
Customer NDIS No:
DOB:

Service Agreement attachment - Schedule of supports

Customer: [insert name] **Dated: [insert date]** **NDIS Plan [insert date] to [insert date]**

The supports (including day/hours), their prices and the forecast costs in providing these supports are set out in this Schedule of Supports. Prices charged do not exceed the price level prescribed for that support in the NSW NDIS Pricing Guide. All prices are GST inclusive and include the cost of providing the supports.

Additional expenses (i.e. things that are not included as part of a Participant's NDIS supports) are the responsibility of the customer. These are not included in the hourly price for support set by the NDIA. Examples include service provider travel and transport fees, public transport costs, community venue activity entrance fees, event tickets, meals, etc.

Support Category	Support Item	Pricing and Payment Information	How the support will be provided	Total
Establishment Fee	01_049_0107_1_1	$500 if customer new to NDIS and ConnectAbility $250 if customer has transitioned from other provider in first NDIS Plan DELETE ROW IF NOT APPLICABLE	This applies to all new NDIS customers in their first plan where they receive at least 20 hrs of community access support per month. This payment is to cover non-ongoing costs for ConnectAbility establishing service and assisting you to implement your plan	
Transport Costs ConnectAbility will charge a fixed amount for the provision of travel and transport services. An estimation of your travel and transport usage be implemented as part of your support schedule/service booking. This is to ensure an indicative and reasonable number of kilometres is estimated as part of your schedule of supports. This estimate is intended to act as a guide for the associated costs of the travel and transport component of your ConnectAbility support schedule. **No. of kilometres per support:** **Estimated cost of transport for Plan Period @ $1.00 per klm:**				
Due to the complexity of your support needs we would be required to include shadow shifts to assist with the introduction of new workers, and this is agreed upon by the customer and/or their family/carer, ConnectAbility will claim for up to 6hours of weekday support per year. ***[Insert support item/support item number & price]***				
ConnectAbility will charge up to 4 hours for each plan period to document and review scheduled supports and expected outcomes. ConnectAbility has included 4 hours support, calculated using the Assistance to access Community-based social and recreational activities – ***[Insert support item/support item number & price]***				

Agreement No: 1
Customer NDIS No:
DOB:

Total Service Booking Amount $	

Signature on behalf of ConnectAbility: .....

Signature of Parent/Authorised Representative: ..... **Name of Parent/Authorised Representative: .....**

FAIR WORK COMMISSION
4 Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award 2010
Matter: AM2018/26

STATEMENT OF ANDREW COLLINS

I, Andrew Collins, of [redacted], affirm as follows:

MY BACKGROUND

1. I am employed by The Benevolent Society (**the Company**) in the role of Executive Director, Ageing.

2. I am based at Glebe, NSW.

3. I have been employed by the Company since January 2014.

4. My role is to support the achievement of the Company's strategic goals through the growth and delivery of innovative, consumer focussed ageing support services. As a community services executive, this role sets and monitors all performance targets and outcomes for the portfolio and direct reports.

5. I started as a Registered Nurse 23 Years ago. Since then I have worked in leadership positions across the Government and NFP sectors including; the Department of Health and Ageing, the Office of the Registrar of Community Housing and Uniting Care NSW ACT.

6. I have a Bachelor of Nursing and a Graduate Diploma in Public Health (Management).

THIS STATEMENT

7. The information in this statement is based on my experience and observations from my roles within the Company and our Ageing Services, and is true to the best of my knowledge.

8. Where I depose particular conversations, I provide either the exact words used or the substance of the conversation to the best of my recollections.

9. Where I comment on matters that I did not personally observe, I identify the source of that information in this statement.

Lodged by:	Australian Business Industrial NSW Business Chamber Ltd Aged & Community Services Australia Leading Age Services Australia	**Telephone:** (02) 4989 1004
Address:	Australian Business Lawyers & Advisors Pty Limited Lvl 15, 140 Arthur Street, North Sydney NSW 2060	**Email:** madeleine.tiedeman@ablawyers.com.au

INFORMATION ABOUT THE BUSINESS

10. The Company has been in operation since 1813 and is a not for profit company limited by guarantee. The Company is registered as a charity.

11. The Company operates in the social, community, home care and disability services industry.

12. Our services operate across NSW, ACT, QLD, and SA from over 70 service locations in metropolitan, regional and rural areas, with a fully mobile workforce. Our service staff have a wide range of expertise, including in the areas of family support, early childhood development, care coordination, in home and community support, and allied health and clinical care for people with disability and older people.

13. The Company brings unique capabilities to services, underpinned by a dedication to working in partnership, investment in robust research, evaluation using strong outcomes framework, consumer engagement and co-design and system advocacy. Our services across the spectrum are aligned with the following approaches: client choice and control, a wellbeing focus, person-centred, strengths-based, trauma-informed and flexibility.

14. The organisation receives funding through multiple sources including block government funding, the National Disability Insurance Scheme, Aged care funding under the Aged Care Act, client fees and philanthropic sources.

INDUSTRIAL ARRANGEMENTS

15. The Organisation has an enterprise agreement in place that covers the majority of staff that operate within our Aged, Carer and Child and Family Portfolios. The enterprise agreement is The Benevolent Society Enterprise Agreement 2016-2019 (**Enterprise Agreement**).

16. Our Disability Service employees are primarily covered under the Crown Employees Award as the majority of those employees transitioned from the employment of the NSW Government to the Company in 2017.

17. The Company typically pays above-Award rates of pay.

THE COMPANY'S WORKFORCE

18. The Company currently employs 1,435 employees. Of these, approximately 167 are employed in our Aged Care Services.

19. The employees in the Company perform a range of roles including clinical health and disability services, family and parenting support, mental health and wellbeing, post-adoption services, foster care, support for carers and early childhood services. Our aged care portfolio employees perform roles including home support and respite services.

20. The table below provides a breakdown of the Company's workforce:

Status	Whole Organisation	Ageing Services
Permanent full-time	812	38
Permanent part-time	417	102
Fixed-term full-time	101	4
Fixed-term part-time	36	0
Casual	69	23
Total	1435	167

21. The organisation's preference is to provide staff secure employment as much as possible. This is the reason that the number of casual employees is considerably less than those employed as permanent part-time employees. In addition to this our Enterprise Agreement provides that casual employees, who have worked on a regular and systematic basis over a period of 26 weeks, are able to make a request to their manager in writing, to convert to full-time or part-time employment on an ongoing basis.

22. Our Ageing Service staffing profile:

(a) Has a turnover rate of 15.85%;

(b) Is 92% female employees and 8% male employees;

(c) Has an age profile that can be broken down into the following age groups and percentages:

(i) 1.2% of employees are less than 25;

(ii) 4.7% of employees are in the 25-34 age bracket;

(iii) 14.2% of employees are in the 35-44 age bracket;

(iv) 28.4% of employees are in the 45-54 age bracket;

(v) 36.7% of employees are in the 55-64 age bracket; and

(vi) 14.8% of employees are over 65.

(d) Has the following lengths of service:

(i) 3% of employees have been employed for less than 3 months;

(ii) 2% of employees have been employed from 3 to 6 months;

(iii) 10% of employees have been employed from 6 to 12 months;

(iv) 8% of employees have been employed from 1 to 2 years;

(v) 16% of employees have been employed from 3 to 4 years;

(vi) 33% of employees have been employed from 5 to 9 years;

(vii) 18% of employees have been employed from 10 to 14 years;

(viii) 8% of employees have been employed from 15 to 19 years; and

(ix) 2% of employees have been employed from 20 to 29 years.

Lodged by:	Australian Business Industrial NSW Business Chamber Ltd Aged & Community Services Australia Leading Age Services Australia	**Telephone:** (02) 4989 1004
Address:	Australian Business Lawyers & Advisors Pty Limited Lvl 15, 140 Arthur Street, North Sydney NSW 2060	**Email:** madeleine.tiedeman@ablawyers.com.au

THE NATIONAL DISABILITY INSURANCE SCHEME

23. The Company is a registered service provider with the National Disability Insurance Agency.

24. The current workforce is involved with the provision of specialist services to people with complex disabilities and are primarily covered by the Crown Employees Award. The employees who are not covered by that state instrument are covered by the Enterprise Agreement.

CONSUMER DIRECTED CARE

25. The Company is a service provider under the Aged Care Act for both the Commonwealth Home Support Program and the Home Care Package Program.

26. The implementation of Consumer Directed Care in the Home Care Package environment, as well as the reduction in red tape in becoming an approved provider, has seen an increase in the amount of competition between providers for clients. This has resulted in an increasing downward pressure on the prices that providers charge against packages.

27. This is of particular importance as the move to individualised funding means that providers are solely reliant on revenue that is generated through the charges made against a package for direct service provision.

CLIENT CANCELLATION ISSUES

28. The Company typically experiences 3 to 4 client cancellations each day.

29. Some of the reasons why a client cancels their scheduled services include sudden changes to their circumstances such as illness, hospitalisation and changes to caring responsibilities.

30. When a client cancels a scheduled service prior to 5.00pm on the day before the service, that service is cancelled with no charge to the client's package. In these circumstances, the Company will provide the employee with notice of the change in roster by 5.00pm the day before the employee is due to work. In those circumstances, the employee will not be paid for that shift and the Company does not incur a cost as a result of the cancellation.

31. When a client cancels a service with less notice than 5.00pm the previous evening, the Company will in the first instance attempt to reschedule the service for an appropriate time for the client. If there

there is a not a suitable time that meets the needs of the client and the staff member we will attempt to find another service for the staff member to attend during the same timeframe.

32. If we are unable to find a suitable alternate service for the staff member we will pay the staff member for the minimum specified hours that the employee is rostered to work for that client on that day; or may direct the employee to make-up time equivalent to the cancelled time, in that or the following roster period. This time may be made up working with other clients or in other parts of the business. If an employee has already received a payment for the shift and subsequently performs make-up time, the employee will not be entitled to be paid for the make-up time as they have already been paid for those hours.

33. Client cancellations vary in the amount of notice that is given, there is a large proportion of cancellations that give very little to no notice and on these occasions the total service is charged against the client's package and the staff member is paid for that service. The next most common amount of notice that clients give is within the preceding 24 hour period. This is because clients generally wait to ascertain whether their circumstances will allow for the service to continue, for example, if they have been unwell they may wait to see if they feel better in time for their service. These circumstances are managed as per the above processes.

34. There are very few instances when we are provided with greater than 48 hours' notice of client cancellations.

35. Providers are reliant on the income received from direct service provision to cover the cost of salaries for staff. If there was a 48 hour notice period introduced, the Company would need to introduce cancellation costs to clients for the equivalent period. This would result in limitation of client flexibility and choice.

36. It is common for aged persons to have unforeseen reasons to cancel shifts in less than 48 hours, as I have set out above. If they were required to pay for those cancellations in full, they would lose a considerable amount of services. The other option I can see would be for providers to increase direct service costs to build enough margin to cover the increased staffing costs in preparation for these cancellations. Given the higher costs, the result would be that clients would receive fewer hours of service.

PART-TIME EMPLOYEES

37. The Company employs part-time employees in a variety of roles, including our Ageing direct service staff.

38. When engaging part-time employees for these roles we classify them as Variable Roster Part-Time Employees and analyse demand and staff member availability to determine minimum contracted hours.

39. At the time of engagement of a Variable Roster Part-Time Employee the Company and the employee agree in writing on the following:

    (a) the minimum number of hours to be worked each week;

    (b) which days of the week the employee is available to work; and

    (c) the earliest and latest time the employee is available to work on any particular day.

40. Approximately 80 per cent of our Ageing direct service staff are employed on a part time basis with an average minimum number of 16 hours per week.

41. The Company offers part-time employees work in excess of their contracted hours. We provide the opportunity for staff to advise us where they have additional availability and would like to work further hours, for example during school holidays. Under our enterprise agreement a part-time employee who consistently works more than their specified minimum ordinary hours of work, over a 6 month period, may request an increase to their minimum ordinary hours. The organisation has committed that it will not unreasonably withhold agreement to increase a part-time employee's minimum ordinary hours.

42. A number of staff have had the opportunity to increase their hours under this clause but have chosen not to do so as they prefer the security of having minimum hours with the flexibility to work additional hours when it is suitable to them.

43. If the Company was required to pay overtime to part-time employees who work in excess of their contracted hours, it is my belief that we would have to immediately cease providing opportunities for our employees to work additional hours as the cost of employment would not be matched by the service charge to home care packages. This change would likely result in the Company utilising more casual staff to assist with the management of fluctuating client demand.

MINIMUM ENGAGEMENTS

44. The Company's work is based on client demands and therefore rostering takes place around the preferred times of our clients. These choices for clients are based on their level of need, the availability of family and friends and their own personal circumstances.

45. The ability to meet the needs and choice of clients is key in the delivery of services and central to the success for the Company. Where we are unable to meet the needs of the clients, we either limit their service options which is contrary to the purpose of Consumer Directed Care, or they would choose an alternate provider that could provide services in accordance with their needs.

46. The Company provides services in blocks of 30 minutes because services such as medication prompting etc. do not require a full hour of service. We always attempt to provide rosters that maximise the hours for staff but do need to balance that against the client demand.

47. There are regular occasions where employees are rostered on for 1 hour and these typically relate to services such as evening meal preparation or personal care services on weekends. While we always look to provide longer shift durations this is dependent on client need and choice.

48. If the Company was required to provide a three hour minimum shift to all employees we would be forced to review our ability to provide the flexibility to our clients and possibly not be able to meet their needs. Continuing to provide these flexible one hour services for clients while guaranteeing a minimum engagement of 3 hours would not be financially sustainable for the organisation.

RECALL TO WORK

49. The Company requires employees to be on call and as such we currently have 2 employees that have the primary responsibility for this function. When on call, these employees generally take phone calls while in their own premises and provide advice to clients, provide over the phone support to people who require emergency assistance and undertake urgent roster requests.

50. Employees who are on call are paid an on call allowance in accordance with the Enterprise Agreement.

51. Under our Enterprise Agreement an employee is taken to have been recalled to work if they have left the Company's premises or a client's premises and:

    (a) have to attend work or a client's home; or

(b) are required to work either at home or at work for a combined period of greater than 30 minutes within a two hour period.

52. If an employee is recalled to work after leaving the Company or a client's premises they will be paid for a minimum of two hours' work at the appropriate rate each time the employee is recalled. If the work required is completed in less than two hours the employee will be released from duty.

[redacted]

Signed by **Andrew Collins**

12 **July 2019**

FAIR WORK COMMISSION
4 Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award 2010
Matter: AM2018/26

STATEMENT OF DEB RYAN

I, Deb Ryan, of [redacted] NSW, affirm as follows:

MY BACKGROUND

1. I am employed by Community Care Options Limited (**the Company**) in the role of Chief Executive Officer (CEO).

2. I am based at Coffs Harbour.

3. I have been employed with the Company since September 2007.

4. My role involves the leadership and management of the Company.

5. Prior to working with the Company, I was employed in the Disability sector for the NSW Department of Family and Community Services Ageing Disability and Home Care. I held numerous positions over the time I was there which was 1982 to 2007, with Management experience from 1988.

6. I have the following qualifications:

   (a) Associate Degree of Management & Professional Studies;

   (b) Graduate Certificate in Management (Public Sector Management); and

   (c) Programme Officer;

   (d) Registered Mental Retardation Nurse.

7. I also have significant training, development and experience in change management, leadership, child protection, out of home care, complaints management and people management.

8. In 2016 I was chosen to be NSW Not for Profit Leader of the Year at the Australian Leadership Excellence Awards.

Lodged by:	Australian Business Industrial NSW Business Chamber Ltd Aged & Community Services Australia Leading Age Services Australia	**Telephone:** (02) 4989 1004
Address:	Australian Business Lawyers & Advisors Pty Limited Lvl 15, 140 Arthur Street, North Sydney NSW 2060	**Email:** madeleine.tiedeman@ablawyers.com.au

THIS STATEMENT

9. The information in this statement is based on my experience and observations from either working at the Company, or from my experience generally working in the social, community, home care and disability services industry, and is true to the best of my knowledge.

10. Where I depose particular conversations, I provide either the exact words used or the substance of the conversation to the best of my recollections.

11. Where I comment on matters that I did not personally observe, I identify the source of that information in this statement.

INFORMATION ABOUT THE BUSINESS

12. The Company has been in operation since around 1990 and was originally an auspice of Coffs Harbour City Council. The Company became an Incorporated Association in 1996 with governance via a volunteer Board of Management. The Company then became a Company Limited by Guarantee in June 2017, with a Board of Directors and Members. The Company operates in the social, community, home care and disability services industry.

13. The Company is a not-for-profit organisation limited by guarantee.

14. The Company provides aged care home care packages and NDIS services. All services that are provided are carried out in the home or in the community, the Company does not have premises on which services are carried out.

15. The Company services approximately 2,500 clients per year, and the approximate number of clients that are currently being serviced is 700.

16. The Company's operations include delivering a range of services to Aged Care clients as well as clients who are funded under the National Disability Insurance Scheme (**NDIS**). Services are delivered across the Coffs Harbour, Nambucca Heads and Bellingen Local Government Areas. The Company's primary objective and mission is to support and facilitate improved quality of life and independence for people living within our community.

17. The Company provides a range of services including Domestic Assistance, Personal Care, Social Support, support to clients requiring further home care on discharge from hospital, Transport and Welfare checks/Medication Prompting.

18. Community Care Options receives funding from Individuals funded by the National Disability Scheme (NDIS), Government Funded Aged Care Home Care packages, federal funding for the Commonwealth Home Support Program (CHSP). We also support client's exiting hospital under the Compacks program funded by NSW Health.

THE COMPANY'S WORKFORCE

19. The Company currently employs approximately 170 employees.

20. These employees perform a range of roles including administration duties, program/package oversight, coordination of supports, domestic assistance, medication prompting, meal preparation, personal care, social support, community participation and transport.

21. The Company's workforce consists of:

    (a) approximately 23 full-time employees;

    (b) approximately 82 part-time employees;

    (c) approximately 71 casual employees; and

    (d) approximately 20 independent contractors.

22. The Company has approximately 30 employees in the office, with the remaining 140 or so employees in the field providing services to clients. Those employees in the field are primarily part-time and casual employees.

23. The reason that the employees engaged in the field are primarily part-time and casual is because the Company cannot commit to providing full-time employment to those employees. This is due to the nature of the industry, which requires typically short shifts and has a high level of client cancellations. Clients can also go into respite or hospital which means they do not require services during these periods.

24. We have trialled employing full-time employees in the past but we found that while we were paying them for 38 hours per week, they weren't working for anywhere near that amount of time. This was losing the Company money and therefore we moved away from employing full-time employees.

25. Since reforms in both the aged care and disability sectors have been undertaken, the Company has experienced a shortage of experienced care staff, this has added an additional training burden on

the Company as due to the time lapse between gaining clearance for staff, for example, a Working With Children Check, a criminal history check as well as induction and training of staff and then providing buddy up shifts for the employee to gain experience takes time.

26. Typically in recent years we have been employing people with no previous experience in this industry.

27. There have been occasions where staff have resigned because of the high level of cancelled shifts, inconsistent work patterns or a realisation that the sector is not for them.

28. Employees complain about down time. However, because the sector is now focussed on client choice and control, clients have individual budgets and they determine what they will and will not pay for.

INDUSTRIAL ARRANGEMENTS

29. The Company does not have an enterprise agreement.

30. The Award is the principal industrial instrument applying to employees and the Company typically pays Award rates with the addition of some above award entitlements relating to travel time, admin time and renewal of first aid certificates.

THE NATURE OF THE INDUSTRY GENERALLY

31. Community Care Options use permanent staff where possible to ensure contract hours are met prior to considering casual employees. However, since the commencement of the NDIS and Consumer Directed Care the Company has experienced employees choosing to remain as casual employees rather than taking up offers of permanency, which appears to be because of the varying rates of pay.

32. The Company endeavours to offer casual staff permanency after 12 months of employment. Where possible the Company will try to ensure that a staff member's work pattern is consistent and where possible that any gaps are filled.

33. Where short notice of cancellation or rescheduling occurs it remains challenging across all service areas to ensure or guarantee an employee's hours. Services can change on a daily basis, depending on what is happening for a client. Our fortnightly rosters are the staff's pattern of work. Clients are not required to have the same services every week. Some clients request additional services.

34. The Company's experience to date regarding sector reforms has resulted in the Company investigating whether some services will remain viable into the future given the current payment models/rates along with undertaking a major restructure to ensure that any conflict of interest is actively avoided as well as re-evaluation of staff roles/responsibilities and classification under the award.

35. The Company continues to monitor the impact of reforms and pay structures and changes to the Award as any one of these areas could and would potentially affect the viability of ongoing services being provided in our local community.

36. Following reforms the Company has increased work for less income. For example, we are now required to manage individual client budgets, monthly statements, quotes and pay suppliers. We have not changed our service offerings but have considered making changes such as not providing non-essential services on weekends due to the impact of additional leave payments to staff which we cannot recoup from an individual clients funding.

37. NDIS does not fund things like staff training or buddy shifts requiring more than one employee for complex clients.

38. It is impossible to give all clients what they want, when they want it. Most clients want their services around the same time, for example early in the morning. If we were to provide clients the exact services they request at all times, we would require significantly more staff and most staff would only work for about three hours per day. We encourage clients to fit in with our staffing resources and usually they understand the difficulties we face and are agreeable.

39. We have had to increase our rostering team to assist with rostering services, changing services and cancelling services. A change by one client can impact all clients on a worker's roster for that day. Rostering staff requires consideration of a number of factors, including gender, location, travel time, staff skills, personality issues, car size and others. Not all staff can go to all clients and we have had to take employees off certain clients to utilise that employee for more complex clients.

THE NATIONAL DISABILITY INSURANCE SCHEME

40. The Company is a registered service provider with the National Disability Insurance Agency.

41. Since the introduction of the NDIS the Company has experienced increased work pattern inconsistency and a higher rate of turnover with newer staff due to client services being cancelled, rescheduled and/or a client choosing to move to another service provider.

42. Some of our employees work across a couple of local organisations to try to achieve a stable income and a regular pattern of work. Service provision under the NDIS requires separation of duties for some services delivered and where this is required it means that the organisation is unable to maximise hours for staff on a permanent basis due to fluctuating client demand and funded hours for separate services.

CONSUMER DIRECTED CARE

43. The Company is an approved aged care provider. We provide Consumer Directed Care.

44. The Company has experienced work pattern disruption and a higher rate of turnover with new staff due to client services being cancelled, rescheduled and/or a client choosing to move to another service provider. The Company is unable to maximise hours for staff on a permanent basis due to fluctuating client demand.

45. The difficulties associated with Consumer Directed Care are very similar to those difficulties we face under the NDIS.

CLIENT CANCELLATION ISSUES

46. The Company experiences client cancellations on a very regular basis. We experience client cancellations on at least a daily basis.

47. From 1 April 2019 to 30 June 2019 the Company had clients cancel their services on the same day on 205 separate occasions.

48. Some of the reasons why a client cancels their scheduled services include that they are feeling unwell, that they have people (such as family) visiting and they don't need the service, they have managed to get a doctor's appointment, they don't like the worker that has been rostered with them, or a number of other reasons.

49. When a client cancels a scheduled service, the Company only charges the client if they cancel after 4.00pm on the day before. If it is after 4.00 pm the Company charges the client for one hour maximum (less if their scheduled service was less, for example 30 minutes). We then pay the

employee for the time that we get from the client. For example if the client had a three hour service scheduled, but cancelled the night before, we would charge the client for one hour and pay the employee for one hour's work.

50. If we have other services that we can get the employee to work, we will give them the alternative service, however it is not common that we are able to find the employee alternative work for the time that they were rostered for.

51. It is easier to just pay the employee one hour than attempt to find them a replacement shift. It takes considerable time to track the employees who have had cancelled shifts, given the high number of cancellations we get, and then to attempt to reallocate them a shift.

52. There is no typical notice given by clients cancelling services. Some clients cancel very early and some clients cancel on the day. Some clients will even cancel when the employee gets to the door.

53. If the Company was required to pay the employee for their rostered shift if a client cancelled with less than 48 hours' notice it would have a fairly significant impact on the business. The Company would need to have the clients pay more to cover that cost, as the Company would not have the money to cover the cost. If the Company was to ask the clients to pay more we would be at considerable risk of losing clients' business to providers that could afford not to make the client pay more.

PART-TIME EMPLOYEES

54. The Company employs part-time staff in a variety of roles, including Support Workers, Service Coordinators, Support Coordinators, Assessment Officer, Project Manager and Administration staff.

55. When engaging part-time employees in service delivery we typically employ them on between 15 and 22 hour per week contracts. Other part time employees are employed as per business requirements. Most part-time employees work above their contracted hours. The reason for this is that we can identify that between 15 and 22 hours per week is sustainable, but cannot commit to any more. If clients get sick and go into hospital for extended periods it can be difficult to fill staff contracts.

56. Most part-time employees are offered additional hours of work. Employees are not required to accept the additional work, this is mutually agreed. The majority of our part-time employees work

above their contract hours, with many working in excess of 30 hours per week. There are times however when we pay staff for their contracted hours, and they have not worked that many hours.

57. In the past year, part-time employees have worked 95,000 hours above their contracted hours.

58. If the Company was required to pay overtime to part-time employees who work in excess of their contracted hours, the Company would likely go bankrupt. It would be unsustainable, and we would need to find more staff, but would have trouble doing that. We have no ability to pass overtime costs onto clients, for example, NDIS does not have an overtime item.

59. We have difficulty finding staff with the appropriate skills each time we undergo recruitment. We have recruited three times this year and have had an intake of 4 to 18 employees each time we undergo a recruitment process, but it is not easy to find people.

MINIMUM ENGAGEMENTS

60. The Company's work is based on client demands and therefore rostering takes place around the preferred times of our clients. As our services are provided around client choice it can be challenging at times when there are cancellations and rescheduling of services, change to a different service provider for some or all of a client's services, or there are specific requests regarding the staff providing the direct services. For example, a client may request more services from a specific staff member, or choose not to have services provided by another staff member.

61. Services such as medication prompts, heating of meals, application of TED stockings and some transport services can be provided in as little as 15 minutes. Therefore we roster all services in 15 minute intervals.

62. While we endeavour to ensure that employees have full rosters, the nature of our industry is that employee rosters are susceptible to change as the needs of our complex client base changes.

63. On any given day, a casual employee may be required to provide one off additional support to meet client demands. If that casual employee does not possess the required skill or client familiarity to provide all aspects of the services that client requires, it may not be possible to provide that employee with three hours' work.

64. Our shifts vary between 15 minutes and 12 hours. A typical service for Domestic Assistance may be two to three hours. Personal Care services typically range from 30 minutes to one and a half hours depending on the client's mobility, age, disability, health issues etc.

65. The Company rosters employees in a run of clients to avoid employees having gaps in their day but if clients cancel then sometimes gaps are unavoidable.

66. Most employees work between five and six hours per day. Some of these are broken shifts and some are consecutive.

67. The Company's busiest time is from 6.00am to 10.00am in the morning and from 5.00pm to 11.00pm in the evening. It's difficult to find staff to work on the evening run.

68. If the Company does not provide services in the requested time period the clients will likely leave for another provider that can provide the services in their requested time period.

69. We have experienced clients leaving because we haven't been able to accommodate their needs. We have seen at least two clients leave in the past 12 months. Usually clients understand when you explain to them why you can't provide them a service at their exact rostered time, but sometimes they do not.

70. We try to allocate domestic assistance shifts (such as cleaning etc) to the middle of the day to provide work for our employees from 10.00am onwards. We leave the early mornings and nights for showers, medication and other services that are necessary for clients at those times.

71. If the Company was required to provide a three hour minimum shift to all employees the potential impact on the Company's bottom line would be significant as many services provided by the Company are short shifts.

72. An introduction of a three hour minimum shift would also impact significantly on staff rostering workloads and there would be a certain level of knowledge required across the organisation in relation to employees and what their skill level is and what particular client requirements are and how they interact with employees' skills.

RECALL TO WORK

73. We don't recall employees to the workplace, but we have staff on call. We provide an above award on call allowance.

74. The Company provides an on call service to clients and staff between 6.00am and 8.30am and 4.30pm to 10.00pm Monday to Friday, and from 6.00am to 10.00pm on weekends and public holidays.

75. The person on call only answers the phone, they don't have to go out and attend to anything. We pay $50.00 per day on weekdays and $100.00 per weekend day. Employees are allocated two weeks per year for on call. They work one full week on call in first 6 months and one in second six months. They are paid $450.00 for the week (in addition to their wages) to answer the phone and manage whatever the call requires.

76. Some days the on call person will receive no calls, and some days they could receive 10 calls.

77. If we were required to pay overtime we would have to stop providing the service as we do not charge clients for this. This would be unfortunate as it is a service that makes our business competitive within the market and something that not all providers offer.

78. Reasons that clients use the on call service can be to change their service, to inform us that they are going to hospital and for cancellations. Clients are asked only to use the on call service if the issue is urgent.

79. Employees use the on call service to call in sick or if they need to change their shift. They also use the service if they require support with a client issue. We encourage employees to use it for this purpose as we want our staff to feel well supported. The on call person will assist by amending the roster.

[redacted]

Signed by **Deb Ryan**

12 July 2019

FAIR WORK COMMISSION
4 Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award 2010
Matter: AM2018/26

STATEMENT OF JOYCE WANG

I, Joyce Wang, of [redacted], affirm as follows:

MY BACKGROUND

1. I am employed by CASS Care Limited (**the Company**) in the role of Senior Executive Officer of Human Resources Management.

2. I am based at Campsie in the state of New South Wales.

3. I have been employed with the Company since around May 2015.

4. My role involves implementing all HR activities from recruitment to separation, ensuring the compliance with all HR policies and practices, providing advice and assistance to managers of all service units in workforce management and in relation to staff issues.

5. I hold a Master's degree of Human Resources Management.

THIS STATEMENT

6. The information in this statement is based on my experience and observations from either working at the Company, or from my experience generally working in the social, community, home care and disability services industry, and is true to the best of my knowledge.

7. Where I depose particular conversations, I provide either the exact words used or the substance of the conversation to the best of my recollections.

8. Where I comment on matters that I did not personally observe, I identify the source of that information in this statement.

9. In preparing this statement I have consulted with the Senior Executive Officer of Home Ageing Services and the Senior Executive Officer of Disability Services in relation to matters specific to their areas.

Lodged by: Australian Business Industrial — **Telephone:** (02) 4989 1004
NSW Business Chamber Ltd
Aged & Community Services Australia
Leading Age Services Australia
Address: Australian Business Lawyers & Advisors Pty Limited — **Email:**
Lvl 15, 140 Arthur Street, North Sydney NSW 2060 — madeleine.tiedeman@ablawyers.com.au

INFORMATION ABOUT THE BUSINESS

10. The Company has been in operation since 2002 and is a subsidiary of Chinese Australian Services Society Limited, which was founded in 1981.

11. The Company operates in multiple industries, including the social, community, home care and disability services industry.

12. The Company is a not-for-profit organisation.

13. The Company provides a comprehensive range of community services and activities in a wide geographical area which currently covers Metropolitan Sydney and Wollongong.

14. We primarily service the Chinese, Korean, Indonesian and Vietnamese community, but we also service other people in the general community as well. At present, over 2,800 families access our services and activities weekly.

15. The Company's mission is to:

    (a) Cultivate a culture of respect and acceptance;

    (b) Assure the provision of qualified and professional services;

    (c) Safeguard open communication and collaboration of all stakeholders;

    (d) Support personal responsibility and empowerment of service users;

    (e) Continue the growth and adaptation to meet the needs of all concerned;

    (f) Adopt person-centred and consumer directed care approaches;

    (g) Respect the rights, privacy, dignity, culture, and beliefs of service users;

    (h) Enhance service innovations and excellence; and

    (i) Sustain team spirit and foster continuous improvement.

16. The Company provides Home Ageing Services, Residential Aged Care Services, Disability Services, Child Care Services, Vocation & Training Services, Settlement and Health Services and Volunteering Services.

17. The Company has the following on-going funding arrangements with Government departments:

(a) Approved provider of residential aged care services subsidised by the Department of Health;

(b) Approved provider of home care package (**HCP**) services subsidised by the Department of Health;

(c) A funding agreement with the Department of Health to provide aged care service under the Commonwealth Home Support Program;

(d) An approved certification with NDIS Quality and Safeguard Commission to deliver services under NDIS; and

(e) A grant agreement with Department of Social Services to provide Settlement Services under the Settlement Service Program.

INDUSTRIAL ARRANGEMENTS

18. We have an Enterprise Agreement titled 'CASS Care Limited Enterprise Agreement (Other Than Children's Services) (NSW) 2018-2021' (**the Enterprise Agreement**). The Enterprise Agreement came into force on 12 February 2019.

19. The Enterprise Agreement has replaced the Award to become the principal industrial instrument applying to eligible employees. The Company pays eligible employees in accordance with the Enterprise Agreement.

THE COMPANY'S WORKFORCE

20. The Company currently employs approximately 350 employees, among which 260 employees were previously covered by SCHCDS Award and are now covered by the Enterprise Agreement.

21. These employees perform a range of roles including Support Worker, Community Worker, Coordinator, Officer, Team Leader, Executive Support Officer and Executive Officer.

22. Of the employees who are covered by the Enterprise Agreement, the workforce consists of:

(a) approximately 21 full-time employees;

(b) approximately 114 part-time employees; and

(c) approximately 125 casual employees.

23. Of all employees covered by the Enterprise Agreement, most of them work in Home Ageing Services or Disability Services, and some of them work in both Home Ageing Services and Disability Services. The Company needs to maintain the flexibility of our workforce due to the nature of these two services and therefore, the majority of our employees are part-time employees and casual employees. The Company cannot employ full-time employees to work in Home Ageing Services and Disability Services because we won't be able to provide them with 38 hours of work each week.

THE NATURE OF THE INDUSTRY GENERALLY

24. The impact of home care reform on the human resources management in our Company includes:

    (a) an increasing demand on the number of trained workers as there is competition in the job market for suitable workers;

    (b) a requirement for a team of support workers who can be more flexible and are trained well; and

    (c) significant pressure on rostering as a result of greater consumer control and decision rights in relation to the day and time that the service is provided and the particular service that they receive.

25. The reforms in the disability industry including the introduction of the NDIS, participant-driven funding and the standardised price guide have resulted in a considerable process shift for the Company. This is particularly in relation to determination of service funding, consideration of overheads, cost of delivery, marketing presence and work efficiency. Employing and releasing staff is based on the continuity of participant's NDIS plan, or the amount of client allocated funds, there is less flexibility in terms of charging financially disadvantaged clients.

26. Both rostering and engagement of new employees are based on the admission and exit of clients. An example is that, if a client who has been accessing 30 hours of service per week, decided to change their service provider to a non-NDIS registered provider, the assigned support worker to this client would face reduction of shift hours and subsequent loss of income, unless the Company receives a new service request. The reason that clients change to non-NDIS registered providers is because they usually yield cheaper prices and are more flexible with the hours they provide services.

27. The NDIS pricing structure does not fit into the existing service model of the Company. When the Company was receiving block funding, permanent support workers could be guaranteed hours of

work and the Company had more flexibility to support clients with very complex needs and/or a sudden increase in support needs. In comparison, with the NDIS, permanent support workers might need to be contracted with very limited weekly hours to allow for the flexibility associated with the NDIS, which the Senior Executive Officer of Disability Services advises me is resulting in support workers working for multiple employers to meet their financial needs to support their families. This trend has also increased the complexity with rostering support workers.

THE NATIONAL DISABILITY INSURANCE SCHEME

28. The Company is a registered service provider with the National Disability Insurance Authority.

29. The Company is currently registered for the following type of services:

(a) Group Centre Activities;

(b) Specialised Disability Accommodation;

(c) Plan Management;

(d) Participant Community;

(e) Assist Prod-Household Tasks;

(f) Household Tasks;

(g) Development Life Skills;

(h) Innovative Community;

(i) Daily Tasks Shared Living;

(j) Assist Travel Transport;

(k) Assist Personal Activities; and

(l) Assist Life Stage transition.

30. Due to the complexity of the claiming and booking system of NDIS, the Company has also been required to spend additional money on new financial and governance systems. For example, the Company has spent money on a new Client Record Management (CRM) and cost of certification to retain the status as an NDIS registered provider.

31. NDIA has the strong emphasis on client choice and control of their individualised funding. There has been an introduction of a self-managed model which the Senior Executive Officer of Disability Services advises me allows clients to choose non-NDIS registered services (for example, private providers and sole traders that charge less than the NDIS price guide).

32. As a result of this, the Company is in competition with these providers and has been losing either entire clients or substantial shift hours to them. For example, of the Company's 61 NDIS Individual Support clients, 12 of them are currently using both the Company and private providers' services. The Senior Executive Officer of Disability Services advises me that based on the move that has already been made towards these non-NDIS providers, there is the potential for these clients to move entirely to private services if they consider that the NDIS pricings are too expensive for them.

CONSUMER DIRECTED CARE

33. The Company is a service provider under the Home Care Package program and Residential Aged Care Services.

34. Consumer Directed Care (**CDC**) is a model of service delivery designed to give more choice and flexibility to consumers. Consumers who receive a Home Care Package have control over the types of care and services they access and the delivery of those services, including who delivers the services and when. From 1 July 2015, all Home Care Packages provided by the Company are delivered in accordance with CDC.

CLIENT CANCELLATION ISSUES

35. For Home Care Services, the Company experiences client cancellations on a regular basis, approximately 40 visits are cancelled per week. In the month of May 2019, there were approximately 180 out of 4,700 visits of all types of service cancelled due to various reasons.

36. For Disability Services, in the month of May 2019 there were 11 cancellations from 6 clients out of 25 attending our day program sessions and there were 5 cancellations from 1 client out of 61 clients using our Individual Supports service.

37. Some of the reasons why a client cancels their scheduled services include social leave, because they are in hospital or casual leave of consumers. Casual leave of consumers refers to the leaves

requested by the clients in general. For example a client may change or stop a service if a friend visits, or if they need to attend a special event, festival celebrations or for medical appointments.

38. When a client cancels a scheduled service, the steps that the Company will take are as follows:

(a) For Home Ageing Services, if a client cancels a scheduled service before 5.00pm for the shift of the following day, the client will not be charged, and the support worker will be informed but not be paid for the rostered shift. The Company tries to arrange another shift for the support worker if there is service request not assigned to other support workers. If the client's cancellation is after 5.00pm, a late cancellation fee of one hour will be charged to the client, and the rostered support worker will receive a one hour shift payment regardless the original length of the shift.

(b) For Disability Services, according to NDIS guidelines, any cancellation by 3pm for the shift of the following day, the provider is not eligible to claim a cancellation fee from client. In these circumstances the assigned support staff will usually get informed immediately and the shift will be cancelled or get rescheduled to another day. If the cancellation happens with less than the required notification, the support staff will still be informed, a two hour cancellation fee will be charged to the client and the assigned staff will receive two hours payment regardless of the original duration of the shift.

39. For Home Ageing Services, we are notified well beforehand if the cancellation is due to the client's scheduled leave, however, the notice of cancellation due to unexpected reasons is usually less than 24 hours. For example a client goes into hospital or one of their close friends or relatives dies.

40. For Disability Services, most of the cancellations happen on our day program and the cancellation notice is usually overnight and less than 24 hours.

41. If the Company was required to pay employees every time a client cancelled and did not provide 48 hours' notice, it would mean that the risk of service cancellation would be solely on the Company if a client cancels before 3.00pm for disability services or before 5.00pm for home care services. This would be unsustainable financially for the Company.

42. This would be a considerable cost to the Company and would be a heavy financial burden. The Company currently has approximately 440 Home Care Package clients, 200 Commonwealth Home Support Program clients and 100 clients in the disability services sector.

PART-TIME EMPLOYEES

43. The Company employs part-time employees in a variety of roles, including Support Worker, Community Worker, Coordinator, Officer, Team Leader and Executive Support Officer.

44. When engaging part-time employees, they are advised of the details of the minimum working hours per week or fortnight and the initial working pattern in their employment contracts.

45. The Company offers part-time employees work in excess of their contracted hours on a regular basis. This is done in order to satisfy the client's needs, including client cancellations or change to the service as requested by the client.

46. For our Home Ageing Services, in the last four weeks between 5 June and 2 July, there have been a total of 1,863 hours offered to part-time employees in excess of their contracted hours. If these hours were to be paid in overtime rates, the cost would be around $42,316 for that four week period.

47. In the past month, about 88 per cent of our permanent part-time support workers in our Home Ageing Services have worked more than their contracted hours. The number of excess hours ranged from 5 hours to 15 hours.

48. In the past month in our Disability Service 100 per cent of permanent part-time support workers have been allocated shift hours that exceeded their contracted hours, and the excess hours ranged from 5 hours to 20 hours.

49. If the Company was required to pay overtime to part-time employees who work in excess of their contracted hours, the Company would need to recruit more casual employees and ensure that part-time employees are only performing their contracted hours and nothing more.

50. In order to control cost and maintain competitiveness in the market, the Company would avoid rostering part-time employees to work overtime. If the Company was to identify that employees may need to work overtime, we would recruit more casual employees in the first instance. If the demand for overtime persisted, we would employ additional permanent part-time staff to provide service in their ordinary hours.

MINIMUM ENGAGEMENTS

51. The Company's work is based on client demands and therefore rostering takes place around the preferred times of our clients.

52. Under the CDC service model, clients have control and choice on the services that they receive. This limits the flexibility of the Company in rostering support workers to provide service to the customers.

53. Under NDIS, one of the elements regarding a provider's code of conduct when delivering services to client states: "To Support people with disability to make decisions", which means people with a disability have the right to make choices and should always be assumed to have the capacity to make those choices, as this is central to their individual rights to freedom of expression and self-determination. Depending of the service nature, the Company will need to make arrangements as per the client's request.

54. As a result, the Company is required to make our workforce as flexible as possible to satisfy the needs of our clients receiving Home Ageing Services or Disability Services.

55. If the Company does not provide services in the requested time period, the clients can leave our service and go to other providers. For Disability Services, aside from choosing another NDIS service provider, the client may choose to self-manage his/her NDIS plan or hire carers that are self-employed through carer hiring platforms like Mable or HireUp. These platforms allow for support workers (as sole traders) to register and upload their qualifications and availability, and clients can view the workers' profiles and choose someone to support their service needs. The hourly rate is usually cheaper and negotiable between the two parties.

56. In relation to client service length, in our Home Ageing Services, shift lengths range from one to five hours. These shifts can be broken down as follows:

    (a) one hour shifts account for 15 per cent of all shifts;

    (b) shifts more than one hour and less than three hours account for 60 per cent of all shifts;

    (c) three hour shifts account for 11 per cent of all shifts;

    (d) four hour shifts account for 7 per cent of all shifts; and

    (e) five hour shifts account for 7 per cent of all shifts.

57. In our Disability Services, shift length ranges from two to ten hours. 15 per cent of these shifts are two hours long, and the remainder of the shifts are longer than two hours. The majority of shifts with longer hours are for employees working in Group Homes, which operate on a 24/7 basis. Whereas for Individual Support services, the hours are much shorter.

Home Care Services

58. Home Care Package customers are classified into four levels. Level 1 is for people with a low care need. Level 2 customers are still low care, but they need more support. Clients who are Level 1 often only need one and a half to two hours of services every week or fortnight, depending on their needs. Clients on Level 2 vary from one and a half hours to four hours per visit.

59. Roughly, 37 per cent of service hours required by the Company's clients are between 1 and 1.5 hours, 38 per cent are between 2 and 2.5 hours and only 25 per cent of the service hours that we provide to clients are 3 hours or more.

60. This means that 75 per cent of our client request service sessions are less than three hours.

Disability Services

61. In the disability support service sector of the business, the percentage of requested service that is less than 3 hours ranges from 11 per cent to 23 per cent.

62. For Group Homes, on a weekly basis, the Company currently rosters four two hour shifts in the morning, for the purpose of transporting clients to attend a day program of work; for other service types, i.e. day program and individual supports, a total of 83 shifts are assigned within a fortnight which are of two hours per shift. The main reasons for these short shifts are the nature of the work (e.g. regular domestic assistance, simple household tasks), the client's choice and the limited funding available under individual NDIS plans.

63. If the Company was required to provide a three-hour minimum shift to all employees there would be a significant impact on the flexibility of our rostering arrangements and there will be a significant increase in costs for the business.

64. In my experience, some employees like short shifts that are less than three hours. In particular, some mothers who need to care for their children like the short shifts because of their caring

responsibilities. In the past, I have had job applicants refused our job offer because the hours we told them were required were too long for them.

BROKEN SHIFTS

65. The Company engages employees to work broken shifts. The reason for this is due to clients' ability to choose how they spend their funding and the fact that this requires our workers to work at a variety of different locations at irregular or unpredictable hours.

66. Of our home care employees, 99 per cent of those workers are working broken shifts. Of our disability services employees, 80 to 90 per cent of the employees work broken shifts.

67. Broken shifts are commonly used in Home Ageing Services because our consumers usually request services of a short time period, ranging from 1.5 to 3 hours in one visit. Support workers normally work for two to three consumers per a working day. Consequently, broken shifts are normally arranged in our service.

Signed by **Joyce Wang**

12 July 2019

FAIR WORK COMMISSION
4 Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award 2010
Matter: AM2018/26

STATEMENT OF DARREN MATHEWSON

I, Darren Mathewson, of [redacted] Tasmania, swear as follows:

MY BACKGROUND

1. I am employed by Aged & Community Services Australia (**ACSA**) in the role of Executive Director for NSW, ACT, Tas & Vic and for the national portfolio areas of Member Support, Services & Engagement which include our Employee Relations and Workforce Units.

2. I am based in Tasmania, however my role involves travelling throughout all States and Territories.

3. I have been employed by ACSA since mid 2016 when the state organisation I had been CEO of for over 9 years became part of this new national organisation.

4. My role involves operational and strategic responsibility for the national areas of policy, member information, support and services, employee relations services, workforce and industry development. I also have a geographic responsibility for our operations in Tasmania, Victoria and NSW & ACT with a focus on member engagement, networking and events.

5. I have more than 12 years' experience working in the aged care industry in roles relating to policy, advocacy, employee relations, governance, members services, and workforce development. Prior to working with ACSA, I was Chief Executive Officer of Aged & Community Services Tasmania for over 9 years. Prior to that I had worked for 17 years in the trade union movement as an industrial advocate, union leader and educator/campaigner. This included State Secretary of the Tasmanian Branch of the LHMU (now United Voice), President of Unions Tasmania and Campaigns Coordinator/Educator for Unions Tasmania.

6. I have a Bachelor of Arts from the University of Tasmania.

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7. The information in this statement is based on my experience and observations from either working at ACSA, or from my experience generally working in the social, community, home care and disability services industry, and is true to the best of my knowledge.

8. Where I depose particular conversations, I provide either the exact words used or the substance of the conversation to the best of my recollections. Where I comment on matters that I did not personally observe, I identify the source of that information in this statement.

INFORMATION ABOUT ACSA

9. ACSA has been in operation since around July 2016 as a national organisation, registered with the ACNC, and operating as a company limited by Guarantee. Prior to that ACSA had been operating since 1975 as a federated body.

10. ACSA is a leading peak body supporting and representing organisations that provide accommodation and care services to older Australians.

11. ACSA represents members who operate in the aged care industry. ACSA has over 600 members based throughout Australia, including some of the largest aged care service providers in Australia, right through to small family run businesses.

12. ACSA's members operate in the public interest and on the basis of a mission to support older Australians. They work in all communities around Australia, including rural, regional and remote areas, and with a wide variety of people, including disadvantaged groups such as those who are homeless and/or have special needs. Our members include church, charitable, community based, not for profit and mission focused services which provide a diverse range of services from residential aged care, home care and support, respite, day centres, wellbeing programs, palliative care and dementia care, and housing and retirement living.

13. ACSA has physical offices in all states of Australia and national portfolio teams including in policy, employee relations and workforce. These teams are responsible for providing member information, communications & publications, events, training and professional development, member support, programs and advice. They also develop policies and positions and respond to requests for submissions, responses, commentary by Government departments at all levels,

agencies and commissions and a range of other external stakeholders. This work is undertaken in close consultation with members who inform, provide evidence and participate as required.

14. In addition to direct contact through our national contact points, website, communications and state offices we have advisory and input structures in place as follows:

    (a) State Divisional Councils;

    (b) State Advisory Committees and Networks covering the areas of Residential, Home Care, Finance, Workforce and Retirement Living & Housing;

    (c) National Advisory Committees & Networks covering Residential, Home Care, Retirement Living & Housing and Rural, Remote & Regional.

    ACSA also has strong relationships with service providers to the aged care industry in the areas of financing, accounting, legal, technology, insurance and superannuation that provide us with access to external expertise.

15. The combination of the internal and external knowledge and expertise available to ACSA allows us to provide commentary on all key issues to the sector and in particular in relation to funding, workforce and other policy areas.

16. ACSA's vision is 'a strong industry delivering the services Australians want' and ACSA's mission is 'to advocate for, and support, our not-for-profit members to continue to provide high quality services valued by older people.'

17. ACSA supports its members through the following methods:

    (a) the provision of policy and advocacy;

    (b) collective representation;

    (c) the provision of opportunities for collaboration, information, support and advice;

    (d) employee relations;

    (e) access to consultancy services;

    (f) workforce development (including training and professional development);

    (g) events and networking opportunities;

(h) access to external corporate expertise and relationships;

(i) promotion of the sector; and

(j) leadership in the sector.

18. In addition we have a key role to play in fostering constructive working relationships with Government Departments at all levels and other key stakeholders. ACSA is a founder and sponsoring organisation of the National Aged Care Alliance (NACA), a collaborative body of key stakeholder groups (providers, unions, health professionals and consumer groups) focused on achieving a system that allows every older Australian to age and live well, with dignity and independence and as part of their community in the place of their choice whilst receiving quality care, services and support.

THE NATURE OF THE INDUSTRY GENERALLY

19. The National Institute of Labour Studies (2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce) (**NILS Report**) provides the best workforce data set available. In its most recent report on the aged care workforce it found that:

(a) there are 130,263 PAYG workers in home care and home support outlets;

(b) 89% of home care workers are female with a median age of 52 years;

(c) 23% of the workforce are from overseas;

(d) 75% of the workforce are employed on a permanent and part time basis with an additional 14% employed as casual or contract employees (note this is a significant reduction from 41% casual or contract employees in 2012);

(e) 75% of workers engaged in work-related training (mostly mandatory) in the previous 12 months; and

(f) 48% of workers undertook continuing and professional development (CPD).

20. In general in relation to the different workforces, the NILS Report found the following:

(a) the aged care workforce is older than the national average, generally in good health with high levels of post-school education and training;

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(b) the direct care workforce is relatively stable, with only a small minority indicating an intention to leave the sector within 12 months; and

(c) the residential workforce is getting younger and the home care and home support workforce is getting older.

21. As home care services grow, there is a need for clear strategies and resourcing (e.g. labour market programs) to allow the supply of skilled labour to match the growth of home care services.

22. The NILS Report found that home care and home support workers reported greater job satisfaction, identifying the time available to care for clients and having freedom in their work and less stress and pressure than their residential care counterparts as key factors.

23. Particular issues facing the home care workforce include the impact and management of consumer directed care (**CDC**) on working conditions and employment and balancing that with compliance with the Award and organisational Enterprise Agreements.

24. Reforms since the 2011 Report of the Productivity Commission into Caring for Older Australians have had a significant impact on service provider operations, the workforce and also on consumers and their families/carers. Of particular note for the home care sector are:

(a) Consumers being able to direct their own care and support has meant providers are required to respond to individual needs and requests and therefore have to be able to access services beyond their scope at times or deploy staff at short notice or for shorter periods. For example, if a group of clients all chose to be assisted in showering at different times then managing this in terms of rostering and deployment can be challenging. Previously when the providers controlled the packages they could deploy a single worker with the required skills set over a set period of time to cover multiple client engagements.

(b) Increased competition between providers for both clients and staff.

(c) A new environment in which the client owns the home care package and can change service providers. In addition when a client leaves their package (for example after death) this package then returns to a nationally controlled prioritisation process and can be assigned to another individual (on the national waiting list) anywhere in Australia who then

choses from an available service provider in their area. This means home care organisations are subject to drops in service demand that can be sizeable and fast and subsequently create pressure on the sector in terms of aiming for the ideal arrangement of secure and permanent work. The gains made in moving from casual to permanent employment are challenged by the consumer driven system.

(d) Examination of new business models, use of technologies, introduction of new roles, and job re-design to adapt and respond to the new consumer driven environment. This has also included looking at partnerships and brokerage (sub-contracting to other service providers who can deliver services in a geographical location) arrangements so that home care service providers can offer a diverse range of services and provide the client with a level of continuity and streamlined access.

THE HOME CARE SECTOR

25. The home care sector is still relatively new with various reforms undertaken in the 1980s resulting in the Home & Community Care (**HACC**) Program, now the Commonwealth Home Support Program (**CHSP**), and then in the 1990s packages of care being delivered into people's homes.

26. The Commonwealth Government controls the supply of services and packages, levels of funding, the regulatory framework, administrative infrastructure for payment of subsidies, consumer entry and navigation through the system (**My Aged Care**).

27. The sector has been subject to accelerated change as it moves away from a dependence-based model to a wellness and reablement approach with greater choice and control by consumers through CDC.

28. The focus on the consumer has led to increasing regulatory requirements around quality, safety and pricing and a need to invest in technology and systems to enable greater efficiency, data collection and accountability.

29. As the supply of home care has grown due to both a Government policy shift and consumer preferences we have seen a greater need for Government administration and infrastructure to support the system. These systems have struggled to be user friendly and responsive to

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consumers in the early stages and home care providers have had to continue to assist aged people and their families with access and navigation.

30. There are various workforce challenges that exist in this sector closely connected with the dispersed nature and indirect supervision of the care and support workforce including access to right fit candidates, skills and qualifications, delivery of education and training, communication and performance management in a regulated environment caring for vulnerable adults. There are however, benefits to the workforce in terms of potentially being able to work close to home and their immediate community.

31. Services in home care are funded by the Commonwealth (approximately 90%), with some consumer contributions (approximately 10%). The Commonwealth funding is subject to an income test plus annual and lifetime caps on care costs. Different fee structures apply between the programs and increasing consumer contributions remain a contentious issue, however the looming demand and demographics and subsequent cost to the Government indicates that a decision to increase these will need to be made soon.

32. The level of regulation has increased in home care as the sector has grown and expectations have increased. The sector has now moved under the Single Quality Standards that apply to all areas of the Commonwealth aged care sector. In addition with the central focus on consumers the sector is required to engage with new and existing clients to present and have them understand their Charter of Rights (for consumers).

33. Greater expectations around pricing have resulted in mandatory requirements for publishing of prices and the form in which they are published on My Aged Care.

34. Providers of Commonwealth subsidised aged care are “Approved Providers” and are subject to screening and an application process. This is the regulated sector. There is a growing group of private providers delivering in home services not subject to the regulatory framework including quality and safety standards.

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VARIOUS PROGRAMS IN THE HOME CARE SECTOR

35. There are a number of different home care programs operating in Australia, which are managed by the Commonwealth government or particular departments of the Commonwealth government.

Commonwealth Home Support Program (CHSP)

36. An entry-level program, the CHSP is intended to provide ongoing or short-term care and support services. The 2018 CHSP Manual, developed by the Federal Department of Health to assist in the guidance of service delivery, notes that services delivered are expected to be, in total, lower than the Government subsidised cost for services provided under a Level 1 HCP (less than $8,000 per annum). Higher intensity services should only be provided for a short term.

37. Services include help with housework, home maintenance, personal care, meals and food preparation, transport, shopping, allied health, social support, planned respite and community transport.

38. Support is underpinned by a wellness approach, which is about building on each person's strengths, capacity and goals to help them remain independent and to live safely at home.

39. The CHSP commenced in July 2015 from a combination of former programs including:

    (a) Home and Community Care Program (which had been managed by state and territory governments) with Victoria and Western Australia joining the program, in July 2016 and July 2018 respectively;

    (b) National Respite for Carers Program;

    (c) Assistance with Care and Housing for the Aged Program4 for those who are homeless or at risk of homelessness (**ACH**); and

    (d) Day Therapy Centre (**DTC**) Program.

40. As part of the CHSP being established, Government created Regional Assessment Services (**RAS**) to undertake an independent assessment of eligible individuals.

41. In 2017–18, CHSP provided support to a total of 847,534 aged persons. Of those, 76% received only one or two service types. There is no published demand data for the CHSP.

42. There is a great deal of variation around the country in how CHSP operates in practice and some people receive larger amounts of care than would be expected for an entry level program. The CHSP is also currently filling gaps created by the high unfulfilled demand for HCPs.

43. The CHSP is a grants-based program. Generally, with grants-based programs new funding is offered through funding rounds with providers applying for additional resourcing. Government has recently offered existing CHSP providers additional funds to increase services seen as a priority for growth.

44. There has not been an open funding round for some time and additional funding, with the exception of the provision of indexation, has not been available on an annual basis. There is a lack of transparency on the application and usage of CHSP growth funding by the Government.

45. The current program structure and funding is in place until 2020, with Government considering integrating the CHSP/HCP programs in line with its 2015 Budget statement of intent. Little work appears to have occurred towards this goal with the deadline now quite close. Planning and development of CHSP services is impacted on by this uncertainty.

Home Care Packages (HCPs)

46. HCPs provide a national consistently structured, and more comprehensive package of home-based care support, over four levels of care:

    (a) Level 1—to support people with basic care needs;

    (b) Level 2—to support people with low level care needs;

    (c) Level 3—to support people with intermediate care needs; and

    (d) Level 4—to support people with high care needs.

47. Under the HCP program, a range of personal care, support services, clinical services and other services are tailored to meet the goals and assessed needs of the person. The consumer is

allocated an individual funding package and they determine their coordinated package of care and services, in consultation with the service provider.

48. Since February 2017, HCPs have been assigned directly to the person needing care rather than allocated to providers. This allows people to direct their HCP to the provider of their choice as well as change providers more easily.

49. People assessed by the ACAT as requiring HCP are placed on the National Prioritisation Queue (**NPQ**) based on how long they have been waiting for care and their individual needs and circumstances, regardless of where they live.

50. The overall number of HCPs available is determined through a funding ratio which builds growth into the system based on the number of older people 70 years or older per 1,000 of the population. This means that the supply of aged care places (beds and HCPs) increases in line with growth in the population but it is not based on demand.

51. The Legislated Review of Aged Care 2017 (**Tune Review**) highlights that there is no clear robust measure of demand for aged care. There are currently around 128,000 people waiting for an HCP which highlights that the planning ratio has not provided the number of HCPs required to meet current demand.

52. Governments have altered the balance between home and residential care over time with most of the growth emphasis remaining on residential care while the public demand is for home care. This is starting to shift and beyond 2022 which is when the current forward planning concludes we expect a significant acceleration in the supply of home base care and support services.

Veterans' Programs

53. Veterans' Home Care (**VHC**) is a program designed to assist Eligible Veteran Beneficiaries (**EVBs**) who need a small amount of practical help to continue living independently in their own home. Services include domestic assistance, personal care, respite care, and safety-related home and garden maintenance. It is not designed to meet complex or high-level care needs. EVBs access VHC via the VHC Assessment Agency but can also access CHSP via MAC.

54. The DVA Community Nursing Program is designed to enhance the independence and health outcomes of eligible veterans by avoiding early admission to hospital and/or residential care through access to community nursing services that meet their assessed clinical and/or personal care needs.

55. In 2017–18, 47,449 older veterans were approved for VHC and 17,253 received community nursing services, representing 36% and 13.1% of older eligible veterans respectively.

56. These Programs are administered and funded separately through DVA despite their similarity to other home care and support services.

57. The Programs were created because there were some concerns about whether Veterans were getting adequate access to the services they needed through other available programs.

Short Term Restorative Care

58. Wellness, re-ablement and restorative approaches are emerging as powerful ways to help older people improve their function, independence and quality of life.

59. The Short-Term Restorative Care (**STRC**) Program aims to reverse and/or slow 'functional decline' in older people and improve their wellbeing. People living at home are eligible to use these services.

60. Carers are encouraged to use the Carer Gateway, which helps them access information about services and support in their local area for people who care for someone with disability, chronic illness, dementia, mental illness or who are frail aged. However, to access respite under CHSP, they must also access and be assessed by MAC.

CONSUMER DIRECTED CARE AND OTHER REFORMS IN THE HOME CARE SECTOR

61. Consumer Directed Care (**CDC**) in home care was first piloted in 2010 before being rolled out across all home care packages from July 2015. It is attributable to this that some providers have a matured approach to CDC, whereas other providers are only 12 months into the journey.

62. Prior to the introduction of CDC, home care packages in Australia were provided as a bundled set of services relatively tightly-specified by government. Availability of Commonwealth funding for those services was capped by the allocation of funded 'places' to a limited group of

approved providers (as provided for in the *Aged Care Act 1997* (Cth)), by the funding levels prescribed and by a cap on consumer fees. The result of this funding, was that the market was characterised by:

(a) Limited supply,

(b) Lack of price competition,

(c) Limited scope for competition on quality, and

(d) Limited product differentiation.

63. With the introduction of the CDC, those characteristics are changing.

Supply changes

64. Prior to the CDC, a set planning ratio dictated the number of 'home care places' which were allocated to approved providers for specific geographic regions, meaning that supply was constrained both in total levels and in location.

65. In February 2017 the Aged Care Act 1997 (Cth) was amended to remove reference to 'home care places'. Instead providers are now approved to deliver home care, and consumers are approved as eligible and are prioritised for services. Prioritised consumers are then able to obtain services from any approved provider.

66. The changes have shifted the sector to a more market-based system, with consumers selecting their suppliers and allocation being based on need rather than location. This resulted in packages being lost to some areas as there were consumers of higher need elsewhere.

67. One of the significant challenges that this change presented to providers was that they no longer had a guaranteed number of participants and therefore no guaranteed income.

Product competition

68. Prior to CDC there was limited scope for product competition from providers as prices were regulated by the government.

69. With the introduction of CDC, the participants have greater choice in selecting what they want their home care package to provide, which allows providers to compete on products.

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New market entrants

70. There were 693 approved home care package providers in March 2017 with 917 at March 2019. The Home Care Packages Data Report provides information regarding home care packages. The most recent report, titled 'Home Care Packages Program Data Report 3rd Quarter 2018-19' attached and marked '**A**'.

71. The CHSP Program has remained stable as contracts have been rolled over with pre-existing providers.

IMPACT OF REFORMS ON FINANCIAL PERFORMANCE

72. There is a trend decline of financial performance and there are issues relating to unspent funds which is a significant impact.

73. The Aged Care Financing Authority recently published their latest report titled '*Seventh Report on the Funding and Financing of the Aged Care Industry 2019*' which examines developments, issues and challenges facing the aged care industry in Australia. The report includes analysis of the financial data supplied by aged care providers in the 2017-2018 financial year and provides comments on financial developments in 2018-2019. A copy of the report is attached and marked '**B**'.

74. ACSA prepared a summary document of the report which was circulated to members. The summary document includes the key information relevant to providers from the report. A copy of this summary document is attached and marked '**C**'.

Signed by **Darren Mathewson**

12 July 2019

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Australian Government
Department of Health

HOME CARE PACKAGES PROGRAM

Data Report 3rd Quarter 2018-19

1 January – 31 March 2019

June 2019

Table of Contents

Executive Summary

- At 31 December 2018, there were 93,331 people in a home care package. This represents an annual increase of 15,413 people (19.8 per cent) since 31 December 2017 (77,918) and a quarterly increase of 2,685 people (3.0 per cent) since 30 September 2018 (90,646).
- There were 43,632 people in a high level (level 3 and 4) home care package at 31 December 2018, which was 3,636 (9.1 per cent) more than 30 September 2018 (39,996).
- There were 10,610 new care recipients entering home care in the December 2018 quarter.
- At 31 March 2019, there were 75,739 people waiting on a home care package at their approved level, who had not yet been offered access to a lower level package. Of these people, 94.9 per cent (71,885) had been provided with an approval to access support through the Commonwealth Home Support Program (CHSP).
- The number of people with a level 4 approval who were waiting for a package at their approved level, who had not yet been offered a home care package, fell by 21.7 per cent (3,685) from 30 June 2018 (16,963) to 31 March 2019 (13,278) due to increased investment.
- At 31 March 2019, there were 53,299 people who were waiting for a home care package at their approved level, who had already been offered a lower level package. Of these people, 30,283 chose to take an offered package, 6,355 were deciding on whether to take up a package and 16,661 had not taken up their previous offer(s) of a lower level package.
- As at 31 March 2019, 97.0 per cent of people who were waiting for a home care package at their approved level had been provided with the opportunity to connect to other Commonwealth subsidised aged care support.
- 94,156 (73.0 per cent) of people in the National Prioritisation System (NPS) who were waiting for a home care package at their approved level also had an approval for a permanent place in a residential aged care facility.
- There were 26,486 approvals for a home care package in the March 2019 quarter, an increase of 266 compared to the December 2018 quarter.
- 31,200 home care packages were released during the March 2019 quarter, at an average of 2,400 per week.
- At 31 March 2019, there were 917 approved home care providers with a home care service. This represents an increase of 15 providers (1.7 per cent) since 31 December 2018 (902).

INTRODUCTION

OVERVIEW

The Australian Government recognises that people want to remain living independently in their own homes for as long as possible. To support this, the Government subsidises packages through the Home Care Packages Program (HCPP) to provide home-based care that can improve senior Australians' quality of life and help them to remain active and connected to their communities.

This report provides an update on the operation of the HCPP for the period between 1 January 2019 and 31 March 2019 (referred to as the March 2019 quarter for the remainder of the report).

This report consists of four chapters:

- Chapter 1: assessment for home care and the number of approvals.
- Chapter 2: the delivery of home care services.
- Chapter 3: the prioritisation of people in the National Prioritisation System (NPS).
- Chapter 4: maximum exit amounts.

A Glossary is also provided at the end of the report explaining specific terminology and abbreviations used throughout the report.

Data in this report was collected from information systems and records held by the Department of Health (the department) and the Department of Human Services (DHS). Data was valid on the date of extraction. Data extracted on a different date may vary from that in this report.

Where possible, data is provided for the period between 1 January 2019 and 31 March 2019. Due to a lag in data availability for some indicators, particularly those dependent on receipt of provider claims by DHS, earlier time periods are reported on. Information on the maximum wait time for a home care package by level is provided for 30 April 2019 in recognition that information for this indicator was available at the time of publication.

Table 1 provides a breakdown of the current number of allocated home care packages across the forward estimates.

Table 1: Number of allocated home care packages across the forward estimates

Package level	2018-19	2019-20	2020-21	2021-22	2022-23
1	6,038	11,240	11,915	13,119	13,453
2	53,452	64,630	65,192	66,133	67,161
3	28,189	30,689	31,559	33,578	35,243
4	36,353	38,353	39,501	40,607	41,297
Total	**124,032**	**144,912**	**148,166**	**153,438**	**157,154**

A person may be asked to pay fees when they take up a home care package. They may be asked to pay a basic daily fee of 17.5 per cent of the single basic age pension (currently $10.43 per day as at 1 January 2019).

If a person is assessed as having the capacity to pay more they may be asked to pay an income-tested care fee based on their income. The Government subsidy to the home care provider is reduced by the maximum income-tested care fee. There is an annual cap on income-tested care fees, which is applied on a daily basis, and a lifetime cap after which a person cannot be asked to pay any income or means-tested care fees.

From 1 July 2019, the maximum basic daily fees for home care will reduce by:

- $400 per annum for level 1
- $200 per annum for level 2
- $100 per annum for level 3.

The Government will increase the value of a package by the same amount to maintain the total value of each package level.

Further information on the HCPP, including eligibility, fees and recent reforms can be found at Home Care Packages Program | Ageing and Aged Care.

1. ELIGIBILITY AND ASSESSMENT

DISTRIBUTION OF HOME CARE PACKAGE LEVELS

- There are four levels of home care packages to help meet the different levels of care needs (Table 2), which are determined by the outcome of an aged care assessment.

Table 2: Home care package annual subsidy, by package level at 31 March 2019

Package level	Aged care services for people with:	Annual subsidy amount ($) paid by the Australian Government
1	Basic care needs	8,271
2	Low-level care needs	15,045
3	Intermediate care needs	33,076
4	High-level care needs	50,286

Note: The amounts in the table do not include additional supplements that a provider may be eligible for.

VOLUME OF HOME CARE APPROVALS

- There were 26,486 home care approvals in the March 2019 quarter (Table 3).

Table 3: Number of home care approvals in the March 2019 quarter, by state and territory of assessment, level and priority

State/ territory	Level 1		Level 2		Level 3		Level 4		Total	Share by state/ territory
	High	Medium	High	Medium	High	Medium	High	Medium		
NSW	17	902	176	3,535	406	2,754	470	733	**8,993**	**34.0%**
VIC	3	381	34	2,657	174	2,117	440	805	**6,611**	**25.0%**
QLD	1	370	37	1,699	233	1,509	285	448	**4,582**	**17.3%**
WA	-	37	4	598	73	837	264	561	**2,374**	**9.0%**
SA	-	103	-	871	26	1,203	100	376	**2,679**	**10.1%**
TAS	-	31	-	227	7	317	49	150	**781**	**2.9%**
ACT	-	7	-	123	4	119	30	61	**344**	**1.3%**
NT	-	-	-	20	3	29	18	28	**98**	**0.4%**
Unknown	-	2	-	13	-	5	2	2	**24**	**0.1%**
Subtotal	**21**	**1,833**	**251**	**9,743**	**926**	**8,890**	**1,658**	**3,164**	**26,486**	**100.0%**
Total	**1,854**		**9,994**		**9,816**		**4,822**		**26,486**	
Share by level	**7.0%**		**37.7%**		**37.1%**		**18.2%**		**100.0%**	

Key point:

- There were 26,486 approvals for a home care package in the March 2019 quarter.

2. HOME CARE SERVICE DELIVERY

NUMBER OF PEOPLE IN A HOME CARE PACKAGE

- There were 93,331 people in a home care package at 31 December 2018 (Table 4). This represents an annual increase of 15,413 people (19.8 per cent) since 31 December 2017 (Chart 1).
- There were 43,632 people in a high level (level 3 and 4) home care package at 31 December 2018, which was 3,636 (9.1 per cent) more than 30 September 2018 (39,996).

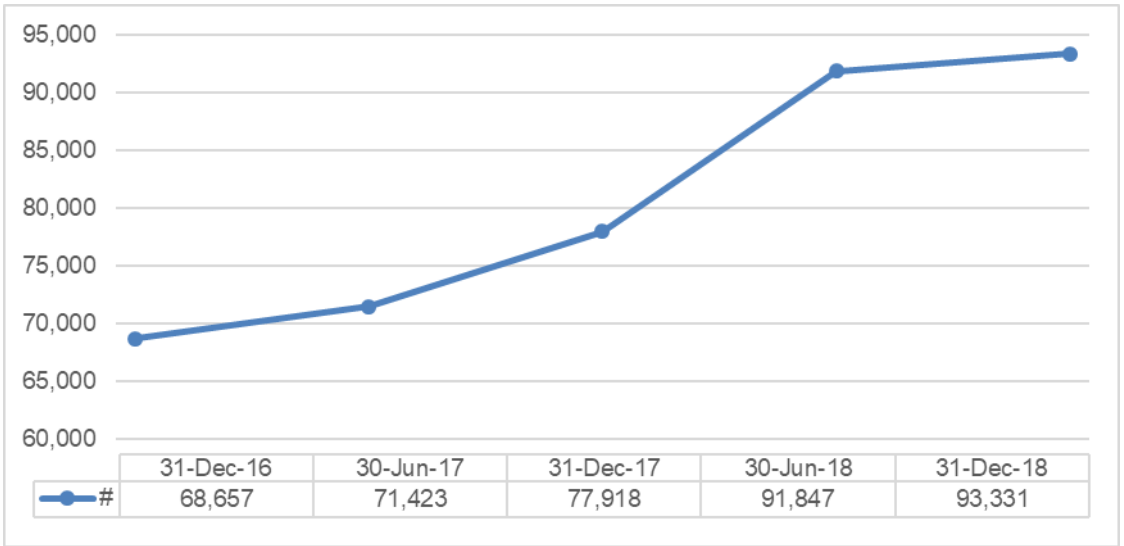
Table 4: Number of people in a home care package by level and state and territory, at 31 December 2018

State	Level 1	Level 2	Level 3	Level 4	Total	Share by state/territory
NSW	1,931	15,200	6,529	7,945	**31,605**	**33.9%**
VIC	1,089	13,677	3,411	5,330	**23,507**	**25.2%**
QLD	884	8,132	3,980	5,851	**18,847**	**20.2%**
WA	276	2,809	1,764	3,334	**8,183**	**8.8%**
SA	326	2,934	1,538	2,010	**6,808**	**7.3%**
TAS	86	1,268	325	647	**2,326**	**2.5%**
ACT	37	593	263	439	**1,332**	**1.4%**
NT	2	414	73	166	**655**	**0.7%**
Unknown	-	41	7	20	**68**	**0.1%**
Total	**4,631**	**45,068**	**17,890**	**25,742**	**93,331**	**100.0%**
Share by Level	**5.0%**	**48.3%**	**19.2%**	**27.6%**	**100.0%**	

Note: Location is based on the address of the person, not the address of their provider.

- Data on the number of people in care at 31 December 2018 by Aged Care Planning Region (ACPR) can be found at Appendix A.

Chart 1: Number of people in a home care package at six-monthly intervals



- There were 10,610 new entries to home care in the December 2018 quarter (Table 5).
- Further information on the number of new entries by ACPR can be found in Appendix B.

Table 5: Number of new entries to home care in the December 2018 quarter, by state and territory

State/ territory	Level 1	Level 2	Level 3	Level 4	Total	Share by state/territory
NSW	405	1,861	946	415	**3,627**	**34.2%**
VIC	160	1,477	665	316	**2,618**	**24.7%**
QLD	174	1,153	644	375	**2,346**	**22.1%**
WA	40	401	301	168	**910**	**8.6%**
SA	48	347	182	122	**699**	**6.6%**
TAS	13	135	51	34	**233**	**2.2%**
ACT	3	75	40	21	**139**	**1.3%**
NT	-	21	7	9	**37**	**0.3%**
Unknown	-	-	-	1	**1**	**0.0%**
National	**843**	**5,470**	**2,836**	**1,461**	**10,610**	**100.0%**
Share by level	**7.9%**	**51.6%**	**26.7%**	**13.8%**	**100.0%**	

Note: Location is based on the address of the person, not the address of their provider.

- Table 6 shows a breakdown of the proportion of the total number of people in home care according to the Modified Monash Model (MMM) classifications – with 1 classified as major metropolitan regions, ranging to 7 which is classified as the most remote region.

Table 6: Proportion of the total number of people in home care by MMM Classification, by last day of the quarter

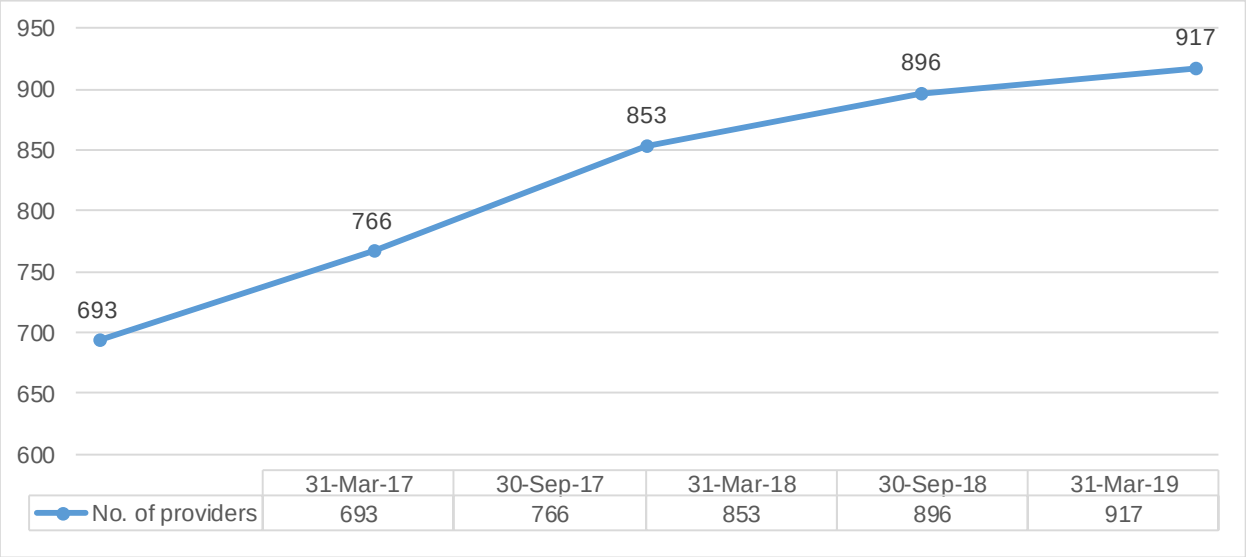
MMM	31-Dec-17	31-Mar-18	30-Jun- 18	30-Sep- 18	31-Dec-18
1	64.0%	63.8%	64.2%	64.0%	**64.0%**
2	9.6%	9.7%	9.7%	9.8%	**9.8%**
3	9.9%	10.0%	10.2%	10.3%	**10.4%**
4	5.2%	5.4%	5.6%	5.6%	**5.7%**
5	8.1%	8.3%	8.5%	8.7%	**8.6%**
6	0.9%	0.8%	0.9%	0.9%	**0.9%**
7	0.7%	0.6%	0.6%	0.6%	**0.6%**
Unknown	1.5%	1.5%	0.2%	0.1%	**0.1%**

Note: Location is based on the address of the person, not the address of their provider.

NUMBER OF APPROVED HOME CARE PROVIDERS

- There continues to be a large number of home care providers in the market, allowing for choice for senior Australians.
- There were 917 approved home care providers at 31 March 2019 (Chart 2).
  This was an increase of 15 providers (1.7 per cent) from 31 December 2018 (902) and an increase of 64 providers (7.5 per cent) since 31 March 2018 (853).

Chart 2: Number of approved providers of home care with home care services at six-monthly intervals since the commencement of the Increasing Choice reforms



Note: Approved provider count is based on the approval effective date.

- Appendix C provides the total number of approved home care providers in each ACPR that have indicated in My Aged Care that they have operational capacity to provide services across all four package levels in that region at 31 March 2019.

Key points

- At 31 December 2018, there were 93,331 people in a home care package. This was an increase of 2,685 people (3.0 per cent) since 30 September 2018 (90,646), and an annual increase of 15,413 people (19.8 per cent) since 31 December 2017.
- There were 43,632 people in a high level (level 3 and 4) home care package at 31 December 2018, which was 3,636 (9.1 per cent) more than 30 September 2018 (39,996).
- There were 10,610 new entries to home care in the December 2018 quarter.
- At 31 March 2019, there were 917 approved home care providers with a home care service, an increase of 15 providers (1.7 per cent) since 31 December 2018.

3. NATIONAL PRIORITISATION SYSTEM

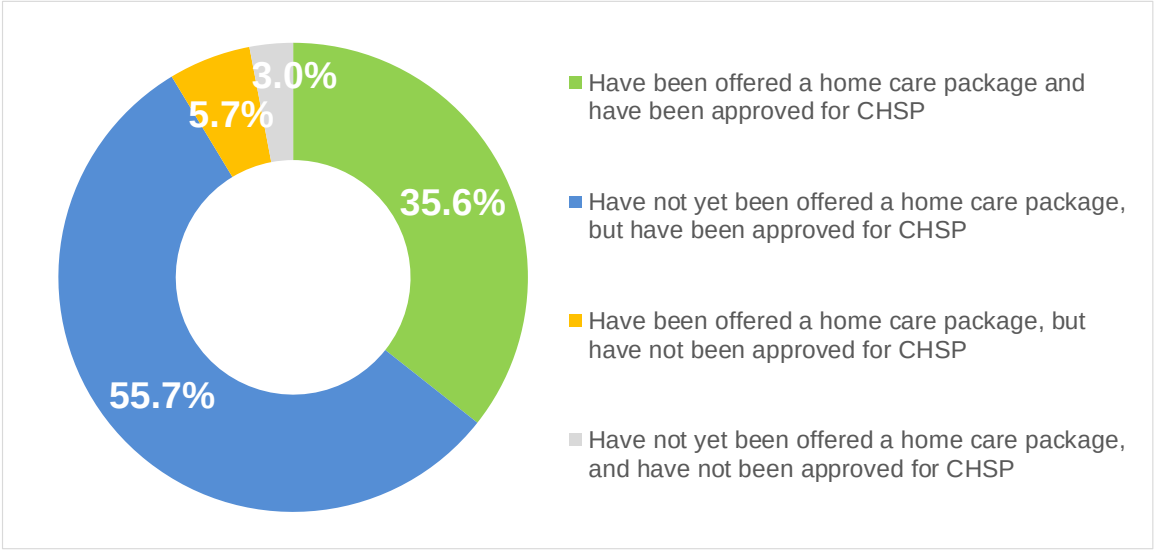
NATIONAL PRIORITISATION SYSTEM

- The National Prioritisation System (NPS) allows for a nationally consistent and equitable process for assigning home care packages based on people's individual needs and circumstances, regardless of where they live.
- The NPS should be considered as more than a single queue. For example, the NPS includes people who have accepted a lower level home care package that allows them to connect with home care services early, as well as others that have not accepted a lower level package. It also includes people that have approvals for other care types such as residential care and CHSP.

ACCESS TO COMMONWEALTH HOME SUPPORT SERVICES

- In addition to receiving an approval for a home care package as an outcome of their assessment, most people are provided with approval to access CHSP to assist with specific care needs identified during the assessment. Assessors provide these approvals to ensure people have options to address care needs, whilst awaiting their approved home care package.
- Over 90 per cent of people on the NPS at 31 March 2019 who were waiting on a home care package at their approved level, have also been approved for access to services through the CHSP.
- Additionally, people retain the option of accessing some specific CHSP services after they are offered a level 1 or 2 home care package when their budget has been expended or where additional short-term episodic care is required. Diagram 1 shows that 97.0 per cent of people in the NPS have been offered a home care package and/or approved for CHSP services.

Diagram 1: Status of people in the National Prioritisation System at 31 March 2018 who are waiting for a home care package at their approved level



PEOPLE WITHOUT A HOME CARE PACKAGE

- At 31 March 2019, there were 75,739 people who were waiting for a home care package at their approved level, who had not yet been offered a home care package (Table 7). Of these people, 94.9 per cent (71,885) had been provided with an approval to access CHSP.
- The number of people with a level 4 approval who were waiting for a package at their approved level, who had not yet been offered a home care package, fell by 21.7 per cent (3,685) from 30 June 2018 (16,963) to 31 March 2019 (13,278).

Table 7: Number and percentage of people without a home care package, who had been approved to access CHSP, by level of approval at 31 March 2019

Approved Level	Number of people in the NPS without an interim Home Care Package	Number of people in the NPS without an interim Home Care Package with CHSP approval	Percentage of people in the NPS without an interim Home Care Package with CHSP approval
Level 1	3,383	3,125	92.4%
Level 2	30,947	29,443	95.1%
Level 3	28,131	27,093	96.3%
Level 4	13,278	12,224	92.1%
Total	**75,739**	**71,885**	**94.9%**

PEOPLE WHO HAVE RECEIVED AN OFFER OF AN INTERIM PACKAGE

- At 31 March 2019, there were 53,299 people who had been offered an interim home care package while they wait for a package at their approved level.
- Those offered an interim package fell into three response categories (Table 8):
  - those who accepted their offer (30,283);
  - those who have not yet accepted their offer but whose offer was still open (i.e. within 56 days of offer) (6,355); and
  - those who did not take up their offer (16,661).

Table 8: Number of people who have been offered a package while they wait for their approved level, by response category and level of approval at 31 March 2019

Approved Level	Number of people in an interim Home Care Package*	Number of people offered an interim Home Care Package, who had not yet accepted their offer	Number of people offered an interim Home Care Package that did not take up their offer
Level 2	3,742	1,804	2,717
Level 3	10,962	2,500	3,824
Level 4	15,579	2,051	10,120
Total	**30,283**	**6,355**	**16,661**

* Counts of people in an interim home care package presented in the table are derived from point-in-time data. Although a count of people in an interim home care package can be derived for 31 March 2019, this Report only records the number of people in a home care package at 31 December 2018 (refer to Chapter 2). This is done to allow for delayed claims to be made by service providers to improve the accuracy of the total count of people in a home care package.

- Of the 16,661 people who had not taken up their previous offer(s) of a package, 81.3 per cent (13,552) had been provided with an approval to access CHSP (Table 9).

Table 9: Number and percentage of people who did not take up an offer of a lower level package, who have been provided approval to access CHSP, by level of approval at 31 March 2019

Approved Level	Number of people who did not take up an offer of an interim Home Care Package	Number of people who did not take up an offer of an interim Home Care Package, that have a CHSP approval	Percentage of people who did not take up an offer of an interim Home Care Package, that have a CHSP approval
Level 2	2,717	2,532	93.2%
Level 3	3,824	3,538	92.5%
Level 4	10,120	7,482	73.9%
Total	**16,661**	**13,552**	**81.3%**

PEOPLE APPROVED FOR RESIDENTIAL CARE

- Aged Care Assessment Teams assess a person's needs and, when making an approval for care, they can approve people for home care packages, residential care, respite care, transitional care, and CHSP, depending on the person's circumstances. Therefore, based on care needs and choice, not everyone with a home care approval will enter home care.

- Many people have approvals for both home and residential aged care, and some will choose to take up a residential care place instead of a home care package.
  At 31 March 2019, there were 94,156 (73.0 per cent) people in the NPS who had dual approvals, having been approved for a permanent place in a residential aged care facility and also currently seeking a home care package at their approved level (Table 10).

Table 10: Number of people awaiting a home care package at their approved level who were also approved for permanent residential care, by level of approval at 31 December 2018

Approved Level	Number of people waiting for a package at their approved level who also have an approval for permanent residential care
Level 1	988
Level 2	22,125
Level 3	34,895
Level 4	36,148
Total	**94,156**

- While many people seek to choose to remain in their own home, this is not always possible. For people with high level care needs, for example, requiring care morning and evening across seven days, they may need to consider the benefits of the level of support offered by residential care.

DISTRIBUTION OF PEOPLE ACROSS STATES

- The distribution of people without a home care package across states and territories largely follows the pattern of population distribution across Australia (Table 11).

Table 11: Number of people awaiting their approved level who have not been offered a lower level package, by state and territory of residence and level of approval at 31 March 2019

State/ territory	Level 1	Level 2	Level 3	Level 4	Total	Share by state/territory
NSW	1,535	9,973	8,542	3,184	**23,234**	30.7%
VIC	773	9,881	7,415	3,944	**22,013**	29.1%
QLD	709	5,587	4,992	1,976	**13,264**	17.5%
WA	71	2,053	2,554	1,901	**6,579**	8.7%
SA	215	2,307	3,278	1,481	**7,281**	9.6%
TAS	63	665	918	496	**2,142**	2.8%
ACT	15	373	331	203	**922**	1.2%
NT	-	88	85	87	**260**	0.3%
Unknown	2	20	16	6	**44**	0.1%
National	**3,383**	**30,947**	**28,131**	**13,278**	**75,739**	**100.0%**
Share by level	**4.5%**	**40.9%**	**37.1%**	**17.5%**	**100.00%**	

Note: A person with an approval at multiple levels is only counted once - at their highest active approved level.

- The number of people without a home care package at their approved level at 31 March 2019, by ACPR, who were not either in, or offered, an interim level package is provided in Appendix D.

WAIT TIMES

- All people approved for a home care package, and seeking services, can access their individual expected wait time to receive their first package, and their approved package level.
- A person's place in the NPS is solely based on date of approval and priority for care. Estimated wait times at 31 March 2019, for a person with a medium priority approval joining the system for a package by level are provided in Table 12.
- People approved for a higher level package have the option of receiving a lower level package to commence receipt of care as early as possible. They may also have the option to access CHSP services, ensuring that the strong majority of people have access to subsidised care while they await a package at their approved level.

Table 12: Estimated wait time for people entering on 31 March 2019, by package level

Package level	First package assignment	Time to first package	Time to approved package
Level 1	Level 1	3-6 months	3-6 months
Level 2	Level 1	3-6 months	12+ months
Level 3	Level 1	3-6 months	12+ months
Level 4	Level 2	12+ months	12+ months

NUMBER OF HOME CARE PACKAGES RELEASED

- The department released 31,200 home care packages during the March 2019 quarter (Table 13), at an average of 2,400 per week.

Table 13: Number of home care packages released in the March 2019 quarter, by state and territory and level

State/territory	Level 1	Level 2	Level 3	Level 4	Total	Share
NSW	2,529	4,817	2,238	1,718	**11,302**	36.2%
VIC	1,203	3,092	1,500	1,059	**6,854**	22.0%
QLD	991	2,752	1,452	1,133	**6,328**	20.3%
WA	395	1,041	793	544	**2,773**	8.9%
SA	436	1,259	627	427	**2,749**	8.8%
TAS	99	295	147	89	**630**	2.0%
ACT	39	209	106	87	**439**	1.4%
NT	7	50	16	17	**90**	0.3%
Unknown	1	15	11	6	**33**	0.1%
Total	**5,700**	**13,530**	**6,890**	**5,080**	**31,200**	**100.0%**

- Of the packages released in the March 2019 quarter:
  - 20.8 per cent (6,497) were offered as upgrades to people who had previously been offered and accepted a lower level interim package.
  - 79.2 per cent (24,703) of packages were offered to people who were not yet in an interim level home care package (Table 14). This included people who were previously offered a package and did not take up the offer, as well as people who were offered a package for the first time.

Table 14: Home care packages released to people in the March 2019 quarter, by level and type of release

	Level 1	Level 2	Level 3	Level 4	Total
New packages	5,700	12,404	4,204	2,395	**24,703**
Upgrades	0	1,126	2,686	2,685	**6,497**
Total	**5,700**	**13,530**	**6,890**	**5,080**	**31,200**
% released that were new	**100.0%**	**91.7%**	**61.0%**	**47.1%**	**79.2%**

- Information on the number of packages released by ACPR and level for the March 2019 quarter can be found at Appendix E.

Key points

- At 31 March 2019, there were 75,739 people who were awaiting their approved level package who had not yet been offered a lower level home care package. Of these people, 94.9 per cent (71,885) had been provided with an approval to access CHSP.
- At 31 March 2019, there were 53,299 people who had been offered an interim home care package while they wait for a package at their approved level.
- 31,200 home care packages were released during the March 2018 quarter with 24,703 (79.2 per cent) being offered to people who were not yet in an interim package.

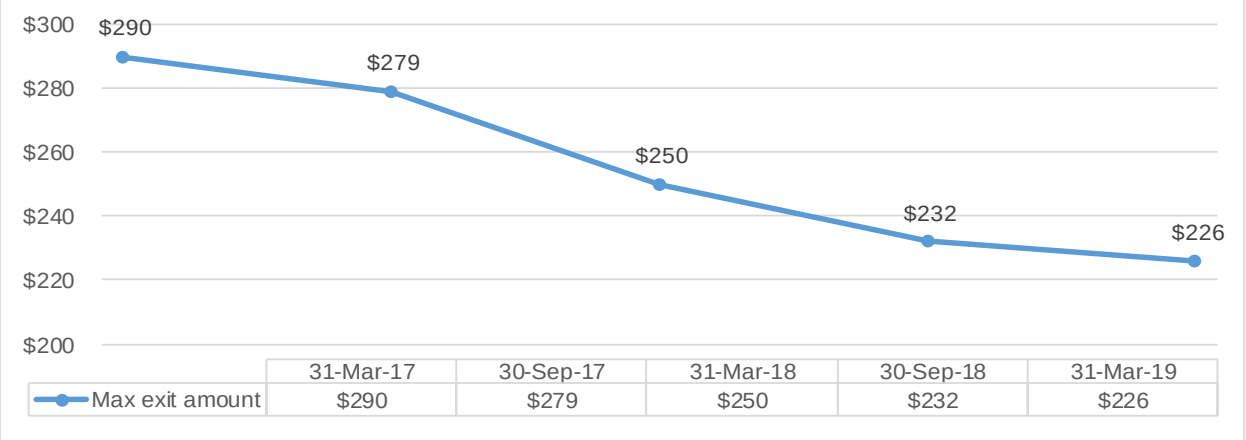
4. MAXIMUM EXIT AMOUNTS

An exit amount is an amount that can be deducted by a home care provider from a person's unspent home care package amount if the person leaves their care. This may happen if the person decides to change their home care provider or when they leave home care altogether.

The maximum exit amount represents the highest dollar value the provider can include in a person's home care agreement and must be published on the My Aged Care website.

- The average published maximum exit amount of all providers at 31 March 2019 was $226 (inclusive of amounts of $0 and where no amount was provided) (Chart 3). This average had decreased by $5 (or 2.2 per cent) since 31 December 2018 ($231) and decreased by $24 (or 9.6 per cent) since 31 March 2018 ($250).

Chart 3: Average maximum exit amount published by home care providers at six-monthly intervals since the commencement of the Increasing Choice reforms



Note: All approved providers, irrespective of whether or not they publish an amount, are included in determining the average.

- 42.3 per cent of approved home care providers had indicated that they would not deduct an exit amount, up from 41.7 per cent at 31 December 2018.
- The number of providers publishing a maximum exit amount of $1,000 or more at 31 March 2019 was 10 (Table 15).

Table 15: Number of approved home care providers with a published maximum exit amount of $1,000 or more

	31-Dec-17	31-Mar-18	30-Jun-18	30-Sep-18	31-Dec-18	31-Mar-19
(A) No. of providers with a published maximum exit amount of more than $1,000	4	5	5	5	4	**4**
(B) No. of providers with a published maximum exit amount of $1,000	11	7	6	6	6	**6**
Combined (A)+(B)	**15**	**12**	**11**	**11**	**10**	**10**

Key points:

- At 31 March 2019, the average published maximum exit amount was $226.
- At 31 March 2019, 42.3 per cent of all approved home care providers indicated that they would not deduct an exit amount.

Glossary

Term	Definition
Aged Care Assessment Teams (ACAT)	ACATs are teams of medical and allied health professionals who assess the physical, psychological, medical, restorative, cultural and social needs of older people and help them and their carers to access appropriate levels of support.
Aged Care Planning Region (ACPR)	The areas marked out in the ACPR maps which can be found on the department's website.
Approved provider	An organisation that has been approved to provide home care under the *Aged Care Act 1997*.
Commonwealth Home Support Programme (CHSP)	Entry-level support at home – Ongoing or short-term care and support services including help with housework, personal care, meals and food preparation, transport, shopping, allied health, social support and planned respite.
Home Care Packages Program	A program that supports older Australians with complex needs to remain living at home through a coordinated package of care and services to meet the individual needs of people.
Interim package	A package at a lower level than a person's approved level, through which they are able to access some home care services while waiting for a higher level package.
My Aged Care	The main entry point to the aged care system in Australia.
National Prioritisation System	The nationally consistent process for allocating home care packages based on peoples' needs and circumstances.
The department	The Department of Health.

Appendices

Appendix A – Number of people in a home care package at 31 December 2018, by ACPR

State/territory	Level 1	Level 2	Level 3	Level 4	Total
NSW					
Central Coast	108	927	586	447	**2,068**
Central West	64	387	171	188	**810**
Far North Coast	156	1,069	317	434	**1,976**
Hunter	145	1,364	878	1,067	**3,454**
Illawarra	119	1,016	384	415	**1,934**
Inner West	121	1,020	277	462	**1,880**
Mid North Coast	202	1,325	703	811	**3,041**
Nepean	42	521	133	174	**870**
New England	9	408	163	209	**789**
Northern Sydney	121	1,553	644	831	**3,149**
Orana Far West	138	400	143	161	**842**
Riverina/Murray	205	1,039	337	359	**1,940**
South East Sydney	114	1,330	482	712	**2,638**
South West Sydney	284	1,258	421	557	**2,520**
Southern Highlands	52	538	290	359	**1,239**
Western Sydney	51	1,045	600	759	**2,455**
Total	**1,931**	**15,200**	**6,529**	**7,945**	**31,605**
VIC					
Barwon-South Western	107	1,075	252	475	**1,909**
Eastern Metro	216	2,823	678	893	**4,610**
Gippsland	188	902	290	404	**1,784**
Grampians	52	681	139	182	**1,054**
Hume	76	831	253	305	**1,465**
Loddon-Mallee	43	831	168	340	**1,382**
Northern Metro	162	1,835	522	853	**3,372**
Southern Metro	182	3,056	732	1,129	**5,099**
Western Metro	63	1,643	377	749	**2,832**
Total	**1,089**	**13,677**	**3,411**	**5,330**	**23,507**

State/territory	Level 1	Level 2	Level 3	Level 4	Total
QLD					
Brisbane North	55	698	380	516	**1,649**
Brisbane South	42	905	557	822	**2,326**
Cabool	103	716	382	488	**1,689**
Central West	-	13	-	6	**19**
Darling Downs	116	640	285	485	**1,526**
Far North	24	454	222	229	**929**
Fitzroy	2	516	295	301	**1,114**
Logan River Valley	63	456	287	484	**1,290**
Mackay	6	167	50	87	**310**
North West	5	59	6	14	**84**
Northern	27	394	216	386	**1,023**
South Coast	151	864	373	646	**2,034**
South West	4	42	8	23	**77**
Sunshine Coast	168	1,218	541	794	**2,721**
West Moreton	74	340	79	198	**691**
Wide Bay	44	650	299	372	**1,365**
Total	**884**	**8,132**	**3,980**	**5,851**	**18,847**
WA					
Goldfields	9	28	11	30	**78**
Great Southern	4	68	79	135	**286**
Kimberley	-	58	30	31	**119**
Metro East	42	452	178	432	**1,104**
Metro North	107	776	446	802	**2,131**
Metro South East	21	486	262	538	**1,307**
Metro South West	17	604	481	870	**1,972**
Mid West	5	55	36	73	**169**
Pilbara	-	25	8	12	**45**
South West	44	161	151	261	**617**
Wheatbelt	27	96	82	150	**355**
Total	**276**	**2,809**	**1,764**	**3,334**	**8,183**

State/territory	Level 1	Level 2	Level 3	Level 4	Total
SA					
Eyre Peninsula	18	117	49	70	**254**
Flinders & Far North	-	39	16	29	**84**
Hills, Mallee & Southern	95	485	187	226	**993**
Metro East	26	328	211	258	**823**
Metro North	33	420	313	344	**1,110**
Metro South	66	621	322	466	**1,475**
Metro West	31	391	215	319	**956**
Mid North	10	50	35	32	**127**
Riverland	4	102	55	69	**230**
South East	20	171	49	63	**303**
Yorke, Lower North & Barossa	23	210	86	134	**453**
Total	**326**	**2,934**	**1,538**	**2,010**	**6,808**
TAS					
North Western	36	291	82	136	**545**
Northern	10	379	87	182	**658**
Southern	40	598	156	329	**1,123**
Total	**86**	**1,268**	**325**	**647**	**2,326**
ACT					
Total	**37**	**593**	**263**	**439**	**1,332**
NT					
Alice Springs	-	147	16	30	**193**
Barkly	-	20	4	6	**30**
Darwin	-	139	43	116	**298**
East Arnhem	1	61	8	6	**76**
Katherine	1	47	2	8	**58**
Total	**2**	**414**	**73**	**166**	**655**
UNKNOWN ACPR					
Total	**-**	**41**	**7**	**20**	**68**
NATIONAL					
Total	**4,631**	**45,068**	**17,890**	**25,742**	**93,331**

Appendix B – Number of entries to home care in the December 2018 quarter, by ACPR

State/territory	Level 1	Level 2	Level 3	Level 4	Total
NSW					
Central Coast	16	105	78	22	**221**
Central West	6	30	30	9	**75**
Far North Coast	76	146	29	24	**275**
Hunter	27	226	153	48	**454**
Illawarra	36	146	53	20	**255**
Inner West	13	101	24	18	**156**
Mid North Coast	61	208	96	48	**413**
Nepean	7	37	19	7	**70**
New England	3	30	16	2	**51**
Northern Sydney	21	164	100	63	**348**
Orana Far West	14	35	19	8	**76**
Riverina/Murray	29	129	30	21	**209**
South East Sydney	23	157	104	30	**314**
South West Sydney	51	116	52	29	**248**
Southern Highlands	11	71	49	20	**151**
Western Sydney	11	160	94	46	**311**
Total	**405**	**1,861**	**946**	**415**	**3,627**
VIC					
Barwon-South Western	8	204	56	62	**330**
Eastern Metro	38	287	121	38	**484**
Gippsland	16	82	54	19	**171**
Grampians	9	120	21	20	**170**
Hume	8	85	45	13	**151**
Loddon-Mallee	6	70	36	9	**121**
Northern Metro	24	186	130	57	**397**
Southern Metro	39	261	135	63	**498**
Western Metro	12	182	67	35	**296**
Total	**160**	**1,477**	**665**	**316**	**2,618**

State/territory	Level 1	Level 2	Level 3	Level 4	Total
QLD					
Brisbane North	18	114	63	32	**227**
Brisbane South	14	175	91	49	**329**
Cabool	19	125	63	29	**236**
Central West	-	2	-	1	**3**
Darling Downs	24	58	47	34	**163**
Far North	3	59	51	12	**125**
Fitzroy	1	79	52	32	**164**
Logan River Valley	20	79	40	22	**161**
Mackay	-	19	8	7	**34**
North West	-	5	-	1	**6**
Northern	1	65	41	34	**141**
South Coast	34	89	57	44	**224**
South West	1	1	1	3	**6**
Sunshine Coast	21	180	69	43	**313**
West Moreton	10	38	11	12	**71**
Wide Bay	8	65	50	20	**143**
Total	**174**	**1,153**	**644**	**375**	**2,346**
WA					
Goldfields	-	4	-	-	**4**
Great Southern	1	14	17	7	**39**
Kimberley	-	2	4	3	**9**
Metro East	5	52	21	21	**99**
Metro North	15	104	71	42	**232**
Metro South East	6	70	45	30	**151**
Metro South West	3	96	94	41	**234**
Mid West	-	2	6	4	**12**
Pilbara	-	4	-	3	**7**
South West	5	31	27	11	**74**
Wheatbelt	5	22	16	6	**49**
Total	**40**	**401**	**301**	**168**	**910**

State/territory	Level 1	Level 2	Level 3	Level 4	Total
SA					
Eyre Peninsula	1	11	3	2	**17**
Flinders & Far North	-	3	-	1	**4**
Hills, Mallee & Southern	18	44	18	8	**88**
Metro East	5	36	31	27	**99**
Metro North	5	66	43	26	**140**
Metro South	12	81	40	19	**152**
Metro West	2	55	25	24	**106**
Mid North	-	3	2	3	**8**
Riverland	1	7	8	3	**19**
South East	2	18	4	2	**26**
Yorke, Lower North & Barossa	2	23	8	7	**40**
Total	**48**	**347**	**182**	**122**	**699**
TAS					
North Western	4	25	13	11	**53**
Northern	4	37	13	7	**61**
Southern	5	73	25	16	**119**
Total across levels	**13**	**135**	**51**	**34**	**233**
ACT					
Total	**3**	**75**	**40**	**21**	**139**
NT					
Alice Springs	-	7	2	2	**11**
Barkly	-	-	-	1	**1**
Darwin	-	12	4	6	**22**
East Arnhem	-	1	1	-	**2**
Katherine	-	1	-	-	**1**
Total	**-**	**21**	**7**	**9**	**37**
UNKNOWN ACPR					
Total	**-**	**-**	**-**	**1**	**1**
NATIONAL					
Total	**843**	**5,470**	**2,836**	**1,461**	**10,610**

Appendix C – Number of approved home care providers by ACPR

State/territory	31-Mar-18	31-Dec-18	31-Mar-19
NSW			
Central Coast	21	22	**22**
Central West	19	20	**20**
Far North Coast	32	33	**34**
Hunter	50	55	**55**
Illawarra	34	36	**37**
Inner West	30	33	**33**
Mid North Coast	42	45	**45**
Nepean	10	12	**12**
New England	19	19	**20**
Northern Sydney	37	39	**42**
Orana Far West	20	20	**20**
Riverina/Murray	31	31	**31**
South East Sydney	48	52	**52**
South West Sydney	39	42	**42**
Southern Highlands	24	25	**25**
Western Sydney	47	51	**51**
VIC			
Barwon-South Western	26	27	**28**
Eastern Metro	48	53	**53**
Gippsland	19	20	**20**
Grampians	16	19	**20**
Hume	26	28	**29**
Loddon-Mallee	11	13	**14**
Northern Metro	34	37	**38**
Southern Metro	57	60	**63**
Western Metro	43	52	**53**

State/territory	31-Mar-18	31-Dec-18	31-Mar-19
QLD			
Brisbane North	39	43	**44**
Brisbane South	47	51	**50**
Cabool	21	20	**20**
Central West	8	8	**9**
Darling Downs	25	29	**30**
Far North	19	21	**21**
Fitzroy	19	21	**22**
Logan River Valley	25	25	**26**
Mackay	11	15	**16**
North West	7	7	**7**
Northern	19	22	**22**
South Coast	32	34	**34**
South West	3	3	**3**
Sunshine Coast	38	40	**42**
West Moreton	21	22	**22**
Wide Bay	18	20	**21**
WA			
Goldfields	8	8	**8**
Great Southern	4	6	**6**
Kimberley	7	8	**8**
Metro East	25	27	**27**
Metro North	26	30	**31**
Metro South East	17	22	**22**
Metro South West	15	19	**19**
Mid West	5	6	**6**
Pilbara	8	8	**8**
South West	13	13	**13**
Wheatbelt	6	7	**7**

State/territory	31-Mar-18	31-Dec-18	31-Mar-19
SA			
Eyre Peninsula	4	4	**4**
Flinders & Far North	9	9	**9**
Hills, Mallee & Southern	11	11	**11**
Metro East	32	37	**39**
Metro North	15	15	**15**
Metro South	14	14	**14**
Metro West	18	24	**24**
Mid North	3	3	**3**
Riverland	2	2	**2**
South East	4	4	**4**
Yorke, Lower North & Barossa	8	8	**8**
TAS			
North Western	13	12	**12**
Northern	15	14	**14**
Southern	28	32	**33**
ACT			
ACT	27	33	**33**
NT			
Alice Springs	14	14	**14**
Barkly	13	13	**13**
Darwin	15	15	**15**
East Arnhem	7	7	**7**
Katherine	12	12	**12**

Notes: Only providers that have indicated in My Aged Care that they can provide services at each of the four levels are included in the figures. Totals per state/territory aren't shown as providers can operate in multiple ACPRs and states/territories.

Appendix D – Number of people awaiting a home care package at their approved level at 31 March 2019, who have yet to be offered a lower level package, by ACPR

State/territory	Level 1	Level 2	Level 3	Level 4	Total
NSW					
Central Coast	34	650	644	95	**1,423**
Central West	47	308	209	57	**621**
Far North Coast	155	760	476	212	**1,603**
Hunter	195	1,051	822	484	**2,552**
Illawarra	138	743	563	187	**1,631**
Inner West	19	458	594	269	**1,340**
Mid North Coast	143	766	614	162	**1,685**
Nepean	33	380	230	43	**686**
New England	7	268	196	67	**538**
Northern Sydney	305	1,147	801	424	**2,677**
Orana Far West	65	261	164	47	**537**
Riverina/Murray	78	515	544	237	**1,374**
South East Sydney	114	986	1,042	373	**2,515**
South West Sydney	122	723	561	179	**1,585**
Southern Highlands	24	407	340	105	**876**
Western Sydney	56	550	742	243	**1,591**
Total	**1,535**	**9,973**	**8,542**	**3,184**	**23,234**
VIC					
Barwon-South Western	74	813	625	198	**1,710**
Eastern Metro	252	2,284	1,404	759	**4,699**
Gippsland	73	545	533	195	**1,346**
Grampians	42	616	297	91	**1,046**
Hume	41	504	446	94	**1,085**
Loddon-Mallee	53	512	404	253	**1,222**
Northern Metro	139	1,462	1,094	610	**3,305**
Southern Metro	66	2,156	1,777	1,221	**5,220**
Western Metro	33	989	835	523	**2,380**
Total	**773**	**9,881**	**7,415**	**3,944**	**22,013**

State/territory	Level 1	Level 2	Level 3	Level 4	Total
QLD					
Brisbane North	14	464	460	189	**1,127**
Brisbane South	117	695	617	228	**1,657**
Cabool	29	462	446	201	**1,138**
Central West	6	14	6	2	**28**
Darling Downs	90	359	303	128	**880**
Far North	41	381	141	57	**620**
Fitzroy	2	434	734	51	**1,221**
Logan River Valley	59	335	290	104	**788**
Mackay	9	130	76	24	**239**
North West	2	22	25	4	**53**
Northern	27	169	282	260	**738**
South Coast	86	507	449	241	**1,283**
South West	5	43	22	15	**85**
Sunshine Coast	75	925	737	333	**2,070**
West Moreton	50	111	62	41	**264**
Wide Bay	97	536	342	98	**1,073**
Total	**709**	**5,587**	**4,992**	**1,976**	**13,264**
WA					
Goldfields	-	13	29	11	**53**
Great Southern	-	38	98	74	**210**
Kimberley	-	32	27	10	**69**
Metro East	5	281	390	211	**887**
Metro North	35	797	633	485	**1,950**
Metro South East	16	408	343	334	**1,101**
Metro South West	8	298	655	476	**1,437**
Mid West	-	38	87	30	**155**
Pilbara	-	7	5	2	**14**
South West	6	88	179	186	**459**
Wheatbelt	1	53	108	82	**244**
Total	**71**	**2,053**	**2,554**	**1,901**	**6,579**

State/territory	Level 1	Level 2	Level 3	Level 4	Total
SA					
Eyre Peninsula	20	136	75	23	**254**
Flinders & Far North	6	27	41	10	**84**
Hills, Mallee & Southern	24	308	204	56	**592**
Metro East	12	210	612	369	**1,203**
Metro North	48	438	840	344	**1,670**
Metro South	32	542	574	180	**1,328**
Metro West	12	218	586	391	**1,207**
Mid North	5	57	66	15	**143**
Riverland	-	95	84	22	**201**
South East	33	91	54	7	**185**
Yorke, Lower North & Barossa	23	185	142	64	**414**
Total	**215**	**2,307**	**3,278**	**1,481**	**7,281**
TAS					
North Western	15	113	172	115	**415**
Northern	22	165	224	164	**575**
Southern	26	387	522	217	**1,152**
Total	**63**	**665**	**918**	**496**	**2,142**
ACT					
Total	**15**	**373**	**331**	**203**	**922**
NT					
Alice Springs	-	20	14	5	**39**
Barkly	-	3	2	1	**6**
Darwin	-	54	62	72	**188**
East Arnhem	-	1	1	2	**4**
Katherine	-	10	6	7	**23**
Total	**-**	**88**	**85**	**87**	**260**
UNKNOWN ACPR					
Total	**2**	**20**	**16**	**6**	**44**
NATIONAL					
Total	**3,383**	**30,947**	**28,131**	**13,278**	**75,739**

Appendix E – Number of home care packages released in the March 2019 quarter, by ACPR

State/territory	Level 1	Level 2	Level 3	Level 4	Total
NSW					
Central Coast	72	209	156	94	**531**
Central West	42	80	46	37	**205**
Far North Coast	238	359	108	97	**802**
Hunter	260	570	318	298	**1,446**
Illawarra	263	312	132	104	**811**
Inner West	154	341	112	95	**702**
Mid North Coast	246	385	213	185	**1,029**
Nepean	57	104	49	22	**232**
New England	29	114	51	27	**221**
Northern Sydney	241	660	212	149	**1,262**
Orana Far West	107	112	59	33	**311**
Riverina/Murray	210	351	106	72	**739**
South East Sydney	229	435	222	158	**1,044**
South West Sydney	267	337	139	85	**828**
Southern Highlands	47	163	86	86	**382**
Western Sydney	67	285	229	176	**757**
Total	**2,529**	**4,817**	**2,238**	**1,718**	**11,302**
VIC					
Barwon-South Western	132	260	96	91	**579**
Eastern Metro	318	656	335	164	**1,473**
Gippsland	110	185	134	71	**500**
Grampians	70	180	38	28	**316**
Hume	68	184	84	55	**391**
Loddon-Mallee	53	160	72	79	**364**
Northern Metro	170	503	221	189	**1,083**
Southern Metro	188	626	351	241	**1,406**
Western Metro	94	338	169	141	**742**
Total	**1,203**	**3,092**	**1,500**	**1,059**	**6,854**

State/territory	Level 1	Level 2	Level 3	Level 4	Total
QLD					
Brisbane North	66	281	161	102	**610**
Brisbane South	111	352	240	155	**858**
Cabool	68	261	122	115	**566**
Central West	2	4	-	-	**6**
Darling Downs	127	221	83	110	**541**
Far North	44	132	90	59	**325**
Fitzroy	5	225	123	49	**402**
Logan River Valley	100	164	93	80	**437**
Mackay	26	48	16	15	**105**
North West	1	11	5	3	**20**
Northern	12	134	89	112	**347**
South Coast	144	357	145	105	**751**
South West	11	20	4	6	**41**
Sunshine Coast	140	365	178	157	**840**
West Moreton	73	69	25	18	**185**
Wide Bay	61	108	78	47	**294**
Total	**991**	**2,752**	**1,452**	**1,133**	**6,328**
WA					
Goldfields	9	15	6	2	**32**
Great Southern	5	23	31	23	**82**
Kimberley	9	12	9	8	**38**
Metro East	65	134	79	68	**346**
Metro North	120	297	167	133	**717**
Metro South East	65	162	119	63	**409**
Metro South West	55	221	233	141	**650**
Mid West	3	17	4	8	**32**
Pilbara	4	5	4	4	**17**
South West	33	104	78	68	**283**
Wheatbelt	27	51	63	26	**167**
Total	**395**	**1,041**	**793**	**544**	**2,773**

State/territory	Level 1	Level 2	Level 3	Level 4	Total
SA					
Eyre Peninsula	18	65	13	19	**115**
Flinders & Far North	2	10	-	3	**15**
Hills, Mallee & Southern	87	153	43	33	**316**
Metro East	35	155	96	82	**368**
Metro North	100	226	160	70	**556**
Metro South	70	265	139	87	**561**
Metro West	43	146	100	70	**359**
Mid North	6	28	14	7	**55**
Riverland	15	44	16	10	**85**
South East	39	53	12	23	**127**
Yorke, Lower North & Barossa	21	114	34	23	**192**
Total	**436**	**1,259**	**627**	**427**	**2,749**
TAS					
North Western	22	79	30	26	**157**
Northern	47	74	62	20	**203**
Southern	30	142	55	43	**270**
Total	**99**	**295**	**147**	**89**	**630**
ACT					
Total	**39**	**209**	**106**	**87**	**439**
NT					
Alice Springs	6	23	4	6	**39**
Barkly	-	2	-	2	**4**
Darwin	-	22	10	8	**40**
East Arnhem	1	1	1	1	**4**
Katherine	-	2	1	-	**3**
Total	**7**	**50**	**16**	**17**	**90**
UNKNOWN ACPR					
Total	**1**	**15**	**11**	**6**	**33**
NATIONAL					
Total	**5,700**	**13,530**	**6,890**	**5,080**	**31,200**

Aged Care Financing Authority

Seventh report on the Funding and Financing of the Aged Care Industry

2019

Contents

Foreword

I am pleased to present the Aged Care Financing Authority's (ACFA) 2019 Report on Funding and Financing in the Aged Care Sector. This is ACFA's seventh annual report.

Consistent with past reports, the 2019 report examines developments, issues and challenges confronting the aged care industry in Australia. It includes analysis of the financial data supplied by aged care providers in their 2017-18 Aged Care Financial Reports, supplemented by more recent data sources where available and feedback from significantly enhanced consultations with stakeholders. Drawing on this consultation and other data, the report provides some comments on financial developments in 2018-19. It also provides some observations on the sustainability and viability of the aged care industry.

A number of Government policies are impacting on the financial performance of aged care providers, in particular the changes to the Aged Care Funding Instrument (ACFI) that took effect in 2016 and 2017 and the introduction of home care consumers having choice of services under their packages and choice of the provider who delivers these services. The impact of these changes were evident in the 2017-18 data submitted by providers, which underlies this report, and is continuing to influence the industry in 2018-19.

While the data collected from providers from their Aged Care Financial Reports represents the most comprehensive data set available on financial issues in the Australian aged care industry, in most cases it is a year old at the time of publication of ACFA's annual report. With the industry currently undergoing some significant changes, ACFA has substantially increased its consultations to gain a more contemporaneous assessment of developments. In November 2018, following its July 2018 annual report, ACFA published an additional report it gave to the Government providing an Update on Funding and Financing in the Residential Aged Care Industry. This Update was based on consultations with a broad cross section of aged care providers, financial institutions and analysts during August and September 2018. A similar round of consultations was undertaken in the first half of 2019 as part of the input to the 2019 Annual Report.

2017-18 presented a number of challenges for the aged care industry. After five years of steady improvement, the overall financial performance of residential aged care providers declined in 2017-18, and the number of providers making a net profit fell from 68 per cent in 2016-17 to 56 per cent in 2017-18. The outcome in 2017-18 was significantly influenced by the changes to ACFI and feedback from providers suggests the pressures have continued into 2018-19.

The overall performance of home care providers also declined in 2017-18 and, as with the residential sector, the financial pressures are continuing in 2018-19. The main influence in the home care sector was the increased competition caused by the introduction of consumers being able to choose the provider from whom they receive their services.

ACFA will continue to assess these developments in the aged care industry. There are also a number of other aspects in residential care that warrant careful monitoring, including the gradual decline in overall occupancy rates, along with the apparent shift in residents' accommodation payments from refundable accommodation deposits (RADs) to daily accommodation payments

(DAPs), as well as the decline in providers intention to rebuild or upgrade their facilities and signs that an increasing number of smaller providers are seeking to leave the industry. In home care, particular aspects to monitor include: the impact of increased competition; the prospect of a rationalisation in the number of approved providers; and the implications of the continuing rise in unspent package funds. A significant development that will likely impact on funding and financing in the aged care industry is the Royal Commission into Aged Care Quality and Safety.

Against the background of recent developments, Chapter 9 of this report includes commentary on the challenges presented in obtaining a viable and sustainable aged care industry and, from a funding perspective, identifies some of the characteristics of a sustainable industry.

ACFA will continue to perform its role not only through its annual reports but also through other projects it is commissioned to undertake by the Minister responsible for aged care.

ACFA would like to acknowledge and thank the aged care providers, peak bodies, consumer representatives, financial institutions and other parties it has consulted and for their input and submissions to the range of projects ACFA has undertaken. ACFA continues to participate in a wide range of industry forums and conferences and has held a number of round tables following the publication of its annual reports.

ACFA looks forward to continuing and enhancing its role in advising the Government and informing other stakeholders of the funding and financing issues confronting the aged care industry, and to work towards ensuring its sustainability and viability and better access by consumers to quality aged care.

Mike Callaghan AM PSM

Chairman

Aged Care Financing Authority

Executive Summary

Overview of developments in 2017-18

A significant development in the funding and financing of the aged care sector in 2017-18 was the sizeable decline in the financial performance of both home care and residential care providers. In November 2018, ACFA published an Update on developments in the residential care sector and noted that, based on consultations, most providers indicated that their financial performance had deteriorated in 2017-18 and a number said they were moving into a loss situation. The results from the 2017-18 Aged Care Financial Reports, which are supplied by all providers and is the basis for ACFA's 2019 annual report, confirms that 2017-18 was a difficult year for aged care providers.

The average Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) per resident for residential care providers had improved each year for five years since 2012-13. In 2017-18, however, it fell by 24 per cent, and 44 per cent of residential care providers reported a loss compared with 32 per cent in 2016-17. There was a very significant decline in the financial performance of regional residential care providers in 2017-18 and, on average the performance of not-for-profit providers dropped significantly more than for-profit providers.

There was also a significant deterioration in the financial performance of home care providers in 2017-18. After several years of relatively stable returns, EBITDA per consumer for home care providers fell by over 60 per cent in 2017-18. After significantly outperforming not-for-profit and government providers in the previous three years, for-profit providers reported the largest fall in financial performance in 2017-18.

A number of Government policies had a significant impact on the financial performance of aged care providers in 2017-18.

An important influence on the decline in the performance of residential care providers was the Government's changes to the Aged Care Funding Instrument (ACFI) that took effect in 2016 and 2017 and the pause in ACFI indexation in 2017-18. The Government said these changes were made because real growth in ACFI expenditure per resident per day was considered to be higher than the frailty growth in the population and was higher than what had been in the Budget. Throughout ACFA's consultation with providers, the reasons for the changes to ACFI remained a controversial issue, with providers saying their ACFI claims, which they note may be subject to the Department's audit program, reflected the care needs of residents, although most acknowledged that they took steps to ensure that they were not under-claiming. With ACFI revenue contributing over 60 per cent of the revenue of residential care providers, the changes to ACFI considerably

constrained providers' revenue while their costs, particularly staff costs, continued to rise. In 2017-18, the expenses of residential care providers increased by 5.3 per cent while their income increased by 1.7 per cent.

The financial performance of home care providers was impacted through the introduction of packages following consumers rather than being allocated to providers. This reform allows consumers to direct their care package to the provider of their choice as well as to change providers. These changes have resulted in a very large increase in the number of approved providers (873 in 2017-18 compared with 496 in 2015-16) and in turn greater competition between providers which has resulted in a decline in profit margins. Expenses per consumer for home care providers increased by 7 per cent in 2017-18 while income per consumer decreased by around 1 per cent compared with 2016-17.

Feedback from consultations with residential care providers suggests the financial pressures they experienced in 2017-18 have continued into 2018-19. Providers note that while the pause in ACFI indexation has ended, the indexation rate in 2018-19 (1.4 per cent for the activities of daily living and behaviour domains and 0.7 per cent for complex health) is below the rate of increase in their costs. While in previous years ACFI payments increased significantly more than the indexation rate, few providers are expecting such an outcome in 2018-19. This would appear to be consistent with the Government's projection of real growth in ACFI payments of 1.4 per cent in 2018-19. Providers welcomed the $50 million increase in subsidies from September 2018 to assist in transitioning to the new quality standards and the $320 million one-off increase in subsidies from March to end June 2019, although they noted that because the increases are not ongoing they will not address their underlying financial pressures.

A development impacting on the financial outlook for residential care providers is the steady overall decline in occupancy rates in recent years. The average occupancy rate was 90.3 per cent in 2017-18, down from 91.8 per cent in 2016-17 and 92.4 per cent in 2015-16. The occupancy rate peaked in 2003-04 at 97.1 per cent. The for-profit providers recorded a sizeable decline in their average occupancy rate, from 90 per cent in 2016-17 to 87.9 per cent in 2017-18. Occupancy rates vary across providers and locations, although in the course of consultations a number of providers indicated that they were particularly concerned about trends in their occupancy, noting that only a small decline in occupancy can have a significant impact on their overall financial performance. A few providers said that they have been reducing accommodation prices in an effort to attract new residents.

The application of additional services for a fee is an option for residential care providers seeking to increase their revenue. While there is no data on additional services, it was apparent from consultations that practices vary widely across the industry. Many providers indicated that while they had not introduced a fee for additional services, given current financial pressures, it was an option they were considering. While the socio-economic composition of their residents is an important consideration in terms of capacity to pay, many providers said a major constraint they faced was regulatory uncertainty around what additional services are permitted.

Another development in 2017-18 that has significant potential implications for the residential care sector is the continuing gradual shift in the proportion of people choosing to pay their residential accommodation by a Daily Accommodation Payment/Contribution (DAP/DAC) rather than a Refundable Accommodation Deposit/Contribution (RAD/RAC). From 2014-15 to 2017-18, the proportion of residents paying for their accommodation through a RAD/RAC has fallen from 43 per cent to 37 per cent, while the proportion paying with a DAP/DAC has risen from 33 per cent to 40 per cent. In consultation with providers, a number indicated that the weakness in the housing market and the decline in house prices was impacting on the preference for DAP/DAC, particularly

when the resident was only expected to stay in a facility for a short-time. A continuation in the trend in favour of DAP/DACs and away from RAD/RACs will have significant financial implications for aged care providers. DAP/DACs are recorded in a provider's accounts as revenue, unlike RAD/RACs which are an interest free loan from residents. A shift from RAD/RACs to DAP/DACs will pose cash management issues for providers, who will have to replace interest free debt with debt with an interest charge, and RAD/RACS have been an important source of funding for capital investment by residential care providers. Unlike RAD/RACs, however, DAP/DACs are recorded as revenue for providers and included in their profit and loss accounts.

Feedback from consultations suggests that there appears to be a growing number of smaller providers, particularly in regional and remote areas, facing significant financial stress and seeking to leave the industry. There is also a view that this number will increase because scale is becoming increasingly important in the residential care sector. There has been an ongoing, gradual consolidation of residential care providers, with the number falling from 1,016 in 2013-14 to 886 in 2017-18. This trend is likely to continue.

Home care is in a period of transition and many providers appear to be still in the process of adjusting their processes and business models to be more responsive to meeting the needs of consumers. The reforms have increased costs for providers and the increased competition, including price competition, has significantly squeezed margins. It appears that a substantial amount of the competition is in attracting new consumers who have been allocated a package, and only a small proportion of consumers are moving between providers. While additional packages will be released, given the large increase in the number of providers, it is likely that there will be a shake-out and a process of consolidation. The beneficiaries of the reforms to home care are the consumers, although some concerns have been raised that the increase in competition has resulted in some providers not only reducing their prices but also the quality of their services.

The 2019-20 Budget extended funding arrangements for Commonwealth Home Support (CHSP) providers by a further two years. This means that the Home Care Packages Program and CHSP will continue to operate as separate programs until at least mid-2022. In 2015-16 the Government announced an intention to integrate CHSP and home care into a single program. During ACFA's consultations, a number of providers were seeking guidance as to whether the Government still intended to combine home care and CHSP.

The demand for aged care services will expand with the aging of the population, and consumers may be more demanding in the range of aged care services they are seeking. It is evident that there is currently a significant undersupply of home care services, with 127,748 people as at December 2018 waiting for a home care package or waiting for a package at their assessed package level.

While there are indications, such as the decline in the occupancy rate, suggesting that the overall demand for residential care is currently being met, the future demand for aged care services will depend not only on demographic developments but also the preferences of consumers, technological changes and the interaction between home care, residential care, retirement living and hospitals. Irrespective of how the future demand for aged care services evolves, there will be a need for substantial future investment in order to deliver these services. This investment will have to come from the non-government sector: not-for-profit and for-profit providers. These providers will not invest in the industry, nor will they be able to attract the required staff, unless they generate a sufficient rate of return and they have confidence in the stability of the funding and regulatory environment.

Against this background, a notable development in 2017-18 is the ongoing decline in the number of residential care providers reporting that they planned to rebuild or upgrade their facilities. Feedback from consultations indicated that many providers have curtailed or delayed investment plans because of policy and regulatory uncertainty. Analysts advised that a number of potential new investors in the aged care industry are waiting to see developments regarding the Royal Commission into Aged Care Quality and Safety.

Many of the developments in 2017-18 raise challenges in terms of achieving the objective of a financially viable, stable, efficient, effective, responsive and sustainable industry delivering high quality aged care services. Against this background, ACFA has offered some preliminary observations in this year's annual report regarding the characteristics of a sustainable aged care industry from a funding perspective.

Aged care in Australia

In 2017-18, Government subsidised aged care services were provided to around 1.3 million people. The majority of these (1.2 million) received services through the three major programs discussed in this report: Home support, home care or residential care. It is estimated that by 2020-21 around 1.5 million people will be accessing aged care.

Australian Government expenditure on aged care in 2017-18 was $18.1 billion, up from $17.1 billion in 2016-17. This is projected to increase to $24 billion by 2021-22. The aged care industry makes a significant contribution to the Australian economy, representing 1 per cent of Gross Domestic Product (GDP).

In 2017-18, aged care services were provided by:

- 1,456 Commonwealth Home Support Programme providers, compared with 1,523 in 2016-17;
- 91 providers of HACC in Western Australia (98 in 2016-17);
- 873 home care providers (702 in 2016-17); and
- 886 residential care providers (902 in 2016-17).

Consumer expenditure on aged care was around $4.9 billion in 2017-18 (excluding accommodation deposits).

There are over 366,000 paid workers in aged care with a further 68,000 volunteers.

Access to aged care

In 2017-18 there was a significant increase in the number of home care consumers, up to 116,843 from 97,516 in 2016-17, a 20 per cent increase. The number of consumers of residential care increased from 239,379 in 2016-17 to 241,723 in 2017-18 (an increase of 1 per cent) and the number of consumers of home support in 2017-18 was 847,534, up from 784,927 in 2016-17 (an increase of 8 per cent).

The overall aged care provision target ratio is being adjusted to progressively increase from the target of 113 operational places per 1,000 people aged 70 and over that applied prior to 2012 to 125 by 2021-22. Over the same period the target for home care packages is increasing from 27 to 45, while the residential care target will reduce from 86 to 78. The remaining two places are for the Short Term Restorative Care Programme (STRC).

The proportion of people using home care and residential care at age 85 and over is more than three times that of people aged 70 and over.

During 2017-18, across all residential care, access to services for supported residents (excluding residents receiving extra services) was stable, as has been the case in previous years.

In residential care, the average occupancy continues to fall, down to 90.3 per cent in 2017-18 from 91.8 per cent in 2016-17 and 92.4 per cent in 2015-16.

Home support

In 2017-18 the CHSP provided services to 783,043 older Australians and the Western Australian HACC services provided services to 64,491 older Australians.

Total Australian Government expenditure on home support in 2017-18 was $2.4 billion, comprising $2.2 billion for CHSP and $195 million in payments to the Western Australian government to support the jointly funded HACC program.

In the 2019-20 Budget, the Australian Government extended funding agreements with CHSP providers by a further two years, meaning that the CHSP and Home Care Packages Program will continue to operate as separate programs until at least mid-2022.

The Western Australian HACC program transitioned into the CHSP on 1 July 2018, making home support a national program.

Home care

Australian Government expenditure on home care in 2017-18 was $2.0 billion, up from $1.6 billion in 2016-17. Services were provided to 116,843 consumers, up from 97,516 in 2016-17.

Consumers of home care contributed $122 million toward the cost of their care through basic daily fees and income tested fees.

The home care sector continues to be predominately not-for-profit with 53 per cent of providers from this group, although this is down from 65 per cent in 2016-17. Seventy-six per cent of consumers had their package with a not-for-profit provider at 30 June 2018.

Seventy per cent of home care providers achieved a net profit in 2017-18, down from 75 per cent in 2016-17 and 2015-16. Across the sector, providers achieved an average EBITDA of $1,217 per consumer, a significant decline from $2,989 for 2016-17 and $3,055 in 2015-16. This decline in financial performance is likely due to increased competition resulting from the changes of February 2017 which introduced the assignment of packages to consumers who then could choose their preferred provider to deliver their services.

After significantly outperforming the not-for-profit and government providers in the previous two years, the for-profits reported by far the worst results in 2017-18, recording average EBITDA per consumer of $169, down from $6,767 in 2016-17 and $7,481 in 2015-16.

Unspent funds continue to increase significantly with home care providers holding $539 million at 30 June 2018, an increase of 64 per cent from 2016-17.

Residential care

Australian Government expenditure on residential care in 2017-18 was $12.2 billion, up from $11.9 billion in 2016-17. Services were provided to 241,723 residents (an increase of 1 per cent). At 30 June 2018 there were 207,142 operational places, up from 200,689 at 30 June 2017 (an increase of 3.2 per cent).

In 2017-18, residents contributed over $4.5 billion toward their living expenses, care and accommodation (excluding lump sum accommodation deposits).

As at 30 June 2018, there were 886 residential care providers, down from 902 in 2016-17, continuing the consolidation of recent years, with the number of residential care places increasing while the number of providers gradually decreases. Not-for-profit providers continue to represent the largest proportion of ownership type in residential care, with 56 per cent of providers and 55 per cent of places, but the proportion of places operated by the for-profits continues to gradually increase.

Residential care providers generated total revenue of $18.1 billion in 2017-18, up from $17.8 billion in 2016-17, an increase of 1.7 per cent, equating to revenue of $272.16 per resident per day, an increase of 1 per cent from $269.55 in 2016-17. Total expenses in 2017-18 were $17.6 billion, up from $16.8 billion in 2016-17, an increase of 5.3 per cent, equating to $265.62 per resident per day, compared with $254.29 the previous year, an increase of 4.5 per cent.

Total profit was $435 million in 2017-18, a significant reduction from $1,006 million in 2016-17. Average EBITDA per resident per annum was 24 per cent lower in 2017-18 compared with 2016-17, $8,746 down from $11,481.

Changes to the Aged Care Funding Instrument (ACFI) and the indexation pause impacted on the financial results of residential aged care providers in 2017-18.

Residential care: capital investment

At 30 June 2018, the residential care sector held total assets of $48.4 billion and total liabilities of $36.6 billion. Total liabilities includes $27.5 billion of refundable accommodation deposits, up from $24.8 billion in 2016-17.

Residential care providers recorded an average return on equity of 13.4 per cent in 2017-18, down from 18.3 per cent in 2016-17. The average return on assets was 3.3 per cent in 2017-18, down from 4.6 per cent in 2016-17.

As at 30 June 2018, $4.9 billion of building works were either completed or in-progress compared with $4.7 billion at 30 June 2017, although planned building activity dropped significantly for the second year in a row.

Future demand for aged care

The demand for aged care services will expand with the ageing of the population, although it is not currently possible to accurately measure demand or to reliably establish consumer preference for residential and home care, due to existing supply constraints. Better evidence about unmet need

and consumer preference is, however, gradually being revealed through the introduction of the national prioritisation system for home care packages.

The structural ageing of the Australian population over the next 20 years will see the size of the 70 years and over cohort increase by around 1 million people each decade; this is on a base of 2.7 million people in 2019. Underneath this, the older age groups will more than double over this period; for example, the 85 years and over cohort will increase from just under 500,000 people in 2019 to just over 1 million people by 2039.

At the same time that ageing population is putting pressure on the demand for aged care, the relative supply of informal carers is diminishing.

The Legislated Review of Aged Care 2017 (Tune Review) recommended changes to the aged care target planning ratio. The current ratio denominator (70+ population) is not aligned to the cohort of the population more likely to use aged care services, and results in the observed periods of relative oversupply and undersupply. ACFA supports the Tune Review recommendation to change the denominator in the ratio to the 75+ cohort in 2021-22.

ACFA also recommends that the change in the denominator be accompanied by a change in the target provision ratio formula so that it is based on the number of consumers and not the number of operational places. This will allow comparable reporting and monitoring of the supply of residential and home care places and overall supply against the provision targets, and help inform unmet demand and consumer preference.

The challenge of achieving a sustainable aged care system

Against the background of developments in aged care in recent years and the challenges confronting the industry, ACFA has identified from a funding perspective the following characteristics of a sustainable aged care system.

Confidence and trust: While government is the main source of funding for aged care, the services are primarily delivered by the non-government sector – for-profit and not-for-profit providers. These providers will not invest unless they have confidence in the adequacy and stability of government policies.

Stable, predictable, efficient, equitable and effective arrangements for allocating government funding: The desirable features of a tool in the residential care sector for allocating government funds includes: administrative simplicity, funding assessments external to providers, equitable allocation of funds based on residents and their needs, recognition that many core costs are shared between residents, independent, annual and transparent studies to determine the cost of care and indexation arrangements that adequately reflect movement in costs. The home care funding arrangements should also be based on transparent studies to determine the cost of care.

Appropriate overall funding: Efficient arrangements for the equitable allocation of funding across residential and home care providers is necessary, but it is also important that the overall funding pool for the aged care system is sufficient to support the level and quality of aged care services required by older Australians and provides an incentive for providers to invest in the industry.

Funding that is flexible and adaptable to changing demographics and demands: While the demographics of the Australian population are such that there will be increasing pressure on funding for aged care, demand will change and there will be innovations in the way services are delivered. Funding arrangements have to be responsive to these changes and should not deter but encourage innovation.

Equitable contribution to costs by consumers: Sustainable aged care funding arrangements will require that consumers who can afford to do so make a greater financial contribution to their living and care costs, complemented by greater choice of high quality services.

Effective prudential oversight: Effective prudential oversight of the aged care industry is necessary given that the range of current and prospective reforms and developments are likely to be disruptive to a number of providers. Any adjustment should be as orderly as possible and any impact on consumers minimised.

Sound management and governance arrangements: A sustainable aged care system will require well managed aged care service and providers with sound governance arrangements. The very wide variation in financial performance across the industry suggests there is scope for many providers to pursue greater efficiency and improve their results.

The Aged Care Financing Authority and the 2019 Annual Industry Report

1 This report

1.1 Aged care in Australia

The aged care industry in Australia provides services to around 1.3 million Australians and generates annual revenues totalling around $22.6 billion. The industry makes a significant contribution to the Australian economy, representing 1 per cent of Gross Domestic Product (GDP).

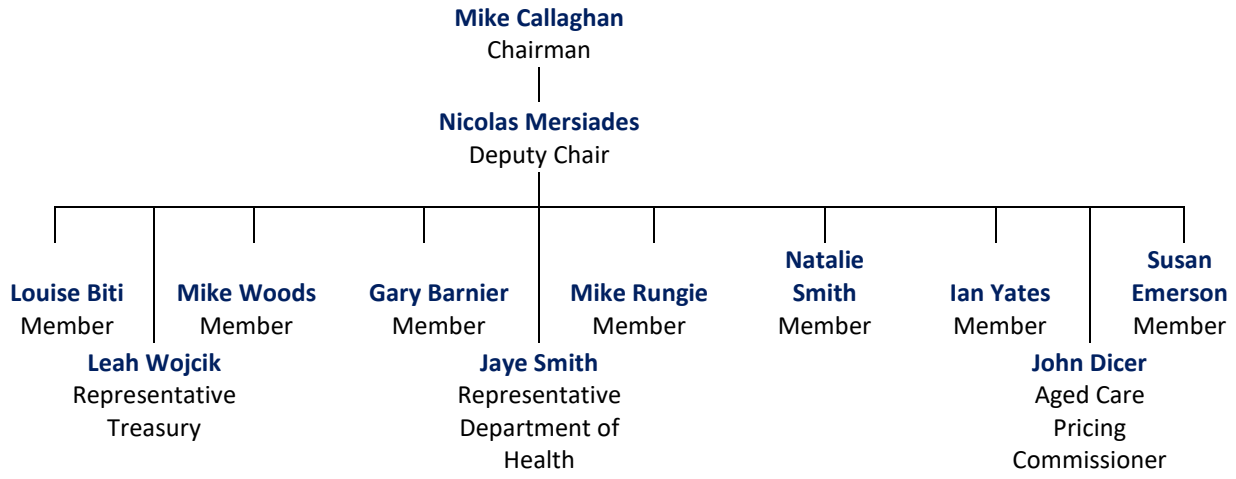
The industry is heavily reliant on taxpayer funding, receiving $18.1 billion in Commonwealth funding in 2017-18, an increase of 5.7 per cent from 2016-17. Almost 70 per cent of total funding ($12.2 billion) was for residential care. Given the amount of taxpayer funding, objective and thorough analysis of the funding and financing of the industry is of central importance to the Government, aged care consumers and providers.

1.2 About the Aged Care Financing Authority

The Aged Care Financing Authority (ACFA) is a statutory committee whose role is to provide independent, transparent advice to the Australian Government on funding and financing issues in the aged care industry. ACFA considers issues in the context of maintaining a viable and sustainable aged care industry and accessible services that balance the needs of consumers, providers, the workforce, taxpayers, investors and financiers.

ACFA is led by an independent Chairman (Mike Callaghan) and Deputy Chair (Nicolas Mersiades) complemented by seven members with aged care or finance industry expertise. Figure 1.1 shows the ACFA membership and structure. Further details about each member are provided in Appendix A. There are three non-voting Australian Government representatives on ACFA.

Figure 1.1: ACFA Membership



1.3 The Annual Report on the Funding and Financing of the Aged Care Industry

Each year ACFA provides the Minister responsible for aged care with a report on the funding and financing of the aged care industry.

Over time, each annual report builds upon the last, producing a substantial body of in-time as well as trend data on the funding and financing of the aged care industry. This is the seventh annual report published.[1]

1.3.1 Methodology

The 2019 annual report mainly presents and analyses 2017-18 data provided by aged care providers and date held by the Department of Health, although this is supplemented by more recent data sources where available along with consultations with industry participants.

The principal data sources are financial and administrative data collected by the Department of Health:

- From Commonwealth Home Support Programme (CHSP) providers (Home and Community Care providers in WA):
  - CHSP Data Exchange; and
  - HACC Minimum Data Set (WA).
- From home care providers:
  - Aged Care Financial Reports (ACFR).
- From residential care providers:
  - Aged Care Financial Reports (ACFR);
  - General Purpose Financial Reports (GPFR);
  - Annual Survey of Aged Care Homes (SACH); and
  - Published aged care accommodation prices (My Aged Care website).
- Other general data:
  - The 2017-18 Report on the Operation of the *Aged Care Act 1997* (ROACA);
  - The 2016 National Aged Care Workforce Census and Survey; and
  - Relevant supplementary information from industry analysts, including StewartBrown.

In addition to these listed data sources, ACFA regularly consults with the sector, relevant financiers and other key stakeholders. The 2019 report is supplemented with feedback from a substantial increase in consultations ACFA has conducted with a cross section of stakeholders in the first half of 2019 to gain an insight into current factors impacting on the industry. This increase in consultation follows the approach undertaken in the preparation of ACFA's *Update on funding and financing issues in the residential aged care sector* that was published in November 2018.

[1] Previous ACFA annual reports can be accessed at https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority

When discussing the financial performance of providers in this report, Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) is the main measure used to analyse profitability. This is because EBITDA excludes items such as interest (both income and expense) and tax expenditures, which can vary depending on the financing decisions of an organisation; and non-cash expenses, such as depreciation and amortisation which can vary greatly based on the size and age of facilities and other assets, and on ownership type and depreciation methods.

EBITDA therefore can be used to compare organisations with each other and against industry averages and is a good measure of core profit trends because it eliminates some of the extraneous factors mentioned above. This is particularly important when analysing aged care given the diversity of ownership and capital structures. EBITDA helps to smooth out these factors.

This report also refers to Net Profit Before Tax (NPBT) which also assists in making comparison between organisations subject to different tax treatments.

The financial analysis and commentary in this report does not include National Aboriginal and Torres Strait Islander Flexible Care Program providers, providers operating Multi-Purpose Services or providers under the Short Term Restorative Care Programme.

As discussed in previous annual reports, it is important to be mindful of the industry composition and the varying objectives of providers when interpreting the data. The industry continues to be dominated by not-for-profit providers. Traditional profit-based measures are not always consistent with the mission and objectives of not-for-profit providers.

Considerations and limitations

As reforms in aged care continue, some forms of service delivery, and therefore data collection, are changing. For this reason, analysis is not always directly comparable with analysis contained in previous reports. Where this is the case it is noted.

In 2017-18, as was the case for 2016-17, the Aged Care Financial Reports (ACFR) were used by home care and residential care providers to report financial data to the Department of Health. Providers previously reported their financial information using different methodologies meaning comparisons with 2015-16 and earlier years is not always possible.

The majority of financial data available to ACFA regarding home and residential care is at the approved provider level. Because many providers have services in multiple locations, ACFA is constrained in its ability to analyse performance at facility or service level or the impact of locational factors on funding, financing and financial performance of services.

1.3.2 Navigating the 2019 annual report

The 2019 annual report is structured as follows:

- **Chapter 2 Aged care in Australia:** Provides an overview of the aged care industry in Australia.
- **Chapter 3 Access to aged care:** Discusses the supply of, and access to, subsidised aged care in Australia.
- **Chapter 4 Home support:** Provides an overview of home support through the Commonwealth Home Support Programme and the Home and Community Care program in Western Australia[2].
- **Chapter 5 Home care:** Provides an overview of the Home Care Packages Program and a summary of financial performance of home care providers in 2017-18.
- **Chapter 6 Residential care:** Provides an overview of residential aged care and a summary of financial performance of residential care providers in 2017-18.
- **Chapter 7 Residential care: capital investment:** Provides discussion and analysis of residential care provider balance sheets and capital investments, as well as building trends in the sector.
- **Chapter 8 Future demand for aged care:** Discusses the future demand for aged care in the short, medium and long-term.
- **Chapter 9 The challenge of achieving a sustainable aged care system:** Provides an outline of some of the challenges facing the Government, providers and consumers for Australia to move to a more sustainable aged care system.

Analysis of providers in this report is generally presented in four ways:

- Whole of sector (refers to all providers operating a particular type of care);
- Ownership type (not-for-profit, for-profit or government owned);
- Location (metropolitan, regional[3] or a mix of metropolitan and regional);
- Scale (number of services[4] operated by a home care provider or number of facilities operated by a residential care provider).

When referring to facility 'size' the report is referring to the number of beds operated by a single residential care facility.

When referring to 'government owned', the report is referring to services owned and operated by state, territory and local governments. The Australian Government does not own or operate aged care facilities or services.

[2] HACC for older Australians in Western Australia transitioned to the Commonwealth Home Support Programme on 1 July 2018.

[3] 'regional' refers to all areas outside of major cities.

[4] A home care service is a location to which a consumer goes to interact with an approved home care provider regarding their package of services.

2 Aged care in Australia

This chapter discusses:

- Types of subsidised aged care in Australia;
- providers of aged care;
- the regulation of the supply of subsidised aged care services;
- Commonwealth and consumer expenditure on aged care; and
- the aged care workforce.

This chapter reports that:

- Australian Government total expenditure on aged care was $18.1 billion in 2017-18, up from $17.1 billion in 2016-17;
- total expenditure is expected to be $20.5 billion in 2018-19, and increase to $24.0 billion by 2021-22;
- services were provided to around 1.3 million[5] people in 2017-18; and is estimated to increase to 1.5 million by 2020-21;
- services were provided by:
  - 1,456 Commonwealth Home Support Programme providers, compared with 1,523 in 2016-17;
  - 91 providers of HACC in Western Australia (98 in 2016-17);
  - 873 home care providers (702 in 2016-17); and
  - 886 residential care providers (902 in 2016-17).

2.1 Overview

The aged care system is continuing to undergo reform so that it more effectively and efficiently supports older people to live in their homes and communities for as long as possible, and enables people to make informed decisions about their care, while remaining sustainable for taxpayers and service providers. Older Australians can access a spectrum of aged care, ranging from home based support through to 24 hour care provided in residential settings.

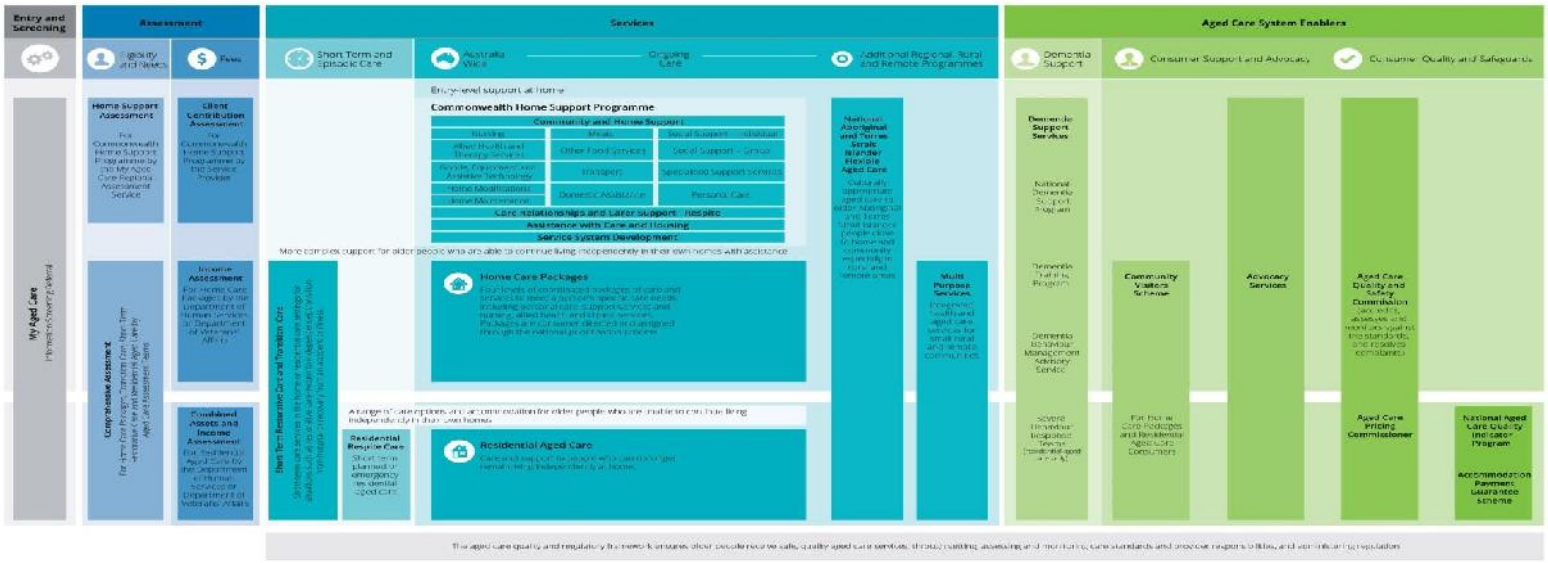
[5] The figure of 1.3 million consumers includes all consumers of Government funded aged care. Much of this report discusses only home support, home care and residential care and therefore total consumers reported may not always match. Consumers of home support, home care and residential care total 1.2 million while consumers of other aged care programs total around 100,000.

Many aged care services are subsidised and regulated by the Australian Government. Figure 2.1 illustrates the Commonwealth subsidised Australian aged care system.

My Aged Care, administered by the Department of Health, is responsible for arranging an assessment of a person's eligibility for Commonwealth subsidised aged care services. The assessment determines the level of care and support for which the individual may be eligible.

Means testing conducted by the Department of Human Services determines whether an individual is required to make a contribution towards the cost of their care and accommodation, and the amount of the contribution.

Figure 2.1: Australian aged care system – guide to Australian Government subsidised aged care services



The Department of Veterans' Affairs also provides Australian Government subsidised aged care services.

1. Current as at February 2019.
2. The Department of Veterans' Affairs also provides Australian Government subsidised aged care services.

2.2 Current aged care

In this report, the aged care industry is discussed in terms of the three main programs:

- **Commonwealth Home Support Programme (CHSP) (Home and Community Care (HACC) in Western Australia):** Provides services for those who require basic services to assist with remaining in their own homes. On 1 July 2015, the CHSP was implemented, combining the previous Commonwealth HACC program[6], the National Respite for Carers Program, Day Therapy Centres and Assistance with Care and Housing for the Aged. On 1 July 2016, the HACC Program in Victoria transitioned to the CHSP and on 1 July 2018 HACC services in Western Australia were also incorporated into the CHSP. All states and territories now operate under the CHSP.
- **Home Care Packages Program:** Provides services for those who have greater care needs and wish to remain living at home. Care and support is provided through a package of home care services.
- **Residential care:** Provides accommodation and 24 hour care for those who have greater care needs and choose or need to be cared for in an aged care facility. Care can be provided on either a temporary (respite) or permanent basis.

Table 2.1 shows the number of providers, services, places, consumers and Commonwealth and consumer funding for each of the three care types for the five years to 2017-18.

In addition there are care types about which, due to a lack of financial data, ACFA does not provide analysis or commentary. These include:

- **Flexible care:** Services in either a residential or home care setting, that, due to difficulties in delivering services in some communities, are delivered using different care approaches than that provided through mainstream residential and home care. Examples of flexible care include Multi-Purpose Services in rural and remote locations and Aboriginal and Torres Strait Islander flexible care.
- **Transition and Restorative care:** Services that focus on enhancing the physical and cognitive function of people who have lost or are at risk of losing condition and independence. The Short-Term Restorative Care (STRC) Programme, which commenced in February 2017, aims to reverse and/or slow 'functional decline' in older people and improve their wellbeing through the delivery of a time-limited, goal-oriented, multi-disciplinary and co-ordinated range of services. The Transition Care Programme seeks to optimise the functioning and independence of older people after a hospital stay, enabling them to return home rather than enter residential care. Unlike the STRC, the Transition Care Programme is a joint Commonwealth-State funded program.
- **Innovative pool:** The Innovative Care Programme supports the development and testing of flexible models of service delivery in areas where mainstream aged care services may not appropriately meet the needs of a location or target group.

[6] The Commonwealth Home and Community Care program was created on 1 July 2012 following agreement to the transfer of all formerly joint Commonwealth-state/territory HACC programs, except Victoria and Western Australia.

Table 2.1: Aged care in Australia 2013-14 to 2017-18

	2013-14			2014-15			2015-16			2016-17			2017-18		
	Home Support	Home care	Residential care	Home support	Home care	Residential care	Home support	Home care	Residential care	Home support	Home care	Residential care	Home support	Home care	Residential care
Number of providers	1,676	504	1,016	1,628	504	972	1,686	496	949	1,621	702	902	1,547	873	886
Number of services/facilities	N/A	2,212	2,688	N/A	2,292	2,681	N/A	2,099	2,669	N/A	2,367	2,672	N/A	2,599	2,695
Number of allocated places	N/A	66,149	189,283	N/A	72,702	192,370	N/A	78,956	195,825	N/A	N/A[1]	200,689	N/A	N/A	207,142
Number of consumers	775,959	83,144	231,515	812,384	83,838	231,255	925,432	88,875	234,931	784,927	97,516	239,379	847,534	116,843	241,723
Commonwealth funding	$1.7b	$1.3b	$9.8b	$1.9b	$1.3b	$10.6b	$2.2b	$1.5b	$11.4b	$2.4b	$1.6b	$11.9b	$2.4b	$2.0b	$12.2b
Consumer contribution	N/A	$87m	$4.0b	N/A	$136m	$4.2b	N/A	$127m	$4.5b	$204m	$128m	$4.5b	$219m	$122m	$4.5b

Notes:

1. This table only shows data for the three main types of Government funded aged care: CHSP (and Vic/WA HACC), home care and residential care. Therefore total consumers of aged care does not match the around 1.3 million stated at the beginning of this chapter as that figure includes all other types of Government funded aged care.
2. Home support for the years 2013-14 to 2014-15 comprises Commonwealth HACC as well as Vic and WA HACC, in 2015-16 comprises CHSP as well as VIC and WA HACC and in 2016-17 and 2017-18 comprises CHSP as well as WA HACC.
3. Commonwealth funding for home support in 2015-16 and 2016-17 includes funding for My Aged Care and Regional Assessment Service (RAS) to support the CHSP ($148 million in 2015-16 and $123 million in 2016-17).
4. The number of consumers of home support in 2015-16 (925,432) includes 285,432 for Vic and WA HACC and an estimate of over 640,000 in the CHSP as accurate data was not available. Due to the lack of accurate data and differences in counting methods the CHSP consumers for 2015-16 are likely overstated.
5. The amounts shown for home care consumer contributions in the 2018 ACFA report ($142m in 2015-16 and $150m in 2016-17) were incorrect.

2.3 Australian Government expenditure on aged care

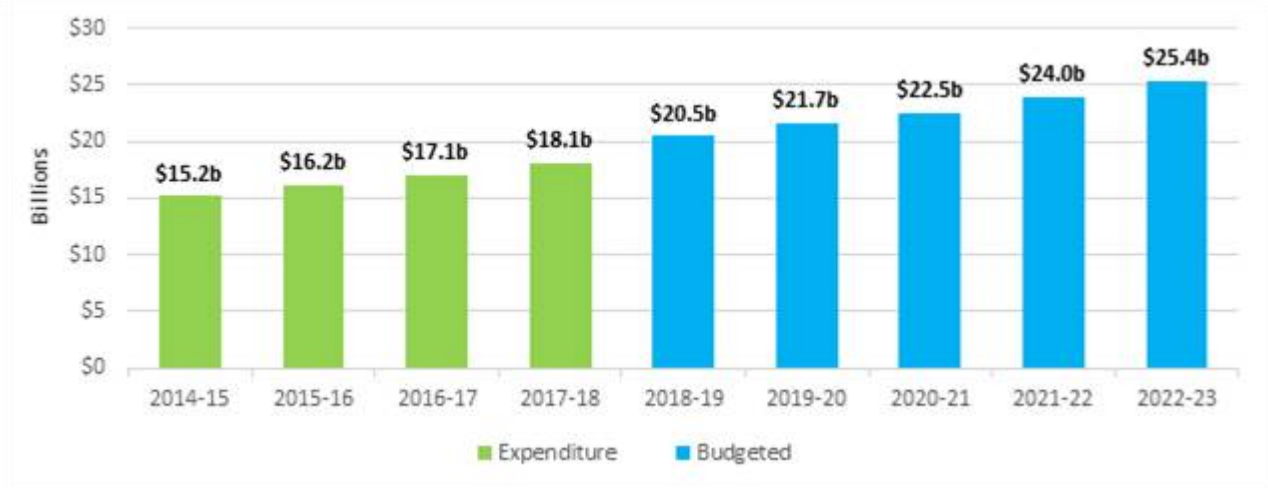
The Australian Government spent $18.1 billion on aged care in 2017-18, up from $17.1 billion in 2016-17. In 2018-19, Australian Government funding is expected to be $20.5 billion with $24 billion budgeted for 2021-2. Chart 2.1 shows Commonwealth funding in aged care since 2013-14 and budgeted expenditure to 2022-23.

More than three quarters of the 5.7 per cent increase in Australian Government funding during 2017-18, ($746.2 million) is attributable to increases in residential and home care expenditure, $300.3 million and $445.9 million respectively. The balance is spread across a mix of programs such as CHSP and flexible aged care programs.

The growth in residential care expenditure can be attributed to a 1.4 per cent increase in the number of days of care provided during the year due to an increase in the number of total residents, and a 1.1 per cent increase in average care subsidy and supplement payments, primarily due to the indexation of the accommodation supplement and more facilities becoming eligible for the higher accommodation supplement.

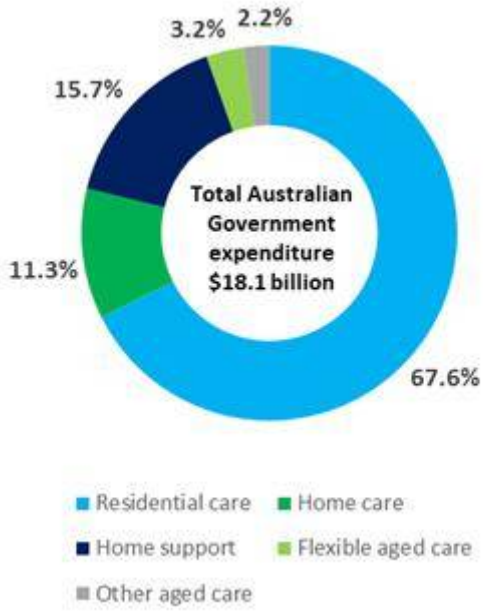
The increase in home care expenditure in 2017-18 is mainly due to a 4.2 per cent increase in the number of days of care provided during the year.

Chart 2.1: Australian Government total aged care expenditure, 2014-15 to 2017-18 and total budgeted aged care expenditure, 2018-19 to 2022-23



Funding for residential care is by far the largest proportion of Commonwealth expenditure at almost 68 per cent. The proportions of Commonwealth expenditure in 2017-18 across the industry are illustrated in Chart 2.2.

Chart 2.2: Australian Government total budgeted aged care expenditure, by major program, 2017-18



Australian Government expenditure on aged care is projected to nearly double as a share of the economy from 1 per cent currently to around 1.7 per cent of GDP by 2055[7]. Costs of care will continue to rise on account of growth in input costs (e.g. wages) and the increasing complexity of chronic health conditions in ageing populations.

ACFA has previously noted that the shift in the balance of care in favour of home care over residential care is expected to improve affordability for taxpayers over the long term. This is because the costs of accommodation associated with residential care are not incurred with home care, and because, on average, higher care subsidies apply in residential care where 24 hour care is provided. As noted in ACFA's annual report last year, there are many home care consumers with higher care needs who are in receipt of a lower level package until a package suitable to their needs becomes available, as well as people with assessed needs who are waiting to be offered a package.

2.4 Consumer contributions

Most aged care consumers contribute to the cost of their care.

In residential care, consumers contribute 85 per cent of the single age pension towards their living expenses (through the Basic Daily Fee) and, subject to means testing, may be required to contribute towards their accommodation and care costs. In 2017-18, residents contributed $3.3 billion towards their living expenses, $780 million towards accommodation costs by those who chose to pay through a Daily Accommodation Payment (which excludes those choosing to pay through a fully refundable lump sum deposit) and $504 million towards care costs. Overall contributions from residents (excluding lump sum deposits) represent 26.6 per cent of total residential care provider revenue.

[7] Department of the Treasury *Intergenerational Report, 2015*.

Consumers of home care packages contributed around $122 million (representing 5.9 per cent of home care provider's revenue) to their care costs in 2017-18, while Commonwealth Home Support Programme consumers contributed $219 million, which represents 9.3 per cent of total expenditure on home support.

Table 2.2 shows the Government and consumer contribution across service types since 2013-14.

Table 2.2: Australian Government expenditure and consumer contribution, by service type, 2013-14 to 2017-18

		2013-14	2014-15	2015-16	2016-17	2017-18
Home care	Government	$1.3b	$1.3b	$1.5b	$1.6b	$2.0b
	Consumer	$87m	$136m	$127m[8]	$126m[9]	$122m
Residential care	Government	$9.8b	$10.6b	$11.4b	$11.9b	$12.2b
	Consumer	$4.0b	$4.2b	$4.5b	$4.5b	$4.5b
Home support	Government	$1.7b	$1.9b	$2.2b	$2.4b	$2.4b
	Consumer[10]	N/A	N/A	N/A	$204m	$219m

Consumers may also choose to pay additional amounts to a provider to access additional levels of care or services (e.g. to 'top-up' funding available under a home care package, or to purchase additional lifestyle-related services in residential care).

ACFA's report *Understanding how consumers plan and finance their aged care* was published in December 2018 and the recommendations in the report are outlined below.

[8] The figure of $142 million in the 2018 ACFA report was incorrect.

[9] The figure of $150 million in the 2018 ACFA report was incorrect.

[10] Cconsumer contributions for home support were not available until 2016-17.

Improving information sources

For consumers to truly understand the range of aged care services available and the cost of these services, and to facilitate both their incentive and capacity to plan for their current and future aged care needs, various information sources need to be improved, including: retirement planning tools; equity release products; My Aged Care website; retirement villages; and fee advice letters issued by DHS; as well as improving the general perception of aged care. ACFA's recommendations included the following themes:

Ensuring retirement planning tools include future aged care needs

Raising the profile of equity release products to assist consumers with funding their aged care costs

Access to information on My Aged Care

Misconceptions regarding retirement villages

Improving fee advice letters from DHS

Improving perceptions of aged care to support increased planning

Aged care fees

ACFA considers that in order to assist consumers in understanding aged care fees, not only is better information required but changes should be made to the aged care fees themselves. ACFA recommends changes to: improve consumer understanding of aged care fees; the fee structures of CHSP and home care; financial hardship for home care packages; residential accommodation payment options; additional service fees; and financial abuse and complaints processes. ACFA's recommendations included the following themes:

Improving consumer understanding of aged care fees

Improving the interface between fees for CHSP and home care packages

Review of financial hardship assistance for home care packages

Improving understanding of residential aged care accommodation payments

Improve understanding of additional service fees for residential aged care

Financial abuse and complaints processes

Financial advisors

ACFA considers that further work is required to encourage financial advisors to more widely upskill and include aged care advice into services, both in the pre-retirement and post-retirement planning phases. ACFA's recommendations included the following themes:

Expansion of Financial Information Service

Ensuring financial planners are skilled to provide advice on aged care

2.5 Aged care providers

In this report, providers of the three main types of Government subsidised aged care in Australia are discussed. These are CHSP (HACC in WA), home care and residential care.

There are over 3,000 providers who provide these services to older Australians. Table 2.3 shows the number of providers over the last five years. The number of home care providers was stable until 2015-16 but has since increased dramatically. By contrast, the number of residential care providers

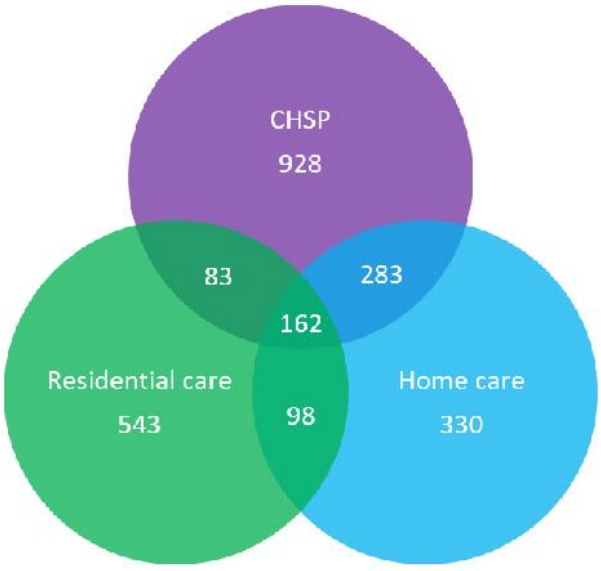
has been steadily declining over the five years. The changing number of home care and residential care providers is discussed in Chapter 3.

Table 2.3: Number of aged care providers, by service type, 2013-14 to 2017-18

	Home support	Home care	Residential care
2013-14	1,676	504	1,016
2014-15	1,628	504	972
2015-16	1,686	496	949
2016-17	1,621	702	902
2017-18	1,547	873	886

While the majority of providers operate only one type of aged care service, some operate two or all three of the major types. Chart 2.3 shows the number of providers providing only one type, two types and all three types of services in 2017-18.[11] As was the case in previous ACFA reports, this analysis excludes Western Australian HACC providers as information on whether these providers also provide residential or home care is not available.

Chart 2.3: Proportion of aged care providers providing more than one type of aged care service, 2017-18



As shown, there appears to be a high degree of specialisation in terms of service types offered by providers. However the proportion of providers who have diversified into more than one type of care is continuing to increase, albeit slowly, as shown in Table 2.4. Of the 162 organisations who provide all three major types of care, only four are for-profit providers. ACFA notes that there

[11] Some aged care providers, particularly not-for-profit providers, also provide disability services and seniors' housing.

would be merit in examining the scope for economies of scale and other benefits from providers engaging in more than one type of service.

Table 2.4: Proportion of aged care providers providing more than one type of service, 2013-14 to 2017-18

	One type of service only	Two types of services	All three types of services
2013-14	85%	13%	2%
2014-15	84%	14%	2%
2015-16	78%	16%	6%
2016-17	76%	17%	7%
2017-18	74%	19%	7%

There may be more occurrences of providers providing more than one type of service than reported here, however separate provider registration in the three different sub-sectors means this is not always apparent, as providers often have different ABNs and different trading names.

2.6 Aged care workforce

The aged care workforce is a shared responsibility between the Australian Government and the aged care industry, with many of the levers to influence the workforce resting with employers/providers. The Australian Government supports the industry through setting policy with appropriate funding that fosters flexibility, responsiveness and innovation, and supporting competitive labour markets. It also supports the industry through funding and regulating the higher education and the vocational education and training systems.

The National Aged Care Workforce Census and Survey[12] is conducted approximately every four years. In its 2017 annual report, ACFA provided a summary of the findings of the 2016 Survey.

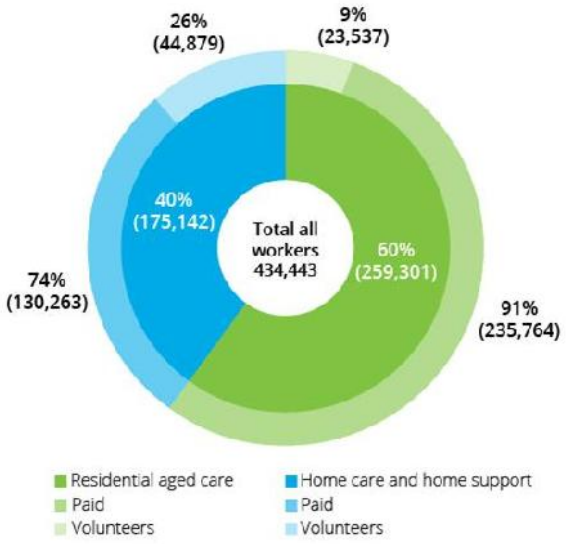
The 2016 census reported the number of paid workers in the aged care industry was around 366,000, with an additional 68,000 volunteers. When the census was conducted in 2012, the number of paid workers was 240,000.

Total paid workers in residential care in 2016 was estimated at 235,764, of whom 153,854 were direct care workers. Total paid workers in home support and home care were estimated at 130,263, of whom 86,463 were in direct care roles.

Of the reported 434,443 people working in aged care in 2016, 60 per cent were in residential care. The remainder of the workforce were in home support and home care. Chart 2.4 shows the composition of the aged care workforce as reported in 2016.

[12] https://agedcare.health.gov.au/news-and-resources/publications/2016-national-aged-care-workforce-census-and-survey-the-aged-care-workforce-2016

Chart 2.4: Aged care workforce composition, 2016



The average age of the residential care workforce decreased from 48 to 46 between 2012 and 2016. In contrast, the average age of the workforce in home support and home care increased from 50 in 2012 to 52 in 2016.

Overseas born workers continue to make up a very significant proportion of the aged care workforce. In 2016, the proportion in residential care was highest with 32 per cent of workers born overseas, while in home support and home care the proportion was 23 per cent. This compares with 35 per cent in residential care and 28 per cent in home support and home care in 2012.

Although aged care remains a female dominated industry, the proportion of males in the workforce is continuing to grow, albeit slowly and from a small base. In residential care, 13 per cent of workers were male (compared with 11 per cent in 2012). In the home support and home care sectors, men represented 11 per cent of all workers (10 per cent in 2012).

More detailed information from the 2016 National Census and Survey is provided in Appendix D. The next census will be conducted around 2020-21.

2.6.1 Aged Care Workforce Strategy

As announced in the 2017–18 Budget, the Australian Government established an industry-led Aged Care Workforce Strategy Taskforce to develop an Aged Care Workforce Strategy. The Taskforce delivered its Strategy to the Minister on 29 June 2018.

In September 2018, the Strategy was released and the Government announced support for industry-led implementation. The Strategy includes 14 actions[13] to grow the professional workforce and attract, train and retain skilled and talented staff to work in aged care services in a variety of settings. A new Aged Care Workforce Industry Council, announced in January 2019, will steward the Strategy and is developing an implementation plan.

[13] https://agedcare.health.gov.au/sites/default/files/documents/09_2018/at_a_glance_-_the_fourteen_strategic_actions_of_the_australias_aged_care_taskforce_strategy.docx

An Aged Services Industry Reference Committee (IRC) has also been established to respond to relevant recommendations in the Aged Care Workforce Strategy and to ensure that the national education and training system is able to deliver an agile workforce that can provide safe and quality care in a variety of settings. This includes addressing the current and future competencies and skill requirements for new workers entering the industry and existing staff needing to upskill in both the vocational education and training (VET) and higher education sectors.

In addition, the Aged Services IRC will establish a number of 'specific interest' advisory committees to provide high-level strategic and policy advice to support the work of the IRC.

2.7 Aged care reforms

The aged care industry has undergone substantial change in recent years with a view to improving the sustainability of aged care services and increasing consumer choice and control. This change includes a suite of reforms that have had a phased implementation as part of a ten-year transition strategy announced in April 2012 and further reform announcements in subsequent years.

The reforms since 2012 are summarised below according to the care type they relate to, that is, CHSP, home care, residential care or cross-program.

Commonwealth Home Support Programme (CHSP)

- From 1 July 2015, the CHSP commenced by combining the former Commonwealth-State Home and Community Care (HACC) programs in all states and territories except Victoria and Western Australia, and the Commonwealth National Respite for Carers, Day Therapy Centres and Assistance with Care and Housing for the Aged programs;
- Victoria transitioned their HACC services to the CHSP on 1 July 2016 and Western Australia transitioned to the CHSP on 1 July 2018; and
- Regional Assessment Services established in 2015 to assess eligibility for CHSP services.

Home care

- New home care packages (levels 1-4) commenced from 1 August 2013;
- income testing with subsidy reduction, including annual and lifetime caps, commenced on 1 July 2014;
- all packages required to be CDC, with individualised budgets, from 1 July 2015;
- from 27 February 2017:
  - creation of a consistent National Prioritisation System to assign home care packages; and
  - home care packages assigned to the consumer rather than allocated to the provider;
- home care providers required to publish their current pricing information on the My Aged Care Service Finder, from 30 November 2018;
- 6,000 additional higher level home care packages in 2017-18 announced in the 2017-18 MYEFO;
- 14,000 additional higher level home care packages announced in the 2018-19 Budget;
- 10,000 higher level home care packages in 2018-19 announced in the 2018-19 MYEFO;
- 10,000 home care packages across all levels in 2019-20 announced as part of the 2019-20 Budget; and

- home care providers required to publish their pricing information in a new standardised schedule from 1 July 2019.

Residential care

- New means testing (combining income and assets test), including annual and lifetime caps, commenced on 1 July 2014;
- new accommodation payment arrangements from 1 July 2014 which allow market-based accommodation prices for all non-supported residents, accompanied by consumer choice to pay by lump sum, daily payment or a combination of both;
- requirements for providers to publish the maximum price they charge for accommodation and extra services, from 1 July 2014;
- higher accommodation supplement payable for supported residents in residential care facilities that were newly built or significantly refurbished since 20 April 2012;
- creation of an Aged Care Pricing Commissioner position in October 2013; and
- rental income from the former home became assessable for all residents who enter care from 1 July 2016 (formerly exempt for residents who made a daily payment for their accommodation).

Cross-program

- Overall target provision ratio for Government subsidised aged care places to increase from 113 places for every 1,000 people aged 70+ to 125 places between 2012-13 and 2021-22;
- creation of a single budget item for home care packages and residential care places from 1 July 2018 that allows flexibility for the Government to direct available funding to home care or residential care in response to consumer preferences;
- establishing the Aged Care Quality and Safety Commission from January 2019 and the commencement of a single set of quality standards across all aged care from 1 July 2019;
- from 1 July 2019, all Commonwealth subsidised residential care facilities must collect and provide clinical quality indicator data to the Department of Health through the National Aged Care Quality Indicator Program. The program had initially started in 2016 as a voluntary program;
- from 1 July 2019, the new Charter of Aged Care Rights will provide the same rights to all consumers, regardless of the type of Commonwealth subsided care and services they receive; and
- further improvements to My Aged Care in 2018-19 and 2019-20.

2.7.1 2017 Legislated Review

The Legislated Review of Aged Care 2017 (the Review), led by David Tune AO PSM, considered the impacts and effectiveness of reforms implemented over the previous five years and included 38 recommendations for future reforms.

The recommendations are designed to move aged care further towards a consumer-focused demand-driven system and to trigger changes that are prerequisites for a fully consumer-driven aged care system. Some do this by targeting better consumer access through better understanding of, and response to, demand, some by improving information and assessment, some by improving sustainability, and others by supporting greater equity in consumer contributions. The latter

includes greater consistency of fee arrangements within and across care types and improved equity in the treatment of different forms of income and assets.

While decisions on some recommendations have already been taken by Government, other recommendations particularly those related to the long-term sustainability of the system, are being considered within the context of long term structural reforms.

In terms of aged care pricing and fees, the Government announced in September 2017 that it does not support recommendations 13 and 15, but did announce in the 2018-19 MYEFO that it will partially implement recommendation 12 by moving towards greater proportionality in home care fees, resulting in a gradual decrease in fees paid by home care recipients with package levels 1, 2 and 3.

To improve the transparency of fees and charges for care recipients, an important element in a consumer driven competitive system, the Government has introduced price publishing requirements for home care providers as per recommendation 11.

2.8 Royal Commission into Aged Care Quality and Safety

In October 2018, a Royal Commission into Aged Care Quality and Safety was established by the Governor-General with Terms of Reference[14] announced by Government. The Royal Commission is looking at the quality of aged care services in Australia, and the future challenges and opportunities for delivering accessible, affordable and high quality aged care services that are person-centred, including through allowing people to exercise greater choice, control and independence in relation to their care.

In December 2018 individuals and organisations were invited to make submissions. The Commission has advised it will accept submissions until at least September 2019 (a date for the closing of submissions will be announced in the second half of 2019). The Royal Commission hearings began in January 2019 and are currently scheduled up until December 2019. An interim report is due by 31 October 2019 and a final report with the Commission's recommendations is to be provided to the Governor-General by 30 April 2020.

In April 2019 ACFA provided a submission to the Royal Commission. ACFA's submission can be found at https://agedcare.health.gov.au/reform/acfas-submission-to-the-royal-commission-into-aged-care-quality-and-safety.

[14] https://agedcare.royalcommission.gov.au/Pages/Terms-of-reference.aspx

3 Access to aged care

This chapter discusses:

- Access to subsidised aged care for older Australians;
- the supply of subsidised aged care; and
- usage of aged care and impacts of a changing population.

This chapter reports that:

- The number of consumers of home care increased from 97,516 in 2016-17 to 116,843 in 2017-18;
- the number of consumers of residential care increased from 239,379 in 2016-17 to 241,723 in 2017-18;
- average occupancy in residential care continues to fall; 90.3 per cent in 2017-18, down from 91.8 per cent in 2016-17 and 92.4 per cent in 2015-16; and
- the proportion of people using home care and residential care at age 85 and over is more than three times that of people aged 70 and over.

3.1 Supply of subsidised aged care

Ensuring access to appropriate quality care remains a fundamental policy objective for the Australian Government in the funding and financing of aged care. However, access to care services needs to be balanced with affordability for both consumers and taxpayers.

The Government regulates the supply of services offered through the Commonwealth Home Support Programme (CHSP) through a capped funding amount that is indexed annually. Similarly, the Commonwealth contribution toward the joint Commonwealth-state funded Western Australian Home and Community Care (HACC) program was also capped and indexed. The Western Australian HACC program transitioned to the CHSP from 1 July 2018 making CHSP a national program. The funding for CHSP and HACC is discussed in Chapter 4.

The Australian Government regulates the supply of home care packages and residential aged care places it funds by specifying targets. These targets, known as the aged care target provision ratios, are based on the number of people aged 70 and over.

The overall aged care target provision ratio was first set in 1985 at 100 operational residential care places per 1,000 people aged 70 and over. The overall provision ratio was increased to 108 in 2004,

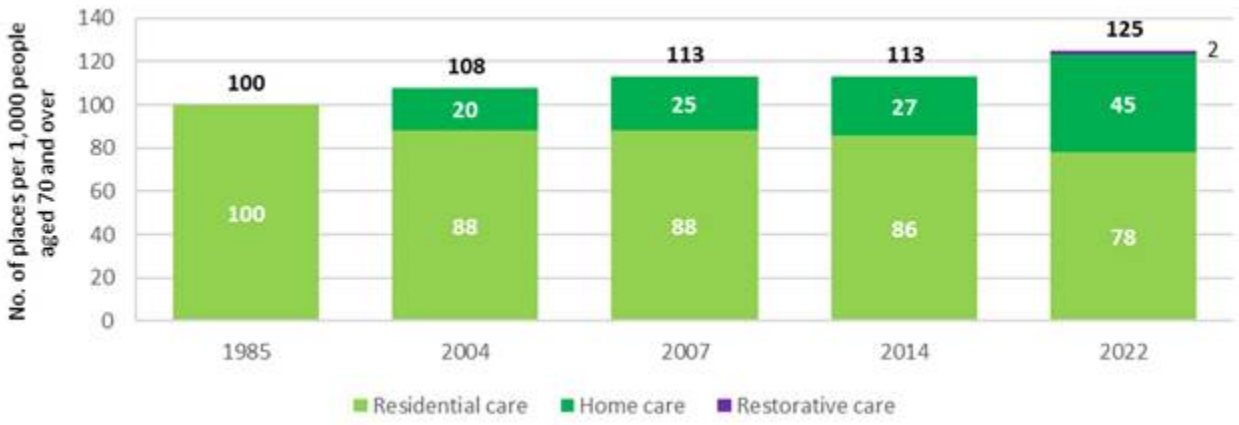
further increased to 113 in 2007, and in 2012 was adjusted to increase progressively to 125 operational places by 2022. Home care packages were first introduced into the ratio in the early 1990s and since then successive Governments have gradually increased home care as a proportion of the overall target provision ratio.

This population-based target provision formula is designed to allow the overall supply of services to increase in line with the ageing of the population, while also defining the total number of places/packages and, thereby, helping control the Commonwealth's expenditure on aged care.

As set in 2012, within the current overall target provision ratio of 125, the mix of home care and residential care is being significantly altered. Over the period 2012 to 2022 the target for home care is increasing from 27 to 45 operational places, while the residential care target is to reduce from 86 to 78. The remaining two places are for the Short Term Restorative Care Programme (STRC).

Chart 3.1 shows the changes in the target ratios since 1985 and the planned increase through to 2022.

Chart 3.1: Increase in target provision ratios, 1985-2022



Implementation of the current target provision ratio will continue to see an overall increase in the supply of home care packages and residential care places. However, the changes result in the number of home care packages increasing at a faster rate than residential care places, which reflects the Government's response to the increasing number of consumers wishing to remain in their own homes.

Up until and including 2015-16, the Department published achieved ratios for the overall provision target and for both home care and residential care in a consistent and comparable way, based on the number of operational places (operational places included allocated places that are vacant). The calculation of this ratio on this basis is still possible in residential care, but no longer possible for home care since February 2017 when packages were directly assigned to consumers. As a result, last year's ACFA report did not include achieved ratios for either the overall target provision ratio or the home care target ratio.

The Department has since calculated and published achieved ratios for home care for 2016-17 and 2017-18 based on the number of consumers in a package, plus the number of consumers who have been offered a package but who have not yet accepted the offer and whose offer still remains open (i.e. within 56 days of offer). The latter effectively substitutes for formerly vacant packages. While not directly comparable to previous years, it can be used to broadly monitor progress towards the achievement of the overall provision target ratio and home care ratio.

Chart 3.2 shows the achieved overall provision ratio and the achieved home care and residential care ratios for the 10 years to 30 June 2018. The chart also shows the target of 45 for home care and 78 for residential care to be reached by 2022.

Chart 3.2: Home care and residential care achieved ratios, 2007 to 2018, and target ratios 2022

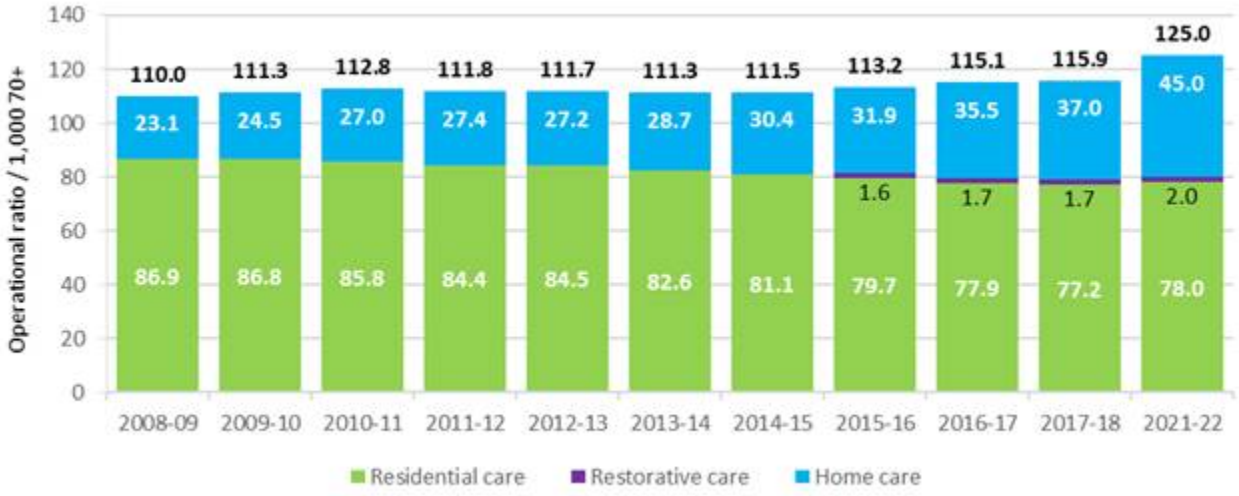
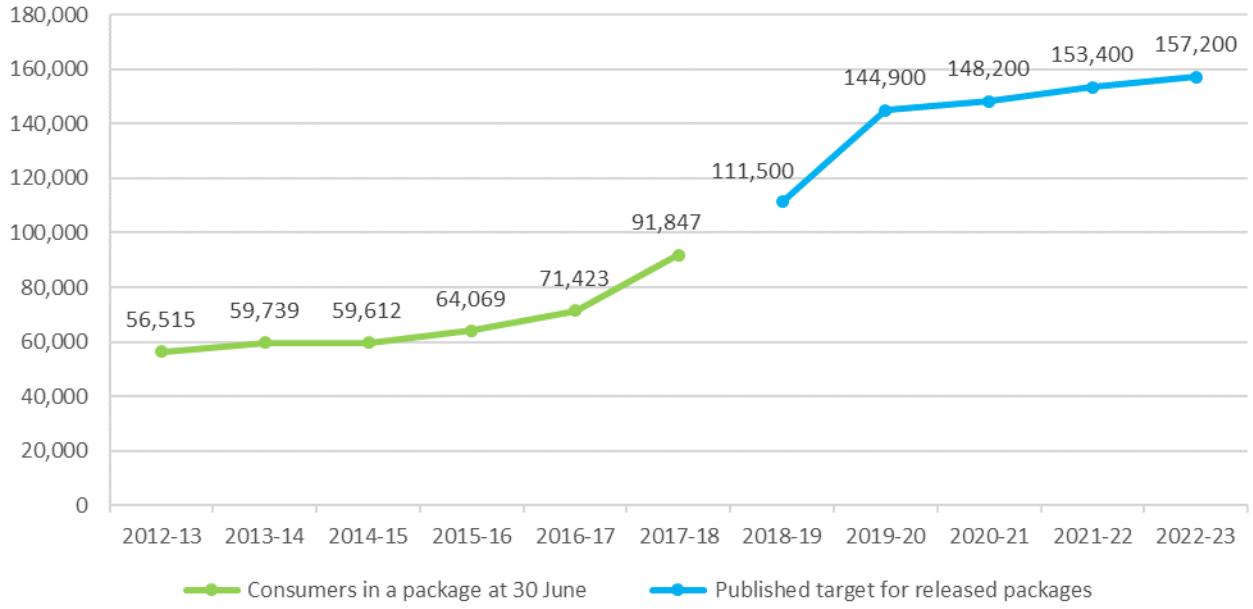


Chart 3.3 shows the number of consumers with a home care package as at 30 June for each of the previous six years, as well as the target number of packages to 2022-23 published in the Department of Health's 2019-20 Portfolio Budget Statement. While the historical and forward estimates numbers are not directly comparable, the chart gives some indication of the increase in home care packages that is planned to be released.

Chart 3.3: Home care consumers, 2012-13 to 2017-18 and published target packages to be released, 2018-19 to 2022-23



The target ratio approach applied to home care packages and residential care places does not apply to the supply of care through the CHSP. Instead, CHSP funding is subject to an annual capped funding allocation, and CHSP providers are grant funded to provide contracted home support services. Consumers who are assessed as eligible through their Regional Assessment Service (RAS) to receive CHSP services can then access those services through a provider who delivers the services for which they have been assessed.

The CHSP is discussed in Chapter 4.

3.2 Aged Care Approvals Round

Unlike home care packages, new residential care places are still allocated to providers through a competitive Aged Care Approvals Round (ACAR).

The Australian Government announced the results of the 2018-19 ACAR[15] on 5 March 2019. Through this ACAR, 13,500 new residential care places were allocated. These places have an estimated annual recurrent funding value of $907 million. This represents an increase of 36 per cent on the 9,911 ACAR places allocated in 2016–17. The 2018-19 ACAR is the largest ACAR, although with no ACAR conducted in 2017-18, the 2018-19 ACAR is effectively allocating more than one years' worth of places. A breakdown of the allocated places by state and territory is in Table 3.1.

A small proportion of the 13,500 residential care places initially made available for allocation were not allocated in the advertised state/territory due to insufficient suitable applications from the Northern Territory, Australian Capital Territory and Tasmania.

- 99 places were not allocated in the Northern Territory from a total of 149 available.
- 158 places were not allocated in the Australian Capital Territory from a total of 360 available.
- 51 places were not allocated in Tasmania from a total of 212 available.

This is similar to what occurred in the 2016-17 ACAR. The 308 unallocated residential care places were re-allocated to New South Wales, Victoria and South Australia.

The 2018-19 ACAR saw the continuation of the trend for a majority of places to be allocated to for-profit providers, with 66 per cent of available places allocated to for-profits. This trend in recent ACARs is reflected in a gradual increase in the proportion of operational places held by for-profit providers, which has increased from 36 per cent in 2012 to 40.5 per cent at 30 June 2018.

The 2018-19 ACAR saw $60 million in capital grants allocated (through the Rural, Regional and Other Special Needs Building Fund) to help aged care providers to construct new or upgrade existing residential care facilities. The capital grants were approved for 28 projects involving 286 new places. The grants targeted services for rural and remote, Indigenous, financially and socially disadvantaged and CALD communities, with the bulk of the funding going to non-metropolitan areas.

In addition to the ACAR, through a separate measure announced in the 2018-19 Budget, $40 million was allocated for infrastructure investment in both residential and home care through The Aged Care Regional, Rural and Remote Infrastructure Grant. This funding is being paid during

[15] https://agedcare.health.gov.au/funding/aged-care-approvals-round-acar/2018-19-aged-care-approvals-round/results

2018-19 and 2019-20 and was designed to target funding in regional, rural and remote regions where services may not have access to infrastructure funding.

The Government also announced the successful applicants for the 775 new STRC places through the 2018-19 ACAR.

The demand for residential care places in the 2018-19 ACAR was not as strong as in recent ACARs. There were 2.8 applications for every available place compared with 4.5 for the 2016-17 ACAR.

Table 3.1: 2018-19 ACAR results summary

State/territory	Residential care places	Estimated annual recurrent funding ($m)	Capital grants ($m)
New South Wales	3,485	$234.2	$14.0
Victoria	1,521	$102.2	$9.9
Queensland	4,289	$288.2	$11.1
Western Australia	3,295*	$221.4	$10.1
South Australia	497	$33.4	$10.7
Tasmania	161	$10.8	$4.2
Australian Capital Territory	202	$13.5	-
Northern Territory	50	$3.4	-
Australia	**13,500**	**$907.1m**	**$60m**

*As at 5 March 2019, the above places include deferred allocations for 244 residential care places in Western Australia, in respect of applicants who are awaiting the required approved provider status.

3.3 Access to aged care

In 2017-18 around 1.3 million older Australians accessed some form of Government subsidised aged care. Table 3.2 shows the number of consumers of the three types of aged care that this report mainly discusses (home support, home care and residential care) since 2013-14.

Table 3.2: Aged care in Australia, number of consumers, 2013-14 to 2017-18

	2013-14	2014-15	2015-16	2016-17	2017-18
Home support	775,959	812,384	925,432[16]	784,927	847,534
Home care	83,144	83,838	88,875	97,516	116,843
Residential care	231,515	231,255	234,931	239,379	241,723

[16] The number of consumers of home support in 2015-16 (925,432) includes 285,432 for Vic and WA HACC and an estimate of over 640,000 in the CHSP as accurate data was not available. Due to the lack of accurate data and differences in counting methods the CHSP consumers for 2015-16 are likely overstated.

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3.4 Access to home care

The number of older Australians who received home care during 2017-18 was 116,843, an increase of 20 per cent from 97,516 in 2016-17. As at 30 June 2018 there were 91,847 consumers in a package, up from 71,423 as at 30 June 2017. Chart 3.4 shows the significant increase in consumer numbers, particularly in 2017-18. Chart 3.5 shows the increase in consumers, by package levels, since 2014-15.

Chart 3.4: Number of home care consumers in a package, 30 June 2013 to 30 June 2018

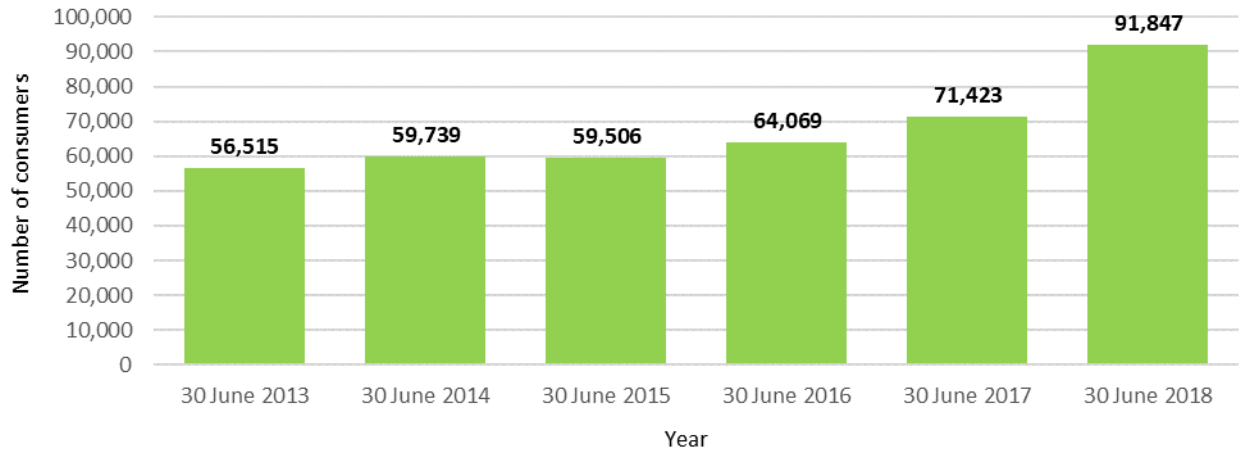


Chart 3.5: Number of home care consumers, by package level, 2014-15 to 2017-18

3.4.1 Release of home care packages

Since February 2017, home care packages have been assigned directly to consumers rather than allocated to providers. This allows consumers to direct their package to the provider of their choice as well as change providers.

Older Australians assessed as requiring home care are placed on the National Prioritisation System based on how long they have been waiting for care and their individual needs and circumstances, regardless of where they live. Packages are periodically released and assigned directly to consumers by the Department of Health within My Aged Care. Packages are assigned to consumers according to when they were approved for home care and urgency of need.

The number of packages released at each level takes into account the number of new packages that are available (having regard to the phased increase in the target home care provision ratio), the number of packages that consumers have exited or not accepted in previous weeks, as well as the amount of unspent Commonwealth funds that have been returned when consumers leave home care. While the total number of packages will increase each year, the number of packages at each funding level will continue to be capped in line with the aged care target provision ratio and the available budget.

3.4.2 Demand for home care packages

ACFA has previously noted that unmet demand for home care is long standing, but was not able to be quantified until the implementation of the National Prioritisation System for assigning packages directly to consumers. The number of people waiting for a package has been increasing since the changes were implemented in February 2017.

Data from the Department of Health shows that as at 31 December 2018 there was a total of 127,748 people waiting for a package. This is an increase of approximately 6,000 in the six months since 30 June 2018. There were 26,220 approvals for home care in the three months to 31 December 2018, of which 56 per cent were for higher level (3 and 4) packages. Although around 75 per cent of the 127,748 people waiting for a package, also had approval for permanent residential care, declining occupancy rates in residential care illustrates the preference of older people for home-based aged care services.

At 31 December 2018, there were 73,978 people waiting on a home care package at their approved level, who had not yet been offered access to a lower level package. Of these people, 93.9 per cent (69,476) had been provided with an approval to access support through the Commonwealth Home Support Program (CHSP).

At 31 December 2018, there were 53,770 people who were waiting for a home care package at their approved level, who had already been offered a lower level package. Of these people, 29,858 were receiving care through a lower level package, 6,270 were deciding on whether to take up a package and 17,642 had not taken up their previous offer(s) of a lower level package.

Information from the Department of Health indicates that waiting times for people to access a package vary depending on package level. People approved for a level 4 package are waiting in excess of 12 months to be assigned a package at any level. People approved for a level 3 package can wait up to six months for an interim package at level 1, but still wait more than 12 months for their assigned package level.

In the 2018-19 Budget, the Government announced a re-profiling of home care packages that will see 14,000 additional higher level packages being released sooner than originally planned.

Since this Budget announcement there have been two additional changes to future home care package releases, aimed at further re-profiling of package releases.

In the 2018-19 Mid-Year Economic and Fiscal Outlook (MYEFO) the Government announced an additional 10,000 higher level packages to be funded in 2018-19, followed by a further 10,000 packages (including 4,500 higher level packages) included in the 2019-20 Budget for release in 2018-19 and 2019-20.

ACFA notes that while the overall effect of these re-profiling changes is to increase the proportion of higher level packages earlier than originally budgeted for (at significant cost to the Budget) and achieve an approximately 50/50 split of higher and lower level packages by 2021-22, the planned growth in total packages numbers by 2021-22 (to 153,437 packages) is broadly in line with the target set in 2012 when the target provision ratio was set at 45 packages per 1,000 people aged 70 and over.

The creation in the 2018-19 Budget of a single budget item for home care packages and residential care places may provide some flexibility to direct available funds to meet the emerging demand for home care packages if demand for residential care reduces.

3.4.3 Length of stay in home care

Length of stay in home care differs between package levels.

For people who entered care in 2015-16, around half the recipients of level 2 packages stayed at their package level for about 15 months and around a quarter stayed over 40 months. By contrast, for those people entering a level 4 package, around half leave care within 13 months and a quarter remain in care for up to 30 months.

For people that entered home care in 2016-17, around half the recipients of level 2 packages stayed at their package level at least 18 months. By contrast, for those people entering a level 4 package, around half leave care within 14 months. This suggests that length of stay in home care is slightly increasing in recent years irrespective of care level.

However, given that many consumers first enter care accessing a package lower than their assessed need and the end of cross subsidisation since the creation of individual budgets, care is needed in how length of stay data is interpreted.

3.5 Access to residential care

The number of older Australians who received permanent residential care during 2017-18 was 241,723, up from 239,379 in 2016-17, an increase of 1 per cent. At 30 June 2018 there were 180,923 residents in care.

As has been the case in recent years, the number of people accessing residential respite care is increasing proportionally faster than those accessing permanent residential care. The number of people who accessed respite care in 2017-18 was 61,993, an increase of 4.4 per cent from 59,228 in 2016-17. Residential respite care usage is discussed later in this chapter.

3.5.1 Occupancy in residential care

Occupancy is measured as the total number of days an allocated place is occupied by a resident, divided by the total number of days an allocated place was available to be occupied. Occupancy rates reflect both demand and the number of places available. In 2017-18, the average occupancy rate across all residential care places was 90.3 per cent, down from 91.8 per cent in 2016-17 and 92.4 per cent in 2015-16. This decline over the last two years follows relative stability for several years at above 92 per cent.

The occupancy rate is comprised of both a numerator and a denominator. The numerator is the number of care days provided and the denominator is the number of bed days that providers had available (based on operational places).

The 1.5 percentage point decline in the occupancy rate in 2017-18 was contributed to by the growth in the number of bed days available (3.0 per cent) which grew at twice the rate of the growth in care days provided (1.4 per cent). Both the for-profit and not-for-profit sectors had faster growth in the available bed days compared with days of care provided (Table 3.3).

Table 3.3: Growth in residential care claims and growth in available beds between 2016-17 and 2017-18

Provider type	Claim day growth	Bed day growth
Not-for-profit	0.9%	1.9%
For-profit	2.5%	5.1%
Government	-2.3%	-2.3%
All providers	1.4%	3.0%

The overall average occupancy rate in residential care peaked at 97.1 per cent in 2003-04.

In terms of ownership type, not-for-profit providers continue to have the highest occupancy at an average of 92.1 per cent in 2017-18, down from 93.0 in 2016-17 and 94.0 per cent in 2015-16 (Table 3.4). For-profit providers recorded a significant decline from 90 per cent for 2016-17 to 87.9 per cent in 2017-18.

Table 3.4: Occupancy rates, by organisation type, 2013-14 to 2017-18

Provider type	2013-14	2014-15	2015-16	2016-17	2017-18
Not-for-profit	94.6%	94.0%	94.0%	93.0%	92.1%
For-profit	91.0%	91.0%	91.0%	90.0%	87.9%
Government	90.0%	89.0%	90.0%	90.0%	90.3%
All providers	**93.0%**	**92.5%**	**92.4%**	**91.8%**	**90.3%**

There are also variations in occupancy by state and territory, as has been the case in previous years. The Northern Territory continues to have the highest occupancy with 94.4 per cent (95.4 per cent in

2016-17) while Queensland recorded the lowest with 89.1 per cent after being relatively high in recent years. Table 3.5 shows occupancy by state and territory for the last five years.

Table 3.5: Occupancy in residential care, by state and territory, 2013-14 to 2017-18

State/territory	2013-14	2014-15	2015-16	2016-17	2017-18
New South Wales	93.1%	92.5%	92.3%	91.1%	89.5%
Victoria	92.5%	91.6%	91.7%	91.1%	90.2%
Queensland	92.8%	92.7%	92.2%	92.3%	89.1%
Western Australia	94.5%	94.4%	94.5%	93.8%	93.2%
South Australia	93.9%	92.3%	93.7%	93.5%	93.4%
Tasmania	92.1%	90.6%	91.0%	91.2%	90.2%
Australian Capital Territory	95.5%	94.5%	88.6%	90.1%	91.0%
Northern Territory	86.0%	92.8%	95.0%	95.4%	94.4%
Australia	**93.0%**	**92.5%**	**92.4%**	**91.8%**	**90.3%**

There remains sizable variation in occupancy rates by remoteness location. In 2017-18 the occupancy in very remote areas was significantly less than in all other locations, as was the case in previous years. The occupancy in remote areas is also around 2-3 per cent lower than in the cities and regional areas.

Table 3.6 shows occupancy in residential care by location over the last five years.

Table 3.6: Occupancy in residential care, by location, 2013-14 to 2017-18

Provider location	2013-14	2014-15	2015-16	2016-17	2017-18
Major cities	93.2%	92.6%	92.4%	91.4%	90.0%
Inner regional	92.9%	92.4%	92.5%	92.7%	91.4%
Outer regional	92.4%	92.1%	92.0%	92.2%	90.8%
Remote	88.6%	86.5%	89.7%	91.7%	88.4%
Very remote	84.4%	84.8%	80.0%	77.4%	77.1%
Australia	**93.0%**	**92.5%**	**92.4%**	**91.8%**	**90.3%**

In ACFA's consultation with the sector, some providers have expressed concern that falling occupancy rates will put pressure on the viability of some residential aged care facilities. This could be a growing issue in future years. The Government has announced in-principle support to the proposal to transition the allocation of residential care places from the current Aged Care Approvals Round (ACAR) approach to alternative arrangements that provide greater choice for

older Australians. The Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology Sydney, in collaboration with aged care accounting and business advisory firm StewartBrown and the Department of Health, are undertaking an impact analysis looking at potential alternative arrangements[17]. One of the options would be to move to a model, similar to home care, where the consumer is assigned a residential care place. This would create greater competition for consumer custom, potentially putting further pressure on occupancy rates for some providers.

3.5.2 Admissions to residential care

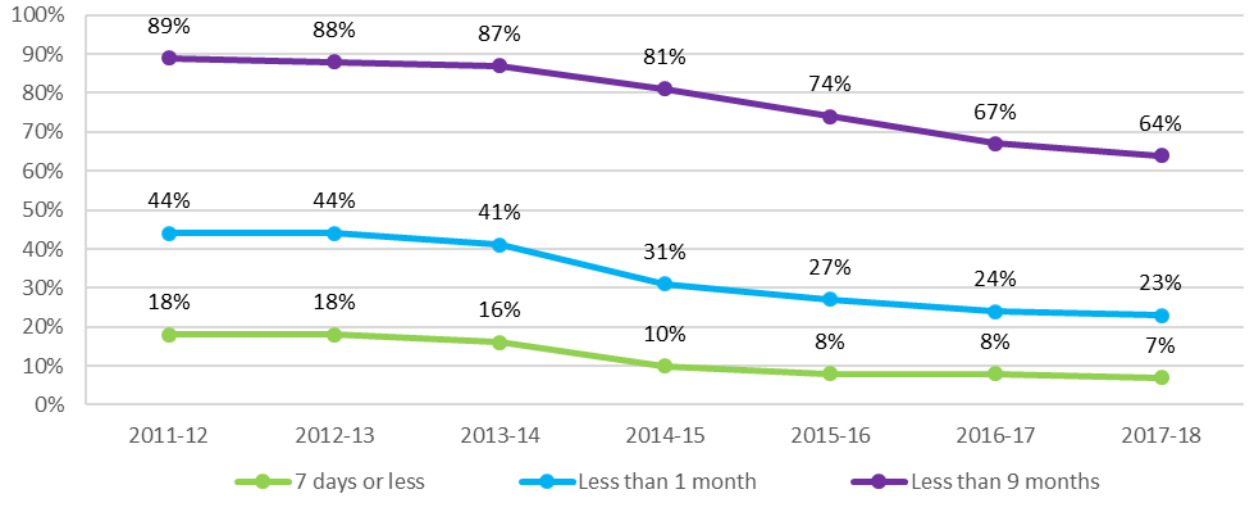
Elapsed time between when a resident is assessed as eligible for residential care and entering permanent care continues to increase (Chart 3.6). This trend has been evident since 2011-12 however has been more obvious since 2013-14. In 2017-18:

- 7 per cent of people entering care did so within one week of being assessed by an ACAT (18 per cent in 2011-12);
- 23 per cent did so within one month (44 per cent in 2011-12); and
- 64 per cent did so within nine months (89 per cent in 2011-12).

However, as ACFA has previously noted, the delay between an assessment of eligibility and a person entering care could be due to consumer choice and not necessarily delays in the system.

The increasing availability of and preference for home care and the increased usage of residential respite care could also be contributing to the longer time between assessment and entering permanent care.

Chart 3.6: Elapsed time between assessment and entering permanent residential care, 2011-12 to 2017-18 (%)



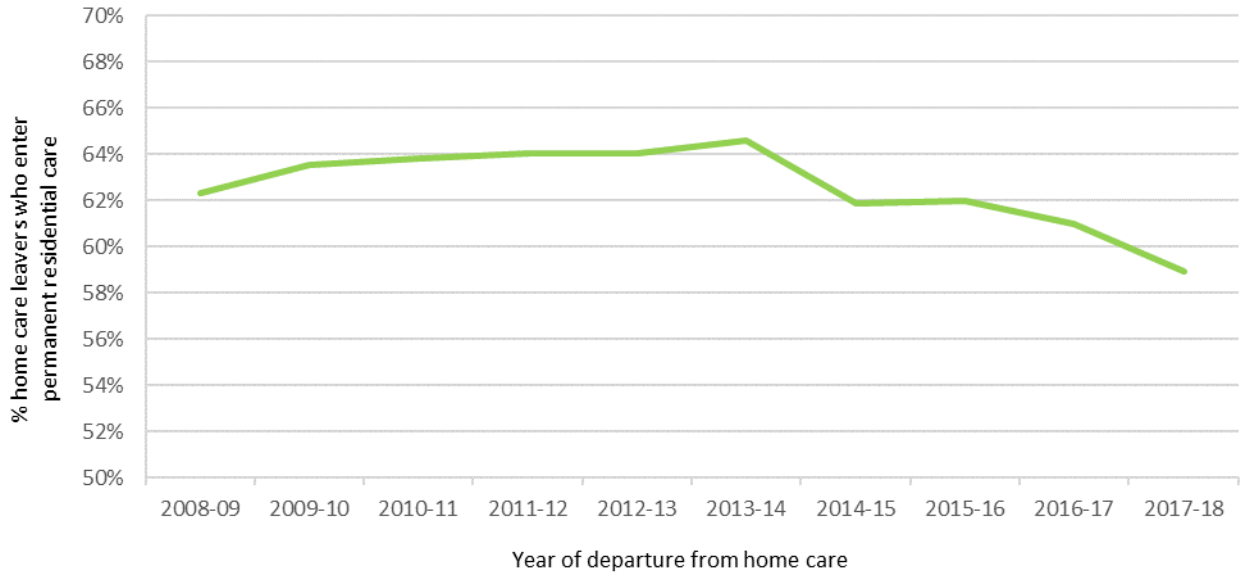
[17] https://agedcare.health.gov.au/funding/impact-analysis-of-alternative-arrangements-for-allocating-residential-aged-care-places

Consumers transitioning from home care to residential care

Chart 3.7 shows the proportion of consumers who enter permanent residential care after leaving home care. The proportion entering residential care was relatively stable at around 60 per cent for the years leading up to the introduction of the Aged Care Funding Instrument (ACFI) in 2008, when it increased to around 63 per cent. Since the start of the major reforms in 2014, the proportion has dropped to below 60 per cent and continued to decrease to below 59 per cent in 2017-18.

This could be partly explained by the increased availability of higher level home care packages, and home care packages overall, which may impact on the proportion of package holders transferring to residential care. ACFA will monitor trends in transfers over the next few years during which a significant increase in the number of packages and the proportion of higher level packages is planned.

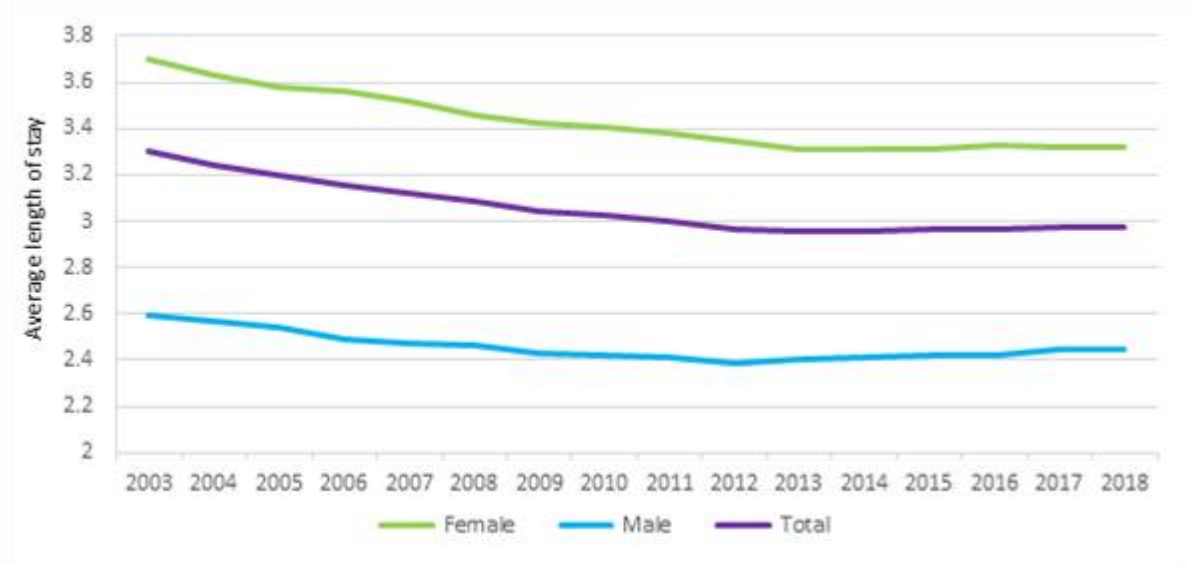
Chart 3.7: Proportion of consumers entering permanent residential care after leaving home care, 2008-09 to 2017-18



3.5.3 Length of stay in residential care

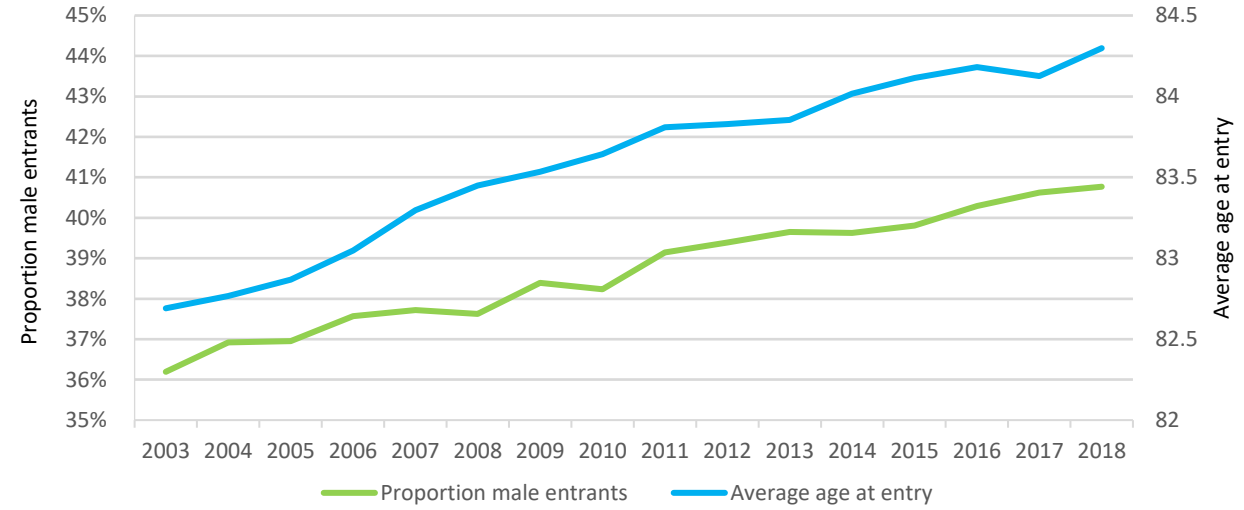
The average length of time between first admission into permanent residential care, and final discharge, was decreasing gradually from around 3.3 years in 2003 to just below 3 years in 2012. Since then it has stabilized and in 2018 the average length of stay (LOS) of those leaving residential care was 2.97 years. There remains a very significant difference between males and females, with females staying in care, on average, 10 months longer than males (Chart 3.8).

Chart 3.8: Average length of stay in residential care, by gender and year of entry, 2003 to 2018



Two drivers of this decrease in LOS have been an increasing average age of entry (both male and female) and an increasing proportion of male residents. Older residents and male residents have shorter average LOS, so increasing proportions of these residents result in a shorter average LOS. Chart 3.9 shows both of these indicators, with the proportion of male entrants increasing from 36 per cent in 2003 to 41 per cent in 2018, and the average age of entry increasing from 82.7 to 84.3 over the same period.

Chart 3.9: Changes in age and gender distribution, 2003 to 2018



The proportion of permanent residents that leave within three, six or 12 months of first entry increased from 2003-04 to 2013-14 (Chart 3.10), which is in line with a decreasing average LOS. However, since 1 July 2014, this proportion has tended to decrease, which will likely have an upwards impact on average LOS. However 2016-17 saw people leaving within 12 months increase slightly.

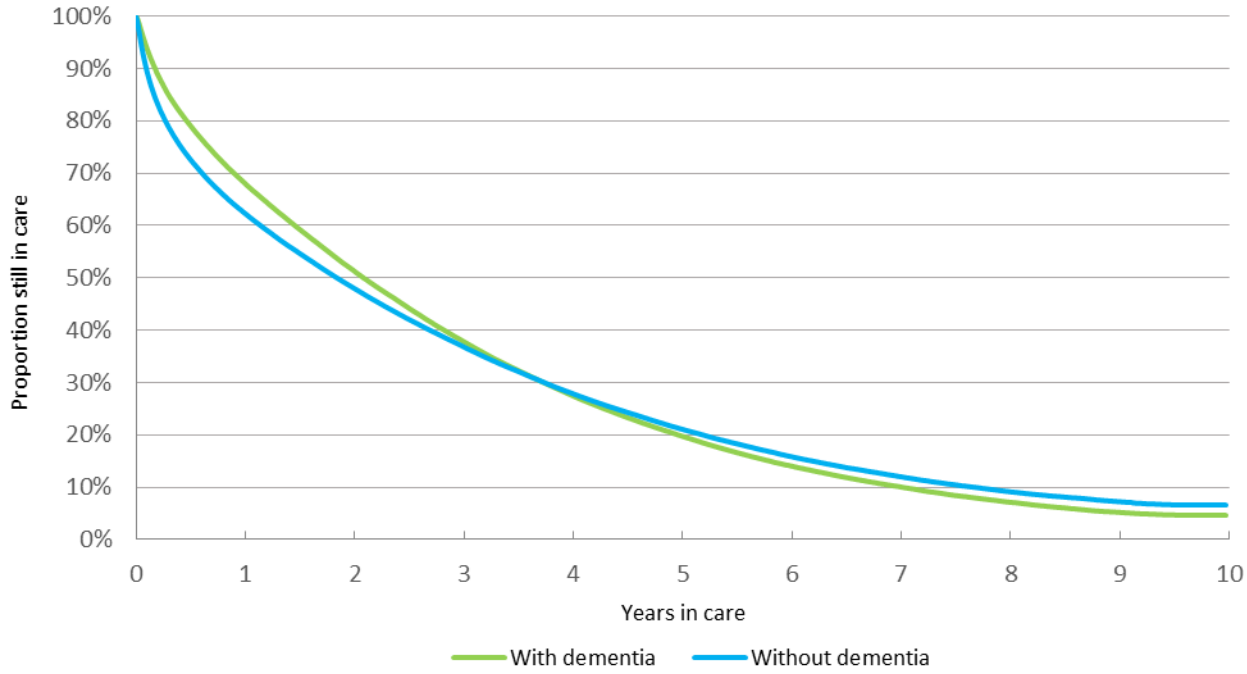
Chart 3.10: Proportion of permanent residents that leave within 3, 6 or 12 months of first entry, 2003-04 to 2017-18

Dementia

Since 2008-09, the proportion of people entering residential care with a diagnosis of dementia has been consistently between around 43 per cent and 45 per cent of all permanent residents entering care, and the average age at admission for people with dementia was around six months older than for those without a diagnosis of dementia.

Chart 3.11 shows the proportion of people still in care over time by dementia status (diagnosis of dementia recorded within first 28 days of admission). It shows that half of the people entering without a dementia diagnosis died or left care within 22 months; compared with around 25 months for people entering care with an initial diagnosis of dementia. People with dementia are less likely to die or leave care in the initial period after entry, however in the longer-term, proportionally fewer people with dementia have longer lengths of stays when compared with those that do not.

Chart 3.11: Proportion of residents in care over time, with and without dementia



3.6 Residential respite care

Residential respite care is short-term care delivered within an aged care facility[18] on either a planned or emergency basis. People are assessed for eligibility by an Aged Care Assessment Team (ACAT), who will approve someone for low care respite or high care respite. The distinction between high and low care was not removed from respite care when it was removed from permanent residential care on 1 July 2014. A consumer can access residential respite for up to 63 days per financial year, with extensions possible when an ACAT considers it necessary.

As noted previously, a significant difference in respite care compared with permanent residential care is that respite residents do not make any means-tested accommodation or care contributions. They can however be asked to pay the basic daily fee for living expenses, which is at the same rate as permanent residents. Respite residents can also purchase additional services, in the same manner as a permanent resident.

Residential care providers have a proportion of their allocated residential care places which may be used for the provision of respite care, and it is up to each provider what mix of permanent and respite care that they provide. Providers can vary this proportion, however currently they have to contact the Department of Health to seek approval.

Access to respite services will depend on a person's need/choice to access this type of care and on an approved provider's willingness and ability to provide respite care.

In its 2017 annual report ACFA discussed the increasing usage of residential respite care since 1 July 2014. Although there were no changes made to the operation of residential respite care, since 1 July 2014 the rate of increase in consumers of respite care is more than triple that of the increase of permanent residents. Following a request from the Minister for Aged Care, ACFA prepared a report on the increasing use and appropriateness of respite care. ACFA provided its

[18] Other types of respite care can be accessed through the CHSP or through a home care package.

Report on respite for aged care recipients[19] to Government in October 2018. ACFA made 19 recommendations concerning key issues around access, funding, consumer fees, administrative processes, and the availability of respite care.

Recommendations from ACFA's report on respite for aged care recipients.

1. Recognising respite care as a vital component of aged care services and, that the Government should implement policies to facilitate a sufficient supply of the different types of respite services to meet care recipient and carer needs and preferences.
2. Ensuring the needs of carers, as well as care recipients, are recognised when assessing access to respite care.
3. Establishing funding arrangements that are neutral between respite residents and permanent residents, and not act as a disincentive to respite care.
4. Ensuring access to, and suitability of, care for special needs groups, including people with dementia, needing bariatric care, and from CALD communities.
5. Recognising that consumers should make an appropriate contribution towards the cost of their respite care and accommodation where they can afford to do so, with appropriate support from the Government where consumers are not able to contribute.
6. Ensuring consistency with other potential reforms, including that consumer fees for respite care be considered in conjunction with wider changes to consumer care fees, such as better integration of fees more broadly in the residential, home care and CHSP sectors as recommended by the Legislated Review.
7. Facilitating care recipients' and carers' easy access to information on respite care options (through CHSP, home care, residential and other DSS services) and in doing so help care recipients and carers readily obtain care when and where they need it.
8. Ensuring Government agencies adopt a co-ordinated approach to the delivery of, and information dissemination around, respite care, including working with providers to establish real time information on the availability of respite care.
9. Recognising that the use of respite care for purposes other than supporting people to live at home for as long as possible and their carers can be responding to a market demand for other uses of respite, but that this should not be crowding out consumers with genuine respite care needs.
10. Examining the need for specific arrangements that facilitate the transition of a resident into permanent care, particularly in the context of the current review of residential aged care funding models following the RUCS exercise.

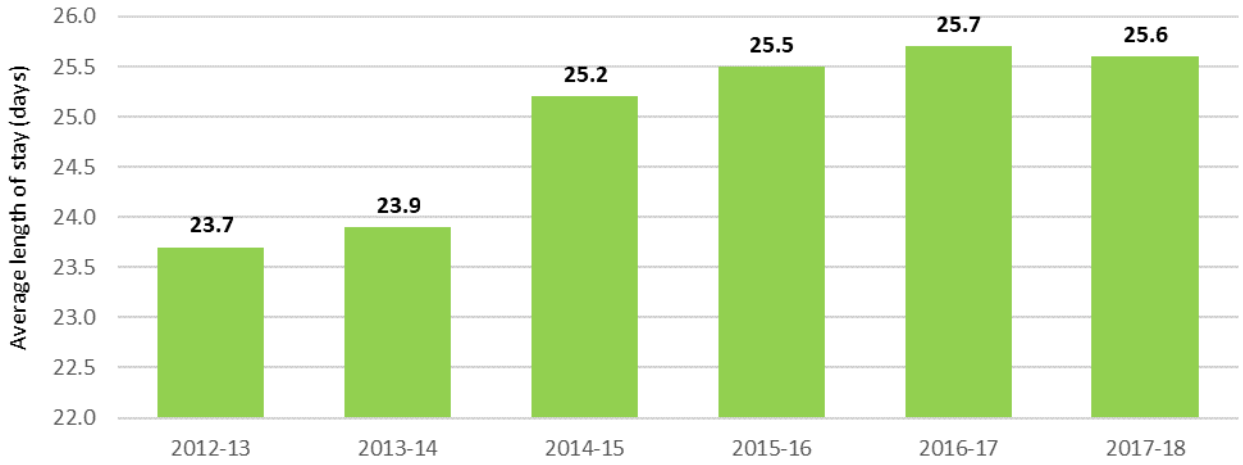
[19] https://agedcare.health.gov.au/acfas-report-on-respite-for-aged-care-recipients

11. Allowing the market to respond to consumer demand and in turn the numbers of respite places that providers offer based on funding arrangements that do not act as a disincentive or incentive to the provision of respite care. Given that respite care is central to the aged care system, there should be an expectation that all providers be prepared to offer respite care.
12. If neutrality in the funding of respite and permanent residential care is achieved, the Government should remove the minimum and maximum allocation rules for respite care and allow providers respond to consumer demand for respite, subject to appropriate transitional arrangements and monitoring of the impacts of such as change on respite availability.
13. Renaming the current respite care supplement as the respite care accommodation supplement to reduce confusion as to its purpose and paying the supplement irrespective of whether a person has been assessed as low or high level care, with rates aligned with those that apply for permanent residents .
14. Reviewing the respite incentive supplement in the context of the outcomes of the University of Wollongong work on broader residential care funding reform. If the relative rates of funding between respite residents and permanent residents are set appropriately, there may not be a need for a separate incentive supplement with all the associated administrative red tape that it brings.
15. Recognising that if the incentive supplement is to continue, the administrative processes that support the incentive supplement are inefficient and should be changed. The current process whereby some providers have a minimum respite allocation and others a maximum allocation is highly confusing and likely contributes to some providers missing out on respite subsidy they should receive.
16. Reconsidering the limitation of 63 days per year per respite client in residential care because it imposes administration burdens on providers, consumers and the Government, and is not readily tracked. ACFA recommends keeping a cap on respite care, but suggests that consideration be given to whether it be less than 63 days and to introducing some form of means testing after a specified period of respite use. The latter would address concerns that other uses of respite care may crowd out respite for supporting people wishing to live at home for as long as possible (and their carers).
17. ACFA does not see the need for any changes to how home care packages can be used to access respite care. While there are issues around different fee structures which should be considered, the purchasing of respite care should remain an appropriate use of home care packages.
18. Similarly, noting that other than in relation to fee contributions, ACFA does not consider there is a need for any major changes to how CHSP respite services are offered.
19. Recognising that cottage respite is in effect another type of short-term residential respite care, when considering neutrality of funding settings following the RUCS study, consideration be given to whether the current funding model for cottage respite is appropriate.

3.6.1 Length and frequency of stay in residential respite care

During 2017-18, 61,993 people received residential respite care. Of these, on average, each person had 1.4 respite care stays[20] with each stay being an average of about 26 days. Until 2014-15 the average stay had been stable at just below 24 days however it has since risen to be between 25 and 26 days, as shown in Chart 3.12. For home care package consumers who access residential respite care, the average length of stay is shorter, at around 22 days and has remained stable since 2014-15.

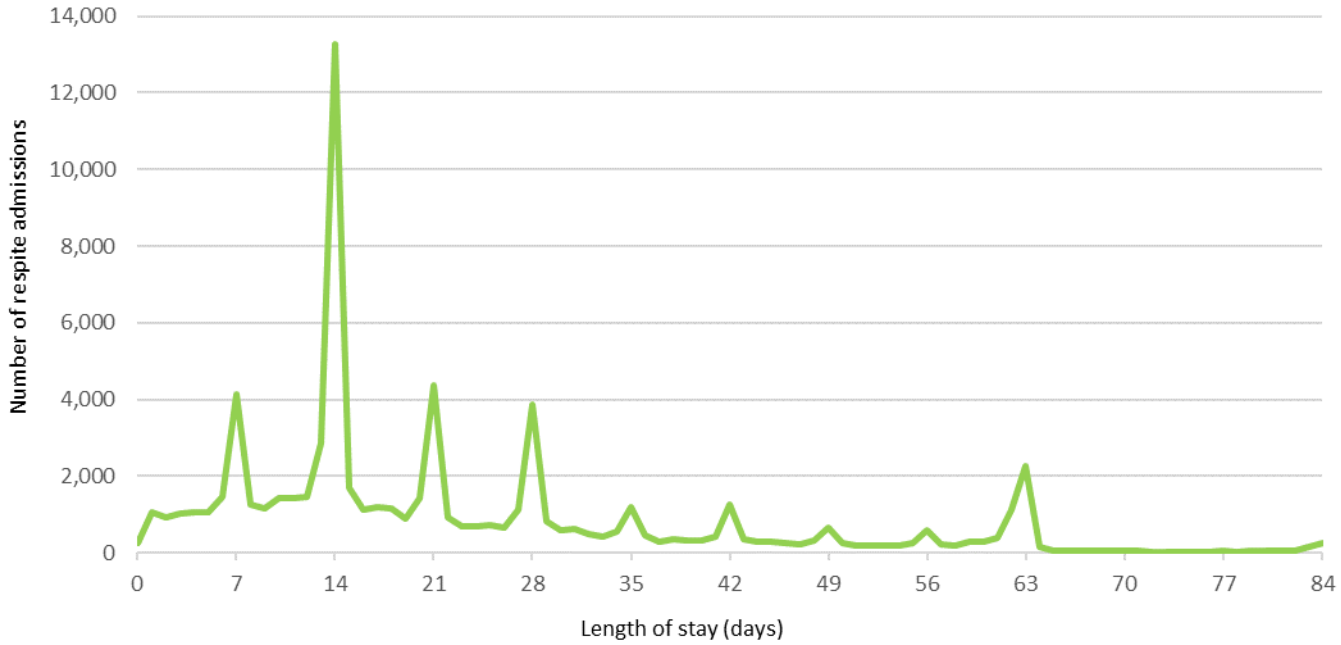
Chart 3.12: Average length of stay (days) in residential respite care, 2012-13 to 2017-18



As has been the case in previous years, a clear pattern of respite care usage in 2017-18 was that it was usually for stays of whole weeks at a time (Chart 3.13). A fortnight is by far the most common residential respite care length of stay. One, three and four weeks are the next most common lengths of stay. Around 4 per cent used the maximum of 63 days in one stay. These usage trends have been stable in recent years.

[20] A residential respite 'stay' refers to a single stay and is from when they enter to when they exit, no matter the duration.

Chart 3.13: Frequency of length of respite care stays, 2017-18

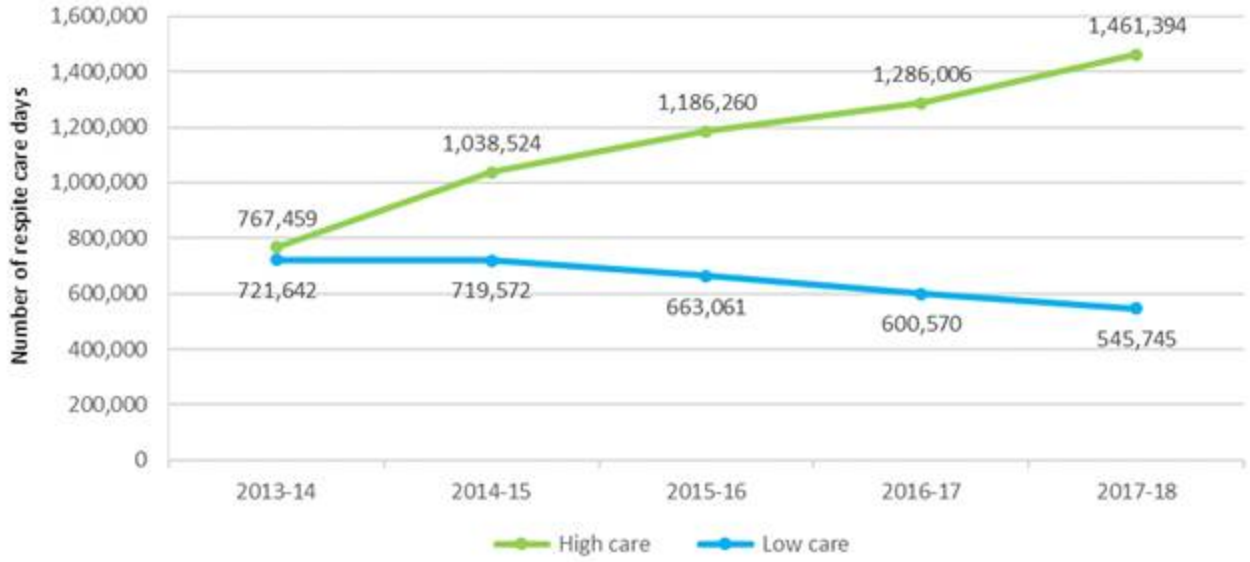


ACFA noted in its report on respite care that, in general, this pattern of respite use is provider driven, primarily due to the relatively high cost of the admission process in residential care. Feedback through consultation was that for many providers offering respite care, providing less than two weeks of residential respite is financially unviable. The feedback from consultation with consumers, however, suggested they would prefer access to shorter periods of respite care.

3.6.2 High and low residential respite care

A trend that has been emerging since 2014-15 and continued in 2017-18 is that the number of respite consumers accessing high level respite care is increasing while the number accessing low level respite care is decreasing (Chart 3.14). This was also discussed in ACFA's report on respite care with ACFA noting the significant difference in funding for providers between high and low care was potentially serving as a disincentive to providers taking respite consumers who had only been approved for low level care. As can be seen, the number of days of high and low level respite care provided were almost the same in 2013-14, whereas in 2017-18, 73 per cent of respite days were for high care consumers.

Chart 3.14: Number of residential respite care days, by level, 2013-14 to 2017-18



One of the recommendations from the 2018 Respite care report was that funding for respite care should be neutral between respite care and permanent residential care and also neutral between high and low care respite consumers, so that providers did not face a financial disincentive to provide respite care. As discussed in Chapter 6, ACFA suggests there would be merit in introducing changes to respite care at the same time as changes are made to broader funding arrangements.

3.7 Supported residents

The Australian Government supports access to permanent residential care by consumers who are assessed as not being able to meet all or part of their own accommodation costs by paying providers an accommodation supplement on their behalf. These residents are known as supported (or low-means) residents.

Since the aged care reforms of 1 July 2014, eligibility for a full or partial accommodation supplement is determined by a combined assessment of an individual's income and assets (the means test).

The amount of accommodation supplement received by a provider on behalf of a supported resident depends on:

- the outcome of the resident's means test assessment;
- whether the residential care facility has been built or significantly refurbished since 20 April 2012; and
- whether the facility provides more than 40 per cent of its care days to supported residents.

Providers have discretion to determine the proportion of supported residents in their facilities. However providers with 40 per cent or fewer supported residents in a facility (excluding those residents receiving extra services) have the accommodation supplement they receive for all supported residents in that facility reduced by 25 per cent.

As shown in Table 3.7 and Table 3.8 the proportion of supported residents was relatively stable in 2017-18 compared with 2016-17. The trend evident in recent years of a higher proportion of supported residents in regional and remote locations compared with metropolitan areas has continued in 2017-18. Also not-for-profit providers continue to have a higher proportion of supported residents compared with for-profit providers.

The analysis used in Table 3.7 and Table 3.8 is based on claims submitted by providers on behalf of their residents.

Table 3.7: Proportion of claims for supported residents, by location, 2014-15 to 2017-18

Location	2014-15	2015-16	2016-17	2017-18
Metropolitan	48.6%	49.6%	48.2%	47.3%
Regional	52.6%	53.4%	52.2%	51.2%
Remote	66.0%	67.9%	67.8%	65.5%
Australia	**50.0%**	**51.0%**	**49.7%**	**48.7%**

Table 3.8: Proportion of claims for supported residents, by ownership type, 2014-15 to 2017-18

Ownership type	2014-15	2015-16	2016-17	2017-18
Not-for-profit	52.4%	53.1%	51.8%	50.6%
For-profit	46.3%	47.6%	46.6%	46.1%
Government	48.6%	49.0%	47.0%	45.5%
All providers	**50.0%**	**51.0%**	**49.7%**	**48.7%**

The relative stability in recent years in the number of supported residents in care seems to indicate that the incentive of the higher accommodation supplement for having a resident profile with more than 40 per cent supported residents, along with the higher accommodation supplement payment for facilities newly built or significantly refurbished, are combining to ensure access to care continues for this cohort of older Australians.

3.8 Age profile across care types

As consumers of aged care get older, the types of care they access changes. Chart 3.15 shows the proportion of older Australians using home support, home care and residential care in 2017-18. The proportion using home care and residential care increases more than three-fold in the 85 and over bracket compared with those aged 70 and over.

Chart 3.15: Proportion of the population 70+ and 85+ accessing aged care, at 30 June 2018

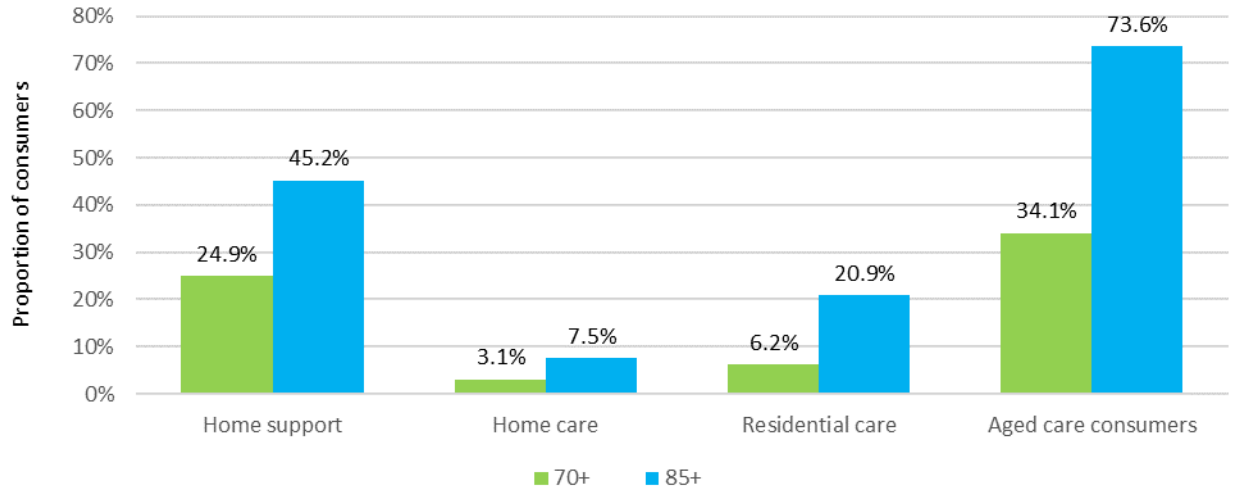
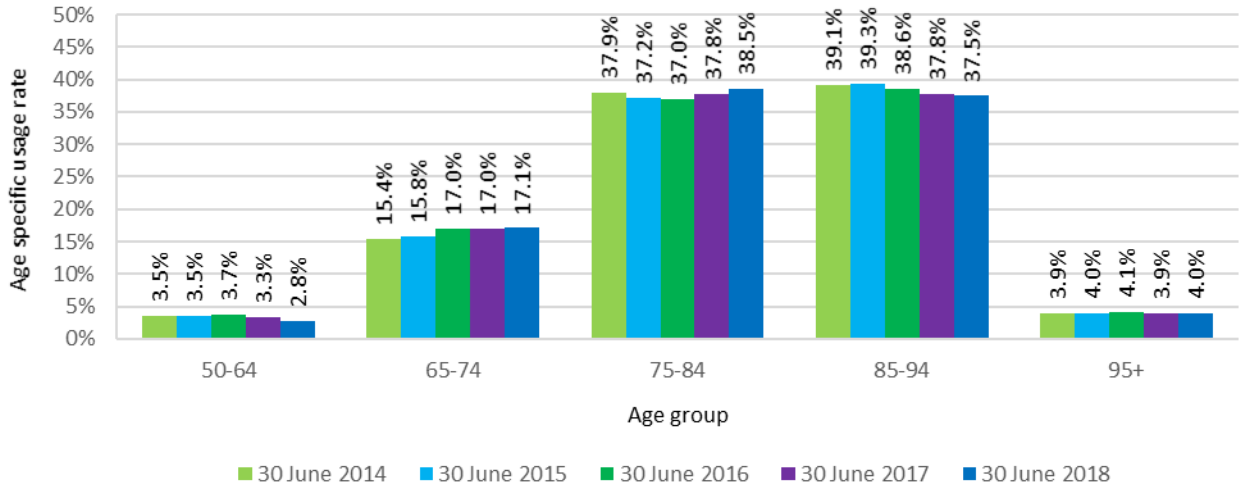


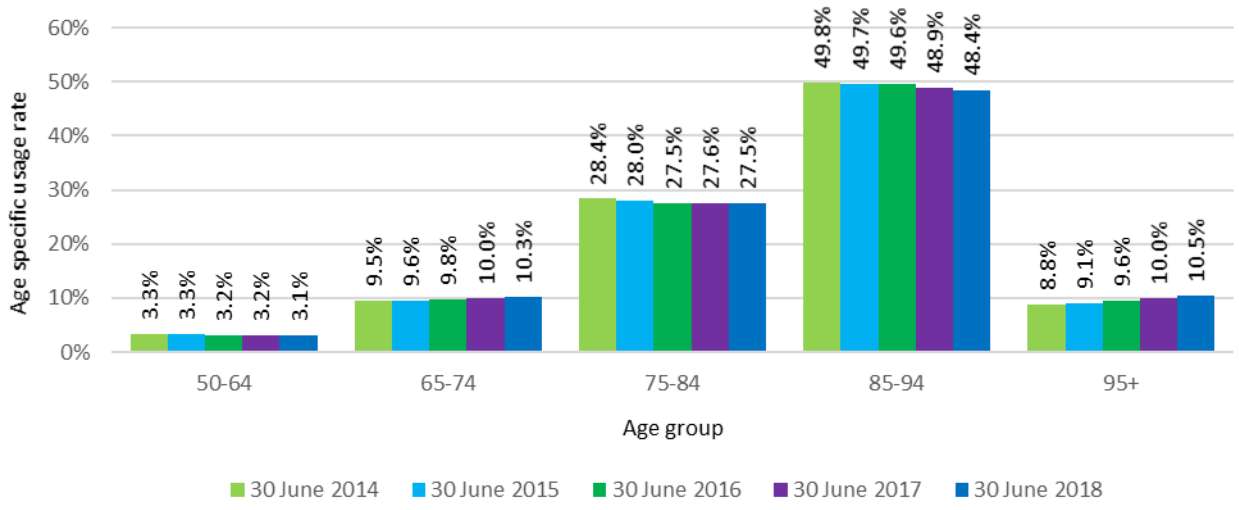
Chart 3.16 shows the age profile for consumers of home care over the five years to 30 June 2018. The proportion of those aged 65-74 has been increasing since 2014-15 and the proportion of those aged 75-84 increased noticeably in 2017-18, as it did in 2016-17, likely reflecting the expansion of home care packages in recent years. The proportion of those aged 85 and over decreased slightly for the third year in a row.

Chart 3.16: Age profile of people in home care, 30 June 2014 to 30 June 2018



In residential care, the trends of recent years generally continued in 2017-18 (Chart 3.17). The proportion of people aged 65-74 in residential care has slowly increased over the five years while the proportions of those aged 75-84 and 85-94 have fallen. The proportion of those aged 95 and over has increased every year over the five years.

Chart 3.17: Age profile of people in residential care, 30 June 2014 to 30 June 2018



Detailed data regarding the age of consumers in CHSP is not readily available for the same level of analysis as it is for home and residential care. However the overall average age of consumers in CHSP in 2017-18 was 79.1 years compared with 79.6 in 2016-17.

3.9 Access by Culturally and Linguistically Diverse and Indigenous Australians

3.9.1 Culturally and Linguistically Diverse Australians

There is significant cultural diversity among Australians and many people from culturally and linguistically diverse (CALD)[21] backgrounds are seeking culturally appropriate aged care. This is an area where aged care is changing and will continue to change as providers respond to the cultural needs of consumers.

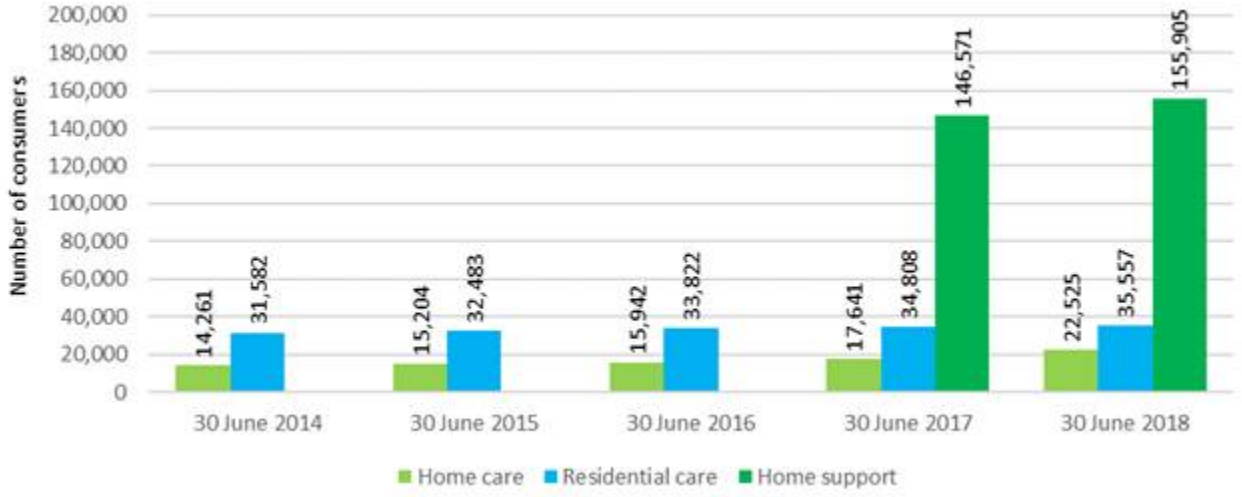
To assist this, the Australian Government provides aged care website information for people who do not speak English, or for whom English is a second language. The My Aged Care website provides translated material in 18 languages. In 2017-18, there were 22,812 visits to the translation pages.

Chart 3.18 shows the number of CALD home care and residential care consumers over the last five years as well as the number of CALD consumers of the CHSP for the last two years (as previous years data was not available).

There were 22,525 older Australians from CALD backgrounds in a home care package as at 30 June 2018, representing around 25 per cent of total home care consumers. This has been stable over recent years. In residential care, as at 30 June 2018, there were 35,557 older Australians from CALD backgrounds in permanent or respite care, which represents around 19 per cent of all residents. As with home care this proportion has been stable in recent years. In 2017-18, 155,905 consumers from a CALD background accessed home support, up from 146,571 in 2016-17.

[21] CALD status is derived from self-reported information provided by consumers.

Chart 3.18: CALD consumers in aged care, 30 June 2014 to 30 June 2018

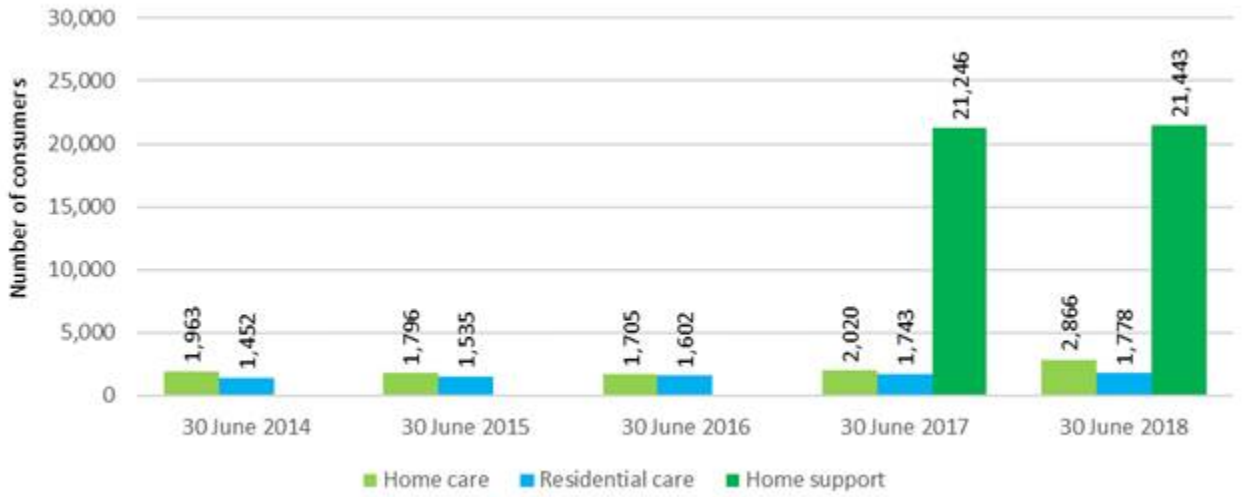


3.9.2 Indigenous Australians

Chart 3.19 shows the number of Indigenous Australians accessing home care and residential care over the last five years, and the number accessing home support in 2016-17 and 2017-18 (as previous years are not available).

The number of Indigenous Australians accessing home care increased by 42 per cent from 2016-17 to 2017-18. The number of Indigenous Australians accessing residential care and home support were relatively stable from 30 June 2017.

Chart 3.19: Indigenous Australians in aged care, 30 June 2014 to 30 June 2018



4 Home support

This chapter discusses:

- The operation of the CHSP;
- the supply and usage of CHSP and the Western Australian HACC; and
- the funding of CHSP and the Western Australian HACC.

This chapter reports that in 2017-18:

- The Commonwealth funded 1,547 providers to deliver CHSP and HACC services (1,456 CHSP providers and 91 HACC providers in Western Australia);
- the CHSP provided services to 783,043 older Australians (722,838 in 2016-17);;
- the Western Australian HACC services provided services to 64,491 older Australians (62,089 in 2016-17); and
- the total number of older Australians that received home support services was 847,534.

The Australian Government contributed $2.4 billion to home support in 2017-18 comprising:

- $2.2 billion for CHSP($2.1 billion in 2016-17); and
- $195 million in payments to the Western Australian government to support the jointly funded HACC program ($188 million in 2016-17).

4.1 Introduction

Home support generally provides small amounts of services (entry-level services) designed to help older Australians continue living in their own homes for as long as they can and wish to do so, and delay the need for higher level care, including home care packages and residential care, through early intervention. The home support programs discussed in this chapter are the Commonwealth Home Support Programme (CHSP) and the Home and Community Care (HACC) program in Western Australia.

4.2 Commonwealth Home Support Programme

The Commonwealth Home Support Programme (CHSP) provides entry-level support services for frail, older people aged 65 years and older (or 50 years and older for Aboriginal and Torres Strait Islander people) who need assistance to keep living independently at home and in their community. CHSP entry level support is underpinned by a 'wellness approach', which is about

building on older people's strengths, capacity and goals to help them remain independent and to live safely at home.

The CHSP also supports homeless people, or people at risk of homelessness, to access care and housing. To be eligible for assistance with care and housing services through the CHSP, a person must be: prematurely aged; 50 years and over (45 years and over for Aboriginal and Torres Strait Islander people); on a low income; and be homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation.

My Aged Care is the Australian Government's single entry point for aged care services. Access to CHSP services is coordinated through My Aged Care and Regional Assessment Services.

Table 4.1 sets out the types of services that may be accessed through the CHSP. Around 54 per cent of CHSP consumers receive one type of service, 41 per cent receive between two and four types of service and the remainder access five or more types of services through the CHSP. On average, CHSP consumers received services to the value of $2,762 per annum in 2017-18, compared with $2,882 for 2016-17. However, there can be significant variation in funding between consumers. Accurate data regarding the range of funding provided for individual consumers through the CHSP is not currently available.

Table 4.1: CHSP services: by sub-program and service type

Sub-program	Community and home support	Care relationships and carer support	Assistance with care and housing	Service system development
Objective	To provide entry-level support services to assist frail, older people to live independently at home and in the community.	To support and maintain care relationships between carers and consumers, through providing good quality respite care for frail, older people so that regular carers can take a break.	To support those who are homeless or at risk of homelessness, to access appropriate and sustainable housing as well as community care and other support services, specifically targeted at avoiding homelessness or reducing the impact of homelessness.	To support the development of the community aged care service system in a way that meets the aims of the CHSP and broader aged care system.

Service types funded	• Meals • Other food services • Transport • Domestic assistance • Personal care • Home maintenance • Home modifications • Social support-individual • Social support-group (formerly centre-based day care) • Nursing • Allied health and therapy services • Goods, equipment and assistive technology • Specialised support services	Flexible respite: • In-home day respite • In-home overnight respite • Community access – individual respite • Host family day respite • Host family overnight respite • Mobile respite • Other planned respite Centre-based respite: • Centre based day respite • Residential day respite • Community access-group respite • Cottage respite (overnight community)	Assistance with care and housing (a person must be: prematurely aged; 50 years and over (45 years and over for Aboriginal and Torres Strait Islander people); on a low income; and be homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation).	Sector support and development activities.

Overall expenditure in 2017-18 on each of the sub-programs detailed above is as follows:

- Community and home support: $1.76 billion
- Care relationships and carer support: $0.26 billion
- Assistance with care and housing: $0.12 billion
- Service system development: $0.51 billion

4.3 Home and Community Care — Western Australia

In 2017-18 the HACC program in Western Australia provided similar services for older people to those provided under the CHSP, but also provided support for younger people with a disability.

During 2017-18, Western Australian HACC services were delivered through the jointly funded HACC program under the *HACC Review Agreement 2007*. Consumers continued to be assessed for HACC services through the HACC program assessment arrangements.

From 1 July 2018 the Western Australian HACC services for older people aged 65 years and over (and 50 years and over for Aboriginal and Torres Strait Islander people) transitioned to the CHSP which means that from 1 July 2018 the CHSP was a national program.

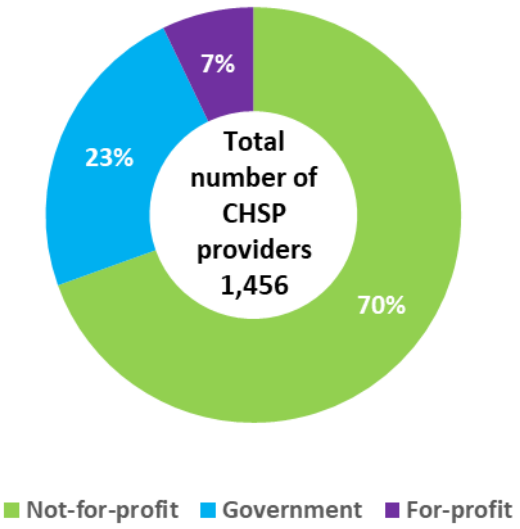
4.4 Sector overview

4.4.1 Providers of home support

In 2017-18, there were 1,456 providers of CHSP and 91 providers of HACC in Western Australia. This compares with 1,523 CHSP providers and 98 HACC providers in Western Australia in 2016-17.

CHSP services are predominately provided by not-for-profit organisations (70 per cent in 2017-18), as shown in Chart 4.1. This has been the case since the inception of the CHSP in 2015-16, and was the case for the former programs that combined to create the CHSP.

Chart 4.1: CHSP providers by ownership type, 2017-18



4.5 Funding for CHSP and HACC

In 2017-18, the Commonwealth contributed funding of $2.2 billion to the CHSP, as well as providing a further $194.9 million to the Western Australian Government for the joint Commonwealth-state funded HACC program in Western Australia, bringing the total Commonwealth expenditure on home support in 2017-18 to $2.4 billion.

Chart 4.2 shows total expenditure on home support since the introduction of the CHSP in 2015-16, along with budgeted expenditure to 2021-22.

Chart 4.2: Government expenditure and budgeted expenditure of CHSP[22] and Victorian and Western Australian HACC programs, 2015-16 to 2021-22

Chart 4.3 shows Commonwealth expenditure for home support (including Western Australian HACC) in 2017-18, by state and territory.

Chart 4.3: Commonwealth expenditure on CHSP and WA HACC services, by state and territory[23], 2017-18

As part of the 2014-15 Budget, the Australian Government announced a reduction in the annual real rate of growth for the CHSP from 6 per cent to 2.8 per cent in 2015-16, 1.5 per cent in 2016-17 and 2.4 per cent in 2017-18. In 2018-19 the growth rate became 3.5 per cent which aligns with the annual growth in the population aged 65 and over. Real growth is in addition to annual indexation. Growth funding enables the CHSP to respond to the changing needs of CHSP consumers and to align with the growth in Australia's aged population. Grants under the CHSP are indexed each year by WCI-3[24] (1.3 per cent in 2018-19).

[22] CHSP expenditure shown here excludes the expenditure on RAS and My Aged Care support services of $148 million in 2015-16 and $123 million in 2016-17 as they were not for services to consumers.

[23] The former non-HACC components of the CHSP all transferred to the CHSP from 2015-16. The $25.5 million identified under the CHSP in 2017-18 for Western Australia relates to the non-HACC components.

[24] WCI-3 is a composite index constructed by the Department of Finance that comprises a wage cost component (weighted at 60 per cent) and a non-wage cost component (weighted at 40 per cent).For all Wage Cost Indices the value of the wage cost component is based on the dollar increase

Table 4.2 shows a breakdown of the size of grants provided through the CHSP in 2017-18 by organisation type. Results from 2017-18 are similar to those in previous years. The vast majority (75 per cent) of providers receive less than $1 million and of those, almost 78 per cent receive less than $500,000.

Table 4.2: CHSP grants, by size of grant and ownership, 2017-18

Grant size	Not-for-profit	For-profit	Government	Total
Less than $500,000	660	59	126	845
$500,000 - $1 million	138	22	84	244
$1-10 million	195	21	120	336
$10-50 million	16	1	9	26
Over $50 million	3	1	1	5

4.5.1 Consumer contributions

The *Client Contribution Framework* and the *National Guide to the CHSP Client Contribution Framework* set out principles to guide CHSP providers in setting and implementing their own consumer contribution policy.

The principles are designed to introduce fairness and consistency, with a view to ensuring that those who can afford to contribute do so, whilst protecting the most vulnerable.

Recommendation 16 of the *Legislated Review of Aged Care 2017* recommended that mandatory consumer contributions based on an individual's financial capacity be introduced for services under the CHSP. This would bring the CHSP fees policy more in line with those under other aged care programs. The Government has not yet responded to this recommendation.

In 2017-18, consumer contributions totalled $219 million which represents around 10 per cent of total CHSP funding. This is stable from 2016-17.

4.6 Looking forward

In the 2019-20 Budget, the Australian Government extended funding agreements with CHSP providers by a further two years, after a similar two year extension in the 2017-18 Budget. This means the CHSP and Home Care Packages Program will continue to operate as separate programs until at least mid-2022. In the 2015-16 Budget, the Australian Government had announced an intention to integrate CHSP and home care into a single home care and support program by July 2018.

in the national minimum wage (as determined annually by the Fair Work Commission) expressed as a percentage of the latest available estimate of average weekly ordinary time earnings (AWOTE) published by the Australian Bureau of Statistics as at November of each year. The value of the non-wage cost component of WCI-3 is based on changes in the Consumer Price Index between March quarters each year.

While no decisions have been made about broader reform of care at home beyond 2022, extending the CHSP by two years will enable the Government to further refine the CHSP to better meet the entry level needs and preferences of older Australians. This includes further embedding wellness and reablement practices within the CHSP and simplifying consumer access to home-based care by combining the current RASs and ACATs into a single assessment and referral process across CHSP and home care.

Following the establishment of the CHSP as a program with full national coverage in 2018, the Department of Health issued a new Program Manual that sets out service providers' responsibilities, including a new emphasis on wellness and reablement. CHSP providers are now required to submit an annual report outlining service level information regarding the implementation of a wellness approach within their organisation. These reports will be used to measure overall progress towards embedding wellness and reablement in CHSP service delivery.

In addition, the 2018-19 Budget provided $29.2 million over two years to 30 June 2020 to trial reablement-based assessment for the CHSP. Under the trial, consumers are asked by the Regional Assessment Services to actively demonstrate how they undertake certain tasks as part of the assessment process to better understand their abilities and limitations. The assessment model being trialled provides a time-limited reablement period, usually between six to eight weeks, prior to being referred for ongoing services. The focus is to build on the individual's confidence and physical or cognitive skills to achieve their own goals.

5 Home care

This chapter discusses:

- The operation of the Home Care Packages Program;
- the funding of the sector; and
- the financial performance of home care providers in 2017-18.

The chapter reports that:

- There were 873 home care providers as at 30 June 2018, up from 702 at 30 June 2017;
- the sector continues to be predominately not-for-profit with 53 per cent of providers (although this is down from 65 per cent in 2016-17) and 76 per cent of consumers; and
- services were provided to 116,843 consumers, up from 97,516 in 2016-17.

Key findings on financial performance in 2017-18 compared with 2016-17:

- home care providers received an estimated $2.07 billion in revenue in 2017-18, paid $1.99 billion in expenses and generated $74 million in profit;
- 70 per cent of home care package providers achieved a net profit in 2017-18, down from 75 per cent in 2016-17 and 2015-16;
- average EBITDA was $1,217 per consumer, a significant decline from $2,989 for 2016-17 and $3,055 in 2015-16;
- EBITDA margin was 4.6 per cent, down from 11.3 per cent in 2016-17; and
- as at 30 June 2018 home care providers held $539 million in unspent funds, an increase of 64 per cent over 30 June 2017.

5.1 Overview of the sector

5.1.1 The Home Care Packages Program

The Home Care Packages Program commenced on 1 August 2013, replacing the former home care programs – Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACH-D) packages.

Home care packages allow consumers to purchase a range of services and equipment which assist them living in their own home. Packages are delivered on a Consumer Directed Care (CDC) basis with consumers having an individualised budget which allows them to decide what type of care and services they purchase and who delivers the services.

In February 2017, an important change occurred in home care in that packages began being assigned directly to the consumer, rather than allocated to the provider. This means that consumers now have choice of provider to deliver their services and can opt to change providers. This has implications for both consumers and providers which are discussed further in this chapter.

Home care consumers may use their package funds to purchase the following:

- **Personal services.** Examples include help with showering or bathing, dressing and mobility;
- **Support services.** Examples include help with washing and ironing, house cleaning, gardening, basic home maintenance, home modifications related to care needs, transport to help with shopping, doctor visits or attending social activities;
- **Clinical care.** Examples include nursing and other health support including physiotherapy (exercise, mobility, strength and balance), services of a dietitian (nutrition assessment, food and nutrition advice, dietary changes) and hearing and vision services; and
- **Care management.** Coordinating care and services that will help consumers achieve the goals identified in their care plan.

In addition, providers may charge consumers a package management fee, which covers regulatory-related costs such as issuing monthly financial statements and managing unspent package funds on behalf of consumers.

For many consumers, home care packages offer an opportunity to remain living at home instead of entering residential care. Packages are categorised into four levels with level 1 being for people with basic care needs through to level 4 which supports people with higher care needs.

To obtain access to a home care package, individuals are first assessed by an Aged Care Assessment Team (ACAT) which determines eligibility for a home care package. Many people assessed as eligible to receive a package are also assessed as eligible for residential care. Once assessed as eligible for home care, an individual is placed on the National Prioritisation System and is offered a package when one becomes available. The National Prioritisation System is discussed later in this chapter.

5.1.2 Providers of home care

Chart 5.1 shows overall home care provider numbers, as well as the proportion by ownership, over the six years to June 2018. There has been a significant increase in home care providers since the February 2017 changes that assigned home care packages directly to consumers rather than to providers. Many new providers have entered the market seeking to compete for consumers.

Chart 5.1: Number of home care providers, by proportion of ownership type, 30 June 2013 to 30 June 2018

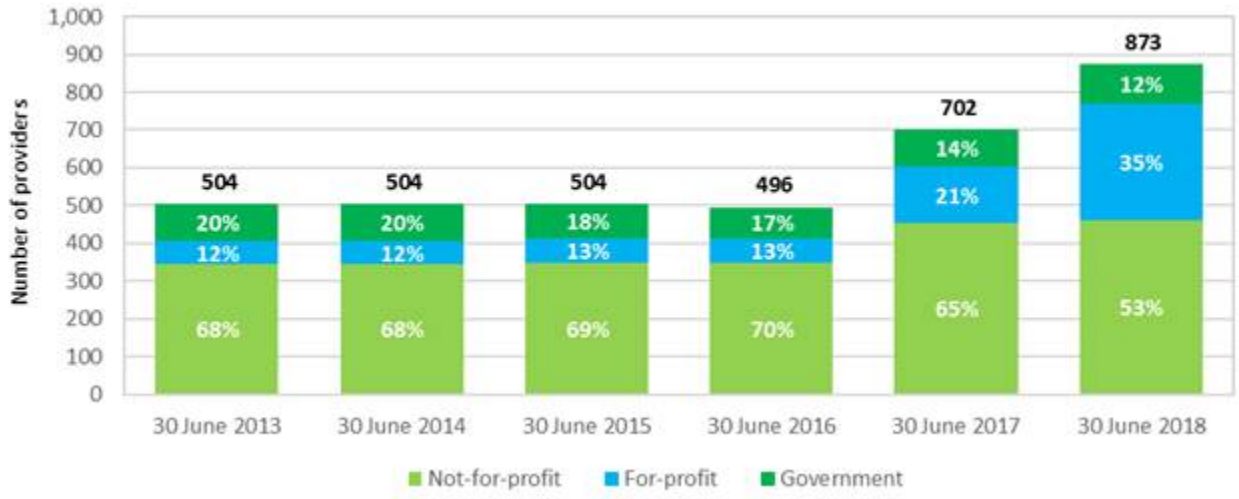


Table 5.1 presents a breakdown of home care providers by ownership type, location and scale in 2017-18.

Table 5.1: Provider numbers, number of services and number of consumers, at 30 June 2018

			Ownership type			Location			Scale		
	30 June 2017	30 June 2018	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metropolitan & regional	Single service	Two to six services	Seven or more services
Number of providers	702	873	461	309	103	482	314	77	619	176	78
			53%	35%	12%	55%	36%	9%	71%	20%	9%
Numbers of services	2,367	2,599	1,860	539	200	1,577	1022	N/A	619	544	1,436
			71%	21%	8%	61%	39%		24%	21%	55%
Number of consumers	71,423	91,847	69,944	15,545	6,358	61,676	30,171	N/A	16,220	20,833	54,736
			76%	17%	7%	67%	33%		18%	22%	60%

As shown in Table 5.2, the mix of provider ownership has significantly altered since the changes of February 2017, along with a significant increase in the number of providers. The for-profits now represent 35 per cent of the sector, up from 21 per cent in 2016-17 and 13 per cent in 2015-16. In contrast, the proportion represented by not-for-profit providers declined to 53 per cent (65 per cent in 2016-17 and 70 per cent in 2015-16).

Table 5.2: Change in number of providers and ownership, 30 June 2016 to 30 June 2018

	30 June 2016	Proportion of total	30 June 2017	Proportion of total	30 June 2018	Proportion of total
Not-for-profit	347	70%	407	65%	461	53%
For-profit	65	13%	200	21%	309	35%

Government	84	17%	95	14%	103	12%
Total	**496**	**100%**	**702**	**100%**	**873**	**100%**

At 30 June 2018 there were 91,847 consumers in home care, compared with 71,423 at 30 June 2017. The number of services operated by all providers also increased in 2017-18 compared with 2016-17 (2,599 up from 2,099). As was the case in 2016-17, the vast majority of the increase in services was due to new single service providers entering the market. At 30 June 2018 there were 619 single service providers (71 per cent of all providers) compared with 55 per cent at 30 June 2017.

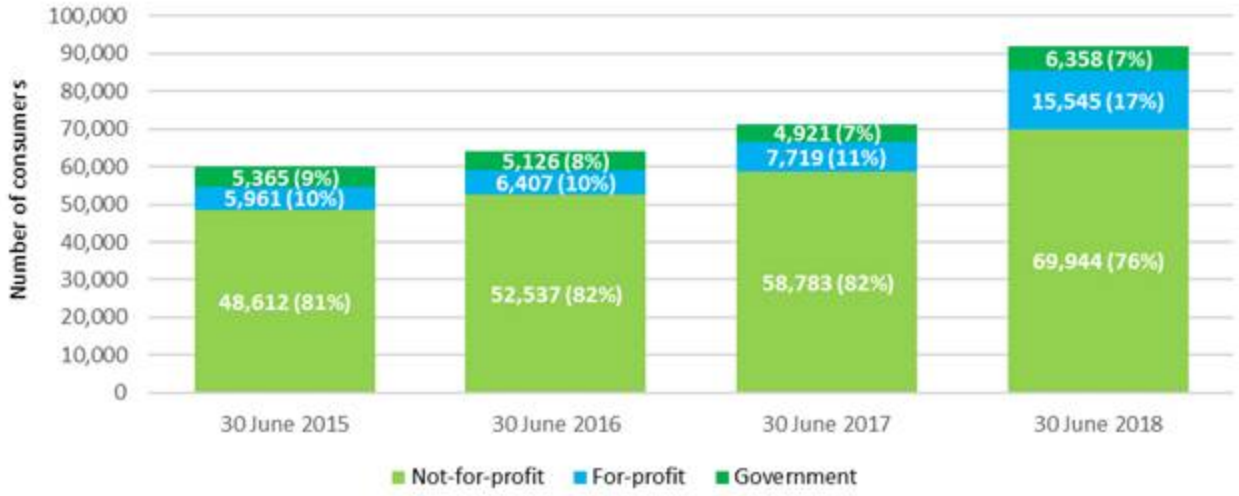
Throughout 2017-18, 116,843 older Australians were in receipt of a home care package at some time (up from 97,516 in 2016-17). In 2016-17, 68 per cent of home care packages were level 1 and 2. In 2017-18 this proportion has decreased to 61 per cent reflecting the trend of more consumers requiring higher level packages and Government decisions to increase gradually the proportion of higher level packages in response to demand (Table 5.3).

Table 5.3: Home care consumers, by package level and ownership, at 30 June 2018

	Not-for-profit	For-profit	Government	Total
Level 1	3,353	1,135	353	4,841
Level 2	39,203	8,183	4,110	51,496
Level 3	9,637	2,281	775	12,693
Level 4	17,751	3,946	1,120	22,817
Total	**69,944**	**15,545**	**6,358**	**91,847**

The recent increase in the proportion of for-profit providers has not resulted in a similar change in the proportion of consumers by provider ownership with not-for-profit providers continuing to provide the majority of home care packages (Chart 5.2).

Chart 5.2: Home care consumers, by ownership type, 30 June 2015 to 30 June 2018



Across Australia, around 67 per cent of home care consumers are in major cities, around 25 per cent in inner regional locations, around 7 per cent of consumers are in outer regional locations, and the remaining 1 per cent are in remote and very remote areas. These proportions have been relatively steady in recent years.

5.2 Operational performance

5.2.1 Methodology

The discussion of financial performance in this chapter predominantly relates to Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA). As discussed in Chapter 1, EBITDA is the commonly used metric for analysis and comparison of the profitability of providers and the sector. Net Profit Before Tax (NPBT), which takes interest, depreciation and amortisation into the calculation, is also used.

Financial information reported in this chapter has been collected through the Aged Care Financial Report (ACFR). The Accountability Principles 2014, made under Section 96-1 of the *Aged Care Act 1997*, require each home care provider to submit a financial report in a form approved by the Secretary of the Department of Health. The ACFR submitted by home care providers is not required to be audited and should not be considered a General Purpose Financial Report.

Until last year's annual report, financial performance of home care providers was largely summarised on a 'per package' basis as the packages were previously allocated to approved providers after a competitive tender through an ACAR. Analysis on this basis included the provider's packages that were not fully utilised for whatever reason in a financial year. The reform changes of February 2017 have resulted in packages being assigned to consumers and as a result, the analysis is now calculated on a 'per consumer' basis. EBITDA calculated on a 'per consumer' basis is generally higher when compared with EBITDA calculated on a 'per package' basis as unutilised packages are excluded. When trend data is analysed, previous years have been re-calculated on the 'per-consumer' basis to allow for direct comparison between years.

5.2.2 Analysis of 2017-18 financial performance of home care providers

2017-18 saw a very significant decline in the overall financial performance of home care providers compared with recent years. Average EBITDA per consumer across the sector was $1,217 after being stable at around or just below $3,000 for three years.

Chart 5.3 shows the whole of sector average EBITDA per consumer for all home care providers since 2014-15.

Chart 5.3: Home care providers average EBITDA per consumer per year, 2014-15 to 2017-18

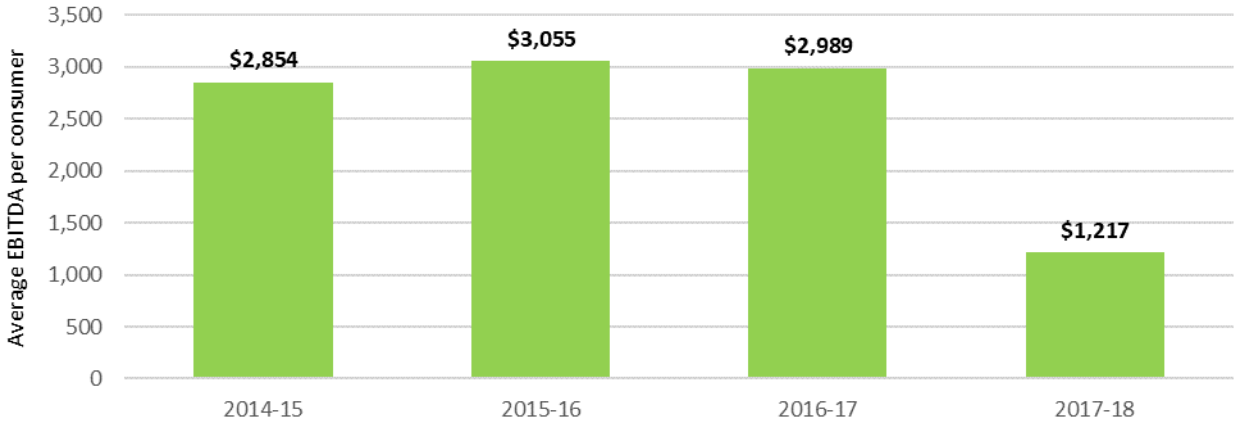


Table 5.4 provides an overview of the 2017-18 financial performance of home care providers, including a breakdown by ownership type, location and scale.

Table 5.4: Summary of financial performance of home care providers, 2017-18

	All providers 2016-17	All providers 2017-18	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metropolitan & regional	Single service	Two to six services	Seven or more services
Total revenue ($m)	$1,733.6	$2,065.5	$1,567.3	$381.5	$116.7	$1,229.4	$321.9	$514.2	$283.0	$406.2	$1,376.3
Total expenses ($m)	$1,548.4	$1,991.1	$1,494.0	$389.7	$107.5	$1,190.3	$304.0	$496.8	$271.2	$383.2	$1,336.8
Profit ($m)	$185.1	$74.4	$73.3	-$8.2	$9.3	$39.1	$17.9	$17.4	$11.8	$23.1	$39.5
EBITDA ($m)	$195.2	$95.6	$84.2	$1.9	$9.5	$53.7	$21.0	$20.9	$14.2	$27.2	$54.2
Average EBITDA per consumer	$2,989	$1,217	$1,358	$169	$1,791	$1,202	$1,555	$1,026	$1,758	$1,680	$999
Average NPBT per consumer	$2,832	$947	$1,183	-$729	$1,741	$876	$1,321	$855	$1,463	$1,423	$728
EBITDA margin	11.3%	4.6%	5.4%	0.5%	8.2%	4.4%	6.5%	4.1%	5.0%	6.7%	3.9%
NPBT margin	10.7%	3.6%	4.7%	-2.1%	7.9%	3.2%	5.6%	3.4%	4.2%	5.7%	2.9%

5.2.3 Revenue

Home care revenue consists of Commonwealth contributions in the form of subsidies and supplements, and a lessor contribution from consumers (the basic daily fee and income tested fees). Total revenue can also include other revenue sources (such as consumer contributions for non-home care related services, interest income and state and territory government payments).

In 2017-18, total Commonwealth expenditure on home care subsidies and supplements was $2.0 billion, up from $1.6 billion in 2016-17.

The basic subsidy for home care is indexed annually based on Wage Cost Index 9 (WCI-9), the same index as applies for the care subsidy in residential care. WCI-9 is a composite index constructed by the Department of Finance that comprises a wage cost component (weighted at 75 per cent) and a non-wage cost component (weighted at 25 per cent). For all Wage Cost Indices, the value of the wage cost component is based on the dollar increase in the national minimum wage (as determined annually by the Fair Work Commission) expressed as a percentage of the latest available estimate of average weekly ordinary time earnings (AWOTE) published by the Australian Bureau of Statistics as at November of each year. The value of the non-wage cost component of WCI-9 is based on changes in the Consumer Price Index (CPI) between March quarters each year.

Some home care supplements are also indexed by WCI-9, including the dementia and cognition and Veterans' supplements, while the remainder, such as the oxygen and enteral feeding supplements, are indexed annually using the Consumer Price Index (CPI).

Commonwealth funding (subsidies and supplements)

Commonwealth funding is determined per consumer based on the level of package accessed. It is calculated on a daily basis and paid monthly in advance[25]. Each package level has a fixed maximum amount of annual funding set by the Commonwealth (Table 5.5). Supplements can also be paid in circumstances where the consumer requires additional care and/or services.

Table 5.5: Maximum home care basic subsidy payments per annum, 2018-19

Package level	annualised subsidy
Level 1	$8,270
Level 2	$15,045
Level 3	$33,076
Level 4	$50,286

Supplements in home care are paid in addition to the amount of basic subsidy applicable at each package level. Supplements are paid if a consumer is eligible due to a specific care need or circumstance. The supplements that apply to home care are at Appendix K. All supplements payable are included in the consumer's individualised budget.

Consumer contributions

Consumers may be asked to pay a basic daily fee up to 17.5 per cent of the single basic age pension ($10.54 a day/$3,847 per annum as at 20 March 2019[26]). The basic daily fee is not subject to an income or asset test and all consumers can be asked to pay unless they prove financial hardship, in which case the Commonwealth pays the provider on their behalf. The basic daily fee, when charged by the service provider, must be included in the individualised budget for the consumer.

Additionally, consumers may be asked to make a contribution towards the cost of their care through an income tested fee. The package amount paid by the Commonwealth on behalf of a consumer is reduced by the amount of the income tested fee regardless of whether the fee is collected by the provider or not.

Consumer contributions in 2017-18 reported by providers totalled around $122 million, compared with $128 million for 2016-17 and $127 million in 2015-16. In 2017-18 the revenue from the basic daily fee was $78 million down from $101 million in 2016-17. This reported reduction in basic daily fees was largely offset by increased revenue from the income tested fee and other consumer fees. Feedback from consultations suggest some providers foregoing charging their consumers, many of whom are pensioners, the basic daily fee, or reducing that fee. As discussed in Section 5.3, this is likely due to the increase in competition in the home care market in response to recent reforms.

[25] In the 2019-20 Budget the Government announced its intention to move to a payment in arrears arrangement based on services delivered.

[26] As of 1 July 2019 the basic daily fee will reduce for level one packages ($400 per annum), level two packages ($200 per annum) and level three packages ($100 per annum) with a commensurate increase in the basic subsidy paid by the Commonwealth.

Unspent funds

Prior to the changes that occurred in February 2017, when home care consumers moved between home care providers or exited care (often to enter residential care), unspent package funds could be retained by their former provider. As part of the changes introduced in February 2017, unspent package funds now follow the consumer to their new provider or are returned to the Commonwealth and the consumer (based on their respective proportions paid) when the consumer leaves home care.

The unspent home care amount is the total amount of each consumer's individual budget (comprising home care subsidy, supplements and home care fees) that has not been spent or committed for the consumer's care, less any agreed exit amount. Unspent package funds will not generally, and should not, be recognised as income by the provider until the funds have been spent or are committed for the consumer's care.

Unspent funds are discussed in more detail at 5.2.6.

Total revenue

In 2017-18, total sector revenue for all home care providers was $2.07 billion, up from $1.85 billion in 2016-17, an increase of 12 per cent. Commonwealth contributions represent more than 90 per cent of the total revenue received by home care providers. As noted unspent funds held by providers ($539 million at 30 June 2018) cannot be treated as revenue.

The average income per consumer per day in 2017-18 for home care providers was $72.04 ($26,295 per annum), down slightly from $72.71 ($26,539 per annum 2016-17). Table 5.6 shows provider income per consumer per day since 2015-16, split by the major types of income. ACFA is not able to compare these results with 2014-15 as some providers operated on a CDC basis, while others did not, which resulted in differences in the treatment of some revenue items.

As shown, there continues to be a significant amount charged for management and administration costs. However these have reduced slightly which may indicate providers responding to an increase in competition following consumers having the ability to choose their provider and the influx of new providers into the market.

Some providers have indicated that the relatively high proportion of income derived from management and administration (30 per cent) reflects the increased costs for providers as part of CDC, including regulatory-related costs such as providers being required to provide consumers with full transparency regarding their packages, negotiating an individualised budget, providing monthly itemised expenditure statements, and having to administer unspent funds in a prudentially appropriate way.

Under the comparative pricing schedule that is required to be published on My Aged Care from July 2019, providers will be required to distinguish between care management fees and package management fees. Normal business overheads will be required to be included in the fees set for services.

Table 5.6: Home care provider income per consumer per day, 2015-16 to 2017-18

Income type	2015-16	% of total	2016-17	% of total	2017-18	% of total

Provision of care / service charged to consumers	$47.15	61.5	$44.71	61.5	$47.94	66.5
Management fees charged to consumers	$11.12	14.5	$10.27	14.1	$9.72	13.5
Administration of packages charged to consumers	$13.63	17.8	$12.88	17.7	$12.10	16.8
Unspent funds and exit amounts deducted	$3.64	4.7	$2.98	4.1	$0.16	0.2
Other revenue	$1.16	1.5	$1.87	2.6	$2.11	2.9
Total	**$76.70**	**100**	**$72.71**	**100**	**$72.04**	**100**

1. Provision of care/services charged to consumers includes income recognised from consumers' packages and private home care consumers as care and services are provided. This amount will include Government subsidies and supplements, consumer contributions in the form of the basic daily fee, income tested care fees, top-ups and private contributions.
2. Management fees charged to consumers is the amount of income recognised for on-going management and coordination of the consumers' packages and care requirements.
3. Administration fees charged to consumers is the amount of income recognised for on-going administration of consumers' packages.
4. Unspent package funds reflect income remaining from a consumer's care package when a consumer leaves the home care service (prior to the February 2017 changes). Exit amounts deducted by the approved provider when ceasing to provide home care to a consumer may also be charged after this date.
5. Other revenue includes other sources of income generated from running the home care services such as state and territory payments, consumer payments for non-home care services, trust distribution, donations and bequests, interest earned on investments, insurance and gains from the sale of assets.
6. The unspent and exit amounts reported in 2017-18 reflects only the exit fees reported by providers as the February 2017 changes in home care provide for the return of funds to the consumer or the Government when a consumers transfers or leaves care. Comparative exit amounts deducted in 2016-17 were $0.12, an increased to $0.16 in 2017-18.

5.2.4 Expenditure

Total sector expenditure in 2017-18 was $1.99 billion, up from $1.65 billion in 2016-17.

The average expenditure per consumer per day in 2017-18 was $69.45 ($25,349 per annum), an increase of 6.9 per cent from $64.94 in 2016-17. While expenses per consumer increased by almost 7 per cent, income received per consumer (as noted above) decreased slightly (1 per cent) from 2016-17 to 2017-18.

As Table 5.7 shows, the increase in expenses in 2017-18 over 2016-17 was driven by a 5.7 per cent ($2.53 per consumer per day) increase in total care costs and a 9.8 per cent ($1.98 per consumer per day) increase in total administration costs.

Within the increase in total care costs in 2017-18, there was an increase in care-related expenses of 23 per cent and an increase in care staff costs of 4 per cent. In terms of the increase in total administration costs, the main driver was a 16 per cent increase in administration staff costs.

Table 5.7: Home care expenditure per consumer per day, 2014-15 to 2017-18

Expenses	2014-15	2015-16	2016-17	2017-18
Care costs				
Wages and salaries - care staff	$29.08	$31.98	$28.78	$29.99
Subcontracted or brokered customer services	$7.07	$9.44	$10.30	$10.32
Care related expenses	$4.43	$5.01	$5.64	$6.94

Total care costs	**$40.58**	**$46.43**	**$44.72**	**$47.25**
Administration costs				
Wages and salaries - administration staff	$7.10	$8.77	$8.00	$9.26
Administration costs and management fees	$10.08	$10.55	$10.18	$10.26
Depreciation and interest costs	$0.54	$0.55	$0.42	$0.74
Other expenses	$1.53	$2.57	$1.62	$1.94
Total administration costs	**$19.25**	**$22.44**	**$20.22**	**$22.20**
Total costs	**$59.83**	**$68.87**	**$64.94**	**$69.45**

Care related expenses represent 68 per cent of total expenses per consumer per day. Administration costs represent 32 per cent of total costs which is significant.

Table 5.8 provides a breakdown of expenditure according to ownership type, location and scale. Overall, there are some notable differences.

In terms of ownership, government providers continue to incur the lowest level of expense per consumer per day with $55.33, compared with $94.97 for the for-profit providers and $66.03 for the not-for-profit providers. The main driver behind these significant differences in total expenses is the care related staff costs. For-profit providers reported care related staff costs of $64.29 per consumer per day compared with $35.98 for the not-for-profits and $24.51 for government providers.

Provider expense per consumer is also influenced to a lesser extent by location. Similar to last year, regional providers had the lowest expenses per day on average with $61.59 per consumer per day compared with providers who operate in metropolitan areas who reported $73.04 per consumer per day.

In terms of scale, single service home care providers seem to suffer from diseconomies of scale, recording expenses on average of $92.28 per consumer per day compared with providers operating two to six services ($64.76) and those operating more than 6 services ($67.46).

Table 5.8: Home care expenditure per consumer per day, by ownership type, location and scale, 2017-18

	Care related salaries	Admin and Mgmt fees	Other care related expenses	Other expenses and non-direct costs	Total
Ownership					
Not-for-profit	$35.98	$10.43	$17.47	$2.16	$66.03
For-profit	$64.29	$10.90	$13.72	$6.06	$94.97
Government	$24.51	$6.97	$22.32	$1.54	$55.33
Location					
Metropolitan	$40.45	$10.72	$19.13	$2.74	$73.04
Regional	$35.78	$7.53	$14.73	$3.55	$61.59
Metropolitan & regional	$38.92	$11.08	$14.84	$1.96	$66.79
Scale					
Single service	$60.50	$11.45	$14.69	$5.64	$92.28
Two to six services	$38.01	$8.27	$15.43	$3.04	$64.76
Seven or more services	$36.47	$10.68	$18.18	$2.13	$67.46
Total sector	**$39.25**	**$10.26**	**$17.26**	**$2.68**	**$69.45**

5.2.5 Profit

In 2017-18, home care providers generated $74 million in profit, down from $201 million in 2016-17.

In terms of profit per consumer, both EBITDA and NPBT saw significant declines (Table 5.9). Average EBITDA per consumer dropped to $1,217 from around $3,000 for the previous three years. Average NPBT per consumer saw an even greater decline down to $947 from $2,832 in 2016-17.

Table 5.9: Summary of financial performance of home care providers, per consumer per year, 2014-15 to 2017-18

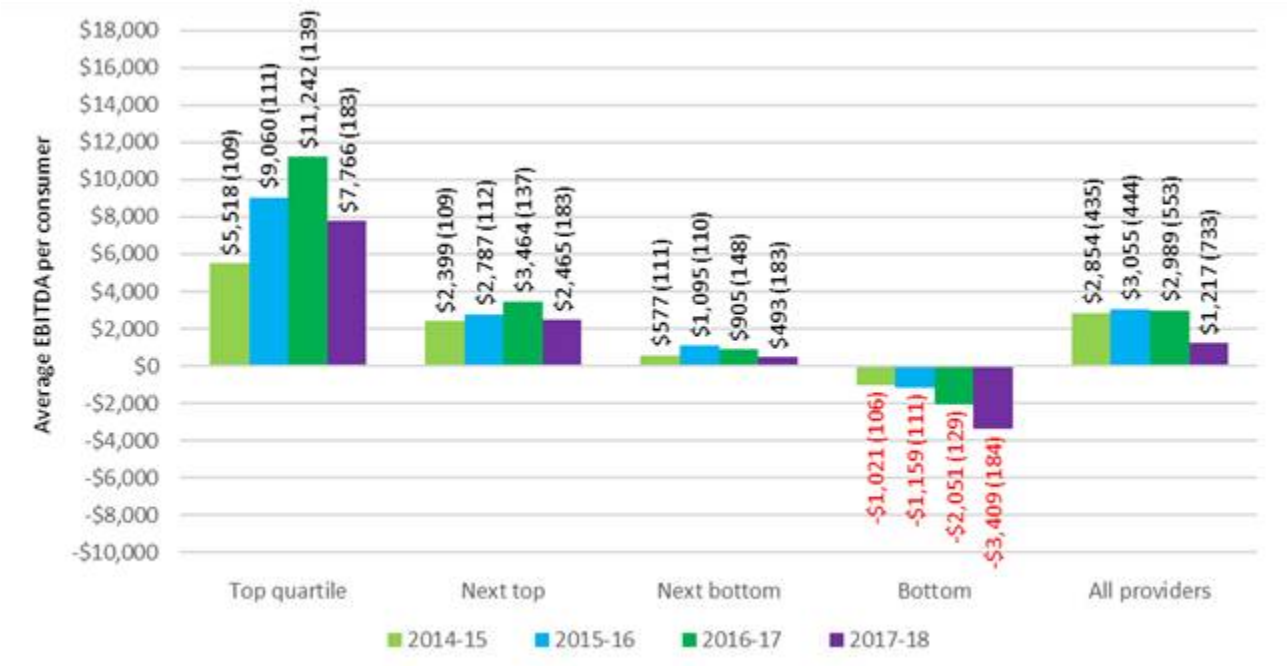
	2014-15	2015-16	2016-17	2017-18
Average EBITDA per consumer	$2,854	$3,055	$2,989	$1,217
Average NPBT per consumer	$2,657	$2,854	$2,832	$947

Approximately 70 per cent of home care providers achieved a profit in 2017-18, down from 75 per cent in 2016-17 and 2015-16.

Chart 5.4 shows average EBITDA per consumer by quartile. As has been the case previously, EBITDA varies considerably across the sector with the top quartile of providers (although still reporting a

decline from 2016-17) performing substantially better than the rest of the home care sector. The average EBITDA per consumer per year for the top quartile was $7,766 compared with the next top quartile returning $2,465.

Chart 5.4: Home care average EBITDA per consumer, by quartile (number of providers in parentheses), 2014-15 to 2017-18



The following analysis examines home care profit based on ownership type, location and scale.

After significantly outperforming the not-for-profits and government providers in the previous two years, the for-profits reported by far the worst results in 2017-18 (Chart 5.5 and Chart 5.6). The for-profit providers recorded average EBITDA per consumer of $169 after reporting $6,767 in 2016-17 and $7,481 in 2015-16. For-profit providers reported average expenses per consumer of almost $95 per day in 2017-18 compared with $80.93 per day in 2016-17.

For the top quartile of for-profit providers, total expenses increased by more than $113.68 per day however this was somewhat offset by increased income of $103.42 per day. For the next top quartile of for-profit providers, total expenses declined by $7.49 per day in 2017-18 to $76.32, however total income fell over the same period by $8.97 to $82.51, down from $91.48 in 2016-17. Total income also fell for the next quartile of provider by $10.90 per day to $62.92, compared with 2016-17 with total expenses falling by $8.74 over the same period. The most noticeable difference was for the bottom quartile of for-profit providers. Total income increased by $0.87 per day to $65.54 and total expenses increased by more than $10 per day to $84.49 in 2017-18.

Not-for-profit providers also showed a significant decline in 2017-18, recording EBITDA per consumer of $1,358 compared with $2,621 for 2016-17. In the top quartile of not-for-profit providers, there was a negligible increase in income per day of $0.09 to $80.48 per day, yet expenses increased by more than $8 to $63.29 per day. For the next top quartile, income declined by $3.31 to $68.81 per day in 2017-18 while expenses only fell by $0.53 to $62.55 per day. For the next bottom quartile of not-for-profit providers, income increased by $2.48 to $66.91 per day, with

expenses increasing by $3.81 to $66.09 in 2017-18. For the bottom quartile of not-for-profit providers, total income decreased by $4.51 to $67.36 in 2017-18, with expenses decreasing by only $3.12 per day.

Despite the overall poor results of for-profit providers, the 76 for-profit providers in the top quartile recorded average EBITDA of $14,493 (Chart 5.5) which was well above that of the top quartile not-for-profit providers ($6,477). However the overall significant decline in the profitability of for-profit providers likely reflects that the influx of new providers were largely for-profit and it could be expected that new entrants into a market may make a loss as they seek to establish market presence. ACFA notes that 30 per cent of all for-profit providers are in the bottom quartile (22 per cent in 2016-17) and they reported, on average, EBITDA of negative $5,624.

Chart 5.5: Home care average EBITDA per consumer per year, by quartile and ownership type, 2017-18 (number of providers in parentheses)

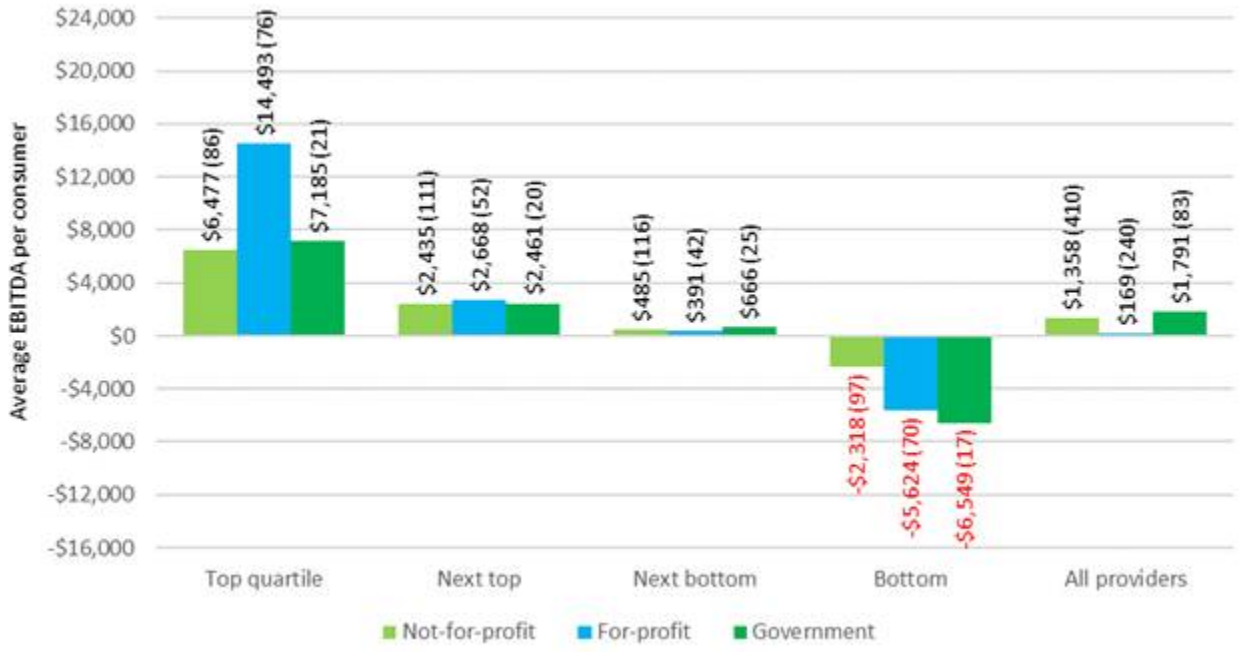
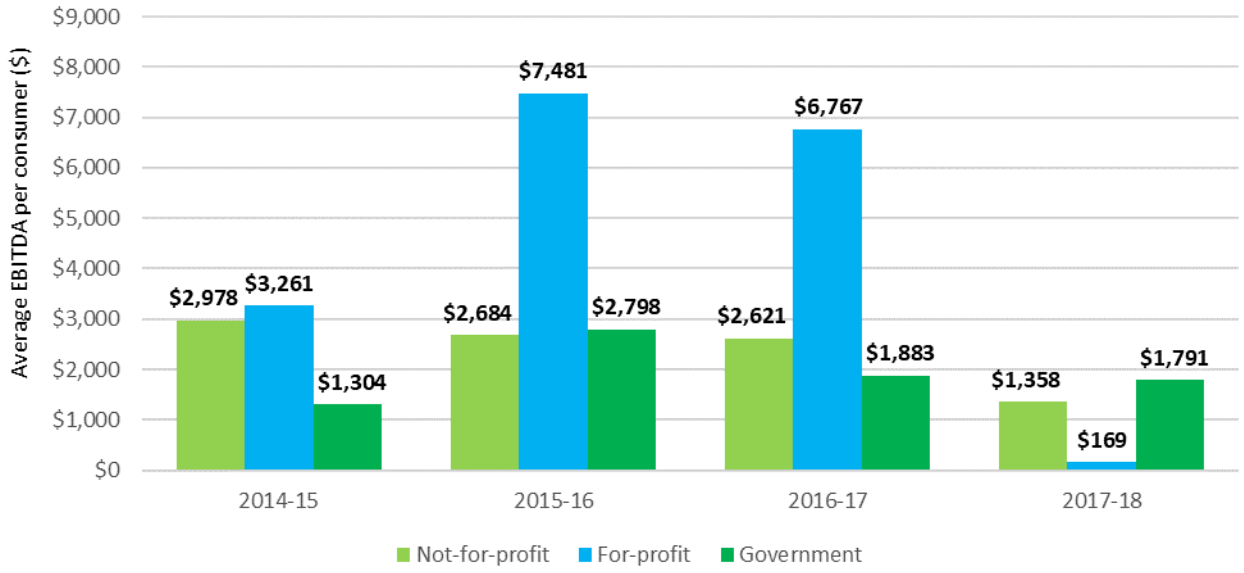


Chart 5.6: Home care average EBITDA per consumer per year, by ownership type, 2014-15 to 2017-18



When performance is considered by location, providers in regional and metropolitan areas reported relatively similar levels of EBITDA per consumer in 2017-18. In contrast, in 2016-17 metropolitan providers were the strongest performers (Chart 5.8).

In terms of quartile analysis (Chart 5.7), metropolitan providers in the top quartile slightly outperformed the regional providers, however metropolitan providers were by far the worst performers in the bottom quartile. Apart from this, the average EBITDA's across the other quartiles remained relatively similar across locations.

Chart 5.7: Home care average EBITDA per consumer per year, by quartile and provider location, 2017-18 (number of providers in parentheses)

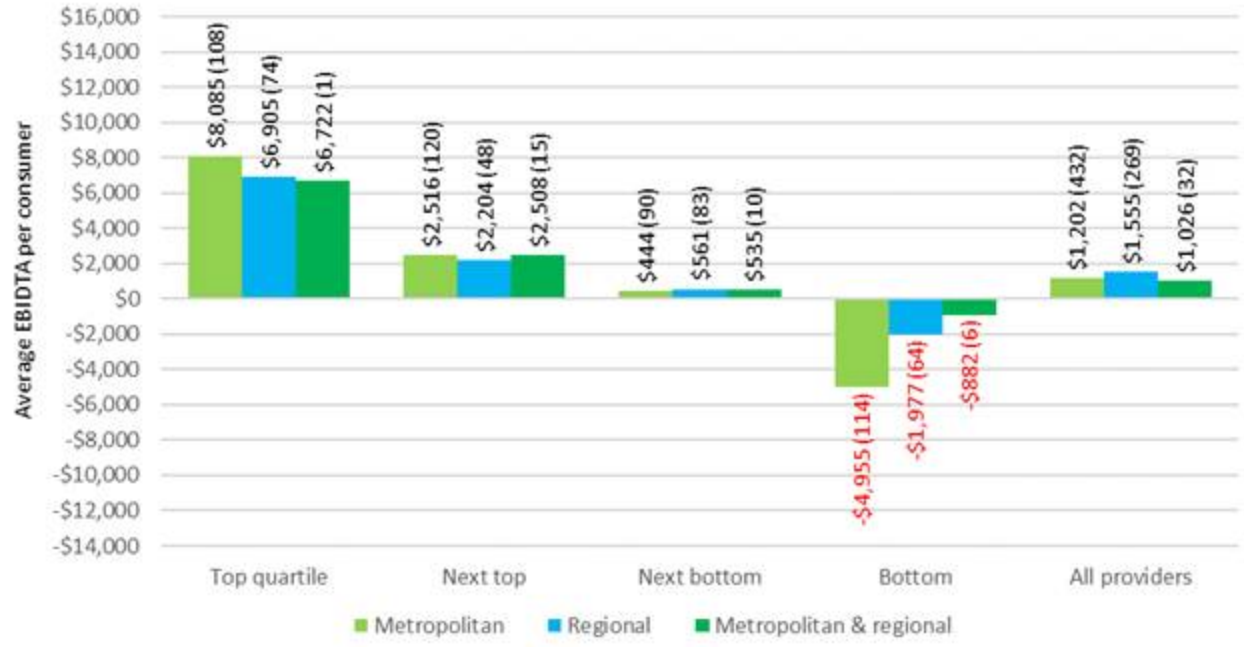
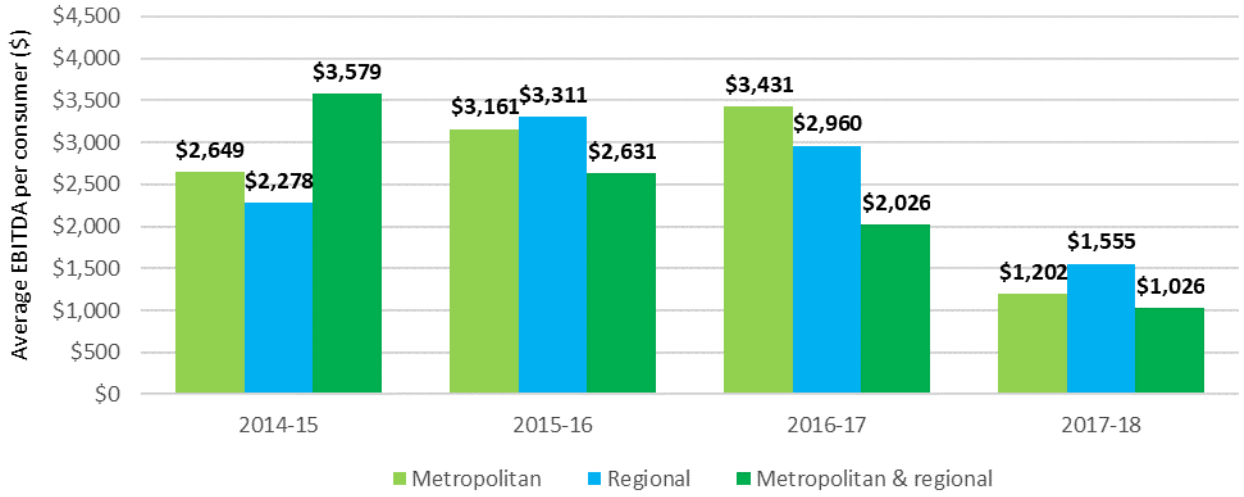


Chart 5.8: Home care average EBITDA per consumer, by provider location, 2014-15 to 2017-18



When performance is considered by scale, up to and including 2016-17, providers who operated multiple services (2-6 and 7 or more) had performed significantly better than single service providers in terms of average EBITDA per consumer (Chart 5.10). However in 2017-18 this trend has reversed with single service providers outperforming their larger counterparts, albeit in a year where providers of all scale reported a significant decline in financial performance. This is despite single service providers reporting significantly higher expenses as noted earlier. Interestingly, when analysed by quartiles, the single service providers were by far the best performers in the top quartile (EBITDA of $10,913) but conversely were the worst performers in the bottom quartile with negative EBITDA of $11,143 per consumer per year compared with larger providers (2-6 services and 7 or more services) reporting negative $4,513 and negative $2,353 respectively (Chart 5.9).

Chart 5.9: Home care average EBITDA per consumer per annum, 2017-18, by quartile and provider scale (number of providers in parentheses)

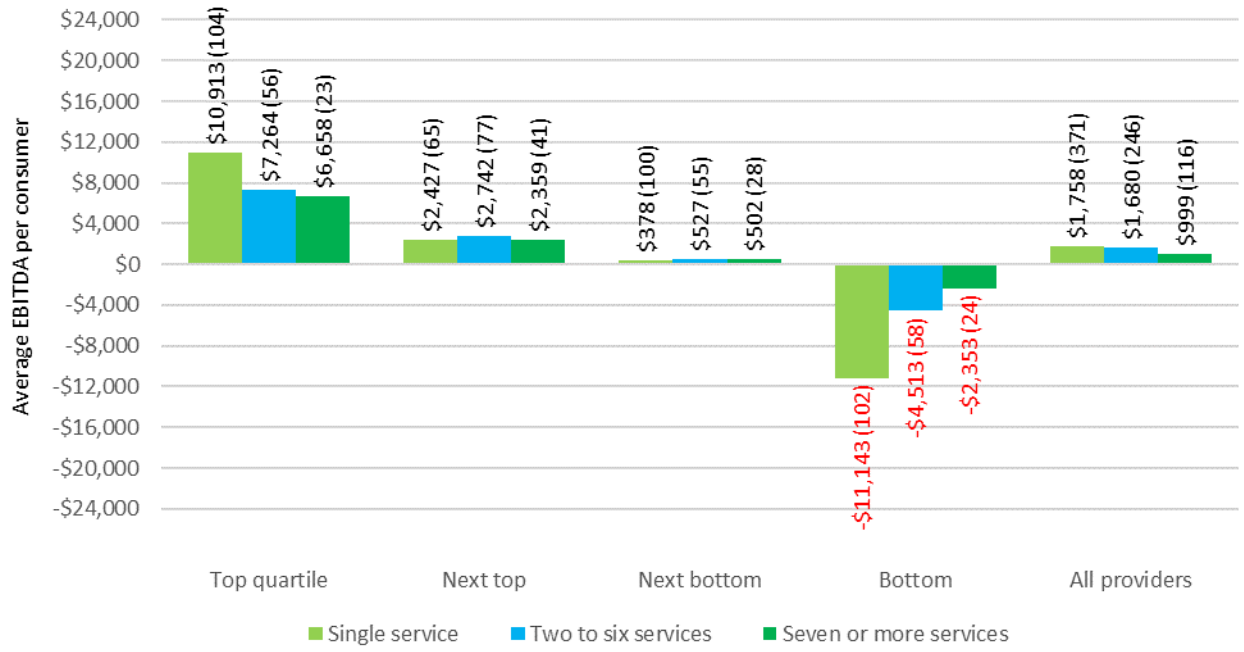
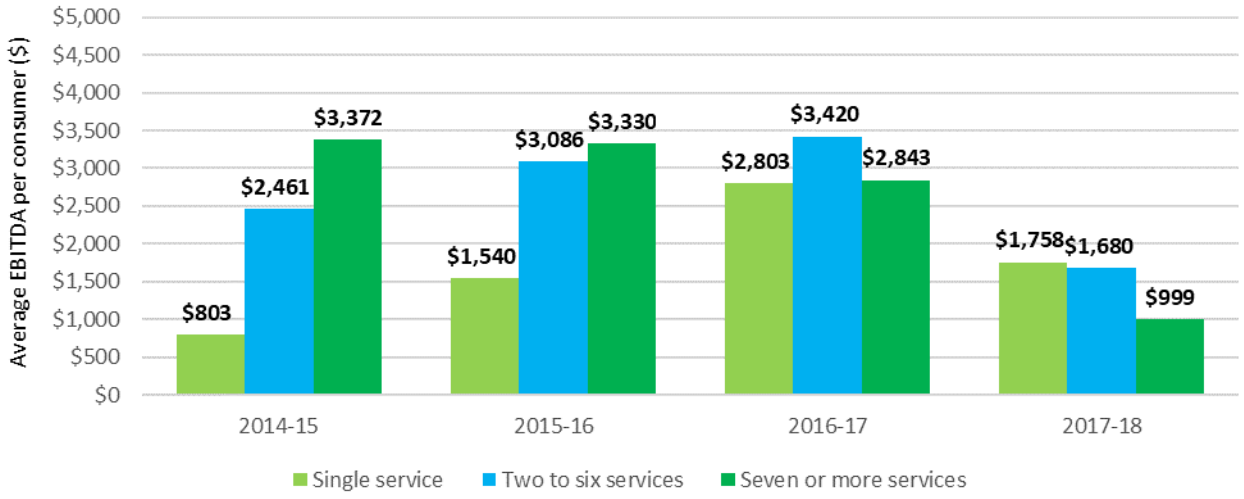


Chart 5.10: Home care average EBITDA per consumer per annum, by provider scale, 2014-15 to 2017-18



5.2.6 Unspent funds

In the last two annual reports, ACFA noted the significant amount of unspent package funds held by providers on behalf of consumers. The amount held has been increasing at a significant rate over the last three years. At 30 June 2018, home care providers reported holding unspent funds of $539 million. This is up from $329 million at 30 June 2017. The level of unspent funds being held at 30 June 2018 equates to holding average unspent funds per consumer of $5,898, up from $4,613 as at 30 June 2017 and $3,667 per consumer at 30 June 2016.

Unspent funds may accumulate for a variety of reasons, including that consumers wish to save a proportion of their budget for future events; the services that the consumer wants are not available; the consumer is reluctant to allow people into their home; misconceptions that the

money not spent under the package belongs to the consumer; or because the consumer does not require all the funds allocated to them. ACFA commented previously that if the consumer does not need all the funds they have been allocated, these funds could be used more effectively elsewhere, including meeting unmet demand. Unspent package funds also raises prudential issues since these funds held by providers need to be available should the consumer leave their care (either transferring to another provider or leaving home care).

The Department of Health does take into account unspent Commonwealth funds that are returned when a consumer leaves home care as an input in determining the number of new home care packages to be released.

In the 2019-20 Budget the Government announced that payment arrangements in home care to be changed from payment in-advance to payment upon delivery of service. This change is intended to avoid Commonwealth subsidies and supplements funding being held as unspent funds by providers. Consumers would still be able to access any unspent funds from the Commonwealth

5.3 Feedback from consultations and developments in 2018-19

After several years of relatively stable overall financial performance among home care providers (although there was always a significant difference in performance across providers), there was a large overall decline in the financial results of the sector in 2017-18.

Feedback from providers, which is confirmed by an analysis of the 2017-18 results, suggests this decline in performance was mainly the consequence of the greater competition resulting from the introduction, in February 2017, of home care packages being assigned directly to consumers and consumers having choice of which provider delivers their services. It was noted in ACFA's annual report last year that only the initial impact of this reform would be influencing the 2016-17 financial results. It is evident that the 2017-18 results have been significantly impacted by the introduction of consumer choice.

Feedback from providers indicates that the reforms have put downward pressure on their revenue and has increased their costs. Among the factors attributed to increasing costs includes having to introduce itemised accounts for consumers and changing business structures to put a greater emphasis on advertising and marketing services along with establishing long term relationships with consumers given the time between when a potential consumer joins the National Prioritisation System and when a consumer is assigned a package. Providers indicated that the introduction of the changes in February 2017 often required attracting staff with new skill sets. As noted previously, there was a significant increase in administration costs for providers in 2017-18.

As regards the impact of the reforms to home care on provider income, accompanying the change that allowed consumers to choose which provider will provide them their services, has been a very substantial increase in the number of approved providers. The result has been a significant increase in the level of competition in the home care sector which has resulted in a decrease in the price of many services, along with providers offering a range of incentives in an effort to attract consumers.

In addition, providers consulted indicate that that they are reducing management and administrative fees charged to consumers as a result of greater competition, notwithstanding that their administration costs have increased. Similarly, and as noted previously, many providers are foregoing charging their consumers the basic daily fee, or are reducing that fee, in an effort to attract consumers. Providers advise that the competition as a result of the home care reforms is not

primarily directed at attracting existing consumers from another provider, and there is limited movement of existing consumers between providers, but is focused on attracting individuals who are waiting or have recently been offered a package. As a result of the increase in the number of providers and greater competition, a number of established home care providers have advised that they have lost market share.

The beneficiary of the home care reforms and the increase in competition in the sector is the consumer. There is downward pressure on prices and fees and pressure on providers to establish relationships with consumers and offer the range of services the consumer is seeking. However in the course of ACFA consultations, a number of established home care providers have suggested that some of the new entrants to the sector are not only reducing prices but also the quality of the services they are providing and that this will be at the detriment of the consumer. The aged care measures announced by the Government in February 2019 included $7.7 million to enhance safety, quality and integrity of home care packages.

A significant development following the introduction of the home care reforms has been the rise of unspent funds – the amount of each consumer's individual budget that the consumer has not spent and now must be held by providers. Previously, a provider could have directed unspent package funds to other consumers. As noted in section 5.2.6, there are a number of possible factors influencing the increase in unspent funds and in some cases consumers may not be receiving all the care they need. From the provider's perspective, unspent funds represent foregone business. Several providers have indicated that they are developing and implementing strategies to reduce unspent funds. To the extent that this involves providers adjusting and introducing services that are more in line with what consumers are seeking and their aged care needs, consumers will be the beneficiary.

Feedback from providers suggests that the competitive pressures evident in 2017-18 have continued in 2018-19. While not directly comparable with the data in this report, the StewartBrown Aged Care Financial Performance Survey suggests some stabilisation in the profitability of home care providers in the six months to December 2018. In the course of consultations, many providers observed that the sector is still in a process of transition and they considered that the current number of approved providers is not sustainable, irrespective of the further release of home care packages. It is also evident that a number of providers still have to adjust their operations so that they are more responsive to meeting consumer preferences. The general feeling appeared to be that a degree of rationalisation in the number of providers would take place. In keeping with this assessment, a few of the providers consulted said that they were reviewing whether they would continue to offer home care packages given the competitive pressure and low returns. In a different vein, but related, some other providers said that they were positioning themselves to take advantage of opportunities that may arise from a shake-out in the number of home care providers.

There are a range of factors influencing the home care sector as a result of the introduction of consumer choice and ACFA notes that it would be opportune to review developments, consider lessons to be learnt from the changes, including possible policy refinements.

6 Residential care

This chapter discusses:

- The operation of residential care;
- the ownership, locational and scale characteristics of residential care providers;
- the funding arrangements in residential care; and
- the financial performance of residential care providers in 2017-18.

This chapter reports that:

- At 30 June 2018 there were 207,142 operational places, up from 200,689 at 30 June 2017;
- during 2017-18 residential care was provided to 241,723 older Australians, up from 239,379 in 2016-17;
- at 30 June 2018 there were 886 providers, down from 902 in 2016-17, continuing the consolidation of recent years with the number of residential care places increasing while the number of providers continues to gradually decrease; and
- not-for-profit providers continue to represent the largest proportion of ownership type in residential care, with 56 per cent of providers and 55 per cent of places, but the proportion of places operated by the for-profits continues to gradually increase.

Key findings on financial performance in 2017-18 compared with 2016-17:

- Total revenue of $18.1 billion, up from $17.8 billion, an increase of 1.7 per cent, equating to revenue of $272.16 per resident per day, an increase of 1.0 per cent from $269.55;
- other income of $955 million down from $980 million;
- total expenses of $17.6 billion, up from $16.8 billion, an increase of 5.3 per cent, equating to $265.62 per resident per day, compared with $254.29, an increase of 4.5 per cent;
- average EBITDA per resident per annum of $8,746 compared with $11,481, a decrease of 24 per cent;
- total profit of $435 million compared with $1,006 million, a decrease of 57 per cent; and
- 56 per cent of providers achieved a net profit compared with 68 per cent.

6.1 Overview of the sector

6.1.1 Supply of residential care

The Australian Government uses a population based planning ratio (target provision ratio) to determine the number of subsidised operational residential care places. This is outlined in Chapter 3.

Table 6.1 shows the number of providers, facilities[27], places and residents since 2013-14. The number of providers continues to decrease each year through consolidation, while the number of places and residents continues to increase. The number of facilities has increased gradually.

Table 6.1 also shows the achieved provision ratio in residential care, as well as provisionally allocated places and respite residents.

The number of allocated residential care places was less at 30 June 2018 (246,536) than it was at 30 June 2017 (247,907), while the number of operational places increased by 6,453 as provisional allocations and offline places came online. The overall reduction in allocated places was due to no new places being allocated during 2017-18 (as there was no ACAR) and 1,371 provisionally allocated places were either surrendered by providers or revoked by the Department. This is discussed in section 6.1.7.

Table 6.1: Number of residential care providers, facilities, places and residents, 30 June 2014 to 30 June 2018

	30 June 2014	30 June 2015	30 June 2016	30 June 2017	30 June 2018
Providers	1,016	972	949	902	886
Facilities	2,688	2,681	2,669	2,672	2,695
Allocated places	217,006	228,024	238,843	247,907	246,536
Operational places	189,283	192,370	195,825	200,689	207,142
Achieved residential care ratio	82.6	81.1	79.7	77.9	77.2
Provisionally allocated places	21,047	28,000	35,124	39,294	31,603
Provisionally allocated places as proportion of allocated places	9.7%	12.4%	14.7%	15.9%	12.8%
Occupancy	93.0%	92.5%	92.4%	91.8%	90.3%
Total residents	176,816	177,820	181,048	184,077	186,597
- Permanent residents	173,974	172,828	175,989	178,713	180,923
- Respite residents	2,842	4,992	5,059	5,364	5,674

1. This table excludes flexible care places.

[27] In residential care, a 'facility' also refers to an aged care home or service.

Table 6.2 shows a breakdown of residential care providers as at 30 June 2018, presented by ownership type, location and scale.

Table 6.2: Number of providers, facilities, places and residents in residential care, by ownership, location and scale, 2017-18

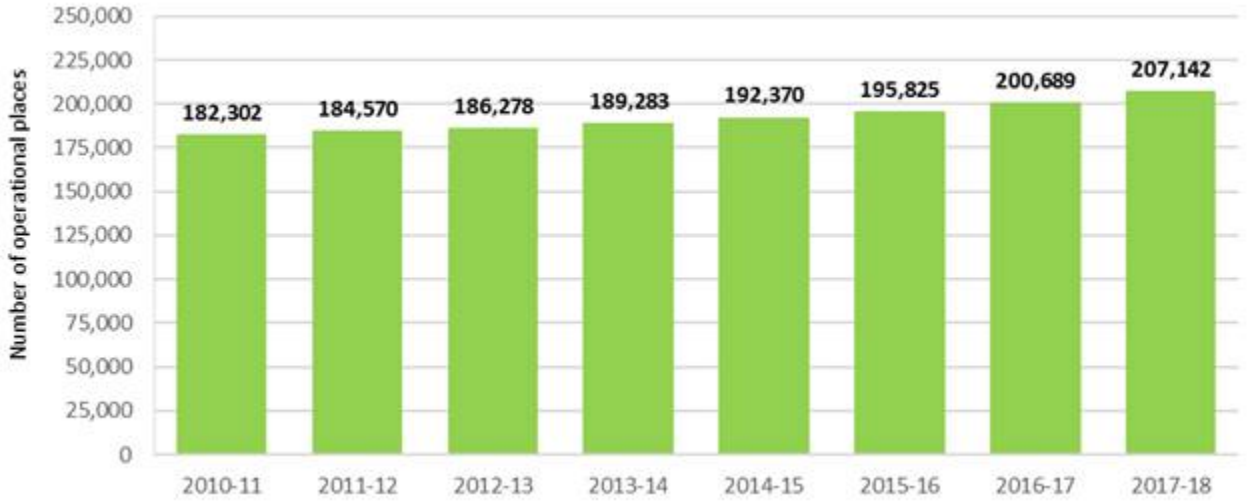
			Ownership type			Location			Scale			
	Total sector 2016-17	Total sector 2017-18	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metropolitan & regional	Single facilities	Two to six facilities	Seven to 19 facilities	20 or more facilities
Providers	902	886	497	294	95	453	343	90	560	246	59	21
Facilities	2,672	2,695	1,549	906	240	739	1,956	N/A	560	694	641	800
Operational places	200,689	207,142	114,463	84,011	8,668	63,305	29,838	113,999	43,001	48,382	50,966	64,793
Occupancy	91.8%	90.3%	92%	88%	90%	89%	92%	91%	90%	90%	91%	91%
Total residents	184,077	186,597	105,308	73,554	7,735	130,611	55,986	N/A	38,377	42,930	46,325	58,965
-Permanent residents	178,713	180,923	102,539	70,856	7,528	126,813	54,110	N/A	36,921	41,593	45,135	57,274
- Respite residents	5,364	5,674	2,769	2,698	207	3,798	1,876	N/A	1,456	1,337	1,190	1,691

6.1.2 Residential care providers

At 30 June 2018, there were 886 residential care providers operating 207,142 residential care places in Australia. This compares with 902 providers operating 200,689 places at 30 June 2017. As has been the case in recent years some providers are continuing to expand the scale of their businesses. As a result there has been a consolidation of residential care providers over a number of years. Chart 6.1 and Chart 6.2 show the decreasing provider numbers but increasing operational places since 2010-11.

Chart 6.1: Number of residential care providers, 2010-11 to 2017-18

Chart 6.2: Number of operational residential care places, 2011-12 to 2017-18



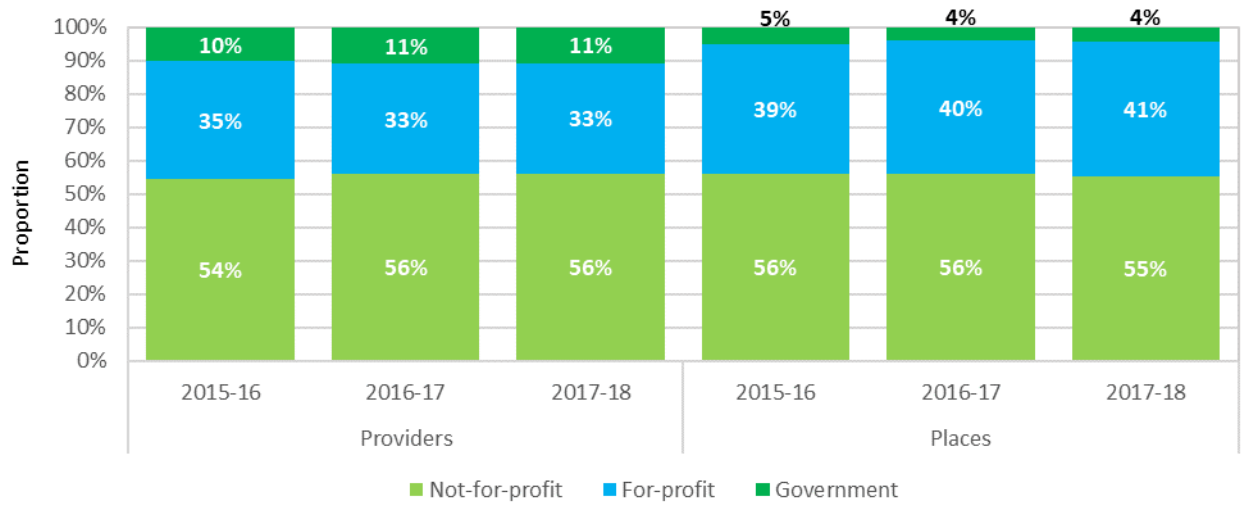
6.1.3 Ownership type

As shown in Chart 6.3, the largest provider group remains the not-for-profit group (religious, charitable and community-based organisations). They represent 56 per cent of providers and operate 55 per cent of all residential aged care places. For-profit providers account for 33 per cent of providers and 41 per cent of places. The remaining providers and places are state and territory and local government-owned providers.

The proportion of providers across ownership types has remained relatively stable. However, as shown, the proportion of operational residential care places held by for-profit providers is continuing to increase gradually. This reflects for-profit providers seeking to increase the scale of their operations through both acquisitions and greater success at gaining new allocations through the Aged Care Approvals Rounds (ACAR).

Not-for-profit providers continue to operate proportionally more of the residential care places in rural and regional areas compared with the for-profits. As at 30 June 2018, not-for-profits (55 per cent of all places) were operating 66 per cent of all regional places. Conversely, and also similar to previous years, for-profit providers operated 41 per cent of all places and only 24 per cent of regional places. Government providers operated the remaining 11 per cent of regional residential care places.

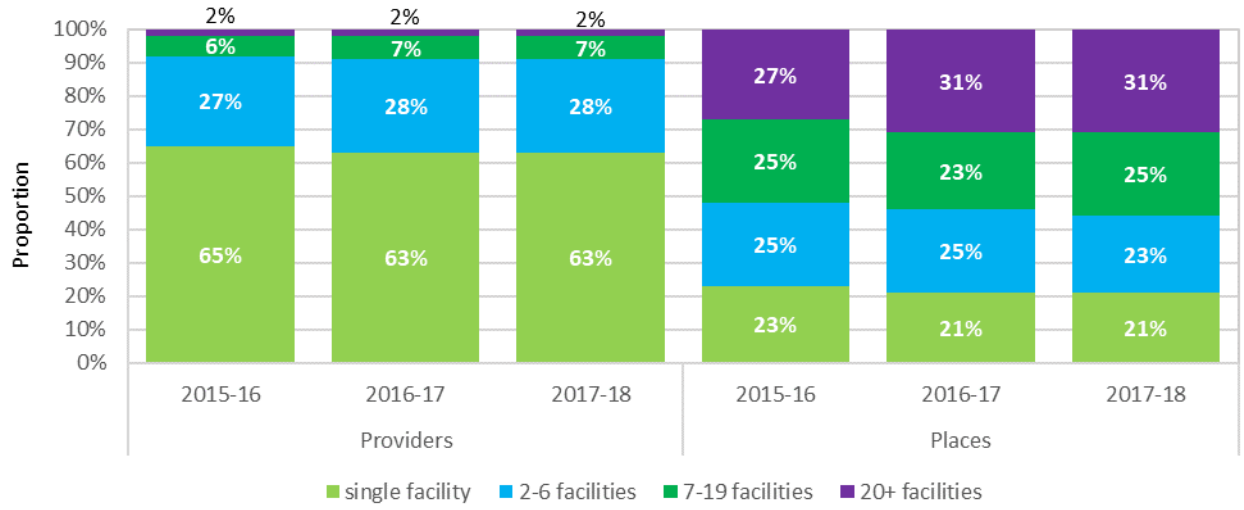
Chart 6.3: Residential care provider and operational places by ownership type, 2015-16 to 2017-18



6.1.4 Provider scale

The majority of residential care providers (63 per cent) operate only one residential care facility (Chart 6.4). These single aged care facility providers account for 21 per cent of all operational residential care places. Conversely, 2 per cent (21 providers in total) operate more than 20 facilities, but they account for 31 per cent of operational places.

Chart 6.4: Residential care provider and operational places by provider scale, 2015-16 to 2017-18



As shown in Table 6.3, for-profit and not-for-profit providers have, on average, around three facilities per provider. However within those facilities, for-profit providers, on average, operate 93 residential care places per facility, compared with not-for-profit providers who operate 74 places per facility. This likely reflects both some for-profit providers expanding their facilities and also reflecting the not-for-profit's bigger presence in regional locations where facility size is usually smaller.

Table 6.3: Number of residential care facilities per provider, by ownership type, 30 June 2018

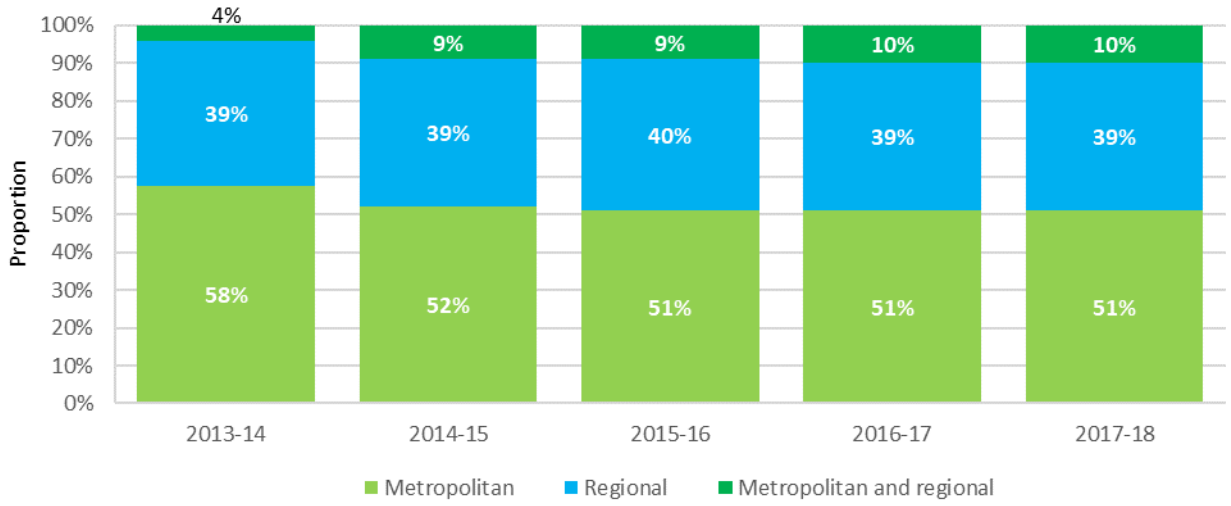
Organisation type	Number of providers	Number of facilities	Average facilities per provider	Total operational places	Average places per provider	Average places per facility
Not-for-profit	497	1,549	3.12	114,463	230	74
For-profit	294	906	3.08	84,011	286	93
Government	95	240	2.53	8,668	91	36

6.1.5 Provider location

ACFA generally categorises residential care providers as those operating only in metropolitan areas, those operating only in regional[28] areas, and those who have facilities in both metropolitan and regional areas. A provider is categorised as being regional if more than 70 per cent of their residents are in facilities in regional areas.

Chart 6.5 shows that 51 per cent of providers operate only in metropolitan areas. However, this number has decreased from 58 per cent in 2013-14 as more providers who previously only operated facilities in metropolitan areas expanded into regional areas. Conversely, 10 per cent of providers operate facilities in both metropolitan and regional areas, up from 4 per cent in 2013-14. The remaining 39 per cent of providers operate in regional areas only.

Chart 6.5: Residential care providers, by location, 2013-14 to 2017-18



6.1.6 Residential care facility size and room configuration

The average size of residential care facilities has been increasing over the last 10 years (Table 6.4). In 2008, 60 per cent of facilities had over 60 places. This has increased to 75 per cent in 2018. By contrast, the proportion of facilities with 40 places or less has decreased from 15 per cent in 2008 to below 9 per cent in 2018. This trend seems particularly evident in the for-profit sector, as

[28] In the aged care context, 'regional' includes rural and remote aged care areas.

discussed in Section 6.1.3, with for-profit providers having, on average, almost 20 more places per facility than the not-for-profits.

Table 6.4: Size of residential care facilities, 2008 to 2018

Number of places	June 2008	June 2009	June 2010	June 2011	June 2012	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018
	Proportion of facilities (%)										
1–20 places	1.6	1.4	1.4	1.4	1.3	1.2	1.1	1.1	1.1	1.0	0.9
21–40 places	13.2	10.7	9.9	10.1	9.4	9.2	8.5	8.1	7.6	7.2	6.8
41–60 places	25.2	22.4	21.4	21.9	20.4	19.6	18.1	17.4	16.4	15.4	14.2
61+ places	59.9	65.5	67.3	66.6	68.9	69.9	72.2	73.3	74.9	76.4	78.0

The predominant room configuration for residential care facilities is a single-bed room with an ensuite. It is estimated that around 80 per cent (77 per cent in 2016-17) of rooms are single-bed rooms with an ensuite and around 3 per cent (5 per cent in 2016-17) are shared rooms with an ensuite. Around 14 per cent of residents are in rooms that could be considered 'ward style' which are shared and have a common shared bathroom (18 per cent in 2016-17).

6.1.7 Provisionally allocated places

The Commonwealth releases residential care places through the ACAR. After a place is allocated to an approved provider, there is usually a period during which the place is considered 'provisional' while the provider constructs the facility or extends the current facility. Once the place is available to be occupied by a resident, it becomes 'operational'. The average time it takes providers to bring places online is around four years.

At 30 June 2018, there were 31,603 provisional residential care places reflecting the carryover of allocated places from previous ACARs which are yet to become operational. This represents around 13 per cent of all allocated places, which compares with 16 per cent at 30 June 2017 and 14 per cent at 30 June 2014. The absence of an ACAR during 2017-18 would largely account for the proportionate reduction in provisional places compared with 2016-17. The provisional allocations are held by around 16 per cent of all facilities.

As was the case last year, Queensland, Western Australia and the ACT have the highest proportion of provisionally allocated places. South Australia and Tasmania have once again the lowest with 3 and 4 per cent respectively (Table 6.5).

Not-for-profit providers, who have 55 per cent of operational places, have only 35 per cent of provisionally allocated places, whereas the for-profit providers, who have 41 per cent of operational places, have 65 per cent of the provisionally allocated places. This is similar to previous years.

In addition, there were also 7,802 formerly operational places at 30 June 2018 that were offline at 30 June 2018 pending refurbishment or redevelopment, or pending sale to another provider.

Table 6.5: Provisionally allocated residential care places, by state and territory, at 30 June 2018

State/territory	Provisionally allocated places	All allocated places	Proportion
New South Wales	8,806	82,169	10.7%
Victoria	8,416	65,366	12.9%
Queensland	8,170	48,502	16.8%
Western Australia	4,638	22,121	21.0%
South Australia	633	18,926	3.3%
Tasmania	208	5,357	3.9%
Australian Capital Territory	647	3,425	18.9%
Northern Territory	85	670	12.7%
Australia	**31,603**	**246,536**	**12.8%**

Changes introduced in 2016 were designed to encourage providers to operationalise their provisional places in a timely manner. The changes limit the provisional allocation period to four years (noting that up to two extensions of 12 months each may be granted by the Department of Health, and further extensions in exceptional circumstances). At the end of this time, the provisional allocations lapse and the places return to the Department for redistribution in a future ACAR.

As noted earlier 1,371 provisionally allocated places were either surrendered by providers or revoked by the Department during 2017-18. The majority (1,083) of these provisionally allocated places were surrendered by providers or lapsed as the six years expired and the provider did not apply for an extension. The remaining 298 provisionally allocated places were revoked by the Department because the providers were not able to meet the exceptional circumstances test for a further extension after six years.

Table 6.6 and Table 6.7 show the distribution of the age of provisionally allocated places by location and state and territory.

Table 6.6: Provisionally allocated residential care places by location and year of distribution, at 30 June 2018

	<1 year old	1-2 years old	2-4 years old	4-6 years old	6-8 years old	8-10 years old	10+ years	Total
Metropolitan	60	6,700	12,504	2,232	1,578	475	603	24,152
Inner regional	0	1,986	3,008	417	163	48	52	5,674
Outer regional	0	394	1,298	12	23	0	0	1,727
Remote	0	0	30	0	20	0	0	50
Total	**0**	**9,080**	**16,840**	**2,661**	**1,784**	**523**	**655**	**31,603**

Table 6.7: Provisionally allocated residential care places by state and territory and year of distribution, at 30 June 2018

	<1 year old	1-2 years old	2-4 years old	4-6 years old	6-8 years old	8-10 years old	10+ years	Total
NSW	0	2,315	4,340	1,030	689	247	185	8,806
VIC	0	2,438	5,035	643	184	24	92	8,416
QLD	60	2,259	4,456	540	695	24	136	8,170
WA	0	1,621	2,131	400	32	228	226	4,638
SA	0	200	336	7	90	0	0	633
TAS	0	103	105	0	0	0	0	208
ACT	0	144	372	41	74	0	16	647
NT	0	0	65	0	20	0	0	85
Total	**60**	**9,080**	**16,840**	**2,661**	**1,784**	**523**	**655**	**31,603**

Transferring residential care places

Residential aged care places (both provisionally allocated and operational) may be transferred between providers. A transfer of places commonly occurs as the result of a business transaction between two approved providers where a decision has been made by the transferor to sell all or some of their residential care places. Transfers of places need to be approved by the Department of Health.

As a general rule, when places transfer between providers, the planning region in respect of which the places are allocated does not change. This rule, and the need for approval by the Department of Health, are designed to discourage attempts to subvert the competitive allocation process and to maintain care delivery in the region where the places were originally allocated.

Data from the Department of Health shows that in 2017-18 there were 64 transactions involving the transfer of around 4,400 operational places and 45 transactions involving the transfer of around 2,400 provisionally allocated places.

Data on the number of places being transferred between providers is an indicator of consolidation within the sector. Given increasing reports of providers looking to leave the sector, ACFA will continue to monitor this data on the transfer of residential care places.

6.1.8 Extra service

Providers with extra service status are able to charge an extra service fee for residents occupying an extra service place for the duration of their stay. Extra service status involves the provision of a higher than average standard of services, including accommodation, range and quality of food, and non-care services such as recreational and personal interest activities.

To be eligible for extra service status, providers must first seek approval from the Department. Providers that have been granted extra service status apply to the Aged Care Pricing Commissioner for approval of their proposed extra service fees, including proposed increases to current extra service fees.

For extra service status places that are occupied by a resident who was in care prior to 1 July 2014 and who is covered under the pre-reform fee arrangements, the care subsidy is reduced by 25 per cent of the approved extra service fee for that place. This is known as the Extra Service Subsidy Reduction. The provider can charge a continuing care recipient an amount equal to the extra service fee plus the extra service reduction for receiving extra service. Extra service subsidy reduction does not apply to residents entering care on or after 1 July 2014.

There was a significant decrease in 2014-15 and 2015-16 in the number of places with extra service status (Chart 6.6). This was likely because changes made to accommodation pricing on 1 July 2014 reduced the need and motivation for providers to have extra service status, partly because:

- lump sum accommodation payments can now be made for all care types – previously they were restricted to low care or high care with extra service;
- market-based prices determined by the provider apply for all new non-supported residents; and
- providers can offer additional care and services for additional fees outside the extra service framework.

This led some providers to reconsider their extra service status, with many offering residents 'additional service' arrangements instead. However, as shown, the number of extra service places has stabilised over the last two years.

Chart 6.6: Number of active extra service residential care places, 30 June 2014 to 30 June 2018

6.1.9 Additional services

Additional services are care and services that aged care providers can make available to consumers above those that they are legislatively required to provide under the Schedule of specified care and services for residential care services. Additional services vary greatly but may include items such as the provision of pay TV, hairdressing, additional beverage offerings (e.g. wine and beer) and access to a gym. Additional services may be offered individually or as part of a bundle of services. These services attract an additional fee for consumers.

An additional service fee can only be charged for services that have been agreed to by the resident, that are over and above those paid for by the Commonwealth, and from which aged care residents receive a direct and tangible benefit.

There is very limited data available on additional services, however, anecdotal evidence is that this is an area that is receiving increasing attention from providers. The department is working with the sector to provide additional clarity and transparency for both providers and residents on the operation of additional services. It is anticipated that additional data will be available in future years to enable analysis.

6.2 Residential care funding sources

6.2.1 Operational funding

Funding for residential care is made up of operational funding and capital financing.

Operational funding supports day-to-day services such as nursing and personal care, living expenses and accommodation expenses. Capital financing supports the construction of new residential care facilities and the refurbishment of existing facilities. Capital financing is discussed in Chapter 7.

A combination of Australian Government and resident contributions provides the operational funding for residential care. Figure 6.1 shows the different funding types from the Commonwealth and residents for operational funding.

Figure 6.1 Residential care services

The Commonwealth determines its contributions on behalf of permanent residents in residential care by setting:

- A basic care subsidy for personal and nursing care;
- the rates of supplements paid to support aspects of residential care that incur higher costs to deliver; and
- the maximum rate of accommodation supplement.

With regard to respite care, the Commonwealth sets the basic respite care subsidy at two levels (low or high) depending on the level of respite care the consumer is approved for by the Aged Care Assessment Team (ACAT).

The Commonwealth also sets the maximum levels for contributions made by residents for the following:

- the maximum rate of the basic daily fee for living expenses (permanent and respite); and
- the maximum means tested care fee that may be charged by providers (permanent only).

6.2.2 Commonwealth operational funding

Commonwealth payments for residential care in 2017-18 can be classified as:

- basic care subsidies
- respite care subsidies and supplements
- accommodation supplements
- viability supplements
- other supplements

A full list of subsidies and supplements is at Appendix G.

Commonwealth subsidies and supplements are generally indexed either biannually (accommodation related) or annually (care related).

The indexation applied to the basic subsidy for residential care is the Wage Cost Index 9 (WCI-9), which is a composite index constructed by the Department of Finance that comprises a wage cost component (weighted at 75 per cent) and a non-wage cost component (weighted at 25 per cent). For all Wage Cost Indices the value of the wage cost component is based on the dollar increase in the national minimum wage (as determined annually by the Fair Work Commission) expressed as a percentage of the latest available estimate of average weekly ordinary time earnings (AWOTE) published by the Australian Bureau of Statistics as at November of each year. The value of the non-wage cost component of WCI-9 is based on changes in the Consumer Price Index between the March quarters each year.

Accommodation related supplements are indexed using the Consumer Price Index (CPI) and are indexed twice a year in line with the aged pension.

6.2.3 Basic care subsidies

- **The basic care subsidy** is a payment to support the costs of providing personal and nursing services for permanent residents. It is calculated based on the assessed need of each permanent resident as determined by the provider by applying the Aged Care Funding Instrument (ACFI). The Commonwealth determines the level of payments on behalf of residents by setting the prices and rules for claiming ACFI care subsidies.
- **The residential respite subsidy** is a payment to support the costs of providing personal and nursing services for respite consumers. Respite consumers are assessed by an ACAT as requiring either low or high level respite care, with payment amounts for each set by the Commonwealth.

The Aged Care Funding Instrument (ACFI)

The ACFI is the funding allocation tool currently used to determine the amount of funding paid to a provider on behalf of a resident for their care. It assesses the care needs of permanent residents as a basis for allocating care funding by focusing the funding allocation around the main areas that differentiate relative care needs and costs among residents.

The ACFI consists of 12 questions about assessed care needs, each having four ratings (A, B, C or D) and two diagnostic sections. ACFI is self-assessed by providers, but is subject to audits by the Department of Health.

As discussed in last year's report, during 2015-16, real growth of expenditure per resident per day through the ACFI was 5.2 per cent, compared with a Government budgeted growth of 3.2 per cent. This resulted in an increase to the Government's forecast expenditure over four years of $3.8 billion.

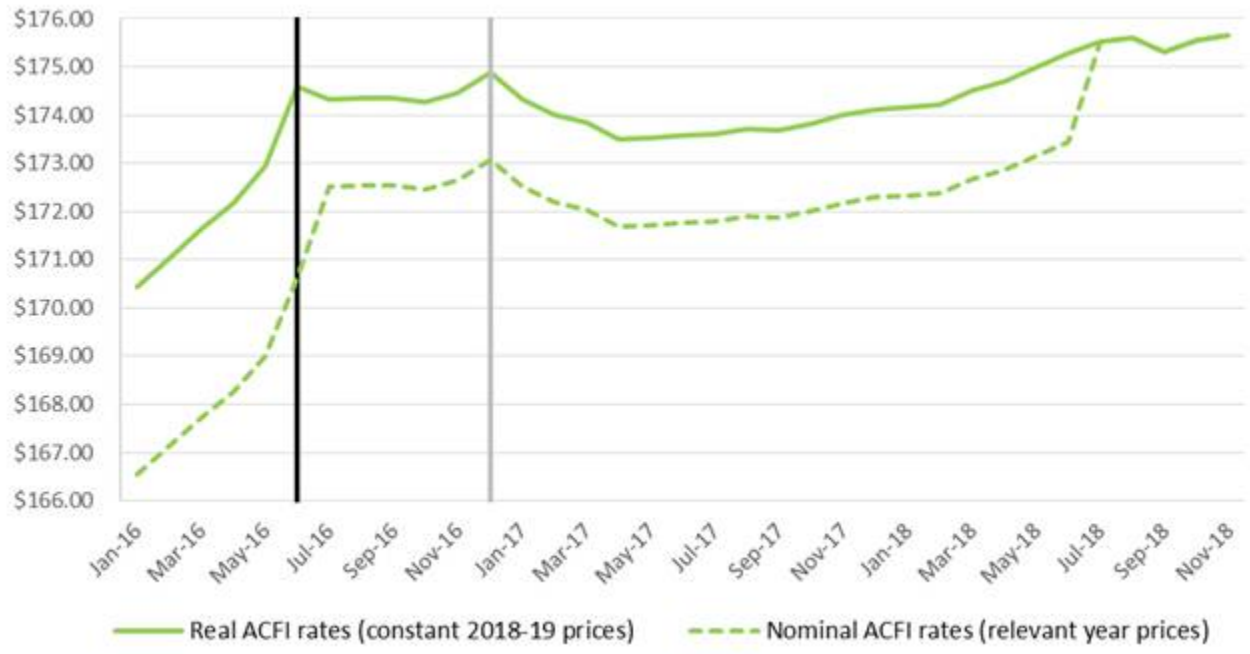
The Government responded by announcing changes to the ACFI and indexation. These changes took effect on 1 July 2016 and 1 January 2017. The changes to ACFI included a new matrix reducing the rating categories for medication under Question 11 of the Complex Health Care domain and changes to the scoring and eligibility requirements for certain Complex Health Care procedures. The changes were complemented by an indexation pause on all ACFI domains in 2017-18 and a partial indexation pause in 2018-19.

Annual growth in the daily average ACFI expenditure for 2017-18 was forecast to be around 2.4 per cent; the actual growth for the year was 0.0 per cent.

For 2018-19, annual real growth in ACFI is forecast to be 1.4 per cent. Real growth up to November 2018 was 1.0 per cent. Real growth refers to growth in the average ACFI above that which can be attributed to the indexation applied to ACFI rates on 1 July 2018. Separate to the annual indexation increases, the government announced two measures that will impact average subsidies paid to providers in 2018-19. These are the $50 million in ACFI funding from September 2018 to assist providers in transitioning to the new Quality Standards, and the $320 million increase in ACFI funding from March to end June 2019. These increases are for the 2018-19 year only.

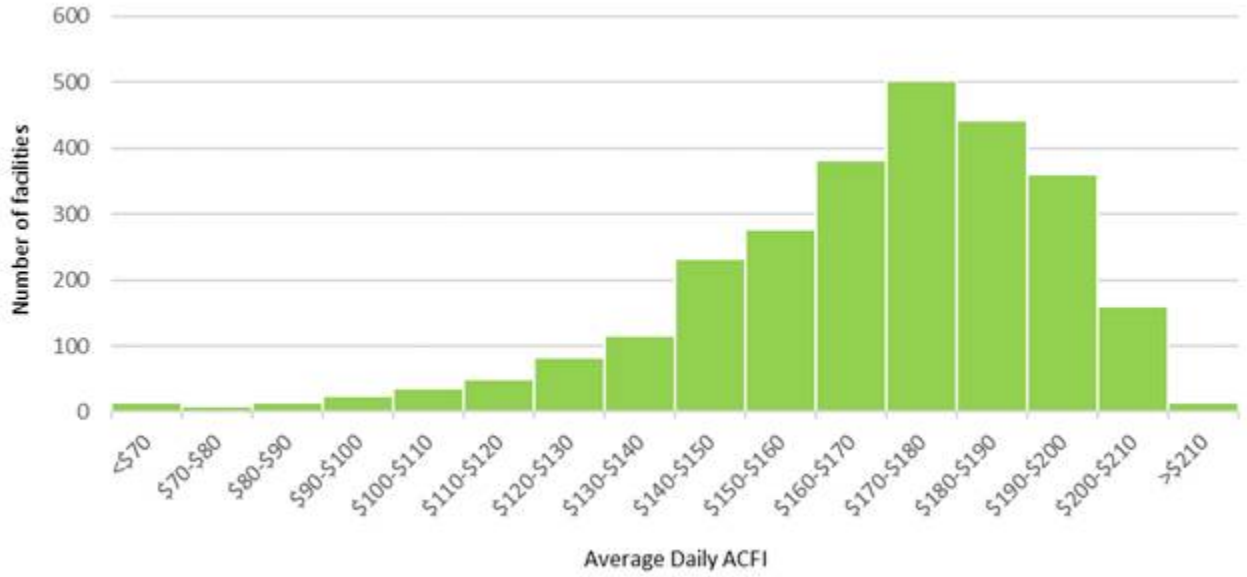
The Department of Health produces monthly reports regarding actual ACFI expenditure compared with Budget estimates. These reports can be found at https://agedcare.health.gov.au/tools-and-resources/aged-care-funding-instrument-acfi-reports.

Chart 6.7: Average monthly ACFI payments (real and nominal), January 2016 to November 2018



The average ACFI claim per resident per day can vary across facilities, reflecting variations in resident profile and the claiming behaviour of providers. A number of providers indicated during consultations that they were 'under claiming' ACFI relative to the care needs of residents and were seeking to improve their ACFI claims process. Chart 6.8 shows the range of claims for 2017-18 with some facilities averaging less than $70 per day while some average over $210 per day.

Chart 6.8: Number of residential care facilities in each range of ACFI claims per resident per day, 2017-18



As noted last year, the Government commissioned a study on the relative costs of providing care for residents with differing care needs and has been consulting with the sector on long-term reform options for residential aged care funding. Reports from the Resource Utilisation and Classification Study (RUCS) were released in March 2019 and include evidence on the drivers of costs of care in residential care facilities as well as a proposed new funding model to replace the ACFI. The Government is consulting with the sector on the recommendations in the reports.

The RUCS suggests that ACFI does not adequately distinguish between the fixed costs of providing residential aged care and the variable costs per resident based on individual care needs. As part of the RUCS, a new assessment and funding model has been proposed, known as the Australian National Aged Care Classification (AN-ACC) system. The system includes a funding assessment tool for use by external assessors, a casemix classification system with 13 classes and a system of base care tariffs that reflects the differences in shared costs faced by providers with different care specialities and locations. Under the proposed model providers would receive a payment that consists of a base care tariff for shared costs, a payment for each resident based on their AN-ACC class and a one-off adjustment payment for each new resident that enters care.

The ACFI does not apply for residential respite care. Instead, respite care funding is paid at either a low or high rate depending on the level of care for which the consumer is approved by the ACAT.

Additionally, providers who use 70 per cent or more of their respite allocation over a 12-month period receive a higher payment[29].

6.2.4 Residential care supplements

Residential care supplements are payments in addition to the basic daily subsidy (ACFI). There are two types of supplements:

- primary supplements, which provide additional funds to meet specific care needs. These include the oxygen supplement and enteral feeding supplement;
- other supplements, which are accommodation-based and assist providers with costs related to the operation of a residential care facility. Other supplements include accommodation supplements, the viability supplement and homeless supplement.

The types and amounts of supplements that a residential care facility will receive depends on the provider and/or residents meeting the eligibility requirements for those supplements.

The major supplements are summarised below and a full list of supplements, including rates and expenditure over the last 3 years are included at Appendices G and H.

Accommodation supplements

Accommodation supplements are paid by the Commonwealth to assist with the accommodation costs of permanent residents who do not have the means to meet all of that cost themselves (supported residents). These supplements include both the current accommodation supplement and grand-parented supplements under previous policies. Accommodation supplements (or accommodation payments) do not apply for consumers accessing residential respite care.

The Commonwealth determines the amount of accommodation supplement payable by setting the maximum rate of accommodation supplement and determining the share paid by residents based on a means test.

Two significant reforms from 1 July 2014 affected accommodation payments. A new means test that combined the formerly separate income and assets tests was introduced for residents entering residential care after 1 July 2014, and the accommodation supplement paid by the Commonwealth to a provider on behalf of supported residents living in aged care facilities that have been built or significantly refurbished since 20 April 2012 was significantly increased.

Viability supplement

The Viability supplement aims to improve the financial position of smaller, rural and remote residential care facilities that incur additional costs due to their location and are constrained in their ability to realise economies of scale due to smaller numbers of beds. In addition, the Viability supplement also supports providers who specialise in aged care services for Indigenous people, or people who are homeless or who are at risk of becoming homeless, in recognition of the often higher costs associated with providing these services.

The supplement is available to residential care facilities, home care services, Multi-Purpose Services and Aboriginal and Torres Strait Islander Flexible services. In 2017-18, on average, the Viability

[29] An additional amount is paid to residential care providers if they use an average of 70 per cent or more of their respite care allocation during the 12 months up to and including the month providing respite care. If the 70 per cent target is met, a payment is made at the end of the month for each of the high care respite days provided during that month.

supplement provided around $10,000 per resident per annum for residential care facilities in remote and very remote areas, directly improving their financial results.

A 30 per cent increase to the rate of the Viability supplement was announced by Government in December 2018, taking effect from March 2019.

Homeless supplement

A Homeless supplement is paid to providers for each resident of an eligible aged care facility. Eligibility for the supplement is based on the facility having more than 50 per cent of its residents who are identified as being homeless, or at risk of being homeless. The supplement is in addition to the funding provided under the Viability supplement.

In 2017-18 the Homeless supplement was paid in respect of around 1,500 residents. During 2017-18 $8.6 million in Homeless supplement was paid to providers.

A 30 per cent increase to the rate of the Homeless supplement was announced by Government in December 2018, taking effect from March 2019.

6.2.5 Payments for residential respite care

The Australian Government pays the provider a residential respite subsidy and a respite supplement for each eligible respite resident.

The subsidy and supplement are paid at either a low or high rate depending on the level of respite care the consumer is approved for by the ACAT. Additionally, facilities that use 70 per cent or more of their respite allocation over a 12 month period receive a higher daily respite supplement rate per eligible high care recipient. Respite subsidies are indexed on 1 July each year. Respite supplements are indexed on 20 March and 20 September each year in line with pension indexation. Table 6.8 shows the residential care respite rates applicable as at 20 March 2019.

A one-off increase in the respite subsidy rates for both high and low level respite care was made on 20 March 2019 as part of the Government's Mid-Year Economic and Fiscal Outlook for 2018-19. This increase will cease on 30 June 2019, and indexation will occur on 1 July 2019 based on the basic subsidy amount less the one-off increase.

Table 6.8: Residential respite care subsidies and supplement rates, at 20 March 2019

	Daily subsidy	Daily supplement	Total paid per day
Low level respite care	$51.17	$39.15	$90.32
High level respite care	$143.47	$54.87	$198.34
High level respite care when a facility uses 70% or more of respite allocation	$143.05	$93.36	$236.83

In addition, residential respite consumers can be eligible for other supplements, such as oxygen supplement, where there is a need.

Chart 6.9 shows total Commonwealth payments for residential respite care since 2011-12.

Chart 6.9: Total residential respite care expenditure, 2011-12 to 2017-18 ($m)

6.2.6 Resident operational funding

Contributions by permanent residents in 2017-18 for operational funding were made up of:

- **A basic daily fee,** which is a contribution towards living expenses such as meals, laundry services, utilities and toiletries. The price is set by the Commonwealth, and is currently set at a maximum of 85 per cent of the single basic age pension.
- **A means tested care fee,** which is a contribution some residents make towards their care costs (personal and nursing) based on their assessable income and assets. Annual and lifetime caps on care contributions apply as a consumer protection. As at 20 March 2019 the annual cap for a means tested care fee was $27,532.59, with a lifetime cap of $66,078.27 also applying.
- **Accommodation payments,** which are daily payments for accommodation in an aged care facility. Lump sum accommodation deposits are not treated as revenue, but as capital financing, discussed in Chapter 7.
- **Extra service fees,** which residents in aged care facilities with extra service status may be asked to pay for significantly higher standards of accommodation, food and non-care services. These vary from facility to facility.
- **Additional services fees,** which are for care and services in non-extra service facilities that are over and above those that providers are required to deliver under the Specified Care and Services Schedule of the *Aged Care Act 1997*, and must be agreed between the resident and provider. These vary from facility to facility, and are not payable at all facilities.

6.3 Operational performance in 2017-18

6.3.1 Revenue

ACFA broadly describes revenue for residential care providers in four categories: care related, living expenses, accommodation and other. Table 6.9 provides a breakdown of the revenue reported by residential care providers in 2017-18 compared with the previous two years.

Table 6.9: Revenue sources for residential care providers, by care, accommodation, living and 'other', 2015-16 to 2017-18 ($m)

Revenue sources	2015-16 ($million)	2016-17 ($million)	Change (%)	2017-18 ($million)	Change (%)
Care related					
Basic care subsidy (ACFI)	$9,991.3	$10,741.7	7.5%	$10,812.3	0.7%
Respite subsidy	$287.7	$301.4	4.8%	$346.9	15.1%
Other supplements	$72.8	$89.3	22.7%	$84.5	-5.4%
Resident means tested care fees	$456.0	$468.9	2.8%	$504.0	7.5%
Resident other care fees	$0	$61.2	N/A	$48.7	-20.4%
Total care revenue	**$10,807.8**	**$11,662.5**	**7.9%**	**$11,796.4**	**1.1%**
Living related					
Resident basic daily fee	$3,088.9	$3,186.7	3.2%	$3,253.4	2.1%
Extra service fees	$146.9	$157.5	7.2%	$119.3	-24.3%
Additional services fees	$0.0	$0.0	N/A	$96.7	N/A
Total living related revenue	**$3,235.8**	**$3,344.2**	**3.4%**	**$3,469.4**	**3.7%**
Accommodation related					
Accommodation supplement	$941.6	$929.7	-1.3%	$1,008.1	8.4%
Accommodation payments from residents	$850.8	$778.4	-8.5%	$781.0	0.3%
Capital grants	$0.0	$61.7	N/A	$56.5	-8.4%
Total accommodation related revenue	**$1,792.4**	**$1,769.8**	**-1.3%**	**$1,845.6**	**4.3%**
Other income					
Interest	$0.0	$313.8	N/A	$326.2	4.0%
Donations and fundraising	$0.0	$32.3	N/A	$29.0	-10.2%
Gain on sale of assets	$0.0	$29.1	N/A	$23.2	-20.3%
Revaluation of assets	$0.0	$130.4	N/A	$37.9	-70.9%
Other	$1,335.8	$474.4	-64.5%	$538.6	13.5%
Total other revenue	**$1,335.8**	**$980.0**	**-26.6%**	**$954.9**	**-2.6%**
Total residential care provider revenue	**$17,171.8**	**$17,756.5**	**3.4%**	**$18,066.3**	**1.7%**

1. The inclusion of a line item for additional services fees has resulted in a decrease in extra services fees, resident other care fees, and comparative decrease in accommodation payments from residents. I.e. providers allocated their revenue from additional service fees across these categories last year. This was mentioned in the note under the table last year.

2. Fees and charges received from a resident in respect of occasional care services like consultation, medication, treatment or procedures provided in addition to services required to be delivered under Schedule 1 of the *Aged Care Act 1997*.

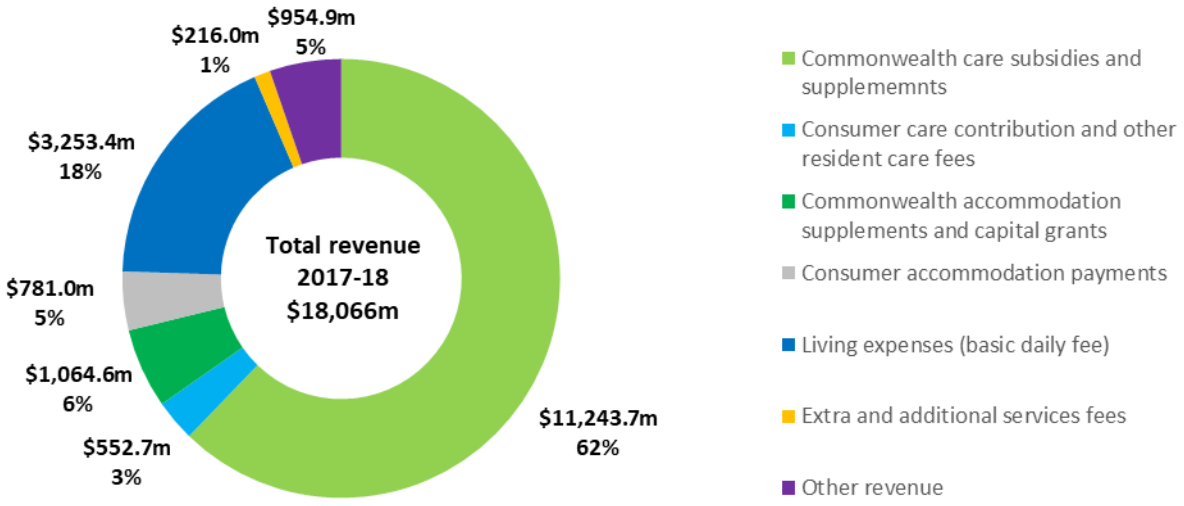
In 2017-18, care related revenue formed the majority (65.2 per cent) of total revenue earned by residential care providers ($11.8 billion), similar to 2016-17. Living related revenue received from residents, which includes the basic daily fee, extra services fees and additional service fees, accounted for 19.2 per cent ($3.5 billion) of total revenue, again similar to 2016-17.

Accommodation payments, consisting of accommodation supplements paid by the Government and daily accommodation payments paid by residents, accounted for 10.2 per cent ($1.8 billion) of total provider revenue in 2017-18, compared with 9.6 per cent in 2016-17.

Other income of $955 million made up the remaining 5.3 per cent of total residential care revenue in 2017-18. Interest revenue, which makes up over a third of total 'other' income may include interest earned on lump sum deposits less any interest payments made on borrowings (providers may show these separately in their balance sheets or may combine them as 'net').

Chart 6.10 shows the proportions of all revenue sources for residential care providers in 2017-18.

Chart 6.10: Proportions of total residential care provider revenue, 2017-18 ($m)



ACFA also analyses revenue sources in terms of those sources provided by the Commonwealth compared with those provided by residents. Table 6.10 shows provider revenue sources for 2016-17 and 2017-18, split by Commonwealth, resident and other.

Table 6.10: Revenue sources for residential care providers, Commonwealth, resident and 'other', 2016-17 and 2017-18 ($m)

Revenue sources	2016-17 ($million)	2017-18 ($million)	Change ($million)	Change (%)
Commonwealth				

Basic care subsidy (ACFI)	$10,741.70	$10,812.30	$70.60	0.7%
Respite subsidy	$301.40	$346.90	$45.50	15.1%
Other supplements	$89.30	$84.50	-$4.80	-5.4%
Accommodation supplements	$929.70	$1,008.10	$78.40	8.4%
Capital grants	$61.70	$56.50	-$5.20	-8.4%
Commonwealth funding sources	**$12,123.80**	**$12,308.30**	**$184.50**	**1.5%**
Resident				
Basic daily fee	$3,186.70	$3,253.40	$66.70	2.1%
Means tested care fees	$468.90	$504.00	$35.10	7.5%
Resident care fees - other	$61.20	$48.70	-$12.50	-20.4%
Accommodation payments	$778.40	$781.00	$2.60	0.3%
Extra services fee	$157.50	$119.30	-$38.20	-24.3%
Additional services fee	N/A	$96.70	$96.70	N/A
Resident funding sources	**$4,652.70**	**$4,803.10**	**$150.40**	**3.2%**
Other income				
Interest	$313.80	$326.20	$12.40	4.0%
Donations and fundraising	$32.30	$29.00	-$3.30	-10.2%
Gain on sale of assets	$29.10	$23.20	-$5.90	-20.3%
Revaluation of assets	$130.40	$37.90	-$92.50	-70.9%
Other	$474.40	$538.60	$64.20	13.5%
Other funding sources	**$980.00**	**$954.90**	**-$25.10**	**-2.6%**
Total revenue	**$17,756.50**	**$18,066.30**	**$309.80**	**1.7%**

1: Extra service subsidy reduction does not apply to new residents entering care from 1 July 2014, however it still applies to residents in ESS places who were in care prior to 1 July 2014.
2: Additional services fees were not reported for 2016-17 so no comparison is possible.

Overall in 2017-18, the Commonwealth contributed 68.1 per cent of total provider funding ($12.3 billion). Residents contributed 26.6 per cent ($4.8 billion) while income from other sources comprised the remaining 5.3 per cent ($955 million). This compares with 2016-17 where the Commonwealth share was 68.3 per cent, residents contributed 26.2 per cent and other income was 5.5 per cent.

Chart 6.11 shows the proportion of revenue that residential care providers received in 2017-18 from the Commonwealth. Basic subsidies (ACFI) comprised by far the greatest share at 88 per cent.

Chart 6.11: Proportions of provider revenue from the Commonwealth, 2017-18 ($m)

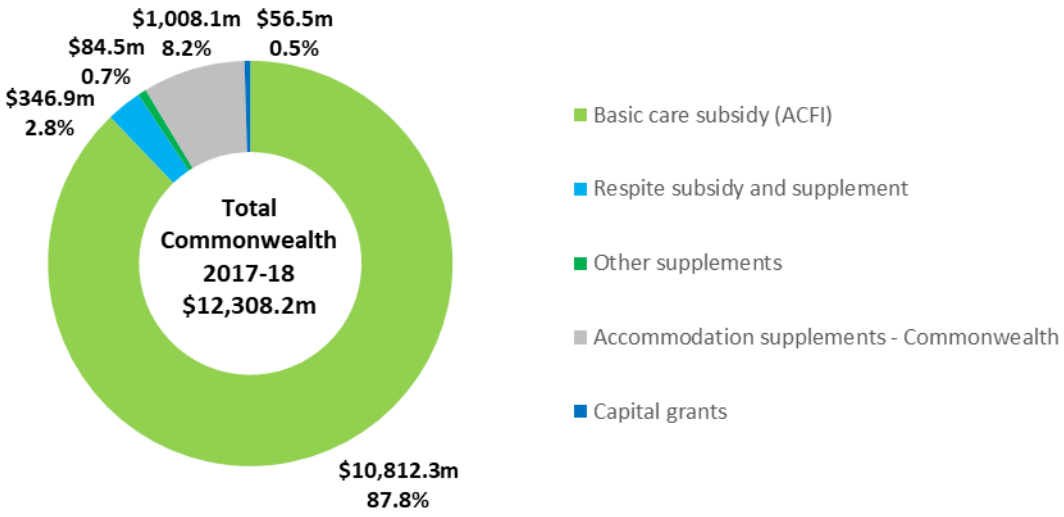


Chart 6.12 shows the proportion of total revenue that residential care providers receive from residents. The basic daily fee forms the greatest share (68 per cent). Means tested care fees formed a further 16 per cent of the revenue received.

Chart 6.12: Proportions of residential care provider revenue from residents, 2017-18 ($m)

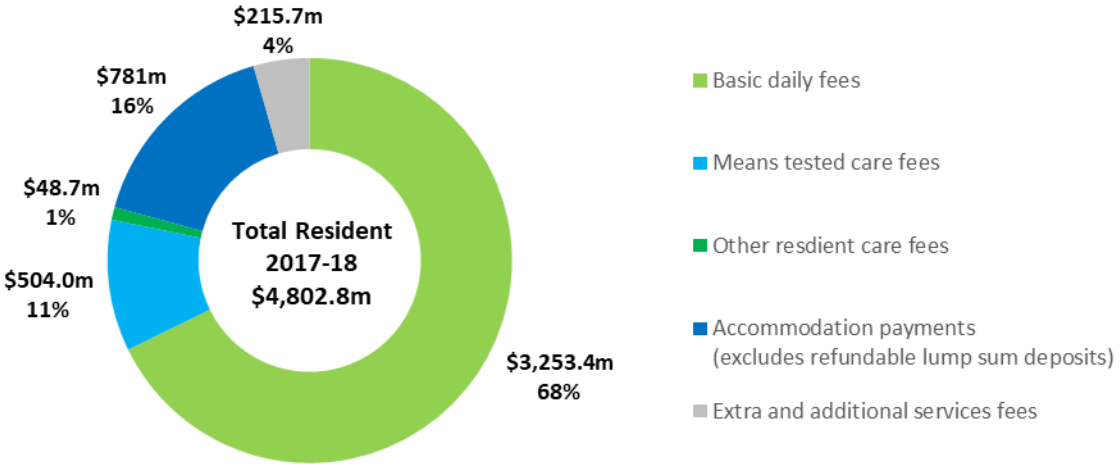


Table 6.11 shows total revenue per resident per day in 2017-18 compared with 2016-17. Total revenue per resident was $272.16, an increase of 1.0 per cent from 2016-17 ($269.58).

Table 6.11: Residential care provider revenue sources per resident per day, 2016-17 and 2017-18

	2016-17	2017-18	Change ($ p.r.p.d.)	Change (%)
Commonwealth revenue sources				
ACFI	$163.07	$162.88	-$0.19	-0.1%

Respite care subsidies and supplements	$4.58	$5.23	$0.65	14.2%
Other supplements	$1.36	$1.27	-$0.09	-6.6%
Accommodation supplements	$14.11	$15.19	$1.08	7.7%
Commonwealth capital grants	$0.94	$0.85	-$0.09	-9.6%
Total Commonwealth revenue	**$184.06**	**$185.42**	**$1.36**	**0.7%**
Resident revenue sources				
Means tested care fees	$7.12	$7.59	$0.47	6.6%
Accommodation payments	$11.82	$11.77	-$0.05	-0.4%
Basic daily fees	$48.38	$49.01	$0.63	1.3%
Extra services fee	$2.39	$1.80	-$0.59	-24.7%
Additional services fees	$0.00	$1.46	$1.46	N/A
Resident care fees - other	$0.93	$0.73	-$0.20	-21.5%
Total resident revenue	**$70.64**	**$72.36**	**$1.72**	**2.4%**
Other				
Other income	$14.88	$14.38	-$0.50	-3.4%
Total revenue	**$269.58**	**$272.16**	**$2.58**	**1.0%**

1. Extra service subsidy reduction does not apply to new residents entering care from 1 July 2014, however it still applies to residents in ESS places who were in care prior to 1 July 2014.
2. The amount shown for ACFI includes a small number of residents who are grand parented under the former 'Resident Classification Scale,' which was the funding instrument in place prior to the ACFI being introduced in 2008.

6.3.2 Expenses

Total expenditure in 2017-18, for residential care providers was $17.63 billion, up 5.3 per cent from $16.75 billion in 2016-17. Chart 6.13 shows total expenses for the six years to 2017-18. While expenses increased by 5.3 per cent in 2017-18 compared with 2016-17 revenue only increased by 1.7 per cent.

Chart 6.13: Total expenses, residential care providers, 2012-13 to 2017-18 ($b)

Table 6.12 shows the expenses for residential care providers in 2017-18 compared with 2016-17 and Chart 6.14 presents the expenses for 2017-18 as a proportion of total expenses.

Table 6.12: Summary of expenses, residential care providers, 2016-17 and 2017-18 ($m)

Expenses	2016-17 ($m)	2017-18 ($m)	Change ($m)	Change (%)
Employee	$11,792.1	$12,426.7	$634.6	5.4%
Depreciation	$895.3	$968.9	$73.6	8.2%
Interest	$171.1	$186.7	$15.6	9.1%
Other expenses	$3,892.3	$4,048.8	$156.5	4.0%
Total expenses	**$16,750.8**	**$17,631.1**	**$880.3**	**5.3%**

Employee costs represent 70 per cent of the total expenses incurred by providers and these increased by 5.4 per cent from 2016-17.

'Other' expenses represented 23 per cent of total costs, stable from 2016-17. 'Other' expenses include building repairs and maintenance expenses, rent, utilities and costs associated with employment support activities, cleaning and administration. Depreciation and interest costs account for the remaining 5 per cent and 1 per cent respectively, the same as in 2016-17.

Chart 6.14: Proportion of residential care provider total expenses, 2017-18 ($m)

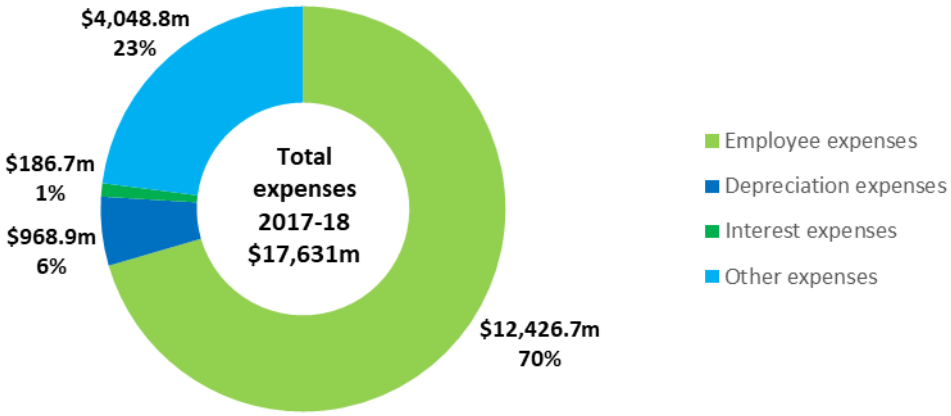


Table 6.13 shows the major expense types for providers, per resident per day, for the six years to 2017-18. Total expenses per resident per day have generally increased each year by around 4-5 per cent.

Table 6.13: Summary of residential care provider expenses, per resident per day, 2012-13 to 2017-18

Expenses	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Employee	$142.92	$148.81	$157.68	$166.84	$179.01	$187.21
Depreciation	$11.59	$11.56	$11.49	$11.87	$13.59	$14.60
Interest	$2.57	$2.34	$2.21	$2.30	$2.60	$2.81
Other	$58.24	$62.81	$63.67	$66.57	$59.09	$61.00
Total expenses	**$215.32**	**$225.52**	**$235.05**	**$247.58**	**$254.29**	**$265.62**

As noted earlier, since 2016-17, a different breakdown of expenditure data was collected through the introduction of the ACFR. The new format has enabled the collection of more detailed expenditure information from 2016-17 onwards. Table 6.14 shows provider expenditure in 2017-18, compared with 2016-17, using the new categories collected through the ACFR.

Table 6.14: Breakdown of residential care provider expenses, 2016-17 and 2017-18 ($m)

	2016-17 ($m)	2017-18 ($m)	Change ($m)	Change (%)
Care				
Employee expenses	$8,549.9	$8,968.7	$418.8	4.9%
Other	$536.1	$588.4	$52.3	9.7%
Total care expenses	**$9,086.0**	**$9,557.0**	**$471.0**	**5.2%**
Accommodation				
Employee expenses	$364.1	$283.7	-$80.4	-22.1%
Repair & maintenance	$470.3	$477.6	$7.3	1.6%

Rent	$342.1	$357.0	$14.9	4.4%
Other	$455.4	$497.8	$42.4	9.3%
Total accommodation expenses	**$1,631.9**	**$1,616.2**	**-$15.7**	**-1.0%**
Hotel				
Employee expenses	$1,463.0	$1,600.4	$137.4	9.4%
Contracted services	$445.9	$495.9	$50.0	11.2%
Other	$712.1	$722.4	$10.3	1.5%
Total hotel expenses	**$2,621.0**	**$2,818.7**	**$197.7**	**7.5%**
Administration				
Employee expenses	$922.6	$970.4	$47.8	5.2%
Management fees	$492.5	$603.5	$111.0	22.5%
Other	$594.0	$662.4	$68.4	11.5%
Total administration expenses	**$2,009.1**	**$2,236.2**	**$227.1**	**11.3%**
Financing				
Depreciation	$874.5	$942.9	$68.4	7.8%
Amortisation	$20.8	$26.0	$5.2	25.0%
Interest	$171.2	$186.7	$15.5	9.1%
Total financing expenses	**$1,066.5**	**$1,155.6**	**$89.1**	**8.4%**
Other				
Revaluation of assets (decrease)	$32.2	$38.7	$6.5	20.3%
Loss on sale of assets	$9.5	$9.4	-$0.1	-1.0%
Other	$294.9	$199.3	-$95.6	-32.4%
Total other expenses	**$336.6**	**$247.4**	**-$89.2**	**-26.5%**
Total expenses	**$16,751.1**	**$17,631.1**	**$880.0**	**5.3%**

Care expenditure relates to the direct costs incurred in providing care for residents within residential care facilities. Care related employee expenses make up 94 per cent of total care expenses, and 51 per cent of total expenditure, making it the largest single expense for providers. Employee expenses include payments made to doctors, nursing, therapists, nutritionists, case managers, health assistants and support staff.

Other care expenses include items such as resident medication, oxygen and related equipment, treatments and procedures, incontinence aids, items that assist mobility, recreation and social activities, rehabilitation support, personal grooming and specific cultural and social events.

Accommodation expenditure (which represents 9 per cent of total expenses) relates to the costs incurred in providing accommodation to residents. Within accommodation, employee expenses as a proportion of total accommodation related expenses decreased from 22.3 per cent in 2016-17 to 17.5 per cent in 2017-18. This perhaps reflects providers trying to reduce costs on non-care related

areas. Repairs and maintenance make up 30 per cent of accommodation related expenses and facility rental (22 per cent), and other (31 per cent) make up the remainder.

Other accommodation expenses include property rates and taxes, bed licence fees/allocation certification fees, utilities and waste disposal.

Hotel expenditure (which represents 16 per cent of total expenses) relates to the costs incurred in the provision of everyday living expenses to residents. Within hotel, expenses relate to employees (57 per cent), contracted services (18 per cent) and other (26 per cent).

Contracted services are payments made to external providers or internal divisions for the provision of catering, cleaning or laundry. Other expenses consist of expenses such as meals, refreshments, other food consumables, bedding materials, toiletry and sanitary goods, cleaning items and laundry items.

Financing expenditure relates to depreciation incurred on property, plant and equipment, amortisation of intangible assets, and interest paid on borrowing used to fund the capital requirements of facilities. Financing accounted for 6.6 per cent of total expenditure in 2017-18.

Other expenses relate to expenditure not covered in any of the above categories.

6.3.3 Financial results

The financial performance of residential care providers is affected by variations in both revenue and expenditure. It can also vary depending on the location in which care is delivered.

Chart 6.15 shows the average EBITDA per resident per annum for all residential care providers since 2010-11. Overall, residential care providers performed significantly worse in 2017-18 compared with recent years. The average EBITDA per resident had improved for five years in a row since 2012-13 before dropping by 24 per cent from $11,481 in 2016-17 to $8,746 in 2017-18.

Chart 6.15: Residential care provider average EBITDA per resident per annum, 2010-11 to 2017-18

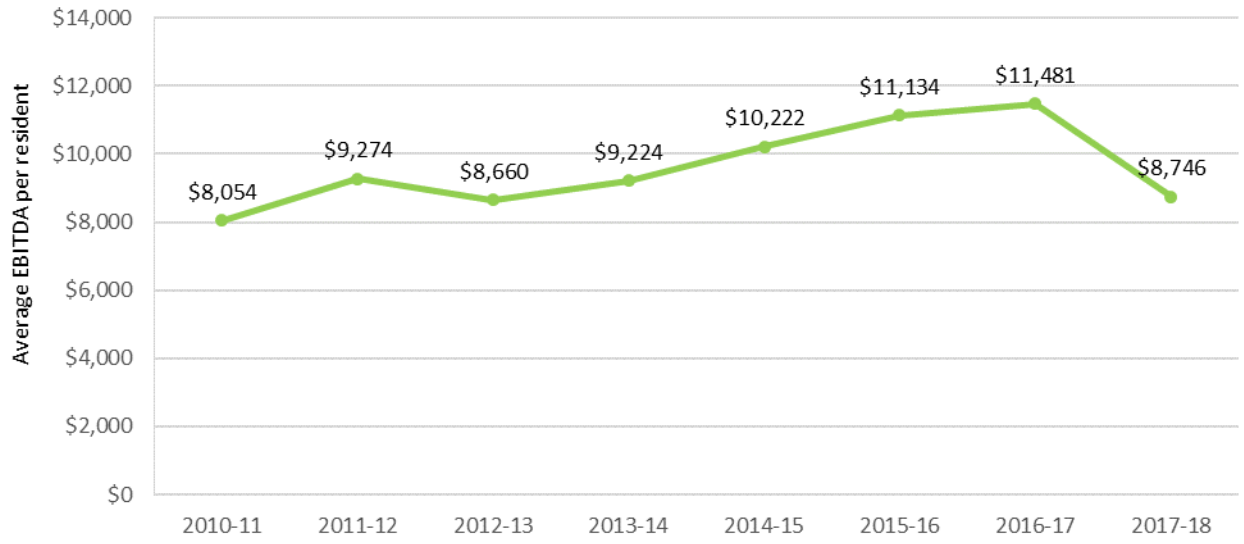


Table 6.15 shows a summary of the overall financial performance of residential care providers since 2012-13.

Table 6.15: Summary of financial performance of residential care providers, 2012-13 to 2017-18 ($m)

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Revenue ($m)	$13,961	$14,826	$15,810	$17,172	$17,757	$18,066
Expenses ($m)	$13,367	$14,115	$14,903	$16,109	$16,751	$17,631
NPBT ($m)	$594	$712	$907	$1,063	$1,006	$435
NPBT margin	4.3%	4.9%	5.8%	6.2%	5.7%	2.4%
EBITDA ($m)	$1,473	$1,582	$1,776	$1,985	$2,072	$1,591
Average EBITDA per resident per annum	$8,660	$9,224	$10,222	$11,134	$11,481	$8,746
EBITDA margin	10.6%	10.7%	11.2%	11.6%	11.7%	8.8%

Table 6.16 shows the financial performance of providers in 2017-18 by ownership type, location and scale. In general terms, for-profit providers outperformed not-for-profit providers and metropolitan providers significantly outperformed regional and rural providers. More detailed discussion of performance based on ownership, location and scale is included later in this section.

Table 6.16: Summary of financial performance of residential care providers, 2017-18

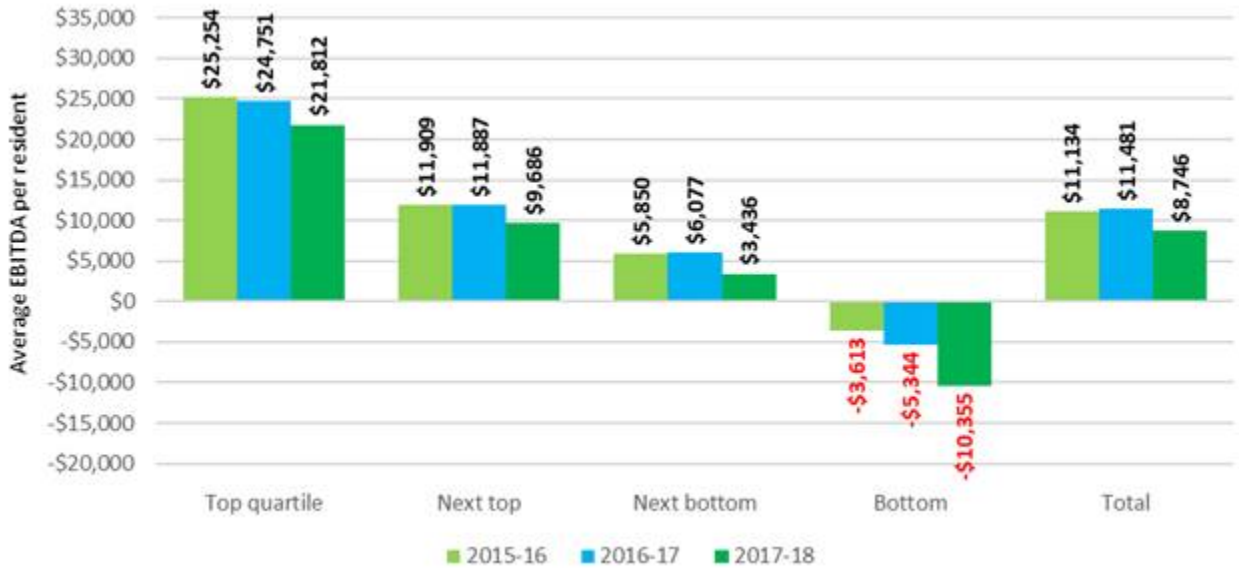
			Ownership type			Location			Scale			
	Total sector 2016-17	Total sector 2017-18	Not-for-profit	For-profit	Government	Metropolitan	Regional	Metropolitan & regional	Single facility	Two to six facilities	Seven to 19 facilities	20 or more facilities
Revenue ($m)	$17,757	$18,066	$9,885	$7,288	$893	$11,997	$2,739	$3,330	$3,605	$4,150	$4,670	$5,641
Expenses ($m)	$16,751	$17,632	$9,762	$6,874	$995	$11,583	$2,827	$3,220	$3,546	$4,148	$4,544	$5,393
Profit ($m)	$1,006	$435	$123	$414	-$102	$414	-$88	$110	$59	$2	$126	$248
EBITDA ($m)	$2,072	$1,591	$819	$822	-$50	$1,186	$75	$330	$262	$266	$449	$614
EBITDA p.r.p.a ($)	$11,481	$8,746	$7,916	$11,634	-$6,411	$9,920	$2,702	$9,571	$7,110	$6,340	$9,914	$10,622
EBITDA margin	11.7%	8.8%	8.3%	11.3%	-5.6%	9.9%	2.8%	9.9%	7.3%	6.4%	9.6%	10.9%
NPBT margin	5.7%	2.4%	1.2%	5.7%	-11.4%	3.4%	-3.2%	3.3%	1.6%	0.0%	2.7%	4.4%

As noted, the residential care sector overall reported a significant decline in financial performance in 2017-18 compared with 2016-17. Providers reported an average EBITDA per resident of $8,746 down from $11,481 in 2016-17. This follows five years of improving financial performance since 2012-13. Fifty-six per cent of residential care providers reported a net profit in 2017-18, a noticeable decline from 68 per cent in 2016-17 and 69 per cent in 2015-16.

The EBITDA margin also decreased to 8.8 per cent after improving each of the previous five years (11.7 per cent in 2016-17). The NPBT margin declined significantly to 2.4 per cent from 5.7 per cent in 2016-17.

Chart 6.16 presents the EBITDA per resident for 2015-16 to 2017-18 by provider performance quartiles. As shown, the average EBITDA dropped noticeably in all four quartiles.

Chart 6.16: Residential care provider comparative EBITDA per resident per annum, 2015-16 to 2017-18



Operating performance has traditionally varied across provider ownership type, location and scale. The following commentary provides analysis across the segments of providers.

By provider ownership type

For-profit providers, like the rest of the sector, derived a noticeable decline in 2017-18 compared with 2016-17. The for-profits recorded EBITDA per resident per annum of $11,634, down from $13,316 in 2016-17. However the not-for-profit providers dropped significantly more by comparison, falling to $7,916 in 2017-18 from $11,408 in 2016-17.

The trend of for-profit providers outperforming not-for-profit providers has been evident for quite some time, as shown in

Chart 6.17.

However, this variable needs to be considered carefully because providers in the not-for-profit and government sectors often have different business motives, business models and funding sources and often operate in areas affected by the impacts of remoteness and facility size.

ACFA has previously noted commentary from the not-for-profit sector that the generally lower operating financial results may be consistent with their community or religious missions. They may fulfil their charters in a range of ways that might be difficult or inappropriate in a more commercial environment where investors are seeking returns.

Specifically, not-for-profit providers may choose to invest in or expend funds on amenities and services for which they are not funded through regulated sources. Not-for-profit providers may be assisted to do this through a range of funding pathways and tax benefits, including payroll tax

relief, income tax exemptions and tax deductible donations. However, where these costs are not covered by such incremental revenue, the comparatively lower EBITDA for many not-for-profit providers may be the product of the delivery of additional "community benefits" or "social impacts" or returns which are not recognised in the annual financial accounts.

Chart 6.17: Residential care provider operating performance ratios, by ownership type, 2015-16 to 2017-18

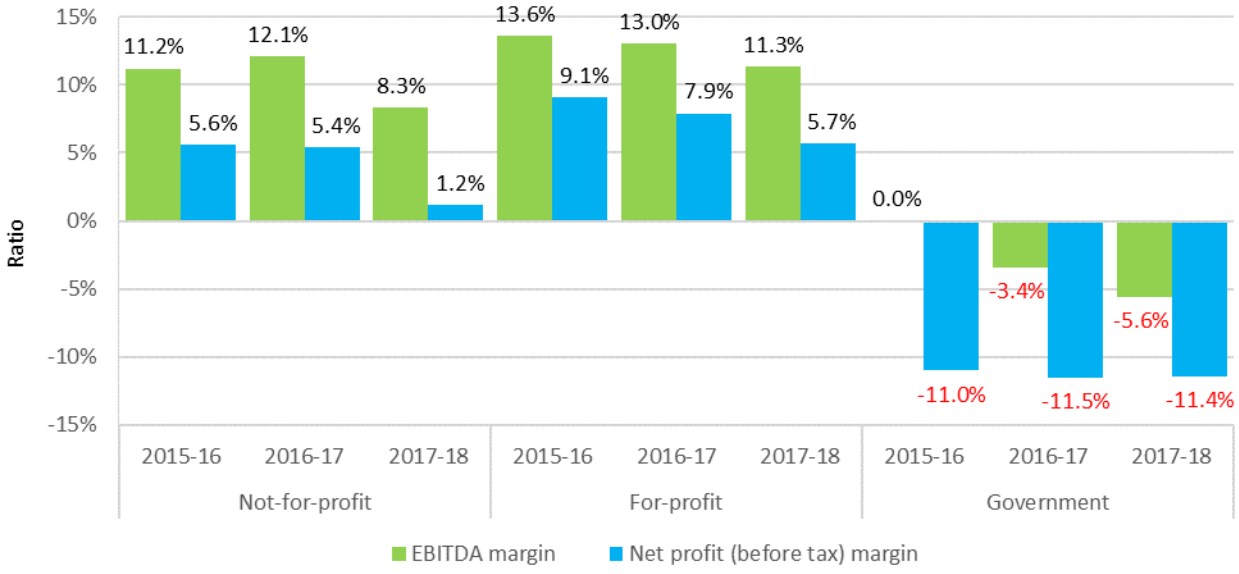
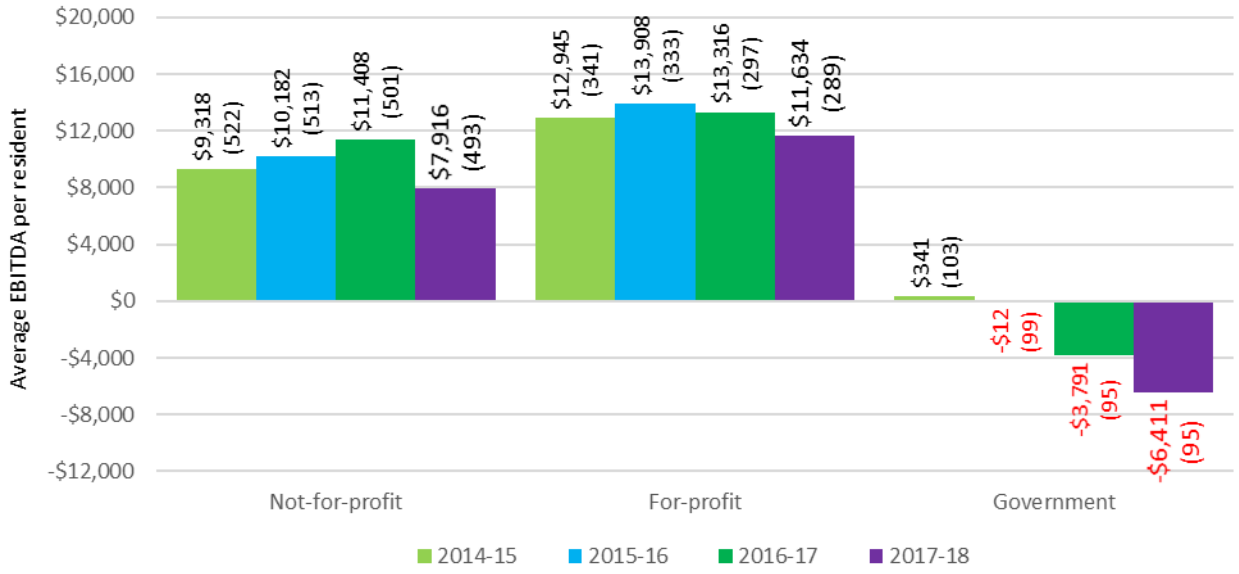


Chart 6.18 shows the average EBITDA for the four years to 2017-18 by ownership type. While the not-for-profits had improved in each of the years previously they declined by almost 31 per cent in 2017-18.

Chart 6.18: EBITDA per resident, by ownership type, 2014-15 to 2017-18



As has been the case in recent years, a significantly higher proportion (33 per cent) of for-profit providers were present in the top quartile of EBITDA performance per resident (Chart 6.19 and

Chart 6.20), compared with not-for-profit (22 per cent) and government (16 per cent) providers. The 94 for-profit providers who are present in the top quartile recorded an average EBITDA per resident per annum of $23,286 compared with the 110 not-for-profit providers in the top quartile who recorded $19,380.

As has been the case with all previous years, there is some representation of all ownership types in each quartile.

Chart 6.19: Residential care provider average EBITDA per resident per annum, by quartile (number of providers in parentheses) – by ownership type, 2017-18

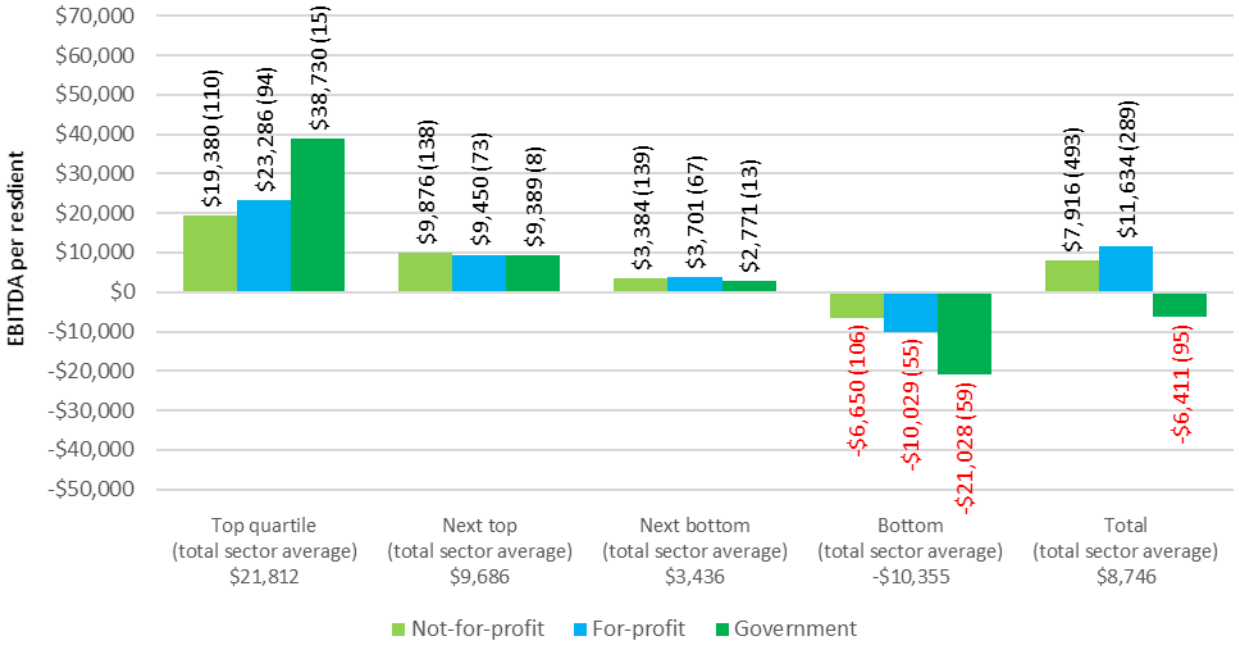
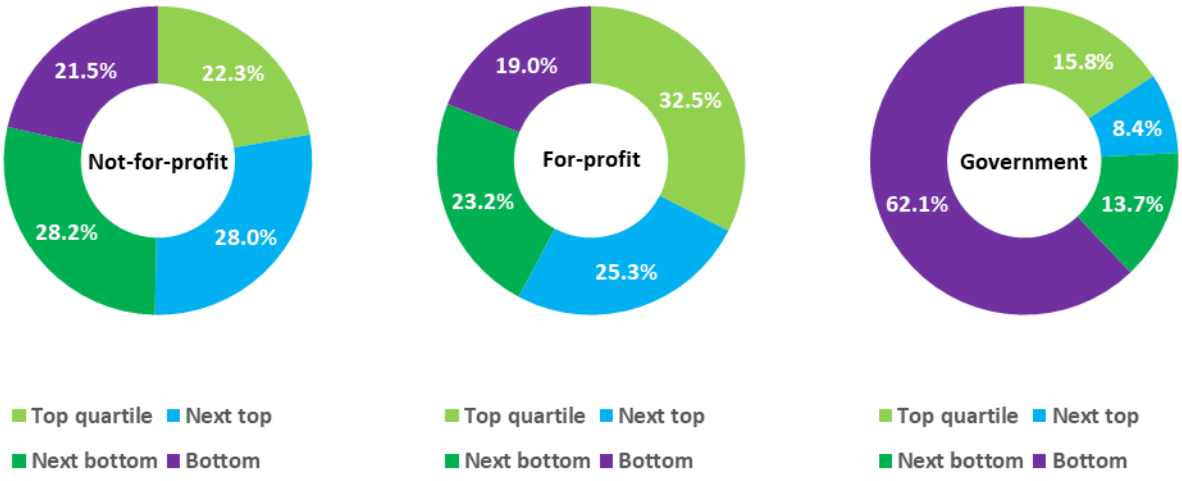


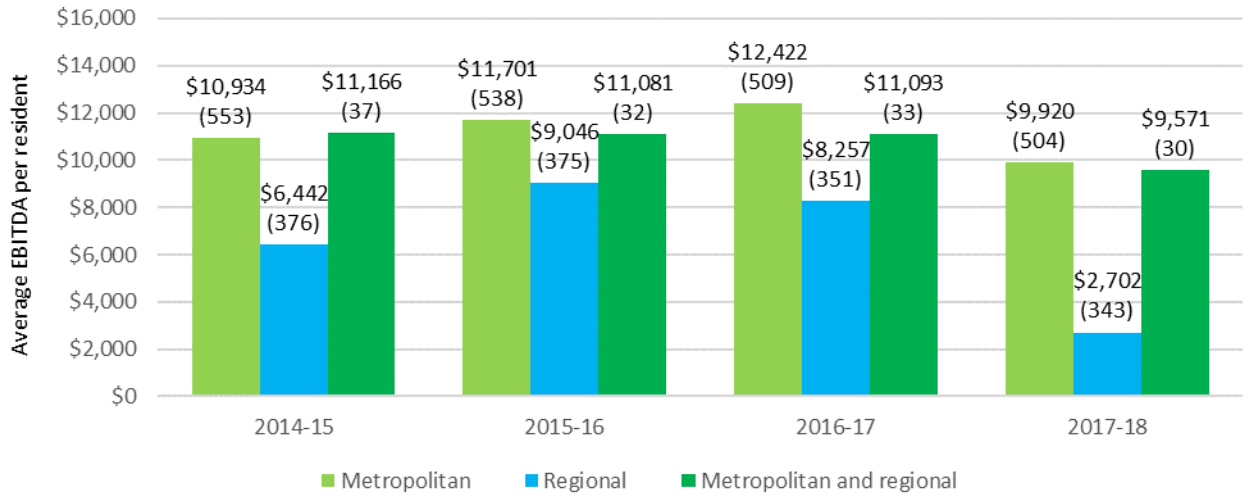
Chart 6.20: Residential care provider distribution between quartile of average EBITDA per resident per annum – by provider ownership type, 2017-18



By provider location

As shown in Chart 6.21, the EBITDA per resident per annum for metropolitan providers improved over the three years to 2016-17 before declining 20 per cent to $9,920 in 2017-18. For regional providers, after relatively strong results in 2015-16 ($9,046 per resident per annum) and in 2016-17 ($8,257) they recorded a very significant decline to $2,702 in 2017-18.

Chart 6.21: Residential care provider EBITDA per resident, by provider location, 2014-15 to 2017-18



As with previous years, a higher proportion (29 per cent) of metropolitan providers are present in the top quartile of ranking by EBITDA per resident compared with regional providers (19 per cent), as shown in Chart 6.22 and Chart 6.23. Conversely, a significantly higher proportion of regional providers (33 per cent) were represented in the bottom quartile.

As was the case with analysis based on ownership type, providers from all locations are present in each quartile.

Chart 6.22: Residential care provider average EBITDA per resident per annum, by quartile (number of providers in parentheses) – by location, 2017-18

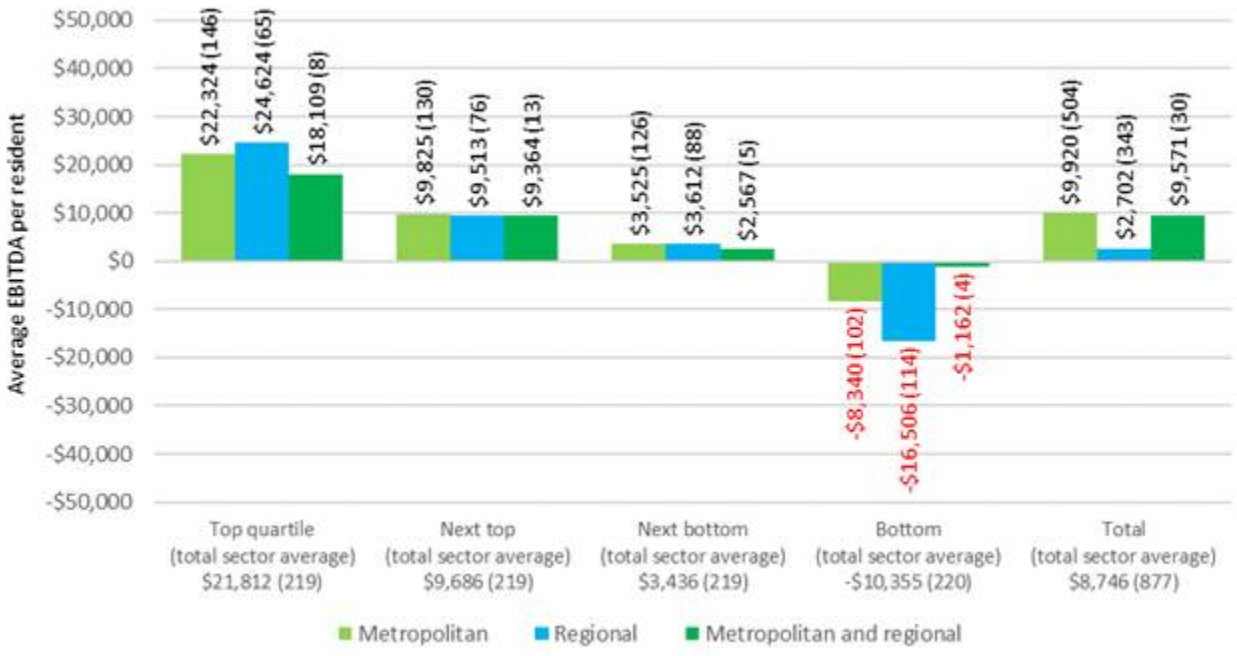
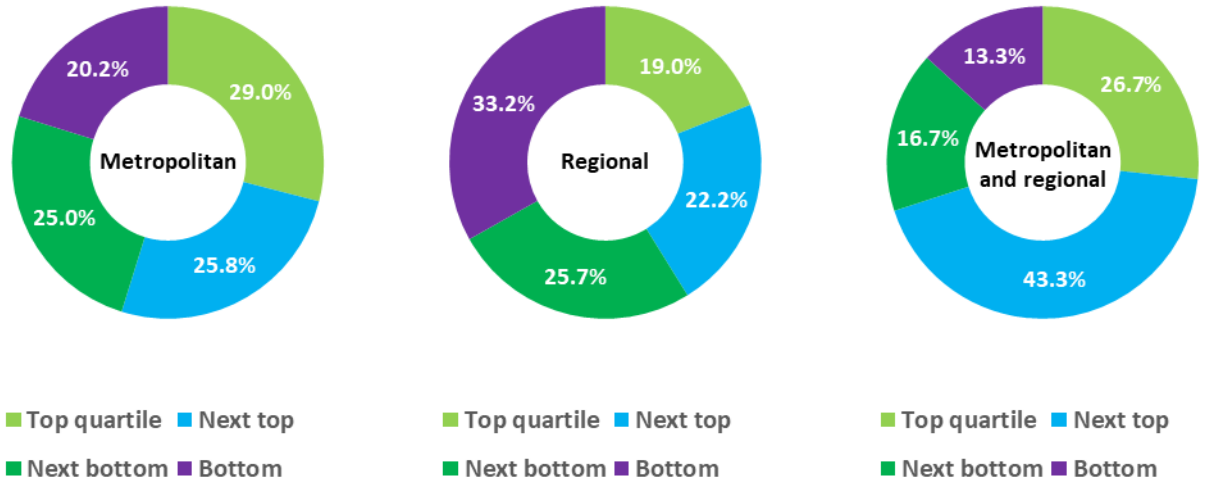


Chart 6.23: Residential care provider distribution between quartile of average EBITDA per resident per annum – by location, 2017-18

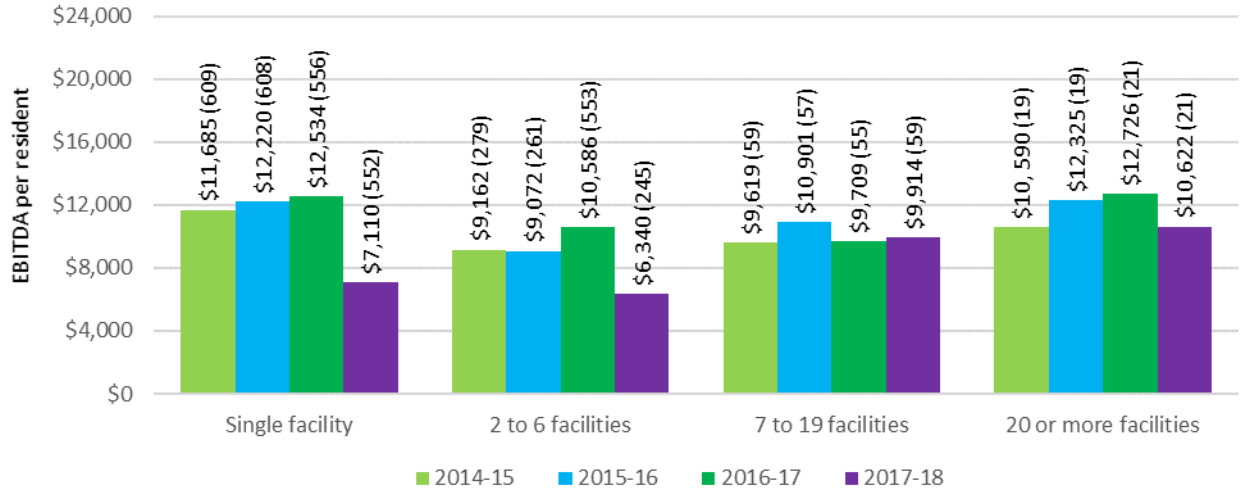


By provider scale

In 2017-18, larger providers (7 and more facilities) clearly outperformed their smaller counterparts (Chart 6.24). Single facility providers recorded average EBITDA per resident per annum of $7,110, after generating higher results of more than $11,000 for the three years previously. The case is similar for providers of 2 to 6 facilities who recorded $6,340 in 2017-18 after deriving more than $9,000 for three years. In contrast, providers operating 7 to 19 facilities improved their performance from $9,709 in 2016-17 to $9,914 in 2017-18. The largest providers, those operating 20 or more

facilities once again recorded the strongest results with average EBITDA of $10,622, despite experiencing a decline of 17 per cent from 2016-17.

Chart 6.24: Residential care provider EBITDA per resident per day, by provider scale, 2014-15 to 2017-18



In 2017-18, 17 of the 21 providers who own more than 20 facilities are in the top two quartiles of ranking by EBITDA per resident per annum (Chart 6.25 and Chart 6.26). This high proportion of the larger scale providers being in the top quartiles has also been the case in previous years. This suggests that the largest providers are benefitting from economies of scale.

As was the case in previous years, providers from all the scale classifications are represented in four quartiles.

Chart 6.25: Residential care provider average EBITDA per resident per annum, by quartile (number of providers in parentheses), by provider scale, 2017-18

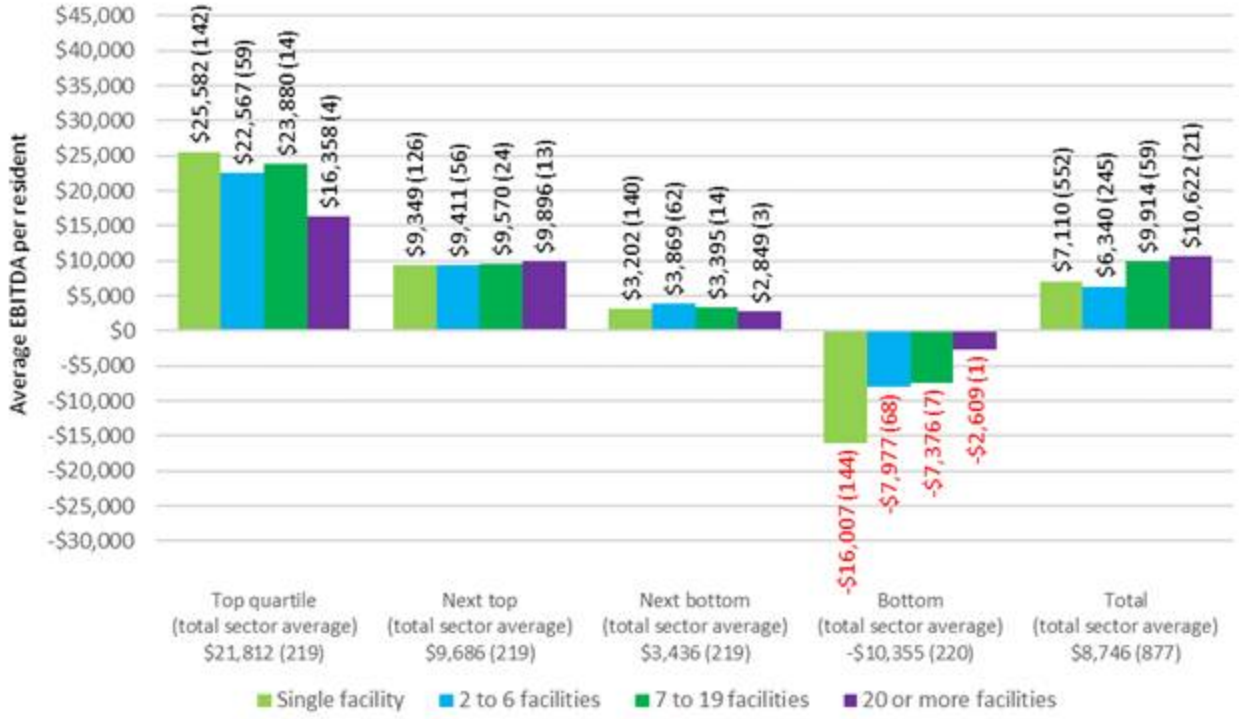


Chart 6.26: Residential care provider distribution between quartile of average EBITDA per resident per annum – by provider scale, 2017-18

6.3.4 Feedback from consultations and developments in 2018-19

2017-18 was a challenging year for the residential aged care sector. After five years of improving financial performance, there was a significant decline in 2017-18.

All providers consulted said that 2017-18 was a difficult year with growth in revenue constrained by the Government's decision to change the scoring arrangements for ACFI and pause indexation, while costs continued to grow, particularly wage costs. As outlined previously, Commonwealth care

subsidies and supplements on behalf of residents represent around 60 per cent of the revenue of providers while employee expenses contribute around 70 percent of their total expenses. The changes to ACFI arrangements significantly contributed to providers' revenue increasing by just 1.7 per cent in 2017-18, while the growth in providers' expenses was over 5 per cent. Problems with the ACFI funding tool for care payments were regularly raised in ACFA's consultations with providers.

All providers said that they took action to constrain costs in response to the compression in margins. With staff costs representing a very large proportion of expenditure, many providers reviewed staff rosters in an effort to reduce staff hours. Some indicated that they identified savings by decentralising their roster arrangements and improving flexibility and some initiated redundancies in response to these reviews. Many providers said they had targeted savings in ancillary and administrative staff rather than care staff.

Many providers referred to the tension they faced in constraining staff costs while the pressure from increased quality audit activity, along with community expectations, was to increase staff hours and skill levels.

As to wages, most providers said their Enterprise Bargaining Agreements (EBA) provided for wage increases of between two to three percent. A few providers consulted said their EBA had expired and they had advised staff that because of financial pressures there would be a pause in wage increases. They noted the difficulties this posed in their quest to attract and retain staff.

ACFA's consultations with providers suggest that the margin pressure felt in 2017-18 has continued in 2018-19. The StewartBrown Aged Care Financial Performance Survey for the six months to December 2018 indicates a further deterioration in the financial performance of the sector. The StewartBrown survey is not directly comparable to the data in this report, but it does give a guide as to developments in the sector. While ACFI indexation has been restored in 2018-19 (1.4 per cent for activities of daily living and behaviour domains and 0.7 per cent in the complex health care domain), providers say that this is still well below the rate of increase in their costs. StewartBrown observed in their survey for the six months ended December 2018 that the gap between direct care costs and ACFI subsidy revenue continued to grow, meaning that ACFI is not keeping pace with associated care costs.

Many providers consulted indicated that they were also experiencing lower occupancy rates and this was adding to pressure on their margins. A number noted that their occupancy rates were also becoming more volatile which added additional challenges in managing their business. All providers consulted welcomed the Government's announcement on 10 February 2019 of a $320 million one-off increase in ACFI funding in 2018-19. While some noted the increase in the aged care subsidy was limited to 2018-19 and did not address the longer-term pressures they were facing, others interpreted the Government's announcement as recognition of the financial pressures facing providers.

In ACFA's Update on funding and financing issues in the residential aged care sector which was provided to the Government in September 2018, it was noted that there were a range of practices among aged care providers in the provision of additional services (that is services over and above those required to be provided under the *Aged Care Act 1997*) for a fee. The application of additional services is an option for providers to boost their revenue and profits. As noted in the Update, many providers indicated that while they had not offered additional services, given financial pressures this was an avenue they were considering, although the scope to introduce additional services was significantly influenced by the socio-economic area in which a facility was located. However many providers also reported that a major constraint they faced was the imprecision around which additional services were allowed. More recent consultations with

providers indicate that the reservations over what additional services are permitted are continuing to constrain some providers to introduce additional services. A number of not-for-profit providers are also concerned about discriminating between the level of service offered to residents while others indicated that they provided the additional services to all residents but only charged the fee to those residents who could afford to pay.

Consistent with what was noted in ACFA's update, recent consultations suggest that there appears to be a growing number of smaller providers, particularly in regional and remote areas, facing significant financial stress. Some providers, mainly not-for-profit providers, said they were receiving an increasing number of approaches from smaller providers who were facing difficulties and were seeking to sell their operations. The providers receiving the approaches said they had declined most of the offers because of difficulties in turning around facilities that were facing not only financial but in many cases quality problems. In addition many of the facilities, but not all of them, consisted of older residential stock.

While many of the aged care providers in regional and remote areas will benefit from the 30 per cent increase in the viability supplement that was announced in the 2018 MYEFO, it appears from recent consultations that the number of providers facing financial pressure and seeking to exit the sector remains significant. There is also a view among some providers that this number is likely to increase as scale is increasingly important, and many of the smaller providers will likely face difficulties in implementing the strengthening in the prudential framework for the residential sector which was announced by the Government in the 2018-19 Budget. The Department of Health is consulting on the detail of the strengthened framework.

Overall there are a number of aspects of the aged care residential sector that warrant close monitoring given the range of financial pressures which impacted on the sector in 2017-18 and are continuing in 2018-19.

7 Residential care: capital investment

This chapter discusses:

- The sources of capital financing for the residential care sector, including the role of Refundable Accommodation Deposits[30];
- key balance sheet metrics for residential care providers for 2017-18; and
- current building and investment trends in the residential care sector.

On 30 June 2018, compared with 30 June 2017, the residential care sector as a whole had:

- Total assets of $48.4 billion, up from $45.0 billion, which includes:
  - $14.1 billion of current assets, an increase of $1.0 billion; and
  - $34.3 billion of non-current assets.
- Total liabilities of $36.6 billion, up from $33.7 billion. This includes $27.5 billion of accommodation deposits held by the sector, up from $24.8 billion;
- Net assets of $11.8 billion, an increase of $500 million;
- average return on equity was 13.4 per cent, down from 18.3 per cent; and
- average return on assets was 3.3 per cent, down from 4.6 per cent.

ACFA Notes:

- $4.9 billion of building works were either completed or in-progress as at 30 June 2018 compared with $4.7 billion at 30 June 2017; and
- planned building activity dropped significantly for the second year in a row.

7.1 Capital financing

Capital for residential care providers is comprised of:

- equity, including retained earnings;
- loans from financial or other institutions;
- interest free loans from residents in the form of lump sum Refundable Accommodation Deposits (bonds pre 1 July 2014);

[30] Includes bonds prior to 1 July 2014

- capital investment support from Government by way of capital grants for eligible projects; and
- capital endowments.

7.1.1 Residents as a source capital

Lump sum accommodation payments by residents is a significant source of funding for capital investment in residential care. Refundable Accommodation Deposits (RAD) act as an interest free loan to providers, paid by residents. At 30 June 2018, a total of $27.5 billion of accommodation deposits were held by providers. The investment of accommodation deposits held by providers is a source of interest income that is included in the other income reported by providers in their operating statement.

As an alternative to RADs, residents can choose to a pay a Daily Accommodation Payment (DAP) or a combination of a RAD and DAP.

Partially supported residents contribute towards accommodation as a Refundable Accommodation Contribution (RAC) or Daily Accommodation Contribution (DAC). In this report, references to RADs also include RACs and references to DAPs include DACs.

7.1.2 Commonwealth as a source of capital

The Australian Government makes capital grants available through the ACAR (via the Rural, Regional and Other Special Needs Building Fund) for services that target communities and geographic areas where there may be insufficient access to capital from other sources.

The 2018-19 ACAR allocated $60 million in capital grants under the Fund to successful approved providers, following a competitive application process. In addition to the ACAR, through a separate announcement in the 2018-19 Budget, one-off funding of $40 million was allocated for infrastructure investment through The Aged Care Regional, Rural and Remote Infrastructure Grant.

Additionally, the higher accommodation supplement, payable where a facility has been built or significantly refurbished since 20 April 2012, is encouraging investment in residential care. Although not strictly a form of capital for providers, it provides an increased rate of return on the capital invested.

The higher accommodation supplement is $57.14 per eligible resident per day compared with $37.24 for the standard accommodation supplement (20 March 2019 rates). As at 31 December 2018, 1,395 facilities (986 at 31 December 2017) or 48 per cent of all facilities qualified for the higher accommodation supplement. Of these, 1,214 were significantly refurbished and 181 were newly built facilities.

7.1.3 Other sources of capital finance

Residential care providers also obtain capital finance from investors, loans from financial and other institutions and donations/endowments. ACFA does not have data across the sector on debt and equity financing, other than that reported in the aggregated balance sheets, which are discussed in this chapter.

7.2 Accommodation deposits

At 30 June 2018, refundable accommodation deposits (including bonds) of residential care providers totalled $27.5 billion and comprised 56 per cent of total assets of $48.4 billion and 75 per cent of liabilities ($36.6 billion).

At 30 June 2018, there were 90,899 refundable accommodation deposits held by providers (86,853 in 2016-17), with an average value of $303,000 ($283,000 in 2016-17). As shown in Table 7.1 the average value of accommodation deposits has steadily increased over the last five years.

Table 7.1: Average value of refundable accommodation deposits held by providers, 2013-14 to 2017-18

2013-14	2014-15	2015-16	2016-17	2017-18
$229,000	$248,000	$267,000	$283,000	$303,000

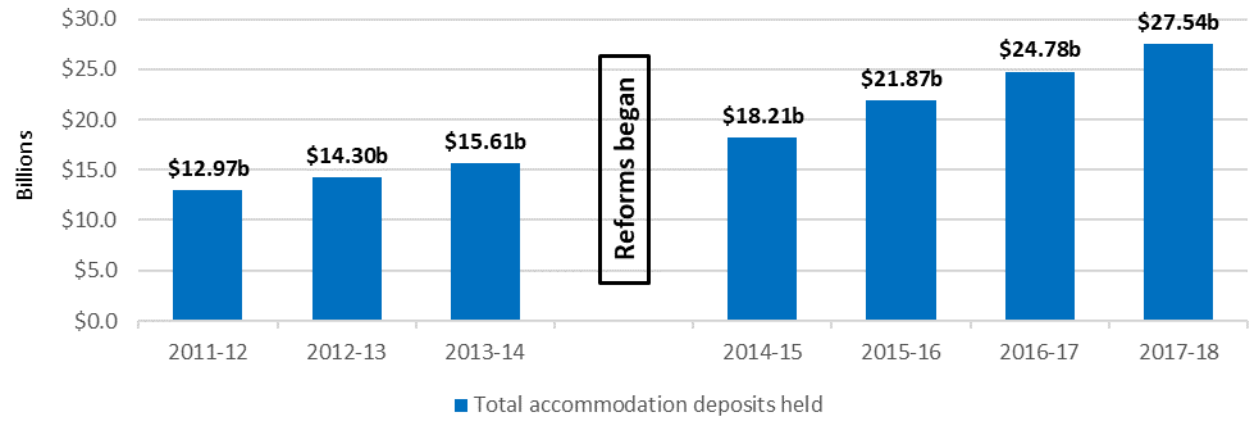
Residents who are assessed as having low financial capacity are eligible for Commonwealth assistance with their accommodation costs as either a partially supported or fully supported resident. Partially supported residents may be asked to contribute towards the cost of accommodation, depending on their means. They can choose to pay their accommodation contribution by a lump sum refundable accommodation contribution (RAC), a daily accommodation contribution (DAC), or a combination of the two. Fully supported residents cannot be asked to make a contribution and have their accommodation costs met in full by Government.

Residents who are not eligible for Commonwealth assistance with their accommodation costs pay the accommodation price they agree with their provider before they enter care and can choose (within 28 days of admission) to pay by a lump sum refundable accommodation deposit (RAD), a daily accommodation payment (DAP) or a combination of the two. The maximum permissible interest rate (MPIR) is used to maintain equivalence between daily payments and lump sums[31].

Error! Reference source not found. shows the total pool of accommodation deposits held by providers since 2011-12

[31] The lump sum RAD amount, which is agreed between the provider and the resident, is multiplied by the MPIR and divided by 365 days to calculate the daily DAP. Conversely, a daily DAC amount, which is advised by the Department of Human Services, is divided by the MPIR and multiplied by 365 days to calculate the lump sum RAC. The MPIR is determined quarterly in accordance with Section 6 of the *Fees and Payments Principles 2014 (No. 2).* Current and historic rates of the MPIR are available on the Department of Health website.

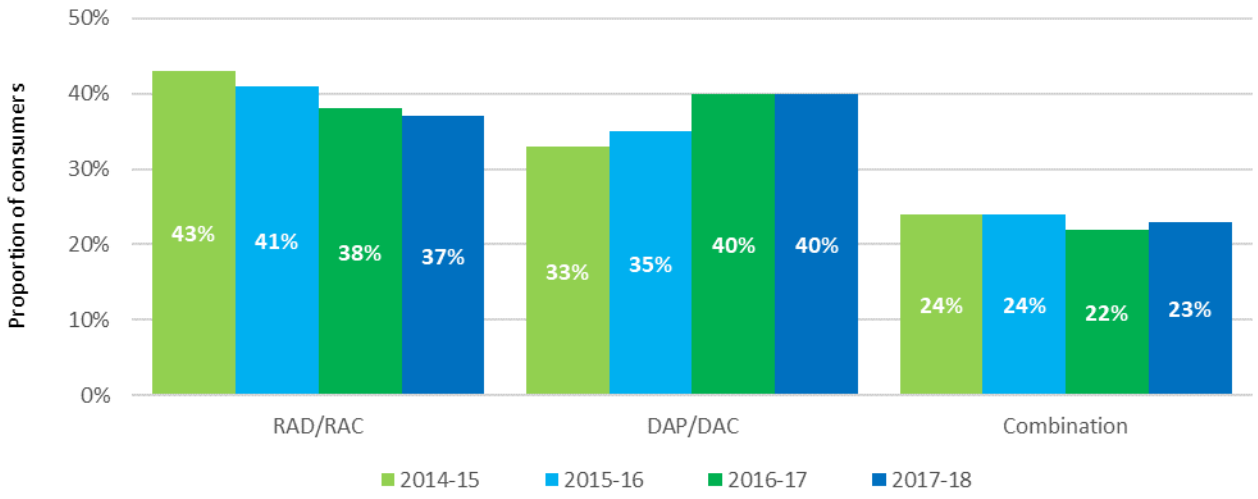
Chart 7.1: Total pool of accommodation deposits held, 2011-12 to 2017-18 ($b)



While the pool of accommodation deposits continues to grow, there is a trend emerging of a move away from RADs in favour of DAPs. Chart 7.2 shows that in 2017-18, as was the case in 2016–17, DAP/DACs were slightly more popular than lump sum RAD/RACs. The proportion of people choosing RAD/RACs has dropped every year, albeit slightly, since 2014-15. The proportion of residents choosing DAP/DACs has gradually increased over the four years from 33 per cent in 2014–15 to 40 per cent in 2017-18.

While the overall shift away from RADs is modest, feedback from consultations suggest that this is a concern for some providers, (including the cash flow implications of a shift away from RADS), and a few providers said that it has resulted in them delaying some investment plans. Other providers noted that they welcomed a move towards DAPs. A sustained shift away from RADs to DAPs would significantly impact on the business model of some providers who have relied significantly on continuing growth in RADs. This is an area that requires close monitoring, including in relation to the potential impact of the recently extended scope of the Commonwealth's Pension Loan Scheme, which could further add to the increase in daily payments over lump sum deposits.

Chart 7.2: Resident method of accommodation payment, 2014-15 to 2017-18



ACFA has previously noted there are several factors that a consumer might take into consideration when determining how to pay the accommodation payment, including in its report *Understanding how consumers plan and finance aged care*[32]. These include; the rate of the MPIR, (if interest rates fall, equivalent daily payments will fall and vice versa), expected length of stay (if shorter then more likely to pay by daily payment), personal financial circumstances and the length of time it takes to sell the family home.

Additionally, feedback from recent consultations suggest that the movement in house prices and conditions in the housing market are contributing factors in the apparent shift towards daily payments.

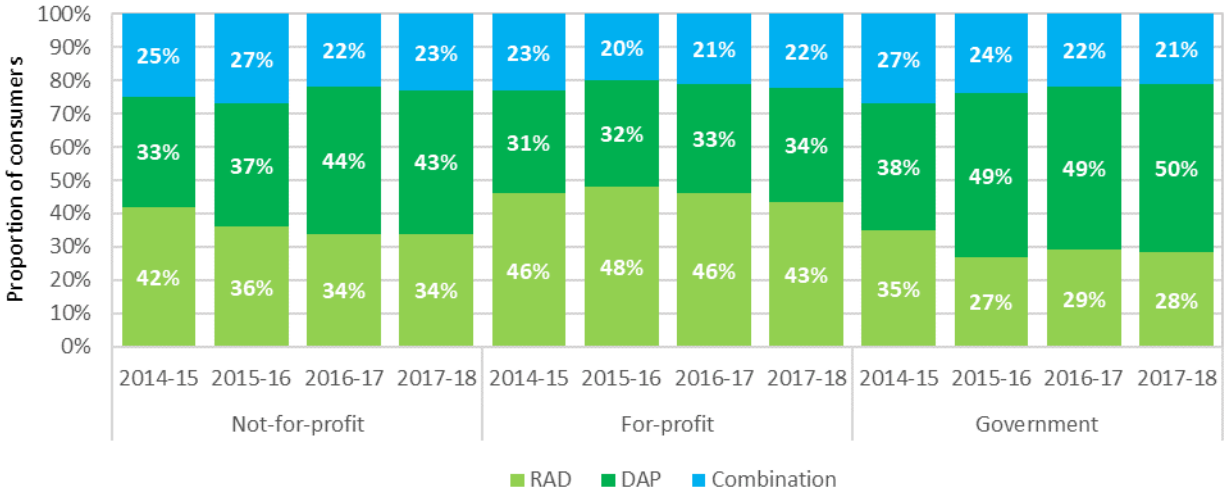
In terms of the MPIR influencing decisions on accommodation payments in aged care, there is the potential for movement from lump sums to daily payments if the equivalence rate is set too low. If all other things are equal, and consumers can achieve a better return, they may be inclined to invest the lump sum and pay the daily payment out of investment earnings. On the other hand, some residents see daily payments as interest charged on the outstanding lump sum. From this perspective, residents see the MPIR as a punitively high rate of interest.

For a full discussion on the MPIR and its impact on residents and providers see page 46 of ACFA's *Report to inform the 2016-17 review of amendments to the Aged Care Act 1997*. In that report ACFA advised that on balance the MPIR is an appropriate rate to determine equivalence between refundable deposits and daily payments.

Part of the reduction in the proportion of residents paying by lump sum could also be transitional and may reflect a greater understanding by consumers of their ability to choose how to pay for their accommodation as was intended by the reforms implemented in 2014.

The decrease in the proportion of RAD/RACs has been most noticeable in for-profit providers, who dropped from 46 per cent in 2016-17 to 43 per cent in 2017-18. This followed a drop from 48 per cent the year before (Chart 7.3). For the not-for-profit providers the proportion of residents choosing RAD/RACs was stable in 2017-18 at 34 per cent.

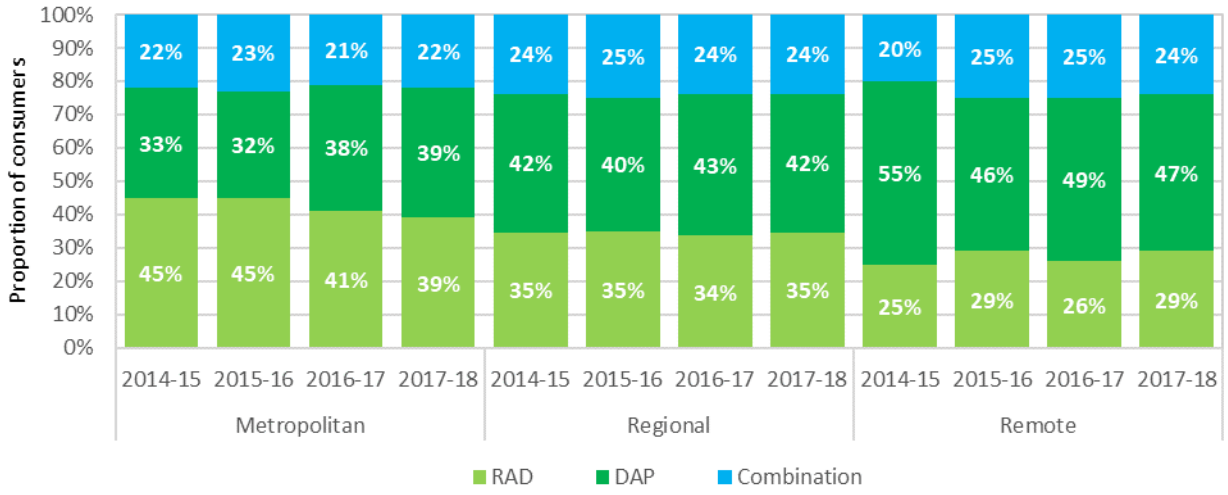
Chart 7.3: Resident choice of payment method, by ownership, 2014-15 to 2017-18



[32] https://agedcare.health.gov.au/reform/acfas-report-on-understanding-how-consumers-plan-and-finance-aged-care

When analysed in terms of location, lump sum payments continued to drop in metropolitan areas to 39 per cent in 2017-18 after dropping from 45 per cent to 41 per cent the year before (Chart 7.4). In contrast, in remote areas the proportion of residents choosing RAD/RACs increased to 29 per cent in 2017-18, up from 26 per cent.

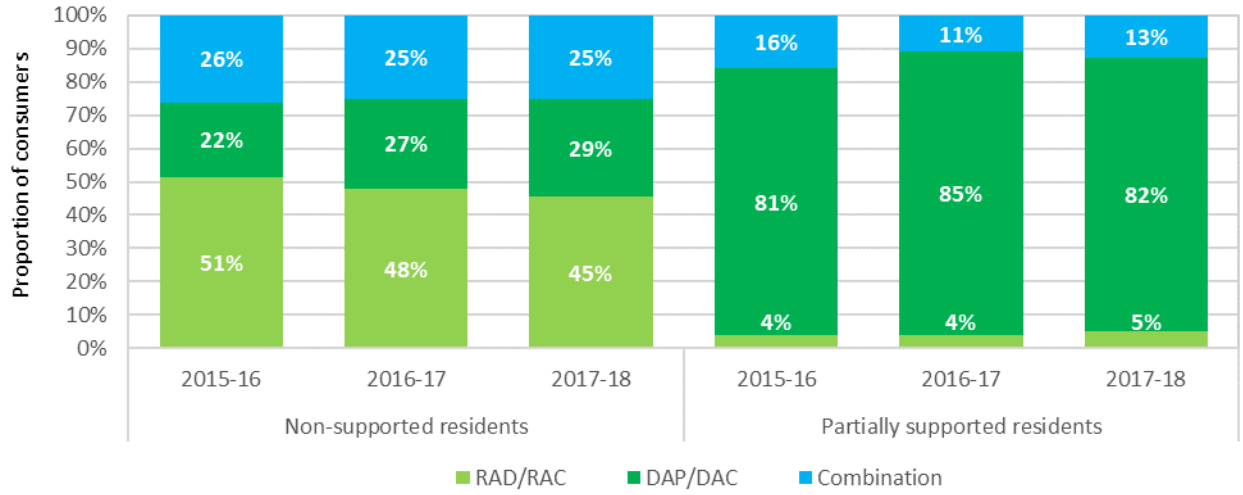
Chart 7.4: Resident choice of payment method, by location, 2014-15 to 2017-18



As noted previously in consultations with providers, a number indicated that a decline in the housing market is contributing to a shift away from RADs to DAPs, particularly where the individual entering residential care is very frail and the expected stay is short. The feedback is that many families are not prepared to sell a house when prices are falling.

In the last two annual reports ACFA reported the very significant difference in choice of payment between non-supported residents and partially supported residents. This trend continued in 2017-18, as shown in Chart 7.5. Forty-five per cent of non-supported residents chose to pay their accommodation payment by a RAD whereas only 5 per cent of partially supported residents chose this option, although the proportion of non-supported residents paying a RAD has also been decreasing, down from 48 per cent in 2016-17 and 51 per cent in 2015-16. The proportion of residents paying by lump sum may include residents who had commenced to pay full or partial daily payments, and then paid a lump sum during the year. Similarly, residents paying a daily payment may subsequently pay a lump sum (e.g. once their house is sold).

Chart 7.5: Resident choice of payment method, by partially supported and non-supported residents, 2015-16 to 2017-18



7.2.1 Accommodation deposit prices

On 1 July 2014, new accommodation pricing arrangements came into effect. The changes were:

- Lump sum accommodation payments became known as Refundable Accommodation Deposits (RADs) instead of Accommodation Bonds;
- providers were able to charge a RAD to any eligible resident whereas they had previously only been able to charge an Accommodation Bond for low care residents, or a high care resident in Extra Service facilities.
- providers were no longer able to deduct a retention amount from the RAD;
- residents became able to, at their discretion, choose to pay a RAD, a Daily Accommodation payment (DAP) or any combination of RAD and DAP; and
- providers were required to publish the maximum price for their rooms, or part of a room, in their aged care facilities. Residents may negotiate a lower price (known as the agreed price) but cannot be asked to pay more than the published price.

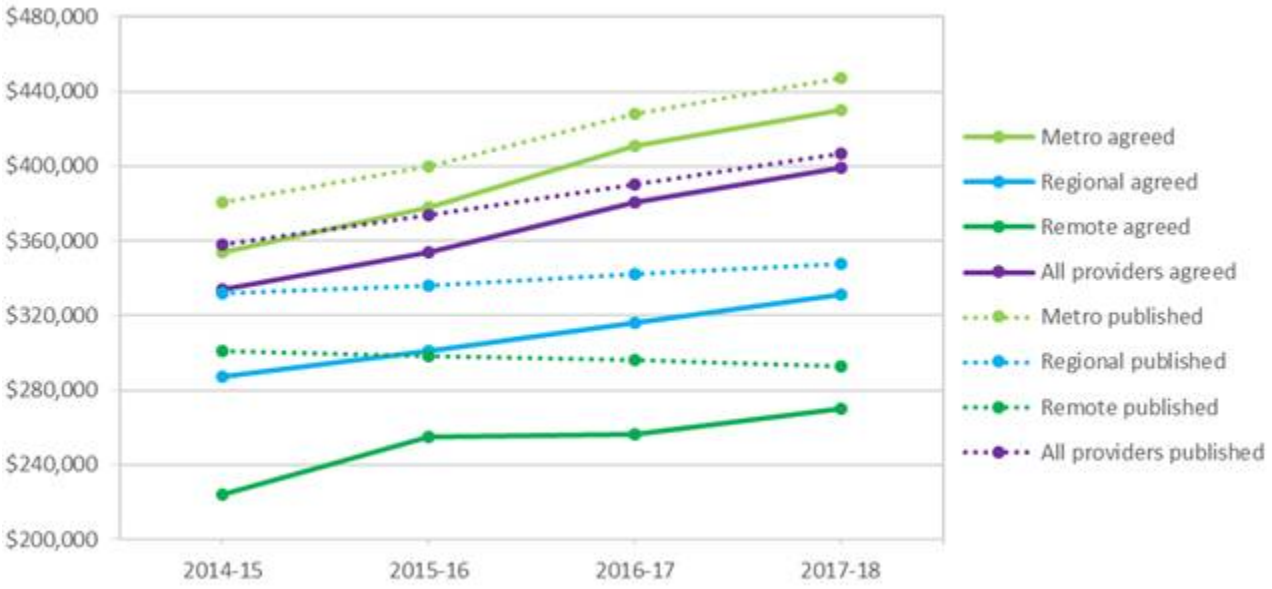
Charts 7.6 and 7.7 show the average published and agreed accommodation prices since 1 July 2014, presented by provider ownership type and location. This data includes RADs, DAPs and combination payments and covers the price of a residential care room, not the method of payment.

In terms of provider ownership (Chart 7.6), the for-profit providers have average published prices around $38,000 higher than the not-for-profit providers. Since 2014-15 the average published price by for-profit providers has increased by around $30,000 each year whereas the average published price for not-for-profit providers only increased by around $8,500 each year. Similarly, agreed prices for the for-profit providers have continued to increase year on year faster than the average agreed price for the not-for-profits. The average agreed price is less than the average published price residents may negotiate a lower price.

Chart 7.6: Average agreed and published accommodation prices (lump sum equivalent), by ownership, 2014-15 to 2017-18

In terms of location (Chart 7.7), as has been the case in previous years, the average published price in metropolitan areas was significantly higher ($447,000) than in regional areas ($348,000) and remote areas ($293,000). This is to be expected given the difference in house prices across these areas. It is a similar case with agreed prices with the metropolitan areas recording an average agreed price almost $100,000 higher than regional areas and $160,000 higher than remote areas.

Chart 7.7: Average agreed and published accommodation prices (lump sum equivalent), by location, 2014-15 to 2017-18



7.3 Financing status - balance sheet

This section focuses on the balance sheet of the residential care sector, showing the liabilities, assets and net assets.

In 2016-17 the Department of Health began collecting financial data from providers via the Aged Care Financial Report (ACFR). This allows greater disaggregation of the total assets and liabilities compared with earlier years. Some analysis contained in this section therefore is restricted to 2016-17 and 2017-18 only whereas other longer term trends are presented at the higher aggregate level.

Table 7.2: Balance sheet of residential care providers, 2016-17 and 2017-18

Assets/Liabilities	2016-17 ($m)	2017-18 ($m)	Change ($m)	Change (%)
Current assets	$13,138	$14,101	$963	7.33%
Fixed assets	$22,963	$24,061	$1,098	4.78%
Other non-current assets	$8,916	$10,238	$1,322	14.83%
Total assets	**$45,017**	**$48,400**	**$3,383**	**7.52%**
Accommodation deposits	$24,710	$27,523	$2,813	11.39%
Other liabilities	$8,981	$9,050	$69	0.76%
Total liabilities	**$33,691**	**$36,573**	**$2,882**	**8.55%**
Net worth/equity	**$11,326**	**$11,827**	**$501**	**4.42%**

At 30 June 2018, the sector as a whole had total assets of $48.4 billion (an increase of $3.4 billion since 30 June 2017). Current assets increased by 7.3 per cent while accommodation deposits increased by 11.4 per cent.

Total liabilities were $36.6 billion (compared with $33.7 billion in 2016-17). This includes the $27.5 billion of accommodation deposits held by the sector). Since 2013-14, the growth in liabilities has exceeded the growth in assets. In 2017-18, liabilities grew by 8.6 per cent while the growth in total assets was 7.5 per cent. Liabilities as a proportion of total assets is a measure that indicates an organisation's leverage and shows the proportion of total assets financed through borrowings.

Overall, net worth/total equity in the sector was $11.8 billion in 2017-18, up from $11.3 billion in 2016-17.

As shown in

accommodation deposits as a proportion of total assets has been increasing gradually over the last five years from 46 per cent in 2013-14 to 57 per cent in 2017-18, increasing the rate of leveraging.

Other liabilities, which include secured bank and related party lenders, creditors and provisions, represent 19 per cent of total asset financing. This has been relatively stable over the last five years.

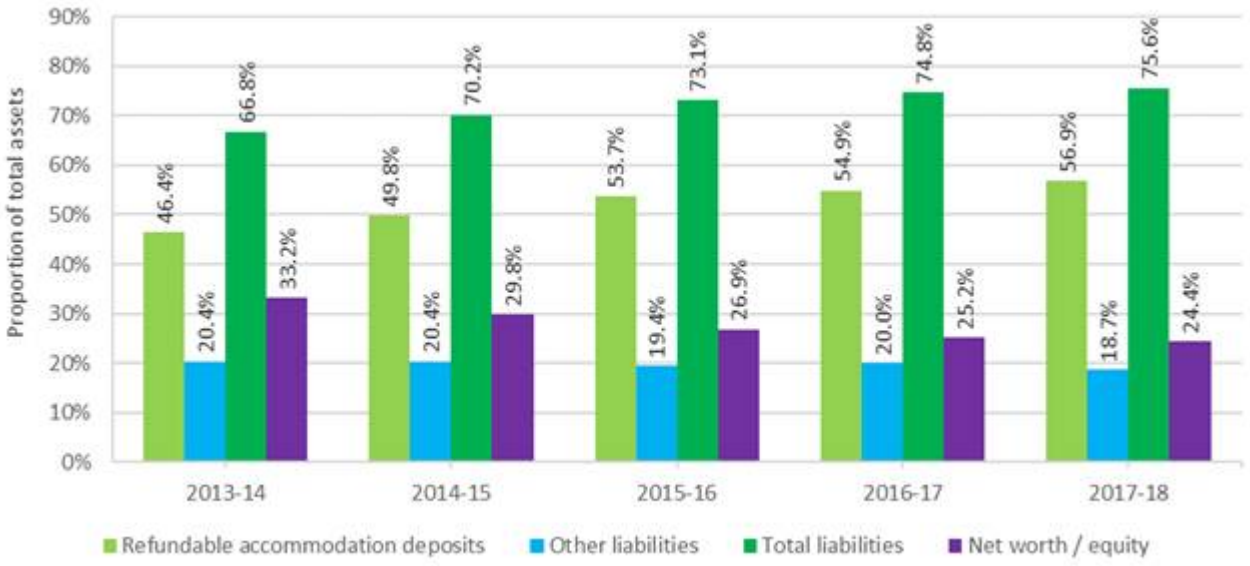
Net worth/total equity as a proportion of assets is a measure of the share of an organisation which is contributed by and held beneficially by the owners/shareholders. Despite the fact that the overall net worth/total equity has increased in 2017-18 ($11.8 billion compared with $11.3 billion in 2016-17), it has continued to fall as a proportion of total assets (Chart 7.8). Over the last five years there has been a gradual decline from 33 per cent in 2013-14 to 24 per cent in 2017-18 (

).

Table 7.3: Balance sheet of residential care providers 2013-14 to 2017-18 ($m)

Assets/liabilities	2013-14 ($m)	2014-15 ($m)	2015-16 ($m)	2016-17 ($m)	2017-18 ($m)
Financial assets	$3,558	$5,170	$5,611	$8,199	$9,047
Fixed assets	$10,238	$10,674	$11,455	$22,963	$24,061
Other assets	$19,866	$20,742	$23,629	$13,855	$15,292
Total assets	**$33,662**	**$36,586**	**$40,695**	**$45,017**	**$48,400**
Refundable accommodation deposits	$15,611	$18,213	$21,872	$24,710	$27,523
Other liabilities	$6,883	$7,472	$7,878	$8,981	$9,050
Total liabilities	**$22,494**	**$25,685**	**$29,750**	**$33,691**	**$36,573**
Net worth/equity	**$11,168**	**$10,901**	**$10,945**	**$11,326**	**$11,827**

Chart 7.8: Residential care provider liability types as a proportion of total assets, 2013-14 to 2017-18



7.3.1 Balance sheet analysis by ownership type

Assets and liabilities have been analysed by ownership type in order to identify differences between not-for-profit, for-profit and government providers. Table 7.4 shows liabilities and net worth/equity as a proportion of total assets by ownership type, while Chart 7.9 shows the same metric for the past three years.

At 30 June 2018, the not-for-profit providers (who hold 56 per cent of places in the sector) had total assets of $26.2 billion (54 per cent of total sector assets). This is the same as in 2016-17. The for-profit providers (who hold 41 per cent of places in the sector) held a slightly higher proportion of total assets of $20.5 billion which represents 42.5 per cent of the total sector assets.

As has been the case in previous years, the for-profit sector had the highest proportion of liabilities, with their total liabilities being 91 per cent (89 per cent in 2016-17) of their total assets, compared with the not-for-profit providers with 66 per cent (same as 2016-17). This significant difference is representative of the way the for-profits operate in terms of higher leveraging.

Net worth has decreased as a proportion of total assets for all provider types over the past three years. Government providers again had by far the highest net worth/equity as a proportion of assets with 57 per cent (61 per cent in 2016-17), followed by the not-for-profit providers (unchanged with 34 per cent). For-profit providers had the lowest net worth/equity as a proportion of assets with 9 per cent (11 per cent in 2016-17), which reflects both a higher proportion of accommodation deposits, greater use of debt to fund investment and greater distribution of profits. These different financing characteristics affect the ratios discussed in the rest of this section.

Table 7.4: Balance sheet, by ownership type, at 30 June 2018 ($m)

	Not-for-profit ($m)	For-profit ($m)	Government ($m)	Total sector ($m)
Total assets funded by:	**$26,168**	**$20,581**	**$1,652**	**$48,400**
Refundable accommodation deposits	$14,077	$12,837	$610	$27,523
Other liabilities	$3,137	$5,812	$101	$9,050
Total liabilities	**$17,214**	**$18,648**	**$711**	**$36,573**
Net worth/equity	**$8,954**	**$1,932**	**$940**	**$11,827**
As a % of total assets				
Refundable accommodation deposits	53.8%	62.4%	36.9%	56.9%
Other liabilities	12.0%	28.2%	6.1%	18.7%
Total liabilities	**66%**	**91%**	**43%**	**76%**
Net worth/equity	**34.2%**	**9.4%**	**56.9%**	**24.4%**

Chart 7.9: Liabilities and net worth as a proportion of total assets, by provider ownership type, 2015-16 to 2017-18

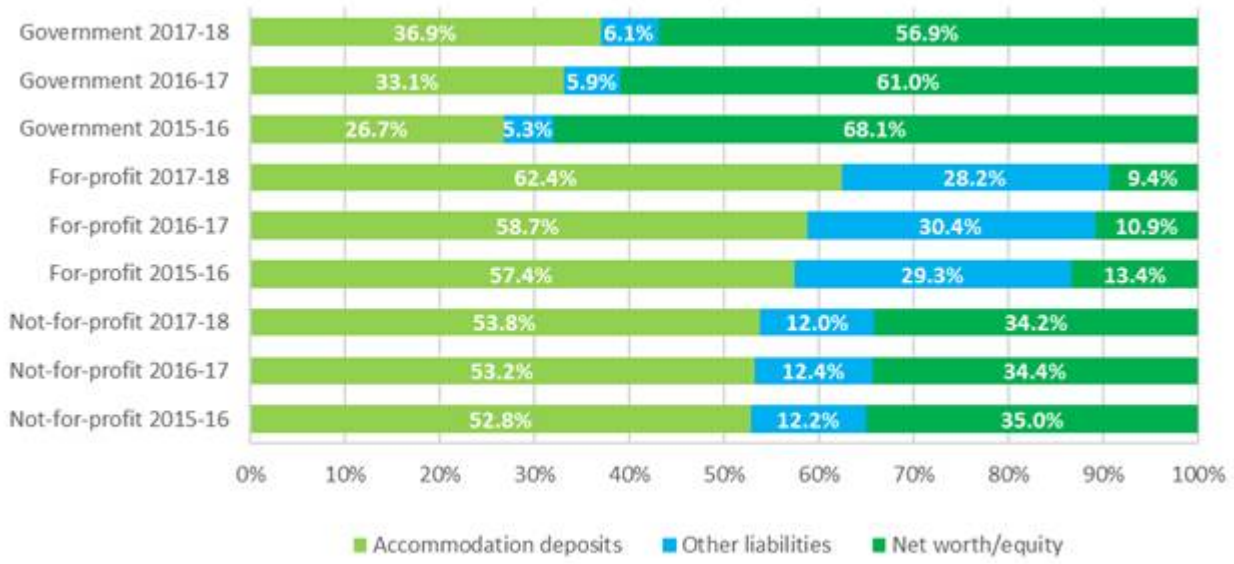


Table 7.5 presents the consolidated balance sheet at segment and organisation level for 2017-18, with the exception of government providers as the disaggregated data is not available to the same level.

Table 7.5: Disaggregated balance sheet by provider ownership type, at 30 June 2018 ($m)

	Not-for-profit ($m)	For-profit ($m)	Government ($m)	All providers ($m)
Assets				
Current assets				
Cash	$4,128	$1,832	$119	$6,078
Financial assets	$2,092	$162	$0	$2,253
Trade receivables	$330	$299	$0	$629
RADs & RACs receivable	$688	$416	$0	$1,104
Related party loans	$236	$2,455	$0	$2,691
Work in progress	$146	$2	$0	$148
Other current assets	$490	$266	$441	$1,197
Total currents	**$8,110**	**$5,431**	**$560**	**$14,101**
Non-current assets				
Financial assets	$503	$212	$0	$715
Related party loans	$166	$1,885	$0	$2,051
Work in progress	$909	$463	$0	$1,372
Intangibles - bed licences	$971	$2,025	$0	$2,996
Intangibles - other	$281	$2,056	$0	$2,337

Fixed assets	$15,033	$8,028	$1,000	$24,061
Other non-current assets	$195	$480	$92	$767
Total non-current assets	**$18,058**	**$15,149**	**$1,092**	**$34,300**
Total assets	**$26,168**	**$20,581**	**$1,652**	**$48,400**
Liabilities				
Current liabilities				
Accommodation deposits (incl. bonds)	$14,077	$12,837	$610	$27,523
Bank borrowings	$194	$319	$0	$514
Related party loans	$95	$1,193	$0	$1,288
Employee provisions	$784	$422	$0	$1,206
Other current liabilities	$1,275	$1,327	$56	$2,658
Total current liabilities	**$16,425**	**$16,098**	**$666**	**$33,189**
Non-current liabilities				
Bank borrowings	$409	$1,306	$0	$1,715
Related party loans	$107	$747	$0	$854
Employee provisions	$129	$89	$0	$217
Other non-current liabilities	$144	$408	$46	$599
Total non-current liabilities	**$789**	**$2,550**	**$46**	**$3,385**
Total liabilities	**$17,214**	**$18,648**	**$712**	**$36,574**
Net assets	**$8,954**	**$1,932**	**$941**	**$11,827**

As shown in Table 7.5, fixed assets – predominantly residential aged care facilities are the single largest asset category held by providers ($24 billion or 48 per cent of total assets). It is also the largest asset category based on ownership type, although for not-for-profit providers, fixed assets represent 57 per cent of total assets whereas for the for-profit providers it represents 39 per cent. The significant difference is likely explained in part by providers in the for-profit sector being more likely to rent the facilities in which they provide residential services, often under arrangements where the facilities are rented from related party entities.

Cash ($6.1 billion) and financial assets ($2.3 billion current and $0.7 billion non-current) represent $9.0 billion (18.7 per cent) of total assets, and $8.3 billion (59 per cent) of current assets. Not-for-profit providers hold 77 per cent, or $6.2 billion of current assets in cash and financial assets, while for-profit providers hold 37 per cent, or $2.0 billion. For-profit providers are more active in placing their funds in other categories of assets, including related parties entities.

Intangible assets make up 11 per cent, or $5.3 billion of total sector assets. Of the $5.3 billion, bed licences make up 56 per cent, or $3.0 billion, and other intangibles of $2.1 billion, consisting mostly of goodwill held by the for-profit sector, makes up the remainder. For-profit providers hold 77 per cent ($4.1 billion) of the intangibles balance for the sector. Whilst for-profit providers hold 41 per cent of residential operational places, they account for 68 per cent of the value attributed to bed licences.

Fifty-eight per cent of for-profit providers have recognised the value of bed licences. In contrast, only 28 per cent of not-for-profit providers have recognised the value of their bed licences.

As noted previously, the Government announced in the 2018-19 Budget that it will fund an impact analysis of allocating residential aged care places to consumers instead of providers. It is important there is a comprehensive assessment of the potential benefits and impacts – for consumers, providers and the whole sector – of a possible alternative allocation model. ACFA notes that if there are changes to the ACAR then this may have some bearing on the valuations currently attributed to bed licences (intangible) in the future.

Another significant asset type is related party loans. Related party loans make up 10 per cent ($4.7 billion) of total assets, and for-profit providers hold $4.3 billion (92 per cent) of this balance. Some of this might be explained by residential facilities being held by related parties as although 57 per cent ($2.5 billion) of related party loans are classified as current assets (receivable within 12 months), and fixed assets are non-current in nature, only a portion can be attributable to facilities being held by related parties. The for-profit providers would have a negative equity position if not for net related party loans ($2.4 billion), and/or intangible assets (bed licences and other).

Given the regulated permitted uses of RADs and bonds, the build-up of categories of assets other than fixed assets is noteworthy. A formal review of the use of RADs and bond financing is part of the annual focus of the Department of Health in their examination of Annual Prudential Compliance Statements. It is important that as RADs and their related investments continue to grow, the Department and Health similarly increases its oversight to ensure it keeps pace with this expanding sector.

In terms of total liabilities, RADs (including bonds) make up 75 per cent ($27.5 billion) of the capital funding of the sector. Fifty-one per cent of RADs are held by not-for-profit providers, 47 per cent by for-profit providers and 2 per cent by government providers. With 41 per cent of places held in the sector, the for-profit providers have the greater exposure to RADs and bonds.

Conversely the not-for-profit providers have proportionally significantly less RADs exposure as they hold 55 per cent of places.

Other capital funding sources include:

- Bank borrowings make up 6 per cent, or $2.2 billion of total liabilities. The for-profit sector hold 73 per cent of bank borrowings, or $1.6 billion, while not-for-profit providers have borrowed 27 per cent, or $0.6 billion; and
- Related party loans make up 6 per cent, or $2.1 billion of total liabilities. The for-profit sector holds the majority of this funding with 91 per cent, or $1.9 billion of borrowings. It is of note that the for-profit providers have a net asset balance, indicating they loan more funding out than they receive.

Other liabilities make up 17 per cent, or $6.0 billion of total liabilities. These include balances that have not been disaggregated from data submitted from providers. Other liabilities include, but not limited to, deferred revenue, trade and other payables, income tax payable, deferred tax liabilities, financial instruments such as interest rate swaps, other financial liabilities such as lease arrangements, and non-employee related provisions.

7.3.2 Balance sheet performance ratios

Balance sheet ratios provide a guide as to the financial health of providers through an analysis of their profitability, liquidity and efficiency as well as their net worth.

Balance sheet performance ratios – definitions
Current Ratio

Current ratio is a measure of an organisation's ability to meet its short term obligations (current liabilities) from its current assets. The current ratio measures an organisation's liquidity and provides an indication of risk that the organisation may not be able to meet its short term obligations as and when they fall due. It is calculated by dividing current assets of an organisation by its current liabilities.

Generally, a current ratio of at least 1.0, shows that an organisation has sufficient current assets to meet its short term obligations. However the requirement to categorise accommodation deposits as current liabilities[33] on the balance sheet of providers means that the current ratio needs to be treated with some caution and considered in conjunction with other financial indicators of liquidity for aged care organisations. For example, although refundable accommodation deposits (RADs) are required to be repaid when a resident leaves care, they are more often than not, repaid after a stay of longer than one year. The average length of stay for residents is currently just over three years.

Cash as a proportion of accommodation deposits

Cash and cash equivalents in the form of financial assets, as a proportion of refundable accommodation deposit balances provides an indication of an organisation's capacity to repay the accommodation deposit balances with liquid resources.

Net Assets Value

The net assets value provides an indication of the value of an organisation. The net assets value is determined by taking the total assets of an organisation and subtracting total liabilities. A low net assets value or a decrease in the value over time indicates higher levels of financial risk for lenders and consumers.

Debt Ratio

The debt ratio is calculated by dividing an organisation's total liabilities by its total assets and provides an indication of the degree of financing of an organisation. Within the aged care sector, total liabilities will consist of an organisation's refundable accommodation deposits as well as other secured and unsecured debt balances. An organisation's total assets will include cash and asset balances to which the refundable accommodation deposits may have been applied. As total liabilities increase as a proportion of total assets, the higher levels of debt could reflect the use of additional borrowings used to fund an organisation's improvements and expansions.

EBITDA to total assets ratio

The EBITDA to total assets ratio measures the operating return generated from an organisation's total assets. The ratio is a measure of financial performance and is calculated by taking the earnings, before interest, tax, depreciation and amortisation (EBITDA) and dividing this by the organisation's total assets. Generally, the higher the EBITDA to total assets ratio, the better the level of return generated from the organisation's total assets.

Equity to total assets ratio

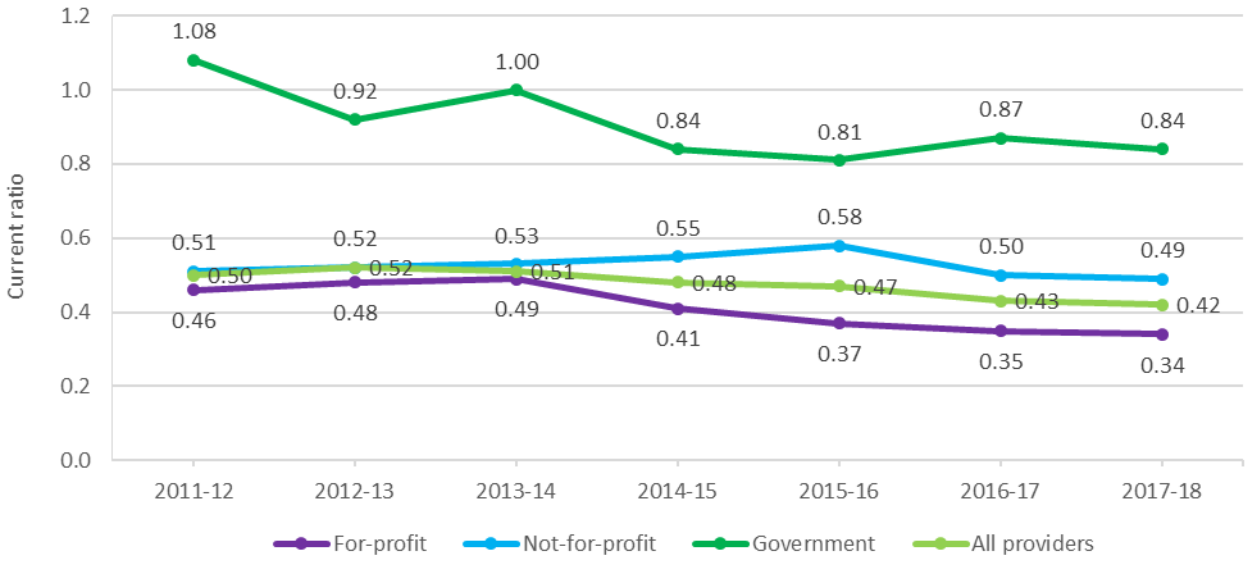
[33] The requirements for the presentation of financial statements is set out in AASB 101 and paragraph 69(d) relates to liabilities where there is no right to defer settlement of the liability for at least 12 months after the reporting period. The average length of stay of a resident is three years and as a result, the liability for repayment of an accommodation deposit can extend beyond 12 months after year end if the resident is still in care.

Net worth/total equity as a proportion of total assets provides an indication of solvency. For the for-profit providers, it shows the proportion of an organisation's assets which have been contributed by the owners/shareholders. For the not-for-profit and government providers, equity typically consists of retained earnings and revaluation reserves. The lower the ratio suggests that an organisation has used more debt to fund its asset balances.

As shown in Chart 7.10 the current ratio for the whole sector continued to decrease to 0.42 from 0.43 in 2016-17 and 0.47 in 2015-16. The decrease indicates a slight increase in the risk that organisations may not be able to meet their current liabilities from the current asset balances.

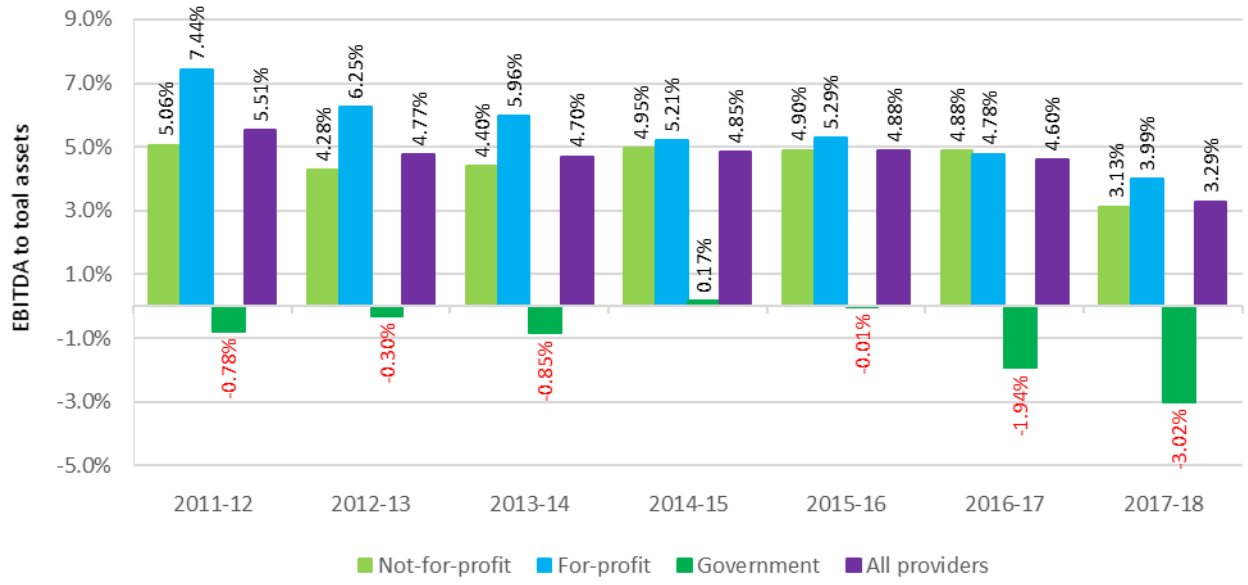
In terms of ownership type, in 2017-18, the current ratio for not-for-profit providers decreased to 0.49 compared with 0.50 in 2016-17. As has been the case in recent years, the current ratio for the not-for-profits was higher than the current ratio achieved by the for-profit providers which decreased slightly to 0.34 from 0.35 in 2016-17. As noted, a current ratio of less than 1.0 ordinarily indicates an organisation has insufficient assets to meet their obligations when they become due and payable. However, although refundable accommodation deposits can become repayable at any time and are classified as current liabilities, in practice, the repayment period for accommodation deposit balances will vary in line with each resident's tenure. This means that the current ratio result should be used with some caution and considered with other financial indicators in the residential aged care sector.

Chart 7.10: Current ratio, by provider ownership, 2011-12 to 2017-18



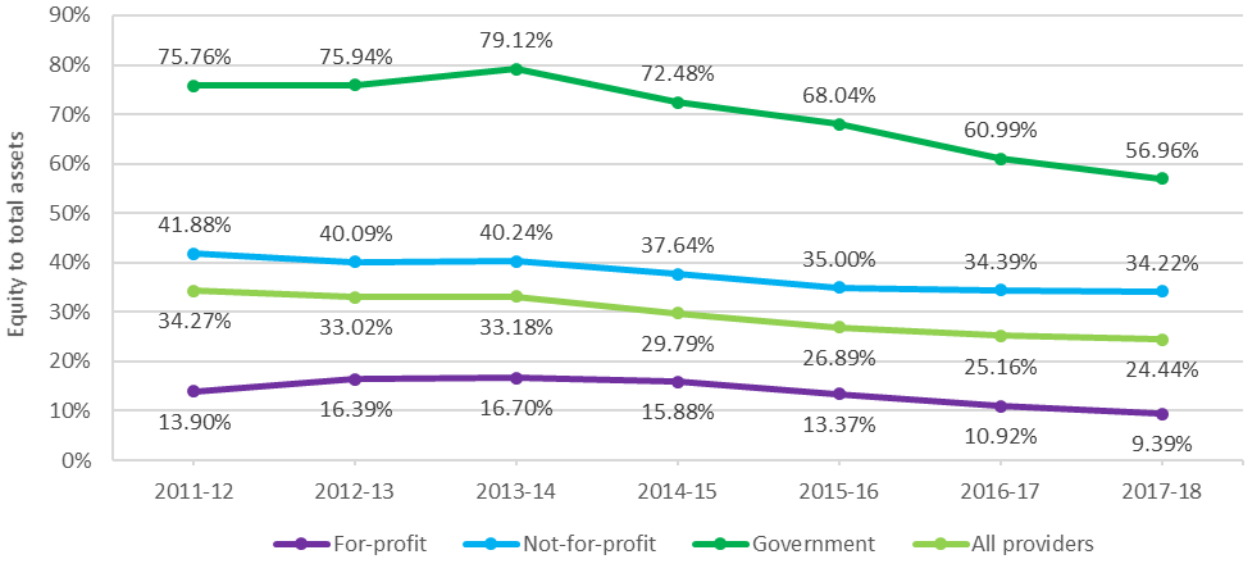
As shown in Chart 7.11 the EBITDA to total assets has been trending downwards since 2011-12. In 2017-18 it was almost the same for the not-for-profit providers (3.1 per cent) as it was for the for-profit providers (4.0 per cent). The EBITDA to total assets ratio measures the operating return generated from an organisation's total assets.

Chart 7.11: EBITDA to total assets, by provider ownership, 2011-12 to 2017-18



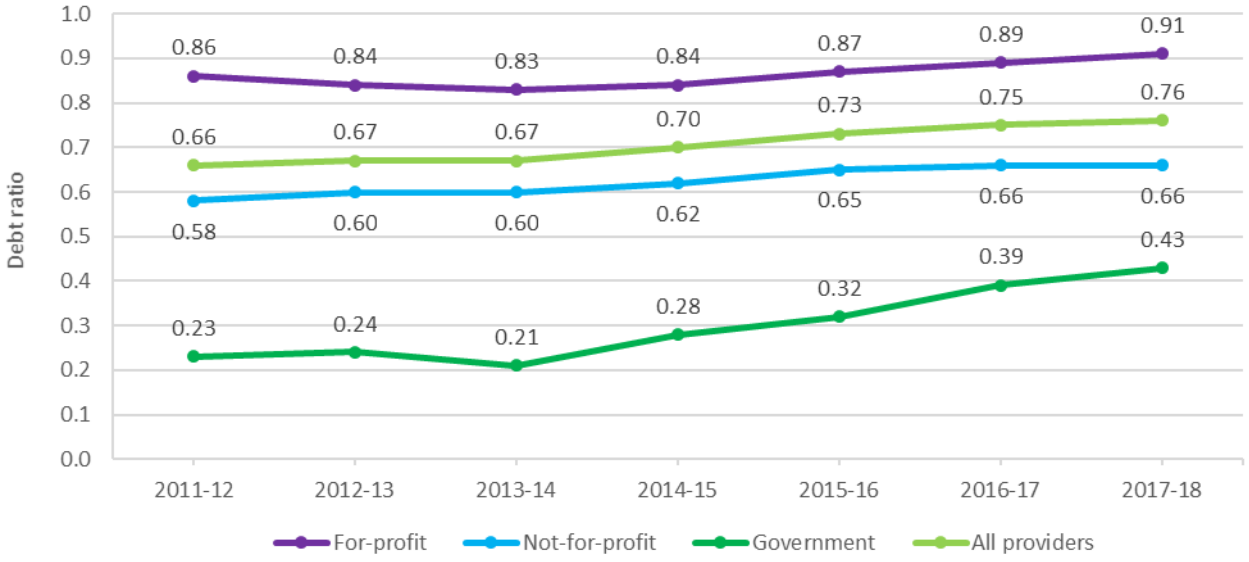
There was a significant difference between the results for provider types when looking at the results for the equity to total assets ratio as shown in Chart 7.12. Not-for-profit providers achieved a higher result of 34 per cent whereas the for-profit providers decreased by 1.5 per cent to 9.4 per cent in 2017-18. The results for all provider types have continued to decrease since 2013-14 suggesting a preference for debt to fund the growth in assets.

Chart 7.12: Equity to total assets, by provider ownership, 2011-12 to 2017-18



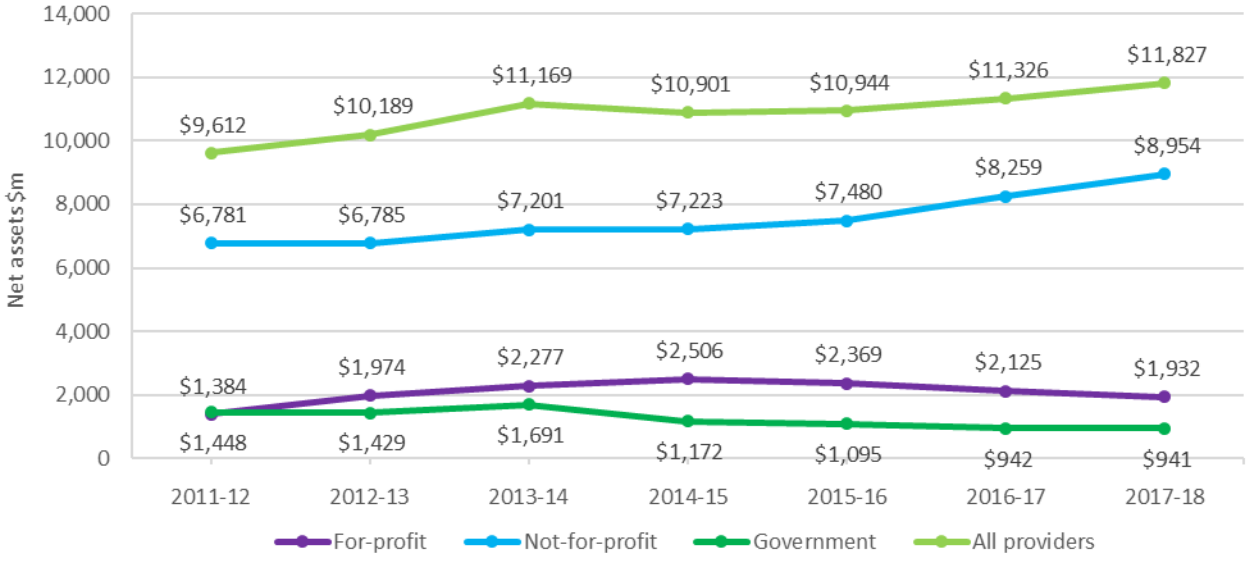
The average debt ratio across the sector again increased slightly with all three ownership types recording an increase compared with 2016-17 (Chart 7.13). The average debt ratio shows the proportion of organisational assets that are financed through debt. A ratio of more than 1.0 indicates that an organisation has a higher debt level than the value of its assets. The debt ratio for all provider types has been increasing since 2013-14.

Chart 7.13: Average debt ratio, by provider ownership, 2011-12 to 2017-18



The net asset position increased across the sector for the not-for-profit providers, increasing by $695 million to $8.9 billion in 2017-18 (Chart 7.14). The net asset position decreased slightly for both the for-profit providers and government providers to $1.9 billion and $941 million respectively. The net asset position of the sector as a whole has been increasing since 2014-15.

Chart 7.14: Net assets, by provider ownership, 2011-12 to 2017-18



Whilst the net asset balances of the sector has increased during 2017-18, the levels of cash and cash equivalents held by not-for-profit providers and government providers has decreased in 2017-18 (Chart 7.15). The levels of cash and cash equivalents held by the for-profit providers increased marginally during this same period, however the for–profit providers held the lowest levels of cash and cash equivalents, as a proportion of refundable accommodation deposit

balances at 15.5 per cent. Cash held as a percentage of accommodation balances received provides an indication of an organisation's capacity to repay the accommodation deposit balances from liquid resources

Chart 7.15: Cash held as percentage of accommodation deposit balances, by provider ownership, 2016-17 and 2017-18

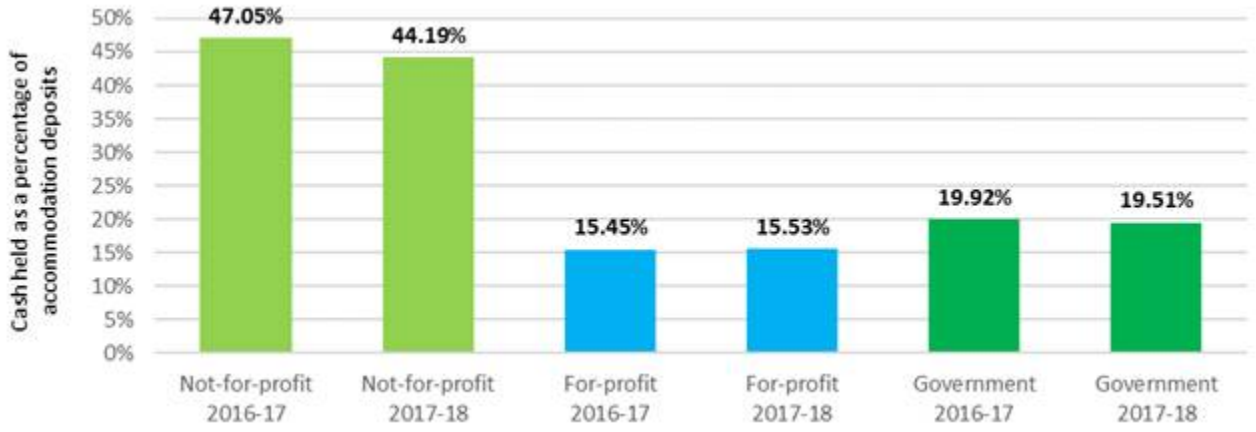
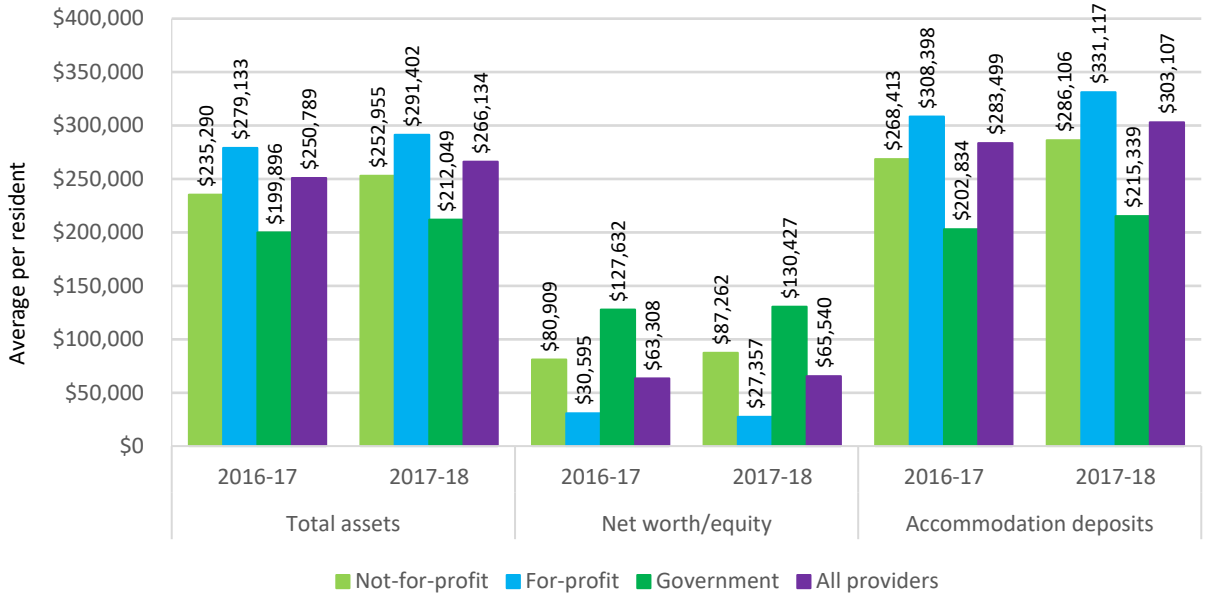


Chart 7.16 shows total assets, net worth/equity and average accommodation deposit value per resident, by ownership type in 2017-18, compared with 2016-17. For the whole of sector, the average for all accommodation deposits held increased to $303,107 per resident from $283,499 in 2016-17, an increase of 7 per cent. This metric measures the average value of all bonds (pre 1 July 2014) and accommodation deposits (post 1 July 2014) that providers hold.

In terms of net worth/equity, for-profit providers recorded a decrease of $3,238 per resident (10.6 per cent) which follows a decrease the year before of around $5,000 (15.7 per cent). In contrast, the not-for-profits recorded an increase for the second year in a row, increasing to $87,262 from $80,909 in 2016-17.

Chart 7.16 total assets, net worth/equity and average accommodation deposit value per resident, by ownership type, 2017-18 and 2016-17



7.3.3 Recent trends in building and investment in the residential care sector

In 2017-18 the total completed or in-progress work was $4.9 billion compared with $4.7 billion in 2016-17 (Chart 7.17).

However, following on from the decline reported in last year's report, in 2017-18, there was a further significant decline in providers reporting they were planning to rebuild or upgrade their facilities (Chart 7.18). In 2015-16 the proportion of facilities planning to rebuild or upgrade were 5 per cent and 14 per cent respectively. In 2017-18, following two years of declining intentions, only 2 per cent of facilities are reporting they are planning rebuilding works and 5 per cent planning to upgrade.

Feedback from consultations with providers indicated that many had curtailed or delayed investment plans in the residential care sector, citing depressed returns and policy and regulatory uncertainty along with the potential impact of increased home care packages. A large number of providers, both for-profit and not-for-profit, said their immediate plans would be directed to retirement living rather than residential care. Factors cited in influencing this decision included: the considerable policy and regulatory uncertainty in the aged care sector; the desirability of diversifying income streams given the volatility in residential aged care; and the advantages of establishing an integrated aged care operation that involved retirement living, home care and residential aged care. Many for-profit providers emphasised that the current return on capital employed in aged care was below the cost of capital and, in the absence of any change, this would curtail additional investment in the sector.

Chart 7.17: Residential care building activity (completed or in-progress), 2012-13 to 2017-18

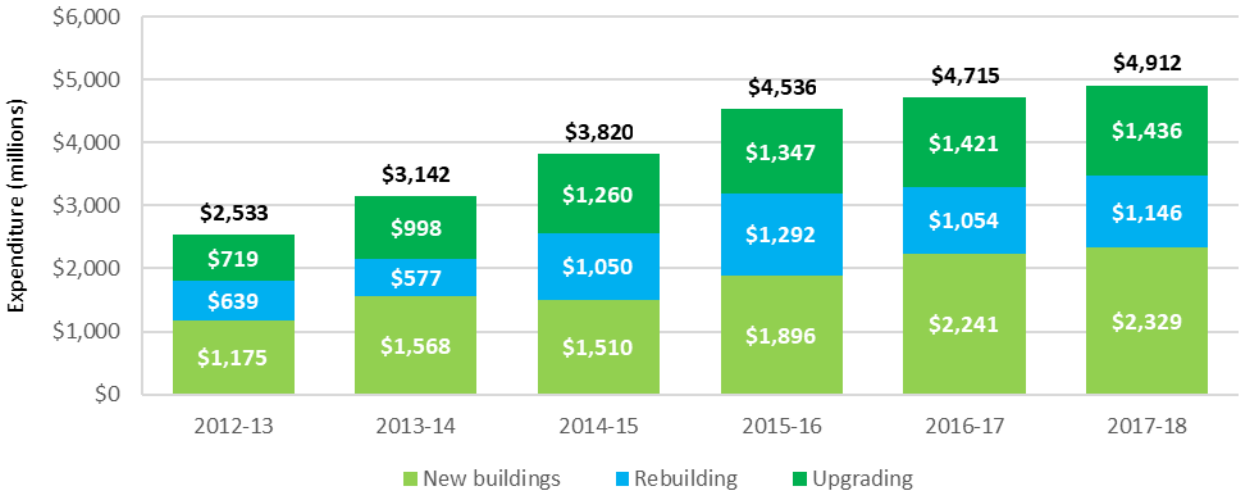
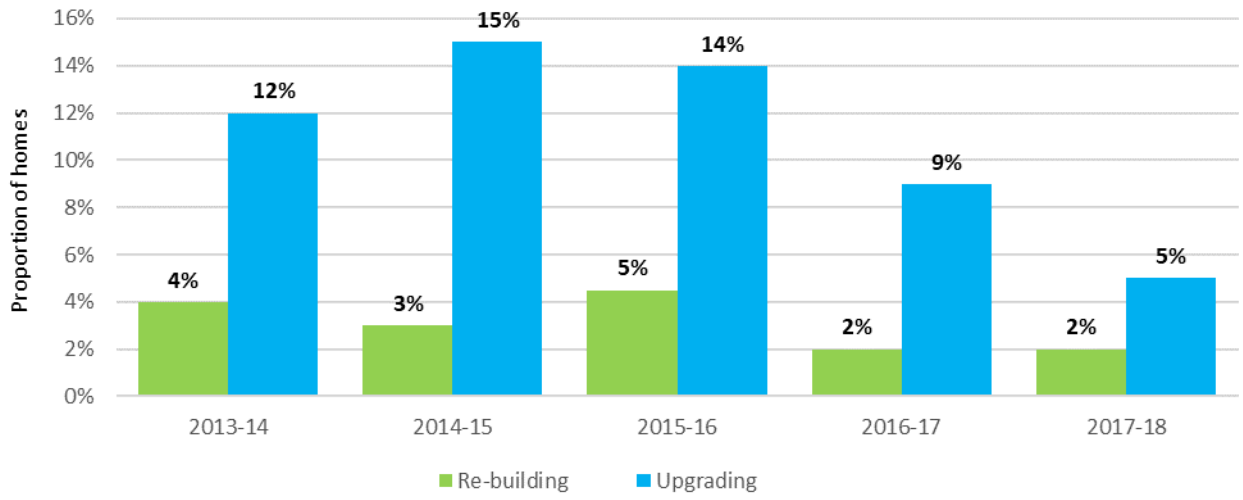


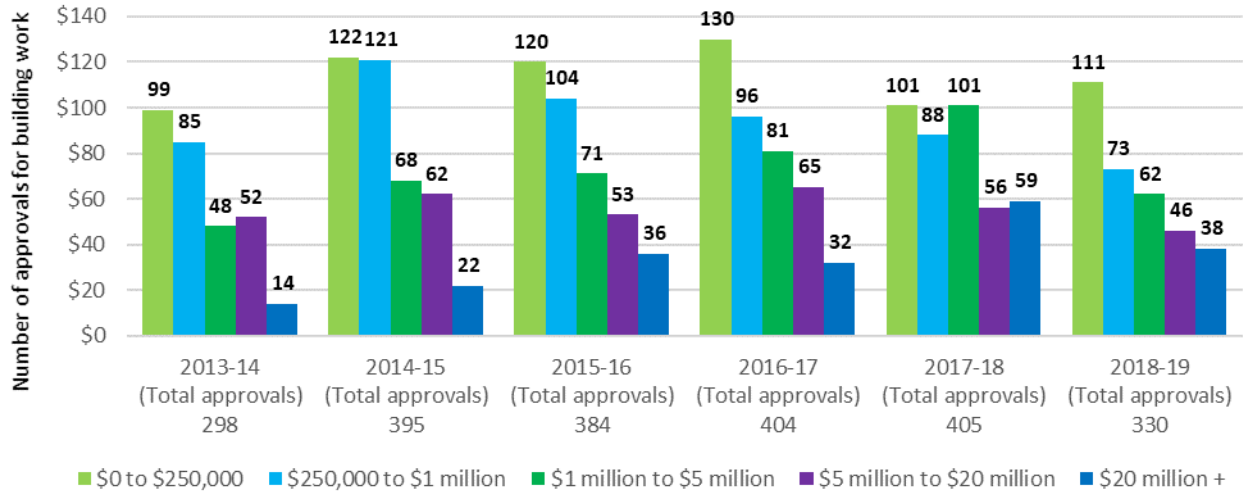
Chart 7.18: Proportion of facilities planning to either upgrade or rebuild, 2013-14 to 2017-18



The decline in planned building activity discussed above is also evident, albeit less significantly, in data regarding aged care building approvals from the Australian Bureau of Statistics. There were 330 building approvals for aged care facilities in the 12 months up to the end of February 2019, compared with 405 for the same period up to February 2017 (Chart 7.19) and similar approval levels in the two years prior to that.

Also, as noted in Chapter 3, there was a dampening in demand for new residential care places in the 2018-19 ACAR with 2.8 applications for every available place, compared with 4.5 for the 2016-17 ACAR.

Chart 7.19: Number of building approvals, by value of building work, 2013-14 to 2017-18



Note: Data is March to February each year.

8 Future demand for aged care

This chapter discusses:

- The factors that affect demand for aged care;
- demand for the different types of subsidised aged care;
- changing population of older Australians requiring aged care; and
- changing preferences of consumers seeking aged care.

8.1 Future demand for aged care services

The demand for aged care services will expand with the ageing of the population. This chapter examines the factors that affect demand for the relevant aged care types, how this is likely to look in the future, and the investment that is needed to ensure the aged care system can adequately cater for the expected future requirements of the population.

An investigation into demand and supply of aged care services was undertaken by David Tune AO PSM in the *Legislated Review of Aged Care 2017*. The Review concluded that there was insufficient data available and that "robust measures of demand and unmet demand in aged care are a significant way off". The Review also noted however that there is no doubt that demographic factors will lead to significant growth in service provision and expenditure requirements.

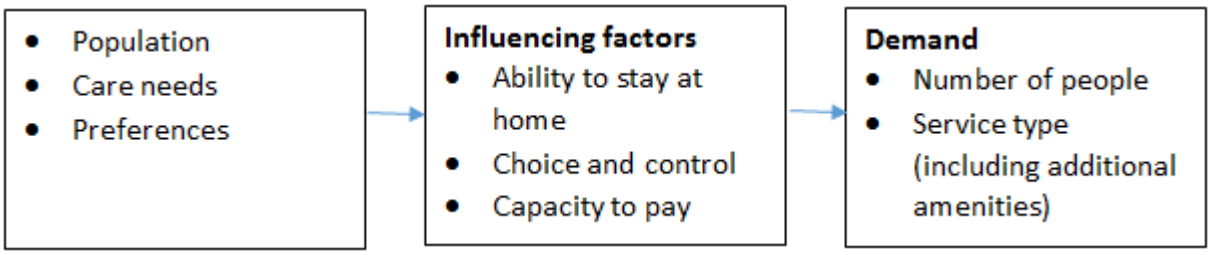
It is also currently not possible to establish consumer preference for residential and home care, due to existing supply constraints. Better evidence about unmet need and consumer preference is however, gradually being revealed as the overall provision target and the proportion of home care packages (including at higher levels) continues to increase, and through the introduction of the national prioritisation system for home care packages. The introduction of flexibility to switch funding across care types in response to consumer demand will also help to inform consumer preferences. The other variable is how providers might respond to increased consumer choice, such as innovation in accommodation options for older people and innovation is service delivery models.

With these limitations in mind, the analysis contained in this chapter focuses on projections based on current use of aged care and population growth, and should not be treated as forecasts of what is likely to happen in terms of future demand for types of aged care.

8.1.1 Determinants of demand

Demand for aged care services is complex and dependent on a range of demographic, service need, and economic factors. The Productivity Commission noted in its 2011 report, *Caring for Older Australians*, that "The demand for aged care services depends on the number of older people needing care and support. However, care needs are not homogenous and the nature and location of aged care services demanded will depend on the physical and mental health of older people, their capacity and willingness to pay, their preferences, and the availability of informal carers."

Figure 8.1: Factors affecting the extent and type of aged care service demand

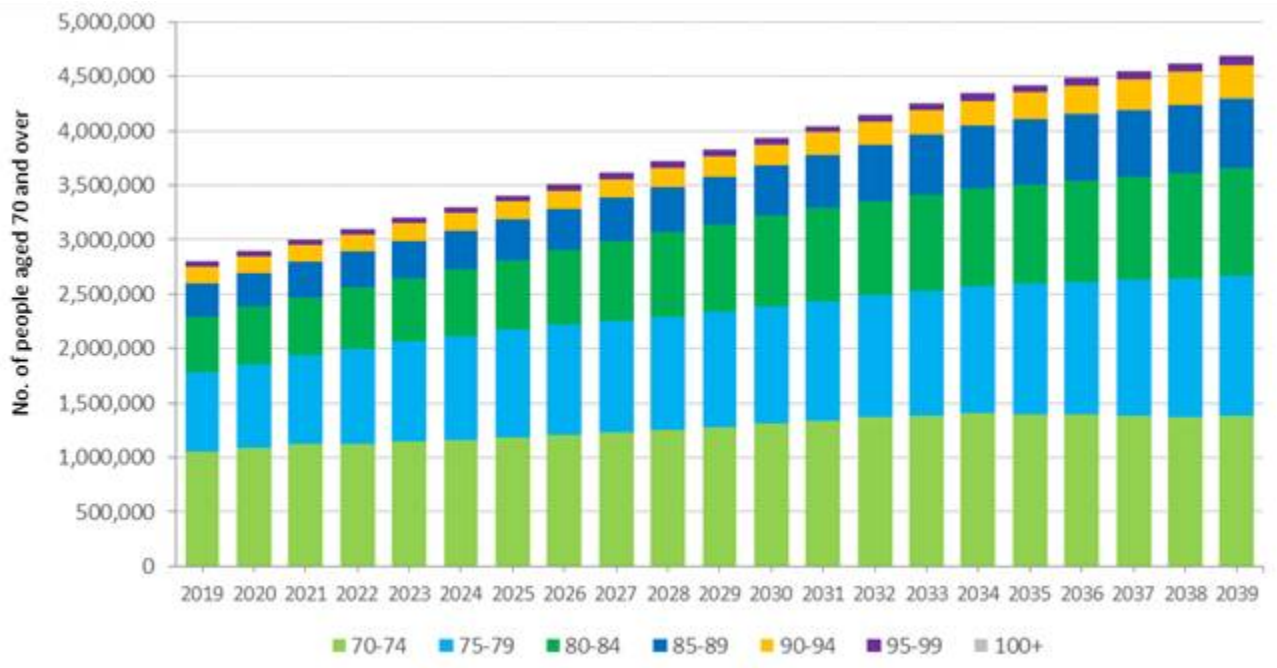


Source: adapted from *Caring for older Australians* (Productivity Commission, 2011)

8.1.2 An ageing population – older people demand more aged care

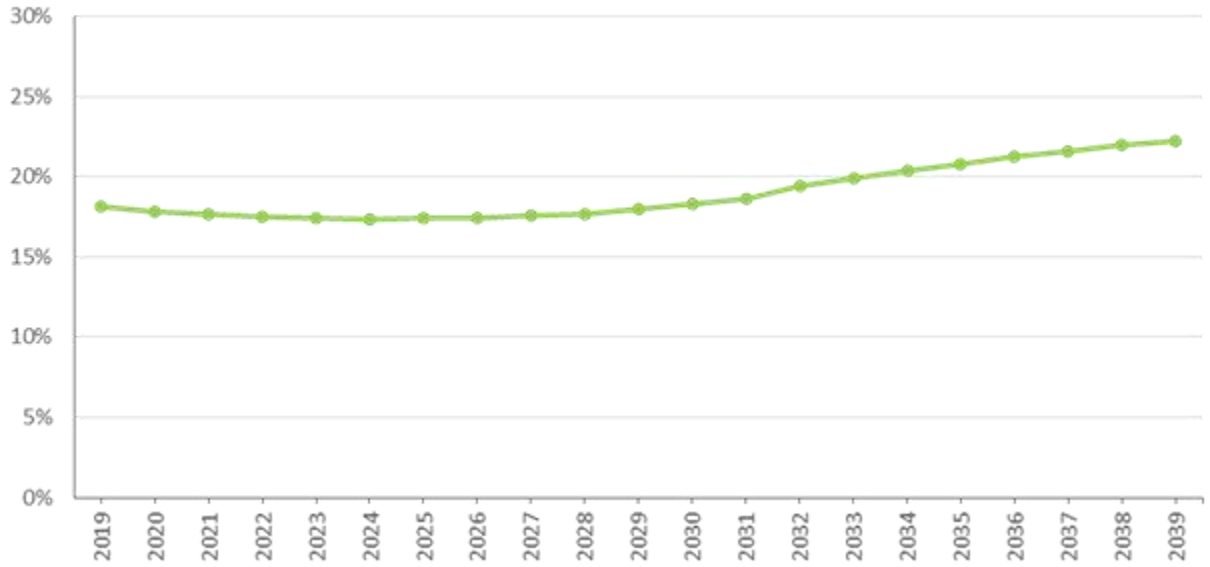
The structural ageing of the Australian population over the next 20 years will see the size of the 70 years and over cohort increase by around 1 million people each decade; this is on a base of 2.7 million people in 2019. Underneath this, the older age groups will more than double over this period; for example, the 85 years and over cohort will increase from just under 500,000 people in 2019 to just over 1 million people by 2039.

Chart 8.1: Number of people aged 70 years and over, by 5 year age cohort, 2019 to 2039



Because the baby boomers are such a large group compared with the pre-war generation, the proportion of the 70 and over population who are aged 85 and over will actually reduce over the next decade before subsequently increasing, as shown in Chart 8.2. This implies that the challenge of ensuring there is sufficient aged care supply to meet demand arising from the baby boomer generation is likely to be most strongly felt in 10–15 years (from the late 2020s) rather than over the next decade.

Chart 8.2: Proportion of 70 years and over age group who are aged 85 and over, 2019 to 2039



8.1.3 Consumer preference

A key characteristic of the baby boomer generation is that they are wealthier than previous generations[34]. The bulk of the people likely to be demanding care in the next two decades have benefitted from high growth in property prices while paying down their mortgage, and are the first generation to have compulsory superannuation. It is reasonable to assume that they will both expect and be able to afford higher standards of residential accommodation, lifestyle amenities and quality of life than previous generations have been willing to accept. Like the current generation, however, baby boomers can be expected to prefer to remain living in their own home for as long as possible as they age.

The consequences of these trends are that while the demand for aged care will grow with the ageing of the population, consumers may be more demanding in the range and quality of aged care services they are seeking, along with having a greater capacity to pay for these services. Nevertheless, maintaining equity in access to aged care services will continue to be important and a robust safety net will continue to be necessary.

To compete in this environment, however, providers will need to be more responsive in meeting consumer needs, including in particular the desire to stay at home for as long as possible, and this may require the introduction of new business models and changes in the interaction between retirement living, home care and residential care. The aged care regulatory system will also need to adapt to enable providers greater flexibility to pursue new business models and innovation.

[34] ABS, *Household Income and Wealth 2015-16* (Cat no. 6253.0)

8.1.4 Availability of alternative care types

According to the Survey of Disability, Ageing, and Carers[35], around 1 in 9 Australians, or 2.7 million people, were informal carers. Almost all carers cared for a family member. The assistance provided by informal carers can avoid or delay entry into residential care, including with the support of home-based care, and is also an important source of support for those in residential care.

At the same time that ageing population structures (discussed earlier) are putting pressures on the demand for care, the relative supply of informal carers is diminishing. This is due to increased participation of women in the workforce, and changing family structures with fewer children being born per family (1.7 babies per woman in 2017 compared with nearly 3 in 1970[36]), generational differences in marriage and divorce rates. And more people living alone.

All else equal, this will increase the demand for formal aged care for older people.

In terms of demand for specific types of aged care, the relative availability of places within each care type under current regulated supply arrangements will also affect the rates at which people access them and to the extent they are not available, redirect demand across care types. As previously outlined in this report, the Government is gradually changing the mix of residential and home care over time through adjustments to the provisional target ratios, and has implemented mechanisms whereby funding for unused residential care places can be redirected into home care where, at least over the short term, demand is expected to be more acute.

In addition, a key objective of the *Legislated Review of Aged Care 2017* was "to trigger changes that are prerequisites for a fully consumer-driven system", and outlined recommendations that were "intended as the next steps on the road to consumer-driven care". Most of the Legislated Review's recommendations in this regard have not been acted upon.

The unknown, therefore, is related to uncertainty about government policy and the extent to which the modes of delivering care may develop in the future in response to consumer preferences, such as further relaxation or removal of supply constraints, the availability of more higher level home care packages and closer integration between retirement living and home care. New ways of service delivery and innovation may widen the scope of aged care services available, which in turn may result in significant shifts in the types of services demand.

8.1.5 Economic factors

The demand for different types of care, and the way consumers distinguish between services in the same type of care, is affected by the price they can be asked to pay and the perceived value of that contribution.

Consumers of residential and home care are currently required to make a co-contribution to the cost of their care (and residential accommodation) if they can afford to do so. However the amount and proportion of contribution required to be made by a consumer varies between residential care and home care, including in relation to capacity to pay. Such anomalies have the potential to distort the demand for types of care or additional services.

Nevertheless a challenge remains for governments to establish funding policies that ensure access to aged care services for all needing aged care and support that meet community quality of life expectation, irrespective of their means and social and cultural circumstances. Incentives in funding

[35] ABS, *2015 Survey of Disability, Ageing and Carers, Australia* (Cat no. 4430.0)

[36] ABS, *Births, Australia, 2017* (Cat no. 3301.0)

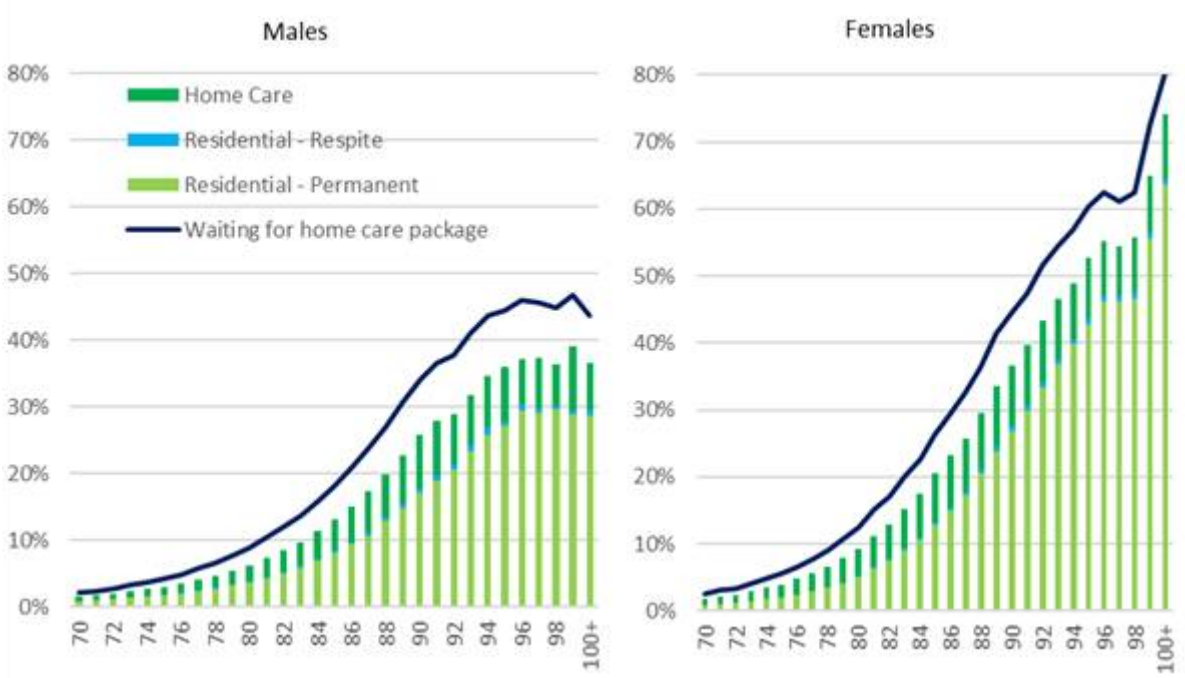
arrangements are also important in influencing the type of care supplied, for example if funding arrangements have no incentive for reablement services and a provider loses funding if there is an improvement in the level of acuity of a consumer, then there will be limited supply of services promoting reablement.

8.2 Current demand for aged care

An understanding of the current profile of aged care usage is helpful for undertaking projections of future demand.

As shown in Chart 8.3 the proportion of each age group who use residential and home care package services increases dramatically with age. By age 80, the proportion of people using either permanent residential care or a home care package is around 7 per cent; this doubles by aged 85; and more than doubles again by age 90.

Chart 8.3: Proportion of people of each age using residential care and home care, by gender and age, 30 June 2018



Note: Home care consumers receiving care in an interim level package are counted as using home care. People waiting for a home care package are only those consumers who do not have a package at any level.

This projection is based on current usage, which may well not reflect the extent to which consumers are having their needs and preferences met by current regulated supply. True demand is much harder to measure given the current highly regulated supply system.

8.2.1 Residential care

There are indicators to suggest that overall the demand for residential care is currently being met. The occupancy rate in 2017-18 was 90.3 per cent, down from 91.8 per cent in 2016-17 and 92.4 per cent in 2015-16. The overall average occupancy rate in residential care peaked at 97.1 per cent in 2003-04. There may, nevertheless, be pockets or regions of the country where

people are waiting to access residential care. The Tune Review asked stakeholders about the level of unmet demand and received little feedback to suggest that there is significant unmet demand.

Residential care usage may, however, be artificially high as result of people entering residential care prematurely as an alternative to waiting on the allocation of a home care package. Current usage also does not reflect the potential for residential care services in a more competitive and flexible system to offer a more attractive service that includes more opportunities for higher quality and meaningful life delivered in a secure environment.

8.2.2 Home care

There is evidence of unmet demand for home care. As noted in section 3.4.2, at December 2018 there were 127,748 people waiting for a home care package (including those already receiving lower level home care) through the National Prioritisation System.

8.3 Projecting demand into the future

Previous ACFA reports have contained a projection of demand for residential care over the next 20 years based on current age-specific use and the current residential aged care target provision ratio which is based on the number of people aged 70 years and over.

A projection on this basis suggests that the projected number of operational places is likely to exceed demand for residential care to 2027. This is because places are linked to growth in the 70+ population, which due to baby boomers entering their 70s, is growing at a faster rate than people who currently are using residential care, who are the 80 plus cohort of the population. Following 2027, as the baby boomers enter their 80s, demand for care is expected to rise faster than the release of places in line with the provision target ratio.

Care is needed in interpreting such projections because they are limited to residential care and do not take into account changes in consumer preferences and changes in modes of delivery of aged care. In particular, no account is taken for substitution of residential care for home care as the number of home care packages continue to expand.

8.3.1 Substitution of residential care and home care

One of the key factors that has to be taken into account in projecting demand for aged care is the potential substitutability of service types. The introduction of the National Prioritisation System indicates there is significant unmet demand for home care services. It is also possible that some people have entered residential care because a home care place at a suitable level was not available.

The proportion of people in each age group (age-specific use) who are in either residential care or home care has remained stable (Chart 8.4, first column) over a long period of time. However, the amount of home care packages available has increased significantly as a share of these two care types (Chart 8.4, second column). As the amount of home care has expanded there has been a clear reduction in the age-specific use of residential care (Chart 8.4, third column and Chart 8.5 which gives a cross-section of Chart 8.4). This would indicate that home care is substituting for residential care.

It is not known what the level of home care availability is that would be needed before all people who wish to remain in their home with a home care package can do so, and do not have to enter

residential care. In addition, the substitutability between residential and home care will also change if, for example, the government were to introduce a new higher level package as recommended by The Tune Review (Recommendation 7). It is possible that the introduction of higher level home care packages could see the age-specific use of residential care potentially reduce. Similarly, other possible policy changes, such as consumer contribution policies and support available for informal carers (such as improved respite services), could influence value for money and consumer choice.

Chart 8.4: Utilisation of residential care and home care, 2000 to 2018

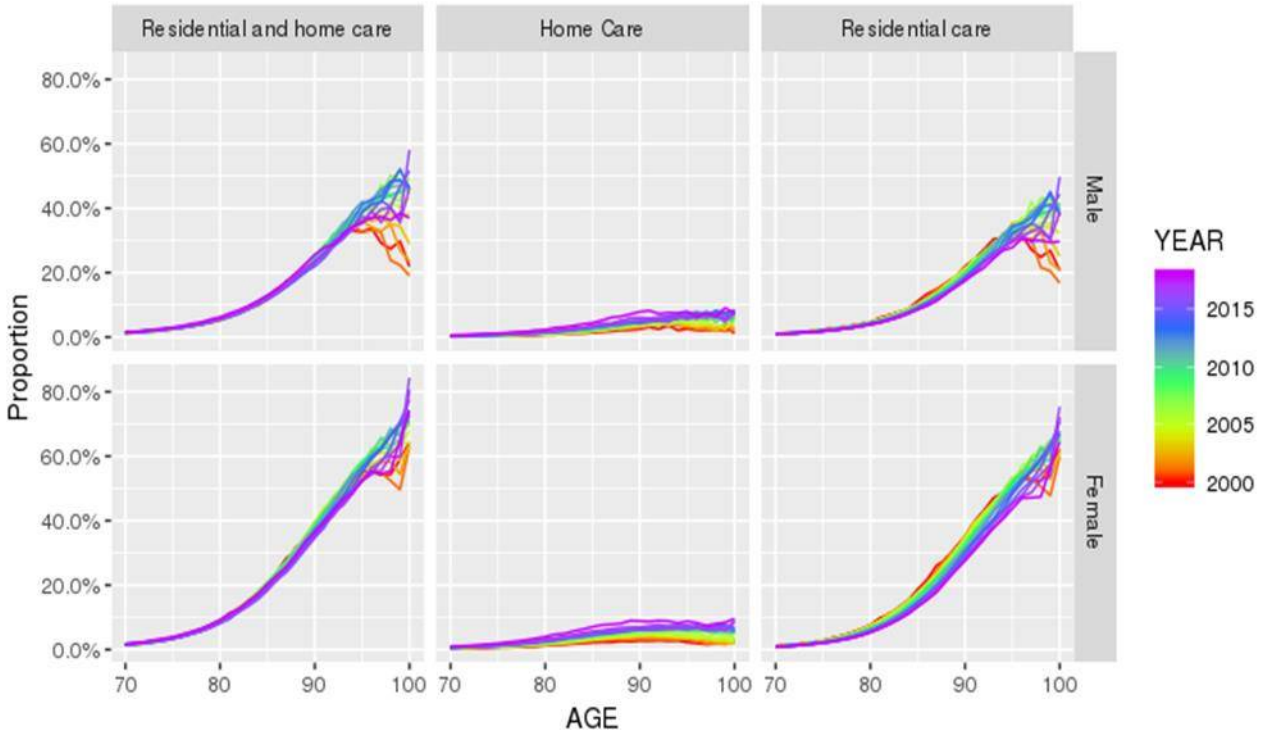
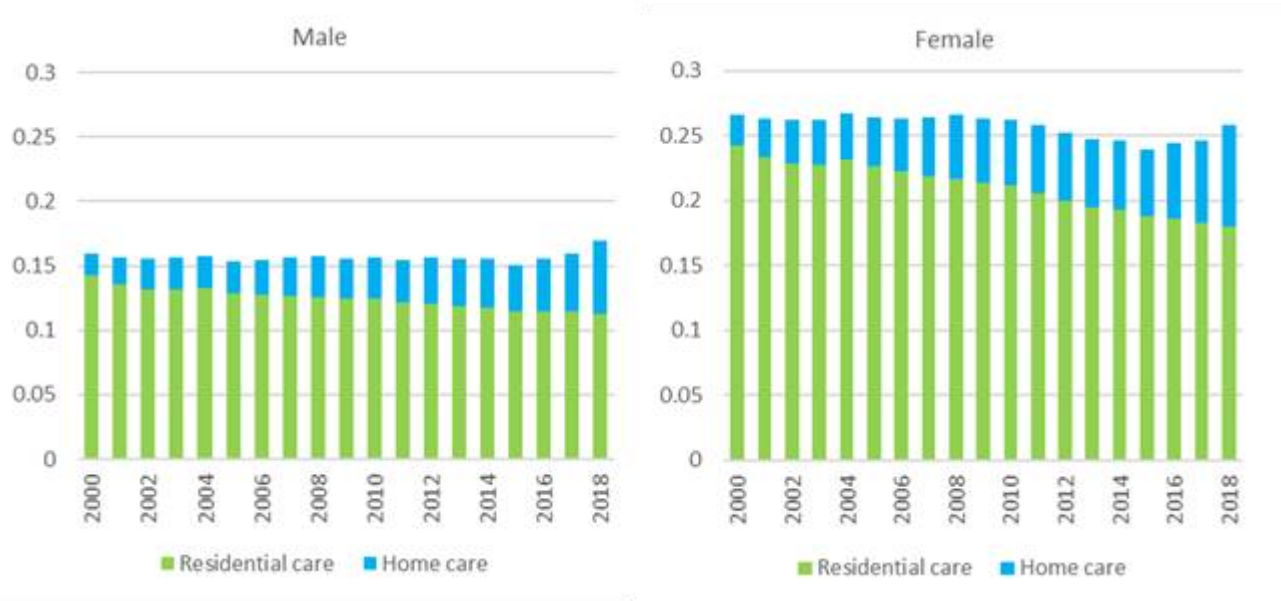


Chart 8.5: Utilisation of residential care and home care for 85-89 year olds, 2000 to 2018



The expansion of home care is likely to not only divert people from entering residential care for longer or at all, but it will also have an impact on people receiving care from informal carers and through other programs such as the Commonwealth Home Support Program (CHSP). It is estimated that 93.9 per cent of people waiting for a home care package as at the end of December 2018 had been provided with approval to access support through CHSP.

8.3.2 Updated projections

The projected demand from the current age-sex specific usage of residential care is one approach to projecting future demand for residential aged care. However, with the expansion of the home care program and the concomitant fall in the usage of residential care in all age groups (Chart 8.4 and Chart 8.5), such projections may over estimate demand for residential care. Chart 8.6 grows the number of people using residential care proportional to growth in the population (using ABS single-year-age and sex population projections).

It is evident from Chart 8.6 that, if the growth in the number of residential care places grows in line with the current target provision ratio (purple line) and not impacted by any other factors, occupancy rates will continue to fall over the 2020s, before rising in the 2030s.

Chart 8.6: Projected demand for and supply of residential care places, 2018 to 2039

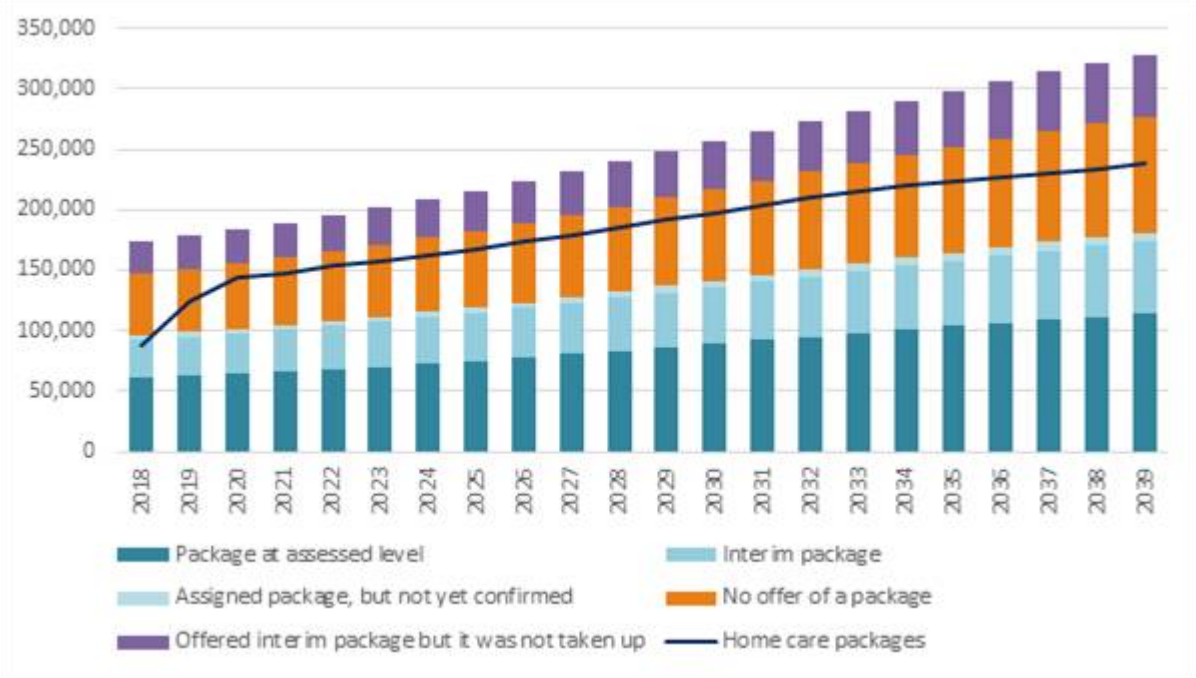
There is currently excess demand for home care. Consequently, projections based on the current usage of home care, which is constrained by current supply, are not going to give a meaningful guide as to future demand. In addition, the current profile of assessment for home care could be influenced by the number of people waiting for home care through the National Prioritisation System and prospect of long wait times.

With this in mind, Chart 8.7 grows the number of people in the home care system at 30 June 2018 - with a package (blue series) or waiting for a package to be offered (orange series) – proportional to growth in the population using the ABS single-year-age and sex population projections. These series have been broken down into sub-components:

- the 'with a package' series (blue) is further sub-divided into those receiving a package at their assessed level, those receiving an interim package and those who have been offered a package and are in the process of deciding whether to take up the offered package;
- the 'waiting for package to be offered' series (orange) is further sub-divided into those who have not been offered any package and those who have been offered an interim package but have not taken this up.

It is evident from this chart that the growth in the number of packages (black line) as the provision target of 45 by 2020 is achieved will, in the short-term, significantly reduce the number of people waiting for home care through the National Prioritisation System who have not yet been offered a package. However, there will still be a significant number of people without a package and over time the number of people waiting will grow again. It needs to be kept in the mind that those people who have declined the offer of an interim package have indicated they are actively seeking care and are awaiting an offer of a higher level package.

Chart 8.7: Projected demand for and supply of home care packages, 2018 to 2038



8.3.3 Planning for the supply of aged care

As noted previously, if residential care places increased in line with the current target provision ratio and current age-specific use rates continued, there would be an excess supply of residential care over most of the 2020s. As the baby boomers start to enter their 80s in the 2030s, this demand could start to put pressure on the sector and its ability to ensure there is adequate supply of residential care. This has been flagged in previous ACFA reports and in the Tune Review.

There is excess demand for home care, and this is likely to remain the pressure point in the supply of aged care over the projection period. At least part of this undersupply can be met through a reduction in residential care places as currently provided for in the target provision ratio.

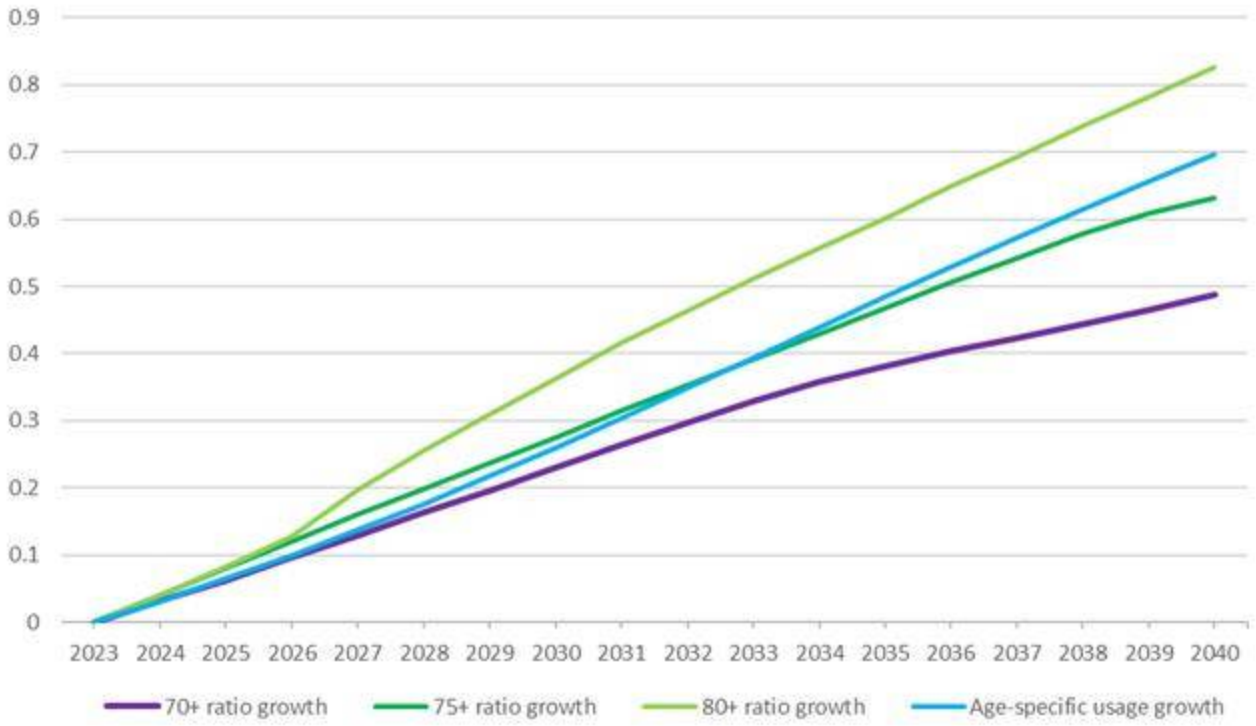
The Tune Review report recommended changes to the target planning ratio. The current ratio denominator of the 70+ population is not aligned to the cohort of the population more likely to use aged care services, and results in the observed periods of relative oversupply and undersupply. ACFA supports the Tune Review recommendation to change the denominator in the ratio to the 75+ cohort of the population following the achievement of the 125 ratio in 2021-22.

ACFA also recommends that the change in the denominator be accompanied by a change in the target provision ratio formula so that it is based on the number of consumers and not the number of operational places. This will allow comparable reporting and monitoring of the supply of

residential and home care places against the provision targets, and help inform unmet demand and consumer preference.

The following analysis shows the supply of aged care places under the 70+ population and 80+ population. The equivalent rates (converted as at 30 June 2023) are 194 per 1,000 people aged 75+ and 351 per 1,000 people aged 80+. As can be seen in Chart 8.8 the expected growth in the number of consumers (blue line) more closely follows the 75+ population growth over the medium term to the mid 2030's.

Chart 8.8: Cumulative growth in aged care places, 2023 to 2040

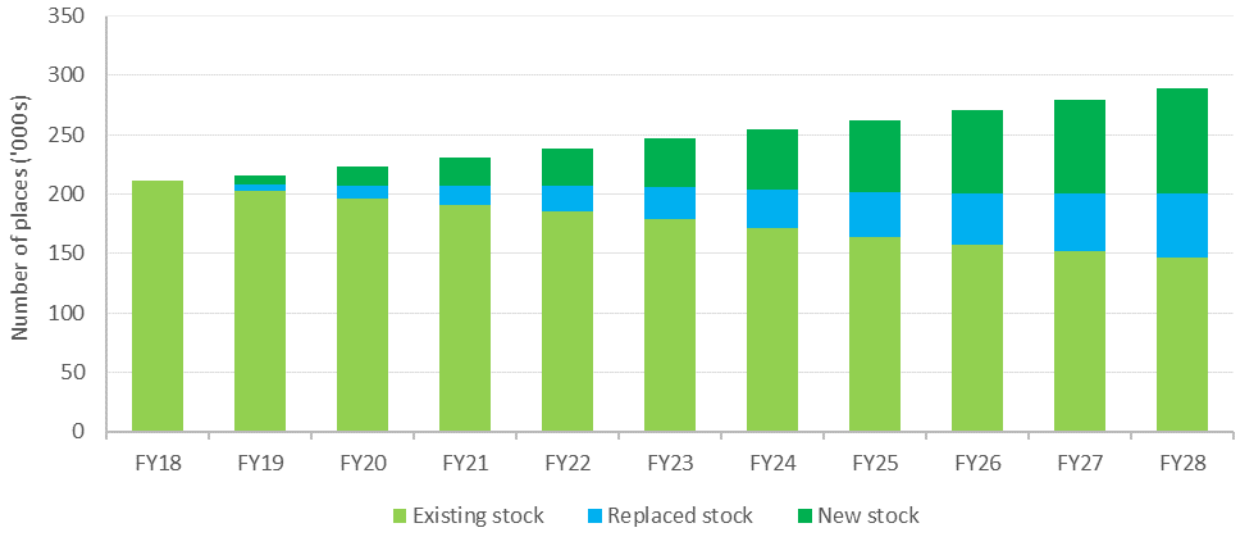


8.4 Investment requirements for residential care

As noted above, there are many variables that will influence the future demand for residential aged care. Nevertheless, it is evident given the ageing of the population, along with increasing consumer expectations, that there will need to be significant future investment in the residential sector to both build new facilities and to refurbish existing facilities.

Using only the current target provision ratio to project the future supply of residential aged care, and not taking into account the impact of increased home care on the demand for residential care, the sector would need to build over 88,000 places over the next decade. At the same time, the sector would need to rebuild or refurbish a substantial proportion of the current stock of aged care facilities. It is assumed that over the next decade around a quarter of the existing stock of buildings, covering around 54,000 places, would need to be rebuilt or refurbished (at an even rate over the period).

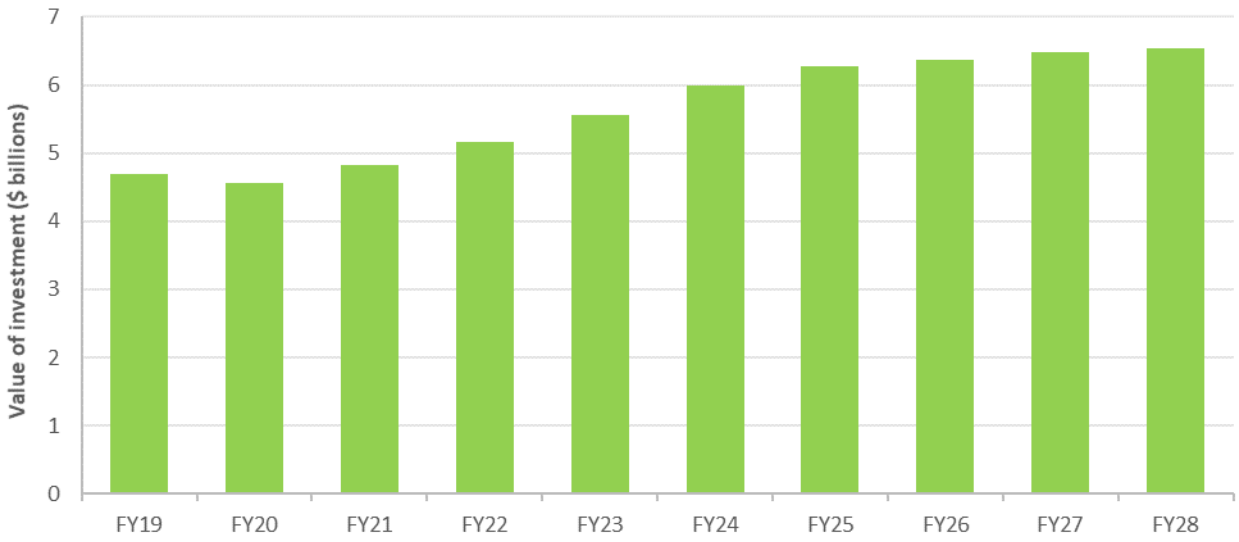
Chart 8.9: Number of operational residential aged care places required 2017-18 to 2027-28



On the basis of the above assumptions, the combined total investment for new and rebuilt places over the next decade would be around $55 billion. The net present value, of this estimate is approximately $50 billion. This compares with an estimate of around $18 billion (in present value) in building and upgrade work completed between 2009 and 2018. As previously noted, however, these projections are based on particular assumptions and should be treated with care.

While the total number of residential care places increased from 174,700 to 210,800 over the last 10 years, the number of mainstream facilities decreased from 2,783 to 2,695. This means that, on average, the investment in new places was primarily through expansion of existing facilities. There is a limit to how big existing facilities can expand and future investment to increase the supply of residential care places may have to be increasingly through greenfield projects.

Chart 8.10: Future annual investment requirement, 2018–19 to 2027–28



The model used to determine the investment requirements was developed for the Department in 2018 by Deloitte Access Economics. The assumptions behind the analysis are:

- Total place requirements (i.e. the total of all new and rebuilt stock) that is estimated to be operational at each point in the future is based on the Department's projections which take into account the current stock of provisionally allocated places; the historical rate of building; and the expected number of flexible residential care places that also contribute to the overall residential care target.
- The share of places that are rebuilt each year is estimated using a flat rate assumption of 2.5 per cent of the stock in that year, i.e. a 40 year average building lifetime.
- The cost of construction differs by region. The base construction costs in 2018-19 of $260,700 per new place, $221,200 per rebuild, and $27,700 per upgrade (from the Survey of Aged Care Homes) have been adjusted by using indices that scale up costs in regional areas relative to the nearest capital city.
- The cost of construction is indexed over time using a 10 year average of Rawlinson's Building Cost Index for each state's metropolitan and regional areas (averaging out at 2.4 per cent per annum nationally).
- The cost of land is sourced from ABS land price data for each state's metropolitan areas and again adjusted using the relevant regional index for that state.
- The cost of land is indexed over time using a flat rate of 4.4 per cent per annum for all areas based on ABS residential property price data.

The value of building work completed and in progress during 2017-18, and other indicators of construction and investment in the sector is discussed in detail in Chapter 7.

8.5 The investment environment

Chapter 9 outlines some of the characteristics of a sustainable aged care industry. This is against the background that the significant capital investment needed to meet the future demand for aged care services will largely come from the non-government sector, both for-profit and not-for-profit sectors.

The challenge facing the Government is to ensure that the funding and regulatory arrangements in the aged care sector are such that it provides the ongoing environment that facilitates the needed investment. A key requirement in this regard is that the non-government sector has confidence in the direction and stability of Government policies and those providers receive a return such that it will attract the necessary capital and labour resources. The funding arrangements will also need to be flexible so that providers can respond and adapt to changes in consumers' preferences for aged care services as well as innovate and embrace new technologies.

8.5.1 Access to capital

Capital investment in the residential aged care industry is required to expand and refurbish existing facilities, as well as building to meet future capacity. To attract investment the industry needs to generate consistent rates of return that are appropriate for the risk involved and are competitive with returns in other sectors that have similar attributes.

Viable and well-run providers are best placed to attract the financial capital, experienced management and quality staff required to deliver long term industry sustainability and growth. Key ingredients of well-run providers include the exercise of good governance that oversees the implementation of strategic investment plans and the ability to successfully monitor their operational performance against those plans.

To be viable, a provider, whether not-for-profit, for-profit or government owned, must have access to sufficient funds to repair and replace their capital stock, be able to maintain working capital to support their operations, and use capital efficiently relative to the other purposes to which it could be deployed. These outcomes are underpinned by sound financial management that effectively manages costs, sets appropriate pricing strategies to derive the revenue stream to support sustainable capital returns.

Investment activity requires equity investor and debt provider confidence in the capacity of providers to deliver sustainable returns on capital and of the sector overall. The amount of (and change in) invested capital is one key metric of sustainability.

In order to attract future investment the industry needs to generate consistent rates of return on capital that are appropriate for the risk involved and are competitive with returns in other sectors that have similar attributes.

Capital investment in the residential sector can include: equity injections or retained earnings; loans from financial institutions or investors which require sufficient profits to be generated to meet the interest costs and repayment amounts; and interest-free loans from residents in the form of lump sum accommodation payments. Where providers are unable to meet the whole cost of essential capital works, limited capital grant funding is available from the Government-funded Rural, Regional and Other Special Needs Building Fund.

Viable and well-run providers are best placed to attract the financial capital, experienced management and quality staff required to deliver long-term industry sustainability and growth. Therefore, key ingredients include the exercise of good governance that oversees the implementation of strategic investment plans and the ability to successfully monitor their operational performance against those plans.

9 The Challenge of achieving a sustainable aged care system

This chapter discusses:

- funding and financing challenges in the aged care industry now and in the future; and
- the characteristics of a viable and sustainable aged care system.

9.1 Funding and financing challenges in the aged care industry

To provide the level and quality of aged care services that older Australians require now and into the future, including to secure a skilled workforce, it is essential that the aged care industry is financially viable, stable, efficient, effective, responsive and sustainable. It is evident from developments in the industry over recent years that it faces many hurdles in achieving this objective. Among them include:

- ACFI has not provided a stable and effective care funding tool for both the Government and providers. The Government has been concerned that the growth in ACFI payments has exceeded the underlying growth in the acuity of the Australian population and subsequent changes it has made to ACFI arrangements have had a significant impact on the financial performance of residential aged care providers. A sizeable proportion of residential care providers are currently making a loss and a number of smaller providers are seeking to leave the sector while many are concerned about their ongoing viability if current financial trends are maintained. Overall, under the ACFI funding tool, there have been cycles of high growth followed by low or no growth causing uncertainty for providers, investors and Governments. Moreover, the current ACFI arrangements cannot satisfactorily resolve the extent to which residents' care needs have been increasing over time compared with the extent to which providers have maximised the potential to use the ACFI tool to increase revenue growth (including in response to low indexation). ACFI is also administratively complex for both providers and the Government and has resulted in the sector diverting resources away from delivering care. In addition, ACFI has some perverse incentives that may encourage outdated modes and types of care and lead to inefficiencies with providers focusing on ACFI claiming rather than on the needs of residents.

- Volatility, uncertainty and margin pressures have resulted in many residential care providers putting investment projects on hold while they assess the future direction of the market and reforms. In addition, a number of providers are investing in activities other than residential aged care in order to diversify their revenue sources and reduce their exposure to the volatility in the residential aged care sector. These developments are not consistent with establishing the environment necessary for facilitating the investment needed to meet the needs of an ageing population.

- The Government continues to fund the bulk of the cost of aged care notwithstanding the Living Longer Living Better reforms which introduced changes to means testing. As noted in ACFA's *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997,* in the case of residential care the Government's share of the overall average cost per resident per year only reduced to 65.6 per cent under the post-reform means test compared with 68.3 if the pre-reform arrangements were applied. The Tune Review observed that given the demand for, and costs of aged care will increase significantly in the future, it is likely to be unsustainable for the Government to continue to cover two-thirds of the cost of residential aged care and there is a strong case to increase the proportion of costs that are met by consumers.

- The contribution aged care residents make to the cost of their everyday living expenses (such as food, linen, utilities) is capped at 85 per cent of the single pension. StewartBrown estimates that this is nearly an average of $8 per bed per day below the cost of providing these services. One area where providers can boost their revenue, and the level of services available to residents, is through the provision of additional services for a fee. However there remains considerable uncertainty as to what additional service fees are permitted and this is precluding a number of providers charging additional service fees to residents who can afford to do so, even where the providers are already providing the additional services.

- There is a wide diversity in the financial performance of providers in both the residential and home care sectors. There are providers, irrespective of size, ownership type and location, who are achieving good returns (albeit somewhat lower than in previous years) under current funding arrangements. While a range of factors would be affecting the individual performance of providers, including in particular the demands facing providers operating in rural and remote areas, the magnitude of the variance in financial results suggests there is scope for many providers to improve their operations and performance.

- The introduction of home care packages following consumers has increased competition in the home care market and compressed providers' returns. Given the large increase in the number of approved home care providers, there is likely to be some rationalisation of providers in the future which could cause some disruption for consumers. A major development is the rise in unspent funds, which may mean that some consumers are not receiving all the care they require and is forgone business for providers. It may also indicate that some consumers could have been assessed as requiring more funding than they actually need. There are also prudential considerations in ensuring that the unspent funds being held by providers is available to be spent on consumers when required or returned to the Government and the consumer when the consumer leaves the provider. Providers also

have to be more flexible in adjusting their procedures and processes so they are more responsive to what consumers are seeking.

9.2 Characteristics of a viable and sustainable aged care system

One of ACFA's functions is to provide advice on the impact of funding and financing arrangements on the viability and sustainability of the aged care system. In pursuing this task, and against the background of developments in the aged care industry in recent years, ACFA has identified from a funding perspective a number of characteristics of a viable and sustainable aged care system.

Confidence and trust

The overriding challenge facing the Government is maintaining confidence and trust in the quality of aged care services and the funding and financing arrangements for the industry.

Towards achieving trust, the regulatory and funding arrangements have to be stable, understood, and transparent. Trust is essential because while the Government is the main source of funding for aged care, the services are primarily delivered by the non-government sector: for-profit and not-for- profit providers. These providers will not invest in the industry, nor will they be able to attract the required staff, unless they understand the basis of regulation, the Government's approach to the funding of the industry, and they have confidence in the adequacy and stability of Government policies.

From the consumer perspective, there needs to be trust in the quality of care people will receive from the aged care system for this will influence the preparedness of consumers and their families to seek the support that they need.

Stable, predictable, efficient, equitable and effective arrangements for allocating Government funding

There needs to be a stable, efficient and effective residential aged care funding tool which provides financial stability to both aged care providers and the Government. The Government also has the challenge of ensuring that the funding tool is consistent with achieving ongoing equity of access for all consumers and that it does not incentivise outmoded or inefficient care practices and use of resources.

The current review of alternative residential care funding arrangements and the Resource Utilisation and Classification Study (RUCS) is an important exercise. Desirable features of a new funding tool include: administrative simplicity, funding assessments external to the provider, equitable allocation of funds based on the mix of residents and their needs, recognition that many care costs are shared between residents, transparent studies to determine the cost of care and indexation arrangements that adequately reflect movement in costs. In introducing a new funding model, it will be important to ensure that providers have confidence in the new arrangements. The new system needs to be transparent, robust and evidence based to achieve this objective.

Similarly, there needs to be stable and efficient funding arrangements for home care that ensure that targeted care is available for all consumers. The home care funding arrangements should also be based on transparent studies to determine the cost of care.

Appropriate overall funding

Efficient arrangements for equitably allocating funding across residential care providers and home care consumers are necessary, but it is also important that the overall funding pool for the aged care system is adequate and sustainable. The funding has to be sufficient to meet the level and quality of aged care needs of current and prospective Australians and in doing so provide the incentive for providers to invest in the industry. The level of funding provided by the Government has to support the delivery of quality aged care services required by Australians. But it should not support inefficient or poorly managed providers nor should it provide higher than necessary funding.

The Government needs to ensure that the Budget forecasts of aged care spending are as realistic as possible. Aged care is a sizeable and growing component of the Commonwealth's Budget and its importance will grow in line with the ageing of the Australian population. An overshooting of aged care expenditure can cause problems for the management of the Government's accounts and bring into question its fiscal sustainability. It is not, however, a simple matter to determine the appropriate amount of funding for the aged care industry, although it is an issue that requires careful consideration. The industry is very diverse and the financial results of providers vary depending on business structures, financing arrangements, and motivations, including those who are mission based. In addition, the Government has to take into account the range of aged care services sought by the community, along with the extent to which consumers will contribute to the cost of their aged care.

It is important to ensure that the Government's contribution to care costs reflects the growth in these costs over time, although the indexation methodology should also make allowance for achievable productivity improvements. While the indexation rate for ACFI has been markedly lower than the rate of growth in the costs of providers, particularly wages, if the new funding model reduces the capacity of providers to boost their revenue through claiming behaviour, it will be important that the new indexation arrangements adequately reflect the growth in costs (while providing an incentive for productivity gains). It may take around two years before a new aged care funding tool is introduced. In the meantime the Government will need to ensure that the indexation of ACFI rates is appropriate and address the financial pressure confronting the industry.

Funding that is flexible and adaptable to changing demographics and demands

The demographics of the Australian population are such that there will be increasing pressure on funding for aged care, both residential and home care. Demand will change and there will be innovations in the way services are delivered and the interaction between aged care and other sectors, such as retirement living and hospitals. The funding arrangements have to be responsive to these changes and should not deter but rather encourage innovation.

Currently the provision of residential aged care places and home care packages is determined by the Aged Care Provision Ratio (the Ratio). The Tune Review concluded that while it would ultimately be desirable for the supply of aged care to be uncapped, significant work needed to be done before government could safely remove supply controls while ensuring the system was fiscally sustainable for government and equitable for consumers. Specifically, before uncapping supply there needs to be: an accurate understanding of underlying demand; equitable and sufficient contributions by consumers to their cost of care; a robust system for assessing eligibility for subsidised services; and provisions for ensuring equitable and continuing supply of aged care services in places where there are higher costs of service delivery limited choice and competition.

There has been progress on some of these requirements, but before they are all met the Tune Review made a number of recommendations to improve the flexibility of current arrangements, including to change the population cohort on which the target provision ratio is based, from people aged 70 years and over to people aged 75 years and over, which would allow the overall supply of aged care to better match the key demand driver in aged care, namely the ageing of the population. At the same time, the provision target ratio formula should be changed from operational places to consumers in order to enable comparable reporting and monitoring of supply and assist with assessing the level of unmet need. All these measures are consistent with ensuring the sustainability of an aged care system based on greater consumer choice and competition in service provision.

Equitable contribution to costs by consumers

Sustainable aged care funding arrangements will require consumers who can afford to do so to make a greater financial contribution towards their residential everyday living expenses and care costs, complemented by a greater choice of higher quality services. This would involve stronger means testing arrangements for care fees, which would reduce pressure on Government expenditure, and uncapping the basic daily fee in residential care, both in line with the recommendations of the Tune Review.

In addition, uncapping the basic daily fee for residential care for consumers who can afford to pay would boost the revenue of residential care providers and for some may provide the opportunity of dispensing with charging fees for the provision of additional services. There is currently uncertainty over what are permissible additional services that aged care providers can offer residents for a fee.

Another recommendation by the Tune Review which should be pursued is requiring that providers charge the income-tested care fee in home care and that the value of the basic daily fee is proportionate to the value of the home care package, although noting the measure to slightly reduce the basic daily fee for lower level care packages that was announced as part of the 2018-19 MYEFO in November 2019 was a step in this direction. There is also a need to improve consumer understanding of the fees they may be asked to pay so that they can more effectively plan for their aged care.

Effective prudential oversight

Effective prudential oversight of the aged care industry is necessary given that the range of current and prospective reforms and developments are likely to be disruptive to a number of providers. The current tight operating conditions will likely be accelerating the trend towards greater consolidation in the residential aged care market. There is also evidence that some providers are thinly capitalised (relatively higher proportion of liabilities to assets) and as a result are more exposed to financial and economic risk events. After a period of very strong growth in home care providers, it is likely that this will be followed by a reduction in the number of providers. In both residential and home care, there will always be a role for smaller operators, but the current tight conditions will likely put pressure on less efficient providers and those unable to achieve economies of scale.

An increasing number of marginal providers will likely need to sell or merge with other providers. Such a trend will lead to a more efficient and resilient aged care industry, however the adjustment should be orderly and any impact on consumers should be minimised. Towards the end, the Government should be proactive in identifying providers facing difficulties, providing advice and

support to such providers, and if necessary facilitate the sale or transfer of facilities or operations to another provider. This may require the Government contributing to meet the costs associated with a provider taking over another facing significant financial and likely quality, difficulties.

Sound management and governance arrangements

A sustainable aged care system will require well managed aged care providers with sound governance arrangements. It will also require adequate sources of financing to support the level of investment required to meet current and future demand for aged care services.

Providers need to look at their internal operations to ensure they are delivering care in the most efficient and effective way. The changes taking place in the sector as it moves towards a more consumer driven and market based system will continue to challenge traditional business and workforce models.

Providers have to take the lead in shaping the aged care workforce to take the industry into the future by implementing in full the recommendations of the Aged Care Work Force Strategy Taskforce. Providers will need to be increasingly responsive and flexible. For some providers this may include adjusting their business models to deal with an apparent shift from RADs to DAPs.

Under the current funding system there are very diverse financial outcomes, with the top quartile of providers in terms of profit continuing to achieve significantly better results than the lowest quartile. The very wide variation in financial performance across the sector suggests there is scope for many providers to pursue greater efficiencies and improve their results. Towards this objective, all providers should seek to ensure that their governance arrangements and management capabilities are best practice.

Appendices

Appendix A. ACFA Membership

Members

ACFA position	Name	Organisation
Chairman	Mr Mike Callaghan AM PSM	Economic consultant
Deputy chair	Mr Nicolas Mersiades	Director Aged Care, Catholic Health Australia
Member	Mr Ian Yates AM	Chief Executive, COTA Australia
Member	Mr Gary Barnier	Former aged care executive, independent advisor
Member	Mrs Natalie Smith	Head of Business Execution, Business and Private Bank, ANZ
Member	Prof Michael Woods	Professor, Centre for Health Economics Research and Evaluation, UTS Business School
Member	Dr Mike Rungie	Former CEO, Aged Care Housing Group
Member	Ms Susan Emerson	General Manager Equip for living and Leef Independent Living Solutions SA/NT
Member	Ms Louise Biti	Director, Aged Care Steps

Government representatives

Representative	Mr Jaye Smith	First Assistant Secretary, Ageing and Aged Care Group, Department of Health
Representative	Mr John Dicer	Aged Care Pricing Commissioner
Representative	Ms Leah Wojcik	Manager, Health and Disability Social Policy Division, Department of the Treasury

Appendix B. Work completed by ACFA to date

Work	Date of completion
ACFA's report on understanding how consumers plan and finance aged care	Published 24 December 2018.
ACFA's report on respite for aged care recipients	Published 28 November 2018.
ACFA's Update on Funding and Financing issues in residential aged care industry	Published 5 November 2018.
2018 ACFA Annual Report on Funding and Financing of the Aged Care Sector	Published 28 August 2018.
2017 Annual Report on Funding and Financing of the Aged Care Sector	Published in August 2017.
Application of the Base Interest Rate	Published in June 2017.
Bond Guarantee Scheme	Published in May 2017.
Report to Inform the 2016-17 Review of Amendments to the *Aged Care Act 1997*	Published in June 2017.
Access to Residential Care by Supported residents	Published in February 2017.
2016 Annual Report on Funding and Financing of the Aged Care Sector	Published in August 2016.
Report on Issues Affecting the Financial Performance of Rural and Remote Providers, Residential and Home Care	Published in February 2016.
2015 Annual Report on Funding and Financing of the Aged Care Sector	Published in August 2016.
Report on Factors Influencing the Financial Performance of Residential Aged Care Providers	Published in June 2015.
Report on Improving the Collection of Financial Data from Aged Care Providers	Published in October 2014.
Reports on the Impact of Financial Reforms on the Aged Care Sector	Monthly reports – August 2014 to April 2015 Quarterly reports – September 2015 to June 2016.
2014 Annual Report on the Funding and Financing of the Aged Care Sector	Published in August 2014.
Supported Residents Data Book	Published in May 2014.
Interim advice to the Minister on Improving the Collection of Financial Data from Aged Care Providers	Published in August 2013.
First Annual Report (2013) on the Funding and Financing of the Aged Care Sector	Published in July 2013.

Work	Date of completion
Estimation of the possible impacts on revenue and balance sheet funding from changes to accommodation payment arrangements	ACFA's advice and KPMG modelling published in May 2013.
The framework for setting accommodation payments in residential aged care	Final ACFA advice provided to Minister in November 2012. Government announced its position in December 2012. Further advice on the method for determining a RAD and a DAP using a MPIR provided to Minister on 17 May 2013. Government announced its position on 23 May 2013.

Appendix C. ACFA's stakeholder engagement

ACFA holds meetings and forums with representatives from the investment and financing industries, providers and consumers. This engagement is critical to ACFA's understanding of the key issues, developments and challenges facing the industry. Since July 2018, ACFA's consultations with the sector have increased significantly as noted in Chapter 1.

After publishing the Sixth report on the Funding and Financing of the Aged Care Sector, ACFA undertook to provide the Minister for Aged Care with an update of its assessment of the funding and financing issues currently impacting on the residential aged care sector. In August and September 2018, ACFA held over 40 consultations with a cross-section of residential care providers, financial institutions and analysts prior to the submission of the update in October 2018. The providers consulted included: profit and not-for-profit; metropolitan, regional and remote; and those operating one or a few facilities along with those operating a substantial number of facilities.

In preparation for its 2019 annual report, ACFA has once again consulted heavily with the sector, with consultations held in March and April 2019. Consultations once again included a wide range of aged care providers, financial institutions and analysts but this time also included home care providers in metropolitan and regional areas. The additional consultation this year has allowed ACFA to present an updated view of both the home care and residential care sectors in 2018-19.

ACFA Roundtables

In September and November 2018, ACFA held Roundtables in Sydney and Melbourne with members of the investment and financing community to share the findings of its 2018 annual report and to hear their views on key issues facing the sector.

Over 50 representatives from various organisations participated in the roundtables and a diverse range of issues and views were discussed regarding current and future investment in aged care, workforce issues and the availability of land and the challenges in developing that land into aged care facilities.

Presentations

Since its last annual report, ACFA has presented at the various forums:

- Aged Care Workforce Summit
- Council on the Ageing Criterion Conference on Post Budget Aged Care Reform
- Council on the Ageing Financial Sustainability in Aged Care Conference
- StewartBrown 2018 Aged Care Finance Forum
- Aged & Community Services Australia SA Finance & Aged Care Sector
- Aged & Community Services Australia NSW Finance & Aged Care Sector
- Aged & Community Services Australia TAS Finance & Aged Care Sector
- Estia Board Meeting

- Leading Age Services Australia State of the Industry Breakfast

Appendix D. Aged care workforce

Table D.1: Full-time equivalent (FTE) direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated FTE and per cent)

Occupation	2003	2007	2012	2016
Nurse practitioner	n/a	n/a	190	293
Registered nurse	16,265	13,247	13,939	14,564
Enrolled nurse	10,945	9,856	10,999	9,126
Personal care attendant	42,943	50,542	64,669	69,983
Allied health professional	5,776	5,204	1,612	1,092
Allied health assistant			3,414	2,862
Total number of employees (FTE)	**76,006**	**78,849**	**94,823**	**97,920**
As a % of total employees				
Nurse practitioner	n/a	n/a	0.2%	0.3%
Registered nurse	21.4%	16.8%	14.7%	14.9%
Enrolled nurse	14.4%	12.5%	11.6%	9.3%
Personal care attendant	56.5%	64.1%	68.2%	71.5%
Allied health professional	7.6%	6.6%	1.7%	1.1%
Allied health assistant			3.6%	2.9%

Table D.2: Size of the home support and home care workforce, all PAYG employees and direct care employees: 2007, 2012 and 2016

Occupation	2007	2012	2016
All PAYG employees	87,478	149,801	130,263
Direct care employees	74,067	93,359	86,463

Table D.3: Direct care employees in the home support and home care workforce, by occupation: 2007, 2012 and 2016 (estimated FTE and per cent)

Occupation	2007	2012	2016
Nurse practitioner	n/a	55	41
Registered nurse	6,079	6,544	4,651
Enrolled nurse	1,197	2,345	1,143
Community care worker	35,832	41,394	34,712
Allied health professional	2,948	2,618	2,785
Allied health assistant		1,581	755
Total number of employees (FTE)	**46,056**	**54,537**	**44,087**
As a % of total employees			
Nurse practitioner	n/a	0.1%	0.1%
Registered nurse	13.2%	12.0%	10.5%
Enrolled nurse	2.6%	4.3%	2.6%
Community care worker	77.8%	75.9%	78.7%
Allied health professional	6.4%	4.8%	6.3%
Allied health assistant		2.9%	1.7%

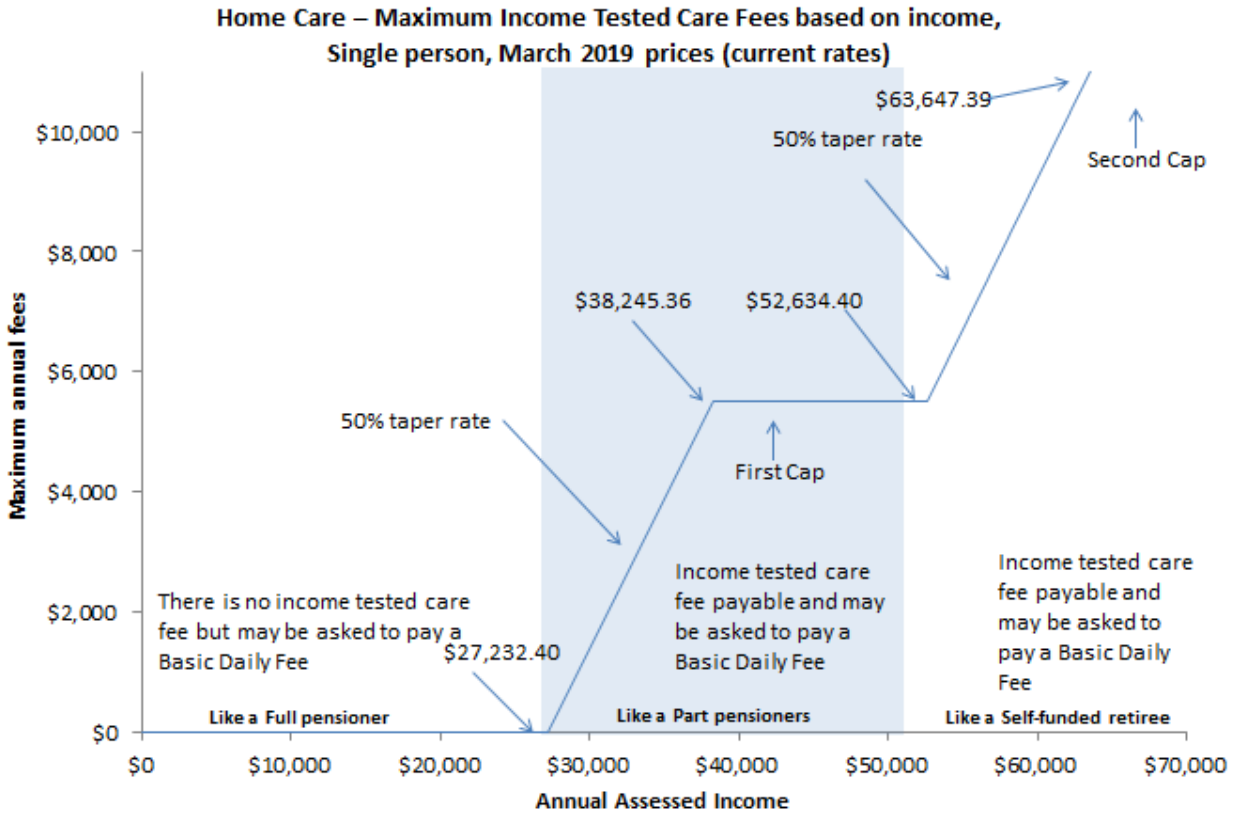
Appendix E. Means testing arrangements

Home care

In addition to the basic daily fee, an income-tested care fee was introduced in home care from 1 July 2014. Unlike the arrangements for the basic daily fee, the Commonwealth payment received by the provider is reduced by the amount of the income-tested care fee. Accordingly, to receive an amount equivalent to the full subsidy the provider needs to charge the appropriate income-tested care fee.

Annual income-tested care fees in home care are currently capped at $5,506.48 for part-pensioners and $11,012.99 for non-pensioners (March 2019 rate). A lifetime cap of $66,078.27 per consumer currently applies for care contributions across home care and residential care (March 2019 rate). Full pensioners are not required to contribute to their care costs and may only be required to pay the basic daily fee.

Figure E.1 Current income testing for home care (post 1 July 2014)



Residential care

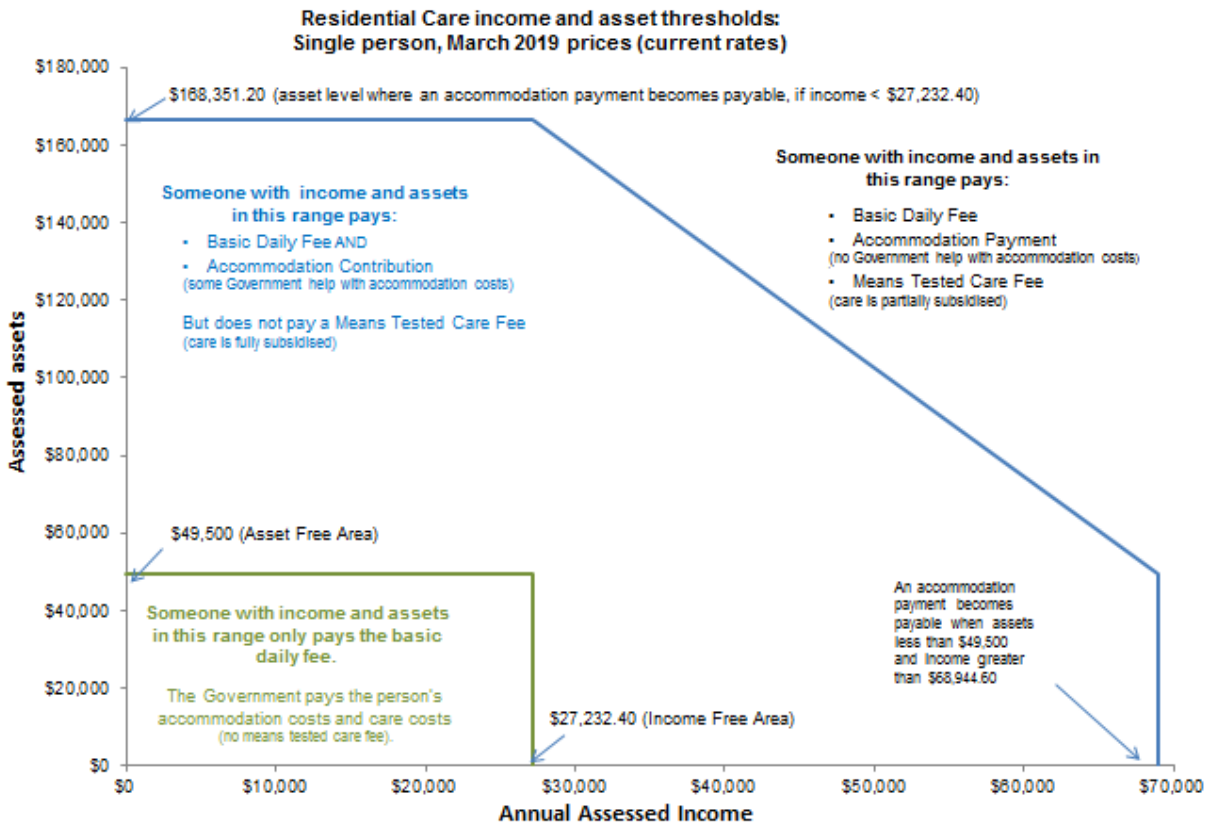
Changes to residential care from 1 July 2014 introduced more comprehensive means testing arrangements by way of a combined assets and income assessment and a new fees structure.

Annual and lifetime caps were also introduced, with an annual cap of $27,532.59 applying to the means-tested care fee and a lifetime cap of $66,078.27 for care contributions (March 2019 rate).

Figure E.2 demonstrates how the means testing arrangements created three tiers of consumer contributions in residential care:

- consumers with low means, who are required to pay only the basic daily fee (85 per cent of the single basic age pension) as a contribution towards their daily living expenses, while their accommodation and care costs are funded by the Australian Government;
- consumers with moderate means, who in addition to contributing towards their daily living expenses by paying the basic daily fee, also make a capped contribution towards their accommodation costs; and
- consumers with greater means, who in addition to contributing towards their daily living expenses, also pay the basic daily fee for their accommodation costs in full and make a capped contribution towards their care costs.

Figure E.2 Current means testing for residential care (post 1 July 2014)



Appendix F. Financial ratios by provider ownership type

Table F.1: Financial ratios of total sector by provider type, 2017-18

	Not-for-profit	For-profit	Government	Total sector
Total RADs ($m)	$14,077	$12,827	$610	$27,513
No. of providers	493	289	95	877
EBITDA p.r.p.a	$7,916	$11,634	-$6,411	$8,746
Capital structure				
Assets p.r.p.a	$252,955	$291,402	$212,049	$266,134
No. of RADs	49,201	38,738	2,832	90,771
Avg RAD per resident	$286,106	$331,117	$215,339	$303,107
Net worth p.r.p.a	$87,262	$27,357	$130,427	$65,540
Working capital p.r.p.a	-$80,521	-$151,175	-$14,663	-$105,445
Non-current liabilities as % of total assets	3.0%	12.4%	2.8%	7.0%
RADs as % of total assets	53.8%	62.3%	36.9%	56.8%
Net worth as % total assets	34.2%	9.4%	56.9%	24.4%
Viability				
Current ratio	0.49	0.34	0.84	0.42
Interest coverage	12.1 times	6.1 times	-17.6 times	7.8 times
NPBT margin	1.2%	5.7%	-11.4%	2.4%
Occupancy	91.6%	87.7%	90.1%	90.0%
% EBITDA to total assets	3.1%	4.0%	-3.0%	3.3%
% EBITDA to net worth	9.1%	42.5%	-5.3%	13.4%
RADs asset cover (T.A.)	1.9 times	1.6 times	2.7 times	1.8 times

Table F.2: Financial ratios for not-for-profit providers, 2017-18

	Top	Next top	Next bottom	Bottom	Total
No. of providers	110	138	139	106	493
EBITDA p.r.p.a	$19,380	$9,876	$3,384	-$6,650	$7,916
Capital structure					
T. Assets p.r.p.a	$294,984	$227,888	$226,148	$337,523	$252,955
No. of RADs	9,092	21,228	12,655	6,226	49,201
Avg RAD per resident	$288,522	$287,627	$269,440	$311,262	$286,106
Net Worth p.r.p.a	$112,188	$74,392	$74,571	$123,173	$87,262
Working Capital p.r.p.a	-$87,749	-$77,613	-$81,220	-$78,831	-$80,521
Non.Curr Liab as % of T.Asts.	4.8%	1.7%	2.5%	4.5%	3.0%
RADs as % of T. Asts	47.4%	58.9%	56.6%	45.6%	53.8%
Net Worth as % T.Asts	37.8%	32.6%	32.2%	36.3%	34.2%
Viability					
Current ratio	0.48	0.48	0.45	0.61	0.49
Interest coverage	23.8 times	19.5 times	5.6 times	-3.5 times	12.1 times
NPBT margin	13.1%	2.9%	-3.2%	-14.2%	1.2%
Occupancy	93.2%	92.7%	91.2%	86.4%	91.6%
%EBITDA to T. Assets	6.6%	4.3%	1.5%	-2.0%	3.1%
%EBITDA to Net Worth	17.4%	13.3%	4.7%	-5.4%	9.1%
RADs Asset Cover (T.A.)	2.1 times	1.7 times	1.8 times	2.2 times	1.9 times

Table F.3: Financial ratios of government providers, 2017-18

	Top	Next Top	Next Bottom	Bottom	Total
No. of providers	15	8	13	59	95
EBITDA p.r.p.a	$38,730	$9,389	$2,771	-$21,028	-$6,411
Capital structure					
T. Assets p.r.p.a	$280,344	$210,942	$225,386	$197,328	$212,049
No. of RADs	316	287	485	1,744	2,832
Avg RAD per resident	$204,383	$175,831	$225,084	$221,115	$215,339
Net Worth p.r.p.a	$183,914	$175,918	$110,799	$111,436	$130,427
Working Capital p.r.p.a	-$13,133	$7,696	-$32,700	-$17,034	-$14,663
Non.Curr Liab as % of T.Asts.	3.5%	3.4%	1.1%	2.9%	2.8%
RADs as % of T. Asts	29.8%	18.2%	41.6%	43.1%	36.9%
Net Worth as % T.Asts	62.0%	83.4%	49.2%	49.8%	56.9%
Viability					
Current ratio	0.87	1.28	0.71	0.84	0.84
Interest coverage	199.1times	42.9 times	12.5 times	-45.3 times	-17.6 times
NPBT margin	24.1%	0.5%	-3.9%	-26.4%	-11.4%
Occupancy	93.6%	84.7%	91.3%	90.9%	90.1%
%EBITDA to T. Assets	13.8%	4.5%	1.2%	-10.7%	-3.0%
%EBITDA to Net Worth	22.3%	5.3%	2.5%	-21.4%	-5.3%
RADs Asset Cover (T.A.)	3.4 times	5.5 times	2.4 times	2.3 times	2.7 times

Table F.4: Financial ratios of for-profit providers, 2017-18

	Top	Next Top	Next Bottom	Bottom	Total
No. of providers	94	73	67	55	289
EBITDA p.r.p.a	$23,286	$9,450	$3,701	-$10,029	$11,634
Capital structure					
T. Assets p.r.p.a	$329,509	$261,792	$239,490	$406,484	$291,402
No. of RADs	12,185	16,875	6,666	3,012	38,738
Avg RAD per resident	$344,292	$313,018	$308,478	$429,326	$331,117
Net Worth p.r.p.a	$26,066	$33,116	$25,406	-$1,869	$27,357
Working Capital p.r.p.a	-$155,557	-$146,381	-$106,567	-$232,393	-$151,175
Non.Curr Liab as % of T.Asts.	17.4%	8.9%	5.2%	16.7%	12.4%
RADs as % of T. Asts	57.6%	57.7%	105.0%	59.3%	62.3%
Net Worth as % T.Asts	7.9%	12.6%	10.6%	-0.5%	9.4%
Viability					
Current ratio	0.37	0.29	0.47	0.32	0.34
Interest coverage	9.3 times	6.1 times	3.2 times	-3.2 times	6.1 times
NPBT margin	14.5%	4.1%	0.5%	-16.5%	5.7%
Occupancy	88.3%	90.1%	85.8%	75.4%	87.7%
%EBITDA to T. Assets	7.1%	3.6%	1.5%	-2.5%	4.0%
%EBITDA to Net Worth	89.3%	28.5%	14.6%	Note 1	42.5%
RADs Asset Cover (T.A.)	1.7 times	1.7 times	1.0 times	1.7 times	1.6 times

Note 1 - The bottom quartile of the for-profit sector has been distorted by a number of providers who have significant deficits in their net assets, which has resulted in the total net assets of that quartile being negative. The %EBITDA to Net Worth calculation does not return a useful amount, and therefore has not been published.

Appendix G. Residential aged care subsidies and supplements

Table G.1: Total expenditure for subsidies and supplements in residential care, 2015-16 to 2017-18

	2015-16	2016-17	2017-18
Basic Care subsidies	**$M**	**$M**	**$M**
Permanent	10,507.7	11,024.2	11,163.5
Respite	264.4	280.6	312.3
Primary care supplements	**$M**	**$M**	**$M**
Oxygen	16.5	17.5	18.3
Enteral feeding	6.3	5.9	5.9
Respite incentive	29.0	30.1	34.6
Hardship	**$M**	**$M**	**$M**
Hardship	5.2	4.9	4.0
Accommodation supplements	**$M**	**$M**	**$M**
Accommodation supplement	845.7	907.5	1,029.6
Hardship accommodation	3.6	2.9	2.6
Transitional accommodation Supplement	22.3	15.5	10.7
Concessional	64.0	55.6	51.3
Accommodation charge top-up	2.1	1.4	1.0
Pensioner supplement	36.3	27.2	20.7
Viability Supplement	**$M**	**$M**	**$M**
Viability	35.6	43.2	55.8
Supplements relating to grand parenting	**$M**	**$M**	**$M**
Transitional	6.0	4.8	3.8
Charge exempt	3.8	2.0	1.8
Basic daily fee	0.6	0.4	0.3
Other supplements	**$M**	**$M**	**$M**
Veterans'	1.8	1.1	1.6
Homeless	7.6	8.3	8.6
Reductions	**$M**	**$M**	**$M**
Means testing reduction	-455.7	-560.8	-564.0
Other	-31.5	31.5	42.0
TOTAL	**11,372.3**	**11,903.8**	**12,204.2**

Appendix H. Residential care subsidy and supplements rates

Table H.1: ACFI rates ($ per day), 2016-17 to 2018-19

ACFI	2016-17	2017-18	2018-19
Activities of daily living (ADL)			
Low	$36.65	$36.65	$37.16
Medium	$79.80	$79.80	$80.92
High	$110.55	$110.55	$112.10
Behaviour (BEH)			
Low	$8.37	$8.37	$8.49
Medium	$17.36	$17.36	$17.60
High	$36.19	$36.19	$36.70
Complex Health Care (CHC)			
Low	$16.37	$16.37	$16.48
Medium	$46.62	$46.62	$46.95
High	$67.32	$67.32	$67.79
Interim rate for new residents pending ACFI assessment	$56.22	$56.22	$57.01

Daily residential respite subsidy rates	2016-17	2017-18	2018-19
Low	$45.45	$46.09	$51.17
High	$127.46	$129.24	$143.47

Table H.2 Residential care supplements table, 2016-17 to 2018-19

Residential care	2016-17	2017-18	2018-19
Oxygen supplement*	$11.12	$11.35	$11.57
Enteral Feeding supplement – Bolus*	$17.62	$17.99	$18.33
Enteral Feeding supplement – Non-bolus*	$19.79	$20.21	$20.59
Adjusted Subsidy Reduction	$12.85	$13.03	$13.21
Veterans' supplement	$6.88	$6.98	$7.08
Homeless supplement	$15.72	$15.94	$21.01

*These supplements are payable in respect of eligible residential respite care recipients.

Table H.3: Residential care supplements (accommodation and hotel related)

Residential care	20/03/17	20/09/17	20/03/18
Higher accommodation supplement - newly built or significantly refurbished facilities	$55.09	$55.44	$57.14

Residential care	20/03/17	20/09/17	20/03/18
Accommodation supplement - facilities that are not newly built or significantly refurbished but do meet set building requirements	$35.90	$36.13	$37.24
Accommodation supplement – facilities that are not newly built or significantly refurbished and don't meet set building requirements	$30.17	$30.36	$31.29
Concessional resident supplement (concessional and assisted residents) - newly built or significantly refurbished facilities	$55.09	$55.44	$57.14
Concessional resident supplement (concessional residents) – facilities that are not newly built or refurbished	$21.95	$22.09	$22.77
Concessional resident supplement (assisted residents) - facilities that are not newly built or significantly refurbished	$9.03	$9.09	$9.36
After 19 March 2008 and before 20 September 2010	$8.22	$8.27	$8.52
After 19 September 2010 and before 20 March 2011	$5.48	$5.51	$5.68
After 19 March 2011 and before 20 September 2011	$2.74	$2.76	$2.84
Transitional supplement	$21.95	$22.09	$22.77
Basic Daily Fee supplement	$0.57	$0.58	$0.60
Respite supplement – high level is equal to or greater than 70% of the specified proportion of respite care for the approved provider	$90.01	$90.59	$93.36
Respite supplement – high level is less than 70% of the specified proportion of respite care for the approved provider	$52.90	$53.24	$54.87
Respite supplement – low level	$37.74	$37.98	$39.15

Table H.4: Residential aged care viability supplement

Residential care viability supplement*	2016-17	2017-18	2018-19
2017 Scheme Services			
Eligibility score of 100	$53.22	$56.09	$73.94
Eligibility score of 95	$47.17	$49.95	$65.85
Eligibility score of 90	$42.35	$45.06	$59.40
Eligibility score of 85	$36.31	$38.94	$51.34
Eligibility score of 80	$30.22	$32.76	$43.19
Eligibility score of 75	$23.03	$25.47	$33.58
Eligibility score of 70	$16.74	$19.09	$25.17
Eligibility score of 65	$11.47	$13.75	$18.12
Eligibility score of 60	$9.38	$11.63	$15.33
Eligibility score of 55	$6.27	$8.48	$11.18
Eligibility score of 50	$4.18	$6.36	$8.39
Eligibility score of 45 #	$0.00	$0.00	$0.00
Eligibility score of 40 #	$0.00	$0.00	$0.00
Less than a score of 40	$0.00	$0.00	$0.00

Note: the Modified Monash Model classification scale was implemented on 1 January 2017

*These supplements are payable in respect of eligible residential respite care recipients.

Appendix I. Residential care financing structures and balance sheets

Table I.1: Distribution of average lump sum accommodation deposits by ownership and quartile of EBITDA, 2017-18

	Top	Next top	Next bottom	Bottom	Total
Not-for-profit					
No. of providers	110	138	139	106	493
No. of providers that held RADs	105	136	134	100	475
Proportion of residents that paid RADs in facilities, where RADs were held	48.7%	47.7%	48.2%	48.7%	48.1%
Average RAD per resident	$288,522	$287,627	$269,440	$311,262	$286,106
For-profit					
No. of providers	94	73	67	55	289
No. of providers that held RADs	93	71	65	52	281
Proportion of permanent residents that paid RADs in facilities, where RADs were held	55.6%	48.6%	83.3%	52.2%	55.0%
Average RAD per resident	$344,292	$313,018	$308,478	$429,326	$331,117
Government					
No. of providers	15	8	13	59	95
No. of providers that held RADs	14	8	12	56	90
Proportion of permanent residents that paid RADs in facilities, where RADs were held	42.8%	22.4%	42.8%	39.9%	37.6%
Average RAD per resident	$204,383	$175,831	$225,084	$221,115	$215,339
Total					
No. of providers	219	219	219	220	877
No. of providers that held RADs	212	215	211	208	846
Proportion of permanent residents that paid RADs in facilities, where RADs were held	52.2%	47.7%	55.9%	47.9%	50.4%
Average RAD per resident	$318,762	$297,952	$281,493	$329,327	$303,107

Appendix J. Home care revenue and expenditure

Table J.1 Financial performance results of home care providers per consumer per day, by ownership type, by quartile, 2017-18

	Top quartile	Next top	Next bottom	Bottom	Total
Not-for-profit					
Number of providers	86	111	116	97	410
Provision of care/services charged	$51.67	$43.65	$43.32	$47.83	$45.27
Admin and management of packages	$26.12	$24.29	$22.19	$17.75	$22.56
Unspent and exit amounts	$0.18	$0.23	$0.14	$0.12	$0.18
Other income	$2.51	$0.64	$1.26	$1.66	$1.26
Total expenses	$63.29	$62.55	$66.09	$74.21	$66.03
Net Profit Before Tax	$17.19	$6.25	$0.82	-$6.85	$3.24
For-profit					
Number of providers	76	52	42	70	240
Provision of care/services charged	$182.96	$59.57	$48.44	$45.23	$67.88
Admin and management of packages	$19.60	$18.70	$14.09	$17.40	$17.67
Unspent and exit amounts	$0.16	$0.12	-$0.19	$0.04	$0.05
Other income	$36.52	$4.12	$0.58	$2.87	$7.37
Total expenses	$203.01	$76.32	$62.42	$84.49	$94.97
Net Profit Before Tax	$36.23	$6.19	$0.51	-$18.95	-$2.00
Government					
Number of providers	21	20	25	17	83
Provision of care/services charged	$43.94	$33.35	$39.14	$37.11	$36.96
Admin and management of packages	$26.34	$23.89	$19.07	$16.22	$22.04
Unspent and exit amounts	$0.39	$0.28	$0.18	$0.31	$0.26
Other income	$2.09	$0.31	$1.28	$0.03	$0.84
Total expenses	$53.36	$51.15	$58.03	$71.71	$55.33
Net Profit Before Tax	$19.41	$6.68	$1.63	-$18.04	$4.77
Total					
Number of providers	183	183	183	184	733
Provision of care/services charged	$71.34	$44.63	$43.31	$46.79	$47.94
Admin and management of packages	$25.13	$23.59	$21.51	$17.61	$21.83
Unspent and exit amounts	$0.19	$0.22	$0.13	$0.10	$0.16
Other income	$7.72	$1.02	$1.22	$1.98	$2.11
Total expenses	$84.09	$63.18	$65.31	$77.21	$69.45
Net Profit Before Tax	$20.29	$6.28	$0.86	-$10.73	$2.59

Table J.2 Financial package results for home care providers per consumer per day, by ownership type, by quartile, 2017-18

	Top quartile	Next top	Next bottom	Bottom	Total
Not-for-profit					
Number of providers	86	111	116	97	410
Total revenue per consumer	$29,374	$25,114	$24,421	$24,588	$25,285
Total expenses per consumer	$23,101	$22,832	$24,121	$27,087	$24,102
NPBT per consumer	$6,273	$2,282	$299	-$2,499	$1,183
For-profit					
Number of providers	76	52	42	70	240
Total revenue per consumer	$87,324	$30,118	$22,967	$23,924	$33,935
Total expenses per consumer	$74,100	$27,857	$22,782	$30,840	$34,664
NPBT per consumer	$13,224	$2,261	$186	-$6,915	-$729
Government					
Number of providers	21	20	25	17	83
Total revenue per consumer	$26,559	$21,106	$21,776	$19,591	$21,937
Total expenses per consumer	$19,476	$18,669	$21,182	$26,175	$20,196
NPBT per consumer	$7,083	$2,437	$594	-$6,585	$1,741
Total					
Number of providers	183	183	183	184	733
Total revenue per consumer	$38,099	$25,355	$24,151	$24,266	$26,296
Total expenses per consumer	$30,694	$23,062	$23,837	$28,183	$25,349
NPBT per consumer	$7,406	$2,293	$314	-$3,917	$947

Appendix K. Home care subsidies and supplements

Table K.1: Home care subsidies per day, 2016-17 to 2018-19

Package level	2016-17	2017-18	2018-19
Level 1	$22.04	$22.35	$22.66
Level 2	$40.09	$40.65	$41.22
Level 3	$88.14	$89.37	$90.62
Level 4	$133.99	$135.87	$137.77

Table K.2: Home care supplement amounts per day, 2016-17 to 2018-19

Home care supplements	2016-17	2017-18	2018-19
Dementia and Cognition and Veterans' supplement (10% of basic care subsidy)			
Level 1	$2.20	$2.24	$2.67
Level 2	$4.01	$4.07	$4.12
Level 3	$8.81	$8.94	$9.06
Level 4	$13.40	$13.59	$13.78
Other			
EACH-D Top Up supplement	$2.66	$2.69	$2.73
Oxygen Supplement	$11.12	$11.35	$11.57
Enteral Feeding supplement – Bolus	$17.62	$17.99	$18.33
Enteral Feeding supplement – Non–bolus	$19.79	$20.21	$22.91
Home Care Viability supplement – Modified Monash Model classification			
MMM 1,2,3	-	$0.00	$0.00
MMM 4	-	$1.04	$1.05
MMM 5	-	$2.29	$2.32
MMM 6	-	$15.16	$15.37
MMM 7	-	$18.20	$18.45

Note: the MMM classification scale was implement on 1 January 2017

Home Care Viability supplement – ARIA value viability supplement amount	2016-17	2017-18	2018-19
ARIA Score 0 to 3.51 inclusive	$0.00	$0.00	$0.00
ARIA Score 3.52 to 4.66 inclusive	$5.30	$5.37	$5.45
ARIA Score 4.67 to 5.80 inclusive	$6.36	$6.45	$6.54
ARIA Score 5.81 to 7.44 inclusive	$8.90	$9.02	$9.15

ARIA Score 7.45 to 9.08 inclusive	$10.69	$10.84	$10.99
ARIA Score 9.09 to 10.54 inclusive	$14.95	$15.16	$15.37
ARIA Score 10.55 to 12.00 inclusive	$17.95	$18.20	$18.45

Note: the MMM classification scale was implement on 1 January 2017

Table K.3: Summary of Australian Government payments of subsidies and supplements of home care, 2015-16 to 2017-18

Supplement	2015-16	2016-17	2017-18
Dementia and cognition supplement	$21.7m	$24.7m	$29.3m
Veterans' supplement	$0.2m	$0.2m	$0.3m
Oxygen supplement	$1.8 m	$2.4m	$3.1m
Enteral feeding supplement	$0.5m	$0.7m	$0.9m
Viability supplement	$7.2m	$11.4m	$16.0m
Hardship supplement	$0.2m	$0.2m	$0.3m

Supplements in home care:

Dementia and Cognition supplement: provides additional funding in recognition of the extra costs of caring for people with cognitive impairment associated with dementia and other conditions. This supplement is available across all levels of home care packages. The supplement is payable at a rate of 10 per cent of the basic subsidy payable for the level of home care package.

Veterans' supplement: provides additional funding for veterans with a mental health condition accepted by the Department of Veterans' Affairs (DVA) as related to their service.

Oxygen supplement: provides additional funding for consumers who have a specified medical need for the continual administration of oxygen.

Enteral Feeding supplement: provides additional funding for care recipients with a specified medical need for enteral feeding.

Viability supplement: is paid in recognition of the higher costs of providing services in rural and remote areas.

Hardship supplement: is available to home care consumers who are having difficulty paying their aged care fees for reasons beyond their control.

Appendix L. Residential care and home care financial data

- Residential care and home care providers financial data is obtained from Aged Care Financial Reports (ACFRs) required to be prepared and submitted by providers of residential aged care under the *Accountability Principles 2014 (Section 35, 35A, 36, 37 and 37A) made under Section 96-1 of the Aged Care Act 1997*.
- Residential and home care financial data and analysis given in this report includes financial information for only those services that were operational from 01 July 2017 to 30 June 2018 and whose financial information is received by the Department of Health.
- Approximately 99 per cent of residential aged care providers and 97 per cent of the home care providers submitted their ACFRs.
- Financial information contained in ACFRs varies from provider to provider. Accounting standards are subject to interpretation and it is possible that interpretations may differ between providers. The Department has not verified provider's interpretation and application of the accounting standards.
- The information in the ACFR is not audited. It is however tested for reasonableness to the Approved Provider's audited General Purpose Financial Report which is also submitted annually. Whilst some verification of data is undertaken by the department, a significant portion of data submitted through the ACFR has not been independently verified.
- Analysis of financial data may be affected by incomplete, aggregated data provided in ACFRs. As a result, averages stated in the report may not fully represent the sector.
- Discrepancies occur in the ACFR home care income statement which can impact the overall average results of the sector. For example, there are instances where the details of the expenses are aggregated to other expenses or total expenses. There are also instances where income and expenditure through brokered services are not disclosed in their entirety thus understating revenue and expenditure. These instances result in inconsistency and limitations in deriving various metrics and measurements.
- The ACFR home care income and expenses are aggregated for Commonwealth Government funded packaged consumers and private consumerss. Therefore, the analysis used in this report is not interpretable for any particular group of clients who are receiving/paying any particular funding type.
- Assets and liabilities reported in the residential aged care balance sheet contain, where not already fully verifiable, some proportional allocations based on the historical and sector trends from other sources within provider ACFRs and GPFRs. These allocations have not been verified.

Appendix M. References

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Glossary

Term	Definition
Accommodation supplement	The accommodation supplement is payable on behalf of residents receiving permanent residential aged care who do not have the capacity to contribute to all or part of the cost of their accommodation.
Aged and Community Services Australia (ACSA)	A national peak body for not-for-profit providers of aged and community care in Australia.
***Aged Care Act 1997* (the Act)**	The primary legislation governing the provision of aged care services.
Aged Care Approvals Round (ACAR)	A competitive application process that enables prospective and existing approved providers of residential aged care to apply for a range of new Australian Government funded aged care places and financial assistance in the form of a capital grant.
Aged Care Assessment Team (ACAT)	ACATs are teams of medical and allied health professionals who assess the physical, psychological, medical, restorative, cultural and social needs of frail older people and help them and their carers to access appropriate levels of support.
Aged Care Financial Report (ACFR)	A reporting template introduced for the 2016-17 reporting year that consolidates prudential and financial reporting information that was previously separately reported. The ACFR consolidates information previously reported through the Annual Prudential Compliance Statement, the Survey of Aged Care Homes, the Home Care Financial Report and the Short Term Restorative Care Financial Report.
Aged Care Financing Authority (ACFA)	ACFA is a statutory committee that provides independent advice to the Australian Government on funding and financing issues, informed by consultation with consumers, and the aged care and finance sectors.
Aged Care Funding Instrument (ACFI)	The classification instrument used to calculate subsidies to residential aged care facilities.
Aged Care Pricing Commissioner	The Aged Care Pricing Commissioner is an independent, statutory office holder appointed under the *Aged Care Act 1997* and reports to the Minister for Aged Care.
Aged Care Sector Committee (ACSC)	The ACSC is a representative committee of the aged care sector appointed by the Minister for Aged Care that provides advice to Government on aged care policy development and implementation and helps to guide future reform of the aged care system.
Agreed accommodation price	Accommodation prices agreed between providers and prospective residents prior to entry, as reported by providers through the Aged Care Entry Record.

Approved provider	An approved provider of aged care is an organisation that has been approved by the Secretary of the Department of Health to provide residential care, home care or flexible care under the *Aged Care Act 1997*.
Assistance with Care and Housing for the Aged (ACHA)	ACHA is a program which provides a range of supports for eligible clients, who are at risk of becoming homeless or are homeless, to remain in the community through accessing appropriate, sustainable and affordable housing and linking them to community care. From 1 July 2015 the ACHA program was incorporated into the new Commonwealth Home Support Programme.
Australian Bureau of Statistics (ABS)	The Government agency responsible for the production and dissemination of statistics in a range of key areas.
Bed days	The number of days for which a residential care place was available to be occupied by care recipients.
Bond Asset Cover	Provides an indication of the extent to which the accommodation bond liability is covered by assets. It is calculated as Total Assets/Total Accommodation Bonds.
Brownfield site	Site where an extension to an existing aged care operation is possible.
Care days	The number of days for which care was actually provided to a care recipient in an aged care place.
Commonwealth Home Support Programme (CHSP)	This program provides entry-level support services designed to help frail older people stay in their homes. It was introduced on 1 July 2015, consolidating four former programs: Commonwealth Home and Community Care (HACC); the National Respite for Carers Program (NRCP); Day Therapy Centres (DTC); and Assistance with Care and Housing for the Aged (ACHA).
Community Aged Care Package (CACP)	A package of services provided to a person in their own home. This type of care was replaced on 1 August 2013 when the new home care package levels 1-4 were introduced. A CACP package is generally consistent with the level of care provided in a level 2 home care package.
Consumer Directed Care (CDC)	Consumer Directed Care in home care gives consumers greater choice over their own lives by allowing them to decide what types of care and services they access and how those services are delivered.
Consumer Price Index (CPI)	CPI measures the changes in the price of a fixed basket of goods and services, acquired by household consumers who are resident in the eight state and territory capital cities.
Culturally and Linguistically Diverse (CALD)	Consumers who have particular cultural or linguistic affiliations due to their: • place of birth or ethnic origin; • main language other than English spoken at home; or • proficiency in spoken English.

Current Ratio	Represents the ability to meet short term debt through current assets. A current ratio of more than one indicates that an organisation's current assets exceed its current liabilities. It is calculated as Current Assets/Current Liabilities. In the aged care context, current ratio needs to be interpreted with caution given all accommodation deposits (bonds pre 1 July 2014) held by providers are treated as current liabilities.
Daily Accommodation Contribution (DAC)	An amount paid by a partially supported resident as a contribution toward their accommodation costs in a residential aged care facility, calculated on a daily basis and paid periodically.
Daily Accommodation Payment (DAP)	An amount paid by a non-supported resident towards their accommodation costs in a residential aged care facility calculated on a daily basis and paid periodically.
Day Therapy Centres Program (DTC)	The DTC program provides a wide range of therapy and services to eligible frail, aged people living in the community and to residents in Commonwealth funded residential aged care facilities. It assists them to regain or maintain physical and cognitive abilities which support them to either maintain or recover a level of independence. As of 1 July 2015 the DTC program became part of the new Commonwealth Home Support Programme.
Department of Health	The department that administers the *Aged Care Act 1997* and regulates the aged care industry on behalf of the Commonwealth.
Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA)	Net profit after tax with interest, tax, depreciation, and amortisation added back to it, and can be used to analyse and compare profitability between companies and industries because it eliminates the effects of financing and accounting decisions.
EBITDA margin	EBITDA margin shows the average net profit after tax (with interest, taxes, depreciation and amortisation added back into it) generated for each $1 of revenue earned. It's calculated as EBITDA/total revenue.
Extended Aged Care at Home (EACH)	Services previously provided to a person in their own home, who required a high level of care. This type of care was replaced on 1 August 2013 when the new home care package levels 1-4 were introduced. An EACH package was generally consistent with the level of care provided in a level 4 home care package.
Extended Aged Care at Home Dementia (EACH-D)	Services previously provided to a person in their own home, with dementia, who required a high level of care. This type of care was replaced on 1 August 2013 when the new home care package levels 1-4 were introduced. An EACH-D package was generally consistent with the level of care provided in a level 4 home care package, with the additional Dementia and Cognition supplement also being paid.
Facility	A residential aged care facility, approved under the *Aged Care Act 1997* to provide government subsidised accommodation and care.
Financial Accountability Reports (FARs)	FARs were non-audited financial statements submitted by approved providers of home care services up until 2014-15 when they were replaced by the new Home Care Packages financial reports. In 2016-17 the Home Care Packages financial reports were subsequently replaced by the Aged Care Financial Reports.

Flexible care	For those in either a residential or home care setting, that may require a different care approach than that provided through mainstream residential and home care.
General Purpose Financial Report (GPFR)	An audited financial report that is submitted by providers with their unaudited Aged Care Financial Report (ACFR). While the ACFR provides a greater level of detail the GPFR is the only audited report and is used to verify information provided.
Government provider	In the context of this report, the term references a provider that is owned by a local, state or territory government.
Greenfield site	Site where an aged care operation is built for the first time.
Gross Domestic Product (GDP)	GDP is the market value of all officially recognised final goods and services produced within a country in a year, or over a given period of time.
High care facility	A facility where over 80 per cent of residents were classified as 'high care'. The distinction between high care and low care in permanent residential care was removed from 1 July 2014.
Higher accommodation supplement	A higher maximum accommodation supplement was introduced on 1 July 2014 for aged care facilities that have been built or significantly refurbished since 20 April 2012.
Home and Community Care (HACC)	A previous program that provided basic support and maintenance to people living at home to help avoid premature or inappropriate admission to long-term residential care (WA only in 2016-17). Note: the former Commonwealth HACC program was consolidated into the new CHSP from 1 July 2015.
Home care	Home based care provided through a home care package to help older Australians to remain in their own homes. Home care is provided through the Home Care Packages Program.
Home care package	A package of services, delivered though the Home Care Packages Program, tailored to meet the care needs of a person living at home. The package is coordinated by an approved home care provider, with funding provided by the Australian Government (with some contributions from the consumer). Home care packages range from level 1 to 4 depending on the care needs of the consumer.
Home Care Packages Program	An Australian Government funded program which has as its objectives to assist people to remain living at home and enable consumers to have choice and flexibility in the way that care and support is provided at home. The Home Care Packages Program commenced on 1 August 2013.
Homeless supplement	A supplement paid to better support aged care facilities that specialise in caring for people with a history of, or at risk of, homelessness. This funding is in addition to the funding provided under the viability supplement.

Increasing choice in home care	From 27 February 2017, funding for a home care package followed the consumer, replacing the former system where home care places were allocated to individual approved providers to deliver services in a particular location or region. A consistent national approach to assigning home care packages, which allowed for a more equitable and flexible distribution of home care packages. A streamlined process for organisations seeking to become approved providers under the Aged Care Act 1997.
Interest Coverage	Shows the number of times that EBITDA will cover interest expense. Indicates an organisation's ability to service the interest on its debt. It is calculated as EBITDA/Interest Expense.
Leading Age Services Australia (LASA)	LASA is a peak body for aged service providers.
Location	Indicates where a provider, service or consumer is located based on whether they are metropolitan or regional areas. Metropolitan is all major cities and regional is any area outside of a major city. A provider is classified as metropolitan if more than 70 per cent of its services are located in metropolitan areas and similarly classified as regional if more than 70 per cent of its services are located in regional areas.
Low care facility	A facility where over 80 per cent of residents were classified as 'low care'. The distinction between high care and low care was removed from 1 July 2014.
Maximum accommodation price	Maximum accommodation prices set by residential care providers for a room (or bed in a shared room) and published on My Aged Care. These are maximum prices (providers and residents may agree lower amounts), that apply to residents who are not eligible for support with their accommodation costs.
Maximum Permissible Interest Rate (MPIR)	The MPIR is the rate used to calculate the equivalent daily payment of a Refundable Accommodation Deposit (RAD). The RAD is multiplied by the MPIR and divided by 365 days. The MPIR is determined in accordance with Section 6 of the *Fees and Payments Principles 2014 (No. 2)*.The MPIR is available on the Department of Health website and is updated every three months.
Mixed care facility	A facility where less than 80 per cent of residents were high care residents and more than 20 per cent were low care residents. The distinction between high care and low care was removed in permanent residential care from 1 July 2014.
My Aged Care	The main entry point to the aged care system in Australia. My Aged Care aims to make it easier for older people, their families, and carers to access information on ageing and aged care, have their needs assessed and be supported to find and access services.
National Disability Insurance Scheme (NDIS)	The NDIS offers support for Australians who are under 65 years of age with a significant and permanent disability, their families and their carers.

National Respite for Carers Program (NRCP)	The NRCP aims to support caring relationships between carers and their dependent family members or friends by facilitating access to information, respite care and other support appropriate to their individual needs and circumstances and those of the people for whom they care. The NRCP was integrated into the CHSP from 1 July 2015.
National Prioritisation System	People who have been approved for home care and have indicated they are actively seeking services are placed in the National Prioritisation System, with each person's place in the system based on the time and date of their approval for home care and their priority for service (medium or high).
Net Profit Before Tax (NPBT)	The NPBT is determined by revenue minus expenses for the period except for taxes.
Net Profit (Before Tax) Margin	Shows the average profitability generated on each $1 of total revenue. It is calculated as Net Profit Before Tax / total revenue.
Non-supported residents	Residents who have been assessed (based on a means test) as able to pay the full cost of their accommodation and contribute toward their care costs. Non-supported residents pay a basic daily fee, accommodation payment and means-tested care fee (may still receive some assistance with care costs).
Offline residential care places	Previously operational places that are currently not being used due to renovations or rebuilding of facilities or pending sale to other providers. Providers do not receive Australian Government subsidies while places are offline.
Operational places	Operational place refers to a residential care place that was allocated to a provider and has since become available for a person to receive care.
Partially supported residents	Residents who have been assessed (based on a means test) as eligible for full government assistance with their care costs, but able to make a part contribution to their accommodation costs. Partially-supported residents pay a basic daily fee and accommodation contribution.
Pay as you go (PAYG)	Pay as you go (PAYG) instalments is a system for making regular payments towards an employee's expected annual income tax liability.
Per consumer per annum (pcpa)	An annual average financial figure relating to home care consumers.
Per consumer per day (pcpd)	A daily average financial figure relating to home care consumers.
Per resident per annum (prpa)	An annual average financial figure relating to residential aged care residents that converts service financial data to daily amount per resident.
Per resident per day (prpd)	A daily average financial figure relating to residential aged care residents.
Provisionally allocated places (PA)	Residential care places allocated through Aged Care Approval Rounds that are not yet operational.
Refundable Accommodation Contribution (RAC)	An amount paid as a lump sum by a partially supported resident as a contribution toward their accommodation costs in a residential aged care facility.
Refundable Accommodation Deposit (RAD)	An amount paid as a lump sum by a non-supported resident for their accommodation costs in a residential aged care facility.

Regional	Geographic region outside of a major city and classified by the Australian Bureau of Statistics as inner regional, outer regional, remote and very remote.
Regional Assessment Services (RAS)	RAS provides in home, face to face assessments of new and existing clients/carers to assess their eligibility to access CHSP services.
Report on the Operations of the *Aged Care Act 1997* (ROACA)	A legal requirement under the Act, the ROACA is tabled in Parliament in November each year and presents an annual snapshot of facts and figures on Commonwealth funded aged care services in Australia.
Resident Classification Scale (RCS)	The basic tool for residential aged care funding prior to 20 March 2008, when it was replaced by the ACFI. A very small number of residents who entered care before 20 March 2008 are still classified using the RCS through grand-parenting arrangements.
Residential aged care	A program that provides a range of care options and accommodation for older people who choose not to continue living in their own homes.
Restorative care	Care focusing on enhancing the physical and cognitive function of people who have lost or are at risk of losing condition and independence. The Short-Term Restorative Care (STRC) Programme, which commenced in February 2017, is a flexible care program to provide restorative care to older people to improve their capacity to stay independent and living in their own homes.
Retained earnings	Refers to the percentage of net earnings not paid out as dividends, but retained by the company to be reinvested in its core business, or to pay debt. This is recorded under shareholders' equity on the balance sheet.
Retention amounts	An amount that an approved provider is allowed to deduct per month from an accommodation bond for up to five years. The maximum retention amount is set by the Australian Government. Retentions are no longer permitted for residents entering residential aged care on or after 1 July 2014.
Return on Assets	Indicates the productivity of assets employed in the organisation. It is calculated as EBITDA/total assets.
Return on Equity/ Return on Net Worth	Indicates the productivity of equity/net worth employed in the organisation. It is calculated as EBITDA/net worth.
Scale (providers)	Refers to the number of services operated by a provider.
Size (providers)	Refers to the number of beds operated by a specific residential aged care service.
Supported residents	Residents who have been assessed (based on a means test) as eligible for full government assistance with their care and accommodation costs. Supported residents only pay a basic daily fee.
Survey of Aged Care Homes (SACH)	Each year SACH seeks information on accommodation payments and planned and actual building activity during the previous financial year for each operating residential aged care service.
Target provision ratio	The Australian Government target of subsidised operational aged care places. These targets are based on the number of persons for every 1,000 people aged 70 years or over. The population-based provision formula ensures that the supply of services increases in line with the ageing of the population.

Transition care	For those requiring time-limited, goal-oriented and therapy-focused packages of services after a hospital stay.
Viability supplement	The viability supplement aims to improve the financial position of smaller, rural and remote aged care services that incur additional costs due to their location and are constrained in their ability to realise economies of scale due to smaller numbers of care recipients. The viability supplement also provides additional funding for residential care providers who specialise in services to Indigenous people, or people who are homeless or who are at risk of becoming homeless, in recognition of the often higher costs associated with providing care to these people.
Working Capital	Defined as current assets less current liabilities.

Charts, tables & figures Index

ACSA
Aged & Community Services Australia

Seventh report on the Funding and Financing of the Aged Care Sector – summation and commentary

July 2019

OVERVIEW

The Aged Care Financing Authority (ACFA) released its seventh report on the Funding and Financing of the Aged Care Sector (the Report) for the 2017-18 year, see here.

The Report's *Forward* contains several key observations, these include:

- Government Policies[1] impacting on financial performance of aged care providers:
  - Changes to the ACFI instrument (from 2016 and 2017)
  - Introduction of home care consumers having choice of services under their packages, including choice of provider;

- The report notes that 'after five years of steady improvement, the overall financial performance of residential aged care providers declined in 2017-18' noting:
  - The number of providers making a net profit fell from 68 percent in 2016-17 to 56 per cent in 2017-18
  - The above decline in numbers of providers making a net profit relates in large part to the changes made to ACFI, and that these pressures have continued into the 2018-19 year[2];

- The Report notes there are a number of aspects of residential care that warrant careful monitoring, these being:
  - Declining overall occupancy rates
  - A shift in resident payments from refundable accommodation deposits (RADs) to daily accommodation payments (DAPs)
  - A decline in providers intention to rebuild or upgrade their facilities and
  - Signs that an 'increasing number of smaller providers are seeking to leave the industry'[3];

- The overall performance of home care providers has also declined in 2017-18, and again as for residential aged care providers, these pressures are continuing on into the 2018-19 financial year, the main influence being:
  - Increased competition 'caused by the introduction of consumers being able to choose the provider from whom they receive their services'[4];

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[1] Seventh report on the Funding and Financing of the Aged Care Industry 2019, Aged Care Financing Authority, Australian Government, 2019, p1
[2] Ibid, p1
[3] Ibid, pp1-2
[4] Ibid, p1

- Again, in relation to home care the report identifies the following as warranting monitoring:
  - The impact of increased competition
  - The prospect of a rationalisation in the number of approved providers, and
  - The implications of the continuing rise in unspent package funds; and

- That the Royal Commission into Aged Care Quality and Safety is likely to be a significant influence on funding and financing in the aged care industry[5].

The Report Executive Summary identifies a range of characteristics that are required for a 'sustainable aged care system[6], these being:

- *Confidence and trust* – approved providers will not invest unless they have confidence in the adequacy and stability of government policies;
- *Stable, predictable, efficient, equitable and effective arrangements for allocating government funding* – being the 'desirable' features of a funding tool;
- *Appropriate overall funding* – that the overall funding pool for aged care is sufficient to support the level and quality of aged care services required by older Australians;
- *Funding that is flexible and adaptable to changing demographics and demands* – funding arrangements needs to be responsive to changes in service demand and they should not deter but encourage innovation;
- *Equitable contribution to costs by consumers* – sustainable aged care funding will require that consumers who can afford to do so make a greater contribution to their living and care costs;
- *Effective prudential oversight* – effective prudential oversight is necessary for the sector; and
- *Sound management and governance arrangements* – a sustainable aged care system will require well managed aged care services and providers with sound governance arrangements.

ACFA acknowledges the time-lag in the data that is presented in its reports. To address this, they undertook an additional report which it provided to the Government providing an update on the funding and financing of the aged care sector, a copy of that November 2018 report can be found here. ACFA's submission to the Royal Commission into Aged Care can be found here.

ACSA commentary

[5] Ibid, p2
[6] Ibid, p9-10

The Report highlights deterioration in the financial position of home care and residential care providers for the 2017-18 financial year, with the expectation that the financial difficulties being experienced by the sector will continue into the 2018-19 year.

The deterioration in key financial metrics as highlighted in Section One below are broadly consistent with data from other sector analysts, such as StewartBrown, see here.

At a high level:

- In residential care:
  - Income grew by around 1.7 per cent in 2017-18, whilst costs rose by around 5.3 per cent, with the number of residential providers making a net profit declining
  - There are declining occupancy rates
  - There is a shift to DAPs away from RADs
  - A decline in providers intending to rebuild or upgrade their facilities, and
  - There being signs of a number of smaller providers looking to exit the sector.
- In home care:
  - Expenses per customer increased by around 7 per cent in 2017-18 whilst over the same period income per provider decreased by around 1 per cent,
  - There are impacts on the viability of home care providers in relation to increased competition resulting in declining margins,
  - Unspent funds are continuing to grow, and
  - EBITDA is falling year on year;

Indexation is simply not keeping up with the growth in expenses. In our submission to the Royal Commission into Aged Care Quality and Safety[7], we argue that it is in the interest of the community, which has a growing number of older people, that there is a healthy, viable and sustainable residential aged care sector. It is in no-one's interest to have a sector where:

- Indexation does not keep pace with the growth in expenses;
- Direct care costs in residential care are outstripping income;
- Long term trends over time show disturbing trends on a per bed day basis; and
- The overall effect of income and expenditure pressures result in 42.3 per cent of residential aged care facilities operating at a loss, with this rising to 61 per cent for regional, rural and remote (RRR) facilities[8].

Separately, in our response to the proposed new funding model in residential aged care[9], we argue that it is the quantum of funding available to the sector that is the primary concern,

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[7] Royal Commission into Aged Care Quality and Safety, Residential Care Submission, Aged & Community Services Australia, May 2019

[8] Aged Care Financial Sector Survey (Six months ended December 2018), StewartBrown, February 2019, p17

[9] Proposal for a New Residential Aged Care Funding Model: Consultation Paper, Aged & Community Services Australia Submission, June 2019, p4

simply put the sector is experiencing the effect of inadequate base level funding compounded by inadequate indexation.

This ongoing inadequate indexation is compounded again for the coming 19-20FY with the recently announced indexation figure of 1.4 per cent.

The Report observes that whilst residential care providers welcomed the temporary boost in funding from Government ($50 million to assist in transitioning to the new Aged Care Quality Standards and the $320 million General Subsidy boost), both of which ceased 30 June this year, providers noted 'that because the increases are not ongoing they will not address their underlying financial pressures'[10]. This observation is consistent with feedback that ACSA has received from many of its members.

ACSA continues to lobby the Minister for Aged Care and Senior Australians and the Government for the extension of the 9.5 per cent general Subsidy boost for the 2019-20 year, and for indexation to be lifted for all aged care programs.

The Report references a consolidation in the number of residential aged care providers, see Table Four below. Separately in the report there is a reference to there being evidence of smaller providers looking to exit the sector (p2). It is vital to understand that where providers are looking to exit we understand the location of where this is occurring, and the impact on these communities, i.e. is it occurring in 'thin markets' where these services are unlikely to be replaced. In our submission to the Royal Commission we discuss the challenges faced by RRR providers, noting that pressures on these communities are mounting and putting their ongoing sustainability at risk[11].

We note the Report's description of the ongoing move away from RADs to DAPs over time. There is a view that this is related to the weakness in the housing market and the decline in house prices, impacting on the preference for a DAP (over a RAD), particularly if it was expected that the resident would be in care for only a short period[12]. The Report indicates that over time this will have significant financial implications for providers as a reduction in RAD/RAC payments will reduce the availability of these funds as a source of 'interest free loans' for re/development works and a provider will consequentially need to source 'debt with interest'. The impact of this on the ability of the sector to rebuild and develop new building stock needs to be considered.

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[10] Seventh report on the Funding and Financing of the Aged Care Industry 2019, Aged Care Financing Authority, Australian Government, 2019, p4

[11] Royal Commission into Aged Care Quality and Safety, Residential Care Submission, Aged & Community Services Australia, May 2019, p25

[12] Seventh report on the Funding and Financing of the Aged Care Industry 2019, Aged Care Financing Authority, Australian Government, 2019, pp4-5

The Report makes some salient points regarding the need for ongoing investment into the sector, and that this investment is going to come from the non-government sector (both for profit (FP) and not for profit (NFP)) but that this investment is not going to occur if there is not a sufficient rate of return nor confidence in the stability of the funding and regulatory environment[13]. The report goes on to note that against this background:

- Is a decline in the number of providers who report that they are planning to rebuild or upgrade their facilities;
- That many providers have delayed or curtailed investment plans because of policy and regulatory uncertainty; and
- That a number of potential new investors into the sector are waiting to see developments regarding the Royal Commission into Aged Care Quality and Safety.

Previous ACFA Reports have provided an estimate that over the next decade there will need to be an additional 88,000 residential places with an estimated investment requirement of $54 billion[14]. Confidence in the sector is vital going forward for investors.

In relation to home care there are some interesting observations to be gleaned from the Report.

- That whilst the number of clients increased from 97,516 in 2016-17 to 116, 843 in 2017-18, and the number of home care services increased from 2,367 to 2,599 over the same period, client contributions fell from $128 million to $122 million over the same period. So proportionally client contributions would appear to be declining in real terms, this needs to be addressed over the longer term if the sector is to be sustainable, particularly when we consider the commentary made in the 'Tune Review', in relation to sustainability of the sector and client contributions, see here.
- In home care the EBTDA results of for profit providers have taken a considerable fall, with an EBITDA result in 2017-18 of only $169 down from $6,767 the previous year (the for profit sector having previously 'outperformed' the not for profit providers). This is a significant decline in EBITDA results over the space of one year and warrants exploration of why this occurred, to what extent is it related to the rapid growth in the number of new home care providers, the increased competition being experienced in the home care market, and most significantly should this EBTDA be considered some sort of 'bell weather' warning for the home care market?

Also of concern to ACSA is a comment in the Executive Summary in relation to Home Care Package providers which notes that whilst the beneficiaries of home care reforms are the consumers themselves there are some concerns 'that the increase in competition has resulted

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[13] Ibid, p5

[14] Sixth Report on the Funding and Financing of the Aged Care Sector – summation and commentary, Aged & Community Services Australia, August 2018, p3

in some providers not only reducing their price but also the quality of their services'[15]. There are some commentators in the sector that have cautioned against 'a race to be bottom' in relation to the setting of home care fees, that it is not in the sector's, or consumer's interest, to have a sector that is not financially viable over time.

A significant undersupply in home care packages is also noted, despite a 20 per cent rise in the number of home care consumers over the last year with the Report quoting that at December 2018 there were 127,748[16] people waiting for a home care package or waiting for a package at their assessed package level. ACSA continues to lobby for the immediate release of an additional 40,000 high level home Care packages to ease this undersupply.

[15] Seventh report on the Funding and Financing of the Aged Care Industry 2019, Aged Care Financing Authority, Australian Government, 2019, p5
[16] Ibid, p5

General Summary

1. Overview of Developments

Residential:

- Most providers indicated a decline in financial performance, and a number indicated they were moving into a loss situation[17]
- Australian Government expenditure on residential aged care in 2017-18 was $12.2 billion, up from $11.9 billion the previous year
- Services were provided to 241,723 residents
- At 30 June 2018 there were 207,142 operational places, up from 200,689 the previous year (an increase of 3.2 per cent)
- Residents contributed over $14.5 billion towards their living expenses, care and accommodation (excluding lump sum accommodation deposits)
- As at 30 June 2018 there were 886 residential care providers, down from 902 the previous year

Table One: Providers - Total Revenue verses Total Expenses Residential Care 2016-17 to 2017-18

Year	*Total Provider Revenue*	*Provider Revenue per Resident per Day*	*Total Provider Expenses*	*Provider Expenses per Resident per Day*
2016-17	$17.1 billion	$269.55	$16.8 billion	$254.29
2017-18	$18.1 billion	$272.16	$17.6 billion	$265.62

- Not for profit providers represent 56 per cent of providers and 55 per cent of places, the proportion of for profit providers continues to gradually increase
- The 2017-18 '*Aged Care Financial Reports*' confirms that 2017-18 was a' difficult year' for aged care providers
- Whilst the pause is ACFI indexation has ceased the indexation rate in 2018-19 (1.4 per cent for Activities of daily living and behavior domains and 0.7 per cent for complex health care) was below re rate of increase in costs.
- Average Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) per resident had improved each year for five years since 2012-13, however in 2017-18 it fell by 24 per cent
- 44 per cent of residential providers reported a loss compared with 32 per cent in 2016-17

[17] Ibid, p3

- There was a 'significant decline' in the financial performance of regional residential care providers in 2017-18[18]
- On average the performance of NFP providers dropped significantly more than for-profit providers
- In 2017-18 residential care providers expenses increased by 5.3 per cent whilst their income increased by 1.7 percent
- There continues to be a steady decline in occupancy in residential care, see table two

Table Two: Average occupancy Residential Care 2003-04 to 2017-18

Ave occupancy Residential 2003-04	*Ave occupancy Residential 2015-16*	*Ave occupancy Residential 2016-17*	*Ave occupancy Residential 2017-18*
97.1%	92.4%	91.8%	90.3%

- There is also an ongoing shift away from Refundable Accommodation Deposits (RADs) to Daily Accommodation Payment/Contributions (DAPs & DACs). From 2014-15 to 2017-18 the proportion of residents paying for their accommodation through a RAD/RAC has fallen from 43 per cent to 37 per cent while the proportion paying with DAP/DAC has risen from 33 per cent to 40 per cent

Home Care:

- Home care providers also experienced a deterioration in financial performance for 2017-18
- Australian Government expenditure was $2.0 billion in 2017-18, and services were provided to 116,843 consumers
- Consumers contributed $122 million toward the cost of their care through basic daily fees and income tested fees
- Unspent funds continue to increase with home care providers holding $539 million at 30 June 2018, an increase of 64 per cent from 2016-17
- Sector continues to be dominated by NFP providers (at 53 per cent) although this is down from 65 per cent in 2016-17
- Seventy six per cent of consumers had their package with a NFP provider at 30 June 2018
- Seventy per cent of home care providers achieved a net profit in 2017-18, compared to 75 per cent the previous year
- EBITDA – across the sector providers achieved an average of $1,217 per consumer, see table three

[18] Ibid, p3

- ***Table Three: Average EBITDA per consumer 2015-16 to 2017-18***

Average EBITDA 2015-16	*Average EBITDA 2016-17*	*Average EBITDA 2017-18*
$3,055	$2,989	$1,217

- After several years of relatively stable returns, EBITDA per consumer for home care providers fell by over 60% in 2017-18
- For Profit (FP) providers experienced the biggest fall in EBIDA outcomes, with an average EBITDA of $169 in 2017-18, down from $6,767 in 2016-17
- After significantly out-performing NFP and government providers over recent years, for-profit providers of home care packages reported the largest fall in financial performance in 2017-18
- Reform changes (where packages follow consumers) have resulted in a 'very large' increase in the number of approved providers, 873 in 2017-18 compared with 496 in 2015-16
- Greater competition between providers (as a result of the above growth in provider numbers) has resulted in a decline in profit margins[19]
- Expenses per customer increased by 7 per cent in 2017-18 whilst income per provider decreased by around 1 per cent compared with 2016-17

Unspent funds are accumulating, being $539 million at 30 June 2018, up from $329 the previous year, this represents 64% growth in one year

Home Support (CHSP):

- In 2017-18 CHSP provided services to 783,043 older Australians, the Western Australia HACC services provided services to 64,491 older Australians
- Total government expenditure on home support in 2017-18 was $2.4 billion, comprising $2.2 billion for CHSP and $195 million for WA jointly funded HACC services
- In the 2019-20 Budget the Australian Government extended funding agreements with CHSP providers by a further two years, meaning the CHSP and Home Care Packages program will continue to operate as two programs until at least mid-2022
- The Western Australian HACC program transitioned into the CHSP on 1 July 2018 making Home Support a national program

[19] Ibid, p4

2. Aged care in Australia

- The aged care sector provides services to over 1.3 million Australians, and makes up approximately 1 per cent of Gross Domestic Product (GDP).
- Total Australian Government expenditure on aged care in 2017-18 was $18.1 billion (up from $17.1 billion in 2016-17), including:
- Consumer expenditure on aged care was $4.9 billion in 2017-18, up from $4.8 billion in 2016-17
- There are over 366,000 paid workers in aged care with a further 68,000 volunteers

Table Four: Aged care in Australia 2016-17 to 2017-18

	Home Support 2016-17	*Home Support 2017-18*	*Home Care 2016-17*	*Home Care 2017-18*	*Residential Care 2016-17*	*Residential Care 2017-18*
Number of providers	1,621	1,547	702	873	902	886
Number of services	N/A	N/A	2,367	2,599	2,672	2,695
Number of places	N/A	N/A	N/A	N/A	200,689	207, 142
Number of consumers	784,927	847,534	97,516	116,843	239,379	241,723
Commonwealth funding	$2.4 b	$2.4 b	$1.6 b	$2.0 b	$11.9 b	$12.2 b
Consumer contribution	$204 m	$219 m	$128 m	$122 m	$4.5 b	$4.5 b
Other income	N/A	N/A	$140 m	N/A	$1.3 b	N/A

The aged care sector provides services to over 1.3 million Australians, with the Australian Government expending $18.1 billion on aged care in 2017-18

3. Aged Care workforce

From the National Aged Care Workforce Census the following is quoted in the Report:

- There are over 366,000 paid workers in 2016[20], this is up from 240,000 in in 2012
- There are 68,000 volunteers in aged care
- The total number of paid workers in in residential care in 2016 was estimated to be 235,764, of whom 153, 854 were direct care workers
- The total number of paid workers in home support and home care were estimated at 130,263, of whom 86,463 were in direct care roles

There are over 366,000 paid workers and 68,000 volunteers in aged care

4. Access to aged care

- The number of consumers of home care increased from 97,516 in 2016-17 to 116,843 in 2017-18
- The number of consumers of residential care increased from 239,379 in 2016-17 to 241,723 in 2017-18
- Average occupancy in residential care continues to fall; 90.3 per cent in 2017-18, down from 91.8 per cent in 2016-17 and 92.4 per cent in 2015-16; and
- The proportion of people using home care and residential care aged 85 and over is more than three times that of people aged 70 and over

[20] The figures quotes in this section are from the 2012 and 2016 National Aged Care Workforce Census and Survey which is conducted approximately every four years

Table Five: 2018-19 ACAR results summary

State/Territory	*Residential care places*	*Estimated annual recurrent funding ($m)*	*Capital grants ($m)*
New South Wales	3,485	$234.2	$14.0
Victoria	1,521	$102.2	$9.9
Queensland	4,289	$288.2	$11.1
Western Australia	3,295	$221.4	$10.1
South Australia	497	$33.4	$10.7
Tasmania	161	$10.8	$4.2
ACT	202	$13.5	-
Northern Territory	50	$3.4	-
Australia	13,500	$907.1m	$60m

(ACFA 2019 Report p35)

5. Residential aged care – capital investment

- As at 30 June 2018 the residential aged care sector held total assets of $48.4 billion and total liabilities of $36.6 billion.
- Total liabilities includes $27.5 billion of refundable accommodation deposits, up from $24.8 billion in 2016-17
- In 2017-18 – compared to 2016-17:
  - Ave return on equity was 13.4 per cent, down from 18.3 per cent
  - Ave return on assets was 3.3 per cent, down from 4.6 per cent

Table Six: New construction work completed or in progress

	2016-17	*2017-18*
$ Value	$4.7 billion	$4.9 billion

- The 2019 Report indicates 'planned building activity' dropped significantly for the second year in a row (p8)

Table Seven: Liabilities and net worth as a proportion of total assets by provider type 2017-18

Type	*Accommodation deposits*	*Other liabilities*	*Net worth/equity*
Government	36.9%	6.1%	56.9%
For profit	62.4%	28.2%	9.4%
Not for profit	53.8%	12%	34.2%

(ACFA 2019 Report p128)

Table Eight: Balance sheet of residential care providers, 2016-17 and 2017-18 ($m)

	2015-16 ($m)	*2016-17 ($m)*	*2017-18 ($m)*
Total assets	$40,695	$45,017	$48,400
Refundable Accommodation Deposits	$21,872	$24,710	$27,523
Total liabilities	$29,750	$33,691	$36,573
Net worth/equity	$10,945	$11,326	$11,827

(ACFA 2019 Report p126)

It is estimated the residential aged care sector will need to build an additional 88,110 places over the next decade with an estimated investment requirement of $54 billion

If you would like further information, or have any comments to make please contact:

Derek Dittrich
State Manager SA&NT

Manager Policy and Member Advice at derek.dittrich@acsa.asn.au

July 2019

FAIR WORK COMMISSION
4 Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award 2010
Matter: AM2018/26

STATEMENT OF JEFFERY WRIGHT

I, Jeffrey Wright, of [redacted], affirm as follows:

MY BACKGROUND

1. I am employed by HammondCare (**the Company**) in the role of People Services Operations Manager.

2. I am based at Hammondville, New South Wales.

3. I have been employed by the Company since around June 2011.

4. My role involves supporting the People Services Team and Operations Team in matters relating to Industrial Relations, matters before the Fair Work Commission, contracts of employment and policy. The People Services Team consists of 16 people.

5. Prior to working with the Company, I was employed with another not-for-profit provider in the aged care sector for 9 years.

THIS STATEMENT

6. The information in this statement is based on my experience and observations from either working at the Company, or from my experience generally working in the social, community, home care and disability services industry, and is true to the best of my knowledge.

7. Where I depose particular conversations, I provide either the exact words used or the substance of the conversation to the best of my recollections.

8. Where I comment on matters that I did not personally observe, I identify the source of that information in this statement.

Lodged by:	Australian Business Industrial NSW Business Chamber Ltd Aged & Community Services Australia Leading Age Services Australia	**Telephone:** (02) 4989 1004
Address:	Australian Business Lawyers & Advisors Pty Limited Lvl 15, 140 Arthur Street, North Sydney NSW 2060	**Email:** madeleine.tiedeman@ablawyers.com.au

INFORMATION ABOUT THE BUSINESS

9. The Company has been in operation since 6 April 1933 and is a registered charity.

10. The Company operates in the social, community, home care and disability services industry through HammondCare At Home.

11. The Company is an independent Christian charity that exists to improve quality of life for people in need. We specialise in aged and dementia care, palliative care, rehabilitation, mental health services for older people, and other related health and aged care services. The Company seeks to embed evidence-based best practice in its services and we provide these services through home care, sub-acute hospitals and residential aged care. Bringing these health, hospital and aged care services together, the Company has been able to develop innovative, flexible care models designed to serve people with complex health or aged care needs, regardless of their circumstances.

HAMMONDCARE'S WORKFORCE

12. The Company currently employs approximately 4,000 employees.

13. These employees perform a range of roles including frontline care, clinical, support/enabling and management roles.

14. The Company's workforce consists of:

    (a) approximately 798 full-time employees;

    (b) approximately 2,350 part-time employees; and

    (c) approximately 632 casual employees.

15. The majority of the front line care staff are part-time and meet various shifts across the sites/locations.

INDUSTRIAL ARRANGEMENTS

16. For our Residential and Home Care Services, the coverage for frontline care and clinical staff is the HammondCare Residential Care and HammondCare At Home Enterprise Agreement 2018 (**Enterprise Agreement**).

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THE NATURE OF THE INDUSTRY GENERALLY

17. Under Consumer Directed Care, clients in the community are able to choose how they use their hours and the funding under their package. This can be a multitude of services under the Quality of Care principles 2014 including care services, clinical services, allied health services, home modifications, transport, respite, socialisation and domestic assistance. Having part-time employees allows the Company to meet the variable care needs of clients, provide continuity of care to clients and allows certainty of hours for our employees. Typically, our care employees are often working around their own commitments, for example, study or school aged children, and part time hours allows them the flexibility they need.

18. As clients have choice and control over their visit times, visits typically follow peak patterns. 55 per cent of visits take place between 7.00am and 12.00pm and the other 45 per cent span a nine hour period to 9.00pm.

CONSUMER DIRECTED CARE

19. The Company is an approved service provider under the *Aged Care Act 1997* (Cth).

20. The Company operates nationally with our HammondCare At Home services operating in NSW, ACT, Queensland and Victoria.

21. Funding arrangements for HammondCare At Home are through the Commonwealth Government for Home Care Packages. Commonwealth Home Support Program funding is also supplied via Health for Compacs and Transpac packages.

22. The number of home care packages fluctuate from week to week depending on intakes and discharges and combined with the clients' needs and choices, employees are rostered to meet those client needs. All these variables impact on how the business operates as it seeks to balance the industrial requirements against the quality care of clients in an ever changing environment.

23. Packages are assigned through the My Aged Care National Prioritisation System, and funding is provided through Medicare. Packages are distributed across 4 levels with varied levels of funding, and it should be noted that clients are usually assigned a lower level of package and funding as an interim measure, whilst waiting on the queue for their higher level package. As the funding that clients receive is usually lower than what they have been approved for, clients seek to maximise

their funding across as many visits as their individual budget will allow, meaning that they will often choose to have shorter duration visits.

24. Home care providers have no way of predicting how many packages will be assigned within their operational areas from the National Prioritisation System, or how many of those assigned within the area will choose them as a provider. It is because of these variables that the Company requires systems that are nimble and able to be flexible according to demand.

CLIENT CANCELLATION ISSUES

25. HammondCare At Home experiences client cancellations on a frequent basis.

26. During May 2019, there were 2,708 cancellations out of 47,704 scheduled visits. That is almost 6 per cent of scheduled services being cancelled in one month alone.

27. Some of the reasons why a client cancels their scheduled services include death, hospitalisation, change of circumstances, family arrangements and other reasons. Clients also have the option under Consumer Directed Care to change or cancel their visits purely to accommodate their convenience and choice.

28. When a client cancels a scheduled service, HammondCare At Home endeavours to reschedule staff to other clients, other parts of the business or make a minimum engagement payment.

29. The vast majority of client cancellations are within 0 to 6 hours of the scheduled commencement time of the service.

30. HammondCare At Home is able to charge the client for the cancellation if less than 24 hours notice is provided by the client. The amount that HammondCare is able to charge is up to 100% of the cost of the change for short notice cancellation and this is determined on a case by case basis.

31. If we were required to pay the employee for the rostered shift if the client cancels with less than 48 hours' notice, this would have significant impact on the business. We would not be able to charge clients for any services cancelled with between 24 and 48 hours' notice and the requirement of such extensive notice is contrary to client choice, supporting the needs of clients and service flexibility as required under Consumer Directed Care.

Lodged by:	Australian Business Industrial NSW Business Chamber Ltd Aged & Community Services Australia Leading Age Services Australia	**Telephone:** (02) 4989 1004
Address:	Australian Business Lawyers & Advisors Pty Limited Lvl 15, 140 Arthur Street, North Sydney NSW 2060	**Email:** madeleine.tiedeman@ablawyers.com.au

PART-TIME EMPLOYEES

32. The Company has a predominantly part-time workforce of frontline care staff to ensure resident/client familiarity and continuity of care and certainty of hours.

33. The Company employs part-time employees in a variety of roles, including Home Care Workers. In HammondCare At Home, part-time employees comprise 76% of the workforce and casual employees are 7% of Home Care employees.

34. When engaging part-time employees, they are offered a part-time contract for hours within their agreed availability. There is an agreed minimum within their contract, but we also ask their availability to enable us to offer them additional hours in excess of the minimum hours in their contract.

35. The Company offers part-time employees work in excess of their contracted hours as agreed. The Company does not want to limit part time employees who are seeking additional work and has provided in excess of 14,000 additional hours above contract hours during May 2019. If the Company was required to pay for these hours at overtime it would be unsustainable for the Company.

36. If the Company was required to pay overtime to part-time employees who work in excess of their contracted hours, we would be required to explore other options instead of providing additional hours and have part-time employees only work their contracted hours. This would have a number of negative impacts, including:

    (a) a decrease in operational flexibility which assists us in meeting ever-changing client demands and needs;

    (b) disadvantaging part-time staff seeking additional hours above their contract hours; and

    (c) may lead to an increase in casual staff in place of part-time employees.

MINIMUM ENGAGEMENTS

37. The work of HammondCare At Home is based on client demands and therefore rostering takes place around the preferred times of our clients as is required by Consumer Directed Care.

38. Rostering also has to take into account employee absences to ensure continuity of care for our clients. Rostering is driven by the clients and their needs, for example, a client may have funding for a number of hours per week and may choose to have them in one block on one day or split into smaller blocks over a number of days, all at their convenience. The provider has no control over their choice, but we need to accommodate it nonetheless. Clients also request specific employees to meet their needs which can be difficult for rostering.

39. During May 2019, client visits that were scheduled for less than one hour comprised 64% of scheduled visits. In the same month, 28% of scheduled visits were for less than 2 hours. Those statistics mean that only 8% of services provided in the month of May 2019 were for more than 2 hours.

40. Visits are usually not less than 30 minutes. The minimum visit duration that the Company has is 30 minutes which is a benefit for client choice as it meets clients' needs for short durations, for example, medication and showers, without having to pay a minimum of one hour. It also enables clients to have more or multiple visits or hours per week.

41. Home Care employees are scheduled to meet client needs and typically there are peak times at mornings, lunch and evening meal times. Given the percentages provided above at paragraph 39 it is difficult to provide some employees with shifts longer than 2 hours, but efforts are made by the Company to provide employees with continuing client visits or runs if possible.

42. If the Company was required to provide a three hour minimum shift to all employees this would remove a significant amount of flexibility and would result in an increase in makeup time where client preferences change and cancellation of services occur.

43. The Company is currently working to ensure a minimum of 2 hours work per day for our part-time community care staff. In the month of May 2019 this division incurred make up hours of 142 hours because of client cancellations. If we were required to provide a three hour minimum engagement it may also lead to clients not being able to access 30 minute visits.

BROKEN SHIFTS

44. HammondCare At Home engages employees to work broken shifts. The reason for this is to meet client needs. Schedules are driven by client, the requirement to meet their needs and continuity of

care. For staff, scheduling aims to meet their contract hours and provide regular work in a day (a run). Broken shifts are inevitable with ever changing client needs and staff absences. During May 2019 there were 4,216 broken shifts and includes more than one broken shift in a day.

45. There are very few shifts that exceed two portions per day, however with client cancellations, sometimes they are necessary.

46. For each engagement on either side of a broken shift the Company pays a minimum engagement of one hour, with an overall daily minimum engagement of two hours. A broken shift allowance is also paid for each break.

Signed by **Jeffrey Wright**

12 July 2019

FAIR WORK COMMISSION
4 Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award 2010
Matter: AM2018/26

STATEMENT OF WENDY MASON

I, Wendy Mason, of [redacted] in the State of New South Wales, affirm as follows:

MY BACKGROUND

1. I am employed by BaptistCare NSW & ACT (**the Company**) in the role of Operations Group Manager for the Home Services (*BaptistCare at Home)* Division.

2. I am based at Level 2, 22 Brookhollow Avenue, Baulkham Hills, New South Wales.

3. I have been employed with BaptistCare since June 2011.

4. My role involves oversight of 11 site managers across the Home Service division ensuring the effective delivery of high quality services to over 9000 clients in compliance with Aged Care legislation and Aged Care Quality Standards.

5. Prior to working with the Company I was employed in senior management roles across the Home Care sector within a number of large providers. I have worked in the Home Care sector for 23 years and have a strong operational management background.

6. I hold an Advanced Diploma in Business Management.

THIS STATEMENT

7. The information in this statement is based on my experience and observations from either working at BaptistCare, or from my experience generally working in the social, community, home care and disability services industry, and is true to the best of my knowledge.

8. Where I depose particular conversations, I provide either the exact words used or the substance of the conversation to the best of my recollections.

9. Where I comment on matters that I did not personally observe, I identify the source of that information in this statement.

Lodged by:	Australian Business Industrial NSW Business Chamber Ltd Aged & Community Services Australia Leading Age Services Australia	**Telephone:** (02) 4989 1004
Address:	Australian Business Lawyers & Advisors Pty Limited Lvl 15, 140 Arthur Street, North Sydney NSW 2060	**Email:** madeleine.tiedeman@ablawyers.com.au

INFORMATION ABOUT THE BUSINESS

10. The Company has been in operation since 1944 and is a public company limited by guarantee.

11. BaptistCare is an aged care provider and operates in both the aged care industry and the social, community, and home care services industries.

12. BaptistCare is a not-for-profit organisation.

13. BaptistCare is one of the largest providers of aged care services in NSW and the ACT. The key operating Divisions are:

    (a) Residential Services Division (17 aged care facilities across NSW and the ACT);

    (b) Home Services (BaptistCare at home) Division (12 Home Service Centres from Canberra in the ACT to Alstonville in the Far North Coast of NSW);

    (c) Housing & Retirement Living Division (7 retirement villages plus Safe & Affordable Housing complexes);

    (d) Community Services Division; and

    (e) Support Services (including Governance & Legal, Property Development, Financial Services, Business & Technology (IT), Chaplaincy, People & Culture, Marketing & Communications, and Research & Policy).

14. The Home Services Division *(BaptistCare at home)* supports older people to remain living independently at home through the Home Care Package (**HCP**), Commonwealth Home Support (**CHSP**) and Transitional Care (**TC**) programs. The services provided under these packages include Personal Care, Domestic Assistance, Medication Assistance, Meal Preparation, Transport, Social Support, Clinical Care, Allied Health, Wellbeing Programs and Palliative Care.

15. Approximately 75 per cent of BaptistCare's home care services are provided outside the metropolitan areas of Sydney and Canberra. Non-Metropolitan Home Service Centres include regional locations at:

    (a) Alstonville – Far North Coast;

    (b) Goulburn;

    (c) Forster;

(d) Wagga Wagga;

(e) Morisset; and

(f) Dubbo/Parkes/Cowra.

16. All programs delivered by BaptistCare at home are funded by the Commonwealth Government under the Home Care Package program, Commonwealth Home Support Program and Transitional Care Program.

BAPTISTCARE'S WORKFORCE

17. As at 30 June 2019 the Company employed 3,605 employees across all Operations and Support Services Divisions of the organisation.

18. In Home Services specifically roles include: personal care, domestic assistance, medication assistance, meal preparation, transport, social support, clinical care, allied health and palliative care.

19. The Company's total workforce has the following demographics:

(a) Approximately 555 full-time employees;

(b) Approximately 2,515 part-time employees;

(c) Approximately 535 casual employees; and

(d) Approximately 1,000 volunteers.

20. Approximately 1,182 home care employees and management/staff are engaged in the Home Services (*BaptistCare at home)* Division. A breakdown of employment numbers in this home care sector that are included in the Item 19 totals above is as follows:

(a) Approximately 176 full-time employees (15%);

(b) Approximately 888 part-time employees (75%); and

(c) Approximately 118 casual employees (10%).

21. The Company employs predominantly part-time employees in its aged care operations. Together with the 10% casual proportion of the workforce (in *BaptistCare at home*) this workforce mix enables increased flexibility to better meet the changing needs of clients, to meet the needs of client preferences for services and service times, to account for the loss or gain of home care

clients and to cover staff absences. Casuals represent an important labour contingency to support the above flexibility within the Company.

22. Relatively high turnover of staff creates difficulties in terms of continuity of services, and staff replacement resources and costs. The staff turnover rate for permanent staff (full time and part time) in the Home Services division was 22% as at end June 2019.

INDUSTRIAL ARRANGEMENTS

23. The majority of the Company's aged care employees are covered by an Enterprise Agreement, the *BaptistCare NSW & ACT Aged Care Enterprise Agreement 2017* (**the Enterprise Agreement**). The Enterprise Agreement covers approximately 2,900 of the Company's aged care employees who are engaged in:

    (a) Residential facilities in the Residential Services Division;

    (b) Retirement villages in the Housing & Retirement Living Division; and

    (c) Home care employees in the Home Services (*BaptistCare at Home*) Division.

24. The Enterprise Agreement is the principal industrial instrument that applies to the Company's employees. It is underpinned by four modern awards:

    (a) *Aged Care Award 2010*;

    (b) *Nurses Award 2010*;

    (c) *Social, Community, Home Care and Disability Services Industry Award 2010*;

    (d) *Health Professionals and Support Services Award 2010*.

25. Of the total of 1,182 staff engaged in the Home Services Division, approximately 980 are covered under the terms and conditions of the Enterprise Agreement and classifications that would otherwise be covered by the terms and conditions of the Award.

26. The Company typically pays above the relevant modern Award rates of pay, and provides considerably more favourable terms and conditions of employment to employees who are covered by the Enterprise Agreement.

27. A further 35 employees in the Community Services Division are engaged directly under the terms and conditions of the Award. These Community Services Division employees operate outside of the aged care industry and provide a range of services that include social work, counselling, homelessness, housing, safe and affordable tenancy services, family and domestic violence services, community and neighbourhood services and provision of nil-interest and low-interest loans to the vulnerable and financially disadvantaged.

THE NATIONAL DISABILITY INSURANCE SCHEME

28. The Company is a registered service provider with the National Disability Insurance Authority.

29. The Company made the decision in 2018 to withdraw from NDIS services as it was not financially viable. The program was operating at a loss.

30. The Company have remained a registered provider to continue to offer services to NDIS participants through our Home Modifications program, however this is a very small part of the Company's services.

CONSUMER DIRECTED CARE

31. The Company is a service provider under the Commonwealth Home Care Package Program.

32. HCP funding constitutes nearly 60 per cent of our funding base. As of 1 July 2019 the Company delivers in excess of 2100 Home Care Packages. The Company believes that the delivery of person-centred home care services is fundamental to the wellbeing and independence of clients.

33. Paramount to person-centred care is the ability to provide flexible services that meet the individual needs of each person. By the very nature of our clients fragility the hours of service provided and therefore rostered changes constantly on a daily, weekly and monthly basis.

34. The nature of the aged care industry is such that operations are required in many areas on a 24 hours per day, seven days per week basis. Since the introduction of the consumer directed care model in Home Care in 2015 clients are increasingly requesting services outside the ordinary hours of work. This includes evening services that extend to 10.00pm, sleepovers and service provision on Saturdays, Sundays and Public Holidays. Consequently, the Company is seeking to recruit care service employees that are willing and available to work evening and weekend hours.

35. In 2015 an individualised funding model was introduced under the HCP program resulting in any operating costs incurred by a provider being passed onto the client.

36. The whole premise of consumer directed care is to put control back in the hands of the client. Clients have more choice regarding how they choose to spend their funds and when they will receive their services. The impact for providers is that we can no longer anticipate the number of hours of work for direct care staff based on the number of packages provided and therefore effectively plan staff resources.

37. Following the move to an open market in March 2017, providers no longer have guaranteed minimum home care package numbers or a cap on the maximum number of home care packages they can deliver. Providers have no control over the number of home care packages released or the level of home care packages allocated, and as a consequence the fluctuating number of service hours delivered, nor the distribution of home care packages in any area. To meet the demand of service provision there is a strong need for a flexible workforce, both around the availability of hours and in relation to geography to meet client need.

38. The move to a national waiting list means providers are unable to plan where packages will be allocated or in what numbers. Providers have no control over the number of packages released in a region. Prior to March 2017 packages were allocated to a region and a provider knew that if a client withdrew from a package it could be replaced with another client located within the same geographical area allowing them to sustain the hours for the workforce in that area. Given this level of uncertainty, it is challenging to maintain staff rosters with this changing client base.

39. Long wait times to access funding are resulting in clients being allocated packages below their assessed level of need. Providers are supporting clients to remain at home on inadequate funding to meet their needs. Clients are unable to fully fund the level of services they have been assessed as requiring, and any increase in costs will potentially force those clients into Residential Care.

CLIENT CANCELLATIONS

40. The Company experiences a high proportion of client cancellations on a very regular basis.

41. For example in the calendar month of May 2019, The Company's Home Services section scheduled a total of 35,083 client services across all of its NSW and ACT operations. Of these scheduled

services for the month 5,140 were cancelled transactions by the client. This represents almost 15 per cent of services planned for May 2019. From my personal experience this is not an abnormal outcome.

42. The reasons why a client cancels their scheduled services typically include the client being unavailable at short notice due to an admission to hospital, clients being discharged from hospital and not requiring (or being able) to undertake a scheduled service for a specified period post-discharge, client illness or death, the client has an unscheduled medical appointment, the client's family visit, the client has a social appointment or the client refuses to have the replacement worker due to their scheduled staff being absent that day (for example on personal leave).

43. When a client cancels a scheduled service, the Company is required to ensure that the employee's minimum contracted hours are paid for the fortnightly roster/pay period. The Enterprise Agreement provides that the Company '*may direct the employee to make-up time equivalent to the cancelled time, in that or the subsequent fortnightly period*.'

44. In the case of cancelled shifts the options are as follows:

    (a) the employee is scheduled to alternative work with other clients;

    (b) contact is made with subsequent clients to move their service forward if possible;

    (c) the employee is provided with administrative work;

    (d) the employee is scheduled to attend online training; or

    (e) replacement hours may be provided on a subsequent day in the current or succeeding roster period.

45. The notice for cancellation varies depending on the client and the circumstance. Notice can be weeks or days ahead in respect of things like family visits or medical appointments, or on the day of service or even when the care worker arrives at the front door in the event of illness and other unforeseen circumstances. In addition to those reasons listed, there are a number of other reasons clients cancel their scheduled services.

46. Providers are dealing with an aged and vulnerable client group whose needs and status change very quickly. In many instances clients are simply unable to provide 48 hours' notice as they are unaware their situation will change.

47. Under an individualised funding model costs incurred by a provider must be passed onto the client. Clients will not be accepting of being charged for a cancelled service that in many instances was not within their control.

48. Implementation of a 48 hour notice period required to be given to employees regarding cancelled shifts in many instances will impact more than one cancelled service. If a client dies or is admitted to hospital and is receipt of 3 services per day this would leave providers liable for paying for up to 6 services within that 48 hour period.

PART-TIME EMPLOYEES

49. The Company employs part-time employees in a variety of roles. In the Home Care division these roles include care service employees at three incremental grading levels, a Care Services supervisory/medication role, administration, allied health and clinical facilitators.

50. When engaging part-time employees, the Company provides a contract of employment guaranteeing the employee a minimum specified (contracted) number of hours per fortnight. Client requirements in terms of timing of services vary from region to region, however, employees are advised at commencement of employment that services will normally be required between specified times of the day Monday to Friday (usually 6.00am/7.00am until around 8.00pm) and whether the particular regional area in which they are based has clients that require weekend services.

51. Home care employees are also requested to provide written details of their preferences for days and times that they prefer to work, and their overall availability – this information is formally confirmed with the new employee during the orientation process and may be amended by the employee from time to time on a 'Change of Preference Form'.

52. The Company is regularly required to offer part-time employees work in excess of their contracted hours in order to be able to effectively meet client needs. This necessity arises for a number of reasons, including client service changes at short notice, new clients that commence within one of the programs during the roster fortnight, scheduled staff absences due to planned leave and unscheduled staff absences including occasions when rostered staff take personal or carers leave, for example. Additional hours are offered to employees where the employee has indicated in

writing that they are available for additional hours if they arise. Employees on the 'Availability List' are offered additional hours and only work such hours by agreement.

53. A recent Staff Satisfaction Survey demonstrated that many of our home care employees are desirous of being provided with extra hours in addition to their contracted hours within their current roster period. I understand from conversations with home care staff that they are happy to accept additional hours to either supplement their income or to enable them to seek an upgrade in their contracted hours under the six-monthly "*Review of Hours for Part Time Employees*" clause of the Enterprise Agreement

54. The payment of overtime for part-timers would have a significant economic impact on the business through increased wage costs and would make the cost of impacted consumer services prohibitive. In many of these cases the Company would either lose the client service or have to absorb the added overtime wage cost into our '*Staff Costs*', which would need to be recouped in overall higher prices for clients.

MINIMUM ENGAGEMENTS

55. The Company's home care activities are based on client demand and therefore rostering takes place around the preferred times of our clients. The imposition of a minimum engagement of three hours, for example, would severely limit consumer choice and would potentially over-extend the individual service budget for the client. The additional cost of having to charge clients for service times that are significantly in excess of the actual service duration will ultimately need to be passed on to the consumer, potentially making the service cost prohibitive. Clients will likely choose to go without rather than paying more than they should be for a service, risking their ability to be supported safely at home.

56. The proposed minimum engagement would also place a restriction on out-of-hours services such as those evening services (for example evening medications and meal services) that are unable to be coupled into a minimum three hour shift.

57. In particular it will have a more significant impact in rural and remote areas – particularly in those circumstances where a client requires more than one service a day in order to remain living at home.

58. For example, in rural areas it is not uncommon for a care worker who lives locally to finish work for the day at 5.00pm and be rostered to go out again at 8.00pm to provide medication assistance, meal preparation and/or support to assist the client to bed. In a small town there may be no other clients requiring a service at this time. The client's funding may not extend to paying 3 hours for a 30 min or one hour duration service.

59. To meet customer preferences providers need to have the flexibility to schedule stand-alone services, short shifts and broken shifts. This becomes even more significant in rural areas where it often is not an option to couple services together to create a minimum service of three hours.

60. When rostering employees there is a fine balance between the Company's policy of providing as many hours as possible to part-time employees in order to enhance engagement and retention, versus the need for flexibility and contingencies around loss of home care clients.

61. It is often difficult to provide some employees with shifts longer than two hours due to regular and frequent changes that are initiated by the consumer themselves e.g. admission to hospital, discharge from hospital, death, illness, or a change in service needs.

62. Unplanned staff absences or personal leave that is not notified in advance also contributes to changes in rosters where services need to be rescheduled to another worker. The impact of applying overtime rates would mean that the services may not be rescheduled to another worker to avoid incurring overtime rates.

63. The majority of our shifts are less than three hours. Of the 35,083 total services scheduled across the Home Services Division operations during the calendar month of May 2019 shift lengths are depicted in the following table:

Duration of Client Service	Number of Services	% of Services
1 hour or less	23,021	65.6%
Between 1 and 2 hours	8,934	25.5%
Between 2 and 3 hours	1,659	4.7%
Over 3 hours	1,469	4.2%
Total All Services May 2019	35,083	100%
(Includes Cancelled Transactions)	*(5,140)*	*(14.7%)*

Lodged by: Australian Business Industrial
NSW Business Chamber Ltd
Aged & Community Services Australia
Leading Age Services Australia
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64. From the table above, it is evident that of the services that the Company provided to clients in May 2019, 95.8 per cent were less than 3 hours in duration, and 65.6 per cent were of one hour's duration or less.

65. If the Company was required to provide a three hour minimum shift to all employees it would have a serious impact on the financial viability of our home care operations.

BROKEN SHIFTS

66. The Company engages employees to work broken shifts. Broken shifts are an essential rostering mechanism in order to be able to effectively meet client requirements in relation to, for example, specified or preferred times for particular services under Consumer Directed Care. Certain services are often inflexible in terms of service time including the administration of or assistance with prescribed medications; early morning preparations for assistance with meals, showering and dressing; and evening preparations for bed which could include a brief service up until 9.00pm or 10.00pm at night.

67. In the month of May 2019 a total of 1,591 broken shifts were worked by the Company's home care employees. These shifts are necessary in order to offer clients the flexible services that they request. Without the broken shifts, we would have significant difficulty providing the services our clients request.

68. The requirement for employees to be available to work broken shifts is particularly the case in regional and remote areas.

69. The Enterprise Agreement only requires employees to be available to work broken shifts following "*consultation and agreement*".

70. Additionally, the Company's Home Services rostering guidelines and procedures aim to minimise the number of breaks (and hence work periods) during the broken shift. This intent is enshrined as a commitment in the Enterprise Agreement which further prescribes at clause 12.4(c) that *'where the number of breaks exceeds two (2) breaks within a single broken shift, this will be by mutual agreement.'*

71. Rostering and scheduling procedures are undertaken with the objective of scheduling home care employees with "blocks" of work wherever possible. These "blocks" will vary from 2 hours to

possibly 5 hours depending, amongst other things, on the regional location, the distance to travel between clients, the availability of care staff, and the flexibility or otherwise of clients in setting service times.

72. Employees will only be scheduled to work more than two portions (or work periods) during the broken shift where no other option exists. Such circumstances may arise due to a client requiring a service in the morning, followed by a (short duration) evening service, and often where such events are in a regional location. Unplanned absences or employees not notifying of their absence until the day of the planned service also create a need to schedule employees who have already worked for periods on the same shift to fill these vacancies at short notice. It is these types of circumstances that lead to us rostering employees in excess of two periods of a broken shift; it is usually out of necessity to meet our clients' needs.

Signed by **Wendy Mason**

17 **July 2019**

Lodged by:	Australian Business Industrial NSW Business Chamber Ltd Aged & Community Services Australia Leading Age Services Australia	**Telephone:** (02) 4989 1004
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National Disability Insurance Scheme

Efficient Cost Model for Disability Support Workers

June 2019

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Terms that we use

DSW	Disability Support Worker
ECM	Efficient Cost Model
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDIS Q&SC	National Disability Insurance Scheme Quality and Safeguards Commission

Further information

Further information on pricing in the National Disability Insurance Scheme can be found at the NDIS website

Contents

1 Introduction

One of the principal objectives of the National Disability Insurance Scheme (NDIS) is for people with disability to exercise choice and control over how, and with which providers, they spend their available budgets. The role of pricing in the NDIS is therefore very important. Prices, or more precisely participants' choices in response to the prices they face in the market, reflect the preferences and relative values that different participants place on different types of supports. The aggregation of these individual responses in turn signals to providers the quantity and mix of supports to supply. Prices also affect the purchasing power of participants. Higher prices reduce the supports participants can purchase within a given support budget. Prices also affect the total costs of the NDIS and therefore its financial sustainability, and the allocation of resources to the NDIS (and therefore possible production), relative to other sectors. Pricing can also affect providers' choices, including by providing incentives: for entering the market; for upskilling and right-skilling; for innovation; and for improvements in service quality and outcomes.

As the markets for disability goods and services develop and operate more effectively, it is expected that the National Disability Insurance Agency (NDIA), as market steward for the NDIS, will be less interventional. However, deregulation will necessarily occur at different points in time for different markets and may not be feasible in some cases. Currently, the NDIA varies its approach to the regulation of prices between:

- **No regulation** (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.
- **The imposition of price limits**: these represent a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for attendant care.
- **Quotable supports**: in which participants are expected to obtain quotations from suppliers to provide to the NDIA as part of verifying that prices are fair and reasonable. This approach is typically used in the case of highly specialised, differentiated supports that may not have a high level of competition – for example, assistive technology. They are also used in cases, such as supported independent living, where a bundle of supports or quasi-outcome is being purchased. In these situations, providers have greater flexibility to adjust how they achieve the required outcomes in response to the input costs they face.

The purpose of this document is to set out the Efficient Cost Model (ECM) that the NDIA uses to inform its pricing decisions for those supports delivered by Disability Support Workers (DSWs) on which it imposes price limits.

The methodology used to inform the NDIA's pricing decisions for those supports delivered by therapists on which it imposes price limits are set out in the *Review of Therapy Pricing Arrangements*.

2 Disability Support Worker Efficient Cost Model

This Chapter sets out the assumptions and methodology of the Efficient Cost Model (ECM) that the NDIA uses to estimate the costs to disability service providers of employing Disability Support Workers (DSWs) to deliver supports through the NDIS. The ECM estimates the cost of delivering a billable hour of support taking into account all of the costs associated with every billable hour, including: base pay; shift loadings; holiday pay; salary on costs; supervision costs; utilisation (non-billable activities); corporate overheads and margin.

The NDIA recognises that providers have to employ DSWs with different skill levels and levels of experience to meet the different needs of participants. It therefore has different sets of cost assumptions for three types of workers, referred to as:

- Standard or Level 1 DSWs;
- High Intensity or Level 2 DSWs; and
- Very High intensity or Level 3 DSWs.

2.1 Applicable Industrial Award

The national award for DSWs is the *Social, Community, Home Care and Disability Services Industry Award 2010*.[1] The NDIA recognises that some DSWs are employed under Enterprise Bargaining Agreements (EBAs). However, these EBAs have to leave the worker no worse off overall than they would be under the relevant Award and, in general, any additional benefits offered by EBAs over the Award have been voluntarily agreed to by providers and are often offset by productivity gains. The NDIA therefore considers the conditions set out in the SCHADS Award to be the appropriate foundation for the ECM.

Note: the nomenclature of Level 1 DSW, Level 2 DSW and Level 3 DSW used in the ECM should not be confused with the classification of workers under the SCHADS Award.

2.2 Base Pay

Table 1 sets out the ECMs assumptions with respect to the base pay of DSWs.[2]

Table 1: NDIS DSW Levels, Assumed SCHADS Classifications and Pay Rates

	Assumed SCHADS Classification	Award pay 1 December 2018
Level 1 (Standard) DSW	2.3	$27.61
Level 2 (High Intensity) DSW	2.4/3.1	$28.63
Level 4 (Very High Intensity) DSW	3.2	$29.74

1 http://awardviewer.fwo.gov.au/award/show/MA000100

2 https://www.fairwork.gov.au/ArticleDocuments/872/social-community-home-care-and-disability-services-industry-award-ma000100-pay-guide.pdf.aspx

2.3 Shift Loadings

Table 2 sets out the ECM's assumptions with respect to shift loadings. These assumptions are in line with the SCHADS Award and are applied to all DSWs and supervisors in the ECM. In line with SCHADS Award, the ECM also provides a 17.5% loading for annual leave to compensate workers for the shifts they would have otherwise taken. The ECM does not provide for any other allowances payable to DSWs.

Table 2: SCHADS Shift Loadings

Shift	Permanent Loading	Casual Loading	Difference
Weekday	0.0%	25.0%	25.0%
Saturday	50.0%	50.0%	0.0%
Sunday	100.0%	100.0%	0.0%
Public Holiday	150.0%	175.0%	25.0%
Afternoon Shift	12.5%	37.5%	25.0%
Night Shift	15.0%	40.0%	25.0%

2.4 Days Worked Versus Days Paid

The ECM recognises that a permanent worker works on 220 days a year, but is also paid for:

- 20 days of annual leave and 10 days of public holidays;
- Up to 10 days of personal leave – the ECM assumes all workers utilise all of their personal leave entitlement each year;
- 4⅓ days of long service leave (if they have qualifying service) – the ECM assumes 18% of permanent workers and 10% of casual workers qualify for long service leave. [3]

As Table 3 shows, leave costs increase the costs per billable hour of a permanent DSW on a weekday by 20.1% over the base salary rate.

Table 3: Impact of Leave on the Cost per Billable Hour of a Permanent DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Standard Hourly Rate	**$27.61**	**$28.63**	**$29.74**
Allowance for Annual leave			
a. No. hours leave in a year (hrs/yr)	152	152	152
b. Loading	17.5%	17.5%	17.5%
c. Proportion of leave taken	100.0%	100.0%	100.0%
Cost	**$2.95**	**$3.06**	**$3.18**
Allowance for Personal leave			
a. No. hours leave in a year (hrs/yr)	76	76	76
b. Loading	0.0%	0.0%	0.0%
c. Proportion of leave taken	100.0%	100.0%	100.0%
Cost	**$1.26**	**$1.30**	**$1.35**

[3] Australian Bureau of Statistics. (2019). *Participation, Job Search and Mobility, Australia, Feb 2019.*

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Allowance for Public Holiday leave			
a. No. hours leave in a year (hrs/yr)	76	76	76
b. Loading	0.0%	0.0%	0.0%
c. Proportion of leave taken	100.0%	100.0%	100.0%
Cost	**$1.26**	**$1.30**	**$1.35**
Allowance for Long Service leave			
a. No. hours leave in a year (hrs/yr)	32.93	32.93	32.93
b. Loading	0.0%	0.0%	0.0%
c. Proportion of leave taken	18.0%	18.0%	18.0%
Cost	**$0.10**	**$0.10**	**$0.10**
Cumulative cost per hour, after leave costs	**$33.17**	**$34.39**	**$35.73**
Increase from permanent standard hourly rate	20.1%	20.1%	20.1%

Note: Columns may not sum due to rounding.

2.5 Salary On-costs

The ECM recognises that providers incur other costs related to the salaries, including:

- Superannuation at the statutory 9.5% of base salary, including leave;[4] and
- Workers compensation insurance at 3% of base salary, including leave, which is higher than the national average for the Health and Community Services Sector of 1.5%[5].

The ECM does not provide for payroll tax as most jurisdictions exempt not for profit and smaller organisations from payroll tax.

As Table 4 shows, salary on-costs and the costs discussed above increase the costs per billable hour of a permanent DSW on a weekday by 35.1% over the base salary rate.

Table 4: Impact of Salary On-costs on the Cost per Billable Hour of a Permanent DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, before on-costs	**$33.17**	**$34.39**	**$35.73**
Superannuation			
Superannuation Rate (%)	9.5%	9.5%	9.5%
Superannuation ($)	$3.15	$3.27	$3.39
Workers Compensation			
Premium Rate (%)	3.0%	3.0%	3.0%
Premium Cost ($)	$1.00	$1.03	$1.07
Cumulative cost per hour, after on-costs	**$37.31**	**$38.69**	**$40.19**
Cumulative increase from permanent standard hourly rate	35.1%	35.1%	35.1%

[4] https://www.ato.gov.au/Business/Super-for-employers/How-much-to-pay/

[5] Safe Work Australia: www.safeworkaustralia.gov.au/workers-compensation/comparing-workers-compensation-scheme-performance

2.6 Supervision costs

The ECM recognises that DSWs require support and supervision and assumes that supervisors have the same shift loadings, leave entitlements and salary on-costs as the workers they manage, and that higher skilled workers require higher skilled supervisors. The ECM also assumes a span of control (ratio of workers per supervisor) of 11 to 1. The average for the sector is reported in the most recent AbleInsight Benchmarking Survey as 9.5 to 1.[6]

As Table 5 illustrates, supervision costs together with the costs discussed above increase the costs per billable hour of a permanent Standard (Level 1) DSW on a weekday by 48.4% over the base salary rate.

Table 5: Impact of Supervision on Cost per Billable Hour of a Permanent DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, before supervision	**$37.31**	**$38.69**	**$40.19**
Supervisor			
Level of supervisor (SCHADS Equivalent)	3.2	4.2	4.2
Base Salary	$29.74	$33.92	$33.92
Leave costs	$5.99	$6.83	$6.83
Salary-on costs	$4.47	$5.09	$5.09
Span of control			
Span of control	11	11	11
Cost of supervision ($)	$3.65	$4.17	$4.17
Cumulative cost per hour, after supervision	**$40.97**	**$42.86**	**$44.36**
Cumulative increase from permanent standard hourly rate	48.4%	49.7%	49.2%

Note: Columns may not sum due to rounding.

2.7 Permanent v Casual Workers

The ECM assumes that 80% of the DSW workforce is permanently employed. As Table 6 illustrates, casual loadings and the other costs discussed above increase the costs per billable hour of employing a Standard DSW on a weekday by 49.5% over the base salary rate. The impact is slightly higher for a Level 2 (High Intensity) DSW at 50.9% and for a Level 3 (Very high Intensity) DSW at 50.3%.

Table 6: Impact of Casual Loading on the Cost per Billable Hour of a DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, at 100% permanent	**$40.97**	**$42.86**	**$44.36**
Cumulative cost per hour, at 80% permanent	$41.28	$43.19	$44.70
Effect of casual loading	**0.8%**	**0.8%**	**0.8%**
Cumulative increase from permanent standard hourly rate	49.5%	50.9%	50.3%

[6] AbleInsight. (2019). *Sector Summary Report: National Disability Service Providers Benchmarking Survey – Collection 3 (2017/18).*

2.8 Utilisation

The ECM recognises that not all working hours are billable. For example, the SCHADS Award provides that a DSW should have a ten minute paid break from work every four hours. DSWs also need to undertake training and attend to other issues. The ECM assumes that higher skilled workers with more responsibilities may require more non-billable hours, to maintain their skills and deal with other issues.

The ECM assumes that supervisors have the same rate of non-billable hours as DSWs.

As Table 7 illustrates, utilisation costs together with the costs discussed above increase the costs of employing a permanent Standard DSW on a weekday by 62.5% over the base salary rate. The impact is higher for a Level 2 (High Intensity) DSW at 69.5% and for a Level 3 (Very High Intensity) DSW at 71.4%.

Table 7: Impact of Utilisation on the Cost per Billable Hour of a DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, before utilisation adjustment	**$41.28**	**$43.19**	**$44.70**
Utilisation rates			
Breaks	4.17%	4.17%	4.17%
Training	3.29%	6.58%	7.89%
Other	0.54%	0.25%	0.24%
Total Utilisation (%)	92.0%	89.0%	87.7%
Cost of utilisation ($)	$3.59	$5.34	$6.27
Cumulative cost per hour, after utilisation	**$44.87**	**$48.53**	**$50.97**
Cumulative increase from permanent standard hourly rate	62.5%	69.5%	71.4%

Note: Columns may not sum due to rounding.

2.9 Overheads

The ECM assumes that corporate overheads are 10.5% of direct costs (all those above).

As Table 8 illustrates, overhead costs together with the costs discussed above increase the costs of employing a permanent Standard DSW on a weekday by 79.6% over the base salary rate. The impact is higher for a Level 2 (High Intensity) DSW at 87.3% and for a Level 3 (Very High Intensity) DSW at 89.4%.

Table 8: Impact of Overheads on the Cost per Billable Hour of a DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, before overheads	**$44.87**	**$48.53**	**$50.97**
Overhead			
Overheads as a share of direct costs (%)	10.5%	10.5%	10.5%
Cost of overheads ($)	$4.71	$5.09	$5.35
Cumulative cost per hour, after overheads	**$49.58**	**$53.62**	**$56.32**
Cumulative increase from permanent standard hourly rate	79.6%	87.3%	89.4%

Note: Columns may not sum due to rounding.

2.10 Margins

The ECM currently assumes a 2% margin on other costs. This equates to a rate of return of 8% against working capital equivalent to three month's wages and entitlements.

As Table 9 illustrates, margin costs together with the costs discussed above increase the costs of employing a permanent Standard DSW on a weekday by 83.2% over the base salary rate. The impact is higher for a Level 2 (High Intensity) DSW at 91.0% and for a Level 3 (Very High Intensity) DSW at 93.2%.

Table 9: Impact of Margins on the Cost per Billable Hour of a DSW

	Level 1 DSW	Level 2 DSW	Level 3 DSW
Cumulative cost per hour, before margin	**$49.58**	**$53.62**	**$56.32**
Margin			
Margin as a share of other costs (%)	2.0%	2.0%	2.0%
Cost of margin ($)	$0.99	$1.07	$1.13
Cumulative cost per hour, after margin	**$50.57**	**$54.69**	**$57.45**
Cumulative increase from permanent standard hourly rate	83.2%	91.0%	93.2%

3 Pricing Model

In order to set price limits for 2019-20, the NDIA indexed the results of the Efficient Cost Model for costs on 30 June 2019 for the expected results of wage inflation over 2019-20.

The assumptions underpinning this indexation are set out in Table 10.

Table 10: Indexation arrangements

Component	Value
Labour costs	
Fair Work Commission Increase to Minimum Wage (1 July 2019)	3.0%
Equal Remuneration Order (1 December 2019)	2.2%
Total expected increase to labour costs	**5.3%**
Capital costs	
CPI	1.3%
Labour Share of costs	**80%**
Total indexation (weighted average)	**4.5%**

Table 11 shows the ECM results for the cost of supports by each DSW level and shift, and the indexed price limits for 2019-20 (without the Temporary Transformation Payment).

Table 11: Indexed Price Limits

Shift	DSW Level	Efficient Cost 2018-19	Indexed Base Price Limit 2019-20
Weekday	Level 1	$50.57	$52.85
Saturday	Level 1	$69.56	$72.69
Sunday	Level 1	$90.45	$94.52
Public Holiday	Level 1	$113.24	$118.34
Afternoon Shift	Level 1	$55.80	$58.31
Night Shift	Level 1	$56.84	$59.40
Weekday	Level 2	$54.69	$57.15
Saturday	Level 2	$75.24	$78.63
Sunday	Level 2	$97.83	$102.24
Public Holiday	Level 2	$122.46	$127.97
Afternoon Shift	Level 2	$60.34	$63.06
Night Shift	Level 2	$61.47	$64.24
Weekday	Level 3	$57.45	$60.04
Saturday	Level 3	$79.02	$82.58
Sunday	Level 3	$102.75	$107.37
Public Holiday	Level 3	$128.63	$134.42
Afternoon Shift	Level 3	$63.38	$66.23
Night Shift	Level 3	$64.56	$67.47

1 JULY PRICE CAPS

Shift Level of Care	Weekday Level 1	Saturday Level 1	Sunday Level 1	Public Holiday Level 1	Afternoon Shift Level 1	Night Shift Level 1	Weekday Level 2	Saturday Level 2	Sunday Level 2
Efficient cost 2018-19	**$ 50.57**	**$ 69.56**	**$ 90.45**	**$ 113.24**	**$ 55.80**	**$ 56.84**	**$ 54.69**	**$ 75.24**	**$ 97.83**
Indexation	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
PRICE LIMIT FOR BASE ITEMS AFTER INDEXATION	**$ 52.85**	**$ 72.69**	**$ 94.52**	**$ 118.34**	**$ 58.31**	**$ 59.40**	**$ 57.15**	**$ 78.63**	**$ 102.24**
	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%			
TTP AMOUNT	**$ 3.96**	**$ 5.45**	**$ 7.09**	**$ 8.88**	**$ 4.37**	**$ 4.46**	**$ 3.96**	**$ 5.45**	**$ 7.09**
PRICE LIMIT FOR TTP ITEMS AFTER INDEXATION	**$ 56.81**	**$ 78.14**	**$ 101.61**	**$ 127.22**	**$ 62.68**	**$ 63.86**	**$ 61.11**	**$ 84.08**	**$ 109.33**

	Public Holiday Level 2	Afternoon Shift Level 2	Night Shift Level 2	Weekday Level 3	Saturday Level 3	Sunday Level 3	Public Holiday Level 3	Afternoon Shift Level 3	Night Shift Level 3
	$ 122.46	**$ 60.34**	**$ 61.47**	**$ 57.45**	**$ 79.02**	**$ 102.75**	**$ 128.63**	**$ 63.38**	**$ 64.56**
	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
	$ 127.97	**$ 63.05**	**$ 64.23**	**$ 60.03**	**$ 82.58**	**$ 107.38**	**$ 134.42**	**$ 66.23**	**$ 67.47**
	$ 8.88	**$ 4.37**	**$ 4.46**	**$ 3.96**	**$ 5.45**	**$ 7.09**	**$ 8.88**	**$ 4.37**	**$ 4.46**
	$ 136.85	**$ 67.42**	**$ 68.69**	**$ 63.99**	**$ 88.03**	**$ 114.47**	**$ 143.30**	**$ 70.60**	**$ 71.93**

StewartBrown

Integrity + Quality + Clarity

Aged Care Financial Performance Survey

Sector Report

(2018 Financial Year)

The StewartBrown June 2018 *Aged Care Financial Performance Survey* incorporates detailed financial and supporting data from over 974 residential care facilities and over 24,952 home care packages (455 home care programs) across Australia. The quarterly survey is the largest benchmark within the aged care sector and provides invaluable insight into the trends and drivers of financial performance at the sector level and at the facility or program level.

CONTENTS

1. HIGHLIGHTS

Key Results From FY18 Survey

Survey includes data from:

974 Residential Aged Facilities

38% of facilities represented in the survey

24,952 Home Care Packages

29% of operational packages represented in the survey

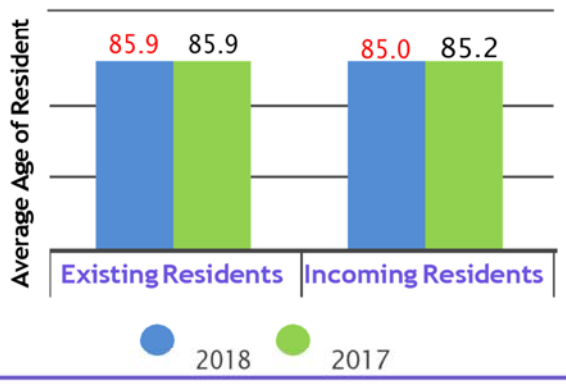
180 approved providers

Organisation Results

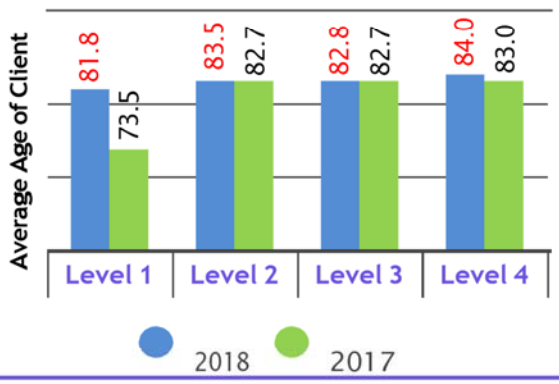
1.4%
EBITDA Return on Assets (ROA)

(0.2%)
Operating Surplus Return on Assets (ROA)

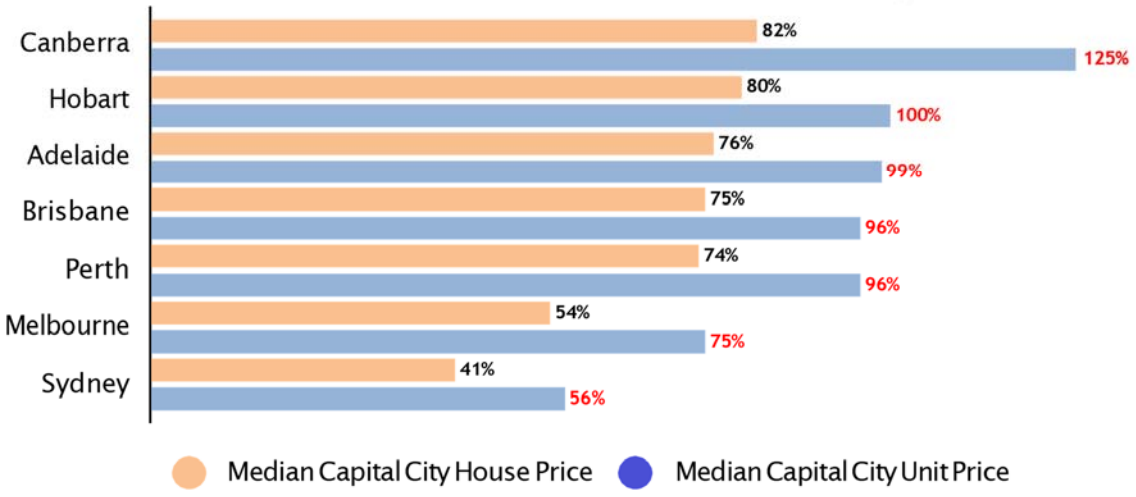
Residential Aged Care



Home Care



Median Published Accommodation Price Comparison



Residential Aged Care

$2.37

EBT per bed day for Survey *Average*
(2017: $9.39)

$30.26

EBT per bed day for *First 25%*
(2017: $37.26)

$6,760

EBITDAR per bed per annum for Survey *Average*
(2017: $8,829)

$16,570

EBITDAR per bed per annum for First 25%
(2017: $18,481)

21%

Proportion of facilities with negative EBITDA
(2017: 14%)

45.1%

Proportion of facilities with negative EBT
(2017: 33.9%)

Home Care

$3.77

EBT per client day for Survey *Average*
(2017: $5.37)

$17.77

EBT per client day for *First 25%*
(2017: $25.03)

$6,022

Survey *Average* for unspent funds
(2017: $4,255)

86.7%

Survey *Average* revenue utilisation
(2017: 92.3%)

9.7%

Case management costs as % of income
(2017: 10.9%)

23.4%

Administration costs as % of income
(2017: $26.0%)

Survey Analytics

Subscribers to the Survey include some of the largest providers nationally, independent stand-alone providers, faith-based and community providers, culturally specific providers, as well as government bodies including the Department of Health (DOH) and Aged Care Financing Authority (ACFA), and aged services sector peak bodies and other service providers to the sector.

The Survey covers residential care, home care packages and retirement villages involving a detailed analysis of the 2018 operating income and expenses of participants including a review of assets and funding engaged in providing aged care facilities. The Survey covered the following participation:-

- 180 approved provider organisations
- 974 residential facilities *(28 additional facilities were excluded due to their operational circumstances)*
- 24,952 home care packages
- Comparisons with 3 listed aged care entities (Estia/Japara/Regis)

In respect of residential care, participants to the Survey represent approximately 40% of facilities within Australia. The profile of the residential care participants, based on the geographical spread, is:-

Table 1: Residential Care Survey Metrics

Number of Residential Facilities / ABS Remoteness	Major City	Inner Regional	Outer Regional, Remote & Very Remote	Total
StewartBrown Residential Care Survey				
Facilities included	632	246	96	974
Facilities excluded	15	5	8	28
Total Survey facilities	**647**	**251**	**104**	**1,002**
GEN Aged Care Data Service Listing (30 June 2018)				
Total (A)	1,680	647	368	2,695
State/local government	34	114	92	240
Service Listing less state/local government (B)	**1,646**	**533**	**276**	**2,455**
Coverage - % of (A)	*38.5%*	*38.8%*	*28.3%*	*37.2%*
Coverage - % of (B)	*39.3%*	*47.1%*	*37.7%*	*40.8%*

StewartBrown Aged Care Reports

StewartBrown issues various detailed financial reports and analysis involving the aged care sector, including the following:-

- Residential and Home Care Sector Reports (quarterly)
- Provider Organisation Report (bi-annual)
- Listed Provider Analysis Report (bi-annual)
- Corporate Administration Report (every second year)

Copies of these reports are located at http://www.stewartbrown.com.au/

2. EXECUTIVE SUMMARY

Abstract

This Sector Report provides an overview of the financial performance of the aged care sector in Australia based on the results of the StewartBrown *Aged Care Financial Performance Survey* for the financial year ended 30 June 2018. This Report is focused at the organisation level of providers in the aged care sector and the average performance achieved by participants to the Survey, whereas the individual participants receive specific comparative data relevant to their location, size and specific facilities within their organisation, including access to an inter-active website.

What the Survey highlights is that the financial performance of the aged care sector is experiencing significant challenges due to a continued decline in profitability in both the residential care and home care segments and this creates challenges for the long-term financial sustainability of the sector. Similar funding challenges exist in the provision of services involving the Commonwealth Home Support Program (CHSP) and Veterans Home Care program (VHC).

FY18 Survey Results Summary

The financial performance of the aged care sector, and specifically the residential care and home care package segments has experienced a significant deterioration in the operating results for FY18. A continuation of this decline or even just maintaining the FY18 results will potentially place a number of residential care facilities in a financially vulnerable position which could impact on the organisation's sustainability.

Following is a summary of the key financial performance results and indicators by segment from participants in the FY18 *Aged Care Financial Performance Survey*.

Organisation (Approved Provider)

- Operating EBT Result (*) (average by organisation) reduced by $1,275k to a deficit of $52k
- Operating EBITDA reduced by $831k to $3,326k surplus
- Operating Result expressed as a return on assets employed has reduced from 0.5% positive to negative 0.02%. ACFA total residential care sector FY17 return on assets was 0.8% and is also expected to decline for FY18
- Operating EBITDA (cash surplus) return on assets has reduced by 0.44% to 1.44% (FY17 1.9%)
- Liquid cash and financial assets as a percentage of debt (RADs and external) has reduced by 2.7% to 38.1% (FY17 40.8%). The listed entity ratio reduced by 1.5% to 1.7% (FY17 3.2%)
  **Operating result excludes non-recurrent revenues and expenses (revaluations/donations/impairment etc)*

Residential Care

- Average ACFI per bed day (pbd) for survey participants was neutral ($172.57 pbd)
- Occupancy levels for survey participants remained neutral (94.3% average occupancy)
- Total care hours per resident per day increased by 0.15 hours to 3.06 hours (FY17 2.91 hours)
- Direct care costs increased by 4.3% ($140.24 pbd)
- Costs for providing everyday living services exceeded revenue by $7.85 pbd
- Average Earnings Before Tax (EBT) for residential facilities reduced by $2,420 per bed per annum (pbpa) to $816 pbpa (FY17 $3,236 pbpa)
- Average EBITDAR for residential facilities reduced by $2,069 pbpa to $6,760 pbpa (FY17 $8,829 pbpa)
- 45.1% of residential facilities recorded a negative Operating Result (EBT) (33.9% for FY17)
- 21.2% of residential facilities recorded a negative EBITDA (16.1% for FY17*) (representing a cash loss)*
- 63.5% of outer regional, rural and remote facilities recorded an EBT loss *(37.5% recorded a cash loss)*

Home Care Packages

- Revenue per client day (pcd) average for survey participants reduced by 6.1% (being $4.48 pcd)
- Operating Result (EBT) surplus average per client day for survey participants reduced by $1.60 pcd to $3.77 pcd (FY17 $5.37 pcd)
- Direct service costs increased by $1.30 pcd (60.9% of total revenue)
- Revenue utilisation (average unspent funds) has deteriorated by 8.3%
- Unspent funds average per client has increased by $1,729 per client (to average $5,984 per client)
- Staff hours per client per week reduced by 0.47 hours (average 6.69 hours per week)
- 45% of clients transitioned to residential care (30% in FY17)
- 9% of clients transferred to another provider (4% in FY17) - the majority being due to change of place of residence

Commentary

The FY18 financial results for the sector indicate clearly that the current funding model is under significant strain. Both residential care and home care experienced declines in financial performance, interestingly though, for somewhat unrelated reasons.

The residential care financial performance decline was revenue related, largely due to the combination of the COPE indexation freeze on AFCI subsidy, amendments to the ACFI scoring matrix, ACFI downgrades and increased costs. Costs rose as would expected due to Enterprise Agreement staff rate increases, CPI increases for other expenses except for electricity which was well above the underlying inflation rate.

Average ACFI subsidy revenue has remained relatively neutral at $172.57 per bed day (an increase of $0.40 per bed day). The last few years have seen ACFI funding plateauing, and this is consistent with the acuity (assessed care) of residents remaining at the same level for the last 2-3 years.

The resultant financial effect is that it is likely that when a resident exit a residential facility they are replaced by an incoming resident with lower assessed needs and therefore, a lower daily ACFI subsidy (often between $20 - $30 per day lower). The cost structure of residential facilities means that it is difficult to defray the subsidy reduction by a compensating cost reduction, so the profitability is immediately affected.

The impact of the regulatory changes and funding pressures has resulted in the disturbing statistic that 45.1% of residential facilities reported an EBT operating deficit for FY18, and even more disconcerting is that 21.2% of facilities had negative EBITDA (indicating a cash loss from operations). All geographic locations reported a decline, however, the outer regional, rural and remote locations have significant financial concerns.

Direct care staffing hours per resident per day increased from 2.91 hours to 3.06 hours, with no additional funding revenue to compensate for these increased staffing hours.

Average Earnings Before Tax (EBT) for FY18 for residential care was $816 per bed per annum, which equates to an unsustainable amount of $15.69 per bed per week.

Occupancy levels in residential care facilities remained steady at 94.3% average occupancy, however the concern is that any facility closures due to financial stress may impact the vulnerable aged requiring high care accommodation.

Capital equity injection and use of existing capital for necessary rebuild and refurbishment of facilities has noticeably slowed, a contributing reason being due to legislative and regulatory uncertainty in addition to the low financial returns. The average EBT return on assets employed (ROA) was a mere 0.5% and after excluding non-recurrent revenue streams such as revaluations and fair value gains on property and investments, the ROA represented a negative return of 0.02%

The financial viability of outer regional, rural and remote aged care providers is reaching a pivotal point. Over 63% of residential facilities in these geographic locations are operating at a loss, with more than 37% now operating at a cash deficiency. There are few opportunities for existing providers to merge or sell their facilities to larger providers, meaning that remedial funding will be essential in our opinion.

Accommodation pricing for residential care (Refundable Accommodation Deposits and Daily Accommodation Payments) have not translated into a major equity pipeline. This is due to the number of supported residents (over 45% nationally) and consumer reluctance to pay high accommodation prices commensurate with the average housing prices.

For FY18 the average surplus from accommodation revenue and accommodation costs (by majority being depreciation and refurbishment) equated to $3,837 per bed per annum. Assuming a new residential bed costs around $300,000 to build and the depreciated bed value (WDV) is currently around $185,000 this is, in itself, not a sustainable return, being less than 2.07% pa for existing facilities and 1.28% for new builds.

However, it should be noted that this surplus is partly due to generally low depreciation charges (buildings being depreciated over 40+ years with little to no refurbishment factored in). If buildings were depreciated at 4% pa (ie 25 years effective life) which is more realistic, then this would create a reported deficit rather than a surplus.

Whilst residential care has attracted significant community and media interest, in-home care has also experienced a financial performance decline with revenues reducing by an average of 6.1% underpinning an overall reduction in profitability of 29.8%. This may explain the reduction in staffing hours delivered to clients.

Since June 2016 the number of approved providers in home care has increased nationally by 373 (75.2% increase), however the number of funding packages has only increased by 17.57% (from 72,272 packages to 84,971 packages) since deregulation in February 2017.

In conclusion, the aged care sector requires significant investment given that the home care national prioritisation queue (consumers assessed for funding but not yet allocated full funding) has increased by over 32,500 since June 2017 to now being over 121,400, coupled with the estimated 83,000 plus new residential beds being required over the next 10 years to meet the ageing population demands.

For this investment to occur the sector must be financially sustainable which will require all stakeholders to engage in exploring sustainable and robust solutions to the funding and operational business models.

Future Financial Sustainability

In ***Chapter 5*** of this report we have prepared a FY19 financial projection for residential care based on a series of assumptions. Our FY19 forecast Facility Result based on the current funding levels projects an operating deficit of $0.20 per bed day for the sector average.

We also identify the following specific issues that we feel need to be considered in relation to improving financial performance and long-term sustainability of the aged care sector.

Residential Care

- ACFI funding - greater annual inflation (COPE) subsidy increases
- Additional subsidy funding for Behaviour (BEH) and Complex Health Care (CHC) domains within ACFI
- Rural, remote and very remote - additional viability supplements
- Workforce strategies and initiatives funding
- Extra and optional fees - deregulation and clearer regulatory guidance
- Accommodation Pricing - increase pricing

Home Care

- National prioritisation queue and waiting lists - increased home care package funding
- Pricing transparency - successful implementation for both consumers and providers
- Pricing and service delivery - more clarity and flexibility in relation to provision of service guidelines
- Quality audits - enhanced monitoring and appropriate responses to non-conformance
- Unspent funds - clearer definition around use of unspent funds
- Consumer education - greater focus on providing increased consumer (and provider) education
- Integration of CHSP and HCP programs (as appropriate)

General

- My Aged Care - enhancement of functionality and portability
- Legislative and regulatory environment - improved clarity and certainty
- Innovation - to be supported and encouraged at regulatory and legislative level
- Consumer education - targeted to include the continuity of care for each segment
- Greater level of congruence between State regulatory environment for Retirement Villages and to provide an easier transition from senior's housing to residential care
- Education and guidance on Governance for aged care providers

3. ORGANISATION ANALYSIS

This section provides a summary of the FY18 financial performance of aged care providers at an organisational level rather than at individual segment or facility level. For the purposes of this analysis, we have included the detailed information provided by 130 organisations who are representative of all states and demographics.

The same provider organisations were used to compare their operating performance for FY18, FY17 and FY16.

Operating Results for year ended 30 June 2018

The following table represents the Survey organisation (approved provider) summary revenue and expenses for the financial years ended 2016 to 2018. The amounts expressed are the average of the 130 organisations for ease of comparison. The ACFA comparisons are for the 2016 and 2017 financial years and include the residential segment only for the approved providers.

Table 2: Income & Expenditure Comparison (average by organisation)

	Survey FY18 (Average)	Survey FY17 (Average)	Survey FY16 (Average)	ACFA FY17 (Residential)	ACFA FY16 (Residential)	Listed Entities FY18 (Average)	Listed Entities FY17 (Average)
Income & Expenditure	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Revenue							
Operating revenue	70,217	65,246	57,085	18,600	17,460	500,816	477,816
Investment income	2,126	2,109	1,824	348	634	136	194
Other income	1,360	3,030	1,252	738		4,408	6,438
Total revenue	73,703	70,385	60,161	19,686	18,094	505,360	484,448
Expenses							
Employee expenses	47,900	44,009	37,650	13,073	11,439	338,871	314,715
Depreciation and amortisation	5,021	4,572	3,863	993	814	23,578	20,873
Finance expenses	483	470	309	190	158	6,774	6,645
Other expenses	18,991	17,080	15,035	4,315	4,564	81,596	79,090
Total expenses	72,395	66,131	56,857	18,571	16,975	450,819	421,323
Surplus (EBT)	**1,308**	**4,254**	**3,304**	**1,115**	**1,119**	**54,541**	**63,125**
Operating Result - Surplus (Deficit)	**(52)**	**1,224**	**2,052**	**377**	**485**	**50,133**	**56,687**
Operating EBITDA	**3,326**	**4,157**	**4,400**	**1,212**	**1,192**	**80,349**	**84,011**

Brief Commentary

- The Operating Result includes Investment Income and excludes non recurrent Other Income (eg fair value revaluations, donations, fundraising etc). Non-recurrent expenses (such as impairment) have been offset against other income
- The operating result has declined each year since 2016 and was an average deficit by organisation of $52k for FY18
- The operating result *excluding* investment income was a deficit by organisation of $2,178k for FY18 ($885k for FY17)
- ACFA income and expenditure is for the residential care segment only and shows a similar decline for the FY16 and FY17 periods and it is likely the FY18 results will also show a significant deterioration

Balance Sheet Summary as at 30 June 2018

A summary of the balance sheet (organisation average) for the 2016 to 2018 financial years is included in the below table.

Table 3: Summary Balance Sheet Comparison (average by organisation)

	Survey FY18 (Average)	Survey FY17 (Average)	Survey FY16 (Average)	ACFA FY17 (Residential)	ACFA FY16 (Residential)	Listed Entities FY18 (Average)	Listed Entities FY17 (Average)
Balance Sheet	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Assets							
Cash and financial assets	50,710	49,871	48,494	9,090	5,913	16,091	27,416
Operating assets	12,669	13,348	6,079	8,262	8,488	18,777	22,955
Property assets	167,622	152,428	126,408	26,431	24,899	913,666	780,715
Intangible assets	8,650	7,562	6,276	6,125	3,583	668,528	648,527
Total assets	239,651	223,209	187,257	49,908	42,883	1,617,062	1,479,613
Liabilities							
Refundable loans	126,177	115,975	100,116	27,395	23,047	763,822	700,008
Borrowings	6,919	6,187	5,006	4,969	3,958	210,696	145,838
Other liabilities	18,536	16,755	11,976	4,987	4,344	150,640	140,178
Total liabilities	151,632	138,917	117,098	37,351	31,349	1,125,158	986,024
Net Assets	**88,019**	**84,292**	**70,159**	**12,557**	**11,534**	**491,904**	**493,589**
Net Tangible Assets	**79,369**	**76,730**	**63,883**	**6,432**	**7,951**	**(176,624)**	**(154,938)**

Brief Commentary

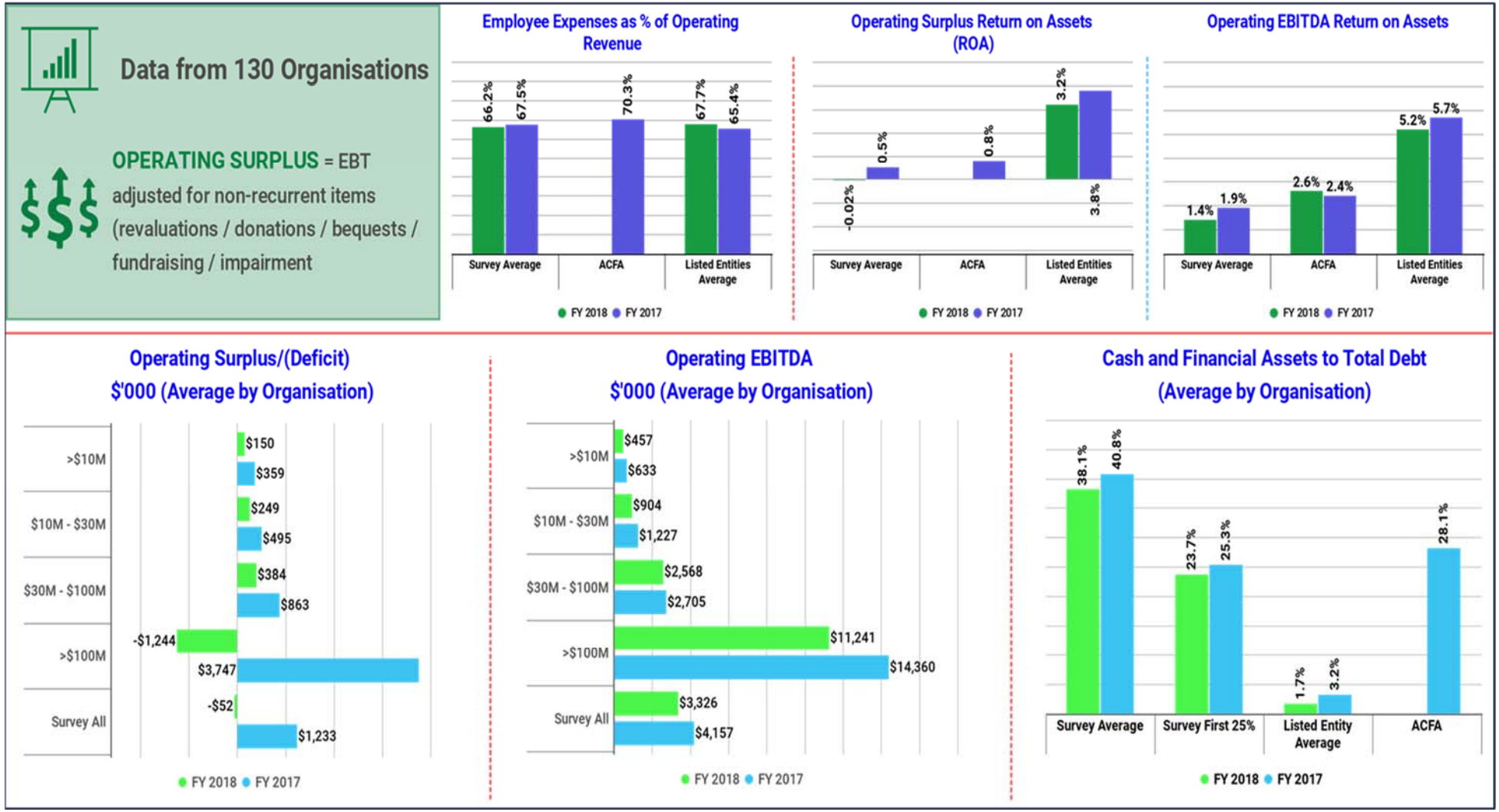
- Net assets and net tangible assets has increased for the Survey organisations but decreased for the listed entities (Estia/Japara/Regis)
- ACFA net assets for the residential care segment has increased in FY17 due to significant bed licence (intangible assets) acquisitions by the for-profit sector. The majority of not-for-profit organisations do not include bed licences as an intangible asset
- The results of the sector indicate that the Operating Result expressed as a Return on Assets employed by organisations is not financially sustainable under the current funding model (refer following page Snapshot)

Organisation Profile

Table 4: Profile of Survey Organisations by Revenue Band

Operating revenue range ($million per annum)	<$10M	$10M - $30M	$30M- $100M	> $100M	Total
Number of Organisations	28	47	28	27	130
%	*21.5%*	*36.2%*	*21.5%*	*20.8%*	*100.0%*
Number of residential care facilities	26	95	151	515	787
%	*3.3%*	*12.1%*	*19.2%*	*65.4%*	*100.0%*
Number of residential operating places	1,931	7,893	13,477	41,038	64,339
%	*3.0%*	*12.3%*	*20.9%*	*63.8%*	*100.0%*
Number of Home Care (HCP) clients	409	1,215	4,604	23,485	29,713
%	*1.4%*	*4.1%*	*15.5%*	*79.0%*	*100.0%*

Snapshot

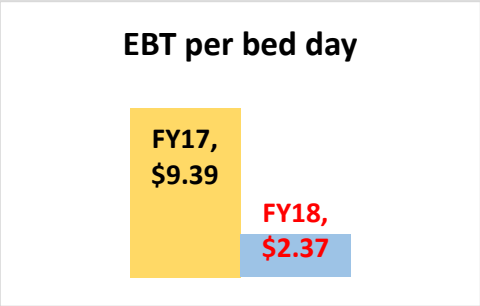


Aged Care Financial Performance Survey
Sector Report *(FY18)*

4. RESIDENTIAL CARE ANALYSIS

Overview

The residential care sector has experienced a significant decline in Facility Result (EBT) mainly due to expenses increasing at a much higher rate (4.7%) than revenue (1.7%). The Facility Result as shown to the right has decreased from $9.39 per bed day (pbd) in FY17 to $2.37 pbd in FY18.



Revenue

- Increase in ACFI revenue by $0.49 pbd - in real terms we are seeing stabilisation of acuity (care) levels. There has only been a slight movement in the proportion of facilities from "low-care" bands to higher care bands - average ACFI subsidy per bed day increased marginally from $172.08 to $172.89
- Increase in Every Day Living revenue by $1.30 pbd mostly due to CPI increase in the Basic Daily Fee
- Increase in Accommodation revenue by $2.41 pbd due to:
  - Resident - $0.63 pbd (due to increase in DAPs ratio as compared to RADs)
  - Subsidy - $1.77 pbd (due to increase in Significant Refurbishment subsidy)

Expenses

- Increase in total care labour costs of $5.64 pbd and increase of roughly 9 minutes per resident per day in total care hours (total direct care hours - 3.06 per resident per day)
- Increase in hotel services $0.96 pbd
- Increase in utilities of $0.59 pbd (mostly due to increase in electricity $0.42 pbd)
- Increase in administration of $2.25 pbd mostly due to increase in corporate recharges
- Increase in accommodation expenditure by $1.20 pbd due to higher depreciation charge

Additional Trends

- Occupancy - slight decrease from 94.6% to 94.3%
- Increase in supported resident ratio
- Increase in average Refundable Accommodation Deposit held and received during the year
- Increasing preference for DAPs over RADs - split is now 31% RAD, 45% DAP and 24% Combination

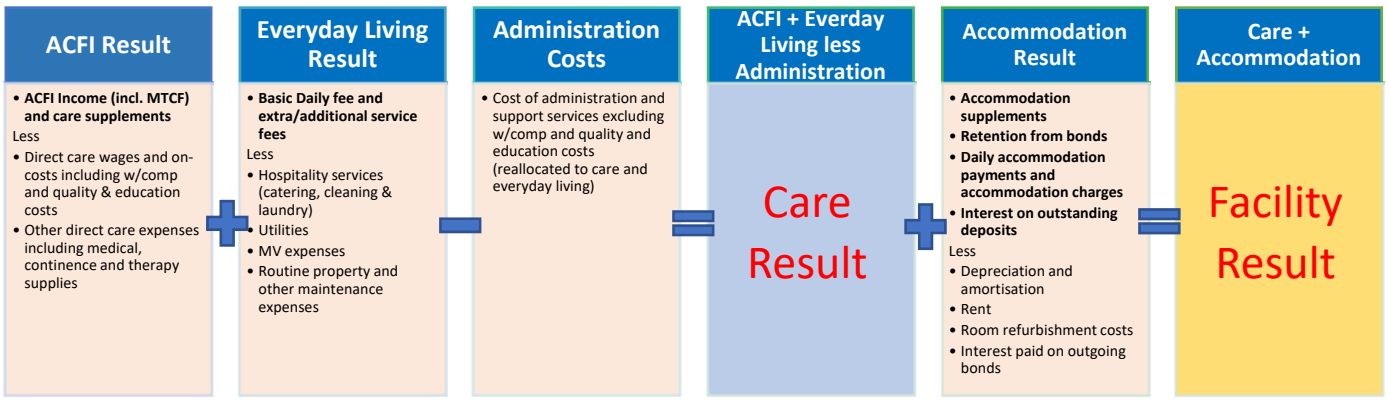
Table 5: Summary Results for FY18 Survey

	FY18 974 Facilities	FY17 957 Facilities		Difference
Facility Result (EBT) $ per bed day	$2.37	$9.39	↓	($7.02)
Facility EBT $ per bed per annum (pbpa)	$816	$3,236	↓	($2,420)
Facility EBITDAR $pbpa	$6,760	$8,821	↓	($2,061)
Average Occupancy	94.3%	94.6%	↓	(0.4%)
Average ACFI per bed day	$172.57	$172.08	↑	$0.49
Direct care hours per resident per day	3.06	2.91	↑	0.15
Care labour costs as % of ACFI	80.7%	77.5%	↑	3.2%
Supported ratio	45.5%	45.4%	↑	0.1%
Average Bond/RAD held	$295,209	$279,513	↑	$15,696
Average RAD taken during period	$321,350	$320,220	↑	$1,130

Definitions

The Facility Result comprises the below components. The Care Result is a derivative of the resident acuity (care) needs whilst the Accommodation Result is derived from revenue streams not directly related to resident acuity but the resident's financial ability to pay for residential accommodation.

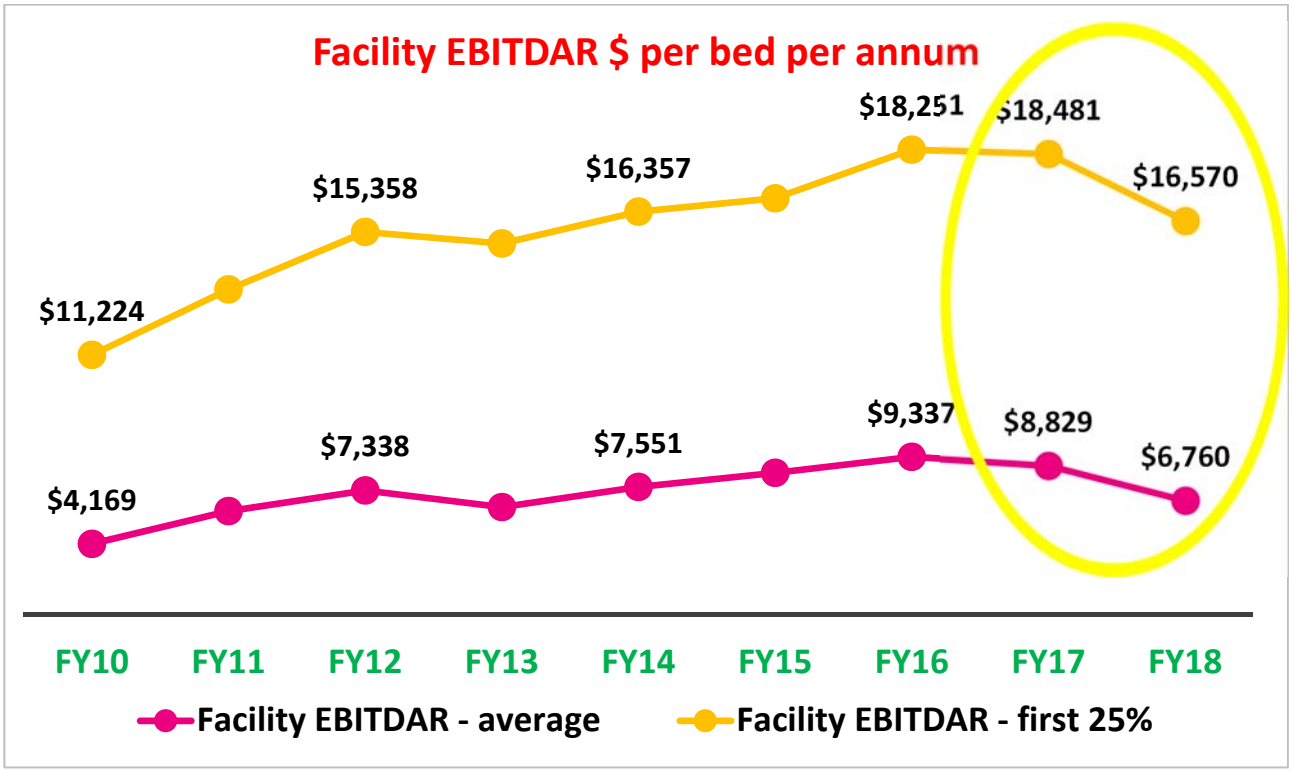
Figure 1: Facility Result Definition



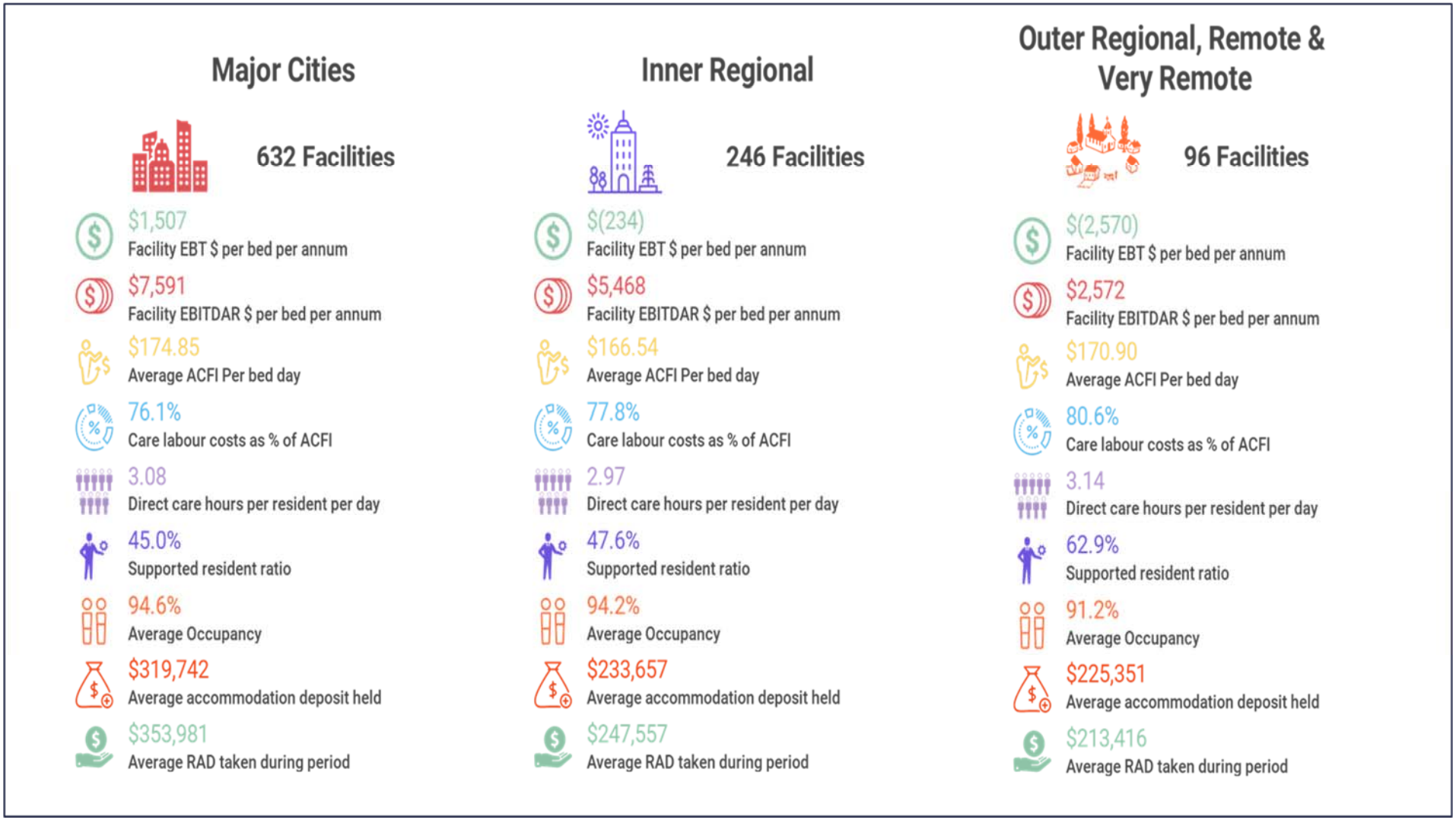
Facility Result Trend

The below graph shows the Facitity EBITDAR (Earnings Before Interest, Taxation, Depreciation, Amortisation and Rent) trend from FY10 to FY18. At the *Average* facility level it is becoming increasingly difficult to remain financially sustainable.

Figure 2: Facility EBITDA trend



Snapshot - FY18 Facility Results By ABS Region



Aged Care Financial Performance Survey
Sector Report *(FY18)*

Impact of FY18 Performance - Number of Facilities with Negative Facility Result (EBT)

Please note that the following analysis is based on the financial operating performance at residential facility level - not at the organisation level.

The total percentage of facilities making an EBITDAR loss (Earnings Before Interest, Taxation, Depreciation, Amortisation and Rent) has increased by 7.0%, from 14.0% to 21.0% of 974 facilities participating in the Survey. In addition to this a further 28 facilities were excluded due to being outside the acceptable range.

The total percentage of facilities making an EBT loss has increased by 11.2%, from 33.9% to 45.1%.

Figure 3: Analysis of Facilities making EBT and EBITDAR losses in total Survey

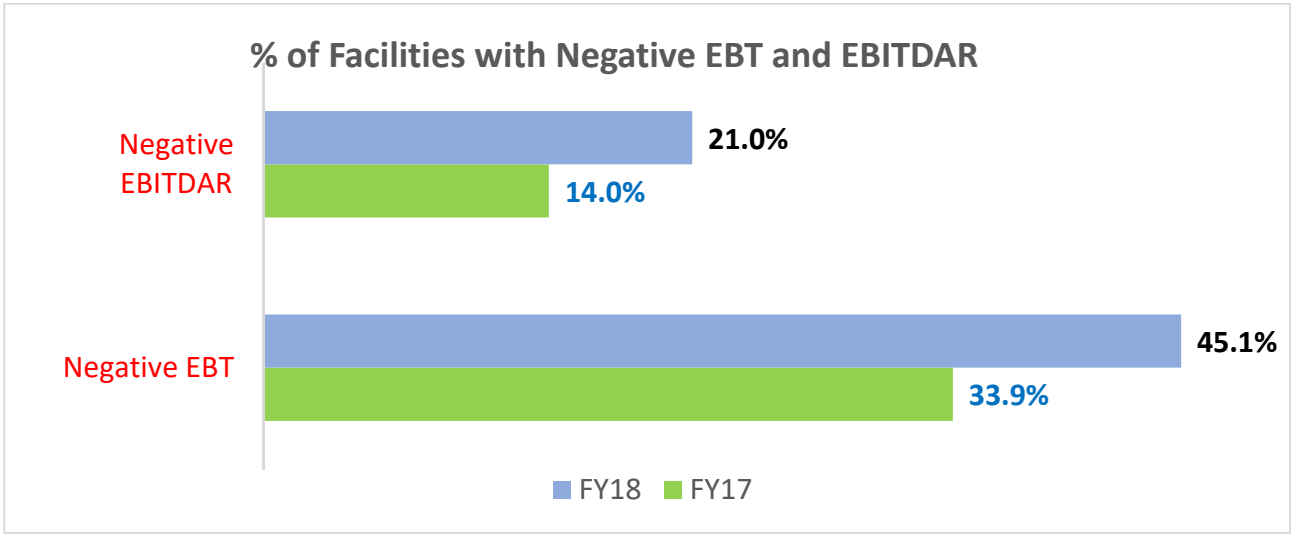


Figure 4: Analysis of Facilities making EBT losses (by remoteness) in total Survey

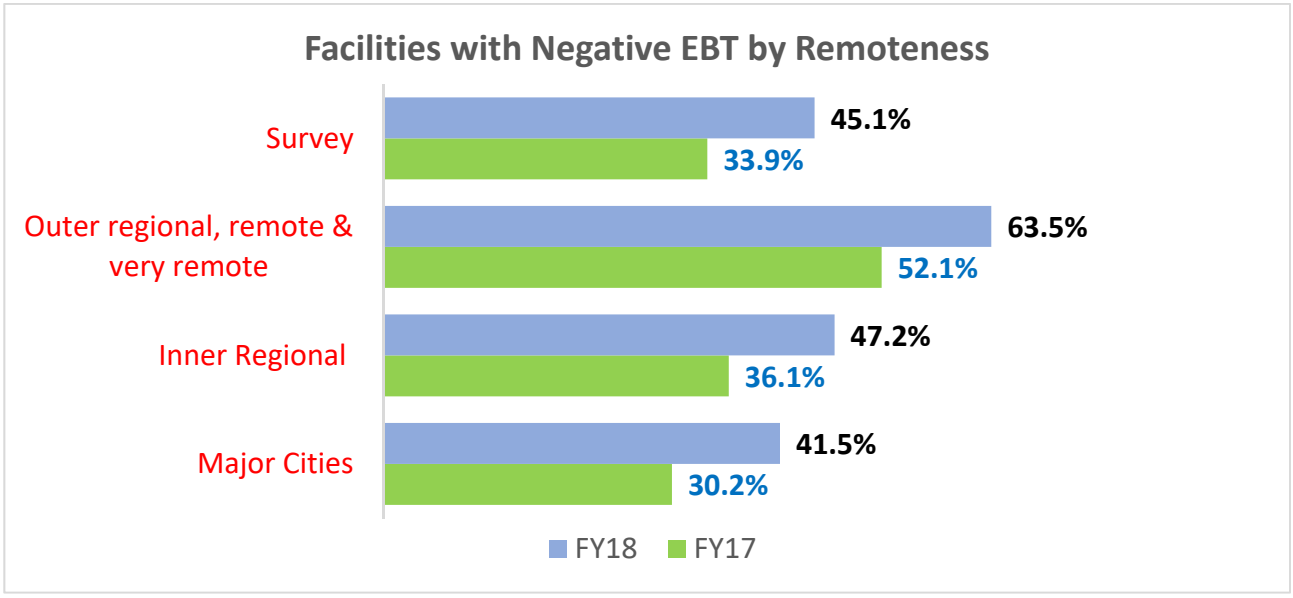
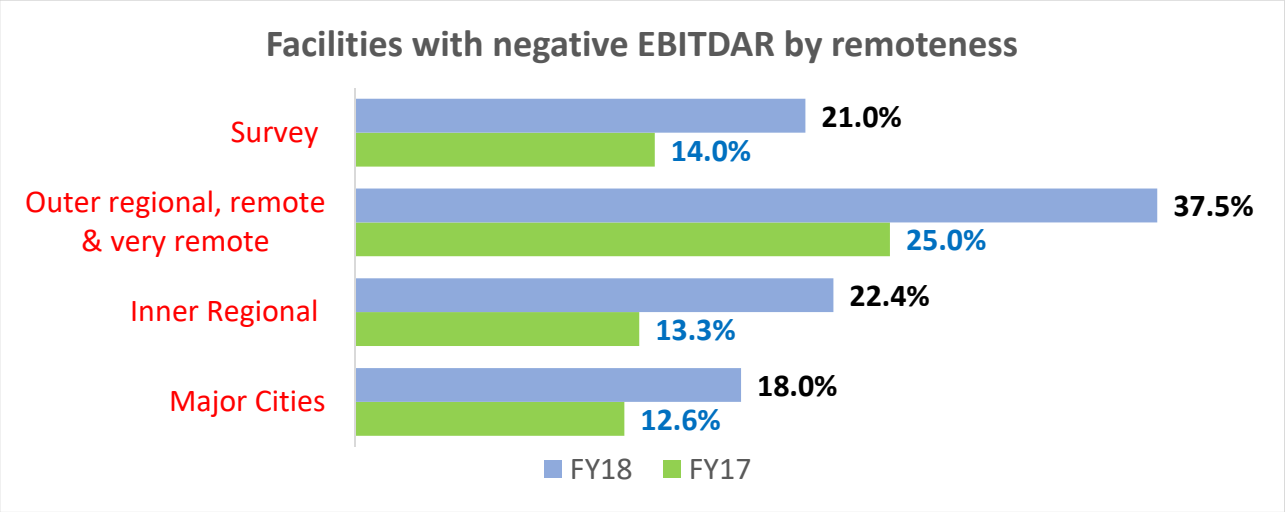


Figure 5: Analysis of Facilities making EBITDAR losses (by remoteness) in total Survey



Brief commentary

Figures 4 and 5 above graph the number of facilities making an EBT and EBITDAR loss as a percentage of total number of facilities in their respective geographic location (remoteness). For each location the number of facilities reporting a loss for FY18 is significant, as follows:-

- Outer regional/remote/very remote facilities - 63.5% of facilities in this geographic area made an EBT loss and 37.5% made an EBITDAR loss
- Inner regional facilities - 47.2% made an EBT loss and 22.4% made an EBITDAR loss
- Similarly, of the facilities located in major cities, some 41.5% made an EBT loss and 18.0% made an EBITDAR loss

Direct Care Staffing Hours

Direct Care staffing metrics include care staff costs and care staff hours. Improvement in the financial performance of a facility are directly related to appropriately aligning staffing hours and levels to the funding and ensuring that the design of the facility is operationally efficient.

A summary of the direct care staff hours by category per resident per day for the Survey *Average* and Survey *First 25%* is included in the table below.

Table 6: Direct Care staffing metrics for Survey Average and Survey First 25%

	Average			*First 25%*		
	FY18	***FY17***		***FY18***	***FY17***	
Hours by Staff Category - hours worked per resident per day						
Care management	0.12	0.12	-	0.11	0.10	↑
Registered nurses	0.37	0.37	-	0.31	0.29	↑
Enrolled & licensed nurses	0.30	0.26	↑	0.24	0.22	↑
Other unlicensed nurses & personal care staff	2.10	2.02	↑	1.93	1.82	↑
Allied health & lifestyle	0.15	0.12	↑	0.15	0.11	↑
Imputed agency care hours implied	0.02	0.02	-	0.02	0.02	-
Total Care Hours	**3.06**	**2.91**	↑	**2.76**	**2.56**	↑

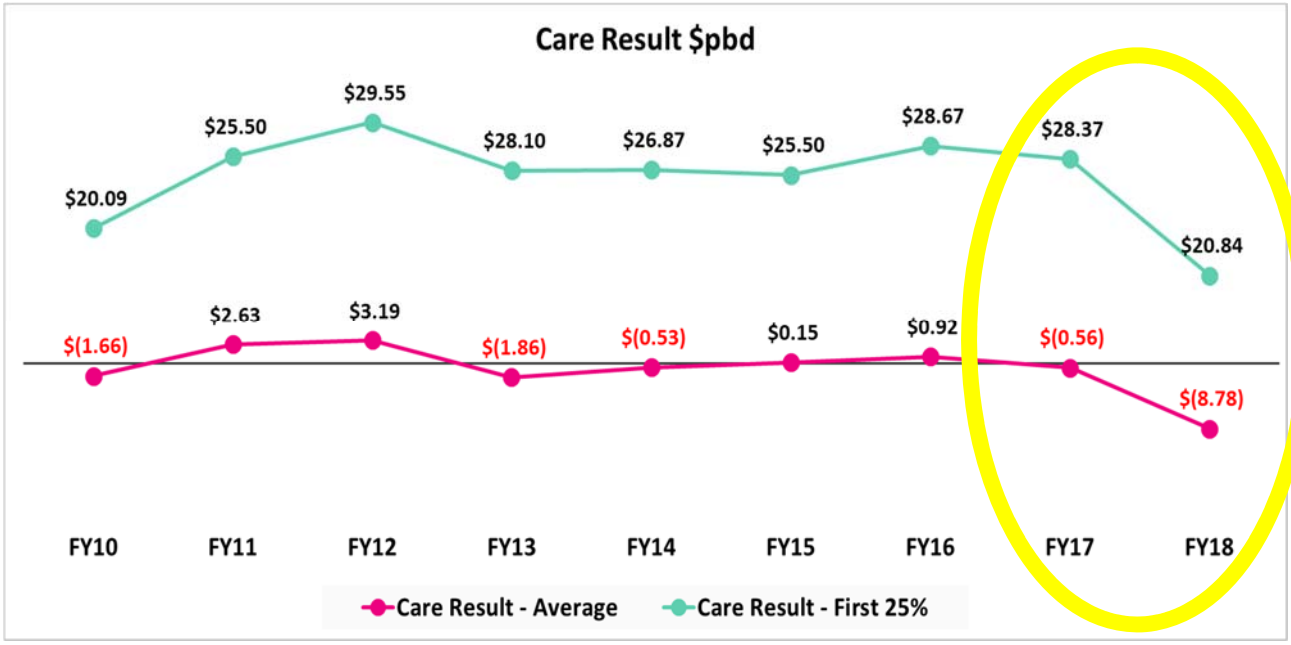
Brief commentary

- The category allocations are consistent with that used by the Nurses and Midwifery Board of Australia, and accordingly AIN and TAFE qualified staff have been included under the "Other unlicensed nurses & personal care staff" classification
- Total labour costs have increased for both the Survey *Average* and *First 25%* since June 2017 by 4.4% and 6.6% respectively
- Total care hours have increased for both the Survey *Average* and for the *First 25%* by 5.2% and 7.6% respectively, and are now at 3.06 hours and 2.76 hours worked per resident per day respectively
- Initial feedback from providers in relation to an explanation for the increase in care hours in the first half of FY18 was that it may be partially due to the impact of influenza and gastro outbreaks, however it is noted that the care hours have not reduced but instead remained at that level

Care Result Trend

The Care Result (ACFI + Everyday Living + Administration) trend is shown in the below graph. The FY18 Facility Care result is a deficit of $8.78 per bed day (FY17 $0.56 pbd deficit). This represents an unstainable operating performance unless additional revenue (subsidy and resident) is achieved.

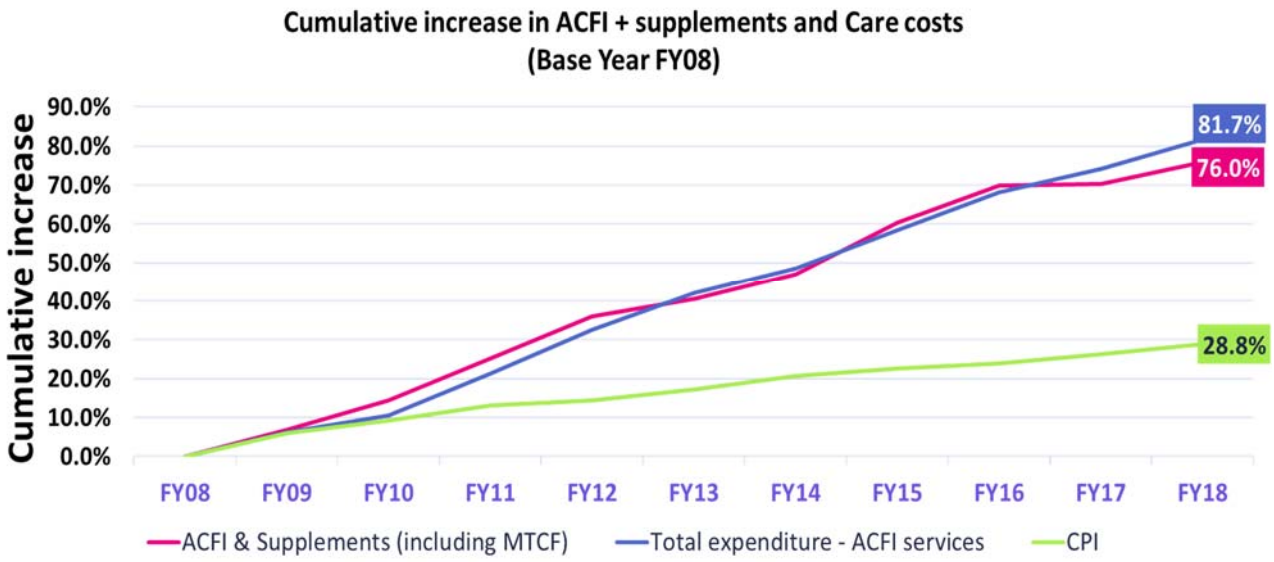
Figure 6: Care Result Trend for Survey Average and Survey First 25%



ACFI Revenue and Direct Care Costs Trend

The relationship between ACFI subsidy received (based on resident assessed acuity) and direct care costs is important in maintaining a sustainable operating financial model. The graph below indicates that the direct care costs are now rising at a greater rate than the corresponding ACFI subsidy, and this gap is likely to increase as staff cost increases (average of 3.0% annually) are greater than ACFI COPE (inflation) increases (1.17% for FY18).

Figure 7: Cumulative increases in ACFI subsidy, Direct Care costs as compared to CPI



Everyday Living Result

The recoupment of everyday living costs is again highlighted as an area of concern for approved providers. Whilst opportunities exist to charge additional optional services to residents, several challenges exist in this regard. A major issue is in relation to supported residents who, by majority, do not have the financial means to pay for additional services, or indeed pay a higher Basic Daily Fee (85% of the single pension).

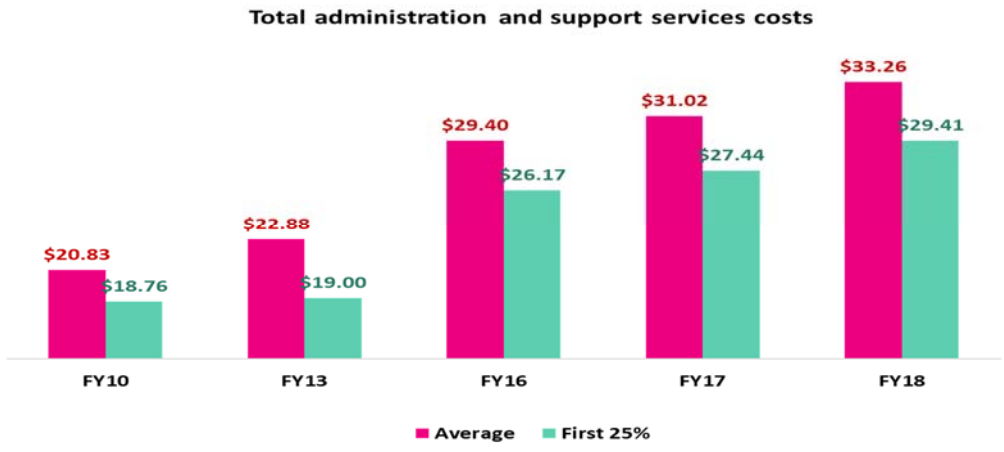
Many providers are also very conscious to not introduce a tiered system whereby some residents are able to access additional services based on their ability to pay whilst others do not receive such additional services due to the inability to pay a higher charge.

For FY18 the costs of providing everyday living services exceeded the revenue by $7.85 pbd (FY17 $7.16 pbd). Refer to the Everyday Living snapshot (next page) for a summary of the various components.

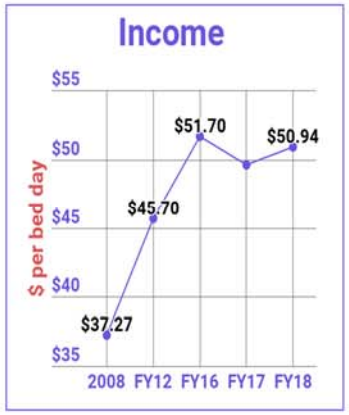
Administration Costs

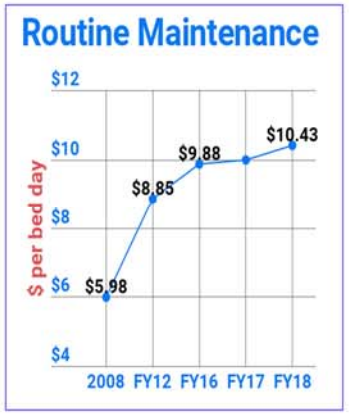
Administration costs have continued to increase at a rate higher than CPI. One of the main drivers for this is the increasing compliance requirements.

Figure 8: Administration Costs FY18 and FY17 ($ per bed day)



Snapshot - Everyday Living Metrics





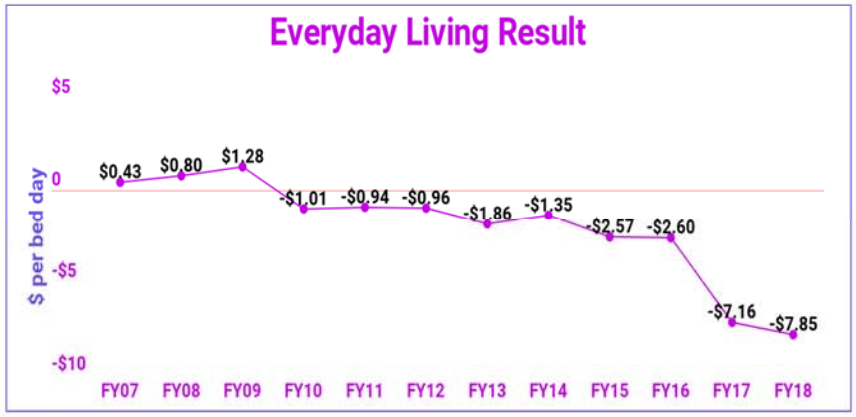
Income increased by an average of $13.67 per bed day or 36.7%

Hotel services costs increased by an average of $14.16 per bed day or 52.0%

Utility costs increased by an average of $3.54 per bed day or 108.6%

Routine Maintenance costs increased by an average of $4.45 per bed day or 74.4%

Total Everyday Living Expenses have increased by an average of $21.75 per bed day or 58.7% during the same period that income increased by only $13.67 per bed day



The Everyday Living Result has declined over the past 10 years by an average of $8.28 per bed day and by $9.13 per bed day from the peak result.

It is clear that the increase in the basic daily fee has not kept pace with cost increases, particularly in catering, cleaning and laundry costs.

Providers, particularly in the not-for-profit sector have not readily embraced extra or additional services to overcome this shortfall so that these costs are being subsidised by other income streams.

Accommodation Result

It is important that facilities achieve a surplus from the accommodation result as this funding is essential to maintain the building and surroundings at a level commensurate with consumer expectations. Discussions with providers, coupled with data collected from participants, indicate that a major internal refurbishment policy of every 8 - 10 years is required, even for new builds.

The accommodation surplus for FY18 was $11.15 per bed day (FY17 $9.95 pbd) which represents $3,837 per room per annum. This result is achieved after an average depreciation expense of $5,566 pa. However, given the necessity to upgrade facilities regularly, a depreciation rate of 4% (i.e. 25 year write-off period for residential care buildings) should be adopted by providers as it is highly probable that this equates to the effective (useful) operational life of a residential facility in an increasing "retail" style accommodation market.

A further relevant consideration is that currently the surplus from the accommodation result is being used to offset the loss from the care result. In FY18 the Care Result was a deficit of $8.78 per bed day which, if funded from the accommodation result, impacts on the ability of organisations to fund future refurbishment of a facility. This not only affects the accommodation revenue (accommodation pricing) but does not allow for efficiency gains to be achieved through building design modifications.

Table 7: Residential Care Accommodation Result

	Survey *Average*			Survey *First 25%*	
	FY18	**FY17**		**FY18**	**FY17**
	$ pbd	$ pbd		$ pbd	$ pbd
Accommodation Revenue	**29.85**	**27.45**		**27.91**	**25.42**
Depreciation	16.18	14.94		16.51	14.55
Refurbishment	1.10	1.23		0.44	0.72
Other accommodation costs	1.42	1.33		1.54	1.33
Accommodation Expense	**18.70**	**17.50**		**18.49**	**16.60**
Accommodation Result	**$11.15**	**$9.95**		**$9.42**	**$8.82**
Accommodation Result $pbpa	**$3,837**	**$3,436**		**$3,306**	**$3,096**
Depreciation charge $pbpa	**$5,566**	**$5,161**		**$5,795**	**$5,111**

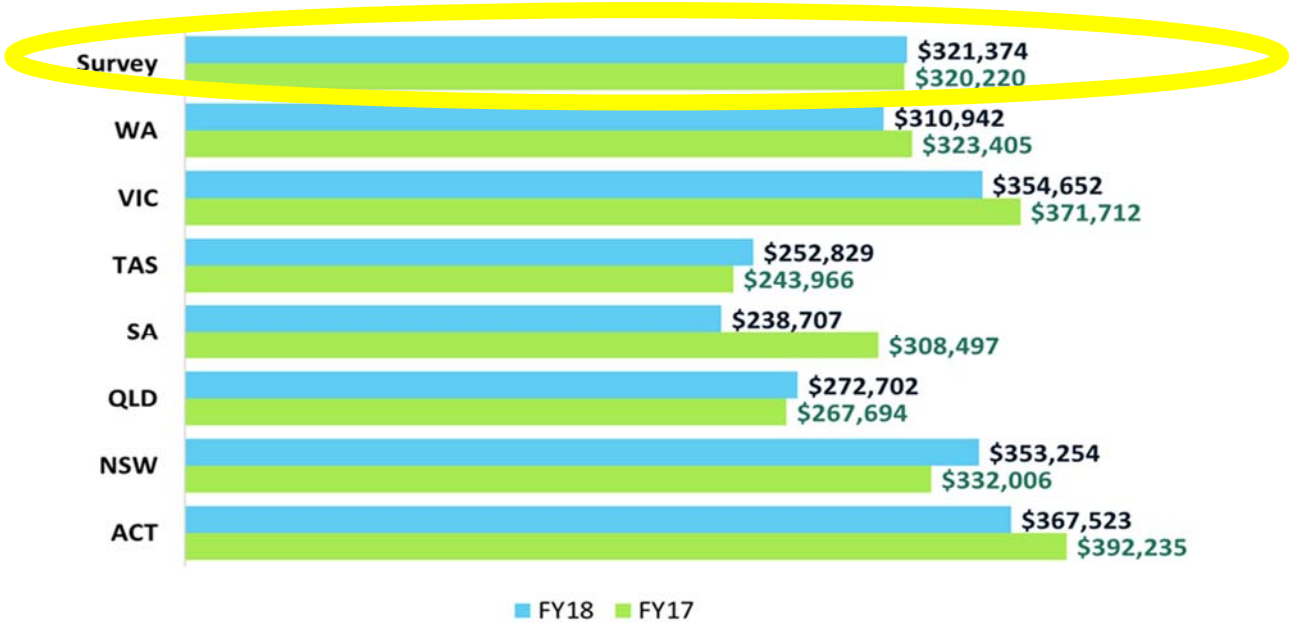
Depreciation charge $pbpa for WDV of $200,000 per bed at 4%	**$8,000**
Depreciation charge $pbpa for new build of $325,000 per bed at 4%	**$13,000**

Accommodation Pricing

There has been a marginal increase in accommodation pricing for FY18. The amount of Refundable Accommodation Deposits (RADs) received during the period increased by a national average of $1,130 (0.35%). The increase in the percentage of new residents paying a Daily Accommodation Payment (DAP) rather than a RAD has been a contributing factor.

Accommodation pricing is an important component for the sustainability of a residential facility. It is a revenue benefit (DAP) or a capital benefit (RAD) depending upon the equity position of the organisation.

Figure 9 : Average Refundable Accommodation Deposits Received for FY18 and FY17

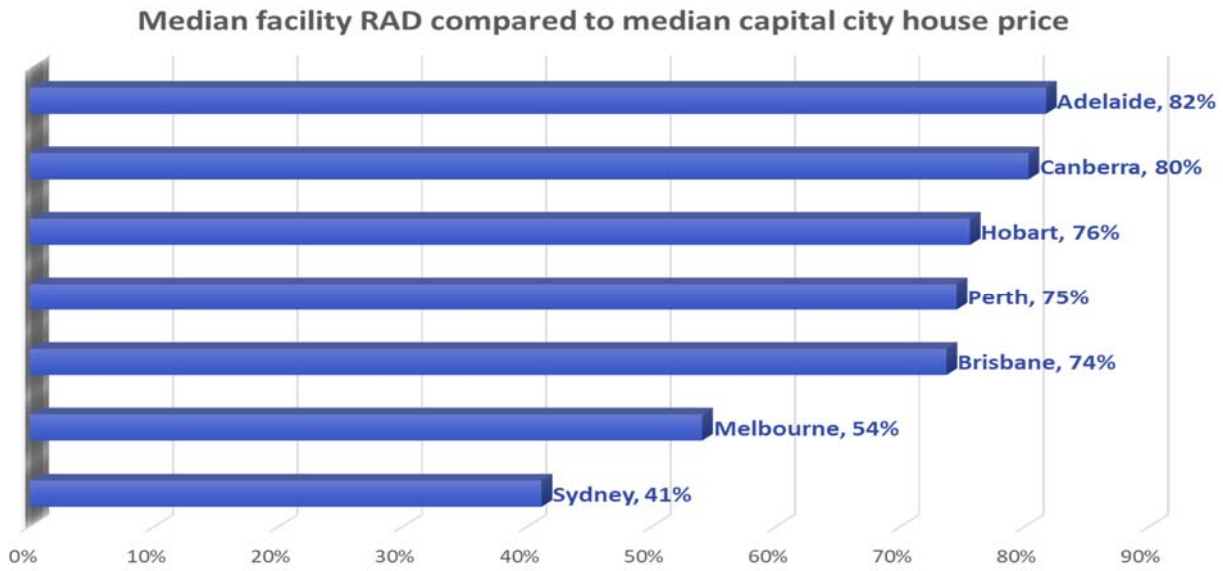


It seems likely that there is still confusion from a consumer perspective in relation to accommodation pricing and this has resulted in providers not having an effective accommodation pricing strategy. The acuity (care needs) of a resident is directly related to the ACFI funding and expenditure. Everyday living expenses are offset against the Basic Daily Fee and additional services (if charged).

Accommodation pricing is not assessed on care needs but on the standard of accommodation and the financial ability of an incoming resident to meet the price through either a RAD, DAP or a combination of both. The consumer expectation that the standard of accommodation, and accordingly, the pricing is relative to direct care provided is somewhat misconstrued. A higher accommodation price does not equate to a higher standard of direct care.

Accommodation pricing strategies should be more targeted to the local house or unit prices in the geographic area. The table below indicates that there is a disparity in this relationship, particularly in Sydney and Melbourne.

Figure 10: Median Advertised RAD compared to Median House Price

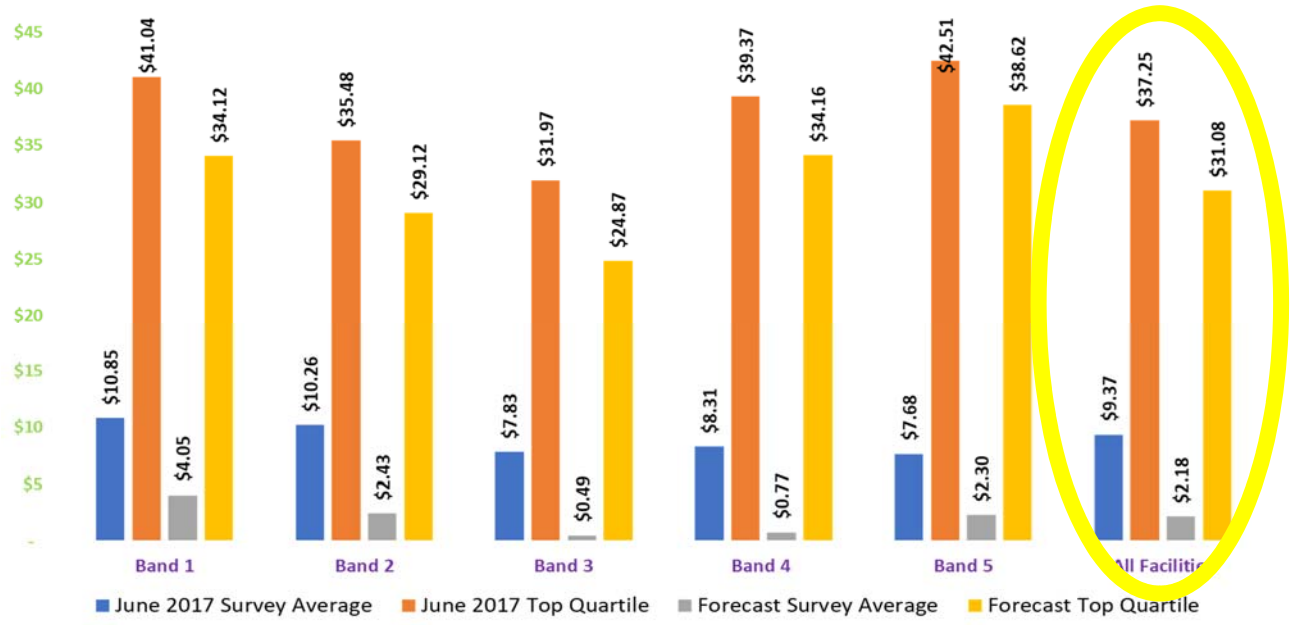


5. RESIDENT CARE - FINANCIAL SUSTAINABILITY

Recap - FY18 Forecast

As background, StewartBrown performed a forecast of the FY18 facility results In October 2017 based on the COPE freeze of ACFI funding, changes in the ACFI assessment and a similar set of assumptions as now used for the FY19 forecast. An extract from the FY18 forecast is below:-

Figure 11: FY18 Residential Care Forecast (Facility Result)



Commentary

The FY18 forecast for the Survey *Average* was $2.18 per bed day (actual FY18 $2.37 pbd) and for the Survey *First 25%* was $31.08 pbd (actual FY18 $30.26 pbd).

This suggests that whilst it was clear early in the FY18 fiscal year that the operating performance was going to deteriorate because of underlying funding and cost increase pressures, the ability of facilities (in all revenue domains and geographic locations) to adjust their business models to minimise this financial effect was negligible. Similar implications will exist in the FY19 financial results.

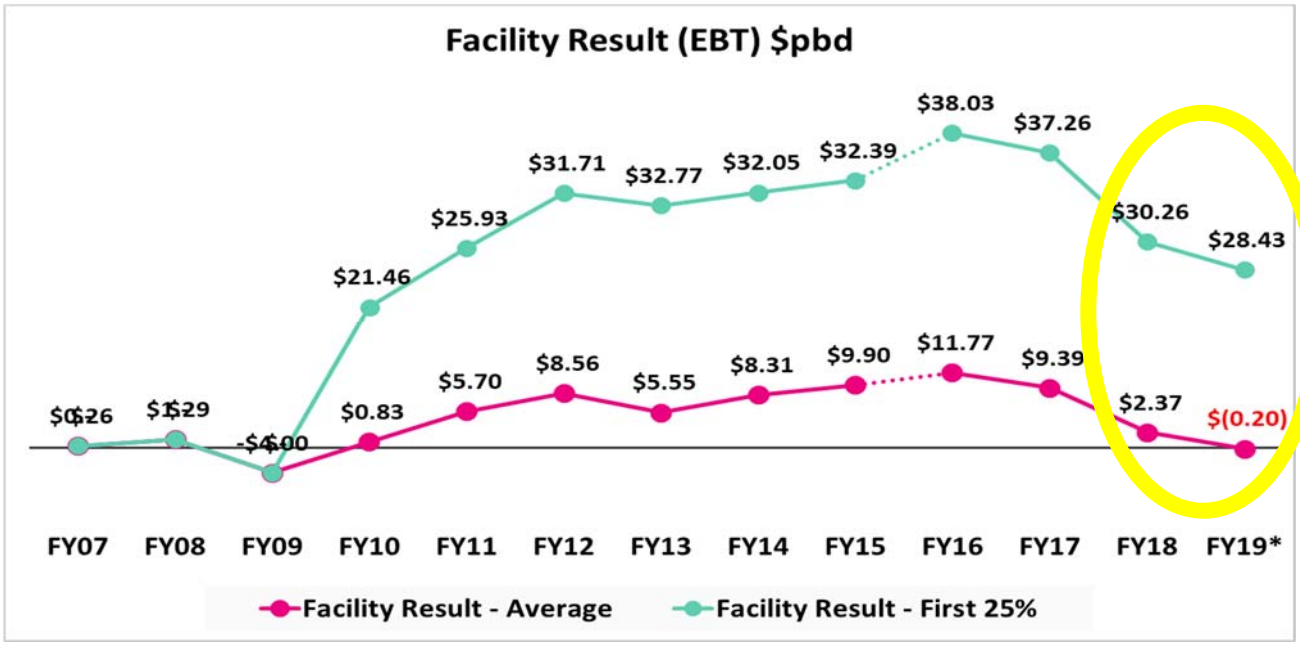
FY19 Residential Care Forecast

Forecast Assumptions

We have calculated the projected Facility Results for FY19 using the following assumptions:

- ✓ Based on FY18 actual Facility Results
- ✓ Adjusted for ACFI inflation of 1.17% on average *(1.4% ADL; 1.4% BEH and 0.7% CHC)*
- ✓ Adjusted for increase of $0.35 per bed day (average) for additional optional services
- ✓ Adjusted for other revenue increases in line with pension/ CPI increase
- ✓ Adjusted for Wage increases of 3.0%
- ✓ Depreciation assumed to remain stable
- ✓ Adjusted for other expenditure increases at CPI of 2.1%

Figure 12: FY19 Residential Care Forecast (Facility Result)



Commentary

As at FY18 the EBITDAR pbpa for the Survey *Average* was $6,760, therefore, the impact of a facility operating deficit of $0.20 per bed day (keeping all else constant) is:-

- A reduction of Facility EBT per bed per annum from $816 to a deficit of $69 per bed per annum and;
- A reduction of Facility EBITDAR from $6,760 per bed per annum to $5,491 per bed per annum

If the above FY19 projections become a reality, then the financial viability of a considerable number of residential care facilities will come under scrutiny. This may necessitate the review of the effective life of assets resulting in asset impairment charges and/or higher depreciation charges in the financial statements of organisations with the effect of reducing the carrying value of the asset base thus increasing losses.

Impact of FY19 Projections - Increase in Number of Facilities with Negative Results

The below table projects the number of facilities that could transition into having EBT and EBITDAR losses should the FY19 projections be realised. A comparison to FY17 and FY18 is included.

Table 8: FY19 Projection Number of Facilities with EBT and EBITDAR deficits

	FY17 %	FY18 %	FY19* %		FY17 No.	FY18 No.	FY19* No.
% of facilities with negative facility EBT by remoteness							
Major Cities	30.2%	41.5%	45.3%		187	262	286
Inner Regional	36.1%	47.2%	52.8%		87	116	130
Outer regional, remote & very remote	52.1%	63.5%	65.6%		50	61	63
Survey	**33.9%**	**45.1%**	**49.2%**		**324**	**439**	**479**
% of facilities with negative facility EBITDAR by remoteness							
Major Cities	12.6%	18.0%	21.8%		78	114	138
Inner Regional	13.3%	22.4%	28.0%		32	55	69
Outer regional, remote & very remote	25.0%	37.5%	42.7%		24	36	41
Survey	**14.0%**	**21.0%**	**25.5%**		**134**	**205**	**248**

Future Financial Sustainability

A number of significant issues need to be considered when assessing the future funding model that is required to meet the requirements of a sector that is experiencing considerable resource pressures.

Whilst residential care has some clear financing issues that should be addressed as a priority, it should be noted that the Home Care Packages Program (HCP), Commonwealth Home Support Programme (CHSP) and Veterans Home Care Program (VHC) amongst a number of similar community programmes must also be considered in relation to the future funding models.

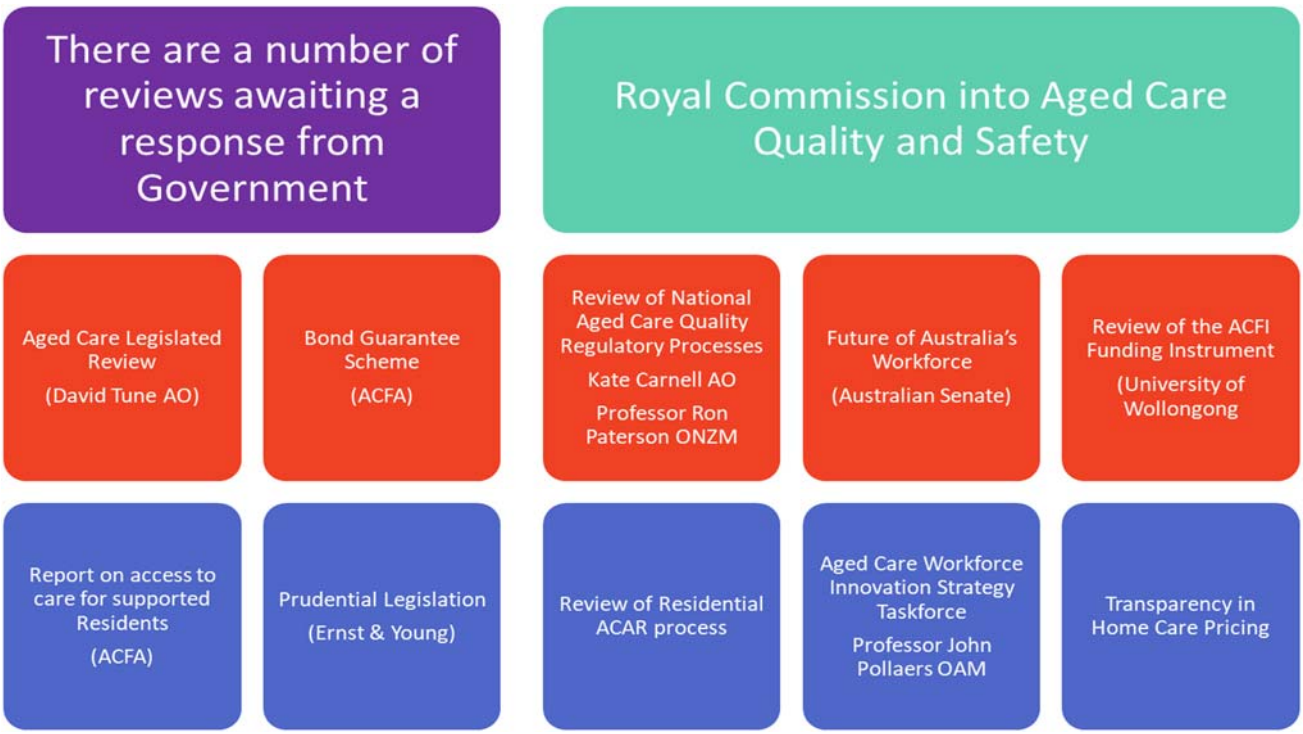
For the purpose of this brief analysis we are making specific comment on the Residential Care and HCP segments.

Current Reforms

The future sustainability of the sector will be dependent upon the impact of impending reforms and initiatives.

The graphic below summarises the current reforms that are progressing within the sector. Individually each reform has considerable importance and support, however, the sector has undergone considerable reforms dating back to 1997 (*Aged Care Act*) which have compounded the administrative and governance burden and affect strategic decisions due to uncertainty.

Figure 13: Summary of Current Aged Care Sector Reforms



Issues to be Considered

Specific areas that will need to be considered in developing a financially sustainable aged care sector include:-

Residential Care

- ACFI Funding - review the quantum of inflation (COPE) increases together with a stronger relationship between the funding instrument and actual resident care needs
- Additional funding is required for the Behaviour (BEH) and Complex Health Care (CHC) CFI domains due to the increased number of residents with dementia or other behaviour attributes, and with greater numbers of residents requiring palliative care and having almost sub-acute health conditions
- Rural, Remote and Very Remote facilities will require a range of specific funding initiatives and support
- Workforce strategies, including retention, career development, staffing levels, remuneration and conditions
- Additional and Optional Service Fees - clearer regulatory guidance, move toward the deregulation of Basic Daily Fee and targeted funding for supported residents
- Accommodation Pricing - consumer education as to what is included in accommodation pricing, providers to increase the pricing and with an emphasis on a receiving a greater percentage of combination (RAD and DAP) receipts
- Innovation to be supported and encouraged at regulatory and legislative level
- Enhancement of My Aged Care functionality and portability
- Clearer and defined legislative and regulatory environment

Home Care

- National Prioritisation Queue and waiting lists - funding initiatives to reduce the size of the prioritisation queue and reduce the length of time from consumer funding approval to the funding being provided
- Pricing Transparency - ensure that it does not disadvantage providers or consumers and allows for care and business model innovation
- Pricing and Service Delivery - more clarity and flexibility in relation to provision of service guidelines
- Quality Audits - enhanced monitoring and appropriate responses to non-conformance
- Unspent Funds - clearer definition around use of unspent funds and possible redistribution of underutilised funds to other consumers on wait lists (dependent on assessment of composition of unspent funds)
- Consumer Education - greater focus on providing increased consumer (and provider) education
- Enhancement of My Aged Care functionality and portability
- Clearer and defined legislative and regulatory environment
- Integration of CHSP and HCP programs (as appropriate)

General

- Better targeted consumer education on the journey through the aged care system from seniors housing, through funded services
- Greater level of congruence between State regulatory environment for Retirement Villages and to provide an easier transition from senior's housing to residential care
- Education and guidance on Governance for aged care providers

6. HOME CARE ANALYSIS

Overview

The home care packages (HCP) sector has also experienced a significant decline in profitability with revenue and overall EBT per client day declining in both the Survey *Average* and Survey *First 25%* quartile. This result was compounded by an increase in unspent funds (revenue utilisation) per client and in aggregate.

The overall Survey *Average* EBT result was a surplus of $3.77 per client day (FY17 $5.37 pcd) with Band 4 (highest acuity mix) have the greatest decline from $12.51 pcd to $8.29 pcd. The Survey *First 25%* also had a reduction in surplus to $17.17 pcd (FY17: $25.03 pcd).

Revenue

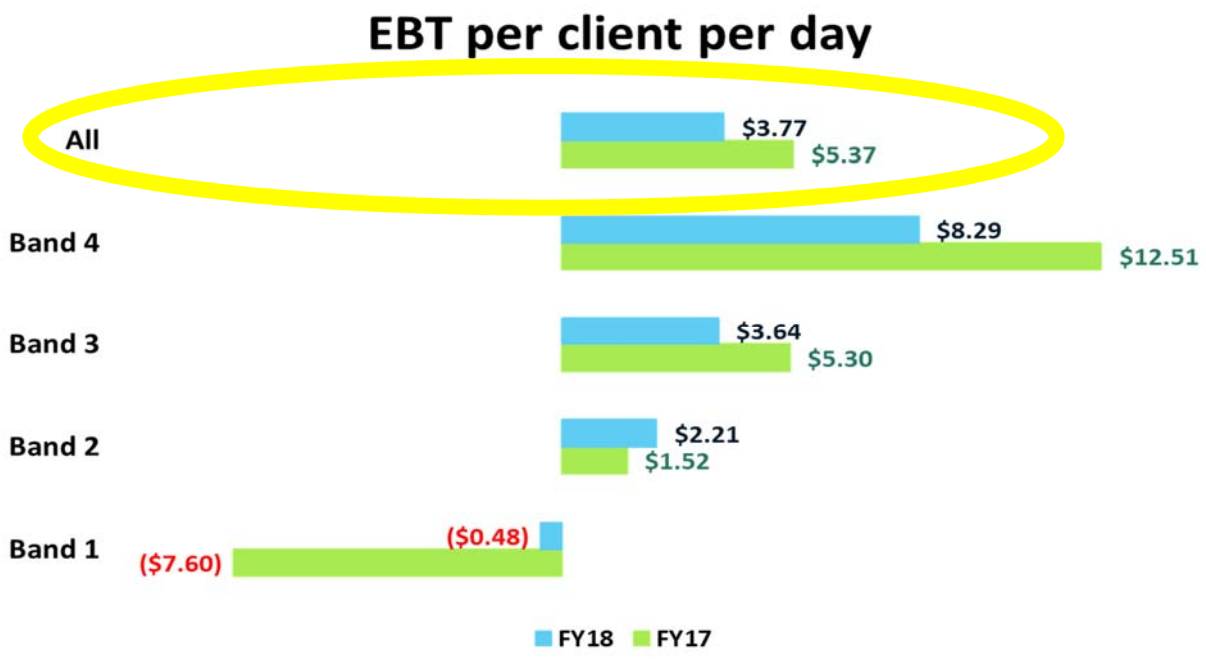
- Decreased by 6.1%
- Pricing pressure due to increased competition
- Lower revenue utilisation
- Higher unspent funds

Expenses

- Decreased by 4.2%
- Direct service costs increased by $1.39 pcd
- Cost of direct service and brokered/sub-contracted as a percentage of total income has increased to 61% from 55% (FY17)
- Decrease in case management and advisory $1.32 pcd (reduction in staff costs)
- Decrease in administration costs of $2.98 (mostly reduction in corporate recharge and staff costs)

For both the Survey *Average* and *First 25%* the profitability declines were in Bands 3 and 4, whilst Bands 1 and 2 had slight increases. The majority of the programs in the Survey are in Band 3 (52%).

Figure 14: Comparison of Survey Average EBT (operating surplus) FY18 and FY17



Snapshot

Profitability

6.1%
Decline in revenue

86.7%
Revenue utilisation compared to 92.3% in FY17

4.2%
Decline in Expenses

$3.77
EBT per client per day compared to average of $5.37 in FY17

$17.77
EBT per client per day for First 25% down from $25.03 in FY17

Client Profile

Average Age

	2018	2017
Level 1	81.8	73.5
Level 2	83.5	82.8
Level 3	82.8	82.7
Level 4	84.0	83.0

(Years)

Average Length of Stay

	2018	2017
Level 1	2.2	1.4
Level 2	2.2	2.0
Level 3	1.4	1.6
Level 4	1.9	1.4

(Years)

Client Exits

225
Data received from 225 home care programs.

7,928
Total client exits in data set

45%
Exited to residential care 30% in FY17

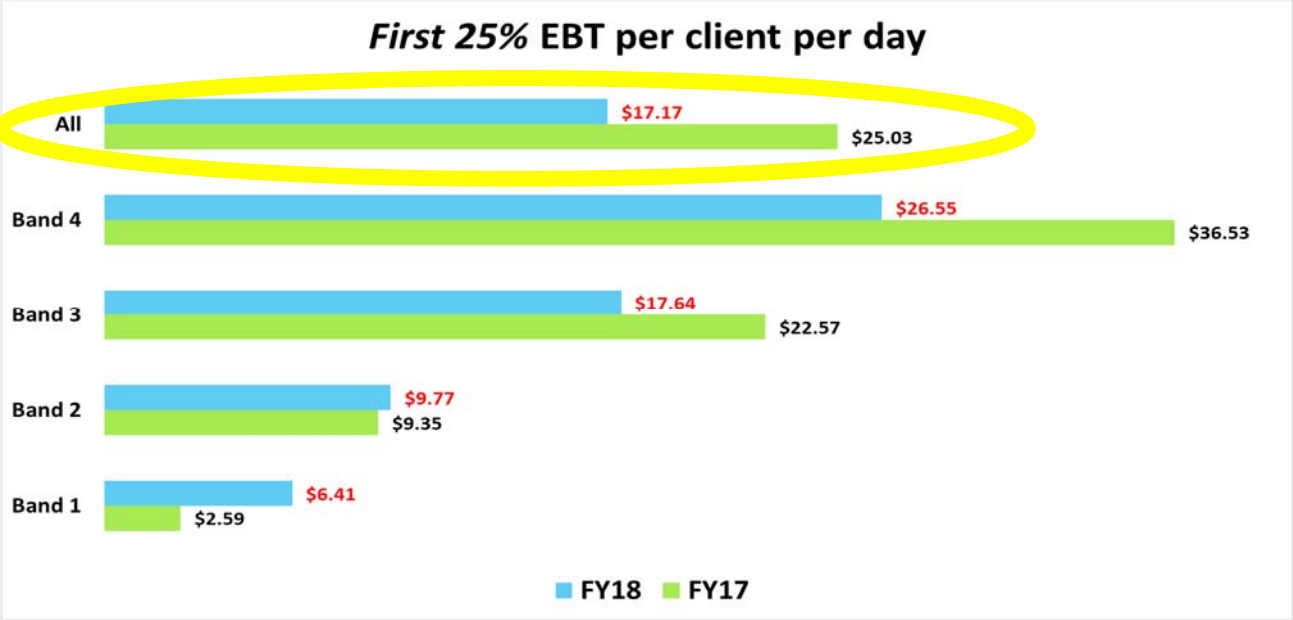
9%
Exited to other home care providers 4% in FY17

45%
Exited system as a result of passing or other reason
66%in FY17

EBT for Survey *First 25%*

The EBT performance of the Survey *First 25%* for FY18 declined to an even greater extent than the Survey *Average* with the effects of the reduced prices, revenue utilisation and increased administration costs being the predominant reasons.

Figure 15: Comparison of Survey First 25% EBT (operating surplus) FY18 and FY17



Sector Data (GEN)

- Additional 373 approved home care providers since Jun-16 (869 in total as at 30 June 2018)
- Post deregulation - growth since Mar-17 to Mar-18 is 23% (176 providers)
- Additional 20,902 consumers since Jun-16 (at Mar-18 is 84,971 consumers)
- Post deregulation - growth since Mar-17 to Mar-18 is 20% (14,392 consumers)
  - More than 7,000 home care consumers in the Dec-17 to Mar-18 quarter!
- 64,688 queued either in or assigned a lower level package and 56,750 not in or assigned a lower level package as at 30 June 2018 (121,438 in total in national prioritisation queue)

Figure 16: Number of Home Care Providers

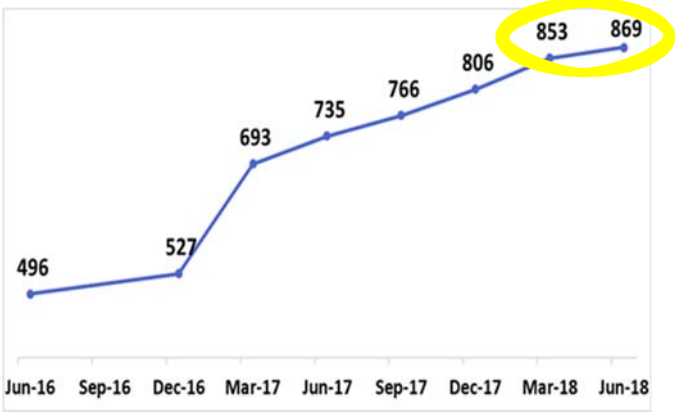
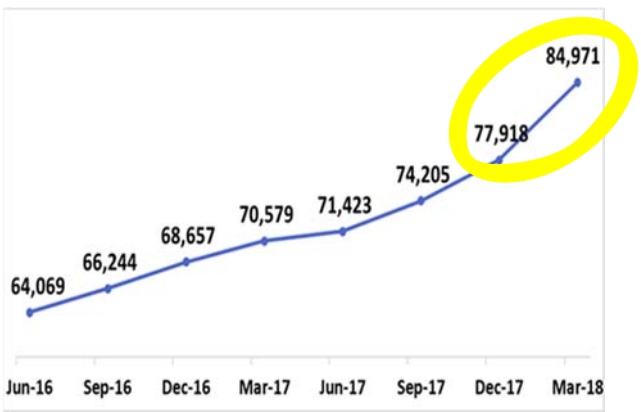


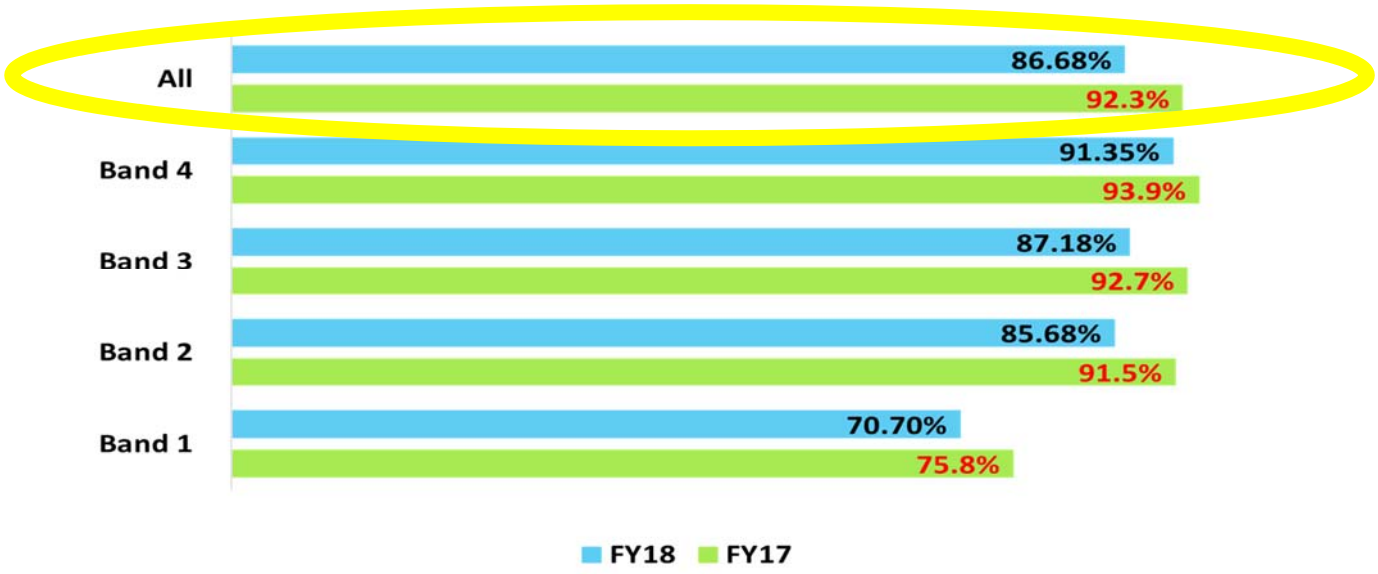
Figure 17: Number of Home Care Consumers



Revenue Utilisation

There has been a considerable decrease in revenue utilisation during the year. This has affected the profitability as the fixed costs have been spread over lower revenues and some of the variable (staff costs) are difficult to defray in a short time period. The improvement in revenue utilisation must be a major priority for FY19.

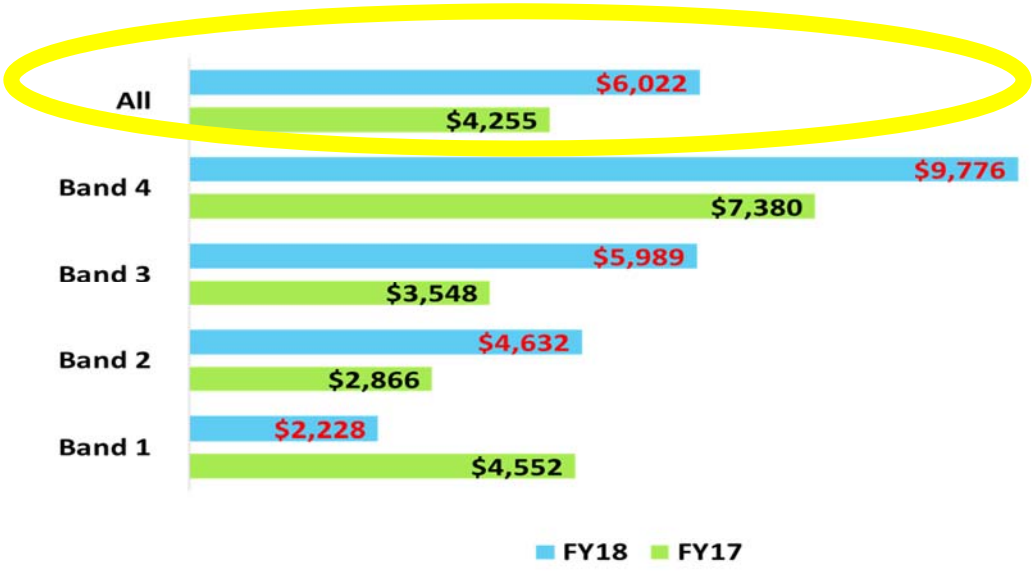
Figure 18: Revenue Utilisation comparison for FY18 and FY17



Unspent Funds

The resultant effect of decreased revenue utilisation is the increase of unspent funds for each client. ACFA estimated the unspent funds liability for FY17 to be $319 million and this is likely to be over $400 million as at FY18 year-end. This represents subsidy funds, by majority, that if not being utilised for direct care delivery could be diverted into those consumers on the national prioritisation queue that do not yet have funding provided.

Figure 19: Average Unspent Funds per Client



Staff Hours Worked per Client

The average direct care hours per client per week have declined from the levels in FY17. This is partly due to lower available package revenue as a direct result of the increased unspent funds.

Notably, there is a decrease in administration and support service hours. Many providers are making a concerted effort to improve efficiencies in this area to reduce costs.

Table 9: Home Care Staff Hours per Client per Day

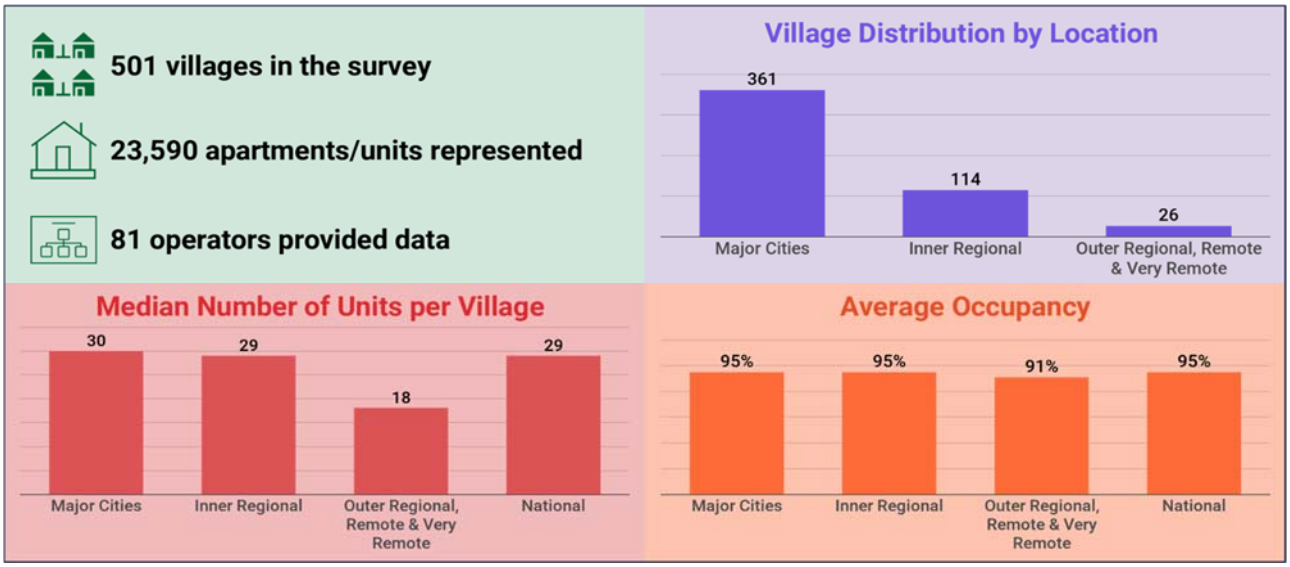
	Average			First 25%		
	FY18	**FY17**		**FY18**	**FY17**	
Direct service provision	5.15	5.31	↓	6.31	7.48	↓
Agency	0.22	0.44	↓	0.15	0.77	↓
Case management & advisory	0.87	0.83	↑	1.31	0.94	↑
Administration & support services (including co-ordination)	0.46	0.58	↓	0.68	0.46	↑
Total Staff Hours	**6.69**	**7.16**	↓	**8.44**	**9.66**	↓

7. RETIREMENT VILLAGES

Snapshot

The FY18 Survey was expanded to now include data collection in relation to the Retirement Village (Seniors Housing) segment. Seniors housing is merging into the aged care sector due to the average age of entry increasing and the corresponding requirement for residents to have access to domestic and care services when required.

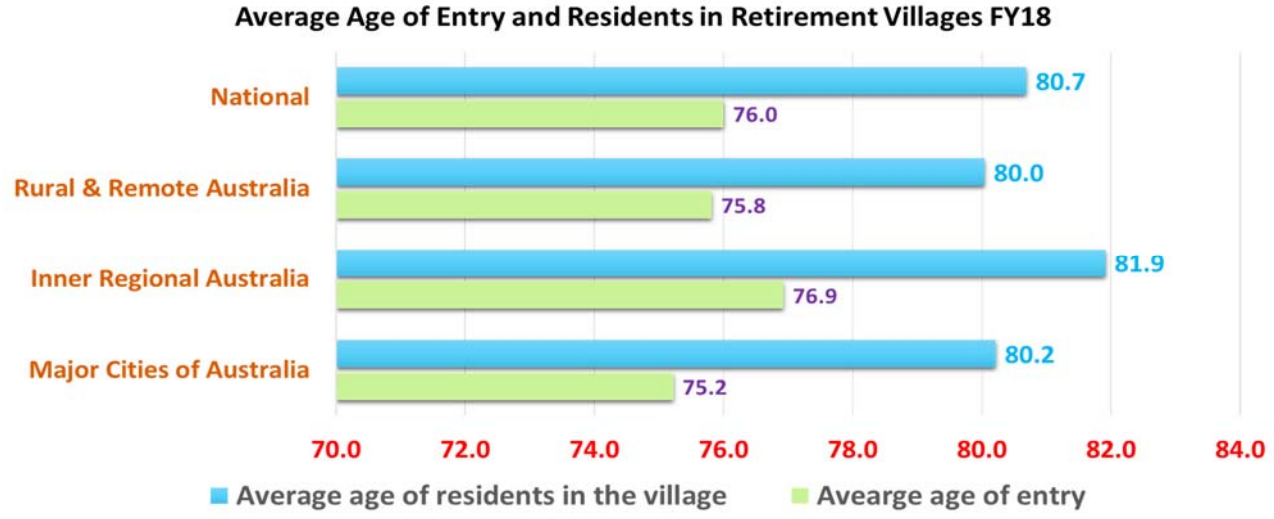
Figure 20: Retirement Village Survey Data Analytics



Average Age of Entry

Retirement villages were established as "over 55's housing" and many providers offered "lifestyle" retirement accommodation. The average age of entry has been progressively increasing over time which has changed the service offering provided. The figure below shows the average age of entry and current residents.

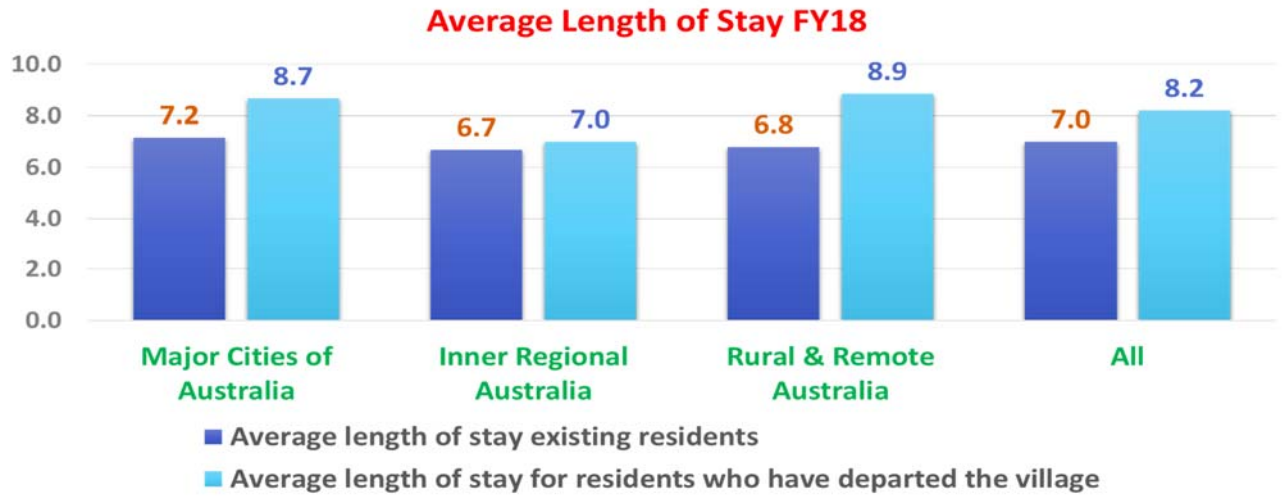
Figure 21: Average Age of Entry and Average Current Age of Retirement Village residents



Average Length of Stay

As would be expected with the increasing average age of entry, the average length of stay has decreased. The graphic below shows the average length of stay for existing and departed residents in the FY18 Survey.

Figure 22: Average Length of Stay for Existing and Departed residents



8. APPENDIX A - GLOSSARY

Accommodation Result
Accommodation Result is the net result of accommodation revenue (DAPs/DACs/Accommodation supplements) and expenses related to capital items such as depreciation, property rental and refurbishment costs. It no longer includes costs associated with recurrent repairs and maintenance and motor vehicles.

ACFA
Aged Care Financing Authority - the statutory authority which provides independent advice to the government on funding and financing issues, informed by consultation with consumers, and the aged care and finance sectors.

ACFI revenue
Aged Care Funding Instrument (ACFI) revenue includes the subsidy received from the Commonwealth and the means-tested care fee component levied to the resident. ACFI revenue includes the additional care supplement subsidies and some specific grant (not capital) funding.

ACFI Result
ACFI Result represents the net result from revenue and expenses directly associated with care. It includes ACFI and Supplements (including means-tested care fee) revenue less total care expenditure, and this includes an allocation of workers compensation and quality and education costs.

Administration Costs
Administration Costs includes the direct costs related to administration and support services and excludes the allocation of workers compensation and quality and education costs to ACFI and Everyday Living.

Averages
For residential care all *averages* are calculated using the total of the raw data submitted for any one-line item and then dividing that total by the total occupied bed days for the facilities in the group. For example, the average for contract catering across all facilities would be the total amount submitted for that line item divided by the total occupied bed days for all facilities in the survey.

For home care all *averages* are calculated using the total of the raw data submitted for any one-line item and then dividing that total by the total client days for the programs in the group. For example, the average for sub-contracted and brokerage costs across all programs would be the total amount submitted for that line item divided by the total client days for all programs in the survey.

***Average* by line item**
This measure is *average*d across only those facilities that provide data for that line item. All other measures are *average*d across all the facilities in the particular group. The *average* by line item is particularly useful for line items such as contract catering, cleaning and laundry, property rental, extra service revenue and administration fees as these items are not included by everyone

Bed day
The number of days that a residential care place is occupied in the Survey period. Usually represents the days for which an ACFI subsidy or equivalent respite subsidy has been received.

Benchmark
We consider the benchmark to be the average of the *First 25%* in the group of programs being examined. For example, if we are examining the results for facilities/ programs in Band 4, then the benchmark would be the average of the *First 25%* of the facilities/ programs in Band 4.

Care Result
This is the element of the facility result that includes the direct care expenses and everyday living costs and administration and support costs. It is calculated as ACFI Result *plus* Everyday Living Result *minus* Administration Costs.

Dollars per bed day
This is the common measure used to compare items across facilities. The denominator used in this measure is the number of occupied bed days for any facility or group of facilities.

Dollars per client day
This is the common measure used to compare items across programs. The denominator used in this measure is the number of client days for any programs or group of programs.

EBIT
Earnings Before Interest (including investment revenue) and taxation. This is a measure that excludes those variables relating to the tax status and financial position of an entity but recognises the consumption of capital in the form of depreciation and amortisation.

EBITDAR
This measure represents earnings before interest (including investment revenue), taxation, depreciation, amortisation and rent. The calculation excludes interest (and investment) revenue as well as interest expense on borrowings.

The main reason for this is to achieve some consistency in the calculation. Different organisations allocate interest and investment revenue differently at the "facility level". To ensure that the measure is consistent across all organisations we exclude these revenue and expense items.

EBITDAR per bed per annum

Calculation of the overall Facility EBITDAR for the financial year divided by the number of operational beds in the facility.

EBT
Earnings before tax. This may also be referred to as the net result or, in the residential facility analysis, as the facility result.

Facility EBITDAR
The starting point for this calculation is the Facility Result which is the combination of the Care and Accommodation results. It excludes all "provider revenue and expenditure" including fundraising revenue, revaluations, donations, capital grants and sundry revenue. It also excludes those items excluded from the EBITDAR calculation above. This measure is more consistent across the facilities because it excludes all those items which are generally allocated at the facility level on an inconsistent and arbitrary basis depending on the policies of the individual provider.

*** The previous metric of Provider EBITDA is no longer included in the reporting as it is not considered to be a key indicator of facility performance.*

Everyday Living Result
Revenue from Basic Daily Fee plus Extra or Optional Service fees less Hotel Services (catering, cleaning, laundry), Utilities, Motor Vehicles and regular Property & Maintenance (includes allocation of workers compensation premium and quality and education costs to hotel services staff)

Facility Result
Combination of the Care and Accommodation Results. It excludes revenue from fundraising, investments, sundry revenue and fair value adjustments.

***First 25%* - Residential Care and Home Care Packages (HCP)**
The Residential Care and Home Care results (EBT) are distributed for the Survey period from highest to lowest in terms of $ per bed/client per day ($pd). This is then divided into four quartiles - the first 25%, second 25%, third 25%, fourth 25% and the average of each quartile is reported. The *First 25%* represents the quartile of programs with the highest EBIT $pd, the second 25% represents the quartile with the second highest EBIT $pd, the third 25% represents the quartile with the third highest EBIT $pd, whilst the fourth 25% represents the quartile of programs with the lowest (fourth highest) EBIT $pd.

Location - City
Facilities have been designated as being city based according to the designation by the Department of Health in their listing of aged care services. Those that were designated as being a “Major City of Australia” have been designated City.

Location - Regional
Facilities have been designated as being regionally based according to the designation by the Department of Health in their listing of aged care services. Those that were designated as being an “Inner Regional”, “Outer Regional” or “Remote” have been designated as Regional.

Survey
Survey is the abbreviation used in relation to the *Aged Care Financial Performance Survey*.

CONTACT DETAILS

For further analysis of the information contained in the Survey report please contact our specialist analyst team at StewartBrown.

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StewartBrown

Integrity + Quality + Clarity

Aged Care Financial Performance Survey

Sector Report

(Six months ended December 2018)

The StewartBrown December 2018 *Aged Care Financial Performance Survey* incorporates detailed financial and supporting data from over 965 residential care facilities and over 27,164 home care packages (503 home care programs) across Australia. The quarterly survey is the largest benchmark within the aged care sector and provides invaluable insight into the trends and drivers of financial performance at the sector level and at the facility or program level.

CONTENTS

1. HIGHLIGHTS

Key Results From December 2018 Survey

Survey includes data from:

965 residential aged care facilities
37% of facilities represented in the survey

27,164 home care packages
30% of operational packages represented in the survey

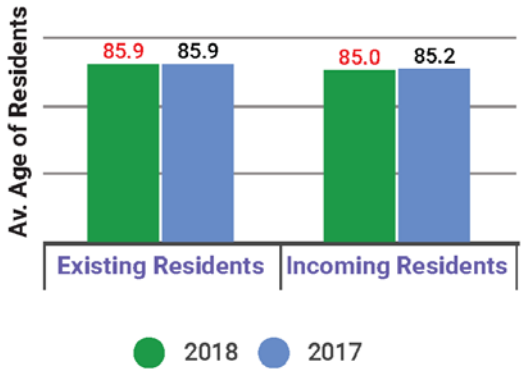
175 approved providers

Organisation Results

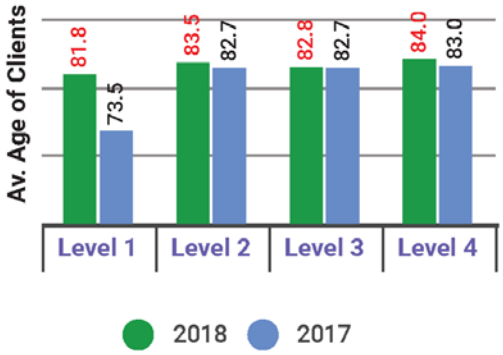
1.02%
EBITDA Return on Assets

(0.36%)
Operating Surplus Return on Assets

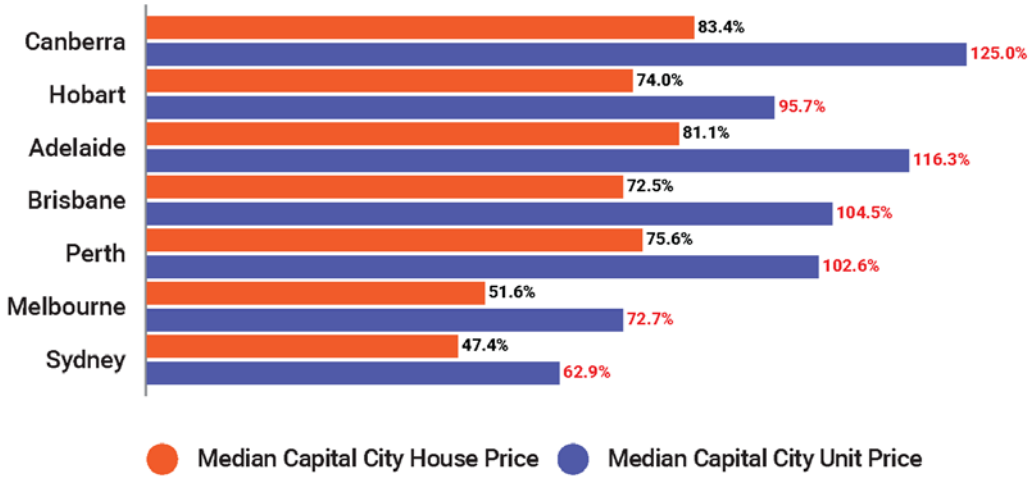
Residential Aged Care



Home Care



Median Published Accommodation Price Comparison to Housing Market



Residential Aged Care

$3.20

EBT per bed day for Survey *Average*
(Dec-17: $4.70)

$32.40

EBT per bed day for *First 25%*
(Dec-17: $34.73)

$7,391

EBITDAR per bed per annum for Survey *Average*
(Dec-17: $7,466)

$17,279

EBITDAR per bed per annum for *First 25%*
(Dec-17: $17,860)

19.5%

Proportion of facilities with negative EBITDAR
(Dec-17: 19.8%)

42.3%

Proportion of facilities with negative EBT
(Dec-17: 41.3%)

Home Care

$3.33

EBT per client day for Survey *Average*
(Dec-17: $3.24)

$18.04

EBT per client day for *First 25%*
(Dec-17: $18.98)

$1,373

EBITDA per client per annum for Survey *Average*
(Dec-17: $1,328)

$6,763

EBITDA per client per annum for *First 25%*
(Dec-17: $7,141)

$6,827

Survey *Average* for unspent funds
(Dec-17: $5,412)

88.9%

Survey *Average* revenue utilisation
(Dec-17: 87.6%)

9.9%

Case management costs as % of income
(Dec-17: 10.6%)

24.2%

Administration costs as % of income
(Dec-17: $24.9%)

Survey Analytics

Subscribers to the *Aged Care Financial Performance Survey* (Survey) include some of the largest providers nationally, independent stand-alone providers, faith-based and community providers, culturally specific providers, as well as government bodies including the Department of Health (DOH) and Aged Care Financing Authority (ACFA), and aged services sector peak bodies and other service providers to the sector.

The December Survey encompasses residential care and home care packages including a detailed analysis of the operating income and expenses of participants and a review of the financial position of organisations providing aged care services. The Survey covered the following participation:-

- 175 approved provider organisations
- 965 residential facilities *(41 additional facilities were excluded due to their operational circumstances)*
- 27,164 home care packages
- Comparisons with 3 listed aged care entities (Estia/Japara/Regis)

In respect of residential care, participants to the Survey represent approximately 40% of facilities within Australia. The profile of the residential care participants, based on the geographical spread, is:-

Table 1: Residential Care Survey Metrics

Number of Residential Facilities / ABS Remoteness	Major City	Inner Regional	Outer Regional, Remote & Very Remote	Total
StewartBrown Residential Care Survey				
Facilities included	626	245	94	965
Facilities excluded	26	9	6	41
Total Survey facilities	**652**	**254**	**100**	**1,006**
GEN Aged Care Data Service Listing (30 June 2018)				
Total (A)	1,680	647	368	2,695
State/local government	34	114	92	240
Service Listing less state/local government (B)	**1,646**	**533**	**276**	**2,455**
Coverage - % of (A)	*38.8%*	*39.3%*	*27.2%*	*37.3%*
Coverage - % of (B)	*39.6%*	*47.7%*	*36.2%*	*41.0%*

StewartBrown Aged Care Reports

StewartBrown issues various detailed financial reports and analysis involving the aged care sector, including the following:-

- Residential and Home Care Sector Reports (quarterly)
- Aged Care Sector Report (quarterly)
- Provider Organisation Report (bi-annual)
- Listed Provider Analysis Report (bi-annual)
- Corporate Administration Report (every second year)
- Managing Prudential Risk in Residential Aged Care (submission to DOH)

Copies of these reports are located at http://www.stewartbrown.com.au/

2. EXECUTIVE SUMMARY

Abstract

This Sector Report provides an overview of the financial performance of the aged care sector in Australia based on the results of the StewartBrown *Aged Care Financial Performance Survey* for the six months to 31 December 2018. This Report is focused at the organisation level of providers in the aged care sector and the average performance achieved by participants to the Survey. Supplementary reports on the Residential and Home Care results are also issued to participant and they include greater granularity in analysis from a benchmarking viewpoint. Individual participants also receive specific comparative data relevant to their location, size and specific facilities within their organisation, including access to an inter-active website.

What the Survey highlights is that the financial performance of the aged care sector continues to experience significant challenges due to a continued decline in profitability in both the residential care and home care segments and this creates challenges for the long-term financial sustainability of the sector. Similar funding challenges exist in the provision of services involving the Commonwealth Home Support Program (CHSP) and Veterans Home Care program (VHC).

To some degree, this has been acknowledged by the Government by a $320 million one-off funding boost that will be received by residential care providers in the period 20 March 2019 to 30 June 2019. ACFI and other basic subsidies will be increased by approximately 9.5% for that period. Subsidy rates will revert back to the pre-20 March levels for COPE indexing purposes from 1 July 2019. While this will be welcomed by all residential care providers, it will not repair the underlying issues relating to the viability of residential care facilities in the future periods unless the funding model (government and consumer) is enhanced.

Dec-18 Survey Results Summary

The financial performance of the residential care and home care package segments has continued to see a deterioration in their results year on year. A continuation of this decline which began in the 2017 financial year will potentially place a number of residential care facilities in a financially vulnerable position which could impact on the provider organisation's sustainability.

Following is a summary of the key financial performance results and indicators by segment from participants in the Dec-18 *Aged Care Financial Performance Survey*. Comparisons are generally year-on-year (Dec-17) with some analysis against the FY18 results.

Organisation (Approved Provider) - Dec-18 compared to FY18

- Operating EBT Result (*) (average by organisation) reduced by $55k to a deficit of $356k
- Operating EBITDA reduced by $1,449k to an average of $1,000 surplus
- Operating Result expressed as a return on assets employed (ROA) has further reduced from negative 0.14% to negative 0.36%. ACFA total residential care sector FY17 return on assets was 0.8% and is also expected to decline for FY18
- Operating EBITDA (cash surplus) return on assets has further reduced by 0.18% to 1.02% (FY18 1.2%)
- Liquid cash and financial assets as a percentage of debt (RADs and external) has increased by 0.6% to 36.3% (FY18 35.7%). The listed entity ratio increased by 1.6% to 3.2% (FY18 1.7%) (prior to dividends)
  **Operating result excludes non-recurrent revenues and expenses (revaluations/donations/impairment etc)*

Residential Care

- Average ACFI per bed day (pbd) for survey participants has increased by 3.1% to $177.68 pbd (Dec-17 $172.36 pbd
- Occupancy levels for Survey participants remained neutral (94.9% average occupancy)

- Total care hours per resident per day increased by 0.10 hours to 3.16 hours (Dec-17 3.06 hours)
- Direct care costs increased by 4.5% ($144.69 pbd)
- Costs for providing everyday living services exceeded contribution revenue by $7.38 pbd
- *Average* Earnings Before Tax (EBT) for residential facilities reduced by $508 per bed per annum (pbpa) to $1,109 pbpa (Dec-17 $1,617 pbpa)
- *Average* EBITDAR for residential facilities reduced by $75 pbpa to $7,391 pbpa (Dec-17 $7,466 pbpa)
- 42.3% of residential facilities recorded a negative Operating Result (EBT) (41.3% for Dec-17)
- 19.5% of residential facilities recorded a negative EBITDA (19.8% for Dec-17*) (representing a cash loss)*
- 61% of outer regional, rural and remote facilities recorded an EBT loss *(37% recorded a cash loss)*

Home Care Packages

- Revenue per client day (pcd) average for Survey participants increased by 9.6% (being $6.70 pcd)
- Operating Result (EBT) surplus *Average* per client day for Survey participants increased by $0.09 pcd to $3.33 pcd (Dec-17 $3.24 pcd)
- Direct service costs increased by $2.78 pcd (51.0% of total revenue)
- Revenue utilisation (average unspent funds) has improved marginally to 88.9%
- Unspent funds average per client has increased by $1,414 per client (to average $6,827 per client)
- Staff hours per client per week reduced by 0.45 hours (average 6.69 hours per week)
- 46% of clients transitioned to residential care (45% in FY18)
- 12% of clients transferred to another provider (9% in FY18) - the majority being due to change of place of residence

Commentary

The Dec-18 financial results for the sector indicate clearly that the current funding model remains under significant strain. While there have been seasonal improvements in results since FY18, the underlying year-on-year results of both residential care and home care indicates declining financial performance

The residential care financial performance decline continues to be largely revenue related, largely due to the combination of a partial COPE indexation freeze on the CHC domain, the average COPE (inflation) increase of 1.17% not matching CPI, ongoing effects of the amendments to the ACFI scoring matrix, ACFI downgrades and increased costs. Costs have risen as would expected due to Enterprise Agreement staff rate increases, CPI increases for other expenses except for electricity which was well above the underlying inflation rate.

Average ACFI subsidy revenue has increased by $5.32 pbd to $177.68 pbd since Dec-17 mainly as a result of the average COPE increase of 1.17% since June 2018. The last few years have seen ACFI funding plateauing, and this is consistent with the acuity (assessed care) of residents remaining at the same level for the last 2-3 years.

The resultant financial effect is that it is likely that when a resident exits a residential facility they are replaced by an incoming resident with lower assessed needs and, therefore, a lower daily ACFI subsidy (often between $20 - $30 per day lower). The cost structure of residential facilities, which are largely fixed in nature, means that it is difficult to defray the subsidy reduction by a compensating cost reduction, so the profitability is immediately affected.

The impact of the regulatory changes and funding pressures has resulted in the disturbing statistic that 42.3% of residential facilities reported an EBT operating deficit for the six months to Dec-18, and even more disconcerting is that 19.5% of facilities had negative EBITDA (indicating a cash loss from operations). All geographic locations reported a decline, however, the outer regional, rural and remote locations have significant financial concerns.

Direct care staffing hours per resident per day increased from 3.06 hours (Dec-17) to 3.16 hours. Staff costs have risen by $5.57 per bed day since Dec-17. This increase alone is in excess of the average rise of ACFI revenue of $5.32 per bed day. It is clear that the revenue base of residential aged care providers is not keeping pace with the rising costs.

Earnings Before Tax (EBT) for FY18 for residential care averaged $1,109 per bed per annum, which equates to an unsustainable amount of $21.33 per bed per week. This is not sufficient to generate future growth or asset replacement and renewal.

Occupancy levels in residential care facilities increased marginally to 94.9% average occupancy, however the concern is that any facility closures due to financial stress may impact the vulnerable aged requiring high care accommodation.

At an organisational level the *Average* EBT return on assets employed (ROA) was a negative 0.02%. After excluding non-recurrent revenue streams such as revaluations, fair value gains on property and investments, and non-recurrent revenues including donations, the ROA represented a negative return of 0.36%.

The financial viability of outer regional, rural and remote aged care providers is reaching a pivotal point. Over 61% of residential facilities in these geographic locations are operating at a loss, with more than 37% now operating at a cash deficiency. There are few opportunities for existing providers to merge or sell their facilities to larger providers, meaning that remedial funding would be essential in our opinion. This need has been recognised with a substantial increase of 30% to the viability supplement for qualifying facilities.

Accommodation pricing for residential care (Refundable Accommodation Deposits and Daily Accommodation Payments) have not translated into a major equity pipeline. This is due to the number of supported residents (over 47% nationally) and consumer reluctance to pay higher accommodation prices commensurate with the average housing prices. Consumer education in relation to accommodation as distinct from care is required.

For Dec-18 the *Average* surplus from accommodation revenue and accommodation costs (by majority being depreciation and refurbishment) equated to $3,983 per bed per annum. Assuming a new residential bed costs around $300,000 to build and the depreciated bed value (WDV) is currently around $185,000 this is, in itself, not a sustainable return, being less than 2.2% pa for existing facilities and 1.3% for new builds.

However, it should be noted that this accommodation surplus is partly due to generally low depreciation charges (buildings being depreciated over 40+ years with little to no refurbishment factored in). If buildings were depreciated at 4% pa (ie 25 years effective life) which is more realistic, then this would create a reported accommodation deficit rather than a surplus.

In-home care had also experienced a financial performance decline in FY18 with revenues reducing by an average of 6.1% underpinning an overall reduction in profitability of 29.8%. The decline appears to have been somewhat stabilised in the current financial year with the results for the six months to Dec-18 showing a $0.09 increase in the result from Dec-17 to $3.33 per client per day.

Since June 2016 the number of approved providers in home care has increased nationally by 400 (80.6% increase), however the number of funding packages has only increased by 43.4% (from 64,069 packages to 91,847 packages) in the same period.

In conclusion, the aged care sector requires significant investment given that the home care national prioritisation queue (consumers assessed for funding but not yet allocated full funding) has increased by over 32,500 since June 2017 to now being over 121,400, coupled with the estimated 83,000 plus new residential beds being required over the next 10 years to meet the ageing population demands.

For this investment to occur the sector must be financially sustainable which will require all stakeholders to engage in exploring sustainable and robust solutions to the funding and operational business models.

3. ORGANISATION ANALYSIS

This section provides a summary of the six months to Dec-18 financial performance of aged care providers at an organisational level rather than at individual segment or facility level. For the purposes of this analysis, we have included the detailed information provided by 122 organisations who are representative of all states and demographics.

The same provider organisations were used to compare their operating performance for FY18 and FY17.

Operating Results for six months ended 31 December 2018

The following table represents the Survey organisation (approved provider) summary revenue and expenses for the six months ended 31 December 2018 and financial years ended 2017 and 2018. The amounts expressed are the average of the 122 organisations for ease of comparison. The ACFA comparisons are for the 2016 and 2017 financial years and include the residential segment only for the approved providers.

Table 2: Income & Expenditure Comparison (average by organisation)

	Survey Dec-18 (6 months) (Average)	Survey 2018 (12 months) (Average)	Survey 2017 (12 months) (Average)	ACFA 2017 (12 months) (Residential)	ACFA 2016 (12 months) (Residential)	Listed Entities Dec-18 (6 months) (Average)	Listed Entities 2018 (12 months) (Average)
Income & Expenditure	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Revenue							
Operating revenue	27,525	60,144	55,711	18,600	17,460	267,034	500,816
Investment revenue	651	1,817	1,712	348	634	35	136
Other income	337	1,128	1,501	738		582	4,408
Total revenue	28,513	63,089	58,924	19,686	18,094	267,651	505,360
Expenses							
Employee expenses	19,087	41,762	38,136	13,073	11,439	181,948	338,871
Depreciation and amortisation	1,795	4,114	3,781	993	814	12,854	23,578
Finance expenses	212	454	438	190	158	4,046	6,774
Other expenses	7,438	15,934	14,226	4,315	4,564	44,251	81,596
Total expenses	28,532	62,263	56,580	18,571	16,975	243,099	450,819
Surplus (EBT)	**(19)**	**826**	**2,343**	**1,115**	**1,119**	**24,552**	**54,541**
Operating Surplus (Deficit)	**(356)**	**(301)**	**842**	**377**	**485**	**23,970**	**50,133**
Operating EBITDA	**1,000**	**2,449**	**3,349**	**1,212**	**1,192**	**40,835**	**80,349**
Ratios							
EBT return on assets (ROA)	*0.0%*	*0.4%*	*1.2%*	*2.2%*	*2.6%*	*2.9%*	*3.4%*
Operating surplus return on assets (ROA)	*-0.36%*	*-0.14%*	*0.4%*	*0.8%*	*1.1%*	*2.9%*	*3.1%*
Operating EBITDA return on assets	*1.02%*	*1.2%*	*1.7%*	*2.4%*	*2.8%*	*4.9%*	*5.0%*
Operating surplus % of operating revenue	*-1.29%*	*-0.50%*	*1.5%*	*2.0%*	*2.8%*	*9.0%*	*10.0%*
Employee expenses % of operating revenue	*69.3%*	*69.4%*	*68.5%*	*70.3%*	*65.5%*	*68.1%*	*67.7%*
Depreciation as % of property assets	*2.6%*	*2.7%*	*2.8%*	*3.8%*	*3.3%*	*2.7%*	*2.6%*

Brief Commentary

- The Operating Result includes Investment Income and excludes non recurrent Other Income (eg fair value revaluations, donations, fundraising etc). Non-recurrent expenses (such as impairment) have been offset against other income
- The operating result has declined each year since 2016 and was an average deficit by organisation of $356k for the six months ending Dec-18
- The operating result *excluding* investment income was a deficit by organisation of $1,007k for six months ending Dec-18 ($2,118k for FY18)
- ACFA income and expenditure is for the residential care segment only and shows a similar decline for the FY16 and FY17 periods and it is likely the FY18 results will also show a further significant deterioration

Balance Sheet Summary as at 31 December 2018

A summary of the balance sheet (organisation average) as at 31 December 2018 and for the full 2018 and 2017 financial years included in the below table.

Table 3: Summary Balance Sheet Comparison (average by organisation)

	Survey Dec-18 (Average)	Survey 2018 (Average)	Survey 2017 (Average)	ACFA 2017 (Residential)	ACFA 2016 (Residential)	Listed Entities Dec-18 (Average)	Listed Entities 2018 (Average)
Number of organisations	*122*	*122*	*122*	*902*	*949*	*3*	*3*
Number of facilities	*634*	*647*	*638*	*2,672*	*2,669*	*180*	*176*
Number of residential beds	*51,721*	*52,881*	*50,730*	*200,689*	*195,825*	*17,313*	*16,868*
Number of home care clients (packages)	*20,041*	*21,106*	*19,020*	*n/a*	*n/a*	*342*	*320*
Balance Sheet	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Assets							
Cash and financial assets	40,177	43,381	43,782	9,090	5,913	32,190	16,091
Operating assets	6,360	8,008	7,573	8,262	8,488	22,349	18,777
Property assets	137,800	150,969	136,779	26,431	24,899	947,709	913,666
Intangible assets	12,754	8,523	7,406	6,125	3,583	669,769	668,528
Total assets	197,090	210,881	195,539	49,908	42,883	1,672,017	1,617,062
Liabilities							
Refundable loans	102,529	114,711	105,161	27,395	23,047	795,994	763,822
Borrowings	8,279	6,937	6,183	4,969	3,958	206,769	210,696
Other liabilities	15,415	14,358	12,675	4,987	4,344	178,819	150,640
Total liabilities	126,223	136,006	124,019	37,351	31,349	1,181,582	1,125,158
Net Assets	**70,867**	**74,875**	**71,520**	**12,557**	**11,534**	**490,435**	**491,904**
Net Tangible Assets (Liabilities)	**58,114**	**66,352**	**64,114**	**6,432**	**7,951**	**(179,334)**	**(176,624)**
Ratios							
Net assets proportion % total assets	*36.0%*	*35.5%*	*36.6%*	*25.2%*	*26.9%*	*29.3%*	*30.4%*
Property assets proportion % total assets	*69.9%*	*71.6%*	*69.9%*	*53.0%*	*58.1%*	*56.7%*	*56.5%*
Cash + financial assets % refundable loans	*39.2%*	*37.8%*	*41.6%*	*33.2%*	*25.7%*	*4.0%*	*2.1%*
Cash + financial assets % debt	*36.3%*	*35.7%*	*39.3%*	*28.1%*	*21.9%*	*3.2%*	*1.7%*

Brief Commentary

- Net assets and net tangible assets has decreased for the Survey organisations and the listed entities (Estia/Japara/Regis)
- Liquidity percentage (cash + financial assets as a percentage of debt) remains high and indicates a conservative approach to capital reinvestment. *This business model varies significantly from the listed entities where cash and financial assets at 31 December was $32.2m before declared dividend payments (March/April) of $52.7m. This would bring the notional percentage to be negative.*
- The results of the sector indicate that the Operating Result expressed as a Return on Assets employed by organisations is not financially sustainable under the current funding model (refer following page Snapshot)

Organisation Profile

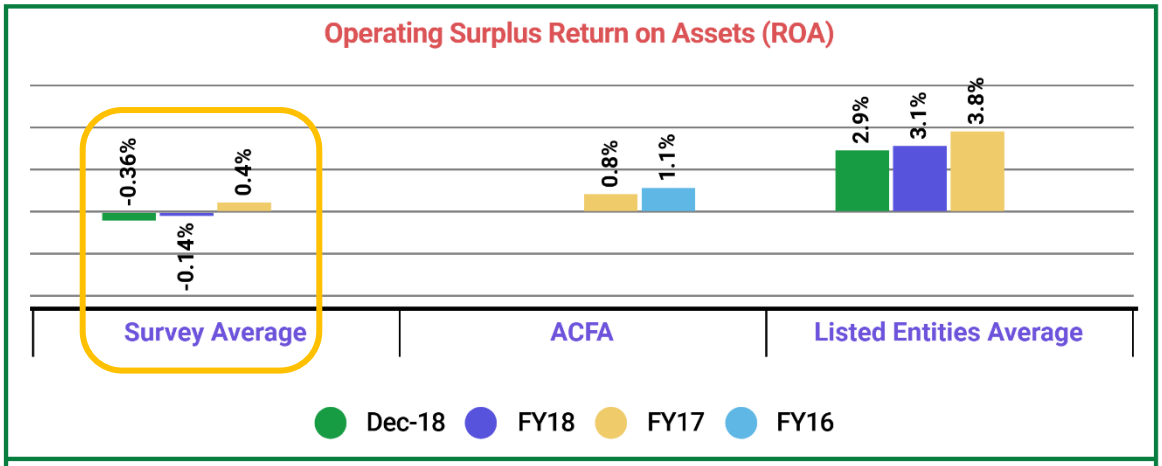
Table 4: Profile of Survey Organisations by Revenue Band

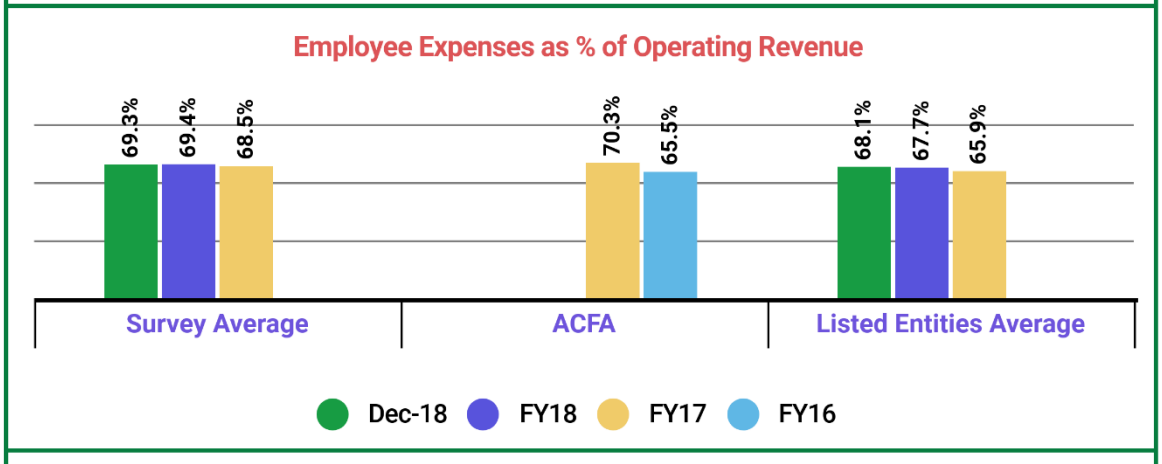
Operating revenue range ($million per annum)	<$10M	$10M - $30M	$30M- $100M	> $100M	Total
Number of Organisations	28	47	26	21	122
%	*23.0%*	*38.5%*	*21.3%*	*17.2%*	*100.0%*
Number of residential care facilities	27	94	109	378	608
%	*4.4%*	*15.5%*	*17.9%*	*62.2%*	*100.0%*
Number of residential operating places	1,921	7,714	10,310	29,360	49,305
%	*3.9%*	*15.6%*	*20.9%*	*59.6%*	*100.0%*
Number of Home Care (HCP) clients	257	1,213	2,960	15,449	19,879
%	*1.3%*	*6.1%*	*14.9%*	*77.7%*	*100.0%*

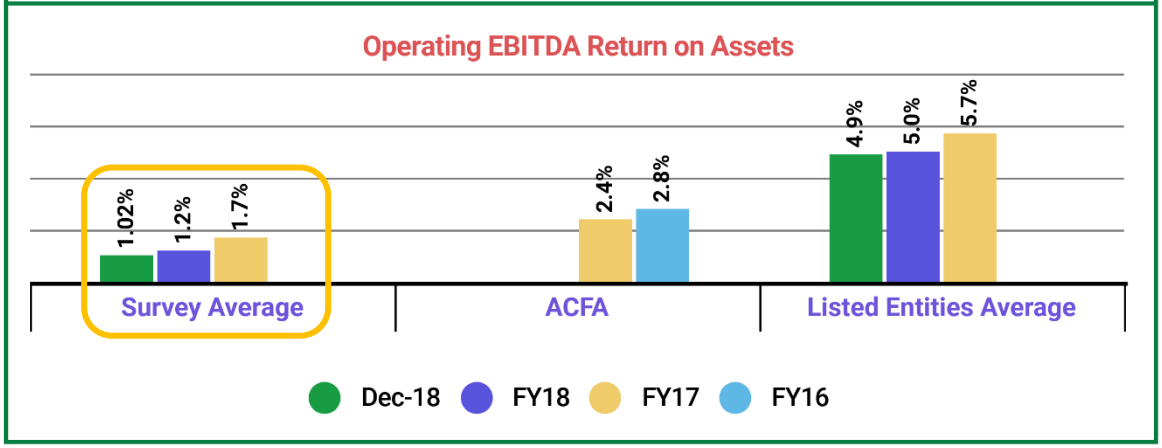
Snapshot

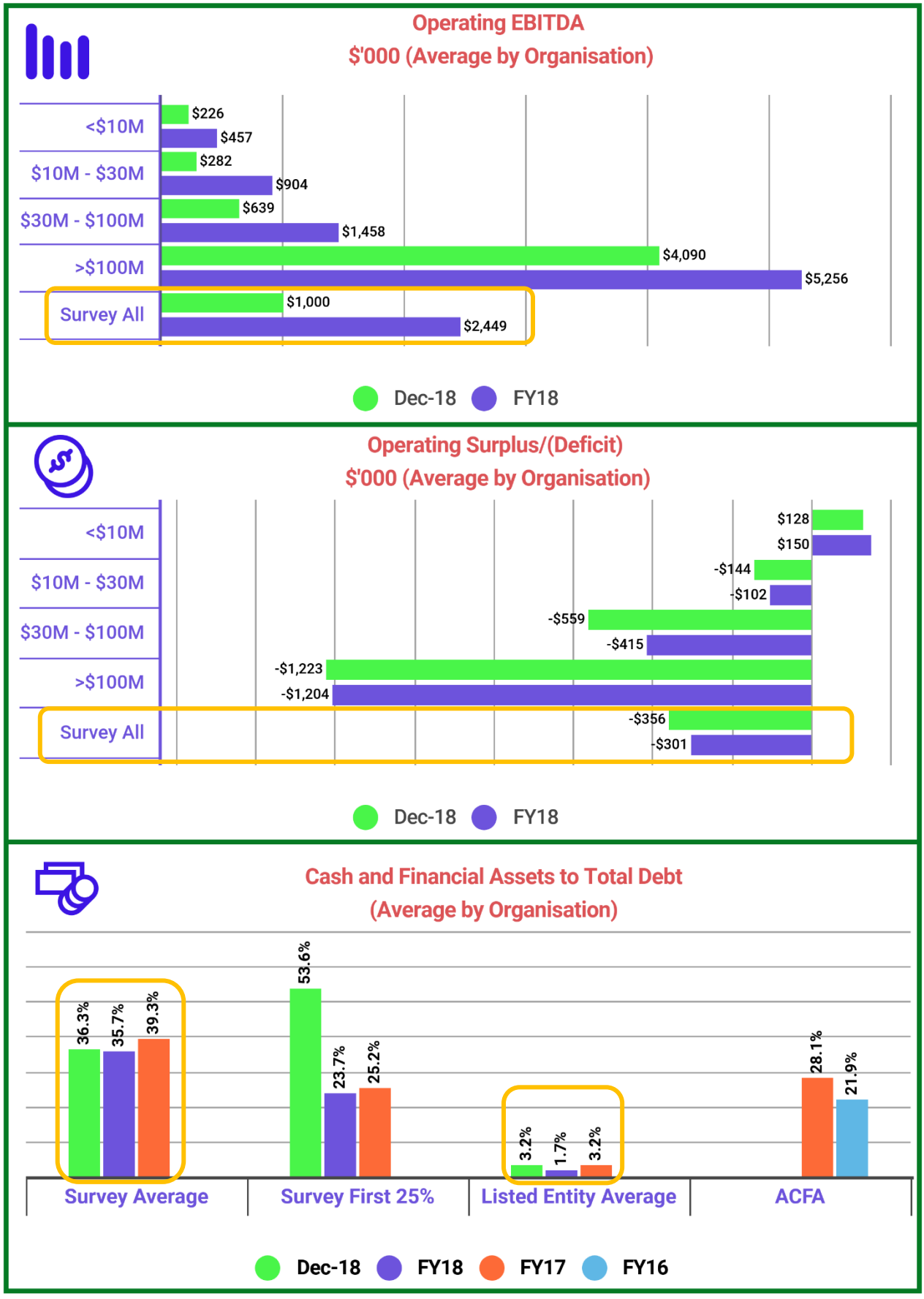
Data from 122 Organisations

OPERATING SURPLUS = EBT adjusted for non-recurrent items (revaluations / donations / bequests / fundraising / impairment







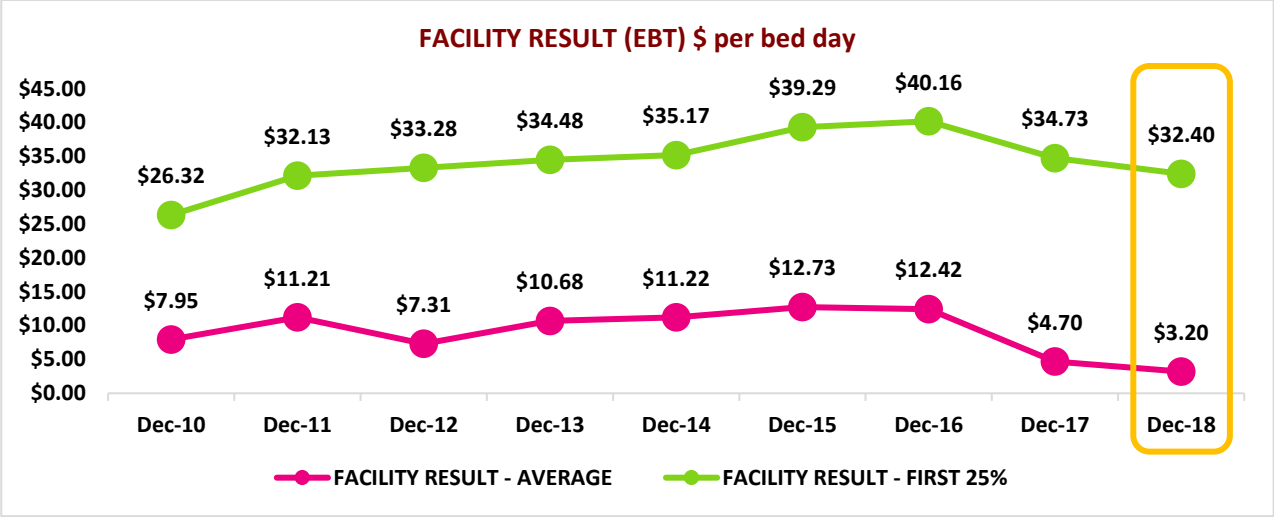

Operating EBITDA
$'000 (Average by Organisation)
<$10M
$10M - $30M
$30M - $100M
>$100M
Survey All
$226
$457
$282
$904
$639
$1,458
$4,090
$5,256
$1,000
$2,449
Dec-18
FY18
Operating Surplus/(Deficit)
$'000 (Average by Organisation)
$128
$150
-$144
-$102
-$559
-$415
-$1,223
-$1,204
-$356
-$301
Cash and Financial Assets to Total Debt
(Average by Organisation)
36.3%
35.7%
39.3%
53.6%
23.7%
25.2%
3.2%
1.7%
3.2%
28.1%
21.9%
Survey Average
Survey First 25%
Listed Entity Average
ACFA
Dec-18
FY18
FY17
FY16

4. RESIDENTIAL CARE ANALYSIS

Facility Result Trend

The residential care sector has experienced a significant decline in Facility Result (EBT) mainly due to care expenses increasing at a much higher rate (4.5%) than revenue (3.1%). The Facility Result as shown to the right has decreased from $4.70 per bed day (pbd) in the period to Dec-17 to $3.20 pbd in the six months to Dec-18.

Figure 1: Facility Result (EBT)



Revenue

- Increase in ACFI revenue by $5.32 pbd - in real terms we are seeing stabilisation of acuity (care) levels. There has only been a slight movement in the proportion of facilities from "low-care" bands to higher care bands - average ACFI subsidy per bed day increased from $172.36 to $177.68 largely as a result of the COPE (inflation) subsidy rate increases
- Increase in Every Day Living revenue by $1.53 pbd mostly due to CPI increase in the Basic Daily Fee
- Increase in Accommodation revenue by $2.09 pbd due to:
  - Resident - $0.41 pbd (due to increase in DAPs ratio as compared to RADs)
  - Subsidy - $1.68 pbd (due to increase in Significant Refurbishment subsidy)

Expenses

- Increase in total care labour costs of $5.57 pbd and increase of roughly 6 minutes per resident per day in total care hours (total direct care hours - 3.16 per resident per day).
- Increase in hotel services $1.09 pbd (2.7%)
- Increase in utilities of $0.49 pbd (mostly due to increase in electricity $0.45 pbd)
- Increase in administration of $1.20 pbd mostly due to increase in corporate increased compliance costs
- Increase in accommodation expenditure by $1.25 pbd (6.8%)

Additional Trends

- Occupancy - slight increase from 94.3% to 94.9%
- Increase in supported resident ratio from 46.2% to 46.9%
- Increase in average Refundable Accommodation Deposit held and received during the year
- Increasing preference for DAPs over RADs - split is now 24.1% RAD, 57.4% DAP and 18.5% Combination

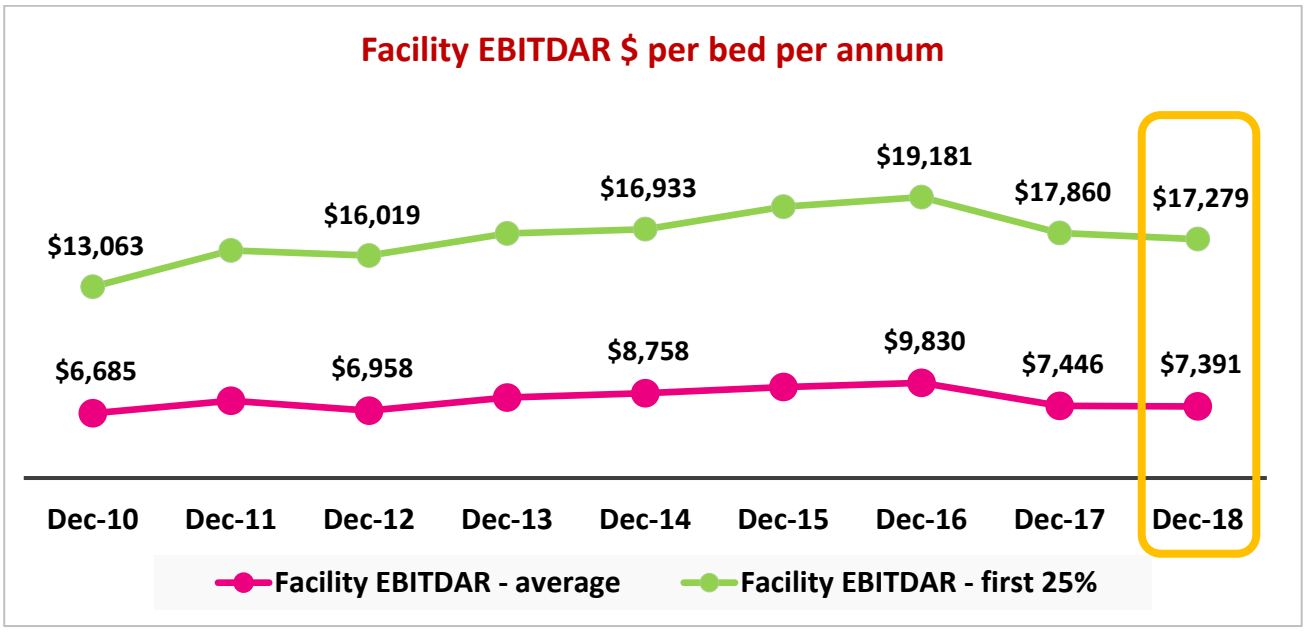
Table 5: Summary Results for Dec-18 Survey

	Dec-18 965 Facilities	Dec-17 915 Facilities		Difference
Facility Result (EBT) $ per bed day	$3.20	$4.70	↓	($1.50)
Facility EBT $ per bed per annum (pbpa)	$1,109	$1,617	↓	($508)
Facility EBITDAR $pbpa	$7,391	$7,466	↓	($75)
Average Occupancy	94.92%	94.37%	↑	0.55%
Average ACFI per bed day	$177.68	$172.36	↑	$5.32
Direct care hours per resident per day	3.16	3.06	↑	0.10
ACFI direct service costs as % of ACFI	81.43%	80.31%	↑	1.12%
Supported ratio	46.90%	46.23%	↑	0.67%
Average Bond/RAD held	$310,680	$284,588	↑	$26,092
Average RAD taken during period	$328,088	$323,849	↑	$4,240

Facility EBITDAR Trend

The below graph shows the Facitity EBITDAR (Earnings Before Interest, Taxation, Depreciation, Amortisation and Rent) trend year on year since 2010 for the December survey period . At the *Average* facility level it is becoming increasingly difficult to remain financially sustainable. A return of $7,391 per bed per annum is unlikely to be sufficient to refurbish or replace infrastructure when the time comes, nor to attract the necessary capital to grow the sector.

Figure 2: Facility EBITDAR trend



At a regional level these results deteriorate further where the average EBITDAR for a facility in outer regional, remote or very remote areas was $3,939 for the half year to Dec-18. We note that the Government has announced an increase in the viability supplements for those facilities that qualify for it, but this will not address the underlying issues facing these facilities, which includes staff shortages, higher costs of goods and services, lower accommodation prices and lower occupancy rates.

Snapshot: Dec-18 Facility Results By ABS Region

Major Cities

626 Facilities

- $1,868 — Facility EBT $ per bed per annum
- $8,308 — Facility EBITDAR $ per bed per annum
- $180.23 — Average ACFI Per bed day
- 80.8% — ACFI services costs as a % of ACFI
- 3.19 — Direct care hours per resident per day
- 45.6% — Supported resident ratio
- 95.1% — Average Occupancy
- $336,739 — Average accommodation deposit held
- $356,910 — Average RAD taken during period

Inner Regional

245 Facilities

- $(171) — Facility EBT $ per bed per annum
- $5,828 — Facility EBITDAR $ per bed per annum
- $171.30 — Average ACFI Per bed day
- 82.6% — ACFI services costs as a % of ACFI
- 3.06 — Direct care hours per resident per day
- 47.3% — Supported resident ratio
- 95.1% — Average Occupancy
- $249,904 — Average accommodation deposit held
- $260,555 — Average RAD taken during period

Outer Regional, Remote & Very Remote

94 Facilities

- $(1,786) — Facility EBT $ per bed per annum
- $3,939 — Facility EBITDAR $ per bed per annum
- $175.05 — Average ACFI Per bed day
- 83.9% — ACFI services costs as a % of ACFI
- 3.24 — Direct care hours per resident per day
- 53.8% — Supported resident ratio
- 92.2% — Average Occupancy
- $237,373 — Average accommodation deposit held
- $256,175 — Average RAD taken during period

Impact of Dec-18 Performance - Number of Facilities with Negative Facility Result (EBT)

Please note that the following analysis is based on the financial operating performance at residential facility level - not at the organisation level.

The total percentage of facilities making an EBT loss has increased from 41.3% to 42.3%. The results have historically declined for the second six months so we would anticipate the percentage to increase further from a recurrent trend perspective. *Please note that the recently announced one-off subsidy will improve the overall results, however our opinion is that this should be discounted when considering the forecast trends.*

The total percentage of facilities making an EBITDAR (cash) loss is 19.5% of the 965 facilities participating in the Survey. In addition to this a further 41 facilities were excluded from the Survey due to being outside the acceptable range.

Figure 3: Analysis of Facilities making EBT and EBITDAR losses in total Survey

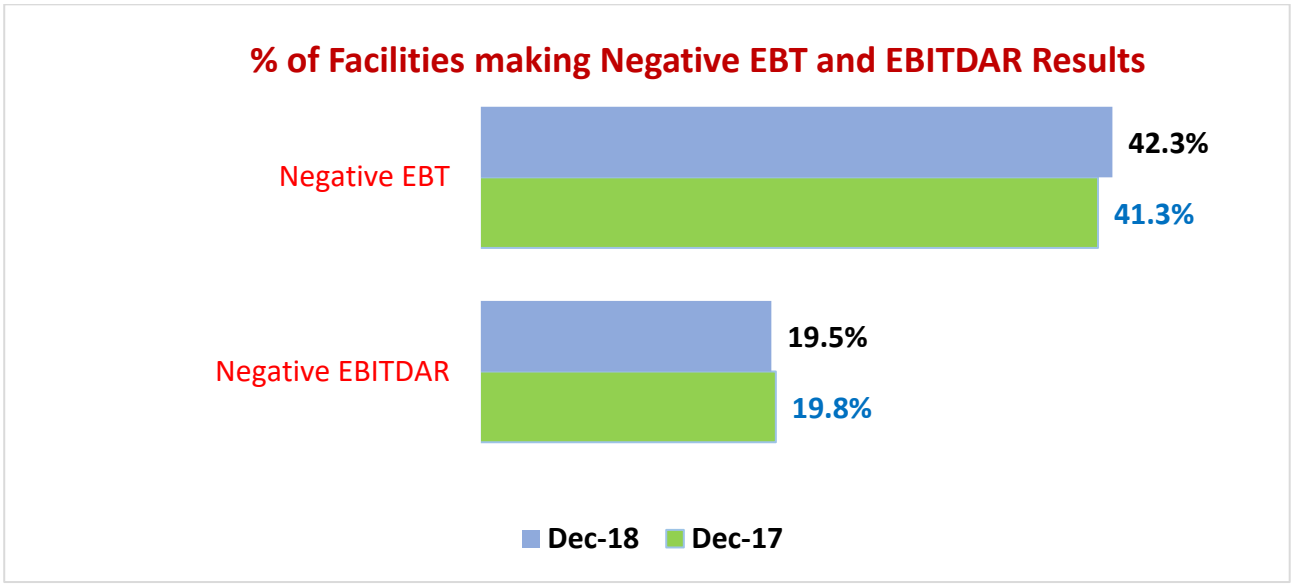


Figure 4: Analysis of Facilities making EBT losses (by remoteness) in total Survey

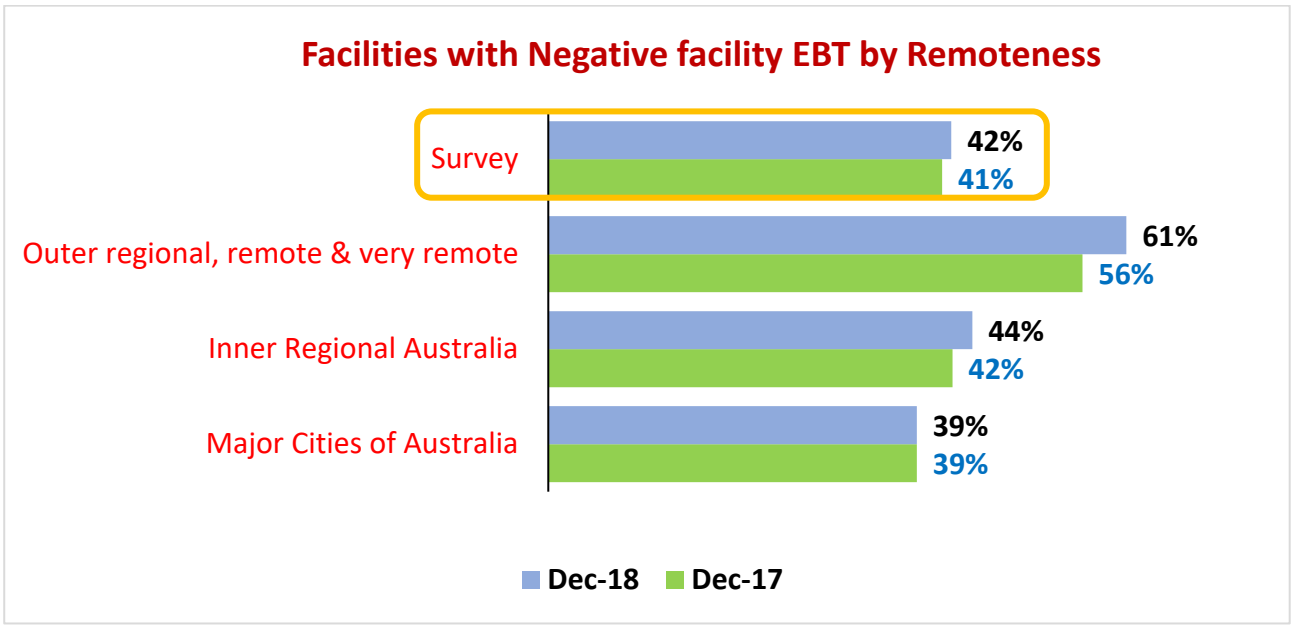
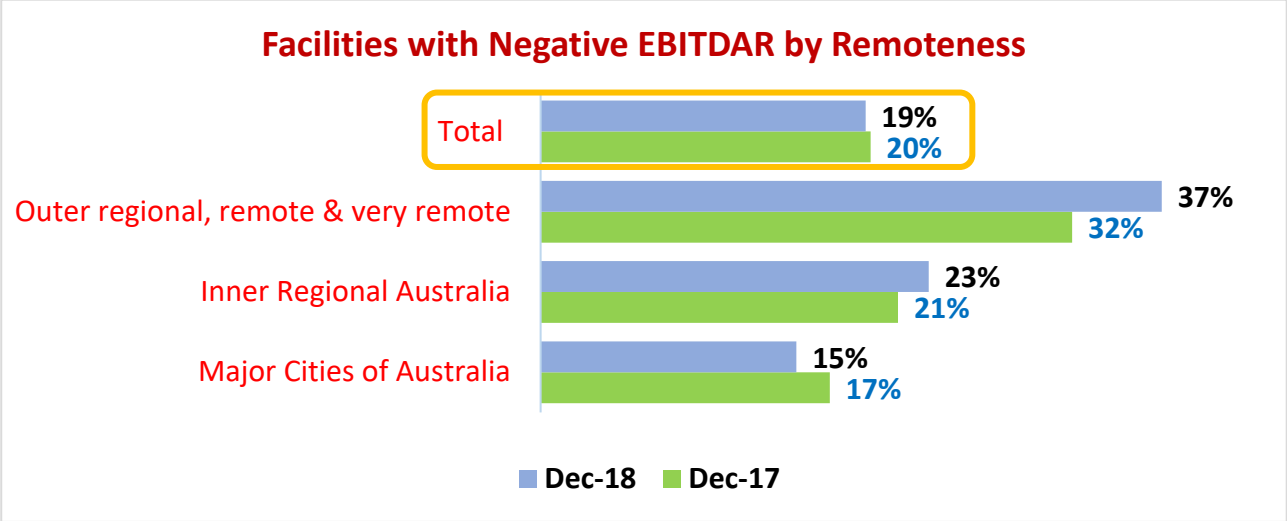


Figure 5: Analysis of Facilities making EBITDAR losses (by remoteness) in total Survey



Brief commentary

Figures 4 and 5 above graph the number of facilities making an EBT and EBITDAR loss as a percentage of total number of facilities in their respective geographic location (remoteness). For each location the number of facilities reporting a loss for the six months ending Dec-18 is significant, as follows:-

- Outer regional/remote/very remote facilities - 61% of facilities in this geographic area made an EBT loss and 37% made an EBITDAR loss
- Inner regional facilities - 44% made an EBT loss and 23% made an EBITDAR loss
- Similarly, of the facilities located in major cities, some 39% made an EBT loss and 15% made an EBITDAR loss

Direct Care Staffing Hours

Direct Care staffing metrics include care staff costs and care staff hours. Improvement in the financial performance of a facility are directly related to appropriately aligning staffing hours and levels to the funding and ensuring that the design of the facility is operationally efficient.

A summary of the direct care staff hours by category per resident per day for the Survey *Average* and Survey *First 25%* is included in the table below.

Table 6: Direct Care staffing metrics for Survey Average and Survey First 25%

	Average			*First 25%*		
	Dec-18	***Dec-17***		***Dec-18***	***Dec-17***	
Hours by Staff Category - hours worked per resident per day						
Care management	0.12	0.12	-	0.10	0.10	-
Registered nurses	0.38	0.38	-	0.33	0.33	-
Enrolled & licensed nurses	0.34	0.29	↑	0.40	0.24	↑
Other unlicensed nurses & personal care staff	2.15	2.11	↑	1.84	1.93	↓
Allied health & lifestyle	0.17	0.15	↑	0.17	0.13	↑
Imputed agency care hours implied	0.02	0.01	↑	0.02	0.02	-
Total Care Hours	**3.16**	**3.06**	↑	**2.87**	**2.74**	↑

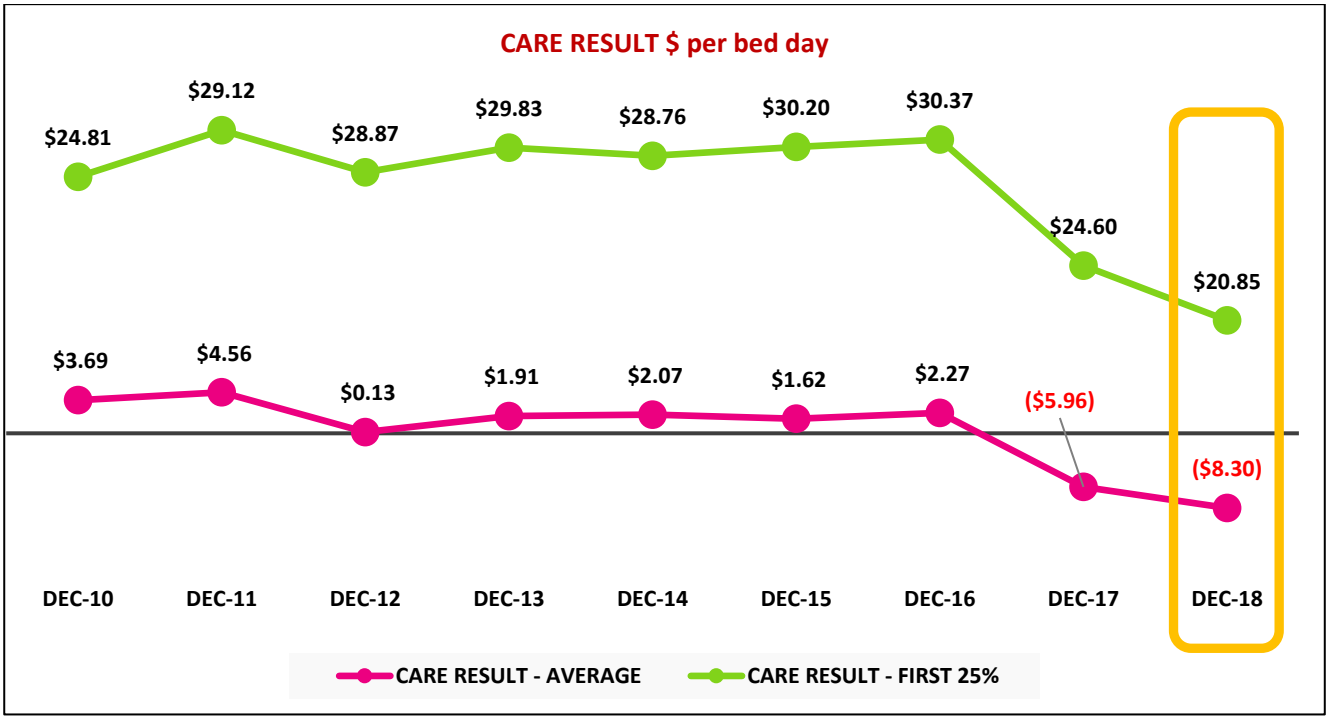
Brief commentary

- The category allocations are consistent with that used by the Nurses and Midwifery Board of Australia, and accordingly AIN and TAFE qualified staff have been included under the "Other unlicensed nurses & personal care staff" classification
- Total labour costs have increased for both the Survey *Average* and *First 25%* since June 2017 by 4.4% and 6.6% respectively
- Total care hours have increased for both the Survey *Average* and for the *First 25%* by 3.2% and 4.6% respectively, and are now at 3.16 hours and 2.87 hours worked per resident per day respectively
- Initial feedback from providers in relation to an explanation for the increase in care hours in the first half of FY18 was that it may be partially due to the impact of influenza and gastro outbreaks, however it is noted that the care hours have not reduced but instead remained at that level

Care Result Trend

The Care Result (ACFI + Everyday Living + Administration) trend is shown in the below graph. The Dec-18 Facility Care result is a deficit of $8.30 per bed day (Dec-17 $5.96 pbd deficit). This represents an unstainable operating performance unless additional revenue (subsidy and resident) is achieved.

Figure 6: Care Result Trend for Survey Average and Survey First 25%



ACFI Revenue and Direct Care Costs Trend

The relationship between ACFI subsidy received (based on resident assessed acuity) and direct care costs remains a key driver for maintaining a sustainable operating financial model. The graph below indicates that the direct care costs are now rising at a greater rate than the corresponding ACFI subsidy, and this gap is likely to increase as staff cost increases (average of 3.0% annually) are greater than ACFI COPE (inflation) increases (1.17% for FY19).

Figure 7: Cumulative increases in ACFI subsidy and Direct Care costs as compared to CPI

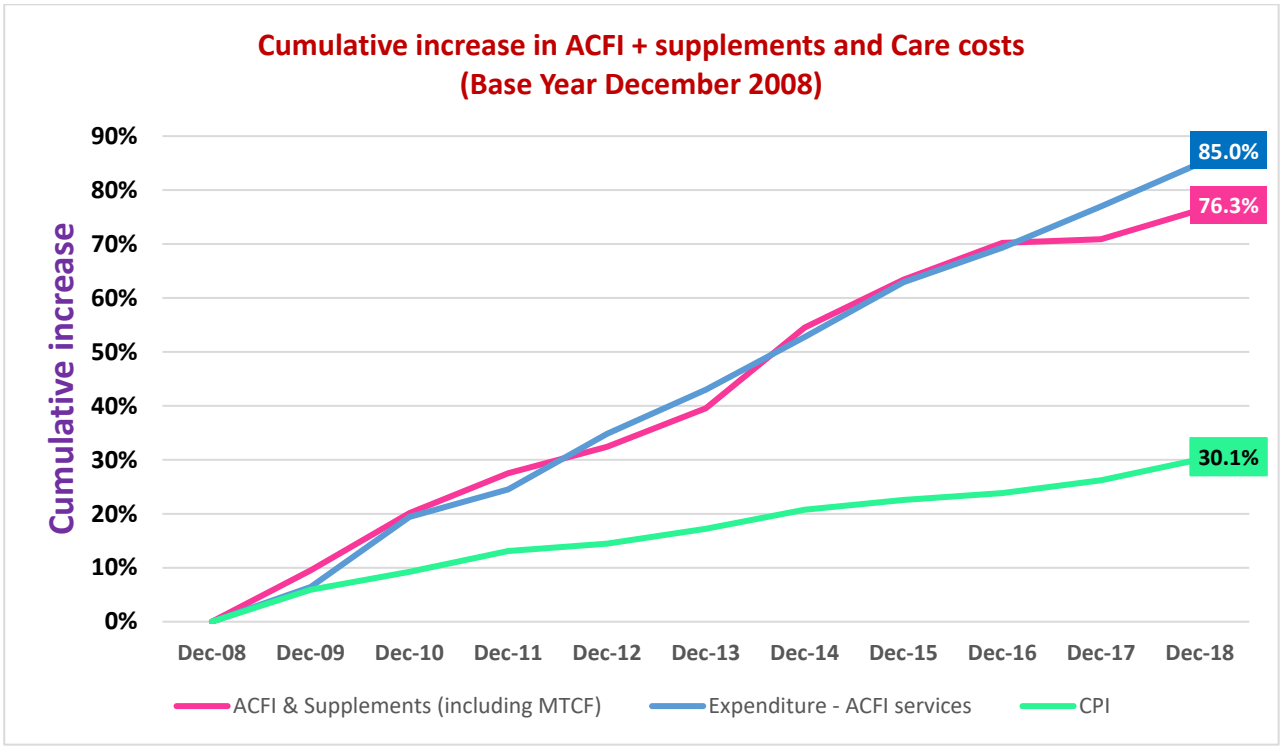


Table 7: ACFI Revenue and Expenditure Trend Points

	Dec-08	Dec-17	Dec-18	Cumulative increase since Dec-08
ACFI & Supplements (including MTCF)	$100.55	171.84	$177.30	76.3%
Expenditure - ACFI services	$78.23	138.43	$144.69	85.0%

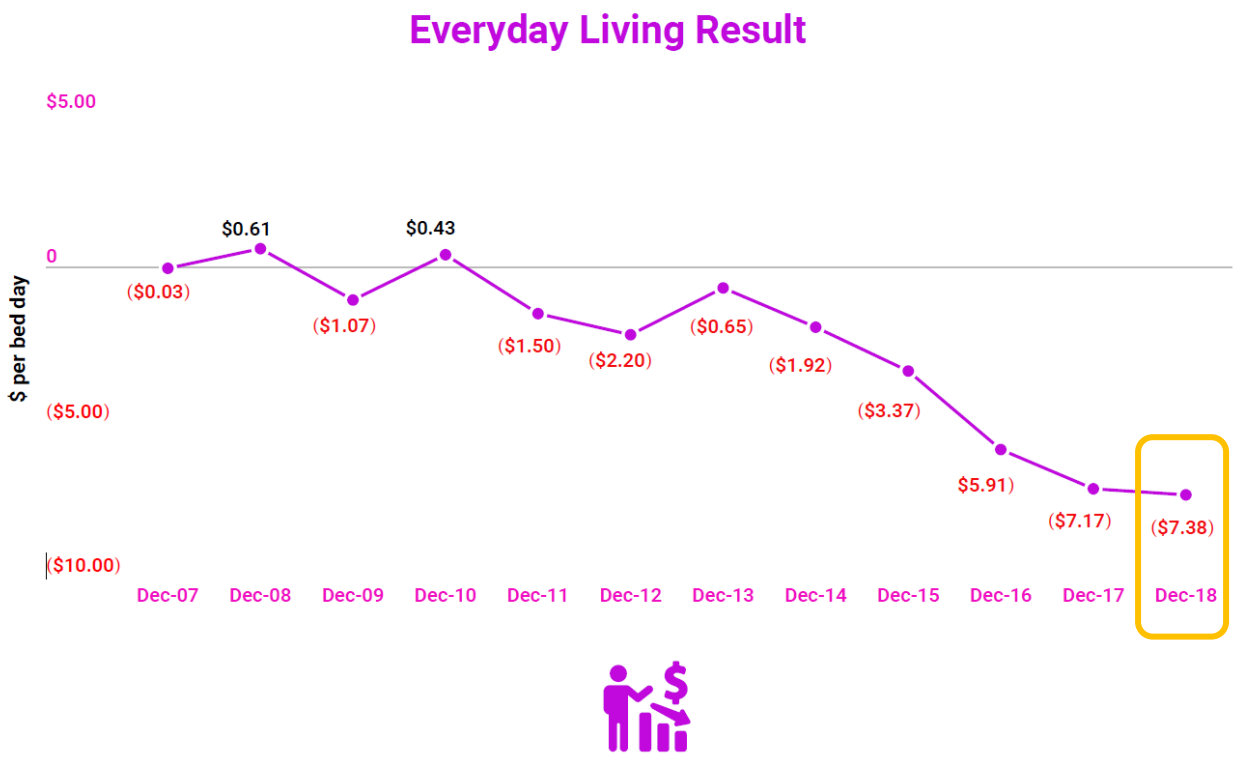
Everyday Living Result

The recoupment of everyday living costs continues to be an area of concern for approved providers. Whilst opportunities exist to charge additional optional services to residents, several challenges exist in this regard. A major issue is in relation to supported residents who, by majority, do not have the financial means to pay for additional services, or indeed pay a higher Basic Daily Fee (85% of the single pension).

Many providers are also very conscious to not introduce a tiered system whereby some residents are able to access additional services based on their ability to pay whilst others do not receive such additional services due to the inability to pay a higher charge.

With a supported resident ratio averaging in excess of 45% across all aged care facilities, this will continue to be an issue for providers in addressing the introduction of additional services.

For the six months to Dec-18 the costs of providing everyday living services exceeded the revenue by $7.38 pbd (Dec-17 $7.17 pbd). Refer to the Everyday Living snapshot (next page) for a summary of the various components.

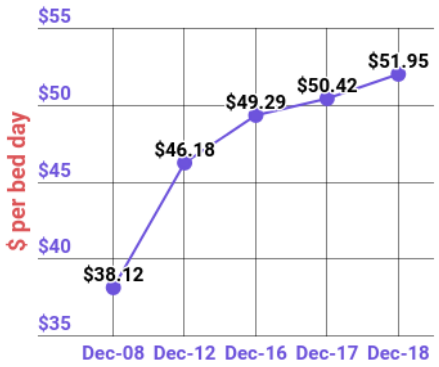


The Everyday Living Result has declined over the past 11 years by an average of **$7.35** per bed day and by **$7.99** per bed day from the peak result (Dec-08). In the past 12 months, the Everyday Living Result has declined by an average of **$0.21** per bed day.

It is clear that the increase in the Basic Daily Fee has not kept pace with cost increases, particularly in catering, cleaning and laundry costs. As noted above, providers have had difficulty in introducing effective additional services to overcome this shortfall so that these costs are being subsidised by other income streams.

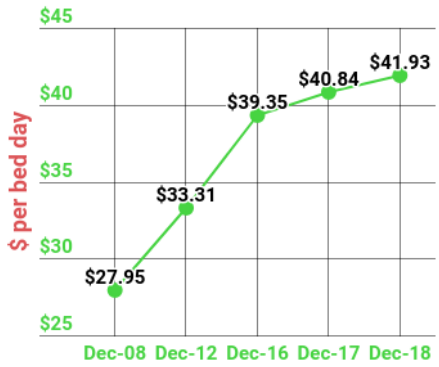
StewartBrown recommends that consideration be given to increasing the Basic Daily Fee base amount by $10 per bed day. Supported residents should be funded by additional subsidy to ensure equity. Such an increase in the base amount will improve the financial sustainability of the residential aged care significantly.

Everyday Living Revenue



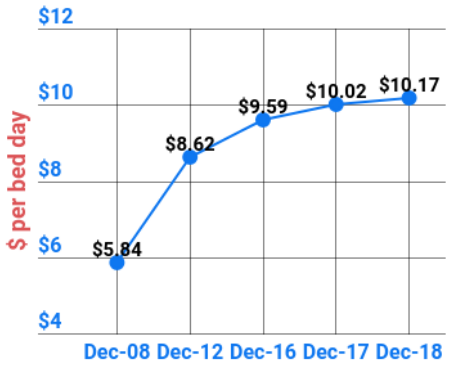
Since Dec-08 Everyday Living Revenue increased by an average of $13.83 per bed day or 36.3%

Hotel Services



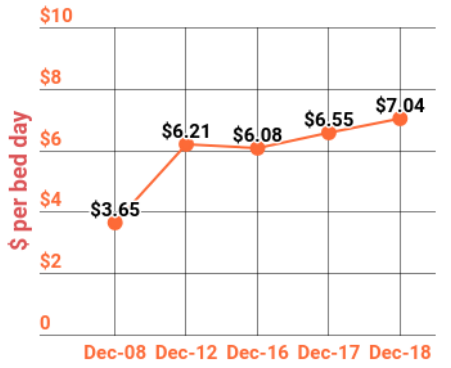
Hotel services costs increased by an average of $13.98 per bed day or 50.0%

Routine Maintenance



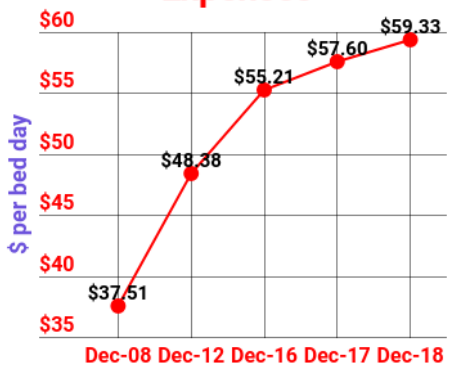
Routine Maintenance costs increased by an average of $4.33 per bed day or 74.1%

Utilities



Utility costs increased by an average of $3.39 per bed day or 93.0%

Everyday Living Expenses

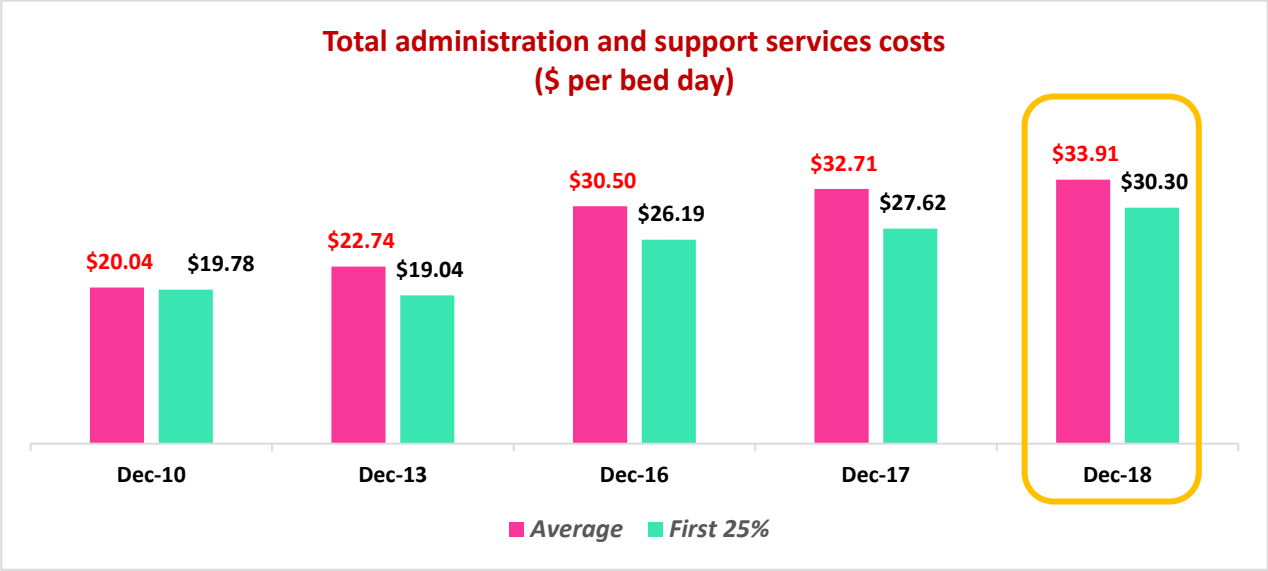


Total Everyday Living Expenses have increased by an average of $21.81 per bed day or 58.1% during the same period that revenue increased by only $13.83 per bed day

Administration Costs

Administration costs have continued to increase at a rate higher than CPI. One of the main drivers for this is increasing compliance requirements and this has now been exacerbated by costs associated with fulfilling information requests in relation to the Royal Commission. In its December half year report to the ASX, Estia stated that the external direct costs associated with preparing for and making submissions to the Royal Commission amounted to $914,000 during that reporting period. While the majority of providers will not be incurring this level of cost, they will be incurring additional costs to meet their obligations to the Commission. It is likely that administration costs will increase again in the second half of this financial year as a result.

Figure 8: Administration Costs Trend ($ per bed day)



Accommodation Result

It is important that facilities achieve a surplus from the Accommodation Result as this funding is essential to maintain the building and surroundings at a level commensurate with consumer expectations. Discussions with providers, coupled with data collected from participants, indicate that a major internal refurbishment policy of every 8 - 10 years is required, even for new builds.

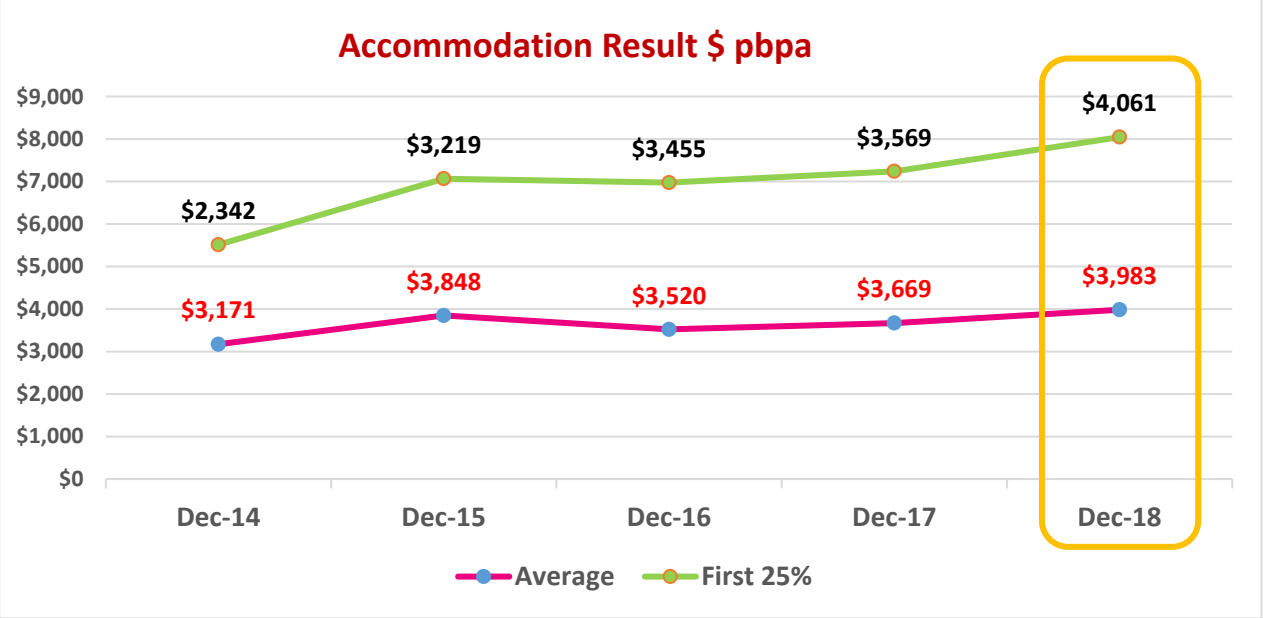
The Accommodation Surplus for Dec-18 was $11.50 per bed day (Dec-17 $10.65 pbd) which represents $3,983 per room per annum. The increase in the percentage of new residents paying a Daily Accommodation Payment (DAP) rather than a RAD has been a contributing factor. This result is achieved after an average depreciation expense of $5,854 pa. However, given the necessity to upgrade facilities regularly, a depreciation rate of 4% (i.e. 25 year write-off period for residential care buildings) should be adopted by providers as it is highly probable that this equates to the effective (useful) operational life of a residential facility in an increasing “retail” style accommodation market.

A further relevant consideration is that currently the surplus from the Accommodation Result is being used to offset the loss from the Care Result. In the six months to Dec-18 the Care Result was a deficit of $8.30 per bed day which, if funded from the Accommodation Result, impacts on the ability of organisations to fund future refurbishment of a facility. This not only affects the accommodation revenue (accommodation pricing) but does not allow for efficiency gains to be achieved through building design modifications.

Table 8: Residential Care Accommodation Result for Survey Average and First 25% for Dec-18 and Dec-17

	Survey *Average*			Survey *First 25%*		
	Dec-18	Dec-17		Dec-18	Dec-17	
	$ pbd	$ pbd		$ pbd	$ pbd	
Accommodation Revenue	**31.12**	**29.03**	↑	**29.70**	**27.59**	↑
Depreciation	16.90	15.83	↑	16.21	15.47	↑
Refurbishment	0.21	0.28	↓	0.19	0.39	↓
Other accommodation costs	2.52	2.26	↑	1.74	1.60	↑
Accommodation Expenses	**19.62**	**18.37**	↑	**18.14**	**17.46**	↑
Accommodation Result	**$11.50**	**$10.65**	↑	**$11.56**	**$10.13**	↑
Accommodation Result $pbpa	**$3,983**	**$3,669**	↑	**$4,061**	**$3,569**	↑
Depreciation charge $pbpa	**$5,854**	**$5,454**	↑	**$5,697**	**$5,450**	↑
Depreciation charge $pbpa for WDV of $200,000 per bed at 4%						**$8,000**
Depreciation charge $pbpa for new build of $325,000 per bed at 4%						**$13,000**

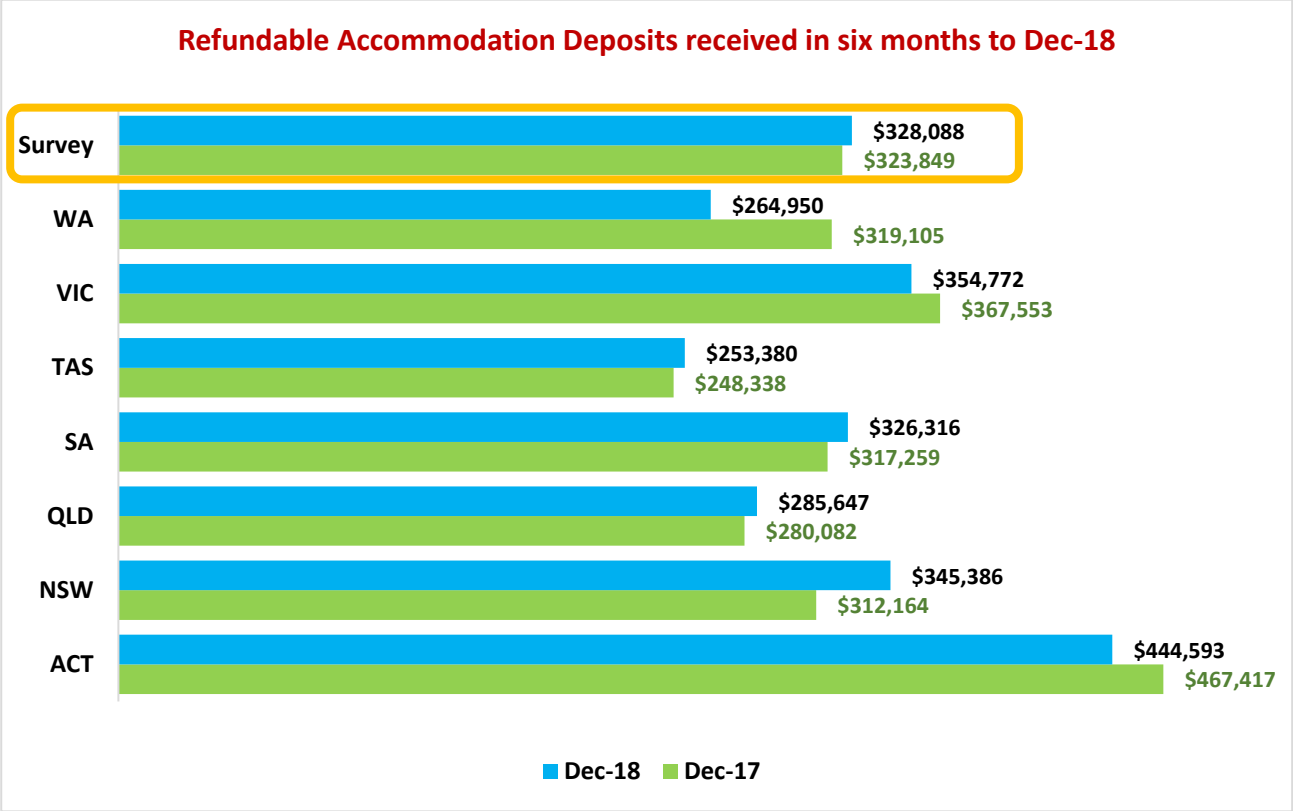
Figure 9: Residential Care Accommodation Result Trend



Accommodation Pricing

There has been a increase in the average published accommodation prices during the year to Dec-18 and this has resulted in the amount of Refundable Accommodation Deposits (RADs) received during the period increasing by a national average of $4,239 (1.3%). Accommodation pricing is an important component for the sustainability of a residential facility. It is a revenue benefit (DAP) or a capital benefit (RAD) depending upon the equity position of the organisation.

Figure 10: Average Refundable Accommodation Deposits Received for Dec-18 and Dec-17



It does appear likely that, from a consumer perspective, there remains some confusion in relation to accommodation pricing and this has resulted in providers not having an effective accommodation pricing strategy.

The acuity (care needs) of a resident is directly related to the ACFI funding and expenditure. Everyday living expenses are offset against the Basic Daily Fee and additional services (if charged).

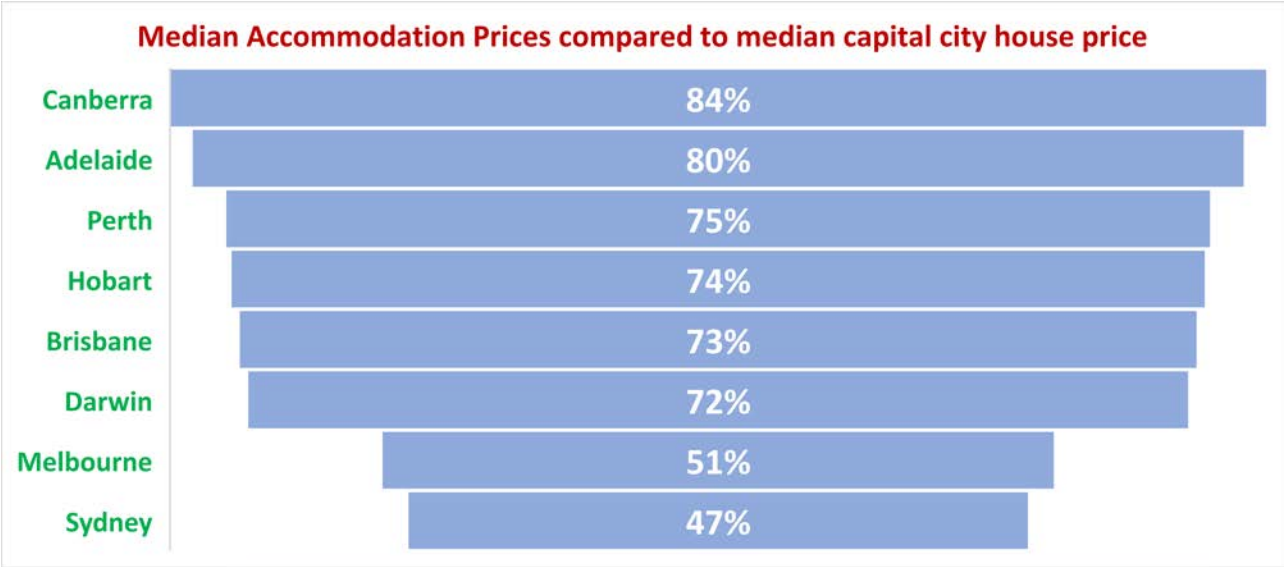
Accommodation pricing **is not** assessed on care needs but on the standard of accommodation and the financial ability of an incoming resident to meet the price through either a RAD, DAP or a combination of both. The consumer expectation that the standard of accommodation, and accordingly, the pricing is relative to direct care provided is somewhat misconstrued. A higher accommodation price does not equate to a higher standard of direct care.

Accommodation pricing strategies should be more targeted to the local house or unit prices in the geographic area. The pricing strategy should also consider other factors such as:

- Amenity and general standard of accommodation offered
- Target market
- Common areas and other facilities available to residents and their families
- Cost to build in the construction of the facility, the standard of accommodation

The figure below indicates that there is a disparity in this relationship, particularly in Sydney and Melbourne.

Figure 11: Median Published RAD compared to Median House Price



Occupancy

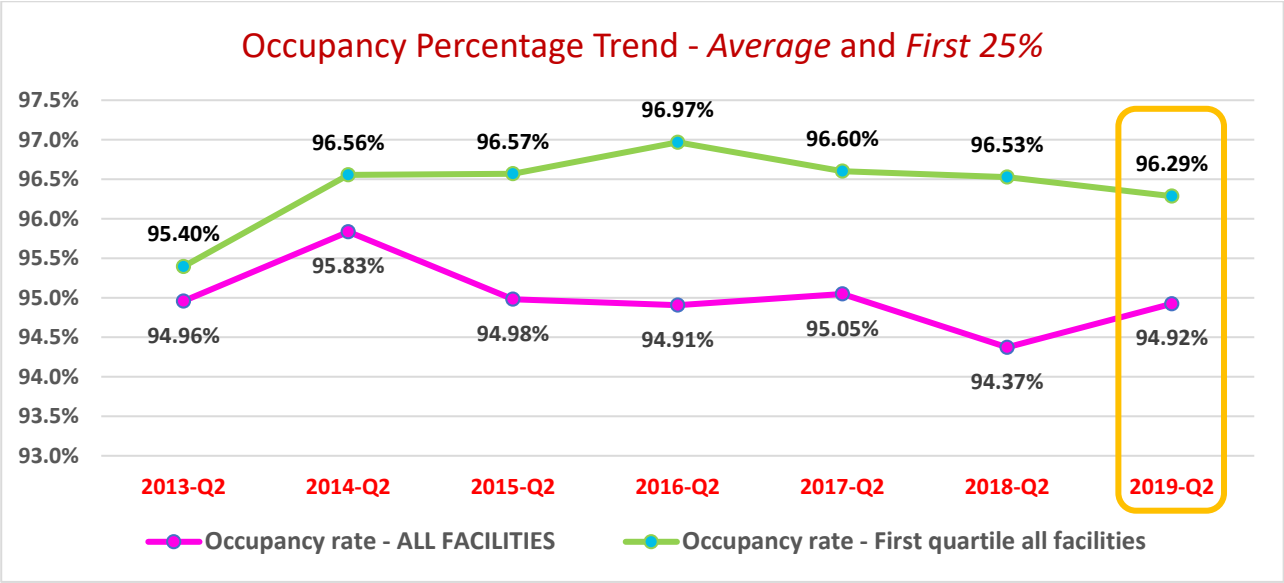
The occupancy percentage overall remains steady at 94.92% nationally (94.37% at Dec-17) with the *First 25%* of providers (based on Facility Result) having and average occupancy of 96.29% (96.53% at Dec-17).

It should be recalled that the occupancy levels dropped in the Dec-17 six months due to a severe influenza outbreak and an expected correction has now largely occurred.

Please note that the DOH calculates occupancy on approved places (and as advised by providers) whereas StewartBrown calculates the occupancy based on number of operational places which exclude off-line places due to refurbishment or other strategic reasons. Additionally, StewartBrown do not include State or local government occupancy levels as these are often unreliable.

A tend analysis of occupancy levels is included in the below figure.

Figure 12: Occupancy Percentage Trend Analysis



5. RESIDENTIAL CARE - FINANCIAL FORECAST

Recap - FY18 Forecast

As background, StewartBrown performed a forecast of the FY18 facility results In October 2017 based on the COPE freeze of ACFI funding, changes in the ACFI assessment and a similar set of assumptions as now used for the FY19 forecast.

The FY18 forecast for the Survey *Average* was $2.18 per bed day (actual FY18 result was $2.37 pbd) and for the Survey *First 25%* was $31.08 pbd (actual FY18 result was $30.26 pbd).

This suggests that whilst it was clear early in the FY18 fiscal year that the operating performance was going to deteriorate because of underlying funding and cost increase pressures, the ability of facilities (in all revenue domains and geographic locations) to adjust their business models to minimise this financial effect was negligible. Similar implications will exist in the FY19 financial results.

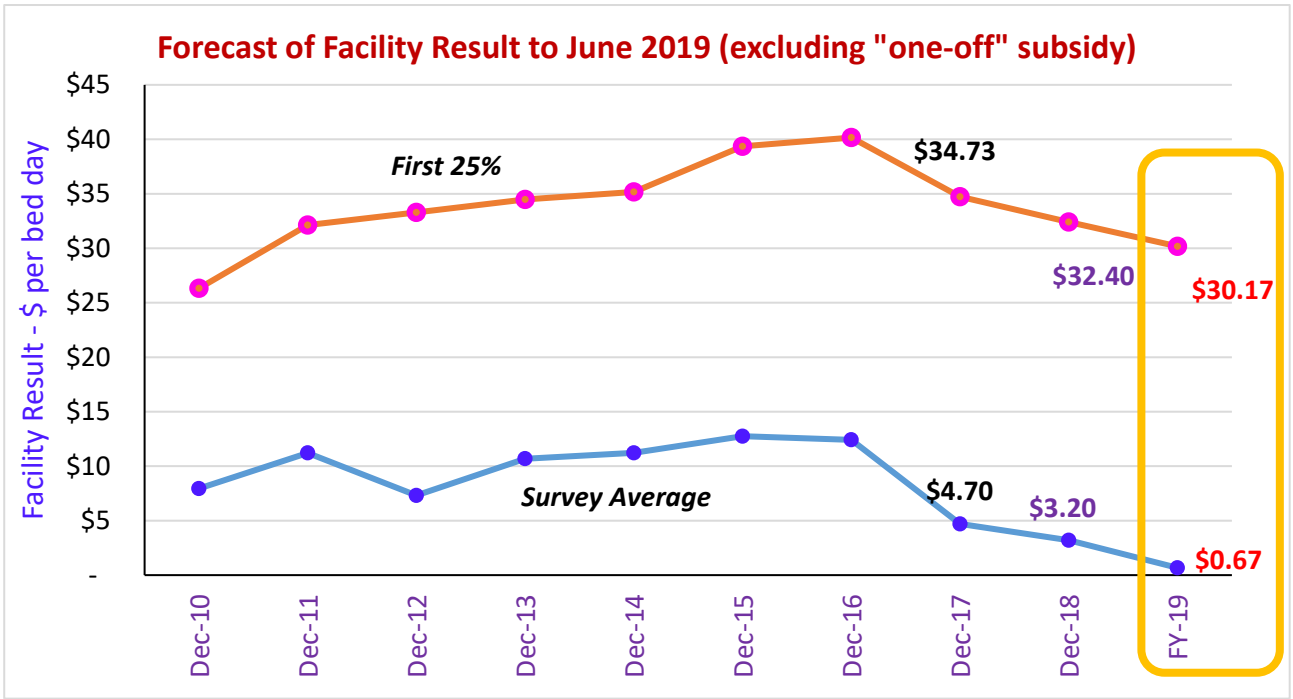
FY19 Residential Care Forecast

Forecast Assumptions

We have calculated the projected Facility Results for FY19 using the following assumptions:

- ✓ Based on Dec-18 actual Facility Results
- ✓ Adjusted for the "one-off" 9.5% increase in subsidy funding effective 20 March, 2019 (refer below)
- ✓ Adjusted for other revenue increases in line with pension/ CPI increase
- ✓ Adjusted for Wage increases of 3.0% pa
- ✓ Depreciation assumed to remain stable
- ✓ Adjusted for other expenditure increases at CPI of 2.1% pa and Utilities at 5.0% pa

Figure 13: FY19 Residential Care Forecast (Facility Result) (excluding "one-off" 9.5% subsidy increase)



Commentary

As at Dec-18 the EBITDAR pbpa for the Survey *Average* was $7,391, therefore, the impact of a facility operating surplus of $0.67 per bed day (keeping all else constant) and excluding the "one-off" 9.5% subsidy increase is:-

- A reduction of Facility EBT per bed per annum from $1,109 to $175 per bed per annum and;
- A reduction of Facility EBITDAR from $7,391 per bed per annum to $6,518 per bed per annum

Additional Funding Support

Background

The Prime Minister announced on 10 February 2019 an additional funding package for residential aged care. The announcement stated "The $320 million residential aged care component equates to approximately $1,800 per permanent resident and will provide additional support to the sector over the next 18 months, to deliver quality aged care services while the Government considers longer-term reform funding options".

Application

The Department of Health have advised how the additional $320 million residential aged care general subsidy will be applied:-

- It will be an effective (non-discriminatory) 9.5% increase on the basic ACFI, RCS and respite subsidies for the period 20 March 2019 to 30 June 2019
- Providers will not be required to acquit the additional funding (ie justify additional expenditure in addition to their current expenditure levels)
- From 1 July 2019, ACFI will revert back to the pre 9.5% level (ie current ACFI level)
- The COPE increase (if approved) from 1 July 2019 will be based on the pre 9.5% level
- Whilst the announcement refers the additional subsidy support effectively covering an 18 month period, the fact that the subsidy will be fully paid up to 30 June 2019 with no requirement to acquit means that in accordance with Australian Accounting Standards *AASB 15 Revenue from Contracts with Customers* (new) or *AABS 118 Revenue* (existing) we are of the opinion the additional subsidy should be fully disclosed in the 2019 financial year (ie no future apportionment in FY20)

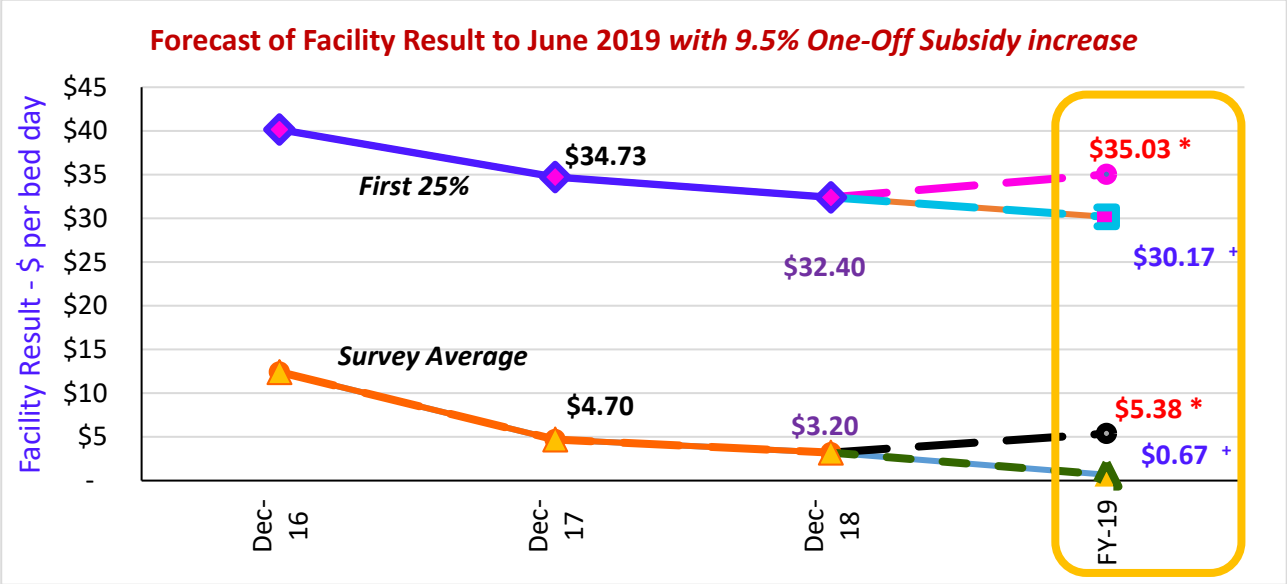
Impact

The additional subsidy will positively impact on the FY19 financial performance for residential aged care providers, however will not impact on FY20 forecasts due to it being a "one-off" subsidy that will be fully remitted by 30 June 2019.

From an trend analysis perspective, StewartBrown will show both the results with the additional subsidy and without the additional subsidy, with the latter trend being of greater importance for forecasting and analysis purposes.

The additional funding support will provide a facility with an average ACFI of $177.30 with approximately $1,720 per bed by June 30. The effect on the forecast results are shown in the graph below.

Figure 14: FY19 Forecast facility Result showing the likely effect of the 9.5% one-off subsidy funding boost



Impact of FY19 Projections - Increase in Number of Facilities with Negative Results

The below table projects the number of facilities that could transition into having EBT and EBITDAR losses should the FY19 projections be realised. A comparison to FY17 and FY18 is included.

Table 9: FY19 Projection Number of Facilities with EBT and EBITDAR deficits (FY19 includes "one-off" subsidy boost)

	FY17 %	FY18 %	FY19* %		FY17 No.	FY18 No.	FY19* No.
% of facilities with negative facility EBT by remoteness							
Major Cities	30.2%	41.5%	35.8%		187	262	224
Inner Regional	36.1%	47.2%	40.8%		87	116	100
Outer regional, remote & very remote	52.1%	63.5%	60.6%		50	61	57
Survey	**33.9%**	**45.1%**	**39.5%**		**324**	**439**	**381**
% of facilities with negative facility EBITDAR by remoteness							
Major Cities	12.6%	18.0%	13.7%		78	114	86
Inner Regional	13.3%	22.4%	21.2%		32	55	52
Outer regional, remote & very remote	25.0%	37.5%	35.1%		24	36	33
Survey	**14.0%**	**21.0%**	**17.7%**		**134**	**205**	**171**

** FY19 forecast includes the additional 9.5% "one-off" subsidy. When considering the forecast without this additional subsidy the number of facilities (and percentage) would likely be an increase on FY18. This is an important consideration when assessing the likely performance (and sustainability) for FY20 and beyond*

6. HOME CARE ANALYSIS

Overview

The Home Care Packages (HCP) segment experienced a significant decline in profitability in FY18 with revenue and overall EBT per client day declining in both the Survey *Average* and Survey *First 25%* quartile. This result was compounded by an increase in unspent funds (revenue utilisation) per client and in aggregate.

For the six months to Dec-18, there are indications that this decline may have stabilised although the results for the *First 25%* continued to decline.

The overall Survey *Average* EBT result was a surplus of $3.33 per client day (Dec-17 $3.24 pcd) however Band 4 (highest acuity mix) have seen their results decline from $7.39 pcd to $5.92 pcd. The Band 4 *First 25%* also had a reduction in surplus to $25.14 pcd (Dec-17: $29.63 pcd). The Survey *First 25%* had a smaller reduction in their results from $18.98 pcd (Dec-17) to $18.04 pcd (Dec-18)

Revenue

- Increased by 9.6%
- Pricing pressure due to increased competition
- Revenue utilisation improved marginally from 87.6% (Dec-17) to 88.9% (Dec-18)
- Higher average unspent funds per client despite improvement in revenue utilisation

Expenses

- Decreased by 9.9%
- Direct service costs increased by $2.78 pcd
- Cost of direct service and brokered/sub-contracted as a percentage of total income has increased to 61% from 59% (Dec-17)
- Decrease in case management and advisory $0.11 pcd (reduction in staff costs)
- Increase in administration costs of $1.15 pcd (mostly reduction in corporate recharge and staff costs)

For both the Survey *Average* and *First 25%* the profitability declines were in Bands 1 and 4, whilst Bands 2 and 3 had slight improvements in results. The majority of the packages in the Survey are in Band 3 (37.9%) followed by Band 4 (31.8%).

Figure 15: Comparison of Survey Average EBT (operating surplus) Dec-18 and Dec-17

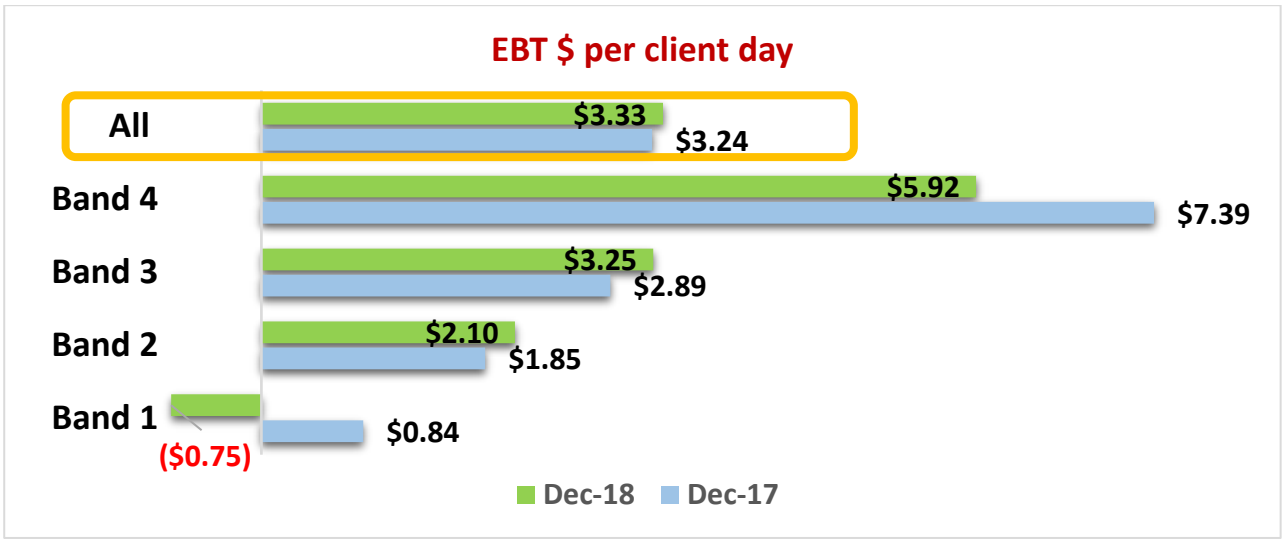


Figure 16: Comparison of Survey Average EBTDA per client per annum Dec-18 and Dec-17

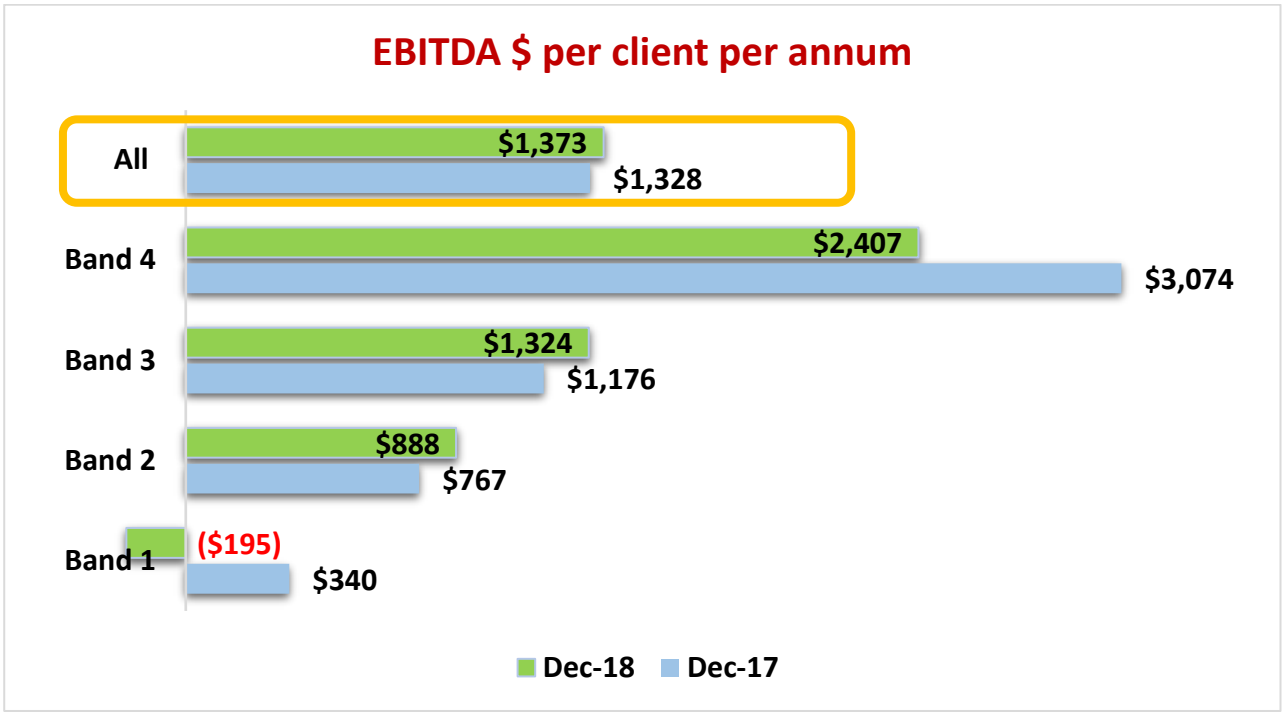
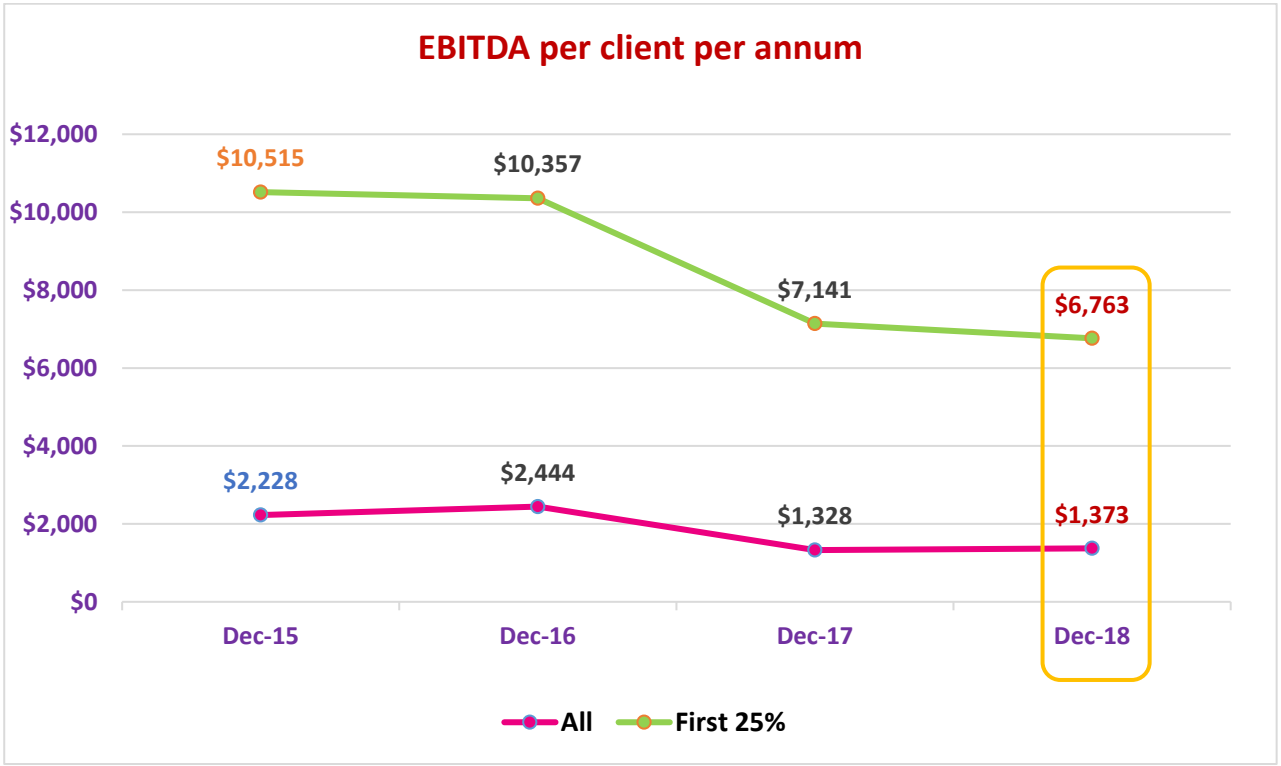
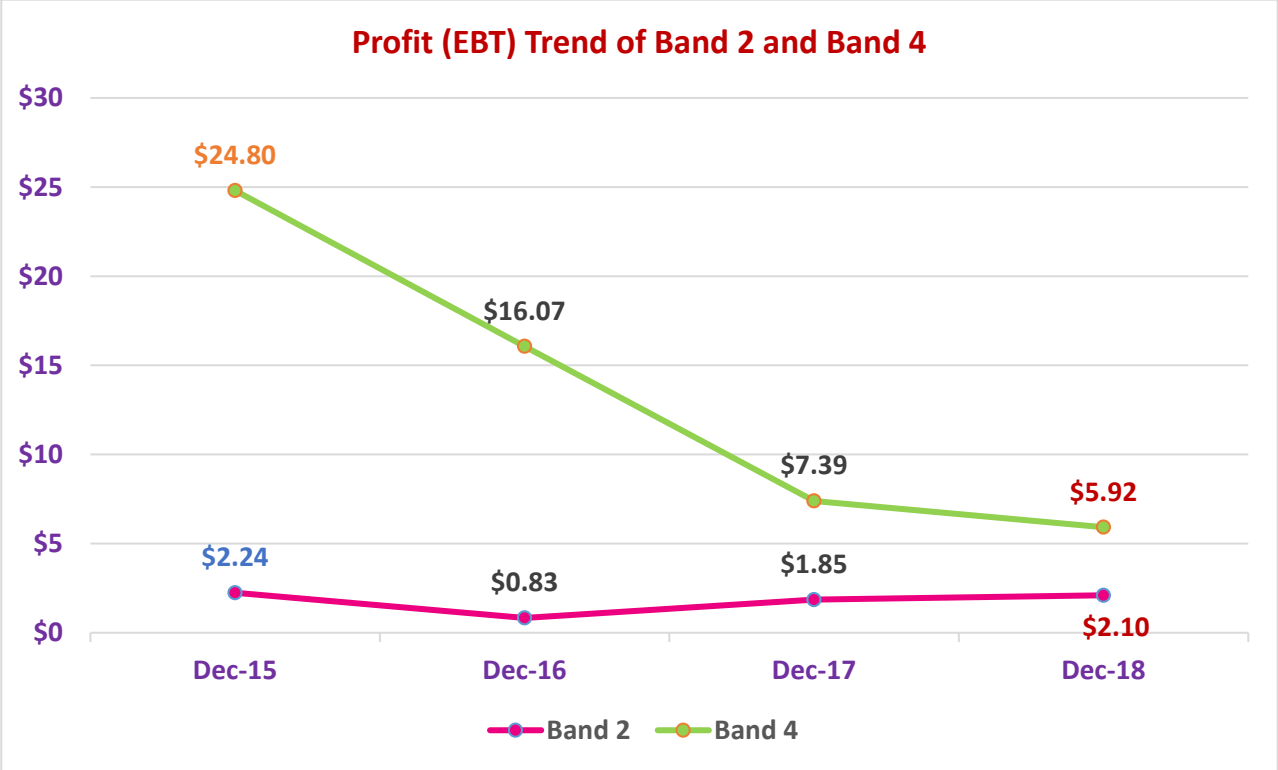


Figure 17: Comparison of Survey Average EBTDA Per client per annum trends



The trend graph above clearly shows the decline in results over time with the *First 25%* being affected in a more significant way than the survey *Average*.

Figure 18: Trend analysis for EBT Band 2 and Band 4



Similarly, as shown by Figure 18, the decline in results for Level 4 (high care) packages has been dramatic. At the commencement of Consumer Directed Care (CDC) Level 4 packages had an *Average* result of $24.80 per client per day but this has now declined to $5.92 per client per day for the Dec-18 survey.

This represents a return on revenue of 5.3% which bordering on being unsustainable given the investment that providers are now required to make in technology, staff recruitment and retention and growth.

Snapshot: Home Care Packages

Profitability

9.6%
Increase in revenue

88.9%
Revenue utilisation compared to 87.6% in Dec-17

9.9%
Increase in Expenses

$3.33
EBT per client per day compared to average of $3.24 in Dec-17

$18.04
EBT per client per day for First 25% down from $18.98 in Dec-17

Client Profile

Average Age

	2018	2017
Level 1	81.8	73.5
Level 2	83.5	82.8
Level 3	82.8	82.7
Level 4	84.0	83.0

(Years)

Average Length of Stay

	2018	2017
Level 1	2.2	1.4
Level 2	2.2	2.0
Level 3	1.4	1.6
Level 4	1.9	1.4

(Years)

Client Exits

330
Data received from 330 home care programs

3,669
Total client exits in data set

46%
Exited to residential care 45% in Jun-18

12%
Exited to other home care providers 9% in Jun-18

42%
Exited system as a result of passing or other reason 45% in Jun-18

EBT for Survey *First 25%*

The EBT performance of the Survey *First 25%* for Dec-18 continued to decline in contrast to the Survey *Average* with the effects of the reduced prices, revenue utilisation and increased administration costs being the predominant reasons.

Figure 19: Comparison of Survey First 25% EBT (operating surplus) Dec-18 and Dec-17

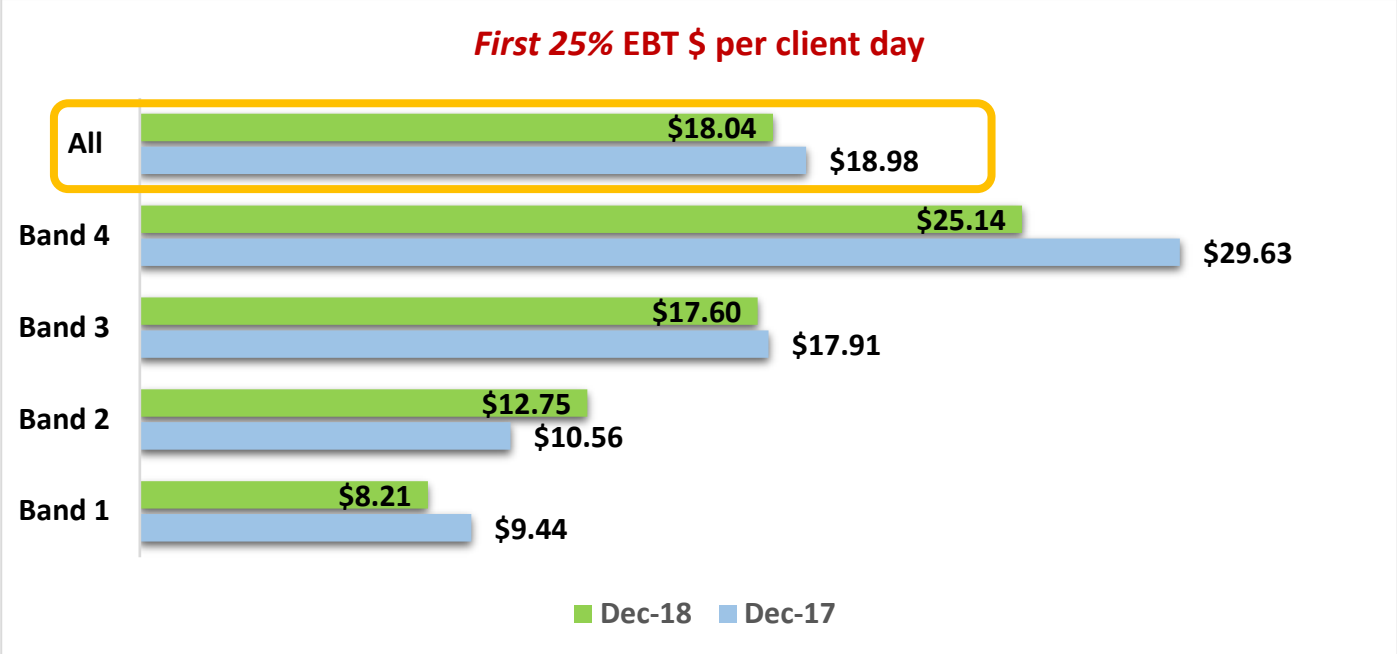
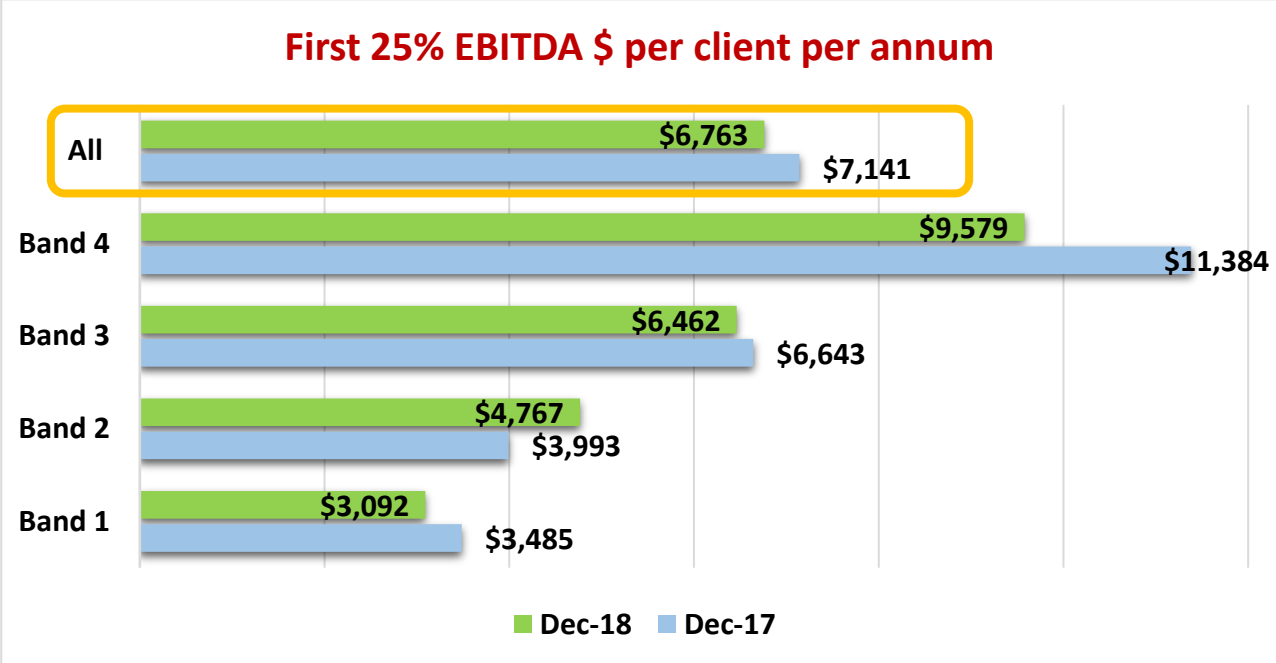


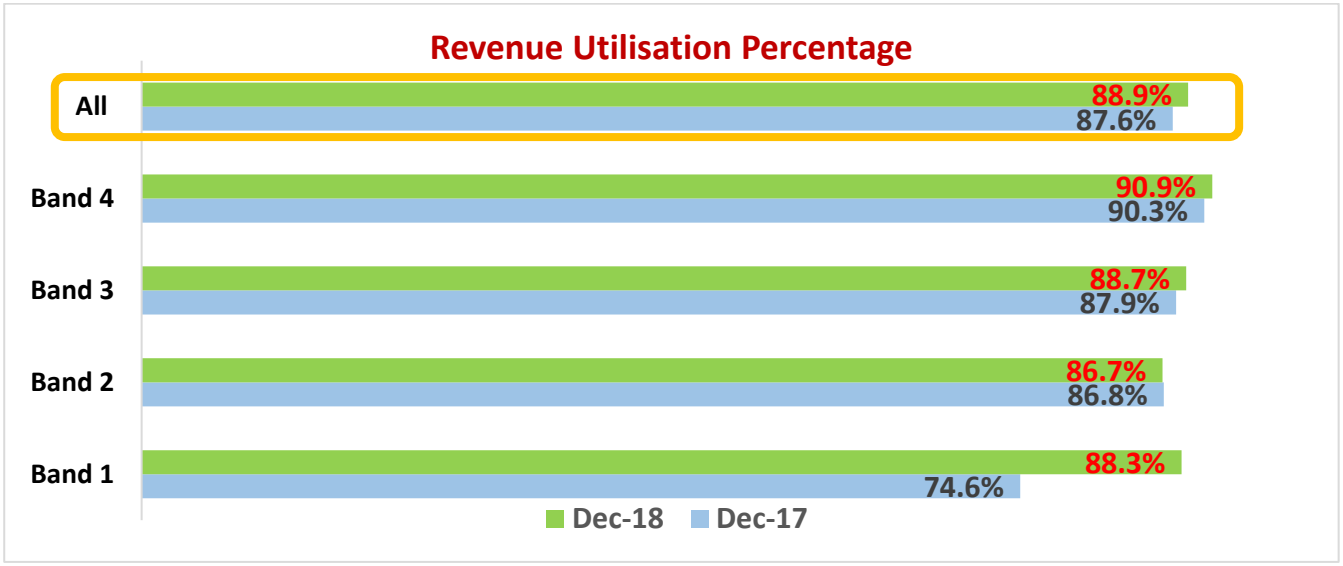
Figure 20: Comparison of Survey First 25% EBTDA Per client per annum Dec-18 and Dec-17



Revenue Utilisation

While there had been a significant decline in revenue utilisation in FY18 the year on year trend for Dec-18 has been a marginal improvement in revenue utilisation from 87.6% at Dec-17 to 88.9% at Dec-18. This has had a marginal affect on profitability as the fixed costs have been spread over slightly revenues and some of the variable (staff costs) are unlikely to have been adjusted a great deal. The improvement in revenue utilisation must be a continuing priority for the remainder of FY19.

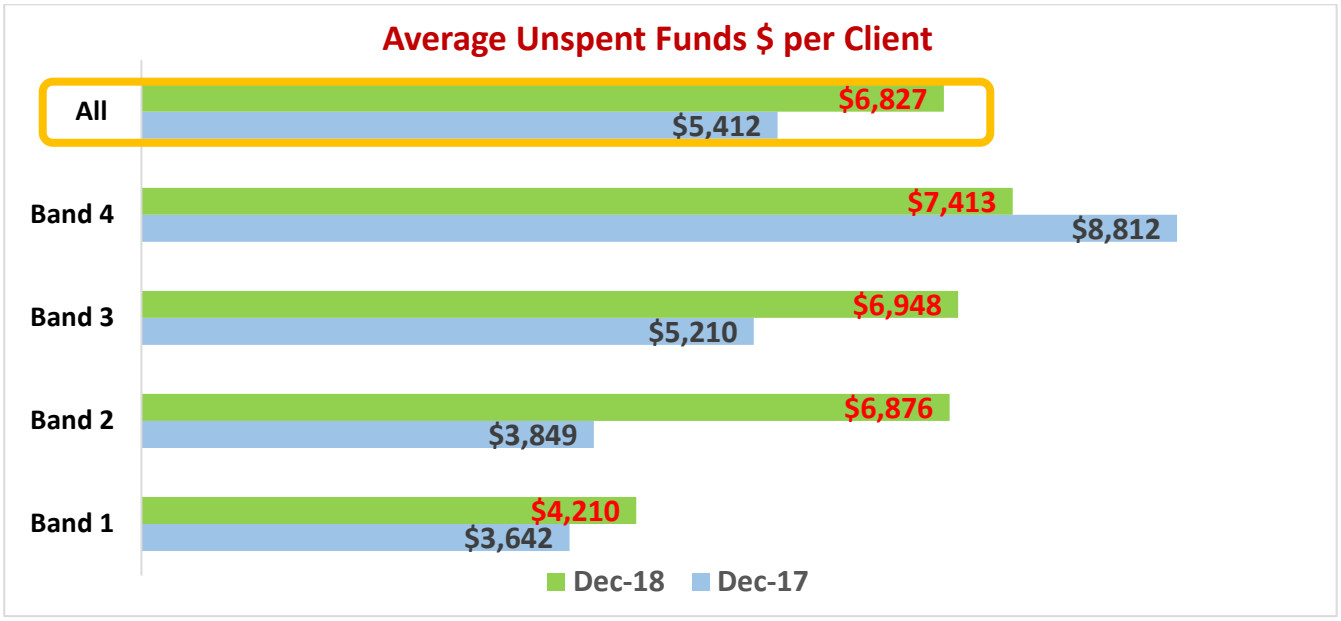
Figure 21: Revenue Utilisation comparison for Dec-18 and Dec-17



Unspent Funds

Despite the marginal improvement in *Average* revenue utilisation there has been a continuation in the increase of unspent funds for each client. ACFA estimated the unspent funds liability for FY17 to be $319 million and this is likely to be over $600 million as at FY19 year-end. This represents subsidy funds, by majority, that if not being utilised for direct care delivery could be diverted into those consumers on the national prioritisation queue that do not yet have funding provided.

Figure 22: Average Unspent Funds per client as at Dec-18 and Dec-17



Comment

The increasing amount of unspent funds is in many respects the most significant from both a service delivery and financial performance perspective.

From a consumer perspective, the large amount of unspent funds could be as a result of not fully utilising the subsidy provided to enable an overall package of care and support. Our indications are that between 8% - 12% of unspent funds are later utilised by a care recipient, with the remainder being used for capital purchases or returned to the government due to the consumer moving out of in-home care.

From a provider perspective, unspent funds affects the profitability (and sustainability) as the fixed costs for each client have already been absorbed and should the funds be utilised it is only the additional variable costs that would be incurred. We estimate the additional variable costs would be in the order of 35% - 40%, and the balance would be profit (in an overall sense).

We are also not aware of any provider who would not prefer to either provide services commensurate to the funding or have the underutilised funds reallocated to other new care recipients that are currently awaiting packages.

Another related issue is that due to the high level of unspent funds per client, there is a reluctance by providers to charge (and consumers to be charged) a client contribution (basic daily care fee) as it would effectively only add to the quantum of unspent funds. This distorts the overall funding model and discourages the notion of consumers "co-contributing" to their care needs.

Staff Hours Worked per Client

The average direct care hours per client per week have declined from the levels in FY17. This is partly due to lower available package revenue as a direct result of the increased unspent funds.

While a decrease in administration and support staff hours was observed across the survey for the FY18, there has been an increase in hours when comparing the Dec-18 period to the Dec-17 period. In contrast, there is a significant reduction in administration and support hours for the First 25% in this Dec-18 period. Many providers are making a concerted effort to improve efficiencies in this area to reduce costs.

Table 10: Home Care Staff Hours per client per week from Dec-18 and Dec-17

	Average			***First 25%***		
	Dec-18	**Dec-17**		**Dec-18**	**Dec-17**	
Direct service provision	5.05	5.38	↓	5.41	6.36	↓
Agency	0.18	0.27	↓	0.10	0.29	↓
Case management & advisory	0.94	0.90	↑	0.91	1.36	↑
Administration & support services (including co-ordination)	0.52	0.58	↑	0.53	0.80	↓
Total Staff Hours	**6.69**	**7.14**	↓	**6.96**	**8.81**	↓

Sector Data (GEN)

- Additional 406 approved home care providers since Jun-16 (902 in total as at 31 December 2018)
- Post deregulation - growth since Mar-17 to Dec-18 is 30.2% (209 providers)
- Additional 26,577 consumers since Jun-16 (at Sep-18 is 90,646 consumers)
- Reduction of 1,201 persons in packages in Sep-18 quarter
- Post deregulation - growth since Mar-17 to Sep-18 is 30% (20,067 consumers)
  - 22.2% increase in home care consumers between Sep-17 and Sep-18 (16,441 additional consumers).
- 53,770 queued either in or offered a lower level package and 73,978 not in or assigned a lower level package as at 30 September 2018 (127,748 in total in national prioritisation queue). This is an overall increase of 1,016 in the September quarter.

Figure 23: Number of Home Care Providers (GEN data)

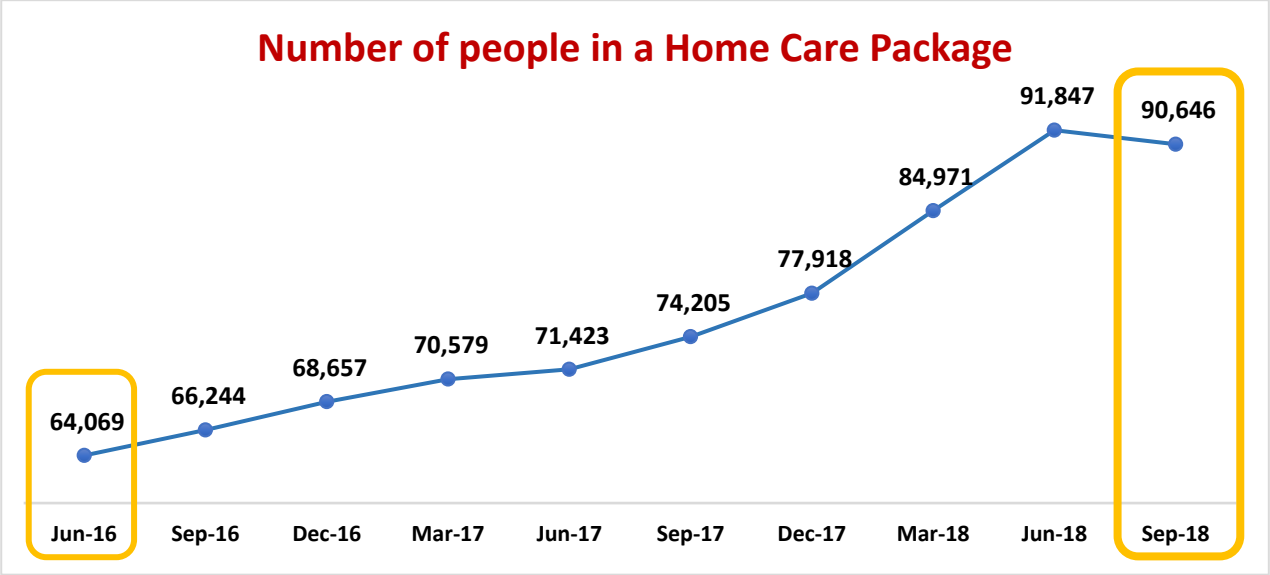
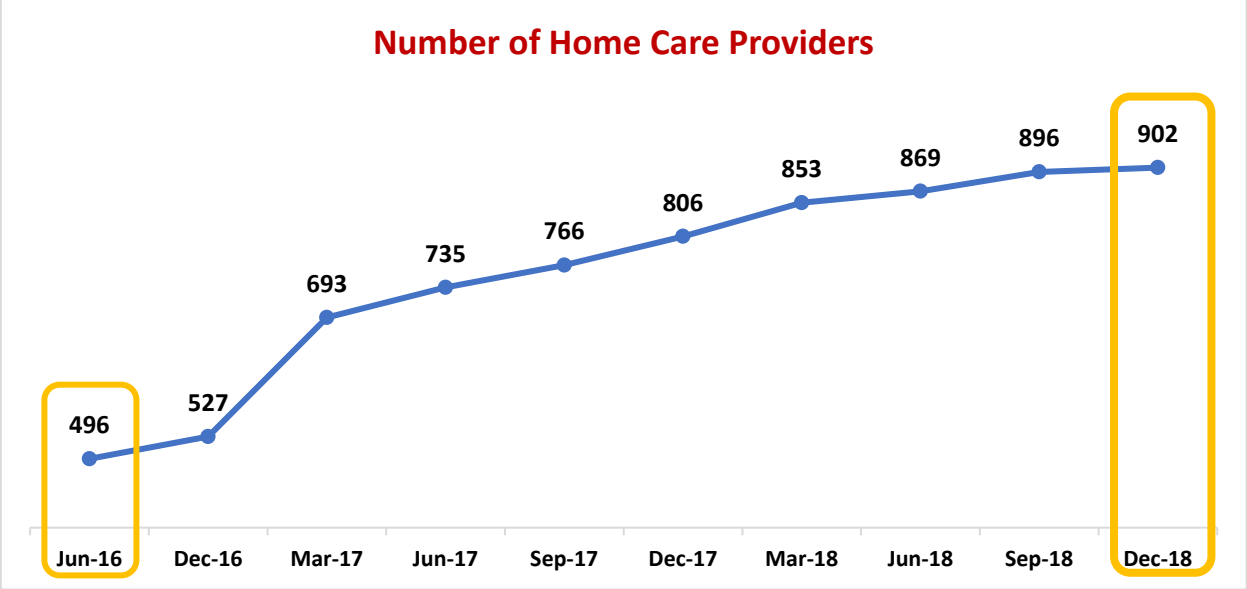


Figure 24: Number of Home Care Consumers (GEN data)



7. FUTURE SUSTAINABILITY - ISSUES TO CONSIDER

Analysis

A number of significant issues need to be considered when assessing the future funding model that is required to meet the requirements of a sector that is experiencing considerable resource pressures.

Whilst residential care has some clear financing issues that should be addressed as a priority, it should be noted that the Home Care Packages Program (HCP), Commonwealth Home Support Programme (CHSP) and Veterans Home Care Program (VHC) amongst a number of similar community programmes must also be considered in relation to the future funding models.

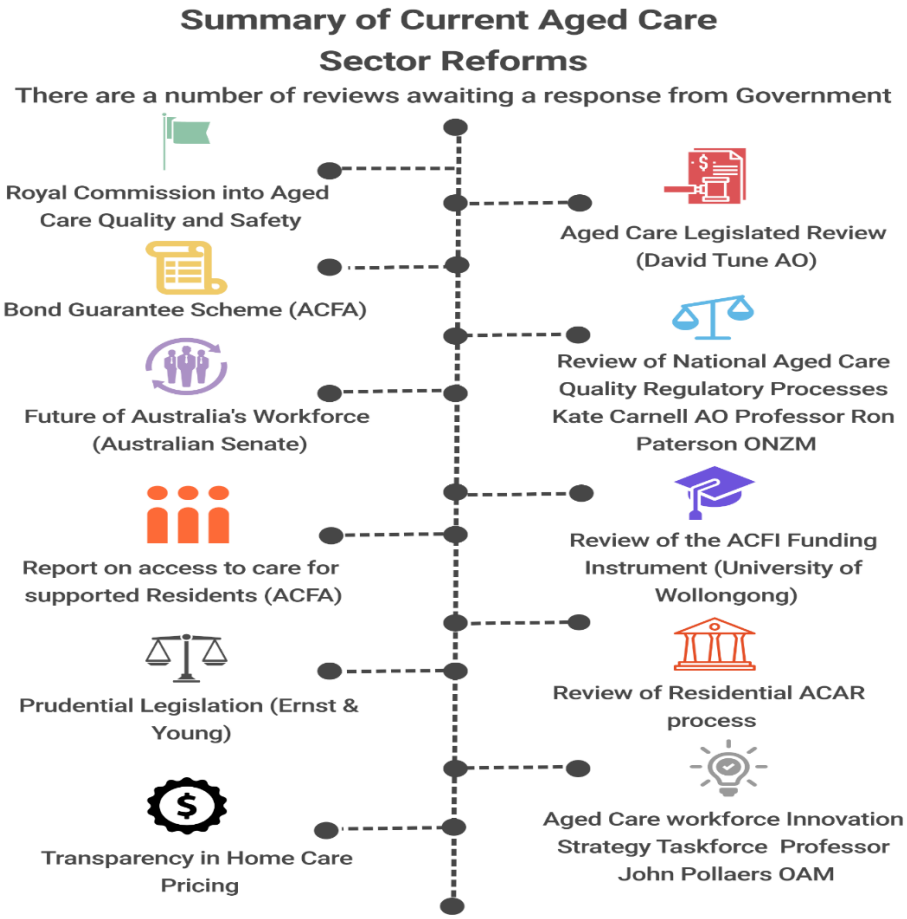
For the purpose of this brief analysis we are making specific comment on the Residential Care and HCP segments.

Current Reforms

The future sustainability of the sector will be dependent upon the impact of impending reforms and initiatives.

The graphic below summarises the current reforms that are progressing within the sector. Individually each reform has considerable importance and support, however, the sector has undergone considerable reforms dating back to 1997 (*Aged Care Act*) which have compounded the administrative and governance burden and affect strategic decisions due to uncertainty.

Figure 25: Summary of Current Aged Care Sector Reforms



Issues to be Considered

Specific areas that will need to be considered in developing a financially sustainable aged care sector include:-

Residential Care

- ACFI Funding - review the quantum of inflation (COPE) increases together with a stronger relationship between the funding instrument and actual resident care needs
- Additional funding is required for the Behaviour (BEH) and Complex Health Care (CHC) CFI domains due to the increased number of residents with dementia or other behaviour attributes, and with greater numbers of residents requiring palliative care and having almost sub-acute health conditions
- Rural, Remote and Very Remote facilities will continue to require a range of specific funding initiatives and support *(a possible remedy may be to fund the facilities at full occupancy levels based on the average ACFI - a similar concept to that adopted for MPS)*
- Workforce strategies, including availability, retention, career development, staffing levels, remuneration and conditions
- Additional and Optional Service Fees - clearer regulatory guidance, move toward either the deregulation of Basic Daily Fee or increasing the Basic Daily Fee base amount *(to $60 per day as a guide)*
- Accommodation Pricing - consumer education as to what is included in accommodation pricing, providers to increase the pricing and with an emphasis on a receiving a greater percentage of combination (RAD and DAP) receipts
- Innovation to be supported and encouraged at regulatory and legislative level
- Enhancement of My Aged Care functionality and portability
- Clearer and defined legislative and regulatory environment

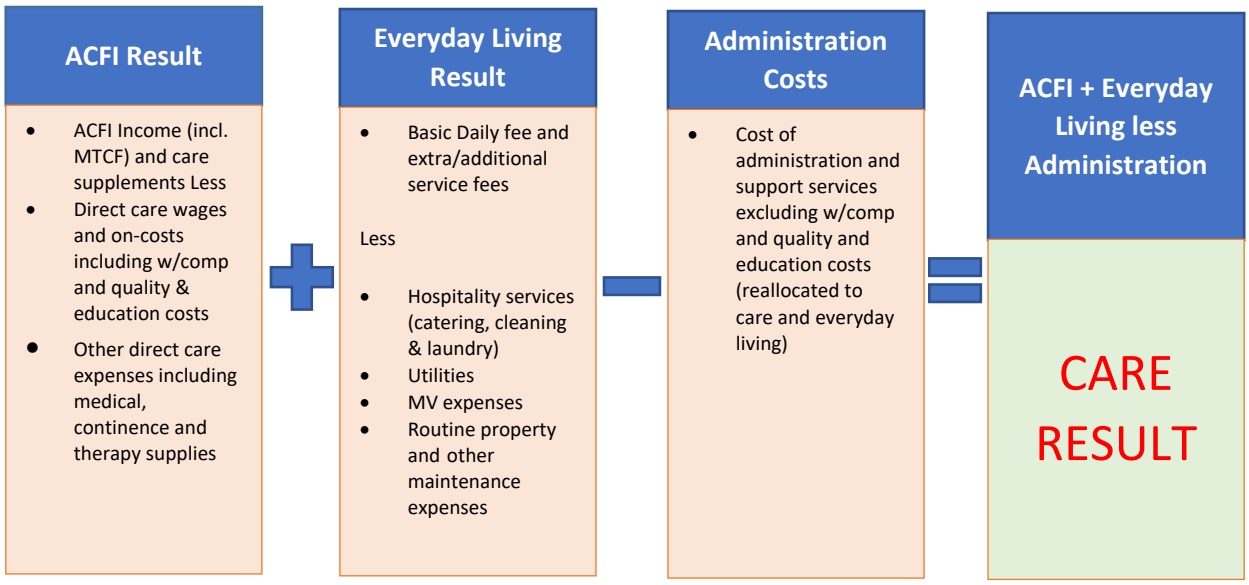
Home Care

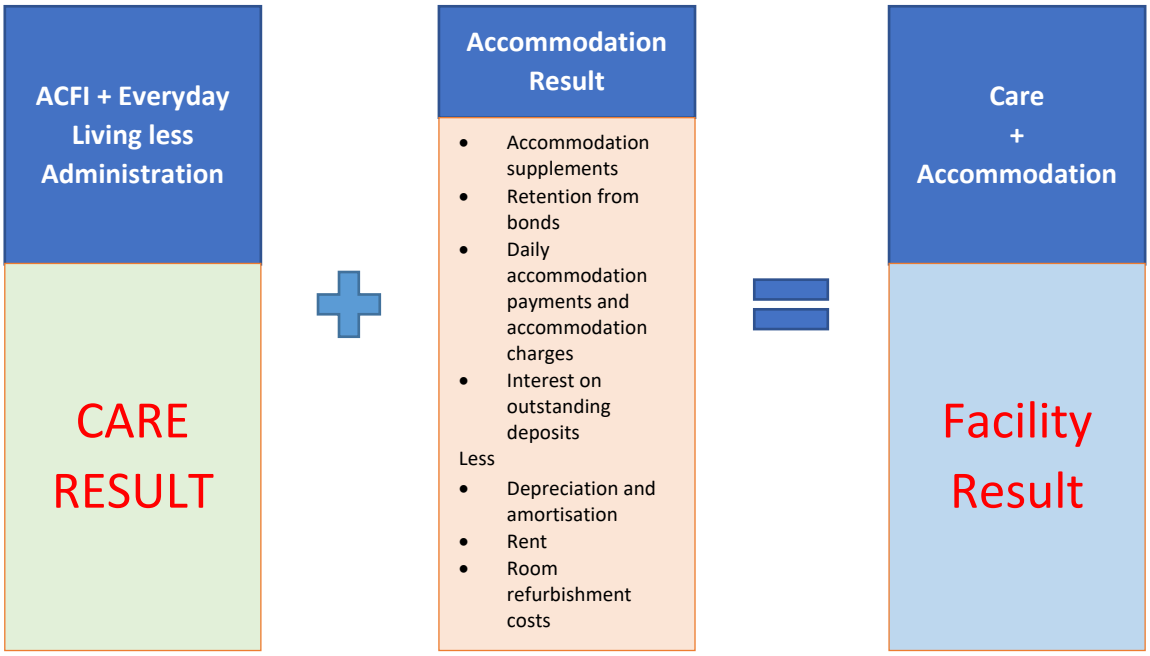
- National Prioritisation Queue and waiting lists - continued funding initiatives (in addition to MYEFO and recently announced increased package funding) to reduce the size of the prioritisation queue and reduce the length of time from consumer funding approval to the funding being provided - we note the additional home care places announced in MYEFO and further packages announced more recently in February
- Pricing Transparency - ensure that it does not disadvantage providers or consumers and allows for care delivery and business model innovation
- Pricing and Service Delivery - more clarity and flexibility in relation to provision of service guidelines *(including clear guidelines in relation to providing a package "bundle")*
- Quality Audits - enhanced monitoring and appropriate responses to non-conformance
- Unspent Funds - clearer definitions around use of unspent funds and possible redistribution of under-utilised funds to other consumers on wait lists (dependent on assessment of composition of unspent funds)
- Consumer Education - greater focus on providing increased consumer (and provider) education
- Enhancement of My Aged Care functionality and portability
- Clearer and defined legislative and regulatory environment (including quality and service delivery guidelines)
- Partial integration of CHSP and HCP programs *(possibly via Levels 1 and 2 funding)*
- Commitment to compulsory charging of client contributions (to encourage the notion of co-contributing to care)

8. APPENDIX A - GLOSSARY

Facility Result

*The **Facility Result** comprises the below components. The Care Result is a derivative of the resident acuity (care) needs whilst the Accommodation Result is derived from revenue streams not directly related to resident acuity but the resident's financial ability to pay for residential accommodation.*





Accommodation Result
Accommodation Result is the net result of accommodation revenue (DAPs/DACs/Accommodation supplements) and expenses related to capital items such as depreciation, property rental and refurbishment costs. It no longer includes costs associated with recurrent repairs and maintenance and motor vehicles.

ACFA
Aged Care Financing Authority - the statutory authority which provides independent advice to the government on funding and financing issues, informed by consultation with consumers, and the aged care and finance sectors.

ACFI revenue
Aged Care Funding Instrument (ACFI) revenue includes the subsidy received from the Commonwealth and the means-tested care fee component levied to the resident. ACFI revenue includes the additional care supplement subsidies and some specific grant (not capital) funding.

ACFI Result
ACFI Result represents the net result from revenue and expenses directly associated with care. It includes ACFI and Supplements (including means-tested care fee) revenue less total care expenditure, and this includes an allocation of workers compensation and quality and education costs.

Administration Costs
Administration Costs includes the direct costs related to administration and support services and excludes the allocation of workers compensation and quality and education costs to ACFI and Everyday Living.

***Average*s**
For residential care all *averages* are calculated using the total of the raw data submitted for any one-line item and then dividing that total by the total occupied bed days for the facilities in the group. For example, the average for contract catering across all facilities would be the total amount submitted for that line item divided by the total occupied bed days for all facilities in the survey.

For home care all *averages* are calculated using the total of the raw data submitted for any one-line item and then dividing that total by the total client days for the programs in the group. For example, the average for sub-contracted and brokerage costs across all programs would be the total amount submitted for that line item divided by the total client days for all programs in the survey.

***Average* by line item**
This measure is *average*d across only those facilities that provide data for that line item. All other measures are *average*d across all the facilities in the particular group. The *average* by line item is particularly useful for line items such as contract catering, cleaning and laundry, property rental, extra service revenue and administration fees as these items are not included by everyone

Bed day
The number of days that a residential care place is occupied in the Survey period. Usually represents the days for which an ACFI subsidy or equivalent respite subsidy has been received.

Benchmark
We consider the benchmark to be the average of the *First 25%* in the group of programs being examined. For example, if we are examining the results for facilities/ programs in Band 4, then the benchmark would be the average of the *First 25%* of the facilities/ programs in Band 4.

Care Result
This is the element of the facility result that includes the direct care expenses and everyday living costs and administration and support costs. It is calculated as ACFI Result *plus* Everyday Living Result *minus* Administration Costs.

Dollars per bed day
This is the common measure used to compare items across facilities. The denominator used in this measure is the number of occupied bed days for any facility or group of facilities.

Dollars per client day
This is the common measure used to compare items across programs. The denominator used in this measure is the number of client days for any programs or group of programs.

EBIT
Earnings Before Interest (including investment revenue) and taxation. This is a measure that excludes those variables relating to the tax status and financial position of an entity but recognises the consumption of capital in the form of depreciation and amortisation.

EBITDAR
This measure represents earnings before interest (including investment revenue), taxation, depreciation, amortisation and rent. The calculation excludes interest (and investment) revenue as well as interest expense on borrowings. EBITDAR is used for residential care analysis only, whereas Home Care uses EBITDA only.

The main reason for this is to achieve some consistency in the calculation. Different organisations allocate interest and investment revenue differently at the "facility level". To ensure that the measure is consistent across all organisations we exclude these revenue and expense items.

EBITDAR per bed per annum

Calculation of the overall Facility EBITDAR for the financial year divided by the number of operational beds in the facility.

EBT
Earnings before tax. This may also be referred to as the net result or, in the residential facility analysis, as the facility result.

Facility EBITDAR
The starting point for this calculation is the Facility Result which is the combination of the Care and Accommodation results. It excludes all "provider revenue and expenditure" including fundraising revenue, revaluations, donations, capital grants and sundry revenue. It also excludes those items excluded from the EBITDAR calculation above. This measure is more consistent across the facilities because it excludes all those items which are generally allocated at the facility level on an inconsistent and arbitrary basis depending on the policies of the individual provider.

*** The previous metric of Provider EBITDA is no longer included in the reporting as it is not considered to be a key indicator of facility performance.*

Everyday Living Result
Revenue from Basic Daily Fee plus Extra or Optional Service fees less Hotel Services (catering, cleaning, laundry), Utilities, Motor Vehicles and regular Property & Maintenance (includes allocation of workers compensation premium and quality and education costs to hotel services staff)

***First 25%* - Residential Care and Home Care Packages (HCP)**

The Residential Care and Home Care results (EBT) are distributed for the Survey period from highest to lowest in terms of $ per bed/client per day ($pd). This is then divided into four quartiles - the first 25%, second 25%, third 25%, fourth 25% and the average of each quartile is reported. The *First 25%* represents the quartile of programs with the highest EBIT $pd, the second 25% represents the quartile with the second highest EBIT $pd, the third 25% represents the quartile with the third highest EBIT $pd, whilst the fourth 25% represents the quartile of programs with the lowest (fourth highest) EBIT $pd.

Location - City

Facilities have been designated as being city based according to the designation by the Department of Health in their listing of aged care services. Those that were designated as being a “Major City of Australia” have been designated City.

Location - Regional

Facilities have been designated as being regionally based according to the designation by the Department of Health in their listing of aged care services. Those that were designated as being an “Inner Regional”, “Outer Regional” or “Remote” have been designated as Regional.

Survey

Survey is the abbreviation used in relation to the *Aged Care Financial Performance Survey*.

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BEFORE THE FAIR WORK COMMISSION

Fair Work Act 2009 (Cth)

Title of matter: 4 yearly review of modern awards – Social, Community, Home Care and Disability Services Industry Award 2010 – Tranche 2 proceedings

Section: s156

Matter Number: AM2018/26

Document: Submissions of the Australian Federation of Employers and Industries (AFEI) in support of ABI proposed variations

Filed: Pursuant to Directions issued 28 June 2019

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Submissions in support of ABI proposed variations

1. These submissions are filed pursuant to Directions of 28 June 2019, in matter AM2018/26, 4-yearly review of the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award), and address the AFEI's support of discrete elements of the variations proposed by Australian Business Industrial, and NSW Business Chamber (**ABI**), as outlined in the draft determinations filed 2 April 2019.

2. To the extent any of the ABI proposed variations are opposed, AFEI intends to file materials in reply by 3 September 2019.

Clause 25.1 and 25.4(a) - Ordinary hours of work

3. AFEI supports the ABI proposed variation to Clause 25.1.

4. The current Award provisions do not provide flexibility for employers to customise its arrangement of shifts and hours for full time employees, beyond the arrangements listed in Clause 25.1. If an employer requires an arrangement of shifts that is not contemplated in Clause 25.1, the employer would need to employ part-time or casual employees, or incur overtime rates.

5. The current restrictions in the Award are not supported by historical provisions in the social and community services industry (at least in NSW), nor current industry needs. Rather,

   a. Such restrictions were not included in the *Social and Community Services Employees (NSW) State Award*, which provided:

      ordinary hours of work shall be no more than 152 hours in any four week period exclusive of meal breaks, worked between the hours of 6am and 8pm Monday to Sunday inclusive.[1]

   b. In the disability services sector in particular, work includes provision of daily services without fixed duration from client to client, and aims to 'maximum choice and control for [NDIS] participants'.[2]

6. AFEI also supports the ABI application to vary Clause 25.4(a) – rest breaks between rostered work.

[1] Clause 11.1

[2] NDIS Market Position Statement, NSW, 2016.

Clause 25.5(d)(ii) – Change in roster

7. AFEI supports the ABI application to vary Clause 25.5(d)(ii) to include an ability to alter a roster at any time '*by agreement between the employer and relevant employee*.'

8. AFEI does not however support the proposed administrative requirement for the agreement between the employer and employee to be recorded in writing, in order for such an agreement to take effect as mutually intended.

9. AFEI supports the ABI application to vary Clause 25.5(d)(ii) to reflect the additional kinds of employee absences that could impact an organisation's ability to enable effective service delivery, as outlined at 25.5(d)(ii)B of the draft determination.

Clause 25.5(f) - Client cancellation

10. AFEI supports the introduction of paragraph 25.5(f)(i) and (ii) as outlined in the draft determination, insofar as it includes disability services as being subject to client cancellation provisions, and outlining the actions that may be taken by an employer in the event of a client cancellation in A and B.

11. AFEI does not support the removal of the words from the current provision at 25.5(f)(i) that '*in such circumstances no payment will be made to the employee*.'

12. AFEI reserves its position in respect to the proposed introduction of Clauses 25.5(f)(iii) – (vi) in the ABI draft determination.

Clause 20.10 - Remote response and Clause 28.5 - Recall to work overtime

13. AFEI supports the ABI's proposed introduction of Clause 20.10 for remote response work.

14. AFEI supports the clarification provided in ABI's proposed variation to Clause 28.5, including that recall to work does not apply to an employee performing remote response duties. Further in support, we say:

    a. ***Firstly,*** the proposed variation is consistent with the ordinary meaning of the term 'recalled,' that '*a person who is recalled is summoned to return to a place in a manner where there is a requirement for the person to return*.'[3]

    b. ***Secondly***, the remote response duties in the ABI proposed variation are also consistent with core responsibilities included in the Award's classification structure. For example, a Level 2 Social and Community Services Employee's responsibilities can include work allocation, rostering, and providing guidance.[4] Performance of core responsibilities as part of an ongoing arrangement are rightly distinguished from being "recalled to work" involving a specific instruction or direction to an employee on a particular occasion and for a more particular purpose.[5]

[3] [2018] FWC 4334 at [59]
[4] B.2.2(n), SCHADS Award
[5] See Polan v Goulburn Valley Health [2016] FCA 440 at [76]

BEFORE THE FAIR WORK COMMISSION

Fair Work Act 2009 (Cth)

Title of matter: 4 yearly review of modern awards—*Social, Community, Home Care and Disability Services Industry Award 2010*—Tranche 2

Section: s.156

Matter Number: AM2018/26

Document: Submissions in reply to outstanding union claims

Filed: Pursuant to Amended Directions issued 11 July 2019

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Background

1. These submissions are made to the Fair Work Commission (the **Commission**) by the Australian Federation of Employers and Industries (AFEI) in respect to the 4 yearly review of the Social, Community, Home Care and Disability Services Industry Award 2010 – Tranche 2 (AM2018/26).

2. In particular, these submissions are in reply to the outstanding union claims listed at Attachment C to the Amended Directions of 11 July 2019, except those claims in relation to travel time. AFEI intends to file submissions in reply to travel-related union claims by 3 September 2019.

The claims

3. Proposed variations to the Social, Community, Home Care and Disability Services Industry Award 2010 ('the **Award'**/'the **SCHADSI Award**') in Tranche 2 have been filed by the Health Services Union (**HSU**), the United Voice, and the Australian Services Union (**ASU**).

4. The union claims relevant to these submissions include proposals to vary the Award in respect to:

   a. Overtime for part-time employees working additional hours (HSU)

   b. Overtime for part-time and casual employees working more than 8hrs (HSU)

   c. Minimum engagements periods (HSU)

   d. Rosters (United Voice)

   e. Broken shifts (United Voice, HSU, ASU)

   f. Recall to work (HSU)

   g. Client Cancellation (HSU)

   h. Telephone allowance (United Voice, HSU)

   i. Clothing allowance (United Voice, HSU)

   j. Sleepovers (HSU)

5. AFEI objects to the claims, as outlined in these submissions.

Legal Framework

6. The legislative framework applicable to the 4 yearly review (the **Review**) was considered in some detail in the 4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues Decision.[1] The Decision outlined a number of principles to be considered in relation to the Review of a modern award.

7. ***Firstly***, in exercising its power to vary an award, the Commission must ensure that the award, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions, taking into account the matters contained in the modern awards objective.[2]

8. ***Secondly***, the objects of the Fair Work Act are also relevant to the exercise of this power.[3] The objects include, amongst other things, providing workplace relations laws that are flexible for businesses and acknowledging the special circumstances of small and medium-sized businesses.[4]

9. ***Thirdly***, the need for a 'stable' modern award system requires a party seeking to vary a modern award to advance a merit based argument in support of the proposed variation. In this regard, the circumstances of the proposal will dictate the extent of argument required. Relevantly, where there is a proposal for a substantial variation, such a proposal must be supported by submissions in addition to probative evidence properly directed at demonstrating facts which support the variation.[5]

10. ***Fourthly***, the party seeking the variation must demonstrate that the variation they propose only includes terms necessary to achieve the modern awards objective.[6]

11. ***Fifthly***, in conducting the review, the Commission will have regard to the historical context of the award.[7]

1 [2014] FWCFB 1788 ('Jurisdictional Issues Decision')
2 Ibid at [23]; the modern award objectives are found at s134 of the *Fair Work Act*
3 Ibid at [10]
4 *Fair Work Act* s.3(a) and (g)
5 *Jurisdictional Issues Decision* at [23]
6 Ibid at [32]
7 Ibid at [24]

Nature of the Industry

12. The Community Services sector is predominantly operated by not-for-profit organisations, many being charitable organisations, and most charitable organisations being small (revenue less than $250,000) to medium (revenue less than $1m) in size.[8]

13. In the disability care sector, around 78 per cent of the businesses are community/not-for-profit organisations while a further 21 per cent operate as commercial/private businesses.[9]

14. The sector is highly labour-intensive, staff/labour costs account for a very high proportion of total operating costs, usually more than 70%, but often more than 80% of total operating costs. Service providers in the industry also operate with very low profit margins.[10]

15. The sources of income for organisations in the industry are diverse, including:

    a. Various Commonwealth Government departments;

    b. Various State Government departments;

    c. Councils;

    d. NDIS fee for services;

    e. Fees as a contribution from clients;

    f. Full fees;

    g. Philanthropic Trusts;

    h. Donations;

    i. Sponsorships for services

16. In 2017-2018:

    a. Total Australian, State and Territory government recurrent expenditure on community services (including aged care services, services for people with disabilities, child protection services, and youth justice services) was estimated to be $31.5 billion in 2017-18, around 13.4 per cent of total government expenditure on services;[11]

    b. Total recurrent expenditure on child protection, out-of-home care, family support services and intensive family support services was $5.8 billion nationally; and[12]

    c. Total recurrent expenditure on youth justice community-based supervision and group conferencing was $333 million across Australia.[13]

[8] Australian Charities and not for Profit Commission definition: website, https://www.acnc.gov.au/tools/topic-guides/charity-size

[9] Department of Jobs and Small Business *Labour market for personal care workers 2017* - Appendix A

[10] Bennett, R, *A Report on the Funding and Sustainability of the Community Services Sector* – Report relied upon in AFEI's submission to the Equal Remuneration Case 2010-2012

[11] https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/community-services

[12] https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/community-services/child-protection

[13] https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/community-services/youth-justice

17. Government block-funding is provided in some sectors, and is obtained by tendering or sometimes commissioning from the funding Government Department or agency. Block funding contracts typically have a specified period or number of years (usually three years, but could be shorter) before being re-tendered. Recipient organisations are contracted to agreed outputs or outcomes and other conditions.

18. In the 2011 Equal Remuneration Decision, the Full Bench of the Commission observed that '*there is widespread reliance on government funding and that because of the pervasive influence of funding models any significant increase in remuneration which is not met by increased funding would cause serious difficulties for employers, with potential negative effects on employment and service provision*'.[14]

19. With 87.2% of respondents to the 2019 Fair Work Commission Survey of SCHADS Employers identifying that they received a *significant* proportion of income from Commonwealth, State or Local Government[15], it is evident that widespread reliance on government funding remains a major feature of the SCHADS industry. Accordingly, it remains true for the purpose of claims made in these proceedings, that increases in remuneration and consequent wage costs which are not met by increased funding would cause serious difficulties for employers, with potential negative effects on employment and service provision.

Developments in the industry

20. More recently, while private investment in welfare operations has increased, industry operators have been forced to increasingly rely on charitable donations by private citizens and companies.[16]

21. In recent years, the National Disability Insurance Scheme (NDIS) and My Aged Care Services have led a dramatic shift in the industry's funding from government block-funding to client directed, and client-specific funding. The NDIS is the first sector of the industry to provide clients the power to exercise choice and control by being able to purchase their supports directly from providers.

22. The NDIS is a fee for service, mostly on an hourly service basis. A client is able to determine the service required and the service provider within an agreed NDIS plan. This plan may be negotiated with the NDIA, with the services of a Plan Adviser, and the administration and information managed by the NDIS Plan organisation. Alternatively the plan may be self-managed where the person with a disability or their designated support person manage the choice of provider and expenditure.

[14] [2011] FWAFB 2700 at [272]

[15] Fair Work Commission Survey analysis of the *Social, Community, Home Care and Disability Services Industry Award 2010* June 2019

[16] IBIS Personal Welfare Services in Australia March 2019

23. The replacement of block grants with individual client funding has reduced certainty of funding for NDIS providers, impacting operational planning and certainty of workforce needs. This is particularly so as under the NDIS model, the fee is paid by the NDIS on delivery of the service, and for most categories of service has a regulated hourly rate set by the NDIS.

24. Under the NDIS there has been a significant increase in market competition for funded, client directed and fee for service clients. Service delivery providers are, however, limited in the use of strategies for remaining competitive (typically employed in more commercial settings), due to the high degree of regulation in pricing and service delivery under the NDIS.

25. Pricing regulation under the NDIS is intended to address various public policy interests, and is intended to continue until the market matures. In the meantime, price regulation needs to strike a fine balance of fiscal sustainability for the relevant stakeholders, which include not only tax-payers, but also some of the most vulnerable members of the community as recipients of the various human service providers.

26. As might be expected from such a diverse industry, the costs of providing services can be varied depending on the size, range and type of services provided, the extent to which it uses volunteers and/or obtains Local Council or other subsidies for its building or other infrastructure.

27. The staffing costs of providing an hour of service include not only direct service delivery staff, but also the management, administration, coordinator(s), and other specialised positions. Many of these positions are also covered by the SCHADSI Award. Cost savings measures to account for increases in staff wage costs which are not fully funded may occur by reducing non-support worker staff, and limiting investment in staff development and training; or alternatively, reducing the amount of supply or service hours if the cost increases are related to the weekend, overtime or other higher staff cost activities.

28. The cost of providing services could also be much higher where there are a limited number of clients, as this means the cost of the infrastructure, administration and other non-direct service delivery costs are higher per hour of service. This is of particular concern in areas of 'thin markets'. In our submissions of 22 May 2019, AFEI addressed the Department of Social Services and NDIA commissioned 'NDIS Thin Markets Project' at [35]-[36]. As highlighted in our earlier submissions, thin market challenges include:

    - '*Low client numbers (or difficulty finding/connecting with clients that are in a region), and/or highly dispersed clients result in higher per-client costs than can be supported under existing NDIS staff utilisation';* and
    - areas where '*providers have said there is not enough participant demand to support them to maintain a trained, skilled workforce*' and that thin market challenges '*not only present barriers to new providers entering the NDIS, they may also constrain the ability of current providers to deliver services'*.

29. As outlined in our earlier submissions, potential responses to thin markets are identified in the Thin Markets Project discussion paper as including 'market facilitation, market deepening, regulation, and alternative commissioning models'.[17] Irrespective of the approach taken by the Department, it is apparent that the market will continue to evolve (with an unknown degree of intervention) at least in the next few years, and is far from 'settled'.

30. It is also noted that the NDIS has not yet been fully rolled out, and that the composition of the NDIS market and labour market has evolved throughout its transition. To this point, we refer to our submissions of 22 May 2019 at [32]-[33].

31. Various government initiatives, including the thin markets project, contribute to the current evolutionary, uncertain, and complex nature of the industry and market, which is by no means 'settled' or 'matured'.

32. In the current state of the industry, unfunded increases in wage costs are likely to have negative effects on employment and services.

Submissions in Reply

Overtime for part-time employees working additional hours (HSU)

33. The HSU seeks to vary Clause 28.1(b)(iii) to require all time worked by part-time employees which exceeds hours agreed in 10.3(c) to be treated as overtime and paid at the rate of time and a half for the first two hours and double time thereafter.

34. The Award currently provides under the heading of Clause 28.1 – Overtime rates, and sub-clause 28.1(b) – Part-time employees and casual employees:

> ***(i)*** *All time worked by part-time or casual employees in excess of 38 hours per week or 76 hours per fortnight will be paid for at the rate of time and a half for the first two hours and double time thereafter, except that on Sundays such overtime will be paid for at the rate of double time and on public holidays at the rate of double time and a half.*
>
> ***(ii)*** *All time worked by part-time or casual employees which exceeds 10 hours per day, will be paid at the rate of time and a half for the first two hours and double time thereafter, except on Sundays when overtime will be paid for at the rate of double time, and on public holidays at the rate of double time and a half.*
>
> ***(iii)*** *Time worked up to the hours prescribed in clause 28.1(b)(ii) will, subject to clause 28.1(b)(i), not be regarded as overtime and will be paid for at the ordinary rate of pay (including the casual loading in the case of casual employees).*

[17] https://engage.dss.gov.au/wp-content/uploads/2019/04/Thin-Markets-Project-Discussion-Paper-2019-04-05.pdf

Reply to HSU contentions concerning the Modern Awards Objective – s134(da)

35. In support of their claim, the HSU argue '*the overtime functions under the Award do not meet the Modern Award objective, which recognises (at s.134(da)), the need to provide additional remuneration for employees working overtime; or employees working irregular or unpredictable hours'*. AFEI disputes this contention for several reasons, as outlined below.

36. ***Firstly,*** the Award clearly already provides additional remuneration for part-time employees who perform overtime. This is outlined in Clause 28.1(b)(i) and (ii) above.

37. ***Secondly,*** it is also clear from the text of the Award that it does not regard the hours worked by a part-time employee up to 38 per week/76 per fortnight, or 8 per day, as overtime. This is expressed in unequivocal terms at clause 28.1(b)(iii).

38. ***Thirdly,*** it is apt to point out that s134(da) does not amount to a statutory directive that modern awards must provide additional remuneration for employees working overtime. This was observed both in the Award Flexibility Decision, and subsequently in the Penalty Rates Decision.[18] Rather, Section 134(da) is but one consideration to be taken into account, along with a number of other considerations to be taken into account in s134, in the Commission's task of ensuring that the modern award provides a 'fair and relevant minimum safety net'.[19] s134(da) therefore does not amount to an imperative to make the variation sought by the HSU.

39. ***Fourthly,*** there are relevant provisions in the Fair Work Act and the Award which address any adverse consequences arising due to working overtime. Section 62(2) gives an employee a right to refuse to work additional hours 'if they are unreasonable'. The criteria for determining whether additional hours are reasonable or unreasonable are set out in s.62(3).[20]

40. ***Fifthly,*** any claim in reliance on the relevance of s134(da) would require probative evidence in support of a merit argument addressing the circumstances of employers and employees in the industries covered by this Award. The HSU evidence is, however, insufficient to make findings of substance on the circumstances of employees covered by the various sectors in the SCHADS industry. Observations may, however, be made that the HSU part-time employee witnesses appeared to suffer negligible inconvenience as a result of working additional hours. For example:

    a. The additional hours worked by Ms Wilcock and Ms Waddell were within their 'available hours';[21] and

    b. Ms Thames expressed that she is contracted to work a 'minimum of 20 hours a week'[22] and would 'like to have more hours'.[23]

[18] Re 4-yearly review of modern awards – Penalty Rates [2017] FWCFB 1001 ('Penalty Rates Decision') [197]

[19] Penalty Rates Decision [196]

[20] See also discussion in the Penalty Rates Decision at [155]

[21] Statement of Pamela Wilcock at [4], Statement of Heather Waddell at [7].

[22] Statement of Thelma Thames at [9]

[23] Ibid

Reply to HSU contentions concerning a 'structural incentive to underestimate hours'

41. The HSU also argue in support of their claim that '*the absence of any penalty associated with the performance of such work creates a 'structural incentive to underestimate the hours of work required of a part-time employee at the time of engagement and/or rostering'*.

42. To address this contention, the specific provisions of clause 10.3(c) and (e) are extracted below:

> ***(c)*** *Before commencing employment, the employer and* [part-time] *employee will agree in writing on:*
>
> ***(i)*** *on a regular pattern of work including the number of hours to be worked each week, and*
>
> ***(ii)*** *the days of the week the employee will work and the starting and finishing times each day.*
>
> ***(e)*** *The agreement made pursuant to clause 10.3(c) may subsequently be varied by agreement between the employer and employee in writing. Any such agreement may be ongoing or for a specified period of time.*

43. AFEI disputes the HSU's inference that employers and part-time employees in the industry should be reaching agreement on a higher quantum of hours as part of the regular pattern of work, at the time of engagement/rostering.

44. From a practical perspective, the regular pattern of hours agreed in Clause 10.3(c) should be hours which the employer can reasonably predict are needed as productive hours of work, and will be needed on an ongoing basis. This is in the circumstances that:

a. the employer is unable to vary the regular pattern of work without agreement from the employee in writing;

b. part-time employment is (by its nature) ongoing.

45. It is therefore reasonable and sensible for employers to be cautious in their predictions of hours of work that can be offered as a regular pattern of work on a permanent basis. Particularly due to fluctuation in service delivery requirements, which may be outside the employer's control, and in the circumstances that NDIS service fees are paid to the service provider on delivery of the service (rather than on service-booking).

46. It is also largely relevant that the regular pattern of hours fixed pursuant to clause 10.3 involves an agreement with the part-time employee. The part-time employee therefore has the prerogative to impose caveats in respect to the hours they will be required to present themselves for work on a regular basis.[24]

[24] Subject to s62 of the Act.

47. To the extent the Award permits employers some degree of prerogative in estimation of the regular pattern of part-time hours of work that may be offered on a permanent basis, this is consistent with the 'need to promote flexible modern work practices and the efficient and productive performance of work' (s.134(1)(d)). It is not an appropriate basis to vary the Award in the manner sought by the HSU.

48. It is also relevant to note that the Full Bench of the Commission rejected a claim from employers in the Part Time and Casual Employment Case for additional flexibility in relation to part-time employment, basing the decision (in part) on the existing ability to roster part-time employees to perform additional hours without incurring overtime rates:

> *'Second, we consider that the current provision as is applied in practice is reasonably flexible…clause 28.2(b)(iii) allows for part-time workers to work additional hours up to 10 in a day or 38 in a week or 76 in a fortnight without the payment of any overtime penalty rate, so there is a considerable capacity to assign additional hours that may arise at short notice to employees* ***without the cost exceeding what the NDIA price structure will allow.*** *The evidence showed that employees are generally willing to work such additional hours if it does not interfere with fixed private commitments'.*[25] [our emphasis]

49. If the Award were varied to include overtime rates for part-time employees working hours additional to those agreed in Clause 10.3(c), this would remove flexibility in the Award which the Commission has already identified as 'reasonable', and has acknowledged the relevance of existing provisions in meeting industry needs.

The impact of applying overtime rates to agreed additional hours up to 38 per week/ 76 per fortnight

50. AFEI also disputes the HSU's inference that overtime rates would result in an increase in hours agreed with part-time employees at the time of engagement/rostering. There is no evidence that the variation would result in part-time employees having any higher agreed/rostered hours if overtime provisions applied for hours worked in excess of those agreed in Clause 10.3(c).

51. It is plain that the variation would, however, result in substantially additional cost to employers for offering any additional hours to part-time employees, as compared to casual employees.

52. Significantly, under the NDIS an employer cannot recover the overtime cost of a part-time employee's additional hours.[26]

[25] Part Time and Casual Employment Decision [637]

[26] https://www.ndis.gov.au/media/1455/download

53. The variation would also have the effect that a full time employee and a part-time employee being entitled to substantially different pay without any difference in the quantity, quality or value of the work. For example:

a. A part-time employee with 20 agreed hours per week, would receive the equivalent of 55x the ordinary hourly rate for working 38 hours in a week.

b. It could even result in a part-time employee being entitled to a higher weekly pay for working less hours than a full time employee. A part-time employee with 20 agreed hours per week would receive the equivalent of 39x the ordinary hourly rate for working 30 hours in a week.

Such a result would be inconsistent with the modern awards objective to promote the efficient and productive performance of work.[27]

54. It would also impact the viability of offering part-time employment (or accepting requests for part-time employment) for those who would prefer reduced permanent hours due to family or other personal commitments, and serve as a further disincentive to offer additional hours to part-time employees. Such a result would also be inconsistent with the modern awards objective to promote social inclusion through increased workforce participation.[28]

Relevance of the increase in cost of part-time employment to the current workforce composition

55. In its submissions, the HSU identify that '*of the permanent workforce of disability support workers, part-time work is the dominant, and increasing, mode of employment*'.[29] In comparing the proportion of part-time employment to casual employment, however, casual employment remains the preferred mode of employment overall in the industry.[30]

56. In its 2017 Part Time/Casual Employment Decision, the Full Bench observed:

> *'…there remains considerable uncertainty as to how the NDIS will operate and what will be the pattern of service demand from participants once the NDIS is fully implemented. We consider it to be likely that this uncertainty is a major reason for the current degree of preferment for casual employment, and that once the NDIS has been fully implemented and its operation becomes more certain and stable, part-time employment will be maintained as a substantial feature of the workforce.'*

[27] s134(1)(d)
[28] s134(1)(c)
[29] HSU submissions at [12]
[30] Fair Work Commission Survey analysis of the *Social, Community, Home Care and Disability Services Industry Award 2010* June 2019, p7

57. Since the 2017 Part Time/Casual Employment decision, there has remained considerable uncertainty in the NDIS market. Most significantly, the NDIS has not yet been fully implemented. Further uncertainty in the pattern of service demand in the NDIS industry was highlighted in our submissions of 22 May 2019 at [35]-[37].

58. The continued uncertainty in the industry and associated preferment for casual employment weighs against a decision that would increase the cost and regulatory burden of part-time employment and undermine the preferred course of establishing part-time employment as a substantial feature of the workforce.

In conclusion

59. The HSU:

a. does not make out a merit argument for the variation;

b. does not provide justification for removing a flexibility for employers in the Award which has been specifically acknowledged by the Full Bench in its 2017 Part-Time and Casual Employment Decision;

c. does not provide justification for the additional cost burden to employers that would arise as a result of the proposed variation;

d. particularly in circumstances where overtime costs are not recoverable, serve as a distinctive to provide additional part time hours;

e. proposes a variation that is not consistent with the modern awards objective;

f. is not supported by probative evidence, and should be rejected.

Claims for overtime after 8 hours per day (HSU)

60. The HSU further propose to vary the Clause 28.1(b)(ii) so that all time worked by part-time or casual employees which exceeds 8 hours per day, will be paid at the rate of time and a half for the first two hours and double time thereafter.

61. Clause 28.1(b)(ii) is under the heading '28.1 Overtime rates'. The provision thus signals to the reader that it deals with incidents of work which are overtime.

62. The Award's current provision of overtime becoming payable after 10 hours per day enables the facilitative provision in clause 25.1(b)[31] to have proper effect. So where an employee or majority of employees have reached agreement with their employer to work 10 ordinary hours in a day pursuant to clause 25.1(b), the hours up to 10 can be treated as 'ordinary hours'. This is important to maintain for several reasons:

    a. ***Firstly***, by having the character of ordinary hours, they will attract superannuation for both part-time employees and casual employees;

    b. ***Secondly,*** by having the character of ordinary hours, they will attract annual leave accruals;

    c. ***Thirdly,*** by having the character of ordinary hours, they can be part of a part-time employee's regular pattern of hours, and can be relied on by the employee as a predictable source of income, and can be relied on by the service provider (employer) and client as predictable hours of the employee's availability;

    d. ***Fourthly,*** if the ninth and tenth hours were not ordinary hours, then this result would undermine the agreement reached pursuant to 25.1(b).

63. The HSU evidence is gravely insufficient for the Commission to make any findings about the overall impact of the current provisions on employees covered by the SCHADSI Award, this is particularly so as:

    a. The evidence referred to in respect to this claim is limited to two support workers.[32] Such evidence would be insufficient for the Commission to make any findings about the overall impact of the current provisions on a single workplace let alone an entire sector, let alone an entire industry;

    b. The HSU rely on a reference to the nature of providing 'personal or domestic assistance for elderly clients or clients with a disability';[33] whereas the SCHADSI Award covers a wide range of other occupations.[34]

64. One relevant observation which may be made about the union evidence includes that a number of witnesses expressed the desire to work more hours[35].

65. If the proposed variation were made, it would also shorten the period of client care that could be available for the same price. This is a particularly undesirable outcome for NDIS participants who may already face high risk of supply shortage, including those in outer regional, remote or very remote areas, those with complex needs, or have acute care needs such as in crisis situations.

66. For the reasons outlined above, the claim should be rejected.

[31] Clause 25.1 corresponds with clause 13.1(b) in the Exposure Draft as at 15 March 2019. The Exposure Draft at Clause 7.2, lists 13.1(b) as a facilitative provision.

[32] HSU Submissions at [47]

[33] HSU Submissions at [47]

[34] SCHADSI Award, Schedule B

[35] See for example statements of Thelma Thames at [9], Deon Fleming at [17], Trish Stewart at [11]

Minimum engagement periods – (HSU) S10

67. The HSU has made a claim for a minimum engagement period of 3 hours for all employees covered by the Award.

68. The HSU minimum engagements claim affects casual employees, part-time employees, and full-time employees in all sectors of the Award.

69. Some observations may be made about the implications of this claim, which are relevant across casual, part-time and full-time employment. These include:

    a. the variation could have the result that an employer would be liable to pay an employee for hours during which no productive work is being performed, particularly in circumstances where the service requirement is set by the client; or,

    b. diminish the services offered to, for example, NDIS participants where services required are less than the proposed minimum engagement of 3 hours.

Claim for 3 Hour Minimum Engagement – Part Time Employees

HSU evidence

70. Contrary to the HSU submission[36], its evidence does not establish that it is '*commonplace within the industry for employees to be "rostered" to perform very short shifts – sometimes less than an hour…'*. The following observations can be made about the HSU evidence in respect to this claim:

    a. The HSU lay witness evidence relied on includes that of several union officials, 3 part-time employees, and three statements from persons whose names and employers are not given. This volume of evidence is gravely insufficient to establish any indicative industry practices.

    b. The evidence of HSU union officials and Ms McDonald, to the extent it deals with shift lengths is hearsay, has little probative value, and should not be given any weight.

    c. In respect to Social and Community Services sectors of the SCHADSI Award (other than disability services) affected by the claim, such as migrant support services, youth support services, Aboriginal and Torres Strait Islander support services, and others, there appears to be no evidence apart from HSU union officials.

    d. In respect to the Family Day Care stream of the SCHADSI Award, which is also affected by this claim, there appears to be no evidence at all filed by the HSU.

    e. The SCHADSI Award does not apply to any of the named part-time employee witnesses relied on by the HSU[37], as they are all covered by enterprise agreements. Evidence about the length of shifts or periods of work performed by those employees pursuant to an enterprise agreement is irrelevant to these proceedings.

[36] Para [29]

[37] Ms Waddell, Ms Thames, and Mr Lobert

f. The subject matter of Ms McDonald's co-authored article (attached to her statement), is limited in scope to disability support workers. Whereas the 'industry' covered by the SCHADSI Award includes not only other sectors, but also different types of workers in the disability services sector. The article further acknowledges:

i. '*The 10 DSWs cannot be seen as representative of all DSWs working under the NDIS*'

ii. '*It is not possible to generalise from the experiences of this small sample…*'

Relevant Award History

71. In Part 10A Award Modernisation, it was brought to the AIRC's attention that there existed minimum engagement periods for part-time employees in some pre-modern awards, and no minimum engagement periods for part-time employees in others.[38]

72. Subsequent to Part 10A Award Modernisation, the absence of a minimum engagement period for part-time employees in the Award was taken into account in a decision by VP Watson in the 2-yearly transitional review, to insert the requirement to agree on a regular pattern of part-time hours. VP Watson stated at [20]:[39]

> ***[20]*** *That part of the application seeking a requirement that part-time arrangements be agreed in writing prior to commencing employment is a common award provision. It requires employees to be given clear information as to the basis of their employment when they are engaged. I consider that the case for such a clause is strong, <u>especially when there is no award minimum engagement period</u>*' [our emphasis].

73. Further, in the Part Time and Casual Employment Decision, the Full Bench again considered the absence of part-time minimum engagement periods in the Award 'most important' in its determination of whether there ought to be variation to the Award safety-net in relation to part-time employment conditions. This is evident at [635] and [638] of the Decision (emphasis added by AFEI):

> *[635] We are not satisfied at this time, having regard to the various matters specified in s134(1), that the new provision proposed by ABI and supported by Jobs Australia is necessary to achieve the modern awards objective. We have reached this conclusion for the following reasons.*
>
> …
>
> *[638] <u>Most importantly, the SCHADSI Award does not contain any requirement for a minimum number of hours' work per week, nor (unlike the current provisions in the Hospitality Awards) does it provide for any minimum hours per day.</u> This latter aspect of the award was emphasised by Vice President Watson in his 2013 decision which added the current clause 10.3(c), in the passage we have earlier set out. <u>That means that the agreed pattern of hours for a part-time employee can encompass short periods of service, which a number of the employer witnesses envisaged would be an increasingly common feature of the NDIS service model…</u>*

[38] AM2008/24, AFEI Submissions, 24 July 2009

[39] [2013] FWC 4141 at [20]

74. The history of the Award demonstrates that the absence of a part-time minimum engagement period has been treated as a flexibility to employers which balances other restrictions on part-time employment, particularly those in clause 10.3(c) of the Award.

75. The absence of a part-time minimum engagement period is thus an important feature of the Award's safety-net and should not be disturbed without flexibility gains for employers. To do so would result in a safety net which is not fair to employers. As flexibility gains for employers are not part of the HSU proposed variation, the claim should be rejected.

Implications of the claim

76. We refer to our submissions above at paras. 19 and 32 concerning implications of the cost of the claim generally.

77. We further refer to our submissions above at paras. 55—58 concerning the impact of increasing costs associated with part-time employment in this Award.

78. As outlined above, the HSU has not established a merit case for the inclusion of a minimum engagement period for part-time employees, supported by evidence. The proposed variation would also unnecessarily disturb the Award's safety net, and would involve additional cost/reduced flexibility for employers. The proposed variation could also have an adverse impact on service delivery. The claim should therefore be rejected.

Minimum Engagements – Casual Employees

79. The HSU seeks to vary the minimum engagement periods provided for casual employees in Clause 10.4(c) of the Award.

80. This would result in a change to the casual minimum engagement periods as follows:

Sector	Current minimum engagement	HSU Proposed variation	Increase proposed by HSU
Home care employees	1 Hr	3 Hrs	2 Hrs
Disability services work	2 Hrs	3 Hrs	1 Hr
Family day care scheme sector	2 Hrs	3 Hrs	1 Hr

81. In support of their claim, the HSU argue that the question of minimum engagement periods did not receive any systematic consideration in the award modernisation process.[40] AFEI disputes this contention particularly in relation to casual employment. The HSU's claim rather re-agitates a matter that has already been given due consideration by the AIRC Full Bench during Part 10A Award Modernisation.

[40] HSU submission at [25]

82. In fact, the first exposure draft for the SCHADSI Award during Part 10A Award Modernisation included a 3hr minimum engagement period for all casuals in all sectors.[41] In response, various parties including AFEI, made submissions to the AIRC, raising the differences in minimum engagement periods across pre-modern awards in the various sectors to be covered by the Award, and arguing the need to maintain casual minimum engagement periods that were relevant to the industry.

83. In respect to the Social and Community Services Sector, the NSW *Social and Community Services Employees (State) Award,* covering both disability work, and other social and community services work, had a casual minimum engagement of 2 hours.

84. In respect to the Home Care sector, the majority of pre-modern awards provided for a minimum casual engagement of 1 hour or less:

Casual Minimum Engagement	**Instrument**
1 hour	*Miscellaneous Workers Home Care Industry (State) Award [NAPSA – NSW]**
	Attendant Care – Victoria Award 2004
	Community Services (Home Care) (ACT) Award 2002
	*Community Services (Home Care Service of New South Wales) Care Workers Award 2002 ***
No minimum engagement	*Home and Community Care Award 2001*

* For casual employees engaged other than Live-In house-workers

** For employees engaged in personal care services, and respite care services to personal care clients.

85. The AIRC also received comprehensive submissions on the rationale for a 1hr minimum engagement period in the home care industry.

86. The Full Bench of the AIRC, when making the SCHADSI Award, ultimately rejected the imposition of a sector-wide 3 hour minimum engagement period for casual employees, stating:

> '*The minimum period of engagement for casuals has been altered to take into account the different sectors of this industry.*'[42]

87. In the circumstances the AIRC has already given specific consideration to the history and needs of the relevant sectors covered by the Award in setting the casual minimum engagement periods, the current provisions should not be disturbed unless there is sufficient evidence of any change in the circumstances of the sectors or employees that would warrant departure from the current provisions.

[41] http://www.airc.gov.au/awardmod/databases/social/Exposure/social.pdf

[42] [2009] AIRCFB 945 at [83]

88. The HSU's direct evidence in relation to its proposal to vary the casual minimum engagement period claim only appears to include two statements from casual employees, one in disability services, and the other in home care. Such limited evidence would be insufficient to give the Commission a proper indication of a single workplace let alone an entire sector, let alone a number of sectors covered by the Award. Furthermore, the HSU has not filed any evidence in respect to its proposal to vary the casual minimum engagement period for the Family Day Care Scheme Sector from 2 hours to 3 hours.

89. Such limited evidence does not assist the Commission in its review of minimum engagement periods for casual home care employees, casual disability services employees, or casual family day care scheme employees.

90. The HSU has not established a merit case for variation to the casual minimum engagement period, and any such variation would unnecessarily disturb arrangements in the Award which have been prescribed specifically for particular industries. The variation would involve increased cost/reduced flexibility for employers, and could also have an adverse impact on service delivery. The proposed variation should therefore be rejected.

Minimum Engagements – Full Time Employees

91. The HSU's proposed minimum engagement period of 3 hours would also apply to full-time employees. AFEI objects to this.

92. In support of their claim, the HSU refer to the rationale for minimum engagement periods as outlined in the 2017 Casual and Part-Time Employment Case.[43] It is clear, from the fact that most modern awards do not include full-time employment minimum engagement periods, that this rationale has nominal relevance to full time employees.

93. The HSU argues in support of their claim that '*it is commonplace within the industry for employees to be 'rostered' to perform very short shifts*…'. This contention cannot, however, be accepted by the Commission on the evidence which has been filed by the HSU. The HSU has not, however, filed any evidence of full-time employees identifying the length of shifts undertaken by them in order to establish what is/ is not commonplace for this mode of employment.

94. Further reasons for rejecting this claim include:

    a. There is no evidence of employers in the industry unnecessarily rostering full-time employees for very short shifts.

    b. Contrary to the circumstances of a casual employment generally (which is by the hour), a person in full time employment will not receive any less pay for working a short shift. Rather, a full time employee will receive 38 hours' pay each week[44] irrespective of whether they work short shifts or not.

[43] HSU Submissions at [23]

[44] Unless the person's hours are averaged over a fortnight/4-week period, in which they will receive 76 hours' pay every fortnight, or 152 hours' pay every month.

c. If a short shift is worked by a full-time employee, they will still have the balance of their full-time hours available to them, which will need to be structured in rostered shifts that comply with the maximum shift length provisions in Clause 25.1.

95. The HSU has not established a merit case for inserting a full-time minimum engagement period in this Award, and has produced no probative evidence in support of this aspect of its claim. For the reasons outlined above, the proposed variation should be rejected.

Rosters (United Voice)

96. The United Voice propose to vary clause 25.5(d)(i) so that full time and part-time employees will be entitled to payment of overtime for roster changes where seven days' notice is not provided.

97. As the United Voice do not propose to vary clause 25.(d)(ii), (iii), or (f), there would appear to be only four circumstances where this variation would have application, these being:

a. Where a full-time employee's roster has been changed with less than 7 days' notice by agreement to include hours that are different, but not additional to their original rostered hours;

b. Where a part-time employee's roster has been changed with less than 7 days' notice by agreement, to include hours that are different, but not additional to their original rostered hours;

c. Where a full-time or part-time employee's roster has been changed with less than 7 days' notice to include hours that are different, but not additional to their original rostered hours, without the employee's agreement; and

d. Where a part-time or full-time employee's hours have been changed with less than 7 days' notice to include hours that are additional to their original rostered hours without the employee's agreement.

98. In respect to the first two circumstances, it would be highly inappropriate that the Award impose an overtime rate for variation to rostered hours where the change has been made by mutual agreement between the employer and the employee. In respect to this, we refer to our submissions in support of the ABL proposed variation to clause 25.5(d).

99. In respect to the third circumstance, the United Voice states '*the Award does not explicitly identify what the consequence is for the employer for failing to provide seven days' notice of a roster change in a situation where the exceptions in clause 25.5(d)(ii) and (iii) do not apply'*. There is, however, no requirement that an Award specify the consequences for non-compliance with a particular term. There is further, no imperative in the Fair Work Act to impose a penalty provision in the Award to address non-compliance. The implications of non-

compliance with Award terms is sufficiently addressed in Chapter 4 of the *Fair Work Act 2009*. The Act also provides:

a. rights and protections to employees so that issues of non-compliance with Award terms can be raised without adverse action taken against them;

b. union rights of entry for investigation of non-compliance;

c. Fair Work Ombudsman powers of investigation of non-compliance;

d. standing of employees, and unions to seek legal redress for non-compliance with an Award; and

e. powers of the Fair Work Ombudsman for compliance enforcement.

100. The United Voice evidence does not address the extent to which any of the avenues already available under the Act to address non-compliance have been exhausted unsuccessfully, prior to seeking variation to the Award to impose further regulation. Additional regulation in such circumstances is inappropriate, particularly taking into account the modern awards objective at s134(f) to take into account the impact of the regulatory burden.

101. Further in respect to the first three circumstances, if a roster change with less than 7 days' notice attracted overtime rates of pay, this would result in uncertainty ascertaining which hours are overtime and which are ordinary hours. This would also have implications for identifying which hours attract superannuation and leave accruals, and could result in uncertainty in determining whether a person had been provided with their full weekly/fortnightly ordinary hours pursuant to any contractual arrangements.

102. In respect to the last circumstance, an employer may require an employee to work reasonable additional hours in accordance with s62 of the Act. The Act already directly addresses the adverse consequences associated with working additional hours by providing a right to refuse to work unreasonable hours. The criteria for determining whether additional hours are reasonable or unreasonable are set out in s62(3) and include the employees personal circumstances,[45] whether the employee is entitled to receive overtime payments,[46] the needs of the workplace or enterprise in which the employee is employed,[47] the nature of the employee's role[48], and the usual patterns of work in the industry in which the employee works.[49]

103. In support of the proposed variation, the United Voice rely on the evidence of Ms Sinclair. The roster changes referred to in Ms Sinclair's statement at [23] appear to largely involve the working of additional hours. Ms Sinclair claims that '*[I] am concerned that if I complain or don't accept additional hours, I will be rostered less.*'. This is, however, at odds with her statement that she '*need*[s] *the hours'.*[50]

[45] s62(3)(b)
[46] s62(3)(d)
[47] s62(3)(c)
[48] s62(3)(h)
[49] s62(3)(g)
[50] Statement of Belinda Sinclair at [26]

104. The United Voice's argument is not supported by probative evidence, and does not provide a basis for the Commission to conclude that the proposed variation is necessary in order for the Awards to achieve the Modern Awards Objective. The proposed variation would, however, result in unnecessarily high regulatory restraints and costs associated with achieving mutually suitable working arrangements with employees, as well as uncertainty for employers and employees in determining entitlements. The proposed variation should therefore be rejected.

Broken Shifts (HSU, United Voice and ASU)

105. The HSU seek to restrict broken shifts in three ways, as outlined at [39] of their submissions:

a. that the shift may only be broken once and not multiple times;

b. that the minimum period of engagement should be applied to each period of work in a broken shift; and

c. that the employee is paid, as if working, for the time necessary to travel between clients required to be undertaken during any break in the shift.

106. In respect to the HSU claim, AFEI will address the first two proposed changes in these submissions, and address the claim concerning time in travel in conjunction with submissions in reply to the Union claims concerning travel time.

107. The United Voice seeks to vary the Award so that shift allowances are determined by 'the starting or finishing time' of the broken shift, and so 'the maximum number of broken shifts which can be worked per day is two'.

108. The ASU seeks to include a 15% loading for employees working broken shifts, payable for each hour of the broken shift from commencement of the shift to conclusion of the shift inclusive of all breaks.

109. Relevant to all the union claims, is the fact that broken shift provisions as they currently stand, were inserted into the Award to specifically address the needs of the disability services and home care industries. This is evident in:

a. the terms of the Award, by limiting operation of the broken shift provision to the social and community services employees performing disability work, and home care employees[51]; and

b. submissions made to the AIRC during Award Modernisation proceedings for the SCHADSI Award about the operational requirements of the industries.[52]

[51] Clause 25.6

[52] See for example, oral submissions in transcript of proceedings, 5 November 2009, at pn3118, and pn1375

The number of breaks in a broken shift

110. In respect to Broken Shifts, the Award currently provides at 25.6(a) that '*a broken shift means a shift worked by an employee that includes one or more breaks (other than a meal break) and where the span of hours is not more than 12 hours'*.

111. It is clear on the Award terms, that the broken shift provision was specifically intended to allow employers the ability to roster an employee for a broken shift which contains more than one unpaid break. If this was not intended, the words 'or more' would not have been included in the provision.

Minimum engagements in a broken shift

112. The proposed variation to require the minimum period of engagement to apply to each period of work in a broken shift is not appropriate for the relevant sectors. This is particularly so in the context of the HSU's claim to increase the minimum engagement period for home care employees from 1 hour to 3 hours.

113. In the Part 10A Award Modernisation process, the AIRC heard the following oral submissions from AFEI concerning one example of the industries' difficulties with applying minimum engagement periods to incidents of work during a broken shift:

> [PN3118] *… Firstly, where in a small community there is one person requiring assistance, assistance to get out of bed, attend to personal matters and get the person ready for the day ahead whatever that might be and that may take an hour, it might take a bit more than an hour.*
>
> [PN3119] *Then that same person in reverse needs to have that whole process reversed at the end of the day to get the person back to bed. If the employer is required to pay a three hour minimum on each one of those staff that's clearly inequitable because the work that's required is significantly less than three hours. The other circumstance is where you may have two or three people in the same community who all require to get out of bed at a certain time and it might be the same time and have all the same processes completed and at the end of the day the same process is completed again. To have one or three people paid three hours for each shift is once again clearly inequitable and it's unable to roster a person to say well, we will use your full three hours, we'll use your full three hours dealing with the three people in the morning and three people in the evening.*
>
> [PN3120] *The trouble is that you have a person then dealt with at 8 o'clock, another person dealt with at 9 o'clock and another person getting out of bed at 10 o'clock and…we say that that needs to be attended to in this award as a unique and critical issue in this award.*

114. The example above of work being required at the start and end of the day is also consistent with the statement of ASU witness Mr Rathbone, concerning his rostering.

115. If the variation to prevent broken shifts from having multiple breaks is made, then this would inevitably have the result of broken shifts finishing earlier (i.e. the shift would need to end once work is completed on the second side of the break). An employer would then be unable to roster the employee for a further shift until the expiration of an additional 10 hours in accordance with the need to provide rest breaks between shifts in Clause 25.4.

The proposed variation could therefore result in inconvenience to employees as:

a. The variation to prevent multiple breaks would limit the amount of remuneration an employee is able to earn over the same span of hours; and

b. Part-time employees wishing to maximise the number hours they work within their available hours may experience longer periods of time during which the employer is prevented from offering them available work, due to the mandatory 10hr rest break.

Shift loading determined by starting or finishing time of the broken shift

116. Currently, the Award stipulates that the shift allowance applicable to a broken shift is determined by the finishing time of the broken shift. The application of shift penalties to broken shifts has already been varied since the Award was made, as part of the 2-yearly review of the SCHADSI Award.

117. When the Award was made, Clause 25.6(b) stated: '*Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the* ***commencing time*** *of the broken shift*.' [emphasis added].

118. A union proposal to vary the Award provision in the 2-yearly review, followed by a conference convened by the Commission, led to a determination by consent issued by SDP Kauffman, to replace the previous Clause 25.6(b) with the current provision, which states '*Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the* ***finishing time*** *of the broken shift."*[53] [Our emphasis].

119. As the provision determining shift penalties to apply to broken shifts has already been the subject of consideration through Commission-based conferencing, and drafting by the consent of the parties, the position should not be departed from unless there has been a material change in circumstances since that time.

120. Since the 2-yearly review, there has been no material variations to the broken shifts provisions or the shift penalties provisions that would justify departure from the approach taken at that time. There is thus no basis to justify the variation, and the claim should therefore be rejected.

[53] 21 Nov 12 PR531544

15% loading

121. The ASU's proposed inclusion of a 15% loading on broken shifts could be expected to have a number of unnecessary and unwarranted adverse impacts, discussed below.

122. For service providers who operate predominantly in disability support/home care, the cost impact of a 15% increase generally would be significant. We refer to our submissions above concerning the serious difficulties for employers, and potential negative effects on employment and service provision where there are increased wage costs without commensurate increases in funding. Taking into account s134(1)(f) of the modern awards objective, the proposed variation would not result in a fair and relevant safety net for employers, and should be rejected.

Conclusions – broken shifts

123. Each of the unions' claims in isolation could be expected to have unnecessary adverse consequences. The combination of multiple and overlapping claims could be expected to have very serious adverse consequences including:

a. increased costs for providers offering discrete incidents of disability support/home care services, and depending on funding arrangements, increased costs to vulnerable clients often dependant on such services;

b. disruption to and/or reductions in services including the times services are available to clients who only require short periods of support at varying times of the day, to maximise independence and choice;

c. potentially, and undesirably, multiple carers providing services to the same client on any one day; and,

d. potentially less hours of work available to individual employees.

124. The limited nature of the union evidence in these proceedings does not provide a basis for factual findings about the relevant industry service needs nationally (including in areas with varying degrees of supply/demand for particular services), how services and broken shifts are structured in the industry nationally, or the impact of broken shifts on award-covered employees. As a result, there is no supported basis to justify departure from the current Award terms.

125. Without a merit basis in support of the proposed variations, and given the potential adverse impacts to employers and service delivery, the Commission cannot be satisfied that the variations would result in a safety-net that only includes terms to the extent necessary to meet the modern awards objective. The claims should therefore be rejected.

Recall to work (HSU)

126. The HSU seek to vary the recall to work provisions to require that an employee be paid for a minimum of one hours' work at the overtime rate for each time *an employee is required to perform work from home after leaving the employer's or a client's premises, including:*

i. Responding to phone calls, message or emails;

ii. Providing advice ('phone fixes')

iii. Arranging call out/rosters of other employees; and

iv. Remotely monitoring and/or addressing issues by remote telephone and/or computer access;

127. AFEI objects to the variation sought.

128. The proposed variation improperly characterises the circumstances under which a person is performing work as a 'recall' as the circumstances described in (i)-(iv) of the proposed variation do not involve any *return to a place.* The proposed provision presupposes that the employee had been performing work at the employer's premises or a client's premises, and then goes home. Work subsequently performed at home does not meet the ordinary meaning of a 'recall,' that is '*a person who is recalled is summoned to return to a place in a manner where there is a requirement for the person to return*.'[54]

129. Taking into account the rationale for minimum engagement periods generally,[55] there is no basis for imposing a minimum payment of one hour for responding to a phone call, remotely addressing issues by computer access, or performing any of the other duties identified in (i)-(iv) of the HSU's proposed variation when the individual is at their home, and is not required to leave their home, and where the individual:

a. Is not inconvenienced by losing any time associated with travelling to the employer's premises to perform the work then return and back home again;

b. Is not incurring the expense of unpaid travel to another location in order to perform the work, and then return home again; and

c. Is not expected to wear work clothes, or change into a work uniform.

130. Unlike the balance of Clause 28.4 of the Award which applies to when an employee is recalled to work an employee recalled to work *overtime,* the proposed provision would appear to impose the minimum payment at overtime rates for work performed that does not necessarily involve overtime (pursuant to clause 28.1). This would have the inappropriate implication of work performed as ordinary hours from home attracting a substantially higher rate of pay than work performed as ordinary hours at the employer's premises or a client's premises.

[54] [2018] FWC 4334 at [59]

[55] HSU Submissions at [23]

131. There is no evidence from the HSU that the work identified in (i)-(iv) would require 1 hour of work. It is more likely, that individual incidents of such work would take substantially less than 1 hour, and could be as short as 5 minutes to respond to a phone call or message. This could have the result that a person who spends a total of 15 minutes on the phone, by taking three 3 x 5 minute calls, could be entitled to 3hrs' pay at overtime rates. That is, the equivalent of 5 hours' pay, for 15 minutes' work. Such an outcome would result in an employee being paid an amount that is extremely disproportionate to the work performed. This would not result in a fair safety net for employers.

132. There are various other aspects of the proposed provision which would cause it to be unfair to employers. These include,

a. While the proposed provision expresses that the employee would need to be 'required' to perform work from home, it does not specify who/from where the 'requirement' arises. An employee might claim an entitlement under this provision for working from home where they have self-determined that they are required to perform the work, where this has not been authorised by the employer; and

b. The provision does not require the employee to provide any evidence of the time undertaken in performing the work from home, or the extent of work that was performed.

133. For the reasons outlined above, the claim should be rejected.

Client cancellation (HSU)

134. As part of the Commission's review of the client cancellation provisions, it will be taking into account proposals to vary the provision from ABL (including on behalf of ABI, NSWBC, ACSA and LASA), as well as from the HSU.

135. In consideration of these competing claims, the Commission should prefer the proposed variation submitted by ABL (including on behalf of various other employers). AFEI relies on its submissions of 3 July 2019 in respect to that claim.

Telephone allowance (United Voice, HSU)

136. The HSU and United Voice both seek to vary Clause 20.6 of the Award, in respect to the telephone allowance.

137. The HSU seeks to replace the current provision so that it states:

> *Where the employer requires an employee to use a mobile phone for any work-related purpose, the employer will either:*
>
> *a. Provide a mobile phone fit for purpose and cover the cost of any subsequent charges; or*
>
> b. *Refund the cost of purchase and subsequent usage charges on production of receipts.*

138. The United Voice seek to vary the current provision so that it states: *Where the employer requires an employee to install and/or maintain a telephone* ***or mobile phone*** *for the purpose of being on call* ***or to access work related information****, the employer will refund the installation costs and the subsequent rental charges on production of receipted amounts.*

139. For ease of reference, the current Award provision is extracted below:

> '*where the employer requires an employee to install and/or maintain a telephone for the purpose of being on call, the employer will refund the installation costs and the subsequent rental charges on production of receipted amounts.'*[56]

140. Some important observations can be made about the current provision. ***Firstly***, it only applies where an employee is required to install/maintain a phone for being on call. This is a very specific and discrete set of circumstances. Insofar as it is limited to on-call, this involves a period of time when the employee is *'required to be available for recall to duty in respect to any 24hr period or part thereof during the period from the time of finishing ordinary duty on Monday to the time of finishing ordinary duty on Friday*.' It is clear that this is in reference to a telephone at the employee's place of residence. ***Secondly,*** it does not require an employer to cover the cost of purchase for a phone.

141. A similar claim was made by the United Voice and HSU in the 4-yearly review of the Aged Care Award 2010, heard earlier this year. In the course of those proceedings, it became apparent that the proposed variation would impose costs on employers to cover phone/rental charges where overwhelmingly, the workforce already owned a personal mobile phone.[57]

142. The breadth of the proposed extension to the current provisions is therefore significant and requires a merit argument with probative evidence demonstrating the relevant facts. The HSU and United Voice have not, however, established such a basis for variation.

[56] Clause 20.6

[57] See in particular, transcript at PN182-PN194

143. Where an employer has not provided a mobile phone, the HSU's proposed variation would allow an employee to seek reimbursement for the cost of their personal mobile phone, even where:

a. the employer does not assume any property rights in the mobile phone, notwithstanding that they have paid the full cost of it; and/or

b. work-related usage of the phone does not result in any expense to the employee that is additional to their personal expenses;

The HSU does not make out a merit basis for imposing such costs on employers.

144. In relation to rental charges for matters unrelated to on-call, the HSU and United Voice proposed variations do not limit reimbursement of charges to those incurred for performance of work only. An employee could therefore incur charges (or use credit from available data on a plan) on a mobile phone due to personal use away from work, and utilise an employer's Wi-Fi when using the mobile phone at work (without using any of the mobile phone plan's data allocation), and still claim reimbursement of rental charges for the phone. Imposing rental charge costs on an employer in these circumstances would not be fair or relevant for employers, and would be inconsistent with the modern awards objective.

145. Both the HSU and the United Voice propose to extend the circumstances in which an employee will be eligible for a telephone allowance. The HSU proposes that the allowance apply to use of a mobile phone '*for any work-related purpose.*' The United Voice proposes that the allowance apply in circumstances of on call and '*to access work-related information*.' Notably:

a. The HSU provide no definition or scope for 'any work-related purposes.' Such words could therefore be open to wide interpretation. For example, 'work calls' can be taken to mean anything including an employee's call because they are sick, will be late for work, train delays etc. Such 'work' calls places an obligation on employers that is simply not fair nor relevant, and is thus inconsistent with the modern awards objective;

b. In support of their claim, the United Voice relies on statements from witnesses that rosters are provided by their employer via their own mobile phone. Communication between an employer and an employee about the hours in which they will be rostered for work does not involve the performance of work, but are rather steps taken by an employee to ensure they are ready, willing and able to work. Imposing such costs on employers is not fair nor relevant, and is also thus inconsistent with the modern awards objective.

146. For the reasons outlined above, the HSU and United Voice proposed variations should be rejected.

Clothing allowance (United Voice, HSU)

147. The HSU and United Voice both make claims in respect to clothing allowance provisions. AFEI objects to these claims.

HSU – Uniform and Damaged Clothing allowance

148. The HSU proposes a 'damaged clothing allowance' as follows:

> *(i) Where an employee, in the course of their employment suffers any damage or soiling of clothing or other personal effects (excluding hosiery), upon provision of proof of the damage, employees shall be compensated at the reasonable replacement value of the damaged or soiled item of clothing;*
>
> *(ii) This clause will not apply where the damage or soiling is caused by the negligence of the employee.*

149. To the extent the proposed provision could require an employee to pay the replacement cost of an item that is 'soiled' but is nonetheless able to be suitably cleaned, the employee could claim compensation from their employer for the value of the item, and then clean the item themselves. In such circumstances, the employee could be receiving compensation where no loss has actually arisen.

150. The proposed provision does not require that the employee actually purchased the clothing which had become damaged or soiled, or even that the employee owned the clothing which had become damaged or soiled. In this way, the employee could seek payment to cover a cost that they have not even incurred themselves.

151. The provision would also appear to allow an employee to claim an uncapped amount of compensation for the replacement of clothing or personal effects. It is common-sense that an employee should bear their own risk for choosing to unnecessarily wear expensive items to work. An employer should not be liable for an employee's decision to unnecessarily wear expensive items to a job where there is a prospect of damage or soiling of those items. This would not result in a fair safety net to employers.

152. Whilst the proposed provision requires that the employee provide proof of damage (to the clothing or personal effects), it does not require that the employee provide evidence that the damage occurred during the course of the employment, and that it did not involve negligence of the employee.

153. The proposed provision appears to replicate a term in the Yooralla Allied Services Agreement. There is, however, no such term in any other Modern Award. To the extent an employer is prepared to agree to an allowance in respect to damaged/soiled clothing or effects, this is more appropriately addressed at the workplace level in enterprise bargaining.

154. The HSU has not established that the variation would result in an Award that only includes terms to the extent necessary in order to achieve the modern awards objective. Rather, the proposed variation would result in uncertainty, and inappropriate additional cost to employers.

155. For the reasons outlined above, the claim should be rejected.

United Voice– Variation to clothing allowance

156. The United Voice proposes to insert a new provision in clause 20.2, that '*an adequate number of uniforms should allow an employee to work their agreed hours of work in a clean uniform without having to launder work uniforms more than once a week.'*

157. The United Voice has not, however, made out a substantive case that the variation is necessary, or that the Award is not operating effectively without it.

158. In support of their claim, the United Voice rely on the sole evidence of Ms Sinclair. Ms Sinclair's evidence shows that, without the United Voice provision:

a. Ms Sinclair is a part-time employee, and was provided two uniform shirts at the commencement of employment.

b. Within two weeks of requesting additional uniform, Ms Sinclair employee was provided with an additional three shirts.

c. Notwithstanding the provision of uniforms, Ms Sinclair (who works five days each week) was also provided a uniform allowance, amounting to 10 x $1.23, that is, the equivalent of a uniform allowance for 10 shifts in the fortnight.

d. Ms Sinclair was also provided a laundry allowance each fortnight.

159. In the circumstances Ms Sinclair received a monetary uniform allowance which satisfied the current Clause 20.2(b), her evidence is not relevant to the United Voice's proposal to define 'adequate number of uniforms' for the purpose of Clause 20.2(a), and does not assist the Commission on this claim. Rather the evidence shows an example of an employer providing uniforms free of charge on request where this was not required, in circumstances where a uniform allowance is being paid.

160. For the reasons outlined above, the claim should be rejected.

Sleepovers

161. The HSU proposes to vary the sleepover provisions d at Clause 25.7(c) to include additional prescription of facilities to be provided to an employee when performing a sleepover. These include for example, a requirement for a 'lockable room with a peephole or similar in the door, a bed, and a telephone connection in the room'.

162. The current Award term already requires employees performing a sleepover to be provided with a separate room with a bed, use of appropriate facilities (including staff facilities where these exist) and free board and lodging for each night when the employee sleeps over.

163. The AIRC, in Award Simplification, undertook removing non-allowable matters from Awards, such as provisions relating to amenities considered to be overly prescriptive. For example, in The Hospitality Industry - Accommodation, Hotels, Resorts and Gaming Award 1995, the following provision was removed:

> *An employer shall provide a separate dressing room each for male and female employees, adequately lighted and ventilated with suitable floor coverings and floor space to be sufficiently roomy to accommodate all employees likely to use it at the one time; a table and adequate seating accommodation for staff to partake of meals, and lounge or settee and steel or vermin-proof lockers; adjacent thereto wash basins and showers with hot and cold water and toilets for staff use.*[58]

164. The approach taken by the AIRC reflects that the determination of which specific amenities should be provided for employees is more appropriately addressed at the workplace level rather than in Award prescription. This allows more individualised consideration of the circumstances in identifying amenity needs, such as the nature of the client's profile, the location at which the sleepover will be performed, the employee's level of training and skill, and other amenities already provided to the employee.

165. The HSU does not explain in it submissions any aspect of its argument for including such a substantial degree of prescription in the Award concerning facilities. The HSU say only '*the clause should be amended to ensure appropriate facilities are provided when employees are required to perform a sleepover shift*.'[59]

166. While it is anticipated that the HSU's concerns may be motivated by work, health and safety reasons, it is relevant that employers are already obliged to ensure, so far as reasonably practicable, the health and safety of its workers. If health and safety obligations are not met, there are avenues for reporting concerns to applicable State/Territory work health and safety regulators.

167. The Commission has not been provided with any basis to be moved to vary the Sleepover provisions of the Award. The claim is without merit and should be rejected.

[58] Re Award Simplification, 1997 H0008 Dec 1533/97 M Print P7500

[59] HSU submissions at [73]

BEFORE THE FAIR WORK COMMISSION

Fair Work Act 2009 (Cth)

Title of matter: *Social, Community, Home Care and Disability Services Industry Award 2010* – Tranche 2 proceedings

Matter Number: AM2018/26

Section: s.156 – 4 yearly review of modern awards

Document: Submission pursuant to Amended Directions of 13 September 2019

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Background

1. These submissions are made pursuant to the Amended Directions of 13 September 2019.

2. These submissions are in response to claims made by the United Voice, and the Health Services Union (HSU) in relation to travel time under the Social, Community, Home Care and Disability Services Industry Award 2010 ('the Award').

3. The Australian Federation of Employers and Industries (AFEI) has an interest in the Award.

The Claims

4. The HSU are seeking variation to the Award so that an employer will be required to pay an employee for what is described as the 'reasonable time of travel' between clients, and for such time to be treated as time worked. A similar claim is advanced by the United Voice. The United Voice claim is supported by the ASU, who has also filed submissions and materials in respect to the claim.

5. The submissions and witness evidence of the relevant unions indicate that the claim is directed at disability services and home care employees, when performing broken shifts.

6. AFEI objects to the claims.

Breaks between working time

7. The Award specifically provides for broken shifts, which may be performed by home care employees, or social and community services employees when undertaking disability services work.

8. A 'broken shift' is one that can include '*one or more breaks (other than a meal break) and where the span of hours is not more than 12 hours*.'

9. The Award does not specify any particular length required for a break in shifts. The period of a break in a broken shift can be a short or substantial period of time. On the evidence of Robert James Steiner, he describes breaks exceeding 5hrs during a broken shift.[1]

[1] Statement of Robert James Steiner, at [16]

10. By the very nature of being 'breaks' an employee does not undertake any work during breaks in a broken shift, or is subject to the employer's instructions. During breaks in broken shifts, an employee could conceivably:
    10.1 Undertake personal errands, such as collecting children from school and dropping them at extra-curricular activities etc.;
    10.2 Undertake social engagements, such as meeting friends for golf;
    10.3 Return home; or
    10.4 Conduct other private affairs, unrelated to the employment.

11. It is therefore appropriate that such periods are not treated as time worked, or as attracting the ordinary rate of pay.

12. These circumstances are distinguishable from other Awards which require travel between locations of work to be treated as time worked, such as the Commercial Sales Award 2010. As the period of travel in such Awards is not undertaken during a 'break,' the employee is performing work, whereas a break between broken shifts in the SCHADSI Award will generally include time which the employee can conduct their own private affairs.

13. To the extent the break includes any periods of time which can be used privately by the employee, the break should not attract payment of the ordinary hourly rate.

14. Even during the break in a broken shift, where an employee is engaged in travel from one client to another, an employer has no control over such travel, including:
    14.1 Which travel route is taken and at what times;
    14.2 The means of travel;
    14.3 The time taken; and
    14.4 Whether cost are incurred.

15. In such circumstances, the treatment of travel time as time worked would inappropriate and would require imprecise calculations, and would be disproportionate to the extent of actual disutility to the employee during time that is a 'break' for the purpose of the Award.

16. The claim, if accepted, would inevitably involve increased cost and administrative burden to employers, in circumstances where the employer would not receive any productivity increases. Rather, the proposed variation would mean that service providers would be delivering less direct care services for the same number of hours' pay to employees.

Employers affected by the claim

17. Not all end users of home care services are funded through the NDIS. The Commonwealth Home Support Programme (CHSP) 'helps senior Australians access entry-level support services to live independently and safely at home.'[2] Services covered in the CHSP include domestic assistance, home maintenance, and personal care services such as 'help with showering, self-care, hygiene and grooming.'[3]

18. Both the NDIS and the CHSP have quality standards which service providers which are independently assessed and audited against. The introduction of these quality standards has meant that service providers have needed to designate resources to developing, reviewing, and maintaining systems for quality assurance, which are capable of being presented in a format appropriate for auditing purposes.

19. As highlighted in our submissions of 23 July 2019, broken shift provisions as they currently stand, were inserted into the Award to specifically address the needs of the disability services and home care industries. This is evident in:
    19.1 the terms of the Award, by limiting operation of the broken shift provision to the social and community services employees performing disability work, and home care employees; and
    19.2 submissions made to the AIRC during Award Modernisation proceedings for the SCHADSI Award about the operational requirements of the industries.

20. The existing broken shifts provisions enable service providers to:
    20.1 Roster employees to attend to in-home personal care requirements of clients who have varying degrees independence and only require specific services at certain times of the day; and,
    20.2 roster specific staff to specific clients, improving relationship-building, ideal skill/suitability matching of staff to clients, and providing continuity of care.

21. The extent of efficiencies that can be introduced into staff rostering for greater continuity of in-home care shifts are constrained, particularly in the circumstances that service demand will depend on regional, demographic and other factors outside the service provider's control.

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

22. Any substantive amendment affecting the broken shift provisions could adversely impact the viability of this crucial type of service delivery. Costs savings measures which may need to be considered by employers if faced with increased labour costs associated with providing in-home care services include:

    22.1 Reducing overheads by restructuring and reducing back-office staff levels or hours (such back-office roles include supervisory positions, and quality assurance);

    22.2 Moving away from providing higher-cost services, to other more attractive markets; or

    22.3 Increasing client fees for services;

    In the circumstances further increases to government funding are not guaranteed, the first to experience the adverse impacts of increased costs will likely be either those most vulnerable members of the community who require in-home services, or other employees.

23. Given the industry imperatives for broken shifts, and the potential implications of the proposed variation, the claim should be rejected.

The evidence

24. The volume of evidence filed in support of the claims is limited, and insufficient to provide an indication of the work patterns for a single organisation, let alone an entire industry sector. Further, the veracity of the evidence is limited in the circumstances that three of the HSU statements are from persons whose names and employers are not given.

25. Given the limited nature of the evidence, it does not establish a merit basis for variation to the Award.

Australian Federation Employers & Industries
17 September 2019

Australian Industry Group

4 YEARLY REVIEW OF MODERN AWARDS

Further Submission

Social, Community, Home Care and Disability Services Industry Award 2010 (AM2016/28)

2 May 2019

AM2018/26 SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES AWARD 2010

1. This submission is filed by the Australian Industry Group (**Ai Group**) in response to a statement[1] issued by the Fair Work Commission (**Commission**) on 23 April 2019. Ai Group was subsequently granted an extension of time to file its submission.

2. The statement relates specifically to the National Disability Insurance Scheme's (**NDIS**) funding arrangements and recent Federal Budget announcements, which were the subject of evidence led by the Health Services Union (**HSU**) during proceedings before the Commission on 17 April 2019. The following exchange is particularly relevant: (our emphasis)

> MS DOUST: No. Mr Farthing, can I just ask you to go to the calculations that are contained in the table after paragraph 21 of your statement?---Yes.
>
> Are any of those calculations going to be affected by the recent Federal Budget?---Yes, they will be.
>
> Can you explain how they will be affected by the budget?---Certainly. So in terms of each of the components, so the hourly rate, the amount of leave, those things, those salary on costs, those will stay the same for that particular price point, which is standard needs week day. However, the price cap by the NDIA has been substantially increased, and the increase applies - the increase varies depending on the time of the day that the care is delivered, and also the level of the support worker and the complexity of the participant being served. So on a level 1 week day, which is where I've made the comparison and done the analysis, that will actually increase by $6.22 per hour.
>
> JUSTICE ROSS: Is that from the $48.14?---Yes, that is correct. So the $48.14 is the current price cap from 1 July 2019. It will increase by $6.22. It will actually increase slightly further than that once the minimum wage case decision is known, because the NDIA will also apply indexation for that.
>
> Have those changes been - are they the subject of legislation to your knowledge, or have they been implemented administratively?---They have been implemented administratively.
>
> …
>
> JUSTICE ROSS: Let's not speculate about the further - when you say it was the subject of ministerial announcement is there a document that sets it out?---Yes. So there is a document on the NDIA website.

[1] *4 yearly review of modern awards—Group 4—Social, Community, Home Care and Disability Services Industry Award 2010—Substantive claims* [2019] FWC 2756.

Can you provide that through Ms Doust's instructors to her and she can tender that and provide it to the other parties?---Sure. Yes.[2]

3. On 18 April 2019, the HSU filed correspondence that:

   (a) Drew the Commission's attention to a NDIS price guide; (**NDIS Price Guide**)

   (b) Included a media release from Minister Fletcher and Assistant Minister Henderson of 30 March 2019; (**Media Release**) and

   (c) Identified further information available on a specific part of the National Disability Insurance Agency's (**NDIA**) website (**Online NDIA Material**).

4. Ai Group makes the following brief submissions in respect of the above material. They should be read in conjunction with the reply submissions we filed on 8 April 2019 (**Reply Submission**) and in particular, chapter 5 of that submission, which deals with the NDIS funding and pricing arrangements in detail.

5. Further, we continue to hold the concerns previously expressed about the funding currently afforded to providers in the industry, the implications that the insufficiency of that funding has had and continues to have on providers (and in turn, on their clients) and the extent to which those implications would be exacerbated if the various unions' claims were granted. The material here presented by the HSU does not cause us to demur from that position.

Online NDIA Material

6. It is convenient to deal with the Online NDIA Material first.

7. The HSU's correspondence directs the Commission to a webpage on the NDIA's website. A copy of that webpage is **attached** to this submission for convenience.

[2] Transcript of proceedings on 17 April 2019 at PN1589 – PN1597.

8. We refer to the 'Indicative change to east Price Guide', which was also extracted in our Reply Submission at paragraph 96. As we observed at paragraph 97 of that submission, the table indicates that the hourly price cap for the most basic level of one-on-one care on a weekday will increase by only $3.55 per hour.

9. Mr Farthing gave evidence that the price cap "on a level 1 week day … will actually increase by $6.22 per hour".[3] When asked by His Honour, Justice Ross, as to whether there was any documentation available that sets out the price increases, Mr Farthing indicated that there was such material available on the NDIA website and that it would be provided by him to the HSU. We take it that, by extension, the Online NDIA Material is that which was relied upon by Mr Farthing for the purposes of his evidence.

10. We have been unable to reconcile the evidence given by Mr Farthing and the Online NDIA Material. Mr Farthing's evidence appears to significantly overstate the extent of the increase that will be afforded for the level 1 care on a weekday as documented in the aforementioned table.

11. We also note that Mr Farthing's evidence proceeded on the basis that the current price cap for such care is $48.14. The aforementioned table suggests that the current price cap is $47.02, however we acknowledge that the NDIS Price Guide prescribes a price cap of $48.14. This further confuses the evidence given.

12. It is unclear whether Mr Farthing's evidence relies on the information contained in the Online NDIA Material regarding 'Temporary Transformation Payments' (**TTP**). If this is so, it must be noted that the payment is a *temporary* one, which is to be phased out by a 1.5% reduction each year. It substitutes the current Temporary Support for Overheads (**TSO**) of 2.5%, which was introduced from 1 July 2018 in light an Independent Pricing Review that was

[3] Transcript of proceedings on 17 April 2019 at PN1591.

undertaken in 2017 – 2018 and a recommendation made by McKinsey and Company, who subsequently published a report regarding their review.

13. The NDIA published the following explanation of the TSO and the reason for implementing it:[4]

Recommendation	Recommendation detail	NDIA Approach
Recommendation #14 **Temporary support overhead (TSO)**	Implement temporary support for overheads in the form of a temporary increase in the price cap for standard intensity attendant care. Government should offer business planning support for large providers that would otherwise exit and create risk of supply shortages.	The IPR recognised the time and effort it takes for providers to establish efficient systems and process to support the roll out of the NDIS. The NDIA will now provide temporary financial relief for providers as they transition their business operations to accommodate the participant-led NDIS funding approach. In 2018/19 a new 2.5 per cent loading will support standard intensity attendant care supports. 'Attendant care' refers both to assistance with daily personal activities and assistance with community participation. The Temporary Support Overhead will remain partially in place, at 1.25 per cent, in 2019/20 rather than be removed after 12 months as originally recommended. While this TSO loading is in place, the NDIA will continue to work to deliver initiatives that will reduce provider administrative costs and deliver a better NDIS provider experience. Significant progress has been made, with the NDIA delivering provider portal enhancements, payments process improvements, and continuous development of helpful tools such as the provider finder.

14. The HSU seeks to rely on a report published by the University of NSW June 2017 titled '*Reasonable, necessary and valued: Pricing disability services for quality support and decent jobs*' (**UNSW Report**). The report considers the assumptions underpinning the 'Reasonable Cost Model' for disability support work. Our Reply Submission summarised the many deficiencies of the NDIS funding model that are highlighted by the UNSW Report. That included concerns about the allowance made in the funding arrangements for corporate overheads.[5]

[4] NDIA, *Independent Price Review Implementation 2018/19* (accessed 2 May 2019).

[5] Reply Submission at paragraph 121 and footnote 56.

15. In this context, the implementation of the TTP cannot be relied upon to alleviate the potential impact of the unions' claims on employers. The temporary payment does not mitigate the concerns we have raised in this regard.

16. Further, at paragraph 125 of our Reply Submission, we observed that it is unclear whether the current funding arrangements account for the penalty rates payable under the Award in full. For example, it is unclear whether the labour component of the hourly rate is doubled for the purposes of the prices applying to Sundays or whether providers are required to partially absorb the additional labour costs incurred on those days. The same concern arises from the interim prices published in the NDIA Online Material.

17. Finally, the price increases are expressed to apply to attendant care, community participation and therapists. They do not appear to extend a the raft of other NDIS-funded supports such as support provided in group homes or supported independent living.

The Media Release

18. The Media Release was referenced at paragraph 95 of our Reply Submission. It regrettably contains little detail about the specific price increases that will be implemented in relation to different forms of care and the extent to which they will be implemented.

19. Whilst the Media Release provides certain headline figures regarding the relevant announcements made by the Morrison Government in March 2019, it does not serve any further probative value.

The NDIS Price Guide

20. The HSU has sought to highlight through its correspondence that the NDIS Price Guide that it specifies different price caps for work performed on a weekday, afternoon, night, Saturday, Sunday and public holiday.

21. The concerns we expressed at paragraphs 124 – 127 of our Reply Submission are apposite. Those submissions were made after having careful regard to the NDIS Price Guide. We remain concerned that the funding arrangements do not take into account various employee entitlements under the Award including overtime rates.

Annual price review

2019-20 Annual price review

The Annual Price Review cycle to determine 2019–20 prices is underway and this year will incorporate outcomes from the Therapy Review and recommendations from the WA Market Review.

In the lead up to the launch of the 2019-20 NDIS Price Guide, the NDIA will make a series of announcements to provide the market with an early insight into proposed changes. The first announcement (Saturday 30 March 2019) outlines changes to therapy and attendant care supports and the introduction of a conditional loading over a five year period to assist attendant care providers transition into the Scheme.
The 2019-20 Price Guide will be made available in June following the release of the minimum wage increase by the Fair Work Commission.

The NDIA Annual Price Review evaluates the effects of wage inflation on support prices and is unable to release the NDIS 2019-20 Price Guide prior to this work being completed.

For changes and recommendations endorsed by the Pricing Reference Group as a result of the Therapy Review, please visit the Pricing review of therapy services page.

For all other Annual Price Review updates please refer below.

Changes to attendant care supports

The NDIA will introduce increases to base attendant care and community participation supports across standard and levels one, two and three of high intensity price limits, effective 1 July 2019.

The increases, endorsed by the NDIA's Pricing Reference Group, aim to ensure the needs and costs to deliver these services are being met for providers. This in turn will ensure an adequate supply in the attendant care and community participation market and therefore enable participants to achieve their goals.

For providers delivering attendant care supports to NDIS participants, the tables below indicate the 2019-20 price limits, dependent on a number of variables such as location, times and days of shifts, and level of worker, etc. The 2019-20 price limits will be further indexed for wage inflation prior to implementation.

Indicative change to East Price Guide (does not yet include indexation for wage inflation)

Shift	Level of care	2019–20 base price	2018–19 base price	Increase in base price
Weekday	Level 1	$50.57	$47.02	7.6%
Saturday	Level 1	$69.56	$65.22	6.7%
Sunday	Level 1	$90.45	$83.47	8.4%
Public Holiday	Level 1	$113.24	$101.66	11.4%
Afternoon Shift	Level 1	$55.80	$51.56	8.2%
Night Shift	Level 1	$56.84	$52.46	8.4%
Weekday	Level 2	$54.69	$49.61	10.2%
Saturday	Level 2	$75.24	$68.92	9.2%
Sunday	Level 2	$97.83	$88.27	10.8%
Public Holiday	Level 2	$122.46	$107.55	13.9%
Afternoon Shift	Level 2	$60.34	$54.43	10.9%
Night Shift	Level 2	$61.47	$55.38	11.0%
Weekday	Level 3	$57.45	$51.86	10.8%
Saturday	Level 3	$79.02	$72.11	9.6%
Sunday	Level 3	$102.75	$92.42	11.2%

Shift	Level of care	2019–20 base price	2018–19 base price	Increase in base price
Public Holiday	Level 3	$128.63	$112.67	14.2%
Afternoon Shift	Level 3	$63.38	$56.91	11.4%
Night Shift	Level 3	$64.56	$57.91	11.5%

Indicative change to West Price Guide
(does not yet include indexation for wage inflation)

Shift	Level of care	2019–20 base price	2018–19 base price	Increase in base price
Weekday	Level 1	$50.57	$47.88	5.6%
Saturday	Level 1	$69.56	$65.86	5.6%
Sunday	Level 1	$90.45	$83.81	7.9%
Public Holiday	Level 1	$113.24	$101.78	11.3%
Afternoon Shift	Level 1	$55.80	$52.39	6.5%
Night Shift	Level 1	$56.84	$53.27	6.7%
Weekday	Level 2	$54.69	$50.30	8.7%
Saturday	Level 2	$75.24	$69.31	8.6%
Sunday	Level 2	$97.83	$88.26	10.8%
Public Holiday	Level 2	$122.46	$107.22	14.2%
Afternoon Shift	Level 2	$60.34	$55.08	9.5%
Night Shift	Level 2	$61.47	$56.00	9.8%
Weekday	Level 3	$57.45	$52.20	10.0%
Saturday	Level 3	$79.02	$71.98	9.8%
Sunday	Level 3	$102.75	$91.71	12.0%
Public Holiday	Level 3	$128.63	$111.47	15.4%
Afternoon Shift	Level 3	$63.38	$57.17	10.9%
Night Shift	Level 3	$64.56	$58.14	11.0%

Temporary Transformation Payment

Providers of attendant care and community participation will also be eligible for an additional pricing boost through a Temporary Transformation Payment. This conditional loading will assist providers to continue transforming their businesses in the move towards a more competitive marketplace. This replaces the Temporary Support for Overheads.

In 2019-20, the conditional loading will be set at 7.5 per cent on the relevant level 1 support item. It will reduce by 1.5 per cent each year thereafter. The loading applied on levels 2 or 3 support items will be the equivalent in dollar amount to the 7.5 per cent increase on the same level 1 support item.

From 1 July 2019, for attendant care and community participation the combined effect of the new price limits and the Temporary transformation Payment is an increase of between 10.9% and 20.4%, dependent on variables such as location, times and days of shifts, and level of worker.

In order to access the Temporary Transformation Payment, providers will have to comply with terms that will be outlined in the 2019-20 NDIS Price Guide. These terms will include:

- publishing their service prices,
- listing their business contact details in the Provider Finder and ensuring those details are kept up-to-date
- participating annually in an Agency-approved market benchmarking survey.

These measures will promote greater transparency for participants seeking to engage with providers in discussions about value for money. They will also improve the robustness of future pricing decisions and give providers the comparative information they need to assist them in becoming as efficient as possible.

Providers will be required to acknowledge compliance to these terms when submitting a payment request through the myplace provider portal.

These terms will be further outlined in the 2019-20 Price Guide.

The WA Market Review is also still to be finalised and may provide additional information about, and as a result impact on, prices in WA. Funding in participant plans will be automatically adjusted to reflect the changes in the price limits for attendant care and community participation, effective from 1 July 2019, as part of the annual indexation of plans. Participants will not need to seek a plan review to access the additional funds. More information around this will be made available leading up to 1 July 2019.

More announcements to come:

These price limit increases form part of a suite of changes that will be outlined through a series of announcements during May and June in the lead up to changes being effective from 1 July 2019.

Other forthcoming announcements from the Annual Price Review will include additional outcomes from the Therapy Services Review, recommendations from the WA Market Review and updated clarifications to policy. The policies currently under review are group and centre-based supports, cancellations, travel, use of volunteers, and charging for non-face-to-face time.

The Annual Price Review will also review and index, with updates effective 1 July 2019, for:

- Short Term Accommodation
- Group Based Care.

Note: Supported Independent Living (SIL) is not affected by these increases as SIL does not have price limits.

The full suite of price changes and associated arrangements for 2019-20 will be presented in a new-look and easier to navigate 2019-20 Price Guide.

The NDIA sets price controls for certain NDIS supports to ensure a balance between NDIS participants obtaining reasonable value for money and enabling providers to operate within a market of adequate size, quality and return

Australian Industry Group

4 YEARLY REVIEW OF MODERN AWARDS

Submission – Survey Results

Social, Community, Home Care and Disability Services Industry Award 2010 (AM2018/26)

3 July 2019

AM2018/26 SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES AWARD 2010 – SURVEY RESULTS

1. This submission is filed by the Australian Industry Group (**Ai Group**) in accordance with directions issued by the Fair Work Commission (**Commission**) on 11 June 2019 regarding a survey conducted by the Commission (**Survey**) and a report setting out the results of the survey, published on 26 June 2019 (**Report**).

General Observations about the Profile of the Survey Respondents

2. The Report notes that the Survey was "not designed to be representative of all enterprises that employ workers covered by the SCHADS award".[1]

3. Ai Group submits that the results of the Survey must be given appropriate weight given that the Survey is not representative of all employers covered by the *Social, Community, Home Care and Disability Services Industry Award 2010* (**Award**). Whilst the Survey results are demonstrative of various propositions, they are not reflective of the practices of all employers covered by the Award and cannot be extrapolated as such.

4. Over 60% of the Survey respondents operated in the disability services sector. This includes residential care and care provided in a person's home.[2] This represents over 500 respondents to the Survey.[3] They Survey results are, therefore, particularly useful when considering the operations of enterprises who operate in the disability services sector.

5. The majority of survey respondents were not covered by an enterprise agreement. Thirty-five percent of respondents indicated that an enterprise agreement applies to their employees covered by the Award[4]. Of those, 30% indicated that not all of their Award covered employees had an enterprise

[1] The Report at page 1.

[2] The Report at page 2.

[3] That is, 63% of the 854 complete responses received to the Survey.

[4] The Report at page 4.

agreement applying to them.[5] The potential impact of the unions' numerous claims advanced in these proceedings is self-evident from these results.

6. The responses of the Survey respondents to whom enterprise agreements apply are also relevant to the proceedings:

   (a) The safety net set by the Award will determine whether the relevant enterprise agreements are capable of passing the 'better off overall' test.[6] Employers covered by such agreements are therefore also potentially exposed to the adverse impacts that will flow from the proposed enhancements to the minimum safety net.

   (b) To the extent that the terms of the relevant enterprise agreements incorporate the Award or parts of the Award, the proposed variations may have a direct bearing on such employers.

   (c) For the purposes of assessing whether the proposed changes are necessary to ensure that the Award achieves the modern awards objective, the Commission must take into account the need to encourage collective bargaining.[7] This involves a consideration of whether employers who are currently covered by enterprise agreements will be incentivised to bargain again as well as whether enterprise agreements who are <u>not</u> covered by enterprise agreements will be incentivised to engage in bargaining.

7. The Survey results demonstrate a high degree of reliance on Commonwealth government funding. Close to 90% of survey respondents identified that they receive Commonwealth government funding.[8] The relevance of the National Disability Insurance Scheme (**NDIS**) and the constraints it imposes on an

[5] The Report at page 4.

[6] Section 193 of the *Fair Work Act 2009*.

[7] Section 134(1)(b) of the *Fair Work Act 2009*.

[8] The Report at page 10.

employer's capacity to recover additional employment costs is apparent from these results.[9]

Survey Results relating to Casual Employees

8. The Health Services Union is seeking a variation to the Award that would have the effect of requiring the payment of the 25% casual loading prescribed by clause 10.4(b) of the Award during the performance of ordinary hours of work on a weekend or a public holiday. The casual loading is not currently payable in those circumstances.

9. Additionally, United Voice is seeking a variation to the Award that would have the effect of requiring the payment of the 25% casual loading prescribed by clause 10.4(b) during the performance of overtime in circumstances where currently, the casual loading is not payable for the performance such work.

10. The aforementioned union claims were heard by the Commission with the other 'Tranche 1' claims. Ai Group filed submissions opposing the claims on 8 April 2019.[10] Amongst the various arguments made by Ai Group in opposition to the claims, we advanced the proposition that the proposed changes would have an adverse impact on business by virtue of the additional employment costs they would impose, which would not be covered by the NDIS's funding arrangements.[11] Submissions were also made about the heavy reliance of employers on casual labour.[12]

11. The results of the Survey support Ai Group's aforementioned contentions.

12. Close to 40% of Award-covered employees employed by the Survey respondents were casual employees.[13] Furthermore, during a four week

[9] Ai Group submission dated 8 April 2019 at paragraphs 153 – 163.
[10] Ai Group submission dated 8 April 2019 at pages 70 – 82.
[11] Ai Group submission dated 8 April 2019 at paragraph 189(f).
[12] Ai Group submission dated 8 April 2019 at paragraph 189(d).
[13] The Report at pages 5 – 6.

period in March 2019, 75% of Survey respondents had employed casual employees.[14]

13. We note that whilst employers covered by enterprise agreements were more likely to employ casual employees than those who were not covered by enterprise agreements[15], the extent of the differential is not remarkable and in either case, a significant proportion of employers employed casual employees.

14. We also observe that 77% of enterprises who receive Commonwealth government funding employed casual employees.[16]

15. The Survey results accordingly demonstrate the significant reliance of employers covered by the Award on casual labour. It is a matter that goes to the potential impact of the claims advanced by the unions. The Survey results demonstrate that the impact of the claims would be significant; both in the aggregate and on individual employers who rely on casual employment to provide the requisite level of flexibility necessary for their operations.

16. This proposition is further advanced by the Survey results concerning the extent to which casual employees are apparently required to work on Saturdays and Sundays:

    (a) 76% of casual employees employed during the aforementioned four week period worked on a Saturday; and

    (b) 70% of casual employees employed during the aforementioned four week period worked on a Sunday.[17]

17. The Survey results demonstrate a high incidence of casual employees working on weekends.

[14] The Report at pages 7 – 8.
[15] The Report at page 14.
[16] The Report at pages 17 – 18.
[17] The Report at page 9.

18. The Survey results indicate that 25% of casual employees employed during the aforementioned four week period worked in excess of 38 hours in a week or 76 hours in a fortnight.[18] We note that these are not the only circumstances in which casual employees are entitled to overtime rates. Pursuant to clause 28.1(b)(ii) of the Award, casual employees are also entitled to overtime rates if they perform more than 10 ordinary hours of work in a day. To that extent, the Survey results do not reveal the full extent to which casual employees are entitled to overtime rates.

[18] The Report at page 8 – 9.

Australian Industry Group

4 YEARLY REVIEW OF MODERN AWARDS

Reply Submission – Second Tranche of Claims

Social, Community, Home Care and Disability Services Industry Award 2010 (AM2018/26)

13 July 2019

4 YEARLY REVIEW OF MODERN AWARDS

AM2018/26 SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

1. INTRODUCTION

1. This submission is filed by the Australian Industry Group (**Ai Group**) in relation to the Fair Work Commission's (**Commission**) 4 yearly review of the *Social, Community, Home Care and Disability Services Industry Award 2010* (**Award**). It responds to the submissions and evidence filed by the Health Services Union (**HSU**), United Voice and the Australian Services Union (**ASU**) (collectively, **Unions**) in support of various substantive changes they seek to the Award.

2. In particular, the submissions respond to the 'second tranche' of substantive claims advanced by the Unions that are set out at chapter 4 of this submission.

3. Each of the claims are opposed by Ai Group. In our submission, they should be dismissed.

2. THE STATUTORY FRAMEWORK

4. The Unions claims are being pursued in the context of the 4 yearly review of modern awards (**Review**), which is conducted by the Commission pursuant to s.156 of the *Fair Work Act 2009* (**FW Act** or **Act**).

5. In determining whether to exercise its power to vary a modern award, the Commission must be satisfied that the relevant award includes terms only to the extent necessary to achieve the modern awards objective (s.138).

6. The critical principle to flow from the operation of s.138 is that a modern award can only include such terms as are *necessary* to achieve the modern awards objective. The requirement imposed by s.138 is an ongoing one. That is, at any time, an award must only include terms that are necessary in the relevant sense.

7. The modern awards objective is set out at s.134(1) of the FW Act. It requires the Commission to ensure that modern awards, together with the National Employment Standards (**NES**), provide a fair and relevant minimum safety net of terms and conditions. In doing so, the Commission is to take into account a range of factors, listed at s.134(1)(a) – (h). This necessarily requires a consideration of the Award, taken as a whole, including the various terms and conditions it provides.

8. In its decision concerning claims to reduce penalty rates in a number of awards (**Penalty Rates Decision**), the Commission made the following observations about various factors listed at s.134(1)(a) – (h), which we respectfully adopt for the purposes of our submission:

> **[165]** Section 134(1)(a) requires that we take into account 'relative living standards and the needs of the low paid'. This consideration incorporates two related, but different, concepts. As explained in the *2012–13 Annual Wage Review* decision:
>
> > 'The former, relative living standards, requires a comparison of the living standards of award-reliant workers with those of other groups that are deemed to be relevant. The latter, the needs of the low paid, requires an examination of the extent to which low-paid workers are able to purchase the essentials for a "decent standard of living" and to engage in community life. The assessment

of what constitutes a decent standard of living is in turn influenced by contemporary norms.'

[166] In successive Annual Wage Reviews the Expert Panel has concluded that a threshold of two-thirds of median full-time wages provides 'a suitable and operational benchmark for identifying who is low paid', within the meaning of s.134(1)(a). There is, however, no single accepted measure of two-thirds of median (adult) ordinary time earnings. The surveys that provide the information about the distribution of earnings from which a median is derived vary in their sources, coverage and definitions in ways that affect the absolute values of average and median wages (and, accordingly, what constitutes two-thirds of those values). The two main Australian Bureau of Statistics (ABS) surveys of the distribution of earnings are the '*Employee Earnings, Benefits and Trade Unions Membership* (the 'EEBTUM') and the survey of *Employee Earnings and Hours* (the 'EEH'). We note that the EEBTUM is no longer published and the relevant data is now produced as part of the *Characteristics of Employment Survey* (the 'CoE'). Some data is also available from the HILDA survey.

[167] In the *2015–16 Annual Wage Review* decision the Expert Panel noted that the submissions provided different estimates of the 'two-thirds of median (adult) ordinary time earnings' threshold. The relevant extract from that decision, and the Expert Panel's conclusion, are set out below:

'In its submission, the Australian Government provided two estimates to identify low-paid workers:

- $18.67 per hour (or about $710.00 per week over a 38-hour week), using the May 2014 EEH data; and

- $18.42 per hour (or about $700.00 per week over a 38-hour week) using the 2014 HILDA survey data.

The Australian Government contended that there were about 1.3 million low-paid employees in 2014 (or 13.3 per cent of all employees), with around one-third of award-reliant workers being low paid in the EEH data. Their analysis took explicit account of the number and the level of pay of junior workers.

The ACTU used unpublished ABS EEH data on the distribution of award only workers by hourly earnings to estimate the number of employees at each award classification level. On the basis of the May 2014 data, the ACTU estimated that 43 per cent of award only employees had hourly earnings at or below the C10 rate of pay in May 2014 ($724.50).

Research Report 6/2013 found that around 75 per cent of adult award-reliant employees in the non-public sector were earning below the C10 rate of $18.60 per hour.

Whilst no specific conclusion is available, the information as a whole suggests that a sizeable proportion—probably a majority—of employees who are award reliant are also low paid by reference to the two-thirds of median weekly earnings benchmark.' (footnotes omitted)

[168] The most recent data for the 'low paid' threshold is set out below:

Two-thirds of median full-time earnings	*$/week*
Characteristics of Employment survey (Aug. 2015)	818.67
Employee Earnings and Hours survey (May 2016)	917.33

[169] The assessment of relative living standards focuses on the comparison between award-reliant workers and other employed workers, especially non-managerial workers. 78 As noted in the 2015–16 Annual Wage Review decision:

> 'There is no doubt that the low paid and award reliant have fallen behind wage earners and employee households generally over the past two decades, whether on the basis of wage income or household income.'

[170] Award reliance is a measure of the proportion of employees whose pay rate is set according to the relevant award rate specified for the classification of the employee and not above that rate. Table 4.8 from the *2015–16 Annual Wage Review* decision sets out the extent of award reliance by industry. Relevantly for present purposes, the most recent data identify the Accommodation and food services and Retail trade industries as among the most award reliant in that they are the industries in which the highest proportion of employees are award reliant (42.7 per cent and 34.5 per cent, respectively).

[171] The relative living standard of employees is affected by the level of wages they earn, the hours they work, tax-transfer payments and the circumstances of the households in which they live. As a general proposition, around two-thirds of low-paid employees are found in low income households (i.e. in the bottom half of the distribution of employee households) and have lower living standards than other employees. Many low-paid employees live in households with low or very low disposable incomes.

[172] In taking into account 'relative living standards' in the context of Annual Wage Reviews, the Expert Panel has paid particular attention to changes in the earnings of all award-reliant employees compared to changes in measures of average and median earnings more generally.

[173] In the *2015–16 Annual Wage Review* decision the Expert Panel also observed that increases in modern award minimum wages have a *positive* impact on the relative living standards of the low paid and on their capacity to meet their needs. It seems to us that the converse also applies, that is, the variation of a modern award which has the effect of reducing the earnings of low-paid employees will have a *negative* impact on their relative living standards and on their capacity to meet their needs.

…

[179] Section 134(1)(c) requires that we take into account 'the need to promote social inclusion through increased workforce participation'. The use of the conjunctive 'through' makes it clear that in the context of s.134(1)(c), social inclusion is a concept to be promoted exclusively '*through* increased workforce participation', that is obtaining employment is the focus of s.134(1)(c).

…

[184] Section 134(1)(da) requires that we take into account the 'need to provide additional remuneration' for:

> '(i) employees working overtime; or
> (ii) employees working unsocial, irregular or unpredictable hours; or
> (iii) employees working on weekends or public holidays; or
> (iv) employees working shifts.'

[185] Section 134(1)(da) was inserted by the *Fair Work Amendment Act 2013* (Cth), with effect from 1 January 2014. The Explanatory Memorandum to the Fair Work Amendment Bill 2013 made the following observation about the addition of s.134(1)(da):

> 'Under the FW Act, the FWC must ensure that modern awards, together with the National Employment Standards, provide a fair and relevant safety net of terms and conditions. In making or varying modern awards, the FWC must take into account the modern awards objective (see subsection 134(1) of the FW Act).
>
> Item 1 of Schedule 2 to the Bill amends the modern awards objective to include a new requirement for the FWC to consider, in addition to the existing factors set out in subsection 134(1) of the FW Act, the need to provide additional remuneration for:
>
> - employees working overtime;
> - employees working unsocial, irregular or unpredictable hours;
> - employees working on weekends or public holidays; or
> - employees working shifts.
>
> This amendment promotes the right to fair wages and in particular recognises the need to fairly compensate employees who work long, irregular, unsocial hours, or hours that could reasonably be expected to impact their work/life balance and enjoyment of life outside of work.'

[186] In the second reading speech to the Fair Work Amendment Bill 2013 the then Minister for Employment and Workplace Relations said:

> '… as part of this Bill, the Government is seeking to ensure that work at hours which are not family friendly is fairly remunerated. This will be done by amending the modern awards objective to ensure that the Fair Work Commission, in carrying out its role, must take into account the need to provide additional remuneration for employees working outside normal hours, such as employees working overtime or on weekends…'

[187] Section 134(1)(da) is a relatively new provision and one which did not exist at the time the modern awards under review were made. These provisions have not yet been the subject of substantive arbitral or judicial comment.

[188] Five observations may be made about s.134(1)(da).

[189] First, s.134(1)(da) speaks of the 'need to provide additional remuneration' for employees performing work in the circumstances mentioned in s.134(1)(da)(i), (ii), (iii) and (iv).

[190] An assessment of 'the need to provide additional remuneration' to employees working in the circumstances identified in paragraphs 134(1)(da)(i) to (iv) requires a consideration of a range of matters, including:

> (i) the impact of working at such times or on such days on the employees concerned (i.e. the extent of the disutility);
>
> (ii) the terms of the relevant modern award, in particular whether it already compensates employees for working at such times or on such days (e.g. through 'loaded' minimum rates or the payment of an industry allowance which is intended to compensate employees for the requirement to work at such times or on such days); and
>
> (iii) the extent to which working at such times or on such days is a feature of the industry regulated by the particular modern award.

[191] Assessing the extent of the disutility of working at such times or on such days (issue (i) above) includes an assessment of the impact of such work on employee health and work-life balance, taking into account the preferences of the employees for working at those times.

[192] The expression 'additional remuneration' in the context of s.134(1)(da) means remuneration in addition to what employees would receive for working what are normally characterised as 'ordinary hours', that is reasonably predictable hours worked Monday to Friday within the 'spread of hours' prescribed in the relevant modern award. Such 'additional remuneration' could be provided by means of a penalty rate or loading paid in respect of, for example, work performed on weekends or public holidays. Alternatively, additional remuneration could be provided by other means such as a 'loaded hourly rate'.

[193] As mentioned, s.134(1)(da) speaks of the 'need' to provide additional remuneration. We note that the minority in *Re Restaurant and Catering Association of Victoria* (the *Restaurants 2014 Penalty Rates decision*) made the following observation about s.134(1)(da):

> 'This factor must be considered against the profile of the restaurant industry workforce and the other circumstances of the industry. It is relevant to note that the peak trading time for the restaurant industry is weekends and that employees in the industry frequently work in this industry because they have other educational or family commitments. These circumstances distinguish industries and employees who expect to operate and work principally on a 9am-5pm Monday to Friday basis. Nevertheless the objective requires additional remuneration for working on weekends. As the current provisions do so, they meet this element of the objective.' (emphasis added)

[194] To the extent that the above passage suggests that s.134(1)(da) '*requires* additional remuneration for working on weekends', we respectfully disagree. We acknowledge that the provision speaks of 'the *need* for additional remuneration' and that such language suggests that additional remuneration is required for employees working in the circumstances identified in paragraphs 134(1)(da)(i) to (iv). But the expression 'the need for additional remuneration' must be construed in context, and the context tells against the proposition that s.134(1)(da) *requires* additional remuneration be provided for working in the identified circumstances.

[195] Section s.134(1)(da) is a relevant consideration, it is *not* a statutory directive that additional remuneration must be paid to employees working in the circumstances mentioned in paragraphs 134(1)(da)(i), (ii), (iii) or (iv). Section 134(1)(da) is a consideration which we are required to take into account. To take a matter into account means that the matter is a 'relevant consideration' in the *Peko-Wallsend* sense of matters which the decision maker is bound to take into account. As Wilcox J said in *Nestle Australia Ltd v Federal Commissioner of Taxation*:

> 'To take a matter into account means to evaluate it and give it due weight, having regard to all other relevant factors. A matter is not taken into account by being noticed and erroneously disregarded as irrelevant'.

[196] Importantly, the requirement to take a matter into account does not mean that the matter is necessarily a determinative consideration. This is particularly so in the context of s.134 because s.134(1)(da) is one of a number of considerations which we are required to take into account. No particular primacy is attached to any of the s.134 considerations. The Commission's task is to take into account the various considerations and ensure that the modern award provides a 'fair and relevant minimum safety net'.

[197] A further contextual consideration is that 'overtime rates' and 'penalty rates' (including penalty rates for employees working on weekends or public holidays) are terms that *may* be included in a modern award (s.139(1)(d) and (e)); they are not terms that *must* be included in a modern award. As the Full Bench observed in the *4 yearly review of modern awards – Common issue – Award Flexibility* decision:

'… s.134(1)(da) does not amount to a statutory directive that modern awards must provide additional remuneration for employees working overtime and may be distinguished from the terms in Subdivision C of Division 3 of Part 2-3 which *must* be included in modern awards…'

[198] Further, if s.134(1)(da) was construed such as to *require* additional remuneration for employees working, for example, on weekends, it would have significant consequences for the modern award system, given that about half of all modern awards currently make no provision for weekend penalty rates. If the legislative intention had been to mandate weekend penalty rates in all modern awards then one would have expected that some reference to the consequences of such a provision would have been made in the extrinsic materials.

[199] Third, s.134(da) does not prescribe or mandate a fixed relationship between the remuneration of those employees who, for example, work on weekends or public holidays, and those who do not. The additional remuneration paid to the employees whose working arrangements fall within the scope of the descriptors in

s.134(1)(da)(i)–(v) will depend on, among other things, the circumstances and context pertaining to work under the particular modern award.

[200] Fourth, s.134(1)(da)(ii) is not to be read as a composite expression, rather the use of the disjunctive 'or' makes it clear that the provision is dealing with separate circumstances: 'unsocial, irregular or unpredictable hours' (emphasis added).

[201] Section 134(1)(da)(ii) requires that we take into account the need to provide additional remuneration for employees working in each of these circumstances. The expression 'unsocial … hours' would include working late at night and or early in the morning, given the extent of employee disutility associated with working at these times. 'Irregular or unpredictable hours' is apt to describe casual employment.

[202] Fifth, s.134(1)(da) identifies a number of circumstances in which we are required to take into account the need to provide additional remuneration (i.e. those in paragraphs 134(1)(da)(i) to (iv)). Working 'unsocial … hours' is one such circumstance (s.134(1)(da)(i)) and working 'on weekends or public holidays' (s.134(1)(da)(iii)) is another. The inclusion of these two, separate, circumstances leads us to conclude that it is not necessary to establish that the hours worked on weekends or public holidays are 'unsocial … hours'. Rather, we are required to take into account the need to provide additional remuneration for working on weekends or public holidays, irrespective of whether working at such times can be characterised as working 'unsocial … hours'. Ultimately, however, the issue is whether an award which prescribes a particular penalty rate provides 'a fair and relevant minimum safety net.' A central consideration in this regard is whether a particular penalty rate provides employees with 'fair and relevant' compensation for the disutility associated with working at the particular time(s) to which the penalty attaches.

…

[204] Section 134(1)(e) requires that we take into account 'the principle of equal remuneration for work of equal or comparable value'.

[205] The 'Dictionary' in s.12 of the FW Act states, relevantly:

> 'In this Act:
>
> ***equal remuneration for work of equal of comparable value:*** see subsection 302(2).'

[206] The expression 'equal remuneration for work of equal or comparable value' is defined in s.302(2) to mean 'equal remuneration for men and women workers for work of equal or comparable value'.

[207] The appropriate approach to the construction of s.134(1)(e) is to read the words of the definition into the substantive provision such that in giving effect to the modern awards objective the Commission must take into account the principle of 'equal remuneration for men and women workers for work of equal or comparable value'.

…

[217] Section 134(1)(f) requires that we take into account 'the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden'.

[218] We note at the outset that s.134(1)(f) is expressed in very broad terms. We are required to take into account the likely impact of any exercise of modern award powers 'on business, including' (but not confined to) the specific matters mentioned, that is, 'productivity, employment costs and the regulatory burden'.

…

[221] 'Productivity' is not defined in the FW Act but given the context in which the word appears it is clear that it is used to signify an economic concept.

[222] The Productivity Commission defines productivity as:

> '… a measure of the rate at which outputs of goods and services are produced per unit of input (labour, capital, raw materials, etc). It is calculated as the ratio of the quantity of outputs produced to some measure of the quantity of inputs used'.

[223] Similarly, the Commonwealth Treasury also defines productivity by reference to volumes of inputs and output:

> 'Productivity is a measure of the rate at which inputs, such as labour, capital and raw materials, are transformed into outputs. The level of productivity can be measured for firms, industries and economies. Productivity growth implies fewer inputs are used to produce a given output or, for a given set of inputs, more output is produced.'

[224] The conventional economic meaning of productivity is the number of units of output per unit of input. It is a measure of the volumes or quantities of inputs and outputs, not the cost of purchasing those inputs or the value of the outputs generated. As the Full Bench observed in the *Schweppes Australia Pty Ltd v United Voice – Victoria Branch*:

> '… we find that 'productivity' as used in s.275 of the Act, and more generally within the Act, is directed at the conventional economic concept of the quantity of output relative to the quantity of inputs. Considerations of the price of inputs, including the cost of labour, raise separate considerations which relate to business competitiveness and employment costs.
>
> Financial gains achieved by having the same labour input – the number of hours worked – produce the same output at less cost because of a reduced wage per hour is not productivity in this conventional sense.'

[225] While the above observation is directed at the use of the word 'productivity' in s.275, it is apposite to our consideration of this issue in the context of s.134(1)(f).

…

> **[228]** Section 134(1)(h) requires that we take into account 'the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy'.
>
> **[229]** We note that the requirement to take into account the likely impact of any exercise of modern award powers on 'the sustainability, performance and competitiveness *of the national economy*' (emphasis added) focuses on the aggregate (as opposed to sectorial) impact of an exercise of modern award powers. …[1]

9. Further, the employer parties in these proceedings do not bear any onus to demonstrate that the Unions' claims will result in increased employment costs, reduced productivity or undermine flexible work practices as contemplated by s.134(1) of the Act. No adverse inference can or should be drawn from the absence of evidence called by employer parties or from the absence of evidence that establishes that a union claim will affect all or most employers covered by the Award.

10. The conduct of the Review differs from an inter-party dispute. Those responding to a claim do not bear an onus. Rather, it is for the proponents of a claim to establish that the variation proposed is necessary in order to ensure that an award is achieving the modern awards objective of providing a fair and relevant minimum safety net of terms and conditions. In determining whether a proponent has in fact established as much, the Commission will have regard to material before it that addresses the various elements of the modern awards objective, including those that go to employment costs, flexible work practices and productivity. These considerations are both microeconomic and macroeconomic; they require evaluation with respect to the practices of different types of businesses as well as industry at large.

[1] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [165] – [229].

11. As the Full Bench stated in the Preliminary Jurisdictional Issues Decision: (emphasis added)

> The proponent of a variation to a modern award must demonstrate that if the modern award is varied in the manner proposed then it would only include terms to the extent necessary to achieve the modern awards objective (see s.138). What is 'necessary' in a particular case is a value judgment based on an assessment of the considerations in s.134(1)(a) to (h), having regard to the submissions and evidence directed to those considerations.[2]

12. It is therefore for the proponents to overcome the legislative threshold established by ss.138 and 134(1), which includes a consideration of the impact upon different types of businesses and industry at large.

13. As will become apparent from our submissions, the Unions claims are not necessary, having regard to ss. 134(1) and 138 of the FW Act and therefore, they should not be granted.

[2] *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at [60].

3. THE COMMISSION'S GENERAL APPROACH TO THE REVIEW

3.1 The Preliminary Jurisdictional Issues Decision

14. At the commencement of the Review, a Full Bench dealt with various preliminary issues. The Commission's Preliminary Jurisdictional Issues Decision[3] provides the framework within which the Review is to proceed.

15. The Full Bench emphasised the need for a party to mount a merit based case in support of its claim, accompanied by probative evidence (emphasis added):

> **[23]** The Commission is obliged to ensure that modern awards, together with the NES, provide a fair and relevant minimum safety net taking into account, among other things, the need to ensure a 'stable' modern award system (s.134(1)(g)). The need for a 'stable' modern award system suggests that a party seeking to vary a modern award in the context of the Review must advance a merit argument in support of the proposed variation. The extent of such an argument will depend on the circumstances. We agree with ABI's submission that some proposed changes may be self evident and can be determined with little formality. However, where a significant change is proposed it must be supported by a submission which addresses the relevant legislative provisions and be accompanied by probative evidence properly directed to demonstrating the facts supporting the proposed variation.[4]

16. The Commission indicated that the Review will proceed on the basis that the relevant modern award achieved the modern awards objective at the time that it was made (emphasis added):

> **[24]** In conducting the Review the Commission will also have regard to the historical context applicable to each modern award. Awards made as a result of the award modernisation process conducted by the former Australian Industrial Relations Commission (the AIRC) under Part 10A of the Workplace Relations Act 1996 (Cth) were deemed to be modern awards for the purposes of the FW Act (see Item 4 of Schedule 5 of the Transitional Act). Implicit in this is a legislative acceptance that at the time they were made the modern awards now being reviewed were consistent with the modern awards objective. The considerations specified in the legislative test applied by the AIRC in the Part 10A process is, in a number of important respects, identical or similar to the modern awards objective in s.134 of the FW Act. In the Review the Commission will proceed on the basis that prima facie the modern award being reviewed achieved the modern awards objective at the time that it was made.[5]

[3] *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788.

[4] *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at [23].

[5] *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at [24].

17. The decision confirms that the Commission should generally follow previous Full Bench decisions that are relevant to a contested issue unless there are cogent reasons for not doing so: (emphasis added)

> **[25]** Although the Commission is not bound by principles of stare decisis it has generally followed previous Full Bench decisions. In another context three members of the High Court observed in Nguyen v Nguyen:
>
> > "When a court of appeal holds itself free to depart from an earlier decision it should do so cautiously and only when compelled to the conclusion that the earlier decision is wrong. The occasion upon which the departure from previous authority is warranted are infrequent and exceptional and pose no real threat to the doctrine of precedent and the predictability of the law: see Queensland v The Commonwealth (1977) 139 CLR 585 per Aickin J at 620 et seq."
>
> **[26]** While the Commission is not a court, the public interest considerations underlying these observations have been applied with similar, if not equal, force to appeal proceedings in the Commission. As a Full Bench of the Australian Industrial Relations Commission observed in Cetin v Ripon Pty Ltd (T/as Parkview Hotel) (Cetin):
>
> > "Although the Commission is not, as a non-judicial body, bound by principles of stare decisis, as a matter of policy and sound administration it has generally followed previous Full Bench decisions relating to the issue to be determined, in the absence of cogent reasons for not doing so."
>
> **[27]** These policy considerations tell strongly against the proposition that the Review should proceed in isolation unencumbered by previous Commission decisions. In conducting the Review it is appropriate that the Commission take into account previous decisions relevant to any contested issue. The particular context in which those decisions were made will also need to be considered. Previous Full Bench decisions should generally be followed, in the absence of cogent reasons for not doing so.[6]

18. In addressing the modern awards objective, the Commission recognised that each of the matters identified at s.134(1)(a) – (h) are to be treated "as a matter of significance"[7] and that "no particular primacy is attached to any of the s.134 considerations"[8]. The Commission identified its task as needing to "balance

[6] *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at [24] – [27].

[7] *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at [31].

[8] *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at [32].

the various s.134(1) considerations and ensure that modern awards provide a fair and relevant minimum safety net"[9]: (emphasis added)

> **[36]** … Relevantly, s.138 provides that such terms only be included in a modern award 'to the extent necessary to achieve the modern awards objective'. To comply with s.138 the formulation of terms which must be included in modern award or terms which are permitted to be included in modern awards must be in terms 'necessary to achieve the modern awards objective'. What is 'necessary' in a particular case is a value judgment based on an assessment of the considerations in s.134(1)(a) to (h), having regard to the submissions and evidence directed to those considerations. In the Review the proponent of a variation to a modern award must demonstrate that if the modern award is varied in the manner proposed then it would only include terms to the extent necessary to achieve the modern awards objective.[10]

19. The frequently cited passage from Justice Tracey's decision in *Shop, Distributive and Allied Employees Association v National Retail Association (No 2)* was adopted by the Full Bench. It was thus accepted that:

> … a distinction must be drawn between that which is necessary and that which is desirable. That which is necessary must be done. That which is desirable does not carry the same imperative for action.[11]

20. Accordingly, the Preliminary Jurisdictional Issues Decision establishes the following key threshold principles:

- A proposal to significantly vary a modern award must be accompanied by submissions addressing the relevant statutory requirements and probative evidence demonstrating any factual propositions advanced in support of the claim;
- The Commission will proceed on the basis that a modern award achieved the modern awards objective at the time that it was made;
- An award must only include terms to the extent necessary to achieve the modern awards objective. A variation sought must not be one that is merely desirable; and

[9] *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at [33].

[10] *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at [36].

[11] *Shop, Distributive and Allied Employees Association v National Retail Association (No 2)* (2012) 205 FCR 227 at [46].

- Each of the matters identified under s.134(1) are to be treated as a matter of significance and no particular primacy is attached to any of the considerations arising from it.

21. In a subsequent decision considering multiple claims made to vary the *Security Services Industry Award 2010*, the Commission made the following comments, which we respectfully commend to the Full Bench (emphasis added):

> **[8]** While this may be the first opportunity to seek significant changes to the terms of modern awards, a substantive case for change is nevertheless required. The more significant the change, in terms of impact or a lengthy history of particular award provisions, the more detailed the case must be. Variations to awards have rarely been made merely on the basis of bare requests or strongly contested submissions. In order to found a case for an award variation it is usually necessary to advance detailed evidence of the operation of the award, the impact of the current provisions on employers and employees covered by it and the likely impact of the proposed changes. Such evidence should be combined with sound and balanced reasoning supporting a change. Ultimately the Commission must assess the evidence and submissions against the statutory tests set out above, principally whether the award provides a fair and relevant minimum safety net of terms and conditions and whether the proposed variations are necessary to achieve the modern awards objective. These tests encompass many traditional merit considerations regarding proposed award variations.[12]

22. The Unions claims conflict with the principles in the Preliminary Jurisdictional Issues Decision. Further, the Unions have not discharged the evidentiary burden described in the above decision. Accordingly, the claims should be rejected.

3.2 Considerations Associated with Procedural Fairness

23. We are of course mindful of the nature of the Review and the Commission's repeated observation that it is not bound by the terms of a proponent's claim. Nevertheless, a respondent party at this stage of the proceedings can deal only with that which has been put before us. That is, these submissions only relate to the variations sought and the material filed by the Unions in support of them. It is not incumbent upon us to provide a response (or a hypothetical

[12] *Re Security Services Industry Award 2010* [2015] FWCFB 620 at [8].

response) to potential derivatives of the variations sought. Such an approach would render the task here before us virtually impossible to undertake.

24. Should the Unions or the Commission, during these proceedings, propose that the Award be varied in terms that differ to those which have been proposed as at the time of drafting these submissions, notions of fairness dictate that respondent parties such as Ai Group be afforded an opportunity to address the Full Bench in relation to whether such a course of action should be permitted or taken in the context of these proceedings. If such a course is to be adopted, there should also be a further opportunity to make submissions and/or call evidence in response to any such new proposal. Absent such a process, it may be argued that procedural fairness has not been afforded to those who oppose the claim because, for instance, such parties have not been granted a chance to be properly heard in relation to the variations ultimately sought to be made, which may well have implications that have not otherwise been put before the Full Bench.

4. THE UNION'S CLAIMS

25. In this section we summarise various claims advanced by the Unions that are being dealt with this second tranche of the proceedings.

4.1 Minimum Engagement Periods

26. The HSU is seeking the deletion of clause 10.4(c), which is in the following terms:

> **(c)** Casual employees will be paid the following minimum number of hours, at the appropriate rate, for each engagement:
>
> **(i)** social and community services employees except when undertaking disability services work—3 hours;
>
> **(ii)** home care employees—1 hour; or
>
> **(iii)** all other employees—2 hours.

27. The HSU also seeks the insertion of a new clause 10.6:

> **10.6** The minimum engagement for employees under this award will be 3 hours.

28. The variations would have the effect of:

(a) Increasing the minimum engagement period for casual employees performing home care, disability services work, crisis accommodation work and family day care employees to three hours.

(b) Introducing a minimum engagement period for full-time and part-time employees of 3 hours.

4.2 Broken Shifts

The HSU Claims

29. The HSU is seeking the following changes to clause 25.6 of the Award:

25.6 Broken shifts

(a) This clause only applies to:

(i) social and community services employees when undertaking disability services work; and

(ii) home care employees.

(~~a~~b) For the purposes of this clause, a ~~A~~ **broken shift** means a shift worked by ~~an~~ a casual or part-time employee that includes no more than one ~~or more~~ break~~s~~ (other than a meal break) and where the span of hours is not more than 12 hours.

(c) A broken shift may only be worked where there is mutual agreement between the employer and employee.

(d) Where an employee works a broken shift, they shall be paid at the appropriate rate for the reasonable time of travel from the location of their last client before the break to their first client after the break, and such time shall be treated as time worked. The travel allowance in clause 20.5 also applies.

(e) The minimum period of engagement specified in clause 10.6 shall apply to each period of work in a broken shift.

(~~b~~f) In addition to the rates at 14.4(d) ~~Payment for a broken shift will be at ordinary pay with~~ penalty rates and shift allowances in accordance with clause ~~29~~20.2—Shiftwork and clause 19—Overtime apply~~, with shift allowances being determined by the finishing time of the broken shift~~.

(g) Shift allowances will be determined by the starting or finishing time of the broken shift, whichever allowance is higher. The allowance will apply across both parts of the shift.

(~~c~~h) All work performed beyond the maximum span of 12 hours for a broken shift will be paid at ~~double time~~ 200% of the minimum hourly rate.

(~~d~~i) An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.

30. The variations proposed seek to significantly alter the current broken shift provisions. Specifically, they would have the following consequences:

(a) Limit the application of the clause to part-time and casual employees. The clause would no longer apply to full-time employees.

(b) Redefine a 'broken shift' such that a shift could only be 'broken' into two parts on a given day.

(c) Require that the employer and employee must *agree* that the employee will work a broken shift in order for a broken shift to be worked.

(d) Introduce an express obligation to pay an employee for time spent travelling during the break in the shift and to treat such time as time worked.

(e) Require that each portion of the broken shift must be at least three hours in length.

(f) In some circumstances, increase an employee's entitlement to the relevant shift allowances during the performance of a broken shift.

31. In light of an extension of time granted to respondent parties on 11 July 2019, Ai Group intends to file its submissions in opposition to the proposed clause 25.6(d) along with material in opposition to other Unions' claims in relation to the issue of 'travel time'. The aforementioned element of the HSU's broken shifts claim is therefore not dealt with in this submission.

The United Voice Claims

32. United Voice is seeking the following changes to clause 25.6 of the Award:

25.6 Broken shifts

This clause only applies to social and community services employees when undertaking disability services work and home care employees.

(a) ~~A **broken shift** means a shift worked by an employee that includes one or more breaks (other than a meal break) and where the span of hours is not more than 12 hours.~~ For the purposes of this award a broken shift is a shift where an employee works in two separate periods of duty on any day within a maximum spread of twelve (12) hours and where the break between periods exceeds one hour.

(b) Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the starting or finishing time of the broken shift, whichever is greater.

(c) All work performed beyond the maximum span of 12 hours for a broken shift will be paid at double time.

(d) An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.

33. The variations proposed seek to:

(a) Redefine a broken shift such that:

i) A shift could only be 'broken' into two parts on a given day;

ii) The break during the shift exceeds one hour.

(b) Potentially increase an employee's entitlement to the relevant shift allowances during the performance of a broken shift.

The ASU Claim

34. The ASU is seeking the insertion of a new clause 25.6(b)(i), in the terms set out below:

> **25.6 Broken shifts**
>
> This clause only applies to social and community services employees when undertaking disability services work and home care employees.
>
> **(a)** A **broken shift** means a shift worked by an employee that includes one or more breaks (other than a meal break) and where the span of hours is not more than 12 hours.
>
> **(b)** An employee who works a broken shift will receive:
>
> **(i)** ~~Payment for a broken shift will be at o~~Ordinary pay plus a loading of 15% of their ordinary rate of pay for each hour from the commencement of the shift to the conclusion of the shift inclusive of all breaks; and
>
> **(ii)** ~~with~~ penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the finishing time of the broken shift.
>
> **(c)** All work performed beyond the maximum span of 12 hours for a broken shift will be paid at double time.
>
> **(d)** An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.

35. The variation sought would see employees working a broken shift entitled to an additional 15% loading for the duration of the entire shift and any intervening breaks.

4.3 Overtime After 8 Hours of Work

36. The HSU is seeking the following amendment to clause 28.1(b)(ii):

28.1 Overtime rates

…

(b) Part-time employees and casual employees

…

(ii) All time worked by part-time or casual employees which exceeds ~~10~~ 8 hours per day, will be paid at the rate of time and a half for the first two hours and double time thereafter, except on Sundays when overtime will be paid for at the rate of double time, and on public holidays at the rate of double time and a half.

(iii) Time worked up to the hours prescribed in clause 28.1(b)(ii) will, subject to clause 28.1(b)(i), not be regarded as overtime and will be paid for at the ordinary rate of pay (including the casual loading in the case of casual employees).

…

37. The proposed variation would create an entitlement to overtime rates for part-time and casual employees for work performed in excess of 8 hours per day. Currently overtime rates are payable for work performed in excess of *10* hours per day.

4.4 Overtime for Part-Time Employees

38. The HSU is seeking the following amendment to clause 28.1(b)(iii):

28.1 Overtime rates

…

(b) Part-time employees and casual employees

(i) All time worked by part-time or casual employees in excess of 38 hours per week or 76 hours per fortnight will be paid for at the rate of time and a half for the first two hours and double time thereafter, except that on Sundays such overtime will be paid for at the rate of double time and on public holidays at the rate of double time and a half.

(ii) All time worked by part-time or casual employees which exceeds 10 hours per day, will be paid at the rate of time and a half for the first two hours and double time thereafter, except on Sundays when overtime will be paid for at the rate of double time, and on public holidays at the rate of double time and a half.

(iii) All time worked by part-time employees which exceeds the hours agreed in clause 10.3(c) will be treated as overtime and paid at the rate of time and a half for the first two hours and double time thereafter, except on Sundays when overtime will be paid at the rate of double time and public holidays at the rate of double time and a half. ~~Time worked up to the hours prescribed in clause 28.1(b)(ii) will, subject to clause 28.1(b)(i), not be regarded as overtime and will be paid for at the ordinary rate of pay (including the casual loading in the case of casual employees).~~

39. Clause 10.3(c) of the Award requires that an employer and part-time employee reach agreement before the employee commences employment about a regular pattern of work including the number of hours to be worked each week, and the days of the week the employee will work and the starting and finishing times each day.

40. The Award does not presently require payment at overtime rates to part-time employees where the employee works hours in addition to the hours they have agreed to work pursuant to clause 10.3(c) of the Award, unless the employee works more than 10 hours in a day or 38 hours in a week / 76 hours in a fortnight.

41. The HSU's claim would alter this position by requiring the payment of overtime rates to part-time employees wherever they work hours in addition to their 'agreed' hours.

4.5 Roster Changes

42. United Voice has proposed amendments to clause 25.5(d)(i) of the Award as follows:

> **25.5 Rosters**
>
> **(a)** The ordinary hours of work for each employee will be displayed on a fortnightly roster in a place conveniently accessible to employees. The roster will be posted at least two weeks before the commencement of the roster period.
>
> **(b)** Rostering arrangements and changes to rosters may be communicated by telephone, direct contact, mail, email, facsimile or any electronic means of communication.
>
> **(c)** It is not obligatory for the employer to display any roster of the ordinary hours of work of casual or relieving staff.
>
> **(d) Change in roster**
>
> **(i)** Seven days' notice will be given of a change in a roster. Full time and part time employees will be entitled to the payment of overtime for roster changes where seven days' notice is not provided.
>
> **(ii)** However, a roster may be altered at any time to enable the service of the organisation to be carried on where another employee is absent from duty on account of illness, or in an emergency.
>
> **(iii)** This clause will not apply where the only change to the roster of a part-time employee is the mutually agreed addition of extra hours to be worked such that the part-time employee still has four rostered days off in that fortnight or eight rostered days off in a 28 day roster cycle, as the case may be.
>
> **(e)** Where practicable, accrued days off (ADOs) will be displayed on the roster.

43. The proposed variation purports to introduce a new substantive entitlement to overtime rates where a full-time or part-time employee is afforded less than 7 days' notice of a change to the roster.

4.6 Recall to Work Overtime

44. The HSU is seeking the insertion of a new clause 28.4(b), as set out below:

28.4 Recall to work overtime

(a) An employee recalled to work overtime after leaving the employer's or client's premises will be paid for a minimum of two hours' work at the appropriate rate for each time so recalled. If the work required is completed in less than two hours the employee will be released from duty.

(b) Where an employee is required to perform work from home after leaving the employer's or client's premises, including:

(i) Responding to phone calls, message or emails;

(ii) Providing advice ("phone fixes")

(iii) Arranging call out/rosters of other employees; and

(iv) Remotely monitoring and/or addressing issues by remote telephone and/or computer access;

the employee will be paid for a minimum of one hours' work at the overtime rate for each time recalled.

45. The proposed new clause would require payment at overtime rates for at least one hour each time an employee is required to perform any work after leaving the employer or client's premises.

4.7 Sleepovers

46. The HSU is proposing the following amendments to clause 25.7(c) of the Award:

25.7 Sleepovers

(a) A sleepover means when an employer requires an employee to sleep overnight at premises where the client for whom the employee is responsible is located (including respite care) and is not a 24 hour care shift pursuant to clause 25.8 or an excursion pursuant to clause 25.9.

(b) The provisions of 25.5 apply for a sleepover. An employee may refuse a sleepover in the circumstances contemplated in 25.5(d)(i) but only with reasonable cause.

(c) The span for a sleepover will be a continuous period of eight hours. Employees will be provided with:

(i) a separate and securely lockable room with a peephole or similar in the door, ~~with~~ a bed and a telephone connection in the room; and,

(ii) suitable sleeping requirements such as a lamp and clean linen; and

(iii) use of appropriate facilities (including staff facilities where these exist); and

(iv) free board and lodging for each night when the employee sleeps over.

(d) The employee will be entitled to a sleepover allowance of 4.9% of the standard rate for each night on which they sleep over.

(e) In the event of the employee on sleepover being required to perform work during the sleepover period, the employee will be paid for the time worked at the prescribed overtime rate with a minimum payment as for one hour worked. Where such work exceeds one hour, payment will be made at the prescribed overtime rate for the duration of the work.

(f) An employer may roster an employee to perform work immediately before and/or immediately after the sleepover period, but must roster the employee or pay the employee for at least four hours' work for at least one of these periods of work. The payment prescribed by 25.7(d) will be in addition to the minimum payment prescribed by this subclause.

(g) The dispute resolution procedure in clause 9 of this Award applies to the sleepover provisions.

47. The variations proposed require the provision of various additional amenities to an employee during a sleepover.

4.8 Uniforms

48. United Voice is seeking the insertion of a new clause 20.2(b), as set out below:

20.2 Clothing and equipment

(a) Employees required by the employer to wear uniforms will be supplied with an adequate number of uniforms appropriate to the occupation free of cost to employees. Such items are to remain the property of the employer and be laundered and maintained by the employer free of cost to the employee.

(b) An adequate number of uniforms should allow an employee to work their agreed hours of work in a clean uniform without having to launder work uniforms more than once a week.

(~~b~~c) Instead of the provision of such uniforms, the employer may, by agreement with the employee, pay such employee a uniform allowance at the rate of $1.23 per shift or part thereof on duty or $6.24 per week, whichever is the lesser amount. Where such employee's uniforms are not laundered by or at the expense of the employer, the employee will be paid a laundry allowance of $0.32 per shift or part thereof on duty or $1.49 per week, whichever is the lesser amount.

(~~c~~d) The uniform allowance, but not the laundry allowance, will be paid during all absences on paid leave, except absences on long service leave and absence on personal/carer's leave beyond 21 days. Where, prior to the taking of leave, an employee was paid a uniform allowance other than at the weekly rate, the rate to be paid during absence on leave will be the average of the allowance paid during the four weeks immediately preceding the taking of leave.

(~~d~~e) Where an employer requires an employee to wear rubber gloves, special clothing or where safety equipment is required for the work performed by an employee, the employer must reimburse the employee for the cost of purchasing such special clothing or safety equipment, except where such clothing or equipment is provided by the employer.

49. Currently, the Award requires that an employer must provide "an adequate number of uniforms appropriate to the occupation" of the employee where the employer requires the employee to wear a uniform. The Award does not purport to prescribe what the "adequate number of uniforms" will be. Rather, this is a matter to be determined by the employer, having regard to the employee's occupation and other relevant circumstances.

50. United Voice seeks the insertion of a new clause that describes or defines what constitutes “an adequate number of uniforms”.

4.9 Damaged Clothing

51. The HSU is seeking the insertion of a new clause 20.3, which is in the following terms:

> **20.3 Damaged clothing allowance**
>
> **(i)** Where an employee, in the course of their employment suffers any damage to or soiling of clothing or other personal effects (excluding hosiery), upon provision of proof of the damage, employees shall be compensated at the reasonable replacement value of the damaged or soiled item of clothing.
>
> **(ii)** This clause will not apply where the damage or soiling is caused by the negligence of the employee.

52. The proposed clause would entitle an employee to compensation “at the reasonable replacement value” of any damaged or soiled clothing or personal effects if they are so damaged or soiled during the course of their employment by virtue of any cause other than the negligence of the employee.

4.10 Telephone Allowance

The HSU Claim

53. Clause 20.6 of the Award provides as follows:

> **20.6 Telephone allowance**
>
> Where the employer requires an employee to install and/or maintain a telephone for the purpose of being on call, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts.

54. The HSU has proposed that the above clause be replaced with the following:

> **20.6 Telephone allowance**
>
> Where an employer requires an employee to use a mobile phone for any work related purpose, the employer will either:
>
> **(a)** provide a mobile phone fit for purpose and cover the cost of any subsequent charges; or
>
> **(b)** refund the cost of purchase and usage charges on production of receipts.

55. The proposed clause would apply wherever an employer requires an employee to use a mobile phone for any work related purpose. It would require the employer to provide the employee with a mobile phone and cover the cost of any usage charges (whether incurred for work purposes of otherwise) or reimburse the employee for the same.

The United Voice Claim

56. United Voice has proposed the following amendments to clause 20.6 of the Award:

> **20.6 Telephone allowance**
>
> Where the employer requires an employee to install and/or maintain a telephone or mobile phone for the purpose of being on call, for the performance of work duties or to access work related information, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts.

57. The variations proposed seek to extend the application of clause 20.6 to circumstances in which:

(a) An employer requires an employee to "install and/or maintain … a mobile phone".

(b) An employer requires an employee to install and/or maintain a telephone for the performance of work duties or access work related information.

(c) An employer requires an employee to install and/or maintain a mobile phone for the performance of work duties or access work related information.

5. THE NATIONAL DISABILITY INSURANCE SCHEME

58. The NDIS was established in 2013, by the *National Disability Insurance Scheme Act 2013* (Cth) (**NDIS Act**). The NDIS is managed by the National Disability Insurance Agency (**NDIA**), which is a statutory agency.

59. In addition to the NDIS Act, a number of rules[13] (**NDIS Rules**) have been made by the relevant Federal minister. The NDIS Rules deal with a range of matters. In some cases, the rules apply only in certain states / territories, whilst in other instances, they have nationwide application.

60. The implementation of the NDIS brought with it significant changes to the way in which support and care for people with permanent and significant disability is provided and funded. Rather than the previous model of providing "block funding" to providers, the NDIS operates through individualised support packages for each participant in the scheme. At its core, the NDIS is directed towards enabling persons with a disability to exercise choice and control over the support and care that they receive. The model espoused by the NDIS is, in essence, a consumer-driven one. This has had and continues to have various implications for providers in the industry, which we later come to.

[13] For example, the *National Disability Insurance Scheme (Becoming a Participant) Rules 2016*; *National Disability Insurance Scheme (Children) Rules 2013*; *National Disability Insurance Scheme (Code of Conduct) Rules 2018*; *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018*; *National Disability Insurance Scheme (Facilitating the Preparation of Participants' Plans—Australian Capital Territory) Rules 2014*; *National Disability Insurance Scheme (Facilitating the Preparation of Participants' Plans—New South Wales) Rules 2016*; *National Disability Insurance Scheme (Facilitating the Participation of Participants' Plans – Queensland) Rules 2016*; *National Disability Insurance Scheme (Facilitating the Preparation of Participants' Plans—South Australia) Rules 2013*; *National Disability Insurance Scheme (Facilitating the Preparation of Participants' Plans – South Australia) Rules 2014*; *National Disability Insurance Scheme (Facilitating the Preparation of Participants' Plans – Tasmania) Rules 2016*; *National Disability Insurance Scheme (Facilitating the Preparation of Participants' Plans—Victoria) Rules 2016*; *National Disability Insurance Scheme (Facilitating the Preparation of Participants' Plans—Western Australia) Rules 2014*; *National Disability Insurance Scheme (Facilitating the Preparation of Participants' Plans—Northern Territory) Rules 2016*.

61. The scope of the NDIS can be characterised by reference to the following defining features, noting that this is not an exhaustive list of the various eligibility criteria stipulated by the NDIS Act[14] and NDIS Rules:

(a) The NDIS relates to the provision of care to persons with "permanent and significant disability". The NDIS Act prescribes "disability requirements" that must be satisfied in order for a person to be eligible for funding under the NDIS. Those requirements are summarised at rule 5.1 of the *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* in the following terms:

- The person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments, or to one or more impairments attributable to a psychiatric condition; and
- The person's impairment or impairments are, or are likely to be, permanent; and
- The impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities: communication, social interaction, learning, mobility, self-care, self-management; and
- The impairment(s) affect the person's capacity for social and economic participation; and
- The person is likely to require support under the NDIS for the person's lifetime.

[14] See for example age and residence requirements at sections 22 and 23 of the NDIS Act.

The rules go on to prescribe further requirements in relation to certain aspects of the above overarching requirements.[15]

(b) The NDIS funds "reasonable and necessary supports", having regard to s.34 of the NDIS Act, which describes the type of supports that will or will not be provided.[16]

62. The rollout of the NDIS commenced on a 'transitional' basis in various states and territories. The chart[17] below identifies the timeframes for the rollouts as agreed between the Commonwealth and State and Territory Governments in 2013:

Table 1 **NDIS transition arrangements by jurisdiction**

	Trial period			Transition to full scheme			Full scheme
	2013 14	2014 15	2015 16	2016 17	2017 18	2018 19	2019 20
NSW	Hunter area trial		Early Transition in Nepean Blue Mountains area (children aged 0–17 years)	Transition to full scheme (by region)		Full scheme	
Vic	Barwon area trial			Transition to full scheme (by region)			Full scheme
Qld			Transition to full scheme from July 2016 (by region). Early Transition from January 2016 in Townsville, Charters Towers and Palm Island				Full scheme
SA	Statewide trial (children aged 0–14 years)			Transition to full scheme (by age and region)		Full scheme	
Tas	Statewide trial (people aged 15–24 years)			Transition to full scheme (by age)			Full scheme
NT		Barkly region trial		Transition to full scheme (by region)			Full scheme
ACT[a]		Territorywide trial		Full scheme			
WA[b]		Perth Hills area trial MyWay trial			Transition to locally administered NDIS		

[a] The Bilateral Agreement for the NDIS launch between the Australian Government and the ACT Government notes that from 2016-17 the ACT will be in 'transition to full scheme'. This transition has been categorised as 'full scheme' because all residents who meet the eligibility criteria will have access to the scheme. [b] In February 2017, the Australian Government and Western Australian Government signed a Bilateral Agreement for a nationally consistent, but locally administered, NDIS.

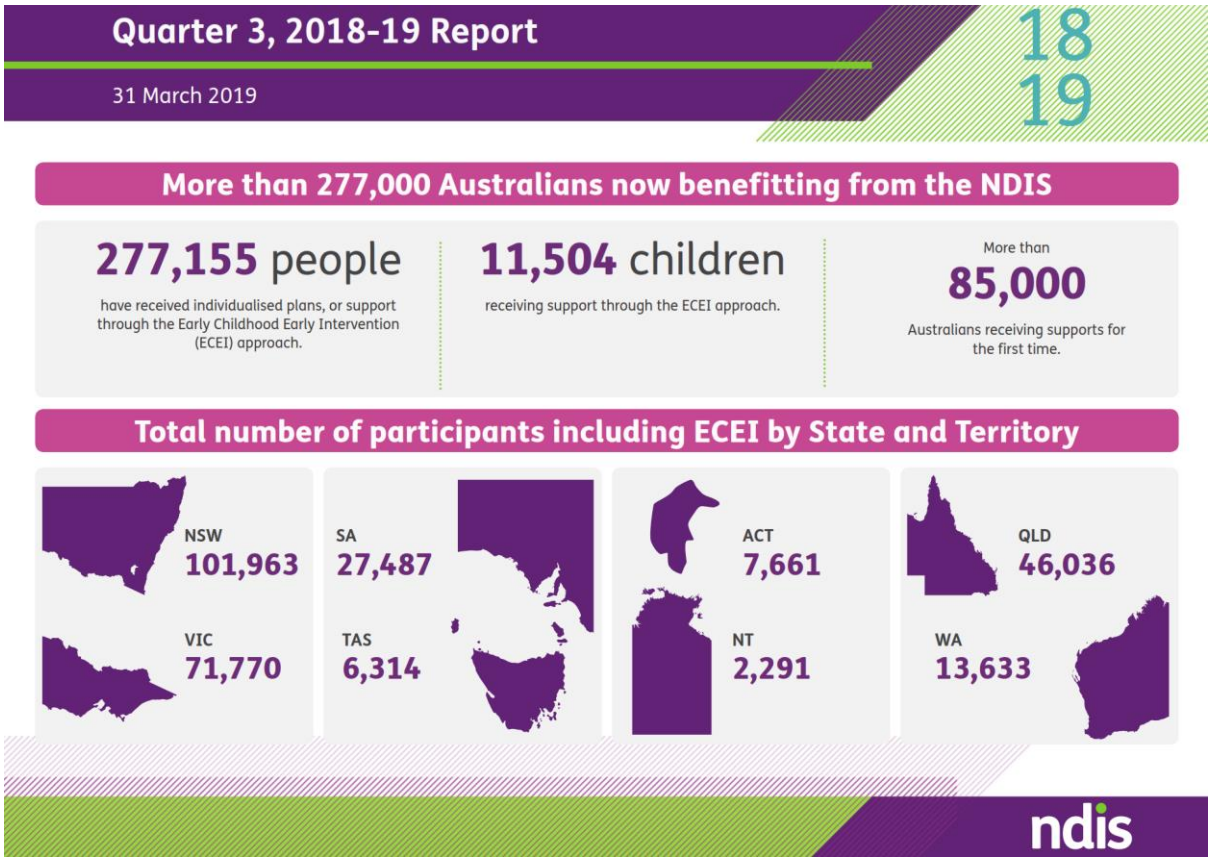
[15] *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* at rules 5.4 – 5.8.

[16] See also the *National Disability Insurance Scheme (Supports for Participants) Rules 2013*.

[17] Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs; Productivity Commission Study Report* (October 2017) at Table 1.

63. The rollout of the NDIS is continuing. In October 2017, the Productivity Commission (**PC**) observed that "the intake of participants with approved plans [had] already [fallen] behind the expected pace" and that if that trend continued, it would take "an additional year before all eligible participants are in the scheme"[18].

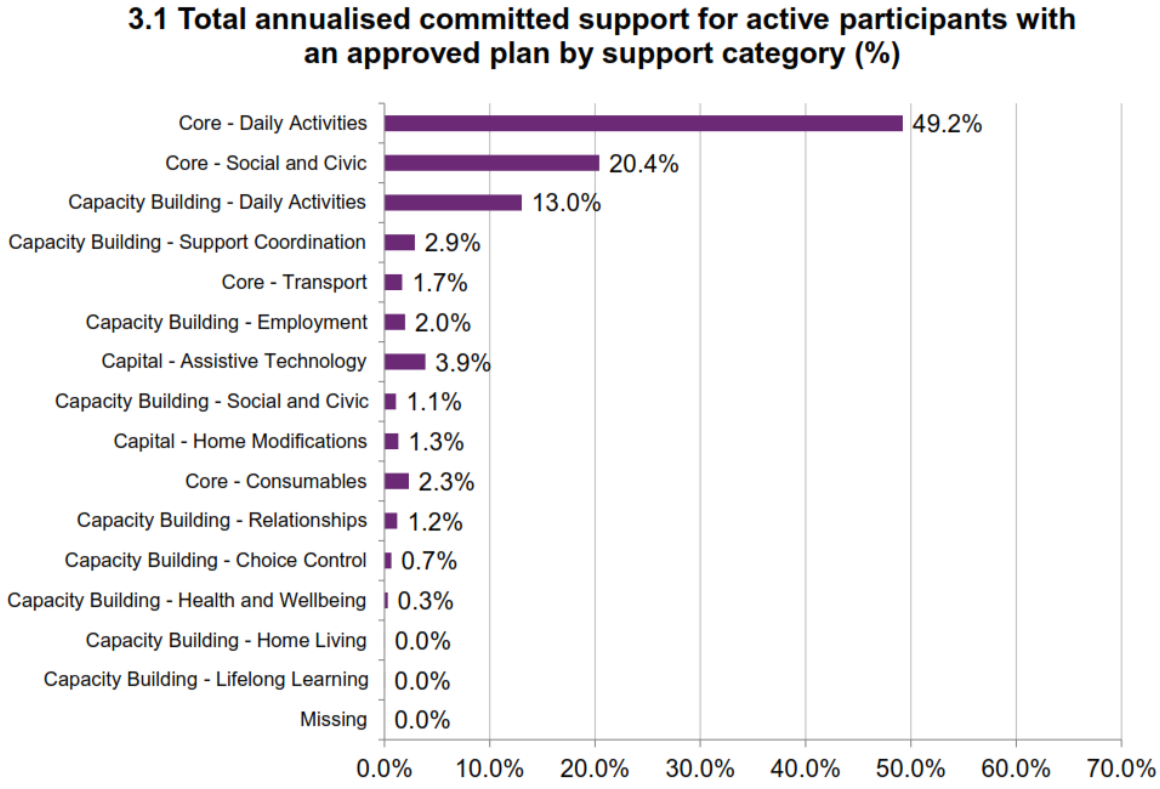
64. Information published by the NDIA indicates that as at 31 March 2019, 277,155 persons were accessing the NDIS, as follows:



65. This represents an increase of 32,502 persons accessing the NDIS during the January – March 2019 quarter.

[18] Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs; Productivity Commission Study Report* (October 2017) at page 11.

66. As the chart below demonstrates[19], as at 31 March 2019, close to 50% of the funding included in active plans related to core daily activities[20]:



67. It is anticipated that when the rollout is complete (previously scheduled for 2019 – 2020), some 475,000 participants would have access to the scheme.[21]

[19] NDIA, *National Dashboard as at 31 March 2019*.

[20] For example, assistance with self-care activities during the day or evening.

[21] Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs; Productivity Commission Study Report* (October 2017) at page 3.

5.1 Participant Plans

68. As previously mentioned, participants under the NDIS have individualised support packages and plans. In broad terms, the process for developing and implementing a plan is as follows:

(a) A person is required to provide various information about themselves and their disability to the NDIA. This is referred to as an 'access request'.[22]

(b) The relevant information is relied upon by the NDIA to assess whether the person is eligible for support under the NDIS. The NDIA's 'assess decision' is communicated to the person in writing, once determined.[23]

(c) The participant will then attend a 'planning meeting', to discuss the participant's current supports and goals for the purposes of developing a plan for the participant, including the specific types of support that the participant requires.

(d) All plans must be submitted to the NDIA for approval.

(e) Once approved, a participant's plan will indicate the funding that has been allocated to each support category. The NDIS' publications for participants in the scheme indicate that there are varying degrees of flexibility contemplated under participants' plans. For example:

[22] Section 18 of the NDIS Act.

[23] Section 28 of the NDIS Act.

i) A participant's "**Core Supports budget**" is "the most flexible, and in most cases, [the participant] can use [their] funding across any of the following four support categories:

- Assistance with daily life;
- Consumables;
- Assistance with social and community participation; and
- Transport.[24]

However, there are instances where [the participant does] not have flexibility in [their] funding, particularly transport funding".

ii) A participant's "**Capacity Building Supports budget** … cannot be moved from one support category to another. Funding can be used to purchase approved individual supports that fall within that Capacity Building category". The categories relevantly include:

- Increased social and community participation;
- Improved relationships;
- Improved health and wellbeing; and
- Improved daily living.[25]

iii) A participant's plan may also include "**stated supports**". Such supports are not flexible. Funding is allocated for specific stated supports or services and that funding cannot be directed towards an alternate support or service.[26]

[24] NDIS, *Using your NDIS plan* at page 6.
[25] NDIS, *Using your NDIS plan* at page 7.
[26] NDIS, *Using your NDIS plan* at page 8.

(f) The participant can choose which provider provides the various supports for which funding has been approved by the NDIA. A participant's funding will be managed in one of three ways:

i) Self-management (the NDIA provides the funding to the participant and the participant then pays the providers directly).

ii) Plan-management (a Plan Manager will pay providers on behalf of the participant).

iii) NDIA-Managed (The NDIA pays providers directly, on behalf of the participant).

(g) Once a participant selects their providers, a service agreement must be entered into between the participant and the provider. The service agreement will identify, amongst other matters, the services to be provided and their respective prices.

69. The function served by participant plans and the strictures contained therein regarding the manner in which participants may use their funding are important features of the scheme for the purposes of these proceedings. We explain the reasons for this below.

5.2 The NDIS Pricing Guides

70. It is expected that, ultimately, supports funded by the NDIS will be provided to participants at prices set by the market, absent regulation by the NDIA. Currently, however, the NDIA has imposed price caps on a range of supports. This market intervention is intended to strike a balance between ensuring that participants are able to access the relevant supports at affordable prices whilst also incentivising providers to in fact offer the relevant services.[27]

[27] Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs; Productivity Commission Study Report* (October 2017) at page 33.

71. In practice, the pricing caps also limit a provider's ability to recover additional, unfunded costs or to increase the margin between the costs incurred in providing the relevant supports and the price charged to participants in the scheme for those same supports.

72. A participant's plan will identify the support category(ies) for which they are entitled to funding. The NDIS recognises numerous specific supports and services, which are referred to as "line items". Providers claim payments by reference to those "line items".

73. As at the time of drafting this submission, the most recent price guide published by the NDIS applies from 1 July 2019 (**Price Guide**). A copy of the Price Guide is **attached** to this submission at **Annexure A.** The Price Guide explains the framework of the NDIS funding arrangements. It also deals specifically with certain issues that are of direct relevance to the Unions' claims, such as travel by employees between participants.

74. The Price Guide operates alongside a 'Support Catalogue', which also applied from 1 July 2019 (**Support Catalogue**). A copy of the Support Catalogue is **attached** to this submission at **Annexure B.** The Support Guide lists the various line items, identifies whether a price cap in relation to the relevant service applies and specifies the quantum of such price caps. In relation to most line items, the same price cap applies nationwide; however in respect of certain types of 'supports', a different price cap applies in the majority of the eastern states and territories (New South Wales, Queensland, the Australian Capital Territory and Victoria) as compared to the remaining states and territories (Western Australia, Northern Territory, South Australia and Tasmania). These price caps operate subject to other (higher) price caps applying to "remote" and "very remote" areas within the various states and territories.

75. On 30 March 2019, the Federal Government announced increases to price limits for therapy, attendant care and community participation [28], which commenced operation from 1 July 2019. The Support Catalogue reflects those price increases.

76. The increases are intended to absorb increases to the Award minimum wages as a result of the Commission's Annual Wage Review decision[29] and the operation of the Equal Remuneration Order[30]. Updated information on the NDIS' website relevantly states as follows:

> 4.5% [increase] for supports listed under Assistance with Daily Activities and Social and Community Participation. This is in response to the Fair Work Commission annual wage review decision and the Equal Remuneration Order.[31]

77. Subject to some specific substantive changes made to the availability of funding in certain circumstances (detailed below), the information published by the NDIA to date does not suggest that the assumptions underpinning the pricing arrangements have been changed or that any additional funding has been released to address broader concerns previously expressed by employers about the inadequacy of the funding to cover the various costs associated with providing the relevant services, including labour costs. We return to these matters at section 5.3 of this submission.

78. As at the time of drafting this submission, limited information appears to be publicly available about the changes made to the NDIS. To the extent that additional relevant information become available to us, we may seek to make further submissions in this regard.

[28] Media release by Minister Fletcher and Minister Henderson, *NDIS price increases for a sustainable and vibrant disability services market* (30 March 2019).

[29] *Annual Wage Review 2018-19* [2019] FWCFB 3500.

[30] PR525485.

[31] NDIS, *Price Guides and Information* (accessed 6 July 2019).

Substantive Changes to the Funding Arrangements

79. The following substantive changes have relevantly been made to the funding arrangements. These changes also commenced operation on 1 July 2019.

80. *First*, a 'Temporary Transformation Payment' (**TTP**) for attendant care and community support participation has been introduced: (our emphasis)

> From 1 July 2019, providers of attendant care and community and centre based activities have access to a higher support price limit through a Temporary Transformation Payment (TTP). The TTP is a conditional loading to assist providers with any costs associated in transitioning to the NDIS.
>
> In 2019–20, the TTP is set at 7.5 per cent on the relevant level 1 support item and will reduce by 1.5 per cent each year thereafter.
>
> The TTP support item number is the support base number with the addition of the letter T. These support item numbers are outlined in the NDIS Support Catalogue 2019–20, effective 1 July 2019.
>
> Providers will need to comply with the following requirements if they wish to claim the higher TTP price limits:
>
> - publish their service prices
> - list and keep up-to-date their business contact details in the Provider Finder
> - participate annually in an Agency-approved market benchmarking survey.
>
> The TTP is similar to the previously introduced Temporary Support of Overheads but is of a higher value and is in place for a longer period.
>
> The TSO will be obsolete as of 1 July 2019 and providers are encouraged to adopt the higher valued TTP and conditions for claiming.[32]

81. It must be noted that the TTP is a *temporary* payment, which is to be phased out by a 1.5% reduction each year. It substitutes the current Temporary Support for Overheads (**TSO**) of 2.5%, which was introduced from 1 July 2018 in light an Independent Pricing Review that was undertaken in 2017 – 2018 and a recommendation made by McKinsey and Company, who subsequently published a report regarding their review.

[32] NDIS, *Annual Price Review* (accessed 1 July 2019).

82. The NDIA published the following explanation of the TSO and the reason for implementing it:[33]

Recommendation	Recommendation detail	NDIA Approach
Recommendation #14 **Temporary support overhead (TSO)**	Implement temporary support for overheads in the form of a temporary increase in the price cap for standard intensity attendant care. Government should offer business planning support for large providers that would otherwise exit and create risk of supply shortages.	The IPR recognised the time and effort it takes for providers to establish efficient systems and process to support the roll out of the NDIS. The NDIA will now provide temporary financial relief for providers as they transition their business operations to accommodate the participant-led NDIS funding approach. In 2018/19 a new 2.5 per cent loading will support standard intensity attendant care supports. 'Attendant care' refers both to assistance with daily personal activities and assistance with community participation. The Temporary Support Overhead will remain partially in place, at 1.25 per cent, in 2019/20 rather than be removed after 12 months as originally recommended. While this TSO loading is in place, the NDIA will continue to work to deliver initiatives that will reduce provider administrative costs and deliver a better NDIS provider experience. Significant progress has been made, with the NDIA delivering provider portal enhancements, payments process improvements, and continuous development of helpful tools such as the provider finder.

83. As the submissions that follow will highlight, documentary material relied upon in these proceedings by the HSU highlights providers' concerns about the insufficient allowance previously made in the funding arrangements for corporate overheads. It remains unclear whether the new TTP will be sufficient to allay such concerns.

84. In this context, the implementation of the TTP cannot be relied upon to alleviate the potential impact of the Unions' claims on employers. The temporary payment does not mitigate the concerns we have raised in this regard.

[33] NDIS, *Independent Price Review Implementation 2018/19* (accessed 2 May 2019).

85. *Second*, changes have been made to the circumstances in which providers can claim costs associated with travel by their employees between participants: (our emphasis)

> If agreed by participants, providers can claim for travel up to 30 minutes between appointments within city areas (MMM 1–3) and up to 60 minutes in regional areas (MMM 4–5). This is an increase from 20 and 45 minutes, respectively.
>
> Before providers can charge for travel, they must first discuss and get agreement on any changes with the participant. Once an agreement is reached, providers will need to update the relevant service bookings to reflect the changes agreed.[34]

86. The Price Guide additionally provides the following qualification on a provider's ability to claim for travel costs: (our emphasis)

> Providers can only claim travel costs from a participant in respect of the delivery of a support item if … the provider is required to pay the worker delivering the support for the time they spent travelling as a result of the agreement under which the worker is employed; or the provider is a sole trader and is travelling from their usual place of work to or from the participant, or between participants.[35]

87. We intend to deal with the implications of the above funding arrangements in the context of the relevant union 'travel time' claims when we file our response to those proposals.

5.3 The Assumptions Underpinning the NDIS Pricing Arrangements

88. The NDIS' pricing arrangements are based on a 'Reasonable Cost Model' (**RCM**). That model is underpinned by various assumptions.

89. The HSU seeks to rely on a report published by the University of NSW[36] in June 2017 titled '*Reasonable, necessary and valued: Pricing disability services for quality support and decent jobs*' (**UNSW Report**). The report considers the assumptions underpinning the RCM for disability support work.

[34] NDIS, *Annual Price Review* (accessed 1 July 2019).

[35] NDIS, *NDIS Price Guide 2019-20, Valid from 1 July 2019* (July 2019) at page 14.

[36] University of NSW; Cortis, N, Macdonald F, Davidson B and Bentham E, *Reasonable, necessary and valued: Pricing disability services for quality support and decent jobs* (June 2017).

90. We here summarise the key assumptions considered in the UNSW Report and the difficulties arising from them. For the reasons subsequently explained, in our submission the pricing arrangements are based on problematic assumptions and as a result, absent significant further adjustments to the NDIS, employers will be unable to recover any additional employment costs associated with enhancements to employee entitlements through these proceedings. The material before the Commission rather demonstrates that the grant of the Unions' claims would serve only to compound the significant existing difficulties experienced by employers under the NDIS.

91. *First*, The RCM assumes that disability support workers are employed at level 2.3 under the 'Social and Community Services' stream of the Award. The NDIA has described this as the "average" level at which such employees are engaged under the Award.[37] This of itself assumes that employees may be classified at a higher level under the Award.

92. The UNSW Report identifies the following problems with the first assumption:

(a) The assumed classification level does not reflect the applicable classification level under the Award when regard is had to the type of work performed by disability support workers. [38] Employers have described Level 2, pay point 3 as the "entry level" classification.[39]

(b) There is no allowance made for above award wages; for example, those provided under an enterprise agreement.[40]

(c) It is resulting in an over-reliance on inexperienced members of staff, which undermines the quality of the service delivered to participants in the scheme.[41]

[37] UNSW Report at page 22.
[38] UNSW Report at page 29.
[39] UNSW Report at page 30.
[40] UNSW Report at page 29.
[41] UNSW Report at page 29.

93. The authors conclude:

> Based on a comparison with definitions in the [Award], and on employer and disability worker accounts, Level 2.3 is considered entry level, and under-classifies disability support workers. This component of the price is misaligned to the actual profile of the workforce, creating incentives to hire less qualified, competent and permanent staff. As expectations of the disability support workforce grow, and new skills demands arise from individualisation and quality and safeguarding measures (DSS, 2016), the assumption that workers will, on average, be employed at Level 2.3 provides a disincentive to support upskilling and career progression.[42]

94. In addition, we note the following further concerns.

95. Clause 13.3(a) of the Award deals with progression through pay points under the Award:

> **13.3 Progression**
>
> **(a)** At the end of each 12 months' continuous employment, an employee will be eligible for progression from one pay point to the next within a level if the employee has demonstrated competency and satisfactory performance over a minimum period of 12 months at each level within the level and:
>
> **(i)** the employee has acquired and satisfactorily used new or enhanced skills within the ambit of the classification, if required by the employer; or
>
> **(ii)** where an employer has adopted a staff development and performance appraisal scheme and has determined that the employee has demonstrated satisfactory performance for the prior 12 months' employment.

96. In addition to the general application of the classification structure of the Award, clause 13.3(a) contemplates that an employee will progress through the pay scales set by the Award if the prescribed criteria are satisfied. On its face, it is apparent that the assumption made for the purposes of the RCM may not hold in the circumstances of a particular employee just 12 months after they are classified at Level 2, pay point 3.

97. Further, clause 30 of the Award ('Higher duties') requires payment at a higher rate than the rate applying to the classification in which the employee is

[42] UNSW Report at pages 30 – 31.

ordinarily engaged in the prescribed circumstances. Its application again distorts the assumption made in the RCM.

98. *Second*, the RCM assumes that only 10% of a disability support worker's paid time will be spent on leave and that of their remaining 'on duty' time, only 5% will constitute time that is spent on duty but not with a participant or travelling between participants. This comes to just 3 minutes per hour.[43]

99. The authors of the report make the following important observation regarding the assumptions underpinning the RCM in relation to employee utilisation: (our emphasis)

> … There does not appear to be any publicly available data or detailed analysis about the extent to which these assumptions reflect the time demands on disability support workers arising from the range of essential tasks required of workers when they are not with participants, and whether administration, handover and communication between disability support workers, supervision, training, team meetings, breaks and other requirements are accounted for.[44]

100. They then go on to say as follows: (our emphasis)

> Evidence from disability workers and employers shows NDIS prices for disability support do not allow adequate time for quality support. For example, there is too little allowance made for legal requirements such as breaks for workers, and for essential tasks such as administration and coordination, or for the development of workers through training and time for supervision and peer support.
>
> …
>
> Analysis of the pricing model in the context of the [Award] shows prices do not adequately account for non-client facing time, including breaks. The pricing model assumes that just 3 minutes per hour of workers' time is not spent either with participants or travelling between them (Section 4.2). This allows for little more than the 10 minute paid tea break required every four hours under the [Award], leaving minimal time for other non-client facing activities.[45]

[43] UNSW report at page 22.

[44] UNSW report at pages 22 – 23.

[45] UNSW Report at page 31.

101. The report criticises the NDIS pricing arrangements for not including, or adequately including, a consideration of other duties or activities undertaken by employees in the course of their employment, including:

(a) Communication between employees for the purposes of handovers;[46]

(b) Attendance at staff / team meetings;[47]

(c) Completion of paperwork and other administrative duties, which have reportedly increased under the NDIS;[48]

(d) Training for new and existing employees;[49]

(e) Leave, noting that:

(i) The assumptions inadequately reflect annual leave entitlements to the extent that they do not taking into account the entitlement to an additional week of leave where an employee meets the definition of 'shiftworker' at clause 31.2 of the Award.[50]

(ii) The assumptions inadequately reflect long service leave entitlements in certain states and territories, including portable long service leave schemes.[51]

(iii) Time spent by employees travelling between clients, which the report describes as a "vexed" issue:[52]

102. In light of the above observations, the assumption made is clearly problematic and without proper foundation. To that end, the funding arrangements

[46] UNSW Report at page 34.
[47] UNSW Report at page 34.
[48] UNSW Report at page 35.
[49] UNSW Report at pages 40 – 43.
[50] UNSW Report at page 43.
[51] UNSW Report at pages 43 – 44.
[52] UNSW Report at 37.

inadequately account for time necessarily spent by employees taking breaks required by the Award and undertaking duties other than attending to clients.

103. *Third*, the RCM assumes that supervisors are employed at level 3.2 under the Award. The NDIA has described this as the "average" level at which employees who undertake program management and administration are engaged under the Award. It also assumes a ratio of one supervisor to 15 members of staff.[53]

104. The authors of the UNSW Report have identified that the ratio "[does] not appear to be based on existing practice or any model of good practice, and [does] not recognise how disability support work is organised"[54].

105. An important link is also draw between this assumption and the first assumption articulated above: (our emphasis)

> … If all workers were employed at SACS Level 2, as per the pricing level, the span would need to be much less than 1:15. However, as Level 2.3 is assumed to be the average for support workers (with some employed at higher levels and some lower), in order to make 1:15 acceptable, supervisors would need to be employed at SACS Level 4 or higher, rather than at Level 3.2 as assumed in the RCM. The [Award] stipulates that Level 3.2 staff 'supervise a limited number of lower classified employees'. The assumed level of supervisors, at Level 3.2, is below the commencement level of a graduate with a three-year degree (Level 3.3). Under the [Award] a characteristic of Level 4, is that positions may involve a 'substantial component of supervision'. This would more plausibly reflect supervision spans of 1:15, than the 'limited number' stipulated at Level 3. Further, larger supervisory spans (such as the 1:18 envisaged in future) require higher levels of responsibility and employment of supervisors at higher levels, and are poorly aligned with the description of responsibilities at Level 3.2.
>
> Empirical data shows supervisory spans of 1:15 and 1:18 are much higher than is common practice. Data from the survey of disability workers shows that among disability workers with supervisory responsibilities, 2 in 3 were supervising 8 or fewer staff (66% of supervisors). Only 16.4% of supervisors reported supervising over 14 staff, although the figure was higher for those working under NDIS (20%) compared with those who were not (12%). …[55]

[53] UNSW Report at page 23.

[54] UNSW Report at page 44.

[55] UNSW Report at page 44.

106. The authors go on to observe as follows: (our emphasis)

> These data underline how the pricing model has assumed a larger supervision span than accords with the [Award] classifications or than is common practice. Supervision of 15 staff as per the pricing model would entail significant (and unrealistic) change to the design of supervisory roles, and would intensify supervisory workloads for around 83% of supervisors in the survey.[56]

107. Clearly, the supervisory ratios and classification levels upon which the pricing assumptions are made are unrealistic and do not reflect common practice. To the extent that employers cannot operate in accordance with those assumptions, the resulting additional employment costs are not provided for in the funding and accordingly, must be absorbed by employers.

108. *Fourth,* the authors state that it is "common practice" to include a loading of 25 – 30% for staff on-costs. They observe however that "it is not clear from public documents precisely how this element of the RCM was calculated and which other costs, if any, were included, making it difficult to assess its adequacy"[57]. They go on to observe that in any event, "the actual amounts in the RCM … are inevitably much less than what is necessary, because on-costs are a percentage mark-up on direct wage costs, which, as shown above, are significantly under-stated, based on the under-classification of workers and supervisors, and under-estimates of the time required to provide disability support …"[58].

109. We again express doubt as to the reliability of this assumption.

110. *Fifth*, the UNSW Report also documents concerns about the allowance made in the pricing arrangements for corporate overheads and return on capital.[59] In particular, in respect of corporate overheads, the authors state:

> Low allowance for overhead expenses in contracts with governments (or donors) is a problem for not-for-profit financing, as it feeds a cycle of under-investment (Lecy & Searing, 2015). Lecy and Searing (2015) identify how the excessive pursuit of

[56] UNSW Report at page 45.

[57] UNSW Report at page 23.

[58] UNSW Report at page 47.

[59] UNSW Report at pages 23 – 24 and 47 – 51.

administrative efficiency has caused a steady, self-perpetuating practice of cost-cutting in organisations, which in turn harms not-for-profits and their service users. Reductions in overheads can cause a myriad of behaviours which are detrimental to the long run productive capacity of not-for-profits, including cutting expenses relating to personnel development. Low overheads also place organisations at risk of financial shock, and have long term consequences by depleting organisational capacity, through starving organisations of funds to invest in skilled and efficient management, and training and development. Low overheads result in burned out staff, under-maintained capital, out of date programs, and other manifestations of poor quality.

It is difficult to assess the appropriateness of NDIS prices for corporate overheads, given the diversity of providers' operational models. Indeed, Lecy and Searing (2015) caution against a simple rule of thumb for all not-for-profits, and instead show that organisations have different levels of overheads depending on their size, subsector and stage of growth. However, it is pertinent that disability service providers report that NDIS pricing arrangements do not adequately cover overheads. One CEO explained, how under NDIS, there is:

> Very little face to face time, eg for supervision, meetings and training and it is inadequate and we will have to reduce all 3. We will be cutting back on our regular 3 full training days a year. We will initially be putting people on casual now as we will be unable to determine ongoing employment. The pricing may cause viability issues for us and is a poor outcome for our staff. (CEO of medium sized metropolitan organisation)

…

As discussed in Section 5.2, workers also identified the loss of paid time for training as something that had occurred with the NDIS with negative impacts on workers' ability to their jobs, and negative impacts on job satisfaction as they observed declining capacity and service quality. Workers we interviewed had experienced their organisations significantly cutting back on support for induction and training of support workers, and for supervision and team meetings. …

…

Some employers also pointed out how under NDIS, organisational overheads were higher, given both the need to spend time negotiating with service users, and the high costs of working with the NDIA:

> NDIS requires both of our organisation and our staff to be more flexible in terms of meeting the more frequently changing needs and demands of clients. It will also increase our administrative cost because our staff members will spend more time in negotiating with clients before they use our services and after they discharge from our services. (Human Resource Manager in large metropolitan service)
>
> At the moment, we still have great confusion among some of our clients and their plans. Even so, there are plans in place, they cannot always be accessed for the service we provide or the client has used up funds in one category but then has difficulties to access another part. To ring NDIA it takes often up to a hour on hold to get to talk to someone, who then in turn cannot always help with a solution. For a small organisation like us NDIS is nearly not worth the

> hassle. We have to pay our staff, but have delays in getting paid. We have one admin staff, who cannot spent hours trying to solve all the issues. Fees do not cover cost of the professional provider and admin cost. We find NDIS very heavy on administrative cost, which is hard to manage for a small organisation like us. We hope with time this gap will significantly reduce and make servicing NDIS clients more viable for us. (CEO of small non-metropolitan organisation)[60]

111. Earlier in this submission we have addressed the newly introduced TTP, which would appear to have been introduced in light of concerns such as those described above.

112. The price cap for relevant services may be increased by virtue of the following factors:

(a) The geographical location of the service (higher price caps apply in regional parts of Australia);

(b) The intensity or complexity of the participant's needs;

(c) The time when the support is provided; and

(d) The number of participants being supported.

113. In relation to the intensity or complexity of the participant's needs (paragraph (b) above), the UNSW Report states: (our emphasis)

> … the evidence … [shows] the loading for intensity is far too limited, as it fails to take account of the range and cost of strategies that are essential to assist participants with complex support needs, in particular the need for more senior workers and the frequent need for more than one worker to work with participants. The loading only takes (inadequate) account of additional non-client time required of workers, with a 5% reduction allowed from the proportion assumed in the base hourly rate. Under current arrangements, the higher rate of supports can be considered where assistance to manage challenging behaviour is required at least once per shift or where continual active support is required, but it is the case that some participants have more intermittent complex support needs. …[61]

[60] UNSW Report at pages 47 – 50.

[61] UNSW Report at page 51.

114. In relation to the time at which a support is provided (paragraph (c) above), the UNSW Report states:

> NDIS prices for a number of service types requiring disability support workers vary by the time of day and/or the day when the service is provided. Depending on the particular service type, there are up to six periods for which prices may be set, namely (i) daytime (6am – 8pm) (ii) weekday evening (8pm – 12am) (iii) Saturday (iv) Sunday (v) public holiday (not used for group programs), and (vi) overnight. The reasons for differences in process between these periods are not completely apparent but they appear to reflect the shift loadings and penalty rates in the [Award] at the time the RCM was developed.[62]

115. It appears that the assumptions have some regard to additional amounts payable under the Award for work performed on weekends and public holidays, however it is unclear whether the pricing arrangements account for the penalty rates payable under the Award in full. For example, it is not apparent whether the labour component of the hourly rate is doubled for the purposes of the prices applying to Sundays or whether providers are required to partially absorb the additional labour costs incurred on those days.

116. Importantly, we have not been able to identify any information that suggests that the following employee entitlements under the Award are accounted for or form part of the NDIA's calculations when setting the price caps for the relevant range of services:

(a) Overtime rates, including where they are payable:

(i) For work performed outside an employee's ordinary hours in accordance with clause 28.1 of the Award;

(ii) For work performed outside the hours stipulated by clause 25.9(a)(i) of the Award on Monday – Friday excursions;[63] and

[62] UNSW Report at page 26.

[63] Clause 25.9(a) of the Award.

(iii) For a minimum of two hours because an employee has been recalled to work overtime after leaving an employer's or client's premises.

(b) Payment at double time for work performed outside the maximum 12 hour span of a broken shift.[64]

(c) Payment at double time where an employee is instructed to resume or continue work without having had 10 consecutive hours off duty as required by clause 28.3(a).[65]

(d) Shift allowances payable except between 8pm and midnight.[66]

(e) Any monetary allowances[67] including the:

(i) Clothing and equipment allowance;

(ii) Meal allowance;

(iii) First aid allowance;

(iv) Travelling, transport and fares allowance;

(v) Telephone allowance;

(vi) Heat allowance;

(vii) Boarding and lodging allowance; or

(viii) On call allowance.

[64] Clause 25.6(c) of the Award.
[65] Clause 28.3(b) of the Award.
[66] Clause 29 of the Award.
[67] Clause 20 of the Award.

(f) Penalty rates payable where an employee is required to work during a meal break.[68]

117. The pricing arrangements do not enable employers to recover the full employment costs incurred for the services provided to participants in the NDIS.

118. The UNSW Report reveals that there are major problems with the RCM and as a result, the pricing arrangements of the NDIS. The evidence cited in the report demonstrates that "[o]verwhelmingly, … NDIS prices are not covering the full costs of disability service provision or supporting quality services".

119. Importantly for the purposes of these proceedings:

> Overall, the data shows how provider organisations are finding it difficult to be 'good employers' and to meet their industrial obligations and cover required pay rates and conditions. Many are reconsidering whether they are likely to be able to provide services in viable ways in the future. …[69]

120. We shortly return to the relevance of the fundamental issues posed by the pricing model to the proceedings here before the Commission.

5.4 Critique of the NDIS

121. The NDIS has been the subject of various reviews and reports since its implementation, including:

(a) The UNSW Report (published in June 2017).

(b) The PC's report titled '*National Disability Insurance Scheme (NDIS) Costs; Productivity Commission Study Report*' (published in October 2017) (**PC Report**).

[68] Clause 27.1(b) of the Award.

[69] UNSW Report at page 54.

(c) McKinsey and Company published a report[70] (**McKinsey Report**) following an Independent Pricing Review (**IPR**) of the NDIS in February 2018.

122. The aforementioned publications highlight the various complexities, difficulties and deficiencies that have emerged since the operation of the NDIS. We here summarise the salient points made in those reports that support the case advanced by Ai Group in opposition to the Unions' claims.

The UNSW Report

123. We have earlier summarised the UNSW Report's treatment of the problematic assumptions underpinning the NDIS pricing arrangements in relation to disability support work.

124. The UNSW Report draws, in part, on a survey on CEOs from 398 not-for-profit community service providers in NSW, conducted in February 2017.[71]

125. The survey results are set out at section 2.2 of the UNSW Report. They reveal that:

(a) Two-thirds of CEO's disagreed with the proposition that "NDIS prices enable us to meet our industrial obligations". Only 14% agreed. The rest were neutral or unsure.[72]

(b) Two-thirds of CEO's disagreed with the proposition that "NDIS prices allow us to pay rates necessary to attract and retain quality support workers". Only 10.9% agreed. The rest were neutral or unsure.[73]

[70] McKinsey & Company, *Independent Pricing Review, National Disability Insurance Agency, Final Report* (February 2018).

[71] UNSW Report at page 9.

[72] UNSW Report at page 15.

[73] UNSW Report at page 15.

126. The UNSW Report identifies that it has been argued on behalf of employers in the disability services sector that the prices set by the NDIA "are too low to cover providers' overheads and the margin necessary to cover future costs, and, as such, the pricing mechanism precludes existing service providers from developing the additional service capacity required to meet demand".[74]

127. The following responses received to the open-ended part of the survey are also telling:

(a) "Covering travel cost is a major concern as most of the clients we support live in rural remote areas. Without adequate funding to cover travel, our service may not be able to continue to provide support to clients in these areas. There are no other services in some of the areas we provide support in." (CEO of medium sized non-metropolitan organisation)[75]

(b) "The hourly rate is unsustainable and does not allow funds for training or CPD or staff meetings and supervision. This all is covered by the org as a commitment to maintaining quality. Hours cannot be guaranteed so we look to a casual workforce in regional areas, we cannot meet demand with staffing and are constantly short staffed. Travel is a nightmare in regional areas with agencies needing to pay mileage as well as travel time." (CEO of medium sized non-metropolitan based)[76]

(c) "The lack of alignment between how NDIS is funded and employers obligations under the Modern award (particularly in NSW with higher rates under transitional arrangements) make it incredibly difficult to attract and retain quality staff and operate at a level of efficiency and

[74] UNSW Report at page 14.

[75] UNSW Report at page 16.

[76] UNSW Report at pages 16 – 17.

quality that is sustainable". (Human resource manager in very large multi-state organisation)[77]

128. The survey results demonstrate that the current NDIS funding is placing employers under immense financial pressure. The funding appears inadequate to cover the costs associated with providing disability services. Indeed, the majority of CEOs surveyed considered that the funding arrangements are deficient to such an extent that they do not enable an employer to meet their "industrial obligations".

129. The survey results, coupled with the analysis presented by the authors of the report, lay bare the serious inadequacies of the NDIS and the very inherent limitation they place on employers to meet their legal obligations and ensure the quality and continuance of their services to persons with a disability.

The PC Report

130. In 2017, the PC undertook a review of the NDIS, for the purposes of informing the final design of the full scheme.[78]

131. The PC highlighted the need for the number of employers and employees in the industry to grow rapidly in order to keep pace with funding increases and demand for services.[79]

132. The PC Report documents the detrimental impact of the NDIS' pricing arrangements on providers and in turn, the market:

> The Commission heard from many stakeholders that the NDIA's pricing methodology has, in some cases, led to perverse incentives, poor participant outcomes and hindered market development – especially for supports required by participants with complex needs. …[80]

[77] UNSW Report at page 17.

[78] PC Report at page 5.

[79] PC Report at page 12.

[80] PC Report at page 33.

133. It made the following finding in this respect:

> FINDING 8.1
>
> The National Disability Insurance Agency's approach to setting price caps to date has hindered market development by discouraging the provision of some disability supports. In some cases, it has led to poor participant outcomes, especially for those with complex needs. The benefits of the National Disability Insurance Scheme will not be fully realised if the Agency continues with its current pricing approach.[81]

134. The submissions and evidence that were put before the PC are consistent with the UNSW Report in various respects, including supporting the following propositions:

(a) Price caps imposed in relation to services provided to participants with complex needs are inadequate and as a result, people with such needs are "struggling to find providers willing and able to provide services to them".[82]

(b) Many providers presented anecdotal evidence of price caps for attendant care being too low.[83]

135. A survey presented to the PC by National Disability Services (a body representing disability service organisations) showed that only 55% of disability support organisations reported making a profit in 2015 – 2016 and 40% of respondents budgeted to make a profit in 2016 – 2017.[84]

136. The PC observed that the uncertainty and low confidence amongst providers in the sector was not conducive to building the capacity of the market. It expressed a concern that there is "a serious risk that both existing and potential disability support providers will choose to provide their services elsewhere".[85]

[81] PC Report at page 304.
[82] PC Report at pages 297 – 298.
[83] PC Report at page 300.
[84] PC Report at page 303.
[85] PC Report at page 304.

137. The PC Report demonstrates that a multitude of consequences have flowed from deficiencies in the NDIS and the implications they have for providers. Importantly, the PC Report highlights the extent to which providers are struggling to profit under the scheme and the long-term implications of this for the market.

138. It is trite to observe that the imposition of additional employment costs in such circumstances will only serve to exacerbate the thin markets referred to by the PC, which have resulted from providers failing to invest in their organisation to build its capacity and from providers opting to not provide the relevant services at all.

The McKinsey Report

139. In June 2017, the Board of the NDIA commissioned McKinsey & Company to undertake the IPR and investigate the appropriateness of the NDIA's pricing.[86] The review included "extensive consultation" with stakeholders such as providers and peak bodies.[87] The process of the IPR is set out at pages 11 – 12 of the McKinsey Report.

140. The following issues of relevance were raised by stakeholders during the consultation process:

    (a) Current loadings for complex participants do not fully reflect the additional costs of serving these participants, such as higher wages for a more skilled workforce, additional time required for training and reporting, and higher supervision ratios.[88]

[86] McKinsey Report at page 3.

[87] McKinsey Report at page 4.

[88] McKinsey Report at page 4.

(b) Current travel allowances do not adequately cover the costs of provider travel and participant transport in regional areas and isolated communities.[89]

(c) The assumptions underpinning the pricing model are flawed, for reasons similar to those identified in the UNSW Report.[90]

141. The following important key findings were made:

(a) There are certain markets for which undersupply is a risk in the future:[91]

> Providers raised issues about price levels inhibiting the growth and development of a skilled workforce. Some providers believe there is a risk of supply shortage as demand increases towards Full Scheme, and there are anecdotal reports that some providers are choosing to reduce their services or not grow beyond their existing service levels due to pricing constraints. Some providers believe there is also potential that new participants and participants with complex needs could have difficulty finding a service provider if the market is not growing at the necessary rate to meet demand. …[92]

(b) A "substantial number" of providers were unable to operate profitably at the applicable pricing caps.[93] The following extract from the McKinsey Report is particularly relevant:

> The financial sustainability of providers in the NDIS is critical to ensuring ongoing supply of supports to participants. <u>While providers may be able to absorb losses for a period, operating in the NDIS needs to be attractive in the long term for enough providers to meet the growth in demand.</u>[94]

142. The McKinsey Report demonstrates that the NDIS has placed a substantial number of employers in an unsustainable position. Those who are unable to profit under the scheme are in turn unable to increase their capacity to provide their services and may ultimately choose not to continue to provide those services at all. The grant of the Unions claims, in circumstances where no

[89] McKinsey Report at page 4.

[90] McKinsey Report at pages 14 – 15.

[91] McKinsey Report at page 5.

[92] McKinsey Report at page 17.

[93] McKinsey Report at pages 5 and 27.

[94] McKinsey Report at page 24.

funding has been made available by the NDIS to cover the additional employment costs, would serve only to compound the difficulties currently faced by employers.

5.4 The Relevance of the NDIS to these Proceedings

143. The inherent connection between the Award and government funding has long been accepted by the Commission.

144. For example, in the context of proceedings concerning the ERO, the Full Bench stated as follows: (our emphasis)

> **[270]** There is considerable evidence in this matter and widespread acceptance by the parties that a major reason for the actual wage rates in the SACS industry is the level of funding provided by governments. This situation appears to be similar across the industry, even in parts which are less female dominated than others such as community legal work. …
>
> **[271]** We deal now with funding so far as it relates to the possible effects on the industry if the application is granted in whole or in part. Opponents of the claim and supporters alike all agreed that if remuneration is increased in the SACS industry as a result of these proceedings, employment levels and services will be affected unless the additional costs are fully met by government. It was also suggested that there is a significant part of the industry which is not dependent on government funding at the moment and the effect on employers in that part should also be taken into account. We were also told that a number of employers fund their operations through a combination of government funding and reserves, as well as income from philanthropy.
>
> **[272]** We accept that there is widespread reliance on government funding and that because of the pervasive influence of funding models any significant increase in remuneration which is not met by increased funding would cause serious difficulties for employers, with potential negative effects on employment and service provision.[95]

[95] *Equal Remuneration Case* [2011] FWAFB 2700 at [270] – [272].

145. When the tribunal ultimately decided to make the ERO, the Commonwealth Government's commitment to increase funding to meet the additional employments costs that would flow from the order was a central consideration that led the majority to conclude that the order jointly proposed by the relevant parties and the Commonwealth should be made: (our emphasis)

> **[4]** We made provision for further submissions and encouraged the parties to hold discussions. … On 17 November 2011, the applicants and the Commonwealth lodged a Joint Submission setting out a number of agreed matters. In particular, the submission contained an agreed outcome, subject to some matters of detail.
>
> …
>
> **[14]** The Commonwealth drew our attention to the Prime Minister's announcement on 10 November 2011 that the Australian Government would provide over $2 billion during the six-year implementation period. It is committed to fund its share of the programs which it funds directly and also in proportion its share of the joint state/federal funding through specific purpose payments and national partnership payments. While the way in which those funding commitments will be applied will be the subject of discussions between relevant parties, it was made clear in submissions that the Australian Government is committed to meeting its share of the burden that will flow from any decision that is given in this case and there is no suggestion of a limit at the figure of $2 billion.
>
> …
>
> **[65]** The Commonwealth has given a commitment to fund its share of the increased costs arising from the proposals. While some state governments are opposed, no government has indicated it will be unable to fund its share. On the other hand there are significant risks which need to be considered. For example, there will be an impact on employers in relation to programmes and activities which are not government funded. As a number of opponents of the proposals pointed out, any order we make has the potential to affect employment levels and service provision where costs cannot be recovered. We are also concerned about the effect on the finances of a number of the states. We have decided that in the circumstances these risks can be satisfactorily addressed by an extension to the length of the implementation period.[96]

146. Whilst the funding model that now applies in the sector is different to that which applied at the time that the ERO was made, the tribunal's observations regarding the reliance of the sector on government funding and the adverse implications that would flow for employers if it were to increase employee entitlements in the absence of funding increases, remain apposite.

[96] *Equal Remuneration Order* [2012] FWAFB 1000 at [4], [14] and [65].

147. In 2017, a Full Bench of the Commission made findings about the operation of the NDIS in the context of a claim made by ABI and the NSW Business Chamber to vary the part-time provisions of the Award. Relevantly, the Commission found that:

> **[630]** … In pricing items, the NDIA has been aggressive in trying to set the absolute minimal cost so as to control the cost to government of the NDIS as a whole. …[97]

148. Whilst the Commission dismissed the claim, its reasoning involved a detailed consideration of the evidence before it regarding the NDIS.[98] The relevance of the NDIS was affirmed in the Commission's concluding paragraph in relation to the proposal:

> **[643]** The ABI's application is therefore rejected. However we emphasise that the conclusions we have reached about it are made at a time when the NDIS is still a long way from full implementation and are therefore necessarily speculative to a degree. The issues raised by the ABI's application may require further review if, after the NDIS has been fully implemented, a different picture emerges.[99]

149. Consistent with the approach previously taken by the Commission and its predecessor when determining claims to enhance terms and conditions in the Award, in our submission, the Commission should in these proceedings have regard to the funding arrangements applying to employers covered by the Award. This is because the funding arrangements under the NDIS currently impose limitations on the price that can be charged by providers to their clients for their services. This places an inherent limitation on the capacity of employers to recover any additional costs flowing from variations to the Award. Additionally, it appears that the terms of approved participant plans place further limitations on the extent to which employers are able to claim additional amounts (for example, because plans limit the purpose or "support" for which certain funding can be used).

[97] *4 yearly review of modern awards – Casual employment and Part-time employment* [2017] FWCFB 3541 at [630].

[98] *4 yearly review of modern awards – Casual employment and Part-time employment* [2017] FWCFB 3541 at [636] – [642].

[99] *4 yearly review of modern awards – Casual employment and Part-time employment* [2017] FWCFB 3541 at [643].

150. Furthermore, the material relied upon by the Unions in these proceedings demonstrates that:

(a) The current funding levels are insufficient to cover the costs associated with providing disability services. The analysis contained in the UNSW Report and the feedback received from surveyed CEOs further demonstrates that the funding model does not take adequate account of the terms and conditions currently stipulated in the Award and that employers, as a result, consider that the funding is insufficient to cover the relevant costs.

(b) A substantial number of employers are unable to make a profit under the current funding arrangements.

(c) The limited funding is having adverse consequences for the extent and quality of services provided by employers. This in turn has consequences for employment opportunities.

(d) The limited funding is having adverse consequences for the extent to which employers are able to provide career progression and training to their employees. This again has consequences for service delivery.

151. Whilst increases to the NDIS funding have recently been implemented, the information available about those increases does not suggest that they are of a sufficient magnitude to address employers' existing difficulties with operating under the scheme. There is nothing to suggest that the fundamental problems identified in the UNSW Report with the RCM will be alleviated by the funding increases. Further and in any event, the increases are certainly not sufficient to cover the additional costs that would flow from the grant of the Unions' claims; nor is there any indication that such funding would necessarily be released by the NDIA if the claims were nonetheless granted.

152. In our submission, the grant of the Unions' claims will serve only to exacerbate the existing concerns voiced by employers about their viability under the scheme and their ability to continue to provide services to persons with a

disability. If the Award were varied as sought by the Unions, employers will be faced with substantial additional costs for which there is no funding and no scope to recover from those who need and access their services.

153. The operation of the NDIS and the constraints it places on employers covered by the Award should, in our respectful submission, form the cornerstone of the Commission's consideration of the impact of the Unions claims on employers. Such a consideration necessarily leads to the inevitable conclusion that employers cannot and should not be saddled with the with the additional employee entitlements sought by the Unions in these proceedings.

6. MINIMUM ENGAGEMENT PERIODS

154. The HSU is seeking the deletion of clause 10.4(c), which is in the following terms:

> **(c)** Casual employees will be paid the following minimum number of hours, at the appropriate rate, for each engagement:
>
> **(i)** social and community services employees except when undertaking disability services work—3 hours;
>
> **(ii)** home care employees—1 hour; or
>
> **(iii)** all other employees—2 hours.

155. The HSU also seeks the insertion of a new clause 10.6:

> **10.6** The minimum engagement for employees under this award will be 3 hours.

156. The variations would have the effect of:

(a) Increasing the minimum engagement period for casual employees performing home care, disability services work, crisis accommodation work and family day care, to three hours.

(b) Introducing a minimum engagement period for full-time and part-time employees of 3 hours. At present, the Award does not stipulate a minimum engagement period for such employees.

The HSU's Case

157. The HSU has advanced its case on the basis of the following propositions:

(a) It might reasonably be concluded that the expense and inconvenience associated with each shift is greatest in respect of home care and disability support work. Despite this, casual home care and disability services workers are guaranteed the shortest minimum engagement periods.

(b) Changes to the industry (marketisation of service delivery, “proliferation” of part-time employment and “employment on decreased hours”) warrant a review of the current minimum engagement periods.

(c) The Award requirement for an employer and part-time employee to reach agreement at the time of engagement is not complied with, is ineffectual and/or does not apply due to the operation of enterprise agreements.

(d) The nature of the work performed by disability support workers and home care employees, which involves travelling between different locations, warrants particular consideration of minimum engagement periods in the Award.

(e) It is commonplace for employees to be rostered to perform “very short shifts … interspersed with unpaid breaks”, during which employees travel between clients.

158. We note at the outset that the propositions summarised at paragraphs (a), (d) and (e) above are inherently connected with the ‘travel time’ claims advanced by the Unions and the material filed in support of those claims, including the proposed clause 25.6(d) by the HSU. We therefore intend to deal with them when we file our submissions in respect of the travel time claims.

Prior Consideration Given to the Relevant Issues

The Part 10A Award Modernisation Process

159. When the Award was made, the AIRC made the following comments about the casual minimum engagement period: (our emphasis)

> **[80]** We have decided to make a modern award based on the terms of the exposure draft but with a number of alterations some of which we deal with below.
>
> …
>
> **[82]** We mention some of the significant changes from the terms of the exposure draft. …
>
> **[83]** The minimum period of engagement for casuals has been altered to take into account the different sectors of this industry. …[100]

160. As a consequence, the Award stipulated (and continues to stipulates) differentiating casual minimum engagement periods for different groups of employees by reference to the nature of the work they perform.

161. It is clear that the AIRC gave express consideration to the appropriate minimum engagement period that should apply to casual employees, having regard to the relevant pre-modern awards that operated in the different sectors of the industry. The HSU's case has not proffered any cogent reasons for departing from this decision.

[100] *Re Award Modernisation* [2009] AIRCFB 945 at [80] – [83].

The Transitional Review

162. During the transitional or two-year award review, the ASU sought to vary the Award to introduce a requirement that a part-time employee be paid for a minimum of three hours for each engagement.[101] This proposal was accompanied by a claim to introduce a new clause that required an employer and part-time employee to reach agreement at the time of engagement as to the employee's hours of work:

> **[16]** The proposed clause 10.3(d) seeks the introduction of a requirement to agree on part-time engagement details, and to record them in writing, before commencing employment as follows:
>
> "(d) Before commencing employment, the employer and the employee will agree in writing on a regular pattern of work including the number of hours to be worked each week, the days of the week the employee will work and the starting and finishing times each day. Any agreed variation to the regular pattern of work will be recorded in writing."[102]

163. Whilst the Commission granted the latter union claim, the proposed introduction of a minimum payment for part-time employees was refused:

> **[19]** It is clear that in common with many other awards, the AIRC deliberately did not insert a minimum engagement period for part-timers in this award. It was obviously influenced by the variable position under predecessor awards. In my view the introduction of a minimum engagement period for part-time employees as part of this review would require a strong case that evaluated the impacts on employees and employers across the various sectors covered by the award. The application fails to meet this standard.
>
> **[20]** That part of the application seeking a requirement that part-time arrangements be agreed in writing prior to commencing employment is a common award provision. It requires employees to be given clear information as to the basis of their employment when they are engaged. I consider that the case for such a clause is strong, especially when there is no award minimum engagement period. In my view the concerns of the employers can be allayed by standard procedures that comply with the clause, such as those that have been developed for employers covered by similar provisions in other awards. I will make this change prospective to allow employers to prepare for the change. If significant practical problems emerge an appropriate variation can be sought. I will insert the clause sought by the ASU with effect from 1 August 2013.[103]

[101] *Re Australian Municipal, Administrative, Clerical and Services Union* [2013] FWC 4141 at [15].

[102] *Re Australian Municipal, Administrative, Clerical and Services Union* [2013] FWC 4141 at [16].

[103] *Re Australian Municipal, Administrative, Clerical and Services Union* [2013] FWC 4141 at [19] – [20].

164. Relevantly, the decision:

(a) Observes that the absence of a part-time minimum engagement period in the Award was clearly the product of a deliberate decision made by the AIRC when the Award was made. It was not the result of any inadvertence or a failure to consider the issue during that process.

(b) Resulted in the Commission introducing a requirement that agreement be reached as to a part-time employee's hours at the time of engagement (now found at clause 10.3(c) of the Award). This evidently influenced the Commission's decision to not introduce a minimum engagement period for part-time employees. The Commission observed that the introduction of the requirement for agreement as to the employee's hours further negated the justification for a minimum engagement period.

165. The second matter is particularly relevant in these proceedings and as we shortly come to, a more recent Commission decision dealing with minimum engagement periods for part-time employees reached a similar conclusion about the justification for part-time minimum engagement periods where an award requires that agreement be reached about the employee's hours of work.

166. For completeness we note that whilst an appeal[104] of the aforementioned decision was filed by the ASU, the grounds of appeal did not relate to the Commission's decision concerning the aforementioned issues.

[104] *Re Australian Municipal, Administrative, Clerical and Services Union* [2014] FWCFB 379.

The Casual and Part-time Common Issues Proceedings

167. Earlier in the current award review, the ACTU advanced a claim to introduce four hour minimum engagement periods for casual and part-time employees in the vast majority of awards, including the Award. The claim, if it had been successful, would have resulted in:

(a) An increase to the casual minimum engagement periods at clause 10.4(c) of the Award such that all such employees would have been entitled to a four hour minimum engagement; and

(b) The introduction of a minimum engagement period for part-time employees of four hours.

168. In dealing with the ACTU's claim, the Commission considered the rationale underpinning minimum engagement periods in the awards system: (our emphasis)

> **[399]** Minimum engagement periods in awards have developed in an ad hoc fashion rather than having any clear founding in a set of general principles. However their fundamental rationale has essentially been to ensure that the employee receives a sufficient amount of work, and income, for each attendance at the workplace to justify the expense and inconvenience associated with that attendance by way of transport time and cost, work clothing expenses, childcare expenses and the like. An employment arrangement may become exploitative if the income provided for the employee's labour is, because of very short engagement periods, rendered negligible by the time and cost required to attend the employment. Minimum engagement periods are also important in respect of the incentives for persons to enter the labour market to take advantage of casual and part-time employment opportunities (and thus engage the consideration in paragraph (c) of the modern awards objective in s.134).
>
> …
>
> **[403]** These decisions confirm the fundamental rationale for minimum engagement periods which we have earlier identified. The *Victorian Employers' Chamber of Commerce and Industry* decision also adds that, in respect of casual employees, particular prejudice may arise where a shift is ended after a short period with little or no notice or where the casual employee agrees to perform unfairly short shifts in order to ensure that the employer continues to allocate work to them in the future. However the decisions also identify that, in establishing award minimum engagement requirements, there are a number of important countervailing considerations that need to be taken into account:

- longer minimum engagement periods may prejudice those persons who wish to and can only work for short periods of time because of family, study or other commitments, or because they have a disability;

- the need for and length of a minimum engagement period may vary from industry to industry, having regard to differences such as in rostering practices and whether there are broken shifts;

- an excessive minimum engagement period may cause employers to determine that it is not commercially viable to offer casual engagements or part-time work, which may prejudice those who desire or need such work; and

- a minimum daily engagement period for part-time employees might not need to be as long as for casual employees, because part-time employees are likely to enjoy the greater security of a guaranteed number of weekly hours of work.

[404] Modern awards contain a range of different minimum daily engagement periods for casual and part-time employees, and some contain no minimum at all, such as the VMRSR Award. These provisions generally derive from provisions in pre-reform awards which were in most cases likely formulated by the agreement of the award parties. It can be presumed that in doing so the parties took into account the circumstances of the industries in which they operated that prevailed at the time, but beyond this it is not possible to generalise about the basis upon which such provisions were struck. In particular modern awards, it is clear that that the minimum engagement periods were intended to meet the peculiar circumstances of special types of work or workers. For example, in clause 10.5(d) of the Bus Award, the minimum engagement period for casuals is 3 hours, but for school bus drivers it is 2 hours per engagement; and in clause 12.2 of the Higher Education Award the minimum engagement period for casuals is 3 hours, except that for undergraduate students who are attending the university as a student on the day they work, or for employees with a primary occupation elsewhere, it is one hour.[105]

169. As highlighted by the Full Bench in the above extract, the purpose of a minimum engagement period is not directed only to the interests of the relevant group of employees. Rather, minimum engagement periods must strike a balance between the relevant group of employees and the operational and rostering conditions that prevail in a particular industry. Put simply, the nature of the work may be such that a minimum engagement period of a certain duration may be entirely impracticable by virtue of the simple fact that there may be insufficient work required to be undertaken to engage an employee for the stipulated minimum period of time, or the work may be such

[105] *4 yearly review of modern awards – Casual employment and Part-time employment* [2017] FWCFB 3541 at [399] and [403] – [404].

that it necessarily needs to be undertaken over several shorter segments of time and cannot be performed over a longer consecutive shift.

170. Ai Group respectfully relies upon the various "countervailing considerations" identified by the Full Bench and submits that they are particularly relevant in the context of the HSU's claim. As is borne out in the evidence filed by the Unions, employees are often required to perform work which, by its very nature, must be completed over a limited period of time. For example:

(a) Heather Waddell, a part-time community care worker, says:

> 4. As a Community Care worker, my role involves assisting clients with all their daily activities of living, including socialisation and personal care and home maintenance. This includes showering, dressing, administering medication from Webster packs, house cleaning and cooking shopping and caring for their pets, leisure activities and community engagement.
>
> …
>
> 21. The minimum client visit at Hammond Care is half an hour. Often we are rostered on back to back, one client to the next, because each client visit is short.[106]

(b) Thelma Thames, a part-time support worker, says: (our emphasis)

> 12. In the past, I have had some half hour shifts. I haven't had one in a while, but some employees do get these. Usually these are at the end of a day to help a client with meal preparation or their medications.[107]

171. Much of the work performed by employees providing home care and disability services work involves assisting clients with specific tasks such as showering, preparing and/or consuming a meal, taking medication, cleaning and so on. These are tasks which, in many instances, necessarily only require a limited period of time to complete. In the context of the NDIS, the question is not simply whether the employer can allocate or roster work differently so as to enable an employee to work a longer shift. The duration of the employee's engagement is determined entirely by the wishes of the client; including both

[106] Statement of Heather Waddell dated 15 February 2019 at paragraphs 4 and 21.

[107] Statement of Thelma Thames dated 15 February 2019 at paragraph 12.

the nature of the assistance they request and the timing of the delivery of that assistance (that is, a client may request two types of assistance be provided on a particular day, but they be provided in two separate instances – once in the morning and another in the afternoon).

172. These difficulties are further compounded by the extent to which multiple clients of an employer may request assistance simultaneously (for example, we understand there to be a particularly high demand for employers' services in the morning when clients typically need assistance with showering, having breakfast etc). An employer can satisfy such service demands only by engaging a larger number of employees, each of whom are rostered to work concurrently. This may result in a situation where those employees are each requested to work shorter engagements rather than arranging the work such that it can be performed by a smaller number of employees as a series of consecutive 'jobs' or 'supports'. As a result, an employer's ability to arrange work in a way that would enable the performance of work over a consecutive 3 hour period is seriously diluted.

173. In this context, "an excessive minimum engagement period may cause employers to determine that it is not commercially viable to offer casual engagements or part-time work, which may prejudice those who desire or need such work"[108]. It would also prejudice those who wish to work shorter engagements due to their personal circumstances or commitments. In either case, the grant of the claim "might have the counter-productive result of reducing workforce participation and social inclusion and … it may inhibit flexible modern work practices and the efficient and productive performance of work"[109].

[108] *4 yearly review of modern awards – Casual employment and Part-time employment* [2017] FWCFB 3541 at [403].

[109] *4 yearly review of modern awards – Casual employment and Part-time employment* [2017] FWCFB 3541 at [407].

174. The observation made in the decision about part-time employment is also apposite and resonates with the comments of the Commission during the two year review, when the ASU's claim to introduce a two hour minimum engagement was refused.

175. Part-time employees covered by the Award have the security of a guaranteed number of weekly hours of work by virtue of clause 10.3(c) of the Award. This of itself creates an important distinction between casual and part-time employment in the context of determining the necessity of a minimum engagement period.

176. The HSU submits that the Award requirement for an employer and part-time employee to reach agreement at the time of engagement is not complied with, is ineffectual and/or does not apply due to the operation of enterprise agreements. Each of these contentions are untenable:

(a) There is no persuasive evidence before the Commission that establishes that there is widespread non-compliance with clause 10.3(c) of the Award.

(b) To the extent that there is any non-compliance, it is trite to observe that there already exist avenues for addressing this. An employee could file a dispute pursuant to the dispute settlement procedure under the Award or seek to prosecute the employer by instituting proceedings in a Court of competent jurisdiction.

(c) The imposition of minimum engagement periods will not address the consequences for a part-time employee of any alleged non-compliance with the relevant requirement. That is, the introduction of a minimum engagement period will not of itself provide a part-time employee with the certainty that clause 10.3(c) is designed to provide.

(d) To the extent that enterprise agreements applying to employees covered by the Award do not contain a requirement that is comparable to clause 10.3(c) (noting that the prevalence of such enterprise agreements has not been established by the HSU), this is not a justification for granting the union's claim. An enterprise agreement represents a deal or a bargain that is struck between an employer and its employees, often with the involvement of the relevant union(s) as bargaining representatives for the employees. The process of negotiation preceding the making of an enterprise agreement generally involves the 'trading' of terms and conditions in a manner that is reflective of the significance of the relevant matters to the employer and employees. The outcome of bargaining between an employer and its employees in respect of the application of a particular clause of the Award is not a proper justification for introducing separate and additional entitlements.

(e) It is unclear how (if at all) the introduction of a minimum engagement period will overcome the union's concern about bargained outcomes in any event.

177. During proceedings concerning the casual and part-time common issues earlier in this award review, ABI and the NSW Business Chamber advanced a claim in which it proposed greater flexibility concerning the engagement of part-time employees under the Award. Whilst the claim was not granted, the Full Bench observed that the absence of a requirement for a minimum number of weekly or daily hours for part-time employees undermined the alleged necessity of the amendment to the part-time provisions pursued by ABI: (our emphasis)

> **[559]** ABI's proposed variation, in its final iteration, was only directed at those aspects of disability service provision which were said to be subject to client control and thus where the employer had least control over the hours required to be worked. In respect of part-time employees in that area, its variation proposed an employment model whereby actual working hours were not determined by agreement at the outset of the employment and were thereafter only alterable by agreement, but rather that the employer would have the ability to roster those hours in accordance with clause 25.5 subject to it providing an agreed guaranteed number of weekly hours and such

working hours being rostered at periods when the employee was agreed to be available to work.

…

[638] Most importantly, the SCHCDSI Award does not contain any requirement for a minimum number of hours' work per week, nor (unlike the current provisions in the Hospitality Awards) does it provide for any minimum hours per day. This latter aspect of the award was emphasised by Vice President Watson in his 2013 decision which added the current clause 10.3(c), in the passage we have earlier set out. That means that the agreed pattern of hours for a part-time employee can encompass short periods of service, which a number of the employer witnesses envisaged would be an increasingly common feature of the NDIS service model. In this respect, part-time employment is more flexible than casual employment under the SCHCDSI Award, since clause 10.4(c) provides, in effect, that disability services workers are to be paid a one hour minimum when performing home care work and a 2 hour minimum for other types of work.[110]

178. The interrelationship between the various Award provisions and the need to ensure that the requisite flexibility to engage employees to work shorter shifts due to the NDIS service model is reflected in the above passage. Indeed we consider that the introduction of a minimum engagement period for part-time employees may call into question the need for other Award variations that improve an employer's ability to engage part-time employees with sufficient flexibility to satisfy their clients' needs.

[110] *4 yearly review of modern awards – Casual employment and Part-time employment* [2017] FWCFB 3541 at [559] and [638].

Other Modern Awards

179. We note that the absence of a part-time minimum engagement period in modern awards is not uncommon. Some 46 modern awards[111] do not impose a part-time minimum engagement or payment period for part-time employees. The relevant awards apply in a broad range of industries however we observe that, relevantly, they include other awards applying in the health and personal care industries such as the *Health Professionals and Support Services Award 2010* and the *Nurses Award 2010*.

180. As the Full Bench observed in the context of the casual and part-time common issues proceedings, there is a broad range of casual minimum engagement / payment periods required by modern awards. We also note that a minimum engagement regime that contemplates differing minimum engagement / payment periods for different categories of employees is not novel. The *Cleaning Services Award 2010* imposes minimum engagement periods in respect of casual employees, ranging from 1 – 4 hours, with reference to the total cleaning area of the location at which they are engaged to work:

[111] The *Airport Employees Award 2010, Animal Care and Veterinary Services Award 2010, Architects Award 2010, Airport Employees Award 2010, Animal Care and Veterinary Services Award 2010, Architects Award 2010, Asphalt Industry Award 2010, Banking, Finance and Insurance Award 2010, Black Coal Mining Industry Award 2010, Building and Construction General On-site Award 2010, Business Equipment Award 2010, Cemetery Industry Award 2010, Coal Export Terminals Award 2010, Concrete Products Award 2010, Cotton Ginning Award 2010, Dredging Industry Award 2010, Educational Services (Schools) General Staff Award 2010, Educational Services (Teachers) Award 2010, Electrical Power Industry Award 2010, Electrical, Electronic and Communications Contracting Award 2010, Gardening and Landscaping Services Award 2010, Health Professionals and Support Services Award 2010, Higher Education Industry-Academic Staff-Award 2010, Higher Education Industry—General Staff—Award 2010, Horse and Greyhound Training Award 2010, Horticulture Award 2010, Hydrocarbons Field Geologists Award 2010, Hydrocarbons Industry (Upstream) Award 2010, Labour Market Assistance Industry Award 2010, Marine Towage Award 2010, Medical Practitioners Award 2010, Mining Industry Award 2010, Miscellaneous Award 2010, Nurses Award 2010, Oil Refining and Manufacturing Award 2010, Plumbing and Fire Sprinklers Award 2010, Port Authorities Award 2010, Professional Employees Award 2010, Rail Industry Award 2010, Real Estate Industry Award 2010, Salt Industry Award 2010, Telecommunications Services Award 2010, Transport (Cash in Transit) Award 2010, Vehicle Manufacturing, Repair, Services and Retail Award 2010, Wine Industry Award 2010* and *Wool Storage, Sampling and Testing Award 2010*.

(c) Where only one employee is engaged at a small stand alone location with a total cleaning area (as defined) of 300 square metres or less, and where it is not practicable for a longer shift to be worked across two or more locations, the minimum engagement will be for one hour.

(d) Where employees are engaged at a location with a total cleaning area (as defined) of up to 2000 square metres the minimum engagement will be for two hours.

(e) Where employees are engaged at a location with a total cleaning area (as defined) of between 2000 and 5000 square metres the minimum engagement will be for three hours.

(f) Where employees are engaged at a location with a total cleaning area (as defined) of more than 5000 square metres the minimum engagement will be for four hours.[112]

181. As is clear from the above, the current position as to casual and part-time minimum engagement periods in the Award is not out of step with other modern awards.

Section 138 and the Modern Awards Objective

182. The Commission cannot be satisfied that the proposed clause is necessary to ensure that the Award achieves the modern awards objective. The union's claim must therefore fail.

A *Fair* Minimum Safety Net

183. The proposed clause is unfair to employers.

184. We have earlier explained the operation of the NDIS and the implications that this has for an employer's service delivery to its clients. The need for flexibility in this context is obvious. It would be unfair to require an employer to pay an employee for time that the employee is not working in circumstances where the scheduling of work, the nature and duration of the work to be performed and the location at which it is to be performed are beyond the employer's control. This is particularly so where the employer does not benefit from any productivity gains (because the employee is not in fact performing any work)

[112] Clause 24.2(c) – (f) of the *Cleaning Services Award 2010*.

and the employer is unable to recover the employment costs (because no claim for such time can be made to the NDIA).

185. To the extent that the resulting additional employment costs and reduced flexibilities render it impracticable for an employer to provide certain services, this may ultimately impact not only the employer but also persons with a disability seeking its services.

A *Relevant* Safety Net

186. As the Full Bench observed in the Penalty Rates Decision, in the context of s.134(1), the word 'relevant' is intended to convey that a modern award should be suited to contemporary circumstances.[113] In this context, the relevant contemporary circumstances include the operation of the NDIS and the need for flexibility in light of the client-focussed nature of the scheme. The grant of the union's claim would therefore be inconsistent with the maintenance of a relevant safety net.

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

187. There is no evidence dealing with the impact of the claim on the relative living standards and needs of the low paid.

188. In the circumstances, we consider that s.134(1)(a) does not advance the union's case. The Commission cannot properly conclude that the relative living standards and needs of the low paid will be enhanced or improved if the claim is granted.

Section 134(1)(b) – The need to encourage collective bargaining

189. The grant of the claim may have an adverse impact on the need to encourage collective bargaining.

[113] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [120].

190. The union's pursuit of the claim here advanced demonstrates that the issue is one of importance to the union and by extension, it is one that may motivate it to engage in collective bargaining. Any such motivation would necessarily be extinguished by the grant of the claim.

191. Further, an improvement to the minimum floor and the imposition of additional employment costs may disincentivise employers from engaging in collective bargaining.

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

192. There is no evidence that might enable the Commission to conclude that the grant of the claim will improve social inclusion through increased workforce participation. To the extent that the imposition of the minimum engagement periods sought precludes employees from being engaged to work because they wish to work shorter engagements or because an employer is unable to facilitate the arrangement of work so as to provide for at least three hours of work, this would instead undermine workforce participation.

193. We consider that s.134(1)(c) does not advance the union's case.

Section 134(1)(d) – The need to promote flexible modern work practices and the efficient and productive performance of work

194. The grant of the claim would clearly be inconsistent with the need to promote flexible modern work practices and the efficient and productive performance of work. An employer would no longer have the ability to roster work for periods shorter than three hours at a time without an obligation to pay the employee for at least three hours.

195. The decisions cited earlier in this submission make clear that a minimum engagement period is intended to strike a balance between the interests of employers and employees; having regard to the rostering practices and operational realities of employers covered by the Award. The grant of the claim

would tip the balance entirely in favour of employees' interests in a manner directly contrary to the promotion of flexible work practices.

Section 134(1)(da) - The need to provide additional remuneration for employees working overtime; unsocial, irregular or unpredictable hours; on weekends or public holidays or shifts.

196. This consideration is not engaged by the union's claim.

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

197. This consideration is not engaged by the union's claim.

Section 134(1)(f) – The impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden

198. It is axiomatic that the grant of the claim would substantially increase employment costs and undermine productivity. As for the latter, we note that in the Penalty Rates Decision, the Commission confirmed that 'productivity' for the purposes of s.134(1)(f) "is directed at the conventional economic concept of the quantity of output relative to the quantity of inputs"[114]. An excessive minimum engagement period during which an employer is required to pay an employee whilst an employee is not performing work is perhaps the very definition of unproductivity. It reflects a situation in which there is simply no output.

199. Further, as we have previously submitted, large portions of the industry covered by the Award are dependent on NDIS funding to cover their employment costs. The NDIS does not provide funding for the additional employment costs contemplated by the proposed clause. The impact on employers is compounded in these circumstances. Employers are unable to

[114] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [224] – [225].

recover the additional costs from participants in the scheme because of the pricing caps imposed by the NDIS.

200. The claim, if granted, would therefore have a serious and significant adverse impact on business.

Section 134(1)(g) - the need to ensure a simple, easy to understand, stable and sustainable modern award system

201. The need to ensure a stable system tells against the grant of the claim; particularly given that the claim lacks any proper foundation.

7. BROKEN SHIFTS

202. Three unions have proposed different claims to vary the provisions of the Award relating to broken shifts.

203. Before turning to the respective claims, we first address the current broken shift provisions, which are contained at clause 25.6:

> **25.6 Broken shifts**
>
> This clause only applies to social and community services employees when undertaking disability services work and home care employees.
>
> **(a)** A **broken shift** means a shift worked by an employee that includes one or more breaks (other than a meal break) and where the span of hours is not more than 12 hours.
>
> **(b)** Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the finishing time of the broken shift.
>
> **(c)** All work performed beyond the maximum span of 12 hours for a broken shift will be paid at double time.
>
> **(d)** An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.

204. The clause is presently limited in its application. It only applies to social and community services employees when undertaking disability services work and home care employees. However, it does apply to all types of employees; that is, it applies to casual, part-time and full-time employees.

205. The clause expressly recognises that a shift may include one or more breaks (other than a meal break).[115] It also serves to regulate the manner in which shift allowances payable under clause 29 are calculated in the context of a broken shift.[116]

[115] Clause 25.6(a) of the Award.

[116] Clause 25.6(b) of the Award.

206. The current clause provides safeguards relating to the use of broken shifts. Double time rates are payable for work performed beyond the maximum 12 hours span and there is a requirement that there be a 10 hour break between broken shifts rostered on successive days.

207. For context, we observe that the Award does not contain a general obligation that ordinary hours of work undertaken during day work be performed on a continuous basis. As such, the broken shift provisions are essentially beneficial to employees as they provide additional safeguards and benefits where ordinary hours are not worked continuously during day work.

The Need for Broken Shifts and the Potential Impact of Restricting Access to such Arrangements

208. The Award terms reflect the flexibility required in working arrangements covered by the Award. It appears to be common ground between the parties that the broken shift provisions are widely utilised. That is, there does not seem to be any dispute that employees are engaged to perform work under arrangements that include one or more breaks.

209. More significantly, it appears to be uncontentious that it is common for employees to be rostered to have multiple breaks in their shift. Such a trend is accepted by the Unions.[117]

210. The need for broken shifts, including shifts encompassing multiple breaks, is a reflection of the unique nature and requirements of the sectors covered by the Award. The capacity to utilise such arrangements is particularly important in the context of the home care and the disability sectors.

211. The evidence advanced by the Unions identifies multiple circumstances in which employees undertake short periods of work. Although it is undoubtedly led for the purposes of portraying the impact of broken shifts on employees, it also provides an insight into the reasons or indeed necessity for such shifts.

[117] HSU submission dated 15 February 2019 at paragraph 37.

212. Given the evidence is yet to be tendered or subject to cross-examination we do not seek to here address it in detail. Nonetheless, we point, by way of example, to the evidence of Thelma Thames, a support worker employed by Uniting, which is an aged care provider. Ms Thames provides a useful articulation of the kinds of services that are provided to clients. This includes personal care, meal preparation, medication assistance, transportation to appointments or other activities, domestic assistance (cleaning related tasks) and various forms of social support.[118]

213. Importantly, the witness attests to the fact that the service is based on what the client's package allows for in the care plan.[119] She also provides evidence of having worked shifts as short as half an hour for the purposes of helping a client with meal preparation or their medicines[120].

214. When regard is had to the type of work undertaken by employees such as the witness, it is not difficult to appreciate the necessity for gaps between periods of work during the course of a day; that is, for broken shifts.

215. Moreover, this form of flexibility has become increasingly essential as a product of the implementation of the NDIS. The scheme has had a profound impact on the way work is undertaken. This is a product of the extent to which services are now both allocated and funded on an individual client basis in a market environment (albeit one which is currently still regulated).

216. Underpinning the NDIS is the proposition that participants should have greater control over the manner in which they obtain care and they are free to select their care or service providers. They also have much greater capacity to control or influence issues such as the time or location at which the relevant service is provided, or even the individual worker that provides the assistance. This requires organisations to operate in a responsive manner.

[118] Statement of Thelma Thames dated 15 February 2019 at paragraph 5.

[119] Statement of Thelma Thames dated 15 February 2019 at paragraphs 5 – 7.

[120] Statement of Thelma Thames dated 15 February 2019 at paragraph 12.

217. The proposition that in many instances employers operating under the NDIS now have far less control over the manner in which work is structured when compared to that which they did under predecessor funding models, such as arrangements under which services were block funded or work was allocated by relevant governments or agencies, should not be contentious.

7.1 The ASU's Claim

218. The ASU seeks that employees working broken shifts receive additional pay. The proposal is the inclusion of the following provision in the clause dealing with broken shifts:

> An employee who works a broken shift will receive:
>
> **(i)** ~~Payment for a broken shift will be at o~~Ordinary pay plus a loading of 15% of their ordinary rate of pay for each hour from the commencement of the shift to the conclusion of the shift inclusive of all breaks; and

219. The manner in which the proposed clause would operate is arguably ambiguous.

220. At the very least, there appears to be a disconnect between the limited description of the ASU's proposal in its submissions and the wording of the clause. In this regard we note that the submission provides:

> 18. The ASU is seeking a variation to clause 25.6 of the SCHDS Award to provide for a 15% loading to be paid to employees who work broken shifts. …
>
> …
>
> 20. The ASU proposes to vary clause 25.6 by deleting clause 25.6 (b) and inserting a new subclause providing for a 15 per cent loading to be paid on the employees ordinary rates of pay…[121]

221. These extracts suggest that all that is being proposed is an additional loading. However, this is not consistent with the wording of the proposed clause. The clause appears to require the payment of "ordinary pay" as well as a loading of 15% of the "ordinary rate of pay" for the entire relevant time period referred

[121] Submission dated 18 February 2019 at paragraphs 18 and 20.

to in the clause. That is, an employee would be entitled to ordinary pay plus the loading for each hour from the commencement of the shift to the conclusion of the shift, inclusive of breaks.

222. If what is being proposed is that employees be paid for the 'breaks' between active parts of their shift, it would be a very significant change to the manner in which the Award currently operates and is entirely unjustifiable.

223. A further difficulty with the proposal is the absence of a definition as to what constitutes the "ordinary rate of pay" in either the proposed amendment or the supporting submissions. Nor is there any definition of the phrase "ordinary pay". Consequently, it is unclear whether the reference to the "ordinary rate of pay" refers to:

(a) All amounts that an employee is ordinarily or routinely paid;

(b) All amounts that an employee is paid in respect of an employee's ordinary hours of work;

(c) Amounts that are payable under the Award for the relevant hours of work (including relevant penalty rates);

(d) Amounts that include over-award payments; or

(e) The employee's minimum rate of pay under the Award or the employee's "ordinary hourly rate of pay" as contemplated in the context of exposure drafts that are being developed for the purpose of the current award review.

224. It is also unclear whether the phrase "ordinary rate of pay" is intended to mean something different to the phrase "ordinary pay". There is no apparent rationale for the different terminology within the clause.

225. Given the above observations, the ASU's proposal is not consistent with a consideration of the need to ensure that the award system is simple and easy to understand.[122]

226. Of course, the Commission is not restricted to varying an award in the terms sought. However, the deficiencies in the drafting of the provision and the absence of a clear explanation by the ASU as to the manner in which the provision is intended to operate renders it impossible to accurately assess the potential impact of the claim.

227. Given the deficiencies in the case advanced, it is appropriate for the Commission to decline to make the proposed variation.

The Alleged Disutility of Working Broken Shifts

228. One of the themes underpinning the union's arguments rests on the assertion that there is a disutility associated with the working of broken shifts.

229. We accept that breaks between active parts of work will not suit or be a preferred work arrangement for some employees. However, it might also reasonably be expected that such arrangements do suit some employees. The ASU does not advance evidence that can be said to be representative of the views or experiences of the workforce covered by the Award relating to the use of broken shifts and as such no firm conclusions can be reached in relation to such matter.

230. The disutility associated with working broken shifts must also be weighed against the evidence that many employees want to work additional hours. The availability of a flexible pattern of working undoubtedly enables some employers to offer individual employees additional hours to that which would be possible if the all hours on a day had to be rostered consecutively.

[122] Section 134(1)(g) of the Act.

231. A requirement to pay an additional loading in circumstances where an employee works a broken shift would instead create an incentive for employers to seek to offer or allocate the separate active parts of what would be a broken shift for a single employee to separate workers in order to minimise costs.

Continuous Work or Broken Shifts in Other Awards

232. The ASU asserts that the disutility of working broken shifts is recognised by the award system generally. In support of that contention, they argue that generally ordinary hours must be worked continuously and that only 18 modern awards permit employers to engage employees on 'broken' or 'split shifts'. The weight that can be afforded to such a submission is undermined by the following considerations.

233. *Firstly*, it appears that the ASU's submission may be based purely on the existence or otherwise of a provision within awards expressly dealing with broken or split shifts. This does not provide a complete picture of the extent to which other awards may permit ordinary hours to be worked on a single day in a non-continuous manner. For example, the *Road Transport (Long Distance Operations) Award 2010* does not contain a broken shift provision, however there is no requirement under that instrument for hours of work to be performed continuously.

234. *Secondly*, the union's analysis reveals that broken shift provisions are by no means rare or novel. Eighteen is not an insignificant number of awards.

235. *Thirdly*, the broken shift provisions currently contained in modern awards are diverse. They vary in the extent to which they regulate matters such as the number or duration of breaks between active performance of work and in the extent to which they provide for any additional payment to employees working under such arrangements.

236. *Fourthly*, the mere fact that there are awards that deal with matters associated with broken shift arrangements does not, of itself, establish that "the disutility of working broken shifts is recognised by the modern award system generally."[123] It simply establishes that there is a level of award regulation of such matters. The ASU has not identified any arbitral consideration of such provisions. It might just as easily be put that the existence of such provisions demonstrates the need for such arrangements and the legitimacy of such arrangements in the context of the safety net.

237. Notwithstanding the above arguments, we acknowledge that the Award does provide the parties covered by it with a high degree of flexibility in relation to the manner in which ordinary hours of work are performed, compared with that applicable under many other awards. However, it cannot be assumed that such a comparative analysis demonstrates any unfairness in the current provisions. In the context of this Review, the Commission will approach the matter on the basis that the terms and conditions were fair and relevant at the time the award was made.[124] Further, there can be multiple permutations and combinations of award terms that may constitute a fair and relevant safety net. [125] Consideration needs to be given to the characteristics and circumstances of employers covered by the particular awards.

238. Ai Group contends that the current provisions are appropriate in the context of the diverse and atypical sectors to which they apply. Simply identifying that the Award provisions differ from the approach adopted in some other awards does not establish that the current provisions should be amended.

[123] ASU submission dated 18 February 2010 at paragraph 31.

[124] *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at [24].

[125] *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at [34].

The Quantum of the Proposed Loading

239. The ASU has not identified any reasoning or logic underpinning the adoption of 15% as the proposed quantum of the loading, much less why this particular amount would be *necessary* to ensure that the Award meets modern awards objective.

240. The union contends that the lay evidence upon which it intends to rely shows that low pay and irregular working hours have caused the relevant proposed witnesses to consider leaving the disability services industry. Without seeking to deal with such material comprehensively at this point, we observe that the evidentiary case advanced does not establish that these are concerns that are at play across the industry as a whole; nor does it establish that the proposed new entitlement would resolve such matters.

241. Ultimately, concerns about the sufficiency of pay rates contained within awards is a matter best dealt with in the context of the Annual Wage Review.

242. The union has not provided any explanation as to the extent to which such costs can be met under NDIS funding arrangements. It appears to us that the costs would not be recoverable or have not been taken into account under such funding arrangements. This weighs heavily against granting the claim.

243. In contrast to the alternate variations to the broken shift provisions proposed by the other unions, the ASU does not, as their primary position, seek to impose any limitation on the use of broken shift arrangements. Instead, they seek to require that an additional amount is paid to employees when they perform work on a broken shift.

244. The union's proposal appears to reflect both an express desire to enhance the compensation that their members receive for working broken shifts as well as a level of implicit recognition of the need for such flexibility and of the disruption to employers that would flow from limiting the availability of such working arrangements: (emphasis added)

> The ASU's variation would ensure that employees are properly compensated for the disability associated with working a broken shift under clause 25.6 without further limiting any flexibility for the employer. This preserves the employer's business models, but will also increase the incentive to work in the disability services.[126]

245. In relation to the union's objective of "increasing the incentive to work in disability services", the submission appears to have been put on the basis that the Award's terms should serve as an incentive to attract employees from other sectors or industries. In out submission, attracting employees to a particular type of work or sector is not necessarily relevant to the Full Bench's consideration of what constitutes a fair and relevant safety net of minimum terms and conditions to the extent that.

Section 138 and the Modern Awards Objective

246. The ASU has not advanced any argument referencing the modern awards objective. It acknowledges s.134 and the Commission's task in the context of this Review[127], however they take the matter no further. They do not, for example, identify any considerations that would weigh in favour of granting the claim.

247. Moreover, the ASU does not assert that the variation is necessary in order to ensure that the Award achieves the modern awards objective. In this regard they have failed to mount an appropriate case for the proposed variation.

[126] ASU submission dated 18 February 2019 at paragraph 33.

[127] ASU submission dated 18 February 2019 at paragraph 7.

Section 134(1)(a) – The relative living standards and the needs of the low paid

248. There is no basis for concluding that employers would continue to engage employees on broken shifts if the union's claim was granted. Accordingly, the Commission cannot be satisfied that a consideration of the relevant living standards and needs of the low paid would support the claim.

Section 134(1)(b) – The need to encourage collective bargaining

249. This is not a factor weighing in favour the claim.

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

250. A consideration of this matter does not support the granting of the claim. Indeed, it is foreseeable that the cost impost that the proposed new entitlement would impose upon employers in the sector may cause such employers to elect not to service clients in circumstances where such work can only viably be performed through the use of a broken shift. To the extent that this resulted in decreased employment opportunities with employers covered by the Award, it would undermine workforce participation.

Section 134(1)(d) – The need to promote flexible modern work practices and the efficient and productive performance of work

251. The granting of the claim may run contrary to such considerations if the financial impact of the proposal would distort employer decisions about the allocation of work.

252. For example, in circumstances where a client in the disability sector may require assistance at different times of the day, the clause would incentivise an employer to allocate different employees to perform such separate tasks in order to avoid the application of the relevant loading.

Section 134(1)(da) – The need to provide additional remuneration for employees working overtime; unsociable, irregular or unpredictable hours; weekends or public holidays; or shifts

253. A central tenant of the ASU's case appears to be an argument that the working hours in the industry are irregular. A consideration of s.134(1)(da) in the context of such an assertion does not weigh in favour of granting the claim. The extent to which the hours of work of employees covered by the Award may be irregular, unsociable or unpredictable is not inherently a consequence of there being a capacity for broken shifts. It is, instead, a consequence of the flexibility afforded more broadly under the Award in relation to the rostering of work. The mere fact that there are breaks between periods of work does not enliven the application of considerations specified in s.134(1)(da).

254. Separate provisions of the Award deal with the issue of remuneration for working overtime, shifts, weekends or public holidays.

Section 134(e) – The principal of equal remuneration for work of equal or comparable value

255. This consideration is not relevant to this claim.

Section 134(1)(f) – The likely impact of the claim on business, including on productivity, employment costs and the regulatory burden

256. It is axiomatic that the claim will increase employment costs and have an associated adverse effect on business. Moreover, it will have a particularly unfair adverse impact on employers operating in the context of the NDIS as they will have no capacity to recover such costs.

257. To the extent that the claim may render the use of broken shifts no longer viable, it will also adversely impact business by reducing the flexibility available to them in the context of rostering arrangements. This may also have a negative impact on productivity.

258. The change will also adversely impact employers in the sector that utilise broken shifts by undermining their ability to take on certain work viably.

Section 134(1)(g) – The need to ensure a simple, easy to understand, stable and sustainable modern award system

259. Given the drafting deficiencies we have earlier identified, the proposal is clearly inconsistent with this consideration.

Section 134(1)(h) – The likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.

260. This factor does not support the granting the claim.

7.2 The HSU and United Voice Claims

261. The HSU and United Voice have also filed claims seeking to amend the Award provisions dealing with 'broken shifts'. These claims differ from the ASU proposal in that they seek, in various ways, to limit the use of broken shifts.

262. The HSU proposes the following changes to clause 25.6:

25.6 Broken shifts

(a) This clause only applies to:

(i) social and community services employees when undertaking disability services work; and

(ii) home care employees.

(~~a~~b) For the purposes of this clause, a ~~A~~ **broken shift** means a shift worked by ~~an~~ a casual or part-time employee that includes no more than one ~~or more~~ break~~s~~ (other than a meal break) and where the span of hours is not more than 12 hours.

(c) A broken shift may only be worked where there is mutual agreement between the employer and employee.

(d) Where an employee works a broken shift, they shall be paid at the appropriate rate for the reasonable time of travel from the location of their last client before the break to their first client after the break, and such time shall be treated as time worked. The travel allowance in clause 20.5 also applies.

(e) The minimum period of engagement specified in clause 10.6 shall apply to each period of work in a broken shift.

(~~b~~f) In addition to the rates at 14.4(d) ~~Payment for a broken shift will be at ordinary pay with~~ penalty rates and shift allowances in accordance with clause ~~29~~20.2—Shiftwork and clause 19—Overtime apply~~, with shift allowances being determined by the finishing time of the broken shift~~.

(g) Shift allowances will be determined by the starting or finishing time of the broken shift, whichever allowance is higher. The allowance will apply across both parts of the shift.

(~~c~~h) All work performed beyond the maximum span of 12 hours for a broken shift will be paid at ~~double time~~ 200% of the minimum hourly rate.

(~~d~~i) An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.

(g) Shift allowances will be determined by the starting or finishing time of the broken shift, whichever allowance is higher. The allowance will apply across both parts of the shift.

263. United Voice has proposed the following amendment to clause 25.6(b):

(b) Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the starting or finishing time of the broken shift, whichever is the greater.

264. The draft determination filed by United Voice is also seeking a new definition of 'broken shift' in the following terms:

(a) For the purposes of this award a broken shift is a shift where an employee works in two separate period of duty on any day within a maximum spread of twelve (12) hors and where the break between periods exceeds one hour.

265. There is a substantial degree of overlap between the HSU and United Voice claims. We accordingly deal with them both in this section of our submission.

266. The unions' cases seek to justify the claim based on the negative perspective of some employees engaged on broken shifts. In particular, they point to the disruption that such arrangements can have on the lives of employees and the negative consequences that can flow from having their work spread out over long periods of the day. The unions seek to portray the use of broken

shifts as potentially exploitative and on this basis, seek restrictions on the use of such provisions.[128]

267. The material fails to grapple with the necessity for such arrangements in order to accommodate the circumstances of the sector and the constraints imposed upon employers operating under funding arrangements (particularly the NDIS).

268. The case advanced by the unions assumes that employers are implementing broken shift arrangements in a deliberate and improper attempt to reduce their costs. Moreover, it rests on the startingly simplistic and erroneous assumption that employers in this sector will have the capacity to, and will as a matter of fact, offer hours of work on a continuous basis if access to broken shifts is limited and that they will respond to the proposed changes by restructuring the engagement of their employees in such a manner.

269. It is not open to the Commission to adopt a similarly optimistic approach.

Restricting Access to Broken Shifts

270. Ultimately, any assessment of the impact of implementing the kind of radical alteration to the arrangement of hours in this sector proposed under the HSU and United Voice proposals will necessarily be speculative. However, it is logically and reasonably foreseeable that restricting the use of broken shifts would potentially result in consequences such as:

(a) Employers electing not to provide a service to some NDIS participants.

(b) Employers electing to not offer employees multiple engagements on the same day, thus resulting in underutilisation/employment of such staff.

(c) Employers being subject to additional and unrecoverable labour costs for time between active periods of engagement of an employee.

[128] United Voice submission dated 4 February 2019 at paragraph 136 and HSU submission dated 15 February 2019 at 36 – 39.

(d) An impact on the viability of organisations that currently rely upon such arrangements.

(e) Intensification of problems flowing from current and anticipated labour shortages given the inefficient allocation and utilisation of labour that would be a product of such award regulation.

Limiting the Number of Breaks per Shift

271. A particularly problematic element of the claims is the proposal to prevent employers from 'breaking' a shift more than once. The Award presently defines a broken shift as one that includes "one or more breaks".

272. Ai Group has received very strong feedback from industry that the removal of this flexibility would have a devastating impact on their operations and ability to viably meet the needs of the clients they service. This is particularly so in the context of the disability and home care sectors.

273. The proposed variations would represent a significant departure from the current Award provisions (which have been in force for almost a decade), and indeed from a long-standing approach to the regulation of such matters in many of the sectors now covered by the Award. A review of various predecessor instruments[129] to the Award also reveals that the availability of broken shift arrangements permitting more than one break is by no means a new element of the industrial regulation of such sectors.

274. The entrenched nature of the availability of broken shifts within at least some sectors covered by the Award adds further weight to the argument that removing this flexibility would be unfair to employers.

[129] *Crisis Assistance, Supported Housing (South Australia) Award 2000, Disability Services (Northern Territory) Award 2002, Social and Community Services Industry - Community Services Workers - Northern Territory Award 2002, Miscellaneous Workers Home Care Industry (State) Award, Disabilities Services Award, Health Services Employees Award* and *Social & Community Services Award*.

Limiting the Clause to Casual and Part-time Employees

275. The HSU has proposed to limit the application of the broken shift clause to casual and part-time employees. It has not however advanced any submissions in support of the proposal.

276. It appears to be the unions' intent to prohibit full-time employees from working on broken shifts (as opposed to exempting full-time employees from the application of the clause).

277. There is no apparent reason why full-time employees should be prevented from being utilised to work broken shifts. This is not in the interests of full-time employees who may be happy to work such arrangements. Moreover, there can be no guarantee that those employers who engage full-time employees on broken shifts could continue to offer such employment if the availability of this arrangement was removed.

278. The proposal is also likely to result in part-time and casual employees being utilised in preference for full-time employees. There is no apparent reason why the union is seeking to promote such an outcome, or why it could be said to be consistent with the modern awards objective.

279. Given the above considerations, and the unions' failure to even attempt to advance an argument as to why such a variation is necessary in the sense contemplated by s.138 of the Act, the variation should be rejected.

The Applicable Shift Allowance

280. Both the HSU and United Voice are proposing that regard be had to the starting time of an employee in assessing the shift allowance that may be payable.

281. Under the current terms of the Award, the finishing time is the reference point for assessing the applicable allowance. Clause 25.6(b) of the award currently states:

> **(b)** Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 29 – Shift work, with shift allowances being determined by the finishing time of the broken shift.

282. In short, the unions seek that the starting time or the finishing time be utilised depending upon which time would result in the more beneficial outcome for employees.

283. The most obvious difficulty with the unions' claim is that the proposed clauses cannot sensibly be applied given that the definitions for an afternoon or night shift under the Award operate by reference to the finishing time for the shift. They do not contemplate the starting point. Indeed a night shift or afternoon shift may, in context of a particular enterprise, have the same starting time.

284. Another difficulty is that if the Award were amended to reflect the intent of the unions, it would operate unfairly and unjustifiably to the benefit of an employee in all instances. There is no inherent rationale for such an approach in the context of a safety net that must be fair to both employers and employees.

285. Ultimately, a case for varying the current arrangements has not been made out. The industrial merit of the proposal in undoubtedly contentious and the evidence does not establish that there is some malicious or widespread practice of employers utilising broken shifts for the purpose of avoiding shift penalties so as to justify an alternate approach.

286. The material advanced by the unions does not enable any detailed assessment of the impact of the claim. Altering the circumstances where shift allowances are payable is a significant change. It could have significant cost implications for employers and ought not be made in an evidentiary vacuum.

287. Curiously, in support of their claim, United Voice point to what they characterise as an anomaly in the manner in which the provision operates in that an employee who commenced a broken shift at 5am and worked until 3pm would not receive a shift loading. In response we observe that there is nothing anomalous about such an outcome. There is no 'early morning' shift allowance payable under the Award and a shift that ends at 3pm would never attract an additional loading as it would not constitute either an afternoon or night shift under the Award.

288. In response to United Voice's contention that the Award is inconsistent with the modern awards objective in that it does not provide "adequate additional remuneration for employees working shifts", we observe that there is no statutory imperative to provide additional remuneration to employees working shifts.

The Requirement for Mutual Agreement

289. The HSU has proposed that broken shifts be worked only by agreement between the employer and employee but has not advanced any submissions in support of this variation. For this reason alone, the claim should fail.

290. The proposal has the potential to significantly disrupt current employment practices in the sector. It would significantly undermine the utility of the broken shift provisions. Accordingly, for all of the reasons that we previously indicated that broken shifts are an important flexibility given the circumstances of the industry, the variation should be rejected.

291. In relation to the specific variation proposed, we also observe that it is unclear whether the provision would require agreement to be reached in relation to each broken shift or whether it would be sufficient for an employer to obtain such agreement once and to then roster the employee on broken shift arrangements on an ongoing basis. Given such a lack of clarity, the proposal would not be consistent with the need to ensure a simple and easy to understand award system, as contemplated by s.134(1)(g) of the Act.

292. More significantly, requiring an employer to reach agreement on each occasion that an employer requires a broken shift to be performed, if this is what the proposal would require, would be extremely burdensome and would be contrary to considerations arising under ss.134(1)(d) and 134(1)(f).

293. If an employee could at any time simply elect to either perform or not perform a particular broken shift, it would also undoubtedly complicate rostering or arrangements and potentially undermine their capacity to align with an employer's operational needs. This would be a particularly problematic development in the context of the participant driven dynamics of the NDIS.

294. It is entirely unclear how, from a practical perspective, such a clause could be fairly imposed in the context of currently engaged employees. If an employee has been engaged on the condition that they work broken shifts (or in circumstances where any agreement as to their hours of work reflect the availability of broken shifts), it would be patently unfair to invalidate such arrangements and it is foreseeable that in some instances the change would jeopardise the ongoing viability of the individual's employment.

Section 138 and the Modern Awards Objective

295. In this section we address the extent to which the various matters identified under s.134(1) would weigh either in favour or against the HSU and United Voice claims to limit the use of broken shifts.

A *Fair and Relevant* Minimum Safety Net

296. To the extent that the proposals restrict the use of broken shifts or render them more expensive, this would be unfair to employers and inconsistent with the maintenance of a relevant safety net.

297. As we have already submitted, many employers covered by the Award require the ability to utilise their workforce in a flexible and agile manner so as to meet the variable needs of clients. For reasons already articulated, this is a flexibility

that is of paramount importance under the NDIS. The proposed changes are entirely out of step with the contemporary circumstances.

298. The unfairness to employers also flows from the extent to which the costs that would potentially be imposed upon employers by virtue of the claim could not be recovered by funding arrangements. This would include, in particular, instances where an employer may need to pay an employee for unproductive time between undertaking work for clients in circumstances which would presently constitutes 'breaks' under the current Award.

299. To the extent that the changes may be a catalyst for employers simply refusing to provide services that they might otherwise have undertaken or reducing the hours of work of an employee who would otherwise be engaged on broken shifts, they would also operate unfairly to those employees that would prefer to undertake such employment in preference to receiving less work.

300. In considering whether the proposed terms form part or a relevant safety net, the potential for the changes to undermine the effective operation of the NDIS, as well as the availability of services for many of the most vulnerable people must also be seriously considered.

Section 134(1)(a) – The relative living standards and needs of the low paid

301. A consideration of s.134(1)(a) does not advance the unions claims. The Commission cannot properly conclude that the relative living standards and needs of the low paid will be enhanced or improved if the claim is granted.

302. United Voice contend that the proposed limitation of the number of breaks in a broken shift would improve the living standards of the low paid because "employers would have to properly roster shifts so that there would only be one break (excluding meal and rest breaks)".[130] They boldly assert that this would reduce the ability of employers to avoid paying travel time and that it

[130] United Voice submission dated 4 February 2019 at paragraph 141.

would "likely reduce the need for employers to seek secondary employment"[131]. There are a number of difficulties with such submissions.

303. *Firstly*, the position rests on an implicit assumption that the variation will cause employers to pay employees more. The difficulty with this contention is that there can be no guarantee that a particular employer will either continue to undertake the relevant work or simply engage employees to work a greater number of hours on a continuous basis. There is no evidentiary or indeed logical basis for such an assumption.

304. *Secondly*, the contention unfairly impugns the actions of employers. The evidence does not establish that employers are rostering employees on broken shifts in circumstances where an alternate approach would be feasible.

305. *Thirdly*, to the extent that they argue the claim will assist by reducing the need for unpaid travel time, we note that there are sperate union claims dealing with this issue and we will address such matters in the context of our response to those claims.

306. *Finally*, we note that there is no probative evidence to support United Voice's contention that secondary employment will be reduced because "more regular steady work will be available" if the variation is granted [132]. Moreover, the union has not explained why the avoidance of secondary employment would be relevant to considerations arising under s.134(1)(a).

307. Contrary to the outcomes envisaged by the unions, it is likely that some low paid employees will be disadvantaged by the variations.

<u>Section 134(1)(b) – The need to encourage collective bargaining</u>

308. The grant of the claim may have an adverse impact on the need to encourage collective bargaining.

[131] United Voice submission dated 4 February 2019 at paragraph 141.

[132] United Voice submission dated 4 February 2019 at paragraph 141.

309. The unions' pursuit of the claims here advanced demonstrates that the issue is one of importance to the unions and by extension, it is one that may motivate them to engage in collective bargaining. Any such motivation would necessarily be extinguished by the grant of the claim.

310. Further, an improvement to the minimum floor and the imposition of additional employment costs may disincentivise employers from engaging in collective bargaining.

311. The extent to which employers may be prepared to bargain over the broken shift arrangements will likely vary. The Award covers organisations undertaking a diverse range of services. It is foreseeable that some may be able to structure the work of their employees in a continuous manner, or at least without making significant use of the flexibility afforded under the Award in relation to broken shifts. Others will not. Given this context, combined with the various problems that limiting access to broken shifts would create in the context of some organisations, it is a matter that is best dealt with context of bargaining.

<u>Section 134(1)(c) – The need to promote social inclusion through increased workforce participation</u>

312. United Voice asserts that their claim to limit broken shifts to containing one break will improve conditions under the Award and that it would encourage employees to stay in the sector.

313. In response it must firstly be observed that s.134(1)(c) does not suggest any imperative to improve conditions of employees as an outcome in and of itself. Indeed, such matters are not relevant to a consideration of the matters referred on s.134(1)(c). As the Full Bench observed in the Penalty Rates Decision: (our emphasis)

> **[179]** Section 134(1)(c) requires that we take into account 'the need to promote social inclusion through increased workforce participation'. The use of the conjunctive 'through' makes it clear that in the context of s.134(1)(c), social inclusion is a concept

to be promoted exclusively '*through* increased workforce participation', that is obtaining employment is the focus of s.134(1)(c).[133]

314. The material before the Commission does not enable it to conclude that the proposed variation to the broken shift provisions would have a positive effect on employment. There can be no guarantee that the variation will result in increased workforce participation in the form of additional hours being worked by currently engaged employees.

315. As we have identified, the claim may result in employers declining to undertake work for clients that could not be performed sustainably from a cost perspective or it may result in fewer hours being allocated to an induvial employee and to the employer instead seeking to use different employees or independent contractors to perform part of the work that might otherwise have been allocated to a single employee through a broken shift.

316. In the circumstances, we consider that s.134(1)(c) does not advance the union's case.

Section 134(1)(d) – The need to promote flexible modern work practices and the efficient and productive performance of work

317. The grant of claims limiting an employer's capacity to utilise broken shifts or to limit the number of breaks would be inconsistent with the need to promote flexible modern work practices and the efficient and productive performance of work. The most obvious reason for this is that it would limit an employer's ability to allocate labour in a manner that accords with the needs of clients.

318. For example, it might prevent an employer from allocating the same worker to assist the same client at different parts of the day because it would necessitate the individual being paid for intervening periods between their performance of activities. There are a range of inefficiencies that would flow from such arrangements depending on the circumstances. Obvious examples would include the need for communication between the employees about the

[133] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [179].

provision of services to the client or the extent to which multiple persons would need to develop an understanding of the discrete needs of a particular client, given the nature of the work undertaken by employees covered by the Award.

319. In the Penalty Rates Decision, the Full Bench addressed what was required as a product of the reference to productivity in s.134(1)(f):

> **[224]** The conventional economic meaning of productivity is the number of units of output per unit of input. It is a measure of the volumes or quantities of inputs and outputs, not the cost of purchasing those inputs or the value of the outputs generated. As the Full Bench observed in the *Schweppes Australia Pty Ltd v United Voice – Victoria Branch*:
>
> > '… we find that 'productivity' as used in s.275 of the Act, and more generally within the Act, is directed at the conventional economic concept of the quantity of output relative to the quantity of inputs. Considerations of the price of inputs, including the cost of labour, raise separate considerations which relate to business competitiveness and employment costs.
> >
> > Financial gains achieved by having the same labour input – the number of hours worked – produce the same output at less cost because of a reduced wage per hour is not productivity in this conventional sense.'
>
> **[225]** While the above observation is directed at the use of the word 'productivity' in s.275,it is apposite to our consideration of this issue in the context of s.134(1)(f).[134]

320. The observations are also relevant to the consideration of the "productive performance of work" pursuant to s.134(1)(d).

321. To extent that the claim has the effect of requiring an employer to engage a worker for a period of time when they are not genuinely required to undertake duties on behalf of their employer, it would be contrary to the need to promote the efficient and productive performance of work. It would mean that, in order to achieve the same output (i.e. the provision of a service to a client), additional hours of work would potentially need to be undertaken in order to achieve award compliance.

[134] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [224] – [225].

Section 134(1)(da) – The need to provide additional remuneration for employees working overtime; unsocial, irregular or unpredictable hours; on weekends or public holidays or shifts

322. This issue is not relevant to a consideration of the claims to restrict the use of broken shifts. To the extent that it is contended to be relevant to proposed changes to the manner in which shift allowances are calculated, we have addressed such matters earlier in our submission.

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

323. This consideration is not relevant to the matter.

Section 134(1)(f) – The impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden

324. The granting of claims restricting the use of broken shifts would substantially increase employment costs. The claims, if granted, would therefore have a significant adverse impact on business.

325. Further, the significant portions of industry that are dependent on NDIS funding to cover their employment costs would be unable to recover the additional costs that may flow from the need to pay employees for unproductive time between active work that is currently undertaken through the use of broken shifts, if the various restrictions on the use of broken shifts are implemented. Given the operation of pricing caps under the NDIS, this renders the proposed variations particularly unfair to such employers.

326. It is also axiomatic that the claim will have an adverse impact on business by greatly curtailing the level of flexibility that is available to them in relation to the manner in which they engage employees.

327. To the extent that the additional employment costs would result in inefficient work practices, this may also undermine productivity. We have addressed this issue in the context of our consideration of s.134(1)(d).

Section 134(1)(g) – The need to ensure a simple, easy to understand, stable and sustainable modern award system

328. The need to ensure a stable system tells against the granting any of the claims pertaining to broken shifts. The changes would not be sustainable given their incompatibility with the needs of the sector.

Section 134(1)(h) – the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy

329. A consideration of matters identified under s.134(1)(h) does not weigh in favour of the proposed claims.

8. OVERTIME AFTER 8 HOURS OF WORK

330. Clauses 28.1(b)(ii) and 28.1(b)(iii) of the Award currently require that time worked by a part-time or casual employee in excess of 10 hours in a day will be treated as overtime and paid at overtime rates.

331. The HSU seeks to alter this position. The union has proposed that the Award be varied such that it requires that time worked by a part-time or casual employee in excess of *eight* hours in a day be treated as overtime and paid at overtime rates.

332. Ai Group opposes the claim and submits that the changes proposed should not be made.

The HSU's Case

333. The HSU has made the following submission in support of its claim: (footnotes omitted)

> 47. Overtime for casual and part-time workers should be paid for shifts longer than 8 hours rather than 10. Work performed by carers in private homes and in the community providing personal or domestic assistance for elderly clients or clients with a disability is both physically and mentally taxing, which is compounded by the (often unrecognised and unpaid) travel involved in the performance of work. During long shifts there may be little opportunity, or appropriate facility to take proper breaks and rest.[135]

[135] HSU Submission dated 15 February 2019 at paragraph 47.

334. The HSU seeks to rely on the evidence of just two individual employees[136] in support of it's claim. Leaving to one side the evidence that relates to travelling between engagements or different portions of a broken shift, the evidence goes no further than establishing that:

(a) One support worker employed by an aged care provider "find[s] domestic assistance to be more physically demanding, wearing on the body and tiring than personal care"[137].

(b) Another disability support worker considers that "it can be difficult working one on one with someone with a disability for 7 hours or more"[138].

335. We note that although clause 28.1(b) applies to part-time and casual employees classified under all streams of the Award, the union has not led any evidence or provided any basis for enhancing the entitlement to overtime rates in other sectors covered by the Award.

336. Self-evidently, the evidence led by the HSU is not persuasive and does not provide a proper foundation for the imposition of the proposed additional employment cost.

[136] Statement of Thelma Thames dated 15 February 2019 at paragraphs [6] – [7] and [13] – [17] and statement of Bernie Lobert date 15 February 2019 at paragraph [21]; cited by the HSU at paragraph 47 of its submissions.

[137] Statement of Thelma Thames dated 15 February 2019 at paragraph [6].

[138] Statement of Bernie Lobert date 15 February 2019 at paragraph [21].

Section 138 and the Modern Awards Objective

337. There is no evidence or material that might justify the proposition that the clause proposed by the HSU is *necessary* to ensure that the Award achieves the modern awards objective for the reasons articulated above.

338. Further, the HSU's submissions do not address s.138 or s134(1) of the FW Act. We nonetheless make the following observations about various factors listed under s.134(1):

(a) Section 134(1)(a): there is no evidence dealing with the impact of the claim on the relative living standards and needs of the low paid. In the circumstances, we consider that s.134(1)(a) does not advance the union's case. The Commission cannot properly conclude that the relative living standards and needs of the low paid will be enhanced or improved if the claim is granted.

(b) Section 134(1)(b): increasing the minimum entitlement of part-time and casual employees may have an adverse impact on the need to encourage collective bargaining.

(c) Section 134(1)(c): there is no evidence that might enable the Commission to conclude that the grant of the claim will improve social inclusion through increased workforce participation. In the circumstances, we consider that s.134(1)(c) does not advance the union's case.

(d) Section 134(1)(d): the proposed variation undermines the need to promote flexible modern work practices and the efficient and productive performance of work by requiring the payment of a premium where an employee is required to work in excess of eight hours. This is particularly so to the extent that it causes employers to alter their rostering arrangements in a way that results in inefficiencies or undermines productivity.

(e) Section 134(1)(da): this is a neutral consideration. We refer to and rely on the relevant observations of the Full Bench in the Penalty Rates Decision[139] regarding this provision of the Act, as cited earlier in this submission. The Award already provides additional remuneration for the performance of overtime. The evidence does not establish that there is any disutility associated with working more than eight hours in a day that would warrant the introduction of a higher rate of pay in respect of such hours of work. Further, there is no material to suggest that work performed after eight hours is "unsocial" in the sense contemplated by s.134(1)(da)(ii).

(f) Section 134(1)(e): the principle of equal remuneration for work of equal or comparable value is not relevant to this matter.

(g) Section 134(1)(f): it is axiomatic that an expansion of the circumstances in which overtime rates are payable will increase employment costs. The claim, if granted, would therefore have an adverse impact on business, which would be exacerbated by the absence of any NDIS funding for the additional Award obligation.

(h) Section 134(1)(g): the need to ensure a stable system tells against the grant of the claim.

339. There is no proper foundation for the HSU's claim. Ai Group submits that it should be dismissed.

[139] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [184] – [202].

9. OVERTIME FOR PART-TIME EMPLOYEES

340. Clause 10.3(c) of the Award requires that an employer and part-time employee must reach agreement before the employee commences employment about a regular pattern of work including the number of hours to be worked each week, and the days of the week the employee will work and the starting and finishing times each day.

341. The Award does not presently require payment at overtime rates to part-time employees where the employee works hours in addition to the hours they have agreed to work pursuant to clause 10.3(c) of the Award, unless the employee works more than 10 hours in a day or 38 hours in a week / 76 hours in a fortnight.

342. The HSU seeks the following variation to clause 28.1(b)(iii) in this regard:

28.1 Overtime rates

…

(b) Part-time employees and casual employees

(i) All time worked by part-time or casual employees in excess of 38 hours per week or 76 hours per fortnight will be paid for at the rate of time and a half for the first two hours and double time thereafter, except that on Sundays such overtime will be paid for at the rate of double time and on public holidays at the rate of double time and a half.

(ii) All time worked by part-time or casual employees which exceeds 10 hours per day, will be paid at the rate of time and a half for the first two hours and double time thereafter, except on Sundays when overtime will be paid for at the rate of double time, and on public holidays at the rate of double time and a half.

(iii) All time worked by part-time employees which exceeds the hours agreed in clause 10.3(c) will be treated as overtime and paid at the rate of time and a half for the first two hours and double time thereafter, except on Sundays when overtime will be paid at the rate of double time and public holidays at the rate of double time and a half. ~~Time worked up to the hours prescribed in clause 28.1(b)(ii) will, subject to clause 28.1(b)(i), not be regarded as overtime and will be paid for at the ordinary rate of pay (including the casual loading in the case of casual employees).~~

343. The HSU's claim would create a requirement to pay overtime rates to part-time employees wherever they work hours in addition to their 'agreed' hours. The claim is opposed by Ai Group.

The HSU's Case

344. The HSU has made only the following submissions in support of its claim: (our emphasis)

> 45. The way in which overtime functions under the Award for part-time employees does not meet the Modern Awards Objective, which recognises (at s.134(da)), the need to provide additional remuneration for employees working overtime; or employees working irregular or unpredictable hours.
>
> 46. Part-time employees only receive payment of the overtime rate for hours which exceed 10 in any shift, 38 in a week or 76 in a fortnight. Part-time employees should be entitled to overtime for work beyond their rostered hours. The absence of any penalty associated with the performance of such work creates a structural incentive to underestimate the hours of work required of a part-time employee at the time of engagement and/or rostering, and to utilise part-time workers like a pool of casual employees. The evidence above suggests the increasing tendency towards engagement of part-time employees in both home care and disability support work, with such employees working less hours.[140]

Section 134(1)(da) of the Act

345. The HSU submits that "the way in which overtime functions under the Award for part-time employees does not meet the Modern Awards Objective".[141] This submission misunderstands the operation of ss.138 and 134(1) of the Act.

346. By virtue of s.138, an award can include only terms that are necessary to ensure that the *award* provides a fair and relevant minimum safety net, taking into account the matters listed at s.134(1) of the Act. The question is not whether *the entitlement to overtime for part-time employees* of itself meets the modern awards objective, as contemplated by the HSU. Section 138 requires a wholistic assessment of the instrument, taking into account the minimum safety net that it provides.

[140] HSU Submission dated 15 February 2019 at paragraph 45 – 46.

[141] HSU Submission dated 15 February 2019 at paragraph 45.

347. Moreover, the HSU submits that the modern awards objective "recognises … the need to provide additional remuneration for employees working overtime; or employees working irregular or unpredictable hours".

348. When determining whether the Award provides a fair and relevant minimum safety net, one of the matters that the Commission is to take into account is the need to provide additional remuneration for employees working overtime [142] and employees working unsocial, irregular or unpredictable hours[143].

349. Notwithstanding the HSU's submission to the contrary, s.134(1)(da)(i) of the Act is not relevant to the Commission's consideration of the claim. This is because hours worked by part-time employees in addition to their "agreed" hours are not overtime, except where they exceed 10 hours in a day, 38 in a week or 76 in a fortnight. This is made clear by clause 28.1(b)(iii) of the Award: (our emphasis)

> **(iii)** Time worked up to the hours prescribed in clause 28.1(b)(ii) will, subject to clause 28.1(b)(i), not be regarded as overtime and will be paid for at the ordinary rate of pay (including the casual loading in the case of casual employees).

350. Our submission in this regard is consistent with the Commission's conclusions about similar submissions made in the context of proceedings regarding the part-time provisions of the *Fast Food Industry Award 2010*:

> **[40]** Finally, RAFFWU's submissions regarding the modern awards objective are unpersuasive. The consideration at s134(1)(da)(i) ('employees working overtime') is not apposite in these circumstances as hours worked pursuant to an agreed variation to an employees' regular pattern of work are not 'overtime' hours.[144]

351. As for s.134(1)(da)(ii), the hours worked by a part-time employee in addition to their 'agreed' hours will not necessarily be unpredictable, by virtue of the Award's rostering provisions, which require that an employee's ordinary hours must be displayed on a fortnightly roster that is published at least a fortnight

[142] Section 134(1)(da)(i) of the Act.

[143] Section 134(1)(da)(ii) of the Act.

[144] *4 yearly review of modern awards—Fast Food Industry Award 2010* [2019] FWCFB 4679 at [40].

prior to the commencement of the roster period. Once published, subject to limited exceptions[145], the roster can be changed with seven days' notice. Accordingly, save for where the relevant exceptions apply, a part-time employee will have at least 7 – 14 days' notice of the ordinary hours that they are rostered to work, including hours in addition to their 'agreed hours' and to this extent, their hours cannot properly be characterised as necessarily being unpredictable.

352. It is also relevant that one of the aforementioned exceptions to providing at least 7 days' notice of a roster change applies specifically to part-time employees:

> **(iii)** This clause will not apply where the only change to the roster of a part-time employee is the mutually agreed addition of extra hours to be worked such that the part-time employee still has four rostered days off in that fortnight or eight rostered days off in a 28 day roster cycle, as the case may be.[146]

353. Clause 25.5(d)(iii) places a limitation on an employer's ability to roster a part-time employee to work additional hours unless the hours are mutually agreed and the employee will have the minimum number of days off over the relevant fortnight or 28 day roster cycle. There is little justification for requiring an employer to pay an employee at overtime rates for such work where this is not already required by clause 28.1 of the Award.

354. To the extent that part-time employees work additional hours that are 'irregular', this serves only to highlight the purpose and utility of the flexibility afforded by the current clause 28.1(b)(iii); a matter to which we return later in this submission.

355. In any event, s.134(1)(da) does not mandate that an Award prescribe a higher rate of pay for the performance of work in the circumstances described at s.134(1)(da). Such a construction of the relevant provisions is directly

[145] See clauses 25.5(d)(ii), 25.5(d)(iii) and 25.5(f) of the Award.

[146] See clause 25.5(d)(iii) of the Award.

inconsistent with the Penalty Rates Decision, in which the Full Bench observed as follows: (emphasis added)

[189] First, s.134(1)(da) speaks of the 'need to provide additional remuneration' for employees performing work in the circumstances mentioned in s.134(1)(da)(i), (ii), (iii) and (iv).

[190] An assessment of 'the need to provide additional remuneration' to employees working in the circumstances identified in paragraphs 134(1)(da)(i) to (iv) requires a consideration of a range of matters, including:

> (i) the impact of working at such times or on such days on the employees concerned (i.e. the extent of the disutility);
>
> (ii) the terms of the relevant modern award, in particular whether it already compensates employees for working at such times or on such days (e.g. through 'loaded' minimum rates or the payment of an industry allowance which is intended to compensate employees for the requirement to work at such times or on such days); and
>
> (iii) the extent to which working at such times or on such days is a feature of the industry regulated by the particular modern award.

[191] Assessing the extent of the disutility of working at such times or on such days (issue (i) above) includes an assessment of the impact of such work on employee health and work-life balance, taking into account the preferences of the employees for working at those times.

[192] The expression 'additional remuneration' in the context of s.134(1)(da) means remuneration in addition to what employees would receive for working what are normally characterised as 'ordinary hours', that is reasonably predictable hours worked Monday to Friday within the 'spread of hours' prescribed in the relevant modern award. Such 'additional remuneration' could be provided by means of a penalty rate or loading paid in respect of, for example, work performed on weekends or public holidays. Alternatively, additional remuneration could be provided by other means such as a 'loaded hourly rate'.

[193] As mentioned, s.134(1)(da) speaks of the 'need' to provide additional remuneration. We note that the minority in *Re Restaurant and Catering Association of Victoria* (the *Restaurants 2014 Penalty Rates decision*) made the following observation about s.134(1)(da):

> 'This factor must be considered against the profile of the restaurant industry workforce and the other circumstances of the industry. It is relevant to note that the peak trading time for the restaurant industry is weekends and that employees in the industry frequently work in this industry because they have other educational or family commitments. These circumstances distinguish industries and employees who expect to operate and work principally on a 9am-5pm Monday to Friday basis. Nevertheless the objective requires additional remuneration for working on weekends. As the current provisions do so, they meet this element of the objective.' (emphasis added)

[194] To the extent that the above passage suggests that s.134(1)(da) '*requires* additional remuneration for working on weekends', we respectfully disagree. We acknowledge that the provision speaks of 'the *need* for additional remuneration' and that such language suggests that additional remuneration is required for employees working in the circumstances identified in paragraphs 134(1)(da)(i) to (iv). But the expression 'the need for additional remuneration' must be construed in context, and the context tells against the proposition that s.134(1)(da) *requires* additional remuneration be provided for working in the identified circumstances.

[195] Section s.134(1)(da) is a relevant consideration, it is *not* a statutory directive that additional remuneration must be paid to employees working in the circumstances mentioned in paragraphs 134(1)(da)(i), (ii), (iii) or (iv). Section 134(1)(da) is a consideration which we are required to take into account. To take a matter into account means that the matter is a 'relevant consideration' in the *Peko-Wallsend* sense of matters which the decision maker is bound to take into account. As Wilcox J said in *Nestle Australia Ltd v Federal Commissioner of Taxation*:

> 'To take a matter into account means to evaluate it and give it due weight, having regard to all other relevant factors. A matter is not taken into account by being noticed and erroneously disregarded as irrelevant'.

[196] Importantly, the requirement to take a matter into account does not mean that the matter is necessarily a determinative consideration. This is particularly so in the context of s.134 because s.134(1)(da) is one of a number of considerations which we are required to take into account. No particular primacy is attached to any of the s.134 considerations. The Commission's task is to take into account the various considerations and ensure that the modern award provides a 'fair and relevant minimum safety net'.

[197] A further contextual consideration is that 'overtime rates' and 'penalty rates' (including penalty rates for employees working on weekends or public holidays) are terms that *may* be included in a modern award (s.139(1)(d) and (e)); they are not terms that *must* be included in a modern award. As the Full Bench observed in the *4 yearly review of modern awards – Common issue – Award Flexibility* decision:

> '… s.134(1)(da) does not amount to a statutory directive that modern awards must provide additional remuneration for employees working overtime and may be distinguished from the terms in Subdivision C of Division 3 of Part 2-3 which *must* be included in modern awards…'

…

[199] Third, s.134(da) does not prescribe or mandate a fixed relationship between the remuneration of those employees who, for example, work on weekends or public holidays, and those who do not. The additional remuneration paid to the employees whose working arrangements fall within the scope of the descriptors in s.134(1)(da)(i)–(v) will depend on, among other things, the circumstances and context pertaining to work under the particular modern award.

…

> **[202]** Fifth, s.134(1)(da) identifies a number of circumstances in which we are required to take into account the need to provide additional remuneration (i.e. those in paragraphs 134(1)(da)(i) to (iv)). Working 'unsocial … hours' is one such circumstance (s.134(1)(da)(i)) and working 'on weekends or public holidays' (s.134(1)(da)(iii)) is another. The inclusion of these two, separate, circumstances leads us to conclude that it is not necessary to establish that the hours worked on weekends or public holidays are 'unsocial … hours'. Rather, we are required to take into account the need to provide additional remuneration for working on weekends or public holidays, irrespective of whether working at such times can be characterised as working 'unsocial … hours'. Ultimately, however, the issue is whether an award which prescribes a particular penalty rate provides 'a fair and relevant minimum safety net.' A central consideration in this regard is whether a particular penalty rate provides employees with 'fair and relevant' compensation for the disutility associated with working at the particular time(s) to which the penalty attaches.[147]

356. Section 134(1)(da) is but one of a number of considerations that are to be taken into account. Accordingly, even if the Commission were to find that it lends support to the HSU's claim, it must be weighed against the various other competing considerations identified at s.134(1) of the Act.

357. Further, in relation to the considerations listed at paragraph [190] of the extract above:

(a) There is no probative evidence in support of the proposition that there is a disutility associated with working hours in addition to a part-time employee's agreed hours such that payment at a higher rate for such work is warranted.

(b) The Award does not appear to afford an employer the unilateral right to require a part-time employee to work additional hours; nor does the Award contain an obligation on a part-time employee to work such hours. This is, in our submission, an important contextual consideration that further undermines the proposition that there is any disutility associated with the performance of additional hours of work that might justify the payment of overtime rates.

(c) Further, a part-time employee is entitled to overtime rates for work performed in excess of 10 ordinary hours in a day (noting that the HSU

[147] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [189] – [202].

has also advanced a claim in these proceedings to reduce this to 8 hours) and in excess of 38 hours in a week or 76 in a fortnight. Similarly, part-time employees are entitled to any relevant penalty rates or loadings associated with additional hours worked on weekends, public holidays or on shifts. To the extent that part-time employees suffer any disutility associated with working additional hours in those circumstances, they are entitled to payment at the relevant higher rate for such work.

(d) The Award does not characterise hours worked in excess of a part-time employee's 'agreed hours' as overtime (subject to the maximum daily and weekly hours). That is, in addition to enabling an employer to engage a part-time employee to work additional hours absent an obligation to pay the employee at overtime rates, it also maintains the characterisation of such hours as ordinary hours. As a result, employees continue to accrue the relevant leave entitlements during such time and their wages would generally constitute ordinary time earnings for the purposes of an employer's superannuation obligations.

(e) To the extent that the relevant Award provisions are utilised such that part-time employees work additional hours, this is reflective the inherent features of the industry regulated by the Award. The client-focussed nature of the work, the variability in the days and times at which clients request the employer's services and the consequential need for flexibility in respect of an employee's hours of work are well-known features of the work performed by employees covered by the Award.

The Perceived Structural Incentive

358. The HSU submits that the "absence of any penalty associated with the performance of such work creates a structural incentive to underestimate the hours of work required of a part-time employee at the time of engagement

and/or rostering, and to utilise part-time workers like a pool of casual employees"[148].

359. There is no probative evidence before the Commission that might establish that employers are utilising the flexibility afforded by the Award in the way that is suggested by the HSU. That is, there is no evidence that employers are systematically, unjustifiably or deliberately engaging part-time employees on the basis of unreasonably few hours in light of the flexibility currently afforded by clause 28.1(b)(iii) of the Award. In fact Belinda Sinclair, a part-time home care worker's evidence demonstrates that her employer goes to great lengths to avoid rostering part-time employees to work additional hours:

> 22. My roster can change without notice when another employee falls ill or is unable to work. I understand that Wesley Mission North at Macquarie Park uses a large number of external staff to meet the workload. If the external company can't meet the services, it is called a "push back" and my roster might change. If Wesley Mission cannot find a casual then they change the roster so that the client will not miss out on service by adding the service onto a permanent employee's roster.[149]

360. The Commission should not, in the circumstances, be moved to vary the Award as sought by the HSU on the basis of the union's perception that the Award creates the alleged "structural incentive".

361. Further, a part-time employee's hours are required by the Award to be *agreed* prior to the employee's engagement. To the extent that agreement is reached at the time of engagement to work a certain number of hours in order to accommodate the employee's availability and preferences, but the employee nonetheless subsequently works additional hours (for example, because there is a change to the employee's availability or preferences; or because the employee is incentivised to agree to fewer hours in anticipation of receiving additional hours of work payable at overtime rates), it would be unfair to require an employer to pay for such work at overtime rates.

[148] HSU Submission dated 15 February 2019 at paragraph 46.

[149] Statement of Belinda Sinclair dated 16 January 2019 at paragraph 22.

362. We also note that the hours of work agreed prior to engagement can be altered subsequently only by written agreement between the employer and employee. A requirement to pay for additional hours at overtime rates would indeed create a structural incentive for employees to *not* agree to an expansion of the scope of their hours of work. To do so would result in a diminution of entitlements for such employees.

Section 138 and the Modern Awards Objective

363. The material before the Commission does not establish that the proposed provision is *necessary* to ensure that the Award achieves the modern awards objective. Indeed, the HSU's submissions do not so much as attempt to argue that this would be so.

364. In our submission, the proposed clause is not necessary in the relevant sense. The union's claim should therefore be dismissed.

A *Fair* Minimum Safety Net

365. The proposed clause is unfair to employers. In order for an employer to meet client needs, access to a flexible and agile workforce that can be deployed to work variable hours is essential. As we have previously submitted, under the NDIS, clients have a significant degree of control over what support or services they receive and when they receive them. In order to meet their client's needs, flexible work practices that enable an employer to arrange the performance of work of its employees to meet clients demands, are essential. It is not fair that employers be required to pay a penalty to part-time employees when they perform additional hours of work in those circumstances.

366. The imposition of a requirement to pay overtime rates is particularly unfair given that there is no Award-derived employer right to direct part-time employees to work additional hours or Award-derived employee obligation to work such hours.

367. The absence of any scope to recover the additional employment costs that would be imposed by the grant of the claim due to the NDIS' funding arrangements furthers the unfairness to employers. In essence, this is not a cost that an employer can simply 'pass on'.

368. To the extent that the resulting additional employment costs and reduced flexibilities render it impracticable for an employer to provider certain services, this may ultimately impact not only the employer but also persons with a disability seeking its services.

A *Relevant* Safety Net

369. As the Full Bench observed in the Penalty Rates Decision, in the context of s.134(1), the word 'relevant' is intended to convey that a modern award should be suited to contemporary circumstances.[150] In this context, the relevant contemporary circumstances include the operation of the NDIS and the need for flexibility in light of the client-focussed nature of the scheme. The grant of the union's claim would therefore be inconsistent with the maintenance of a relevant safety net.

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

370. There is no evidence dealing with the impact of the claim on the relative living standards and needs of the low paid.

371. In the circumstances, we consider that s.134(1)(a) does not advance the union's case. The Commission cannot properly conclude that the relative living standards and needs of the low paid will be enhanced or improved if the claim is granted.

[150] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [120].

Section 134(1)(b) – The need to encourage collective bargaining

372. The grant of the claim may have an adverse impact on the need to encourage collective bargaining.

373. The union's pursuit of the claim here advanced demonstrates that the issue is one of importance to the union and by extension, it is one that may motivate it to engage in collective bargaining. Any such motivation would necessarily be extinguished by the grant of the claim.

374. Further, a further improvement to the minimum floor and the imposition of additional employment costs may disincentivise employers from engaging in collective bargaining.

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

375. There is no evidence that might enable the Commission to conclude that the grant of the claim will improve social inclusion through increased workforce participation.

376. In the circumstances, we consider that s.134(1)(c) does not advance the union's case.

Section 134(1)(d) – The need to promote flexible modern work practices and the efficient and productive performance of work

377. The grant of the claim would be inconsistent with the need to promote flexible modern work practices and the efficient and productive performance of work.

378. The Award presently enables a part-time employee to work additional hours without the imposition of a higher rate of pay. This enables an employer to respond to client demands for its services on specific days and at specific times, often at short notice. Short of refusing to provide the service, the employer has little if any control over the scheduling of such work. The clause

also enables an employer to respond to short-term needs for labour, such as relief for employees who are on leave.

379. For example, Belinda Sinclair, a part-time home care worker, gives the following evidence:

> My roster can change without notice when another employee falls ill or is unable to work.[151]

380. The importance of the flexibility afforded by the current clauses is self-evident.

381. Furthermore, an employer will not always enjoy certainty as to the demand for its services or the rate at which that demand will grow. As a result, the employer may be unable to agree to engaging a part-time employee on the basis of a greater number of weekly hours. Put simply, the demand for labour may be unpredictable as it is entirely contingent upon the desires of its clients.

382. During proceedings concerning the casual and part-time common issues earlier in this award review, ABI and the NSW Business Chamber advanced a claim in which it proposed greater flexibility concerning the engagement of part-time employees under the Award. Whilst the claim was not granted, the Full Bench observed that clause 28.1(b)(iii) afforded employers an important flexibility which, in its view, undermined the alleged necessity of the amendment to the part-time provisions pursued by ABI: (our emphasis)

> **[559]** ABI's proposed variation, in its final iteration, was only directed at those aspects of disability service provision which were said to be subject to client control and thus where the employer had least control over the hours required to be worked. In respect of part-time employees in that area, its variation proposed an employment model whereby actual working hours were not determined by agreement at the outset of the employment and were thereafter only alterable by agreement, but rather that the employer would have the ability to roster those hours in accordance with clause 25.5 subject to it providing an agreed guaranteed number of weekly hours and such working hours being rostered at periods when the employee was agreed to be available to work.
>
> …
>
> **[637]** Second, we consider that the current provision as it is applied in practice is reasonably flexible. Although the pattern of hours of work must be fixed in a written

[151] Statement of Belinda Sinclair dated 16 January 2019 at paragraph 22.

> agreement established at the commencement of the employment, they may thereafter be changed by agreement to meet either temporary exigencies or permanent changes in service demand. The evidence before us did not disclose any significant difficulty in obtaining the agreement of employees to alter their hours to meet changing circumstances, although we accept that the need for the agreement to be obtained and then recorded in writing does impose an administrative burden to some extent. Further, clause 28.2(b)(iii) allows for part-time workers to work additional hours up to 10 in a day or 38 in a week or 76 in a fortnight without the payment of any overtime penalty rate, so that there is a considerable capacity to assign additional hours that may arise at short notice to employees without the cost exceeding what the NDIA price structure will allow. The evidence showed that employees are generally willing to work such additional hours if it does not interfere with fixed private commitments; for example, in the case of a person with a disability attending a social event which ran over time, the employee involved readily agreed to stay on for the additional time until it ended.[152]

383. The grant of the union's claim could give rise to the need to reassess whether the flexibility of the nature sought by ABI is necessary.

384. The HSU submits that its evidence "points to a level of underemployment in the industry" amongst part-time employees.[153] The material before the Commission does not suggest that part-time employees seeking additional hours of work will in fact be afforded such hours if the claim is granted; and to the extent that employers are unable to absorb the additional employment costs associated with the performance overtime, it is likely that employers will in fact look to avoid having part-time employees work such overtime. This could conceivably result in a greater reliance on casual employment in order to ensure that employers have access to the necessary flexibility.

Section 134(1)(da) - The need to provide additional remuneration for employees working overtime; unsocial, irregular or unpredictable hours; on weekends or public holidays or shifts.

385. We have dealt with s.134(1)(da) earlier in our submission.

[152] *4 yearly review of modern awards – Casual employment and Part-time employment* [2017] FWCFB 3541 at [559] and [637].

[153] HSU submission dated 15 February 2019 at paragraph 27.

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

386. This consideration is not relevant to the matter.

Section 134(1)(f) – The impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden

387. It is axiomatic that the grant of the claim would substantially increase employment costs. The claim, if granted, would therefore have a significant adverse impact on business.

388. Further, as we have previously submitted, significant portions of the industry covered by the Award are dependent on NDIS funding to cover their employment costs. The NDIS does not provide funding for the additional employment costs contemplated by the proposed clause. The impact on employers is compounded in these circumstances.

389. To the extent that the additional employment costs result in efficient work practices, this may also undermine productivity.

Section 134(1)(g) - The need to ensure a simple, easy to understand, stable and sustainable modern award system

390. The concept of a part-time employee working additional hours without the payment of overtime rates is not new. As was highlighted by a number of submissions made by interested parties during the Part 10A Award Modernisation Process[154], the current regime is reflective of the prevailing standard that applied in respect of at least some sectors in New South Wales[155] and potentially other states / territories prior to the making of the modern award.

[154] See for example AFEI submission dated 24 July 2008, CCIWA submission dated 24 July 2008 and a draft award filed by Jobs Australia on 24 July 2008.

[155] See for example the *Social and Community Services Employees (State) Award* (AN120505).

391. The need to ensure a stable system tells against the grant of the claim; particularly given that the claim lacks any proper foundation.

10. ROSTER CHANGES

392. United Voice seeks the following amendment to clause 25.5 of the Award:

25.5 Rosters

(a) The ordinary hours of work for each employee will be displayed on a fortnightly roster in a place conveniently accessible to employees. The roster will be posted at least two weeks before the commencement of the roster period.

(b) Rostering arrangements and changes to rosters may be communicated by telephone, direct contact, mail, email, facsimile or any electronic means of communication.

(c) It is not obligatory for the employer to display any roster of the ordinary hours of work of casual or relieving staff.

(d) Change in roster

(i) Seven days' notice will be given of a change in a roster. Full time and part time employees will be entitled to the payment of overtime for roster changes where seven days' notice is not provided.

(ii) However, a roster may be altered at any time to enable the service of the organisation to be carried on where another employee is absent from duty on account of illness, or in an emergency.

(iii) This clause will not apply where the only change to the roster of a part-time employee is the mutually agreed addition of extra hours to be worked such that the part-time employee still has four rostered days off in that fortnight or eight rostered days off in a 28 day roster cycle, as the case may be.

(e) Where practicable, accrued days off (ADOs) will be displayed on the roster.

393. Ai Group opposes the variation and submits the claim should be dismissed.

United Voice's Case

394. United Voice's case for varying clause 25.5(d)(i) can be summarised as follows:

(a) Clause 25.5(d)(i) currently permits changes to rosters to be made with seven days' notice;

(b) Rosters can be changed with less than seven days' notice if one of two exceptions apply;

(c) Clause 25.5(d)(i) does not expressly state what consequence flows from a change in the roster that is made with less than 7 days' notice, in circumstances where one of the two exceptions do not apply;

(d) It is logical that overtime must be paid in these circumstances; and

(e) Therefore, the clause ought to expressly state that overtime rates will apply.

395. Ai Group's overarching response to the case advanced by United Voice is that the variation is not necessary having regard to matters including the following considerations:

(a) It is not necessary (in the sense contemplated by s.138 of the Act) or appropriate to provide for the payment of overtime penalties by reference to circumstances which constitute a breach of an award clause;

(b) The Award already appropriately and comprehensively regulates the manner in which overtime should be paid;

(c) The proposal would introduce inconsistencies between award clauses and give rise to various problems, including uncertainty as to whether the rostering provisions can be breached if a relevant payment is made; and

(d) The evidentiary case advanced does not establish the various factual assertions relied upon in support of the variation.

The Interaction between the Rostering and Overtime Provisions of the Award

396. Clause 25.5 of the Award contains a number of rules that govern rostering in the industry. They dictate how rosters can be communicated, the classes of employees for whom a roster must be prepared, and how rosters can be changed.

397. The manner in which the hours of work may be rostered and arranged under the Award is regulated in a relatively detailed way, compared to the approach adopted under most awards. This appears intended to reflect the needs of the sectors covered by the Award. It also, in various respects, reflects elements of the relevant predecessor awards. United Voice have not advanced a case that warrants a departure from such arrangements.

398. Under the Award, rosters may not be changed except as expressly contemplated by clause 25.5. Where a roster is changed in other circumstances, it would be a breach of the Award and expose an employer to a relevant penalty for such a breach. It cannot be considered necessary, in the sense contemplated by s.138, for an award to regulate the amount that should be payable to an employee in the event that the provisions of the award are breached.

399. Further, the Award already contemplates the circumstances where an employee is entitled to be paid overtime rates. This is dealt with under clause 28.1. It is unnecessary and indeed potentially both confusing and problematic for the Award provisions dealing with rostering to be amended to include an additional and contradictory provision establishing a separate basis upon which such rates would be payable.

400. We acknowledge that the Award differs in its approach to the regulation of overtime entitlements based on an employee's type of employment; that is, whether they are engaged as a full-time, casual or part-time employee as defined under the instrument.

401. For a full-time employee, hours worked outside of their rostered hours will constitute overtime and will attract relevant penalty rates, pursuant to clause 28.1(a): (emphasis added)

> (a) A full-time employee will be paid the following payments for all work done in addition to their rostered ordinary hours on any day:

402. Given this clause, the provision proposed by United Voice would have no work to do in the context of full-time employment, as it appears intended to merely deliver the same outcome as is already provided for under the current terms of the Award.

403. For part-time or casual employees, the situation is different. Clause 28.1(b) of the Award provides as follows:

> **(i)** All time worked by part-time or casual employees in excess of 38 hours per week or 76 hours per fortnight will be paid for at the rate of time and a half for the first two hours and double time thereafter, except that on Sundays such overtime will be paid for at the rate of double time and on public holidays at the rate of double time and a half.
>
> **(ii)** All time worked by part-time or casual employees which exceeds 10 hours per day, will be paid at the rate of time and a half for the first two hours and double time thereafter, except on Sundays when overtime will be paid for at the rate of double time, and on public holidays at the rate of double time and a half.
>
> **(iii)** Time worked up to the hours prescribed in clause 28.1(b)(ii) will, subject to clause 28.1(b)(i), not be regarded as overtime and will be paid for at the ordinary rate of pay (including the casual loading in the case of casual employees).
>
> **(iv)** Overtime rates payable under this clause will be in substitution for and not cumulative upon:
>
> **(A)** the shift premiums prescribed in clause 29—Shiftwork; and
>
> **(B)** the casual loading prescribed in clause 10.4(b),
>
> and are not applicable to ordinary hours worked on a Saturday or a Sunday.

404. On our construction, the Award simply does not permit a part-time employee's roster to be changed with less than seven days' notice unless one of the exceptions under the Award applies. In such circumstances there is no apparent necessity for regulating what rate of pay should attach to such an outcome.

405. Moreover, under clause 10.3 of the Award (which defines and deals specially with part-time employment) there are a raft of additional protections or limitations that restrict the extent to which a part-time employee's hours of work may be altered. Relevantly, there is no Award-derived right to require an employee to work outside of the hours set in accordance with these provisions. This reinforces our contention that there is no necessity to grant the claim.

406. It is also apparent, on the face of the Award, that the flexibility afforded to employers and part-time employees to work hours in addition to their 'agreed' hours without attracting overtime rates has been provided for quite deliberately. There is no 'gap' that might justify the granting of the claim.

407. Contrary to United Voice's submissions, there is no ambiguity about what might be payable if an employee's roster is varied in breach of the Award.

The Consequences of United Voice's Claim

408. If the Commission were to grant the proposed variation, it will lead to ambiguity and inconsistencies within the Award and would purport to create an additional substantive entitlement for part-time employees.

409. If the Award where to provide a payment that applies in circumstances where the roster is changed without providing the requisite notice, it might be interpreted by employers and employees as suggesting that this is permissible, if the relevant payment is made. Ironically, the clause might consequently be a catalyst for greater irregularity in working hours.

410. The proposed change may also lead to increased costs, which are not funded by the NDIS and are not factored into the funding model.

411. Ai Group also submits that the drafting of United Voice's proposed wording is problematic in the following significant respects.

412. *Firstly*, we submit that an employee being "entitled to the payment of overtime for roster changes" is inherently ambiguous. If an employee is entitled to the "payment of overtime", it is unclear whether those hours are actually overtime, or ordinary hours subject to a penalty equivalent to overtime. Whichever it is, it has significant implications; for example:

(a) In respect to the accrual of various kinds of paid leave, such as annual leave;

(b) Whether the payment is considered ordinary time earnings for superannuation purposes;

(c) It may have implications on how provisions of the National Employment Standards, such as those in s.62 of the FW Act would apply.

413. *Secondly*, it is unclear how United Voice's proposed clause 25.5(d)(i) would interact with the exceptions found at clauses 25.5(d)(ii) and (iii) (which are not sought to be varied). On one construction, even though clauses 25.5(d)(ii) and (iii) are currently considered 'exceptions', they would no longer operate as exceptions under the proposed clause. While the roster may be changed in those circumstances, it does not necessarily follow that overtime would not still be payable. Rather than provide clarity, (as United Voice submits their clause is intended to achieve), the variation will likely cause confusion and the incorrect application of the Award.

414. Given the proposed variation would in various respects be inconsistent with existing Award provisions regarding payment for overtime and the prohibition on altering rosters without the provision of the requisite notice, and the other deficiencies in its drafting identified above, it cannot be considered consistent with the need to ensure a simple and easy to understand award system, as contemplated by s.134(1)(g).

415. In our submission, there are serious doubts as to the utility and necessity of a variation to the clause.

416. United Voice offers two contradictory factual assertions in respect to the operation of clause 25.5(d). On one hand, United Voice submits that it is the "stand industrially generally" for overtime to be paid in circumstances where seven days' notice is not provided.[156] At the same time, United Voice posits that "many employers do not heed this".[157] United Voice has not provided any evidence to support either of these factual contentions.

417. Although United Voice submits that "many employers do not heed to this", they have not provided any examples of cases where this matter has been considered either by the Commission or a Court. It is difficult to reconcile United Voice's submission that the Award is so frequently breached, with the glaring absence of any evidence that they have ever disputed its application in a Court or tribunal.

United Voice's Evidentiary Case

418. United Voice relies on three witness statements in support of its claim. It appears to rely principally on the evidence of Ms Belinda Sinclair[158], a part-time home care worker with Wesley Mission. Ai Group submits that Ms Sinclair's evidence does not provide a basis for varying the Award as proposed by the union.

[156] United Voice submissions at paragraph 68.

[157] United Voice submissions at paragraph 69.

[158] Statement of Belinda Sinclair dated 16 January 2019 at paragraphs 22 – 26.

419. It is Ms Sinclair's evidence that her roster can change without notice when another employee falls ill.[159] This is an uncontroversial statement and generally accords with clause 25.5(d)(ii) of the Award. Her evidence is that her employer, Wesley Mission, will undertake the following steps to cover such absences:

(a) Firstly, Wesley Mission will try to engage one of a large number of "external" employees;

(b) Where the absence cannot be covered by external staff, Wesley Mission will try to engage a casual employee to cover the absence;

(c) As a last resort, it may change Ms Sinclair's roster to accommodate the absence.[160]

420. Ms Sinclair's evidence illustrates that it is not the case that her rosters are changed 'on a whim', but rather as a final resort.

421. United Voice also relies on the evidence of Mr Deon Fleming. Mr Fleming's description of when his roster can change[161] is entirely consistent with clauses 25.5(d)(ii) and 25.5(f) of the Award. Mr Fleming's evidence provides no support for United Voice's submission that clause 25.5(d)(i) should be varied in the way it seeks.

422. Finally, United Voice relies on the evidence of Ms Trish Stewart, a part-time employee of LiveBetter Support Services Limited. In summary, Ms Stewart's evidence is that her roster can change frequently due to a colleague being absent due to illness, or alternatively because she is offered, and accepts, additional shifts.[162] These roster changes are contemplated and permitted by

[159] Statement of Belinda Sinclair dated 16 January 2019 at paragraph 22.

[160] Statement of Belinda Sinclair dated 16 January 2019 at paragraph 22.

[161] Witness statement of Deon Fleming dated 16 January 2019.

[162] Witness statement of Trish Steward dated 17 January 2019 at paragraph [10]-[11].

the current clause 25.5(d). The evidence provides no support for the variation sought by United Voice.

423. Self-evidently, the evidence led by United Voice does not justify a variation to clause 25.5(d).

Section 138 and the Modern Awards Objective

424. United Voice's only reference to the modern awards objective in seeking to justify the proposed variation is to s.134(1)(da)(ii). In this regard it merely asserts that "there should be proper compensation for employees who are required to work unpredictable hours as a result of late roster changes."

425. In response, we firstly note that s.134(1)(da)(ii) does not constitute a legislative imperative to provide additional remuneration in the relevant circumstances.[163]

426. We also note that the extent to which the Award heavily regulates the manner in which hours must be rostered, this weighs against the need for additional compensation. This is reinforced by our observation that the evidentiary case advanced does not establish that employers are breaching the award provisions pertaining to rosters.

[163] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [195].

11. RECALL TO WORK OVERTIME

427. The HSU has proposed a new clause that would create an obligation to provide certain payments to an employee performing work from home after leaving the employer or client's premises.

428. In this section we address the reasons why the Full Bench should reject the union's claim. In our submission, a case for the proposed changes has not been made out. Further, there are a range of deficiencies or problems with the proposed clause that would in any event weigh against granting the variation.

429. The HSU seeks the following changes to clause 28.4:

> **28.4 Recall to work overtime**
>
> **(a)** An employee recalled to work overtime after leaving the employer's or client's premises will be paid for a minimum of two hours' work at the appropriate rate for each time so recalled. If the work required is completed in less than two hours the employee will be released from duty.
>
> **(b)** Where an employee is required to perform work from home after leaving the employer's or client's premises, including:
>
> **(i)** Responding to phone calls, message or emails;
>
> **(ii)** Providing advice ("phone fixes")
>
> **(iii)** Arranging call out/rosters of other employees; and
>
> **(iv)** Remotely monitoring and/or addressing issues by remote telephone and/or computer access;
>
> the employee will be paid for a minimum of one hours' work at the overtime rate for each time recalled.

430. Before addressing the merits of the HSU's proposal, we note that a variation to the Award directed at 'remote response work' was an element of the consent variations that was previously agreed between several, but not all parties to the proceedings. The provision was cast in the following terms:

> 17.2(e) Remote response
>
> (i) In this award, unless the contrary intention appears, remote response duties include:
>
> (a) responding to phone calls, messages or emails;
>
> (b) providing advice ("phone fixes");
>
> (c) arranging call out/rosters of other employees; and
>
> (d) remotely monitoring and/or addressing issues by remote telephone and/or computer access.
>
> (ii) If an employee is required to perform remote response duties between 6.00am and 10.00pm in any day, the employee will be paid at the prescribed overtime rate for the time worked, rounded up to the nearest 15 minutes.
>
> (iii) If an employee is required to perform remote response duties between 10.00pm and 6.00am in any day the employee will be paid at the prescribed overtime rate for the time worked, with a minimum payment as for one hour. Where such work exceeds one hour, payment will be made at the prescribed overtime rate for the duration of the work.
>
> (iv) An employee remotely responding will be required to maintain and provide to the employer a time sheet of the length of time taken in dealing with each matter remotely for each day commencing from the first remote response.

431. This proposal was the subject of conferences before the Commission in the context of the current proceedings. Ai Group expressed concerns during that process about the drafting of the proposed provision. Although agreement between the parties was not ultimately reached in relation to such matters, several employer parties have subsequently filed a proposal for an award variation dealing with related issues (**Joint Employer Proposal**). Accordingly, there are now what may be described as competing claims before the Commission relating the performance of work that occurs away from an employer or client's premises.

432. The Joint Employer Proposal is in the following terms:

20.10 Remote response

(a) In this award, remote response duties means the performance of the following activities by an employee outside of hours at the direction of, or with the authorisation of, their employer:

(i) responding to phone calls, messages or emails;

(ii) providing advice ('phone fixes');

(iii) arranging call out/rosters of other employees; and

(iv) remotely monitoring and/or addressing issues by remote telephone and/or computer access,

in circumstances where the employee is not required to attend their employer's premises, or any other particular place of work, and at a time when the employee is either on call or has not otherwise been rostered to work.

(b) Subject to clause 20.10(f), where an employee is directed or authorised by their employer to perform remote response duties between 6.00am and 10.00pm, the employee will be paid at the applicable rate of pay specified in this Award for any such work performed between these hours, with a minimum payment of 15 minutes.

(c) Where an employee undertakes multiple separate instances of remote response duties during a particular period referred to in clause 20.10(b), and the total time spent performing such duties does not exceed 15 minutes, only one minimum payment is payable.

(d) Subject to clause 20.10(f), where an employee is directed or authorised to perform remote response duties between 10.00pm and 6.00am the employee will be paid at the applicable rate of pay specified in this Award for any such work performed between these times, with a minimum payment of one hour. Where such work exceeds one hour, payment will be made at the applicable rate for the duration of the work.

(e) Where an employee undertakes multiple separate instances of remote response duties during a particular period referred to in clause 20.10(d), and the total time spent performing duties does not exceed one hour, only one minimum payment is payable.

(f) Subject to clause 20.10(g), an employee who performs remote response duties must maintain and provide to their employer a time sheet specifying the time at which they commenced and concluded performing any remote response duty and a description of the work that was undertaken. This record must be provided to the employer prior to the end of the next full pay period or in accordance with any other arrangement as agreed between the employer and the employee.

(g) An employer may implement an alternate method or system for the recording and notification of the details referred to in clause 20.10(f).

(h) An employer is not required to pay an employee for any time spent performing remote duties if the employee does not comply with the requirements of clause 20.10(f) or any alternate method or system pursuant implemented under clause 20.10(g).

(i) For the purposes of this clause, remote response duties do not include employees undertaking administrative tasks such as (but not limited to) reviewing or inquiring about their roster or seeking changes to their roster.

433. In the context of the Review, the Commission is not bound to grant a remedy in the terms sought. Accordingly, although Ai Group has not advanced a claim for a new clause imposing additional obligations on employers that require employees to work remotely, we observe that many of the deficiencies or criticisms we identify in relation to the union's claim might be ameliorated or even negated by adopting elements of the Joint Employer Proposal in any clause dealing with the kinds of issues that the competing claims seek to address.

The Merits of the HSU's Claim

434. The HSU has advanced very little by way of submission in support of its claim for a major change to the Award. The substance of the union's arguments in support of the proposed variation are contained in the following paragraphs of its submission:

71. The award does not clearly identify whether employees required to perform additional work without attending the place of work are entitled to compensation. Many employees are now able to perform valuable work for the employer outside the employer's premises connecting remotely with employer systems. Such work should be compensated appropriately.

72. The HSU contends the Award should be amended to make clear that employees required to perform work out of hours should be compensated, with a minimum payment of one hour attached to such work.[164]

[164] HSU Submission dated 15 February 2019 at paragraph 71 – 72.

435. The union's case can be characterised as resting upon the following two contentions:

(a) That there should be greater clarity about what employees should be paid for work undertaken without attending the workplace, and

(b) Employees performing work "out of hours" should be paid for a minimum of one hour.

436. The Commission should not accept that the HSU has established a case for a variation to the Award.

437. Ai Group does not dispute the proposition that many employees are now able to perform valuable work for their employer outside the employer's premises. Our opposition to the union's claim centres on a disagreement as to:

(a) Whether an additional clause is necessary to provide clarity as to the payment that attaches to work undertaken at home;

(b) What constitutes *appropriate* compensation for such work;

(c) The extent to which the proposed minimum payment is justifiable;

and a potential disagreement with the HSU as to what should constitute 'work' that attracts such a payment.

Is Greater Clarity Necessary?

438. The HSU's submission appears to allude to the prospect that it is either unclear whether an employee is entitled to be paid for work undertaken in the circumstances contemplated by the proposed variation, or, that it is unclear whether or not clause 28.4 (Recall to Work Overtime) applies in such instances.

439. In responding to the union's proposal, it is convenient to first address the manner in which the Award currently regulates payment for the type of work contemplated by the proposed clause.

440. Where work is performed, at the direction of an employer, and after leaving a client's or employer's premises, it would currently attract a payment at the appropriate rate specified in the Award for the relevant circumstances. This may be at the ordinary rate of pay (inclusive or not inclusive of shift rates or a relevant penalty rate) or at overtime rates. It is not, generally, the location at which the work is performed that governs the amount that should be paid, or indeed whether a payment should be made.

441. The exception to this arises from clause 28.4, which deals with the circumstances of an employee being recalled to work overtime after leaving the employer or client's premises:

> **28.4 Recall to work overtime**
>
> An employee recalled to work overtime after leaving the employer's or client's premises will be paid for a minimum of two hours' work at the appropriate rate for each time so recalled. If the work required is completed in less than two hours the employee will be released from duty.

442. Ai Group contends that clause 28.4 addresses the circumstances where an employee is directed to return to perform overtime work at an employer or client's premises. Such an interpretation aligns with the common approach adopted in similar provisions in other awards.

443. The text of the provision provides further support for the interpretation that we advance. Relevantly, the term "recalled" suggests that an employee has been called back or ordered back to work. Its use in the context of a sentence referencing the physical location of the employer or client's premises suggests that it is to such a location that the employee must be recalled to work. Moreover, the notion that the provision might be apt to cover the employee's performance of discrete work activities, whist at their home, is difficult to reconcile with the element of the clause that provides that the employee will be "released from duty" if the required work is completed in less than two hours.

444. Implicit in the approach proposed by the HSU is that circumstances where an employee performs work from home after leaving the employer or client's premises are different to those involving situations where an employee is recalled to work at an employer or client's premises and as such should be remunerated differently.

445. Notwithstanding the above contentions, we do not here seek to address the interpretation of clause 28.4 in detail as we do not understand that any party is seriously asserting that it operates in a manner different to that which we have canvassed. Moreover, an award clause that required an employee be paid for two hours on every occasion that they are required to undertake any activity at the direction of their employer would be exceedingly generous and would not be *necessary*, in the sense contemplated by s.138. As such it would have no place in the safety net.

446. A further difficulty with accepting that the proposed variation is necessary is that the union has failed to establish the extent to which the performance of work at home by employees covered by the Award actually occurs. The HSU's submissions in support of this variation do not assert that employees are undertaking large amounts of unpaid work. Similarly, the lay witness evidence that they have advanced does not establish that this is a problematic phenomenon.

447. There is some reference to unpaid work in the expert witness statement of Dr McDonald; however, this relates to the diary entries of 10 unnamed employees who have not given evidence attesting to the accuracy of such entries. It is in the nature of hearsay evidence, which cannot be tested and ought not be given any significant weight.

448. The role of NDIS' funding arrangements must be carefully considered. The difficulty, or indeed pointlessness, of responding to alleged problems flowing from deficiencies in the current funding arrangements to the extent that they

are resulting in employees performing unpaid administrative duties[165], by simply modifying or further regulating terms and conditions specified in the Award, is apparent. Simply imposing more strident obligations on employers is not a productive or appropriate response and it does not grapple with the underlying root causes of such issues.

449. Ultimately, the union's claim may simply intensify the kinds of problems that the aforementioned report identifies. Moreover, we cannot identify any basis upon which it might be said that the NDIS funding arrangements would enable employers to cover the costs of the proposed clause. In such circumstances it is unfair to simply impose an additional unrecoverable cost upon employers.

Deficiencies in the HSU's Proposed Clause

450. There is a lack of clarity as to the circumstances in which the proposed clause will apply. Moreover, there is a risk that the provision will expose an employer to payments in circumstances where they do not want and/or direct the relevant "work" to be undertaken.

451. The proposed clause does not define "work" in an exhaustive or descriptive manner. It merely lists a number of tasks that are included in the concept. In the context of the award system, "work" attracting a payment should be restricted to labour that is undertaken by an employee under authorisation, or at the direction, of an employer in the course of their employment.

452. Moreover, the tasks identified in clause 24.5(b) are referred to in a fairly unclear and ambiguous manner. For example, there are no parameters around either what kind of 'advice' is referred to in clause 25.5(b)(ii), or to whom the 'advice' must be given, in order to attract payment. Similarly, there is no indication as to the kinds of "issues" that are intended to be caught by clause 28.4. The provision would give rise to uncertainty as to precisely what activities might attract payment under the clause. For example, if an employee

[165] UNSW, *Working under the NDIS: Insights from a survey of employees in disability services* (June 2017) at page 46.

elects at their own initiative to monitor their emails on their phone or computer; or elects at their own initiative to respond to an email; or takes a phone call from a colleague seeking assistance (without the knowledge or approval of management); or indeed simply actively thinks about the manner in which to assist a client during their own time, would it be work for the purposes of the clause?

453. The clause also creates a risk that simple administrative tasks that might currently reasonably be considered a necessary task for employees to undertake in order to maintain their employment, without constituting work attracting a payment under the Award, might now unreasonably attract a significant additional payment. For example, it is not uncommon in many industries for employees to be expected to check their roster in their own time, or to make contact with their employer in their own time in order to verify when they will either be offered or allocated work. It can be assumed that this occurs in the context of the sectors covered by the Award.

454. In many ways technological developments have impacted upon such practices. For example, the prevalent use of smart phones means that such activities can and are now commonly be undertaken remotely; a change that in many instances will be to the mutual benefit of all parties. The proposed variation would mean that these conveniences would trigger a payment under the Award, which is not warranted.

455. Similarly, the use of online platforms for the allocation of work is a phenomenon that has arisen in the sectors covered by the Award and other industries.[166] Given the drafting of the proposed clause, there is a risk that activities undertaken by a casual employee who engages with such a platform in order to advise of their availability, or to secure their next casual engagement, would be undertaking “work” as envisaged by the proposed clause or, at the very least, it would be unclear whether or not such activities constitute work. If it would, and employees would therefore be entitled to

[166] McKinsey Report at page 28.

significant additional payments for undertaking such activities, this could potentially have a significant adverse impact upon employers utilising such technologies.

456. In advancing the above criticisms, we nonetheless recognise that the obligation to provide the payments contemplated by the proposed clause is tempered by the prerequisite that to be eligible for a payment the employee must be "required to perform work from home after leaving the employer's or client's premises". However, the condition that the employee is "required to perform remote response duties" is not sufficient to render the clause reasonable or workable. The clause does not specify the basis upon which the employee may be *required* to perform the overtime work. It does not, for example, specify that it is only work that an employee has been asked or authorised by their employer to perform that attracts the payment. This can be contrasted with the current requirement in clause 28.1 to only pay for overtime work in circumstances where it is "authorised" overtime.

457. There is a risk that the proposed provision might result in (or might be perceived by employees to result in) an entitlement to the additional payment whenever an employee undertakes work away from the employer or client's premises because they *believe* that it is necessary, even if it has not been authorised or requested by their employer. Indeed, we are concerned that this may be the outcome that the HSU is intending to achieve.

458. There is a very real possibility in this sector that employees may undertake activities that they have not been instructed or authorised to undertake. The material before the Commission suggests that in some instances employees will do more than is requested or required by their employer in order to assist a client or indeed facilitate the services of their employer.

459. We do not seek to impugn the actions or motivations of such employees; however, it cannot be that an employee's own assessment of whether a task is "necessary" is sufficient to render a payment to the employee under the safety net. If an Award clause is to impose a financial obligation upon an

employer, it is fair and appropriate that the employer be afforded a capacity to manage their exposure to such costs. A clause that did otherwise would risk exposing employers to unsustainable costs.

460. The Joint Employer Proposal provides an alternate approach to regulating payment for work undertaken away from an employer or client's premises. In various respects it remedies a number of the abovementioned deficiencies by expressly providing that it applies in the context of activities performed by employees "at the direction of, or with the authorisation of, their employer". Moreover, it applies to a discrete range of duties (thus limiting the difficulties associated with a reference to "work", absent a definition of what this term constitutes). If the Full Bench were minded to grant an award variation addressing the matter that has been put in issue by the HSU and Joint Employers, it should include these elements of the Joint Employer Proposal.

The Rates that are Payable

461. The proposed clause would require that all remote duties would be paid at overtime rates.

462. It is unclear why overtime rates should apply to duties undertaken at home that are undertaken within the span of hours and would constitute ordinary hours. Three obvious issues flow from this.

463. *Firstly*, the clause fails to recognise that employees may be performing their ordinary hours of work at home as part of their usual working arrangements (for example, by virtue of flexible working arrangements). This may well be part of their rostered hours of work. In such circumstances the proposed provision would now require that overtime rates apply to such work. We do not know whether this is intended, but it is clearly unjustifiable. In contrast, we note that the Joint Employer proposal only applies in the context of activities performed at the direction or authorisation of an employer when the employee is "on-call" or "not otherwise rostered to work."

464. *Secondly*, the proposed clause greatly restricts an employer's capacity to utilise casual and part-time employees to perform work at home at ordinary hourly rates. Under the Award, a full-time employee will generally be entitled to be paid overtime for all authorised overtime worked outside of their rostered ordinary hours. However, casual and part-time employees can work outside of rostered hours (indeed a casual does not even need to be provided with a roster) subject to such hours not exceeding certain specified daily and weekly or fortnightly limits.[167]

465. *Thirdly*, it does not appear that the work would, at least for casual and part-time employees be overtime. It would just be paid at overtime rates. There is no reference to the employee being required to work "overtime" at home in a manner equivalent to the approach adopted in clause 28.4(a). Consequently, such employees would not only have the benefit of a higher rate of pay; their employer would also generally be required to take such payments into account when making superannuation contributions. There would also arguably be a need to accrue relevant NES entitlements (at least for employees other than casuals) by reference to such payments. There is no apparent justification for such outcomes.

466. If the Commission is to vary Awards to specify that work undertaken at home and after leaving a client or employer's premises is payable, it should only attract the rates that would ordinarily be applicable (depending on the circumstances this might be the ordinary rates, overtime rates or penalty rates). We note that this is broadly the approach taken in the Joint Employer Proposal.

The Proposed One Hour Minimum Payment

467. The proposed clause requires that on each occasion that an employee is required to work, they will receive a minimum payment of one hour at overtime rates. This does not account for the possibility (or indeed likelihood) that some

[167] Clause 28.1(b)(iii) of the Award.

of the activities contemplated by the clause may only be undertaken for a very short duration. No submission has been advanced as to why a one hour minimum payment is justified.

468. The paucity of evidentiary material before the Commission in relation to this claim does not render it feasible for the Full Bench to make any firm assessment of the level of disruption or the disutility associated with performing such activities. Nor does it enable a proper consideration of the cost impact of the claim to be made.

469. In such circumstances, the Commission should not impose any requirement for a minimum payment. A case for such a provision has not been made out.

470. In the alternate, we contend that the Commission should not impose such a significant minimum payment as is suggested by the HSU. The need for a cautious approach in this regard is reinforced by the risk that such costs will not be able to be recovered given the NDIS's funding constraints. If a minimum payment is to be applied (contrary to our submissions) it should be no longer than the 15 minutes that is proposed to apply in some instances under the Joint Employer Proposal.

Multiple Separate Instances of Work

471. A further difficulty is that it appears that on each occasion an employee is required to perform work in the circumstances contemplated by the HSU, they may be eligible for a one hour minimum payment. Accordingly, in circumstances where an employee may, on multiple occasions, undertake several short instances of work at their home, each for a short duration, they may become entitled to several hours of pay at overtime rates, even if this is entirely disproportionate to the activities undertaken. For example, an employee who receives several short separate phone calls after leaving work at a client or employer's premises would be eligible to several hours of pay at overtime rates, even if the total time spent undertaking such calls was less than one hour. Such an approach is unreasonable.

472. In contrast to the HSU's proposal, the Joint Employer Proposal attempts to address circumstances of employees undertaking multiple separate instances of work by ensuring that only one minimum payment should be payable where the cumulative amount of time spent performing the relevant activities does not exceed the applicable minimum amount payable:

> (C) Where an employee undertakes multiple separate instances of remote response duties during a particular period referred to in clause 20.10(b), and the total time spent performing such duties does not exceed 15 minutes, only one minimum payment is payable.

473. If the Commission were to vary the Award to include a clause dealing with work undertaken at an employee's home, after they have left the client or employer's premises, it should include a comparable provision to clause (C) in the corresponding Joint Employer Proposal.

Verifying that the Work was Undertaken

474. Another difficulty with the union's proposal is that an employer subject to the clause will, at least in some instances, have no ability to supervise the relevant activities or indeed verify either that they were undertaken or, importantly, when such work is undertaken. The second point is of more significance should the Commission accept that such work should not always be payable at overtime rates, as the rate of remuneration payable may consequently vary depending upon the time at which the work is undertaken.

475. Ai Group notes that the Joint Employer Proposal seeks to address this through proposed subclauses (f), (g) and (h), which are cast in the following terms:

> (f) Subject to clause 20.10(g), an employee who performs remote response duties must maintain and provide to their employer a time sheet specifying the time at which they commenced and concluded performing any remote response duty and a description of the work that was undertaken. This record must be provided to the employer prior to the end of the next full pay period or in accordance with any other arrangement as agreed between the employer and the employee.
>
> (g) An employer may implement an alternate method or system for the recording and notification of the details referred to in clause 20.10(f).

(h) An employer is not required to pay an employee for any time spent performing remote duties if the employee does not comply with the requirements of clause 20.10(f) or any alternate method or system pursuant implemented under clause 20.10(g).

476. Should the Full Bench decide to amend the Award to include a provision dealing with work undertaken either at home or remotely, comparable provisions to the above extracted elements of the Joint Employer Proposal should be included.

Section 138 and the Modern Awards Objective

477. The HSU has not so much as attempted to justify why the proposed provision is *necessary* or sought to deal with the various elements of s.134(1) of the Act.

478. In our submission:

(a) The proposed clause is *unfair* to employers[168] in various ways, for the reasons set out in our submissions above.

(b) There is no material that might establish that the proposed provision would enhance or improve the relative living standards and needs of the low paid[169]. Further, the HSU does not appear to contend as much.

(c) The need to encourage collective bargaining[170] does not lend support to the grant of the claim.

(d) There is no material that might establish that the proposed provision would promote social inclusion through increased workforce participation[171].

[168] Section 134(1) of the Act.
[169] Section 134(1)(a) of the Act.
[170] Section 134(1)(b) of the Act.
[171] Section 134(1)(c) of the Act.

(e) The proposed clause is inconsistent with the need to promote flexible modern work practices and the efficient and productive performance of work.[172]

(f) The principle of equal remuneration for work of equal or comparable value[173] is not a relevant consideration in this matter.

(g) The proposed clause would likely have a negative impact on business.[174] In particular it would impose significant new employment costs absent any ability to recover such costs through the NDIS' funding arrangements.

(h) The need to ensure a stable and sustainable modern awards system[175] tells against the grant of the claim.

[172] Section 134(1)(d) of the Act.
[173] Section 134(1)(e) of the Act.
[174] Section 134(1)(f) of the Act.
[175] Section 134(1)(g) of the Act.

12. SLEEPOVERS

479. The HSU seeks that employees be provided with additional amenities when undertaking sleepovers. The claim would result in the following variations to clause 25.7(c):

> **(c)** The span for a sleepover will be a continuous period of eight hours. Employees will be provided with:
>
> **(i)** a separate and securely lockable room with a peephole or similar in the door, ~~with~~ a bed and a telephone connection in the room; and,
>
> **(ii)** suitable sleeping requirements such as a lamp and clean linen; and
>
> **(iii)** use of appropriate facilities (including staff facilities where these exist); and
>
> **(iv)** free board and lodging for each night when the employee sleeps over.

480. The only HSU submission in support of the proposal is as follows:

> 73. The clause should be amended to ensure appropriate facilities are provided when employees are required to perform a sleepover shift. Such shifts are compensated modestly.[176]

481. Notwithstanding the characterisation of the Award as only "modestly" compensating employees for sleepovers, no party seeks to fundamentally alter the current provisions dealing with payment for sleepovers.

482. On any reasonable assessment, the union has failed to mount a case warranting such a variation. The union does not assert that the variation is necessary to achieve the modern awards objective or indeed otherwise refer to the relevant considerations identified in s.134. At an even more fundamental level, no meaningful reasoning for the variation is contained in the union's submission. We are left to speculate as to the why the HSU contends that the additional amenities would be "appropriate".

[176] HSU Submission dated 15 February 2019 at paragraph 73.

483. The HSU's submission does not identify an evidentiary basis for the variation. Moreover, it does not identify any evidence establishing any significant deficiency with the operation the current award provisions in practice.

484. Despite the paucity of material in support of the claim, it appears to us that it seeks, at least in part, to inappropriately deal with safety issues through an extremely simplistic mechanism. Employer obligations relating to the management of the safety of their employees at work is comprehensively dealt with under specialised laws dealing with workplace health and safety obligations for employers. It is not desirable or necessary, in the sense contemplated by s.138, for the award system to regulate such matters in a piecemeal manner.

485. The evidentiary material advanced by the union does not establish that the kind of amenities specified in clause 25.7(c) are actually warranted in the context of all circumstances in which a sleepover occurs. In reality, they are not. To take an obvious example, there is no apparent necessity for the separate room utilised for the sleepover arrangement to be locked or to contain a peephole if the client that is being assisted is not able to independently mobilise and the entrance to the property is otherwise secure. We do not here suggest that the kinds of amenities contemplated by the proposal would never have relevance, but it would be heavy handed and unrealistic to assert that that such amenities be provided in all instances in which a sleepover occurs.

486. Similarly, the need for each room to contain a phone connection is also unrealistic. Depending on the particular circumstances, it might be sufficient that a client has access to a centrally located landline phone or to a mobile phone.

487. Compliance with the proposed variation to clause 25.7(c) would also be problematic from a practical perspective. The provision assumes a level of control over particular premises that does not accord with the practical realities of the industry. An employer will not always own the premises at which a

sleepover occurs. For example, the premises may be an individual client's residence, or it may be a rented facility. In such circumstances an employer will not always have the capacity or legal right to make the kind of physical modifications proposed.

488. We also note that the references to "*suitable sleeping requirements such as a lamp and clean linen*" is imprecise. The provision does not provide for an exhaustive list of items or conditions that might be said to constitute suitable sleeping requirements or any indication as to the basis upon which the requirements might be regarded as "suitable". The inclusion of such wording would be fertile ground for disputation and, at the very least, inconsistent with the need to ensure a simple and easy to understand modern award system.[177]

489. To the extent that the proposed variation seeks to impose new and potentially expensive obligations upon employers, it is axiomatic that a consideration of s.134(1)(f) (the likely impact of any exercise of modern award powers on business) would weigh against granting the claim.

490. Further, the inclusion of terms establishing these new obligations would be beyond power. Section 136 of the Act limits the kinds of terms that can be included within a modern award. It provides, in effect, that a modern award must only include terms that are permitted or required by certain provisions of the Act. Ai Group cannot identify any provision of the Act that would permit a modern award to include provisions of the nature proposed. They do not appear to be about any of the matters specified in s.139 and it has not been established that the provision satisfies the requirements for inclusion in the Award under s.142. On its face, the inclusion of the proposed clause in a modern award would be contrary to s.136.

[177] Section 134(1)(g) of the Act.

13. UNIFORMS

491. United Voice is seeking the insertion of a new clause 20.2(b), as set out below:

20.2 Clothing and equipment

(a) Employees required by the employer to wear uniforms will be supplied with an adequate number of uniforms appropriate to the occupation free of cost to employees. Such items are to remain the property of the employer and be laundered and maintained by the employer free of cost to the employee.

(b) An adequate number of uniforms should allow an employee to work their agreed hours of work in a clean uniform without having to launder work uniforms more than once a week.

(~~b~~c) Instead of the provision of such uniforms, the employer may, by agreement with the employee, pay such employee a uniform allowance at the rate of $1.23 per shift or part thereof on duty or $6.24 per week, whichever is the lesser amount. Where such employee's uniforms are not laundered by or at the expense of the employer, the employee will be paid a laundry allowance of $0.32 per shift or part thereof on duty or $1.49 per week, whichever is the lesser amount.

(~~c~~d) The uniform allowance, but not the laundry allowance, will be paid during all absences on paid leave, except absences on long service leave and absence on personal/carer's leave beyond 21 days. Where, prior to the taking of leave, an employee was paid a uniform allowance other than at the weekly rate, the rate to be paid during absence on leave will be the average of the allowance paid during the four weeks immediately preceding the taking of leave.

(~~d~~e) Where an employer requires an employee to wear rubber gloves, special clothing or where safety equipment is required for the work performed by an employee, the employer must reimburse the employee for the cost of purchasing such special clothing or safety equipment, except where such clothing or equipment is provided by the employer.

492. Currently, the Award requires that an employer must provide "an adequate number of uniforms appropriate to the occupation" of the employee where the employer requires the employee to wear a uniform. The Award does not purport to prescribe what the "adequate number of uniforms" will be. Rather, what is adequate will depend on the relevant circumstances.

493. United Voice seeks the insertion of a new clause that describes or defines what constitutes "an adequate number of uniforms".

494. Ai Group opposes the claim and submits that the proposed changes should not be made.

United Voice's Claim

495. United Voice's claim appears to rest on the following propositions:

(a) Employees are "often" not provided with an "adequate" number of uniforms.

(b) Many of the employees covered by the Award carry out work which can easily result in uniforms becoming stained or dirty quickly.

(c) The burden of ensuring they have a clean uniform for work falls on individual employees.

(d) Having to wash uniforms several times a week can be onerous.

496. The only witness evidence called by the union in support of its claim is that of Belinda Sinclair.[178] Ms Sinclair gives evidence that she was provided with two uniforms upon the commencement of her employment; however, after raising the issue with her employer, she was provided with an additional three uniforms.[179]

497. Quite clearly, the factual propositions relied upon by the union, as listed at paragraphs (a) – (d) above, are not made out by its evidentiary case. Specifically:

(a) At its highest, the union has called evidence from just one employee who perceived that at the commencement of her employment, she was not provided with an adequate number of uniforms. The evidence does not establish that employees are "often" not provided with an adequate number of uniforms, as asserted by United Voice.

[178] Statement of Belinda Sinclair dated 16 January 2019.

[179] Statement of Belinda Sinclair dated 16 January 2019 at paragraphs 18 – 21

(b) The union's evidence does not deal with, let alone establish, that "many" employees covered by the Award carry out work which can easily result in uniforms becoming stained or dirty quickly.

(c) On its face, it is clear from the terms of the Award that the "burden" of ensuring that employees have clean uniforms does not fall squarely on employees. Clause 20.2(a) of the Award contemplates that an employer covered by the Award will maintain and launder an employee's uniform, without cost to the employee. It is only where this does not occur that the employee is responsible for laundering their own uniform and they are entitled to the allowance prescribed by the current clause 20.2(b). The union's evidence does not establish the extent to which employees in fact launder their own uniforms because their employers do not do so.

(d) There is no evidence before the Commission that establishes that laundering uniforms "several times a week can be onerous". We note firstly that the assertion proceeds on the assumption that employees covered by the Award launder their uniforms "several times a week"; a proposition that has not been made out. Further, the union's case does not appear to take into account:

(i) The extent to which employees do their laundry more than once a week in the ordinary course and therefore, laundering their uniforms during the week does not create any additional burden or inconvenience.

(ii) The extent to which the working hours and/or personal circumstances of employees in the industry facilitates their ability to undertake any necessary laundry more than once a week; for example, because they do not work full-time. We note that the Unions have consistently observed for the purposes of these proceedings that casual and part-time employment prevail in this industry.

498. There is, as such, no justification for creating an Award-derived obligation on an employer for providing uniforms by refence to the benchmark proposed by United Voice (i.e. that employees not be required to launder their uniforms more than once a week).

499. The evidence relied upon by United Voice falls far short of being probative and does not advance its case. Further, the union has not advanced any meritorious arguments which might otherwise, on their face, lend support to their claim.

Section 138 and the Modern Awards Objective

500. There is no evidence or material before the Commission that might justify the proposition that the clause proposed by United Voice is *necessary* to ensure that the Award achieves the modern awards objective.

501. We note also that the variation proposed by United Voice is out of step with the modern awards system. To the extent that awards deal with the issue of uniforms, overwhelmingly (if not consistently) they do not prescribe the *number* of uniforms to be provided to employees. Furthermore, we note that other awards in the health and aged care sectors, take a similar approach to that currently adopted in the Award.[180] The number of uniforms to be provided is, appropriately in our submission, left to be determined by reference to the relevant circumstances; including the nature of the work undertaken by the employee. United Voice has not provided any rationale for why different approach should be adopted by the Commission in this matter.

502. Also relevant to the question of whether the proposed clause is necessary in the relevant sense is the current obligation on an employer to provide an *adequate* number of uniforms. To the extent that an employee considers that they have not been provided with an adequate number of uniforms, the Award's dispute settlement procedure provides a readily accessible avenue

[180] See for example clause 15.2 of the *Aged Care Award 2010*, clause 18.3 of the *Health Professionals and Support Services Award 2010*, clause 16.2 of the *Nurses Award 2010* and clause 15.3 of the *Aboriginal Community Controlled Health Services Award 2010*.

to deal with such issues. Notwithstanding the availability of this mechanism, United Voice has not pointed to any disputes that have arisen in relation to the question of the adequacy of the number of uniforms provided by employers covered by the Award. Rather, the evidence demonstrates that employers and employees are able to discuss and resolve the matter within the workplace.

A *Fair* Minimum Safety Net

503. The proposed clause is unfair to employers.

504. The provision requires the payment of an allowance where an employee is required to launder their own uniform. Such an allowance compensates an employee for the cost and/or inconvenience associated with laundering their uniform. If an employer is required to provide employees with additional uniforms such that they need only launder their uniforms once a week, the justification for the payment of the allowance (and/or the quantum of the allowance) is potentially called into question.

505. It is unfair that employers are required to provide their employees with additional uniforms on the basis that they should not be required to launder them more than once a week *and* pay the laundry allowance currently prescribed by clause 20.2(b).

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

506. There is no evidence dealing with the impact of the claim on the relative living standards and needs of the low paid.

507. In the circumstances, contrary to United Voice's submission, we consider that s.134(1)(a) does not advance the union's case. The Commission cannot properly conclude that the relative living standards and needs of the low paid will be enhanced or improved if the claim is granted.

Section 134(1)(b) – The need to encourage collective bargaining

508. The grant of the claim may have an adverse impact on the need to encourage collective bargaining.

509. The union's pursuit of the claim here advanced demonstrates that the issue is one of importance to the union and by extension, it is one that may motivate it to engage in collective bargaining. Any such motivation would necessarily be extinguished by the grant of the claim.

510. Further, a further improvement to the minimum floor and the imposition of additional employment costs may disincentivise employers from engaging in collective bargaining.

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

511. There is no evidence that might enable the Commission to conclude that the grant of the claim will improve social inclusion through increased workforce participation.

512. In the circumstances, we consider that s.134(1)(c) does not advance the union's case.

Section 134(1)(d) – The need to promote flexible modern work practices and the efficient and productive performance of work

513. This is a neutral consideration in this matter.

Section 134(1)(da) - The need to provide additional remuneration for employees working overtime; unsocial, irregular or unpredictable hours; on weekends or public holidays or shifts.

514. This is a neutral consideration in this matter.

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

515. This consideration is not relevant to the matter.

Section 134(1)(f) – The impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden

516. It is axiomatic that the grant of the claim would increase employment costs. The claim, if granted, would therefore have an adverse impact on business.

517. Further, as we have previously submitted, significant portions of the industry covered by the Award are dependent on NDIS funding to cover their employment costs. The NDIS does not provide funding for the additional employment costs contemplated by the proposed clause. The impact on business is compounded in these circumstances. Employers are unable to recover the additional costs from participants in the scheme because of the pricing caps imposed by the NDIS, nor does the NDIS provide specific funding for employee uniforms.

Section 134(1)(g) - The need to ensure a simple, easy to understand, stable and sustainable modern award system

518. The clause is not simple and easy to understand. The interaction between the proposed clause 20.2(b) and an employer's obligation to launder and maintain the uniforms at clause 20.2(a) is not clear. There is, however, no apparent no justification for the application of clause 20.2(b) where an employer launders the employees' uniforms.

519. Finally, the need to ensure a stable system tells against the grant of the claim; particularly given that the claim lacks any proper foundation.

14. DAMAGED CLOTHING ALLOWANCE

520. The HSU is seeking the insertion of a new clause 20.3, which is in the following terms:

> **20.3 Damaged clothing allowance**
>
> **(i)** Where an employee, in the course of their employment suffers any damage to or soiling of clothing or other personal effects (excluding hosiery), upon provision of proof of the damage, employees shall be compensated at the reasonable replacement value of the damaged or soiled item of clothing.
>
> **(ii)** This clause will not apply where the damage or soiling is caused by the negligence of the employee.

521. The proposed clause would entitle an employee to compensation "at the reasonable replacement value" of any damaged or soiled clothing or personal effects if they are so damaged or soiled during the course of their employment by virtue of any cause other than the negligence of the employee.

522. Ai Group opposes the claim and submits that the proposed variation to the Award should not be made.

The HSU's Case

523. The HSU has made only the following submission in support of its case: (footnotes omitted)

> 61. Clause 20.2 of the Award provides for payment of an allowance for uniforms and their laundering. The reality of work in the industry, particularly for home carers and disability support workers, is that employees are not provided with uniforms, but wear their own clothes to work, which are at risk of being soiled or damaged in the course of their duties.
>
> 62. The award should include a damaged clothing allowance, which takes into account that employees' clothing will frequently become damaged, soiled or worn given the nature of the work they do. Where such damage occurs, upon provision of proof of the damage, employees should be compensated at the reasonable replacement value of the damaged or soiled item of clothing.[181]

[181] HSU submission dated 15 February 2019 at paragraphs 61 – 62.

524. The HSU also seeks to rely on the following evidence:

(a) The evidence of Pamela Wilcock (a community care worker) that her role involves cleaning duties in a client's home, which can include using cleaning agents that "can" damage clothing however her employer providers protective clothing and gloves.[182] She also states that her role also includes cleaning bodily fluids and urine.[183]

(b) The evidence of Heather Waddell (a community care worker) that clothing can be spoiled by bodily fluids cleaning agents.[184] She also gives evidence that her employer provide single use aprons and goggles for employees to use, however she chooses not to because to do so would require her to travel to her employer's office, which "is usually in the opposite direction of [her] clients".[185]

525. The case advanced by the union falls well short of providing a proper basis for the proposed clause, for the reasons explained below.

Section 138 and the Modern Awards Objective

526. There is no evidence or material that might justify the proposition that the clause proposed by the HSU is *necessary* to ensure that the Award achieves the modern awards objective.

527. Further, the HSU's claim is unfair to employers in various ways:

(a) The proposed clause would appear to apply even where an employee such as Ms Waddell elects not to use equipment, clothing or protective effects provided by an employer for the very purpose of ensuring that an employee's clothing and personal effects are protected from damage and/or soiling. This is clearly unfair and unjustifiable.

[182] Statement of Pamela Wilcock dated 15 February 2019 at paragraph 13.
[183] Statement of Pamela Wilcock dated 15 February 2019 at paragraph 14.
[184] Statement of Heather Waddell dated 15 February 2019 at paragraph 33.
[185] Statement of Heather Waddell dated 15 February 2019 at paragraph 34.

(b) The proposed clause requires reimbursement "at the reasonable replacement value". Whilst not abundantly clear, the provision appears intended to entitle an employee to replace the value of clothing or personal effects that they have elected to wear during the course of their employment, irrespective of their value. Accordingly, the proposed clause appears to create an Award-derived obligation to reimburse an employee for potentially pricey items, even though they were not essential for the purposes of enabling the employee to undertake their work (e.g. designer brand glasses). This is clearly unfair.

(c) The scope of the clause is broad. It applies wherever there is *any* damage or soiling, even if the extent of the damage or soiling does not necessitate or warrant the replacement of the clothing or other item (for example, because it can be cleaned or replaced). This is unfair and unjustifiable.

(d) The proposed clause does not require an employee to provide proof of the "reasonable replacement value" or absolve an employer from their liability to reimburse an employee where such proof is not forthcoming. This is also unfair.

528. These matters of themselves provide a basis for dismissing the HSU's claim.

529. The HSU's submissions do not address s.138 or s.134(1) of the FW Act. We nonetheless make the following additional observations about various factors listed under s.134(1):

(a) Section 134(1)(a): there is no evidence dealing with the impact of the claim on the relative living standards and needs of the low paid. In the circumstances, we consider that s.134(1)(a) does not advance the union's case. The Commission cannot properly conclude that the relative living standards and needs of the low paid will be enhanced or improved if the claim is granted.

(b) Section 134(1)(b): the grant of the claim may have an adverse impact on the need to encourage collective bargaining.

(c) Section 134(1)(c): there is no evidence that might enable the Commission to conclude that the grant of the claim will improve social inclusion through increased workforce participation. In the circumstances, we consider that s.134(1)(c) does not advance the union's case.

(d) Section 134(1)(d): this is a neutral consideration.

(e) Section 134(1)(da): this is a neutral consideration.

(f) Section 134(1)(e): the principle of equal remuneration for work of equal or comparable value is not relevant to this matter.

(g) Section 134(1)(f): it is axiomatic that the grant of the claim will increase employment costs. It will also increase the regulatory burden imposed on employers in order to deal with and process requests for reimbursement made by their employees. The claim, if granted, would therefore have an adverse impact on business. Such an impact is compounded in the case of NDIS-funded services, because the funding does not contemplate the proposed entitlement.

(h) Section 134(1)(g): the need to ensure a stable system tells against the grant of the claim. Further, the proposed clause is not simple and easy to understand. The meaning of "reasonable replacement value" – a central element of the proposed clause – is unclear.

530. There is no proper foundation for the HSU's claim. Ai Group submits that it should be dismissed.

15. TELEPHONE ALLOWANCE

531. Clause 20.6 of the Award provides as follows:

> **20.6 Telephone allowance**
>
> Where the employer requires an employee to install and/or maintain a telephone for the purpose of being on call, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts.

532. The HSU has proposed that the above clause be replaced with the following:

> **20.6 Telephone allowance**
>
> Where an employer requires an employee to use a mobile phone for any work related purpose, the employer will either:
>
> **(a)** provide a mobile phone fit for purpose and cover the cost of any subsequent charges; or
>
> **(b)** refund the cost of purchase and usage charges on production of receipts.

533. The proposed clause would apply wherever an employer requires an employee to use a mobile phone for any work related purpose. It would require the employer to provide the employee with a mobile phone and cover the cost of any usage charges (whether incurred for work purposes of otherwise) or reimburse the employee for the same.

534. United Voice has proposed the following amendments to clause 20.6 of the Award:

> **20.6 Telephone allowance**
>
> Where the employer requires an employee to install and/or maintain a telephone <u>or mobile phone</u> for the purpose of being on call, <u>for the performance of work duties or to access work related information,</u> the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts.

535. The variations proposed seek to extend the application of clause 20.6 to circumstances in which:

(a) An employer requires an employee to "install and/or maintain … a mobile phone".

(b) An employer requires an employee to install and/or maintain a telephone for the performance of work duties or access work related information.

(c) An employer requires an employee to install and/or maintain a mobile phone for the performance of work duties or access work related information.

536. While the variations proposed are not in the same terms, their essence is similar.

537. Ai Group opposes the variations proposed and submits that they should not be made.

The Union's Cases

538. The HSU has made only the following submissions in support of their claim: (footnotes omitted, our emphasis)

> 59. The current telephone allowance clause – as worded in both the exposure draft and current award – is outdated. The language of the clause refers to a landline telephone. The Commission would safely conclude that the vast bulk of employees now have mobile phones and that they are available to them during the course of their work.
>
> 60. Employers frequently require or expect care workers to be contactable by mobile phone when performing their duties. Employees commonly need to use smart phones to check their rosters, make notes on clients, take photographs, log onto company apps or portals, call ambulances or supervisors in emergencies, as well as answer calls about their availability for shifts, often at the last minute. Any employees required to use a phone for work in this way should receive a telephone allowance which reflects the cost of maintaining and using such mobile phone. Employees required to use a smart phone

should be reimbursed for the cost of purchasing one if such purchase is necessary.[186]

539. United Voice advances its case on the following bases:

(a) Employees covered by the Award are required to use mobile phones in the course of their duties and they have, in effect, become tools of trade.

(b) The Award is out of date to the extent that it does not contemplate mobile phone usage.

Section 138 and the Modern Awards Objective

540. The material before the Commission does not establish that the clause proposed by the HSU or United Voice is *necessary* to ensure that the Award achieves the modern awards objective.

A *Fair* Safety Net

541. The HSU's claim is unfair to employers, for the reasons that follow.

542. *First*, the grant of the HSU's claim would see employers liable for "any subsequent charges" or "usage charges" incurred by an employee. It is plainly unfair that an employer be required to pay for costs incurred by an employee for usage unrelated to work. The proposed clause does not create an Award-derived limitation on the purpose for which the mobile phone may be used, nor does it absolve employers from the liability for paying for such expenses.

543. *Second,* the HSU's proposed subclause (b) would entitle an employee to the reimbursement of expenses incurred through acquiring a phone and usage, even where those costs are excessive or unnecessary. For example, the clause would entitle an employee to reimbursement even if the employee selected a phone plan with inclusions that are not necessary for the purposes of fulfilling the employee's duties.

[186] HSU submission dated 15 February 2019 at paragraphs 59 – 60.

544. *Third*, the proposed clause would afford employees a windfall gain where they are employed by more than one employer covered by the Award; a situation which, on the unions' material, is apparently not uncommon.

545. *Fourth,* the clause does not account for circumstances in which an employee already possesses a mobile phone which is adequate for the purposes of an employee's duties. The clause applies to any employee who is required to use a mobile phone and essentially delivers to them an entitlement to an additional mobile phone and/or reimbursement for the purchase and usage of such a mobile phone, even if they already have one.

546. The unions have not presented any material that establishes the proportion of employees covered by the Award who are required by their employer to use a mobile phone for the purposes of their employment and of those, the percentage who do or do not own a mobile phone that is fit for purpose. Of the evidence called by the unions, only one of the witnesses claims that they did not own a smartphone as required by their employer.[187]

547. Indeed the evidence before the Commission rather suggests that most employees either own a mobile phone[188] or that they are provided with a device by their employer[189].

548. Further, a report published by Deloitte in 2018[190], which sets out the results of a survey of a nationally representative sample of over 2,000 Australian consumers aged 18–75, found that 89% of those surveyed owned a smartphone. Another 11% owned a standard mobile phone.[191] The survey

[187] Statement of Deon Fleming dated 16 January 2019 at paragraph 27.

[188] Statement of Belinda Sinclair at 16 January 2019 at paragraphs 15 – 17, statement of Trish Stewart dated 17 January 2019 at paragraphs 20 – 22, statement of William Elrick dated 15 February 2019 at paragraph 30 and statement of Bernie Lobert dated 15 February 2019 at paragraph 20.

[189] Statement of Robert Sheehy dated 15 February 2019 at paragraphs 12 – 13, statement of Pamela Wilcock dated 15 February 2019 at paragraph 19, statement of Heather Waddell dated 15 February 2019 at paragraph 31 and statement of Thelma Thames dated 15 February 2019 at paragraph 22.

[190] Deloitte, *Behaviour Unlimited, Mobile Consumer Survey 2018, The Australian cut* (2018).

[191] Deloitte, *Behaviour Unlimited, Mobile Consumer Survey 2018, The Australian cut* (2018) at page 6.

results appear to suggest that the entire survey population owned a mobile phone of some description.

549. In this context, the unions' proposed variations are plainly unjustifiable and unfair.

550. The variation proposed by United Voice is unclear. It appears to grant employees an entitlement to "installation costs and the subsequent rental charges" in relation to mobile phone usage notwithstanding that the concepts of installation and rent are generally not relevant to mobile phone usage. In any event, assuming that the proposed variations are intended to deliver a similar outcome to the HSU's claim; the submissions we have made above regarding the HSU's claim are apposite.

551. In our submission, these matters of fairness of themselves provide a basis for dismissing the HSU and United Voice's claims.

A *Relevant* Safety Net

552. We also note that the variations proposed by the unions are out of step with the way in which the modern awards system typically deals with the matter of telephones, including mobile telephones.

553. The vast majority of awards do not make any provision for telephones. Of those that do, most appear to contemplate only landline telephones, as per the current clause 20.6 of the Award.[192] Other award provisions either deal expressly with mobile phones or are drafted such that they appear to apply, implicitly, to mobile phone usage. In each case, they include various important parameters that do not appear in the union's proposals.

[192] See for example clause 19.6 of the *Air Pilots Award 2010*, clause C.1.10 of the *Aircraft Cabin Crew Award 2010*, clause 18.5 of the *Broadcasting and Recorded Entertainment Award 2010*, clause 18.11 of the *Health Professionals and Support Services Award 2010*, clause 16.5 of the *Medical Practitioners Award 2010*, clause 31.2 of the *Plumbing and Fire Sprinklers Award 2010* and clause 15.2 of the *Rail Industry Award 2010*.

554. For example:

(a) The *Commercial Sales Award 2010*[193], *Contract Call Centres Award 2010*[194], and *Telecommunications Services Award 2010*[195] entitle an employee to reimbursement for the reasonable cost of purchasing a phone *only where the employee does not already have a telephone*.

(b) The aforementioned awards entitle an employee to reimbursement for the *reasonable cost* of purchasing a mobile phone; not to *all* costs incurred by purchasing a mobile phone.

(c) The *Real Estate Industry Award 2010* requires the payment of only *reasonable reimbursement*, as agreed between the employee and employer.[196]

(d) The *Stevedoring Industry Award 2010* provides for the payment of a set weekly allowance, as prescribed by the award.[197]

555. The approach proposed by the HSU and United Voice is inconsistent with that adopted in the aforementioned awards and lacks any of the limitations found in the relevant provisions. The unions have failed to point to any justification for this.

<u>Sections 134(1)(a) – (g) of the FW Act</u>

556. We also make the following additional observations about various factors listed under s.134(1):

(a) Section 134(1)(a): there is no evidence dealing with the impact of the claim on the relative living standards and needs of the low paid. In the circumstances, we consider that s.134(1)(a) does not advance the

[193] Clause 16.1(a).
[194] Clause 20.3(a).
[195] Clause 17.1(c)(i).
[196] Clause 18.6.
[197] Clause 14.5.

union's case. The Commission cannot properly conclude that the relative living standards and needs of the low paid will be enhanced or improved if the claim is granted.

(b) Section 134(1)(b): the grant of the claim may have an adverse impact on the need to encourage collective bargaining.

(c) Section 134(1)(c): there is no evidence that might enable the Commission to conclude that the grant of the claim will improve social inclusion through increased workforce participation. In the circumstances, we consider that s.134(1)(c) does not advance the union's case.

(d) Section 134(1)(d): the imposition of additional employment costs and the accompanying regulatory burden will not promote flexible modern work practices and the efficient and productive performance of work to the extent that it deters employers from using mobile technology. This issue is particularly important in light of the observations made in the McKinsey Report about the importance of employers under the NDIS funding arrangements implementing and leveraging technological systems and solutions.[198] In particular:

> While there is no single model of care that will work for all providers and participants, and acknowledging the substantial investment providers have already made in transforming their organisations, the significant variation in cost to serve across the market indicates there are opportunities to innovate and lessons to be learned from operating models that are working well in standard intensity attendant care. Providers will generally need to achieve corporate overheads of 10-15% and improve workforce utilisation rates to above 90% to make a profit while complying with SCHADS award obligations. To do this, most existing providers will be required to adjust their operating models, driving efficiencies and innovation through technology and other operational improvements.[199]

(e) Section 134(1)(da): this is a neutral consideration.

[198] See for example, McKinsey Report at pages 20, 27 and 28.

[199] McKinsey Report at page 71.

(f) Section 134(1)(e): the principle of equal remuneration for work of equal or comparable value is not relevant to this matter.

(g) Section 134(1)(f): it is axiomatic that the grant of the claim will increase employment costs. The effect on business resulting from these employment costs would be exacerbated by the various elements of the proposals discussed above; including the broad application of the clause and the absence of any limitation on an employer's liability to pay costs arising from an employee's usage.

The proposed clauses would also increase the regulatory burden imposed on employers in order to deal with and process requests for reimbursement made by their employees and/or providing employees with all-expenses-paid mobile phones.

The claim, if granted, would therefore have an adverse impact on business. Such an impact is compounded in the case of NDIS-funded services, because the funding does not contemplate the proposed entitlement.

(h) Section 134(1)(g): the need to ensure a stable system tells against the grant of the claim. Further, the clause proposed by United Voice is not simply and easy to understand. The clause requires the payment of "installation costs and the subsequent rental charges" where an employee is required to maintain a mobile phone. Mobile phones do not incur installation costs and generally do not involve rental charges. Accordingly, the application of the clause is unclear.

557. A proper foundation of the provisions proposed by the unions has not been made out. Ai Group submits that the claims should not be granted. The issue of mobile phones is more appropriately dealt with at the enterprise level where employees are in fact required to use mobile phones; having regard to the purpose for which they are required to use mobile phones and the extent to which the employer's employees already own appropriate mobile phones. The

one-size-fits-all approach proposed by the unions is not appropriate for the reasons set out above.

ANNEXURE A

NDIS Price Guide 2019-20

Valid from: 1 July 2019

Delivered by the National Disability Insurance Agency

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Version Control

The NDIS Price Guide is subject to change. The latest version of the NDIS Price Guide is available on the NDIS website.

Version	Page.	Details of Amendment	Date
1.0			25 June 2019
1.1	p. 7	• Text added to clarify the link between the Price Guide and the Support Catalogue	28 June 2019
	p. 12	• Text added to clarify that non-registered providers are not eligible for the TTP.	
	p. 13-15	• Text added to better distinguish between Core travel and Capacity Building travel • Added 4 examples of the application of the travel rules	
	p. 16	• Text added to clarify that "no shows" are treated as short notice cancellations. • Added an example of the application of the cancellation rules;	
	p. 27	• Price limits in the Support Catalogue for group based supports have been substantially revised. • Text added to clarify that providers of group-based supports are not permitted to bill for non-face-to-face services as the hourly price limits for these supports include an allowance for non-face-to-face services.	
	p. 36	• Further text added on Employment Related Assessment and Counselling supports.	
	p. 36	• Further text added on Workplace Assistance supports.	

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Contents

Scope of the NDIS Price Guide

Where possible, the National Disability Insurance Agency (NDIA) utilises market mechanisms to deliver the level of supply required by the he National Disability Insurance Scheme (NDIS) to meet participant demand and deliver the correct mix of goods/services, produced at market clearing (efficient) prices. However, in underdeveloped or non-existent markets, reliance on a deregulated market mechanism may not meet participant demands; may not deliver adequate supply; may not deliver the correct mix of disability supports and may not produce efficient prices. To address these issues, the NDIA has a role, as market steward, to create an efficient and sustainable marketplace through a diverse and competitive range of suppliers who are able to meet the needs of a consumer driven market.

As part of its market stewardship role, the NDIA imposes price controls on some supports by limiting the prices that registered providers can charge for those supports and by specifying the circumstances in which registered providers can charge participants for supports. Price controls are in place to ensure that participants receive value for money in the supports that they receive. In the short to medium term, price controls are required for some disability supports because the markets for disability goods and services is not yet fully developed. The longer-term goal of the NDIA is to remove regulatory mechanisms from the markets for disability supports.

This Price Guide is a summary of NDIS price limits and the associated pricing arrangements that will apply from 1 July 2019 as set by the NDIA. It is designed to assist participants and disability support providers, both current and prospective, to understand the way that price controls for supports and services work in the NDIS. The price limits within this Price Guide are the maximum prices that Registered Providers can charge NDIS participants for specific supports. There is no requirement for providers to charge at the maximum price for a given support or service. Participants and providers are free to negotiate lower prices.

Currently, the NDIA varies its approach to the regulation of prices, depending on market conditions, between:

- **No regulation** (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.
- **The imposition of price limits**: these represent a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for attendant care.
- **Quotable supports**: in which participants are expected to obtain quotations from suppliers to provide to the NDIA, which will verify that the prices are fair and reasonable. This approach is typically used in the case of highly specialised, differentiated supports that may not have a high level of competition – for example, assistive technology. They are also used in cases, such as supported independent living, where a bundle of supports is being purchased.

This Price Guide is principally concerned with the rules that apply to NDIS supports that are subject to price limits.

A comprehensive list of all NDIS supports ("the Support Catalogue") is at https://www.ndis.gov.au/providers/price-guides-and-information.

The Support Catalogue:

- **includes item descriptors to assist providers to claim payments using a "best-fit" approach, and to assist participants in engaging and negotiating with service providers; and**
- **lists the price limits of those support items that are subject to price limits.**

In general, support items subject to price controls have a single national price limit. However, some Capacity Building supports have two price limits: one for New South Wales, Victoria, Queensland and the Australian Capital Territory; and a different price limit for South Australia, Western Australia, Tasmania and the Northern Territory.

The NDIA publishes separate price guides for:

- Assistive Technology at https://www.ndis.gov.au/providers/essentials-providers-working-ndia/providing-assistive-technologies-and-home-modifications
- Specialist Disability Accommodation at https://www.ndis.gov.au/providers/essentials-providers-working-ndia/specialist-disability-accommodation

Application of this Price Guide

The price limits and other arrangements in this Guide must be followed when supports are delivered to NDIS participants who have either an agency-managed plan or a plan manager.

A provider of supports to a participant with an agency-managed plan (or of a support that is agency managed):

- must be a registered provider with the NDIS;
- must declare relevant prices to participants before delivering a service, including any notice periods or cancellation terms;
- must adhere to the arrangements in the Price Guide, including ensuring that their prices do not exceed the price limits prescribed in the Pricing Guide

Plan managers can purchase supports on behalf of participants from either registered or unregistered providers, but they are registered providers themselves, and therefore responsible for ensuring that prices paid for supports on behalf of their participants adhere to the arrangements in the Price Guide, including price limits.

Self-managing participants can use registered or unregistered providers and are not subject to the pricing arrangements in the Price Guide.

In addition, all registered providers, regardless of whether funding for the support is managed by the participant, by a registered provider, or by the NDIA, must not add any other charge to the cost of the supports they provide, including credit card surcharges, or any additional fees including any 'gap' fees, late payment fees or cancellation fees.

Support Purposes, Categories and Line Items

This section describes the way that the NDIS categorises disability supports. These categories can be relevant to rules for participants about how they can spend their support budgets, and for providers when seeking payment for delivered supports.

Support Purpose Types

NDIS participant budgets can be allocated to three separate types of support purpose:

1. CORE – Supports that enable participants to complete activities of daily living. Participant budgets often have a lot of flexibility to choose specific supports with their core support budgets, but cannot reallocate this funding for other support purposes (i.e. capital or capacity building supports).
2. CAPITAL – Investments, such as assistive technologies - equipment, home or vehicle modifications, or for Specialist Disability Accommodation (SDA). Participant budgets for this support purpose are restricted to specific items identified in the participant's plan.
3. CAPACITY BUILDING - Supports that enable a participant to build their independence and skills.

Support Categories aligned to the NDIS Outcomes Framework

Participant budgets are allocated at a support category level and must be used to achieve the goals set out in the participant's plan.

Support categories are aligned with the NDIS Outcomes Framework, which has been developed to measure goal attainment for individual participants and overall performance of the Scheme. There are eight outcome domains in the Framework, which help participants think about goals in different areas of their life and assist planners explore where supports in these areas already exist and where further supports are required. These domains are:

1. Daily Living	5. Work
2. Home	6. Social and Community Participation
3. Health and Wellbeing	7. Relationships
4. Lifelong Learning	8. Choice and Control

NDIS service providers should be aware that all supports and services for NDIS participants must contribute to the achievement of their individual goals as outlined in the participant's plan. Support purpose categories are designed to align with the Outcomes Framework and the 15 support categories (listed below). This helps participants choose supports that help them achieve their goals, and providers to understand how the supports they provide contribute to the participant's goals. The following table shows the links between support purpose types, domains in the Outcomes Framework and support categories.

SUPPORT PURPOSE	OUTCOME DOMAINS in FRAMEWORK	SUPPORT CATEGORY
CORE	Daily Living Daily Living Daily Living Social & Community Participation	Assistance with Daily Life Transport Consumables Assistance with Social & Community Participation
CAPITAL	Daily Living Home	Assistive Technology Home Modifications and Specialised Disability Accommodation (SDA)
CAPACITY BUILDING	Choice & Control Home Social and Community Participation Work Relationships Health & Wellbeing Lifelong Learning Choice and Control Daily Living	Support Coordination Improved Living Arrangements Increased Social and Community Participation Finding and Keeping a Job Improved Relationships Improved Health and Wellbeing Improved Learning Improved Life Choices Improved Daily Living Skills

Support items

Each support category has many specific supports and services that are recognised in the NDIS payment system. These are referred to as 'support items' and are, in most cases, not prescribed in participant plans.

Providers should claim payments against a support item that most closely aligns to the service they have delivered.

Each support item has a unique reference number, according to the following structure:

For example:

01_013_0107_1_1 - Assistance with Self-Care Activities - Standard - Saturday

Support Category	Sequence Number	Registration Group	Outcome Domain	Support Purpose
01	013	0107	1	1

Units of Measure

The NDIS payment system includes units of measure to suit each support item as follows:

• Each	• Hour	• Daily
• Week	• Month	• Annual

Claiming supports and services

Registered Providers can make a claim for payment for a support once that support has been delivered or provided. Where price limits apply, prices charged to participants must not exceed the price limit prescribed for that support in this Guide. Providers cannot add any other charges to the cost of the support, including credit card surcharges, or any additional fees including any 'gap' fees, late payment fees or cancellation fees unless otherwise stated in this Price Guide.

When claiming, it is the responsibility of the provider to ensure that the claim accurately reflects the supports delivered, including the frequency and volume of supports. Falsifying claims for any aspect of supports delivered is a serious compliance issue and may result in action against the provider. Providers are also required to keep accurate records of claims, which are subject to audit at any time.

Providers should claim payments against a support item that most closely aligns to the service they have delivered.

Service Agreements

A Service Agreement is a formal agreement between a participant and provider. They help to ensure there is a shared understanding of:

- expectations of what supports will be delivered and how they will be delivered; and
- the respective responsibilities and obligations of the provider and the participant and how to resolve any problems that may arise.

Service Bookings

Service bookings are used to set aside funding for an NDIS registered provider for a support or service they will deliver. Each service booking sets out the specific supports or support domains agreed to be provided and the length of time that agreement is applicable within the current participant plan dates. Service bookings are not the same as 'service agreements', which set out the terms and conditions negotiated with the participant.

The Agency recommends that service bookings should be created at the category level, where possible. This allows providers and participants to negotiate or access supports on a more flexible basis, especially for on-the-spot assessments or less predictable support needs. This is preferable to having to edit existing service bookings or create another service booking for that item at a later date or have funds locked into a support item that may not eventuate, which restricts funding for alternate services.

See the 'NDIS Myplace Provider Portal Step-by-step guide' on the Provider Toolkit for further information.

Special NDIS Pricing Arrangements

Regional, Remote and Very Remote Areas

The NDIA uses the Modified Monash Model (MMM) to determine regional, remote and very remote areas using a scale based on population size and locality (see Table below).

	Zones	MMM	Inclusion
Metropolitan	MMM 1-3	1	All areas categorised as Major Cities of Australia.
		2	Areas categorised as Inner Regional Australia or Outer Regional Australia that are in, or within 20km road distance, of a town with population >50,000.
		3	Areas categorised as Inner Regional Australia or Outer Regional Australia that are not in MM 2 and are in, or within 15km road distance, of a town with population between 15,000 and 50,000.
Regional	MMM 4-5	4	Areas categorised as Inner Regional Australia or Outer Regional Australia that are not in MM 2 or MM 3, and are in, or within 10km road distance, of a town with population between 5,000 and 15,000.
		5	All other areas in Inner Regional Australia or Outer Regional Australia.
Remote	MMM 6	6	All areas categorised Remote Australia that are not on a populated island that is separated from the mainland and is more than 5km offshore.
Very Remote	MMM 7	7	All other areas – that being Very Remote Australia and areas on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.

Further details on the MMM can be found on the Department of Health's DoctorConnect website, which contains a resource to look up the MMM area for particular locations[1].

Participants located in MMM4 and MMM5 areas are classified as 'Regional', MMM6 as 'Remote', and MMM7 as 'Very Remote'. In general, price limits are 40% higher in remote areas and 50% higher in very remote areas. There is no additional loading applied for supports in regional areas.

Providers should refer to support price limits based on where the support is delivered, which is not necessarily where the participant lives. For example, if a participant living in a Remote location visits a therapist in their capital city, the therapist should not attempt to claim a price that is higher than the price limit for the support in that city. On the other hand, if the therapist was to visit the participant in their local area to deliver the support, then the therapist could claim a price that is within the limit set by the 'Remote' Price Guide.

If local providers are not available, the NDIA may enter into arrangements (and at times contracts) with specific providers for provision of services to more remote regions. The contract with a service provider will specify the cost of travel and any other associated expenses in these areas.

Temporary Transformation Payment (TTP)

Providers of attendant care and community participation supports who meet the eligibility criteria set out below will have access to a higher price limit through a Temporary

[1] www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

Transformation Payment (TTP). This conditional loading will assist providers to continue transforming their businesses in the move towards a more competitive marketplace. This replaces the Temporary Support for Overheads.

In order to access the higher TTP price limits, providers will have to:

- publish their service prices;
- list their business contact details in the Provider Finder and ensure those details are kept up-to-date; and
- participate annually in an Agency-approved market benchmarking survey.

TTP Providers will have to until 31 December 2019 to meet these requirements, and to include in their contractual arrangements with their participants that they are entitled to use the TTP support items (and price limits) because they are compliant with the TTP terms.

That is, in the first year, providers can commence making claims using the TTP items from 1 July 2019, and will have until 31 December 2019 to meet the three compliance requirements. In later years, providers will need to be compliant by the start of the financial year, noting that the Benchmarking Requirement is met up until 31 December of any year by the provider's intention to take part in the next Benchmarking Survey, and after that date by actual participation in the most recent Benchmarking Survey.

Providers who become non-compliant during a financial year should not claim for TTP items while they are non-compliant.

Every support item in scope of the TTP has two support items and two price limits. The non-TTP items should be used by providers who are not compliant with the TTP conditions. The TTP items should be used by providers who are compliant with the TTP conditions, an example is given in the following Table.

01_011_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Daytime
01_011_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Daytime - TTP

There will be no formal registration process for TTP providers. Providers indicate that they intend to fulfil the TTP conditions by making a claim for a TTP support item through the payment system. They will be required to acknowledge compliance to the Price Guide terms, including the TTP terms if applicable, when submitting a payment request through the Myplace Provider Portal. By claiming TTP items through the NDIA payment system, or from a plan manager, providers are warranting that they have complied with the TTP conditions, or intend to comply with the TTP conditions by the relevant time.

Plan managers will not be responsible for ensuring providers are TTP compliant. They can accept the claim for a TTP support item by a registered provider as proof of TTP compliance. However, non-registered providers are not eligible for the TTP and plan managers should not use TTP line items to claim for services delivered by non-registered providers.

Claims for the new TTP support items can be made against existing service bookings that were made at the support category level.

Billing for non-direct services

Provider Travel

Providers can only claim travel costs from a participant in respect of the delivery of a support item if:

- the Support Catalogue indicates that providers can claim for Provider Travel in respect of that support item;
- the provider has the agreement of the participant in advance (i.e. the service agreement between the participant and provider should specify the travel costs that can be claimed); and
- the provider is required to pay the worker delivering the support for the time they spent travelling as a result of the agreement under which the worker is employed; or the provider is a sole trader and is travelling from their usual place of work to or from the participant, or between participants.

Where a provider claims for travel time in respect of a support then the maximum amount of travel time that they can claim for the time spent travelling to each participant (for each eligible worker) is 30 minutes in MMM1-3 areas and 60 minutes in MMM4-5 areas. (Note the relevant MMM classification is the classification of the area where the support is delivered.)

In addition to the above travel, capacity-building providers who are permitted to claim for provider travel can also claim for the time spent travelling from the last participant to their usual place of work. The maximum amount of travel time that they can claim for the time spent on return travel (for each eligible worker) is 30 minutes in MMM1-3 areas and 60 minutes in MMM4-5 areas. (Note the relevant MMM classification is the classification of the area where the support is delivered.)

Where a worker is travelling to provide services to more than one participant in a ‘region’ then the provider can apportion that travel time (including the return journey where applicable) between the participants, with the agreement of each participant in advance.

Claims for travel in respect of a support must be made separately to the claim for the primary support (the support for which the travel is necessary) using the same line item as the primary support and the “Provider Travel” option in the Myplace portal. When claiming for travel in respect of a support, a provider should use the same hourly rate as they have agreed with the participant for the primary support (or a lower hourly rate for the travel if that is what they have agreed with the participant) in calculating the claimable travel cost.

Remote and very remote travel

In remote areas, capacity-building providers may enter specific arrangements with participants to cover travel costs, up to the relevant hourly rate for the support item. Providers should assist participants to minimise the travel costs that they need to pay (e.g. co-ordinating appointments with other participants in an area, so that travel costs can be shared between participants).

Example 1 – Core support – Single Participant – MMM 1-3
(In this example, the support is 01_301_0104_1_1, which has a price limit of $58.31 per hour)

A Provider travels for 25 minutes to a participant who is located in zone 3 of the Modified Monash Model. They provide two hours of support to the participant They then spend 25 minutes returning to their usual place of business.

The provider and participant have agreed an hourly rate of $50.00, which is below the price limit for this item. They have also agreed that the provider can claim for travel time.

The provider is entitled to apply the 30 minute time-cap against the 25 minutes of travel to the participant. They are not entitled to claim for the time spent travelling back to their usual place of business, even though some of that time is could fit within the 30 minute time-cap. In total, 25 minutes of travel can be claimed.

The provider's claim for this support is in two parts, which should be shown separately on their invoice to the participant and claimed for separately in the system.

- $100.00 for the two hours of support
- $20.83 for the 25 minutes travel to the participant.
  $\left(\frac{25}{60}\right) \times \$50\ agreed\ price = \$20.83\ travel\ claim$

Example 2 – Capacity building support – Multiple Participants – MMM 1-3
(In this example, the support is 15_056_0128_1_3, which has a price limit of $193.99 per hour)

A Provider travels for 35 minutes to a participant who is located in zone 3 of the Modified Monash Model. They provide two hours of support to the participant They then spend 25 minutes returning to their usual place of business.

The provider and participant have agreed an hourly rate of $190.00. They have also agreed that the provider can charge for their travel time.

The provider is entitled to apply the 30 minute time-cap against the 35 minutes of travel to the participant. They are also entitled to claim for the time spent travelling back to their usual place of business by applying the 30 minute time-cap against the 25 minutes of return travel. In total, 55 minutes of travel can be claimed.

The provider's claim for these supports is in two parts, which should be shown separately on their invoice to the participant and claimed for separately in the system.

- $380.00 for the two hours of support
- $174.17 for the 55 minutes travel to the participant.
  $\left(\frac{55}{60}\right) \times \$190\ agreed\ price = \$174.17\ travel\ claim$

Example 3 – Core support – Multiple Participants – MMM 4-5
(In this example, the support is 01_301_0104_1_1, which has a price limit of $58.31 per hour)

A Provider travels for 65 minutes to Participant A who is located in zone 4 of the Modified Monash Model. They then provide two hours of the support to participant A. The provider then travels 25 minutes to Participant B, who is also located in zone 4. They deliver one hour of support to participant B. They then spend 45 minutes returning to their usual place of business.

The provider and participants have agreed an hourly rate of $50.00. They have also agreed that the provider can charge for their travel time and that the provider can apportion the costs of the travel between the participants.

The provider is entitled to apply the 2x60 minute time-cap against the 65 minutes of travel to participant A and the 25 minutes of travel to participant B. They are not entitled to claim for the time spent travelling back to their usual place of business, even though some of that time is could fit under the 2x60 minute time-cap. In total, 90 minutes of travel can be claimed.

The provider's claim for these supports is in two parts for each participant, which should be shown separately on their invoice to the participant and claimed for separately in the system.

Participant A
- $100.00 for the two hours of support to the participant
- $37.50 for the 45 minutes travel to and between participants

Participant B
- $50.00 for the two hours of support to the participant
- $37.50 for the 45 minutes travel to and between participants

Example 4 – Core support – Multiple Participants – MMM 1-3 - Participants do not agree to share travel costs.
(In this example, the support is 01_301_0104_1_1, which has a price limit of $58.31 per hour)

A Provider travels for 35 minutes to Participant A who is located in zone 3 of the Modified Monash Model. They then provide two hours of the support to participant A. The provider then travels 10 minutes to Participant B who is also located in zone 3. They deliver one hour of support to participant B. They then spend 25 minutes returning to their usual place of business.

The provider and participants have agreed an hourly rate of $50.00. They have also agreed that the provider can charge for their travel time. They have not agreed that the provider can apportion the costs of the travel between the participants.

The provider is entitled to apply the 30 minute time-cap against the 35 minutes of travel to participant A. They are also entitled to apply the 30 minute time-cap against the 10 minutes of travel to participant B. They are not entitled to claim for the time spent travelling back to their usual place of business, even though some of that time is could fit under the 30 minute time-cap. In total, 40 minutes of travel can be claimed.

The provider's claim for these supports is in two parts for each participant, which should be shown separately on their invoice to the participant and claimed for separately in the system.

Participant A
- $100.00 for the two hours of support to the participant
- $25.00 for the 30 minutes travel to the participant

Participant B
- $50.00 for the two hours of support to the participant
- $8.33 for the 10 minutes travel to the participant

Participant transport as part of a community participation support

Providing community participation supports may, at the request of a participant, involve a worker accompanying a participant on a community outing and/or transporting a participant from their home to the community. In these situations, the worker's time can be claimed at the agreed hourly rate for the relevant support item for the total time the worker provides support to one or more participants, including time spent accompanying and/or transporting the participant. Where a provider is transporting two or more participants on the same trip, the worker's time should be claimed at the appropriate group rate for the relevant support.

This claim should be made using the relevant community participation support item and against the participant's core budget. In essence, the participant transport is a part of the community participation activity and should be billed accordingly.

Contribution towards costs of transport itself

If a provider incurs costs, in addition to the cost of a worker's time, when accompanying and/or transporting participants in the community (such as cost of ticket for public transport, road tolls, parking fees and the running costs of the vehicle), they may negotiate with the participant for them to make a reasonable contribution towards these costs.

A participant's support budget may include funding for transport, and this funding can be used for these types of contributions, which should be clearly specified in the service agreement. If the participant's support budget does not include funding for transport, then these costs should not be met from the participant's plan, but can be charged as an out of pocket expense to the participant.

Cancellations

Where a provider has a short notice cancellation (or no show) they are able to recover 90% of the fee associated with the activity, subject to the terms of the service agreement with the participant. Providers are only permitted to charge for a short notice cancellation (or no show) if they have not found alternative billable work for the relevant worker and are required to pay the worker for the time that would have been spent providing the support.

A cancellation is a short notice cancellation if the participant:

- does not show up for a scheduled support within a reasonable time, or is not present at the agreed place and within a reasonable time when the provider is travelling to deliver the support; or
- has given less than two (2) clear business days' notice for a support that meets both of the following conditions:
    - the support is less than 8 hours continuous duration; AND
    - the agreed total price for the support is less than $1000; or
- has given less than five (5) clear business days' notice for any other support.

Claims for a short notice cancellation should made using the same support item as would have been used if the support had been delivered, using the "Cancellation" option in the

Myplace portal. When making a claim for a cancelled support the provider should claim for the full agreed price of the support and indicate in the payment system that the claim is for a cancellation. The payment system will reduce the claim to 90% of the full agreed price.

Example 5
(In this example, the support is 01_301_0104_1_1, which has a price limit of $58.31 per hour)

A one hour support is scheduled for 10 am on a Tuesday following a Public Holiday Monday.

The provider and participant have agreed an hourly rate of $50.00 and have agreed that the provider can charge for short notice cancellations and no shows.

The participant cancels the support after 10 am on the preceding Thursday and the provider is not able to find alternative billable work for the relevant worker and is required to pay the worker for the time that would have bene spent providing the support.

The provider's claim for this support should be made at the agreed rate for the service and indicate that the support was cancelled at short notice. The system will reduce the claimed amount by 10%.

There is no limit on the number of short notice cancellations (or no shows) that a provider can claim in respect of a participant. However, providers have a duty of care to their participants and if a participant has an unusual number of cancellations then the provider should seek to understand why they are occurring.

The NDIA will monitor claims for cancellations and may contact providers who have a participant with an unusual number of cancellations.

NDIA Reporting

Providers will be expected to provide progress reports to the participant and NDIS at agreed times. A provider may charge for the time taken to write a therapy report (including functional assessment) that is requested by the NDIA, and claim this against the appointment at the hourly rate for the relevant support item. A report requested by the NDIA is considered a report that is required at the commencement of a plan which outlines plan objectives and goals, and at plan review which measures functional outcomes against the originally stipulated goals. Providers are also expected to make recommendations for ongoing identified needs (informal/community/mainstream and/or funded supports). Providers may charge for any other NDIA-requested therapy report that is stipulated as being required in a participant's plan.

Claims for a NDIS requested reports are made using the relevant support item, using the "NDIA Report" option in the Myplace portal.

Non-Face-to-Face Supports

Non face to face activities are billable if:

- the activities are part of delivering a specific disability support item to that participant (rather than a general activity such as enrolment, administration or staff rostering); and

- the provider explains the activities to the participant, including why they represent the best use of the participant's funds (i.e. explains the value of these activities to the participant); and
- the proposed charges for the activities comply with the NDIS Price Guide, and
- the participant agrees to pay for the activities (preferably in a service agreement).

For example, the Assistance with Self Care support items are described as covering activities "Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible". Therefore, time spent on non-face to face activities that assist the participant - for example, writing reports for co-workers and other providers about the client's progress with skill development – could be charged against this support item. The costs of training and upskilling staff, and of supervision, are also included in the base price limits for supports and are not considered to be billable non-face-to-face supports. However, research undertaken by a capacity building provider specifically linked to the needs of a participant and to the achievement of the participant's goals may be billable as a non-face-to-face support with the participant's prior agreement.

Service agreements with each client can 'pre-authorise' these activities, but providers should only charge a participant for delivering a support item if they have completed activities that are part of the support for that participant. Charging a fee that is not linked to completed activities would not be appropriate.

Time spent on administration, such as the processing of NDIS payment claims for all clients, is outside the description of the support item and should not be claimed from a participant's budget as a non-face-to-face support. The NDIS price limits include an allowance for overheads, so that providers can fully recover the efficient costs, including the costs of administration tasks. Examples of administrative activities that are covered by the overhead component of the primary support price limits and that should not be billed as non-face-to-face supports include:

- Pre-engagement visits
- Developing and agreeing Service Agreements
- Entering or amending participant details into system
- Making participant service time changes
- Staff / participant travel monitoring and adjustment
- Ongoing NDIS plan monitoring
- Completing the Quoting tool
- Making service bookings and payment claims

In working out the cost of non-face-to-face supports it is not appropriate to charge all participants an average additional fee. The additional fee must be worked out in each case and related specifically to the non-face-to-face services delivered to the particular participant. This is not to say that the same additional fee might end up being charged to a number of participants, but it must be worked out separately.

Claims for a non-face-to-face supports are made using the relevant support item, using the "Non-face-to-face" option in the Myplace portal.

Other Payment Considerations

This section outlines various other considerations that may be relevant to participants and providers. These should be reviewed when entering into a new Service Agreement or if there is a significant change in the participant's circumstances.

Medicare and insurance

Some elements of a participant's care may be covered by funds outside the NDIS. These expenses are commonly medical, including those covered by private health insurance or Medicare. These medical expenses are not funded under the NDIS, even if they are related to, or a symptom of the disability. These expenses should be claimed under the relevant health care scheme or insurance policy. Some providers (e.g. therapists) may need to distinguish between the health services and disability supports that they provide to a single client, and make separate payment claims (e.g. claim payments from Medicare for health services, and the NDIS for disability supports).

Prepayments

Registered Providers can make a claim for payment once a service booking has been created and the support has been delivered or provided. Prepayment is not permitted unless the NDIA has given prior approval in writing to the Registered Provider. This will only occur in exceptional circumstances such as for certain assistive technologies, home modifications and remote area servicing where this has been agreed to by the participant.

Co-Payments for Capital items, including assistive technology

Co-Payments by the participant are not required; however, where the participant would like a customisation to a support or assistive technology that is not considered reasonable or necessary, they are required to pay for this themselves. These may include an aesthetic customisation to an assistive technology or modifications to a vehicle that are additional to the assistive components.

Goods and Services Tax (GST)

Most items are GST-Free, as per Australian Tax Office information about GST and NDIS and the application of section 38-38 of the GST Act.[2] For a small number of items where GST is applicable (for example, delivery fees and building materials), the price limit is inclusive of GST.

Other fees (Commissions and exit fees)

Participants are generally not required to pay exit fees, even when changing provider's part way through a plan. A core principle of the NDIS is choice and control for participants, allowing them to change providers without expense. Further information on establishment fees claimable by the incoming provider can be found below under *Establishment fee for personal care/community access*.

[2] http://www8.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/antsasta1999402/s38.38.html

Core – Assistance with Daily Life (includes Supported Independent Living)

This support category relates to assisting with and/or supervising personal tasks of daily life to enable the participant to live as autonomously as possible. These supports are provided individually to participants and can be provided in a range of environments, including but not limited to, the participant's own home.

Daily Personal Activities, including High Intensity Daily Personal Activities

A hierarchy of price limits applies to this group of supports, based on:

A) the time of day that the support is delivered;

B) the day of week that the support is delivered;

C) whether the support is Standard Intensity or High Intensity;

D) if the support is High Intensity then whether it is a Level 1 (Standard), Level 2 (High Intensity) or Level 3 (Very High Intensity) support; and

E) whether the provider is eligible for the Temporary Transformation Payment.

Time of day

In determining which price limit is applicable to a support, providers should note that a support is considered to be:

- a Daytime Support is it is delivered between 6 am and 8 pm;
- an Evening Support if it is delivered after 8 pm and before 12 midnight; and
- an Overnight Support is it is delivered between 12 midnight and 6 am.

Day of week

In determining which price limit is applicable to a support, providers should note:

- a weekday is Monday to Friday;
- the extra rates paid for Saturday, Sunday and Public holidays are in substitution for, and not cumulative upon, the shift premiums payable for evening and overnight supports; and
- the extra rates for Saturday/Sunday/Public holidays do not increase further when the support finishes after 8pm.

High intensity supports

A support is considered a high intensity support if the participant requires assistance from a support worker with additional qualifications and experience relevant to the participant's complex needs. The high intensity price limits may be considered when:

- frequent (at least 1 instance per shift) assistance is required to manage challenging behaviours that require intensive positive behaviour support; and/or
- continual active support is required due to high medical support needs (such as unstable seizure activity or respiratory support)

In determining which price limit for High Intensity Supports should apply to a given support, the provider should consider the skills and experience of the worker delivering the support. In general, the Level 2 price limit applies to most high intensity supports. However, if the particular instance of support is delivered by a worker who does not have the skills and experience to deliver a high intensity support then the Level 1 price limit should be applied. If the particular instance of the support is delivered by a more highly skilled or experienced worker then the provider can consider applying the Level 3 price cap, with the participant's prior agreement.

Other matters

Provisions for 'shadow shifts'

Shadow shifts may be considered where the participant has complex individual support needs that are best met by introducing a new worker to the participant before it is reasonable that they commence providing the support independently. These are considered where the specific individual support needs include:

- Very limited communication;
- Behaviour support needs; and/or
- Medical needs/procedures such as ventilation or Home Enteral Nutrition (HEN).

Where the individual would require shadow shifts to assist with the introduction of new workers, and this is the desired method by the participant or their family, the provider may claim for up to 6 hours of weekday support per year.

Introducing new workers is not designed to replace formal, recognised training that will be provided by an employer to their workforce, such as Shadowing (or "Buddying") less experienced staff or new staff with experienced workers or informal carers to help build knowledge and social capital (worker retention), which is not claimable under the NDIS.

Establishment fee for personal care/community access

This fee applies to all new NDIS participants in their first plan where they receive at least 20 hours of personal care/community access support per month. This payment is to cover non-ongoing costs for providers establishing arrangements and assisting participants in implementing their plan.

An establishment fee is claimable by the provider who assists the participant with the implementation of their NDIS Plan, delivers a minimum of 20 hours per month of personal care/community access support and has made an agreement with the participant to supply these services.

A budget of $750 is included in the first plan for NDIS participants, in case they need this type of assistance from providers to design and implement support arrangements. Providers can draw against this budget as follows:

- If the participant is new to the NDIS and new to the provider, then the provider can charge a maximum of $500 against the participant's plan;
- If the participant is new to the NDIS but is an existing client of the provider, then the provider can charge a maximum of $250 against the participant's plan; and
- If the participant is choosing to change providers, then the new provider can charge a maximum of $250 against the participant's plan to assist the participant in changing providers.

Assistance with household tasks

These support items enable participants to maintain their home environment. This may involve undertaking essential household tasks that the participant is not able to undertake.

Preparation and delivery of meals

This support item is for the preparation and delivery of food to participants who are unable to do this themselves, and are not in receipt of other supports that would meet the same need. The cost of the food itself is not covered by the NDIS. The cost of this support will vary based on the number of meals prepared and the deliveries required.

Assistance in Shared Living Arrangements – Supported Independent Living

Supported Independent Living (SIL) is the assistance with and/or supervising tasks of daily life in a shared living environment, with a focus on developing the skills of each individual to live as autonomously as possible. The support is provided to each person living in the shared arrangement in accordance with their need.

SIL does not include rent, board and lodging or other day to day usual living expenses such as food and activities. It also does not include the capital costs associated with a participant's accommodation.

SIL does not have fixed price limits, and providers can quote for the specific SIL service that they offer to each participant. To assist providers with quoting, the NDIA has developed a Provider SIL Pack[3]. The Provider SIL Pack contains templates that assist providers in developing an individualised quote. The purpose of this quote is to identify:

- The individual supports that will be available for the person, focussed on maximising the person's capacity to be as independent as possible with household decision making, personal care and domestic tasks,

[3] https://www.ndis.gov.au/providers/essentials-providers-working-ndia/supported-independent-living

- The typical roster of supports that is shared between participants to maximise the efficient use of resources, and
- What supports are available to all residents to ensure the smooth operation and running of the household.

Once a quote is received, the NDIA uses a 'SIL Tool' to analyse provider quotes and to make sure that they represent value for money. In some cases, negotiation between the NDIA and providers will be necessary to agree appropriate prices for SIL.

For those providers who wish to continue to use the previous version of the quoting templates they may do so as these will continue to be accepted by the Agency.

Short Term Accommodation and Assistance

From time to time, participants may require temporary supports that are different from their usual arrangements. These are non-typical days and may include short stays in a group-based facility (short term accommodation), or the purchase of additional in-home support.

For the purposes of this Price Guide, the 'short term accommodation' price limit includes all expenses in a 24 hour period including assistance with daily personal activities, accommodation, food and negotiated activities. Typically, this type of support would be used for short periods of up to 14 days at a time. For longer term arrangements, other options are likely to be more appropriate (e.g. Supported Independent Living).

In cases where a participant will receive substantially less than 24 hours of assistance with daily personal activities, it may be appropriate for the participant and provider to negotiate a lower price than the maximum price specified in this Guide, based on the actual support provided. This situation might arise, for example, if a participant enters a short term accommodation facility in the evening, and exits again early the following morning. Also, where a participant enters accommodation late in the day, it may be appropriate to claim the daily rate for the day of the week that the majority of the support is provided. In each case, support arrangements, including price, should be **agreed with participants in advance**.

Short term accommodation price limits vary according to the support needs of the participant and the day of the week the support is provided. Providers claiming at the rates for high intensity (i.e. ratio of 1 support worker for 2 participants) or 1:1 support must deliver assistance with daily personal activities at those support ratios for the duration of the participant's stay.

Core - Transport

Transport enables participants to access disability supports outside their home, and to pay for transport that helps them to achieve the goals in their plan. Transport supports generally do not have price limits; however, participants should use the least expensive transport that meets their needs. Transport funding is paid fortnightly in advance to self-managed participants. Funding transport assistance is limited to those who cannot use public transport due to their disability. If the participant has questions about their transport support, providers may direct them to the NDIS factsheet available on the NDIS Website[4].

Accompanying participants for community access

Providing community access supports may, at the request of a participant, involve a worker accompanying a participant on a community outing and/or transporting a participant from their home to the community. In these situations, the worker's time can be claimed at the agreed hourly rate for the relevant support item for the total time the worker provides support to one or more participants, including time spent accompanying and/or transporting the participant. Where a provider is transporting two or more participants on the same trip, the worker's time should be claimed at the appropriate group rate for the relevant support.

This claim should be made using the relevant community participation support item and against the participant's core budget. In essence, the participant transport is a part of the community participation activity and should be billed accordingly.

Contribution towards costs of transport itself

If a provider incurs costs, in addition to the cost of a worker's time, when accompanying and/or transporting participants in the community (such as cost of ticket for public transport, road tolls, parking fees and the running costs of the vehicle), they may negotiate with the participant for them to make a reasonable contribution towards these costs.

A participant's support budget may include funding for transport, and this funding can be used for these types of contributions, which should be clearly specified in the service agreement.

If the participant's support budget does not include funding for transport, then these costs should not be met from the participant's plan, but can be charged as an out of pocket expense to the participant.

[4] https://www.ndis.gov.au/participants/creating-your-plan/plan-budget-and-rules/transport-funding

Core - Consumables

Consumables are a support category available to assist participants with purchasing everyday use items. Supports such as Continence and Home Enteral Nutrition (HEN) products are included in this category. More information on these supports can be found in the *Assistive Technology and Consumables Code Guide* on the Assistive Technology webpage.[5]

[5] https://www.ndis.gov.au/providers/essentials-providers-working-ndia/providing-assistive-technologies-and-home-modifications

Core - Assistance with Social and Community Participation

These supports enable a participant to engage in community, social or recreational activities. They may be provided in a centre or in community settings at standard or higher intensity rates. If arranged in advance with participants, providers may charge up to four hours for each plan period to document proposed supports and expected outcomes. Price limits vary according to the support needs of the participant and the day of the week the support is provided.

Providers should not claim payment for:

- expenses related to recreational pursuits, such as event tickets for the participant, as they are not covered by the NDIS; and
- the cost of entry for a paid support worker to attend a social or recreational event.

A hierarchy of price limits also applies to this group of supports, based on:

A) the time of day that the support is delivered;

B) the day of week that the support is delivered;

C) whether the support is Standard Intensity or High Intensity;

D) if the support is High Intensity then whether it is a Level 1 (Standard), Level 2 (High Intensity) or Level 3 (Very High Intensity) support; and

E) whether the provider is eligible for the Temporary Transformation Payment.

(See the definitions and notes in the Assistance with Daily Living Support Category.)

Community and social activity costs

This support is included in a participant's plan to enable them to pursue recreational activities and engage in the community when associated with a participant's disability and goals. Participants may use this funding for activities such as camps, vacation and outside school hours' care, course or membership fees. More information can be found in the Operational Guidelines[6]

Where appropriate, funded hours in a Community Access budget may be converted to a fee and claimed by a provider for these purposes.

Group based supports

Assistance to access community, social and recreational activities is often provided in a group setting, either in the community or in a centre.

A hierarchy of price limits applies to group based supports, based on:

A) the time of day that the support is delivered;

[6] https://www.ndis.gov.au/about-us/operational-guidelines/planning-operational-guideline/planning-operational-guideline-deciding-include-supports-participants-plan

B) the day of week that the support is delivered;

C) whether the support is Standard Intensity or High Intensity (complex);

D) whether the provider is eligible for the Temporary Transformation Payment;

E) the size of the group and ratio of staff to participants; and

F) whether the support is provided in a Centre or in the community.

(See the definitions and notes in the Assistance with Daily Living Support Category.)

For support ratios that are not stated in this Guide (e.g. two workers for three participants), participants and providers should discuss and agree the most appropriate line item to be used for payments, and the appropriate price to be paid (which might be lower than the price limit for that line item).

Providers of group based supports are not permitted to bill for non-face-to-face services as the hourly price limits for these supports include an allowance for non-face-to-face services.

Capital – Assistive Technology

This support category includes all aids or equipment supports that assist participants to live independently or assist a carer to support the participant. It also includes related delivery, set-up and some training support items. Usually, providing independent advice, guidance, trials, set-up and training (not bundled with the sale of an item) is funded through a capacity building support.

More detailed information on assistive technologies and consumables codes can be found in the *Assistive Technology and Consumables Guide* on the Assistive Technology webpage[7].

Vehicle Modifications

Vehicle modifications include the installation of, or changes to, equipment in a vehicle to enable a participant to travel safely as a passenger or to drive.

A participant is free to choose a more expensive option at their own expense, where the more expensive option is not considered to be reasonable and necessary. An example of this situation would be where a vehicle modification has been approved for a participant, but the participant would like cosmetic or personalised fittings that are not related to their disability or are more expensive than others that have an equivalent function. In this situation, the NDIA will cover the reasonable and necessary component of the modification, and the participant will pay the additional cost.

[7] https://www.ndis.gov.au/providers/at/supplying-at.html

Capital – Home Modifications and Specialist Disability Accommodation

This support category includes home modifications and Specialist Disability Accommodation (SDA) supports.

Home Modifications

Home modifications include design, construction, installation of or changes to equipment or non-structural components of the building, and installation of fixtures or fittings, to enable participants to live as independently as possible or to live safely at home. All home modifications in excess of $1,500 are quotable.

A participant is free to choose a more expensive option or modification that achieves the same outcome at their own expense, where the more expensive option is not reasonable and necessary. For example, where a home modification has been approved for a participant, but the participant would like cosmetic or personalised fittings that are not reasonable and necessary, the NDIA will provide funding for the reasonable and necessary component of the modification, and the participant will pay any extra costs.

Specialist Disability Accommodation (SDA)

SDA funding is intended for participants who require a specialist dwelling that reduces their need for person-to-person supports, or improves the efficiency of the delivery of person-to-person supports. SDA funding will only be provided for participants who meet the eligibility criteria. Participants who meet the eligibility criteria will have an extreme functional impairment and/or very high support needs.

SDA does not refer to the support services, but the homes in which these are delivered. SDA may include special designs for people with very high needs or may have a location or features that make it feasible to provide complex or costly supports for independent living.

SDA payments are an adjusted contribution to the cost of capital required for the land and physical building required for SDA needs. Importantly, SDA funding is not intended to cover personal support costs, which are assessed and funded separately by the NDIS. Additionally, SDA does not cover accommodation costs where these are not linked to a person's disability or where specialist accommodation with integrated supports is not required. SDA is a separate support category and does not replace Supported Independent Living (SIL) or any other support. Participants receiving SDA could also be eligible for SIL supports in their package.

All providers who are registered with the NDIA for the Registration Group 'Specialist Disability Accommodation' will also be required to declare and ensure that the infrastructure meets the NDIA's specialist built form requirements and the relevant legislation and standards applicable to the state in which the accommodation is situated. These individual sites/locations must also be enrolled with the NDIA.

Due to the nature of the support, the identification of maximum SDA prices and the process by which providers can claim for SDA are more complex than for most other supports.

Providers should refer to the Specialist Disability Accommodation section of the NDIS website for detailed information about maximum prices that can be charged, dwelling enrolment and participant assessments[8].

SDA has two support items: Specialist Disability Accommodation and SDA person-specific adjustments.

Each SDA dwelling has a unique maximum price, based on a standard set of factors. There are also limits on the amount that providers of SDA can charge participants in addition to the SDA price, for rent and other board-like services provided. Providers should refer to the SDA section of the NDIS website for detailed guidance on maximum prices[9]. Participants are able to choose to move between SDA dwellings, as long as the SDA dwelling is commensurate with their SDA budget.

SDA person specific adjustments

In certain limited circumstances, the NDIA will continue to make SDA payments on behalf of a participant who has moved out of an enrolled SDA dwelling. Provided all conditions are met in section 6.3 of the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016*, vacancy payments may continue to be made for a period of up to 90 days if the dwelling is enrolled to house four or five residents, or up to 60 days if the dwelling is enrolled to house two or three residents[10]. Vacancy payments will not be made where a dwelling is only enrolled to house one resident. Vacancy payments will only be payable if the vacancy is available to another NDIS participant and the NDIA has been notified.

[8] https://www.ndis.gov.au/providers/essentials-providers-working-ndia/specialist-disability-accommodation
[9] https://www.ndis.gov.au/providers/price-guides-and-information/sda-pricing-and-payments
[10] https://www.legislation.gov.au/Details/F2017L00209

Capacity Building - Support Coordination

Support Coordination (if required) is included in the Capacity Building budget. This is a fixed amount for strengthening participant's abilities to coordinate and implement supports in their plans and to participate more fully in the community.

There are three items in the NDIS Price Guide that describe different layers of support coordination activity.

Level 1: Support Connection

Assistance for participants to implement their plan by strengthening the ability to connect with the broader systems of supports and understand the purpose of the funded supports and participant in the community Support Connection will assist a participant to understand their NDIS plan, connect participants with broader systems of supports, and provide assistance to connect with providers. Support Connection will assist participants to achieve effective utilisation of their NDIS plan.

Support Connection will increase a participant's capacity to maintain (or in some cases change) support relationships, resolve service delivery issues, and participate independently in NDIA processes. Support Connection includes, but not limited to:

- Understand the Plan;
- Connect with Supports and Services;
- Establish Supports;
- Coach, Refine, Reflect; and
- Report to the NDIA.

Where a participant aged 0-6 years is receiving assistance from Partners in the Community (PITC) delivering Early Childhood Early Intervention (ECEI) services, linking the family to a service provider/s (under ECEI best practice principles, a service provider operating under the key worker approach) and support through changes in circumstance will be delivered through Partner arrangements.

Where a participant aged seven (7) and over is receiving assistance from Partners in the Community (PITC) delivering Local Area Coordination (LAC) services, plan implementation and monitoring support will be delivered by a Participant's Local Area Coordinator.

Level 2: Coordination of Supports

The delivery of Coordination of Supports is to assist strengthening a participant's ability to design and then build their supports with an emphasis on linking the broader systems of support across a complex service delivery environment. Coordination of Supports is to focus on supporting participants to direct their lives, not just their services. This involves working together to understand the funding, identify what participants expect from services, and how participants want this designed. Coordination of Supports also includes coaching participants, and working with participants to develop capacity and resilience in their network.

Support coordinators are focussed on assisting participants to build and maintain a resilient network of formal and informal supports.

It is generally expected that participants will develop their capacity to implement and manage their supports and network more independently over time. Some participants however will require Coordination of Supports funding in subsequent plans to support ongoing capacity building or manage the complexity within the participants support environment and/or circumstances. This is to be identified in the plan review process. Coordination of Supports includes, but is not limited to:

- Understand the Plan;
- Connect with Supports and Services;
- Design Support Approaches;
- Establish Supports;
- Coach, Refine, Reflect;
- Targeted Support Coordination;
- Crisis: Planning, Prevention, Mitigation and Action;
- Build Capacity and Resilience; and
- Report to the NDIA.

Over time as a participant's capacity is strengthened, this support may be replaced by Support Connection or the introduction of a Local Area Coordinator (LAC) or Early Childhood Early Intervention (ECEI) Partner in subsequent plans.

Level 3: Specialist Support Coordination

Specialist Support Coordination is delivered utilising an expert or specialist approach, necessitated by specific high complex needs or high level risks in a participant's situation. Specialist Support Coordination is delivered by an appropriately qualified and experienced practitioner to meet the individual needs of the participant's circumstances such as a Psychologist, Occupational Therapist, Social Worker, or Mental Health Nurse. Specialist Support Coordination will address highly complex barriers impacting on the ability to implement their plan.

Specialist support coordination is expected to address complex barriers impacting a participant's ability to implement their plan and access appropriate supports. Specialist support coordinators assist participants to reduce complexity in their support environment, and overcome barriers to connecting with broader systems of supports as well as funded supports.

Specialist support coordinators are expected to negotiate appropriate support solutions with multiple stakeholders and seek to achieve well-coordinated plan implementation. Specialist support coordinators will assist stakeholders with resolving points of crisis for participants, assist to ensure a consistent delivery of service and access to relevant supports during crisis situations.

Specialist support coordination is generally delivered through an intensive and time limited period necessitated by the participant's immediate and significant barriers to plan

implementation. Depending on individual circumstances, a specialist support coordinator may also design a complex service plan that focusses on how all the stakeholders in a participant's life will interact to resolve barriers and promote appropriate plan implementation. Once developed, a specialist support coordinator will continue to monitor the plan, but it may be maintained by one of the participant's support workers or other care supports.

In some instances depending on the individual circumstances, a participant may have specialist support coordination as well as Coordination of Supports funded in the same plan. For instance, when immediate complex barriers have been addressed and the participant still requires more general coordination of supports for the remainder of their plan period. For others, they may have specialist support coordination in one plan, and Coordination of Supports in subsequent plans. Specialist Support Coordination includes, but is not limited to:

- Understand the Plan;
- Connect with Supports and Services;
- Design Support Approaches;
- Establish Supports;
- Coach, Refine, Reflect;
- Targeted Support Coordination;
- Crisis: Planning, Prevention, Mitigation and Action;
- Address Complex Barriers;
- Design Complex Service Plan;
- Build Capacity and Resilience; and
- Report to the NDIA.

Capacity Building and Training in Plan and Financial Management by a Support Coordinator

This reasonable and necessary support focusses on strengthening the participant's ability to undertake tasks associated with the management of their supports. This includes:

- Building financial skills
- Organisational skills
- Enhancing the participant's ability to direct their supports
- Develop self-management capabilities

Plan and Financial Capacity Building providers are expected to assist the participant to develop their skills for self-management in future plans, where this is possible. As a part of this capacity building support, providers are to assist the participant to build capacity in the overall management of the plan including engaging providers, developing service agreements, paying providers and claiming payment from the NDIA and maintain records.

Capacity Building - Improved Living Arrangements

Support is provided to guide, prompt, or undertake activities to ensure the participant obtains and/or retains appropriate accommodation. This may include assisting to apply for a rental tenancy or to undertake tenancy obligations in line with the participant's tenancy agreement.

Capacity Building - Increased Social and Community Participation

This support category involves supports for participation in skills-based learning to develop independence in accessing the community.

Skills Development and Training

These support items are price controlled. Providers of these supports can also claim for: Provider Travel; Cancellations, NDIA Report Writing and Non-Face-to-Face supports.

The group rate is based on a staff/participant ratio of 1:3. If the group size differs, providers should claim at the rate applicable for the group size. A higher staff ratio for groups may be indicated when a participant has challenging behaviour or high medical support needs, which require additional assistance from another worker and this is referred to as a higher intensity support.

Innovative Community Participation

This support item is not price controlled. It is designed to allow providers to offer new and innovative services to NDIS participants. Any standards applicable to the industry in which the provider operates would need to be met.

Community Participation Activities

These support items are not price controlled. They are designed to enable providers to claim for tuition fees, art classes, sports coaching and similar activities that build skills and independence. Camps, classes and vacation activities that have capacity building components. These may include assistance to establish volunteer arrangements in the community, mentoring, peer support or individual skill development.

All supports funded under these items need to be determined as reasonable and necessary given the participant's plan goals and could include, but are not limited to:

- Universal recreational activities: A limited number of lessons could be funded to enable a participant to try out an activity and test their capability and interest in further pursuing this activity – such as horse riding, art, dance or singing classes
- Funding to attend a "camp" or groups that build a person's relationship skills and offer a range of activities and opportunities to explore wider interests.
- Other items or adjustments such as customised tools required because of the person's disability could also be funded.

Capacity Building - Finding and Keeping a Job

Employment Related Assessment and Counselling

This support is designed to provide workplace assessment and/or counselling to assist participants successfully engage in employment. For workplace assessments - if a participant is employed and on award wages, then in most instances a work place assessment is available through the Employment Assistance Fund administered by JobAccess and is a free service to employers. For employment related counselling, this service may benefit participants who have, for example, experienced traumatic injury and need significant support (over and above a mainstream employment related service) to develop a new work pathway.

Please note that this support item falls under a different registration group, therapeutic supports, and as such a provider needs to have registration for this group to deliver this supports.

Workplace assistance

These supports provide workplace assistance that enables a participant to successfully obtain and/or retain employment in the open or supported labour market.

These supports can be applied to any working age participant (including students reaching working age) with an employment goal. This may include supports to:

- explore what work would mean for them (discovery);
- build essential foundation skills for work;
- managing complex barriers to obtaining and sustaining employment;
- specialised job customisation;
- supports to transition from an Australian Disability Enterprise (ADE) to open employment;
- develop a career plan; and
- other capacity building supports which are likely to lead to successful engagement in a Disability Employment Service (DES).

School Leaver Employment Supports (SLES)

School Leaver Employment Supports (SLES) is a support for school leavers to assist them to transition from school into employment. Some students may already be engaged with the mainstream DES Eligible School Leaver (ESL) program during Year 12 and therefore not require SLES.

These supports are designed to plan and implement a pathway to inclusive employment, focussing on capacity building for goal achievement. With appropriate supports, it is expected that the majority of SLES participants will transition to DES to undertake the job seeking, placement and post placement support phases of their pathway.

Supports will have an individualised approach, with a strong emphasis on “try and test” work experience opportunities, (generally in work places that would pay award wages). Capacity building should focus on hard and soft skill development.

Supports, more generally, should facilitate positive experiences that contribute to developing an understanding of work capability and confidence to step into employment. SLES should also help inform the level and nature of future supports needed to obtain and sustain employment.

Capacity Building - Improved Relationships

This support category is the provision of specialised assessment where the participant may have complex or unclear needs, requiring long term and/or intensive supports to address behaviours of concern.

Behaviour support requires a behaviour support plan to be developed that aims to limit the likelihood of behaviours of concern developing or increasing once identified. This plan outlines the specifically designed positive behavioural support strategies for a participant, their family and support persons that will achieve the intended outcome of eliminating or reducing behaviours of concern.

This support category includes specialist behavioural intervention support, which is an intensive support for a participant, intending to address significantly harmful or persistent behaviours of concern.

Capacity Building - Improved Health and Wellbeing

Physical Wellbeing Activities

These activities support, maintain or increase physical mobility or well-being through personal training or exercise physiology. Physical well-being activities promote and encourage improved physical capacity and health.

Dietetics

These supports provide individual advice to a participant on managing diet for health and wellbeing due to the impact of their disability.

Capacity Building - Improved Learning

This support is for provision of skills training, advice, assistance with arrangements and orientation to assist a participant moving from school to further education.

Capacity Building - Improved Life Choices

Plan Management – Financial Administration

Plan Management – Financial Administration funding applies to registered providers who undertake financial administration of a plan on behalf of a participant.

Plan Management – Financial Administration funding includes a setup fee to establish the payment arrangements with providers and a monthly processing fee. This support assists a participant by:

- Giving increased control over plan implementation and utilisation with plan financial assistance
- Managing and monitoring budgets over the course of the plan
- Managing NDIS claims and paying providers for delivered service
- Maintaining records and producing regular (at least monthly) statements showing the financial position of the plan
- Providing access to a wider range of service providers, including non-registered providers whilst remaining in line with the price limits contained within this Guide.

A Plan Management – Financial Administration provider will possess bookkeeping / accounting skills and qualifications. They will have systems in place for efficiently processing payments on behalf of a participant.

Capacity Building and Training in Plan and Financial Management by a Plan Manager

This reasonable and necessary support focusses on strengthening the participant's ability to undertake tasks associated with the management of their supports. This includes:

- Building financial skills
- Organisational skills
- Enhancing the participant's ability to direct their supports
- Develop self-management capabilities

Plan and Financial Capacity Building providers are expected to assist the participant to develop their skills for self-management in future plans, where this is possible. As a part of this capacity building support, providers are to assist the participant to build capacity in the overall management of the plan including engaging providers, developing service agreements, paying providers and claiming payment from the NDIA and maintain records.

Capacity Building - Improved Daily Living

This support category includes assessment, training, strategy development and/or therapy (including Early Childhood Intervention) supports to assist the development or increase a participant's skills and/or capacity for independence and community participation. Supports can be delivered to individuals or groups.

Therapy Supports (over 7 years)

In the NDIS, therapy supports are for participants with an established disability, where maximum medical improvement has been reached, to facilitate functional improvement. For people who access the Scheme as 'early intervention' NDIS participants, reasonable and necessary supports are likely to be a blend of medical and disability therapies, but should be predominantly disability therapy supports. Therapy in this context must be aimed at adjustment, adaption and building capacity for community participation.

For NDIS participants whose medical condition, illness or disease requires a particular treatment to maintain the functioning of a body part, or slow/prevent the deterioration, the NDIS may fund reasonable and necessary training for non-skilled personnel to undertake this intervention as part of the usual daily personal care. For participants where such treatment can only be met through skilled rather than non-skilled care, this treatment is to be funded through medical funds, not the NDIS.

Ongoing funding for therapy is subject to a detailed support plan that is designed to deliver progress or change for the participant. Providers develop this plan with the participant and it should clearly state the expected therapy outcomes and demonstrate a link to the participant's goals, objectives and aspirations.

Massage Therapy (over 7 years)

Massage, delivered directly to impact a body part or body system, is more appropriately provided by the health system and is therefore not funded by the NDIS.

Maintenance Therapy (over 7 years)

Where maintenance therapy is reasonable and necessary, it is funded as part of ongoing direct support hours (delivered by carers who are or can be trained in this if required), and is not funded as ongoing therapy.

For participants whose medical condition or disability requires a particular regime to maintain functioning of a body part, or to slow the deterioration of a medical condition or body part, the NDIS will fund reasonable and necessary training for non-qualified personnel to assist the individual as part of usual daily care.

Where a skilled therapist is involved in establishing a therapy program for a participant, funding can include the development of a plan and training for a therapy assistant, informal or funded carers, as part of usual care. Building capacity with family and carers to undertake therapy or exercises under the supervision of a skilled therapist can deliver ongoing benefit to NDIS participants.

Group Supports for Therapy

The NDIA prefers to allow participants and providers flexibility in negotiating arrangements, so there may not be price limits or support items for specific group ratios beyond what is currently in place.

For support ratios that are not stated in this Guide (such as one therapist to two participants, or one therapist to four participants), the NDIA encourages participants and providers to discuss arrangements both parties agree to, including price. Therapy delivered in a group may be claimed using the relevant therapy support item, but with lower prices than the price limit, as agreed between provider and participant. This arrangement for support ratios is intended to allow providers to offer a range of services and discuss with participants about more flexible arrangements which both parties prefer.

Early Childhood Intervention Supports (under 7 years)

Early Childhood Intervention (ECI) provides specialised support and services for infants and young children with disability and/or development delay and their families, to help their development, well-being and participation in family and community life.

The aim of ECI is to ensure that parents and other important adults in the child's life can provide young children with disability and/or developmental delay, with experiences and opportunities that help them gain and use the skills they need to participate meaningfully in their everyday lives.

Families know their child best and will continue to be involved in their child's life. Family centred ECI services understand that parents and caregivers have the most powerful influence on their child's development. ECI services partner with families to ensure that family life and family priorities and choices drive what happens in planning and intervention.

We know that children learn best in everyday situations with familiar people. ECI is about encouraging and supporting everyday learning to naturally build on opportunities for learning and development already being provided at home, childcare, preschool, playgroups and in the community such as parks and shopping.

Early intervention is much more effective if the adults who have the deepest relationships and spend the most time with the child, are skilled to provide intervention through the child's everyday activities and daily routines.

This category includes supports provided in small groups or to individual families by an ECI provider. It can also include supports provided by an allied health assistant under the supervision of a therapist and/or any other combination of ECI supports.

Eligible participants will have budgets built by Early Childhood Partners to reflect the child and family individual needs, applying the reasonable and necessary criteria as per the Early Childhood Early Intervention (ECEI) approach. Budgets will allow flexibility in service delivery by ECI providers to reflect the changing needs of the participant.

The provision of supports under ‘capacity building supports for early childhood’ are expected to deliver outcomes for the child that will enable them to participate meaningfully in everyday

life. Each child's NDIS plan will focus on functional, participation based goals and will summarise the outcomes expected from early intervention and will be reviewed at regular intervals.

These supports are price controlled. Providers of these supports can also claim for: Provider Travel; Cancellations, NDIA Report Writing and Non Face to Face supports.

Multidisciplinary Team Intervention (over 7 years)

This support item enables a coordinated multidisciplinary approach to be delivered to participants beyond the age covered by the Early Childhood Early Intervention approach. All team members will claim against a single support item, thereby increasing flexibility in service delivery to reflect the changing needs of a participant. This support item is not price controlled.

NDIS Support Catalogue 2019-20

Valid from 1 July 2019

The NDIS Price Guide is subject to change. The latest version of the NDIS Price Guide is available on the NDIS website.
(Version 1.1)

Delivered by the
National Disability
Insurance Agency

NDIA Support Catalogue

Registration Group Number	Registration Group Name	Support Category Number	Support Category Name	Support Item Number	Support Item Name	Support Item Description	Unit	Price Controlled	Quote Required	NT - SA TAS-WA (MM 1-5)	ACT - NSW QLD - VIC (MM 1-5)	National Non-Remote (MM 1-5)	National Remote (MM 6)	National Very Remote (MM 7)	Travel	Cancellations	NDIA Reporting	Non-F2F
0101	Accommodation / Tenancy Assistance	1	Assistance with daily life (includes Supported Independent Living)	01_001_0101_1_1	Transitional Support	Transition to NDIS funding – payment of rent and utility accounts. Short term payment as per participant plan.	EA	N	Y						✗	✗	✗	✗
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_002_0107_1_1	Assistance With Self-Care - Standard - Active Overnight	Assistance with, or supervision of, personal tasks of daily living where overnight support is needed and the care giver will not have the option to sleep.	H	Y	N			$59.40	$83.16	$89.10	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_002_0107_1_1_T	Assistance With Self-Care Activities - Standard - Active Overnight - TTP	Assistance with, or supervision of, personal tasks of daily living where overnight support is needed and the care giver will not have the option to sleep. Support delivered by a TTP provider.	H	Y	N			$63.85	$89.39	$95.78	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_003_0107_1_1	Assistance From Live-In Carer	A person lives in the house of, or travels with the participant and provides assistance with, and/or supervision of, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	H	N	Y						✗	✗	✗	✗
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_004_0107_1_1	Assistance With Personal Domestic Activities	Assist participant to undertake and/or develop skills to maintain their home environment where the participant owns their own home and/or has sole or substantial responsibility for its maintenance. Includes assisting participant to do basic house and yard work.	H	Y	N			$50.03	$70.04	$75.05	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_010_0107_1_1	Assistance With Self-Care - Night-Time Sleepover	Assistance with, or supervision of, personal tasks of daily living where overnight support is needed, but the care giver can sleep when not required to provide support.	EA	Y	N			$214.03	$299.64	$321.05	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_011_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Daytime	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	H	Y	N			$52.85	$73.99	$79.28	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_011_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Daytime - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Support delivered by a TTP provider.	H	Y	N			$56.81	$79.53	$85.22	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_012_0107_1_1	Assistance With Self-Care Activities - Standard - Public Holiday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	H	Y	N			$118.34	$165.68	$177.51	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_012_0107_1_1_T	Assistance With Self-Care Activities - Standard - Public Holiday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Support delivered by a TTP provider.	H	Y	N			$127.21	$178.09	$190.82	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_013_0107_1_1	Assistance With Self-Care Activities - Standard - Saturday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	H	Y	N			$72.69	$101.77	$109.04	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_013_0107_1_1_T	Assistance With Self-Care Activities - Standard - Saturday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Support delivered by a TTP provider.	H	Y	N			$78.14	$109.40	$117.21	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_014_0107_1_1	Assistance With Self-Care Activities - Standard - Sunday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	H	Y	N			$94.52	$132.33	$141.78	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_014_0107_1_1_T	Assistance With Self-Care Activities - Standard - Sunday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Support delivered by a TTP provider.	H	Y	N			$101.61	$142.25	$152.42	✓	✓	✗	✓

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0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_015_0107_1_1	Assistance With Self-Care Activities - Standard - Evening	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	H	Y	N			$58.31	$81.63	$87.47	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_015_0107_1_1_T	Assistance With Self-Care Activities - Standard - Evening - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Support delivered by a TTP provider.	H	Y	N			$62.69	$87.77	$94.04	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_016_0104_1_1	Specialised Home Based Assistance For A Child	Specialist assistance in the home required due to additional requirements of a child's disability; may be provided to strengthen the sustainability of informal supports.	H	Y	N			$50.03	$70.04	$75.05	✓	✓	✗	✓
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_017_0107_1_1	On-Call Overnight Monitoring - Off Site Or Onsite (Inc. 1 Hr Assist)	Overnight on-call assistance with, or supervision of, personal tasks of daily living.	EA	N	Y						✗	✗	✗	✗
0120	Household Tasks	1	Assistance with daily life (includes Supported Independent Living)	01_019_0120_1_1	House And/Or Yard Maintenance	Performing essential house and/or yard activities that the participant is not able to undertake.	H	Y	N			$48.28	$67.59	$72.42	✓	✓	✗	✓
0120	Household Tasks	1	Assistance with daily life (includes Supported Independent Living)	01_020_0120_1_1	House Cleaning And Other Household Activities	Performing essential house cleaning activities that the participant is not able to undertake.	H	Y	N			$49.16	$68.82	$73.74	✓	✓	✗	✓
0120	Household Tasks	1	Assistance with daily life (includes Supported Independent Living)	01_021_0120_1_1	Linen Service	Provision of clean linen to a participant unable to do their own laundry without assistance.	EA	N	Y						✗	✗	✗	✗
0120	Household Tasks	1	Assistance with daily life (includes Supported Independent Living)	01_022_0120_1_1	Assistance With The Cost Of Preparation And Delivery Of Meals	Preparation and delivery of meals to a participant who is unable to do this themselves, and is not in receipt of other supports that would meet the same need. Food costs are not included. Cost varies with the number of meals prepared and deliveries required.	EA	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_026_0115_1_1	Assistance In Living Arrangements (Host Family/Alternative Family Situation)	Agreement for a participant with high support needs to stay with a host family. The host family will have minimum qualifications & provide support in the home for the agreed time. The quote will reflect the hours of assistance required & length of stay.	D	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_027_0115_1_1	Assistance In A Shared Living Arrangement	Daily living support provided in a shared living arrangement. This rate is paid by the hour for one-to-one assistance, divided by the number of people supported.	EA	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_028_0115_1_1	Supported Independent Living - For 2 - Complex	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with complex support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_029_0115_1_1	Supported Independent Living - For 3 - Complex	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with complex support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_030_0115_1_1	Supported Independent Living - For 4 - Complex	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with complex support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗

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0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_031_0115_1_1	Supported Independent Living - For 5 - Complex	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with complex support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_032_0115_1_1	Supported Independent Living - For 6 - Complex	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with complex support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_033_0115_1_1	Supported Independent Living - For 7 - Complex	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with complex support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_034_0115_1_1	Supported Independent Living - For 2 - Standard	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with standard (or mixed) support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_035_0115_1_1	Supported Independent Living - For 3 - Standard	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with standard (or mixed) support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_036_0115_1_1	Supported Independent Living - For 4 - Standard	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with standard (or mixed) support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_037_0115_1_1	Supported Independent Living - For 5 - Standard	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with standard (or mixed) support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_038_0115_1_1	Supported Independent Living - For 6 - Standard	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with standard (or mixed) support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_039_0115_1_1	Supported Independent Living - For 7 - Standard	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with standard (or mixed) support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_040_0115_1_1	Supported Independent Living - For 3 - Lower Need	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with lower support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_041_0115_1_1	Supported Independent Living - For 4 - Lower Need	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with lower support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_042_0115_1_1	Supported Independent Living - For 5 - Lower Need	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with lower support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_043_0115_1_1	Supported Independent Living - For 6 - Lower Need	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with lower support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_044_0115_1_1	Supported Independent Living - For 7 - Lower Need	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with lower support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗

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0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_045_0115_1_1	Short Term Accommodation And Assistance - 1:4 - Weekday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$546.33	$764.86	$819.50	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_046_0115_1_1	Assistance In Individual Living Arrangement For Person With Complex Needs		EA	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_047_0115_1_1	Supported Independent Living - For 2 - Lower Need	Assisting with and/or supervising tasks of daily life to develop the skills of the individuals with lower support needs to live as autonomously as possible.	WK	N	Y						✗	✗	✗	✗
0107	Daily Personal Activities (Assist Personal Activities)	1	Assistance with daily life (includes Supported Independent Living)	01_049_0107_1_1	Establishment Fee For Personal Care/Community Access	Establishment Fee for Personal Care/Community Access (20 hours per month).	EA	Y	N			$861.13	$1,205.58	$1,291.70	✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_051_0115_1_1	Short Term Accommodation And Assistance - 1:4 - Saturday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$644.56	$902.38	$966.84	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_052_0115_1_1	Short Term Accommodation And Assistance - 1:4 - Sunday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$765.78	$1,072.09	$1,148.67	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_053_0115_1_1	Short Term Accommodation And Assistance - 1:4 - Public Holiday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$885.95	$1,240.33	$1,328.93	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_054_0115_1_1	Short Term Accommodation And Assistance - 1:2 - Weekday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$879.68	$1,231.55	$1,319.52	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_055_0115_1_1	Short Term Accommodation And Assistance - 1:2 - Saturday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$1,076.14	$1,506.60	$1,614.21	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_056_0115_1_1	Short Term Accommodation And Assistance - 1:2 - Sunday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$1,317.54	$1,844.56	$1,976.31	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_057_0115_1_1	Short Term Accommodation And Assistance - 1:2 - Public Holiday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$1,558.93	$2,182.50	$2,338.40	✗	✓	✗	✓

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0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_058_0115_1_1	Short Term Accommodation And Assistance - 1:1 - Weekday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$1,546.39	$2,164.95	$2,319.59	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_059_0115_1_1	Short Term Accommodation And Assistance - 1:1 - Saturday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$1,939.31	$2,715.03	$2,908.97	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_060_0115_1_1	Short Term Accommodation And Assistance - 1:1 - Sunday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$2,422.10	$3,390.94	$3,633.15	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_061_0115_1_1	Short Term Accommodation And Assistance - 1:1 - Public Holiday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$2,904.89	$4,066.85	$4,357.34	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_062_0115_1_1	Short Term Accommodation And Assistance - 1:3 - Weekday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$657.10	$919.94	$985.65	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_063_0115_1_1	Short Term Accommodation And Assistance - 1:3 - Saturday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$788.77	$1,104.28	$1,183.16	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_064_0115_1_1	Short Term Accommodation And Assistance - 1:3 - Sunday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$949.70	$1,329.58	$1,424.55	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_065_0115_1_1	Short Term Accommodation And Assistance - 1:3 - Public Holiday	Integrated support for self-care, accommodation, food & activities in a centre or group residence for short periods. Includes all expenses in 24 hour period with no additional loading. May be used for up to 14 consecutive days, then weekly rates apply.	D	Y	N			$1,110.63	$1,554.88	$1,665.95	✗	✓	✗	✓
0117	Development Of Daily Living And Life Skills	1	Assistance with daily life (includes Supported Independent Living)	01_134_0117_8_1	Self-Management Capacity Building	Self-Management Capacity Building	H	Y	N			$63.23	$88.52	$94.85	✓	✓	✗	✓

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0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_200_0115_1_1	Assistance With Self-Care Activities in a STA - Standard - Weekday Daytime	Additional support provided at the same time as a Short Term Accommodation (STA) support, where the participant requires 1:1 assistance with self-care activities in addition to the STA support. For example, where the STA support is at the 1:1 rate and the participant requires more than one support worker for a period of time, or where the STA is not at the 1:1 rate and the participant requires 1:1 support for a period of time.	H	Y	N			$52.85	$73.99	$79.28	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_201_0115_1_1	Assistance With Self-Care Activities in a STA - Standard - Evening	Additional support provided at the same time as a Short Term Accommodation (STA) support, where the participant requires 1:1 assistance with self-care activities in addition to the STA support. For example, where the STA support is at the 1:1 rate and the participant requires more than one support worker for a period of time, or where the STA is not at the 1:1 rate and the participant requires 1:1 support for a period of time.	H	Y	N			$58.31	$81.63	$87.47	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_202_0115_1_1	Assistance With Self-Care Activities in a STA - Standard - Saturday	Additional support provided at the same time as a Short Term Accommodation (STA) support, where the participant requires 1:1 assistance with self-care activities in addition to the STA support. For example, where the STA support is at the 1:1 rate and the participant requires more than one support worker for a period of time, or where the STA is not at the 1:1 rate and the participant requires 1:1 support for a period of time.	H	Y	N			$72.69	$101.77	$109.04	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_203_0115_1_1	Assistance With Self-Care Activities in a STA - Standard - Sunday	Additional support provided at the same time as a Short Term Accommodation (STA) support, where the participant requires 1:1 assistance with self-care activities in addition to the STA support. For example, where the STA support is at the 1:1 rate and the participant requires more than one support worker for a period of time, or where the STA is not at the 1:1 rate and the participant requires 1:1 support for a period of time.	H	Y	N			$94.52	$132.33	$141.78	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_204_0115_1_1	Assistance With Self-Care Activities in a STA - Standard - Public Holiday	Additional support provided at the same time as a Short Term Accommodation (STA) support, where the participant requires 1:1 assistance with self-care activities in addition to the STA support. For example, where the STA support is at the 1:1 rate and the participant requires more than one support worker for a period of time, or where the STA is not at the 1:1 rate and the participant requires 1:1 support for a period of time.	H	Y	N			$118.34	$165.68	$177.51	✗	✓	✗	✓
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_205_0115_1_1	Assistance With Self-Care Activities in a STA - Standard - Active Overnight	Additional support provided at the same time as a Short Term Accommodation (STA) support, where the participant requires 1:1 assistance with self-care activities in addition to the STA support. For example, where the STA support is at the 1:1 rate and the participant requires more than one support worker for a period of time, or where the STA is not at the 1:1 rate and the participant requires 1:1 support for a period of time.	H	Y	N			$59.40	$83.16	$89.10	✗	✓	✗	✓

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0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_280_0115_1_1	Individual Living Option - Co-residency	Assist the participant to maintain an Individual Living Option co-residency transitional arrangement.	EA	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_281_0115_1_1	Individual Living Option - Host Arrangement	Specialist assistance to maintain an Individual Living Option Host family transitional arrangement.	D	N	Y						✗	✗	✗	✗
0115	Assistance With Daily Life Tasks In A Group Or Shared Living Arrangement	1	Assistance with daily life (includes Supported Independent Living)	01_282_0115_1_1	Individual Living Option - Rostered Supports	Assist the participant though a particular range of flexible supports to maintain their existing Individual Living Option transitional arrangement, being either Living Alone or Living Together specifically.	EA	N	Y						✗	✗	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_300_0104_1_1	Assistance With Self-Care Activities - Level 1 - Weekday Daytime	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	H	Y	N			$52.85	$73.99	$79.28	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_300_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Weekday Daytime - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Support delivered by a TTP provider.	H	Y	N			$56.81	$79.53	$85.22	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_301_0104_1_1	Assistance With Self-Care Activities - Level 1 - Evening	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	H	Y	N			$58.31	$81.63	$87.47	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_301_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Evening - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Support delivered by a TTP provider.	H	Y	N			$62.69	$87.77	$94.04	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_302_0104_1_1	Assistance With Self-Care Activities - Level 1 - Saturday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	H	Y	N			$72.69	$101.77	$109.04	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_302_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Saturday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Support delivered by a TTP provider.	H	Y	N			$78.14	$109.40	$117.21	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_303_0104_1_1	Assistance With Self-Care Activities - Level 1 - Sunday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	H	Y	N			$94.52	$132.33	$141.78	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_303_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Sunday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Support delivered by a TTP provider.	H	Y	N			$101.61	$142.25	$152.42	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_304_0104_1_1	Assistance With Self-Care Activities - Level 1 - Public Holiday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	H	Y	N			$118.34	$165.68	$177.51	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_304_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Public Holiday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible. Support delivered by a TTP provider.	H	Y	N			$127.21	$178.09	$190.82	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_305_0104_1_1	Assistance With Self-Care Activities - Level 1 - Active Overnight	Assistance with, or supervision of, personal tasks of daily living where overnight support is needed and the care giver will not have the option to sleep.	H	Y	N			$59.40	$83.16	$89.10	✓	✓	✗	✓

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_305_0104_1_1_T	Assistance With Self-Care Activities - Level 1 - Active Overnight - TTP	Assistance with, or supervision of, personal tasks of daily living where overnight support is needed and the care giver will not have the option to sleep. Support delivered by a TTP provider.	H	Y	N			$63.85	$89.39	$95.78	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_400_0104_1_1	Assistance With Self-Care Activities - Level 2 - Weekday Daytime	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required.	H	Y	N			$57.15	$80.01	$85.73	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_400_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Weekday Daytime - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$61.11	$85.55	$91.67	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_401_0104_1_1	Assistance With Self-Care Activities - Level 2 - Evening	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required.	H	Y	N			$63.06	$88.28	$94.59	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_401_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Evening - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$67.44	$94.42	$101.16	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_402_0104_1_1	Assistance With Self-Care Activities - Level 2 - Saturday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required.	H	Y	N			$78.63	$110.08	$117.95	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_402_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Saturday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$84.08	$117.71	$126.12	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_403_0104_1_1	Assistance With Self-Care Activities - Level 2 - Sunday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required.	H	Y	N			$102.23	$143.12	$153.35	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_403_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Sunday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$109.32	$153.05	$163.98	✓	✓	✗	✓

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_404_0104_1_1	Assistance With Self-Care Activities - Level 2 - Public Holiday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required.	H	Y	N			$127.97	$179.16	$191.96	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_404_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Public Holiday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$136.84	$191.58	$205.26	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_405_0104_1_1	Assistance With Self-Care Activities - Level 2 - Active Overnight	Assistance with, or supervision of, personal tasks of daily living where overnight support is needed and the care giver will not have the option to sleep in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required.	H	Y	N			$64.24	$89.94	$96.36	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_405_0104_1_1_T	Assistance With Self-Care Activities - Level 2 - Active Overnight - TTP	Assistance with, or supervision of, personal tasks of daily living where overnight support is needed and the care giver will not have the option to sleep in circumstances where the support delivered is high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$68.69	$96.17	$103.04	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_500_0104_1_1	Assistance With Self-Care Activities - Level 3 - Weekday Daytime	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required.	H	Y	N			$60.04	$84.06	$90.06	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_500_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Weekday Daytime - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$64.00	$89.60	$96.00	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_501_0104_1_1	Assistance With Self-Care Activities - Level 3 - Evening	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required.	H	Y	N			$66.23	$92.72	$99.35	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_501_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Evening - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$70.61	$98.85	$105.92	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_502_0104_1_1	Assistance With Self-Care Activities - Level 3 - Saturday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required.	H	Y	N			$82.58	$115.61	$123.87	✓	✓	✗	✓

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_502_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Saturday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$88.03	$123.24	$132.05	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_503_0104_1_1	Assistance With Self-Care Activities - Level 3 - Sunday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required.	H	Y	N			$107.37	$150.32	$161.06	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_503_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Sunday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$114.46	$160.24	$171.69	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_504_0104_1_1	Assistance With Self-Care Activities - Level 3 - Public Holiday	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required.	H	Y	N			$134.42	$188.19	$201.63	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_504_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Public Holiday - TTP	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$143.29	$200.61	$214.94	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_505_0104_1_1	Assistance With Self-Care Activities - Level 3 - Active Overnight	Assistance with, or supervision of, personal tasks of daily living where overnight support is needed and the care giver will not have the option to sleep in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required.	H	Y	N			$67.47	$94.46	$101.21	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	1	Assistance with daily life (includes Supported Independent Living)	01_505_0104_1_1_T	Assistance With Self-Care Activities - Level 3 - Active Overnight - TTP	Assistance with, or supervision of, personal tasks of daily living where overnight support is needed and the care giver will not have the option to sleep in circumstances where the support delivered is very high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$71.92	$100.69	$107.88	✓	✓	✗	✓
0108	Assistance With Travel/Transport Arrangements	2	Transport	02_050_0108_1_1	Specialised Transport To School/Educational Facility/Employment/Community	Specialised transport to school/educational facility/employment/community	D	N	Y						✗	✗	✗	✗
0108	Assistance With Travel/Transport Arrangements	2	Transport	02_051_0108_1_1	Transport	Transport	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_050903053_0103_1_1	Incontinence Alarms	Buzzer or similar used in continence training	EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	3	Consumables	03_060000911_0135_1_1	Low Cost AT For Prosthetics And Orthotics		EA	Y	N			$100.00	$100.00	$100.00	✗	✗	✗	✗

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0121	Interpreting And Translation	3	Consumables	03_089_0121_1_1	Auslan Or Signed English Training	Training in the use of Auslan and other communication techniques; tafe course fee or equivalent.	H	N	N						x	x	x	x
0121	Interpreting And Translation	3	Consumables	03_090_0121_1_1	Interpreting And Translating	Services to interpret or translate another language.	H	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_090000911_0103_1_1	Low Cost AT For Personal Care And Safety		EA	Y	N			$100.00	$100.00	$100.00	x	x	x	x
0121	Interpreting And Translation	3	Consumables	03_091_0121_1_1	Telephone Or Video Interpreting	Telephone or video services to interpret or translate another language or format.	H	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_092403054_0103_1_1	Continence Package A - Child - Annual Amount	Indwelling catheters, bags, night bottle or bags and change kits.	YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_092403055_0103_1_1	Continence Package A - Adult - Annual Amount	Indwelling catheters, bags, night bottle or bags and change kits.	YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_092406057_0103_1_1	Continence Package B - Intermittent Mild - Annual Amount	3 per day intermittent catheters with gel and lubricant - annual amount.	YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_092406058_0103_1_1	Continence Package C - Intermittent Moderate - Annual Amount	4 per day intermittent catheters with gel and lubricant - annual amount.	YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_092406059_0103_1_1	Continence Package D - Intermittent Higher Needs - Annual Amount	6 per day intermittent catheters with gel and lubricant - annual amount.	YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_092406061_0103_1_1	Adult Intermittent Catheters Standard 3/Day - Annual Amount		YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_092406062_0103_1_1	Adult Intermittent Catheters Standard 4/Day - Annual Amount		YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_092406063_0103_1_1	Adult Intermittent Catheters Standard 6/Day - Annual Amount		YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_092488056_0103_1_1	Continence Products Urinary - Other For Child	Individualised continence package or products not listed elsewhere in this list.	EA	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_092489060_0103_1_1	Continence Products Urinary - Other For Adult		EA	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_092718064_0103_1_1	Continence Package E - External	Sheaths, leg bags, drain bag or bottle, straps- annual amount	YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093012065_0103_1_1	Child Nappy Single-Use 3/Day - Annual Supply	Nappy for a child's disability specific needs	YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093012066_0103_1_1	Child Nappy Single-Use 4/Day - Annual Supply	Nappy for a child's disability specific needs	YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093012067_0103_1_1	Child Nappy Single-Use 6/Day - Annual Supply	Nappy for a child's disability specific needs	YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093012068_0103_1_1	Child Nappy Single-Use 12/Day - Annual Supply	Nappy for a child's disability specific needs	YR	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093015069_0103_1_1	Washable Incontinence Products For Children		EA	N	N						x	x	x	x

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0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093018070_0103_1_1	Single-Use Inserts/Pads - Adult 3/Day - Annual Supply		YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093018071_0103_1_1	Single-Use Inserts/Pads - Adult 4/Day - Annual Supply		YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093018072_0103_1_1	Single-Use Inserts/Pads - Adult 6/Day - Annual Supply		YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093018073_0103_1_1	Single-Use Inserts/Pads - Adult 12/Day - Annual Supply		YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093021074_0103_1_1	Adult Absorbent Pull Up Or Brief 3/Day - Annual Supply	Single-use diapers	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093021075_0103_1_1	Adult Absorbent Pull Up Or Brief 4/Day - Annual Supply	Single-use diapers	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093021076_0103_1_1	Adult Absorbent Pull Up Or Brief 6/Day - Annual Supply	Single-use diapers	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093021077_0103_1_1	Adult Absorbent Pull Up Or Brief 12/Day - Annual Supply	Single-use diapers	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093036132_0103_1_1	Washable Incontinence Pants For Adults	Washable incontinence pants for adults	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_093045133_0103_1_1	Non-Body-Worn Washable Products For Absorbing Urine And Faeces	Non-body-worn washable products for absorbing urine and faeces.	EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	3	Consumables	03_120000911_0105_1_1	Low Cost AT For Personal Mobility		EA	Y	N			$100.00	$100.00	$100.00	✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_150930078_0103_1_1	HEN Pump Accessory - Items Required For Syringe Feeding - Annual Amount	Pump often free on loan, includes gastrostomy, extension tubes, giving sets, containers and syringes.	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_150930079_0103_1_1	HEN Pump With Associated Consumables (Non-Syringe Feed) - Annual Amount	Pump often free on loan but includes other consumables for people who do not also syringe feed	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_150930080_0103_1_1	HEN Bolus Syringe Only - Annual Amount	Average annual allocation	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_150930081_0103_1_1	Additional Gastrostomy Devices- 3 Annual	Average annual allocation	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_150930082_0103_1_1	Additional Extension Sets For Bolus Feeding - 10/Annual	Average annual allocation	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_150930083_0103_1_1	Additional Extension Sets For Pump Feeding - 10/Annual	Average annual allocation	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_150930084_0103_1_1	Additional Giving Sets - 270/Annual	Average annual allocation	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_150930085_0103_1_1	Additional Containers - 50/Annual	Average annual allocation	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_150930086_0103_1_1	Additional Bolus Syringes - 100/Annual	Average annual allocation	YR	N	N						✗	✗	✗	✗

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0103	Assistive Products For Personal Care And Safety	3	Consumables	03_150930087_0103_1_1	Additional Water Flush Syringes - 100/Annual	Average annual allocation	YR	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_150930088_0103_1_1	Other HEN Equipment Including Additional Cost Of Food When Necessary	HEN equipment outside usual 12 month bundles	EA	N	N						✗	✗	✗	✗
0113	Vision Equipment	3	Consumables	03_220300911_0113_1_1	Low Cost AT For Vision Related AT		EA	Y	N			$100.00	$100.00	$100.00	✗	✗	✗	✗
0122	Hearing Equipment	3	Consumables	03_220600911_0122_1_1	Low Cost AT For Hearing Related AT		EA	Y	N			$100.00	$100.00	$100.00	✗	✗	✗	✗
0124	Communication And Information Equipment	3	Consumables	03_222100911_0124_1_1	Low Cost AT For Communication Or Cognitive Support		EA	Y	N			$100.00	$100.00	$100.00	✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_501509092_0103_1_1	HEN Equipment Repairs		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_710930093_0103_1_1	Continence Aids Delivery - Non Metropolitan	Delivery of continence items in regional and remote areas - expected maximum up to 4 deliveries per year. Price guidance is per delivery.	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_710930094_0103_1_1	Continence Aids Delivery - Metropolitan	Delivery of continence items in regional Metropolitan areas - expected maximum up to 4 deliveries per year. Price guidance is per delivery.	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	3	Consumables	03_711509095_0103_1_1	HEN Equipment Delivery		EA	N	N						✗	✗	✗	✗
0130	Assistance Animals (Other Innovative Supports)	3	Consumables	03_900100155_0130_1_1	Assistance Dog (Including Guide Dog) Ongoing Costs	Assistance dog (including guide dog) ongoing costs	MON	Y	N			$222.00	$222.00	$222.00	✗	✗	✗	✗
0125	Participation In Community, Social And Civic Activities	4	Assistance with social and community participation	04_102_0125_6_1	Access Community, Social And Rec Activities - Standard - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$118.34	$165.68	$177.51	✓	✓	✗	✓
0125	Participation In Community, Social And Civic Activities	4	Assistance with social and community participation	04_102_0125_6_1_T	Access Community, Social And Rec Activities - Standard - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$127.21	$178.09	$190.82	✓	✓	✗	✓
0125	Participation In Community, Social And Civic Activities	4	Assistance with social and community participation	04_103_0125_6_1	Access Community, Social And Rec Activities - Standard - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$58.31	$81.63	$87.47	✓	✓	✗	✓
0125	Participation In Community, Social And Civic Activities	4	Assistance with social and community participation	04_103_0125_6_1_T	Access Community, Social And Rec Activities - Standard - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$62.69	$87.77	$94.04	✓	✓	✗	✓
0125	Participation In Community, Social And Civic Activities	4	Assistance with social and community participation	04_104_0125_6_1	Access Community, Social And Rec Activities - Standard - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$52.85	$73.99	$79.28	✓	✓	✗	✓
0125	Participation In Community, Social And Civic Activities	4	Assistance with social and community participation	04_104_0125_6_1_T	Access Community, Social And Rec Activities - Standard - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$56.81	$79.53	$85.22	✓	✓	✗	✓
0125	Participation In Community, Social And Civic Activities	4	Assistance with social and community participation	04_105_0125_6_1	Access Community, Social And Rec Activities - Standard - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$72.69	$101.77	$109.04	✓	✓	✗	✓
0125	Participation In Community, Social And Civic Activities	4	Assistance with social and community participation	04_105_0125_6_1_T	Access Community, Social And Rec Activities - Standard - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$78.14	$109.40	$117.21	✓	✓	✗	✓

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0125	Participation In Community, Social And Civic Activities	4	Assistance with social and community participation	04_106_0125_6_1	Access Community, Social And Rec Activities - Standard - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$94.52	$132.33	$141.78	✓	✓	✗	✓
0125	Participation In Community, Social And Civic Activities	4	Assistance with social and community participation	04_106_0125_6_1_T	Access Community, Social And Rec Activities - Standard - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$101.61	$142.25	$152.42	✓	✓	✗	✓
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_111_0136_6_1	Group Activities In The Community - 1:2 - Standard - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$29.60	$41.43	$44.39	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_111_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$31.81	$44.54	$47.72	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_112_0136_6_1	Group Activities In The Community - 1:2 - Standard - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$40.71	$56.99	$61.06	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_112_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$43.76	$61.26	$65.64	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_113_0136_6_1	Group Activities In The Community - 1:2 - Standard - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$52.93	$74.10	$79.40	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_113_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$56.90	$79.66	$85.35	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_114_0136_6_1	Group Activities In The Community - 1:2 - Standard - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$32.65	$45.72	$48.98	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_114_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$35.11	$49.15	$52.66	✓	✓	✗	✗
0125	Participation In Community, Social And Civic Activities	4	Assistance with social and community participation	04_115_0125_6_1	Community, Social And Recreational Activities	Annual support to enable a participant to independently engage in community, social and recreational activities when costs of participation exceed an affordable level and without, the participant would be at risk of social isolation.	YR	N	N						✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_116_0104_6_1	Group Activities In The Community - 1:2 - Complex - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$32.00	$44.81	$48.01	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_116_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$34.22	$47.91	$51.33	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_117_0104_6_1	Group Activities In The Community - 1:2 - Complex - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$44.03	$61.65	$66.05	✓	✓	✗	✗

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_117_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$47.08	$65.92	$70.63	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_118_0104_6_1	Group Activities In The Community - 1:2 - Complex - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$57.25	$80.15	$85.87	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_118_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$61.22	$85.71	$91.83	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_119_0104_6_1	Group Activities In The Community - 1:2 - Complex - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$35.31	$49.44	$52.97	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_119_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$37.77	$52.87	$56.65	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_120_0136_6_1	Group Activities In The Community - 1:3 - Standard - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$21.84	$30.58	$32.77	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_120_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$23.48	$32.87	$35.22	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_121_0136_6_1	Group Activities In The Community - 1:3 - Standard - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$30.05	$42.06	$45.07	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_121_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$32.30	$45.22	$48.45	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_122_0136_6_1	Group Activities In The Community - 1:3 - Standard - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$39.07	$54.70	$58.60	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_122_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$42.00	$58.80	$63.00	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_123_0136_6_1	Group Activities In The Community - 1:3 - Standard - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$24.10	$33.74	$36.15	✓	✓	✗	✗

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0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_123_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$25.91	$36.28	$38.87	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_124_0104_6_1	Group Activities In The Community - 1:3 - Complex - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$23.62	$33.07	$35.43	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_124_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$25.26	$35.36	$37.89	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_125_0104_6_1	Group Activities In The Community - 1:3 - Complex - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$32.50	$45.50	$48.75	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_125_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$34.75	$48.65	$52.13	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_126_0104_6_1	Group Activities In The Community - 1:3 - Complex - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$42.26	$59.16	$63.38	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_126_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$45.19	$63.26	$67.78	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_127_0104_6_1	Group Activities In The Community - 1:3 - Complex - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$26.06	$36.49	$39.10	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_127_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$27.88	$39.03	$41.81	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_128_0136_6_1	Group Activities In The Community - 1:2 - Standard - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$66.27	$92.78	$99.41	✓	✓	✗	✗

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0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_128_0136_6_1_T	Group Activities In The Community - 1:2 - Standard - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$71.24	$99.73	$106.86	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_129_0136_6_1	Group Activities In The Community - 1:3 - Standard - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$48.91	$68.48	$73.37	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_129_0136_6_1_T	Group Activities In The Community - 1:3 - Standard - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$52.58	$73.61	$78.87	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_130_0104_6_1	Group Activities In The Community - 1:2 - Complex - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$71.66	$100.33	$107.49	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_130_0104_6_1_T	Group Activities In The Community - 1:2 - Complex - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$76.63	$107.28	$114.95	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_131_0104_6_1	Group Activities In The Community - 1:3 - Complex - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$52.89	$74.05	$79.34	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_131_0104_6_1_T	Group Activities In The Community - 1:3 - Complex - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$56.56	$79.18	$84.84	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_136_0136_6_1	Group Activities In The Community - 1:4 - Standard - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$17.97	$25.16	$26.95	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_136_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$19.32	$27.04	$28.97	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_137_0136_6_1	Group Activities In The Community - 1:4 - Standard - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$19.83	$27.76	$29.74	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_137_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$21.31	$29.84	$31.97	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_138_0136_6_1	Group Activities In The Community - 1:4 - Standard - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$24.71	$34.60	$37.07	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_138_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$26.57	$37.19	$39.85	✓	✓	✗	✗

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0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_139_0136_6_1	Group Activities In The Community - 1:4 - Standard - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$32.14	$44.99	$48.21	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_139_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$34.55	$48.37	$51.82	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_140_0136_6_1	Group Activities In The Community - 1:4 - Standard - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$40.24	$56.33	$60.35	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_140_0136_6_1_T	Group Activities In The Community - 1:4 - Standard - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$43.25	$60.55	$64.88	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_141_0136_6_1	Group Activities In The Community - 1:5 - Standard - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$15.64	$21.90	$23.47	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_141_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$16.82	$23.54	$25.22	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_142_0136_6_1	Group Activities In The Community - 1:5 - Standard - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$17.26	$24.16	$25.89	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_142_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$18.56	$25.98	$27.83	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_143_0136_6_1	Group Activities In The Community - 1:5 - Standard - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$21.52	$30.12	$32.27	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_143_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$23.13	$32.38	$34.69	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_144_0136_6_1	Group Activities In The Community - 1:5 - Standard - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$27.98	$39.17	$41.97	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_144_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$30.08	$42.11	$45.11	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_145_0136_6_1	Group Activities In The Community - 1:5 - Standard - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities.	H	Y	N			$35.03	$49.04	$52.54	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_145_0136_6_1_T	Group Activities In The Community - 1:5 - Standard - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$37.65	$52.72	$56.48	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_146_0104_6_1	Group Activities In The Community - 1:4 - Complex - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$19.43	$27.20	$29.15	✓	✓	✗	✗

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_146_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$20.78	$29.09	$31.17	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_147_0104_6_1	Group Activities In The Community - 1:4 - Complex - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$21.44	$30.02	$32.16	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_147_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$22.93	$32.10	$34.39	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_148_0104_6_1	Group Activities In The Community - 1:4 - Complex - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$26.73	$37.43	$40.10	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_148_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$28.59	$40.02	$42.88	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_149_0104_6_1	Group Activities In The Community - 1:4 - Complex - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$34.76	$48.66	$52.14	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_149_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$37.17	$52.04	$55.75	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_150_0104_6_1	Group Activities In The Community - 1:4 - Complex - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$43.51	$60.91	$65.26	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_150_0104_6_1_T	Group Activities In The Community - 1:4 - Complex - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$46.53	$65.14	$69.79	✓	✓	✗	✗

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_151_0104_6_1	Group Activities In The Community - 1:5 - Complex - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$16.92	$23.68	$25.37	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_151_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$18.09	$25.32	$27.13	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_152_0104_6_1	Group Activities In The Community - 1:5 - Complex - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$18.67	$26.13	$28.00	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_152_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$19.96	$27.95	$29.94	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_153_0104_6_1	Group Activities In The Community - 1:5 - Complex - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$23.27	$32.58	$34.91	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_153_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$24.89	$34.84	$37.33	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_154_0104_6_1	Group Activities In The Community - 1:5 - Complex - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$30.26	$42.36	$45.39	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_154_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$32.36	$45.30	$48.54	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_155_0104_6_1	Group Activities In The Community - 1:5 - Complex - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$37.88	$53.03	$56.82	✓	✓	✗	✗

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_155_0104_6_1_T	Group Activities In The Community - 1:5 - Complex - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$40.50	$56.71	$60.76	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_160_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$54.95	$76.93	$82.43	✓	✓	✗	✓
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_160_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$58.91	$82.47	$88.37	✓	✓	✗	✓
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_161_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$60.41	$84.57	$90.62	✓	✓	✗	✓
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_161_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$64.79	$90.71	$97.19	✓	✓	✗	✓
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_162_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$74.79	$104.71	$112.19	✓	✓	✗	✓
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_162_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$80.24	$112.34	$120.36	✓	✓	✗	✓
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_163_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$96.62	$135.27	$144.93	✓	✓	✗	✓
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_163_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$103.71	$145.19	$155.57	✓	✓	✗	✓
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_164_0136_6_1	Group Activities In A Centre - 1:1 - Standard - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$120.44	$168.62	$180.66	✓	✓	✗	✓
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_164_0136_6_1_T	Group Activities In A Centre - 1:1 - Standard - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$129.31	$181.03	$193.97	✓	✓	✗	✓
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_165_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$31.70	$44.37	$47.54	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_165_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$33.91	$47.48	$50.87	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_166_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$34.75	$48.66	$52.13	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_166_0136_6_1_T	Group Activities In A Centre - 1:2 - Standard - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$37.21	$52.09	$55.81	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_167_0136_6_1	Group Activities In A Centre - 1:2 - Standard - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$42.81	$59.93	$64.21	✓	✓	✗	✗

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0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_167_0136_6_1_T	Group Activities In A Centre - 1:2 Standard - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$45.86	$64.20	$68.79	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_168_0136_6_1	Group Activities In A Centre - 1:2 Standard - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$55.03	$77.04	$82.55	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_168_0136_6_1_T	Group Activities In A Centre - 1:2 Standard - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$59.00	$82.60	$88.50	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_169_0136_6_1	Group Activities In A Centre - 1:2 Standard - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$68.37	$95.72	$102.56	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_169_0136_6_1_T	Group Activities In A Centre - 1:2 Standard - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$73.34	$102.67	$110.01	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_170_0136_6_1	Group Activities In A Centre - 1:3 Standard - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$23.94	$33.52	$35.92	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_170_0136_6_1_T	Group Activities In A Centre - 1:3 Standard - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$25.58	$35.81	$38.37	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_171_0136_6_1	Group Activities In A Centre - 1:3 Standard - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$26.20	$36.68	$39.30	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_171_0136_6_1_T	Group Activities In A Centre - 1:3 Standard - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$28.01	$39.22	$42.02	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_172_0136_6_1	Group Activities In A Centre - 1:3 Standard - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$32.15	$45.00	$48.22	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_172_0136_6_1_T	Group Activities In A Centre - 1:3 Standard - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$34.40	$48.16	$51.60	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_173_0136_6_1	Group Activities In A Centre - 1:3 Standard - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$41.17	$57.64	$61.75	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_173_0136_6_1_T	Group Activities In A Centre - 1:3 Standard - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$44.10	$61.74	$66.15	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_174_0136_6_1	Group Activities In A Centre - 1:3 Standard - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$51.01	$71.42	$76.52	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_174_0136_6_1_T	Group Activities In A Centre - 1:3 Standard - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$54.68	$76.55	$82.02	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_175_0136_6_1	Group Activities In A Centre - 1:4 Standard - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$20.07	$28.10	$30.10	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_175_0136_6_1_T	Group Activities In A Centre - 1:4 Standard - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$21.42	$29.98	$32.12	✓	✓	✗	✗

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0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_176_0136_6_1	Group Activities In A Centre - 1:4 Standard - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$21.93	$30.70	$32.89	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_176_0136_6_1_T	Group Activities In A Centre - 1:4 Standard - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$23.41	$32.78	$35.12	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_177_0136_6_1	Group Activities In A Centre - 1:4 Standard - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$26.81	$37.54	$40.22	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_177_0136_6_1_T	Group Activities In A Centre - 1:4 Standard - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$28.67	$40.13	$43.00	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_178_0136_6_1	Group Activities In A Centre - 1:4 Standard - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$34.24	$47.93	$51.36	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_178_0136_6_1_T	Group Activities In A Centre - 1:4 Standard - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$36.65	$51.31	$54.97	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_179_0136_6_1	Group Activities In A Centre - 1:4 Standard - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$42.34	$59.27	$63.50	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_179_0136_6_1_T	Group Activities In A Centre - 1:4 Standard - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$45.35	$63.49	$68.03	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_180_0136_6_1	Group Activities In A Centre - 1:5 Standard - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$17.74	$24.84	$26.62	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_180_0136_6_1_T	Group Activities In A Centre - 1:5 Standard - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$18.92	$26.48	$28.37	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_181_0136_6_1	Group Activities In A Centre - 1:5 Standard - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$19.36	$27.10	$29.04	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_181_0136_6_1_T	Group Activities In A Centre - 1:5 Standard - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$20.66	$28.92	$30.98	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_182_0136_6_1	Group Activities In A Centre - 1:5 Standard - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$23.62	$33.06	$35.42	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_182_0136_6_1_T	Group Activities In A Centre - 1:5 Standard - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$25.23	$35.32	$37.84	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_183_0136_6_1	Group Activities In A Centre - 1:5 Standard - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$30.08	$42.11	$45.12	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_183_0136_6_1_T	Group Activities In A Centre - 1:5 Standard - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$32.18	$45.05	$48.26	✓	✓	✗	✗
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_184_0136_6_1	Group Activities In A Centre - 1:5 Standard - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre.	H	Y	N			$37.13	$51.98	$55.69	✓	✓	✗	✗

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Registration Group Number	Registration Group Name	Support Category Number	Support Category Name	Support Item Number	Support Item Name	Support Item Description	Unit	Price Controlled	Quote Required	NT - SA TAS-WA (MM 1-5)	ACT - NSW QLD - VIC (MM 1-5)	National Non-Remote (MM 1-5)	National Remote (MM 6)	National Very Remote (MM 7)	Travel	Cancellations	NDIA Reporting	Non-F2F
0136	Group And Centre Based Activities	4	Assistance with social and community participation	04_184_0136_6_1_T	Group Activities In A Centre - 1:5 Standard - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre. Support delivered by a TTP provider.	H	Y	N			$39.75	$55.66	$59.63	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_185_0104_6_1	Group Activities In A Centre - 1:1 Complex - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$59.25	$82.95	$88.88	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_185_0104_6_1_T	Group Activities In A Centre - 1:1 Complex - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$63.21	$88.49	$94.82	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_186_0104_6_1	Group Activities In A Centre - 1:1 Complex - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$65.16	$91.22	$97.74	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_186_0104_6_1_T	Group Activities In A Centre - 1:1 Complex - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$69.54	$97.36	$104.31	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_187_0104_6_1	Group Activities In A Centre - 1:1 Complex - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$80.73	$113.02	$121.10	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_187_0104_6_1_T	Group Activities In A Centre - 1:1 Complex - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$86.18	$120.65	$129.27	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_188_0104_6_1	Group Activities In A Centre - 1:1 Complex - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$104.33	$146.06	$156.50	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_188_0104_6_1_T	Group Activities In A Centre - 1:1 Complex - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$111.42	$155.99	$167.13	✓	✓	✗	✓

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_189_0104_6_1	Group Activities In A Centre - 1:1 Complex - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$130.07	$182.10	$195.11	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_189_0104_6_1_T	Group Activities In A Centre - 1:1 Complex - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$138.94	$194.52	$208.41	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_190_0104_6_1	Group Activities In A Centre - 1:2 Complex - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$34.10	$47.75	$51.16	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_190_0104_6_1_T	Group Activities In A Centre - 1:2 Complex - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$36.32	$50.85	$54.48	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_191_0104_6_1	Group Activities In A Centre - 1:2 Complex - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$37.41	$52.38	$56.12	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_191_0104_6_1_T	Group Activities In A Centre - 1:2 Complex - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$39.87	$55.81	$59.80	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_192_0104_6_1	Group Activities In A Centre - 1:2 Complex - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$46.13	$64.59	$69.20	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_192_0104_6_1_T	Group Activities In A Centre - 1:2 Complex - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$49.18	$68.86	$73.78	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_193_0104_6_1	Group Activities In A Centre - 1:2 Complex - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$59.35	$83.09	$89.02	✓	✓	✗	✗

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_193_0104_6_1_T	Group Activities In A Centre - 1:2 Complex - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$63.32	$88.65	$94.98	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_194_0104_6_1	Group Activities In A Centre - 1:2 Complex - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$73.76	$103.27	$110.64	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_194_0104_6_1_T	Group Activities In A Centre - 1:2 Complex - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$78.73	$110.22	$118.10	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_195_0104_6_1	Group Activities In A Centre - 1:3 Complex - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$25.72	$36.01	$38.58	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_195_0104_6_1_T	Group Activities In A Centre - 1:3 Complex - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$27.36	$38.30	$41.04	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_196_0104_6_1	Group Activities In A Centre - 1:3 Complex - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$28.16	$39.43	$42.25	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_196_0104_6_1_T	Group Activities In A Centre - 1:3 Complex - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$29.98	$41.97	$44.96	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_197_0104_6_1	Group Activities In A Centre - 1:3 Complex - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$34.60	$48.44	$51.90	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_197_0104_6_1_T	Group Activities In A Centre - 1:3 Complex - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$36.85	$51.59	$55.28	✓	✓	✗	✗

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_198_0104_6_1	Group Activities In A Centre - 1:3 Complex - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$44.36	$62.10	$66.53	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_198_0104_6_1_T	Group Activities In A Centre - 1:3 Complex - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$47.29	$66.20	$70.93	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_199_0104_6_1	Group Activities In A Centre - 1:3 Complex - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$54.99	$76.99	$82.49	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_199_0104_6_1_T	Group Activities In A Centre - 1:3 Complex - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$58.66	$82.12	$87.99	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_200_0104_6_1	Group Activities In A Centre - 1:4 Complex - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$21.53	$30.14	$32.30	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_200_0104_6_1_T	Group Activities In A Centre - 1:4 Complex - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$22.88	$32.03	$34.32	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_201_0104_6_1	Group Activities In A Centre - 1:4 Complex - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$23.54	$32.96	$35.31	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_201_0104_6_1_T	Group Activities In A Centre - 1:4 Complex - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$25.03	$35.04	$37.54	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_202_0104_6_1	Group Activities In A Centre - 1:4 Complex - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$28.83	$40.37	$43.25	✓	✓	✗	✗

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_202_0104_6_1_T	Group Activities In A Centre - 1:4 Complex - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$30.69	$42.96	$46.03	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_203_0104_6_1	Group Activities In A Centre - 1:4 Complex - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$36.86	$51.60	$55.29	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_203_0104_6_1_T	Group Activities In A Centre - 1:4 Complex - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$39.27	$54.98	$58.90	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_204_0104_6_1	Group Activities In A Centre - 1:4 Complex - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$45.61	$63.85	$68.41	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_204_0104_6_1_T	Group Activities In A Centre - 1:4 Complex - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$48.63	$68.08	$72.94	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_205_0104_6_1	Group Activities In A Centre - 1:5 Complex - Weekday Daytime	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$19.02	$26.62	$28.52	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_205_0104_6_1_T	Group Activities In A Centre - 1:5 Complex - Weekday Daytime - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$20.19	$28.26	$30.28	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_206_0104_6_1	Group Activities In A Centre - 1:5 Complex - Evening	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$20.77	$29.07	$31.15	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_206_0104_6_1_T	Group Activities In A Centre - 1:5 Complex - Evening - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$22.06	$30.89	$33.09	✓	✓	✗	✗

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_207_0104_6_1	Group Activities In A Centre - 1:5 Complex - Saturday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$25.37	$35.52	$38.06	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_207_0104_6_1_T	Group Activities In A Centre - 1:5 Complex - Saturday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$26.99	$37.78	$40.48	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_208_0104_6_1	Group Activities In A Centre - 1:5 Complex - Sunday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$32.36	$45.30	$48.54	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_208_0104_6_1_T	Group Activities In A Centre - 1:5 Complex - Sunday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$34.46	$48.24	$51.69	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_209_0104_6_1	Group Activities In A Centre - 1:5 Complex - Public Holiday	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required.	H	Y	N			$39.98	$55.97	$59.97	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_209_0104_6_1_T	Group Activities In A Centre - 1:5 Complex - Public Holiday - TTP	Provision of support to enable a participant to engage in community, social and/or recreational activities in a centre, where a support worker with additional qualifications and experience relevant to the participant's complex needs is required. Support delivered by a TTP provider.	H	Y	N			$42.60	$59.65	$63.91	✓	✓	✗	✗
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_300_0104_1_1	Access Community, Social And Rec Activities - Level 1 - Weekday Daytime	Supporting a participant to engage in community, social and/or recreational activities.	H	Y	N			$52.85	$73.99	$79.28	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_300_0104_1_1_T	Access Community, Social And Rec Activities - Level 1 - Weekday Daytime - TTP	Supporting a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$56.81	$79.53	$85.22	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_301_0104_1_1	Access Community, Social And Rec Activities - Level 1 - Evening	Supporting a participant to engage in community, social and/or recreational activities.	H	Y	N			$58.31	$81.63	$87.47	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_301_0104_1_1_T	Access Community, Social And Rec Activities - Level 1 - Evening - TTP	Supporting a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$62.69	$87.77	$94.04	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_302_0104_1_1	Access Community, Social And Rec Activities - Level 1 - Saturday	Supporting a participant to engage in community, social and/or recreational activities.	H	Y	N			$72.69	$101.77	$109.04	✓	✓	✗	✓

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_302_0104_1_1_T	Access Community, Social And Rec Activities - Level 1 - Saturday - TTP	Supporting a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$78.14	$109.40	$117.21	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_303_0104_1_1	Access Community, Social And Rec Activities - Level 1 - Sunday	Supporting a participant to engage in community, social and/or recreational activities.	H	Y	N			$94.52	$132.33	$141.78	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_303_0104_1_1_T	Access Community, Social And Rec Activities - Level 1 - Sunday - TTP	Supporting a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$101.61	$142.25	$152.42	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_304_0104_1_1	Access Community, Social And Rec Activities - Level 1 - Public Holiday	Supporting a participant to engage in community, social and/or recreational activities.	H	Y	N			$118.34	$165.68	$177.51	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_304_0104_1_1_T	Access Community, Social And Rec Activities - Level 1 - Public Holiday - TTP	Supporting a participant to engage in community, social and/or recreational activities. Support delivered by a TTP provider.	H	Y	N			$127.21	$178.09	$190.82	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_400_0104_1_1	Access Community, Social And Rec Activities - Level 2 - Weekday Daytime	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is high intensity and a more skilled or experienced support worker is required.	H	Y	N			$57.15	$80.01	$85.73	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_400_0104_1_1_T	Access Community, Social And Rec Activities - Level 2 - Weekday Daytime - TTP	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$61.11	$85.55	$91.67	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_401_0104_1_1	Access Community, Social And Rec Activities - Level 2 - Evening	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is high intensity and a more skilled or experienced support worker is required.	H	Y	N			$63.06	$88.28	$94.59	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_401_0104_1_1_T	Access Community, Social And Rec Activities - Level 2 - Evening - TTP	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$67.44	$94.42	$101.16	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_402_0104_1_1	Access Community, Social And Rec Activities - Level 2 - Saturday	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is high intensity and a more skilled or experienced support worker is required.	H	Y	N			$78.63	$110.08	$117.95	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_402_0104_1_1_T	Access Community, Social And Rec Activities - Level 2 - Saturday - TTP	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$84.08	$117.71	$126.12	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_403_0104_1_1	Access Community, Social And Rec Activities - Level 2 - Sunday	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is high intensity and a more skilled or experienced support worker is required.	H	Y	N			$102.23	$143.12	$153.35	✓	✓	✗	✓

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_403_0104_1_1_T	Access Community, Social And Rec Activities - Level 2 - Sunday - TTP	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$109.32	$153.05	$163.98	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_404_0104_1_1	Access Community, Social And Rec Activities - Level 2 - Public Holiday	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is high intensity and a more skilled or experienced support worker is required.	H	Y	N			$127.97	$179.16	$191.96	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_404_0104_1_1_T	Access Community, Social And Rec Activities - Level 2 - Public Holiday - TTP	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$136.84	$191.58	$205.26	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_500_0104_1_1	Access Community, Social And Rec Activities - Level 3 - Weekday Daytime	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is very high intensity and a more skilled or experienced support worker is required.	H	Y	N			$60.04	$84.06	$90.06	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_500_0104_1_1_T	Access Community, Social And Rec Activities - Level 3 - Weekday Daytime - TTP	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is very high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$64.00	$89.60	$96.00	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_501_0104_1_1	Access Community, Social And Rec Activities - Level 3 - Evening	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is very high intensity and a more skilled or experienced support worker is required.	H	Y	N			$66.23	$92.72	$99.35	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_501_0104_1_1_T	Access Community, Social And Rec Activities - Level 3 - Evening - TTP	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is very high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$70.61	$98.85	$105.92	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_502_0104_1_1	Access Community, Social And Rec Activities - Level 3 - Saturday	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is very high intensity and a more skilled or experienced support worker is required.	H	Y	N			$82.58	$115.61	$123.87	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_502_0104_1_1_T	Access Community, Social And Rec Activities - Level 3 - Saturday - TTP	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is very high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$88.03	$123.24	$132.05	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_503_0104_1_1	Access Community, Social And Rec Activities - Level 3 - Sunday	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is very high intensity and a more skilled or experienced support worker is required.	H	Y	N			$107.37	$150.32	$161.06	✓	✓	✗	✓

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0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_503_0104_1_1_T	Access Community, Social And Rec Activities - Level 3 - Sunday - TTP	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is very high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$114.46	$160.24	$171.69	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_504_0104_1_1	Access Community, Social And Rec Activities - Level 3 - Public Holiday	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is very high intensity and a more skilled or experienced support worker is required.	H	Y	N			$134.42	$188.19	$201.63	✓	✓	✗	✓
0104	High Intensity Daily Personal Activities (Assist Integrate School/Ed)	4	Assistance with social and community participation	04_504_0104_1_1_T	Access Community, Social And Rec Activities - Level 3 - Public Holiday - TTP	Supporting a participant to engage in community, social and/or recreational activities, where the support delivered is very high intensity and a more skilled or experienced support worker is required. Support delivered by a TTP provider.	H	Y	N			$143.29	$200.61	$214.94	✓	✓	✗	✓
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_043006111_0103_1_2	Cooling Vest - All Sizes		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_043303111_0103_1_2	Postural Support Using Foam And/Or Gel (One Surface)		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_043303211_0103_1_2	Postural Support Using Foam And/Or Gel (Seat, Back And Other Supports Included)		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_043303511_0103_1_2	Postural Support Using Air Floatation Or Automated Pressure Management		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_043306002_0103_1_2	Pressure Mattress Air Filled Section		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_043306003_0103_1_2	Pressure Reduction Mattress	Mattress with pressure reduction properties	EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_043306004_0103_1_2	Pressure Reduction Overlay	Overlay with air or other substance, mechanical or not	EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_043306111_0103_1_2	Assistive Products For Tissue Integrity When Lying Down - Non Powered		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_043306211_0103_1_2	Pressure Mattress - Low Air Loss, Alternating Pressure		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_043318111_0103_1_2	Water Chairs		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_053603010_0103_1_2	Standing Frame - Child Under 5	Apparatus to hold a person in a standing position	EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_053603111_0103_1_2	Standing Frames And Supports For Standing		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_053603131_0103_1_2	Standing And/Or Walking Frame - Child		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_060000011_0135_1_2	Assistive Products And Accessories Relating To Prosthetics And Orthotics		EA	N	Y						✗	✗	✗	✗

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0135	Customised Prosthetics	5	Assistive technology	05_060000112_0135_1_2	Orthotic Or Prosthetic Componentry Rental		WK	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_060315111_0135_1_2	Cervical And Cranial Orthoses		EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_060318121_0135_1_2	Cervico-Thoraco-Lumbo-Sacral Orthoses		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_060600111_0135_1_2	Orthosis - Upper Limb - Prefabricated		EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_060600121_0135_1_2	Orthosis - Upper Limb - Custom Made		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_060688121_0135_1_2	Upper Limb Orthotic - Dynamic Or Lycra		EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061203111_0135_1_2	Orthotic - Foot Support/Orthotic Footwear (Prefabricated)		EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061203121_0135_1_2	Orthopaedic Shoes - Other Custom Made		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061206111_0135_1_2	Orthosis - Ankle Foot (AFO) - Prefabricated		EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061206121_0135_1_2	Orthosis - Ankle Foot (AFO) - Custom Made		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061206221_0135_1_2	Orthosis - Ankle Foot With Ankle Joints - Custom Made		EA	N	Y						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_061209111_0105_1_2	Orthosis - Knee - Prefabricated		EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061209121_0135_1_2	Orthosis - Knee - Custom Made		EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061209221_0135_1_2	Orthosis - Thigh Knee Ankle - Custom Made		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061212121_0135_1_2	Orthosis - Knee Ankle Foot - Custom Made		EA	N	Y						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_061215111_0105_1_2	Orthosis - Hip - Prefabricated		EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061218121_0135_1_2	Orthosis - Hip Thigh Knee Ankle - Custom Made		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061218221_0135_1_2	Orthosis - Bilateral Hip Knee Ankle Foot Orthosis (Rgo) - Prefabricated		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061219121_0135_1_2	Body Orthotic - Dynamic Or Lycra		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061219221_0135_1_2	Orthosis - Bilateral Thoracolumbar/Lumbo-Sacral Hip Knee Ankle Foot - Custom		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061236191_0135_1_2	Prosthetic - Additional Cost For Use In Wet Environment (E.G. Waterproofing)		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061500111_0135_1_2	Trunk/Lower Body Orthoses - FES Or Powered - To Support Standing And/Or Walking		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061800121_0135_1_2	Prosthetic - Upper Limb (Including Powered)		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_061826171_0135_1_2	Adaptions For Arm And Hand Prosthetics For Sport And Leisure		EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_062200921_0135_1_2	Prosthetic - Osseo-Integration Mounting Additional Cost (Upper Or Lower)		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_062409121_0135_1_2	Prosthetic - Transtibial Or Lower		EA	N	Y						✗	✗	✗	✗

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0135	Customised Prosthetics	5	Assistive technology	05_062415121_0135_1_2	Prosthetic - Transfemoral Or Higher		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_062488034_0135_1_2	Lower Limb Prostheses - Other		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_062488121_0135_1_2	Specialist Prosthetic Lower Limb For Sports		EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_063000121_0135_1_2	Prosthetic - Not Limb Related		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_090000011_0103_1_2	Assistive Products And Accessories For Personal Care, Hygiene, Beds		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_091200111_0103_1_2	Toilet Attachments And Accessories - Seat And/Or Toilet Raiser/Toileting Bidet		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_091203053_0103_1_2	Mobile Shower Commode - Low Transporter		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_091203055_0103_1_2	Mobile Shower Commode - Child Transporter		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_091203111_0103_1_2	Shower Commode - Wheeled		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_091203121_0103_1_2	Shower Commode - Wheeled - Custom Made		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_093300115_0103_1_2	Toilet And Bathroom Equipment Rental		WK	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_093305121_0103_1_2	Bathing Support - Special Design		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_093307111_0103_1_2	Change Table/Shower Trolley - Manual Or Fixed		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_093307211_0103_1_2	Change Table/Shower Trolley - Powered Adjustment		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_098800044_0103_1_2	Personal Care And Safety Equipment - Other	Includes other reasonable and necessary personal care and safety equipment not listed, due to impact of participant's disability.	EA	N	Y						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_120303111_0105_1_2	Walking Supports - Sticks, Canes And Crutches		EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_120600115_0105_1_2	Walking Equipment Rental		WK	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_120606111_0105_1_2	Walking Frame Or Walker		EA	N	Y						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_120606131_0105_1_2	Rollator And Wheeled Walkers - Paediatric - Special Design		EA	N	Y						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_120612100_0105_1_2	Walking Tables	Devices with wheels and supporting table or forearm support	EA	N	N						✗	✗	✗	✗
0109	Vehicle Modifications	5	Assistive technology	05_121200011_0109_1_2	Assistive Products Relating To Vehicles And Transport Safety		EA	N	Y						✗	✗	✗	✗
0109	Vehicle Modifications	5	Assistive technology	05_121205111_0109_1_2	Vehicle - Accessories/Adaptions For Driver Control e.g. Steering/Braking/Accel		EA	N	Y						✗	✗	✗	✗
0109	Vehicle Modifications	5	Assistive technology	05_121208111_0109_1_2	Vehicle - Accessories/Adaptions For Ancilliary Functions e.g. Lights, Locking		EA	N	N						✗	✗	✗	✗

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0109	Vehicle Modifications	5	Assistive technology	05_121209121_0109_1_2	Car Seating And/Or Seat Belts - Modifier Installed		EA	N	Y						x	x	x	x
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_121212111_0103_1_2	Specialised Child Car Seats - No Vehicle Modification Required		EA	N	Y						x	x	x	x
0109	Vehicle Modifications	5	Assistive technology	05_121215111_0109_1_2	Vehicle Hoist For Passenger Only + Sling System		EA	N	Y						x	x	x	x
0109	Vehicle Modifications	5	Assistive technology	05_121218111_0109_1_2	Vehicle Hoist For Wheelchair And Passenger + Accessories		EA	N	Y						x	x	x	x
0109	Vehicle Modifications	5	Assistive technology	05_121221111_0109_1_2	Vehicle Hoist or Ramp For Loading And/Or Securing Unoccupied Wheelchair		EA	N	Y						x	x	x	x
0109	Vehicle Modifications	5	Assistive technology	05_121227121_0109_1_2	Vehicle Chassis And/Or Body Modification For Access - Wheelchair Passengers		EA	N	Y						x	x	x	x
0108	Assistance With Travel/Transport Arrangements	5	Assistive technology	05_121227122_0108_1_2	Rental Vehicle - Adapted For Access		WK	N	N						x	x	x	x
0109	Vehicle Modifications	5	Assistive technology	05_121227221_0109_1_2	Vehicle Chassis And Body Modification For Access - Wheelchair Seated Driver		EA	N	Y						x	x	x	x
0109	Vehicle Modifications	5	Assistive technology	05_121230111_0109_1_2	Wheelchair Carrier/Trailer		EA	N	Y						x	x	x	x
0109	Vehicle Modifications	5	Assistive technology	05_121290111_0109_1_2	Vehicle Modification Engineers Certification Cost		EA	N	N						x	x	x	x
0112	Assistive Equipment For Recreation	5	Assistive technology	05_121800121_0112_1_2	Bicycle, Tricycle And/Or Carts - Adapted For Functional Needs		EA	N	Y						x	x	x	x
0112	Assistive Equipment For Recreation	5	Assistive technology	05_121805111_0112_1_2	Bicycle - Adapted For Hand Propulsion		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122200112_0105_1_2	Mobility Equipment Rental		WK	N	N						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122203107_0105_1_2	Wheelchair - Manual Folding - Child		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122203121_0105_1_2	MWC Self-Propel + Custom Folding/Rigid Frame (Add Specialised Seating)		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122203211_0105_1_2	MWC Basic Folding/Light Weight/Transit		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122203221_0105_1_2	MWC Lightweight/Ultra-Light Weight (Without Seating)		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122203321_0105_1_2	MWC - Sport And Recreation Use		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122218111_0105_1_2	MWC Attendant Propel + Custom Folding/Rigid Frame		EA	N	N						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122303111_0105_1_2	Scooter: Indoor/Outdoor Use		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122303191_0105_1_2	Scooter: Heavy Duty/Robust Activity Specific		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122303211_0105_1_2	Scooter (Electrically Powered) - Portable		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122303511_0105_1_2	Scooter: Small Folding/Travel Light-Weight Scooter		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122306111_0105_1_2	PWC Basic + Factory Seating		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122306139_0105_1_2	Wheelchair - Powered With Powered Standing Mechanism		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122306191_0105_1_2	PWC All Terrain/Heavy Duty Base (Without Seating)		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122306211_0105_1_2	PWC Basic Frame + Factory Control (Add Specialised Seating)		EA	N	Y						x	x	x	x

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0105	Personal Mobility Equipment	5	Assistive technology	05_122306221_0105_1_2	PWC Customised Base + Manual Postural Adjustment (Without Seating)		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122306321_0105_1_2	PWC Customised Base + Power Assist Height/Tilt-In-Space (Without Eating)		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122403111_0105_1_2	PWC Accessory - Alternate Operator Control System		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122409171_0105_1_2	MWC Accessory - Power-Assist Drive Technology		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122442171_0105_1_2	Wheelchair Accessory - Health-Related At/Ventilator Carrier		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122490111_0105_1_2	PWC Accessory - Powered Adjustment For Limbs Or Recline		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122707131_0105_1_2	Stroller/Pram/Buggy/Push Chair With Supportive Seating		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122707231_0105_1_2	Stroller/Pram/Buggy With Specialised Seating System		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122707331_0105_1_2	Paediatric Stroller/Wheelchair Height Adaptable Base - Specialised Seating System		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122715131_0105_1_2	Crawlers/Mobility Boards/Trolley		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_122718150_0105_1_2	Wheeled Stretcher - Self Propelled		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_123600112_0105_1_2	Transfer Equipment Rental		WK	N	N						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_123603111_0105_1_2	Mobile Hoist + Slings(X2) (Including Standing)		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_123606168_0105_1_2	Mobile Hoist - Seat Or Table		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_123612111_0105_1_2	Ceiling Hoist + Slings(X2)		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_123612511_0105_1_2	Hoists For Transfer Into/Out Of Pools/Adverse Environment		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_123621111_0105_1_2	Hoist Sling		EA	N	N						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_123621121_0105_1_2	Hoist Sling - Custom Made Or Bariatric		EA	N	N						x	x	x	x
0113	Vision Equipment	5	Assistive technology	05_123909111_0113_1_2	Visual Navigation - Tactile Maps/Acoustic Device		EA	N	Y						x	x	x	x
0105	Personal Mobility Equipment	5	Assistive technology	05_129000011_0105_1_2	Assistive Products And Accessories Relating To Personal Mobility Or Transfer		EA	N	Y						x	x	x	x
0123	Assistive Products For Household Tasks	5	Assistive technology	05_150000011_0123_1_2	Assistive Products And Accessories Relating To Participating In Household Tasks		EA	N	Y						x	x	x	x
0111	Home Modification Design And Construction	5	Assistive technology	05_180000011_0111_1_2	Assistive Products And Accessories Relating To Home Modification And Access		EA	N	Y						x	x	x	x
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_180315111_0103_1_2	Bed Furniture: Over-Bed Table Or Support		EA	N	N						x	x	x	x
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_180909111_0103_1_2	Specialised Seating With Sit-Stand Assistance		EA	N	Y						x	x	x	x

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0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_180921121_0103_1_2	Specialised Static Seating With Pressure Management And/Or Postural Support		EA	N	Y						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_180939111_0105_1_2	Customised Postural Support Componentry		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_180943112_0103_1_2	Seating/Standing Frame Equipment Rental		WK	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_181000121_0105_1_2	Custom Made Postural Seating System		EA	N	Y						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_181006111_0105_1_2	Seat Or Back Postural Support - Prefabricated (1 Piece)		EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_181006188_0105_1_2	Seat Or Back Support For Tissue Integrity Management (1 Piece)		EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_181009111_0105_1_2	Limb Or Positioning Postural Support - Prefabricated (1 Piece)		EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_181009121_0105_1_2	Limb, Foot Or Head Support For Tissue Integrity Management (1 Piece)		EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_181012111_0105_1_2	Head Postural Support - Prefabricated		EA	N	Y						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_181024111_0105_1_2	Wheelchair Accessory - Tray/Anterior Support		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_181200112_0103_1_2	Bed And Mattress Rental		WK	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_181200711_0103_1_2	Bed Access/Transfer Pole/Blocks/Rails/Rail-Covers		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_181207111_0103_1_2	Manual Beds: Bed Frame/Cot/Cradle		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_181210111_0103_1_2	Electric Beds: Adjustable Hi Lo Bed/Cot Frames With Repositioning Systems		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_181224711_0103_1_2	Custom Sleep Positioning System And Accessories		EA	N	Y						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_220000011_0124_1_2	Assistive Products And Accessories Supporting Comms And Information Needs		EA	N	Y						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_220000112_0124_1_2	Communication Equipment Rental		WK	N	N						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_220300011_0113_1_2	Assistive Products Relating To Vision		EA	N	Y						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_220318111_0113_1_2	Image Enlargement - Software		EA	N	N						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_220318211_0113_1_2	Electronic Reading Technology Using Video/Cctv		EA	N	Y						✗	✗	✗	✗
0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_220600214_0119_1_2	Services To Non-CSO Adults Who Meet OHS Complex Criteria (AH Only)		EA	N	N						✗	✗	✗	✗
0134	Hearing Services	5	Assistive technology	05_220615111_0134_1_2	Hearing Aid (One) Higher Needs - Amount In Addition To Ohs Subsidy		EA	N	Y						✗	✗	✗	✗
0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_220615211_0119_1_2	Hearing Aid (One) Non-CSO Complex Adult - AH Only - In Addition To OHS Subsidy		EA	N	Y						✗	✗	✗	✗

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0134	Hearing Services	5	Assistive technology	05_220615211_0134_1_2	Hearing Aid (Two) Higher Needs - Amount In Addition To Ohs Subsidy		EA	N	Y						✗	✗	✗	✗
0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_220615212_0119_1_2	Hearing Aid (Two) Non-CSO Complex Adult - AH Only - In Addition To OHS Subsidy		EA	N	Y						✗	✗	✗	✗
0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_220618111_0119_1_2	Vibro Tactile Devices		EA	N	Y						✗	✗	✗	✗
0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_220621111_0119_1_2	Cochlear Implant Speech Processor And Coil - Cso - Ah Only (In Kind)		EA	N	N						✗	✗	✗	✗
0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_220621211_0119_1_2	Cochlear Implant Speech Processor And Coil - Non Cso		EA	N	Y						✗	✗	✗	✗
0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_220621218_0119_1_2	External Components For Other Implantable Devices	External components for other implantable devices	EA	N	N						✗	✗	✗	✗
0122	Hearing Equipment	5	Assistive technology	05_220627111_0122_1_2	Personal Amplifiers/Binaural Listener		EA	N	Y						✗	✗	✗	✗
0134	Hearing Services	5	Assistive technology	05_220627159_0134_1_2	Hearing Aid Maintenance Ohs Voucher Client Contribution		YR	N	N						✗	✗	✗	✗
0122	Hearing Equipment	5	Assistive technology	05_220627171_0122_1_2	Remote Control For Hearing Aids		EA	N	N						✗	✗	✗	✗
0122	Hearing Equipment	5	Assistive technology	05_220627232_0122_1_2	Tv Device For Hearing Assistance	Systems for delivering sound directly from the TV to the ear	EA	N	N						✗	✗	✗	✗
0122	Hearing Equipment	5	Assistive technology	05_220627271_0122_1_2	Music Devices		EA	N	N						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_220906234_0124_1_2	Voice Amplifiers For Personal Use	Device to amplify voice.	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_221200111_0103_1_2	Education Communication: Reading/Writing/Input/Output Items		EA	N	N						✗	✗	✗	✗
0111	Home Modification Design And Construction	5	Assistive technology	05_221200111_0111_2_2	Safety: Slip Resistance Coating/Grab And/Or Guide Rails		EA	N	N						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_221221111_0113_1_2	Communication: Note-Taking/Braille/Tactile Displays		EA	N	Y						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_2218112_0113_1_2	Vision Equipment Rental		WK	N	N						✗	✗	✗	✗
0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_221824246_0119_1_2	Radio Frequency Transmission Systems For Hearing	Remote microphone sound transmission systems can be used to overcome difficulties with distance, background noise and reverberation.	EA	N	Y						✗	✗	✗	✗
0122	Hearing Equipment	5	Assistive technology	05_221830247_0122_1_2	Induction Loop Devices	Designed for individual use in private and public situations including reception counters, meetings and other appointments.	EA	N	N						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_222100111_0124_1_2	Face To Face Communication: Non-Electronic Comms Devices, Books And Tools		EA	N	N						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_222102111_0124_1_2	Software And Related Items For Advanced Comms Functions - Computer/Tablet/Phone		EA	N	N						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_222102211_0124_1_2	Adapted Commercial Comp Tablet Or Smartphone For Sensory Or Cognitive Disability		EA	N	Y						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_222106253_0124_1_2	Communication Amplifiers	Device to amplify voice	EA	N	N						✗	✗	✗	✗
0122	Hearing Equipment	5	Assistive technology	05_222106443_0122_1_2	Remote Microphone System	Remote microphone system	EA	N	Y						✗	✗	✗	✗

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0124	Communication And Information Equipment	5	Assistive technology	05_222109111_0124_1_2	Electronic Face To Face Comms - Speech Generating/Visual/Communication Devices		EA	N	Y						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_222109254_0124_1_2	Static - Single Button Device Which Provides Audible Message Output		EA	N	N						✗	✗	✗	✗
0122	Hearing Equipment	5	Assistive technology	05_222403225_0122_1_2	Adapted Landline Telephone	Assistive technology	EA	N	N						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_222406258_0113_1_2	Mobile Phone With Voice Output And Text Enlargement		EA	N	N						✗	✗	✗	✗
0111	Home Modification Design And Construction	5	Assistive technology	05_222421111_0111_2_2	Dwelling Adjustments Or Changes Required Not Otherwise Described		EA	N	N						✗	✗	✗	✗
0123	Assistive Products For Household Tasks	5	Assistive technology	05_222704111_0123_1_2	Safety Devices: Adapted Smoke Detector/Doorbells		EA	N	N						✗	✗	✗	✗
0122	Hearing Equipment	5	Assistive technology	05_222704266_0122_1_2	Baby Cry Alerting Systems For Hearing Impaired	Visual or vibrating alert	EA	N	N						✗	✗	✗	✗
0123	Assistive Products For Household Tasks	5	Assistive technology	05_222716260_0123_1_2	Adapted Devices For Phone Access/Alarms /Clocks/Programmable Memory Devices		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_222718111_0103_1_2	Seizure Mat, Location Alert Type Alarm Systems		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_222718115_0103_1_2	Monitored Alarm/Alert System		MON	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_222721111_0103_1_2	Safety Devices: Flashing – Vibrating Doorbell/Smoke Alert/ Personal Alarms		EA	N	N						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_223003279_0124_1_2	Personal Reader - Speech Output		EA	N	Y						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_223030280_0124_1_2	Personal Reader - Speech And Visual Output		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_223612175_0103_1_2	Electronic Input Device - Visual, Neural Or Neuromuscular Control		MON	N	N						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_223621191_0124_1_2	Specialised Computer Input Device Using Eye Or Neural/Neuromuscular Control		EA	N	Y						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_223621271_0124_1_2	Head Pointer	Assistive products to position screen pointer and to select items on computer display.	EA	N	Y						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_223906111_0113_1_2	Alternate Format Printer - Computer - Braille Etc.		EA	N	Y						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_223906115_0113_1_2	Braille Printers - Lease - Annual Amount		MON	N	N						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_223907278_0124_1_2	Portable Audible Player For Computer		EA	N	N						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_223912111_0113_1_2	Print Disability Software/Lp Keyboard		EA	N	Y						✗	✗	✗	✗
0123	Assistive Products For Household Tasks	5	Assistive technology	05_241300112_0123_1_2	Ecu Rental		WK	N	N						✗	✗	✗	✗
0123	Assistive Products For Household Tasks	5	Assistive technology	05_241303121_0123_1_2	Environmental Control (Ecu)/ Safety-Related Products		EA	N	Y						✗	✗	✗	✗

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0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_242400111_0103_1_2	Technology And Other Device Positioning Systems		EA	N	Y						✗	✗	✗	✗
0112	Assistive Equipment For Recreation	5	Assistive technology	05_300000011_0112_1_2	Assistive Products Relating To Recreation And Sport		EA	N	Y						✗	✗	✗	✗
0112	Assistive Equipment For Recreation	5	Assistive technology	05_300000112_0112_1_2	Recreation Equipment Rental		WK	N	N						✗	✗	✗	✗
0112	Assistive Equipment For Recreation	5	Assistive technology	05_300309111_0112_1_2	Play: Adapted Toys/Switch Toys/Adapted Game Interface		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_301_0103_1_2	Equipment Alterations And Adjustments		EA	N	N						✗	✗	✗	✗
0112	Assistive Equipment For Recreation	5	Assistive technology	05_308800285_0112_1_2	Adapted Recreation Equipment - Other	Products such as card holders, camera holders and adaptions to enable a person with disability to participate in recreational activity.	EA	N	Y						✗	✗	✗	✗
0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_351_0119_1_2	Hearing Services Program - Child 4-25 Years Old (AH Only)		EA	N	N						✗	✗	✗	✗
0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_352_0119_1_2	Referral To Australian Hearing Community Service Obligation Program	For more info see http://hearingservices.gov.au/wps/portal/hso/site/eligibility/!ut/p/a1/04_Sj9CPykssy0xPLMnMz0vMAfGjzOJ9PA2MDI1MDLz8jc2NDDzNg0LNzExdDQ28TPULsh0VAaWtp70!/	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_500000303_0103_1_2	Repairs - Other Equipment		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_500433443_0103_1_2	Repairs - Personal Care/Safety, After-Hours (One Unit)	Repairs - personal care/safety, after-hours (one unit)	EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_500612441_0135_1_2	Orthotic Repair	Orthotic repair	EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_500624304_0135_1_2	Minor Prosthetic Repair - Average Price		EA	N	N						✗	✗	✗	✗
0135	Customised Prosthetics	5	Assistive technology	05_500624305_0135_1_2	Major Prosthetic Repair - Average Price		EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_500933306_0103_1_2	Bathing And Toileting Equipment Repair	Repairs to any toileting and bathing equipment	EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_501200307_0105_1_2	Repairs - Mobility Domain - Wheeled Mobility Minor Repair	Smaller repairs on newer chairs recently past warranty	EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_501200308_0105_1_2	Repairs - Mobility Domain - Wheeled Mobility Major Repair	Includes repairs for chairs usually over 4 years old, which may require work on actuators or other parts.	EA	N	Y						✗	✗	✗	✗
0109	Vehicle Modifications	5	Assistive technology	05_501212373_0109_1_2	Repair Vehicle Modification	Repairs to specialist vehicle hoists, tie downs, driving adaptions	EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_501224309_0105_1_2	Tyres		EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_501224310_0105_1_2	Battery Or Charger		EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_501236025_0105_1_2	Transfer Equipment Repair	Transfer equipment repair	EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_501288435_0105_1_2	Repairs - Mobility Domain - After-Hours (One Unit)	Repairs - mobility domain, after-hours (one unit)	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_501812311_0103_1_2	Electric Bed Repair		EA	N	N						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_502200312_0124_1_2	Communication Equipment Or ECU Repairs	Communication equipment or ECU repairs	EA	N	N						✗	✗	✗	✗

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0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_502206151_0119_1_2	Cochlear And Other Implantable Processor Repairs		EA	N	N						✗	✗	✗	✗
0119	Specialised Hearing Services (Equipment Special Assess Setup)	5	Assistive technology	05_502206413_0119_1_2	Voice Generators		EA	N	Y						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_502218315_0113_1_2	Vision Equipment Repair		EA	N	N						✗	✗	✗	✗
0112	Assistive Equipment For Recreation	5	Assistive technology	05_503000316_0112_1_2	Specialised Recreation Equipment Repairs		EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_700912325_0103_1_2	Toilet And Bathroom Equipment Delivery - Set Up/Training	Equipment delivery, removal from wrapping, fitting/adjusting for participant's disability specific needs and or training.	H	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_701206326_0105_1_2	Walking Equipment Delivery - Set Up/Training	Equipment delivery, removal from wrapping, fitting/adjusting for participant's disability specific needs and or training.	EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_701236327_0105_1_2	Transfer Equipment Delivery - Set Up/Training	Equipment delivery, removal from wrapping ready, fitting/adjusting for participant and or training.	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_701809328_0103_1_2	Seating/Standing Frame Equipment Delivery To A Participant	Equipment delivery, removal from wrapping, fitting/adjusting for participant's disability specific needs and or training.	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_701809338_0103_1_2	Seating/Standing Frame Equipment Delivery - Set Up/Training	Equipment delivery, removal from wrapping ready, fitting/adjusting for participant and or training.	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_701812329_0103_1_2	Bed/Mattress Equipment Delivery - Set Up/Training	Equipment delivery, removal from wrapping, fitting/adjusting for the participant's disability specific needs and/or training in usage.	EA	N	N						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_702218330_0113_1_2	Vision Equipment Delivery - Set Up/Training	Equipment delivery, removal from wrapping, fitting/adjusting for participant and or training.	EA	N	N						✗	✗	✗	✗
0124	Communication And Information Equipment	5	Assistive technology	05_702288440_0124_1_2	Programming/Customisation Of Electronic Equipment	Programming / customisation of electronic equipment	H	N	N						✗	✗	✗	✗
0123	Assistive Products For Household Tasks	5	Assistive technology	05_702413331_0123_1_2	ECU Equipment Delivery - Set Up/Training	Equipment delivery, removal from wrapping, fitting/adjusting for participant disability specific needs and/ or training.	EA	N	N						✗	✗	✗	✗
0112	Assistive Equipment For Recreation	5	Assistive technology	05_703000332_0112_1_2	Recreation Equipment Delivery - Set Up/Training	Equipment delivery, removal from wrapping, set up adjustment and training for the participant's disability specific needs.	EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_705012333_0105_1_2	Mobility Equipment Delivery - Set Up/Training	Equipment delivery, removal from wrapping ready, fitting/adjusting for participant and or training.	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_710912335_0103_1_2	Toilet And Bathroom Equipment Delivery	Equipment delivery and removal from wrapping ready for use	EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_711206336_0105_1_2	Walking Equipment Delivery To A Participant	Equipment delivery and removal from wrapping ready for use	EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_711236337_0105_1_2	Transfer Equipment Delivery To A Participant	Equipment delivery and removal from wrapping ready for use	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_711812339_0103_1_2	Bed/Mattress Equipment Delivery To A Participant	Equipment delivery and removal from wrapping ready for use	EA	N	N						✗	✗	✗	✗
0113	Vision Equipment	5	Assistive technology	05_712218340_0113_1_2	Vision Equipment Delivery To A Participant	Equipment delivery and removal from wrapping ready for use	EA	N	N						✗	✗	✗	✗
0123	Assistive Products For Household Tasks	5	Assistive technology	05_712413341_0123_1_2	ECU Equipment Delivery To A Participant	Equipment delivery and removal from wrapping ready for use	EA	N	N						✗	✗	✗	✗
0112	Assistive Equipment For Recreation	5	Assistive technology	05_713000342_0112_1_2	Recreation Equipment Delivery To A Participant	Equipment delivery and removal from wrapping ready for use	EA	N	N						✗	✗	✗	✗
0105	Personal Mobility Equipment	5	Assistive technology	05_715012343_0105_1_2	Mobility Equipment Delivery	Equipment delivery and removal from wrapping ready for use	EA	N	N						✗	✗	✗	✗

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0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_718888439_0103_1_2	General Satchel/Post Delivery Of Equipment To A Participant	General satchel/post delivery of equipment to a participant	EA	N	N						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	5	Assistive technology	05_801288434_0103_1_2	Flexible Equipment Package (For Changing Need) - Annual Amount	Flexible equipment package (for changing need) - annual amount	EA	N	Y						✗	✗	✗	✗
0130	Assistance Animals (Other Innovative Supports)	5	Assistive technology	05_900101111_0130_1_2	Assistance Dog (Including Dog Guide)		EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_121703375_0111_2_2	Stair Climber Directed By Attendant For Wheelchair	Portable tracked device which a wheelchair attaches to and then is tracked upstairs by attendant.	EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_181806381_0111_2_2	Grab Rails - Internal Supply And Install		EA	N	N						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_181806382_0111_2_2	Home Modifications - Rails - External		EA	N	N						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182400121_0111_2_2	Internal Dwelling Access/Doors /Minor Steps		EA	N	N						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182400221_0111_2_2	Home Modifications - Kitchen Adaption - No Structural Work		EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182400321_0111_2_2	Bathroom/Shower/Toilet/Taps & Sinks/Grab Rails		EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182488377_0111_2_2	Home Modifications - Bathroom Mod - Extensive Structural Work	Extensive structural bathroom changes. For example, removal of a bath or hobless-shower, electrical work, relocating plumbing, widening doorway, waterproofing or changes to the fit-out such as toilet, tap ware, basin, shower, rails paint and tiles.	EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182488378_0111_2_2	Home Modifications - Bathroom Mod - Incl. Combining Bathroom, Toilet Or Laundry	Modifications to combine bathroom, toilet and laundry. Includes bath removal, hobless shower creation, plumbing relocation, electrical work, doorway changes, waterproofing and changes to bathroom fittings.	EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182490112_0111_2_2	CHM – Building Works Project Management		EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182495121_0111_2_2	CHM – Deposit		EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182495221_0111_2_2	CHM – Progress Stage		EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182495321_0111_2_2	CHM – Practical Completion		EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182495421_0111_2_2	CHM – Certification And Compliance Approval		EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182499111_0111_2_2	Certification Or Approval Of Home Modifications		EA	N	N						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_182499211_0111_2_2	Project Management Of Home Modifications		EA	N	N						✗	✗	✗	✗

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0111	Home Modification Design And Construction	6	Home modifications	06_182499311_0111_2_2	Consultation About Home Modification Designs With Builder		EA	N	N						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_183003384_0111_2_2	Elevator - Home		EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_183010387_0111_2_2	Lifts/Stair Climbers/Elevator	Seat and rails attached to stairs or incline for ambulant person to ride up stairs on.	EA	N	Y						✗	✗	✗	✗
0103	Assistive Products For Personal Care And Safety	6	Home modifications	06_183015111_0103_2_2	Portable Fibreglass Ramp		EA	N	N						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_183018396_0111_2_2	Ramps Timber With Galvanised Rails - 300 Per Lineal Meter	Permanently installed timber ramp with galvanised rails	EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_183018397_0111_2_2	Ramps Concrete With Galvanised Rails - 400 Per Lineal Meter	Permanently installed concrete ramp with galvanised rails	EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_183018398_0111_2_2	Ramps Modular Aluminium Removable - 2400mm X 1200mm	Temporary removable ramps which are not portable	EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_183018399_0111_2_2	Ramps Modular Aluminium Removable - 600mm X 1200mm	Temporary removable ramps which are not portable	EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_183018400_0111_2_2	Ramps Modular Aluminium Removable - 2400mm X 1800mm (Landing)	Temporary removable ramps which are not portable	EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_183018401_0111_2_2	Ramps Modular Aluminium Removable - 1200mm X 1200mm (Landing)	Temporary removable ramps which are not portable	EA	N	Y						✗	✗	✗	✗
0111	Home Modification Design And Construction	6	Home modifications	06_183018403_0111_2_2	Fixed Dwelling Access/Entrance/Ramp		EA	N	N						✗	✗	✗	✗
0131	Specialised Disability Accommodation	6	Home modifications	06_431_0131_2_2	Specialist Disability Accommodation (SDA)	SDA is an adjusted contribution to the cost of the physical building, including the land it is on. The quote will reflect unique dwelling price based on the SDA enrolment process.	EA	N	Y						✗	✗	✗	✗
0131	Specialised Disability Accommodation	6	Home modifications	06_432_0131_2_2	SDA Vacancy - Person-Specific Adjustment	A temporary payment for providers, available in limited circumstances when a participant moves out of an SDA dwelling accommodates 4 or more residents.	EA	N	Y						✗	✗	✗	✗
0106	Assistance In Coordinating Or Managing Life Stages, Transitions And Supports	7	Support Coordination	07_001_0106_8_3	Level 1: Support Connection	Assistance for participants to implement their plan by strengthening the ability to connect with the broader systems of supports and understand the purpose of the funded supports and participate in the community. Support Connection will assist a participant to understand the aspects of the plan, assisting in ongoing management of supports, and answer questions as they arise.	H	Y	N			$60.16	$84.22	$90.24	✓	✓	✓	✓
0106	Assistance In Coordinating Or Managing Life Stages, Transitions And Supports	7	Support Coordination	07_002_0106_8_3	Level 2: Coordination Of Supports	Further qualifications/experience required to strengthen a participant's ability to design and the build their supports with an emphasis on linking the broader systems of support across a complex service delivery environment. Coordination of Supports is to focus on supporting participants to direct their lives, not just their services. This may include resolving points of crisis, and developing resilience in the participant's network.	H	Y	N			$98.06	$137.28	$147.09	✓	✓	✓	✓

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0117	Development Of Daily Living And Life Skills	7	Support Coordination	07_003_0117_8_3	CB and Training in Plan and Financial Management by a Support Coordinator	Capacity building and training in plan administration and management with a participant to strengthen their ability to undertake tasks associated with the management of their supports. Providers of this support are to assist the participant to build capacity to undertake all aspects of plan administration and management, including: engaging providers; developing service agreements; maintaining records; claiming payments from the NDIA; and paying providers.	H	Y	N			$58.52	$81.93	$87.78	✓	✓	✓	✓
0132	Support Coordination	7	Support Coordination	07_004_0132_8_3	Level 3: Specialist Support Coordination	Generally delivered in a time limited, outcomes focused manner and by an appropriately qualified and experienced practitioner to meet the individual needs of the participant's circumstances. Necessitated by specific high complex needs or high level risks in a participant's situation, to reduce complexity in the participant's support environment in the context of broader systems of support, whilst also assisting the participant to connect with NDIS supports, negotiate solutions with multiple stakeholders and build capacity and resilience.	H	Y	N			$186.58	$261.21	$279.87	✓	✓	✓	✓
0106	Assistance In Coordinating Or Managing Life Stages, Transitions And Supports	8	Improved living arrangements	08_005_0106_2_3	Assistance With Accommodation And Tenancy Obligations	Support is provided to guide, prompt or undertake activities to ensure the participant obtains and/or retains appropriate accommodation. May include assisting to apply for a rental tenancy or to undertake tenancy obligations.	H	Y	N			$60.16	$84.22	$90.24	✗	✓	✗	✗
0106	Assistance In Coordinating Or Managing Life Stages, Transitions And Supports	9	Increased social and community participation	09_006_0106_6_3	Life Transition Planning Incl. Mentoring, Peer-Support And Indiv Skill Develop	Establishing volunteer assistance within the participant's home or community to develop skills. For instance, assistance in attending appointments, shopping, bill paying, taking part in social activities and maintaining contact with others.	H	Y	N			$60.16	$84.22	$90.24	✓	✓	✗	✗
0117	Development Of Daily Living And Life Skills	9	Increased social and community participation	09_007_0117_6_3	Skills Development In A Group	Training for the participant in a group of 2 or more to increase their independence in daily personal activities.	H	Y	N			$29.26	$40.96	$43.89	✓	✓	✗	✗
0116	Innovative Community Participation	9	Increased social and community participation	09_008_0116_6_3	Innovative Community Participation	Mainstream services that promote inclusion of people with disability to expand opportunities for community participation and employment.	EA	N	N						✗	✗	✗	✗
0117	Development Of Daily Living And Life Skills	9	Increased social and community participation	09_009_0117_6_3	Individual Skills Development And Training	Individual life skills development and training including public transport training and support, developing skills for community, social and recreational participation.	H	Y	N			$58.52	$81.93	$87.78	✓	✓	✗	✗
0125	Participation In Community, Social And Civic Activities	9	Increased social and community participation	09_010_0125_6_3	Community Participation Activities	Participation in community based activities that build skills and independence.	YR	N	N						✗	✗	✗	✗

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0128	Therapeutic Supports	10	Finding and keeping a job	10_011_0128_5_3	Employment Related Assessment And Counselling	This support is designed to provide workplace assessment and/or counselling to assist participants successfully engage in employment. For workplace assessments - if a participant is employed and on award wages, then in most instances a work place assessment is available through the Employment Assistance Fund administered by JobAccess and is a free service to employers. For employment related counselling, this service may benefit participants who have, for example, experienced traumatic injury and need significant support (over and above a mainstream employment related service) to develop a new work pathway.	EA	Y	N			$193.99	$271.59	$290.99	✓	✓	✓	✓
0133	Specialised Supported Employment	10	Finding and keeping a job	10_012_0133_5_3	Assistance In Specialised Supported Employment Level 1 DMI	Assistance in specialised supported employment Level 1 DMI	WK	N	N						✗	✗	✗	✗
0133	Specialised Supported Employment	10	Finding and keeping a job	10_013_0133_5_3	Assistance In Specialised Supported Employment Level 2 DMI	Assistance in specialised supported employment Level 2 DMI	WK	N	N						✗	✗	✗	✗
0133	Specialised Supported Employment	10	Finding and keeping a job	10_014_0133_5_3	Assistance In Specialised Supported Employment Level 3 DMI	Assistance in specialised supported employment Level 3 DMI	WK	N	N						✗	✗	✗	✗
0133	Specialised Supported Employment	10	Finding and keeping a job	10_015_0133_5_3	Assistance In Specialised Supported Employment Level 4 DMI	Assistance in specialised supported employment Level 4 DMI	WK	N	N						✗	✗	✗	✗
0102	Assist To Access/Maintain Employ/Ed (Assist Access/Maintain Employ)	10	Finding and keeping a job	10_016_0102_5_3	Individual Employment Support	This support can be applied to any working age participant (including students reaching working age) with an employment goal. This may include supports to: • explore what work would mean for them (discovery) • build essential foundation skills for work • managing complex barriers to obtaining and sustaining employment • specialised job customisation • supports to transition from an ADE to open employment. • develop a career plan • other capacity building supports which are likely to lead to successful engagement in a DES.	H	Y	N			$59.03	$82.64	$88.55	✓	✓	✓	✓

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0102	Assist To Access/Maintain Employ/Ed (Assist Access/Maintain Employ)	10	Finding and keeping a job	10_017_0102_5_3	Employment Preparation And Support In A Group - Group Of 3	These support can be applied to any working age, as above, but is offered in a group environment. This may include supports to: • explore what work would mean for them (discovery) • build essential foundation skills for work • managing complex barriers to obtaining and sustaining employment • specialised job customisation • supports to transition from an ADE to open employment. • develop a career plan • other capacity building supports which are likely to lead to successful engagement in a DES. • Please note: this support item would not applied to a Certified education course, even if run within the provider's services, as this would be funded through the Vocational Education system. (e.g. Certificate I in Workplace Education)	H	Y	N			$19.68	$27.55	$29.52	✓	✓	✓	✓
0133	Specialised Supported Employment	10	Finding and keeping a job	10_018_0133_5_3	Supported Employment Start-Up Fee (ADE)	Supported employment administrative start-up fee, paid only once when a participant starts with an ADE.	EA	N	N						✗	✗	✗	✗
0133	Specialised Supported Employment	10	Finding and keeping a job	10_020_0133_5_3	Support In Employment (ADE)	Support in employment (ADE)	EA	N	N						✗	✗	✗	✗
0102	Assist To Access/Maintain Employ/Ed (Assist Access/Maintain Employ)	10	Finding and keeping a job	10_021_0102_5_3	School Leaver Employment Supports	School leaver employment supports are capacity building supports for students transitioning from school to employment. These supports should be included, where reasonable and necessary, as part of the students scheduled plan review in the final year of school to ensure supports are available at school exit.	EA	N	N						✗	✗	✓	✗
0110	Behaviour Support	11	Improved relationships	11_022_0110_7_3	Specialist Behavioural Intervention Support	Highly specialised intensive support interventions to address significantly harmful or persistent behaviours of concern. Development of behaviour support plans that temporarily use restrictive practices, with intention to minimise use of these practices.	H	Y	N	$234.83	$214.41		$328.76	$352.25	✓	✓	✓	✓
0110	Behaviour Support	11	Improved relationships	11_023_0110_7_3	Behaviour Management Plan Incl. Training In Behaviour Management Strategies	Training for carers and others in behaviour management strategies required due the participant's disability.	H	Y	N	$193.99	$193.99		$271.59	$290.99	✓	✓	✓	✓
0117	Development Of Daily Living And Life Skills	11	Improved relationships	11_024_0117_7_3	Individual Social Skills Development	Social skills development with an individual, for participation in community and social activities.	H	Y	N			$58.52	$81.93	$87.78	✓	✓	✓	✓
0128	Therapeutic Supports	12	Improved health and wellbeing	12_025_0128_3_3	Dietician Consultation And Diet Plan Development	Individual advice to a participant on managing diet for health and well-being due to the impact of their disability.	H	Y	N	$193.99	$193.99		$271.59	$290.99	✓	✓	✓	✓
0128	Therapeutic Supports	12	Improved health and wellbeing	12_026_0128_3_3	Dietician Group Session - Group of 3	Group based specialist dietary advice on managing diet for well-being due to the impact of their disability. This assumes a group of 3.	H	Y	N	$64.66	$64.66		$90.52	$96.99	✓	✓	✓	✓
0126	Exercise Physiology And Physical Wellbeing Activities (Physical Wellbeing)	12	Improved health and wellbeing	12_027_0126_3_3	Exercise Physiology	Individual advice to a participant regarding exercise required due to the impact of their disability.	H	Y	N			$166.99	$233.79	$250.49	✓	✓	✓	✓

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0126	Exercise Physiology And Physical Wellbeing Activities (Physical Wellbeing)	12	Improved health and wellbeing	12_028_0126_3_3	Exercise Physiology In A Group - Group of 3	Advice to a participant regarding exercise required due to the impact of their disability, provided in group setting, assuming a group of 3.	H	Y	N			$55.66	$77.92	$83.49	✓	✓	✓	✓
0126	Exercise Physiology And Physical Wellbeing Activities (Physical Wellbeing)	12	Improved health and wellbeing	12_029_0126_3_3	Personal Training	Personal training provided to a participant due to the impact of their disability.	H	Y	N			$56.89	$79.65	$85.34	✓	✓	✓	✓
0102	Assist To Access/Maintain Employ/Ed (Assist Access/Maintain Employ)	13	Improved learning	13_030_0102_4_3	Transition Through School And To Further Education	Provision of skills training, advice, assistance with arrangements and orientation to assist a person with disability moving from school to further education.	H	Y	N			$60.16	$84.22	$90.24	✗	✓	✗	✗
0127	Management Of Funding For Supports In Participants Plan	14	Improved life choices	14_031_0127_8_3	CB and Training in Plan and Financial Management by a Plan Manager	Capacity building and training in plan administration and management with a participant to strengthen their ability to undertake tasks associated with the management of their supports. Providers of this support are to assist the participant to build capacity to undertake all aspects of plan administration and management, including: engaging providers; developing service agreements; maintaining records; claiming payments from the NDIA; and paying providers.	H	Y	N			$58.52	$81.93	$87.78	✗	✓	✗	✗
0127	Management Of Funding For Supports In Participants Plan	14	Improved life choices	14_033_0127_8_3	Plan Management And Financial Capacity Building - Set Up Costs	A one-off (per plan) establishment fee for setting up of the financial management arrangements for managing of funding of supports.	EA	Y	N			$227.53	$318.54	$341.30	✗	✓	✗	✗
0127	Management Of Funding For Supports In Participants Plan	14	Improved life choices	14_034_0127_8_3	Plan Management - Financial Administration	A monthly fee for the ongoing maintenance of the financial management arrangements for managing of funding of supports.	MON	Y	N			$102.28	$143.19	$153.42	✗	✓	✗	✗
0118	Early Intervention Supports For Early Childhood	15	Improved daily living skills	15_001_0118_1_3	Capacity Building Supports For Early Childhood Interventions - Psychology	Capacity building supports, including key worker, to assist a child with developmental delay and/or disability and their family/carers in home, community and early childhood education settings, to work towards increased functional independence and social participation. To be delivered by a Psychologist.	H	Y	N	$234.83	$214.41		$328.76	$352.25	✓	✓	✓	✓
0118	Early Intervention Supports For Early Childhood	15	Improved daily living skills	15_002_0118_1_3	Capacity Building Supports For Early Childhood - Group up to 4 - Psychology	Group based specialist interventions to assist a child with disability or developmental delay and their family in home, care, community and education settings. Maximum group of 4. To be delivered by a Psychologist.	H	Y	N	$78.28	$71.47		$109.59	$117.42	✓	✓	✓	✓
0118	Early Intervention Supports For Early Childhood	15	Improved daily living skills	15_003_0118_1_3	Capacity Building Supports For Early Childhood Interventions - Physiotherapy	Capacity building supports, including key worker, to assist a child with developmental delay and/or disability and their family/carers in home, community and early childhood education settings, to work towards increased functional independence and social participation. To be delivered by a Physiotherapist.	H	Y	N	$224.62	$193.99		$314.47	$336.93	✓	✓	✓	✓
0118	Early Intervention Supports For Early Childhood	15	Improved daily living skills	15_004_0118_1_3	Capacity Building Supports For Early Childhood - Group up to 4 - Physiotherapy	Group based specialist interventions to assist a child with disability or developmental delay and their family in home, care, community and education settings. Maximum group of 4. To be delivered by a Physiotherapist	H	Y	N	$74.87	$64.66		$104.82	$112.31	✓	✓	✓	✓

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0118	Early Intervention Supports For Early Childhood	15	Improved daily living skills	15_005_0118_1_3	Capacity Building Supports For Early Childhood Interventions - Other Therapy	Capacity building supports, including key worker, to assist a child with developmental delay and/or disability and their family/carers in home, community and early childhood education settings, to work towards increased functional independence and social participation.	H	Y	N	$193.99	$193.99		$271.59	$290.99	✓	✓	✓	✓
0118	Early Intervention Supports For Early Childhood	15	Improved daily living skills	15_006_0118_1_3	Capacity Building Supports For Early Childhood - Group up to 4 - Other Therapy	Group based specialist interventions to assist a child with disability or developmental delay and their family in home, care, community and education settings. Maximum group of 4.	H	Y	N	$64.66	$64.66		$90.52	$96.99	✓	✓	✓	✓
0118	Early Intervention Supports For Early Childhood	15	Improved daily living skills	15_007_0118_1_3	Capacity Building Supports For Early Childhood Allied Health Assistant – Level 1	Capacity building supports, including key worker, to assist a child with developmental delay and/or disability and their family/carers in home, community and early childhood education settings, to work towards increased functional independence and social participation. To be delivered by an allied health assistant working under the delegation and direct supervision at all times of a therapist. The allied health assistant must be covered by the professional indemnity insurance of the supervising therapist (or the therapist's employing provider).	H	Y	N			$56.16	$78.62	$84.24	✓	✓	✓	✓
0118	Early Intervention Supports For Early Childhood	15	Improved daily living skills	15_008_0118_1_3	Capacity Building Supports For Early Childhood Allied Health Assistant – Level 2	Capacity building supports, including key worker, to assist a child with developmental delay and/or disability and their family/carers in home, community and early childhood education settings, to work towards increased functional independence and social participation. To be delivered by an allied health assistant working under the delegation and supervision of a therapist, where the therapist is satisfied that the allied health assistant is able to work independently without direct supervision at all times. The allied health assistant must be covered by the professional indemnity insurance of the supervising therapist (or the therapist's employing provider).	H	Y	N			$86.79	$121.51	$130.19	✓	✓	✓	✓
0106	Assistance In Coordinating Or Managing Life Stages, Transitions And Supports	15	Improved daily living skills	15_035_0106_1_3	Assistance With Decision Making, Daily Planning and Budgeting	Provision of time limited support to assist a person to develop and maintain daily budget, including assisting in planning purchases.	H	Y	N			$46.31	$64.83	$69.47	✓	✓	✓	✓
0114	Community Nursing Care For High Needs	15	Improved daily living skills	15_036_0114_1_3	Individual Assessment And Support By A Nurse	Provision of care, training and supervision of a delegated worker to respond to the complex care needs of a participant where that care is not the usual responsibility of the health system.	H	Y	N			$99.83	$139.76	$149.75	✓	✓	✓	✓
0117	Development Of Daily Living And Life Skills	15	Improved daily living skills	15_037_0117_1_3	Individual Skill Development And Training Including Public Transport Training	Individual training provided in the home for general life skills to increase independence.	H	Y	N			$46.31	$64.83	$69.47	✓	✓	✓	✓
0117	Development Of Daily Living And Life Skills	15	Improved daily living skills	15_038_0117_1_3	Training For Carers/Parents	Training for carers in matters related to caring for a person with disability.	H	Y	N			$58.52	$81.93	$87.78	✓	✓	✓	✓

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0118	Early Intervention Supports For Early Childhood	15	Improved daily living skills	15_041_0118_1_3	Transdisciplinary Early Childhood Intervention	A coordinated & integrated program where multiple professionals share responsibility in evaluating, planning & implementing supports to improve capacity of a child with disability or developmental delay & their family. Quote based on annual amount.	EA	N	Y						✗	✗	✗	✗
0128	Therapeutic Supports	15	Improved daily living skills	15_042_0128_1_3	Counselling Group - Group Of 3	Facilitating self-knowledge, emotional acceptance and growth and the optimal development of personal resources through a group session. Assisting participants to gain their personal goals and gain greater insight into their lives. Group of 3.	H	Y	N			$52.05	$72.87	$78.08	✓	✓	✓	✓
0128	Therapeutic Supports	15	Improved daily living skills	15_043_0128_1_3	Individual Counselling	Facilitating self-knowledge, emotional acceptance and growth and the optimal development of personal resources on a one to one basis. Assist participants to work towards their personal goals and gain greater insight into their lives.	H	Y	N			$156.16	$218.62	$234.24	✓	✓	✓	✓
0128	Therapeutic Supports	15	Improved daily living skills	15_045_0128_1_3	Community Engagement Assistance	Program to empower participants and improve interactions between participants and their social networks. Assistance to engage effectively in the community through a group approach to help achieve goals, gain insight into their lives and make informed decisions.	H	Y	N			$43.48	$60.87	$65.22	✓	✓	✓	✓
0129	Specialised Driver Training	15	Improved daily living skills	15_046_0129_1_3	Specialised Driver Training	Driving lessons required due to the impact of a participant's disability. This item should be in response to a driver trained specialist Occupational Therapist Assessment.	EA	N	Y						✗	✗	✗	✗
0135	Customised Prosthetics	15	Improved daily living skills	15_047_0135_1_3	Selection And/Or Manufacture Of Customised Or Wearable Technology	Selection and/or manufacturing of customised or wearable technology.	H	Y	N	$193.99	$193.99		$271.59	$290.99	✓	✓	✓	✓
0128	Therapeutic Supports	15	Improved daily living skills	15_049_0128_1_3	Multidisciplinary Team	Multidisciplinary team	EA	N	N						✗	✗	✗	✗
0114	Community Nursing Care For High Needs	15	Improved daily living skills	15_051_0114_1_3	Community Nursing Care For Continence Aid	Continence aids: assessment, recommendation, and training delivered by a nurse.	H	Y	N			$99.83	$139.76	$149.75	✓	✓	✓	✓
0128	Therapeutic Supports	15	Improved daily living skills	15_052_0128_1_3	Therapy Assistant - Level 1	Allied health assistant working under the delegation and direct supervision at all times of a therapist. The allied health assistant must be covered by the professional indemnity insurance of the supervising therapist (or the therapist's employing provider).	H	Y	N			$56.16	$78.62	$84.24	✓	✓	✓	✓
0128	Therapeutic Supports	15	Improved daily living skills	15_053_0128_1_3	Therapy Assistant - Level 2	Allied health assistant working under the delegation and supervision of a therapist, where the therapist is satisfied that the allied health assistant is able to work independently without direct supervision at all times. The allied health assistant must be covered by the professional indemnity insurance of the supervising therapist (or the therapist's employing provider).	H	Y	N			$86.79	$121.51	$130.19	✓	✓	✓	✓
0128	Therapeutic Supports	15	Improved daily living skills	15_054_0128_1_3	Assessment, Recommendation, Therapy And/Or Training (Incl. AT) - Psychology	Assessment, Recommendation, Therapy And/Or Training (incl. AT). To be delivered by a Psychologist.	H	Y	N	$234.83	$214.41		$328.76	$352.25	✓	✓	✓	✓
0128	Therapeutic Supports	15	Improved daily living skills	15_055_0128_1_3	Assessment, Recommendation, Therapy And/Or Training (Incl. AT) - Physiotherapy	Assessment, Recommendation, Therapy And/Or Training (incl. AT). To be delivered by a Physiotherapist.	H	Y	N	$224.62	$193.99		$314.47	$336.93	✓	✓	✓	✓
0128	Therapeutic Supports	15	Improved daily living skills	15_056_0128_1_3	Assessment, Recommendation, Therapy And/Or Training (Incl. AT) - Other Therapy	Assessment, Recommendation, Therapy And/Or Training (incl. AT).	H	Y	N	$193.99	$193.99		$271.59	$290.99	✓	✓	✓	✓

NDIA Support Catalogue

Registration Group Number	Registration Group Name	Support Category Number	Support Category Name	Support Item Number	Support Item Name	Support Item Description	Unit	Price Controlled	Quote Required	NT - SA TAS-WA (MM 1-5)	ACT - NSW QLD - VIC (MM 1-5)	National Non-Remote (MM 1-5)	National Remote (MM 6)	National Very Remote (MM 7)	Travel	Cancellations	NDIA Reporting	Non-F2F
0128	Therapeutic Supports	15	Improved daily living skills	15_057_0128_1_3	Group Therapy - Group Of 3 - Psychology	Provision of interventions by more than one professional in a group session towards the participants agreed goals. Group of 3. To be delivered by a Psychologist.	H	Y	N	$78.28	$71.47		$109.59	$117.42	✓	✓	✓	✓
0128	Therapeutic Supports	15	Improved daily living skills	15_058_0128_1_3	Group Therapy - Group Of 3 - Physiotherapy	Provision of interventions by more than one professional in a group session towards the participants agreed goals. Group of 3. To be delivered by a Physiotherapist	H	Y	N	$74.87	$64.66		$104.82	$112.31	✓	✓	✓	✓
0128	Therapeutic Supports	15	Improved daily living skills	15_059_0128_1_3	Group Therapy - Group Of 3 - Other Therapy	Provision of interventions by more than one professional in a group session towards the participants agreed goals. Group of 3.	H	Y	N	$64.66	$64.66		$90.52	$96.99	✓	✓	✓	✓
0126	Exercise Physiology And Physical Wellbeing Activities (Physical Wellbeing)	15	Improved daily living skills	15_200_0126_1_3	Exercise Physiology	Individual advice to a participant regarding exercise required due to the impact of their disability.	H	Y	N			$166.99	$233.79	$250.49	✓	✓	✓	✓
0126	Exercise Physiology And Physical Wellbeing Activities (Physical Wellbeing)	15	Improved daily living skills	15_201_0126_1_3	Exercise Physiology In A Group - Group of 3	Advice to a participant regarding exercise required due to the impact of their disability, provided in group setting, assuming a group of 3.	H	Y	N			$55.66	$77.92	$83.49	✓	✓	✓	✓
0135	Customised Prosthetics	15	Improved daily living skills	15_306_0119_1_3	Selection And/Or Manufacture Of Customised Or Wearable Technology	Selection and/or manufacturing of customised or wearable technology.	EA	Y	N	$193.99	$193.99		$271.59	$290.99	✓	✓	✓	✓

The NDIS Price Guide is subject to change. The latest version of the NDIS Price Guide is available on the NDIS website.

Version	Details of Amendment	Date
1.0		25-Jun-19
1.1	Updated the price limits for support items for Group Based Community Participation with ratios 1:2 - 1:5.	28-Jun-19
	Clarified that providers are not able to claim for non-face-to-face services for Group Based Community Participation with ratios 1:2 - 1:5.	
	Corrected an error in the names of states in the state based columns.	
	Updated the name of one Support Category from "Coordination of Supports" to "Support Coordination".	

Australian Industry Group

4 YEARLY REVIEW OF MODERN AWARDS

Reply Submission – Claims Concerning Travel

Social, Community, Home Care and Disability Services Industry Award 2010 (AM2018/26)

16 September 2019

AM2018/26 SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES AWARD 2010

CLAIMS CONCERNING TRAVEL

1. INTRODUCTION

1. The Australian Industry Group (**Ai Group**) advances these submissions in response to the Australian Services Union (**ASU**) United Voice and the Health Services Union (**HSU**) claims relating to the payment of travel undertaken by employees (**Travel Time Claims**) and the HSU's proposed variation to clause 20.5(a), which relates to the vehicle allowance provided by the *Social, Community, Home Care and Disability Services Industry Award 2010* (**Award**).

2. The submission addresses the following matters:

   (a) The context in which the claims are advanced, including a consideration of the relevant circumstances of the industry and the other claims being pursued by the unions.

   (b) The nature and effect of the proposed variations.

   (c) The operation of relevant current award provisions.

   (d) Considerations associated with the merit of the claims, including:

      (i) The current funding arrangements;

      (ii) Concerns over the workability of the Travel Time Claims; and

      (iii) The modern awards objective.

   (e) Specific arguments relating to the HSU's proposed amendments to the current award provisions governing when a vehicle allowance is payable.

2. THE CONTEXT IN WHICH THE CLAIMS ARE ADVANCED

3. It is uncontentious that the work of some employees covered by the Award requires employees to work at different locations during the course of a single day.

4. Moreover, we doubt that it is contentious that in some instances employees will travel directly and immediately between consecutive clients in order to undertake such work. In other instances, employees may, during the course of a single day, undertake work at different locations but at times which mean that there is a substantial break between the time spent undertaking client facing work.

5. It should be uncontentious that the above described working arrangements are widespread and long standing in the context of this sector. This is both reflected in the material filed in these proceedings and the provisions of various predecessor instruments to the Award.

6. The implementation of the National Disability Insurance Scheme (**NDIS**) and the resulting necessity for the implementation for client-orientated working arrangements in the sector has, we argue, been an even greater catalyst for the adoption of such practices than traditional funding arrangements. This is because:

   (a) Employers now have reduced capacity to schedule the manner in which clients are serviced; and

   (b) There are limits on the amount an employer in this sector can charge for time spent travelling.

7. In thiss context, United Voice, the ASU and the HSU have advanced claims and submissions that variously assert that time spent travelling between clients either is or should be regarded as ‘work’ and that it should attract a relevant payment. The HSU has also sought to expand the circumstances in which the vehicle allowance currently provided under the Award applies, so as to make employers liable for an employee’s costs associated with getting to and from work.

8. In assessing the unions' claims, the Full Bench should consider the degree of interconnectedness between them and the other claims advanced in the context of these proceedings. In this regard we point in particular to the claims advanced by the unions relating to minimum engagements and restrictions on the use of broken shifts. Without accepting that any of the proposed variations are warranted, we observe that granting any of the proposed changes would lessen the force of any argument that the other changes are necessary, in the sense contemplated by s.138 of the *Fair Work Act 2009* (**Act**).

9. The various proposed changes may be seen as different mechanisms to address many of the unions' underlying concerns about employees undertaking short periods of work that do not provide sufficient remuneration for the associated effort and cost of getting to and from such work and the associated disutility of performing such work. For example, the granting of a minimum engagement period would negate the validity of arguments that there is a need to also provide additional entitlements directed at compensating employees for travel that they undertake to or from work.

3. THE CLAIMS

10. The HSU, ASU and United Voice have all proposed provisions dealing with payment for travel undertaken by employees covered by the Award. In certain respects, the claims are relatively similar, although it is important that the Full Bench appreciates that they do reflect subtly different approaches. In the section below we identify what we perceive to be the effect of the relevantly overlapping proposed variations.

11. As previously mentioned, the HSU has also proposed a variation to the current provisions of clause 20.5(a), which provides for the payment of a vehicle allowance. It appear that it is intended to operate in addition to the entitlements that would flow from the Travel Time Claims.

The HSU's Travel Time Claim

12. The HSU has proposed a variation to the Award provisions regulating broken shifts to provide a payment for travel that may be undertaken in the course of a break during a broken shift:

> **(d)** Where an employee works a broken shift, they shall be paid at the appropriate rate for the reasonable time of travel from the location of their last client before the break to their first client after the break, and such time shall be treated as time worked. The travel allowance in clause 20.5 also applies.

13. A number of observations can be made about the effect of the proposed provision.

14. *Firstly*, it only operates in the context of a broken shift. In this regard, the claim varies from that advanced by other unions.

15. *Secondly*, the clause requires payment for the "reasonable time of travel from the location of [an employee's] last client before the break to their first client after the break". In this regard, the provision does not appear to require payment for time an employee actually spends travelling between the aforementioned locations. Instead, it appears to contemplate an assessment of what constitutes "reasonable time of travel" between such locations. This might serve to create a basis for calculating an entitlement where an employee does not travel directly between such clients (given the employee is on a break and free to undertake other activities in the interim); an arrangement that is likely not uncommon.

16. This element of the clause appears to potentially place some limitation on the payment an employer is liable to make under the clause. It might, for example, mean that an employer is not required to pay the entirety of the period of time that an employee spends travelling between such locations if they elect to undertake such travel by means of car during peak hour conditions if it could have been undertaken more efficiently at a different time. It might also mean that an employer is not put to the costs of paying for time spent travelling via an inefficient route or mode of transport.

17. *Thirdly*, there is no articulation of how or when such travel is to be undertaken. It does not specify the mode of transportation or the route that must be undertaken for the purposes of making the relevant assessment.

18. *Fourthly***,** the clause provides that the "reasonable time of travel" is to be "treated as time worked". This appears to reflect an appropriate acknowledgment by the HSU that travel between clients in the context of a broken shift will not be work and will not attract a payment under the Award, where it occurs during a break. It also appears that the intent is for the clause to effectively deem the reasonable travel time as being time worked by force of the Award, or at least to compel an employer to treat the time as though it was spent working.

19. The purpose for which such time is to be treated as time worked is not clear; but we assume that it is to be so treated at least for all purposes under the Award. Accordingly, we assume that it is to be treated as time worked so as to attract a relevant payment under the Award.

20. It is unclear as to whether the HSU intends that such time to be treated as time worked in a broader sense. For example, is such time intended to be regarded as time worked in the context of the Act or other legislative or regulatory schemes, such as relevant workers compensation and workplace health and safety laws. We return to this issue in section 6 of our submission.

The United Voice & ASU Travel Time Claim

21. The ASU and United Voice have proposed the following variation:

> **25.7 Travel time**
>
> (a) Where an employee is required to work at different locations they shall be paid at the appropriate rate for reasonable time of travel from the location of the preceding client to the location of the next client, and such time shall be treated as time worked. The travel allowance in clause 20.5 also applies.
>
> (b) This clause does not apply to travel from the employee's home to the location of the first client nor does it apply to travel from the location of the last client to the employee's home.

22. The claim advanced by the ASU and United Voice is, in various respects, similar to that advanced by the HSU. As such, most of the observations pertaining to the HSU's proposed clause are apposite to the United Voice proposal.

23. The claim advanced by these unions is however different in that it does not only apply in relation to travel undertaken during breaks that occur in the context of a broken shift.

24. It is not clear whether the proposed clause applies in the context of notional travel between the "preceding" and "next" client when the work is undertaken on a single day, single shift, single engagement or some other unspecified context. This issue does not arise in the context of the HSU provision given it operates in the context of a broken shift, as defined in the Award.

25. It is particularly unclear how the proposed provision would operate in the context of casual employment. It is arguable that under the Award, a casual employee may be able to be employed on entirely separate engagements on the same day without attracting the application of the broken shift provisions. On one view, where this occurs the minimum engagement provisions of the Award would have application. If the proposed variation was adopted, such a casual employee might also receive the benefits flowing from the proposed clause.

26. We do however acknowledge that ASU and United Voice proposal also expressly, and in our view appropriately, excludes travel between an employee's home and the location of a client. This does not however clarify what occurs if the employee does not travel from their "home" to work or from work to "home".

27. Put simply, the operation of the proposed clause 25.7(b) is not clear. The provision does not actually reference the context in which a client is to be assessed as being either the first or last client. It may be that it is the first and/or last client per engagement that is excluded. If so, this would negate the potential application of the clause to casual employees who are engaged to perform work for particular clients.

The HSU's Additional Claim

28. The HSU has proposed a variation to clause 20.5(a) so that it provides as follows:

> **(a)** Where an employee is required and authorised by their employer to use their motor vehicle in the course of their duties, the employee is entitled to be reimbursed at the rate of $0.78 per kilometre. Disability support workers and home care workers shall be entitled to be so reimbursed in respect of all travel:
>
> **(i)** from their place of residence to the location of any client appointment;
>
> **(ii)** to their place of residence from the location of any client appointment;
>
> **(iii)** between the locations of any client appointments on the basis of the most direct available route.

29. We understand the effect of the proposed variation to be that travel which does not occur in the course of an employee's duties would attract the payment of the vehicle allowance.

30. The claim only provides for payment in relation to travel that is actually undertaken, although clause 20.5(a)(iii) appears to provide an alternate "basis" for calculating the amount that is payable to a mechanism that is simply linked to the kilometres actually travelled.

4. THE CURRENT AWARD PROVISIONS

31. Before responding to the individual claims, it is convenient to address the current Award provisions.

32. It must firstly be observed that the Award already provides a travelling allowance:

> **20.5 Travelling, transport and fares**
>
> **(a)** Where an employee is required and authorised by their employer to use their motor vehicle in the course of their duties, the employee is entitled to be reimbursed at the rate of $0.78 per kilometre.
>
> **(b)** When an employee is involved in travelling on duty, if the employer cannot provide the appropriate transport, all reasonably incurred expenses in respect to fares, meals and accommodation will be met by the employer on production of receipted account(s) or other evidence acceptable to the employer.
>
> **(c)** Provided that the employee will not be entitled to reimbursement for expenses referred to in clause 20.5(b) which exceed the mode of transport, meals or the standard of accommodation agreed with the employer for these purposes.

> **(d)** An employee required to stay away from home overnight will be reimbursed the cost of reasonable accommodation and meals. Reasonable proof of costs so incurred is to be provided to the employer by the employee.

33. On its face, this provision is directed at compensating an employee for the costs of travel undertaken in the course of their duties. No party appears to have undertaken an analysis of the history of the provision.

34. This application of clause 20.5 was considered by Commissioner Saunders in *Re Alzheimer's Australia WA Ltd*[1]. Here, an application was made for approval of an enterprise agreement that contained a provision similar to clause 20.5(a). Commissioner Saunders noted that both provisions provided for a travel allowance of not less than $0.78 per kilometre to be paid to an employee when the employee is required and authorised to use their motor vehicle in the course of their duties. Although it was not necessary for him to decide this point, Commissioner Saunders stated:

> **[7]** The SACS Award does not specify when an employee commences their duties, whereas the Agreement does. Clause 18.8 of the Agreement makes clear that an employee commences their duties each day on arrival at the first place of work and finishes work on departure from the last place of work for the day. For a Support Worker who travels to and between the residences of clients, the residences of the clients are the Support Worker's places of work (clause 18.9 of the Agreement).
>
> **[8]** Although the SACS Award does not expressly state when an employee commences their duties, if an employee made a claim under the SACS Award for the payment of a travel allowance in respect of their travel from their home to the residence of their first client for the day in circumstances where the employee's usual practice was to travel from their home directly to the residence of a client, I am of the view that such a claim would not succeed. That is because an employee's duties do not commence until they arrive at their workplace. For an employee who is engaged to provide services at the residences of clients, the employee's places of work are the residences of their clients. Accordingly, the SACS Award would, in my view, be given the same interpretation as clauses 18.8 and 18.9 of the Agreement in the circumstances to which I have referred.
>
> **[9]** Because the Agreement confers on a Support Worker an entitlement to the payment of a travel allowance insofar as the Support Worker is required to travel more than 20km from their home to the residence of a client whereas the SACS Award does not, the Agreement provides a benefit over and above the SACS Award. Accordingly, in my view, the motor vehicle allowances in the Agreement are more beneficial than the motor vehicle allowances in the SACS Award.

[1] [2016] FWCA 4863.

35. The Award also compensates employees for the time they spend travelling where this occurs in the course of their work or duties. Such work would attract the application of award provisions providing for the remuneration of the performance of work (i.e. the minimum hourly rates and penalty rates etc). However, where an employee is engaged exclusively to undertake work at a client's premises, they would not receive payment under the Award for time that they spend travelling to or from such location. Relevantly, an employee would not receive such compensation in relation to travel undertaken during the breaks that occur in the course of a broken shift.

36. It also relevant to consider the provisions of the Award dealing with the arrangement of ordinary hours of work and rostering. This includes the provisions dealing with 'broken shifts' and any requirement to structure hours of work in a continuous manner. In simple terms, the relevance of such matters is that the Award provides mandatory payments for work performed. The pertinent issue for consideration in the context of the current proceedings is consequently the extent or manner in which an employee's employment may be structured such that activities performed either before or after assisting a client might be said to fall outside an employee's employment and therefore not attract payment under the Award on the basis that such activities do not constitute work.

37. Clause 25 deals with ordinary hours of work and rostering. It is relevant to observe that clause 25.1 deals with the arrangements of ordinary hours:

> **25.1 Ordinary hours of work**
>
> **(a)** The ordinary hours of work will be 38 hours per week or an average of 38 hours per week and will be worked either:
>
> **(i)** in a week of five days in shifts not exceeding eight hours each;
>
> **(ii)** in a fortnight of 76 hours in 10 shifts not exceeding eight hours each; or
>
> **(iii)** in a four week period of 152 hours to be worked as 19 shifts of eight hours each, subject to practicality.

> **(b)** By agreement, the ordinary hours in clause 25.1(a) may be worked up to 10 hours per shift.

38. Significantly, although clause 25 provides for very restrictive limits on the span of ordinary hours that may be worked, it does not provide that ordinary hours must be worked *continuously*.

39. The ASU appears, arguably erroneously, to contend that the hours of work for employees other than disability service workers must be performed continuously. We understand that they contend that this is a product of clause 25.6, which deals with the issue of broken shifts in the following terms:

> **25.6** This clause only applies to social and community services employees when undertaking disability services work and home care employees.
>
> **(a)** A **broken shift** means a shift worked by an employee that includes one or more breaks (other than a meal break) and where the span of hours is not more than 12 hours.
>
> **(b)** Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the finishing time of the broken shift.
>
> **(c)** All work performed beyond the maximum span of 12 hours for a broken shift will be paid at double time.
>
> **(d)** An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.

40. Clause 25.6 is limited in its application to social and community service employees undertaking disability services work and home care employees. On its face, clause 25.6 appears to do four things:

    (a) Define a broken shift[2];

    (b) Provide for payment for hours of work on a broken shift[3];

    (c) Set a maximum span of hours for a broken shift beyond which double time rates apply[4]; and

[2] Clause 25.6(a).

[3] Clause 25.6(b).

[4] Clause 25.6(c).

(d) Provided a minimum 10 hour beak between broken shifts rostered on successive days.[5]

41. On a literal reading of the Award, clause 25.6 does not permit the working of broken shifts but instead regulates the use of broken shifts that may otherwise be worked under the terms of the Award. It is, on one view, the flexibility afforded under clause 25.1, and in particular the absence of any requirement for ordinary hours of work to be performed in a continuous manner that enables work to be structured under the award around 'breaks'.

42. The above framework is relevant to a determination of whether time spent undertaking travel currently attracts a payment under the Award.

43. In simple terms, time spent travelling by an employee at the direction of their employer, and in the course of their employment, will already attract payment and constitute time worked. That is, where an employer directs an employee to travel in the course of their employment it will constitute work and must be paid.

44. However, time that an employee spends travelling, either before or after work, will not attract a payment. This is not a novel proposition. It represents the manner in which most awards typically operate. Further, time spent travelling during a break on a broken shift will not attract payment.

5. THE CURRENT FUNDING ARRANGEMENTS

45. Ai Group has previously filed detailed written submissions regarding the operation of the NDIS funding arrangements.[6]

46. In addition, we draw the Commission's attention to the following information displayed on the NDIS' website as at the time of drafting this submission which

[5] Clause 25.6(d).

[6] Chapter 5 of the Ai Group Submission dated 8 April 2019.

summarises the funding arrangements in relation to travel undertaken by employees:

Provider travel

The length of time providers can claim for travel has changed, effective 1 July 2019.

If agreed by participants, providers can claim for the time spent travelling to each participant, for core supports—as indicated by the travel column in the Support Catalogue 2019–20. Only the actual travel time can be claimed, up to a maximum of:

- 30 minutes within city areas (MMM 1–3)
- 60 minutes in regional areas (MMM 4–5).

This is an increase from 20 and 45 minutes, respectively. Examples are provided to help give further clarification. Refer to the NDIS Price Guide 2019–20.

Providers delivering capacity-building supports are also able to claim time spent travelling from the last participant to their usual place of work. The maximum amount that can be claimed for return travel is 30 minutes within city areas and 60 minutes in regional areas.

Before providers can charge for travel, they must first discuss and get agreement on any changes with the participant. Once an agreement is reached, providers will need to update the relevant service bookings to reflect the changes agreed.

47. As is apparent from the above extracts, NDIS funding in respect of travel undertaken by employees providing 'core supports' is constrained in the following ways:

(a) Funding is available only if the client / participant agrees that the provider may claim the funding. Such agreement would diminish the amount of funding available to the participant to utilise in respect of other services or supports. Unless an employer declines to provide the relevant services if the participant does not agree to the funding being claimed, there is, as such, no imperative for a participant to consent to the funding being claimed.

(b) A maximum of 30 minutes of travel can be claimed in respect of travel in 'city areas' and up to 60 minutes can be claimed in 'regional areas'. In the context of large cities that suffer from significant congestion (such as Sydney and Melbourne) it is readily apparent that 30 minutes of travel time may fall well short of the time an employee actually spends travelling from

one client to the next. The same can be said of long distances travelled in regional areas.

48. We acknowledge the Commission's recent decision[7] in relation to the 'tranche 1' claims and the observations it made about Ai Group's previous submissions about the constraints imposed by the NDIS funding arrangements. We understand that these funding arrangements are not determinative of the matter. In our submission, however, they weigh heavily against the grant of the claim for the reasons articulated later in this submission in relation to the modern awards objective. We emphasise the unfairness that will be visited upon employers in circumstances where they are prohibited under the NDIS from recovering the costs that would be associated with paying an employee for time spent travelling pursuant to the unions' claims unless the relevant prerequisites are satisfied.

6. WORKABILITY OF THE PROPOSED TRAVEL TIME CLAUSES

49. The claims advanced by the unions have been the subject of extensive conferencing before the Commission. Since the commencement of Ai Group's involvement in these proceedings, we have openly and consistently expressed concern about the workability, from a practical perspective, of proposals that are intended to require payment for travel undertaken in the context of beaks or non-work time. [8]

50. There has ultimately been no serious attempt or indeed willingness by the unions to grapple with such issues or to address them through the refinement or amendment of the claims they are seeking to propose. Consequently, the unions have proposed provisions directed at establishing a new and significant entitlement to payment for travel which are not only in various respects unjustifiable, but also manifestly unworkable.

[7] *4 yearly review of modern awards – Group 4 – Social. Community, Home Care and Disability Services Industry Award 2010 – Substantive Claims* [2019] FWCFB 6067.

[8] See, for example the transcript of the Conference before Commissioner Lee on 31 January 2019

51. In this section we identify the various problems that would flow from the proposed provisions. This is discrete from arguments that we will raise as to whether, from a broader merit perspective, it is appropriate to impose additional obligations upon employers covered by the Award to provide additional payment for travel undertaken by employees.

52. We also observe that these proceedings are being conducted through the prism of the specific proposals advanced. In this context, the unions have been given ample opportunity to refine their claims and the cases that they have advanced in support of their proposals. The Commission has already devoted significant resources to facilitating conferences concerning parties' claims.

53. If the Full Bench is not satisfied that a case for the specific variation proposed is made out, it is appropriate that the Full Bench exercise its discretion to not make the relevant variations for the reasons that follow. Put bluntly, while we accept that in the course of the current award review the Commission is not bound by the terms of a party's claim, it should similarly not be sufficient for a party in this review to propose an ill-thought-out proposal in the blatant hope that the Commission will, if not satisfied that the specific claim advanced is warranted or workable, undertake the process of developing an alternate provision to address the party's concerns over the operation of the Award. Such an approach unfairly requires respondent parties to expend their resources (including, where relevant, costs) to respond to multiple iterations of a claim.

54. In relation to the specific practical problems or deficiencies with the travel time claims proposed, we raise the following points.

55. *Firstly*, the unions' approach of requiring payment by reference to travel which is notionally, but not actually, undertaken is fundamentally flawed.

56. The approach would leave an employer in the difficult position of having to determine what the reasonable travel time in the relevant context would be absent any guidance as to how to approach this task. This is very problematic given that travel times between locations can vary wildly due to variables such as traffic conditions.

57. The unions have made no attempt to explain how an employer would calculate the reasonable travel time in circumstances where the travel is not actually undertaken.

58. *Secondly***,** even if it were assumed that the provisions only require an employer to pay for time actually spent travelling, no effort has been made to consider how an employer would be able to verify what time was spent undertaking such travel.

59. It might be suggested that this could be achieved through monitoring the employee's location through electronic means. However, no effort has been made to establish through submission or evidence how this could occur. There are also limits under state legislation on the extent to which employers can undertake surveillance of their employees. For example, the *Workplace Surveillance Act 2005* (NSW) prevents surveillance of employees while they are not at work.[9]

60. *Thirdly*, it cannot be assumed that an employee engaged under the Award to perform work at different locations on the same day, but who is not directed to undertake the travel in the course of their duties will, as a matter of fact actually travel directly from one client to the next. Take, for example, the circumstances of an employee working a broken shift who may perform a couple of hours in the morning but then may not be required to perform work at another nearby location until several hours later. There is no reason to conclude that the employee will actually travel directly between the locations of the two clients without undertaking some deviation (such as to obtain lunch, return home or undertake some other activity).

61. *Fourthly*, if an employee has been engaged to perform work at two different locations on the same day but has not been directed to undertake the travel between such locations in the course of their duties, the employee will retain control over the time at which they travel. This could have a significant impact on

[9] Section 47.

the time they spend travelling. It is unclear how the requirement to only pay for reasonable travel time would address this issue.

62. The reference to “reasonable travel time” contained in the proposed clauses is also inherently imprecise and accordingly inappropriate for inclusion in the safety net, given that the provision potentially creates significant monetary entitlements.

63. *Fifthly*, there are a raft of problems, uncertainties and likely unintended consequences that will flow from a requirement to deem or “treat” time that is not work as work. Relevantly, the following question inevitably arise in relation to this aspect of the provision’s proposed operation:

- For what purposes will such time be considered time worked? Is it only for purposes under the Award or is the intended that it be regarded as time worked for the purposes of determining employer obligations under the Act and/or other legislation or regulation (this would include legislation dealing with workplace health & safety, workers compensation and long service leave)?

- Will such work form part of the employee’s ordinary hours of work?

- Will employees accrue or be credited NES entitlements by reference to such time?

- Will an employer, by virtue of the clause, have capacity to direct an employee’s conduct during such time?

64. If the effect of the proposed clause is to deem time spent travelling as time worked, for all purposes under the Award, it may also give rise to a number of difficulties and potentially unintended consequences associated with the manner in which the provision interacts with other Award clauses. This would include provisions dealing with rostering, ordinary hours of work, types of employment, overtime and penalty rates. The current practical application of all of these provisions would potentially be altered by the proposed clause.

65. Ai Group doubts that an award clause can have the legal effect of causing a notional period of time to constitute work under any legislative scheme. However, at the very least, an award clause that has the effect of requiring an employer to treat such time as time worked, without specifying the purpose for which it should be so treated would be potentially very confusing.

66. *Finally*, we would observe that none of the proposed clauses specify the mode of transport that is assumed to be adopted for the purposes of the clause.

7. SECTION 138 AND THE MODERN AWARDS OBJECTIVE – TRAVEL TIME CLAIMS

67. Ai Group contends that the Travel Time Claims are not necessary in the sense contemplated by s.138 of the Act. In the section below we address the mandatory considerations contemplated by s.134(1).

The relative living standards and the needs of the low paid (s.134(1)(a))

68. An assessment of whether this matter weighs either for or against the claim is not straight forward.

69. In its treatment of this issue, the ASU contends that "if employees are paid for travel time, their incomes will increase". To the extent that this an accurate assessment of the outcome that would flow from the granting of the ASU or other unions claims, it might reasonably be asserted that the needs of the low paid would support the granting of the claim.

70. The evidence advanced does not permit the conclusion that employees will always benefit from the proposed variation.

71. As already identified, there are funding constraints that mean an employer may, in some circumstances, not be able to recover amounts paid pursuant to the proposed provisions. It is likely that some employers will accordingly respond to any such variation by seeking to minimise their exposure to such unrecoverable costs. This may mean that the employer either declines to provide a relevant service that it might otherwise provide, or that it allocates the work to its workforce in a manner that avoids the obligation to make the relevant payments. In the

second scenario it might, for example, minimise the extent to which it offers multiple engagements to an employee on the same day. Either way, it is entirely foreseeable that the proposed variation could have the perverse effect of actually reducing the amount that some employees earn under the Award.

72. Any assumption that employers will simply incur additional unrecoverable costs is unrealistic and ought not be adopted by the Full Bench in weighing the merits of the claim.

73. This matter we here identify temper the extent to which a consideration of the matters identified in s.134(1)(a) could be said to weigh in favour of the claims.

The need to encourage collective bargaining (s.134(1)(b))

74. To the extent that either employees or the relevant unions strongly support the adoption of enhanced entitlements pertaining to travel undertaken by employees, it can be argued that declining to afford such an outcome through the Award could encourage such employees to engage in collective bargaining to obtain such an outcome.

75. It is also arguable that the kinds of matters raised in the unions' claims are perhaps best dealt with at the enterprise level. This would, for example, enable parties to develop agreement provisions that reflect enterprise specific practices relating to travel. Such an approach might be more feasible than the development of provisions in a safety net that must be workable in the context of all employers.

76. In support of our contentions we observe that it appears that parties covered by the Award do bargaining over issues associated with payment for travel. Nonetheless, we accept that there is no evidence before the Commission to establish that these issues have, to date, themselves been a major catalyst for widespread collective bargaining in the sector.

77. Given the notoriously low margins in the sector, we also observe that the proposed variation would potentially discourage employers from bargaining as it would 'raise the bar' for the application of the "better off overall test".

78. Ultimately, we contend that a consideration of the need to encourage collective bargaining is matter that might be said to weigh against the claim, but we accept that it would by no means be a determinative consideration.

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

79. This is not a matter that would weigh in favour of the claim. Indeed, it may weigh against the claim, although we accept that it is not possible to be definitive about the specific impact that the claim would have on such matters, based on the material advanced.

80. As already indicated, it is foreseeable that some employers will respond to being saddled with additional unrecoverable costs by limiting their exposure to such costs. This may take the form of a reduction in the services they provide or limiting the allocation of work to individual employees. Either outcome may reduce workforce participation.

81. The ASU contends that if workers are paid for the time actually worked, they may reduce their weekly hours of work. To the extent that this occurs it may actually reduce workforce participation.

82. The ASU optimistically submits that this will create opportunities for other workers to increase their hours. It is not clear how this will actually increase total employment. Moreover, it cannot be simplistically assumed that the labour of such workers is always readily substitutable or even available. Indeed, this is an especially problematic proposition given current and impending issues associated with labour shortages in the sector.

83. There is no merit to the ASU contentions that if employed workers are paid for the hours they actually work it will increase the hours that they work. The outcome will just result in additional pay, not additional labour force participation.

The need to promote flexible modern work practices and the efficient and productive performance of work (s.134(1)(d))

84. To the extent that the proposed clauses would cause employers to modify their rostering practices to negate the application of the provisions, a consideration of the matters identified in s.134(1)(d) would be inconsistent with the granting of the claim. It may mean that employees who could most efficiently and productively perform the relevant task cannot viably be utilised. To take a practical example, if an employee provides services to a particular client in the morning there may be a range of efficiencies that can be achieved by having the same employee provide services to the same client in the afternoon. However, the proposed clauses would incentivise, if not force, employers to consider allocating the discrete engagements to different employees in order to avoid the proposed new obligations.

85. Union submissions to the effect that the proposed provisions will cause employers to arrange work so that it can be undertaken continuously by an employee ignore the realities of the sector and in particular the impact of the NDIS on such matters. It should not be assumed that employers commonly elect to roster work in a manner which is inefficient. Instead, there are external pressures that dictate the manner in which work may be arranged, not the least of which is the client driven nature of work that is undertaken in the context of the NDIS.

86. Ultimately, we observe that the ASU submissions relating to s.134(1)(d) do not actually grapple with how the variation will encourage modern work practices or the efficient and productive performance of work. They instead appear to be directed towards the implicit contention that their claim might reduce unpaid waiting time which is not currently regarded as work under the Award.

87. At paragraph 31 of the ASU's submissions they point to a range of current Award provisions that are said to afford employers in the sector with a significant amount of flexibility. In response we observe that various union claims advanced in these proceedings seek to alter such provisions and undermine the "flexibility" afforded under the Award.

The need to provide additional remuneration for working overtime; unsocial, irregular or unpredictable hours; weekends or public holidays; or shifts (s.134(1)(da))

88. This is not a relevant consideration in this matter.

The principle of equal remuneration for work of equal or comparable value (s.134(1)(e))

89. The ASU contends that "the failure to pay travel time" is an equal remuneration matter. The material advanced does not establish this proposition.

90. The comparison between conditions for disability support workers under the Award and the conditions under the *Business Equipment Industry Award 2010* (**Business Equipment Award**) is inaccurate and consequently unhelpful. Relevantly, the ASU has not acknowledged that the Business Equipment Award contains an exemption provision that has the effect of rendering many of the provisions of the award not applicable to employees in the technical stream if they are in receipt of a salary above a certain level.

91. Regardless, the limited material advanced does not allow a proper comparison of the work undertaken by employees covered by the two awards.

92. It should not be accepted that the approach to regulating brokens shifts or travel time is a product of any gender-based considerations. The provisions reflect the unique nature of the industry.

93. It must also be observed that not all travel that would attract payment under the travel time claims would constitute work, as contemplated under s.134(1)(f).

The likely impact of any exercise of modern award powers on business, including productivity, employment costs and regulatory burden (s.134(1)(f))

94. A consideration of s.134(1)(f) weighs heavily against the granting of the claims.

95. The unions' proposed claims would have a dramatic impact on employers in this industry and the manner in which work in the sector is undertaken. The potential

imposition of new obligations relating to the payment for travel which are fundamentally out of step NDIS funding arrangements is a major concern for elements of the industry covered by the Award and has indeed been a significant catalyst for Ai Group's involvement in the proceedings.

96. It is axiomatic that the claims will have an adverse impact on business. They will impose new, and in many instances significant, costs on employers. For the reasons already explained, many employers will be prohibited from recovering such costs under current funding arrangements.

97. Ai Group accepts that the NDIS' funding arrangements are not of themselves determinative of whether the proposed provisions are a necessary element of the safety net. They are, nonetheless, a relevant consideration. The Full Bench should give careful consideration to whether it is *fair* to impose upon employers such a radical change to Award obligations in circumstances where it is apparent that the employers (for reasons beyond their control) are unable to recover such costs and where they will, at least in some circumstances, have no capacity to avoid incurring the costs.

98. The claims will also expose employers to costs that are potentially very difficult to foresee with precision. For example, the period of time that an employee may spend in traffic travelling might be expected to vary dramatically depending on variables such as the time of day which it is undertaken and the geographical location at which such travel occurs.

99. To the extent that the claims will require employers in the sector to measure or indeed calculate time spent travelling (or notionally travelling) by their workers, in circumstances where they are not currently so required, it will also impose an administrative burden on such employers.

100. The claims may also undermine an employer's capacity to undertake particular work if the costs of travel time cannot be recovered, thus resulting in a reduction in revenue. Such difficulties may also render it difficult for employers to afford their employees sufficient levels of work.

The need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards (s.134(1)(g))

101. The proposed clauses are far from simple or easy to understand. We here refer to earlier observations regarding the operation of the provisions and their "workability".

102. We also contend that the need to ensure a "stable and sustainable modern award system" weighs against granting such fundamental changes to the obligations that the Award imposes upon employers absent certainty around whether such entitlements can be met under current funding arrangements. Any submission that funding arrangement will change to mirror award obligation should be treated cautiously in the context of such a significant change to the Award. There are of course no certainties regarding whether funding arrangements will be altered to reflect the outcome of these proceedings.

103. We also here observe that it is not apparent how the funding arrangements could be altered to provide cost recovery for the kind of entitlements contemplated by the claims.

104. In advancing these submissions we accept that our arguments may have less force once the price caps that currently constitute such a substantial feature of NDIS funding arrangements are ultimately removed. However, in the current context, the potential impact of the claims on employers, and the extent to which the proposals would be simply unaffordable, should lead the Full Bench to declining to grant the claims.

The likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy (s.134(1)(g))

105. There is insufficient material before the Commission to enable a proper consideration of the matters identified in s.134(1)(g).

8. THE HSU'S VEHICLE ALLOWANCE CLAIM

106. The HSU has proposed the following amendments to the current clause dealing with the payment of an allowance to employees using their own motor vehicle:

> **(a)** Where an employee is required and authorised by their employer to use their motor vehicle in the course of their duties, the employee is entitled to be reimbursed at the rate of $0.78 per kilometre. Disability support workers and home care workers shall be entitled to be so reimbursed in respect of all travel:
>
> **(i)** from their place of residence to the location of any client appointment;
>
> **(ii)** to their place of residence from the location of any client appointment;
>
> **(iii)** between the locations of any client appointments on the basis of the most direct available route.

107. The extent to which the proposed amendments would extend the current obligation is somewhat unclear. The last sentence of the provision is interconnected with the operation of the first sentence of the current clause. It relevantly provides that "Disability support workers and home care workers shall be entitled to be so reimbursed in respect of all travel". It is accordingly unclear whether the amended provision would merely operate to clarify that the identified instances of travel by an employee using their own motor vehicle would attract payment under the clause, when the threshold requirements that such travel be undertaken in the course of their duties and that it is authorised by the employer are met, or, whether it is simply intended that all use of an employee's motor vehicle in respect of any of the identified circumstances of travel would attract the payment regardless of whether it is undertaken in the course the employee's duties or is authorised.

108. The wording of the proposed amendment also fails to clarify whether an individual needs to utilise their own vehicle in order to receive the payment, or whether merely undertaking the identified travel is sufficient.

109. The provision is far from simple and easy to understand. As such a consideration of the matters referred to in s.134(1)(g) would weigh against granting the claim.

110. The union's submissions are similarly somewhat unclear as to whether the travel time needs to occur during work (that is, in the course of the employee's duties)

for the obligation to apply. Indeed, the intended operation of the proposed new provision is not directly explained in the submissions. In this regard they simply submit as follows:

> The HSU makes claims for variation of the Award to ensure that it achieves the modern awards objective by:
>
> > c) amending the "Travelling, transport and fares" clause, to ensure that employees are compensated appropriately for the cost of travel required to perform their duties – (Clause 20.5; ED 16.3(c)) – S19)

111. It might reasonably be inferred from the reference to "*the cost of travel required to perform their duties*" that the union intends for the clause to cover not only travel undertaken in the course of the employee's duties but also travel that enables the performance of the duties or which is a consequence of the performance of their duties.

112. The HSU's submissions do, however, address the manner in which the existing provision is applied in industry.[10] They contend, in effect, that the evidence suggests that disability support workers and home care workers perform work travelling to their first client and from the final client but that such work is not regarded by some employers as occurring in the course of their duties.

113. The union also identifies some limited evidence that they intend to lead that they contend, in effect, establishes that some employers regard travel undertaken in the context of a break that occurs during a broken shift as not being undertaken in the course of an employee's duties and therefore as not attracting compensation.[11]

114. Ai Group agrees that, subject to the terms of an individual employee's engagement, travel to an initial client and travel that occurs after servicing a final client for the day, are activities would not form part of an employee's duties.

115. Under the terms of the Award, it is open to an employer to engage an employee on the basis that they commenced work at the location of their first client and

[10] At paragraphs 41 and 42

[11] Ibid at 42 (we assume that the reference here to compensation is intended to cover reimbursement pursuant to clause 20.5)

conclude it at the location of their last client. In such circumstances, travel from wherever an employee may be prior to first commencing work for the day or to wherever they next go after finishing work for the day is not part of their duties, as contemplated by clause 20.5. The situation may be different in circumstances where an employee is required to attend a separate location (such as an employer's premises) before or after undertaking work for a client, or where an employer directs that the travel be undertaken in a particular manner.

116. It seems that the union's intent is to require the all travel undertaken by disability support workers and home care workers be paid for the rate of $0.78 per kilometre, regardless of whether or not it is undertaken in the course of their duties. That is, it is intended to compensate employees for the costs of getting to or from work.

Arguments against the claim

117. Imposing an obligation on an employer to reimburse or compensate an employee for the cost of getting to or from work would be a very significant change to the safety net.

118. The proposal would unfairly expose employers to potentially open ended and uncontrollable costs. Under the proposal, the amount an employee earns would in large part be dependent upon where they elect to live. Indeed, under the proposal an employee could move to a location a significant distance from the location of clients that their employer services and consequently impose unreasonable additional costs upon their employer.

119. The union appears to argue that travel undertaken by disability support workers "well exceeds the usual travel engaged in by employees to and from their workplaces". However, an evidentiary basis for such an assertion is not made out. The material does not identify the amount of travel typically undertaken by employees so as to enable such a comparative analysis.

120. The proposal is also out of step with NDIS funding arrangements. Accordingly, employers operating under this regime would not be able to recover the costs that would flow from the implementation of the proposed clauses 20.5(a)(i) or

20.5(a)(ii). Depending on the circumstances, the costs associated with the application of the proposed clause 20.5(a)(iii) would be similarly unfunded.

121. The HSU has not made out a sufficient case to establish that the proposed variations are necessary, in the sense contemplated by s.138.

Australian Industry Group

4 YEARLY REVIEW OF MODERN AWARDS

Reply Submission – Employer Claims

Social, Community, Home Care and Disability Services Industry Award 2010 (AM2018/26)

26 September 2019

AM2018/26 SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

EMPLOYER CLAIMS

1. INTRODUCTION

1. The Australian Industry Group (**Ai Group**) advances these submissions in relation to certain variations (**Employer Claims**) to the *Social, Community, Home Care and Disability Services Industry Award 2010* (**Award**) that are sought by Australian Business Industrial, the New South Wales Business Chamber, Aged and Community Services Australia and Leading Age Services Australia Limited (**ABLA's Clients**).

2. Specifically, the relate to the following changes proposed by ABLA's Clients:

   (a) Changes proposed to clause 25.1 of the Award (**Ordinary Hours Claim**);

   (b) Changes to clause 25.5(d)(ii) of the Award (**Rostering Claim**); and

   (c) Changes to clause 25.5(f) of the Award (**Client Cancellation Claim**).

2. THE ORDINARY HOURS CLAIM

3. Clause 25.1 of the Award is presently in the following terms:

> **25.1 Ordinary hours of work**
>
> **(a)** The ordinary hours of work will be 38 hours per week or an average of 38 hours per week and will be worked either:
>
> **(i)** in a week of five days in shifts not exceeding eight hours each;
>
> **(ii)** in a fortnight of 76 hours in 10 shifts not exceeding eight hours each; or
>
> **(iii)** in a four week period of 152 hours to be worked as 19 shifts of eight hours each, subject to practicality.
>
> **(b)** By agreement, the ordinary hours in clause 25.1(a) may be worked up to 10 hours per shift.

4. The provision enables an employee's ordinary hours to be averaged over a period of one week, two weeks or four weeks.

5. ABLA's Clients propose that clause 25.1 be replaced with the following: (our emphasis)

> **25.1 Ordinary hours of work**
>
> **(a)** The ordinary hours of work will be 38 per week or an average of 38 hours per week <u>over the employee's roster period</u>, up to a maximum of four weeks.
>
> **(b)** Subject to clause 25.1(c), the maximum ordinary hours that can be worked per shift is 38.
>
> **(c)** By agreement between an employer and an individual employee, ordinary hours may be worked up to 10 hours per shift.

6. The intention underpinning the proposed clause is explained by ABLA's Clients as follows:

> 4.7 Our clients propose a simplified clause 25.1, that retains all of the key elements of the existing provision, but which removes unnecessary and superfluous prescription which does not actually have any operative effect.[1]

[1] ABLA's Clients' submission dated 2 July 2019 at paragraph 4.7.

7. The proposed variation introduces the notion of an employee's "roster period" to the Award's regulation of the period over which an employee's ordinary hours may be averaged. The underlined words in the proposed clause 25.1(a) are, at the very least, confusing. Moreover, we are concerned that they potentially substantively alter the operation of the extant clause 25.1 in a manner that removes existing flexibility and is seemingly unintended by ABLA's Clients.

8. Clause 25.5(a) of the Award requires an employer to display a fortnightly roster for each employee (subject to the exemptions otherwise provided by the Award[2]). The Award thereby prescribes a roster period of two weeks.

9. Read in the context of clause 25.5(a), the changes proposed by ABLA's Clients would appear to have the effect of limiting the period of time over which an employee's ordinary hours may be averaged. Whilst the Award presently enables that an employee's ordinary hours maybe averaged over a period of four weeks, the underlined portion of the proposed clause 25.1(a) would potentially limit this to a fortnight. To that extent the proposed provision is also internally inconsistent. This is because the clause goes on to state that an employee's ordinary hours may be averaged over a period of up to four weeks.

10. The relevant aspect of the proposed variation is inconsistent with the need to promote flexible modern work practices and the efficient and productive performance of work[3]. The proposed variation is also likely to have an adverse impact on business[4].

11. There is no material before the Commission that would justify the change. In Ai Group's submission, the reference to an employee's roster period should not be introduced to clause 25.1(a).

[2] For example, clause 25.5(c) of the Award.

[3] Section 134(1)(d) of the *Fair Work Act 2009*.

[4] Section 134(1)(f) of the *Fair Work Act 2009*.

3. THE ROSTERING CLAIM

12. Clause 25.5(d) of the Award provides for changes to rosters in the following terms: (our emphasis)

> **(d) Change in roster**
>
> **(i)** Seven days' notice will be given of a change in a roster.
>
> **(ii)** However, a roster may be altered at any time to enable the service of the organisation to be carried on where another employee is absent from duty on account of illness, or in an emergency.
>
> **(iii)** This clause will not apply where the only change to the roster of a part-time employee is the mutually agreed addition of extra hours to be worked such that the part-time employee still has four rostered days off in that fortnight or eight rostered days off in a 28 day roster cycle, as the case may be.

13. The extant provision requires that seven days' notice be provided by an employer to an employee of a roster change. However, such notice is not required where a roster is altered in order to enable the service of the organisation to be carried on where another employee is absent on account of illness. The clause does not require that the employee absent on account of illness is taking personal/carer's leave during their absence.

14. ABLA's Clients propose that clause 25.5(d)(ii) be replaced with the following: (our emphasis)

> **(ii)** However, a roster may be altered at any time:
>
> **A.** by agreement between the employer and the relevant employee, provided the agreement is recorded in writing;
>
> **B.** to enable the services of the organisation to be carried out where another employee is absent from work on account of personal/carer's leave, compassionate leave, community service leave, ceremonial leave, leave to deal with family and domestic violence, or in an emergency; or
>
> **C.** where the change involves the mutually agreed addition of hours for a part-time employee to be worked in such a way that the part-time employee still has four rostered days off in that fortnight or eight rostered days off in a 28 day roster cycle.

15. The proposed provision would limit the scope of the exemption currently afforded by clause 25.5(d)(ii) to the extent that it would no longer apply where another employee is absent on account of illness but is not taking personal/carer's leave. Ai Group opposes this element of the claim and submits that the reference to "illness" should be retained (in addition to the specific forms of leave that ABLA's Clients have proposed be referenced in the clause).

16. ABLA's Clients have made only the following submission in support of the proposed variation: (our emphasis)

> 4.13 Our clients propose a relatively minor variation to clause 25.5(d)(ii) to:
>
> …
>
> (b) clarify the operation of the existing provision allowing for roster changes in the event of another employee being absent from duty on account of "illness".
>
> 4.14 The wording proposed is consistent with the Full Bench decision in the 4 yearly review of the modern awards – *Nurses Award 2010* [2018] FWCFB 7347.[5]

17. ABLA's Clients contend that the variation proposed "clarifies" the operation of the current clause where another employee is absent due to illness. We respectfully disagree. The proposal instead:

    (a) Expands the scope of the exemption afforded by clause 25.5(d)(ii) to the extent that it would apply:

        (i) Where an employee takes carer's leave. The entitlement to carer's leave under the NES arises in circumstances that extend beyond an illness suffered by the employee taking the leave (or, for that matter, the person to whom they are providing care or support).

        (ii) Where an employee takes compassionate leave. The entitlement to compassionate leave under the NES arises in circumstances that extend beyond an illness suffered by the employee taking the leave (or, for that matter, another person).

[5] ABLA's Clients' submission dated 2 July 2019 at paragraphs 4.13 – 4.14.

(iii) Where an employee takes community services leave or ceremonial leave. The entitlement to these forms of leave under the NES and / or the Award self-evidently arise in circumstances that extend beyond an illness suffered by the employee.

(iv) Where an employee takes leave to deal with family and domestic violence. Whilst in some cases an employee taking such leave may be absent due to illness, there are a range of other circumstances in which such lave may be taken, which are not associated with illness.

(b) Narrows the scope of the exemption afforded by clause 25.5(d)(ii) to the extent that it would apply in the event of another employee's absence due to illness only if the employee had taken personal/carer's leave.

18. An employee will not in all circumstances take personal/carer's leave when absent from work due to illness. For example, an employee may be absent from work due to illness whilst on workers' compensation or on (authorised or unauthorised) unpaid leave because the employee has exhausted their paid leave entitlements.

19. There is no warrant or justification for narrowing the application of the current exemption in the manner proposed. Clause 25.5(d)(ii) of the Award relieves employers of needing to provide 7 days' notice of a roster change in a manner that better enables employers to respond to employee absences. The rationale for such flexibility also applies to employee absences due to illness, even if the employee is not taking personal leave.

20. The relevant aspect of the proposed variation is inconsistent with the need to promote flexible modern work practices and the efficient and productive performance of work[6]. The proposed variation is also likely to have an adverse impact on business[7].

[6] Section 134(1)(d) of the *Fair Work Act 2009*.

[7] Section 134(1)(f) of the *Fair Work Act 2009*.

21. The remaining considerations listed at s.134(1) of the Act are either not enlivened by the claim or are neutral considerations.

22. ABLA's Clients refer to a recent decision[8] made by the Commission to vary the *Nurses Award 2010* (**Nurses Award**) in relevantly similar terms to the change here proposed.

23. The relevant aspect of the decision concerning the Nurses Award related primarily to a claim advanced by the Aged Care Employers:

> **[146]** ACE proposes to vary clause 8.2 of the Nurses Award exposure draft (clause 25 of the current award) in order to provide an employer with the ability to alter an employee's roster without the requirement of giving the employee seven days' notice, in circumstances where the employee has agreed to the roster change.[9]

24. The Commission determined not to grant the claim, but went on to say as follows: (our emphasis)

> **[159]** We do not intend to make the change proposed by ACE however we will provide greater flexibility. We will remove the words "due to illness" from clause 25.4 and insert the words "pursuant to clauses 33 – Ceremonial leave; 34 – Personal/carers' leave and compassionate leave and 36 – Leave to deal with Family and Domestic Violence."
>
> **[160]** We propose that clause 25.4 will read as follows:
>
> **25. Rostering**
>
> …
>
> 25.4 Seven days' notice of a change of roster will be given by the employer to an employee. Except that, a roster may be altered at any time to enable the functions of the hospital or facility to be carried out where another employee is absent from work pursuant to clauses 33 – Ceremonial leave; 34 – Personal/carers' leave and compassionate leave and 36 – Leave to deal with Family and Domestic Violence, or in an emergency. Where any such alteration requires an employee working on a day which would otherwise have been the employee's day off, the day off instead will be as mutually arranged.
>
> **[161]** Interested parties are invited to file submissions in relation to the proposed wording of clause 25.4.[10]

25. Respectfully, it appears to us that the change proposed (and ultimately made) by the Commission to the Nurses Award does not in fact have the Commission's

[8] *4 yearly review of modern awards—Nurses Award 2010* [2018] FWCFB 7347.
[9] *4 yearly review of modern awards—Nurses Award 2010* [2018] FWCFB 7347 at [146].
[10] *4 yearly review of modern awards—Nurses Award 2010* [2018] FWCFB 7347 at [159] – [161].

stated intent. That is, in the context of illness, the amended provision does not provide “greater flexibility”.

26. It appears that no interested party raised this issue in response to the above decision. The Full Bench subsequently determined that it would vary the Nurses Award in the terms proposed at paragraph [160] above.[11]

27. In the circumstances, the Full Bench should not simply adopt the decision made by the Commission in the context of the Nurses Award. The absence of submissions before the Commission in that matter in relation to this issue is a cogent reason for departing from it.

[11] *4 yearly review of modern awards—Nurses Award 2010* [2019] FWCFB 121 at [24].

4. THE CLIENT CANCELLATION CLAIM

28. Clause 25.5(f) of the Award provides for client cancellation. It operates as follows:

    (a) The clause applies only to home care services.

    (b) Where a client cancels or changes a rostered home care service, it requires an employer to provide an employee with notice of a change to their roster by 5pm the day before the service.

    (c) Where notice is provided in accordance with paragraph (b) above, the employee is not entitled to any payment. Accordingly, if a client cancelled their service and an employer notified the relevant employee before 5pm on the day prior that they are no longer required to work, the employee would not be entitled to any payment.

    (d) Where notice is <u>not</u> provided in accordance with paragraph (b), the employee is entitled to payment for their minimum specified hours.

    (e) An employer has an Award-derived right to direct an employee to perform make-up time where a client cancels or changes a rostered home care service. Further:

        (i) The employer may direct the employee to work make-up time only during the same or the following fortnightly period.

        (ii) The time may be made up working with other clients or in other areas of the employer's business, if the employee has the skills and competence to perform the work.

29. ABLA's Clients have proposed a significantly different regime for dealing with client cancellations. It is our understanding that it would operate as follows:

    (a) The clause would apply to home care and disability services.

    (b) The clause would apply in the event of any cancellation to a service by a client, regardless of whether an employee is provided with notice of the cancellation (and, by extension, regardless of the period of notice provided to the employee).

    (c) In the event of a client cancellation, the clause would provide an employer with two options:

        Option 1: The employer would have the right to direct the employee to perform other work during the hours that they were rostered to work; in which case the employer would be required to pay the employee the amount they would have been paid had the employee performed the cancelled service or the amount payable for the work actually performed; whatever is greater.

        Option 2: The employer would be permitted to cancel the shift; in which case, the employer would be required to:

        (i) Pay the employee the amount they would have received had they performed the cancelled service; or

        (ii) Provide the employee with make up time. Such make up time must be rostered to be performed within 3 months of the date of the cancelled shift. The employer must consult with the employee about when the make up time will be performed.

30. We also note that whilst the proposed clause 25.5(f)(i) states that the clause is to apply where a client cancels or changes a service; clause 25.5(f)(ii), which is the operative provision, is expressed to apply only where a service is *cancelled* by a client. Read literally, neither it nor the rest of the clause appear to apply where a client *changes* a service. In this way, the proposed clause appears to limit the scope of the flexibility currently afforded under the Award.

31. The written submissions filed on behalf of ABLA's Clients summarised the funding arrangements that applied to client cancellations under the National Disability Insurance Scheme as at the time that the submissions were prepared.[12] Those funding arrangements have since changed. They now operate as follows:

> **Cancellations**
>
> Where a provider has a short notice cancellation (or no show) they are able to recover 90% of the fee associated with the activity, subject to the terms of the service agreement with the participant. Providers are only permitted to charge for a short notice cancellation (or no show) if they have not found alternative billable work for the relevant worker and are required to pay the worker for the time that would have been spent providing the support.
>
> A cancellation is a short notice cancellation if the participant:
>
> - does not show up for a scheduled support within a reasonable time, or is not present at the agreed place and within a reasonable time when the provider is travelling to deliver the support; or
> - has given less than two (2) clear business days' notice for a support that meets both of the following conditions:
>   - the support is less than 8 hours continuous duration; AND
>   - the agreed total price for the support is less than $1000; or
> - has given less than five (5) clear business days' notice for any other support.
>
> …
>
> There is no limit on the number of short notice cancellations (or no shows) that a provider can claim in respect of a participant. However, providers have a duty of care to their participants and if a participant has an unusual number of cancellations then the provider should seek to understand why they are occurring.

[12] ABLA's Clients' submission dated 2 July 2019 at paragraphs 5.11 – 5.13.

The NDIA will monitor claims for cancellations and may contact providers who have a participant with an unusual number of cancellations.[13]

32. Having summarised the NDIS funding arrangements as they then applied, ABLA's Clients submit:

> 5.14 While the intention behind the NDIS cancellation rules is to attempt to strike a balance between the interests of service providers and participants, the reality is that the cancellation rules place service providers in a very difficult position.
>
> 5.15 Unless there is an ability to cancel the rostered shift (without being required to pay the employee), or redeploy the rostered employee to other available work, service providers will incur costs regardless of the scheduled service having been cancelled, yet not derive any revenue.
>
> …
>
> 5.16 There is a clear disconnect between the terms of the Award and the funding arrangements under the NDIS when it comes to client cancellations. The disconnect is having a materially adverse impact on the viability of businesses operating in this sector.[14]

33. The disconnect between the Award's extant client cancellation provisions and the NDIS funding arrangements is potentially less problematic than was previously the case in light of the revised NDIS rules concerning client cancellations. The proposal advanced by ABLA's Clients will, however, exacerbate or further any existing disconnect between the two in some respects.

[13] National Disability Insurance Scheme, *Price Guide 2019 – 2020* (valid from 1 July 2019, accessed on 26 September 2019) at pages 17 – 18.

[14] ABLA's Clients' submission dated 2 July 2019 at paragraphs 5.14 – 5.16.

34. We provide the following example. If a client cancels a home care service that is less than 8 hours in duration and $1000 in price with 72 hours' notice and the employer immediately notifies the employee that their corresponding shift is cancelled:

    (a) **Under the NDIS**, the cancellation is not a "short notice" cancellation. The employer therefore cannot recover any amount under the NDIS funding arrangements.

    (b) **Under the current Award clause:** the employer is not required to pay the employee or to afford the employee make-up time. The employee's shift can be cancelled.

    (c) **Under ABLA's Clients' proposal:** the employer no longer has the ability to cancel the employee's shift without payment to the employee. The employer must either:

        (i) Direct the employee to perform other work at the same time and pay the employee in accordance with clause 25.5(f)(iii); or

        (ii) Cancel the shift and pay the employee the amount they would have received had they performed the cancelled service; or

        (iii) Provide the employee with make-up time.

35. Ironically, a claim advanced by the HSU in relation to client cancellations is more modest than that of ABLA's Clients. The HSU has proposed that clause 25.5(f) be varied as follows:

> **(f) Client cancellation**
>
> **(i)** Where a client cancels or changes the rostered home care service, an employee will be provided with notice of a change in roster at least 48 hours' in advance ~~by 5.00 pm the day prior~~ and in such circumstances no payment will be made to the employee. If a full-time or part-time employee does not receive such notice, the employee will be entitled to receive payment for their rostered hours of that visit ~~minimum specified hours~~ on that day.
>
> **(ii)** The employer may direct the employee to make-up time equivalent to the cancelled time, in that or the subsequent fortnightly period. This time may be made up working with other clients or in other areas of the employer's business providing the employee has the skill and competence to perform the work.

36. Under the HSU's claim, in the above scenario, the employer would not be required to pay the employee or to afford the employee make-up time. The employee's shift would simply be cancelled.

37. The claim advanced by ABLA's Clients is in some respects more onerous, more costly and more inflexible than the existing client cancellation scheme. It is problematic in at least the following respects.

38. *First,* it operates in the event of *any* client cancellation, even where ample notice of the cancellation is provided by the client to the employer and, in turn, by the employer to the employee. No justification for this significant expansion of the current clause is provided by ABLA's Clients.

39. The extant clause is clearly designed to deal with changes to an employee's roster at short notice due to client cancellations or changes. It appears intended to strike a balance between ensuring that an employer has some flexibility to respond to changes to service demands (which, in the context of the NDIS, are entirely beyond its control) and the inconvenience caused to an employee by changes made to their rosters at short notice.

40. Under the proposal advanced by ABLA's Clients, even where an employee has, for instance, four weeks of notice of a cancellation, the clause will require the employer to either pay them or to afford them make-up time. There is, however, no foundation for proceeding on the basis that the purpose or rationale underpinning the requirement to pay an employee in the context of a short notice change under the current clause is also relevant in the context of an employee having weeks of notice. Rather, the proposition that an employee should be compensated in the same way for a roster change with multiple weeks of notice as they should for a change made after 5pm on the preceding day, self-evidently has little force.

41. *Second*, the proposed clause will in many instances increase employment costs and the regulatory burden. The clause will require an employer, in the context of any client cancellation to either pay the employee for the shift or to find other work for the employee to perform (either at the same time or later, in the form of make-up time).

42. Whilst the existing provision creates an Award-derived employer *right* to direct an employee to perform make-up time, the proposed clause instead creates an employer *obligation* to provide make-up time (unless payment is made to the employee). In our consultation with employers covered by the Award, they have repeatedly expressed concern about the regulatory burden associated with managing accrued make-up time under the proposed clause, particularly given the frequency with which client cancellations occur.

43. The proposal potentially overlooks the complexities associated with allocating other work to an employee either at the same time as the cancelled shift or subsequently. Various factors are taken into account by an employer when allocating employees to the performance of home care and disability services including client preferences, continuity of care, the employees' skills and the clients' location.

44. Whilst Ai Group supports greater flexibility being afforded in respect of client cancellations to the provision of disability services; the scheme proposed by ABLA's Clients for dealing with client cancellations is not consistent with the need to afford flexible modern work practices[15] and it will have an adverse impact on many employers[16].

45. In Ai Group's submission, any scheme dealing with client cancellation should retain an ability to cancel an employee's shift without payment where a client cancels or changes their service request.

[15] Section 134(1)(d) of the *Fair Work Act 2009*.

[16] Section 134(1)(f) of the *Fair Work Act 2009*.

SURVEY

Fair Work Act 2009
s.156 - 4 yearly review of modern awards

4 yearly review of modern awards—Award stage—Group 4—*Social, Community, Home Care and Disability Services Industry Award 2010*— Substantive claims

(AM2018/26) SYDNEY, 2019

The Fair Work Commission (the Commission) is conducting a review of the *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award) as part of the 4 yearly review of modern awards.

The sectors covered by the SCHADS Award include:

- crisis accommodation for women, children, families, young people and men;
- sexual assault, domestic and family violence services;
- women's domestic violence court advocacy services;
- youth and child protection services;
- out of home care for children and young people at risk;
- homelessness, housing and tenancy services;
- family support services;
- disability services, including residential care and care provided in a private residence;
- health and mental health services;
- alcohol, gambling and other drugs of addiction and rehabilitation services;
- aged care services;
- first nation people's services;
- migrant and settlement services;
- prisoner rehabilitation;
- community legal services;
- community and neighbourhood services;
- policy, research and advocacy services;
- community transport;
- family day care; and

- home care (provision of personal care, domestic assistance or home maintenance to an aged person or person with a disability in a private residence)

Welcome

The Fair Work Commission requests that you complete the survey below to assist in the review of the *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award).

This survey should only be completed by you if your enterprise is currently covered by the SCHADS Award (including where an enterprise agreement applies).

You should only complete the survey **once**, regardless of how many times you have received an invitation to complete this survey.

If you are unable or unwilling to complete the survey you may be required to attend the Commission to give evidence in respect of the questions asked in this survey.

How the survey data will be used

Information collected by the Commission about the enterprises that complete the survey will be used for the sole purpose of excluding those enterprises from attending to give evidence.

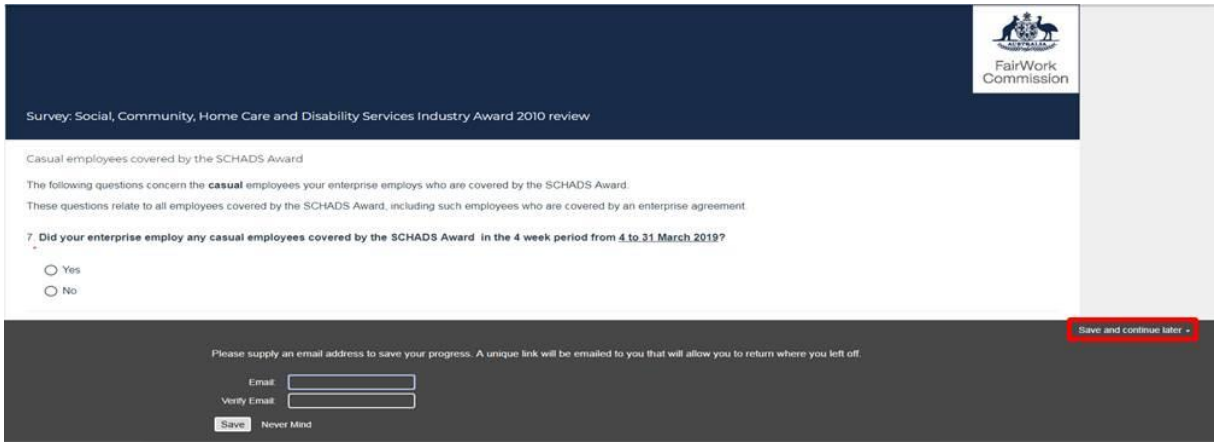
Data will be presented in aggregate form and will not identify the enterprises that completed the survey.

Instructions for completing the survey

Please complete the survey at your earliest convenience. The survey will close at **4.00 pm** on **Wednesday, 12 June 2019**.

It is recommended that you complete the online survey in one session. It may be helpful to review this survey and to consult your relevant records before commencing the online survey.

If necessary, the **'Save and continue later'** feature can be used which enables you to complete the online survey at another time. This feature can be accessed by clicking on **Save and continue later** in the bottom right-hand corner of the page and entering an email address for a unique link to the online survey to be sent.



The unique link will direct to the question where you left the online survey and retains the responses already provided. The email containing the unique link can get picked up in SPAM filters. It can take several hours to be delivered, can be delivered to your junk mail folder or may be undeliverable. Therefore, this feature should be used with caution.

Sectors

1. Which sector or sectors does your enterprise operate in?
Please select all that apply.

☐ Crisis accommodation for women, children, families, young people and men

☐ Sexual assault, domestic and family violence services

☐ Women's domestic violence court advocacy services

☐ Youth and child protection services

☐ Out of home care for children and young people at risk

☐ Homelessness, housing and tenancy services

☐ Family support services

☐Disability services, including residential care and care provided in a private residence

☐ Health and mental health services

☐ Alcohol, gambling and other drugs of addiction and rehabilitation services

☐ Aged care services

☐ First nation people's services

☐ Migrant and settlement services

☐ Prisoner rehabilitation

☐ Community legal services

☐ Community and neighbourhood services

☐ Policy, research and advocacy services

☐ Community transport

☐ Family day care

☐ Home care services

☐ Other sector – please specify _____

Employees covered by the SCHADS Award

The remaining questions in this survey relate to all employees covered by the SCHADS Award, including such employees who are covered by an enterprise agreement.

2. **Does an enterprise agreement apply to employees currently covered by the SCHADS award?**

☐Yes ☐ No

3. **Does your enterprise agreement (or agreements) cover <u>all</u> of your SCHADS Award–covered employees?**

☐Yes ☐ No

4. **How many employees does your enterprise <u>currently</u> employ who are covered by the SCHADS Award?**

☐ Fewer than 20 employees
☐ Between 20 and 49 employees
☐ Between 50 and 99 employees
☐ 100 or more employees

5. [If employs 100 or more employees who are covered by the SCHADS Award] **How many employees covered by the SCHADS Award does your enterprise employ?**

ENTER NUMBER

6. **Of the employees your enterprise employs who are covered by the SCHADS Award; how many employees are employed in the categories set out below?**

Category	**No. of Employees**
Permanent full time employees	ENTER NUMBER
Permanent part time employees	ENTER NUMBER
Fixed term contract full time employees	ENTER NUMBER
Fixed term contract part time employees	ENTER NUMBER
Casual employees (i.e. in receipt of the 25% casual loading and not in receipt of any paid leave entitlement)	ENTER NUMBER

Casual employees covered by the SCHADS Award

The following questions concern the casual employees you employ in the sectors covered by the SCHADS Award.
These questions relate to all employees covered by the SCHADS Award, including such employees who are covered by an enterprise agreement.

7. **Did your enterprise employ any casual employees covered by the SCHADS Award in the 4 week period from <u>4 to 31 March 2019</u>?**

☐Yes ☐ No [SKIP TO Q11]

8. **Did any of the casual employees work in excess of 38 hours per week or 76 hours per fortnight?**

☐Yes ☐ No

9. **Did any of the casual employees work on a Saturday?**

☐Yes ☐ No

10. **Did any of the casual employees work on a Sunday?**

☐Yes ☐ No

Income from government sources

11. **Does your enterprise receive a significant proportion of its income from the Commonwealth, a State Government or a Local Government?**

☐Yes ☐ No [SKIP TO Q13]

12. [If the answer to Question 11 is Yes] **What is the source of the income?**
Please select all that apply.

☐ Commonwealth

☐ State Government

☐ Local Government

24 hour care shifts

Clause 25.8 of the SCHADS Award provides that home care employees may be rostered for a 24 hour care shift which requires an employee to be available for duty in a client's home for a 24 hour period.

13. **Has your enterprise rostered a home care employee for a 24 hour care shift in the 12 month period from 1 March 2018 to 1 March 2019?**

☐Yes ☐ No [SKIP TO Q15] ☐ Don't know [SKIP TO Q15]

14. [If the answer to Question 13 is Yes] **How many times has your enterprise rostered a home care employee for a 24 hour care shift in the 12 month period from 1 March 2018 to 1 March 2019?**

ENTER NUMBER

About your enterprise

Please note that information collected by the Commission about the enterprises that complete the survey will be used for the sole purpose of excluding those enterprises from attending to give evidence.
Data will be presented in aggregate form only and will not identify the enterprises that completed the survey.

15. **Where is the primary location of your enterprise?**

☐Metropolitan area
☐Regional area
☐Rural/remote area

16. **What is the name of your enterprise?**

ENTER NAME

17. **Is your enterprise a member of one or more of the organisations listed below?**
Please select all that apply.

☐ Jobs Australia

☐ Australian Federation of Employers and Industry (AFEI)

☐ Australian Business Industrial (ABI)

☐ NSW Business Chamber

☐Aged and Community Services Australia

☐ Leading Age Services Australia

☐ National Disability Services (NDS)

☐ Australian Industry Group (Ai Group)

☐ None of these organisations [SINGLE RESPONSE ONLY]

Thank you

Thank you for completing the survey.

The survey results will be used for the purpose of reviewing the *Social, Community, Home Care and Disability Services Industry Award 2010* as part of the Commission's 4 yearly review of modern awards.

Survey data will be presented in aggregate form only and will not identify the enterprises that participated.

If you have any queries or concerns about this survey and how your responses will be used, please contact:

INGRID SUMMERS
Modern Awards, Economics and Research Section
Fair Work Commission
Tel: 03 8656 4709
Email: ingrid.summers@fwc.gov.au

Survey analysis of the *Social, Community, Home Care and Disability Services Industry Award 2010*

June 2019

The contents of this paper are the responsibility of Commission staff and the research has been conducted without the involvement of members of the Fair Work Commission.

Table of Contents

1 Introduction

The Fair Work Commission (the Commission) is conducting a review of the *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS award) as part of the 4 yearly review of modern awards (the Review). A number of substantive claims have been made to vary the SCHADS award as part of the Review and these are being dealt with in matter AM2018/26.

A survey was conducted by the Commission titled 'Survey - *Social, Community, Home Care and Disability Services Industry Award 2010*'.

The purpose of the survey is to assist the Full Bench (in matter AM2018/26) in informing itself and the relevant parties about the information relating to the matter. The survey is not designed to be representative of all enterprises that employ workers covered by the SCHADS award.

The survey questions were developed in consultation with parties in matter AM2018/26. Relevant documentation is posted to the Commission's website and is accessible via the link below:

https://www.fwc.gov.au/awards-and-agreements/modern-award-reviews/4-yearly-review/award-stage/award-review-documents/MA000100?m=AM2014/285

The survey was open for a period of 5 weeks (from 15 May 2019 until 19 June 2019).

The survey was administered via an online survey platform. A link was sent by the Commission to each party (in matter AM2018/26) and the email was forwarded by each employer party to their members. Participation in the survey is limited to the membership of parties in matter AM2018/26 (or enterprises represented in the proceedings).

In total, 854 enterprises provided a complete response to the survey with the survey sent out to approximately 2980[1] enterprises, generating an approximate response rate of just under 30 per cent.

The analysis is conducted on the 854 complete responses. Incomplete or responses from enterprises not covered by the SCHADS award were also received but were not included as part of the analysis. A number of responses were not included for the following reasons:

- 496 enterprises provided responses that were incomplete;
- 17 enterprises provided multiple responses—duplicates were removed;
- 3 enterprises were not covered by the SCHADS award; and
- 4 enterprises provided responses that included errors or were missing key data.

[1] This figure is an approximation as it may include organisations that are members of more than one party to the matter and may have been sent the survey more than once.

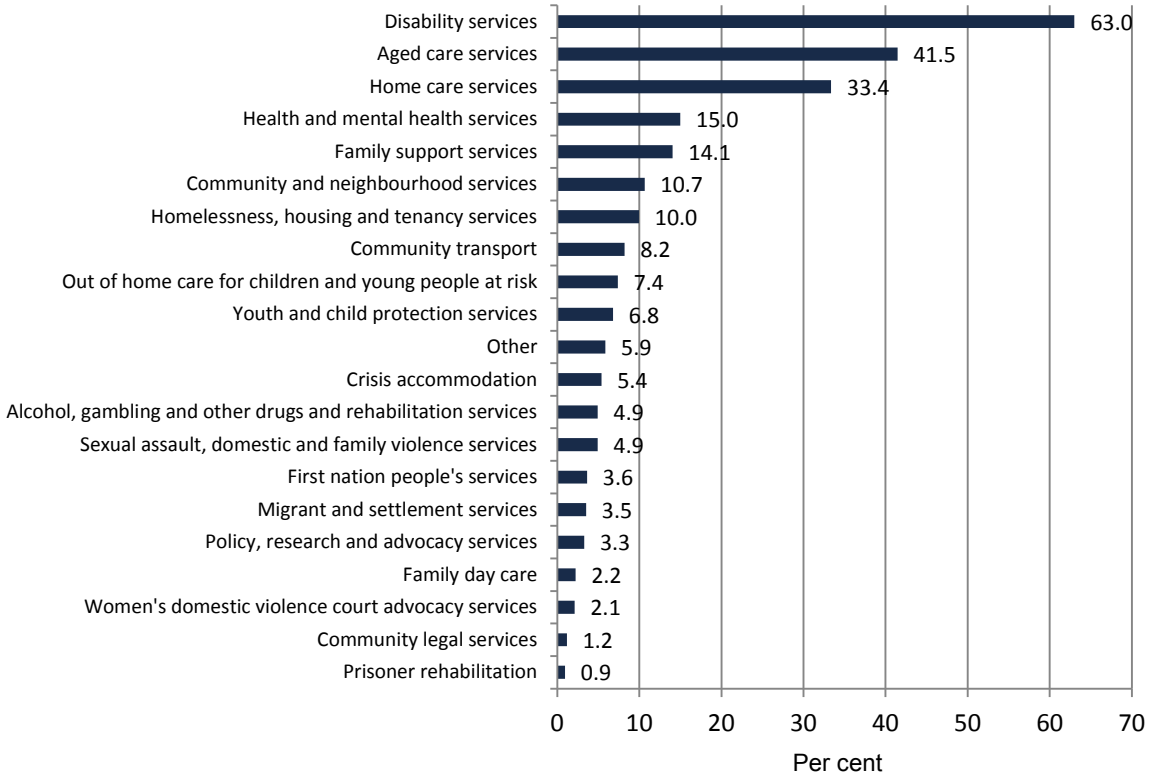
2 Aggregate analysis of responses

This section provides an analysis of responses to the survey from enterprises that are members of parties in matter AM2018/26.

2.1 Sectors

Chart 1 shows the sector or sectors that the enterprises operated in. The most common sector that the enterprises operate in is Disability services, including residential care and care provided in a private residence (Disability services) (63.0 per cent), followed by Aged care services (41.5 per cent) and Home care services (33.4 per cent).

Chart 1: Which sector or sectors does your enterprise operate in?



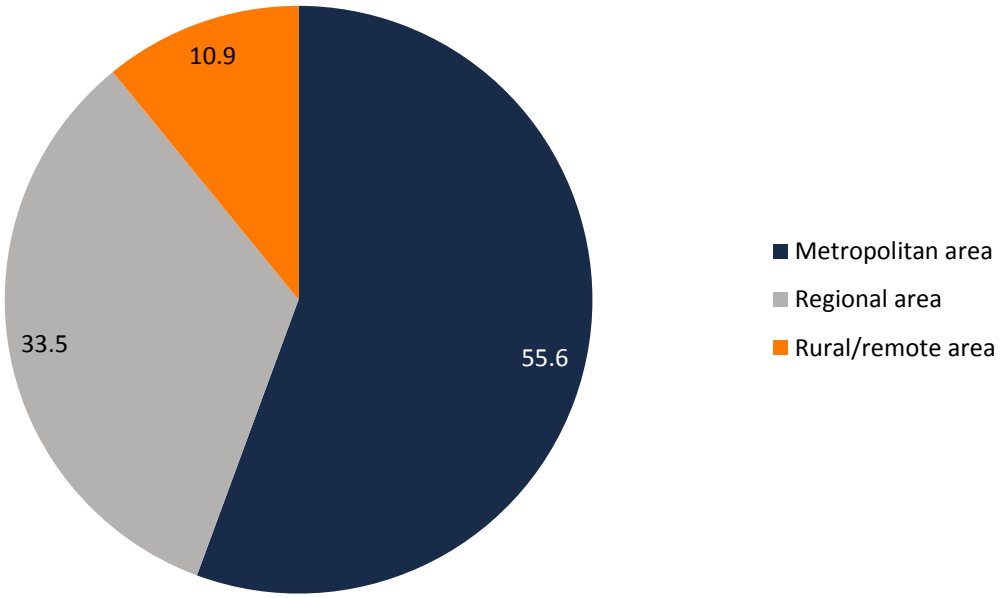
Note: The total sums to more than 100 as enterprises can operate in multiple sectors.

Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010*, 2019, Question 1.

2.2 About your enterprise

More than half (55.6 per cent) of enterprises that responded to the survey have their primary location in a metropolitan area, while around one third (33.5 per cent) have their primary location in a regional area. Only around one in ten enterprises operated in a rural/remote area (Chart 2).

Chart 2: Where is the primary location of your enterprise?

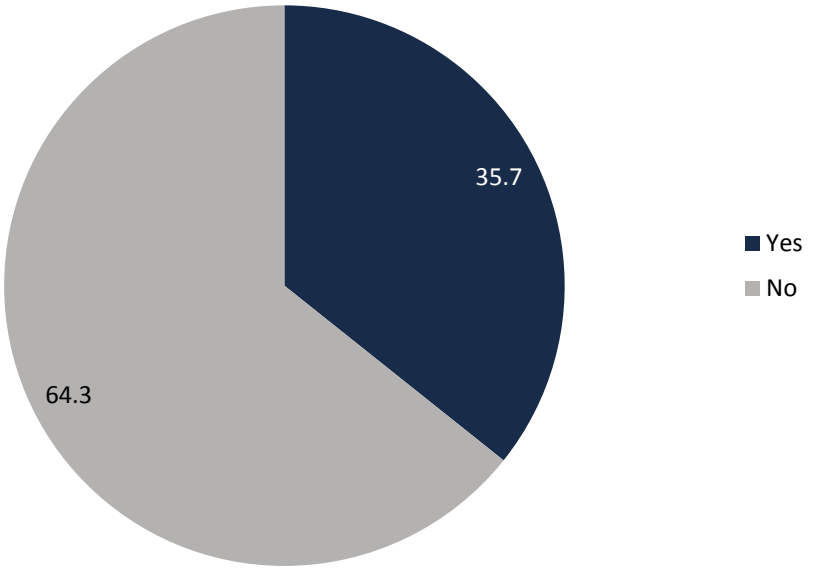


Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Question 15.

2.3 Employees covered by the SCHADS award

Over one third (35.7 per cent) of enterprises that responded to the survey have an enterprise agreement which applies to employees currently covered by the SCHADS award (Chart 3).

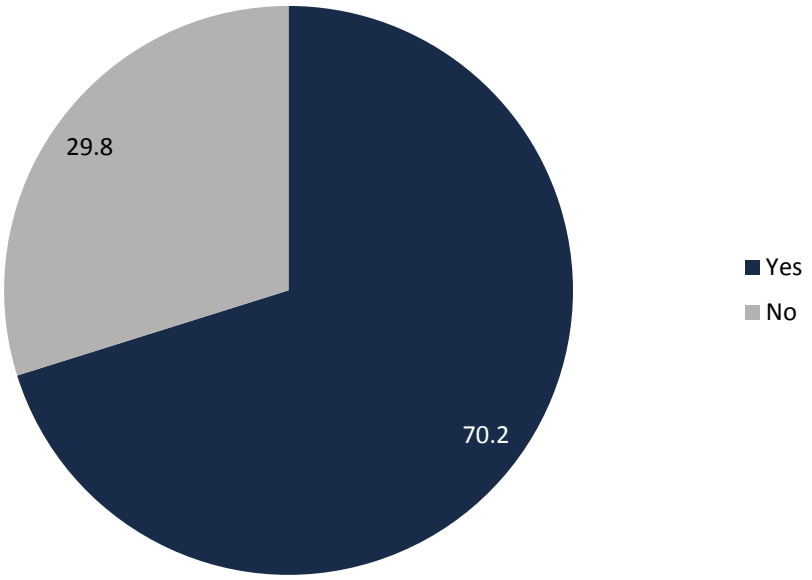
Chart 3: Does an enterprise agreement apply to employees currently covered by the SCHADS award?



Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Question 2.

Of those enterprises that responded that they have an enterprise agreement, around seven in ten (70.2 per cent) responded that their enterprise agreement (or agreements) covers all of their SCHADS award-covered employees (Chart 4).

Chart 4: Does your enterprise agreement (or agreements) cover all of your SCHADS Award-covered employees?

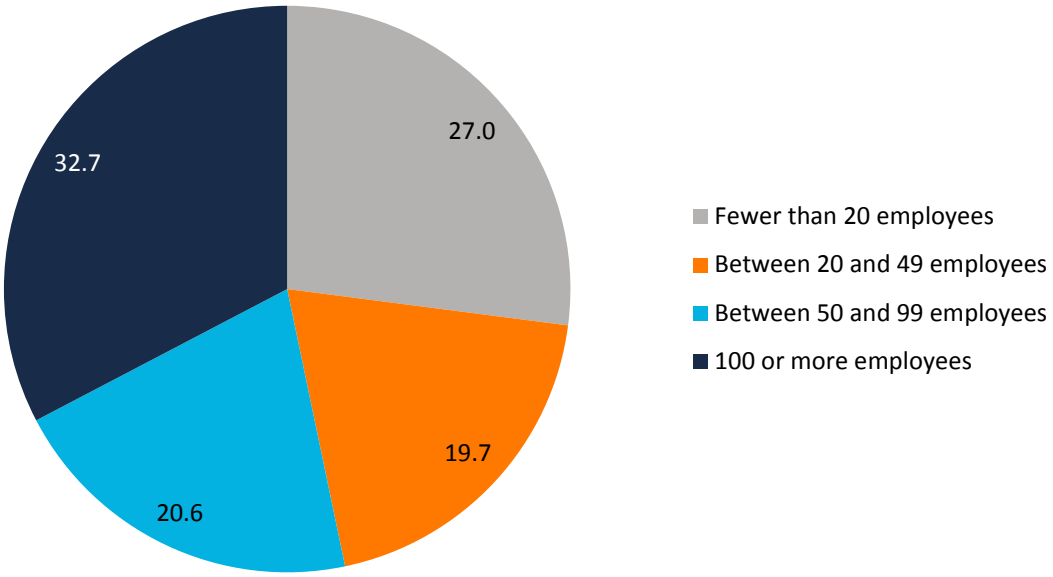


Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Question 3.

2.4 Number of SCHADS employees by enterprises

Around one third (32.7 per cent) of enterprises that responded to the survey employ 100 or more employees who are covered by the SCHADS award, while over one quarter (27 per cent) employ fewer than 20 employees who are covered by the SCHADS award (Chart 5).

Chart 5: How many employees does your enterprise currently employ who are covered by the SCHADS award?



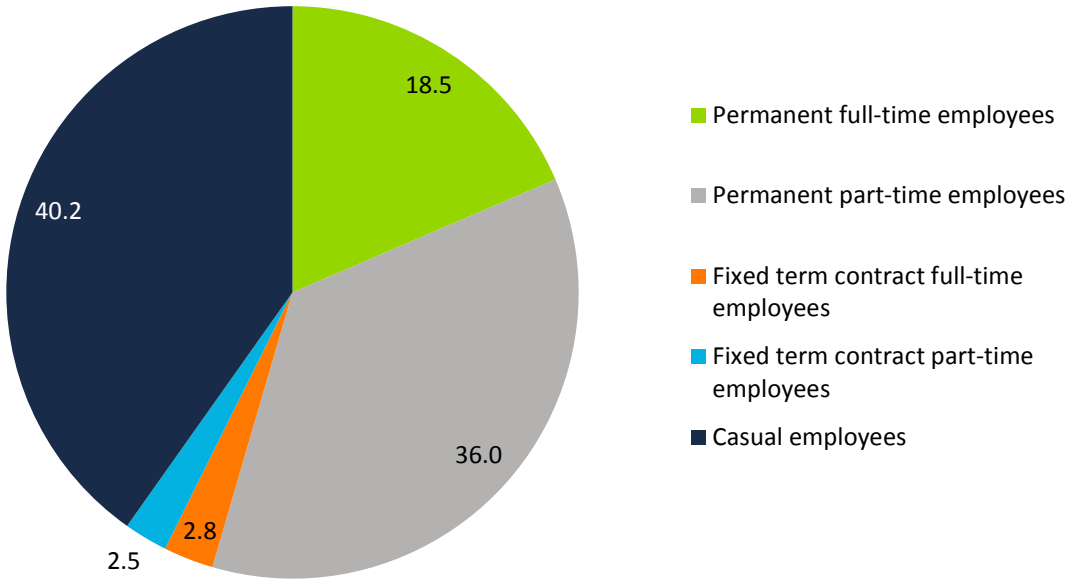
Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Question 4.

Enterprises that employ 100 or more employees covered by the SCHADS award had an average of 397 employees covered by the SCHADS award and a median of 175 employees covered by the SCHADS award.[2]

Around four in ten employees covered by the SCHADS award that are employed in the enterprises that responded to the survey are casual employees (i.e. in receipt of the 25 per cent casual loading and not in receipt of any paid leave entitlements) (Chart 6). The next most common employment type was permanent part-time employees (36.0 per cent), followed by permanent full-time employees (18.5 per cent).

[2] AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Question 5.

Chart 6: Of the employees your enterprise employs who are covered by the SCHADS Award; how many employees are employed in the categories set out below?



Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Question 6.

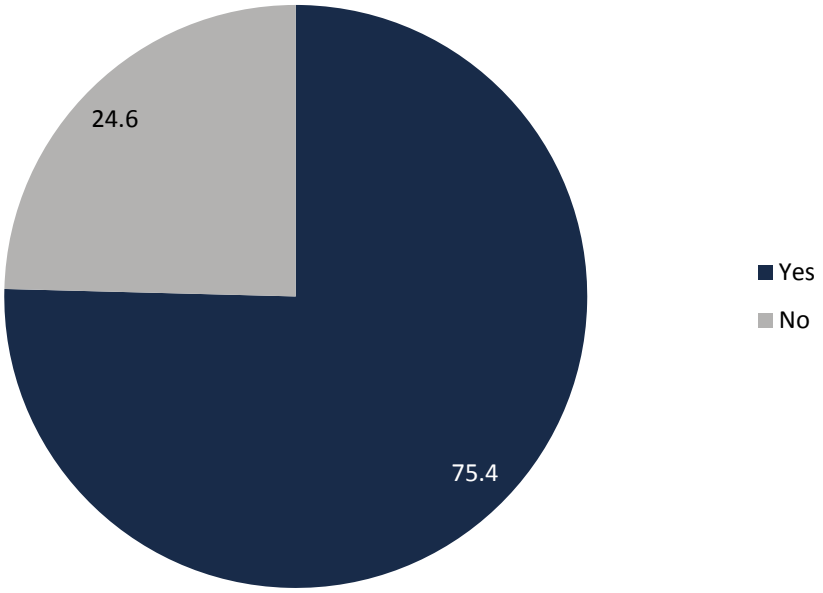
2.5 Casual employees covered by the SCHADS award

As noted in the survey, the following questions concerning casual employees, relate to all employees covered by the SCHADS award, including employees covered by an enterprise agreement.[3]

In the 4 week period from 4 to 31 March 2019, around three-quarters (75.4 per cent) of enterprises that responded to the survey employed casual employees that were covered by the SCHADS award (Chart 7).

[3] AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, pp. 4–7.

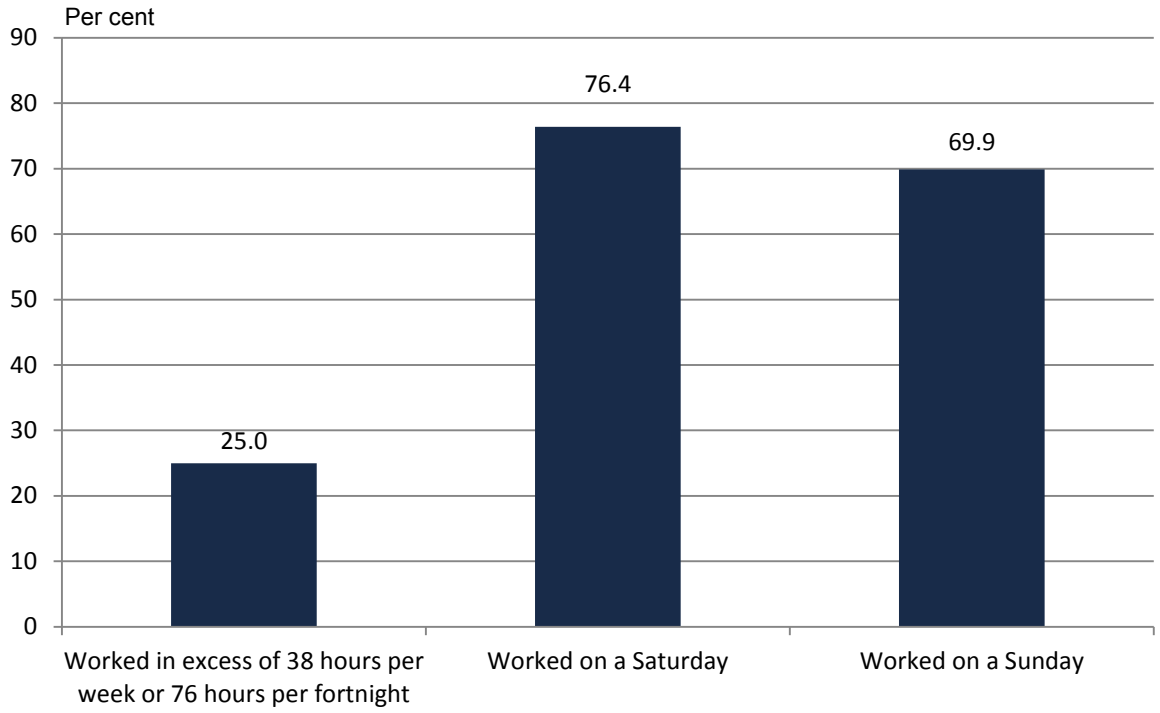
Chart 7: Did your enterprise employ any casual employees covered by the SCHADS award in the 4 week period from 4 to 31 March 2019



Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Question 7.

Of the enterprises that employed casual employees in the 4 week period from 4 to 31 March 2019, one quarter had casual employees that worked in excess of 38 hours per week or 76 hours per fortnight (Chart 8). Around three-quarters of enterprises (76.4 per cent) responded that casual employees worked on a Saturday during this period, and around seven in ten enterprises (69.9 per cent) responded that casual employees worked on a Sunday.

Chart 8: Did any of the casual employees work in excess of 38 hours per week or 76 hours per fortnight, work on a Saturday, or work on a Sunday



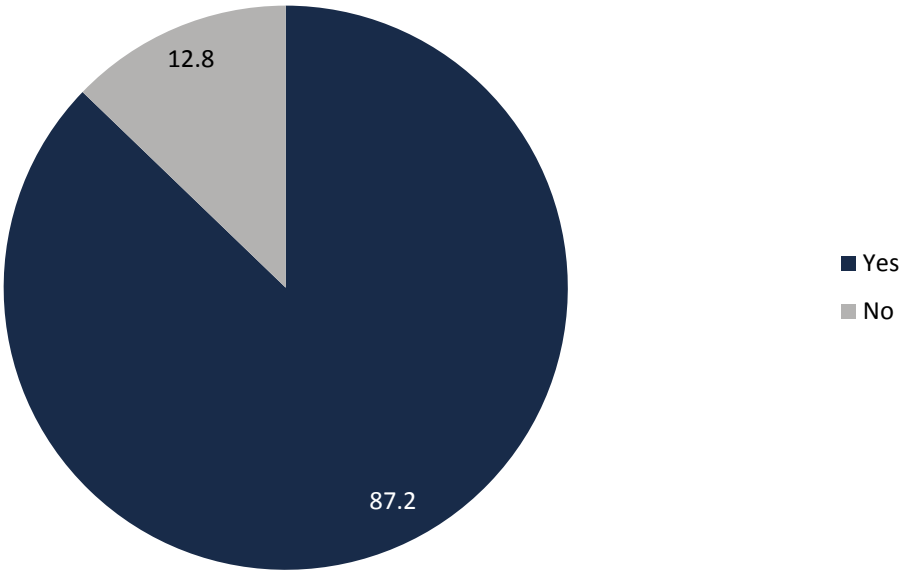
Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 8, 9 and 10.

2.6 Income from government sources

Almost nine in ten (87.2 per cent) enterprises that responded to the survey receives a significant proportion of its income from the Commonwealth, State or Local Government (Chart 9).[4]

[4] These responses may include enterprises that receive NDIS funding indirectly from a government source (i.e. via a client).

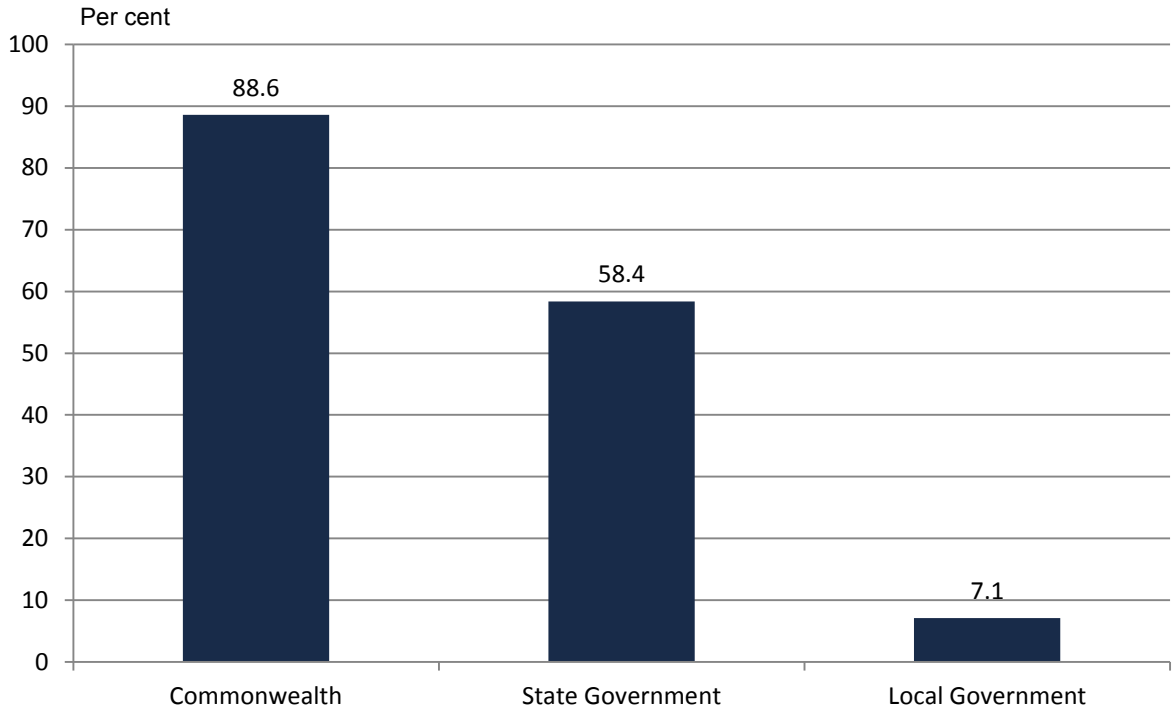
Chart 9: Does your enterprise receive a significant proportion of its income from the Commonwealth, a State Government or a Local Government?



Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 11.

Around nine in ten enterprises that responded to the survey received income from the Commonwealth Government (88.6 per cent) and around six in ten (58.4 per cent) received income from the State Government. Only 7.1 per cent of these enterprises received income from the Local Government (Chart 10).

Chart 10: What is the source of the income?



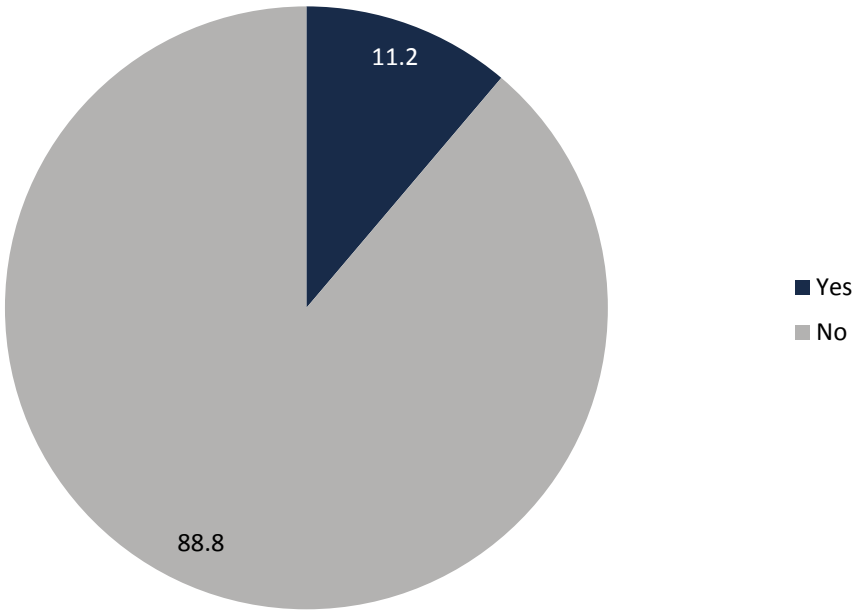
Note: The total does not sum to 100 as enterprises can receive income from multiple government sources.

Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Question 12.

2.7 24 hour care shifts

Around one in ten enterprises (11.2 per cent) that responded to the survey rostered a home care employee for a 24 hour care shift between 1 March 2018 and 1 March 2019 (Chart 11).

Chart 11: Has your enterprise rostered a home care employee for a 24 hour care shift in the 12 month period from 1 March 2018 to 1 March 2019?



Note: The 14 enterprises that responded with 'don't know' in regard to whether they had rostered a home care employee for a 24 care shift were excluded.

Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Question 13.

For enterprises that rostered a home care employee for a 24 hour care shift in this period, the average number of times that the enterprise rostered a home care employee in the 12 month period from 1 March 2018 to 1 March 2019 was 304.[5]

[5] AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010*, 2019, Question 14.

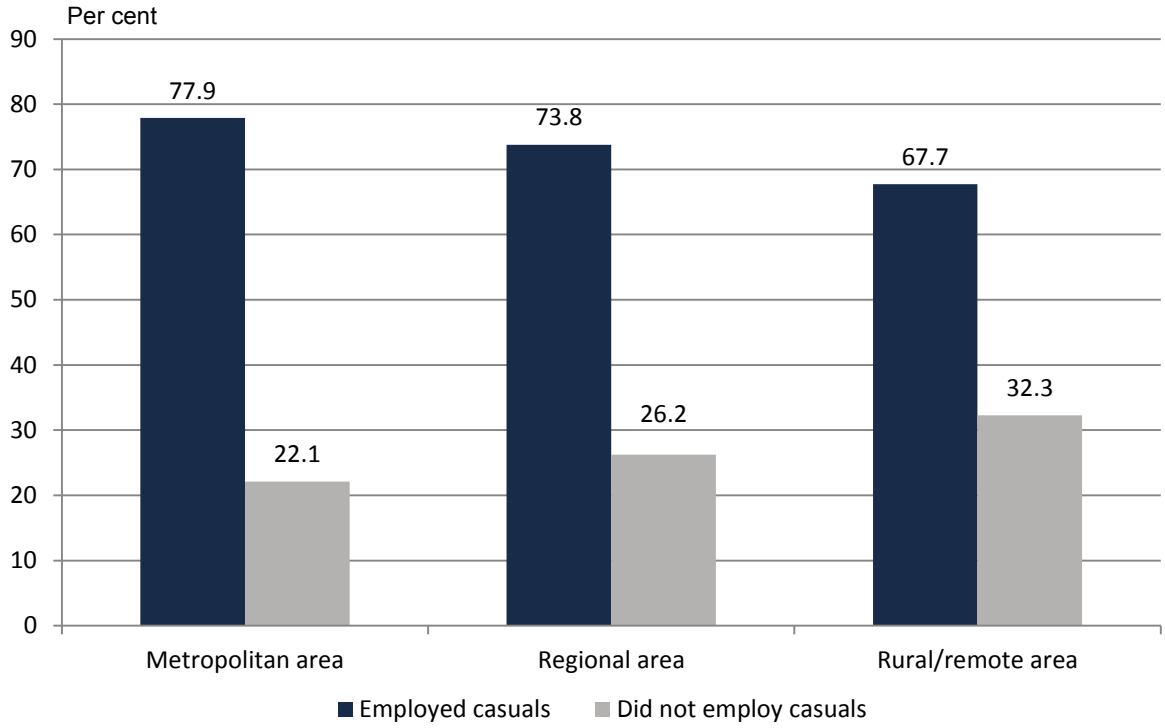
3 Enterprises that employ casuals

This section provides further analysis of enterprises that responded they employ casual employees by comparing them with the responses of enterprises that do not employ casual employees for a range of variables.

3.1 Location

Chart 12 presents the proportion of enterprises that employed casuals by the primary location of the enterprise. The chart shows that across all locations, enterprises that responded to the survey were more likely to have employed casuals. The highest proportion of enterprises that employed casuals had their primary location in metropolitan areas (77.9 per cent), followed by regional areas (73.8 per cent), while enterprises with their primary location in rural/remote areas had the lowest proportion of enterprises that employed casuals (67.7 per cent).

Chart 12: Enterprises that employed casual employees by location

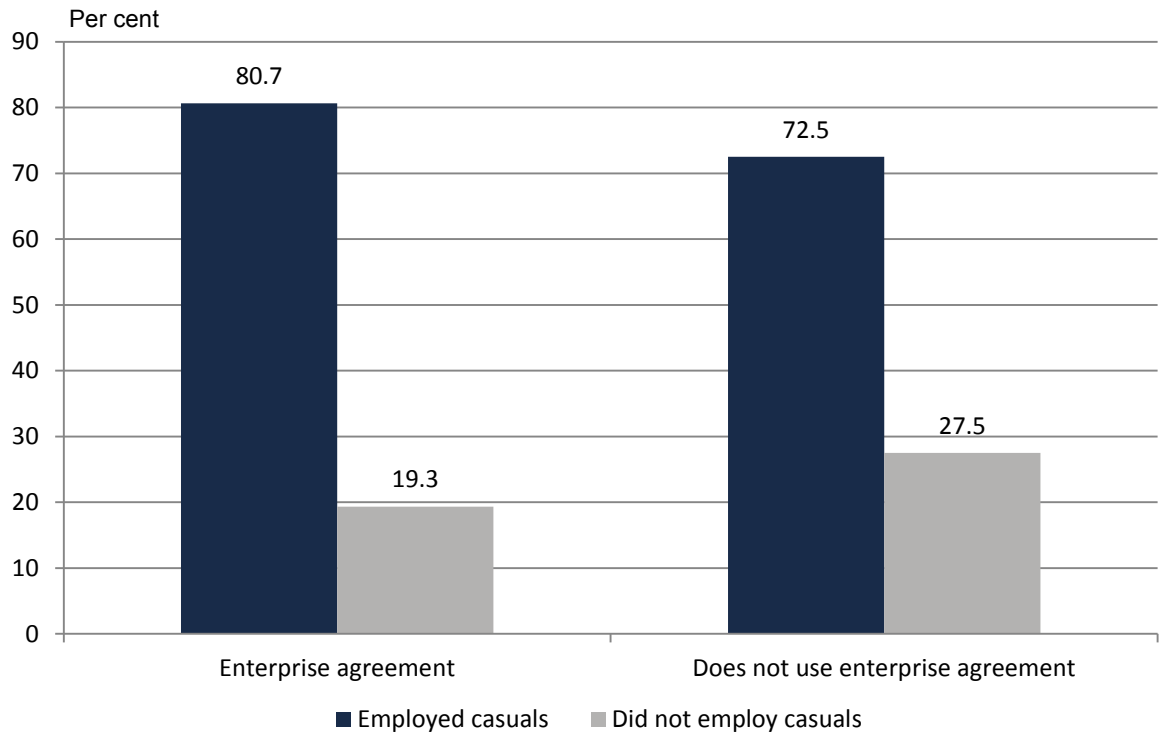


Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 7 and 15.

3.2 Enterprise agreement coverage

Enterprises that responded that they have an enterprise agreement that applies to employees currently covered by the SCHADS award were more likely to employ casual employees than enterprises that do not use enterprise agreements (Chart 13).

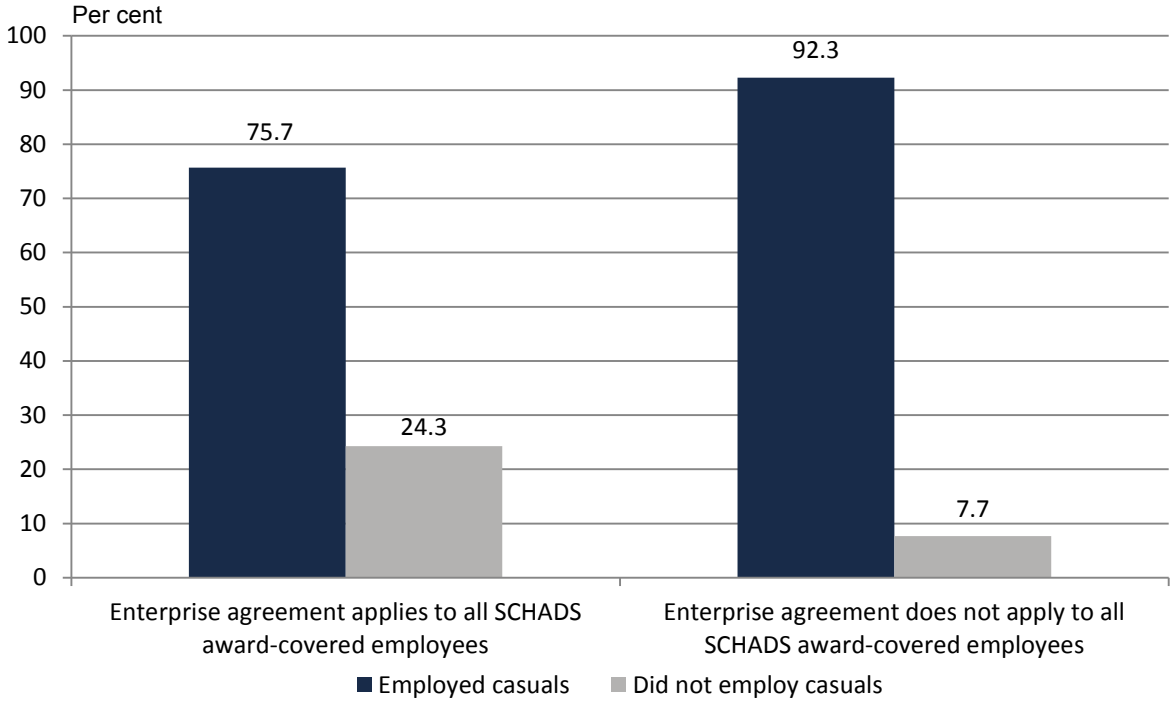
Chart 13: Enterprises that employed casual employees by use of enterprise agreement



Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 2 and 7.

Enterprises that responded using an enterprise agreement (or agreements) for all of their SCHADS award-covered employees were less likely to employ casual employees than enterprises that use enterprise agreements that do not cover all of their SCHADS award-covered employees (Chart 14).

Chart 14: Enterprises that employed casuals by whether the enterprise agreement (or agreements) covers all SCHADS award-covered employees

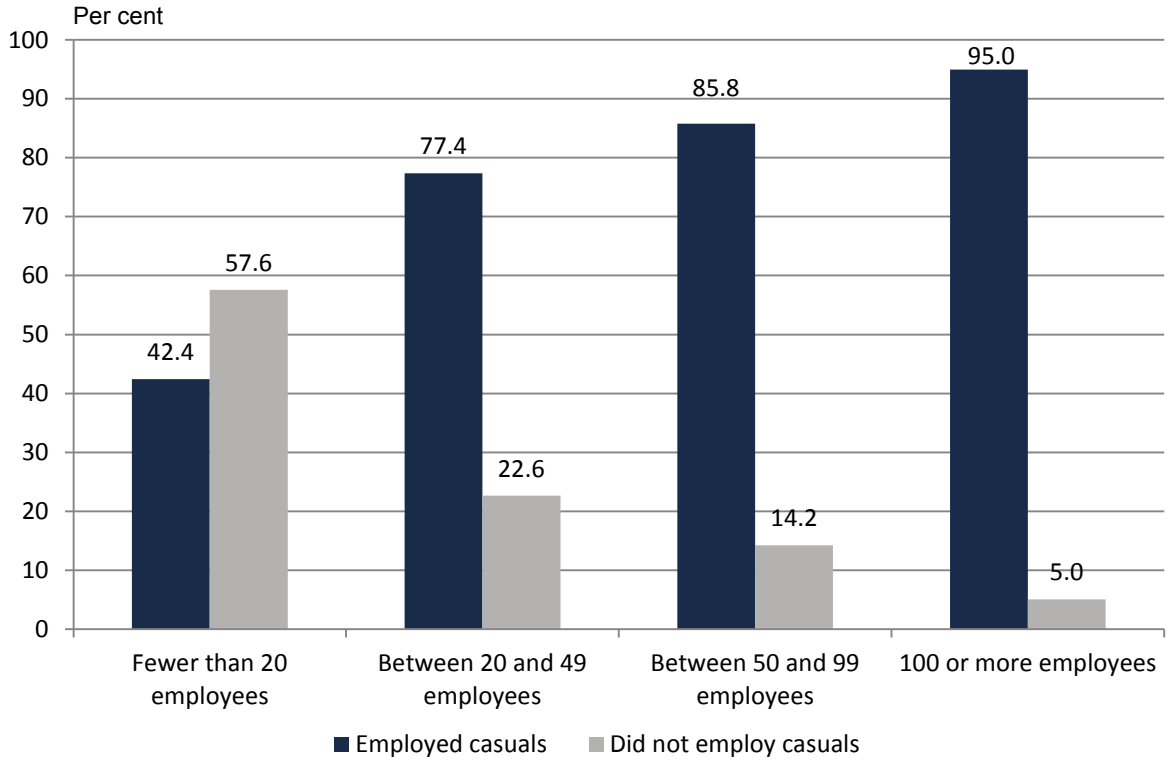


Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 3 and 7.

3.3 Number of SCHADS award-covered employees

Enterprises that responded employing a higher number of employees covered by the SCHADS award were more likely to employ casual employees (Chart 15). Enterprises that employ fewer than 20 employees covered by the SCHADS award were less likely to employ casual employees.

Chart 15: Enterprises that employed casuals by number of SCHADS employees

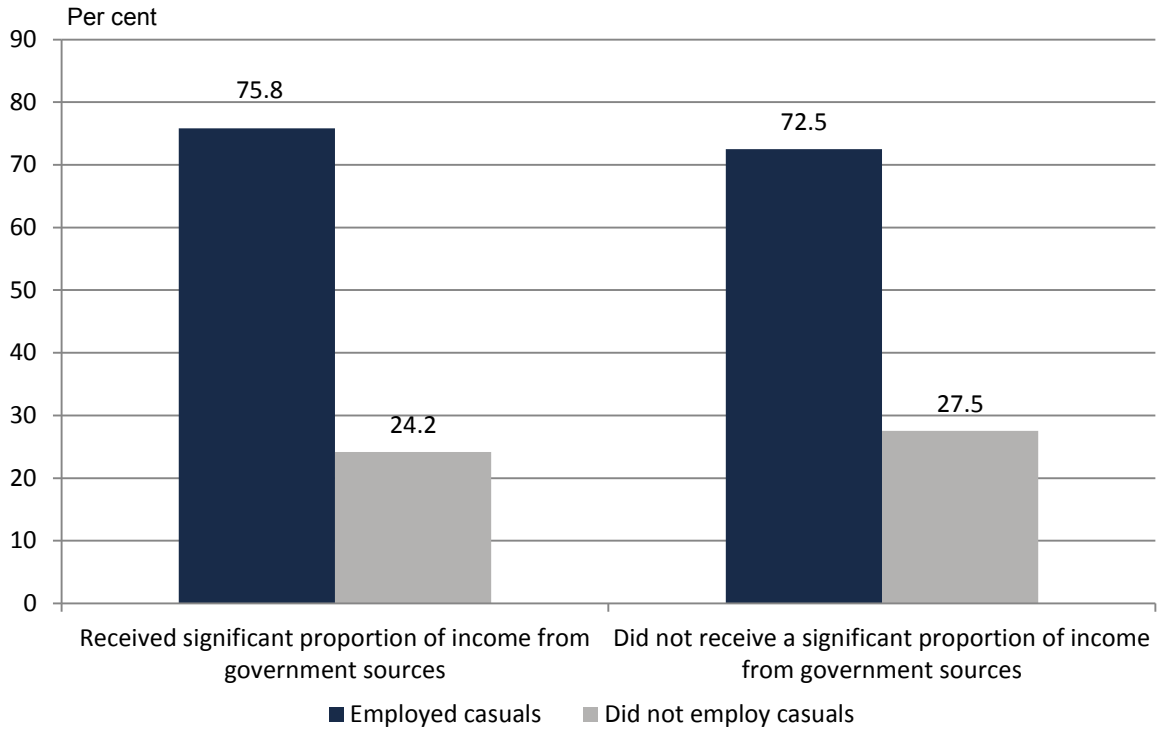


Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 4 and 7.

3.4 Income from government sources

Chart 16 shows the proportion of enterprises that responded to the survey that employed casual employees by whether they receive a significant proportion of their income from government sources. There was a slightly higher proportion of enterprises employing casuals that received a significant proportion of income from government sources (75.8 per cent compared with 72.5 per cent).

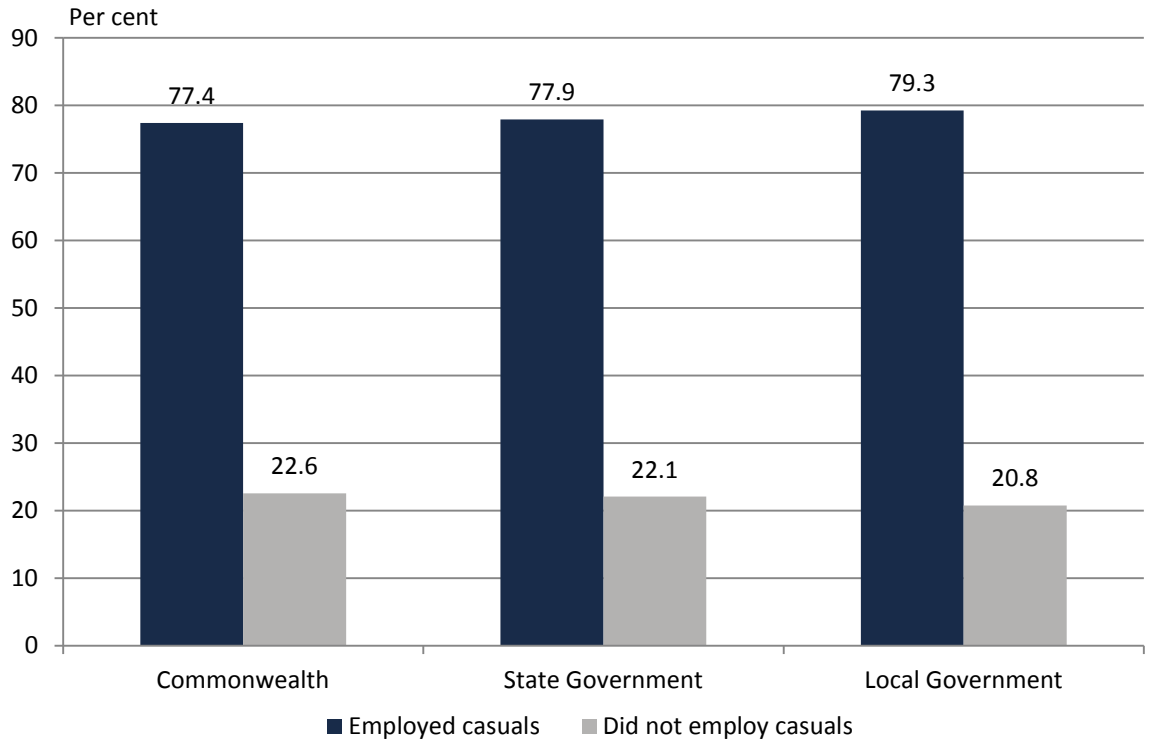
Chart 16: Enterprises that employed casual employees by whether received a significant proportion of income from government sources



Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 7 and 11.

Chart 17 presents the proportion of enterprises that employ casuals by source of government income. There is little difference in the employment of casuals across the sources of income. As many enterprises receive funding from multiple levels of government, there is overlap between the groups.

Chart 17: Enterprises that employed casual employees by government funding source



Note: Enterprises may receive funding from more than one level of government.

Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 7 and 12.

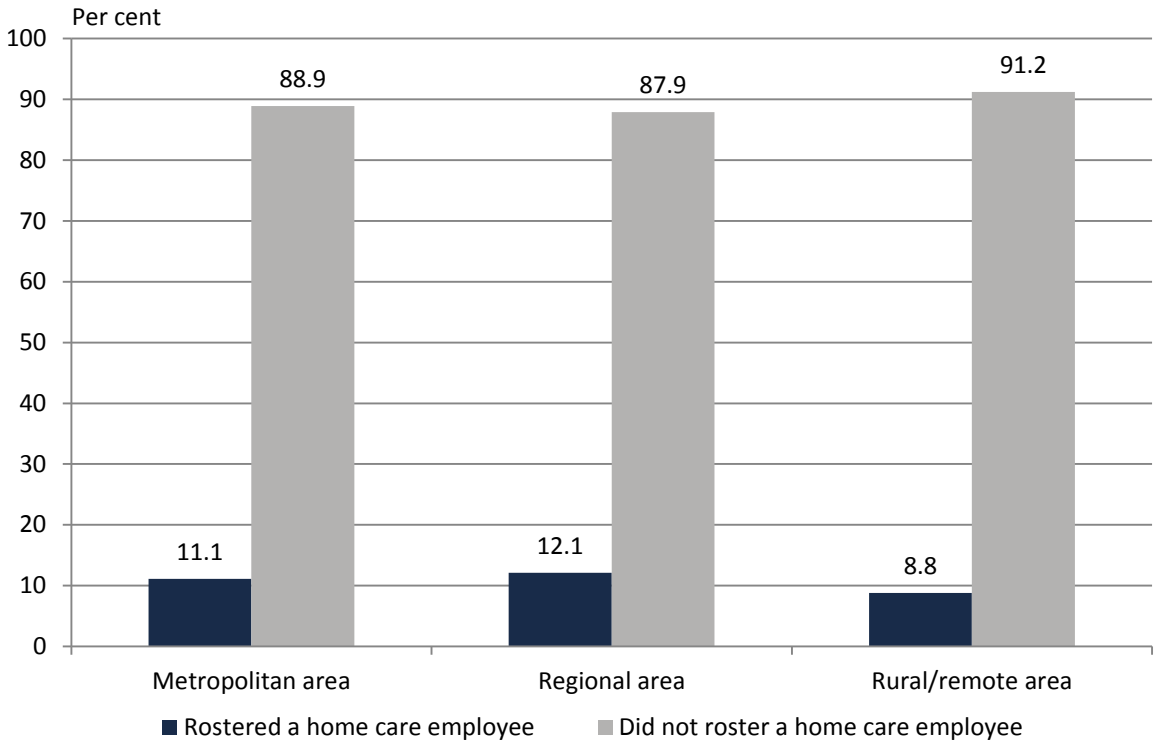
4 24 hour care shifts

This section provides further analysis of enterprises that responded that they rostered a home care employee for a 24 hour care shift in the period from 1 March 2018 to 1 March 2019 by comparing them with the responses of enterprises that did not roster a home care employee for a 24 hour care shift during the same period. Clause 25.8 of the SCHADS Award provides that home care employees may be rostered for a 24 hour care shift which requires an employee to be available for duty in a client's home for a 24 hour period.

4.1 Location

Chart 18 presents the proportion of enterprises that responded that they rostered a home care employee for a 24 hour care shift by the primary location of their enterprise. The chart shows that across all areas, around one in ten enterprises rostered a home care employee for a 24 hour care shift. Enterprises in regional areas had the highest proportion that rostered a home care employee (12.1 per cent), followed by metropolitan areas (11.1 per cent), while rural/remote areas have the lowest proportion (8.8 per cent).

Chart 18: Enterprises that rostered a home care employee for a 24 hour shift by location

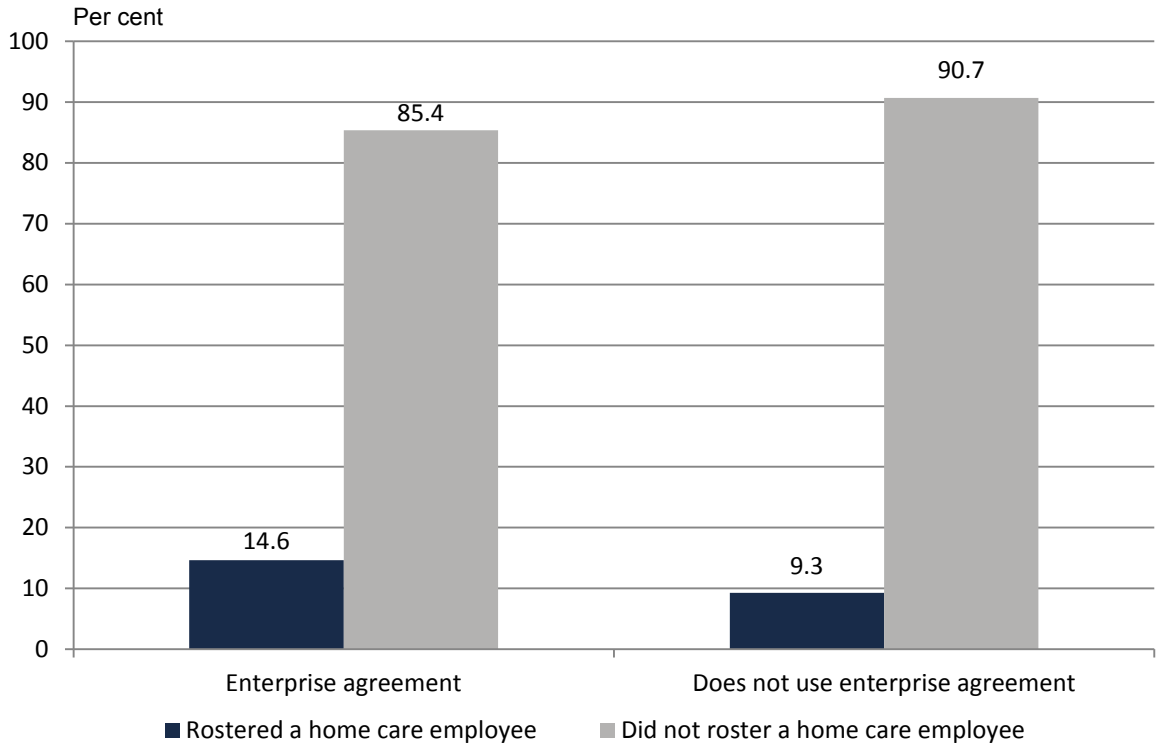


Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 13 and 15.

4.2 Enterprise agreement coverage

Enterprises that responded having an enterprise agreement that apply to employees currently covered by the SCHADS award were more likely to roster a home care employee for a 24 hour care shift than enterprises that do not use an enterprise agreement for these employees (Chart 19).

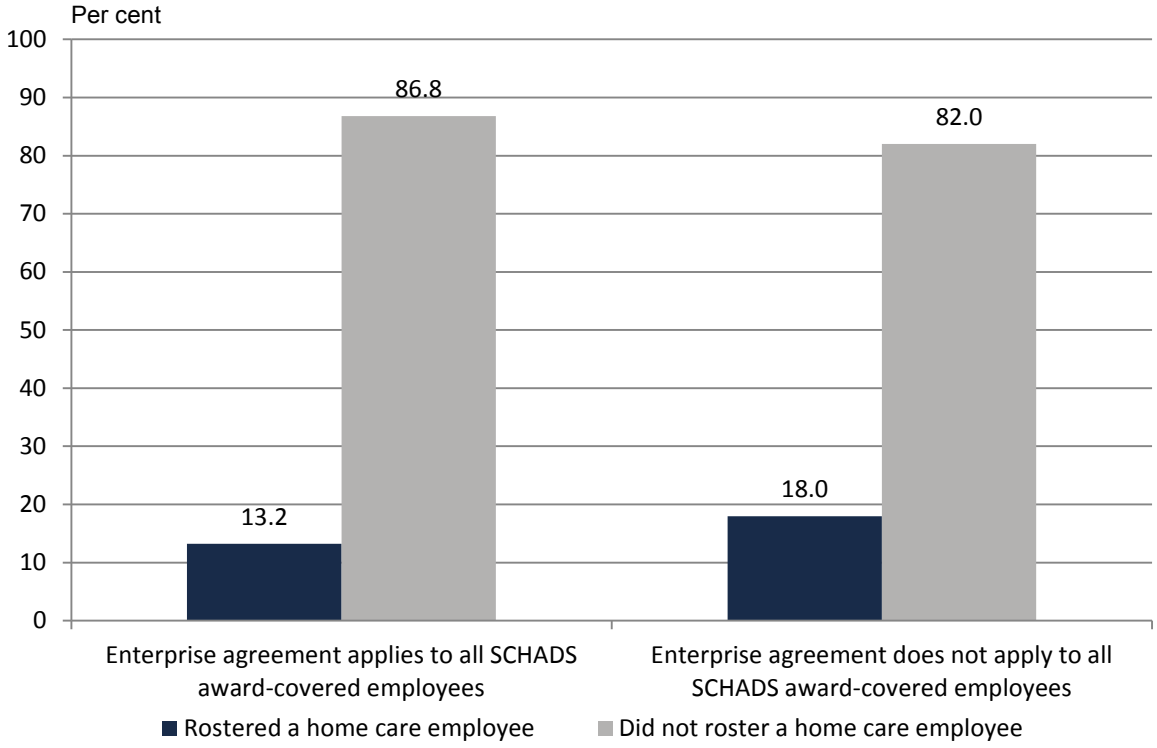
Chart 19: Enterprises that rostered a home care employee for a 24 hour shift by use of enterprise agreement



Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 2 and 13.

Enterprises that use an enterprise agreement (or agreements) that apply to all of their SCHADS award-covered employees were less likely to roster a home care employee for a 24 hour care shift than enterprises that use enterprise agreements that do not cover all of their SCHADS award-covered employees (Chart 20).

Chart 20: Enterprises that rostered a home care employee for a 24 hour shift by whether the enterprise agreement covered all SCHADS employees

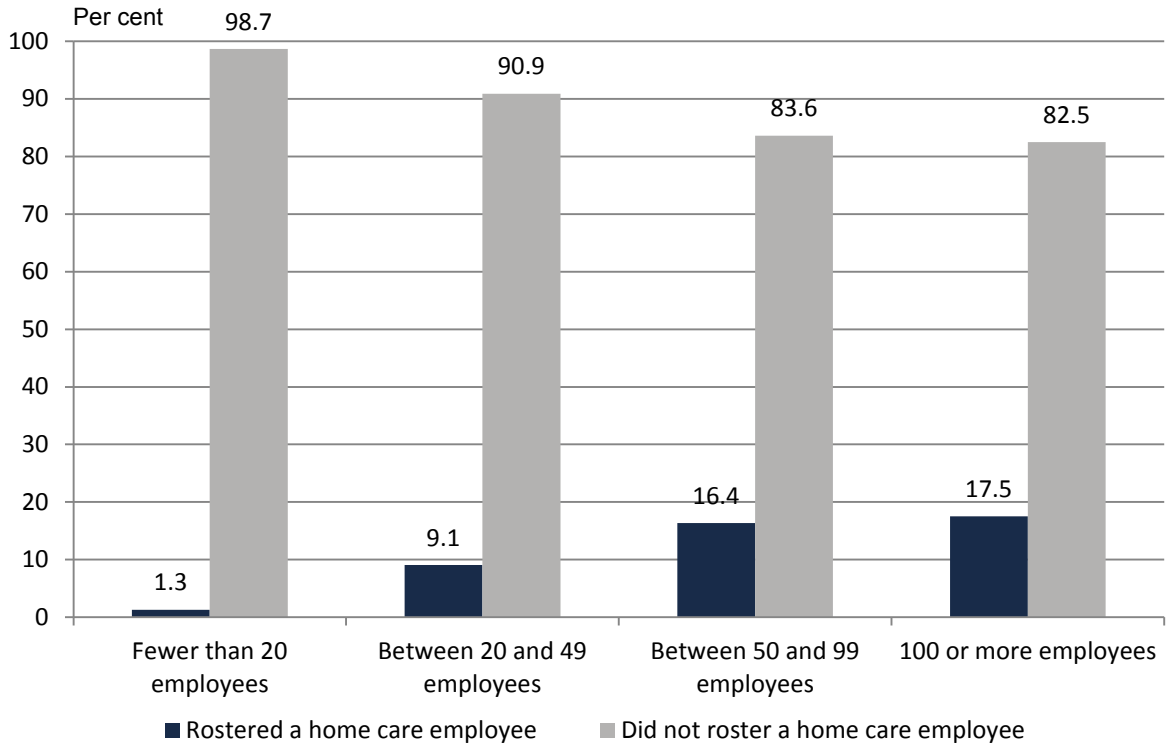


Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 3 and 13.

4.3 Number of SCHADS award-covered employees by enterprises

Enterprises that responded employing a higher number of employees covered by the SCHADS award were more likely to have rostered a home care employee for a 24 hour care shift. Enterprises that employ 100 or more SCHADS award-covered employees (17.5 per cent) and between 50 and 99 SCHADS award-covered employees (16.4 per cent) had the highest proportion of enterprises that rostered a home care employee for a 24 hour care shift (Chart 21).

Chart 21: Enterprises that rostered a home care employee for a 24 hour shift by number of SCHADS employees

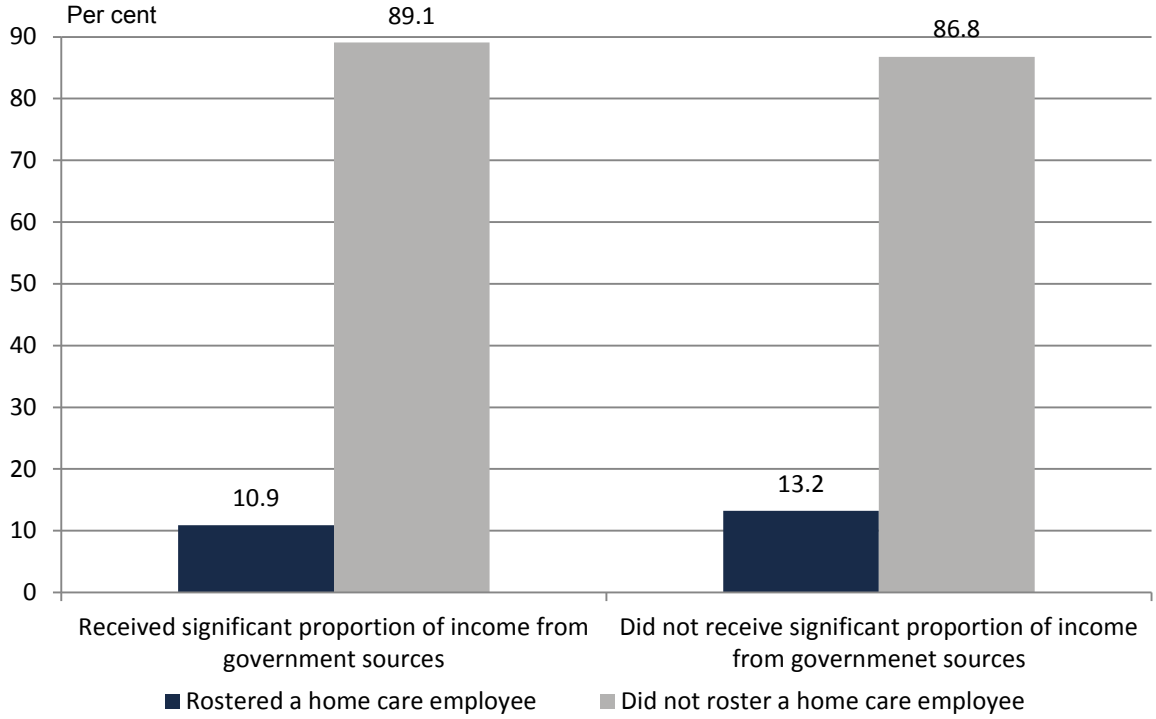


Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 4 and 13.

4.4 Income from government sources

Chart 22 shows the proportion of enterprises that responded to the survey that rostered a home care employee for a 24 hour care shift by whether they received a significant proportion of their income from government sources. The chart shows that enterprises that did not receive a significant proportion of income from government sources were more likely to have rostered a home care employee for a 24 hour care shift (10.9 per cent compared with 13.2 per cent).

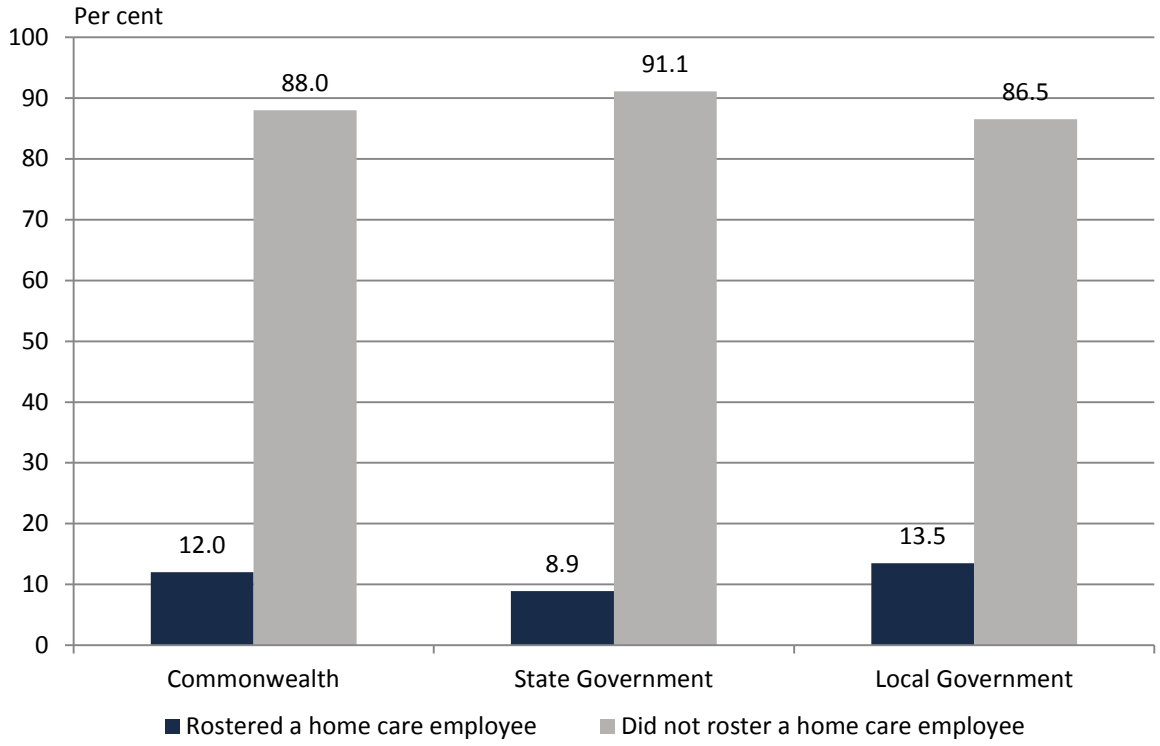
Chart 22: Enterprises that rostered a home care employee for a 24 hour shift by whether it received income from Government sources



Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 11 and 13.

Chart 23 presents the proportion of enterprises that rostered a home care employee for 24 hour care shift by income from government sources. Enterprises that received income from the State Government were less likely to roster a home care employee relative to enterprises that received income from the Commonwealth or local Government.

Chart 23: Enterprises that rostered a home care employee for a 24 hour shift by Government funding source



Note: Enterprises may receive funding from more than one level of government.

Source: AM2018/26, Survey - *Social, Community, Home Care and Disability Services Industry Award 2010,* 2019, Questions 12 and 13.

MA000100<<PRxxxxx>>
FAIR WORK COMMISSION

DRAFT DETERMINATION

Fair Work Act 2009
s.156 - 4 yearly review of modern awards

4 yearly review of modern awards –
(AM2014/285)

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010
[MA000100]

Social, Community, Home Care and Disability Services Industry

COMMISSION MEMBER PLACE, DATE

Further to the Decision issued by the Fair Work Commission on the above award is varied as follows:

[1] By deleting clause 25.6 and inserting in lieu thereof:

25.6 Broken shifts

This clause only applies to social and community services employees when undertaking disability services work and home care employees.

(a) A **broken shift** means a shift worked by an employee that includes one or more breaks (other than a meal break) and where the span of hours is not more than 12 hours.

(b) An employee who works a broken shift will receive:

(i) Ordinary pay plus a loading of 15% of their ordinary rate of pay for each hour from the commencement of the shift to the conclusion of the shift inclusive of all breaks; and

(ii) penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the finishing time of the broken shift.

(c) All work performed beyond the maximum span of 12 hours for a broken shift will be paid at double time.

(d) An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.

[2] The determination shall operate on and from [ ].

BY THE COMMISSION

MA000100<<PRxxxxx>>
FAIR WORK COMMISSION

DRAFT DETERMINATION

Fair Work Act 2009
s.156 - 4 yearly review of modern awards

4 yearly review of modern awards –
(AM2014/285)

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010
[MA000100]

Social, Community, Home Care and Disability Services Industry

COMMISSION MEMBER PLACE,

DATE

Further to the Decision issued by the Fair Work Commission on the above award is varied as follows:

[1] By inserting a new sub clause 25.7 Travel Time as follows:

25.7 Travel Time

(a) Where an employee is required to work at different locations they shall be paid at the appropriate rate for reasonable time of travel from the location of the preceding client to the location of the next client, and such time shall be treated as time worked. The travel allowance in clause 20.5 also applies.

(b) This clause does not apply to travel from the employee's home to the location of the first client nor does it apply to travel from the location of the last client to the employee's home.

[2] The determination shall operate on and from [ ].

BY THE COMMISSION

IN THE FAIR WORK COMMISSION

Matter No.: AM2014/285

S 156 – Four Yearly Review of Modern Awards - Social, Community, Home Care and Disability Services Industry Award 2010

SUBMISSION OF THE AUSTRALIAN SERVICES UNION

Submitter:	David Smith, National Secretary
Organisation:	Australian Services Union
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Email:	info@asu.asn.au
Date:	Monday 18 February, 2019

Contents

Attachments:

Annexure A – Summary of Branch Shift provisions

Annexure B – Future Ability Project Report 2016 SSI

Witness Statements

- Augustino Encabo
- Richard Rathbone
- Olav Muurlink
- Ruchita
- Nadia Saleh
- Lou Bacchiela
- Natalie Lang

NDIS Costs Productivity Commission Paper June 2017

UNSW Workforce Issues in the NSW Community Services Sector April 2017

Australian Institute of Health and Welfare - Australia's Welfare 2017

1. This submission regards the substantive claims pursued by the Australian Services Union ('**ASU**') in the Four yearly review ('**the Review**') of the *Social, Community, Home Care and Disability Services Industry Award* 2010 ('**SCHDS** Award'). It is made pursuant to the Directions issued by the Fair Work Commission ('**Commission**') on 9 November 2018.
2. The ASU filed draft determinations for each of its claims on 7 November 2018. These include:
    a. a variation to clause 25.6 to provide a loading to be paid to employees who work broken shifts;
    b. a new clause providing an allowance to employees who use community language skills to provide services to speakers of languages other than English or to provide signing services to those with hearing difficulties; and
    c. a variation to clause 4.2 of the SCHDS Award to ensure that health professionals employed in the Social and Community Sector are not excluded from coverage of the SCHDS Award.
3. The proposed variation to clause 4.2 is withdrawn.
4. The ASU notes that conciliations occured in January regarding the Draft Consent Determinations filed by the parties in February 2017. Discussions may continue in the lead up to the hearing. We reserve our right to propose additional variations in the Four yearly review of modern awards.

JURISDICTIONAL ISSUES

5. The Commission's task in the Review is to 'decide if a particular modern award achieves the modern awards objective'.[1] If the modern award does not meet the modern awards objective it must be varied. However variations must be 'necessary to achieve the modern awards objective' not merely desirable because modern awards must only include terms that are 'necessary to achieve the modern awards objective' (s 138). Any case for change must be accompanied by probative evidence properly directed to demonstrating the facts supporting the proposed variation.[2]
6. The modern awards objective, in s 134(1), requires the Commission to ensure that modern awards, together with the National Employment Standards (NES) provide a fair and relevant minimum safety net of terms and conditions'. As noted by the Full Bench in the *Penalty Rates Decision*: 'The word

[1] *Four yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001, [36].
[2] *Re Four Yearly Review of Modern Awards – Preliminary Jurisdictional Issues* [2014] FWCFB 1788, (2014) 241 IR 189 ('**Jurisdictional Issues Decision**').

'relevant', in the context of s.134(1), is intended to convey that a modern award should be suited to contemporary circumstances.'[3] 'Fairness' means fairness to both employees and employers.

7. Paragraphs 134(1)(a) through (h) set out a number of considerations that the Fair Work Commission must take into account. The obligation to take into account the matters set out in paragraphs 134(1)(a) to (h) means that each of the matters set out must be treated as a matter of significance in the decision making process.[4] However, no particular weight should be given to any one consideration over another; and not all considerations will be relevant to a particular proposed variation.[5] The Commission's task is to balance the considerations to ensure that the modern awards meet the modern awards objective.[6]

THE AUSTRALIAN SERVICES UNION

8. The ASU's interest in the SCHDS Award comes from our coverage of the social and community services sector. The ASU is the largest union of workers in the social and community services sector. Our members predominantly work in non-government, not-for-profit organisations that support people experiencing or at the risk of experiencing crisis, disadvantage, social dislocation or marginalisation.
9. ASU members in the community and disability sector work to protect vulnerable women, babies, children, young people, men and families in their own homes, in out-of-home care, in refuges and in after care. Our members also work to support and protect those same people when they are living with violence, homeless, living in cars, on the streets, 'couch surfing', and in other dangerous circumstances. Our members provide case work, crisis intervention, referral, financial and other support for individuals of all ages and families experiencing poverty, isolation and homelessness, gambling, drug and alcohol addictions, disabilities, mental health issues, overwhelming legal and financial problems, very young parents and those who are refugees or have other settlement issues. They work with women, children, young people and men who are experiencing or escaping violence and those who are living with physical, intellectual and other disabilities and mental health issues.

THE SOCIAL AND COMMUNITY SECTOR

10. The social and community services sector is highly diverse sector. It covers a range of workers from:

[3] *Penalty Rates Case*, [1948].
[4] *Jurisdictional Issues Decision*, [31].
[5] *Four Yearly Review of Modern Awards – Annual Leave* [2015] FWCFC 3406, [19], [20] (**'Annual Leave Decision'**).
[6] *Annual Leave Decision*, [20].

a. crisis accommodation for women, children, families, young people and men;

b. sexual assault, domestic and family violence services;

c. women's domestic violence court advocacy services;

d. youth and child protection services;

e. out of home care for children and young people at risk;

f. homelessness, housing and tenancy services;

g. family support services;

h. disability services, including residential care;

i. health and mental health services;

j. alcohol, gambling and other drugs of addiction and rehabilitation services;

k. aged care services;

l. first nation people's services;

m. migrant and settlement services;

n. prisoner rehabilitation;

o. community legal services;

p. community and neighbourhood services;

q. policy, research and advocacy services; and

r. community transport.

11. These workers are almost entirely covered by the classifications in Schedule B – Classification Definitions – Social and Community Services Employees and Schedule C – Classification Definitions – Crisis Accommodation Employees of the SCHDS Award.

12. The size of the social and community services workforce is hard to measure but it is very large. Disability services, providing supports to the 4.3 million Australians with a disability,[7] is the largest area of growth. Spurred by the introduction of the National Disability Insurance Scheme, one in five new jobs created in Australia will be in disability services during the transition to the NDIS.[8] In 2017, the Productivity Commission found that the disability services workforce was growing quickly, but not fast enough to meet the overall growth target.[9]

[7] ABS 2016a. Disability, ageing and carers, Australia: first results, 2015. ABS cat. no. 4430.0.10.001. Canberra: ABS.
[8] Productivity Commission 2017. National Disability Insurance Scheme (NDIS) Costs, 2017. Canberra: Productivity Commission. ('**Productivity Commission Report**').
[9] Productivity Commission Report, p 36.

13. 80 percent of people who work in the social and community sector are women. The Fair Work Commission recognised the gendered undervaluation of work performed in this sector when it made the ERO. The case, which was successfully lead by the ASU, argued that people in the social and community sector carry out work that was identical to that carried out by employees of state and federal government, but was not equally remunerated, in large part because of the gendered nature of the community sector and also because historically workers in the community sector had not been recognised for their skills and qualifications or for the professionalism of their work.

INDUSTRIAL REGULATION OF THE SOCIAL AND COMMUNITY SECTOR

14. The social and community sector is largely award reliant. Rates of pay in the sector are almost always set by the 2012 Equal Remuneration Order ('**ERO**').[10]
15. The industry is award reliant because of the structural impediments to bargaining in an industry that is reliant on government funding. Even where cooperation and industrial power exists in organisations, employees' ability to bargain is stymied by the nature of the industry. Community sector employers are constrained by the funding arrangements that are dictated to them by governments and funding bodies. They are forced to engage in competitive tendering processes to 'win' funding contracts to continue to deliver vital services on behalf of governments, yet governments do not participate in negotiating and setting the wages and conditions of the workforce who are employed to deliver these services. While the 'employer' is the not-for-profit organisation, the effective decision maker is whichever level of government funds the organisation. This also means that employers are unable to tailor industrial conditions to their needs through bargaining.
16. The effect of the transition of the Modern Award system has been to increase the 'distance' between the social and community sector employees and their ultimate economic employer in government. Under previous industrial relations regimes, it was easier to negotiate with government funders in their respective industrial relations system. However, the Act provides that the modern award system must provide a minimum safety net for all employees in Australia with no state-based differences.[11] Since then, state and federal governments have largely accepted the rates of pay and conditions set by the Commission and set their funding accordingly.

[10] PR525485.
[11] The Act, s 154.

17. This means that the safety net is 'higher' for the social and community sector than for other industries. The SCHDS Award must include terms and conditions that would normally be dealt with through bargaining, for instance clause 25.7 – Sleepovers or clause 25.5(f) Client Cancellation, to ensure that it provides a fair and relevant safety net.

BROKEN SHIFTS

18. The ASU is seeking a variation to clause 25.6 of the SCHDS Award to provide for a 15 percent loading to be paid to employees who work broken shifts. The purpose of this allowance is to compensate employees for the disutility associated with working unusual broken shift arrangements of the Award.

The ASU's proposed variation

19. Clause 25.6 currently provides that the ordinary hours of work of social and community services employees undertaking disability services work and home care employees do not need to be worked continuously. It states:

> **25.6 Broken Shifts**
>
> *This clause only applies to social and community services employees when undertaking disability services work and home care employees.*
>
> ***(a)** A broken shift means a shift worked by an employee that includes one or more breaks (other than a meal break) and where the span of hours is not more irrthan 12 hours.*
>
> ***(b)** Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the finishing time of the broken shift.*
>
> ***(c)** All work performed beyond the maximum span of 12 hours for a broken shift will be paid at double time.*
>
> ***(d)** An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.*

20. The ASU proposes to vary clause 25.6 by deleting clause 25.6(b) and inserting a new subclause providing for a 15 per cent loading to be paid on the employees ordinary rates of pay, as follows:

> ***25.6 Broken shifts***
>
> *This clause only applies to social and community services employees when undertaking disability services work and home care employees.*
>
> ***(a)*** *A broken shift means a shift worked by an employee that includes one or more breaks (other than a meal break) and where the span of hours is not more that 12 hours.*
>
> ***(b)*** *An employee who works a broken shift will receive:*
>
> > ***(i)*** *Ordinary pay plus a loading of 15% of their ordinary rate of pay for each hour from the commencement of the shift to the conclusion of the shift inclusive of all breaks; and*
> >
> > ***(ii)*** *penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the finishing time of the broken shift.*
>
> ***(c)*** *All work performed beyond the maximum span of 12 hours for a broken shift will be paid at double time.*
>
> ***(d)*** *An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.*

21. Clause 25.6 does not provide a fair and relevant safety net of minimum terms and conditions. The clause offers an employer exceptional flexibility to roster a disability services or home care employee in broken engagements, without significant restriction or any compensation. Under clause 25.6:
    a. ordinary hours do not need to be worked continuously;
    b. there are no restrictions on the number of breaks in work;
    c. there is no minimum engagement;
    d. there is no requirement for the employee to agree to work broken shifts, so broken shifts may be rostered at the discretion of the employer;
    e. shift allowances are determined by the finishing time of the broken shift; and

f. no allowance is paid to compensate for the disability associated with working a broken shift.

22. Employees do not receive any additional remuneration to compensate for this extreme variability in rostering.

23. Further, the SCHDS Award has the following unique features which provide employers with significant flexibility:

a. the roster of part-time employees may be changed at any time under clause 25.5 (d) (iii) which provides that the restrictions on changing the roster do not apply to mutually agreed additional hours worked by part-time employees;

b. part-time employees are not paid overtime until they work 10 hours in a day or 38 hours in a week or 79 hours in a fortnight;[12]

c. there is no minimum engagement for part-time or full-time employees;

d. employers are not required to roster meal breaks if they require an employee to have a meal with a client or clients;[13]

e. casual disability services employees are only entitled to a 2 hour minimum engagement;[14]

f. casual home care employees are only entitled to a 1 hour minimum engagement;[15] and

g. if a client cancels an appointment, a home care employee's roster can be changed if the client is notified that their roster is being changed because of a client cancellation before 5.00 PM the day before, they will not be paid for the shift if they are notified about the client cancellation after that time, they will only be paid for the minimum specified hours, an employee can also be directed to work make up time sometime in that roster period or the next;[16]

24. The combined effect of clause 25.6 and the other unique features of the SCHDS Award is that an employee may be rostered to work broken shifts with little restriction on how those hours may be worked. This permits employers to roster employees in highly irregular and unsociable patterns of work.

[12] SCHDS Award, Cl 28.1(b).
[13] SCHDS Award, Cl 27.1(c).
[14] SCHDS Award, Cl 10.4(c)(iii).
[15] SCHDS Award, Cl 10.4(c)(ii).
[16] SCHDS Award, cl 25.5(f).

Lay evidence

25. The ASU's lay witness evidence will show that employees working broken shifts experience a wide range of disabilities. The ASU's members report a variety of disabilities associated with working broken shifts under clause 25.6. The evidence of Augustino Encabo and Richard Rathbone will show that working broken shifts spreads their working day over a long period of time, causing fatigue and interfering with family, social and community engagement. The witnesses report both relatively short and relatively long unpaid periods between engagements. Both cause significant disutility.
26. Further, short breaks between engagements are often rostered to avoid paying for time spent travelling between clients at different locations by engaging employees only for the period of time spent directly servicing a client. Each witness explains that these shift patterns cause them significant disutility. Both employees report that they are required to eat meals with their clients and are not rostered for meal breaks.
27. Each witness will also show that low paid social and community sector employees need to maximise their incomes by working additional hours and at times that attract a penalty. Further, the witness evidence will show that disability services employees do not refuse additional hours, even when this is inconvenient to them, because they require the additional income and are worried that additional hours will not be offered to them in the future if they refuse.
28. Each witness explains that the low pay and irregular working hours in the industry have caused them to consider leaving the disability services industry. This is undesirable when the disability workforce is growing so rapidly and struggling to attract staff.

Expert evidence

29. We also rely on the Report of Olav Muurlink entitled '*Predictability and control in working schedules*' filed in the Part-time Work Common Issue on 14 July 2016.[17] We also rely on paragraphs 59 top 71 of the joint submissions ASU, Health Services Union ('**HSU**') and United Voice filed in the Part-Time Work Common Issue on 11 November 2016.
30. Dr Muurlink's evidence will demonstrate that working irregular and unsystematic hours, as is permitted by clause 25.6, has a negative effect on the physical and psychological health, and on the social life, of workers and their families and the people they care for.

[17] AM2014/196

Regulation of continuous work in other modern awards

31. The disutility of working broken shifts is recognised by the modern award system generally. The majority of modern awards do not permit broken shifts. It appears that the general position is that ordinary hours of work are worked continuously. Only 18 modern awards provide permit employers to engage employees on 'broken' or 'split' shifts.
32. The SCHDS Award provisions are unique in the flexibility they offer the employer almost complete freedom to roster broken engagements, they do not provide the employee any right to refuse broken shifts, and they do not provide any additional remuneration. Attached at **Annexure A** is a summary of the broken shift provisions in other modern awards.
33. The ASU's variation would ensure that employees are properly compensated for the disability associated with working a broken shift under clause 25.6 without limiting any flexibility for the employer. This will preserve the employer's business models, but will also increase the incentive to work in the disability services. This approach consistent with the decision of the Commission in the *Penalty Rates Decision*, which found that deterrence was not a relevant consideration in setting a penalty rate. Instead, penalties should be set at a rate that compensates for the disutility associated with the work.
34. The ASU notes that the HSU and United Voice have also proposed variations to clause 25.6. The other unions' claims deal with the same problems addressed by the ASU claim but seek to fix the problem in different ways. Rather than providing a loading to compensate for the disability arising from the clause, they seek to impose restrictions on how broken shifts may be worked. If the Commission is not minded to make the variations proposed by the ASU, we would support either one of the variations proposed by the other unions. The other union's proposals would bring the SCHDS Award into line with the standard set by most other modern awards.

COMMUNITY LANGUAGE ALLOWANCE

35. The ASU has proposed a variation to the SCHDS Award to provide a community language allowance Culturally and Linguistically Appropriate Services ('**CLA**') to remunerate employees when they use a language other than English in the course of their duties.

The proposed variation

36. This variation would:

a. Recognise and endorse the fundamental principles of the ERO which recognise equal pay for equal work in the social and community services sector
b. Better position community sector organisations to meet the policy challenge of ensuring access and equity for Australia's culturally and linguistically diverse population
c. Assist in the provision of the highest standard of effective professional communication, programmes and services that are responsive to the needs of all Australians
d. Be an efficient and effective use of limited resources in the community sector, allowing less reliance upon external translators and interpreters
e. Be capacity building for the community sector workforce, which is currently the fastest growing sector in the country.

37. Australia is one of the most diverse societies in the world. Almost one in four Australian residents were born outside of Australia and many more are first or second generation Australians, the children and grandchildren of recently arrived migrants and refugees. These wide varieties of backgrounds, together with the culture of Indigenous Australia, have helped create a uniquely Australian identity. Many people in our society speak one or more languages other than English and use those languages in their working lives.
38. The ASU's proposed variation promotes flexible modern work practises and the efficient and productive performance of work, by attracting skilled staff to the social and community sector and thus reducing the costs associated with the sector's reliance on interpreters. It addresses the needs of the low paid by providing additional remuneration to low paid workers and promotes equal remuneration for work of equal value. Unless the award is varied in the manner proposed by the ASU, it will not provide a fair and relevant safety net.

Language skills are vital to the industry, but are not remunerated

39. The ability to communicate in more than one language is a skill that is highly sought after in potential employees in the social and community sector. This skill is often enhanced by a deep understanding of cultural issues associated with the language(s) in which the employee is proficient. Because of the nature of the work that is done by employees in the community sector, it is therefore very common for organisations to seek to employ people who are bilingual, even if the advertised position description to be filled does not specify a requirement for this skill. The use of language skills is not contemplated

by the classifications of the award. It is therefore not compensated for in the base rates of pay provided by the Award and ERO.

40. The evidence of Ruchita and Nadia Saleh will describe the important of using community languages in the social and community sector.

Bilingual workers are valued by employers

41. Employers in the social and community sector actively seek out bi-lingual workers to ensure that they can service their diverse communities. Engaging bilingual workers is more efficient and cost-effective than using translation services or fee-for-service interpreters. However, these valuable skills are not rewarded by employers who are constrained by their funding arrangements. These funding arrangements are set by reference to the modern award.
42. The value of bilingual workers in the community sector is recognised as providing a superior professional service to clients and the community, particularly where a community organisation works with complex and traumatised clients and communities. In these instances, the establishment of a professional counselling and/or trusting relationship is essential. Particular issues arise in regional and remote communities and in small or isolated communities where clients and the community may not trust 'outsiders' or there may be political or other cultural issues that mean an interpreter will be rejected by the client.
43. Community organisations make extensive use of professional interpreters and translators to assist people who find themselves unable to communicate effectively with essential community services. These interpreters and translators are professionally qualified and adhere to professional standards and guidelines. Most community organisation access interpreters through external interpreting services or by engaging individual interpreters on a fee for service or casual basis.
44. The evidence of Nadia Saleh and Lou Bacchiela will show that bilingual workers are sought after by social and community sector employers because they are the most efficient way to deliver services to culturally and linguistically diverse communities.

Alternatives to using bilingual workers

45. While there are times where professional interpreters and translators must be used, it is a far more efficient for social and community sector organisations to utilise bilingual staff for much of their work. Interpreters are expensive. The availability of appropriate bilingual workers in an organisation means

that funds used to pay for interpreters could be directed towards the delivery of programs to the community. Further, it is often time consuming, or even impossible, to arrange a professional interpreter for a meeting or appointment.

46. In many circumstances it is undesirable to use an interpreter, because they are not usually specially trained social and community workers. They often lack the qualifications and experience required for social and community sector work. Sometimes this also means that interpreters often lack the commitment to the values and principles of all the organisations that employ them. Bilingual social and community service workers will hold appropriate qualifications and have an understanding and commitment to the values of their organisation.
47. Further, while interpreters are well trained and qualified in their own profession, they cannot reasonably be expected to have the same qualifications and experience as professional counsellors and others who often work with highly complex and traumatised clients. Greater use of bilingual professional community workers would mean that professional interpreters and translators would not be forced to deal with the high level of traumatic work that is currently undertaken, for which they are unsuited.
48. Nadlia Saleh and Lou Bacchiella report that the alternative to bilingual workers is to use fee for service interpreters or translating services. While they are suitable in some circumstances, interpreters are poorly suited to casework. The costs of interpreters are significant and that government puts the burden of funding interpreters on the service.
49. In the community sector, it is also very common for organisations to find ways to work around the inconvenience and expense of using interpreters. This is often because it is time consuming, inconvenient and expensive to book and pay for a professional person to assist. It may also be because the client declines or refuses to utilise an interpreter. This could be for many reasons, including perceived political or confidentiality issues which often arise in some communities.
50. It is common for family and other community members to be asked to assist clients. Sometimes, unqualified employees who speak a required language, such as administrative staff, are asked to interpret. These arrangements, where untrained and unqualified people are asked to interpret for clients who may be experiencing serious trauma or other very personal and sensitive issues can be very traumatic for both the client and the worker concerned. This is an entirely inappropriate arrangement, which has negative outcomes for both clients and their informal translators.

51. Nadiah Saleh and Ruchita will give evidence regarding the issues with using community and family members as translators. Lou Bacchiella will give evidence about his attempts to limit use of unqualified staff for casework.

Capacity building in the Social and community sector

52. Employers in the social and community sector report difficult finding adequately skilled staff. The evidence of Lou Bacchiella will show that employers require qualified staff with the relevant community language skills for the efficient running of their organisation.
53. The community sector, which includes aged care services and disability services, is the fastest growing sector in the Australian workforce. Providing a CLAS system in the community sector equal to that paid to government employees would enhance opportunities for the sector to attract the best possible employees as potential employees make a decision whether to work in the community sector or for government. Payment of a CLAS would also be capacity building for the community sector as current and potential bilingual employees undertake additional training and skills development that would enable them to be eligible for payment of the community languages allowance.
54. Lou Bacchiella will give evidence that he has trouble recruiting and retaining staff because of competition with government. Government can offer better pay and conditions, including a community language allowance. Lou Bacchiella will also give evidence that the reason he cannot offer his staff additional remuneration for using their community language skills because he is not funded to offer anything other than the modern award pay and conditions. He also gives evidence that if the SCHDS Award were varied, his funders would be obliged to adjust their funding to reflect the change.
55. Being Culturally and Linguistically Diverse is a barrier to accessing essential services as the evidence of Lou Bachiella demonstrates. One such service is the National Disabilty Insurance Scheme ("NDIS") . Workers in the NDIS are covered by the SCHDS Award. A report commissioned by Family and Community Services ("FACS") and Aging Disability and Home Care ("ADHC") and completed by Settlement Services International makes clear that the lives of people with a disability would be improved if there more access to community language speakers in the NDIS, both at the assessment stage and support stage. It is acknowledged in the report that there is a lack of cultural competency within organisations that provide support under the NDIS (at 4.2 pg 36). Lou Bachiella's evidence confirms that attracting suitably qualified staff would be easier if there was financial enticement for workers with this skill set see **Annexure B**.

CONCLUSION

56. The ASU's proposed variation is necessary for the SCHDS Award to achieve the modern awards objective. Community language skills are essential to the function of the industry. However, qualified and skilled workers are not attracted to the industry because of the unfavourable conditions and low pay. The majority of the industry relies on the SCHDS Award to set their pay and conditions. Employers cannot offer this entitlement through bargaining or individual contracts, because the labour cost component of their funding is calculated based on the conditions of the SCHDS Award.

ANNEXURE A

	Award	General Position	Notes

1.	AGED CARE	Clause 59	• Only where agreed
			• Only for part time and casual workers
			• Overtime and penalties may be payable :
			  • not *because* its a broken shift, only because of the hours that might be worked as part of it; and, separately
			  • if the span of hours over the broken shift is more than 12
			• If there are broken shifts 2 days in a row, there must be 10 hours between the end of one and the start of the next

2.	SECURITY SERVICES	Clause 64 defines and permits it, clauses 33 & 39 provide an allowance	• Can only be broken in two • Must be at least 3 working hours on *each* side of the break • An allowance is payable
3.	EDUCATIONAL SERVICES (SCHOOLS) GENERAL STAFF	Clause 68 defines, permits and prescribes entitlements. Clause 60, 66 & 69 create consequential exceptions to other entitlements/restrictions.	• Can only be broken in two • Employees (other than casuals) entitled to minimum pay of 2 hours on *each* side of the break • 15% penalty rate payable (but not for casuals)

	Award	General Position	Notes
			• Overtime is payable if the span of hours over the broken shift is more than 12
4.	CLEANING SERVICES	Clause 34 defines and creates an allowance. Clause 71 allocates tea breaks.	• Can only be broken in two • Break between periods of work must be at least an hour • (subject to the above) Spread of hours must be no more than 13 • allowance is payable • entitled to paid morning and afternoon tea breaks
5.	FITNESS INDUSTRY	Clause 51 defines and creates conditions. Some conditions repeated in clause 14. Clause 33 creates an allowance.	• Can only be broken in two • Total length must be at least three hours (e.g. 1.5 at the start and 1.5 at the end) • Span of hours must be 12 or less • An allowance is payable
6.	SOCIAL, COMMUNITY, HOME CARE & DISABILITY SERVICES	Clause 81 defines and creates conditions.	• Only applicable to some categories of workers covered by the award, and only when some are performing particular kinds of work • Unlimited number of breaks in the shift (e.g. can be more than 2 working periods) • Span of hours must be not more than 12, if it is then payable at double time

	Award	General Position	Notes
			• Other penalties & overtime might be available, not *because* it is broken shift but because of when the hours are worked. • 10 hours break between broken shifts on successive days
7.	CHILDREN'S SERVICES	Clause 35 vaguely defines and creates an allowance	• Allowance is payable "where an employee works two separate shifts in a day" • Note the concept of working two separate shifts in a day is at odds with the description of ordinary hours given in clause 53.1
8.	ABORGINAL COMUNITY CONTROLLED HEALTH SERVICES	Undefined, but clause 57 provides some overtime for broken shifts and presumes they may be rostered.	• Time and half if the period extends beyond 9 hours • Double time if the period extends beyond 12 hours
9.	PASSENGER VEHICLE TRANSPORTATION	Defined in clause 3.1. Permitted in clause 51.4. Allowance for some employee in clause 51.5. Minimum engagement for some employees.	• Only two portions of work permitted • Unpaid break of more than 60 minutes is part of definition. • Definition interacts with spreads of hours permitted in State & Territory legislation. • Waiting time allowance for some employees • Appears that only casuals

	Award	General Position	Notes
			transporting schoolkids gets minimum engagement payment (2 hours) either side
10.	REGISTERED AND LICENSED CLUBS	Not defined. Allowance payable to some employees.	• Allowance payable (but nor for casual employees, or some managerial employees on salaries)
11.	HOSPITALITY INDUSTRY GENERAL	Not defined. Allowance payable, overtime may be payable	• Allowance payable, depending on the length of the break between shifts • Casuals not entitled to the allowance • Spread of hours can be no greater than 12 (but these restrictions don't apply to casual employees) or else overtime is payable.
12.	MINING INDUSTRY	Not defined. Allowance available for some.	• Clause 43(ii) provides an allowance for some employees. • Note that shiftworkers must work "consecutive" hours, the word absent in the provision relating to non-shiftworkers.
13.	RESTAURANT INDUSTRY	Not defined. An allowance payable, but not to casual employees. Overtime entitlements might apply to Full Time workers as well, but this is unclear.	• No restriction on how many breaks in the work day • Unclear whether for full timers there is an outright probhibition on the spread of a broken shift being over 12 hours, or whether

	Award	General Position	Notes
			this attracts overtime (interplay between 60 & 65(a)). • Overtime might come from rest period prescriptions (but this happens whether or not there is a broken shift).
14.	ANIMAL CARE AND VETINARY SERVICES	Not defined. An allowance is payable	• Allowance contemplates shifts being broken into more than two, with allowance payable for all but the first shift. • Hours of work clause for dayworkers says that hours must be worked continuously. Shiftwork clause is silent on the issue. • Predecessor NSW NAPSA had a separate category of workers called “broken shift workers”.
15.	HIGHER EDUCATION INDUSTRY (GENERAL STAFF)	Not defined, but an allowance is payable to some employees. Rostering provisions very flexible, with only real restriction being the span of hours.	• Allowance is payable to the only categories of workers (outside of shiftwork who are permitted to be rostered for ordinary hours on weekends.
16.	BUILDING AND CONSTRUCTION INDUSTRY (GENERAL) ON SITE	Specific definition, appears to relate to an entirely different issue arsing from shiftwork	• Penalty rates are payable for some shiftworkers in some sub-sectors, but seems to deal with situations where insufficient work is provided.
17.	SUGAR INDUSTRY	Not defined. For non-shiftworkers,	• Appears prohibited for non-

	Award	General Position	Notes
		ordinary hours are required to be worked continuously. Ordinary hours for shiftworkers prescribe only 1 in each 24 hours, else overtime is payable. Broken shifts prohibited for shiftwork during the "crushing season". Silent re the "slack season"	shiftworkers • Attracts overtime for shiftworkers, but not permitted at all for shiftwork during the "crushing season".
18.	MEDICAL PRACTITIONERS	Not defined. Prohibited for one class of employees, silent re others. No positive stipulation of "consecutive" or "continuous" hours for any class of employee.	• Prohibited in relation to doctors in training. • Otherwise silent

AGED CARE AWARD

59. Broken shifts
With respect to broken shifts:
(a) Broken shift for the purposes of this clause means a shift worked by a casual or permanent part-time employee that includes breaks (other than a meal break) totalling not more than four hours and where the span of hours is not more than 12 hours.
[22.8(b) varied by PR995161 ppc 23Mar10]
(b) A broken shift may be worked where there is mutual agreement between the employer and employee to work the broken shift.
[22.8(c) varied by PR994419 from 01Jan10]
(c) Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clauses 65—Overtime penalty rates and 73—Shiftwork, with shift allowances being determined by the commencing time of the broken shift.
(d) All work performed beyond the maximum span of 12 hours for a broken shift will be paid at double time.
(e) An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.

SECURITY SERVICES AWARD

33. Wage related Allowances

Allowance	Payable	% of standard rate
Broken Shift	Per broken shift	1.62

39. Broken shift allowance
A broken shift allowance is payable to an employee who is required to work a rostered shift in two periods of duty (excluding crib breaks).

64. Broken shifts broken
Employees may be rostered to work ordinary hours in up to two periods of duty, exclusive of crib breaks, per day, with a minimum payment of three hours for each period of duty.

EDUCATIONAL SERVICES (SCHOOLS) GENERAL STAFF

60. Breaks between periods of duty
(a) An employee will be entitled to a minimum break of 10 consecutive hours between the end of one period of duty and the beginning of the next. This applies in relation to both ordinary hours and where overtime is worked.
(b) Where an employer requires an employee to continue or resume work without having a 10-hour break off duty, the employee is entitled to be absent from duty without loss of pay until a 10-hour break has been taken, or be paid at 200% of the ordinary rate of pay until released from duty.
(c) The entitlements in clauses 60.1(a) and (b) do not apply to:
(i) a boarding supervision services employee, where the periods of duty are concurrent with a sleepover; [22.5(c)(ii) substituted by PR575283]
(ii) an employee who is provided with accommodation on the employer's premises or in the vicinity of the employer's premises at no cost to the employee;
(iii) an employee who is attending a school camp or excursion; or
(iv) an employee working a broken shift.

65. Shiftwork
66. Ordinary hours for shiftwork
The ordinary hours for shiftwork will:
(a) be worked continuously each shift (except for broken shifts and meal breaks);
(b) not exceed 10 hours, inclusive of a meal break in any single shift; and
(c) be rostered in accordance with clause 70.

68. Broken shifts
(a) An employee may be rostered to work ordinary hours in a broken shift, that is a rostered shift in two periods of duty, exclusive of breaks, per day, with a minimum payment (other than for a casual) of two hours for each period of duty.
(b) An employee, other than a casual, required to work a broken shift will be paid at the ordinary time rate plus a penalty of 15% of the ordinary time rate.
(c) The maximum spread between the start of the first period of duty and cease of the second period of duty for a broken shift is 12 hours. Any hours in excess of this 12 hour spread will be paid for as overtime.

69. The provisions of clause 68.1(c) do not apply to a boarding supervision services employee who is provided with reasonable accommodation including living quarters, fuel and light, and available to the employee for their exclusive use for 52 weeks of the year, at no cost to the employee.

CLEANING SERVICES

34. Broken shift allowance
[17.1 substituted by PR543432 ppc 21Oct13]
An employee who works a broken shift will be paid an allowance of 0.458% of the standard rate per day up to a maximum of 2.29% of the standard rate per week. For the purposes of this award a broken shift is a shift where an employee works in two separate periods of duty on any day within a maximum spread of thirteen 13 hours and where the break between periods exceeds one hour.

71. Non-shift workers
[26.2 replaced by PR502506 ppc 06Oct10]
Non–shift workers are entitled to an unpaid meal break of not less than 30 minutes, and not more than one hour. An employee will not be required to work for more than four and one half hours without a meal break, except in cases of emergency, when the time may be extended to five hours. All day workers and broken shift workers are entitled to a 10 minute paid morning tea break and a 10 minute paid afternoon tea break.

FITNESS INDUSTRY

14. Part-time employment
14.1 A part-time employee is an employee who:
(a) works less than the full-time hours of 38 hours per week;
(b) has reasonably predictable hours of work; and
(c) receives, on a pro rata basis, equivalent pay and conditions to those of full-time employees who do the same kind of work.
14.2 At the time of engagement the employer and the part-time employee will agree in writing on a regular pattern of work, specifying at least the hours worked each day, which days of the week the employee will work and the actual starting and finishing times each day.
14.3 Any agreed variation to the hours of work will be recorded in writing.
14.4 An employer is required to roster a part-time employee for a minimum of three consecutive hours on a shift or a minimum of three hours, exclusive of meal breaks, on a broken shift.
14.5 An employee who does not meet the definition of a part-time employee and who is not a full-time employee will be paid as a casual employee in accordance with clause 15—Casual employment.
14.6 All time worked in excess of the hours as agreed under clause 14.2 or varied under clause 14.3 will be overtime and paid for at the rates prescribed in clause 57—Overtime and penalty rates.
14.7 A part-time employee employed under the provisions of this clause must be paid for ordinary hours worked at the rate of 1/38th of the weekly rate prescribed in clause 24—Minimum wages for the work performed.

33. Broken shift allowance
[18.4 varied by PR998115, PR523076, PR536879, PR551802 ppc 01Jul14]
An employee working a rostered broken shift must be paid per day 1.7% of the standard rate extra and for excess fares $1.89 extra.

51. Ordinary hours of work and rostering

51.1 The ordinary hours of work for a full-time employee must not exceed an average of 38 hours per week over a period of four weeks. Such hours may be worked over any five days of the week, between the hours of:
(a) 5.00 am and 11.00 pm, Monday to Friday; and
(b) 6.00 am and 9.00 pm, Saturday and Sunday.
51.2 The ordinary hours of work for a full-time or part-time employee must not exceed 10 hours on any one day.
51.3 An employee may be rostered to work a broken shift on any day provided that:
(a) the shift is not broken into more than two parts;
(b) the total length of the shift is not less than three hours, exclusive of meal breaks; and
(c) the span of hours from the start of the first part of the shift to the end of the second part of the shift is not more than 12 hours.
broken

SOCIAL, COMMUNITY, HOME CARE & DISABILITY SERVICES

81. Broken shifts
[25.6 varied by PR995399 ppc 26Mar10]
This clause only applies to social and community services employees when undertaking disability services work and home care employees.
(a) A broken shift means a shift worked by an employee that includes one or more breaks (other than a meal break) and where the span of hours is not more than 12 hours.
[25.6(b) substituted by PR531544 ppc 21Nov12]
(b) Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 99—Shiftwork, with shift allowances being determined by the finishing time of the broken shift.
(c) All work performed beyond the maximum span of 12 hours for a broken shift will be paid at double time.
(d) An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.

CHILDREN'S SERVICES

35. Broken shift allowance
Where an employee works two separate shifts in a day, they will be paid an allowance of 1.91% of the standard rate per day for each day on which a broken shift is worked.

ABORIGINAL COMMUNUTY CONTROLLED HEALTH SERVICES

57. Overtime rates
57.1 The following overtime rates will be paid for all work done:
(a) in excess of the number of hours fixed as a day's, a week's or a fortnight's work as the case may be—time and a half for the first two hours and double time thereafter;
(b) outside the span of hours in clause 53.1—time and a half for the first two hours and double time thereafter;
(c) outside a spread of nine hours from the time of commencing work by an employee rostered to work broken shifts—time and a half; and
(d) outside a spread of 12 hours from the time of commencing work by an employee rostered to work broken shifts—double time.

PASSENGER VEHICLE TRANSPORTATION

3.1 In this award, unless the contrary intention appears:
…
broken shift means a shift with a spread of hours permitted under the relevant State or Territory driving hours legislation and with an unpaid break of greater than 60 minutes between the two portions of work

16. Casual employment
(a) A casual employee is an employee engaged as such and paid by the hour.
(b) An employer must wherever practicable notify a casual employee if their services are not required the next working day.
(c) A casual employee while working ordinary hours must be paid on an hourly basis 1/38th of the appropriate weekly wage rate prescribed by the award, plus 25% of ordinary time earnings for the work performed.
[10.5(d) corrected by PR598965 ppc 01Jan18]
(d) A casual employee is to be paid a minimum payment of three hours pay for each shift.
[10.5(e) inserted by PR598502 ppc 01Jan18]
(e) A casual employee solely engaged for the purpose of transportation of school children to and from school may be rostered to perform one engagement or two separate engagements per day, with a minimum payment of two hours for each separate engagement.

51.4 All known rostered duty, which may include broken shifts and days off, must be displayed at least seven days prior to the commencement of such duty. Changes to the roster, including alterations to days off, must be displayed at least 24 hours in advance and the employee must be notified. Any changes for which less than 24 hours' notice has been given must be agreed to by the employee.
[21.5 substituted by PR538349 ppc 01Aug13]

51.5 An employee who is engaged as a coach driver or a bus driver on a single day charter may have a rostered shift divided into two working periods with no requirement to return to the depot during a rostered shift. Such an employee will be paid waiting time at the rate of 50% of the ordinary rate of pay plus any

applicable penalty or loading, provided that the waiting time so paid for will not be taken into account in the computation of hours for overtime purposes.

REGISTERED AND LICENSED CLUBS

66. Allowance for disabilities associated with the performance of particular tasks or work in particular conditions or locations—broken periods of work
An employee (other than casual) who is required to work any of their ordinary hours on any day in more than one period of employment, other than for meal breaks as prescribed in accordance with the provisions of clause 77—Meal breaks, will be paid an allowance of 0.4% of the standard weekly rate per day, for such broken work period worked.

HOSPITALITY INDUSTRY GENERAL

63. Broken periods of work
[21.3(a) substituted by PR994455 from 01Jan10]
Employees other than casuals who have a broken work day must receive an additional allowance as follows:
where the time between periods of work is two hours and up to three hours—an allowance per day equal to 0.33% of the standard weekly rate; or
where the time between periods of work is more than three hours—an allowance per day equal to 0.5% of the standard weekly rate.

98. Entitlement to overtime rates
(a) A full-time employee is paid at overtime rates for any work done outside of the hours set out in clause 80—Ordinary hours of work.
[33.2(b) substituted by PR598473 ppc 01Jan18]
(b) A part-time employee is paid at overtime rates in the circumstances specified in clause 15.8.

82. Part-time employees
[29.2 varied by PR598473 ppc 01Jan18]
A part-time employee's rostered hours of work under clause 15.5 must meet the following conditions:
(a) A minimum of three hours and a maximum of 11 and a half hours may be worked on any one day. The daily minimum and maximum hours are exclusive of meal break intervals.
(a) An employee cannot be rostered to work for more than 10 hours per day on more than three consecutive days without a break of at least 48 hours immediately following.
(b) No more than eight days of more than 10 hours may be worked in a four week period.
(c) Where broken shifts are worked the spread of hours can be no greater than 12 hours per day.

15. Part-time employment
…
15.8 All time worked in excess of:
(a) 38 hours per week or, where the employee works in accordance with a roster, an average of 38 hours per week over the roster cycle; or
(b) the maximum hours limitations specified in clause 82; or
(c) the employee's rostered hours;
will be overtime and paid for at the rates prescribed in clause 99—Overtime rates.

80. Ordinary hours of work (Full-time and part-time employees)
[29–Ordinary hours of work renamed as Ordinary hours of work (Full-time and part-time employees) and substituted by PR540249; corrected by PR540578; varied by PR598473]
81. Full-time employees
(a) The average of 38 hours per week is to be worked in one of the following ways:
a 19 day month, of eight hours per day;
four days of eight hours and one day of six hours;
four days of nine and a half hours per day;
five days of seven hours and 36 minutes per day;
152 hours each four week period with a minimum of eight days off each four week period;
160 hours each four week period with a minimum of eight days off each four week period plus a rostered day off;
any combination of the above.
(b) The arrangement for working the average of 38 hours per week is to be agreed between the employer and the employee from the alternatives in clause 81(a) and must meet the following conditions:
(i) A minimum of six hours and a maximum of 11 and a half hours may be worked on any one day. The daily minimum and maximum hours are exclusive of meal break intervals.
(ii) An employee cannot be rostered to work for more than 10 hours per day on more than three consecutive days without a break of at least 48 hours immediately following.
(iii) No more than eight days of more than 10 hours may be worked in a four week period.
(iv) Where broken shifts are worked the spread of hours can be no greater than 12 hours per day.

MINING INDUSTRY

43. Drilling, prospecting and exploration allowances
[14.3(d) renumbered as 14.3(c) by PR561478 ppc 05Mar15]
The following allowances apply only to employees who are required to perform drilling, prospecting and exploration duties.
….

(i) Employees who are classified as cooks and cooks assistants will be paid an all purpose allowance of 1.07% of the standard rate per week, whilst they are required by their employer to work broken shifts.

55. Ordinary hours of work
[Varied by PR992071 from 01Jan10; 17 renumbered as 18 by PR545968 ppc 01Jan14]
55.1 A full-time employee’s ordinary hours of work will be an average of 38 hours per week. The ordinary hours of part-time and casual employees will be in accordance with clause 14—Types of employment.

56. Employees other than shiftworkers
(a) Subject to clause 56.1(c) employees, other than shiftworkers, may be required to work up to 10 ordinary hours per day, between the hours of 6.00 am and 6.00 pm, Monday to Sunday.
(b) An employer may agree with a majority of affected employees to alter the spread of hours in clause 56.1(a) and/or to increase the ordinary hours per day to a maximum of 12.

(c) Where employees were required to work 12 hour shifts under roster and working hours arrangements which were in place before 1 January 2010 those arrangements may continue to operate in respect to both existing employees and new employees.

57. Shiftworkers
(a) Subject to clause 57.1(c) shiftworkers may be required to work a shift of up to 10 **consecutive** ordinary hours (including meal breaks). Shiftwork may be worked on any or all days of the week.
(b) An employer may agree with a majority of affected employees to alter the spread of hours in clause 57.1(a) and/or to increase the ordinary hours per day to a maximum of 12.
(c) Where employees were required to work 12 hour shifts under roster and working hours arrangements which were in place before 1 January 2010 those arrangements may continue to operate in respect to both existing employees and new employees.

RESTAURANT INDUSTRY

43. Split shift allowance
[24.2 substituted by PR994479 from 01Jan10]
Full-time and part-time employees who have a broken work day will receive an additional allowance of 0.5% of the weekly standard rate for each separate work period of two hours or more.

60. Spread of hours
Where broken shifts are worked the spread of hours can be no greater than 12 hours per day.

61. Minimum break between shift
The roster for all employees other than casuals will provide for a minimum 10 hour break between the finish of ordinary hours on one day and the commencement of ordinary hours on the following day. In the case of changeover of rosters, eight hours will be substituted for 10 hours.

59. Hours of work
59.1 The hours of work of a full-time employee are an average of 38 per week over a period of no more than four weeks.
59.2 The arrangement of ordinary hours must meet the following conditions:
…
(d) an employee must be given a minimum break of 10 hours between the finish of ordinary hours of work on one day and the commencement of ordinary hours of work on the next day. In the case of a changeover of rosters the minimum break must be eight hours;

64. Overtime
[Varied by PR585805, PR598487]
65. Requirement to pay overtime rates
[33.1 substituted by PR598487 ppc 01Jan18]
(a) Full-time employees shall be paid at overtime rates for any work done outside of the **spread of hours** or rostered hours set out in clause 59—Hours of work.
(b) Part-time employees shall be paid at overtime rates in the circumstances specified in clause 15.8.
(c) Casual employees shall be paid at overtime rates in the circumstances specified in clause 16.5.

15. Part-time employment
….
15.8 All time worked in excess of:
(a) 38 hours per week or, where the employee works in accordance with a roster, an average of 38 hours per week over the roster cycle; or
(b) the maximum hours limitations specified in clause 59.2; or
(c) the employee's rostered hours;
will be overtime and paid for at the rates prescribed in clause 66—Overtime rates.

ANIMAL CARE AND VETINARY SERVICES

39. Broken shift allowance
[16.2(b) substituted by PR539252 ppc 22Jul13]
Where an employee is required to carry out their ordinary hours of duty in more than one shift, the employee will be paid 1.60% of the standard rate, per shift so worked. This is to be paid only once per 24 hour period.

62. Span of hours—day work
(a) The ordinary hours of work will be between 6.00 am and 9.00 pm Monday to Sunday.
(b) The ordinary hours of work are to be worked continuously, except for meal breaks, at the discretion of the employer. The spread of hours may be altered by agreement between the employer and the individual employee.

HIGHER EDUCATION INDUSTRY (GENERAL STAFF)

51. Ordinary hours and spread of ordinary hours
Ordinary hours may be worked in a manner agreed over a four week cycle.

Category of staff employees	**Ordinary hours**	**Spread of hours (non shiftworkers)**
…	…	…
Catering and retail staff	38	6.00 am – 7.30 pm Monday – Sunday
Security staff	38	6.00 am – 6.00 pm Monday – Sunday

Schedule K —Allowances
….
The following additional allowances apply to certain trades and services staff only as specified in the following table, subject to the terms in the table:

Allowance	Staff Category	Rate	Application
…	…	…	…
Broken shift	Catering and retail staff; and security staff	0.28% of SR per day to a maximum of 1.38% of SR per week	When an employee is required to work shift in two periods of duty

BUILDING AND CONSTRUCTION INDUSTRY (GENERAL) ON SITE

200. Shiftwork
[34.1(a) substituted by PR538792 ppc 15Jul13]
201. General building and construction and metal and engineering construction sectors
(a) Definitions
For the purposes of this clause:
afternoon shift means a shift commencing at or after 1.00 pm and before 3.00 pm
night shift means a shift commencing at or after 3.00 pm and before 11.00 pm
morning shift means a shift commencing at or after 4.30 am and before 6.00 am
early afternoon shift means a shift commencing on or after 11.00 am and before 1.00 pm.
[34.1(b) substituted by PR538792 ppc 15Jul13]
(b) When an employee is employed continuously (inclusive of public holidays) for five shifts Monday to Friday, the following rates will apply:
(i) afternoon and night shift— ordinary time hourly rate plus 50%;
(ii) morning and early afternoon shifts— ordinary time hourly rate plus 25%.
(c) Where a job finishes after proceeding on shiftwork for more than five consecutive days or the employer terminates the employee's services during the week, the employee must be paid at the rate specified in clause 201.1(b) for the time actually worked.
(d) In the case of broken shifts (i.e. less than 38 ordinary hours worked over five consecutive shifts Monday to Friday) the rates prescribed will be time and a half for the first two hours and double time thereafter.
[34.1(e) substituted by PR538792 ppc 15Jul13]
…….

SUGAR INDUSTRY

(in the section dealing with workers other than shiftworkers)
105. Altering spread of hours
The ordinary hours of work are to be worked continuously, except for meal breaks, at the discretion of the employer. The spread of hours may be altered by up to one hour at either end of the spread by agreement between an employer and the majority of employees concerned or, in appropriate circumstances, between the employer and an individual employee.

(in the section dealing with shift workers)
125. Nominal crushing season—shiftwork
[32.8(a) varied by PR542207 ppc 04Dec13]
(a) The ordinary working hours in the nominal crushing season must not exceed 40 in any one week or eight in any one day, which may be worked in accordance with a roster system as mutually agreed upon between the employer and the majority of employees directly affected, or as approved by the Fair Work Commission. Provided that with agreement between the employer and the majority of employees directly affected, shifts of more or less than eight hours may be worked. The working of broken shifts or six hour shifts in mills is prohibited.
(b) In mills where locomotive drivers, their assistants and weighbridge clerks are working two shifts, such shifts may be worked between 6.00 am and 2.00 pm and between 2.00 pm and 10.00 pm or such other roster as mutually agreed upon between the employer and the majority of employees directly affected.

126. Nominal slack season—shiftwork
The ordinary working hours for shiftworkers in the nominal slack season must not exceed 40 in any one week or eight in any one day, provided that with agreement between the employer and the majority of employees directly affected, shifts of more or less than eight hours may be worked.

(a) For employees other than seasonals and also other than those deemed to be seasonals, the ordinary working hours must be worked in accordance with an agreed roster which will provide for nine ordinary working days or 72 ordinary working hours per fortnight. One day of such two week cycle must be an unpaid rostered day off.
(b) For seasonal employees the ordinary working hours must be worked in accordance with an agreed roster which will provide for 19 working days or 152 ordinary working hours per four week cycle. One day of such four week cycle must be an unpaid rostered day off.
(c) The agreed rosters provided for must provide for a rostered day off on a Monday, or if agreed between the employer and employees at a particular mill, on a Friday.
(d) If a rostered day off falls on a public holiday, the rostered day off must be taken on the next ordinary working day.
(e) Rostered days off may, by agreement between the employer and the majority of employees directly affected, be accrued up to a maximum of six rostered days off, which must be taken within 12 calendar months of the date on which the first rostered day off was accrued, at a time or times agreed between the employer and the employees directly affected.
(f) Employees terminated prior to taking any banked rostered day(s) off must receive one fifth of average weekly pay over the previous six months multiplied by the number of banked substitute days.

MEDICAL PRACTITIONERS

72. Shift length—Doctors in training
(a) No shift will be less than eight hours in length on a week day or less than four hours in length on Saturday, Sunday or a public holiday.
(b) No broken or split shifts will be worked.
(c) All time worked in excess of 10 hours in any one shift will be paid as overtime.

IN THE FAIR WORK COMMISSION

Matter No: AM2018/26

S 156 – Four yearly review of modern awards - Social, Community, Home Care and Disability Services Industry Award 2010 – Substantive matters

Submission of the Australian Services Union

I – INTRODUCTION

1. This submission regards the Australian Services Union's ('**ASU**') claim for paid travel time in the *Social, Community, Home Care and Disability Services Industry Award 2010* ('**SCHDS Award**'). We support the Commission varying the SCHDS Award in the form of the Draft Determination filed by United Voice ('**UV**') on 1 April 2019.

2. The broken shift provisions permit employers to drain the working day of paid time by breaking shifts: limiting paid time to that spent directly with the client. For employees who perform in-home care, this means that they regularly travel at their employer's direction but they are not paid for it. This is work and should be remunerated. To meet the modern awards objective, the SCHDS Award must be varied pay employees when they travel for work.

The proposed variation

3. Some disability services employers are using the clause 25.6 of the SCHDS Award to avoid paying '*social and community services employees when undertaking disability services work*' ('**disability support workers**') (covered by Schedule B) and home care employees home care employees (covered by Schedule E of the SCHDS Award) for time spent travelling at their employers direction.

4. The ASU is seeking to insert the following new clause into the SCHDS Award:

> *Clause 25.7 Travel time*
>
> *(a) Where an employee is required to work at different locations they shall be paid at the appropriate rate for reasonable time of travel from the location of the preceding client to the location of the next client, and such time shall be treated as time worked. The travel allowance in clause 20.5 also applies.*
>
> *(b) This clause does not apply to travel from the employee's home to the location of the first client nor does it apply to travel from the location of the last client to the employee's home.*

5. The proposed variation would ensure that all hours worked by disability services and home care employees are paid and that travel time will be recorded as hours worked for the purposes of service and the accrual of entitlements.

6. This claim will not affect employers and employers in other streams of the SCHDS Award, who must work their ordinary hours continuously. These employees are already paid for any time spent travelling within their ordinary hours. Disability services and home care employers should be given the same entitlements as their colleagues.

II – THE DISABILITY SECTOR AND DISABILITY SERVICES WORKERS

7. The ASU represents employees covered by the SACS and Crisis Accommodation streams of the SCHDS Award.[1] Our submissions are directed to the circumstances of the disability sector, disability services workers and their employers.

What are disability services?

8. Disability services covers employers and employees engaged in the provision of personal care and domestic and lifestyle support and/or training to a person with a disability. This includes work done in a community setting whether residential or non-residential, a respite centre, a day service facility or in a private residence where work in that residence involves either teaching, promoting or maintaining living skills, client advocacy, promoting or supporting community access and social inclusion or developing or assisting in developing care or support plans including assessment of client needs. The skill of work required will vary depending on the needs of the client.

9. Most disability services workers will be working under the National Disability Insurance Scheme ('**NDIS**'). However, the NDIS only provides support to those people with a significant and permanent disability under the age of 65. This means that only 475,000 of the 4.3 million people with a disability will be covered by the NDIS when it is fully rolled out.[2] Some disability support workers may work with clients who are not entitled to NDIS funding, for example disabled persons over the age of 65.

10. The statements of Tino Encabo, Richard Rathbone, Tracy Kinchin and Rob Steiner describe the typical duties of a disability support worker.

In-home disability support

11. While some people with disabilities live in group homes and residential facilities, many people live in private residences. Disability services organisations will cater to the needs of these people

[1] We continue to rely on paragraphs 8-13 of the ASU's Submissions dated 18 February 2019.
[2] Productivity Commission, Review of the National Disability Agreement, Study Report, 3.

by offering in-home services. They will direct their employees to attend the client's residence to provide supports. Often, disability support workers will be directed by their employer to work at several different clients' residences in one day or shift. This necessitates travel between those locations. This is an integral part of the job. Services could not provide in-home supports if employees did not travel between locations. The statements of Tino Encabo, Richard Rathbone, Tracy Kinchin and Rob Steiner describe the hours of work of disability support workers providing in-home care.

Working patterns in in-home care

12. Employers are permitted to roster disability services workers on broken shifts under clause 25.6. It is a common practice amongst disability employers to use the broken shifts clause to design jobs whose ordinary hours of work are restricted to the time spent directly working with the client. This includes rostering unpaid 'breaks' for the time taken travelling between client's homes, despite the employer directing the employee to travel between those locations.

13. But for the broken shift clause, this time would otherwise form part of the employee's ordinary hours of work. This is not time that could be used by the employee for their own purposes, this is time controlled by the employer. Employees rostered to work broken shifts, and directed to work at different locations at each of those shifts, could not lawfully refuse to travel. This travelling time is the 'service' which is the source of the entitlement to wages under the employment contract.[3] The SCHDS award is not functioning as a fair and relevant safety net if it permits employers to make contracts of employment with award dependent workers that require, potentially substantial, periods of unpaid service.

14. Each of the ASU's witnesses gives evidence that they are not paid for most or all of their travel time. Tino Encabo and Richard Rathbone are part-time employees who give evidence that they are sometimes paid an informal 20 minute travelling allowance when there is less than an hour's gap between shifts. Tracy Kinchin gives evidence that she was previously engaged to work her full-time hours continuously, but her employer has recently started rostering broken shifts so that she is not paid for travel time. Rob Steiner is also a full-time employee. He gives evidence that his employer rosters broken shifts so that they do not have to pay for travel time. These statements are supported by the findings of a recent research paper authored by Fiona McDonald, Eleanor Bentham and Jenny Malone. Using diaries kept by 10 disability support workers, they found that '*unpaid travel was equivalent to between 1% and 15% of the employee's paid time over 3 days, and as much as 25% in a single day*'.[4]

[3] *Automatic Fire Sprinklers v Watson* (1946) CLR 435, 465.
[4] Fiona McDonald, Eleanor Bentham and Jenny Malone, 'Wage theft, underpayment and unpaid work in marketised social care' (2018) 29(1) *The Economic and Labour Relations Review*, 80, 88.

15. We also rely on the expert report of Dr Olav Muurlink filed entitled '*Predictability and control in working schedules*' filed in the Part-time Work Common Issue on 14 July 2016. Dr Muurlink

16. According to the *NDIS Price Guide 2019-2020*, providers are entitled to claim up funding for up to 30 minutes travel time in urban areas and 60 minutes travel in regional areas.[5]

III - THE MODERN AWARDS OBJECTIVE

17. The Commission may make a determination vary a modern award if the Commission is satisfied that the determination is necessary to achieve the modern awards objective (s 156). When deciding if a modern award meets the modern awards objective it must consider a number of matters listed at s 134 of the Act. We address those considerations below.

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

18. Some disability support workers are low paid employees. Others may receive a rate of pay that is higher than the two-thirds of median time earnings threshold, but are at risk of poverty because of their short hours of work. Ensuring that employees are remunerated for all working hours, including travel time, will make sure that relative living standards are maintained and help the SCHDS Award meet the needs of the low paid.

Relative living standards of low paid employees

19. According to the July 2018 NDS Workforce Report, Most employees in the sector work part-time hours.[6] Roughly 20% of disability support workers are full-time.[7] There is a downward trend in the number of hours worked by employees (from 26 to 20).[8] 58% of employees in the sector were permanent employees and 46 percent of employees were casual in March 2018.[9]

20. The evidence of the ASU is that part-time employees are concerned about getting enough hours of work, despite some employees also preferring to be part-time employees. These employees report that they seek to maximise their income through a variety of strategies. Some seek to increase the number of penalty hours they work to increase their income. Other witnesses report seeking additional hours of work. These witnesses report that they rarely refuse additional hours (including the attendant unpaid travel time), even if they are inconvenient, because they are worried that they will not be offered additional hours in the future. These witnesses may work more hours of work than they would prefer.

[5] National Disability Insurance Agency, *DIS Price Guide 2019-2020*, 12. ('**NDIA Price Guide 2019**')
[6] National Disability Services, *Australian Disability Workforce Report February 2018*, 10. ('**NDS Workforce Report**'),
[7] NDS Workforce Report, 24.
[8] NDS Workforce Report, 24.
[9] NDS Workforce Report, 22.

21. If these employees are paid for travel time, their incomes will increase. Some employees may be able to reduce the number of hours they work each week without losing pay. Employees may also be able to reduce their reliance on additional hours and weekend penalty shifts if they earn enough income during the normal working week.

22. Further, under clause 10.3(c) part-time employees are entitled to a written agreement on their regular pattern of work. If travel time is treated as working time, then at least some of that time may need to be recorded in the written agreement. This would increase the employee's certainty about their pay each week.

Most disability service workers are likely to earn less than two-thirds of median full-time earnings threshold

23. Almost all disability services workers are classified at SACS employee level 2 ('**SACS2**') or SACS employee level 3 ('**SACS3**'). ERO rates of pay apply to SACS2 and SACS3 employees. SACS2 employees support people with a disability who do not have complex needs. SACS3 employees support people with complex needs. This is reflected in the NDIA pricing.[10] The McKinsey Pricing Report found that some employers engaged workers at SACS Employee level 4 where a client's needs are unusually complex.[11]

24. Two-thirds of median full-time wages is used by the Commission as an operational benchmark for identifying which workers are low paid.[12] The Commission uses two sources of data two estimate this figure: the ABS *Characteristics of Employment Survey* ('**COE**')[13] and the ABS *Survey of Employee Earnings and Hours* ('**EEH**').[14] In the 2019 Annual Wage Decision, the Commission found that two-thirds of median earnings was $886.67 per week ($23.33 per hour) in the August 2018 COE survey.[15] EEH survey data has not been released since May 2018: at that time $973.33 (or $25.61 per hour) was two-thirds of median earnings.[16]

25. Given the age of this data, it is difficult to make comparisons between rates of pay that are relevant to June 2019. Under the two-thirds of median full time earnings metric, some full-time SACS2 employees covered by the ERO were low paid in either May or August 2018 and may be so now. The Commission cannot be satisfied either way. In any case, the incidence of part-time employment in the industry means that comparing full-time weekly incomes will not give an accurate picture of incomes in the sector.

[10] National Disability Insurance Agency, *2018-2019 support catalogue (NSW/Vic/Qld/Tas*). ('**Support Catalogue**').
[11] Mckinsey and Company, *Independent Pricing Review Final Report*, ('**NDIS Pricing Report**'), p 48.
[12] *Annual Wage Decision 2018/2019* [2019] FWCFB 3500, [205]. ('**AWR 2018/2019**')
[13] ABS, *Characteristics of Employment, Australia, August 2018*, Catalogue No. 6333.0.
[14] ABS, *Employee Earnings and Hours, Australia, May 2018*, Catalogue No. 6306.0.
[15] *AWR 2018/209*, [205].
[16] ABS, *Employee Earnings and Hours, Australia, May 2018*, Catalogue No. 6306.0.

1(b) – the need to encourage collective bargaining

26. This claim is properly a safety net matter because it concerns the payment of employees for hours worked at the direction of their employer. Employees should not be required to bargain with their employer to simply be paid for time worked. The evidence of the ASU is that this gap in the safety net undermines negotiated working time arrangements and promotes unfair job design.

27. The evidence of Tracy Kinchin shows that the absence of a safety net allows employers to alter long standing rostering arrangements to the detriment of the employee. The evidence of Rob Steiner shows that the absence of paid travel time allows employers to build jobs that require travel over a wide area without accounting for the costs of travel. The evidence of Tino Encabo and Richard Rathbone is that they are sometimes paid a travel time allowance. However, this does not cover all time spent travelling.

1(c) – the need to promote social inclusion through increased workforce participation

28. Underemployment is a significant issue in the social and community sector, including social community services. Community and personal service workers have one of the highest underemployment ratios of all occupations at 16.7 percent.[17] The ASU's evidence is that part-time employees in disability services are seeking to increase their hours (see above at paragraphs 18 and 19 for discussion of the incidence of part-time work and the falling average hours in the sector).

29. The proposed variation may increase workforce participation in a number of ways. Firstly, currently employed workers will be paid for the hours they actually work. This will increase the hours worked by each employee. Secondly, if workers are paid for the time they actually work, they may reduce their weekly hours of work, creating opportunities for other workers to increase their hours. Consequently, this variation may increase total employment while reducing the incidence of underemployment.

1(d) – the need to promote flexible modern work practices and the efficient and productive performance of work

30. Requiring employee's to pay for time spent travelling at the direction of the employer will promote flexible modern work practice. Unpaid travel time is not a flexible modern work practice. It is an atavism dating from an era when women's work was deliberately undervalued (see our submissions regarding the principle of equal remuneration for equal or comparable work below at paragraphs 27 through 33).

[17] Kelvin Yuen and Oliver Smith, *Insights into under employment*, Fair Work Commission Research Report 2/2019, February, 10, see table 2.2.

31. The SCHDS Award provides employers with a significant amount of flexibility in arranging ordinary hours, rostering employees and paying employees for their time. This includes:

    a. the roster of part-time employees may be changed at any time under clause 25.5 (d) (iii) which provides that the restrictions on changing the roster do not apply to mutually agreed additional hours worked by part-time employees;

    b. part-time employees are not paid overtime until they work 10 hours in a day or 38 hours in a week or 79 hours in a fortnight;

    c. there is no minimum engagement for part-time or full-time employees;

    d. employers are not required to roster meal breaks if they require an employee to have a meal with a client or clients;

    e. casual disability services employees are only entitled to a 2 hour minimum engagement;

    f. casual home care employees are only entitled to a 1 hour minimum engagement; and

    g. if a client cancels an appointment, a home care employee's roster can be changed if the client is notified that their roster is being changed because of a client cancellation before 5.00 PM the day before, they will not be paid for the shift if they are notified about the client cancellation after that time, they will only be paid for the minimum specified hours, an employee can also be directed to work make up time sometime in that roster period or the next;

32. These flexibilities will not be impacted by a requirement to pay for travel time.

33. Further, by not paying for travel time employers must tailor rosters to the exact times they require their employees to support clients. This is not only unfair to the employee works without pay; it is also inefficient and unproductive for the employer. The evidence of Tracy Kinchin is that her employer has ceased to roster hours of work continuously. She is now no longer paid for time spent travelling. This means that her roster must be varied each time her client changes or cancels their service time. Previously, her hours were rostered continuously. She received advanced notice of start and finish times over a 4 week roster. This allowed her employer to direct her work within those times without needing to change the roster. This was preferable to her because it made her hours of work more certain.

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

34. The failure to pay travel time is an equal remuneration matter. Disability services is a female dominated sector of the female dominated SACS industry. The March 2018 NDS Workforce

report found that 70% of disability support workers are women,[18] while a 2017 survey commissioned by the ASU, HSU and United Voice found that 74.1% of the workforce were women. [19] The historical undervaluation of the work performed by disability support workers was recognised by a Full Bench of Fair Work Australia in the *SACS Equal Remuneration Decision*.[20] This decision dealt with gendered undervaluation of base rates of pay and did not address other equal remuneration issues.

35. There is no rational way to find that travel time is not equal or comparably valuable work between industries. If employees covered by a modern award covering a male-dominated industry are paid for their travel time, then employees covered by the SCHDS Award should be paid for this work too. **Annexure A** sets out the travel time provisions for a number of modern awards covering male dominated industries that involved regular travel between work locations.

Business equipment: an example male industry[21]

36. The *Business Equipment Industry Award 2010* ('**BEI Award**') covers the business equipment industry, defined as:

> *sale or lease and associated installation and servicing of business equipment such as computers, data processing equipment, photocopiers, facsimile machines, cash registers, accounting and adding machines, calculators and peripheral equipment associated with such equipment including keyboards, display screens, printers, routers and multifunction devices.* (Clause 4.2,

37. The business equipment industry is male dominated. A niche industry which does not have an ANZSIC code, data is hard to come by. However, the most recent Form F17's lodged by the largest employers in the sector: Ricoh Australia, Konica Minolta Business Solutions, Canon Australia Pty Ltd, Fuji Xerox Australia Pty Ltd and NCR Australia Pty Ltd reveal a total of three women employed in the sector. The majority of (possibly all) employees in the industry would be covered by enterprise agreements.

38. Business Equipment employees are engaged to sell, install and service business equipment. They are generally assigned an area of operations. Technical employees travel within that area of operations on their employers business. They will regularly travel between warehouses, workshops and customers offices. The witness statement of Paul O'Brien describes work patterns

[18] NDS Workforce report, 10.
[19] Cortis, Natasha, *Working under the NDIS: Insights from a survey of employees in disability services (Report prepared for Health Services Union, Australian Services Union and United Voice, June 2017)*, Social Policy Research Centre, University of New South Wales, Sydney, 5.
[20] *Equal Remuneration Case* [2012] FWAFB 1000.
[21] We note that there is no obligation under s 134(e) to demonstrate a male comparator.

of technical employees in the industry. Paul O'Brian is paid for time spent travelling because his hours of work are rostered continuously.

39. There is no provision in the BEI Award for broken or split shifts. Ordinary hours are worked continuously.[22] Consequently, all time spent travelling, except to the place where the employee commences work and time travelling home after the finish of work, is treated as working time. Where a commercial traveller is '*travelling on their employer's business will be regarded as being "on duty" for all purposes of this award*'.[23] This provides a safety net for improved bargained outcomes around travel time, such that at clause 25 of the *Canon Australia Pty Ltd. (Technical Consultants) Enterprise Agreement 2019*.

40. Further, technical stream employees must either be provided with '*all required means of locomotion*' or a vehicle allowance if they are required to use their own vehicle.[24] The allowance is paid for periods of personal and annual leave. If the employee is paid a vehicle allowance, they also must be paid an allowance of $0.34 per kilometre travelled during the course of business.[25]

Comparison with the disability support workers

41. The work value of travel to an employer who must service clients away from their premises is undeniable: the employers business could not operate if the employee did not attend the client/customers premises. This value is the same if the service provided to the client is photocopier maintenance or in-home disability support. Travel is travel.

42. The relevant difference between disability services employees and the business equipment employees is that disability services are almost all women and business equipment employees are almost entirely male. The modern award covering each industry should remunerate this valuable work equally.

43. We also note that disability services employees are only entitled to $0.78 per kilometre travelled. This allowance is not paid on periods of annual or personal leave. There is no obligation to provide a vehicle to a SCHDS employee required to travel by their employer. All male dominated awards in Annexure A require the employer to provide means of transportation, or provide a vehicle allowance, when they require their employee to work at more than one employee per day or shift.

[22] BEI Award, cl 27.1(a), cl 28.2(a)(ii).
[23] BEI Award, Cl 22.2(C)(iii).
[24] BEI Award, Cl 22.1(b)(i), 22.1(b)(ii)(A).
[25] BEI Award, Cl 22.1(b)(ii)(B).

1(f) – the likely impact of any exercise of modern award powers on business, including productivity, employment costs and the regulatory burden

44. This claim is unlikely to have any impact on productivity or the regulatory burden. If this claim does have any effect on employment costs, this consideration does not outweigh the other considerations.

1(g) – the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards

45. The proposed variation is simple, easy to understand, sustainable, and does not overlap with other modern awards.

1(h) – the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.

46. This claim may increase employment growth. By ensuring that employees are paid for all the hours that they work, this variation will increase the income of those employees. Consequently, some employees, particularly those who work part-time by preference, may reduce their hours of work. This will make more hours of work available to employees who desire them.

47. It is unlikely that this claim will have any effect on inflation or the sustainability, performance and competitiveness of the national economy.

IV – NATIONAL EMPLOYMENT STANDARDS ('NES') EXCLUSIONS

48. The failure to pay for travel time is inconsistent with Division 3 of Part 2-2 of the Act which deals with the NES entitlements regarding weekly working hours. Under s 55(1) a modern award must not exclude the National Employment Standards.

49. Section 62 provides that an employer must not request or require an employee to work additional hours unless they are reasonable. For a fulltime employee, that means more than 38 hours. For a part-time employee that means the lesser of 38 hours or the employee's ordinary hours in a week. Subsection 62(2) of the Act provides the right to refuse additional work beyond 38 hours per week if it is unreasonable. Subsection 62(3) lists the criteria to judge the reasonableness of a request or direction to work additional hours for the purposes of s 62(1).

50. These criteria are:

    (a) any risk to employee health and safety from working the additional hours;

    (b) the employee's personal circumstances, including family responsibilities;

    (c) the needs of the workplace or enterprise in which the employee is employed;

(d) whether the employee is entitled to receive overtime payments, penalty rates or other compensation for, or a level of remuneration that reflects an expectation of, working additional hours;

(e) any notice given by the employer of any request or requirement to work the additional hours;

(f) any notice given by the employee of his or her intention to refuse to work the additional hours;

(g) the usual patterns of work in the industry, or the part of an industry, in which the employee works;

(h) the nature of the employee's role, and the employee's level of responsibility;

(i) whether the additional hours are in accordance with averaging terms included under section 63 in a modern award or enterprise agreement that applies to the employee, or with an averaging arrangement agreed to by the employer and employee under section 64;

(j) any other relevant matter.

51. Section 63 of the Act provides that modern awards may provide for the averaging of hours of work and, at s 63(2), may also provide for average weekly hours that exceed 38 hours per week if '*the excess hours are reasonable for the purposes of subsection 62(1)*'.

52. As noted above, where an employee travels at the direction of their employer they are working. However, the broken shift provision allows employers to avoid recording this working time as ordinary hours of work. Unpaid travel time is then 'additional hours' for the purposes of Division 3 of Part 2-2. Because these hours are unpaid they may be unreasonable.

53. Consequently, clause 25.6 permits employers to require employees to work additional hours without remuneration at the base rate of pay, let alone at penalty or overtime rates. Further, this working time is not counted as hours of work, artificially shortening the working day. This allows an employer to roster further additional hours. However, an employee is not able to refuse to work these additional hours, which may be unreasonable, because they are not recognised as hours of work by the SCHDS Award. Consequently, that employee is denied their right under s 62(2) to refuse to work additional hours. Clause 25.6 therefore excludes section 62 of the Act.

54. Moreover, clause 25.1 of the Award provides for the averaging of full-time hours of work. The evidence of Tracy Kinchin and Robert Steiner is that they regularly work more than 38 hours each week because they are rostered 38 paid hours and are required to travel between clients. This clause, when it interacts with clause 25.6, may exclude section 63 of the Act because it provides for average weekly hours that exceed the hours referred to in s 63(1) which are unreasonable for the purposes of s 62(1).

55. The variation proposed by the ASU would ensure that the SCHDS Award does not exclude the NES.

V – INTERACTIONS WITH OTHER CLAIMS

56. The ASU has also made a claim for a 15 percent loading for employees required to work broken shifts. We filed submissions and evidence in support of this claim on 18 February 2019. We note that the disutility of a lack of payment for travel time is an element of the 15 percent loading. If the ASU's claim for paid travel time were successful, we would still press the broken shift loading claim, but would accept that the quantum of the loading should be less than 15 percent.

57. We also rely on the statements of Tracy Kinchin and Robert Steiner in support of that claim.

VI – CONCLUSION

58. The Commission should vary the SCHDS Award to ensure that disability services and home care employees are paid for all time they spend travelling at the direction of their employer. the current provisions artificially reduce the paid working time of employees who are mostly low income women. The current provisions of the SCHDS Award are unfair to disability support employees and are not relevant to the current state of the disability services sector. The SCHDS Award will not achieve the modern awards objective until it ensures all work performed by employees is treated as work and fairly remunerated.

AUSTRALIAN SERVICES UNION

2 JULY 2019

Appendix A - List of Awards that contain travelling time provisions in male dominated industries

	Award	Clause	Provision	Percentage female employment
1.	Building and Construction General On-site Award 2010	25. Fares and travel patterns allowance	25.1 Employees will start and cease work on the job at the usual commencing and finishing times within which ordinary hours may be worked, and will transfer from site to site as directed by the employer. Other than in the case of an employee directed by the employer to pick up and/or return other employees to their homes, time spent by an employee travelling from the employee's home to the job and return outside ordinary hours will not be regarded as time worked. No travelling time payment is required except as provided for in clauses 21.1, 24.7, 25.5, 25.7	12.4%[26]

[26] ABS Labour Force May 2019

			and 36.3. The fares and travel patterns allowance recognises travel patterns and costs peculiar to the industry, which include mobility in employment and the nature of employment on construction work. 25.9 Transfer during working hours (a) An employee transferred from one site to another during working hours will be paid for the time occupied in travelling and, unless transported by the employer, must be paid reasonable cost of fares by the most convenient public transport between such sites.	
2.	Business Equipment Award 2010	22.2 Commercial Travellers stream	(c) Expenses and accommodation reimbursement (iii) Employees whilst travelling on their employer's business will be regarded as being "on duty" for all purposes of this award and for the purposes of all relevant State	~3 (Actual figure, not percentage)

			workers compensation legislation. Notes: • 28.2(ii) - The ordinary hours of work are to be worked continuously. • Award does not contain a broken shift provision	
3.	Car Parking Award 2010	15.4 Transfer from job-to-job allowance	An employee transferred by the employer from one job to another job on the same day will be paid for the time spent in travelling as for time worked. An employee will be reimbursed all reasonably incurred travel costs. Notes: • Award does not specify continuous ordinary hours • Award does not contain a broken shift provision	27.8%
4.	Commercial Sales Award 2010		3.1 Commercial Traveller means a person employed, substantially away from	35.8%

			the employer's place of business, for the purpose of soliciting orders for, or selling articles, goods, wares or merchandise or material for wholesale sale, for resale, or for use in or in connection with the production and/or preparation and/or distribution of commodities for sale by the customer. 21. Ordinary hours of work and rostering 21.2 The ordinary hours of work for a full-time employee will be an average of 38 per week with a maximum of 152 hours over 28 consecutive days. 21.3 The ordinary hours of work may be worked on any days of the week. 21.4 The ordinary hours of work will not exceed 10 hours on any day	
5.	Meat Industry Award 2010	26.5 Travelling and transfers	Where an employee is temporarily transferred during working hours from one location to another the employer	Meat, Poultry & Seafood Process Workers; Persons TOTAL: 20,400 (33.7% of workers are

			will pay such employee all reasonable costs of transit and travelling time. Notes: • 31.2(b) - The ordinary hours of work are to be worked continuously at the discretion of the employer, except for meal breaks or other breaks prescribed in the award. • Award does not contain a broken shift provision	female) Meat Boners and Slicers and Slaughterers; Persons TOTAL: 7,100 (12.1% of workers are female)
6.	Plumbing and Fire Sprinklers Award 2010	21.8 Fares and travelling time	(e) Transfer between job sites during working hours (i) Employees transferred from one job site to another during ordinary working hours must be paid their ordinary rate of pay for the time occupied in travelling, and unless transported by the employer, will be reimbursed the reasonable cost of fares by the most convenient	0.8%

			public transport between such job sites. Notes: • Award only defines a continuous shiftworker (3.1) • Award does not contain a broken shift provision	
7.	Silviculture Award 2010	18.1 Fares and travelling time	(k) Transfer during ordinary working hours An employee transferred from one site to another during working hours will be paid for the time occupied in travelling and, unless transported by the employer, will be paid reasonable cost of fares by most convenient public transport between such sites. Notes: • Award does not specify continuous ordinary hours • Award does not contain a broken shift provision	3.1%

IN THE FAIR WORK COMMISSION

Matter No.: AM2014/285

S 156 – Four Yearly Review of Modern Awards - Social, Community, Home Care and Disability Services Industry Award 2010

SUBMISSION IN REPLY OF THE AUSTRALIAN SERVICES UNION

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Contents

Attachment

Annexure A – Judith Wright Witness Statement

I - INTRODUCTION

1. This submission is made in reply to various submissions filed by employer groups in support of variations to the *Social, Community, Homecare and Disability Services Industry Award 2010* ('**Award**') proposed by Australian Business Industrial, the NSW Business Chamber, Aged & Community Services Australia and Leading Age Services Australia, ('**collectively ABI**') as set out in the Draft Determination filed on 2 April 2019 ('**ABI Claims**'). It is made in accordance with the amended Directions issued on 11 July 2019. ABI is supported, broadly, by National Disability Services ('**NDS**'), the Australian Federation of Employers and Industries ('**AFEI**') and Business SA ('**collectively the Employers**'). Australian Industry Group's ('**AIG**') position is unclear.

2. The variations proposed by the Employers can be grouped into three categories.

   a. Firstly, there are the claims for additional 'flexibility'. However, this 'flexibility' is entirely the employer's: employees will experience this 'flexibility' as arbitrary variability. These include a claim to remove the protections for the regularity working hours for full-time employees at cl 25.1; a claim to change rosters by agreement; and the removal of the requirement to roster 10 hour breaks between rostered periods of non-working duty such as sleepover or 24 hour care.

   b. Secondly, the Employers seek the extension of the cl 25.5(f) ('**the Home Care client cancellation term**') to social and community services employees undertaking disability services ('**disability services employees**'). The purpose of this claim is to shift risk from the employer to the employee. This puts the cost of client choice on the person least capable of bearing the costs or mitigating the risk.

   c. Finally, the Employers seek to impinge on the employee's private time, by instituting a 'remote response' term that would permit an employer to require employees to work from home outside of ordinary hours. This provision also undermines the on call arrangements of the Award.

3. The Australian Services Union ('**ASU**') opposes each of the ABI claims. If the Award were varied in the manner proposed by the Employers it would not provide fair and relevant safe terms and conditions. The Employers have not provided the Commission with the substantial evidentiary case or the comprehensive submissions necessary to satisfy it that the proposed

variations should be made. In many cases, the Employers evidence and submissions suggest that they misunderstand significant elements of their case, including the coverage of the Award and the operation of the NDIS.

The Employers are unrepresentative of the industries covered by the Award

4. The Award covers a diverse industry with a number of related, but quite different sectors. The Employers appear to largely represent home care sector and social and community services ('**SACS**') employers operating disability services. Certainly, this is where they have directed their evidence. But home care and disability services are only part of the industry covered by the Award.

5. The Award also covers the Family Day Care and Crisis Accommodation sectors. These sectors will be also be affected by the proposed variations to the arrangement of ordinary hours for full-time employees, rostering and remote response. Further, disability services are not the only organisations covered by the SACS stream of the Award. The SACS sector also covers: sexual assault, domestic and family violence services; women's domestic violence court advocacy services; youth and child protection services; out of home care for children and young people at risk services; homelessness, housing and tenancy services; family support services; health and mental health services; alcohol, gambling and other drugs of addiction and rehabilitation services; aged care services; first nation people's services; migrant and settlement services; prisoner rehabilitation; community legal services; community and neighbourhood services; policy, research and advocacy services; and community transport organisations.

6. These organisations operate under different funding arrangements, work with different clients and engage different types of employees than disability services. The Employers' proposed variations regarding the arrangement of ordinary hours for full-time employees, rostering and remote response will affect these organisations and their employees. The Employers have nothing to say about these sectors. In the absence of submissions and evidence about the full breadth of the Award's coverage, the Commission should not make the variations proposed by the Employers.

The implementation of the NDIS is a period of opportunity and growth for the disability sector, not a crisis

7. The Employers generally assert that their claims are necessary because of changes in the disability sector driven by the implementation of the NDIS. From the employer submissions, it would appear that there is a crisis in the disability sector. They argue that employers have lost control of their businesses and so the minimum safety net of the Award needs to be reduced. However, while the disability sector is clearly changing in response to the NDIS, the variations proposed by the Employers are a knee-jerk overreaction.

8. Firstly, it is apparent from the Employers' evidence that organisations in the sectors are successfully adapting their operations to the new NDIS model. From the Employers' evidence, it is apparent that employers in this sector are experimenting with new operational models and innovating in response to the challenge of the NDIS. This is desirable, and appears to be uninhibited by the safety net provided by the Award. There is no evidence of any genuine hardship on the employer's behalf.

9. However, these organisations appear to be unused to their clients acting as 'customers' with the right to choose, but also the obligation to negotiate and compromise. Unused to dealing with their clients as empowered economic actors, employers are lashing out at their employees. This appears to be the real basis of the Employer's claims and it is not a reason to reduce the Award safety net.

10. Secondly, the NDIS is still relatively new. It is going through a process of implementation, review and revision. It is not in its final form and its administrator, the NDIA, has shown itself to be willing to change the system in response to feedback from clients, support providers and workers. For example, the Employers have made many submissions about the inadequacy of funding arrangements under the NDIS. However, they ignore the fact that pricing is reviewed annually, and the pricing structure has been updated several times in response to employee feedback. As the NDIA notes on their website:

> *Changes to prices are updated to respond to market trends and changes in costs and are generally identified through an Annual Price Review. The Annual Price Review is undertaken by the NDIA in the lead up to new financial year, with any new prices outlined in an updated price guide, effective 1 July each year*.[1]

[1] 'Price Guides and Information', *National Disability Insurance Agency*, (Web page, 13 September 2019), <https://www.ndis.gov.au/providers/price-guides-and-information>.

11. Further, the NDIA has also commissioned external research into NDIS pricing and updated their pricing arrangements accordingly. In 2019, NDIS pricing was reviewed by McKinsey and Company on behalf of the Board of the NDIA. In their *NDIA Independent Pricing Review Report* they identified a number of changes to funding in response to input from NDIS participants, NDIS providers and disability advocates. These recommendations were progressively adopted by the NDIA in the 2018 and 2019 NDIS Price Guides.[2] The recommendations included, amongst other items, funding for 45 minutes of travel time in rural areas, a new client cancellation policy (discussed in detail below), a third pricing tier to account for higher skilled workers (SACS employees Level 3) for more complex care.[3] The Commission should not accept a submission that changes in the disability sector since the introduction of the NDIS means that disability services employees should not be protected by the same modern award safety net as other employees. The NDIS has evolved significantly since it was first introduced and continues to evolve in response to the concerns of providers and participants.

12. In any case, the statutory duty of the Commission is to ensure that the Award, along with the NES, provides a fair and relevant safety net. As the Commission noted in the Decision of 2 September 2019, '*The Commission's statutory function should be applied consistently to all modern award employees*'.[4] The Employers have not supported their claim with probative evidence or cogent arguments about why the NDIS (or consumer directed care) should mean that employees in the SCHDS industry should have lower terms and conditions than those in other industries.

The Award is already unusually flexible, and the minimum safety net does not need to be lowered further

13. The Employers have proposed a number of variations to increase the variability of working hours under the Award. These claims are unnecessary because the Award is already so flexible that the ordinary hours, overtime and rostering terms may not meet the modern awards

[2] National Disability Insurance Agency , *Price Guide 2018-2019*; National Disability Insurance Agency , *Price Guide 2019-2020*.
[3] 'Price Guides and Information', *National Disability Insurance Agency*, (Web page, 13 September 2019), <https://www.ndis.gov.au/providers/price-guides-and-information>.
[4] *Four Yearly Review of Modern Awards* [2019] FWCFB 6067, [142].

objective.[5] The Award has the following unique features which provide employers with significant flexibility:

a. the roster of part-time employees may be changed at any time under cl25.5 (d) (iii) which provides that the restrictions on changing the roster do not apply to mutually agreed additional hours worked by part-time employees;

b. Home care employees and SACS employees undertaking disability services may work broken shifts with no restrictions (cl 25.6);

c. part-time employees are not paid overtime until they work 10 hours in a day or 38 hours in a week or 76 hours in a fortnight;[6]

d. there is no minimum engagement for part-time or full-time employees;

e. employers are not required to roster meal breaks if they require an employee to have a meal with a client or clients;[7]

f. casual disability services employees are only entitled to a 2 hour minimum engagement;[8]

g. casual home care employees are only entitled to a 1 hour minimum engagement;[9] and

h. if a client cancels a rostered home care service, a home care employee's roster can be changed if the client is notified that their roster is being changed because of a client cancellation before 5.00 pm the day before, they will not be paid for the shift if they are notified about the client cancellation after that time, they will only be paid for the minimum specified hours, an employee can also be directed to work make up time sometime in that roster period or the next;[10]

14. The evidence of the ASU's witnesses is that they experience significant variability in their hours of work and are willing to agree to their employer's requests out of a sense of duty to their clients and a need to maximise their income. The Employer's variations will only further weaken the safety net for these employees. The detail of these claims will be discussed below, but the Employers have not advanced any evidence that proves that these claims are necessary to

[5] See the various ASU, HSU and United Voice claims regarding paid travel time, broken shifts, overtime for part-time employees and minimum engagements.
[6] SCHDS Award, Cl 28.1(b).
[7] SCHDS Award, Cl 27.1(c).
[8] SCHDS Award, Cl 10.4(c)(iii).
[9] SCHDS Award, Cl 10.4(c)(ii).
[10] SCHDS Award, cl 25.5(f).

achieve the modern awards objective. The Commission should not accept that employers need to impose more variability upon Award employees.

15. Further, the Commission has found that some SCHDS Award employees are low paid. The extreme variability of working time under this Award means that low paid workers seek to maximise their income by working longer hours, acceding to employer requests and working penalty hours, even though working those hours has negative personal and social effects. The evidence of Augustino Encabo is that he seeks to maximise his hours of work, overtime and working during periods of time that attract a penalty rate to maximise his income. In contrast, Tracy Kinchin gives evidence that, at least before the introduction of broken shifts in her workplace, her fulltime job offered her stability of income and work/life balance.

II – VARIABILITY CLAIMS

Roster Changes

16. ABI proposes that clause 25.5(d) of the Award should be varied to permit rosters to be changed at any time by agreement and in certain other circumstances where an employee takes leave. This claim is supported by the other employer groups, except that AFEI submits that employers should not have to keep written records of the agreed change. The Employers have little to say in support of this claim. ABI simply describes the proposed variation as '*relatively minor*'[11] and make no submissions about the merits of this claim other than to refer to a Decision[12] regarding the rostering clause of the *Nurses Award 2010*. They do not offer evidence or submissions about why this decision is relevant to their proposed variation. This is unsurprising because in that Decision, the Commission rejected a claim to change rosters at any time by agreement.[13]

<u>The rostering term of the Award is already sufficient flexible</u>

17. As noted in above in Part 1 of these submissions, the Award is already very flexible, which has a significant impact on employees. The proposed variation would only further undermine the already sparse safety net for hours of work. It is unclear what issue the Employers hope to address through the proposed variation. Under the current terms and conditions of the Award, an employer could engage a casual employee or offer a permanent part-time employee voluntary additional hours if they needed staff at short notice. The evidence before the

[11] ABI, Submission of 2 July 2019, [4.13]
[12] *Four Yearly Review of Modern Awards* [2018] FWCFB 7347
[13] *Four Yearly Review of Modern Awards* [2018] FWCFB 7347, [158].

Commission shows that part-time employees are generally willing to work additional hours unless doing so would interfere with another commitment. Further, the evidence before the Commission shows that employees are worried that if they do not agree to requests to work additional hours they will not be offered additional hours in the future.

Employees are likely to feel pressured to agree to change their roster if the proposed variation is made

18. Further, if the proposed variation were made, it is likely that some employees would feel pressured to change their roster at short notice.

19. This is consistent with findings of the Commission regarding similar applications in other Modern Awards. In making the Aged Care Award, the Australian Industrial Relations Commission ('**AIRC**') expressly rejected part-time employment arrangements like those proposed by the Employers.[14] Instead, they created a clause which balanced the need to protect the part-time employee without preventing an employer from offering additional hours of work. The Full Bench noted that they held reservations regarding the nature of consent where a supervisor requests an employee to work additional hours. The AIRC said (at [148]):

> *We have some reservations about the nature of the consent in circumstances where a supervisor directly requests a change in hours on a day where the part-timer had otherwise planned to cease work at a particular time. Existing provisions require that any amendment to the roster be in writing and we have retained this provision. We also have no doubt that many part-time employees would welcome the opportunity to earn additional income.* ***However, there may also be part-timers who would be concerned to ensure that their employment is not jeopardised by declining a direct request from a supervisor to work additional non-rostered hours at ordinary rates. From the submissions of the employers this is a major cost saving and used widely.***

20. In a 2018 Decision regarding the *Nurses Award*, the Commission rejected a claim to allow an employer to ask an employee to agree to a change in the roster within the 7 day period before the commencement of the roster period. The Commission said '*we have considered the ANMF's submission concerning the possibility that an employee may feel pressured to agree to*

[14] *Re Award Modernisation* [2009] AIRCFB 345, [147]-[149].

a change to the roster within the 7 day period and we agree with it'.[15] The Commission then echoed the AIRC in *Re Award Modernisation*, saying:

> '*We consider that the nature of the employer-employee relationship is such that if a supervisor asks an employee to change rosters within the 7 day period before the commencement of the roster period the employee's decision making may be compromised by fear (even if unwarranted) of repercussions if the request is declined*'.[16]

21. In the absence of probative evidence and cogent submissions about the merit of ABI's claim, the Commission should adopt the approach of previous Full Benches which protect employees covered by the Award from undue pressure to change their rosters at short notice.

Ordinary hours of work

22. ABI is seeking a variation to clause 25.1 Ordinary Hours of work. If the proposed variation were made by the Commission, the Award would not provide a fair and relevant safety net for full-time employees covered by the Award.

23. Currently, clause 25.1 provides as follows:

(a) *The ordinary hours of work will be 38 hours per week or an average of 38 hours per week and will be worked either:*

(i) *in a week of five days in shifts not exceeding eight hours each;*

(ii) *in a fortnight of 76 hours in 10 shifts not exceeding eight hours each; or*

(iii) *in a four week period of 152 hours to be worked as 19 shifts of eight hours each, subject to practicality.*

(b) *By agreement, the ordinary hours in clause 25.1(a) may be worked up to 10 hours per shift.*

24. The Employers propose a new clause that removes the restrictions on the arrangement of ordinary hours at clause 25.1(a)(i)-(iii). ABI describe this proposal as a '*minor or technical variation rather than a substantive amendment*'.[17] However, because the Award's working time protections are relatively weak, the full-time employees need the protections of clause 25.1(a). Otherwise, employers would be able to structure a full-time employee's ordinary hours in a

[15] *Four Yearly Review of Modern Awards* [2018] FWCFB 7347, [156].
[16] *Four Yearly Review of Modern Awards* [2018] FWCFB 7347, [157].
[17] ABI, Submission of 2 July 2019, [4.9].

highly irregular manner. The Commission should not make this variation without evidence of the impact on employees.

III – CLIENT CANCELLATION

25. Australian Business Industrial has proposed that the Commission should delete clause 25.5(f) Client Cancellation and replace it with a new clause. The proposed variation would make several changes to the current entitlement, the most significant of which is to extend the coverage of 25.5(f) to social and community sector employees when undertaking disability services.

The proposed variation unfairly shifts risk from the employer to the employee

26. The purpose of a client cancellation clause is to transfer the risk associated with a client's cancelling their services from the employer to the employee. It does so by allowing an employer to vary the roster or withhold payment from an employee where a client cancels their service. This is unfair to the employee and presents a moral hazard to the employer.

27. The employer is best placed to manage the risk of client cancellation and to absorb any unavoidable costs. Employers can draw on institutional knowledge and expertise that employees cannot access. They have oversight of their entire workforce. Employers also have control over operational matters such as rostering and staffing levels. Employers also have a contractual relationship with the client that allows them to influence the client's behaviour. In the extreme case, they may choose to terminate an agreement with a client. The employer is also able to draw income from a multiple sources, and have access to commercial financial products. Most employers in this sector are not for profit organisations and do not pay income tax. Some are charitable organisations with deductible gift status.

28. In contrast, the employee does not have access to the employer's institutional knowledge or expertise. Even if they did, employees are obliged to follow the lawful and reasonable directions of the employer. They do not control when they are required to work, who they are required to work with, or how the work of the organisation is structured. They are also more likely to draw income from one source, their wages; have less money in reserve; and pay tax. Many disability services employees are low paid. They already seek to maximise their income by working additional hours and working hours that attract overtime or a penalty rate. If the proposed clause were adopted they would be at risk of losing vital income at a moment's notice. They

would then be forced to work even longer hours to replace this income. The employee cannot control the client relationship, cannot mitigate the risk of cancellations and cannot absorb the cost of lost income. The employer can. Why then should the employee bear the burden? More importantly, how can a safety net of terms and conditions be '*fair and relevant*' if it shifts risk to the party least able to bear it?

29. The ASU is not advancing a claim to delete clause 25.5(f) from the Award. However, we do suggest that clause 25.5(f) in its current state does not achieve the Modern Awards Objective. The Commission should consider whether clause 25.5(f) should be varied to offer better protections, if not deleted.

Funding arrangements for client cancellation under the NDIS

30. Finally, if the proposed variation were made, employers would lose any incentive to work with their clients to manage cancellations or to modernise their business practices so as to effectively utilise their staff. This would mean that that Award promotes inefficient and unproductive business practices *while* reducing participation in the workforce.

31. From 1 July 2019, the following arrangements will apply where a client cancels their service:

> ***Client Cancellation***
>
> *Where a provider has a short notice cancellation (or no show) they are able to recover 90% of the fee associated with the activity, subject to the terms of the service agreement with the participant.*
>
> *A cancellation is a short notice cancellation (or no show) if the participant has given*
>
> - *less than 2 clear business days' notice for a support that is less than 8 hours continuous duration and worth less than $1000; and*
> - *less than 5 clear business days' notice for any other support.*
>
> *There is no limit on the number of short notice cancellations (or no shows) that a provider can claim in respect of a participant.*
>
> *However, providers have a duty of care to their participants and if a participant has an unusual number of cancellations then the provider should seek to understand why they are occurring.*

> *The NDIA will monitor claims for cancellations and may contact providers who have a participant with an unusual number of cancellations.*[18]

32. The new client cancellation arrangements were set by reference to the existing terms and conditions that apply to Social and Community Services employees undertaking disability services work. They have been designed to minimise the impact of client cancellations on employers, while also encouraging those employers to reduce the incidence of cancellations.

33. The current arrangements were adopted by the NDIA in response to a recommendation in the *Independent Pricing Review Report*. In their report, McKinsey and Company set out the reasoning for their proposed cancellation policy:

> *This revised policy minimises the financial loss incurred by providers on short-notice cancellations and recognises that while providers should work with participants to minimise short notice cancellations, providers should also not bear financial risk for these incidents. It also incentivises positive behaviour by all actors in the market: participants are incentivised to give sufficient notice, while providers are incentivised to work with participants and implement processes to minimise risk of cancellations. It is not expected that this change in policy will have an adverse impact on participant outcomes or Scheme costs. In most cases, the cost of cancellations will be absorbed by participants' budgets. If the nature of a participant's disability makes him or her more susceptible to cancellations, then the participant's budget should be increased accordingly. It is expected this will be a small proportion of participants.*[19] (Emphasis added)

34. The NDIS client cancellation policy was consciously designed, with reference to the current award provisions, to promote the efficient and productive performance of work in the sector. The proposed variations would in fact promote less efficient and productive working practices. They would also permit an employer to 'double dip', because it would permit the employer to bill the NDIA for a cancelled service, but also require the employee to work make up time, for which the employer could claim further fees.

35. Disability services employers do not need a Home Care style client cancellation clause, because they may claim 90 percent of the price of a cancelled service in most circumstances. This will cover the cost of the employee's wages. The claim is not relevant to the circumstances

[18] National Disability Insurance Agency, NDIS Price Guide 2019-2020, p 12.
[19] Mckinsey and Company, *Independent Pricing Review Final Report*, ('**NDIS Pricing Report**'), p76.

of employers covered by the Award. In any case, for the reasons discussed above, any client cancellation clause would not meet the modern awards objective.

ABI submissions about the coverage of Clause 25.5(f)

36. ABI have wrongly asserted that the clause presently applies to disability services provided in the home. This 'mistake' obscures the true significance of ABI's claim. Clause 25.5(f) does not apply to any disability services work, whether that service is provided in a private residence, a residential facility, a group home or in a community setting. Consequently, the claim is not simply a matter of extending client cancellation from one group of employees providing disability services to another. The proposed variation is a much more significant change than ABI's submissions would suggest.

37. ABI bases their assertion on the definition of '*home care sector*' at clause 3.1 of the Award, which provides:

> ***'home care sector*** *means the provision of personal care, domestic assistance or home maintenance to an aged person or a person with a disability in a private residence'*

38. ABI correctly says that the application of clause 25.5(f) is strictly limited to employees covered by the Home Care classification definitions at Schedule E of the Award. However, they wrongly say that the reference to '*person with a disability*' means that all work with a person with a disability in a private residence is covered by Schedule E. However, this ignores the clear distinction made by the Award between disability services work and home care work.

Employees providing disability services are covered by Schedule B of the Award

39. Disability services are exclusively covered by the SACS classification definitions at Schedule B. '*Disability Services*' are not defined by the Award. However, the definition of Social Community Sector explicitly references '*disability services*'. Clause 3 of the Award relevantly provides:

> ***social and community services sector*** *means the provision of social and community services including social work, recreation work, welfare work, youth work or community development work, including organisations which primarily engage in policy, advocacy or representation on behalf of organisations carrying out such work and the provision of disability services including the provision of personal care and domestic and lifestyle support to a person with a disability in a community and/or residential setting including respite centre and day services. To avoid doubt, an employee will not be precluded from*

being engaged under Schedule B, instead of another schedule, merely because they provide services in a private residence or in outreach. (emphasis added)

40. ABI fails to cite the definition of the Social and Community Sector in their submissions regarding the coverage of clause 25.5(f) and Schedule E of the Award. Presumably because to do so would be fatal to their argument.

41. The work of Home Care (Schedule E) employees is distinct from the work of SACS (Schedule B) employees undertaking disability services. Disability services may include the provision of personal care or domestic assistance, but it also involves a significant element focused on building the client's capacities and supporting their life choices. This includes either teaching, promoting or maintaining living skills, client, advocacy, promoting or supporting community access and social inclusion or developing or assisting in developing care or support plans including assessment of client needs. The complexity of this work and the prerequisite higher skill and qualification is reflected in the classification definitions at Schedule B.

42. In contrast, Home Care work is strictly limited to '*personal care, domestic assistance or home maintenance*'. Home care is simply the provision of personal and household services, and the classification system covers handy men as much as it covers care workers. The classification definitions at Schedule E do not refer to capacity-building or lifestyle support.

43. The distinction between disability services and home care services provided to a person with a disability was at issue in the 2010-2012 Equal Remuneration Case. In that case, AFEI tendered a document setting out an agreed position between it and the ASU regarding the distinction between home care and disability services. This was not challenged by any party to the proceeding. The witness statement of Judith Wright, Deputy Secretary of the ASU New South Wales and Australian Capital Territory (Services) Branch (see Annexure A), describes this history and the differences between home care and disability services work.

IV – REMOTE RESPONSE

44. We have not filed evidence or submissions in respect of the ABI Remote Response Claim due to a without prejudice settlement. We reserve our rights to file evidence and submissions in the case that the settlement does not progress.

V – DELETION OF PERIOD OF WORK

45. Clause 25.4 (a) provides as follows:

An employee will be allowed a break of not less than 10 hours between the end of one shift or period of work and the start of another.

46. ABI proposes that the words '*period of work*' should be deleted from the clause. They say that these words have no work to do.

47. This is incorrect. Clause 25.7 Sleepovers and cl 25.8 24 hour care provide for working time arrangements that do not fit comfortably with the word 'shift'. The purpose of '*period of work*' is to ensure that 24 hour care shifts and sleepovers are not worked back to back.

Annexure A.

BEFORE THE FAIR WORK COMMISSION
MATTER NO. AM2014/286
S. 156 - Four yearly review of modern awards – Social, Community, Home Care and Disability Services Industry Award 2010

STATEMENT OF JUDITH WRIGHT

I, Judith Wright, Union Official, of Level 1, 39-47, Renwick Street, Redfern, in the State of New South Wales, say;

1. I am the Deputy Secretary of the Australian Services Union, NSW & ACT (Services) Branch ('**the NSW Branch**'). I am also a member of the Australian Services Union National Executive. I have held these positions since April 2015. I have been an official of the Branch for ten years. Prior to taking up the position of Deputy Secretary, I was a Senior Industrial Officer from 2009 then Assistant Secretary responsible for industrial services from 2012.

2. Prior to working for the NSW Branch I practiced as a solicitor in New South Wales then New Zealand.

3. I have responsibility, amongst other things, for the legal and industrial activities of the NSW Branch. I have significant experience dealing with the Social and Community Services Sector (SACS), in:

    a. Being responsible for ten years for the NSW Branch's Industrial Services Team which provides advice and representation to ASU members in the SACS sector in relation to workplace grievances, disciplinary matters, unfair dismissal cases, Award and Agreement entitlements, classification issues, workplace health and safety, discrimination and bully and harassment matters.

    b. Representing SACS members in Enterprise Bargaining.

    c. Appearing in the Fair Work Commission in a range of matters affecting SACS members including disputes, adverse action and unfair dismissal matters, and the 2012 and 2015 SCHADS Award Reviews.

4. In my position as Senior Industrial Officer, I was involved in the Social, Community and Disability Services Industry Equal Remuneration Case. I worked extensively on the case from the time the application was lodged in March 2010 until the final order was made in June 2012. I briefed and instructed Counsel throughout the hearing, organised all of the workplace

inspections in New South Wales, attended all of the workplace inspections in New South Wales and Queensland, prepared all of the witness statements for witnesses based in New South Wales and the ACTU and some in other states and territories, engaged all of the expert witnesses called by the ASU and assisted with research and written submissions.

5. I have been shown the submissions filed by the Australian Business Industrial on 2 July 2019. I note that at paragraph 5.2, they assert that clause 25.5(f) '*already applies to a significant part of the disability services sector, as it applies to services provided to people with a disability in their home.*' They base this assertion on the description of '*Home Care Sector*' at clause 3.1 of the *Social, Home Care and Disability Services Award 2010* ('**the Award**').

6. Clause 25.5(f) does not apply to any part of the Disability Services sector, it only applies to employees classified under Schedule E of the Award as Home Care employees. Employees providing disability services are properly classified under the Social and Community Services Sector classification definitions (Schedule B of the Award). This work is distinct from work carried out by home care employees (covered by Schedule E of the Award) for people with a disability.

7. Clause 3 of the Award relevantly describes the Social and Community Sector as follows:

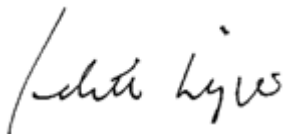
> ***social and community services sector*** *means the provision of social and community services including social work, recreation work, welfare work, youth work or community development work, including organisations which primarily engage in policy, advocacy or representation on behalf of organisations carrying out such work and the provision of disability services including the provision of personal care and domestic and lifestyle support to a person with a disability in a community and/or residential setting including respite centre and day services. To avoid doubt, an employee will not be precluded from being engaged under Schedule B, instead of another schedule, merely because they provide services in a private residence or in outreach.* (emphasis added)

8. Disability services involves the provision of personal care and domestic and lifestyle support and/or training to a person with a disability including in a community setting whether residential or non-residential, a respite centre, a day service facility or in a private residence where work in that residence involves either teaching, promoting or maintaining living skills, client, advocacy, promoting or supporting community access and social inclusion or developing or assisting in developing care or support plans including assessment of client needs.

9. Disability services (classified under Schedule B of the Award) can be distinguished from the provision of home care services to people with a disability (classified under Schedule E). These are roles where the workers only provide personal care for a client.

10. The distinction between Home Care employees and Social and Community Services employees undertaking disability services was the subject of controversy during the Equal Remuneration Case 2010-2012. In that case, the Australian Federation of Employers and Industries sought to clarify that the proposed Equal Remuneration Order did not apply to employees covered by Schedule E of the Award.

11. The parties came to an agreed position, which was filed by AFEI and marked as Exhibit AFEI 6. Attached and marked **Annexure A** is a copy of Exhibit AFEI 6.



JUDITH WRIGHT

Dated: 12 September 2019

ANNEXURE A

EXHIBIT: AFEI 6

Extract from transcript: 11 February 2011 — PN5572–PN5583

AFEI Letter to ASU: 9 February 2010

ASU Letter to AFEI: 22 February 2011

Extract from transcript: 3 February 2011 — PN3155–PN3177

Extract from Witness Statement – Sally McManus: ASU Exhibit 34 – page 21 and 22

PN5572

JUSTICE GIUDICE: Very well. In the circumstances, what we'll do is vary the timetable to provide for the New South Wales government to file submissions by 30 March and for the Victorian - I'm sorry. Just a moment. What date does the caretaker period commence?

PN5573

MS DOUST: The caretaker period commences on 4 March.

PN5574

JUSTICE GIUDICE: Yes. So what I had in mind was an extra couple of days only which would take it to 2 March for the New South Wales submissions.

PN5575

MS DOUST: We would be grateful for that, your Honour.

PN5576

JUSTICE GIUDICE: In relation to Victoria, then that will be 21 March.

PN5577

MS DOYLE: Yes, your Honour.

PN5578

JUSTICE GIUDICE: Otherwise the timetable will not be varied. Yes, any other matters? Mr Warren, yes.

PN5579

MR WARREN: Your Honour, one short matter. I raised prior to the luncheon adjournment, I indicated there was a difficult issue that the AFEI had. We've had some discussions over the luncheon adjournment and it appears to have been resolved. In short frame, it grew out of the cross-examination of Mr Di Troia and his evidence with respect to the coverage of the home care industry by this proposed order. A letter has been written by AFEI to Mr Harvey. I understand that Mr Harvey or his union will be responding to AFEI next week in writing and that may well resolve the matter and we will inform the tribunal of that resolution.

PN5580

JUSTICE GIUDICE: Right.

PN5581

MS DOUST: I have (indistinct) relates to the questionnaires that Ms Lowson raised earlier on. I think she indicated that it's proposed to have them. I'll ultimately post it to the web site if that occurs on the basis that they de-identify (indistinct) witnesses who have been treated. That became contentious if we (indistinct) basically supported that position, but as I understand it there's going to be some more discussions occurring anyway between Ms Lowson and Mr Warren.

PN5582

JUSTICE GIUDICE: Yes.

PN5583

MS LOWSON: Your Honour, could I just put on the record my thanks to Judith Wright and Keith Harvey for the work that they've done during the course of these proceedings; in particular juggling witnesses and re-scheduling matters and arranged a couple of matters that has helped the matter proceed more smoothly.

AFEI
Australian Federation of Employers & Industries

9 February 2010

Mr Keith Harvey
National Industrial Officer
ASU National Office
Ground Floor, 116 Queensberry St.,
Carlton South VIC 3053

Via email: kharvey@asu.asn.au

Dear Mr Harvey,

Re: FWA Matter No.: C2010/3131 – Application for Equal Remuneration Orders

We write with regard to the above matter and in particular seek clarification of the intended scope of the Equal Remuneration Order (ERO) sought by the applicants.

We note with concern that the evidence of Mr David Di Troia given in cross examination to Fair Work Australia on 3 February 2010 (PN3170) indicated that he understood the application is intended to cover employees in the Home Care Industry.

We note also that, whereas the Social, Community, Home Care and Disability Services Industry Award 2010 contains a separate classification structure for Home Care Employees (Schedule E), the amended application dated 23 December 2010 does not.

The Home Care Industry, in our view, is comprised of a significant number of *for profit* organizations which operate on a fee for service basis without assistance through government funding.

We request, as a matter of urgency, clarification as to whether it is the intention of the applicants that the ERO sought by the applicants apply to the Home Care Industry.

If you require any further information, please call me on (02) 9264 2000.

Yours faithfully,

Tony Doyle
Manager – Workplace Relations

LEVEL 2, 97-99 BATHURST STREET, SYDNEY 2000 PO BOX A233, SYDNEY SOUTH NSW 1235
PHONE: 02 9264 2000 FAX: 02 9261 1968 WEB: WWW.AFEI.ORG.AU EMAIL: ADMIN@AFEI.ORG.AU
TRAINING SERVICES FAX: 02 9264 5699 EMAIL: TRAINING@AFEI.ORG.AU

A•S•U

File/Our Ref: C2010/3131 KH
Your Ref:
Please quote in reply

Tuesday, 22 February 2011

Mr T Doyle
Manager – Workplace Relations
AFEI

By email: Tony.doyle@afei.org.au

Dear Mr Doyle,

Re: FWA Matter No.: C2010/3131 – Application for Equal Remuneration Order – Home care employees

I refer to your letter dated 9 February 2010 [sic].

The intended scope of the Application is clearly defined in paragraphs 3 and 4 of the Amended Application filed on 23 December 2010. It covers employers and employees engaged in:

> *The provision of personal care and domestic and lifestyle support and/or training to a person with a disability including in a community setting whether residential or non-residential, a respite centre, a day service facility or in a private residence where work in that residence involves either teaching, promoting or maintaining living skills, client advocacy, promoting or supporting community access and social inclusion or developing or assisting in developing care or support plans including assessment of client needs.* [See definition of Disability Services Sector at paragraph 3.1 of the Amended Application].
>
> and/or
>
> *The provision of social and community services including social work, recreation work, welfare work, youth work or community development work, including organisations which primarily engage in policy, advocacy or representation on behalf of organisations carrying out such work.* [See definition of Social and Community Services Sector at paragraph 3.1 of the Amended Application].

The Application is not intended to cover employers and employees of "the home care sector" as defined in paragraphs 139 and 140 of Exhibit 34 (witness statement of Sally McManus) as follows:

> *There are some roles where workers are supporting people with a disability or an aged person which do not fit the definition of "disability services sector" or "social and community services sector" work. Therefore, these roles do not fall under the classification definitions in Schedule B of the Order sought in this matter. These are roles where the workers only provide personal or physical support for a client. A typical example of this is the type of support required for clients who have a physical disability but do not have an intellectual disability.*

Australian Services Union

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National Secretary
Paul Slape

Assistant National Secretaries
Greg McLean
Linda White

For example, a person who depends on a wheelchair may need assistance getting out of bed, showering, dressing and with housework. However, they may not need and are not provided with other support such as living skills. These clients would live in their own homes and otherwise live independently. The workers who provide this role would be considered to work in the home care sector.
The same example could be given where workers are providing only personal care, domestic assistance or home maintenance for an aged person in their own homes. These workers are part of the home care sector.

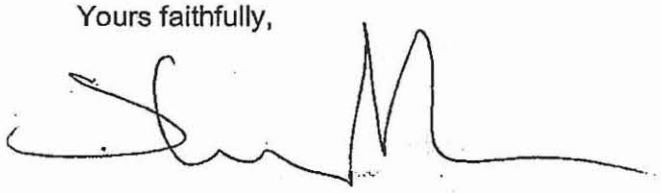
However the Application does cover the following work which may be performed at a client's home and which falls within the definitions of Disability Services Sector and/or Social and Community Services Sector:

- The provision of personal care and domestic and lifestyle support and/or training to a person with a disability involving either teaching, promoting or maintaining living skills, client advocacy, promoting or supporting community access and social inclusion or developing or assisting in developing care or support plans including assessment of client needs.
- Provision of outreach or home visiting for aged people to identify needs or to provide support of a social or welfare nature, which could include support with organising appointments, monitoring medications, assistance with communication, meal planning, accompaniment on outings and the coordination of home care services.
- Recruiting and organising volunteers or paid workers to visit aged people in their homes as part of overcoming social exclusion.

We understand that the term "Home Care Industry" has different meanings in different parts of Australia so we trust that the contents of this letter makes clear the scope of the Application.

Please contact me if you require further clarification.

Yours faithfully,



Keith Harvey
National Industrial Officer

PN3155
JUSTICE GIUDICE: Defer it, yes, very well. All right, we'll adjourn now until 2 o'clock.

<SHORT ADJOURNMENT [12.56PM]

<RESUMED [2.04PM]

PN3156
MS LOWSON: Your Honours, Commissioners, the next witness is David Di Troia.

PN3157
JUSTICE GIUDICE: Yes.

<DAVID DI TROIA, SWORN [2.05PM]

<EXAMINATION-IN-CHIEF BY MS LOWSON [2.05PM]

PN3158
MS LOWSON: Would you tell the tribunal your current occupation?---I'm the branch secretary of the LHMU's South Australian branch.

PN3159
Did you, for the purpose of these proceedings, prepare a statement?---Yes, I have.

PN3160
Do you have a copy of that with you?---Yes, I do.

PN3161
Can I just take you to paragraph 24 of that statement?---Yes.

PN3162
There's a reference there in the first line to "local government sector". Do you see that?---Yes, I do.

PN3163
Is that meant to refer to the state government sector?---Yes, the word "local" should be replaced with the word "state".

PN3164
With that amendment, is the content of your statement otherwise true and correct to the best of your knowledge and belief?---Yes.

PN3165
I tender that statement.

PN3166
JUSTICE GIUDICE: It will be exhibit ASU39.

EXHIBIT #ASU39 STATEMENT OF DAVID DI TROIA

PN3167
MS LOWSON: Yes, thank you, your Honour. I have no further questions.

<CROSS-EXAMINATION BY MR WARREN [2.07PM]

PN3168

MR WARREN: Mr Di Troia, you mention in your evidence in paragraph 2 of your statement that you speak of your branch membership. Does your branch membership spread across government and non-government employees, the non-government employees being in the SACS sector?---Yes, it does.

PN3169

So when you speak in paragraph 2 of your branch membership records - "64 per cent of these members are women" - that's a mix. Those women you are therein referring to are a mix of both SACS and government employees? ---I believe so.

PN3170

In paragraphs 3, 4 and 5 at least, you mention the home care classification stream. Is it your position that persons employed in home care would be covered by the order sought in these proceedings?---That's my understanding.

PN3171

Could I take you to annexure A to your statement please, Mr Di Troia?---Yes.

PN3172

Are you familiar with the enterprise agreements therein contained?---Other than seeing a final copy of those documents at the time of signing, I've not had any involvement in the negotiations of those agreements listed in attachment A. What I can say is that since tendering my statement in relation to the Minda agreement, I had some involvement in finalising the new agreement.

PN3173

There has been a new agreement?---Yes, there has.

PN3174

If I could just take you to attachment A?---Yes.

PN3175

I want to put a proposition to you. If you're unable to answer it, please say so. I'm suggesting to you that the enterprise agreements listed as Anglicare, Hills Community, Community Living Options, La Vida, Elizabeth Bowey Lodge, Helping Hand Aged Care, all specifically have a capacity of the employees covered by those agreements to have beneficial concessional tax with respect to fringe benefits tax within the agreements?---Look, I'm not in a position to answer that.

PN3176

You're not in a position because you don't have particular knowledge of those agreements?---I don't have the knowledge of what I'm suggesting you're putting to me - is that there are some salary sacrifice arrangements.

PN3177

Yes?---I'm not aware as to the actual arrangements when it comes to salary sacrificing.

The Nature of Work in the Disability Sector

132. Over the last fourteen years of being an official at my Branch, I have had extensive interaction with workers and employers in the disability sector. I have visited many workplaces where our members in the disability sector work; these include residential facilities, day program facilities and offices. I have had discussions with hundreds of workers in the disability sector, I have met many clients who use the services our members work in, I have had discussions with all the major employers in the sector in NSW and been directly involved in many industrial disputes in the disability sector. For these reasons, I am very familiar with nature of work undertaken by our members in the disability sector in NSW.

133. Since November 2008 I have been a member of the National People with Disabilities and Carer Council. I was appointed by the Federal Government to this Council whose role is to advise the Australian Government on the needs of people with disability, their families and carers. Through this role, I have met and had many discussions with employers in other States, as well as people who advocate for service users (or clients) of these disability services.

134. According to our membership records our Branch has about 2000 members employed in the disability sector.

135. I have read the witness statements of W59, W60, W64, W65, W66, W67, and Lloyd Williams. The nature of the work they describe accurately reflects the work performed by the members of our Branch in the disability sector. There are some differences in terminology only, for example, in NSW residential services for people with disabilities are referred to as "group homes", not "community residential units".

136. W60 works at Kirinari Community Services (Kirinari). She works both in NSW and in Victoria. I have visited workplaces and met members and clients from Kirinari in Albury, the Blue Mountains and Inverell. I have also been involved in negotiating their enterprise agreements over many years. The nature of the work W60 describes is the same as the work performed by residential disability sector workers throughout NSW. The only differences are differences that come about because of the particular mix of clients.

137. Workers in the disability sector develop or implement individual or person plans for each of the clients they support.

138. Many workers in the disability sector will perform duties that are of a personal care nature, however this is only part of their role. They implement personal plans that cover all aspects of a person's life. They also perform work that includes teaching, promoting or maintaining living skills, client advocacy, promoting or supporting community access and social inclusion.

139. There are some roles where workers are supporting people with a disability or an aged person which do not fit the definition of "disability services sector" or "social and community services sector" work. Therefore, these roles do not fall under the classification definitions in Schedule B of the Order sought in this matter. These are

roles where the workers *only* provide personal or physical support for a client. A typical example of this is the type of support required for clients who have a physical disability but do not have an intellectual disability. For example, a person who depends on a wheelchair may need assistance getting out of bed, showering, dressing and with housework. However, they may not need and are not provided with other support such as living skills. These clients would live in their own homes and otherwise live independently. The workers who provide this role would be considered to work in the home care sector.

140. The same example could be given where workers are providing *only* personal care, domestic assistance or home maintenance for an aged person in their own homes. These workers are part of the home care sector.

141. There are roles within the social and community sector where workers will be providing outreach or home visiting aged people to identify needs or to provide support of a social or welfare nature. These workers are part of the social and community services sector. Similarly, there are roles within the social and community sector that involve recruiting and organising volunteers or paid workers to visit aged people in their homes as part of overcoming social exclusion. These workers are considered part of the social and community services sector. In NSW these workers are funded by the Home and Community Care (HACC) program or Federal Government Aged Care packages funding.

Public Sector Awards

NSW

142. The following public sector awards apply to persons performing the same or similar work as performed in the SACS industry in New South Wales:

a. *Crown Employees (New South Wales Department of Ageing, Disability and Home Care) Community Living and Residential Award* – applies to Disability Support Workers and Team Leaders employed by the New South Wales Department of Ageing, Disability and Home Care;

b. *Crown Employees (Administrative and Clerical Officers - Salaries) Award 2007* - applies to Case Workers employed by the Community Services NSW, Client Service Officers employed by Housing NSW and Alcohol & Other Drug Officers, Welfare Officers and Accommodation Support Officers employed by Corrective Services NSW;

c. *Health & Community Employees Psychologists (State) Award 2008* – applies to Mental Health Workers (psychologist) and Sexual Assault Counsellors employed by NSW Department of Health;

IN THE FAIR WORK COMMISSION

Matter No.: AM2014/285

S 156 – Four Yearly Review of Modern Awards - Social, Community, Home Care and Disability Services Industry Award 2010

SUBMISSION OF THE AUSTRALIAN SERVICES UNION

Submitter:	Robert Potter, Acting National Secretary
Organisation:	Australian Services Union
Address:	116 Queensberry Street
	Carlton South, Victoria, 3053
Phone:	03 9342 1400
Fax:	03 9342 1499
Email:	info@asu.asn.au
Date:	Monday 23 September, 2019

Contents

Attachments

Annexure A – Witness Statement of Deborah Anderson

Annexure B – Witness Statement of Emily Flett

Annexure C – Draft Determination

1. This submission is made in reply to evidence and submissions filed by the employer groups in support of Australian Business Industrial's ('**ABI**') claim to vary the *Social, Community, Homecare and Disability Services Industry Award 2010* ('**Award**') by inserting clause a 'remote response' term and consequential amendments to clause 28.4 Recall to work overtime term.

2. We note the correspondence from Commissioner Lee regarding the without prejudice in principle agreement reached on 9 September 2019. The ASU has consulted its members. Consequently, we are no longer a party to that agreement.

Australian Business Industrial's Claim

3. The ASU opposes the ABI's claim because the proposed variation has the following deficiencies:

   a. The description of '*remote response*' appears to be derived from the *Local Government (State) Award (NSW)* and the *Local Government Award 2010* (Cth) ('**the Act**'). It may be appropriate for the local government industry, but it does not describe work in the SCHDS Industry.

   b. An employer would be entitled to direct an employee to perform work outside of their ordinary hours of work. Currently, an employee would be entitled to refuse to work these hours if they were unreasonable under s 62 of the *Fair Work Act 2009* (Cth).

   c. The clause expands the scope of the current on call term, which currently applies where an employee is '*required to be on call (i.e. available for recall to duty*)'. That is, available to be recalled to duty under clause 28.4.

   d. The draft variation makes no distinction between a '*remote response*' where an employee is rostered on call and where an employee is not rostered to work. Employers may decide not to require employees to be on call to avoid the payment of the on call allowance, but still direct employees to perform work. This promotes unproductive and inefficient work practices while permitting significant interference with an employee's private life.

   e. If an employee performs work in such circumstances, then the employee will be paid at the '*applicable rate*' for any time worked. This means that part-time employees may be paid at their minimum rate of pay if they have not worked more than 10 hours in a day or an average of 38 hours or 76 hours per fortnight. Given that this clause could only reasonably apply where work is required out of normal hours and at short notice, it should attract a penalty rate to compensate for the disutility of the work. Additionally, if the time work is paid at the minimum rate of pay, it may mean that these hours are not '*reasonable*' for the purposes of s 62 and 2 63 of the Act.

f. Employers may refuse payment where an employee does not provide a timesheet to their employer by the next full pay period. However, there is no obligation placed on the employer to inform the employee of the appropriate recording keeping practices. This may create the perverse situation where an employee is obliged to perform work without payment.

g. The clause explicitly excludes '*administrative tasks*'. However, from the limited evidence and submissions filed in support of this claim, it appears that the application is actually directed at administrative tasks.

h. Clause 28.3 does not apply where an employee performs work under this clause. This means employees could be required to attend work after a disrupted rest period or after working a significant amount of overtime.

4. ABI has led very little evidence in support of its claim. Indeed, the only reference to anything like 'remote response' is found in Scott Harvey's statement where he states that his employer '*has an on-call team*' but does not give any detail about how the team operates or give any indication of how the propose variation would affect his operations. Given the magnitude of the proposed variation, this level of evidence is insufficient to satisfy the Commission that the proposed variation is necessary to achieve the Modern Awards Objective.

5. Further, ABI have not supported their claim with submissions of any substance. They have not described the work that this provision will cover or how it would operate in practice. They also mischaracterise the disutility of working remotely. At paragraph 6.12 of their submissions of 2 July 2019, they identify a number of considerations which suggest that '*the level of disutility associated with employees performing remote response work is significantly less*' than being recalled to the workplace. The Commission should not accept this submission for the following reasons:

a. ABI asserts that employees are not '*required to stay in the vicinity of the workplace while on call*' or incur additional expenses and travel time. However, there is nothing in the proposed clause that would ensure that may only employee is required to be on call solely for the purpose of remote response. The witness statement of Deborah Anderson demonstrates that employees may be required to be available for both recall to the workplace and remote response. Further, this submission ignores the circumstances of the SCHDS Industry where employees required to be on call will return to their homes, even if they are likely to be recalled physically to the workplace.

b. ABI asserts that an employee '*can be on-call remotely from anywhere*'. This is wrong. Employees in the SCHDS Industry, and especially the SACS Sector, deal with highly confidential and sensitive issues. In many cases they are rostered to be on call to provide expert advice or assistance to more junior employees rostered to work a night shift. Employees required to be on call will often need to refer to their employer's policies

and procedures, relevant legislation and other regulatory matters. This work cannot be done at the local café, while bushwalking or a busy bar. The witness statement of Emily Flett describes the work on call work in the Youth Services sector.

c. Further, the clause proposed by ABI permits an employer to '*require*' an employee to work remotely. This is different from the Recall to work overtime term, which only permits an employer to '*request*' an employee to return to the workplace. This element of compulsion increases the disutility of the work.

d. Additionally, the proposed clause does not distinguish between a time where an employee is required to be on call and any time outside of ordinary hours. Employees covered by the Award would then live in apprehension that they could be required to work. This creates a disincentive to properly structure work.

The ASU's Position

6. There is in fact significant disutility to the employee associated with working outside of ordinary hours even if they are not recalled to the physical workplace. The ASU relies on the witness statements of Deborah Anderson (see Annexure A) and Emily Flett (see Annexure B) in support of our application. Both witnesses have had long careers in the Social and Community sector. They are qualified and experienced employees who have been selected for on call work by their employers to support less senior employees working weekends and night shifts. This is a cost saving for employers who would otherwise need to roster a senior employee on a night shift. Both witnesses report that while they derive satisfaction from their work and feel loyal to their clients, the hardship of on call work is significant. Both witnesses describe the severe physical, psychological and social impact on working remotely. In both cases, their employer has offered an above award two hour minimum payment at overtime rates to attract them to the work. Both witnesses report that they would be less willing to do this work if they were paid any less. These arrangements are common in the Social and Community Sector.

7. If the Commission is minded to make a term dealing with recall to work overtime remotely it should have the following features:

a. Remote work, like physical recall to the workplace, should be voluntary and paid at overtime rates.

b. There should be a clear incentive for remote work to only occur while an employee is required to be on call. This can be achieved by a structure of minimum payments.

c. A two hour minimum payment at overtime rates should apply where an employee works remotely when they are not required to be on call. This aligns with the minimum payment for a recall to work overtime at the physical workplace.

d. A one hour minimum payment when an employee works remotely when they are required to be on call. This aligns the minimum payment for remote work while on call with the minimum payment for work performed during a sleepover.

e. Further, because this is a significant expansion of the current 'on call provision', cl 25.3 Roster days off should be varied to ensure that on call time counts as duty for the purposes of the clause. This is to ensure that the expansion of the scope of on call work does not reduce an employee's personal time.

8. We filed with this submission a draft determination (see Annexure C) that would give effect to these principles.

Annexure A.

BEFORE THE FAIR WORK COMMISSION
MATTER NO. AM2014/285
S. 156 - Four yearly review of modern awards – Social, Community, Home Care and Disability Services Industry Award 2010

STATEMENT OF DEBORAH LEE ANDERSON

I, Deborah Lee Anderson, Shared and Supported Living Co-ordinator of 17/3 Parkside Parade Toronto, The Leisure Life Village in the State of New South Wales, say;

1. I am a Delegate of the Australian Services Union, New South Wales.

2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. I was born on 17 July 1958, I am 61 years old.

4. I am single and live with my aged mother to help support her. My mother is 81 and I assist her by doing the shopping and taking her out on weekends to visit her specialist.

My work history

5. I have worked as a Shared and Supported Living Co-ordinator since on or about 14 June 2018.

6. I hold a Certificate 4 in Youth and Community, a Diploma in Community Services, a Certificate 2 in Frontline Business Management, and Certificate 2 in Leadership.

7. During the early years of my life I was raising my children and worked part time on and off as a bar attendant. This was over a period of about 25 years, although for about 2 years at the end of this period I worked as a teacher's aide at Lake Macquarie High School. I then worked as a teacher's aide at Toogoolawa, a private school for disadvantaged youth, for about three years.

8. In 2013, I entered the Social and Community Services sector when I began work with Life Without Barriers as a Disability Support Worker. In June 2016, I was employed by St Vincent de Paul as an NDIS Local Area Co-ordinator. In June 2018 when I returned to work with Life Without Barriers in my current role as a Shared and Supported Living Co-ordinator. Life Without Barriers is a not for profit community organisation and a registered NDIS provider.

Current employment

9. On 18 June 2018, I commenced work with Life Without Barriers as a Shared and Supported Living Co-ordinator. I am a full time employee. Attached and marked **Annexure A** is a copy of my contract of employment.

10. I am employed under the *Social, Community, Home Care and Disabilities Services Industry Award 2010* (**'the Award')**. I am paid a yearly salary of $74,865.75.

11. I manage up to 30 frontline staff in two group homes. One group home has five high needs medical clients. These client's needs are constantly changing. I must continually monitor their needs to make sure we meet their requirements. The second home has two women with their own particular needs and compliance requirements.

12. Managing two homes in different physical locations makes it difficult to monitor and ensure compliance in both places. It is common for me to wake up through the night with worries about what hasn't been done. I monitor emails in personal time on weekends and evenings, when not rostered on, because management still send emails at this time and I feel obliged to stay on top of things and to do work outside hours unpaid

13. My job involves many different tasks:

    a. This includes overseeing rostering, conducting formal supervisions, finding staff to fill roster gaps as needed, conducting team meetings, and interviewing frontline staff for vacancies.

    b. I am also responsible for ensuring staff are up to date with training; monitoring and writing incident reports and monitoring follow up actions; monitoring Work Health and Safety systems and practices: conducting work cover processes: and monitoring restricted work practices. I also have to ensure that all compliance documentation is in line with NDIS Commission requirements.

    c. I am responsible for ordering the stationary requirements of the houses; placing orders for client medical supplies; (e.g. incontinence, ventral stomach (peg) feeding requirements): arranging house maintenance: and ensuring first aid compliance.

    d. I liaise with external services for the clients, (eg medical practitioners, therapists, dieticians, dentists), and am responsible for ensuring that their recommendations are endorsed and followed, (eg a transfer procedure). I also monitor client finance processes, monitor medications to ensure they are in place and current, and notify staff of any medication changes.

My hours of work

14. I work 76 hours over a fortnight on weekdays starting at 8.00 am until 4:30 pm. My pattern of daily work doesn't change. However, I am also on a rotating roster to perform On Call duties which can overlap my regular hours and extend well beyond them. I only receive a roster for my on call duties.

15. I am usually rostered to be on call once a week. If I am rostered to be on call during the week my normal hours of work will change. I will start work at 11.30 am and finish at 8.00 pm. I will start on call duties 5.00 pm and finish at 8.00 am the following morning. This means that there is a three hour overlap between starting my on call duties and the end of my normal rostered work. However, there are still urgent tasks that need to be done, and no-one else takes over those tasks in my place. Staff and management still contact me during this period. I usually start begin working at around 8.00 am, even if I am not rostered to start until 11.30 am. I am sometimes rostered to be on call on weekends. Then I will be rostered between 9.00 am and 9.00am.

16. Attached and marked are copies of my on call roster for the period 17 June 2019 to 16 December 2019.

On Call Duties

17. When I am rostered on call, I am expected to perform a wide range of duties. Typically, this includes responding to emergencies, administrative tasks such as rostering, providing phone advice and assisting less experienced staff with their issues. However, I can be called for any reason. I have to make an assessment over the phone of what action should be taken. I am

also responsible for reporting and recording all incidents. On a busy shift this can mean continuing after the shift to ensure all incidents have been logged and recorded.

18. When I am on call, I will usually take calls from staff at group homes when another staff member has not turned up or a staff member becomes sick and has to leave work early. I will then find another staff member to fill in for the absent staff member. This can require calling many people. It is not unusual for me to make up to 12 calls to find an available person. I am also required to contacting our labour hire agency when agency staff do not attend work as they were rostered. I will also rearrange rosters that flow on from this change to manage overtime and breaks.

19. Ultimately, if there are no staff available to cover a shift then I have to cover the absent workers duties. This means I will need to return to the workplace and directly support our clients. I must also continue responding to 'on call' calls after I have been recalled to work. This has happened twice so far since starting on the on call roster in August 2018.

20. Being on call also involves assisting staff to find information. This may require contacting other staff to find out where the information is located. It also involves advising on medication issues, and recommending corrective action when equipment is not functioning correctly.

21. I am also required to assist staff in our group homes to deal with emergencies that arise. For example, when clients have escalated behaviour, such as becoming violent or have seizures. This requires talking the staff through the situation, helping resolve the issue, ensuring incident reports are made, and logging the occurrence.

22. I am paid an above Award allowance of $30.00 when I am rostered on call between Monday and Friday, and $50.00 when I am rostered on call on weekends and public holidays. When I am working while rostered on call I am paid at the rate of time and half for the first 2 hours and double time after that.

Other work outside of rostered working hours

23. I am not usually required to work out of hours unless I am rostered to be on call. If I am contacted out of hours, this is usually just a telephone call from a new coordinator or a more junior staff member with a quick enquiry. There is no overt expectation from my employer to do this work. However, there is a clear expectation that I will be available to answer calls from management outside of working hours. But this does not happen very often and has only minor impact on me.

Impact of on call work

24. When I am on call, I cannot leave my home as I need to have phone, internet and computer access. I must also be ready and able to respond to any requests for work. I cannot go anywhere nor do anything else. This is particularly difficult on weekends when doing an on call shift from 9am until 9am. This causes high anxiety for me as I could be called out to any site to handle difficult incidences. This has occurred 3 times so far, and once resulted in me having to do a 23 hour shift. This can also result in me being required to attend at two places at the one time which is highly stressful as I can't go to a house to attend an incident when I am already attending an incident at another house.

The Australian Business Industrial remote response claim

25. I have been show a copy of ABI's remote response draft determination. I understand that it means that from 5pm until 10pm at night, I could be called to respond to an issue and I may only be paid for 15 minutes. There is no obligation for my employer to roster me to be on call.

26. I am greatly concerned by this proposal. The proposed 15 minute minimum engagement is completely inadequate payment for the inconvenience and stress involved with being contacted out of hours. You can never know what call may come through. It could be enormously inconvenient. What if I was out with a family member and I received a call that required me to attend a house? What would I do with my family member? How could this payment reimburse me for the significant imposition on my family life.

27. I was not previously considering leaving my job, but if something like this proposal was brought in as compulsory I would seriously consider leaving the industry. Doing work out of hours is only worthwhile for the additional pay it provides. Without significant remuneration to provide for not just the time involved, but the inconvenience as well, it is not worthwhile doing this work.

_____

WITNESS SIGNATURE

DEBORAH ANDERSON

DATE: 02/09/209

ANNEXURE A

WE LIFE WITHOUT BARRIERS VE

Employment Agreement

Deborah Lee Anderson

Life Without Barriers

ABN: 15 101 252 171

06 June 2018

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SCHEDULE 1

Item No.	Item	Detail
Item 1	Commencement Date	18 June 2018
Item 2	Duties	Refer to Position Description
Item 3	Employee	Deborah Lee Anderson
Item 4	Position	Shared & Supported Living Coordinator
Item 5	Base Remuneration	$74,865.75
	Additional Benefits 1	Not Applicable
	Additional Benefits 2	Not Applicable
	Superannuation 9.5%	$7,112.25
	Total Fixed Remuneration	$81,978.00
Item 6	Term of Appointment	Permanent
Item 7	Start Date of Employment	18 June 2018
Item 8	Reporting to	Shared & Supported Living Manager
Item 9	Hours of work	Full Time 38 hours per week.
	Hours of Work Averaging Period	6 monthly
Item 10	Probationary Period	6 months from start date of employment.
Item 11	Licences and Qualifications	Certificate IV or equivalent in Disability, Mental Health or Community and Social Services First Aid Certificate Current driver's license
Item 12	Probity Clearances Required	National Criminal History Record Check NSW Working with Children Check
Item 13	Governing Law	New South Wales
Item 14	Annual Leave	20 days for each 12 months of service (pro-rated for part time employees), accrued and cumulative in accordance with the National Employment Standards.

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Item 15	Personal/Carers Leave	10 days for each 12 months of service (pro-rated for part time employees), accrued and cumulative in accordance with the National Employment Standards.
Item 16	Guarantee of Annual Earnings	Not applicable
Item 17	Termination Notice Period after expiration of Probationary Period	The Employee or Organisation will provide 4 weeks' written notice to the other party of their intention to terminate employment. If the Employee is at least 45 years of age at the time of Termination of Employment and has completed at least 2 years' continuous service at the time the notice is given, the Organisation will increase the notice period by 1 additional week. The Organisation may provide payment in lieu of the equivalent notice period or part thereof.
Item 18	Tool of Trade Vehicle	A tool of trade vehicle is provided to the position outlined in Item 4 of Schedule 1. As per the Vehicle Eligibility & Allowances Policy Guideline, a tool of trade vehicle is required to meet the inherent requirements of the position. The allocation of this vehicle is subject to change by the Organisation. Tool of trade vehicles may be utilised for personal use in accordance with the Fleet Management Policy, however they do not form part of an employee's remuneration package and the vehicle is to be made available for use by others in the Organisation as required. Utilising a tool of trade vehicle for business travel restricts you from claiming kilometre reimbursements.

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1. APPOINTMENT

1.1 Commencement

a) Subject to the terms of this Agreement, the Organisation appoints the Employee to the Position set out in Item 4 of Schedule 1 and the Employee accepts that appointment (**the Employment**).

b) The Organisation will employ the Employee from the Commencement Date specified in Item 1 of Schedule 1 until the Employment is terminated by either party in accordance with this agreement.

c) Subject to the terms of this Agreement, the appointment is for the term outlined in Item 6 of Schedule 1.

1.2 Prior Employment or Agreements

a) This Agreement replaces all previous contracts of employment and other employment arrangements between you and the Organisation.

b) Where this Agreement replaces an existing employment Agreement, the Organisation will recognise continuity of service and your period of prior service with the Organisation for the purposes of all employment related entitlements. For the purpose of calculating your period of continuous service with the Organisation, your employment by the Organisation is deemed to have commenced on the date listed in Item 7 of Schedule 1.

1.3 Probation

a) From the Start Date the Employee is subject to the probationary period specified in Item 10 of Schedule 1.

b) During the probationary period, either the Organisation or the Employee may terminate the Employee's employment by giving one (1) weeks' notice in writing or, in respect of the Organisation, payment in lieu of such notice.

1.4 Reporting

a) The Employee will report to the Position described in Item 8 of Schedule 1 or such other position as nominated by the Organisation.

1.5 Work Location & Travel

a) Due to the nature of services provided by the Organisation, the Employee may reasonably be required to travel to and perform work at various work sites or locations at the Organisation's discretion. The Employee will not be entitled to any additional remuneration for such travel, but travel expenses for approved travel will be paid for by the Organisation in accordance with the Organisation's travel policies.

1.6 Hours of Work

a) The Employee's ordinary hours of work are set out in Item 9 of Schedule 1. The Employee may be required to work reasonable additional hours as required to fulfil the requirements of their role. The Organisation may require the Employee to work varying hours each week in order to satisfy the requirements of their position. In this case the Organisation may average the ordinary hours of work over a period of time greater than one week. This averaging period is outlined in Item 9 of Schedule 1.

b) The organisation may vary these hours from time to time after giving a minimum of 7 days' notice to the Employee

c) The Employee's Total Fixed Remuneration includes compensation for all hours the Employee is required to work. The Employee is not entitled to receive payments for reasonable additional hours worked.

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2. PROBITY, CONDITIONS AND CONSENTS

2.1 Probity

a) The Organisation is committed to the safety and protection of clients we support. This means that we need to make sure that all employees, whether in client-facing roles or not, do not pose any risk to our clients or to the Organisation. To ensure this, all employees, must undergo suitability and probity checks in accordance with State and Federal legislation and internal policy requirements.

b) The employee promises to obtain and maintain the probity checks and relevant Federal and State based clearances listed in Item 12 of Schedule 1, and any other checks as reasonably required by the Organisation.

c) This offer of employment is conditional upon the Organisation receiving satisfactory probity and Federal and State based clearances from the Employee. If such clearances are not provided, the offer of employment may be withdrawn.

d) The Organisation may unilaterally terminate this Agreement if the Employee is unable to obtain or maintain satisfactory probity and Federal and State based clearances by providing the notice period prescribed in clause 6.1 of this Agreement or payment in lieu of notice.

2.2 Conditions of Employment

a) The Employee must have the necessary skills and experience to carry out the duties and responsibilities referred to in the Position Description.

b) The Employee must be competent to properly carry out their duties and any representations as to qualifications, experiences, skills and employment history must be true and correct. The Organisation may at any time request reasonable evidence of the Employee's ability to meet these requirements.

c) In addition to clause 2.2 (b), it is a condition of employment that the Employee maintains the specific qualifications, licences, and professional admissions set out in Item 11 of Schedule 1. Additionally, the Employee may be required to undertake mandatory training in order to meet the inherent requirements of the role as listed in the Position Description. Failure by the employee to maintain the qualifications or satisfactorily complete mandatory training for any reason (including suspended qualifications) may result in the Organisation terminating this agreement in accordance with clause 6.1.

d) The Employee must be eligible to work in Australia and meet all Australian immigration requirements to work in the position set out in Item 4 of Schedule 1.

2.3 Consent

The Employee consents to all or any acts or omissions by or on behalf of the Organisation (whether occurring before or after this consent is given) which infringe or may infringe any of the Employee's Moral Rights in relation to any works and other Intellectual Property Rights described in clause 5.2 made or created by the Employee in the course of the Employee's employment with the Organisation. Furthermore, the Employee acknowledges that as a result of providing such consent, the Employee waives their right to bring any Moral Rights claim against the Organisation.

2.4 Extent of consent

The Employee's consent under this clause is irrevocable and extends to:

a) the Organisation's licensees and successors in title in respect of the Works; and

b) any person authorised by the Organisation or its licensees or successors in title to do acts comprised in the copyright for the Works.

2.5 Genuine consent

The Employee acknowledges that the consent in this clause is a genuine consent given under Part IX of the *Copyright Act 1968* (Cth) and has not been induced by duress or any false or misleading statement.

3. EMPLOYEE'S DUTIES

3.1 General and alternative duties

The Employee will serve the Organisation in the Position set out in Item 4 of Schedule 1 and perform the Duties set out in the Position Description. The Employee may reasonably be directed to perform alternative duties within the Employee's skills, capabilities and expertise as required.

3.2 Client Care

A primary duty of all employees, whether directly client facing or not, is to ensure the delivery of service to clients is of the highest quality. We expect all employees to contribute to our clients feeling safe and respected and to make sure they are cared for and protected from abuse, neglect and exploitation. All employees have a responsibility to report the inappropriate, or suspected inappropriate, treatment of clients to their manager.

3.3 Work Health, Safety and Environment

The Employee is obliged to follow all reasonable and lawful instructions, policies and procedures relating to health, safety, and the environment as directed by Officers or duly authorised delegates.

3.4 Fitness for Duty

a) The Employee must maintain the required fitness for duty necessary to perform the inherent requirements of the Position.

b) Where the Organisation has concerns about the Employee's fitness for duty or capacity to perform the inherent requirements, the Organisation may direct the employee to undergo a medical assessment by a nominated registered medical practitioner at the Organisation's expense. Any resulting recommendations or diagnosis provided by the registered medical practitioner may be relied upon by the Organisation to determine the Employee's ongoing ability to safely perform the terms of this agreement.

3.5 Additional duties

The Employee must:

a) devote the whole of the Employee's time, attention and skill during Ordinary Hours of Work and at other times as reasonably necessary, to the duties of office;
b) faithfully and diligently perform the duties and exercise the powers entrusted to the Employee from time to time;
c) promote the interests and prosperity and enhance the reputation of the Organisation;
d) comply with all reasonable and lawful orders and directions given to the Employee by the Organisation;
e) notify the Organisation of any charges or convictions gained during the course of the Employment;
f) comply with the Organisation's policies and procedures as amended from time to time;
g) not be engaged or interested in any other business or occupation (whether paid or unpaid), accept appointments as a director or other officer of any corporation or to the boards of committees or charities without the prior written consent of the Organisation; and
h) promptly disclose any breaches of the Organisation's policy and procedures including any serious misconduct or wrong doings (including but not limited to your own, other employees, volunteers, carers and/or external representatives to the Organisation).

4. REMUNERATION AND ENTITLEMENTS

4.1 Total Fixed Remuneration

a) Unless agreed otherwise, the Employee's Total Fixed Remuneration is comprised of the following:

i. Base Remuneration as set out at Item 5 of Schedule 1;
ii. Superannuation payable at 9.5%; and
iii. any additional benefits set out at Item 5 of Schedule 1.

b) The Total Fixed Remuneration (including the Base Remuneration, Superannuation and Additional Benefits) as set out in Item 5 of Schedule 1, is expressed as the full-time equivalent remuneration for the Position. Part-time employees will receive a pro-rata amount of the Total Fixed Remuneration based on the Ordinary Hours of Work as outlined in Item 9 of Schedule 1.

c) The Organisation will pay to the Employee the Base Remuneration component (pro-rata for part-time employees) of the Total Fixed Remuneration by electronic funds transfer on a fortnightly basis into the Employee's nominated account.

d) The Employee may apply to receive part of the Total Fixed Remuneration by way of other benefits which can be lawfully provided by the Organisation, in accordance with any relevant policies of the Organisation, as varied from time to time. The Employee may apply to receive these benefits, provided that:
i. the election is consistent with any policy of the Organisation, as varied from time to time; and
ii. the costs of the election to the Organisation (including any liability for Fringe Benefits Tax) do not result in the total payments and benefits being paid or provided to the Employee exceeding the Total Fixed Remuneration.

e) The Employee's Base Remuneration as set out at Item 5 of Schedule 1 includes and absorbs all entitlements the Employee may have to any and all minimum rates of pay, loadings, allowances, penalty rates or overtime payments (other than as set out in this Agreement) that arise under any statute, any applicable modern award or any other applicable industrial agreement.

f) Any remuneration set out at Item 5 of Schedule 1 that is in excess of the minimum rate of pay under any applicable statute or applicable industrial instrument may be set-off against (ie be taken to satisfy) any other monetary obligations imposed by that statute or instrument.

g) The rates used for calculating any set-off will be the relevant rates contained in the applicable instrument or prescribed under the applicable statute.

4.2 Superannuation

a) The Organisation will make superannuation contributions in accordance with the Employer Superannuation Component and for any additional amounts elected by the Employee to any complying superannuation fund nominated in writing by the Employee or, if no fund is nominated by the Employee, the Organisation's nominated superannuation fund provider at the time.

b) The Employee's Total Fixed Remuneration will be altered with any changes to the Employer Superannuation Component as provided by relevant legislation.

4.3 Expense Benefit Payment

a) As a Public Benevolent Institution, the Employee may be eligible to benefit from tax savings by packaging a portion of their Base Remuneration.

b) The Organisation bears no responsibility or liability, nor has any discretion as to whether you are eligible to receive this benefit. We recommend you seek independent advice in relation to the Expense Benefit Payment and any such matters.

4.4 Review

a) The performance of the Employee and the amount of the Base Remuneration may be reviewed as part of an annual review process which takes effect at such times as the Organisation in its absolute discretion determines throughout the Employment in accordance with Organisation policies. There is no expectation that remuneration will increase as a result of the annual review.

b) In undertaking such a review the Organisation may take into account all circumstances that it considers relevant, including but not limited to the performance of the Employee, the performance of the Organisation, the prevailing economic conditions, the Organisation's business requirements and the Organisation's capacity to pay.

4.5 Annual leave

a) The Employee will be entitled to Annual Leave as outlined in Item 14 of Schedule 1 and in accordance with the entitlements provided by the Fair Work Act or any subsequent legislation. Annual Leave will be accrued progressively throughout the year.

b) Where possible, Annual Leave is to be taken at times agreed between the parties, having regard to the Organisation's operational requirements.

4.6 Long service leave

The Employee will accrue Long Service Leave in accordance with the Governing Law of the State set out in Item 13 of Schedule 1 and any relevant Organisation policy.

4.7 Personal/Carer's leave

The Employee is entitled to paid Personal/Carers leave as outlined in Item 15 of Schedule 1 and in accordance with the entitlements provided by the Fair Work Act or any subsequent legislation.

4.8 Other leave

All other leave, including unpaid leave, compassionate leave, parental leave, parental partner leave, and community service leave, will be provided to the Employee in accordance with the Organisation's policy or the Fair Work Act, whichever is more generous.

4.9 Public holidays

The Employee will be entitled to paid absence from work on the public holidays referred to in the Fair Work Act. The Organisation may request the Employee to work on a public holiday and this will be a matter for discussion between the Employee and the Organisation at the time of any such request.

4.10 Guarantee of Annual Earnings

The Employee is not provided with a Guarantee of Annual Earnings

5. PROTECTION OF BUSINESS

5.1 Confidentiality Obligations

a) Employee's obligations

The Employee must:

i. keep any **Confidential Information** which the Employee has received (whether before the date of this Agreement and in whatever capacity) secret and confidential, except to the extent that the Employee is required by law to disclose it;
ii. take all reasonable and necessary precautions to maintain the secrecy and prevent the disclosure of any Confidential Information;
iii. refrain from using or attempting to use Confidential Information in any manner which will or may cause or be calculated to cause injury or loss to the Organisation or its customers or clients; and
iv. not, except in the ordinary and proper course of employment with the Organisation, use or disclose or allow to be used or disclosed any Confidential Information to any third party without the prior written consent of the Organisation.

b) Survival of obligations

The Employee's confidentiality obligations survive the termination of this Agreement.

5.2 Ownership of Intellectual Property Rights

a) Ownership

i. Subject to any written agreement to the contrary, all Intellectual Property Rights created by the Employee solely or jointly with others in the course of the Employee's employment automatically vest in the Organisation.
ii. Employee must disclose Inventions.
iii. The Employee must disclose to the Organisation the full details of any Invention. The Employee agrees that all rights in such Invention will belong to the Organisation.

b) Assistance

The Employee must at the request and expense of the Organisation do all things necessary or desirable to vest in the Organisation or its nominee absolutely as legal and beneficial owner all rights, title and interest in:

i. any Intellectual Property Rights created by the Employee in the course of the Employee's employment, including executing any documents which are reasonably required by the Organisation; and
ii. any Invention, including securing patent or other protection anywhere in the world and executing any documents which are reasonably required by the Organisation.

c) Inventions

The Employee must not disclose or make use of any Invention with external parties without the Organisation's prior written consent.

d) No prejudice

The Employee will not do or fail to do any act which would, or might, prejudice the rights of the Organisation under this clause.

e) Survival of obligations

The Employee's intellectual property obligations survive the termination of this Agreement.

6. TERMINATION AND SUSPENSION

6.1 Notice of Termination

a) This Agreement may be terminated at any time by either the Organisation or the Employee giving the notice prescribed in Item 17 of Schedule 1, or by the Organisation giving the Employee pay in lieu of notice for part or all of the notice period

b) Following the giving of notice by the Organisation or the Employee, the Organisation at it discretion do any of the following (or a combination thereof):

i. make payment in lieu of part or all of the notice period

ii. require the Employee to perform alternative or no duties

iii. require the Employee not to attend work

6.2 Immediate Termination – Summary Dismissal

The Organisation may terminate this Agreement immediately without notice, if the Employee commits any act constituting serious misconduct including, but not limited to, acts of dishonesty, theft, fraud, violence, serious breaches of occupational health & safety procedures, wilful disobedience, breach of duty, or persistent breaches of the Organisation's policies or provisions of this Agreement.

6.3 Return of Equipment

On termination of this Agreement the Employee must return to the Organisation all property of the Organisation including all Confidential Information, books, any physical means of storing the Organisation's Confidential Information such as, but not limited to: laptops, tablets, mobile phones, discs or USB sticks, documents, papers, materials, credit cards, cars and keys held by or under the control of the Employee.

6.4 Deductions

Subject to law, the Organisation has the right to seek to recover any sums owed to the Organisation. The Employee agrees to provide authorisation to the Organisation in writing to deduct from their pay or otherwise recover any amounts owing to the Organisation.

6.5 Suspension

The Organisation may suspend the Employee from their Employment for any period on full pay, including to investigate any concerns the Organisation has regarding the Employee's performance or conduct, or a suspected breach of this Agreement. The Employee must continue to comply with all terms of this Agreement and the policies and procedures of the Organisation during the period of suspension.

6.6 Termination for Redundancy

In the event the Employee's employment is terminated on the basis of redundancy, the Employee will be entitled to a severance payment in accordance with the Fair Work Act.

7. GENERAL

7.1 Policies, Procedures and Code of Conduct

a) The Employee agrees to comply with the Organisation's policies and procedures.

b) These policies, procedures and code of conduct may be amended and varied by the Organisation from time to time. It is the obligation of the Employee to ensure they understand the terms and conditions of the Organisation's policies and procedures and maintains currency with these policies and procedures as they may change from time to time at the organisation's discretion.

c) The employee acknowledges and accepts that the Organisation's policies and procedures are not incorporated into this Agreement and do not form part of the Employee's contract of employment.

7.2 Governing law

This Agreement is governed by the laws of the State detailed in Item 13 of Schedule 1.

7.3 Severance

If a clause is void, illegal or unenforceable, it may be severed without affecting the enforceability of the other provisions in this Agreement.

7.4 Continued operation

Despite any change to the Employee's place of work, position description, Duties, Remuneration or any matters contained in Schedule 1, this Agreement will continue to apply to the parties unless otherwise agreed in writing.

7.5 Entire Agreement

This Agreement supersedes all previous agreements or representations in respect of the Employee's employment by the Organisation and embodies the entire Agreement between the parties.

7.6 Amendment

This Agreement can only be amended by agreement in writing by both parties. Any understanding, agreement, representation or warranty outside of this Agreement which relates to the Employee's employment has no effect unless it is an agreement in writing, with terms duly authorised by a relevant delegate of the Organisation, and signed by both parties.

7.7 Effect of waiver

The waiver by either party of a breach of any provision may not be held to be a waiver of any later breach of the provision or a waiver of the provision itself.

8. DEFINITIONS

In this Agreement, unless the context of the clause indicates an alternative intention:

Agreement means this agreement.

Award means the *Social, Community, Home Care and Disability Services Industry Award 2010*, or any subsequent Award.

Business Day means any day that is not a Saturday, Sunday or Public Holiday.

Commencement Date means the date set out in Item 1 of Schedule 1.

Confidential Information means the confidential information of the Organisation relating to the Organisation or its operations or business affairs and includes, but is not limited to:

a) financial information and policies, business plans, strategic plans, acquisition or business expansion plans, pricing policies and reporting procedures of the Organisation whether relating to past, present or future operations of the Organisation;
b) the Organisation's past, present and future client information, including client identity and terms of dealing with specific clients;
c) the Organisation's past, present and future supplier information, including supplier identity, price for supply, terms and conditions of supply and the value of accounts to suppliers;
d) the Organisation's past, present and future employee information, including terms of employment and remuneration packages;
e) information marked as confidential or which the receiving party could reasonably regard as confidential; and
f) the Organisation's general know-how and procedures whether or not marked as confidential;
g) but Confidential Information does not include information which:
    i. is legally in the public domain or is generally known or is available by publication; or
    ii. the receiving party either already possesses at the time of disclosure to it by the disclosing party or independently acquires except through a breach of an obligation of confidentiality by any third party.

Duties means the duties described in the Position Description.

Employee means the person listed in Item 3 of Schedule 1.

Employer Superannuation Component means the contributions the Organisation is required to make to a complying superannuation fund as a result of the operation of the *Superannuation Guarantee (Administration) Act 1992* and the *Superannuation Guarantee Charge Act 1992*.

Fair Work Act means the *Fair Work Act 2009* (Cth).

Intellectual Property Rights means all present and future rights to:

a) trademarks, trade names, domain names, logos, set-up, patents, inventions, registered and unregistered design rights, copyrights, circuit layout rights, and all similar rights in any part of the world (including know-how); and
b) where the rights referred to in paragraph a) are obtained or enhanced by registration, any registration of such rights and applications and rights to apply for such applications.

Invention means any discovery, invention, design, development, technique, idea, method, secret process, system or improvement made or discovered by the Employee (alone or with others) during the course of the Employee's Agreement with the Organisation, in connection with or in any way affecting or relating to the

Organisation's operations or capable of being used or adapted for use by the Organisation or in connection with its operations.

Materials means all things brought into existence by the Employee in the course of their employment by the Organisation including inventions, ideas, discoveries and improvements (whether patentable or not); information and data, designs, drawings, presentations, proposals, reports, lists, plans and software.

Moral Rights means the right of attribution of authorship, the right not to have authorship falsely attributed, the right of integrity of authorship, or any other similar rights arising under any statute, including the *Copyright Act 1968* (Cth).

Ordinary Hours of Work means the hours stated in Item 9 of Schedule 1.

Organisation means Life Without Barriers ACN 101 252 171.

Position means the position set out at Item 4 of Schedule 1.

Probity is an assessment of the Employee's suitability and clearance to perform the role. This assessment includes a review of the Employee's national criminal history and police record and any other State based checks as legislated by governing law or in accordance with the Organisation's policies and procedures.

Total Fixed Remuneration means the Employee's Total Fixed Remuneration, as set out in Item 5 of Schedule 1.

Work means the performance of the Duties in the course of employment.

8.1 Interpretation

In this Agreement, headings are for convenience only and do not affect the interpretation of this Agreement and, unless the context otherwise requires:

a) a reference to termination of this Agreement includes a reference to termination of the Employee's contract of employment;
b) the singular includes the plural and vice versa;
c) words that imply a gender include all other genders;
d) a word that is derived from other parts of speech and grammatical forms of a word or phrase defined in this Agreement have a corresponding meaning;
e) an expression that implies or refers to a natural person includes any Organisation, sovereign state, government, government department or agency, partnership, joint venture, association, unincorporated association, corporation or other body corporate and vice versa;
f) a reference to a statute, regulation, proclamation, ordinance or by-law includes all statutes, regulations, proclamations, ordinances or by-laws amending, consolidating or replacing it, whether passed by the same or another government agency with legal power to do so, and a reference to a statute includes all regulations, proclamations, ordinances and by-laws issued under that statute; and
g) a reference to a document or agreement includes all written amendments or supplements to, or replacements or novation's of, that document or agreement.

WE
LIFE WITHOUT BARRIERS
VE

EMPLOYMENT AGREEMENT ACCEPTANCE

The signatures of the parties on this page confirm their mutual acceptance of the terms and conditions of this Employment Agreement and Schedule.

ORGANISATION AUTHORISED REPRESENTATIVE

Executed online by:

Name: Leanne Millard

Position: Operations Manager

Date: 06 June 2018

EMPLOYEE

Signed: Executed online by Deborah Lee Anderson

Name: Deborah Lee Anderson

Address: 17/3 Parkside Parade, TORONTO NSW 2283

Date: 06/06/2018

Position Title:	Shared & Supported Living Coordinator

Position Purpose & Scope

Purpose & Objective	The Shared & Supported Living Coordinator ensures that customers who require a high level of support are enabled to live in their home, and in their community. The role coordinates and delivers a range of supports that reflect the customer's individual needs and goals as described in their Service Agreement. The Shared & Supported Living Coordinator is responsible for engaging with customers, families, guardians and other key stakeholders so as to facilitate a cohesive, quality and inclusive support system around the customer. The incumbent takes a leadership role in organising, supervising and coaching support workers around a customer or group of customers.	
Business Unit	Client Services	
Reporting Relationships	**Direct Manager**	Shared and Supported Living Manager
	Direct Reports	Between 1-30 (this comprises F/T, P/T, casual workforce) *the number of direct reports will depend upon program / operational requirements*
Delegated Authority	Level 8 - Specific delegations are outlined in the Delegation of Authority Schedule - http://intranet.lwb.local/su/practiceandquality/qa/Pages/Delegations.aspx	

Organisation Purpose & Values

Our Purpose	To partner with people to change lives for the better.
Our Values	Our Values state our beliefs. They define our purpose and drive everything we do. Our Values fuel our passion for working with people and by living our Values, we are in a better position to champion opportunities for the people we work with and support. All people engaged by Life Without Barriers are required to uphold our Values of; *Responsive*, *Imaginative*, *Courageous*, *Respectful* and *Relationships*.
Our Stance on Child Safety & Wellbeing	Every day, Life Without Barriers offers support and care to children. We want each and every one of those children to feel as safe and respected as they should. We all have a responsibility to make sure their safety comes first – and that they're well cared for, protected from abuse and given the respect they deserve.

Key Responsibilities

Support Customers	• Work within relevant legislation, LWB policy and procedures and the National Disability Service Standards to ensure that Shared & Supported Living supports are delivered which reflect the customer's Service Agreement with LWB. • Engage with customers to build rapport and understand their needs, preferences and expectations; where required, work directly with customers • Ensure that direct support is delivered, as far as possible, by the support worker who best matches the customer in terms of relevant skills, capability and interests.

	• Build positive relationships with stakeholders by:
	  ○ working directly families, guardians and mainstream services to enhance opportunities for the customer in their communities
	  ○ engaging with health professionals, support coordinators, community, other agencies and other stakeholders including advocate
	• Actively develop and maintain an environment and ecology that balances the needs of any other customers who share the same residence; for example type of residence, compatibility.
	• Monitor, and where appropriate, adjust support based on the customer's changing needs.
	• Advocate where required with the NDIA, support coordinators, families, guardians and other stakeholders to respond to customer changing needs or goals.
	• Respond to feedback and complaints promptly.
	• Routinely utilise the established mechanisms, including client scheduling system, technical solutions and documentation systems to ensure that support is provided, outcomes are recorded and a transparent and accountable service is delivered.
	• Complete service satisfaction activities as directed by manager

Team Leadership	• Provide guidance, supervision and support to direct support staff. • Promote a positive environment through demonstrating good communication and interpersonal skills and appropriate peer support. • Model appropriate conflict resolution, communication and positive behaviour management skills. • Escalate any issues of concern to the manager immediately, where a serious risk of harm or to reputation is apparent
Organisational Responsibilities	• Communicate and act in ways that are consistent with Life Without Barriers Values of *Responsive*, *Imaginative*, *Courageous*, *Respectful* and *Relationships* • Provide an environment free of abuse, harm and exploitation for people we support • Support and promote the work of Life Without Barriers, maintaining a positive image of the organisation in accordance with the level of position. • Comply with all Life Without Barriers policy, code of conduct, procedures and practices, external funding body requirements and legislation. • Apply and uphold the principles of a respectful, inclusive and diverse workplace, free from discrimination, harassment or bullying • Adhere to organisational and legislative Health, Safety and Environment requirements.

Required Knowledge, Skills & Experience

Qualifications & Licenses	• Minimum Cert IV or equivalent in Disability, Mental Health or Community and Social Services • First Aid Certificate • Current driver's license
Required Experience	• Demonstrated experience in similar role and / or relevant experience in providing and improving customer support/service

	• Demonstrated experience in supporting complex customers (clients) • Demonstrated experience in working both independently and as part of a team • Demonstrated coordination and leadership experience • Demonstrated experience in managing competing priorities and to deliver outcomes within agreed timeframes and quality standards
Essential Knowledge & Skills	• An excellent understanding of the principles of the National Disability Insurance Scheme (NDIS) and relevant legislation • Demonstrated commitment to customer choice, inclusion and quality practice • Demonstrated knowledge of contemporary disability practice approaches including but not limited to, positive behaviour support, medication management and complex medical management. • Demonstrated leadership and coaching skills, with the ability to build a shared understanding of, and commitment to the organisation's Purpose and Values • The ability to work collaboratively and in partnership with a range of stakeholders including customers, peers, employees, external organisations, funding bodies and government agencies • Ability to support organisation-wide initiatives that support Life Without Barriers' Purpose and Values • Excellent verbal and written communication skills • Demonstrated understanding and / or ability to use Data Bases and Microsoft Office suite of programs, for example Outlook, Word and Excel • Ability to work in a complex environment and respond appropriately to high risk or critical events and situations • Demonstrated problem solving and conflict management skills and an ability to think creatively and use initiative

Additional Requirements & Conditions

Probity Requirements	All positions within Life Without Barriers will be required to undergo probity checks including criminal record checks and working with children checks (where relevant to the position) and as outlined in their Contract of Employment.
Work Hours	As per Contract of Employment, the incumbent may be required to work reasonable additional hours to fulfil the requirements of the position. To fulfil the requirements of the position the incumbent may be required to be on-call and / or work an alternating work pattern e.g. day and afternoon pattern on a fortnightly basis.
Travel	The position may require the incumbent to travel to various work locations to discharge the responsibilities of the position

ATTACHMENT B

17/06/2019	1	Deb	Michael	Carlos/Cha	Jo	Char/Jamie	Melissa/Ca	Jamie/Char
24/06/2019	2	Carlos	Melissa/Jo	Char	Michael/Cl	Jamie	Deb	Jo
1/07/2019	1	Jamie	Deb	Char	Jo	Melissa	Michael/Jc	Carlos/Cha
8/07/2019	2	Melissa	Jo	Carlos/Lee	Leesa/Carl	Deb	Char	Jamie
15/07/2019	1	Deb/Char	Char/Deb	Leesa	Jamie	Carlos	Jo/Char	Melissa/ Jo
22/07/2019	2	Jo/Jamie	Carlos	Char/Leesa	Melissa/Jo	Leesa	Jamie/Jo	Deb
29/07/2019	1	Melissa/Jo	Jo/Natalie	Jamie/Jo	Char/Deb	Deb/Char	Carlos	Leesa
5/08/2019	2	Carlos/Del	Deb/Carlos	Jo	Leesa/Chai	Melissa/Le	Jo	Char
12/08/2019	1	Deb	Leesa	Jamie	Jo	Char	Melissa/Ch	Jamie
19/08/2019	2	Jo	Melissa/Le	Char	Leesa	Jamie	Deb	Jo
26/08/2019	1	Jamie	Deb	Char	Jo	Melissa/Na	Leesa	Jo
2/09/2019	2	Melissa /H	Jo	Natalie	Hayley	Deb	Char/Deb	Jamie/Lees
9/09/2019	1	Deb	Char	Leesa	Jamie	Hayley	Jo	Melissa
16/09/2019	2	Jo	Hayley	Char	Melissa	Leesa	Jamie	Deb
23/09/2019	1	Melissa	Jo	Jamie	Char	Deb	Hayley	
30/09/2019	2	Hayley	Deb	Jo	Leesa	Melissa	Jo	Char
7/10/2019	1	Deb	Leesa	Hayley	Jo	Char	Melissa	Jamie
14/10/2019	2	Hayley	Melissa	Char	Leesa	Jamie	Deb	Jo
21/10/2019	1	Melissa	Jo	Jamie	Char/Mich	Deb	Carlos	Michael/Ch
28/10/2019	2	Carlos	Deb/Jo	Jo/Deb	Michael/Jo	Melissa	Jamie	Char
4/11/2019	1	Deb	Michael	Carlos/Cha	Jo	Char/Jamie	Melissa/Ca	Jamie/Char
18/11/2019	2	Carlos	Melissa/Jo	Char	Michael/Cl	Jamie	Deb	Jo
25/11/2019	1	Jamie	Deb	Char	Jo	Melissa	Michael/Jc	Carlos/Cha
2/12/2019	2	Melissa	Jo	Carlos/Lee	Leesa/Carl	Deb	Char	Jamie
9/12/2019	1	Deb/Char	Char/Deb	Leesa	Jamie	Carlos	Jo/Char	Melissa/ Jo
16/12/2019	2	Jo/Jamie	Carlos	Char/Leesa	Melissa/Jo	Leesa	Jamie/Jo	Deb
23/12/2019		Monday	Tuesday	Wednsday	Thursday	Friday	Sat	Sun
30/12/2019		this is a 2 week roster						

Annexure B.

BEFORE THE FAIR WORK COMMISSION

MATTER NO. AM2014/286

S. 156 - FOUR YEARLY REVIEW OF MODERN AWARDS – SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

Statement of Emily Flett

I, Emily Flett, Youth Worker, of Unit 7, [redacted] in the State of Victoria, say;

1. I am a member of the Australian Services Union, Victorian and Tasmanian Authorities and Services Branch

2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. I was born on the 25th of November 1981.

4. I have a partner. We have been together for eight years. We are hoping to buy a house and live together soon.

My work history

5. I am a qualified youth worker. I have a Bachelors of Youth Work from Victoria University and Certificate IV in Child, Youth and Family Intervention.

6. I have worked in the community sector for about sixteen years. I have worked at Anglicare Victoria for most of that time. I have worked at other organisations in the youth work sector and community services roles but I have always maintained some type of employment with Anglicare.

Current employment

7. Since 2015, I have worked with Anglicare Victoria as After Hours Practitioner. I am a part-time employee. Attached and marked **Annexure A** is a copy of my position description

I am employed under *Social, Community, Home Care and Disabilities Services Industry Award 2010* (**'the Award'**). I am classified as Social and Community Services Employee Level Level 6 (Social Worker Class 3)

8. I am paid $42.36 per hour. With overtime I earn approximately $80 – 85K per year.

9. I work in a dedicated team that provides after hours on call support to staff, volunteers and young people in our care. We work from the Anglicare Offices in Collingwood, we respond to phone calls from all regions of the metro area. This position tests you out because you get a variety of calls every night, some of these calls are day to day issues, such as staffing matters, but we spend a lot of our time providing risk mitigation and managing crisis. The position is relatively senior as it holds a large amount of responsibilities and Anglicare staff calling in can use this management structure for support, guidance and direction, while out of hours for their regular line manager.

10. Anglicare created our dedicated on-call team to address the impact of on call work on staff performing their regular duties during the day time and to reduce impacts on them as previously, house managers, specialist practitioners and other frontline staff were required to be on call.

Now this work has been given to our team so appropriate breaks can be structured in to a roster and we reduce burnout on valuable staff.

11. We often support staff members who need advice and support about how to proceed with dealing with young people with volatile behaviours. Another important part of my work is dealing with emergency referrals, where we need to urgently find a safe place for a young person in a case of family or guardian break down. In that case, I will try to find a place for them in one of our residential facilities or emergency foster care. I will also need to conduct an assessment of risk, I will consider the care needs of the young person, and judge whether we have the resources to safely meet those needs.

12. I am also available to provide advice to youth workers with basic troubleshooting or we might just refer the caller to one of our employer's policies dealing with the issue. The After Hours Practitioners in our team help youth workers to apply trauma informed theory and assist in seeing the young person in context. Youth workers are professionals who draw on a wide range of knowledge and skills in their work, if there is a grey area, we assist them to find a solution that is in the best interest of young person. This feels like important work that involves risk mitigation for our young people, our staff and the organisation.

13. We a responsible for ensuring that policies, legislation and best practices are followed, when staff are calling in for assistance around how to manage a situation. If there is a Quality of Care Investigation the After Hours Practitioner's on call notes as used as evidence along with other relevant client case notes. Our documentation has been used in court when the investigation proceeds to that end.

My hours of work

14. I work according to a rotating roster fortnightly roster. I have a line in the roster, with all my shifts fixed and I am able to plan well in advance around these shifts as my contract is ongoing for each shift in the fortnight. I can tell if I'm rostered on for Christmas or another public holiday easily. I am contracted to work 41 base hours each fortnight, but a component of my work hours are as re-call hours as this is the nature of my job.

15. My roster follows this pattern:

    a. I will work my ordinary hours at the Anglicare Victoria offices in Collingwood. I will commence work at some time between 4.30 pm and 7.30 pm depending on my rostered hours.

    b. I will finish work late at night, often around 11.00 pm. I have a break, in which I drive home, un-paid for 1 hour.

    c. Then I will be on call from 12.00 pm to 9.00am. I am not expected to return to the workplace when I am on call. Instead I will respond to issues by telephone or by computer. We refer to this period of the shift as 'Recall'. I am then paid at a re-call rate and if I receive no calls at all I will not be paid – but I will have had some sleep so a win there!

    d. At the end of the re-call shift at 9am, I will then have a 10 hour break between the end of my on call period and the start of my next shift.

16. I am paid two hours pay at double time when I receive a call and no more if I receive 20/30 calls in that same period, once I get a call in the next call block after the two hours I will again be paid another two hour block. I believe this is an above award condition, I understand that it

was necessary for my employer to offer this condition to attract sufficiently skilled staff to the after hours on call team.

17. The number of Recall hours I work each week fluctuates and is most defiantly seasonal, calls are quiet over winter for the most part. I usually work between 10 and 15 hours Recall each fortnight and this greatly subsidises my low part-time base hours and brings me closer to full time wages.

18. Attached and marked **Annexure B** are copies of my roster for the period [7-9-19] to [*20-9-19*] & [24-8-19] to [6-9-19]

Roster Changes

19. Each worker in my team has a line on the roster. We have set days and nights that rotate over a long period of time according to fixed pattern. We all know when we will be working. This is important for many of the other people in my team because many of us have caring responsibilities. But it is also important for me because it helps ensure that I have work/life balance. Without a fixed roster it is hard to be a shift worker and participate in social events and sporting clubs. We very rarely try to change or swap our shifts. If Anglicare does change the roster, we have a mini-meltdown in the office and it causes much distress.

20. I am worried that if rosters could be changed by agreement at any time, I would be pressured to change my shifts to accommodate my employer. We have a sense of duty to keep the place running. A good example of this was in April 2019. Anglicare Victoria had restructured the on call team to centralise the work that was done by the regional North West After hour's team in the Collingwood office. This required roster changes. We felt incredible pressure to adhere to whatever the organisation told us they needed to do, even if it would cause us problems. We just tried to adapt and have come across to the central roster. We have all lost income doing this, we are now working more nights for less money.

Impact of on call work

21. When I work through the night on call, I feel exhausted the following day. I find it is different from working a shift when you are awake through the night. In the morning, you just feel like you are jetlagged as you have only slept in parts and will need to sleep again later in the day once the mornings duties are finalised and you go off shift.

22. The following day after a night shift I can't do the things I like to do. I cannot exercise at a high level, my balance is affected, I cannot ride my motorbike or pushbike. I also find it harder to engage with my partner friends and family. I find that I don't have the energy to socialise, so I tend to withdraw a little bit and miss out.

23. I find that I do not get that regular connection with my partner in an undisturbed space. It is tricky to maintain a relationship when my working patterns are one of the reasons I do not live with my partner. When I am on call, we cannot share the same bed: or he would just be on call with me. That would be unfair to him.

24. I also find it hard to access to fresh and healthy food. This is one thing I really notice. I cannot go to the supermarket after work, because supermarkets are not open late at night. So I do a lot of food preparation to make sure I have healthy food to eat. But this is different from having access to fresh fruit and vegetables as you would after work 9-5pm.

25. I am always weighing up if this job is worth it. I can guarantee that if I was paid any less I would not do this job. Instead, I would take a small pay cut and work as a case manager for similar money and I would still be working hard, but at least I would be working normal hours

in line with my partner friends and family. It's the balance of the eight hour day, it looks after you. If your working hours are not in balance like that you need some sort of special conditions, there is a reason they call it a penalty rate, because you are paying a personal penalty to be working at 3am.

WITNESS SIGNATURE

Emily Flett

WITNESS NAME

DATE: 22-09-19

Annexure A.

Anglicare Victoria

AFTER HOURS PRACTITIONER

AFTER HOURS SERVICE

At Anglicare Victoria our focus is on transforming the futures of children, young people, families and adults. Our work is based on three guiding pillars: Prevent, Protect and Empower.

We strive to create an environment where employees feel valued and rewarded.

By living the Anglicare Victoria values and actively fostering fairness, equality, diversity and inclusion, our people make Anglicare Victoria a truly great place to work.

So come and join us at Anglicare Victoria where there is a rewarding career ready for you in a dedicated, professional team where respecting each other; leading with purpose; working together; and creating a positive difference are valued, and learning and creativity are encouraged.

BETTER TOMORROWS

Anglicare Victoria

BETTER TOMORROWS

Position details

Position	After Hours Practitioner
Program	After Hours Service
Classification	SCHADS Award Level 6 (Social Worker Class 3) (Classification will be dependent on qualification and years of experience within the relevant field consistent with the SCHADS Award)
Hours	Part Time or Full Time applications will be considered
Hours per week	Base Hours + OnCall and Recall Allowances
Duration	Ongoing
Fixed term end date	N/A
Location	Collingwood Requirement to complete outreach if required.
Reporting Relationship	Team Leader After Hours Service
Effective date	

Overview of program

Anglicare Victoria are establishing a new Afterhours response team, which will provide an out of business hours crisis response service to relevant program areas. Programs will include but not be limited Residential Care, Home Based Care, Lead Tenant, Youth Refuge and Targeted Care Packages.

This afterhours service will provide high quality risk assessment, advocacy, and will coordinate and manage any complex issues which arise out of business hours.

This support will be provided to clients, staff and volunteers and will primarily be provided by telephone, however in person responses will also occur as needed.

Position Objectives

Anglicare Victoria

This section has the position objectives of the position. A maximum of four to six objectives is regarded as sufficient. Please delete rows that are not required.

1.	Be part of a team who delivers a high quality afterhours emergency response to staff, clients and volunteers who present with a range of complex and high risk issues across a range of programs areas.
	Provide immediate response, support, intervention, information, guidance and if required direct care to clients, staff and volunteers.
	Manage and respond to incoming referrals, as well as make any relevant outgoing referrals.
	To work within a professional framework and complete professional documentation as required.
	To provide an in person response if required.

Key responsibilities

This section has the key responsibilities of the position. A maximum of seven responsibilities is regarded as sufficient. Please delete rows that are not required. Focus on the key responsibilities of the role and don't list every task and duty.

The key responsibilities are as follows but are not limited to:

	Be an active part of the emergency afterhours roster, which includes evening, weekend and OnCall/ReCall work, both over the phone and in person when required
	Provide high quality risk assessment and emergency responses to staff, client and volunteers, across a range of services, including statutory services. This will require both phone and in person responses as required.
	Conduct risk assessments to determine the current and ongoing risks, as well as negotiate with relevant stakeholders (including but not limited to: DHHS, Police, Hospitals etc) to implement a response which is in the best interests of all involved.
	Complete timely, accurate and appropriate case notes, CIMS reports and statistical documentation, as well as engage in staff meetings, supervision and other relevant professional forums.
	Work with the team to enable continual improvement to the new service model to further extend our commitment to improving the lives of children, young people and their families.

Anglicare Victoria

Key Selection Criteria

The Key Selection Criteria are based on role specific requirements ***and*** the Anglicare Victoria Capability Framework. Applicants are required to provide a written response to ***both*** a) and b).

a) Role specific requirements

Applicants are required to provide a written response to the role specific requirements. The five criteria are to be addressed individually (no more than 2 pages in total).

 Role Specific	1. Tertiary qualifications, preferably in social work, psychology or behavioural sciences or equivalent.
	2. Excellent understanding and experience working within the child protection, placement and support, and family service system, including a sound understanding of relevant legislative and policy framework.
	3. Ability to demonstrate excellent communication and negotiation skills, both over the phone and in person, in complex and demanding situations.
	4. Experience in working in fast paced, high pressured situations, which includes triaging complex issues, and negotiating with other stakeholders including statutory services.
	5. Highly developed skills in risk assessment and responding to and managing complex, high risk and critical incidents across statutory and other services, including over the phone and in person responses.
	6. Excellent knowledge of, and experience in the application of relevant theoretical approaches that underpin casework practice to vulnerable children, young people and families.
	7. Highly developed written and organisation skills.

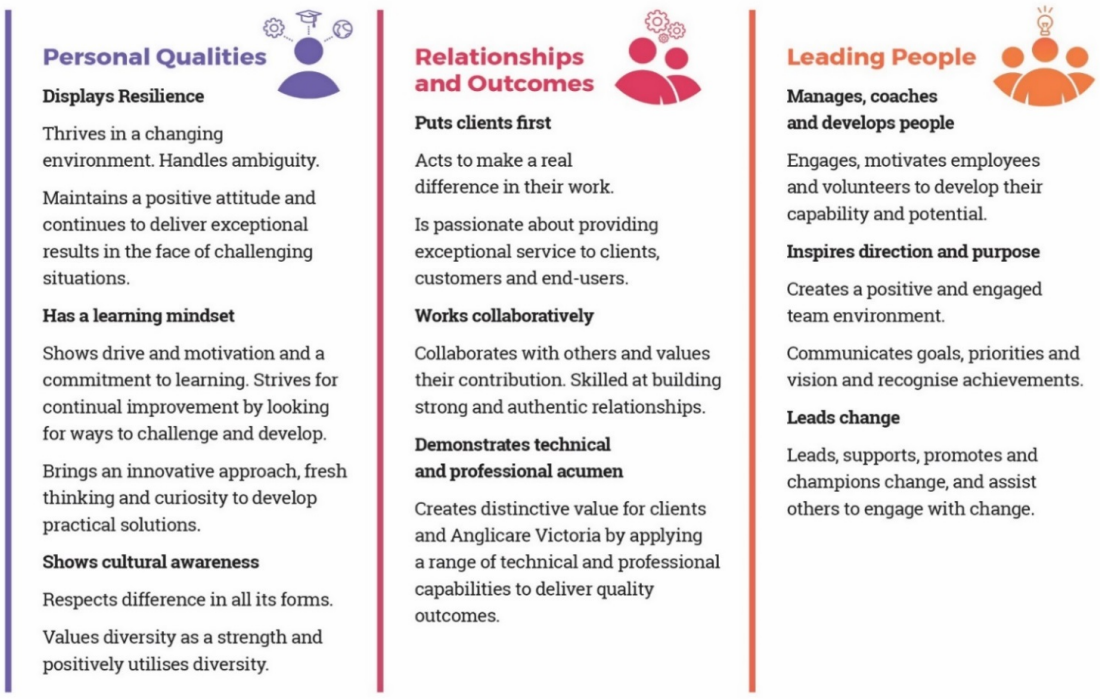
Key Selection Criteria (continued)

b) Anglicare Victoria Capability Framework

Applicants are required to provide a written response to the Anglicare Victoria Capability Framework. Applicants are to describe how they demonstrate the characteristics in each of the two capability groups; **Personal Qualities and Relationship and Outcomes** (no more than 1 page in total).

The Anglicare Victoria Capability Framework describes the capabilities required to meet the expectations of clients, colleagues and communities in today's changing environment.

These capabilities work together to provide an understanding of the knowledge, skills and abilities required of all employees.



Occupational health & safety (OHS)

Anglicare Victoria is committed to ensuring the health and safety of its employees and any other individuals present in our workplaces.

In achieving and maintaining workplace health and safety, Anglicare Victoria will apply best practice in OHS in accordance with statutory obligations at all times.

All Anglicare Victoria employees, contractors and volunteers are required to:

- take reasonable care for their own health and safety and for that of others in the workplace by working in accordance with legislative requirements and the company's OHS policies and procedures
- take reasonable care their actions or omissions do not adversely affect the health and safety of themselves and others
- cooperate with any reasonable directions, policies and procedures relating to health and safety in the workplace
- report all injuries, illness or 'near misses' to their Supervisor or Manager
- participate in relevant health and safety training based on roles and responsibilities
- as required, participate in the development and implementation of specific OHS hazard and risk management strategies.

In addition to the above, positions with supervision or management responsibility are required to ensure a safe and healthy work environment for all employees, clients, contractors and visitors. This can be achieved by ensuring all people are aware of and have access to OHS policies, procedures, training and reporting systems

Cultural Safety in the Workplace

Anglicare Victoria recognises the important and unique contribution Aboriginal and Torres Strait Islander employees make by bringing their unique skills, knowledge and experience to the workplace. They also contribute important insight into how Anglicare Victoria can provide for and engage with Indigenous clients and communities more effectively.

Our Reconciliation Action Plan (RAP) and Workforce Strategy outlines Anglicare Victoria's commitment to leading and facilitating sustainable employment, training, retention and career development opportunities for Aboriginal and Torres Strait Islanders people.

Conditions of employment

- Salary and conditions are in accordance with the click to select. Salary packaging is offered with this position.
- All offers of employment at Anglicare Victoria are subject to a six month probationary period. The staff member will be asked to participate in an annual performance review linked to objectives set out for the position.
- All offers of employment are subject to a satisfactory Criminal History Check, a current Driver's License and an Employment Working with Children Check prior to commencement.

Acceptance of Position Description requirements

To be signed upon appointment

Employee

Name: _____

Signature: _____

Date: _____

Annexure B.

CENTRAL AFTER HOURS MASTER ROSTER - Updated 18-08-19

	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Contracted Hours
DATE:	24/08/2019	25/08/2019	26/08/2019	27/08/2019	28/08/2019	29/08/2019	30/08/2019	31/08/2019	1/09/2019	2/09/2019	3/09/2019	4/09/2019	5/09/2019	6/09/2019	
After Hours Practitioners															
BACKUP	SINEAD	SINEAD	TREVOR	TREVOR	TREVOR	TREVOR	TREVOR	TREVOR	TREVOR	LANA	LANA	LANA	LANA	LANA	SE
MANAGERS	NEIL	NEIL	NEIL	NEIL	NEIL	NEIL	CAROL	CAROL	CAROL	CAROL	CAROL	CAROL	CAROL	CAROL	NW
LIST	BRIE	BRIE	BRIE	BRIE	BRIE	BRIE	JACINTA	JACINTA	JACINTA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	EAST RESI
			GINA	GINA	GINA	GINA	GINA	DEAN	DEAN	DEAN	DEAN	DEAN	DEAN	DEAN	EAST HBC
			KAREN	KAREN	VIRGINIA	VIRGINIA	KAREN	VIRGINIA	KAREN	KAREN	KAREN	KAREN	KAREN	KAREN	HBC s'port
Team Leader MARK	4.30 - 12am	3pm - 10pm. Recall @11pm & 8am-9am	7.30 - 11pm. Recall @12am & 8am-9am		10am - 6pm (Admin)	4.30 - 10pm & ReCall 11pm & 8am-9am					4.30 - 10pm & ReCall 11pm & 8am-9am		10am - 6pm (Admin)	10am - 6pm (Admin)	
Total Line Hours	7	7.5	4.5		7.5	6					6		7.5	7.5	53.5
Super-Melissah														Supervision	
Team Leader SANDRA			10am - 6pm (Admin)	4.30 - 12am	11am -7pm (Admin)	10am - 6pm (Avail by Phone)			9am - 5pm	10am - 6pm (Admin)		10am - 6pm (Admin)	4.30 - 12am	Additional 4.30 - 12am	
Total Line Hours			7.5	7	7.5	7.5			7.5	7.5		7.5	7	7	66
Super-Melissah			Supervision												
SARAH	9am - 5pm	4.30 - 12am		7.30 - 11pm. Recall @12am & 8am-9am	Super 12pm-1.30pm and 2.30-4.30 Mtg	4.30 - 12am				4.30 - 12am					
Total Line Hours	7.5	7		4.5	4.5	7				7					37.5
Super-Sandra					**12-1.30pm**										
EMILY		**Annual Leave** 9am - 5pm	3pm - 12am		2.30 - 4.30 Mtg & 4.30pm - 12.00am		4.30 - 12am			7.30 - 11pm. Recall @12am & 8am-9am	**SICK** 7.30 - 11pm. Recall @12am & 8am-9am	4.30pm - 10pm & ReCall 11pm & 8am-9am			
Total Line Hours		7.5	8.5		9		7			4.5	4.5	4 + 2			41
Super-Sandra		**A/L**	**3.00-4.30pm**												
LINDA					2.30-.4.30 Mtg			9am - 5pm	4.30 - 12am	Super 3pm - 4.30pm & 4.30 - 10pm. Recall @11pm & 8-9am		6pm - 11pm. Recall @12am & 8am-9am			
Total Line Hours					2			7.5	7	7.5		6			30
Super-Sandra										**3pm - 4.30pm**					
TAMMY					2.30 - 4.30 Mtg & 7.30 - 11pm. Recall @12am & 8am-9am	7.30 - 11pm. Recall @12am & 8am-9am			3pm - 10pm. Recall @11pm & 8am-9am		4.30 - 12am	4.30 - 12am	Super 6pm - 7.30pm & 7.30 - 11pm. Recall @12am & 8am-9am		
Total Line Hours					9	4.5			7.5		7	7	6		41
Super-Sandra													**6 - 7.30pm**		
TU			4.30 - 10pm & ReCall 11pm & 8am-9am		2.30 - 4.30 Tm Mtg & 4.30 - 10pm & ReCall 11pm & 8am-9am		4.30 - 10pm & ReCall 11pm & 8.30am-9.30am	7.30 - 11pm. Recall @12am & 8.30-9.30am	7.30 - 11pm. Recall @12am & 8am-9am				**ANNUAL** 4.30 - 10pm & ReCall 11pm & 8am-9am		
Total Line Hours			6		8		6	4.5	4.5				6		35
Super-Mark			**7.30 - 9pm**												
PAUL				4.30 - 10pm & ReCall 11pm & 8am-9am	2.30-4.30 Team Mtg & 4.30-6PM Super (Dble Time)			4.30pm - 12am		Active	Active	Active		4.30 - 12am A/L	
Total Line Hours				6	3.5			7		6	6	6		7	41.5
Super-Mark					**4.30-6PM**										
VICTOR	7.30 - 11pm. Recall @12am & 8.30-9.30am	7.30 - 11pm. Recall @12am & 8.00-9.00am	Active		2.30-.430 Mtg and Super 4.30-6pm	Active	7.30 - 11pm. Recall @12am & 8.30-9.30am	Additional Shift		Active	Additional Shift			7.30pm - 11pm & OnCall and 8.30am-9.30am	
Total Line Hrs	4.5	4.5	6		3.5	6	4.5			6				4.5	39.5
Super-Sandra					**4.30 - 6pm**										
BRENDAN	3pm - 10pm OnCall and 8.30am-9.30am				2.30-.4.30 Mtg									**LWOP** 4.30 - 10pm & ReCall 11pm & 8.30-9.30am	
Total Line Hrs	7.5				2									6	15.5
Super-Mark														**4.30 - 6pm**	
VACANT SHIFTS								**3pm - 10pm OnCall and 8.30am-9.30am Victor**			7.30 - 11pm. Recall @12am & 8am-9am		4.30 - 10pm & ReCall 11pm & 8am-9am	4.30 - 10pm & ReCall 11pm & 8.30-9.30am	
Total Line Hrs								**7.5**					6	6	7.5
STAFF NAME:								**VICTOR**			**VICTOR**		**BRENDAN**		

DATE:	24/08/2019	25/08/2019	26/08/2019	27/08/2019	28/08/2019	29/08/2019	30/08/2019	31/08/2019	1/09/2019	2/09/2019	3/09/2019	4/09/2019	5/09/2019	6/09/2019	
Active Outreach Practitioners NORTH WEST															
VICTOR			11.30pm - 6am			11.30pm - 6am				11.30pm - 6am					
Total Line Hrs			6			6				6					18
NICOLE	11.30pm - 6am	11.30pm - 6am		11.30pm - 6am	**1.30-2.30 Supervision** & 2.30-4.30 Mtg & 11.30pm - 6am		11.30pm - 6am				**Annual** 11.30pm - 6am	**Annual** 11.30pm - 6am			
Total Line Hrs	6	6		6	9		6				6	6			45
NW VACANT LINE					**Supervision** & 2.30-4.30 Mtg			11.30pm - 6am	11.30pm - 6am				11.30pm - 6am	11.30pm - 6am	
Total Line Hrs					3			6	6				6	6	27
STAFF NAME:								**CHRISTINE**	**RICHARD**		Victor		**RICHARD**	**RICHARD**	
Active Outreach Practitioners SOUTH EAST															
PAUL										11.30pm - 6am	11.30pm - 6am	11.30pm - 6am			
Total Line Hrs										6	6	6			18
SE VACANT LINE	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am				11.30pm - 6am	11.30pm - 6am	
Total Line Hrs	6	6	6	6	6	6	6	6	6				6	6	66
STAFF NAME:	**RICKY**	**Tina Su'a (BW)**	**DENG - No Show**	**DENG**	**Moevasa BW**	**Transitions Matthew Uyanna**	**Barnabus BW**	**Barnabus BW**	**Transitions Akoi Guong**					**RICKY**	

Siju Poplar Line & Availability			**Poplar House 4pm-12am**	**Poplar House 4pm-12am**				**Poplar House 8:30-4:30**	**Poplar House 8:30-4:30**	**Poplar House 4pm-12am**	**Poplar Team Meeting 11am-1pm**		**Not Available Until Early November - Get well soon Siju!**	

September
Wed 4th – through to – Sunday 15th

Works on Level 2 Refurb – Team can remain in Level 1, but will need to utilise bottom level car park as Level Car Park will be used by tradesman.
October
Thurs 3rd – through to – Fri 14th (except Oct 4th)

Works on Level 2 Refurb - Office Closed – Plan for After Hours Team to all Work From Home.
October
Fri 4th

CENTRAL AFTER HOURS MASTER ROSTER - Updated 01-09-19

	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Contracted Hours
DATE:	7/09/2019	8/09/2019	9/09/2019	10/09/2019	11/09/2019	12/09/2019	13/09/2019	14/09/2019	15/09/2019	16/09/2019	17/09/2019	18/09/2019	19/09/2019	20/09/2019	
After Hours Practitioners															
BACKUP	LANA	LANA	SINEAD	SINEAD	SINEAD	SINEAD	SINEAD	SINEAD	SINEAD	TREVOR	TREVOR	TREVOR	TREVOR	TREVOR	SE
MANAGERS	SHAWN	SHAWN	SHAWN	SHAWN	SHAWN	SHAWN	LISA	LISA	LISA	LISA	LISA	LISA	LISA	NADA	NW
BACKUP	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	EAST RESI
MANAGERS	TORI	TORI	TORI	TORI	TORI	TORI	MICHELE	MICHELE	MICHELE	MICHELE	MICHELE	MICHELE	MICHELE	TARNI	HBC
HBC support	KAREN	KAREN	VIRGINIA	VIRGINIA	VIRGINIA	VIRGINIA	VIRGINIA	VIRGINIA	VIRGINIA	KAREN	KAREN	KAREN	KAREN	KAREN	HBC s'port
Team Leader MARK	4.30 - 12am	3pm - 10pm. Recall @11pm & 8am-9am	7.30 - 11pm. Recall @12am & 8am-9am		10am - 6pm (Admin)	4.30 - 10pm & ReCall 11pm & 8am-9am					4.30 - 10pm & ReCall 11pm & 8am-9am		10am - 6pm (Admin)	10am - 6pm (Admin)	
Total Line Hours	7	7.5	4.5		7.5	6					6		7.5	7.5	53.5
Super-Melissah														Supervision	
Team Leader SANDRA			10am - 6pm (Admin)	4.30 - 12am	11am -7pm (Admin)	10am - 6pm (Avail by Phone)			9am - 5pm	10am - 6pm (Admin)		10am - 6pm (Admin)	4.30 - 12am		
Total Line Hours			7.5	7	7.5	7.5			7.5	7.5		7.5	7		59
Super-Melissah			Supervision												
SARAH	9am - 5pm	4.30 - 12am		7.30 - 11pm. Recall @12am & 8am-9am	Super 12pm-1.30pm and 2.30-4.30 Mtg	4.30 - 12am		4.30pm - 12am		4.30 - 12am					
Total Line Hours	7.5	7		4.5	4.5	7		7		7					44.5
Super-Sandra					12-1.30pm										
EMILY		9am - 5pm	3pm - 12am		2.30 - 4.30 Mtg & 4.30pm - 12.00am		4.30 - 12am			7.30 - 11pm. Recall @12am & 8am-9am	7.30 - 11pm. Recall @12am & 8am-9am	7pm - 10pm & ReCall 11pm & 8am-9am			
Total Line Hours		7.5	8.5		9		7			4.5	4.5	4			45
Super-Sandra			3.00-4.30pm												
LINDA					2.30-.4.30 Mtg			9am - 5pm	4.30 - 12am	Super 3pm - 4.30pm & 4.30 - 10pm. Recall @11pm & 8-9am		6pm - 11pm. Recall @12am & 8am-9am			
Total Line Hours					2			7.5	7	7.5		6			30
Super-Sandra										3pm - 4.30pm					
TAMMY					2.30 - 4.30 Mtg & 7.30 - 11pm. Recall @12am & 8am-9am	7.30 - 11pm. Recall @12am & 8am-9am			3pm - 10pm. Recall @11pm & 8am-9am		4.30 - 12am	4.30 - 12am	Super 6pm - 7.30pm & 7.30 - 11pm. Recall @12am & 8am-9am		
Total Line Hours					9	4.5			7.5		7	7	6		41
Super-Sandra													6 - 7.30pm		
TU			4.30 - 10pm & ReCall 11pm & 8am-9am		2.30 - 4.30 Tm Mtg & 4.30 - 10pm & ReCall 11pm & 8am-9am		4.30 - 10pm & ReCall 11pm & 8.30am-9.30am	7.30 - 11pm. Recall @12am & 8.30-9.30am	7.30 - 11pm. Recall @12am & 8am-9am				4.30 - 10pm & ReCall 11pm & 8am-9am		
Total Line Hours			6		8		6	4.5	4.5				6		35
Super-Mark			7.30 - 9pm												
PAUL				4.30 - 10pm & ReCall 11pm & 8am-9am	2.30-4.30 Team Mtg & 4.30-6PM Super (Dble Time)			4.30pm - 12am A/L		Active	Active	Active		4.30 - 12am	
Total Line Hours				6	3.5			7		6	6	6		7	41.5
Super-Mark					4.30-6PM										
VICTOR	7.30 - 11pm. Recall @12am & 8.30-9.30am	7.30 - 11pm. Recall @12am & 8.00-9.00am	Active		2.30-.430 Mtg and Super 4.30-6pm	Active	7.30 - 11pm. Recall @12am & 8.30-9.30am	Additional Shift		Active				7.30pm - 11pm & OnCall and 8.30am-9.30am	
Total Line Hrs	4.5	4.5	6		3.5	6	4.5			6				4.5	39.5
Super-Sandra					4.30 - 6pm										
BRENDAN	3pm - 10pm OnCall and 8.30am-9.30am				2.30-.4.30 Mtg			10am-3pm SUPPORT						4.30 - 10pm & ReCall 11pm & 8.30-9.30am	
Total Line Hrs	7.5				2			5						6	20.5
Super-Mark														4.30 - 6pm	
VACANT SHIFTS								3pm - 10pm OnCall and 8.30am-9.30am Victor							
Total Line Hrs								7.5							7.5
STAFF NAME:								VICTOR							
	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	
DATE:	7/09/2019	8/09/2019	9/09/2019	10/09/2019	11/09/2019	12/09/2019	13/09/2019	14/09/2019	15/09/2019	16/09/2019	17/09/2019	18/09/2019	19/09/2019	20/09/2019	
Active Outreach Practitioners NORTH WEST															
VICTOR			11.30pm - 6am			11.30pm - 6am				11.30pm - 6am					
Total Line Hrs			6			6				6					18
NICOLE	11.30pm - 6am	11.30pm - 6am		11.30pm - 6am	**1.30-2.30 Supervision** & 2.30-4.30 Mtg & 11.30pm - 6am		11.30pm - 6am				11.30pm - 6am	11.30pm - 6am			
Total Line Hrs	6	6		6	9		6				6	6			45
NW Main Road West					Supervision & 2.30-4.30 Mtg			11.30pm - 6am	11.30pm - 6am				11.30pm - 6am	11.30pm - 6am	
Total Line Hrs					3			6	6				6	6	27
STAFF NAME:								CHRISTINE	RICHARD				HENRY	RICHARD	
Active Outreach Practitioners SOUTH EAST															
PAUL										11.30pm - 6am	11.30pm - 6am	11.30pm - 6am			
Total Line Hrs										6	6	6			18
SE Kershaw Drive	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am				11.30pm - 6am	11.30pm - 6am	
Total Line Hrs	6	6	6	6	6	6	6	6	6				6	6	66
STAFF NAME:	RICKY	Kuda Mashatise Transitions	Njokuocha Ikechukwu	Njokuocha Ikechukwu	Njokuocha Ikechukwu	Tina S'ua	RICKY	Tina S'ua	Tina S'ua					RICKY	
SE Popes Road (Additional)					11pm-8am	11pm - 8am	11pm - 8am	11pm - 8am		11pm - 8am	11pm - 8am	11pm - 8am	11pm - 8am	11pm - 8am	
Total Line Hrs						8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	76.5
STAFF NAME:					Tina S'ua		Barnabas Tavu'i-leota (BWx)	Barnabas Tavu'i-leota (BWx)	Barnabas Tavu'i-leota (BWx)	Barnabas Tavu'i-leota (BWx)	Barnabas Tavu'i-leota (BWx)	Barnabas Tavu'i-leota (BWx)		Barnabas Tavu'i-leota (BWx)	

September
Wed 4th – through to – Sunday 15th

Works on Level 2 Refurb – Team can remain in Level 1, but will need to utilise bottom level car park as Level Car Park will be used by tradesman.
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Works on Level 2 Refurb - Office Closed – Plan for After Hours Team to all Work From Home.
October
Fri 4th

Annexure C.

MA000100<<PRxxxxx>>
FAIR WORK COMMISSION

DRAFT DETERMINATION

Fair Work Act 2009

s.156 - 4 yearly review of modern awards

4 yearly review of modern awards –
(AM2014/47)

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

[MA000100]

Social, Community, Home Care and Disability Services Industry

COMMISSION MEMBER PLACE, DATE

A. Further to the Decision issued by the Fair Work Commission on the above award is varied as follows:

1. By inserting the following words at clause 3.1:

   Workplace means a place where work is performed except for the employee's residence.

2. By deleting clause 25.3 and inserting a new clause 25.3 as follows:

   25.3 Rostered days off

   Employees, other than a casual employee, will be free from duty for not less than two full days in each week or four full days in each fortnight or eight full days in each 28 day cycle. Where practicable, days off will be consecutive. For the purposes of this sub-clause, duty includes time an employee is on call.

3. By deleting clause 28.4 and inserting a new clause 28.4 as follows

   28.4 Recalled to work overtime

   (a) An employee who is recalled to work overtime after leaving the workplace

and requested by their employer to attend a workplace in order to perform such overtime work will be paid for a minimum of two hours' work at the appropriate overtime rate for each time recalled. If the work required is completed in less than two hours the employee will be released from duty.

(b) An employee who is not required to be on call and who is requested to perform work by the employer via telephone or other electronic communication away from the workplace will be paid at the appropriate overtime rate for a minimum of two hours work. Multiple electronic requests made and concluded within the same hour shall be compensated within the same one hour's overtime payment. Time worked beyond two hours will be rounded to the nearest 15 minutes.

(c) An employee who is required to be on call and who is requested to perform work by the employer via telephone or other electronic communication away from the workplace will be paid at the appropriate overtime rate for a minimum of one hours work. Multiple electronic requests made and concluded within the same hour shall be compensated within the same one hour's overtime payment. Time worked beyond one hour will be rounded to the nearest 15 minutes.

B. The determination shall operate on and from [ ].

BY THE COMMISSION

IN THE FAIR WORK COMMISSION
Matter No.: AM2018/26

Four Yearly Review of Modern Awards - Social, Community, Home Care and Disability Services Industry Award 2010

AUSTRALIAN SERVICES UNION REPLY SUBMISSION TO UNION CLAIMS ON BROKEN SHIFTS AND TRAVEL TIME

Submitter:	David Smith, National Secretary
Organisation:	Australian Services Union
Address:	116 Queensberry Street Carlton South, Victoria, 3053
Phone:	03 9342 1400
Fax:	03 9342 1499
Email:	info@asu.asn.au
Date:	Wednesday 2 October, 2019

Contents

Attachment

Expert Report of Dr. Jim Stanford & Attachments A-H

Introduction

1. This submission is made in reply to various submissions filed by employer groups around the 16 September 2019 in opposition to the Australian Services Union's claims for paid travel time in the Social, Community, Homecare and Disability Services Industry Award 2010 (Award). They include submissions by the Australian Industry Group (AIG), the Australian Federation of Employers and Industries (AFEI), Australian Business Industrial et al(ABI) and the National Disability Services(NDS).

2. Our submission relies on the statements of Rob Steiner, Tracy Kinchin, Tino Encabo and Richard Rathbone (previously submitted). Furthermore, we rely on the Expert Report of Dr. Jim Stanford (attached) and are generally supported in our application by Jeffrey Owen Smith from People with Disability Australia.

3. The ASU notes that the HSU and United Voice have also proposed variations to Clause 25.6 of the Award. As we said in our submission dated 18/2/2019, 'if the Commission is not minded to make variations proposed by the ASU, we would support either one of the variations proposed by the other unions' (paragraph 34).

4. The ASU further notes that in their submissions the National Disability Services and the ABI et al suggest alternative proposals to the ASU to address the issues of broken shifts and travel times. If the Commission were not of a mind to accept the ASU proposals, the union would like the opportunity to make further submissions regarding any alternative proposals, including the one suggested by ABI et al.

The ASU Proposals

5. The ASU seeks to make two variations to the Award. Firstly, to vary Clause 25.6 Broken Shifts, so that an employee who works a broken shift will receive a loading of 15% of their ordinary

rate of pay. Secondly, the ASU supports the United Voice variation to create a new Clause 25.7 Travel Time, so that an employee required to work at different locations shall be paid at the appropriate rate for reasonable time of travel.

6. The ASU submits that the acceptance of these proposals would more properly remunerate already low paid employees and assist the disability sector, which is struggling to attract skilled, experienced and qualified staff because of the low conditions in the existing Award.

The Disability Services Workforce Profile

7. According to the Expert Report by Dr. Jim Stanford, the following are some of the characteristics of the Disability Services Workforce:
   - About 80% of employees work part-time while casual and fixed term account for over one half of all jobs;
   - Women account for about 70% of the workforce;
   - Fewer than 10% of the workforce are employed on a full-time permanent basis;
   - Turnover in the industry is very high with over 25% of workers changing jobs in one year; and,
   - average hours of work are low and highly variable with workers working an average of 22 hours per week. (Paragraph 18 Stanford Report)

8. This workforce can be characterised as highly casualised, female dominated with insecure work and low average hours. It is an industry where workers are low paid and often seek extra shifts just to make ends meet. This precarious work is exacerbated by the problem of discontinuous or split or broken shifts which are allowed under the current Award, where working days are split between increasingly multiple shorter shifts.

9. This is also further exacerbated by the behaviour of employers who, faced with fluctuating client demand for specific support services, "…are attempting to shift the resulting uncertainty and risk associated with these fluctuations in demand onto their employees, through the imposition

of increasingly insecure and unstable employment relationships, rostering practices, and compensation" (Paragraph 8 Stanford Report).[1] The effect of this on the employee according to Stanford can be that, "The time spent in travelling to and from work under these split or broken shifts, and the often wasted time between these short periods of work, (added emphasis) has the effect of greatly reducing the effective skill level hourly income associated with this work – as well as imposing considerable stress on the workers and their families." (Paragraph 29, Stanford Report)

10. The time spent travelling by the employee between broken shifts cannot be characterised as private time to conduct private affairs as advocated in the AFEI submission where the employee could "undertake social engagements, such as meeting friends for golf" (Paragraph 10, AFEI submission). This example would be risible if it wasn't for the serious effect of broken shifts on employees' working and family lives.

The SCHDS Award is already very flexible

11. The employers complain in their submissions that the union proposals are 'unjustifiable, but also manifestly unworkable' (Paragraph 50 AIG). They say that the union proposals will increase costs and administrative burdens for the employers while reducing rostering flexibility for both the employer and employee. However, the reality is that the Award already gives employers a significant amount of flexibility in arranging ordinary hours, rostering employees and paying employees for their time. In the ASU submissions dated 2 July 2019, the ASU gave a number of examples of this flexibility including that part-time employees are not paid overtime until they work 10 hours in a day, 38 hours in a week or 76 hours in a fortnight. In a sea of broken shifts and limited hours this seems a very high threshold before the employee qualifies for any overtime. Furthermore, there is no minimum engagement for part-time or full-time employees, while casual disability services employees are only entitled to a 2 hour minimum engagement and casual home care employees are only entitled to 1 hour minimum engagement. (Paragraph 31)

[1] See also Para 26 of the Stanford Report for further problems experienced by the workforce in this sector, such as disability service workers experiencing increased levels of violence in their work.

12. This theme is evidenced by Stanford's original research in his Expert Report. He finds that the Award has permitted the growing use of casual labour which lacks some basic protections in shift scheduling or entitlements (Paragraph 54(a)). The Award allows employers to assign "broken shifts" to both permanent and casual employees in disability services, with no penalty (Paragraph 54(c)). He also finds that given the fragmentation of work assignments under the NDIS this has meant "… the increasingly common requirement that DSW (workers) must travel to their clients – in some cases to multiple locations in the course of a day…" (added emphasis) (Paragraph 56). Stanford concludes by saying "Note that the hyper-flexibility permitted by the SCHDS Award in shift scheduling, short assignments, broken shifts, and required but uncompensated travel time serves to eliminate the incentive or pressure on employers to try to organise work in the most efficient and stable manner" (Paragraph 57).

13. Regarding the unions' Award variation proposals, Stanford concludes "To this end, I find the proposed amendments to the SCHDS Award to be modest, incremental and sensible. They would make a small but important difference in stabilising jobs and schedules, preventing further fragmentation of work, and somewhat improving fairness in compensation practices" (Paragraph 77). In other words, the modest reforms proposed by the Unions would improve the working lives of employees without significantly impacting the great flexibility and power employers already possess under the Award.

The Employer Submissions

14. The Commission should note that that the employer submissions are not ignorant of the plight of the employee working broken shifts and some of the implications for employees working in the disability services sector. In tis respect the AIG acknowledges the reality of discontinuous work for employees when it says, "In other instances, employees may, during the course of a single day, undertake work at different locations but at times which mean there is a substantial break between the time spent undertaking client work" (added emphasis) (Paragraph 4). Similarly the National Disability Service (NDS) submission also says that "… the NDS accepts

that there is the potential for this to be onerous on the employee where there are a number of such periods of travel and in particular where the portions of the shift are of a short duration" (Paragraph 35).

15. Furthermore, the National Disability Service (NDS) submission also recognises the difficult working environment of disability workers when it says "… the NDS is aware of international evidence of the risks of a market-based system such as the NDIS leading to employment practices that undermine reasonable minimum employment standards, resulting in high levels of employee turnover and deskilling of the workforce, resulting in a higher risk of abuse and neglect of clients" (Paragraph 9).

16. Nor should it be assumed by the Commission that employers are necessarily opposed to varying the Award so as to address the kind of issues the unions are concerned about. Thus the ABI et al submission says, "To the extent that Clause 25.6 (broken shifts) is capable of being applied in a manner that does not appropriately compensate employees for time spent travelling between clients' residencies when working broken shifts, our clients are not opposed to that issue being rectified".(added emphasis) (Paragraph 7.6) Similarly the NDS in its submission says, "However, to the extent that there is any doubt about payment for such travel under the current provisions of the award, NDS does not oppose a variation to clarify the situation (added emphasis) (Paragraph 26)

17. Thus the Commission should be encouraged that the employers are not necessarily opposed to variations to Clause 25.6 of the Award. In fact two of the employer submissions suggest solutions to ameliorate the conditions of disability workers working broken shifts. The NDS for example recognises that the Award sets no minimum engagement for part-time or full-time employees and only very limited engagement for casual home care employees and casual disability workers (Paragraph 37). It suggests the Commission may alleviate the problems associated with broken shifts "… by specifying a minimum engagement for each portion of a broken shift (which) could provide a basis for enduring reasonable compensation for associated travel during the break" (Paragraph 39).

18. The Unions have a separate application regarding minimum engagement under the Award and so will not comment further here. However the ASU notes that the NDS goes further by saying that if its minimum engagement suggestion was to fail it would support the idea of the ABI et al to pay an allowance for those working broken shifts (Paragraph 41)

19. The ABI et al submission is also sympathetic to varying the Award to improve the conditions of those employees working broken shifts by way of paying an allowance. It suggests providing a payment of an allowance at the rate of 3% of the ordinary hourly rate per kilometre travelled where employees were rostered to work with consecutive clients (Paragraph 9.4). The ABI et al argues that an allowance "… would appear to be a sensible way of compensating employees for time spent travelling during periods that are expressed in Clause 25.6 (a) as not being work time" (Paragraph 9.6).

20. The Commission should note that the employers are open to varying the Award regarding broken shifts by either having mandated minimum engagements for employees or compensating them via the payment of an allowance.

21. However, regarding the ABI's call for an allowance, this falls a long way short of the proposal advanced for an allowance by the ASU. The ASU seeks to vary Clause 25.6 Broken Shifts, so that an employee who works a broken shift will receive ordinary pay plus a loading of 15% of their ordinary rate of pay, for each hour from the commencement of the shift to the conclusion of the shift inclusive of all breaks.

22. This contrasts markedly with the ABI proposal where it intends to pay 3% of the ordinary hourly rate and only per kilometres travelled from one client to another. The proposed payment would only be made where the employee is rostered to work with consecutive clients. It does not seek to compensate the employee where the shifts are non-consecutive as the ASU proposal does.

23. The ABI proposal would amount to a small and inadequate compensation to the employee working broken shifts. The ASU would recommend for the Commission to adopt its model of allowance as compensation for all disability workers, but as we said in the introduction to this submission, if our proposal fails then the Union would like the opportunity to make further submissions regarding any alternative proposals, including the one suggested by the ABI et al.

24. Finally, the People with Disability Australia submission is generally supportive of the Unions' ambition to improve the working lives of disability workers. It says, "Devaluing the work of disability support workers devalues the lives of the people with disability they support" (Paragraph 18). It sees a direct correlation between the working conditions of disability employees and the welfare of its vulnerable clients in stating, "People with disability want to employ staff who are paid appropriately for their work… Resentful and disgruntled staff are more likely to be more difficult for people with disability to work with, influence high rates of staff turnover, and ultimately can result in people with disability being put at risk of harm" (Paragraph 13).

25. Furthermore, People with Disability Australia is opposed to employer applications to change the Award so as to remove overtime protections and changes to roster provisions, which it says makes disability support work an unattractive career path and lowers the level of skills and commitment required to do these critical jobs properly.

26. The ASU encourages the Commission when it reviews the views of the employer submissions to distinguish between the view of the AIG which opposes the unions' proposals in their totality without presenting a viable alternative, with those of the NDS and ABI et al who appreciate the difficulties of those workers who experience broken shifts and suggest viable alternatives which either support (through minimum engagement) or try to remunerate (through an allowance) this low paid, casualised and vulnerable workforce.

27. Furthermore, the Commission should heed the submission of the People with Disability Australia which, like the unions, supports a skilled, stable and properly remunerated workforce that would in turn be best equipped to deal with its sensitive clients.

Conclusion

28. The ASU respectfully submits that the Commission should vary the SCHDS Award to ensure that disability services and home care employees are paid for all time they spend travelling at the direction of their employer.

29. We have seen the Expert Report from Dr. Jim Stanford characterise these employees as a low paid, highly casualised, female dominated workforce who work fragmented shifts with limited hours. Stanford calls the ASU proposed variations to the Award "modest, incremental and sensible" and states that they would make a small but important difference in stabilising jobs and schedules and somewhat improving fairness in compensation practices. The Union proposals are also generally supported by the submission by People with Disability Australia, who like the Unions would like to see a properly remunerated workforce which is stable and skilled in carrying out its vital work with its vulnerable clients.

30. We have also shown that the employers do acknowledge some of the problems experienced by employees who work broken shifts. Furthermore, two of the employer submissions by NDS and ABI et al are open to variations to the Award and in fact suggest proposals to assist employees subject to broken shifts and the absence of travel time payments.

31. The ASU submits that its variations to the Award would ensure that employees are properly compensated for the disadvantage associated with working a broken shift under clause 25.6 without limiting any flexibility for the employer. Our proposed variations would preserve the employer's business model as well as increase the incentive to work in the disability services sector. This approach is consistent with the decision of the Commission in the *Penalty Rates Decision*, which found that deterrence was not a relevant consideration in setting a penalty rate.

Instead, penalties should be set at a rate that compensates for the disutility associated with the work.

32. The ASU encourages the Commission to adopt its proposed changes to the Award. It reminds the Commission that only 18 modern awards allow employers to engage employees on 'broken' or 'split' shifts. It is not a common clause. The ASU seeks to amend the clause so it more properly remunerates disability workers who experience discontinuous shifts. This will lead to a more stable, experienced and happier workforce that is better equipped to deal with the care of their clients.

BEFORE THE FAIR WORK COMMISSION

MATTER NO. AM2014/286

S. 156 - FOUR YEARLY REVIEW OF MODERN AWARDS – SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

Statement of Augustino Encabo

I, Augustino Alfonso Encabo, Support Worker, of [redacted], Western Australia, say;

1. I am a member of the Australian Services Union, Western Australia Branch.

2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. I was born on 15 August 1964, I am 54 years old.

4. I am married and I live with my wife.

My work history

5. Since 23 December 2015, I have worked as a Support Worker at the Community Living Association.

6. I have a completed a *Certificate IV in Disability Services*. I have also completed substantial in-house training while working in the industry, including leadership and development courses, medication administration, St John First Aid Awareness, and administration of PEG Feeding.

7. I have Bachelor of Arts from Edith Cowan and a Postgraduate Diploma in Business Administration from Curtin University.

8. My first experience with disability was caring for my first wife who had multiple sclerosis. This was in the early days of one-on-one disability care, so I did not have that much support to care for my wife. Everything I do now as a disability services worker, I now apply in my current job as a Disability Support Worker. I worked as a cook in the hospitality industry for 30 years, because this fitted around my caring responsibilities.

Current employment

9. On Since 21 December 2015, I commenced work with the Community Living Association (‘**CLA**’) as a as Disability Support Worker. I am a permanent part-time employee.

10. I am employed under the *Social, Community, Home Care and Disabilities Services Industry Award 2010* (**‘the Award’)**. I am classified as a Social and Community Services Employee Level 2.2.

11. My role is to assist my clients with their day to day living, engaging with the community, achieving their life goals and empowering them to make decisions. I do not simply provide services; I am expected to support people to improve their day-to-day skills so that they can live more independently and make their own decisions. I work with my clients on a one-on-one basis.

12. I have a wide range of duties, reflecting the fact that CLA provides support to people all types of disability. I have worked with people with physical and mental disabilities, each of whom have different needs.

13. I provide personal care to most clients. This includes assisting my clients with showering, cooking, cleaning and taking medication. However, while providing care I will work with them so that they learn how to better look after themselves. I might engage a client with planning their meals or teach them cooking skills. I might also support a client to be more responsible for their personal hygiene or taking their medication.

14. I will also assist my clients with day to day living; such as going to the shops or taking them out to engage with the community. Again, the focus of my role is to empower the client to make decisions and do things for themselves. For example, I do not just go to the shops to buy groceries for my clients. I might help my client work out a shopping list, figure out how much money they have in their budget and then help them to decide if they have enough money to pay for the things they want. At the shops, I will support them to find their items on the shelves and pay at the cashier.

15. Some of my clients need support with the activities they enjoy and to engage with the community. For example, a client may enjoy going to a café. Some clients might only need assistance with mobility or transport to the venue. But other clients may need support to develop social skills, such as ordering from a waiter or having a conversation at an appropriate volume.

16. There are many barriers that keep my clients from engaging in the community or achieving their goals. I will support my clients to overcome these barriers or advocate for their rights and basic human dignity. If we are at a restaurant, I might need to negotiate with the manager for a quieter space for a client with autism or extra room for a client in a wheelchair. I might also need to explain to a fellow customer that my client has a right to be at the restaurant, even if their disability means they behave in ways that are not always socially acceptable.

17. My clients do not live in residential facilities. They live in their own personal home or group homes with small groups of people with disability. This means I am required to travel between clients to work.

My hours of work

18. I am contracted to work 69 hours in each fortnight. My contracted days of work are Monday, Tuesday, Wednesday, Thursday, Saturday and Sunday. I work according to a fortnightly roster. Attached and marked **Annexure A** are copies of my roster for the period 24 September 2018 to 16 December 2018.

19. Although I have contracted hours of work, my actual hours of work change regularly. In the period between 24 September 2018 and 16 December 2018 I worked between 66 and 113 hours in each fortnight.

20. My contracted hours can be varied by agreement between me and CLA under clause 10.3(e) of the Award. I can also agree to work additional hours without overtime under clause 25.5 (iii) of the Award. These additional hours do not have to be continuous with my contracted ordinary hours of work. I am regularly rostered on broken shifts at short notice when my employer needs me to cover a shift.

21. I often agree to additional hours or roster changes, even if they do not suit me, because I am worried that my employer will not offer me additional hours of work in the future. Even

though they say I can refuse these hours, but if I refuse the shifts I am given, I cannot earn enough money to support my family.

22. I am not rostered for meal breaks because I am required to have meals with my clients under clause 27.1(c) of the Award.

23. I am not entitled to a minimum engagement because I am a permanent part-time employee. I am regularly engaged to work for short periods of time. For example, I am engaged to work for one hour between 2:45PM and 3:45PM on Thursdays.

24. I am rostered for broken shifts under clause 25.6 of the Award. My employer can, and does, break my engagements so that I am not engaged to work when I am travelling between clients. My union has negotiated an above-award allowance for travel time equal to 15 minutes work at ordinary time rates, regardless of the time actually taken to travel. Because this is an allowance it does not count as time worked.

25. For example, I am rostered on a broken shift every Monday. I work from 9.30AM to 2.30PM at one client's house. I am required to have a meal with the client, so I am not rostered a meal break. I am then engaged to work another shift from 3.00PM to 5.00PM at another client's house. I have a half hour unpaid break between 2.30PM and 3.30PM.

26. I cannot understand why I cannot be rostered for a normal 8 hour shift. I think the broken shift provision encourages bad rostering practices. I know this because my shift was originally rostered when my client was attending school. I was engaged to care for him after he finished school. My client hasn't attended school for a few years, but someone else has been rostered between 9.30AM and 3.00PM. Another worker has been rostered for a sleepover shift after 5.00PM. If my employer wasn't permitted to engage me on broken shifts, I could have an 8 hour continuous shift. Instead I have a half hour unpaid break and a 2 hour 'left over' shift. If you add up all the little half hours over the years I have worked there, I have wasted a lot of time.

27. I also regularly work sleep overs under clause 25.7 of the Award. I work between 3 and 4 sleepover shifts each fortnight. Sometimes I am rostered a morning shift before afternoon shift that is rostered next to a sleepover. I come off work at 8.30AM and start work again at 5.00PM. I have an 8 hour break between shifts, but it's not like I have 8 hours to do what I want. I am not super human and I need sleep. After resting, I really only have 3 hours before I need to start work again.

My income and expenses

28. My pay varies considerably because I rely on additional hours to increase my income. In an normal week I earn between $2,400 and $3,000 per fortnight after tax. Attached and marked **Annexure B** are copies of my payslips for the period 24 September 2018 to 2 December 2018.

29. My employer offers salary packaging. This allows me to pay for some essential items out of my pre-tax salary. This helps, but does not completely fix the problems with a low rate of pay.

30. My wife is self-employed as a portrait photographer. The amount she earns each week depends on how many clients she can book. On average, she brings home about $500 each week after tax and business expenses.

31. We are just keeping our head above board, we are living mostly pay check to pay check, with a little put away for a holiday and the future. If a big bill comes in, we would have trouble

paying it. We would have trouble if something unexpected happened, like my partner being hospitalised or our car breaking down.

My problems with working broken shifts

32. My pattern of work significantly interferes with my time with my friends and family, my hobbies and my involvement in the community. I am always trying to get more hours so I can earn more money. The breaks in my shifts just mean I have to work more hours and longer spans of hours to make the same money I would if I was rostered continuously. I work very long hours, and this is very tiring.

33. My wife works during the days, so if I am working nights, we just pass by each other by. Sometimes I do not see her for a few days. Even If she is home while I am on a broken shift, we can't spend that time together because she needs to do her work. She is not happy with my working hours and is encouraging me to leave the disability sector.

34. The breaks between shifts are also a problem. Often, there is not enough time to go home from work and then get to the next workplace. Other times it's just not cost effective to go home because of the cost of fuel. If I can't go home, I will I would head to the library to read for a bit. This is not what I really want to do with my time; it's just all I can do in the time available. If I am able to go home, I am usually only there for about an hour after travelling between clients. It's not really enough time to do anything useful or have a real rest.

35. I find it hard to maintain friendships or participate in the community, because I work long and irregular hours. No groups meet in the middle of the day. I can't join the bowls club because they compete on a Saturday when I am working. I joined a photography club, and attended one meeting, but I quit because I was working all the other meeting times. I would like to join a bushwalking group, but they go walking at time I am working. I also enjoy fishing, but I cannot find the time to fit it in. I cannot use my breaks between shifts to socialise because most people are working when I have my breaks.

36. I do not think I could get a second job. I need to ask for permission to work for another organisation, and it cannot conflict with my employer's rostering needs. In any case, I do not really want a second job. I need a job with consistent and stable hours that gives me the income I need to support my family.

My problems with working broken shifts

37. I have considered leaving the disability sector. I am unsure how long I can keep working this pattern of work. Some days I reach my limit, but sometimes I think I can keep doing this. My wife wants me to find another job. I am staying because I get so much out of supporting people with disability. I have strong emotional attachments to my work and the people I support. I have been an advocate for people with a disability since I was caring for my first wife. My connection to this sector is deeply personal.

38. I love the actual job that I do, but I want some consistency in hours, with full shifts during the day. I would like to be able to support myself and my family without working such long shifts over such irregular hours.

39. I have been shown the variation proposed by the Australian Services Union. If I was paid a 15 percent loading when I was engaged to work a broken shift, it would increase my income. If my income increased I would need to work fewer hours to make the same amount of money. I would need to work fewer night and weekend shifts. I would be able to see my wife more. I might even be able to join a photography or bushwalking club.

[redacted]

WITNESS SIGNATURE

AUGUSTINO ALFONSO ENCABO

WITNESS NAME

DATE: 13/02/2019

Community Living Association Inc

Staff Roster

ENCABO AUGUSTINO | **003** | Period Ending :07/10/2018 | Printed : 01/10/2018 10:59 am | Page Number : 1

				Activity	In	Out	Dur'n	T/Time	Kms	Signature
Monday 24-Sep-2018										
09:30	**- 14:30**	**05:00**	**ROLJIC EUGENE**	**DSC-SGL-DAY**						
14:45	**- 15:00**	**00:15**	**STF-TRAVEL TIME**							
15:00	**- 17:00**	**02:00**	**BERESI ANTHONY**	**DSC-SGL-DAY**						
Tuesday 25-Sep-2018										
15:00	**- 21:00**	**06:00**	**MARSHALL STEVEN**	**DSC-SGL-AFTERNOON**						
Wednesday 26-Sep-2018										
16:30	**- 22:00**	**05:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
22:00	**- 00:00**	**02:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
Thursday 27-Sep-2018										
00:00	**- 06:00**	**06:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
06:00	**- 08:30**	**02:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
Monday 01-Oct-2018										
09:30	**- 10:00**	**00:30**	**ROLJIC EUGENE**	**DSC-SGL-DAY**						
10:00	**- 12:00**	**02:00**	**ROLJIC EUGENE**	**DSC-GRP-DAY**						
12:00	**- 13:00**	**01:00**	**ROLJIC EUGENE**	**DSC-GRP-DAY**						
13:00	**- 14:30**	**01:30**	**ROLJIC EUGENE**	**DSC-SGL-DAY**						
14:45	**- 15:00**	**00:15**	**STF-TRAVEL TIME**							
15:00	**- 17:00**	**02:00**	**BERESI ANTHONY**	**DSC-SGL-DAY**						
Tuesday 02-Oct-2018										

Community Living Association Inc

Staff Roster

ENCABO AUGUSTINO | **003** | Period Ending :07/10/2018 | Printed : 01/10/2018 10:59 am | Page Number : 2

				Activity	In	Out	Dur'n	T/Time	Kms	Signature
15:00	**- 21:00**	**06:00**	**MARSHALL STEVEN**	**DSC-SGL-AFTERNOON**						
Wednesday 03-Oct-2018										
16:30	**- 22:00**	**05:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
22:00	**- 00:00**	**02:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
Thursday 04-Oct-2018										
00:00	**- 06:00**	**06:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
06:00	**- 08:30**	**02:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
14:45	**- 15:45**	**01:00**	**MARSHALL STEVEN**	**RAD-CASE PLANNING-DSC**						
Saturday 06-Oct-2018										
08:30	**- 16:30**	**08:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SATURDAY**						
Sunday 07-Oct-2018										
09:00	**- 13:00**	**04:00**	**BERESI ANTHONY**	**DSC-SGL-SUNDAY**						
13:00	**- 17:00**	**04:00**	**BERESI ANTHONY**	**DSC-SGL-SUNDAY**						

Hours Total : 75.50 **Staff Signature :** _____ **Approved By :** _____ **Data Entry :** _____

Kms Total :

Notifications :

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :21/10/2018 | Printed : 16/10/2018 05:03 pm | Page Number : 1

				In	Out	Dur'n	T/Time	Kms	**Signature**
Monday	**08-Oct-2018**								
09:30 am	**10:00 am**	**00:30**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290						
10:00 am	**12:00 pm**	**02:00**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290						
12:00 pm	**01:00 pm**	**01:00**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290						
01:00 pm	**02:30 pm**	**01:30**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290						
02:45 pm	**03:00 pm**	**00:15**	**STF-TRAVEL TIME**						
03:00 pm	**05:00 pm**	**02:00**	**BERESI ANTHONY** 20 Pegasus Boulevard MCKAIL 6330 P.9842 9834						
05:45 pm	**06:00 pm**	**00:15**	**STF-TRAVEL TIME**						
06:00 pm	**09:30 pm**	**03:30**	**WATMORE LIAM** Unit 6 213 Albany Hwy ALBANY 6330 P.0438 255 797						
09:30 pm	**10:00 pm**	**00:30**	**STF-ADMINISTRATION**						
09:30 pm	**10:00 pm**	**00:30**	**WATMORE LIAM** Unit 6 213 Albany Hwy ALBANY 6330 P.0438 255 797						
10:00 pm	**12:00 am**	**02:00**	**WATMORE LIAM** Unit 6 213 Albany Hwy ALBANY 6330 P.0438 255 797						

Daily Hours **14.00** hh:mm **14:00**

Community Living Association Inc

Staff Roster

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ENCABO AUGUSTINO | **003** | Period Ending :21/10/2018 | Printed : 16/10/2018 05:03 pm | Page Number : 2

			In	Out	Dur'n	T/Time	Kms	**Signature**

Tuesday 09-Oct-2018

12:00 am - 06:00 am **06:00** **WATMORE LIAM**
Unit 6 213 Albany Hwy ALBANY 6330 P.0438 255 797

03:00 pm - 09:00 pm **06:00** **MARSHALL STEVEN**
Unit 9 Maley Place, Spencer Park ALBANY 6330

Daily Hours **12.00** hh:mm **12:00**

Wednesday 10-Oct-2018

04:30 pm - 10:00 pm **05:30** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

10:00 pm - 12:00 am **02:00** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

Daily Hours **7.50** hh:mm **07:30**

Thursday 11-Oct-2018

12:00 am - 06:00 am **06:00** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

06:00 am - 08:30 am **02:30** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

Daily Hours **8.50** hh:mm **08:30**

Saturday 13-Oct-2018

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :21/10/2018 | Printed : 16/10/2018 05:03 pm | Page Number : 3

				In	Out	Dur'n	T/Time	Kms	**Signature**
09:00 am - 05:00 pm	**08:00**	**COOPER STEPHEN** 37 Paterson St DENMARK 6333 P.9848 3805							
Daily Hours	**8.00**	hh:mm	**08:00**						

Sunday 14-Oct-2018

01:00 pm - 05:00 pm	**04:00**	**BERESI ANTHONY** 20 Pegasus Boulevard MCKAIL 6330 P.9842 9834							
Daily Hours	**4.00**	hh:mm	**04:00**						

Monday 15-Oct-2018

08:30 am - 04:30 pm	**08:00**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573							
Daily Hours	**8.00**	hh:mm	**08:00**						

Tuesday 16-Oct-2018

03:00 pm - 06:30 pm	**03:30**	**MARSHALL STEVEN** Unit 9 Maley Place, Spencer Park ALBANY 6330							
06:45 pm - 07:00 pm	**00:15**	**STF-TRAVEL TIME**							
07:00 pm - 10:00 pm	**03:00**	**GREY CAMERON** 2 Hogarth St MCKAIL 6330 P.2 Hogarth St Mckail 6330							
10:00 pm - 12:00 am	**02:00**	**GREY CAMERON** 2 Hogarth St MCKAIL 6330 P.2 Hogarth St Mckail 6330							
Daily Hours	**8.75**	hh:mm	**08:45**						

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :21/10/2018 | Printed : 16/10/2018 05:03 pm | Page Number : 4

			In	Out	Dur'n	T/Time	Kms	**Signature**
Wednesday 17-Oct-2018								
12:00 am - 06:00 am	**06:00**	**GREY CAMERON** 2 Hogarth St MCKAIL 6330 P.2 Hogarth St Mckail 6330						
06:00 am - 08:15 am	**02:15**	**STF-ADMINISTRATION**						
06:00 am - 08:15 am	**02:15**	**GREY CAMERON** 2 Hogarth St MCKAIL 6330 P.2 Hogarth St Mckail 6330						
04:30 pm - 10:00 pm	**05:30**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573						
10:00 pm - 12:00 am	**02:00**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573						
Daily Hours	**18.00** hh:mm	**18:00**						
Thursday 18-Oct-2018								
12:00 am - 06:00 am	**06:00**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573						
06:00 am - 08:30 am	**02:30**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573						
Daily Hours	**8.50** hh:mm	**08:30**						
Saturday 20-Oct-2018								
08:30 am - 04:30 pm	**08:00**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573						
Daily Hours	**8.00** hh:mm	**08:00**						

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :21/10/2018 | Printed : 16/10/2018 05:03 pm | Page Number : 5

	In	Out	Dur'n	T/Time	Kms	**Signature**

Sunday 21-Oct-2018

09:00 am - 01:00 pm 04:00 **BERESI ANTHONY**
20 Pegasus Boulevard MCKAIL 6330 P.9842 9834

01:00 pm - 05:00 pm 04:00 **BERESI ANTHONY**
20 Pegasus Boulevard MCKAIL 6330 P.9842 9834

Daily Hours **8.00** hh:mm **08:00**

Hours Total : **113.25**
Kms Total :

Staff Signature : _____ **Approved By :** _____ **Data Entry :** _____

Notifications :

Community Living Association Inc

Staff Roster

ENCABO AUGUSTINO | **003** | Period Ending :04/11/2018 | Printed : 18/10/2018 02:16 pm | Page Number : 1

			Activity	In	Out	Dur'n	T/Time	Kms	Signature
Monday	**22-Oct-2018**								
09:30 am	**10:00 am**	**00:30**	**ROLJIC EUGENE** **DSC-SGL-DAY**						
10:00 am	**12:00 pm**	**02:00**	**ROLJIC EUGENE** **DSC-GRP-DAY**						
12:00 pm	**01:00 pm**	**01:00**	**ROLJIC EUGENE** **DSC-GRP-DAY**						
01:00 pm	**02:30 pm**	**01:30**	**ROLJIC EUGENE** **DSC-SGL-DAY**						
02:45 pm	**03:00 pm**	**00:15**	**STF-TRAVEL TIME**						
03:00 pm	**05:00 pm**	**02:00**	**BERESI ANTHONY** **DSC-SGL-DAY**						
Daily Hours	**7.25**	hh:mm	**07:15**						
Tuesday	**23-Oct-2018**								
03:00 pm	**09:00 pm**	**06:00**	**MARSHALL STEVEN** **DSC-SGL-AFTERNOON**						
Daily Hours	**6.00**	hh:mm	**06:00**						
Wednesday	**24-Oct-2018**								
10:00 am	**11:00 am**	**01:00**	**COOPER STEPHEN** **RAD-CASE PLANNING-DSC**						
04:30 pm	**10:00 pm**	**05:30**	**JOHNSON ZOEY DAVID** **DSC-SGL-NIGHT**						
10:00 pm	**12:00 am**	**02:00**	**JOHNSON ZOEY DAVID** **DSC-SGL-SLEEPOVER ALLOWANCE**						
Daily Hours	**8.50**	hh:mm	**08:30**						
Thursday	**25-Oct-2018**								
12:00 am	**06:00 am**	**06:00**	**JOHNSON ZOEY DAVID** **DSC-SGL-SLEEPOVER ALLOWANCE**						
06:00 am	**08:30 am**	**02:30**	**JOHNSON ZOEY DAVID** **DSC-SGL-NIGHT**						
Daily Hours	**8.50**	hh:mm	**08:30**						

Community Living Association Inc

Staff Roster

ENCABO AUGUSTINO | **003** | Period Ending :04/11/2018 | Printed : 18/10/2018 02:16 pm | Page Number : 2

			Activity	In	Out	Dur'n	T/Time	Kms	Signature
Saturday 27-Oct-2018									
09:00 am	**05:00 pm**	**08:00**	**COOPER STEPHEN**	**DSC-SGL-SATURDAY**					
Daily Hours	**8.00**	hh:mm	**08:00**						
Sunday 28-Oct-2018									
01:00 pm	**05:00 pm**	**04:00**	**BERESI ANTHONY**	**DSC-SGL-SUNDAY**					
Daily Hours	**4.00**	hh:mm	**04:00**						
Monday 29-Oct-2018									
09:30 am	**10:00 am**	**00:30**	**ROLJIC EUGENE**	**DSC-SGL-DAY**					
10:00 am	**12:00 pm**	**02:00**	**ROLJIC EUGENE**	**DSC-GRP-DAY**					
12:00 pm	**01:00 pm**	**01:00**	**ROLJIC EUGENE**	**DSC-GRP-DAY**					
01:00 pm	**02:30 pm**	**01:30**	**ROLJIC EUGENE**	**DSC-SGL-DAY**					
02:45 pm	**03:00 pm**	**00:15**	**STF-TRAVEL TIME**						
03:00 pm	**05:00 pm**	**02:00**	**BERESI ANTHONY**	**DSC-SGL-DAY**					
Daily Hours	**7.25**	hh:mm	**07:15**						
Tuesday 30-Oct-2018									
03:00 pm	**09:00 pm**	**06:00**	**MARSHALL STEVEN**	**DSC-SGL-AFTERNOON**					
Daily Hours	**6.00**	hh:mm	**06:00**						
Wednesday 31-Oct-2018									
04:30 pm	**10:00 pm**	**05:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**					
10:00 pm	**12:00 am**	**02:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**					

Community Living Association Inc

Staff Roster

ENCABO AUGUSTINO | **003** | Period Ending :04/11/2018 | Printed : 18/10/2018 02:16 pm | Page Number : 3

	Activity			In	Out	Dur'n	T/Time	Kms	Signature
Daily Hours	**7.50**	hh:mm	**07:30**						
Thursday 01-Nov-2018									
12:00 am - 06:00 am	**06:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
06:00 am - 08:30 am	**02:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
Daily Hours	**8.50**	hh:mm	**08:30**						
Saturday 03-Nov-2018									
08:30 am - 04:30 pm	**08:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SATURDAY**						
Daily Hours	**8.00**	hh:mm	**08:00**						
Sunday 04-Nov-2018									
09:00 am - 01:00 pm	**04:00**	**BERESI ANTHONY**	**DSC-SGL-SUNDAY**						
Daily Hours	**4.00**	hh:mm	**04:00**						

Hours Total : 83.50

Kms Total :

Staff Signature : _____ **Approved By :** _____ **Data Entry :** _____

Notifications :

PLEASE SUBMIT THIS TIMESHEET BY 12 NOON Monday 5 th NOVEMBER 2018 **
PLEASE ENSURE YOU SIGN YOUR TIMESHEET BEFORE SUBMITTING####

Community Living Association Inc

Staff Roster

ENCABO AUGUSTINO | **003** | Period Ending :04/11/2018 | Printed : 18/10/2018 02:16 pm | Page Number : 1

		Activity		In	Out	Dur'n	T/Time	Kms	Signature
Monday	**22-Oct-2018**								
09:30 am	**10:00 am** **00:30**	**ROLJIC EUGENE**	**DSC-SGL-DAY**						
10:00 am	**12:00 pm** **02:00**	**ROLJIC EUGENE**	**DSC-GRP-DAY**						
12:00 pm	**01:00 pm** **01:00**	**ROLJIC EUGENE**	**DSC-GRP-DAY**						
01:00 pm	**02:30 pm** **01:30**	**ROLJIC EUGENE**	**DSC-SGL-DAY**						
02:45 pm	**03:00 pm** **00:15**	**STF-TRAVEL TIME**							
03:00 pm	**05:00 pm** **02:00**	**BERESI ANTHONY**	**DSC-SGL-DAY**						
Daily Hours	**7.25** hh:mm	**07:15**							
Tuesday	**23-Oct-2018**								
03:00 pm	**09:00 pm** **06:00**	**MARSHALL STEVEN**	**DSC-SGL-AFTERNOON**						
Daily Hours	**6.00** hh:mm	**06:00**							
Wednesday	**24-Oct-2018**								
10:00 am	**11:00 am** **01:00**	**COOPER STEPHEN**	**RAD-CASE PLANNING-DSC**						
04:30 pm	**10:00 pm** **05:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
10:00 pm	**12:00 am** **02:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
Daily Hours	**8.50** hh:mm	**08:30**							
Thursday	**25-Oct-2018**								
12:00 am	**06:00 am** **06:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
06:00 am	**08:30 am** **02:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
Daily Hours	**8.50** hh:mm	**08:30**							

Community Living Association Inc

Staff Roster

ENCABO AUGUSTINO | **003** | Period Ending :04/11/2018 | Printed : 18/10/2018 02:16 pm | Page Number : 2

			Activity	In	Out	Dur'n	T/Time	Kms	Signature
Saturday 27-Oct-2018									
09:00 am	**- 05:00 pm**	**08:00**	**COOPER STEPHEN**	**DSC-SGL-SATURDAY**					
Daily Hours	**8.00**	hh:mm	**08:00**						
Sunday 28-Oct-2018									
01:00 pm	**- 05:00 pm**	**04:00**	**BERESI ANTHONY**	**DSC-SGL-SUNDAY**					
Daily Hours	**4.00**	hh:mm	**04:00**						
Monday 29-Oct-2018									
09:30 am	**- 10:00 am**	**00:30**	**ROLJIC EUGENE**	**DSC-SGL-DAY**					
10:00 am	**- 12:00 pm**	**02:00**	**ROLJIC EUGENE**	**DSC-GRP-DAY**					
12:00 pm	**- 01:00 pm**	**01:00**	**ROLJIC EUGENE**	**DSC-GRP-DAY**					
01:00 pm	**- 02:30 pm**	**01:30**	**ROLJIC EUGENE**	**DSC-SGL-DAY**					
02:45 pm	**- 03:00 pm**	**00:15**	**STF-TRAVEL TIME**						
03:00 pm	**- 05:00 pm**	**02:00**	**BERESI ANTHONY**	**DSC-SGL-DAY**					
Daily Hours	**7.25**	hh:mm	**07:15**						
Tuesday 30-Oct-2018									
03:00 pm	**- 09:00 pm**	**06:00**	**MARSHALL STEVEN**	**DSC-SGL-AFTERNOON**					
Daily Hours	**6.00**	hh:mm	**06:00**						
Wednesday 31-Oct-2018									
04:30 pm	**- 10:00 pm**	**05:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**					
10:00 pm	**- 12:00 am**	**02:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**					

Community Living Association Inc

Staff Roster

ENCABO AUGUSTINO | **003** | Period Ending :04/11/2018 | Printed : 18/10/2018 02:16 pm | Page Number : 3

	Activity			In	Out	Dur'n	T/Time	Kms	Signature
Daily Hours	**7.50**	hh:mm	**07:30**						
Thursday 01-Nov-2018									
12:00 am - 06:00 am	**06:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
06:00 am - 08:30 am	**02:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
Daily Hours	**8.50**	hh:mm	**08:30**						
Saturday 03-Nov-2018									
08:30 am - 04:30 pm	**08:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SATURDAY**						
Daily Hours	**8.00**	hh:mm	**08:00**						
Sunday 04-Nov-2018									
09:00 am - 01:00 pm	**04:00**	**BERESI ANTHONY**	**DSC-SGL-SUNDAY**						
Daily Hours	**4.00**	hh:mm	**04:00**						

Hours Total : 83.50

Kms Total :

Staff Signature : _____ **Approved By :** _____ **Data Entry :** _____

Notifications :

PLEASE SUBMIT THIS TIMESHEET BY 12 NOON Monday 5 th NOVEMBER 2018 **
PLEASE ENSURE YOU SIGN YOUR TIMESHEET BEFORE SUBMITTING####

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :18/11/2018 | Printed : 08/11/2018 02:28 pm | Page Number : 1

			In	Out	Dur'n	T/Time	Kms	**Signature**
Monday	**05-Nov-2018**							
09:30 am - 10:00 am	**00:30**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290						
10:00 am - 12:00 pm	**02:00**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290						
12:00 pm - 01:00 pm	**01:00**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290						
01:00 pm - 02:30 pm	**01:30**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290						
02:45 pm - 03:00 pm	**00:15**	**STF-TRAVEL TIME**						
03:00 pm - 05:00 pm	**02:00**	**BERESI ANTHONY** 20 Pegasus Boulevard MCKAIL 6330 P.9842 9834						
Daily Hours	**7.25**	hh:mm **07:15**						
Tuesday	**06-Nov-2018**							
03:00 pm - 09:00 pm	**06:00**	**MARSHALL STEVEN** Unit 9 Maley Place, Spencer Park ALBANY 6330						
Daily Hours	**6.00**	hh:mm **06:00**						
Thursday	**08-Nov-2018**							
07:00 am - 04:30 pm	**09:30**	**STF-PERSONAL LEAVE**						
Daily Hours	**9.50**	hh:mm **09:30**						

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :18/11/2018 | Printed : 08/11/2018 02:28 pm | Page Number : 2

			In	Out	Dur'n	T/Time	Kms	**Signature**

Saturday 10-Nov-2018

09:00 am - 05:00 pm 08:00 **BERESI ANTHONY**
20 Pegasus Boulevard MCKAIL 6330 P.9842 9834

Daily Hours **8.00** hh:mm **08:00**

Sunday 11-Nov-2018

01:00 pm - 05:00 pm 04:00 **BERESI ANTHONY**
20 Pegasus Boulevard MCKAIL 6330 P.9842 9834

Daily Hours **4.00** hh:mm **04:00**

Monday 12-Nov-2018

09:30 am - 10:00 am 00:30 **ROLJIC EUGENE**
128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290

10:00 am - 12:00 pm 02:00 **ROLJIC EUGENE**
128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290

12:00 pm - 01:00 pm 01:00 **ROLJIC EUGENE**
128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290

01:00 pm - 02:30 pm 01:30 **ROLJIC EUGENE**
128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290

02:45 pm - 03:00 pm 00:15 **STF-TRAVEL TIME**

03:00 pm - 05:00 pm 02:00 **BERESI ANTHONY**
20 Pegasus Boulevard MCKAIL 6330 P.9842 9834

Daily Hours **7.25** hh:mm **07:15**

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :18/11/2018 | Printed : 08/11/2018 02:28 pm | Page Number : 3

			In	Out	Dur'n	T/Time	Kms	**Signature**

Tuesday 13-Nov-2018

08:30 am - 04:30 pm **08:00** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

Daily Hours **8.00** hh:mm **08:00**

Wednesday 14-Nov-2018

04:30 pm - 10:00 pm **05:30** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

10:00 pm - 12:00 am **02:00** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

Daily Hours **7.50** hh:mm **07:30**

Thursday 15-Nov-2018

12:00 am - 06:00 am **06:00** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

06:00 am - 08:30 am **02:30** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

Daily Hours **8.50** hh:mm **08:30**

Saturday 17-Nov-2018

08:30 am - 04:30 pm **08:00** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

Daily Hours **8.00** hh:mm **08:00**

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :18/11/2018 | Printed : 08/11/2018 02:28 pm | Page Number : 4

	In	Out	Dur'n	T/Time	Kms	**Signature**

Sunday 18-Nov-2018

09:00 am - 01:00 pm 04:00 **BERESI ANTHONY**
20 Pegasus Boulevard MCKAIL 6330 P.9842 9834

Daily Hours **4.00** hh:mm **04:00**

Hours Total : **78.00**
Kms Total :

Staff Signature : _____ **Approved By :** _____ **Data Entry :** _____

Notifications :

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :02/12/2018 | Printed : 20/11/2018 10:11 am | Page Number : 1

			In	Out	Dur'n	T/Time	Kms	**Signature**

Monday 19-Nov-2018

08:30 am - 04:30 pm **08:00** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

Daily Hours **8.00** hh:mm **08:00**

Tuesday 20-Nov-2018

01:00 pm - 05:00 pm **04:00** **WATMORE LIAM**
Unit 6 213 Albany Hwy ALBANY 6330 P.0438 255 797

Daily Hours **4.00** hh:mm **04:00**

Wednesday 21-Nov-2018

08:00 am - 09:00 am **01:00** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

04:30 pm - 10:00 pm **05:30** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

10:00 pm - 12:00 am **02:00** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

Daily Hours **8.50** hh:mm **08:30**

Thursday 22-Nov-2018

12:00 am - 06:00 am **06:00** **JOHNSON ZOEY DAVID**
22 Admiral Street ALBANY 6330 P.08 9842 5573

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :02/12/2018 | Printed : 20/11/2018 10:11 am | Page Number : 2

				In	Out	Dur'n	T/Time	Kms	**Signature**
06:00 am - 08:30 am	**02:30**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573							
Daily Hours	**8.50**	hh:mm	**08:30**						
Saturday 24-Nov-2018									
08:30 am - 05:00 pm	**08:30**	**COOPER STEPHEN** 37 Paterson St DENMARK 6333 P.9848 3805							
Daily Hours	**8.50**	hh:mm	**08:30**						
Sunday 25-Nov-2018									
01:00 pm - 05:00 pm	**04:00**	**BERESI ANTHONY** 20 Pegasus Boulevard MCKAIL 6330 P.9842 9834							
Daily Hours	**4.00**	hh:mm	**04:00**						
Monday 26-Nov-2018									
09:30 am - 10:00 am	**00:30**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290							
10:00 am - 12:00 pm	**02:00**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290							
12:00 pm - 01:00 pm	**01:00**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290							
01:00 pm - 02:30 pm	**01:30**	**ROLJIC EUGENE** 128 Frenchman Bay Rd ALBANY 6330 P.08 9841 7290							
02:45 pm - 03:00 pm	**00:15**	**STF-TRAVEL TIME**							

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :02/12/2018 | Printed : 20/11/2018 10:11 am | Page Number : 3

			In	Out	Dur'n	T/Time	Kms	**Signature**
03:00 pm - 05:00 pm	**02:00**	**BERESI ANTHONY** 20 Pegasus Boulevard MCKAIL 6330 P.9842 9834						

Daily Hours **7.25** hh:mm **07:15**

Wednesday 28-Nov-2018

04:30 pm - 10:00 pm	**05:30**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573						
10:00 pm - 12:00 am	**02:00**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573						

Daily Hours **7.50** hh:mm **07:30**

Thursday 29-Nov-2018

12:00 am - 06:00 am	**06:00**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573						
06:00 am - 08:30 am	**02:30**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573						

Daily Hours **8.50** hh:mm **08:30**

Saturday 01-Dec-2018

08:30 am - 04:30 pm	**08:00**	**JOHNSON ZOEY DAVID** 22 Admiral Street ALBANY 6330 P.08 9842 5573						

Daily Hours **8.00** hh:mm **08:00**

Sunday 02-Dec-2018

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

ENCABO AUGUSTINO | **003** | Period Ending :02/12/2018 | Printed : 20/11/2018 10:11 am | Page Number : 4

		In	Out	Dur'n	T/Time	Kms	**Signature**
09:00 am - 01:00 pm 04:00	**BERESI ANTHONY** 20 Pegasus Boulevard MCKAIL 6330 P.9842 9834						

Daily Hours **4.00** hh:mm **04:00**

Hours Total : **76.75**

Kms Total :

Staff Signature : _____ **Approved By :** _____ **Data Entry :** _____

Notifications :

Community Living Association Inc

Staff Roster

ENCABO AUGUSTINO | **003** | Period Ending :16/12/2018 | Printed : 29/11/2018 03:21 pm | Page Number : 1

		Activity		In	Out	Dur'n	T/Time	Kms	Signature
Monday	**03-Dec-2018**								
09:30 am	**10:00 am**	**00:30**	**ROLJIC EUGENE**	**DSC-SGL-DAY**					
10:00 am	**12:00 pm**	**02:00**	**ROLJIC EUGENE**	**DSC-GRP-DAY**					
12:00 pm	**01:00 pm**	**01:00**	**ROLJIC EUGENE**	**DSC-GRP-DAY**					
01:00 pm	**02:30 pm**	**01:30**	**ROLJIC EUGENE**	**DSC-SGL-DAY**					
02:45 pm	**03:00 pm**	**00:15**	**STF-TRAVEL TIME**						
03:00 pm	**05:00 pm**	**02:00**	**BERESI ANTHONY**	**DSC-SGL-DAY**					
Daily Hours	**7.25**	hh:mm	**07:15**						
Wednesday	**05-Dec-2018**								
04:30 pm	**10:00 pm**	**05:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**					
10:00 pm	**12:00 am**	**02:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**					
Daily Hours	**5.50**	hh:mm	**05:30**						
Thursday	**06-Dec-2018**								
12:00 am	**06:00 am**	**06:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**					
06:00 am	**08:30 am**	**02:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**					
Daily Hours	**2.50**	hh:mm	**02:30**						
Saturday	**08-Dec-2018**								
08:30 am	**05:00 pm**	**08:30**	**COOPER STEPHEN**	**DSC-SGL-SATURDAY**					
Daily Hours	**8.50**	hh:mm	**08:30**						
Sunday	**09-Dec-2018**								

Community Living Association Inc

Staff Roster

ENCABO AUGUSTINO | **003** | Period Ending :16/12/2018 | Printed : 29/11/2018 03:21 pm | Page Number : 2

				In	Out	Dur'n	T/Time	Kms	**Signature**
01:00 pm - 05:00 pm	**04:00**	**BERESI ANTHONY**	**DSC-SGL-SUNDAY**						
Daily Hours **4.00** hh:mm **04:00**									
Monday 10-Dec-2018									
09:30 am - 03:30 pm	**06:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-DAY**						
05:00 pm - 09:30 pm	**04:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
09:30 pm - 10:00 pm	**00:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
10:00 pm - 12:00 am	**02:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
Daily Hours **11.00** hh:mm **11:00**									
Tuesday 11-Dec-2018									
12:00 am - 06:00 am	**06:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
06:00 am - 08:30 am	**02:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
05:00 pm - 10:00 pm	**05:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
10:00 pm - 12:00 am	**02:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
Daily Hours **7.50** hh:mm **07:30**									
Wednesday 12-Dec-2018									
12:00 am - 06:00 am	**06:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
06:00 am - 08:30 am	**02:30**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
05:00 pm - 10:00 pm	**05:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-NIGHT**						
10:00 pm - 12:00 am	**02:00**	**JOHNSON ZOEY DAVID**	**DSC-SGL-SLEEPOVER ALLOWANCE**						
Daily Hours **7.50** hh:mm **07:30**									
Thursday 13-Dec-2018									

Community Living Association Inc

Staff Roster

ENCABO AUGUSTINO | **003** | Period Ending :16/12/2018 | Printed : 29/11/2018 03:21 pm | Page Number : 3

			Activity	In	Out	Dur'n	T/Time	Kms	Signature
12:00 am	**- 06:00 am**	**06:00**	**JOHNSON ZOEY DAVID DSC-SGL-SLEEPOVER ALLOWANCE**						
06:00 am	**- 08:30 am**	**02:30**	**JOHNSON ZOEY DAVID DSC-SGL-NIGHT**						
09:30 am	**- 11:30 am**	**02:00**	**JOHNSON ZOEY DAVID DSC-SGL-DAY**						
11:30 am	**- 03:30 pm**	**04:00**	**JOHNSON ZOEY DAVID DSC-SGL-DAY**						

Daily Hours **8.50** hh:mm **08:30**

Sunday 16-Dec-2018

09:00 am	**- 01:00 pm**	**04:00**	**BERESI ANTHONY DSC-SGL-SUNDAY**						

Daily Hours **4.00** hh:mm **04:00**

Hours Total : **66.25**

Kms Total :

Staff Signature : _____ **Approved By :** _____ **Data Entry :** _____

Notifications :

PLEASE SUBMIT THIS TIMESHEET BY 12 NOON Monday 17 th DECEMBER 2018 **
PLEASE ENSURE YOU SIGN YOUR TIMESHEET BEFORE SUBMITTING####

Process Date: 10 October 2018, 15:50:53 Page: 1

Community Living Association Inc

ABN: 16 123 793 282

Payee: 003 Encabo, Augustino **Pay Type:** Part-Time

Pay Period: 24/09/2018 to 07/10/2018 **Pay Number:** 023655 **Classification:** CSE 2.2

Pay Details

Tran Type		Reference	Qty	Rate	Amount
AFT	Afternoon Rate + 12.5%		12.00	29.4900	353.88
ALSAT	Annual Leave Saturday		8.00	39.3200	314.56
ALSUN	Annual Leave Sunday		4.00	52.4200	209.68
DY	Day Rate		7.25	26.2100	190.03
DYPH	Public Holiday + 150%		7.25	65.5300	475.09
DYSAT	Day Rate Saturday + 50%		8.00	39.3200	314.56
DYSUN	Day Rate Sunday +100%		8.00	52.4200	419.36
NIGHT	Night Rate + 15%		13.00	30.1400	391.82
OC	Sleepover Allowance		16.00	5.8800	94.08
OT20	Overtime + 100%		5.00	52.4200	262.10
TRVKM	Travel - Kilometre Rate		96.00	0.7800	74.88
SALPCK	Salary Packaging	003			-792.74 -
C02	Tax	161538716			-446.00 -
SGC	Superannuation Guarantee *Sun Super*	009908956			262.49

Expected payment of SGC on or before 28/01/2019

	Hours Entitled
AL Annual Leave	68.53
PL Personal Leave	13.94

Bank Details

Account Name	Account No	Payment Method	Amount
Encabo, Augustino	0172594	Direct Credit	1,861.30

	Total Pay	Total Deductions	Total Tax	Total Net
This Pay	3,100.04	792.74	446.00	1,861.30
YTD	25,507.62	4,089.27	4,472.00	16,946.35

Mr Augustino Encabo
44 Melville Street
Albany WA 6330

Process Date: 24 October 2018, 14:10:55 Page: 1

Community Living Association Inc

ABN: 16 123 793 282

Payee: 003 Encabo, Augustino **Pay Type:** Part-Time

Pay Period: 08/10/2018 to 21/10/2018 **Pay Number:** 023840 **Classification:** CSE 2.2

Pay Details

Tran Type		Reference	Qty	Rate	Amount
AFT	Afternoon Rate + 12.5%		6.00	29.4900	176.94
DY	Day Rate		8.00	26.2100	209.68
DYSAT	Day Rate Saturday + 50%		16.00	39.3200	629.12
DYSUN	Day Rate Sunday +100%		12.00	52.4200	629.04
NIGHT	Night Rate + 15%		25.75	30.1400	776.12
OC	Sleepover Allowance		32.00	5.8800	188.16
OT15	Overtime + 50%		2.00	39.3200	78.64
OT20	Overtime + 100%		8.75	52.4200	458.68
TRVKM	Travel - Kilometre Rate		130.00	0.7800	101.40
SALPCK	Salary Packaging	003			-792.74 -
C02	Tax	161538716			-488.00 -
SGC	Superannuation Guarantee *Sun Super*	009908956			247.86

Expected payment of SGC on or before 28/01/2019

	Hours Entitled
AL Annual Leave	75.04
PL Personal Leave	16.54

Bank Details

Account Name	Account No	Payment Method	Amount
Encabo, Augustino	0172594	Direct Credit	1,967.04

	Total Pay	Total Deductions	Total Tax	Total Net
This Pay	3,247.78	792.74	488.00	1,967.04
YTD	28,755.40	4,882.01	4,960.00	18,913.39

Mr Augustino Encabo
44 Melville Street
Albany WA 6330

Process Date: 07 November 2018, 14:15:59 Page: 1

Community Living Association Inc

ABN: 16 123 793 282

Payee:	003 Encabo, Augustino	**Pay Type:**	Part-Time
Pay Period:	22/10/2018 to 04/11/2018	**Pay Number:**	023844
Classification:	CSE 2.2		

Pay Details

Tran Type		Reference	Qty	Rate	Amount
AFT	Afternoon		12.00	29.4900	353.88
DY	Day		14.50	26.2100	380.06
DYSAT	Saturday		16.50	39.3200	648.78
DYSUN	Sunday		8.00	52.4200	419.36
NIGHT	Night		13.00	30.1400	391.82
OC	Sleepover Allowance		16.00	5.8800	94.08
OT20	Overtime 2		5.00	52.4200	262.10
TRVKM	Travel - Kilometre Rate		96.00	0.7800	74.88
SALPCK	Salary Packaging	003			-792.74 -
C02	Tax	161538716			-280.00 -
SGC	Superannuation Guarantee *Sun Super*	009908956			217.36

Expected payment of SGC on or before 28/01/2019

	Hours Entitled
AL Annual Leave	81.19
PL Personal Leave	18.99

Bank Details

Account Name	Account No	Payment Method	Amount
Encabo, Augustino	0172594	Direct Credit	1,552.22

	Total Pay	Total Deductions	Total Tax	Total Net
This Pay	2,624.96	792.74	280.00	1,552.22
YTD	31,380.36	5,674.75	5,240.00	20,465.61

Mr Augustino Encabo
44 Melville Street
Albany WA 6330

Process Date: 21 November 2018, 14:12:48 Page: 1

Community Living Association Inc

ABN: 16 123 793 282

Payee:	003 Encabo, Augustino	**Pay Type:**	Part-Time
Pay Period:	05/11/2018 to 18/11/2018	**Pay Number:**	024058
Classification:	CSE 2 2		

Pay Details

Tran Type		Reference	Qty	Rate	Amount
AFT	Afternoon		6.00	29.4900	176.94
DY	Day		22.50	26.2100	589.74
DYSAT	Saturday		16.00	39.3200	629.12
DYSUN	Sunday		8.00	52.4200	419.36
NIGHT	Night		8.00	30.1400	241.12
OC	Sleepover Allowance		8.00	5.8800	47.04
PL	Personal Leave		9.50	26.2100	249.00
TRVKM	Travel - Kilometre Rate		109.00	0.7800	85.02
SALPCK	Salary Packaging	003			-792.74 -
C02	Tax	161538716			-212.00 -
SGC	Superannuation Guarantee *Sun Super*	009908956			223.47

Expected payment of SGC on or before 28/01/2019

	Hours Entitled
AL Annual Leave	87.92
PL Personal Leave	12.17

Bank Details

Account Name	Account No	Payment Method	Amount
Encabo, Augustino	0172594	Direct Credit	1,432.60

	Total Pay	Total Deductions	Total Tax	Total Net
This Pay	2,437.34	792.74	212.00	1,432.60
YTD	33,817.70	6,467.49	5,452.00	21,898.21

Mr Augustino Encabo
44 Melville Street
Albany WA 6330

Process Date: 05 December 2018, 14:35:10 Page: 1

Community Living Association Inc

ABN: 16 123 793 282

Payee:	003 Encabo, Augustino			**Pay Type:**	Part-Time
Pay Period:	19/11/2018 to 02/12/2018	**Pay Number:**	024404	**Classification:**	CSE 2.2

Pay Details

Tran Type		Reference	Qty	Rate	Amount
DY	Day		27.25	26.2100	714.23
DYSAT	Saturday		5.00	39.3200	196.60
DYSAT	Saturday		11.75	40.1900	472.24
DYSUN	Sunday		3.00	52.4200	157.26
NIGHT	Night		12.50	30.1400	376.75
OC	Sleepover Allowance		16.00	5.8800	94.08
OCWE	Sleepover Allowance - WE		16.00	5.8800	94.08
OT20	Overtime 2		12.00	52.4200	629.05
OT20	Overtime 2		4.50	53.5800	241.11
TRVKM	Travel - Kilometre Rate		70.00	0.7800	54.60
SALPCK	Salary Packaging	003			-792.74 -
C02	Tax	161538716			-428.00 -
SGC	Superannuation Guarantee *Sun Super*	009908956			200.00

Expected payment of SGC on or before 28/01/2019

	Hours Entitled
AL Annual Leave	93.64
PL Personal Leave	14.45

Bank Details

Account Name	Account No	Payment Method	Amount
Encabo, Augustino	0172594	Direct Credit	1,809.26

	Total Pay	Total Deductions	Total Tax	Total Net
This Pay	3,030.00	792.74	428.00	1,809.26
YTD	36,847.70	7,260.23	5,880.00	23,707.47

Mr Augustino Encabo
44 Melville Street
Albany WA 6330

BEFORE THE FAIR WORK COMMISSION

MATTER NO. AM2014/286

S. 156 - FOUR YEARLY REVIEW OF MODERN AWARDS – SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

Statement of Richard Rathbone

I, Richard Rathbone, Disability Support Worker, [redacted] Western Australia, say;

1. I am a member of the Australian Services Union, Western Australia Branch.

2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. I was born on 4 June 1956, I am 62 years old.

4. I have worked in the disability services industry since 2011. Before I worked in disability I had a number of jobs in a variety of industries.

5. I do not have any formal qualifications in disability services. However, I have worked in the industry for a long time. Before I worked in the industry, I was at various times a carer, supporter and advocate for my first wife who suffered from bipolar disorder. My experience of caring for my wife has given me skills which I apply in my work.

6. I am a person with a disability. My right arm was amputated after a car crash. The nature of my amputation means that I am unable to use prosthesis. I also suffered a stroke, which means that my other arm is not fully functional. I have been assessed as being able to work 30 hours a week.

7. I am currently married, and I have three step-children. I live with my wife and my 16 year old son.

Current employment

8. I commenced work with Community Living Association ('**CLA**') as a Disability Support Worker in March 2011. I am a permanent part-time employee.

9. I am employed under the *Social, Community, Home Care and Disabilities Services Industry Award 2010* (**'the Award')**. I am classified as Social and Community Services Employee Level 2.4.

10. CLA provides disability services to clients with many different types of disability. The support I provide my clients varies significantly from client to client, depending on the nature of their disability. Some clients need mainly physical support and assistance whilst others need cognitive and emotional support, while some need all three. I have a preference for working with clients with cognitive and psychological disabilities due to my experience caring for my first wife.

11. The objective of my job is to provide my clients with a healthy environment, nourishing food, engagement in the community, and to provide as much support as possible for them to live as independently as they are able to. Attached and marked **Annexure A** is a copy of my Job Description dated 16 September 2016.

12. My duties involve caring for and supporting clients in their daily life. That includes some personal care. For instance, I assist one client with their personal hygiene. They suffer from cognitive issues which means I need to talking them through each step of cleaning themselves. I will also assist by cleaning some harder to reach places, like their back. I also provide support with housework, gardening and cooking. I also help my clients to engage with the community. This involves taking them to events and activities. An important part of this job is finding out what the client would enjoy. I am always looking for suitable things to take them to.

13. An important part of my job is supporting clients to learn new skills and abilities. One element of this is to identify where assistance will be effective, and assess if this is an issue that can be overcome with support. Sometimes this means taking a step back, because providing them with too much help can prevent a client from achieving a result that they 'own' and that benefits their sense of independence and control.

14. I need to make sure that the support I provide is suited to my client's needs. For example, when I am working with autistic and bipolar people, the key is to guide them without being overwhelming. It's important to be non-threatening. It is really important for a support worker to look at their own attitude and behaviour see if that is negatively impacting the client.

My hours of work

15. I am contracted to work 46 hours in each fortnight. I have regular shifts every Sunday and Monday and every second Tuesday, Wednesday and Saturday. Attached and marked **Annexure B** are copies of my roster for the period 5 November 2018 to 16 December 2018.

16. I am rostered for broken shifts under clause 25.6 of the Award. There is no minimum engagement for permanent part-time employees under the Award, so some of my rostered broken shifts are for very short periods of time. I often start work at 8.30 in the morning and finish work at 7.00PM but only work 4 hours. My employer is also able to roster my shifts over a 12 hour span, so there can be very long breaks in the middle of the day.

17. I can also work for more than one client in a day. CLA sometimes, but not always, rosters paid working time for time spent travelling between clients. I have been told that there is a practice where there is less than one hour between shifts they will pay 15 minutes travel time.

18. My regular roster of work includes the following broken shifts:

<u>Week1</u>

a. Mondays, 8.00AM to 9.30AM then 4.00PM to 7.00PM;

b. Sunday, 9.00AM to 11.00PM and 4.00PM to 6.30PM;

<u>Week 2</u>

a. Mondays, 8.00AM to 9.30AM then 4.00PM to 7.00PM;

b. Tuesday, 4.00PM to 7.00PM;

c. Wednesday, 5.00PM to 7.00PM;

d. Saturday, 9.00AM to 1.30PM then 4.00PM to 6.30PM; and

e. Sunday, 9.00am to 2.00pm and 4.00pm to 6.30pm second week.

19. My contracted hours can be varied by agreement between me and CLA under clause 10.3(e) of the Award. My employer regularly asks me to make short term variations to my contracted hours to meet the needs of its clients. I usually agree to these variations.

20. I can also agree to work additional hours without overtime under clause 25.5 (iii) of the Award. Sometimes I am given additional hours through my roster. This is posted on a Thursday and starts the following Monday. I also receive additional hours during my roster period, for example to cover the shift of someone who is on leave.

21. I usually agree to work additional hours. These additional hours are highly variable and they are not guaranteed. I can be offered additional hours at any time, they do not need to be posted with my roster. Further, additional hours do not have to be continuous with my contracted ordinary hours of work. I am regularly rostered on broken shifts at short notice.

22. I usually work between 50 and 52 hours in a fortnight. The number of hours varies based on amount of work; I have worked as much as 60 hours in a fortnight.

My income and expenses

23. In an average fortnight I earn about $1800 net. Attached and marked **Annexure C** are copies of my payslips for the period 22 October 2018 to 16 December 2018.

24. My income depends on the number of hours that I work each week and the days I work those hours. I try to work on the weekend because I am paid penalty rates for those hours and I need the additional income.

25. I receive a partial disability pension. The amount I receive changes according to how much my wife and I earn each fortnight. It averages to about $100 per fortnight.

26. My partner used to be a cleaner but she recently quit her job to become a student, she has no income at the moment. She has applied for Austudy but it has not yet been granted. She was earning between $500 and $800 per fortnight in 2018. She is studying so that she can get a more reliable and better paying job.

27. My wife and I also receive Family Tax Benefit A.

28. Most of my money is spent on groceries and bills. I try to put away money each week, but this comes at the expense of other things. I am trying to get buy a house at the age of 62. This is not easy, especially with my low income. I am not thinking about retirement very much. I do not have enough money in superannuation or savings to retire.

My problems with working broken shifts

29. One problem with working broken shifts is the wasted time. The time between shifts is time I need to fill in, not time I can choose what to do with. Most of my breaks between shifts are too long for a meal and too short to do something else.

30. Longer breaks are easier to handle. Even during longer breaks it's hard to do anything, because I need a longer period of time to really focus on a task. I like being able to be spend my free time in a way that is satisfying or rewarding. For example, I like woodworking but my breaks between shifts are usually too short to do anything productive. It is not a long enough period of time to set up my tools, do my work and then clean up afterwards.

31. However, if I have a long break between shifts it means I am working a very long day. I will start early in the morning and usually finish around 7.00PM. This is very tiring and it means I will miss meal times with my wife and son.

32. My wife and son are really only available on the weekend, and I have most of my shifts on the weekend because they are both studying. I miss out on quality time with my family because I need to earn penalty rates to support my family. I am also rostered to work broken shifts on Saturdays and Sundays, which draws out the time I spend working.

33. Working broken shifts makes it hard to keep friendships. Most of my friends work regular hours. They aren't available during the middle of the day, and I usually finish to late in the evening to see them after work.

34. I am lucky that I live near my current clients. Most of my clients are within 5 or 6 minutes' drive of my house. Any problems would be worse if I lived further away from my clients, like many of my co-workers do. If I had to drive longer than I do, I would find this to be a bigger problem.

35. I feel that I have reached my used by date in the disability sector. Maybe if the working hours were better I would feel differently. At the moment I am actively investigating leaving the disability sector. I am looking for work experience in engineering, local government or administration. I want to work in an industry where I can earn the same or more money with a more compact working day.

[redacted]

WITNESS SIGNATURE

RICHARD RATHBONE

WITNESS NAME

DATE: 13th FEBRUARY 2019

ATTACHMENT A

Community Living Association Inc

SCHEDULE 1: JOB DESCRIPTION

1. JOB DETAILS

Job Title	**SUPPORT WORKER**
Position Number	N/A
Location	Albany or Denmark
Employment Status	Various

2. REPORTING RELATIONSHIPS

This Position reports to	• Coordinator, CLA
Positions reporting to this position	• Senior Support Worker • Support Worker

3. PRIMARY ROLE

Support individuals with disabilities by promoting personal well-being, choice and inclusion.

4. EXTENT OF AUTHORITY

Under the direction of the Coordinator, adhere to the Staff Code of Conduct and organisational policies and procedures to provide a professional service which is able to meet individual needs and maintain CLA values.

5. KEY TASKS & RESPONSIBILITIES

Brief Summary:

- Provide support and encouragement to the individual you are supporting to develop skills and participate in the community;
- Provide assistance with the daily routine activities such as personal hygiene, grooming, eating, dressing and medication;
- Provides a homely environment at the residence of the client, where applicable;
- Attend to the individual's physical and material well-being and safety, while encouraging independence.

Skills Development:

- Incorporate opportunities for skill development into all activities;
- Enable the person you are supporting to develop independence by encouraging them at all times to be involved or complete activities themselves;
- Ensure the person you support has real choices in all aspects of their daily life;
- Provide opportunities for the person you are supporting to have:
  a. Functional skills and meaningful activities;
  b. Relationships with other people;
  c. Social, community and civic activities;
  d. Personal development and fulfilment;
  e. Access to community and generic services;
- Adhere to any skill development program;
- Monitor skill development program to ensure that it remains relevant and report to the Coordinator in the first instance any need for review or change.

Health Care & Safety:

- Show due care and diligence in all aspects of supporting the person with a disability;
- Administer medications with care and according to schedule prescribed by GP;
- Follow all guidelines outlined in the occupational safety and health manual;
- Assist with meal preparation where necessary, adhering to dietary guidelines;
- If necessary accompany person you are supporting to medical appointments, whilst respecting privacy and confidentiality.

Personal Care and Grooming:

- Encourage a high standard of personal hygiene and grooming. Assist with bathing, showering, hair washing and styling, shaving, toileting, cleaning teeth and dressing where necessary. Encourage independence in these areas;
- Encourage and assist with general household chores such as washing clothing and changing and washing bed linen.

Behaviour Management:

- Encourage behaviours that are likely to increase independence and positive social relationships;
- Ensure that perceptions that others have of the person you support are managed in a positive manner;
- Follow any behaviour management plans consistently;
- Ensure that expectations placed on the person you support are realistic and will not cause anxiety;
- Act in a manner that provides positive role modelling for the person that you support in all situations.

Records and Reporting:

- Follow all reporting and recording requirements of the CLA;
- Report to the coordinator any matters relating to the daily program of the person you support;
- Report to the Coordinator any matters relating to the health of the person that you are supporting;
- Report to the Executive officer any concerns or issues relating to conditions of employment;
- Provide legible, completed payment claim forms for processing of wages. Record description of activities on claim form;
- Grievances to be dealt with by following the grievance policy and procedure.

Maintenance of Routines and Schedules:

- Ensure that you are ready to commence any activity or program in good time. Assist the person you support to develop good time keeping skills if appropriate.
- Ensure that every effort is made to enable the person you support to attend and participate in the planned activities;
- Give as much notice as possible to the Coordinator or work colleagues if you are unable to work due to illness.

Performance Standards:

- Provide a high standard of care and attend to duties with skill and competence;
- Act in a manner which ensures the safety and well-being of the person you support and which respect's their right to privacy, dignity and confidentiality;
- Demonstrate a positive and contemporary attitude towards people with a disability.
- Abide by the policies and procedures of the CLA, including the Staff Code of Conduct and occupational safety and health policies;
- Performance will be appraised as part of formal appraisal program;
- Attend training sessions as identified by the CLA.

Community Living Association Inc

6. ESSENTIAL CRITERIA

- Sound knowledge and understanding of the Disability Service Standards.
- Sound level of verbal, written and interpersonal skills.
- Ability to work with minimal supervision and as part of a team.
- Highly developed time management skills.

7. DESIRABLE CRITERIA

- Experience in working with people from diverse cultural backgrounds
- Previous experience in the provision of in-home/community support services.
- Current First Aid Certificate
- Demonstrated experience in providing a creative, flexible and person-centred approach to people with disabilities.
- Demonstrated experience in the provision of quality care and support for individuals who are vulnerable.
- Commitment to participate in training and development.
- Capacity to work within relevant legislation, Standards and adherence to CLA policies and procedures.

8. SPECIAL CONDITIONS

Appointment is subject to the following:

- Proof of Eligibility to work in Australia
- Valid National Police Clearance (not older than 3 months on commencement)
- "C" Class Driver's Licence

9. CERTIFICATION

Employer Representative

C Cleopyons 16/9/16

Signature Date

Employee

R Rathbone 16/9/16

Signature Date

Community Living Association Inc

Staff Roster

RATHBONE RICHARD | **768** | Period Ending :04/11/2018 | Printed : 31/10/2018 10:31 am | Page Number : 1

				Activity	In	Out	Dur'n	T/Time	Kms	Signature
Monday	**29-Oct-2018**									
08:00	**- 09:30**	**01:30**	**BAXTER IAN**	**DSC-SGL-DAY**						
16:00	**- 19:00**	**03:00**	**BAXTER IAN**	**DSC-SGL-DAY**						
Tuesday	**30-Oct-2018**									
16:00	**- 19:00**	**03:00**	**BAXTER IAN**	**DSC-SGL-DAY**						
Wednesday	**31-Oct-2018**									
10:00	**- 12:30**	**02:30**	**BAXTER IAN**	**DSC-SGL-DAY**						
17:00	**- 19:00**	**02:00**	**SMITH GARY**	**DSC-SGL-DAY**						
Friday	**02-Nov-2018**									
16:00	**- 19:00**	**03:00**	**HILDER TREVOR**	**DSC-SGL-DAY**						
Saturday	**03-Nov-2018**									
09:00	**- 13:30**	**04:30**	**BAXTER IAN**	**DSC-SGL-SATURDAY**						
16:00	**- 18:30**	**02:30**	**BAXTER IAN**	**DSC-SGL-SATURDAY**						
Sunday	**04-Nov-2018**									
09:00	**- 14:00**	**05:00**	**BAXTER IAN**	**DSC-SGL-SUNDAY**						
16:00	**- 18:30**	**02:30**	**BAXTER IAN**	**DSC-SGL-SUNDAY**						

Hours Total : 29.50

Kms Total :

Staff Signature : _____

Approved By : _____

Data Entry : _____

Notifications :

Community Living Association Inc

Staff Roster

RATHBONE RICHARD | **768** | Period Ending :18/11/2018 | Printed : 13/11/2018 10:43 am | Page Number : 1

			Activity	In	Out	Dur'n	T/Time	Kms	Signature
Monday 05-Nov-2018									
08:00	**- 09:30**	**01:30**	**BAXTER IAN**	**DSC-SGL-DAY**					
13:00	**- 15:30**	**02:30**	**HILDER TREVOR**	**DSC-SGL-DAY**					
16:00	**- 19:00**	**03:00**	**BAXTER IAN**	**DSC-SGL-DAY**					
Wednesday 07-Nov-2018									
08:30	**- 13:00**	**04:30**	**BAXTER IAN**	**DSC-SGL-DAY**					
Thursday 08-Nov-2018									
08:00	**- 13:00**	**05:00**	**BAXTER IAN**	**DSC-SGL-DAY**					
13:30	**- 14:30**	**01:00**	**SMITH GARY**	**RAD-CASE PLANNING-DSC**					
Friday 09-Nov-2018									
16:00	**- 19:00**	**03:00**	**HILDER TREVOR**	**DSC-SGL-DAY**					
Sunday 11-Nov-2018									
16:00	**- 18:30**	**02:30**	**BAXTER IAN**	**DSC-SGL-SUNDAY**					
Monday 12-Nov-2018									
08:00	**- 09:30**	**01:30**	**BAXTER IAN**	**DSC-SGL-DAY**					
13:00	**- 15:30**	**02:30**	**HILDER TREVOR**	**DSC-SGL-DAY**					
16:00	**- 19:00**	**03:00**	**BAXTER IAN**	**DSC-SGL-DAY**					
Tuesday 13-Nov-2018									
09:00	**- 10:00**	**01:00**	**ILKA MERVYN**	**RAD-CASE PLANNING-DSC**					
11:00	**- 15:00**	**04:00**	**ILKA MERVYN**	**DSC-SGL-DAY**					

Community Living Association Inc

Staff Roster

RATHBONE RICHARD | **768** | Period Ending :18/11/2018 | Printed : 13/11/2018 10:43 am | Page Number : 2

				Activity	In	Out	Dur'n	T/Time	Kms	Signature
16:00	**- 19:00**	**03:00**	**BAXTER IAN**	**DSC-SGL-DAY**						
Wednesday 14-Nov-2018										
08:30	**- 12:30**	**04:00**	**BAXTER IAN**	**DSC-SGL-DAY**						
17:00	**- 19:00**	**02:00**	**SMITH GARY**	**DSC-SGL-DAY**						
Saturday 17-Nov-2018										
09:00	**- 13:30**	**04:30**	**BAXTER IAN**	**DSC-SGL-SATURDAY**						
16:00	**- 18:30**	**02:30**	**BAXTER IAN**	**DSC-SGL-SATURDAY**						
Sunday 18-Nov-2018										
09:00	**- 14:00**	**05:00**	**BAXTER IAN**	**DSC-SGL-SUNDAY**						
16:00	**- 18:30**	**02:30**	**BAXTER IAN**	**DSC-SGL-SUNDAY**						

Hours Total : 58.50 **Staff Signature :** _____ **Approved By :** _____ **Data Entry :** _____

Kms Total :

Notifications :

Community Living Association Inc

Staff Roster

RATHBONE RICHARD | **768** | Period Ending :02/12/2018 | Printed : 03/12/2018 09:42 am | Page Number : 1

			Activity	In	Out	Dur'n	T/Time	Kms	Signature
Monday 19-Nov-2018									
08:00	**- 09:30**	**01:30**	**BAXTER IAN**	**DSC-SGL-DAY**					
16:00	**- 19:00**	**03:00**	**BAXTER IAN**	**DSC-SGL-DAY**					
Wednesday 21-Nov-2018									
08:30	**- 13:00**	**04:30**	**BAXTER IAN**	**DSC-SGL-DAY**					
Friday 23-Nov-2018									
16:00	**- 18:00**	**02:00**	**HILDER TREVOR**	**DSC-SGL-DAY**					
Saturday 24-Nov-2018									
08:00	**- 10:00**	**02:00**	**BAXTER IAN**	**DSC-SGL-SATURDAY**					
12:00	**- 17:30**	**05:30**	**BAXTER IAN**	**DSC-SGL-SATURDAY**					
Sunday 25-Nov-2018									
09:00	**- 11:00**	**02:00**	**SMITH GARY**	**DSC-SGL-SUNDAY**					
16:00	**- 18:30**	**02:30**	**BAXTER IAN**	**DSC-SGL-SUNDAY**					
Monday 26-Nov-2018									
08:00	**- 09:30**	**01:30**	**BAXTER IAN**	**DSC-SGL-DAY**					
16:00	**- 19:00**	**03:00**	**BAXTER IAN**	**DSC-SGL-DAY**					
Tuesday 27-Nov-2018									
16:00	**- 19:00**	**03:00**	**BAXTER IAN**	**DSC-SGL-DAY**					
Wednesday 28-Nov-2018									

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

RATHBONE RICHARD | **768** | Period Ending :16/12/2018 | Printed : 17/12/2018 09:34 am | Page Number : 1

			In	Out	Dur'n	T/Time	Kms	**Signature**

Monday 03-Dec-2018

08:00 am - 09:30 am 01:30 **BAXTER IAN**
Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990

01:00 pm - 03:30 pm 02:30 **HILDER TREVOR**
Unit 1/213 Albany Highway ALBANY 6330 P.not connected

03:45 pm - 04:00 pm 00:15 **STF-TRAVEL TIME**

04:00 pm - 07:00 pm 03:00 **BAXTER IAN**
Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990

Daily Hours **7.25** hh:mm **07:15**

Wednesday 05-Dec-2018

08:30 am - 01:00 pm 04:30 **BAXTER IAN**
Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990

Daily Hours **4.50** hh:mm **04:30**

Friday 07-Dec-2018

08:00 am - 09:30 am 01:30 **BAXTER IAN**
Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990

11:00 am - 04:30 pm 05:30 **ILKA MERVYN**
Unit 4/69 Angove Road ALBANY 6330

04:30 pm - 04:45 pm 00:15 **STF-TRAVEL TIME**

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

RATHBONE RICHARD | **768** | Period Ending :16/12/2018 | Printed : 17/12/2018 09:34 am | Page Number : 2

				In	Out	Dur'n	T/Time	Kms	**Signature**
04:45 pm - 07:00 pm	**02:15**	**BAXTER IAN**							
		Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990							

Daily Hours **9.50** hh:mm **09:30**

Sunday 09-Dec-2018

				In	Out	Dur'n	T/Time	Kms	**Signature**
08:00 am - 10:00 am	**02:00**	**SMITH GARY**							
		Unit 17 Bethel Village ALBANY 6330 P.9841 6068							
04:00 pm - 06:30 pm	**02:30**	**BAXTER IAN**							
		Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990							

Daily Hours **4.50** hh:mm **04:30**

Monday 10-Dec-2018

				In	Out	Dur'n	T/Time	Kms	**Signature**
08:00 am - 09:30 am	**01:30**	**BAXTER IAN**							
		Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990							
04:00 pm - 07:00 pm	**03:00**	**BAXTER IAN**							
		Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990							

Daily Hours **4.50** hh:mm **04:30**

Tuesday 11-Dec-2018

				In	Out	Dur'n	T/Time	Kms	**Signature**
04:00 pm - 07:00 pm	**03:00**	**BAXTER IAN**							
		Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990							

Daily Hours **3.00** hh:mm **03:00**

Friday 14-Dec-2018

Community Living Association Inc

Staff Roster

For all roster queries please contact your manager - ERIC GLAS

RATHBONE RICHARD | **768** | Period Ending :16/12/2018 | Printed : 17/12/2018 09:34 am | Page Number : 3

				In	Out	Dur'n	T/Time	Kms	**Signature**
04:00 pm - 06:00 pm	**02:00**	**HILDER TREVOR**							
		Unit 1/213 Albany Highway ALBANY 6330 P.not connected							
Daily Hours	**2.00**	hh:mm	**02:00**						

Saturday 15-Dec-2018

				In	Out	Dur'n	T/Time	Kms	**Signature**
09:00 am - 01:30 pm	**04:30**	**BAXTER IAN**							
		Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990							
04:00 pm - 06:30 pm	**02:30**	**BAXTER IAN**							
		Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990							
Daily Hours	**7.00**	hh:mm	**07:00**						

Sunday 16-Dec-2018

				In	Out	Dur'n	T/Time	Kms	**Signature**
09:00 am - 02:00 pm	**05:00**	**BAXTER IAN**							
		Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990							
04:00 pm - 06:30 pm	**02:30**	**BAXTER IAN**							
		Unit 1/23 Suffolk St MOUNT CLARENCE 6330 P.08 9842 3990							
Daily Hours	**7.50**	hh:mm	**07:30**						

Hours Total : 49.75

Kms Total :

Staff Signature : _____ **Approved By :** _____ **Data Entry :** _____

Notifications :
A Gentle Reminder for all Staff
Please ensure that you read your timesheets carefully and check when and what shifts you are required to work within the fortnight

Community Living Association Inc

Staff Roster

RATHBONE RICHARD | **768** | Period Ending :02/12/2018 | Printed : 03/12/2018 09:42 am | Page Number : 2

			Activity		In	Out	Dur'n	T/Time	Kms	Signature
08:00	**- 10:00**	**02:00**	**STF-ALEAVE-ANNUAL**							
08:00	**- 09:00**	**01:00**	**STF-ANNUAL LEAVE LOADING**							
Saturday	**01-Dec-2018**									
09:00	**- 13:30**	**04:30**	**BAXTER IAN**	**DSC-SGL-SATURDAY**						
16:00	**- 18:30**	**02:30**	**BAXTER IAN**	**DSC-SGL-SATURDAY**						
Sunday	**02-Dec-2018**									
09:00	**- 14:00**	**05:00**	**BAXTER IAN**	**DSC-SGL-SUNDAY**						
16:00	**- 18:30**	**02:30**	**BAXTER IAN**	**DSC-SGL-SUNDAY**						

Hours Total : 48.00 **Staff Signature :** _____ **Approved By :** _____ **Data Entry :** _____

Kms Total :

Notifications :

Process Date: 07 November 2018, 14:17:28 Page: 1

Community Living Association Inc

ABN: 16 123 793 282

Payee:	768 Rathbone, Richard	**Pay Type:**	Part-Time
Pay Period:	22/10/2018 to 04/11/2018	**Pay Number:**	023973
Classification:	CSE 2.4		

Pay Details

Tran Type		Reference	Qty	Rate	Amount
AL	Annual Leave		11.50	27.7300	318.90
ALSUN	Annual Leave Sunday		4.50	55.4600	249.57
DY	Day		15.00	27.7300	415.96
DYSAT	Saturday		7.00	41.6000	291.20
DYSUN	Sunday		7.50	55.4600	415.95
LLOAD	Leave Loading		11.50	4.8530	55.81
TRVKM	Travel - Kilometre Rate		174.00	0.7800	135.72
C02	Tax				-276.00
SGC	Superannuation Guarantee *IOOF*	059498M			160.70

Expected payment of SGC on or before 28/01/2019

	Hours Entitled
AL Annual Leave	97.15
PL Personal Leave	30.42

Bank Details

Account Name	Account No	Payment Method	Amount
Rathbone, Richard	656310	Direct Credit	1,607.11

	Total Pay	Total Deductions	Total Tax	Total Net
This Pay	1,883.11	0.00	276.00	1,607.11
YTD	20,499.83	0.00	3,172.00	17,327.83

Mr Richard Rathbone
28 Abercorn Street
ORANA WA 6330

Process Date: 21 November 2018, 14:14:36 Page: 1

Community Living Association Inc

ABN: 16 123 793 282

Payee: 768 Rathbone, Richard **Pay Type:** Part-Time

Pay Period: 05/11/2018 to 18/11/2018 **Pay Number:** 024144 **Classification:** CSE 2.4

Pay Details

Tran Type		Reference	Qty	Rate	Amount
DY	Day		40.50	27.7300	1,123.08
DYSAT	Saturday		7.00	41.6000	291.20
DYSUN	Sunday		10.00	55.4600	554.60
PL	Personal Leave		2.00	27.7300	55.46
TRVKM	Travel - Kilometre Rate		289.00	0.7800	225.42
C02	Tax				-374.00 -
SGC	Superannuation Guarantee *IOOF*	059498M			192.31

Expected payment of SGC on or before 28/01/2019

	Hours Entitled
AL Annual Leave	102.87
PL Personal Leave	30.70

Bank Details

Account Name	Account No	Payment Method	Amount
Rathbone, Richard	656310	Direct Credit	1,875.76

	Total Pay	Total Deductions	Total Tax	Total Net
This Pay	2,249.76	0.00	374.00	1,875.76
YTD	22,749.59	0.00	3,546.00	19,203.59

Mr Richard Rathbone
28 Abercorn Street
ORANA WA 6330

Process Date 05 December 2018, 14:38:37 Page 1

Community Living Association Inc

ABN: 16 123 793 282

Payee:	768 Rathbone, Richard			**Pay Type:**	Part-Time
Pay Period:	19/11/2018 to 02/12/2018	**Pay Number:**	024491	**Classification:**	CSE 2.4

Pay Details

Tran Type		Reference	Qty	Rate	Amount
AL	Annual Leave		2.00	27.7300	55.46
DY	Day		18.50	27.7300	513.02
DYSAT	Saturday		7.50	41.6000	312.00
DYSAT	Saturday		7.00	42.5300	297.72
DYSUN	Sunday		4.50	55.4600	249.57
DYSUN	Sunday		7.50	56.7000	425.25
LLOAD	Leave Loading		2.00	4.8530	9.71
TRVKM	Travel - Kilometre Rate		246.00	0.7800	191.88
C02	Tax				-318.00 -
SGC	Superannuation Guarantee *IOOF*	059498M			176.04

Expected payment of SGC on or before 28/01/2019

	Hours Entitled
AL Annual Leave	105.39
PL Personal Leave	32.50

Bank Details

Account Name	Account No	Payment Method	Amount
Rathbone, Richard	656310	Direct Credit	1,736.61

	Total Pay	Total Deductions	Total Tax	Total Net
This Pay	2,054.61	0.00	318.00	1,736.61
YTD	24,804.20	0.00	3,864.00	20,940.20

Mr Richard Rathbone
28 Abercorn Street
ORANA WA 6330

Process Date: 19 December 2018, 15:04:41 Page: 1

Community Living Association Inc

ABN: 16 123 793 282

Payee:	768 Rathbone, Richard			**Pay Type:**	Part-Time
Pay Period:	03/12/2018 to 16/12/2018	**Pay Number:**	024592	**Classification:**	CSE 2.4

Pay Details

Tran Type		Reference	Qty	Rate	Amount
ADJ	Pay Adjust - Reclassification				117.99
DY	Day		30.75	28.3500	871.80
DYSAT	Saturday		7.00	42.5300	297.72
DYSUN	Sunday		12.00	56.7000	680.40
TRVKM	Travel - Kilometre Rate		250.00	0.7800	195.00
C02	Tax				-354.00 -
SGC	Superannuation Guarantee *IOOF*	059498M			186.95

Expected payment of SGC on or before 28/01/2019

	Hours Entitled
AL Annual Leave	110.17
PL Personal Leave	34.41

Bank Details

Account Name	Account No	Payment Method	Amount
Rathbone, Richard	656310	Direct Credit	1,808.91

	Total Pay	Total Deductions	Total Tax	Total Net
This Pay	2,162.91	0.00	354.00	1,808.91
YTD	26,967.11	0.00	4,218.00	22,749.11

Mr Richard Rathbone
28 Abercorn Street
ORANA WA 6330

BEFORE THE FAIR WORK COMMISSION
MATTER NO.: AM2018/26
S. 156 - Four yearly review of modern awards – Social, Community, Home care and Disability Services industry award 2010

Statement of Tracy Lee Kinchin

I, Tracy Lee Kinchin, Disability Support Worker, of [redacted] in the State of New South Wales, say;

1. I am a member of the Australian Services Union, NSW & ACT (Services) Branch.
2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. I am 40 years old.
4. I am single, and I live with my 20 year old daughter.

My work history

5. I have worked in the disability sector for approximately 18 years.
6. I have Diploma in Community Services.
7. While I was studying for my diploma I worked as an after-school carer for a child with a disability. Once I completed by diploma I was employed part-time as a disability support worker by Newcastle & Hunter Community Access, now known as Connect Ability. I was also employed by the Salvation Army as a homelessness case manager at the Single Women's Refuge. I was made redundant by the Salvation Army. Connect Ability was not able to give me enough hours so I was forced to leave Connect Ability. I went to Leap Frog because I was offered full-time work.

Current employment

8. At the beginning of 2014, I commenced work with Leap Frog Ability as a disability support worker. Attached and marked Annexure A is my contract of employment.
9. I am employed under *Social, Community, Home Care and Disabilities Services Industry Award 2010* (**'the Award'**). I am classified as Social and Community Services Employee, level 2.4. I am paid $28.35 per hour. I am a full-time employee.
10. Leap Frog Ability is a not for profit disability service operating in Newcastle, Central Coast and Hunter Valley region. Since April 2018, Leap Frog Ability has merged with Live Better Services Limited ('**Live Better**').
11. I provide support to people with disabilities. I work one-on-one with clients in their private homes. I support their social needs, help them engage with the community and assist them with the daily life. Any important part of my role is assisting clients to develop life skills and new capacities. I also provide personal care and domestic assistance. My work involves a significant amount of travel because my clients are spread out over the city of Newcastle, Central Coast and the Hunter Region.

My hours of work

12. Until recently, I worked an average of 40 hours per week over a 4 weekly rotating roster. I was entitled to an RDO. I would work 8 continuous hours per day with a half hour lunch break. I travelled between the homes of my clients but did so during paid time. However, I would often be required to travel between client's houses during my lunchbreak.

13. I usually received my roster 2 weeks in advance. Sometimes, I would receive my roster by email, but I usually received my roster in paper. My roster did not specify the clients I would be working with each day. Instead, my roster only showed me my start and finishing times for the day. My start and finish times could change from roster to roster, but I would know the hours I was working well in advance.

14. I would normally find out what I was doing, which client's I was working with and where I needed to be when I started work for the day. This was not a problem for me because I already knew my starting and finishing times. I would start and finish work at the Leap Frog Ability office. Each morning, I would attend the offices to do administrative work and pick up my work car. This would take between 15 minutes and half an hour depending on where and when my 1st client was. Then I would perform 6 to 7 hours face to face support work with clients. I would travel between clients in a company car in paid time. At the end of the day, we were given half an hour to return to the office to do our case notes. Sometimes I spent the whole half hour driving back to the office, but this was balanced out by the times when I had a much shorter drive back to the office.

15. I liked having this level of certainty about my hours of work. This meant I could plan my life around my work with certainty. I would go to the gym, walk my dog and see my friends. I really love bushwalking in winter, so I save up my annual leave so I can do multi-night trips. Because I had certainty about my rosters in advance, I could plan my annual leave.

Recent changes to my hours of work

16. Since Leap Frog Ability merged with Live Better, rostering practices have changed. I now receive my roster through a smart phone application. In May 2019, we were told by the new management that we will not be paid for travel time between our clients.

17. As a full-time employee, my employer must roster me an average of 40 hours each week. However, because I am not paid for travel time I work those hours over a longer period of time. I am now often working my 8 hours of 9 or 10 hours spans. I have not been getting my RDO due to new rostering practices. I find working such long days exhausting and I am not coping with it. I have found it hard to go to the gym or walk my dog.

18. I am only being rostered to work at the times I am doing client facing work. This means that my roster needs to change each time a client changes the time or date of their service. This means that my days or work and start and finish times are constantly changing. It is difficult to plan my annual leave. I have found it hard to go hiking since Live Better has stopped paying me for travel time.

19. The changes at my work have been significant and I have taken stress leave.

WI[redacted]

Tracy Kinchin

WITNESS NAME

DATE: 24/06/2019

17 January 2014

Tracy-Lee Kinchin
20 Norfolk Avenue
ISLINGTON NSW 2296

Dear Tracy-Lee

Re: Offer of Employment

I am pleased to offer you full time employment with LeapFrog ability ("the Employer") as a Support Worker commencing 28 January 2014.

In addition to the terms and conditions contained in this letter, the Social, Community, Home Care and Disability Services Industry Award 2010 (the 'Award'), and National Employment Standards (the 'NES') along with the Fair Work Act 2009 apply to your position.

In addition to the Award and the NES the following conditions apply:

1. Criminal Record and Child Protection Records

(a) A criminal record check must be undertaken in order to secure your employment. If your check does not show a clear criminal record, your employment may be terminated. The Employer reserves the right to undertake ongoing criminal history checks. You are required to immediately notify the Employer if you are subject to any official investigation which may lead to criminal charges. Failure to notify the Employer of any official investigation may give rise to termination of employment.

(b) As your employment may involve working directly with children, employment is offered only on the condition that you provide us with a copy of your current Working With Children Check.

2. Position Responsibility

(a) You will report to the Service Manager – Individual Services however, the Employer may change your reporting arrangements in accordance with the needs of the business.

(b) It is expected that you will use your best endeavours and skills to further the Employer's interests and comply with all lawful directions and instructions given to you.

(c) Your duties and responsibilities are contained in the Position Description attached to this letter of offer. In addition, you may be required to perform work that is incidental or peripheral to these duties or at the reasonable request of the employer.

(d) The Employer may alter your position, position description and responsibilities in accordance with the changing needs of the business.

3. Probation and Qualifying Period

As indicated at your interview and in the application material your permanent employment is subject to the completion of the first six (6) months of probationary period. During the probationary period the Employer or you may terminate the employment by giving one (1) week's written notice.

Any legislated qualifying period will also apply to your employment.

4. Ongoing Employment

Your employment will continue subject to the availability of funding, or until terminated in accordance with the provisions specified in this offer.

5. Drivers License

You are offered employment on the condition that you hold and maintain a current driver's licence. If during your employment with the Employer your licence is cancelled or suspended for any reason you must notify the Employer as soon as practicable.

6. Hours of Work

Your normal ordinary hours of work are 40 per week, however you may be may be requested to work reasonable additional hours from time to time.

Your hours of work may be performed at any time between 6.00am and 8.00pm, 7 days per week. You will be provided with a roster and all payments will be made in accordance with the Award.

In recognition of working 40 hours per week, you are entitled to receive one *Rostered Day Off (RDO)* each month which may be taken on a day agreed to be the Employer.

You will be required to take an unpaid meal break of 30 minutes per day no later than after 5 hours of work. However, the taking of the break may be varied, or staggered to meet work demands and/or personal commitments.

7. Time off in lieu of working overtime

You may at times be required to start work earlier or later or work back outside your ordinary hours, or work additional days to those stated above, by working reasonable additional hours as overtime. Where you are required to do so by the Employer, you agree to elect to take time off in lieu of overtime for all time worked (on an hour per hour basis) in excess of your ordinary hours, in substitution for the payment of overtime.

8. Remuneration

You will be paid at the rate of $876.64 per week which is equivalent to that of a Level 2, Pay Point 4 under the current Award.

You may chose to salary sacrifice part of your remuneration in accordance with the Employers Salary Sacrifice Policy.

If for whatever reason, the remuneration paid to you is over and above the amount payable for your classification under the Award, the Employer may offset such payments against any future Award wage increases.

9. Payment of Wages

You will be paid fortnightly in arrears by direct credit to your nominated bank, credit union or building society account subject to you completing and returning an approved timesheet within the required deadline by the Employer.

10. Superannuation

The Employer will contribute compulsory employer superannuation guarantee contributions into a fund nominated by us on your behalf or another fund nominated by you in accordance with relevant superannuation choice of fund legislation.

11. Employment Policies

You are directed to read and comply with the obligations imposed upon you within the Employer's policies and procedures as they relate to your employment. These policies and procedures may be varied from time to time, and you are directed to comply with such variations.

12. Other Employment; Conflicts of Interest and Media

During your employment with the Employer, you must not engage, directly or indirectly, in any employment or business that is similar to or competitive with the business of the Employer, without the prior written approval of the Employer.

You must declare any potential conflicts of interest between your employment and any involvement in outside activities and never use or disclose the Employer's confidential information for private gain or malicious purposes. You must not provide any of the Employer's confidential information to the media or any other organisation, other than when required by law.

13. Confidential Information

(a) **Definition**

(i) "Confidential Information" means information (whether in writing or otherwise) given to or gained by you in confidence at any time, whether before, during or after your employment with the Employer that relates to:

(a) the Employer and other related offices or subsidiaries,

(b) customers, clients or suppliers of the Employer and other related offices or subsidiaries.

(ii) Confidential Information includes, but is not limited to:

(a) trade secrets;

(b) information relating to the Employer's business affairs, accounts, clients, marketing plans, sales plans, prospects, price information, supplier lists, research, management, financing, products, inventions, designs or processes;

(c) computer data bases and computer software;

(d) data surveys, customer lists, supplier lists, client lists, specifications, drawings, records and reports;

(e) private information provided to the Employer by any arm of government.

(f) private information provided to the Employer by any of its suppliers, or customers.

(b) **Confidentiality**

You must, at all times, including following the termination of your employment with the Employer, keep secret and confidential any Confidential Information of any kind and must not make use of any Confidential Information for your own benefit or for the benefit of any other person, business or entity.

(c) **Uncertainty about Confidential Information**

If there is uncertainty about whether information is Confidential Information, or is lawfully within the public domain, the information is taken to be Confidential Information unless you are advised by the Employer, in writing, that the information is not Confidential Information.

If you wish to accept this offer of employment, please sign the enclosed copy of this letter and return it to me.

Yours sincerely

VANESSA CUMMING
HR/Office Manager

I have read and accepted the policy and Procedures of the employer and agree to abide by them.

Signed: _____ *Dated:* 20/01/14

I hereby acknowledge that I accept the offer of employment with the Employer on the terms and conditions contained in this letter.

Signed: _____ *Dated:* 20/01/14

liveBetter
community services

27th April 2018

Ms. Tracey Kinchin
3 Nothumberland Street
Maryville NSW 2293

Dear Tracey,

I am pleased to offer you employment with LiveBetter Services Limited (LiveBetter) on the terms set out in this Letter of Employment. Please read these terms carefully and, if you wish to accept this offer, sign and return the attached copy to the Human Resources Department.

TERMS AND CONDITIONS OF EMPLOYMENT

1. Commencement date

This Letter of Employment will be effective from the 9th May 2018.

2. Term of employment

Your employment with LiveBetter will continue for an indefinite period, subject to successful relevant background checks including a review of your national police record and working with children check. You will also be required to successfully complete a pre-employment Health & Wellness Check. If you do not consent to these background checks and pre-employment Health & Wellness Check or, if your background checks reveal past behaviors that are inconsistent with the expectations of you in this role and this Letter of Employment, then this offer of employment will be revoked immediately.

3. Role, duties and performance

You are engaged as a Support Worker on a permanent, full time basis of 76 nominal hours per fortnight plus any reasonable additional hours. You will be working in the Newcastle area, in the Client Services Team and reporting to David Lewsam, Community Living Program Coordinator.

During your employment with LiveBetter, in addition to those duties outlined in your position description, you are required to:

- comply with all policies and procedures (as amended from time to time) that pertain to your employment and the performance of your duties, which are published by e-mail and/or located on the LiveBetter Intranet;
- perform the duties assigned to you from time to time and comply with all lawful and reasonable directions given to you by your Manager;
- perform your duties and responsibilities in a proper and efficient manner;

Level 1, 235 Lords Place
Orange NSW 2800

PO Box 2500
Orange NSW 2800

T 02 6391 2400
F 02 6391 2444

livebetter.org.au
ABN 13 160 259 512

- except in the case of absence by reason of illness or incapacity or leave in accordance with this contract of employment, devote your time, attention and abilities during normal business hours exclusively to the business of LiveBetter;
- use your best endeavors to promote and enhance the interests, welfare, business, growth and reputation of LiveBetter; and
- not intentionally do anything which is or may be harmful to LiveBetter.

Your duties, responsibilities, team and location may be revised from time to time in consultation with you to meet the changing needs of the organisation. Any changes will be discussed with you in advance and confirmed in writing.

4. Remuneration

Classification
Your conditions of employment will be governed by the applicable provisions of the *Social, Community, Home Care and Disability Services Industry Award 2010 (SCHCDSI).*

Due to the nature and scope of your role, your position been classified as Level 2 Pay Point 4 schedule (B) Social and Community Services Employee on the basis of the nature and scope of the role and your qualifications and experience. Under the transitional arrangements, we are also required to classify you under the Social and Community Services Award, as such your classification is Grade 2, Year 4 (Community Service Worker). You will be paid the higher rate of the two classifications until the transitional arrangements cease.

Rate of Pay
Your rate of pay upon commencement will be $27.37 per hour as per the Award. This rate is subject to change as per LiveBetter's obligations under the *Social, Community, Home Care and Disability Services Industry Award 2010.* LiveBetter will also make superannuation contributions on your behalf in accordance with the Superannuation Guarantee legislation.

Payment of Salary
Payment of your salary will be made on a fortnightly basis, in arrears, by electronic deposit to an account nominated by you. Your manager will confirm if you are required to complete a timesheet.

Superannuation contributions
You are free to direct your superannuation contributions to a regulated complying superannuation fund of your choice. If you do not advise us of your choice of a regulated complying fund, your contributions will be made to the superannuation fund chosen by LiveBetter as the default fund, currently HESTA. If you choose your own fund and do not become a member of the LiveBetter default fund, you are required to provide the information about your chosen fund as listed in the Choice of Superannuation Fund form.

Additional contributions to superannuation
In addition to the legislated employer superannuation contributions, you may direct an additional amount to the fund by means of automatic deduction from your pay. For further information please contact the Payroll Officer.

Salary packaging
You may be entitled to participate in LiveBetter's salary packaging scheme, which at present is administered by AccessPay.
Remuneration reviews
Salaries are reviewed annually in conjunction with the annual performance review process, the relevant industrial Award and the LiveBetter remuneration framework.

5. Hours of work

LiveBetter's normal hours of work are 38 hours per week, Monday to Friday, with an unpaid lunch break of not less than 30 minutes and not more than 1 hour in duration.

You will work an average of 38 hours/week each month which will enable the maintenance of your Rostered Day Off (RDO), including normal ordinary working hours of 40 hours per week, and one RDO each month at a time agreed to by your supervisor.

6. Overtime

All overtime worked must be approved by your manager in advance and, providing approval is obtained, you will be paid in accordance with the overtime provisions of the appropriate Award. Alternatively, you may like to make use of time in lieu provisions, if mutually agreed between yourself and your supervisor and in accordance with the relevant Modern Award.

7. Leave entitlements

Annual leave
You will be entitled to accrue entitlements to paid annual leave at the rate of 20 days for each year of continuous service (or, if part-time, pro-rated) in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time and the appropriate Award.

Annual leave loading of 17.5% will be paid on accrued leave when it is taken.

Unused annual leave will be paid out on termination of employment.

Personal/carer's leave
You will be entitled to ten days paid personal/carer's leave for each year of continuous service (or, if part-time, pro-rated) in accordance with the LiveBetter Leave Entitlements Policy as amended from time to time.

You are not entitled to any payment in lieu of accrued personal leave on termination of your employment.

Compassionate leave
You will be entitled to up to two days paid compassionate leave per permissible occasion in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time.

Parental leave
You will be entitled to parental leave in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time and relevant industrial instruments, such as the Fair Work Act.

Long Service Leave
You will be entitled to long service leave in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time.

Public holidays
You will be entitled to public holidays as proclaimed in your relevant state or territory without loss of pay. Payment will be made in accordance with the National Employment Standards.

Other leave
For information regarding all other leave such as community service leave, religious holidays, study leave and leave without pay, refer to LiveBetter's Leave Entitlements Policy or contact the HR team.

Service Date
For the purpose of calculating service and leave accruals, your original start date with Leapfrog Ability will be used.

Transfer of leave entitlements
As part of your transition from Leapfrog Ability, LiveBetter will be transferring your statutory entitlement accruals. This transfer is conditional upon LiveBetter receiving sufficient funds from Leapfrog Ability to cover these entitlements prior to commencement.

8. Workers' compensation

LiveBetter has workers' compensation insurance in accordance with the relevant state or territory legislation. In the event of any injury occurring during working hours you should immediately notify your manager.

9. Code of Conduct

LiveBetter is committed to ensuring that all individuals are treated with dignity and respect. The LiveBetter Code of Conduct explains what is meant by equal employment opportunity, discrimination, harassment, victimisation and bullying. It is essential that you understand and comply with the Code of Conduct as amended from time to time. A copy of the Code of Conduct is included in your employee handbook which is issued at induction and is also available on the Intranet.

10. Conduct and attire

You will be expected to conduct yourself in a manner that enhances the professional standing of LiveBetter, whether in the office, at third party locations, or any forum in which you may be seen as representing LiveBetter.

11. Driver's Licence

Given the nature of the role, a condition of employment is that you must possess and maintain a valid unrestricted Australian driver's licence. You must provide LiveBetter with a copy of your valid driver's licence and must notify LiveBetter immediately if you are disqualified from driving.

12. Confidentiality

You must not disclose, or allow access to, any confidential information, to any person except in the proper course of your duties, or as permitted by LiveBetter, either during or after the course of your employment. Confidential information is defined as any information relating to LiveBetter employees and clients, which is not lawfully available to the general public.

Further, as an employee of LiveBetter you will have access to "Know-How" and have a detailed knowledge of LiveBetter's clients and business' clients. You will have the opportunity to build professional relationships with those clients, employees and others engaged in LiveBetter's Business (goodwill). It is reasonable for LiveBetter to protect the goodwill of the business and as such, you must not during or post-employment with LiveBetter, induce, solicit, canvas or approach any customers of LiveBetter on behalf of any other business. This includes but is not limited to soliciting or approaching LiveBetter clients/and or families to move providers or encouraging LiveBetter client/ and or families to select another service provider on the basis of your employment with that provider.

In addition, you must not during or post-employment with LiveBetter, do or say anything that may be harmful to the reputation of LiveBetter in any forum, or that may lead a person to cease, curtail or alter their dealings with LiveBetter.

13. Medical Examinations and Considerations

Where a specific medical examination is not required for your position, LiveBetter assumes that you are medically fit to undertake employment with LiveBetter unless you notify it otherwise. If you have a medical condition that may have an impact upon your ability to carry out your duties or may require LiveBetter to provide you with assistance to undertake your duties, then it is important to disclose the extent of the medical condition to LiveBetter so that it may fulfil any requirements it has to assist you.

Where during the course of your employment with LiveBetter the CEO forms the opinion that there are reasonable concerns that you are not fit to undertake your normal duties you may be required to attend a medical examination.

14. Termination of employment

Either you or LiveBetter may terminate your employment with LiveBetter at any time by giving written notice in accordance with the National Employment Standards as outlined below.

Period of continuous service at the end of the day the notice is given	Notice period
Not more than 1 year	1 week
More than 1 year but not more than 3 years	2 weeks
More than 3 years but not more than 5 years	3 weeks
More than 5 years	4 weeks

Notwithstanding any other provision contained in the Letter of Employment, LiveBetter may terminate your employment at any time without prior notice if you commit an act of serious misconduct. Serious misconduct includes both of the following:

- wilful or deliberate behaviour that is inconsistent with the continuation of this Letter of Employment;
- conduct that causes imminent and serious risk to the health and safety of a person, or the reputation or viability of LiveBetter.

Examples of serious misconduct include but are not limited to:

- theft, fraud, assault, intoxication, or refusing to carry out a lawful and reasonable instruction consistent with this Letter of Employment;
- the commission of a crime in the course of your employment;
- the commission of a crime outside your employment with LiveBetter (e.g. criminal dishonesty, where your duties require good faith and honesty);
- neglect of duties; and/or
- the use of objectionable or obscene language in certain circumstances (e.g. if such language is directed towards managers, employees or clients of LiveBetter).

LiveBetter may suspend you on full pay from part or all of your duties at any time, including during any period of notice of termination of your employment.

15. Security of equipment and documentation

Whilst working at LiveBetter you are required to take care to secure your personal belongings. LiveBetter will not reimburse an individual who suffers a loss due to theft of cash or personal possessions. You are also responsible for all equipment issued to you and documentation in your custody. This includes computers, mobile phones and confidential documentation. Any losses must be reported to your manager immediately.

16. Variation and entire agreement

This Letter of Employment may only be varied, replaced or terminated by agreement in writing signed by you and an authorised representative of LiveBetter. This Letter of Employment embodies the entire understanding of the parties in relation to your employment by LiveBetter and supersedes all previous negotiations, representations or agreements. This offer of employment is valid for strictly two weeks from the date of issue unless otherwise agreed.

Please indicate your written acceptance of this offer by signing, dating and returning the copy of this Letter of Employment to the Human Resources Department.

Yours sincerely,

Nerissa Marat
General Manager People & Culture

I have read and accept the terms and conditions of employment as set out in this Letter of Employment.

Tracey Kinchin		
Employee Name	Signature	Date

LeapFrog ability
overcoming disadvantage

Position Description

Position Title:	**Support Worker**
Reports to:	**Individual Services Manager**
Status:	**Full Time/Part Time and Casual**
Award:	**MA000100 - Social, Community, Home Care and Disability Services Industry Award 2010 (Modern Award)**
Classification:	**SACS Level 2**
Last Updated:	**October 2013**

LeapFrog ability Vision:

To be the innovative leader in helping people overcome disadvantage

LeapFrog ability Mission:

To inspire the community to join us in helping people overcome disadvantage

ORGANISATIONAL CONTEXT

LeapFrog ability provides a number of different services to disadvantaged people in the community.

The Individual Supports Team work with people to assist them to help themselves to live more independently and to improve access to the wider community. Functions managed by this team include: Drop-in Support, Case Management, Behaviour Management, Skills Training, Gym and the Connections group.

The Flexible Supports and Respite Team provide practical support to carers of people with a disability by providing direct assistance to the family unit or by brokering respite opportunities. Our Flexible Support Options, Flexible Respite, Hunter CRA Panel co-ordination, Emergency Respite and Crisis Management functions are currently managed by this team.

Both of the above services are funded either through the Federal Government's DisabilityCare Australia or via the NSW Government through the Department of Family and Community Services.

The Fair Go For Kids Program (FGFK) is an initiative that specifically targets disadvantaged children that would benefit from early intervention that they would not otherwise be able to receive. Funding comes from both corporate and private donations.

POSITION SUMMARY

Responsible for the provision of support to clients, including but not limited to, education, skills training, positive behavioural support and direct care to people with a disability and their support networks.

SELECTION CRITERIA

Essential

- Relevant qualifications such as Cert III in Disability.
- An understanding of the needs of people with disabilities and those who support the.
- High level verbal and written communication skills.
- Ability to work independently and a commitment to a team approach.
- Computer skills – MS Office.
- First Aid Certificate.
- Working With Children Check.
- Current NSW driver's license.

Desirable

- Experience working with people with an intellectual disability.

PERFORMANCE EXPECTATIONS

In addition to the key accountabilities outlined below, the incumbent is expected to perform their role with the same skills, responsibility, delegation and aptitude to the level required under the award classification of this position.

KEY RELATIONSHIPS

Internal

Program Manager, Case Managers and Support Workers.

External

Clients, Families of Clients, Agency/Sector Staff including Accommodation and Day Service Providers and other Support Staff, Public Guardians, Caseworkers, Medical and Health Professionals.

KEY ACCOUNTABILITIES

FINANCIAL

- Operate within delegation in a responsible manner.

- Purchase orders are completed for all expenditure and receipts provided for petty cash expenditure.
- All expenditure is approved and signed by Program Manager (CLP) before being forwarded to finance.
- All monies received from clients or services are forward to finance immediately for receipt.

OPERATIONS & ADMINISTRATION

- Develop and maintain effective networks and relationships with government and community organisations, families, and consumer groups.
- Adhere to organisational administrative policies and procedures.
- Contact Program Manager at commencement of after hours shift.
- Submit and or confirm all requests for leave, resources, expenditure etc. to the Program Manager (CLP).
- Report critical incidents and OH&S issues immediately and complete documentation within 48 hours of incident.
- Client documentation is accurate and timely.
- Complete all data entry for LeapFrog's data base daily.
- Read and access policy and procedures manual during induction and as necessary
- Prepare for and contribute to probationary review after 3 months service and also for performance review annually.
- Contact Program Manager direct for all leave absences eg sick leave etc.

SUPPORT SERVICES

- All Client Support is performed with strict adherence to the published Process documentation, a subsection of the LeapFrog Policies and Procedures.
- Assist in the dissemination of Client Service Information.
- Attend interagency forums as directed by Program Manager.
- Professional development sessions and case review is prepared for.
- Support and guidance is sought from Program Manager/Case Manager immediately in response to significant client issues.
- Support and guidance is sought from Program Manager in response to routine client support.
- Attend regular meetings with Program Manager or Case Manager regarding client support.
- Other duties as required by the Program Manager.

EMPLOYEE AGREEMENT

As the incumbent of this position, I have read the Position Description, understand its contents and agree to work in accordance with the requirements of the position.

I also agree to strictly observe LeapFrog ability's policy on confidentiality of client information or such other sensitive or confidential information that I may come across in the course of my employment.

Signatories	Name (print)	Signature	Date
Employee	Tracy Kinchin		20/01/14
Manager			

Reviews of this position description should occur at performance review and any agreement to amend/alter signed and dated as a new document.

A copy of this signed agreement is to be given to the employee and a 2nd copy kept on file.

liveBetter

Position Description

Private and Confidential

Support Worker

The Organisation

LiveBetter is an organisation formed through an amalgamation of several like-minded, regionally based community service organisations that recognised the need for specialist service provision for the people of regional Australia.

Delivering a range of aged, disability, carer, child & family, mental health and clinical services, LiveBetter takes a holistic approach to working with customers seeking to ensure that customer needs and preferences are met. As well as service delivery LiveBetter assists customers with information, linking and referrals.

The major organisations that merged to form LiveBetter are CareWest [Central West, Orana, Far West, Northern and Riverina Murray regions of NSW], Excelcare [Central Queensland], Age Concern [Albury NSW], Family Link [Wagga Wagga NSW], There4U [Central Queensland], Home and Community Care services [Broken Hill], Translinc [Central West NSW] and Nambucca Valley Phoenix [Mid North Coast NSW]. Several other organisations had previously amalgamated with CareWest over the past ten years.

LiveBetter and its antecedent organisations have undergone a period of significant growth, with continuing growth in staff numbers, service capacity and diversity and geographic spread. To support this growth, LiveBetter invests heavily in corporate infrastructure and management systems as well as staff training and development.

LiveBetter employs approximately 1500 staff operating in offices, homes, preschool, respite centres and community hubs across regional and rural Queensland and NSW. Working alongside our staff are more than 250 volunteers who provide extra support and services to our customers and communities. Our annual revenue is now more than $90 million with strong growth forecast.

LiveBetter is positioned as one of the largest regionally-based providers of community services in Australia. Although we are a large organisation, we remain focused on ensuring programs and services are provided by local staff, and tailored to the individual needs of local people and communities.

Our Purpose: Enabling the people in regional rural and remote Australia to live their best lives.

Our Values

LiveBetter's Values guide the way we conduct ourselves. This includes how we interact with our clients, community and business partners and how we treat each other. LiveBetter's Values are:

- **Integrity:** We live out our values, are honest and ethical in all our dealings and are accountable for our actions.
- **Respect:** We value the individual. We recognise the rights and choices of the client, employees and the community. We encourage teamwork and support diversity within the team.
- **Cooperation:** We strive to identify and create value from partnerships and alliances with other organisations, agencies, businesses, communities and within our own organisation.
- **Empowerment:** We believe that individuals and communities should be encouraged and supported to realise their full potential.
- **Excellence:** We strive for excellence and best practice in all that we do as individuals, teams and as an organisation.

The Position

Position title:	**Support Worker**
Location:	
Job Type:	Casual / Full Time / Part Time
Reports to:	CLP Coordinator
Direct reports:	Nil

Key Position Responsibilities

This position is responsible for the provision of support to clients, including but not limited to, education, skills training, positive behavioral support and direct care to people with a disability and their support networks accessed through NDIS funding. This position is an integral part of supporting people living with a disability lead more independent lives and improve their access to the wider community.

Key Accountabilities

- Operate within delegation in a responsible manner.
- Purchase orders are completed for all expenditure and receipts provided for petty cash expenditure.
- All expenditure is approved and signed by CLP Coordinator before being forwarded to finance.
- All monies received from clients or services are forward to finance immediately for receipt.
- Develop and maintain effective networks and relationships with government and community organisations, families, and consumer groups.
- Adhere to organisational administrative policies and procedures.
- Contact CLP Coordinator at commencement of after-hours shift.
- If casual, submit and confirm all shift availabilities 1 week in advance to the CLP Coordinator.
- Submit and or confirm all requests for leave, resources, expenditure etc. to the CLP Coordinator.
- Report critical incidents and WHS issues immediately and complete documentation within 48 hours of incident.
- Contributing to a safe and non-discriminatory workplace.
- Client documentation completed and updated in CIMS is accurate and timely.
- Complete all data entry for LiveBetter's data base daily.
- Read and access policy and procedures manual during induction and as necessary.
- Contact CLP Coordinator direct for all leave absences e.g. sick leave etc.

- All Client Support is performed with strict adherence to the published Process documentation, a subsection of the LiveBetter Policies and Procedures.
- Assist in the dissemination of Client Service Information.
- Attend interagency forums as directed by CLP Coordinator.
- Support and guidance is sought from CLP Coordinator immediately in response to significant client issues.
- Support and guidance is sought from CLP Coordinator in response to routine client support.
- Attend regular meetings with CLP Coordinator regarding client support.
- Other related tasks as directed by management from time to time.

Performance Expectations

In addition to the key accountabilities outlined below, the incumbent is expected to perform their role in a professional manner with all skills, responsibility, delegation and aptitude to the level required under the award classification of this position.

The duties and responsibilities of the position are to be carried out in a manner that is consistent with the core values of LiveBetter; Teamwork, Fairness and Impartiality, Honesty and Respect. You are expected to conduct yourself in a manner that aligns with the below:

- Work effectively with the team. Strives to contribute to the overall success of the team and organisation. Work effectively in teams across boundaries.
- Are committed to social justice, opposes prejudice, dishonesty and injustice. Free from bias or favouritism; disinterestedness; equitableness; fairness; as, impartiality of judgment, of treatment, etc.
- Are passionate, committed and enthusiastic about the organisation and inspires a positive attitude to their work. Acts with integrity while promoting consistency among principles, values and behaviours.
- Respects, values and considers the opinion, circumstances, feelings and views of colleagues and clients. Is tactful and diplomatic when dealing with people.

Risk

All staff must be aware of operational and business risks.

They should;

- Provide input into various risk management activities assist in identifying risks and controls
- Report all emerging risks, issues and incidents to their manager or appropriate officer

Person Specification

Background and Experience

Essential

- Relevant tertiary qualifications/certificates in Disability or Individual Support.
- An understanding of the needs of people with disabilities and those who support them.
- High level verbal and written communication skills.
- Ability to work independently and a commitment to a team approach.
- Computer skills – MS Office.
- Knowledge and understanding of relevant NDIS policies and procedures and an ability to provide services in line with LiveBetter's Policy and Procedural guidelines.
- First Aid Certificate.
- Current Working with Children Check clearance.
- Current driver's license.
- Preparedness to undertake a National Criminal History check.

Desirable

- Previous experience working with people with an intellectual disability.

Other requirements

1. Pass a National Criminals History Check, Working with Children Check and a pre-employment medical assessment (including drug and alcohol screening).
2. Advise LiveBetter in writing of any conditions which may impact ability to carry out the responsibilities required of the role.
3. Ability to be flexible with work hours to meet reasonable demands of the position.
4. **Reasonable Travel:** Employees may be required to travel to client's premises, or some other location, as part of their job requirements. It is a condition of employment that employees agree to undertake any reasonable travel required in the performance of their duties

Remuneration

An appropriate remuneration package in line with the skills and experience of the successful candidate will be negotiated. Salary packaging opportunities are available.

I hereby acknowledge that I have received my Position Description and understand what my duties and responsibilities are:

Employee Name:		Date:	
Signature:			

Date Approved:			
Approved by HRM:	Nerissa Marat		
Version:	1	Document Name:	

IN THE FAIR WORK COMMISSION

Matter no. AM2018/26
S. 156 - Four yearly review of modern awards – social, community, home care and disability services industry award 2010

Statement of Robert James Steiner

I, Robert James Steiner, Disability Support Worker, of [redacted] in the State of New South Wales, say;

1. I am a member of the Australian Services Union, NSW & ACT Branch.

2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. I was born on 2 June 1996, I am 23.

4. I have a partner who I lived with. My partner is not a citizen of Australia and does not have her driver's license. She is not able to work, so I support both of us with my income. My partner also relies on me when she needs to be driven somewhere.

5. I also live with my parents, my grandparent and brother. I am the half-owner of our house which it mortgaged. I make mortgage payments from my income.

My work history

6. I have worked as Disability Support Worker since 7 October 2017. Before I worked as a Disability Support Worker I was employed Challenge Community Services as a Youth Worker for about one year.

7. I have a hold Certificate IV in Youth Work.

Current employment

8. On 7 October 2017, I commenced work with Butter Fish Services ('**Butter Fish**') as a casual disability support worker. I became a full-time employee on 6 July 2018. Butterfish is a disability support service operating in Newcastle and the Hunter Region. It provides services to both adults and children with a disability.

9. I am employed under *Social, Community, Home Care and Disabilities Services Industry Award 2010* (**'the Award')**. I am paid $20.58 per hour. My union has advised me that I am being underpaid and will raise this as a dispute with my employer.

10. I work with several clients who have psychosocial disabilities: including autism, schizophrenia, and depression. Mostly I help my clients to living independently. This involves helping clients with day to day tasks, while also teaching them the skills they need to do those tasks for themselves. I will take clients to appointments or shopping. I will help them take their medication. I also provide some domestic assistance, such as house cleaning. I also support my clients to participate in community activities, like going to the beach. While I am caring for my clients I will teach them new skills, like using public transport, which will bring them closer to doing to do those things for themselves.

11. I do most of my work at my clients' homes or out with them in the community. I usually only attend my employer's offices for team meetings.

12. I live and work in a regional area. I live south of Newcastle in the Lake Macquarie area. My clients live in the city of Newcastle and the Hunter Valley towns of Maitland and Singleton. It can take more than an hour to drive between my home and my clients in the Hunter Valley.

My working patterns

13. I work an average of 38 hours each week with some overtime. I regularly work overtime and I also work on the weekend.

14. I work on a four week roster, which I generally receive one week in advance. I receive my rosters electronically through my employer's website. I usually work 8 hours each day. However, I can work as much as twelve hours depending on my roster or if I have been required to work overtime. I work sleepovers. Attached and marked **Annexure A** is a summary of my roster for the period between 6 November 2018 and 6 June 2019.

15. I am sometimes rostered to work a broken shift. If I work multiple shifts in one day it is most likely because I am working at multiple locations. My employer does not pay me for the time I spend travelling between work locations.

16. Below is a table setting out the occasions I worked a broken shifts for the period Friday, 23 November 2018 to Thursday, 6 June 2019.

Date	**Start**	**Finish**	**Hours**	**Hours between shifts**	**Hours of Duty**
Tuesday, 6 November 2018	6:00am	10:00am	4		
Tuesday, 6 November 2018	3:30pm	6:30pm	3	5.5	12.5
Wednesday, 7 November 2018	9:00am	10:30am	1.5		
Wednesday, 7 November 2018	3:30pm	5:30pm	2	5	7.5
Friday, 9 November 2018	9:00am	1:00pm	4		
Friday, 9 November 2018	3:00pm	8:00pm	5	2	11
Saturday, 10 November 2018	6:00am	11:00am	5		
Saturday, 10 November 2018	3:00pm	8:00pm	5	4	10
Tuesday, 13 November 2018	6:00am	1:00pm	7		
Tuesday, 13 November 2018	3:00pm	6:00pm	3	2	12
Thursday, 6 December 2018	9:30am	1:30pm	4		
Thursday, 6 December	2:30pm	7:30pm	5	1	10

2018					
Wednesday, 12 December 2018	9:30am	2:00pm	4.5		
Wednesday, 12 December 2018	3:00pm	7:00pm	4	1	10.5
Friday, 28 December 2018	6:00am	11:00am	5		
Friday, 28 December 2018	3:00pm	8:00pm	5	4	10
Wednesday, 2 January 2019	6:00am	7:15am	1.25		
Wednesday, 2 January 2019	3:00pm	7:15pm	4.25	7.75	10.75
Thursday, 3 January 2019	6:00am	11:00am	5		
Thursday, 3 January 2019	2:45pm	3:45pm	1	3.75	9.75
Sunday, 6 January 2019	6:00am	7:00am	1		
Sunday, 6 January 2019	5:00pm	8:00pm	3	10	14
Wednesday, 16 January 2019	11:30pm	1:30pm	2		
Wednesday, 16 January 2019	2:00pm	8:00pm	6		
Tuesday, 22 January 2019	6:00am	11:30am	5.5		
Tuesday, 22 January 2019	12:50pm	1:20pm	0.5	1.33	
Tuesday, 22 January 2019	3:30pm	7:45pm	4.25	2.167	14
Wednesday, 30 January 2019	7:30am	9:30am	2		
Wednesday, 30 January 2019	10:30am	12:00pm	1.5	1	4.5
Monday, 4 February 2019	8:30am	11:30am	3		
Monday, 4 February 2019	2:30pm	8:00pm	5.5	2.5	11.5
Tuesday, 5 February 2019	6:00am	10:00am	4		
Tuesday, 5 February 2019	4:00pm	8:00pm	4	6	10
Tuesday, 12 February 2019	6:00am	10:00am	4		
Tuesday, 12 February 2019	4:00pm	8:00pm	4	6	14
Thursday, 28 February 2019	6:00am	12:00pm	6		
Thursday, 28 February 2019	3:30pm	6:30pm	3	3.5	12.5

Friday, 1 March 2019	6:00am	1:00pm	7		
Friday, 1 March 2019	5:00pm	9:00pm	4	4	15
Sunday, 3 March 2019	6:00am	9:00am	3		
Sunday, 3 March 2019	10:00am	4:00pm	6	1	10
Sunday, 10 March 2019	10:00am	4:00pm	6		
Sunday, 10 March 2019	5:00pm	8:00pm	3	1	10
Saturday, 6 April 2019	6:00am	10:00am	4		
Saturday, 6 April 2019	3:30pm	7:00pm	3.5	3.5	11
Sunday, 7 April 2019	6:00am	10:00am	4		
Sunday, 7 April 2019	3:00pm	7:00pm	4	3	11
Monday, 8 April 2019	12:00pm	1:30pm	1.5		
Monday, 8 April 2019	3:00pm	8:00pm	5	1.5	8
Wednesday, 24 April 2019	12:30pm	2:00pm	1.5		
Wednesday, 24 April 2019	6:30pm	7:00pm	0.5	4.5	6.5
Wednesday, 1 May 2019	6:00am	12:00pm	6		
Wednesday, 1 May 2019	2:00pm	5:00pm	3	2	11
Tuesday, 4 June 2019	11:30am	2:30pm	3		
Tuesday, 4 June 2019	4:00pm	8:00pm	4	1.5	8.5

Issues associated with unpaid travel time

17. I work long days, which I find tiring. I am routinely on duty for much longer than the time I am actually paid for. I often work for more than 10 hours a day, but a lot of that time will be unpaid. I do not always receive consecutive days off work. If I have a single day off, I will usually spend that time resting.

18. My days are longer than my rostered start and finish times. For example, in a normal day, I might start work at 6.00 am. I will have to wake up at 5.00 am or earlier to get ready for work. I will drive to work, and start my first shift. Then I will drive to my next appointment in unpaid time. I will work might then finish at 8.00pm. But my day is not done. It might take me an hour to drive home, which could take an hour. Then I will need to unwind and have dinner. I probably won't be able to get to bed before 10.00 pm. It is likely I will be rostered on at 6.00 am again.

19. I would prefer to be at home earlier, so I can spend time with your partner. My partner gets lonely with me being gone for so long. It can be difficult to see my friends. My friends work

the same kinds of jobs with rosters all over the place. We have to match up the time we have off if we want to see each other.

20 When I have time off, there are limits me on what I can do. It can be difficult to do chores because businesses might not be open when I am off work. I would prefer to work shorter hours, but I need to make sure I earn enough money to support me and my partner.

[redacted]

WITNESS SIGNATURE

Robert James Steiner

WITNESS NAME

DATE: 24/6/19

Date	Start	Finish	Hours
Tuesday, 6 November 2018	6:00am	10:00am	4
Tuesday, 6 November 2018	3:30pm	6:30pm	3
Wednesday, 7 November 2018	9:00am	10:30am	1.5
Wednesday, 7 November 2018	3:30pm	5:30pm	2
Thursday, 8 November 2018	6:00am	9:30am	3.5
Friday, 9 November 2018	9:00am	1:00pm	4
Friday, 9 November 2018	3:00pm	8:00pm	5
Saturday, 10 November 2018	6:00am	11:00am	5
Saturday, 10 November 2018	3:00pm	8:00pm	5
Monday, 12 November 2018	3:30pm	6:30pm	3
Tuesday, 13 November 2018	6:00am	1:00pm	7
Tuesday, 13 November 2018	3:00pm	6:00pm	3
Wednesday, 14 November 2018	3:30pm	5:30pm	2
Thursday, 15 November 2018	6:00am	1:00pm	7
Thursday, 15 November 2018	3:00pm	6:30pm	3.5
Friday, 16 November 2018	6:00am	1:00pm	7
Saturday, 17 November 2018	6:00am	1:00pm	7
Monday, 19 November 2018	3:30pm	6:30pm	3
Tuesday, 20 November 2018	3:30pm	6:30pm	3
Wednesday, 21 November 2018	3:30pm	5:30pm	2
Thursday, 22 November 2018	6:00am	11:00am	5
Friday, 23 November 2018	1:00pm	8:00pm	7
Friday, 23 November 2018	3:30pm	6:30pm	3
Saturday, 24 November 2018	1:00pm	8:00pm	7
Sunday, 25 November 2018	6:00am	8:00pm	14
Monday, 26 November 2018	6:00am	12:00pm	6
Tuesday, 27 November 2018	6:00am	10:30am	4.5
Wednesday, 28 November 2018	6:00am	12:00pm	6
Wednesday, 28 November 2018	3:00pm	6:00pm	3
Thursday, 29 November 2018	6:00am	11:00am	5
Thursday, 29 November 2018	3:00pm	6:00pm	3
Friday, 30 November 2018	6:00am	11:00am	5
Saturday, 1 December 2018	1:00pm	8:00pm	7
Sunday, 2 December 2018	1:00pm	8:00pm	7
Tuesday, 4 December 2018	6:00am	1:00pm	7
Wednesday, 5 December 2018	3:00pm	7:00pm	4
Thursday, 6 December 2018	9:30am	1:30pm	4
Thursday, 6 December 2018	2:30pm	7:30pm	5
Friday, 7 December 2018	3:30pm	6:30pm	3

Saturday, 8 December 2018	1:00pm	8:00pm	7
Monday, 10 December 2018	6:00am	1:00pm	7
Tuesday, 11 December 2018	1:00pm	8:00pm	7
Wednesday, 12 December 2018	9:30am	2:00pm	4.5
Wednesday, 12 December 2018	3:00pm	7:00pm	4
Thursday, 13 December 2018	1:00pm	8:00pm	7
Friday, 14 December 2018	8:00am	9:00am	1
Saturday, 15 December 2018	1:00pm	8:00pm	7
Monday, 17 December 2018	1:00pm	8:00pm	7
Tuesday, 18 December 2018	6:00pm	10:30pm	4.5
Wednesday, 19 December 2018	3:30pm	6:30pm	3
Thursday, 20 December 2018	1:00pm	8:00pm	7

Annual Leave			35
Thursday, 27 December 2018	3:00pm	8:00pm	5
Friday, 28 December 2018	6:00am	11:00am	5
Friday, 28 December 2018	3:00pm	8:00pm	5
Saturday, 29 December 2018	6:00am	1:00pm	7
Sunday, 30 December 2018	1:00pm	8:00pm	7
Monday, 31 December 2018	6:00am	9:30am	3.5
Wednesday, 2 January 2019	6:00am	7:15am	1.25
Wednesday, 2 January 2019	3:00pm	7:15pm	4.25
Thursday, 3 January 2019	6:00am	11:00am	5
Thursday, 3 January 2019	2:45pm	3:45pm	1

Friday, 4 January 2019	6:00am	11:00am	5
Saturday, 5 January 2019	6:00am	1:00pm	7
Sunday, 6 January 2019	6:00am	7:00am	1
Sunday, 6 January 2019	5:00pm	8:00pm	3
Monday, 7 January 2019	6:00am	12:00pm	6
Tuesday, 8 January 2019	6:00am	1:00pm	7
Wednesday, 9 January 2019	3:00pm	7:00pm	4
Friday, 11 January 2019	10:30am	11:30pm	1
Tuesday, 15 January 2019	3:00pm	7:00pm	4
Wednesday, 16 January 2019	11:30pm	1:30pm	2
Wednesday, 16 January 2019	2:00pm	8:00pm	6
Thursday, 17 January 2019	1:00pm	8:00pm	7

Friday, 18 January 2019	12:30pm	7:30pm	7
Tuesday, 22 January 2019	6:00am	11:30am	5.5
Tuesday, 22 January 2019	12:50pm	1:20pm	0.5
Tuesday, 22 January 2019	3:30pm	7:45pm	4.25
Wednesday, 23 January 2019	3:00pm	8:00pm	5
Thursday, 24 January 2019	1:00pm	8:00pm	7
Saturday, 26 January 2019	1:00pm	8:00pm	7

Monday, 28 January 2019	6:00pm	7:30pm	1.5
Tuesday, 29 January 2019	3:30pm	7:30pm	4
Wednesday, 30 January 2019	7:30am	9:30am	2
Wednesday, 30 January 2019	10:30am	12:00pm	1.5

Saturday, 2 February 2019	1:00pm	8:00pm	7
Sunday, 3 February 2019	1:00pm	8:00pm	7
Monday, 4 February 2019	8:30am	11:30am	3
Monday, 4 February 2019	2:30pm	8:00pm	5.5
Tuesday, 5 February 2019	6:00am	10:00am	4
Tuesday, 5 February 2019	4:00pm	8:00pm	4
Thursday, 7 February 2019	1:00pm	8:00pm	7
Saturday, 9 February 2019	3:00pm	8:00pm	5
Sunday, 10 February 2019	6:00am	12:00pm	6
Monday, 11 February 2019	1:00pm	8:00pm	7
Tuesday, 12 February 2019	6:00am	10:00am	4
Tuesday, 12 February 2019	4:00pm	8:00pm	4
Wednesday, 13 February 2019	11:00am	2:00pm	3
Thursday, 14 February 2019	11:30am	2:30pm	3

Friday, 15 February 2019	6:00am	1:00pm	7
Saturday, 16 February 2019	1:00pm	8:00pm	7
Sunday, 17 February 2019	1:00pm	8:00pm	7
Monday, 18 February 2019	6:00am	1:00pm	7
Tuesday, 19 February 2019	3:30pm	7:30pm	4
Friday, 22 February 2019	4:00pm	9:00pm	5
Saturday, 23 February 2019	4:00pm	9:00pm	5
Sunday, 24 February 2019	10:00am	4:00pm	6
Tuesday, 26 February 2019	4:00pm	8:00pm	4
Wednesday, 27 February 2019	3:30pm	6:30pm	3
Thursday, 28 February 2019	6:00am	12:00pm	6
Thursday, 28 February 2019	3:30pm	6:30pm	3

Friday, 1 March 2019	6:00am	1:00pm	7
Friday, 1 March 2019	5:00pm	9:00pm	4
Saturday, 2 March 2019	7:00am	12:00pm	5
Sunday, 3 March 2019	6:00am	9:00am	3
Sunday, 3 March 2019	10:00am	4:00pm	6
Monday, 4 March 2019	6:00am	12:00pm	6
Tuesday, 5 March 2019	3:30pm	7:30pm	4
Wednesday, 6 March 2019	3:30pm	6:30pm	3
Thursday, 7 March 2019	2:00pm	9:00pm	7
Friday, 8 March 2019	2:00pm	9:00pm	7
Sunday, 10 March 2019	10:00am	4:00pm	6
Sunday, 10 March 2019	5:00pm	8:00pm	3

Tuesday, 12 March 2019	3:30pm	7:30pm	4
Wednesday, 13 March 2019	4:00pm	7:00pm	3
Thursday, 14 March 2019	10:00am	4:00pm	6

Annual Leave			76
Friday, 15 March 2019			
Thursday, 28 March 2019			

Annual Leave			45.6
Saturday, 6 April 2019	6:00am	10:00am	4
Saturday, 6 April 2019	3:30pm	7:00pm	3.5
Sunday, 7 April 2019	6:00am	10:00am	4
Sunday, 7 April 2019	3:00pm	7:00pm	4
Monday, 8 April 2019	12:00pm	1:30pm	1.5
Monday, 8 April 2019	3:00pm	8:00pm	5
Tuesday, 9 April 2019	3:30pm	6:30pm	3
Wednesday, 10 April 2019	3:30pm	6:30pm	3
Thursday, 11 April 2019	12:00pm	4:30pm	4.5

Friday, 12 April 2019	1:00pm	8:00pm	7
Saturday, 13 April 2019	1:00pm	8:00pm	7
Sunday, 14 April 2019	1:00pm	8:00pm	7
Tuesday, 16 April 2019	4:00pm	8:00pm	4
Wednesday, 17 April 2019	3:00pm	7:00pm	4
Thursday, 18 April 2019	6:00am	2:00pm	8

Friday, 19 April 2019	6:00am	1:30pm	7.5
Saturday, 20 April 2019	6:00am	3:00pm	9
Sunday, 21 April 2019	6:00am	3:00pm	9
Wednesday, 24 April 2019	12:30pm	2:00pm	1.5
Wednesday, 24 April 2019	6:30pm	7:00pm	0.5
Thursday, 25 April 2019	3:00pm	8:00pm	5

Friday, 26 April 2019	12:00pm	8:00pm	8
Saturday, 27 April 2019	12:00pm	8:30pm	8.5
Sunday, 28 April 2019	12:00pm	8:00pm	8
Monday, 29 April 2019	6:00am	1:30pm	7.5
Tuesday, 30 April 2019	6:00am	1:30pm	7.5
Wednesday, 1 May 2019	6:00am	12:00pm	6
Wednesday, 1 May 2019	2:00pm	5:00pm	3

Friday, 3 May 2019	12:00pm	8:00pm	8
Saturday, 4 May 2019	7:00am	1:00pm	6
Sunday, 5 May 2019	12:00pm	8:00pm	8
Monday, 6 May 2019	12:00pm	8:00pm	8

Tuesday, 7 May 2019	12:00pm	8:00pm	8

Personal / Carer's Leave			8
Friday, 10 May 2019	12:00pm	8:00pm	8
Saturday, 11 May 2019	12:30pm	8:00pm	7.5
Sunday, 12 May 2019	12:30pm	8:00pm	7.5
Monday, 13 May 2019	12:00pm	8:00pm	8

Saturday, 18 May 2019	12:00pm	8:00pm	8
Sunday, 19 May 2019	12:00pm	8:00pm	8
Monday, 20 May 2019	12:00pm	8:00pm	8
Tuesday, 21 May 2019	4:00pm	7:30pm	3.5
Wednesday, 22 May 2019	12:00pm	8:00pm	8

Friday, 24 May 2019	12:00pm	8:00pm	8
Saturday, 25 May 2019	12:00pm	8:00pm	8
Tuesday, 28 May 2019	3:30pm	7:30pm	4
Wednesday, 29 May 2019	12:00pm	8:00pm	8
Thursday, 30 May 2019	12:00pm	8:00pm	8

Friday, 31 May 2019	12:00pm	8:00pm	8
Monday, 3 June 2019	12:00pm	8:00pm	8
Tuesday, 4 June 2019	11:30am	2:30pm	3
Tuesday, 4 June 2019	4:00pm	8:00pm	4
Wednesday, 5 June 2019	12:00pm	8:00pm	8
Thursday, 6 June 2019	12:00pm	8:00pm	8

BEFORE THE FAIR WORK COMMISSION
MATTER NO. AM2014/286
S. 156 - Four yearly review of modern awards – Social, Community, Home care and Disability Services Industry Award 2010

Statement of Paul Edward O'Brien

I, Paul Edward O'Brien, Customer Service Engineer, Unit [redacted] in State of the New South Wales, say;

1. I am a member of the Australian Services Union, NSW & ACT (Services) Branch ('**ASU**'). I am a workplace delegate. I have been representing the ASU in national consultation, industrial disputes and bargaining.

Employment in the business equipment industry

2. I am employed by Canon Australia Pty Ltd ('**Canon**') as Customer Service Engineer. I have been employed by Canon for about 23 years.

3. I am employed under the *Canon Australia Pty Ltd. (Technical Consultants) Enterprise Agreement 2019* ('**Agreement**'). Attached and marked **Annexure A** is a copy of the Agreement. The reference instrument for the purposes of the Better Off Overall Test for the agreement is *Business Equipment Award 2010* ('**the Award**'). Attached and marked **Annexure B** is a copy of the Award.

4. I am a full-time employee. I work an average of 37.5 hours averaged over 28 days. I do not receive a roster because I have a normal start and finishing time. However, my employer is entitled to shift the span of hours to accommodate the needs of customers.

Payment for travel time

5. I install and service business equipment sold by my employer. I am employed to install and maintain Canon photocopiers and other business equipment.

6. I am assigned a region of operation by my employer. I am required to travel between work locations by my employer. This includes travelling to a customer's premises to perform work, picking up parts from the warehouse, attending my employers offices or workshops. I may be required to start and finish work at a customer's premises during my rostered ordinary hours.

7. I am what is known as a 'walking tech'. I am based in the central business district. I walk to and from my jobs. Some of my co-workers are 'driving techs', they have a larger area and are required drive between locations.

8. I spend a reasonable amount of time travelling between work locations each day. It is hard to estimate because it does vary and I am not required to keep track of it. It could be between 10 and 30 minutes travel for each job.

9. I am paid at ordinary time rates of pay for travel in excess of hours outside my ordinary hours of work but within my region of operations under clause 25 (a) of my Agreement. If I am travelling outside my region, I will be paid for all travel time outside my hours of work under clause 25(c) of my Agreement.

Characteristics of my sector

10. In my experience, most people who work in my industry are men. I believe that only one woman is covered by my Agreement.

11. This is supported by the Form F17 lodge by my employer, at the time the Agreement was made it covered 74 employees. Only one was a woman. Attached and marked **Annexure C** is a copy of the Form F17 – Employers statutory declaration in support of an application for approval of an enterprise agreement (other than a greenfields agreement) lodged by Canon on 22 February 2019.

12. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

[redacted]

Witness Signature

Paul O Briens

Witness Name [PRINTED]

DATE: 27/6/2019

ATTACHMENT A

[2019] FWCA 2275

DECISION

Fair Work Act 2009
s.185—Enterprise agreement

Canon Australia Pty Ltd
(AG2019/435)

CANON AUSTRALIA PTY LTD (TECHNICAL CONSULTANTS) ENTERPRISE AGREEMENT, 2019.

Business equipment industry

DEPUTY PRESIDENT SAUNDERS NEWCASTLE, 4 APRIL 2019

Application for approval of the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement, 2019.

[1] An application has been made for approval of an enterprise agreement known as the *Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement, 2019* (***Agreement***). The application was made pursuant to s.185 of the *Fair Work Act 2009* (***Act***). It has been made by Canon Australia Pty Ltd**.** The Agreement is a single enterprise agreement.

[2] The Employer has provided written undertakings (***Undertakings***). A copy of the Undertakings is attached in Annexure A to this decision. I am satisfied that the effect of accepting the Undertakings is not likely to:

(a) cause financial detriment to any employee covered by the Agreement; or

(b) result in substantial changes to the Agreement.

[3] The views of each person who the Fair Work Commission knows is a bargaining representative for the Agreement have been sought in relation to the Undertakings.

[4] Pursuant to subsection 190(3) of the Act, I accept the Undertakings.

[5] Subject to the Undertakings, I am satisfied that each of the requirements of ss.186, 187, 188 and 190 as are relevant to this application for approval have been met.

[6] The Australian Municipal, Administrative, Clerical and Services Union being a bargaining representative for the Agreement, has given notice under s.183 of the Act that it wants the Agreement to cover it. In accordance with s.201(2) of the Act, I note that the Agreement covers the organisation.

[7] The Agreement is approved and, in accordance with s.54 of the Act, will operate from 11 April 2019. The nominal expiry date of the Agreement is 3 April 2022.

DEPUTY PRESIDENT

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Annexure A

IN THE FAIR WORK COMMISSION

FWC Matter No.:
AG2019/435

Applicant:

Canon Australia Pty Ltd

Section 185 – Application for approval of a single enterprise agreement

Undertaking - Section 190

I, Sara Marshall, Director, Human Resources, Communications and Facilities for Canon Pty Ltd give the following undertakings with respect to the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement, 2019 ("the Agreement"):

1. I have the authority given to me by Canon Australia Pty Ltd to provide this undertaking in relation to the application before the Fair Work Commission.

2. Canon Australia Pty Ltd undertakes that in the event of an inconsistency between the NES and the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement, 2019 and the NES provides a greater benefit to an employee, the NES provision will apply to the extent of the inconsistency.

3. This undertaking is provided on the basis of issues raised by the Fair Work Commission in the application before the Fair Work Commission.

Signature

28/3/19.

Date

Note - this agreement is to be read together with an undertaking given by the employer. The undertaking is taken to be a term of the agreement. A copy of it can be found at the end of the agreement.

CANON AUSTRALIA PTY LTD (TECHNICAL CONSULTANTS)

ENTERPRISE AGREEMENT, 2019

PART A – PRELIMINARIES

1. TITLE

This agreement shall be known as the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement, 2019.

2. TABLE OF CONTENTS

3. AREA, INCIDENCE AND PARTIES BOUND

a) This Agreement shall be binding upon Canon Australia Pty. Ltd. ('Canon') and positions classified within the "Technical Consultant" stream as reflected in Appendix B and the Australian Municipal, Administrative, Clerical and Services Union (**ASU**).

b) The parties agree that such employees who are engaged by Canon during the term of this Agreement will become a party to the Agreement. This Agreement replaces all other Agreements.

c) This Agreement is comprehensive and is intended to operate to the exclusion of the Business Equipment Award 2010 to the extent allowable by law.

4. DATE AND PERIOD OF OPERATION

a) The Agreement shall operate from the date the Fair Work Commission's approval notice advises the Agreement comes into operation and shall reach its nominal expiry date 3 years after the date of approval.

5. AIM OF AGREEMENT

a) The aim of this Agreement is to gain continuous improvement in productivity, efficiency, flexibility, communication and co-operation in the workplace.

b) The parties also recognise the necessity of adopting a consultative and participative approach to workplace reform to achieve change. In order to achieve this, a National Consultative Committee may operate in each State. In addition, a National Consultative Committee will operate on an 'as requested' basis.

6. NO EXTRA CLAIMS

a) It is a term of this agreement that the parties undertake not to pursue any extra claims during the life of this Agreement.

7. NATIONAL CONSULTATIVE COMMITTEE

a) Canon is committed to the on-going maintenance of a National Consultative Committee ('NCC') constituted by nominated management and elected employee representatives and Australian Services Union (ASU) delegate.

b) The NCC is a structured forum, whose purpose is to provide a forum for two-way communication between management and employees.

c) The members of the NCC reserve the right to communicate with their respective constituents with regard to any NCC matters.

d) Any requests by the representatives to communicate with their constituents shall not be unreasonably refused by management.

e) The NCC will determine its own Constitution.

8. INTRODUCTION OF CHANGE

a) All parties recognise that we work in a competitive and changing industry. As such, all recognise that there may be required changes to business operations, both by way of structural enhancements and skill development.

b) With this in mind, Canon is committed to providing secure employment for employees in a manner consistent with prudent management.

c) Canon acknowledges that some business decisions will impact on employees' personal and working lives and is committed to minimising any adverse impact to the extent that is practicable. The process described below aims to assist in this process.

d) Canon will consult with the employees and their union where Canon proposes to introduce:

(i) significant business initiatives or major changes, which is likely to have a significant effect on employees (including Canon policy which affects employment conditions); or

(ii) a change to their regular roster or ordinary hours of work, unless specifically contemplated by this Agreement,

managers will consult with the employees who may be effected by the proposed changes as early as practicable.

e) A significant effect on staff members will arise in circumstances such as major change in technology, outsourcing, or the composition, operation or size of Canon's workforce or in the skills required, the elimination or diminution of job opportunities.

f) Canon will consult with employees affected and their union on the introduction of the changes referred to at subclause 8 d), by providing information about the changes, the effect the changes are likely to have on staff, and where possible the measures to avert or mitigate the adverse effects of such changes on staff. Canon will give an opportunity for the relevant employees affected to provide their views on the impact of the changes (including any impact of a change to their regular roster or ordinary hours of work in relation to their family or caring responsibilities). Further, Canon will give consideration to matters raised by employees about the impact of the changes and give reasons for its decisions.

g) The relevant employees affected by major changes or changes to their regular roster or ordinary hours of work may appoint a representative for the purposes of this process.

9. NEW TECHNOLOGIES

From time to time Canon may implement new technologies as an aid to business improvements.

10. ACCESS TO RECORDS AND PRIVACY

a) All employees will be given a copy of this Agreement.

b) Canon agrees to provide a copy of this Agreement on request to any employee.

c) All employees shall have access to their personal file.

d) Whenever an appraisal is made by Canon in relation to an employee, then that employee shall be entitled to see and comment on such appraisal.

e) The Canon Australia group of companies is subject to statutory privacy obligations.

11. ETHICS

a) The contents of Canon's 'Code of Ethical Conduct' (as amended from time to time) is also part of this Agreement. Prior to amendment, the National Consultative Committee will be consulted. (Refer to handbook)

b) All employees covered by this Agreement will be given one month's written notice of change to make comments.

12. AGREEMENT FLEXIBILITY

a) Canon and an employee covered by this Agreement may agree to make an individual flexibility arrangement to vary the effect of terms of the Agreement if:

(i) the arrangement deals with 1 or more matters arising under any term of the Agreement;

(ii) the arrangement meets the genuine needs of Canon and the employee; and

(iii) the arrangement is genuinely agreed to by Canon and the employee.

b) Canon must ensure that the terms of the individual flexibility arrangement:

(i) are about permitted matters under section 172 of the Fair Work Act 2009; and

(ii) are not unlawful terms under section 194 of the Fair Work Act 2009; and

(iii) result in the employee being better off overall than the employee would be if no arrangement was made.

c) Canon must ensure that the individual flexibility arrangement:

(i) is in writing; and

(ii) includes the name of Canon and the employee; and

(iii) is signed by Canon and employee and if the employee is under 18 years of age, signed by a parent or guardian of the employee; and

(iv) includes details of:

1. the terms of the Agreement that will be varied by the arrangement; and
2. how the arrangement will vary the effect of the terms; and
3. how the employee will be better off overall in relation to the terms and conditions of his or her employment as a result of the arrangement; and

(v) states the day on which the arrangement commences.

d) Canon must give the employee a copy of the individual flexibility arrangement within 14 days after it is agreed to.

e) Canon or employee may terminate the individual flexibility arrangement;

(i) by giving no more than 28 days written notice to the other party to the arrangement; or

(ii) if Canon and the employee agree in writing - at any time.

PART B – WAGES, ALLOWANCES AND RELATED MATTERS

13. WAGES

a) Employees covered by this agreement will be paid on a Total Remuneration Cost (TRC) basis. This includes base salary, Superannuation Guaranteed Contribution (SGC), Annual Leave Loading and any other salary sacrifice items as elected by the employee and agreed to by Canon.

b) Minimum TRCs for each job classification are shown in Appendix A.

c) Notwithstanding the rates paid for various job classifications, factors which will be considered when placing individuals in the TRC band will include, but not be limited to, the following:

(i) the individual employee's past experience;

(ii) appropriate skills and qualifications;

(iii) overall job performance over time;

(iv) the individual employee's employment record with Canon; and

(v) any other relevant matters.

d) All TRC ranges will be reviewed, although not necessarily adjusted, on an annual basis. TRC range reviews will take account of the value of each job, Canon performance, Government legislation and market rates.

e) Unless otherwise agreed, all salaries will be paid by direct deposit to a bank, building society or credit union.

f) Salaries will be paid fortnightly. Salaries will be paid on a one week in advance, one week in arrears basis.

g) An employee may authorise Canon to deduct monies on a salary sacrifice basis. In the event that an employee requests Canon to make any such deductions, each instance will be confirmed in writing by the employee.

h) The minimum TRC increases for each employee are set out in Appendix A.

14. SUPERANNUATION

a) For the purpose of this clause, "Ordinary time earnings", is defined as the expressed base salary earned by an employee during a twelve month period. In the event that an employee's base salary is adjusted, Canon contributions are adjusted accordingly.

b) Canon will make superannuation contributions in accordance with the provisions of the Superannuation Guarantee (Administration) Act 1992 (Cth) and any other applicable legislation.

c) An employee may authorise Canon to make additional superannuation contributions to the fund, such additional contributions being deducted from the employee's earnings as a salary sacrifice.

d) The employee must specify an amount as a percentage of ordinary time earnings as defined above by which his or her salary is to be reduced ("the salary sacrifice").

e) Canon will continue to calculate the contributions required by sub-clause a) above on the basis of the employee's ordinary time earnings before the salary sacrifice is deducted.

f) The employee may revoke the salary sacrifice agreement or alter the amount to be deducted at any time.

g) All superannuation contributions will be made into a MySuper default fund selected by Canon unless otherwise advised by the employee of an alternate approved fund of the employee's choice. These do not include funds that require Canon to become a participating member of that fund.

h) Casual employees become members at the end of the month in which they first earn the amount prescribed under Federal legislation.

15. UNIFORMS

a) Canon will provide a uniform to employees annually. Canon requires employees to wear the provided uniforms.

b) In the event that Canon intends to change or alter any portion of the Canon uniform, Canon will consult the NCC on any such intended change.

16. FIRST AID ALLOWANCE

An employee holding a current first aid qualification from St Johns Ambulance or similar body, who is appointed by Canon to perform first aid duties, will be paid a first aid allowance of $22.05 per week.

The first aid allowance will increase to:

a) $22.05 per week effective from 1 March 2019;

b) $22.46 per week effective from 1 March 2020; and

c) $22.89 per week, effective from 1 March 2021.

17. MEAL BREAKS AND MEAL ALLOWANCES

a) Unless agreed by both parties, an employee shall not work for longer than five (5) hours without a meal break. The minimum meal break shall be 30 minutes. This time shall be unpaid.

b) An employee required to work two (2) hours or more overtime is entitled to be paid a meal allowance. If overtime extends a further four (4) hours, an additional meal allowance will be paid.

c) A meal allowance shall not be payable if Canon provides a meal.

d) The value of the meal allowance is $14.66 per meal.

The meal allowance will increase to:

(i) $14.66 per meal effective from 1 March 2019;

(ii) $14.94 per meal effective from 1 March 2020; and

(iii) $15.22 per meal, effective from 1 March 2021.

18. MOTOR VEHICLES / WALKING ALLOWANCE

a) Where a motor vehicle is required to perform normal duties, the Canon will at its option provide either a:

(i) motor vehicle as per the relevant Canon Australia Fleet Policy (as amended from time to time) which includes a fleet card to cover all running costs; or

(ii) suitable car / walking allowance as applicable to the position; or

(iii) kilometre allowance - for an employee who is required to use his/her motor vehicle to carry out the employers business on a casual basis they shall be paid an allowance of 90 cents per kilometre.

This allowance will increase to:

a) 90.00 cents per kilometre effective from 1 March 2019;

b) 92.00 cents per kilometre effective from 1 March 2020; and

c) 94.00 cents per kilometre, effective from 1 March 2021.

b) A walking allowance is paid to compensate for day to day travel expenses, together with the foregone benefit of driving a Canon motor vehicle during business hours and the private benefits associated with a Canon motor vehicle.

c) The walking allowance for the life of this Agreement will be $13,269 per annum (for part time employees and casual employees this will be on a pro-rata basis).

d) Walking allowances and motor vehicle allowances will not be payable, and Canon motor vehicles shall be returned during unpaid absences unless otherwise agreed with Canon.

e) Where a new Canon motor vehicle is provided the following shall apply (unless otherwise agreed with the employee):

(i) The vehicle shall have an ANCAP/NCAP rating of five (5) or greater;

(ii) The vehicle shall have an automatic transmission;

(iii) The vehicle shall have appropriate safety equipment including but not limited to reverse parking sensors, reversing camera, hands-free mobile phone capability, window tinting, cargo barrier, laptop charging port in cargo area and current first aid kit;

(iv) The vehicle shall have seating for five people;

(v) The vehicle shall have suitable secure parts carrying capacity;

(vi) The vehicle shall be available for Canon business use as and when required; and

(vii) The employee, and their spouse may (subject to being over 21 and holding an unrestricted driver's license for a minimum of 2 years which is not suspended or cancelled) use the vehicles for private non-business use within areas defined within Canon's Fleet Policy (as amended from time to time) unless otherwise provided within this agreement.

f) Canon will be responsible for the payment of all FBT costs associated with the provision or use of a Canon motor vehicle in accordance with this clause.

19. ELECTRICAL LICENCES

a) Where State legislation requires electrical licenses to be held in order to work on office equipment, Canon will pay any reasonable costs incurred in the initial acquisition and renewal of the electrical license for employees.

20. HIGHER DUTIES ALLOWANCES

a) Where an employee is required to perform duties or accept responsibilities in a role other than that of their substantive classification for a period of; 5 working days or greater for a Service Supervisor role or, 10 working days or greater for

all other roles, they shall be paid at the rate from day one which would be applicable if such work was performed on a permanent basis.

Where an employee is required to act in the role of a Supervisor, they shall be paid an annualised allowance of $5,900. This equates to $113.46 per week.

This annualised allowance will increase to:

(i) $5,900 (rounded) per year (or $113.46 per week) effective from 1 March 2019;

(ii) $6,000 (rounded) per year (or $115.38 per week) effective from 1 March 2020; and

(iii) $6,100 (rounded) per year (or $11.30 per week) effective from 1 March 2021.

b) For the purposes of this clause, the allowances and payments referred to above shall be paid on a pro rata basis for the period the employee acts in the higher role.

c) Rates of pay for other higher roles will be determined in line with Canon's Remuneration, Allowance & Subsidy policy.

PART C – HOURS OF WORK AND RELATED MATTERS

21. HOURS OF WORK

a) A work cycle means the pattern of daily start and finishing times as may be agreed between the employee and his or her Supervisor.

b) Ordinary hours means those hours worked in a work cycle for which the ordinary rate of pay is paid.

(i) The span of hours shall be between 6:00 am and 6:30 pm, Monday to Friday.

(ii) The ordinary hours of work shall average 37.5 hours per week within a work cycle not exceeding twenty eight (28) consecutive days.

(iii) Ordinary hours worked on a daily basis must not exceed an average of 7.5 hours per day within a work cycle not exceeding twenty eight (28) consecutive days, except by agreement, provided that the maximum hours worked shall not exceed twelve (12) hours per day.

(iv) Unless otherwise agreed, an employee's work cycle will commence at 8:30 am and will not be less than four (4) hours per day, except that the minimum period of four (4) hours will not apply to part-time or casual employees.

(v) Where any period of an employee's work cycle commences or finishes outside of the span of hours, a loading of 20% of the ordinary hourly rate of pay will apply to all time outside of the span of hours.

22. START OF DAY

a) It is an inherent condition of employment that an employee may be required to start and finish their work cycle at the customer's premises. It is acknowledged that for most employees, the variability in daily travel time from their principal place of residence to their first job requires due recognition to ensure scheduling flexibility is maintained without excessive periods of unpaid travel time being imposed on the employee. Acknowledging this, employees are expected to start work by their scheduled starting time (normally 8.30 am). Examples of work include;

(i) at customer's premises (after picking up parts if the additional travel time to the warehouse, drop point or storage lock up is less than or equal to fifteen (15) minutes);

(ii) picking up parts from warehouse, drop point or storage lock up if picking up parts would extend travel time to the customer premises by more than fifteen (15) minutes;

(iii) in office;

(iv) attending meetings;

(v) attending training; or

(vi) as directed by a Supervisor.

23. OVERTIME

a) Overtime is all time worked in excess of an employee's work cycle as defined in Clause 21.

b) Before requiring an employee to work overtime Canon must take into consideration the amount of overtime already worked in the period and the employee family responsibilities.

c) Overtime shall be calculated to the nearest fifteen (15) minutes of the total overtime worked in the work cycle.

d) All overtime worked Monday to Saturday shall be paid for at the rate of 150% of the employee's ordinary hourly rate.

e) All overtime worked on Sunday shall be paid for at the rate of 200% of the employee's ordinary hourly rate.

f) Subject to Clause 44, all overtime worked on public holiday shall be paid for at the rate of 200% of the employee's ordinary hourly rate.

g) An employee (other than a casual or part-time employee) who works so much overtime between the end of their daily work cycle and the commencement of their next work cycle, that they have not had at least ten (10) consecutive hours off duty between those times, shall be released after the completion of such overtime until they have had ten (10) consecutive hours off duty, without loss of pay for all ordinary working time occurring during the ten (10) hour break.

h) If, on the instruction of Canon, such employees resume or continue work without having had ten (10) hours off duty, they shall be paid at double time

until released from duty for such period and then be entitled to be absent until they have had ten (10) consecutive hours off duty without loss of pay.

i) All overtime must be approved prior to it being worked.

j) For the avoidance of doubt, where an employee is entitled to the allowance under clause 21.b)(v) or any other shift allowance, overtime will not apply for the hours during which the allowance is applicable.

24. TIME OFF IN LIEU / ROSTERED DAY OFF

a) Employees will be entitled to payment for overtime. Alternatively, time off in lieu of payment may be arranged subject to agreement of both the manager and the employee concerned.

b) Subject to agreement of both the manager and the employee concerned, any time off in lieu must be taken within four (4) weeks of having been worked. Failure to take the time off in lieu shall result in the overtime being paid to the employee in their next salary payment. Requests for time off in lieu will not be unreasonably refused by management.

c) Other than the restrictions in this clause, nothing in this agreement shall prohibit any flexibility in working arrangements to meet customer needs. A rostered day off (RDO) arrangement may be agreed to between a manager and individual or group where the arrangement meets customer and business needs.

25. TRAVEL AND ACCOMMODATION

a) Time spent travelling within an employee's region of operation to and from seminars, conferences, training, etc in excess of two (2) hours each way, which is outside the employee's agreed work cycle, will be paid at ordinary rates of pay. For the purposes of this clause an employee's region of operation is defined as the area where Canon provides direct service.

b) Time spent travelling outside an employee's region of operation to and from kick-offs, trips/travel organised as a reward or bonus, which is outside the employee's normal working hours, will not be paid.

c) For all other travel outside an employee's region of operation, all travelling time outside their ordinary hours of employment shall be paid at their ordinary rates.

d) All allowances and reimbursements will be as per Canon policy.

26. STAND-BY AND CALL-OUT

a) Employees who are rostered on to stand-by shall be paid a stand-by allowance of $13.09 for each hour for which they are rostered on to stand-by.

The stand-by allowance will increase to:

(i) $13.09 per hour effective from 1 March 2019;

(ii) $13.33 per hour effective from 1 March 2020; and

(iii) $13.58 per hour, effective from 1 March 2021.

b) Employees who are on stand-by must be available and able to work when they are called.

c) If an employee is called to work while on stand-by they shall be paid a minimum of three (3) hours.

d) Employees on stand-by who are called out shall be paid at the overtime rate. While receiving the appropriate overtime rate, the stand-by allowance will not be paid.

e) In the event that an employee on standby:

(i) Is called out and completes the work before midnight (including travelling time) they will be required to commence work by 8:30 am the following morning, provided that they have already had at least one and a half (1.5) hours break prior to being called out, otherwise the employee will commence work by 10 am the following morning.

(ii) Is called out and completes the work after midnight, then the employee is required to take a minimum break of ten (10) hours without loss of pay for the ordinary working time occurring during the ten (10) hour break;

(iii) Is called out after 5.00 am, they will continue to work until such time as they have completed their ordinary work cycle. However, they must take a thirty (30) minute meal break (on full pay) on the completion of the first five (5) hours worked.

f) Employees who are not on stand-by that are called out after having completed their normal daily work cycle will be paid for a minimum of four (4) hours at the overtime rate.

PART D – MODE OF EMPLOYMENT

27. CLASSIFICATION STRUCTURE

a) The employees covered by this Agreement are those employees classified in accordance with the Positions in Appendix B. All parties to this Agreement acknowledge that these Positions may need to be changed from time to time to accommodate the changing business needs. Any significant change will be made in accordance with Clause 8. Changes affecting a group of employees will be reviewed with the National Consultative Committee prior to implementation.

b) Employees will be notified of their classification prior to commencement of employment.

c) Employees shall carry out such duties as directed by Canon from time to time subject to the limits of their skills, competence and training.

d) Where Canon requires a employees to be seconded to a position utilising a different job title then, where possible, expressions of interest will be sought and discussed with individuals. Such voluntary secondments will be reviewed on a monthly basis.

e) Where no volunteer is forthcoming, Canon reserves the right to direct a employee to perform the required duties to meet operational requirements. In such circumstances the secondment will be reviewed on a monthly basis and will be for a maximum period of three (3) months.

28. JOB SHARE

a) Where two or more employees with similar skills seek to enter into a job share arrangement, such requests will not be unreasonably refused. In such a job share situation all tools of trade will need to be shared (this includes but not limited to laptop, phone, spares inventory and vehicle). The exchange of such tools will need to take place in the employee's own time to preserve the opportunity for 37.5 hours of work per week to be completed.

b) In the event that one job sharer resigns or is terminated Canon will make every attempt to locate a replacement job share partner. In the event no new job share partner can be found, the remaining job sharer will revert to a full-time position.

29. PROBATION

a) The purpose of the probationary period is to allow both Canon and the employee to assess the employment relationship and to decide whether to continue the employment beyond the probationary period.

b) Normally an employee may be engaged for an initial probationary period of three (3) months on the following basis:

(i) Canon will advise the employee in writing, prior to the commencement of their employment, of the applicability and length of the probationary period;

(ii) At any time during the probationary period, either party may elect to end the employment relationship without giving reasons by giving one weeks' notice of termination of the employment. The probation period may be extended by mutual agreement for an additional period of up to three months; and

(iii) Nothing in this clause affects Canon's right to dismiss a probationary employee without notice for misconduct which justifies summary dismissal.

30. PART-TIME EMPLOYMENT

a) Part time employment means a person employed to work less than an average of 37.5 hours a week within a work cycle not exceeding twenty eight (28) consecutive days.

b) The span of hours for a part time employee will be those outlined in Clause 21.

c) Overtime shall apply in accordance with clause 23 or any other relevant provision of this Agreement.

d) An employee employed on a part-time basis shall be paid an hourly rate based pro rata of the weekly rate for their appropriate classification.

e) Personal/carer's leave and annual leave entitlements shall be provided on a pro-rata basis.

f) Walking allowance shall be provided on a pro rata basis, if applicable.

g) Compassionate leave and long service leave shall be provided in accordance with the relevant legislation.

h) Part-time employees are entitled to public holidays only if the public holiday falls on their normal work day, and will be paid for the number of hours they would have received had they worked the public holiday in question.

i) A Part-time employee who is provided a motor vehicle by Canon may be required to return that vehicle on days that the employee is not working.

31. CASUAL EMPLOYMENT

a) Casual Employment means a person engaged by the hour and paid by the hour who may be dismissed or leave Canon's service with one (1) hours' notice. Casual employees are engaged on an 'as and when required' basis.

b) Casual employees will be paid a 25% loading on the relevant hourly rate for the work being done.

c) Casual employees are not entitled to paid leave of any kind, public holidays, or redundancy payments except as may be provided for in any applicable State or Federal legislation.

d) Walking allowance shall be provided on a pro rata basis, if applicable.

e) A casual employee who is provided a motor vehicle by Canon may be required to return that vehicle at times that the employee is not working.

PART E – WORKPLACE FLEXIBILITY

32. CHANGE OF WORK LOCATION

a) Canon requires the flexibility to re-balance the workforce and skills required across service delivery areas to meet operational and client service needs. In determining any such change of work location, Canon will have regard to the impact of any proposed change and an employee's personal circumstance, which will be determined in direct consultation with the employee(s) involved.

b) When any new work location arrangements are established (whether temporary or permanent), any such arrangement will be formally recorded and provided to the employee(s) involved. Any subsequent change from the established and recorded arrangements will require the same consideration and consultation process outlined above to be undertaken.

33. GOALS

a) Goals will be developed for each level of Technical Consultant. The following process will occur in developing and communicating the Technical Consultants' Goals:

(i) The National Consultative Committee will establish a working party.

(ii) The drafted Goals will be presented in each location with appropriate feedback being considered by the working party.

(iii) Once Canon has confirmed that the Goals meet business requirements, all affected employees will receive a copy.

b) The parties acknowledge and agree that Goals should be:

(i) Specific / Unambiguous;

(ii) Measurable;

(iii) Achievable;

(iv) Realistic; and

(v) Time Bound;

and that these 'SMART' goals are intended to meet business requirements and target reasonable and fair productivity improvements.

c) The Goals for each year will be in place in line with the published Canon Australia timetable.

d) Should there be reasons for this deadline not being achieved, those reasons will be communicated to the affected employees.

e) Existing Goals remain in place until the new Goals confirmed by Canon. This confirmation will be served as the presentation of the final document.

f) If there are outstanding issues in relation to the Goals, of a generic nature, then they are to be raised with the National Consultative Committee if it relates to a group of employees. Issues that affect a single individual may be pursued either through the National Consultative Committee or through Clause 39..

PART F – CESSATION OF EMPLOYMENT

34. TERMINATION OF EMPLOYMENT

a) On termination, all employees are entitled to superannuation benefits (as per the Trust Deed) plus their accrued Long Service Leave (as per the relevant

State Act) and pro rata Annual Leave. If an employee on termination owes any money to Canon, or any of its related companies, as a result of debt or because of theft, misconduct or failure to work out notice, Canon has the right to deduct the money from any benefits to which the employee may be entitled.

b) Termination By Canon

(i) In order to terminate the employment of an employee, Canon shall give the employee the notice indicated in the table below. If the employee is within their probationary period only one weeks' notice will be required. Employees over 45 years of age will receive an additional one weeks' notice unless sub-clause 34.e) applies.

Employee's period of continuous service with Canon	**Period of notice**
Not more than 1 year	At least 1 week
More than 1 year but not more than 3 years	At least 2 weeks
More than 3 years but not more than 5 years	At least 3 weeks
More than 5 years	At least 4 weeks

(ii) In the case of redundancy, all employees will receive four weeks' notice. If an employee is over 45 years of age, they will receive an additional weeks' notice.

(iii) Payment in lieu of notice may be made at Canon's discretion. All termination payments will be calculated using the employee's base salary at the time of termination.

(iv) Where an employee no longer has any paid leave entitlements and absences without pay have exceeded three (3) months in total over any 12 month period, and the employee is unable to provide a reasonable return date, Canon reserves the right to terminate employment.

c) Resignation By Employee

(i) In order to resign, the employee must give Canon the same period of notice as in Clause 34.b)(i). If the employee fails to work the required notice period, then Canon shall have the right to deduct from any monies payable an amount equal to the base salary the employee would have received had they have worked the notice.

(ii) Neither party has the right to use annual leave or long service leave during the notice period without the agreement of the other party. If an employee is sick during the notice period, personal/Carer's leave will not be paid unless a doctor's certificate is provided.

d) Abandonment of Employment

Should the employee fail to attend work for three (3) consecutive working days and not contact their supervisor / manager within those three days, then it will be assumed that employment has been abandoned. The employee can therefore be terminated without the required notice. However, before termination, Canon will make reasonable attempts to contact employees. The employee's last day of attendance shall serve as the last day of their employment for the purpose of calculating entitlements.

e) Summary Dismissal

Canon may dismiss any employee immediately and without notice for serious misconduct. Examples of serious misconduct include but are not limited to

theft, insubordination, neglect of duty, possession of, trafficking in, or use of illicit drugs (at work), or working under the influence of intoxicating liquor or drugs (whether illicit, prescription or over the counter medication). No payment in lieu of notice will be paid.

35. REDUNDANCY

a) Redundancy occurs where Canon Australia has made a definite decision that it no longer requires the job the employee has been doing to be done by anyone and that decision leads to the termination of employment of the employee, except where this is due to the ordinary and customary turnover of labour. Where practicable, expressions of interest for voluntary redundancy will be called for before a decision is made as to who will be retrenched. However, Canon reserves the right to select the employees who will be made redundant.

b) Redundancy does not apply:

(i) Where employment is terminated as a consequence of:

1. Resignation;
2. Dismissal due to conduct, capacity or performance;
3. Abandonment of employment;
4. Expiration of a fixed term contract, or completion of a specified project/task or tasks or maximum term contract;
5. Death;
6. Ill health;
7. Transfer of business (as that term is defined in the *Fair Work Act*) where suitable alternative employment is found for an employee within any of Canon's associated entities or another employer.

(ii) Where suitable alternative employment is found for an employee within Canon.

(iii) To the following categories of employees:

1 Probationary employees;
2 Apprentices;
3 Trainees whose employment under a traineeship agreement or an approved traineeship is for a specified period or is, for any other reason, limited to the duration of the agreement;
4 Employees engaged for a specific period of time or for a specified task or tasks;
5 Casual employees; and
6 Temporary employees.

For the purposes of this sub-clause b), 'suitable alternative employment' shall mean employment which;

1. Is paid at a rate not less than the employee's current hourly rate; and
2. Is within the employee's skills and competence to perform; and
3. Recognises the employee's service with Canon as service with the new employer; and
4. Is in terms and conditions that are substantially similar and no less favourable, considered on an overall basis, than the terms and conditions applicable to the employee at the time of ceasing employment with Canon.

36. MAXIMUM REDUNDANCY PAYMENT:

a) When a definite decision has been made that an employee is to be retrenched, that employee will be notified as soon as it is reasonably possible.

b) An employee who is retrenched will be entitled to the following redundancy pay:

Service	Entitlement
Less than 1 year	Nil
1 year to completion of 2 years	4 weeks
2 years to completion of 3 years	7 weeks
3 years to completion of 4 years	10 weeks
4 years to completion of 5 years	12 weeks
5 years to completion of 6 years	14 weeks
6 years to completion of 7 years	16 weeks
7 years to completion of 8 years	18 weeks
8 years to completion of 9 years	20 weeks
9 years to completion of 10 years	22 weeks
10 years to completion of 11 years	24 weeks

i) An additional two (2) weeks for each completed year of service will be paid for more than eleven (11) years' service.

c) Employees who commenced employment with Canon prior to 1 September 2015 and who have been employed by Canon continuously up to the date of redundancy are entitled to an additional loading of twenty-five percent (25%) on any redundancy payments if they are aged forty (40) years or more at the time their employment is terminated on the basis of redundancy.

d) The maximum amount payable to:

(i) an employee who is employed by Canon after 1 September 2015 or is under the age of forty (40) years at the time their employment is terminated due to redundancy, is twelve (12) months pay; or

(ii) an employee who commenced employment with Canon prior to 1 September 2015 and has been employed by Canon continuously up to the date of redundancy and is aged forty (40) years or more at the time their employment is terminated due to redundancy, is eighteen (18) months pay.

e) Time off of up to 7.5 hours each week to attend job interviews will be made available, however, proof of attendance may be required if payment for the time off is to be made.

f) Canon may make an offer of alternative employment to an employee who may choose to either accept or reject the offer.

37. TRANSFER OF BUSINESS

a) Where Canon proposes a Transfer of Business from Canon to another employer and:

(i) Canon and the new employer wish to retain all employees covered by this Agreement who are employed in the particular business which Canon proposes to transfer:

a) Expressions of interest to transfer to the new employer will be invited; and

b) If the number of expressions of interest exceeds or is less than the number of employees who the new employer wishes to employ, Canon will consult with the National Consultative Committee on how to determine those employees who will be offered transfer.

(ii) Canon and the new employer do not wish to employ all of the employees covered by this agreement who are employed in the particular business which Canon proposes to transfer:

a) Expressions of interest for voluntary redundancy will be called for;

b) If the voluntary redundancy process is undersubscribed then all employees who applied for voluntary redundancy will be successful in their application and Canon will consult with the National Consultative Committee on the selection process to be implemented by Canon to determine the additional employees to be made redundant. However, if the voluntary redundancy process is oversubscribed, then Canon will consult with the National Consultative Committee on the selection process to be implemented by Canon to determine the employees to be made redundant;

c) Following completion of the process in B. above, expressions of interest to transfer to the new employer will be invited from those employees who have not been made redundant or identified as redundant in B. above; and

d) If the number of expressions of interest arising from the process in C. above exceeds or is less than the number of employees who the new employer wishes to employ, Canon will consult with the National Consultative Committee on the selection process to be implemented to determine those employees who will be offered transfer.

b) Clause 37.d) will apply where:

(i) a Transfer of Business from Canon to another employer (new employer) has taken place; and

(ii) an employee has accepted and commenced employment with the new employer (transferred employee); and

(iii) under the terms of that employment the new employer has recognised the employee's prior continuous service with Canon for the purpose of all service related entitlements and assumed the employee's accrued but untaken entitlements to leave;

at any time prior to the nominal expiry date of this agreement.

c) In clause 37.d), the term "Accrued Entitlements" shall mean:

(i) the value of the transferred employee's accrued but untaken annual leave entitlements as at the date of the transfer; and

(ii) the value of the transferred employee's accrued but untaken long service leave entitlements as at the date of the transfer; and

(iii) the redundancy payment that the transferred employee would have received from Canon under the terms of this Agreement had they been entitled to redundancy pay as a result of the termination of their employment with Canon at the time of the transfer;

less any part of these entitlements actually paid to the transferred employee by Canon upon termination of their employment with Canon.

d) If, at any time within three (3) years of a transfer as defined in clause 37.c):

(i) the employment of the transferred employee with the new employer terminates; and

(ii) the transferred employee is entitled upon termination to receive a payment:

a) in lieu of accrued but untaken entitlements to annual leave;

b) in lieu of accrued but untaken entitlements to long service leave; or

c) of a redundancy payment under the terms of this Agreement,

but the new employer is unable to pay any or all of those amounts to the employee due to the insolvency of the new employer, Canon will ensure the transferred employee receives any of the Accrued Entitlements which the new employer is unable to pay.

However, Canon has no such obligation with respect to any entitlement the employee receives under the General Employee Entitlements and Redundancy Scheme or any replacement of or successor to, that scheme.

e) **Election to Receive Accrued Entitlements Upon Transfer Of Business**

Where a Transfer of Business takes place from Canon to another employer, and an employee accepts the offer of employment with the new employer, the employee may elect to receive upon termination of their employment from Canon:

(i) a payment in lieu of their accrued but untaken annual leave entitlements; and/or

(ii) if the employee would be entitled under the applicable long service leave legislation to a payment in lieu of long service leave upon termination of their employment with Canon, a payment in lieu of their pro rata long service leave accrual,

provided that such election may be made only where the new employer is not obliged under the Fair Work Act 2009 or any other statute to recognise these accrued or pro rata entitlements.

Where an employee has elected to receive payments under this clause 37.f):

(i) the new employer will not, to the extent permitted by the Fair Work Act or the applicable long service leave legislation, be required to recognise the accrued entitlements which have been paid out under this clause; and

(ii) the paying out of those entitlements by Canon will not mean that the offer of employment from the new employer was not suitable alternative employment, or not an offer on similar terms and conditions in which the employee's service with Canon was recognised, for the purposes of clause 35.

f) Where Canon proposes a Transfer of Business (as that term is defined in the Fair Work Act) from Canon to another employer and the new employer wishes to retain some or all of the employees covered by this agreement, Canon will consider, in consultation with the NCC, the payment of an incentive to employees who accept employment with the new employer.

g) For the purposes of this clause 37, "Transfer of Business" has the meaning given to that term in the Fair Work Act.

h) For the avoidance of doubt the provisions in Clause 36 are not applicable where the employee rejects an offer of employment with another employer:

(i) in which the terms and conditions are substantially similar and no less favourable, considered on an overall basis, than the terms and conditions applicable to the employee at the time of ceasing employment with Canon; and

(ii) which recognises the period of service which the employee had with Canon and any prior transmitter to be continuous service of the employee with the new employer (except to the extent leave entitlements are paid out by Canon on termination of the employee's employment with Canon).

PART G – DISCIPLINE AND RELATED MATTERS

38. DISCIPLINARY PROCEDURE

a) If Canon considers that the performance of an employee is unsatisfactory, Canon's representatives will:

b) Discuss the matter informally with the employee to ascertain the cause/reason for poor performance and discuss:

(i) the areas of the employee's performance which are unsatisfactory;

(ii) the reasons for the employee's unsatisfactory performance;

(iii) the steps available to Canon which would assist the employee to perform satisfactorily, which may include arranging for the employee to receive training or additional training or altering the employee's working conditions; and

(iv) the steps available to the employee to remedy the unsatisfactory performance.

c) During any such informal discussions, the employee may have a union delegate or witness of their choice. The representative of Canon will remind the employee of that entitlement at the beginning of the discussion.

d) If the problem continues, or after the informal discussion it is considered that the problem is of a serious nature, Canon will advise the employee in writing of:

(i) the areas of the employee's performance which are unsatisfactory;

(ii) Canon's response to any reasons offered by the employee for his or her unsatisfactory performance;

(iii) the steps which would assist the employee to perform satisfactorily;

(iv) the steps of the employee to remedy the unsatisfactory performance; and

(v) the time allowed for improvement before further assessment.

e) Where, after following the steps set out in paragraph a), b) and c) above, the required improvement has not occurred, the employee will be given a written warning that failure to improve performance within a given time may lead to the employee's dismissal from employment or transfer to a lower paid position, and steps necessary to be taken by the employee to improve their performance to a satisfactory level will be set out.

f) Where an employee is transferred to lower paid duties for reasons set out in d) above, the employee shall be entitled to the same period of notice of transfer as he/she would have been entitled to if his/her employment had been terminated, and Canon may, at Canon's option, make payment in lieu thereof of an amount equal to the difference between the former ordinary time rate of pay and the new lower ordinary time rates for the number of weeks of notice still owing.

39. DISPUTES AND GRIEVANCES

a) All parties agree to abide by the following procedure in the resolution of any dispute/grievance arising under this Agreement or the National Employment Standards.

b) The matter must first be discussed by the aggrieved employee(s) with the immediate supervisor/manager.

c) If not settled, the employee(s) will then discuss the matter with the next level manager arising between them.

d) If not settled, the employee will then discuss the matter with the Senior Manager – Direct Services and/or a member of the Human Resources Department (or a person designated by him/her).

e) If the matter is not resolved after all agreed steps have been taken, it must be submitted to either the Fair Work Commission or another agreed mediator who is independent of the parties to the Agreement, for the purpose of conciliation and mediation. Alternatively the parties may agree to go straight to 'f' below. For the purposes of this provision "party" includes an employee or group of employees.

f) If the matter is not resolved it must be submitted to the Fair Work Commission or an agreed arbitrator who is independent of the parties to the Agreement for arbitration. The Fair Work Commission may exercise the procedural powers in relation to hearings, witnesses, evidence and submissions which are necessary to make the arbitration effective. The decision of the member will bind the parties subject to either party exercising a right of appeal against the decision to a Full Bench.

g) Until the matter is determined normal work must continue where practical (this includes, but is not limited to, the employee complying with a direction given by Canon to perform other available work at the same workplace or a different workplace). No party shall be prejudiced as to the final settlement by the continuance of work in accordance with this procedure.

h) The parties must cooperate to ensure that these procedures are carried out expeditiously.

i) A party to a dispute or matter arising under this clause may appoint another person from an organisation, association or union to accompany or represent them in relation to carrying out any of the procedures, under this clause.

PART H – LEAVE ENTITLEMENTS

40. ANNUAL LEAVE

a) Each full-time employee shall accrue 150 hours (20 days) annual leave in respect of each twelve (12) months of service, and a pro-rata entitlement applies for part-time employees. Annual leave will be accumulated and be payable on a pro rata basis from the day of commencement.

b) Annual Leave will be taken within twelve (12) months of falling due and at a time agreed between Canon and the employee. As a general rule, leave should be taken at a time convenient to the work cycle of the department in which the employee works. Where possible annual leave should be taken in the same pattern as it is worked. Where agreement cannot be reached, then either party can require the leave to be taken with six (6) months' notice in writing.

c) No employee can accrue more than forty (40) days leave without written permission. Once the level exceeds forty (40) days then Canon or the employee may, by giving one (1) months' notice, require the employee take the leave in excess of this amount. As a last resort, Canon will also have the

option to pay out any leave in excess of forty (40) days in line with statutory requirements.

d) Pro rata annual leave may be taken in advance if Canon and the employee agree.

e) An employee and Canon may enter a separate written agreement to cash out a portion of an employee's entitlement to annual leave, provided that the employee has at least four (4) weeks of accrued annual leave available after the annual leave has been cashed out. Under any cashing out agreement, Canon will pay the employee the full amount that would have been payable to the employee had the employee taken the annual leave that the employee has forgone. All other annual leave accrued shall be taken by the employee in accordance with the provisions of this Agreement.

f) All accrued leave and pro rata leave will be paid on termination.

g) Annual leave loading is included in the Total Remuneration Cost (TRC), and shall not be paid as a separate entitlement. Existing employees employed by Canon prior to 1 July 2002 have the choice as to whether or not they will roll the leave loading into their TRC. For those employees, annual leave loading at the rate of 17.5% will be paid. Once an employee prior to 1 July 2002 has made the decision to roll it into their TRC, it cannot be reversed. All new employees after 1 July 2002, do not have this choice, and their leave loading will automatically be part of their TRC.

h) Full-time employees that are continuous shift workers who are regularly rostered to work on Sundays and public holidays are defined as shiftworkers for the purposes of the NES and are entitled to a base entitlement of 187.5 hours (25 days) annual leave in respect of each twelve (12) months of service (pro rata for part time employees pursuant to clause 30.e)).

41. PERSONAL/CARER'S LEAVE

Personal Leave

a) A full time employee shall be entitled to ten (10) days Personal Leave per year of service. Personal Leave accumulates on a pro rata basis for part-time employees. This clause does not apply to casual employees.

b) Personal Leave will be accumulated and be payable on a pro rate basis from the date of commencement.

c) The balance of Personal Leave not taken in any year shall accumulate.

d) If an employee is absent on Personal Leave, the employee should take all reasonable steps to advise their immediate supervisor of the absence as soon as possible. It is expected that this will be no later than one (1) hour after normal commencement time on that day. Such advice shall, as far as practicable, estimate the duration of the absence.

e) Where an employee falls sick whilst on annual leave, then Personal Leave, not Annual Leave is payable provided:

   (i) the employee has an entitlement to Personal leave; and

   (ii) satisfactory medical evidence is provided on the day of return from leave.

f) Accumulated Personal Leave will not be paid out on termination of employment for any reason including resignation and retrenchment.

g) A Medical Certificate from a registered medical practitioner (or Statutory Declaration) is required for:

   (i) any absence of two (2) or more consecutive days;

(ii) any single day absence where prior written notification has been given by the Department Manager to the individual employee;

(iii) any day before or after a public holiday or annual leave; and

(iv) Canon reserves the right to request medical evidence in lieu of a statutory declaration from any individual. This will occur when any unacceptable Personal leave pattern has been established or the manager has doubts about the genuine nature of the illness.

h) For any Personal Leave absence, the onus of proof remains with the employee.

Carer's Leave

i) Canon recognises that employees have commitments to their family, as well as having commitments to work. An employee, other than a casual employee, is entitled to use the employee's personal leave entitlement for the purpose of carer's leave which is subject to the person being either a member of the employee's immediate family or a member of the employee's household. Each day counts in line with Clause 21 b). (iii) Carer's leave may be taken by an employee to provide care and support to a member of the employee's immediate family or household who requires care or support because of either a personal illness or injury or an unexpected emergency affecting the member of the employee's immediate family or household. Carer's leave does not accrue.

j) The term *"immediate family"* includes the employee's spouse/partner (including a former spouse, de facto spouse/partner and a former de facto spouse/partner) and the following relatives of either the employee or the employee's spouse/partner being:

- Child (including adopted child, step child, ex nuptial child and adult child);
- Parent;
- Grandparent;
- Grandchild;
- Sibling;
- Aunt/uncle;
- Niece/nephew;
- Any step relation of the above kind, and;
- Anyone living in the same household.

k) The entitlement to use personal leave is subject to the production of a medical certificate or Statutory Declaration is required at the request of their supervisor.

l) The employee shall, wherever practicable, give their supervisor:

(i) notice, prior to the absence, of their intention to take leave;

(ii) the name and the relationship to the employee of the person requiring care;

(iii) the reasons for the taking of the leave; and

(iv) the estimated length of absence.

If it is not practical to give notice, the employee shall notify their supervisor as soon as possible.

m) Where an employee has exhausted their carer's leave entitlement in any year the employee is entitled to an additional two (2) days unpaid carer's leave per permissible occasion. This leave does not accrue.

42. LONG SERVICE LEAVE

a) The entitlement dates, amount and accrual of long service leave vary from State/Territory to State/Territory and in this regard the relevant legislation applicable in each State will apply except as may be provided for below.

b) All accrued leave must be taken within five (5) years of the full entitlement falling due. This may be extended to seven (7) years with the written agreement of Canon. An exception to this is an employee who is over fifty (50) years of age and who requests that his/her leave is preserved until retirement.

c) Long service leave must be taken at a suitable time agreed between Canon and the employee. As a general rule, however, leave should be taken at a time convenient to the work cycle of the department in which the employee works. Where agreement cannot be reached, either party can require the leave to be taken with twelve (12) months' notice in writing.

d) Long service leave cannot be taken in daily lots. A minimum of one (1) week's leave must be taken at any one time.

e) All employees are entitled to take their pro rata long service leave, by agreement, in accordance with the relevant State or Territory legislation or Canon policy, whichever is the more generous.

f) Where permitted by applicable State/Territory legislation and the Fair Work Act or any replacement of it, and in accordance with that legislation, long service leave entitlements may be paid out with the written agreement of Canon and the employee.

g) When an employee transfers from State/Territory to State/Territory, pro rata accrued leave (whether the person is eligible to actually take the leave or not) will transfer with him/her. From the date of the transfer, leave will accrue at the appropriate rate of the new location. The terms and conditions that apply to the entitlement dates, amount and accrual of long service leave, however, will be those terms and conditions that apply in the new location.

43. PUBLIC HOLIDAYS

a) With the exception of casual employees, all employees are entitled to the public holidays gazetted for that State or Territory without loss of pay. In addition all employees, except casual employees will receive two (2) Canon Days (one is at their Birthday, the second is at Christmas).

b) Where an additional public holiday is proclaimed or gazetted by a Commonwealth, State or Territory government, that additional day will be a public holiday in the location if it is to be observed generally by people throughout the State or Territory.

c) Where a public holiday falls on a Saturday or Sunday, the following Monday will be observed as the public holiday, if gazetted, unless the day is normally observed on the day that it falls (eg: Easter Sunday).

d) By agreement between Canon and the majority of employees covered by this Agreement in each location, other days may be substituted for the public holiday.

44. WORK ON A PUBLIC HOLIDAY

a) The parties agree that working a public holiday may arise due to Canon's operational requirements or the need to meet customer requests and that the need to work on a public holiday arises from time to time.

b) For the purposes of this clause, all work performed on any of the following public holidays shall be paid at the rate of 250% of the employee's ordinary hourly rate.

- New Year's Day;
- Australia Day;
- Easter[1];
- ANZAC Day;
- Christmas Day[2];
- Boxing Day (except S.A.);
- Proclamation Day (SA only)
- Queen's Birthday (on the day on which it is celebrated in a State or Territory or region of a State or Territory);

c) If an employee works on a public holiday other than as prescribed in Clause 44 a) above, then either double time will be paid for all time worked or a day in lieu may be taken at a suitable time agreed to by both parties. If a suitable day is not agreed upon within six (6) months of the public holiday having been worked, then either party can require the taking of the entitlement with one (1) months' notice.

45. PARENTAL LEAVE

a) Parental leave is available to all eligible employees, with at least twelve (12) months continuous service, who have care or responsibility for the child, in compliance with the National Employment Standards (NES) or Canon policy, whichever is the more generous. This leave entitlement also applies to circumstances of adoption.

b) Where an eligible employee has planned to take less than twelve (12) months parental leave and subsequently wishes to use the balance of the twelve (12) month entitlement, the period of leave may be lengthened once only by the employee, giving four (4) weeks' notice in writing before the end date of the original leave period. The notice must specify the new end date for the leave.

c) The period of leave may, with the consent of Canon, be shortened by the employee.

d) Where an eligible employee wishes to take more than twelve (12) months parental leave, the employee must apply in writing for Canon's approval. The request must be made at least 4 weeks before the end of the available parental leave period.

e) Provided the aggregate of any leave does not exceed fifty two (52) weeks, or where an extension is granted (104) weeks, an employee may, in lieu of or in conjunction with parental leave, take any annual leave or long service leave or any part thereof to which she/he is entitled.

f) Paid sick leave or other paid authorised absences (excluding annual leave or long service leave), shall not be available to an employee during her/his absence on parental leave.

g) Absence on parental leave shall not break the continuity of service of an employee, but shall not be included in calculating the period of service for any purpose.

h) An employee on parental leave may terminate employment at any time during the period of leave by giving two (2) weeks' notice.

i) An employee shall confirm the intention of returning to work by giving notice in writing to Canon of not less than four (4) weeks prior to the expiration of her/his period of parental leave.

j) If during parental leave absence, the employee wishes to undertake casual employment with Canon, they are entitled to do so without breaking their

[1] Easter shall mean the period of Friday to Monday inclusive
[2] Christmas shall mean from 5pm on Christmas Eve

parental leave. Any time worked during this period will be used to calculate length of service, including Long Service Leave entitlements. The hourly rate of pay in these circumstances will be determined by the classification of the role that individual is performing.

k) An employee shall have the right to defer up to no more than 50% of their pay prior to the commencement of Parental Leave.

46. COMPASSIONATE LEAVE

a) On each occasion Canon will allow up to three (3) days leave with normal pay to employees (other than casual employees) who suffer a death in the immediate family or household or where a member of the employee's immediate family or household has a personal illness or injury that poses a serious threat to his or her life. If the family member is overseas or in Australia and more than four (4) hours travelling time (by commercial aeroplane), an additional two (2) days may be granted if the employee is to go to the funeral.

b) The term *"immediate family"* includes the employee's spouse/partner (including a former spouse, de facto spouse/partner and a former de facto spouse/partner) and the following relatives of either the employee or the employee's spouse/partner being:

- Child (including adopted child, step child, ex nuptial child and adult child);
- Parent;
- Grandparent;
- Grandchild;
- Uncle/Aunt;
- Sibling;
- Niece/nephew; and
- Any step relation of the above kind; and
- Anyone living in the same household.

c) Where the absence coincides with a Public Holiday, only those compassionate days falling outside the Public Holiday will be paid as Compassionate Leave.

d) Compassionate Leave does not accumulate.

47. COMMUNITY SERVICE LEAVE

Community Service leave will be available in accordance with the requirements of the *Fair Work Act*.

48. STUDY LEAVE

Study leave will be available in accordance with Canon policy as varied from time to time. Canon policy applicable as at the date of this agreement will not be varied without consultation between Canon and the employees concerned.

49. JURY SERVICE

a) An employee must notify his/her manager as soon as possible of the date upon which he/she is required to attend for jury service.

b) Canon will allow time off work to employees who are required to serve periods of jury duty and will pay full-time employees their normal base salary during this period of absence. Part-time employees are entitled to receive payment if the Jury Service falls on their usual working day. Casual employees are entitled to be absent for Jury Service but will not receive any payment, unless required by law in the State in which the employee works.

c) Payments received by the employee, excluding travel expenses, must be paid to Canon through the Payroll Department.

d) Proof of attendance is required.

50. BLOOD DONORS LEAVE

An employee who elects to donate blood will be granted leave on full pay for the period of the leave required for each attendance to a maximum of four hours per year and proof of attendance must be supplied.

51. TRAINING

a) Staff training is considered important for each employee's personal development and for increasing the productivity and efficiency in Canon. To aid in this development, each staff member may be required to attend up to three (3) days training in each calendar year outside of their normal work hours.

b) Time off in lieu, or an additional payment for wages/salaries at the normal base rate of pay, (ie: not overtime rates), will be made for this time. Canon will be required to give a minimum of one (1) months' notice of such training.

52. UNIONS

a) Trade union membership is voluntary. Discrimination against or victimisation of individuals (including contractors) based on membership or non-membership of a union is prohibited. Unwanted pressure from employees or managers to either join or not join a trade union will lead to disciplinary action.

Canon will recognise as an accredited ASU Representative an employee where notification, in writing, has been given to Canon by the ASU.

Such employees will be allowed the necessary time during working hours to interview Canon on matters affecting the employees whom he/she represents, however, the ASU representative remains fully responsible for his/her own job performance.

Canon is only required to recognise a maximum of two union representatives at each location.

b) An accredited union official has the right to enter Canon premises provided:

(i) he/she is on legitimate union business;

(ii) he/she conducts himself/herself properly and does not interfere with work proceedings;

(iii) the site manager is given suitable notice;

(iv) the visit is during a meal break, outside the normal work hours of the establishment or permission is gained from the site managers; and

(v) he/she complies with all other applicable right of entry requirements of the Fair Work Act.

c) To be eligible for trade union training leave a person must:

(i) be the accredited ASU representative;

(ii) have at least twelve (12) months continuous service with Canon; and

(iii) apply in writing to the department manager at least one month prior to the leave.

An eligible employee will be granted up to five (5) days leave, with pay, each calendar year. A total of five (5) days leave per calendar year at any single location is the maximum leave that will be granted if there is one or two

representatives. The granting of leave is totally dependent upon Canon being able to make adequate staffing arrangements amongst current employees. Canon should be advised of the nature, content and duration of the course to be attended. Canon shall not incur any liability with respect to any expenses associated with or incurred by the employee attending the course. Should an employee who is granted leave, fail to attend the nominated course, Canon will be notified by the Union as soon as is practicable. Proof of attendance may be requested by Canon.

53. GPS TRACKING

a) Changes will not be made to the GPS Tracking Policy without consulting with impacted employees in accordance with Canon's consultation obligations in clause 8. For the avoidance of doubt the GPS Tracking Policy does not form part of this agreement. It will be reviewed annually. The GPS Tracking Policy can be found on the company intranet.

54. SIGNATORIES

This Agreement is made at Macquarie Park on the 21st day of February 2019.

Signed for and on behalf of **Canon Australia Pty. Ltd.**

Signature — Date: 21/2/19

Sara Marshall — 5 Talavera Rd
by its authorised representative (print name) HR Director — Address Macquarie Park Sydney.

In the presence of:

Signature — Date: 21/02/2019

PAUL GRAVINA J.P. 150837 — 44 Fingal Ave Glenhaven NSW
Print name of witness — Address

Signed for and on behalf of **Australian Municipal, Administrative, Clerical and Services Union** as Bargaining Representative

Signature — Date: 21/02/19

DAVID SMITH — NATIONAL SECRETARY
Print name of Employee — Authority to sign

116 QUEENSBERRY ST
CARLTON 3003
Address

In the presence of:

Signature — Date: 21/2/19

MICHAEL RIZZO — 116 Queensberry St Carlton South, Victoria.
Print name of witness — Address

PART I – APPENDICES

APPENDIX A – 2019 TOTAL REMUNERATION COSTS (TRC)

NATIONAL

Level	Minimum TRC
Trainee	$45,000
Customer Service Technician	$53,803
Customer Service Engineer	$61,771
Senior Customer Service Engineer / Production Specialist	$70,623

Note 1: The above rates include an annual Representation Allowance

Note 2: The above rates are effective from the commencement of operation of this Agreement.

Note 3: The Total Remuneration Cost ('TRC') includes base salary, annual leave loading, superannuation and any other salary sacrifice approved items.

TRC INCREASES

Year	TRC Increase
1 March 2019	$2500 (pro-rated for part-time employees)
1 March 2020	$2000 (pro-rated for part-time employees)
1 March 2021	$2000 (pro-rated for part-time employees)

APPENDIX B – POSITIONS

Technical Consultants position Matrix:

Position titles	Customer Service Technician	Customer Service Engineer	Senior Customer Service Engineer Production Specialist
Tasks			
Contribute to and comply with OH&S policy and procedure	✓	✓	✓
Assure a safe working environment	✓	✓	✓
Perform break fix repairs beyond user replaceable parts on MFDs	✓	✓	✓
Perform break fix repairs on other technologies as assigned	✓	✓	✓
Perform Preventative Maintenance tasks as required	✓	✓	✓
Complete and pass technical product training	✓	✓	✓
Installation of equipment to customer network environment	✓	✓	✓
Upgrading software / firmware	✓	✓	✓
Manage resources effectively to balance the financial needs of Canon and the needs of the customer	✓	✓	✓
Work closely with the Sales Dept to increase installed machine base	✓	✓	✓
Return/recycle products where appropriate/practicable and encourage/educate customers in what products	✓	✓	✓
Contribute to and work towards own personal development	✓	✓	✓
Demonstrating of device hardware, printer drivers and associated applications		✓	✓
Faultfinding and diagnostic network skills		✓	✓
Perform break fix repairs on advanced devices (e.g. production print)			✓
Assist other Techs with technical problems, in areas of own expertise			✓
Advanced System installations			✓
Contribute to the creation of Solution Design Documents for major roll outs			✓
Conduct Site Inspections on relevant products			✓
Keep up to date with current technologies, workflow and applications within the Production Printing arena			✠
Manage spare parts for On-site parts customers and contribute to the up skilling of customers in Operator Maintenance programs.			✠
Actively seek opportunities to share knowledge with your colleagues and seek opportunity to further develop your own skills			✓
Skills			
Applicable Electrical qualification	✓	✓	✓
understanding across multiple operating systems	✓	✓	✓
Current drivers licence	✓	✓	✓
Electrical mechanical aptitude / interest	✓	✓	✓
Electrical based experience	Min 1 year	Min 2 years	Min 5 years
Communication	✓	✓	✓
Intermediate to advanced understanding across multiple operating systems		✓	✓
Faultfinding and diagnostic networking skills		✓	✓
Ability to work under pressure			✓
Clear Verbal and Written Communication skills			✓
Excellent Organisational Skills			✓
Advanced hardware fault finding skills			✓
Mentoring / coaching			✓
Manage difficult conversations			✓
Intermediate to advanced colour management and application software skills			✓

✓ / Min period = Mandatory requirement of role
O = Optional requirement of role (expectation to have completed more at more senior levels)
✠ = Mandatory only for Production Specialist

IN THE FAIR WORK COMMISSION

FWC Matter No.:
AG2019/435

Applicant:

Canon Australia Pty Ltd

Section 185 – Application for approval of a single enterprise agreement

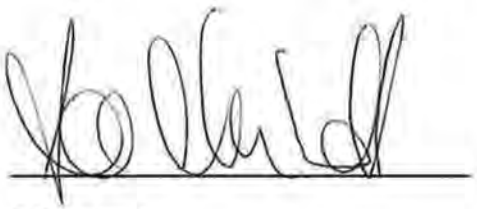
Undertaking- Section 190

I, Sara Marshall, Director, Human Resources, Communications and Facilities for Canon Pty Ltd give the following undertakings with respect to the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement, 2019 ("the Agreement"):

1. I have the authority given to me by Canon Australia Pty Ltd to provide this undertaking in relation to the application before the Fair Work Commission.

2. Canon Australia Pty Ltd undertakes that in the event of an inconsistency between the NES and the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement, 2019 and the NES provides a greater benefit to an employee, the NES provision will apply to the extent of the inconsistency.

3. This undertaking is provided on the basis of issues raised by the Fair Work Commission in the application before the Fair Work Commission.



Signature

28/3/19.

Date

ATTACHMENT B

Business Equipment Award 2010

This Fair Work Commission consolidated modern award incorporates all amendments up to and including 20 June 2019 (PR704120, PR707431, PR707628, PR709080).

Clause(s) affected by the most recent variation(s):

13—Casual employment

20—Classifications and adult rates

21—Exemptions

22—Allowances

Schedule D—Supported Wage System

Current review matter(s): AM2014/47; AM2014/190; AM2014/196; AM2014/197; AM2014/218; AM2014/300; AM2014/301; AM2015/1; AM2015/2; AM2016/8; AM2016/15; AM2016/17; AM2016/35

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[Varied by PR988401, PR994507, PR532630, PR544519, PR546288, PR557581, PR573679, PR582973, PR584081, PR609338, PR610182, PR701415]

Part 1—Application and Operation

1. Title

This award is the *Business Equipment Award 2010*.

2. Commencement and transitional

[Varied by PR988401, PR542141]

2.1 This award commences on 1 January 2010.

2.2 The monetary obligations imposed on employers by this award may be absorbed into overaward payments. Nothing in this award requires an employer to maintain or increase any overaward payment.

2.3 This award contains transitional arrangements which specify when particular parts of the award come into effect. Some of the transitional arrangements are in clauses in the main part of the award. There are also transitional arrangements in Schedule A. The arrangements in Schedule A deal with:

- minimum wages and piecework rates
- casual or part-time loadings
- Saturday, Sunday, public holiday, evening or other penalties
- shift allowances/penalties.

[2.4 varied by PR542141 ppc 04Dec13]

2.4 Neither the making of this award nor the operation of any transitional arrangements is intended to result in a reduction in the take-home pay of employees covered by the award. On application by or on behalf of an employee who suffers a reduction in take-home pay as a result of the making of this award or the operation of any transitional arrangements, the Fair Work Commission may make any order it considers appropriate to remedy the situation.

[2.5 varied by PR542141 ppc 04Dec13]

2.5 The Fair Work Commission may review the transitional arrangements in this award and make a determination varying the award.

[2.6 varied by PR542141 ppc 04Dec13]

2.6 The Fair Work Commission may review the transitional arrangements:

(a) on its own initiative; or

(b) on application by an employer, employee, organisation or outworker entity covered by the modern award; or

(c) on application by an organisation that is entitled to represent the industrial interests of one or more employers or employees that are covered by the modern award; or

(d) in relation to outworker arrangements, on application by an organisation that is entitled to represent the industrial interests of one or more outworkers to whom the arrangements relate.

3. Definitions and interpretation

[Varied by PR994507, PR997772, PR503625, PR545988]

3.1 In this award, unless the contrary intention appears:

[Definition of **Act** substituted by PR994507 from 01Jan10]

Act means the *Fair Work Act 2009* (Cth)

[Definition of **agreement-based transitional instrument** inserted by PR994507 from 01Jan10]

agreement-based transitional instrument has the meaning in the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* (Cth)

[Definition of **award-based transitional instrument** inserted by PR994507 from 01Jan10]

award-based transitional instrument has the meaning in the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* (Cth)

[Definition of **Commission** deleted by PR994507 from 01Jan10]

[Definition of **default fund employee** inserted by PR545988 ppc 01Jan14]

default fund employee means an employee who has no chosen fund within the meaning of the *Superannuation Guarantee (Administration) Act 1992* (Cth)

[Definition of **defined benefit member** inserted by PR545988 ppc 01Jan14]

defined benefit member has the meaning given by the *Superannuation Guarantee (Administration) Act 1992* (Cth)

[Definition of **Division 2B State award** inserted by PR503625 ppc 01Jan11]

Division 2B State award has the meaning in Schedule 3A of the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* (Cth)

[Definition of **Division 2B State employment agreement** inserted by PR503625 ppc 01Jan11]

Division 2B State employment agreement has the meaning in Schedule 3A of the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* (Cth)

[Definition of **employee** substituted by PR994507, PR997772 from 01Jan10]

employee means national system employee within the meaning of the Act

[Definition of **employer** substituted by PR994507, PR997772 from 01Jan10]

employer means national system employer within the meaning of the Act

[Definition of **enterprise award** deleted by PR994507 from 01Jan10]

[Definition of **enterprise award-based instrument** inserted by PR994507 from 01Jan10]

enterprise award-based instrument has the meaning in the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* (Cth)

[Definition of **enterprise NAPSA** deleted by PR994507 from 01Jan10]

[Definition of **exempt public sector superannuation scheme** inserted by PR545988 ppc 01Jan14]

exempt public sector superannuation scheme has the meaning given by the *Superannuation Industry (Supervision) Act 1993* (Cth)

[Definition of **MySuper product** inserted by PR545988 ppc 01Jan14]

MySuper product has the meaning given by the *Superannuation Industry (Supervision) Act 1993* (Cth)

[Definition of **NAPSA** deleted by PR994507 from 01Jan10]

[Definition of **NES** substituted by PR994507 from 01Jan10]

NES means the National Employment Standards as contained in sections 59 to 131 of the *Fair Work Act 2009* (Cth)

[Definition of **on-hire** inserted by PR994507 from 01Jan10]

on-hire means the on-hire of an employee by their employer to a client, where such employee works under the general guidance and instruction of the client or a representative of the client

standard rate means the minimum weekly wage for a Level 4 Technician in clause 20

[Definition of **transitional minimum wage instrument** inserted by PR994507 from 01Jan10]

transitional minimum wage instrument has the meaning in the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* (Cth)

3.2 Where this award refers to a condition of employment provided for in the NES, the NES definition applies.

4. Coverage

[Varied by PR994507]

4.1 This industry award covers employers throughout Australia in the business equipment industry and their employees in the classifications listed in this award to the exclusion of any other modern award.

4.2 **Business equipment industry** means the sale or lease and associated installation and servicing of business equipment such as computers, data processing equipment, photocopiers, facsimile machines, cash registers, accounting and adding machines, calculators and peripheral equipment associated with such equipment including keyboards, display screens, printers, routers and multifunction devices.

[4.3 varied by PR994507 from 01Jan10]

4.3 The award does not cover:

(a) an employee excluded from award coverage by the Act;

(b) persons wholly or mainly engaged in managerial positions;

(c) employees whilst undertaking formal training courses or schools in connection with their employment; or

[4.3(d) deleted by PR994507 from 01Jan10]

[4.3(e) renumbered as 4.3(d) by PR994507 from 01Jan10]

(d) employees of electrical contractors or manufacturers of business equipment.

[4.4 inserted by PR994507 from 01Jan10]

4.4 The award does not cover employees who are covered by a modern enterprise award, or an enterprise instrument (within the meaning of the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* (Cth)), or employers in relation to those employees.

[4.5 inserted by PR994507 from 01Jan10]

4.5 The award does not cover employees who are covered by a State reference public sector modern award, or a State reference public sector transitional award (within the meaning of the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* (Cth)), or employers in relation to those employees.

[4.6 inserted by PR994507 from 01Jan10]

4.6 This award covers any employer which supplies labour on an on-hire basis in the industry set out in clause 4.1 in respect of on-hire employees in classifications covered by this award, and those on-hire employees, while engaged in the performance of work for a business in that industry. This subclause operates subject to the exclusions from coverage in this award.

[4.7 inserted by PR994507 from 01Jan10]

4.7 This award covers employers which provide group training services for apprentices and/or trainees engaged in the industry and/or parts of industry set out at clause 4.1 and those apprentices and/or trainees engaged by a group training service hosted by a company to perform work at a location where the activities described herein are being performed. This subclause operates subject to the exclusions from coverage in this award.

[4.8 inserted by PR994507 from 01Jan10]

4.8 Where an employer is covered by more than one award, an employee of that employer is covered by the award classification which is most appropriate to the work performed by the employee and to the environment in which the employee normally performs the work.

NOTE: Where there is no classification for a particular employee in this award it is possible that the employer and that employee are covered by an award with occupational coverage.

5. Access to the award and the National Employment Standards

The employer must ensure that copies of this award and the NES are available to all employees to whom they apply either on a noticeboard which is conveniently located at or near the workplace or through electronic means, whichever makes them more accessible.

6. The National Employment Standards and this award

The NES and this award contain the minimum conditions of employment for employees covered by this award.

7. Individual flexibility arrangements

[Varied by PR542141; 7—Award flexibility renamed and substituted by PR610182 ppc 01Nov18]

7.1 Despite anything else in this award, an employer and an individual employee may agree to vary the application of the terms of this award relating to any of the following in order to meet the genuine needs of both the employee and the employer:

(a) arrangements for when work is performed; or

(b) overtime rates; or

(c) penalty rates; or

(d) allowances; or

(e) annual leave loading.

7.2 An agreement must be one that is genuinely made by the employer and the individual employee without coercion or duress.

7.3 An agreement may only be made after the individual employee has commenced employment with the employer.

7.4 An employer who wishes to initiate the making of an agreement must:

(a) give the employee a written proposal; and

(b) if the employer is aware that the employee has, or reasonably should be aware that the employee may have, limited understanding of written English, take reasonable steps (including providing a translation in an appropriate language) to ensure that the employee understands the proposal.

7.5 An agreement must result in the employee being better off overall at the time the agreement is made than if the agreement had not been made.

7.6 An agreement must do all of the following:

(a) state the names of the employer and the employee; and

(b) identify the award term, or award terms, the application of which is to be varied; and

(c) set out how the application of the award term, or each award term, is varied; and

(d) set out how the agreement results in the employee being better off overall at the time the agreement is made than if the agreement had not been made; and

(e) state the date the agreement is to start.

7.7 An agreement must be:

(a) in writing; and

(b) signed by the employer and the employee and, if the employee is under 18 years of age, by the employee's parent or guardian.

7.8 Except as provided in clause 7.7(b), an agreement must not require the approval or consent of a person other than the employer and the employee.

7.9 The employer must keep the agreement as a time and wages record and give a copy to the employee.

7.10 The employer and the employee must genuinely agree, without duress or coercion to any variation of an award provided for by an agreement.

7.11 An agreement may be terminated:

(a) at any time, by written agreement between the employer and the employee; or

(b) by the employer or employee giving 13 weeks' written notice to the other party (reduced to 4 weeks if the agreement was entered into before the first full pay period starting on or after 4 December 2013).

Note: If an employer and employee agree to an arrangement that purports to be an individual flexibility arrangement under this award term and the arrangement does not meet a requirement set out in s.144 then the employee or the employer may terminate the arrangement by giving written notice of not more than 28 days (see s.145 of the Act).

7.12 An agreement terminated as mentioned in clause 7.11(b) ceases to have effect at the end of the period of notice required under that clause.

7.13 The right to make an agreement under clause 7 is additional to, and does not affect, any other term of this award that provides for an agreement between an employer and an individual employee.

8. Facilitative provisions

8.1 A facilitative provision provides that the standard approach in an award provision may be departed from by agreement between an individual employer and an employee, or the majority of employees in the enterprise or part of the enterprise concerned. Facilitative provisions are not to be used as a device to avoid award obligations nor should they result in unfairness to an employee or employees covered by this award.

8.2 Facilitative provisions in this award are contained in the following clauses:

(a) clause 27—Ordinary hours of work and rostering;

(b) clause 28—Special provisions for shiftworkers;

(c) clause 29—Meal breaks; and

(d) clause 34.2—Public holidays.

Part 2—Consultation and Dispute Resolution

9. Consultation about major workplace change

[9—Consultation regarding major workplace change renamed and substituted by PR546288, 9—Consultation renamed and substituted by PR610182 ppc 01Nov18]

9.1 If an employer makes a definite decision to make major changes in production, program, organisation, structure or technology that are likely to have significant effects on employees, the employer must:

(a) give notice of the changes to all employees who may be affected by them and their representatives (if any); and

(b) discuss with affected employees and their representatives (if any):

(i) the introduction of the changes; and

(ii) their likely effect on employees; and

(iii) measures to avoid or reduce the adverse effects of the changes on employees; and

(c) commence discussions as soon as practicable after a definite decision has been made.

9.2 For the purposes of the discussion under clause 9.1(b), the employer must give in writing to the affected employees and their representatives (if any) all relevant information about the changes including:

(a) their nature; and

(b) their expected effect on employees; and

(c) any other matters likely to affect employees.

9.3 Clause 9.2 does not require an employer to disclose any confidential information if its disclosure would be contrary to the employer's interests.

9.4 The employer must promptly consider any matters raised by the employees or their representatives about the changes in the course of the discussion under clause 9.1(b).

9.5 In clause 9:

significant effects, on employees, includes any of the following:

(a) termination of employment; or

(b) major changes in the composition, operation or size of the employer's workforce or in the skills required; or

(c) loss of, or reduction in, job or promotion opportunities; or

(d) loss of, or reduction in, job tenure; or

(e) alteration of hours of work; or

(f) the need for employees to be retrained or transferred to other work or locations; or

(g) job restructuring.

9.6 Where this award makes provision for alteration of any of the matters defined at clause 9.5, such alteration is taken not to have significant effect.

9A. Consultation about changes to rosters or hours of work

[9A inserted by PR610182 ppc 01Nov18]

9A.1 Clause 9A applies if an employer proposes to change the regular roster or ordinary hours of work of an employee, other than an employee whose working hours are irregular, sporadic or unpredictable.

9A.2 The employer must consult with any employees affected by the proposed change and their representatives (if any).

9A.3 For the purpose of the consultation, the employer must:

(a) provide to the employees and representatives mentioned in clause 9A.2 information about the proposed change (for example, information about the nature of the change and when it is to begin); and

(b) invite the employees to give their views about the impact of the proposed change on them (including any impact on their family or caring responsibilities) and also invite their representative (if any) to give their views about that impact.

9A.4 The employer must consider any views given under clause 9A.3(b).

9A.5 Clause 9A is to be read in conjunction with any other provisions of this award concerning the scheduling of work or the giving of notice.

10. Dispute resolution

[Varied by PR994507, PR542141; substituted by PR610182 ppc 01Nov18]

10.1 Clause 10 sets out the procedures to be followed if a dispute arises about a matter under this award or in relation to the NES.

10.2 The parties to the dispute must first try to resolve the dispute at the workplace through discussion between the employee or employees concerned and the relevant supervisor.

10.3 If the dispute is not resolved through discussion as mentioned in clause 10.2, the parties to the dispute must then try to resolve it in a timely manner at the workplace through discussion between the employee or employees concerned and more senior levels of management, as appropriate.

10.4 If the dispute is unable to be resolved at the workplace and all appropriate steps have been taken under clauses 10.2 and 10.3, a party to the dispute may refer it to the Fair Work Commission.

10.5 The parties may agree on the process to be followed by the Fair Work Commission in dealing with the dispute, including mediation, conciliation and consent arbitration.

10.6 If the dispute remains unresolved, the Fair Work Commission may use any method of dispute resolution that it is permitted by the Act to use and that it considers appropriate for resolving the dispute.

10.7 A party to the dispute may appoint a person, organisation or association to support and/or represent them in any discussion or process under clause 10.

10.8 While procedures are being followed under clause 10 in relation to a dispute:

(a) work must continue in accordance with this award and the Act; and

(b) an employee must not unreasonably fail to comply with any direction given by the employer about performing work, whether at the same or another workplace, that is safe and appropriate for the employee to perform.

10.9 Clause 10.8 is subject to any applicable work health and safety legislation.

Part 3—Types of Employment and Termination of Employment

11. Full-time employment

Any employee not specifically engaged as being a part-time or casual employee is for all purposes of this award a full-time employee, unless otherwise specified in this award.

12. Part-time employment

An employee may be engaged to work on a part-time basis involving a regular pattern of hours which average less than 38 hours per week. An employee so engaged will be paid, per hour, 1/38th of the weekly rate prescribed by clause 20 of this award for the work performed.

13. Casual employment

[Varied by PR579782, PR592117, PR606345, PR700548, PR700649, PR707431, PR707431]

13.1 An employer may engage employees on a casual basis in which case employment may be terminated by an hour's notice given either by the employer or the employee, or by the payment or forfeiture of an hour's wage as the case may be.

[13.2 varied by PR579782, PR592117, PR606345, PR707431 ppc 01Jul19]

13.2 A casual employee is one engaged and paid as such, and for working ordinary time will be paid, per hour, 1/38th of the weekly wage prescribed by this award for the work which the employee performs, plus 24%.

[13.3 inserted by PR700649 ppc 01Oct18]

13.3 A casual employee must be engaged and paid for at least 2 consecutive hours of work on each occasion they are required to attend work.

13.4 Right to request casual conversion

[13.4 inserted by PR700548 ppc 01Oct18]

(a) A person engaged by a particular employer as a regular casual employee may request that their employment be converted to full-time or part-time employment.

(b) A **regular casual employee** is a casual employee who has in the preceding period of 12 months worked a pattern of hours on an ongoing basis which, without significant adjustment, the employee could continue to perform as a full-time employee or part-time employee under the provisions of this award.

(c) A regular casual employee who has worked equivalent full-time hours over the preceding period of 12 months' casual employment may request to have their employment converted to full-time employment.

(d) A regular casual employee who has worked less than equivalent full-time hours over the preceding period of 12 months' casual employment may request to have their employment converted to part-time employment consistent with the pattern of hours previously worked.

(e) Any request under this subclause must be in writing and provided to the employer.

(f) Where a regular casual employee seeks to convert to full-time or part-time employment, the employer may agree to or refuse the request, but the request may only be refused on reasonable grounds and after there has been consultation with the employee.

(g) Reasonable grounds for refusal include that:

(i) it would require a significant adjustment to the casual employee's hours of work in order for the employee to be engaged as a full-time or part-time employee in accordance with the provisions of this award – that is, the casual employee is not truly a regular casual employee as defined in paragraph (b);

(ii) it is known or reasonably foreseeable that the regular casual employee's position will cease to exist within the next 12 months;

(iii) it is known or reasonably foreseeable that the hours of work which the regular casual employee is required to perform will be significantly reduced in the next 12 months; or

(iv) it is known or reasonably foreseeable that there will be a significant change in the days and/or times at which the employee's hours of work are required to be performed in the next 12 months which cannot be accommodated within the days and/or hours during which the employee is available to work.

(h) For any ground of refusal to be reasonable, it must be based on facts which are known or reasonably foreseeable.

(i) Where the employer refuses a regular casual employee's request to convert, the employer must provide the casual employee with the employer's reasons for refusal in writing within 21 days of the request being made. If the employee does not accept the employer's refusal, this will constitute a dispute that will be dealt with under the dispute resolution procedure in clause 10. Under that procedure, the employee or the employer may refer the matter to the Fair Work Commission if the dispute cannot be resolved at the workplace level.

(j) Where it is agreed that a casual employee will have their employment converted to full-time or part-time employment as provided for in this clause, the employer and employee must discuss and record in writing:

(i) the form of employment to which the employee will convert – that is, full-time or part-time employment; and

(ii) if it is agreed that the employee will become a part-time employee, the employee's hours of work fixed in accordance with clause 12 and, as applicable, clause 27.

(k) The conversion will take effect from the start of the next pay cycle following such agreement being reached unless otherwise agreed.

(l) Once a casual employee has converted to full-time or part-time employment, the employee may only revert to casual employment with the written agreement of the employer.

(m) A casual employee must not be engaged and re-engaged (which includes a refusal to re-engage), or have their hours reduced or varied, in order to avoid any right or obligation under this clause.

(n) Nothing in this clause obliges a regular casual employee to convert to full-time or part-time employment, nor permits an employer to require a regular casual employee to so convert.

(o) Nothing in this clause requires an employer to increase the hours of a regular casual employee seeking conversion to full-time or part-time employment.

(p) An employer must provide a casual employee, whether a regular casual employee or not, with a copy of the provisions of this subclause within the first 12 months of the employee's first engagement to perform work. In respect of casual employees already employed as at 1 October 2018, an employer must provide such employees with a copy of the provisions of this subclause by 1 January 2019.

(q) A casual employee's right to request to convert is not affected if the employer fails to comply with the notice requirements in paragraph (p).

14. School-based apprentices

[Varied by PR988401]

See Schedule C

15. Trainees

[15 varied by PR994507, PR593816 ppc 01Jul17]

The terms of this award apply to trainees, except where otherwise stated in this award. See also clause 20.4.

16. Absence from duty

[16 varied by PR994507 from 01Jan10]

Unless a provision of this award states otherwise, an employee not attending for duty will lose pay for the actual time of such non-attendance.

17. Abandonment of employment

[17 deleted by PR703315 ppc 20Dec18]

18. Termination of employment

[18 substituted by PR610182 ppc 01Nov18]

Note: The NES sets out requirements for notice of termination by an employer. See ss.117 and 123 of the Act.

18.1 Notice of termination by an employee

(a) This clause applies to all employees except those identified in ss.123(1) and 123(3) of the Act.

(b) An employee must give the employer notice of termination in accordance with **Table 1—Period of notice** of at least the period specified in column 2 according to the period of continuous service of the employee specified in column 1.

Table 1—Period of notice

Column 1 **Employee's period of continuous service with the employer at the end of the day the notice is given**	**Column 2** **Period of notice**
Not more than 1 year	1 week
More than 1 year but not more than 3 years	2 weeks
More than 3 years but not more than 5 years	3 weeks
More than 5 years	4 weeks

Note: The notice of termination required to be given by an employee is the same as that required of an employer except that the employee does not have to give additional notice based on the age of the employee.

(c) In paragraph (b) **continuous service** has the same meaning as in s.117 of the Act.

(d) If an employee who is at least 18 years old does not give the period of notice required under paragraph (b), then the employer may deduct from wages due to the employee under this award an amount that is no more than one week's wages for the employee.

(e) If the employer has agreed to a shorter period of notice than that required under paragraph (b), then no deduction can be made under paragraph (d).

(f) Any deduction made under paragraph (d) must not be unreasonable in the circumstances.

18.2 Job search entitlement

Where an employer has given notice of termination to an employee, the employee must be allowed time off without loss of pay of up to one day for the purpose of seeking other employment.

18.3 The time off under clause 18.2 is to be taken at times that are convenient to the employee after consultation with the employer.

19. Redundancy

[Varied by PR994507, PR503625, PR561478; substituted by PR706927 ppc 03May19]

NOTE: Redundancy pay is provided for in the NES. See sections 119–123 of the Act.

19.1 Transfer to lower paid duties on redundancy

(a) Clause 19.1 applies if, because of redundancy, an employee is transferred to new duties to which a lower ordinary rate of pay applies.

(b) The employer may:

(i) give the employee notice of the transfer of at least the same length as the employee would be entitled to under section 117 of the Act as if it were a notice of termination given by the employer; or

(ii) transfer the employee to the new duties without giving notice of transfer or before the expiry of a notice of transfer, provided that the employer pays the employee as set out in paragraph (c).

(c) If the employer acts as mentioned in paragraph (b)(ii), the employee is entitled to a payment of an amount equal to the difference between the ordinary rate of pay of the employee (inclusive of all-purpose allowances, shift rates and penalty rates applicable to ordinary hours) for the hours of work the employee would have worked in the first role, and the ordinary rate of pay (also inclusive of all-purpose allowances, shift rates and penalty rates applicable to ordinary hours) of the employee in the second role for the period for which notice was not given.

19.2 Employee leaving during redundancy notice period

(a) An employee given notice of termination in circumstances of redundancy may terminate their employment during the minimum period of notice prescribed by section 117(3) of the Act.

(b) The employee is entitled to receive the benefits and payments they would have received under clause 19 or under sections 119–123 of the Act had they remained in employment until the expiry of the notice.

(c) However, the employee is not entitled to be paid for any part of the period of notice remaining after the employee ceased to be employed.

19.3 Job search entitlement

(a) Where an employer has given notice of termination to an employee in circumstances of redundancy, the employee must be allowed time off without loss of pay of up to one day each week of the minimum period of notice prescribed by section 117(3) of the Act for the purpose of seeking other employment.

(b) If an employee is allowed time off without loss of pay of more than one day under paragraph (a), the employee must, at the request of the employer, produce proof of attendance at an interview.

(c) A statutory declaration is sufficient for the purpose of paragraph (b).

(d) An employee who fails to produce proof when required under paragraph (b) is not entitled to be paid for the time off.

(e) This entitlement applies instead of clauses 18.2 and 18.3.

Part 4—Minimum Wages and Related Matters

20. Classifications and adult rates

[Varied by PR988401, PR997901, PR509052, PR522883, PR536686, PR551609, PR566690, PR579782, PR592117; PR593816, PR606345, PR707431]

20.1 The definitions of the classifications referred to in this clause are set out in Schedule B—Classifications, Skill Levels and Definitions.

20.2 Adult employees

(a) The classifications and minimum rates for an adult employee other than trainees in clause 15 and employees receiving a supported wage clause 20.3 are set out in the following tables.

(i) Technical stream

[20.2(a)(i) varied by PR509052, PR522883, PR536686, PR551609, PR566690, PR579782, PR592117, PR606345, PR707431 ppc 01Jul19]

Classification	Rate per week $	Annual salary $
Technical employee		
Level 1	761.20	39,580
Level 2	790.80	41,122

Classification	Rate per week $	Annual salary $
Technician		
Level 3	818.00	42,536
Level 4	862.50	44,849
Level 5	915.90	47,627
Level 6	966.70	50,267

(ii) Clerical and Administration stream

[20.2(a)(ii) varied by PR509052, PR522883, PR536686, PR551609, PR566690, PR579782, PR592117, PR606345, PR707431 ppc 01Jul19]

Classification	Rate per week $	Annual salary $
Clerical and Administration Employee Level 1	791.30	41,150
Clerical and Administration Employee Level 2	818.50	42,562
Clerical and Administration Employee Level 3	862.50	44,849
Clerical and Administration Employee Level 4	940.90	48,926
Clerical and Administration Employee Level 5	1009.10	52,471

(iii) Commercial Travellers stream

[20.2(a)(iii) varied by PR509052, PR522883, PR536686, PR551609, PR566690, PR579782, PR592117, PR606345, PR707431 ppc 01Jul19]

Classification	Rate per week $	Annual salary $
Salesperson Level 1	840.20	43,692
Salesperson Level 2	921.70	47,929
Salesperson Level 3	1066.50	55,456

(b) Junior employees

Junior employees must be paid the following percentage of the appropriate adult wage rate:

(i) Technical steam

Age	Percentage of adult salary %
16 years and under	60
17 years	75
18 years and over	100

(ii) Clerical stream

Age	Percentage of adult salary
	%
16 years and under	55
17 years	65
18 years	75
19 years	87.5

(c) For the purposes of ascertaining weekly wage rates for each classification (as referred to in various clauses of this award, e.g. casual employment, part-time employment) the salaries in clause 20 must be divided by 52.

(d) Higher duties

An employee who is directed by the employer to perform work of a higher grade than that in which the employee is normally engaged must, provided the employee is capable of performing the higher grade work, be paid at the rate which would be applicable if such work was performed on a permanent basis. This clause will not apply where the employee being relieved is absent on annual leave or personal/carer's leave until the absence has exceeded one week at which time the employee must be paid for that week and any additional days.

20.3 Supported wage system

See Schedule D

20.4 National training wage

[20.4 substituted by PR593816 ppc 01Jul17]

(a) Schedule E to the *Miscellaneous Award 2010* sets out minimum wage rates and conditions for employees undertaking traineeships.

[20.4(b) varied by PR606345, PR707431 ppc 01Jul19]

(b) This award incorporates the terms of Schedule E to the *Miscellaneous Award 2010* as at 1 July 2019. Provided that any reference to "this award" in Schedule E to the *Miscellaneous Award 2010* is to be read as referring to the *Business Equipment Award 2010* and not the *Miscellaneous Award 2010.*

21. Exemptions

[Varied by PR997901, PR509052, PR522883, PR536686, PR551609, PR566690, PR579782, PR592117, PR606345, PR707431]

21.1 Exemptions for employees in the technical stream

[21.1 varied by PR997901, PR509052, PR522883, PR536686, PR551609, PR566690, PR579782, PR592117, PR606345, PR707431 ppc 01Jul19]

The following award provisions will not apply to an employee in the technical stream in receipt of a salary of $61,991 or higher:

(a) clause 20.2(d)—Higher duties;

(b) clause 22.1(c)—First aid allowance;

(c) clause 22.1(e)—Representation allowance;

(d) clause 22.1(g)—Area allowance;

(e) clause 22.1(h)—Living away from home allowance;

(f) clause 27—Ordinary hours of work and rostering;

(g) clause 28—Special provisions for shiftworkers;

(h) clause 29—Meal breaks;

(i) clause 30—Overtime; and

(j) clause 34.3—Payment for time worked on a public holiday.

21.2 Exemptions for employees in the clerical stream

Except as to:

(a) clause 31—Annual leave

(b) clause 32—Personal/ carers leave and compassionate leave

(c) clause 33—Community service leave, and

(d) clause 34—Public holidays.

the terms of this award will not apply to any employee in the Clerical stream who is in receipt of a salary which exceeds the appropriate rate prescribed in clause 20 in which they are employed by 10%.

21.3 Exemptions for employees in the commercial travellers stream

The following award provisions will not apply to employees in the commercial travellers stream:

(a) clause 20.2(d)—Higher duties; and

(b) Part 5—Hours of work and related matters.

22. Allowances

To view the current monetary amounts of work-related allowances refer to the Allowances Sheet.

[Varied by PR994507, PR998133, PR509174, PR523004, PR536807, PR551730, PR566831, PR579527, PR592279, PR606503, PR704120, PR707628]

22.1 Technical stream and Clerical stream

(a) Leading hands

The following allowance applies for all purposes of the award:

In charge of	Percentage of the standard rate per week extra
	%
2 to 5 employees	3.21
6 to 10 employees	4.75
More than 10 employees	6.20

(b) Motor vehicle allowances

(i) All means of locomotion required by an employer must be provided and maintained by the employer. Provided that any existing arrangements as to the payment of an allowance for kilometres travelled other than for business purposes may continue or be at the discretion of the employer. Provided that an employee will be required to ensure that a vehicle supplied by the employer is kept in a reasonably clean and tidy condition where such vehicle is used by the employee for the employee's own private purposes.

(ii) Where an employee, by arrangement with the employer, provides a motor vehicle for use in connection with the employer's business the employee must be paid for the use of such vehicle on the following basis:

[22.1(b)(ii)(A) varied by PR523004, PR536807, PR551730 ppc 01Jul14]

(A) If it is necessary for an employee to provide and/or use their own motor vehicle for each day to carry out assigned duties, the employee must be paid an allowance of $621.14 per month. Provided however that in the case of an employee who is assigned duties in a country territory, the employee must be paid an allowance of $719.22 per month.

[22.1(b)(ii)(B) varied by PR536807, PR551730 ppc 01Jul14]

(B) In addition an allowance of $0.34 must be paid per kilometre travelled during the course of business. This allowance will not apply to an employee in respect of distance travelled to the employee's normal place of employment or to the place at which work is to commence as the case may be, whichever the lesser unless the employee is required to transport tools or equipment or parts or reference materials to perform the work.

(C) The allowance must be paid each month and will cover the periods the employee is taking annual or sick leave entitlement in accordance with this award or is undertaking a training course or school of no more than three months duration, but will not include any period of long service leave.

(D) An employer must give one month's notice to an employee that the employee will not be required to use the employee's motor vehicle to carry out assigned duties. Provided that notice is not given by the employer to avoid payment of the motor vehicle allowance while the employee is on annual or personal/carer's leave or attending a training school.

[22.1(b)(ii)(E) varied by PR523004, PR536807, PR551730 ppc 01Jul14]

(E) An employee who is required to use their own motor vehicle to carry out the employer's business on a casual basis must be paid an allowance of $0.78 per kilometre.

(c) First aid allowance

An employee holding a current first aid qualification from St John Ambulance or a similar body and appointed by the employer to perform first aid duties must be paid a weekly allowance of 2.35% of the standard weekly rate for any week the employee is so appointed.

(d) Meal allowance

[22.1(d)(i) varied by PR998133, PR509174, PR523004, PR536807, PR551730, PR566831, PR579527, PR592279, PR606503, PR704120, PR707628 ppc 01Jul19]

(i) An employee must receive a meal allowance of $14.69 for each rest break prescribed in clause 30.3(d).

(ii) The meal allowance will not apply where the employer provides a meal to an employee on overtime or the employee lives in the same locality in which the employee is working and can reasonably return home for a meal.

(e) Representation allowance

Employees regularly expected to be engaged in technical service or technical support in the field on behalf of their employer must, in addition to the salary and any other allowance prescribed by this award, be paid a representation allowance of 2.18% of the standard weekly rate per week.

(f) Service centre allowance

(i) An employee who is required by the employer to accept responsibility for the company's premises together with equipment and other materials in the employer's depot or satellite service centre must be paid an allowance of 6.08% of the standard weekly rate per week.

(ii) A **depot** or **satellite service centre** means an establishment which falls within the definition of a registered shop under the terms of the appropriate State factories and shops legislation.

(g) Area allowance

(i) Where an employee is located or required to perform work in any of the areas specified below for a period exceeding five working days, such employee must be paid the appropriate allowance prescribed for each continuous week of service in that area:

[22.1(g)(i) varied by PR998133, PR523004, PR536807, PR551730, PR566831, PR606503, PR704120, PR707628 ppc 01Jul19]

Area	Per week extra $
Northern Territory	31.10
Mt Isa, Queensland	72.54
Broken Hill, New South Wales	36.38
That area of Western Australia, North of a line running East from Carrot Bay to the Northern Territory border	25.58
That area of Western Australia situated between latitude 24 degrees and a line running East from Carrot Bay to the Northern Territory border	21.98
That area within a line commencing on the coast at latitude 24 degrees, then East to the Northern Territory border, then South to the coast, then along the coast to a longitude 123 degrees, North to the intersection of latitude 26 degrees, then West along latitude 26 degrees	9.91

(ii) The above allowances are not payable when an employer provides an employee with accommodation or other similar benefit of at least an equivalent amount to that prescribed above for the relevant area and such will be in full satisfaction of the employer's obligation under this clause.

(iii) Northern Territory area allowance ceases to operate on 31 December 2014.

(h) Living away from home allowance

[22.1(h)(i) varied by PR998133, PR523004, PR536807, PR551730, PR606503, PR704120, PR707628 ppc 01Jul19]

(i) A living away from home allowance of $70.43 per day must be paid when an employee is required to spend a night away from their usual place of residence. Provided that when calculating the living away from home allowance the first and last days will count as one day.,

[22.1(h)(ii) varied by PR998133, PR509174, PR523004, PR536807, PR551730, PR566831, PR579527, PR592279, PR606503, PR704120, PR707628 ppc 01Jul19]

(ii) If it is necessary for an employee to travel for more than two and a half hours after their normal finishing time the employee will be entitled to a further meal allowance of $12.82 for the evening meal.

(iii) The allowances in clauses 22.1(h)(i) and (ii) are not payable in circumstances where they are provided by the employer.

22.2 Commercial Travellers stream

(a) Motor vehicle allowance

(i) Where an employee, by arrangement with the employer, provides a motor vehicle in connection with the employer's business, the employee must:

- be paid a motor vehicle allowance which will be determined in accordance with this clause; and
- be given at least one month's written notice of the employer's intention to terminate or alter such arrangement or instead must be paid the motor vehicle allowance referred to in this clause for one month.

(ii) The motor vehicle allowance referred to in this clause will be determined by agreement between the employer and the employee, subject to the following:

- such agreement will specify the amount of the allowance, the conditions under which it is payable or not payable and the frequency and method of payment.

(iii) where the employer provides the salesperson with a motor vehicle for use in the employer's business without cost to the employee, the employer will not be required to pay the motor vehicle allowance referred to in this clause. Provided that where a motor vehicle has been provided by the employer it will be fully maintained by the employer.

(b) New employee required to purchase vehicle

An employee who:

(i) at the time of their application for employment neither owned nor was in the process of acquiring the ownership of a motor vehicle by hire, purchase or otherwise;

(ii) informed the employer of the fact prior to their engagement;

(iii) was thereafter engaged on terms requiring them to provide a vehicle for use in their employment; and

(iv) did provide such vehicle and if the employer dismisses the employee within the first three months of employment, otherwise than for misconduct justifying summary dismissal, the employer must pay the employee the rate of remuneration prescribed by clause 20 for the unexpired portion of the period of three months and also pay them the motor vehicle allowance prescribed by this clause for a maximum of six months from the date of commencement of employment.

(c) Expenses and accommodation reimbursement

(i) All reasonable expenses actually incurred by an employee in connection with the employer's business, authorised by the employer and properly paid by the employee, must be reimbursed by the employer. Such expenses as can be reasonably anticipated must be advanced to the employee.

(ii) Without limiting the generality of clause 22.2(c)(i) the following will be deemed to be reasonable expenses and must be reimbursed by the employer:

(A) Approved entertainment expenses;

(B) Bridge, road and ferry tolls;

(C) The cost of reasonable hotel/motel accommodation when the employee is required to remain away from the employee's usual place of residence on any night and the cost of breakfast, a midday meal and an evening meal when the employee is, and is required to be, away from the employee's usual place of residence at the employee's usual time for taking such meal in pursuance of the performance of the employee's duties. Provided that when an employee is specifically directed to work after 6.00 pm on any one day, the employee must be reimbursed the reasonable expense actually incurred in obtaining an evening meal.

(D) In the event that an employee suffers injury or incapacity, necessitating the employee's return to the employee's usual place of residence, or to a hospital, the expenses actually incurred in returning thereto.

(E) Where air or rail travel is necessarily involved, the expenses for economy class air tickets or for first class rail tickets and for sleeping accommodation where available.

(F) Reasonable laundry expenses incurred by an employee after the employee has been away from his or her place of residence for more than one weekend in the course of his or her employment.

(G) Such expenses as the employer and the employee agree, either by the terms of the contract of employment or otherwise, to be reasonable expenses or to be expenses for which the employee should be reimbursed or paid.

(iii) Employees whilst travelling on their employer's business will be regarded as being "on duty" for all purposes of this award and for the purposes of all relevant State workers compensation legislation.

(d) Relocation allowance

(i) Where an employee is transferred to another location or another state, the cost of removal expenses reasonably incurred must be borne and paid for by the employer, provided that an employee who is transferred at their own request may be required to pay their own expenses.

(ii) Where such employee is directed by the employer to another locality for employment which can be reasonably regarded as permanent and involving a change of residence, and where the employee is in the process of buying a place of residence in that new location, the employee must be reimbursed for the cost of accommodation for a period not exceeding six weeks. Where the employee has difficulty in obtaining a place of residence, the abovementioned period may be extended to a period not exceeding three months. Provided that the employer is not

required to reimburse the employee where the employer provides accommodation at no cost to the employee.

(iii) Where an employee is not in the process of buying a place of residence, the employer must reimburse the employee for the cost of accommodation for a period not exceeding four weeks. Provided that the employer is not required to reimburse the employee where the employer provides accommodation for the employee at no cost to the employee.

(iv) The provision of the above will cease to apply immediately after the employee assumes their new place of residence or when the purchase has been completed, whichever is the sooner.

(v) For the purpose of this clause, accommodation will be limited to the provision of housing.

22.3 Adjustment of expense related allowances

(a) At the time of any adjustment to the standard rate, each expense related allowance will be increased by the relevant adjustment factor. The relevant adjustment factor for this purpose is the percentage movement in the applicable index figure most recently published by the Australian Bureau of Statistics since the allowance was last adjusted.

[22.3(b) varied by PR994507 from 01Jan10]

(b) The applicable index figure is the index figure published by the Australian Bureau of Statistics for the Eight Capitals Consumer Price Index (Cat No. 6401.0), as follows:

Allowance	Applicable Consumer Price Index figure
Meal allowance	Take away and fast foods sub-group
Living away from home and Area allowances	Domestic holiday travel and accommodation sub-group
Motor vehicle allowance	Private motoring sub-group

23. District allowances

[23 varied by PR994507; deleted by PR561478 ppc 05Mar15]

24. Accident pay

[24 varied by PR994507, PR503625; deleted by PR561478 ppc 05Mar15; new 24 inserted by PR571819 ppc 15Oct15]

24.1 Definitions

For the purpose of this clause, the following definitions will apply:

(a) **Accident pay** means a weekly payment made to an employee by the employer that is the difference between the weekly amount of compensation paid to an employee pursuant to the applicable workers' compensation legislation and the

employee's ordinary rate of pay (not including over award payments, shift loadings or overtime).

(b) **Injury** will be given the same meaning and application as applying under the applicable workers' compensation legislation covering the employer.

24.2 Entitlement

The employer must pay accident pay where an employee suffers an injury and weekly payments of compensation are paid to the employee under the applicable workers' compensation legislation for a maximum period of 26 weeks.

24.3 Calculation of the period

(a) The 26 week period commences from the date of injury. In the event of more than one absence arising from one injury, such absences are to be cumulative in the assessment of the 26 week period.

(b) The termination by the employer of the employee's employment within the 26 week period will not affect the employee's entitlement to accident pay.

(c) For a period of less than one week, accident pay (as defined) will be calculated on a pro rata basis.

24.4 When not entitled to payment

An employee will not be entitled to any payment under this clause in respect of any period of paid annual leave or long service leave, or for any paid public holiday.

24.5 Return to work

If an employee entitled to accident pay under this clause returns to work on reduced hours or to perform modified duties, the amount of accident pay due will be reduced by any amounts paid for the performance of such work.

24.6 Redemptions

In the event that an employee receives a lump sum payment in lieu of weekly payments under the applicable workers' compensation legislation, the liability of the employer to pay accident pay will cease from the date the employee receives that payment.

24.7 Casual employees

For a casual employee the weekly payment referred to in clause 24.1(a) will be calculated using the employee's average weekly ordinary hours with the employer over the previous 12 months or, if the employee has been employed for less than 12 months by the employer, the employee's average weekly ordinary hours over the period of employment with the employer. The weekly payment will include casual loading but will not include over award payments, shift loadings and overtime.

24.8 Other

This clause does not operate to diminish an employee's entitlement to compensation payments under the applicable workers' compensation legislation.

25. Payment of wages

25.1 Wages must be paid weekly, fortnightly, four-weekly, half-monthly, monthly or in accordance with existing practices, by cash or by cheque or to the credit of the employee's account in a bank or other recognised financial institution, or in any agreed combination of the foregoing.

25.2 Wages must be paid, either:

(a) according to the average number of ordinary hours worked per pay period; or

(b) by agreement with either the majority of employees or with an individual employee according to the actual ordinary hours worked each pay period.

25.3 Where wages are paid in cash, such payment must be made during normal working hours.

25.4 Upon termination of employment, the wages due to an employee must be paid on the day of such termination or forwarded by post on the next working day.

26. Superannuation

[Varied by PR994507, PR545988]

26.1 Superannuation legislation

(a) Superannuation legislation, including the *Superannuation Guarantee (Administration) Act 1992* (Cth), the *Superannuation Guarantee Charge Act 1992* (Cth), the *Superannuation Industry (Supervision) Act 1993* (Cth) and the *Superannuation (Resolution of Complaints) Act 1993* (Cth), deals with the superannuation rights and obligations of employers and employees. Under superannuation legislation individual employees generally have the opportunity to choose their own superannuation fund. If an employee does not choose a superannuation fund, any superannuation fund nominated in the award covering the employee applies.

(b) The rights and obligations in these clauses supplement those in superannuation legislation.

26.2 Employer contributions

An employer must make such superannuation contributions to a superannuation fund for the benefit of an employee as will avoid the employer being required to pay the superannuation guarantee charge under superannuation legislation with respect to that employee.

26.3 Voluntary employee contributions

(a) Subject to the governing rules of the relevant superannuation fund, an employee may, in writing, authorise their employer to pay on behalf of the employee a specified amount from the post-taxation wages of the employee into the same superannuation fund as the employer makes the superannuation contributions provided for in clause 26.2.

(b) An employee may adjust the amount the employee has authorised their employer to pay from the wages of the employee from the first of the month following the giving of three months' written notice to their employer.

(c) The employer must pay the amount authorised under clauses 26.3(a) or (b) no later than 28 days after the end of the month in which the deduction authorised under clauses 26.3(a) or (b) was made.

26.4 Superannuation fund

[26.4 varied by PR994507 from 01Jan10]

Unless, to comply with superannuation legislation, the employer is required to make the superannuation contributions provided for in clause 26.2 to another superannuation fund that is chosen by the employee, the employer must make the superannuation contributions provided for in clause 26.2 and pay the amount authorised under clauses 26.3(a) or (b) to one of the following superannuation funds or its successor:

(a) AustralianSuper;

(b) CareSuper;

[26.4(c) varied by PR545988 ppc 01Jan14]

(c) any superannuation fund to which the employer was making superannuation contributions for the benefit of its employees before 12 September 2008, provided the superannuation fund is an eligible choice fund and is a fund that offers a MySuper product or is an exempt public sector scheme; or

[26.4(d) inserted by PR545988 ppc 01Jan14]

(d) a superannuation fund or scheme which the employee is a defined benefit member of.

26.5 Absence from work

Subject to the governing rules of the relevant superannuation fund, the employer must also make the superannuation contributions provided for in clause 26.2 and pay the amount authorised under clauses 26.3(a) or (b):

(a) **Paid leave—**while the employee is on any paid leave;

(b) **Work-related injury or illness**—for the period of absence from work (subject to a maximum of 52 weeks) of the employee due to work-related injury or work-related illness provided that:

(i) the employee is receiving workers compensation payments or is receiving regular payments directly from the employer in accordance with the statutory requirements; and

(ii) the employee remains employed by the employer.

Part 5—Hours of Work and Related Matters

27. Ordinary hours of work and rostering

[Varied by PR529161]

27.1 Ordinary hours of work—day workers

(a) Subject to this award, the ordinary hours of work for day workers are to be an average of 38 per week, of no more than eight hours per day, between the hours of 6.30 am to 6.30 pm at the discretion of the employer on any day or all of the days of the week, Monday to Friday.

27.2 Flexibility in relation to day work hours

(a) The following forms of flexibility may be implemented in respect of all employees in a workplace or section/s thereof, subject to agreement between the employer and the majority of the employees concerned in the workplace or relevant section/s. Agreement in this respect may also be reached between the employer and an individual employee:

(i) the spread of hours (i.e. 6.30 am to 6.30 pm) may be altered by up to one hour at either end of the spread;

(ii) the days on which ordinary hours are worked may include Saturday and/or Sunday, subject to the penalties in clause 27.4 and 27.5;

(iii) in excess of eight hours and up to 12 hours of ordinary time may be worked per day, exclusive of meal breaks. The implementation of 12 hour days is subject to the provisions of clause 28.4 of this award.

(b) Where an agreement is reached by the majority of employees it will apply to all the employees in the workplace or section/s to which the agreement applies. This does not in any way restrict the application of an individual agreement.

(c) Where agreement is reached in accordance with this paragraph, the agreement must be recorded in the time and wages records.

27.3 Day work outside the spread of hours

Where a day worker works part of the ordinary hours outside:

(a) the spread of hours referred to in clause 27.1; or

[27.3(b) varied by PR529161 ppc 27Sep12]

(b) the spread of hours as varied in accordance with clause 27.2;

the employee is entitled to an allowance of 24.7% of the standard hourly rate for each ordinary hour worked outside the spread of hours. Where such ordinary hours are worked after the spread of hours prescribed in clause 27.1, such hours will be limited to a maximum of four days per week.

27.4 Working ordinary hours on Saturday

[27.4 varied by PR529161 ppc 27Sep12]

Day workers are entitled to an allowance of 59.2% of the standard hourly rate per hour for ordinary time worked on Saturday.

27.5 Working ordinary hours on Sunday

[27.5 varied by PR529161 ppc 27Sep12]

Day workers are entitled to an allowance of 82.95% of the standard hourly rate per hour for ordinary time worked on Sunday.

27.6 General conditions relating to hours of work for day workers and shiftworkers

(a) The arrangement of hours under clause 27 and shifts under clause 28, once determined may be altered as follows:

(i) by the employer giving one week's notice of the requirement to change the arrangement of hours or shifts;

(ii) by mutual agreement between the employees concerned and their employer;

(iii) by the employer giving 24 hours' notice to the employee in the case of an emergency; or

(iv) at the discretion of the employer, employees may be permitted to exchange shifts or days off to perform duty for another employee. In such circumstances the employer is not required to make any additional payment.

27.7 Rosters

Rosters will specify the commencement and finishing times of ordinary working hours for employees.

27.8 Casual and part-time employees

Casual and part-time employees are entitled to the hourly allowances set out in clause 27—Ordinary hours of work and rostering and clause 28—Special provisions for shiftworkers of this award, where applicable, for the hours that the employees work.

27.9 Special provisions for country employees

The provisions of clause 27—Ordinary hours of work and rostering and clause 28—Special provisions for shiftworkers of this award will not apply to employees covered by this clause provided that the hours of such work will not exceed an average of 38 per week, exclusive of meal breaks, Monday to Friday inclusive.

28. Special provisions for shiftworkers

[Varied by PR529161]

28.1 For the purposes of this award:

(a) **Standard shiftwork** means shiftwork performed:

- on shifts of not more than eight hours; or
- on shifts of more than eight hours but not more than 10 hours in accordance with clause 28.2(b)(i).

(b) **Non-standard shiftwork** means any arrangement of shiftwork of up to 12 hours per day worked over a seven day period Monday to Sunday, other than standard shiftwork.

(c) **Afternoon shift** means any shift finishing after 6.30 pm and at or before midnight.

(d) **Night shift** means any shift finishing after midnight and at or before 8.00 am.

28.2 Standard shiftwork

(a) Ordinary hours of work

(i) The ordinary hours of work for standard shiftworkers are to be an average of 38 hours per week.

(ii) The ordinary hours of work are to be worked continuously. Such hours will be worked at the discretion of the employer. Standard shiftworkers are entitled to a 20 minute meal break on each shift which will be counted as time worked.

(b) Flexibility in relation to standard shiftwork

(i) The following forms of flexibility may be implemented in respect of all employees engaged on standard shiftwork in a workplace or section/s thereof, subject to agreement between the employer and the majority of the employees concerned in the workplace or relevant section/s. Agreement in this respect may also be reached between the employer and an individual employee:

- the shift definitions in clause 28.1(a) may be altered by up to one hour at either end of the span of hours referred to in the definition;
- in excess of eight hours and up to 10 hours of ordinary time may be worked per shift.

(ii) Where an agreement is reached by the majority of employees it will apply to all the employees in the workplace or section/s to which the agreement applies. This does not in any way restrict the application of an individual agreement.

(iii) Where agreement is reached in accordance with this clause, the agreement will be recorded in the time and wages records.

(c) Afternoon and night shift allowances

[28.2(c) varied by PR529161 ppc 27Sep12]

The following allowances apply to standard shiftworkers (as defined).

(i) Employees are entitled to an allowance of 14.68% of the standard hourly rate per hour for time worked on an afternoon shift.

(ii) Except as provided for in clause 28.2(c)(iii), employees are entitled to an allowance of 17.59% of the standard hourly rate per hour for time worked on a night shift.

(iii) An employee who:

- during a period of engagement on shift, works night shift only;
- remains on night shift for a longer period than four consecutive weeks; or
- works on a night shift which does not rotate or alternate with afternoon shift or with day work so as to give the employee at least one third of the working time off night shift in each shift cycle;

is entitled to an allowance of 21% of the standard hourly rate, per hour for time worked on such night shift, instead of the allowance prescribed in clause 28.2(c)(ii).

(d) Rate for Saturday shifts

The minimum rate to be paid to a standard shiftworker for work performed between midnight on Friday and midnight on Saturday will be time and a half for the first four hours and double time thereafter. This extra rate is in substitution for and not cumulative upon the shift allowances prescribed in clauses 28.2(c)(i), (ii) and (iii).

(e) Rate for Sunday shifts

The minimum rate to be paid to a standard shiftworker for work performed between midnight on Saturday and midnight on Sunday will be double time. This extra rate is in substitution for and not cumulative upon the shift allowances prescribed in clauses 28.2(c)(i), (ii) and (iii).

28.3 Non-standard shiftwork

(a) Ordinary hours of work

(i) The ordinary hours of work for non-standard shiftworkers (as defined) are to be an average of 38 hours per week to be worked over a shift cycle which does not exceed 13 weeks in duration.

(ii) The ordinary hours of work are to be worked continuously at the discretion of the employer. Non-standard shiftworkers are entitled to a 20 minute meal break on each shift which will be counted as time worked.

(b) Allowance for non-standard shiftworkers

[28.3(b) varied by PR529161 ppc 27Sep12]

Employees are entitled to an allowance of 30% of the standard hourly rate, for each ordinary hour worked on a non-standard shift (as defined). The extra rate

in this clause is in substitution for and not cumulative upon the shift premiums prescribed in clauses 28.2(c), (d) and (e) and clause 27.

28.4 Twelve hour days or shifts

Implementation of 12 hour days or shifts is subject to the following:

(a) suitable roster arrangements being made, including a review process relating to such rosters; and

(b) adequate breaks being provided.

28.5 Daylight saving

For work performed on any shift which spans the time of introduction or cessation of a system of daylight saving as prescribed by relevant State legislation, an employee must be paid according to adjusted time (i.e. the time on the clock at the beginning of the shift and the time on the clock at the end of the shift).

28.6 Make-up time

A day worker or a shiftworker may elect, with the consent of the employer, to work make-up time under which the employee takes time off during ordinary hours, and works those hours at a later time, during the spread of ordinary hours provided in the award.

29. Meal breaks

29.1 Except as provided for in clause 29.2, where practicable, an employee will not be required to work for more than five hours without a break for a meal which must be for a period of not less than 30 minutes and not more than 60 minutes.

29.2 Flexibility in relation to breaks

(a) The following forms of flexibility may be implemented in respect of all employees in a workplace or section/s thereof, subject to agreement between the employer and the majority of the employees concerned in the workplace or relevant section/s. Agreement in this respect may also be reached between the employer and an individual employee:

(i) employees may work in excess of five hours but not more than six hours without a meal break (except in the case of 12 hour days or shifts);

(ii) meal breaks may be for a period of less than 30 minutes, but not less than 20 minutes.

(b) Where an agreement is reached by the majority of employees it will apply to all the employees in the workplace or section/s to which the agreement applies. This does not in any way restrict the application of an individual agreement.

(c) An employee directed by the employer to work in excess of five hours without a meal, or such period as extended in accordance with clause 29.2, will be paid at the rate of time and one half for the meal period and the employee will be permitted to have the employee's usual meal period without deduction from the employee's wage as soon as possible after the prescribed meal period.

(d) This clause will not operate outside an employee's ordinary working hours. Meal breaks during overtime are prescribed in clause 30—Overtime of this award.

30. Overtime

[Varied by PR994507, PR584081]

30.1 Overtime rates

(a) An employee who works in excess of or outside the employee's ordinary hours established in accordance with clause 27—Ordinary hours of work and rostering or clause 28—Special provisions for shiftworkers, of this award will be paid at the rate of time and a half for the first three hours and double time thereafter, until the completion of work.

(b) Provided that employees who are late starting or are absent for part of their ordinary hours on unpaid leave will complete their ordinary hours for that day prior to the entitlement to overtime.

30.2 Scheduling of overtime

The assignment of overtime by an employer will be based on the specific work requirements and the practice of one in, all in overtime will not apply.

30.3 Work on a day off

(a) Days other than Sunday

An employee required to work overtime on any day off that is not a Sunday will be paid in accordance with clause 30.1.

(b) Sunday

An employee required to work on a Sunday that is a day off will be paid double time for all work.

(c) Minimum payment

(i) An employee required to work overtime on a Saturday or Sunday will be paid for a minimum of four hours at the appropriate rate except where such overtime is worked prior to or at the conclusion of ordinary hours of work.

(ii) In such circumstances, the employee will receive payment at the rate prescribed in clause 30.1 for the actual time worked.

(d) Rest break during overtime

(i) An employee working overtime will be allowed a rest break of 20 minutes without deduction of pay after each four hours of overtime if the employee continues to work after such rest break.

(ii) An employee working overtime for two or more hours after the completion of ordinary working hours will receive a paid rest break of

20 minutes. This rest break is to be taken at the commencement of overtime and is to be paid at the employee's ordinary time rate.

(iii) An employer and employee may agree to a variation of this provision to meet the circumstances of the work at hand provided that the employer will not be required to make any payment in respect of any time allowed in excess of 20 minutes.

30.4 Call-back

(a) An employee recalled to work overtime after leaving work will be paid a minimum of four hours or where the employee has been paid for standing by in accordance with clause 30.5, the employee will be paid for a minimum of three hours at the appropriate overtime rate for each time recalled, except where the overtime is continuous (subject to a meal break) with the commencement or completion of ordinary hours.

(b) Provided that the employee will not be required to work the full four or three hours as the case may be if the job(s) recalled to perform are completed within a shorter period.

(c) Notwithstanding the above, where an employee is recalled within the four or three hour guarantee period, the four or three hours' minimum for the first recall will be cancelled and the employee will be paid up to the commencement of the second or subsequent recalls.

(d) The provisions of this clause will not apply in circumstances where an employee provides technical service or technical support over the telephone or via remote access arrangements.

(e) Overtime worked in circumstances specified in this clause will not be regarded as overtime for the purposes of clause 30.6.

30.5 Stand-by

[30.5(a) varied by PR994507 from 01Jan10]

(a) An allowance of 59.42% of the standard hourly rate per hour will be paid to an employee for the period the employer requires the employee to remain in readiness for a return to work outside the employee's ordinary hours.

(b) While receiving the appropriate overtime rate in accordance with clause 30.1 the stand-by allowance will not be paid.

30.6 Rest period after overtime

(a) When overtime work is necessary, it will wherever reasonably practicable be so arranged that employees have at least 10 consecutive hours off duty between the work of successive days.

(b) An employee (other than a casual or part-time employee) who works so much overtime between the termination of the ordinary work on one day and the commencement of the ordinary work on the next day that the employee has not had at least 10 consecutive hours off duty between those times will, subject to this clause, be released after completion of such overtime until the employee has had 10 consecutive hours' off duty without loss of pay for ordinary working time occurring during such absence.

(c) If on the instructions of the employer an employee resumes or continues work without having 10 consecutive hours off duty, the employee will be paid at double time until released from duty for such period and then is entitled to be absent until the employee has had 10 consecutive hours off duty without loss of pay.

(d) The provisions of this clause will not apply to call-backs or in circumstances where an employee provides technical service or technical support over the telephone or via remote access arrangements.

30.7 Technical service/support

(a) An employee required to work overtime providing technical service or technical support over the telephone or via remote access arrangements will be paid for each occasion that such work is carried out:

(i) for a minimum of half an hour at the appropriate overtime rate where such work commences between 5.00 am and 10.00 pm; or

(ii) for a minimum of one hour at the appropriate overtime rate where such work commences after 10.00 pm and before 5.00 am except where the overtime is continuous (subject to a meal break) with the commencement or completion of ordinary hours.

(b) Provided that, the employee will not be required to work the full half an hour or one hour as the case may be if the work which the employer requires to be performed is completed within a shorter period.

(c) Notwithstanding the above, where an employee is required to carry out further overtime work within the half an hour or one hour guarantee period, the half an hour or one hour minimum for the first work period will be cancelled and the employee will be paid up to the commencement of the second or subsequent work period.

(d) Overtime worked in circumstances specified in this subclause will not be regarded as overtime for the purposes of clauses 30.4 and 30.5.

30.8 Rates not cumulative

The rates prescribed in this clause are in substitution for and not cumulative upon the rates prescribed in clause 27—Ordinary hours of work and rostering and clause 28—Special provisions for shiftworkers.

30.9 Time off instead of payment for overtime

[30.9 inserted by PR584081 ppc 22Aug16]

(a) An employee and employer may agree in writing to the employee taking time off instead of being paid for a particular amount of overtime that has been worked by the employee.

(b) Any amount of overtime that has been worked by an employee in a particular pay period and that is to be taken as time off instead of the employee being paid for it must be the subject of a separate agreement under clause 30.9.

(c) An agreement must state each of the following:

(i) the number of overtime hours to which it applies and when those hours were worked;

(ii) that the employer and employee agree that the employee may take time off instead of being paid for the overtime;

(iii) that, if the employee requests at any time, the employer must pay the employee, for overtime covered by the agreement but not taken as time off, at the overtime rate applicable to the overtime when worked;

(iv) that any payment mentioned in subparagraph (iii) must be made in the next pay period following the request.

Note: An example of the type of agreement required by this clause is set out at Schedule I. There is no requirement to use the form of agreement set out at Schedule I. An agreement under clause 30.9 can also be made by an exchange of emails between the employee and employer, or by other electronic means.

(d) The period of time off that an employee is entitled to take is the same as the number of overtime hours worked.

EXAMPLE: By making an agreement under clause 30.9 an employee who worked 2 overtime hours is entitled to 2 hours' time off.

(e) Time off must be taken:

(i) within the period of 6 months after the overtime is worked; and

(ii) at a time or times within that period of 6 months agreed by the employee and employer.

(f) If the employee requests at any time, to be paid for overtime covered by an agreement under clause 30.9 but not taken as time off, the employer must pay the employee for the overtime, in the next pay period following the request, at the overtime rate applicable to the overtime when worked.

(g) If time off for overtime that has been worked is not taken within the period of 6 months mentioned in paragraph (e), the employer must pay the employee for the overtime, in the next pay period following those 6 months, at the overtime rate applicable to the overtime when worked.

(h) The employer must keep a copy of any agreement under clause 30.9 as an employee record.

(i) An employer must not exert undue influence or undue pressure on an employee in relation to a decision by the employee to make, or not make, an agreement to take time off instead of payment for overtime.

(j) An employee may, under section 65 of the Act, request to take time off, at a time or times specified in the request or to be subsequently agreed by the employer and the employee, instead of being paid for overtime worked by the employee. If the employer agrees to the request then clause 30.9 will apply, including the requirement for separate written agreements under paragraph (b) for overtime that has been worked.

Note: If an employee makes a request under section 65 of the Act for a change in working arrangements, the employer may only refuse that request on reasonable business grounds (see section 65(5) of the Act).

(k) If, on the termination of the employee's employment, time off for overtime worked by the employee to which clause 30.9 applies has not been taken, the employer must pay the employee for the overtime at the overtime rate applicable to the overtime when worked.

Note: Under section 345(1) of the Act, a person must not knowingly or recklessly make a false or misleading representation about the workplace rights of another person under clause 30.9.

31. Annual leave

[Varied by PR994507, PR567229, PR582973]

31.1 Annual leave is provided for in the NES.

31.2 Annual leave loading

[31.2(a) varied by PR994507 from 01Jan10]

(a) During a period of annual leave an employee will receive a loading calculated on the rate of wage prescribed in clause 20—Classifications and adult rates. Annual leave loading payment is payable on leave accrued.

(b) The loading is as follows:

(i) Day work

Employees who would have worked on day work only had they not been on leave—17.5% or the relevant weekend penalty rates, whichever is the greater but not both.

(ii) Shiftwork

Employees who would have worked on shiftwork had they not been on leave—a loading of 17.5% or the shift loading (including relevant weekend penalty rates) whichever is the greater but not both.

31.3 Annual leave in advance

[31.3 renamed and substituted by PR582973 ppc 29Jul16]

(a) An employer and employee may agree in writing to the employee taking a period of paid annual leave before the employee has accrued an entitlement to the leave.

(b) An agreement must:

(i) state the amount of leave to be taken in advance and the date on which leave is to commence; and

(ii) be signed by the employer and employee and, if the employee is under 18 years of age, by the employee's parent or guardian.

Note: An example of the type of agreement required by clause 31.3 is set out at Schedule G. There is no requirement to use the form of agreement set out at Schedule G.

(c) The employer must keep a copy of any agreement under clause 31.3 as an employee record.

(d) If, on the termination of the employee's employment, the employee has not accrued an entitlement to all of a period of paid annual leave already taken in accordance with an agreement under clause 31.3, the employer may deduct from any money due to the employee on termination an amount equal to the amount that was paid to the employee in respect of any part of the period of annual leave taken in advance to which an entitlement has not been accrued.

31.4 Close-down

[31.4 renamed and substituted by PR582973 ppc 29Jul16]

An employer may require an employee to take annual leave as part of a close-down of its operations, by giving at least four weeks' notice.

31.5 Definition of shiftworker

[31.5 varied by PR994507; substituted by PR567229 ppc 27May15]

For the purpose of the additional week of annual leave provided for in s.87(1)(b) of the Act, a **shiftworker** is a seven day continuous shiftworker who is regularly rostered to work on Sundays and public holidays.

31.6 Country employees

[31.6(a) varied by PR994507 from 01Jan10]

(a) Employees who are required by their employer to remain away from their usual place of residence on more than two nights in any week, Monday to Sunday inclusive, for each week of the working year, will in addition to the annual leave prescribed in s.87(1)(a) of the Act receive a further seven consecutive days' leave including nonworking days

(b) Where an employee operates in country areas as prescribed in clause 31.6(a) for only part of the time the employee will receive an additional leave entitlement on the basis of an extra half day's annual leave for each five weeks in any one year during which the employee is required to be away from the usual place of residence.

(c) This clause will not apply to employees undertaking training courses.

31.7 Excessive leave accruals: general provision

[31.7(a) varied by PR994507 from 01Jan10; 31.7 renamed and substituted by PR582973 ppc 29Jul16]

Note: Clauses 31.7 to 31.9 contain provisions, additional to the National Employment Standards, about the taking of paid annual leave as a way of dealing with the accrual of excessive paid annual leave. See Part 2.2, Division 6 of the Fair Work Act.

(a) An employee has an **excessive leave accrual** if the employee has accrued more than 8 weeks' paid annual leave (or 10 weeks' paid annual leave for a shiftworker, as defined by clause 31.5).

(b) If an employee has an excessive leave accrual, the employer or the employee may seek to confer with the other and genuinely try to reach agreement on how to reduce or eliminate the excessive leave accrual.

(c) Clause 31.8 sets out how an employer may direct an employee who has an excessive leave accrual to take paid annual leave.

(d) Clause 31.9 sets out how an employee who has an excessive leave accrual may require an employer to grant paid annual leave requested by the employee.

31.8 Excessive leave accruals: direction by employer that leave be taken

[31.8 deleted by PR567229 ppc 27May15; New 31.8 inserted by PR582973 ppc 29Jul16]

(a) If an employer has genuinely tried to reach agreement with an employee under clause 31.7(b) but agreement is not reached (including because the employee refuses to confer), the employer may direct the employee in writing to take one or more periods of paid annual leave.

(b) However, a direction by the employer under paragraph (a):

(i) is of no effect if it would result at any time in the employee's remaining accrued entitlement to paid annual leave being less than 6 weeks when any other paid annual leave arrangements (whether made under clause 31.7, 31.8 or 31.9 or otherwise agreed by the employer and employee) are taken into account; and

(ii) must not require the employee to take any period of paid annual leave of less than one week; and

(iii) must not require the employee to take a period of paid annual leave beginning less than 8 weeks, or more than 12 months, after the direction is given; and

(iv) must not be inconsistent with any leave arrangement agreed by the employer and employee.

(c) The employee must take paid annual leave in accordance with a direction under paragraph (a) that is in effect.

(d) An employee to whom a direction has been given under paragraph (a) may request to take a period of paid annual leave as if the direction had not been given.

Note 1: Paid annual leave arising from a request mentioned in paragraph (d) may result in the direction ceasing to have effect. See clause 31.8(b)(i).

Note 2: Under section 88(2) of the Fair Work Act, the employer must not unreasonably refuse to agree to a request by the employee to take paid annual leave.

31.9 Excessive leave accruals: request by employee for leave

[31.9 inserted by PR582973; substituted by PR582973 ppc 29Jul17]

(a) If an employee has genuinely tried to reach agreement with an employer under clause 31.7(b) but agreement is not reached (including because the employer refuses to confer), the employee may give a written notice to the employer requesting to take one or more periods of paid annual leave.

(b) However, an employee may only give a notice to the employer under paragraph (a) if:

(i) the employee has had an excessive leave accrual for more than 6 months at the time of giving the notice; and

(ii) the employee has not been given a direction under clause 31.8(a) that, when any other paid annual leave arrangements (whether made under clause 31.7, 31.8 or 31.9 or otherwise agreed by the employer and employee) are taken into account, would eliminate the employee's excessive leave accrual.

(c) A notice given by an employee under paragraph (a) must not:

(i) if granted, result in the employee's remaining accrued entitlement to paid annual leave being at any time less than 6 weeks when any other paid annual leave arrangements (whether made under clause 31.7, 31.8 or 31.9 or otherwise agreed by the employer and employee) are taken into account; or

(ii) provide for the employee to take any period of paid annual leave of less than one week; or

(iii) provide for the employee to take a period of paid annual leave beginning less than 8 weeks, or more than 12 months, after the notice is given; or

(iv) be inconsistent with any leave arrangement agreed by the employer and employee.

(d) An employee is not entitled to request by a notice under paragraph (a) more than 4 weeks' paid annual leave (or 5 weeks' paid annual leave for a shiftworker, as defined by clause 31.5) in any period of 12 months.

(e) The employer must grant paid annual leave requested by a notice under paragraph (a).

31.10 Cashing out of annual leave

[31.10 inserted by PR582973 ppc 29Jul16]

(a) Paid annual leave must not be cashed out except in accordance with an agreement under clause 31.10.

(b) Each cashing out of a particular amount of paid annual leave must be the subject of a separate agreement under clause 31.10.

(c) An employer and an employee may agree in writing to the cashing out of a particular amount of accrued paid annual leave by the employee.

(d) An agreement under clause 31.10 must state:

(i) the amount of leave to be cashed out and the payment to be made to the employee for it; and

(ii) the date on which the payment is to be made.

(e) An agreement under clause 31.10 must be signed by the employer and employee and, if the employee is under 18 years of age, by the employee's parent or guardian.

(f) The payment must not be less than the amount that would have been payable had the employee taken the leave at the time the payment is made.

(g) An agreement must not result in the employee's remaining accrued entitlement to paid annual leave being less than 4 weeks.

(h) The maximum amount of accrued paid annual leave that may be cashed out in any period of 12 months is 2 weeks.

(i) The employer must keep a copy of any agreement under clause 31.10 as an employee record.

Note 1: Under section 344 of the Fair Work Act, an employer must not exert undue influence or undue pressure on an employee to make, or not make, an agreement under clause 31.10.

Note 2: Under section 345(1) of the Fair Work Act, a person must not knowingly or recklessly make a false or misleading representation about the workplace rights of another person under clause 31.10.

Note 3: An example of the type of agreement required by clause 31.10 is set out at Schedule H. There is no requirement to use the form of agreement set out at Schedule H.

32. Personal/carer's leave and compassionate leave

32.1 Personal/carer's leave and compassionate leave are provided for in the NES.

32.2 Personal/carer's leave for casual employees

(a) Casual employees are entitled to be not available for work or to leave work to care for a person who is sick and requires care and support or who requires care due to an emergency.

(b) Such leave is unpaid. A maximum of 48 hours' absence is allowed by right with additional absence by agreement.

33. Community service leave

Community service leave is provided for in the NES.

34. Public holidays

34.1 Public holidays are provided for in the NES.

34.2 An employer and the employees may by agreement substitute another day for a public holiday.

34.3 Work on a public holiday or a substituted day must be paid at double time and a half. Where both a public holiday and substitute day are worked, public holiday penalties are payable on the holiday and the employee is entitled to not less than four hours' pay at penalty rates provided the employee is available to work for four hours.

35. Leave to deal with Family and Domestic Violence

[35 inserted by PR609338 ppc 01Aug18]

35.1 This clause applies to all employees, including casuals.

35.2 Definitions

(a) In this clause:

family and domestic violence means violent, threatening or other abusive behaviour by a family member of an employee that seeks to coerce or control the employee and that causes them harm or to be fearful.

family member means:

(i) a spouse, de facto partner, child, parent, grandparent, grandchild or sibling of the employee; or

(ii) a child, parent, grandparent, grandchild or sibling of a spouse or de facto partner of the employee; or

(iii) a person related to the employee according to Aboriginal or Torres Strait Islander kinship rules.

(b) A reference to a spouse or de facto partner in the definition of family member in clause 35.2(a) includes a former spouse or de facto partner.

35.3 Entitlement to unpaid leave

An employee is entitled to 5 days' unpaid leave to deal with family and domestic violence, as follows:

(a) the leave is available in full at the start of each 12 month period of the employee's employment; and

(b) the leave does not accumulate from year to year; and

(c) is available in full to part-time and casual employees.

Note: 1. A period of leave to deal with family and domestic violence may be less than a day by agreement between the employee and the employer.

2. The employer and employee may agree that the employee may take more than 5 days' unpaid leave to deal with family and domestic violence.

35.4 Taking unpaid leave

An employee may take unpaid leave to deal with family and domestic violence if the employee:

(a) is experiencing family and domestic violence; and

(b) needs to do something to deal with the impact of the family and domestic violence and it is impractical for the employee to do that thing outside their ordinary hours of work.

Note: The reasons for which an employee may take leave include making arrangements for their safety or the safety of a family member (including relocation), attending urgent court hearings, or accessing police services.

35.5 Service and continuity

The time an employee is on unpaid leave to deal with family and domestic violence does not count as service but does not break the employee's continuity of service.

35.6 Notice and evidence requirements

(a) Notice

An employee must give their employer notice of the taking of leave by the employee under clause 35. The notice:

(i) must be given to the employer as soon as practicable (which may be a time after the leave has started); and

(ii) must advise the employer of the period, or expected period, of the leave.

(b) Evidence

An employee who has given their employer notice of the taking of leave under clause 35 must, if required by the employer, give the employer evidence that would satisfy a reasonable person that the leave is taken for the purpose specified in clause 35.4.

Note: Depending on the circumstances such evidence may include a document issued by the police service, a court or a family violence support service, or a statutory declaration.

35.7 Confidentiality

(a) Employers must take steps to ensure information concerning any notice an employee has given, or evidence an employee has provided under clause 35.6 is treated confidentially, as far as it is reasonably practicable to do so.

(b) Nothing in clause 35 prevents an employer from disclosing information provided by an employee if the disclosure is required by an Australian law or is necessary to protect the life, health or safety of the employee or another person.

Note: Information concerning an employee's experience of family and domestic violence is sensitive and if mishandled can have adverse consequences for the employee. Employers should consult with such employees regarding the handling of this information.

35.8 Compliance

An employee is not entitled to take leave under clause 35 unless the employee complies with clause 35.

35A. Requests for flexible working arrangements

[35A inserted by PR701415 ppc 01Dec18]

35A.1 Employee may request change in working arrangements

Clause 35A applies where an employee has made a request for a change in working arrangements under s.65 of the Act.

Note 1: Section 65 of the Act provides for certain employees to request a change in their working arrangements because of their circumstances, as set out in s.65(1A).

Note 2: An employer may only refuse a s.65 request for a change in working arrangements on 'reasonable business grounds' (see s.65(5) and (5A)).

Note 3: Clause 35A is an addition to s.65.

35A.2 Responding to the request

Before responding to a request made under s.65, the employer must discuss the request with the employee and genuinely try to reach agreement on a change in working arrangements that will reasonably accommodate the employee's circumstances having regard to:

(a) the needs of the employee arising from their circumstances;

(b) the consequences for the employee if changes in working arrangements are not made; and

(c) any reasonable business grounds for refusing the request.

Note 1: The employer must give the employee a written response to an employee's s.65 request within 21 days, stating whether the employer grants or refuses the request (s.65(4)).

Note 2: If the employer refuses the request, the written response must include details of the reasons for the refusal (s.65(6)).

35A.3 What the written response must include if the employer refuses the request

Clause 35A.3 applies if the employer refuses the request and has not reached an agreement with the employee under clause 35A.2.

(a) The written response under s.65(4) must include details of the reasons for the refusal, including the business ground or grounds for the refusal and how the ground or grounds apply.

(b) If the employer and employee could not agree on a change in working arrangements under clause 35A.2, the written response under s.65(4) must:

(i) state whether or not there are any changes in working arrangements that the employer can offer the employee so as to better accommodate the employee's circumstances; and

(ii) if the employer can offer the employee such changes in working arrangements, set out those changes in working arrangements.

35A.4 What the written response must include if a different change in working arrangements is agreed

If the employer and the employee reached an agreement under clause 35A.2 on a change in working arrangements that differs from that initially requested by the employee, the employer must provide the employee with a written response to their request setting out the agreed change(s) in working arrangements.

35A.5 Dispute resolution

Disputes about whether the employer has discussed the request with the employee and responded to the request in the way required by clause 35A, can be dealt with under clause 10—Dispute resolution.

Schedule A—Transitional Provisions

[New Sched A inserted by PR988401 from 01Jan10; varied by PR994507, PR503625]

A.1 General

A.1.1 The provisions of this schedule deal with minimum obligations only.

A.1.2 The provisions of this schedule are to be applied:

[A.1.2 substituted by PR994507 from 01Jan10]

(a) when there is a difference, in money or percentage terms, between a provision in a relevant transitional minimum wage instrument (including the transitional default casual loading) or award-based transitional instrument on the one hand and an equivalent provision in this award on the other;

(b) when a loading or penalty in a relevant transitional minimum wage instrument or award-based transitional instrument has no equivalent provision in this award;

(c) when a loading or penalty in this award has no equivalent provision in a relevant transitional minimum wage instrument or award-based transitional instrument; or

(d) when there is a loading or penalty in this award but there is no relevant transitional minimum wage instrument or award-based transitional instrument.

A.2 Minimum wages – existing minimum wage lower

A.2.1 The following transitional arrangements apply to an employer which, immediately prior to 1 January 2010:

(a) was obliged,

[A.2.1(b) substituted by PR994507 from 01Jan10]

(b) but for the operation of an agreement-based transitional instrument or an enterprise agreement would have been obliged, or

(c) if it had been an employer in the industry or of the occupations covered by this award would have been obliged

by a transitional minimum wage instrument and/or an award-based transitional instrument to pay a minimum wage lower than that in this award for any classification of employee.

A.2.2 In this clause minimum wage includes:

(a) a minimum wage for a junior employee, an employee to whom training arrangements apply and an employee with a disability;

(b) a piecework rate; and

(c) any applicable industry allowance.

A.2.3 Prior to the first full pay period on or after 1 July 2010 the employer must pay no less than the minimum wage in the relevant transitional minimum wage instrument and/or award-based transitional instrument for the classification concerned.

A.2.4 The difference between the minimum wage for the classification in this award and the minimum wage in clause A.2.3 is referred to as the transitional amount.

A.2.5 From the following dates the employer must pay no less than the minimum wage for the classification in this award minus the specified proportion of the transitional amount:

First full pay period on or after	
1 July 2010	80%
1 July 2011	60%
1 July 2012	40%
1 July 2013	20%

A.2.6 The employer must apply any increase in minimum wages in this award resulting from an annual wage review.

A.2.7 These provisions cease to operate from the beginning of the first full pay period on or after 1 July 2014.

A.3 Minimum wages – existing minimum wage higher

A.3.1 The following transitional arrangements apply to an employer which, immediately prior to 1 January 2010:

(a) was obliged,

[A.3.1(b) substituted by PR994507 from 01Jan10]

(b) but for the operation of an agreement-based transitional instrument or an enterprise agreement would have been obliged, or

(c) if it had been an employer in the industry or of the occupations covered by this award would have been obliged

by a transitional minimum wage instrument and/or an award-based transitional instrument to pay a minimum wage higher than that in this award for any classification of employee.

A.3.2 In this clause minimum wage includes:

(a) a minimum wage for a junior employee, an employee to whom training arrangements apply and an employee with a disability;

(b) a piecework rate; and

(c) any applicable industry allowance.

A.3.3 Prior to the first full pay period on or after 1 July 2010 the employer must pay no less than the minimum wage in the relevant transitional minimum wage instrument and/or award-based transitional instrument for the classification concerned.

A.3.4 The difference between the minimum wage for the classification in this award and the minimum wage in clause A.3.3 is referred to as the transitional amount.

A.3.5 From the following dates the employer must pay no less than the minimum wage for the classification in this award plus the specified proportion of the transitional amount:

First full pay period on or after	
1 July 2010	80%
1 July 2011	60%
1 July 2012	40%
1 July 2013	20%

A.3.6 The employer must apply any increase in minimum wages in this award resulting from an annual wage review. If the transitional amount is equal to or less than any increase in minimum wages resulting from the 2010 annual wage review the transitional amount is to be set off against the increase and the other provisions of this clause will not apply.

A.3.7 These provisions cease to operate from the beginning of the first full pay period on or after 1 July 2014.

A.4 Loadings and penalty rates

For the purposes of this schedule loading or penalty means a:

- casual or part-time loading;
- Saturday, Sunday, public holiday, evening or other penalty;
- shift allowance/penalty.

A.5 Loadings and penalty rates – existing loading or penalty rate lower

[A.5.1 substituted by PR994507 from 01Jan10]

A.5.1 The following transitional arrangements apply to an employer which, immediately prior to 1 January 2010:

(a) was obliged,

(b) but for the operation of an agreement-based transitional instrument or an enterprise agreement would have been obliged, or

(c) if it had been an employer in the industry or of the occupations covered by this award would have been obliged

by the terms of a transitional minimum wage instrument or an award-based transitional instrument to pay a particular loading or penalty at a lower rate than the equivalent loading or penalty in this award for any classification of employee.

[A.5.2 substituted by PR994507 from 01Jan10]

A.5.2 Prior to the first full pay period on or after 1 July 2010 the employer must pay no less than the loading or penalty in the relevant transitional minimum wage instrument or award-based transitional instrument for the classification concerned.

A.5.3 The difference between the loading or penalty in this award and the rate in clause A.5.2 is referred to as the transitional percentage.

A.5.4 From the following dates the employer must pay no less than the loading or penalty in this award minus the specified proportion of the transitional percentage:

First full pay period on or after	
1 July 2010	80%
1 July 2011	60%
1 July 2012	40%
1 July 2013	20%

A.5.5 These provisions cease to operate from the beginning of the first full pay period on or after 1 July 2014.

A.6 Loadings and penalty rates – existing loading or penalty rate higher

[A.6.1 substituted by PR994507 from 01Jan10]

A.6.1 The following transitional arrangements apply to an employer which, immediately prior to 1 January 2010:

(a) was obliged,

(b) but for the operation of an agreement-based transitional instrument or an enterprise agreement would have been obliged, or

(c) if it had been an employer in the industry or of the occupations covered by this award would have been obliged

by the terms of a transitional minimum wage instrument or an award-based transitional instrument to pay a particular loading or penalty at a higher rate than the equivalent loading or penalty in this award, or to pay a particular loading or penalty and there is no equivalent loading or penalty in this award, for any classification of employee.

[A.6.2 substituted by PR994507 from 01Jan10]

A.6.2 Prior to the first full pay period on or after 1 July 2010 the employer must pay no less than the loading or penalty in the relevant transitional minimum wage instrument or award-based transitional instrument.

[A.6.3 substituted by PR994507 from 01Jan10]

A.6.3 The difference between the loading or penalty in this award and the rate in clause A.6.2 is referred to as the transitional percentage. Where there is no equivalent loading or penalty in this award, the transitional percentage is the rate in A.6.2.

A.6.4 From the following dates the employer must pay no less than the loading or penalty in this award plus the specified proportion of the transitional percentage:

First full pay period on or after	
1 July 2010	80%
1 July 2011	60%
1 July 2012	40%
1 July 2013	20%

A.6.5 These provisions cease to operate from the beginning of the first full pay period on or after 1 July 2014.

A.7 Loadings and penalty rates – no existing loading or penalty rate

[A.7.1 varied by PR994507 from 01Jan10]

A.7.1 The following transitional arrangements apply to an employer not covered by clause A.5 or A.6 in relation to a particular loading or penalty in this award.

A.7.2 Prior to the first full pay period on or after 1 July 2010 the employer need not pay the loading or penalty in this award.

[A.7.3 substituted by PR994507 from 01Jan10]

A.7.3 From the following dates the employer must pay no less than the following percentage of the loading or penalty in this award:

First full pay period on or after	
1 July 2010	20%
1 July 2011	40%
1 July 2012	60%
1 July 2013	80%

[A.7.4 inserted by PR994507 from 01Jan10]

A.7.4 These provisions cease to operate from the beginning of the first full pay period on or after 1 July 2014.

A.8 Former Division 2B employers

[A.8 inserted by PR503625 ppc 01Jan11]

A.8.1 This clause applies to an employer which, immediately prior to 1 January 2011, was covered by a Division 2B State award.

A.8.2 All of the terms of a Division 2B State award applying to a Division 2B employer are continued in effect until the end of the full pay period commencing before 1 February 2011.

A.8.3 Subject to this clause, from the first full pay period commencing on or after 1 February 2011 a Division 2B employer must pay no less than the minimum wages, loadings and penalty rates which it would be required to pay under this Schedule if it had been a national system employer immediately prior to 1 January 2010.

A.8.4 Despite clause A.8.3, where a minimum wage, loading or penalty rate in a Division 2B State award immediately prior to 1 February 2011 was lower than the corresponding minimum wage, loading or penalty rate in this award, nothing in this Schedule requires a Division 2B employer to pay more than the minimum wage, loading or penalty rate in this award.

A.8.5 Despite clause A.8.3, where a minimum wage, loading or penalty rate in a Division 2B State award immediately prior to 1 February 2011 was higher than the corresponding minimum wage, loading or penalty rate in this award, nothing in this Schedule requires a Division 2B employer to pay less than the minimum wage, loading or penalty rate in this award.

A.8.6 In relation to a Division 2B employer this Schedule commences to operate from the beginning of the first full pay period on or after 1 January 2011 and ceases to operate from the beginning of the first full pay period on or after 1 July 2014.

Schedule B—Classifications, Skill Levels and Definitions

[Sched A renumbered as Sched B by PR988401 from 01Jan10]

B.1 Technical services stream

B.1.1 Level 1 Technical Employee

(a) Classification requirements

An employee at this level must be capable of performing:

- routine mechanical/electro-mechanical/electronic assembly;
- is responsible for the quality assurance of the employee's own work;
- works under direct supervision either individually or in a team environment;
- exercises discretion within the employee's level and training;
- able to follow specific verbal/written instructions relating to assembly assignments;
- able to measure accurately;
- able to inspect products and/or materials for conformity with established operational standards; and
- operates all lifting equipment incidental to the employee's work.

(b) Duties

- repetition work on automatic, semi-automatic or single purpose machines or equipment;
- assembles components using basic written, spoken and/or diagrammatic instructions in an assembly environment;
- basic soldering or butt and spot welding; and
- may be directed to perform other duties consistent with training and skill levels required for this position.

B.1.2 Level 2 Technical Employee

(a) Classification requirements

An employee at this level must be capable of performing work above, beyond and including the requirements of a Level 1 Technical Employee:

- is responsible for the quality assurance of the employee's own work;
- works under routine supervision either individually or in a team environment;
- exercises discretion within the employee's level of skills and training;

- follows specific verbal/written instructions relating to repair assignments; and
- able to maintain records or reports in accordance with company procedures.

(b) Duties

- receiving, dispatching, distributing, sorting, checking, packing, documenting and recording of goods, materials and components other than repetitive packing in a standard container or containers in which goods are ordinarily packed;
- basic inventory control in the context of a production process;
- operation of mobile equipment including forklifts, hand trolleys, pallet trucks, overhead cranes and winches;
- routine maintenance of mechanical, electro-mechanical, or electronic business equipment; and
- may be directed to perform other duties consistent with training and skill levels required for this position.

B.1.3 Level 3 Technician

(a) Classification requirements

An employee at this level must be capable of performing work above, beyond and including the requirements of a Level 2 Technical Employee:

- able to perform basic technical duties in accordance with company procedures;
- is responsible for the quality assurance of the employee's own work;
- works under routine supervision either individually or in a team environment;
- understands and applies quality control techniques;
- exercises good interpersonal and communication skills;
- exercises limited discretion within the scope of this grade;
- performs non-technical tasks incidental to the employee's work;
- able to inspect products and/or materials for conformity with established operational standards;
- able to apply a logical approach to solving technical problems;
- able to maintain reports or records in accordance with company procedures;
- able to effectively communicate and to work with other technicians, technical employees and customers in technical service situations;
- able to work independently at a customer site as assigned; and
- able to perform technical duties in accordance with company procedures on basic equipment.

(b) Duties

- applies routine diagnostic procedures;
- performs option checkout to ensure proper equipment performance to meet company standards and customer expectations;
- resolves routine malfunctions where cause and correction are readily identifiable;
- performs preventative maintenance and repair service on demand and/or to agreed schedules;
- renders technical support in conformity with the manufacturer's/company procedures and specifications;
- assists other employees by skill sharing and the provision of advice and assistance;
- reviews the performance of equipment being serviced;
- runs routine diagnostics on printed circuit boards; and
- may be directed to perform other duties consistent with the training and skill levels required for this position.

B.1.4 Level 4 Technician

(a) Classification requirements

An employee at this level must be capable of performing work above, beyond and including the requirements of a Level 3 Technician:

- performs technical service, support and installation of equipment;
- services and installs networks and maintains communication facilities;
- performs non technical tasks incidental to the employee’s work;
- able to work under routine supervision either individually or in a team environment;
- able to work independently at customer site as assigned;
- demonstrates and applies greater knowledge of the company's product;
- sufficient for diagnosis of complicated hardware production faults;
- able to exercise limited discretion in deviating from standard practice to solve problems within area of experience;
- able to apply logical, methodical, analytical approach to isolate and solve complicated hardware problems; and
- able to effectively communicate and to work with other technicians, technical employees, managers and customers in technical support situations.

(b) Duties

- installation or relocation of hardware;
- assists in the provision of on-the-job training;
- assists in the analysis and preparation of component failure impact plans; and
- may be directed to perform other duties consistent with training and skills levels required for this position.

B.1.5 Level 5 Technician

(a) Classification requirements

An employee at this level must be capable of performing work above, beyond and including the requirements of a Level 4 Technician:

- applies specialised technical knowledge to problem solve difficult or complex situations;
- able to exercise broad discretion in defining and solving technical problems where alternative choices may be applicable within standard practice;
- able to perform varied technical duties involving the use of a wide range of alternative procedures;
- capable of providing technical guidance and assistance as part of a work team;
- capable of assistance in the provision of training, in conjunction with other support staff;
- able to work under general supervision either individually or in a team environment;
- able to use system level diagnostics to isolate and correct problems; and
- able to apply verbal and written communication skills.

(b) Duties

- handles more complex/critical equipment;
- operates diagnostic systems to debug and isolate problems; and
- may be directed to perform other duties consistent with training and skills levels required for this position.

B.1.6 Level 6 Technician

(a) Classification requirements

An employee at this level must be capable of performing work above, beyond and including the requirements of a Level 5 Technician and consistent with this award:

- demonstrates an ability to respond to issues such as complex, unusual, intermittent or undefined malfunctions;

- researches problems and recommends solutions;
- maintains contact with problem situations and assists until a satisfactory resolution is achieved;
- summarises problem resolution and follow-up requirements for management. communicates final status to local management prior to leaving site;
- demonstrates an ability to review background of problems and performs on-site technical activities;
- conducts technical product performance improvement projects;
- identifies procedures to improve service support delivery;
- exercises broad discretion in defining and solving technical problems which may require the development of new alternative approaches;
- applies logical, methodical, analytical approaches to isolate and solve complex problems;
- able to lead a small team;
- works under limited supervision; and
- able to handle the technical functions of all aspects of computer systems, networks and communications.

(b) Duties

- provides assistance with installation planning;
- provides guidance to customers on component failure impact and problem determination procedures;
- provides guidance to employees engaged at lower levels;
- responsible for customer satisfaction and quality of service provided;
- provides technical direction and guidance to customers;
- handles more complicated projects; and
- may be directed to perform other duties consistent with training and skills levels required for this position.

B.2 Clerical and Administration Stream

B.2.1 Clerical and Administration Employee Level 1

(a) Role definition

An employee at this level:

- works under direct supervision with regular checking of progress;
- applies knowledge and skills to a limited range of tasks; and

- performs work within established routines, methods and procedures that are predictable and which require the exercise of limited discretion.

(b) Indicative tasks

The following tasks are indicative of those performed by an employee at this level:

- prepare for work;
- complete daily work activities;
- apply basic communication skills;
- plan skills development;
- use business equipment;
- follow workplace safety procedures;
- operate a personal computer;
- develop keyboard skills; and
- follow environmental work practices.

(c) Qualifications

An employee who holds a Certificate I in Business or equivalent would be classified at this level when employed to perform the functions in the Role definition and taking into account the Indicative tasks.

B.2.2 Clerical and Administration Employee Level 2

(a) Role definition

An employee at this level:

- works under routine supervision with intermittent checking;
- applies knowledge and skills to a range of tasks; and
- usually performs work within established routines, methods and procedures, which involve the exercise of some discretion and minor decision making.

(b) Indicative tasks

The following tasks are indicative of those performed by an employee at this level:

- work effectively in a business environment;
- organise and complete daily work activities;
- communicate in the workplace;
- work effectively with others;
- use business technology;

- process and maintain workplace information;
- prepare and process financial/business documents;
- deliver a service to customers;
- provide information to clients;
- implement improved work practices;
- participate in workplace safety procedures;
- handle mail;
- produce simple word-processed documents;
- create and use simple spreadsheets; and
- participate in environmental work practices.

(c) Qualifications

An employee who holds a Certificate II in Business or equivalent would be classified at this level when employed to perform the functions in the Role definition and taking into account the Indicative tasks.

B.2.3 Clerical and Administration Employee Level 3

(a) Role definition

An employee at this level:

- works under limited supervision with checking related to overall progress;
- may be responsible for the work of others and may be required to co-ordinate such work;
- applies knowledge with depth in some areas and a broad range of skills; and
- performs work within routines, methods and procedures where some discretion and judgment is required.

(b) Indicative tasks

The following tasks are indicative of those performed by an employee at this level:

- exercise initiative in a business environment;
- organise personal work priorities and development;
- contribute to effective workplace relationships;
- contribute to personal skill development and learning;
- organise workplace information;
- produce business documents;
- maintain business resources;

- maintain financial records;
- recommend products and services;
- deliver and monitor a service to customers;
- maintain workplace safety;
- support innovation and change;
- maintain environmental procedures;
- produce texts from shorthand notes;
- produce texts from notes;
- produce texts from audio transcription;
- design and develop text documents;
- create and use databases;
- create electronic presentations;
- organise schedules;
- process payroll;
- process accounts payable and receivable;
- maintain a general ledger;
- support leadership in the workplace;
- participate in work teams;
- support operational plans;
- provide workplace information and resourcing plans;
- support continuous improvement systems and processes;
- deliver and monitor a service to customers; and
- support a workplace learning environment.

(c) Qualifications

An employee who holds a Certificate III in Business or equivalent would be classified at this level when employed to perform the functions in the Role definition and taking into account the Indicative tasks.

B.2.4 Clerical and Administration Employee Level 4

(a) Role definition

An employee at this level:

- works without supervision, with general guidance on progress and outcomes sought;

- may be responsible for the organisation of the work of others;
- applies knowledge with depth in some areas and a broad range of skills;
- performs a wide range of tasks, and the range and choice of actions required will usually be complex; and
- performs work within routines, methods and procedures where discretion and judgment is required for both self and others.

(b) Indicative tasks

The following tasks are indicative of those performed by an employee at this level:

- develop work priorities;
- establish business networks;
- develop teams and individuals;
- analyse and present research information;
- maintain business technology;
- co-ordinate business resources;
- report on financial activity;
- promote products and services;
- co-ordinate implementation of customer service strategies;
- monitor a safe workplace;
- promote innovation and change;
- implement and monitor environmental policies;
- show leadership in the workplace;
- manage effective workplace relationships;
- lead work teams;
- implement operational plan;
- implement workplace information system;
- implement continuous improvement;
- develop teams and individuals;
- produce complex texts from shorthand notes;
- produce complex business documents;
- develop and use complex databases;
- develop and use complex spreadsheets;

- organise meetings;
- organise business travel;
- administer projects; and
- prepare financial reports.

(c) Qualifications

An employee who holds a Certificate IV in Business or equivalent would be classified at this level when employed to perform the functions in the Role definition and taking into account the Indicative tasks.

B.2.5 Clerical and Administration Employee Level 5

(a) Role definition

An employee at this level:

- may be responsible for the planning and management of the work of others;
- applies knowledge with substantial depth in some areas and a range of skills which may be varied or highly specific;
- applies knowledge and skills independently and non-routinely; and
- exercises considerable judgment and initiative.

(b) Indicative tasks

The following tasks are indicative of those performed by an employee at this level:

- manage personal work priorities and professional development;
- provide leadership in the workplace;
- establish effective workplace relationships;
- facilitate work teams;
- manage operational plan;
- manage workplace information systems;
- manage quality customer service;
- ensure a safe workplace;
- promote continuous improvement;
- facilitate and capitalise on change and innovation;
- develop a workplace learning environment;
- manage the establishment and maintenance of a workgroup network;
- manage meetings;

- plan or review administration systems;
- manage payroll; and
- manage business document design and development.

(c) Qualifications

An employee who holds a Diploma which is recognised within the Business Services Training Package or equivalent would be classified at this level when employed to perform the functions in the Role definition and taking into account the Indicative tasks.

B.2.6 Interpretation

The indicative tasks set out in Schedule B.2 are aligned to the units of competency in Business Services Training Australia's endorsed competency standards in the Business Services Training Package (BSB2001). In the event of a dispute over the meaning of the indicative tasks the relevant standards will be used to assist interpretation.

B.3 Commercial Travellers Stream

B.3.1 **Trainee Salesperson** means an employee engaged in accordance with the provisions of clause 15 of this award and who has not been assigned a sales quota and who is undertaking training as a Salesperson.

B.3.2 **Salesperson** means an employee who has undertaken an appropriate course of training and who has been assigned a sales quota for the sale of, and/or the soliciting of orders for business equipment and operating supplies therefore within one of the undermentioned levels:

(a) **Salesperson Level 1** means a salesperson who has been assigned a quota for the sale of all other forms of business equipment and operating supplies therefore which have not been referred to elsewhere in this clause.

(b) **Salesperson Level 2** means a salesperson who, without limiting the generality of the undermentioned types of business equipment has been assigned a quota and is engaged predominantly in the sale of the following electronic business equipment:

- accounting machines;
- billing (and/or invoicing) machines;
- data transceiving equipment;
- magnetic tape encoders and storage equipment;
- units of peripheral equipment and/or terminal equipment capable of on-line connection to, but excluding, the central processing unit (CPU); and
- visible record computers.

(c) **Salesperson Level 3** means a salesperson who has been assigned a quota predominantly for the sale of business equipment specifically designated as a digital computer and not referred to elsewhere in this clause.

Schedule C—School-based Apprentices

[Sched B renumbered as Sched C by PR988401 from 01Jan10]

C.1 This schedule applies to school-based apprentices. A school-based apprentice is a person who is undertaking an apprenticeship in accordance with this schedule while also undertaking a course of secondary education.

C.2 A school-based apprenticeship may be undertaken in the trades covered by this award under a training agreement or contract of training for an apprentice declared or recognised by the relevant State or Territory authority.

C.3 The relevant minimum wages for full-time junior and adult apprentices provided for in this award, calculated hourly, will apply to school-based apprentices for total hours worked including time deemed to be spent in off-the-job training.

C.4 For the purposes of clause C.3, where an apprentice is a full-time school student, the time spent in off-the-job training for which the apprentice must be paid is 25% of the actual hours worked each week on-the-job. The wages paid for training time may be averaged over the semester or year.

C.5 A school-based apprentice must be allowed, over the duration of the apprenticeship, the same amount of time to attend off-the-job training as an equivalent full-time apprentice.

C.6 For the purposes of this schedule, off-the-job training is structured training delivered by a Registered Training Organisation separate from normal work duties or general supervised practice undertaken on the job.

C.7 The duration of the apprenticeship must be as specified in the training agreement or contract for each apprentice but must not exceed six years.

C.8 School-based apprentices progress through the relevant wage scale at the rate of 12 months progression for each two years of employment as an apprentice.

C.9 The apprentice wage scales are based on a standard full-time apprenticeship of four years (unless the apprenticeship is of three years duration). The rate of progression reflects the average rate of skill acquisition expected from the typical combination of work and training for a school-based apprentice undertaking the applicable apprenticeship.

C.10 If an apprentice converts from school-based to full-time, all time spent as a full-time apprentice will count for the purposes of progression through the relevant wage scale in addition to the progression achieved as a school-based apprentice.

C.11 School-based apprentices are entitled pro rata to all of the other conditions in this award.

Schedule D—Supported Wage System

[Sched C renumbered as Sched D by PR988401 from 01Jan10; varied by PR994507, PR998748, PR510670, PR525068, PR537893, PR542141, PR551831, PR568050, PR581528, PR592689, PR606630, PR709080]

D.1 This schedule defines the conditions which will apply to employees who because of the effects of a disability are eligible for a supported wage under the terms of this award.

[D.2 varied by PR568050 ppc 01Jul15]

D.2 In this schedule:

approved assessor means a person accredited by the management unit established by the Commonwealth under the supported wage system to perform assessments of an individual's productive capacity within the supported wage system

assessment instrument means the tool provided for under the supported wage system that records the assessment of the productive capacity of the person to be employed under the supported wage system

disability support pension means the Commonwealth pension scheme to provide income security for persons with a disability as provided under the *Social Security Act 1991*, as amended from time to time, or any successor to that scheme

relevant minimum wage means the minimum wage prescribed in this award for the class of work for which an employee is engaged

supported wage system means the Commonwealth Government system to promote employment for people who cannot work at full award wages because of a disability, as documented in the Supported Wage System Handbook. The Handbook is available from the following website: www.jobaccess.gov.au

SWS wage assessment agreement means the document in the form required by the Department of Social Services that records the employee's productive capacity and agreed wage rate

D.3 Eligibility criteria

D.3.1 Employees covered by this schedule will be those who are unable to perform the range of duties to the competence level required within the class of work for which the employee is engaged under this award, because of the effects of a disability on their productive capacity and who meet the impairment criteria for receipt of a disability support pension.

D.3.2 This schedule does not apply to any existing employee who has a claim against the employer which is subject to the provisions of workers compensation legislation or any provision of this award relating to the rehabilitation of employees who are injured in the course of their employment.

D.4 Supported wage rates

D.4.1 Employees to whom this schedule applies will be paid the applicable percentage of the relevant minimum wage according to the following schedule:

Assessed capacity (clause D.5)	Relevant minimum wage
%	%
10	10
20	20
30	30
40	40
50	50
60	60
70	70
80	80
90	90

[D.4.2 varied by PR994507, PR998748, PR510670, PR525068, PR537893, PR551831, PR568050, PR581528, PR592689, PR606630, PR709080 ppc 01Jul19]

D.4.2 Provided that the minimum amount payable must be not less than $87 per week.

D.4.3 Where an employee's assessed capacity is 10%, they must receive a high degree of assistance and support.

D.5 Assessment of capacity

D.5.1 For the purpose of establishing the percentage of the relevant minimum wage, the productive capacity of the employee will be assessed in accordance with the Supported Wage System by an approved assessor, having consulted the employer and employee and, if the employee so desires, a union which the employee is eligible to join.

D.5.2 All assessments made under this schedule must be documented in an SWS wage assessment agreement, and retained by the employer as a time and wages record in accordance with the Act.

D.6 Lodgement of SWS wage assessment agreement

[D.6.1 varied by PR994507; PR542141 ppc 04Dec13]

D.6.1 All SWS wage assessment agreements under the conditions of this schedule, including the appropriate percentage of the relevant minimum wage to be paid to the employee, must be lodged by the employer with the Fair Work Commission.

[D.6.2 varied by PR994507; PR542141 ppc 04Dec13]

D.6.2 All SWS wage assessment agreements must be agreed and signed by the employee and employer parties to the assessment. Where a union which has an interest in the award is not a party to the assessment, the assessment will be referred by the Fair Work Commission to the union by certified mail and the agreement will take effect unless an objection is notified to the Fair Work Commission within 10 working days.

D.7 Review of assessment

The assessment of the applicable percentage should be subject to annual or more frequent review on the basis of a reasonable request for such a review. The process of review must be in accordance with the procedures for assessing capacity under the supported wage system.

D.8 Other terms and conditions of employment

Where an assessment has been made, the applicable percentage will apply to the relevant minimum wage only. Employees covered by the provisions of this schedule will be entitled to the same terms and conditions of employment as other workers covered by this award on a pro rata basis.

D.9 Workplace adjustment

An employer wishing to employ a person under the provisions of this schedule must take reasonable steps to make changes in the workplace to enhance the employee's capacity to do the job. Changes may involve re-design of job duties, working time arrangements and work organisation in consultation with other workers in the area.

D.10 Trial period

D.10.1 In order for an adequate assessment of the employee's capacity to be made, an employer may employ a person under the provisions of this schedule for a trial period not exceeding 12 weeks, except that in some cases additional work adjustment time (not exceeding four weeks) may be needed.

D.10.2 During that trial period the assessment of capacity will be undertaken and the percentage of the relevant minimum wage for a continuing employment relationship will be determined.

[D.10.3 varied by PR994507, PR998748, PR510670, PR525068, PR537893, PR551831, PR568050, PR581528, PR592689, PR606630, PR709080 ppc 01Jul19]

D.10.3 The minimum amount payable to the employee during the trial period must be no less than $87 per week.

D.10.4 Work trials should include induction or training as appropriate to the job being trialled.

D.10.5 Where the employer and employee wish to establish a continuing employment relationship following the completion of the trial period, a further contract of employment will be entered into based on the outcome of assessment under clause D.5.

Schedule E—National Training Wage

[Sched D renumbered as Sched E by PR988401; substituted by PR994507 from 01Jan10; varied by PR997901, PR509052, PR522883, PR536686, PR545787, PR551609, PR566690, PR579782; deleted by PR593816 ppc 01Jul17]

Schedule F—Part-day Public Holidays

[Sched F inserted by PR532630 ppc 23Nov12; renamed and varied by PR544519 ppc 21Nov13; renamed and varied by PR557581, PR573679, PR580863, PR598110, PR701683 ppc 21Nov18]

This schedule operates where this award otherwise contains provisions dealing with public holidays that supplement the NES.

F.1 Where a part-day public holiday is declared or prescribed between 7.00pm and midnight on Christmas Eve (24 December in each year) or New Year's Eve (31 December in each year) the following will apply on Christmas Eve and New Year's Eve and will override any provision in this award relating to public holidays to the extent of the inconsistency:

(a) All employees will have the right to refuse to work on the part-day public holiday if the request to work is not reasonable or the refusal is reasonable as provided for in the NES.

(b) Where a part-time or full-time employee is usually rostered to work ordinary hours between 7.00pm and midnight but as a result of exercising their right under the NES does not work, they will be paid their ordinary rate of pay for such hours not worked.

(c) Where a part-time or full-time employee is usually rostered to work ordinary hours between 7.00pm and midnight but as a result of being on annual leave does not work, they will be taken not to be on annual leave between those hours of 7.00pm and midnight that they would have usually been rostered to work and will be paid their ordinary rate of pay for such hours.

(d) Where a part-time or full-time employee is usually rostered to work ordinary hours between 7.00pm and midnight, but as a result of having a rostered day off (RDO) provided under this award, does not work, the employee will be taken to be on a public holiday for such hours and paid their ordinary rate of pay for those hours.

(e) Excluding annualised salaried employees to whom clause F.1(f) applies, where an employee works any hours between 7.00pm and midnight they will be entitled to the appropriate public holiday penalty rate (if any) in this award for those hours worked.

(f) Where an employee is paid an annualised salary under the provisions of this award and is entitled under this award to time off in lieu or additional annual leave for work on a public holiday, they will be entitled to time off in lieu or pro-rata annual leave equivalent to the time worked between 7.00pm and midnight.

(g) An employee not rostered to work between 7.00pm and midnight, other than an employee who has exercised their right in accordance with clause F.1(a), will not be entitled to another day off, another day's pay or another day of annual leave as a result of the part-day public holiday.

This schedule is not intended to detract from or supplement the NES.

Schedule G—Agreement to Take Annual Leave in Advance

[Sched G inserted by PR582973 ppc 29Jul16]

Link to PDF copy of Agreement to Take Annual Leave in Advance.

Name of employee: _____

Name of employer: _____

The employer and employee agree that the employee will take a period of paid annual leave before the employee has accrued an entitlement to the leave:

The amount of leave to be taken in advance is: ____ hours/days

The leave in advance will commence on: ___/___/20___

Signature of employee: _____

Date signed: ___/___/20___

Name of employer representative: _____

Signature of employer representative: _____

Date signed: ___/___/20___

[If the employee is under 18 years of age - include:]

I agree that:

if, on termination of the employee's employment, the employee has not accrued an entitlement to all of a period of paid annual leave already taken under this agreement, then the employer may deduct from any money due to the employee on termination an amount equal to the amount that was paid to the employee in respect of any part of the period of annual leave taken in advance to which an entitlement has not been accrued.

Name of parent/guardian: _____

Signature of parent/guardian: _____

Date signed: ___/___/20___

Schedule H—Agreement to Cash Out Annual Leave

[Sched H inserted by PR582973 ppc 29Jul16]

Link to PDF copy of Agreement to Cash Out Annual Leave.

Name of employee: _____

Name of employer: _____

The employer and employee agree to the employee cashing out a particular amount of the employee's accrued paid annual leave:

The amount of leave to be cashed out is: ____ hours/days

The payment to be made to the employee for the leave is: $_____ subject to deduction of income tax/after deduction of income tax (strike out where not applicable)

The payment will be made to the employee on: ___/___/20___

Signature of employee: _____

Date signed: ___/___/20___

Name of employer representative: _____

Signature of employer representative: _____

Date signed: ___/___/20___

Include if the employee is under 18 years of age:

Name of parent/guardian: _____

Signature of parent/guardian: _____

Date signed: ___/___/20___

Schedule I—Agreement for Time Off Instead of Payment for Overtime

[Sched I inserted by PR584081 ppc 22Aug16]

Link to PDF copy of Agreement for Time Off Instead of Payment for Overtime.

Name of employee: _____

Name of employer: _____

The employer and employee agree that the employee may take time off instead of being paid for the following amount of overtime that has been worked by the employee:

Date and time overtime started: ___/___/20___ ____ am/pm

Date and time overtime ended: ___/___/20___ ____ am/pm

Amount of overtime worked: _____ hours and _____ minutes

The employer and employee further agree that, if requested by the employee at any time, the employer must pay the employee for overtime covered by this agreement but not taken as time off. Payment must be made at the overtime rate applying to the overtime when worked and must be made in the next pay period following the request.

Signature of employee: _____

Date signed: ___/___/20___

Name of employer representative: _____

Signature of employer representative: _____

Date signed: ___/___/20___

ATTACHMENT C

About the F17 statutory declaration

Employer's statutory declaration in support of an application for approval of an enterprise agreement (other than a greenfields agreement)

About enterprise agreements

Enterprise agreements are agreements made at the enterprise level that contain terms and conditions of employment.

The Fair Work Commission (the Commission) assesses and approves enterprise agreements. It can also assist in the process of making agreements and can deal with disputes arising under the terms of an agreement. Before the Commission can approve an agreement, it must be satisfied that the agreement meets the requirements for approval set out in the Fair Work Act 2009, including that the employees will be 'better off overall' under the agreement than they would be if the relevant award applied.

For information about the process that employers and employees must follow to make an enterprise agreement see Guide – Making an enterprise agreement on the Commission's website.

Who can use this form

Use this form if:

- a Form F16 – Application for approval of an enterprise agreement (other than a greenfields agreement) has been or is being lodged with the Commission **and**
- you are an employer that is covered by the agreement (or an officer or authorised employee completing this form for an employer).

Lodgment and service of your completed form

1. **Within 14 calendar days** after the agreement is made, you must lodge with the Commission:

   ☐ This statutory declaration **and**

   ☐ A copy of the notice of employee representational rights (see question 2.4) **and**

   ☐ Copies of any materials provided to employees to notify them of the time and place at which the vote was to occur and the voting method to be used (see question 2.6) **and**

   ☐ Copies of any materials used to explain to employees the terms of the agreement and the effect of those terms (see question 2.7) **and**

   ☐ Copies of any materials used to ensure the explanation was provided in an appropriate manner taking into account the particular circumstances and needs of the relevant employees (see question 2.8).

   If you are lodging this form at the same time as the Form F16, you can use the Commission's Online Lodgment Service. Alternatively, you can lodge the form by post, fax, email or in person at the Commission office in your state or territory, either at the same time as the Form F16 or separately.

   Each employer that will be covered by the agreement must notify employees who will be covered by the agreement that an application has been made to the Commission for approval of

the agreement. Notification should be made through the usual means that are adopted by the employer for communicating with employees.

2. **As soon as practicable** after this statutory declaration is lodged with the Commission, you must **serve a copy** of this statutory declaration on:

   - each other employer that is covered by the agreement **and**
   - each employee organisation that was a bargaining representative **and**
   - any employee bargaining representative of whom you are aware.

Where to get help

Commission staff & resources

Commission staff cannot provide legal advice. However, staff can give you information on:

- Commission processes
- how to make an application to the Commission
- how to fill out forms
- where to find useful documents such as legislation and decisions
- other organisations that may be able to assist you.

The Commission's website www.fwc.gov.au also contains a range of information that may assist.

Throughout this form

This icon appears throughout the form. It indicates information to help you complete the form.

Legal or other representation

Representation is where another person (such as a lawyer or employee of a union or employer organisation) speaks or acts on a party's behalf in relation to a matter. There is no requirement to be represented at the Commission. A party will need the permission of the Commission member dealing with the matter if the party wishes to be represented by a lawyer or paid agent at a conference or hearing, unless the lawyer or paid agent is:

- an employee or officer of the party, or
- a bargaining representative that is representing the party, or
- an employee or officer of an employee or employer organisation, an association of employers, or a peak council, that is representing a party.

If you represent a party in proceedings you will need to make sure you are well prepared.

Glossary of common terms

Applicant – This is the person or organisation making an application.

Party – A party is an Applicant, a Respondent or another person or organisation involved in a matter or case that is brought to the Commission.

Respondent – The person or organisation responding to an application made by an Applicant.

Service – Serving a document means giving a copy of the document to a person or organisation, usually to the other party to the matter. You can serve a document in a number of

ways, including by email, fax, express or registered post, or in person. Parts 7 and 8 of the Fair Work Commission Rules 2013 deal with service.

Privacy

The Commission collects the information (including personal information) provided to it in this form in order to deal with the application for approval of the agreement. The information will be included on the case file, and the Commission may disclose the information to the other parties to this matter and to other persons. For more details of the Commission's collection, use and disclosure of this information, please see the Privacy notice for this form, or ask for a hard copy to be provided to you.

Remove this cover sheet and keep it for future reference – it contains useful information.

Form F17 – Employer's statutory declaration in support of an application for approval of an enterprise agreement (other than a greenfields agreement)

Fair Work Act 2009, s.185; Fair Work Commission Rules 2013, rule 24 and Schedule 1

This is a statutory declaration in support of an application to the Fair Work Commission for approval of an enterprise agreement under Part 2-4 of the Fair Work Act 2009.

STATUTORY DECLARATION

Statutory Declarations Act 1959

I,

Name	Lisa Bounds		
Postal address	PO Box 313		
Suburb	North Ryde		
State or territory	NSW	**Postcode**	1670
Occupation	Senior Human Resources Business Partner		

make the following declaration under the *Statutory Declarations Act 1959:*

Part 1 – Preliminary

1.1 What is the name of the employer?

Legal name of employer	Canon Australia Pty Ltd
Employer's ACN (if a company)	66 005 002 951
Employer's trading name or registered business name	
Employer's ABN	

1.2 Is the employer a "designated emergency management body" as defined in s.195A(4) and (5) of the Fair Work Act 2009?

☐ Yes

☒ No

1.3 What is the name of the agreement?

Write the name exactly as it appears in the title clause of the agreement.

Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement, 2019.

1.4 Has a scope order, a low paid authorisation or a majority support determination been issued in relation to the agreement?

☐ Yes

☒ No

If you answered **Yes** – Provide the unique print number (PR) and the date the order was made

Print number

Date of order

Part 2 – Requirements for approval

Nominal expiry date

2.1 What is the nominal expiry date of the agreement? What is the number of the clause in the agreement that specifies the date?

See section 186(5) of the Fair Work Act 2009. The nominal expiry date must not be more than 4 years after the day on which the Commission approves the agreement.

Nominal expiry date	Clause 4
Clause number	3 years after the date of approval.

Scope of the agreement

2.2 Does the agreement cover all the employees of the employer?

See s.186(3) and s.186(3A) of the Fair Work Act 2009. The Commission must be satisfied that the group of employees covered by the agreement was fairly chosen.

☐ Yes

☒ No

If you answered **No** – What group of employees is covered by the agreement and what group of employees is not covered? Explain why you think the Commission should be satisfied that the group covered was fairly chosen. If appropriate, describe how the group of employees covered is geographically, operationally or organisationally distinct.

The group of employees covered by the Agreement are employees who are engaged by Canon throughout Australia who are classified within the Technical Consultants/Senior Tehcnical Consultant stream that is outlined at Appendix B of the Agreement. (see also clause 3 of the Agreement).

This group was fairly chosen because of their operational distinctness as the employees primarily carry out the same fundamental role of servicing business equipment throughout Australia that is located at customer premises. The roles are the same across all locations and States.

In addition, these employees spend most of their time travelling to various sites, and carry most of their tools and spare parts with them. They are not physically located in a Canon office.

The group is also operationally distinct as they report through our Services & Support function, reporting to Supervisors and subsequently Service Managers.

2.3 What was the notification time for the agreement?

The notification time is defined in s.173(2) of the Fair Work Act 2009. The notification time is the time when: the employer agrees to bargain, or initiates bargaining, for the agreement; or a majority support determination in relation to the agreement comes into operation; or a scope order in relation to the agreement comes into operation; or a low-paid authorisation in relation to the agreement that specifies the employer comes into operation.

Notification time

On Friday 14 September 2018, Canon and the ASU agreed to enter bargaining in relation to the terms of a new agreement, which would replace our existing agreement following it's expiry.

2.4 What steps did the employer take to give notice of the right to be represented by a bargaining representative to each employee who will be covered by the agreement and is employed at the notification time for the agreement?

See section 173 of the Fair Work Act 2009 and the prescribed notice of employee representational rights in Schedule 2.1 of the Fair Work Regulations 2009. The employer must take all reasonable steps to give the prescribed notice to each employee who will be covered by the agreement and is employed at the notification time for the agreement. The employer must give the prescribed notice as soon as practicable, and not later than 14 days, after the notification time.

Describe each step taken and state the date on which it was taken.

You must lodge a copy of the notice given to employees with this form. If multiple notices were provided, explain why.

Steps taken	**Date**
A Notice of Employee Representational Rights (in accordance with s.173 of the Fair Work Act and Schedule 2.1 of the Fair Work Regulations 2009) was provided to all employees to be covered by the Agreement on 17 September 2018. A copy of the Notice/Email (**Notice**) is **attached as Attachment B.** The steps taken to give the Notice to each employee was to send the Notice to all employees to be covered by the Agreement on 17 September 2018 via email. The email account to which the Notice was sent was each individual employees' Canon email account. As noted above at section 2.2, the employees to be covered by the Agreement perform the fundamental role of servicing business equipment at various customer sites and, as such, they spend most of their time working remotely and are not physically located in a Canon office. This means the primary method of communication between Canon and the employees to be covered by the Agreement is via their Canon email. All employees to be covered by the Agreement have access and use their Canon email account on a regular basis via either their Canon provided mobile device, and/or laptop.	17 September 2018

Agreement genuinely agreed

2.5 What steps were taken by the employer to ensure that the relevant employees either:

a. were given a copy of the written text of the agreement and any other material incorporated by reference in the agreement during the access period, or

b. had access to a copy of the above materials throughout the access period?

See section 180(2)(a) of the Fair Work Act 2009. The employer must take all reasonable steps to ensure relevant employees are given or have access to the materials at the specified time. The 'relevant employees' are defined in s.180(2) as the employees employed at the time who will be covered by the agreement. The 'access period' is defined in s.180(4) as the 7-day period immediately before the start of the voting process for the agreement.

Describe each step taken and provide the date on which it was taken.

Step taken	Date
In addition to the matters set up in 2.7.	
An email was sent to all employees to be covered by the Agreement notifying them that a web page was available on Canon's intranet that contained copies of: - a clean copy of the Agreement (after all the changes agreed between Canon and the bargaining representatives had been made from the existing 2015 Agreement); - a marked up version of the Agreement (for comparison which indicates all of the changes that had been made from the existing 2015 Agreement); and - documents referred to within the Agreement, comprising: 1. Canon Australia Fleet Policy 2. Canon's Remuneration, Allowance & Subsidy Policy 3. Canon's Travel & Entertainment Policy 4. The Superannuation Trust Deed 5. Canon Study Leave Policy 6. GPS Tracking Policy 7. Parental Leave 8. Code of Conduct All employees to be covered by the Agreement have access and use their Canon email account on a regular basis via either their Canon provided mobile device, and/or laptop. Further, all employees covered by the Agreement have remote access to Canon's intranet 24/7.	21 January 2019
Canon's intranet web page Pixel was updated to include a copy of the revised Agreement (both a clean copy and a marked up copy) and the documents referred to within the Agreement.	21 January 2019

2.6 What steps did the employer take to notify the relevant employees by the start of the access period of:

a. the time and place at which the vote was to occur, and

b. the voting method to be used?

See s.180(3) of the Fair Work Act 2009. The employer must take all reasonable steps to notify relevant employees by the specified time.

Do not simply state that the relevant employees were notified by the specified time. Describe the steps taken and the information given to employees, and provide the date on which it was taken. Also lodge copies of any materials that were provided to employees to notify them of the time and place at which the vote was to occur and the voting method to be used.

Step taken and the information given	**Date of step**
Steps taken were as follows:	
1. An email was sent out on 24 January 2019 to all employees covered by the Agreement confirming the voting date, time, place and voting method. As noted in 2.4 above, all employees to be covered by the Agreement have access and use their Canon email account on a regular basis via either their Canon provided mobile device, and/or laptop. Further, all employees covered by the Agreement have remote access to Canon's intranet 24/7.	24 January 2019
2. Ballot conducted on the 8th of February 2019	8 February 2019

2.7 What steps were taken by the employer to explain the terms of the agreement, and the effect of those terms, to the relevant employees?

See section 180(5)(a) of the Fair Work Act 2009. The employer must take all reasonable steps to ensure the explanation is given to relevant employees.

Do not simply state that the terms of the agreement were explained to relevant employees. Describe the steps taken and what was explained, and provide the date on which each step was taken. Also lodge copies of any materials that were used to explain to employees the terms of the agreement and the effect of those terms.

Step taken and the explanation given	**Date of step**

Steps taken were as follows:

1. On 14 September, Canon sent an email to all employees covered by the Agreement notifying them that we would be entering into Good Faith Bargaining with the union and representatives for a new agreement.	14 September 2018
2. Notice of representational rights was sent by Canon.	17 September 2018
3. Canon then set up fortnightly meetings to engage and bargain in good faith with the union, other bargaining representatives and employees.	16 October 2018/
4. Further Canon and its leadership team, then had meetings in each of the local Canon Branch offices with all the employees covered by the Agreement to discuss the log of claims from both the union and the individual representatives, and to seek to understand from any employees covered by the Agreement if they had feedback or questions about the Agreement, log of claims and the terms of the Agreement.	30 October 2018/ 14 November 2018/ 27 November 2018/

A total of 6 road show/information sessions were run by Canon. The dates, locations and times of the road shows/information sessions are set out directly below:

Date	City
18 October	Canberra
19 October	Melbourne/Clayton
25 October	Sydney CBD
26 October	Macquarie Park
1 November	Adelaide
2 November	Perth

At each road show/information session, the Canon representative delivered a PowerPoint presentation which explained the terms of the Agreement and the current log of claims for which we were negotiating, and confirmed for the employees the effect of those terms to the employees, and in addition explained to the employees covered by the Agreement, that the majority of the current Agreement was not being renegotiated for the purposes of renewal, and actually that the union had put forward a proposal to roll-over the current terms of the Agreement. These sessions gave the employees covered by the Agreement access to the Canon representative and provided for a good understanding of the differences between the Agreement and the proposed new enterprise agreement.

At the conclusion of each road show/information session, Mrs Rebecca Ullman, General Manager, Services and Support (**Mrs Ullman**), made herself available to answer individual questions from employees on a one-on-one basis.

In addition to the above, after each bargaining session, the Employee Bargaining Representatives had local meetings in each branch, to discuss process, log of claims and agreement terms, including how they were different from the 2015 Agreement.

An email was sent to the employees covered by the Agreement on 29 November, detailing the proposed changes and sought feedback from the employees covered by the Agreement, including seeking questions where employees covered by the Agreement may not have understood the terms. Feedback could be made in person, with Mrs. Ullman, Lisa Bounds, Senior HR Business Partner, or Paul Gravina, Senior Manager Direct Services, or via email, as all employees to be covered by the Agreement have access and use their Canon email account on a regular basis via either their Canon provided mobile device, and/or laptop.

Feedback was received from 6 of the employees covered by the Agreement, in relation to the application of the remuneration increase via a pool, and the use of email to update the employees covered by the Agreement, for which the employee felt that all updates should come via the Employee Bargaining Representative. Noted. The Employee Bargaining Representative were asked verbally to go back to the employees covered by the Agreement to seek feedback, and provide that to Canon.

On 5 December, 2018 a final document was circulated with the Union and the Employee Bargaining Representatives, to confirm alignment of the proposed Agreement pre vote, and to seek final feedback from the employees if there were questions pertaining to the terms of the Agreement via the Employee Bargaining Representatives.

5 December 2018

5. An email was sent on 24 January 2019 to all employees to be covered by the Agreement which contained links to:
    - a clean copy of the Agreement (after all the changes agreed between Canon and the bargaining representatives had been made from the existing 2015 Agreement);
    - a marked up version of the Agreement (for comparison which indicates all of the changes that had been made from the existing 2015 Agreement); and
    - documents referred to within the Agreement, comprising:

    1. *Canon Australia Fleet Policy*
    2. *Canon's Remuneration, Allowance & Subsidy Policy*
    3. *Canon's Travel & Entertainment Policy*
    4. *The Superannuation Trust Deed*
    5. *Canon Study Leave Policy*
    6. *GPS Tracking Policy*
    7. *Parental Leave*
    8. *Code of Conduct*

6. This email notified employees to be covered by the Agreement that Canon would welcome feedback from all the employees covered by

the Agreement and if there were any parts that the employees did not understand or had questions about they could seek support from either Rebecca Ullman, General Manager Services & Support, or Lisa Bounds, Senior HR Generalist.

8. No employees to be covered by the Agreement are under the age of 21 years old.

9. Canon is not aware of any employees for whom English is not spoken and written on a regular basis. In that regard, all employees to be covered by the Agreement are required to have a sufficient proficiency in the English language that allows them to communicate with Canon's customers in English and communicate with Canon via email in English (using a Canon provided mobile device and laptop) to receive instructions with respect to the allocation and performance of their duties. As such, none of the employees to be covered by the Agreement have difficulties in understanding written or verbal communications in the English language.

2.8 When the employer explained the terms of the agreement, and the effect of those terms, to the relevant employees, what was done to take into account the particular circumstances and needs of the relevant employees?

See s.180(5)(b) of the Fair Work Act 2009. The employer must take all reasonable steps to ensure that the explanation is provided in an appropriate manner. Examples of employees whose circumstances and needs are to be taken into account include employees from non-English speaking backgrounds, young employees and employees who don't have a bargaining representative.

Do not simply state that the employer took reasonable steps to ensure the explanation was provided in an appropriate manner. Describe the steps taken, identifying the relevant group of employees addressed, and provide the date on which each step was taken. Also lodge copies of any materials that were used to ensure the explanation to employees was provided in an appropriate manner (if not lodged in response to question 2.7).

Step taken	Relevant group of employees addressed	Date of step
	Canon is not aware of any employees covered by the Agreement for whom English is not spoken and written on a regular basis	
	No employees covered by the Agreement were under the age of 21 years.	

2.9 Provide the following dates:

See ss.173, 181, and 182 of the Fair Work Act 2009.

Event	Date
The last date that a notice of the right to be represented by a bargaining representative ("notice of employee representational rights") was given to an employee who will be covered by the agreement and is employed at the notification time for the agreement.	17 September 2018
The date voting for the agreement commenced (that is, the first date that an employee was able to cast a vote).	8 February 2019
The date that the agreement was **made** (that is, the date on which the voting process by which the employees approved the agreement concluded).	8 February 2019

2.10 Provide the following details about the vote on the agreement:

See s.53 of the Fair Work Act 2009. An enterprise agreement covers an employee if it is expressed to cover the employee.

At the time of the vote, how many employees were covered by the agreement?	74
How many of these employees cast a valid vote?	70
How many of these employees voted to approve the agreement?	59

Interaction with the National Employment Standards

2.11 Do any terms of the agreement exclude in whole, or in part, the National Employment Standards?

See Part 2-2 – National Employment Standards of the Fair Work Act 2009.

☐ Yes

☒ No

If you answered **Yes** – List the terms below.

2.12 Are any terms of the agreement detrimental to an employee in any respect when compared to the National Employment Standards?

☐ Yes

☒ No

If you answered **Yes** – List the terms below.

Right of entry

2.13 Does the agreement contain any terms that deal with the rights of officials or employees of employee organisations to enter the employer's premises?

See ss.186(4) and 194(f) and (g) of the Fair Work Act 2009. Terms providing entitlements to enter premises to investigate suspected contraventions or hold discussions with employees, or for the exercise of a State or Territory occupational health and safety right, are unlawful if they are not in accordance with Part 3-4 of the Fair Work Act 2009.

☒ Yes

☐ No

If you answered **Yes**– List the clauses in the agreement dealing with entry to premises below.

Clause 52 UNIONS

Unlawful terms

2.14 Does the agreement contain any of the following kinds of terms? Tick the relevant box below if the agreement does contain that kind of term:

☐ discriminatory terms (as defined in s.195)

☐ objectionable terms (as defined in s.12)

☐ terms dealing with employee rights in relation to unfair dismissal (see s.194(c) and s.194(d))

☐ designated outworkers terms (as defined in s.12)

☐ terms that deal with the taking of industrial action that are inconsistent with Part 3-3 of the Fair Work Act 2009 (see s.194(e))

☐ terms that do not comply with the superannuation contribution requirements for default fund employees (see s.194(h))

☐ objectionable emergency management terms (as defined in s.195A)

If you have ticked any of the above, list the relevant terms of the agreement below.

Required terms

2.15 Provide the clause numbers in the agreement for the following required terms:

Required term	Clause number
Dispute resolution procedure (see s.186(6))	Clause 39
Flexibility term (see s.202(1) and s.203)	Clause 12

Consultation term (see s.205(1) and s.205(1A))	Clause 8

Particular types of workers

2.16 Are employees covered by the agreement also covered by a modern award that defines or describes them as shiftworkers for the purposes of the National Employment Standards?

See s.196 of the Fair Work Act 2009. The Commission must be satisfied that the agreement defines or describes the employees as shiftworkers for the purposes of the National Employment Standards.

☒ Yes

☐ No

If you answered **Yes** – does the agreement define or describe the employees as shiftworkers for the purpose of the National Employment Standards?

☒ Yes – List the clause(s) in the agreement that define shiftworkers for the purposes of the National Employment Standards.

☐ No

Clause 40(h)

2.17 Tick the relevant boxes below if the agreement:

☐ covers any pieceworkers (see s.197)

☐ covers any outworkers (see s.200)

☐ contains terms for school-based apprentices or trainees that provide for loadings in lieu of paid leave or paid absence (see s.199)

If you have ticked any of the above, list the relevant clause(s) of the agreement below.

Part 3 – Better off overall test

See s.186(2)(d) and s.193 of the Fair Work Act 2009.

The *better off overall test* requires the Commission to be satisfied, as at the time the application for approval of the agreement by the Commission was made, that each award covered employee, and each prospective award covered employee, would be better off overall under the agreement than the relevant modern award.

Modern awards

3.1 List the modern award(s), if any, that cover the employer and any of the employees covered by the agreement.

You should include the MA number for each award. This number can be found using the title search on the find an award search facility on the Commission's website.

Business Equipment Award 2010 [MA000021]

Translating classifications

3.2 Are any of the employee classifications in the agreement different from the classifications in any of the modern award(s) listed in your answer to question 3.1?

☒ Yes

☐ No

If you answered **Yes** – For each modern award, use the following table to identify how the classifications in the agreement correspond to the classifications in the modern award.

Name of modern award:

Classification in modern award	**Corresponding classification in agreement**
Business Equipment Award 2010 Classification	Comparable Agreement Level
Technical Employee Level 1	Trainee
Technical Employee Level 2	Customer Service Technician
Technician Level 4	Customer Service Engineer
Technician Level 6	Senior Customer Service Engineer

Attach additional tables if there is more than one modern award.

Improvements and reductions

3.3 Does the agreement contain any terms or conditions of employment that are *more beneficial* than equivalent terms and conditions in the modern award(s) listed in question 3.1?

☒ Yes

☐ No

If you answered **Yes** – List the terms and conditions of the agreement that are **more beneficial** than equivalent terms and conditions in the modern award(s). Your answer should indicate whether all or only some of the employees are affected and, if only some employees are affected, identify the groups of employees affected. Include relevant clause numbers.

See attachment A

3.4 Does the agreement confer any entitlements that are not conferred by the modern award(s) listed in question 3.1?

☐ Yes

☒ No

If you answered **Yes** – List the entitlements conferred by the agreement that are **not conferred** by the modern award(s). Your answer should indicate whether all or only some of the employees are affected and, if only some employees are affected, identify the groups of employees affected. Include relevant clause numbers.

3.5 Does the agreement contain any terms or conditions of employment that are *less beneficial* than equivalent terms and conditions in the modern award(s) listed in question 3.1?

☐ Yes

☒ No

If you answered **Yes** – List the terms and conditions of the agreement that are **less beneficial** than equivalent terms and conditions in the modern award(s). Your answer should indicate whether all or only some of the employees are affected and, if only some employees are affected, identify the groups of employees affected. Include relevant clause numbers.

3.6 Does the agreement omit any entitlements that are conferred by the modern award(s) listed in question 3.1?

☐ Yes

☒ No

If you answered **Yes**– List the entitlements conferred by the modern award(s) that are **omitted** by the agreement. Your answer should indicate whether all or only some of the employees are affected and, if only some employees are affected, identify the groups of employees affected. Include relevant clause numbers.

3.7 Does the agreement contain any terms or conditions of employment different to those under the modern award(s) listed in question 3.1, which you have not already identified in your answers to questions 3.3 to 3.6?

☐ Yes

☒ No

If you answered **Yes** – List these terms and conditions. Your answer should indicate whether all or only some of the employees are affected and, if only some employees are affected, identify the groups of employees affected.

Exceptional circumstances (where the agreement fails the better off overall test)

3.8 If you think that the agreement does not pass the better off overall test, are there exceptional circumstances the Commission should consider when deciding whether approving the agreement would not be contrary to the public interest?

Section 189 of the Fair Work Act 2009 sets out when the Commission may approve an enterprise agreement that does not pass the better off overall test.

☐ Yes

☒ No

If you have answered **Yes** – Explain what the exceptional circumstances are.

Part 4 – Statistical information

This information is necessary for the Commission to assess whether the employer took all reasonable steps to ensure that the terms of the agreement, and the effect of those terms, were explained to the relevant employees and the explanation was provided in an appropriate manner taking into account the particular circumstances and needs of the relevant employees, for example:

(a) employees from culturally and linguistically diverse backgrounds;
(b) young employees;
(c) employees who did not have a bargaining representative for the agreement. (s.180 (5) and s.180(6) of the Fair Work Act 2009).

In addition, this information is collected to enable the General Manager of the Fair Work Commission to comply with the statutory reporting obligations in s.653 of the Fair Work Act 2009 and to be provided to the Department of Employment for inclusion in the Department's Workplace Agreements Database.

4.1 What is the primary activity of the employer?

For example music retailer, plumbing contractor, steel fabricator, etc.

Business services

4.2 Tick the relevant boxes for the states or territories this agreement will be operating in.

☒ Australian Capital Territory

☒ New South Wales

☒ Northern Territory

☒ Queensland

☒ South Australia

☐ Tasmania

☒ Victoria

☒ Western Australia

☐ An external territory

4.3 Of the employees covered by this agreement, how many employees are in the following demographic groups?

Demographic group	Number of employees
Female	1
Non-English speaking background	Not aware
Aboriginal or Torres Strait Islander	0
Disabled	0

Demographic group	Number of employees
Part-time	0
Casual	0
Under 21 years of age	0
Over 45 years of age	63

4.4 List the full name(s) of all collective agreement(s) (including ID numbers) that presently apply to any employees covered by this agreement.

Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement, 2015.

The employer covered by this previous enterprise agreement is Canon Australia Pty Ltd. The agreement ID number is AE417507.

Consent to contact by researchers

The Fair Work Commission undertakes research with participants in agreement approval matters to ensure a high quality process. Some research may be undertaken by external providers on behalf of the Fair Work Commission.

Do you consent to the contact details provided on page 1 of this form being provided to an external provider of research services for the sole purpose of inviting you to participate in this research?

☒ Yes

☐ No

Signature of person making the declaration

A statutory declaration must be made before a **prescribed person**. For a full description of prescribed persons please see the Commission's Guide – Statutory declarations on the Commission's website.

I understand that a person who intentionally makes a false statement in a statutory declaration is guilty of an offence under section 11 of the *Statutory Declarations Act 1959*, and I believe that the statements in this declaration are true in every particular.

Signature

Declared at (place) Macquarie Park in the state of NSW

on (day) of (month) (year)

Before me,

Signature of person before whom the declaration is made

Full name of person before whom declaration is made

Qualification of person before whom declaration is made	
Address of person before whom declaration is made	
Suburb	
State or territory	**Postcode**
Phone number	

Note 1: A person who intentionally makes a false statement in a statutory declaration is guilty of an offence, the punishment for which is imprisonment for a term of 4 years – see section 11 of the *Statutory Declarations Act 1959*.

Note 2: Chapter 2 of the *Criminal Code* applies to all offences against the *Statutory Declarations Act 1959* – see section 5A of the *Statutory Declarations Act 1959*.

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Comparison between the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019 and the *Business Equipment Award 2010*

Description	Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019		*Business Equipment Award 2010*		Better Off under Agreement than Award?
Provision	**Clause**	**Description**	**Clause**	**Description**	
Types of Employment	21, 30, 31	• Full time • Part-time • Casual	11, 12, 13	• Full-time • Part-time • Casual	Yes, because hours of work for full-time employees are 30 minutes less per week under the Agreement (per the Agreement the ordinary hours of work shall average 37.5 hours per week within a 28 day work cycle for full-time employees)
Classifications	See Appendix A	• See FWC Form 17 • Trainee (being the equivalent of a Technical Employee level 1 under the Award) • Customer Service Technician (being the equivalent of a Technical Employee Level 2 under the Award • Customer Service Engineer (being the equivalent of a Technician Level 4 under the Award • Senior Customer Service Engineer / Production Specialist (being the equivalent of a Technician Level 6 under the Award	20.2 and Schedule B	• Technical Employee Level 1 • Technical Employee Level 2 • Technician Level 3 • Technician Level 4 • Technician Level 5 • Technician Employee Level 6	Not applicable.
Rates of Pay	Appendix A	Minimum rates of pay for a full-time employee working a **37.5 hour week** are paid on a TRC	20.2	Relevant classifications for a **38 hour week** include:	Yes, and fewer ordinary hours per week. The differences

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		basis, which includes salary, superannuation, representation allowance and annual leave loading. Those rates are: • Trainee (being the equivalent of a Technical Employee level 1 under the Award) - $45,000 • Customer Service Technician (being the equivalent of a Technical Employee Level 2 under the Award) - $53,803 • Customer Service Engineer (being the equivalent of a Technician Level 4 under the Award - $61,771 • Senior Customer Service Engineer / Production Specialist (being the equivalent of a Technician Level 6 under the Award - $70,623		• Technical Employee Level 1 - $35,100 per annum ($34,632 on a 37.5 hour week) • Technical Employee Level 2 - $36,467 ($35,997 on a 37.5 hour week) • Technician – Level 3 - $37,720 • Technician Level 4 - $39,772 ($39,253.76 on a 37.5 hour week) • Technician Level 5 – $42,235 • Technician Level 6/ production specialist - $44,577 ($43,992 on a 37.5 hour week) The above relevant rates grossed up on an equivalent TRC basis for a full-time employee working a **37.5 hour week**, which includes salary, superannuation, representation allowance and annual leave loading are: • Technical Employee Level 1 - $39,324.90 (calculated to comprise: salary -$34,632; annual leave loading - $466.20; representation allowance - $855.40 and	are: • Trainee is $3,675.10 better off per annum under the Agreement in terms of TRC, this equates to 5.5 additional weeks' pay than the Award • Customer Service Technician is $6,965.04 better off per annum in terms of TRC under the Agreement, this equates to 10 additional weeks' pay than the Award • Customer Service Engineer is $11,323.46 better off per annum in terms of TRC under the Agreement, this equates to 15 weeks' additional pay than the Award • Senior Customer Service Engineer / Production Specialist is $14,922.90 better off per annum in terms of

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				superannuation - $3,371.30 (calculated on salary and representation allowance)) • Technical Employee Level 2 - $40,837.96 (calculated to comprise: salary -$35,997; annual leave loading - $484.58; representation allowance - $855.40 and superannuation - $3,500.98 (calculated on salary and representation allowance)) • Technician Level 4 - $44,447.95 (calculated to comprise: salary -$39,253.76; annual leave loading - $528.42; representation allowance - $855.40 and superannuation - $3,810.37 (calculated on salary and representation allowance)) • Technician Level 6/ production specialist - $49,700.10 (calculated to comprise: salary -$43,992; annual leave loading - $592.20; representation	TRC under the Agreement, this equates to 17.6 weeks additional pay than the Award

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				allowance - $855.40 and superannuation - $4,260.50 (calculated on salary and representation allowance))	
Salary and Allowance Increases	Appendix A	Minimum increases to TRC apply as follows for each classification: • 1 March 2019 - $2,500 • 1 March 2020 - $2,000 • 1 March 2021 - $2,000 The amount of the actual increase will be no less that the minimum Increases to allowances are specified separately in other items of this table	N/A	Increases in accordance with the Annual Wage Review	• Likely yes • Additionally, section 206 of the Fair Work Act provides 'base rate of pay' in Enterprise Agreement must not be less than the modern Award rate
Superannuation	14	• Contributions made In accordance with ordinary time earning and superannuation legislation • Employees have choice of fund	26	In accordance with ordinary time earning and superannuation legislation	Yes, as the superannuation is paid on a higher overall rate of pay
Representational Allowance	Appendix A	This is included in the employees total remuneration costs	21.1, 22.1(e)	• Employees regularly expected to be engaged in technical service or technical support in the field on behalf of their employer must, in addition to the salary and any other allowance prescribed by this	• Yes as this is included in the employees higher overall rate of pay • Additionally, employees receive a

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				award, be paid a representation allowance of 2.18% of the standard weekly rate per week of a level 4 technician which is $764.80. • The allowance is $0.44 per hour up to a maximum of $16.67 per week (based on a 38 hour week) • Allowance does not apply if the employee's salary is more than $60,185 per annum	higher overall rate of pay; some employees receive a significant walking allowance or per kilometre allowance, others have the benefit of the private use of the company motor vehicle assigned to them; 2 additional public holidays, additional carer's leave and compassionate leave (**Additional Benefits**) • Additionally, some employees under the Agreement will be paid more than $54,973 per annum and will still receive the allowance under the Agreement, whereas they would not have under the Award
Casual loading	31	25% casual loading	13	20% casual loading	Yes – we have increased to the proposed change to the Award over time

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Hours of Work	21(b), 30(a), 31	• The ordinary hours of work shall average 37.5 hours per week within a 28 day work cycle • The ordinary span of hours shall be between 6.00 am and 6.30 pm, Monday to Friday	12, 21.1, 27.1(a)	• Average of 38 per week • Span of hours between 6.30 am to 6.30 pm at the discretion of the employer on any day or all of the days of the week, Monday to Friday (span can be altered by up to 1 hour in each direction by agreement with employees) • Does not apply if the employee's salary is more than $60,185 per annum	• Yes – for ordinary weekly hours as the employees work 30 minutes less per week than required under the Award • In relation to the 30 minute difference in span of hours, the higher hourly rates of pay received by employees under the Agreement more than compensates for the difference • Employees also receive the Additional Benefits
Overtime	21(b)(v), 23(a), 23(c), 23(d), 23(f), 24, 26	• Work outside span of hours attracts a loading of 20% • Overtime applies for all hours of work outside 6am to 630pm Monday to Friday • Overtime worked Monday to Saturday is paid at time and one half • All overtime worked on a Sunday will be paid at double time	21.1, 27.3, 30.1	• Work outside span of hours attracts a loading of 24.7% • Overtime applies for all hours of work outside 630am to 630pm Monday to Friday • Overtime paid at the rate of time and a half for the first three hours and double time thereafter, until the completion	• While the work outside of span under the Award attracts a marginally higher loading, the employees are compensated by a higher overall rate of pay as well as the Additional Benefits • In relation to the 30 minute difference in span

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		• Overtime worked on a public holiday will be paid at double time • Entitlement to be absent from work for 10 hours after performing overtime without loss of pay (full-time only) • Time off in lieu may be taken instead of overtime • Employees on standby who are called to work are entitled to payments at overtime rates		of work • Overtime does not apply if the employee's salary is more than $60,185 per annum	of hours, the employees have the benefit of a working week that is 30 minutes shorter under the Agreement than the Award, and also receive the Additional Benefits • Yes – in relation to Sunday work as double time starts immediately • In relation to any hours in excess of 3 on a Saturday, the employees the Additional Benefits • Additionally, some employees under the Agreement will be paid more than $54,973 per annum and will still receive overtime under the Agreement, whereas they would not have under the Award
Minimum overtime hours payments	26	• Employees on standby who are called to work are entitled to a minimum payment of 3 hours at overtime rates • Employees who are not on stand-by that are called out after having	21.1, 30.3(c)(i)	• An employee required to work overtime on a Saturday or Sunday will be paid for a minimum of four hours except where such overtime is worked prior to or at the conclusion of	• Despite the minimum guarantee of hours, the employees receive a higher overall rate of pay and receive the

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		completed their normal daily work cycle will be paid for a minimum of four (4) hours at the overtime rate		ordinary hours of work • Provision does not apply if the employee's salary is more than $60,185 per annum	Additional Benefits • Additionally, some employees under the Agreement will be paid more than $54,973 per annum and will still receive the benefit of the payments under the Agreement, whereas they would not have under the Award
Ordinary hours on a Saturday	23(d)	Overtime rates apply for Saturday work as those hours are not classified as ordinary hours. Those overtime rates are payable at time and half on a Saturday	21.1, 27.4	• Allowance of 59.2% of the standard level hourly rate per hour for ordinary time worked on Saturday • Allowance does not apply if the employee's salary is more than $60,185 per annum	• Yes, despite the fact the hourly allowance is lower, the higher hourly rates of pay received by employees under the Agreement more than compensates for the difference. • Employees also receive the Additional Benefits. • It is rare for employees to work on a Saturday because it is not part of their

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					standard hours • Additionally, some employees under the Agreement will be paid more than $54,973 per annum and will still receive overtime pay under the Agreement, whereas they would not have under the Award
Ordinary hours on a Sunday	23(e)	• Overtime rates apply for Sunday work as those hours are not classified as ordinary hours • Those overtime rates are payable at double time	21.1, 27.5	• Employees are entitled to an allowance of 82.95% of the standard level hourly rate per hour for ordinary time worked on Sunday • Does not apply if the employee's salary is more than $60,185 per annum	• Yes, as the overtime rate of double time will apply • Additionally, it is rare for employee to work on a Sunday because it is not part of their standard hours • Additionally, some employees under the Agreement will be paid more than $54,973 per annum and will still receive overtime under the Agreement, whereas they would not have

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					under the Award
Saturday penalty rates	23(d)	All overtime worked on a Saturday will be paid at time and one half	21.1, 30.3	• All overtime worked on a Saturday that would otherwise be a day off, will be paid at time and one half for the first three hours and double time thereafter, until the completion of work • Penalty does not apply if the employee's salary is more than $60,185 per annum	• Yes, despite the fact that double time applies after 3 hours, the higher hourly rates of pay received by employees under the Agreement more than compensates for the difference • Employees also receive the Additional Benefits. • Additionally, some employees under the Agreement will be paid more than $54,973 per annum and will still receive overtime under the Agreement, whereas they would not have under the Award
Sunday penalty rates	23(e)	All overtime worked on a Sunday will be paid at double time.	21.1, 30.3(b)	• An employee required to work on a Sunday that is a day off will be paid double time for all work. • Penalty does not apply if the	• Yes – the employees also receive a higher overall rate of pay when they work • Employees also

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				employee's salary is more than $60,185 per annum	receive the Additional Benefits • Additionally, some employees under the Agreement will be paid more than $54,973 per annum and will still receive the overtime penalty rate under the Agreement, whereas they would not have under the Award
Rest periods during overtime	17(a)	An employee shall be allowed a 30 minute unpaid meal break after 5 hours of work	30.3(d), 21.1	• 20 minute paid break after four hours of overtime • 20 minute paid rest break after working 2 hours overtime after ordinary working hours • Does not apply if the employee's salary is more than $60,185 per annum	• Despite the fact the employees do not receive paid rest breaks, they are still better off because they receive a higher overall rate of pay and the Additional Benefits • Additionally, some employees under the Agreement will be paid more than $54,973 per annum and will still receive the benefit of the rest period under the

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					Agreement, whereas they would not have under the Award
Rest period after performing overtime duty	23(g) and 23(h)	• Employees should have at least **ten** consecutive hours off duty between work on successive days. Full-time employees only will be paid at ordinary rates for any hours not worked to allow them to have the 10 hour break. • If an employee resumes without 10 hours break the employee will be paid double time and is then entitled to be absent until the employee has had 10 consecutive hours off duty without loss of pay.	30.6, 21.1,	• Employees should have at least **ten** consecutive hours off duty between work on successive days. Full-time employees only will be paid at ordinary rates for any hours not worked to allow them to have the 10 hour break. • If an employee resumes without 10 hours break the employee will be paid double time and is then entitled to be absent until the employee has had 10 consecutive hours off duty without loss of pay. • Does not apply if the employee's salary is more than $60,185 per annum • Does not apply to call-backs or in circumstances where an employee provides technical service or technical support over the telephone or via remote access arrangements	Yes – under the Agreement, there is no exclusion in the event of call backs or where work is performed via phone or remote access arrangements, nor is there an exclusion based on salary

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Standby allowance	26	• Employees rostered on stand by will be paid a stand by allowance of $13.09 for each hour. The allowance will increase as follows:
		  • 1 March 2019 - $13.09 per hour
		  • 1 March 2020 - $13.33 per hour
		  • 1 March 2021 - $13.58 per hour
		• Employees on standby who are called to work are entitled to a minimum payment of 3 hours
		• Employees on standby who are called to work are entitled to payments at overtime rates
			30.5	• An allowance of 59.42% of the standard hourly rate for a level 4 technical employee will be paid to an employee for the period the employer requires the employee to remain in readiness for a return to work outside the employee's ordinary hours
				• The allowance is $11.96 per hour
				• Employees on standby who are called to work are entitled to a minimum payment of 3 hours
				• The allowance is not paid while the employee is receiving overtime pay
					• Yes – call back provisions are the same
					• Despite the fact the hourly allowance is lower, the higher hourly rates of pay received by employees under the Agreement more than compensates for the difference.
					• Employees also receive the Additional Benefits

Call back	26	• Employees who are not on stand-by but that are called back to work are entitled to payment for 4 hours at the overtime rate • Employees on standby who are called to work are entitled to a minimum payment of 3 hours at overtime rates	30.4	• An employee recalled to work overtime after leaving work will be paid a minimum of four hours • An employee on stand by will be paid for a minimum of three hours at the appropriate overtime rate for each time recalled	Yes – there is also no exclusion under the Agreement where the work is performed over the phone or via remote access arrangements

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				• These provisions do not apply if the employee provides technical service or technical support over the telephone or via remote access arrangements	
Shift work	40	• Employees working shift work are paid at ordinary rates • Canon's shift work policy applies to such employees	28, 21.1	• Afternoon shift is any shift finishing after 6.30 pm and at or before midnight, on such shifts, employees are entitled to an allowance of 14.68% of the standard hourly rate per hour for time worked on an afternoon shift • Does not apply if the employee's salary is more than $60,185 per annum	• Despite the fact the employees do not receive the afternoon shift work allowance, they are still better off because they receive a higher overall rate of pay and the Additional Benefits
Public holidays	43	Entitlement is the same as the National Employment Standards except that the employer also provides two additional public holidays	34.1	In accordance with the National Employment Standards	Yes, as employees receive 2 additional paid days off work which are also paid at a higher rate of pay than the Award
Payment for public holidays	44	• Work on the following public holidays is paid at double time or the employee will be given a paid day off in lieu: Labour Day and two additional Canon	34.3, 21.1	• Work on a public holiday or a substituted day must be paid at double time and a half. • Where both a public holiday	• Yes for the following public holidays - New Year's Day, Australia Day, Easter Friday,

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		provided public holidays • Work on the following public holidays is paid at double time and a half: New Year's Day, Australia Day, Easter Friday, Easter Saturday, Easter Sunday, Easter Monday, ANZAC Day, Proclamation Day (SA only), Queens birthday, Christmas Day (which includes from 5pm on 24 December), and Boxing Day (except SA)		and substitute day are worked, public holiday penalties are payable on the holiday and the employee is entitled to not less than four hours' pay at penalty rates provided the employee is available to work for four hours • Does not apply if the employee's salary is more than $60,185 per annum	Easter Saturday, Easter Sunday, Easter Monday, ANZAC Day, Proclamation Day (SA only), Queens birthday, Christmas Day and Boxing Day as the employees also receive a higher rate of pay than they would under the Award for the absence • Employees also receive the Additional Benefits • Despite the difference in penalty rates on Labour Day, the employees receive the Additional Benefits • Additionally, some employees under the Agreement will be paid more than $54,973 per annum and will still receive the public holiday

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					rates under the Agreement, whereas they would not have under the Award
Overtime on public holidays	23(f), 44	• Overtime worked on a public holiday will be paid at double time, unless the public holiday is New Year's Day, Australia Day, Easter Friday, Easter Saturday, Easter Sunday, Easter Monday, ANZAC Day, Proclamation Day (SA only), Queens birthday, Christmas Day and Boxing Day (excluding SA) – in which case the employee is paid at double time and a half	N/A	No equivalent provision	Yes
Make up time	N/A	No equivalent provision	28.6	Employees may elect, with the consent of the employer, to work make-up time under which the employee takes time off during ordinary hours, and works those hours at a later time, during the spread of ordinary hours provided in the Award	• Yes as the employee will still receive payment for all hours work, and that payment will be at a higher rate than would have applied under the Award • Additionally, the employees work 30 minutes less per week under the Agreement

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					• Employees also receive the Additional Benefits
Probationary period	29	Employee may be engaged for an initial probationary period of three (3) months during which their notice period (except in cases of serious misconduct) is 1 week	18.1	No provision for probationary period but notice to terminate is the same	Yes, as the same notice period applies and under the Agreement, it is paid at a higher rate of pay

Meal Allowance	17	• Applies if an employee is required to work two (2) hours or more overtime.
		• If overtime extends a further four (4) hours, an additional meal allowance will be paid, unless Canon provides a meal
		• The allowance is $14.66 per meal
		• The allowance will also increase as follows:
		  • 1 March 2019 - $14.66
		  • 1 March 2020 - $14.94
		  • 1 March 2021 - $15.22
			22.1(d) and 30.3(d)	• An employee must receive a meal allowance of $13.50 where the employee is required to work more than 2 hours overtime and more than 4 hours overtime.
				• The meal allowance will not apply where the employer provides a meal to an employee on overtime or the employee lives in the same locality in which the employee is working and can reasonably return home for a meal
					Yes, and the allowance is higher

Walking Allowance	18(c)	• A walking allowance is provided to compensate for day to day travel expenses – the allowance is $13,269	N/A	• No equivalent provision	Yes

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		• The allowance is not provided to employees who have the benefit of the private use of the company motor vehicle assigned to them and is pro-rata for part-time employees			

Motor vehicle / motor vehicle allowance	18	• If a motor vehicle is required, Canon will at its option, either provide the vehicle at its own cost, a motor vehicle allowance, or if the employee uses their car for business on a casual basis – an allowance of $0.90 per kilometre is paid.
		• The allowance for casual use will increase as follows:
		  • 1 March 2019 - $0.90
		  • 1 March 2020 - $0.92
		  • 1 March 2021 - $0.94
			22.1 (b)(ii)(A) and 22.1(b)(ii) (B) and 22.1(b)(ii) (E)	• Employer to provide motor vehicle, car allowance or kilometre allowance for casual usage.
				• Motor vehicle allowance is $621.14 per month if the employee is required to use their own motor vehicle to perform their duties or $719.2 per month for duties performed in a country territory. In addition an allowance of $0.34 must be paid per kilometre travelled during the course of business
				• If the employee uses their motor vehicle for business on a casual basis –an allowance of $0.78 per kilometre must be paid
					• Yes - in relation to the per kilometre allowance for casual use
					• Yes - under the Agreement, no employee would be eligible for the monthly motor vehicle allowance because they are either provided with a company vehicle (and have the benefit of private use and payment of all maintenance costs by Canon) or they receive a per kilometre allowance for casual use of their vehicle, or a significant walking allowance

Leading Hand Allowance	N/A	No equivalent provision as the Agreement does not cover leading hands	22.1(a)	Leading Hand Allowance provided	Not applicable

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Living Away from Home Allowance		No equivalent provision as employees are not required to live away from home	22.1(h)	The Award contains living away from home allowances which are not applicable to the employees covered by the Agreement	N/A
Travelling time	25	• Time spent travelling to and from seminars, conferences, training, etc in excess of two (2) hours each way, which is outside the employee's agreed work cycle, will be paid at ordinary rates of pay • Time spent travelling outside an employee's region of operation outside their ordinary hours will be paid at ordinary rates	N/A	No equivalent provision	Yes

First Aid allowance	16	• An employee appointed to perform first aid duty shall be paid an allowance of $22.05 per week
		• The allowance will increase as follows:
		  • 1 March 2019 - $22.05 per week
		  • 1 March 2020 - $22.46 per week
		  • 1 March 2021 - $22.89 per week
			21.1, 22.1(c)	• An employee holding a current first aid qualification from St John Ambulance or a similar body and appointed by the employer to perform first aid duties must be paid a weekly allowance of 2.35% of the standard weekly rate (of a level 4 technical employee) for any week the employee is so appointed
				• The actual rate is $0.47 per hour up to a maximum of
					• Yes, despite the fact the hourly allowance is lower, the higher hourly rates of pay received by employees under the Agreement more than compensates for the difference
					• Employees also receive the Additional Benefits

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				$17.97 per week	
Higher duties allowance	20	Employee who works at a higher classification must be paid at rate of higher classification provided they work for at least 5 days in the role (if a supervisor) or 10 days for other roles Where an employee is required to act in the role of a Supervisor, they shall be paid an annualised allowance of $5,900. This equates to $113.46 per week. This annualised allowance will increase to: (i). $5,900 (rounded) per year (or $113.46 per week) effective from 1 March 2019; (ii). $6,000 (rounded) per year (or $115.38 per week) effective from 1 March 2020; and (iii). $6,100 (rounded) per year (or $11.30 per week) effective from 1 March 2021.	20.2(d), 21.1	• Employee who works at a higher classification must be paid at rate of higher classification for duration unless the employee they are replacing is on annual leave or personal/carer's leave for less than 1 week • Allowance does not apply if the employee's salary is more than $60,185 per annum	• Same if the employee works on higher duties for at least 5 or 10 days. Additionally, the higher hourly rates of pay received by employees under the Agreement more than compensates for the difference • Employees also receive the Additional Benefits • Additionally, some employees under the Agreement will be paid more than $54,973 per annum and will still receive the allowance under the Agreement, whereas they would not have under the Award
Meal Break	17(a)	Unpaid meal breaks shall be 30 minutes after 5 hours of work	21.1, 29.1	• An employee will not be required to work for more than five hours without a break for a	Yes – as under the Agreement, the meal break still applies even if the

Comparison between the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019 and the *Business Equipment Award 2010*

Description	Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019		*Business Equipment Award 2010*		Better Off under Agreement than Award?
Provision	**Clause**	**Description**	**Clause**	**Description**	
				meal which must be for a period of not less than 30 minutes and not more than 60 minutes • Does not apply if the employee's salary is more than $60,185 per annum	employee earns more than $54,973 per annum
Annual Leave	40	Same as the National Employment Standards, including the additional week for shiftworkers	31.1	In accordance with the National Employment Standards	• Yes, as it is also paid on a higher salary than under the Award • Additionally, the employees receive the Additional Benefits
Cashing out annual leave	40	Cashing out permitted	N/A	No equivalent provision	Yes
Annual leave loading	40	Annual leave loading of 17.5% is included as a component of employees' salary (TRC)	31.2	Annual leave loading of 17.5% applies	• Yes, as it is also paid on a higher salary than under the Award • Employees also receive the Additional Benefits
Personal/carer's leave	41	The amount of the entitlement is the same as the National Employment Standards but the definition of "immediate family" for the purposes of carer's leave is broader and more	32	In accordance with the National Employment Standards	• Yes, as the definition of "immediate family" for the purposes of carer's leave is

Comparison between the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019 and the *Business Equipment Award 2010*

Description	Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019		*Business Equipment Award 2010*		Better Off under Agreement than Award?
Provision	**Clause**	**Description**	**Clause**	**Description**	
		generous than the NES as it also applies to aunts, uncles, nieces and nephews and anyone living in the same household.			broader under the Agreement • Employees also receive the Additional Benefits
Compassionate leave	46	• 3 days paid compassionate leave is available to full-time and part-time employees • An additional 2 paid days is also available if the employee attends the funeral of a family member who is overseas or in Australia and more than 4 hours travelling time (by commercial aeroplane) is required • The definition of "immediate family" for the purposes of compassionate leave is broader and more generous than the NES as it also applies to aunts, uncles, nieces and nephews and anyone living in the same household.	32	In accordance with the National Employment Standards	• Yes, as an extra day is provided, more leave is provided in the event of travel and the definition of "immediate family" is broader under the Agreement • Employees also receive the Additional Benefits
Parental Leave	45	Entitlement is the same as the National Employment Standards except that employees have the option of performing casual work without breaking their parental leave	N/A	In accordance with the National Employment Standards	Yes, due to the benefit of casual work being available
Community service leave (including jury	47 and 49	Entitlement is the same as the National Employment Standards, except there is no 10 day limit on paid jury service leave	33	In accordance with the National Employment Standards	Yes, as there is no limit on the period Canon will pay the employee

Comparison between the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019 and the *Business Equipment Award 2010*

Description	Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019		*Business Equipment Award 2010*		Better Off under Agreement than Award?
Provision	**Clause**	**Description**	**Clause**	**Description**	
service)					
Study Leave	48	In accordance with Canon's policy which will not be varied without consultation with employees	N/A	No equivalent provision	Yes
Blood donor leave	50	Employees absent to give blood will receive leave on full pay up to a maximum of 4 hours per year	N/A	No equivalent provision	Yes
Union activities	52	Recognised ASU representatives are entitled to interview the employer on matters affecting employees they represent without loss of pay	N/A	No equivalent provision	Yes
Union training leave	52	Union delegates are entitled to be absent from work for 5 days per calendar year without loss of pay to attend training courses and seminars	N/A	No equivalent provision	Yes
Notice of Termination	34, 31(a)	• Same as the National Employment Standards except in cases of redundancy where all employees irrespective or years of service receive 4 weeks notice or 5 weeks if aged over 45 over. • Additionally, casual employees are entitled to 1 hours notice.	13, 18.1	In accordance with the National Employment Standards • Additionally, casual employees are entitled to 1 hours notice.	Yes, as the amount the employees are paid will be higher under the Agreement
Job search entitlement (termination)	12.3	No equivalent provision	18.3	Where an employer has given notice of termination to an employee, an employee must be allowed up to one	• Yes as the employees receive a higher overall rate of pay and the

Comparison between the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019 and the *Business Equipment Award 2010*

Description	Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019		*Business Equipment Award 2010*		Better Off under Agreement than Award?
Provision	**Clause**	**Description**	**Clause**	**Description**	
				day's time off without loss of pay for the purpose of seeking other employment. However, this would not apply in the event payment in lieu of notice was given.	Additional Benefits • Additionally, in the event an employer provided an employee with payment in lieu of notice under the Award, they would be in the same position as they would under the Agreement (albeit under the Agreement, the payment they would receive for notice would be higher)
Job search entitlement (redundancy)	36(e)	When employee has been given notice of termination, the employee must be allowed 7.5 hours time off each week of their notice period without loss of pay for the purpose of seeking other employment	19.4	Where an employer has given notice of termination to an employee, an employee must be allowed up to one day's time off for each week of notice without loss of pay for the purpose of seeking other employment	Yes, as the employees receive a higher overall rate of pay as well as the Additional Benefits
Redundancy pay	36	• Employees will be provided redundancy pay in accordance with the following scale: • Less than 1 year – nil • 1 to 2 years – 4 weeks • 2 to 3 years – 7 weeks • 3 to 4 years – 10 weeks	19.1	In accordance with the National Employment Standards	Yes, as it is also paid on a higher salary than under the Award

Comparison between the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019 and the *Business Equipment Award 2010*

Description	Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019		*Business Equipment Award 2010*		Better Off under Agreement than Award?
Provision	**Clause**	**Description**	**Clause**	**Description**	
		• 4 to 5 years – 12 weeks • 5 to 6 years – 14 weeks • 6 to 7 years – 16 weeks • 7 to 8 years – 18 weeks • 8 to 9 years – 20 weeks • 9 to 10 years – 22 weeks • 10 to 11 years – 24 weeks • 11 years + - 2 additional weeks for each year of service capped at either 12 or 18 months based upon age and time of commencement of employment with Canon. • For employees who were employed by Canon as at 1 September 2015, an additional 25% loading applies to redundancy payments if they are over 40 years at the time they are retrenched			
Access to records	10	• Employees have a right to access their personal file and be given a copy of the Agreement	N/A	No equivalent provision	Yes
Job share arrangement	28	• Requests for job share arrangements will not be unreasonably refused	N/A	No equivalent provision	Yes

Comparison between the Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019 and the *Business Equipment Award 2010*

Description	Canon Australia Pty Ltd (Technical Consultants) Enterprise Agreement 2019		*Business Equipment Award 2010*		Better Off under Agreement than Award?
Provision	**Clause**	**Description**	**Clause**	**Description**	
Agreement flexibility	12	• Employee and Canon can seek to reach an IFA covering any matter covered under the Agreement	7	Employee and Canon can seek to reach an IFA covering only 5 restricted matters detailed in the Award	Yes
Salary sacrifice	13 and 14	• Employees are permitted to salary sacrifice	N/A	No equivalent provision	Yes
Electrical licences	19	• If an employee requires an electrical licence to work on office equipment, Canon will pay any reasonable costs incurred in the initial acquisition and renewal of the electrical licence for employees	N/A	No equivalent provision	Yes
Uniforms	15	Canon will provide a uniform to employees at its own cost annually.	N/A	No equivalent provision	Yes

Form F18 – Statutory declaration of employee organisation in relation to an application for approval of an enterprise agreement (other than a greenfields agreement)

Fair Work Act 2009, s.185; Fair Work Commission Rules 2013, rule 24 and Schedule 1

This is a statutory declaration in support of an application to the Fair Work Commission (the Commission) for approval of an enterprise agreement under Part 2-4 of the Fair Work Act 2009.

STATUTORY DECLARATION

Statutory Declarations Act 1959

I,

Name	Linda White		
Postal address	Ground Floor, 116 Queensberry Street		
Suburb	Carlton South		
State or territory	Victoria	**Postcode**	3053
Occupation	Assistant National Secretary		

make the following declaration under the *Statutory Declarations Act 1959:*

1. I am an officer or authorised employee of the following employee organisation (the Union):

Name of Union	Australian Municipal, Administrative, Clerical and Services Union

2. This declaration relates to an application for approval of the following enterprise agreement (the Agreement):

Name of Agreement	Canon Australia Pty Ltd (Technical Consultants) Agreement 2019
Name(s) of employer(s) to be covered by the Agreement	Canon Australia Pty Ltd

3. Is the Union a bargaining representative for the Agreement?

See s.176 of the Fair Work Act 2009. An employee organisation will be a bargaining representative if it has a member who will be an employee covered by the Agreement (unless the employee has appointed another person as his or her bargaining representative or has revoked the status of the organisation as his or her bargaining representative) and the organisation is entitled to represent the industrial interests of the employee in relation to work to be performed under the Agreement.

☒ Yes
☐ No

4. Does the Union want to advise the Commission about whether it supports approval of the Agreement?

☒ Yes
☐ No

5. If you answered yes to question 4 – Does the Union support approval of the Agreement by the Commission?

☒ Yes
☐ No

If you answered **No** – Specify the grounds on which the Union opposes approval of the Agreement, using numbered paragraphs.

Attach additional pages if necessary.

6. Does the Union want to advise the Commission about whether it agrees with one or more statements in an employer's statutory declaration (the Employer's Declaration)?

☒ Yes
☐ No

If you answered **Yes**- Provide details of the Employer's Declaration.

Name of person who made the Employer's Declaration	Sarah Marshall
Date of Employer's Declaration	22/02/2019

7. If you answered Yes to question 6- Set out the statements which the Union wishes to advise it agrees and disagrees with and state why the Union agrees or disagrees with them, using numbered paragraphs.

The union agrees to all the statements in the Canon form 17

Attach additional pages if necessary.

8. Does the Union give notice pursuant to s.183 of the Fair Work Act 2009 that it wants the Agreement to cover it?

☒ Yes
☐ No

Consent to contact by researchers

The Fair Work Commission undertakes research with participants in agreement approval matters to ensure a high quality process. Some research may be undertaken by external providers on behalf of the Fair Work Commission.

FAIR WORK COMMISSION

Form F18 – Statutory declaration of employee organisation in relation to an application for approval of an enterprise agreement (other than a greenfields agreement)

Do you consent to the contact details provided on page 1 of this form being provided to an external provider of research services for the sole purpose of inviting you to participate in this research?

☒ Yes
☐ No

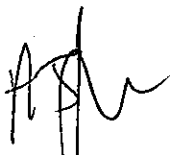
Signature of person making the declaration

A statutory declaration must be made before a **prescribed person**. For a full description of prescribed persons, see the Commission's Guide – Statutory declarations on the Commission's website.

I understand that a person who intentionally makes a false statement in a statutory declaration is guilty of an offence under section 11 of the *Statutory Declarations Act 1959*, and I believe that the statements in this declaration are true in every particular.

Signature	
Declared at (place)	Carlton South
on (day) of (month) (year)	22 February 2019

Before me,

Signature of person before whom the declaration is made	
Full name of person before whom declaration is made	**ALEXANDER JOHN NUCIFORA**
Qualification of person before whom declaration is made	**Ground Floor, 116 Queensberry Street, Carlton South Vic 3053**
Address of person before whom declaration is made	***An Australian Legal Practitioner within the meaning of the Legal Profession Uniform Law (Victoria)***
Suburb	
State or territory	**Postcode**
Phone number	

Note 1: A person who intentionally makes a false statement in a statutory declaration is guilty of an offence, the punishment for which is imprisonment for a term of 4 years – see section 11 of the *Statutory Declarations Act 1959*.

Note 2: Chapter 2 of the *Criminal Code* applies to all offences against the *Statutory Declarations Act 1959* – see section 5A of the *Statutory Declarations Act 1959*.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR OWN RECORDS

FORM F18 CHECKLIST

(For National Industrial Officers preparing Form F18s for the ASU National Secretary)

Employer: Canon Australia

Agreement Title: Canon Australia Pty Ltd (Technical Consultants) Agreement 2014

Other Unions covered by the Agreement: N/A

National Industrial Officer: MICHAEL RIZZO

ASU Members

☐ All States and Territories ☑ Victoria ☑ Queensland

☑ New South Wales ☐ Tasmania ☑ South Australia

☑ ACT ☑ Western Australia ☑ Northern Territory

Bargaining outcome

All ASU branches with members were given an opportunity to review and endorse/oppose the Agreement? Yes ☑ No ☐

Ballot Outcome:

Total employees covered by Agreement 74 Total votes in favour 84% (59).

Total employees voted 70 Total votes against 11

Confirm Ballot Outcome

The National Industrial Officer has reviewed the returning officer's report? Yes ☑ No ☐

Prepare Form F18

The National Industrial Officer has reviewed the employer's Form F17? Yes ☑ No ☐

F18 Question 5 *(re F17)* - National Industrial Officer recommends the National Secretary:

☑ Agree with the employer's Form F17 Statutory Declaration.

☐ Oppose the employer's Form F17 Statutory Declaration *(List in Q5 matters disagreed).*

☐ Decline to answer Question 5.

The National Industrial Officer recommends that the National Secretary sign the following:

☑ The prepared Form F18 Statutory Declaration ☑ The signatory page of the Agreement

Annexure A.

BEFORE THE FAIR WORK COMMISSION
MATTER NO. AM2014/285
S. 156 - Four yearly review of modern awards – Social, Community, Home Care and Disability Services Industry Award 2010

STATEMENT OF DEBORAH LEE ANDERSON

I, Deborah Lee Anderson, Shared and Supported Living Co-ordinator of [redacted], The Leisure Life Village in the State of New South Wales, say;

1. I am a Delegate of the Australian Services Union, New South Wales.

2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. I was born on 17 July 1958, I am 61 years old.

4. I am single and live with my aged mother to help support her. My mother is 81 and I assist her by doing the shopping and taking her out on weekends to visit her specialist.

My work history

5. I have worked as a Shared and Supported Living Co-ordinator since on or about 14 June 2018.

6. I hold a Certificate 4 in Youth and Community, a Diploma in Community Services, a Certificate 2 in Frontline Business Management, and Certificate 2 in Leadership.

7. During the early years of my life I was raising my children and worked part time on and off as a bar attendant. This was over a period of about 25 years, although for about 2 years at the end of this period I worked as a teacher's aide at Lake Macquarie High School. I then worked as a teacher's aide at Toogoolawa, a private school for disadvantaged youth, for about three years.

8. In 2013, I entered the Social and Community Services sector when I began work with Life Without Barriers as a Disability Support Worker. In June 2016, I was employed by St Vincent de Paul as an NDIS Local Area Co-ordinator. In June 2018 when I returned to work with Life Without Barriers in my current role as a Shared and Supported Living Co-ordinator. Life Without Barriers is a not for profit community organisation and a registered NDIS provider.

Current employment

9. On 18 June 2018, I commenced work with Life Without Barriers as a Shared and Supported Living Co-ordinator. I am a full time employee. Attached and marked **Annexure A** is a copy of my contract of employment.

10. I am employed under the *Social, Community, Home Care and Disabilities Services Industry Award 2010* (**'the Award')**. I am paid a yearly salary of $74,865.75.

11. I manage up to 30 frontline staff in two group homes. One group home has five high needs medical clients. These client's needs are constantly changing. I must continually monitor their needs to make sure we meet their requirements. The second home has two women with their own particular needs and compliance requirements.

12. Managing two homes in different physical locations makes it difficult to monitor and ensure compliance in both places. It is common for me to wake up through the night with worries about what hasn't been done. I monitor emails in personal time on weekends and evenings, when not rostered on, because management still send emails at this time and I feel obliged to stay on top of things and to do work outside hours unpaid

13. My job involves many different tasks:

    a. This includes overseeing rostering, conducting formal supervisions, finding staff to fill roster gaps as needed, conducting team meetings, and interviewing frontline staff for vacancies.

    b. I am also responsible for ensuring staff are up to date with training; monitoring and writing incident reports and monitoring follow up actions; monitoring Work Health and Safety systems and practices: conducting work cover processes: and monitoring restricted work practices. I also have to ensure that all compliance documentation is in line with NDIS Commission requirements.

    c. I am responsible for ordering the stationary requirements of the houses; placing orders for client medical supplies; (e.g. incontinence, ventral stomach (peg) feeding requirements): arranging house maintenance: and ensuring first aid compliance.

    d. I liaise with external services for the clients, (eg medical practitioners, therapists, dieticians, dentists), and am responsible for ensuring that their recommendations are endorsed and followed, (eg a transfer procedure). I also monitor client finance processes, monitor medications to ensure they are in place and current, and notify staff of any medication changes.

My hours of work

14. I work 76 hours over a fortnight on weekdays starting at 8.00 am until 4:30 pm. My pattern of daily work doesn't change. However, I am also on a rotating roster to perform On Call duties which can overlap my regular hours and extend well beyond them. I only receive a roster for my on call duties.

15. I am usually rostered to be on call once a week. If I am rostered to be on call during the week my normal hours of work will change. I will start work at 11.30 am and finish at 8.00 pm. I will start on call duties 5.00 pm and finish at 8.00 am the following morning. This means that there is a three hour overlap between starting my on call duties and the end of my normal rostered work. However, there are still urgent tasks that need to be done, and no-one else takes over those tasks in my place. Staff and management still contact me during this period. I usually start begin working at around 8.00 am, even if I am not rostered to start until 11.30 am. I am sometimes rostered to be on call on weekends. Then I will be rostered between 9.00 am and 9.00am.

16. Attached and marked are copies of my on call roster for the period 17 June 2019 to 16 December 2019.

On Call Duties

17. When I am rostered on call, I am expected to perform a wide range of duties. Typically, this includes responding to emergencies, administrative tasks such as rostering, providing phone advice and assisting less experienced staff with their issues. However, I can be called for any reason. I have to make an assessment over the phone of what action should be taken. I am

also responsible for reporting and recording all incidents. On a busy shift this can mean continuing after the shift to ensure all incidents have been logged and recorded.

18. When I am on call, I will usually take calls from staff at group homes when another staff member has not turned up or a staff member becomes sick and has to leave work early. I will then find another staff member to fill in for the absent staff member. This can require calling many people. It is not unusual for me to make up to 12 calls to find an available person. I am also required to contacting our labour hire agency when agency staff do not attend work as they were rostered. I will also rearrange rosters that flow on from this change to manage overtime and breaks.

19. Ultimately, if there are no staff available to cover a shift then I have to cover the absent workers duties. This means I will need to return to the workplace and directly support our clients. I must also continue responding to 'on call' calls after I have been recalled to work. This has happened twice so far since starting on the on call roster in August 2018.

20. Being on call also involves assisting staff to find information. This may require contacting other staff to find out where the information is located. It also involves advising on medication issues, and recommending corrective action when equipment is not functioning correctly.

21. I am also required to assist staff in our group homes to deal with emergencies that arise. For example, when clients have escalated behaviour, such as becoming violent or have seizures. This requires talking the staff through the situation, helping resolve the issue, ensuring incident reports are made, and logging the occurrence.

22. I am paid an above Award allowance of $30.00 when I am rostered on call between Monday and Friday, and $50.00 when I am rostered on call on weekends and public holidays. When I am working while rostered on call I am paid at the rate of time and half for the first 2 hours and double time after that.

Other work outside of rostered working hours

23. I am not usually required to work out of hours unless I am rostered to be on call. If I am contacted out of hours, this is usually just a telephone call from a new coordinator or a more junior staff member with a quick enquiry. There is no overt expectation from my employer to do this work. However, there is a clear expectation that I will be available to answer calls from management outside of working hours. But this does not happen very often and has only minor impact on me.

Impact of on call work

24. When I am on call, I cannot leave my home as I need to have phone, internet and computer access. I must also be ready and able to respond to any requests for work. I cannot go anywhere nor do anything else. This is particularly difficult on weekends when doing an on call shift from 9am until 9am. This causes high anxiety for me as I could be called out to any site to handle difficult incidences. This has occurred 3 times so far, and once resulted in me having to do a 23 hour shift. This can also result in me being required to attend at two places at the one time which is highly stressful as I can't go to a house to attend an incident when I am already attending an incident at another house.

The Australian Business Industrial remote response claim

25. I have been show a copy of ABI's remote response draft determination. I understand that it means that from 5pm until 10pm at night, I could be called to respond to an issue and I may only be paid for 15 minutes. There is no obligation for my employer to roster me to be on call.

26. I am greatly concerned by this proposal. The proposed 15 minute minimum engagement is completely inadequate payment for the inconvenience and stress involved with being contacted out of hours. You can never know what call may come through. It could be enormously inconvenient. What if I was out with a family member and I received a call that required me to attend a house? What would I do with my family member? How could this payment reimburse me for the significant imposition on my family life.

27. I was not previously considering leaving my job, but if something like this proposal was brought in as compulsory I would seriously consider leaving the industry. Doing work out of hours is only worthwhile for the additional pay it provides. Without significant remuneration to provide for not just the time involved, but the inconvenience as well, it is not worthwhile doing this work.

_____

WITNESS SIGNATURE

DEBORAH ANDERSON

DATE: 02/09/209

ANNEXURE A

WE LIFE WITHOUT BARRIERS VE

Employment Agreement

Deborah Lee Anderson

Life Without Barriers

ABN: 15 101 252 171

06 June 2018

WE
LIFE WITHOUT BARRIERS
VE

SCHEDULE 1

Item No.	Item	Detail
Item 1	Commencement Date	18 June 2018
Item 2	Duties	Refer to Position Description
Item 3	Employee	Deborah Lee Anderson
Item 4	Position	Shared & Supported Living Coordinator
Item 5	Base Remuneration	$74,865.75
	Additional Benefits 1	Not Applicable
	Additional Benefits 2	Not Applicable
	Superannuation 9.5%	$7,112.25
	Total Fixed Remuneration	$81,978.00
Item 6	Term of Appointment	Permanent
Item 7	Start Date of Employment	18 June 2018
Item 8	Reporting to	Shared & Supported Living Manager
Item 9	Hours of work	Full Time 38 hours per week.
	Hours of Work Averaging Period	6 monthly
Item 10	Probationary Period	6 months from start date of employment.
Item 11	Licences and Qualifications	Certificate IV or equivalent in Disability, Mental Health or Community and Social Services First Aid Certificate Current driver's license
Item 12	Probity Clearances Required	National Criminal History Record Check NSW Working with Children Check
Item 13	Governing Law	New South Wales
Item 14	Annual Leave	20 days for each 12 months of service (pro-rated for part time employees), accrued and cumulative in accordance with the National Employment Standards.

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Item 15	Personal/Carers Leave	10 days for each 12 months of service (pro-rated for part time employees), accrued and cumulative in accordance with the National Employment Standards.
Item 16	Guarantee of Annual Earnings	Not applicable
Item 17	Termination Notice Period after expiration of Probationary Period	The Employee or Organisation will provide 4 weeks' written notice to the other party of their intention to terminate employment. If the Employee is at least 45 years of age at the time of Termination of Employment and has completed at least 2 years' continuous service at the time the notice is given, the Organisation will increase the notice period by 1 additional week. The Organisation may provide payment in lieu of the equivalent notice period or part thereof.
Item 18	Tool of Trade Vehicle	A tool of trade vehicle is provided to the position outlined in Item 4 of Schedule 1. As per the Vehicle Eligibility & Allowances Policy Guideline, a tool of trade vehicle is required to meet the inherent requirements of the position. The allocation of this vehicle is subject to change by the Organisation. Tool of trade vehicles may be utilised for personal use in accordance with the Fleet Management Policy, however they do not form part of an employee's remuneration package and the vehicle is to be made available for use by others in the Organisation as required. Utilising a tool of trade vehicle for business travel restricts you from claiming kilometre reimbursements.

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1. APPOINTMENT

1.1 Commencement

a) Subject to the terms of this Agreement, the Organisation appoints the Employee to the Position set out in Item 4 of Schedule 1 and the Employee accepts that appointment (**the Employment**).

b) The Organisation will employ the Employee from the Commencement Date specified in Item 1 of Schedule 1 until the Employment is terminated by either party in accordance with this agreement.

c) Subject to the terms of this Agreement, the appointment is for the term outlined in Item 6 of Schedule 1.

1.2 Prior Employment or Agreements

a) This Agreement replaces all previous contracts of employment and other employment arrangements between you and the Organisation.

b) Where this Agreement replaces an existing employment Agreement, the Organisation will recognise continuity of service and your period of prior service with the Organisation for the purposes of all employment related entitlements. For the purpose of calculating your period of continuous service with the Organisation, your employment by the Organisation is deemed to have commenced on the date listed in Item 7 of Schedule 1.

1.3 Probation

a) From the Start Date the Employee is subject to the probationary period specified in Item 10 of Schedule 1.

b) During the probationary period, either the Organisation or the Employee may terminate the Employee's employment by giving one (1) weeks' notice in writing or, in respect of the Organisation, payment in lieu of such notice.

1.4 Reporting

a) The Employee will report to the Position described in Item 8 of Schedule 1 or such other position as nominated by the Organisation.

1.5 Work Location & Travel

a) Due to the nature of services provided by the Organisation, the Employee may reasonably be required to travel to and perform work at various work sites or locations at the Organisation's discretion. The Employee will not be entitled to any additional remuneration for such travel, but travel expenses for approved travel will be paid for by the Organisation in accordance with the Organisation's travel policies.

1.6 Hours of Work

a) The Employee's ordinary hours of work are set out in Item 9 of Schedule 1. The Employee may be required to work reasonable additional hours as required to fulfil the requirements of their role. The Organisation may require the Employee to work varying hours each week in order to satisfy the requirements of their position. In this case the Organisation may average the ordinary hours of work over a period of time greater than one week. This averaging period is outlined in Item 9 of Schedule 1.

b) The organisation may vary these hours from time to time after giving a minimum of 7 days' notice to the Employee

c) The Employee's Total Fixed Remuneration includes compensation for all hours the Employee is required to work. The Employee is not entitled to receive payments for reasonable additional hours worked.

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2. PROBITY, CONDITIONS AND CONSENTS

2.1 Probity

a) The Organisation is committed to the safety and protection of clients we support. This means that we need to make sure that all employees, whether in client-facing roles or not, do not pose any risk to our clients or to the Organisation. To ensure this, all employees, must undergo suitability and probity checks in accordance with State and Federal legislation and internal policy requirements.

b) The employee promises to obtain and maintain the probity checks and relevant Federal and State based clearances listed in Item 12 of Schedule 1, and any other checks as reasonably required by the Organisation.

c) This offer of employment is conditional upon the Organisation receiving satisfactory probity and Federal and State based clearances from the Employee. If such clearances are not provided, the offer of employment may be withdrawn.

d) The Organisation may unilaterally terminate this Agreement if the Employee is unable to obtain or maintain satisfactory probity and Federal and State based clearances by providing the notice period prescribed in clause 6.1 of this Agreement or payment in lieu of notice.

2.2 Conditions of Employment

a) The Employee must have the necessary skills and experience to carry out the duties and responsibilities referred to in the Position Description.

b) The Employee must be competent to properly carry out their duties and any representations as to qualifications, experiences, skills and employment history must be true and correct. The Organisation may at any time request reasonable evidence of the Employee's ability to meet these requirements.

c) In addition to clause 2.2 (b), it is a condition of employment that the Employee maintains the specific qualifications, licences, and professional admissions set out in Item 11 of Schedule 1. Additionally, the Employee may be required to undertake mandatory training in order to meet the inherent requirements of the role as listed in the Position Description. Failure by the employee to maintain the qualifications or satisfactorily complete mandatory training for any reason (including suspended qualifications) may result in the Organisation terminating this agreement in accordance with clause 6.1.

d) The Employee must be eligible to work in Australia and meet all Australian immigration requirements to work in the position set out in Item 4 of Schedule 1.

2.3 Consent

The Employee consents to all or any acts or omissions by or on behalf of the Organisation (whether occurring before or after this consent is given) which infringe or may infringe any of the Employee's Moral Rights in relation to any works and other Intellectual Property Rights described in clause 5.2 made or created by the Employee in the course of the Employee's employment with the Organisation. Furthermore, the Employee acknowledges that as a result of providing such consent, the Employee waives their right to bring any Moral Rights claim against the Organisation.

2.4 Extent of consent

The Employee's consent under this clause is irrevocable and extends to:

a) the Organisation's licensees and successors in title in respect of the Works; and

b) any person authorised by the Organisation or its licensees or successors in title to do acts comprised in the copyright for the Works.

2.5 Genuine consent

The Employee acknowledges that the consent in this clause is a genuine consent given under Part IX of the *Copyright Act 1968* (Cth) and has not been induced by duress or any false or misleading statement.

3. EMPLOYEE'S DUTIES

3.1 General and alternative duties

The Employee will serve the Organisation in the Position set out in Item 4 of Schedule 1 and perform the Duties set out in the Position Description. The Employee may reasonably be directed to perform alternative duties within the Employee's skills, capabilities and expertise as required.

3.2 Client Care

A primary duty of all employees, whether directly client facing or not, is to ensure the delivery of service to clients is of the highest quality. We expect all employees to contribute to our clients feeling safe and respected and to make sure they are cared for and protected from abuse, neglect and exploitation. All employees have a responsibility to report the inappropriate, or suspected inappropriate, treatment of clients to their manager.

3.3 Work Health, Safety and Environment

The Employee is obliged to follow all reasonable and lawful instructions, policies and procedures relating to health, safety, and the environment as directed by Officers or duly authorised delegates.

3.4 Fitness for Duty

a) The Employee must maintain the required fitness for duty necessary to perform the inherent requirements of the Position.

b) Where the Organisation has concerns about the Employee's fitness for duty or capacity to perform the inherent requirements, the Organisation may direct the employee to undergo a medical assessment by a nominated registered medical practitioner at the Organisation's expense. Any resulting recommendations or diagnosis provided by the registered medical practitioner may be relied upon by the Organisation to determine the Employee's ongoing ability to safely perform the terms of this agreement.

3.5 Additional duties

The Employee must:

a) devote the whole of the Employee's time, attention and skill during Ordinary Hours of Work and at other times as reasonably necessary, to the duties of office;
b) faithfully and diligently perform the duties and exercise the powers entrusted to the Employee from time to time;
c) promote the interests and prosperity and enhance the reputation of the Organisation;
d) comply with all reasonable and lawful orders and directions given to the Employee by the Organisation;
e) notify the Organisation of any charges or convictions gained during the course of the Employment;
f) comply with the Organisation's policies and procedures as amended from time to time;
g) not be engaged or interested in any other business or occupation (whether paid or unpaid), accept appointments as a director or other officer of any corporation or to the boards of committees or charities without the prior written consent of the Organisation; and
h) promptly disclose any breaches of the Organisation's policy and procedures including any serious misconduct or wrong doings (including but not limited to your own, other employees, volunteers, carers and/or external representatives to the Organisation).

4. REMUNERATION AND ENTITLEMENTS

4.1 Total Fixed Remuneration

a) Unless agreed otherwise, the Employee's Total Fixed Remuneration is comprised of the following:

i. Base Remuneration as set out at Item 5 of Schedule 1;
ii. Superannuation payable at 9.5%; and
iii. any additional benefits set out at Item 5 of Schedule 1.

b) The Total Fixed Remuneration (including the Base Remuneration, Superannuation and Additional Benefits) as set out in Item 5 of Schedule 1, is expressed as the full-time equivalent remuneration for the Position. Part-time employees will receive a pro-rata amount of the Total Fixed Remuneration based on the Ordinary Hours of Work as outlined in Item 9 of Schedule 1.

c) The Organisation will pay to the Employee the Base Remuneration component (pro-rata for part-time employees) of the Total Fixed Remuneration by electronic funds transfer on a fortnightly basis into the Employee's nominated account.

d) The Employee may apply to receive part of the Total Fixed Remuneration by way of other benefits which can be lawfully provided by the Organisation, in accordance with any relevant policies of the Organisation, as varied from time to time. The Employee may apply to receive these benefits, provided that:
i. the election is consistent with any policy of the Organisation, as varied from time to time; and
ii. the costs of the election to the Organisation (including any liability for Fringe Benefits Tax) do not result in the total payments and benefits being paid or provided to the Employee exceeding the Total Fixed Remuneration.

e) The Employee's Base Remuneration as set out at Item 5 of Schedule 1 includes and absorbs all entitlements the Employee may have to any and all minimum rates of pay, loadings, allowances, penalty rates or overtime payments (other than as set out in this Agreement) that arise under any statute, any applicable modern award or any other applicable industrial agreement.

f) Any remuneration set out at Item 5 of Schedule 1 that is in excess of the minimum rate of pay under any applicable statute or applicable industrial instrument may be set-off against (ie be taken to satisfy) any other monetary obligations imposed by that statute or instrument.

g) The rates used for calculating any set-off will be the relevant rates contained in the applicable instrument or prescribed under the applicable statute.

4.2 Superannuation

a) The Organisation will make superannuation contributions in accordance with the Employer Superannuation Component and for any additional amounts elected by the Employee to any complying superannuation fund nominated in writing by the Employee or, if no fund is nominated by the Employee, the Organisation's nominated superannuation fund provider at the time.

b) The Employee's Total Fixed Remuneration will be altered with any changes to the Employer Superannuation Component as provided by relevant legislation.

4.3 Expense Benefit Payment

a) As a Public Benevolent Institution, the Employee may be eligible to benefit from tax savings by packaging a portion of their Base Remuneration.

b) The Organisation bears no responsibility or liability, nor has any discretion as to whether you are eligible to receive this benefit. We recommend you seek independent advice in relation to the Expense Benefit Payment and any such matters.

4.4 Review

a) The performance of the Employee and the amount of the Base Remuneration may be reviewed as part of an annual review process which takes effect at such times as the Organisation in its absolute discretion determines throughout the Employment in accordance with Organisation policies. There is no expectation that remuneration will increase as a result of the annual review.

b) In undertaking such a review the Organisation may take into account all circumstances that it considers relevant, including but not limited to the performance of the Employee, the performance of the Organisation, the prevailing economic conditions, the Organisation's business requirements and the Organisation's capacity to pay.

4.5 Annual leave

a) The Employee will be entitled to Annual Leave as outlined in Item 14 of Schedule 1 and in accordance with the entitlements provided by the Fair Work Act or any subsequent legislation. Annual Leave will be accrued progressively throughout the year.

b) Where possible, Annual Leave is to be taken at times agreed between the parties, having regard to the Organisation's operational requirements.

4.6 Long service leave

The Employee will accrue Long Service Leave in accordance with the Governing Law of the State set out in Item 13 of Schedule 1 and any relevant Organisation policy.

4.7 Personal/Carer's leave

The Employee is entitled to paid Personal/Carers leave as outlined in Item 15 of Schedule 1 and in accordance with the entitlements provided by the Fair Work Act or any subsequent legislation.

4.8 Other leave

All other leave, including unpaid leave, compassionate leave, parental leave, parental partner leave, and community service leave, will be provided to the Employee in accordance with the Organisation's policy or the Fair Work Act, whichever is more generous.

4.9 Public holidays

The Employee will be entitled to paid absence from work on the public holidays referred to in the Fair Work Act. The Organisation may request the Employee to work on a public holiday and this will be a matter for discussion between the Employee and the Organisation at the time of any such request.

4.10 Guarantee of Annual Earnings

The Employee is not provided with a Guarantee of Annual Earnings

5. PROTECTION OF BUSINESS

5.1 Confidentiality Obligations

a) Employee's obligations

The Employee must:

i. keep any **Confidential Information** which the Employee has received (whether before the date of this Agreement and in whatever capacity) secret and confidential, except to the extent that the Employee is required by law to disclose it;
ii. take all reasonable and necessary precautions to maintain the secrecy and prevent the disclosure of any Confidential Information;
iii. refrain from using or attempting to use Confidential Information in any manner which will or may cause or be calculated to cause injury or loss to the Organisation or its customers or clients; and
iv. not, except in the ordinary and proper course of employment with the Organisation, use or disclose or allow to be used or disclosed any Confidential Information to any third party without the prior written consent of the Organisation.

b) Survival of obligations

The Employee's confidentiality obligations survive the termination of this Agreement.

5.2 Ownership of Intellectual Property Rights

a) Ownership

i. Subject to any written agreement to the contrary, all Intellectual Property Rights created by the Employee solely or jointly with others in the course of the Employee's employment automatically vest in the Organisation.
ii. Employee must disclose Inventions.
iii. The Employee must disclose to the Organisation the full details of any Invention. The Employee agrees that all rights in such Invention will belong to the Organisation.

b) Assistance

The Employee must at the request and expense of the Organisation do all things necessary or desirable to vest in the Organisation or its nominee absolutely as legal and beneficial owner all rights, title and interest in:

i. any Intellectual Property Rights created by the Employee in the course of the Employee's employment, including executing any documents which are reasonably required by the Organisation; and
ii. any Invention, including securing patent or other protection anywhere in the world and executing any documents which are reasonably required by the Organisation.

c) Inventions

The Employee must not disclose or make use of any Invention with external parties without the Organisation's prior written consent.

d) No prejudice

The Employee will not do or fail to do any act which would, or might, prejudice the rights of the Organisation under this clause.

e) Survival of obligations

The Employee's intellectual property obligations survive the termination of this Agreement.

6. TERMINATION AND SUSPENSION

6.1 Notice of Termination

a) This Agreement may be terminated at any time by either the Organisation or the Employee giving the notice prescribed in Item 17 of Schedule 1, or by the Organisation giving the Employee pay in lieu of notice for part or all of the notice period

b) Following the giving of notice by the Organisation or the Employee, the Organisation at it discretion do any of the following (or a combination thereof):

i. make payment in lieu of part or all of the notice period

ii. require the Employee to perform alternative or no duties

iii. require the Employee not to attend work

6.2 Immediate Termination – Summary Dismissal

The Organisation may terminate this Agreement immediately without notice, if the Employee commits any act constituting serious misconduct including, but not limited to, acts of dishonesty, theft, fraud, violence, serious breaches of occupational health & safety procedures, wilful disobedience, breach of duty, or persistent breaches of the Organisation's policies or provisions of this Agreement.

6.3 Return of Equipment

On termination of this Agreement the Employee must return to the Organisation all property of the Organisation including all Confidential Information, books, any physical means of storing the Organisation's Confidential Information such as, but not limited to: laptops, tablets, mobile phones, discs or USB sticks, documents, papers, materials, credit cards, cars and keys held by or under the control of the Employee.

6.4 Deductions

Subject to law, the Organisation has the right to seek to recover any sums owed to the Organisation. The Employee agrees to provide authorisation to the Organisation in writing to deduct from their pay or otherwise recover any amounts owing to the Organisation.

6.5 Suspension

The Organisation may suspend the Employee from their Employment for any period on full pay, including to investigate any concerns the Organisation has regarding the Employee's performance or conduct, or a suspected breach of this Agreement. The Employee must continue to comply with all terms of this Agreement and the policies and procedures of the Organisation during the period of suspension.

6.6 Termination for Redundancy

In the event the Employee's employment is terminated on the basis of redundancy, the Employee will be entitled to a severance payment in accordance with the Fair Work Act.

7. GENERAL

7.1 Policies, Procedures and Code of Conduct

a) The Employee agrees to comply with the Organisation's policies and procedures.

b) These policies, procedures and code of conduct may be amended and varied by the Organisation from time to time. It is the obligation of the Employee to ensure they understand the terms and conditions of the Organisation's policies and procedures and maintains currency with these policies and procedures as they may change from time to time at the organisation's discretion.

c) The employee acknowledges and accepts that the Organisation's policies and procedures are not incorporated into this Agreement and do not form part of the Employee's contract of employment.

7.2 Governing law

This Agreement is governed by the laws of the State detailed in Item 13 of Schedule 1.

7.3 Severance

If a clause is void, illegal or unenforceable, it may be severed without affecting the enforceability of the other provisions in this Agreement.

7.4 Continued operation

Despite any change to the Employee's place of work, position description, Duties, Remuneration or any matters contained in Schedule 1, this Agreement will continue to apply to the parties unless otherwise agreed in writing.

7.5 Entire Agreement

This Agreement supersedes all previous agreements or representations in respect of the Employee's employment by the Organisation and embodies the entire Agreement between the parties.

7.6 Amendment

This Agreement can only be amended by agreement in writing by both parties. Any understanding, agreement, representation or warranty outside of this Agreement which relates to the Employee's employment has no effect unless it is an agreement in writing, with terms duly authorised by a relevant delegate of the Organisation, and signed by both parties.

7.7 Effect of waiver

The waiver by either party of a breach of any provision may not be held to be a waiver of any later breach of the provision or a waiver of the provision itself.

8. DEFINITIONS

In this Agreement, unless the context of the clause indicates an alternative intention:

Agreement means this agreement.

Award means the *Social, Community, Home Care and Disability Services Industry Award 2010*, or any subsequent Award.

Business Day means any day that is not a Saturday, Sunday or Public Holiday.

Commencement Date means the date set out in Item 1 of Schedule 1.

Confidential Information means the confidential information of the Organisation relating to the Organisation or its operations or business affairs and includes, but is not limited to:

a) financial information and policies, business plans, strategic plans, acquisition or business expansion plans, pricing policies and reporting procedures of the Organisation whether relating to past, present or future operations of the Organisation;
b) the Organisation's past, present and future client information, including client identity and terms of dealing with specific clients;
c) the Organisation's past, present and future supplier information, including supplier identity, price for supply, terms and conditions of supply and the value of accounts to suppliers;
d) the Organisation's past, present and future employee information, including terms of employment and remuneration packages;
e) information marked as confidential or which the receiving party could reasonably regard as confidential; and
f) the Organisation's general know-how and procedures whether or not marked as confidential;
g) but Confidential Information does not include information which:
    i. is legally in the public domain or is generally known or is available by publication; or
    ii. the receiving party either already possesses at the time of disclosure to it by the disclosing party or independently acquires except through a breach of an obligation of confidentiality by any third party.

Duties means the duties described in the Position Description.

Employee means the person listed in Item 3 of Schedule 1.

Employer Superannuation Component means the contributions the Organisation is required to make to a complying superannuation fund as a result of the operation of the *Superannuation Guarantee (Administration) Act 1992* and the *Superannuation Guarantee Charge Act 1992*.

Fair Work Act means the *Fair Work Act 2009* (Cth).

Intellectual Property Rights means all present and future rights to:

a) trademarks, trade names, domain names, logos, set-up, patents, inventions, registered and unregistered design rights, copyrights, circuit layout rights, and all similar rights in any part of the world (including know-how); and
b) where the rights referred to in paragraph a) are obtained or enhanced by registration, any registration of such rights and applications and rights to apply for such applications.

Invention means any discovery, invention, design, development, technique, idea, method, secret process, system or improvement made or discovered by the Employee (alone or with others) during the course of the Employee's Agreement with the Organisation, in connection with or in any way affecting or relating to the

Organisation's operations or capable of being used or adapted for use by the Organisation or in connection with its operations.

Materials means all things brought into existence by the Employee in the course of their employment by the Organisation including inventions, ideas, discoveries and improvements (whether patentable or not); information and data, designs, drawings, presentations, proposals, reports, lists, plans and software.

Moral Rights means the right of attribution of authorship, the right not to have authorship falsely attributed, the right of integrity of authorship, or any other similar rights arising under any statute, including the *Copyright Act 1968* (Cth).

Ordinary Hours of Work means the hours stated in Item 9 of Schedule 1.

Organisation means Life Without Barriers ACN 101 252 171.

Position means the position set out at Item 4 of Schedule 1.

Probity is an assessment of the Employee's suitability and clearance to perform the role. This assessment includes a review of the Employee's national criminal history and police record and any other State based checks as legislated by governing law or in accordance with the Organisation's policies and procedures.

Total Fixed Remuneration means the Employee's Total Fixed Remuneration, as set out in Item 5 of Schedule 1.

Work means the performance of the Duties in the course of employment.

8.1 Interpretation

In this Agreement, headings are for convenience only and do not affect the interpretation of this Agreement and, unless the context otherwise requires:

a) a reference to termination of this Agreement includes a reference to termination of the Employee's contract of employment;
b) the singular includes the plural and vice versa;
c) words that imply a gender include all other genders;
d) a word that is derived from other parts of speech and grammatical forms of a word or phrase defined in this Agreement have a corresponding meaning;
e) an expression that implies or refers to a natural person includes any Organisation, sovereign state, government, government department or agency, partnership, joint venture, association, unincorporated association, corporation or other body corporate and vice versa;
f) a reference to a statute, regulation, proclamation, ordinance or by-law includes all statutes, regulations, proclamations, ordinances or by-laws amending, consolidating or replacing it, whether passed by the same or another government agency with legal power to do so, and a reference to a statute includes all regulations, proclamations, ordinances and by-laws issued under that statute; and
g) a reference to a document or agreement includes all written amendments or supplements to, or replacements or novation's of, that document or agreement.

WE
LIFE WITHOUT BARRIERS
VE

EMPLOYMENT AGREEMENT ACCEPTANCE

The signatures of the parties on this page confirm their mutual acceptance of the terms and conditions of this Employment Agreement and Schedule.

ORGANISATION AUTHORISED REPRESENTATIVE

Executed online by:

Name: Leanne Millard

Position: Operations Manager

Date: 06 June 2018

EMPLOYEE

Signed: Executed online by Deborah Lee Anderson

Name: Deborah Lee Anderson

Address: 17/3 Parkside Parade, TORONTO NSW 2283

Date: 06/06/2018

Position Title:	Shared & Supported Living Coordinator

Position Purpose & Scope

Purpose & Objective	The Shared & Supported Living Coordinator ensures that customers who require a high level of support are enabled to live in their home, and in their community. The role coordinates and delivers a range of supports that reflect the customer's individual needs and goals as described in their Service Agreement. The Shared & Supported Living Coordinator is responsible for engaging with customers, families, guardians and other key stakeholders so as to facilitate a cohesive, quality and inclusive support system around the customer. The incumbent takes a leadership role in organising, supervising and coaching support workers around a customer or group of customers.	
Business Unit	Client Services	
Reporting Relationships	**Direct Manager**	Shared and Supported Living Manager
	Direct Reports	Between 1-30 (this comprises F/T, P/T, casual workforce) *the number of direct reports will depend upon program / operational requirements*
Delegated Authority	Level 8 - Specific delegations are outlined in the Delegation of Authority Schedule - http://intranet.lwb.local/su/practiceandquality/qa/Pages/Delegations.aspx	

Organisation Purpose & Values

Our Purpose	To partner with people to change lives for the better.
Our Values	Our Values state our beliefs. They define our purpose and drive everything we do. Our Values fuel our passion for working with people and by living our Values, we are in a better position to champion opportunities for the people we work with and support. All people engaged by Life Without Barriers are required to uphold our Values of; *Responsive*, *Imaginative*, *Courageous*, *Respectful* and *Relationships*.
Our Stance on Child Safety & Wellbeing	Every day, Life Without Barriers offers support and care to children. We want each and every one of those children to feel as safe and respected as they should. We all have a responsibility to make sure their safety comes first – and that they're well cared for, protected from abuse and given the respect they deserve.

Key Responsibilities

Support Customers	• Work within relevant legislation, LWB policy and procedures and the National Disability Service Standards to ensure that Shared & Supported Living supports are delivered which reflect the customer's Service Agreement with LWB. • Engage with customers to build rapport and understand their needs, preferences and expectations; where required, work directly with customers • Ensure that direct support is delivered, as far as possible, by the support worker who best matches the customer in terms of relevant skills, capability and interests.

	• Build positive relationships with stakeholders by:
	  ○ working directly families, guardians and mainstream services to enhance opportunities for the customer in their communities
	  ○ engaging with health professionals, support coordinators, community, other agencies and other stakeholders including advocate
	• Actively develop and maintain an environment and ecology that balances the needs of any other customers who share the same residence; for example type of residence, compatibility.
	• Monitor, and where appropriate, adjust support based on the customer's changing needs.
	• Advocate where required with the NDIA, support coordinators, families, guardians and other stakeholders to respond to customer changing needs or goals.
	• Respond to feedback and complaints promptly.
	• Routinely utilise the established mechanisms, including client scheduling system, technical solutions and documentation systems to ensure that support is provided, outcomes are recorded and a transparent and accountable service is delivered.
	• Complete service satisfaction activities as directed by manager

Team Leadership	• Provide guidance, supervision and support to direct support staff. • Promote a positive environment through demonstrating good communication and interpersonal skills and appropriate peer support. • Model appropriate conflict resolution, communication and positive behaviour management skills. • Escalate any issues of concern to the manager immediately, where a serious risk of harm or to reputation is apparent
Organisational Responsibilities	• Communicate and act in ways that are consistent with Life Without Barriers Values of *Responsive*, *Imaginative*, *Courageous*, *Respectful* and *Relationships* • Provide an environment free of abuse, harm and exploitation for people we support • Support and promote the work of Life Without Barriers, maintaining a positive image of the organisation in accordance with the level of position. • Comply with all Life Without Barriers policy, code of conduct, procedures and practices, external funding body requirements and legislation. • Apply and uphold the principles of a respectful, inclusive and diverse workplace, free from discrimination, harassment or bullying • Adhere to organisational and legislative Health, Safety and Environment requirements.

Required Knowledge, Skills & Experience

Qualifications & Licenses	• Minimum Cert IV or equivalent in Disability, Mental Health or Community and Social Services • First Aid Certificate • Current driver's license
Required Experience	• Demonstrated experience in similar role and / or relevant experience in providing and improving customer support/service

	• Demonstrated experience in supporting complex customers (clients) • Demonstrated experience in working both independently and as part of a team • Demonstrated coordination and leadership experience • Demonstrated experience in managing competing priorities and to deliver outcomes within agreed timeframes and quality standards
Essential Knowledge & Skills	• An excellent understanding of the principles of the National Disability Insurance Scheme (NDIS) and relevant legislation • Demonstrated commitment to customer choice, inclusion and quality practice • Demonstrated knowledge of contemporary disability practice approaches including but not limited to, positive behaviour support, medication management and complex medical management. • Demonstrated leadership and coaching skills, with the ability to build a shared understanding of, and commitment to the organisation's Purpose and Values • The ability to work collaboratively and in partnership with a range of stakeholders including customers, peers, employees, external organisations, funding bodies and government agencies • Ability to support organisation-wide initiatives that support Life Without Barriers' Purpose and Values • Excellent verbal and written communication skills • Demonstrated understanding and / or ability to use Data Bases and Microsoft Office suite of programs, for example Outlook, Word and Excel • Ability to work in a complex environment and respond appropriately to high risk or critical events and situations • Demonstrated problem solving and conflict management skills and an ability to think creatively and use initiative

Additional Requirements & Conditions

Probity Requirements	All positions within Life Without Barriers will be required to undergo probity checks including criminal record checks and working with children checks (where relevant to the position) and as outlined in their Contract of Employment.
Work Hours	As per Contract of Employment, the incumbent may be required to work reasonable additional hours to fulfil the requirements of the position. To fulfil the requirements of the position the incumbent may be required to be on-call and / or work an alternating work pattern e.g. day and afternoon pattern on a fortnightly basis.
Travel	The position may require the incumbent to travel to various work locations to discharge the responsibilities of the position

ATTACHMENT B

17/06/2019	1	Deb	Michael	Carlos/Cha	Jo	Char/Jamie	Melissa/Ca	Jamie/Char
24/06/2019	2	Carlos	Melissa/Jo	Char	Michael/Cl	Jamie	Deb	Jo
1/07/2019	1	Jamie	Deb	Char	Jo	Melissa	Michael/Jo	Carlos/Cha
8/07/2019	2	Melissa	Jo	Carlos/Lee	Leesa/Carl	Deb	Char	Jamie
15/07/2019	1	Deb/Char	Char/Deb	Leesa	Jamie	Carlos	Jo/Char	Melissa/ Jo
22/07/2019	2	Jo/Jamie	Carlos	Char/Leesa	Melissa/Jo	Leesa	Jamie/Jo	Deb
29/07/2019	1	Melissa/Jo	Jo/Natalie	Jamie/Jo	Char/Deb	Deb/Char	Carlos	Leesa
5/08/2019	2	Carlos/Deb	Deb/Carlos	Jo	Leesa/Chai	Melissa/Le	Jo	Char
12/08/2019	1	Deb	Leesa	Jamie	Jo	Char	Melissa/Ch	Jamie
19/08/2019	2	Jo	Melissa/Le	Char	Leesa	Jamie	Deb	Jo
26/08/2019	1	Jamie	Deb	Char	Jo	Melissa/Na	Leesa	Jo
2/09/2019	2	Melissa /H	Jo	Natalie	Hayley	Deb	Char/Deb	Jamie/Lees
9/09/2019	1	Deb	Char	Leesa	Jamie	Hayley	Jo	Melissa
16/09/2019	2	Jo	Hayley	Char	Melissa	Leesa	Jamie	Deb
23/09/2019	1	Melissa	Jo	Jamie	Char	Deb	Hayley	
30/09/2019	2	Hayley	Deb	Jo	Leesa	Melissa	Jo	Char
7/10/2019	1	Deb	Leesa	Hayley	Jo	Char	Melissa	Jamie
14/10/2019	2	Hayley	Melissa	Char	Leesa	Jamie	Deb	Jo
21/10/2019	1	Melissa	Jo	Jamie	Char/Mich	Deb	Carlos	Michael/Ch
28/10/2019	2	Carlos	Deb/Jo	Jo/Deb	Michael/Jo	Melissa	Jamie	Char
4/11/2019	1	Deb	Michael	Carlos/Cha	Jo	Char/Jamie	Melissa/Ca	Jamie/Char
18/11/2019	2	Carlos	Melissa/Jo	Char	Michael/Cl	Jamie	Deb	Jo
25/11/2019	1	Jamie	Deb	Char	Jo	Melissa	Michael/Jo	Carlos/Cha
2/12/2019	2	Melissa	Jo	Carlos/Lee	Leesa/Carl	Deb	Char	Jamie
9/12/2019	1	Deb/Char	Char/Deb	Leesa	Jamie	Carlos	Jo/Char	Melissa/ Jo
16/12/2019	2	Jo/Jamie	Carlos	Char/Leesa	Melissa/Jo	Leesa	Jamie/Jo	Deb
23/12/2019		Monday	Tuesday	Wednsday	Thursday	Friday	Sat	Sun
30/12/2019		this is a 2 week roster						

BEFORE THE FAIR WORK COMMISSION
MATTER NO. AM2014/286
S. 156 - Four yearly review of modern awards – Social, Community, Home Care and Disability Services Industry Award 2010

STATEMENT OF JUDITH WRIGHT

I, Judith Wright, Union Official, of [redacted], in the State of New South Wales, say;

1. I am the Deputy Secretary of the Australian Services Union, NSW & ACT (Services) Branch ('**the NSW Branch**'). I am also a member of the Australian Services Union National Executive. I have held these positions since April 2015. I have been an official of the Branch for ten years. Prior to taking up the position of Deputy Secretary, I was a Senior Industrial Officer from 2009 then Assistant Secretary responsible for industrial services from 2012.

2. Prior to working for the NSW Branch I practiced as a solicitor in New South Wales then New Zealand.

3. I have responsibility, amongst other things, for the legal and industrial activities of the NSW Branch. I have significant experience dealing with the Social and Community Services Sector (SACS), in:

    a. Being responsible for ten years for the NSW Branch's Industrial Services Team which provides advice and representation to ASU members in the SACS sector in relation to workplace grievances, disciplinary matters, unfair dismissal cases, Award and Agreement entitlements, classification issues, workplace health and safety, discrimination and bully and harassment matters.

    b. Representing SACS members in Enterprise Bargaining.

    c. Appearing in the Fair Work Commission in a range of matters affecting SACS members including disputes, adverse action and unfair dismissal matters, and the 2012 and 2015 SCHADS Award Reviews.

4. In my position as Senior Industrial Officer, I was involved in the Social, Community and Disability Services Industry Equal Remuneration Case. I worked extensively on the case from the time the application was lodged in March 2010 until the final order was made in June 2012. I briefed and instructed Counsel throughout the hearing, organised all of the workplace

inspections in New South Wales, attended all of the workplace inspections in New South Wales and Queensland, prepared all of the witness statements for witnesses based in New South Wales and the ACTU and some in other states and territories, engaged all of the expert witnesses called by the ASU and assisted with research and written submissions.

5. I have been shown the submissions filed by the Australian Business Industrial on 2 July 2019. I note that at paragraph 5.2, they assert that clause 25.5(f) '*already applies to a significant part of the disability services sector, as it applies to services provided to people with a disability in their home.*' They base this assertion on the description of '*Home Care Sector*' at clause 3.1 of the *Social, Home Care and Disability Services Award 2010* ('**the Award**').

6. Clause 25.5(f) does not apply to any part of the Disability Services sector, it only applies to employees classified under Schedule E of the Award as Home Care employees. Employees providing disability services are properly classified under the Social and Community Services Sector classification definitions (Schedule B of the Award). This work is distinct from work carried out by home care employees (covered by Schedule E of the Award) for people with a disability.

7. Clause 3 of the Award relevantly describes the Social and Community Sector as follows:

> ***social and community services sector*** *means the provision of social and community services including social work, recreation work, welfare work, youth work or community development work, including organisations which primarily engage in policy, advocacy or representation on behalf of organisations carrying out such work and the provision of disability services including the provision of personal care and domestic and lifestyle support to a person with a disability in a community and/or residential setting including respite centre and day services. To avoid doubt, an employee will not be precluded from being engaged under Schedule B, instead of another schedule, merely because they provide services in a private residence or in outreach.* (emphasis added)

8. Disability services involves the provision of personal care and domestic and lifestyle support and/or training to a person with a disability including in a community setting whether residential or non-residential, a respite centre, a day service facility or in a private residence where work in that residence involves either teaching, promoting or maintaining living skills, client, advocacy, promoting or supporting community access and social inclusion or developing or assisting in developing care or support plans including assessment of client needs.

9. Disability services (classified under Schedule B of the Award) can be distinguished from the provision of home care services to people with a disability (classified under Schedule E). These are roles where the workers only provide personal care for a client.

10. The distinction between Home Care employees and Social and Community Services employees undertaking disability services was the subject of controversy during the Equal Remuneration Case 2010-2012. In that case, the Australian Federation of Employers and Industries sought to clarify that the proposed Equal Remuneration Order did not apply to employees covered by Schedule E of the Award.

11. The parties came to an agreed position, which was filed by AFEI and marked as Exhibit AFEI 6. Attached and marked **Annexure A** is a copy of Exhibit AFEI 6.

JUDITH WRIGHT

Dated: 12 September 2019

ANNEXURE A

EXHIBIT: AFEI 6

Extract from transcript: 11 February 2011 — PN5572–PN5583

AFEI Letter to ASU: 9 February 2010

ASU Letter to AFEI: 22 February 2011

Extract from transcript: 3 February 2011 — PN3155–PN3177

Extract from Witness Statement – Sally McManus: ASU Exhibit 34 – page 21 and 22

PN5572

JUSTICE GIUDICE: Very well. In the circumstances, what we'll do is vary the timetable to provide for the New South Wales government to file submissions by 30 March and for the Victorian - I'm sorry. Just a moment. What date does the caretaker period commence?

PN5573

MS DOUST: The caretaker period commences on 4 March.

PN5574

JUSTICE GIUDICE: Yes. So what I had in mind was an extra couple of days only which would take it to 2 March for the New South Wales submissions.

PN5575

MS DOUST: We would be grateful for that, your Honour.

PN5576

JUSTICE GIUDICE: In relation to Victoria, then that will be 21 March.

PN5577

MS DOYLE: Yes, your Honour.

PN5578

JUSTICE GIUDICE: Otherwise the timetable will not be varied. Yes, any other matters? Mr Warren, yes.

PN5579

MR WARREN: Your Honour, one short matter. I raised prior to the luncheon adjournment, I indicated there was a difficult issue that the AFEI had. We've had some discussions over the luncheon adjournment and it appears to have been resolved. In short frame, it grew out of the cross-examination of Mr Di Troia and his evidence with respect to the coverage of the home care industry by this proposed order. A letter has been written by AFEI to Mr Harvey. I understand that Mr Harvey or his union will be responding to AFEI next week in writing and that may well resolve the matter and we will inform the tribunal of that resolution.

PN5580

JUSTICE GIUDICE: Right.

PN5581

MS DOUST: I have (indistinct) relates to the questionnaires that Ms Lowson raised earlier on. I think she indicated that it's proposed to have them. I'll ultimately post it to the web site if that occurs on the basis that they de-identify (indistinct) witnesses who have been treated. That became contentious if we (indistinct) basically supported that position, but as I understand it there's going to be some more discussions occurring anyway between Ms Lowson and Mr Warren.

PN5582

JUSTICE GIUDICE: Yes.

PN5583

MS LOWSON: Your Honour, could I just put on the record my thanks to Judith Wright and Keith Harvey for the work that they've done during the course of these proceedings; in particular juggling witnesses and re-scheduling matters and arranged a couple of matters that has helped the matter proceed more smoothly.

AFEI
Australian Federation of Employers & Industries

9 February 2010

Mr Keith Harvey
National Industrial Officer
ASU National Office
Ground Floor, 116 Queensberry St.,
Carlton South VIC 3053

Via email: kharvey@asu.asn.au

Dear Mr Harvey,

Re: FWA Matter No.: C2010/3131 – Application for Equal Remuneration Orders

We write with regard to the above matter and in particular seek clarification of the intended scope of the Equal Remuneration Order (ERO) sought by the applicants.

We note with concern that the evidence of Mr David Di Troia given in cross examination to Fair Work Australia on 3 February 2010 (PN3170) indicated that he understood the application is intended to cover employees in the Home Care Industry.

We note also that, whereas the Social, Community, Home Care and Disability Services Industry Award 2010 contains a separate classification structure for Home Care Employees (Schedule E), the amended application dated 23 December 2010 does not.

The Home Care Industry, in our view, is comprised of a significant number of *for profit* organizations which operate on a fee for service basis without assistance through government funding.

We request, as a matter of urgency, clarification as to whether it is the intention of the applicants that the ERO sought by the applicants apply to the Home Care Industry.

If you require any further information, please call me on (02) 9264 2000.

Yours faithfully,

Tony Doyle
Manager – Workplace Relations

LEVEL 2, 97-99 BATHURST STREET, SYDNEY 2000 PO BOX A233, SYDNEY SOUTH NSW 1235
PHONE: 02 9264 2000 FAX: 02 9261 1968 WEB: WWW.AFEI.ORG.AU EMAIL: ADMIN@AFEI.ORG.AU
TRAINING SERVICES FAX: 02 9264 5699 EMAIL: TRAINING@AFEI.ORG.AU

A•S•U

File/Our Ref: C2010/3131 KH
Your Ref:
Please quote in reply

Tuesday, 22 February 2011

Mr T Doyle
Manager – Workplace Relations
AFEI

By email: Tony.doyle@afei.org.au

Dear Mr Doyle,

Re: FWA Matter No.: C2010/3131 – Application for Equal Remuneration Order – Home care employees

I refer to your letter dated 9 February 2010 [sic].

The intended scope of the Application is clearly defined in paragraphs 3 and 4 of the Amended Application filed on 23 December 2010. It covers employers and employees engaged in:

> *The provision of personal care and domestic and lifestyle support and/or training to a person with a disability including in a community setting whether residential or non-residential, a respite centre, a day service facility or in a private residence where work in that residence involves either teaching, promoting or maintaining living skills, client advocacy, promoting or supporting community access and social inclusion or developing or assisting in developing care or support plans including assessment of client needs.* [See definition of Disability Services Sector at paragraph 3.1 of the Amended Application].
>
> and/or
>
> *The provision of social and community services including social work, recreation work, welfare work, youth work or community development work, including organisations which primarily engage in policy, advocacy or representation on behalf of organisations carrying out such work.* [See definition of Social and Community Services Sector at paragraph 3.1 of the Amended Application].

The Application is not intended to cover employers and employees of "the home care sector" as defined in paragraphs 139 and 140 of Exhibit 34 (witness statement of Sally McManus) as follows:

> *There are some roles where workers are supporting people with a disability or an aged person which do not fit the definition of "disability services sector" or "social and community services sector" work. Therefore, these roles do not fall under the classification definitions in Schedule B of the Order sought in this matter. These are roles where the workers only provide personal or physical support for a client. A typical example of this is the type of support required for clients who have a physical disability but do not have an intellectual disability.*

Australian Services Union

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National Secretary
Paul Slape

Assistant National Secretaries
Greg McLean
Linda White

For example, a person who depends on a wheelchair may need assistance getting out of bed, showering, dressing and with housework. However, they may not need and are not provided with other support such as living skills. These clients would live in their own homes and otherwise live independently. The workers who provide this role would be considered to work in the home care sector.
The same example could be given where workers are providing only personal care, domestic assistance or home maintenance for an aged person in their own homes. These workers are part of the home care sector.

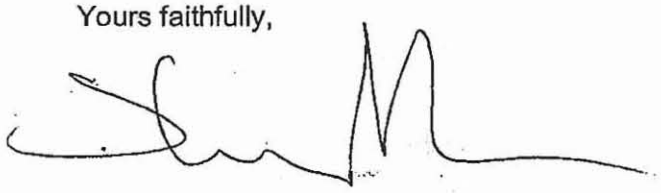
However the Application does cover the following work which may be performed at a client's home and which falls within the definitions of Disability Services Sector and/or Social and Community Services Sector:

- The provision of personal care and domestic and lifestyle support and/or training to a person with a disability involving either teaching, promoting or maintaining living skills, client advocacy, promoting or supporting community access and social inclusion or developing or assisting in developing care or support plans including assessment of client needs.
- Provision of outreach or home visiting for aged people to identify needs or to provide support of a social or welfare nature, which could include support with organising appointments, monitoring medications, assistance with communication, meal planning, accompaniment on outings and the coordination of home care services.
- Recruiting and organising volunteers or paid workers to visit aged people in their homes as part of overcoming social exclusion.

We understand that the term "Home Care Industry" has different meanings in different parts of Australia so we trust that the contents of this letter makes clear the scope of the Application.

Please contact me if you require further clarification.

Yours faithfully,



Keith Harvey
National Industrial Officer

PN3155
JUSTICE GIUDICE: Defer it, yes, very well. All right, we'll adjourn now until 2 o'clock.

<SHORT ADJOURNMENT [12.56PM]

<RESUMED [2.04PM]

PN3156
MS LOWSON: Your Honours, Commissioners, the next witness is David Di Troia.

PN3157
JUSTICE GIUDICE: Yes.

<DAVID DI TROIA, SWORN [2.05PM]

<EXAMINATION-IN-CHIEF BY MS LOWSON [2.05PM]

PN3158
MS LOWSON: Would you tell the tribunal your current occupation?---I'm the branch secretary of the LHMU's South Australian branch.

PN3159
Did you, for the purpose of these proceedings, prepare a statement?---Yes, I have.

PN3160
Do you have a copy of that with you?---Yes, I do.

PN3161
Can I just take you to paragraph 24 of that statement?---Yes.

PN3162
There's a reference there in the first line to "local government sector". Do you see that?---Yes, I do.

PN3163
Is that meant to refer to the state government sector?---Yes, the word "local" should be replaced with the word "state".

PN3164
With that amendment, is the content of your statement otherwise true and correct to the best of your knowledge and belief?---Yes.

PN3165
I tender that statement.

PN3166
JUSTICE GIUDICE: It will be exhibit ASU39.

EXHIBIT #ASU39 STATEMENT OF DAVID DI TROIA

PN3167
MS LOWSON: Yes, thank you, your Honour. I have no further questions.

<CROSS-EXAMINATION BY MR WARREN [2.07PM]

PN3168

MR WARREN: Mr Di Troia, you mention in your evidence in paragraph 2 of your statement that you speak of your branch membership. Does your branch membership spread across government and non-government employees, the non-government employees being in the SACS sector?---Yes, it does.

PN3169

So when you speak in paragraph 2 of your branch membership records - "64 per cent of these members are women" - that's a mix. Those women you are therein referring to are a mix of both SACS and government employees? ---I believe so.

PN3170

In paragraphs 3, 4 and 5 at least, you mention the home care classification stream. Is it your position that persons employed in home care would be covered by the order sought in these proceedings?---That's my understanding.

PN3171

Could I take you to annexure A to your statement please, Mr Di Troia?---Yes.

PN3172

Are you familiar with the enterprise agreements therein contained?---Other than seeing a final copy of those documents at the time of signing, I've not had any involvement in the negotiations of those agreements listed in attachment A. What I can say is that since tendering my statement in relation to the Minda agreement, I had some involvement in finalising the new agreement.

PN3173

There has been a new agreement?---Yes, there has.

PN3174

If I could just take you to attachment A?---Yes.

PN3175

I want to put a proposition to you. If you're unable to answer it, please say so. I'm suggesting to you that the enterprise agreements listed as Anglicare, Hills Community, Community Living Options, La Vida, Elizabeth Bowey Lodge, Helping Hand Aged Care, all specifically have a capacity of the employees covered by those agreements to have beneficial concessional tax with respect to fringe benefits tax within the agreements?---Look, I'm not in a position to answer that.

PN3176

You're not in a position because you don't have particular knowledge of those agreements?---I don't have the knowledge of what I'm suggesting you're putting to me - is that there are some salary sacrifice arrangements.

PN3177

Yes?---I'm not aware as to the actual arrangements when it comes to salary sacrificing.

The Nature of Work in the Disability Sector

132. Over the last fourteen years of being an official at my Branch, I have had extensive interaction with workers and employers in the disability sector. I have visited many workplaces where our members in the disability sector work; these include residential facilities, day program facilities and offices. I have had discussions with hundreds of workers in the disability sector, I have met many clients who use the services our members work in, I have had discussions with all the major employers in the sector in NSW and been directly involved in many industrial disputes in the disability sector. For these reasons, I am very familiar with nature of work undertaken by our members in the disability sector in NSW.

133. Since November 2008 I have been a member of the National People with Disabilities and Carer Council. I was appointed by the Federal Government to this Council whose role is to advise the Australian Government on the needs of people with disability, their families and carers. Through this role, I have met and had many discussions with employers in other States, as well as people who advocate for service users (or clients) of these disability services.

134. According to our membership records our Branch has about 2000 members employed in the disability sector.

135. I have read the witness statements of W59, W60, W64, W65, W66, W67, and Lloyd Williams. The nature of the work they describe accurately reflects the work performed by the members of our Branch in the disability sector. There are some differences in terminology only, for example, in NSW residential services for people with disabilities are referred to as "group homes", not "community residential units".

136. W60 works at Kirinari Community Services (Kirinari). She works both in NSW and in Victoria. I have visited workplaces and met members and clients from Kirinari in Albury, the Blue Mountains and Inverell. I have also been involved in negotiating their enterprise agreements over many years. The nature of the work W60 describes is the same as the work performed by residential disability sector workers throughout NSW. The only differences are differences that come about because of the particular mix of clients.

137. Workers in the disability sector develop or implement individual or person plans for each of the clients they support.

138. Many workers in the disability sector will perform duties that are of a personal care nature, however this is only part of their role. They implement personal plans that cover all aspects of a person's life. They also perform work that includes teaching, promoting or maintaining living skills, client advocacy, promoting or supporting community access and social inclusion.

139. There are some roles where workers are supporting people with a disability or an aged person which do not fit the definition of "disability services sector" or "social and community services sector" work. Therefore, these roles do not fall under the classification definitions in Schedule B of the Order sought in this matter. These are

roles where the workers *only* provide personal or physical support for a client. A typical example of this is the type of support required for clients who have a physical disability but do not have an intellectual disability. For example, a person who depends on a wheelchair may need assistance getting out of bed, showering, dressing and with housework. However, they may not need and are not provided with other support such as living skills. These clients would live in their own homes and otherwise live independently. The workers who provide this role would be considered to work in the home care sector.

140. The same example could be given where workers are providing *only* personal care, domestic assistance or home maintenance for an aged person in their own homes. These workers are part of the home care sector.

141. There are roles within the social and community sector where workers will be providing outreach or home visiting aged people to identify needs or to provide support of a social or welfare nature. These workers are part of the social and community services sector. Similarly, there are roles within the social and community sector that involve recruiting and organising volunteers or paid workers to visit aged people in their homes as part of overcoming social exclusion. These workers are considered part of the social and community services sector. In NSW these workers are funded by the Home and Community Care (HACC) program or Federal Government Aged Care packages funding.

Public Sector Awards

NSW

142. The following public sector awards apply to persons performing the same or similar work as performed in the SACS industry in New South Wales:

a. *Crown Employees (New South Wales Department of Ageing, Disability and Home Care) Community Living and Residential Award* – applies to Disability Support Workers and Team Leaders employed by the New South Wales Department of Ageing, Disability and Home Care;

b. *Crown Employees (Administrative and Clerical Officers - Salaries) Award 2007* - applies to Case Workers employed by the Community Services NSW, Client Service Officers employed by Housing NSW and Alcohol & Other Drug Officers, Welfare Officers and Accommodation Support Officers employed by Corrective Services NSW;

c. *Health & Community Employees Psychologists (State) Award 2008* – applies to Mental Health Workers (psychologist) and Sexual Assault Counsellors employed by NSW Department of Health;

Annexure B.

BEFORE THE FAIR WORK COMMISSION

MATTER NO. AM2014/286

S. 156 - FOUR YEARLY REVIEW OF MODERN AWARDS – SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

Statement of Emily Flett

I, Emily Flett, Youth Worker, of Unit 7, [redacted] in the State of Victoria, say;

1. I am a member of the Australian Services Union, Victorian and Tasmanian Authorities and Services Branch

2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. I was born on the 25th of November 1981.

4. I have a partner. We have been together for eight years. We are hoping to buy a house and live together soon.

My work history

5. I am a qualified youth worker. I have a Bachelors of Youth Work from Victoria University and Certificate IV in Child, Youth and Family Intervention.

6. I have worked in the community sector for about sixteen years. I have worked at Anglicare Victoria for most of that time. I have worked at other organisations in the youth work sector and community services roles but I have always maintained some type of employment with Anglicare.

Current employment

7. Since 2015, I have worked with Anglicare Victoria as After Hours Practitioner. I am a part-time employee. Attached and marked **Annexure A** is a copy of my position description

I am employed under *Social, Community, Home Care and Disabilities Services Industry Award 2010* (**'the Award'**). I am classified as Social and Community Services Employee Level Level 6 (Social Worker Class 3)

8. I am paid $42.36 per hour. With overtime I earn approximately $80 – 85K per year.

9. I work in a dedicated team that provides after hours on call support to staff, volunteers and young people in our care. We work from the Anglicare Offices in Collingwood, we respond to phone calls from all regions of the metro area. This position tests you out because you get a variety of calls every night, some of these calls are day to day issues, such as staffing matters, but we spend a lot of our time providing risk mitigation and managing crisis. The position is relatively senior as it holds a large amount of responsibilities and Anglicare staff calling in can use this management structure for support, guidance and direction, while out of hours for their regular line manager.

10. Anglicare created our dedicated on-call team to address the impact of on call work on staff performing their regular duties during the day time and to reduce impacts on them as previously, house managers, specialist practitioners and other frontline staff were required to be on call.

Now this work has been given to our team so appropriate breaks can be structured in to a roster and we reduce burnout on valuable staff.

11. We often support staff members who need advice and support about how to proceed with dealing with young people with volatile behaviours. Another important part of my work is dealing with emergency referrals, where we need to urgently find a safe place for a young person in a case of family or guardian break down. In that case, I will try to find a place for them in one of our residential facilities or emergency foster care. I will also need to conduct an assessment of risk, I will consider the care needs of the young person, and judge whether we have the resources to safely meet those needs.

12. I am also available to provide advice to youth workers with basic troubleshooting or we might just refer the caller to one of our employer's policies dealing with the issue. The After Hours Practitioners in our team help youth workers to apply trauma informed theory and assist in seeing the young person in context. Youth workers are professionals who draw on a wide range of knowledge and skills in their work, if there is a grey area, we assist them to find a solution that is in the best interest of young person. This feels like important work that involves risk mitigation for our young people, our staff and the organisation.

13. We a responsible for ensuring that policies, legislation and best practices are followed, when staff are calling in for assistance around how to manage a situation. If there is a Quality of Care Investigation the After Hours Practitioner's on call notes as used as evidence along with other relevant client case notes. Our documentation has been used in court when the investigation proceeds to that end.

My hours of work

14. I work according to a rotating roster fortnightly roster. I have a line in the roster, with all my shifts fixed and I am able to plan well in advance around these shifts as my contract is ongoing for each shift in the fortnight. I can tell if I'm rostered on for Christmas or another public holiday easily. I am contracted to work 41 base hours each fortnight, but a component of my work hours are as re-call hours as this is the nature of my job.

15. My roster follows this pattern:

    a. I will work my ordinary hours at the Anglicare Victoria offices in Collingwood. I will commence work at some time between 4.30 pm and 7.30 pm depending on my rostered hours.

    b. I will finish work late at night, often around 11.00 pm. I have a break, in which I drive home, un-paid for 1 hour.

    c. Then I will be on call from 12.00 pm to 9.00am. I am not expected to return to the workplace when I am on call. Instead I will respond to issues by telephone or by computer. We refer to this period of the shift as 'Recall'. I am then paid at a re-call rate and if I receive no calls at all I will not be paid – but I will have had some sleep so a win there!

    d. At the end of the re-call shift at 9am, I will then have a 10 hour break between the end of my on call period and the start of my next shift.

16. I am paid two hours pay at double time when I receive a call and no more if I receive 20/30 calls in that same period, once I get a call in the next call block after the two hours I will again be paid another two hour block. I believe this is an above award condition, I understand that it

was necessary for my employer to offer this condition to attract sufficiently skilled staff to the after hours on call team.

17. The number of Recall hours I work each week fluctuates and is most defiantly seasonal, calls are quiet over winter for the most part. I usually work between 10 and 15 hours Recall each fortnight and this greatly subsidises my low part-time base hours and brings me closer to full time wages.

18. Attached and marked **Annexure B** are copies of my roster for the period [7-9-19] to [*20-9-19*] & [24-8-19] to [6-9-19]

Roster Changes

19. Each worker in my team has a line on the roster. We have set days and nights that rotate over a long period of time according to fixed pattern. We all know when we will be working. This is important for many of the other people in my team because many of us have caring responsibilities. But it is also important for me because it helps ensure that I have work/life balance. Without a fixed roster it is hard to be a shift worker and participate in social events and sporting clubs. We very rarely try to change or swap our shifts. If Anglicare does change the roster, we have a mini-meltdown in the office and it causes much distress.

20. I am worried that if rosters could be changed by agreement at any time, I would be pressured to change my shifts to accommodate my employer. We have a sense of duty to keep the place running. A good example of this was in April 2019. Anglicare Victoria had restructured the on call team to centralise the work that was done by the regional North West After hour's team in the Collingwood office. This required roster changes. We felt incredible pressure to adhere to whatever the organisation told us they needed to do, even if it would cause us problems. We just tried to adapt and have come across to the central roster. We have all lost income doing this, we are now working more nights for less money.

Impact of on call work

21. When I work through the night on call, I feel exhausted the following day. I find it is different from working a shift when you are awake through the night. In the morning, you just feel like you are jetlagged as you have only slept in parts and will need to sleep again later in the day once the mornings duties are finalised and you go off shift.

22. The following day after a night shift I can't do the things I like to do. I cannot exercise at a high level, my balance is affected, I cannot ride my motorbike or pushbike. I also find it harder to engage with my partner friends and family. I find that I don't have the energy to socialise, so I tend to withdraw a little bit and miss out.

23. I find that I do not get that regular connection with my partner in an undisturbed space. It is tricky to maintain a relationship when my working patterns are one of the reasons I do not live with my partner. When I am on call, we cannot share the same bed: or he would just be on call with me. That would be unfair to him.

24. I also find it hard to access to fresh and healthy food. This is one thing I really notice. I cannot go to the supermarket after work, because supermarkets are not open late at night. So I do a lot of food preparation to make sure I have healthy food to eat. But this is different from having access to fresh fruit and vegetables as you would after work 9-5pm.

25. I am always weighing up if this job is worth it. I can guarantee that if I was paid any less I would not do this job. Instead, I would take a small pay cut and work as a case manager for similar money and I would still be working hard, but at least I would be working normal hours

in line with my partner friends and family. It's the balance of the eight hour day, it looks after you. If your working hours are not in balance like that you need some sort of special conditions, there is a reason they call it a penalty rate, because you are paying a personal penalty to be working at 3am.

WITNESS SIGNATURE

Emily Flett

WITNESS NAME

DATE: 22-09-19

Annexure A.

Anglicare Victoria

AFTER HOURS PRACTITIONER

AFTER HOURS SERVICE

At Anglicare Victoria our focus is on transforming the futures of children, young people, families and adults. Our work is based on three guiding pillars: Prevent, Protect and Empower.

We strive to create an environment where employees feel valued and rewarded.

By living the Anglicare Victoria values and actively fostering fairness, equality, diversity and inclusion, our people make Anglicare Victoria a truly great place to work.

So come and join us at Anglicare Victoria where there is a rewarding career ready for you in a dedicated, professional team where respecting each other; leading with purpose; working together; and creating a positive difference are valued, and learning and creativity are encouraged.

BETTER TOMORROWS

Anglicare Victoria

BETTER TOMORROWS

Position details

Position	After Hours Practitioner
Program	After Hours Service
Classification	SCHADS Award Level 6 (Social Worker Class 3) (Classification will be dependent on qualification and years of experience within the relevant field consistent with the SCHADS Award)
Hours	Part Time or Full Time applications will be considered
Hours per week	Base Hours + OnCall and Recall Allowances
Duration	Ongoing
Fixed term end date	N/A
Location	Collingwood Requirement to complete outreach if required.
Reporting Relationship	Team Leader After Hours Service
Effective date	

Overview of program

Anglicare Victoria are establishing a new Afterhours response team, which will provide an out of business hours crisis response service to relevant program areas. Programs will include but not be limited Residential Care, Home Based Care, Lead Tenant, Youth Refuge and Targeted Care Packages.

This afterhours service will provide high quality risk assessment, advocacy, and will coordinate and manage any complex issues which arise out of business hours.

This support will be provided to clients, staff and volunteers and will primarily be provided by telephone, however in person responses will also occur as needed.

Position Objectives

Anglicare Victoria

This section has the position objectives of the position. A maximum of four to six objectives is regarded as sufficient. Please delete rows that are not required.

1.	Be part of a team who delivers a high quality afterhours emergency response to staff, clients and volunteers who present with a range of complex and high risk issues across a range of programs areas.
	Provide immediate response, support, intervention, information, guidance and if required direct care to clients, staff and volunteers.
	Manage and respond to incoming referrals, as well as make any relevant outgoing referrals.
	To work within a professional framework and complete professional documentation as required.
	To provide an in person response if required.

Key responsibilities

This section has the key responsibilities of the position. A maximum of seven responsibilities is regarded as sufficient. Please delete rows that are not required. Focus on the key responsibilities of the role and don't list every task and duty.

The key responsibilities are as follows but are not limited to:

	Be an active part of the emergency afterhours roster, which includes evening, weekend and OnCall/ReCall work, both over the phone and in person when required
	Provide high quality risk assessment and emergency responses to staff, client and volunteers, across a range of services, including statutory services. This will require both phone and in person responses as required.
	Conduct risk assessments to determine the current and ongoing risks, as well as negotiate with relevant stakeholders (including but not limited to: DHHS, Police, Hospitals etc) to implement a response which is in the best interests of all involved.
	Complete timely, accurate and appropriate case notes, CIMS reports and statistical documentation, as well as engage in staff meetings, supervision and other relevant professional forums.
	Work with the team to enable continual improvement to the new service model to further extend our commitment to improving the lives of children, young people and their families.

Key Selection Criteria

The Key Selection Criteria are based on role specific requirements ***and*** the Anglicare Victoria Capability Framework. Applicants are required to provide a written response to ***both*** a) and b).

a) Role specific requirements

Applicants are required to provide a written response to the role specific requirements. The five criteria are to be addressed individually (no more than 2 pages in total).

	1. Tertiary qualifications, preferably in social work, psychology or behavioural sciences or equivalent.
	2. Excellent understanding and experience working within the child protection, placement and support, and family service system, including a sound understanding of relevant legislative and policy framework.
	3. Ability to demonstrate excellent communication and negotiation skills, both over the phone and in person, in complex and demanding situations.
	4. Experience in working in fast paced, high pressured situations, which includes triaging complex issues, and negotiating with other stakeholders including statutory services.
	5. Highly developed skills in risk assessment and responding to and managing complex, high risk and critical incidents across statutory and other services, including over the phone and in person responses.
	6. Excellent knowledge of, and experience in the application of relevant theoretical approaches that underpin casework practice to vulnerable children, young people and families.
	7. Highly developed written and organisation skills.

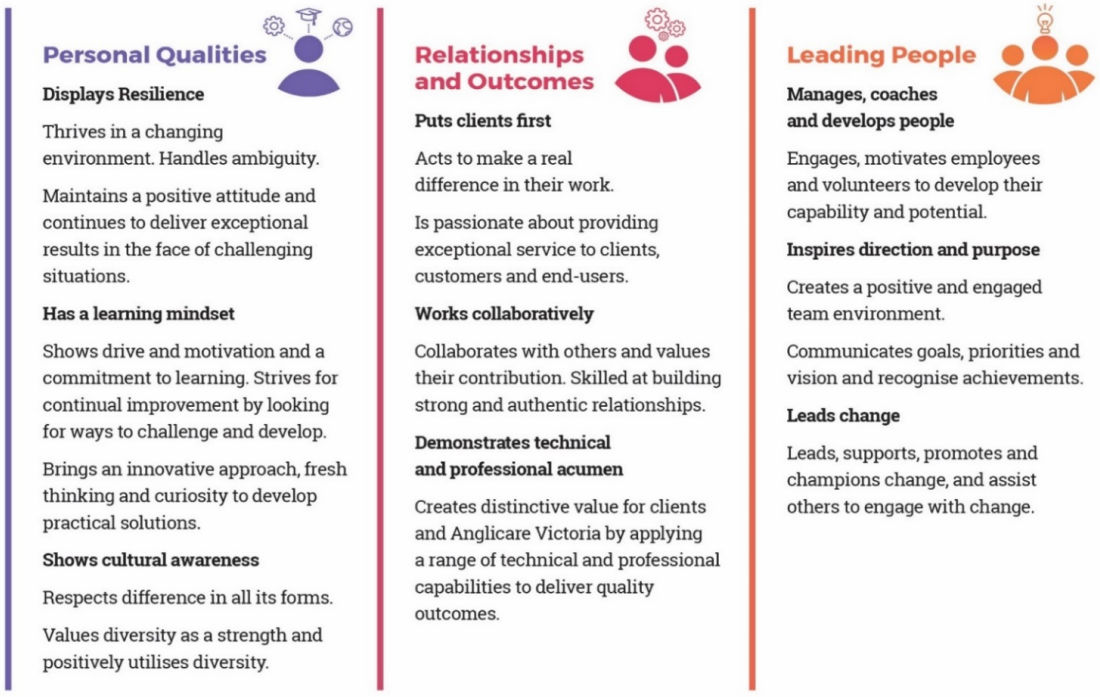
Key Selection Criteria (continued)

b) Anglicare Victoria Capability Framework

Applicants are required to provide a written response to the Anglicare Victoria Capability Framework. Applicants are to describe how they demonstrate the characteristics in each of the two capability groups; **Personal Qualities and Relationship and Outcomes** (no more than 1 page in total).

The Anglicare Victoria Capability Framework describes the capabilities required to meet the expectations of clients, colleagues and communities in today's changing environment.

These capabilities work together to provide an understanding of the knowledge, skills and abilities required of all employees.



Occupational health & safety (OHS)

Anglicare Victoria is committed to ensuring the health and safety of its employees and any other individuals present in our workplaces.

In achieving and maintaining workplace health and safety, Anglicare Victoria will apply best practice in OHS in accordance with statutory obligations at all times.

All Anglicare Victoria employees, contractors and volunteers are required to:

- take reasonable care for their own health and safety and for that of others in the workplace by working in accordance with legislative requirements and the company's OHS policies and procedures
- take reasonable care their actions or omissions do not adversely affect the health and safety of themselves and others
- cooperate with any reasonable directions, policies and procedures relating to health and safety in the workplace
- report all injuries, illness or 'near misses' to their Supervisor or Manager
- participate in relevant health and safety training based on roles and responsibilities
- as required, participate in the development and implementation of specific OHS hazard and risk management strategies.

In addition to the above, positions with supervision or management responsibility are required to ensure a safe and healthy work environment for all employees, clients, contractors and visitors. This can be achieved by ensuring all people are aware of and have access to OHS policies, procedures, training and reporting systems

Cultural Safety in the Workplace

Anglicare Victoria recognises the important and unique contribution Aboriginal and Torres Strait Islander employees make by bringing their unique skills, knowledge and experience to the workplace. They also contribute important insight into how Anglicare Victoria can provide for and engage with Indigenous clients and communities more effectively.

Our Reconciliation Action Plan (RAP) and Workforce Strategy outlines Anglicare Victoria's commitment to leading and facilitating sustainable employment, training, retention and career development opportunities for Aboriginal and Torres Strait Islanders people.

Conditions of employment

- Salary and conditions are in accordance with the click to select. Salary packaging is offered with this position.
- All offers of employment at Anglicare Victoria are subject to a six month probationary period. The staff member will be asked to participate in an annual performance review linked to objectives set out for the position.
- All offers of employment are subject to a satisfactory Criminal History Check, a current Driver's License and an Employment Working with Children Check prior to commencement.

Acceptance of Position Description requirements

To be signed upon appointment

Employee

Name: _____

Signature: _____

Date: _____

Annexure B.

CENTRAL AFTER HOURS MASTER ROSTER - Updated 18-08-19

	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Contracted Hours
DATE:	24/08/2019	25/08/2019	26/08/2019	27/08/2019	28/08/2019	29/08/2019	30/08/2019	31/08/2019	1/09/2019	2/09/2019	3/09/2019	4/09/2019	5/09/2019	6/09/2019	
After Hours Practitioners															
BACKUP	SINEAD	SINEAD	TREVOR	TREVOR	TREVOR	TREVOR	TREVOR	TREVOR	TREVOR	LANA	LANA	LANA	LANA	LANA	SE
MANAGERS	NEIL	NEIL	NEIL	NEIL	NEIL	NEIL	CAROL	CAROL	CAROL	CAROL	CAROL	CAROL	CAROL	CAROL	NW
LIST	BRIE	BRIE	BRIE	BRIE	BRIE	BRIE	JACINTA	JACINTA	JACINTA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	EAST RESI
			GINA	GINA	GINA	GINA	GINA	DEAN	DEAN	DEAN	DEAN	DEAN	DEAN	DEAN	EAST HBC
			KAREN	KAREN	VIRGINIA	VIRGINIA	KAREN	VIRGINIA	KAREN	KAREN	KAREN	KAREN	KAREN	KAREN	HBC s'port
Team Leader MARK	4.30 - 12am	3pm - 10pm. Recall @11pm & 8am-9am	7.30 - 11pm. Recall @12am & 8am-9am		10am - 6pm (Admin)	4.30 - 10pm & ReCall 11pm & 8am-9am					4.30 - 10pm & ReCall 11pm & 8am-9am		10am - 6pm (Admin)	10am - 6pm (Admin)	
Total Line Hours	7	7.5	4.5		7.5	6					6		7.5	7.5	53.5
Super-Melissah														Supervision	
Team Leader SANDRA			10am - 6pm (Admin)	4.30 - 12am	11am -7pm (Admin)	10am - 6pm (Avail by Phone)			9am - 5pm	10am - 6pm (Admin)		10am - 6pm (Admin)	4.30 - 12am	Additional 4.30 - 12am	
Total Line Hours			7.5	7	7.5	7.5			7.5	7.5		7.5	7	7	66
Super-Melissah			Supervision												
SARAH	9am - 5pm	4.30 - 12am		7.30 - 11pm. Recall @12am & 8am-9am	Super 12pm-1.30pm and 2.30-4.30 Mtg	4.30 - 12am				4.30 - 12am					
Total Line Hours	7.5	7		4.5	4.5	7				7					37.5
Super-Sandra					**12-1.30pm**										
EMILY		**Annual Leave** 9am - 5pm	3pm - 12am		2.30 - 4.30 Mtg & 4.30pm - 12.00am		4.30 - 12am			7.30 - 11pm. Recall @12am & 8am-9am	**SICK** 7.30 - 11pm. Recall @12am & 8am-9am	4.30pm - 10pm & ReCall 11pm & 8am-9am			
Total Line Hours		7.5	8.5		9		7			4.5	4.5	4 + 2			41
Super-Sandra		**A/L**	**3.00-4.30pm**												
LINDA					2.30-.4.30 Mtg			9am - 5pm	4.30 - 12am	Super 3pm - 4.30pm & 4.30 - 10pm. Recall @11pm & 8-9am		6pm - 11pm. Recall @12am & 8am-9am			
Total Line Hours					2			7.5	7	7.5		6			30
Super-Sandra										**3pm - 4.30pm**					
TAMMY					2.30 - 4.30 Mtg & 7.30 - 11pm. Recall @12am & 8am-9am	7.30 - 11pm. Recall @12am & 8am-9am			3pm - 10pm. Recall @11pm & 8am-9am		4.30 - 12am	4.30 - 12am	Super 6pm - 7.30pm & 7.30 - 11pm. Recall @12am & 8am-9am		
Total Line Hours					9	4.5			7.5		7	7	6		41
Super-Sandra													**6 - 7.30pm**		
TU			4.30 - 10pm & ReCall 11pm & 8am-9am		2.30 - 4.30 Tm Mtg & 4.30 - 10pm & ReCall 11pm & 8am-9am		4.30 - 10pm & ReCall 11pm & 8.30am-9.30am	7.30 - 11pm. Recall @12am & 8.30-9.30am	7.30 - 11pm. Recall @12am & 8am-9am				**ANNUAL** 4.30 - 10pm & ReCall 11pm & 8am-9am		
Total Line Hours			6		8		6	4.5	4.5				6		35
Super-Mark			**7.30 - 9pm**												
PAUL				4.30 - 10pm & ReCall 11pm & 8am-9am	2.30-4.30 Team Mtg & 4.30-6PM Super (Dble Time)			4.30pm - 12am		Active	Active	Active		4.30 - 12am A/L	
Total Line Hours				6	3.5			7		6	6	6		7	41.5
Super-Mark					**4.30-6PM**										
VICTOR	7.30 - 11pm. Recall @12am & 8.30-9.30am	7.30 - 11pm. Recall @12am & 8.00-9.00am	Active		2.30-.430 Mtg and Super 4.30-6pm	Active	7.30 - 11pm. Recall @12am & 8.30-9.30am	Additional Shift		Active	Additional Shift			7.30pm - 11pm & OnCall and 8.30am-9.30am	
Total Line Hrs	4.5	4.5	6		3.5	6	4.5			6				4.5	39.5
Super-Sandra					**4.30 - 6pm**										
BRENDAN	3pm - 10pm OnCall and 8.30am-9.30am				2.30-.4.30 Mtg									**LWOP** 4.30 - 10pm & ReCall 11pm & 8.30-9.30am	
Total Line Hrs	7.5				2									6	15.5
Super-Mark														**4.30 - 6pm**	
VACANT SHIFTS								**3pm - 10pm OnCall and 8.30am-9.30am Victor**			7.30 - 11pm. Recall @12am & 8am-9am		4.30 - 10pm & ReCall 11pm & 8am-9am	4.30 - 10pm & ReCall 11pm & 8.30-9.30am	
Total Line Hrs								**7.5**					6	6	7.5
STAFF NAME:								**VICTOR**			**VICTOR**		**BRENDAN**		

DATE:	24/08/2019	25/08/2019	26/08/2019	27/08/2019	28/08/2019	29/08/2019	30/08/2019	31/08/2019	1/09/2019	2/09/2019	3/09/2019	4/09/2019	5/09/2019	6/09/2019	
Active Outreach Practitioners NORTH WEST															
VICTOR			11.30pm - 6am			11.30pm - 6am				11.30pm - 6am					
Total Line Hrs			6			6				6					18
NICOLE	11.30pm - 6am	11.30pm - 6am		11.30pm - 6am	**1.30-2.30 Supervision** & 2.30-4.30 Mtg & 11.30pm - 6am		11.30pm - 6am				**Annual** 11.30pm - 6am	**Annual** 11.30pm - 6am			
Total Line Hrs	6	6		6	9		6				6	6			45
NW VACANT LINE					**Supervision** & 2.30-4.30 Mtg			11.30pm - 6am	11.30pm - 6am				11.30pm - 6am	11.30pm - 6am	
Total Line Hrs					3			6	6				6	6	27
STAFF NAME:								**CHRISTINE**	**RICHARD**		Victor		**RICHARD**	**RICHARD**	
Active Outreach Practitioners SOUTH EAST															
PAUL										11.30pm - 6am	11.30pm - 6am	11.30pm - 6am			
Total Line Hrs										6	6	6			18
SE VACANT LINE	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am				11.30pm - 6am	11.30pm - 6am	
Total Line Hrs	6	6	6	6	6	6	6	6	6				6	6	66
STAFF NAME:	**RICKY**	**Tina Su'a (BW)**	**DENG - No Show**	**DENG**	**Moevasa BW**	**Transitions Matthew Uyanna**	**Barnabus BW**	**Barnabus BW**	**Transitions Akoi Guong**					**RICKY**	

Siju Poplar Line & Availability			**Poplar House 4pm-12am**	**Poplar House 4pm-12am**				**Poplar House 8:30-4:30**	**Poplar House 8:30-4:30**	**Poplar House 4pm-12am**	**Poplar Team Meeting 11am-1pm**		**Not Available Until Early November - Get well soon Siju!**	

September
Wed 4th – through to – Sunday 15th

Works on Level 2 Refurb – Team can remain in Level 1, but will need to utilise bottom level car park as Level Car Park will be used by tradesman.
October
Thurs 3rd – through to – Fri 14th (except Oct 4th)

Works on Level 2 Refurb - Office Closed – Plan for After Hours Team to all Work From Home.
October
Fri 4th

CENTRAL AFTER HOURS MASTER ROSTER - Updated 01-09-19

	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Contracted Hours
DATE:	7/09/2019	8/09/2019	9/09/2019	10/09/2019	11/09/2019	12/09/2019	13/09/2019	14/09/2019	15/09/2019	16/09/2019	17/09/2019	18/09/2019	19/09/2019	20/09/2019	
After Hours Practitioners															
BACKUP	LANA	LANA	SINEAD	SINEAD	SINEAD	SINEAD	SINEAD	SINEAD	SINEAD	TREVOR	TREVOR	TREVOR	TREVOR	TREVOR	SE
MANAGERS	SHAWN	SHAWN	SHAWN	SHAWN	SHAWN	SHAWN	LISA	LISA	LISA	LISA	LISA	LISA	LISA	NADA	NW
BACKUP	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	ANGELA	EAST RESI
MANAGERS	TORI	TORI	TORI	TORI	TORI	TORI	MICHELE	MICHELE	MICHELE	MICHELE	MICHELE	MICHELE	MICHELE	TARNI	HBC
HBC support	KAREN	KAREN	VIRGINIA	VIRGINIA	VIRGINIA	VIRGINIA	VIRGINIA	VIRGINIA	VIRGINIA	KAREN	KAREN	KAREN	KAREN	KAREN	HBC s'port
Team Leader MARK	4.30 - 12am	3pm - 10pm. Recall @11pm & 8am-9am	7.30 - 11pm. Recall @12am & 8am-9am		10am - 6pm (Admin)	4.30 - 10pm & ReCall 11pm & 8am-9am					4.30 - 10pm & ReCall 11pm & 8am-9am		10am - 6pm (Admin)	10am - 6pm (Admin)	
Total Line Hours	7	7.5	4.5		7.5	6					6		7.5	7.5	53.5
Super-Melissah														Supervision	
Team Leader SANDRA			10am - 6pm (Admin)	4.30 - 12am	11am -7pm (Admin)	10am - 6pm (Avail by Phone)			9am - 5pm	10am - 6pm (Admin)		10am - 6pm (Admin)	4.30 - 12am		
Total Line Hours			7.5	7	7.5	7.5			7.5	7.5		7.5	7		59
Super-Melissah			Supervision												
SARAH	9am - 5pm	4.30 - 12am		7.30 - 11pm. Recall @12am & 8am-9am	Super 12pm-1.30pm and 2.30-4.30 Mtg	4.30 - 12am		4.30pm - 12am		4.30 - 12am					
Total Line Hours	7.5	7		4.5	4.5	7		7		7					44.5
Super-Sandra					12-1.30pm										
EMILY		9am - 5pm	3pm - 12am		2.30 - 4.30 Mtg & 4.30pm - 12.00am		4.30 - 12am			7.30 - 11pm. Recall @12am & 8am-9am	7.30 - 11pm. Recall @12am & 8am-9am	7pm - 10pm & ReCall 11pm & 8am-9am			
Total Line Hours		7.5	8.5		9		7			4.5	4.5	4			45
Super-Sandra			3.00-4.30pm												
LINDA					2.30-.4.30 Mtg			9am - 5pm	4.30 - 12am	Super 3pm - 4.30pm & 4.30 - 10pm. Recall @11pm & 8-9am		6pm - 11pm. Recall @12am & 8am-9am			
Total Line Hours					2			7.5	7	7.5		6			30
Super-Sandra										3pm - 4.30pm					
TAMMY					2.30 - 4.30 Mtg & 7.30 - 11pm. Recall @12am & 8am-9am	7.30 - 11pm. Recall @12am & 8am-9am			3pm - 10pm. Recall @11pm & 8am-9am		4.30 - 12am	4.30 - 12am	Super 6pm - 7.30pm & 7.30 - 11pm. Recall @12am & 8am-9am		
Total Line Hours					9	4.5			7.5		7	7	6		41
Super-Sandra													6 - 7.30pm		
TU			4.30 - 10pm & ReCall 11pm & 8am-9am		2.30 - 4.30 Tm Mtg & 4.30 - 10pm & ReCall 11pm & 8am-9am		4.30 - 10pm & ReCall 11pm & 8.30am-9.30am	7.30 - 11pm. Recall @12am & 8.30-9.30am	7.30 - 11pm. Recall @12am & 8am-9am				4.30 - 10pm & ReCall 11pm & 8am-9am		
Total Line Hours			6		8		6	4.5	4.5				6		35
Super-Mark			7.30 - 9pm												
PAUL				4.30 - 10pm & ReCall 11pm & 8am-9am	2.30-4.30 Team Mtg & 4.30-6PM Super (Dble Time)			4.30pm - 12am A/L		Active	Active	Active		4.30 - 12am	
Total Line Hours				6	3.5			7		6	6	6		7	41.5
Super-Mark					4.30-6PM										
VICTOR	7.30 - 11pm. Recall @12am & 8.30-9.30am	7.30 - 11pm. Recall @12am & 8.00-9.00am	Active		2.30-.430 Mtg and Super 4.30-6pm	Active	7.30 - 11pm. Recall @12am & 8.30-9.30am	Additional Shift		Active				7.30pm - 11pm & OnCall and 8.30am-9.30am	
Total Line Hrs	4.5	4.5	6		3.5	6	4.5			6				4.5	39.5
Super-Sandra					4.30 - 6pm										
BRENDAN	3pm - 10pm OnCall and 8.30am-9.30am				2.30-.4.30 Mtg			10am-3pm SUPPORT						4.30 - 10pm & ReCall 11pm & 8.30-9.30am	
Total Line Hrs	7.5				2			5						6	20.5
Super-Mark														4.30 - 6pm	
VACANT SHIFTS								3pm - 10pm OnCall and 8.30am-9.30am Victor							
Total Line Hrs								7.5							7.5
STAFF NAME:								VICTOR							
	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	
DATE:	7/09/2019	8/09/2019	9/09/2019	10/09/2019	11/09/2019	12/09/2019	13/09/2019	14/09/2019	15/09/2019	16/09/2019	17/09/2019	18/09/2019	19/09/2019	20/09/2019	
Active Outreach Practitioners NORTH WEST															
VICTOR			11.30pm - 6am			11.30pm - 6am				11.30pm - 6am					
Total Line Hrs			6			6				6					18
NICOLE	11.30pm - 6am	11.30pm - 6am		11.30pm - 6am	**1.30-2.30 Supervision** & 2.30-4.30 Mtg & 11.30pm - 6am		11.30pm - 6am				11.30pm - 6am	11.30pm - 6am			
Total Line Hrs	6	6		6	9		6				6	6			45
NW Main Road West					Supervision & 2.30-4.30 Mtg			11.30pm - 6am	11.30pm - 6am				11.30pm - 6am	11.30pm - 6am	
Total Line Hrs					3			6	6				6	6	27
STAFF NAME:								CHRISTINE	RICHARD				HENRY	RICHARD	
Active Outreach Practitioners SOUTH EAST															
PAUL										11.30pm - 6am	11.30pm - 6am	11.30pm - 6am			
Total Line Hrs										6	6	6			18
SE Kershaw Drive	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am	11.30pm - 6am				11.30pm - 6am	11.30pm - 6am	
Total Line Hrs	6	6	6	6	6	6	6	6	6				6	6	66
STAFF NAME:	RICKY	Kuda Mashatise Transitions	Njokuocha Ikechukwu	Njokuocha Ikechukwu	Njokuocha Ikechukwu	Tina S'ua	RICKY	Tina S'ua	Tina S'ua					RICKY	
SE Popes Road (Additional)					11pm-8am	11pm - 8am	11pm - 8am	11pm - 8am		11pm - 8am	11pm - 8am	11pm - 8am	11pm - 8am	11pm - 8am	
Total Line Hrs						8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	76.5
STAFF NAME:					Tina S'ua		Barnabas Tavu'i-leota (BWx)	Barnabas Tavu'i-leota (BWx)	Barnabas Tavu'i-leota (BWx)	Barnabas Tavu'i-leota (BWx)	Barnabas Tavu'i-leota (BWx)	Barnabas Tavu'i-leota (BWx)		Barnabas Tavu'i-leota (BWx)	

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Fri 4th

Expert Report of Dr. James Stanford

Fair Work Commission

Four-Yearly Review of Modern Awards:

AM2018/26 Social, Community, Home Care and Disability Services Industry Award 2010

September 2019

Table of Contents

Glossary of Acronyms

ABS – Australian Bureau of Statistics

DSW – Disability Support Worker

NDS – National Disability Services (peak body of disability service providers)

NDIA – National Disability Insurance Agency (agency empowered to administer the NDIS)

NDIS – National Disability Insurance Scheme

NILS – National Institute of Labour Studies

QSF – Quality and Safeguarding Framework

RCM – Reasonable Cost Model

RTO – Registered Training Organisation

SACS – Social and Community Services (classification stream in SCHDA Award)

SCHDS – Social, Community, Home Care and Disability Services

SCHDS Award – Social, Community, Home Care and Disability Services Industry Award

TTP – Temporary Transformation Payment

Summary

1. I am Economist and Director of the Centre for Future Work, a labour market policy research institute based in Sydney, NSW, and associated with the Australia Institute. I have 25 years of professional experience in applied labour market research and policy analysis. My full curriculum vitae is appended to this report (Attachment A).

2. The purpose of this report is to provide my expert opinion on the following four questions addressed to me by the Australian Services Union, as part of its instruction letter to me dated 27 August 2019 (Attachment B):

   "1. What training, skills and qualifications are required by the disability sector?
   2. What is the connection between the terms and conditions of the SCHDS Award, including broken shifts and unpaid travel time, and the disability sectors' ability to attract a sufficient number of appropriately skilled workers?
   3. Is the disability sector able to attract a sufficient number of appropriately skilled workers?
   4. Are there any implications for quality of care?"

3. My expert opinion is based primarily on original research which I conducted as a co-investigator of two significant research projects examining changes in the nature and conditions of work for disability support workers (DSWs) in the wake of the roll-out of the new National Disability Insurance Scheme (NDIS).

4. The first of these original research projects involved qualitative interviews with 19 front-line DSWs (including service coordinators and local area coordinators) working in the Hunter region of NSW, along with subsequent analysis of the data and development of policy conclusions and recommendations. This work was conducted jointly with Prof. Donna Baines (formerly Chair of the School of Social Work at the University of Sydney, now Director of the Department of Social Work at the University of British Columbia) and Dr. Fiona Macdonald (Vice-Chancellor's Senior Research Fellow in the

School of Business at RMIT University). To date this research work has led to the publication of four reports (three of which were subject to formal academic peer-review), which are appended to this expert submission, and are listed in the Bibliography:

i. Baines and Macdonald (2019; Attachment C)
ii. Baines, Kent and Kent (2019; Attachment D)
iii. Baines, Macdonald, Stanford and Moore (2019; Attachment E)
iv. Baines, Macdonald and Stanford (forthcoming; Attachment F).

5. The second original research project involved an investigation into the intensifying skills and training requirements faced by the disability services workforce as the sector increases its overall activity to meet the operational targets of the NDIS. This project also developed a proposal for a new system for financing ongoing training requirements for workers in the sector (both new recruits and longer-term workers). This work was conducted jointly with Dr. Rose Ryan: then an independent labour market researcher and analyst, now Manager of the Workforce and Workplace Evidence and Insights Branch of the New Zealand Ministry of Business, Innovation and Employment. Two key publications arising from this research are also appended to this submission and listed in the Bibliography:

i. Ryan and Stanford (2018; Attachment G)
ii. Stanford (2018; Attachment H).

6. My expert opinion is also based on my own further exploration of published literature, official statistical data, and government policy documents. That review of external resources was conducted in part as input to the two original research projects described above, and in part to supplement my knowledge in preparation for this expert opinion. The sources which I consulted in the course of that research, and which are referred to in my report, are listed in the Bibliography.

7. My report is organised according to the following structure. Part I provides a general review of the labour market for disability services work in Australia, in the wake of the roll-out of the NDIS and consequent significant expansion in demand for disability services. This section highlights some of the major challenges facing workforce development in the sector, and some of the specific consequences arising from the observed increase in the instability and precarity of work in the industry. Part II discusses in turn the four specific questions addressed to my attention by the Australian Services Union. The Conclusion of this report summarises and restates my views.

8. As will be discussed in more detail in this report and the supporting attachments, it is clear that work in the disability support services industry is being dramatically transformed as a result of the implementation of the NDIS. The individualised, market-based system which the NDIS uses to deliver services to participating clients is creating a profound fragmentation and instability in the nature of delivered services. Demand for specific services fluctuates constantly due to changes in the number of clients, their approved budgets, their specific choices of services, and other factors. In the context of the NDIS's unit-price model for funding disability services provision, this instability imposes financial uncertainty on the agencies and employers which undertake to provide these services. In turn, those agencies are attempting to shift the resulting uncertainty and risk associated with fluctuations in demand and other causes of revenue fluctuations onto their employees, through the imposition of increasingly insecure and unstable employment relationships, rostering practices, and compensation. A clear consequence of this structural shift in the nature of work in the sector has been a marked increase in precarious work practices in various forms, including: casualisation, increased part-time employment, irregular and discontinuous shift assignments, requirements that DSWs work in multiple locations (often in the course of a single day, and often working inside clients' private residences), and the expectation that DSWs provide private or informal transportation services in the course of their work (including transporting clients, in some cases without compensation).

9. This observed deterioration in the stability of work in disability services occurs in the context of the sector's need to undertake a substantial increase in the total number of people working in the sector. The full roll-out of the NDIS is anticipated to increase employment in the sector by some 70,000 full-time equivalent positions. That represents an approximate doubling of the sector's workforce over the coming transition period (as the new system is rolled out).[1] In addition to recruiting a large number of new workers to the sector, the industry faces the related challenge of quickly developing the skills and capacities of those workers – many of whom will have never worked with people with disabilities before. Given this daunting workforce development challenge, the deteriorating quality and stability of work in the industry can only exercise a counterproductive influence. Many of the front-line workers we interviewed as part of our original research (most of whom had several years of experience in the sector) were considering leaving the industry altogether in response to intolerable insecurity and deteriorating conditions. Without urgent measures to enhance the stability, conditions, and compensation associated with these jobs, it is unlikely that the industry will be able to recruit and retain the motivated, trained workers that will be essential if the NDIS is to meet its goal of providing high-quality, individualised service to all Australians with disabilities.

10. In the context of the deep challenges of labour force development in this rapidly growing industry, myself and my co-investigators identified several specific issues which are undermining the predictability, stability, and fairness of work in the sector. Two of the specific problems we identified are now being considered in the course of this Four-Yearly Review of the SCHDS Industry Award: the problem of discontinuous or "split" shifts, and the financial and other burdens associated with increasingly onerous requirements on DSWs to provide transportation services as part of their normal work (including using their own vehicles, often without compensation, and often to transport clients).

[11] Productivity Commission, 2017a, pp. 36-37.

11. In my judgment, the increasingly common practice of scheduling DSWs to work split or broken shifts considerably undermines the quality and sustainability of work in disability support services. Hourly wages in this industry are generally relatively low, and hours are already uncertain and often inadequate. If, on top of that unappealing starting point, workers are now expected to divide their working days between multiple even-shorter shifts, then the effective hourly wage received for their labours is reduced even further (once account is taken of the transportation time, preparation time, and other fixed costs associated with performing any single engagement of work).

12. Similarly, the requirement that DSWs perform informal and often uncompensated transportation services as part of their work days also imposes an additional burden on workers whose conditions and compensation are already challenging. With workers commonly being required to travel to places other than a central office or agency, often visiting multiple locations in the course of a day, the relative burden of transportation time becomes more severe. Our qualitative research confirmed that DSWs are commonly required to transport clients in their own vehicles (often without clear rules and practices regarding safety equipment, insurance, and other costs), and that compensation practices for both travel time and vehicle use are inconsistent. If DSWs are going to be required to undertake these transportation-related functions as a normal feature of work, the whole industry needs to quickly adopt and implement fair, transparent and safe practices and procedures: including fair compensation for all transportation time other than normal commutes to a single regular place of work, full compensation and insurance for the use of personal vehicles for work-related transportation, employer provision of adequate safety features and insurance, and adequate training for DSWs in the safe operation of vehicles while supervising clients. Including these requirements in the SCHDS Award is the most appropriate and effective way to ensure that the sector improves its practice in this regard.

13. These two problems (split or broken shifts and uncompensated transportation time) can interact to reinforce the negative impact on DSWs. Workers who are required to travel (without compensation) to and from several different locations in the course of a day

(often including clients' private homes), with paid work time often split across discontinuous shifts, will experience a doubly negative impact on their effective hourly wages.

14. On the other hand, addressing and ameliorating these two burdensome problems in the current pattern of disability support work holds the prospect of a dual benefit for the sector. First, reforms in these areas would enhance the fairness and quality of work for those already employed in this occupation. Second, they would lessen the negative impact of job insecurity and unreasonable scheduling and compensation practices on the industry's already-daunting recruitment and retention goals. If the disability services sector is serious about successfully meeting the challenge of building a high-quality, well-trained, and motivated workforce to achieve the goals of the NDIS, it must move quickly to resolve some of the most egregious and unsustainable work practices currently experienced by many DSWs. Addressing these two specific shortcomings would mark an important first step in that broader challenge.

Part I: General Condition of the Disability Services Workforce Under the NDIS

15. Disability support services constitutes one of the fastest-growing industries in Australia. This is largely a result of the historic increase in social resources being devoted to the provision of these services under the NDIS. Once fully rolled-out, the new scheme will allocate an estimated $22 billion per year (shared across federal and state governments) to supporting Australians under 65 with a wide range of disabilities in accessing support services. It is anticipated that some 475,000 Australians under 65 will be receiving services under the NDIS once it is fully rolled-out; at present, about 300,000 individual clients are registered,[2] implying that the system is about two-thirds of the way toward full implementation.

16. Comprehensive and consistent statistics describing the disability services workforce are difficult to attain. The Australian Bureau of Statistics does not define a disability services sector in its regular labour market surveys and statistics; the sector is lumped in with other health and social service occupations in the large Health Care and Community Services sector (Australia's largest employer).[3] Conditions of work differ greatly between different sub-sectors and occupations within that broad umbrella category, and hence it is impossible to generalise from that broader data regarding the specific employment patterns and practices in disability services.

17. One useful source of data has been developed by the National Disability Services peak body (which represents many disability service providers). This database is derived from the Workforce Wizard employment platform which NDS has supported, as part of the industry's efforts to recruit and match prospective workers.[4] This data set is not comprehensive; at present it covers approximately 45,000 workers (NDS, 2018b, p.4),

[2] See NDIS (2019a) and Cluff (2019).
[3] Even in the more detailed breakdowns of labour force statistics reported by the ABS (such as Labour Force, Australia, Detailed, Quarterly, Catalogue 6291.0.55.003), the definition of sub-categories is not sufficiently disaggregated to permit the isolation of disability services.
[4] See NDS (2018b).

perhaps half of the current disability services workforce. But its sample is sufficiently broad to provide reasonably robust indicators of broad patterns in employment practice.

18. Key conclusions derived from the NDS data regarding employment and work practice include:

    a. About 80% of employees in the sector work part-time (NDS, 2018b, p.5).
    b. Women account for about 70% of the disability services workforce (NDS, 2018b, p.15).
    c. Casual and fixed-term employees account for over one-half of all jobs; permanent positions account for less than one-half of all jobs (NDIS, 2018b, p.5).
    d. Fewer than 10 percent of the disability support workforce are employed on a full-time and permanent basis.[5]
    e. 44 percent of disability service workers are 45 years or older – making the sector's workforce one of the oldest of any sector in Australia's economy (NDS, 2018a, p. 46).
    f. Turnover in the industry is very high: over one-quarter of workers change jobs in the course of a year (NDIS, 2018b, p. 9).[6] That is approximately three times higher than the average turnover rate in the overall Australian labour force.[7]
    g. Average hours of work are low and highly variable. Workers covered by the database worked an average of 22 hours per week in the March 2018 quarter (NDS, 2018b, p. 10). Some workers work very short hours, and many workers experience regular fluctuations in their hours of work.

19. The NDS data also confirm that, in the face of increasing demand driven by the NDIS rollout, there is strong growth in employment in the sector of around 11 percent per year

[5] NDS (2018a, p.23) reports that only 35 percent of permanent employees (which in turn make up just 19 percent of the total workforce) are employed on a full-time basis, implying that just 7 percent of the workforce work in permanent full-time positions.
[6] The NDS (2018b) report does not directly report an annual turnover figure, but it can be derived from data presented on quarterly turnover for casual and permanent employees. The average quarterly turnover rate across those two categories is approximately 6.5%, implying an annual turnover rate of over 25%. This conclusion is affirmed explicitly in an earlier version of the NDS report (NDS, 2018a, p. 18).
[7] See Australian Bureau of Statistics (2019, 'Summary'), which reports average annual turnover of 8.5% among Australian employees in the 12 months ending in February 2019.

(NDS, 2018b, p.7). However, even this rapid expansion will be inadequate to meet the expected need for the disability services workforce to double by the time the NDIS roll-out is complete.

20. While positive, this employment growth masks two significant concerns. The first is that growing employment is being driven almost entirely by a growth in casual employment. The growth in casual employment in the sector was 26 percent per year, compared to just a 1.3 percent per year increase in permanent employment (NDS, 2018b, p.7). Virtually all the new jobs in the sector, therefore, are casual. Secondly, turnover issues remain a huge concern – exacerbated by the rapidly ageing cohort of more experienced workers, and the unattractive conditions and compensation of most jobs.

21. The Productivity Commission has also attempted to assemble a statistical portrait of the disability services workforce, in the face of the unavailability of precise data from conventional sources (Productivity Commission, 2017a and 2017b). The Commission developed its own estimates of employment numbers, qualifications, and other workforce characteristics by interpolating and disaggregating ABS data covering broader categories of employees. Key findings from the Productivity Commission's analysis include:
    a. Over half of all workers in the sector possess a Certificate III or IV as their highest qualification (Productivity Commission, 2017b, p. 334).
    b. About 60% of disability support workers work part-time – twice as large a proportion as in the overall Australian workforce (Productivity Commission, 2017b, p. 333).

22. Providing services to a large and growing population of registered NDIS clients as the system is rolled-out will require many tens of thousands of new workers. It is estimated that the sector's workforce will have to approximately double in order to meet the needs of the NDIS, growing by approximately 70,000 full-time equivalent positions.[8] Since most DSWs are employed on a part-time basis, this implies a much larger total number

[8] Productivity Commission (2017a), pp. 36-37.

of individuals who must be recruited to work in the sector.[9] The growth in disability services employment is therefore projected to account for about one in five of all new jobs created in Australia over the period of the transition.[10]

23. One feature of the new system is its emphasis on individual choice in developing support plans and accessing desired resources. Registered clients meet with NDIS planners who identify and evaluate their needs, and determine overall individual budgets for their care and support. The clients then (on their own, supported by family members, or with the formal support of paid coordinators) identify and contract with suppliers to provide the desired services. Services are funded on a unit basis by the NDIS, following a schedule of prices which are reviewed and adjusted annually.

24. Traditionally, disability support services were provided by a mixture of government departments and charitable, religious or community agencies. The latter were funded primarily on a block- or grant-based basis by governments to perform specified services in their respective communities, typically supplemented by charitable donations. Under the new marketised NDIS system, funding for services now depends on each agency's success in contracting with individual clients to provide their services under their respective individual plans. This transition from block- or charitable funding to requiring agencies to successfully "market" their services to individual service users has proven very challenging for many of these agencies, some of which have experienced financial crisis, reduced their staff, and even entered liquidation.[11] The NDS annual Business Confidence Survey (NDS, 2016) found that 22 percent of providers reported a financial loss in the previous year, with immediate impacts on supervision and training provision. Many reported that they would not be able to continue to provide services at currently NDIA-set unit prices, and would have to reduce the quality of their services if prices did not improve.

[9] With DSWs working an average of just 22 hours per week (para. 18 above), this implies a need to recruit over 120,000 workers in order to provide an additional 70,000 full-time equivalent positions.
[10] Productivity Commission (2017b), p. 331.
[11] See, for example, Campbell (2018) and Lenaghan (2016).

25. Research regarding initial experience under the NDIS confirms that providers are experiencing severe difficulties in recruiting new staff to even maintain existing operations, let alone scale up to the dramatic degree implied by forecasts of fully rolled-out NDIS operations.[12] This challenge has been exacerbated by inadequate conditions of work in the sector: most workers are engaged in casual, part-time, and irregular positions; staff turnover is high; and there has been a consequent reduction in the availability of training (including in-house supervision and support) provided for employees – just as new workers need more skills to fulfil the goals of the NDIS. This situation poses significant challenges for the quality of service received by NDIS participants, for the job quality and opportunities of disability support workers, and for the organisational stability and financial viability of providers.

26. I was a co-investigator on an original qualitative research project to investigate the impact of the NDIS on the quality and stability of jobs in disability services work. The research involved structured interviews with front-line DSWs in the Newcastle, NSW region (one of the first regions to experience the trial roll-out of the NDIS model). The data gathered through this research confirmed widespread and acute concerns with the fragmentation and insecurity of work under the new system.[13] This research identified eight broad categories of concern on the part of these front-line workers, including:

    a. The new system is not providing sufficient support for participants with intellectual and other cognitive disabilities, including in designing and managing their individualised programs of care;
    b. DSWs are experiencing increased instability and precarity in their jobs, elevated levels of mental and physical stress, and irregular hours and incomes;
    c. New workers joining the disability services sector are often less skilled, less trained, less experienced, and sometimes reluctant;

[12] Other research documenting these growing challenges experienced by workers under the NDIS include Macdonald and Charlesworth (2016), Cortis *et al*. (2017), and Macdonald *et al*. (2018),
[13] Findings of this original research are detailed in Baines and Macdonald (2019); Baines, Kent and Kent (2019); Baines, Macdonald, Stanford and Moore (2019); and Baines, Macdonald and Stanford (forthcoming). These four publications are attached to this submission in full.

d. DSWs experience particular challenges working in the private realm of NDIS clients' homes;
e. The informal and inconsistent provision of transportation and other necessary support functions to NDIS clients results in a significant shift of costs and risks to workers;
f. DSWs are experiencing increased levels of violence in their work;
g. Relationships with managers have changed dramatically under the new system, undermining effective supervision, coaching, and training; and
h. Worker turnover, given the insecurity of work and income and the challenging conditions of work, is extreme.

27. Despite expressing a strong commitment to the profession of disability services in general, and the goals of the NDIS in particular, several of our research participants (most of whom were long-term employees in the sector) expressed an expectation that they would leave the industry, due to the intolerable nature of some of these problems.

28. These first-hand reports of dissatisfaction with conditions of work in the industry, and a growing risk of departure from the sector, reinforce aggregate data regarding high rates of turnover in the disability services sector. NDS (2018b) reports average job turnover of over 25% of workers per year in disability services (derived from NDS, 2018b, p. 9), about three times as high as turnover in the overall labour force (ABS, 2019, Summary).

29. It is important to note that two of the most commonly-expressed problems encountered in our qualitative research relate directly to the topics under consideration in this Four-Yearly Review of the SCHDS industry Award. Multiple interviewees reported the great difficulties of managing very unstable and unpredictable shift and roster schedules, and balancing the demands of such unpredictable work with their other family and community responsibilities. The assignment of DSWs to work discontinuous shifts, often in diverse locations, greatly exacerbates the personal cost and stress of this instability in work. The time spent in traveling to and from work under these split or broken shifts, and the often wasted time between these short periods of work, has the

effect of greatly reducing the effective hourly income associated with this work – as well as imposing considerable stress on the workers and their families.

30. Similarly, multiple interview participants expressed strong concern about the growing requirements to perform transportation services as part of their jobs as DSWs. It is now common to require DSWs to use their own personal vehicles – both to travel to multiple sites of work, and in many cases to transport NDIS clients. Reported practices are highly inconsistent regarding compensation for the costs involved in that use (with some participants instructed by employers to claim these costs as business expenses on their income tax returns, rather than being directly reimbursed). Provision of safety equipment, appropriate insurance, and training in the safe operation of vehicles while supervising clients (who may have pressing and immediate needs),[14] was also found to be inadequate or non-existent.

[14] This challenge is particularly acute for DSWs transporting clients with intellectual, cognitive, or complex needs, who may require immediate attention from their carers.

Part II: Responses to Specific Questions Addressed

31. In this section of my export opinion I will respond in turn to the four specific questions addressed to me in the letter of instruction received from the Australian Services Union.

A. Training, skills and qualifications required by the disability sector

32. The disability services workforce is very diverse. Some workers are specialised professionals who have obtained advanced education and qualifications. Some workers do not possess any formal post-school training or qualifications at all.

33. One important concern regarding the implementation of the NDIS, given its reliance on decentralised and individualised decisions regarding service provision, is the extent to which financial and cost-cutting pressures may steer the industry toward the provision of lower-cost services by workers with less formal training and qualifications.

34. The NDIS is still developing its approach to regulating the registration and qualifications of service providers. At this point there is no required qualification or registration procedure for individual DSWs employed at service-providing firms or agencies.[15] Effective 1 July 2020, workers in certain specified roles will need to be screened and receive a check (similar to existing checks for people working with children).[16] But there is no required formal training or qualification for people to be hired as DSWs. This means that individuals working in these roles may have no formal training or qualification in this occupation.[17]

[15] Agencies and organisations providing disability support services must register with the NDIA and, where relevant, state governments. And of course, some specialised health services are covered by NDIS funding, and the allied health professionals delivering those services are covered by the same regulations and qualification requirements that normally apply to their respective professions. For individuals employed in general disability support work, however, similar regulations and requirements are absent.
[16] NDIS Quality and Safeguards Commission (2019).
[17] The State of Victoria is considering a system of mandatory registration and accreditation for disability support workers that would be the first step toward regulating qualifications for DSWs. See Department of Premier and Cabinet of Victoria (2017).

35. A common misperception about work in disability services is that it is unskilled and that workers in the industry do not need any special qualifications to work there. This stands in contrast to the view of clinicians, social workers, disability specialists and participants themselves: namely, that this work requires sophisticated communications skills, a high level of emotional intelligence, and (depending on the complex and varied needs of the participant) specialist knowledge (for example, in relation to particular medical conditions, dealing with challenging behaviour, or understanding the side-effects of medications). In addition to multiple and complex needs, people with disabilities may also need support in managing multiple and complex interactions with government and non-government agencies in the course of addressing their housing, medical, and educational support needs.

36. At present there is no requirement for disability support workers to have any minimum industry-relevant qualification. However, analysis of the skills and qualifications of the existing workforce in the lead-up to the introduction of the NDIS confirms that many are in fact very well-qualified. In 2010, a survey undertaken by the National Institute of Labour Studies (NILS, 2010, p. 129) found that 72 percent of non-professionals working in the industry held a nationally recognised Certificate III or IV qualification, with 48 percent of these holding a Certificate IV in Disability. Although not compulsory, the NDIA advises registered providers that a Certificate III or similar is desirable for support roles (Windsor and Associates, 2014b), and the industry as a whole regards the Certificate III as a minimum base-level qualification.

37. In addition to those holding these industry specific qualifications, a high proportion of the current workforce also have additional tertiary level qualifications. An online survey of 300 respondents undertaken by the Australian College of Community and Disability practitioners between November 2016 and March 2017 found that 31 percent held a Bachelor's or Master's degree or graduate Diploma, 28 percent held a Diploma-level qualification, and 38 percent had Certificate III or IV level qualifications.[18] The Productivity Commission estimated that over 80% of the current workforce in aged and

[18] Australian College of Community and Disability Practitioners survey, cited in Ryan and Stanford (2018, p. 24). The survey did not indicate whether the qualifications were directly related to disability services.

disability care roles possess some form of tertiary qualification (Productivity Commission, 2017b, p. 334).

38. Unfortunately, despite the significant qualifications possessed by the current workforce, evidence collected by NDS (2018b) indicated that most new recruits to the sector do not possess any formal qualification in disability services work. Just one in five new recruits to the industry in 2017 held a Certificate III designation in disability services or higher qualification (NDS, 2018b, p.19).

39. Similarly, citing Department of Employment survey research, the Productivity Commission reported that 89% of employers in the disability and personal care field indicated that a certificate-level qualification was essential for the job (Productivity Commission, 2017b, p. 339). Contradicting this view, however, over one-quarter of responding employers indicated that they regularly hire workers with no formal qualifications.

40. The gap between the broadly-shared view that high-quality disability services work requires workers with specialised tertiary qualifications, and the fact the most new recruits do not possess such skills (in the context of the rapid expansion of disability services provision under the NDIS) indicates a looming crisis in both quality of work (for workers in the industry) and quality of care (for NDIS participants). It also constitutes prima facie evidence that the industry needs to improve its "offer" to prospective employees. It is impossible to imagine that the requisite number of qualified, skilled and motivated workers could be attracted to this industry, given the unappealing or even intolerable conditions and insecurities which they would face in their new jobs.

41. We may now consider some of the current vocational education offerings that are presently available in Australia for prospective workers who wish to specialise in disability services work. Two qualifications in the sector are recognised nationally as part of the formal Vocational Education and Training (VET) framework. These two qualifications are:

a. *CHC 33015: Certificate III in Individual Support (Disability)*;
b. *CHC 43115: Certificate IV in Disability Support.*

42. For a Certificate III, students must undertake 7 core and 6 elective Units of Competency; and complete 120 hours of work experience (including completing a set of written and practical tasks in the workplace).

43. Defined qualifications for the sector are overseen by SkillsIQ (the Skills Service Organisation that covers the disability support sector as part of the wider community and social services area). No higher-level qualification vocational pathways are formally defined for disability support work, although many people working in the sector have higher-level qualifications in health or allied health disciplines (such as nursing and social work).

44. For a workforce that is low-paid and works a limited number of hours, there are significant barriers to enrolment and completion of vocational qualifications. There are a large number of private RTOs offering these and other relevant training packages (including some larger employers that have their own internal training and development divisions); and a considerable amount of training is undertaken in publicly-funded TAFEs. The costs of courses vary from provider to provider (and may depend on government-determined eligibility for funding requirements), but can range upwards of $2,000. A compulsory work placement (of 120 hours), with workplace assessments, is also required, along with course work. There is no reliable evidence about the extent to which those completing these qualification are employed during the course of their training (i.e. people may complete courses on a pre-employment basis); whether they pay the costs of their own training; and whether costs of attendance (including paid time off) are met by their employer.

45. In recognition of the need for workers to complete some minimal level of training to work in the sector, an accredited induction skill set, *CHCSS00081 Induction to Disability*, was approved in 2015. It comprises four units of competency from the Health and the Community Services Training Packages, all focused on NDIS-specific aspects of

broader care work. The *Induction to Disability* skill set is designed for newly appointed disability support workers. It can be included as credit towards completion of the Certificate III Individual Support (Disability) or other national qualifications. However, take-up of this program by employers has so far been relatively rare.

46. In my original research with Ryan on the unmet skills needs of the disability services sector (Ryan and Stanford, 2018), we identified the instability of employment arrangements, the low wages, and the absence of defined and regulated career paths as key barriers inhibiting current and prospective disability support workers from accumulating more formal training. We proposed several measures to help improve and stabilise working conditions, and suggested that efforts to regulate more closely the job classifications and qualifications of different roles in the industry could reinforce efforts through other channels (including changes to the SCHDS Award) to develop better jobs.

47. Finally, it is worth considering further how the implementation of the new market-driven, individualised structure of the NDIS is affecting the industry's skills requirements. Indeed, the NDIS pricing model has had significant consequences for training and development in the sector. One of the major concerns has been a reduction in the time allocated for training within agencies, as a result in part of the lack of resources to support these broader overhead functions under the NDIS's unit-pricing model. Team meetings having all but disappeared; supervision has been severely curtailed; and many casual workers have been newly-employed with almost no supervision at all. These concerns are corroborated by employers, over a third of whom agree that support staff are not paid to attend regular team meetings or attend training and development activities (Cortis *et al*., 2017).

48. A well-trained workforce is essential for achieving the quality of support promised by the system, but the experience so far in Australia supports international findings (Iancono, 2010) that consumer-directed delivery models tend to pay little attention to the need for long-term workforce development. Market forces cannot autonomously resolve these fundamental shortcomings; it will require pro-active regulation, attention and fiscal support to mobilise the ongoing investments in skills upgrading that the sector

requires. One of those pro-active initiatives would be to stabilise working hours, incomes, and conditions, to make the prospect of a career in disability services more appealing, and hence motivate the entry of additional recruits. Moreover, by stabilising and regulating work, opportunities are opened up to attach greater formal training requirements to job classifications and career paths.

B. Connection between the terms and conditions of the SCHDS Award, including broken shifts and unpaid travel time, and the disability sector's ability to attract appropriately skilled workers

49. The SCHDS Award plays an important role in establishing a benchmark of minimum wages, working conditions, and practices that applies across the broader community and human services sector, in line with the general Modern Awards objective to "provide a fair and relevant minimum safety net of terms and conditions."[19] Without the influence of the Award, there is no doubt that the downward pressure on job stability, compensation, and working practices that has been evident in the sector as it transitions toward the NDIS would be even more intense and damaging. The provisions of the Award clearly moderate the extent to which the fiscal pressures and operational flux associated with the roll-out of the new system have impacted on the stability and quality of work for disability service workers.

50. The unit price framework specified by the NDIS for disability services (under the NDIS's Reasonable Cost Model, RCM) makes explicit reference to the need of disability services agencies and employers to at least meet the minimum conditions specified in the Modern Award.[20] The price guides published by the NDIA proscribe maximum hourly payments for different categories of support (with slight variations depending on time of day, complexity of support needs and for remote locations). Those hourly payments explicitly require that all costs of providing support by a support worker employed under the SCHDS Award by a "reasonable" service provider be

[19] Fair Work Act, Section 134(1). The full text of the Award is at Fair Work Commission (2019).
[20] NDIS participants with self-managed plans can determine their own prices for contracted services, presumably in negotiation with providers.

included in the cost base. However, since the roll-out of the NDIS began, the realism of this pricing model in relation to the true costs of providing support, and the transparency of the decisions made in respect of price-setting, have come under increasing criticism (Cortis *et al*., 2017; McFadden, 2017).

51. Many agencies report challenges in covering the costs of those minimum standards from within the unit prices specified under the NDIS. For example, one survey of approximately 130 registered NDIS providing organisations found that current pricing levels do not enable them to meet the obligations specified under the SCHDS Award, to recruit or retain staff, and/or to cover the costs of support workers travelling between clients (Cortis and Blaxland, 2017, p. 10). In this regard, inadequacies in the NDIS fiscal system – including both inadequate unit price levels, and the deeper failure of the unit price system to allocate sufficient resources for overhead and infrastructural tasks (like training, supervision, and consultations among staff) clearly establishes a negative context for the development of a skilled, motivated disability services workforce.

52. Partly in response to these criticisms, the NDIA has recently announced some significant revisions to unit prices under its RCM, effective 1 July 2019.[21] These changes include:[22] price increases for various services (ranging between 1 and 5% for most services); adjustments to pricing for group activities; a new Temporary Transformation Payment (TPP) to supplement revenue for registered providers during the transition to the NDIS;[23] and an expansion of allowable transportation charges for some services (in some cases, such as core support services, allowing for up to 30 minutes travel time charged for traveling to an appointment in urban areas, and up to 60 minutes in regional areas).[24]

53. These changes will incrementally improve the ability of service providers to cover reasonable and necessary costs for their workers, as well as for overhead functions (like

[21] See NDIS (2019b).
[22] See Naufal (2019).
[23] The TPP will be phased out over time.
[24] Workers providing capacity building supports can charge more travel time, including return trips to their central place of work.

staff meetings, training and supervision). But they will clearly not eliminate the fiscal "squeeze" on the ability of the industry to meet the needs of NDIS clients, while simultaneously respecting the minimum standards set out in the SCHDS award, let alone aspiring to set higher standards in work practice. In particular, allowing providers to charge participants for things like travel and non-face-to-face overhead activities will mean little if participants' personal budgets are still unrealistically constrained; without additional funding to participants, these changes in allowable billing may simply force clients to abandon certain aspects of their personal programs in order to stay within their respective budgets.

54. While the SCHDS Award contains important provisions which protect DSWs from some of the worst potential consequences of the industry's shift toward a more fragmented, irregular, and market-driven mode of service delivery, features of the Award have nevertheless permitted and facilitated the growth in insecurity and precarity which has been confirmed by our original research. In particular:

a. The SCHDS Award has permitted the growing use of casual labour, which now accounts for most employment in the sector (and virtually all new hires). Casual workers are not protected by many of the same basic provisions (for example, regarding stability in shift scheduling or entitlements to notice of termination or redundancy pay) as permanent workers.
b. The SCHDS provisions for minimum call-out periods are weak; casual DSWs can be engaged for as little as 2 hours at a time, and there is no minimum call-out period for part-time workers.[25] The absence of stronger rules on minimum call-out has clearly facilitated the evolution of work in disability services toward discontinuous, unstable, and irregular hours of work.
c. The Award also allows employers to assign "broken shifts" (with one or more uncompensated non-meal breaks within any 12-hour period), to both permanent and casual employees in disability services, with no penalty.[26] This also facilitates the fragmentation and disruption of normal work schedules, complicates the challenges

[25] Sections 10.3 and 10.4.
[26] Section 25.6.

facing disability service workers to maintain health work-life balance, and undermines their effective hourly compensation (since time between portions of broken shifts typically occurs at sub-optimal locations and times of the day, thus preventing workers from experiencing full "value" for their leisure time).

55. Our original research noted the importance of the growing burden of transportation-related duties in contributing to the insecurity of work for DSWs, adding to their stress and safety risks, and undermining their effective hourly compensation. On this matter, the SCHDS Award is also clearly incomplete in establishing minimum safety net protections. It broadly specifies that the required use of a private vehicle for work purposes must be compensated by employers at $0.78 per kilometer.[27] However, our original research has indicated that this provision is not uniformly applied in practice.[28] The SCHDS Award is silent on the other important problems we discovered regarding DSWs' performance of transportation services, including inadequacy of necessary safety equipment and insurance, and inadequacy of training in safe operation of vehicles for work purposes. These issues are especially important when workers are required to transport clients in their own vehicles. Nor does the Award discuss issues regarding extra costs related to damage of personal vehicles during work use (which was also identified as a major concern by participants in our original research).

56. Finally, and perhaps most importantly, the Award presently does not specify minimum standards of practice regarding compensation for workers in work-related travel. Given the fragmentation of work assignments under the NDIS, and the increasingly common requirement that DSWs must travel to their clients – in some cases to multiple locations in the course of a day – work-related transportation is occupying a growing share of DSWs' total time. This is especially true for the casual employees who now make up the majority of employees. Failure to compensate workers for this often-onerous transportation time (a practice, again, that was confirmed in our original research with

[27] Section 20.5.
[28] See Baines, Macdonald and Stanford (2019), pp. 22-26.

front-line workers[29]) thus translates into a substantial reduction in effective compensation. To describe an extreme example, if a part-time worker were required to attend to 4 different clients in the course of a day, with each visit compensated for one hour, and requiring 1 hour of travel or non-compensated down time between assignments[30] plus 30 minutes travel at each end of the day, then the worker spends a total of 8 hours time to perform 4 hours of compensated work. Thus their effective compensation per hour spent working or getting to work is cut in half relative to the nominal amount specified in the Award: to under $11 per hour for a worker at the SACS Grade 1 level. Allowing employers free reign to organise work in such a fragmented, inefficient and unfair manner will only further degrade effective conditions and compensation in the sector, and clearly exacerbate the challenges of recruitment and retention.

57. Note that the hyper-flexibility permitted by the SCHDS Award in shift scheduling, short assignments, broken shifts, and required but uncompensated travel time serves to eliminate the incentive or pressure on employers to try to organise work in the most efficient and stable manner. From the employer's perspective, there is little if any incentive to avoid scheduling work in small, discontinuous blocks (motivated, presumably, by the fragmented and unpredictable nature of demand from clients), nor to geographically plan the assignment of appointments to minimise travel time. When something is "free" (in this case, the disruption and uncompensated time of workers), it will not be treated with value and used efficiently. The weakness of the SCHDS Award in addressing these problems of instability and unpredictability in working arrangements is thus clearly facilitating the further fragmentation and destabilisation of work in the sector.

58. Other ways in which the framework determined by the SCHDS Award does not fully regulate working conditions and practices in the industry include the fact that it applies

[29] See Baines, Macdonald and Stanford (2019), pp. 22-26.
[30] Since the shifts can be broken without penalty, there is no requirement for the employer to align assignments in an efficient and continuous manner, so it would be unusual for the timing of assigned visits to perfectly align with travel schedules.

only to employees in the sector (not to independent service providers, contractors, and suppliers), and the fact that NDIS participants with self-managed plans are able to negotiate their own prices for contracted services (and hence are not directly bound by the minimum compensation and practice standards specified in the SCHDS Award, unless they contract with registered providers who are themselves bound by the Award).

59. In my judgment the two proposed revisions to the SCHDS Award – to specify penalty wage rates in cases of split or broken shifts, and to require minimum payment at normal rates for work-required transportation services – are both well-justified responses to problems of work fragmentation and unfairness that were documented in our original research, and in other studies. They would represent small, partial but important steps in addressing the growing fragmentation of work in this sector: a trend that is undermining the quality of work life for DSWs, the quality of service for clients, and the fundamental economic efficiency of agencies and employers.

60. In addition to these important reforms, the Commission, the Fair Work Ombudsman, and the industry need to pay more attention to regular enforcement of the Award's provisions. Our original research indicated that even existing provisions of the Award regarding transportation (such as the requirement to compensate workers for use of their personal vehicles) are not always applied in practice.

C. Disability sector's ability to attract a sufficient number of appropriately skilled workers

61. As our original research, and other published literature, has confirmed, the profound and growing instability and precarity of working arrangements in the disability services sector is clearly contributing to the industry's workforce development challenges. With good reason, potential and motivated new recruits have grave doubts about their ability to earn a decent, stable living in this industry, or their ability to balance work and family/life commitments in a sustainable and healthy manner (given the constant turmoil they should expect to experience in their working lives). By endorsing and facilitating this degradation and destabilisation of work, the SCHDS Award as presently specified is

clearly failing to address this growing challenge – despite its incremental benefits in establishing and improving minimum standards and practices in some important areas. I expect that the sector's recruitment and training difficulties will become more acute over time, as the demand from NDIS participants grows, as the sector becomes even more casualised, as disability service jobs become even more precarious, and as the existing cadre of more experienced and skilled workers continues to exit the industry (due to normal retirement or to premature departure as a result of intolerable conditions).

62. At present, the majority of new workers recruited to work in the sector do not possess any formal qualification in disability services work. According to the NDS (2018b) database, just one in five new recruits to the industry in 2017 held a Certificate III designation in disability services or higher qualification (NDS, 2018b, p.19).

63. This suggests that new recruits to the industry have considerably less training and qualifications than the existing workforce (as described by the Productivity Commission, 2017b, p. 334). This finding is consistent with the findings of the original qualitative research I conducted with Baines and Macdonald (Baines, Macdonald and Stanford, 2019, pp. 18-21), which similarly reported that incoming recruits had relatively weak qualifications and capacities; this resulted in an increase in workloads, responsibilities, and stress for existing more senior workers (who had to try to fill in tasks which new recruits were unable to perform).

64. The relatively less-skilled nature of new recruits reinforces the urgency of developing and funding ongoing training programs to enhance the skills and capacities of new recruits. It also underlines the importance of trying to stabilise the existing workforce and reduce turnover, thus preserving the skill base and human capital of current DSWs. Finally, it certainly reinforces the conclusion that the industry is unable, given its current practices, to attract the skilled workers that will be required to meet the expanded service delivery needs associated with the NDIS.

65. There is additional empirical evidence confirming that employers in the sector face major challenges in attracting new workers to the industry. The NDS (2018b) database indicates that four-fifths of all agencies attempted to hire new staff during the March 2018 quarter (NDS, 2018b, p.21). Of those, nearly one-third were unable to fill all the vacancies they advertised for, and unfilled positions accounted for 25% of all advertised positions (NDIS, 2018b, p. 22). Some agencies advertise permanently for new recruits, with no limit on hiring – in essence hiring all the new staff they can find.

66. In the March 2018 quarter, 43% of employers with unfilled vacancies cited an absence of suitable qualified candidates as the main reason for their unsuccessful recruitment effort (NDS, 2018b, p. 23). That was up sharply from 29% answering the similar question a year earlier, attesting to the increasing recruitment challenges facing the industry. Employers also cited the requirement "to work flexible hours in order to fit shifts that align with client needs" as another factor in their recruitment challenges (NDS, 2018b, p. 22).

67. At present, in conclusion, it is clear that the disability services sector is not meeting the challenge of recruiting, retaining and training a workforce of suitably qualified and motivated disability service workers that will be essential to meet the laudable goals of the NDIS. Part of the problem in this regard clearly rests with inadequacies in the structure and funding model of the NDIS itself. But part of the problem also related directly to the practices of disability agencies and providers, which are shifting the risks and uncertainties associated with the new system onto the backs of their workers. In most respects the SCHDS Award has permitted and facilitated this shifting of risk and uncertainty, and in so doing is contributing to a situation in which the quality of work and the quality of care in this sector are both damaged.

68. Disability sector employers can rightly complain about the failures of current NDIS funding practices to allow for normal costs of high-quality, sustainable service delivery: including inadequate allowances for training, supervision, and other overhead staff functions; and an unrealistic and extreme unit pricing system which fails to recognise that it is impossible to organise disability services work without down time, travel time,

and non-face-to-face time. But if providers are allowed to respond to those pressures by simply shifting the resulting costs, risks, and instability to workers, the long-run result will certainly be a workforce that is unstable, demoralised, and unqualified. Moreover, pressure to fix the underlying problem (flaws in the design of the NDIS pricing and delivery models) will be dissipated. It is unreasonable to expect DSWs to effectively subsidise the operation of an inadequately designed and funded system, through their own precarious and intolerable working conditions.

69. In this regard, by establishing firm benchmarks for fair and sustainable work practices in this rapidly-changing industry, and preventing employers from forcing DSWs to "pay" for the resulting fragmentation and uncertainty, these reforms to the SCHDS Award will contribute to the longer-run task of improving NDIS design. Agencies may have to go back to the NDIA (as part of the annual unit price review process) to argue for additional resources to account for changes in the SCHDS Award (regarding fair compensation for broken shifts and transportation time).[31] But that is necessary in a system which is still "finding its way" in building a fiscal system within which high-quality disability services can be sustainably provided.

D. Implications for quality of care

70. There is a well-established relationship reported in peer-reviewed international research from a range of disciplines that the quality of care provided to recipients of various human services depends importantly on the stability, tenure, training, and motivation of the caring workforce.[32] Improving the quality and appeal of jobs in human and caring services occupations will thus have a direct and necessary impact on improved quality of care. As summed up by the Organisation for Economic Cooperation and Development,

[31] The 2019 adjustments to unit pricing will provide some additional resources to address those problems.
[32] Representative examples of this extant literature from education, health care, aged care, disability services, and other caring industries include: Aiken *et al*. (2002); Dieleman and Harnmeijer (2006); Steinwachs *et al*. (2003); Kashen *et al.* (2016); Geisler *et al*. (2019); Carr (2014); Hotta (2007); Baines and Armstrong (2015); and Molineuvo *et al.* (2014).

"measures to improve retention can have a good return on investment, such as lower turnover, higher job satisfaction and better quality of care."[33]

71. In the specific context of disability services provision in Australia, accumulating evidence paints a similar picture that high levels of staff turnover; inadequate training, especially of new staff; inadequate opportunities for supervision and support of workers; inadequate systems for exchanging information between DSWs; inadequate provisions for transportation services related to accessing services; and other shortcomings in service delivery are all serving to negatively affect the quality of service and care received by NDIS participants.[34]

72. Our original research interviews with front-line workers under the NDIS in the Newcastle region revealed several ways in which instability and fragmentation of work, high staff turnover, inadequate and unfair compensation, inadequate training, inadequate supervision and support, and unreasonable requirements on staff all directly undermined the quality of service and care which DSWs are able to provide to their clients. Some of these specific channels of impact on quality of care include:

a. DSWs who work broken shifts in multiple locations rarely attend a central office or agency site, which prevents them from accessing information about clients or conferring with colleagues on treatment strategies (Baines, Macdonald and Stanford, 2019, pp. 28-30).
b. Very high staff turnover exacerbates problems with underskilled new workers, who do not have the skills or experience to address complex needs, consequently resulting in a higher burden of responsibility on the remaining more senior staff (Baines, Macdonald and Stanford, 2019, pp. 18-21).
c. The requirement that DSWs transport clients in their own vehicles creates situations where DSWs cannot simultaneously meet their clients' needs and safely operate their vehicles (Baines, Macdonald and Stanford, 2019, pp. 22-26).

[33] OECD (2008), p. 199.
[34] Concerns regarding quality of care under the NDIS, and the connection between quality of care and the stability and conditions of work, are discussed by Cortis (2017), pp. 41-42; United Voice (2017); Ryan and Stanford (2018), pp. 33-34; and Australian Service Union (2019).

d. Working without peer support in clients' private homes exposes DSWs to greater risk of violence and safety issues, and there is no opportunity to consult with or get support from colleagues in difficult situations (Baines, Macdonald and Stanford, 2019, pp. 21-22).

73. In sum, there is no doubt that the increasing fragmentation and insecurity of work for DSWs under the NDIS, the pattern of inadequate training, supervision and team support, and the very high staff turnover experienced in the industry, are having negative consequences for the delivery of high-quality disability support services, and thus defeating the ambitious goals of the NDIS. It is incumbent on all stakeholders in the system – including funders, managers of agencies, workers and their unions, clients and their advocates, and regulators – to find ways to stabilise the pattern of work in the sector. This will have many positive impacts on the quality of service and care received by participants in the system.

Conclusion and Declaration

74. My original research (in conjunction with co-investigators) of working practices, working conditions, and training needs in disability services work under the NDIS has confirmed that the new system is having a major negative effect on the stability and quality of work. In particular, work has been increasingly casualised, working hours have become highly irregular and fragmented, training and staff supports are sadly inadequate, and (as a result of these problems) staff turnover is very high.

75. This general finding is confirmed by my review of the extant academic, statistical and policy literature regarding negative trends in job stability, turnover, training and supervision for disability service workers, and the resulting negative impacts on both the retention and quality of the disability services workforce and the quality of care for people with disabilities.

76. The very important and laudable ambitions of the NDIS to provide disability services in a more respectful, democratic, and flexible manner will be squandered without urgent attention to the emerging crisis in the stability and quality of work in the sector. Urgent attention should be given by all stakeholders to the priority of improving job quality, stability, training, and compensation as a precursor for attracting and retaining the skilled, motivated workforce that is essential to the future success of the scheme.

77. To this end, I find the proposed amendments to the SCHDS Award to be modest, incremental, and sensible. They would make a small but important difference in stabilising jobs and schedules, preventing the further needless fragmentation of work, and somewhat improving fairness in compensation practices. Much more needs to be done to address the issues of precarity and fragmentation in disability service work, but these two steps would constitute a significant step in the right direction.

78. I have made all the inquiries that I believe are desirable and appropriate and no matters of significance that I regard as relevant have, to my knowledge, been withheld from the Commission.

Signed:

Dr. James Stanford

Sydney, Australia

23 September, 2019

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List of Attachments

A. Curriculum vitae for Dr. James Stanford

B. Letter of instruction from Australian Services Union

Full reports appended to expert opinion of James Stanford:

C. Baines and Macdonald (2019)

D. Baines, Kent and Kent (2019)

E. Baines, Macdonald, Stanford and Moore (2019)

F. Baines, Macdonald and Stanford (forthcoming)

G. Ryan and Stanford (2018)

H. Stanford (2018)

Curriculum Vitae

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1. Current Status:

Economist and Director, Centre for Future Work
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Harold Innis Industry Professor (fractional appointment)
Department of Economics, McMaster University
Hamilton, Ontario, L8S 4L8, Canada

Honorary Professor, Department of Political Economy
University of Sydney
Sydney 2006 Australia

2. Education:

Graduate Faculty, New School for Social Research, New York (1990-95)
Ph.D. in Economics

Degree conferred in 1995.
Dissertation: *Social Structures, Labor Costs, and North American Economic Integration*.
Areas of concentration: international economics, macroeconomics, labour economics.

University of Cambridge, Cambridge, U.K. (1985-1986)
M.Phil. in Economics
Degree conferred with distinction in 1986.
Areas of concentration: labour economics, macroeconomics.

University of Calgary, Calgary, Alberta (1979-1984)
B.A. (Hons.) in Economics
Degree conferred with distinction in 1984.

3. Employment History:

Centre for Future Work, The Australia Institute, Sydney, Australia (2016-present)
Economist and Founding Director.
Responsible for research, publication, public commentary, and fund-raising for research centre addressing labour market and employment policy issues.

McMaster University, Department of Economics, Hamilton, Canada (2015-present)
Harold Innis Industry Professor, Department of Economics (fractional appointment).
Responsibilities: teaching postgraduate courses in economic policy, co-supervising graduate students, participation in funded research.

Unifor, Toronto, Canada (1994-2015)
Economist, and Director of Economic, Social and Sectoral Policy.
Canada's largest private sector trade union (formerly Canadian Auto Workers).
Responsibilities: macroeconomic, labour market, fiscal, and trade policy analysis; collective bargaining and corporate research; union strategy; member education.
Oversaw union's policy development, co-managed department with 7 total staff.
Continuing role as economic advisor to Unifor's leadership team.

Brookings Institution, Washington DC (1992-1993)

Research Fellow, Economic Studies Program.
Conducted research project on quantitative models of the economic effects of North American free trade.

Canadian Union of Public Employees, Ottawa (1989-1990)

Research Assistant, Research Department.
Responsibilities: macroeconomic and fiscal policy analysis; collective bargaining research; pension planning.

Canadian Energy Research Institute, Calgary (1986-1989)

Research Economist.
Responsibilities: world oil demand and supply modelling and market analysis; analysis of electricity industry regulation and deregulation.

4. Professional Organizations:

Member, Canadian Economics Association.
Member, Economic Society of Australia.
Steering Committee Member and Past Chairperson, Progressive Economics Forum.
Founding Member, World Economics Association.
Member, Former Steering Committee Member, Union for Radical Political Economics.

5. Scholarly and Professional Activity:

5.1 Academic Journals:

Member, Editorial Board, *Studies in Political Economy*, 1999-present (Canada's leading political economy journal).

Member, Editorial Board, *Labour – Le Travail*, 2003-2017 (Canadian labour studies and labour history journal).

Have served as peer reviewer for several other academic journals, including the *Cambridge Journal of Regions, Economies, and Society*; the *International Review of Applied Economics*; *Canadian Public Policy*; *Economic and Labour Relations Review*; and the *Journal of*

Australian Political Economy.

5.2 Other Academic Activity:

Honorary Professor, Department of Political Economy,
University of Sydney, Australia, 2016-present.

Visiting Scholar, School of Population Health,
University of Melbourne, Australia, 2006-2007.

Adjunct Professor and Council Member,
Centre for Research on Work and Society (renamed Global Labour Research Centre),
York University, Toronto, 1997-2007.

Co-Chair, Working Group on Labour Market Regulation and Deregulation,
Centre for Research on Work and Society, York University, Toronto, 1998-2002.

5.3 Government and Policy Bodies:

Member, Jobs and Prosperity Council, Government of Ontario, 2012-2013.

Technical Expert, Ontario Workplace Safety and Insurance Board Funding Review,
2010-2011.

Vice Chair, Ontario Manufacturing Council, Government of Ontario, 2007-present.

Member, Board of Directors,
Public Policy Forum, Ottawa, 2004-2010.

Member, Expert Panel on Business Innovation,
Council of Canadian Academies / Industry Canada, 2007-2009.

Member, Mayor's Independent Fiscal Review Panel,
City of Toronto, 2007-08.

Canadian Automotive Partnership Council (CAPC), Industry Canada,
Co-Chair, CAPC International Trade Committee, 2002-2015.

Selected Specialist on Budgetary Estimates,
House of Commons of Canada, Finance Committee, 2004-2006.

Member, Minister's Advisory Committee on Air Policy Issues,
Ministry of Transportation, Government of Canada, 1996-1997.

Co-Chair, Marketing, Investment and Finance Task Force,
Machinery, Tool, Die and Mould Industry Sectoral Partnership Initiative,
Government of Ontario, 1994-1995.

Co-Chair, Export Development Task Force,
Electrical and Electronics Industry Sectoral Partnership Initiative,
Government of Ontario, 1994-1995.

5.4 Community and Voluntary Activities:

Member, Members' Council, and Research Associate,
Canadian Centre for Policy Alternatives, Ottawa, 1996-present.

Chair, Advisory Board, Ontario Office, Canadian Centre for Policy Alternatives,
Toronto, 2012-2015.

Member, Advisory Committee, *leadnow.ca*, 2011-2015 (internet social activist organization).

Director (2002-15) and Member of Advisory Committee (2015-present), Canadian Foundation for Economics Education.

Member, Steering Committee and Co-Author, Alternative Federal Budget Project,
Ottawa, 1995-2015.

6. Main Areas of Research Interest:

Economic structure and sectoral policy: Impact of resource and commodity cycles on economic and industrial structure; industrial and sectoral development strategies under globalization; environmental constraints, environmental policy, and industrial structure.

Precarious work, unions, and new models of organization: Economic and social effects of trade unions and collective bargaining; impact of economic changes and globalization on union power; new forms of union organizing and collective representation; collective organization in precarious and non-standard work; relationships between technology, productivity, union power, and inequality.

Globalization, trade policy, and economic modelling: Economic impacts of trade policy and new free trade agreements; critique of neoclassical models of international economic integration; national industrial policy and global supply chains; alternative trade and development policies.

7. Honours and Awards:

Progressive Economics Forum (2018)
"Galbraith Prize," for lifetime contribution to progressive economic research and pedagogy.

Ontario History and Social Science Teachers Association (2015)
"Outstanding Canadians Leadership Award," for economic literacy initiatives.

Canadian Civil Liberties Association (2012)
Award for outstanding "Public Engagement," for economic commentary and economic literacy initiatives.

Canadian Association of Labour in Media (2011)
Best Public Advocacy Video in 2010, awarded for "The Curious Case of the Missing Recovery" (dir. Michael Connolly, 12 minutes).

Public Policy Forum Testimonial Award (2011)
Award for noteworthy contributions to public policy in Canada.

New Unionism Network (2009)
Best Labour Book of 2008, awarded for *Economics for Everyone: A Short Guide to the Economics of Capitalism* (London: Pluto Books).

Frieda Wunderlich Memorial Award, New School for Social Research (1995)
Awarded for best dissertation by a non-U.S. graduating Ph.D. student.

SSHRC Post-Doctoral Fellowship, York University (1994)
Awarded for two years, "Institutional Structures and North American Economic Integration." (Fellowship declined in favour of position with Canadian Auto Workers.)

Leo Model Research Fellowship, Brookings Institution, Washington D.C. (1993-94)
Awarded for quantitative study of the economic consequences of the NAFTA.

Social Sciences and Humanities Research Council, Doctoral Fellowship (1991-1995)
Four-year award to support doctoral studies in economics.

Eberstadt Prize Fellowship, New School for Social Research (1990-1993)
Three-year award to support doctoral studies in economics.

National Journalism Award, Canadian Petroleum Association (1991)
Best feature article prize, for magazine article on Canadian natural gas exports.

Letter of Distinction, University of Cambridge (1986)
Awarded for highest grades in M.Phil. graduating class.

Commonwealth Scholarship (1985-1986)
Award to support M.Phil. studies in economics.

8. Teaching Experience:

Australian Council of Trade Unions, Australia (2016-present)
Designed and taught 5-day and 2-day residential courses on "Economics for Unionists" as part of The Union Education Foundation programme.

Dept. of Economics, McMaster University, Hamilton, Canada (2016-2018)
Postgraduate seminar course in economic policy (fractional position).

University Guest Lectures
Delivered dozens of guest lectures, both undergraduate and postgraduate, in economics, political economy, and economic policy at universities around the world, including: Renmin University (Beijing), University of Sydney, University of Melbourne,

University of Strathclyde, University of Wisconsin in Madison, University of Vermont, New School for Social Research, University of Massachusetts at Amherst, University of Toronto, York University, Ryerson University, University of British Columbia, University of Guelph, Trent University, Laurentian University, University of Western Ontario, King's College (London, Canada), and Queen's University (Canada).

Unifor, Toronto, Canada

Designed and taught annual courses from 2006 through 2015 on "Economics for Trade Unionists" in on-line, classroom, and residential settings.

Other Labour Movement Education

Have designed and taught courses, based on my book *Economics for Everyone: A Short Guide to the Economics of Capitalism*, for other labour organizations including the Australian Council of Trade Unions (ACTU), International Transport Workers Federation (ITF), the Canadian Labour Congress (CLC), the Australian Manufacturing Workers Union (AMWU), and the New Zealand Council of Trade Unions (NZCTU), in classroom and residential settings.

Eugene Lang College, New York City (1992)

Undergraduate Instructor, Social Sciences Department: Introductory economics.

Graduate Faculty, New School for Social Research, New York (1991)

Teaching Assistant, Economics Department: Postgraduate macroeconomics.

University of Calgary, Calgary, Alberta (1987-1988)

Undergraduate Instructor, Economics Department: Microeconomics, macroeconomics.

9. Postgraduate Students Supervised or Examined:

Phillipe J. Scrimger, Ph.D., Industrial Relations, Université de Montréal, successfully completed, 2018."The Distributive Effects of Trade Unionism: A Look at Income Inequality and Redistribution in Canada's Provinces." External examiner.

Martin Duck, M.A., Political Economy, University of Sydney, successfully completed, 2016. "The Australian Resource Boom: Consolidating Neoliberal Hegemony." External examiner.

Natasha Heenan, M.A. (Research), Political Economy, University of Sydney, successfully completed, 2018, "The Radical Political Economy of Tourism in Emerging Countries," committee member.

Nicholas Falvo, Ph.D., Public Administration, Carleton University, successfully completed, 2015. "Three Essays on Social Assistance in Canada: A Multidisciplinary Focus on Ontario Singles." Committee member.

Troy Henderson, M.A. (Research), Political Economy, University of Sydney, successfully completed, 2014. "The Four-Day Workweek as a Policy Option for Autralia." External examiner.

Freya Kodar, LLM, York University, successfully completed, 2002. "Corporate Law, Pension Law and the Transformative Potential of Pension Fund Investment Activism." Committee member.

10. Research Funding:

2018-. Partner, FASS Strategic Research Grant, University of Sydney, "Class in the 21st Century: Australia's New Political Economy of Assets," Lisa Adkins, Melinda Cooper and Martijn Konings, P.I.'s.

2016-2018. Collaborator, SSHRC Partnership Development Grant, $199,740, "Austerity and its Alternatives," Stephen McBride, P.I., McMaster University.

2015-2018. Community Partner, SSHRC Partnership Program, $2,496,543, "Mapping the Power of the Carbon-Extractive Corporate Resource Sector," Willian Carroll, P.I., University of Victoria.

2015-2016. Collaborator, SSHRC Partnership Development Grant, $200,000, "Productivity, Firms, and Incomes," Michael Veall, P.I., McMaster University.

2014-2016. Collaborator, SSHRC Partnership Development Grant, $170,962, "Policy Engagement at Multiple Levels of Governance: A Case Study of the Minimum Wage/Living Wage Policy Community," Bryan Evans, P.I., Ryerson University.

2012. Applicant, Metcalf Foundation, $25,000, for Ontario office of the Canadian Centre for Policy Alternatives, Living Wage Initiative.

2012-2016. Executive Member, Automotive Partnership Council and SSHRC, $2,011,000, "Manufacturing Policy and the Canadian Automotive Sector: Analysis and Options for Growth, Sustainability and Global Reach," Charlotte Yates, P.I., McMaster University.

2012-2016. Community Partner, SSHRC Partnership Program, $2,500,000, "On the Move: Employment-Related Geographical Mobility in the Canadian Context," Barbara Neis, P.I., Memorial University.

2004-2006. Community Partner, SSHRC New Economy Program, $900,000, "Restructuring Work and Labour in the New Economy," Norene Pupo, P.I., York University.

2001. Applicant and Conference Co-chair, SSHRC Conference Grant, $12,500, "Challenging the Market," York University.

2000-2003. Community Partner, SSHRC Globalization and Social Cohesion Initiative, $600,000, "Strengthening Canada's Environmental Community Through International Regime Reform," EnviReform, John Kirton, P.I., University of Toronto.

1998-2000. Collaborator, SSHRC Research Development Initiative, $90,000, "Defining the Public Domain," Daniel Drache, P.I., York University.

11. Peer-Reviewed Publications:

11.1 Books:

Stewart, Andrew, Jim Stanford, and Tess Hardy, eds. (2018). *The Wages Crisis in Australia: What It Is and What To Do About It* (Adelaide: University of Adelaide Press), 328 pp.

Stanford, Jim (2015). *Economics for Everyone: A Short Guide to the Economics of Capitalism, Second Edition* (London: Pluto Books), 402 pp.

Stanford, Jim (2008). *Economics for Everyone: A Short Guide to the Economics of Capitalism* (London: Pluto Books), 350 pp. Published in 6 languages.

Stanford, Jim, and Leah Vosko, eds. (2004). *Challenging the Market: The Struggle to Regulate Work and Income* (Montreal: McGill-Queen's University Press).

Stanford, Jim, Lance Taylor, and Ellen Houston, eds. (2000). *Power, Employment and Accumulation* (Armonk, N.Y. M.E.Sharpe).

Stanford, Jim (1999). *Paper Boom: Why Real Prosperity Requires a New Approach to Canada's Economy* (Toronto: James Lorimer).

Reinsch, Anthony E., Kevin J. Brown, and Jim Stanford (1988). *Stability Within Uncertainty: Evolution of the World Oil Market* (Calgary: Canadian Energy Research Institute).

11.2 Book Chapters:

Jim Stanford (forthcoming). "Dimensions and Implications of the Slowdown in OECD Business Investment," in Louis-Phillipe Rochon and Hassan Bougrine, eds., *Essays in Honour of Marc Lavoie and Mario Seccareccia* (Cheltenham: Edward Elgar).

Jim Stanford (forthcoming). "Staples Dependence Renewed and Betrayed: Canada's 21st Century Boom and Bust," in Mark Thomas, Leah Vosko, and Carlo Fanelli, eds., *Change and Continuity: Canadian Political Economy in the New Millennium* (Montreal: McGill-Queen's University Press).

Jim Stanford (2019). "The North American Free Trade Agreement: History, Structure and Prospects," in Jonathan Michie, ed., *Handbook of Globalization* (Oxford: Oxford University Press, 3rd edition), pp. 272-303.

Jim Stanford (2019). "The Great Stagnation and the Failure of Business Investment," in Dieter Plehwe, Moritz Neujeffski, Stephen McBride and Bryan Evans, eds., *Austerity: 12 Myths Exposed* (Berlin: Social Europe), pp. 1-9

Jim Stanford (2018). "'Fair Go' No More: Australian Neoliberalism and Labour Market Policy," in Damien Cahill and Phil Toner (eds.), *Wrong Way: The Legacy of Reform* (Carlton: Black Inc.), pp. 166-185.

Stanford, Jim (2016). "Is More Trade Liberalization the Remedy for Canada's Trade

Woes?," in Stephen Tapp, Ari Van Assche and Robert Wolfe, eds., *Redesigning Canadian Trade Policies for New Global Realities* (Montreal: Institute for Research on Public Policy), pp. 435-452.

Stanford, Jim (2014). "Why Austerity?", in Donna Baines and Stephen McBride, eds., *Orchestrating Austerity: Impacts and Resistance* (Halifax: Fernwood), pp. 198-209.

Stanford, Jim (2014). "Adding Value to Canada's Petroleum Wealth: A National Economic and Environmental Priority," in Clement Bowman and Richard Marceau, eds., *Canada: Becoming a Sustainable Energy Powerhouse* (Ottawa: Canadian Academy of Engineering), pp. 25-46.

Stanford, Jim (2014). "The Experience of Neoliberalism in New Zealand: The View From Afar," in David Cooke, Claire Hill, Pat Baskett, and Ruth Irwin, eds., *Beyond the Free Market: Rebuilding a Just Society in New Zealand* (Auckland: Dunmore).

Stanford, Jim (2013). "The Economic Consequences of Taxing and Spending," in Alex Himelfarb and Jordan Himelfarb (eds.), *Tax is Not a Four-Letter Word* (Kitchener: Wilfred Laurier University Press), pp. 17-38.

Murnighan, Bill, and Jim Stanford (2013). "'We Will Fight This Crisis': Auto Workers Respond to an Industrial Meltdown," in Hugh Chessire and Tim Fowler (eds.), *Labour, State and Crisis* (Ottawa: Red Quill), pp. 129-165.

Stanford, Jim (2011). "The North American Free Trade Agreement: Context, Structure and Performance," in Jonathan Michie, ed., *The Handbook of Globalization* (Cheltenham, U.K.: Edward Elgar), 2nd edition, pp. 324-355.

Stanford, Jim (2010). "What Determines Wages? Income Distribution in the Surplus Tradition," in Hassan Bougrine, Mario Seccareccia, and Ian Parkers (eds.), *Introducing Microeconomic Analysis: Issues, Questions, and Competing Views* (Toronto: Emond Montgomery).

Stanford, Jim (2010). "What Drives Investment: A Heterodox Perspective?", in Hassan Bougrine and Mario Seccareccia (eds.), *Introducing Macroeconomic Analysis: Issues, Questions, and Competing Views* (Toronto: Emond Montgomery), pp. 101-115.

diCarlo, Angelo, Chad Johnston, and Jim Stanford (2010). "Canada's Labour Movement in Challenging Times: Unions and their Role in a Changing Economy," in Norene Pupo, Dan Glenday, and Ann Duffy (eds.), *The Shifting Landscape of Work* (Toronto: Thomson Nelson).

Stanford, Jim (2005). "Reform, Revolution, and a Bottom Line that Has to Add Up: Balancing Vision and Relevance in the Alternative Budgeting Movement," in Haroon Akram-Lodhi, Robert Chernomas, and Ardeshir Sepehri (eds.), *Globalization, Neo-Conservative Policies, And Democratic Alternatives: Essays In Honour Of John Loxley* (Winnipeg: Arbeiter Ring).

Stanford, Jim (2005). "Industrial Policy in an Era of Free Trade: What Isn't, and Is, Possible?", in Mark Setterfield (ed.), *Interactions in Analytical Political Economy: Theory, Policy and Applications* (Armonk, N.Y.: M.E. Sharpe), pp. 114-139.

Stanford, Jim (2004). "Testing the Flexibility Paradigm: Canadian Labor Market Performance in International Context," in David R. Howell, ed., *Fighting Unemployment: The Limits of Free-Market Orthodoxy* (Oxford: Oxford University Press).

Stanford, Jim (2003). "The North American Free Trade Agreement: Context, Structure and Performance," in Jonathan Michie, ed., *The Handbook of Globalization* (Cheltenham, U.K.: Edward Elgar).

Gindin, Sam, and Jim Stanford (2003). "Canadian Labour and the Political Economy of Transformation," in Wallace Clement and Leah F. Vosko (eds.), *Changing Canada: Political Economy as Transformatio*n (Montreal: McGill-Queen's University Press).

Stanford, Jim (2001). "Social Democratic Policy and Economic Reality: the Canadian Experience," in Philip Arestis and Malcolm Sawyer (eds.), *The Economics of the Third Way: Experiences from Around the World* (Cheltenham, U.K.: Edward Elgar), pp. 79-105.

Stanford, Jim (2001). "RRSPs and Reality: The Economic Consequences of Financial Inequality," in Edward Broadbent (ed.), *Democratic Equality: What Went Wrong?* (Toronto: University of Toronto Press).

Stanford, Jim (2000). "A Reality Check," in L. Ian MacDonald (ed.), *Free Trade: Risks and*

Rewards (Montreal: McGill-Queen's University Press).

Stanford, Jim (1998). "Openness with Equity: Regulating Labour Market Outcomes in a Globalized Economy," in Dean Baker, Gerald Epstein, and Robert Pollin (eds.), *Globalization and Progressive Economic Policy* (Cambridge: Cambridge University Press).

Stanford, Jim (1998). "The Rise and Fall of Deficit-Mania: Public-Sector Finances and the Attack on Social Canada," in Wayne Antony and Les Samuelson (eds.), *Power and Resistance: Critical Thinking About Canadian Social Issues* (Halifax: Fernwood).

Stanford, Jim (1996). "Discipline, Insecurity, and Productivity: The Economics Behind Labour Market 'Flexibility'," in Jane Pulkingham and Gordon Ternowetsky (eds.), *Remaking Canadian Social Policy* (Halifax: Fernwood).

Stanford, Jim (1995). "The Permanent Recession and Canada's Debt: The Fiscal Context of Social Reform," in Daniel Drache and Andrew Ranachan (eds.), *Warm Heart, Cold Country: Fiscal and Social Policy Reform in Canada* (Ottawa: Caledon Institute).

Stanford, Jim (1993). "North American Economic Integration and the International Regulation of Labor Standards," in Bruno Stein (ed.), *Proceedings of New York University 46th Annual National Conference on Labor* (Boston: Little Brown).

Stanford, Jim (1989). "Future Capacity Additions," in K. Morgan MacRae (ed.), *Critical Issues in Electric Power Planning in the 1990s* (Calgary: Canadian Energy Research Institute).

11.3 Journal Articles:

Jim Stanford (forthcoming). "A Turning Point for Labour Market Policy in Australia," *Economic and Labour Relations Review*.

Jim Stanford (2018). "The Declining Labour Share in Australia: Definition, Measurement, and International Comparisons," *Journal of Australian Political Economy* 81, pp. 11-32.

Stanford, Jim (2017). "The Resurgence of Gig Work: Historical and Theoretical Perspectives," *Economic and Labour Relations Review* 28(3), pp. 382-401.

Stewart, Andrew, and Jim Stanford (2017). "Regulating work in the gig economy: What are the options?", *Economic and Labour Relations Review* 28(3), pp. 420-437.

Stanford, Jim (2017). "Automotive Surrender: The Demise of Industrial Policy in the Australian Vehicle Industry," *Economic and Labour Relations Review* 28(2), pp. 197-217.

Stanford, Jim (2017). "U.S. Private Capital Accumulation and Trump's Economic Program," *Real-World Economics Review* 79, pp. 74-90.

Stanford, Jim (2017). "When an Auto Industry Disappears: Australia's Experience and Lessons for Canada," *Canadian Public Policy* 43(S1), pp. 57-74.

Stanford, Jim (2016). "Symposium on Heterodox Economics and the Economic Crisis: Introduction," *Studies in Political Economy* 97, pp. 56-57.

Stanford, Jim (2015). "Toward an Activist Pedagogy in Heterodox Economics: The Case of Trade Union Economics Training," *Journal of Australian Political Economy* 75, pp. 11-34.

Stanford, Jim (2013). "The Myth of Canadian Exceptionalism: Crisis, Non-Recovery, and Austerity," *Alternate Routes 2013*, pp. 19-32.

Stanford, Jim (2010). "The Geography of Auto Globalization, and the Politics of Auto Bailouts," *Cambridge Journal of Regions, Economies, and Society* 3(3), pp. 383-405.

Stanford, Jim (2009/10). "Understanding the Economic Crisis: The Importance of Training in Critical Economics," *Journal of Australian Political Economy* 64, pp. 9-21.

Sran, Garry, and Jim Stanford (2009). "Further Tests of the Link Between Unionization, Unemployment, and Employment: Findings From Canadian National and Provincial Data," *Just Labour: A Canadian Journal of Work and Society* 15, pp. 29-77.

Stanford, Jim, ed. (2009). "Forum on Labour and the Economics Crisis: Can the Union Movement Rise to the Occasion?", *Labour/Le Travail* 64, pp. 135-172.

Stanford, Jim (2008). "Radical Economics and Social Change Movements: Strengthening the Links between Academics and Activists," *Review of Radical Political Economics* 40(3), pp. 205-219.

Stanford, Jim (2008). "Staples, Deindustrialization, and Foreign Investment: Canada's Economic Journey Back to the Future," *Studies in Political Economy* 82, pp. 7-34.

Stanford, Jim (2008). "Privatization if Necessary but not Necessarily Privatization," *Review of Income and Wealth* 54(1), pp. 116-125.

Stanford, Jim (2005). "Revisiting the 'Flexibility' Hypothesis," *Canadian Public Policy* 31(1), pp. 109-116.

Stanford, Jim (2003). "Economic Models and Economic Reality: North American Free Trade and the Predictions of Economists," *International Journal of Political Economy* 33(3), pp. 28-49.

Stanford, Jim (2001). "The Economic and Social Consequences of Fiscal Retrenchment in Canada in the 1990s," *Review of Economic Performance and Social Progress* 1, pp. 141-160.

Stanford, Jim (2000). "Canadian Labour Market Developments in International Context: Flexibility, Regulation, and Demand," *Canadian Public Policy* 26(supp.), pp. 27-58.

Stanford, Jim (1997). "Is There a Risk Premium in Canadian Interest Rates?," *Canadian Business Economics* 5(4), Summer, pp. 53-60.

Stanford, Jim (1995). "The Economics of Debt and the Remaking of Canada," *Studies in Political Economy* 48, Autumn, pp. 113-135.

Stanford, Jim (1995). "Bending Over Backwards: Is Canada's Labour Market Really Inflexible?", *Canadian Business Economics* 4(1), Fall, pp. 70-85.

Stanford, Jim (1993). "Continental Economic Integration: Modeling the Impact on Labor," *Annals of the American Academy of Political and Social Science* (526), March, pp. 92-110.

Spriggs, William E. and Jim Stanford (1993). "Economists' Assessments of the Likely Employment and Wage Effects of the North American Free Trade Agreement," *Hofstra Labor Law Review* 10(2), Spring, pp. 495-536.

11.4 Encyclopaedia Entries:

Stanford, Jim (2015). "Mark Carney," in Louis-Philippe Rochon, Sergio Rossi, and Matias Vernengo, eds., *The Elgar Encyclopaedia of Central Banking* (Cheltenham: Edward Elgar), pp. 71-74.

12. Non-Peer-Reviewed Research Publications:

12.1 Technical and Policy Papers:

Stanford, Jim, Troy Henderson, and Matt Grudnoff (2019). *What's a Million, Anyway? Australia's 2013-18 Job Creation in Historical Perspective* (Canberra: Centre for Future Work at the Australia Institute), 41 pp.

Stanford, Jim, and Alison Pennington (2019). *Turning 'Gigs' Into Decent Jobs* (Canberra: Centre for Future Work at the Australia Institute), 35 pp.

Stanford, Jim and Matt Grudnoff (2018). *The Future of Transportation Work: Technology, Work Organisation and the Quality of Jobs* (Canberra: Centre for Future Work at the Australia Institute), 76 pp.

Stanford, Jim (2018). *Subsidising Billionaires: Simulating the Net Incomes of UberX Drivers in Australia* (Canberra: Centre for Future Work at the Australia Institute), 32 pp.

Ryan, Rose, and Jim Stanford (2018). *A Portable Training Entitlement System for the Disability Support Services Sector* (Canberra: Centre for Future Work at the Australia Institute), 68 pp.

Watson, Ian, and jim Stanford (2018). *Restoring Security and Respect: Rebuilding NSW's Workers Compensation System* (Canberra: Centre for Future Work at the Australia Institute), 95 pp.

Stanford, Jim (2018). *Raising the Bar: How Government Can Use its Economic Leverage to Lift*

Labour Standards Throughout the Economy (Canberra: Centre for Future Work at the Australia Institute), 45 pp.

Carney, Tanya, and Jim Stanford (2018). *Advanced Skills for Advanced Manufacturing: Rebuilding Vocational Training in a Transforming Industry* (Canberra: Centre for Future Work at the Australia Institute), 31 pp.

Stanford, Jim (2018). *A Secret Weapon in the Fight Against Financial Misconduct: Sectoral Collective Bargaining* (Canberra: Centre for Future Work at the Australia Institute), 46 pp.

Henderson, Troy, and Jim Stanford (2018). *Under The Employer's Eye: Electronic Monitoring & Surveillance in Australian Workplaces* (Canberra: Centre for Future Work at the Australia Institute), 54 pp.

Stanford, Jim, and Tom Swann (2017). *Manufacturing: A Moment of Opportunity* (Canberra: Centre for Future Work at the Australia Institute), 48 pp.

Henderson, Troy, and Jim Stanford (2017). *False Economies: The Unintended Consequences of NSW Public Sector Wage Restraint* (Canberra: Centre for Future Work at the Australia Institute), 33 pp.

Stanford, Jim (2017). *The Consequences of Wage Suppression for Australia's Superannuation System* (Canberra: Centre for Future Work at the Australia Institute), 46 pp.

Pennington, Alison, and Jim Stanford (2017). *Technology, Work Organisation, and Employment in Public Transport* (Canberra: Centre for Future Work at the Australia Institute), 102 pp.

Stanford, Jim (2017). *Technology and the Future of Transportation Work,* by Jim Stanford, prepared for ITF World Congress Documents, 23 pp.

Stanford, Jim (2017). *Summary of Automotive Industry Collective Bargaining Models in Four Countries* (Report prepared for the International Labour Office, Geneva), 31 pp.

Stanford, Jim (2017). *Tip of the Iceberg: Weekend Work and Penalty Pay in 108 Australian Industries* (Canberra: Centre for Future Work at the Australia Institute), 31 pp.

Stanford, Jim (2016). *The Economic, Fiscal, and Social Importance of Aluminium Manufacturing in Portland, Victoria* (Canberra: Centre for Future Work at the Australia Institute), 65 pp.

Stanford, Jim (2016). *Economic Aspects of Domestic Violence Leave Provisions* (Canberra: Centre for Future Work at the Australia Institute), 29 pp.

Stanford, Jim (2016). *Beyond Belief: Construction Labour and the Cost of Housing in Australia* (Canberra: Centre for Future Work at the Australia Institute), 30 pp.

Swann, Tom, and Jim Stanford (2016). *Excessive Hours and Unpaid Overtime: An Update* (Canberra: Centre for Future Work at the Australia Institute), 17 pp.

Stanford, Jim (2016). *Penny Wise and Pound Foolish: The Economic and Fiscal Costs of Offshoring Public Procurement* (Canberra: Centre for Future Work at the Australia Institute), 32 pp.

Stanford, Jim (2016). *Jobs and Growth… And a Few Hard Numbers: A Scorecard on Economic Policy and Economic Performance* (Canberra: Centre for Future Work at the Australia Institute), 22 pp.

Stanford, Jim (2016). *Manufacturing (Still) Matters: Why the Decline of Australian Manufacturing is Not Inevitable, and What Government Can Do About It* (Canberra: Centre for Future Work at the Australia Institute), 15 pp.

Stanford, Jim, and Jordan Brennan (2015). *Rhetoric and Reality: Evaluating Canada's Economic Record Under the Harper Government* (Toronto: Unifor), 63 pp.

Brennan, Jordan, and Jim Stanford (2014). *Dispelling Minimum Wage Mythology: The Minimum Wage and the Impact on Jobs in Canada, 1983–2012* (Ottawa: Canadian Centre for Policy Alternatives), 24 pp.

Haley, Brendan, and Jim Stanford (2014). *Short-Circuited: Assessing the Ontario Progressive Conservative Party's Energy Policy* (Toronto: Canadian Centre for Policy Alternatives Ontario), 15 pp.

Stanford, Jim (2014). *CETA and Canada's Auto Industry: Making a Bad Situation Worse* (Ottawa: Canadian Centre for Policy Alternatives), 40 pp.

Stanford, Jim (2014). *Canada's Auto Industry and the New Free Trade Agreements: Sorting Through the Impacts* (Ottawa: Canadian Centre for Policy Alternatives), 34 pp.

Stanford, Jim, ed. (2014). *The Staple Theory @ 50: Reflections on the Lasting Significance of Mel Watkins' "A Staple Theory of Economic Growth"* (Ottawa: Canadian Centre for Policy Alternatives), 135 pp.

Clarke, Tony, Diana Gibson, Brendan Haley, and Jim Stanford (2013). *Bitumen Cliff: Lessons and Challenges of Bitumen Mega-Developments for Canada's Economy in an Age of Climate Change* (Ottawa: Canadian Centre for Policy Alternatives), 102 pp.

Stanford, Jim (2012). *A Cure for Dutch Disease: Active Sector Strategies for Canada's Economy* (Ottawa: Canadian Centre for Policy Alternatives), 11 pp.

Stanford, Jim (2012). "Wage-Cutting as Industrial Strategy: Rejoinder to Shiell and Somerville." Montreal: Institute for Research on Public Policy, 12 pp.

Dryden, Robert, and Jim Stanford (2012). *The Unintended Consequences of Outsourcing Cleaning Work*. Ottawa: Canadian Centre for Policy Alternatives, 42 pp.

Stanford, Jim (2012). *Canada's Incomplete, Mediocre Recovery*. Ottawa: Canadian Centre for Policy Alternatives, 2012, 7 pp.

Stanford, Jim (2011). *Graphs for Dummies: The Troubled Geometry of Tim Hudak's 'changeboook'* (Ottawa: Canadian Centre for Policy Alternatives), 15 pp.

Stanford, Jim (2011). *Having Their Cake and Eating It Too: Business Profits, Taxes, and Investment in Canada, 1961 Through 2010* (Ottawa: Canadian Centre for Policy Alternatives), 37 pp.

Stanford, Jim (2010). *Out of Equilibrium: The Impact of EU-Canada Free Trade on the Real Economy* (Ottawa: Canadian Centre for Policy Alternatives), 44 pp.

Stanford, Jim (2009). *The Profitability of Automotive Manufacturing in Canada, 1972-2007* (Toronto: CAW-Canada), 10 pp.

Mackenzie, Hugh, and Jim Stanford (2008). *A Living Wage for Toronto* (Ottawa:

Canadian Centre for Policy Alternatives), 28 pp.

Stanford, Jim, and Pat Conroy (2007). *The Potential Employment Impacts of an Australia-China Free Trade Agreement* (Sydney: Australian Manufacturing Workers Union), 44 pp.

Poon, Daniel, and Jim Stanford (2006). *Employment Implications of Trade Liberalization with East Asia* (Toronto: CAW-Canada), 33 pp.

Stanford, Jim (2000). "A Success Story: Canadian Productivity Performance in Auto Assembly," Conference Proceedings, Conference on the Canada-U.S. Manufacturing Productivity Gap (Ottawa: Centre for the Study of Living Standards).

Stanford, Jim (1998). *Economic Freedom (For the Rest of Us)* (Ottawa: Canadian Centre for Policy Alternatives), 43 pp.

Stanford, Jim (1996). *The Macroeconomics of Cutbacks* (Ottawa: Canadian Centre for Policy Alternatives), 22 pp.

Stanford, James (1993). *The Economic Impact of North American Free Trade: A Three Country General Equilibrium Model with Real-World Assumptions* (Ottawa: Canadian Centre for Policy Alternatives), 53 pp.

Stanford, Jim, Christine Elwell and Scott Sinclair (1993). *Social Dumping: An Empirical and Institutional Investigation* (Ottawa: Canadian Centre for Policy Alternatives), 38 pp.

Stanford, Jim (1991). *Going South: Cheap Labour as an Unfair Subsidy in North American Free Trade* (Ottawa: Canadian Centre for Policy Alternatives), 44 pp.

12.2 Book Reviews:

Stanford, Jim (2014). Review of *Autonomous State: The Struggle for a Canadian Car Industry from OPEC to Free Trade*, by Dimitry Anastakis, in *Canadian Journal of Political Science* 47(1), pp. 204-207.

Stanford, Jim (2011). Review of *The Economics Anti-Textbook: A Critical Thinker's Guide to*

Micro-Economics, by Rod Hill and Tony Myatt, in *Labour/Le Travail* 68 (Autumn), pp. 249-252.

Stanford, Jim (2008). Review of *The State of Working America 2006/07* and Related Books, in *Review of Radical Political Economics* 40(2), pp. 239-243.

Stanford, Jim (2005). Review of *Corporate Governance in Global Capital Markets*, ed. by Janis Sarra, in *Labour/Le Travail*, 56, pp. 304-307.

Stanford, Jim (2004). Review of *Minimum Wages in Canada: A Statistical Portrait with Policy Implications*, by Ken Battle, in *Canadian Review of Social Policy* (54), pp. 151-153.

Stanford, Jim (2001). Review of *Sharing the Work, Sparing the Planet: Work Time, Consumption and Ecology*, by Anders Hayden, in *Labour/Le Travail* 48 (Fall), pp. 326-329.

12.3 Book Chapters:

Stanford, Jim (2013). "The Failure of Corporate Tax Cuts to Stimulate Business Investment Spending," in Richard Swift, ed., *The Great Revenue Robbery* (Toronto: Between the Lines), pp. 66-83.

Stanford, Jim (2011). "Canada's Productivity and Innovation Failures: Questioning the Conventional View," in *The Canada We Want in 2020: Towards a Strategic Policy Roadmap for the Federal Government* (Ottawa: Canada 2020), pp. 20-24.

Stanford, Jim (2008). "Backsliding: Manufacturing Decline and Resource Dependency," in Teresa Healy, ed., *The Harper Record* (Ottawa: Canadian Centre for Policy Alternatives), pp. 71-95.

Stanford, Jim (2008). "Canada's Economic Structure: Back to the Future?", in Rudyard Griffiths (ed.), *Canada in 2020: Twenty Leading Voices Imagine Canada's Future* (Toronto: Key Porter), pp. 139-148.

Stanford, Jim (2006). "CGE Models of North American Integration: Pushing the Envelope of Reality," in Bruce Campbell and Ed Finn, eds., *Living With Uncle: Canada-U.S. Relations in an Age of Empire* (Toronto: James Lorimer & Co.), pp. 151-

182.

Stanford, Jim (2001). "Paul Martin's Tax Revolt," in Paul A.R. Hobson and Thomas A. Wilson (eds.), *The 2000 Federal Budget: Retrospect and Prospect* (Kingston, Ont.: John Deutsch Institute), pp. 167-180.

Stanford, Jim (1999). "Waiting For 'It': The Mechanics of Financial Boom and Bust," in Brian MacLean (ed.), *Out of Control: Canada in an Unstable Financial World* (Ottawa: Canadian Centre for Policy Alternatives and James Lorimer & Co.), pp. 43-66.

Stanford, Jim (1999). "Why Global Financial Markets are so Unpredictable," in Lorne Nystrom (ed.), *Just Making Change* (Ottawa: Golden Dog).

Stanford, Jim (1997). "Topsy-Turvy Economics," in Marilyn Spink (ed.), *Bad Work: A Review of Papers on 'Right-to-Work Laws* (Toronto: Centre for Research on Work and Society).

Stanford, Jim (1997). "Disappearing Deficits and Incredible Interest Rates: Canada's Hollow Economic Victories," in Bruce Campbell and John Loxley (eds.), *The Alternative Federal Budget Papers* (Ottawa: Canadian Centre for Policy Alternatives).

Stanford, Jim (1997). "Growth, Interest and Debt: Canada's Fall from the Fiscal Knife-Edge," in Bruce Campbell and John Loxley (eds.), *The Alternative Federal Budget Papers* (Ottawa: Canadian Centre for Policy Alternatives).

Stanford, Jim (1994). "Economic Frameworks and Free Trade," in Jan Joel (ed.), *Building a Vision* (Regina: University of Regina).

Stanford, Jim (1993). "Investment," in Duncan Cameron and Mel Watkins (eds.), *Canada Under Free Trade* (Toronto: Lorimer).

12.4 Magazine Articles:

Stanford, Jim (2013). "Canada's Sluggish Labour Market and the Myth of the Skills Shortage," *Academic Matters: The Journal of Higher Education* (November).

Stanford, Jim (2011). "Foreign Exchange and the Canadian Dollar: A Primer," *Relay* 31, pp. 22-27.

Stanford, Jim (2010). "Financial Literacy: Getting Beyond the Markets," *Education Canada* 50(4), Fall, pp. 21-25.

Stanford, Jim (2006). "To Convert Economic Growth Into Well-being," *Policy Options* 27(4), pp. 34-38.

Stanford, Jim (2004). "The Dark Side of Debt Reduction," *Policy Options* 25(4), pp. 22-25.

Stanford, Jim (1991). "When the Ship Doesn't Come In," *Perception: Journal of the Canadian Council on Social Development*, Winter, pp. 28-31.

12.5 Popular Economics Writing and Commentary

I have written hundreds of shorter economic articles and commentaries in a range of outlets, including major newspapers, specialist magazines, electronic media, blogs, and other platforms.

Since 2000 I have published economics columns in the *Globe and Mail* newspaper, Canada's most prominent daily newspaper. I have written economic commentary articles for numerous other newspapers, including the *Financial Times, New York Post, National Post, Ottawa Citizen,* and *Toronto Star*.

I am regularly sought for economic comment by mainstream print and broadcast media in Australia, Canada and internationally.

I am an active and effective participant in social media. My Twitter and Facebook accounts (@jimbostanford and Jimbo Stanford) have over 20,000 followers combined.

I contribute economic commentary to a variety of on-line platforms, including the *Progressive Economics Forum* and *Real-World Economics Review* blog sites.

13. Conference Papers and Lectures:

13.1 Peer-Reviewed:

Sept. 2018 "Historical and Theoretical Perspectives on Gig Work."
Union of Radical Political Economists
University of Massachusetts, Amherst

June 2018 "The Future of Work is What We Make It."
Progressive Economics Forum Panel
Canadian Economics Association, Montreal

Feb. 2018 "Technological Determinism and the Future of Work."
Keynote Address, Association of Industrial Relations Academics of Australia and New Zealand, Canberra

Dec. 2017 "The Declining Labour Share: Empirical and International Perspectives."
Society of Heterodox Economists, University of NSW, Sydney

Dec. 2016 "Theoretical and Historical Perspectives on the 'Gig' Economy."
Society of Heterodox Economists, University of NSW, Sydney

March 2016 "When an Auto Industry Disappears:
Australia's Experience and its Lessons for Canada."
Automotive Policy Research Centre, King City, Ontario

July 2015 "Industrial Policy in the Auto Industry:
National Interests, Regional Production, and Global Supply Chains."
USyd/ASSA Workshop, University of Sydney, Australia
Industrial Policies in the Era of Globalisation and Financialisation

June 2013 "The Stylized Facts and Economic Analysis of Foreign Direct Investment."
Institute for Research in Public Policy Panel
Canadian Economics Association, Montreal

June 2012 "Analytical Foundations of the Distinction Between the 1% and the 99%."
Canadian Economics Association, Calgary

Nov. 2011 "Financialization and the Business Strategies of Non-Financial Corporations: The Case of Air Canada."
International Confederation of Associations for Pluralism in Economics,

Third Global Congress, Amherst, Massachusetts

May 2009 "Financialization, Production, and Ideology."
Fourth Annual CLPE Conference: Knowledge in Labour, Work & Action
York University, Toronto

May 2009 "Financial Meltdown, Financial Recovery:
Does Bay Street Matter to Main Street at All?"
Canadian Economics Association, Toronto

Dec. 2006 "Unions and Labour Market 'Flexibility': Beyond the Jargon."
Society of Heterodox Economists, University of NSW, Sydney

Sept. 2004 "Controlling Pensions? Or Controlling Capital?"
Center for Economic Policy Analysis, New School for Social Research

Aug. 2004 "Canada's Auto Industry: Smokestack Industry or High-Tech Winner?"
Canadian Association for Business Economics, Kingston, Ont.

June 2004 "How Low Should We Go? Federal Debt Reduction in Canada."
Canadian Economics Association, Toronto

May 2003 "Labour Market 'Flexibility' and Canada-U.S. Comparisons."
Canadian Economics Association, Ottawa

May 2003 "Industrial Policy In An Era of Free Trade: What Isn't, and Is, Possible?"
Analytical Political Economy Conference, Trinity College, Hartford

Nov. 2002 "Reform, Revolution and a Bottom Line That Has to Add Up."
International Symposium in Honour of John Loxley
University of Manitoba

May 2002 "An 'Auto Pact' That's Perfectly Legal: A System of Taxes and Grants to Promote Auto Investment and Production in Canada."
Canadian Economics Association, Calgary

Nov. 2000 "Flexibility, Regulation and Demand:
International Labor Market Comparisons and the 'OECD Hypothesis'."

Centre for Economic Policy Analysis Seminar
New School for Social Research, New York

Sept. 1998 "Canada's Paper Economy: What Does it Actually Do?"
Fifth Annual Economic Policy Conference
Laurentian University, Sudbury

Mar. 1998 "The Dubious Economics of Debt Repayment."
Annual Policy Conference,
Canadian Association for Business Economics, Ottawa

July 1996 "Openness With Equity: Regulating Labor Markets in an Open Economy."
Conference on Globalization and Progressive Economic Policy,
Economic Policy Institute, Washington DC

Oct. 1993 "Socio-Economic Regimes and Economic Competitiveness."
Conference on New Directions in Analytical Political-Economy
University of Vermont

Mar. 1993 "Alternative Approaches to Modeling Free Trade."
Eastern Economics Association, Washington DC

Jan. 1994 "Socio-Economic Regimes and Economic Competitiveness."
Annual Meetings of the Allied Social Sciences Association, Boston

Apr. 1995 "The Impact of Real Competitiveness on Monetary Policy
and Exchange Rates in an Open Economy."
Conference on Money, Financial Institutions, and Macroeconomics,
York University, Toronto

June 1995 "Discipline, Insecurity, and Productivity."
7th Biennial Canadian Social Welfare Policy Conference,
University of British Columbia, Vancouver

13.2 Invited and Keynote Lectures:

May 2018 "The Future of Work and the Future of Pensions."

Keynote Address, International Federation of Employment and Pension Benefits, Ottawa

Sept. 2017 "Work and Inequality."
Keynote Address, T.J. Ryan Foundation Conference, Queensland University of Technology, Brisbane

Aug. 2017 "What's New About the Gig Economy, Anyway?"
Annual Employment Relations Keynote Lecture, University of Western Australia, Perth

Nov. 2016 "Theoretical and Historical Perspectives on the 'Gig' Economy."
Seminar Address, Dept. of Sociology, Macquarie University, Sydney

Sept. 2015 "Evaluating the Economic Record of Post-War Prime Ministers."
Graduate Seminar, Dept. of Economics, McMaster University, Hamilton

June 2015 "Economic Literacy and Social Justice."
Keynote Address, Ontario Social Justice Tribunals, Toronto

May 2015 "Canada's Jobs Future: How to Sustain and Create More Good Jobs."
University Anniversary Conference, Trent University, Peterborough

May 2015 "Margin of Manoeuvre in the New Generation of Free-trade and Bilateral Investment Agreements."
Interuniversity Research Centre on Globalization and Work (CRIMT) International Conference, HEC, Montreal

Mar. 2015 "Economic Literacy: Beyond Supply and Demand."
Annual Bell Lecture, Carleton University, Ottawa

Mar. 2015 "Resource-Driven Deindustrialization."
Seminar Series, Institute for Political Economy, Carleton University

Aug. 2014 "Pension Risks and the 'Real' Economy."
Keynote Address, International Foundation of Employee Benefit Plans Calgary

May 2014 "Resource-Driven Deindustrialization:
Comparing the Canadian and Australian Experiences."
Economics Society of Australia, Sydney

May 2014 "Financialization and the Behaviour of Non-Financial Corporations"
Dept. of Political Economy, University of Sydney

May 2014 "The Theory and the Reality of Free Trade."
Keynote Address, Australian Fair Trade and Investment Network, Sydney

Oct. 2013 "Supply, Demand, and Life:
Why Conventional Economics is So Wrong About Society."
Keynote Address, Canadian Association of American Studies
University of Waterloo, Kitchener

Oct. 2013 "Labour Market Institutions and Inequality."
University of Toronto, School of Policy Studies, Toronto

Oct. 2013 "The Economic Case for Collective Bargaining."
Keynote Address, Canadian Association of Counsel to Employers, Banff

Apr. 2013 "Resource-Driven Deindustrialization:
What the Data Do and Do Not Prove."
Economics Dept., University of Ottawa, Ottawa

Mar. 2013 "The Self-Defeating Economic Logic of Austerity."
The Jack and Kay Graham Memorial Lecture
Dept. of Economics & School of Labour Studies
McMaster University, Hamilton

Feb. 2013 "The Theory and Reality of Free Trade."
Library of Parliament Seminar, House of Commons, Ottawa

Feb. 2013 "Addressing Canada's Innovation Deficit:
Public, Private and Community."
Keynote Address, York University Inaugural Research Gala, Toronto

Oct. 2012 "Union Renewal and Union Innovation in Canada."

Interuniversity Research Centre on Globalization and Work (CRIMT)
International Conference, HEC, Montreal

June 2012 "The Economics, and the Ethics, of Pensions."
Pension and Benefits Section, Ontario Bar Association, Toronto

Mar. 2012 "Canadian (Non)Exceptionalism: Crisis, Recovery, Austerity."
Center for Labour Management Relations, Ryerson University, Toronto

Mar. 2012 "Wage-Cutting as Industrial Strategy."
Institute for Research on Public Policy, Toronto

Feb. 2012 "European Free Trade & Canadian Deindustrialization: Deeper Problems."
European Studies Network in Canada, Toronto

Nov. 2011 "Financialization and Flying:
Air Canada's Post-Bankruptcy Business Strategy."
Department of Public Administration, Ryerson University, Toronto

Nov. 2011 "The Ethics of Pensions."
The Ethics Centre, Toronto

Sept. 2011 "Defined Benefit Pension Plans: Beyond the Accounting."
Association of Canadian Pension Managers, St. John's, Nfld.

Aug. 2011 "Labour Costs and the Future of North America's Auto Industry."
Center for Automotive Research Management Briefing Seminar,
Grand Traverse, MI.

June 2011 "Foreign Direct Investment and Labour Relations."
Interuniversity Network on Globalization and Work, Montreal

June 2011 "Debt and Deficit in Context."
Canadian Economics Association Annual Conference, Ottawa

Jan. 2011 "Lessons from the Global Automotive Crisis."
Automobility Seminar, Schulich School of Business

York University, Toronto

Nov. 2010 "Ontario's Fiscal Challenges: Taking a 'Chill Pill'."
State of the Federation Conference, Mowat Centre
University of Toronto, Toronto

Oct. 2010 "Out of Equilibrium: Impact of Canada-EU Free Trade in the Real World."
Canada-Europe Transatlantic Dialogue Conference
Carleton University, Ottawa

June 2010 "Beware the 'Insurance Model' for Unemployment Benefits:
Cautionary Evidence from the Canadian Experience."
Dept. of Economics and Retirement Policy Research Centre
University of Auckland, New Zealand

May 2010 "Globalization, Financial Crisis, and the Auto Industry:
The View from North America."
Dept. of Political Economy, University of Sydney, Australia

Dec. 2009 "Perverse Manifestations of Globalization in Canada."
Ottawa Economics Association, Ottawa

Aug. 2009 "Understanding the Economic Crisis:
The Importance of Training in Critical Economics"
Ted Wheelright Annual Lecture, Political Economy Program
University of Sydney

June 2009 "Crisis, Recovery, and the Role of Government:
Is the Pendulum Swinging Back?"
Public Policy Forum, Ottawa

May 2009 "Meltdown, and Beyond:
Opportunities (and Threats) for the Left in the Current Crisis."
Keynote Address, Canadian Dimension Annual Tribute Dinner, Ottawa

May 2008 "The Resource Curse, Deindustrialization, and the Loonie:
Putting It All Together"
Canadian Economics Association Annual Conference, Vancouver

Mar. 2008 "Unions in Tough Times: Preserving our Space, Building our Power."
Annual Sefton Memorial Lecture, Centre for Industrial Relations
University of Toronto

Jan. 2008 "Building a Diversified, Value-Added Economy."
Competition Policy Review Panel, Toronto

Jan. 2008 "The Loonie and Canadian Deindustrialization."
Public Policy Forum, Toronto

Nov. 2007 "Sharp Curves Ahead: Canada's Auto Industry in Turbulent Times."
Toronto Association for Business Economics

Aug. 2007 "Radical Economics and Social Change Movements:
Strengthening the Links Between Academics and Activists."
David M. Gordon Memorial Lecture
Union of Radical Political Economists, New York

July 2007 "Labour's Incredible Shrinking Slice of the Economic Pie."
Labour Relations Association, Toronto

June 2007 "International Dimensions of Labour Market 'Flexibility'"
School of Population Health
University of Melbourne, Australia

May 2007 "Commodity Booms, Exchange Rates, and Deindustrialization"
Dept. of Economics
Monash University, Australia

Oct. 2006 "The Canadian Labour Relations System:
History, Challenges and Trends."
Renmin University, Beijing

May 2006 "Canada's Economy: Problems and Prospects."
Finance Canada Policy Seminar, Ottawa

Mar. 2005 "Riding Labour's Roller-Coaster."

Dr. Jennifer Keck Lecture Series on Social Justice
Laurentian University, Sudbury

Mar. 2005 "Canada's Industrial Structure: Why Is It Regressing, Is It a Problem, and What Can We Do About It?"
John F. Graham Memorial Lecture
Dalhousie University, Dept. of Economics, Halifax

Feb. 2005 "What's Next for Canada's Economy?"
Grain World Conference, Canadian Wheat Board, Winnipeg

Sept. 2004 "Imagining Industrial Policy in a Neoliberal World."
Canadian Labour Congress Industrial Policy Conference, Ottawa

June 2004 "Pension Fund 'Activism': Some Sober Second Thoughts."
Real Utopias Conference, University of Wisconsin, Madison

June 2004 "Pension Funding and Demographics: The Sky Isn't Falling."
Conference de Montréal, Montreal

May 2004 "Economics on the Edge:
Why Most Economists Love Globalization, and How to Change That."
Keynote Address, Topshee Conference, Antigonish, N.S.

May 2004 "An Investment-Driven Capitalist Economy."
Seminar on Millenial Development and the Governance of
Social Reproduction, York University, Toronto

Mar. 2004 "Is Economics an Addiction?"
King's University College, Social Justice & Peace Studies Lecture
London, Ont.

Feb. 2004 "Canadian Competitiveness: Fact and Fiction."
CAN>WIN 2004 Conference, Toronto

Oct. 2003 "Does Growth Matter? GDP and the Well-Being of Newfoundlanders."
Newfoundland & Labrador Federation of Labour Convention
Gander, Nfld.

Oct. 2003 "Industrial Policy in an Era of Free Trade: What Isn't, and Is, Possible?"
Deep Integration Conference, York University, Toronto

Aug. 2003 "The Global Airline Crisis: More Turbulence Ahead."
International Transport Federation Summer School, Port Elgin, Ont.

June 2003 "Confessions of a Tax-Loving Economist."
Dept. of Finance Canada Annual Seminar, Ottawa

June 2003 "Business Cycles and Labour Relations Over the Postwar Era."
Connections & Directions: Sharing Visions for Clinic Law, Hamilton

May 2003 "Taking the First Step:
Climate Change, the Kyoto Protocol, and Canada's Economy."
University of Western Ontario Labour Law Conference, London, Ont.

Mar. 2003 "Income Security, Labour Market 'Flexibility,' and Canada's Employment Performance."
Canadian Council on Social Development, Ottawa

Jan. 2003 "Bending Over Backwards: Labour Market Flexibility in the Real World."
Economics Department Seminar, Trent University, Peterborough

Dec. 2002 "Jim Stanford's Most Excellent Day in the Free Market."
Canadian Conference on Unity, Sovereignty and Prosperity, Toronto

Nov. 2002 "Bending Over Backwards: Labour Market Flexibility in the Real World."
Unemployed Help Centres Conference, Toronto

Jan. 2002 "The Global Economy After September 11."
McMaster University, Hamilton, Ont.

Nov. 2001 "Trade and Sovereignty After September 11: What's Really At Stake?"
Public Policy Forum Conference on the Canada-U.S. Border, Toronto

Apr. 2001 "Enforcing Corporate Accountability in a Global Economy."
Canadian Corporate Accountability Commission, Toronto

Mar. 2001 "Cut Your Nose to Spite Your Face:
The Long Run Implications of Tax Cuts."
Kingston Action Network Conference, Kingston, Ont.

June 2000 "What Canadian Macroeconomists Learned from the 1990s."
President's Panel, Canadian Economics Association, Vancouver

Apr. 2000 "Taming the Paper Boom."
Phyllis Clarke Memorial Lecture
Ryerson University, Toronto

Mar. 2000 "Paul Martin's Tax Revolt."
School of Policy Studies, Queen's University

Mar. 2000 "Investment, Real and Imagined."
Labour Studies Department, McMaster University

Jan. 2000 "A Success Story: Canadian Productivity Performance in Auto Assembly."
Conference on the Canada-U.S. Manufacturing Productivity Gap,
Centre for the Study of Living Standards, Ottawa

Jan. 2000 "Social-Democratic Policy and Economic Reality."
Meeting of the Allied Social Sciences Association, Boston

Oct. 1999 "Fixed Investment and Capital Accumulation in Canada."
Toronto Association for Business Economics

May 1999 "Economic Freedom (For the Rest of Us)."
Canadian Economics Association Annual Meetings, Toronto

April 1999 "Canada's Labour Market Performance in International Context."
Conference on Structural Aspects of Canadian Unemployment,
Centre for the Study of Living Standards, Ottawa

Dec. 1998 "Fixed Investment and Capital Accumulation in Canada."
Economics Department Seminar, Dalhousie University, Halifax

Nov. 1998 "RRSPs and Reality."
Conference on Equality and the Democratic State,
Simon Fraser University, Vancouver

Apr. 1997 "Is there a Risk Premium in Canadian Interest Rates?"
Economics Department Seminar, University of Manitoba, Winnipeg

Mar. 1997 "Social Structures and Economic Mobility: What's Really at Stake?"
Conference in Memory of David M. Gordon,
New School for Social Research, Economics Department

Feb. 1997 "The Micro and Macro Foundations of Labour Market Deregulation."
Economics Department Seminar, York University, Toronto

Dec. 1996 "The Regulation and Deregulation of Labour Markets."
Conference on Law in the Public Interest,
Canadian Environmental Law Association, Toronto

Nov. 1996 "Globalization and Canada's Auto Industry."
Seminar, Toronto Association of Business Economists

May 1996 "The Economics of the 'Flexible' Labour Market."
Seminar, Association of Professional Economists of B.C., Vancouver

Mar. 1995 "The Grim Economy."
Annual Economic Policy Conference, Laurentian University, Sudbury

Apr. 1994 "Long-Run Constraints on Employment Policy in an Open Economy."
International Conference on Full Employment, University of Ottawa

Nov. 1993 "Labor Standards and the NAFTA."
Economics Dept., American University, Washington DC

File/Our Ref: AM2018/26 MR:db
Your Ref:
Please quote in reply

Tuesday 27 August, 2019

CONFIDENTIAL

Dr Jim Stanford
Economist and Director of the
Centre for Future Work at the Australia Institute

By email: jim@tai.org.au

Dear Dr Stanford

Re: Four Yearly Review of Modern Awards – AM2018/26 Social, Community, Home Care and Disability Services Industry Award 2010

As part of the current 4 yearly review of modern awards being conducted by the Fair Work Commission, there is a review of the *AM2018/26 Social, Community, Home Care and Disability Services Industry Award 2010* ('**SCHDS Award**').

You are retained by the Australian Services Union ('**ASU**') to prepare a written report containing your expert opinion in relation to the connection between the conditions that apply to disability services employees under the SCHDS Award and the difficulty experience by the disability sector in attracting the required numbers of appropriately qualified, skilled and experienced workers.

In this letter, we set out:

(a) background information;

(b) your ethical duties;

(c) the questions your expert report must address;

(d) the form of your report; and

(e) information about timing and communication.

A Background Information

The ASU represent workers covered by the SCHDS Award. The Commission is reviewing the SCHDS Award as part of the 4 yearly review.

The *SCHDS Award* covers, amongst other types sectors, disability services. Disability services involve the provision of personal care and domestic and lifestyle support and/or training to a person with a disability. Disability can be provided in a community setting, whether residential or non-residential, a respite centre, a day service facility or in a private residence where work in that residence involves either teaching, promoting or maintaining living skills, client, advocacy, promoting or supporting community access and social inclusion or developing or assisting in developing care or support plans including assessment of client needs.

The 4 yearly review of modern awards concern broadly the consideration of whether current modern awards meet the *Fair Work Act* 2009 ('the Act')

modern award objectives. The ASU is advancing a number of claims in this matter, including a penalty rate of 115 per cent of their ordinary hourly rate for employees who work a broken shift and for employees undertaking disability services work to be paid for reasonable travel time between different work locations.

To avoid doubt, we confirm that we do **not** seek your opinion as to the appropriateness or otherwise of any of the variations sought by any party including the ASU.

B Duty

You are engaged by the ASU to assist the Commission by providing your expert opinion in accordance with the terms of this and any other letter of instruction. Your overriding duty is to assist the Commission. You are not an advocate for the Union.

Enclosed with this letter is a copy of the Federal Court of Australia's *Practice Note GPN-EXPT: Expert Evidence Practice Note.* Although you are not formally bound by the *Practice Note*, as a matter of proper practice we adopt the terms of the *Practice Note* when engaging expert witnesses before the Commission and ask that you as a condition of your retainer comply with it. Please read the *Practice Note* carefully.

C Your opinion

You are asked to provide your opinion on the following questions:

1. What training, skills and qualifications are required by the disability sector?
2. What is the connection between the terms and conditions of the SCHDS Award, including broken shifts and unpaid travel time, and the disability sectors' ability to attract a sufficient number of appropriately skilled workers?
3. Is the disability sector able to attract a sufficient number of appropriately skilled workers?
4. Are there any implications for quality of care?

D Form of your report

Your role is to assist the Commission by providing your expert opinion in accordance with this letter of instruction. Please address your report to the Fair Work Commission.

In order to ensure your report can be used easily at the hearing of this matter, we ask that you include the following matters in the report:

1. a brief summary of your opinion or opinions at the beginning of the report, this would take the form of a summary of the answers to the questions asked in Part C;

2. a glossary of any specialised terminology;

3. references to any literature or other materials cited in support of your opinions. Please use a uniform citation method throughout the report. If you use parenthetical referencing (Chicago-style citation), please provide pinpoint citations where applicable;

4. a bibliography;

5. numbered paragraphs and page numbers, and headings where appropriate; and

6. margins of at least 2.5 centimetres, and line spacing of at least 1.5 points, with 12 points between paragraphs.

Please annex to your report:

7. a detailed curriculum vitae, setting out the study, training, and experience that establishes your expertise in relation to the issues raised by these instructions; and
8. this letter of instruction (and any additional written instructions) and all attachments.

At the conclusion of your report, please include a declaration to the following effect:

I have made all the inquiries that I believe are desirable and appropriate and that no matters of significance that I regard as relevant have, to my knowledge, been withheld from the Commission.

E Communications and timing

Timing

Your report is due to be filed in the Commission on **24 September 2019**.

Communication

Please note that all communications between yourself and the ASU can, on request, be provided to the employer parties and the Commission. This includes any draft of your report, including your working notes.

Yours faithfully

Michael Robson
National Industrial Officer

AUSTERITY and its ALTERNATIVES

Zero-Sum Social Policy

Going Gig and the Australian National Disability Insurance Program

Donna Baines & Fiona Macdonald
University of Sydney & RMIT University

February, 2019

McMaster University

ABOUT US

Austerity and its Alternatives is an international knowledge mobilization project committed to expanding discussions on alternatives to fiscal consolidation and complimentary policies among policy communities and the public. To learn more about our project, please visit www.altausterity.mcmaster.ca.

Austerity and its Alternatives is funded through the Partnership Development stream of the Social Sciences and Humanities Research Council (SSHRC).

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Donna Baines is a Professor and Chair of Social Work and Social Policy at the University of Sydney, and Fiona Macdonald is a Senior Research Fellow at RMIT University.

Report designed by the Centre for Communicating Knowledge at Ryerson University (excluding cover page).

Introduction

The disability rights movement views disability as socially constructed and has long sought full social inclusion through increased respect, autonomy and control for those with disabilities (Howard et al., 2015; Williams, 2014). Australia's newly introduced National Disability Insurance Scheme (NDIS) establishes a cash-for-care model which some see as a radical step towards social inclusion, though evidence from the early roll-out of the NDIS shows that many service users have serious concerns with the scheme and (Warr et al., 2017, p. 8) and workers are experiencing the privatization and marketization of their work (Cortis et al., 2017). Although Australia's policy context is unique, it joins other European and North American countries that have pursued individualised funding.

Prior to the NDIS, most workers in the Australian disability sector were employed in organisations and were protected by: a sector-wide industrial Award; a significant level of unionisation; and employers who paid, at least ideological, tribute to a non-profit ethos of social care and fairness. The NDIS model means that people with disabilities to use their individualized funding package to either work with a case manager to assemble services to meet their needs or hire their own staff and act as their own director of services. Either process recasts care workers as highly casualised and precarious, and increasingly working in gig market conditions.

Australia's industrial relations regime's enforcement pathways are increasingly convoluted as service users may be both client and employer, making it difficult to raise concerns about hours, wages or conditions. For the most part, small scale employers have little or no experience with, knowledge of, or capacity to enforce employment standards, health and safety legislation and other regulations offering protection to employees. This places workers in a murky grey zone where they seem to exist outside of regulatory protections within the context of marketised "social" care and fragmented, gig-like work places.

The paper contributes to our understanding of the drivers behind emerging gig labour markets by exploring the zero-sum game precipitated by social policy aimed at expanding human rights in the context of marketized care and individualisation of service users. The paper begins with a short discussion of the NDIS, human rights, the disability sector, the regulatory context, and changes in the sector under the new NDIS policy. The paper then outlines methods and is followed by a presentation of findings, discussion and conclusions.

The Disability Sector and the Regulatory Context (Disability Sector and the Workforce)

Similar to other wealthy countries, from the 1970s onwards, deinstitutionalisation resulted the closure of most public institutions intended for people with disabilities (Howard et al. 2015). Prior to the NDIS most disability

services were provided by non-profit organisations; most received 60–80% of their income from government in the form of block funding (Williams, 2014). Though under-funding plagued this arrangement, disability organisations provided a range of services including: recreation, everyday activities and employment; accommodation and community living; respite and family support; and advocacy, referral and public education.

The minimum pay and conditions for disability workers are set out in the Social, Community, Home Care and Disability Services Award. However, the Award differentiates between disability and other care workers in community services which has exerted a downward pressure on the Award. For example, under the Award, workers classified as 'home care' workers have a minimum engagement period of one hour compared to two hours for 'disability support' workers. This and consumer demand have resulted in employers calling for all shift minimums to be one hour and means that they prefer to hire into the category of home care worker (Macdonald and Charlesworth, 2016).

Union density in the disability services sector is relatively strong. However, due to underfunding, few organisations have had an enterprise agreement. Where there are agreements these do not often provide for above-award wages, rather they provide for improved conditions. In the new fragmented context of the NDIS, organisations are pushing for change in order to meet the demand for short shifts, short notice shifts, varied tasks, personal preferences and new risks and skills (Macdonald and Charlesworth, 2016).

Short Description of the NDIS

The NDIS is argued to be Australia's largest social reform since the introduction of universal national healthcare (Gilchrist, 2016). The NDIS introduces a national system of funding through a cash-for-care model for 'people with permanent and significant disability, their families and carers' (NDIS, 2013). Combined, funding for assistance with daily living and assistance with civic and social participation account for three quarters of NDIS funding to support individuals, with these two activities accounting for 76.5% of funding for people aged over 25 in 2018 (National Disability Insurance Agency [NDIA] 2018, p. 6). In other words, most NDIS funding pays for wages for frontline disability support workers to provide in-home, gig-like direct care.

After receiving their assessment and funding package, people with disabilities can opt to: i) employ and supervise their own employees in which case the employees do not need to be registered with the National Disability Insurance Agency; ii) work with a third party plan management provider registered with the NDIA in which case only the plan management provider needs to be registered with NDIA; or iii) have their plan managed by NDIA in which case all service providers need to be registered (NDIS Registered Providers of Supports Rules, 2013). Until the recent introduction of a Code of Conduct for all workers providing NDIS-funded

supports only employees of registered service providers were subject to any regulatory oversight by the NDIA. The Code of Conduct sets out obligations for workers does nothing to diminish the clear incentive for informal, low wage and unregulated work under two of the three options outlined above, as self-managed individual service users and non-NDIA care managers seek to extend funding packages as far as possible (though even so, this may or may not be adequate to individual needs and wants).

A further way that employment rights are undermined involves the fragmented and unregulated worksites. Rather than being organisation- and group-based, most of the work under the NDIS is located in people's private homes. Feminist scholars have long identified that care work in the private sphere is largely invisible, keeping wages low or non-existent and making it difficult to assess or regulate (Folbre 2009; Meagher, 2003). Evidence from European countries further confirms that cash-for-care policies introduce new demands for flexibility, travel between multiple work locations, very short working hours, and may be a cover for deepening austerity policies (Cunningham and Nickson, 2010; Glendinning, 2012; Christensen, 2012).

Short notice shifts, multiple job holding, dispersed work sites and short-term work assignments (less than an hour) signal an important shift from a largely, publicly funded, nonprofit delivered, organisation-based employer to a quasi-gig or on-demand economy (van Doorn, 2017; Friedman, 2014). Gig work has thus far been mostly found in the arts, entertainment, delivery and private domestic work. However, it is increasingly seen in care work in various forms and acts as a mechanism for reproducing gender and racial inequities (Aliosi, 2015; van Doorn, 2017).

While there is no debate as to whether a new service model was essential for people with disabilities, the pro-market, cash-for-care that characterizes the NDIS interprets the achievement of these goals exclusively through a market lens. As with individualised and marketised care systems, under the NDIS individual care users are constructed as consumers empowered through the exercise of consumer choice to buy care (Brennan et al., 2012, p. 378; Productivity Commission, 2017, 2011).

Methods

Qualitative, in-depth, semi-structured, audio-taped interviews, using an interview guide, were undertaken with 39 disability sector workers in one of the early-roll-out regions. The sample was 70% female which is slightly lower than the sector (80%; Martin and Healy, 2010) and all had higher education and/or training. They ranged in length of employment from 1.5 to 30 years, with majority having 8+ years of experience in the sector.

Findings

Drawing on the words of the workers, this section will address the strongest themes in the data, namely: increased precarity and a gig economy-like working conditions; less training and skill in the labour force; and working short shifts in private homes.

Increased Precarity and Gig Economy Working Conditions

In contrast with the workforce prior to the NDIS, all research participants reported that employment had become increasingly temporary with undependable hours, lowered earnings and conditions, and increased overall precarity. As one long term disability worker observed, "They don't want full time workers. What they say is we need to have flexibility …because clients could come and go now with their choice." Another worker added, "Every single person working at my agency is casual …no permanent. In my old agency, almost everyone was permanent." Organisations exclusively employing casual staff can save costs in terms of sick leave and can dismiss staff more easily to cut costs. Casualisation also makes it more possible for employers to schedule work around shorter periods of service provision and more variability in the timing of services (early morning and late night), and location (private homes).

Characteristic of gig economies, short notice of shifts and short shifts were particularly disruptive. As one long time worker noted, "My stress and fatigue are both way up. I've been living on the phone for shifts, some of which I get less than two hours' notice for." Other workers noted that apps notifying workers of their constantly changing shifts and hours were a commonplace aspect of their employment, suggesting a further shift to on-demand work, platform labour market. As one long-term worker noted, "all our rosters are electronic" and constantly changing meaning that worker never "know exactly what shifts you're gonna have that week because something will just randomly change".

The data show that costs were shifted to workers in a number of ways including travel costs between multiple and widely dispersed job sites (service users' homes). After her employer refused her travel claim, one worker was told that she should consider each private home to be her worksite, regardless of how much distance or travel time was between them, "we don't pay kilometres. That's deemed your workplace". Travel time is also usually unpaid, with workers expected to use their own cars and claim mileage as a reduction on their income tax return.

Workers were also expected to cover the cost of meals and other activities accompanying service users, and to, as one worker put it "model appropriate behaviour" for the service users, while shouldering their own costs. Summing it up for a number of the research participants, one worker noted, "We as workers are

expected to pay for ourselves so out of my day, I might earn $250.00 but $50.00 of my pay needs to go on being able to support that person in the NDIS to those activities." These additional costs are, in effect, a cut to wages and a subsidy to the employer.

Though much of the disability sector has tried and tries to operate on an ethos of care and equity, the research participants were disturbed by new trends emphasizing profit over support for service users and generating divisions between staff and management. In a number of instances, employers made it explicit to frontline workers that the culture of the workplace had changed to one of ensuring that every interaction with clients was charged and chargeable, otherwise it had to be eliminated. One worker received the following instructions from her manager regarding billing service users for phone calls - - even when no one answers, "you call them, you charge 'em. If they don't answer, you write it down and you charge 'em. And you charge 15 mins because that's the minimum you can charge."

Despite a significant level of alienation and instability, many workers continued to find satisfaction in working with people with intellectual and other cognitive disabilities and to try to make the NDIS system work. Though two workers told us that they felt it was likely that they would soon be fired because they refused to abandon the principles of equity and support, other workers told us that the job still held meaning because, "You can put things in place for people that can give them hope". Despite the challenges posed by inadequate funding and short notice shifts, most workers found rewards in, as one worker put it, "Watching [] the participants reach their goals." Another long-time frontline worker summed up the feelings of most research participants thusly, "I love working with the people. I love making their lives… as high quality as we can".

However, it was notable how many workers were thinking of leaving the sector entirely: some planned early retirement, others sought a career change, while others had no definite plans other than to seek a job they could like. Part of this intention to leave was based on working conditions, but for most workers it was also based on no longer feeling part of a job where one feels appreciated and where one could find meaning. In the words of another long-time worker, "It is chaos. It's awful. We really tried to raise all these issues that we could foresee was gonna happen and it seemed to fall on deaf ears of the state and government and now we're seeing all those things that we feared."

The revolving door of casual staff, a lack of training and supervision, and increased distance between management and workers exacerbated the stressed and sometimes dangerous situations noted above, putting workers in a position where they felt replaceable and disposable. A senior worker summed it up for the bulk of the research participants by observing, "morale has never been lower".

Less Training and Skill in the Labour Force

Prior to the NDIS, there was time and funding for training and upgrading as well as supervision and meetings, "we would have regular staff meetings, training days, staff development days…That's gone. We get told there's no money for it". Participants noted that their employers now have very limited requirements for hiring new staff, whereas previously skills, formal education and experience were definite perquisites. The lack of training and experience presented risks for the new labour force, service users and existing staff. As one long time worker observed, "Because I have more experience than most of the staff, I get all the hard guys. They are all one-on-ones (one staff to one client) because they need that much support. They have complex needs and the work is always hard work. No down time or variety." This makes the work more draining and adds to workplace stress and unsafe conditions. However, temporary and casual staff are less likely to complain as they need to position themselves positively in order to be assigned to future shifts.

Private Working in Private Homes

Though an increasing portion of the disability labour force works in service users' homes, there is no way to assess whether private homes are safe or appropriate worksites. The constantly shifting pool of on-demand workers made for a more hazardous work environment as casual staff cannot possibly know the service users, their preferences or triggers. Workers reported knowing little or nothing beyond the service user's name and address when they showed up for a shift. Noting an overall increase in workplace injuries, one worker quipped, "Nothing major, just black eyes, broken noses, the normal sort of things with people just being out their routine, not knowing the support workers and the support workers not knowing clients."

One research participant noted a lowered likelihood of accurate reporting because workers all needed more shifts and feared reprisals if they reported incidents, "Some workers are scared to complain about challenging behaviours from the clients, to the client or the family or the agency. The workers don't want to upset anyone, or they might not get more shifts."

Discussion and Conclusions

Some characteristics of the former disability sector remain constant in the new NDIS context: particularly the commitment of workers to the service users and/or social equity and justice; the gendering of the workforce; and the increasingly poor wages and conditions. Most of these constants remain because, ironically, social justice, gender, unpaid work and poor wages were seen as unimportant to a piece of legislation addressing the human rights of a very marginalised population that had long been treated inequitably. As a result, the work force and many disability service providers have lost out in a zero-sum game in which some people

with disabilities experience increased autonomy and self-determination while others experience diminished life choices and reduced quality of service. This is largely because the NDIS was conceived of narrowly as an exclusively market solution to a complex and pressing human rights issue.

A truncated, marketized version of human rights played an ideological role in convincing service users, the public and workers that management and the state need to drive down workplace protections and weaken employment regulations in order to meet the commercialised needs of vulnerable populations. By embracing a pro-market ideology, the NDIS sets the terms for a zero-sum game involving the emergence of a precarious labour market with significant gig-like, on-demand economy aspects and a temporary workforce that lacks the constancy, supervision or training to properly support the autonomy and self-determination of all people with disabilities. Current employment regulation seems ill-equipped to defend disability workers and governments are more interested in containing costs and fostering private markets than in protecting a highly gendered, increasingly precarious labour force. Though our conclusion is tentative, based on just this example, the evidence suggests that zero-sum games, in which a few wins and many lose, may be a feature of social policy change in market-driven contexts, such as the NDIS, and that current workplace protections mean little in the context of restructuring and marketisation.

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'Off My Own Back': Precarity on the Frontlines of Care Work

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Abstract

Hailed by some as representing the 'most profound change in Australian disability history', care work in the disability sector under the new National Disability Insurance Scheme is described by one frontline worker as 'a massive swing towards a casual workforce and a massive cultural shock'. This firsthand account draws on 13 pages of unsolicited hand-written notes from a long-time, frontline care worker and his wife, as well as an in-depth interview and subsequent telephone and email conversations. The article gives voice to the experience of the frontline as disability workers grapple with almost complete casualization of their work, as the state retreats from its role in regulating employment and protecting workers in favour of the marketization of services and the advancing of the human rights of people with disabilities.

Keywords

care work, casualization, National Disability Insurance Scheme, precarity, privatization, risk transference

Hailed as representing the 'most profound change in Australian disability history' (Reddihough et al., 2016: 66), the National Disability Insurance Scheme (NDIS)

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provides individual funding packages aimed at increased human rights, choice and autonomy for people with disabilities (Williams, 2014). Failing on two counts, service users have serious concerns with the NDIS and feel that their views and those of their families and carers are often overlooked, while Warr et al. (2017: 8–9; see also Productivity Commission, 2017) found numerous workforce problems including 'staff shortages, high turnover of staff and staff working as planners with limited experience of working in the disability sector'.

The workforce in the disability sector has been covered by a set of employment regulations known as the Social, Community, Home Care and Disability Services Industry Award (2018) as well as some union protection including enterprise-level collective agreements. However, like the third sector in Australia as a whole, the disability sector is undergoing rapid restructuring and casualization (Meagher and Goodwin, 2015; Productivity Commission, 2017).

The Australian state assumes three contradictory and conflicting regulatory roles in this sector: defender of the human rights of people with disabilities; defender of minimum employment standards; and key driver of precarity and market processes, which largely subsume the first two roles (see also Jaehrling et al., 2018; Kallenberg, 2012 on precarity). While disability rights movements sought new systems of support based on individuals' lifetime goals and strengths, the NDIS model interprets these goals exclusively through a market lens. This places workers in a situation where the conditions of their work are driven down within the context of marketized care and fragmented workplaces.

This article draws on the data provided by a disability worker with many years' experience in the field, Paul,[1] and his wife, Sally. As Paul explained, he and Sally hoped their perspectives might help us 'understand the way that the NDIS changed my work and how it's impacting on me'. The qualitative data paint a portrait of frontline workers, many of whom are drawn to the sector to give support to this particular marginalized population, however rather than find meaning and satisfaction in this work, the sector is in the throes of uncertainty where casualization and heightened stress co-exist in a changing landscape of: precarious, fragmented and highly commodified labour; risk transference (from government to frontline workers and service users); decreased wages; and growing personal costs for frontline workers. The article briefly reviews the context in which Paul's story plays out and relevant sociological debates. A note on methods is followed by an introduction to Paul and Sally.

Brief review of contexts and debates

The rights of people with disabilities have been debated across the social sciences with the majority advancing a social disability model that promotes a human rights agenda and full social inclusion (Howard et al., 2015; Thill, 2015; Thomas, 2007). Claiming to ensure human rights, and provide expanded choice and improved quality, individualized models of funding services are commonplace among neoliberal welfare states, existing for some years in the UK, Canada and other industrialized countries, though just recently introduced in Australia (Fawcett and Plath, 2014; Lymbery, 2014; Thill, 2015). Individualized funding is intended to incentivize the development of an array of

disability services competing for clients in an open, private market (Cunningham and James, 2009).

Consistent with the risk economy literature (Beck, 2006; Beddoe, 2010), these programmes represent a shift in risk and responsibility from the government to individual citizens, in the form of frontline employees and care recipients (Giddens, 1999; Howard et al., 2015; Lymbery, 2014). The recommodification of labour (Greer, 2016; Rubery et al., 2018) works hand-in-glove with the downloading of risk, generating a sector where new workers accept precarity and insecure employment as 'normal' and long-time workers argue that 'things were better before', including permanent employment, reasonable hours and income and better care provided to people with disabilities.

Alberti et al. (2018: 450) argue that precarity is an ill-defined term that provides little clarity to a range of processes and conditions 'with potentially negative political implications'. Instead, they encourage the study of the drivers and patterns of precarization, particularly management and the state (Alberti et al., 2018: 450). In the NDIS as the state plays the multiple roles as a driver of the marketization of disability services and, simultaneously, as a defender of minimum work standards and human rights. Management also drives the precarity agenda by pressuring governments for less employment regulation and the diminished power of unions in order to redevelop the labour market in this sector as low wage, insecure and less regulated or unregulated.

A specific driver of precarization under the NDIS is the loss of block funding from governments to organizations. With people with disabilities suddenly in receipt of personalized funding, relatively stable, long-term organizations lost clients and were compelled to market themselves to cash-carrying individuals with multiple desires and requirements for support and activities. Many long-term organizations are struggling to survive (Productivity Commission, 2017) and the sector has seen the rapid growth of for-profit, non-profit organizations and 'pop-up' providers, many of which have little or no experience in providing social services or fulfilling their obligations as employers.

At this early stage of the NDIS, very little is known about how this rapidly changing world of work is experienced at the frontline. The balance of this article speaks to that gap through the voice of a long-term disability support worker and his wife caught up in the vast restructure. This article will also comment on and attempt a very preliminary contribution to the theory of drivers and patterns.

Method note

The author originally met Paul as part of a larger, qualitative study undertaken in conjunction with one of Australia's unions. The union's official position, and that of the workers interviewed, is strong commitment to service users' human rights and autonomy, and ongoing optimism that this may still happen under the NDIS, despite growing evidence of problems. The union plans to protect enterprise-level agreements and defend conditions and wages, though this is proving difficult in the fragmented context of business failures, amalgamations and multiple new organizations.

Paul arrived at his interview with 13 pages of handwritten notes; nine were written by him and three by Sally. These notes were written entirely on their own initiative because, as Paul explained, they wanted the researchers to get a clear picture of what

was going on for workers in the sector and he was not sure he would remember everything he wanted to say during the interview. Paul asked Sally if she would like to contribute her 'take on things' in the form of written notes. Sally is the more highly credentialed and educated half of the couple and Paul told us that he 'really values her opinion'. Both sets of notes were thoughtful and insightful, with Sally's providing slightly more analysis and overview and Paul's providing more on-the-spot detail. The handwritten notes were a surprise to the researchers but proved to be very useful during the hour-long, audio-recorded, semi-structured, qualitative interview with Paul and subsequent email and telephone discussions over the course of more than six months. One of the researchers proposed this article and initiated a subsequent email exchange with Paul and Sally. Other team members were over committed and encouraged the development of this article but demurred further involvement. The author undertook a close analysis through multiple readings and comparisons of the notes, the interview transcripts, email exchanges and telephone calls with Paul and Sally. The final text was reviewed and approved by Sally and Paul, with various edits and comments added.

Paul is in his mid-50s and started working in the disability sector 10 years ago, employed by a long-standing, non-profit agency that provided community support to people with intellectual disabilities. Until recently, Paul liked his work and found it rewarding. He has been active within the union and is concerned about the rights of workers and service users.

Sally is of a similar age and has steady employment as a care professional. She is very involved in her community and with volunteer commitments. Though Paul expresses pride in her community work, his unpredictable schedule means that they have very little time together at a point in their personal lives where they feel they have a lot to process.

Previously, Paul worked in a day programme that provided community activities and support to people with intellectual disabilities. He misses his regular schedule and steady wages, as well as his colleagues and the service users he worked with for many years. Due to upheavals in the sector, Paul started employment with a new company, just three weeks before our interview, after 10 years' steady, full-time employment with the same company. Phone calls and emails after the interview confirmed that the sector continues to be, as Paul quipped, 'in chaos'.

Consistent with unmediated workers' accounts, the next section is in the words of Paul and Sally. The article starts with Paul's story and moves on to Sally's. The stories are organized according to the strongest themes in the notes and transcript, which parallel themes found in the literature and other transcripts for this project.

Paul's and Sally's stories

Paul

My stress and fatigue are both way up. I've been living on the phone for shifts, some of which I get less than two hours' notice for. Like this week, I got three shifts with less than two hours' notice. I have completely irregular hours.

It's irregular, irregular. It is impossible to plan and impossible to feel you know what's facing you the next day, let alone the next week. It makes me feel not valued and my self-esteem is plummeting. My family suddenly has questionable financial security, if any. I am venting a lot more at home and that leads to marital disharmony as my wife tries to cope with me.

The NDIS is a massive swing towards a casual workforce and a massive cultural shock. My first week I had 18 hours and the second week I had 12. I used to work 40 hours a week, regular. I'd prefer 40 hours if I could get them. At my age I want to squirrel away as much as I can.

Every single person working at my agency is casual and that's the nature of the beast nowadays. There's 53 casual workers at my new agency, no permanent. In my old agency, almost everyone was permanent.

It's also a very, very young workforce, they're all new to the industry, very few skills. Most of the staff are 18 to 20 with no experience with people with disabilities. At this stage, the workforce is very, very green; very, very raw. This throws a disproportionate amount of responsibility on the few staff with skills, like me.

Because I have more experience than most of the staff, I get all the hard guys. They are all one-on-one (one staff to one client) because they need that much support. They have complex needs and the work is always hard work. No down time or variety.

Some of the new staff get all the easy clients where you go have a cup of tea and watch a film with them. I get it that they (the employer) want to ease some of the new people into the job but they can't burn the rest of us out working constantly one-on-one with complex guys and no variety or option to work with the happy, smiley, easy people.

The individualization of risks. I've mostly been in day programmes in the past, out in the community. Now, sometimes I'm in a group home. I work with these really new staff and even though I'm new to group home work, I see hazards they don't see. Like, one of our guys, he's got these behaviours. One of them is throwing things, mostly pots. So, every meal we get out as many pots as we need and then as soon as we are finished with them, we go lock them in the storeroom. And, I am thinking this is ridiculous. We've got a tool box with sharps in it lying around. He has self-harmed with a spoon before, so I am thinking the box could be thrown and the sharps are not safe to have around anyone, particularly him.

So, I said, 'there's a big friggin' metal tool box there, why can't he just pick that up and hit someone with it, if he can throw a pot, he can throw the box'. They just said, 'well he hasn't done that yet. He throws pots.' The tool box has a handle, it's easier to throw. I'm thinking, we aren't keeping anyone safe this way. Why wait until someone gets hurt? But just they shrug me off.

Talking to staff across the sector, I am hearing of an increase in assaults on staff, mainly due to staff putting themselves in dangerous situations due to inexperience and no training. Nothing major, just black eyes, broken noses, the normal sort of things with people just being out of their routine, not knowing the support workers and the support workers not knowing clients.

Some of the younger guys and girls, some of the less experienced people will get right in people's faces and you can just see the client's eyes, you think no, no, no, no. I've tried

to get them both to back down. I say to the client, 'Tell you what, watch your TV, mate.' And then to the staff, 'I need a hand, can you come and help me for a minute', and then, say privately, 'Back off, you put him in a corner, his only option is to cave or to lash out and you're gonna get hit, he's not gonna cave.'

I heard a new staff talking to one of our guys, right up in his face and it's, 'Go away, get away, fuck off', from the client, over and over. And, I'm thinking, there's red flags all over the place, back away, give him some space. But, he didn't so he (the client) kicked nine holes in his bedroom door. That was okay cos it's not self-harm or hurting us but it's still not good because he's under stress and really unhappy, and we are wondering what's next.

I heard one young staff boast about her injuries, like a badge of honour. Her exact words were, 'He didn't break my nose like so and so, he only gave me two black eyes.' This is what gets discussed, instead of 'Shit, what went wrong? Did I do something wrong? What did I misunderstand? What can we do better next time? What can we learn? How can we keep everyone safer?'

These situations could be avoided with a bit of training and supervision. But, the NDIS doesn't provide for ongoing supervision or upskilling, so no one seems to get better at this stuff. It's not just this company, they're not the worst but they've got a bit to learn, it's really scary with some of the people in the community with guys looking after them and they just don't have the knowledge or the inclination.

I'm generally under employed but I think it will build up because they've been trying me out with different people (service users) and so far, I've been a good fit. The problem is that I keep getting sent to work with people I know nothing about, and that can make it bad for everyone.

Like yesterday at 7.10 a.m. I get a call, 'Hi Paul, are you able to work today? The shift is 9 a.m. to 1 p.m., very easy-going client.' When I got there I find out he had schizophrenia and depression and tried to attempt suicide this year. I met him at his house and went in totally cold. No information from the agency. He is the one who gave me his background, at the top of his voice. Told me and all of the town. I said, 'How about we go sit somewhere quiet and talk about this?' I should have that information from the agency before I go in to see him. How can I keep him, or me, safe if I don't know? It is fraught with danger!

The only way I get information on the clients is if I go into the head office on my own time and read the files. There is no paid time for it. The NDIS only pays for face-to-face time, no prep time. With short notice and new clients I usually can't manage to get to the office before my shift. Plus, the files are not always where they are supposed to be or they are incomplete and I have to hunt all over the office. I came in unpaid, off my own back, before I started working with three of my new clients. Since then, I've worked with another two clients without any access to their files. The communication and information systems are very poor. We keep being promised new systems and better communication but it is a bit ad hoc at the moment.

I had three guys, three consecutive days who had schizophrenia, two were also depressed, and two were self-harmers. They are really complex guys with complex needs but I knew nothing about it until I walked through the front door at the start of my shift. A lot of new clients have entered the sector or are changing service providers for the first time in years. There is very poor, scant background provided to staff. I sometimes

wonder if previous service providers withhold some of the information in the hopes that the new provider will fail to do a good job and the cash cow, sorry I mean, client will come back to the first agency.

Shifting the costs to workers. A big issue is use of private cars. Prior to the NDIS, I worked a regular shift that saw me use a company car and get paid one hour each way to get to a client. Used to see a client every Saturday, which was at time and a half because it was the weekend rate. That meant I got three hours' pay for the two hours of driving. With the introduction of the NDIS, I'm casual and don't get the weekend rate anymore. Plus, I have to use my own car to drive 126 kilometres with no payment for the driving time. On top of that my car was soiled in a number of times, and I had to cover the cleaning cost.

Also, when I asked about claiming my kilometres they said, 'Oh, no, don't claim against the company, claim it on tax and get more.' I'm thinking, how the hell does that work? The company is singing that song and all the young ones are saying 'yeah, okay'. I'm thinking, no, I'll claim it off the company, thanks. I'll lose a third of it in tax but I'll get two-thirds up front. If I put in my tax I'm only gonna get a third and also every cent I get off you, a couple of cents go into my [pension], so I'll be putting it through them.

I also have to pay my own costs when a client wants to eat out. I always brown bag my meals but I am supposed to model appropriate social behaviour when we are out in the community, so I am supposed to buy a meal and eat with him. The cheapest option at the venue we went to was $21. So, I was obviously out of pocket. I handed in receipts in person and the company said we aren't paying for them anymore. WTF! But they still want me to buy meals to model appropriate behaviour.

With this casual, almost transient workforce, there is greater turnover of staff. Which is easy for the companies to just keep filling the jobs over and over, because they don't hire people with great skills in the first place, so they don't replace them with people with any great skill. Most staff work across a multitude of companies to get enough hours per week. So, this means staff are often not available to work because they are working elsewhere.

In my old job, yeah, there was a bit of recognition, a bit of esteem for what you did. Now, not so much. One of my bosses, her words were, 'We lost a really good worker', and I said, 'Oh, that's a pity.' She says, 'Oh, well, support workers come, support workers go', and I couldn't help myself, I said, 'Well, with an attitude like that you've gotta wonder why.'

I'm not feeling the love. To be honest, there's not a whole lot I like about my job at the moment. I'll give it 12 months and then if it's not any better, I'm gone.

Sally

From my perspective as a partner of someone who has worked in the sector for a long time, it's clear that more uncertainty faces the workers each day when they go to work: which clients will they work with; which programme; which location; and which colleagues will they work with? The agencies are staffing with more casuals, who are unable to do many things, due to lack of training. This puts more responsibilities on workers who are trained, like Paul. This makes him much more stressed when he comes home.

Agencies used to staff mostly with permanent staff who had skills and were highly dedicated. These permanents would really get to know the clients, their likes and dislikes, and keep things safe and supportive. Now the agencies want any remaining permanent staff to reduce their contracted hours and become casual. That's what everyone is these days; casual.

So, you end up in a situation where less staff with less training and less familiarity with the clients are working with more people, with serious disabilities. It is very frustrating for workers and the people with disabilities.

Also, the system has no money in it to pay for anything but direct service to service users. So, there is much less paid prep time or none, and clients are dropped off earlier and picked up later which means that staff have to stay back with the clients with no compensation. Shift turnovers are also on the worker's own time and notes are often written at home rather than at work or during work time as there is no time allotted.

Another thing that we've all noticed is that the agencies have dropped their hourly wage rate but they want more staff, which doesn't appeal to skilled workers. They are used to better conditions and better pay. The agencies are expecting more work for less pay.

Transportation is also full of problems now. Kilometre limits are often exceeded for appointments that Paul has to take clients to and there is no compensation for the extra. Some family members also expect to be taken where they want to go, like Paul is their care provider. And, he is supposed to claim parking on his tax claim, not from the company, which is just not right. Transportation used to be covered by the agency and it still should be. It is both the workers and the service users who are hurt by this new transportation policy.

Challenges of working in the private realm of home. Working one-on-one with families in their own homes is another a new problem. Paul used to work in the community centre, now he works in people's own homes. In the community centre, everyone followed basic rules of drop off times, pick up times, appropriate behaviour, start time, end time, etc. In this new situation, some families have unrealistic expectations of what can be done in a day and what the client is capable of, and there are no rules or guidelines they have to follow. There is nothing Paul can do in an immediate situation if people are acting inappropriately in their own homes.

For example, families don't always acknowledge when a shift is finished and don't let the staff person leave. Or don't come home on time to take over. On one shift, Paul had to work four extra hours waiting for a family member to return home to a client who was unstable and could not be left alone. Paul finally had to tell the family that he would have to leave the client alone if no one came home to take over. He shouldn't have to deal with this kind of terrible decision or insist that family members take care of their own. This places too much responsibility on workers. In another case, a client was very afraid to be left alone and so Paul could not leave until a family member finally showed up.

Some workers are scared to complain about challenging behaviours from the clients, to the client or the family or the agency. The workers don't want to upset anyone or they might not get more shifts. This means that the agency doesn't get accurate information on the clients' behaviours or on what might be brewing. It means that they can't make

good plans or support clients properly. Team leaders/managers tend to brush off comments by workers about clients, saying they are just 'having a bad day' or that 'it's just a personality clash'. They don't care if the support workers are injured or disheartened. They can always get someone else to take their place; more often than not, they are not trained or have very limited training, and don't stay in the job long anyway. In this new agency where Paul works, there seems to be even less care for staff members if they are injured. We heard of one example where a client didn't want to use his walking aids but then had to grab hold of the worker for stability, causing injury to the worker. But workers are too scared to say they are injured or they won't get further shifts. There are examples of workers not getting further shifts even after they recover from injury, so no one wants to report.

Conclusion

Three conflicting roles of the state were noted earlier in this article, namely as: the defender of the human rights of people with disabilities; a regulator of employment, defending or maintaining standards; and the key driver of precarity and market processes, which largely subsume the first two roles. The accounts above substantiate a hierarchy of rights at play within the marketized, personalized-funding actualities of care work in the NDIS, in which choice and protections are pitted against each other in a zero-sum game. Within the NDIS, clients are remade as individual consumers and their human rights are putatively realized within commercialized transactions with a changing kaleidoscope of largely unskilled, low pay care givers. The frontline of care work is remade as insecure and casual, with numerous costs and risks downloaded on the worker, who is required to 'model appropriate behaviour' regardless of the costs or degradation. These stories show that Paul was frustrated with his work but did not shirk his responsibilities or put clients in jeopardy, despite the disruption to his life, sense of self-esteem or level of exploitation. The data also showed that Paul and Sally experienced increased stress in their family life and longed for greater employment stability.

This account contributes tentatively to theory concerning the drivers and patterns of precarity (Alberti et al., 2018) by observing that, in the unfolding experience of the NDIS, human rights have been subsumed to the larger goal of marketizing care and recommodifying labour (Greer, 2016; Rubery et al., 2018). Human rights played an ideological role in convincing service users, the public and workers that the needs of a vulnerable population could be best met if management and the state drove down workplace protections in order to meet the commercialized needs of vulnerable populations. This article also contributes to empirical studies on precarity by suggesting that this zero-sum game may be an aspect of care work in the context of neoliberalism in which the human rights of service users and workers are in increasing conflict and growing jeopardy.

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1. Not their real names.

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Precarity and Job Instability on the Frontlines of NDIS Support Work

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The Centre for Future Work
at the Australia Institute

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Summary

With the goal of providing choice and upholding the human rights of people with disability, the National Disability Insurance Scheme (NDIS) constitutes a historic change to the provision of disability services in Australia. The system was initially trialed in four regions, beginning in 2013. Since 2016 the system has been rolling out across the country, and is presently about two-thirds of the way toward its expected ultimate enrolment.[1] In addition to fundamentally altering how people with disability interact with the care system, the NDIS is also producing enormous changes in the nature of work and employment in this important and rapidly-growing sector of the economy.

There is tremendous opportunity for disability service workers associated with the new system, which will allocate tens of billions of dollars of additional public funding for disability care work, and lead to the creation of an estimate 70,000 new full-time equivalent positions in the field over the first years of its operation.[2] But there are also tremendous risks facing workers in the profession, as the delivery of services shifts from a traditional block-funded agency-based model to an individualised, market-based system. Disability service workers are facing a whole new set of pressures arising from the NDIS's market-driven approach, including:

- Instability in work and income, associated with fluctuations in demand for work from individual participants.
- Unpaid work associated with traveling to and from clients, performing various overhead and administrative tasks, etc.
- Inadequacies in the NDIS's "unit price" model of establishing cost parameters for particular care functions or services.
- An absence of institutional support for training, supervision, mentoring, and professional development (since agencies have few resources under the NDIS pricing system to provide these broader functions).

[1] Cluff (2019). At present the system is intended to cover Australians under 65 with a range of specified physical, intellectual, and other disabilities. Once fully rolled-out, an estimated 475,000 Australians with disabilities will be covered.

[2] Productivity Commission (2017), p. 323.

- High levels of staff turnover, made worse by the lack of training and support given to the new workers recruited to meet the rapid expansion in service delivery as the NDIS is rolled out.[3]

In the extreme, many disability support workers end up working under especially precarious, "gig"-type arrangements: waiting to be instructed (often via digital platforms or smart phone) to attend the next client, with no continuity or stability in work, and no capacity to fully develop their professional capacities. A disability services program that organises support in the same manner as digital platforms organise fast food delivery or taxi services, is not likely to achieve the high standards of respectful, individualised support that the NDIS's architects hoped for. And it will also be a very challenging place to earn a living.

To gather direct evidence regarding the impact of the present NDIS delivery model on working conditions, job stability, skills acquisition, and quality of care, this report analyses 19 personal interviews conducted with NDIS-funded disability support workers (DSWs) and case managers, regarding their experience under the new system. The interviews were conducted with workers in NSW, most of whom work in the Hunter region – one of the four sites for the initial NDIS trials. Hence the interview subjects have a relatively long period of experience with the new system – which can hopefully inform (and caution) participants in the program in other parts of Australia.

The qualitative interviews with front-line staff identified several major challenges and problems associated with disability support work under the NDIS, that should be considered carefully by policy-makers and agencies. The most important and concerning insights gleaned from the interviews include the following:

1. The new system is not providing sufficient support for participants with intellectual and other cognitive disabilities, including in designing and managing individual programs of care;

[3] Other research which has also documented the challenges facing workers under the NDIS include Baines and Macdonald (2019), Baines, Kent and Kent (2019), Macdonald and Charlesworth (2016), Cortis et al. (2017), Macdonald et al. (2018), and Ryan and Stanford (2018). NDS (2018, p.14) reports an average turnover rate in the disability workforce of close to 5% per quarter for permanent staff, and nearly twice that high for casual staff; therefore, about one in four disability service workers leave their jobs in any given year (for a "churn" rate about three times higher than in the overall workforce; ABS Catalogue 6226.0).

2. DSWs are experiencing increased instability and precarity in their jobs, elevated levels of mental and physical stress, and irregular hours and incomes;
3. New workers joining the disability services sector are often less skilled, less trained, less experienced, and sometimes reluctant;
4. DSWs experience particular challenges working in the private realm of NDIS clients' homes;
5. The informal and inconsistent provision of transportation and other necessary functions to NDIS clients results in a significant shift of costs and risks to workers;
6. DSWs are experiencing increased levels of violence in their work;
7. Relationships with managers have changed dramatically under the new system, undermining effective supervision, coaching, and training; and
8. Worker turnover, given the insecurity of work and income and the challenging conditions of work, is extreme.

The report concludes that the insecurity of the workforce and the ongoing churn of workers will greatly undermine the development of the labour force which is essential to make the most of this historic innovation in social policy. Other expert reviews have already indicated that the effective roll-out of the NDIS is being negatively affected by inadequacies in recruiting and retaining a suitably qualified, motivated, and compensated workforce.[4] Our interviews provide corroborating case-study evidence for this concern from the front lines of disability service delivery. They show that the potential of the NDIS to enhance the lives of people with disability, and to establish a high-quality and flexible service industry, could be squandered without urgent attention to the quality and stability of work. The problem has many sources: including the market-based method of service provision established under the NDIS, inadequacies in funding and compensation, the lack of a systematic strategy and resources for training and upgrading, and inadequate support for participants with intellectual disabilities to successfully formulate and manage their own plans.

It is impossible to envision the delivery of high-quality, respectful, and responsive disability services, if the people employed to deliver those services are treated merely as disposable productive "inputs." And the promise of dignity and individual program design that was so central to the rationale for the NDIS will be betrayed, without urgent and systematic investments in the quality, skills, and stability of disability services work. To that end, the report concludes with several broad policy

[4] See, for example, Productivity Commission (2017), Joint Committee (2018), and Ryan and Stanford (2018).

recommendations aimed at ensuring that disability services work can become the respected, valued, and productive vocation that so many of its workers dream of.

Introduction

The Australian NDIS will eventually provide services to an estimated 475,000 participants, at an estimated cost of $22 billion Australia per year (Productivity Commission, 2017). Claiming to respect the human rights of people with disability, and to provide expanded choice and improved quality in service delivery, individualised models of funding disability services have been implemented in several neoliberal welfare states. For example, this approach has been utilised for some years in the UK, Canada and some other industrialised countries; with the introduction of the NDIS, it is now being introduced in Australia (Lymberry, 2014; Reddihough et al., 2016; Thill, 2015).[5] In theory, individualised funding is supposed to spark the development of an array of disability services providers, all competing to attract clients[6] in an open, competitive market (Cunningham and James, 2009). Like any other market (again, in theory), this competitive pressure will purportedly ensure highest-quality, customized service delivery, while restraining costs.

However, even in its initial years of roll out, the NDIS quickly encountered delays and operational problems, sparking far-reaching critiques from many stakeholders – including participants, workers, and long-standing disability service agencies. The Productivity Commission (2017) has concluded that the initial timetable for participant intake cannot be met; it noted in particular that the disability sector workforce is growing much too slowly to meet demand (p. 211). A study by Warr *et al*. (2017) found numerous workforce problems including "staff shortages, high turnover of staff and staff working as planners with limited experience of working in the disability sector" (p. 9). Other recent research and surveys of employers and employees in the disability services sector have documented similar problems, including:

[5] Of course, the individualised, market-based model of service delivery has been tried in several other areas of Australian public services, including employment services, vocational education, and child care – typically with disastrous results. For critiques of these other experiments with marketised human service delivery, see Australian Council of Social Service (2018), Hill and Wade (2018), and Toner (2018).

[6] Many terms are used for people using disability services including: service users; consumers; community members; people; participants; and clients. For clarity, and because it designates the capacity to hire and terminate services, the term "client" is used in this report, though we acknowledge the lack of consensus regarding appropriate and respectful terminology. Similarly, we acknowledge there is also a variety of terminology used in referring to the service provided to people with disabilities (including "support", "care" and "service").

- The costs of minimum entitlements for workers (including basic wages and conditions as specified under the relevant Modern Awards) cannot be adequately covered under the current NDIS pricing schedule (Cortis *et al*., 2017; McFadden, 2017; Worthington, 2016);
- Jobs in the sector are marked by very high levels of part-time work, irregular hours, casualisation, and independent contracting (United Voice, 2017; Ryan and Stanford, 2018; Australian Services Union, 2019);
- There is inadequate funding for agencies to pay for necessary supervision and training (Cortis, 2017; Ryan and Stanford, 2018);
- Workers have inadequate time to perform tasks that are necessary to high-quality support, and this negatively affects the quality of care provided to participants (Cortis *et al*. 2017; National Disability Services 2017).

The Warr *et al*. (2017) study found that service users also expressed serious concerns with their experience with the scheme, feeling that their views (and those of their families and carers) were often overlooked in the rush to approve individual plans and enrol participants – all within strict financial constraints (p. 8). As Howard *et al*. (2017) note, the NDIS early roll out created a situation where a human rights empowerment strategy for people with disabilities was immediately confronted with the realities of fiscal austerity and a competitive market; this placed service users, workers and communities in jeopardy, and clearly undermined the original, laudable goals of the program.

The Social, Community, Home Care and Disability Services Industry (SCHADS) Modern Award (2018) sets out minimum "safety-net" pay and conditions for the disability support workforce. Over and above these minimum conditions, unions in some workplaces have been able over the years to gain further benefits for workers through enterprise-level collective agreements. However, like the Australian non-profit sector as a whole, the disability services sector has suffered from chronic under-funding by governments for contracted services for many years – long before the NDIS was ever contemplated (Productivity Commission 2010, p. 280-281). This made collective bargaining for improved wages and conditions difficult in most workplaces.[7] While the community sector as a whole has been undergoing rapid restructuring and

[7] In some cases, especially in government-run facilities and large and better-funded agencies, unions were able to negotiate significant improvements in pay and conditions for DSWs, above the Awards. Those workplaces, however, constituted the exception to a general pattern of low-wage, precarious work – and those historic gains are now in jeopardy as much of that work is transferred to smaller or non-profit agencies as a result of the cost-sharing arrangements of the NDIS.

casualisation of the workforce in recent years (Meagher and Goodwin, 2015), the changes to the disability services sector under the NDIS are especially far-reaching and disruptive.

The fiscal basis for service provision is being changed from block-funding and grants, to a model based on attracting and retaining enough individual participants as customers to cover both direct costs of purchased services and the infrastructure and overhead of the overall operation. With the elimination of stable, core funding, even long-standing agencies have been pressured to restructure employment relations, reduce training and supervision functions, and allocate enormous resources to marketing services and attracting "paying customers" – a costly and peripheral function which was not even necessary under the former funding model. This sea change in financing structure is driving further casualisation, outsourcing, and individualisation in employment relationships for service workers, and demonstrably undermining wages and employment conditions (Cortis *et al*, 2017; Macdonald *et al*, 2018; NDS, 2017; Productivity Commission, 2017).

The Australian government has assumed three contradictory and conflicting regulatory roles as the NDIS has been rolled out, and this mission confusion has exacerbated the deterioration in employment stability and working conditions. The government is charged with the responsibility to defend the human rights safety of people with disability; to establish a framework and rules for the defence or maintenance of minimum labour standards (through the SCHADS award and, in some cases, through enterprise bargaining); and to implement the market-based delivery process for the whole scheme. These goals and responsibilities are clearly contradictory; in practice, the latter goal has largely subsumed and overwhelmed the first two (see also Macdonald and Charlesworth, 2016).

Methodology

To further investigate the challenges posed to the quality of work by the market-based delivery model of the NDIS, researchers from RMIT University, the University of Sydney and the Centre for Future Work undertook and analysed 19 semi-structured, qualitative interviews in 2018 with frontline disability support workers, including service coordinators and Local Area Coordinators. All research participants worked with people with intellectual or other cognitive disabilities or psycho-social disabilities, and many worked with clients with complex needs.

The overwhelming majority of the interviewees had more than 5 years of experience in the profession (one had 25 years' experience). Two of the interviewees were relatively new to the sector, with less than 2 years of experience.[8]

The interviewees were employed in various locations in New South Wales. All of them were performing work that was compensated through the new NDIS system.

Drawing on an interview guide, research participants were asked broad questions about their experience of working in the NDIS, as well as any relevant past experience working in this sector. The interviews ranged in length from 15 minutes to 1.25 hours. They were audio recorded, transcribed and analysed for similarities and differences, until patterns could be discerned and themes confirmed (Glesne, 2015; Kirby *et al*., 2006). Field notes were also taken at the time of the interviews, and folded into data analysis.

Requisite ethics approval for the research was received from each of the institutions involved.

[8] Some details have been changed to protect confidentiality.

Major Findings of the Interviews

The following themes emerged most strongly from the qualitative data collected through the interviews:

1) At present, the NDIS system does not provide adequate support for people with intellectual and other cognitive disabilities, including support to allow the successful design and implementation of individual service plans.
2) DSWs are experiencing increased precarity, stress and irregular hours in their work. Two key factors contributing to that problem include:
    a. Casualisation of work arrangements.
    b. Poor communication with managers and clients.
3) New entrants to the DSW workforce, recruited to help meet the rapid growth in demand associated with the NDIS roll-out, are inadequately skilled and trained, with very little experience working with people with disabilities. Sometimes these workers are reluctant recruits to the industry – seeing it as fall-back career path when other work opportunities did not eventuate. Two key dimensions of this set of problems include:
    a. The consequences of reliance on an underdeveloped, undervalued labour force.
    b. The influx of low skill, young workforce implies more challenging work for more experienced workers, as well as greater vulnerability for new staff.
4) DSWs experience several specific risks and problems from performing their work in the private realm of clients' homes.
5) Time and expense related to transportation (to clients' homes and other locations of work) shift a significant burden of costs to workers, that is uncompensated in many cases. There are other costs that are also shifted to workers, not recognised in the NDIS unit price model and in normal wages.
6) Several workers report increased risk of violence in the context of individualised care, working in clients' homes, and working without adequate training, supervision and support.
7) Workers reported sub-optimal, often counterproductive relationships with their managers – who were also grappling with severe challenges and constraints as their own jobs evolved in the wake of the new funding and operational systems.

8) High rates of worker turnover in the sector undermine any efforts to address these problems through training, mentoring, and experience.

We explore each of these themes in further detail below, drawing on exemplar quotes from the original data to illustrate and confirm the findings.

1. SYSTEM PROVIDES INADEQUIATE PLANNING SUPPORTS FOR PEOPLE WITH INTELLECTUAL AND OTHER COGNITIVE DISABILITIES

The research participants expressed strong support for the goals of the NDIS. The goals of empowerment, choice, and respect for the human rights and dignity of people with disabilities were broadly shared and endorsed. However, the majority of workers also reported that the NDIS "does not feel like it is designed for people with intellectual disabilities" (as distinct from physical and other medical disabilities). People with intellectual and cognitive disabilities had great difficulty negotiating the complex and bureaucratic processes and hurdles involved in designing and implementing individual support plans (Collings *et al*. 2016); they also were less capable of advocating for themselves in that process than other people with disabilities. The system therefore left many people with intellectual and cognitive disabilities with under-funded plans (particularly for transportation and activities), no one to advocate for them, fewer access to needed resources and supports (especially for people with complex issues), less effective choice (in contrast to the promised emphasis in this system on individual choices), and more instability and uncertainty in support schedules and providers.

This quote echoed the concerns of many of our research participants:

> "The NDIS is not designed for people with intellectual disabilities. There's a lot greater need for case management than people with … physical disabilities. [People with physical disabilities] do okay in the NDIS; have the intellectual capacity to advocate for themselves and navigate the system."

Another worker added:

> "Our guys have an intellectual disability, [so] they don't have a voice. They're the ones who're losing out...These guys we support are the ones that are getting the money taken off them because they can't speak up. It's like a tier system with people with disabilities, and people with intellectual disabilities are on the bottom tier."

Referring to the NDIS administration:

> "They truly don't seem to be aware of people with intellectual disabilities."

This marginalisation of some people with disabilities was confirmed by other repeated findings in the data, particularly regarding the casualisation and instability of the workforce – and the resulting consequences in limiting and reducing choice for clients.

2. DSWS ARE EXPERIENCING INCREASED PRECARITY, STRESS AND IRREGULAR HOURS

a) Casualisation of work arrangements.

All research participants reported that disabilities services employment has become increasingly precarious. In many cases, *all* the front-line staff in the interviewee's agency were casual; no one was permanent except management. The contrast with the workforce prior to the NDIS was striking. As one long-term worker in disability services noted:

> "Every single person working at my agency is casual and that's the nature of the beast nowadays. There's 53 casual workers at my new agency, no permanent. In my old agency, almost everyone was permanent."

This often exclusive reliance on casual employment allows agencies to save costs for paid sick leave and holiday; they can also dismiss or reallocate staff more easily, whether to meet fluctuations in client demand or to discipline employees. In essence, a casualised employment system devolves the risks of fluctuations in demand to employees, by making it possible for employers to continuously schedule and

reschedule work around the varying demands arising from the individualised service provision system. Moreover, since there are fewer group activities, and shorter units of service provision (often as short as an hour with a particular client), the individualised service model imposed a higher degree of variability in the timing of services.

Another long-time worker questioned her agency's explanation for why they continue to hire casual staff:

> "They don't want full time workers. What they say is we need to have flexibility because we don't know, clients could come and go now with their choice. But they don't go. They don't go anywhere, once they are with us."

Of great concern to the research participants, casualisation was seen to have serious consequences for consistency of support, and for increased violence and workplace injury (as discussed further in section 6 below). For clients with intellectual and cognitive disabilities, it is well-known that frequent turnover and disruptions in staffing and support routines enhances the risks of emotional turmoil and conflict. As one worker noted:

> "We all know that 'routine is king' in the disability world and swapping up or changing up staff constantly can create challenges for both clients and staff… In the past three weeks, I've seen this lead to damage to property from clients and self-harm. Makes the work harder for everyone. Makes it stressful and depressing. Where is service user choice in all this? It's nowhere. We are all in the same boat: the work is harder and the clients' needs aren't being met!"

Some workers told us that prior to the NDIS, their employers tried to ensure that each worker was assigned a mixed caseload of people: including those with challenging behaviours, and those without. This allowed for more sociability for clients, and variable intensity of demands for workers – as opposed to burdening workers with the constant high intensity of working exclusively with people with complex needs. While long-time staff in the sector generally have the skills and experience to work with people with complex needs, it can be exhausting and stressful. An additional layer of complexity is that many of the new staff have no experience or training to work with

complex behaviours. Research participants expressed concerned that this means that "people with complex needs often struggle finding workers because people decline to work with them." In this clear and unintended manner, choice is being *reduced* for clients as a result of a fragmented, unplanned delivery system – rather than being expanded.

As one interviewee poignantly put it:

> "Most of the negative stuff that has happened is because they've said, 'We don't get the money that we used to get. We're not getting money for this.' I've often said, 'The NDIS has come in, we've got more choice to do less.'"

Casualisation also implies unpredictable schedules and incomes for workers, which adds to their stress experienced on the job and at home. As one long-time worker noted:

> "It is impossible to plan and impossible to feel you know what's facing you the next day, let alone the next week. It makes me feel not valued and my self-esteem is plummeting. My family suddenly has questionable financial security, if any. I am venting a lot more at home and that leads to marital disharmony as my wife tries to cope with me."

Similarly, another worker noted:

> "My stress and fatigue are both way up. I've been living on the phone for shifts, some of which I get less than two hours' notice for."

Because of the shift to a unit pricing fiscal system, disability service agencies now face constant instability in their revenue flows. If individual clients change or cancel their requests for service, the agencies' revenue flows will also change. Agencies try to grapple with the financial effects of this instability by passing the risks of fluctuating demand onto their workers. Staff planning and rostering has therefore become less stable, more haphazard, and more subject to sudden changes. This instability in revenue is a direct consequence of the NDIS's unit-based funding model. But if employers are allowed to transfer the instability solely onto workers – whose ability to earn a livelihood now depends

on fluctuations in client demands that are clearly beyond their control – then the challenges facing the sector in recruiting and retaining high-quality staff will become all the more daunting.

b) Poor communication with management and clients.

Many research participants expressed concern that there were very few, if any, systems for ensuring that staff had access to client files and other necessary information before they started to work with them. The information in these files is critical to ensuring continuity of care, good programming, and safety for clients, the community and the workers. However, the only way most workers have access to this information was to use their personal, unpaid time to travel to head office to review files before assignments to meet with clients.

One long term worker noted:

> "The only way I get information on the clients is if I go into the head office on my own time and read the files. There is no paid time for it. The NDIS only pays for face-to-face time, no prep time. With short notice and new clients I usually can't manage to get to the office before my shift."

Other research participants added that files were often incomplete, missing or lost, making the unpaid trip to headquarters futile and even more frustrating. Unreliable communication between workers, managers, and clients also exacerbated the instability in scheduling. Workers did not always know about changes or cancellations in their work assignments, resulting in additional insecurity and wasted time. The individualisation of work assignments and poor communication between clients, managers and DSWs created many challenges in responding to unexpected events, delays or problems.

One long-time worker phrased the issue as follows:

> "If they get caught out shopping or there's a car accident and they're held up and things like that it puts pressure on that worker if he's gotta go to another client so it's important that there's good communication. But then it often puts pressure on the next person they're supposed to

> go to and they get really crabby because it's getting to that where you're supposed to be with me, I needed you that time and you weren't there."

3. NEW DSW RECRUITS ARE LESS SKILLED, LESS TRAINED, INEXPERIENCED AND SOMETIMES RELUCTANT

a) Underdeveloped, under-valued labour force.

The Productivity Commission (2017) notes that the NDIS labour force is under-developed and not growing fast enough to meet demand. This means that many agencies seem prepared to recruit almost anyone, including people with few skills and possibly little interest in the sector beyond having a job. Interviewees all expressed serious concern about this situation, as well as the lack of resources devoted to training:

> "You get casual people coming through being support workers that have got no idea, no training, there's not much training available."

Experienced, skilled workers expressed alarm at the general reduction in skill and experience among their colleagues:

> "It makes you feel very devalued in your work. It really feels like they're dumbing down our role, I guess."

Another senior worker expressed concern regarding the inadequacy of qualifications for new staff:

> "At the moment, our HR manager, she advertises for Cert 3 but everyone I've spoken to, none of them have got Cert 3. They're all literally, one was working at KFC last Friday night and yet he's out with complex kind of behaviours."

Another way this devaluing occurs is in recruitment. In the past, staff were often drawn to the sector because of their commitment to the service user population, and/or a sense of social justice ethics. Some experienced staff believe some new recruits to the sector are coerced through the threat of loss of Newstart Allowance if they do not apply for and accept the jobs – even though they may have little interest in working with people with disabilities and few relevant skills. This does not make for quality care or a positive work environment.

As one long term worker observed:

> "A lot of them have had no choice but then to take up positions because they've been on the dole and they're not interested or trained. They don't pay attention to clients, they're not giving them the quality of service; they spend more time on their phones than talking to the clients."

b) Low-skill, young recruits create more challenges for experienced workers, and greater vulnerability for new staff.

The new workforce in NDIS-funded services provision was described as "very, very green", young, low skill and inexperienced. This resulted in even greater workload and work intensity for experienced staff, who were required to support and compensate for the limited capacities of newer workers.

Noting this dynamic, one long time worker observed:

> "Because I have more experience than most of the staff, I get all the hard guys. They are all one-on-ones (one staff to one client) because they need that much support. They have complex needs and the work is always hard work. No down time or variety."

This makes the work more draining and adds to workplace stress. Another long-time worker commented:

> "I remember when I first started in the field as a support worker and we used to get a lot of students from universities and that, and you can tell

> the difference – the quality was there, their attention to the clients were there but under the NDIS it's just…nah. They're just basically hiring anyone because we need the workers."

As will be discussed below, this leads to more stressed and dangerous conditions for all workers: both new recruits and veterans. This seems to undermine the goals of human rights and self-determination which are meant to be core to the NDIS. The story below is typical of the sector at this point, and highlights how inexperienced workers are put in positions where they do not have the skills to handle complex situations and hence, unintentionally, increase the likelihood of workplace stress and conflict:

> "I heard a new staff talking to one of our guys, right up in his face. I hear, 'Go away, get away, fuck off,' from the client, over and over. And, I'm thinking, there's red flags all over the place, back away, give him some space. But, he didn't so he [the client] kicked holes in his bedroom door. In a way, that was okay cos it's not self-harm or hurting us. But it's still not good because he's under stress and really unhappy, and we are wondering what's next."

Lacking appropriate training and supervision, new staff have few opportunities to improve their skills. This can lead to a culture of bravado, rather than a culture of support. One long-time worker related the following example:

> "I heard one young staff boast about her injuries, like a badge of honour. Her exact words were, 'He didn't break my nose like so and so, he only gave me two black eyes.' This is what gets discussed, instead of 'Shit, what went wrong? Did I do something wrong? What did I misunderstand? What can we do better next time? What can we learn? How can we keep everyone safer?'"

As another long-time worker noted, "These situations could be avoided with a bit of training and supervision".

Lack of knowledge and experience among new, untrained staff can create safety issues for both workers and clients alike. As one interviewee reported:

> "We've had near misses. We've had wandering out on the road. In my own experience, I like parents, I like people that have had children not only because there's the parental aspect to your care, you're thinking of other things that young kids aren't. Eighteen and nineteen year olds, they're not thinking of which side of car to load particular participants in and out of; they're not thinking of where they're parking for a particular client in a busy strip or a quiet place. Just different things like that. I know they seem trivial but they lead to accidents, they lead to mistakes."

Many workers highlighted that the NDIS does not provide adequate funds within the unit price structure for regular training of staff. Hence, in most agencies, training opportunities for newly hired staff range from minimal to non-existent:

> "Very little. We get our first aid. It's up to us to go and find a Cert 3 or whatever like that."

In almost all cases, workers had to pay for their own work-specific training and all upgrading. This lack of support for training and upskilling was very frustrating for workers encountering new clients with complex behaviours, and wanting to further develop appropriate skills. This problem was seen as all the more acute in light of the sector's new, inexperienced labour force.

4. CHALLENGES OF WORKING IN THE PRIVATE REALM OF CLIENTS' HOMES

Working one-on-one with families in their own homes poses many serious challenges for workers (Flanagan, 2019). Many DSWs had worked primarily in community programs with groups. Now, many workers are assigned to work in clients' own homes. In a community centre context, basic rules of drop-off times, pick-up times, appropriate behaviour, etc. were regularly understood and followed by clients, family and staff.

In the new situation of in-home work, in contrast, some families have unrealistic expectations of what can be done in a day and what the clients are capable of. There is a lack of clarity regarding rules or guidelines they must be followed. The work occurs in an individualised setting, with no colleagues or supervisors who a DSW can call on for

support or direction. There is little workers can do in an immediate situation if people are acting inappropriately in their own homes.

As one research participant told us:

> "Families don't always acknowledge when a shift is finished and don't let the staff person leave. Or don't come home on time to take over… In some cases, clients are very afraid to be left alone or too unstable to be left alone and so we can't leave until a family member finally shows up."

5. TRANSPORTATION: SHIFTING THE COSTS

Problems with transportation arrangements for NDIS clients figure prominently in the experiences related by our interviewees. These problems can be broadly classified into two main areas. The first is that clients are not provided with sufficient funds to cover transportation needs associated with activities they may be used to doing, or that they would like to start. Prior to the NDIS, transportation costs were often covered by community agencies, typically pooled across a number of clients – making travel and activities both safer and more cost effective. Under the NDIS, in contrast, each client has their own budget for travel; for many clients, especially those in regional areas, that budget runs out quickly. Moreover, by requiring clients to "trade off" service choices in order to stay within a fixed budget, the NDIS system encourages clients to downgrade the importance of good transportation services – or, perhaps even worse, to dip into funds allocated for clinical or core supports in order to subsidise transport costs. This pattern is very concerning to both clients and DSWs, since choice of activity is meant to be a cornerstone of the NDIS. True choice requires a fiscal regime which recognises the importance of transportation for people with disabilities – allowing them to get out of their homes, engage in community activities, and access specialised services. At present the system is clearly not providing adequate resources to meet that need.

Many of our interviewees reported that their clients often forego activities because of inadequate transportation funding – and this in turn results in more intense demands imposed on staff to meet clients' needs with less access to outside activities or resources. In one agency, most clients were allotted funding for 100 kilometres of transportation per week. As one worker put it:

> "If we stuck rigidly to the hundred kilometres a week, they wouldn't go anywhere hardly. From where we live in …, you can't go anywhere for under 30 or 40 kilometres a trip return. That's just the most basic community access. It gets gobbled up very quickly."

These clients are not living in remote areas where distances would be even longer. However, under the NDIS, even they have had to curtail their outings. As one worker noted regretfully, "It's very tight already and they simply can't go out every day."

Kilometre limits are often exceeded for appointments that staff are required to take clients to, and there is no compensation for those extra unfunded distances when workers are expected to use their own cars. According to one worker:

> "Some family members also expect to be taken where they want to go, like we are the care providers for the whole family."

The perverse trade-off between transportation costs and other budget items in each client's personal plan can lead to clients sacrificing core services and supports just in order to finance desired or necessary transportation:

> "A lot of participants have been taking their travel money out of their core support so that then means that families aren't really getting the correct respite hours or the participant's not getting the correct one-on-one supports."

The second major problem with transportation arrangements under the new system is that a large proportion of DSWs are now being required to use their private vehicles to visit clients' homes (or other locations of work), and in many cases even to transport their clients. In many of these instances no compensation is provided for this transportation functions: neither for the cash outlays associated with providing this private transportation (including petrol, maintenance, insurance and registration, and vehicle amortisation), nor for the workers' time spent traveling to meet their clients. Several interviewees reporting that their vehicles sustained serious soiling or damage in work-related use; some also reported no longer feel safe using their own vehicles to transport clients:

> "I've had a situation…, one of the guys shoved a CD in my CD player and it was scratched and he did it a few times and ended up jamming the mechanism and it cost me about 400 bucks and they wouldn't reimburse me cos I couldn't specifically prove that that had happened. That's the thing you're faced with there."

> "I had my car soiled a few times, some guy wanked on it, some guy tried to wank in it... So that's the reality there that with the contract."

We received numerous and consistent reports about employers pressuring DSWs to use their own vehicles for work-related transportation functions. In many cases it was reported this requirement is now built into initial employment contracts. There is widespread confusion about workers' responsibility for providing a vehicle, and for their responsibilities regarding ancillary requirements such as insurance:

> "We got dragged into a special meeting. It wasn't a reprimand, it was a compliance meeting to remind us that contractually, we're obligated, we signed that the use of our vehicles was, in fact, mandatory; that we couldn't cherry pick our clients; there was another issue, none of which related to me at all but I can see how they're gonna use that in the future. Originally, I said, 'I don't comprehensively insure my car because it's just a piece of garbage. It's a little $600.00 run around and it wasn't worth the comprehensive insurance,' so I've never included my vehicle in the fleet but then they said, 'No, you don't have to be comprehensively insured, we cover that.' I thought, that's the first I've ever heard of it and it's written in our contract that it says that our vehicles need to be comprehensively insured."

> "Work now are looking to cut back anywhere they can to squeeze a profit or a dollar to actually run. As far as we're now limited to use of vehicles; there's no choice now. If we don't like it, we leave. If you don't wanna use your own car, get another job."

> "If you don't use our own vehicle, you won't be working. They're not playing ball, they're not being nice about it, they're not even hiding it anymore. They've said, 'This is in your job description.' It's not in the

> job description. It says, you may have to use your own vehicle. Now they're saying, 'No, you have to.'"

> "Now we're expected to provide our own phones, our own cars, our own resources, our own supervision and pretty much pay if there's things that participants that we're working with would like to go to, we're expected to pay, too, ourselves."

Some workers reported that their employers reimbursed their vehicle expenses at various rates per kilometre; some reported that NDIS clients were actually charged a higher rate for those worker-provided travel services than the workers were reimbursed (with the margin retained by the agency, perhaps to cover administrative costs related to the transportation services, or to help defray general overhead costs). But some workers indicated that they were not reimbursed at all for the use of their own vehicles for work-related transportation:

> "Previously I had a company car, got paid an hour each way for transit, being Saturday that was time and a half so there was three hours' pay. When NDIS came in there was no longer the ability to use a company vehicle hence there was no payment for travel so I was doing 126ks in my vehicle for no compensation plus losing that three hours pay."

Reimbursement for the workers' time spent driving clients, or driving between different clients, was also reported to be inconsistent.

Some workers indicated that their employers told them to claim parking and client transportation costs as an employment expense on their tax returns, rather than being reimbursed directly by the company. Of course, claiming transportation costs as a deduction (even where it is legally allowed and adequately documented) does not fully recompense DSWs for those out-of-pocket costs.[9] As one research participant expressed:

> "Transportation used to be covered by the agency and it still should be. It is both the workers and the service users who are hurt by this new transportation policy, which is just not right."

[9] Deducting transportation costs through the income tax return will result in partial reimbursement at the rate at which the worker pays marginal tax; since DSWs are generally low-paid and part-time, that rate is low (and in some cases even zero).

The expectation that workers spend their own time transporting themselves and clients in the course of work that may inevitably involve multiple trips to multiple locations in a single day,[10] and moreover that they provide their own means for this transportation, without compensation, is an extraordinary and unusual imposition on these workers. This practice would not be tolerated in most other sectors of the economy; it occurs in the case of disability services only because of the relatively powerless position of both the clients and the workers, and the fragmented, inadequately-funded nature of the program.

The requirement that DSWs transport their clients in their personal vehicles also raises significant safety concerns, related to the quality of the vehicle, inconsistent installation of necessary safety equipment (such as fire extinguishers and first aid kits), and the difficulty of driving a vehicle while simultaneously supervising a client with intellectual or cognitive disabilities. As one worker put it:

> "Our car's not suitable for the guys… They did quite an amount of damage to our cars; when we're driving in our cars there's no partition so we're put at danger while we're driving… You're supposed to be driving, you should not have to be watching the people in the back. You should have a hundred per cent attention on the road and to be put in a position to drive with trying to see if people are taking their seat belts off. It's not safe."

6. INCREASED RISK OF VIOLENCE AGAINST WORKERS

Research participants regularly reported an increased incidence of violence against workers and property after the roll-out of the NDIS. This occurred alongside and despite a generally lowered likelihood of accurate reporting of violent incidents – because of the casualisation and fragmentation of disability services work. Insecure workers are generally anxious to attain more shifts and feared reprisals if they reported incidents; moreover they have less access to reporting procedures given the general lack of supervision and support, and their common assignment to work by themselves in locations away from any central office or agency.

[10] Of course, it is common to expect workers to travel to and from a single place of work at their own expense. But when a job involves traveling to several or various workplaces to perform different units of work, clearly there is a responsibility for the employer to both arrange and compensate for that additional transportation burden.

As one long-time worker noted:

> "Some workers are scared to complain about challenging behaviours from the clients, to the client or the family or the agency. The workers don't want to upset anyone, or they might not get more shifts."

The revolving door of casual staff makes for a more stressed work environment, as DSWs cannot possibly adequately come to know their clients, their preferences or their triggers. Some workers tried to diminish workplace assaults, despite acknowledging an overall increase in their frequency. As one worker put it:

> "Nothing major, just black eyes, broken noses, the normal sort of things with people just being out their routine, not knowing the support workers and the support workers not knowing clients."

That such serious violence could somehow be normalised for workers, who are implicitly expected to "put up" with violence as a sign of their commitment to their clients, is a shocking indictment of the lack of resources, supervision and support which is provided to DSWs under the NDIS's marketised model.

The chronic lack of training and supervision for workers clearly contributes to the increased frequency of dangerous situations. As another research participant told us:

> "Team leader/managers tend to brush off comments by workers about clients, saying they are just 'having a bad day' or that 'it's just a personality clash'. They don't care if the support workers are injured or disheartened. They can always get someone else to take their place; more often than not, they are not trained or have very limited training, and don't stay in the job long anyway."

The frequency of violence from clients, the general absence of reliable reporting systems, and the inadequacy of training, support and back-up for DSWs are all exacerbated by the fragmented model of service delivery inherent to the NDIS's marketised model. In a system in which workers and agencies must "hustle" for business, work is performed in fragmented and geographically dispersed locations, and agencies and employers have sparse resources (given the unit price model) to provide essential overhead functions (like training in how to handle violence), violence

becomes a normalised but unnecessary feature of the work. This represents a very serious failure of the current system.

7. DETERIORATING MANAGEMENT RELATIONSHIPS WITH WORKERS

Early disability services provision arose from the needs of clients and communities, and was most often provided according to a non-profit ethos of care and equity. In contrast, our research participants were disturbed by new trends that emphasized profit over support, and consequently generated wider divisions between staff and management. Some supervisors continued to provide strong and consistent support for their frontline workers. However, the profit motive and pressure for cost-cutting unleashed under the NDIS has created a deterioration in relationships that feels unethical and demoralising for many of the workers.

This comment from one support coordinator reflects widely-shared feelings expressed by our research participants:

> "You think you're going to something with the full belief that you can help change things for people… We can make things a bit more tolerable for their condition, but we're told we can't do that. Even a courtesy phone call, we can't do it unless we can get paid for it."

Employers made it explicitly clear to front-line workers that the culture of the workplace had to change: workers had to ensure that every interaction with clients was charged and chargeable, otherwise it had to be eliminated. This close focus on cost and profit did not sit well with the professional and personal ethics of long-time workers, who had spent their work lives trying to make a positive difference in the lives of people with disabilities. It seemed especially incongruous in the case of long-standing non-profit agencies – which had traditionally operated on a public and community service mandate, but now were being forced (by the unit price model) to act like other "businesses."

A particularly poignant example was provided by a support coordinator, whose manager told her to "drop clients and stop helping them" once their support coordination budget had been used up – even when the clients' needs remained unmet. In a similar vein, another worker told us:

> "My boss said, 'You need to look at things a lot different. It's about money. There's morals and ethics and then there's the organisational standards and you need to bring them down to the same level,' and I said, 'How can I change my morality that I've had for 28 years previous to starting this role to suit an organisation? I can't do that, and I don't think it's ethical…"

Despite this ethical conflict, because of their casual status and resulting economic insecurity, many workers were afraid to speak up to managers or express concerns; they feared that their shifts would be cut instantly. These concerns dovetailed with a sense that workers were not appreciated by many management groups; workers reported a growing mentality among their managers that "everyone is replaceable. One long time worker summed it up bluntly: "Attitudes from management are basically, you're not an asset anymore."

New and long-time staff also commented on the adversarial climate that more frequently seems to pervade their organisations. As one long term worker noted:

> "There's now a very big us-and-them in our organisation. Very big. They deny it but there is a very big us and them [sustained] by certain members of management. There's no objectiveness."

Favouritism was a widespread concern, with some workers feeling that shifts and clients with complex needs for support were not evenly or fairly distributed. Along with infrequent or non-existent supervision, this vulnerability increased workers' sense of demoralization and stress.

Inadequate conflict resolution was also identified as a problem in a number of organisations. One worker found himself unable to resolve issues with a manager and asked four times for mediation, which was supposed to be available to all staff. However, none was provided. This had negative impacts on his stress levels and health. As the worker put it:

> "I asked three more times for conflict resolution over the space of three months, finally it got to a point where I was so anxious before getting to work I felt like I was vomiting, I started medication."

8. HIGH TURNOVER IN AN INSECURE SECTOR

Despite widespread demoralization and instability, many workers continue to seek satisfaction in working with people with intellectual and other cognitive disabilities, and trying to make the new NDIS system work. Two workers told us that they felt it was likely that they would soon be dismissed, because they refused to abandon the principles of equity and support that they felt defined their work. However, other workers told us their jobs still held positive meaning because, "You can put things in place for people that can give them hope".

Despite the insecurity of working hours and incomes, the challenges posed by inadequate funding for transportation, and the pervasive risk of violence, most workers still were motivated by (as one worker put it) "watching … the participants reach their goals." Another worker expressed a similar positive commitment to their work:

> "I like getting them out and about to places. I love hearing 'he's never done that before.' Love that. I love hearing 'how did you do that?' I get chuffed every time."

A long-time frontline worker summed up the feelings of most research participants thusly:

> "I love working with the people. I love making their lives, it sounds really cliché, making their lives as high quality as we can".

This commitment to client care, despite the difficulties faced by DSWs, is extraordinary. However, it was also notable how many of our interviewees were considering leaving the sector entirely. Some planned early retirement, others were seeking a career change (such as moving into management or administration), while others had no definite plans other than to seek a different job they could like and sustainably perform. As one long time frontline worker told us:

> "To be honest, there's not a whole lot I like about my job at the moment. I'll give it 12 months and then if it's not any better, I'm gone."

Part of this common intention to leave the profession was based on working conditions. For most workers, however, it also reflected the loss of a feeling of being appreciated and finding meaning in their jobs. In the words of another long-time worker:

> "In my old job, yeah, there was a bit of recognition, a bit of esteem for what you did. Now, not so much. I'm not feeling the love."

These personal reflections from our interviewees thus underline the empirical data indicating high job turnover rates in this sector.[11] Needless to say, given the already-inadequate training systems for newly-recruited DSWs, the reluctant departure from the sector of many long-time, more experienced will only exacerbate the problems of skill and capacity faced under the NDIS. Most frustrating is the fact that most of these workers support the goals of the NDIS and would prefer to stay in their current occupation, if those immediate problems (such as inadequate training and supervision, unfair transportation arrangements, risks of violence, and others) could be resolved.

[11] Data compiled by NDS (2018) indicate that roughly one-quarter of disability service workers leave their jobs in any given year. That is approximately three times as many as the average job turnover rate in the labour force as a whole (ABS Catalogue 6226.0).

Conclusions and Policy Responses

Interviews with front-line workers and case managers working in NDIS-funded disability services delivery strongly indicate a system that is experiencing rapid change and instability. Until the advent of the NDIS, services for people with intellectual disabilities were most commonly provided through direct public departments, or by agencies supported with block-funding government grants (supplemented by incremental funding from charitable donations and other sources). While jobs in the sector have never been lucrative, the previous approach did provide a significant number of relatively secure, permanent employment opportunities to workers. That allowed them to develop their skills, progress along defined career paths, and build more stable relationships with service users over time.

In contrast, the new delivery model under the NDIS has been characterised by the rapid casualisation of work, alongside the fragmentation and individualisation of supports to many NDIS clients. Especially vulnerable in this regard have been people with intellectual and other disabilities. Typically, they would have previously received most support from a single organisation, and/or attended specialist day services. Now they are expected to arrange for complex programs of services and support on an individual basis: working within a personal budget, trading off various services and supports to meet the financial constraint, and holding ultimate responsibility themselves for the coherence and success of their treatment and support program. Many clients are experiencing great uncertainty and instability in their disability support services as a result. This places both clients and DSWs in a highly vulnerable position. Both are grappling to find their way within a fragmented, market-based system that in many ways fails to meet its core motivating goals: to reduce the vulnerability of people with disabilities, to respect and enhance their self-determination, and to move them from the margins into the mainstream of society. Highly dedicated DSWs are trying to fill the gaps that clearly exist in the new system, yet the whole system is predicated on the narrow assumption that clients must be charged for every interaction and service. This commercialization of support and interpersonal relationships undermines the social fabric of inclusion and full participation. Meanwhile, failures in the unit price model are threatening the sector's capacity to invest in crucial overhead and infrastructure functions: not least including staff training, supervision, and even safety.

Workers are compelled by employers and the system to "price out" every interaction they experience with clients, while clients are left without the consistent and capable support they require due to a highly unstable, underdeveloped and insecure labour force. Especially acute in this regard is the lack of training for new staff in complex needs and behaviours associated with many clients with intellectual and cognitive disabilities. In addition, with transportation costs charged to each client and often delivered informally (including in workers' own vehicles), rather than pooled over community programs and provided by specialists, many clients quickly deplete their travel funds. As a result, clients are forced to cut out needed activities and services, due to inadequate access to transportation – and DSWs are compelled to subsidise transportation costs through the often uncompensated use of their own vehicles, on their own time.

It is hard to imagine how the laudable goals of voice and empowerment can occur within this increasingly cost-focused, under-resourced, commercialised space. Overall, workers reported a very strong sense that the NDIS as it stands was not well-designed for people with intellectual disabilities. The ongoing churn and turnover among the disability service workforce, and the instability and even financial crisis experienced by many agencies,[12] will surely further delay the development of the much larger labour force that will be required to fulfil the NDIS's vision.[13]

A great deal of ongoing dialogue, research and policy development will be required in coming years to address the realised shortcomings of the current NDIS plan design, and implement reforms that will allow the scheme's laudable objectives to be met more completely. We limit our policy recommendations in this report to specific measures that would help to address the severe problems in job instability, inadequate training, and unfair and often dangerous work arrangements that were highlighted by our interviews with front-line workers under the NDIS. In addition to undermining both the quality of work for DSWs and the quality of support for NDIS clients, these problems are also clearly making it even harder to recruit a motivated, high-quality workforce to this rapidly-growing industry.

[12] Many agencies have reduced staff and taken other dramatic measures to respond to the financial instability they have experienced under the NDIS; see, for example, Campbell (2018) and Lenaghan (2016).

[13] The Productivity Commission (2017) has already warned that the growth of a qualified workforce is far behind schedule, and new workers lack the skills and experience necessary to provide high-quality services to the .

To this end, we propose the following broad recommendations:

1. MORE STABILITY IN WORK AND SCHEDULES

With the dramatic shift toward individualised support plans, funded through a fragmented market-based regime, disability support workers have experienced a gut-wrenching destabilisation in their work lives. Hours of work and incomes have become highly precarious. Wages, which were never lucrative for most of the workforce, have been suppressed under the constraints of inadequate unit prices and the financial crises experienced by many agencies as the transition to the NDIS continues. They have been left to their own devices in most cases to deal with the challenges and risks of supporting clients with complex needs. Basic support services from their employers, including basic supervision, case management, information sharing, and scheduling, are inadequate and inconsistent. And value-added opportunities for training and career advancement are rare.

The workers we interviewed are both passionately committed to the well-being of their clients, and still hopeful about the potential of the NDIS to meet their clients' needs in a more respectful, flexible and democratic manner. But despite this continued dedication, the turmoil and insecurity of providing these essential services under the NDIS's fragmented, market-driven delivery model are taking a severe toll, and leading many seasoned workers to exit the industry (or seriously consider exiting it) altogether. If there is to be any hope of attracting the requisite workforce, possessing adequate motivation and skills, to support 475,000 potential registered clients once the NDIS is fully rolled-out, there is an urgent need to improve the quality and stability of work in this sector.

Specific and incremental reforms which could contribute to higher-quality, more stable jobs in disability support services would include:

- Improving basic standards for minimum engagement periods, continuity of engagement, reasonable notices of roster and scheduling changes, and stability in weekly hours of work. Individuals cannot be expected to build sustainable careers in jobs which do not offer reasonable regularity in scheduling and income. In response to the fragmentation and uncertainty of client demand for NDIS-funded services, employers in the sector are increasingly meeting staffing needs through piecemeal unit-based assignments. This results in very short shifts, discontinuous or "split" shifts, and continuing uncertainty in work patterns that imposes

tremendous stress on both work and home life for DSWs. Workers cannot be expected to fully absorb the instability of client demand resulting from the individualised, market-based model of NDIS delivery through instability and fragmentation in their own work and income.

- Changes in the funding model to allow agencies and employers to provide adequate infrastructure and support services for their workers. Sufficient allowances for these functions, which are essential to support DSWs in their jobs, must be built into the overall NDIS funding structure; that will most likely require the implementation of new revenue streams beyond the revenues currently generated through the unit price system (which do not provide an adequate or stable source of funds for those broader overhead tasks).
- Providing workers with secure opportunities to express their opinions, priorities, and grievances, and to advocate (including through collective bargaining) for improvements in wages, working conditions, management systems, and policies. Avenues in this regard could include the establishment of multi-employer, region-wide or even sector-wide collective bargaining processes. The regularisation of employee voice and representation will also help sectors in the agency build more consistent and professional management structures, which have clearly deteriorated under the organisational and financial turmoil experienced since the NDIS was implemented.

2. ACCESS TO TRAINING FOR BOTH NEW RECRUITS AND LONGER-TERM EMPLOYEES

The disability services workforce must grow very quickly to meet the needs associated with the full roll-out of the system across Australia. The coming large increase in the sector's workforce implies enormous up-front training investments. Incoming workers immediately need basic induction and orientation training to work with people with disabilities, and learn fundamental prerequisites (such as the NDIS code of conduct, basic health and safety procedures, and more). Then they need an opportunity to acquire foundational skills through formal training programs (preferably provided through public and recognised non-profit providers, with a particular reliance on TAFEs). In our judgment, this basic training should be a regulatory requirement for newly recruited workers under the NDIS, enforced through some system of mandatory registration and certification (perhaps overseen through the NDIS's Quality and Safeguards Commission).

Beyond these initial training requirements, those who choose to make disability services their long-term career should also have access to ongoing training and professional upgrading. Those opportunities for advanced training should be matched with clear paths for acquiring formal qualifications over time, and entering more advanced job classifications (with corresponding increases in pay) to reflect those accumulating skills. Providing the opportunity for lifelong training and upgrading, within the context of a more regulated professional structure for the industry, would help to provide disability support workers with similar opportunities and responsibilities as are currently associated with other allied health professions.

Initial experience with the roll-out of the NDIS unit price system has confirmed that agencies have been starved of resources to provide even the most basic infrastructure and overhead services for their workers. This means it will be impossible to organise and fund consistent, high-quality training opportunities through the unit price model. Instead, agencies and registered providers need to be provided with block funding to support those functions and meet minimum professional standards. Individual workers could also accumulate personal credits for training, as they provide more hours of NDIS-funded service[14] -- and this could provide an additional source of revenues to support ongoing training.

3. FAIR TREATMENT OF TRANSPORTATION TIME AND COSTS

The widespread expectation that disability support workers are responsible for transportation time and costs (even when traveling between multiple clients), and in many cases responsible for transporting clients, imposes a very unfair and unsustainable burden on workers whose wages and conditions are already low. Moreover, the informal and often non-compensated private provision of transportation services by DSWs raises important issues of safety for workers, clients and the public.

Clear and consistent policies regarding the provision of transportation services by DSWs should be described and enforced through sector-wide regulatory bodies –

[14] Ryan and Stanford (2018) propose a system of portable training credits which would be assigned to individual workers even when they work for various employers in the sector, or even directly for NDIS clients; in this way, ongoing training could be guaranteed despite the highly mobile, individualised nature of the delivery system.

including through the NDIA itself, and through the Fair Work Commission's oversight of standards spelled out in relevant Modern Awards. Specifically,

- Where DSWs are required to provide their own vehicles for transporting themselves between clients, and/or transporting clients to activities or appointments, this requirement must be explicitly communicated at time of employment. The employer must be responsible for providing ancillary equipment, safety improvements, and insurance.
- Expenses related to the operation of a private vehicle for transportation from the normal workplace to and from meeting clients, and/or expenses related to the transportation of clients, must be directly compensated by employers on a generous basis (meeting or exceeding the benchmark specified in the SCHADS award). Time spent by DSWs in such transportation must also be fully compensated according to regular wage scales.
- The application of these practices will also be shaped by the implementation of stronger standards regarding minimum engagement periods (discussed above). In particular, the assignment of multiple visits to workers in a single day or shift, and/or the requirement that workers make more than one trip to work in a day (resulting from discontinuous or split shifts) must include fair allowance for excess transportation time (Macdonald *et al*. 2018).
- Damage incurred to vehicles in the course of work-related travel (to and from meeting clients, and/or transporting clients) must be fully compensated by employers.
- DSWs required to provide transportation services should be trained in the safe operation of vehicles while supervising clients, and procedures governing unsafe situations (such as driving while a client requires assistance or attention) must be communicated and respected.

4. BETTER SUPPORT FOR SERVICES WORK IN PRIVATE HOMES, AND BETTER TRAINING AND SUPPORT FOR DEALING WITH VIOLENCE

Another area of flagrant risk and unfairness reported by several of our interviewees is the challenges and safety risk of working with clients in the private realm of clients' homes. In addition, our interviewees expressed a distinct rise in the incidence of violence in their jobs under the NDIS system. It is clear to us that more training is required for DSWs to be more aware of safety and other risks in those situations, and to be better-supported by their employers and managers in confronting those risks.

Specific measures which could help to address these problems include:

- More training for all DSWs required to work in clients' homes in evaluating the safety of those environments, and recognising and responding to dangerous situations.
- More systematic and efficient systems for sharing information between clients, their families, managers, and case workers about clients' needs and challenges. Time spent by DSWs in accessing and managing that information must be compensated (rather than requiring workers to obtain and process case files, often from offices which they don't normally visit in the course of their work, on their own time).
- More effective and well-understood safety and back-up protocols to supports DSWs who encounter violent, dangerous or overwhelming situations with their clients, including generous entitlements to paid leave and support services.

* * * * *

Reforms such as those recommended above are ambitious, and will require a deep rethink of some of the fundamental assumptions and structures of the NDIS as it is currently being implemented. Specifically, the limits of the unit price model underlying the scheme at present must be recognised and addressed. It is unrealistic to expect that agencies can provide the critical infrastructure and overhead services essential to the development and maintenance of a high-quality workforce, on the basis of tiny "margins" (for management, overhead, training, etc.) built into NDIS unit prices which are already inadequate to cover many of the basic costs of service provision. Moreover, instability in the volume of NDIS work being charged (due to fluctuations in demand from clients, clients losing access to funds, etc.) inhibit the extent to which unit price revenues could ever fund quality workforce development infrastructure.

In this regard, running a national disability services system cannot be treated like any other "business": whereby entrepreneurs harvest surplus from ongoing unit revenues to cover their management, overhead and profits. Our recommendations suggest a very different approach must be taken to paying for the fundamental building blocks of a higher-quality disability support services system. And that must start with the front line workers whose passion, skills, and reliability are utterly indispensable to realising the lofty founding goals of the NDIS.

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Zero-Sum Social Policy, Going Gig and the Australian National Disability Insurance Program

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Zero-Sum Social Policy, Going Gig and the Australian National Disability Insurance Program

Australia's newly introduced National Disability Insurance Scheme establishes a cash-for-care model that pits the human rights of people with disabilities against the employment rights of care workers, generating a zero-sum game that sees the emergence of gig labour markets, a downward spiral in wages and conditions, and concerns about quality of care. This article introduces the concept of pro-market/gig market to analyse this state-led initiative to restructure a largely publicly funded, non-profit workforce into a privatised, casualised, and fragmented one.

Keywords: care work; cash-for-care; precarity; pro-market/gig-market; privatization; nonprofit

The disability rights movement views disability as socially constructed and has long sought full social inclusion through increased respect, autonomy and control for those with disabilities (Howard et al., 2015; Thill, 2015; Williams, 2014). Introduced across the country in 2018, the National Disability Insurance Scheme (NDIS) establishes a cash-for-care model which some see as a radical step towards social inclusion, though evidence from the early roll-out of the NDIS (starting in July, 2016) shows that many service users have serious concerns with the scheme and feel that their views and those of their families and carers are often overlooked (Warr et al., 2017, p. 8; Howard et al., 2015).

Prior to the NDIS, most workers in the Australian disability sector were employed in organisations and were protected by a sector-wide industrial Award (government-business union agreement covering the sector), a significant level of unionisation, and employers who paid, at least ideological, tribute to a nonprofit ethos of social care and fairness. The NDIS personalised funding model requires people with disabilities to use their individualized funding package to either work with a case manager to assemble services to meet their individual needs or to hire their own staff and act as their own director of services. Either process recasts care workers as highly casualised and precarious, often with multiple employers.

Though Australia's relatively strong industrial relations regime should protect workers, enforcement pathways are increasingly convoluted as service users may be both client and employer, making it difficult to raise concerns about hours, wages or conditions. This is particularly the case since most workers identify strongly with the human rights and equity aspects of the NDIS mission and hesitate to critique initiatives that might improve service users' lives. For the most part, small scale employers and isolated workers have little or no experience with, knowledge of, or capacity to enforce employment standards, health and safety legislation and other regulations protecting employees.

Drawing on data collected from workers in an early pilot region that started in July 2016, this article grapples with the question of whether the workforce has been harmed in this new policy context. This question is under-girded by a further question, namely whether harming workers is an acceptable way to advance social justice objectives. The article explores the zero-sum game precipitated by social policy aimed at expanding human rights in the context of highly marketized care, individualisation of service users, underfunding and the erosion of protections for care workers.

The article also contributes to our understanding of the drivers behind the new labour market. As part of this theory, the article introduces the concept of pro-market/gig market to analyse the dynamics of this state-led initiative to restructure a largely publicly funded, non-profit sector with a relatively stable, usually permanent, developed labour market into one in which the work is highly casualised and increasingly features short-term, on-demand shifts (van Doorn, 2017; Friedman, 2014; Author A, 2019). The article also contributes to labour process theory (Braverman, 1994; Thompson, 2010) where shifts in control are taking place at multiple levels and involve multiple players. Although Australia's policy context is unique, it joins other European and North American countries that have pursued individualised

funding. This article aims to contribute insights and preliminary theorizing that may be useful in other contexts and countries.

The article begins with a short discussion of the NDIS, human rights, the disability sector, the regulatory context, and changes in the sector under the new NDIS policy. The article then outlines theory and methods and is followed by findings. The article ends with discussion and conclusions.

Background and Contexts

i) Disability Sector and the Workforce

Deinstitutionalisation in the 1970s was the first step on the path to greater realization of human rights for people with disabilities[1] (Howard et al. 2015; MacKinnon and Coleborne, 2003). Post-institutionalisation, but prior to the NDIS, most disability services were provided by non-profit organisations (particularly faith-based and parent-led organisations) and received 60–80% of their income from government in the form of block funding (PwC, 2012: 15). Disability organisations provided services including recreation, everyday activities and employment, accommodation and community living, respite and family support; advocacy, referral, and public education. Prior to the NDIS the disability workforce consisted of roughly 68,700 employees in 2000 organisations with 73% employed in the nonprofit sector, 21% in the public sector, and 6% in the private for-profit sector (Martin and Healy, 2010: 126–127). Most worked in direct care and support, over 80% were women and over 80% of the workforce had further education, most commonly a certificate or college-level credential (Martin and Healy, 2010: 126–127).

The NDIS

The NDIS is argued to be Australia's largest social reform since the introduction of universal national healthcare (Gilchrist, 2016; Productivity Commission, 2017). Like personalised funding in the UK, the NDIS introduces a national system of funding through a cash-for-care model for 'people with permanent and significant disability, their families and carers' (NDIS, 2013). This system replaces the organisation-based system of funding described above. Funding for assistance with daily living and assistance with civic and social participation accounting for 76.5% of funding in 2018 (National Disability Insurance Agency, 2018, p. 6), meaning that most NDIS funding pays for wages for the frontline care work of disability workers.

Two forms of under-funding have long plagued disability funding: 1) underfunding services in relation to the needs of people; and 2) underfunding of contracted services (Productivity Commission, 2010: 135, 281). These problems have continued under the NDIS, with government acknowledging widespread problems in terms of worker shortages due to low wages and poor conditions (Productivity Commission, 2017). In their exhaustive report on pricing and quality, Cortis et al. (2017) argue that cost containment underlies the NDIS where prices, and thus funding for people with disabilities, has been set too low, providing an incentive to pay lower wages (see also, Williams, 2014). Cortis et al. (2017) assert that, "Prices do not account for what is required to deliver high quality services, and arrangements are not fully enabling disability support workers to deliver services which are personalised, co-ordinated, responsive or safe (p. 1)." The ripple effect of low pricing is extensive: it is hard to attract or retain workers; there is no incentive for workers to upskill; and no monies for supervision, training or support.

The minimum pay and conditions for disability workers are set out in the Social, Community, Home Care and Disability Services Award. However, as Cortis et al. (2017) argue, pricing has been set too low to meet Award minimums, let alone to cover the costs of those employers committed to paying above the Award. In addition, the Award differentiates between disability and other care workers, with home care having a minimum engagement period of one hour compared to two hours for a disability support worker. This and consumer demand have resulted in employers calling for shift minimums to be one hour or less and means that they prefer to hire into the category of home care worker rather than the longer minimum shift disability services worker (Author B, 2016). In addition, the Equal Pay decision in 2012 that recognised the gendered undervaluation of care work did not apply to 'home care' workers though they may do the same or similar work as workers who are covered by the equal pay increases (Charlesworth, 2012). In the context of the new NDIS, few protections exist for workers and strong incentives exist for employers and service users to reduce costs as far as possible, generating greater precarity for workers and uncertain quality and choice for people with disabilities (Author B, 2018).

The amount of funding each disabled person receives is determined by a professional assessment. After receiving their assessment and funding package, people with disabilities can opt to: i) employ and supervise their own employees in which case the employees do not need to be registered with the National Disability Insurance Agency (NDIA); ii) work with a third party provider registered with the NDIA in which case only the plan manager needs to be registered; or iii) have their plan managed by the NDIA in which case all service providers have to be registered (NDIS, 2013). The first two options provide a clear incentive to pay low wages as Award and other regulatory protections do not apply and cash-strapped service users need to stretch their funding as far as possible. While it may be logical to seek the best

value for money, it systematically undermines employment rights and gains in this highly gendered sector.

A further way that workers' rights and gains are undermined involves new fragmented and unregulated worksites. Rather than being organisation- and group-based, much of the work under the NDIS is located in people's private homes. Service users are now required to cover their own travel costs to and from programs, whereas in the past, the disability organisation often covered these costs. This means service users carefully assess travel and likely deny themselves activities in order to contain costs.

Feminist scholars have long identified that care work in the private home is largely invisible, keeping wages low or non-existent and making it difficult to improve or regulate (Folbre 2009; Meagher, 2003). Experience in the UK confirms this trend in poorly regulated cash-for-care systems, as well as increasingly blurred lines between paid care work and the unpaid domestic work traditionally expected of women, contributing to further informalisation of care work and the gendered undervaluation of this work (Hussein and Manthorpe, 2014). Evidence from European countries shows that cash-for-care policies also introduced new demands for flexibility, travel between multiple work locations, very short working hours, and may be a cover for deepening austerity policies (Cunningham and Nickson, 2010; Glendinning, 2012; Christensen, 2012). Under the NDIS, an increasing number of workers are multiple job holders and/or work in multiple worksites, hence unpaid travel time seriously undercuts wages and adds to the growing precarity of the workforce (Author B, 2018).

Short notice shifts, multiple job holding, dispersed work sites and short-term work assignments (less than an hour) signal an important shift from a largely publicly funded, nonprofit delivered, organisation-based employer to a privatized, quasi-gig or on-demand economy (van Doorn, 2017; Friedman, 2014). Gig economies are characterized by temporary

employment where workers are remade as independent contractors rather than employees, and organisations exist primarily to interface between service users and short- term providers. Gig work has thus far been mostly found in the arts, entertainment, delivery and private domestic work. However, it is increasingly seen in care work and acts as a mechanism for reproducing gender and racial inequities (Aliosi, 2015; van Doorn, 2017).

The IT apps and digital platforms associated with gig work have extended into NDIS work. Author B (2015) has documented the emergence of uber-like, digital platforms through which service users can recruit disability workers. Though these parts of the disability labour market are currently under-developed in Australia, this article argues that with its exclusive focus on market solutions, the NDIS prepares the ground for a gig labour market/on-demand service market. In this case, ironically, a social policy aimed at empowerment has ushered in the undermining of employment regulation in a highly gendered arena, remaking the gain of one group (people with disabilities able to advocate effectively for themselves) into the loss for many workers and other people with disabilities who are less able to assert themselves in this new, competitive environment.

Market-driven Social Policy

While there is little or no debate as to whether a new service model was essential for people with disabilities, the cash-for-care model is just one of many models for improved service provision (Kvist and Fritzell, 2011; Williams, 2014; Cristiano et al., 2016; Martinelli, 2017). While disability rights movements sought new systems based on an individuals' lifetime goals and strengths, the NDIS model interprets the achievement of these goals exclusively through a market lens. As with individualised and marketised care systems, under the NDIS

individual care users are constructed as consumers empowered through the exercise of consumer choice to buy care (Brennan et al., 2012, p. 378; Productivity Commission, 2011).

Theory

Preliminary theorizing in this article will draw on labour process theory (LPT), a meso-level theory that assists in the analysis of the social relations of control and power in the workplace (Thompson, 2010; Thompson and Smith, 2009), including the power of workers and of management to negotiate the conditions and wages of work. Originating in the work of Braverman (1974), LPT analyses the avenues through which power and control are played out between management and workers. In the context of care work some of these shifts include: ongoing sector restructuring; New Public Management and austerity; precarious work; wages, conditions and work organisation; as well as the gendering of the sector and gender's connection to unpaid labour (Aronson and Smith, 2009; Carey, 2007; Cunningham et al., 2013; Glendinning, 2012). This article supplements an LPT argument that social service restructuring has been 'pro-market/non-market' (Author A, 2004), by arguing that under the NDIS, it has become pro-market/gig market.

Since the mid-1980s, governments have privatized, down-sized and contracted-out human services. These processes are pro-market in that they extend and legitimize private market ideology, logics and practices, even in realms (such as the public and non-profit sectors) where they would previously have been an anathema (Author A, 2004). The processes are simultaneously non-market in that government funded, contracted-out services continued to run on a not-for-profit basis, that is, no surplus is produced though ongoing cost cutting is demanded (Author A, 2004). Thus, these services remain nominally outside the profit model.

The NDIS policy is pro-market; it is underscored by the assertion that the private providers are the most adept and mobile in meeting the vast and diverse needs and wants of service users (Harris, 2014). The policy simultaneously delegitimizes the government as a provider of disability services with all state-provided disability services closing across Australia (Author B, 2018; Mavromaros et al., 2018). By exclusively funding service users, the NDIS also removes government as a direct funder of disability services. The NDIS policy makes the ground ready for the expansion of a gig economy in disability services, with the aggressive emergence of very short work periods (sometimes less than an hour, with some service users arguing that shifts should be as short as 20 minutes); multiple job holding; no paid travel time; multiple work assignments in a single day; very short notice (often a few hours or less) and a constantly changing rota of workers and work assignments. These reduced conditions of work and the reduced capacity of workers to resist and negotiate these conditions, represents a shift in workplace power from workers to management.

Methods

Qualitative, in-depth, semi-structured interviews, using an interview guide were undertaken with 39 disability sector workers in one of the early-roll-out regions (the roll-out started in July 2016). The interviews took place in a central location. They were audio-taped, transcribed and analysed for patterns and themes (Kirby et al., 2005). Research participants were recruited through an open call distributed by unions in the sector. Interviewees were asked questions regarding changes in their work under the NDIS, challenges, successes, and where they saw themselves in the future. The sample was 70% female which is slightly lower, and all had higher education and/or training. They ranged in length of employment from 1.5 to 30 years, with majority having 8+ years of experience.

Ethics approval was received at the universities involved. Limitations of the study include its small sample size, the possible bias in its union-linked recruitment strategy, and qualitative method, which precludes generalisation but permits insights which may be valuable across a number of contexts and conditions.

Findings

Drawing on exemplar quotes, this section will address the strongest themes in the data, namely: increased precarity and a gig economy-like working conditions; less training and skill in the labour force; and the challenges of working multiple short shifts in private homes.

Increased Precarity and the Gig Economy Working Conditions

In contrast with the workforce prior to the NDIS, all research participants reported that employment had become increasingly temporary with undependable hours, lowered earnings and conditions, and increased overall precarity. As per labour process theory, this precarity represents a shift in workplace power as workers lose dependable wages and schedules, and experience increased personal and income insecurity. As one long term disability worker observed, "Every single person working at my agency is casual …no permanent. In my old agency, almost everyone was permanent." Another worker added, "They don't want full time workers. What they say is we need to have flexibility because we don't know, clients could come and go now, it's their choice."

Organisations exclusively employing casual staff can more easily reduce costs in terms of sick leave and dismissing staff. Casualisation also makes it more possible for

employers to schedule work around shorter periods of service provision and more variability in the timing of services (early morning and late night) and location (private homes).

Characteristic of gig economies, short notice of shifts and short shifts were particularly disruptive. As one long time worker noted, "My stress and fatigue are both way up. I've been living on the phone for shifts, some of which I get less than two hours' notice for." Other workers noted that apps notifying workers of their constantly changing shifts and hours were a commonplace aspect of their employment, suggesting a further swing to an on-demand work, platform labour market. As one long-term worker noted, "all our rosters are electronic" and constantly changing meaning that workers never "know exactly what shifts you're gonna have that week because something will just randomly change".

The new, gig-like, short, solo shifts generated serious concerns about quality of care and the likelihood that workers will have any information on service users' needs, preferences and plans. However, as Cortis et al. (2017) note, there is little or no funding for supervision or administration under the NDIS. Instead, research participants subsidized the system by using their own unpaid time to review case files and connect with supervisors on specific service user issues. Reflecting the experience of most workers and representing a reduction in workplace control, one long term worker told us, 'The only way I get information on the clients is if I go into the head office on my own time and read the files. There is no paid time for it. The NDIS only pays for face-to-face time, no prep time. With short notice and new clients, I usually can't manage to get to the office before my shift." Other research participants added that files were often incomplete, missing or lost, making the unpaid trip to headquarters futile, more frustrating and further jeopardizing service quality and consistency.

The data show that costs were shifted to workers in several ways including travel costs between multiple and widely dispersed job sites (service users' homes). After her

employer refused her travel claim, one worker was told that she should consider each private home to be her worksite, regardless of how much distance or travel time was between them, "we don't pay kilometres. That's deemed your workplace". Representing an additional reduction in workplace control, workers expected to use their own cars and claim mileage as a reduction on their income tax return.

Research participants argued that the organisation should cover the cost of mileage as it adds to overall income which plays into pension contributions and should be a cost of doing business, not a cost born by the individual worker. As one research participant observed, "Transportation used to be covered by the agency and it still should be. It is both the workers and the service users who are hurt by this new transportation policy, which is just not right." Workers were also expected to cover the cost of meals and other activities accompanying service users, and to, as one worker put it "model appropriate behaviour" for the service users, while shouldering their own costs. Summing it up for several research participants, one worker noted, "We as workers are expected to pay for ourselves so out of my day, I might earn $250.00 but $50.00 of my pay needs to go on being able to support that person in the NDIS to those activities." These additional costs are, in effect, a cut to wages, a subsidy to the employer and reflect the reduced power of workers.

Though much of the disability sector has aspires to operate on a nonprofit ethos of care and equity, the research participants were disturbed by new trends emphasizing profit over support for service users and generating divisions between staff and management. In a number of instances, employers made it explicit to frontline workers that the culture of the workplace had changed to one of ensuring that every interaction with clients was charged and chargeable, otherwise it had to be eliminated. One worker received the following instructions from her manager regarding billing service users for phone calls - - even when no one

answers, “you call them, you charge ‘em. If they don’t answer, you write it down and you charge ‘em. And you charge 15 mins because that’s the minimum you can charge.”

Another poignant example can be seen in a story provided by a support coordinator whose manager told her “drop clients and stop helping them” once their support coordination budget had been used up, even when the clients’ needs remained unmet. In a similar vein, another worker told us, “My boss said, ‘You need to look at things a lot different. It’s about money. There’s morals and ethics and then there’s the organisational standards and you need to bring them down to the same level,’ and I said, ‘How can I change my morality that I’ve had for 28 years previous to starting this role to suit an organisation? I can’t do that…”

Research participants also reported an “everyone’s replaceable mentality” coming from managers who had previously been supportive. Underscoring diminished worker control in the workplace, one long time worker noted that, “Attitudes from management are basically, you’re not an asset anymore.” New and long-time staff also commented on the adversarial climate that seemed to pervade many organisations. As one long term worker noted, “There’s now a very big us and them in our organisation. Very big… There’s no objectiveness.” In a further example of shrinking workplace power, favouritism was a widespread concern with most workers feeling that shifts and service users with complex needs were not evenly distributed. This, as well as infrequent or non-existent supervision, increased workers’ sense of alienation and stress.

Despite a significant level of instability and frustration, many workers continued to find satisfaction in working with people with disabilities. Though two workers told us that they felt it was likely they would soon be fired because they refused to abandon the principles of equity and support, other workers told us that the job still held meaning because, “You can put things in place for people that can give them hope”. Despite the challenges posed by inadequate funding and short notice shifts, most workers found rewards in, as one worker put

it, “Watching [] the participants reach their goals.” Another worker expressed a similar experience, “I like getting them out and about to places. I love hearing ‘he’s never done that before.’ Love that. I love hearing ‘how did you do that?’ I get chuffed every time.” A long-time frontline worker summed up the feelings of most research participants thusly, “I love working with the people. I love making their lives… as high quality as we can”.

However, it was notable how many workers were thinking of leaving the sector: some planned early retirement, others sought a career change, while others had no definite plans other than to seek a job they could like. As one long time frontline worker told us, “I’m leaving disabilities. I’m actually training in counselling, so I don’t intend to stay in disabilities. I don’t wanna be in that world. I don’t see it as very safe for my clients and the people with disabilities, but certainly not safe for workers”. Another added, “a lot of people are just going, we’re hanging around for maybe a year or two and then we’re going.’’ Part of this intention to leave was based on working conditions, but for most workers it was also based on no longer feeling part of a job where one feels appreciated and where one could find meaning. Reflecting a widespread sense of growing powerlessness, another long-time worker told us, “It is chaos. It’s awful. We really tried to raise all these issues that we could foresee was gonna happen and it seemed to fall on deaf ears of the state and government and now we’re seeing all those things that we feared.”

The revolving door of casual staff, a lack of training and supervision, and increased distance between management and workers exacerbated the stressed and sometimes dangerous situations noted above, putting workers in a position where they felt disposable and unable to change things. Higher and mid-level managers also seemed disposable in this rapidly changing environment, with workers noting, “managers don’t seem to last, nobody seems to know anyone”. One participant reported that her place of employment had three CEOS in the last five years, “they will just fill positions and then if they fall through, they fall

through. They'll just bring in someone else". A long-time casual worker noted further that, "it's not a great industry to work in…they're supposed to be a caring, nurturing sort of industry, looking after people yet they just treat their staff so terribly." A senior worker summed it up for the bulk of the research participants by observing, "morale has never been lower".

Less Training and Skill in the Labour Force

The NDIS generated increased demand for disability workers, particularly home care workers. This new workforce in the NDIS was described as new, young, low skill and inexperienced. Prior to the NDIS, there was time and funding for training and upgrading as well as supervision and meetings, "we would have regular staff meetings, training days, staff development days…That's gone; there's no money for it". Participants noted that their employers now have very minimal requirements for hiring new staff, whereas previously skills, formal education and experience were definite pre-requisites. As one worker noted, "I remember when I first started in the field as a support worker and we used to get a lot of students from universities and that and you can tell the difference – the quality was there, their attention to the clients were there but under the NDIS it's just…nah. They're just basically hiring anyone because we need the workers." Experienced skilled workers expressed alarm at this trend and reflected a further axes of diminished workplace control, "It makes you feel very devalued in your work. It really feels like they're dumbing down our role."

The lack of training and experience presented risks for the new labour force, service users and existing staff. As one long time worker observed, "Because I have more experience than most of the staff, I get all the hard guys. They are all one-on-ones (one staff to one

client) because they need that much support. They have complex needs and the work is always hard work. No down time or variety." This makes the work more draining, adds to workplace stress and unsafe conditions and represents a further shift in control to management. Temporary and casual staff are less likely to complain as they need to position themselves positively in order to be assigned to future shifts.

Private Working in Private Homes

Though an increasing portion of the disability labour force works in service users' homes, there is no way to assess whether private homes are safe or appropriate worksites. The constantly shifting pool of on-demand workers made for a more hazardous work environment as staff were unfamiliar with the service users, their preferences or triggers. Workers reported knowing little or nothing beyond the service user's name and address when they showed up for a shift. Noting an overall increase in workplace injuries, one worker quipped, "Nothing major, just black eyes, broken noses, the normal sort of things with people just being out their routine, not knowing the support workers and the support workers not knowing clients." Reduced workplace safety and their inability to stop it a further aspect of decreased worker control.

One research participant noted that it was less likely that the casual workforce would report workplace injuries because they all needed more shifts and feared reprisals: "Some workers are scared to complain about challenging behaviours from the clients, to the client or the family or the agency. The workers don't want to upset anyone, or they might not get more shifts."

Service users' families were sometimes an additional source of workplace stress and risk, and there was little that workers could do if people were acting inappropriately in their

own homes. Some families had unrealistic expectations of what could be completed in a day and what the service user was capable of, and there were no rules or guidelines they were required to follow. As one research participant told us, "Families don't always acknowledge when a shift is finished and don't let the staff person leave. Or [they] don't come home on time to take over." He continued, "In some cases, clients are very afraid to be left alone or too unstable to be left alone and so we can't leave until a family member finally shows up."

Discussion and Conclusions

Various aspects of the former disability sector remained constant in the early roll-out area studied. This included: the commitment of workers to the service users and/or social equity and justice; the gendering of the workforce; the expectation of unpaid work; and the increasingly poor wages and conditions. Within the legislation, the human rights of people with disabilities were recognised at the level of discourse but not at the level of pricing. The gender undervaluation of care work remains constant with the failure of government to price NDIS at levels where Award rates or above could be paid. This reflects a sidelining of the rights of the highly gendered labour force and continued gender inequity.

Self-determination and autonomy for people with disabilities can flourish in contexts where staff have stable employment, supportive supervision and fair wages (Kvist and Fritzell 2011). However, by embracing a pro-market ideology, the NDIS set the terms for a zero-sum game involving a precarious labour market with significant gig-like, on-demand economy aspects and a temporary workforce that lacks the constancy, supervision or training to properly support the autonomy and self-determination of all people with disabilities.

Figure 1 (below) highlights various aspects of this zero-sum game by detailing changes in the policy arena as the disability sector moved from a largely publicly funded non-

profit labour market to a quasi-gig economy. The term quasi-gig is used to underscore the similarities with an on-demand labour market as can be seen in the NDIS emerging labour market - - very short shifts; split shifts; short notice of shifts; multiple employers; unpaid travel time; working primarily alone in private homes; the use of IT apps to notify workers of shifts and employers acting primarily as an interface between service users and workers. In terms of differences from the gig economy, some workers have been remade as private contractors, particularly higher credentialled workers, though most continue to work for organisations, where they have been remade as fragmented, precarious and casualised, while management has increased workplace control.

Figure 1 contributes to labour process theory by analysing the shifts in workplace control, precipitated by changing work organisation and the new policy and regulatory context. The data analysed in this article suggests that the government instigated massive restructure precipitated a zero-sum game in which, like poker, there are a few winners and many losers. The first policy arena analysed in Figure 1 is human rights. In 2011, the Inquiry into Disability Care and Support (Productivity Commission 2011) recommended the establishment of a national scheme to replace existing policies that were not ensuring the rights and wellbeing of people with disabilities. A commendable central plank of the NDIS is recognition of the right of people with a disability to be at the centre of decision-making and planning for their life (Productivity Commission 2011). However, the cash-for-care model, introduced with the NDIS, precipitated the massive restructuring of the labour market discussed above, in which some people with disabilities appear to be experiencing human rights, while those left behind include people with intellectual and other cognitive disabilities, families with very young children, Indigenous people, and people living in rural and remote settings (Howard et al 2015; Warr et al. 2017). The on-balance column in Figure 1, row one, notes that service users, who can advocate for themselves or have an effective advocate, have

made human rights gains (Productivity Commission, 2017). Unfortunately, those without advocacy remain on the margins of this commercialized policy project. The on-balance column also adds the loss of rights for workers, an indication of the cynical trade-off between the rights of various groups within the NDIS.

Figure 1. Moving from non-profit labour market to gig economy, managed market

Policy Arena or Specific Regulation	Change	Yes/No shift in control	From whom/to whom	On-Balance
Human rights	NDIS – individualised funding	Yes	From organisations to specific service users who are effective advocate or have access to an effective advocate	Significant gain for some service users Significant loss for organisations Significant loss for workers
Employment regulation	NDIS – individualised funding & mostly casual employment	Yes	From organisations to individual service users (only those who can advocate for themselves or have an effective advocate), or From workers to individual service users (only those who can advocate for themselves or have an effective advocate)	Significant gain for some service users Significant loss for organisations Significant loss for workers
Sector-wide award (SCHCDS)	Casualised workforce, multiple employers (many non-standard); few standardised workplaces	Yes	From union (and workers) to management & service users who act as employers From union (and workers) to informal, pop-up organisations	Significant loss for unions & their members Harder to organise & represent fragmented sector

In labour process theory, as the second row in Figure 1 shows, these dynamics have resulted in significant losses in workplace control in the form of decreased employment conditions, regulation and protection. This produces a significant transfer of control from workers to management and, indirectly, to the state as the lowball funder who sets the terms for this outcome but without having to step in to directly orchestrate the changes. Governmentality analyses identify these processes as "governing at a distance" in which the state exerts control through policy setting rather than hands-on operations (Rose et al., 2006). A shift in control from organisations to individual service users, who are effective advocates or have an effective advocate, is also observable as a shift in control from workers to this specific group of service users.

The policy and regulatory context in the NDIS are set by the Australian state which assumes three contradictory and conflicting regulatory roles: defender of the human rights of people with disabilities; defender of minimum employment standards; and key driver of precarity and market processes (Jaehrling et al., 2018). By providing continued low pricing and individual funding, the state acts as a key driver of precarity and casualisation while simultaneously distancing itself from responsibility to defend minimum employment standards for a highly gendered, low wage labour force.

Another driver of precaritization under the NDIS is the loss of block funding from governments to organisations. With people with disabilities suddenly in receipt of personalised funding and required to pay for their own services and transportation, relatively stable, long-term organisations lost most of the clients who once partook of group programs and supports in which transportation costs were covered by block funding. These organisations were compelled to remake themselves as providers of largely home-based, individualised services and market themselves to cash-carrying individuals with multiple requirements for support. Many long-term organisations are struggling to survive

(Productivity Commission, 2017) and the sector has seen the rapid growth of for-profit, non-profit organisations and "pop-up" providers, many of which have little or no experience in providing social services or fulfilling their obligations as employers. Unions have difficulty contacting workers in this rapidly restructuring sector and even employers once seen as progressive, are pushing for changes to enterprise agreements and the SCHADS Award (Author B, 2018).

The third row of Figure 2 captures some of this dynamic. The on-demand, quasi-gig work means that workers have multiple workplaces and generally work alone, in service user's homes. This makes it difficult for workers to communicate with each other or share concerns, both of which tend to build shared analyses that can lead to union participation (Simms, 2007). It also makes it difficult for unions to communicate with workers or to be part of their everyday work lives. This results in a shift in control from the union (and workers) to management. It also represents a shift in control from the union to informal, pop-up organisations that may not be aware of or interested in meeting the terms of the SCHADS Award. The balance column notes the losses for unions and workers.

This article extends our understanding of labour process theory by adding the concept of pro-market/gig market to signal the shift from the non-market mandate that previously undergird the largely non-profit disability services sector. Instead, a pro-market/gig market has propelled forward by government policy. The effect is that permanent work is destabilized, better working conditions and better wages are replaced with on-demand/gig work, impermanence and fragmentation. A truncated, marketized version of human rights (Stainton, 2002; Ife, 2012) played an ideological role in convincing service users, the public and workers that management and the state need to drive down workplace protections and employment regulations in order to meet the commercialised needs of vulnerable populations. Current employment regulation seems ill-equipped to defend disability workers and

governments are more interested in containing costs and fostering private markets than in protecting a highly gendered, increasingly precarious labour force. Though our conclusion is tentative, based on just this example, the evidence suggests that zero-sum games, in which a few wins and many lose, may be a feature of social policy change in market-driven contexts, such as the NDIS, and that current workplace protections for care work mean little in the context of restructuring and marketisation.

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A Portable Training Entitlement System for the Disability Support Services Sector

By Dr. Rose Ryan and Dr. Jim Stanford
The Centre for Future Work at the Australia Institute

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Table of Contents

Abbreviations

AQF	Australian Qualifications Framework
ASQA	Australian Skills Quality Authority
ASU	Australian Services Union
DSTA	Disability Services Training Administration (proposed in this paper)
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Service (provider peak body)
QSF	Quality and Safeguarding Framework
RCM	Reasonable Cost Model
RTO	Registered Training Organisation
SCHADS	Social, Community, Home Care and Disability Services modern award
SSO	Skills Services Organisation

Summary

The NDIS Act is often described as the largest social reform in Australia since the introduction of Medicare in 1975 (Productivity Commission, 2017; Cortis et al., 2017). It was designed to provide a nationally consistent approach to the provision of services, supports and activities to people with disabilities aged from birth to 65 years of age. Employment in the sector is experiencing significant growth, at a time when public expectations about the quality of service provided through the system's individualised packages of support are higher than ever.

A person-centred model of support (consumer-directed support) had been adopted as part of the NDIS. A funding envelope for each consumer is determined by an assessment of individual needs. Eligible individuals participate in a planning process, and individualised support packages are developed and funded for them. A Quality and Safeguarding Framework (QSF) has been developed to support the quality of service delivery. Policy statements have reiterated the need for a highly skilled and qualified workforce that will deliver high quality services in line with the needs determined in individual plans, and the requirements of the QSF.

Evidence from both Australia and internationally, from the disability support sector and from other human service industries, demonstrates conclusively that high quality support services are dependent on high quality employment standards and training for those who provide those services. Implementation of the NDIS has relied on the sector to recruit, retain and train the growing pool of workers with the required skills to meet the challenges of consumer-directed support. To maximise the potential of the NDIS to deliver a suite of high-quality, individualised services to hundreds of thousands of individual participants, the system desperately needs a strong and immediate strategy to facilitate ongoing investments in workforce development, training, and job quality. This strategy must ensure:

- Wages and working conditions attractive enough to recruit and retain tens of thousands of new workers.
- Good job quality, including employment security, autonomy and recognition.
- The development of a range of appealing career paths in the sector, so that workers can see a positive long-term future working in this field.
- A systematic strategy for training, qualifications and workforce development.

New recruits must be supported to demonstrate their prior skills and learning, and attain additional training for which they are recognised and credited. And all disability

support workers must have access to ongoing training, to broaden and update their skills throughout their careers, accumulate more credentials, and pursue recognised career paths.

Unfortunately, research regarding the initial experience with the NDIS demonstrates that insufficient attention has been paid to the importance of workforce training and development, as a crucial precondition for high quality service delivery. Specifically, research is revealing that providers experience difficulties in recruiting new staff; that conditions of work have become more difficult; that most workers are engaged in casual, part-time, and irregular positions, and that staff turnover is horrendously high; and that there has been a consequent reduction in the quantity of training (including in-house supervision and support) provided for employees, just as workers need more skills to fulfil the goals of the NDIS. This situation poses a significant risk for the quality of life and safety of NDIS participants, for the job quality and opportunity of disability service workers, and for the organisational stability and success of providers.

Inadequacies in the pricing/costing model at the heart of the NDIS are a central factor in these inadequate outcomes in the realm of skills and training. Specified costs for individual packages of support supposedly include a component for training of workers, along with other workforce and administrative overhead costs. But the resources allocated to these activities within the NDIS pricing model are woefully inadequate, based on outdated and incorrect assumptions about the range and level of skills, knowledge and competencies needed to successfully perform work in the sector. Moreover, there is no clear and consistent strategy for defining qualifications, and ensuring that workers get the training they need.

Increased investment in training for disability support workers is important for improving the lives of people with disability. Some of the skills needed by disability support workers are general ones – but they still need to be learned; and people with disabilities deserve to be provided with the assurance, through recognised qualifications, that those providing them with support have achieved a recognised level of competency. Moreover, some people with disabilities have diverse, complex and varying needs. Providing individualised supports under the NDIS needs a workforce that can provide specialist as well as generalist skills; and also be highly adaptive in response to the individual and changing needs of each person they support.

Achieving the full positive potential of the NDIS, and ensuring that participants receive the high-quality, individualised services that the scheme was intended to provide, will require a thorough commitment to high-quality, well-funded training for everyone working in the system. A far-reaching change in culture is necessary, one that

recognises the value of ongoing and substantive investments in training and professional development as the foundation for delivery of high quality support services. This will require a comprehensive and systematic approach to training. In short, the sector needs a holistic, ecosystem approach to meeting its skills challenges, through a system of qualifications and career paths with internal consistency and integrity, supported by a national infrastructure for developing, delivering, quality-assuring, certifying, funding and tracking training. Benefits for workers, participants and providers from this approach would include the promotion of high industry standards, making the industry a more attractive place to work, establishment of clear and more stable career structures, and a better basis for workforce planning.

This paper describes the dimensions of the skills and training challenge facing the disability services sector as the NDIS is rolled out. It proposes a comprehensive strategy for addressing training needs, including both immediate induction and foundation programs to provide new entrants to the workforce with basic skills and qualifications, and an ongoing portable scheme through which disability service workers accumulate regular entitlements to training opportunities – and then utilise those entitlements to undertake career-long training in the specialised topics which they choose. A well-defined and regulated structure of qualifications and career paths will assist workers in leveraging that ongoing training into ongoing occupational progression. Workers will come to see this sector as one offering great opportunities for learning, training, advancement, and compensation – rather than as an industry dominated by irregular, unsupported, and often isolated short-term "gigs." That will lay the foundation for a more successful recruitment and retention strategy by service providers, as well as for much higher-quality service provision to people with disabilities.

This report has been developed on the basis of analysis of official statistics, published research, and original interviews with key informants. Our recommendations include:

- Ensuring that training is directed towards nationally recognised and transferable certifications, overseen by industry-recognised authorities, and integrated with career pathways for workers in the sector.
- Linking the accumulation of training to the establishment and implementation of minimum training requirements for specific types of support.
- Large-scale roll-out of induction training to ensure that new hires have basic levels of skill, knowledge and experience prior to working with NDIS participants.
- Registration of NDIS-funded disability support workers, in part to facilitate ongoing accounting of their training credit accumulations.

- Establishing a separate and protected Capacity-Building Fund, housed within the NDIA, to fund training activity across the sector – including courses for individual workers, and group training and capacity-building at the organisational level.
- Implementing an ongoing system for workers to accrue portable entitlements for training, based on the number of hours that they have delivered NDIS-funded supports, transferable across providers and jurisdictions; and ensuring workers have the opportunity to utilise those credits in accumulating ongoing qualifications.
- Developing a new planning and administrative body, the Disability Services Training Administration (located within the NDIS Quality and Safeguards Commission), to oversee training standards, curriculum development and qualification benchmarks across for the sector, in collaboration with existing VET regulatory authorities.

The paper also presents preliminary fiscal estimates regarding the costs associated with the establishment and operation of this system. It confirms that the costs of providing essential, recognised, and portable training opportunities for NDIS workers would represent a very small fraction of incremental costs of operating the NDIS.

The training program would be phased in over five years, funded through the Capacity Building Fund (jointly endowed by the Commonwealth and State governments in line with the overall NDIS cost-sharing model). This independent funding stream would be established parallel to the unit pricing system that governs NDIS-funded services, rather than being funded from margins embedded within those unit prices (a system which has already proved unworkable). Costing simulations indicate that all elements of the training program (including induction, foundation, and ongoing portable training entitlements for individual workers, the creation of the DSTA, and funding for organisation-level training initiatives) could be funded for a total cost averaging about $190 million per year. Compared to the anticipated $22 billion annual cost of the NDIS once fully rolled-out, this represents an investment of less than one cent for each dollar of total payments. That is a very small investment indeed in the skills, qualifications, and career paths that will be essential to realise the NDIS's full potential: both as a system for delivering high-quality care to participants, and as a source of rewarding, high-value work for service providers.

I. Introduction and Overview

The importance of training and human resource development has been high on government policy agendas for decades. Recognised as a tool for both industry and national economic development, governments have made significant investments in education and training from early-childhood through to higher education.[1] However, some areas of the economy have missed out on this commitment, with little attention paid to the need for training and skill development. In these sectors, many jobs are low-paid and insecure, work is perceived as unskilled or low skilled, and the little training available is often limited to narrowly defined "competencies."

Some sectors have experienced significant skills shortages as a result of this inattention and underinvestment; and organisational exposure to various operational and legal risks has increased as a result of employing insufficient numbers of skilled staff. Nowhere is this more true than in the disability sector, and related fields (including Aged Care Support and Mental Health Support) in the broader community services field. There is no denying the human importance of the work performed in these sectors. But funders and providers have not made adequate recognition of the need for ongoing high-quality training, to support service workers in performing their tasks with the utmost of skill, safety, and respect for people with disability.

In this context, the passage of the National Disability Insurance Scheme (NDIS) Act in 2013 poses enormous challenges and opportunities to a sector which was already underinvesting in skills and training. The NDIS has been described as the largest social reform in Australia since the introduction of Medicare in 1975 (Productivity Commission, 2017; Cortis et al, 2017). It has been designed to provide a nationally consistent approach to the provision of services, supports and activities to people with disabilities aged from birth to 65 years of age. Employment in the sector is growing more rapidly than any other sector; employers are competing with other areas of community services in an effort to recruit and retain workers. This labour supply challenge is being experienced at a time when public expectations about the quality of supports are higher than ever. The sector has been unable to attract sufficient numbers of suitable new employees to meet this increasing demand, let alone to ensure that they have adequate skills and training. The importance of training and workforce skill development to respond to these labour market demands has had a

[1] We note that some parts of the education and training system have benefited from this attention to a greater extent than others. In particular, and of relevance to this report, funding for vocational education and training (VET) has fallen well behind that for higher education in Australia; as have increases in enrolments (cited in Noonan, 2016: pp13 and 19).

surprisingly low profile in public discussions about the NDIS, its goals, and its challenges.

This report focuses on issues related to the supply and demand for skilled labour in the disability sector, and proposes the development of a comprehensive system for investing in ongoing training and skills development. The key components of this system include:

- A mandatory induction/orientation to the industry, and minimum qualifications as a pre-requisite for on-going employment.
- A portable training entitlement that allows workers within the sector to both gain initial qualifications, and then participate in on-going professional development through their entire careers.
- The stipulation of nationally recognised qualifications linked to the Australian Qualifications Framework (AQF), delivered and assessed by public and non-profit training bodies accredited under the Australian Skills Quality Authority (ASQA).
- The definition of clear pathways into advanced qualifications and specialisations, which can guide disability workers in advancing their careers over time (as they accumulate skills and qualifications), and linked to clear classifications in pay and job responsibilities.
- The establishment of a new body, the Disability Services Training Authority, operating within the NDIS's Quality and Safeguarding Commission, and including representatives of people with disabilities, to work in collaboration with existing VET regulatory agencies to develop curriculum, establish qualification benchmarks, and manage the portable training entitlement system.

Research for this report has been conducted on the basis of analysis of official statistics, publicly available policy documents, other published research reports, and original interviews with key informants working in the sector.

The report documents the skills and training challenges facing the current workforce (including barriers to access, current levels of skill, and working conditions), among the wide range of other challenges faced by this growing sector. It suggests a need for increased levels of training across the industry as a whole, which can be best met by developing an integrated training "ecosystem" within the sector to support current and future skills needs.

Section II of the report describes the current disability services workforce, including reviewing existing training practices and documenting the challenges faced during

NDIS implementation. Section III provides an overview of the design, structure and implementation of the NDIS. Section IV discusses in more detail the implications for skills development of the NDIS, identifying the system's current treatment of training needs and its shortcomings. Section V then provides a proposal for a comprehensive training structure within disability services, including all its key components: initial induction and foundation skills, ongoing portable training opportunities, and a regulatory and funding structure underpinning both. This section also discusses the key fiscal parameters of the proposed system. Section VI provides a summary of conclusions and proposed strategies for winning support from all stakeholders (including government) for including a commitment to ongoing, high-quality training as a core component of the NDIS.

II. The Disability Support Services Sector

Describing the disability support services sector is a challenging task, given the incredible transformation that it is undergoing in the wake of the introduction of the NDIS. In addition to state-based disability support services, the sector has always relied heavily on not-for profit service providers, often faith-based. Common categories of service provision included general and specialist services, residential support services, accommodation support, day programs, respite services and transition to work programs. Funding was provided by both the State and Commonwealth levels of government, based largely block funding for specified levels of service provision. This funding generally constituted around 60-80% of total income; with many organisations supplementing their income from charitable donations (PWC, 2012). Block funding meant that providers managed their income based on organisation-specific policies and strategies, including the costs of employing (and training) staff. Currently, it is estimated that there are around 2,000 disability service providers nationally (NDS, 2016). The sector is growing rapidly, however, and competition for the available workforce is fierce – a situation that is exacerbated by simultaneous growth also occurring in aged care, mental health and community services sectors.

WORK AND WORKERS IN THE DISABILITY SUPPORT SECTOR

The work undertaken by the disability support workforce, all the more so under the NDIS, is incredibly diverse and varied. It involves work with people living with disability, providing a person-centred approach to support in a residential, home or community-based environment. Disability support workers may work alongside families and community workers, allied health professionals, diversional therapy assistants, mental health workers, peer support workers, and professionals in mainstream health and education services, or they could be lone workers to deliver services that support the active social and economic participation of NDIS participants in the life of the community and in the Australian economy (Skills IQ, 2017b).

One of the key findings of the 2011 Productivity Commission report which was influential in the design of the NDIS, was that there were no reliable estimates of the exact size of the disability serevices workforce (Productivity Commission, 2011). Since

then, with assistance from government, National Disability Services[2] has introduced *Workforce Wizard*, an on-line tool, to collect and analyse workforce data entered quarterly by human resource managers and executives within the disability support sector. Key information sought includes types of employment, organisational growth, turnover rates, working hours and age and gender distribution of the workforce (NDS, 2017). The first report based on this tool was released in July 2017, with an update published in February 2018 (NDS, 2018), based on a total sample of over 35,000 disability support workers.

Data attained through the NDS tool confirm that the disability support workforce is extraordinarily concentrated in casual, part-time, and very insecure positions. Most recent data (NDS 2018) indicates that 81 percent of the workforce are in part-time positions. 42 percent of workers fill casual jobs. Staff turnover is extremely high: around 25 percent per year for the workforce as a whole, and over 35 percent per year among casual employees. The average number of hours that employees work in the course of a week is low and falling: down to just over 20 hours per week. Fewer than 10 percent of the disability support workforce are employed on a full-time and permanent basis.[3] Many workers work irregular hours in multiple locations; research indicates many do not receive minimum legal compensation (including for time spent traveling between locations, and other essential job functions; see Macdonald et al. 2018). The workforce reflects a high concentration of women workers, and older workers: 70 percent are women, and 44 percent are 45 years or older (making the sector's workforce one of the oldest of any sector in Australia's economy). The advancing age of the existing disability support workforce only reinforces the need for a comprehensive and ongoing training system for the industry, in order to replace the skills and experience of those older workers who will be retiring within the next few years. In contrast to disability support workers, allied health workers in the sector tend to be younger (64% are aged between 25 and 45), and are much more likely to be employed on a permanent basis.

The precarious instability of work in the sector highlights the need for a systematic and comprehensive approach to training. It is impossible to imagine that the NDIS will be able to fulfil its potential in improving the lives of people with disabilities, on the basis of a workforce that is so overwhelmingly employed in casual, part-time, high-turnover roles. Workers need an opportunity to accumulate skills, and that requires some basic assurances of stability and predictability in future employment. By providing disability

[2] National Disability Services is Australia's peak body for non-government disability service organisations, representing around 1100 service providers.

[3] NDS (2018) reports that only 35 percent of permanent employees (which in turn make up just 19 percent of the total workforce) are employed on a full-time basis, implying that just 7 percent of the workforce fills permanent full-time positions.

support workers, even those working for multiple employers or moving to new positions, with a mechanism to accumulate recognised and portable qualifcations, the training strategy proposed here could play an important role in stabilising and uplifting the whole sector's employment practices.

The NDS data also confirm that, in the face of increasing demand driven by the NDIS rollout, there is strong growth in employment in the sector of around 11 percent per year (NDS, 2018). While positive, this growth masks two significant concerns. The first is that growing employment is being driven almost entirely by a growth in casual employment. The growth in casual employment in the sector was 26 percent per year, compared to just a 1.3 percent per year increase in permanent employment (NDS, 2018). Secondly, turnover issues remain a huge concern.

High turnover rates are exacerbated by recruitment difficulties. In the March 2017 quarter, 76 percent of responding organisations had advertised a vacancy to fill a direct support worker role. Of these, 35 percent remained unfilled, with higher than average unfilled vacancies in Western Australia, Victoria, and South Australia. The most common reasons given for difficulties in filling vacancies was a lack of suitable or qualified candidates. This general response masks issues that reflect the unwillingness of candidates to accept employment in the sector in line with the wages and conditions being offered. These include poor wages and conditions of employment, lack of permanent and full-time roles, and the necessity of working irregular/non-social hours and shift work. Other difficulties in finding candidates reflect the greater focus on meeting the individualised needs of people with disability – for example, 22 percent of responses noted that the unfilled roles involved specific job skills (e.g. experience in gardening or horticulture, community access support, etc.), specific demographic characteristics (such as experience working with a specific cultural background), or other skills (such as dealing with people with challenging behaviours) that may be difficult to match with suitable applicants. There is also some evidence of a shift in what employers believe constitutes a "suitable and willing" candidate: providers are placing more emphasis on hiring people with attitudes and values that meet specific participant requirements, as part of complying with NDIS policy to offer choice and control to people with disability. All of these factors reinforce the conclusion that this sector desperately needs a comprehensive training strategy to provide the workforce with all the skills (both general and specific) necessary to fulfil the promise of the NDIS.

III. Implementation of the NDIS

As noted earlier, implementation of the NDIS is probably the most significant social reform in Australia for several decades. The model of services on which the NDIS is based has several distinctive features:

- It adopts a person-centred model of support. Individuals apply for an assessment of eligibility, and once this is determined, they are enrolled. Following this, support packages based on individualised planning are developed and funded.
- It is an insurance-based scheme, assessing costs and funding requirements based on actuarial estimates of life-time participant needs. This includes early investment and intervention in order to facilitate independence, social and economic participation; and to reduce the need for long-term support.

Discussions prior to the introduction of the NDIS Act noted the need for significant change in the sector in order to support achievement of its policy objectives. This involved the creation of a disability support sector "market" with new providers and new types of service offerings. This would allow consumers greater choice in the provision of services based on their individual and local needs. Consumer-directed support[4] reflects the evolution in service delivery models internationally, where funding is allocated to individuals or families to purchase services to meet personal needs and preferences rather than accessing standardised services (MacDonald & Charlesworth, 2016). The new model has had significant implications for service providers: they must provide new forms of support, adjust to a more competitive market, and manage the costs of employing staff to meet increasing demand. In addition, there are consequent implications for training and skill development, canvassed in the next section of this report.

The NDIS started in July 2013 in four trial sites, and was gradually extended; with roll-out starting progressively in the rest of Australia from 1 July 2016. Full roll-out is expected to be completed by 2019-20. Over the course of this transition an estimated 475,000 participants are expected to be enrolled. Uncertainty remains regarding the precise quantum of new employment that will be generated as the roll-out continues, but all observers agree that the program will require a huge expansion in the disability support workforce. In 2016, the former Chair of the NDIA Board claimed the system would need up to 70,000 new full-time equivalent workers over the coming three years – about one in five of the new jobs estimated to be created in Australia during

[4] The model is variously referred to in the literature as cash-for-care, individualised funding or personalised care.

the transition period – and this estimate has been repeated by other analysts (eg. Productivity Commission, 2017, p. 323.). This employment growth is happening at the same time as providers are engaged in significant organisational change as they adjust to new service delivery, funding, and marketing arrangements.

The scale of this undertaking is enormous and complex – and not surprisingly has encountered a number a road-blocks. A recent report from the Productivity Commission noted that roll-out is falling behind anticipated targets (Productivity Commission, 2017), with transitional issues posing risks to the integrity of the scheme. In particular, a focus on meeting targets for participant intake has resulted in lack of attention to the development of high quality plans for participants, slower than expected growth in new services, and insufficient growth in the employment of disability support workers. At the same time, information collected by NDS shows that although demand for support services is growing rapidly, 38 percent of providers are unable to keep up with demand, with the key reason being an inability to attract suitably qualified applicants for jobs (NDS, 2016).

In addition to the challenge of increasing the sheer number of workers, providers have also been required to adjust to new funding arrangements, and a new quality assurance framework. Details of these are outlined below. These in turn have had significant implications for training and workforce development, which are dealt with in the next section of this report.

THE NDIS FUNDING MODEL

As noted above, once an individual's eligibility for the NDIS has been determined, participants participate in a planning process with an NDIS representative. The purpose of this planning is to determine the reasonable and necessary supports needed for the participant to experience lives as full and engaged as possible. This is reflected in an individual support plan, and funding is allocated on the basis of what supports are needed. Participants then choose (in line with their plan) what supports they wish to purchase, and who will manage their funding. They have the option to select a registered provider to manage and provide their support, or can self-manage their funds (including directly employing support workers). In actuality, only 7 percent of participants self-manage their plans, with 58 percent opting to have registered providers managing their plans and providing support; and the remainder opting for a mix of agency- and self-management (Productivity Commission, 2017).

Individual plans and packages of support can include capital items (such as assistive technologies) but the two main categories of support involving disability support

workers are *Assistance with Daily Living* (e.g.; assistance with self-care activities) and *Assistance with Social and Community Participation* (e.g.; access to and participation in recreational activities). Where providers employ disability support workers to provide these supports, they invoice the NDIA and are paid out of the participant's individual account.

The basis of payment is derived from a "Reasonable Cost Model" (RCM), which determines prices to be paid for various categories of support. Price guides have been published by the NDIA and consist of maximum hourly payments for different categories of support (with slight variations depending on time of day, complexity of support needs and for remote locations). Hourly payments explicitly require all costs of providing support by a support worker employed under the Social, Community, Home Care and Disability Services (SCHADS) Award by a "reasonable" service provider to be included. Over the period of roll-out, the realism of the pricing model in relation to the costs of providing support and the transparency of the decisions made in respect of price-setting has come under increasing criticism, not only from providers and academics (NDS, 2016; Macdonald and Charlesworth, 2016) but also from the Productivity Commission (2017).

The most robust analysis of the RCM has been undertaken by Cortis et al 2017, whose interest was in exploring the impact of the RCM on disability support providers and workers. Based on an analysis of the assumptions underpinning the RCM, they clearly demonstrate that set prices fail to recognise the nature and value of disability support work (pp. 22-27). This has had significant consequences for employment and training in the sector. Based on a survey of CEOs from registered providers, and interviews and survey responses from disability support workers, identified problems include:

- The pricing model assumes that workers, on average, are paid at Level 2.3 of the SCHADS award.[5] Under the award, this is the minimum pay point for workers with a Level III qualification; it applies to workers undertaking largely routine work with readily available guidance and assistance. Evidence from employer surveys, in contrast, suggests that they regarded this as an entry-level (rather than an "average") rate. Experienced support workers are employed in higher classifications under the award, and employers need to provide advancement opportunities for these staff in order for them to be retained. Thus the pricing model vastly underestimates the average pay rate for disability support workers.
- The base hourly rate for disability support workers assumes that 95% of a worker's time (excluding annual and personal leave time) is spent in direct

[5] Classification levels refer to classification for Social and Community Services workers.

participant contact. This allows for just 3 minutes of every hour paid to cover all activities that need to be completed to provide quality supports and comply with the requirements of the award. These include the need for breaks for workers, communication with other team members (for example, handovers at shift changes, or in relation to new NDIS participants), meetings, administration requirements (such as completing shift notes), travel time, and time needed for training, supervision, team meetings and general professional development. The woefully inadequate amount of time allowed for non-contact time activities that are required as part of providing quality support results in support workers frequently working additional hours on an unpaid basis (Macdonald et al., 2018).

- Supervisors are expected to be paid on average at Level 3.2 of the SCHADS Award, with an expected ratio of one supervisor to 15 staff or even higher.[6] Survey evidence from both employers and workers, however, suggests that supervisors are more likely to be paid at Level 4 or above; and with ratios around 1:10. This is based on SCHADS award requirements that set limitations on the number of people that can be supervised by any one person and the level of complexity needed for supervision. Thus the supervisory ratios and rates assumed by the RCM are clearly out of line with current industry practice. In addition, given that the sector is employing many workers who have no previous experience, it is reasonable to expect supervisory ratios to be lower than this in order to provide adequate oversight of their work while they are learning the job. Thus, the pricing model again fundamentally underestimates the costs incurred by providers in providing the training and supervisory support necessary for delivering high quality services.
- An allowance of 15 percent for corporate overheads is allowed for in the RCM. This includes the costs of governance, training, staff development and back office support. Cortis et al (2017, p.47) cite international literature demonstrating how "… the excessive pursuit of administrative efficiency has caused a steady, self-perpetuating practice of cost-cutting in organisations, which in turn harms not-for-profits and their service users." Unrealistic pricing of corporate overheads in the NDIS pricing model limits the extent to which organisations can provide staff cover when people attend training courses, hold staff meetings, and engage in continuous improvement of their organisational practices.

[6] The high incidence of part-time work implies that supervisors would likely end up supervising a larger number of employees according to this formula, based on supervisory ratios defined in FTE terms.

Generally, the analysis suggests that the RCM significantly underestimates the costs of employing both support workers and supervisors, to the point where a provider survey found that two-thirds of employers disagreed or strongly disagreed that NDIS pricing allowed them to meet their obligations under the award, or to be able to pay rates necessary to allow them to attract and retain quality support staff (NDS, 2016). Providers were also strongly of the view that the RCM vastly underestimates both the time needed by support workers and supervisors to deliver quality supports and the range of other costs that providers incur in delivering services.

As a consequence, the sector is experiencing significant issues in financial performance. The NDS annual Business Confidence Survey (NDS, 2016) found that 22 percent of providers reported a financial loss in the previous year, and that this had an immediate impact on supervision and training provision. Many reported that they would not be able to continue to provide services at currently NDIA-set prices, and would have to reduce the quality of their services if prices did not improve. Similar findings are reported as part of the Disability Services National Benchmarking Project being completed at the University of Western Australia (Gilchrist & Knight, 2017). This showed a drop in net profit margins (relative to total income) earned by disability service providers: from 4.4 percent to 3.5 percent from 2014-15 to 2015-2016; more worrisome, if disability-related donations and bequests were removed from income, the margin falls effectively to zero. The report notes that providers are paying the costs of transitioning to the new system from their own resources (donations, financial reserves, sale of assets) or by incurring debt. It concludes that many services are likely to close within 2-3 years, or change their service offerings away from disability support to aged care or other human services which offer higher returns (Gilchrist & Knight, 2017, p. 5).

IMPROVING QUALITY

The delivery of high quality supports to people living with disability has been one of the key policy aims of the NDIS. Measures put in place to do this include the Quality and Safeguarding Framework, mandatory Terms of Business for registered providers (mostly focused on provider business processes), and a Code of Conduct (yet to be finalised) for providers and support workers.

The Quality and Safeguarding Framework (QSF) was foreshadowed from earliest policy discussions, and a draft framework was released early in 2015 by the Disability Reform Council. Following extensive consultations around Australia, it was finalised and released in December 2016 (Department of Social Services, 2016). The framework includes both developmental measures to help strengthen the capabilities of people

with disability, disability workers and suppliers of supports under the NDIS, and preventative and corrective measures to ensure appropriate responses to problems that arise.

QSF measures are targeted at individual NDIS participants, as well as the workforce and providers. In relation to workforce skills, the framework includes the following components:

- Developmental: Building a skilled and safe workforce – with the attitudes and skills that meet the needs of participants.
- Preventative: Screening workers – to help ensure that they keep people with disability safe and ensuring workers have the skills for specific roles through provider quality assurance and registration.
- Corrective: Monitoring worker conduct through screening, serious incident reports, complaints and breaches of the Code of Conduct.

Action taken by government to give effect to these measures, however, has been predominantly focused on preventative and corrective measures, rather than developmental ones. The draft Framework sets out an expectation that recruiting and training staff is the employer's responsibility (Department of Social Services, 2016, p. 55), noting the importance of employers ensuring that workers have the right attitudes, knowledge and skills to effectively support participants. It rejects the importance of qualifications being held by people doing support work in favour of the view that the right "attitudes" are more important. It does, however, propose the introduction of a compulsory orientation/induction module for the sector, for registered providers and their employees, as well as registered sole traders. Providers would be required to demonstrate that their workers have undertaken or are scheduled to complete the induction module, either as an e-learning module or as part of their workplace induction and training processes. Thus the QSF introduces for the first time training and development requirements for the sector, but leaves the responsibility for addressing these solely with providers.

Essentially, the Quality and Safeguarding Framework demonstrates a very passive attitude toward the task of quality assurance and workforce development. It is heavily reliant on screening, and investigating complaints and incidents; instead of a positive approach to workforce development that would prevent incidents from arising in the first place. An alternative would place emphasis on investment for capacity-building: attracting people into the industry by supporting long term development of a skilled workforce through providing opportunities for training to allow workers to deliver high quality services that make a difference in the lives of people with disability. We deal in more detail with our prescriptions for addressing this challenge later in this report.

A similar attitude is evident in the discussion paper on the proposed Code of Conduct released by the Department of Social Services in May 2017. The proposed Code is based on a number of national and international frameworks and regulations, aimed at upholding the rights of people with disability as people and as citizens. It includes reference to the need for providers to ensure that staff have appropriate supervision and training to make sure that support workers are able to identify, monitor and act when situations arise that could result in breaches of the Code. This would need to cover training both about the Code itself, and the service standards that they have been expected to comply with. However, it has already been noted that the RCM constrains the extent to which providers are currently able to provide training to staff, in this or any other area.

The draft Code also appears to be based on a simplistic view of ethics and integrity in caring occupations. While there are some behaviours that are clearly unacceptable, it is not uncommon for situations to arise in which a degree of ambiguity is present, and where workers may be required to exercise judgement. Providing quality support under the NDIS requires a degree of familiarity and trust between participants and their support workers which requires time, continuity of care and team coordination. The very nature of the personal relationship between the support worker and the NDIS participant (which may be close enough at times that the participant and support worker see their relationship as akin to a familial one) may involve complexities and ambiguities that support workers may find difficult to navigate. Resolution may require the worker to be able to discuss these issues with a supervisor or manager, in a supportive environment, without fearing that their employment may be at risk. It will require the evolution of practice standards over time, as the industry comes to understand the issues being faced on a day-to-day basis by workers.

In the end the Code places primary responsibility on workers, as the people with day-to-day responsibility for meeting support needs, for meeting the established standards. In addition, there appears to be no provision for a complaints process to involve the worker concerned, or to appeal against an unfavourable decision. Without additional investment in both initial and ongoing training on the rights of people with disability and the practice standards that support workers need to comply with, and an open and positive workplace culture that encourages support workers to be open about any queries they may have about how to deal with situations that they are facing, it is highly likely that it will be workers themselves who experience the consequences of complaints or investigations. This in turn may increase the risk for providers who potentially could find themselves in breach of employment law for failing to properly train support workers – who may later face sanctions for breaches of the Code of Conduct.

A more systematic approach to training in these areas would provide the knowledge and protections that workers need to ensure that they act in compliance with the Code, and gain thorough understanding of how their organisation approaches compliance with the Quality and Safeguarding Framework. Initial approaches give the impression that the NDIS is approaching service quality through a reactive and punitive approach. A pro-active focus on systematic, high quality and nationally consistent processes for training disability support workers in these issues would reduce risk for both workers and providers. While screening and rigorous complaints processes may be necessary, in the absence of high quality initial and on-going training they are unlikely to achieve the positive working environment that is so essential for providers and support workers to fulfil their duties to the utmost.

SUMMARY

The implementation of the NDIS has brought about significant change in the disability support sector. The roll-out requires a substantial rate of workforce growth (likely doubling total employment) over the next 5 years. However, providers are not able to attract suitably qualified workers into the sector; poor pay and working conditions, weak employment security, and limited access to training and development opportunities are significant factors behind this failure. At the same time, pricing caps introduced through the NDIS restrict the ability of sector providers to overcome any of these underlying conditions. While the provision of high quality services is at the heart of the success of the NDIS, little attention or resourcing has been provided to assist providers to recruit and train the new workforce. The Productivity Commission has warned that insufficient workforce growth poses a risk to a successful full roll-out, and will compromise the quality of support that has been promised to people living with disability.

IV. Training, Skills and Qualifications

Quite apart from the rapid growth in employment, there is a need for NDIS workers to be adequately skilled. In this section, we examine the level of skills and training of the existing workforce and the qualifications that are currently available to disability support workers. We then proceed to examine the skills implications of consumer-directed support, those initiatives that have been put in place to support sector development, and the implications of the NDIS pricing model and QSF for training and development in the sector. These set the backdrop for proposals set out in the final section of this report, to develop a nationally based skills ecosystem for the sector.

A common misperception of work in disability services is that it is unskilled and that workers in the industry do not need any special qualifications to work within it. This stands in contrast to the view of clinicians, social workers, disability specialists and participants themselves : namely, that this work requires sophisticated communications skills, a high level of emotional intelligence, and (depending on the complex and varied needs of the participant) specialist knowledge (for example, in relation to particular medical conditions, dealing with challenging behaviour, or understanding the side-effects of medications). In addition to multiple and complex needs, people with disabilities may also need support in managing multiple and complex interactions with government and non-government agencies in the course of addressing their housing, medical, and educational support needs. Internationally it has been argued that many disability services workers do not have the necessary skills or supports required to engage in daily work settings that are varied and demanding (Iancono, 2010). In the Australian context, research has also expressed concerns about the ability of support workers to meet workplace demands (see for example, Health Workforce Australia, 2014), particularly in relation to people with intellectual and cognitive disabilities and other complex needs.

At present there is no requirement for disability support workers to have any minimum industry-relevant qualification. However, analysis of the skills and qualifications of the existing workforce in the lead-up to the introduction of the NDIS confirms that many are in fact very well-qualified. In 2010, a survey undertaken by the National Institute of Labour Studies (NILS, 2010, p. 129) found that 72 percent of non-professionals working in the industry held a nationally recognised Certificate III or IV qualification, with 48 percent of these holding a Certificate IV in Disability. Although not compulsory, the NDIA advises registered providers that a Certificate III or similar is desirable for support

roles (Windsor and Associates, 2014b), and the industry as a whole regards the Certificate III as a base-level qualification. In addition to those holding these industry specific qualifications, a high proportion of the current workforce also have additional tertiary level qualifications. An online survey of 300 respondents undertaken by the Australian College of Community and Disability practitioners between November 2016 and March 2017 found that 31 percent held a Bachelors or Masters degree or graduate Diploma, 28 percent held a Diploma-level qualification, and 38 percent had Certificate III or IV level qualifications.[7]

VOCATIONAL EDUCATION AND TRAINING IN THE SECTOR

There are two qualifications in this sector that are recognised nationally as part of the formal Vocational Education and Training (VET) framework – *CHC 33015: Certificate III in Individual Support (Disability)*, and *CHC 43115: Certificate IV in Disability Support.*[8] For Certificate III, students must undertake 7 core and 6 elective Units of Competency; and complete120 hours of work experience (including completing a set of written and practical tasks in the workplace). Qualifications for the sector are overseen by SkillsIQ[9] (the Skills Service Organisation that covers the disability support sector as part of the wider community and social services area); Certificate III programs are presently offered by 476 different registered training providers[10] (RTOs), while Certificate IV

[7] Australian College of Community and Disability Practitioners survey, 2016 (unpublished). The survey did not indicate whether the qualifications were directly related to disability services.

[8] Certificates at Levels III and IV (of the Australian Qualifications Framework) are made up of agreed Units of Competence within an agreed training package. In this instance the disability qualifications are made up of agreed Units of Competence from the Health and Community Services training package. While there are expectations about the amount of time that it is expected that students will be able to complete the qualification in (6 months for Level III and 1 year for Level IV), in reality these can vary significantly based on modes of delivery.

[9] SkillsIQ is the Skills Service Organisation (SSO) covering workers providing direct client care and support to individuals, including in the disability sector. The role of SSOs in the Australian VET system is to develop and review training packages, in line with decisions made by Industry Reference Committees about future training needs in specified industry sectors. The relevant Industry Reference Committee for the Disability Support Sector is the Direct Client Care and Support Industry Reference Committee. The Committee consists of 2 employer representatives, 6 representatives from peak bodies, 2 representatives from Registered Training Organisations, 3 union representatives and 1 government representative. The two qualifications that are specific to the disability are included in the Community Services Training Package, which is one of 10 training packages that SkillsIQ is responsible for.

[10] In the Australian VET system, RTOs are registered by Australian Skills Quality Authority (ASQA) to deliver VET services. Registration requires assessment against quality standards both for providers and for courses offered. Only RTOs can deliver recognised qualifications that are accredited under the Australian Qualifications Framework, and are periodically reviewed by ASQA for quality assurance purposes. We recognise that the quality of teaching and assessment offered by RTOs in the sector is of concern to some employers, but this is largely a result of underfunding and the failed experiment of private market delivery of VET.

programs are offered by 225 RTOs. No higher-level qualification vocational pathways are formally defined for disability support work, although many people working in the sector have higher-level qualifications in health or allied health disciplines (such as nursing and social work).

For a workforce that is low-paid and works a limited number of hours, there are significant barriers to enrolment and completion of vocational qualifications. There are a large number of private RTOs (including some larger employers that have their own associated training and development arms), but a considerable amount of training is undertaken in publicly-funded TAFEs. The costs of courses vary from provider to provider (and may depend on government-determined eligibility for funding requirements), but can range upwards of $2,000. A compulsory work placement (of 120 hours), with workplace assessments, is required, along with course work. There is no reliable evidence about the extent to which those completing these qualification are employed during the course of their training (i.e. people may complete courses on a pre-employment basis); whether they pay the costs of their own training; and whether costs of attendance (including paid time off) are met by their employer.

In recognition of the need for workers to complete some minimal level of training to work in the sector, an accredited induction skill set,[11] *CHCSS00081 Induction to Disability*, was approved in 2015. It is currently offered by 280 RTOs and comprises four units of competency from the Health and the Community Services Training Packages, all focused on NDIS-specific aspects of the cultural change needed in the sector. These are:

- CHCCCS015 - Provide individualised support
- CHCCOM005 - Communicate and work in health or community services
- CHCDIS007 - Facilitate the empowerment of people with disability
- HLTWHS00 - Follow safe work practices for direct client care.

The *Induction to Disability* skill set is designed for newly appointed disability support workers. It can be included as credit towards completion of the Certificate III Individual Support (Disability) or other national qualifications. Take up of this program by employers has so far been relatively rare.

[11] A "skill set" is not a qualification in its own right, but is made up of Units of Competence that have been developed for a qualification. The fact that students have completed those Units of Competence is recorded, and students receive a Certificate of Attainment when they have completed all Units within a skill set.

OTHER TRAINING IN THE SECTOR

In addition to these nationally recognised training qualifications, several other training initiatives have been developed in the sector over recent years.

An additional orientation program, the *Disability Induction eLearning Program,* has been developed by the NDS. It is available through *Carecareers* (a web-based platform associated with the NDS), and is designed for potential as well as newly recruited employees. It consists of five modules that can be completed on-line, in a space of around 4-5 hours, and is largely an introduction to the principles of person-centred support. It has primarily been designed as an introductory training resource for employers, and the pricing structure for access to the modules reflects this.[12] Unsurprisingly, the vast majority of those completing the program are enrolled through organisations. Anecdotally, this is said to reflect the fact that some larger organisations are enrolling all newly recruited staff as a matter of course, with some also using it as part of pre-employment screening tools.

The NDS eLearning induction is a course rather than a qualification: it is not recognised within the Australian Qualifications Framework, and has no formal assessment requirements. Its role is limited to being an information and awareness raising tool for prospective and new employees about the principles underpinning services being offered to people with disability. Anecdotal evidence suggests that it is typically used in isolation from nationally recognised training packages. Two additional concerns with the program were also noted by previous participants: it can be completed on-line without any opportunity to discuss the content with an experienced worker or supervisor, and it does not include any work placement component to expose new workers to the reality of disability support work.

In addition to these induction initiatives, two internet based “hubs” have been established that provide support workers (including those new to the sector) with a range of information about courses, an introduction to the principles of the NDIS, and a catalogue of workshops, webinars and on-line learning opportunities that they could pursue. [13] Anecdotal evidence suggests that some providers are establishing committees and reference groups to identify training needs and are also putting employer-specific training in place. Little is known about the number of these courses, how many people attend them and the quality of teaching, learning and assessment. In addition, a number of providers are making increased use of digital and on-line learning. While these have the advantage of reaching a larger number of people

[12] Single user access costs $50; groups of 10-50 users are charged at $45 per user; and larger organisations can pay a flat fee for a corporate licence for unlimited users for 12 months.

[13] https://www.ndp.org.au/learning-hub and https://www.carecareers.com.au/courses/

(particularly people in remote areas) at a lower cost than face-to-face training, they may also contribute to support workers feeling isolated from their colleagues and others in the industry. Some employers are dealing with this by holding staff conferences, in which large groups of staff are brought together, and training makes up a significant component of these events.

SKILLS IMPLICATIONS OF CONSUMER DIRECTED SUPPORT

Earlier in this report we noted some of the implications on training and development of the NDIS rollout – particularly as a result of the pricing model and new mechanisms for ensuring service quality. This section goes into more detail on those issues:– namely, the implications of the consumer-directed funding model for the skills of the workforce; and the need to recruit increasing numbers of disability support workers, many of whom will have no previous knowledge of the sector. It also summarises the limited initiatives that have been put in place to support skills development as the NDIS was rolled-out, and how these represented lost opportunities to invest in genuine training. Lastly we analyse how the pricing model and the quality and safeguarding framework are undermining in practice the goal of developing highly qualified workforce, delivering high-quality services.

As noted earlier, the introduction of consumer-directed support has implications for workforce skills. Because packages of activities and supports are designed around the individual needs of people with disability, the skills needed by the workers supporting them can vary widely. This has led to a perception in the industry that worker "attitudes" are considerably more important than formal training and qualifications in delivering high quality supports. We strongly disagree with this sentiment and argue that to employ people without qualifications (or at least undergoing training) poses an unacceptable level of risk to those that they are supporting, as well as undermining the quality of jobs in the sector. Consumer-directed support requires a wide range of skills. These range from essential areas of knowledge required by all workers in the sector, skills and competencies (foundation knowledge) needed by anyone engaged in direct contact with people with disability, and more advanced skills and knowledge required by people providing support for people with specific conditions or disability-related needs.

There are some general areas of knowledge that all disability support workers must possess regarding the NDIS and the principles on which it is based – irrespective of whatever other skills and qualifications they have. This includes the insurance values underpinning the NDIS, the commitment to increasing community and economic

integration and participation, and the promotion of independence and self-management for people with disability (Windsor 2014b). As noted earlier, these knowledge areas are included in the recognised skill set developed from Units of Competence that are part of the Health and Community Services Training Package, that can be recognised in worker accounts on the Australian Qualifications Framework and can built on to complete the Certificate III or IV qualification.

The nature of consumer-directed support also requires support workers to have a range of other skills however, and the changing nature of these has been considered by both employer and worker organisations. Surveys of workers undertaken by both the Australian Services Union and the College of Community and Disability Practitioners note the importance of "soft" skills such as an understanding of person-centred and human rights approaches to disability support, interpersonal skills, verbal communication, active listening and being able to manage challenging behaviours. Others, required by workers to undertake changed roles demanded by the introduction of the NDIS, include record-keeping, written communication, time management, computer skills and financial management.

Questions about the ability of support workers to meet the needs of people with complex physical and emotional health needs have also been raised; and responding appropriately to these challenges is one of the key aims of the new training system we propose. This requires support workers to have more advanced skills in aspects of support needed by individuals with specific conditions (eg. autism spectrum disorder, motor-neurone diseases, and others). Some workers may have a particular interest in developing expertise and specialist skills. If the NDIS is to adequately respond to the needs of people with complex needs, training pathways that extend beyond Certificate IV into Diploma and Advanced Diploma level (and corresponding career opportunities that reflect those qualifications) are needed.

In general, the policy shift to consumer-directed support requires a re-think of the knowledge and skills required by the disability support workforce. SkillsIQ, in association with its Industry Reference Committee, is the organisation whose formal role it is to forecast skills requirements for the future. Over recent years, it has undertaken several research projects, based on both an examination of the literature, and interviews with industry stakeholders. Based on an industry stakeholder survey about the skills that would be most needed in the next 3-5 years, interpersonal skills, customer service, communication skills, technological fluency, leadership and flexibility were seen as most crucial (SkillsIQ 2017b),[14] as summarised in Table 1 below. This list

[14] Although this survey was carried out across all industries, 258 of the 1,480 respondents identified themselves as providing direct client care and support services.

of required skills has a high degree of congruence with the skills identified in our discussions with key informants (including several existing disability support workers).

Table 1:

Skills Required by Workers Delivering Care and Support Under Consumer-Directed Support Models

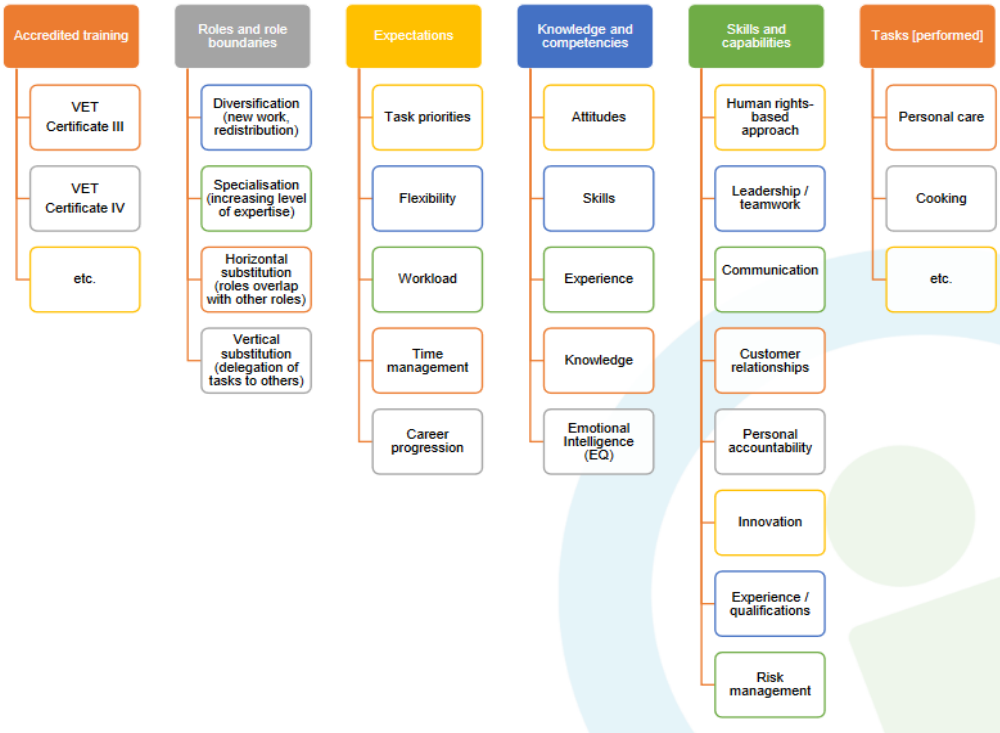
Flexibility (with work times and roles)
Person - centred approaches
Technical proficiency
Cross-sectoral skills and ability (generalist skills and shared competencies for cross - sectoral support)
Understanding the interface between the health sector, aged care and the disability sector
Time management
Understanding about relevant systems and schemas (particularly for 'wrangler' or 'coordinator' roles)
Record keeping (including budgets)
Ability to work independently, autonomously
Strong interpersonal skill set (to build trust and nurture relationships)
Developed communication skills
Cultural competence
Emotional intelligence
Advocacy skills
Customer service skills
Client engagement and enablement - focused
Leadership and management skills
Responsive to the needs of the local market.

Source: Adapted from SkillsIQ 2017a.

The SkillsIQ report notes, however, that there is limited empirical evidence about how these skills are used in practice by workers while performing a support role (SkillsIQ 2017a). In addition, Skills IQ argues that some skills that will be needed have not yet been properly specified. For example, given the need for support to be delivered across specialist services, mainstream services and in collaboration with family and community support, one of the skills most critical in the future is the ability to work across sectors in support of the personal goals of people with disability.

Based on its comprehensive analysis of literature, skills forecasts based on internal expertise, reports on the introduction of the NDIS and interviews with providers involved in NDIS trial sites and other NDIS stakeholders, SkillsIQ has proposed a model (summarised in Figure 1, below) for training needs analysis for the disability support sector, organised into several major domains of knowledge and expertise. It proposes that this model form the basis for empirical research over time to ascertain those skills and competencies that are most necessary for support workers to deliver high quality supports. Importantly, by cross-matching these domains against nationally recognised accredited training, the model establishes a foundation for the establishment of a skills ecosystem for the sector, based on vocational pathways (and corresponding career structures) for workers in the disability support sector.

Figure 1: Analysing Training Needs in Disability Services



Source: SkillsIQ 2017a.

FUNDING FOR SECTOR DEVELOPMENT

The consumer-directed support model also has significant implications for the nature of relationships between people with disability, providers and support workers; and has required what has been rightly described as a culture shift in the industry. In support of this shift, in 2015 the NDIA set out an integrated market, sector and workforce strategy as a vision of what it expected a "mature" and robust disability support market would look like, and how it would function (NDIA, 2015).

The workforce development aspects of the strategy include a number of dimensions. In addition to vastly increased workforce numbers, there is a need for a changing workforce profile that could respond to the needs of a diverse participant base (e.g.; ability to respond to the needs of people of different ages, ethnicities, and needs); and that could meet newly expressed and more complex needs for support. All of these changes would require an innovative approach to workforce management, developing new and differentiated functions and roles, re-designing work and re-deploying workers, and new models of supervision and management.

The integrated strategy is very much based on the recognition that a quality workforce is essential for the delivery of quality services. A Sector Development Fund was put in place in support of the strategy, to assist participants, providers and the overall workforce to transition to the new operational environment. This fund provided $149M over a period of 5 years (2012-13 – 2016-17) to be directed towards a mix of workforce, provider and participant development needs:

- Increase the capacity of people with disability and their families to exercise choice and control, both in engaging with the NDIS, and in purchasing supports in an open market in order to realise their aspirations.
- Develop a market capable of providing the necessary supports required for full scheme.
- Increase the mix of support options and innovative approaches to provision of support.
- Increase the disability services workforce, making it more diverse and better equipped to meet the needs to people with disability.
- Develop an evidence base to inform an insurance approach to disability support (Department of Social Services, 2015, p. 5).

Despite the acknowledged centrality of a skilled workforce in delivering high quality support, an examination of the operation of the Fund suggests that workforce development requirements were viewed as secondary to community, provider and participant capacity building. The operational guidelines were specific in preferencing

innovative projects that did not duplicate any activity previously funded. This meant that the fund could not be used for ensuring that the workforce had nationally recognised qualifications, and ignored the fact that a critical aspect of expansion of the workforce for sector development simply included a need to scale up existing training provision for new recruits. In addition, a large proportion of funds available through the Sector Development Fund were provided to State-level authorities for disbursement. States applied local priorities for the allocation of funds, while the national priority for ensuring an increased number of skilled workers was left unaddressed. This represented a significant lost opportunity. While the existing system for training disability support workers in nationally recognised qualification may have its faults, providers largely support it as a means of training workers in the necessary skills to undertake disability support work. Had more of the fund been allocated to support development and acquisition of nationally recognised qualifications, this may have helped to addressed some of the problems around recruitment and retention that providers are facing now.

The Fund was additionally intended to support the development of new models of supervision and work organisation. This led to the allocation of $5M of the Sector Development Fund to establish the *Innovative Workforce Fund* to fund projects across four funding streams:

- Redesigning support worker roles and testing new work roles.
- Streamlined practices in areas such as human resource management, recruitment and retention of staff and workforce practices.
- Use of technology in workforce practices.
- Workforce development in rural and remote areas.

Of the total $5M funding, $1M was paid to the NDS to administer and manage a competitive application process. There was maximum funding of $200,000 for each funded project and all projects were required to be completed by June 2018. Two funding rounds have been held. The first, announced in July 2017, provided funding to 21 providers, with funding to an additional eight providers announced later in the year. Only headline information is available, however, on the specifics of these projects,[15] and only a minority appear to be directed towards innovation that will provide tangible benefits for the workforce. Neither is information available about plans for evaluations of projects against the objectives of the Sector Development Fund.

[15] See https://www.dss.gov.au/grants/grants/closed-funding-rounds/innovative-workforce-fund-management

Overall, many questions should be asked about whether the Fund has represented good value for money. There is evidence that administration of the Fund has been highly unstable, with administration being undertaken by the Department of Social Services from 2012-13; moving to the NDIA in 2013; and being transferred back to the Department in 2014. Little aggregate information is available on what projects have been funded, the extent to which they have achieved each of the five outcomes that the Fund was directed towards achieving, and why some outcomes were accorded higher priority that others (for example, provider development as opposed to workforce development). As a whole, use of the Sector Development Fund has been a lost opportunity to take a nationally consistent approach to systematic training of a large number of newly recruited workers necessary to support sector development over the long term.

While the integrated strategy for sector development set out by the NDIS was laudable, in many ways it represented "magical thinking": lacking understanding of the operation of real labour markets or the complexity of organisational and industry-wide change and development. For example, the strategy suggests that providers could demonstrate innovative models of service delivery that "…make better use of the talent and skills of the workforce and to stimulate innovation" (NDIA, 2015, p. 21). While the involvement of the workforce has been demonstrated in a number of industries to make a significant contribution to innovation in work processes and organisation, this is most likely to occur in workplaces where workers have a full-time and well-paid job, a degree of employment security that results in them being invested in the future of the organisation, and successful experience with expressing their collective voice in organisational decision-making processes.

ADDRESSING QUALITY ISSUES

As noted earlier, the most important indicators of quality in caring professions relate to the training of staff. This includes both induction and initial foundation training; and the establishment of workplace support for ongoing professional development (such as supervision, reflective practice and opportunities for team support). The draft QSF and Code of Conduct are based on preventative and corrective components of the Framework, rather than developmental ones. This is likely to create a reactive quality culture, focused on screening and complaints, rather than a proactive strategy that supports skills development and capacity building. Essentially the difference between the two is the difference between quality control processes (in which services are measured against whether they meet participant expectations, based on a "tick box" approach) and quality assurance (in which services are measured against a diverse range of quality indicators and processes designed to limit the risk of service failure).

The quality goals for the NDIS are unlikely to be achieved without building a strong induction and training infrastructure that provides all workers in the industry with the skills and knowledge to deliver support services informed not only by knowledge about the principles of the Act, but also by up-to-date and accurate information about the participants to whom they are providing support and working in collaboration with family members and other specialist and mainstream providers. The risks of not doing so can be immediate and consequential. We note, for example, the findings of a recent Coronial Inquiry,[16] where lack of training and back-up for support workers, and poor workplace systems and procedures were implicated in a death at a residential facility.

The draft Code of Conduct in particular has significant implications. It includes reference to the need for providers to ensure that staff have appropriate supervision and training to make sure that support workers can identify, monitor and act when situations arise that could result in breaches of the Code. However, the ASU, in its submission to the Senate Standing Committee on Community Affairs (ASU, 2017), presented evidence showing that only 12 percent of workers felt they were adequately informed about the draft Code. Training needs to address this: providing both information about the Code itself, and the service standards that workers are expected to comply with. However, there are a number of other aspects of the draft Code which exacerbate the risks associated with an inadequate training infrastructure. These include:

- Lack of consultation with workers and their representatives in the development of the draft Code.
- The need to ensure procedural fairness in dealing with any complaints that are made against a worker alleging a breach of the Code.
- Adjustment to the pricing arrangements to ensure that workers and providers have sufficient time to be informed about and meet their quality and safeguarding obligations.

TRAINING IMPLICATIONS

As noted previously in this report, the NDIS pricing model has had significant consequences for training and development in the sector. The most significant of the concerns voiced by workers was a cut-back in the time allocated for training; team meetings having all but disappeared; supervision has been severely curtailed; and large numbers of casual workers are being newly employed with almost no supervision at all. These concerns were corroborated by employers, over a third of whom agreed that

[16] http://www.coroners.justice.nsw.gov.au/Documents/Veech_findings_redacted.pdf.

support staff were not paid to attend regular team meetings or attend training and development activities (Cortis et al., 2017).

Inadequate training and support to do the job will have immediate consequences for quality support services. It means that support workers do not have adequate information to provide support for some NDIS participants, particularly those with complex needs. Neither do they have time to meet with other workers in a support team; or with other people in their organisation. All this is viewed by workers as important for reducing their sense of isolation, for sharing information about those to whom they are providing support, and developing new ideas and strategies about innovative practices.

The reality is that rhetoric about the need for a well-skilled workforce as an essential part of the NDIS has never been matched by the reality of implementation. A well-trained workforce is essential for achieving the quality of support promised by the system, but the experience so far in Australia supports international findings that consumer-directed delivery models tend to pay little attention to the need for long-term workforce development. Market forces cannot autonomously resolve these fundamental shortcomings; it will require pro-active attention and fiscal support to lead the ongoing investments in skills upgrading that the sector requires.

V. A New Model for Training and Qualifications in Disability Services

The previous sections identify existing skills and training practices in the Disability Support Sector; including issues and challenges arising out of the NDIS roll-out. This section looks forward, making recommendations to strengthen training and development as a foundation for delivery of high quality disability support services. We argue in favour of a more systematic approach to training investment, based on the needs of the sector as a whole and creating a comprehensive skills "ecosystem". Significantly increased government funding for training is needed over the long term in order to achieve the quality of service that has been promised as part of the NDIS. The argument here is for a systematic and holistic approach; based on the following elements:

- Ensuring that investment is directed towards nationally recognised training, overseen by industry-recognised authorities, and builds integrated career pathways for workers.
- Large-scale roll-out of induction and foundation training to ensure that new hires have a minimum level of skill and knowledge as they start work with NDIS participants.
- Mandatory minimum qualifications and registration of disability support workers
- Establishing a separate and protected Capacity-Building Fund, housed within the NDIA, to fund training activity across the sector – including courses for individual workers, and group training and capacity-building at the organisational level.
- Implementing an ongoing system for workers to accrue portable entitlements for training, based on the number of hours that they have delivered NDIS-funded supports, transferable across providers and jurisdictions; and ensuring workers have the opportunity to utilise those credits in accumulating ongoing qualifications.
- Developing a new planning and administrative body, the Disability Services Training Administration (located within the NDIS Quality and Safeguards

Commission), to oversee training standards, curriculum development and qualification benchmarks across for the sector, in collaboration with existing VET regulatory authorities.

THE IMPORTANCE OF A NATIONAL TRAINING FRAMEWORK

There is a need for large-scale and long-term investment in training for the disability support sector to support implementation of the NDIS. Without this, the sector cannot attract sufficient numbers of workers to provide either the quantity or quality of support services needed in order to meet increasing demand. Inability to attract labour is symptomatic of a poorly functioning labour market in the industry. Lack of specified minimum skills requirements means that barriers to entry are low, even for people who have few employment alternatives. It sends a signal to prospective employees that the work is undemanding, when in fact this is far from the truth. Unrealistic expectations about what is required of workers in turn leads to high turnover. In addition, many potential employees are discouraged by poor wages and conditions in relation to work demands, lack of employment security and few opportunities for advancement.

The importance of training for high standards of service delivery in the sector is not contested. The roll-out of the NDIS is based on a well-established evidence base that high quality services support the achievement of life-time goals by individuals living with a disability. Nevertheless, international studies suggest that the skills and training of support workers can shape whether these changes improve or worsen the position of NDIS participants. In particular, three main factors have important effect: the extent to which cost containment underpins the scheme, the regulation and monitoring of service delivery, and the regulation of employment (Macdonald and Charlesworth, 2016, p.629). In the Australian case, evidence collected so far suggests that quality of plans is being compromised in an attempt to meet quantitative targets (Productivity Commission, 2017). In addition, it is the disability support workforce itself that will shoulder the costs of increased flexibility for NDIS participants, with many of the risks associated with increased flexibility (e.g.; last minute changes to the hours during which support is delivered) being transferred from organisations to workers (Cortis et al., 2013).

Australia's Vocational and Education Training (VET) system has evolved significantly over the past 50 years, in response to changing economic and social conditions. One of the most significant of those changes has been the shift from state-based systems to a national training system from 1992 onwards. There were very good reasons for doing

this, which remain relevant today. In particular, having a training system operating at the level of the Commonwealth efficiently delivers qualifications to address national labour shortages, and helps to achieve portability of VET skills across the nation, thus promoting labour mobility (Bowman and McKenna, 2016). It also ensures consistency in training outcomes, so that individuals do not face barriers when moving between jurisdictions and jobs. Bowman and McKenna (2016:43) go on to summarise other advantages of a national system as being:

- *responsiveness*: to industry, individual and community needs.
- *equity*: of access, participation and outcomes for individuals.
- *quality*: in training delivery and learning outcomes.
- *efficiency and public value*: for government-funded VET to be efficiently priced and steered to skills areas that support job outcomes, where this would not be the case if left entirely to enterprises and individuals.
- *sustainability*: by funding the VET system through shared investment by governments (where there is public value), enterprises (private value) and individuals (private value).
- *transparency*: to enable better understanding of the VET system among students so they are able to navigate the system and make informed decisions.

The Australian system can also be placed in the context of the development of VET systems world-wide to respond to the changing economic conditions of the 21st century. As Stanley (2016: p.125) notes, these have often been based on the need for professional standards to be recognised across national borders. Most countries have developed systems for licensing professional standards through accreditation and registration of both training organisations and workers themselves. Training organisations can only be registered where they can provide evidence that they have the capacity to deliver graduates of VET that can meet the standards set by employers across the industry. This commonly includes requirements related to a robust training infrastructure, suitably qualified instructors, course entry requirements and other requirements considered appropriate for effective outcomes.

The foundation for training in the disability support sector should be rooted in national qualifications, accredited on the Australian Qualifications Framework, developed by the appropriate industry regulatory authority on the basis of Units of Competence taught by Registered Training Organisations that have been quality assured by ASQA. The argument that having a national system in place reduces local flexibility cannot be sustained. Bowman and McKenna (2016) have pointed to the advantages of the dynamic tension that exists between consistency and flexibility. For example, providers with a NDIS participant base with specific needs (e.g. meeting the needs of a particular demographic group, or people with a specific type of disability) can provide training for

additional skill sets, on top of the general skills required by all disability support workers.

It is essential that the RTOs registered to deliver qualifications do so to the highest standards possible, and in this area there is room for improvement. We appreciate that the existing VET system in Australia, generally and within the disability support sector, is not without its detractors. Some of these problems have occurred as a result of underinvestment in VET. However, opportunistic behaviour by private, for-profit providers has also contributed to exploitation of vulnerable groups of workers (Myconos et al, 2016; Noonan, 2016). International evidence has also suggested that smaller for-profit training establishments deliver poorer educational outcomes as a result of under-capitalisation poor connections to the wider needs of the industry (Stanley, 2016). In respect of the disability support sector in Australia, particular concerns have been raised about the quality of assessment. We therefore suggest the need for attention to be paid to the following issues identified by the industry:

- Tutors within VET programmes are expected to have practiced the skills that they are teaching to students. Because of the newness of consumer-directed support, there are a limited number of tutors currently working in TAFEs and other RTOs who have experience in this way of working. Efforts must be taken to ensure that tutors (and senior practitioners in provider organisations who are supervising students completing initial training programs) have sufficient knowledge and skills in this area to be able to work with and assess students.
- Compulsory workplace placements have a high degree of support within the industry. However, the quality of assessment of workplace-based competencies may need to be given greater consideration to ensuring validity and reliability. In particular, workers need to be able to not just demonstrate their competency in undertaking specific tasks; but also to demonstrate that they have task management skills (planning and organising, balancing conflicting demands); contingency management skills (knowing how to respond to unexpected events, correcting problems) and job environment management skills (interpersonal skills, team working) that allow skills transfer across different providers (Stanley, 2016, p.132).
- Given the poor experience with private vocational training in Australia, funding should be limited to publicly funded TAFEs and selected not-for-profit RTOs (especially those affiliated to non-profit providers).
- Billett et al (2015) notes that the current VET system is geared towards entry-level learners, participating in training shortly after completing school. This is not the case for workers in the disability support sector, some of whom may be participating in learning having left compulsory schooling some years in the

past, and some of whom may use English as a second language. The needs of older and CALD learners may also need to be specifically addressed by TAFEs and other RTOs in order to facilitate successful engagement with learning by a workforce that is expected to be more diverse in the future.

- There is a need for vocational pathways that extend beyond Certificate IV. We note that the Community Services Training Package already includes some Diplomas and Advanced Diplomas, but these assume a career pathway that moves from direct support into supervisory, policy or management roles. While these are important, there is also a need for pathways into advanced "vocational streams"[17] with higher skills or specialisations at Levels 5 and 6 of the Australian Qualifications Framework, that can be applied in direct support roles (rather than in supervisory roles). Given the increasing concern in Australia with greater continuity across the VET and Higher Education sectors, this would allow workers, if they so choose, to build skills in their chosen areas in ways that could ultimately be recognised for University level study (for example as clinicians). There is an opportunity to do this through the Direct Client Care and Support Industry Reference Committee, on which both the Australian Services Union and the Health Services Union are represented. In particular, electives at this level could be developed to enable workers to develop support specialisations – for example in support for people with particular conditions, or demographic groups.

We believe that with these improvements (and in particular limiting funding to public and selected non-profit training providers), the current national system offers the best hope for building a supportive infrastructure to train the large number of new workers that are entering into the disability support sector.

Recommendations:

1. All recognised foundation training for the industry should be based on qualifications that are registered through the Australian Qualifications Framework.
2. All training should be conducted by public or selected non-profit RTOs, and quality audits undertaken by ASQA to ensure that RTOs have the training infrastructure to deliver educational outcomes that are of the highest possible

[17] "Vocational streams" require and understanding of the knowledge, skills and attributes underpinning related occupations; and stakeholder collaboration and cooperation on workforce issues across a range of institutions (such as government, employers and unions) in a sector (Yu, 2015).

level of quality. Incremental funding should be prioritised towards TAFES as the highest-quality publicly funded RTOs.

3. Vocational pathways available to workers should be extended through the development of qualifications at Diploma and Advanced Diploma level on the Australian Qualifications Framework.

INDUCTION INTO THE INDUSTRY

The draft Quality and Safeguarding Framework recommends the introduction of a compulsory industry induction, to provide a basic knowledge base essential for working in the industry. We are strongly in support of this proposal. The industry desperately needs to recruit more workers, and to retain those workers over time, to avoid a high proportion of organisational resources being spent in constantly recruiting staff. In addition, a number of newly employed workers have had little or no contact with the industry in the past, and are therefore being employed in a completely unfamiliar environment. Anecdotal evidence reports many newly engaged workers leaving the industry after a very short period of time on the job, having been "thrown in at the deep end." Universal induction would provide newly engaged workers with more comfort and confidence as they embark on the learning curve of their new roles.

Regarding the content of induction training, we noted earlier that there are two existing "induction" packages available for the industry. In our view, these two packages represent very different notions of what constitutes an "induction". While the NDS package provides some very basic information about disability support, it does not equip workers with skills and knowledge that would enable them to work in even the most basic jobs in the industry.

The accredited skill set put in place in 2015, tied as it is to the Australian Qualifications Framework, provides a more substantive foundation for induction training that goes some way to providing workers with the skills and knowledge that adequately equip them to successfully carry out entry-level positions. We believe, however, that the content of this skill set should be extended in two areas. The first of these would be educating workers about the requirements of the Code of Conduct, providing them with a good understanding of their obligations and what is expected of them. The second is the introduction of a workplace placement for completion of the induction skill set, ensuring that new workers have some contact, under supervision, with people with a disability, and an understanding of the service standards that are expected of

them in relation to that person. We further recommend that all discussions on the content of induction training should include representatives of NDIS participants.

Regarding training delivery, we note that currently the Induction course is delivered via 280 different existing RTOs. Given the large number of employees that will need to enrol in the induction program over a short period of time, capacity building support will be required to train additional industry trainers to deliver induction training; this is especially true within workplaces employing large numbers of new staff, and in rural and remote regions that currently have limited access to RTOs.

Enrolment in induction training should be available on a pre-employment basis for prospective employees considering a career in the industry. This would allow people who have an interest in working in the industry, but who are uncertain or unconfident, to get a better understanding of what work in the industry involves. The workplace component would need to be managed through connections between RTO trainers and local workplaces. This would also deliver advantages to employers, who may be more willing to employ someone who has invested some of their own time in having commenced an induction programme. The cost of induction training for people who have not been hired in a disability support role would be borne by themselves, or by employers who choose to use the induction program as a pre-employment screening mechanism.

Compulsory induction should be completed within 6 months of commencing a job in disability support; workers would not be able to work with clients without close supervision until the induction was completed. New employees would be paid for the time spent on the induction program.

Recommendations:

4. That the content of the new compulsory induction be reviewed (in consultation with all stakeholder organisations, including representatives of people with disabilities) to ensure that it includes a workplace component, and information about the requirements on workers under the proposed new Code of Conduct. Assessment standards should also be introduced to ensure that the learning objectives are achieved by all students completing the induction.
5. That it should be compulsory for employers to support workers to successfully complete the induction programme within 6 months of being newly employed.

OCCUPATIONAL REGISTRATION AND MANDATORY MINIMUM QUALIFICATIONS

As discussed above, there is a strong case for requiring disability support workers to achieve foundation qualifications recognised under the Australian Qualifications Framework. A separate question is whether employment in the industry should be conditional on the achievement of these qualifications; and whether registration on the basis of holding a relevant qualification is necessary. Occupational licensing is common in a number of areas – health care, education from pre-school through to secondary schooling), social work, real estate, and across most trades (e.g.; building and construction, plumbing, electrical work). Occupational licensing requires workers employed in a job to demonstrate that they are suitably qualified to work in that occupation/industry, having achieved a nationally (or internationally) recognised qualification prior to employment in the sector.

Occupational licensing has been the subject of discussions in the disability sector for some time. In the early 2010s, the NDS established a project entitled *Roadmap to a Sustainable Workforce*, which amongst other things, considered entry requirements for the disability sector workforce (Windsor and Associates, 2014b). The working party whose discussions formed the basis of the report noted that most employers already had in place basic training and induction to ensure compliance with regulations associated with the disability sector – including manual handling, first aid, infection control, administration of medication, food safety, fire safety, and health and safety. It also noted considerable interest in developing a standardised industry-based approach to induction, for the purposes of managing costs, improving quality and reducing duplication of training to facilitate the movement of workers between employers. While the desirability of this as a basic minimum qualification for entry into the sector was recognised, the introduction of the NDIS made it more difficult. Creation of an explicitly competitive market between service providers meant that inevitably providers would use initial induction and training to embed organisation-specific service standards and values to differentiate them from their competitors. In addition, the philosophy of the NDIS, based on consumer-directed support, implies that while workers require a common core of knowledge, the needs of individual people with disability vary, and so inevitably must the skills needed by their support workers. As noted earlier, however, it has now been proposed that an industry induction be made compulsory.

Suggestions for a mandatory minimum condition of entry for the industry have been controversial within the industry. This is despite the fact that, as discussed earlier, almost 80 percent of the current workforce have already completed some form of

vocational or tertiary training (Macdonald and Charlesworth, 2016, pp. 636-637). For example, the 2011 Productivity Commission report recommended against a qualifications requirement or compulsory training for disability support workers (Productivity Commission, 2011, p. 693). The NDS's *Roadmap to a Sustainable Workforce* project (NDS, 2014) also argued for maintaining low barriers to entry to the disability support workforce, despite recognising that training was critical for the maintenance of quality.

In our view, however, these expose the half-hearted commitment of many industry observers to training. While nominally acknowledging the importance of training to the quality of delivered services, these approaches nevertheless focus on containing costs more than optimising service quality. Overall it is difficult to escape the conclusion that opposition to mandatory qualifications is not based on the desirability of minimum standards per se, but rather motivated by reducing the costs for employers associated with training in the context of the current, inadequate NDIS pricing model.

Concerns with the cost of training can be addressed through increased funding to support high-quality training and a modern, flexible regime of qualifications, such as is proposed in this report. Input from NDIS participants and their organisations into the definition of minimum qualifications would also be important in ensuring that the workforce better matches the needs of participants as the training and qualifications system is implemented. Others have expressed concern about the unreliable quality of vocational education provided through "fly-by-night" private VET providers (in the wake of the VET fee-help scandals and other instances of private market failure in vocational training). Again, the solution to these problems is not to abandon the goal of minimum qualifications for workers who provide such critical human services, but rather to ensure that the training system is organised around reliable, high-quality public institutions which deliver training on the basis of a public policy mandate (rather than to earn quick profits); this is why the training system proposed here is centred around public and selected non-profit vocational training.

In this respect, an important precedent has been set by the Victorian Government's announcement that it will establish an independent, legislated registration and accreditation scheme for the disability support workforce in that State.[18] This decision emerged from a 2016 Parliamentary Inquiry into Abuse in Disability Services, following which the government announced a "zero tolerance" approach to the abuse of people with disability. This approach to managing the risk of abuse highlighted, in their view,

[18] See https://www.vic.gov.au/ndis/registration-and-accreditation-scheme-for-victoria-s-disability-workforce.html.

the necessity of a registration process to ensure that only workers with sufficient skills and competencies work within the industry. The registration and accreditation scheme is expected to help drive continuous improvement, especially as the disability workforce grows so quickly. The consultation paper makes a clear connection between satisfying the needs of the workforce and the delivery of high quality services. It sets out goals for the disability workforce as including:

- Workers uphold participant rights and treat them with compassion and respect.
- Disability work attracts talented, compassionate people.
- Workers can build a productive and rewarding career in the disability sector.

These goals will be met through a regulatory system that has the following functions, based on international practice in similar jurisdictions:

- Setting enforceable qualifications for entry into the profession and for registration.
- Pre-registration screening (e.g.; police checks, worker screening).
- Accredited education and training programmes (as discussed earlier).
- Maintaining a public register of qualified workers.
- Providing practice guidelines.
- Monitoring ongoing fitness to practice.
- Managing complaints and disciplinary issues.
- Managing prosecutions.
- Collecting and analysing workforce data for the purposes of service and workforce planning.

While the decision to include registration and accreditation requirements in Victoria has been made, a consultation process is asking for feedback from the sector to ensure that the system operates in a way which supports the needs of the workforce, providers and participants. In particular, it raises questions about whether registration should be required for all workers in the industry (including those working in specialist services where there are already existing accreditation processes; and workers who do not have direct contact with NDIS participants); or should be targeted at those performing high risk work (such as those working with those who are particularly vulnerable, participants requiring medication, and people for whom personal services are being performed). Discussion is also being held about whether distinct classes of registration may be needed. For example, provisional registration could be offered to those who are working in the industry and completing an initial qualification under supervision.

Secondly, consideration is being given to whether registration should be mandatory or voluntary. In either case, registration (with public access to the register) would provide assurances that a worker has met registration standards; and only those workers would have the right to use one or more reserved professional titles (e.g.; Registered Disability Support worker). Under a mandatory registration scheme, only registered workers would be able to be employed. Under a voluntary registration scheme, service providers would be entitled to offer employment to unregistered workers (except workers who have lost their registration as a result of misconduct), but those workers would not be able to use reserved professional titles. This would send a signal to NDIS participants that workers were not registered and provide them with more informed choice about the level of skills and knowledge that a worker has.

Introducing a new comprehensive system for accreditation and registration based on minimum qualifications for disability support workers will require time, and transition arrangements will be necessary for workers already employed in the field. In particular, workers who have been working in the industry must have ample opportunity to have their existing experience and skills formally recognised. In addition, many new workers bring to the job skills and knowledge that they have gained in other contexts. Australia's VET system has existing processes for recognition of prior learning (RPL), to give workers credit for skills and knowledge they already possess. Efforts to support workers to apply for RPL in relation to the Units of Competence that will be included within Certificate III and IV qualifications for disability services.

Recommendations:

6. That an accreditation and registration regime be introduced to support improvements in quality standards in the disability sector. Registration should be based on the achievement of a minimum foundation qualification at Certificate III level; with the proviso that newly employed workers enrolled in a Certificate III could apply for provisional registration for up to 18 months.

A CAPACITY BUILDING FUND FOR THE SECTOR

This report is based on the premise that the culture in the industry around training needs to be changed significantly. A systematic approach to training investment, based on the development of a skills ecosystem formed around nationally recognised qualifications, is essential for achieving the outcomes of the NDIS. As we have noted earlier, many workers in the sector experience difficulties in accessing training. Barriers

to access include the cost of training, and finding time to study given long hours of work as pertinent. In addition, many casual workers (who comprise 42 percent of the total workforce; NDS, 2018) miss out on training entirely. While many employers have systems in place for on-job training, much of it is perfunctory and employer-specific, meaning that even where workers are experienced, they are not able to demonstrate their skills to a new employer. While the Certificate III is recognised nationally, and a significant proportion of long-term workers in the industry have completed this qualification, we note concern expressed in the sector about the variable quality of training and assessment (including in RTOs).

Finding the financial resources to support employee training is always a challenge for employers in Australia. This is particularly the case in health, community and social services where the prices paid for services are tightly controlled by government agencies. Within the disabiilty sector, this has been made worse with the introduction of the NDIS pricing model. As noted earlier, this has severely limited the aspiration of providers to provide induction and training. Over half of CEOs disagree or strongly disagree that the NDIS provides pathways for staff to advance their careers; and workers identify restricted time for training as a key consequence of the roll-out (Cortis et al., 2017).

There is a strong case for funding training and professional development for the sector from a separate and ring-fenced Capacity Building Fund that is not tied to participant plans. The Capacity Building Fund would be jointly funded by the Commonwealth and State levels of government (in line with the current cost-sharing model for other NDIS services), and integrated with existing NDIS fiscal structures. At the current time, training is supposed to be funded out of participant accounts, on the basis of tiny margins built into the NDIS unit prices. Quite apart from the fact that prices for supports are inadequate for covering non-contact activities in general, this situation creates an unnecessary competition for resources between NDIS participants and the workers who provide them with services; participants should be guaranteed that workers delivering their services are sufficiently trained and qualified to do their job, but not at the expense of the resources allocated to their individual plans.

The challenges to be addressed by the Capacity Building Fund (CBF) are significant, given the underinvestment in training that is a legacy of the roll-out of the NDIS to date, combined with the need to increase the scale of the system's operations in the coming years. The Fund would have two broad areas to direct investment:

- Funding directed towards training individual disability support workers to develop their skills and knowledge on the basis of nationally recognised qualifications. Individual training opportunities would be delivered in three

stages: induction training, foundation training, and an ongoing portable training entitlement to facilitate career-long training and upgrading.

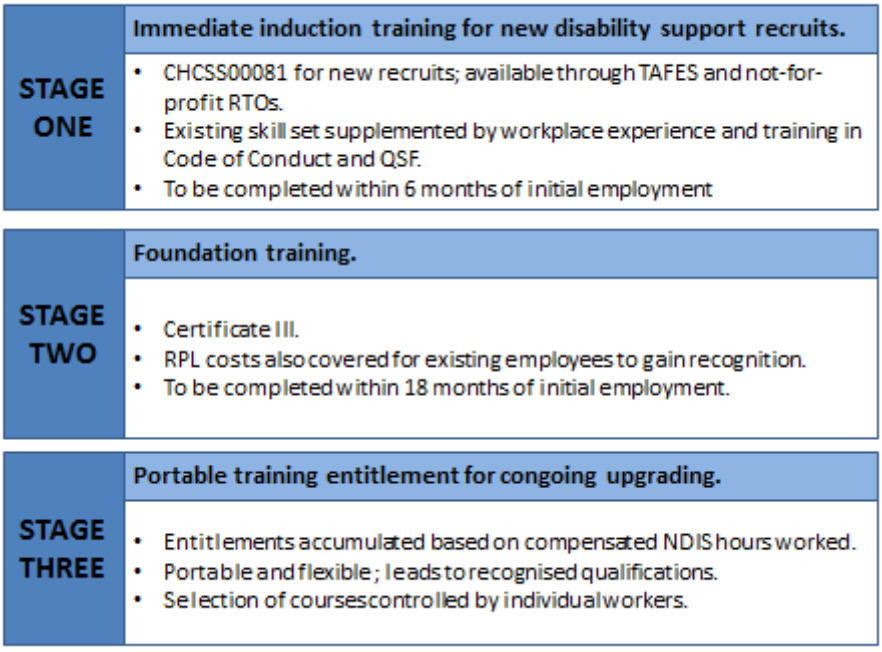
- Funding for building training and professional development capacities in the industry as a whole, at an organisational level. This would provide fiscal support to providers to build their internal capacity to deliver high-quality supervision and professional development in support of quality standards within their workplaces. It would also support the development of training capacity within RTOs to deliver training to workers in the skills associated with the NDIS's consumer-directed model.

The specific functions associated with these two areas are described in further detail below.

Individual capacity building

Because of the scale of investment necessary, we suggest the need for individual training in three stages, as summarised in Figure 2. The first stage would be provision of basic induction training for new recruits to disability support roles. This would be closely followed, in Stage 2, by larger-scale funding for those new hires (if they stay with their jobs) to complete foundation qualifications (Certificate III) at public or selected non-profit RTOs, as will now be required under our proposed mandatory

Figure 2: Three Stages of NDIS Training



qualifications scheme. Then, in Stage 3, investment is directed towards ongoing and continuous upgrading of the qualifications of workers throughout their careers, through a portable training entitlement.

Ensuring coherence and quality within this three-stage structure will require planning and close administrative oversight. Therefore, we also recommend the establishment of a Disability Services Training Administration (DSTA) to oversee the CBF's training investments, coordinate with other agencies within the vocational education and training system, and oversee administration of accumulation and spending of training credits (through individual training accounts for each disability support worker).

Stage One: Induction to Disability

There is an urgent need for an increase in the numbers of workers with sufficient skills to be employed in the industry. Through the CBF, the NDIA would cover the full cost of compulsory induction training in order to address the urgent need for recruitment of a skilled workforce. There is precedent for this approach, in federal government's funding provided for people training for early childhood education during the early 2000s (see Noonan, 2016).

The intent of the investment is to ensure that:

- Funding is delivered separately from the NDIS pricing model (which pays for delivered services).
- A large number of new recruits can access and complete training in a short time.
- Providers have certainty about the quality of teaching/learning/assessment that new hires are receiving.
- Workers that have successfully completed the training have a better understanding of the service requirements that are expected of them; and having achieved an accredited qualification are incentivised to consider a long-terms investment in their employment in the sector.

Stage Two: Foundation Qualifications

In addition to immediate induction training, newly recruited workers must also gain a complete foundation in the knowledge and skills to enable them to provide the high quality, flexible, and individualised supports expected by the NDIS. We recommend the introduction of a registration scheme for disability support workers based on a minimum qualification level at Certificate III level. The NDIA's CBF would cover the cost of in-class teaching and resources (including wage continuation for the workers enrolled in the course); wages paid during on-the-job placement time would be

covered by the employers. Stage 2 funding would also cover the cost for existing workers to have previous training and work experience assessed through the RPL process, to further boost the number of workers with formal foundation-level qualifications.

Stage Three: Portable Training Entitlement for Continuous Upgrading

Stage Three would address the need for developing specialised and advanced vocational streams for the industry, on the basis of ongoing and continuous upgrading of credentials and career paths. This would be achieved by:

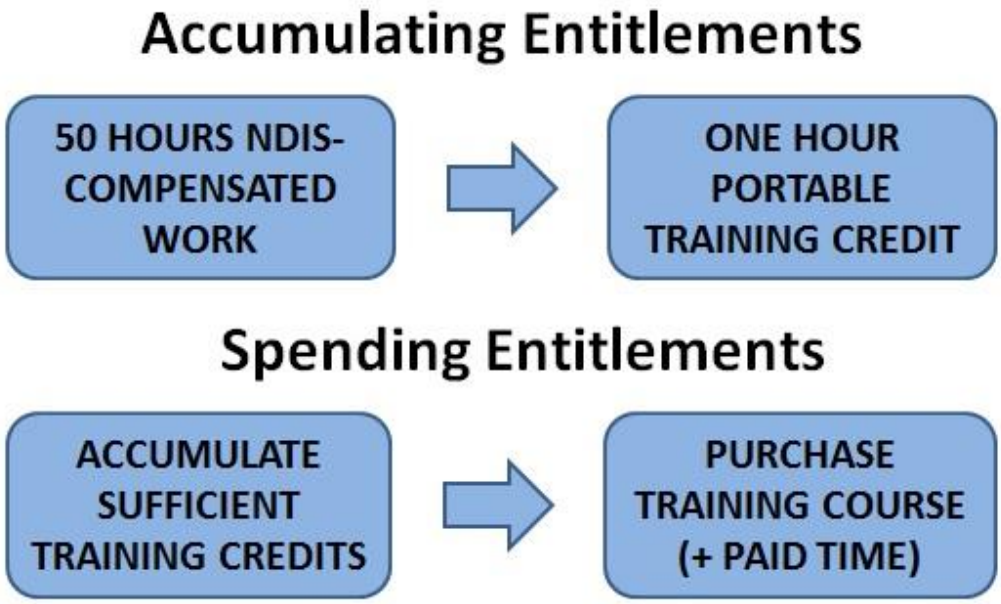
- Establishing an entitlement to paid training, vested with each individual worker, accumulated on the basis of NDIS-funded hours worked.
- Establishing corresponding vocational qualification pathways that extend beyond Certificate IV into specialist Diploma, Advanced Diploma, and University-level qualifications.
- Defining specialised and sub-specialised career paths, integrated with graduated pay scales, so that workers can ultimately get credit for their accumulating qualifications.

To this end, we propose the introduction of a training entitlement, with all workers (including those working on a casual basis) accumulating credit for one hour of paid training, for every 50 hours of NDIS-compensated work. These credits would be "banked" through individual accounts maintained by the DSTA, allowing workers to gain credit for work performed for various or multiple employers. At a 1-for-50 rate of accumulation, this scheme would allow an employee working average hours of work in the industry (around 20 hours per week, according to NDS, 2018) to engage in one 3-day training course (or 21 hours of training) per year. Credits could only be "spent" on Units of Competence that are part of the Australian Qualifications Framework, and delivered through public or selected non-profit RTOs.

Upon becoming employed in a disability support role, workers would supply their unique student identifier (already required as part of the national education and training system) and details of existing qualifications to the DSTA. The DSTA would then create a learning account for each individual, searching previous training records to identify any Units of Competency that might allow the worker to apply for RPL. Workers and their employers would then be notified of the requirement to enrol in and complete the *Induction to Disability* skill set within 6 months. Employers would be required to complete quarterly returns identifying how many hours of NDIS-compensated work each worker has worked over the course of the previous quarter, and their pay; this record of hours worked is converted into credits for paid hours of training at the 1-to-50 ratio. These credits are available to "purchase" training in the

future, with workers choosing the specific topics and timing for training; workers would be paid for the time spent in training by the NDIA (through the CBF), at the average rate of pay they experienced on NDIS-compensated work over the previous year. Once a worker enrols in a qualifying course, credits would be "debited" against a workers account (see Figure 3).[19]

Figure 3: Accumulating and Spending Entitlements



Many other professions have also established requirements and funding mechanisms to support career-long training and upgrading by workers, on the basis of a certain number of required development days each year (including teachers, many medical and allied health occupations, and others). The proposal here to establish a system to support continuous upgrading for disability support work follows the same logic: in an occupation in which the skills and knowledge of service providers is essential to safe and quality care, it is essential that those providers have opportunity to continuously upgrade those skills, develop specialisations, and keep up with new knowledge and leading practices in their field. Of course, the accumulation and spending of training credits as described would be a minimum entitlement only. Should workers and/or providers elect to make additional investments in training above the minimum entitlement at their own expense, that is acceptable, and those additional qualifications (so long as they are attained at approved public and non-profit RTOs) would be fully recognised within the sector's vocational qualification system.

[19] We propose that participation in Induction and processes for RPL are not offset against training credits.

There are several important benefits of this portable training entitlement system. Newly-hired workers will begin accumulating training credits as soon as they have completed their required foundation certificate;[20] existing employees would begin accumulating credits as soon as the scheme is implemented. Disability support workers accumulate credits for work with any employer (including if they work for multiple employers); they would even accumulate credits when providing services as sole traders directly to individual NDIS participants. This flexibility and continuity is essential because of the fluid and insecure work practices that typify the sector, all the more so as the NDIS market system is implemented. Workers employed on a casual basis, or who switch employers (for example, because of changes in personal circumstances for the participants they were working for), or workers providing services directly to NDIS participants (rather than being employed by a provider organisation), are all equally able to accumulate training credits.

The portable training entitlement system is also fully compatible with the flexible, individualised model of service which underpins the whole NDIS model. After all, the NDIS is organised on the principle that services must be tailoured to the specific needs of each participant. For that goal to be realised, it is essential that the workforce providing those services is fully capable of providing a comprehensive range of needed, individual services. This will require ongoing upgrading and development of specialised career paths in dozens of specific sub-disciplines. By endowing individual disability support workers with the opportunity to customise their own advanced vocational path and qualifications, informed by the emerging needs of NDIS participants communicated through the market system, the portable training entitlement system will play a critical role in developing a workforce that can meet the expectations of flexible, individualised care that motivated the creation of the NDIS in the first place.

A critical component of this program is to develop a system of qualifications and matching career paths in a systematic and integrated way. Existing workers who do not have a qualification equivalent to the Certificate III or IV with disability specialisms will be encouraged to complete those or an equivalent qualification (or apply for RPL) as a priority; new workers will be required to complete one within the first 18 months of their employment. Once those basic qualifications have been completed, workers then have personal flexibility in how to use their accumulating training credits. They could be used to pay for any relevant skill sets and qualifications under the Australian Qualifications Framework, or alternatively to undertake specialist courses in specific conditions affecting people with disability, therapists using different modalities, other training that may assist participants with specific needs, or relevant personal

[20] Costs associated with the induction and foundation courses offered to new workers in the sector are directly covered by the CBF, not paid through the individual training accounts.

development activities which individual workers may be interested in. In conjunction with existing VET governance practices, higher-level qualification pathways will be defined so that workers' ongoing training can be reflected in recognised, portable qualifications.

Sector capacity building

In addition to these three stages of training opportunities for individual employees, the program would also provide direct funding to provider organisations for selected workplace-level training initiatives, as well as establishing a system to consistently administer course curriculum and related qualifications. There are two specific sector-wide priorities which would be addressed and supported by the CBF:

The first is to address concerns that have been expressed regarding the variable and inconsistent quality of training and assessment in existing training programs for disability services, and about the ability of existing RTOs to teach the new competencies associated with the NDIS model of consumer-directed support. The CBF would support up-front investments in curriculum, resource, and professional development by publicly-funded and selected non-profit RTOs to upgrade their capacities in these areas.

There is an even greater need for ongoing investments to ensure that provider organisations are able to provide continuous training and supervisory support to their workforce as the transition occurs to the NDIS delivery model. Priorities would include the development of practice standards, establishing new systems for team meetings and supervision, and more.

Support by the CBF for these organisation-level capacity enhancements would be delivered on a grant basis, with interested provider organisations and RTOs submitting applications, and resources allocated from budgeted amounts by an independent jury of sector experts appointed by the DSTA.

Recommendations:

7. That an independent Capacity Building Fund be established under the NDIA, jointly endowed by the Commonwealth and State governments, separate from the funding mechanisms associated with the NDIS unit pricing system.
8. The Capacity Building Fund would cover the full costs of compulsory induction and foundation training for newly hired disability support workers (and the cost

of completing RPL procedures for existing workers), as a means of quickly boosting the number of skilled workers in the industry.

9. The Capacity Building Fund would also cover the costs of a portable training entitlement system, under which disability support workers accumulate credits for paid training hours and then utilise those credits to enrol in qualifying courses.
10. The Capacity Building Fund would also fund organisation-level investments in training capacity, by both public and qualifying non-profit RTOs, and by disability service providers.

COST ESTIMATES

Cost simulations have been developed to estimate the fiscal dimensions of the training program, including estimates for each of the major components, based on reasonable assumptions regarding the number of participants, benchmark training costs, and other parameters.

Several studies have estimated that the overall disability services workforce will double in size in coming years as a result of the full roll-out of the NDIS. This will involve the recruitment and placement of 70,000 new full-time equivalent (FTE) positions. We assume that initial "surge" in hiring is completed over the first four years, following which the flow of new recruits to the industry slows to a steady-state rate of 5,000 per year. Our costing simulations assume that two-thirds of the NDIS workforce consists of individuals performing broadly-defined disability support functions – excluding those in otherwise recognised and regulated allied health professions (who are already integrated into well-defined training and qualifications regimes of their own), and those performing other tasks and functions which do not generally involve direct disability support skills (including office and administrative staff, transportation services, maintenance, etc.). Based on existing average working hours in the sector, we assume that FTE positions are converted into headcounts at a ratio of 1.5. For the induction and foundation stages of training, we assume that all new workers will complete these programs. For the portable training entitlement, we assume a 90 percent utilisation rate of earned credits.[21]

[21] Of course, the goal of the program is maximum take-up of earned credits, but in reality some small proportion of entitlements will never be utilised due to workers exiting the industry, scheduling issues, etc.

Stage One: Induction

This is a minimal induction training package provided to new workers starting with NDIS providers. It would involve 30 hours of on-line and face-to-face orientation to the goals and principles of the NDIS, and core features such as the code of conduct and basic safety practices; and 20 hours of supervised contact with people with disabilities.

We assume the time in training is paid according to Level 2(1) of the SCHADs award induction pay classification (currently just under $25 per hour), and a relatively small per student cost for course resources and materials ($250 per student); given the large number of students participating, course resources and instruction can be developed and delivered at large scale, with consequent savings in unit cost. We assume the program would train 70,000 new inductees over the first four years (representing two-thirds of the estimated 105,000 new hires, equivalent to 70,000 FTE workers, entering the sector). The stage one induction program would thus cost $30 million per year for the first three years, $15 million in the fourth year, and $7.5 million per year thereafter (as the mass induction program was reduced to a steady stream of 5000 new inductees per ytear).

Stage Two: Foundation (Certificate III)

This foundation entry-level course would be required for all new disability support workers within the first 18 months of their employment in NDIS-funded service delivery (unless they already possess relevant Certificate III or IV qualification or equivalent RPA). The *Induction to Disability* Skill Set (described above, to be completed within the first 6 months of employment) would count toward this Certificate III qualification. The course involves 90 hours of classroom training, and 120 hours of workplace training and assessment. The classroom time would be paid at workers' normal hourly wage.[22] Teacher, resource, and material costs are assumed to equal $500 per participant (including administration). This represents a cost per participant of just under $3000, or total costs of about $60 million per year for the first three years. After the first 70,000 recruits receive their foundation training, annual costs decline to just under $15 million per year (for an assumed ongoing inflow of 5,000 workers per year).

Stage Three: Portable training entitlement

The largest element of the comprehensive NDIS training program would be the portable training entitlement system, through which NDIS-providing workers would

[22] The costings assume an average wage slightly higher than the induction-level SCHADs 2 induction pay, at $27.50 per hour, recognising that some participating workers will have already begun advancing through the industry pay scale

accumulate credits toward additional training through the normal course of their work. Training credits are earned as workers complete NDIS-funded work – whether with a provider-employer, or even directly for NDIS participants (working as sole traders). Workers can choose how and when to allocate accumulated credits toward additional training. The resulting credentials would be recognised and portable between employers, and count toward recognised qualifications (Certificate III and IV qualifications, as well as the diploma-level and higher vocational pathways which will be developed as the system is implemented).

Credits would cover the teacher, resource, and material costs associated with the courses, as well as paying the worker their normal hourly wage for time spent in the courses (assessed at the average hourly NDIS-funded compensation received by them during the previous 12 months, as recorded by the DSTA). Workers would earn credit for one hour of funded training, for every 50 hours of NDIS-compensated work.[23] This accumulation rate would be sufficient to allow an NDIS worker logging average weekly hours (currently around 22 hours per week, according to NDS estimates) year-round to undertake one three-day (21-hour) course per year.

Allowing for $750 per course in teaching, resource, and material costs for a typical 3-day course,[24] and with paid time in the classroom evaluated at an average hourly rate of $35, this results in a total cost of around $1500 for a typical 3-day course. This represents around 3% of the annual salary, superannuation, and overhead costs for a typical NDIS worker. The cost, pro-rated over the worker's yearly NDIS workload, would add about $1.30 to the total NDIS-charged hourly cost of their services (less than 2%).

We assume that the portable training entitlement stage of the program will require five years to reach full operation (as workers accumulate new credits, and then identify preferred courses and qualifications to pursue). Once fully phased-in, a total of over 120,000 workers would be entitled to paid training opportunities, at an average rate of three paid days per year. The estimated total cost of the program would thus grow from $36 million in the first year, to $182 million per year once fully phased-in.

[23] For new workers, accumulation of credits would begin once they have completed the induction and foundation stages of training described above (since those programs are funded directly by government). For existing workers, accumulation of credits would begin immediately upon commencement of the program.

[24] The cost per student for teaching is higher on an ongoing basis than for the entry-level Induction, because of the more specialised, smaller-scale training contemplated.

Total costs:

We have also allowed for administrative expenses of $5 million per year for the Disability Services Training Authority (sufficient to cover 25 FTE staff plus operational expenses) and related functions. We have also provided for organisation-level investments in training, also financed through the Capacity Building Fund, of $10 million per year. All costs are covered by the NDIA through its CBF (endowed jointly by the Commonwealth and State governments).

The training program proposed here is ambitious, aimed at meeting the pressing need for skills and qualifications for the growing disability services workforce: including rapid skilling of the large numbers of new recruits coming into the sector, and career-long training and upgrading opportunities for the whole workforce. The immediate costs for induction and foundation courses are significant in the first years of the program, but then abate to modest ongoing levels (required to train a smaller steady-state flow of new recruits to the industry in future years). The costs for the ongoing portable training entitlement are more significant, but take some years to phase in. On average over the first five years of the program, total costs (including administrative and overhead expenses) average just over $190 million per year. The fiscal estimates are detailed in Table 2.

The total cost of the NDIS is currently estimated to reach $22 billion for fiscal 2019-20,[25] and more in subsequent years. Therefore, the combined expenses for all three stages of the training program, combined with new administrative costs and organisation-level investments, amounts to less than 1 percent of the expected costs of the overall NDIS. In other words, this proposal would involve an investment of less than 1 cent, for each dollar of overall NDIS funding, to develop high-quality skills and qualifications for this ambitious new social program. This is a small investment indeed, given the close relationship between the quality of service delivery, and the skills and capacities of the disability services workforce.

[25] See Tale and Buckmaster (2015).

Table 2 Fiscal Estimates for Disability Services Training Program ($ million)							
	Costing Assumptions	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**5-Year Average**
Stage 1	105K headcount (70K FTE); 2/3 disability support workers; 100% utilisation; 70K trained over 4 yrs, then 5K per yr; 50 hours at $25 + $250 course cost.	$30.0	$30.0	$30.0	$15.0	$7.5	
Stage 2	105K headcount (70K FTE); 2/3 disability support workers; 100% utilisation; 70K trained over 4 yrs, then 5K per yr; 90 hours @ $27.50 + $500 course cost.	$59.5	$59.5	$59.5	$29.8	$14.9	
Stage 3	210K headcount (140 FTE); 2/3 disability support; 90% utilisation; phase in to 123K per year trained by year 5; 21 hours per worker per year @ $35 + $750 course cost.	$36.5	$73.0	$109.5	$145.9	$182.4	
Disability Services Training Authority		$5.0	$5.0	$5.0	$5.0	$5.0	
Organisation-Level Investments		$10.0	$10.0	$10.0	$10.0	$10.0	
Total		**$141.0**	**$177.5**	**$214.0**	**$205.7**	**$219.8**	**$191.6**
Source: Authors' estimates as described in text.							

IMPLICATIONS FOR THE SCHADS AWARD

A comprehensive new approach to investment in training will have implications for entitlements currently specified in the SCHADS modern award that applies to , including job classifications and pay structure. The SCHADS pay grid covers a range of direct disability support functions, but it is relatively truncated: there is limited opportunity for direct service providers (as opposed to supervisors and managers) to move up in classification and pay. Furthermore,, Cortis et al's (2017) analysis of the NDIS pricing model suggests that providers are often paying above the minimum pay rates specified in the SCHADS grid, because of the challenge of retaining valued and skilled workers.

In a tightening general labour market, exacerbated by the challenges of recruiting suitably qualified workers for the sector, there may be upward pressure on wages. In the context of the highly constrained NDIS pricing model, this implies that financial

pressures on providers will get even worse. While we recognise that the existing bargaining environment is not in the control of any single party, over time it is reasonable to expect that increased training across the sector (as envisioned under our proposal) should lead to higher pay rates, and a more comprehensive grid of classifications (related to the growing set of qualifications possessed by disability support workers). In other words, the SCHADS system of classifications will need to be extended commensurate with the acquisition by more workers of advanced vocational qualifications; there may also arise a need to ensure parity with workers in other health-related industries. A continual review of the NDIS pricing structures in relation to competencies, qualifications and career paths will be necessary in order to ensure that providers are able to both address their costs in relation to employment standards and improve quality standards.

Another implication of the proposed training scheme for the SCHADS award is the need to specify in the award that workers have a clear and protected right to use their accumulated training hours, and to enrol in courses that they choose.

Recommendations:

11. That parties to the SCHADS award consider how to develop and implement an extended structure of classifications and pay that will reflect the accumulating advanced vocational qualifications attained by disability support workers under the proposed portable training entitlement.
12. That the SCHADS award explicitly recognise the right of disability support workers to utilise their paid training entitlements in working hours, on course and vocational streams of their choice.

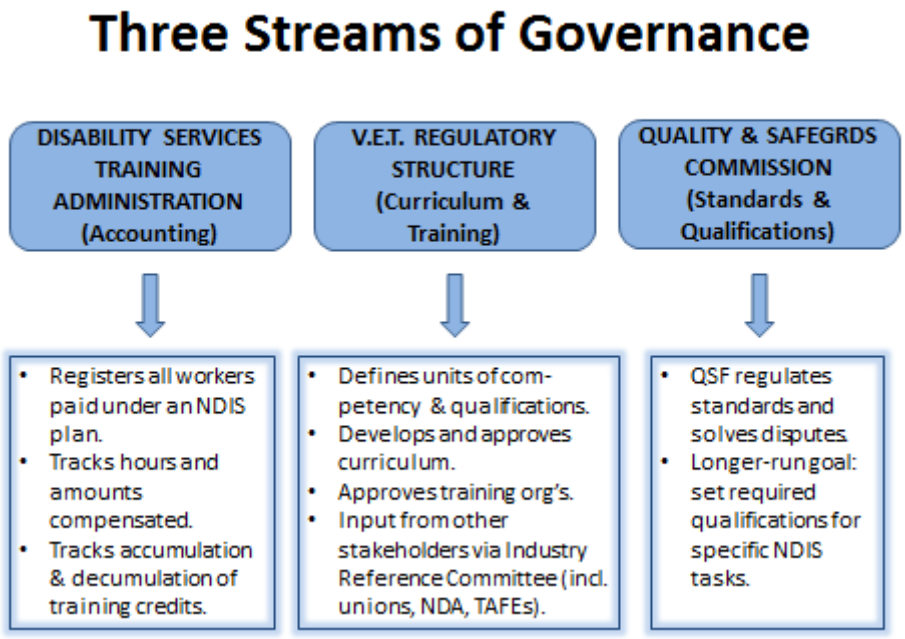
THE DISABILITY SERVICES TRAINING ADMINISTRATION

Our proposals for a new “ecosystem” of training and career-long upgrading in the disability support sector will require consistent oversight, an integrated capacity to account for entitlement s, and an ongoing liaison with the NDIA and the AQF. We propose the establishment of a Disability Services Training Administration (DSTA), located within the NDIS’s Quality and Safeguards Commission, to perform four specific functions:

- Ensure that quality and safeguarding standards set by the Commission are supported by initial and on-going training of the disability support workforce, particularly in response to regulatory requirements.
- Work with existing VET authorities operating in the sector to ensure and maintain relevance of qualifications, develop skills pathways that extend beyond Level IV, and facilitate the achievement of a high quality learning environment through RTOs.
- Administer individual learning accounts for disability support workers, including determining the financial value of training credits.
- Champion cultural change within the sector in respect of investment in training and skills development.

The regulatory model envisioned would require the coordination of three channels of responsibility, as summarised in Figure 4:

Figure 4: Regulatory Structure for Proposed NDIS Training Regime



While the DSTA would be located within the NDIS Quality and Safeguards Commission, it should maintain a degree of independence in its governance arrangements. Accordingly we recommend that the strategic direction and workplan of the DSTA be overseen and coordinated by a Steering Committee that includes the voices of people with disability, a representative group of industry stakeholders (including workforce representatives) and those currently involved in overseeing and delivering training for workers employed in the Disability Support sector.

Recommendations:

13. That the Quality and Safeguards Commission include an independently constituted Disability Services Training Administration (DSTA), with responsibility for tracking the portable training entitlement for workers across the disability support sector, and regulatory oversight of curriculum, training and quality assurance (in collaboration with relevant VET authorities).

VI. Summary and Conclusions

The NDIS is world-leading in its approach to providing supports to people with disabilities. Achieving its vision, however, requires an available workforce that understands the philosophy and values underpinning the NDIS and has the skills and training necessary to deliver the services that are required. It also requires high trust relationships between participants and their support workers, relationships that can only be built up over time, in a context of stable, high-quality work. Current policy settings place a large degree of responsibility on disability support workers, without providing them with the support or quality working conditions they need to deliver high quality services. This is particularly the case in respect of training and skill development. While the necessity of a skilled workforce is nominally acknowledged in NDIS policy documents, the reality is that this goal requires more meaningful funding, leadership, and commitment. Immediate investments are needed simply to recruit and train the large number of additional workers that are needed for the national roll-out in coming years. In the longer term, investment is also needed to ensure continuous upgrading of the skills and qualifications of the workforce. We have argued that this requires a change in the culture of the industry, including a core commitment by its government funders, that recognises training as an investment, and not just a "cost". Initial and ongoing training must be seen as a necessary part of delivering high quality support services to people with disability.

The proposal developed here for a comprehensive, well-funded training system fits well with the flexible nature of service delivery envisioned under the NDIS. Workers undertake a range of different tasks, for different NDIS participants, depending on shifting needs and demand patterns. Without a training ecosystem that recognises and adapts to that highly mobile work context, the industry will chronically underinvest in training and skills provision, to the detriment of both workers and participants.

Australians with disabilities are excited about the positive potential of the NDIS to meet their needs in a more respectful, flexible, and individualised manner. Society as a whole should be proud of the shared commitment that has been made to better meeting the needs of people with disabilities, and recognise that society will be much stronger thanks to better support and fuller participation. This positive potential, however, is put at risk by a failure to recognise the contribution made to this goal by a dedicated and skilled workforce, securely employed and paid fairly, and capable of delivering the best-quality services possible.

The training and skills development structure that has been described here is feasible, pragmatic, and affordable, and consistent with the founding vision that motivated the development and implementation of the NDIS. By emphasising that a commitment to quality benefits all participants in the sector – people with disabilities, workers, providers, and ultimately government itself – a consensus can be built that investing a very small proportion of total costs (less than a cent in each dollar of NDIS funding) in ongoing training will help to achieve the full potential that the NDIS's architects hoped for.

LIST OF RECOMMENDATIONS

1. All recognised foundation training for the industry should be based on qualifications registered through the Australian Qualifications Framework.
2. All training should be conducted by public or selected non-profit RTOs, and quality audits undertaken by ASQA to ensure that RTOs have the training infrastructure to deliver educational outcomes that are of the highest possible level of quality. Incremental funding should be prioritised towards TAFES as the highest-quality publicly funded RTOs.
3. Vocational pathways available to workers should be extended through the development of qualifications at Diploma and Advanced Diploma level on the Australian Qualifications Framework.
4. That the content of the new compulsory induction be reviewed (in consultation with all stakeholder organisations, including representatives of people with disabilities) to ensure that it includes a workplace component, and information about the requirements on workers under the proposed new Code of Conduct. Assessment standards should also be introduced to ensure that the learning objectives are achieved by all students completing the induction.
5. That it should be compulsory for employers to support workers to successfully complete the induction programme within 6 months of being newly employed.
6. That an accreditation and registration regime be introduced to support improvements in quality standards in the disability sector. Registration should

be based on the achievement of a minimum foundation qualification at Certificate III level; with the proviso that newly employed workers enrolled in a Certificate III could apply for provisional registration for up to 18 months.

7. That an independent Capacity Building Fund be established under the NDIA, jointly endowed by the Commonwealth and State governments, separate from the funding mechanisms associated with the NDIS unit pricing system.
8. The Capacity Building Fund would cover the full costs of compulsory induction and foundation training for newly hired disability support workers (and the cost of completing RPL procedures for existing workers), as a means of quickly boosting the number of skilled workers in the industry.
9. The Capacity Building Fund would also cover the costs of a portable training entitlement system, under which disability support workers accumulate credits for paid training hours and then utilise those credits to enrol in qualifying courses.
10. The Capacity Building Fund would also fund organisation-level investments in training capacity, by both public and qualifying non-profit RTOs, and by disability service providers.
11. That parties to the SCHADS award consider how to develop and implement an extended structure of classifications and pay that will reflect the accumulating advanced vocational qualifications attained by disability support workers under the proposed portable training entitlement.
12. That the SCHADS award explicitly recognise the right of disability support workers to utilise their paid training entitlements in working hours, on course and vocational streams of their choice.
13. That the Quality and Safeguards Commission include an independently constituted Disability Services Training Administration (DSTA), with responsibility for tracking the portable training entitlement for workers across the disability support sector, and regulatory oversight of curriculum, training and quality assurance (in collaboration with relevant VET authorities).

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COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

JOINT STANDING COMMITTEE ON THE NATIONAL DISABILITY INSURANCE SCHEME

Market readiness for provision of services under the National Disability Insurance Scheme

THURSDAY, 14 JUNE 2018

MELBOURNE

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JOINT STANDING COMMITTEE ON THE NATIONAL DISABILITY INSURANCE SCHEME

Thursday, 14 June 2018

Members in attendance: Senators Gallacher, Steele-John and Mr Andrews, Ms Husar.

Terms of Reference for the Inquiry:

To inquire into and report on:

Market readiness for provision of services under the NDIS, with particular reference to:

a. the transition to a market based system for service providers;

b. participant readiness to navigate new markets;

c. the development of the disability workforce to support the emerging market;

d. the impact of pricing on the development of the market;

e. the role of the NDIA as a market steward;

f. market intervention options to address thin markets, including in remote Indigenous communities;

g. the provision of housing options for people with disability, with particular reference to the impact of Specialist Disability Accommodation (SDA) supports on the disability housing market;

h. the impact of the Quality and Safeguarding Framework on the development of the market;

i. provider of last resort arrangements, including for crisis accommodation; and

j. any other related matters.

WITNESSES

BREBNER, Associate Professor Christine (Chris), Dean of Education, College of Nursing and Health Sciences, Flinders University

HAYWARD, Professor David, Director, Future Social Service Institute

STANFORD, Dr Jim, Economist and Director, Centre for Future Work, Australia Institute

Evidence from Dr Stanford was taken via teleconference—

Committee met at 09:31

CHAIR (Mr Andrews): I declare open this hearing of the Joint Standing Committee on the National Disability Insurance Scheme for the inquiry into market readiness under the NDIS. These are public proceedings, although the committee may determine, or agree to a request, to have evidence heard in camera. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as contempt. It is also contempt to give false or misleading evidence to a committee.

If a witness objects to answering a question, the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist on an answer, having regard to the ground which has been claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such requests may be made at any other time.

Could I please remind those contributing that you cannot divulge confidential, personal or identifying information when you speak. If you wish to supplement your evidence with written information, please forward it to the secretariat after the hearing.

I welcome Associate Professor Chris Brebner, from Flinders University; Professor David Hayward, from the Future Social Service Institute; and, from the Centre for Future Work, Dr Jim Stanford. Do you have any comments to make on the capacity in which you appear?

Prof. Hayward: I'm a professor of public policy at RMIT University as well as being the director of VCOSS-RMIT Future Social Service Institute.

CHAIR: Thank you. Could I invite you, if you would like, to make some opening comments.

Prof. Brebner: The rollout of the NDIS has had an impact on service providers in South Australia. We've been running a project, funded by the Department of State Development, in northern Adelaide looking at the development of the allied health workforce in the northern suburbs through placement engagement. We've partnered with eight different service providers in northern Adelaide and have also interviewed a large number of key stakeholders about their experiences. What we've found is that there's been a significant impact on the training of allied health professionals to work in the service context for people with disabilities. We've found that people have been withdrawing placement opportunities for students to have work-integrated learning experiences, primarily because they're very anxious about billing compliance within the NDIA framework.

They're also talking about the short-term nature of plans for individuals with disabilities impacting on the services that they deliver and therefore how they integrate students into those. And they're concerned that the billing mechanisms do not promote best practice for allied health service delivery, and therefore they do not wish to involve students in those services. For example, interpreters are not able to be charged for, say for families who speak a language other than English in the home—they're not able to provide services in those languages and actually bill for those services.

We've found that a high level of anxiety is being communicated to students, and this anxiety is about financial distress due to uncertainties about payment, and that's enhanced by some of the problems around the payment of fees and delays in payments. And there has been significant uncertainty about plans. With plans rotating on a three-monthly or one-yearly basis, that's making it very difficult for people to plan their services.

We see a need to train students to be flexible service providers in a disability context in this new market-style environment. So we need some clarity and consistency for service providers about the plans and the services they can offer and how they can bill for those. We'd recommend explicitly being able to bill for student-led services, as long as they're providing adequate supervision for those students. We'd also recommend flexible pricing for services that are delivered to enable innovative models of service delivery. Thank you.

CHAIR: Thank you. Professor Hayward?

Prof. Hayward: I will begin by acknowledging the traditional owners of the land on which we meet, the Wurundjeri people of the Kulin nations, and pay my respects to elders past, present and future. The Future Social

Service Institute has the objective of looking at the workforce issues that confront health care and social assistance.

There is a graph that I could happily distribute to people, indicating our main concern. It's an eye-catching graph because the most significant growth in the labour force over the next five years and the past 10 years has been in that broad healthcare and social assistance workforce. Over the next five years, it'll grow by about a quarter of a million, Australia wide, and the next fastest growing segment of the workforce will be professional scientific services.

I raise that as an issue because most people aren't aware of the rapid growth of this sector. Yesterday's financial review picked it up, but they carried it in a way that was misleading in that they only talked about it as 'health care'. It's health care and social assistance.

The driver of the growth is the NDIS—that's No. 1—and, I think, in particular, the ageing of the population structure. In Victoria it's family violence reform and also other community services reform. But what we are looking at is a rapid growth of what we call the social economy. It's the fastest-growing part of the Australian economy. It is being driven very heavily by government funding, but what's happening is that the workforce is not being looked at in a uniform way. If you look at what's happening in Victoria, there is now a commitment to a gold-plated family-violence workforce, and a strong commitment towards professionalisation and new qualifications, requiring the primary workforce to have at least a social work qualification.

If you look at aged care and the federal government's recently convened task force looking at aged-care workforce issues for the future, chaired by John Pollaers from Melbourne university, his conclusion is that it's time to dramatically improve the pay, conditions and qualifications for the aged-care workforce. His argument is that, without that, there is no way on earth we will meet the needs of generating an extra million people working in aged care by 2050, and he's recommending a significant amount of improvement in working conditions.

Sitting in the middle of that is the disability workforce. One thing that has struck me about the NDIA and the NDIS is that there has been too little attention paid to the disability workforce and the qualifications needed, and not just at the vocational level but at the higher education level. Last week, I heard Professor Pollaers talk at a CEDA conference, and he made the point that he has talked to the NDIA about the need to dramatically improve pay and conditions across the sector. His view is that the NDIA has been distracted by other concerns, but he can't wait, he said. So he's pushing ahead with mechanisms to make the aged-care sector the most attractive part of the workforce to be in. I think what's going to happen is that, over time, without serious attention being paid to it, we'll be looking at a crisis in the workforce in this most important sector. Without a really good workforce in disability, and without a really impressive set of pay and conditions to make it every bit as attractive as family violence, aged care or other parts of the community services workforce, the NDIS will not meet its objectives. So that's really our basic argument.

I want to finish by making the point that I think that making it far worse at the moment are the qualifications that are available through vocational education. They are not fit for purpose. The more consultation we do, the more it is really clear that they have been degraded over the years. And it's no wonder that people with disabilities say that people with those cert IIIs and cert IVs that are coming out are not the sort of people who should be working in the sector. They say repeatedly that often people have cert IIIs and cert IVs but don't have the values needed to work in the sector. That tells you that the curriculum is not fit for purpose. If people are coming out with cert IIIs and cert IVs and diplomas and they aren't able to treat people with disability in a dignified and good way, that means that the curriculum is failing, and it's failing critically. With that, I'm happy to take any questions on my submission.

CHAIR: Thanks, Professor Hayward. Dr Stanford?

Dr Stanford: Thank you very much to the committee. I'm very grateful for the opportunity to meet with you, even by teleconference. I wish I could be there in person. I'll be speaking mostly today from a report which we published in April this year and which we developed in conjunction with the New South Wales branch of the Australian Services Union. I do want to acknowledge the work that was done by my co-author on that report, Dr Rose Ryan, who is unable to join us today.

The gist of our report I think builds very much on the previous two opening statements. We do want to address both the potential of the NDIS to meet the needs of people with disability in a flexible, individualised and respectful manner, as is the intent of the decentralised, market-oriented delivery model on which the NDIS is based. But we also recognise the challenges of doing that, in the context of a workforce that, in part as a result of that market-based delivery model, neither experiences stability in job and employment patterns nor has access to ongoing training and skills-acquisition opportunities. What we've tried to do is to develop an innovative model for

how, within the context of the market based system, workers who are providing those services would have opportunities, both when they join the industry and on a career-long basis, to acquire skills and credentials that would improve their jobs but, most importantly, improve the quality of service that is delivered to participants in the program.

The full report of course has been tabled with the committee, but I think what I'd like to do is just to summarise the main features of the training model that we would propose. We imagine a system based on three tiers of training. The first tier would be induction training, consisting of a minimal orientation and training for new recruits to the industry of 50 hours training total, 30 in the classroom and 20 in a supervised work setting. The second tier would be a foundation level of training that, in our judgement, should be compulsory training and recognition of a credential for people to work in this field, that would be equivalent to a certificate III level of training from the existing vocational education and training system, that would consist of 90 hours of classroom training and 20 hours of supervised on-the-job training.

The third tier—and, I think, the most important and innovative aspect of our proposal—would be to establish an entitlement for workers providing disability services funded under the NDIS for a portable training entitlement. As they work in the field and accumulate experience, they would gain entitlement to certain numbers of hours of paid training. The training would be covered, and they would be paid their average wage while they were taking the training. We've proposed setting this entitlement at a ratio of one hour of paid training entitlement for every 50 hours of work performed under an NDIS compensated service. This would work out so that a person working average hours in disability services provision—as you're aware, the incidence of both casual and part-time work in this sector is very high. Average hours are currently between 20 and 22 hours of work per week. Someone working at that average would gain entitlement to three days of paid training per year. We think that is on a par with other human service professions which are also required to conduct ongoing training and skills development as part of their part responsibilities.

In addition to establishing the fiscal mechanisms that would provide for this entitlement, including a system for tracking how many hours registered providers of disability services are working and tracking their growing entitlements to the paid training leave as they work through their careers, we would also need to see a parallel development of career paths, classifications and pay tiers that would match the accumulation of credentials that this system would allow. This is because, of course, in a field as diverse as disability services, there are all kinds of specialised services and specialised areas that people in the field will want to concentrate on. But if they're going to have the proper incentives to do that, even though the cost of the training will be covered and they will be paid their normal wages while they're doing it, they have to know that the training will be reflected in growing credentials for themselves and growing opportunity to match those credentials with defined, specialised career paths and pay classifications. That would be an important and complicated parallel task in addition to just providing the training opportunities.

We've done some rough costings of the proposal—of all three tiers of our proposed training system. The costing is described and the assumptions are described in the full paper. The bottom line is that we think it's a very incremental and modest investment in the capacity of the NDIS workforce to make the most of the promise of this system. In fact, if we want to realise the potential of a flexible, individualised service delivery model, as was hoped, we are going to have to provide the people providing those services with sufficient stability and quality in their job and the opportunity to accumulate ongoing skills and credentials.

We estimate the total cost, on average, over the first five years would be around $190 million per year in total. That would cover all three of the tiers of training we're imagining, plus the cost of administration, including a very close relationship with the qualifications management system within the NDIS, as well as continuing some funding for training provided at the group level by major providers. So that $190 million per year works out to less than one per cent of the expected total cost of the NDIS.

We think it would be best for that to be provided through a separate stream of funds rather than trying to build the cost of this training into the unit price system of the NDIS. In experience, embedding a certain unit cost for training within the overall unit price, first of all, creates an unnecessary competition for resources between the workers getting the training and the participants, and, secondly, it has just been very inadequate. So we will propose a separate stream of funding we call a capacity-building fund to cover the three tiers of training, plus the associated administration. It's an innovative proposal that fits with the spirit of the NDIS for a flexible, individualised model of service delivery but one that recognises that will not on the basis of the digital platform that matches workers with participants as if you were ordering fast food from Deliveroo. That's the downside risk of this current model. Instead, we're proposing a model where workers would have the capacity to increase their skills and qualifications throughout their careers.

That's a summary of our proposal, and I look forward to your questions and discussion. Thank you again.

CHAIR: Thank you Dr Stanford. I will lead off to whoever would like to respond. It seems to me that there are at least three areas of concern here: the first is the quantity of the training—the number of people available to do the work; the second is the quality aspects; and the third is the pricing, which has an impact on both the others. Can I start with the numbers. On current provision of training, is there any ability to estimate what the shortage might be when it's fully rolled out if we don't do something more?

Prof. Hayward: We have done some modelling where we reckon it's somewhere around a 6,000 to 10,000 shortfall per annum, but that's across the social and community services—it's not just disability. Unfortunately, one of the things that are most frustrating is that we're looking at this rapidly growing part of the economy but the data just aren't there to tell us all the answers that we'd like. It just reflects the fact that it was previously thought of as welfare, but I think now we're increasingly realising it's actually a crucial part of the economy, and it's time for the data to catch up to need.

Senator GALLACHER: The Productivity Commission indicated that no matter what the training or the growth in the workforce in Australia is achieved the workforce in forward would need to be supplemented by immigration. Do you have a view on that?

Prof. Hayward: The Productivity Commission sort of hedged its bets a bit. I think that what it was saying was that in the short term there's a need to be pragmatic about it, and I agree with that, but I think what they've also hinted at is—and it's something we've found—that attracting young people into this sector is by no means easy, partly because people are caught with images of the past rather than what the future might look like. We've invested heavily in renewing the curriculum and making sure it's a really enjoyable experience. With the students that we've had we've had a really high rate of completion—95 per cent of the students have completed. If you have a look across the system at the moment, with the vocational qualifications about 35,000 students a year start but only about 10,000 finish. That's about as inefficient a system as I could possibly imagine. Just imagine if you were able to close that gap, but you're not going to close the gap under the current system, because too much of the qualifications and the organisations delivering them aren't fit for purpose.

CHAIR: That dropout rate seems to be much higher than is generally the case across tertiary studies.

Prof. Hayward: It is. Sadly, there's been a counterargument put up: 'That's because people are putting their toe in the water. They've got what they've wanted out of it and then they've decided they don't want to continue.' That's a terrible answer. If universities had a completion rate that low we'd be slammed, quite appropriately. It's a very, very inefficient way. Imagine all the costs of enrolling people and doing all that sort of stuff for them to drop out. This curriculum should be really exciting. One of the great things we've found from our cert. III students is that they've said they'd begun doing the course and they weren't sure whether they'd do disability or aged care, but they so enjoyed the experience—because we're getting people from industry to come and talk to them, people from, say, Women with Disabilities Victoria. We've had some really eye-catching presenters. They've gone off to film nights, they've met film producers who are producing films on disability advocacy. And they've said this has changed their whole view of the world. Their whole view of people with disability has shifted. Instead of seeing people with disability as the 'other' they see them as people, and it's altered their whole—so what your seeing is an education experience that's given them a sense of humanity. How good is that? I was thinking of these very young women predominantly from disadvantaged backgrounds. Wouldn't you want everybody to have that experience? I would.

CHAIR: Is that figure of 6,000 to 10,000 per annum a standard figure, year after year, or does it compound?

Prof. Hayward: Yes. Remember it's across the sector. Aged care and disability are the two big ones. Aged care has the really big challenge, but disability is sitting in there too. It's been thrown a little bit off balance because of the argument put forward by disability advocates that it's about choice and control, so we've taken attention away from what that—the flip side is what are the workforce needs? What do we need in terms of people who have got the skills that are required?

I should add one other point. We're caught up with a very modernist view of education at the moment where we think about certificates, diplomas and degrees. The latest thinking in tertiary education is: how can you break down qualifications into microcredentials? How could you get little bits of qualifications? Begin with this: the ethics of care. It's a little unit that might take, say, 20 hours with a microcredential and a badge that comes with it. Work for a little period of time and then come back and build up another microcredential. Then, after a period of time, what you might have is the equivalent of a degree that enables you to come in and go out and pick up majors and minors that enable you to work across what I think is a really exciting, rapidly growing workforce, if that

Predictability and control in working schedules

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Biography:

Dr Muurlink is a member of the Australian Psychological Society and the Working Time Society (Switzerland). He is a senior lecturer in organisational behaviour at Central Queensland University (Brisbane), and Senior Research Fellow (adjunct) at Griffith University (Griffith Institute of Educational Research). Dr Muurlink is a member of the Central Queensland University's Academic Board, and the Human Research Ethics Committee. He is also chair of management of the international charity Co-operation in Development (Australia) Inc (CO-ID), and head of country, Bangladesh, of CO-ID and has held management positions in manufacturing and media companies in Australia and overseas.

Previously Dr Muurlink has held positions at the University of St. Andrews' Environmental Policy and Research Unit lead by Professor Terence Lee FBPsS, and Griffith University's Centre for Work, Organisation and Wellbeing, and was later later senior research fellow at the Centre for Learning Futures. He has also held senior management positions in manufacturing and media firms.

His PhD studies were conducted at Griffith University under the supervision of health psychologist Associate Professor Frances O'Callaghan and Emeritus Professor Drew Nesdale. He gained his undergraduate qualification at Charles Sturt University winning the 1990 University Medal, completing his masters at the Psychological Laboratory at the University of St Andrews with distinction on a project relating to the perception of risk.

1.0 Overview

This report relates to the current four-yearly review of modern awards being conducted by the Fair Work Commission, in particular common issue proceedings concerning part time employment (AM2014/197) and casual employment (AM2014/196) ('the Common Issue Proceedings'). These proceedings include claims to vary the part time work provisions in the Social, Community, Homecare and Disability Services Industry Award 2010, Aged Care Award 2010 and Nurses Award 2010 ('The Awards'). This report includes a

- review of work on scholarly work on unpredictable patterns of work and the effect of a roster on workers' well-being (with an emphasis on material that is specific to the types of workers covered by the above Awards); and

- review of scholarly work on the impact of lack of control over patterns of work on workers' well-being (with an emphasis on material that is specific to the types of workers covered by the above Awards);

2.0 The literature search

Comprehensive searches were conducted using search terms commonly and internationally associated with non-standard shifts and working patterns. In addition to the searches (including wild card searches) conducted in Google Scholar (see Table 1) a further non-exhaustive search on "control over * hours" was conducted. This search was not exhaustive because comprehensive searches returned too many results to enable complete coverage.

Note that while perhaps a decade ago it would be considered inappropriate to base scholarly literature reviews on Google Scholar searches alone, there has been a significant shift in thinking in the last decade. Early studies criticised the coverage of Google Scholar, but more recently, it has become clear that Google Scholar has matched or overtaken rivals. For example, Gehanno et al in 2012 reanalysed searches in 29 systematic Cochrane reviews (the gold standard of reviews with a medical focus) and found that ***100%*** of articles drawn from specialist medical databases were found in Google Scholar (Gehanno, Rollin, & Darmoni, 2013). This is in addition to earlier studies already confirming its superiority in accessing less mainstream scholarly material (Falagas, Pitsouni, Malietzis, & Pappas, 2008).

Table 1: List of complete searches conducted

“unpredictable * hours”
"inconsistent work hours"
“unpredictable rosters”
“flexible rosters”
“flexible * rosters”
"workers on standby"
"standby work"
"inconsistent working hours"
“inconsistent * rosters”
“inconsistent rosters”
“variable rosters”
“variable * rosters”

3.0 Unpredictability and its correlates

In Australia, there is relatively little regulation pertaining to the amount of consecutive hours worked, or the minimum length of rest periods, relative to for example, the US and Europe. However, regardless of regional variation, there is little focus on the *predictability* of work patterns. Australian working patterns continue to follow an international trend toward greater variety. Where once the police officer or nurse stood apart in terms of their working hours, now there is a large and growing cohort of workers from a range of occupational categories whose work day is characterised by unpredictability and lack of control over work hours, in addition to lack of real or perceived job security. In Australia in the twenty year period from 1982 alone, the percentage of all employees who were casual more than doubled to 27.3% (Campbell, 2004) and these casual workers generally over-represent the number of workers who experience a unsteady ‘beat’ in their working week. The ABS (2009) notes, for example, that variability in working days is more than twice as common amongst casual employees (24%) than other employees (11%).

I will deal in this section, as cleanly as possible, with the issue of unpredictability/ variability/flexibility/inconsistency in working patterns, and separately with the issue of control, but the two broad constructs are closely related in practice.

The arhythmicity of the working week for an increasingly large proportion of workers contrasts with the traditional regular seven-day work/rest ‘beat’ (Zerubavel, 1989, p. 136) which forms the basis on which we have traditionally considered occupational health and safety. This “weekly rhythm” (Almeida, 2004, p. 128) is influenced by work schedules (Zerubavel, 1989), as well as other factors, including social norms and conventions, and biological parameters such as the circadian and other ‘clocks’ that govern our response to light and the seven day week.[1]

[1] There is evidence, for example, of a circaseptum (seven-day) rhythm evident in both human, animal and even plant (Duca, 2015) studies.

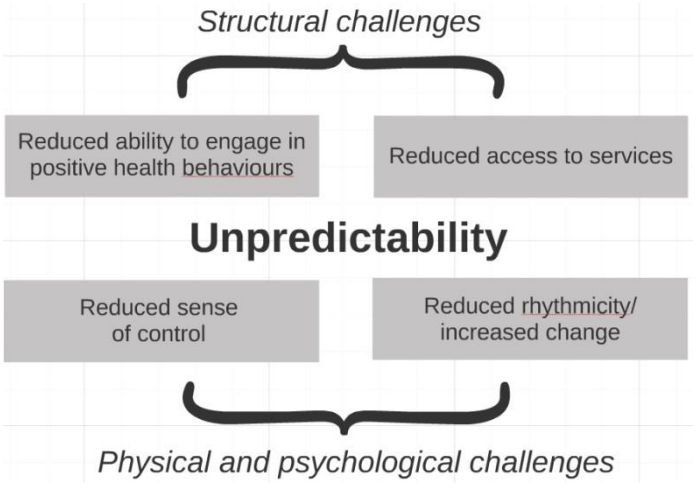
Contrast the increasingly complex working week (featuring night work, shift work, weekend work, overtime, compressed working weeks and on-call patterns) with the relatively predictable and steady beat of non-working life: Saturday sport, children's school hours, television or public transport scheduling. Not surprisingly, then, rhythmicity has clear implications for a worker's ability to maintain work-life balance. Increased variability in working hours has not been matched by increased flexibility in non-work activities. Hofäcker and Konig (2013) found that rather than the quantum of working hours, *this* issue was critical in predicting work-life conflict.

"Flexibility" is a broad term that does not specify *for whom* the flexibility exists, and who controls that flexibility and it is important to make the distinction between worker and employer-controlled variability. Giovanni Costa, a past chairman of the International Commission of Occupational Health Scientific Committee on Shift work and Working Time, thus prefers to split 'flexibility' into two terms, two very different ways of looking at non-standard working schedules. One, which Costa et al (2006) calls 'variability', reflects employer control over working hours designed to respond to the evolving requirements of the business and service sector. By contrast, 'flexibility' refers to "individual *workers'* discretion and autonomy to adjust working hours to reduce work-life conflict and better accommodate other activities needs and responsibilities' (Costa et al., 2006, p. 56). The two have an almost opposite relationship with employee control, variability tending to reduce it, flexibility tending to increase it. Flexibility is thus often associated with employee wellbeing[2] while variability is high on the list of desired employer outcomes. The US Survey of Employers in the Low Skill Labor Market report that applicants' willingness to be flexible about work hours is prominent in employer's preferences for low-skilled new hires (Acs & Loprest, 2008).

Unpredictability in the workplace has a range of corollaries for employee physical, psychological and social health (see Figure 1). I will first focus on two aspects of unpredictability that relate to *structural* changes in time management.

[2] Costa et al found in fact using a sample of 21,505 European workers, that health and psychosocial well-being were favourably associated with higher flexibility and lower variability. Notably, flexibility was the *strongest* predictor of job satisfaction.

Figure 1: Overview of the challenges posed by unpredictable or less predictable work schedules.



3.1 Structural challenges to health posed by unpredictability in time scheduling

Firstly, it results in the reduction of employee ability to engage in positive health behaviours. If work has a predictable 'beat', health behaviours can be more easily synchronised with work, for example family meal times and team sports (Sargent et al 2015). Unusual hours tend to be significantly associated with an increase in smoking and alcohol consumption (Bushnell, Colombi, Caruso, & Tak, 2010) and lack of exercise (C. Thomas & Power, 2010), and are reliably associated with long term increases in BMI, particularly in countries such as Australia and the US. Some of these consequences of irregular work patterns, such as drinking alcohol, may have secondary health impacts, for example, further increasing sleep impairment (Vitello, 1997) which in itself has health consequences.

Crouter and Maguire (1998) refer to the clash between different schedules as closing "windows of socialisation" but equally, erratic schedules close windows of self-care. Bittman's careful diary studies (2005) using ABS data, for example, finds that those who work on Sunday, for example, are less able to undertake activities usually associated with Sunday, notably sleeping in and undertaking personal care activities such as doing one's teeth or eating with family members. The minutes 'lost' in these traditional non-work periods of the week are not fully recovered elsewhere in the week (Bittman, 2005; Craig & Brown, 2015). Higher wage individuals, however, are able to recover 'lost' time more effectively; for lower wage earners, there is less elasticity in a 24-hour schedule. As Ennis (1968) suggested in the wake of dramatic increases in employment in the 1960s, "higher level occupations …[may] have the same amount of leisure time [now as previously]because they spend less time (but maybe more money_ on maintenance-nurturance" (p. 556), spending money for example on cleaning services to 'buy back' time. Time and money have long been linked in scholarly literature in disciplines as distinct as economics and psychology. "Consumers not only spend time and money to

acquire products and services but also often use time as a substitute for money and vice versa" (Jacoby, Szybillo, & Berning, 1976, p. 320). So for lower paid workers, these changes to work schedules have amplified work-life balance implications.

Secondly, unpredictability may reduce the ability of the individual to access services that follow a predictable 'beat'. These may include, relatively more trivially, access to health maintenance services such as gyms or good quality food options (as opposed to fast food options, which tend to have higher degree of accessibility regardless of time), or more significantly, access to medical facilities. There is evidence that workers who experience accidents at non-standard hours may well suffer a worse fate than those who work during standard working periods. Crowley et al (2009) reviews a number of relatively recent studies of death rates by day, suggesting that higher mortality rates are associated with poorer treatment available on the weekends in hospitals. This may be due to lower staffing on weekends, or it may be due to those who are present at hospitals on weekends are suffering from greater weariness accumulated during the working week. (The weariness effect on medical professional's effectiveness is measurable: Thomas et al (2012) found a relationship between the number of hours a surgeon worked—independent of all other variables—and the increased risk of complications when performing pulmonary lobectomies for example, while Virtanen et al (2009) found relationships between work stress and hours and hospital-associated infection in patients.) Studies by Crowley and others on off-peak mortality (e.g. Bell & Redelmeier, 2001; Epstein, Barmania, Robin, & Harbord, 2007; Hamilton, Mathur, Gemeinhardt, Eschiti, & Campbell, 2010) suggest that medical services are not evenly spread around the clock or the calendar week.

4.0 Physical and psychological challenges of unpredictability

4.1 Reduced sense of control

The overwhelming evidence from health psychology is that a sense of control (which needs to be distinguished from actual control, even though the two concepts are clearly related) is one of the most critical psychological variables in both directly and indirectly determining health responses to stressors such as work conditions. I will review some of the larger studies that relate specifically to control in the workplace, however, more generally, a stronger sense of control is associated with better health outcomes, fewer symptoms, faster recovery from illness, and even longer life (Lachman & Weaver, 1998a). Animal studies confirm that depriving even laboratory animals of control over the environment will lead to premature and sometimes otherwise unexplained death (Gatchel, Baum, & Singer, 1980).

Even small amounts of 'actual' or 'perceived' control can have significant and measurable impacts on health outcomes, and to anticipate a later section of this report, *change* in degree of control (in particular a reduction) can itself be negative, while higher levels of stress combined with loss of control (as in the animal studies alluded to earlier) can have catastrophic effects. When residents at another nursing home had their feelings of choice and personal responsibility over pot plants in their rooms curtailed, Rodin and Langer (1977) even observed a significant increase in mortality, an

early study that influenced the later inclusion of control in epidemiological studies of occupational health.

Work stress is in fact now commonly defined as a combination of work *demand* with work *control* (Karasek et al., 1998), and a significant component of this sense of control relates to *control over work hours.* Perceived control over working hours correlates highly with overall sense of job control, (Ala-Mursula, Vahtera, Kivimäki, Kevin, & Pentti, 2002). Job control is thought to ameliorate the role that job demands place on human health, with a job that places high demand on the worker without concomitant high job control regarded as high strain work, which has in turn been associated with a very broad range of negative physical and psychological health outcomes: coronary heart disease (Kivimäki et al., 2012), dementia in late life (Wang, Wahlberg, Karp, Winblad, & Fratiglioni, 2012), depression (Siegrist, 2008) and illness determined through absenteeism (Niedhammer, Sultan-Taïeb, Chastang, Vermeylen, & Parent-Thirion, 2012) and disability pensioning (Laine et al., 2009).

One of the most significant epidemiological studies looking at control in the workplace, Kopp et al (Kopp, Skrabski, Szántó, & Siegrist, 2006), is worth examining in greater detail. Working with a very large Hungarian dataset, the Kopp team found that low levels of perceived control at work, along with job insecurity and a high weekend workload were the best of the working-time predictors of premature cardiovascular disease mortality for men, and also highly predictive for women. The Kopp studies (Kopp et al., 2006; Kopp, Skrabski, Szekely, Stauder, & Williams, 2007) are particularly well assembled, although their measure of control is a single item "how much can you influence what happens in your working group?" Control at work is likely to be multidimensional (Loudoun, Muurlink, Peetz, & Murray, 2014; Wergeland & Strand, 1998). However—remarkably—this single item measure of control was the second strongest work-related predictor amongst female and male workers of premature death from cardiovascular disease (Kopp et al 2006) and the single most powerful predictor of female ischaemic heart disease mortality. To put this in perspective, the correlation between the strongest single demographic or behavioural predictor, education and premature death from heart disease is between 0.385 and 0.599, while the correlation between control and heart disease lies between 0.188 and 0.344. Education increases sense (if not reality) of control, and when factoring education and other classically-associated variables such as drinking and smoking into account, unusual hours and low control at work still accounts for upwards of 10% of the variation in death rates from heart disease. In modelling predicting death, this is an extraordinarily large proportion

In an earlier Kopp study (Kopp et al 2005), the same job control was examined in relation to common measures of depression and the WHO wellbeing score. In bivariate analysis the connection between control on the one hand and depression and wellbeing was very significant. In multiple regression models, where other factors are taken into account, sense of control (and job security) remained an important predictor of wellbeing, but not of depression, although other studies show depressive symptoms *are* associated with depressive symptoms, after adjusting for age and gender (e.g. Steptoe, Tsuda, & Tanaka, 2007). In the Kopp study job control and security were the most important work-related determinants of wellbeing (ahead of working hours, income, job satisfaction or work troubles). It is important to note that depression in and of itself is an independent risk factor in the development of cardiovascular disease.

There are studies, not surprisingly, looking at the issue of control over work scheduling in the care sector specifically. An Australian study (Pisarski, Lawrence, Bohle, & Brook, 2008) found that nurses who judged their work environment as more controllable reported reduced work-life conflict and superior psychological well-being, with the work-life conflict finding particularly robust. Karhula et al (2013) measured job control with Karasek's Job Content Questionnaire and used job strain at a ward level rather than an individual level to do their comparisons. This reduces the subjective element of measuring control and demand. Job strain was associated with cognitive and physical workload perceptions. Sense of control has also been strongly associated with another, less direct marker of wellbeing: intention to leave the profession and absenteeism. Dalton and Mesch (1990) found that both markers of discontent went down when a system of nurse-controlled flexible rostering operated consistent with findings elsewhere that nurse sense of control is associated with lower turnover intentions (Weisman, Alexander, & Chase, 1981) in common with findings from other professions.

While the evidence that lack of control over work characteristics has serious health consequences, there is also a more positive body of evidence emerging that employees given greater control over, for example, work scheduling, can experience positive outcomes. These outcomes are also measurable in terms of outcomes valued by employers (such as lower turnover and greater productivity).

Barton et al. (1993) examined individual choice and shift system tolerance, finding greater tolerance was associated with greater control over work hours[3]. Either regular or flexible (worker controlled) rostering was found to lead to a greater sense of control than irregular or rotating shifts. In a more recent example from the work setting, however, Garde et al (2012) implemented self-rostering in employees, and found favourable consequences for health, stress and recovery, without changing actual working hours. In a study of police officers, Vila (2006), analogously found that those who preferred to work evening hours did not experience the same negative effects as those who were assigned to shift work non-voluntarily. More generally, Costa et al's (2006) analysis of a European dataset of 21,505 participants – a Third European Survey on Working Conditions found that *flexibility* had positive effects on health. Mikko Harma (2006), a specialist in working time at the Finish Institute for Occupational health[4], believes that other than regulating overtime or excessive hours and provisioning more sleep-friendly principles into roster design, the best way to decrease the negative health effects of work hours in general would be to "increase individual work-time control" (Härmä, 2006, p. 502).

However, another overarching variable here is socioeconomic status, or at least job role. Control over work variables, not surprisingly is significantly determined by rank: that is, more senior positions (often associated with higher income) perceive that they have greater control over their work conditions. Where lower income workers perceive a high sense of control, their health levels are remarkably comparable to that of higher income workers (Lachman & Weaver, 1998b). Control requirements may also differ by occupational level. Stein (2015) looked at different occupational levels within the US

[3] Wilson (2002) recommends that regular shift rotas are superior due to the ability of staff to organise personal and social lives, and I will deal specifically with the issue of regularity and change.

[4] Prof. Harma's recent work includes examinations of shift ergonomics/working hours in nurses.

health care profession, ranging from physicians to certified nursing assistants and showed how different kinds of control over work hours impacted differently on different occupational levels. Stein found, for example, that physicians were stressed by having the *ability* to work extra hours, while for low level workers, the desire to work fewer hours than 'offered' was a significant stressor. An hours mismatch was not a significant stressor for higher levels of health care workers, while supervisor pressure was not a significant stressor for entry-level positions—possibly because lower level employees have different expectations of supervisor behaviour.

These findings about control are so universal as to be considered almost a rule. The exact mechanism by which sense of control impacts on human health is not fully understood, however. It does appear to relate to coping resources, and these differ between individuals. "The emotional impact [of stress]," Frankenhaeuser found, is "determined by the person's cognitive appraisal of the severity of the demands in relation to his or her own coping resources" (Frankenhaeuser, 1986, p. 101). Amongst the resources that the individual can draw on (apart from wealth in giving sense of freedom and control) is support offered by supervisors or colleagues which can help ameliorate the impacts of a uncontrolled or uncontrollable work environment (Pisarski et al., 2008).

There are a number of work scheduling variables that have been associated with sense of control. A qualitative study of casual employees in five star hotels in Sydney found marked differences sense of control between permanent and casual staff (Bohle, Quinlan, Kennedy, & Williamson, 2004). Lower sense of tenure may be a contributing cause for the negative impacts of unusual work schedules (Brogmus, 2006). In a study of Scandinavian nurses, Abrahamsen et al (Abrahamsen, Holte, & Laine, 2012) note that "under-employed nurses frequently take extra shifts at short notice to reach desired working hours" (p. 70). For these workers, increased irregularity in hours may be a function of their choice. These choices may have idiosyncratic reasons not associated with working hours. In studies I have co-authored of heavily over-worked shift workers, it is obvious that there is always a proportion of staff, for example, which *prefers* to work nights, not for the additional money, but because of the absence of supervisory staff.

In the following section I will be examining the role of sleep in mediating unpredictability of work practices in determining health, but it is worth pointing out that studies show that sense of control over work variables has itself been related to key sleep quality (Smith & Iskra-Golec, 2003).

4.2 Change and arhythmia

Like control, change has a long relationship in the scholarly literature with negative health effects. There are a number of studies looking specifically at major (divorce, marriage, moving house and so on) and minor changes in life showing significant associations with negative health outcomes. These studies, such as the Americans' Changing Lives Study, tend to show a close relationship between socioeconomic status and negative life events that constitute major changes, and that a simple 'count' of

negative life events is positively associated with mortality (Lantz, House, Mero, & Williams, 2005). Remarkably, minor life events ('hassles') also retain this significant relationship with serious health outcomes (DeLongis, Coyne, Dakof, Folkman, & Lazarus, 1982). This relationship between change and health outcomes holds true for psychological outcomes such as depression (Kendler et al., 2010) or physical health outcomes such as breast cancer, with Lillberg et al (2003) suggesting immunologic and other hormonal changes, or changes, as I proposed earlier, in positive health behaviours that in turn could trigger negative health effects. Change is also capable of directly interrupting sleep, and circadian disruption in turn is a well-established pathway to health impacts.

However, a new US study (Tamaki, Bang, Watanabe, & Sasaki, 2016) found that even sleeping in a new bed takes at least a day's accommodation, associated with an increase in relatively unconscious levels of *vigilance*, and it is the issue of perpetual vigilance associated with not knowing when work will commence that I want to emphasise here.

4.3 On-call or standby work

A particular category of variable work that I will emphasise in this report is 'on call' or 'standby' work, as it is a common work practice in the care sector and beyond. On call work has been predominantly studied in the area of 'high value' professions, particularly in medicine (medical technologists, doctors, midwives), but also transport and marine (ship engineers, junior airline pilots, tug boat pilots) and IT workers (Nicol & Botterill, 2004a). On-call work, like casual work itself, is no longer a rarity, with over a quarter of Australian workers having an on-call component to their work (ABS, 2012)

On-call or standby work is often not an optional choice, but an operational requirement, used to ensure particular essential hours of duty or tasks are covered. On-call work requires the worker to subsume control over lifestyle choices to allow the ability to respond to work requirements, "limiting behaviours…to activities that would not interfere with their ability to work" (Nicol & Botterill, 2004a, p. 1). Studies have focused heavily on work-life balance and domino impacts on family and home life of on-call work patterns, however there is also a substantial emerging literature on the role of being on call on physical health.[5] Some of these impacts may, when separated out, be *positive*: for example, on-call surgeons are forced to restrict alcohol intake in order to be able to respond to work requirements as required. The 'unique' negative impacts of on-call work appear to be related to the requirement to remain alert and available to being called to work, and not surprisingly, this requirement impacts on sleep.

[5] The two areas of impact are of course not independent. Emslie et al's UK study of 2176 full time white collar bank employees found that work-life conflict strongly predicted self-reported physical symptoms including minor psychological problems, and did so equally for men and women (2004).

The research into 'on-call' workers is focused quite heavily, but not exclusively, on the medical industry. For example, Tucker et al (2010) found that on-call work was associated with increased work-life interference and psychological strain. A series of studies of British GPs, while focused on job satisfaction showed that until GP co-operatives (designed facilitate out-of-hours calls) were introduced in the 1998, on-call at night in particular was either the most or second most stressful aspect of their jobs (Cooper, Rout, & Faragher, 1989; Sibbald, Enzer, Cooper, Rout, & Sutherland, 2000; Sutherland & Cooper, 1992).

There are a series of studies looking at on-call work and sleep. A comparison by Richardson et al (2007) of doctors sleeping on site at a hospital, between those who were on-call and those who were protected from being woken found poor sleep efficiency and poorer quality sleep in the former category findings replicated to a significant degree in sleeping-off-site studies (e.g. Jay, Thomas, Weissenfeld, Dawson, & Ferguson, 2008) and in laboratory studies where on-call vigilance is replicated (Wuyts et al., 2012). In other words, the anticipation of being woken up is sufficient to disturb sleep quantity and quality, and the degree of uncertainty appears to exacerbate this effect (Ferguson, Paterson, Hall, Jay, & Aisbett, 2016). Smithers' (1995) study of organ transplant co-ordinators found that on-call impacts on sleep spilt over to periods when workers were *not* on call, suggesting that sleep patterns established during periods of disruption have inertia.

Outside the health industry, Pilcher et al (2000) looked at on-call work patterns and sleep of 198 train engineers, using a diary method, and a timescale of 14 days. The study methodology is solid, but the response rate was low (around 25%) allowing the possibility that only the worse effected are over-represented (or underrepresented) in the study. They found that those on-call were more likely to report sleep related problems, and interestingly found that being on-call *at home* was, if anything worse than being on-call at other locations (e.g. worker 'bunks' on site), possibly because the presence of family interfered with the worker's ability to implement sleep patterns that would conform with on-call requirements. In a major review of health impacts of on-call work (focused away from the medical industry), Nicol and Botterrill (2004) identified 16 papers of relevance. The authors (Nicol & Botterill, 2004b) conclude that on-call work poses a risk to psychological health in particular.

The research finds that even when workers are *not* working, they are not sleeping or resting as effectively as a result of being on-call. Torsvall and Åkerstedt (1988) using objective and subjective measures of sleepiness in a study of ship engineers, found that on-call workers experienced higher levels of sleepiness during the day following an on-call period, and a decrease in the quality of sleep . These effects were largely independent on whether or not they *had* been called to work. The authors reported that being on-call was associated with apprehension, uneasiness and anxiety. These impacts once might be 'passed on' to those living with or near the worker. A French study of electrical and gas engineers found that on-call work also impacted on family life (Imbernon, Warret, Roitg, Chastang, & Goldberg, 1993).

Ferguson et al's very recent re-examination of the issue (Ferguson et al., 2016) expands the evidence by looking at laboratory evidence where the factors in causal relationships

are better controlled, but the scale of the outcome variables are necessarily obtained. To be clear, it is possible in a laboratory to examine the impact of on-call work (recreated for the laboratory) on outcomes such as sleep or attention, but not to, say heart disease (although other studies have shown long term relationships between sleep disruption and heart disease). The laboratory evidence confirms that being 'on call' appears to equate to being vigilant: the apprehension of being woken up impacts on quality of sleep. Other researchers have also shown that early morning shifts are associated with "apprehension of difficulty wakening" in cabin crew (Kecklund, Åkerstedt, & Lowden, 1997), and the association between shorter sleeps and apprehension about waking was echoed in the recollections of on-call fire and emergency service workers (Paterson, Aisbett, & Ferguson, 2016).

A Swedish study of ship engineers, while using a smaller sample than some of its rival studies, did have a more objective measure of sleep disruption (Torsvall & Åkerstedt, 1988), using electroencephalogram (EEG) and electrocardiogram (ECG) recordings and subjective ratings, providing evidence that subjective ratings *are* a reliable measure of sleep disruption (something I have confirmed in my own sleep laboratory work) (Korompeli et al., 2016). Interestingly, the Swedish study established that disruption to sleep often occurs during the anticipatory phase. That is, workers experience disrupted sleep *before* their sleep is actually disrupted. Being on-call, thus involves the brain being switched 'half on' to receive call signals, something this team found in previous research with ship engineers (Torsvall, Castenfors, Åkerstedt, & Fröberg, 1987).

The issue of naps—short sleeps of less than four hours—is relevant here, with on-call workers more likely to engage in brief 'catch-up' sleeps. Most sleep researchers agree that naps of at least 4 hours in length can partially or fully restore eroded functioning (Krueger, 1989). However, if sleep occurs in shorter lengths over a period of 24 hours, its effectiveness is degraded, even if the total quantum of sleep over a whole 24 hour period is the same (Naitoh & Angus, 1987). Thus, the process of 'grabbing a quick nap' to recover sleep may not be entirely successful.

Turning to impacts other than sleep[6], one of the better longitudinal studies, albeit tracking participants for a total of two weeks (one week on-call and one week not on-call) found no differences in cortisol (a marker of stress) but found significant increases in irritation and a reduction in mood and social activities, household activities, and low-effort activities (Bamberg, Dettmers, Funck, Krähe, & Vahle-Hinz, 2012). Bamberg et al's study focused on a relatively low stress work—software administrators--but found the effects were independent of whether or not the workers were *actually* called to work.

[6] It is important to note that sleep has serious implications for both physical and mental health. Apart from the direct physiological consequences noted elsewhere in this report, studies show that even restricting daily sleep by as little as 30 minutes can make significant differences to outcomes such as vigilance that have personal and societal health implications (Dinges, 1990; Harrison & Horne, 2000) such as accidents and failure to maintain proper self or other-care.

A small handful of studies have examined the impact of on-call work on mental health, again with an emphasis on the medical profession. The studies rely on self-report, using either questionnaires or mood diaries. Chambers (R Chambers & Belcher, 1994; Ruth Chambers & Campbell, 1996) conducted studies looking at anxiety and depression in two published studies in the 1990s. The studies showed on-call night work was associated with depression and anxiety, roughly equally predictive in male and female GP samples. This is correlational data, which does not in itself provide strong evidence. Measuring outcomes such as mental health *at the same time* as measuring (presumably) causal factors (such as on-call work) does not allow one to firmly establish causation. Similarly, Rout, Cooper and Rout's (1996) 'one-shot' questionnaire study uses terms such as 'predictors of health' to describe correlates (Rout, Cooper, & Rout, 1996). A better test of the impact of on-call work on mental health was a French study of male gas and electrical employees because a comparison was conducted between on-call workers and those working in similar roles but *not* on-call. The study produced the weakest 'mental health' impacts, but psychological and global wellbeing were significantly worse, and family and social wellbeing were severely impacted (Imbernon et al., 1993).

Studies have also looked at the impact of on-call work on personal security, and seem to indicate that workers in on-call professions *feel* significantly more at risk (Masterson, Ashcroft, & Shah, 1994).[7] Some cross-sectional studies do offer a degree of longitudinal strength. Heponiemi et al (2016) used a large panel of over 2500 physicians, and found that those who had been on call for more than 40 hours per month experienced highly significantly more distress than those not on call, and were more likely to indicate they were considering leaving their job. Lindfors et al (2006) sampled 60% of all working Finnish anaesthetists finding highly significant relationships between on-call workload and stress symptoms. One of the very few true longitudinal studies of on-call work, again conducted in the health sector, found that being on-call, independent of a range of other variables was significantly associated with the outcome measured in this study, musculo-skeletal disorders (Trinkoff, Le, Geiger-Brown, Lipscomb, & Lang, 2006)

4.4 Newness in work practices

Part of the problem here, as noted as the outset of this section, is that change *per se* presents a challenge. An influential article by Stinchcombe (1965) introduced the term the 'liability of newness' to the lexicon. Stinchcombe's focus was organisational: new organisations require bedding down before they become robust. His point can be easily transferred to individuals, and the evidence that newness is a liability is extensive.

Cornélissen et al (2008) for example show that frequent *change* in exposure to light (associated with changes in shift patterns) is associated with mortality in a number of species—not just humans. Adaptation to change is not immediate, and inconsistent patterns of change do not assist the process. An individual worker's body clock adjusts after 10 or more night shifts in a row (much in the manner of jet lag) (Hakkinen, 1969). Not surprisingly, *rotating* shift work even more than shift work *per se* is associated with objectively measured illness (Nicholson, Jackson, & Howes, 1978) and stable patterns

[7] These subjective feelings, as with the issue of control, may have objective health implications.

are thought to be associated with lower negative impacts of night shift work (Ahasan, Lewko, Campbell, & Salmoni, 2001).

Adaption is also occurring at a behavioural level, and again, takes time. Change in the workplace is generally accompanied by risk, and no change accompanied by a gradual reduction in risk (as much as 1.5% a year). Askenazy's (2001)analysis suggests a 1.5% annual reduction in workplace injuries and illnesses in the US during the 1970s, a period characterised by stagnant workplace reform, was contrasted by a sharp spike (as much as 10% a year) during periods of change in workplace practices in the 1980s.

In coming to these conclusions, Askenazy's (2001) relied on a meta-analysis of American Bureau of Labor Statistics Occupational Safety and Health Administration data. His focus was on a basket of practices known in the management literature as "high performance practices". These practices include job rotation, team work, contract work, flexible work hours, and unusual work hours. Askenazy's (2001) narrowly focused on injuries rather than illnesses. Askenzay argues that after an initial period of increase in autonomy, the long term effects are a diminution of autonomy and an intensification of work (see also Skorstad, 1994).

His analysis concludes that "the adoption of high performance practices seems correlated with a dramatic increase in occupational injuries and illnesses" (p. 485)[8]. The increase is in the order of 30%, which is reasonably consistent with the order of effect noted elsewhere in this report.[9] However, his analysis is muddied by having poor empirical linkage between particular work practices and particular outcomes. He says "the logic of flexible production is to reduce waste, to maximise the use of production factors, notably labour, so as to reduce downtime and enhance the pace of work" (p. 490),

Haouas and Yagoubi (Haouas & Yagoubi, 2008) conducted a similar study to Askenazy's, focusing on a single large representative Tunisian sample of 2000 workers. The Haouas and Yagoubi study has the advantage of addressing each captured form of 'flexible' work practices separately, and the nature of the dataset also controls for characteristics of the job, such as industry and firm size. An overview of results is shown in Table 2. The authors note that flexible hours *per se*[10] are not associated with injury, but the study finds a strong relationship between flexible work forms and psychological strain. Psychological strain, it should be noted, has been linked with workplace injury in a large (N=21,505) study of European workers by Costa and Sartori (2006).

[8] Askenazy's use of the word "dramatic" probably relates more to the statistical significance of the increase rather than the order of the increase itself.

[9] Not all studies find a relationship between non-secure, non-stable working time practices and occupational health. For example, Guest and Clinton (2006) in a study of 642 workers in the UK, found the association between temporariness and a sense of job insecurity, with no significant impact on wellbeing.

[10] Probably what Costa (2006) called variability, not flexibility .

Table 2: Impact of various flexible work forms on injury rates

	Correlation	Significance
Part-time work	0	NS
Flexible hours	0.002	NS
Night work	0.036	NS
Overtime	0.046	p<.05
Weekend work	0.071	p<.01
Job rotation	0.078	p<.01
Short term contract	0.11	p<.01

NS= not significant Source: Hauoas and Yagoubi (2008)

In relation to part-time and casual work, there are definite 'liabilities' in relation to worker vulnerability to accidents. The rate of occupational accidents in the first year of employment (regardless of part-time status) is substantially higher than for experienced workers (Jeong, 1997), and one Turkish study showed that 32.5% of occupational accidents happen in during the first hour of work (Ünal, Gök, & Gök, 2008) as workers become accustomed to routines. Smith et al's meta-analysis similarly showed risks associated first shift of a series of shifts (Smith, Folkard, Tucker, & Macdonald, 1998). There is a limit to which 'newness' can be seen as a liability, however. With overload and associated fatigue being in itself a significant factor in predicting injuries and other negative health outcomes for workers, a study by Alamgir et al (Alamgir, Yu, Chavoshi, & Ngan, 2008) found that injury rates for full-time nurses and care aides, per 100 person years, was greater than for part-time or casual staff. This relationship held after adjusting for age and gender (N. I. Thomas et al., 2006), and almost certainly relates to risks that rise at the end of shifts or longer working weeks, due to fatigue.

4.5 Gender effects

Hofäcker and Konig (2013) found that irregularity and unpredictability of working hours is associated with work-life conflict for both genders. The Hofäcker and Konig study takes advantage of the 2010 European Social Survey which includes large nationally representative samples of workers in 26 countries. Their study finds that short-notice overtime accounts for a significant amount of variance in the relationship between long working hours and negative effects on work-life balance. The issue of control also shows itself in effects for poor fit between actual working hours and working hour preferences leading to particularly strong effects on work-life imbalance for men. Women, it seems, suffer disproportionately when it comes to issues of synchronicity of working hours with their partners. Working women with a husband who experience less predictable working hours are more likely to experience greater difficulties with their own reconciliation of family tasks and employment. Finally, Hofäcker and Konig (2013) found a positive impact for job security, reducing work-life-conflict for both genders, but particularly for men.

There is a literature focusing specifically on the impact of irregular work hours on marital satisfaction and other aspects of family life. Studies tend to indicate that 'ordinary' day workers experience greater job and marital satisfaction and social integration (Frost & Jamal, 1979; Khaleque & Rahman, 1984; Newey & Hood, 2004; Simon, 1990), while those who work non-standard hours experience greater marital strain (Hughes, Galinsky, & Morris, 1992; Mills & Täht, 2010; Perry-Jenkins, Repetti, & Crouter, 2000; Rogers & May, 2003).

Some studies have observed domino effects in terms of child behaviour (Joshi & Bogen, 2007), despite studies showing that parents, particularly mothers, work hard to shield children from the strains caused by parental work-life conflict. Amongst men, an Australian study showed that the main predictor for working fathers not being involved with their children is working in excess of 40 hours a week (Jeffery, Luo, Kueh, Petersen, & Quinlivan, 2015), but such relationships are much weaker for women. Non-standard work practices can of course also be used to *enhance* contact between parents and children. For example, a recent large Dutch study shows how couples desynchronized schedules to facilitate 'tag-team' parenting in dual-income parents (Täht & Mills, 2012).

Interestingly, the majority of studies tend to find that the impact of rotating/night shifts on relationship quality is overall greater for women (Perry-Jenkins, Goldberg, Pierce, & Sayer, 2007; Raudenbush, Brennan, & Barnett, 1995). However there are exceptions to this pattern (e.g. Barnett, Brennan, Raudenbush, & Marshall, 1994; Keizer & Schenk, 2012; Rogers & May, 2003).

These effects may be significantly dependent on the degree of synchronisation between partners' working patterns; however it is logical that irregularity in patterns on the part of one or both partners working hours will have desynchronisation as a consequence. Simon's (1990) study, for example, details a range of problems associated with poor integration of partner waking and sleeping cycles include challenges relating to parental roles, sexual activity and eating routines. The degree of difficulty of reconciling partners' working hours may be dependent on the stage of the week being examined. For example, Schneider et al (Schneider, Ainbinder, & Csikszentmihalyi, 2004) found no gender effect for stress during the normal working week, but evidence of stress emerged on weekends, particularly for women.

5.0 Conclusions

Responses to stressful events are not fixed, but depend on their meaning for the individual (Thompson, 1981) and when psychologists talk about individual control they almost invariably talk about *sense of* control or *perceived* control, not 'real' levels of control. It has long been established that manipulating behavioural control in the laboratory or beyond leads to significant increases in physiological arousal and self-report of negative arousal, particularly during the period prior to the aversive event (Thompson, 1981), but while this arousal may govern responses to measures of variables such as 'job satisfaction' or 'burnout', they are also very probably a marker of physiological changes in the human endocrinal system.

I have focused, where possible, on evidence directly specific to the health and care sector. It is important to note that the health and care sector, due to the 24-hour nature of many tasks within the sector, is also closely tied, both empirically and in the public mind, with shift work, but it is important to disentangle shift work from irregular or unpredictable work.

Shift work (even regular, predictable shift work) is associated independently with deleterious effects on human health (for a landmark review, see Costa, 2003) and WHO's International Agency for Research on Cancer Monograph Working Group in 2007 went further, declaring that circadian disruption is "probably carcinogenic"(Cornélissen et al., 2008). If one *adds* variability and unpredictability to shift work, for example with the addition of rotating shift work, then the impacts are amplified. For example, in a study of steel workers, Nicholson and Jackson (1978) found that multiple rotations (as well as weekend work) were associated with objectively measured illness and stable patterns of consecutive night shifts are thought to be associated with lower negative impacts of night shift work (Ahasan et al., 2001).

Irregularity, on-call and flexible work practices have been heavily linked in the literature with work-life imbalance, and the impact is particularly strong for women—and thus has particular relevance to the care sector, where there is a significant continuing gender imbalance in favour of women (Zurn, Dal Poz, Stilwell, & Adams, 2004). When events that constitute ' life' follow a relatively regular beat, and are not flexible (for example, school play times, or sporting fixtures) reconciling 'life' with work becomes inevitably more difficult when work becomes less predictable and regular.

Amongst the 'life' aspects that are most critical for physical and psychological health are positive health behaviours or habits that are ruptured by irregular work demands (including social links with the community, sporting activities, and healthy eating). The link between irregular hours or unusual work schedules and outcomes such as smoking, drinking and weight gain, is also very well established. Perhaps less well established is the disadvantage that this sector of workers suffer in relation to access to services, or the same quality of service. There is an emerging literature on the increased risk of sub-standard health services offered to those who experience a health event for example on Saturdays and Sundays.

While work-life balance is one of the impacts that workers subjectively notice first when work becomes less regular or predictable, I have focused relatively more attention on the less intuitively 'obvious' challenges posed by irregular or unpredictable work practices. I have focused most closely on two particular challenges: the issue of control, and the issue of change.

It is highly likely that these two factors are the root of many of the negative health effects that emerge in broad-scale epidemiological studies of work practices and health. Control is a variable that is rarely excluded from analysis when studies are planned in the field of health psychology; such is its importance in determining the impact of interventions. The dominant set of models on the impact of work on health, all sourced in Karasek's foundation work (Karasek, 1979) has *control* at its centre. Evidence is that level of control in a work context can predict everything from depression to cardiovascular disease to a highly significant degree. *Change*, in Karasek's models, is

cast as a demand variable, i.e. a stressor. Demand without control is a recipe for ill health and dissatisfaction.

Apart from being a general challenge to the human adaptability (with implications for workplace accidents for example) change also predicts sleep disturbance. In the section headed "newness in work practices" I summarise some of the better evidence relating to flexible work practices and their impact on injury rates. **Control and change are *the* two key psychosocial dimensions of work, and as noted in the research summarised in this report, have significant predictive power in determining a wide variety of health outcomes.** Control is particularly relevant for staff in relatively junior positions within care settings, and for these staff, I recommend particular care is taken with interfering with the predictability of work, as it is likely to compound existing problems associated with uncontrollability in the workplace.

DECLARATION.

I have made all the inquiries that I believe are desirable and appropriate and that no matters of significance that I regard as relevant have, to my knowledge, been withheld from the Commission.

Olav Titus Muurlink
14/05/2016

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From:	Michael Robson
To:	Chambers - Hatcher VP
Cc:	"Michael Pegg (mpegg@ja.com.au)"; AMOD; Kyle Scott; Beth Robinson
Subject:	AM2014/196&197 - Part-time and Casual Employment - NDIS and other matters
Date:	Thursday, 14 July 2016 2:11:03 PM
Attachments:	Muurlink CV 2015b-1.pdf

Dear Associate,

Please find attached the curriculum vitae of Dr Olav Muurlink. This was meant to have been filed with his report.

We copy the applicant parties.

Best regards,

Michael Robson
National Industrial Officer
United Voice
0412213186

Sent from my mobile

Curriculum Vitae, Olav Titus Muurlink

CONTACT INFORMATION

Name	Olav Titus Muurlink
Address	
Mobile	
Work Email	o.muurlink@cqu.edu.au
Personal Email	o.muurlink@gmail.com

EDUCATION

2002 **PhD, Griffith University**
Social Psychology (Evidence of Escape in Cognitive Dissonance Studies)

Examiners: Professor Michael Leippe, John Jay College of Criminal Justice, New York (formerly of Illinois State, and a Fellow of the Association for Psychological Science and the Society of Experimental Social Psychology) and Emeritus Professor Cindy Gallois, University of Queensland.

Supervisors were Professor Drew Nesdale (recently retired) from Griffith University and Associate Professor Frances O'Callaghan, at Griffith University Gold Coast.

1993 **MPhil (Coursework), University of St. Andrews**
Psychology (Health, Cognition, Clinical, Developmental)

Supervisor was the late Professor Terence Lee FBPsS

Awarded "with distinction", equivalent to First Class Honours.

1991 **BA (Hons), University of Queensland (Australia) Communications**
Awarded First Class Honours

1990 **BA, Charles Sturt University**
Psychology
Awarded the University Medal

EMPLOYMENT HISTORY

Current roles

2014- **Senior Lecturer, Organisational Behaviour, Central Queensland University, Brisbane Campus**

2014 **Senior Research Fellow (adjunct)** Griffith Institute of Educational Research.

2000 Chairman, Management Committee, Co-operation in Development (Australia) Inc

Role description: Member of the management committee since 1994. Management committee has oversightof one of the first Australian charities to be established in Bangladesh (in the first 100 of all charities established since the founding of the new nation in 1971). CO-ID is a medium-sized charity (paid staff of 170; voluntary management committee, 15) and student body of 12,750 full time year 1-7 students. It has built and operates one of the largest private primary school systems in Bangladesh, delivering the full national curriculum. Students are often the first in their family for generations to be able to read or write. As chairman of the management committee, I oversee governance, policy development, media liaison (which has seen media coverage ranging from ABC's *Australian Story* to the *Herald Sun*), and regularly visit Bangladesh for audit purposes. I oversaw the process whereby CO-ID was granted tax deductible gift recipient status with the Australian Tax Office, the first purely overseas-focused charity in many years to achieve this status.

Previous, academic:

2013-2014 Research Consultant, CIRA Research (since November, 2013)

Providing support services, including data analysis, survey design, case study handling, academic writing assistance, and methodological advice to academic clients. The consultancy also provides transcription services, Qualtrics, SPSS, R, and graphic design assistance for paper-based surveys. Clients ranged from individual academics to university administration.

2013-2014 Senior Research Fellow, Centre for Learning Futures, Griffith University (since August 2013)

Supervisors: Professors Alf Lizzio and Keithia Wilson.
Role description: Handling quantitative and qualitative analysis of models of first year student attrition, university-wide dataset.

2010-2014 Research Fellow, Centre for Work, Organisation and Wellbeing, Griffith University (since Feb 2010)

Supervisors: Professors David Peetz (academic supervisor), Professor Adrian Wilkinson, and Associate Professors Georgina Murray and Keith Townsend.
Role description: Work and stress research projects, spanning a number of fields: project management, quantitative analysis and report and article authoring on the continuing Australian Coal and Energy Survey (ACES) examining shiftwork and its psychological and physical health impacts in a large longitudinal mixed partner survey; project management, quantitative and qualitative analysis and authoring on the New Workplaces project, examining management of firms under growth stress, and innovation in human resource management.

1991-1992 Researcher, Social Policy Research Unit, University of St. Andrews,

Role description: Principal Researcher of psychological component of report published by Robens Institute, University of Surrey, for the British government in relation to public willingness to pay to electricity utilities to reduce the risk of nuclear power. Supervised by Professor Terence Lee, I also worked on projects relating to perceptions of communication brochures for the British Forestry Commission, and the perception of household radon risk for the British government (the NRPB).

Previous, non-academic:

1999-2009 Managing director of Free Media Pty Ltd (1999-2009)

Role description: Founding publisher and managing editor of the *Southern Free Times* (now owned by the Victorian-based Star News Group), and founder of the Pressstream heatset printing facility. I managed a large staff across two states and a number of publications in Brisbane, Kingaroy, Warwick and the Gold Coast. The role required working closely with journalists, graphic artists, printers, accountants and other staff, as well as suppliers and clients. The role was highly challenging, involving co-ordinating the output of a number of weekly publications, as well as handling external printing clients. Major achievements include project management of the installation of the only heatset four colour press outside metropolitan Australia on a greenfields site on the Warwick Crown Industrial Estate. It was a multi-million dollar project that attracted national industry attention.

(Media link: www.swug.com.au/downloads/SWUG_sunco200712.pdf)

1998-2008 Director/Marketing director Wyco International/T.T. Merino (Australia) (1998-2008)

Role description: These companies were export-orientated manufacturers and processors, with markets in China, the UK, Greece, Italy, Switzerland, Denmark and Sweden. Broad ranging roles including developing strategy, market research, grant applications, personnel management.

1989-1990 Pacific correspondent, World Information Service on Energy.

Role description: Reporting on issues relating to nuclear and alternative energy and uranium mining in Australia for a small news service based in Amsterdam. Contributor to Roger Moody's *The Gulliver File*, an encyclopedia of the corporate world of uranium mining, picked as one of *The Guardian* (UK) newspaper's Top Ten Green books for 1993.

ACADEMIC ENGAGEMENT

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2016 **Member, Academic Board,** Central Queensland University. Elected by national poll of academic staff.
2016 **Member, Human Ethics Committee,** Central Queensland University. By invitation.
2016 **Member, Bachelor of Business Review Advisory Committee,** Central Queensland University. By invitation.
2015 **Member, Campus Life Committee,** Central Queensland University, Brisbane Campus. By invitation.

Curriculum Vitae, Olav Titus Muurlink

TEACHING EXPERIENCE

2016- Research Methods (postgraduate), Introduction to Management (undergraduate), Contemporary Organisational and HRM Studies (undergraduate), Human Resource Development (undergraduate).

2014- Organisational behaviour subjects at undergraduate and postgraduate level, Central Queensland University

2012- presented guest lectures and workshops, including on The Psychology of Leisure and the Social Psychology of Leisure for Dr Maureen Harrington at Griffith University, and lectures for HDR students and junior staff at QUT on creativity, research strategy at University of Queensland, Griffith University, Jagganath University, the University of Dhaka, the Institute of Statistical Research and Training, and Central Queensland University.

1993, convened full-year Introduction to Psychology course at Sophia College, Warwick (students graduated to second year at the University of Southern Queensland).

PHD SUPERVISION

Completed: *Alex Roper.*

Topic: The use of sport as an instrument of attitude change in Malaysian society. Co-supervised with Prof. Chris Auld.

Ongoing:

Ben French. Topic: First year course enhancement strategies, retention and performance in B.Bus courses, Griffith University. Co-supervised with Dr Richard Copp. PhD.

Shane Doyle Topic: Leadership development in senior police. Co-supervised with Dr Shelley Wakefield. PhD.

Vipada Charoensuk Topic: Extravert/Introvert Personality Characteristics Affect Consumer Taste Preferences and Behaviour in a Public Food Consumption Context. Masters by research.

Samantha Dunham Topic: Emotional labour in managers.

Pratima Durga Topic: The children of shiftworkers.

AWARDS

Best Oral Presenter, Public Health Foundation, 2015.

Student Voice Award, 2015, Central Queensland University.
University Medal, 1990, Charles Sturt University.
Australian Postgraduate Award, 1996.
Griffith University Postgraduate Top-Up Award, 1996.

RESEARCH INTERESTS

Health psychology, occupational health and organisational behaviour, attitude and behavioural change, shift work, education and innovation.

POSTDOCTORAL TRAINING

2012	*Structural Equation Modelling using AMOS*, three-day course, Griffith University Gold Coast, November 2012.
2011	*Multiple Regression*, ACSPRI course, week-long course, University of Queensland, June 2011.
2010	*Responsibilities of being a Research Higher Degree Supervisor*, Griffith University.
2009	*Managing the supervisory process*. One day symposium, presented by Dr Calvin Smith. Griffith University
2009	*Copyright, teaching and research*. Presented by Mark Magener.
2009	Two-day induction, tutoring, 2009.

Computer and programming skills:

Programming:	Windows Interactive Language
Statistical:	SPSS
Other:	Quark XPress (advanced), Indesign (advanced), Remark data entry automation, Qualtrics

PROFESSIONAL AFFILIATIONS

……..

Member, Australian Psychological Society

Member, Centre for Work, Organisation and Wellbeing, Griffith University.

Member, Griffith Institute of Educational Research.

Member, Working Time Society.

Associate Editor, Journal of Management History (2016-) (A ranked).

Member, College of Reviewers, Higher Education Research and Development (A ranked)

Reviewer for the *International Journal of Small Business*, the *International Journal of Climate Change*, *Community Work and Family,* and the *Interdisciplinary Journal of Economics and Business Law*.

SIGNIFICANT RESEARCH OUTPUTS

……

(i) SCHOLARLY BOOK CHAPTERS (5)

1. 2013 Wilkinson, A., Muurlink, O., Peetz, D, and Townsend, K. Growing up fast – how gazelles manage HRM. In A. Wilkinson and T. Redman (Eds.), *Contemporary Human Resource Management* (pp. 27-30). 4th edition. London: Pearson.
2. 2013 French, B., and Muurlink, O. The Law of Employment. In C. Turner (Ed.), *Australian Commercial Law (*pp. 967-998). Sydney: Thomson Reuters.
3. 2012 French, B., Harpur, P., & Muurlink, O. A Pandora's Box of General Protections under the Fair Work Act 2009. In K. Abbott, B. Hearn-Mackinno, L. Morris, & K. Saville (Eds.), *Fair Work Act: Revision or Restitution* (pp. 75-92). Melbourne: Heidelberg Press.
4. 2012 Muurlink, O. Rigidity as a cause and effect in SME business failure. In T. Dundon, & A. Wilkinson (Eds.), *Case Studies in Global Management: Strategy, Innovation and People Management* (pp. 46-51). Sydney: Tilde University Press.
5. 2011 Muurlink, O., & Poyatos Matas, C. A higher degree of stress: Academic wellbeing in higher education. In L. Marshall, C. Morris (Eds.), *Taking Wellbeing Forward in Higher Education: Reflections on theory and practice* (pp. 60-71). Brighton: University of Brighton Press.

(ii) SCHOLARLY BOOKS (1)

6. 2011 Turner, C., Gamble, R., French, B., & Muurlink, O. *Business Law for Managers*. Sydney: Thomson Reuters.

(iii) REFEREED JOURNAL ARTICLES (20)

7. Loudoun, R, Muurlink, O, Peetz, D and Murray, G. (2015), Does age moderate the relationship between control at work and sleep disturbances? *Chronobiology International*, 31(10), 1190-1200.

8. Kabir, R, Muurlink, O., and Hossain, M. (2015) Arsenicosis and social contamination *Global Public Health, 10, 8.*

9. Peetz, D., Murray, G, Muurlink, O, and May, M. (2015, forthcoming). The meaning and making of union networks, *The Economic and Labour Relations Review*

10. French, B, Muurlink, O, and Boyle, M. (2015). Workplace Bullying in Australia: the Fair Work Act. *New Zealand Journal of Human Resource Management.* 14(20), 69-81.

11. Korompeli, A., Muurlink, O., et al Ad libitum and restricted day and night sleep architecture. *Chronobiology International.*

12. Wilkinson, A., Townsend, K., Graham, T, and Muurlink, O. (2015), Fatal consequences: an analysis of the failed employee voice system at the Bundaberg Hospital, *Asia Pacific Journal of Human Resources. 53,* 265-280.

13. Muurlink, O. and McAllister, P.J. *(2015)* Biographising trend in popular science writing. *The International Journal of the Book,* 13(3), 1-12.

14. Muurlink, O. and McAllister, P.J. (2015) Narrative risks in science writing for the lay public. *Journal of Science Communication*, 14(3), A01.

15. Kent, S. & Muurlink, O. (2014). Getting a grip of why incivility happens within the workplace: A commentary essay. *Social Justice Research, 26(1),* 137-148.

16. Muurlink, O., Murray, G. and Peetz, D. (2014) Wor-related influences on marital satisfaction amongst shiftworkers and their partners: a large matched-pair study. *Community, Work and Family*, 17(3), 288-307.

17. Peetz, D., Murray, G. and Muurlink, O. (2014) Work-life interference and gender in the mining and energy industry. *Labour and Industry,* 24(4), 286-301.

18. Korompeli, A., Muurlink, O., Tzavara, C., Velonakis, E., Lemonidon, C., and Sourtzi, P. (2014). Influence on Greek nursing personnel. *Safety and Health at Work,* 5(2), 73-79.

19. Islam, M., Rutherford, S., Muurlink, O., Baum, S., and Chu, C. (2014) Lay

perceptions of climate change and climate change impacts. *International Journal of Climate Change: Impacts and Response*, 5(3).

20. Muurlink, O. (2013). The three not-so-wise manoeuvres behind willingness-to-pay calculations. *Interdisciplinary Journal of Economics and Business Law, 2*(4), 118-144.

21. 2012 Muurlink, O. T., Wilkinson, A., Peetz, D., & Townsend, K. Managerial autism: Threat rigidity and rigidity's threat. *British Journal of Management*, *23*(S1), S74-S87.

22. 2011 Peetz, D., Muurlink, O., Townsend, K., Allan, C., & Fox, A. Quality and quantity in work-home conflict: The nature and direction of effects of work on employees' personal relationships and partners. *Australian Bulletin of Labour*, *37*(2), 138-163.

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$150,000, Queensland Investment Incentives Scheme (QIIS) Committee and the Grants Review Committee, for T.T. Merino, to develop new supply streams for purpose-specific sheepskins.

$48,000 Business Systems Improvement (New Employee) Process Improvement grant, for Wyco International, for developing automation of key processes in sheepskin paintroller production.

Consultancies and expert testimony

2015-2016

2014 Union consortium versus Aurizon (rail freight company) before the Fair Work Commission, expert witness on employee attitudes to the abandonment of enterprise bargaining agreement.

2014 New Zealand Ministry of Business, Innovation and Employment (MBIE): Working under Professor David Peetz and Auckland University of Technology's Dr Katherine Ravenswood, on a consultancy "Productive and high wage workplaces - regulatory levers"

2013 United Voice: Expert witness in an arbitration before the Full Bench of the Queensland Industrial Relations Commission on behalf of the respondent (United Voice union, representing ambulance workers) challenging attempts to remove meal penalty allowance. Report accepted without cross-examination by the Queensland Ambulance Service (the plaintiff).

2013 United Firefighters Union: Preparing submission to review of emergency services.

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SELECTED RECENT MEDIA

Radio:

2016	Interview with Elizabeth Jackson, AM, penalty rates. http://www.abc.net.au/am/content/2016/s4471168.htm
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Professor Brad Bowden
Professor, Industrial Relations

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NATIONAL DISABILITY INSURANCE AGENCY

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THE NDIS AND PRICING

The National Disability Insurance Scheme (NDIS) is a new way of providing support for 460,000 Australians with permanent and significant disabilities ('participants'). It represents a fundamental shift in how disability support is delivered. Under the NDIS, participants can exercise choice and control by purchasing their supports directly from providers. This means funding of disability supports will no longer take place through block funding for providers, but rather through individualised support funding for participants.

Once the NDIS reaches maturity, it is intended that the market itself will set the price of supports. However, temporary price controls are needed to ensure participants can access affordable supports, while the market is still growing. The National Disability Insurance Agency (NDIA) uses price caps on many supports and services to regulate price, but striking the right balance is challenging. If prices are set too high, this will encourage the supply of supports, but reduce the purchasing power of participants and negatively impact the sustainability of the NDIS. If prices are set too low, this could lead to a supply shortfall in the market and compromise participant outcomes.

Some providers of disability supports and other stakeholders have expressed views that current price caps are too low and are hindering market development. These issues have been raised in submissions by providers to the NDIA, as part of the NDIA FY2017/18 Price Review, as well as to the Productivity Commission as part of the review of NDIS costs.

THE INDEPENDENT PRICING REVIEW PROCESS

In June 2017, the Board of the NDIA commissioned McKinsey & Company to undertake an Independent Pricing Review (IPR) to investigate the appropriateness of the NDIA's pricing strategy and approach, and the suitability of current price levels for supports and services. The scope of the IPR was defined by the NDIA Board in the Terms of Reference (TOR):

1. Provide recommendations in relation to improved pricing effectiveness, including but not limited to:
   - National versus regional pricing
   - Pricing of services with different levels of complexity
   - Pricing of respite services
   - Thin and undersupplied markets, particularly in regional and remote areas
   - Relative provider efficiencies, including overheads
   - Adequacy of provider returns
   - Effectiveness of the Hourly Return approach used to set prices

2. Provide recommendations in relation to the potential early deregulation of price in more mature sub-markets and the glide path for the eventual deregulation of price more generally.

Over the last six months the IPR team has conducted its review, including extensive consultations with stakeholders – providers, peak bodies, the NDIA, academics, and state and territory governments. Through the provider consultation process, the IPR team engaged with over 1000 individuals across Australia through 10 open forums, 9 webinars and 45 one-on-one interviews, to understand how providers have been responding to current price settings. The IPR team also undertook detailed analyses of provider economics, market development and NDIA data. This report provides a summary of the evidence gathered by the IPR team, and 25 recommendations for changes to the NDIA's pricing approach and policies. Recommendations are grouped by the items in the Terms of Reference.

FEEDBACK FROM CONSULTATION

Key issues raised by providers and other stakeholders in submissions and during the consultation process were:

- The NDIS requires a significant change in providers' operating models and there are administrative costs associated with transition; as well as opportunities to improve the efficiency of the NDIA's systems and processes, for example, the online portal.
- Current loadings for complex participants do not fully reflect the additional costs of serving these participants, such as higher wages for a more skilled workforce, additional time required for training and reporting, and higher supervision ratios. In addition, there is no clear definition of what constitutes 'complex', and as a result the high intensity loading is applied inconsistently.
- Current travel allowances do not adequately cover the costs of provider travel and participant transport in regional areas and isolated communities.

Other issues were raised in relation to specific support types:

- In attendant care, some providers, who have historically been funded by state-administered block funding, are struggling to adjust their business models to operate under the NDIS unit-funding model and the current level of price caps. To operate profitably within the price caps requires improved levels of utilisation and overheads; and better matching of skills to participant needs.
- In therapy, the existing single price point does not reflect the diversity in therapy supports and the travel allowance is insufficient for some participants in regional areas. In addition, limiting therapists to recover the costs from a maximum of 2 hours of cancellations per year is imposing additional costs on some therapists.

Additionally, issues regarding the price setting process and the opportunity for innovative price setting were raised, including:

- The price setting process could be more transparent, and providers would appreciate earlier communication of changes to price level and/or structure to refresh service agreements and adapt operating models.

- Some providers and participants expressed the desire for the NDIA to explore outcomes-based approaches to pricing on the basis that would create better incentives to improve outcomes than the current hourly rate approach.

KEY FINDINGS AND SUPPORTING EVIDENCE

To address the issues raised by providers and other stakeholders during consultation, and to assess whether current price caps are adequate, the IPR team looked at three sources of evidence: evidence of market development/supply shortages; provider economics and operating models; and benchmarks of comparable schemes.

The key findings of the IPR are:

- While there is not yet evidence of generalised supply shortages, data on market development is mixed and there are certain markets for which undersupply is a risk in the future:
  - Across support types, provider entry and exit data suggests market growth is keeping pace with demand and utilisation data does not provide compelling evidence of supply shortages:
    - The rate of growth of month-to-month provider registration outpaced the rate of growth of participant registration throughout 2017.
    - Utilisation data from the trial sites suggests lower than expected utilisation was driven by participants being unfamiliar with the NDIS and how to use their supports, rather than a supply shortage.
  - In the attendant care market, there is not yet compelling evidence of participants being unable to access supports, but there are signals that are concerning, including a significant proportion of providers that currently have unprofitable operating models.
  - There are cohorts of participants for which supply shortages are high-risk due to the increased cost of service provision and limited availability of workforce, including those who: are in outer regional, remote or very remote areas; have complex needs; are from culturally and linguistically diverse backgrounds; are Aboriginal and Torres Strait Islander Australians; or have acute care needs such as in crisis situations.
- While some providers have operating models that are profitable at current price points, many are struggling, particularly traditional providers delivering attendant care supports:
  - In the attendant care market, there is significant variation (from <$40 to $55+ per hour) in the cost of service delivery between providers. There are examples of low cost models that are profitable at current price points, including the online platform model and lean-operating model. However, many traditional providers are struggling to operate profitably at current price points. This is attributable to a combination of factors: higher overheads; challenges in adapting to unit pricing and NDIA systems improvement opportunities; lower utilisation of workers; and higher labour costs.
  - In therapy, the single price point is working for some providers, such as physio and speech therapy providers and many sole traders. However, it is not working so well for some others, such as psychological therapy for more complex participants.

  - In Supported Independent Living (SIL), Support Coordination and Plan Management, feedback indicates that most providers can operate profitably at current price caps/benchmarks for lower complexity participants. However, the rollout of a more accurate SIL pricing process may make it more challenging for providers to cross-subsidise other supports in the future.

- Benchmarking of NDIA support price caps against comparable schemes highlighted that the NDIA price is broadly aligned with prices of accident compensation schemes, including the Transport Accident Commission and WorkSafe, although market prices for some similar aged care services are higher.

RECOMMENDATIONS

Ultimately, the test of whether the price caps set by the NDIA are adequate is whether participants can access the quality supports and services required to achieve their goals. While there is not yet evidence of widespread supply gaps occurring, the Scheme is in a state of transition and rapid growth, and the situation could change quickly. Further, the absence of supply gaps does not diminish the fact that the current price caps are challenging, and many providers are unable to operate profitably within those price caps. Providers and participants have raised concerns that where providers are unable to supply services at a given price level, new supply will not be made available quickly enough to ensure that participants have access to an adequate level of support.

To proactively manage the key risk of supply gaps, the IPR team proposes three steps for the NDIA to undertake. Firstly, the NDIA should collect and analyse a broader set of indicators of market development and participant outcomes to both better monitor the risk of supply gaps and build institutional capacity to avert supply challenges through market intervention.

Secondly, the NDIA should implement appropriate amendments to price loadings and policies, to improve the economics of efficient providers and reduce the risk of supply shortages in high-risk markets – particularly rural and remote, and highly complex participants. Those changes include:

- Adding a third tier to the complexity loading of 10%, to account for higher level of skills/experience of workers and additional training required.
- Allowing providers to charge up to 45 minutes of travel time in rural areas, and quote for services in isolated regions.
- Changing the cancellation policy to allow providers to charge participants for cancellations after 3pm on the day before the service.
- Removing the $1000 travel cap for therapy supports and aligning the travel policy with attendant care travel policy.
- Changing the therapy prices to better reflect different therapy types, and introducing a second tier of pricing for therapy assistants.
- Addressing specific NDIA systems and processes, such as portal functionality and quoting, to enable providers to reduce administrative tasks and overhead costs.

Finally, the NDIA should assess the implementation of a temporary price supplement to the attendant care price cap to address short-term issues with provider economics. The IPR team's assessment is that while generalised supply gaps have not occurred to date, there is a material risk of gaps emerging over the next year. Demand will continue to rapidly increase as new participants enter the Scheme, and many providers are struggling to operate a surplus at the price cap with their current operating model. There is a risk that profitable providers will not grow quickly enough to supply the services required. The IPR team proposes a model of Transitional Support for Overheads (TSO) in the form of a 2-3% increase in the price cap of 1:1 attendant care for the next 12 months. This would apply in addition to the normal annual indexation of the price cap. This adjustment reflects what the IPR team believes are reasonable cost improvement assumptions for most providers to achieve in the near term. The exact quantum of the TSO should be a policy decision the NDIA makes in view of other more targeted interventions government will undertake in the next 12 months to mitigate the risk of supply shortages. There should be a review in 12 months to determine whether any level of temporary support is required for a further period. The expectation is that 12 months is a reasonable timeframe for providers to make the necessary changes to their business models, and for the NDIA to assist and encourage the development of efficient and effective alternative supply options (e.g. e-marketplaces), so that the TSO would not need to be renewed.

Longer term, the development of a competitive marketplace should enable changes to the Scheme's current pricing model of price caps and fee-for-service. The IPR team's recommendations include actions that the NDIA can take to pilot and prepare for different pricing models. Firstly, the NDIA should conduct a trial of outcomes-based pricing. This is an appealing alternative to input-based pricing as it encourages providers to maximise outcomes, rather than the volume of services provided. However, it is significantly more complex and requires strong baseline data and measurement systems. A trial would provide valuable learnings on how this approach might be implemented in some supports.

Deregulation of pricing remains an appropriate goal, but there is not yet a clear path towards reaching it. To better prepare the market and the NDIS for deregulation, the IPR team proposes strengthening and monitoring provider and participant readiness, including investing in key infrastructure, such as an e-market. Trialling price deregulation in one geography or support type market will also help the NDIA collect more detailed information on the impact of deregulation on market development and participant outcomes.

IMPLICATIONS

In developing its recommendations, the IPR team has sought to address provider concerns in a way that best balances potential trade-offs between participant outcomes, market development and Scheme sustainability. The effectiveness and efficiency of pricing mechanisms and levels was considered, subject to available data. Some recommendations go directly to changing the effective price, such as Temporary Support for Overheads (TSO) and a new complexity loading for very complex participants; some target root causes of the problems, such as changes to cancellation and travel policies; and some propose stronger market monitoring and intervention capabilities. Each of these recommendation types will have different impacts on the three Scheme aspirations: better participant outcomes; a growing market with innovative supports; and a financially sustainable scheme.

In the aggregate, the IPR team estimates that the above recommendations will have a potential financial impact of ~$250-420m per annum over the next 12 to 24 months, will alleviate some of the financial pressure currently placed on some providers, and will improve participant outcomes by addressing challenges that are impacting some providers' abilities to deliver quality services. Cost estimates have been made on the best data available. However, data will remain incomplete until the Scheme becomes more mature. As a result, the IPR has made a number of assumptions leading to a wide range of estimates.

Beyond the next 24 months, the IPR team believe it is possible to implement the IPR recommendations and manage the Scheme so that it is financially sustainable and within the current budget estimates. Approximately 50% of the total cost implication of the IPR recommendations is temporary and will therefore not have an adverse impact on the Scheme's longer-term financial sustainability. Also, as the Scheme matures, the NDIA should be able to offset any financial impact of these recommendations by appropriately assessing their effectiveness and efficiency. For example, as evidence develops as to which interventions are most effective in reducing costs associated with complexity, it should be possible to reduce the number of complex participants and provider costs and prices. It should also be possible to encourage more local providers in rural and remote areas that will assist in reducing travel costs. There should also be some savings from introducing tiered therapy pricing.

1 Introduction

1.1 OVERVIEW OF THE NDIS AND NDIA

The National Disability Insurance Scheme (NDIS) is a new scheme designed to change the way supports and services are provided to Australians with significant and permanent disabilities ('participants'). By 2020, the NDIS will provide about 460,000 people with the reasonable and necessary supports they need to live an ordinary life. The NDIS is currently in the transition period, with participants entering the Scheme according to an agreed phasing plan.

The National Disability Insurance Agency (NDIA) is the statutory authority responsible for administering the NDIS. The NDIA has three external aspirations (NDIA aspirations):[1]

1. Facilitate outcomes of economic and social independence and deliver an exceptional service for participants, and their families, carers and providers ('better participant outcomes').
2. Work with participants and other stakeholders to facilitate the growth of a market of adequate size, quality and innovation ('a growing market with innovative supports').
3. Deliver a financially sustainable scheme based on insurance principles within agreed funding ('a financially sustainable Scheme').

1.2 THE ROLE OF PRICE

The NDIS represents a fundamental shift in the way disability supports are provided. Under the NDIS, people with disability will be able to exercise choice and control over the supports they receive. This way of providing supports and services requires a transition from a prior model of block funding for providers, to individualised funding for supports for participants.

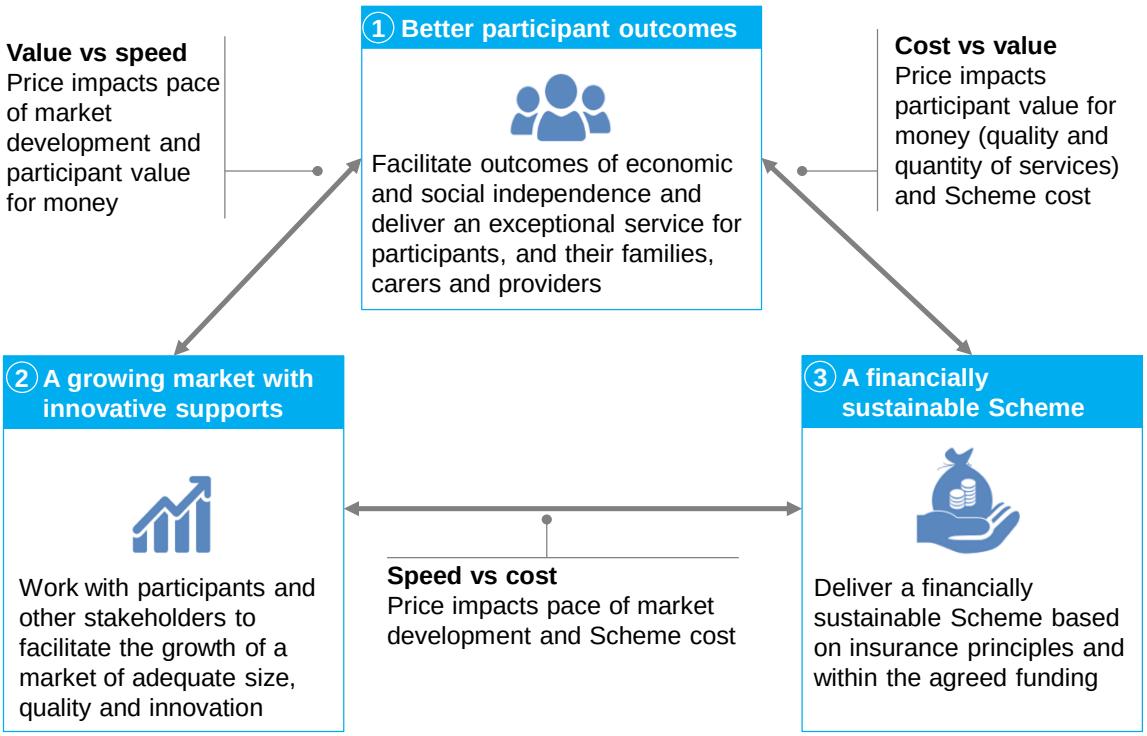
In a mature market, participants exercising choice and control will drive the price of supports, and in turn drive competition and innovation among providers. This is an important feature of the NDIS. However, where the market is not sufficiently mature and where there is an imbalance in bargaining power between participants and providers, price regulation helps ensure value for money for participants.

The NDIA sets price caps for many supports. The price of supports has implications for the NDIA aspirations, and trade-offs may be required among them (see Exhibit 1). For example, higher prices may encourage the supply of supports, but reduce the purchasing power of participants and negatively impact Scheme sustainability, whereas lower prices may increase value for money but lead to a supply shortfall in the market. Ultimately, the test of whether the price caps set by the NDIA are adequate is whether participants can access quality supports and services required to achieve their goals.

[1] NDIA: *Corporate Plan 2017-21*. The Corporate Plan outlines four aspirations for the NDIA: three 'external aspirations' and one 'internal aspiration', which is to build a high performing NDIA.

EXHIBIT 1

Impact of price on three Scheme aspirations



SOURCE: NDIS Corporate Plan 2017-21

1.3 BACKGROUND AND SCOPE OF THE IPR

Some providers of disability supports and other stakeholders have expressed concerns that some of the current price caps are constraining market development and outcomes for participants. These concerns were raised in submissions to the NDIA, as part of the NDIA FY2017/18 Price Review, as well as to the Productivity Commission as part of its review of NDIS costs. In June 2017, the Board of the NDIA commissioned McKinsey & Company to undertake an Independent Pricing Review (IPR) to understand the significance of provider concerns, and create an evidence base to inform decision making and help to mitigate the risk of future supply shortages as the NDIS transitions to full scheme. The objective of the IPR was to investigate the appropriateness of NDIA's current pricing strategy and approach, and assess the suitability of current price levels for supports and services.

The scope of the IPR was defined by the NDIA Board in the Terms of Reference:

1. Provide recommendations in relation to improved pricing effectiveness, including but not limited to:
   - National versus regional pricing
   - Pricing of services with different levels of complexity
   - Pricing of short-term accommodation (respite) services

- Thin and undersupplied markets, particularly in regional and remote areas
- Relative provider efficiencies, including overheads
- Adequacy of provider returns
- Effectiveness of the Hourly Return approach used to set prices

2. Provide recommendations in relation to the potential early deregulation of price in more mature sub-markets and the glide path for the eventual deregulation of price more generally.

Pricing of specialist disability accommodation (SDA) was excluded from the scope of the IPR on the basis that there was separate work being undertaken by the NDIA on this topic.

This report provides a summary of the evidence and findings from provider consultation and analysis conducted by the IPR team (Sections 2 and 3), and presents recommendations against each item of the IPR Terms of Reference (Section 4).

1.4 PHASES OF THE IPR

Phase 1 (Jul-Aug 2017): Review of submissions and NDIA documents and initial assessment of provider economics

The first phase of work consisted of reviewing and analysing the NDIA's market stewardship role, building a provider economics/cost model, and analysing supply challenges likely to emerge at the sub-market level. Submissions to the NDIA and the Productivity Commission were reviewed and documented, to identify priority issues for further consultation.

The IPR team also conducted analysis of comparable schemes, e.g. Accident Compensation, Aged Care, and State-funded disability – to assess NDIA prices versus other relevant sectors.

Phase 2 (Sep-Oct 2017): Provider consultation and evaluation of options

Phase 2 focussed on engaging with providers and other stakeholders. The IPR team held ten provider forums in: Adelaide (SA), Townsville (QLD), Melbourne (VIC) (2), Darwin (NT), Canberra (ACT), Sydney (NSW) (2), Newcastle (NSW) and Campbell Town (TAS), with ~800 individuals attending in total. In addition, nine online forums were held, with a total of 270 individuals joining from across Australia.

The IPR team engaged individually with 45 NDIS and aged care providers, and participated in working groups with providers, peak bodies, advisory groups, and state and territory governments. This included multiple consultations with the Independent Advisory Council (IAC) representing participants.

Though no formal written submissions were requested, many providers chose to submit supporting evidence/documentation to the IPR. In total ~20 written submissions were received from across the sector; this was in addition to the submissions made to the Productivity Commission and NDIA FY2017/18 Price Review.

Phase 3 (Oct-Nov 2017): Development of draft recommendations

The third phase of work focused on summarising findings, conducting further analysis and developing draft recommendations. The consultation phase highlighted examples of providers operating profitably at current price points, as well as examples of providers who find the current price points very challenging. Phase 3 involved collecting data on different operating models to identify features of models that are working, and key drivers of cost in models that are not. The IPR team engaged with providers to identify options for solutions that would help improve provider economics.

In considering solution options, the IPR assessed the appropriateness of options in achieving NDIA's three aspirations- better participant outcomes, a growing market with innovative supports, and a financially sustainable scheme. Implications of the recommendations were assessed, and the effectiveness and efficiency of pricing mechanisms and levels were considered, subject to available data.

Phase 4 (Dec 2017): Syndication and refinement of recommendations and preparation of final report

The final phase of the IPR involved testing of recommendations with providers and other stakeholders and preparation of the final report. The implications of recommendations were identified and quantified, where possible, in terms of impact on the three NDIA aspirations. Estimates of costs were made based on the best information available. Given a lack of appropriate data as the Scheme matures, the IPR made several assumptions to inform estimates of costs, leading to wide ranges in estimates presented in this report.

1.5 ACKNOWLEDGEMENTS

The IPR team is grateful for the cooperation of many providers and representatives of peak bodies, member groups and state and territory governments, who generously gave up their time to meet with the team and provide input to the IPR. The IPR would like to especially thank the 45 providers who met one-on-one with the IPR team and shared detailed financial information, modelling and analysis, as well as the IAC that invited the IPR to join four of its meetings.

The IPR team would also like to acknowledge the many individuals within the NDIA who shared their expertise and helped the team understand current practices related to pricing and work underway in the NDIA.

Further, the IPR team would like to thank AlphaBeta Advisors who provided support to McKinsey & Company throughout the entirety of the IPR.

2 Input from submissions and consultation

The IPR team examined input from various sources, including:

- Written submissions to the Productivity Commission report on NDIS Costs; the NDIA FY2017/18 Price Review; and the IPR team.
- Face-to-face consultation with providers to the NDIS; providers in adjacent sectors such as aged care; peak bodies including the Independent Advisory Council (IAC) representing participants; state and territory governments; and academics.

Provider submissions to the Productivity Commission report on NDIS Costs and the NDIA FY2017/18 Price Review had different areas of focus. The Productivity Commission sought responses on pricing with a holistic view of the disability market, whereas the NDIA FY2017/18 Price Review sought responses focused on specific modelling assumptions detailed in the *2017 Price Review – Discussion Paper*.

The objective of consultation undertaken through the IPR was to identify a comprehensive list of issues and challenges faced by providers that the IPR team could test for significance and impact on the NDIA aspirations: improving participant outcomes, growing a market with innovative supports, and a financially sustainable scheme. To do this, the IPR team consulted with over 1000 provider representatives through provider forums; and consulted individually with 45 providers that are broadly representative of the disability market, including providers across NDIS support types, large and small providers, providers with new service models, providers delivering services in regional and remote areas, and new entrants with potential to scale in size.

This section of the report records the challenges and opportunities raised by stakeholders – as was committed to do during consultation, prior to testing their significance on the NDIA aspirations. Actions being taken to address some of these challenges, as advised by the NDIA, are also recorded. Section 3, *Key findings and supporting evidence*, details evidence the IPR team sought to test, challenge and validate opportunities, including those raised by providers, that are within the scope of the TOR. Section 4, *Recommendations*, outlines the IPR team's recommendations to address the challenges and opportunities raised by providers and other stakeholders, underpinned by further analysis and data to support how these recommendations assist the NDIA in achieving its three aspirations.

The IPR team recognises that not all challenges and opportunities raised by providers are specifically within the scope outlined in the TOR. However, where these challenges are likely to have a flow on impact on provider economics, they have been noted below. Other challenges that are less likely to impact on provider economics, but could assist the NDIA to improve participant outcomes, will be raised separately with the NDIA.

Feedback received during consultation can be summarised into four areas:

- Increasing price loadings to adequately cover the cost of service delivery for rural and remote geographies, participant cohorts, and support types (see Section 2.1 below).
- Reducing the cost of administration for providers by improving the NDIA's provider-facing systems and processes (see Section 2.2).

- Increasing the emphasis on policies that support the development and growth of the market, including a greater focus on participant outcomes (see Section 2.3).
- Improving aspects of participant planning quality and consistency that would assist provider economics as well as participant outcomes (see Section 2.4).

While discussions with providers centred around challenges they are facing, most expressed their strong support for the reforms and objectives of the NDIS, and aspirations of the NDIA, as well as the positive work underway by the NDIA to achieve these aspirations and address provider challenges. Several providers were also excited about their success in developing new business models that could work successfully in helping participants achieve their objectives, and improve their outcomes, in a financially sustainable way.

The remainder of this section summarises provider and other stakeholder feedback on the following topics:

- 2.1 Provider economics
- 2.2 NDIA processes and systems
- 2.3 Market growth and development
- 2.4 Planning process.

2.1 PROVIDER ECONOMICS

Many providers raised challenges with the assumptions included in the NDIA's *2017 Price review – Discussion Paper*, which detailed the input assumptions to be used by the NDIA to model the price of attendant care (a combined category comprising Assistance with Daily Living and Assistance with Social and Community Participation). In Section 3 – *Key findings and supporting evidence*, the IPR team tests these challenges by benchmarking against other schemes, and examining effective models that are working in the market, as well as those that are not working.

These providers considered that the NDIA should continue to refine the following assumptions:

- The wage assumption. The NDIA assumes that the disability support worker will be employed at a level 2.3 under the Social, Community, Home Care and Disability Services Industry Award (SCHADS Award). Some providers believe the assumption is low and does not allow for career progression. Other providers commented that they pay higher wages due to Enterprise Bargaining Agreements (EBA) or a more mature workforce. By way of contrast, some providers commented that they are successfully operating in a consistent way with the wage assumption, utilising different mixes of part-time/full-time employee models, casual employment and accessing new talent pools.
- The utilisation assumption for support workers. The NDIA assumes a utilisation level of 95% for disability support workers. Some providers believe this level of utilisation is difficult to achieve. Some providers that consulted with the IPR reported that 80-85% utilisation of direct support staff is typical. By way of contrast, some are achieving 95% to 100% utilisation.

- The utilisation assumptions for supervisors. The NDIA assumes a 1/15 supervision ratio, and a utilisation level of 95% for supervisors. Some providers believe this level of supervision is difficult to achieve, and that it does not allow sufficient time to undertake quality/compliance requirements and support worker management. Others are finding that they do not require the level of supervision of 1/15 to offer quality support to the participants they serve.
- The overhead assumption. The NDIA assumes an overhead level of 10%, which equates to 15% if a provider is not subject to payroll tax. Some providers are finding it difficult to achieve this level of overheads, particularly those with higher expenditure on training, reporting and participant engagement during transition. While the Department of Social Services (DSS) and states and territories have provided funding to support transition, some providers claim this is insufficient – given that the participant-driven service model requires most providers to make new investments in areas such as training, IT, marketing, and recruiting. Further, some providers noted that NDIS processes contribute to higher overheads, e.g. through lost administration time associated with information and communication technology (ICT) challenges. By way of contrast, some providers reported that they are currently able to achieve an overhead level of 10%.

Providers also raised issues related to the higher cost of service provision for certain cohorts of participants. This includes participants living in remote areas, with complex needs, and those requiring Assistive Technology (AT). More specifically, they considered that the NDIA should consider the following:

- Remote loadings are not sufficient for some remote areas where there are high costs-to-serve due to factors including extra travel time, lack of infrastructure and facilities, and the cost of deploying/housing a workforce. In some cases, such as for communities in the Northern Territory, air travel and overnight accommodation is necessary to reach participants, and this cannot be claimed from the NDIA.
- Travel is also a concern in some regional areas, as providers are not being fully remunerated for travel in all circumstances.
- The differentiation in price levels for support workers serving participants with complex needs is not sufficient to cover the costs of a higher skilled worker with increased qualifications or experience, which some providers believe are required to provide high quality support to these participants. Some providers expressed a view that the current price could discourage providers, both existing and new entrants, from serving participants with complex needs and instead focus on those that can be served with a lower cost support model.

The NDIA has recently announced the development of an independent provider benchmarking function to generate important strategic information both for providers and the NDIA. The initiative seeks to collate and share market knowledge on the cost structures and pricing of providers. Participating providers will receive information that enables them to understand how they are performing relative to their peers, and where there are specific opportunities for organisational improvement. The data generated by the project will be at an aggregate and anonymised level, and will provide government with a clearer sense of what is happening in the sector, and where intervention by the NDIA may be necessary.

2.2 NDIA PROCESSES AND SYSTEMS

Providers raised challenges relating to additional overhead costs associated with operating in the NDIS, which they believe are partly attributable to NDIA processes and systems. Opportunities identified by providers for the NDIA to improve system and processes include:

- Reducing the administrative load when providers interact with the NDIS, including the one-time costs associated with pre-planning and quoting (where applicable) when a participant enters the NDIS, and ongoing administration such as billing, invoicing, and reporting. For example:
  - Improve the functionality and efficiency of the Provider Portal, as they consider errors are still occurring and can be time consuming to resolve.
  - Increase the speed at which SIL quotes can be created and processed. Some providers commented that they have submitted reports between 100-200 pages in length as part of the additional information they consider is required for 'above benchmark' SIL quotes, while other providers reported that they have waited up to 3 months to receive a response from the NDIA on SIL quote outcomes.
  - The quoting process for Assistive Technology and home modifications can disadvantage the provider developing the initial quote, as they are required to spend more time and effort to develop a quote together with a participant, typically in-home, and often an assessor, usually an occupational therapist. As the NDIA requires at least 3 quotes, additional providers are sent the initial quote to develop their own quote in isolation from the participant and assessor. This advantages subsequent providers by giving them the opportunity to undercut the initial quote due to the reduced cost of quote development.
- Improving the clarity and consistency in communication of policies to providers. Some providers commented that they spend significant amounts of time contacting the NDIA, and become frustrated with the inconsistency of responses from NDIA staff. Others commented that they're increasingly satisfied with NDIA staff responses.
- Increasing the transparency of the price setting process, and the timeliness of communications relating to price changes, to allow providers sufficient time to update service agreements prior to pricing changes coming into effect.

The NDIA has advised the IPR team that they have made several improvements in the design and functionality of the Provider Portal in the last 12-18 months in response to feedback from providers. However, the NDIA also recognises there are opportunities to further improve functionality and provider experience, and will continue focusing on this as part of its ongoing work. The NDIA also has two projects underway to address the challenges providers are facing relating to SIL: the SIL Tool project, and the SIL Redesign project. Data from the NDIA shows the SIL Tool has reduced the processing time for SIL quotes by up to 50%, however additional improvements will be required for the NDIA to achieve its target of a 14-day turnaround time.

2.3 MARKET GROWTH AND DEVELOPMENT

Providers raised issues about price levels inhibiting the growth and development of a skilled workforce. Some providers believe there is a risk of supply shortage as demand increases towards Full Scheme, and there are anecdotal reports that some providers are choosing to reduce their services or not grow beyond their existing service levels due to pricing constraints. Some providers believe there is also potential that new participants and participants with complex needs could have difficulty finding a service provider if the market is not growing at the necessary rate to meet demand. At the same time, these providers recognise there are also new providers entering the market and some other existing providers are expanding their services. Providers suggested:

- Setting prices at a point that allows providers to attract and retain a more skilled workforce to care for participants with complex needs. Some providers serving participants without complex needs also raised this as an issue, as they are having difficulty attracting highly skilled workers necessary for some categories of service.
- Explicitly allowing a provision for training, as some providers believe the utilisation assumption used in modelling is not sufficient to cover enough time for training, in addition to other non-client facing activities such as incident management, administration and reporting. This issue is more pronounced for providers serving participants with complex needs.
- Developing market infrastructure to increase the ability for the market to grow. For example, there is no functioning e-market, and participants vary in their abilities to exercise choice and control.

Some participants and providers suggest that the hourly rate approach to pricing does not provide sufficient incentives to improve outcomes and consistent adherence to insurance principles. Specifically, they requested the NDIA to consider the following:

- An approach to pricing consistent with an outcome focus. Prices are currently focused on units of care in hours. The IAC and some providers would like to see an incentive in the pricing structure for providers to reduce a participant's support needs over time. While the focus on units of care helps to ensure participants receive a defined number of service hours, it can also inhibit innovation by limiting flexibility in how participant packages can be spent.
- A more consistent adherence to insurance principles that focuses on early investment to reduce participant needs over time and reduce their lifetime cost to the NDIS. Participant plans should be looked at more holistically to understand how a greater investment in capital supports such as Assistive Technology and home modifications could reduce the need for other supports. Looking at capital supports in combination with opportunities to reduce other supports, and focusing on quality as well as price could improve outcomes for participants, as well as assist the sustainability of the NDIS.

The NDIA has advised the IPR team that it has identified initiatives to expand its monitoring and support of market development. It is developing a market assessment framework, which seeks to bring together disparate data sources and metrics into a coherent assessment process. It is also investing in a benchmarking function to share market knowledge and identify opportunities for providers to improve their businesses. The NDIA is also focused on

increasing its understanding of how the NDIS is affecting participant outcomes through regular surveys and participant consultation. For example, the Short-form Outcomes Framework questionnaire has helped the NDIA build a baseline understanding of participant outcomes during the NDIS transition period.

2.4 PLANNING PROCESS

The planning process is not formally within the scope of the IPR, as defined in the TOR. During consultation, issues were raised by providers about how the quality and consistency of plans could be improved to positively impact both participant outcomes and provider economics, both initial plans and plan reviews:

- Improving the planning process to support NDIA planners and Local Area Coordinators (LACs) to consistently capture all the needs of a participant to deliver quality plans for participants. This can reduce the time and resources providers invest to help some participants rectify issues with their plans such as correcting plan errors and submitting additional documentation to justify the need for additional funding in participant budgets. It can also help reduce the time providers spend educating participants and their families on how to engage with the NDIA and LACs, including how to utilise their plans with providers. These improvements will benefit participant outcomes by ensuring they have sufficient funds for specific functions. It is recognised by providers that there will always be more opportunities to improve plans, and the role of the NDIA is to improve the capabilities of its planners over time in identifying and planning for all needs of participants and how to improve outcomes.
- Improving the consistency in timing and communications for plan reviews, to make sure providers are aware reviews are taking place. This would help providers understand when they may need to update service agreements with participants, and alert them to when there could be service continuity issues if there are changes to a participant's funding allocation across different supports.

The NDIA has advised the IPR team that significant improvements are underway to the planning process to address many of the challenges raised by providers, and are currently being implemented as part of the Participant and Provider Pathways Review. Piloting has commenced in Victoria in December 2017, with improvements including:

- A significantly re-designed planning process to make it easier for participants to see how their goals have been recorded and linked to community, other government services and funded supports.
- Face-to-face planning meetings with an LAC, an NDIA planner and a participant to improve plan quality and educate participants and their families on how to utilise participant packages.
- Participants being able to see a working version of their plan as it is developed and the opportunity to ask questions and provide feedback during the planning meeting, to allow for any queries to be discussed and addressed before the plan is finalised.
- The use of simple language to improve communication.

Some providers argue that the challenges described in this section are having an impact on their abilities to operate at a sufficient surplus in the sector. In Section 3 – *Key findings and supporting evidence*, and Section 4 – *Recommendations*, the IPR team has worked with the providers, the NDIA and other stakeholders to explore the challenges raised by providers that are within the scope of the TOR, to provide a sufficient evidence base to justify the need for action, and propose recommendations relating to pricing that can be adopted by the NDIA to address these challenges.

3 Key findings and supporting evidence

To address the issues raised by providers and other stakeholders during consultation, and to assess whether current price caps are adequate, the IPR team looked at three sources of evidence:

- **3.1. Evidence of market development and shortages in supply,** including analysis of the available market data such as utilisation rates, rates of market entry and exit, and market surveys.
- **3.2 Provider economics and models,** including detailed bottom-up analysis of providers' costs-to-serve and comparison with the hourly rate model.
- **3.3 Benchmarks from other schemes,** including comparison of NDIS prices to state accident compensation schemes and the Commonwealth's aged care and veterans' support programs.

3.1 MARKET DEVELOPMENT

Close to 11,000 service providers have been approved to cater to participants in the NDIS, with approximately 5,000 service providers already active in supplying support services.[2] Many of these service providers are small suppliers, with 60% of active providers catering to fewer than 10 clients each. The larger providers account for most of the Scheme expenditure to date. Approximately 70% of NDIS payments have been to providers which cater to 100 or more participants each.[3]

The IPR team recognises that the provider market landscape is likely to change significantly in response to providers shifting to a new consumer-driven, unit funded environment. For example, the current provider landscape for in-home attendant care, a significant support type in the Scheme, is dominated by not-for-profits and medium to large providers.[4] Going forward, new providers, many of whom are likely to be for-profit organisations, and could leverage technology innovatively, are expected to enter the market, having identified a profitable niche or operating model. Some existing providers will exit the support category because they cannot adjust to this new market landscape, while providers who successfully adjust their operating models are likely to expand to meet demand. It is unclear how quickly this market adjustment and new provider entry will occur. A dynamic and responsive approach to monitoring the market will be critical to ensuring there is sufficient and quality supply to allow participants to continue to receive safe and quality supports.

The key test of whether current prices are adequate is whether participants can access the quality supports and services needed to achieve their goals, as defined and funded in their

[2] National Insurance Disability Agency: *National Insurance Disability Scheme COAG Disability Reform Council Quarterly Report* (30 September 2017).

[3] Analysis based on NDIS payment data.

[4] Not-for-profits consist of 62% of the disability sector, while 88% of in-home attendant care service volume in 2016-17 was delivered by medium to large providers.

plans. Market data on participant and provider behaviour and intent offers the most direct evidence of whether current prices are consistent with this test. Analysis of provider entry and exit rates, utilisation rates, and participant outcomes reveals a market that is, to date, providing the supply required to match demand. However, this evidence is not unequivocal. Gaps in the available data and the volatility of a transitional and rapidly growing market mean that this data does not yet provide certainty as to whether participants will be able to continue to access the supports they need into the future.

The remainder of this section examines the available data sources on market development:

Provider entry and exit data

Provider entry and exit data offer evidence of a market that is growing to meet demand. The number of registered providers more than doubled in FY16/17. The rate of growth of quarter-to-quarter provider registration has outpaced the rate of growth of participant registration throughout 2017. In the latest quarter, provider registrations grew by 21%, with a total of 10,507 providers currently registered in the Scheme.[5]

In the trial regions, less than 15% of providers decreased or ceased supply during the trial, whereas 30% of providers increased supply or entered after the trial began (FY13/14 to FY15/16).[6] The existence of some provider exits is also not in itself an indication of inappropriate prices. It is to be expected that as providers adjust to the NDIS, some will be unable to make enough changes to their business models and operations to supply services at an efficient price, while others will choose to specialise in some supports but exit other supports. It is also important to recognise that providers may have been willing to invest in the trial to test whether they could develop an effective model, so limited exits during trial may also not be predictive of future provider behaviour.

Participant utilisation data

Another key data point – utilisation – also does not provide compelling evidence of supply shortages. The utilisation rate is the share of a participant's budgeted supports that has been used. The average utilisation rate across the Scheme in FY16/17 was 66%, which is well below the expected utilisation of the Scheme at maturity of 85-95%.[7] However, the available evidence suggests that it is more likely caused by participants being unfamiliar with the Scheme and how to use their supports, rather than a supply shortage. In the trial sites, the average utilisation rate also started low, at 64%, but increased to 75% in the final year, reaching 80% in some sites. This change occurred without a reduction in the average size of plans, discounting the possibility that individual plans simply became more restrictive, despite the number of participants increasing as the trial progressed. Evidence from transition also indicates that the utilisation rate increases as participants spend more time in the Scheme and move onto their second and subsequent plans. The share of participants with high utilisation rates (>75%) almost doubles from first to subsequent plans. There is little participant survey

[5] National Insurance Disability Agency: *National Insurance Disability Scheme COAG Disability Reform Council Quarterly Report* (30 September 2017).

[6] Analysis based on NDIS payment data.

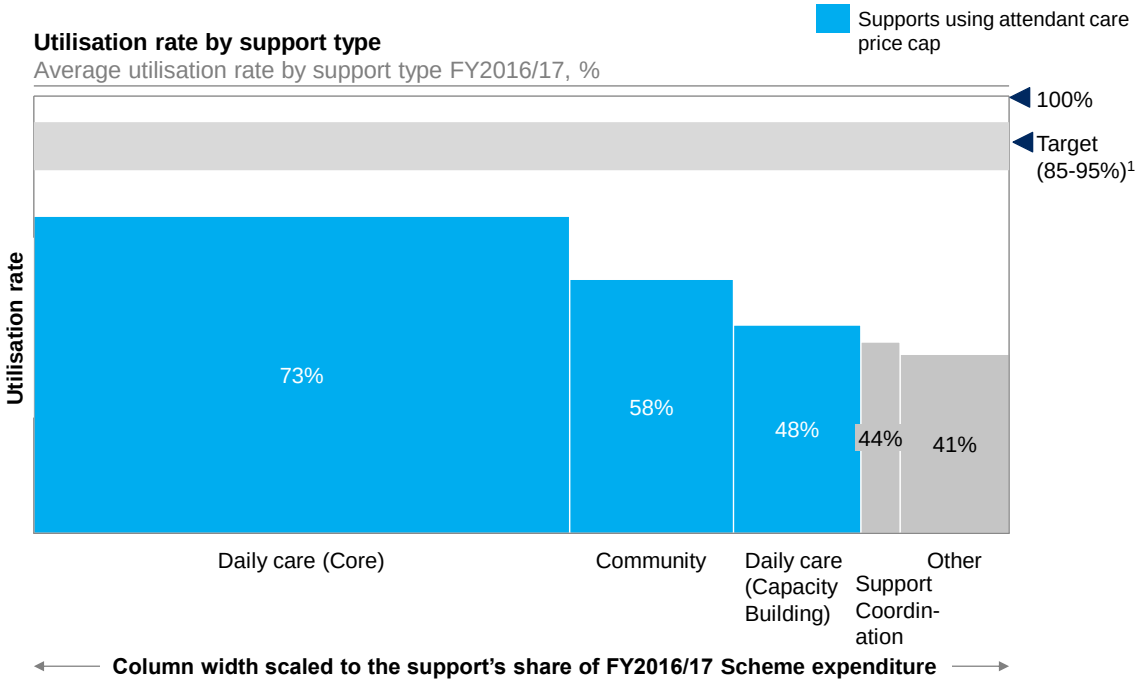
[7] Average utilisation rate for FY16/17 as at December 2017. Utilisation rates continue to increase after the end of the period being measured due to delays in claims and payment processing, so it is likely the final average utilisation rate for FY16/17 will be higher.

data to understand the drivers of this utilisation rate. Surveys during the NDIS trial showed that 27% of NDIS participants had at least some difficulty in accessing supports for which they had funding. More recently, baseline outcomes performance reported quarterly by the NDIA shows that 68% of participants nominate having no difficulty in accessing health services they require. However, a similar metric for NDIS services is not reported.

Analysis of utilisation by support type shows utilisation rates are highest in the largest support types and supports using attendant care, with the category of core daily care support services having a utilisation rate of 73% (Exhibit 2). This category includes support services such as assistance with daily living. Other support types reliant on attendant care, like assistance with social and community participation ('Community') and support for capacity building daily activities, have the next highest utilisation rates. The lowest utilisation rates are in capital and intermediary supports, which are of concern but are less likely to represent an imminent shortfall in critical supports.

EXHIBIT 2

Average utilisation of daily care (core) supports was higher than any other support type



1 Target utilisation rate estimated based on consultation with the NDIA and review of annual budget papers.
SOURCE: Scheme Actuary, FY17 utilisation data by support category

Aggregate analysis of firm entry/exit and utilisation data is complemented by anecdotal evidence of new private sector investment and innovation. For example, firms such as HireUp and BetterCaring[8] have made large investments to build new digital infrastructure to provide services in the disability services market. Such upfront investments offer evidence of the private sector's willingness to invest in this market. Similarly, the state government in New South Wales sold its Home Care business for $114 million, indicating the willingness of private capital to enter the disability services market.

Participant survey data

An evaluation of the NDIS trial by the National Institute of Labour Studies (NILS) revealed most participants found supports for which they had funding. This survey was initiated in 2014 and therefore covers more of the early experience of the Scheme. Approximately 73% of participants responded that they were able to access all supports for which they had funding. The average number of different supports accessed by participants has increased to 3.3 from 2.2 since the introduction of the Scheme, and 44% of participants report having greater choice and control over the supports they do receive since their enrolment in the NDIS. [9]

More recent measurement of participant outcomes reveals that 71% of participants believe that the NDIS has helped the level of choice and control they experience. 75% of participants identify the NDIS as having helped their daily living conditions, and 63% identify that it has helped their social, community, and civic participation.[10]

Evidence of provider intent

Other factors point to significant challenges as the Scheme continues to grow. The Productivity Commission acknowledged several studies that point to a potential future shortfall in supply to meet projected demand, with current workforce growth rate estimated between 6-13% versus a required growth rate of 18%. However, this can partly be explained by the ramp-up in demand that is expected, i.e. future growth rates are expected to be higher than current growth rates. The Productivity Commission also identified several participant cohorts for which a shortfall in supply is a risk. These included participants in remote and very remote areas and participants with complex needs. While there is not yet evidence of a shortfall in supply occurring across the Scheme, this is a risk that needs to be closely monitored.

Furthermore, some providers reported to the IPR team during its consultation process that they were drawing on surpluses and other funding sources, and cross-subsidising some support types, to continue to serve participants while they transition. They are concerned as to whether they can achieve a sustainable operating model in the future. Some major providers also reported that due to challenging economics operating in the Scheme, they are not accepting new participants for some services and are planning to reconsider their support

[8] Better Caring is not a registered provider under the NDIS, but has a profitable operating model in the disability services market supporting self-managed participants.

[9] National Institute of Labour Studies: *NDIS Survey of people with disability, their family and carers* (2014 – 2017), available at http://ndisevaluation.net.au/information/ndis-survey.cfm

[10] National Insurance Disability Agency: *National Insurance Disability Scheme COAG Disability Reform Council Quarterly Report* (30 September 2017).

offerings in 2018. Ongoing close market surveillance and liaison with providers will be essential for identifying the intention of large providers to exit or reduce services.

3.2 ANALYSIS OF PROVIDER ECONOMICS

The financial sustainability of providers in the NDIS is critical to ensuring ongoing supply of supports to participants. While providers may be able to absorb losses for a period, operating in the NDIS needs to be attractive in the long term for enough providers to meet the growth in demand.

To understand the economics of providers in the NDIS, the IPR team gathered evidence from various sources, including a detailed cost-to-serve analysis of a sample of NDIS providers. The IPR team is grateful for the cooperation of many providers, who generously shared detailed financial information to enable the team to analyse their costs-to-serve.

The remainder of this section examines the evidence available on the following:

- 3.2.1 Cost of transitioning to the NDIA
- 3.2.2 Overview of provider economics across support types
- 3.2.3 Provider economics in attendant care

3.2.1 Cost of transitioning to the NDIS

For providers across all support types, the cost of transitioning to the NDIS and interacting with the NDIA's systems and processes added materially to their cost base and affected their short term financial position.

Moving to a unit-funded, consumer-driven environment has required providers to employ new staff to process payments and invest in IT systems and marketing. Some providers estimate that these costs have added 1.5% to their annual expenditure.[11] This is detailed further in Section 4.6.1.

Improving the NDIA's systems and processes related to the portal and planning as articulated in Section 4.6.2, would reduce administrative costs and cash flow risk. Anecdotal evidence indicates that these improvements could amount to ~0.5% of total annual expenditure for some providers.[12] Anecdotal evidence also indicates that the cumulative effect of unapproved SIL quotes, unresolved portal errors and expired plans has resulted in cash flow risk for some providers; one large provider submitted that at one point they were owed ~10% of their total revenue in services unclaimed. The IPR team has been advised by the NDIA that substantial improvements to the portal have been made in the last 12-18 months, and the NDIA currently has a significant program of work underway, the Provider Pathway Project, to review and address the issues noted above.

[11] Based on 45 one-on-one interviews with providers in September 2017, in which three large providers (revenue > 50 million in FY16/17) gave detailed evidence of these costs.

[12] Based on 45 one-on-one interviews with providers in September 2017, in which three large providers (revenue > 50 million in FY16/17) gave detailed evidence of these costs.

3.2.2 Overview of provider economics across support types

Across all support types there were examples of providers operating profitably, and examples of providers struggling (see Exhibit 3).

EXHIBIT 3

Provider cohorts where pricing is working economically versus where it is challenging

Support type[1]	Working economically	Challenging
Assistance with daily life and social/ community participation (36.1%)	▪ Tech-enabled for-profit providers serving participants with lower complexity needs or strong informal supports ▪ Some incumbents with economies of scale ▪ New entrants with lean operating models	▪ Providers serving complex participants or operating in low density areas ▪ Providers with more qualified, specialist or experienced workforces ▪ Providers with EBAs that are more generous than the Award
Short term accommodation (1.7%)	▪ (Limited) Providers serving less complex participants with lower care ratios	▪ Providers serving complex participants ▪ Providers operating on weekends/ holiday periods/ overnight
Therapy (5.0%)	▪ Some therapy providers (e.g. sole traders in physio, speech) ▪ Providers in high density, metro areas	▪ Remote/rural areas where lots of travel is required ▪ Some psychotherapy service providers
Life skills and support coordination (5.3%)	▪ Support coordination and plan management providers for low complexity participants ▪ Some employment service providers	▪ Providers serving complex participants, where plans do not adequately cover coordination activities undertaken
Supported independent living (39.0%)	▪ Some SIL providers, as SIL is a quoted item	▪ Providers serving complex participants with onerous quoting requirements ▪ Emergency/crisis situations

1 Numbers in brackets represent percentage of Scheme spend in FY17, based on payments data provided bythe NDIA
SOURCE: Provider Consultation, Sep-Oct 2017

In Supported Independent Living (SIL), Therapy, Support Coordination and Plan Management, analysis indicated that most providers can operate profitably at current price points/benchmarks. However, the costs involved in meeting quoting requirements and delays in approving quotes in SIL are impacting provider overheads.[13] In addition, the rollout of the new SIL pricing process may reduce surpluses that providers are generating, and reduce their ability to cross-subsidise other services.

In attendant care, there was a higher proportion of providers who submitted they were unable to operate profitably. Given the emphasis from providers on the challenges associated with profitably delivering attendant care, the IPR team conducted detailed analysis of provider economics for this support type.

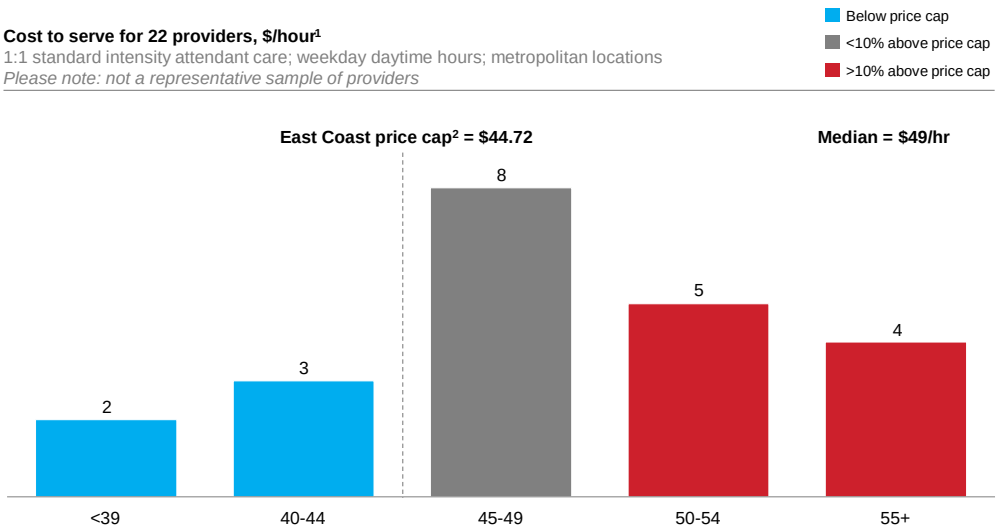
13 Anecdotal evidence from provider consultation indicates that SIL quoting requirements can be onerous: some providers have submitted reports of 100-200 pages in length to justify above benchmark quotes. NDIA data indicates that the average time to approve a SIL quote in Jul-Sept 2017 was 40 days, down from 107 days pre-July 2017.

3.2.3 Provider economics in attendant care

There is significant variation in the cost of service delivery for attendant care between providers. For the 22 providers who shared their financials, costs-to-serve ranged from under $40 to $55+ per hour for standard intensity weekday support (see Exhibit 4).[14]

EXHIBIT 4

Distribution of provider costs-to-serve for attendant care



1 Based on 22 providers who provided costings information for 1:1 standard intensity attendant care as part of the IPR or the 17/18 Price review. Some providers submitted a cost to serve based on actual data that represented their actual workforce mix. Where a provider submitted a cost to serve that assumed an 100% permanent or 100% casual workforce, and where the IPR had information about their workforce mix of permanent v casual staff, the IPR team adjusted their costings to reflect their true workforce mix. 2 Price cap for VIC, NSW, QLD and TAS. The 'East Coast' price cap is shown here as this is the cap that applies to most providers on this chart. The price cap for ACT, SA, WA and NT is $45.54.

This variation is attributable to differences in operating models and different cost structures across providers:

- For providers with more mature and formally highly qualified workforces, or who are bound by more generous working conditions and pay scales compared to the SCHADS award and pay scale, base labour wages were a key differential cost driver.
- For providers with heavier supervision structures, the cost of supervision was a key differentiating cost driver.
- For providers in regional geographies, travel was often a key cost driver.
- For providers with predominantly casual workforces, workforce utilisation was significantly easier to manage.

14 While the IPR's sample of 22 medium to very large providers was not comprehensive or representative of the market, the IPR was limited by the information providers were able to provide.

- There was significant variation in the cost of corporate or indirect overheads between providers, with expenditure on corporate overheads as a percentage of direct labour costs ranging from less than 10% to over 20%.[15]

For a more detailed summary of key drivers of differences in costs between providers, see Appendix A.

Participant characteristics can also influence provider economics. Margins were more compressed (or negative) for providers operating in areas with low density of participants, e.g. rural, remote and very remote areas, and for those serving participants with complex needs. On the other hand, the profitability of some providers can be in part attributed to their focus on specific participant segments. Providers who serve participants at the lowest end of the complexity spectrum often have lower labour and supervisory costs. These providers submitted that it is not necessary to pay a highly qualified or trained worker to deliver attendant care supports to participants that are not medically or behaviourally complex, for whom the risk of incidents is extremely low. Rather what they focussed on ensuring was that they had support workers with the right mindset, compassion and soft skills to deliver high quality support.[16] Providers who serve participants with predictable and high volumes of care are also able to operate profitably in attendant care, because workforce rostering and utilisation is easier to manage.

While a substantial number of providers assessed are not yet able to operate profitably at the current price cap, there are some providers who submitted they are able to deliver 1:1 standard intensity attendant care at a sustainable surplus, while complying with their award or enterprise agreement obligations. These providers often have lean operating models, leverage technology successfully, or are sole traders. Some of these providers have operated in the sector for some time, while others are new providers that entered the disability space in response to the NDIS opportunity.

- **Traditional providers with lean operating models:** Some traditional providers who run extremely efficient operations and have achieved a degree of scale are able to operate profitably. These providers exhibited some, or all, of the following characteristics: lean corporate overheads facilitated by effective investments in IT systems; effective rostering systems and a mix of casual and permanent staff to maximise staff utilisation; and/or a supervision model where supervisors only focus on quality assurance and co-ordination, while rostering work is done by a separate team. Providers in this group submitted they can achieve corporate overheads of ~10% of direct labour costs. Providers in this group who hire predominantly casual workers can maximise the amount of time their workers perform client-charging work and achieve 95+% workforce utilisation rates. These

[15] Data based on information from 22 providers who provided detailed financial information to the IPR. Corporate overheads refers to costs that are not directly attributable to client care (e.g. IT, HR, rent, marketing, business development, senior management salaries).

[16] This is particularly relevant in the context that there will be more than 100,000 people who receive NDIS funding who did not previously receive disability funding, A segment of the 100 000 new participants will have a psychosocial disability and may need highly qualified workers to support them. A segment of the new participants whom will have lower packages relative to participants who were existing recipients of State block funding, are likely to be at the lower complexity end of the spectrum. For these participants, a support worker with the right mindset may be more appropriate than a highly qualified worker.

working models provide insights on tactics that can be used by struggling traditional providers to improve their financial performance.

- **Tech-enabled providers**: These providers serve participants via online platforms, which allow participants to book and manage their own care schedule directly, reducing the work required to be completed by a provider and minimising corporate overheads. Support workers are typically casual, allowing providers to achieve high utilisation levels, as staff will only work when there is known demand from a participant. These providers estimate their cost of service delivery is up to ~20% lower than the current price cap. These providers also leverage technology to manage quality and safety: customers are able provide feedback after every shift online and an algorithm helps detect potential problems with service quality or customer satisfaction. However, this operating model relies on participants or their carers having the capacity and desire to manage their own supports. These providers currently only serve a small proportion of the market, and while this model appears to hold significant potential, it is unclear as yet what percentage of the standard intensity attendant care market this model will be able to serve at full Scheme.
- **Sole traders:** Sole traders can deliver attendant care significantly below the current price cap. This is because a self-employed support worker does not incur the supervisory or corporate overhead expenses of a small provider. While sole traders currently deliver less than 1% of service volume in in-home attendant care market, the emergence of e-marketplaces connecting self-employed care workers and participants could see a significant growth in this group of providers.[17]

The IPR believes these profitable and successful operating models offer valuable lessons to learn from for other providers who are struggling.

3.3 BENCHMARKING WITH COMPARABLE SCHEMES

There are several other State and Commonwealth schemes in Australia that offer comparable supports to their participants, including state accident compensation schemes and the Commonwealth's aged care sector. There is also significant overlap in the provider markets that service these other schemes. For example, ~90% of providers in one of the benchmarked schemes are also registered NDIS providers.[18]

To assess the adequacy of NDIS price caps for various supports, the IPR team benchmarked prices against available prices in the other schemes. The IPR team undertook detailed benchmarking for attendant care and therapy supports. Attendant care was chosen given the large proportion of Scheme spend attendant care represents, and given the recent scrutiny on the price cap for 1:1 attendant care (see Section 4.6.3.1). Therapy supports was chosen

[17] NDIA data. Sole-traders that are registered NDIS providers can serve all NDIS participants, whereas sole traders that are not registered NDIS providers cannot serve Agency-managed participants.

[18] McKinsey analysis, conducted by checking providers in the comparable scheme with NDIS registration data.

because the single NDIS price cap for therapy appeared to be inconsistent with the multiple price levels, and structure, of other comparable schemes.

3.3.1 Attendant care

Benchmarking the unit price of 1:1 attendant care under the NDIS with comparable schemes is complicated by a variety of factors: each scheme has a different funding model, different cohorts of clients, different business rules associated with care delivery (e.g. travel rules, cancellation policy, funding for training), and different fee structures (e.g. weekly price cap versus hourly price caps, composite versus time differentiated price caps). For instance, the Transport Accident Commission (TAC) and Worksafe have composite price caps in which the price cap for 1:1 care does not vary for time of the day or day of the week. By way of contrast, the NDIS rates are specific to the time of the day and day of the week. While TAC and Worksafe attendant care standard price caps do not vary for complex participants, the NDIS price caps differentiate for 'higher intensity' and 'standard intensity' prices.

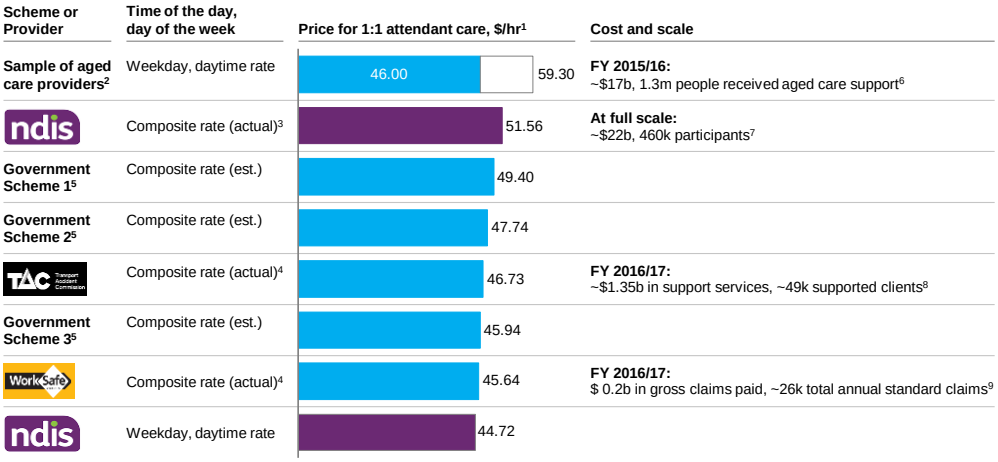
It is also important to recognise that other government schemes such as the TAC and Worksafe are significantly smaller than the NDIS, and revenue from these schemes is less likely to be the primary source of revenue for providers. Further, providers under other government schemes such as Worksafe are often guaranteed they will serve a participant for a set amount of time, and this demand certainty allows providers to manage their business and workforce planning more efficiently.

Despite these limitations in comparing across schemes, benchmarking is nonetheless useful to understand whether NDIS prices are broadly aligned with prices of other schemes. This benchmarking highlighted that the NDIS prices for standard intensity attendant care are in fact broadly aligned with prices of the accident compensation schemes, although market prices for many aged care services are higher (see Exhibit 5). While the NDIS composite price is higher than the composite rate for other schemes, other schemes provide more generous conditions associated with the delivery of care.[19] For example, TAC and WorkSafe offer establishment fees of ~$1200, compared to $500 in the NDIS. TAC also reimburses providers for training at a rate of $43.10 per hour, compared to no specific provision for training reimbursement under the NDIS.

[19] The NDIS composite rate is a weighted average of the various NDIS standard intensity time of the day and day of the week price caps.

EXHIBIT 5

The NDIS attendant care price cap is aligned with comparable compensation schemes, although market prices for aged care appear higher



1. Benchmarking the unit price of 1:1 attendant care under the NDIS with comparable schemes is difficult for a variety of factors: each Scheme has a different funding model, serve different cohorts of clients, different business rules associated with care delivery (travel rules, cancellation policy, funding for training etc) and fee schedules with different fee structures (e.g. weekly price cap vs hourly price caps, composite vs time differentiated price caps). 2. We sampled a range of aged care home care providers in metro regions in Sydney and Melbourne for their weekday daytime attendant care prices. These rates were private rates, meaning they are not necessarily fully government subsidised. 3. NDIScomposite rate for Eastern States, based on actual distribution of service volume between time of the day and day of the week;. 4.IQRS accredited rate. 5. For these Government Schemes, we estimated the composite rate. Where the Government Scheme provided a weekly cap, we divided this cap by the recommended number of hours of care per week. Where the Government Scheme provided different rates for time of the day and day of the week, we estimated the distribution of service volume to calculate a composite rate. 6. 2015/16 Report on the Operation of the AgedCare Act 1997, p9 and 10. 7. NDIA 2017 Corporate Plan, p11. 8. TAC 2017 Annual report, p6. 9. Worksafe Victoria Annual Report 2017, p57 and 15

3.3.2 Therapy

The NDIA has a single price cap in place for all therapy supports delivered by a qualified therapist under the NDIS. The price cap allows therapists to charge participants up to $175.57/hr for the delivery of services in a participant's own environment, which for a child could be in their home or at school, or in a therapist's office.[20] When a participant requires therapy supports to be delivered in their own environment, a therapist can make a separate claim for travel against a participant's package to reimburse them for the costs they incur. The NDIA has created a separate allowance in participant packages for therapy travel, which is capped at $1000 each year per therapy support type. The current travel policy allows therapists to claim travel time at the hourly rate of the service being delivered for travel over 10km.[21]

Other comparable insurance schemes in Australia offer different therapy prices dependent on the number and complexity of the conditions experienced by the participant. Examples include the TAC, WorkSafe, Department of Veterans Affairs (DVA), and NSW State Insurance Regulatory Authority (SIRA). The categorisation of the number and complexity of conditions vary by scheme. To simplify, the IPR team has named them Level 1, Level 2, and Level 3, with the number of conditions and/or complexity of the support increasing with each level (see

[20] NDIA: *2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017)*, p. 61
[21] NDIA: *2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017)*, p. 15

TABLE 1). Price ranges to equate each level of therapy support were observed both across schemes and within schemes for common types of physical therapy including physiotherapy, speech therapy, and occupational therapy. These schemes are typically associated with physical disabilities, but each include psychological therapy as a reimbursable support. When benchmarking to comparable schemes, it is important to recognise that travel policies specifically for therapy services vary across different schemes, and the NDIS travel policy is more generous than other schemes. For example, the TAC does not pay any travel allowance above the hourly rate for out-of-room care, and the DVA pays an allowance for every kilometre travelled above 10km of $0.90/km excluding GST.[22]

For physical therapy, three discrete levels of therapy support exist, each with a different range of prices (see TABLE 1).

TABLE 1: BENCHMARK PRICES FOR PHYSICAL THERAPY SUPPORTS[23,24,25,26,27]

Level of support	Benchmark price range ($/hr)	NDIS price cap ($/hr)	Description
Level 1	$90 - $130	$175	Includes treatment on a one-on-one basis and focused on treatment of a single physical condition
Level 2	$120 - $160	$175	Includes treatment of multiple (2-3) entirely separate injuries or conditions, where treatment applied to one condition does not affect the symptoms of the other injury
Level 3	$170 - $200	$175	Includes treatment related to complex pathology and clinical presentation (including complicated injuries involving multiple joints and tissues, spinal cord injuries, head injuries, major trauma)

[22] Department of Veteran Affairs: *Occupational Therapist Schedule of Fees (Effective 1 November 2013)*, p. 5

[23] Transport Accident Commission: *Fee Schedules* (2017), Government of Victoria, available at http://www.tac.vic.gov.au/providers/invoicing-and-fees/fee-schedules

[24] Worksafe: *Fees and Policies* (2017), Government of Victoria, available at https://www.worksafe.vic.gov.au/health-professionals/fees-and-policies

[25] Department of Veterans Affairs: *Dental and Allied Health Fee Schedules* (2017), Government of Australia, available at https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules

[26] State Insurance Regulatory Authority: *Physiotherapy, Chiropractic, Osteopathy Fees Order* (2017), Government of New South Wales, available at https://www.sira.nsw.gov.au/__data/assets/pdf_file/0019/112870/Physiotherapy,-chiropractic-and-osteopathy_Fees-Order-2017.pdf

[27] Comcare: *Allied Health Rates* (2017), Government of Australia, available at https://www.comcare.gov.au/claims_and_benefits/benefits_and_entitlements/fees,_rates_and_reimbursements/allied_health_rates

For psychological therapy, the entry level of support is at a higher level of complexity than Level 1 physical therapy, and more equivalent to Level 2 physical therapy (see TABLE 2).

TABLE 2: BENCHMARK PRICES FOR PSYCHOLOGICAL THERAPY SUPPORTS

Level of support	Benchmark price range ($/hr)	NDIS price cap ($/hr)	Description
Level 1	$160 - $180	$175	Includes psychological therapy on a one-to-one basis focused on treatment of a psychological disability in a low risk environment
Level 2	$190 - $240	$175	Complex psychological therapy requiring a very skilled and experienced clinical professional, often necessary where a participant poses a high risk to themselves or others because of their disability

The findings outlined in this section form the basis of the suite of recommendations detailed in the following section. Recommendations are grouped by the items of the Terms of Reference. Under each item, further detail is also provided on the issues and evidence relevant to the topic.

4 Recommendations

As outlined in Section 3.1, the fundamental test of whether price caps are adequate is whether participants can access quality supports and services. There is not yet compelling evidence of supply shortages occurring, other than what was recently observed in short term accommodation and has now been addressed through price changes. However, there is still a risk of future supply shortage, particularly for participants in rural, remote and very remote areas and those with complex needs. The IPR team's analysis also identified a significant number of providers that have not yet developed a profitable operating model, particularly in the service category of attendant care.

To improve provider economics and confidence in the NDIS, minimise the risk of supply shortages in the future, and assist the NDIA to achieve its aspirations, the IPR team has made 25 recommendations, detailed in this section. These recommendations are designed to target the root cause of issues identified through consultation and further analysis.

Together, these recommendations will have a positive impact on provider economics, improving overall industry margins by 2% to 4%, with even higher margin improvements for providers serving participants with complex needs or in rural, remote and very remote areas. Examples of these recommendations that will have a direct impact on provider economics are:

- Adding a third tier to the complexity loading of 10%, to account for higher level of skills/experience of workers and additional training required.
- Allowing providers to charge up to 45 minutes of travel time in rural areas.
- Allowing providers to quote on the delivery of services in isolated regions.
- Changing the cancellation policy to allow providers to charge participants for cancellations. after 3pm on the day before the service.
- Removing the $1000 travel cap for therapy supports and align the travel policy with attendant care travel policy.
- Changing the therapy prices to better reflect different therapy types, and introduce a second tier of pricing for therapy assistants.
- Continuing to improve NDIA systems and processes (e.g. portal functionality, quoting) to enable providers to reduce administrative tasks and reduce costs.
- Introducing temporary overhead assistance equivalent to a 2% to 3% loading on the price for providers delivering attendant care for the next 12 months.

The recommendations in this section have been grouped according to items in the IPR's Terms of Reference (see Section 1.4). There were some issues raised during the consultation phase that were outside the scope of this review. These issues have been captured and will be raised separately with the NDIA.

The structure of this section is as follows:

- Section 4.1: Approach to price setting, covering Recommendations 1 to 2
- Section 4.2: National versus regional pricing, covering Recommendations 3 to 5

- Section 4.3: Pricing of services with different levels of complexity, covering Recommendations 6 to 9
- Section 4.4: Pricing of short-term accommodation (respite) services, covering Recommendation 10
- Section 4.5: Thin and undersupplied markets, covering Recommendations 11 to 12
- Section 4.6: Provider efficiencies and adequacy of provider returns, covering Recommendations 13 to 21
- Section 4.7: Price deregulation, covering Recommendations 22 to 25

4.1 APPROACH TO PRICE SETTING

The NDIA sets price caps for an hour of service for most support services supplied in the NDIS. The price caps are reviewed annually and a new price guide is published, though the NDIA has also twice amended prices outside the annual review process. In assessing the approach to price setting used by the NDIA, the IPR considered both the process for setting price caps, and the way in which price caps are applied as an hourly (or other time-based) rate.

Section 4.1 covers the following topics:

- 4.1.1 Determining appropriate price caps
- 4.1.2 Alternatives to an hourly rate

The use of price ranges and deregulated pricing are considered separately in Section 4.7.

4.1.1 Determining appropriate price caps

Issues and evidence

The NDIA has amended prices through its annual price reviews as well as interim changes where required. The current price caps are a result of the NDIA FY2017/18 Price Review concluded in June 2017 and a change to short term accommodation price caps from 30 October 2017. The NDIA FY2017/18 Price Review was based on an assessment of the underlying methodology used to estimate the hourly costs of personal care and community supports, feedback from the disability services sector including 82 provider submissions directly in response to the annual review process, new economic data such as increases in the Wage Price Index, and an assessment of the impact of proposed changes by external consultancy HoustonKemp. The annual price adjustment also accounted for changes in the national minimum wage and the operation of the Equal Remuneration Order (ERO).[28] This led to several changes. For example, base prices for the support type 'Assistance with daily living' were increased by 4.5%, loadings for remote and very remote areas were increased, and the

[28] The Equal Remuneration Order is an order made by the Fair Work Commission in 2012 which required wages in the social and community services industry to be increased regularly to 2020. The ERO increases occur each December according to a prescribed formula.

cancellation policy of therapy services was amended. The NDIA published the amended Price Guide on 12 June 2017 before it took effect on 1 July 2017. These changes were then followed by a tailored change to price caps for short term accommodation services, announced on 18 October this year, with the new prices being revealed a week later and taking effect two weeks later, on 30 October.

The NDIA does not yet have a comprehensive evidence base to inform its regular pricing decisions, but it has been increasing its scope of data collection. For example, the NDIA does not keep a collated record of supply shortfalls identified by LACs and regional offices, nor does it directly survey participants on whether they experienced shortages in supply of supports for which they had funding.[29] However, it has developed and implemented a Short-form Outcomes Framework questionnaire which measures participant outcomes and it is deploying a benchmarking survey of providers to understand evolving cost structures across the NDIS. The NDIA is also working with DSS to develop a set of metrics to monitor market development, as well as developing a market intervention strategy to identify and respond to instances in which prices have been unable to attract sufficient supply.

Recommendations

1: The NDIA should include a broader set of indicators of participant outcomes and market development in its price setting process, and clarify its methodology for implementing price setting decisions.

The NDIA's current process for setting prices and ensuring provision of services for participants can be enhanced. The IPR team recommends a four-step process (see Exhibit 6). This process should apply to the annual price reviews, as well as any interim adjustments which may be necessary in response to changing market conditions. The IPR team recommends that the NDIA considers the following four steps as it develops its market intervention strategy:

1. Continuous market monitoring
2. Focused data collection on at-risk markets
3. Data analysis and policy decision
4. Implementation of decision

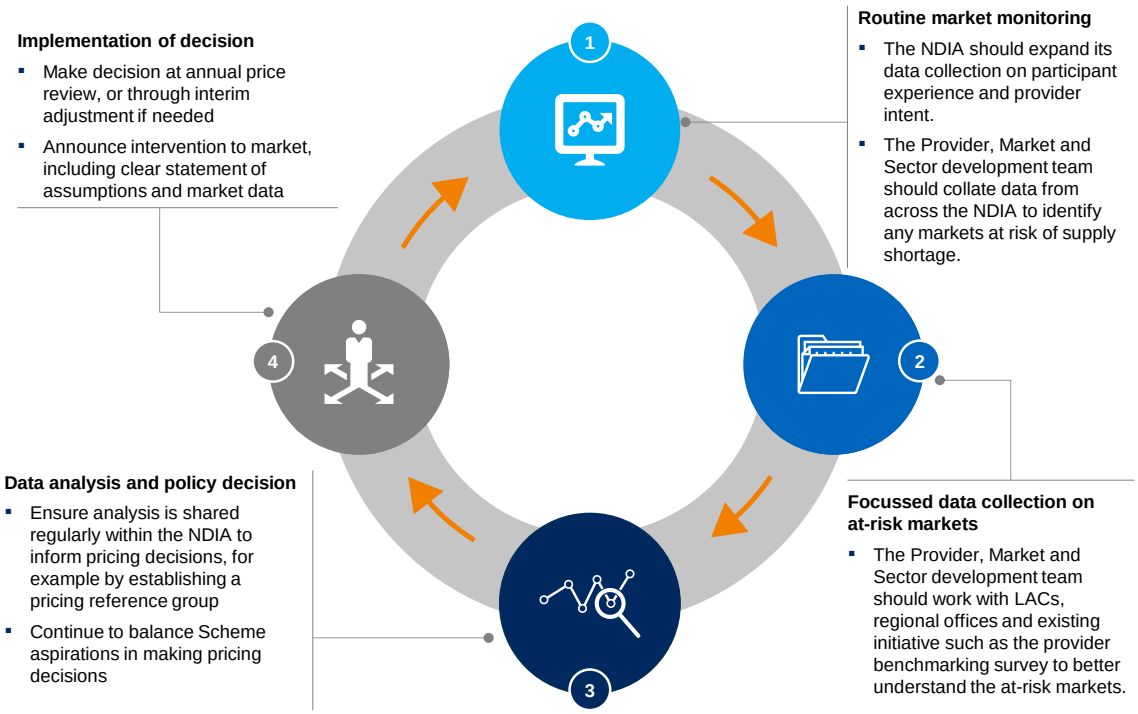
The most significant departure of this prescribed process from NDIA's current practice is to include a more thorough assessment of the risk of supply shortages, including a more comprehensive analysis of alternative supply options and the range and distribution of costs to serve of providers. The driving question should be whether participants are able to access all the services for which they have funding. In the case of an existing provider no longer being able to offer services, participants will require options to access alternative providers. Where there are signals that participants are at risk of not being able to access services, the NDIA should assess options to intervene through evaluating impact on the NDIA aspirations.

[29] The NDIA does monitor the number and broad category of complaints lodged by participants, as well as tracking the overall participant satisfaction rate, which has consistently been above 85%. However, neither of these are directly related to observations of supply gaps in the Scheme.

It is important that the price-setting process continually balances the NDIA aspirations, which can involve trade-offs. This is because in an immature and developing market, price caps not only regulate provider competition but also act as a signal of efficient prices, enable value-for-money for participants, and affect the long-term development of the NDIS.

EXHIBIT 6

The process for testing whether to amend price caps should incorporate thorough market monitoring and transparent decision making



Step 1: Routine market monitoring

The NDIA should complement its existing initiatives to advance its market monitoring capabilities through three additional initiatives: collecting data on the share of participants affected by supply gaps, extending its provider consultation and feedback processes, and collating market data and sharing internally to all relevant decision-makers.

The NDIA should collect more comprehensive data on the ability of participants to find the supports they require across each geographical region and support type. The most desirable way to collect this information is regular surveying of participants. This could be done through a new survey, or by expanding the existing participant assessment in the Short-form Outcomes Framework.

Secondly, the NDIA should establish proactive and regular consultations with providers, including surveys, to assess provider experience and intent. The NDIA should construct a representative sample of new and mature providers to gauge their financial sustainability, intent for growth, self-assessment of ability to cater to demand, and knowledge of any current or emerging supply gaps. Whilst some of this data is currently collected by other

organisations, the NDIA should have access to a more regular and reliable source of data that it can rely on for its own decision making.

The above sources of data should be part of a regular monitoring framework which also incorporates existing market data such as utilisation rates and evidence of provider entry or exit (see Exhibit 7). See Section 4.5.1 for a detailed discussion of the relevant metrics.

Finally, all relevant market information should be collated and analysed by the Provider, Market and Sector development team. Regional offices, LACs, the Scheme Actuary and other parts of the NDIS should share the relevant data with this team. The data and analysis should then be regularly reported to key stakeholders within the NDIA such as the Chief Executive Officer (CEO) and the Board. This will enable rapid identification of any markets that may be at high risk of undersupply and a consistent flow of information within the NDIA.

If this market monitoring process reveals any markets that are at risk of developing supply gaps, the NDIA should take immediate steps to collect more focussed data on those at-risk markets.

EXHIBIT 7

Supply in Scheme markets can be evaluated through considering a mix of indicators from surveys, utilisation rates and entry/ exit data

Indicator and relevant metrics		Data Source	Discussion on limitations
1 Participant experience	**1.1**: Share of participants with funding who had difficulty or were unable to find services	▪ Participant survey, e.g. "In the past year, did you have difficulty or were you unable to access supports because of a lack of suppliers in your market?" ▪ Compare across respondent region and support type	▪ Broad surveys may be too expensive or time-consuming to be sufficiently representative and timely ▪ Consider focusing on "at-risk" markets which show other indicators of supply shortages, such as low rates of market entry or poor utilisation rates
	1.2: Share of participants who are unsatisfied with quality of services accessed	▪ Participant survey, e.g. "Were you satisfied with the quality of supports you have received in the past year?" ▪ Compare across region and support-types of respondents	
2 Provider intent	**2.1**: Share of providers intending to grow/ shrink number of participants served	▪ Provider survey, e.g. "Are you intending to serve more participants in the next year than you did in the last?" ▪ Compare across respondent region and support type.	▪ Provider intent may be informed by non-Scheme features ▪ However, reason for withdrawal/ expansion is not as relevant as identifying the outcomes that are consistent with existing price settings
	2.2: Share of providers intending to expand into/ withdraw from support types/ regions.	▪ Provider survey, e.g. "Are you intending to expand the number of regions in which you operate? ▪ Compare across respondent region and support type.	
3 Utilisation rate	**3.1**: Level of utilisation by support type and geography ("utilisation rate")	▪ NDIA planning and claims data ▪ Share of funds allocated in participant plan which were disbursed in the relevant time period ▪ Compare relative averages and distribution across markets	▪ Utilisation rates are affected by many non-supply factors, e.g. plan quality ▪ However, comparing to average utilisation rates and measuring change over time can help to determine markets in which persistent low utilisation is likely to be due to insufficient supply.
	3.2: Change in utilisation rate over time by support type and geography	▪ NDIA planning and claims data ▪ Percentage point change in utilisation rate from one time period to the next	
4 Rates of market entry/ exit	**4.1**: Number and share of providers which withdrew from current markets.	▪ NDIA payment and claims data ▪ Number of providers who sought payments from fewer regions/ support types in this year than last	▪ Benchmark entry/ exit rates are difficult to establish due to volatility in transitioning markets ▪ However, the data can be used to identify outlier markets which warrant further investigation
	4.2: Number and share of providers which expanded into new markets.	▪ NDIA payment and claims data ▪ Number of providers who sought payments from more regions/ support types in this year than last	

Step 2: Focussed data collection on at-risk markets

More focussed data collection on specific markets should include investigating the causes of participants being unable to access supports, through LAC feedback and qualitative research with participants. It may also include assessing the economic performance of providers to

understand whether the supply gap is likely to worsen over time. If this data confirms that providers are struggling to provide the required supports in a financially sustainable fashion, and supply gaps are likely to continue, the NDIA should proceed to evaluate the effectiveness of different interventions to address this risk of supply shortage.

In some cases, this market monitoring process will identify instances where participants require a more immediate solution than amendments to price controls or related policies. This is discussed in further detail in Section 4.5 (*Thin and undersupplied markets*).

Step 3: Policy decision

The data collected by the NDIA should inform its annual price review, but also inform any interim price or non-price interventions that may be required. Interim interventions should be used where there is an immediate market concern, as was the case with the change of short term accommodation prices in October 2017. Once the NDIA has assessed markets that need intervention, it should identify intervention options which may involve targeted adjustments to specific policies or terms of business (e.g. travel or remoteness policies), non-price levers such as changes to the planning process or NDIA's systems and processes, or changes to prices.

The identified policy options should be assessed against each of the NDIA aspirations, to test which options will have the most favourable impact on all aspirations while ensuring that participants are able to access all the services for which they have funding. This should be done with input from all relevant parts of the NDIA, so that information on how the options will affect each of participant outcomes, market development, and Scheme sustainability can be fully considered. The assessment of policy options should be coordinated by the Provider, Market and Sector development team and made available to all relevant decision makers, including the CEO and the Board.

The NDIA should consider the addition of new organisational mechanisms to support this stronger internal collaboration and ensure proper governance of the pricing process. It may be appropriate to establish a pricing reference group with participation from all relevant parts of the NDIA, such as the Scheme Actuary, senior management, the Provider, Market and Sector development team etc. For pricing decisions which affect a smaller part of the market or Scheme spend, the NDIA may consider authorising the CEO or the Provider, Market and Sector development team to make policy decisions. Regardless of the model chosen, the NDIA should be satisfied that holistic information is available on the rationale and consequences of changes in price levels or other policies.

Step 4: Implementation of decision

The NDIA should give providers sufficient notice of price changes that result from the annual price reviews. The IPR team recommends that this notification period be one month for core and capacity building supports. A notification period of a month will allow organisations to calculate the impact of new prices and make informed business decisions. It will also allow providers to communicate and advocate for their new prices to participants. Price changes should also be scheduled to take effect at the beginning of the financial year to align with the corporate planning procedures of providers. The NDIA should also make clear the reasoning for price decisions and disclose relevant market data.

For interim price adjustments where a single support service or market is being affected, a shorter notice period of two weeks would be acceptable. This is because by their nature interim pricing decisions need to be implemented more rapidly, and are likely to affect a smaller proportion of the Scheme.

4.1.2 Alternatives to an hourly rate

Issues and evidence

It is important to differentiate between the funding model and the pricing approach of the NDIS. The NDIS funds individual supports for participants, to help them achieve their goals and desired outcomes. Under the previous block-funding model, providers were funded to deliver a range of services to a participant over a quarter or year.

The predominant mechanism for setting prices across the NDIS is a cap on the hourly (or other time-based) rate that can be charged for providing the relevant support service. Under this approach, providers are paid for their 'inputs'.

Input-based pricing, sometimes referred to as fee-for-service, rewards providers for work done, and creates a transparent price that can be used to stimulate provider efficiency. However, this form of pricing is sometimes criticised for creating incentives for providers to increase volume of services, rather than focusing on how to improve outcomes.

Outcome-based pricing is an alternative method which remunerates service providers based on an agreed improvement in the service user's outcomes resulting from the provision of services. For example, employment services could be priced based on whether users of the services are able to obtain and maintain stable employment. An example of such a payment model for providers is the Federal Government's jobactive program. Outcome-based pricing encourages innovation by prioritising the delivery of the desired outcomes at the lowest cost. It encourages providers to find more productive ways to deliver services, rather than rewarding providers who simply provide the highest volume of services. However, this method requires outcomes which are able to be clearly defined and monitored so that the improvements can be measured and an appropriate price established. The method also requires careful design choices so that providers are not encouraged to deliver short-term measurable outcomes at the expense of more sustainable, long-term improvements in a participant's welfare.

Recommendations

2: The NDIA should continue to use an hourly rate approach, but trial outcomes-based pricing

The current measures of participant outcomes are not yet sufficiently defined or tested to support an outcomes-based pricing model. Currently the NDIA is measuring progress of participants against multiple outcomes through the Short-form Outcomes Framework questionnaire, and as part of participant plan reviews. However, many of these outcomes are broadly defined such as increased choice and control or community participation. Given that many participants are receiving different supports from a range of providers, it will be difficult to attribute improvements in outcomes to a specific support. In addition, there are not yet clear

outcomes baselines for most services, or alignment on evidence-based approaches to test and monitor improvements in outcomes. As a result, outcomes-based pricing approaches will require further development and testing before becoming a viable alternative to the current hourly rate approach.

The NDIA should start to build its capability to design and manage outcome-based pricing through a trial for a support service which is amenable to outcomes measurement. Services which are most amenable to outcome measurements include employment services, learning supports, and some types of physical or behavioural therapy. For example, the NDIA could pay providers of employment supports a bonus based on their ability to find stable employment for participants. To encourage long-term improvements in outcomes, such bonuses could be paid out in part at the time of placing a participant in a job, and in part at the 12-month mark if the participant continues to be in work. For behavioural supports, the NDIA could reward providers based on their ability to reduce the incidence of certain behaviours or behavioural interventions such as restrictive practices. Before commencing any trial, the NDIA will need to be satisfied that it has a good understanding of baseline outcomes in that market, and the capability to both monitor and price outcomes going forward. A trial would develop the NDIA's capacity in designing outcomes-based pricing systems, offer useful insights on whether the NDIA is able to sufficiently monitor outcomes, test whether providers can adjust to this model of service provision, and provide evidence for whether such a system improves participant outcomes.

4.2 NATIONAL VS REGIONAL PRICING

One of the questions posed for the IPR team was whether there are significant differences in the costs of serving participants within and across states and territories.

Within states and territories, the cost of service provision varies by geography due to travel and other service delivery costs associated with remote and very remote areas. For example, in very remote areas providers often incur higher wages, higher accommodation and food costs and higher staff turnover. To compensate providers for these costs, the NDIA applies loadings to prices of 25% in very remote areas and 20% in remote areas.

Once travel and remoteness are accounted for, there is little difference in cost structures within a state. In the disability sector, approximately 80% of the cost of service provision is labour, and labour costs are typically based on the SCHADS Award.[30] Most providers pay their workers in line with these award rates or their EBAs, with no further adjustments for the location of service provision.

Across states, labour costs vary a little due to some small differences in award rates. These differences are minor (under 3%) and will converge by 2020.[31] The NDIA currently has two

[30] Estimate based on independent modelling of the IPR, consultation with providers and comparison with modelling of comparable Schemes. The NDIA's current pricing methodology makes a similar assumption as to share of labour costs.

[31] See Appendix C for further detail on SCHADS Awards by state. Convergence of national awards is a result of the Equal Remuneration Order (ERO) made by the Fair Work Commission in 2012. For full detail on the ERO and SCHADS Awards rates, see: https://www.fairwork.gov.au/pay/minimum-wages/social-and-community-services-industry-pay-rates.

price guides – one for Eastern states (NSW, VIC, QLD, TAS) and one for Western states (ACT, NT, SA, WA). The difference in prices between these guides does not correlate with differences in SCHADS Awards or other cost differences between those states. The current disparity between these price guides appears to be based on legacy arrangements among jurisdictions, rather than any direct correlation with regional costs.

Section 4.2 covers the following topics:

- 4.2.1 Service provision in remote and very remote regions
- 4.2.2 Service provision in rural areas
- 4.2.3 Single national price

4.2.1 Service provision in remote and very remote regions

Issues and Evidence

The NDIS operates in several regions which are located far from existing providers and workforces. These regions are categorised as remote or very remote, depending on classification systems that assess a combination of population size and distance factors. The NDIA is currently changing the classification system it uses from 'Remoteness Areas' (RA),[32] which ranges from category 1 to 5 by increasing remoteness, to the 'Modified Monash Model' (MM), which ranges from category 1 to 7 in the same way.[33]

'Remote' regions are those classified as 'MM 6' and are broadly comparable to RA – 4. Examples include the Central Highlands region in Queensland and Western NSW. 'Very remote' regions are those with the 'MM 7' classification and are broadly comparable to RA – 5. Examples of the most remote regions catered to by the NDIS include the unincorporated regions of far western NSW, the Central Desert region in the Northern Territory, and the Central Highlands region in Queensland.

The cost of service provision in remote and very remote areas is often higher than in other regions due to travel and other service delivery costs – for example, higher wages, higher accommodation and food costs, and higher staff turnover. To compensate providers for these costs, the NDIA applies loadings to prices of 25% in very remote areas and 20% in remote areas. These percentages are based on loadings developed by the Independent Hospital Pricing Authority (IPHA). Some providers stated that the remoteness loadings are inadequate in situations where air travel or long-distance road travel is required to serve isolated communities, or where local market infrastructure is limited.

In the absence of local supply, providers sometimes need to resort to fly-in, fly-out (FIFO) or drive-in, drive-out (DIDO) service models to reach isolated communities that may be located tens to hundreds of kilometres from the nearest town (e.g. Palm Island). Furthermore, the cost of running and maintaining off-road vehicles is very high. Providers have reported to the IPR

[32] Remoteness Area classifications are based on the Accessibility/Remoteness Index of Australia (ARIA) and the Australian Statistical Geography Standard (ASGS).

[33] See National Disability Insurance Agency: *Rural and Remote Strategy 2016 – 2019* (February 2016) for more detail on how the NDIA classifies areas according to remoteness.

team that they could spend up to $2,000 per vehicle per month for leasing (or depreciation) and operational costs. Due to the remote areas that they cater to, there are few opportunities for economies of scale and some providers maintain fleets with tens of vehicles. Many of these costs can be avoided if service delivery was instead conducted by more local workforces but this is difficult in the short term.

Many isolated communities are discrete Indigenous communities. In these communities, service provision must account for a range of cultural factors such as: gender matching for workforce and clients, family-based decision making, differences in conceptualisation of disability, and travel challenges for participants that may result in unexpected cancellations.

Providers indicated that catering to remote and very remote areas often requires an investment to build up foundational market infrastructure. For example, participants in the region might not yet have been identified by the NDIA, nor is there an understanding within the community of the value of disability support services. One provider consulted by the IPR team illustrated this issue with recent experience. The provider described a market in remote North Queensland with a population of approximately 1,000 people (60% of whom were of CALD background) where just one NDIS participant had been identified, even though a greater need for support existed. The provider worked with health care providers and the local community to identify a further dozen people in need of disability supports and facilitated their introduction to the NDIS. This provider has been able to introduce sustainable services in these regions but the market is unlikely to be large enough for two providers, and the provider is unlikely to be able to invest in developing other new markets without some support for the upfront investment that is required.

Recommendations

3: In very remote/isolated areas, the NDIA should work with other community services and providers to support local workforce development to deliver services in the most efficient way possible. In regions with limited local supply, allow providers to quote on cost of delivering NDIS services in the short term to ensure supply.

The challenges described above are not unique to the NDIS. Many other government services, such as health and education, have faced similar challenges in providing services to remote and very remote communities. While price is one lever that can help encourage supply, a more holistic approach is needed.

The NDIA should prioritise identifying areas and individuals that constitute either thin markets at risk of under-supply or underpenetrated markets with unmet demand. Analysis to identify these markets should leverage data on participant residences and support requirements, provider office locations and support offerings, and plan utilisation. Many of the isolated communities falling into this category will be discrete Indigenous communities (including ATSI participants) that will require a coordinated and culturally sensitive approach to service provision.

The NDIA should then work with other community services and providers to support local workforce development that increases the reliability and quality of care while driving down the cost of supply. This could include working with the Aboriginal Medical Services (AMS) to deliver services in predominantly Indigenous communities. Extending the reach of the AMS

may be preferable to new providers who have little experience working with Indigenous communities.

Whilst development of a local workforce is preferable, there will be some regions where this is not possible in the short term and where cost of service provision is high. In these areas, the NDIA should establish a quoting system by which providers can bid for supplying services to underserved areas. In some regions, it may be feasible to establish panels of providers to quote on service delivery, to streamline the procurement process. While the quoting method is bureaucratically more demanding, other policy options are unlikely to address the lack of supply in these areas. For example, adjustments to the price loadings for remote areas (20%) and very remote areas (25%) are unlikely to cater to the full spectrum of challenges that providers face. The variability in cost of service provision and the non-price challenges that must be overcome (e.g. engaging with local communities) require a coordinated effort from the NDIA, other mainstream services, and providers.

Implications

Participant outcomes and market development will be improved at lower cost if the NDIA successfully works with existing health service providers and communities to develop local capacity. However, this may not be able to be achieved immediately.

In the short term, establishing the operational capacity to manage a quoting process will be important. It is expected that higher prices are likely to result from this process in isolated areas, but given the small proportion of participants in these regions, Scheme expenditure will not increase significantly. This process is likely to lead to more sustainable coverage of these areas and improvement in participant outcomes, including ATSI communities.

4.2.2 Service provision in rural areas

Issues and evidence

Some of the challenges associated with service provision in remote/very remote areas are relevant to providers serving rural areas as well. While price loadings exist for MM 6 and MM 7 areas, providers serving individuals and communities in ‘outer regional’ or ‘rural’ areas, which correspond anecdotally to MM 4 and MM 5 areas, cite geographic spread and high travel costs as contributing to higher costs. As a result, it appears that some providers have terminated services to participants living more than a certain distance away from offices or have expressed plans to withdraw services from rural communities.

MM4 areas are defined as areas in Remoteness Area 2 (RA2) and Remoteness Area 3 (RA3), per the Australian Standard Geographical Classification, that are not in MM3, and are within 10 km road distance of a town with population between 5,000 and 15,000 people. MM5 areas are all other areas in RA2 and RA3. Provider travel times to and between participants in MM 4 and MM 5 areas exceed 20 minutes, the current limit on time that attendant care providers can charge for travel between participants, in a significant number of cases. Providers cite averages that are often closer to 30-45 minutes due to low participant density and geographic spread of rural farms and communities. In extreme cases, providers in rural areas take an hour to several hours to reach the site of support service provision. In practice, many providers absorb all travel costs, inclusive of the first 20 minutes of travel, due to a reluctance

to reduce service levels, as plans are often insufficient to cover travel times while still ensuring that clients receive necessary supports. Participants may also expect to be charged for and receive a full hour of service due to unclear communication and insufficient participant education.

Several providers have instituted policies that stipulate a radius outside of which they are no longer able to provide service. For example, upon transitioning to the NDIS, a provider in regional Victoria has chosen to no longer serve clients located more than 10 kilometres from its office, while a provider in regional New South Wales has chosen to only serve participants located within 30 minutes from an office. Travel costs often compound other challenges of rural service delivery including lack of appropriate facilities and extreme weather, and inefficient staff rostering. Some providers consulted by the IPR team expressed an intent to withdraw from such areas due to these location-specific costs of service. For example, a provider in Queensland identified that supports in the Charters Towers regions (MM 4) were financially unsustainable as it involved costs associated with servicing regional areas which were not adequately recognised by the current NDIS pricing arrangements. These difficulties are currently challenging to identify or diagnose, as travel expenses are not monitored as a separate line item in the NDIA payments system. It is instead included as a part of the care provided. There is therefore no ongoing record of providers' travel times.

It is important to note that as the Scheme matures, development of local workforces will help alleviate this problem. It is expected that participants in rural areas – in particular in MM4, which is defined as being within 10km of a town of 5,000-15,000 people – will be served by local providers. However, the IPR recognises that development of these local workforces takes time, and there needs to be a mechanism to ensure that participants in these areas are not disadvantaged in the short term, by compensating providers for costs incurred.

Recommendations

4: The NDIA should clearly define rural areas and lift travel allowance from 20 minutes to 45 minutes for providers serving a participant located in MM5 (or ARIA equivalent) and MM4 in the short term. Adjust participant plans to account for travel and track travel as a separate line item.

While the NDIA released a Rural and Remote Strategy in February 2016, some providers noted continued ambiguity over the official definition of 'rural'. Thus, 'rural' areas should first be formally defined with reference to a consistent geographical category. This classification could rely on either the Modified Monash Model (likely Levels 4 and 5), or on Remoteness Areas calculated with reference to the Accessibility/Remoteness Index of Australia (ARIA).

Once this definition is in place, adjustment to the provider travel policy would be the most direct and cost-effective way to support supply. To compensate providers for high travel times in rural areas, the NDIA should increase the 20-minute travel cap for providers of eligible supports, and should align this travel policy with that of therapy (see Section 4.6.4 for recommendations relating to travel for therapy supports). The IPR believes a travel cap of 45 minutes is more appropriate.

The IPR team recognises the risk that more generous compensation of travel costs may create an incentive for some providers to use travelling workforces rather than the more efficient model of building local workforces, which is a core aspiration for the NDIA. However,

workforce development in small towns of less than 15,000 people can often be challenging in the short term. Therefore, the IPR recommends that this change in policy be applied to participants in MM4 and MM5 in the near term, but changed in the medium term (3 to 4 years) to apply only to participants in MM5. A travel cap of 45 minutes is unlikely to cover all costs of travel to participants in MM5. Providers will need to look for opportunities to cluster participants and coordinate service provision to reduce travel times.

This policy does not remove the commercial incentive for participants to choose providers who are able to provide services without the additional expense of travel costs. As such, the IPR team believes this travel adjustment is an acceptable balancing of competing priorities In the medium term, the NDIA could explore mechanisms to reduce the incentive for providers to travel, such as planning processes that only allow providers to charge for travel where there are no local alternatives.

An alternative option would be to add a price loading to rural areas, as is done with remote and very remote areas. The Health system, via the General Practice Rural Incentives Program, and Aged Care system, via the viability supplement and home care subsidy rates, currently provide additional compensation for service in MM 4-5 areas. However, it is mainly travel driving the increased cost of service to participants in rural areas. More than doubling the travel time allowed to be claimed by providers would provide a more targeted and effective intervention than a broad price loading, which does not account for the specific amount of travel a provider undertakes.

Travel should be tracked as a separate line item in NDIA payment data. This will allow the NDIA to monitor travel costs and better understand how providers and participants are allocating the costs of travel. Such monitoring will also allow the NDIA to understand whether more generous travel pricing provides a perverse incentive for providers to travel long distances rather than invest in local workforce development, or to encourage participants to attend the provider premises. This monitoring and better understanding of travel behaviour might then pave the way for the deregulation of travel costs. Removing travel caps to allow complete fungibility of travel versus direct service funding would enable providers to charge for any amount of travel (subject to agreement with participants), affording participants maximum choice and control and requiring providers to reduce travel costs to remain competitive. In some areas with high participant density and sufficient supply, travel deregulation may be appropriate provided participants can make informed choices between providers located at varying distances from their residence. Participants, planners, and LACs would require education to understand the availability of supply for each participant as well as the outcome implications of trading off travel and direct service. The NDIA should maintain travel caps in the near term, including an expanded cap for travel in rural areas, with the option of exploring travel deregulation as the NDIS matures.

Service provision in rural areas can also be affected by restrictions on the ability of participants to transport themselves to and from support services. This was an issue highlighted by providers during the IPR team’s consultation process (see Section 2). However, this issue is beyond the remit of the IPR. The NDIA could work with LACs, planners as well as the states and other local authorities to understand if a participant has public transport available to them and the capability to utilise the service. The IPR team recognises that solutions to transport will have implications for the adequacy of supply and support access in remote and rural areas.

Implications

The short-term implications of this change in travel policy for Scheme expenditure is difficult to estimate with precision as the NDIA does not currently track travel as a separate item. For instance, a provider who charges for an hour of service provision may have had no travel, or have used the full travel entitlement of 20 minutes and provided 40 minutes of care.

The IPR has made a number of assumptions to estimate potential costs, based on available information. Assuming a quarter of the participants who receive supports in regional areas (MM 4 and MM 5) are now provided services which attract additional travel entitlements, and that 45 minutes of travel is charged for approximately every four hours of support provided, the additional annual cost to the NDIS would be approximately $75 million.

Increasing the amount of travel time providers can charge will require planning process adjustments. Participants living in rural areas who require providers to travel to them, and who can only be served by providers requiring more than 20 minutes travel, should be given proportionally larger plan allocations to account for the cost of travel within these areas. As with other changes to price caps which affect how plans are constructed, participant education initiatives and additional coordination of support should be offered in parallel, to ensure that participants are able to factor in provider travel times when exercising choice and control.

As the Scheme matures and local workforces develop, the NDIA should review this policy and assess whether other incentives may be more appropriate to encourage local supply and reduce the incentive for providers to travel long distances to deliver supports.

4.2.3 Single national price

Issues and evidence

The NDIA currently has two different price guides, with typically lower prices in Eastern states (NSW, VIC, QLD, TAS) and higher prices in Western states (ACT, NT, SA, WA). For example, the price for ‘assistance with self-care activities during daytime weekdays’ differs by 1.8% between the two guides. In the ACT, NT, South Australia or Western Australia, providers can charge $45.54, while in the remaining states the cap is $44.72. The differences between other prices range from 0-12%. For example, higher intensity group care on Sundays is capped at $57.18 in ACT and the western states and territories, while it is capped at $52.84 in the other states.

There is no clear rationale for maintaining separate price guides. Current disparity between the Eastern and Western price guides appears to be based largely on legacy arrangements between jurisdictions, rather than on a direct correlation with regional costs. Whilst there is currently some minor variation in labour costs between states, it is not correlated to the division of price guides. Analysis of labour costs other than award wages, such as payroll tax, leave entitlements and workers compensation requirements, does not show a consistent difference between the eastern states and western states.[34]

[34] See Appendix C for more details on differences in award rates between States and analysis of other cost differences.

Recommendations

5: The NDIA should converge the two Price Guides and move toward a single national price guide by 2021.

In the absence of stronger justification for differentiated price guides across states, the NDIA should progressively converge prices to promote pricing simplicity, ease of communication, and systems efficiency for providers operating across multiple states. This price convergence should occur by 2021.

It is the IPR team's view that the NDIA should not attempt to capture the price differences between each state through tailored state-specific price guides, as this is likely to lead to significant pricing complexity and may also fracture a national market. Cost differences within states, driven for example by remoteness of a region, are more important factors, and these are accounted for through specific policies (see Sections 4.2.1 and 4.2.2 above).

Implications

Transition to a single national price guide will need to occur over the next three years. This can be done by adjusting the relative rates of annual inflation between the eastern and western price guides such that the two price guides converge over time. Once implemented, providers operating nationally will benefit from the simplicity of one national price guide.

4.3 PRICING OF ONE-TO-ONE SERVICES WITH DIFFERENT LEVELS OF COMPLEXITY

The NDIA recognises participants entering the NDIS will have a range of disability types, levels of functional impairment, and requirements of a support worker to meet their needs. A two-tiered pricing structure is in place to allow a high intensity rate to be charged by a provider. The high intensity rate is set at 5.5% higher than the standard rate, applicable where a participant's complex needs require assistance from a support worker with a higher skill level. Support workers serving participants with complex needs are sometimes exposed to a higher level of safety risk, which can be to a participant or to themselves, and the higher skill levels and pay rates ensure the support worker is fit to provide quality services to participants in these environments. Examples of environments with greater safety risk could include a support worker serving a participant with medical needs where health-related intervention is a core component of service delivery, or serving a participant with behaviours of concern that could result in the participant attempting to self-harm or harm the support worker.

The key concerns raised by providers related to the quantum of the high intensity loading being insufficient to cover the cost of employing a higher skilled worker, and the loading not accounting for the additional time required to service participants with complex needs, including team meetings, report writing, training, and more frequent incident management. Additional concerns included the inconsistent application of high intensity loading across Core Support Items in the Price Guide. Examples include centre-based care having no high intensity rate, and not allowing for increased carer ratios, and the inconsistent allocation of the high intensity loading across participants. Currently, responsibility falls on a provider to agree with a participant that a high intensity loading is necessary for them to receive the level of care that will help them achieve their desired outcomes.

This section covers the following topics:

- 4.3.1 Definition of complexity and quantum of the high intensity rate
- 4.3.2 Participants with extreme behaviours of concern
- 4.3.3 Consistency of pricing for participants with complex needs across core supports

4.3.1 Definition of complexity and quantum of the high intensity rate

Issues and evidence

There is no simple definition communicated to the sector of what complexity means in a pricing context, and as a result, the term complexity is used inconsistently. Providers link complexity to the ratio of care a participant requires i.e. the number of carers, the number of hours of care a participant has allowance for in their plans, also referred to as 'intensity of care', and more subjectively, to how difficult a provider believes it is to serve a participant. There are cohorts of participants that require support workers with specific skillsets above the level of a typical support worker, which cost providers more to employ. Providers are not consistently receiving a high intensity loading to serve these participants due to the lack of clarity in the definition of complexity. The link between a participant's needs, the cost drivers of a provider, and price is not clear, which leads to inconsistent application of the high intensity price loading. The policy placing the responsibility on providers to determine whether a participant should be charged a high intensity rate exacerbates the issue, as providers each have their own definition of complexity.

Provider submissions to the IPR showed that many providers employ support workers serving participants without complex needs between SCHADS Level 2.2 to Level 2.4. This is consistent with NDIA expectations and the responsibilities outlined in the Award for a Social and Community Services Employee Level 2.[35] To serve participants with complex needs, providers often employ support workers at a base wage level between a SCHADS 2.4 and 3.3 to match the workers increased level of skill and experience. There is evidence of some providers employing workers up to and above SCHADS Level 4. For participants classified as having complex needs because of a medical condition, additional skills of a support worker can include the ability to recognise the need for health-related intervention, and administer medication by injection, or feeding through a nasogastric tube. For participants classified as having complex needs because of behaviours of concern, additional skills of a support worker can include the ability to recognise symptoms or presentations of mental illness and intervene to de-escalate violent behaviours. To serve participants with complex needs resulting from medical or behavioural presentations, support workers are required to exercise judgement based on prior knowledge and experience to determine the course of action necessary to

[35] The Award states the responsibilities of a Level 2 employee are: *'(k) implementing client skills and activities programmes under limited supervision either individually or as part of a team as part of the delivery of disability services'* and *'(l) supervising or providing a wide range of personal care services to residents under limited supervision either individually or as part of a team as part of the delivery of disability services'.* The Fair Work Commission: *Social, Community, Healthcare and Disability Services Industry Award 2010 (updated 29 July 2017), p. 52*

address the situation. These attributes closely align to the characteristics necessary of a Level 3 employee.[36]

The high intensity loading of 5.5% is intended to provide additional funds where a participant requires assistance from a support worker with additional skills or experience relevant to a participant's complex needs. The loading provides enough funding to allow an employer to pay a support worker between a SCHADS 2.4 and 3.1, which is at the lower end of the wage level currently being paid by providers, assuming a base level of SCHADS 2.3, which is consistent with the rate paid by many providers for participants without complex needs. This could be adequate in some situations such as feeding through a nasogastric tube in a standard environment. However, where a participant has very serious behaviours of concern, or a combination of medical needs and behaviours of concern, a worker with a higher level of skill may be required.

Many providers raised concerns about the high intensity loading not taking into consideration the incremental ongoing training and development requirements for support workers serving complex participants. Submissions to the IPR indicated providers are conducting approximately 3-4 hours of additional training for these support workers each quarter. These training sessions often bring together groups of support workers and other professionals to discuss individual client situations and techniques that have been used or developed to deliver improved outcomes. As the sessions are often internal, the costs incurred by providers are for support worker time, with no opportunity to recover the cost for the delivery of the training.

Providers serving participants with complex needs reported that they spend more time on incident management and reporting than other providers, due to the nature of the disabilities of the participants cohorts they serve. One small provider estimated spending over 200 hours per year on incident management, with an average of one incident per fortnight, and each incident requiring a review, report, care team meetings, and a response plan. This was estimated to have up to a 2-3% impact on the provider's overall margin. While not all incidents are avoidable, providers are expected to have effective internal processes to prevent and respond to incidents.

[36] The Award states the characteristics of a Level 3 employee include: *'General features of this level involve solving problems of limited difficulty using knowledge, judgment and work organisational skills acquired through qualifications and/or previous work experience. Assistance is available from senior employees. Employees may receive instruction on the broader aspects of the work. In addition, employees may provide assistance to lower classified employees.'* The Fair Work Commission: *Social, Community, Healthcare and Disability Services Industry Award 2010 (updated 29 July 2017)*, *p. 54*

Recommendations

6: The NDIA should develop a definition for complexity linked to the skills required to meet participant's needs, and use its specialised planning resources to classify what skills are required, and which participants require higher skilled support workers.

The NDIA should develop a definition for what complexity means in a pricing context and communicate it to the sector. The definition must create a clear link between a participant's needs and the cost drivers for a provider, that can be translated into price. To serve participants with complex needs, providers employ support workers with additional skills and experience, and are required to compensate them with a higher base wage level. The increased cost of employing these support workers should be translated into the price. The NDIA can leverage most of the existing definition for high intensity supports in the Price Guide, but the focus should be on skill level rather than on qualifications, as in some cases additional qualifications may not develop the specific skills necessary to serve a participant's complex needs.

This revised definition should include a clear link between a participant and their needs, and the relevant and most significant cost driver of a provider being support worker wages. Examples of participants that would be defined as complex in a pricing context include participants that exhibit rapid, severe and frequent escalation of violent or self-harm behaviour, including some participants in the psychosocial and cognitive disability participant cohorts, and participants that require health-related intervention as part of ongoing support. In both situations, participants may require a support worker with additional skills to serve them. The skill level required to service a participant increases with the severity of a participant's complex needs, and there should be different tiers of pricing to match the different levels of skills needed.

The NDIA should use the specialist team of planners it is developing as part of the Participant Pathway project to develop a set of criteria to determine whether a participant's requirements are complex for the purposes of pricing. The objective of the criteria should be to determine whether a participant requires a higher skilled or qualified support worker for their needs.

The NDIA should assign the responsibility of classifying participants with complex needs for the purposes of pricing to the specialist planning team. Planners have visibility into participant records and complexity classifications throughout the participant pathway (see Appendix D – Existing definitions of complexity that exist within the NDIA), and under the revised pathway should have face to face interactions with participants to understand their needs and goals. Each of these sources of information should allow a planner to determine if a participant requires a support worker with additional skills or experience, and hence a price loading.

As the specialist team builds capability, it should develop and refine the service models used for participants with complex needs, both health and behaviour related, to make sure participants receive plans that meet their needs and deliver the best possible outcomes. It may be difficult for the planning team to build expertise quickly, and in the short-term the NDIA should consider leveraging industry experts for support until the team is able to manage most of the cases in-house. The team could continue to reach out to outside experts for advice in very difficult cases which are outside its area of expertise.

7: The NDIA should add an additional tier to the high intensity loading to allow a provider to recover the cost of a support worker with a higher level of skill than can be procured with the current high intensity loading.

The current loading may be sufficient to employ a higher skilled support worker for some complex needs, such as health-related intervention in a standard environment. However, it may be less suitable for situations where a participant has serious behaviours of concern, or a combination of medical needs and behaviours of concern. A third tier classification of 'Very Complex', should allow a provider to employ a mix of support workers at SCHADS Level 3.1 or Level 3.2. The loading should also take into consideration the incremental ongoing training and development necessary for support workers serving very complex participants estimated at 1%. The specialist planning team should be responsible for assessing and classifying participants considered to be Very Complex. The IPR team recognises that there is a small number of participants for whom it is very difficult develop prices due to the nature of their disabilities and the environments necessary to deliver their services, and believe a quoting process is the most appropriate mechanism to ensure they receive the supports required to meet their needs (see Section 4.3.2). TABLE 3 describes the characteristics of participants that would be classified as Standard, Complex, Very Complex, and Quoted.

Incidents are more likely to occur for providers serving participants with complex needs. Providers incur costs associated with incidents such as the time spent on team briefing meetings and incident report writing. Providers are expected to have effective internal processes to prevent and respond to incidents, but it is recognised that not all incidents are avoidable.

The introduction of the NDIS Quality and Safeguarding Framework will have some implications for providers on the scope of incident reporting requirements. Given the operational implications of this are not yet known, the IPR recommends that the NDIA revisits this recommendation in the future to evaluate if providers need to be compensated for the costs of incident reporting – for example by introducing an incident reporting line item in the Price Guide to allow for providers to charge for time spent on this activity.

TABLE 3: DESCRIPTION OF PROPOSED LEVELS FOR PARTICIPANTS WITH COMPLEX NEEDS

Classification	Participant characteristics
Standard (no price loading)	■ No health-related intervention needs (e.g. feeding through a nasogastric tube, ventilation support) ■ None or mild behaviours of concern
Complex (5.5% price loading)	■ Health-related intervention needs (e.g. feeding through a nasogastric tube, ventilation support) ■ Mild-moderate behaviours of concern (e.g. infrequent rapid escalation of challenging behaviour)
Very Complex (10% price loading)	■ Combination of health-related intervention needs and mild-moderate behaviours of concern ■ Severe behaviours of concern (e.g. rapid, severe and frequent escalation of challenging behaviour)
Quoted	■ Extreme behaviours of concern – see Section 4.3.2 for further details

Implications

The NDIA has commenced work to establish specialist planning teams as they develop the new participant pathway. The specialist team will need to be trained to categorise participants with complex needs as informed by the tool/set of criteria defined by the NDIA. It is important that the team monitors the outcomes of their categorisations to help improve accuracy and consistency over time.

An improved definition of complexity and allocation process will ensure providers are able to charge a higher rate to participants that require a higher skilled support worker. This will allow providers to recover the increased cost of direct supports required to service the complex participant cohort. It will be important to engage with the relevant segments of the sector, both participant and provider representatives, when developing the final set of characteristics to be used during the complexity classification. This will limit the number of times providers request the NDIA to review participant categorisations. In a situation where a provider challenges a participant's categorisation, a process needs to be put in place to allow individual cases to quickly be reviewed by the NDIA if a provider can provide evidence to show the categorisation is not correct. It should be noted that it is possible some participants are currently being charged the high intensity rate that would not apply under a new definition. To reduce the financial impact on providers, the definition should be phased in for participants already in the NDIS as their plans come up for review.

The expected cost of the additional tier of price loading for participants with complex needs is between $100m-$140m, which represents 0.5%-0.7% of costs at Full Scheme[37]. The IPR team expects the costs to be at the lower end of the range, as the improved definition and classification process for participants with complex needs will limit the number of participants that receive the price loading to only those that require a support worker with additional skills. It is possible the price increase could be absorbed by the utilisation levels within participant budgets, meaning there could be no impact on the funding envelope. The suggested approach is to fix each of the definition and classification issues related to complexity before adjusting the price. This will ensure price loadings are only applied to participants considered to have complex needs under the improved definition of complexity.

4.3.2 Participants with extreme behaviours of concern

Issues and evidence

Participants with extreme behaviours of concern include participants that are subject to orders under the justice system, also referred to as forensic disability participants, and previous offenders no longer subject to orders. Participants with extreme behaviours of concern are not explicitly recognised in NDIS pricing. Forensic disability participants are typically individuals with cognitive impairments that have committed criminal offences in the past, but are unable to be institutionalised due to their condition. They often fall at the extreme end of the spectrum of behaviours of concern. Providers have historically served this participant cohort with a very

[37] Based on 12% of participants qualifying for the complex level (a 6% loading) and 10% of participants qualifying for the very complex level (a 10% loading), with a margin of error of +/- $20m, and assuming all participant plans are adjusted to compensate for the change in policy

skilled workforce, such as tertiary educated support workers, and it is not possible for them to recover costs at the high intensity rate set in the Price Guide.

There is legislation in place that details the responsibilities of the NDIS to participants that have been offenders under the criminal justice system. The NDIS (Supports for Participants) Rules 2013, made for the purposes of Sections 33 and 34 of the National Disability Insurance Scheme Act 2013, outline that forensic disability services are to be funded and delivered as part of the NDIS.[38] Services to be provided to this participant cohort are legislated under a number of state-based Acts related to the nature of the offence and disability of the participant.[39] A provider requires extensive knowledge of the legislative environment to deliver services to this participant cohort, who often need intensive supports and services, delivered by very skilled and experienced professionals. As the services necessary for a participant can vary significantly from one circumstance to another, it is very difficult for the NDIA to develop pricing schedules and plans that meet the needs of participants while also adhering to state-specific legislation.

Providers serving forensic disability participants, often referred to as forensic providers, are exposed to increased risk compared to providers focused on other participant cohorts. NDIA policy does not allow providers to deliver all support items from the Support Coordination support category, to mitigate the risk of a conflict of interest. There are cases of forensic service providers pulling out of Support Coordination or refusing to provide the services to participants not in their care to minimise risk, where they are not in full control of a participants care. This puts the specific sub-market at risk of supply shortages.

The NDIA has put rules in place for the Support Coordination support category to mitigate the risk of conflicts of interest, specifically for Local Area Coordinators (LACs), which are included in the NDIS Partners in the Community Program: Program Guidelines (August 2016).[40] There are three Support Items within the Support Coordination support category relevant to the discussion: Support Connection, Coordination of Supports, and Specialist Support Coordination. Participants that are classified as Supported or General during the pre-planning phase, meaning it is easier for the planning team to engage with a participant throughout the participant pathway, receive Support Connection. Support Connection is delivered by LACs, and it is not possible for LACs to deliver Support Connection and provide services to the participant. Participants classified as Intensive or Super Intensive during the pre-planning phase, meaning it is more difficult to engage with a participant throughout the participant

[38] Section 7.23 explains the meaning of a person not in custody: '*person not in custody means a person who is subject to the justice system (including relevant elements of the civil justice system), but is not in a custodial setting (for example, a person on bail, a person under a community based order that places controls on the person to manage risks to the individual or to the community, a former prisoner on parole, or a person in home detention)'*. Section 7.24 goes on to explain the NDIS responsibilities for a person not in custody *'The NDIS will be responsible for: (a) in relation to a person not in custody –reasonable and necessary supports on the same basis as all other persons'. National Disability Insurance Scheme Act 2013* (the Act): *National Disability Insurance Scheme (Supports for Participants) Rules 2013, Section 7.23 and 7.24, p. 20*

[39] In Victoria, this can include Supervision Orders under the Serious Sex Offender and Detention Supervision Act 2009 and the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, Parole Orders (and Bail Conditions) under the Crimes Act 1958 and Corrections Act 1986, and Community Treatment Orders under the Mental Health Act (2014).

[40] Section 4.1.1.3 states 'An Applicant which applies to deliver LAC Services, must not be a Registered Provider of Supports as defined under section 9 of the NDIS Act'. NDIA: NDIS Partners in the Community (Round One) – Program Guidelines, Section 4, p. 9

pathway, receive Coordination of Supports and/or Specialist Support Coordination. These Support Items are delivered by providers, not by LACs. It is possible for a provider to deliver Coordination of Supports and/or Specialist Support Coordination and be a participant's service provider, but the provider must ensure they proactively manage conflicts of interest, as per the Terms of Business for Registered Providers (July 2016).[41]

The NDIA is currently addressing cases of participants with extreme behaviours of concern out of their regional offices, and providers have communicated that in some cases they have been allowed to develop quotes to deliver services to this participant cohort. However, there are examples of providers being advised that they need to follow the Price Guide, and price according to the high intensity rate. There is not yet a consistent approach for addressing the needs of this participant cohort.

Recommendations

8: The NDIA should develop a consistent process for participants with extreme behaviours of concern that acknowledges the specialised needs of the participant cohort, and the environment providers operate in. Providers serving this cohort should quote on the delivery of services to these participants, and be allowed to deliver all services they require to be adequately supported i.e. all Support Coordination items.

The quotes, which would include a detailed support plan for a participant, would be submitted directly to the specialist planning team (see Section 4.3.1) for review and approval. A quoting mechanism will be most effective for this participant cohort given that the number of participants in this cohort is very small, the number of providers servicing the participant cohort is also very small, effectively making it a thin market, and the services necessary to support participants will vary significantly from one individual to another.

Allowing providers to deliver all Support Coordination services will ensure individuals in this participant cohort receive the services they require to be adequately supported, and help to eliminate the risk of supply shortages leading to participants not being able to procure services. Detailed reviews of the quotes submitted to the specialist planning team to ensure participants are only receiving the supports required to meet their needs can help the NDIA protect against conflicts of interest.

Implications

The NDIA will need to set up a quoting process to allow providers to submit quotes for review and approval. For the NDIA to review and approve quotes, the capability of the specialist planning team needs to be place with a clear understanding of the needs of the forensic disability participant cohort as well as of the legislative environment in which forensic service providers operate. To speed up the quoting process and ensure forensic disability participants can move into a care environment as quickly as possible, the NDIA may identify a list of preferred providers in each state that can be contacted at short notice.

[41] The Terms state *'Registered Providers must ensure that they proactively manage perceived and actual conflicts of interest, including through development and maintenance of organisational policies'* NDIA: *Terms of Business for Registered Providers (effective 18 April 2016)*, p. 3

From a participant perspective, allowing forensic service providers to deliver all supports to them could be considered as a conflict that limits choice and control. Considering the legislative environment providers operate in, it is unlikely a participant will receive a range of services from multiple providers. It is a better outcome for the participants to have the services available to them than not at all due to providers not wanting to take on additional risk.

4.3.3 Consistency of pricing for participants with complex needs across core supports

Issues and evidence

There are inconsistencies with the application of high intensity loadings and care ratios across different core supports. Support items including 'Assistance with self-care activities' and 'Assistance to access community, social/recreational activities' allow providers to charge a high intensity loading where assistance is required from a support worker with additional skills or experience relevant to the participant's complex needs. The support items also allow providers to charge different prices dependent on the care ratio necessary to support a participant. This can either be a lower care ratio, such as 1:2 or 1:3, where a single support worker can service multiple participants at the same time, or higher care ratio, such as 2:1 or 3:1, where multiple support workers are required to serve a single participant.

The support item 'Group based activities in a centre', does not allow providers to charge a high intensity loading, meaning providers cannot be compensated for the additional cost they incur for a highly skilled support worker if a participant with complex needs chooses to utilise the service. This support item is also set at a price between the 1:2 and 1:3 care ratio for Assistance with self-care activities and Assistance to access community, social/recreational activities, and does not provide the flexibility to providers to either increase or decrease the price based on the number of participants in the group.

Recommendations

9: The NDIA should update the pricing structure for the core support item 'Group based activities in a centre', to allow providers to charge a high intensity loading where a more skilled worker is required to serve a participant, and set prices consistent with the care ratio required to serve a participant.

The NDIA should ensure pricing for 'Group based activities in a centre' adopts the same approach used for other core supports, including Support Items 'Assistance with self-care activities' and 'Assistance to access community, social/recreational activities'. This recommendation is not designed to encourage a participant to lead a life with a high intensity of support. Rather, it is expected that as the Scheme matures and evidence develops, providers and the NDIA will be able to assess which interventions are most effective in supporting participants with complex behaviours and needs to achieve improved outcomes and, in some cases, no longer require high intensity support.

Implications

Participants with complex needs utilising 'Group based activities in a centre' will be required to pay a higher price for the service. They will need to choose whether they would like to

continue utilising the services at the higher price, or if their funding can be used more effectively with a different mix of services.

4.4 PRICING OF SHORT TERM ACCOMMODATION SERVICES

The NDIA recognises participants may at times have periods where their support arrangements need to be different from the regular level of support they receive. Short-term accommodation (STA), also known as Respite, is a Core Support available to participants to provide third-party care in a group based facility or in-home support. The service is often used by participants whose regular support is delivered at home by family members, allowing family members the opportunity to have some time off from being the primary care giver. It also gives participants the opportunity to socialise with peers in a safe environment.

At the time of the provider consultation phase of the IPR, a flat price of $501.71/day[42] was in place for STA, and most concerns by providers related to the lack of price differentiation. The key concern voiced by providers was that a single price for the STA support item did not reflect variations in the cost of service delivery by the day of the week, or by the care ratio necessary to serve a participant. Providers also raised the issue that there was no allowance in the price to compensate them for the capital invested in the facilities. After the completion of the consultation phase of the IPR, the NDIA announced price changes effective 30 October 2017 to address issues related to the STA price.

Issues and evidence

Under a single price point, many providers found it difficult to operate economically on weekends and public holidays, when they were required to pay penalty rates to support workers, and when participants required higher care ratios such as one-on-one support. As a result, providers began to withdraw services from the market, either by closing their facilities on specific days of the week, by no longer providing services to participants that required high care ratios, or by shutting down their short-term accommodation services completely. Recently, this issue became acute in the ACT, where providers Duo and Carers ACT closed their short-term accommodation services, and Marymead, the only other provider, signalled they were going to follow, having already restricted services to participants that required low care ratios on specific days of the week that did not involve substantially higher labour costs.

The NDIA responded to the market reaction and revised the price of STA, releasing a new price schedule, effective 30 October 2017. The NDIA adjusted the price, basing it on the price of attendant care, to better reflect the variable costs of service delivery on different days of the week and at different care ratios for participants, and capital employed in facilities. The revised pricing schedule includes differentiated prices for weekdays, weekends, and public holidays, as well as for care ratios of 1:4, 1:2, and 1:1 support needs. Each of the prices also includes a capital allowance. The NDIA has established a process for participants who are fully utilising their plans to review participant budgets and ensure participants are not disadvantaged by the price increases.

[42] NDIA: *2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017)*, p. 40

Recommendations

10: The NDIA should continue to refine the assumptions for high intensity rates, active overnight, and capital allowances used to develop the new STA price schedule, to ensure they reflect the cost of service delivery.

The IPR team agrees with the approach used by the NDIA to develop a differentiated price schedule based on the price of attendant care, that is more reflective of the cost of service delivery for providers. Assumptions around provider operating models have been used to develop the new pricing schedule, and the NDIA should continue to refine each of these to reflect an efficient provider's costs.

The NDIA has applied the high intensity loading to each care ratio to build up the new STA pricing schedule. This high intensity loading should only be used where a participant requires assistance from a support worker with additional skills or experience relevant to the participant's complex needs. Participants with complex needs are less likely to be served under low care ratios. The NDIA should consider using the standard intensity rate for lower care ratios (1:4 and 1:2), and in those special cases have two prices for a 1:1 care ratio, one price based on the standard rate (for participants with high physical disabilities) and one price based on the high intensity rate for participants with complex needs.

For each care ratio, the assumption made in the price is that the support worker will be required to work 8 hours of an active overnight shift, meaning the support worker is required to be awake and active throughout the night. Provider consultation raised the point that this should only be necessary in extreme cases, and it would be reasonable to assume that for participants without complex needs, a support worker works a night-time sleepover shift, with up to two hours of active overnight hours to allow for disruptions during the night. The NDIA should consider using an overnight shift with up to two hours of active overnight for low care ratios, and an active overnight shift only when a high care ratio is required for a participant with highly complex behavioural needs.

An accommodation allowance of $200 per night has been included to cover board and meals throughout the new pricing schedule. The $200 figure is the average cost of i) accommodation costs for a day of respite in aged care facilities ($140), based on rates set by the Australian Government for My Aged Care, and ii) accommodation costs for a day in acute care or a hospital setting ($260), as sourced from the Independent Hospital Pricing Authority (IHPA). The NDIA should continue to refine the capital allowance by reviewing the operating costs of providers. A review of the financials of providers that made submissions related to STA indicated accommodation and other overhead costs could be below $100 per day. This is from a small sample of providers, but it indicates that the operating costs are much less comparable to hospitals, and the aged care comparison of $140 per day could be a more reasonable assumption.

4.5 THIN AND UNDERSUPPLIED MARKETS

A 'thin' or 'undersupplied' market is one in which there is a persistently low level of supply relative to demand. This is often due to structural features of the market that makes it expensive or difficult for providers to compete effectively. Thin markets are a key policy concern for the NDIS as the presence of thin and undersupplied markets can compromise participant outcomes in that region.

While price caps may have an impact on thin and undersupplied markets, other policy considerations can often be more important. Once a market has been assessed as thin or undersupplied, increasing prices can be a way to attract new suppliers and investment. However, some structural features cannot be overcome by price alone. This includes when the suppliers do not have the capacity to cater to some specialised markets, or when the market has structural features such as geographical isolation which make it difficult for providers to operate in these areas.

The NDIA should bolster its market evaluation framework to identify thin markets before they develop, invest in market development infrastructure, and make pricing changes where necessary.

Section 4.5 covers the following topics:

- 4.5.1 Process to identify thin and undersupplied markets
- 4.5.2 Addressing emerging thin and undersupplied markets

4.5.1 Process to identify thin and undersupplied markets

Issues and evidence

The NDIS is too young and the available data too incomplete to make a definitive assessment of whether certain markets are at risk of being thin or undersupplied. The NDIS has only been in operation for more than 12 months in a few geographic regions. 79% of supports committed in the latest financial year were in NSW, ACT and Victoria, with the NDIS yet to be rolled out in much of Queensland, Tasmania and the western states and territories. NDIS expenditure on support services in FY 2016/17 was 15% of the projected annual expenditure by 2021. Not only is the NDIS in its early stage, there are also some limitations to the current data on market supply. For example, comprehensive surveys of participants and providers are limited to the trial sites or have only just been initiated in other parts of the Scheme. More discussion of this evidence is presented in Section 3.1 – Market Development. It is too early to form definitive assessments about which markets are likely to emerge as thin or undersupplied, as any evidence of supply gaps may be a product of temporary transitional pressures, or reflect gaps in data collection.

The NDIA is currently designing a market analysis and intervention strategy to identify thin and undersupplied markets. It is also developing a strategy to maintain critical supports which will support its efforts to identify short-term responses to supply gaps. These strategies are yet to be finalised and implemented. The NDIA does not currently have a framework with clearly identified metrics and data sources to ensure that its monitoring strategies are more comprehensive and transparent.

Recommendations

11: As part of its market intervention strategy, the NDIA should adopt a clear set of metrics to more comprehensively identify and respond to risks of thin markets emerging.

The NDIA should include a clear set of metrics and data sources within a robust evaluation framework to test markets for potential undersupply. The IPR team recommended above the

adoption of a clear and robust market evaluation and decision-making process to set appropriate price levels (see Section 4.1.1). The foundation of this process is a comprehensive understanding of market indicators to understand whether there is sufficient supply in each Scheme market. The following section identifies the key metrics that the NDIA should monitor, the data sources it can rely on, and the teams within the NDIA that should have responsibility for collection and analysis of these metrics.

The IPR team recognises that no single set of Scheme-wide indicators can offer a definitive answer on whether supply challenges are likely to occur in each rapidly changing market. Therefore, the focus of the monitoring framework should be on identifying the markets that most warrant further investigation. The NDIA should err on the side of caution when identifying thin markets. Identifying the markets 'most at risk', rather than whether they are currently undersupplied or not, will position the NDIA well to respond to emerging supply challenges.

Participant survey data

The NDIA should have a regularly updated awareness of the share of participants who are unable to access supports for which they have a budgeted plan, and the share of participants who are satisfied with the quality of supports to which they have access. This can be constructed through a participant survey, as well as by accessing informal information flows from LACs and planners. As NDIS-wide participant surveys may be more difficult to update continuously, the NDIA can target participant surveys in markets that demonstrate other indicators of supply shortages.

The NDIA currently conducts a regular participant survey through its Short-form Outcomes Framework assessment. The NDIA should include in this survey a question as to whether participants were able to access supports for which they had funding, and if not, if this was due to a lack of available providers. The NDIA currently reports on the share of participants who identified having difficulty in accessing health services, but this question is not specific to either NDIS-supported services or difficulty caused by a lack of adequate supply. The NDIA should also collate instances of participants contacting their LACs to report an inability to find providers. The results of these queries should be included by the Provider, Markets and Sector development team in its regular assessment of markets and reported to senior management.

Provider intent

Understanding whether providers intend to expand services to a new market, continue in current markets, or withdraw from the markets in which they provide support services, is a good leading indicator of the adequacy of supply in the future. The NDIA can monitor this intent through provider surveys and regular consultation with providers. Where indications exist of provider exit, more thorough consultation should be conducted to inform the NDIA's understanding of provider economics, participant demand, and Scheme performance in that area. This will inform whether the prices in that market should be changed, including through interim pricing adjustments.

The provider benchmarking initiative currently being developed by the NDIA will give some indirect indication of provider economics and intent.[43] The NDIA also manages relationships with providers through its regional offices and LAC network. However, standardised and regular reporting of provider intent should be part of its permanent market monitoring framework.

Utilisation rate

The utilisation rate is the share of a participant's budgeted plan that has been used to purchase services. It is calculated annually and, since services provided in one year may not be claimed for reimbursement until some months later, updated retrospectively. If a participant were unable to find providers of sufficient quality to meet their needs as specified in their plan, it would be reflected in the utilisation rate, and could signpost a lack of appropriate supply in that market.

Utilisation rates should be used by comparing changes in relative levels to overcome some of the metric's shortfalls. Absolute levels of utilisation rates are less informative because they may be affected by many factors other than supply. The most important of these is the content of the plans themselves; a utilisation rate might appear high simply because the plans catered for inadequate supports in the first place. Similarly, plans that provide for more services than required in a support category may appear underutilised, even though the participants are accessing all the high-quality support they require. Some plan managers who were consulted by the IPR team reported that their participants sometimes had spare allocations for capital equipment in case some of it was damaged and needed to be replaced. Such items are only intended to be used infrequently and could account for low utilisation rates in some support markets.

Despite these alternate explanations for any given level of a utilisation rate, observing the relative rates across markets, and the change in rates over time, will give some indication of which markets may be experiencing supply shortfalls.

The Scheme Actuary currently collects and shares utilisation data quarterly. The IPR team proposes the Provider, Markets and Sector development team should identify quarterly markets in the Scheme with low levels of relative utilisation using more tailored samples of participant utilisation rates, e.g. support type by geography, or a subset of participant characteristics within a geography. Markets with utilisation rates that are persistently lower than other markets can be investigated using surveys and interviews, through working with LACs, regional offices, participants and providers in that market.

Rates of market entry and exit

Rates of market entry and exit are a basic measure of the willingness of providers to supply disability support services in the NDIS at existing price levels. A combination of registration and payment data can help inform this measure. Registration data indicates instances where firms enter or exit the NDIS, but a provider can register while not actively providing supports and stop providing supports without deregistering. Analysis of payment data to identify provider activity offers the most direct observation of market supply. It is recognised that provider entry and exit rates will be affected by many commercial (and other) factors that are

[43] National Disability Insurance Agency: *Overview of benchmarking project,* available at https://www.ndis.gov.au/providers/market-information-useful-links/benchmarking-Project-Overview

not a result of just the price level. However, significant variations in provider entry or exit rates in some markets should serve as a trigger for further investigation.

The Scheme Actuary currently collects and reports payment data which shows rolling averages of provider entry and exit. This should be reviewed monthly by the Provider, Market and Sector development team, who should work with the Scheme Actuary to identify the markets by support type or geography which are experiencing the highest net declines in provider activity. This should be a trigger for further investigation in the relevant markets.

4.5.2 Addressing emerging thin and undersupplied markets

Issues and evidence

Provider submissions to the IPR during the consultation process for this review identified some markets as being at risk of undersupply due to the additional expense and difficulty in catering to them. These included markets for participants in remote regions and those with complex needs. These markets were also identified by the Productivity Commission as potential thin or undersupplied markets.[44]

Remote and very remote areas account for 3-5% of the current committed supports in the Scheme. Provider consultation and market data suggest a risk of undersupply in these markets. The non-financial obstacles to providing services in remote and very remote areas, include insufficient information about the participants in that region, limited Scheme infrastructure such as LACs, and the lack of a local workforce. Providers also revealed difficulties in travel to and from these areas which made service provision unsustainable (see Section 4.2.1).

Participants with very complex needs are defined here to include those that most require assistance from a support worker with additional skills and experience due to a medical need or challenging behaviour (see Section 4.3 for further detail). Based on the current application of ‘high intensity’ loadings, this cohort is estimated to comprise approximately 4% of participants enrolled in the Scheme but 13% of expenditure in the latest financial year.[45] Service provision to these participants is highly specialised and the participant density is low, creating a risk of undersupply that should be monitored and addressed (see Section 4.3.3).

Across all markets, as the Scheme transitions, the current assessment of market supply will change. Participants will change their demand patterns, new suppliers will come online while others leave, and Scheme infrastructure will be developed that helps participants and providers find each other – through LACs, and events at which providers can present their services, for example. These changes can continually affect the adequacy of supply in the market and must be proactively monitored by the NDIA.

[44] Productivity Commission: *National Disability Insurance Scheme (NDIS) Costs* (19 October 2017) , pp. 268 – 270.

[45] Share of participants who have been assessed as Level 13 – 15 according to the Disability Severity Indicator. It should be noted that this current definition of complexity does not adequately capture all participants with complex needs (see Section 4.3.1).

Recommendations

The supply challenges faced by the markets identified above can be addressed in part through changes to pricing and related policies. These changes are briefly outlined below, and discussed in more detail in the relevant other sections of this report:

- In very remote areas, including isolated Indigenous communities, the NDIA can work with providers to develop local workforces, and allow providers to quote on services to ensure supply in the short term (see Section 4.2.1).
- In rural areas, the NDIA can amend travel policies to enable providers to recoup costs associated with delivering services to participants in these areas (see Section 4.2.2).
- For participants with complex needs, the NDIA should more clearly define these participants, and adopt a more appropriate tiered pricing structure to reflect the costs of providing services for these participants (see Section 4.3).

In some cases, thin and undersupplied markets will require immediate intervention to ensure the provision of critical supports. For example, participants with daily care needs may require assistance in locating providers if a major provider in an already thin market were to withdraw. The NDIA is undertaking an initiative to ensure access to critical supports at any time, and facilitating a provider of last resort solution to address this scenario. In these circumstances, a price solution alone may not address the short-term requirements of participants, and LACs will likely play a significant role to help participants find suitable providers.

12: The NDIA should invest in Scheme infrastructure such as an e-market tool, which would empower participants in thin or undersupplied markets to find suitable providers.

One of the priorities for the NDIA as the NDIS has developed has been ensuring participants can connect with providers. To assist in this, the NDIA is establishing a ‘Provider Finder’, which enables a participant to search by postcode for a provider in his or her area. This is a useful tool for identifying providers, but does not yet let participants compare prices or transact directly through the platform. As the market grows, an e-market tool with this functionality will empower participants and increase price transparency and competition amongst providers. In addition to helping the NDIA address thin and undersupplied markets, easier identification of services and prices could support a faster transition towards deregulated prices (see Section 4.7).

An e-market would enable a participant to search by support type or features of the provider, such as location, price-range, or quality rating, and could also allow participants and providers to book support services on the platform. The e-market will not be a suitable solution for all providers and participants, for example where there are difficulties in accessing the internet or navigating an online portal. As such, the NDIA through its regional offices and LAC network should also continue experimenting with other forms of Scheme infrastructure, such as physical market fairs where participants can come to one place to meet providers and compare offerings.

In addition to its own activities, the NDIA can speed up the process of delivering an e-market by allowing private firms to develop and compete on online marketplace platforms. There are firms that are already providing similar products, but some are not registered in the NDIS,

meaning Agency-managed participants cannot access supports on these platforms. The NDIA should explore options to incentivise private providers to build e-market tools.

4.6 PROVIDER EFFICIENCIES AND ADEQUACY OF PROVIDER RETURNS

Section 3 of this report included analysis on provider economics and benchmarking with other schemes. The IPR team found that across all support types there were examples of providers operating profitably, as well as examples of providers struggling (see Exhibit 3). The successful models provide inspiration for how the market can innovate and drive efficiencies, while providing high quality services to participants that meet their needs. However, some providers, particularly those providing attendant care services, are struggling to make the transition to the NDIS.

The IPR team has focused on the adequacy of provider returns for attendant care and therapy. Attendant care was chosen given the large proportion of Scheme spend it represents, and given the recent scrutiny on the price cap for 1:1 attendant care. Therapy supports was chosen because the single NDIS price cap for therapy appeared to be inconsistent with the multiple price levels, and structure, of other comparable schemes.

Section 4.6 covers the following topics:

- 4.6.1 Costs of transitioning to the NDIS that impact provider returns
- 4.6.2 Administrative costs related to operating within the NDIS
- 4.6.3 Attendant care adequacy of provider returns and efficiencies
- 4.6.4 Therapy adequacy of provider returns and efficiencies

4.6.1 The cost of transitioning to the NDIS

Section 4.6.1 provides context for all of Section 4.6 by outlining the transitional costs and organisational challenges providers across all supports face as they move to a unit-funded, consumer-driven environment under the NDIS. It also provides an overview of federal and state and territory government spending to date to support NDIS transition, specifically as it relates to supporting provider readiness.

4.6.1.1 Changes providers must adapt to under the NDIS

Transitioning to the NDIS requires existing providers to develop new organisational capabilities and make significant changes and innovations to their systems and process. This requires significant investment by providers. This was recognised by DSS in a 2015 document.

'A substantial proportion of existing service providers are unlikely to operate effectively in the new environment without significant transformation…Providers long accustomed to block funding will require support to transition to business models responsive to individualised funding, and to diversify their service offerings to meet the support requirements of NDIS participants'.

Anecdotal evidence from provider consultations indicated that the cost of transition could amount to 1.5% of total annual expenditure for a provider.[46] The four biggest transitional changes to which providers must adapt are: a shift from block funding to unit funding; adapting to a consumer-driven service environment; a shift from payment in advance to payment in arrears; and compliance with a new quality and safeguards framework. Many providers have invested in IT, organisational capability, and organisational restructures.

Shift from block funding to unit funding

The shift from receiving and reporting against block funding every quarter, to claiming and reporting against individual units of service, has created challenges for providers.

First, many providers are struggling to manage the additional administrative burden of unit-funding. Anecdotal evidence from consultation suggests many providers have hired new corporate staff to manage payments and invoicing, increasing corporate overhead costs.

Second, providers have had to invest to understand whether they can deliver services under NDIS pricing. The unit costing regime requires providers to accurately measure each component of their service delivery, including on-costs and corporate overheads. Anecdotal evidence suggests many providers of disability support services did not understand their unit cost to serve prior to the NDIS. Nor did they possess data or organisational capability to measure unit costs, and therefore did not understand whether they could deliver services profitably within NDIS price caps. Not understanding whether they could deliver services within the price caps, or whether they had the short-term financial resilience to cope with transition, was a significant source of stress for many organisations. Many larger organisations hired external consultants to help them understand their unit costs to serve, while the federal government and state governments have also funded programs to help develop this capability in the sector.

Adapting to a consumer-driven service environment

In a new consumer-driven, competitive service delivery environment, providers must develop marketing capabilities to attract and retain customers. There is broad recognition amongst providers that this capability is underdeveloped in this sector, and many providers are investing significantly in their direct-to-customer marketing capabilities:

- One industry expert states: ‘There is a low level of sophistication in understanding the marketing funnel and the sequence of events through the activities of reaching, engaging, converting and servicing customers’.
- In transitioning to the NDIS, one provider invested in 10 full-time equivalent (FTE) staff to perform sales and relationship management functions at a cost of $750 000 per year, and incurred marketing and other new costs of $250 000. This represents an increase of over 1% to their total annual expenditure.

[46] Based on data from 3 large providers with revenue of over 50 million in FY16/17. Included spending on IT, new business teams and NDIS transition teams.

The empowerment of participants to choose not only their supports and providers, but also to have a greater say in when these are received, has also been challenging for providers. There is greater pressure to ensure that service times meet the needs of the participant, rather than the rostering requirements of the provider. This means providers are required to manage more peaks and troughs in demand between days of the week and hours of the day, making it more difficult to plan consecutive client bookings. Some providers have introduced a new human resources role to manage these new challenges, while others have invested in workforce rostering systems. Many providers have moved towards more casualised workforces to manage this challenge.

Shift from payment in advance to payment in arrears

Prior to the introduction of the NDIS, most disability organisations were paid by state and territory governments in advance on a quarterly basis. The switch from payments in advance to payments in arrears has represented a short-term cash flow challenge for providers, who now need to fund salaries and other expenses for a period in transition before they receive payments.

Compliance with a new quality and safeguarding framework

The NDIS Quality and Safeguarding Framework, released by the Council of Australian Governments Disability Reform Council in February 2017, introduces a nationally consistent system for regulating the safety and quality of disability services in Australia.[47]

The new framework will, among other things, introduce a new risk-based provider registration system. Registered providers whose registration group is deemed to be lower risk will only undergo a simple, periodic verification process while providers delivering higher-risk supports will be required to gain third party quality assurance certification.[48] In addition, all providers and workers will be required to comply with a new code of conduct, registered providers and their employees will be required to undertake a mandatory compulsory orientation module, and registered providers will be required to have effective internal complaints arrangements.[49]

In the short term, the new framework represents an added compliance cost for providers, who will have to adapt internal systems and processes to comply with these new standards. In the longer term, the framework may represent a cost efficiency for national providers – who will only need to comply with one set of standards, as opposed to one in each jurisdiction.

[47] Department of Social Services: *NDIS Quality and Safeguarding framework, factsheet for providers*, available at https://www.dss.gov.au/sites/default/files/documents/04_2017/ndis_quality_and_safeguarding_framework_fact_sheet_for_providers_final_2.pdf

[48] Department of Social Services: *NDIS Quality and Safeguarding framework, factsheet for providers*, available at https://www.dss.gov.au/sites/default/files/documents/04_2017/ndis_quality_and_safeguarding_framework_fact_sheet_for_providers_final_2.pdf

[49] Department of Social Services: *NDIS Quality and Safeguarding framework, factsheet for providers*, available at https://www.dss.gov.au/sites/default/files/documents/04_2017/ndis_quality_and_safeguarding_framework_fact_sheet_for_providers_final_2.pdf

4.6.1.2 Federal and state and territory government funding for provider readiness to date

To date, federal and state and territory governments have committed significant funds to support the NDIS transition. At the federal level, the Sector Development Fund (SDF), a pool of $146 million administered by DSS from 2012/13-2017/18,[50] has funded provider readiness projects under the primary outcome area of 'building disability sector capacity and service provider readiness'.[51] At the state and territory level governments have also invested significantly in the transition, often over and above the money they have received via SDF funding. For instance, the NSW Government spent over $30 million between 2009-2016 on NDIS sector development and capacity building.[52]

Of the money dedicated to provider readiness, some has been used to fund publicly accessible education tools that give providers practical business advice to assist the transition to the NDIS world, and some has been used to provide direct individualised provider support, financial and non-financial. It is unclear how much of this funding has been provided as funding to support provider education, versus direct financial assistance to providers.

Examples of provider readiness initiatives funded by federal and state and territory governments include:

- **Education tools for all providers:** The SDF funded a 'Unit Costing Tool Project' in New South Wales, which developed a suite of resources to help providers develop the capability to operating in a unit-funded NDIS world.[53]
- **Direct individualised non-financial assistance:** The SDF funded contractors to give providers in South Australia one-on-one support in helping them transform their business models, including assistance with financial and costing analysis, bookkeeping, IT and data management integration, and marketing and communication.[54]
- **Direct individualised financial assistance:** The NSW Government's Round 1 Transition Assistance Program (TAP), launched in 2016, provided over $ 4 million in financial assistance to small and medium providers regional areas. Providers with less than $3 million in annual turnover were offered up to $35,000 to help with readiness activities like updating business plans or purchasing software.[55] In TAP Round 2,

[50] The Fund was administered by the NDIA between 2013-2014.

[51] This is one of five outcome areas funded by the SDF. It is unclear at the time of writing this report, how much of the $146 million to date has been committed to this outcome area. The SDF is now closed for new applications.

[52] Audit Office of New South Wales: *New South Wales Auditor-General's Report Performance Audit: Building the readiness of non-government sector for the NDIS* (February 2017), available at http://www.audit.nsw.gov.au/news/building-the-readiness-of-the-non-government-sector-for-the-ndis

[53] National Disability Insurance Agency: *State and Territory Government SDF activities,* available at https://www.ndis.gov.au/sdf_state_territory.html

[54] National Disability Insurance Agency: *State and Territory Government SDF activities,* available at https://www.ndis.gov.au/sdf_state_territory.html

[55] NSW Government Department of Family and Community Services: *Funding boost to help regional NSW to get NDIS-ready* (19 July 2016), available at https://www.facs.nsw.gov.au/about_us/media_releases/media_release_archive/funding-boost-to-help-regional-nsw-get-ndis-ready

launched in 2017, the NSW Government awarded a further $600,000 in grants to providers.[56]

The effectiveness of this spending is not yet clearly established. Two audits have noted that these interventions have not been systematically evaluated. [57] Therefore, there is an opportunity for federal and state and territory governments to review the effectiveness of spending on provider readiness to date where possible, to evaluate the effectiveness of future interventions, and to assess whether any further support for provider readiness is required.

4.6.2 Costs of interacting with the NDIA

Issues and evidence

In addition to the expected costs associated with transition to the NDIS, consultation with providers revealed opportunities for the NDIA to improve its systems and processes, and reduce the administrative costs and cash flow risk of providers. Sections 2.2 and 2.4 summarised the provider feedback relating to the portal, NDIA responsiveness and planning raised in consultation, while Section 3.2 quantified the potential impact of these issues on provider financials based on a small sample of provider submissions. This sample indicated that the Agency could reduce provider costs by ~0.5% of total annual expenditure through improvements to its systems and processes.[58]

This section highlights a measures the NDIA should prioritise to address key provider feedback relating to NDIA systems and processes raised in consultation. The focus of the IPR is pricing and these recommendations are made in the context of the relative emphasis placed on these issues in consultation, and through an assessment of relative impact of these issues on provider economics.

The IPR team has been advised by the NDIA that there are multiple initiatives currently underway as part of the Participant and Provider Pathway Reviews that go to addressing the issues outlined in Sections 2.2 and 2.4, or to implementing some of the recommendations below.

[56] Consultation with the NSW Government Department of Family and Community Services.

[57] The Australian National Audit Office's audit of the Management of Transition of the Disability Services Market (November 2016) found *'limited evidence of evaluation of some higher cost projects'* funded by the SDF. Australian National Audit Office: *National Disability Insurance Scheme – Management of Transition of the Disability Services Market* (November 2016), available at https://www.anao.gov.au/work/performance-audit/national-disability-insurance-scheme-transition-disability-services. The NSW Audit Office's performance audit on *'Building the readiness of the non-government sector for the NDIS*' (February 2017) found the overall impact of the NSW Department of Family and Community Services spending on provider capability was not clear, as baseline information on provider capability was not collected and targets for improvement in provider capability were not set. Audit Office of New South Wales: *New South Wales Auditor-General's Report Performance Audit: Building the readiness of non-government sector for the NDIS* (February 2017), available at http://www.audit.nsw.gov.au/news/building-the-readiness-of-the-non-government-sector-for-the-ndis

[58] Based on 45 one-on-one interviews with providers in September 2017, in which three large providers (revenue > 50 million in FY16/17) gave detailed evidence of these costs.

Recommendations

13: The NDIA should prioritise the implementation of measures to continue to improve its portal, responsiveness and communication as part of the Participant and Provider Pathway Reviews.

Portal

- **Allow for automatic notification of plan review commencement, if participant consent is provided:** The NDIA has advised the IPR team that as of December 2017, changes to the portal will allow providers to view relevant sections of a participant's plan, including plan start and end dates, given the participant has a current service booking with the provider and the participant has provided their consent. The IPR team recommends the Agency also consider allowing providers to receive an automatic notification through the portal that a plan review has been triggered, given the participant has a current service booking with the provider and the participant has provided their consent.
- **Provide more detailed descriptions of claim rejection reasons:** The NDIA should consider providing a more detailed description of the cause of payment rejection in the portal.
- **Improve provider education tools:** The NDIA should continue simplifying and improving tools (like the provider toolkit) that educate providers how to navigate and troubleshoot portal issues. In the medium term, the NDIA should consider setting up a dummy portal that peak bodies and the NDIA can use to train providers on how to use the portal. This recommendation should be considered after changes in the provider pathway project have been implemented, and the new portal has been standardised.
- **Consult with providers when designing portal improvements:** The NDIA should consider making future improvements to the portal by consulting with a representative group of providers. The NDIA advised the IPR that this is already underway.

Agency responsiveness and communications

- **Stream call centre inquiries:** The NDIA should upskill call centre staff and stream call centre inquiries to specialist teams, to ensure that most provider inquiries are resolved by staff with the knowledge and the authority to resolve the issue. The IPR has been advised by the NDIA that there are current initiatives underway to address these issues.
- **Improve response times for SIL quote approvals:** The NDIA should aim to further reduce the average time it takes to process a SIL quote, building on its success to date in reducing the time required. The NDIA's current target is 14 days.
- **Improve communication of policy and process changes:** The NDIA should build on recent improvements such as the provider toolkit to clearly communicate all planned policy and process changes to providers, as far ahead of time as possible, and preferably through a single touchpoint. The IPR has been advised that the NDIA is aware of these issues and has recently implemented initiatives to address them e.g. the provider e-newsletter has been recently revised to include more 'need to know' information that is valued by providers.

Planning

The IPR team will not make any recommendations relating to the planning process as this is outside of the IPR's TOR. Moreover, the NDIA has advised the IPR team that most of the planning issues raised in Section 2.4 are being considered and addressed as part of the Participant and Provider Review projects.

4.6.3 Attendant care supports

Attendant care refers to 'Assistance with daily living' and 'Assistance with social and community participation'. 'Assistance with daily living' involves assisting with, and/or supervising personal tasks of daily life to develop the skills of the participant to live as independently as possible. 'Assistance with social and community participation' involves the provision of support to enable a participant to independently engage in community, social and recreational activities. Together these supports account for 45% of committed scheme spend at full Scheme. Attendant care can be provided by one carer to one participant (one to one) as well as by one carer to more than one participant in the case of 'Assistance with social and community participation' (group care).

Pricing for 'Supported Independent Living' (SIL) is derived from the price cap for attendant care. If SIL is included together with all other supports involving attendant care, together they are estimated to account for 75% of committed scheme spend at full scheme.[59]

This section covers the following topics:

- 4.6.3.1 Base price for one to one attendant care
- 4.6.3.2 Cancellation policy for attendant care
- 4.6.3.3 Group price for attendant care

4.6.3.1 Base price for one to one attendant care

Issues and evidence

Attendant care supports are currently subject to price caps. There are different price limits for the provision of these supports:

- At different times of day i.e. daytime, evening
- At different days of the week i.e. weekdays, Saturdays, Sundays and public holidays
- By the complexity of the care required i.e. standard and higher intensity
- By the location of the service i.e. metropolitan, remote or very remote.

The base price of one to one (1:1) attendant care (daytime, weekday, standard intensity, metropolitan location) is subject to a price limit set by the NDIA of $44.72 in the 2017/18 Price Guide for Victoria, New South Wales, Queensland and Tasmania, and $45.54 in the

[59] Source: NDIA Scheme Actuary.

Australian Capital Territory, Northern Territory, South Australia and Western Australia. The NDIA also sets service definitions, payment rules and terms of business that affect the cost of service delivery for this support.

The price of 1:1 attendant care has come under recent scrutiny.

- The price of 1:1 attendant care was the focus of the NDIA's FY2017/18 Price Review. The NDIA published a discussion paper '2017 Price Controls Review' in March 2017 and invited providers to give feedback on questions related to the price setting process and the adequacy of pricing for attendant care.
  - The NDIA found that 'divergent facts and views were presented' with some providers submitting that 'existing prices did not allow for recovery of costs', and some participants submitting that 'providers were overpricing supports in some categories'.[60]
  - In June 2017, the NDIA increased the base price of attendant care by 4.5% to $44.72, reflecting the increase in the national minimum wage, the Equal Remuneration Order and the impact of inflation.[61]
- More broadly, the NDIA's view on the pricing of attendant care is reflected in its March 2017 submission to the Productivity Commission Costs Paper, which states that '*Contradictory views in the provider population might be evidence that some are struggling to adjust to a funding model that is based on market principles. There is also evidence of a wide variety in operating costs under pre-NDIS approaches where efficiency was not a key consideration'*.[62]
- The Productivity Commission in its NDIS Costs Paper (October 2017) noted, based on anecdotal evidence from provider submissions, that attendant care price caps may be too low to achieve safe and quality outcomes, with estimates of the shortfall as a percentage of the current price cap varying considerably.[63]

One objective of the NDIS is to develop an efficient market of providers while providing safe and high quality supports for participants.

In assessing the price of 1:1 standard intensity attendant care, the IPR team examined evidence of supply shortages, benchmarked NDIA price caps against comparable schemes, and consulted with providers about their unit cost to serve. Detailed findings relating to these

60 National Disability Insurance Agency: *Letter from David Bowen to providers outlining the outcome of the FY17-18 Review* (12 June 2017), available at https://www.ndis.gov.au/news/letter-to-ndia-registered-providers.html

61 The 4.5% increase was based on the rise in the national minimum wage (3.3% from 1 July 2017) and the application of the Equal Remuneration Order (1.7% in some disability roles from 31 December 2016) for labour costs, and inflation (2.1% for the 12 months to 31 March 2017) for non-labour costs. Labour costs and non-labour costs were assumed to constitute 80% and 20% of the cost base for attendant care respectively. National Disability Insurance Agency: *Letter from David Bowen to providers outlining the outcome of the FY17-18 Review* (12 June 2017), available at https://www.ndis.gov.au/news/letter-to-ndia-registered-providers.html

62 National Disability Insurance Agency: *NDIA Submission to Productivity Commission Issues Paper on NDIS Costs* (March 2017), p. 101, available at https://www.pc.gov.au/__data/assets/pdf_file/0013/216031/sub0161-ndis-costs.pdf

63 Productivity Commission: *National Disability Insurance Scheme (NDIS) Costs* (October 2017), p. 300, available at https://www.pc.gov.au/inquiries/completed/ndis-costs/report/ndis-costs.pdf

are presented in Section 3. The IPR team recognises the limitations of each of these evidence sources.

The IPR team found no conclusive evidence of general supply shortages in the standard intensity attendant care market, with the NDIS price caps for attendant care being comparable to similar government funded schemes. The IPR team also found that some providers with different operating models currently deliver attendant care at a profit, but many providers in the market are struggling to make an adequate return. Based on a sample set of 22 providers who shared detailed operating cost breakdowns with the IPR team, the median cost to serve was ~$49 per hour, or ~10% higher than the current price cap (see Exhibit 4), with some providers stating they are cross-subsiding the loss on this support from other NDIS or non-NDIS funding sources, including state and territory government block funding.[64]

Many providers with profitable operating models in attendant care have recently started their business and specifically designed it to work for the NDIS, or are for-profit organisations, while many providers who are finding it difficult to deliver services under NDIS unit prices are incumbents or more traditional providers.

While there is no single model of care that will work for all providers and participants, and acknowledging the substantial investment providers have already made in transforming their organisations, the significant variation in cost to serve across the market indicates there are opportunities to innovate and lessons to be learned from operating models that are working well in standard intensity attendant care. Providers will generally need to achieve corporate overheads of 10-15% and improve workforce utilisation rates to above 90% to make a profit while complying with SCHADS award obligations. To do this, most existing providers will be required to adjust their operating models, driving efficiencies and innovation through technology and other operational improvements.

While this transformation will be challenging, examples of providers who are delivering quality supports at a profit suggest that it is achievable. Appendix E provides examples of strategies employed by some providers that have operating models that work under current prices. The NDIA's recently announced independent provider benchmarking function will also be a key reference point for providers as they make this transformation. In its first phase, this provider benchmarking project, run by an independent third-party survey manager, will survey providers for detailed information about their input costs for delivering attendant care, as well as for provider (e.g. provider scale, workforce mix, industrial agreements) and client characteristics (e.g. client complexity, location). The customised reports produced for participating providers will benchmark providers' input costs against similar providers in the sector. This will be an important piece of strategic information in helping providers understand how they are performing relative to their peers, potential drivers in variations in their input costs, and in identifying where there are specific opportunities to for improvement.

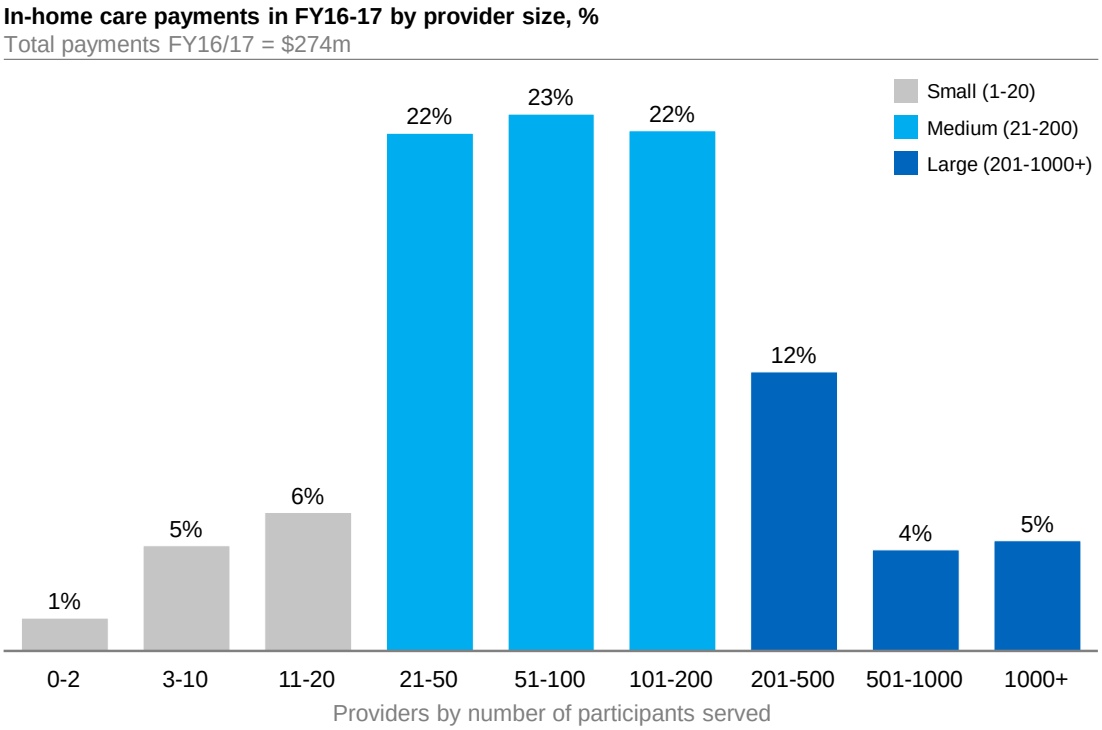
The IPR team also recognises that provider adjustment will take time: 88% of in-home care service volume under the NDIS is delivered by medium and large providers (see Exhibit 8)

[64] Data based on information from 22 providers who provided detailed financial information to the IPR. While the IPR's sample of 22 providers was not comprehensive or representative of the market, the IPR was limited by the information providers were able to provide.

who are less agile by nature of their size, while new entrants – although growing rapidly – have yet to capture a material share of the market.

EXHIBIT 8

Distribution of providers by size for in-home attendant care



SOURCE: Scheme Actuary, distribution of FY17 NDIS payments by provider size (in terms of number of participants served)

Recommendations

14: The NDIA should implement 'temporary support for overheads' (TSO) in the form of a temporary increase to the price cap for standard intensity attendant care. Government should offer business planning support for large providers that would otherwise exit and create the risk of supply shortages.

While the IPR team has not seen evidence of generalised supply shortages in attendant care to date, the IPR team's assessment is that there is a future risk of this occurring given rapidly increasing demand and supply side uncertainty. On the demand side, there will be rapid growth in demand for attendant care, as funding for disability doubles from $11 billion per annum prior to the NDIS, to more than $22 billion per annum at full Scheme. On the supply side, the market is undergoing significant adjustment. Some traditional providers, new technology-based entrants and sole traders can deliver attendant care support profitably under the price cap. However, many existing providers are not at the operating efficiency required to operate at a surplus under the price cap, and achieving the necessary efficiencies will take some more time.

The IPR team also notes the evidentiary difficulty of detecting how quickly the market is adjusting in a timely way, as articulated in Section 3.1. Critically, there is not one or a set of leading indicators that currently conclusively predict future generalised supply shortages.

In this uncertain context, and given the essential daily support that attendant care provides participants, the IPR team believes it is prudent to act cautiously and pre-emptively using a combination of price and non-price instruments to mitigate the risk of market failure.

The IPR team recommends the NDIA implement 'temporary support for overheads' (TSO) in the form of an increase of 2-3% in the price cap of 1:1 attendant care for 12 months. The TSO should apply in addition to ordinary annual indexation of the price. The presumption should be that the TSO is a one-off measure and will not be extended. The IPR believes that 12 months is a reasonable time frame for providers to implement changes to operating models to reduce overhead costs, and for the NDIA to assist and encourage the development of efficient and effective alternative supply options, such as e-marketplaces. At the end of the 12 months, the loading would be removed by reducing the annual indexation of the price by the TSO amount of 2-3%.

Before the end of this 12 months, there should be a review that examines the progress providers have made in transforming their business models and the ongoing risk of supply shortages. The expectation should be that providers have improved their performance sufficiently that they no longer require the TSO. Government should also consider using non-price instruments such as business planning support for providers to address the risk of supply shortages in attendant care, if further funding becomes available for this purpose.

In developing this recommendation, the IPR considered several alternatives including funding providers for specific activities (e.g. training, IT investments) and by-application support for providers. Given there is no legislative mechanism for NDIA to fund providers directly, and that a policy that advantaged one provider over another was unfavourable, the TSO was selected as the most appropriate option.

The specific quantum of the TSO increase should be a policy decision the NDIA makes in view of other more targeted interventions government will undertake to mitigate the risk of supply shortages. Based on current information, a 2-3% TSO adjustment reflects what the IPR team believes are reasonable assumptions for providers to achieve in the short term. While no one model of care will work for the entire market, if a 3% TSO is applied, providers will be able to achieve a ~5 % margin under the price cap if they can meet the following benchmarks:[65]

- **Labour costs (including supervisors):** SCHADs 2.3 support worker; 1:15 span of control, SCHADs 3.2 supervisor
- **Workforce mix:** 80% full-time or part-time workforce, 20% casual workforce

[65] Assumes the midpoint where an assumption range was provided. Analysis assumes labour costs in NSW as of November 2017, and the $44.72 price cap for attendant care in the Victoria, New South Wales, Queensland and Tasmania. The IPR recognises that on 1 December 2017 pay rates under the SCAHDS award were adjusted to reflect an increase from the Equal Remuneration Order (ERO). This will compress provider margins by ~2% for 6 months, until the Agency's July 2018 price increase, which should adjust the new price to reflect the 1 December 2017 ERO increase.

- **Workforce utilisation**: 90-95% utilisation of full-time and part-time workforce, 100% utilisation of casual workforce
- **Corporate overheads:** 10-15% corporate overheads as a % direct of labour costs.

These benchmarks should be achievable, as some providers are demonstrating they are able to operate more efficiently than these benchmarks, as described in Section 3.2. Some of these providers have already reduced corporate overheads to 10% and below. Improvements in utilisation above 90% should be realised as providers improve their rostering and adjust their workforce mix; and, labour costs can be reduced by creating different workforce pools for standard and high intensity participants. While achieving these efficiencies will be challenging for some providers, existing providers demonstrate they are attainable.

The IPR team recommends that the government fund business planning services for large providers who deliver high volumes of service in attendant care that are at risk of ceasing service provision, but who have the willingness to develop and implement an action plan to deliver attendant care profitably in the future. This focus on providers who deliver high volumes of service reflects the fact that the exit of these providers would increase the risk of supply shortages.

The TSO adjustment should not be made available to SIL. The high volume and certainty of demand for SIL allows providers to manage their business and workforce planning more effectively, and reduces the need for SIL providers to undergo large scale business model changes to adapt to the NDIS.

Implications

The quantum and the timing of the TSO balances the need to ensure the market has sufficient support to adjust, with the aspiration to achieve an efficient, high quality market of providers. The TSO will relieve some pressure on providers as they transform their operating models, while any targeted planning support will help protect against identified supply risks.

Implementing the TSO in conjunction with other recommendations relating to attendant care will improve the margins of providers, recognising that the TSO willonly last for 12 months. The other recommendations that will improve margins both in the short and long term, are the addition of a very high intensity rate for the most complex participants, adjustments to travel and cancellation policies, and the NDIA's ongoing work to improve the design of its systems and processes. The aggregate effect of these recommendations is that providers who were previously making a small loss on attendant care will now be able to provide the service at a profit while they adjust and improve their business models.

4.6.3.2 Cancellation policy for attendant care

Issues and evidence

Under the Price Guide, a provider can charge a maximum of 8 booking cancellations a year against a participant's plan for assistance with self-care activities and assistance to access community, social and recreational activities. A provider can only charge a booking cancellation if there are unforeseen circumstances, and the participant agrees that they (the participant), did not comply with the agreed requirements in the service agreement. The

NDIA's Price Guide does not distinguish between cancellations made far in advance and those made at short notice. The Price Guide also stipulates that providers are expected to have business arrangements in place to minimise the risk of participant cancellations, no shows or late changes.

Providers submitted that this policy does not reflect the frequency at which cancellations occur in this sector, particularly for medically or behaviourally complex participants. They submitted that where more than 8 cancellations occur per participant, this policy can be loss-incurring given providers' obligation under the SCHADS award to pay full-time and part-time employees as if they had worked a cancelled shift, if notification is not provided prior to 5pm the day before the scheduled service.

Recommendations

15: The cancellation policy for attendant care should be amended so that up to a certain threshold, providers can charge against a participant's plan for up to 90% of the entire duration of the scheduled service if the participant makes a short notice cancellation. Above this threshold, providers will need to demonstrate they are actively working with participants to minimise the risk of cancellations in order to continue charging for cancellations.

The Price Guide should distinguish between short-notice cancellations and other cancellations.

For short-notice cancellations, the cancellation policy for attendant care should be amended so that providers can charge against a participant's plan for up to 90% of the entire duration of the scheduled service.[66] A short-notice cancellation should be defined as occurring where the participant provides notice of cancellation after 3pm on the day before the scheduled service. This amended policy is designed to bring the NDIA's cancellation policy in line with providers' obligations under the SCHADS award. The 3pm cut-off time recognises that providers need time to redeploy a support worker or to give them notice of a cancelled shift before 5pm on the day before the scheduled service, as required under the SCHADS award for a full-time or part-time employee. Limiting providers to charging 90% provides an incentive to redeploy the worker if possible to recover overheads. It also provides an incentive for the provider to work with participants to reduce the volume of cancellations to the extent possible. If the worker can be redeployed by the provider, the provider should not charge the cancelling participant.

For other cancellations, where the participant has provided notice of cancellation prior to 3pm the day before the scheduled service, no cancellation fee should be able to be charged against a participant's plan. This is because providers are not obligated under the SCHADS award to pay full-time and part-time employees for a cancelled shift if notification is provided prior to 5pm the day before the scheduled service.

Additionally, the NDIA should introduce a new core support line item in the Price Guide for short-notice cancellations. This will allow the NDIA to monitor the volume of short-notice cancellations for two purposes. The first purpose is to provide better information on which participant cohorts have a defensible and higher risk of cancellations from their condition, for

[66] The terms of each provider's cancellation policy should be clearly laid out in the service agreement between the provider and the participant.

example a high risk of hospitalisation. The Scheme Actuary already factors in a level of cancellations into plan packages, but a line item would provide better information and may allow for a reduction in planned cancellations for certain cohorts of participants. The second purpose is that data on cancellations will allow the NDIA to detect anomalies in the volume of cancellations, and work with providers and participants to reduce the level of cancellations as appropriate.

The NDIA should also introduce a policy that above a specific threshold, providers will not be able to charge for short-notice cancellations unless they submit a report to the NDIA outlining the circumstances of each above-threshold cancellation, and actions taken to work with participants to minimise the risk of their short-notice cancellations. This threshold could be defined by the number of short-notice cancellations per participant per provider, or the percentage of short notice cancellations per participant per provider. The NDIA should consult with experienced practitioners in the disability sector to determine what a reasonable threshold should be.

Implications

This revised policy minimises the financial loss incurred by providers on short-notice cancellations and recognises that while providers should work with participants to minimise short notice cancellations, providers should also not bear financial risk for these incidents. It also incentivises positive behaviour by all actors in the market: participants are incentivised to give sufficient notice, while providers are incentivised to work with participants and implement processes to minimise risk of cancellations.

It is not expected that this change in policy will have an adverse impact on participant outcomes or Scheme costs. In most cases, the cost of cancellations will be absorbed by participants' budgets. If the nature of a participant's disability makes him or her more susceptible to cancellations, then the participant's budget should be increased accordingly. It is expected this will be a small proportion of participants.

4.6.3.3 Group pricing for attendant care

Issues and evidence

The NDIS has separate pricing schedules in place for the delivery of group-based community, social and recreational activities; and centre-based group care.

The current price schedule for group-based community, social and recreational activities assumes the price per participant is inversely proportionate to the number of participants in a group. The price per participant for a group of 1 support worker to 2 participants (1:2 care ratio) is half the price of a 1:1 care ratio. The price per participant for a group of 1 support worker to 3 participants (1:3 care ratio) is one third price of a 1:1 care ratio. For example, using the current price for attendant care of $44.72/hr[67], a provider will receive the same total of $44.72 whether a support worker delivers one hour of care to one participant, or a group of two or three participants.

[67] NDIA: 2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017), p. 29

Some providers believe the pricing of group care in the community does not consider the incremental fixed costs they incur when an additional participant is added to a care setting. These fixed costs include overhead costs for scheduling and invoicing, and the costs associated with completing case notes or outcome journals for a participant. Providers believe that in a 1:1 care setting it is possible to complete case notes during a consultation, however in group sessions this is difficult as there are greater demands on a support workers time due to the increased number of participants they are caring for. Some providers also believe that delivering care in a group setting requires a more highly skilled worker, because they need the skills and experience to manage multiple participants at the same time. For group-based community, social and recreational activities, it is possible to charge a high intensity rate when serving participants with complex needs. However, some providers believe that even for participants without complex needs, a higher skilled worker is required for group settings.

Providers that deliver care to large group sizes believe the Price Guide should include prices for groups larger than 3 participants to 1 support worker. The Price Guide displays prices for groups of up to 3 participants per support worker, but there are no prices indicated for groups of 4 or 5 participants per support worker. Some providers told the IPR team that because they do not believe the prices for group supports are correct, they stopped delivering care to small groups and only deliver care to groups of 4 or 5 participants, and charge them the price for a group size of 3 participants to 1 support worker. This results in their receiving more than $44.72 per hour as each of the 4 or 5 participants pays one third of the hourly rate. The NDIA is aware of this practice by providers, and is allowing it to take place because there is no policy that mandates providers need to charge a price below the 1:3 rate for groups with more than 3 participants.

The pricing schedule for centre-based group care is different to the pricing schedule for group care in the community, and some providers delivering centre-based group care believe it is difficult for them to operate with a surplus at the current price cap. The Price Guide has a flat hourly rate for centre based group care, and providers are not able to vary the price paid per participant based on the number of participants in a group, or to reflect the cost of a higher skilled support worker when they are caring for participants with complex needs (see Section 4.3.2). Some providers also believe the price does not consider the incremental fixed costs incurred when an additional participant is added to a care setting, as discussed for group based community, social and recreational activities, as well as the costs of operating a facility, and the capital providers have invested to make the facilities fit-for-purpose for participants, such as investment in modifications.

Some providers also raised the issue of cancellations impacting their ability to operate with a surplus. When a single participant in a group cancels, it is not possible for a provider to charge a higher rate to the other participants in a group to compensate for the difference in revenue. This results in the provider receiving less revenue than was expected if they delivered the support to the remaining participants in the group.

Recommendations

16: The NDIA should implement a new pricing schedule for group care (both community based and centre based) outlined in Table 4 that allows providers to recover additional costs incurred for groups, while still retaining the incentives and efficiencies of group based care. It should also assess whether a capital allowance should be provided for centre based care based on whether there is demand to increase the number of centres.

The price schedule of group based community, social and recreational activities should reflect the additional overhead costs for scheduling and invoicing, the additional administrative time required to write case notes/populate outcome journals, and consider an allowance for a higher skilled or experienced worker if it is determined to be appropriate for participants without complex needs. The price schedule should maintain high intensity loadings which can be applied above the standard rate for participants with complex needs. Section 4.3.1 includes a discussion on price loadings for participants with complex needs. This recommendation is not designed to encourage a participant to lead a life with a high intensity of support. Rather, it is expected that as the Scheme matures and evidence develops, providers and the NDIA will be able to assess which interventions are most effective in supporting participants with complex behaviours and needs to achieve improved outcomes and, in some cases, no longer require high intensity support.

TABLE 4 shows a comparison of the current price per participant without complex needs for 1:2, 1:3, and 1:4 care ratios compared to price ranges calculated using assumptions for the incremental fixed costs discussed above. Using data from a small sample of providers for the share of overheads scheduling and invoicing account for (10-20%), the amount of time spent per participant writing notes (3-5 mins/hr), and the SCHADS level of support workers for group care ratios (Level 2.3-3.1). The NDIA should conduct further work to refine the cost driver assumptions used to develop the new group prices. Once the assumptions have been refined by the NDIA, it can create a pricing schedule for group sizes larger than 1 support worker to 3 participants, up to a level deemed to be appropriate for a single support worker to be able to manage. This pricing schedule should be included in the Price Guide. TABLE 4 indicates prices for group based community, social and recreational activities for groups of up to 4 participants per support worker.

To support centre based group care, the NDIA should remove the flat pricing schedule that currently exists and adopt the same approach proposed for group based community, social and recreational activities. It should also assess whether a capital allowance is required based on whether there is demand to increase the number of centres. This should involve an assessment of the future demand for these services relative to the current supply.

TABLE 4: EXAMPLE OF PRICING SCHEDULE FOR GROUP BASED COMMUNITY, SOCIAL, AND RECREATIONAL ACTIVITIES

Care ratio	Current price per participant	Price per participant (without complex needs) including incremental fixed costs
1 staff – 1 participant	$44.72/hr	$44.72/hr
1 staff – 2 participants	$22.36/hr	$25.04/hr - $29.07/hr
1 staff – 3 participants	$14.91/hr	$16.76/hr - $19.68/hr
1 staff – 4 participants	No price - providers use $14.91/hr	$12.97/hr - $15.20/hr

Care ratio	Current price per participant	Price per participant (without complex needs) including incremental fixed costs
1 staff – 5+ participants	No price - providers use $14.91/hr	NDIA to determine the largest group size they will set prices for.

Implications

Increasing the price of group based care to reflect the incremental costs of service delivery could result in more supply of group care entering the market. This could be beneficial to participants, particularly for those with higher needs that cannot be cared for in large group sizes. By giving participants greater opportunity to access group care, they could choose to spend more of their budget on group care rather than 1:1 care, giving them more funds to utilise on other supports.

Once the NDIA has finalised a new pricing schedule for group care, they will need to ensure providers adopt the new prices and discontinue the current practice of charging the price of 1 staff to 3 participants for groups of 4 or more. The NDIA should consider including audits of group care delivery in their existing provider audit process to help enforce the use of the updated pricing schedule.

4.6.4 Therapy supports

The NDIA recognises therapeutic supports may be necessary for many participants to help build capacity to participate in the broader community. For example, for young participants (0-6 years), early intervention in the form of medical and disability therapy supports may help build their capacity to become more independent.

In therapy supports, participants, providers and other stakeholders identified an opportunity to differentiate pricing for different types of services to better match market rates for services, and enable the NDIS to provide better value for money to participants. This was supported by the IPR's benchmarking with other comparable schemes described in Section 3.3.2 above. Some providers delivering specialised therapy, for example clinical psychology, believe the price is not adequate for their participants. Other providers also raised the issue that the current description for therapy assistants does not reflect the activities undertaken, and that the price is not adequate to recover their costs, which leads them to serve participants with qualified therapists when the support could have been delivered by a therapy assistant at a lower price. Providers also raised issues relating to travel and cancellation policies, and NDIA-required report writing.

This section provides recommendations and rationale for:

- 4.6.4.1 Differentiated pricing for therapy supports delivered by a qualified therapist
- 4.6.4.2 Pricing for therapy supports delivered by therapy assistants
- 4.6.4.3 Travel policy
- 4.6.4.4 Cancellation policy
- 4.6.4.5 NDIA-required report writing

4.6.4.1 Differentiated pricing for therapy supports delivered by a qualified therapist

Issues and evidence

Providers, participant bodies, and other stakeholders raised issues associated with the single price of therapy. Some providers consider that the current price is more than adequate for many therapy supports, but where more complex therapy is required, for example complex psychological therapy delivered by a clinical psychologist, the price is not adequate. Participant bodies and other stakeholders have raised issues about the single price being too high where standard therapy is required. For example, for a typical physiotherapy consultation, participants are being charged a price higher price than the market rate for the service.

While the NDIA has a single price for therapy supports, other comparable insurance schemes in Australia have differentiated pricing. Examples include the TAC, WorkSafe, Department of Veterans Affairs (DVA), and NSW State Insurance Regulatory Authority (SIRA). Section 3.3, *Benchmarking with comparable schemes*, indicates that there is opportunity to differentiate the price of therapy supports based on the type of therapy being delivered, and level of service a participant requires to meet their needs.

Recommendation

17: The NDIA should develop differentiated price levels for physical therapy and psychological therapy based on price levels being paid in comparable schemes.

Physical therapy should be differentiated across three levels of care, and psychological therapy across two levels of care (TABLE 5 and TABLE 6).

TABLE 5: RECOMMENDED PRICES FOR PHYSICAL THERAPY SUPPORTS

Level of support	Proposed price ($/hr)	Description
Level 1	$110 - $120	The delivery of therapy for a single physical condition (which can result in multiple symptoms) in a low risk environment. An example is occupational therapy to develop the balance of a child with low level cerebral palsy that has a low level of severity on the Gross Motor Function Classification System (GMFCS).
Level 2	$140 - $150	The delivery of therapy for multiple physical conditions where treatment of one condition does not affect symptoms from another condition e.g. occupational therapy for a child with a middle level of severity on the GMFCS that results in multiple physical conditions; can also include treatment of a single physical condition if a participant also has mild-moderate behaviours of concern.
Level 3	$180 - $190	The delivery of therapy to participants with extreme presentations, e.g. occupational therapy for a child with cerebral palsy that has a high level of severity on the GMFCS, that results in physical conditions such as convulsions or spasms or swallowing difficulty such as dysphagia; can also include a combination of physical disabilities and severe behaviours of concern.

TABLE 6: RECOMMENDED PRICES FOR PSYCHOLOGICAL THERAPY SUPPORTS

Level of support	Proposed price ($/hr)	Description
Level 1	$160 - $170	The delivery of therapy focused on treatment of a psychological disability in a low risk environment. Typically administered by a registered psychologist.
Level 2	$210 - $220	The delivery of therapy focused on the treatment of a complex psychological disability where a very skilled and experienced clinical professional is necessary. Often necessary where a participant poses a high risk to themselves or others due to their disability. Typically administered by a clinical psychologist.

For each level of care in physical therapy and psychological therapy, the NDIA will need to define the characteristics of the type of therapy support a participant should expect to receive, and a provider should expect to deliver. The NDIA should work with therapy providers and the broader therapy market to develop these characteristics.

Implications

Providers of Level 1 and 2 therapy will have price caps lower than the current NDIA price cap. Providers of Level 3 therapy will be able to charge prices higher than the existing price cap for participants that require a high level of support due to their disability. When using the increased prices, providers will need to justify that the higher level of service is necessary to serve a participant. The NDIA will need to reflect the changes to therapy prices in the packages developed for participants. These changes should consider a participant's physical and psychological conditions, and reflect their likelihood to need a higher proportion of one level of therapy compared to another.

4.6.4.2 Differentiated pricing for therapy supports delivered by a therapy assistant

Issues and evidence

The current Price Guide describes therapy assistants as *'Program to empower participants & improve interactions between participants & their social networks. Assistance to engage effectively in the community through a group approach to help achieve goals, gain insight into their lives & make informed decisions*' and prices these supports at $41.71/hr[68]. Consultation with providers suggests that this description does not accurately reflect the role of therapy assistants, and that the price for a therapy assistant should be at least the same as the price of attendant care because therapy assistants, at a minimum, require the same level of skill as a standard level support worker. They believe the price of a therapy assistant should reflect the cost of a higher skilled support worker due to the increased difficulty of the support being delivered.

Providers believe they can utilise therapy assistant in two ways. The first is to have a therapy assistant to help deliver therapy supports, for example to help deliver hydrotherapy by

[68] NDIA: 2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017), p. 61

supporting a participant to stand in the water, while a physical therapist instructs a consultation. The second is in situations where a consultation could be delivered independently and in full by a therapy assistant with adequate qualifications (such as an exercise scientist). This might occur in the case of a physical therapy consultation where a treatment schedule has been developed by a physiotherapist with input from an exercise scientist, but can be delivered independently by the exercise scientist. The Price Guide does not currently allow for these two types of roles, and as a result there are examples of providers serving participants with physiotherapists at $175.57/hr[69] when an exercise scientist could be delivering the consultation at a much lower rate.

Recommendations

18: The NDIA should amend the description for therapy assistants and introduce two tiers of prices for therapy assistants – one that is comparable to the attendant care price, and a second that is for the delivery of therapy supports by a professional with a lower level of skill than a qualified therapist.

A Level 1 therapy assistant could support the delivery of therapy services and be priced in the range of $44.72-$49.20/hr. The activities performed by this type of therapy assistant is comparable to those performed by a disability support worker, but with a focus on capacity building. The relevant benchmark is therefore the attendant care price, and this is consistent with the price set by other similar schemes such as the Transport Accident Commission (TAC). The low end of the price range reflects the current price of attendant care, and the high of the range reflects the price proposed for a highly skilled support worker delivering care to a participant with very complex needs. This is the current price of attendant care plus an additional 10% price loading, and should be the absolute upper bound of the price of a Level 1 therapy assistant. This price is aligned with external benchmarks for a Level 1 therapy assistant. The TAC prices Allied Health Assistants at $37.04/hr and prices therapy supports for Independently Reviewed against Quality Standards (IRQS) Providers at $46.73/hr.

A Level 2 therapy assistant should deliver therapy supports where a qualified therapist has developed a treatment plan with input from an exercise scientist, and a consultation can be delivered by a qualified professional that is not a qualified therapist. This could be an employee with a qualification in exercise science or human movement that has the skill and knowledge to deliver a treatment plan they have helped develop at a high level of quality. The price of a Level 2 therapy assistant should be above the price of a Level 1 therapy assistant ($44.72-$49.20/hr) and below the proposed price of Level 1 physical therapy ($110-$120/hr). The market for the delivery of some therapy supports by professionals such as exercise scientists is new and growing, therefore data on pricing is limited. Discussions with some therapy providers and an observation of a small sample of private market rates suggest the price of a Level 2 therapy assistant should be between $70-90/hr, however the NDIA should conduct further analyses to refine and validate the price, and verify the relevant benchmark.

[69] NDIA: 2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017), p. 61

Implications

Increasing the price of a standard therapy assistant to be comparable to the price of attendant care will allow providers to recover the costs of employing workers with the same level of skill as a support worker. Introducing a second tier to the therapy assistant price could allow participants to receive some therapy supports at a lower price when the support is not required to be delivered by a qualified therapist, and can be delivered with a high level of quality by a professional with a lower skill level. This could represent value for money for some participants, as they could utilise Level 2 therapy assistants where they were previously seeing a qualified therapist, and redirect the funds they save to other supports.

4.6.4.3 Travel policy for therapy supports

Issues and evidence

Many providers believe the $1000 travel cap for therapy supports and the approach defined by the NDIA to calculate travel costs are appropriate for participants that are located close to a therapist or do not require frequent support. However, when a participant requires a provider to travel a reasonable distance on a frequent basis, the therapy travel policies can make it difficult for some providers to profitably serve participants, even in a metropolitan area.

For attendant care supports, there is no monetary cap on the amount a provider can charge a participant for travel. It is a different case for therapy as a $1000 per annum cap exists, and in situations where a moderate amount of travel is required, the therapy travel cap can run out quickly, as it equates to less than 6 hours of travel that a provider can charge over a year at the current therapy price cap of $175.57/hr[70].

Separating therapy support funding from therapy travel has positive and negative consequences. Placing a limit on the amount a therapist can charge for travel incentivises participants to receive supports from providers where less travel is needed to reach them. However, there are examples of providers ceasing to serve participants that have funds remaining in their plans for therapy supports, because they have exhausted the $1000 allowance that providers can charge for travel.

The policy providers are required to follow to charge for travel is also making it difficult for providers, as the calculation does not allow providers to charge for the first 10km of travel. Beyond 10km providers can charge up to the hourly rate of therapy supports based on the distance travelled, with the assumption being that the average speed of travel is always 60km/hr. For core supports such as attendant care, providers can charge the first 20 minutes of travel between participants (excluding travel to the first participant).

An effective travel policy should encourage participants to find services that require less travel where adequate supply is available, and discourage providers from serving participants where more travel is required if there are closer options available. The policy should also acknowledge that there are situations where travel is necessary, and allow providers to be

[70] NDIA: 2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017), p. 61

remunerated for a reasonable amount of travel. However, the policy should only apply where the participant cannot travel to the provider.

Recommendations

19: The NDIA should align the travel policy for therapy supports to the travel policy for attendant care by removing the $1000 travel cap, allowing providers to charge up to 20 minutes at the hourly rate when travelling between participants.

The travel policy for therapy should be consistent with the travel policy for attendant care, where there is no travel cap or separate travel allowance, and a provider can charge the first 20 minutes of travel between participants. The policy should also follow the approach suggested in Section 4.2.2, where providers serving participants located in rural areas (MM 4 and MM 5) can charge up to 45 minutes at the hourly rate when travelling between participants.

Implications

The NDIA will need to communicate with participants receiving therapy supports in-home that they will no longer have a separate budget for provider travel, and that a provider will be able to charge travel against their combined therapy budget with no maximum set by the NDIA. Participants will need to take this into consideration when they select a provider. If the preference of the participant is to receive supports from a therapist located far from their home they may receive less supports, as the provider will be able to charge up to 20 minutes in a metro area (45 minutes in rural areas) each time they travel to the participant.

The NDIA will need to communicate with providers that there are limitations on the amount of travel time they can be reimbursed for each time they visit a participant. If a provider chooses to serve a participant located outside of the area they can service based on the time caps set for metro and rural areas, they will not be reimbursed for the incremental travel time.

4.6.4.4 Cancellation policy for therapy supports

Issues and evidence

The therapy cancellation policy limits the number of hours a provider can charge to a maximum of 2 cancelled hours per year, compared to a maximum of 8 booking cancellations per year for core support items including Assistance with self-care activities and Assistance to access community, social/recreational activities. Providers believe 2 hours is insufficient as many participants cancel more than 2 hours of services per year. For example, participants with health-related needs may cancel due to hospitalisation due to their condition, and participants with behaviours of concern may cancel due to sudden escalations of behaviour. Currently providers are often required to absorb the cost of cancellations over 2 hours, even where they are short-notice, as it is typically very difficult to substitute in another patient on short notice, especially when services are delivered in-home.

Recommendations

20: The cancellation policy for therapy should be amended so that up to a certain threshold, providers can charge against a participant's plan for up to 90% of the scheduled service if the participant makes a short notice cancellation. A cancellation line item should be created as a governance mechanism for the NDIA.

The cancellation policy for therapy should follow the same approach as that suggested for attendant care (see Section 4.6.3.2). A short notice cancellation should be defined as occurring where a participant provides notice of cancellation after 3pm the day before the scheduled service. A cancellation line item should be introduced in the Price Guide to enable the NDIA to monitor the volume of cancellation by providers, which will help build an understanding of participant cohorts with higher risks of cancellations, and help detect anomalies in the volume of cancellations. Providers should not charge a cancellation where they have been able to substitute another customer.

The NDIA also should introduce a policy that above a specific threshold, providers will not be able to charge for cancellations unless they submit a report to the NDIA outlining the circumstances of each above-threshold cancellation, and actions taken to work with participants to minimise the risk of their cancellations.

Implications

As discussed in Section 4.6.3.2 the proposed policy minimises the financial loss incurred by providers on short-notice cancellations and recognises that while providers should work with participants to minimise short notice cancellations, providers should also not bear the financial risk for this occurring.

4.6.4.5 NDIA-required reports for therapy supports

Issues and evidence

Some providers indicated they were confused about whether they could be reimbursed for the time they spend developing reports for participants. The NDIA has set the expectation that providers are required to develop progress reports for participants, the Price Guide states *'Therapists will be expected to provide progress reports to the participant and NDIS at agreed times'.*[71] Currently there are some therapy providers that believe they can be reimbursed for report writing, and charge the time against a participant's package. However, there are other providers that do not believe it is possible to charge a participant for report writing, and they are absorbing the cost of the time to develop a report.

There are two types of reports therapists typically write: end-of-session notes and progress reports. Therapists write end-of-session notes to capture what has taken place during an individual consultation. This is a standard activity and should be considered as being included in the hourly rate for the support. Therapists write progress reports upon request, often by a third party, where information is sought to understand how a participant's condition is

[71] NDIA: 2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017), p51

improving due to their therapy. This is not considered a standard activity and therefore should be reimbursed separately.

Comparable schemes such as SIRA, TAC, and Worksafe each reimburse providers for reports, and have discrete line items in their fee schedules for reports requested by the insurers. SIRA has a single line item for report writing, and TAC and Worksafe have multiple line items for the development of the initial treatment plan, and also for treatment reviews. For each of the schemes, they will only allow a provider to charge for the reports if they have been specifically requested by an agent within insurer.

To provide therapy supports in the NDIS there are two types of reports that a provider must deliver to help the NDIA track a participant's progress: 1) at the commencement of supports, the NDIA requires a report to be submitted including the assessment of a participant, their goals, and the care plan developed to achieve those goals; and 2) as a participant progresses through their care plan, the NDIA requires a therapist to submit one or more reports per year to the NDIS to communicate the progress a participant has made against their goals, including evidence of specific areas of improvement and outcomes that have been achieved. The progress reports also include recommendations from a therapist on what they believe a participant's new or revised goals should be based on their progress at the time, and a proposal for a new or revised care plan to support a participant to achieve those goals.

Recommendations

21: The NDIA should allow providers to charge participants for the time spent writing reports that are requested by the NDIA. A new line item should be introduced for tracking purposes.

The time that a therapist can charge does not include time spent at the end of a consultation writing notes, which is factored into the rate paid for the consultation. However, for additional reports mandated by the NDIA, providers should be allowed to charge for time spent developing these reports at the same rate as a regular consultation, as they are an essential part of the service being delivered to a participant. This should be communicated to the market to ensure there is consistent application across all therapy providers.

Implications

The impact on participants of allowing therapists to be reimbursed for the development of NDIA-required progress reports is expected to be small, as it should occur no more than once or twice a year. Adding a separate line item in the Price Guide for NDIA-required reports will allow the NDIA to track therapists that are charging participants for report writing, to make sure it is only occurring when they have requested a report to be written by a therapist.

4.7 PRICE DEREGULATION

The deregulation of NDIS prices offers some compelling advantages for providers and participants operating in a mature market. The effect of current NDIS price controls is that nearly all transactions take place at the specified price cap. Forcing the market to a single regulated price introduces the risk that the market will be undersupplied (if the price is too low), or that participants will not be able to achieve value for money (if the price is too high). In

a market like disability services, regulated prices also restrict the ability of providers to offer a range of different service types and thereby limit participants' ability to choose the best mix of quality and price that suits their needs for any service. Deregulation also has the benefit of reducing bureaucracy, making it easier for participants and providers to interact with the NDIS. However, price deregulation comes with risks if implemented in an underdeveloped market. In particular, it may result in providers charging higher prices and participants receiving less value for money.

To navigate this choice, the NDIA should collect more information to understand the likely impact of deregulation of prices, prepare participants and providers for deregulation, and undertake trial(s) before deregulating prices across large portions of the market.

This section covers the following topics:

- 4.7.1 Developing more information and insights on self-managed participants
- 4.7.2 Assessing and advancing participant and provider readiness for de-regulation
- 4.7.3 Conducting a deregulation trial

4.7.1 Developing more information and insights on self-managed participants

Issues and evidence

There is currently limited information to understand how the NDIS would operate if prices were deregulated. One source of possible insight is the experience of self-managed participants, who operate in a commercial environment that is broadly comparable to a deregulated market. These participants are allocated a budgeted plan through the same process as all other participants. However, the providers they choose and manage are not bound by the NDIA's price caps in providing support services to them[72]. This is therefore somewhat comparable to the experience of participants in a deregulated market.

According to the latest NDIA data, 18% of Scheme participants have at least partially self-managed plans[73]. Anecdotal evidence from participants who self-manage their supports suggests there are many benefits of self-managing, including much greater flexibility in how funds are used across support categories. However, further analysis is required to understand whether this experience is likely to be replicated across the Scheme as a result of broader price deregulation.

There is currently only partial data available on the experience of self-managed participants. Through auditing processes, the NDIA has the potential to gather data on how self-managed participants allocate funds within their budgeted plans. The NDIA also collects participant outcomes data which can be used to track the performance of self-managed participants against those of Agency-managed or plan-managed participants.

[72] Note: providers serving both self-managed and NDIA-managed participants typically charge both groups of participants at the price cap. Therefore, only a small part of the self-managed market is effectively operating as per a deregulated market.

[73] Source: Scheme Actuary

Recommendations

22: The NDIA should collect and analyse information on the experience of self-managed participants to help inform its assessment of price deregulation.

A better understanding of the outcomes of self-managed participants can help the NDIA understand the opportunities and challenges of potential price deregulation.

The NDIA should collect information on:

- The pricing of support services provided to self-managed participants, including prices relative to the rest of the Scheme, the distribution of prices within the market for self-managed participants, and the responsiveness of prices to competitive pressure.
- Outcomes for self-managed participants.
- The supply response to price changes for supports catering to self-managed participants.

This information can be gathered through existing sources, as well as through new initiatives. Data on outcomes of self-managed participants can be gathered by categorising responses to the Short-form Outcomes Framework survey. Comparing self-managed participants with Agency-managed participants may be affected by some sampling bias, as self-managed participants are likely to have better support structures around them, which could lead to better outcomes. Therefore, it will be more useful for the NDIA to compare changes within cohorts over time, rather than across cohorts.

Some general scheme data, such as utilisation rates, are also already being collected by the NDIA and could be monitored by the participant's type of support management. The NDIA is planning to collect more thorough data on which supports are being accessed by self-managed participants, and for what prices, as part of its assurance process for self-managed participants.

Implications

The NDIA will need to collate the information it has on self-managed participants from the Scheme Actuary, the Provider, Market and Sector Development team, and its quality and safeguards assurance processes.

The NDIA will also need to expand its data collection and analysis efforts in some instances, including amending the Short-form Outcomes Framework survey or other participant consultation as necessary. The NDIA should also include queries specific to self-managed participants in its regular consultation with providers, including through LACs, its annual request for submissions into the pricing process, and ad hoc consultations throughout each year.

4.7.2 Assessing and advancing participant and provider readiness

Issues and evidence

Deregulated markets will allow providers and participants to transact freely without being bound by price caps. The NDIS marketplace is yet to be guided by a clear set of pre-conditions which would need to be satisfied for such transactions to function effectively. Price

controls cannot be relinquished until the NDIA is satisfied that such pre-conditions have been articulated and satisfied.

A broad review of provider and participant capacity makes clear that it remains too early for the Scheme to pursue price deregulation across markets at this point in time. Most providers and participants have spent under a year in the Scheme, and the Scheme continues to grow rapidly from quarter to quarter. As such, there is little stable evidence to evaluate the performance and capabilities of participants and providers in the Scheme. Even in existing competitive and well-supplied markets like those for some forms of therapy, it is important to observe participant and provider behaviour over a longer timeframe.

The NDIA supports the capability development of participants and providers through various initiatives. This ranges from core elements of the NDIS such as LACs, through to the release of market information such as the Market Position Statements. Others, such as support coordinators or online marketplaces, also work to expand the capacity of participants and providers to locate and compare with each other.

Recommendations

23: The NDIA should collect information on and assess the readiness of participants and providers for price deregulation.

The NDIA can test the readiness of the market for price deregulation by considering the commercial and other characteristics required to operate in a deregulated market. Before deregulating a market, the following conditions should be met:

- Participants must first have a thorough awareness of their supports and prices in their market.
- Participants must have the ability to exercise choice and control by switching between providers as required. The development of the e-market would support this by giving participants greater information about alternative providers and greater transparency on the range of prices charged in the market.
- Providers must have the commercial capacity to make efficient pricing decisions.
- Providers must have the ability to provide sufficient supply to drive competition and moderate price fluctuations.

The required information can be collected through participant and provider consultation, analysis of existing market and NDIA data, and by collating NDIA experience from its network of LACs and regional offices. This assessment of the readiness of markets for deregulation should consider specific markets and not just the Scheme in aggregate. Different markets within the Scheme – be they geographic regions or various support types – will be ready for deregulation at different times. Deregulation should, therefore, not be considered as a single event to be rolled out across the Scheme, but rather as a process to be introduced to markets as they become sufficiently mature.

24: The NDIA should provide more comprehensive market data to support the development of provider and participant capacity.

The NDIA should make available more detailed market information on participants' demand for services, and the available supply of support services. In addition to market overviews

presented in its Market Position Statements, the NDIA can provide further evidence of what support services participants are demanding and accessing in each market – defined by support type and geographic region – and the state of supply in those markets. This could take the form of more detailed Market Position Statements, the Provider Finder, or e-markets (see Section 4.5). Market information can also be disseminated through the NDIA's existing LACs and regional office network, as well as through support coordinators. Information on where participants are located, their patterns of demand, and the current state of service provision in a given market are very relevant to providers making pricing or supply decisions. Ensuring that such market data is available will likely lead to increased competition in the market, and improve the readiness for price deregulation.

Implications

Ensuring timely access to detailed market data will promote participant outcomes in the short term. It will also support market development in the medium to long term, with the potential to accelerate readiness for price deregulation across markets.

4.7.3 Conducting a deregulation trial

Issues and evidence

It is essential that price deregulation begins with a trial, given the limited information currently available on how the disability support services market in Australia would operate in a deregulated pricing environment, as well as the lack of directly comparable markets elsewhere.

A trial will allow the NDIA to collect more detailed information on the impact of deregulation. This information can help the NDIA confirm its assessment of the readiness of markets for deregulation, and help refine the design choices to be made in implementing deregulation. A deregulation trial would involve the removal of price caps in a specified market, defined by support type or region.

Recommendations

25: The NDIA should pursue a trial of price deregulation in one market, once the preconditions for deregulation have been satisfied.

The market chosen for deregulation should have well-equipped participants and providers as identified in Section 4.7.2, as well as meet three additional criteria:

- The chosen market should have been active in the Scheme for at least 2 years. This will allow the NDIA to assess whether the information collected about that market reflects a stable state.
- The chosen market should be clearly defined and demarcated from the remainder of the Scheme. For geographies, this would mean that the defined area is aligned to other boundary definitions affecting how businesses operate (e.g. state borders, remoteness thresholds).
- The market should be one in which the NDIA is satisfied that it has monitoring capacity and a good understanding of Scheme and market performance to date.

Some therapy supports and well-defined geographical areas such as the ACT have been identified to the IPR team by providers and other Scheme stakeholders as potential candidates for deregulation. These do not yet appear to be ready for deregulation as the Scheme is still in its early stages and there is insufficient evidence that providers and participants have the capacity to navigate a deregulated market. The NDIA should monitor the progress of these and other markets against the above criteria to identify a suitable market for a deregulation trial.

The NDIA could consider transitioning toward the trial by replacing prescriptive price caps with suggested price ranges as a way of testing market capacity for price competition. To do this, a price guide for that market would identify two prices for a given support item, a lower price which is nominated as the suggested efficient price, and a higher price which acts as the price cap. Even though the current price is only a price cap for most support services, the great majority of providers charge at this price point, and there is no way to indicate an efficient price using a single price cap.

The introduction of deregulated pricing in a chosen trial market should be accompanied by enhanced safeguards and monitoring in that area. The NDIA should be able to identify risks of supply shortages or where providers are charging well above their cost to serve to the detriment of participants' ability to secure plan outcomes.

Implications

Designing and delivering a deregulation trial will require an investment of resources from the NDIA in the medium term. However, a well delivered deregulation trial will provide a lower risk way to test the proposed preconditions for deregulation of prices and ultimately, promote a more innovative and sustainable Scheme.

Appendix A: Differences in cost drivers between attendant care providers

Summary of key differences in cost drivers between attendant care providers

The following table summarises some differences in cost drivers between providers, and explains the significant variation in cost to serve between different attendant care providers.

TABLE 7:

Issue	Provider feedback
Labour costs	■ Some providers found it difficult to manage labour costs under the current price. This was particularly true for providers who had a mix of complex and standard intensity clients, and therefore had more qualified or mature workforces. For instance, for some providers, the average worker had a Cert IV qualification and was paid at SCHADS 2.3. By contrast providers who focus on participants at the lowest end of the complexity spectrum submitted it was neither necessary nor proportionate to pay a highly qualified worker to deliver attendant care; rather it was the support worker's mindset that was important. ■ Under the SCHADS Award, employers pay casual workers a 25% loading on the base salary of an FTE. The more expensive base wage of and fixed cost of onboarding and training a casual worker is offset by a various factors: first, casual workers have lower on-costs as they are not entitled to annual or sick leave; second, it is easier to manage the utilisation rates of casual workers; finally, anecdotal evidence suggests employers with heavily casualised workforces tend to pay lower base salaries. Depending on the difference in utilisation and base salary paid to casual workers vis a vis FTEs, casual workers can be either more or less expensive to hire.
Workforce utilisation	■ Factors that make workforce utilisation difficult to manage include: unchargeable time spent travelling to clients, particularly in regional and remote areas; the frequency of cancellations in the sector; and, the time required for care co-ordination (e.g. team meetings, debriefing) and reporting, particularly for behaviourally and medically complex participants. Utilisation is particularly challenging to manage in areas of lower population density and for providers with less casualised workforces. ■ Utilisation was significantly easier to manage for providers with highly casualised workforces, as staff are only rostered when there is known demand. However, because casual workers are paid a 25% loading under the SCHADs award (which is only partially offset by the lower on-costs associated with casual workers), whether a casual worker is more expensive to employ than a permanent employee depends on how well an employer can utilise its casual workers relative to its permanent workforce.
Supervision structures	■ Some providers had heavy supervision structures, reflecting the complex participants in their client mix. For instance, some providers have 2 layers of supervision consisting of a supervisor and a team leader. Providers who only serviced lower complexity participants with strong informal supports had minimal supervision in their operating models, rather relying on instant customer feedback to detect potential risks to service quality.
Corporate overheads	■ This was a key differentiating cost driver between providers. Traditional providers that had achieved relatively efficient overheads had typically invested in IT and had achieved a degree of scale. Online platform providers also leveraged

Issue	Provider feedback
	technology to minimise overhead costs, while sole traders incurred very low overhead costs.
Other issues	■ *Training:* While there are currently no legislative requirements for disability support workers to undergo specific trainings, some providers, particularly those with complex participants in their client mix, require their staff to complete a mandatory training as a matter of internal policy.[74]

74 Some of these trainings include: First Aid, Manual Handling, Corporate Induction, Medication and infection control; CPR; Epilepsy; Diabetes; Bowel care; Oxygen Training; Management of PEG feeding.

Appendix B: Summary of IPR recommendations

Below is a summary of the IPR team's recommendations, as well as an assessment of the potential impact of these recommendations on the NDIA's three aspirations. Cost estimates have been made on the best information available. Where information is incomplete due to immaturity of the Scheme, the IPR has made a number of assumptions, which has led to wide ranges in estimates. In the aggregate, the IPR team estimates that the recommendations made in this report will have a potential financial impact of ~$250-420m per annum over the next 12 to 24 months, but will alleviate some of the financial pressure currently placed on some providers, and will improve participant outcomes by addressing challenges that are impacting some providers' abilities to deliver quality services.

Beyond the next 24 months, the IPR team believe it is possible to implement the IPR recommendations and manage the Scheme so that it is financially sustainable and within the current budget estimates. Approximately 50% of the total cost implication of the IPR recommendations is temporary and will therefore not have an adverse impact on the Scheme's longer-term financial sustainability. Also, as the Scheme matures, the NDIA should be able to offset any financial impact of these recommendations by appropriately assessing their effectiveness and efficiency. For example, as evidence develops as to which interventions are most effective in reducing costs associated with complexity, it should be possible to reduce the number of complex participants and provider costs and prices. It should also be possible to encourage more local providers in rural and remote areas that will assist in reducing travel costs. There should also be some savings from introducing tiered therapy pricing.

EXHIBIT 9

Summary of recommendations (1/3)

Positive impact | Neutral/No impact
Potential minor negative impact | Potential significant negative impact
E.g. <$50m for Scheme sustainability | E.g. >$50m for Scheme sustainability
Short term = < 1 year | Medium term = 1-2 years | Long term = 3+ years
($Xm) = Value used by IPR team to calculate the total financial impact of recommendations if different from range provided by the Scheme Actuary

	Recommendation	Direct impact on NDIA aspirations: Participant outcomes	Direct impact on NDIA aspirations: Market development	Direct impact on NDIA aspirations: Scheme sustainability	Implications: Implementation timeframe
Price-setting process	1 Include a broader set of indicators of participant outcomes and market development in its price setting process, and clarify the methodology for making price setting decisions.				Short-term
	2 Continue to use an hourly rate approach, but trial outcomes-based pricing.				Medium-term
National vs regional pricing	3 In very remote/isolated areas, work with other community services and providers to support local workforce development to deliver services in the most efficient way possible. In regions with limited local supply, allow providers to quote on cost of delivering NDIS services in the short term to ensure supply.				Medium-term
	4 Clearly define rural areas and lift the travel allowance from 20 mins to 45 mins for providers serving a participant located in MM5 (or ARIA equivalent) and MM4 in the short term. Adjust plans to account for travel and track as a separate line item.			$26-75m[1]	Short-term
	5 Converge the two Price Guides and move toward a single national price guide by 2021.				Long-term
Comp-lexity	6 Develop a definition for complexity linked to the skills required to meet participant's needs, and use specialised planning resources to classify what skills are required, and which participants require higher skilled support workers.				Medium-term
	7 Add an additional tier to the high intensity loading to allow a provider to recover the cost of a support worker with a higher level of skill than can be procured with the current high intensity loading.			$100m – $140m[2]	Medium-term (require definition first)
	8 Develop a consistent process for participants with extreme behaviours of concern that acknowledges the specialised needs of the participant cohort, and the environment providers operate in. Providers serving this cohort should quote on the delivery of services to these participants, and also be allowed to deliver them all of the services they require to be adequately supported (i.e. all Support Coordination items).				Short-term
	9 Update the pricing structure for the core support item 'Group based activities in a centre' to allow providers to charge a high intensity loading where a more skilled worker is required to serve a participant, and set prices consistent with the care ratio required to serve a participant.				Short-term

1 $26m assumes 25% of participants in ARIA-outer regional get the additional loading and the impact of the loading is only 10% (i.e. 45 mins hr travel for every 6.75 hrs of care). $75m assumes 25% of participants in MM4 and MM5 receive a loading and the impact of the loading is 20%. If all participants in MM4 and MM5 received the additional loading (and impact was 20%), this would equate to a cost of $296m. The IPR does not believe this to be a likely scenario.
2 Based on 12% of participants qualifying for the complex level (a 6% loading) and 10% of participants qualifying for the very complex level (a 10% loading), with a margin of error of +/- $20m to account for uncertainty in data, and assuming all participant plans are adjusted to compensate for the change in policy

EXHIBIT 10

Summary of recommendations (2/3)

Positive impact | Neutral/No impact
Potential minor negative impact | Potential significant negative impact
E.g. <$50m for Scheme sustainability | E.g. >$50m for Scheme sustainability
Short term = < 1 year | Medium term = 1-2 years | Long term = 3+ years
($Xm) = Value used by IPR team to calculate the total financial impact of recommendations if different from range provided by the Scheme Actuary

	Recommendation	Direct impact on NDIA aspirations: Participant outcomes	Direct impact on NDIA aspirations: Market development	Direct impact on NDIA aspirations: Scheme sustainability	Implications: Implementation timeframe
STA	10 Continue to refine the assumptions for high intensity rates, active overnight, and capital allowances used to develop the new STA price schedule, to ensure they reflect the cost of service delivery				Short-term
Thin markets	11 Adopt a clear set of metrics to more comprehensively identify and respond to risks of thin markets emerging.				Short-term
	12 Invest in Scheme infrastructure such as an e-market tool, which would empower participants in thin or undersupplied markets to find suitable providers.				Medium-term
Relative provider efficiencies and ade-quacy of provider returns	13 Prioritise the implementation of measures to continue to improve the NDIA's portal, responsiveness and communication as part of the Participant and Provider Pathway Reviews.				Long-term
	14 Implement 'temporary support for overheads' (TSO) in the form of a temporary increase to the price cap for standard intensity attendant care. Government should offer business planning support for large providers that would otherwise exit and create the risk of supply shortages.			$130-190m[1]	Short-term
	15 Amend the cancellation policy so that up to a certain threshold, providers can charge against a participant's plan for up to 90% of the entire duration of the scheduled service if the participant makes a short notice cancellation. Above this threshold, providers will need to demonstrate they are actively working with participants to minimise the risk of cancellations in order to continue charging for cancellations.				Short-term
	16 Implement a new pricing schedule for group care (both community based and centre based) that allows providers to recover additional costs incurred for groups, while still retaining the incentives and efficiencies of group based care. Also assess whether a capital allowance should be provided for centre based care based on whether there is demand to increase the number of centres.				Short-term
	17 Develop differentiated price levels for physical therapy and psychological therapy based on price levels being paid in comparable schemes.				Short-term
	18 Amend the description for therapy assistants and introduce two tiers of prices for therapy assistants – one that is comparable to the attendant care price, and a second that is for the delivery of therapy supports by a professional with a lower level of skill than a qualified therapist.				Short-term

1 $130m assumes 2% TSO for the 12 months in FY18/19, $190m assumes 3% TSO for the 12 months in FY18/19. Assumes TSO is applied to attendant care supports only (excludes SIL).

EXHIBIT 11

Summary of recommendations (3/3)

Positive impact
Neutral/No impact
Potential minor negative impact
Potential significant negative impact
E.g. <$50m for Scheme sustainability
E.g. >$50m for Scheme sustainability
Short term = < 1 year
Medium term = 1-2 years
Long term = 3+ years
($Xm) = Value used by IPR team to calculate the total financial impact of recommendations if different from range provided by the Scheme Actuary

	Recommendation	Direct impact on NDIA aspirations			Implications
		Participant outcomes	Market development	Scheme sustainability	Implementation timeframe
Relative provider efficien-cies and ade-quacy of provider returns	19 Align the travel policy for therapy supports to the travel policy for attendant care by removing the $1000 travel cap, and allowing providers to charge up to 20 minutes at the hourly rate when travelling between participants.				Short-term
	20 Amend the cancellation policy for therapy so that up to a certain threshold, providers can charge against a participant's plan for up to 90% of the scheduled service if the participant makes a short notice cancellation. Create a cancellation line item as a governance mechanism for the NDIA				Short-term
	21 Allow providers to charge participants for the time spent writing reports that are requested by the NDIA. Introduce a new line item for tracking purposes.				Short-term
Price deregula-tion	22 Collect and analyse information on the experience of self-managed participants to help inform NDIA's assessment of deregulation.				Medium-term
	23 Collect information on and assess the readiness of all participants and providers for deregulation.				Medium-term
	24 Provide more comprehensive market data to support the development of provider and participant capacity				Medium-term
	25 Pursue a trial of price deregulation in one market, once the preconditions for deregulation have been satisfied				Medium-term

Appendix C: Variation in attendant care cost drivers across jurisdictions

EXHIBIT 12

SCHADS awards are broadly comparable across states and territories

STATE	Relevant Award (adjusted to 2016/17 per Equal Remuneration Order)	Hourly pay rate of full or part time worker at Level 2.3	Hourly pay rate of full or part time worker at Level 3.2
NSW	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services Employee (State) Award [AN120505] (NSW)	$25.52 (Grade 1) $25.97 (Grade 2)	$28.21
ACT	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Social and Community Services (ACT) Award 2001 [AP808334]	$25.52	$27.68
Victoria	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services – Victoria – Award 2000 [AP796561]	$25.52 (Youth or welfare worker) – $26.11 (Community development worker)	$27.35 (Youth or welfare worker) $27.59 (Social worker)
South Australia	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services Award [AN150140] (SA)	$25.71	$27.68
Western Australia	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services – Western Australia Award 2002 [AP815319]	$25.52	$27.35 – $27.68 (Depending on experience)
NT	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services Industry – Community Services Workers – Northern Territory Award 2002 [AP817216]	$25.75	$27.76
Queensland	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services (Queensland) Award 2001 [AP808848]	$25.52	$27.35

Source: Social, Community, Home Care and Disability Services Industry Award 2010, accessed in November 2017.

Labour costs make up 80% of the costs of attendant care services (which account for approximately 75% of NDIS expenditure)[75]. There is currently some variation in labour costs between states, but they are not correlated to the differences in prices between the Eastern Price Guide and Western Price Guide. For example, New South Wales and Victoria are covered by the same Price Guide but include Award provisions for Level 2.3 workers with slightly different pay rates. Similarly, the ACT and Western Australia have the same Award rate for Level 2.3 workers despite being covered by different Price Guides.

Analysis of other labour costs such as payroll tax, leave entitlements and workers compensation requirements does not show a consistent difference between the eastern states versus the western states. For example, the payroll tax rate in South Australia and Victoria (which are administered by different price guides) is similar at just under 5% annual rate and annual threshold of approximately $600,000. Meanwhile, the ACT and Western Australia are

administered by the same guide but the former has a payroll tax rate 1.35 percentage points higher and an annual threshold $1.15 million higher. Similarly, the qualifying period for long service leave is 15 years in Victoria and WA (again, there are different price guides), while it is 10 years in NSW which is regulated by the same price guide as Victoria. Finally, workers compensation premiums are higher in the ACT and Tasmania, while Western Australia has much lower premiums than South Australia. Non-labour components of cost such as utilities, rent, and cost of goods vary within states as much as they do vary between states.

Appendix D: Existing definitions of participant complexity within the NDIA

The NDIA currently uses three discrete approaches to categorise participants with complex needs through the pre-planning, planning, and plan implementation phases of the participant pathway. There is no relationship between any of the three approaches, and they are used in isolation. This means specific characteristics relating to a participant's level of need that surface during pre-planning or planning phases are not always used to inform whether they receive a high intensity loading during plan implementation.

During the pre-planning phase participants are segmented based on 'streaming factors' that are designed around workflow, to help the NDIA understand the amount of time required to keep a participant engaged in the participant pathway. These factors include behaviours of concern, involvement in multiple service systems (e.g. the justice system or Child Protection), and the level of informal supports. Participants are streamed into four categories – General, Supported, Intensive, and Super Intensive, with the greater the intensity the more time/effort required to be spent on participant.

As participants progress to the planning phase, they are assessed using a Disability Severity Indicator, which measures of the impact of the disability on the participant's day-to-day life, to determine their level of functional impairment. The level of functional impairment, together with to the participant's age and location, are used to determine the level of funding a participant receives. Participants are allocated a rating between 1-15 describing their level of functional impairment, as follows: 1-5 Low level of disability-high functional capacity; 6-10 Medium functional capacity; (11-15) High level of disability-low functional capacity.

Once a participant receives a plan and selects the providers to deliver their services, providers assess the participant based on a range of additional factors, such as disability type, budget, personal/family situation, to determine if they should be charged at a standard intensity rate or a high intensity rate. The Price Guide notes that a provider can charge a high intensity rate where a participant requires assistance from a support worker with additional qualifications or experience relevant to the participant's complex needs. High intensity rates can be considered when assistance is required to manage challenging behaviours, or when active support is required due to high medical support needs, such as unstable seizure activity or respiratory support.

Appendix E: Opportunities for attendant care providers to innovate

The IPR team has identified three broad areas where traditional providers of attendant care can innovate and drive efficiency, based on the information it received in provider consultation.

Going forward, the new benchmarking project should provide tailored and strategic information to providers to help them understand how their input costs benchmark against their peers, and where there are specific opportunities to drive efficiency. In the longer term, the aspiration of this benchmarking project is to link data collected on provider input costs, to information about service quality and participant outcomes. This will build a more wholistic picture of how the sector can drive better participant outcomes with greater efficiency.

A. Achieve efficiencies in corporate overheads

The significant variation in provider cost to serve from the sample of cost inputs submitted to the IPR team indicates that, there is significant opportunity for some providers to improve their corporate overhead efficiencies.

Medium to large providers should be investing in technology (for attendance, online booking, automation, rostering) to achieve efficiencies in indirect overheads, while smaller providers should consider using shared services.

B. Optimise staff mix and staff rostering

Workforce planning and support worker utilisation is critical under the NDIS now that providers are only for funded for units of direct client service. Providers are facing a heightened need to maximise the time staff spend performing-chargeable activities. In response, providers should improve their ability to predict demand for services, and use this information to optimise their workforce mix (e.g. full-time, part-time and casual workers) and workforce rostering.

The IPR team notes that predicting and optimising staff mix and staff rostering may be particularly difficult in the current NDIS context for a number of reasons: first, providers may not have the data and capability to analyse historical demand for services; second, even if providers had this data, the transition to full Scheme will means historical demand may not be the best predictor of future demand; finally, in rostering staff, providers of disability staff need to optimise for many variables (including participant needs, participant preferences, staff skill, staff available, staff preference, and staff geography) to ensure it can supply adequate and high quality services.

While these workforce utilisation challenges exist in many other industries, the relatively fragmented nature of disability care means many traditional providers do not have the financial capacity or the scale to justify investing in digital solutions that could assist providers improve workforce.

C. Segment service lines based on participant needs

Many providers currently maintain the same staff pool and supervision structures across all their participants. This is often driven by rostering, which is easier to do if all staff are

capable of serving the most complex participants the provider serves, that is they are trained to the highest common denominator.

Providers should identify participant segments and design customer-centric operating models to ensure staffing and supervision structures are commensurate with the participant segment's needs.

The level of staff qualification, training, experience, and supervision, and therefore the labour costs involved in delivering safe and high quality care varies significantly between participants at different points on the complexity spectrum: At the lowest end of the spectrum, soft skills rather than formal certifications are more important to delivering a high quality service; At the highest end of the spectrum, formal qualifications and experience are needed to deliver supports safely to medically and behaviourally complex participants. This was recognised by the Quality and Safeguarding Framework.

These changes will be easier to implement for smaller providers with defined customer segments and new entrants into the market who focus on specific customer segments. Large providers should also have sufficient scale in a geography to better design service models around different participant segments, although the challenge and time taken for transformation is not underestimated.

Glossary and Abbreviations

TABLE 8:

Abbreviation	Meaning
AMS	Aboriginal Medical Services
ARIA	Accessibility/Remoteness Index of Australia
Assistive Technology	Any device or system using a device that allows individuals to perform tasks that would otherwise be more difficult, unsafe or not possible. It does not include items for treatment, mainstream technology without modifications.
ATSI	Aboriginal and/or Torres Strait Islander
Attendant Care	Refers to all supports which are either assistance with daily living or assistance with social and community participation.
Award	Regulatory instrument which outlines the minimum pay rates and conditions of employment for a particular industry and/or occupation.
Board	The corporate governing board of the National Disability Insurance Agency
CALD	Culturally and linguistically diverse
CEO	Chief Executive Officer of the National Disability Insurance Agency
COAG	Council of Australian Governments
DIDO	Drive-in, drive-out; refers to services provided by non-local workforces who are required to drive to/from a separate town or region.
DVA	Department of Veterans Affairs
DSS, or 'the Department'	The Commonwealth Department of Social Services
Eastern Price Guide	*NDIS Price Guide Victoria, New South Wales, Queensland Tasmania* released by the NDIA, the latest of which is valid from 1 July 2017
EBA	Enterprise Bargaining Agreement
ECEI	Early Childhood Early Intervention [x]
NDIA Aspirations	The three external aspirations of the NDIA as identified in its *Corporate Plan 2016 – 2021*: better participant outcomes, a growing market with innovative supports ('market development'), and a financially sustainable scheme ('Scheme sustainability').
FIFO	Fly-in, fly-out; refers to services provided by non-local workforces who are required to fly to/from a separate town or region.
FTE	Full-time equivalent
Full Scheme	Refers to the fully implemented state of the NDIS, estimated to operate from 2020.
FY	Financial Year
IAC	Independent Advisory Council
ICT	Information and communication technology
IHPA	Independent Hospital Pricing Authority
IPR	Independent Pricing Review
IT	Information Technology

Abbreviation	Meaning
LAC	Local Area Coordinator
Modified Monash Model, including 'MM 4', 'MM 5' etc.	A geographical classification system predominantly used to estimate health workforce needs, based on the population size and proximity of each geographical region.
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NILS	National Institute of Labour Studies
Participant and Pathway Review	A review of the process by which participants are enrolled into and managed within the NDIS, finalised in late 2017.
Price cap or price level	The applicable maximum price that can be charged by a provider registered under the NDIS for a particular support service, as identified in the relevant Price guide.
Price guide	One or all of the Eastern price guide, Western price guide, *NDIS Price Guide Very Remote* or *NDIS Price Guide Remote*
Portal	A secure website that enables registered providers to transact online with the NDIA.
QSC	Quality and Safeguards Commission
Quality and Safeguarding Framework	Refers to the content in the following document – Department of Social Services: *NDIS Quality and Safeguarding Framework* (9 December 2016)
Quoting	A price-setting process by which the supplier of a good or service states the price required to supply a particular support service to be assessed by the purchaser.
SCHADS Award, or SCHADS	*Social, Community, Home Care and Disability Services Award 2010* [MA000100] or its applicable state or territory equivalent
Scheme Actuary	A Board-appointed person whose duties are set out in section 180B of the *National Disability Insurance Scheme Act 2013* (Cth)
SDA	Specialist Disability Accommodation
SDF	Sector Development Fund
SIL	Supported Independent Living
SIRA	NSW State Insurance Regulatory Authority
STA	Short term accommodation
TAC	Transport Accidents Commission
TAP	Transition Assistance Program
TOR	Terms of Reference
TSO	Temporary Support for Overheads
Western Price Guide	*NDIS Price Guide Australian Capital Territory, Northern Territory, South Australia, Western Australia* released by the NDIA, the latest of which is valid from 1 July 2017

National Disability Services

Australian Disability Workforce Report

February 2018

WORKFORCE WIZARD

care careers

Findings from Workforce Wizard and carecareers – the best sources of disability workforce data in Australia

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About this report

This is the second edition of a twice yearly publication. It was prepared by Dr Ian Watson, Freelance Researcher and Caroline Alcorso, NDS. The next edition will be published in July 2018.

About National Disability Services

National Disability Services ('NDS') is the peak body for non-government disability services. Its purpose is to promote quality service provision and life opportunities for people with disability. NDS's Australia-wide membership includes more than 1000 non-government organisations, which support people with all forms of disability. NDS provides information and networking opportunities to its members and policy advice to state, territory and federal governments.

National Disability Services

Contents

Executive summary

The second edition of **Australian Disability Workforce Report** revisits the issues first identified in our mid-2017 edition. The richness of nine quarters of Workforce Wizard data covering between 35,000 and 38,000 people each quarter significantly deepens our understanding of front-line disability and allied health professional work.

The analysis presented confirms the distinctive character of the of the disability workforce: a majority female, mainly part-time group of workers, over two-fifths of whom are casually employed.

Trends and features that appear to be associated with the way the sector is responding and adapting to the National Disability Insurance Scheme are also becoming clearer as the rollout gathers pace.

Changes in support worker employment as the NDIS rolls out

Since 2015, casual work has been increasing slightly, and now accounts for 42 per cent of all workers. Most employment gains appear to be coming from casual employment growth. This trend is mainly driven by small and medium organisations, where casual employment at the end of 2017 formed close to half of their workforce.

Two potential downsides to this high casual employment, however, are revealed elsewhere in the data analysis. First is the very high turnover rate of casual workers – a two-year average of nearly 9% per quarter (equal to 35% per annum). This is a significant cost and administrative burden for providers. Second, detailed investigation of NDS carecareers job board data shows job applicants have a clear preference for permanent over casual roles. In the competition for talented people, offering casual jobs only or mainly is likely to be a liability.

Part-time work has also been growing; but unlike casual employment large organisations are also contributing to this tendency. It appears that both large and small/medium organisations are seeking to achieve flexibility in their staffing, but have chosen different strategies. Again, the NDS carecareers job board data offers useful insights. Most job applicants want part-time rather than full-time work, so this growth in the sector is partly driven by worker preferences.

Allied health professionals facing an uncertain environment

Allied health professional employment offers a stark contrast to that of disability support workers. Instead of being majority part-time, the allied health workforce is split almost evenly between people who work full and part time. Three-quarters are permanent workers. But around 16% of applied health professionals were employed as fixed term (on short term contracts) over the last two years and this rose to above 20% during some quarters.

Again, different strategies to minimise risk in an uncertain environment are being used with this young, mainly female professional workforce.

Spotlight topics of interest suggested by Workforce Wizard users

The two spotlight topics featured in this edition of **Australian Disability Workforce Report** are staff absences and industrial instrument coverage.

This is the first time we have reliable data on the use of personal and carers' leave in disability: well over ten days per year. The data is important to achieving fair prices since these figures run counter to the figures assumed by the NDIA.

The disability sector also has an above-average proportion of workers on enterprise agreements than the labour market average, although we know that many of these are due to be renegotiated.

Workforce Wizard and carecareers data continue to fill a major gap

Despite government's legitimate concern about the sector's capacity to scale up as quickly as NDIS participants need, no publicly funded workforce data collection process exists. ABS classifications continue to merge disability workers with other groups, making it impossible to obtain regular labour force analysis.

NDS thanks the many regular Workforce Wizard users whose quarterly data entries allow us to fill this pressing information gap.

1 Introduction

This is the second edition of the **Australian Disability Workforce Report**, an NDS publication that documents current trends in the disability workforce. The features of this workforce is a key question for the sustainability of the National Disability Insurance Scheme (NDIS), and the disability sector as a whole.

Disability's key workforce metrics are reported and discussed in this and every edition. A primary focus is how the workforce is changing (or not) with the introduction of the NDIS.

Australia's capacity to provide a workforce that is of sufficient quantity and quality to meet the increasing workload that the NDIS demands will be crucial to the success of the scheme.

Where does the data come from?

Since ABS labour force data is not classified in a way that allows us to pinpoint the disability workforce, the **Australian Disability Workforce Report** relies on data from NDS's purpose-built two-way workforce metrics application, Workforce Wizard.

Workforce Wizard (www.workforcewizard.com.au) is a free online tool into which disability service providers enter data quarterly. An important design element of Workforce Wizard is that it is short and simple, making it convenient for users. Once the data period closes, benchmark reports are quickly generated showing the organisation's workforce characteristics benchmarked against the sector.

Organisations enter data based on workforces of their own defining. For the purposes of this report, if an organisation entered data for more than one workforce, those workforces were consolidated into one organisational result. This is to avoid multiple counts of a single organisation with more than one (and sometimes duplicate) workforces. When the unit 'organisation' is used in this report, it needs to be understood that the real life organisation may have other streams of activity, such as aged care, plus other staff (eg back office staff) who are not included in our analysis.

The data sample used in this report is nine quarters of data entered up to the end of the September quarter in 2017. Roughly 35,000 to 38,000 disability support workers and allied health professionals data were entered each quarter, from across Australia. Considering the significant coverage of the sector that Workforce Wizard provides, aggregate results have been mainly used.

A longitudinal 'balanced panel' has also been created of organisations that have entered data across the seven consecutive quarters between March 2016 and September 2017. The longitudinal nature of this panel means the disability support worker results from each quarter are more truly comparable to each other, and can confirm trends.

There is no separate longitudinal analysis for the allied health workforce, as most participants of this sample are consistently engaged with Workforce Wizard and therefore constitute a longitudinal panel.

Data on jobseekers

The second major source of data used in this report comes from carecareers (www.carecareers.com.au). This is NDS's job board where employers advertise for disability sector and aged care staff. The data from this job board spans about five years, from the end of 2012 to the beginning of 2018, and is a rich source of information on what is happening in the disability job market. Around one million people use this site every year to find disability and aged care jobs.

A more detailed discussion of Workforce Wizard and carecareers data and our methodology can be found in the first edition of the **Australian Disability Workforce Report**, which can be found at www.nds.org.au/workforce-hub.

What's in this report

In the next three chapters, the Report presents data on the key metrics Workforce Wizard collects about disability support workers:

- types of employment
- organisation growth
- turnover rates
- working hours; and
- age and gender distribution.

Chapter Six analyses these same workforce trends among allied health workers.

Chapter Four reports on our newly introduced special topics, so-called Spotlight Topics, which shed light on important policy issues in the sector. These issues are generated by users and reflect their concerns and interests. One or two additional questions are asked each quarter about these subjects, on a one-off basis.

In this edition, the topics covered are:

- Number of staff absences
- Industrial instrument use in the organisation.

carecareers data analysed in Chapter Five concerns the number of views and applications made by jobseekers for each advertisement.

Throughout the report there are hyperlinks (in blue) to various other parts of the text, to all the figures, and to the tables in the appendix. These tables provide the data which sit behind all the figures. Clicking on these links will take you directly there, and clicking on the Back Button in your PDF Reader will take you back to where you were reading.

2 How are workers employed?

The disability workforce is quite distinctive. About 70% of disability support workers are women, compared to a figure of 46% in the wider Australian workforce.[1] Disability support workers are also slightly older than the Australian workforce: some 44% are aged 45 years or more. In the workforce more generally, the figure is 39%.

Over time, as the disability sector grows strongly, these features may change. More men and more younger workers may enter the sector. At present these features pose challenges that many services are overcoming as they broaden their recruitment targets. On the other hand, there are two areas where the characteristics of the sector pose considerable ongoing challenges. These arise around the forms of employment—whether workers are permanents or casuals—and the hours of work.[2] The disability sector is quite unique in both these areas and the steady growth of casual employment and the increased use of part-time hours raises important issues about the viability of the sector's workforce. Will the disability workforce of the future be a stable, highly-skilled and well-motivated workforce? Or will we see the emergence of pockets of heavily casualised and part-time work, where high turnover, low morale and inconsistent standards prevail?

It is still early days in the rollout of the NDIS, but the sector needs to be alert to developments in the disability workforce which may undermine the positive outcomes promised by the scheme. By focusing on changes in forms of employment and hours of work, NDS is drawing attention to issues that industry, government and service users need to solve collaboratively.

1. It is important to stress that this gender characteristic is shared by other community sector workers, such as carers and aides (the group which includes child-care aged-care workers) where the proportion is 85%.
2. See the discussion of these concepts in the Appendix, on page A1.

Overview

Most disability support workers are employed as permanent or casual workers. Very few are fixed-term workers.[3] In September 2017 the proportion of permanent workers in the disability workforce was 55%; the proportion of fixed-term workers was 3%; and the proportion of casual workers was 42%. Figure 1 shows these proportions in each of the quarters over last two years.

The largest group in the disability workforce are permanent workers ...

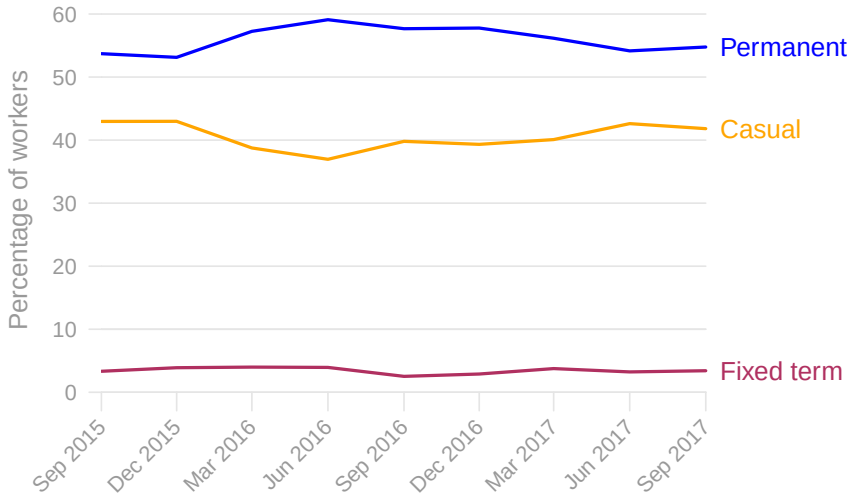


Figure 1: Forms of employment

Notes: Details in Table A10

The figures for September 2017 are close to the overall averages for this two-year period, though the permanent proportion is somewhat lower and the casual proportion somewhat higher, suggesting that the share of casual employment may be slowly increasing. The analysis of workforce growth (page 14 onward) does indeed suggest that casual employment is increasing in the sector.

... but casual workers make up two-fifths of the workforce, a share which has been increasing over the last 18 months

3. Permanents are employed with an expectation of on-going employment; fixed-term workers have a termination date in their contracts; and casuals have no expectation of any ongoing employment and can, in theory, be terminated at short notice.

Does organisational size make a difference?

While the overall trend towards increased casualisation is only slight, when we look more closely at the different organisational sizes in the disability sector, it becomes apparent that small and medium organisations are definitely engaging more casuals. This is shown in Figure 2. In both cases, the proportion of casuals among their disability support workers is now greater—or about to become greater—than the share of permanents. Only for large organisations is the gap between the share of casuals and permanents not closing.[4]

Permanent employment is increasingly the preserve of large organisations ...

In the September 2017 quarter the proportion of permanent disability support workers in large organisations was 57%, while the proportion of casuals was 40%. By contrast, in small organisations permanents made up just 44% and casuals had reached 47%, while in medium organisations the figures were 49% permanents to 48% casuals.

... and casual employment is becoming dominant in small and medium size organisations

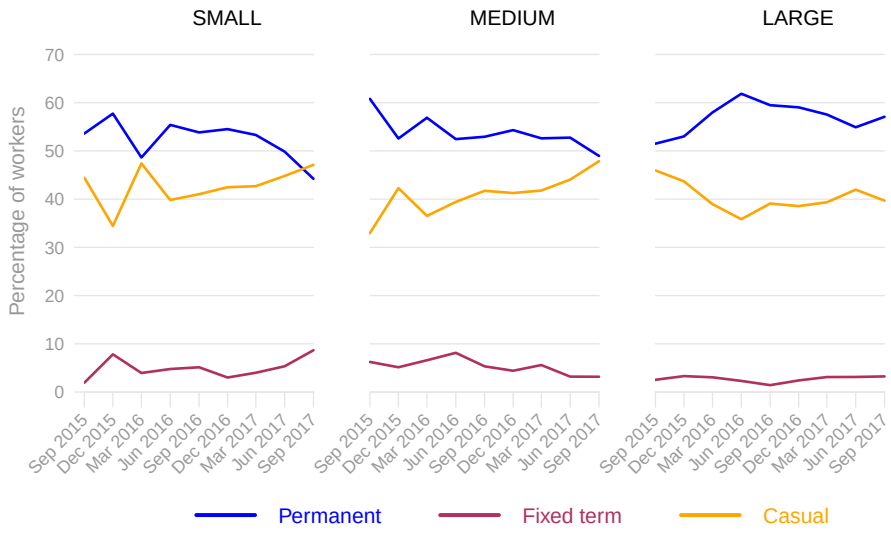


Figure 2: Forms of employment by size of organisations

Notes: Details in Table A11

4. We categorise organisational size on the basis of the number of disability support workers in the organisation: Small: less than 50 workers; Medium: 50 to 199 workers; and Large: 200 or more workers.

Is there a gender story?

There is also a striking pattern according to the gender of the workforce. We saw in the last chapter that women make up the majority of the workforce—averaging around 70 percent—so this makes it difficult to define organisations by their gender proportion. Nevertheless, by pooling the data from all quarters, we have a sufficient number of observations to define four categories based on the ratio of female to male staff, that is, the percentage of women within each organisation's workforce.[5]

By comparing the forms of employment across these four categories we find a distinctive result: organisations with higher female-to-male ratios have higher levels of casual employment and lower levels of permanent employment. Indeed, there is an almost linear relationship: as the proportion of women increase in organisations, so too does the proportion of casuals (see the red line in Figure 3.)

> As the proportion of women increase in organisations, so too does the proportion of casuals

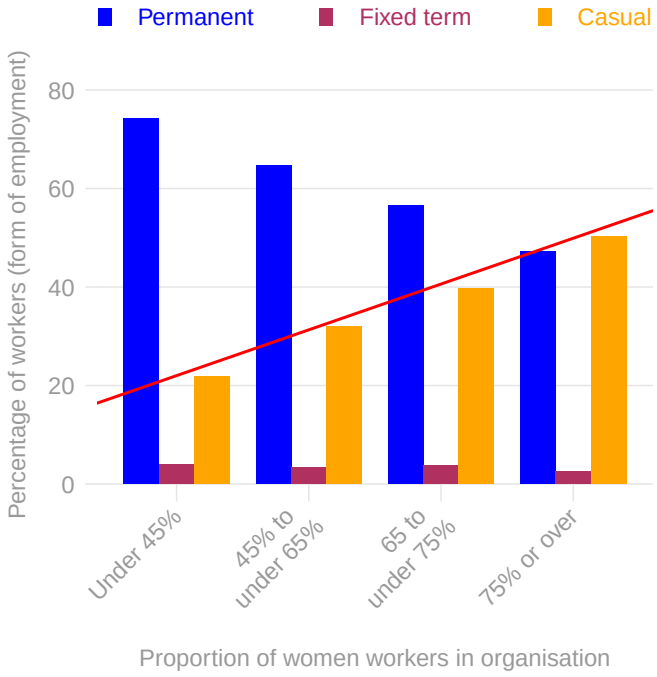


Figure 3: Forms of employment by the proportion of women employed

Notes: Note that data is pooled over all quarters. Details in Table A12.

In organisations which are clearly majority male—that is, where

> Permanent employment is dominant in organisations where there are a large majority of male workers

5. These categories are: Under 45% women; 45% to under 65% women; 65% to under 75% women; 75% or over women.

male workers make up 55% or more of the staff—the proportion of permanents in those organisations is 74% and the proportion of casuals is just 22%. By way of contrast, in organisations where women make up three quarters of the staff—only slightly above the overall average—we find almost equal proportions of permanents (47%) and casuals (50%).

The growth in the workforce

One of the most striking aspects of the disability workforce is the strong growth taking place. As the NDIS rollout proceeds, new organisations have arisen and existing organisations have expanded their staff to cope with the increased demand for services. During 2016 the Australian workforce as a whole increased by about 1.6% per year, but the workforce in the broader social assistance / personal assistance / residential care sectors grew much more strongly, by 9.5% per year.[6] In the case of the disability sector the growth, as measured by Workforce Wizard, has been even stronger: 11.1% per year (averaged over the two year period).

It is possible to examine workforce growth in the disability sector by analysing the numbers of workers who leave an organisation and the numbers who are recruited in each quarter. The difference between these is a measure of 'net change' in the workforce. These figures are collected by Workforce Wizard for permanent and casual staff, and an overview of these data are shown in Figure 4.

Employment losses come from permanent workers leaving ... and the gains come from increased recruitment of casuals

It appears that employment losses in the sector tend to come from permanent workers departing and that most of the employment gains are, in absolute terms, from increased employment of casuals. Given that casuals make up just under half of the disability support workforce one might expect that the net change would also reflect a similar ratio. Clearly, this is not the case, and the increased propensity for organisations to recruit more casuals is evident in Figure 4.

If we want to look at this in percentage terms, the permanent growth rate was 1.3% per year. The casual growth rate, on the other hand, was 26% per year.[7]

6. Figures from Australian Bureau of Statistics, *Characteristics of Employment*, 2016, Cat. No. 6333.0.
7. There is considerable quarterly variability in these percentages, so the figures given here are averaged over the two year period. A different approach to calculating growth rates, based on a balanced panel, is discussed below on page 18.

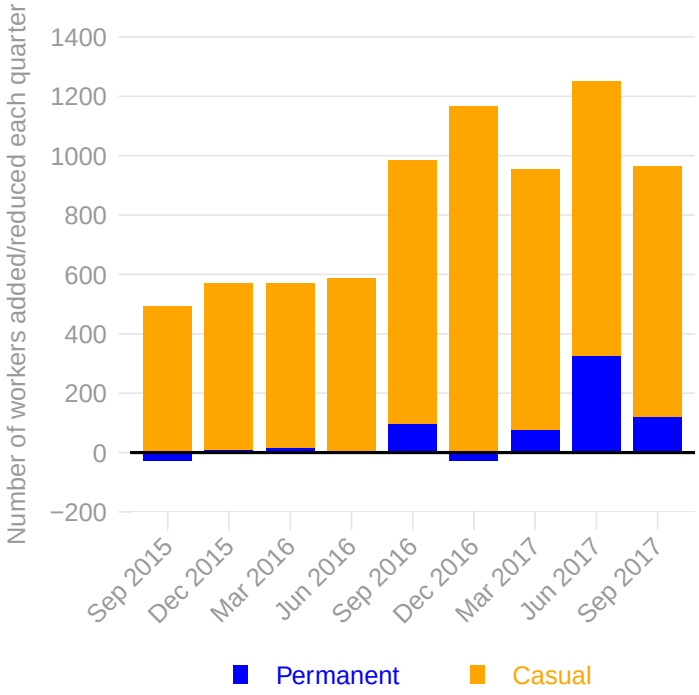


Figure 4:
Net change in permanent and casual staff

Notes: Details in Table A13

In large organisations permanent and casual employment are growing at the same rate ...

We saw earlier (page 12) that in both small and medium size organisations the proportion of casual staff was growing strongly, and becoming the dominant form of employment. For medium size organisations, this picture is confirmed in Figure 5, which shows the net change in permanent and casual staff across medium and large organisations (with trend lines shown in black). In large organisations the **ratio** between permanent and casual net changes in staff appears reasonably stable over time—both are growing together at the same rate.

... but in medium organisations casual employment is growing strongly while permanent employment is declining

By contrast, in medium size organisations, the net change in casual staff is growing rapidly, while the net change in permanent staff shows a downward trend.

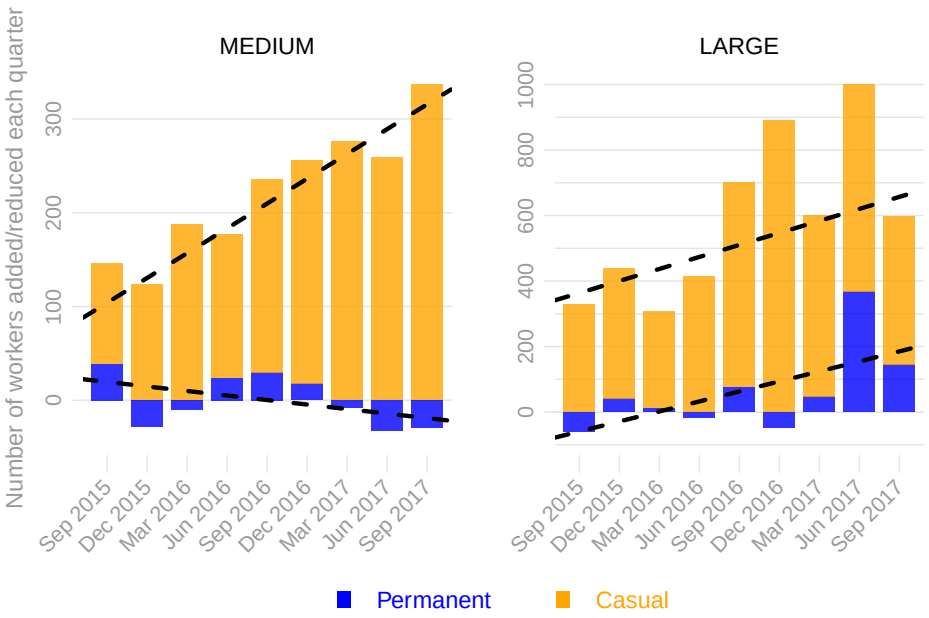


Figure 5:
Net change in permanent and casual staff, by organisational size

Notes: Details in Table A14

What do these changes mean? Essentially, over time a downward trend in the net change of permanent staff means that the sector is diluting its permanent workforce, and that in the long term the share of jobs in the sector held by casual workers will steadily increase. While large organisations are 'holding the line' and not contributing to this potential problem, the drivers of this transition lie in the medium size organisations.

Another perspective on these changes in employment entails categorising organisations by how their permanent and casual staffing profile changed during the quarter. We can define three categories: where a particular type of workforce is declining, where it is stable, and where it is increasing. (The definitions of these categories, and the detailed data for them, are shown in the appendix, see Table A17).

Looking first at the casual staffing profile, about 71% of organisations have had a stable casual workforce in each quarter. Only a small proportion of organisations—an average of 3%—had seen their casual workforce decline during the quarter. By contrast, 25% of all organisations experienced an increase in their casual workforce.

25% of all organisations experienced an increase in their casual workforce ...

... but the majority of organisations maintained a stable permanent workforce

In the case of permanent workers, about 85% of organisations had a largely stable workforce during the quarter. Another 7% of organisations had seen their permanent workforce decline. The remaining 8% of organisations had seen their permanent workforce increase. This organisational approach to the issue of forms of employments is important because it emphasises the **stability**, as well as the changes, in the sector.

As the sector grows rapidly, more of the increased recruitment of workers takes place through the creation of casual jobs

While the losses in employment which do take place are largely in permanent jobs—as we saw earlier—the magnitude of this is relatively small. The strong growth in casual employment may not represent a 'conversion' of permanent work into casual work. Rather, it suggests that as the sector grows rapidly, more of the increased recruitment of workers takes place through the creation of casual jobs.

Workforce turnover

Workforce turnover is an important measure of the amount of 'churn' in an organisation. High levels of labour turnover lead to instability, as experienced workers with good organisational knowledge depart and are replaced with less experienced workers. High labour turnover can signal problems with the organisation, such as low worker morale, or uncompetitive wages or working conditions. On the hand, turnover rates which are too low may leave an organisation without fresh ideas, and the organisations may suffer from routines which reflect old habits no longer suited to the organisation. For the clients, turnover which is too high disrupts continuity in their access to supports; turnover which is too low may leave them deprived of the new ideas which new recruits might bring.

About one quarter of the disability workforce changed jobs every year

The turnover rate is measured as the number of workers who leave an organisation during a quarter, expressed as a percentage of the average total number of workers for that quarter and the previous quarter. Thus the all-worker turnover rate, shown in Figure 6, was 6.5% in the September 2017 quarter; the permanent turnover rate was 4.9% and the casual turnover rate

was 8.6%. In annual terms, about one quarter of the disability workforce changed jobs every year.

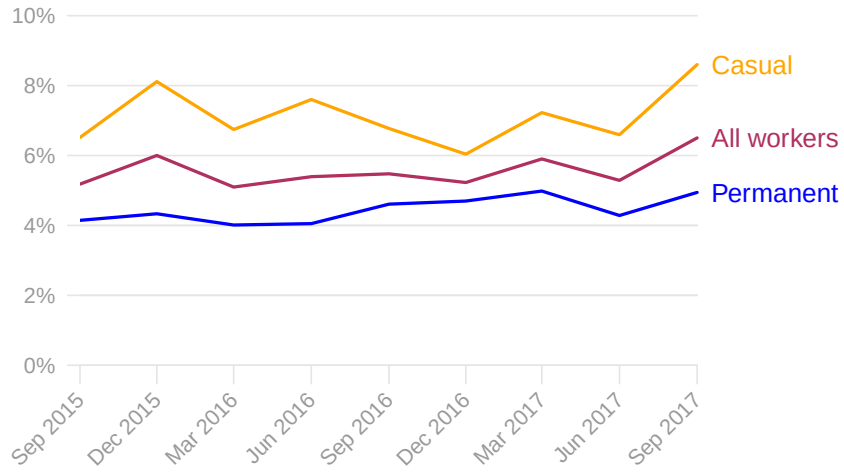


Figure 6: Quarterly turnover rates by forms of employment

Notes: Details in Table A18

The turnover rate for all workers averaged 5.6% per quarter over the last two years, so the 6.5% figure for September 2017 represents a small rise. The turnover rate for permanent workers has fluctuated between 4.1% per quarter and 5% per quarter over the last two years, and has averaged 4.4% per quarter for the period. In the case of casuals, the turnover rate has been even more erratic, ranging from a low of 6% per quarter through to a high of 8.6% per quarter, with the average for the last two years being 7.1% per quarter. The rate for the last quarter—at 8.6%—is above this longer-term average.

Casual workers have 1.6 times the turnover rate of permanent workers

In summary, the turnover rate for casuals has averaged about 1.6 times as high as the permanent rate over the last two years and appears to be increasing. This reinforces the observation made at the start of the chapter: organisations gain apparent flexibility by employing more casual staff but the cost is a greater increase in labour turnover in their workforce, and a consequent drop in the quality of the service provision for their clients.

Another look at growth in the workforce

The information provided by Workforce Wizard on departures and recruitment is valuable in looking at growth and turnover rates. There is, however, an issue around compositional change in the Workforce Wizard sample. As new organisations join the Workforce Wizard, and others drop out, the composition of the workforce

represented by all these organisations may change. To capture a more enduring picture of the workforce we can create what is called a 'balanced panel', a longitudinal sample made up of the same organisations.[8]

Using this balanced panel, we look at where the growth in the workforce came from with respect to forms of employment (see Table A15 for details). In overall terms, most quarters saw growth in numbers (with the exception of the March 2017 quarter) with the strongest growth taking place in the June and December quarters of 2016 (Figure 7).

We can also look at these data in terms of growth rates, that is, the percentage change in numbers in each quarter. Figure 8 shows that the quarterly growth rate for the permanent workforce is consistently lower than the growth rates for casuals (except for the last quarter). In annual terms, and averaging across all quarters, the growth rate for permanents was about 4% percent and for casuals it was 15.2%. The growth in the workforce overall was 8.4%.[9]

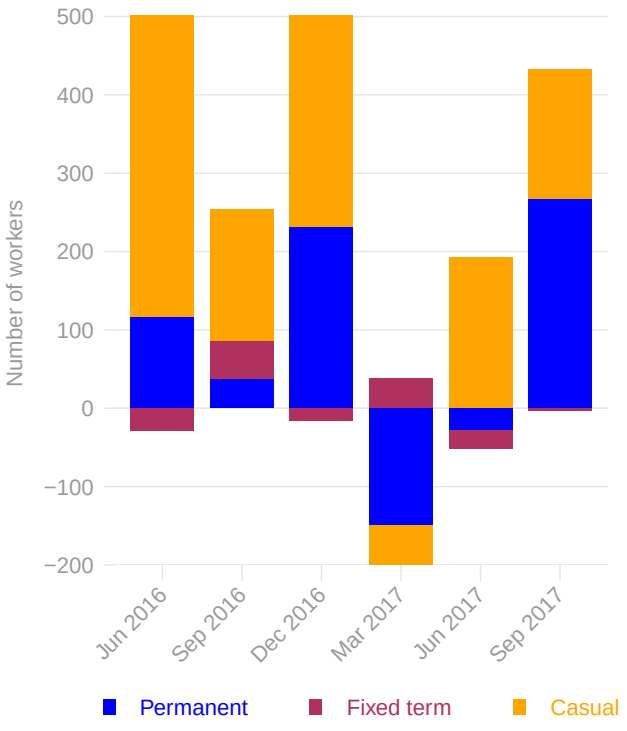


Figure 7: Growth in disability support workforce by forms of employment (counts)

Notes: Details in Table A15

8. In this case, we have selected only those organisations with complete data in Workforce Wizard for all of the seven previous quarters. While this reduces the size of the sample considerably, the numbers are still adequate for our analysis.
9. Growth rates for fixed-term workers are not shown because they are so erratic, based as they are on very small counts. The average growth rate across all quarters for fixed-term workers is 1.1%.

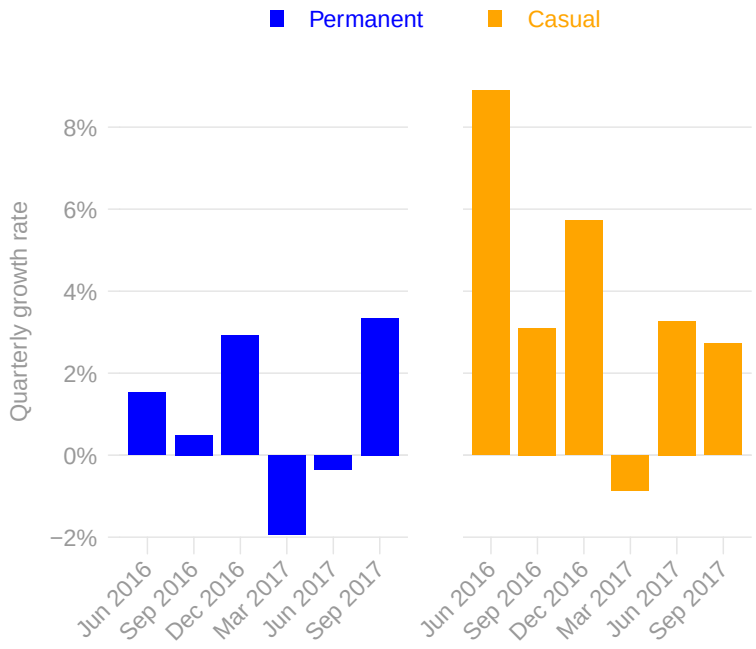


Figure 8: Growth in disability support workforce by forms of employment (quarterly growth rates)

Notes: Details in Table A16

Both these figures show that the majority of the growth in the sector's workforce was through the increased employment of casuals, with only the most recent quarter breaking from this pattern. This analysis confirms the overall picture shown earlier: that casual employment is overwhelmingly driving employment growth in the sector but that in the last quarter (September 2017) permanent employment fared much better. Additional quarters of Workforce Wizard will indicate if this is the beginning of a new trend.

Casual employment has driven employment growth ... but permanent employment has begun to fare better

How does the sector compare?

In 2016 the proportions of casuals, permanents and fixed-term workers in disability, compared with the labour market more generally were as follows:

Permanent: 58% (disability) to 67% (in general);
Casual: 40% (disability) to 23% (in general);
Fixed term: 3% (disability) to 10% (in general).

This comparison shows that casual employment in the disability sector is considerably higher than in the labour market more generally. At the same time, fixed-term employment is much lower.

Casual employment in disability is much higher than in the labour market more generally

If we look at the ABS category of ‘carers and aides’—which includes child care, aged care and disability—this difference in casualisation rates shrinks considerably: some 33% of carers are casuals. The full details of these comparisons can be found in the appendix (Table A6).

In summary, casual employment is much higher in the disability sector than in the Australian workforce more generally. But if we compare the sector to other similar sectors, then the comparison is less stark, though these higher casualisation rates are still exceptional.

3 What hours are worked by disability workers?

Overview

Flexibility in the hours of employment is important for both employers and workers. The former often need to manage varying demand for staff, while workers often need flexibility to juggle their work and non-work lives. In this chapter we look at the hours patterns in the permanent workforce: mainly the split between part-time (under 38 hours per week) and full-time (38 hours or more). We also look at the average hours worked each week.

The disability sector shares in what has been a national trend towards increased part-time work. Within the disability sector, part-time work is dominant and also increasing (see Figure 9). In the September 2017 quarter, the proportion of the permanent workforce who worked part-time was 81%. Full-time workers made up the remaining 19%.

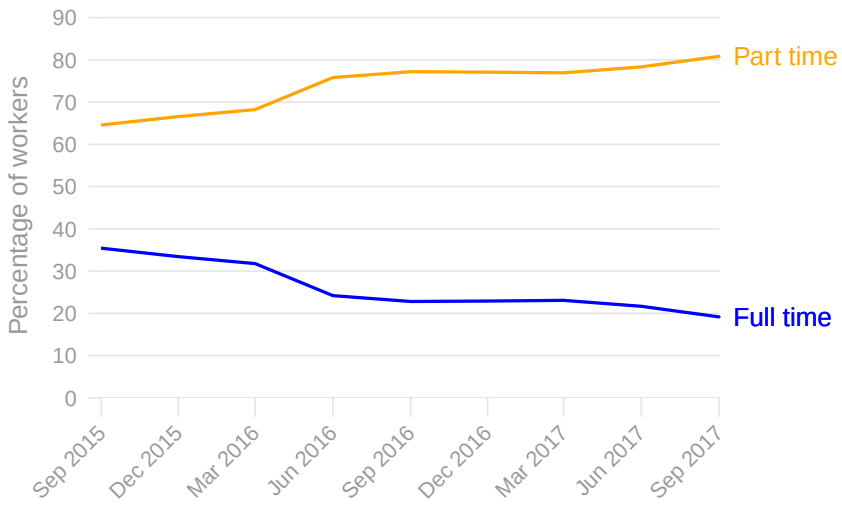


Figure 9: Full-time and part-time workers: overview (%)

Notes: Details in Table A19

Over the last two years part-time work has grown strongly among permanent disability support workers. In September 2015 part-time workers made up 65% of this workforce (with full-timers making up the remaining 35%). The part-time workforce (among permanent workers) has thus grown by 16 percentage points in just two years.

The permanent workforce is dominated by part-time work, and this is growing strongly

Does organisational size make a difference?

Over the last two years large organisations have been steadily increasing their part-time workforce. As Figure 10 on page 24 shows, at the start of the period part-timers made up 62% of their workers. By the end of the period the figure was 83%, an increase of 21 percentage points. From being behind small and medium organisations in their employment of part-timers back in 2015, by late 2017 large organisations now have the highest proportion of part-timers.

Large organisations have increased their part-time workforce ... and now have the highest proportion of part-time workers

In both small and medium organisations the proportion of part-timers has remained reasonably stable over the period (with more volatility in small organisations). By the end of the period medium organisations had slightly higher proportions of part-timers than did small organisations (74% to 68%).

Because the analysis discussed here applies to the **permanent** workforce, a number of inferences can be drawn. First, this high proportion of part-timers in large organisations is predominantly **permanent part-time**. Secondly, the slightly lower proportion of part-timers in small and medium organisations needs to be seen in the context of higher levels of casual workers in those organisations. In other words, both large and small/medium organisations have sought to achieve flexibility in their staffing, but have chosen different strategies.

Both large and small/medium organisations aim for workforce flexibility ... but have chosen different strategies

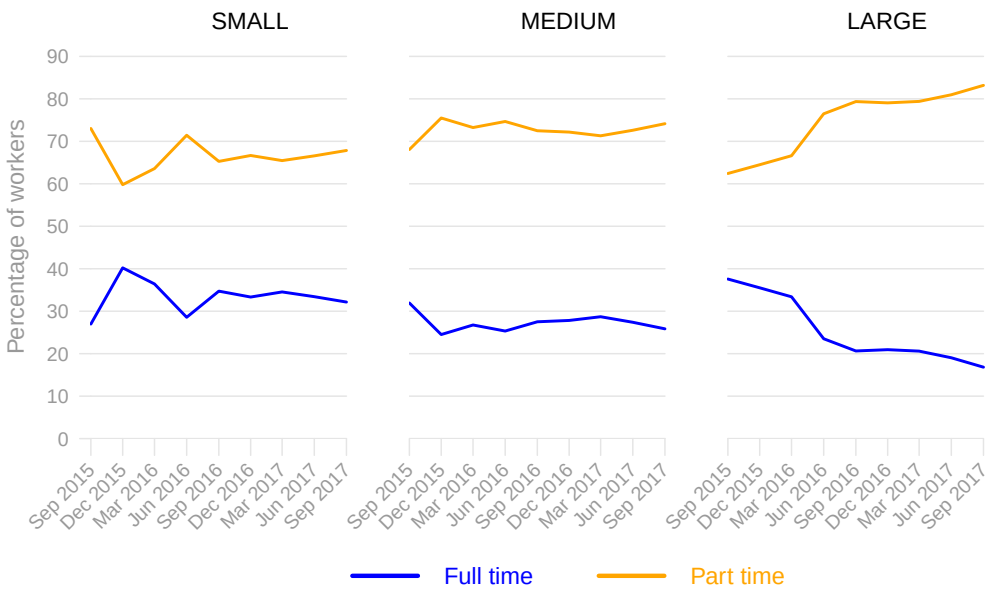


Figure 10:
Full-time and part-time workers by size of organisation

Notes: Details in Table A20

Average hours worked by each worker

Does the increased use of part-time workers also mean a reduction in the average hours worked by each worker within the disability sector? In general, the answer appears to be yes. There is a downward trend over the last two years in overall average hours of work, as shown by the red line in Figure 11.

There is a long-term downward trend in average hours of work ...

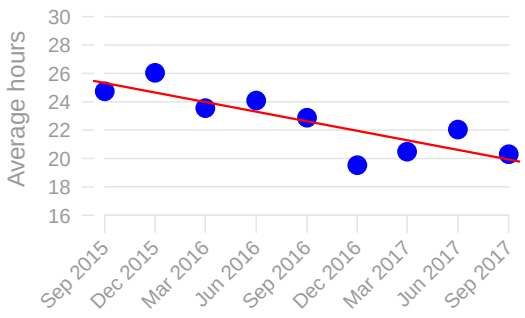


Figure 11:
Average hours of work per week per worker

Notes: Details in Table A21

If we look at the size of the organisations we can see that this is driven by the medium and large organisations (see Figure 12). In small organisations, average hours of work are stable whereas in both medium and large organisations they are declining steadily. This last result is not surprising: given

... and this is most pronounced in medium and large organisations

the increased use of part-time workers by large organisations, it follows that their average hours per worker will be declining.

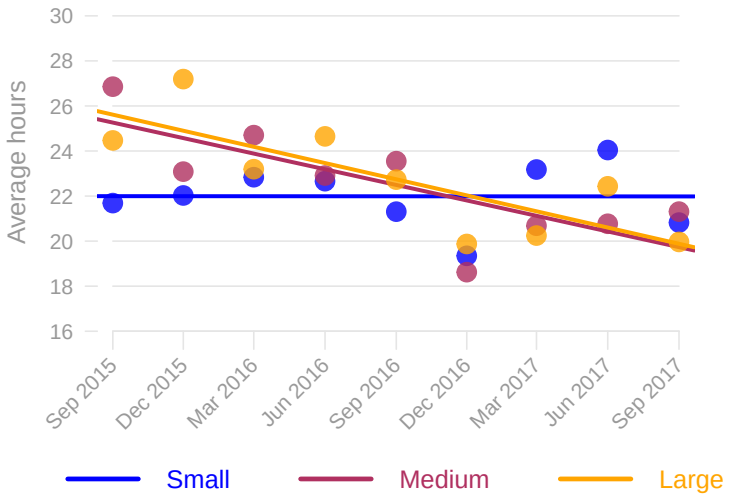


Figure 12:
Average hours of work per week per worker by organisational size

Notes: Details in Table A22

Both the level and the decline in average hours worked are a cause for concern. The decline appears unusual, and departs from the general pattern in the labour market. The level—averaging 22.6 hours per week over the last two years—is considerably lower than elsewhere in the labour market. For example, in workforces with similarly large proportions of part-time workers the figure is closer to 26 hours per week.[10] In the last quarter, the average hours worked by disability support workers had actually fallen to just 20 hours per week. Such low average hours raise important questions about sustainable growth for the sector's workforce: how does one earn a living wage without taking on a second job, or leaving the sector for a better paid position elsewhere?

Gender and hours of work

Is there a gender effect with full-time and part-time work, as there is with forms of employment? Using the same definitions as before, we look at whether organisations with higher concentrations of female disability support workers are also more likely to have higher proportions of part-time workers.

10. This is a ten year average for the general category of 'carers and aides', which includes aged-care workers as well as disability workers. Based on HILDA data.

There is no clear linear relationship between gender and hours of work

Figure 13 suggests that unlike forms of employment, there is no clear linear relationship. Until one looks at those workplaces with the highest concentrations (three quarters or more women) the proportion of part-time workers shows no distinct pattern. However, in those organisations with these large concentrations of women, there is a distinctly higher proportion of part-time workers: some 84% working part-time compared with an average of about 75% across the other categories.

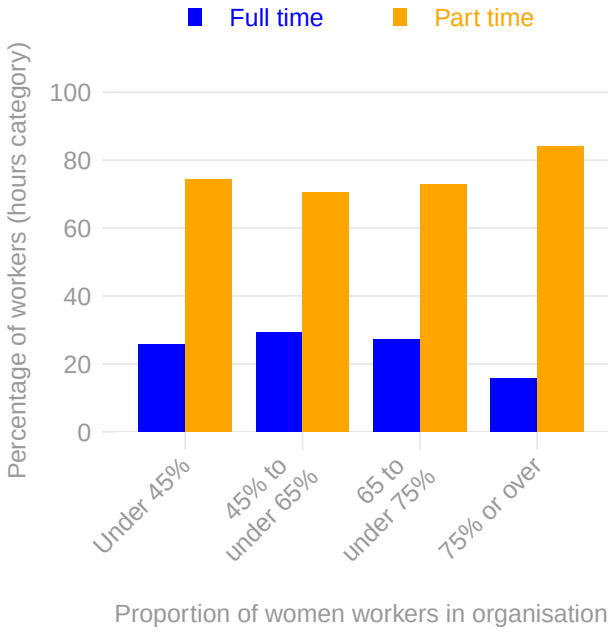


Figure 13: Full-time and part-time workers by the gender composition of the organisation

Notes: Note that data is pooled over all quarters. Details in Table A23.

Hours of work and workforce growth

Employment gains come from increases in part-time workers ... job losses are from declines in full-time workers

We saw earlier that workforce growth was strongly driven by an increased employment of casual workers. Using the same approach, with a balanced panel (see page 14), we analyse the composition of workforce growth according to the full-time and part-time status of the workers entering and leaving organisations. While the totals are smaller—because this full-time / part-time analysis is restricted to the permanent workforce—it seems clear that the growth in employment is largely driven by the increased employment of part-time workers. At the same time most of the job losses have been for full-time workers. Only in the September 2016 quarter did growth in full-time workers exceed growth in part-time workers. Figure 14 illustrates these findings.

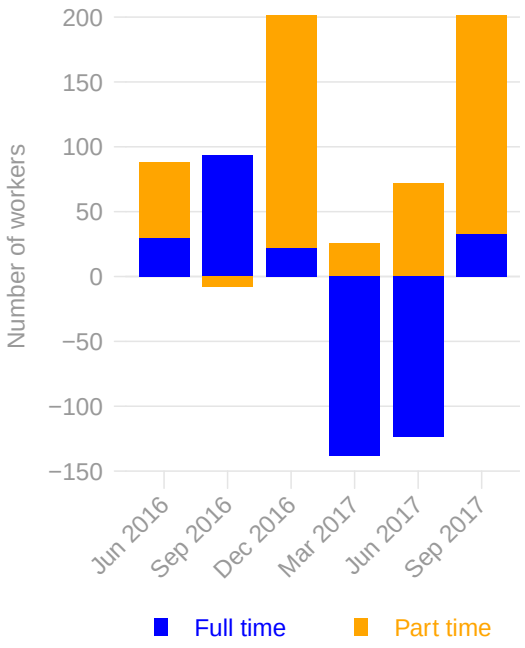


Figure 14: Growth in disability support workforce by full-time and part-time work (counts)

Notes: Details in Table A24

How does the sector compare?

We conclude this chapter by looking at how disability support workers compare with other workers. A more detailed comparison is in the appendix (see Table A7). It needs to be kept in mind that the population here is the permanent workforce and the comparisons are for September 2016.

The high levels of part-time employment in disability appear exceptional

In the September quarter of 2016 about 23% of disability workers within the permanent workforce were full-time; the remaining 77% were part-time. By comparison, the figures for the labour market as a whole are vastly different: 69% full-time and 31% part-time. In other words, in its use of part-time employees, the disability sector appears quite exceptional. However, this seems to be a feature of this type of sector, since the occupational category of 'carers and aides'—which includes the aged-care sector—has similar proportions: here some 30% are full-time and 70% part-time.

The strong growth of part-time work in disability over the last two years is a departure from the general trend

Is the growth in part-time employment which this chapter has illuminated part of a wider development in the labour market, or is it

somewhat unique to the disability sector? Over the last 15 years, part-time employment has grown steadily among permanent employees, rising from 26% of the workforce in 2001 to 30% in 2016. However, this growth has been uneven: and the figure of 30% has been largely stable since 2011 suggesting that the strong growth of part-time work in disability over the last two years is a departure from the general trend, and is likely to be NDIS-related.

If we again look at the broad category of 'carers and aides'—keeping in mind that it includes aged-care workers as well as disability support workers—the 15 year-trend is largely static: 72% were part-time in both 2001 and 2016. However, in the period since 2011, the proportion has been dropping, from a high of 75% down to 72%. While these figures need to be treated with caution (given the small sample size on which they are based), they confirm the earlier impression: the increasing use of part-time work in the disability sector is not shared more widely in the labour market.

4 Spotlight topic: absences

Introduction

Each quarter the Workforce Wizard contains an additional 'spotlight topic', a topic which throws light on important policy issues within the sector. It is not essential that these topics be collected every quarter. They will be repeated every two years and thereby provide the sector with a long-term perspective on these crucial issues.

In the March 2017 quarter the topic was recruitment trends and difficulties, and the results for this topic were discussed in the previous **Australian Disability Workforce Report**. In June 2017 the topic was workforce absences, specifically personal and carers' leave and leave without pay. Since these conditions were only available to the permanent workforce, they were only collected by Workforce Wizard for workers engaged as permanent or fixed term.

Personal and carers' leave and leave without pay

The Workforce Wizard collected the actual **number** of days workers were absent, but to take account of the fact that large organisations have a larger numbers of workers, we need to analyse leave as a **ratio**: the number of days taken per worker per quarter. Using this figure we compare averages across the states (with some of the smaller areas grouped with their neighbour to make the numbers adequate for analysis).

Workers took an average of about 6 days of personal and carers' leave per person per year

During the June quarter of 2017 disability support workers took an average of 1.8 days of personal and carers' leave per person during the quarter (see Table 1). Using the median, which removes more extreme values, the average was 1.2 days. Based on these figures, an annual estimate is that workers took about 6 days of personal and carers' leave per person per year.[11]

11. This is based on multiplying by 4 the mid-point figure of 1.5 days.

Personal and carers' leave was highest in Queensland (2.9 days per quarter) and New South Wales / ACT (2.5 days per quarter), and lowest in Victoria / Tasmania (1 day per quarter) and in organisations that were spread across states (0.8 day per quarter).

Leave without pay was much less common. The national average was 0.5 day, which in annual terms equated to 2 days of leave without pay. The highest figures were just 0.7 day per quarter in Queensland and South Australia / Northern Territory. The lowest figures (0.3 day per quarter) were again in the multi-State organisations.

> Workers took an average of 2 days of leave without pay per person per year

While there is no discernible pattern in the leave without pay figures according to the size of the organisation, there is when it comes to personal and carers' leave. Those disability support workers employed by large organisations accessed about half of the amount of leave compared to those employed by small and medium organisations. Those in large organisations took 1.1 days per quarter, while those in small organisations took 2 days and those in medium organisations took 2.1 days.

Table 1: Average number of days per worker per quarter, personal and carers' leave and leave without pay, by State

	Personal and carers' leave		Leave without pay		
State	**Mean**	**Median**	**Mean**	**Median**	**n**
Queensland	2.5	1.3	0.4	0.0	33
Multi-state	1.0	1.1	0.5	0.2	47
Victoria / Tasmania	2.9	1.8	0.7	0.0	31
Western Australia	1.3	1.2	0.7	0.0	30
New South Wales / ACT	1.6	1.2	0.4	0.0	34
South Australia / NT	0.8	0.4	0.3	0.0	18
National average	1.8	1.2	0.5	0.0	193

Notes: Population is permanent and fixed term workers only. n is number of organisations in the sample. *Source*: Workforce Wizard

The National Employment Standards for a full-time employee provide for 10 days per year for personal and carers' leave. This minimum figure feeds into the pricing assumptions of the NDIS. Yet the disability sector figure of 6 days for each worker, in a workforce where over 80% of workers are **part time**, equates to a much higher number, well over 10 days. While it is well-known that workers in stressful and emotionally demanding jobs have higher sickness rates, this is the first time we have data on the actual use of personal and carers' leave entitlements in disability.

Industrial instruments covering the workforce

In the September quarter of 2017 the spotlight topic was the type of industrial instrument which covered the workforce for which that organisation was entering data. The industrial instrument provided the basis for wages and conditions for a defined group of employees. There were two main instruments:

1. Awards: which are negotiated by trade unions and often operate at an industry level. They usually provide a 'floor' to both wages and conditions in that industry, though individual organisation may sometimes provide 'over-award' pay or conditions.
2. Enterprise agreements: these are based on bargaining outcomes within the organisations between the union or workers and the management. They usually provide better pay and conditions than the award, but may also involve 'trade-offs' on the part of the workers in return for these advantages.

Traditionally, many disability organisations have undertaken enterprise bargaining, but this may be changing in the new market environment and this spotlight topic will assist in monitoring such changes.

Nearly 60% of organisations were covered by awards, about 40% by enterprise agreements

Overall about 59% of organisations were covered by awards and the remaining 41% were covered by agreements. However, the variation across states was considerable. As Table 2 shows, the coverage of awards was much higher in New South Wales / ACT and Queensland: 87% and 73% respectively. It was lowest in South Australia / NT (just 25%) and somewhat lower in Victoria / Tasmania (49%).

Table 2: Industrial instruments operating in organisations, by state (%)

State	Award	Agreement	Total	n
New South Wales / ACT	87	13	100	30
Victoria / Tasmania	49	51	100	37
Queensland	73	27	100	22
South Australia / NT	25	75	100	16
Western Australia	54	46	100	26
Multi-state	56	44	100	16
Total	59	41	100	147

Notes: Population is organisations and coverage refers to disability support workers. n is number of organisations in the sample. *Source*: Workforce Wizard

These figures for industrial coverage are for **organisations** in the disability sector, but it is also possible to calculate coverage for the **workforce** by taking account of the number of workers in each organisation. Table 3 shows the patterns in industrial coverage for some 31,000 disability support workers in Australia.

Overall, workers are split almost evenly between award coverage (51%) and enterprise agreements (49%). The state patterns, however, are quite diverse. New South Wales / ACT and Queensland are again the States with the highest proportion of workers under the award (82% and 63%), and South Australia / NT is again much lower. An interesting difference is evident in the figures for Victoria / Tasmania. Award coverage for organisations is 49%, but for the workforce the figure is half this at 25%.

Workers are split evenly between award coverage and enterprise agreements

Table 3: Industrial instruments for the workforce, by state (%)

State	Award	Agreement	Total	n
New South Wales / ACT	82	18	100	6,658
Victoria / Tasmania	25	75	100	5,008
Queensland	63	37	100	2,911
South Australia / NT	17	83	100	3,429
Western Australia	44	56	100	5,999
Multi-state	58	42	100	6,819
Total	51	49	100	30,824

Notes: Population is the disability support workforce. n is number of workers covered by the organisations in the sample. *Source*: Workforce Wizard

Historically, enterprise bargaining has been more common in large organisations, while smaller organisations have often stayed on the award. To some extent, this pattern is confirmed in the Workforce Wizard data, particularly for the workforce figures. In the case of organisational coverage, some 46 percent of large organisations have enterprise agreements, slightly higher than the average (41%) but considerably higher than small organisations (35%). Turning to workforce coverage, some 53% of workers in large organisations are covered by enterprise agreements compared with just 35% of the workforce found in small organisations.

Table 4: Industrial instruments for organisations and for the workforce, by organisational size (%)

	Organisations				Workers			
Org size	Award	Agree-ment	Total	n	Award	Agree-ment	Total	n
Small	65	35	100	40	65	35	100	1,083
Medium	59	41	100	66	61	39	100	6,757
Large	54	46	100	41	47	53	100	22,984
Total	59	41	100	147	51	49	100	30,824

Notes: Population in first panel is organisations; in second panel the workforce. n in first panel is number of organisations; in second panel, number of workers covered. *Source*: Workforce Wizard

The disability sector has a higher proportion of workers on enterprise agreements than the labour market average

How do these figures compare with the industrial relations situation more generally? The Australian Bureau of Statistics collects workplace information on methods of setting pay and it's data for May 2016 provides an overall estimate of 37% of employees[12] on enterprise agreements, with the balance split between award coverage and individual arrangements.[13] This suggests that the disability sector has a higher proportion of workers (49%) on enterprise agreements than in the labour market more generally.

However, if we look at the broad industry category of 'health care and social assistance', the figures are much closer to the disability sector figures in Workforce Wizard. These ABS estimates show that 53% of employees were employed on enterprise agreements. This industry finding mirrors the findings in other chapters, where if we focus more closely on occupational groups such as carers and aides, the disability sector appears much less exceptional.

12. The data come from ABS, *Employee Earnings and Hours*, Australia, May 2016, Cat.No. 6306.0 (Spreadsheet: 63060DO007_201605). Note that the population for these estimates is full-time non-managerial employees. The all-employee data combines awards and collective agreements and is therefore of no use in this particular comparison.
13. The ABS has always distinguished between award coverage and individual arrangements but this overlooks two issues. First, individual arrangements are 'underpinned' by the award, so the low figures given for award coverage are mislead-ing. Secondly, the number is further reduced because 'over-award' payments are also classified as individual arrangements. For these reasons, it is best to just focus on the figures for enterprise agreements, which the ABS terms collective agreements.

5 What are workers looking for?

The job market is where employers in the disability sector look for workers and where people interested in working in the sector seek out jobs. The **carecareers** website which is run by NDS accepts advertisements for jobs ('job ads') from employers where they currently have vacancies. People who land on the website scan this 'job board' looking for suitable employment, and when they find a position which interests them, they may click on the 'view details' button and continue by clicking on an 'apply' button.

The data from this job board spans about 5 years, from the end of 2012 to the beginning of 2018, and is a rich source of information on what is happening in the disability jobs market. In this chapter we look at the job applications posted by individuals who transact with the carecareers job board. These people—termed 'job seekers'—may be already working, and looking around for a different job; they may be unemployed; or they may be outside the labour force and contemplating entering or returning to the workforce. We don't have information on their situation, but we can look in some detail at the kinds of jobs for which they are looking.

We use the data from 2013 to 2017 because it is complete for each year. Through to end of June 2016 NSW employers (accounting for over 50% of the total advertiser base) were able to list ads for free, so there is a steady growth in jobs over the period. However, during 2017—once employers were required to pay a (modest) amount for listing ads—the number of job ads declined. It is important to keep this decline in mind. It does not imply a decline in the availability of work in the sector and the decline in ads does not weaken the useful of the various comparative measures used here.

All the jobs examined here are only those applying to the disability sector (carecareers posts a much larger range of jobs in other areas of the community sector) and we also analyse the occupational groupings which apply to these jobs.[14]

14. The definitions of the occupational groupings used here are to be found in the appendix. See Table A26. The combined disability sector jobs include some health professional, and allied health professional jobs, but for sampling reasons the occupational groupings omit all of the health jobs.

What interests job seekers?

One measure of what people look for when they transact on the jobs board of carercareers is whether they click to find out more details about the job. We calculate **the ratio of views to each listing** to gauge the 'popularity' of listings over the period from 2013 to 2017. These data are shown in Figure 15 and suggest that in the first full year of operation, each listing on the jobs board for direct support workers was 'viewed' on average by more than 450 potential workers.[15]

These popularity ratios fell in 2014, but then grew steadily from then on, and the pattern was generally repeated across most occupational groups. One interpretation of these data is that the initial year represented heightened interest in a new job-seeking platform available on the internet, and that subsequent years reflected the underlying growth of interest in these jobs. What seems particularly notable about the listings for direct support workers is the reduction in listings during 2017 did not lead to a diminishing level of interest by job seekers. The ratio (of over 400) held up during 2017, despite fewer jobs on offer on the platform.

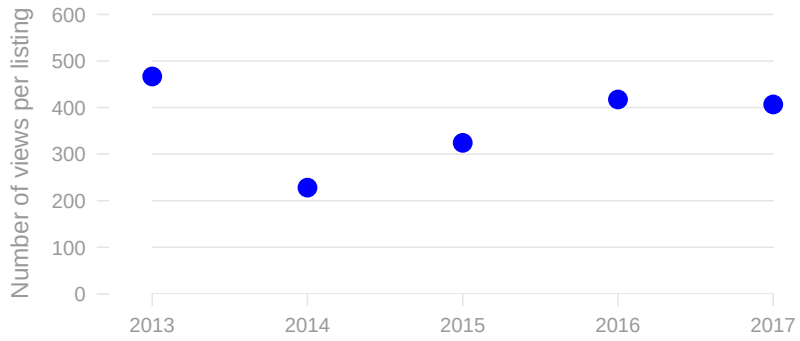


Figure 15:
Views of job listings for direct support workers

Source: carecareers job board

15. We need to keep in mind that actual job listings were only shown for a month, so this figure is an average based on dividing the total number of views in a year by the total number of listings, broken down by the occupational grouping.

Job applications

A much stronger measure than viewing the details for job ads is making an application. While there are some difficulties in knowing whether job seekers follow through completely with their online applications, there is no reason to assume that systematic patterns will influence this outcome. With this in mind, we examine information on forms of employment and hours of work to see what kinds of jobs disability workers are looking for. We plot the data as monthly counts and then fit trend lines to illuminate the overall pattern. As we did in earlier chapters, we focus on both forms of employment (permanent and casual jobs) as well as hours of work (full time and part time jobs). The latter distinction is only applicable to job ads for permanent positions.

As Figure 16 shows, most job seekers preferred permanent jobs over casual jobs. The growth in the latter category remained almost flat from 2016 onward, whereas growth in applications for permanent jobs grew strongly until early 2017, when applications began to fall.

Most job seekers preferred permanent over casual jobs ...

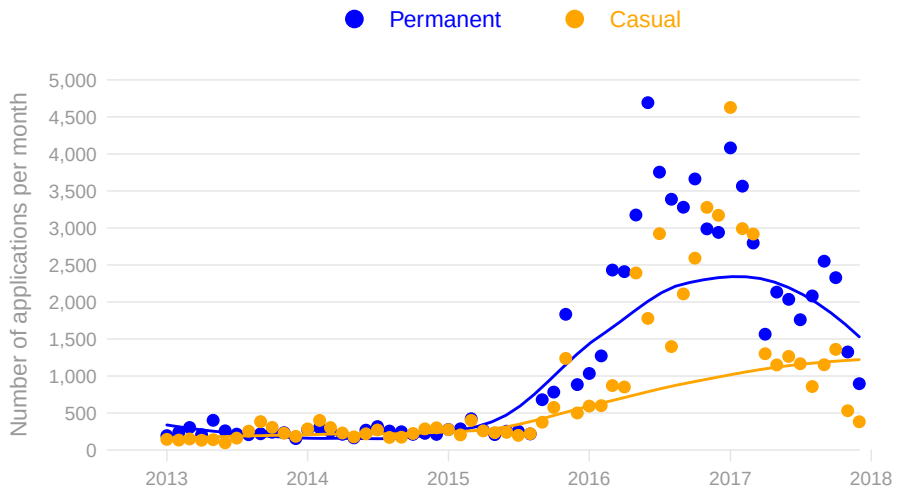


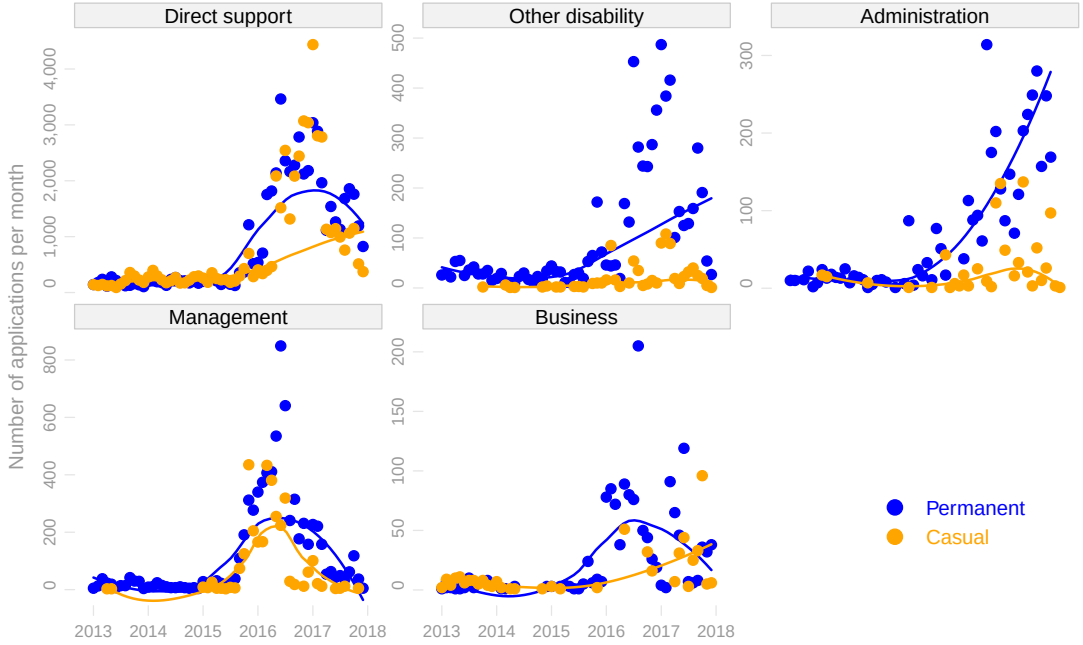
Figure 16: Monthly applications for disability jobs, by forms of employment

Source: carecareers job board

Because 80% of the applications were for direct support workers, the occupational breakdown for this group closely matched the overall patterns. That is, direct support workers had a much stronger preference for permanent jobs over casual jobs (see Figure 17). This carried through to the other occupational groups with some minor variations. For example, while casual jobs barely

featured in administration, they were more common in the management occupations, with applications split evenly between permanent and casual jobs during the middle of 2016.

Figure 17: Number of job applications per month, by forms of employment and by occupational grouping (*Source:* carecareers job board)



When we turn to hours of work, a very different picture emerges. Not only did part-time applications outnumber full-time applications across the period, but they continued to grow strongly during 2017 when full-time applications were falling away (Figure 18). This is quite a striking difference to the picture which emerges with forms of employment. Again, because of the dominance of direct support workers in this population, the breakdown by occupational groups reinforces this general pattern of a strong preference for part-time work. There is, however, is one interesting variation. While full-time applications were more common than part-time ones in administrative occupations, the numbers were very close and there was strong growth in both during 2017 (Figure 19).

... but workers preferred part-time jobs over full-time jobs

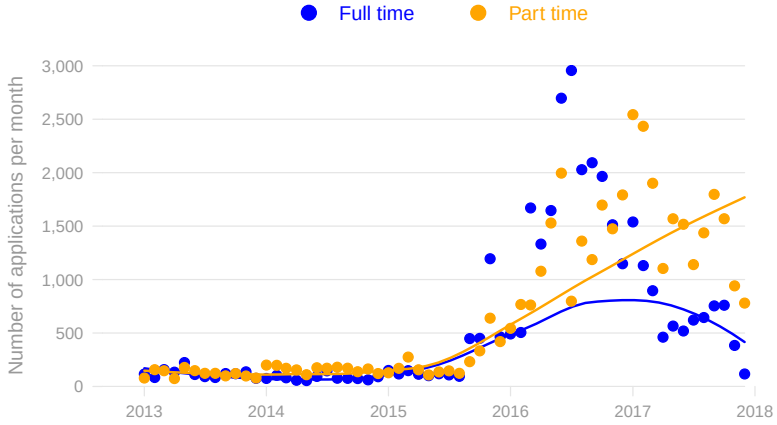
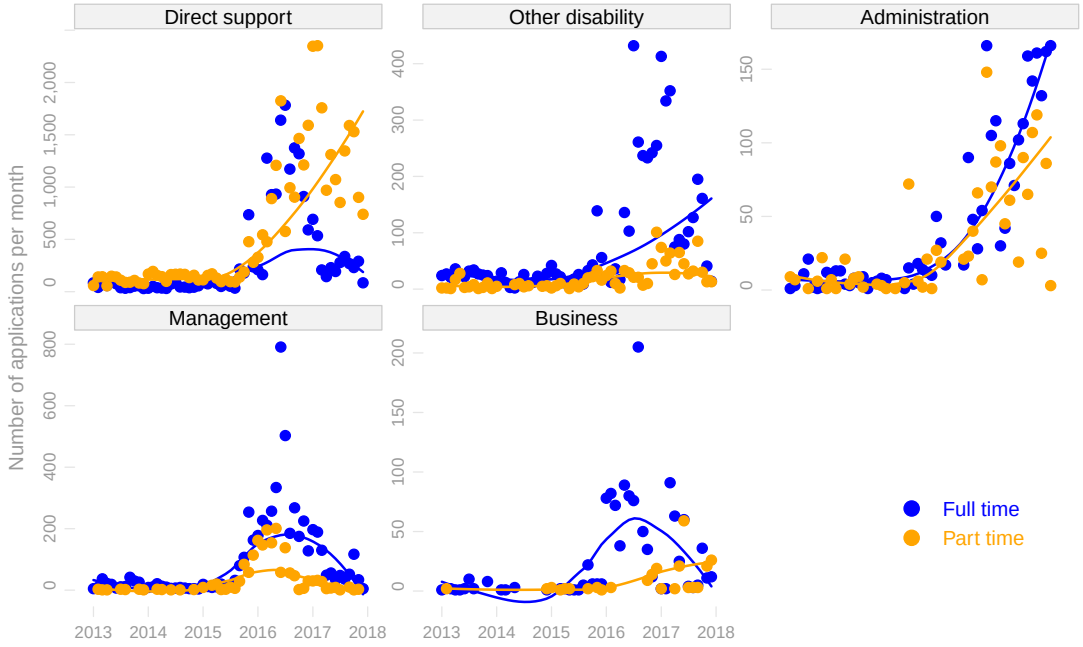


Figure 18: Monthly applications for disability jobs, by hours of work

Source: carecareers job board

Figure 19: Number of job applications per month, by hours of work and by occupational grouping (*Source:* carecareers job board)



One of the enduring questions posed by the growth of part-time employment in the Australian labour market is whether this growth is mainly driven by what employers offer, or by what workers are looking for. The high levels of **underemployment**[16] in some sectors of the labour market suggests that many of the part-time jobs are all that is on offer. Nevertheless, some sectors have large numbers of female workers and students who seek out part-time work because of its suitability for work-life balance.

16. This is where part-timers wish to work more hours than are provided by their employers.

The job applications data for the disability sector provides some insights into this enduring question. When it comes to offering jobs for direct support workers, carecareers employers appear to be offering both permanent and casual jobs in roughly comparable numbers. Similarly, when it comes to whether the permanent jobs on offer are full-time or part-time jobs there is some variability over the period, but the overall pattern in the proportions are also close to even.

Most job seekers want permanent jobs in preference to casual jobs, and part-time jobs in preference to full-time jobs

However, when we turn to look at the data on what interests job seekers, we find that workers are more interested in applying for the permanent jobs. And within those permanent jobs, they are more interested in the part-time positions. This is particularly so among workers looking for direct support jobs and for jobs in administration.

6 What does the allied health workforce look like?

Demographic aspects

The allied health workforce in the disability sector is much smaller than the disability support workforce, but is quite a distinctive group of workers. It is made up of allied health professionals such as occupational therapists, physiotherapists and speech pathologists, as well as nurses.

The workforce is overwhelmingly made up of women. In the September quarter of 2017, 92% of allied health professionals were women. In very few organisations (about 12%) is the female-to-male ratio of the allied health workforce less than 80%. Indeed, in more than one fifth of disability organisations, the whole of their allied health workforce is female. These figures compare starkly with the disability support workforce, where the female proportion in the September quarter of 2017 was 70%.

Similarly, the age profile of allied health workers stands out: they are a much younger workforce. Some 65% were in the middle years of 25 to 44, compared with a figure of 44% among disability support workers. As we saw earlier, the latter group had more older workers—about 21% were older than 55 years—whereas in the allied health workforce only 11% were in this age group.

Forms of employment

Three quarters of the allied health workforce were permanent workers

Unlike disability support workers, an important aspect of employment among allied health workers is the dominance of permanent employment and the relatively larger role played by fixed-term appointments. Whereas casual employment is a striking feature of the disability support workforce, among allied health workers it is

insignificant: only about 7% of workers were employed in this way over the period.[17] By contrast, some 16% were employed as fixed-term and this figure had moved above 20% during some quarters. Most importantly, an average of three quarters of the allied health workforce were employed as permanent employees.

If we look at this in terms of workforce density within organisations, we see that both casual and fixed-term employment is not prominent. As Table 5 shows, 47% of organisations with allied health workers employ none of these worker as casuals, and 44% employ none as fixed-term workers. Only about 10% of organisations had densities of more than 30% for these forms of employment, and these were overwhelmingly the smaller organisations.

Table 5: Organisations by casual and fixed-term density: allied health workers

	Casual employment		Fixed-term employment	
Density	**No.**	**%**	**No.**	**%**
None	91	47	85	44
10% or less	46	24	31	16
Between 10% and 30%	35	18	58	30
More than 30%	23	12	21	11
Total	195	100	195	100

Notes: Data has been pooled over all quarters. *Source*: Workforce Wizard

Hours of work

The allied health workforce is split almost evenly between full-time and part-time workers.[18] In the September quarter of 2017 49% were employed full-time and 51% were employed part-time. This situation is, however, the culmination of a steady increase in part-time workers over the two year period. At the start of the period part-time workers made up 45% of the workforce.

Consistent with this development, the average hours of work seem to have been declining over the period. As Figure 20 shows, despite the fluctuations, the longer-term trend appears to be downward.[19]

17. The data for the last quarter shows a threefold increase in the proportion of casuals (from 6.6% to 18.7%), but because of the small number of organisations in the Workforce Wizard sample, one needs to treat this figure with considerable caution. The average of 7% for the period excludes this outlier. Including it only moves the average higher by one percentage point.
18. The population for this is both permanent and fixed-term workers. Unlike the situation with disability support workers, fixed-term employment is significant in allied health, and is thus included in the analysis.
19. One needs to be cautious with these quarterly figures for the allied health work-

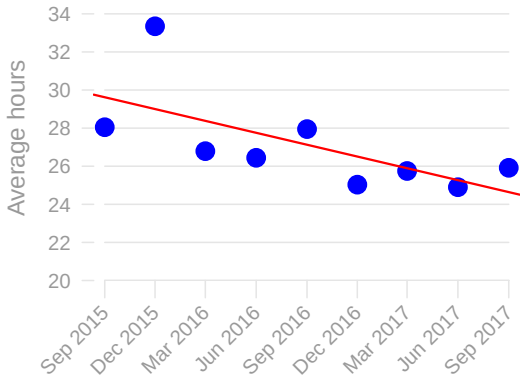


Figure 20: Average hours per week: allied health professionals

Notes: Details in Table A25

Spotlight topics

Like the disability support workers, the allied health professionals also answered question about absences and industrial relations. In the case of personal and carers leave, allied health professional took an average of 2 days leave per person during the quarter. This was a slightly higher figure than that taken by disability support workers (1.8 days).

Allied health workers use of leave without pay was low: 0.7 days per quarter. Again, this figure was slightly higher than the comparable figure for disability support workers (0.5 days).

In nearly two-thirds of organisations the industrial coverage for allied health professionals was an industrial award, with the remainder of organisations using enterprise agreements (63% to 37%). This figure for award coverage was slightly higher than for organisations with disability support workers (59%).

force because the number of observations are quite small. See Table A25 for these counts.

Appendix

Important concepts

Workers may be engaged by employers as permanent, fixed term, or casual, a mode of engagement referred to as the **form of employment**. The first two categories are characterised by the workers having access to holiday and sick leave, while those in the third category have neither of these. Permanents are also employed with an expectation of on-going employment; fixed-term workers have a termination date in their contracts; and casuals have no expectation of any ongoing employment and can, in theory, be terminated at short notice.[20]

Fixed term workers are often used to fill a gap, such as when staff are on parental leave or long service leave. Because the number of fixed-term disability support workers is very small, we mostly combine permanent and fixed-term workers and refer to them as the permanent workforce. Only in Chapter 2, the chapter which deals with forms of employment, do we report on all three categories.

One of the key issues for workforce planning in the disability sector is the extent of casualisation. As we will see, the sector has a higher proportion of casual workers than most other sectors in the workforce and it is growing over time. There are a number of important policy issues raised by this development. While casuals offer apparent flexibility to employers in meeting their staffing needs, the downside is the higher staff turnover which results, and a more uneven mix in their workforce when it comes to quality (such as skills, experience and qualifications). For workers, these jobs offer a 'casual loading' in their wages, which they may be reluctant to forgo in favour of the increased security which permanent jobs might bring. The main downside for workers is that casual employment is insecure: there is no guarantee of the job continuing, nor how much income they may earn and institutions such as banks will often not make large loans to those in casual employment.

20. The casual category is a complicated one, since industrial tribunals have modified the rights of employers to terminate casuals at short notice. The labour market is also characterised by large numbers of 'permanent casuals' who have worked in that form of employment with the same employer over many years.

The **hours** an employee works, whether full-time or part-time, is a different matter to the **form of employment**, but in popular usage the term 'casual' is often taken to mean part-time. In the case of the disability workforce, we distinguish full-time and part-time only for the combined permanents category (that is, permanents and fixed term workers). In the case of casuals, disability services do not systematically record data on their hours of work, so we are not in a position to discuss levels of part-time work among the casual workforce.

Comparisons

In this section of the appendix we look in more detail at how disability support workers compare with other workers, and how the Workforce Wizard data compare with other data sources (in this case the HILDA data).[21] The comparison for forms of employment is summarised in Table A6. We need to keep in mind the difficulties of lining up disability support workers with occupational and industry categories available in other data sources.[22] There is no clear one-to-one correspondence. The occupational category which is the closest analogy for these workers is **carers**, so this comparison is the best one for comparing the data as such.[23] The other comparisons in this table illuminate how the workforce in this sector differs from other workforces.

Table A6: Comparisons for forms of employment (%)

Category	Casual	Fixed term	Permanent
Disability service workers (Workforce Wizard)	40	3	58
Carers (HILDA)	33	9	58
Community Sector (HILDA)	19	11	70
All males (HILDA)	20	9	70
All females (HILDA)	25	11	64
All persons (HILDA)	23	10	67

Notes: The data for Workforce Wizard come from the September quarter of 2016, the closest period in time to when the HILDA data was collected. *Source*: Workforce Wizard and unpublished data from HILDA, Release 16

21. The Household, Income and Labour Dynamics in Australia (HILDA) Survey is a longitudinal survey of Australian households which has been conducted annually since 2001. It is carefully sampled to be representative of the Australian population and collects information on households, and on individuals living in those households. It is managed by the Melbourne Institute of Applied Economic and Social Research.
22. For more details see NDS and Windsor and Associates 2014, *Roadmap to a Sustainable Workforce: Improving the quality of disability workforce data*, Report for DSS Project Report 1, Sydney: National Disability Services.
23. Carers are defined as ANZSCO [42] Carers and Aides. This category also includes childcare workers, education aides and aged care workers.

The most notable difference shown here is the remarkably high incidence of casual employment among organisations in the Workforce Wizard. The comparison with carers has the smallest gap: 40% compared to 33%. Compared to the community sector as an industry category,[24] the difference is stark: 40% compared to 19%. A similar gap is evident for the workforce more generally: 40% to 23%.

However, part of the explanation for these differences lies with the category of fixed-term employment. What is notable about the occupational comparison is that the incidence of permanent employment is identical between Workforce Wizard and carers, at 58%. The difference in casualisation is solely due to the differences in fixed-term employment: Workforce Wizard organisations have a far smaller proportion of fixed-term workers than is the case for carers. A similar difference is evident with the community sector. Here the gap in permanent employment between that sector (70%) and the disability sector (58%) is narrower than is the gap in casual employment between that sector (19%) and the disability sector (40%).

Turning now to a comparison with hours, Table A7 summarises the results. It needs to be kept in mind that the population here is the permanent workforce, and this applies to the HILDA data as well as to the Workforce Wizard figures.

Table A7: Comparative split between part-time and full-time permanent workers (%)

Category	Part time	Full time
Disability service workers (Workforce Wizard)	77	23
Carers (HILDA)	70	30
Community Sector (HILDA)	56	44
All males (HILDA)	16	84
All females (HILDA)	47	53
All persons (HILDA)	31	69

Notes: Population is non-casual workforce for both Workforce Wizard and HILDA data. The data for Workforce Wizard come from the September quarter of 2016, the closest period in time to when the HILDA data was collected. *Source*: Workforce Wizard and unpublished data from HILDA, Release 16

As with forms of employment, Workforce Wizard organisations are closer to the category of carers: about 7 percentage points difference in the incidence of part-time workers: 77% to 70%. As noted earlier this occupational category is probably the closest match for disability support workers so these similar figures suggest

24. The community sector is defined as ANZSIC [86] Residential Care Services and [87] Social Assistance Services.

the Workforce Wizard data is reasonably representative of the sector.

The broader comparison is quite stark. For all the other comparisons in this table the gap is particularly large. There is a 21 percentage point gap with the community sector more broadly, and a 46 percentage point gap with the general workforce. Given the high incidence of female employment in the sector, a fairer comparison for the latter would be with the female workforce more generally and the gap here is 30 percentage points: 77% to 47%. Clearly, the incidence of part-time employment within the permanent workforce in the disability sector is remarkable.

Acknowledgements

This report uses unit record data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey. The HILDA Project was initiated and is funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and is managed by the Melbourne Institute of Applied Economic and Social Research (MIAESR). The findings and views reported in this report, however, are those of the author and should not be attributed to either FaHCSIA or the MIAESR.

Additional tables

Table A8: Age profile of staff of disability support workers (%)

Quarter	Under 25 year	25 to 44 years	45 to 54 years	55 years and over	n
Sep 2015	10.1	42.2	25.7	22.0	123
Dec 2015	9.7	42.0	25.3	23.1	132
Mar 2016	10.2	42.6	24.7	22.5	157
Jun 2016	11.5	43.6	24.0	20.9	167
Sep 2016	10.3	42.9	24.2	22.6	182
Dec 2016	10.6	43.6	24.0	21.8	183
Mar 2017	10.9	43.5	23.7	21.9	189
Jun 2017	11.2	44.3	22.9	21.5	193
Sep 2017	11.5	44.2	22.9	21.4	165

Notes: n is number of organisations in the sample. *Source*: Workforce Wizard

Table A9: Gender profile of disability support workers (%)

Quarter	Female	Male	n
Sep 2015	71.0	29.0	123
Dec 2015	71.5	28.5	132
Mar 2016	70.5	29.5	157
Jun 2016	66.6	33.4	167
Sep 2016	70.6	29.4	182
Dec 2016	70.8	29.2	183
Mar 2017	70.6	29.4	189
Jun 2017	70.2	29.8	193
Sep 2017	69.8	30.2	165

Notes: n is number of organisations in the sample. *Source*: Workforce Wizard

Table A10: Forms of employment: overview (%)

Quarter	Permanent	Fixed term	Casual	n
Sep 2015	53.7	3.3	43.0	123
Dec 2015	53.1	3.9	43.0	132
Mar 2016	57.3	4.0	38.8	157
Jun 2016	59.1	3.9	37.0	167
Sep 2016	57.7	2.5	39.8	182
Dec 2016	57.8	2.9	39.3	183
Mar 2017	56.2	3.8	40.1	189
Jun 2017	54.2	3.2	42.6	193
Sep 2017	54.8	3.4	41.8	165

Notes: n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A11: Forms of employment by organisational size (%)

Quarter	Size	Permanent	Fixed term	Casual	n
Sep 2015	Small	53.6	1.9	44.4	50
Sep 2015	Medium	60.8	6.2	33.0	44
Sep 2015	Large	51.5	2.5	46.0	29
Dec 2015	Small	57.7	7.8	34.4	46
Dec 2015	Medium	52.6	5.1	42.3	51
Dec 2015	Large	53.0	3.3	43.7	35
Mar 2016	Small	48.6	4.0	47.4	53
Mar 2016	Medium	56.9	6.6	36.5	66
Mar 2016	Large	58.0	3.1	39.0	38
Jun 2016	Small	55.4	4.8	39.8	55
Jun 2016	Medium	52.4	8.1	39.4	75
Jun 2016	Large	61.9	2.3	35.8	37
Sep 2016	Small	53.8	5.1	41.0	56
Sep 2016	Medium	52.9	5.3	41.7	78
Sep 2016	Large	59.5	1.4	39.1	48
Dec 2016	Small	54.5	3.0	42.5	53
Dec 2016	Medium	54.3	4.4	41.3	83
Dec 2016	Large	59.0	2.4	38.6	47
Mar 2017	Small	53.3	4.0	42.7	55
Mar 2017	Medium	52.6	5.6	41.8	87
Mar 2017	Large	57.5	3.1	39.3	47
Jun 2017	Small	49.8	5.3	44.8	55
Jun 2017	Medium	52.8	3.2	44.0	92
Jun 2017	Large	54.9	3.1	42.0	46
Sep 2017	Small	44.2	8.7	47.1	44
Sep 2017	Medium	49.0	3.2	47.9	75
Sep 2017	Large	57.1	3.2	39.7	46

Notes: Size of organisation is based on the number of employees: Small = Less than 50; Medium = 50 to 199; Large = 200 or over. n is number of organisations in the sample. *Source*: Workforce Wizard

Table A12: Forms of employment by the gender composition of the organisation (%)

Female % of workforce	Permanent	Fixed term	Casual	n
Under 45%	74.1	4.0	21.8	54
45% to under 65%	64.6	3.4	32.0	372
65 to under 75%	56.5	3.8	39.8	542
75% or over	47.2	2.6	50.2	519

Notes: Data has been pooled over all quarters. n is number of organisations in the sample. Workforce refers to all disability support workers in that organisation.*Source*: Workforce Wizard

Table A13: Net change in permanent and casual staff

	Permanent staff			Casual staff			
Quarter	Depart	Recruit	Net change	Depart	Recruit	Net change	n
Sep 2015	458	431	-27	559	1,054	495	123
Dec 2015	603	611	8	891	1,452	561	132
Mar 2016	635	651	16	704	1,258	554	157
Jun 2016	702	697	-5	801	1,389	588	167
Sep 2016	892	990	98	877	1,763	886	182
Dec 2016	1,000	972	-28	839	2,005	1,166	183
Mar 2017	995	1,071	76	1,000	1,878	878	189
Jun 2017	824	1,151	327	976	1,902	926	193
Sep 2017	912	1,034	122	1,179	2,022	843	165

Notes: Population is all organisations.
n is number of organisations in this sample. *Source*: Workforce Wizard

Table A14: Net change in permanent and casual staff by organisational size

		Permanent staff			Casual staff			
Quarter	Size	Depart	Recruit	Net change	Depart	Recruit	Net change	n
Sep 2015	Small	26	19	-7	35	96	61	50
Sep 2015	Medium	131	170	39	93	200	107	44
Sep 2015	Large	301	242	-59	431	758	327	29
Dec 2015	Small	31	25	-6	20	59	39	46
Dec 2015	Medium	147	119	-28	147	271	124	51
Dec 2015	Large	425	467	42	724	1,122	398	35
Mar 2016	Small	27	42	15	36	106	70	53
Mar 2016	Medium	204	194	-10	177	365	188	66
Mar 2016	Large	404	415	11	491	787	296	38
Jun 2016	Small	34	23	-11	57	77	20	55
Jun 2016	Medium	165	189	24	271	424	153	75
Jun 2016	Large	503	485	-18	473	888	415	37
Sep 2016	Small	41	33	-8	41	95	54	56
Sep 2016	Medium	178	208	30	249	455	206	78
Sep 2016	Large	673	749	76	587	1,213	626	48
Dec 2016	Small	26	26	0	44	82	38	53
Dec 2016	Medium	193	211	18	232	470	238	83
Dec 2016	Large	781	735	-46	563	1,453	890	47
Mar 2017	Small	52	89	37	59	107	48	55
Mar 2017	Medium	209	201	-8	244	520	276	87
Mar 2017	Large	734	781	47	697	1,251	554	47
Jun 2017	Small	26	18	-8	62	96	34	55
Jun 2017	Medium	235	202	-33	301	560	259	92
Jun 2017	Large	563	931	368	613	1,246	633	46
Sep 2017	Small	23	30	7	41	94	53	44
Sep 2017	Medium	165	136	-29	248	585	337	75
Sep 2017	Large	724	868	144	890	1,343	453	46

Notes: Size of organisation is based on the number of employees: Small = Less than 50; Medium = 50 to 199; Large = 200 or over.
n is number of organisations in this sample. *Source*: Workforce Wizard

Table A15: Growth in disability support workforce by forms of employment (counts)

Quarter	Permanent	Fixed term	Casual	Total	n
Jun 2016	117	-29	467	555	64
Sep 2016	38	48	168	254	64
Dec 2016	231	-16	329	544	64
Mar 2017	-150	38	-50	-162	64
Jun 2017	-28	-24	193	141	64
Sep 2017	268	-3	165	430	64

Notes: Counts refer to the change in the number of employees from the previous quarter. Sample is longitudinal sample limited to seven quarters where each organisation is present in every quarter (a balanced panel). n is number of organisations in this sample. *Source*: Workforce Wizard

Table A16: Growth in disability support workforce by forms of employment (quarterly growth rates %)

Quarter	Permanent	Fixed term	Casual	Total
Jun 2016	1.5	-6.0	8.9	4.1
Sep 2016	0.5	9.0	3.1	1.9
Dec 2016	2.9	-3.1	5.7	3.8
Mar 2017	-1.9	6.8	-0.9	-1.2
Jun 2017	-0.4	-4.5	3.3	1.0
Sep 2017	3.3	-0.6	2.7	2.9
Average	1.0	0.3	3.8	2.1
Annual average	4.0	1.1	15.2	8.4

Notes: Sample is longitudinal sample limited to seven quarters where each organisation is present in every quarter (a balanced panel). Number of organisations in this sample is the same as for Table A15.
Source: Workforce Wizard

Table A17: Categorisation of organisations according to workforce changes, by forms of employment

		Percentages in each category			
Quarter	**Forms emp**	**Decline**	**Stable**	**Increase**	**n**
Sep 2015	Permanent	7	89	4	123
Dec 2015	Permanent	8	83	8	132
Mar 2016	Permanent	7	85	8	157
Jun 2016	Permanent	7	86	7	167
Sep 2016	Permanent	8	81	11	182
Dec 2016	Permanent	9	83	8	183
Mar 2017	Permanent	8	85	7	189
Jun 2017	Permanent	4	89	8	193
Sep 2017	Permanent	7	83	10	165
Sep 2015	Casual	2	72	25	123
Dec 2015	Casual	3	76	21	131
Mar 2016	Casual	6	73	21	157
Jun 2016	Casual	5	76	19	167
Sep 2016	Casual	3	71	26	182
Dec 2016	Casual	1	70	29	183
Mar 2017	Casual	3	67	30	189
Jun 2017	Casual	3	70	26	193
Sep 2017	Casual	4	67	29	165

Notes: These definitions are based on: **decline**: where the net change in staff (in each form of employment) in that organisation has fallen by more than 5 workers during the quarter; **stable**: where the net changes lie between a fall in 5 workers and a rise in 5 workers; and **increase**: where the net changes are greater than 5 workers increasing.
n is number of organisations in the sample. *Source*: Workforce Wizard

Table A18: Turnover rates: all workers, permanents and casuals

Quarter	**Permanent**	**Casual**	**All workers**	**n**
Sep 2015	4.1	6.5	5.2	123
Dec 2015	4.3	8.1	6.0	132
Mar 2016	4.0	6.7	5.1	157
Jun 2016	4.1	7.6	5.4	167
Sep 2016	4.6	6.8	5.5	182
Dec 2016	4.7	6.0	5.2	183
Mar 2017	5.0	7.2	5.9	189
Jun 2017	4.3	6.6	5.3	193
Sep 2017	4.9	8.6	6.5	165

Notes: Turnover rate is the number of workers in organisations who leave during the quarter, expressed as a percentage of the average total number of workers for that quarter and the previous quarter. All workers refers to the sum of permanents and casuals (ie. excludes fixed-term workers). n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A19: Full-time and part-time workers: overview (%)

Quarter	Full time	Part time	n
Sep 2015	35.4	64.6	123
Dec 2015	33.4	66.6	132
Mar 2016	31.8	68.2	157
Jun 2016	24.2	75.8	167
Sep 2016	22.8	77.2	182
Dec 2016	22.9	77.1	183
Mar 2017	23.1	76.9	189
Jun 2017	21.7	78.3	193
Sep 2017	19.2	80.8	165

Notes: Population is the non-casual workforce. n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A20: Full-time and part-time workers by size of organisations (%)

Quarter	Size	Full time	Part time	n
Sep 2015	Small	27.0	73.0	50
Dec 2015	Medium	31.9	68.1	44
Mar 2016	Large	37.6	62.4	29
Jun 2016	Small	40.2	59.8	46
Sep 2016	Medium	24.5	75.5	51
Dec 2016	Large	35.5	64.5	35
Mar 2017	Small	36.4	63.6	53
Jun 2017	Medium	26.8	73.2	66
Sep 2017	Large	33.4	66.6	38
Sep 2015	Small	28.6	71.4	55
Dec 2015	Medium	25.3	74.7	75
Mar 2016	Large	23.5	76.5	37
Jun 2016	Small	34.7	65.3	56
Sep 2016	Medium	27.5	72.5	78
Dec 2016	Large	20.6	79.4	48
Mar 2017	Small	33.3	66.7	53
Jun 2017	Medium	27.8	72.2	83
Sep 2017	Large	20.9	79.1	47
Sep 2015	Small	34.5	65.5	55
Dec 2015	Medium	28.7	71.3	87
Mar 2016	Large	20.6	79.4	47
Jun 2016	Small	33.4	66.6	55
Sep 2016	Medium	27.4	72.6	92
Dec 2016	Large	19.0	81.0	46
Mar 2017	Small	32.2	67.8	44
Jun 2017	Medium	25.8	74.2	75
Sep 2017	Large	16.8	83.2	46

Notes: Population is the non-casual workforce. Size of organisation is based on the number of employees: Small = Less than 50; Medium = 50 to 199; Large = 200 or over. n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A21: Average hours of work per week per worker

Quarter	Average hours	n
Sep 2015	24.7	97
Dec 2015	26.0	109
Mar 2016	23.6	128
Jun 2016	24.1	149
Sep 2016	22.9	165
Dec 2016	19.5	161
Mar 2017	20.5	166
Jun 2017	22.0	172
Sep 2017	20.3	147

Notes: n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A22: Average hours of work per week per worker by organisational size

Quarter	Organisational size	Average hours	n
Sep 2015	Small	21.7	40
Sep 2015	Medium	26.9	32
Sep 2015	Large	24.5	25
Dec 2015	Small	22.0	41
Dec 2015	Medium	23.1	40
Dec 2015	Large	27.2	28
Mar 2016	Small	22.8	45
Mar 2016	Medium	24.7	53
Mar 2016	Large	23.2	30
Jun 2016	Small	22.7	54
Jun 2016	Medium	22.9	63
Jun 2016	Large	24.6	32
Sep 2016	Small	21.3	53
Sep 2016	Medium	23.5	70
Sep 2016	Large	22.7	42
Dec 2016	Small	19.3	50
Dec 2016	Medium	18.6	74
Dec 2016	Large	19.9	37
Mar 2017	Small	23.2	49
Mar 2017	Medium	20.7	76
Mar 2017	Large	20.2	41
Jun 2017	Small	24.0	52
Jun 2017	Medium	20.8	81
Jun 2017	Large	22.4	39
Sep 2017	Small	20.8	41
Sep 2017	Medium	21.3	67
Sep 2017	Large	20.0	39

Notes: Size of organisation is based on the number of employees: Small = Less than 50; Medium = 50 to 199; Large = 200 or over. n is number of organisations in the sample. *Source*: Workforce Wizard

Table A23: Full-time and part-time workers by the gender composition of the organisation (%)

Female % of workforce	Full time	Part time	n
Under 45%	25.7	74.3	54
45% to under 65%	29.3	70.7	372
65 to under 75%	27.2	72.8	542
75% or over	15.9	84.1	519

Notes: Data has been pooled over all quarters. n is number of organisations in the sample. Workforce refers to all disability support workers in that organisation. *Source*: Workforce Wizard

Table A24: Growth in disability support workforce by full-time and part-time work (counts)

Quarter	Full time	Part time	Total	n
Jun 2016	30	58	88	64
Sep 2016	94	-8	86	64
Dec 2016	22	193	215	64
Mar 2017	-138	26	-112	64
Jun 2017	-124	72	-52	64
Sep 2017	33	232	265	64

Notes: Population is the non-casual disability service workforce. Counts refer to the change in the number of employees from the previous quarter. Sample is longitudinal sample limited to seven quarters where each organisation is present in every quarter (a balanced panel). n is number of organisations in this sample. *Source*: Workforce Wizard

Table A25: Average hours of work per week per worker: allied health professionals

Quarter	Average hours	n
Sep 2015	28.0	15
Dec 2015	33.3	14
Mar 2016	26.8	14
Jun 2016	26.4	17
Sep 2016	28.0	20
Dec 2016	25.0	21
Mar 2017	25.8	24
Jun 2017	24.9	23
Sep 2017	25.9	19

Notes: n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A26: Definitions of occupational groups

Occupational group	Detailed occupation
Direct support	Professional Support Workers
Direct support	Support Workers
Other disability	Case Manager
Other disability	Service Co-ordinators
Other disability	Employment Consultant
Administration	Accounting & Finance
Administration	Administration
Administration	Facilities & Maintenance
Administration	Legal
Administration	Payroll
Administration	Trades & Services
Administration	Transport
Management	Executive
Management	Human Resources
Management	Management
Management	Service Managers
Business	Business Development
Business	Call Centre & Customer Service
Business	Education & Training
Business	Fundraising & Marketing
Business	Graduate
Business	Hospitality, Tourism & Travel
Business	Information Technology
Business	Marketing & Communications
Business	Sales
Omitted	Occupational Therapist
Omitted	Physiotherapist
Omitted	Speech Pathologist

Source: carecareers job board

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WORKFORCE WIZARD

NDS National Disability Services

Australian Government
Productivity Commission

National Disability Insurance Scheme (NDIS) Costs

Productivity Commission Position Paper

June 2017

This position paper has been prepared for further public consultation and input. The Commission will finalise its report after these processes have taken place.

An appropriate reference for this publication is:

Productivity Commission 2017, *National Disability Insurance Scheme (NDIS) Costs*, Position Paper, Canberra.

Publications enquiries

Media and Publications, phone: (03) 9653 2244 or email: maps@pc.gov.au

The Productivity Commission

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Further information on the Productivity Commission can be obtained from the Commission's website (www.pc.gov.au).

Opportunity for further comment

You are invited to comment on this position paper by written submission to the Productivity Commission by Wednesday 12 July 2017. Further information on how to provide a submission is included on the study website: http://www.pc.gov.au/inquiries/current/ndis-costs/make-submission.

The final report will be prepared after further submissions have been received.

Commissioners

For the purposes of this study the Commissioners are:

Angela MacRae	Commissioner
Richard Spencer	Commissioner

Terms of reference

REVIEW OF NATIONAL DISABILITY INSURANCE SCHEME COSTS

I, Scott Morrison, Treasurer, pursuant to Parts 2 and 4 of the Productivity Commission Act 1998, hereby request that the Productivity Commission (the Commission) undertake a study into the National Disability Insurance Scheme (NDIS) costs.

Background

The Heads of Agreement between the Commonwealth and the States and Territories (States) on the NDIS stated that the Commission would undertake a review of scheme costs in 2017. This review is intended to inform the final design of the full scheme, prior to its commencement.

Scope of the study

The Commission should address the following issues identified in the Heads of Agreement for the review of scheme costs:

- the sustainability of scheme costs;
- jurisdictional capacity;
- cost pressures (including wages pressures);
- changes in the agreed escalation parameters;
- if efficiencies have been achieved within the scheme;
- whether there has been any impact on mainstream services; and
- examine the most appropriate levers to manage any potential cost overruns.

In addressing these issues, the Commission should consider:

1. Commonwealth and State funding and governance arrangements for the NDIS, including financial contributions and risk-sharing;
2. the interaction with, and role of, other services in meeting reasonable and necessary support for people with severe and profound disability; and

3. whether there are any issues with the scheme's design, including the application of market and insurance principles, in ensuring the best possible outcomes for people with severe and profound disability.

In conducting the analysis, the Commission should take into account its 2011 report into disability care and support and subsequent agreements between governments for the implementation of the NDIS. The Commission will be provided with all the data on scheme rollout it considers necessary for the analysis.

Process

The Commission is to consult broadly, including with the Australian, State and Territory Governments.

The Commission will report within eight months of receipt of the terms of reference, or by 15 September 2017, whichever is later.

Scott Morrison
Treasurer

[Received 20 January 2017]

Contents

Abbreviations

AAT	Administrative Appeals Tribunal
ANAO	Australian National Audit Office
CALD	Culturally and Linguistically Diverse
CEO	Chief Executive Officer
COAG	Council of Australian Governments
DRC	COAG Disability Reform Council
DSS	Department of Social Services
ECEI	Early Childhood Early Intervention
FCA	Federal Court of Australia
FTE	Full-time equivalent
IAC	Independent Advisory Council
ICT	Information and communication technology
ILC	Information, Linkages and Capacity Building
LACs	Local Area Coordinators
NDA	National Disability Agreement
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NIIS	National Injury Insurance Scheme
OECD	Organisation for Economic Cooperation and Development
PC	Productivity Commission
PEDI-CAT	Paediatric Evaluation of Disability Inventory-Computer Adaptive Test
WHODAS	World Health Organization Disability Assessment Tool

OVERVIEW

Key points

- The National Disability Insurance Scheme (NDIS) is a complex and highly valued national reform. The scale, pace and nature of the changes it is driving are unprecedented in Australia. If implemented well, it will substantially improve the wellbeing of people with disability and Australians more generally.
- The level of commitment to the success and sustainability of the NDIS is extraordinary. This is important because 'making it work' is not only the responsibility of the National Disability Insurance Agency (NDIA), but also that of governments, participants, families and carers, providers, and the community.
- Based on trial and transition data, NDIS costs are broadly on track with the NDIA's long-term modelling. While there are some emerging cost pressures (such as higher numbers of children entering the scheme), the NDIA has put in place initiatives to address them. The benefits of the NDIS are also becoming apparent. Early evidence suggests that many (but not all) NDIS participants are receiving more disability supports than previously, and they have more choice and control.
- Nevertheless, the speed of the NDIS rollout, as specified in Bilateral Agreements between governments, has put the scheme's success and financial sustainability at risk. It has resulted in the NDIA focusing too much on meeting participant intake estimates and not enough on planning processes, supporting infrastructure and market development.
  - This focus is manifest in poor outcomes such as confusion for many participants about planning processes; rushed phone planning conversations; inadequate pre-planning support for participants; problems for providers with registering, pricing and receiving payment; and a lack of effective communication with both participants and providers.
- For the scheme to achieve its objectives, the NDIA must find a better balance between participant intake, the quality of plans, participant outcomes, and financial sustainability. Steps are now being taken by the NDIA to better balance these aspects. Greater emphasis is needed on pre-planning, in-depth planning conversations, plan quality reporting, and more specialised training for planners. The Commission is unable to form a judgment on whether such a refocus can be achieved while also meeting the rollout timetable.
- The interface between the NDIS and other disability and mainstream services is also critical for participant outcomes and the financial sustainability of the scheme. Some disability supports are not being provided because of unclear boundaries about the responsibilities of the different levels of government. Governments must set clearer boundaries at the operational level around 'who supplies what' to people with disability, and only withdraw when continuity of service is assured.
- A significant challenge is growing the disability care workforce required to deliver the scheme — it is estimated that 1 in 5 new jobs created in Australia over the next few years will need to be in the disability care sector. Present policy settings are unlikely to see enough providers and workers as the scheme rolls out. Some emerging shortages need to be mitigated by better price monitoring and regulation; better tailored responses to thin markets; formal and informal carers allowed to provide more paid care; and a targeted approach to skilled migration.
- NDIS funding arrangements could better reflect the insurance principles of the scheme, including by allowing more flexibility around the NDIA's operational budget and providing a pool of reserves. Funding contributions made 'in-kind' must be phased out.

Overview

This position paper outlines the Commission's early thinking on the National Disability Insurance Scheme (NDIS) Costs study. The purpose of this position paper is to seek feedback on the Commission's preliminary conclusions and draft recommendations, and on any additional issues that should be considered before the public release of the completed study in September 2017. The Commission welcomes further written comment on this paper, and will undertake consultations to facilitate feedback from participants to inform the preparation of the study report.

More data and information, while still only reflecting the transition stage of the NDIS, will be available before the study's final report is released. As such, the recommendations made in this paper should be viewed as indicative.

1 About the National Disability Insurance Scheme

The NDIS is a new scheme designed to change the way that support and care are provided to people with permanent and significant disability (a disability that substantially reduces their functional capacity or psychosocial functioning). The scheme seeks to create opportunities for people with disability to live 'an ordinary life'. The NDIS is currently being rolled out across Australia. At full scheme, about 475 000 people (460 000 participants under the age of 65 years, and 15 000 aged 65 years and over) with disability will receive individualised supports, at an estimated cost of $22 billion in the first year of full operation.

The NDIS is based on the premise that individuals' support needs are different, and that scheme participants should be able to exercise choice and control over the services and support they receive. The scheme differs from previous approaches in a number of ways:

- it adopts a person-centred model of care and support
- it is an insurance-based scheme — it takes a long-term view of the total cost of disability to improve participant outcomes and to meet the future costs of the scheme (box 1)
- funding is determined by an assessment of individual needs (rather than a fixed budget)
- it is a national scheme.

The NDIS funds reasonable and necessary supports for Australians with permanent and significant disability. Reasonable and necessary supports are those that help participants live as ordinary a life as possible, including care and support to build their skills and capabilities, so that they can engage in education, employment and community activities.

Box 1 **The NDIS is based on insurance principles**

The National Disability Insurance Scheme provides universal coverage by pooling risk across all Australians and taking the risk of disability support costs away from individuals. It is based on four insurance principles.

1. Actuarial estimate of long-term costs — updated to reflect the experience of the scheme, and used to help ensure the scheme is financially sustainable and continuously improved.
2. A long-term view of funding requirements — takes a lifetime view of participant needs and seeks early investment and intervention for people in order to maximise their independence, and social and economic participation, and reduce their long-term support requirements.
3. Investment in research and innovation — to encourage and build the capacity and capability for innovation, outcome analysis and evidence-based decisions on early interventions.
4. Investment in community participation and building social capital — to make the community accessible and inclusive for people with disability, and provide participants and non-participants with necessary supports outside of the scheme, through: mainstream services; Information, Linkages and Capacity Building initiatives; and education programs.

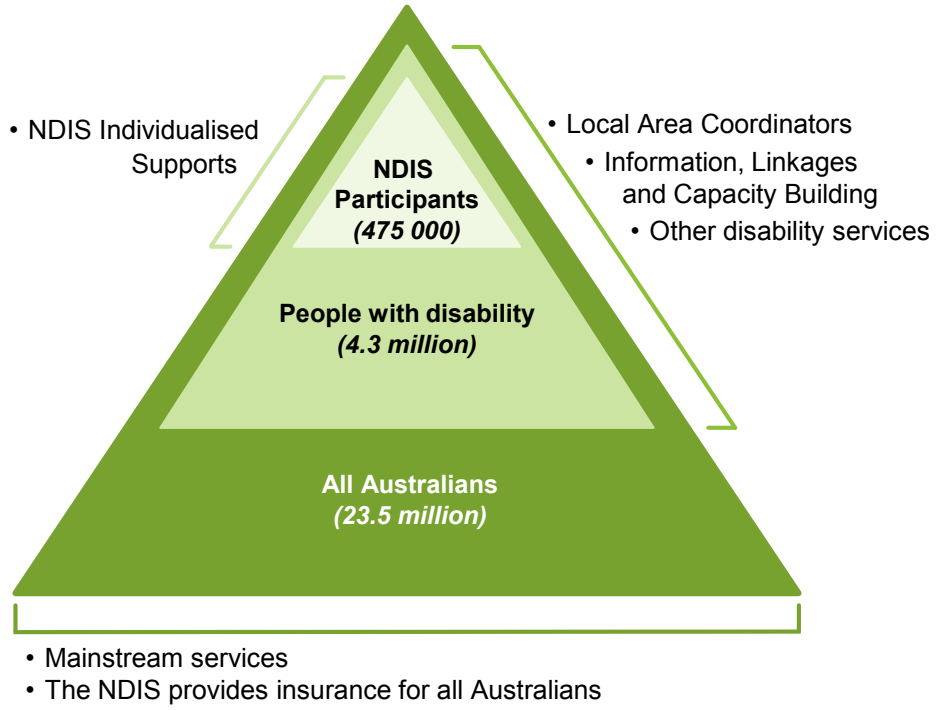
The NDIS also funds supports for people who meet early intervention criteria. This covers cases where early intervention can significantly improve an individual's outcomes and is cost-effective. The focus on early intervention reflects the lifetime approach of the scheme (which is consistent with insurance principles, box 1).

Individuals eligible for the scheme are assessed, and individualised support packages are developed and funded for them. Individualised supports will be available for about half a million people at full scheme (figure 1). NDIS access, planning and payments are managed by the National Disability Insurance Agency (NDIA). (In Western Australia, arrangements are different to reflect a recently announced Bilateral Agreement with the Commonwealth, but the scheme in Western Australia is intended to be consistent with the NDIS.)

Information, Linkages and Capacity Building (ILC) services will also be provided under the NDIS from July 2017. ILC services will provide information about, and referrals to, community and mainstream services (including health, education, employment, transport, justice and housing). These services will be available to the 4.3 million people with disability in Australia (figure 1).

The governing legislation for the NDIS is the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act). The Act also establishes the NDIA, the independent statutory agency responsible for administering the NDIS. The NDIS Rules and Operational Guidelines set out the operational details of the NDIS. Funding for the NDIS is shared by the Australian, and State and Territory Governments.

Figure 1 **The NDIS is part of a broader system of supports**[a]



[a] Number of Australians and those with disability are based on 2015 data. NDIS participants are the projected number of people eligible in 2020.

Some background to the scheme

The Commission's inquiry in 2011 on *Disability Care and Support* found that Australia's system of disability support was inequitable, underfunded, fragmented, inefficient, and gave people with disability little choice and no certainty of access to appropriate supports. The Commission recommended a new national scheme to provide insurance cover to all Australians in the event of significant disability. This recommendation was based on the finding that such a scheme would generate substantial benefits, including:

- improved wellbeing of people with disability (and their families and carers)
- better options for people with disability for education, employment, independent living and community participation
- efficiency gains and cost savings in the disability support system and savings to other government services.

The Commission's recommendations on the national scheme were largely accepted by Australian governments. The *Intergovernmental Agreement for the NDIS Launch* was signed by the Commonwealth and all States and Territories in December 2012.

2 What we have been asked to do and our approach

In the Heads of Agreement on the NDIS signed by the Commonwealth and the States and Territories in 2012 and 2013, it was agreed that the Productivity Commission would review NDIS costs in 2017 to inform the final design of the full scheme prior to its commencement. The Commission has been asked to look at:

- the sustainability of scheme costs, including current and future cost pressures, and how to manage any potential cost overruns
- whether jurisdictions have the capacity to deliver disability care and support services as the scheme expands
- how the NDIS impacts on, and interacts with, mainstream services
- whether efficiencies have been achieved within the scheme
- whether there are any issues with scheme design, including the application of market and insurance principles, in ensuring the best possible outcomes for people with profound or severe permanent disability
- funding and governance arrangements.

What factors drive scheme costs?

Assessing the sustainability of the scheme involves examining the factors that drive costs. The majority of NDIS costs are for individualised supports, but there are also the costs of operating the scheme and funding ILC activities.

Key factors driving scheme costs include the:

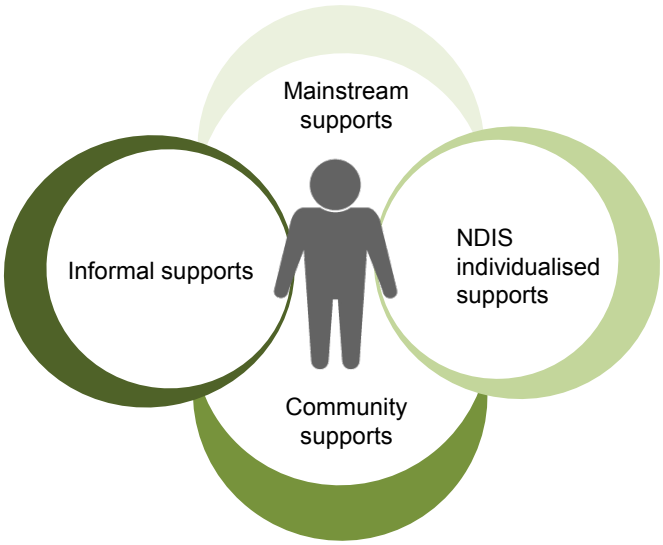
- number and characteristics of scheme participants
- scope of supports provided to scheme participants
- quantity of supports received by scheme participants
- proportion of supports in a plan that is utilised by a participant
- price paid for supports under the scheme
- costs associated with operating the scheme.

Scheme culture will also be an important driver of costs. Moving away from the welfare culture of current disability systems to one of providing reasonable and necessary supports, and managing down the total cost of disability over a participant's lifetime, will be critical for the financial sustainability of the scheme.

Other support systems can also affect scheme costs. The NDIS, as a person-centred approach to providing disability supports, relies on supports and services outside the scheme, including informal supports (family, friends and neighbours), community supports

(local sporting teams, social and interest groups), and mainstream supports (public transport, health and education), to help people with disability to live ordinary lives (figure 2). If these supports are not available, people with disability could seek NDIS funding to fill the gap, and this could pose a risk to scheme costs.

Figure 2 **A person-centred approach relies on supports beyond the NDIS**



Costs are just one side of the equation

While the focus of this study is on scheme costs and the financial sustainability of the scheme, the Commission examined costs in light of the benefits and impacts of the scheme on the lives of people with disability, and Australians more generally, using a wellbeing framework (figure 3).

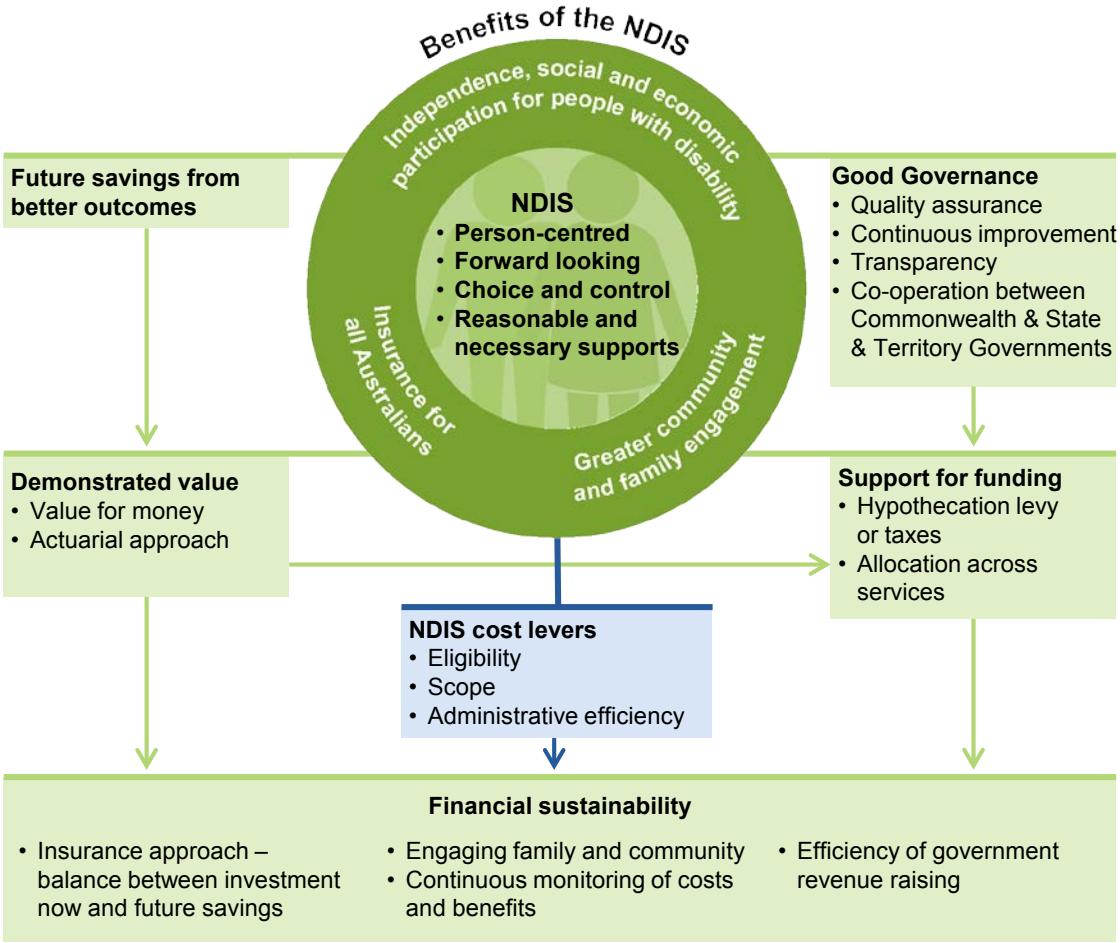
The NDIS was introduced because it has potential to improve the lives of people with disability and the community more generally (by providing insurance for all Australians and lowering future costs of providing disability support). It is therefore essential that the costs to the community are considered in the context of scheme outcomes.

Taxpayers' willingness to fund the NDIS will depend on their perception of value for money, in terms of:

- people with disability experiencing better lives as a result of the scheme
- the scheme making it easier for families and carers to play a supporting role
- the way the scheme invests in people with disability
- the supports that are funded (and the evidence base to support what is funded)

- efficiency gains and cost savings in the disability support system and other government services.

Figure 3 **A wellbeing framework for considering costs and benefits**



While the NDIS is sometimes described as an 'uncapped scheme', the ultimate cap — and test of financial sustainability — is taxpayers' continuing willingness to pay for it. In line with this, the NDIA defines financial sustainability for the NDIS as:

- the scheme is successful on the balance of objective measures and projections of economic [and] social participation and independence, and on participants' views that they are getting enough money to buy enough high-quality goods and services to allow them reasonable access to life opportunities — that is, reasonable and necessary support; and
- contributors think that the cost is and will continue to be affordable, under control, represents value for money and, therefore, remain willing to contribute.

The NDIA's actuarial estimates of long-term costs (which reflect the experience of the scheme and management responses to cost pressures) play an important role in demonstrating to the Australian community that the scheme is sustainable.

Perceptions about the governance arrangements for the NDIS are also important. For example, the community expects planning processes to be in line with the objectives of the scheme and that services meet quality standards. Governments also need to demonstrate that the NDIS funds are dollars well spent, and that funding the scheme is not to the detriment of other important social expenditure (such as health and education).

Financial sustainability of the NDIS also needs to be considered in the context of the efficiency and effectiveness of the NDIA, the readiness of participants and providers, and the integration of the scheme with mainstream and other disability services. Only a system that is integrated and holistic in its focus will bring the benefits that the scheme is expected to deliver.

Modelling costs

In 2011, the Commission estimated that a national disability insurance scheme would cover 411 000 participants and cost $13.6 billion (gross) at maturity. The NDIA's current projections are that the NDIS will cover 475 000 participants and cost $22 billion at full scheme commencement.[1] The NDIA's estimates are broadly consistent with the Commission's 2011 modelling (table 1).

There is an $8.9 billion difference between the Commission's original estimates and the NDIA's current estimates. This is largely the effect of pay rises awarded to social and community services employees by the Fair Work Commission in 2012, accounting for over $6 billion or 71 per cent of the difference. Combined with population changes and the cost of participants aged over 65 years (who entered the scheme when they were under 65 years of age), this brings the estimates to within one per cent of each other (table 1).

Table 1 **Comparing the Commission's and the NDIA's costings**

	Participant numbers	*Scheme costs ($ billions)*
Productivity Commission estimates 2011[a]	**411 250**	**12.82**
Population projections to 2019-20	49 544	1.54
Inflation in disability sector (wages)	..	6.38
Participants aged 65 years and older	15 285	1.09
Updated Productivity Commission estimates 2017	**476 079**	**21.84**
The NDIA's projections for participants 2017[b]	**473 653**	**21.76**
Difference (%)	2 426 (0.5%)	0.08 (0.4%)

[a] Excluding operating costs and offsets associated with the National Injury Insurance Scheme and assumed efficiency dividends. [b] Excluding operating costs ($1.5 billion), offsets associated with the National Injury Insurance Scheme (-$0.7 billion) and assumed efficiency dividends (-$0.3 billion).

[1] While the gross cost of the NDIS is estimated to be $22 billion in 2019-20, the scheme is expected to reduce the funding required for a range of government programs. A review by the Australian Government Actuary in 2011 estimated that these offsets were around $11 billion.

It is too early and the data are too limited for new cost projections

It is still very early days in the NDIS's transition to full scheme. And while the transition experience should inform estimates of full scheme costs, the data have too many limitations to update the prevalence and package cost assumptions. An important limitation is small and unrepresentative trial populations, but approaches to planning and assessments have also changed.

The Commission has not developed new projections of scheme costs for the position paper and will not, given the data limitations, be in a position to do so for the final report. Rather, we have assessed the risks to the financial sustainability of the scheme, including both those within and outside the control of the NDIA. Many of these risks cannot be modelled.

3 An enormous challenge

The NDIS is a major, complex national reform, the largest social reform since the introduction of Medicare. It will:

- involve a shift away from a block-funded welfare model of support, to a fee-for-service market-based approach
- increase funding in the sector from around $8 billion per year to $22 billion in 2019-20
- involve assessing the 'reasonable and necessary' needs of around 475 000 people
- require around 70 000 additional disability support care workers (or around 1 in 5 of all new jobs created in Australia over the transition period)
- substantially improve the wellbeing of people with disability and Australians more generally (if implemented well).

It is therefore no surprise that the NDIS has been described as a 'ground-breaking reform' and a 'once-in-many-generation reform'.

The level of commitment to the NDIS is extraordinary

There is an extraordinary level of commitment to the success and sustainability of the NDIS (and to preserving the core principles of the scheme) shared by governments, people with disability and their families and carers, providers of disability services and disability advocates (box 2). As the Australian Disability Discrimination Commissioner said:

> Yes — the NDIS is big, it is complex, and it changes everything, but it is the change that we need. And when we think about what life might be like for people with disability without the NDIS, I think it becomes clear that it is the change we cannot afford to prevent. … If we want real and lasting change for people with disability, we cannot absolve ourselves of our responsibility to make the NDIS work.

Box 2 **There is overwhelming support for the NDIS**

NSW Council for Intellectual Disability:

> … we have been strong supporters of the development of the NDIS and we continue to see [the] scheme as having a fundamental capacity to improve the lives of people with disability around Australia.

Flourish Australia:

> …. strongly supports the NDIS and the opportunity it provides for greater certainty, choice and control, and economic and social participation for people with disability who require life-long support.

JFA Purple Orange:

> … the NDIS is a major, once-in-many-generations opportunity to invest in the life chances of people living with disability, to achieve a fair go, so that people living with disability take their rightful place as … valued active members of Australian community life and the economy.

National Disability Services:

> The principles on which the NDIS is founded remain compelling and inspiring.

Australian Federation of Disability Organisations:

> We want to begin … by emphasising our unwavering support for the NDIS. AFDO and its members regularly hear from people with disability and their families about the difference the NDIS is making to their lives. People who now have the dignity of appropriate and timely support, the opportunity to be more involved in their communities, the chance to move out of home, the economic freedom of a new job. These are the kinds of differences the NDIS is making.

Anglicare Australia:

> Anglicare Australia strongly believes that the establishment of the NDIS is a major achievement. Our member agencies are already witnessing the transformative power of the scheme for participants, and finding that reconfiguring services to reflect their needs and aspirations is creating opportunities to reimagine and create better outcomes in people's lives.

Health Services Union:

> The HSU has always been a strong supporter of the NDIS and our longstanding position has been that quality disability services depend on a quality workforce.

New South Wales Government:

> The NSW Government is a strong advocate of the National Disability Insurance Scheme (NDIS). The improvement in the lives of people with disability, as outlined by the Productivity Commission (PC) in its 2011 inquiry report into Disability Care and Support, is a goal embraced by NSW.

A highly ambitious rollout schedule

The NDIS was trialled from 2013 in different jurisdictions across Australia in four trial sites (including two whole-of-state age cohort trial sites). Trials commenced in July 2013 in New South Wales, Victoria, South Australia and Tasmania (table 2).

Table 2 **NDIS transition arrangements by jurisdiction**

	Trial period			Transition to full scheme			Full scheme
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
NSW	Hunter area trial		Early Transition in Nepean Blue Mountains area (children aged 0-17 years)	Transition to full scheme (by region)		Full scheme	
Vic	Barwon area trial			Transition to full scheme (by region)			Full scheme
Qld			Transition to full scheme from July 2016 (by region). Early Transition from January 2016 in Townsville, Charters Towers and Palm Island				Full scheme
SA	Statewide trial (children aged 0-14 years)			Transition to full scheme (by age and region)		Full scheme	
Tas	Statewide trial (people aged 15-24 years)			Transition to full scheme (by age)			Full scheme
NT		Barkly region trial		Transition to full scheme (by region)			Full scheme
ACT[a]		Territorywide trial		Full scheme			
WA[b]		Perth Hills area trial MyWay trial			Transition to locally-administered NDIS		Full scheme

[a] The Bilateral Agreement for the NDIS launch between the Australian Government and the ACT Government notes that from 2016-17 the ACT will be in 'transition to full scheme'. This transition has been categorised as 'full scheme' because all residents who meet the eligibility criteria will have access to the scheme. [b] In February 2017, the Australian Government and Western Australian Government signed a Bilateral Agreement for a nationally consistent, but locally administered, NDIS.

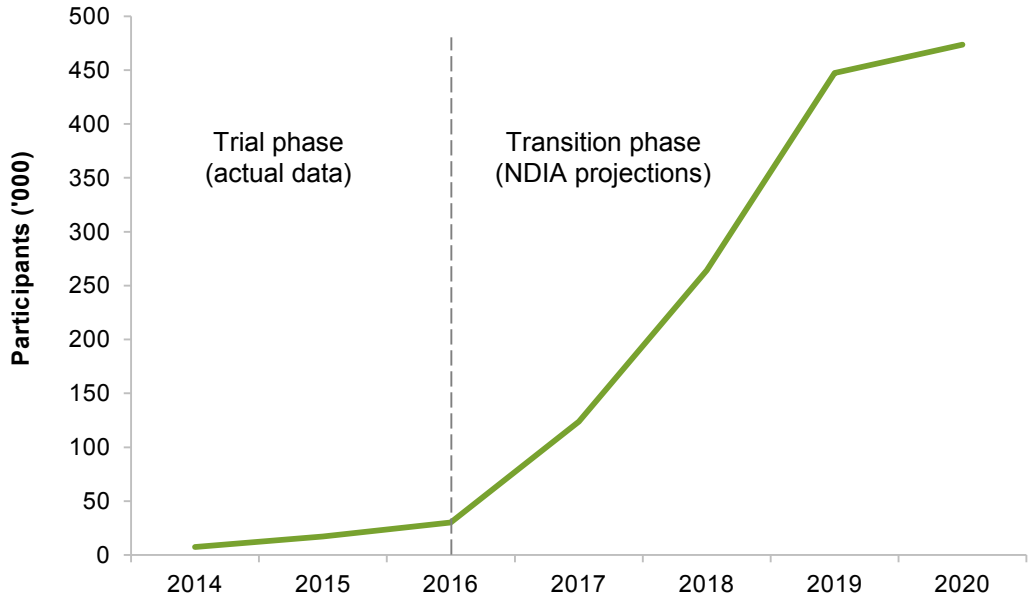
The Bilateral Agreements between the Commonwealth and the States and Territories set out the timeframes, and the estimated number of people who will become participants in the scheme, for the transition to full scheme in each jurisdiction. The transition to the full scheme began in all states and territories in July 2016, with the exception of Western Australia (which will transition from July 2017). The full scheme is scheduled to be rolled out by 2019-20, but some jurisdictions will move to full scheme earlier.

The Commission's 2011 report recommended that the trials start a year later than they did and also that they operate in only two geographic locations. According to the NDIA, the changed timing and breadth of the trial compromised what the NDIA could achieve in the short term and as a consequence, some aspects of the scheme were being built and tested over the trial period. For example, the NDIA started the trial without an assessment tool to determine reasonable and necessary supports, and had to build one over the first three months of operation. And the ICT system used during trial was an interim system which would not scale up to full scheme.

An independent review of the capabilities of the NDIA described the Agency as 'a plane that took off before it had been fully built and is being completed while it is in the air'.

The NDIA has been given an extremely difficult task — the rollout schedule is highly ambitious given the magnitude of the reform. To reach the estimated 475 000 participants at full scheme by 2019-20 (figure 4), the NDIA will need to approve hundreds of plans a day. In the March 2017 quarter, the NDIA approved about 14 000 plans, or roughly 160 plans a day. In 2018-19 (the final year of transition), the NDIA's modelling indicates that about 500 plans a day will need to be approved, while reviewing hundreds more.

Figure 4 **Participant numbers will increase substantially over the next three years[a]**



[a] The projections of scheme participants were prepared by the Scheme Actuary for the NDIA's 2015-16 Annual Financial Sustainability Report using data at 30 June 2016. They do not incorporate actual participant numbers beyond June 2016.

Given the size, speed and complexity of the reform, it is inevitable that there will be transitional issues with the rollout of the NDIS that require careful risk management. It needs to be recognised that the scheme is still in its infancy and it will take time to get things right.

But already there are signs that the rollout schedule is compromising the NDIA's ability to implement the NDIS as intended and putting the financial sustainability of the scheme at risk — and the number of participants entering the scheme is only now just starting to ramp up. At the end of March 2017, around 78 000 participants had approved plans. This is just 82 per cent of the bilateral estimate.

Many of the concerns raised in this study were about the rollout schedule, including concerns around market and provider readiness, the capacity of the NDIA systems to function at full scheme, and the quality of plans (box 3).

The NDIA is aware of the risks of focusing on participant numbers, noting that:

> … bilateral estimates can and do impact upon the way in which the Scheme is delivered. This can put sustainability at risk and impact on the way in which early intervention and investment initiatives are implemented in the short term. It may also have adversely impacted the quality of plans.

The rollout schedule is compromising the integrity of the planning process, and the quality of participant plans. While the NDIA has been set a challenging task of completing high numbers of plans in a short period of time, it is important that it also undertakes the planning process in a way that achieves the objectives of the scheme and financial sustainability. A focus on participant numbers can compromise the depth and quality of the planning process, with the result that some participants are allocated resources without meaningful consultation and are sometimes unable to manage their plans. Quality plans are critical not only for participant outcomes but for containing long-term costs of the scheme (section 6).

The rollout schedule has also meant that parts of the supporting infrastructure that are essential to the objectives of the scheme are not operating as intended. For example, Local Area Coordinators (LACs), who play a key role in delivering information and linking participants to disability services, were supposed to be ‘on the ground’ in rollout areas six months before participants joined the scheme. Some areas were without LACs after they had joined the scheme.

One option to address these concerns is to slow down the timetable for the rollout. Further discussion of this option is in section 11.

Box 3 Risks from the rollout schedule are highlighted

Community Mental Health Australia:

> If the focus purely becomes about signing as many people up as quickly as possible and preventing cost-overruns, then the intent of what the NDIS was actually meant to deliver starts to become lost.

JFA Purple Orange said:

> The NDIS transition arrangements, as set out in the bilateral agreements, mean a tsunami of new participants will be processed into the scheme over the next two years. During this time, any fledgling design features intended to advance what we understand to be the NDIS's underlying values — choice and control, and participation in community life and economy — are at risk, due to the provisions in the various bilateral agreements where a specific volume of people are to enter the NDIS in a specific timeframe and with an associated transfer of specific costs.

Maurice Blackburn Lawyers said:

> We believe the roll-out timeline of the NDIS is highly ambitious and increases the serious risk of inadequate delivery of services to participants. It also poses significant financial risks to the scheme as a whole.

Blind Citizens Australia:

> While we understand that the agency is under intense pressure to meet the targets that have been agreed upon under the bilateral agreements between state and territory governments, meeting these targets should not come at the expense of the basic rights and freedoms of people with disability.

Australian Federation of Disability Organisations:

> The need to bring in a large number of participants into the scheme to meet bilateral targets has during transition led to practices which have not always been consistent the original vision of the scheme.

House with No Steps:

> … the Scheme has aggressive ramp-up targets. These are putting pressure on the NDIA's capacity to develop quality plans for participants. Unfortunately, the need to achieve high growth in participant numbers appears to be outweighing considerations of plan quality and consistency.

Department of Social Services:

> … there are risks arising from the scale and pace of roll-out that has potential to place strain on the NDIA, and on agreed transition timeframes.

Victorian Government:

> Victoria recognises the NDIA has been set the task of completing a very large number of plans in a relatively short period of time and it is important the NDIA perform its planning function adequately. Too great an emphasis on cost containment at this early stage of the NDIS rollout risks undermining the effectiveness of the scheme in meeting the reasonable support needs of participants with adverse implications for longer term costs both to the NDIS and to mainstream services.

4 Key insights from trial and transition data

Costs in the trial phase aligned with expectations

Given the uncertainties around the costings of the scheme before it commenced, an important rationale for trial sites was to inform more reliable estimates of full scheme costs (and for testing and refining the scheme). At the end of the trial phase:

- the number of participants with an approved plan (30 821) was 83 per cent of bilateral estimates (36 307) (there were 35 695 people who had been determined eligible but who did not yet have an approved plan)
- the average annualised package cost was $36 049.

The scheme, at the end of the trial, also came in under budget — there was a surplus of around 1.5 per cent of the funding envelope over the three years. However, this was in large part because not all committed supports were used — in 2015-16, 74 per cent of committed supports were used.

Transition — the latest data

The Commission have data for the first three quarters of transition (July 2016 to March 2017). More data are expected after the release of the position paper.

At the end of March 2017, an additional 63 000 people were eligible for the scheme, taking the total number of participants to 99 092. Around 75 000 participants are currently active (they have not exited the scheme) and have an approved plan. Some insights from the transition data are that:

- autism and intellectual disability are the largest primary disability groups (accounting for almost two-thirds of scheme participants). Psychosocial disability is the next most common disability, accounting for about 6 per cent of scheme participants
- most scheme participants at the end of 2016 were children aged 14 years and under (around 43 000 or 44 per cent of participants). Around 45 per cent of the children in the scheme have autism, while 34 per cent have an intellectual disability (including developmental delay)
- while only 18 per cent of packages approved from 1 July 2016 are more than $100 000, they account for 56 per cent of scheme costs.

Emerging cost pressures

The Commission compared trial and transition data on participant numbers and package costs with the assumptions in the NDIA's modelling to better understand how the scheme

is tracking in terms of costs. Noting the limitations of the data, scheme costs are broadly in line with expectations.

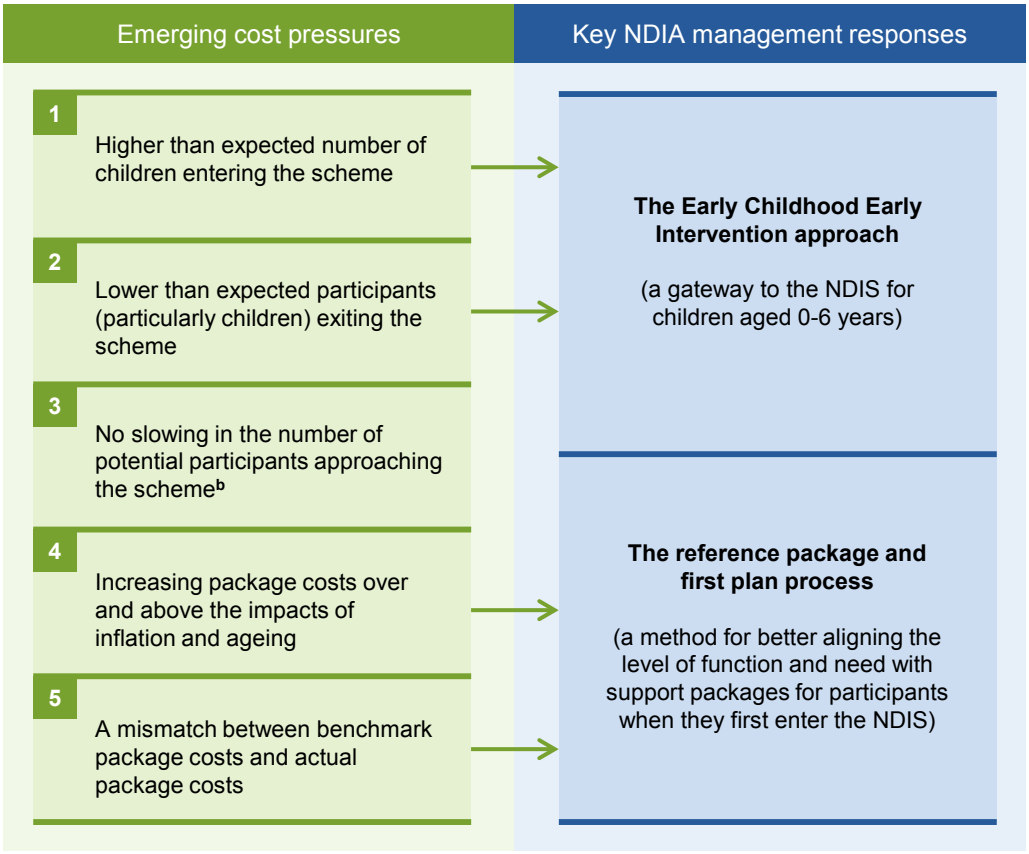
- For most disabilities, participant numbers broadly match the modelling assumptions for all but the largest disability groups — there are more children with autism and intellectual disability than expected.
- Average package costs (for plans effective from 1 July 2016) are higher than the modelling assumptions (after accounting for disability, age and level of function). Breaking this down further:
  - the average package provided to participants with low levels of function is less than expected ($120 000 compared to $150 000)
  - the average package for participants with medium levels of function is higher than the modelling assumptions ($56 000 compared to $41 000)
  - participants with high levels of function are receiving higher packages on average than the modelling assumes ($29 000 compared to $11 000).
- Utilisation rates are lower than expected. Underutilisation is currently offsetting the increase in scheme costs attributable to higher prevalence rates for children and higher than expected package costs.

The NDIA is tasked with ensuring the NDIS is financially sustainable. This involves identifying and managing emerging cost pressures. The NDIA has identified five early cost pressures that need to be managed for the full scheme going forward (figure 5).

- The number of children entering the scheme is higher than expected.
- The number of people approaching the scheme in trial sites that have been operating the longest (since 2013) is higher than would be expected if only people with newly acquired conditions were approaching the scheme.
- The number of participants exiting the scheme has been lower than expected (particularly for children entering under the early intervention requirements).
- Levels of committed support tend to increase as participants move to their second and third plans (over and above the impacts of inflation and ageing).
- There is greater than expected variability in package costs for participants with similar conditions and levels of function (suggesting inconsistencies in planners' decisions).

The NDIA has not updated its baseline cost projections to reflect these cost pressures. But it has put in place initiatives to address these cost pressures, including the Early Childhood Early Intervention (ECEI) approach for children aged 0-6 years (section 5, box 4), and the first plan process to reduce variability in the level of support provided to participants (section 6, box 5). As discussed below, while these initiatives appear appropriate, it is too early to tell whether they will be effective at containing costs.

Figure 5 **The NDIA's responses to emerging cost pressures**[a]



[a] The NDIA's two main responses to emerging cost pressures. The NDIA has also initiated several smaller projects to address emerging cost pressures, such as an analysis of reasonable and necessary costs across the lifespan of participants. Box 4 provides details on the Early Childhood Early Intervention approach and box 5 outlines the first plan process. [b] Potential participants continuing to approach the scheme is not a cost pressure that can easily be addressed by the NDIA.

Benefits are already being realised

Realising the benefits of the scheme is critical for the wellbeing of people with disability and for ensuring that the community continues to be willing to pay for the scheme. However, at this early stage, only some of the benefits are being realised.

The NDIS Outcomes Framework and a National Institute of Labour Studies evaluation of the NDIS provide some insights into the scheme's benefits. Both find that the NDIS has:

- increased supports — more hours of support, a wider range of supports and greater access to equipment — than under the previous system
- on average, improved wellbeing of NDIS participants and their families and carers
- given people more choice and control over their supports
- increased social participation for some scheme participants and their carers.

The Commission also received numerous submissions supporting these findings. As one disability advocate said:

> … I have seen the life changes in people with disability who now have the NDIS funding. They are now accessing community, have a good life and have hope for their futures. The burdens are off the family, some aged carers, and there is job creation. Broken wheelchairs are now being replaced and people who never had wheelchairs, now have and can access the community. I now see happy people.

However, not all people with disability report improved outcomes under the NDIS. The National Institute of Labour Studies evaluation found that:

- some people with disability are experiencing poorer outcomes under the NDIS and receiving fewer services than previously. Often these are people who cannot effectively advocate for themselves, particularly people with psychosocial disability, and those who find it difficult to navigate NDIS processes
- many NDIS participants are experiencing difficulties accessing supports (due to lengthy waiting lists for some providers and types of supports, the absence of local providers and concerns about quality). Also, unmet demand is more common for participants living in rural and remote areas and for older participants
- about 15 per cent of participants feel they have less choice and control, while about one quarter of participants are accessing fewer distinct supports. Qualitative data suggests that those who are unable to navigate the NDIA website to find service providers, and those less able to articulate support needs, are less likely to feel that they have more choice and control.

There has also been a significant fall in participant satisfaction with the scheme since the scheme entered the transition phase — participants reporting that they were satisfied or very satisfied fell from an average of 95 per cent to 85 per cent between 2015-16 and 2016-17 (the first three quarters). This could be linked to the speed of the rollout, and changes to the planning process (discussed below).

The remainder of this overview discusses the longer-term issues that affect financial sustainability and highlights where the major risks lie.

5 Scheme eligibility

The eligibility criteria are the main instrument available to influence how many people will be eligible for individualised support through the NDIS. It is important that these criteria are clear, aligned with the objectives of the scheme, and rigorously upheld.

When the Commission designed the national disability insurance scheme, it recommended that the eligibility for the scheme for individualised supports uphold the following principles:

- individuals should have a disability that is or is likely to be permanent, reflecting the irreversible nature of disabilities

- individuals would meet one of the following conditions:
  - have significantly reduced functioning in self-care, communication, mobility or self-management and require significant ongoing support
  - be in an early intervention group, comprising of individuals for whom there is good evidence that the intervention is safe, significantly improves outcomes and is cost effective
- individuals would meet residence and age requirements.

The eligibility criteria for the NDIS are broadly in line with what the Commission recommended in 2011, with two exceptions:

- the inclusion of supports to undertake activities of *learning or social interaction*
- the inclusion of developmental delay in the early intervention criteria (table 3).

Both these criteria allow more people to qualify for individualised supports under the NDIS than the Commission included when costing the scheme.

Adding learning or social interaction — what effect?

The Commission was unable to assess the effect of adding learning or social interaction to the eligibility criteria, because the NDIA does not collect data on which (or how many) of the six activity domains are relevant to each participant when they enter the NDIS (table 3). Speech Pathology Australia, however, said that their members who are NDIS providers are not providing services to children whose *only* disability relates to learning and literacy.

Collecting data at entry on the domains would provide information on the impact of each part of the eligibility criteria on participant numbers (and therefore scheme costs). Such information would also allow for more granular analysis of who is in the scheme and what their needs are likely to be (which could also be useful to the NDIA in its monitoring and forecasting roles). The NDIA should collect this information.

Adding developmental delay — what effect?

The evidence suggests that providing individualised supports for children with developmental delay can improve outcomes for individuals and reduce costs. It is therefore consistent with the early intervention principles of the scheme.

A review undertaken for the Department of Social Services (DSS) estimated that around 11 600 children with developmental delay or global developmental delay would be eligible for support under the scheme at a cost of $155 million each year. While no definitive data are available to test this estimate, trial site data (which may not be reflective of full scheme prevalence rates) suggest higher prevalence rates than the estimate provided to the DSS.

Table 3 **A summary of the NDIS eligibility requirements**

Age requirements	Residence requirements
Aged under 65	• Australian citizen • Permanent resident • Hold a protected special category visa
And meet either:	
Disability requirements	**Early intervention requirements**
Disability attributable to one or more: • intellectual • cognitive • neurological • sensory • physical impairments; or • an impairment attributable to a psychiatric condition; and	• Has one or more identified intellectual, cognitive, neurological, sensory or physical impairments, and likely to be **permanent**; or • Has one or more identified psychiatric conditions, and likely to be **permanent**; or • Is a child who has developmental delay; and
The impairments are, or are likely to be, **permanent**; and	The early intervention support is likely to benefit the person by **reducing the person's future needs** for supports in relation to disability; and
Impairments substantially reduce **functional capacity** or **psychosocial functioning** to undertake one or more of the following activities: • communication • social interaction • learning • mobility • self-care • self-management.	The early intervention support is likely to benefit the person by: • **mitigating or alleviating** the impact of the person's impairment on their functional capacity • **preventing the deterioration** of such functional capacity • **improving** functional capacity • strengthening the **sustainability of informal supports** available to the person, including through building the capacity of the person's carer.

For children to be eligible for individualised supports, they need to have a delay across multiple domains. This suggests that the eligibility criteria set an appropriately high hurdle. However, assessment of the functional capacity of children in the scheme suggests that the entry pathway may not be sufficiently robust, as 40 per cent of children in the scheme do not have any identified deficits compared to the normal range for their age. This points to a problem with eligibility screening, and underscores the importance of rigorous entry and exit pathways in moderating scheme costs. The development of the ECEI pathway for children to enter the scheme seeks to tighten the entry pathway for children aged 0-6 years (box 4).

Box 4 **Early Childhood Early Intervention (ECEI)**

The ECEI approach is designed to be a 'gateway' to the NDIS for children aged 0 to 6 years. It aims to ensure that only those children who meet the eligibility criteria of the NDIS become participants of the scheme. Under the ECEI approach, families meet with an early childhood intervention service provider to discuss the needs of their child. The provider then identifies appropriate supports for the child and family, and whether the supports should be provided through the NDIS or through mainstream services. As the NDIA put it, 'the ECEI approach aims to ensure children are provided with the right level of support at the right time for the right length of time'.

The ECEI approach is also aimed at ensuring early intervention supports are effective and result in the exits expected in the 0-6 years cohort. The NDIA plots a child's progress against development milestones and supports the child to access mainstream supports when NDIS supports are no longer required.

Effective entry and exit pathways?

Effective entry pathways uphold the eligibility criteria of the NDIS and allow only individuals who meet the criteria to qualify for supports. The two entry pathways for people to receive individualised supports under the NDIS are the ECEI pathway for children aged 0-6 years (box 4), and a more general pathway for people aged 7-65 years.

The ECEI approach was put in place in response to the higher than expected number of children entering the scheme in the trials.[2] The approach is designed so that children in the 0-6 years cohort requiring early intervention supports will have their needs met either through the NDIS or by other support systems.

It is too early to gauge the success of the ECEI in upholding the eligibility criteria of the NDIS and to assess its effectiveness in supporting children who are not eligible for individualised supports. However, given that children receiving early intervention supports are one of the largest participant groups in the scheme, it is critical that the NDIA builds an evidence base on early intervention to inform the types of intervention that are most beneficial and should be funded. The NDIA has developed an evaluation and monitoring framework for the ECEI approach.

Streamlined entry for early intervention

The NDIA maintains a list (List D in the latest NDIA operational guidelines) that allows for streamlined entry into early intervention supports for children who have a condition on this list. List D contains about 130 conditions, including Global Developmental Delay.

2 The NDIA is also developing an early intervention approach for the 7-14 years cohort.

Maintaining such a list represents a trade-off. The appeal of such a list is that it places less onus on families to demonstrate eligibility, reduces the administrative burden on the NDIA and provides a degree of certainty for the families of children with these conditions. However, the list can also affect incentives, and can represent an overly-generous entry gateway if set too expansively. A list can also stifle exits from the scheme. If diagnosis forms the basis of early intervention, a child would remain eligible for early intervention supports so long as their condition is present, even if the expected benefits from early intervention have been realised (or are unlikely to be realised).

The Commission is seeking feedback on the advantages and disadvantages of List D, with a view to determining whether it should continue to be a pathway for children to enter the scheme under the early intervention requirements.

Scheme exits

The NDIA has identified lower than expected exit rates as an early cost pressure. At the end of March 2017, while just under 700 participants had exited the scheme, only 10 per cent were people with early intervention plans. The NDIA should address trends in exit rates that appear inconsistent with scheme objectives.

Psychosocial disability and the NDIS

In 2011, the Commission recommended that people with psychosocial disability be supported through the NDIS. This was on the basis that:

- the day-to-day support needs for people with significant and enduring psychiatric disability are often the same as people who have an intellectual disability or an acquired brain injury
- some important parts of the care requirements of people with psychosocial disability — namely community supports — are best met through the NDIS
- providing supports to people with psychosocial disability through the NDIS provides them with the wider benefits of the scheme, including personalisation of supports to meet the needs of the individual, more choice in what supports are provided, when and by who, and greater access to early intervention supports.

These points remain salient, and lend support to people with psychosocial disability being supported through the NDIS. And, while the Commission heard a range of views about whether the NDIS is the 'right' vehicle to provide support to people with psychosocial disability, the majority of submissions to this study were supportive of its inclusion.

Concerns were also raised about the need for permanency under the NDIS Act being incompatible with the recovery models used in supporting people with psychosocial disability. However, the investment approach to the NDIS and the recovery model of mental health are both about building capacity, and appear to be well aligned.

Scheme participant numbers suggest that people with psychosocial disability are able to demonstrate that their condition is, or is likely to be, permanent. At the end of March 2017, about 5000 people with psychosocial disability received individualised supports through the NDIS. Data also indicated that 81 per cent of people with psychosocial disability who lodged an access request to the NDIS were eligible for the scheme.

The Commission does not support changing the eligibility criteria to relax the definition of permanency and how it relates to psychosocial disability.

Estimating the number of participants with psychosocial disability is difficult because a robust and comprehensive database from which to draw is lacking. However, given that a range of estimates have been prepared by a number of stakeholders and agencies, it would be beneficial for the methodology used to be made fully transparent, so that each could be assessed and considered in relation to projections of numbers of participants with psychosocial disability at full scheme.

Concerns about gaps in support for people with psychosocial disability not eligible for the NDIS are discussed in section 7.

6 Supports and plans

Scope of supports

The NDIS is designed to cover specialist disability supports that are 'reasonable and necessary'. This includes supports that help people with disability to:

- pursue their goals and maximise their independence
- live independently and be included in the community as fully participating citizens
- participate in the community and in employment.

The concept of 'reasonable and necessary supports' is not specifically defined in the NDIS Act, nor does it provide direct guidance on how to determine whether a support is a reasonable and necessary support. There is good reason for this — flexibility around what is reasonable and necessary allows participants to exercise choice and control, and to be innovative about supports.

However, what is 'reasonable and necessary' will ultimately be shaped by court and tribunal decisions over time, having regard to the legislation, rules and operational guidelines. Such decisions will affect what supports are funded and scheme costs. This is one policy lever that is outside the control of the NDIA. The Commission is seeking feedback on whether greater legislative clarity is required around whether and how the test of 'reasonable and necessary' should be applied.

About plans and the planning process

The planning process is about matching scheme participants with support packages. It involves conversations between the participant and the NDIA to ascertain, for each participant: their goals and aspirations, their level of function and an appropriate support package. The NDIS Act requires the development of a plan to, where possible, be individualised, directed by the participant, and maximise participant choice and control.

Good planning processes are essential for the long-term sustainability of the NDIS. Poor planning processes can:

- be unreliable and contribute to underutilisation of supports, undermining the predictability of scheme costs and the ability of governments to plan for the future of the scheme
- mean that participants are allocated supports that are not right for them, with the result that the benefits of the NDIS (such as increased quality of life, greater social and economic participation, and reduced need for other or future supports) are not realised
- result in greater variability in plans and outcomes for participants with similar needs, compromising equity within the scheme
- place greater stress on review processes, adding to the workload of planners and the NDIA.

Planning processes were changed in response to trial experience

In July 2016, the NDIA introduced a 'first plan process' for determining participants' support packages (box 5). The first plan process has resulted in more plans being in line with benchmark costs (compared to the trial period).

The move to transition also saw a shift from face to face to phone planning conversations (although face to face meetings can be requested). This was a decision by the NDIA to allow people to enter the scheme as quickly as possible. The decision was based on trial experience which suggested that people want to join the scheme as soon as they can, and want time to think about their goals, supports and how to use them. The NDIA's approach is that the first planning conversation is the start of a lifetime journey and plans can be adjusted and improved over time.

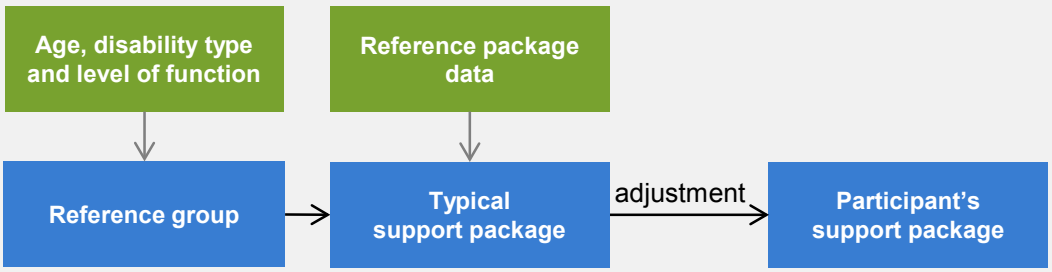
There is a lot of dissatisfaction with phone planning (box 6). The Commission heard (on numerous occasions) that participants had been called with no forewarning of the planning conversation, so the person was not prepared and could not have an advocate present. Others said that they had not known that the conversation they were having with the Agency was a planning conversation until they had received their plan.

A number of participants also said they felt rushed during their planning meetings. As one study participant put it:

> … the transition time pressures appear to have resulted in a reduction in the time available to assist people to resolve their plan; in some cases this is reported to have reduced to a 30 minute phone call. This could not be further removed from the feature of a 'person centred model of care and support' that is meant to distinguish the NDIS from previous approaches.

Box 5 How does the first plan process work in practice?

Participants are first allocated a 'typical support package', based on their reference group (which is determined by their age, disability type and level of function). The typical support package may include funding across the following eight core domains: daily activities; social participation; consumables; transport; home modifications; assistive technology; capacity building; and support coordination.



For each participant, the level of funding is adjusted according to the participant's circumstances. This is done using a questionnaire, which asks the participant about each of the domains, including what supports they already have in place, and whether these are sufficient and sustainable. For example, where it is reasonable that sustainable informal, community or mainstream supports continue to assist the participant, or where the participant believes that other informal, community or mainstream supports may provide a better outcome, funding is adjusted in the participant's support package.

The speed of transition has placed a lot of pressure on the NDIA to finalise plans quickly and phone planning conversations are seen as part of the solution. The NDIA said:

> The current process is designed to balance the need to gather sufficient information for a decision-maker to make a valid decision under the NDIS legislation, with making the process non-intrusive and convenient for the participant.

An individualised approach to planning is a key feature of the NDIS and sufficient time is required to match participants with the supports that are right for them. Phone planning conversations can mean that planners do not 'get the full picture'. For example, the living environment of participants may not be adequately reviewed (which means issues such as accessibility, safety and appropriate assistive technology can be difficult to identify).

Phone planning conversations are not appropriate for some participants, including some participants with particular accessibility requirements, mental illness, cognitive impairment and neurodegenerative diseases or people of culturally and linguistically diverse backgrounds. However, they may be adequate for others, particularly if there has been adequate pre-planning.

Box 6 Dissatisfaction with phone planning

Social Support & Precarious Workforce Research Discussion Group:

> … some participants are not fully aware that the phone conversation occurring with the NDIS staff member is actually their planning process occurring. This confusion is also evident in the NDIS marketing of phone-planning as a 'planning conversation', where the suggestion is you will 'talk-about' the plan whereas the reality is that it is a full and structured assessment and plan procedure.

The Disability Services Commissioner:

> Planners are not providing clear and accessible information about the planning process including when and how planning will take place. A sister of a participant said that someone from NDIA had rang her while she was in the car. They advised that they were 'only collecting answers' and it would 'only take a minute'. Following that conversation, her sister received a plan for approval from the NDIA, with less funds than she had previously received.

Alzheimer's Australia:

> Annie called the Parkinson's 1800 support line as she worried about an over the phone NDIS planning session that had taken place earlier that day. Annie's volume and quality of speech has been impaired due to Parkinson's and she also requires longer to respond to questions. She felt rushed and because her response is delayed she felt that the assessor didn't get a clear indication of her needs. Annie and a Parkinson's Nurse Specialist were able to take the time [to] put information together in order to apply for a review for Annie's plan.

Ethnic Communities' Council of Victoria:

> … anecdotal evidence from advocates and providers in the North Eastern Melbourne Region indicates that some participants are not being adequately informed about the purpose of phone contact by the NDIA or their LAC. These participants are having plans being completed without realising that they are engaging in the process or providing informed consent.

Blind Citizens Australia:

> [Phone planning] severely compromises the ability of people who are blind or vision impaired to demonstrate the difficulties they may face with completing tasks like reading, navigating the environment or household chores.

But the Commission considers that the pre-planning phase of the planning process has not received the attention that it requires and many participants are ill-prepared for planning conversations (which is affecting the quality of plans). The NDIA acknowledges that there has been some dissatisfaction with the way the planning process has been operating and because of the speed of the transition, it was not able to engage LAC partners in time to provide participant and community development during the pre-planning stages (and this has made the first plan process more difficult to implement).

A greater focus on pre-planning should mean that phone planning conversations will be suitable for a larger pool of participants. LACs need to be in place six months in advance in the areas in transition to assist participants with pre-planning. The Commission considers this to be a better (and likely less costly) option than trying to 'fix' plans twelve months after they are first put in place. It will also mean that participants are not only in the scheme, but are also more likely to be exercising choice and control (and this is more likely to induce a provider response).

Participants need to understand the planning process

The planning process has changed a lot since the NDIS commenced in 2013. As with all insurance-based schemes, the tools and processes for handling claims and assessing entitlements are a matter of ongoing refinement. This is necessary to ensure that the insurance scheme remains 'on track' and is viable in the long term. Dynamic processes are also important to allow the scheme to adapt to changing circumstances or incorporate information that becomes available over time.

In light of this, it is important that stakeholders can access accurate and up-to-date information about planning processes. Clear messaging about how and why things are changing is also important to maintain the credibility of evolving planning practices.

At present, the planning process is complex and confusing, and often lacks clarity and transparency. Study participants found it difficult to access information about what assessment tools the NDIA uses (including tools used for measuring level of function), and many were unsure or unaware of how the first plan process operated. In addition, limited information is publicly available to help scheme participants and their families, carers and advocates to navigate the planning system. Scheme participants are often not aware of their rights and options, such as their entitlement to request a face-to-face meeting, or have an advocate present during the planning meeting.

For many scheme participants, pre-planning support can assist them in navigating a confusing and complex system. But demand for pre-planning support services is partly driven by how accessible and complex planning processes are. There is considerable scope for the NDIA to improve transparency and clarity around planning processes. This includes providing clear and up-to-date information about what to expect during the planning conversation, when it will occur, and how the information gathered during that conversation will be used.

Planners need more disability knowledge

Planners' limited disability knowledge is an issue of real concern (box 7). Many advocacy groups said that planners do not have sufficient knowledge of particular disabilities or the impact that particular conditions have on people's lives, and they often did not know what supports would be most effective for the participant's disability. Alzheimer's Australia, for example, reported that a person with Multiple Sclerosis (MS) was asked by the LAC at a planning meeting 'How long will MS last?'

Box 7 Concerns about planners' and LACs' lack of knowledge about disabilities

MND Australia:

> LAC's do not have the expertise to support people with [motor neurone disease]. … They have no understanding of MND and the disability it creates. They attempt to plan via a telephone conversation, when speech and communication can be one of the early losses created by MND.

Alzheimer's Australia:

> Peter, the carer of a woman with younger onset dementia, felt unprepared when he and his wife attended their first NDIS planning session. … The NDIS planner had no understanding of dementia and the needs of people living with dementia and as a result the planning session focused on physical needs and solutions. As a result their first NDIS plan provided funded supports totalling $600 … Feedback from people with progressive neurodegenerative diseases has revealed that Local Area Coordinators (LACs) have also shown insufficient knowledge of their disease, the impact of that condition on their lives, the most effective service interventions and the degenerative and fatal nature of their disease.

Amaze:

> We are also concerned that participants appear to be receiving very inconsistent and at times, misleading advice, from planners and NDIA staff. The NDIA must support planners with clear policy and guidelines to provide consistent advice to participants about the planning process, criteria for supports and how plans may be implemented … Amaze's 2017 survey found: 65% of respondents rated their planner's knowledge and understanding of autism as none to moderate a level (with the remainder rating the planner's knowledge as high). … given 30% of participants identify autism as their primary diagnosis, a high level of ongoing training in autism will be a necessity to developing and maintaining their capacity to reliably develop plans.

New South Wales Government:

> … planner knowledge and capability is highly varied, as is their interpretation of reasonable and necessary supports and understanding of interim working arrangement with mainstream services. Approved supports are less likely to be based on a participant's needs and more on a planner's knowledge of the disability and / or how effectively the participant or their carer advocate for certain supports.

Planners should, at a minimum, have a general understanding about different types of disability. The Commission recommends specialised planning teams for some types of disability, such as psychosocial disability.

An alternative (or complementary) approach would involve leveraging expertise from within the industry, and getting specialist disability organisations or service providers more involved in the planning process. While this could give rise to potential conflicts of interest, these can be managed or mitigated by ensuring that such organisations have an advisory role, with final decision-making powers being exercised by an impartial planner. This approach would also mean that the NDIA would not need to compete with others in an already thin market to recruit planners with specialist qualifications or experience.

7 Boundaries and interfaces — the NDIS and services outside the scheme

People with disability, their families and carers rely on a wide range of services — including mainstream services, specialist disability services and community supports. For the NDIS to work efficiently and effectively, the interface of the scheme with these other services on which people rely must be as seamless as possible.

While the level of funding provided to the NDIS recognised that the aggregate level of funding available to people with disability was inadequate, it is also the case that the NDIS was not expected to fill *all* the service gaps that predated the scheme. The responsibility to provide services to people with disability remains a shared responsibility between all levels of government.

The interface between supports for people with disability will take time to determine at the coalface, but until those interfaces and the associated boundaries are settled it is important that governments do not withdraw from services too quickly, as any gaps that emerge will place added burdens on people with disability and their families. As the interface issues become more defined, it is essential to understand and manage the incentives that are set up where boundaries exist. Most critically, it is important that people with disability do not see the NDIS as an oasis of support, surrounded by a desert, where little or nothing is available. Should such a dynamic develop, the financial pressures on the NDIS could be unsustainable, particularly if people feel the need to test their ability to qualify for the scheme, or remain in the scheme for as long as possible, for fear of not gaining access again should the need arise.

This contrasts to the more sustainable situation where supports within the NDIS are well tailored, so that those with high needs will receive substantially more than those with low needs. The gap between participants with the lowest needs, and hence with the lowest level of supports, and those outside the scheme, should be such that there is not a large difference between the two. In such a system, people will not have an incentive to enter the scheme as their needs will be adequately met outside it, and those inside the scheme who are assisted sufficiently to no longer need individualised supports will have little incentive to stay in the scheme longer than necessary.

Clearly there is much detail yet to be worked through. Nevertheless, establishing clear and robust boundaries (and appropriately tailored supports) is an essential element to the fiscal sustainability of the NDIS, and for the surrounding network of supports. When people are accessing the services they need, the system as a whole should be providing supports at the most efficient and cost effective level.

Linking people to the right services

The Commission's 2011 report recommended a bridging and capacity building service for any person with, or affected by, a disability. The ILC program is a key component of the NDIS and has been set up to provide information, linkages and referrals to people with disability, their families and carers, with the appropriate community and mainstream supports (box 8). The focus of ILC is on community inclusion.

ILC will be important for scheme sustainability because it is expected to reduce reliance on NDIS funded support and costs over time, by reducing the demand for individualised packages and the need for supports within funded packages, as well as making supports more effective at helping people achieve their goals. Therefore, it is important that ILC is adequately funded.

ILC is still to be implemented and the funding for ILC will gradually increase over transition (from $33 million in 2016-17 to $131 million in 2019-20). The timing of ILC funding (starting with a small budget that increases over time) has prevented the NDIA investing in ILC activities and the rollout of initiatives that would allow the infrastructure of a national ILC framework. Withdrawal of existing ILC-type activities by State and Territory Governments may also have affected the supports available.

Box 8 **What role for ILC?**

In July 2015, COAG members endorsed the ILC Policy Framework. The framework describes five streams to achieve the objectives of ILC.

- Information, Linkages and Referrals — connect people with disability, their families and carers with appropriate disability, community and mainstream supports.
- Capacity building for mainstream services — ensure people with disability connect with and access mainstream supports.
- Community awareness and capacity building — support organisations (such as not-for-profit organisations, local councils, businesses) and communities to be inclusive of people with disability, and understand the needs of families and carers.
- Individual capacity building — foster the principle of choice and control, improving outcomes for people with disability, their families and carers.
- Local Area Coordination (LAC) — the development of relationships between the NDIS; people with disability; their families and carers; and the local community. The LAC's role connects across each of the streams of ILC, which include information and linkages and individual capacity building, as well as working with mainstream services and communities to better enable access and participation. Twenty per cent of LACs annual funding is for ILC activities.

It is a false economy to have too few resources for ILC activities in the transition period when it is critical to have structures in place to ensure that people eligible for the NDIS can access the scheme, and that those who are not eligible can access supports and services outside the NDIS.

Although directing additional funds to ILC in transition could crowd out state and territory 'ILC-like' activities, the grants process by which organisations receive ILC funding means that these activities can be targeted to where they are most needed. There may also be a risk of duplicating services, but the risk of service gaps appears much more likely under current arrangements, particularly as determining precisely what ILC should cover is unclear at the operational level.

It is the Commission's view that ILC funding should be increased to the full scheme amount for each year during the transition to allow for an accelerated national rollout of ILC activities. The additional funding should come from the NDIA's program delivery budget.

The effectiveness of the ILC program in improving the outcomes for people with disability and its impact on the sustainability of the NDIS should be reviewed as part of the 2023 review of NDIS costs when data on ILC activities is available. In the interim, there should be much greater transparency about the specific programs that are being funded as ILC activities by each jurisdiction over the transition and at full scheme. The ILC budget should be maintained at a minimum of the full scheme amount each year until results from this review are available.

Interface with mainstream services is not clear at an operational level

The Australian Government has entered into Bilateral Agreements with State and Territory Governments to delineate the types of services to be provided and funded by the NDIS and mainstream services. Schedule 1 of the *National Disability Insurance Scheme Rules (Supports for Participants) 2013* (Cwlth) sets out the rules to determine whether the scheme or another system is more appropriate to fund the specific supports for individuals.

COAG has accountability for the NDIS and the *National Disability Strategy,* and through its Disability Reform Council (DRC), receives reports and advice on progress and risks. While the principles agreed to by COAG on the boundaries between the NDIS and mainstream services are relatively clear, greater clarity is required at the operational level.

The boundary issues are yet to be tested. However, the NDIA reports some instances of possible cost-shifting, scope creep and service gaps, including:

- providers trying to extend the amount of therapeutic (health) interventions through use of NDIS funding
- reports that mainstream services are refusing entry to people who are likely to be eligible for the NDIS
- issues around a lack of accessible public transport options, particularly in regional, rural and remote areas, which means NDIS participants seek transport funding through the NDIS despite having the capacity to travel independently.

The current arrangements under the *National Disability Strategy* should be strengthened to include more detail around boundaries (based on challenges faced when seeking to operationalise boundaries), and greater accountability. This could be achieved through review points of National Agreements and National Partnership Agreements under the Federal Financial Relations Intergovernmental Agreements by setting out specific commitments, key performance targets and outcomes. As the DSS said:

> Translating the National Disability Strategy into tangible results for people with disability, their families and carers is a major factor in successful implementation of the NDIS.

Adding a standing item to the agenda of each COAG council that is responsible for any services which interface with the NDIS to discuss any gaps in service provision would also help build clarity around what services governments will provide and ensure ongoing monitoring and solutions for potential future gaps.

Concerns that some people with disability may be left without services

Many are concerned that, as disability support programs are rolled into the NDIS, people using these services (including those not eligible for the NDIS) may no longer receive continuity in support. This is a key risk to the financial sustainability of the NDIS — and one that the NDIA has little control over.

Mental health services are an area of particular concern. The National Mental Health Commission's report on Mental Health Programs and Services estimated that about 700 000 Australians experience a severe mental illness in any one year. However, according to the NDIA, only around 64 000 people with psychosocial disability are expected to be eligible for individual packages in the NDIS.

Clearly, there needs to be support for people with mental health illnesses outside of the scheme — a responsibility that remains (largely) with State and Territory Governments. However, governments have been withdrawing their funding for a number of mental health support programs in their jurisdictions and using this funding to offset part of their contribution to the NDIS. At this stage, it is unclear what supports will be available for people with a mental illness who do not meet the NDIS eligibility criteria and this should be clarified as a matter of urgency.

The implications of this are significant. Not only is this uncertainty distressing for those with mental illness, any gap in support would place an additional call on the generosity of informal support. Gaps could place another pressure on the financial sustainability of the NDIS should it encourage scope creep, or force those who are unlikely to meet the eligibility criteria to test their access for fear of having few supports should they not qualify for the scheme. Mental health and psychosocial disability have been made a key priority of the DRC, but more clarity is required.

While the Australian and State and Territory Governments have agreed to provide continuity of support for disability services outside the NDIS, in practice there is confusion

and uncertainty about what services will continue to be provided and/or funded. Governments need to be clearer about how they will approach continuity of care, and in particular about what disability services they will continue to provide for people who are not eligible for the NDIS.

Gaps in disability services need to be quickly identified (possibly with the assistance of ILC and LACs) and managed, to ensure the sustainability of the overall scheme. The NDIA should report, as part of the quarterly COAG DRC report, on boundary issues. There should also be mandatory public reporting by all governments on the number of people covered by disability programs pre- and post-NDIS, and it should cover all disability services — that is, those within and outside the responsibility of the NDIS.

The National Injury Insurance Scheme

In 2011, the Commission recommended a National Injury Insurance Scheme (NIIS) that would operate in parallel to the NDIS. The scheme was to cover the care costs of people who acquired severe disabilities through catastrophic accidents. The Commission also recommended that the NIIS be in full operation before the full rollout of the NDIS.

The NIIS is only partially implemented, with the motor vehicle and workplace accident streams effectively operating, but the medical and general accident streams still to be implemented. This means that some people who would be expected to have their needs met through NIIS will instead need to have them met by the NDIS.

In principle, states and territories should bear the consequential NDIS costs if the NIIS remains only partially implemented for an extended period. The Commission is seeking feedback on a mechanism to ensure that the States and Territories bear the cost of NDIS participants who were intended to be covered by the NIIS.

8 Market readiness

The market-based approach of the NDIS means that there will be significant changes in the way that supports are demanded by and provided to, participants. This disruption of the disability services market is designed to maximise the choice and control of participants, while also providing incentives to providers to efficiently and effectively deliver the supports that participants want and need (table 4).

While efficiencies are likely to be driven by the scheme, the increase in funding and considerable unmet need in the disability support sector means that the number of workers and providers will need to grow quickly over the transition period. For example, the NDIS workforce will need to more than double from 2014-15 to 2019-20, and the number of NDIS providers will need to increase by between four- and ten-fold.

Table 4 **Intended effects of the NDIS in the disability services market**

Features of Disability Services Market pre-NDIS	*Features of a Mature Disability Services Market*
• Largely 'block funded', with funding provided in advance of service delivery and little freedom to innovate.[a]	• Predominantly fee-for-service paid on invoice. In principle, prices for services are set by the competitive market, and there is innovation by service providers seeking to attract and retain consumers.
• Services often limited and priorities for families in immediate crisis, rather than for early intervention. Consumers have little control over the services they receive and limited choice of provider.	• Funding to meet the reasonable and necessary support needs of each NDIS participant. Consumers have choice and control regarding the services received and providers used.
• The primary relationship is between the service provider and the funder, with consumers often described as 'passive' recipients of services.	• The primary relationship is between the consumer and service provider. Intermediaries and access to information about provider quality, performance and pricing help consumers exercise choice.
• Providers are subject to various statutory provisions (at all levels of government) regarding quality. The system is complex, difficult to navigate and not well integrated nationally.	• Compliance with a national quality framework. A nationally consistent and navigable system.
• High transaction costs for both consumers and service providers.	• Lower transaction costs for consumers and service providers. There is adequate depth and resilience in the market to underpin financial sustainability.

[a] Block funding refers to the process where governments purchase a 'block' of services from a provider, which is to be delivered to clients who meet certain criteria, or are referred to those providers as part of an individualised plan.

As the success of the NDIS relies on the timely provision of the right supports to participants, the readiness of the market will affect the trend in costs during transition and beyond. The following sections look at the readiness of disability support providers, the workforce, and participants.

Providers face challenges to be ready for the NDIS

To meet the needs of NDIS participants, there needs to be an increase in the quantity, quality, range and responsiveness of disability supports supplied. But as noted by House With No Steps, the disability support market is not a typical market.

> The disability support 'market' is not a normal or 'perfect' market in classical economic terms. It is about providing a range of customised supports, human and technological, paid and unpaid, to meet complex and often poorly-defined human needs and wants. Outcomes are often hard to measure and report. Information is unbalanced. Regional, rural and remote markets are 'thin'. The 'buyers' of services and their local situations are diverse and heterogeneous, not homogeneous. Many are vulnerable.

In making the transition to a market-based system for disability support services, providers are facing the prospect of workforce shortages and coming to grips with operating in a

market that will, for some time, be characterised by price caps. The best ways to service thin markets will also need to be considered in the new environment.

Prices are important for market development and participant outcomes

In a mature market, the choice and control that participants exercise will increasingly drive the price of disability supports. In turn, these prices will drive providers to supply the supports that participants most value, and encourage competition and innovation among providers to efficiently deliver those supports. Allowing the market to determine the price of supports is an important tenet of the NDIS, as it will contribute to both participant outcomes and the financial sustainability of the scheme.

However, prices are currently regulated (box 9). The NDIA currently sets maximum prices ('price caps') for many of the supports provided by NDIA-registered providers to:

- ensure value for money for participants — as the price of supports may be bid up too quickly before the sector grows sufficiently to meet the increased demand
- encourage the market supply of disability supports.

Box 9 Why regulate the price of disability supports?

Governments have historically regulated the price of human services, including disability care and support services, on the grounds of equity and efficiency. Without appropriate price regulation, the provision and use of disability services may be below socially optimal levels for a number of reasons, including abuse of market power arising from a lack of competition.

The simplest example is that there may be too few providers in a market for there to be competition. This is a real risk in the market for disability supports. For example, early data indicate a market concentration of more than 80 per cent in some disability service sub-markets. If prices are not regulated, this may result in limited access to services for some disadvantaged groups over the transition period.

This was recognised by the Commission in 2011, who recommended that an early — but temporary — task for the NDIA was to set efficient prices to allow providers to recover the costs of service provision (including adequate returns for capital investment), and in turn, ensure the supply of disability supports. But price regulation should not persist unnecessarily, have excessive scope, nor shape the market — such as by benefiting some providers or participants over others.

In practice, the NDIA must balance these two objectives. Setting prices too high may induce greater supply in the market, but reduce the purchasing power of participants. Setting prices too low may ensure lower costs, but may lead to shortages of particular supports. Striking the right balance is difficult.

Some existing providers — who would benefit from an increase in price caps — argued that some price caps are too low to provide quality supports. In turn, the NDIA stated that existing providers — many of whom relied on block funding previously — may be finding

it difficult to adjust to the fee-for-service model. Given that the NDIA's most recent price review has only just concluded (with new prices to take effect on 1 July 2017), the Commission has made no findings or recommendations about the adequacy of those prices.

However, there is a potential conflict of interest with the NDIA setting prices and also being responsible for the financial sustainability of the scheme. This is a structural issue in the design of the scheme that needs to be addressed, as the mere perception of a conflict is sufficient to disrupt the transition to price deregulation.

Mindful of the immediate and significant challenges being managed by the NDIA, the Commission proposes moving towards the deregulation of prices in three stages. The first stage is to immediately introduce an independent price monitor with responsibilities including to:

- examine how the market is responding to prices set by the NDIA
- review the NDIA's price caps based on the available evidence, including comparing NDIA's price caps to other care sectors (such as aged care)
- report publicly on its assessment of the NDIA's price controls with regard to market development and participant outcomes.

The independent price monitor would improve transparency around how price caps are set, and in turn, lead to greater accountability and thereby confidence to participants, providers and the wider community. It should be put in place immediately to serve as a 'check and balance' on the NDIA's pricing over the crucial transition period.

The second stage is to shift the NDIA's price-setting powers to a regulator that is an independent statutory authority — an approach consistent with the evolution of other markets for consumer-directed care, such as the aged care sector. Such a move would allow the NDIA to focus on its core responsibilities of delivering and administering the NDIS, remove the potential conflict of interest, and provide ongoing independence and transparency of price regulation.

The body tasked with price regulation (including the NDIA while it remains the price regulator) should, among other things:

- collect data and publicly report on providers' characteristics and costs
- communicate with disability support providers, participants and the NDIA to transparently set prices at regular intervals, with sufficient time for providers to phase in price changes
- periodically review its price model for transitional and efficient prices in a transparent and comprehensive manner
- send more granular and targeted price signals — that is, provide prices by supports at the state and territory level, with an expectation that price signals could be set at a more disaggregated regional level where possible

- assess and recommend — on the basis of transparent consultation and evidence — when prices for particular NDIS supports in each region should be deregulated, and evaluate whether there remains a need for price controls. To enable efficiencies to be driven by the market wherever possible, the price regulator should presume that it is appropriate for prices to be deregulated — that is, to only have price controls when there is clear evidence that unregulated prices are likely to lead to inflation that would harm participants.

At this time, the Commission envisions that the independent price monitor would be best placed to take over these pricing powers, as it would have developed the knowledge and expertise necessary to understand the disability support market.

The third and final stage of deregulation occurs when the price of a given disability support has been deregulated, but is still subject to subsequent monitoring. The independent price monitor would maintain an ongoing watch on pricing, collect data, and publicly report on emerging market issues that affect the purchasing power of scheme participants.

A key question is when the NDIA's pricing powers should be transferred to an independent price regulator. There appears to be broad consensus among many (including the NDIA, the DSS and the Australian National Audit Office) that price controls are likely to be needed for the foreseeable future. Given the potential conflict of interest that the NDIA faces in setting prices, the need for price regulation to persist over coming years, and the imminent significant increase in participants, the Commission's view is that the price regulation powers should be transferred to the independent body by 1 July 2019.

Thin markets need more attention

When creating a new market for disability supports, there is a risk that, in some areas, or for some types of supports, the market (the number of providers or participants) will be too small to support the competitive provision of services ('thin market'). Thin markets are not new — they have been, and will continue to be, a persistent feature of the disability sector, even under the NDIS.

In the absence of government intervention, there may be greater shortages, less competition, and poorer outcomes for participants in thin markets. Participants at most risk are those who:

- live in outer regional, remote or very remote areas
- have complex, specialised or high intensity needs, or very challenging behaviours
- are from culturally and linguistically diverse backgrounds
- are Aboriginal and Torres Strait Islander Australians
- have an acute and immediate need (crisis care and accommodation).

A more considered and timely approach is needed to address access issues in thin markets. More flexible funding, service delivery and other measures tailored to the specific circumstances are needed. Block-funding may continue to play a role, as well as provider of last resort arrangements. Regardless of the approach chosen, there is a need for: transparent reporting and evaluation of thin market arrangements; strong market stewardship; and collaboration between the Commonwealth and the State and Territory Governments.

The Commission is seeking feedback on when particular measures should be used to provide services in thin markets, when provider of last resort arrangements should be used, and any other information on ways to address thin markets.

The workforce is not growing fast enough

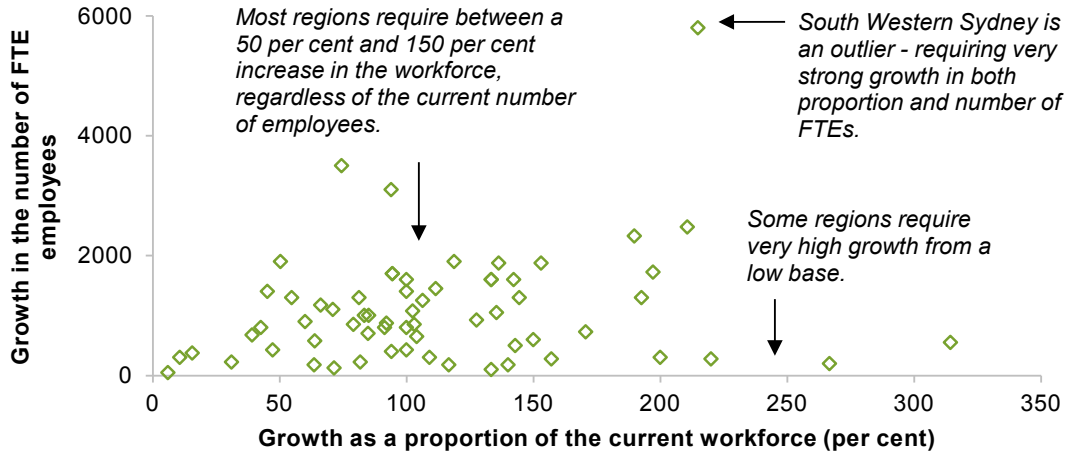
As the NDIS provides more individualised supports for people with disability, the workforce needed to provide those supports will not only need to increase, but also become more diverse. While precise estimates of the size of the necessary workforce differ, there is broad consensus that the number of full-time equivalent positions will need to roughly double over the three year transition period. At a more local level, some regions will need to expand their workforce only marginally, while others will need to more than double (figure 6).

Three policy changes are recommended to mitigate the potential workforce shortage over the short term:

- Meeting the desires of many existing workers — who are more qualified and experienced, and usually work part-time — to work additional hours. While in some cases this may not expand the *effective* workforce (especially given that many participants need care at particular hours of the day), this approach will provide more scope for 'on-the-job' training and mentoring of new staff to expand the overall workforce more quickly.
- Temporarily relaxing the restrictions on NDIA payments to informal carers to encourage them to provide more care over the transition period. This involves removing the restriction that paid informal carers must not live at the same residence as the participant, which is an obstacle to providing care for those in rural and remote areas. Such payments will need to be monitored closely, and their scope reduced as the workforce develops.
- Allowing for skilled migration where residual shortages remain persistent — especially in the case where allied health professionals may be lacking in particular regions. It remains to be seen how recently announced changes to skilled migration visas will affect labour supply for the NDIS.

Figure 6 **Variation in growth required in different regions[a]**

Each dot represents the growth in the amount of full-time equivalent (FTE) employees needed relative to the current situation, both in terms of the number and proportion, between 2015-16 and 2019-20.



[a] The NDIA's market position statements provide 'low and high' estimates for the number of FTE disability workers at present and what will be needed in the future. To derive these estimates for growth, the midpoints of each range are used. No data available for Western Australia. Regions are areas consisting of several local government areas.

Building the workforce is a long-term exercise

While these measures will help to address workforce shortages in the transition period, more attention also needs to be paid to the longer-term development of the workforce.

The responsibility for workforce development is currently shared jointly between the DSS and the NDIA — with the former having 'oversight' of workforce development and the NDIA allocated the task of 'market steward'. The COAG DRC also plays a role in workforce development issues, along with the relevant State and Territory Government departments.

The fragmented landscape of roles and responsibilities is understandable given the breadth and reach of the scheme, and the speed of implementation. The risk is that a fragmented workforce policy may lead to duplication or unnecessary programs at a time when the scheme can least afford it.

The Commission considers that a 'big tent' approach to workforce development remains appropriate, but that the roles and responsibilities of different parties should be clarified further and made public.

- State and Territory governments should have more responsibility for workforce development issues over the transition period, as they have the best experience of

where there has been historically unmet need and which approaches may be best suited to solve such issues in particular jurisdictions.

- The Australian Government should retain oversight of the scheme and focus on areas such as tertiary education and immigration, and how increased demand affects and interacts with other caring sectors, in particular aged care.
- The NDIA is best placed to provide more information to Australian Governments in the form of actuarial and scheme data collected to provide more granular detail on where supply gaps are emerging, or likely to emerge.
- Providers should also have a means to have a greater say in emerging workforce policy issues, such as where the incentives of the scheme may interact with other laws and regulations, like minimum standards, conditions of State and Commonwealth awards, and training and development.

Over the long term, the workforce development responsibilities of State and Territory Governments will diminish as the NDIS fully rolls out and supplants their existing disability support programs. However, State and Territory Governments should remain 'in the tent' when it comes to workforce policymaking given the interaction between the NDIS and other mainstream services.

Building the evidence base is also important

Existing data on the size and scope of disability care workers and the organisations they are employed by are poor, and not commensurate with the importance of the NDIS. This was acknowledged by many study participants, including the DSS (the agency currently tasked with market development oversight), who said that 'a significant limitation to assessing the NDIS market readiness is the availability of market and workforce data'.

Given the size of the scheme, and its importance to participants, the NDIS needs an evidence base about the providers and workforce who deliver supports. To remedy this deficiency, the Australian Government should fund the collection of more fit-for-purpose data by the Australian Bureau of Statistics and the university sector.

Participants need help to make the most of the NDIS

The NDIS is about giving participants more choice and control over their supports. While some participants will be ready to manage and work with the NDIS to implement their plans, others will be less so, and may find it difficult to get the most out of the scheme. This in turn will reduce the overall benefits and financial sustainability of the scheme.

How ready participants are to make the most of their plan will depend on a number of factors, including: an individual's capacity; their network of informal carers and peers; the assistance provided under the NDIS; how ready the market is to provide supports; and the

complexity of the scheme. As participants spend more time in the NDIS, there will also be some degree of 'learning by doing'.

However, some scheme participants are finding the NDIS hard to understand and interact with, particularly because the scheme is a new way of allocating and supplying disability supports. Some transitional issues are also making it harder for participants.

The NDIS provides some assistance to participants to implement their plans, including through support coordination (the key means to bolster the readiness of participants with complex needs). The Commission is seeking feedback on possible improvements to support coordination and complementary actions that may make support coordination more efficient.

Other groups can also help participants navigate the NDIS and access the supports that they need, such as:

- peer support groups and disability support organisations, who can provide participants and their families with information on how best to find and secure disability supports
- advocacy groups, who may be able to help participants find supports. They can also provide systemic feedback to the NDIA and Governments about the difficulties that participants may face in accessing supports within their plans.
- intermediaries, who can provide tailored supports to participants, including helping to pay providers and hiring workers.

Each of these groups play an important role in helping participants and their families to be ready for the NDIS. Intermediaries, in particular, can assist those who may struggle to deal with the administrative burden of managing their own affairs (while allowing participants to retain choice and control), and reduce scheme costs by aggregating participants' purchases of common supports. The Commission is seeking feedback on the role of intermediaries and disability support organisations within the NDIS.

While finding ways to bolster readiness is important, a complementary approach is to reduce the complexity of the scheme. One way is for the NDIA to implement its proposed eMarketPlace — an online platform that, among other things, is designed to provide participants with timely information on the number, quality and past performance of providers. This would make it easier for participants to find the supports that they need at a time when many are finding it difficult to identify and engage with providers.

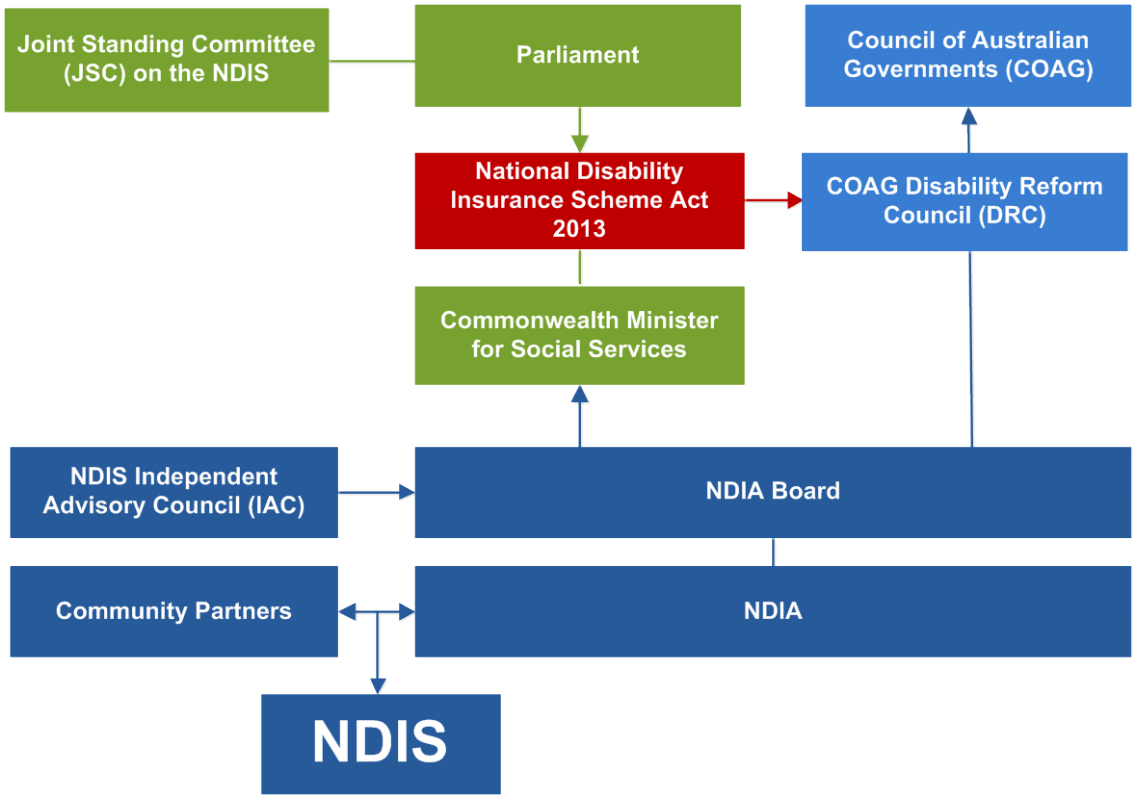
9 Governance

The governance arrangements for the NDIS are complex and reflect the shared responsibility of the scheme between the Australian and State and Territory Governments (figure 7). While the NDIS is administered by an Australian Government Authority (the NDIA) under Commonwealth legislation and under the direction of an Australian

Government Minister, it is designed and funded by the Australian, State and Territory Governments.

The NDIA is governed by a Board, which is appointed by the Minister for Social Services in consultation with State and Territory Governments. The Board is responsible for managing risk and setting the strategic direction of the NDIA. It is also responsible for monitoring and reporting on the performance of the Agency. The NDIA Board was expanded from 1 January 2017 by the Australian Government with the aim to ensure it has the disability service, financial management, corporate governance and insurance-based expertise needed to guide it through its critical three year expansion to 2019-20.

Figure 7 **Summary of NDIS governance arrangements**



In 2011, the Commission recommended a single national scheme, and a single national agency, to provide disability care and support. All states and territories, except Western Australia, joined the national scheme. In 2017, the Australian Government and Western Australian Government signed a bilateral agreement for the implementation of the WA NDIS. Under the agreement, the WA NDIS (intended to be consistent with the NDIS) will be administered by the Western Australian Government, not the NDIA. The Commission considers Western Australia should be in the national NDIS. That said, given the concerns about the transition timetable, Western Australia could delay joining the national scheme until after 2019-20.

Lack of transparency and clarity

Clear and transparent governance arrangements for the NDIS are crucial, especially given the scale and complexity of this reform. Effective governance is also essential for ensuring accountability and trust in the scheme.

The high-level governance arrangements generally provide a strong foundation for the development of the NDIS, including in relation to managing scheme costs and sustainability, but they lack clarity and transparency in some key areas. This includes, for example, confusion over the role of LACs, how the NDIS interfaces with mainstream services, the continuity of care arrangements of State and Territory Governments, and the planning process.

It is important that governments and the NDIA work to strengthen the clarity and transparency of governance arrangements and processes. The Commission has made recommendations with this aim.

Australian Government responsibility for NDIS

In 2011, the Commission recommended that the Australian Government Treasurer should be responsible for the NDIS because of the proposed commercial focus of the NDIA, and the need to ensure strong cost controls, insurance characteristics, long-run sustainability and appropriate management of funds. The Commission also envisaged other ministers, such as the Minister for Social Services, playing a prominent role in disability policy.

However, primary responsibility for the NDIS was given to the Minister for Social Services. While the Commission does not recommend a change to the current arrangements (given that stability is important amidst the pace and extent of reform), it is important that the governance supporting the NDIS is akin to that of an insurance scheme and it is not managed as a welfare program.

NDIS rules

Under the current governance arrangements, the states and territories play a significant role in setting NDIS policy. For example, while the Minister for Social Services is responsible for creating NDIS Rules, in many cases these rules require unanimous agreement from the Australian Government and each host jurisdiction.

There have been cases where NDIS rules have taken considerable time to implement, including the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* (Cwlth), which is reported to have taken at least eight months. This is a significant period of time in a transition period of three years.

The benefits of requiring agreement from all jurisdictions to implement many NDIS rules needs to be balanced against the need for the NDIS to be agile and able to adapt to emerging risks, especially during the transition, to ensure the financial sustainability of the scheme. The requirement for unanimous agreement from the Australian Government and all host jurisdictions for changes to some rules should be relaxed. There is also a need to align the governance and risk-sharing arrangements (discussed below).

Review processes

There are review processes both internal and external to the NDIA. Concerns were raised about the review processes, including that: there is confusion about the distinction between a plan review and a review of a decision; the information provided about the review processes is inadequate and the review processes are not accessible; and the time taken for reviews can vary drastically and can be significant.

The NDIA and governments are taking steps to improve review processes. However, publicly reporting on reviews, including on the numbers of reviews, review timeframes, outcomes of reviews, and participant satisfaction with the review process, would improve clarity, transparency and accountability around the effectiveness of the review process.

Review processes can also influence costs, both by the number of internal reviews undertaken and external reviews resulting in changes to eligibility or supports provided. For internal reviews, it is important that issues with the planning process that are resulting in increased numbers of plan reviews are addressed. The NDIA should adopt a process for amending or adjusting plans without triggering a full plan review to reduce costs and time delays associated with plan reviews.

For external reviews, it is essential that where such reviews lead to significant impacts on scheme sustainability that mechanisms are available to swiftly respond. The Commission is seeking more information on what is required in this regard.

Monitoring the performance of the NDIS

Performance reporting is important for ensuring outcomes are realised and that there is accountability when they are not. It is also an important component of the insurance approach. Effective performance reporting involves timely and transparent reporting of output and outcome indicators that measure performance against the objectives of the scheme.

The performance of the NDIS is currently monitored and reported through a number of mechanisms and reports, the main one being the *Integrated National Disability Insurance Scheme Performance Reporting Framework*. This framework includes the measures and indicators of scheme performance that the NDIA is required to report against to the COAG DRC and information the NDIA is required to provide to jurisdictions.

While the NDIA is still developing its performance reporting (which makes it too early to determine whether the performance reporting is sufficient to shed light on scheme objectives), the Commission has identified some gaps in the framework and the performance reporting against this framework. There is limited reporting against the outcomes indicators. And, there are few indicators for mainstream services, ILC and LACs. Given the importance of understanding the interaction between the NDIS and mainstream services, and the critical role that ILC and LACs play in the scheme, data on these activities should be an important component of reporting on the NDIS performance.

The performance reporting framework also does not have a strong enough focus on reporting on quality, including the quality of participants' plans. Over time, as reporting on outcomes under the reporting framework develops, evidence of good outcomes will be evidence of good quality plans, processes and experiences. However, it could be many years until this outcomes reporting is of a sufficient standard. Until then, reporting on quality is needed.

10 Funding

To ensure that the integrity of the NDIS' objectives are maintained, the scheme needs to be funded so that it operates in a way that is consistent with an insurance scheme, rather than a welfare program. It is also important that the way the funding mechanisms are designed create good incentives for appropriate allocation of responsibility between the Australian and State and Territory Governments to act in the long-term best interests of Australians with disability requiring services provided by the NDIS, and by mainstream and other disability services.

In 2011, the Commission recommended that the Australian Government fully fund the NDIS from general revenue (because of an absence of reliable growth in taxes at the State and Territory level). However, the scheme has been implemented with funding from Australian, State and Territory Governments governed by a range of Bilateral Agreements that are to be revisited every five years.

Escalation parameters

People covered by insurance schemes are generally required to contribute premiums in exchange for having their risk covered. For the NDIS, the Australian and State and Territory Governments make these contributions using taxation revenue.

At full scheme, the State and Territory Governments will contribute a combined $10.3 billion each year to the NDIS (the transition period has separate funding arrangements). The current Bilateral Agreements between the Australian Government and the States and Territory Governments require that these contributions increase by

3.5 per cent each year (the 'escalation parameters') until 2023, subject to the outcomes from this study.

The current escalation parameters are based on the long-term annual projections of the consumer price index of 2.5 per cent and a net population growth rate of 1 per cent. If the objective of the escalation parameters is to maintain the real per capita contributions to the NDIS from the States and Territories, they should be based on the best available estimates of inflation and population growth for the period of the agreement, at the time of making the agreement. The 3.5 per cent currently specified in Bilateral Agreements is at the lower bound of a range that would be expected to keep real per capita contributions from the states and territories constant over time.

However, if scheme costs were to rise faster than the current escalation parameters (for example, because of greater than expected increases in wages or prevalence rates of disability), the proportion of funding by the Australian Government would increase relative to that of the states and territories over time (in the absence of any other mechanisms being applied).

An alternative way to set escalation parameters would be to explicitly link them to scheme costs so that the proportion of funding allocated to the Australian Government and the State and Territory Governments is maintained over time. The Commission seeks further views on the appropriate role of escalation parameters.

Flexibility of funding

For the NDIS to operate as an insurance scheme, the NDIA needs to have the capacity to manage the lifetime risk of participant costs — for example, by making large upfront investments to yield future cost savings. This requires more funding flexibility than is allowed under the existing 'pay as you go' approach (which effectively operates on a cash reimbursement basis, much like a welfare program).

The NDIA will have a capped operational budget of 7 per cent of total package costs each year at full scheme. While acknowledging the need to constrain administrative expenditure, the Commission considers that a target range of 7 to 10 per cent of package costs would be more appropriate given the insurance approach, as constraining the operating budget within a particular year could undermine the objectives of the scheme.

The NDIA called for increased flexibility around the use of funding currently exclusively allocated to program delivery to better manage risks in accordance with insurance principles. However, the Commission's preferred option, in the longer-term, is to provide the NDIA with a pool of reserves (as recommended by the Commission in 2011). A pool of reserves would enable the NDIA to operate the scheme more like an insurance scheme, which could facilitate a cultural and operational shift within the Agency. It could also result in improved lifetime outcomes for participants and provide assurance to the community that the scheme is insulated (to some extent) from the vagaries of the budget

cycle. The Commission is seeking feedback on how this could be achieved, and what level of reserves would be required.

Creating the right incentives

The allocation of funding responsibility between the Australian and State and Territory Governments needs to be designed to create the right incentives. Importantly, funding cost overruns should be based on good risk management principles — that is, risks should be allocated based on who is best able to manage them. Under the funding arrangements during the transition, the Australian Government is responsible for all cost overruns of the NDIS, but there are a number of potential cost drivers that are in the control of the State and Territory Governments. For example:

- State and Territory Governments' funding and management of mainstream services can impact on scheme costs
- State and Territory Governments provide the majority of 'in-kind' contributions, which can drive up scheme costs and limit participant choice
- State and Territory Governments have a key governance role in the scheme — unanimous support is needed to change the NDIA Board or many of the NDIS Rules, or to direct the NDIA to take specific action, which gives them leverage over cost mitigation tools.

This creates a disconnect between the Australian Government's ability to control costs and the liability for cost overruns. There are two options available to address this at full scheme.

- The responsibility for funding cost overruns could be reallocated between the Australian and State and Territory Governments based on their ability to manage cost overruns. Determining what these should be is not straightforward (allocations of between 25 and 50 per cent of the cost overruns to the State and Territory Governments were suggested to the Commission by some stakeholders. The Bilateral Agreements currently state that the Commonwealth will accept at least 75 per cent of the cost overruns at full scheme.)
- Adjust the governance arrangements to allow the Australian Government to manage a greater proportion of the risk of the cost overruns in line with their greater responsibility for funding these overruns.

More information is requested given that these options are not necessarily mutually exclusive.

In-kind services

The Australian, State and Territory Governments are also able to provide in-kind services (that is, they can transfer already funded disability services to be used by NDIS participants) to the NDIA in lieu of cash contributions towards their NDIS funding commitments. In practice, what this means is that supports in individual participant's plans are described specifically as having to be provided by a particular provider (that is, the provider engaged through the in-kind arrangement).

In-kind contributions are estimated to account for about 19 per cent of total NDIS package costs during transition, and are expected to fall to about 10 per cent in 2020-21. While all governments are reviewing their in-kind contributions on an ongoing basis (with the intention of minimising in-kind contributions in full scheme), there is still some uncertainty around the quantum and scope of in-kind contributions at full scheme. The Commission recommends that all in-kind funding of supports be phased out by the end of the transition. Governments should not continue to make such costly contributions without any requirement to provide additional resources to balance the adverse impacts that such contributions have on financial sustainability, and participant choice and control.

11 Summing it all up

While the issues described above may seem considerable, it is important to consider them in the context of the scale, pace and complexity of the NDIS reform. It will take time to get things right. It is this need for more time that makes the roll out timetable such a key focus for addressing the many and considerable risks identified in this report.

The rollout timetable

As highlighted throughout this position paper, the ambitious timetable for the rollout presents an immediate risk to the success and financial sustainability of the scheme. The speed of the rollout has:

- compromised the quality of plans
- implications for the development of other parts of the scheme, especially the disability care workforce, which is unlikely to be sufficiently developed by 2020 to deliver the supports the NDIA is expected to allocate
- imposed challenging timeframes on the development of important structural elements of the scheme — including details around responsibilities at the coalface in services like health and transport, and instituting the new Quality and Safeguarding Framework.

Some study participants argued that the scheme rollout should be slowed down (box 10). For example, the Mental Health Community Coalition of the ACT argued that slowing

down the implementation of the NDIS would mean that you could 'replace costly mistakes with getting it right in the first place'.

Box 10 **Some argued for a slowdown of the transition timetable**

Cerebral Palsy Alliance:

> We would strongly recommend that the Commonwealth and States revise the transition timetable to support a realistic and manageable change management process for all stakeholders — as per NSW Bilateral Agreement Management of Risk Clauses 48-51 — if the risk of market, sector and system readiness to transition emerges — changes to the participant phasing schedule may be considered by both parties.

David Parkin:

> The rollout to new areas needs to be slowed. Get the current system as right as it can be. There are enough participants now … who are actually using the system to understand where the effort needs to be applied. The NDIS has to listen to people and Providers.

Australian Lawyers Alliance:

> One important response to the challenges ought in our view to be a reconsideration of the rollout schedule. As at the date of this submission, the rollout is less than nine months old, yet the level of dissatisfaction with the scheme, and the clarity with which problems are being identified, are both rapidly escalating.

Australian Physiotherapy Association:

> Our members are concerned that the balance between the speed of the roll-out and its effectiveness needs to be changed, and the roll-out slowed so that the NDIS can properly train its team, manage its workload and provide consistent support to the regions in which the roll-out is occurring.
>
> Alternatively, the financing of the Scheme needs to be adjusted to address the substantial implementation costs.

Maurice Blackburn Lawyers:

> A prudent approach would be to consider a slower roll-out schedule to help minimise the risks associated with the introduction of the scheme. … A revised rollout schedule could involve a complete cessation of the rollout on a regional basis for a specified period, to enable the remedial work to be undertaken, and a fresh analysis of readiness after that period.
>
> Aside from managing financial risks, a roll-out over an extended period would avoid significant frustration and distress for those living with disabilities and their families, and allow lessons learned from the early results to be incorporated into the scheme's final design.

However, others argued that the rollout schedule should not be changed. For example, the Australian Federation of Disability Organisations said:

> Some in the sector have responded by arguing for a slow down [to] the roll out and to lengthen the transition period. To AFDO and its members, this would be completely unacceptable. For many people with disability, the wait has already been too long. For people who have had little or no support for many years, the NDIS cannot come quickly enough. Slowing down the roll out is therefore not an option.

The Commission acknowledges the hardship that has been imposed on some people with disability under the pre-NDIS arrangements. Given the problems under the current rollout schedule, however, it may be in the interests of people with disability to slow down the

rollout timetable with the objective of securing for them the NDIS's ultimate success and sustainability.

The rollout timetable is tied to the schedules set out in the Bilateral Agreements. Given that the numbers of scheme participants in the Bilateral Agreements are estimates and not hard targets, there may already exist some flexibility for the NDIA to slow down the pace of the rollout should that be required. However, any slowdown would have implications for scheme funding arrangements and the disability services provided by the states and territories. These matters would need to be careful addressed should a slowdown be implemented.

The NDIA is aware of the current problems …

The NDIA acknowledges that the scale of the participant intake has affected the quality of participants' and providers' experiences. The NDIA has been working with participants, providers, peak disability bodies and other stakeholders to identify changes or improvements required to achieve:

- the intake of participants at the rate required by the Bilateral Agreements
- plans that maximise choice and control for participants, and contribute to improved participant outcomes
- plans that are of a high quality
- plans that are financially sustainable so that the aggregate value of all plans remains within the funding envelope.

While the NDIA's proposed new approach is yet to be tested with participants and providers, at this stage the Agency plans to have a greater focus on outcomes, more active involvement with communities, more face-to-face communications, and improved interaction with providers and disability organisations. The NDIA also plans to make improvements to its call centre and portal to make it easier to navigate.

The Commission appreciates that it will take time to implement the changes and for the changes to be reflected in the performance reporting data. On the information received to date about the changes proposed by the Agency, the Commission is unable to form a judgment about whether the much needed focus on participant and provider experiences (and ultimately participant outcomes) can be achieved while also meeting the rollout timetable. A slowdown in the rollout of the scheme may be required. The Commission is seeking feedback on how a slowdown, if required, could be operationalised, and what the implications of a slowdown would be.

… but scheme success and financial sustainability are about more than the rollout

The Commission has identified several other key risks to the success and sustainability of the scheme beyond the rollout, including decisions by the Administrative Appeals Tribunal or courts about what are 'reasonable and necessary' supports, changes to NDIS rules, market readiness, and State and Territory Government responsibility for disability care and mainstream services.

A significant challenge is the need to develop the disability supports market, so that there are enough providers and workers to meet the increased demand for services from scheme participants. Without a sufficient supply of disability supports, the NDIS cannot function as intended.

And all governments need to work together to better manage the integration of the NDIS and other services. As noted earlier, there is evidence of service gaps opening up and an apparent reluctance in some instances to find ready solutions. In these circumstances, it is critical that all governments take greater care when withdrawing from services to ensure that there is genuine continuity of supports for people with disability. Without such care, families and informal carers can be left bearing the burden of unintended gaps, which would be contrary to the objectives of the scheme.

Only an integrated and holistic system, supported by the ongoing and shared commitment and goodwill of people with disability and their families and carers, providers of disability services, governments and the community more broadly, will bring about the expected benefits from the seismic shift in the delivery of supports to those that need them the most. There is enormous goodwill behind the NDIS — and it is needed now more than ever.

Draft recommendations, findings and information requests

How is the scheme tracking?

DRAFT FINDING 2.1

The scale and pace of the National Disability Insurance Scheme (NDIS) rollout to full scheme is highly ambitious. It risks the National Disability Insurance Agency (NDIA) not being able to implement the NDIS as intended and it poses risks to the financial sustainability of the scheme. The NDIA is cognisant of these risks.

DRAFT FINDING 2.2

While a different methodology is used, the National Disability Insurance Agency projections of scheme costs are broadly consistent with the Productivity Commission's modelling of the scheme in 2011, after accounting for sector-specific wage increases, population changes, and costs associated with participants aged over 65 years (who were not included in the Commission's estimates).

DRAFT FINDING 2.3

The National Disability Insurance Scheme, at the end of trial, came in under budget. This was in large part because not all committed supports were used (in 2015-16 the utilisation rate was 74 per cent).

Based on trial and transition data, scheme costs are broadly on track compared to the National Disability Insurance Agency's (NDIA) long-term modelling. At this stage, early cost pressures (such as greater than expected numbers of children and higher than expected package costs) have been offset by lower than expected levels of utilisation.

The NDIA has put in place initiatives to address emerging cost pressures. It is too early to assess the effectiveness of these initiatives.

DRAFT FINDING 2.4

Early evidence suggests that the National Disability Insurance Scheme is improving the lives of many participants and their families and carers. Many participants report more choice and control over the supports they receive and an increase in the amount of support provided.

However, not all participants are benefiting from the scheme. Participants with psychosocial disability, and those who struggle to navigate the scheme, are most at risk of experiencing poor outcomes.

Scheme eligibility

DRAFT RECOMMENDATION 3.1

When determining that an individual is eligible for individualised support through the National Disability Insurance Scheme under the disability requirements, the National Disability Insurance Agency should collect data on which of the activity domains outlined in section 24 of the *National Disability Insurance Scheme Act 2013* (Cwlth) are relevant for each individual when they enter the scheme.

INFORMATION REQUEST 3.1

The Commission is seeking feedback on the advantages and disadvantages of maintaining 'List D — Permanent Impairment/Early Intervention, Under 7 years — No Further Assessment Required' *in the National Disability Insurance Agency's operational guidelines on access. Feedback is sought on the extent to which the list:*

- *reduces the burden on families to demonstrate that their child will benefit from early intervention and/or provides certainty that support will be provided*
- *reduces the burden on the National Disability Insurance Agency of assessing whether children are eligible for early intervention support under the* National Disability Insurance Scheme Act 2013 *(Cwlth)*
- *may be contributing to supports being provided to children who are unlikely to benefit from such supports*
- *may be discouraging or inhibiting exit from the scheme.*

INFORMATION REQUEST 3.2

The Commission is seeking feedback on the benefits and risks of maintaining 'List A — Conditions which are Likely to Meet the Disability Requirements in section 24 of the NDIS Act'. *In particular:*

- *to what extent does List A reduce the burden for people with permanent and significant disability of entering the National Disability Insurance Scheme under the disability requirements?*
- *is there any evidence that people who do not meet the disability requirements are entering the scheme under List A?*

Scheme supports

INFORMATION REQUEST 4.1

Is the National Disability Insurance Scheme Act 2013 *(Cwlth) sufficiently clear about how or whether the 'reasonable and necessary' criterion should be applied? Is there sufficient clarity around how the section 34(1) criteria relate to the consideration of what is reasonable and necessary?*

Is better legislative direction about what is reasonable and necessary required? If so, what improvements should be made? What would be the implications of these changes for the financial sustainability of the scheme?

INFORMATION REQUEST 4.2

Should the National Disability Insurance Agency have the ability to delegate plan approval functions to Local Area Coordinators? What are the costs, benefits and risks of doing so? How can these be managed?

DRAFT RECOMMENDATION 4.1

The National Disability Insurance Agency should:

- implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review
- review its protocols relating to how phone planning is used
- provide clear, comprehensive and up-to-date information about how the planning process operates, what to expect during the planning process, and participants' rights and options
- ensure that Local Area Coordinators are on the ground six months before the scheme is rolled out in an area and are engaging in pre-planning with participants.

DRAFT RECOMMENDATION 4.2

The National Disability Insurance Agency should ensure that planners have a general understanding about different types of disability. For types of disability that require specialist knowledge (such as psychosocial disability), there should be specialised planning teams and/or more use of industry knowledge and expertise.

Boundaries and interfaces with the NDIS

DRAFT FINDING 5.1

It is a false economy to have too few resources for Information Linkages and Capacity Building, particularly during the transition period when it is critical to have structures in place to ensure people with disability (both inside and outside the National Disability Insurance Scheme) are adequately connected with appropriate services.

DRAFT RECOMMENDATION 5.1

Funding for Information, Linkages and Capacity Building (ILC) should be increased to the full scheme amount (of $131 million) for each year during the transition. The funds that are required beyond the amounts already allocated to ILC to reach $131 million should be made available from the National Disability Insurance Agency's program delivery budget.

The effectiveness of the ILC program in improving outcomes for people with disability and its impact on the sustainability of the National Disability Insurance Scheme should be reviewed as part of the next COAG agreed five-yearly review of scheme costs. The ILC budget should be maintained at a minimum of $131 million per annum until results from this review are available.

DRAFT RECOMMENDATION 5.2

The Australian, State and Territory Governments should make public their approach to providing continuity of support and the services they intend to provide to people (including the value of supports and number of people covered), beyond supports provided through the National Disability Insurance Scheme. These arrangements for services should be reflected in the upcoming bilateral agreements for the full scheme.

The National Disability Insurance Agency should report, in its quarterly COAG Disability Reform Council report, on boundary issues as they are playing out on the ground, including identifying service gaps and actions to address barriers to accessing disability and mainstream services for people with disability.

DRAFT RECOMMENDATION 5.3

Each COAG Council that has responsibility for a service area that interfaces with the National Disability Insurance Scheme (NDIS) should have a standing item on its agenda to address the provision of those services and how they interface with NDIS services. This item should cover service gaps, duplications and other boundary issues.

Through the review points of National Agreements and National Partnership Agreements under the Federal Financial Relations Intergovernmental Agreement, parties should include specific commitments and reporting obligations consistent with the National Disability Strategy. The Agreements should be strengthened to include more details around how boundary issues are being dealt with, including practical examples.

INFORMATION REQUEST 5.1

The Commission is seeking feedback on a mechanism to ensure that the States and Territories bear the cost of participants who were intended to be covered by the National Injury Insurance Scheme.

Provider readiness

DRAFT RECOMMENDATION 6.1

The Australian Government should:

- immediately introduce an independent price monitor to review the transitional and efficient maximum prices for scheme supports set by the National Disability Insurance Agency (NDIA)
- transfer the NDIA's power to set price caps for scheme supports to an independent price regulator by no later than 1 July 2019.

The body tasked with price regulation for scheme supports should:

- collect data on providers' characteristics and costs. This should include appropriate funding to continue the business characteristics and benchmarking study currently undertaken by National Disability Services and Curtin University
- determine transitional and efficient prices for supports at a state and territory level
- comprehensively review and publish its price model on an annual basis. This review should be transparent, have public consultation, be evidence-based and evaluate the effectiveness of prices in meeting clearly-defined objectives
- assess and recommend when to deregulate prices for supports, with particular regard to the type of support and region, on the basis that prices should only be regulated as narrowly, and for as short a time, as possible.

DRAFT FINDING 6.1

In a market-based model for disability supports, thin markets will persist for some groups, including some participants:

- living in outer regional, remote and very remote areas
- with complex, specialised or high intensity needs, or very challenging behaviours
- from culturally and linguistically diverse backgrounds
- who are Aboriginal and Torres Strait Islander Australians
- who have an acute and immediate need (crisis care and accommodation).

In the absence of effective government intervention, such market failure is likely to result in greater shortages, less competition and poorer participant outcomes.

INFORMATION REQUEST 6.1

In what circumstances are measures such as:

- *cross-government collaboration*
- *leveraging established community organisations*
- *using hub and spoke (scaffolding) models*
- *relying on other mainstream providers*

appropriate to meet the needs of participants in thin markets? What effects do each have on scheme costs and participant outcomes? Are there barriers to adopting these approaches?

Under what conditions should block-funding or direct commissioning of disability supports (including under 'provider of last resort' arrangements) occur in thin markets, and how should these conditions be measured?

Are there any other measures to address thin markets?

INFORMATION REQUEST 6.2

What changes would be necessary to encourage a greater supply of disability supports over the transition period? Are there any approaches from other consumer-directed care sectors — such as aged care — that could be adopted to make supplying services more attractive?

Workforce readiness

DRAFT FINDING 7.1

It is unlikely that the disability care workforce will be sufficient to deliver the supports expected to be allocated by the National Disability Insurance Agency by 2020.

DRAFT RECOMMENDATION 7.1

The roles and responsibilities of different parties to develop the National Disability Insurance Scheme workforce should be clarified and made public.

- State and Territory Governments should make use of their previous experience in administering disability care and support services to play a greater role in identifying workforce gaps and remedies tailored to their jurisdiction.
- The Australian Government should retain oversight of workforce development, including how tertiary education, immigration and aged care policy interact and affect the development of the workforce. In doing so, the Australian Government should pay particular attention to immigration policy to mitigate workforce shortages over the transition period.
- The National Disability Insurance Agency should provide State and Territory Governments with data held by the Agency to enable those jurisdictions to make effective workforce development policy.
- Providers of disability supports should have access to a clear and consistent mechanism to alert those tasked with market development about emerging and persistent workforce gaps.

INFORMATION REQUEST 7.1

What is the best way for governments and the National Disability Insurance Agency to work together to develop a holistic workforce strategy to meet the workforce needs of the National Disability Insurance Scheme?

DRAFT RECOMMENDATION 7.2

The National Disability Insurance Agency should publish more detailed market position statements on an annual basis. These should include information on the number of participants, committed supports, existing providers and previous actual expenditure by local government area.

The Australian Government should provide funding to the Australian Bureau of Statistics to regularly collect and publish information on the qualifications, age, hours of work and incomes of those working in disability care roles, including allied health professionals.

DRAFT RECOMMENDATION 7.3

The National Disability Insurance Agency's (NDIA) guidelines on paying informal carers who live at the same residence as a participant should be relaxed for core supports for the period of the National Disability Insurance Scheme (NDIS) transition. Such payments should be:

- accessible under clearly defined and public guidelines, which make reference to worker shortages in the relevant market using the NDIA's information about providers and supports in the participant's region
- set at a single rate determined by the NDIS price regulator in a transparent manner
- reviewed by the NDIA as part of plan reviews.

INFORMATION REQUEST 7.2

How has the introduction of the National Disability Insurance Scheme affected the supply and demand for respite services? Are there policy changes that should be made to allow for more effective provision of respite services, and how would these affect the net costs of the scheme and net costs to the community?

Participant readiness

INFORMATION REQUEST 8.1

Is support coordination being appropriately targeted to meet the aims for which it was designed?

DRAFT RECOMMENDATION 8.1

The National Disability Insurance Agency should implement the eMarketPlace discussed in the *Integrated Market Sector and Workforce Strategy* as a matter of priority.

INFORMATION REQUEST 8.2

Is there scope for Disability Support Organisations and private intermediaries to play a greater role in supporting participants? If so, how? How would their role compare to Local Area Coordinators and other support coordinators?

Are there any barriers to entry for intermediaries? Should intermediaries be able to provide supports when they also manage a participant's plan? Are there sufficient safeguards for the operation of intermediaries to protect participants?

Governance

DRAFT RECOMMENDATION 9.1

The requirement that changes to National Disability Insurance Scheme Category A Rules have unanimous agreement from the Australian Government and all host jurisdictions should be relaxed.

DRAFT RECOMMENDATION 9.2

The Western Australian Government and Australian Government should put in place arrangements for Western Australia to transition to the National Disability Insurance Scheme. Any decision to join the national scheme should be made public as soon as possible.

DRAFT RECOMMENDATION 9.3

The National Disability Insurance Agency should publicly report on the number of unexpected plan reviews and reviews of decisions, review timeframes and the outcomes of reviews.

DRAFT RECOMMENDATION 9.4

The performance of the National Disability Insurance Scheme (NDIS) should be monitored and reported on by the National Disability Insurance Agency (NDIA) with improved and comprehensive output and outcome performance indicators that directly measure performance against the scheme's objectives.

The NDIA should continue to develop and expand its performance reporting, particularly on outcomes, and Local Area Coordination and Information, Linkages and Capacity Building activities. The NDIA should also fill gaps in its performance reporting, including reporting on plan quality (such as participant satisfaction with their plans and their planning experience, plans completed by phone versus face-to-face, and plan reviews).

The *Integrated NDIS Performance Reporting Framework* should be regularly reviewed by the NDIA and the COAG Disability Reform Council and refined as needed.

DRAFT RECOMMENDATION 9.5

In undertaking its role in delivering the National Disability Insurance Scheme, the National Disability Insurance Agency needs to find a better balance between participant intake, the quality of plans, participant outcomes and financial sustainability.

INFORMATION REQUEST 9.1

The Commission is seeking feedback on the most effective way to operationalise slowing down the rollout of the National Disability Insurance Scheme in the event it is required. Possible options include:

- *prioritising potential participants with more urgent and complex needs*
- *delaying the transition in some areas*
- *an across-the-board slowdown in the rate that participants are added to the scheme.*

The Commission is also seeking feedback on the implications of slowing down the rollout.

Funding arrangements

DRAFT FINDING 10.1

The objective of the escalation parameters is not specified in the Bilateral Agreements between the Australian Government and the State and Territory Governments at full scheme.

The existing escalation parameters are unlikely to reflect the full increase in National Disability Insurance Scheme (NDIS) costs over time, which would result in the Australian Government bearing a higher share of NDIS costs over time.

INFORMATION REQUEST 10.1

The Commission is seeking views on the role of the escalation parameters in the Bilateral Agreements between the Australian Government and the State and Territory Governments.

Should escalation parameters be set on the basis of maintaining a constant real per capita contribution to the National Disability Insurance Scheme by State and Territory Governments; or should they be more explicitly tied to scheme costs so that the proportion of funding allocated to the Australian Government and the State and Territory Governments is maintained over time?

DRAFT FINDING 10.2

Responsibility for funding National Disability Insurance Scheme (NDIS) cost overruns should be apportioned according to the parties best able to manage the risk. This is not the case in the transition period, as the Australian Government bears all the risk of any cost overruns, but not all the control.

The governance arrangements for the NDIS do not allow the National Disability Insurance Agency to respond swiftly when factors outside its control threaten to impose cost overruns.

INFORMATION REQUEST 10.2

The Commission is seeking information on the best way to align the ability to control cost overruns with the liability to fund cost overruns. Possible options include:

- *estimating the proportion of cost overruns that the Australian and State and Territory Governments are responsible for and allocating funding responsibility accordingly*
- *altering the governance arrangements of the National Disability Insurance Scheme to give the Australian Government greater authority to manage the risk of cost overruns, to better reflect their funding liability.*

DRAFT RECOMMENDATION 10.1

At full scheme, the annual operating budget for the National Disability Insurance Agency should be set within a funding target of 7-10 per cent of package costs with the expectation that, on average, it would sit at the lower end of the band.

The National Disability Insurance Agency should be required, in its annual report, to state reasons why it has not met this target in any given year.

DRAFT RECOMMENDATION 10.2

The Australian Government should reconsider the staffing cap on the National Disability Insurance Agency, given the importance of developing internal capability and expertise.

INFORMATION REQUEST 10.3

The Commission seeks feedback on the level of a future contingency reserve that would enable the National Disability Insurance Agency to operate like an insurance scheme, and how this would best be implemented, including any transitional arrangements.

DRAFT RECOMMENDATION 10.3

In-kind funding arrangements should be phased out by the end of transition and should not form part of the intergovernmental agreements for full scheme funding. Should in-kind funding persist beyond transition, jurisdictions should face a financial penalty for doing so.

1 About this study

The National Disability Insurance Scheme (NDIS) is a new scheme designed to change the way that support and care are provided to people with permanent and significant disability. It is currently being rolled out across Australia and is expected to be fully implemented in all states and territories by mid-2019.

This study is a review of NDIS costs. It looks at the sustainability of scheme costs in light of the benefits and impacts of the scheme on the lives of people with disability, and Australians more generally. The study will help inform the final design of the full scheme.

Some background to the study

In 2011, a Productivity Commission inquiry into *Disability Care and Support* found that Australia's system of disability supports was inequitable, underfunded, fragmented, inefficient and gave people with disability little choice and no certainty of access to appropriate supports (PC 2011). The Commission recommended that a national disability insurance scheme be established to change the way that support and care are provided to people with significant disability, and to provide insurance cover to all Australians in the event of such a disability. The recommendation was based on the finding that such a scheme would generate substantial community-wide benefits, including improving the lives of people with disability and their families and carers.

The Commission's recommendation was accepted by Australian Governments and on 7 December 2012, COAG signed an Intergovernmental Agreement for the launch of the NDIS (COAG 2012b). In the Heads of Agreement between the Commonwealth and the States and Territories, it was established that the Productivity Commission would review NDIS costs in 2017, to inform the final design of the scheme ahead of its full rollout. The terms of reference for this study were received on 20 January 2017.

1.1 About the NDIS

The NDIS is based on the premise that individuals' support needs are different, and those participating in the scheme should be able to exercise choice and control over the services and support they receive. The objectives of the NDIS (as outlined in the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act)) are to:

- support the independence and social and economic participation of people with disability

- provide reasonable and necessary supports, including intervention supports
- enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports
- facilitate the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability
- promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community
- raise community awareness of issues that affect people with disability.

The NDIS operates under the NDIS Act, and is administered by the National Disability Insurance Agency (NDIA). Funding for the NDIS is shared by the Australian and State and Territory Governments.

The NDIS provides individualised supports to assist people with permanent and significant disability to participate in economic and social life.[3] This paper refers to people who are eligible for individualised supports as 'participants' of the scheme.

For each participant, the NDIS funds 'reasonable and necessary' supports related to their disability. Reasonable and necessary supports are those that help participants live as ordinary a life as possible, including care and support to build skills and capabilities, so that they can engage in education, employment and community activities.

Supports are also available to those who meet early intervention criteria. This covers cases where early intervention can significantly improve outcomes and is cost effective. The focus on early intervention reflects the lifetime, insurance-based approach of the scheme.

Individuals eligible for the scheme are assessed, and individual support packages are developed and funded. Access, planning and payments are managed by the NDIA. (In Western Australia, arrangements will be different to reflect a recently announced bilateral agreement with the Commonwealth, but are intended to be consistent with the NDIS (Porter, Barnett and Faragher 2017)).

The individualised supports provided to participants account for the vast majority of scheme costs and therefore references to 'the scheme' (including in this paper) often refer to these supports.

However, the NDIS is broader than just supports for eligible participants. Information, linkages and capacity building (ILC) services will also be provided under the NDIS from July 2017 to help all people with disability (not just scheme participants), and their families and carers, with information and referrals to community and mainstream services (including health, education, employment, justice, transport and housing) (NDIA 2016g).

3 Permanent and significant disability is defined in this paper as a disability that substantially reduces a person's functional capacity or psychosocial functioning. This is in line with the eligibility criteria contained in the Act.

ILC will also facilitate greater social cohesion by promoting awareness and acceptance of disability in the wider community.

More detail on the scheme, including eligibility criteria, planning processes and governance arrangements, is provided throughout this paper.

The NDIS is part of a broader system of support

The NDIS is part of a wider disability system. It is one component of the broader *National Disability Strategy 2010–2020*, which was endorsed by the Council of Australian Governments in February 2011 and provides a ten-year national policy framework for improving life for Australians with disability, their families and carers (COAG 2011b).

Only a proportion of people with disability will become participants and receive individualised supports. There are approximately 4.3 million people with disability in Australia (figure 1.1). Once fully implemented, the NDIS will provide individual packages to about 475 000[4] people — those people with a 'permanent and significant' disability.

Supports for people with disability (both NDIS participants and non-NDIS participants) are also provided through other Australian and State and Territory Government funded disability services, and mainstream services, such as health and education.

1.2 The benefits of the NDIS

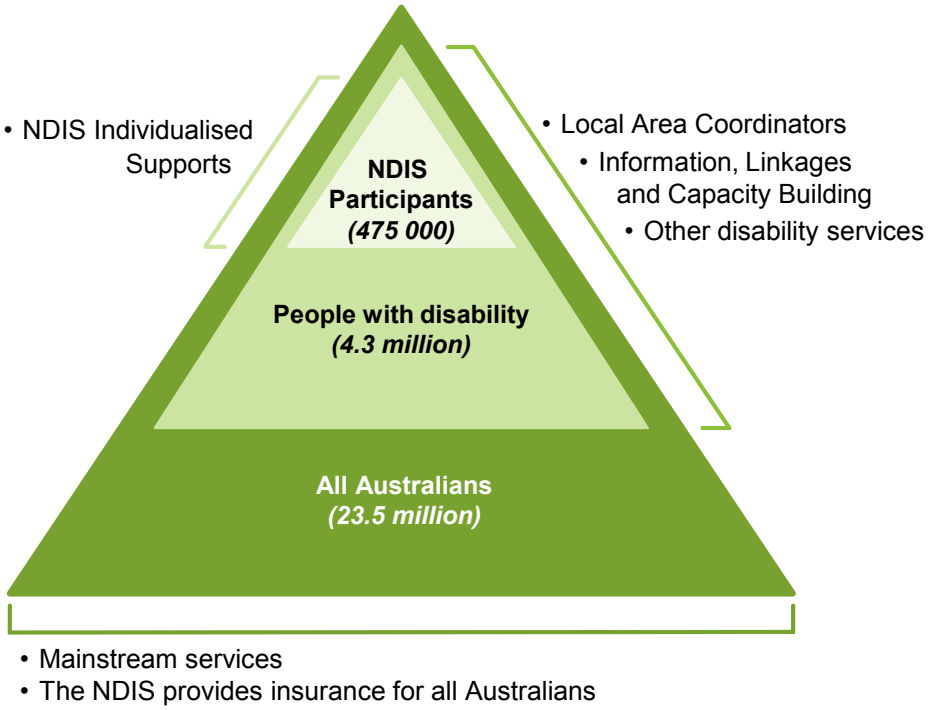
The Commission recommended a national disability insurance scheme in 2011 on the basis of the substantial net benefits it would generate in the long term from:

- improved lives for people with disability and their families and carers through increased care and support and more choice and control over the supports they receive. This was identified as the area of largest benefit with more, and better targeted, support for participants leading to greater social participation and independence
- efficiency gains in the disability sector — through increased competition and innovation, and better value for money
- savings to other government services — by better supporting people with disability and reducing their reliance on mainstream services
- increased economic participation for people with disability — by overcoming obstacles to employment for those with disability through direct interventions, like school to work transition programs, and through changes to community attitudes. The Commission estimated that employment of people with mild to profound disabilities could increase by 100 000 by 2050 (catching up to OECD levels) resulting in $8 billion in additional gross domestic product in that year alone

4 460 000 participants under the age of 65 and 15 000 aged 65 years and over (chapter 2).

- increased economic participation for informal carers — the Commission estimated that an additional 7500 carers could re-enter the workforce (PC 2011).

Figure 1.1 **The NDIS is part of a broader system of supports**[a]



[a] Number of Australians and those with a disability are based on 2015 data. NDIS participants are the projected number of people eligible in 2020.

Sources: Commission estimates based on unpublished NDIA data and ABS *(Disability, Ageing and Carers, Australia: Summary Findings, 2015, Cat. no. 4430.0)*.

A new approach to disability care and support

The scheme is designed to change the way that participants and disability support providers interact, and the way that supports are funded. Two of the key changes from previous approaches include a more market-based, person-centred approach to care and support, and a scheme based on insurance principles.

A market-based approach aims to create incentives that better provide participants with the quantity, quality and variety of services they desire in an efficient way. It is expected to overcome many of the previous system's shortcomings (table 1.1), including by providing participants more choice and control over their supports and services, and encouraging innovation by service providers through increased competition.

Table 1.1 **Intended effects of the NDIS in the disability services market**

Features of Disability Service Markets pre-NDIS	*Features of Mature Disability Service Markets*
• Largely 'block funded', with funding provided in advance of service delivery and little freedom to innovate.[a]	• Predominantly fee-for-service paid on invoice. In principle, prices for services are set by the competitive market, and there is innovation by service providers attracting and retaining consumers.
• Services often limited and priorities for families in immediate crisis, rather than for early intervention. Consumers have little control over the services they receive and limited choice of provider.	• Funding to meet the reasonable and necessary support needs for each NDIS participant. Consumers have choice and control regarding the services received and providers used.
• The primary relationship is between the service provider and the funder, with consumers often described as 'passive' recipients of services.	• The primary relationship is between the consumer and service provider. Intermediaries and access to information about provider quality, performance and pricing help consumers exercise choice.
• Providers are subject to various statutory provisions (at all levels of government) regarding quality. The system is complex, difficult to navigate and not well integrated nationally.	• Compliance with a national quality framework. A nationally consistent and navigable system.
• High transaction costs for both consumers and providers.	• Lower transaction costs for consumers and service providers. There is adequate depth and resilience in the market to underpin financial sustainability.

[a] Block funding refers to the process where governments purchase a 'block' of services from a provider, which is to be delivered to clients who meet certain criteria, or are referred to those providers as part of an individualised plan.

Sources: Adapted from ANAO (2016, p. 20), which is based on analysis of PC (2011); DRC (2015a) and NDIA presentations on the market transition.

As an insurance-based scheme, the NDIS takes a lifetime approach to a participant's support needs and life goals (box 1.1). It is intended to provide assurance to both those with a permanent and significant disability, and those who may acquire such a disability in the future, that they will receive the support they require. In other words, there is essentially no cap on funding — anyone who meets the eligibility criteria is guaranteed to get funding for supports and services. It also focuses on early intervention investment in people with disability so that their outcomes can be improved later in life, and so that costs can be minimised over the long term, even if that involves more spending upfront.

This contrasts with the previous system which operated on an annual capped amount and did not tailor supports to individuals, leading to short-term planning, limited choice, higher long-term support needs, unmet demand and adverse outcomes for some (PC 2011).

Box 1.1 **The NDIS is an insurance-based scheme**

The insurance approach of the NDIS takes a long-term view of the total cost of disability in order to improve participant outcomes and meet the future costs of the scheme. Key elements of the approach include:

- universal coverage by pooling risk across all Australians and taking the risk of disability support costs away from individuals
- creating an innovative and competitive market for disability support, through which participants can exercise choice and control over the planning and delivery of their supports
- a long-term view of the total future social cost of disability for all people who are insured and yet to be insured
- the NDIA — in its role as the social insurance manager — managing the total cost of disability over a participant's lifetime and incentivising short-term investment in participants to reduce long-term costs.

The NDIA identifies four principles for the way that the insurance approach is operationalised:

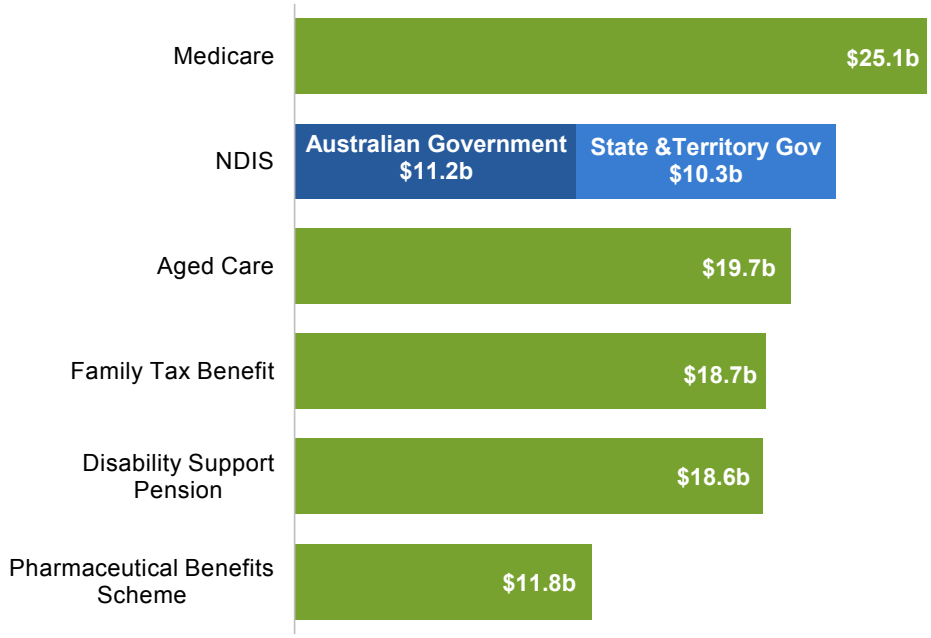
1. Actuarial estimate of long-term costs — updated to reflect the experience of the scheme, and used to help ensure the scheme is financially sustainable and that the scheme is continuously improved.
2. A long-term view of funding requirements — takes a lifetime view of participant needs and seeks early investment and intervention for people in order to maximise their independence, and social and economic participation, and reduce their support requirements in the long term.
3. Investment in research and innovation — to encourage and build the capacity and capability for innovation, outcome analysis and evidence-based decisions on early interventions.
4. Investment in community participation and building social capital — to make the community accessible and inclusive for people with disability, and provide participants and non-participants with necessary supports outside of the NDIS, through mainstream services, ILC initiatives and education programs.

Source: NDIA (sub. 161, pp. 23–26).

1.3 The NDIS is a major reform

The NDIS is a major reform. As the NDIA said, the scheme is 'on a scale not previously contemplated in Australia and is designed to address un-met need' (NDIA 2016k, p. 7). The NDIS will be the largest social reform since the introduction of Medicare. At a currently estimated annual cost of about $22 billion when fully implemented, government expenditure on the NDIS will exceed that on Aged Care and will be almost double that spent on the Pharmaceutical Benefits Scheme (figure 1.2).

Figure 1.2 **Projected NDIS expenditure compared with other Australian Government programs, 2019–20**



Source: Adapted from Department of Parliamentary Services (2017), which is based on Australian Treasury (2016a, 2016b).

At full rollout, the NDIS is expected to cover 475 000 people with disability. This is almost 200 000 more people than were covered under the previous system (NDIA 2016k, p. 8). To meet this increased demand, the disability workforce will need to more than double.

Introducing a scheme of this scale and nature is a challenging task and it is inevitable that it will take many years before the scheme is fully established and operating smoothly. The enormity and significance of the task was acknowledged by many participants to the study. For example, the ACT Disability Aged Carer and Advocacy Service said:

> The NDIS is monumental reform for Australia: a grand scheme (akin to the introduction of Medicare) that has the potential to make vast differences in the life experiences of an array of people with disability, their families and carers both now and in decades to come. (sub. 87, p. 1)

Richard Madden, from the Centre for Disability Research and Policy at University of Sydney, said:

> The NDIS has been introduced quickly, and involves a large increase in public expenditure, and inevitably some uncertainty as long standing support arrangements change. The change effort has been huge for all involved. Inevitably, there have been issues to be addressed, and some delay in ambitious timetables. These issues, while important, must not detract from the achievements made and the opportunities that exist. (sub. 101, p. 3)

There is overwhelming support for the scheme

While many submissions to this study commented on the scale and complexity of the reform, there is an extraordinary level of commitment to the success and sustainability of the NDIS (and to preserving the core principles of the scheme as set out by the Commission). This commitment is shared by governments, people with disability and their families and carers, providers of disability services and disability advocates (box 1.2). For example, Every Australian Counts said:

> The Scheme is a once-in-a-lifetime change to the way disability support is delivered in Australia. It is going to affect millions of Australians. Because of the relative unfamiliarity of this model, there are issues that need ironing out. A reform of this size will take time to get right. Long-term, the NDIS will give back to the economy. Indeed, it would cost far more not to implement it. (sub 92, p. 2)

It is also acknowledged that 'making the scheme work' is not just the responsibility of the NDIA, but also of governments, providers, participants (and their families and carers). As the Australian Disability Discrimination Commissioner said:

> Yes — the NDIS is big, it is complex, and it changes everything, but it is the change that we need. And when we think about what life might be like for people with disability without the NDIS, I think it becomes clear that it is the change we cannot afford to prevent. … ensuring the sustainability and success of the NDIS is not only the responsibility of the NDIA or its board — it is the responsibility of all governments, service providers, participants, their families and carers. If we want real and lasting change for people with disability, we cannot absolve ourselves of our responsibility to make the NDIS work. (McEwin 2017)

Box 1.2 There is overwhelming support for the NDIS

Australian Federation of Disability Organisations:

> We want to begin … by emphasising our unwavering support for the NDIS. AFDO and its members regularly hear from people with disability and their families about the difference the NDIS is making to their lives. People who now have the dignity of appropriate and timely support, the opportunity to be more involved in their communities, the chance to move out of home, the economic freedom of a new job. These are the kinds of differences the NDIS is making. (sub. 180, p. 6)

Anglicare Australia:

> Anglicare Australia strongly believes that the establishment of the NDIS is a major achievement. Our member agencies are already witnessing the transformative power of the scheme for participants, and finding that reconfiguring services to reflect their needs and aspirations is creating opportunities to reimagine and create better outcomes in people's lives. (sub. 157, p. 4)

NSW Council for Intellectual Disability:

> … we have been strong supporters of the development of the NDIS and we continue to see the scheme as having a fundamental capacity to improve the lives of people with disability around Australia. (sub. 193, p. 2)

Flourish Australia:

> Flourish Australia strongly supports the NDIS and the opportunity it provides for greater certainty, choice and control, and economic and social participation for people with disability who require life-long support. … However, we are also mindful that, as with any reform of such a substantial scale, there can be unintended consequences, implementation issues and uncertainty, especially during the transition phase. We are particularly mindful of the impact of this on the people we support. (sub. 74, p. 1)

JFA Purple Orange:

> … the NDIS is a major, once-in-many-generations opportunity to invest in the life chances of people living with disability, to achieve a fair go, so that people living with disability take their rightful place as valued active members of Australian community life and the economy. (sub. 186, p. 4)

National Disability Services:

> The principles on which the NDIS is founded remain compelling and inspiring. Doubling the funding for disability support to rectify the chronic under-supply of services, choice and control for people with disability and their families, an insurance approach that focuses on early intervention and building the capacity of individuals and families and increased equity across Australia. (NDS 2016, p. 3)

Scope Australia:

> Scope is fully committed to the implementation of the National Disability Insurance Scheme. The Scheme creates a paradigm shift in social policy and recognises the rights of all Australians to live an ordinary life. It has enhanced the lives of more than 60,000 participants and their families and for the first time fully recognises the rights of people with a disability to live their lives as empowered and equal citizens. (sub. 72, p. 29)

Health Services Union:

> The HSU has always been a strong supporter of the NDIS and our longstanding position has been that quality disability services depend on a quality workforce. (sub. 132, p. 5)

New South Wales Government:

> The NSW Government is a strong advocate of the National Disability Insurance Scheme (NDIS). The improvement in the lives of people with disability, as outlined by the Productivity Commission (PC) in its 2011 inquiry report into Disability Care and Support, is a goal embraced by NSW. (sub. 60, p. 2)

1.4 The Commission's approach to the study

This study is a review of NDIS costs. The Commission has been asked to look at:

- the sustainability of scheme costs, including current and future cost pressures, and how to manage any potential cost overruns
- whether jurisdictions have the capacity to deliver disability care and support services as the scheme expands
- how the NDIS impacts on, and interacts with, mainstream services
- whether efficiencies have been achieved within the scheme
- whether there are any issues with scheme design, including the application of market and insurance principles, in ensuring the best possible outcomes for people with permanent and significant disability
- funding and governance arrangements, including financial contributions, risk-sharing, and the 'escalation parameters', which define the annual increase in funding required by different jurisdictions.

A number of stakeholders expressed concern that the Commission would focus on costs and not take into account the intent of the scheme and the potential impact that it could have on the lives of people with disability (box 1.3). As the Australian Federation of Disability Organisations said:

> A focus on costs should not be at the expense of a focus on outcomes for the very people the scheme is intended to support. Any decisions made in the interests of ensuring sustainability should also be consistent with improving outcomes for people with disability. (sub. 180, p. 6)

And while the focus of this study is on scheme costs, the Commission's approach (consistent with the *Productivity Commission Act 1998* (Cwlth)), is to examine costs in light of the benefits and impacts of the scheme on the lives of people with disability, and Australians more generally, using a wellbeing framework (see figure 1.5 below). This is also consistent with the insurance approach of the NDIS, which is about 'maximising outcomes for participants and their families/carers at the lowest possible sustainable cost' (NDIA, sub. 161, p. 26).

The objectives of the NDIS (choice and control, independence, social and economic participation, reasonable and necessary support) are seen by the Commission as an integral part of the analysis of the scheme costs. Costs cannot be considered in isolation of the benefits they provide.

Box 1.3 **Stakeholders said the focus should not be solely on costs**

Anglicare Australia:

> … measures of the financial sustainability of the NDIS should not be narrowly held and applied solely within the scheme itself. Although such measures are of course essential, questions regarding the overall worth of the scheme that capture the cost and benefit to Australian society should be included … (sub. 157, p. 21)

Community Mental Health Australia:

> … CMHA … believes that the Commission in assessing whether or not the NDIS is financially sustainable must investigate how the scheme is being implemented and how this is being managed. (sub. 11, p. 2)

Australian Blindness Forum:

> The financial sustainability of the NDIS should be defined and measured by the standard that all people with disability can access and participate in the community. (sub. 48, p. 17)

NSW Government:

> Any review of costs and sustainability isn't necessarily about minimising short term costs. Costs must be considered in relation to the objectives of the NDIS (reasonable and necessary support; choice and control; increased social and economic participation). (sub. 60, p. 9)

SDN Children's Services:

> SDN believes that a drive for financial sustainability must not be disconnected from a drive for quality, effective practices. (sub. 73, p. 2)

Autism Aspergers Advocacy Australia:

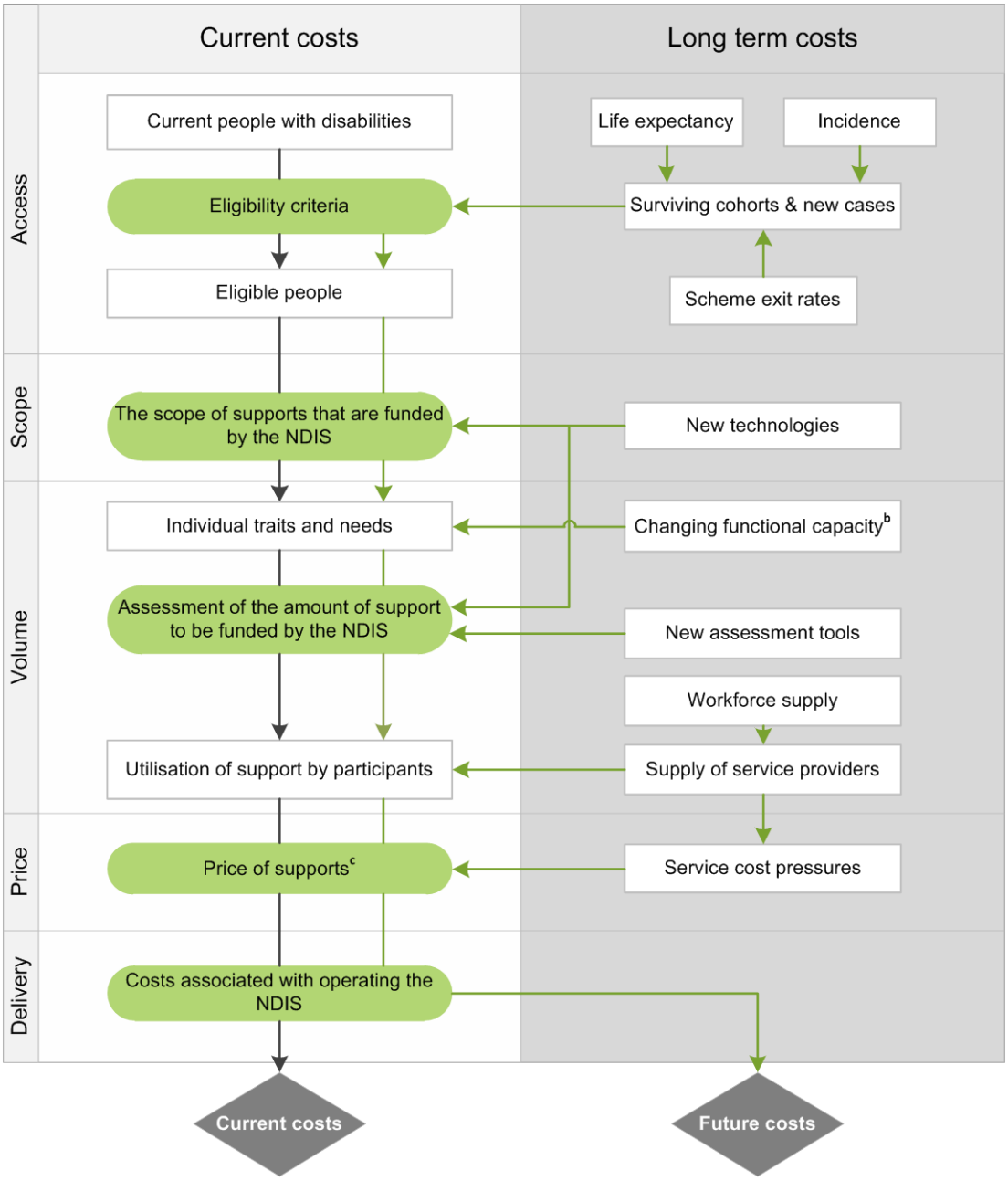
> Maybe 'sustainability' is the wrong notion. It is more about benefit versus cost, and people having a reasonable standard of living in our community. (sub. 178, p. 36)

What are the factors driving scheme costs?

Assessing the sustainability of scheme costs, including current and future cost pressures, involves examining the factors that drive scheme costs. Key factors driving scheme costs include:

- access — the number and profile (age, sex, disability type, disability severity) of participants in the scheme
- scope — the scope of supports provided to participants in the scheme
- volume — the quantity of supports in a participant's plan and the proportion of supports in a plan that are utilised by a participant
- price — the price paid for supports under the scheme
- delivery — the costs associated with operating the scheme (figure 1.3).

Figure 1.3 **What drives scheme costs?**[a]



[a] Green cells denote cost drivers that the NDIA and/or governments have direct control over. Grey cells are cost drivers that can only be *indirectly* influenced by governments. [b] This includes changes in participants' functional capacity attributable to early intervention. [c] Prices of disability supports are currently set by the NDIA. The NDIA intends to deregulate prices as the market matures (NDIA 2016h, p. 11).

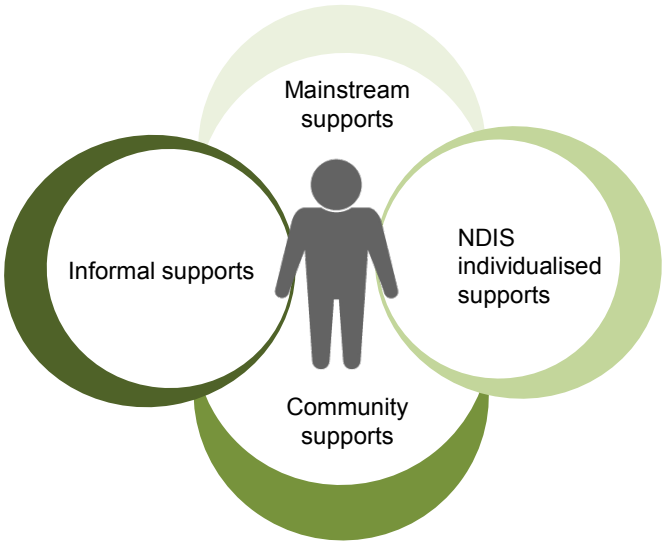
Scheme culture will also be an important driver of costs. Moving away from the welfare culture of current disability systems to one of seeking reasonable and necessary supports and managing down the total cost of disability over a participant's lifetime (in line with an

insurance approach) will be critical for the financial sustainability of the scheme. As noted by Bruce Bonyhady, the former Chair of the NDIA Board:

> Importantly, the NDIS cannot be allowed to be turned into a Centrelink-type entitlement model, because under this approach costs would continually escalate. (sub. 100, p. 2)

Other support systems can also affect scheme costs. The NDIS, as a person-centred approach to providing disability supports, relies on supports and services outside of the NDIS (including informal, community and mainstream supports) to be in place to help people with disability to live ordinary lives (figure 1.4). If these supports are not available, people with disability could seek NDIS funding to fill the gap, and this could pose risks to scheme costs.

Figure 1.4 **A person-centred approach relies on supports outside the NDIS**



Source: Adapted from NDIA (sub. 161, p. 22).

Sustainability — interpreted as financial sustainability

The Commission has interpreted scheme sustainability to mean 'financial sustainability'. This is in line with the NDIS Act. Under the Act, the NDIA manages, advises and reports on the financial sustainability of the NDIS. While financial sustainability is not defined or listed as one of the explicit objectives of the Act, the Act (s. 3) does state that 'regard is to be had to … the need to ensure the financial sustainability of the National Disability Insurance Scheme'.

The insurance approach to the scheme and financial sustainability are inextricably linked. For a commercial insurer, financial sustainability is about balance sheet adequacy — there needs to be enough capital to meet some proportion of future expected liabilities by way of

cash claims (as set out in prudential standards set by the Australian Prudential Regulation Authority) (NDIA 2016j).

However, the financial risks inherent in the NDIS are unique. The NDIS is funded on a cash-flow basis — annual contributions meet the cash claims expense — so a balance sheet approach to financial sustainability is not appropriate. And because there is no annual capped amount (as there was in previous disability support systems), the financial risk associated with satisfying all valid claims for reasonable and necessary support needs to be managed. As the NDIA explained:

> … unlike traditional disability systems, it is not open to the NDIA to refuse to fund reasonable and necessary supports for a participant who has been found to be eligible on the basis that the 'budget has been exhausted'. The NDIS, therefore, faces significant financial risks in the same way that an insurer does and these risks must be managed. Indeed, the NDIS Act explicitly requires the Agency to manage the financial risk that goes with a regime under which any valid claim has to be satisfied. However, the NDIS is still concerned with people rather than claims, and outcomes as well as financial result. (2016j, p. 6)

In light of this, the NDIA defines financial sustainability for the NDIS as:

- the scheme is successful on the balance of objective measures and projections of economic [and] social participation and independence, and on participants' views that they are getting enough money to buy enough goods and services to allow them reasonable access to life opportunities — that is, reasonable and necessary support; and
- contributors think that the cost is and will continue to be affordable, under control, represents value for money and, therefore, remain willing to contribute. (2016j, p. 18)

Based on the NDIA's definition, achieving financial sustainability requires continuous monitoring of both participants' outcomes and costs. It is not about minimising costs or maximising benefits, but rather balancing the two in a way that ensures there is a net benefit over time. As the NDIA put it:

> … while cost efficiency will be of prime importance to an insurer it will not be the sole focus of the NDIS. Rather, good participant outcomes will be an ongoing objective and, so, finding the right balance between participant outcomes and cost will be critical. (2016j, p. 12)

And as pointed out by the New South Wales Government, financial sustainability must be considered against a long term (not a short term) view of costs:

> The lifetime costs for supporting participants must be considered and an investment approach taken. Early intervention principles are appropriate (including beyond just early childhood), and may increase costs in the short term before delivering lower lifetime costs. The alternative is immediate cost reductions that deliver worse social or economic outcomes for participants or the need for acute responses later in life: this is not an improvement to financial sustainability.
>
> … Financial sustainability must be considered with reference to a suite of indicators, with a long-term view, and with consideration of broader impacts elsewhere. (sub. 60, pp. 9–10)

The Department of Social Services (sub. 146, p. 17) said it supported the NDIA's definition of financial sustainability, and noted that 'considerations of NDIS sustainability

need to weigh the success of the Scheme in improving economic and social outcomes and the value-for-money proposition for contributors'.

As outlined above, financial sustainability is a difficult concept to define in a unique scheme like the NDIS, but the Commission supports the definition used by the NDIA. The definition provides a clear link between scheme costs and benefits and support from taxpayers.

A wellbeing framework for considering costs and benefits

The Commission has examined scheme costs and the financial sustainability of the scheme in light of the benefits to people with disability and Australians more generally using a wellbeing framework (figure 1.5).

The NDIS aims to improve the lives not only of current scheme participants, but also future participants. This will only be the case if the scheme is financially sustainable. Financial sustainability is also essential if scheme participants are to consistently receive reasonable and necessary care while they remain in the scheme. Cost overruns could jeopardise the level of care and support participants receive, or result in a return to some of the less desirable features of the previous system (including, for example, an inequitable rationing of support services).

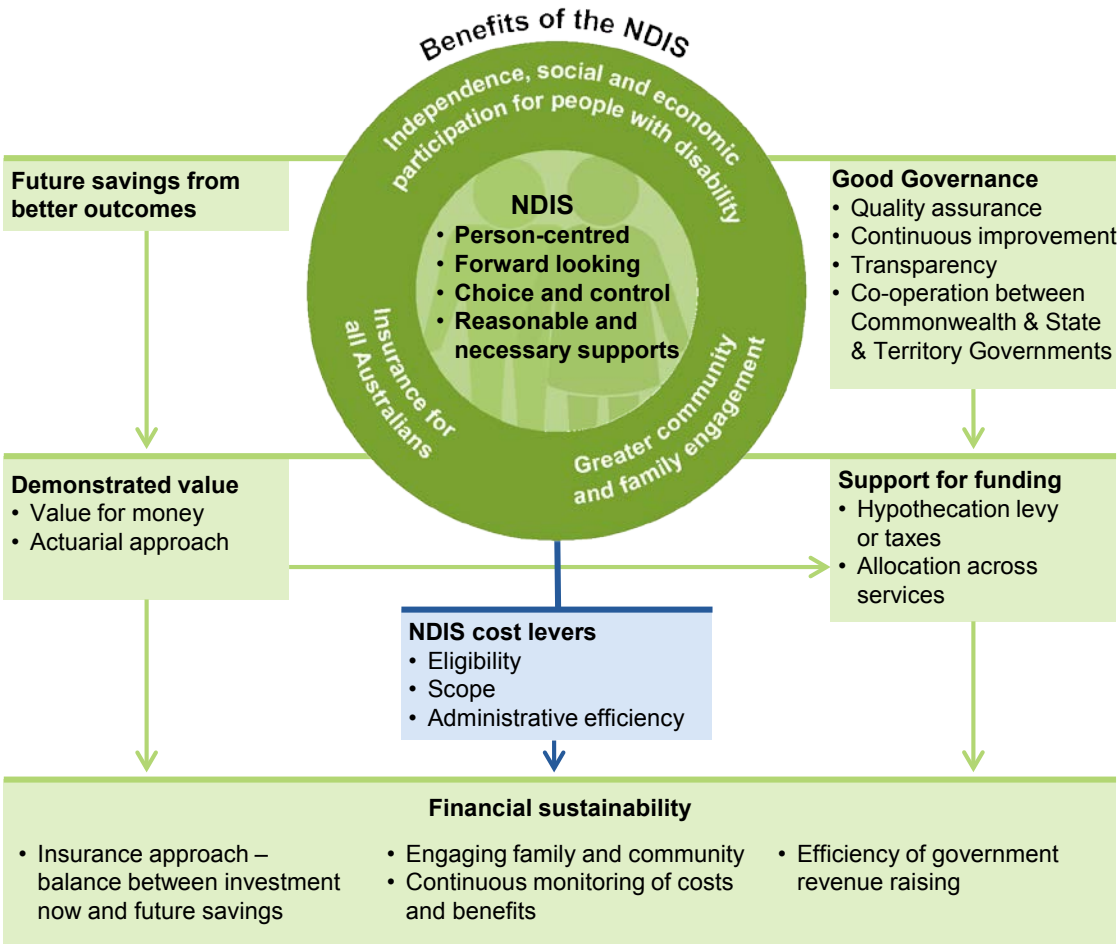
And, unlike other insurance schemes that rely on premiums to fund costs, the NDIS will only be funded as long as taxpayers consider it is a good use of taxes.

Taxpayers' willingness to fund the NDIS will depend on their perception of value for money in terms of:

- people with disability experiencing better lives as a result of the scheme
- the scheme making it easier for families and carers to play a supporting role
- the way the scheme invests in people with disability
- the supports that are funded (and the evidence base to support what is funded)
- efficiency gains and cost savings in the disability support system and other government services.

While the NDIS is sometimes described as an 'uncapped scheme', the ultimate cap — and test of financial sustainability — is taxpayers' continuing willingness to pay for it. Cost overruns could lead to pressure to reduce the scope and certainty of care and supports provided under the NDIS, or require governments to provide more funding at the expense of other programs.

Figure 1.5 **Wellbeing framework for considering costs and benefits**



The NDIA's actuarial estimates of long-term costs (which reflect the experience of the scheme and management responses to cost pressures) play an important role in demonstrating to the Australian community that the scheme represents value for money.

Perceptions about the effectiveness of governance arrangements for the NDIS are also important. For example, the community expects planning processes to be in line with the objectives of the scheme and services to meet quality standards. Governments also need to demonstrate that the funds for the NDIS are dollars well spent from a limited tax revenue bucket and funding the scheme is not to the detriment of other important expenditures.

Assessing the financial sustainability of the NDIS also involves looking at interrelated systems. This includes, but is not limited to, the efficiency and effectiveness of the NDIA, the readiness of participants, the readiness of providers, and the integration of the NDIS with mainstream services. Only a system that is integrated and holistic in its focus will bring the benefits to people with disability that the scheme is expected to deliver.

Transitional issues can become entrenched problems

It is no surprise that, given the size, speed and complexity of the reform as noted above, there have been considerable transitional issues with the rollout of the NDIS. All major reforms are followed by a (sometimes protracted) period of disruption and adjustment.

Many of these transitional issues are expected to be ironed out as the scheme rollout is completed and the scheme matures. It is evident to the Commission through consultation with the NDIA, and from its submission to this study, that the Agency is devoting resources to addressing implementation issues. The NDIA said:

> The NDIS is still in its infancy and delivering the Scheme will evolve and improve over time. The NDIA is intent on learning from experience and improving systems, processes and practices as quickly as possible to ensure the success of the Scheme. (sub. 161, p. 14)

However, if transitional issues are not dealt with quickly and effectively, they can become entrenched problems that endure in the longer term and affect the success and sustainability of the scheme.

It is still early days

The Commission is mindful that, while significant benefits are expected to result from the new approach to providing disability care and support, like any major reform it will be many years before the full extent of the benefits are realised or reflected in objective measures.

Even once the scheme is fully implemented by mid-2019, the transition to a mature market will be gradual, and participants, carers and providers will need time to adjust to the new system. According to an Australian National Audit Office report, the disability services market under the NDIS is expected to take up to ten years to develop, and perhaps longer in some market segments (ANAO 2016, p. 19). The NDIA, in its Market Approach Statement 2016–2019, said that:

> Developing a strong, contestable marketplace for disability supports is a long term project. All stakeholders in the marketplace will require time to build capability, confidence and systems to support the market mechanisms. Participants, possessing greater consumer power, are learning to make choices and explore different service options. Providers are building an understanding of their customer base and preferences, positioning service offers and transforming their operations. (2016k, p. 12)

The Commission is also mindful that, because the scheme is not yet fully rolled out and there are some transitional issues, the experience to date may not be reflective of the underlying long-term outlook (chapter 2 discusses in more detail the limitations of the trial and transition data).

1.5 A guide to this paper

This position paper outlines the Commission's early thinking on the sustainability of NDIS costs. The purpose of this position paper is to seek feedback on the Commission's preliminary conclusions, and on any additional issues that should be considered before the public release of the final study report in September 2017. The Commission welcomes written comment on this paper, and will undertake further consultation to facilitate feedback from participants to inform the preparation of the final study report.

The Commission is aware that more data and information will be available before the study's final report is released. As such, the draft recommendations in this paper should be viewed as indicative.

In conducting this study, the Commission has drawn on a range of evidence. It consulted widely, including with NDIS participants, advocacy groups, peak bodies, service providers, disability care and support workers and academics. It also met with Australian and State and Territory Government departments and agencies, including extensive liaison with the NDIA and the Department of Social Services. There have also been a number of other reviews of various aspects of the NDIS since the trial began and the Commission has drawn on these where relevant.

The Commission has used the information and evidence provided in the 206 submissions it received in response to the issue paper released in February 2017 (a full list of submissions and consultations is provided in appendix A). The Commission wishes to thank study participants for their input.

Submissions on this paper are due by 12 July 2017.

Structure of this paper

Chapter 2 looks at how the scheme is tracking based on scheme experience to date. Two of the key drivers of cost are then discussed in more detail in chapters 3 and 4 — the scheme eligibility (which determines the number of participants in the scheme), and the supports NDIS participants receive (as determined by the planning process). These components essentially form the demand for NDIS services.

Chapter 5 looks at how the NDIS interfaces with non-NDIS disability services and mainstream services and the ways in which this impacts on the financial sustainability of the scheme.

Chapters 6 and 7 look at the supply side of the equation. Chapter 6 assesses whether providers will be capable of meeting demand for disability services and chapter 7 analyses workforce readiness. Chapter 8 looks at whether participants have the knowledge and skills to successfully engage with the scheme. Governance arrangements are discussed in chapter 9 and chapter 10 looks at funding arrangements.

2 How is the scheme tracking?

Key points

- Tracking scheme costs and participant outcomes (and making adjustments in response to scheme experience) is critical to ensuring that the National Disability Insurance Scheme (NDIS) achieves its objectives and is financially sustainable.
- The NDIS was launched a year earlier than recommended by the Commission in 2011 and the scope of the trials was broadened. The changed timing and scope of the planning phase meant that some aspects of the scheme were being built and tested over the trial period, including assessment tools and ICT systems.
- The rollout schedule of the NDIS is highly ambitious. To reach the estimated 475 000 participants at full scheme, the National Disability Insurance Agency (NDIA) will need to approve hundreds of plans a day — in 2018-19, about 500 plans a day will need to be approved and hundreds more reviewed.
- It is inevitable that there will be transitional issues with the rollout of the NDIS given the size, speed and complexity of the reform, but already there are signs that the rollout schedule risks the NDIA not being able to implement the NDIS as intended.
  - The focus on getting participants into the scheme has come at the expense of the quality of plans. Some key planning supports for participants have not been in place and this has affected participant readiness. And the supply side of the market has had very little time to adjust.
- The NDIA's projection of full scheme costs ($22 billion) is broadly consistent with the Commission's 2011 modelling. The Commission has not updated its own projection of scheme costs. Early scheme data have too many limitations to update assumptions on prevalence rates and package costs.
- Based on trial and transition data, NDIS costs are broadly on track with the NDIA's long-term modelling. While there are more children entering the scheme than expected and higher than expected package costs, these factors are offset by lower levels of utilisation than expected.
- The NDIA has put in place initiatives to address emerging cost pressures, including the Early Childhood Early Intervention approach and the first plan process to reduce variability in the level of support provided to participants.
- The benefits of the NDIS are becoming apparent. The early evidence suggests that many (but not all) scheme participants are receiving more disability supports than previously, and they have more choice and control. There is also evidence that the NDIS is improving the wellbeing of participants and their families and carers.

Tracking scheme costs and participant outcomes is critical to ensuring that the National Disability Insurance Scheme (NDIS) achieves its stated objectives and is financially sustainable over the longer term. In 2011, when the Commission estimated full scheme

costs for a national insurance scheme, it noted that insights from the early experience of the scheme should be used to provide a more precise estimate of the long-term scheme costs, given the uncertainties at the time around the costings of the scheme (PC 2011, p. 932).

The National Disability Insurance Agency (NDIA) estimates that at full scheme about 475 000 participants will have individualised supports and the scheme will cost $22 billion in the first year of full operation (NDIA 2017o, p. 5, 2016b, p. 18). The number of participants is higher than what is reported in the NDIA's publications because the NDIA only reports the number of scheme participants under the age of 65 years.[5]

These estimates are consistent with the Commission's 2011 estimates of scheme costs (discussed further below). The Commission has not calculated its own estimate of long-term scheme costs for this position paper. There are too many limitations with the early scheme data to update the modelling assumptions. That said, early scheme data can be used to assess where cost pressures may be emerging.

The first section (section 2.1) of this chapter looks at the NDIS rollout schedule. Section 2.2 looks at the assumptions that drive the NDIA's long-term estimates of scheme costs. Section 2.3 provides an overview of scheme participants and costs to date, and looks at how they compare with the NDIA's assumptions. Section 2.4 looks at the early evidence on the benefits of the scheme to participants and their families and carers.

2.1 The rollout of the scheme so far

The NDIS was trialled from 2013 in different jurisdictions across Australia. Trials commenced in July 2013 in New South Wales, Victoria, South Australia and Tasmania (table 2.1). The trial sites varied in size and scope. For example, the trial sites in:

- South Australia and Tasmania covered the whole jurisdiction but were restricted to certain age groups (children aged 0-14 years for South Australia and 15-24 years in Tasmania)
- Victoria and New South Wales were limited geographically (the Barwon and Hunter regions) but had no age restrictions (apart from the NDIS-wide restriction that participants must be aged under 65 years to enter the scheme).

The transition to full scheme began in all states and territories in July 2016, with the exception of Western Australia (which will transition from July 2017). The Bilateral Agreements between the Australian and State and Territory Governments set out the timeframes for the transition in each jurisdiction, including quarterly estimates of the number of participants who will enter the scheme. Jurisdiction-specific Heads of Agreements signed by the Australian and the State and Territory Governments outline that

5 The NDIA project that in 2019-20, the NDIS will include 460 000 participants under the age of 65 years and 15 000 participants aged 65 years and over. The NDIA reports 460 000 participants in its publications.

the full scheme is scheduled to be rolled out nationally by 2019-20, with the timeframes for the transition to differ across jurisdictions (NDIA ndb) (table 2.1).[6]

Table 2.1 **NDIS transition arrangements by jurisdiction**

	Trial period			Transition to full scheme			Full scheme
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
NSW	Hunter area trial		Early Transition in Nepean Blue Mountains area (children aged 0-17 years)	Transition to full scheme (by region)		Full scheme	
Vic	Barwon area trial			Transition to full scheme (by region)			Full scheme
Qld			Transition to full scheme from July 2016 (by region). Early Transition from January 2016 in Townsville, Charters Towers and Palm Island				Full scheme
SA	Statewide trial (children aged 0-14 years)			Transition to full scheme (by age and region)		Full scheme	
Tas	Statewide trial (people aged 15-24 years)			Transition to full scheme (by age)			Full scheme
NT		Barkly region trial		Transition to full scheme (by region)			Full scheme
ACT[a]		Territorywide trial		Full scheme			
WA[b]		Perth Hills area trial MyWay trial			Transition to locally-administered NDIS		Full scheme

a The Bilateral Agreement for the NDIS launch between the Australian Government and the ACT Government notes that from 2016-17 the ACT will be in 'transition to full scheme'. This transition has been categorised as 'full scheme' because all residents who meet the eligibility criteria will have access to the scheme. **b** In February 2017, the Australian Government and Western Australian Government signed a Bilateral Agreement for a nationally consistent, but locally-administered, NDIS.

Sources: Adapted from ANAO (2016, p. 79); NDIA (ndb); Porter, Barnett and Faragher (2017).

The speed of the rollout is creating problems

In 2011, the Commission recommended that the NDIS commence in July 2014 in two geographic regions (PC 2011, p. 938).[7] But the scheme was launched a year earlier, and

6 The Bilateral Agreements covering the trial phase (signed between 2012 and 2014) included the planned intake of participants and the balance of cash and in-kind contributions to the scheme. A second set of Bilateral Agreements cover the arrangements for transitioning the NDIS to full scheme. These were signed in 2015 and 2016. The ACT reached full scheme at the completion of the trial period so a second bilateral agreement was not required.

the scope of the trials was broadened significantly. The changed timing and scope of the trials compressed the planning phase for the scheme. Some aspects of the scheme were being built and tested over the trial, for example:

- the NDIS commenced without an assessment tool to help determine reasonable and necessary supports and had to build one over the first three months of operation (in 2011 (NDIA, sub. 161. p. 3). The Commission acknowledged that there was no ideal assessment tool to use in the NDIS, but also said that the scheme should not be delayed in the absence of 'perfect' tools (PC 2011, pp. 338–339)
- the ICT system used during trial was an interim system that would not scale to full scheme (a new system was put in place in 2016 for full scheme) (NDIA, sub. 161. p. 3).

A review of the capabilities of the NDIA described the Agency as being 'like a plane that took off before it had been fully built and is being completed while it is in the air' (Whelan, J., Acton, P. and Harmer, J. 2014, p. 7).

The rollout schedule is highly ambitious given the magnitude of the reform. To reach the estimated 475 000 participants at full scheme by 2019-20, the NDIA will need to approve hundreds of plans a day (figure 2.1). In the March 2017 quarter, the NDIA approved about 14 000 plans, or roughly 160 plans a day (NDIA 2017o, p. 12). In 2018-19 (the final year of transition), NDIA modelling indicates that about 500 plans a day will need to be approved, and hundreds more reviewed.

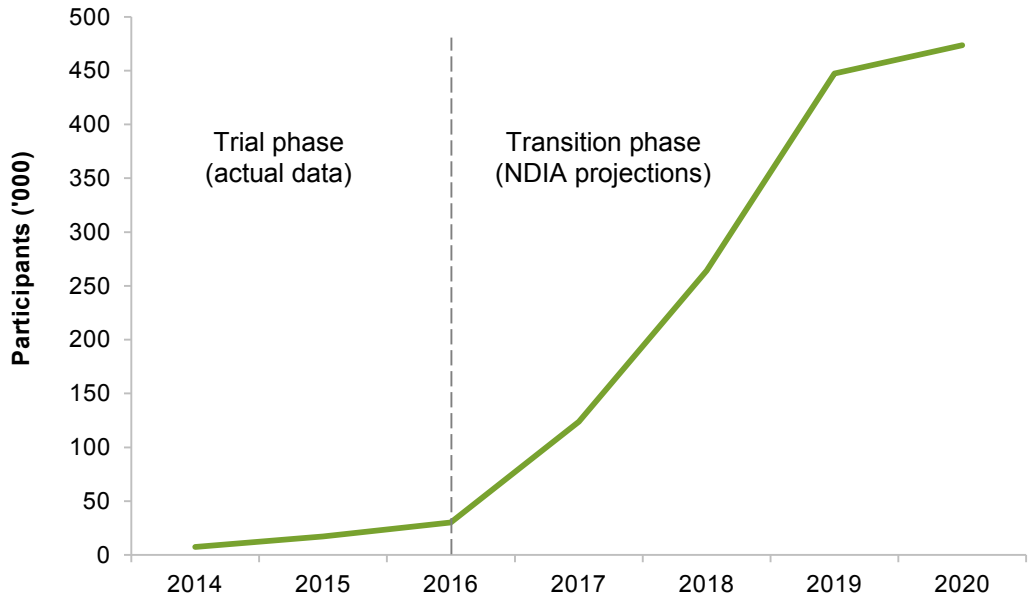
As JFA Purple Orange said (sub. 186, p. 7), the NDIS transition arrangements 'mean a tsunami of new participants will be processed into the scheme over the next two years'. Associate Professor Helen Dickinson of the Public Service Research Group at the University of New South Wales (2017) also recently commented that 'this vast reform is being implemented at break-neck speed'.

The NDIA is already struggling to keep up with the participant numbers included in the Bilateral Agreements — at the end of March 2017, there were 78 000 participants with approved plans, which was just 82 per cent of the bilateral estimates (table 2.2).[8] If the number of people approved to enter the scheme but awaiting a plan (23 000) are added to scheme participant numbers, then the bilateral estimates have just been reached.

7 The Commission also recommended that the scheme would be national by July 2015 and reach full scheme by 2018-19.

8 The 78 000 participants with an approved plan reported by the NDIA includes children who have entered the Early Childhood Early Intervention pathway but who *do not* have an approved plan.

Figure 2.1 **Growth in number of participants in the scheme[a]**



[a] The projections of scheme participants were prepared by the Scheme Actuary for the NDIA's 2015-16 Annual Financial Sustainability Report using data at 30 June 2016. They do not incorporate actual participant numbers beyond June 2016.

Source: NDIA (2016b).

Table 2.2 **NDIS participants and bilateral estimates**

	Participant cohort with approved plans				*Bilateral estimate*	*Per cent of estimate*
	Existing disability service clients	*New*	*ECEI[a]*	*Total*		
End of 2015-16	16 112	14 169		30 281	36 307	83
End of 2016-17 Q1	21 473	16 395		37 868	56 573	67
End of 2016-17 Q2	38 516	22 694	2 267	63 477	74 833	85
End of 2016-17 Q3	48 391	27 176	2 439	78 006	95 148	82

[a] 'ECEI' denotes the number of children who have entered the Early Childhood Early Intervention pathway but who *do not* have an approved plan.

Source: NDIA (2017o, p. 16).

The NDIA, commenting on the bilateral estimates, said:

> The transition to full scheme commenced on 1 July 2016 and immediately there were problems. The new systems and process, coupled with the scale of intake and issues with the ICT portals saw the NDIA fall behind both in terms of the bilateral estimates and the quality of the participant and provider experience.

> The NDIA was able to recover against the bilateral estimates, but problems emerged during this time with the quality of plans and concerns were expressed about aspects of the planning process and the impact on the participant experience. These are matters that the NDIA is now actively addressing. (sub. 161, p. 4)

The NDIA indicated that there appear to be fewer clients in existing programs than the national minimum dataset suggested, and compared to the estimated number of transitioning participants in Bilateral Agreements (noting that the numbers in the Bilateral Agreements are estimates, not hard targets). And while this is expected to affect the mix of transitioning and new participants, at this stage the NDIA has not revised the overall expected number of participants in full scheme (sub. 161, p. 76).

Given the size, speed and complexity of the reform, it is inevitable that there will be transitional issues with the rollout of the NDIS. It needs to be recognised that the scheme is still in its infancy and it will take time to get it right. As the Australian Federation of Disability Organisations (AFDO) said:

> We acknowledge that there have been many issues during trial and the transition to full scheme implementation. But we also recognise that this is a unique period in the life of the NDIS. Never again will the scheme have to grapple with the multiple challenges posed by bringing in a large number of participants in such a short period of time. Once this period of transition is over, growth will be limited to a small number of new participants. AFDO understands that there are significant operational challenges in ensuring hundreds of thousands of people enter the scheme in a short period of time. (sub. 180, p. 5)

But already there are signs that the rollout schedule is compromising the NDIA's ability to implement the NDIS as intended, and risking the financial sustainability of the scheme — and the number of participants entering the scheme is only just starting to ramp up. Many of the concerns raised with the Commission in this study relate to the rollout schedule and the risks of focusing on participant numbers (box 2.1). The NDIA is also aware of the risks, noting that:

> … bilateral estimates can and do impact upon the way in which the Scheme is delivered. This can put sustainability at risk and impact on the way in which early intervention and investment initiatives are implemented in the short term. It may also have adversely impacted the quality of plans. (sub. 161, p. 109)

While the NDIA has been set a challenging task of generating plans for tens of thousands of participants each quarter, it is important that it also undertakes the planning process in a way that achieves the objectives of the scheme (chapter 4).

Box 2.1 Risks from the rollout schedule are highlighted

House with No Steps:

> … the Scheme has aggressive ramp-up targets. These are putting pressure on the NDIA's capacity to develop quality plans for participants. Unfortunately, the need to achieve high growth in participant numbers appears to be outweighing considerations of plan quality and consistency. (sub. 104, p. 5)

Community Mental Health Australia:

> If the focus purely becomes about signing as many people up as quickly as possible and preventing cost-overruns, then the intent of what the NDIS was actually meant to deliver starts to become lost. (sub. 11, p. 2)

Maurice Blackburn Lawyers:

> We believe the roll-out timeline of the NDIS is highly ambitious and increases the serious risk of inadequate delivery of services to participants. It also poses significant financial risks to the scheme as a whole. (sub. 58. p. 6)

Blind Citizens Australia:

> While we understand the agency is under intense pressure to meet the targets that have been agreed upon under the bilateral agreements between state and territory governments, meeting these targets should not come at the expense of the basic rights and freedoms of people with disability. (sub. 130, pp. 2–3)

Australian Federation of Disability Organisations:

> The need to bring in a large number of participants into the scheme to meet bilateral targets has during transition led to practices which have not always been consistent the original vision of the scheme. (sub. 180, p. 5)

Young People in Nursing Homes Alliance:

> Trying to meet the very demanding targets in the bi-lateral agreements has been torturous for both the scheme and for its partners. The NDIS has had to divert resources away from core commitments to manage these urgent imperatives … (sub. 187, pp. 26–27)

Plan Management Partners:

> … the volume of plans to be completed in order for the scheme to achieve its milestone rollout targets is ultimately generating more work for LACs and plan reviewers due to the variability in quality of resultant plans. (sub. 126, p. 11)

Catholic Social Services Australia:

> The speed of the NDIS rollout will put considerable pressure on processing participants' eligibility, assessment and planning. This pressure will be exacerbated by annual plan reviews that are required for those already in the scheme (sub. 166, p. 7)

The Department of Social Services:

> … there are risks arising from the scale and pace of roll-out that has potential to place strain on the NDIA, and on agreed transition timeframes. (sub. 146, p. 24)

A further problem resulting from the rollout schedule is that parts of the supporting infrastructure that are essential to the objectives of the scheme are not operating as intended. For example, Local Area Coordinators (LACs), which play a key role in delivering information and linking individuals to disability services, were supposed to be 'on the ground' in rollout areas six months before participants joined the scheme (chapter 5). But this did not occur and some areas were still without a LAC months after

they joined the scheme. The need to meet bilateral targets has also resulted in LACs being asked to divert resources away from Information, Linkages and Capacity Building (ILC) tasks to undertake planning-related activities. ILC is important for containing scheme costs and reducing reliance on individualised supports (chapter 5).

The NDIA (sub. 161, p. 16) acknowledges that its 'systems and processes are not at peak efficiency and are not ideal in terms of dealing with the speed and scale of the intake challenge'. Also that:

> While the NDIA remains committed to meeting the bilateral estimates, it recognises that the systems and processes that underpin delivery must continue to improve to meet the scale of the challenge while delivering appropriate high quality individual outcomes. The achievement of the bilateral estimates must be done in a manner that maintains the commitment in all jurisdictions to quality, safety, improved outcomes and sustainability. (sub. 161, p. 16)

The rollout schedule has also meant that the market for disability care and support (including providers, workers and participants and their families) has had very little time to adjust to the new scheme (chapters 6–8). As One Door Mental Health said:

> The speed with which the roll-out has occurred has placed significant financial strain on providers, particularly small providers, as a result of needing to move from the relative stability of block-funding arrangements to the uncertainty of unknown revenue through fee-for-service. (sub. 179, p. 11)

Without time to allow for the demand side to become better informed and active, and for the supply side to adjust and grow, there is a risk that participants will be unable to utilise their supports, either because the services are simply not there, or because participants are not sufficiently well equipped to navigate the scheme.

Chapter 9 explores the issue of whether a slowdown in the rollout schedule is required.

DRAFT FINDING 2.1

The scale and pace of the National Disability Insurance Scheme (NDIS) rollout to full scheme is highly ambitious. It risks the National Disability Insurance Agency (NDIA) not being able to implement the NDIS as intended and it poses risks to the financial sustainability of the scheme. The NDIA is cognisant of these risks.

2.2 Projections of scheme costs

One of the NDIA's insurance principles is to develop actuarial estimates of long-term costs (chapter 1). Actuarial estimates are compared with the actual scheme experience, so that the NDIA can identify cost pressures, and track and monitor responses put in place to address those pressures.

However, estimating future scheme costs presents a number of challenges. For example, while there is information on the number of potential participants who are currently receiving support from existing State and Territory Government programs, there is only survey data (which is subject to sampling error) on the number of potential participants not receiving support from government programs.

There is also uncertainty about the support needs of potential participants. While there is comprehensive data on the catastrophic injuries that are covered by compensation schemes (mostly spinal cord, brain and burn injuries), for most disabilities, comprehensive data on the level of funding required to achieve good long-term outcomes are not available. The NDIA has constructed reference packages for different disabilities with the help of expert reference groups (chapter 4). These packages will be refined over time as data are collected from the NDIS on the effectiveness of different supports and their cost.

In 2011, the Commission estimated a national disability insurance scheme would cover 411 000 participants at a gross cost of $13.6 billion at full scheme (PC 2011) (box 2.2).

The NDIA (2017o, p. 5) projects that by 2019-20 the NDIS will cover 475 000 participants and cost about $22 billion each year.[9] These estimates are broadly consistent with the Commission's 2011 modelling after taking into account inflation (including the effects of pay rises awarded to social and community services workers by the Fair Work Commission in 2012), population changes, and costs associated with participants aged over 65 years (who enter the scheme prior to 65 years) (box 2.3).

The NDIA's methodology is more refined than that used by the Commission in 2011 (the Commission has been supplied with the long-term cost projection model developed by the NDIA to produce the 2015-16 Annual Financial Sustainability Report). The key differences are:

- participant numbers are modelled for 14 separate disability groups (apart from psychosocial disability, there was no distinction between disabilities in the Commission's 2011 modelling)
- average package costs assumptions are based on reference package data developed by expert reference groups (the Commission in 2011 used data from injury and accident schemes that operate in Australia)
- epidemiological data on incidence and mortality rates for different disabilities were used to model participant numbers over time (the Commission did not explicitly model entry and exit rates in 2011).

9 Both the Commission's and the NDIA's projections of scheme costs include Western Australia. While the gross cost of the NDIS is estimated to be $22 billion in 2019-20, the scheme is expected to reduce the funding required for a range of government programs. A review by the Australian Government Actuary in 2011 estimated these offsets to be about $11 billion (NDIA, sub. 161, p. 29).

Box 2.2 The Commission's modelling approach in 2011

In its 2011 report on *Disability Care and Support*, the Commission estimated that the National Disability Insurance Scheme would cover 411 000 participants and would have a gross cost of $13.6 billion (and a net cost of $6.5 billion) at full scheme. The costings were based on three calculations:

- the number of people who would be eligible for the scheme
- the level of support that these people would require
- the average per person cost associated with each level of support — four types of support were costed: care and support, aids and appliances, home modifications and transport.

No single data source contained all the information required.

- The primary data source for numbers of people and level of support was the 2009 ABS Survey of Disability, Ageing and Carers. The number of participants entering with psychosocial disabilities was calculated by consulting with experts who had previously examined the prevalence of enduring psychiatric disability.
- A variety of sources were used to estimate the average per person costs for different types of support, including data from the Victorian Transport Accident Commission, the NSW Lifetime Care and Support Scheme, and the Multiple Sclerosis Longitudinal Study.

The Commission also estimated that when the National Disability Insurance Scheme matures (around 2050), the *net* cost would be $4.4 billion. The long-term savings were attributable to assumptions regarding early interventions and community capacity building (for example, more people with disability are able to live in the community with intensive supports rather than in supported accommodation).

A further offset of about $720 million was assumed when the National Injury Insurance Scheme matured.

The Commission recognised that there were significant uncertainties about the cost estimates because of the nature and quality of the data, and undertook a number of sensitivity analyses to explore these uncertainties.

Source: PC (2011, pp. 748–780).

The NDIA has made some adjustments to their long-term cost projections using some trial data, but have not yet made more extensive changes to cost projections based on all trial and transition data. This is because these data have too many limitations to update assumptions about prevalence and package costs, and reflect a period of the scheme prior to management responses implemented by the NDIA to address early cost pressures (discussed below). As the scheme rolls out, the transition data collected will be used to better inform estimates of full scheme costs, and to assess the effectiveness the NDIA's responses to address cost pressures.

Box 2.3 Comparing NDIA's estimates and the PC's 2011 estimates

While the National Disability Insurance Agency (NDIA) uses a different methodology to that used by the Commission in 2011 to estimate costs, the differences in projected costs are mainly attributable to incorporating population projections, industry-specific wage increases and costs associated with participants aged 65 years and older (table below).

Population

Between 30 June 2012 and 30 June 2020, Australia's residential population aged under 65 years is projected to increase by 12 per cent. Applying this increase to the Commission's estimate of 411 250 scheme participants (aged under 65) results in 461 000 participants aged under 65 years — this in line with the 458 368 participants estimated by the NDIA. Incorporating population projections adds about $1.5 billion to the Commission's estimates of scheme costs.

Wage increases in the disability sector

In February 2012, the Fair Work Commission found that employees in the community and disability sectors were underpaid compared to public service workers doing similar jobs. The subsequent Equal Remuneration Order applies adjustments ranging from 23 per cent (for employees at the lowest level) to 45 per cent (for employees at the highest level) in nine instalments between December 2012 and December 2020. These adjustments are applied on top of increases from the annual wage review undertaken by the Fair Work Commission.

The NDIA's modelling of scheme costs assumes that average cost of care in the disability sector will increase 29 per cent between 30 June 2014 and 30 June 2020. If Australian Government Actuary assumptions regarding cost increases from the Department of Social Services' funding model are applied between 2011-12 and 2013-14, the total increase in average costs to 2020 is 44 per cent. The NDIA assumptions imply an increase in average costs from $31 183 to $45 018 per participant. These cost increases would add about $6.4 billion to the Commission's estimates of scheme costs.

Participants aged 65 and older

The NDIA modelling projects that there will be 15 000 participants aged over 65 in 2019-20 and that they will add an extra $1.09 billion to scheme costs (with an average cost of $71 000 per participant). The Commission's 2011 estimates of costs did not include participants over 65 years on the basis that they did not represent a net increase in costs to the Australian Government (as their support was funded under the aged care system).

Comparing the NDIA's costings and the PC's costings

	Participant numbers	*Scheme costs*
		$b
Productivity Commission estimates 2011[a]	**411 250**	**12.82**
Population projections to 2019-20	49 544	1.54
Inflation in disability sector (wages)	..	6.38
Participants aged 65 years and older	15 285	1.09
Updated Productivity Commission estimates	**476 079**	**21.84**
NDIA projections for participants[b]	**473 653**	**21.76**
Difference (%)	2 426 (0.5%)	0.08 (0.4%)

[a] Excluding operating costs and offsets associated with the National Injury Insurance Scheme and assumed efficiency dividends [b] Excluding operating costs ($1.5b), offsets associated with the National Injury Insurance Scheme (-$0.7b) and assumed efficiency dividends (-$0.3b). .. Not applicable.

Sources: Commission estimates; NDIA unpublished estimates; PC (2011); Fair Work Australia (2012).

DRAFT FINDING 2.2

While a different methodology is used, the National Disability Insurance Agency projections of scheme costs are broadly consistent with the Productivity Commission's modelling of the scheme in 2011, after accounting for sector-specific wage increases, population changes, and costs associated with participants aged over 65 years (who were not included in the Commission's estimates).

Some key assumptions behind the NDIA's cost projections

There are a number of key assumptions that drive the NDIA's long term projections:

- *prevalence and incidence rates* — the estimate of participant numbers at full scheme (prevalence) is derived using the Survey of Disability, Ageing and Carers and epidemiological data. Estimates of entry (incidence) and exit rates used to make long-term projections also use these data.
- *long-term prices* — inflation of 4.3 per cent per year is assumed in the short term based on current wage rates (including the Social, Community, Home Care and Disability Services Award), with a long-term assumption of 4 per cent per year.
- *utilisation* — there is no explicit assumption regarding underutilisation in the NDIA's projections. The projections assume that participants are allocated, and completely spend, a reference package of supports (the expected level of support required by participants given their age, disability and level of function).
- *early intervention and early investment* — the NDIA's projections assume that early investment will reduce costs by 0.35 per cent per year. This assumption was originally developed for the Commission's modelling in 2011.
- *technology* — advances in technology can both increase and decrease costs. The NDIA does not make any assumptions about the effect of technological advances on scheme costs.

No new projections of scheme costs

The Commission has not revised its own projection of scheme costs for this position paper. There are a number of reasons for this.

- The early scheme data have too many limitations to update assumptions about prevalence and package costs (as noted above, the NDIA made a similar assessment)
- The prevalence and package cost estimates made by the Scheme Actuary (and reviewed by the Australian Government Actuary) involved a significant amount of work — assumptions about package costs are directly linked to reference packages, which were developed over many months by expert reference groups including representatives

from industry, government and academia. Any Commission modelling would need to be based on this information which is already incorporated in the NDIA modelling.

In any case, point estimates of total scheme costs do not tell the whole story. Financial sustainability is about both costs and benefits, and risks to financial sustainability cannot always be modelled, or easily identified from scheme data. A long-term focus, both within and outside of the NDIS, is therefore important. While the NDIA is responsible for monitoring scheme costs and responding to the cost pressures that it can control, all governments have a responsibility to ensure the success of the scheme and its financial sustainability.

2.3 Key insights from trial and transition data

This section provides some insights from the early experience of the NDIS (from July 2013 to March 2017). It looks at participant characteristics, package costs, and utilisation of supports. These three factors determine the year to year cost incurred by the NDIA on individualised supports.

The first point to note is that data from the trial and transition phase need to be interpreted with caution. This is because:

- differences in trial sites and phasing schedules mean that the data cannot necessarily be used as a guide to anticipate full scheme experience (for example, the average level of committed support by a jurisdiction will reflect the trial cohorts for each jurisdiction)
- early scheme data are often subject to small sample sizes — minimal weight should be placed on disaggregated results where sample sizes are small
- the number of scheme participants in a region is likely to be an underestimate of the full scheme number because it takes time for potential participants to approach and gain access to the scheme. (Conversely, the number of exits due to successful early intervention are likely to be lower in the first years of the scheme as it can take some years for the benefits of early intervention to accrue.)
- it can be difficult to determine whether observed cost pressures are transitional or whether they are likely to persist
- during transition, about 20 per cent of committed support is expected to be provided in-kind (Commonwealth or State/Territory Government programs delivered under existing block-funding arrangements) (DSS, sub 146, p. 22) and these supports tend to be more expensive than standard supports (NDIA, sub. 161, p. 101).
- there have been some data integrity concerns that may impact upon the analysis, arising in part as a result of the NDIA transitioning to a new ICT system in July 2016, and in part from gradual improvements in the way that scheme data are collected in response to any identified data integrity concerns.

What do the early data tell us about participants?

At the end of the trial phase in June 2016, the number of participants with an approved plan (30 821) was 83 per cent of bilateral estimates (36 307) (NDIA 2016g, p. 42). (There were another 5500 participants who had been determined as eligible, but who did not yet have an approved plan.)

By the end of March 2017 (the most recent quarterly report), an additional 63 000 people had been found eligible for the scheme (this took the total number of scheme participants who had ever been active to 99 092) (NDIA 2017o). About 75 000 participants are currently active (they have not exited the scheme) and have an approved plan (NDIA 2017o, p. 16).

Participants by disability

Almost two-thirds of current scheme participants either have an intellectual disability (37 per cent) or autism (28 per cent) as their primary disability (figure 2.2). Psychosocial disability is the next most common disability, accounting for about 6 per cent of scheme participants.[10]

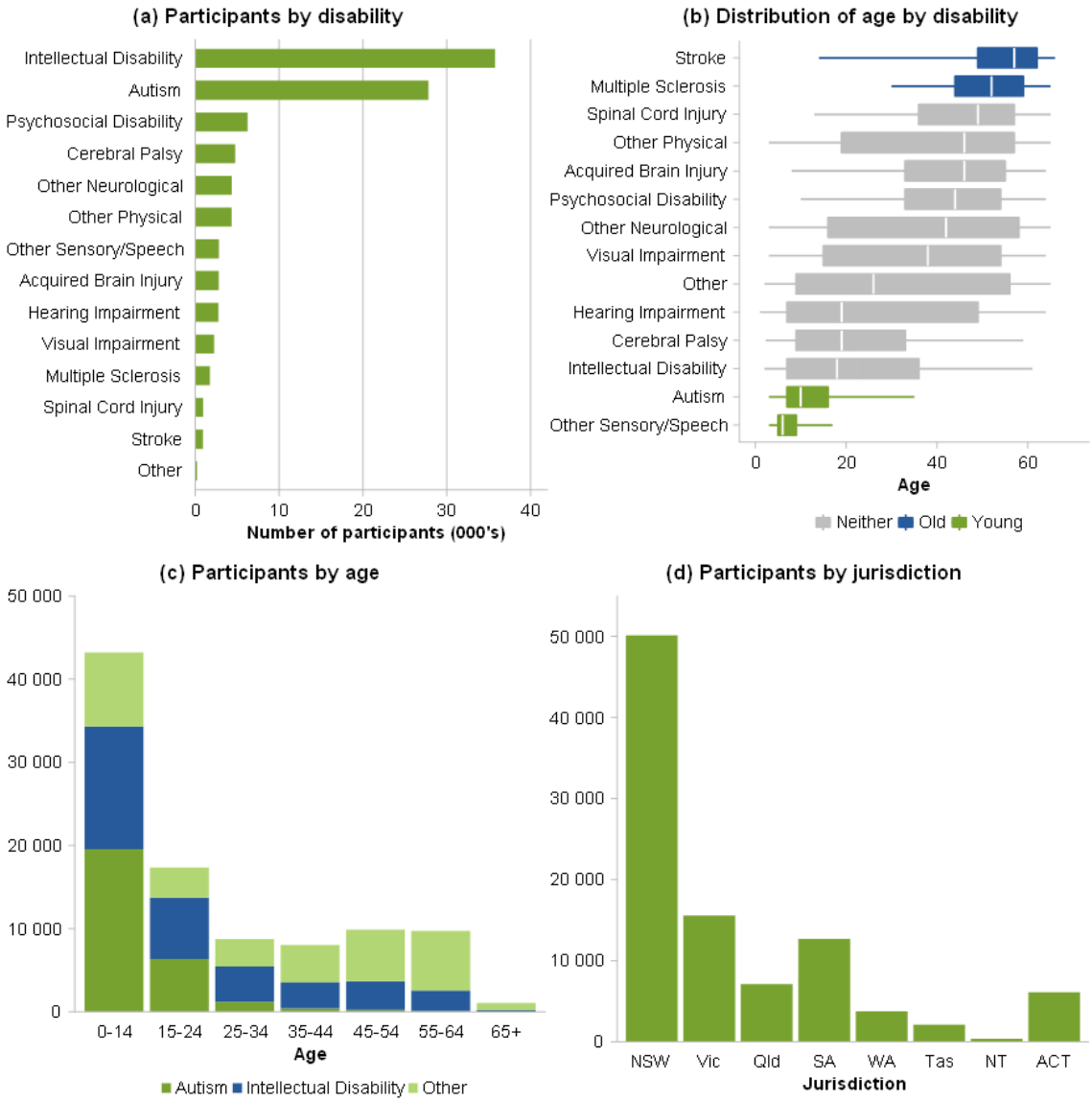
Participants with some disabilities (like stroke and multiple sclerosis) tend to be older, while participants with autism and other sensory/speech disabilities are relatively young (figure 2.2). Most participants with autism enter the scheme under early intervention requirements (and early intervention is most effective at younger ages). In recent years there has been an increase in the number of autism diagnoses — likely in part due to a growing awareness of autism and more sensitive screening tools leading to higher prevalence rates for younger ages (Gothe-Snape, J. 2017).

Disability-specific prevalence rates at the Barwon and Hunter trial sites broadly match those assumed in the NDIA's long-term modelling for all but the largest disability groupings (figure 2.3) (box 2.4). Prevalence rates were higher than the NDIA's long-term modelling assumptions for:

- autism, where prevalence rates were significantly higher in both trial sites (the NDIA has implemented initiatives in response, discussed below)
- intellectual disability, where prevalence rates were much higher in the Barwon region, but not the Hunter region. The higher prevalence rate for intellectual disability in the Barwon region was most pronounced in participants aged under 18 years.

[10] The NDIA (sub. 161, p. 82) noted that, in addition about 4 per cent of participants have a psychosocial disability that is not considered their primary disability.

Figure 2.2 **Some insights: NDIS participants[a,b,c]**



a All figures include data on active eligible participants at 31 March 2017. **b** Figure (b) shows box plots of the distribution of the age of participants for different disability groups. The white dash represents the median and the box shows the interquartile range (quartiles 1 and 3). The box plot tails show the 2.5 and 97.5 percentiles. **c** In figure (d), the number of participants in Western Australia includes the Perth Hills NDIS trial site, but not the WA NDIS MyWay trial.

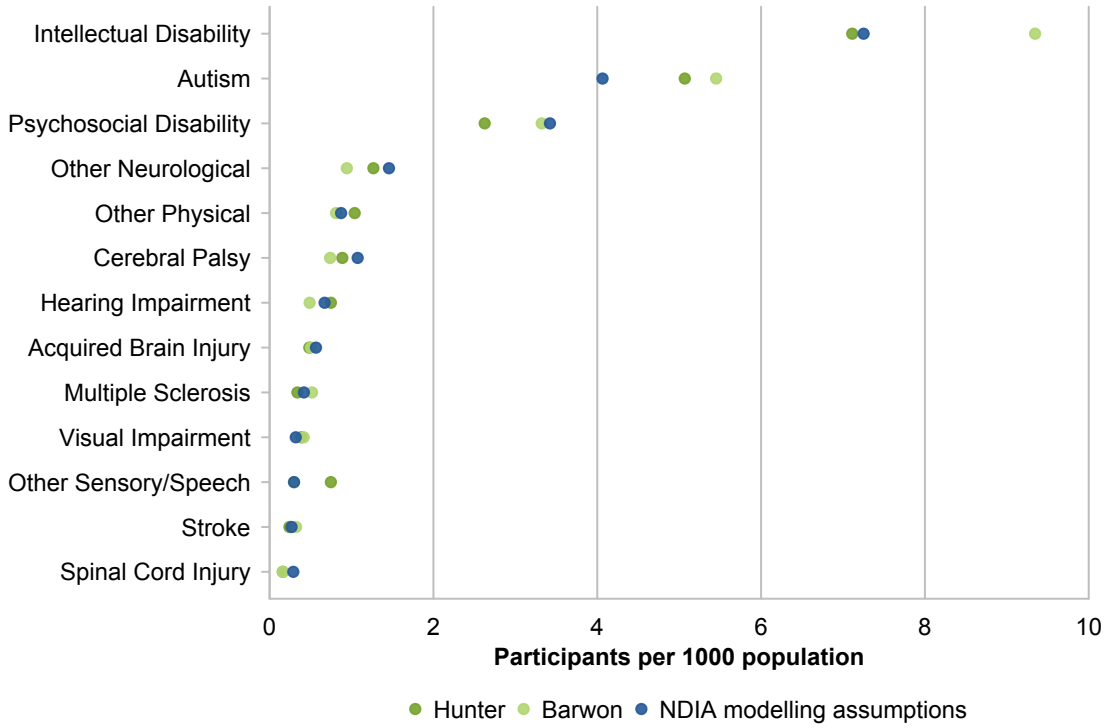
Source: Commission estimates based on unpublished NDIA data.

Box 2.4 Calculating prevalence rates

It is difficult to assess how participant numbers are tracking compared to the National Disability Insurance Agency's long-term modelling assumptions, as it takes time for potential participants to approach and gain access to the scheme. To address this issue, the Commission used data from the Barwon and Hunter trial sites. Both these sites have been in operation since July 2013 and are open to everyone under the age of 65 years.

One significant limitation of this approach is that these trial sites may not be representative of the broader Australian population. Another limitation is that the NDIA have found that participants are continuing to approach the scheme at mature trial sites at a rate that is above that expected if only participants with newly acquired disabilities were approaching the scheme (though this latter factor would suggest prevalence may be even higher relative to the modelling assumptions than the numbers so far collected would indicate). Similarly, the number of exits from the scheme due to successful early intervention is likely to be lower than would be expected at full scheme, as it can take some years for the benefits of early intervention to accrue.

Figure 2.3 Prevalence rates by disability — trial compared to the NDIA's long-term estimates[a]



[a] Prevalence rates for a region are calculated as the number of active eligible participants with the selected disability per 1000 of the population aged 0-64 years at 30 June 2016. Data on the population for the Barwon and Hunter trial regions were sourced from ABS (*Data by Region, 2011–16*, Cat no. 1410.0) with 2015 data projected to 2016 using data from ABS (*Australian Demographic Statistics, Sep 2016*, Cat. no. 3101.0).

Source: Commission estimates based on unpublished NDIA data.

There is a lot of uncertainty around the number of participants with psychosocial disability at full scheme.

- Modelling work undertaken by the Department of Health in 2016, using the National Mental Health Service Planning Framework, estimated that about 92 000 people (18-64 years) have severe and complex psychosocial disorders that would closely align with the NDIS eligibility criteria for individualised supports (sub. 175, p. 4).
- David McGrath Consulting estimated that 'approximately 289 000 people with a severe mental illness will need individualised, intensive 'NDIS-like' community supports in any 12-month period' in work conducted for Mental Health Australia in 2015 (sub. 155, p 10).
- The NDIA (2016g, p. 26) expects that there will be about 64 000 participants with a primary disability of psychosocial disability in the scheme in 2019-20. According to the NDIA, at this stage of the rollout, the number of participants with psychosocial disability is tracking broadly in line with their modelling assumptions in mature trial sites (Scheme Actuary 2016).

The Commission is very aware that estimating the number of participants with psychosocial disability is difficult because a robust and comprehensive data base from which to draw is lacking. However, given that a range of estimates have been prepared by stakeholders and agencies, it would be beneficial if the methodology used was made fully transparent, so that these estimates could be assessed and considered in relation to projections of numbers of participants with psychosocial disability at full scheme.

Participants by age

The largest share of scheme participants at the end of March 2017 were children aged 14 years and under (about 43 000 or 44 per cent of total participants) (figure 2.2). About 45 per cent of children in the scheme have autism, while 34 per cent have an intellectual disability (including development delay).

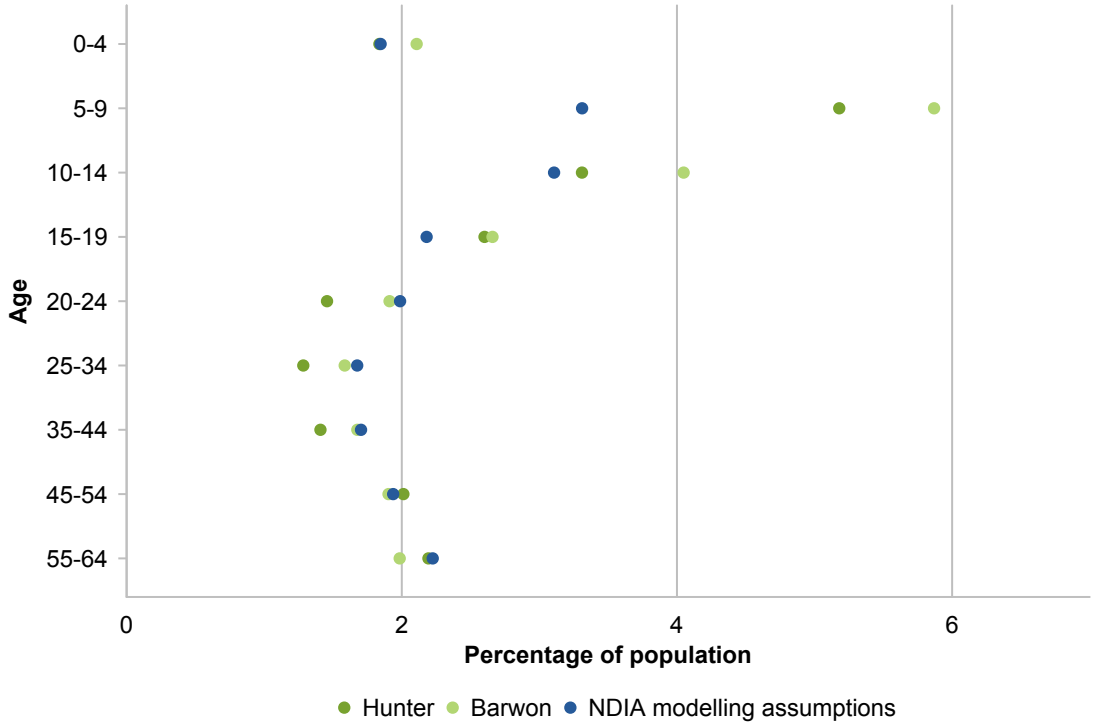
There are more children in the scheme than originally expected — this is even after accounting for the fact the number of children in the scheme is skewed by the South Australian trial site, which only contained children. The NDIA analysed the experience of trial sites and found that the prevalence rates for children aged 0 to 6 years:

- exceeded the Commission's 2011 estimates in South Australia, Barwon and ACT trial sites
- were in line with the Commission's 2011 estimates in Western Australia and the Hunter trial sites (sub 161, p. 78).

Looking at the data from the Barwon and Hunter trials sites, the Commission has reached a similar conclusion. The largest gaps between actual and expected prevalence rates (based on the NDIA's long-term modelling) are for children aged 5 to 9 years followed by

children aged 10 to 14 years. There are larger gaps for the Barwon region than the Hunter region (figure 2.4).

Figure 2.4 **Prevalence rates by age group — trial compared to the NDIA's long-term estimates[a]**



[a] Prevalence rates for a region are calculated as the number of active eligible participants in a given age group per 1000 of the population in the age group at 30 June 2016. Data on the population for the Barwon and Hunter trial regions was sourced from ABS (*Data by Region, 2011–16*, Cat no. 1410.0) with 2015 data projected to 2016 using data from ABS (*Australian Demographic Statistics, Sep 2016*, Cat. no. 3101.0).

Source: Commission estimates based on unpublished NDIA data.

Participants by level of function

Since July 2016, participants have been assessed for their level of functional capacity when they enter the scheme (box 2.5). There is level of function data available for just over 70 per cent of participants. At the end of March 2017, of those who had been assessed:

- 39 per cent of participants had a high level of function
- 38 per cent had a medium level of function
- almost a quarter had a low level of function.

Box 2.5 Assessing level of function

As part of the planning process, the National Disability Insurance Agency assesses each participant's level of function. This is one of many pieces of information that it uses to develop plans to help participants progress towards their personal goals and aspirations.

The National Disability Insurance Agency currently uses different assessment tools for 11 key disability types and the World Health Organization Disability Assessment Schedule version II (for adults) and the Paediatric Evaluation of Disability Inventory-Computer Adaptive Test (for children) where no specific tool is identified. The scores of each assessment tool are mapped to a scale of 1 (high functional capacity) to 15 (low functional capacity), which provides a common measure across different types of disability.

To simplify its analysis, the Commission aggregated levels of function into three groups: high (levels 1-5), medium (levels 6-10) and low (levels 11-15).

Source: NDIA (sub. 161, p. 10).

Compared to the NDIA's long-term modelling assumptions, the distribution of participants by level of function to date is more heavily weighted towards the medium and low levels of function. This difference reflects, in part, the scheme's phasing schedules — participants with the greatest support needs are typically the first to enter the scheme in a region (figure 2.5). This is supported by the fact that the distribution of level of function for mature trial sites (Barwon and Hunter) is closer to the modelling assumptions.[11] (The distribution of level of function for the Hunter trial site is not expected to match modelling assumptions as it included a number of large residential facilities.)

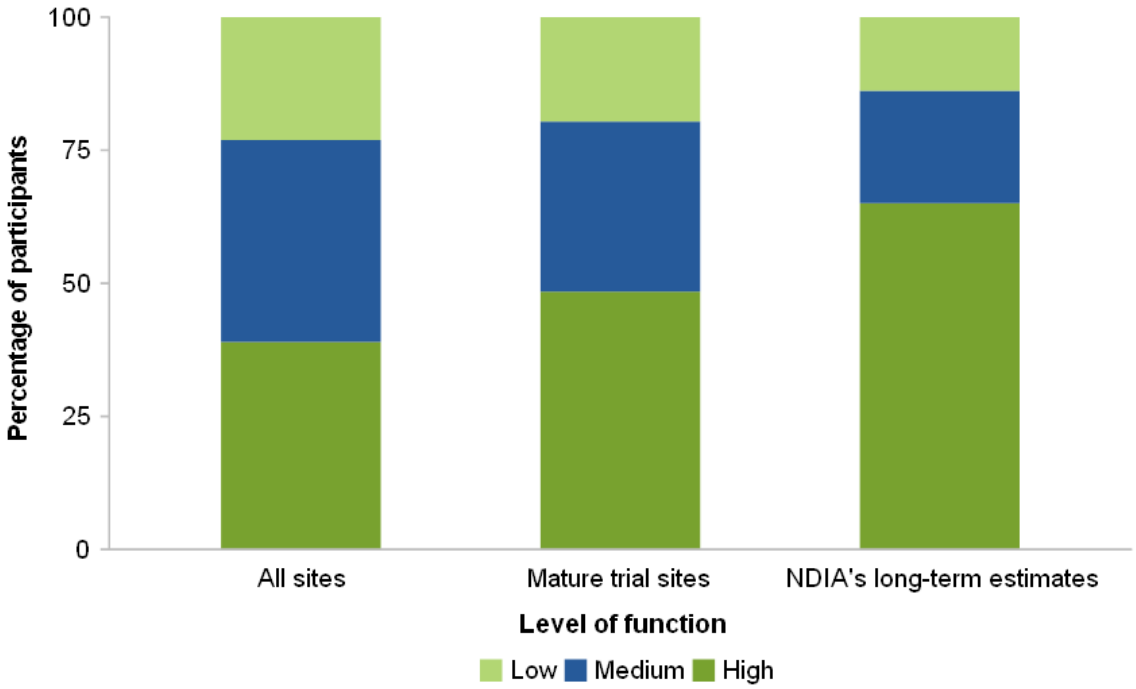
That said, scheme costs will be higher than estimated if the early trend of participants having lower levels of function than expected persisted at full scheme.

Participants by jurisdiction

About half of current NDIS participants are located in New South Wales (figure 2.2) — in comparison the state accounts for 32 per cent of Australia's total population. This overrepresentation is because New South Wales had two trial sites while other jurisdictions had one. New South Wales is also further along the transition to full scheme (NSW is scheduled to reach full scheme by the July 2018 — a year earlier than all the jurisdictions except South Australia and the ACT) (table 2.1).

[11] Data on level of function have not yet been collected for all trial participants.

Figure 2.5 **Distribution of participants by level of function at 31 March 2017 compared to the NDIA's long-term estimates[a]**



[a] 'All sites' denote all eligible scheme participants at 31 March 2017 for whom level of function data are available. 'Mature trial sites' denotes all eligible scheme participants at 31 March 2017 who were trial participants at the Barwon and Hunter trial sites and for whom level of function data are available. 'NDIA long-term estimates' denote the distribution of level of function implicitly assumed in the NDIA's projections of scheme costs.

Source: Commission estimates based on unpublished NDIA data.

What do the early data tell us about package costs?

The level of committed support (or a participant's package cost) is the dollar amount of support in a participant's plan. However, it is not necessarily the amount of support that a participant receives — there are a range of reasons why supports may be underutilised (discussed below).

Over the course of the trial, the average annualised package cost was $36 049.[12] This is slightly below long-term modelling assumptions of average package costs ($38 360 in 2015-16 dollars).

[12] This figure excludes the cost of three large residential centres — Stockton and Kanangra (in the Hunter area trial site) and Colanda (in the Barwon area trial site) — which include a high concentration of high cost participants in one geographical area. The average annualised package cost increases to $39 065 when they are included (NDIA 2016g, p. 46).

However, making this comparison is of limited value because it does not account for the composition of participants included in the trial. Notably, the trial included a higher proportion of children (who typically receive less funded support than other participants because they receive more informal care). While participants with lower levels of function typically entered the scheme first during the trial — which would increase package costs — this was more than offset by the number of children entering the scheme.

To address this limitation, the Commission compared annualised package costs to the reference package amounts for each participant where level of function data were available. Reference packages represent the average expected package amount for a participant given their age, disability and level of function, and are a building block for the NDIA's modelling of scheme costs (box 2.6). Importantly, the package cost of a single participant is *not* expected to be equal to the reference package amount (factors such as scope for informal support and requirements for aids are important inputs into a participant's plan and can generate large differences between individual packages and reference package amounts), but package costs can be compared to reference packages at an aggregate level.

Box 2.6 Reference packages — fundamental to assessing financial sustainability, not individual packages

To acquit the study's terms of reference, it is necessary to examine the assumptions of the NDIA's financial sustainability modelling, and to consider the reference packages used to project costs for different cohorts of people with different disabilities over the long term. Reference packages form a key part of understanding long-term costs, and whether the scheme is 'on track' in aggregate. That said, reference packages (and the data presented in this chapter) should not be conflated with what an individual might expect to receive in an individualised funded package at any given time. This is because a package received by an individual is determined by much more than a reference package (chapter 4), and the reference package amount does not account for an individual's particular goals, nor what supports may be reasonable or necessary in a particular individual's circumstances.

Comparing annualised package costs to the reference package amounts is further complicated by participants in Shared Supported Accommodation (SSA). SSA is accommodation for people who require specialist housing solutions and intensive support needs. SSA is designed for participants with extreme functional impairment. As such, package costs for participants in these facilities are substantially higher than other scheme participants (typically about $200 000).

At 31 March 2017, 11 per cent of participants with plans approved from July 2016 were in SSA. While the Commission's estimates include participants in SSA, there are reasons why the package costs of these participants may be lower as the scheme matures. First, there are a number of participants with relatively high levels of function in SSA who will potentially require significantly less support if they receive appropriate capacity building supports early in their lives. Second, SSA services are currently delivered under in-kind

arrangements and for this reason may not be priced correctly (states and territories determine the price of in-kind services, chapter 10).

Using the above approach, the average annualised cost of packages effective after 1 July 2016 is higher than expected given the characteristics of participants ($60 000 compared to $56 000). (Unless otherwise stated, the Commission has used plans effective after 1 July 2016 when analysing package costs.)

Packages by disability

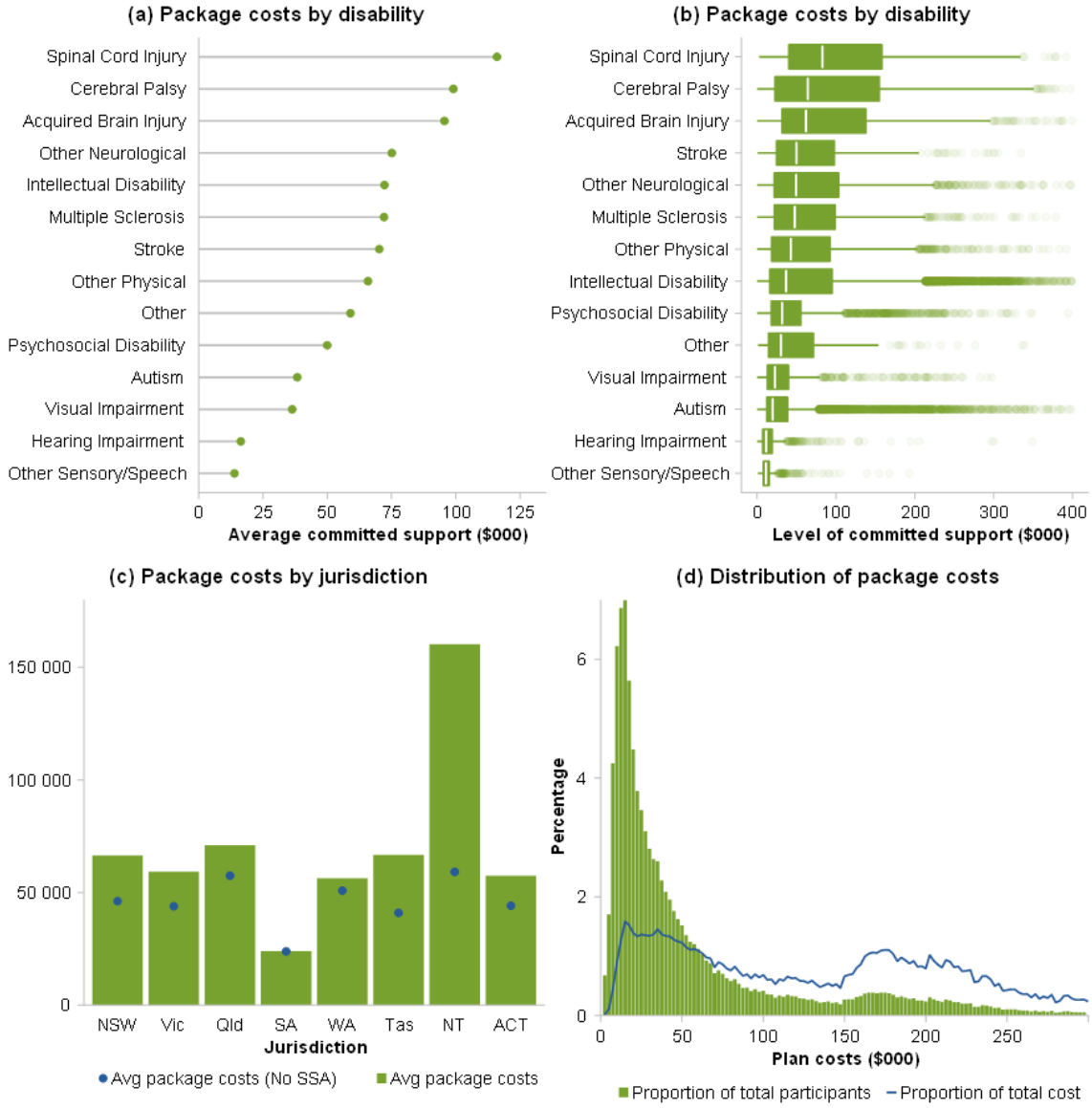
Scheme participants with spinal cord injuries have the highest annualised average level of committed support ($120 000), followed by those with cerebral palsy ($99 000) and acquired brain injury ($96 000) (figure 2.6). If participants included in SSA are excluded, the averages fall to $110 000, $78 000 and $74 000 respectively.

There is significant variation in the amount of committed support received by participants with high cost disabilities. The distribution of committed support for these disabilities is skewed towards some very high cost participants, many of which are in SSA (figure 2.6). Disabilities with lower average levels of committed support (like autism and visual and hearing impairment) exhibit less variation in costs. Some participants with high cost packages may have comorbidities that increase the level of support required, but are classified into a single disability group for reporting purposes.

Average annualised package costs are significantly lower than the NDIA's long-term modelling assumptions for five of the high-level disability groupings (figure 2.7). However, package costs for participants with intellectual disability (the most common disability grouping) and visual impairments are significantly higher than long term modelling assumptions (though the number of participants with visual impairment is much lower than the number with intellectual disability so the aggregated impact is much lower). Average annualised package costs are broadly in line with long-term modelling assumptions for the remaining disabilities.

Figure 2.6 **Some insights on annualised package costs[a,b,c]**

Plans effective from 1 July 2016

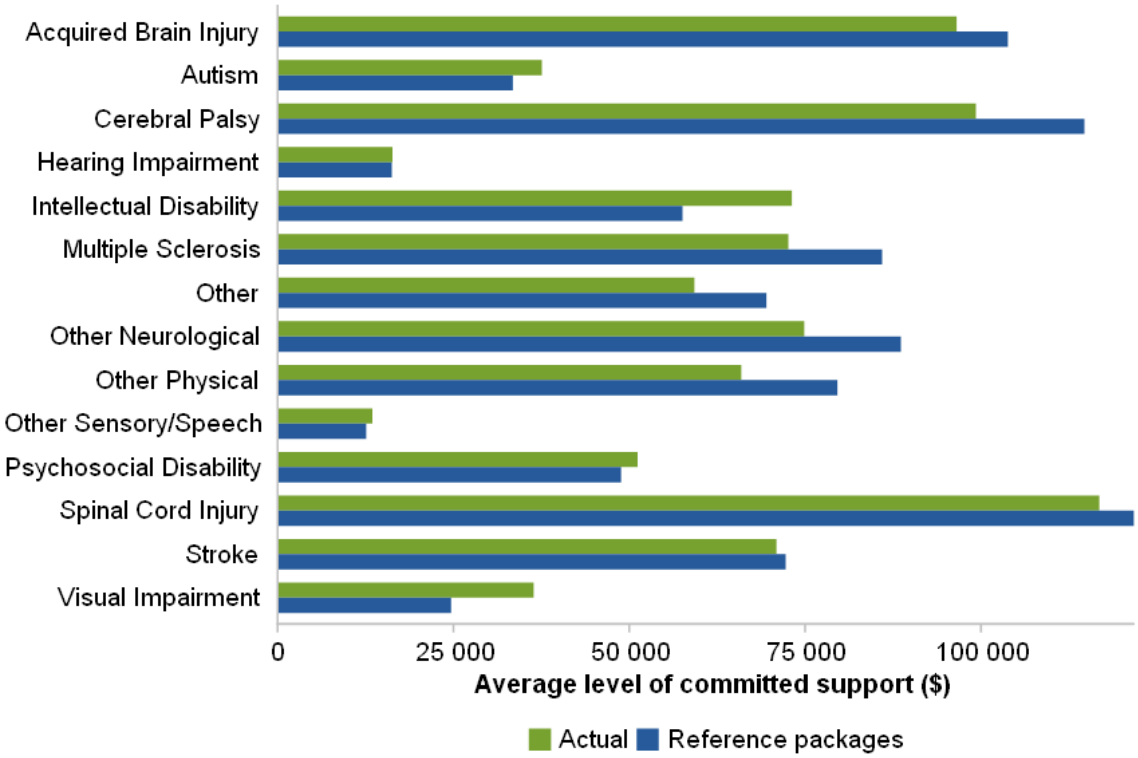


[a] For participants with multiple plans over the time period, the latest plan is used. [b] Figure (b) shows box plots of the distribution of the level of committed support for different disability groups. The white dash represents the median and the box shows the interquartile range (quartiles 1 and 3). The box plot tails show the minimum and maximum observations (though points that deviate by more than 1.5 times the interquartile range from the box are considered outliers and are denoted by a dot point). [c] In figure (c), Western Australia includes the Perth Hills NDIS trial site but not the WA NDIS MyWay trial.

Source: Commission estimates based on unpublished NDIA data.

Figure 2.7 **Average annualised level of committed support compared to reference packages, by disability[a,b,c]**

Plans effective from 1 July 2016



[a] Reference packages are the average package cost assumed in the NDIA's long term modelling based on age, disability and level of function. They *are not* what an individual should expect to receive in an individualised funded package at any given time. [b] For participants with multiple plans over the time period, the latest plan is used. [c] Reference packages are linked to assessment tools. Therefore, participants who are assessed using the generalised assessment tools (including all participants with psychosocial disability) are linked to a 'generalised' reference package.

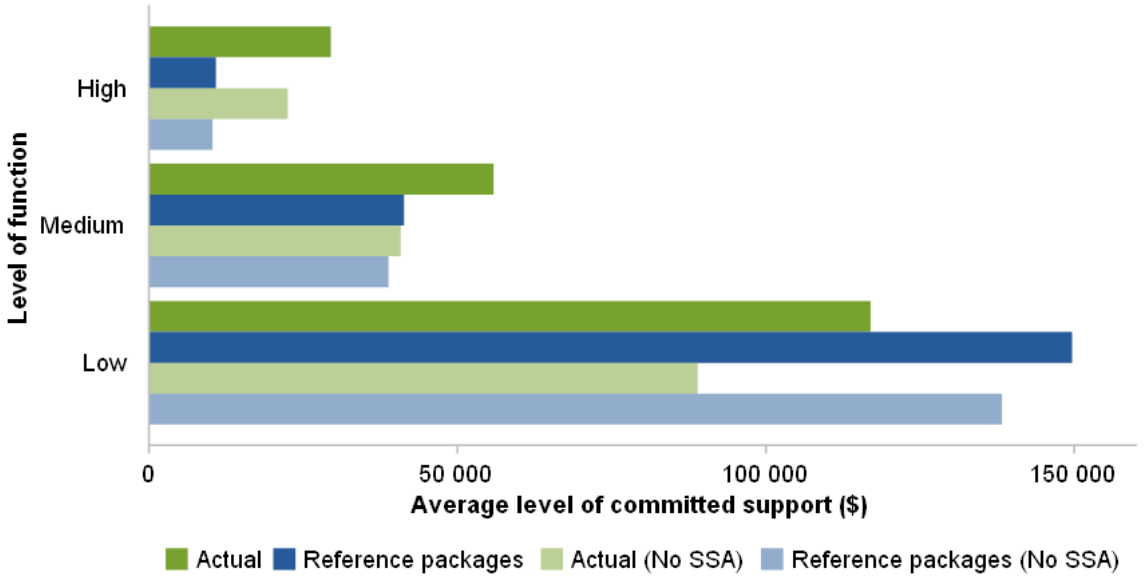
Source: Commission estimates based on unpublished NDIA data.

Packages by level of function

As expected, the average annualised package cost is highest for participants with the lowest level of function (figure 2.8). The average level of committed support for plans associated with low levels of function is almost $120 000, just under four times the amount for participants with high levels of function (about $31 000).

Figure 2.8 **Average annualised level of committed support compared to reference packages, by level of function[a,b]**

Plans effective from 1 July 2016



[a] Reference packages are the average package cost assumed in the NDIA's long-term modelling based on age, disability and level of function. They *are not* what an individual should expect to receive in an individualised funded package at any given time. [b] For participants with multiple plans over the time period, the latest plan is used.

Source: Commission estimates based on unpublished NDIA data.

There are significant differences between average annualised packages costs and the NDIA's long-term modelling assumptions by level of function (figure 2.8).

- The average level of committed support for participants with low levels of function (who require more support) is less than expected (about $120 000 compared to $150 000). One explanation for this result may be that reference packages are underestimating the amount of informal support provided by families and carers.
- The average level of committed support for participants with medium levels of function is higher than modelling assumptions ($56 000 compared to $41 000).
- Participants with high levels of function (who require less support) are obtaining higher packages on average than the modelling assumes ($29 000 compared to $11 000).[13] The NDIA noted that fewer participants than expected are entering the scheme with small package amounts (less than $10 000), and indicated that this is in part due to problems with planning processes (NDIA 2016b, p. 40).

[13] The average annualised package cost for participants with high levels of function presented here ($29 000) only includes participants for whom reference package data are available. Average annualised package costs equal $31 000 when all participants with high levels of function are included.

Participants in SSA are a significant driver of average costs for the high and medium levels of function cohorts (figure 2.8). Given that SSA is designed for people with low levels of function, this suggests that there may have been issues with how SSA has been managed in the past. Such historical experience suggests that investing in capacity building supports early to keep participants with high and medium levels of function out of SSA is critical for minimising scheme costs in the future.

Packages by jurisdiction

The average package cost is highest in the Northern Territory ($160 000) followed by Queensland ($71 000), and lowest in South Australia ($24 000) (figure 2.6(c)). These differences are driven by the phasing schedules. About 39 per cent of Northern Territory participants with an approved plan are in SSA with an average package cost of $320 000.[14] The NDIS only began operating in Queensland at the beginning of 2016 and therefore has a disproportionate number of participants with low levels of function. In contrast, because of the scope of their trial, almost all the scheme participants in South Australia are children who tend to have lower levels of committed support than older participants.

The distribution of total committed supports

The distribution of committed supports (for plans effective from July 2016) is heavily weighted to low cost packages with the most common package costing between $10 000-$15 000 (figure 2.6(d)). The distribution of committed supports weighted by total cost of packages is flatter, peaking at $10 000-$15 000 and $175 000. The second of these peaks is attributable to participants in SSA. A significant proportion of scheme costs is attributable to high cost participants — while only 18 per cent of packages cost more than $100 000, these account for 56 per cent of total committed supports.

Types of support provided

Over half of committed supports are earmarked to help scheme participants with their daily life — usually through support for daily activities (figure 2.9) (box 2.7).[15] A significant proportion of support is also allocated to help participants become more involved in social and community programs (19 per cent), and to improve their daily living skills (11 per cent).

[14] Scheme participants in SSA in the Northern Territory tend to be in the most complex types of SSA.

[15] Participants have some control over how they allocate their support budget depending on the support category (that is, they do have some scope to deviate from the support described in their plan).

Box 2.7 Types of support

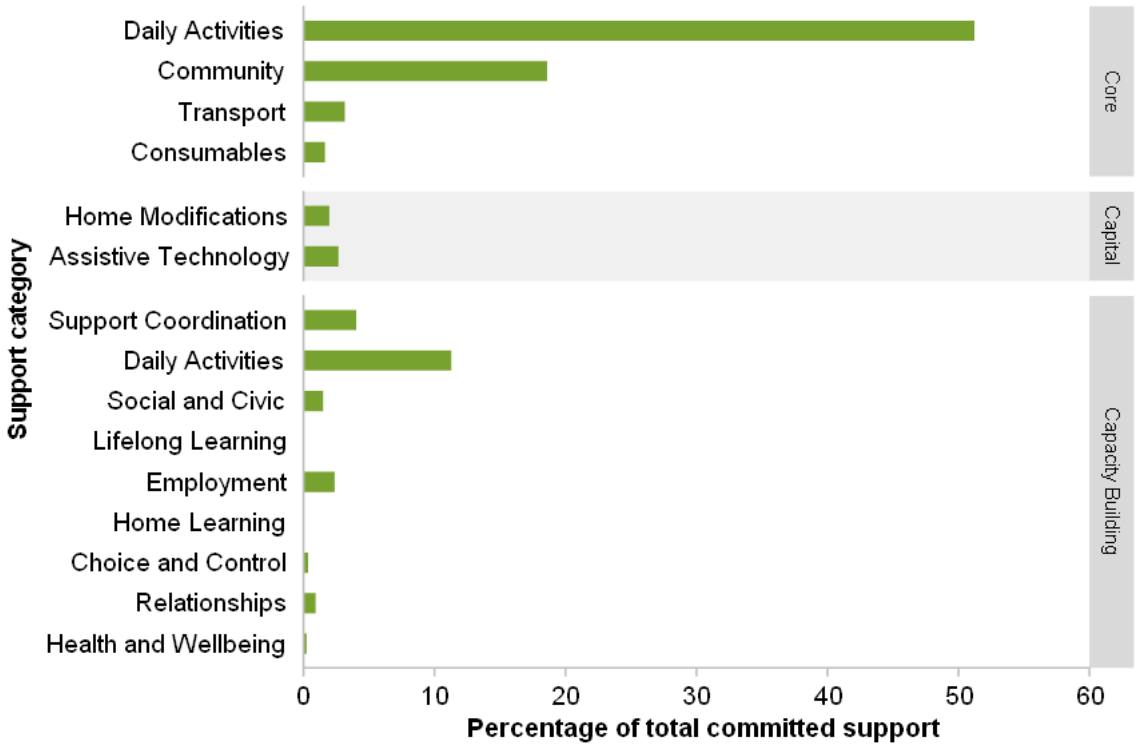
Supports provided under the National Disability Insurance Scheme fall into one of fifteen *support categories,* which in turn can be grouped into three *support purpose categories*:

- Core supports — support that enables participants to complete activities of daily living, and enables them to work towards their goals and meet their objectives.
- Capital supports — an investment, such as assistive technologies, equipment, home or vehicle modifications, and funding for capital costs associated with specialised housing.
- Capacity building supports — support that enables participants to build their independence and skills.

Source: NDIA (2016s).

Figure 2.9 Committed supports provided by support category[a]

Plans effective from 1 July 2016



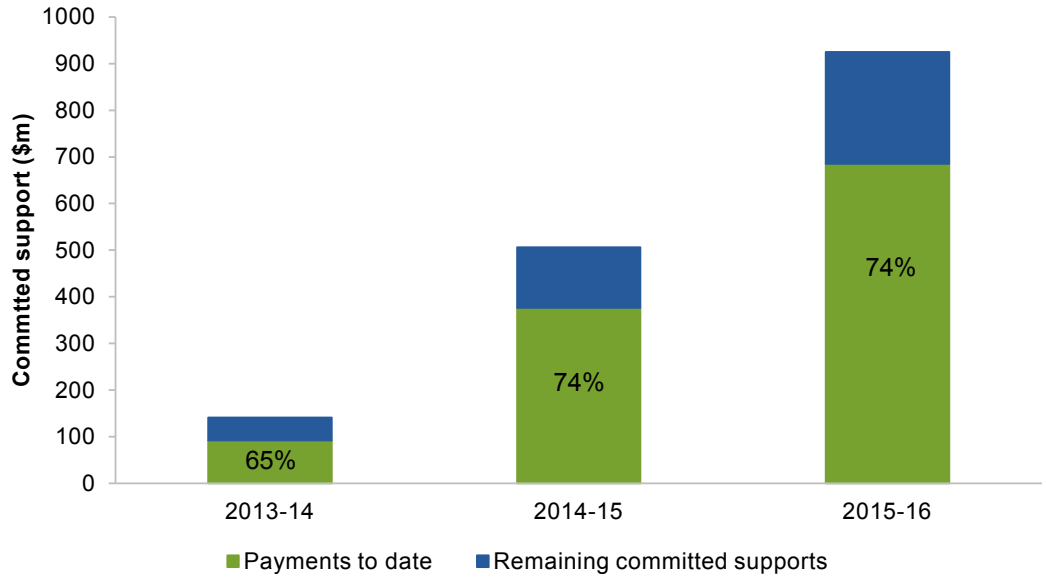
[a] For participants with multiple plans over the time period, the latest plan is used.

Source: Commission estimates based on unpublished NDIA data.

Utilisation

There has been significant underutilisation of committed supports in the scheme so far — in 2015-16, 74 per cent of committed supports have been utilised to date (figure 2.10).

Figure 2.10 **Utilisation of committed supports**



Source: NDIA (2017o, p. 34).

According to the NDIA (and supported by comments from other study participants), on-the-ground experience indicates that the reasons for the utilisation rates being below full utilisation vary by the individual and their circumstances. Some reasons include:

- insufficient supply of supports to meet demand, especially for specific supports (such as short-term accommodation) and in particular markets (such as remote and very remote areas) (PDCN, sub. 29; Public Service Research Group, sub. 56; Jeff Scobie, sub. 57; APA, sub. 93; Commonwealth Ombudsman, sub. 137)
- participants experiencing difficulties navigating the system, which can mean they are unable to implement a plan once it has been approved (PDA, sub. 38; ABF, sub. 48; Jeff Scobie, sub. 57; CSSA, sub. 166)
- scheme participants not needing all the supports they are entitled to (planners overestimating the amount of funded support that will be needed, or including supports that do not meet the needs of participants) (Jeff Scobie, sub. 57)
- the market for plan supports (such as support co-ordination and plan management) being relatively immature and therefore limiting the help that participants can obtain (Anglicare Australia, sub 157)
- some participants cannot easily access information about how much of their supports are available (Public Service Research Group, sub. 56).

Some underutilisation of supports could be expected in the early stages of the scheme as participants and providers adapt to a new system for providing disability care. While the NDIA's estimates of scheme costs implicitly assume that all committed supports are

completely spent when the scheme is fully implemented the NDIA said (sub. 161 p. 70) that 'in a person-centred system the utilisation rate will never be 100%'. The NDIA also noted experience in other schemes suggests a utilisation rate of between 80 and 95 per cent could be expected.

Some emerging cost pressures

Bringing the analysis of these three components of scheme costs together, the Commission is of the view that the early scheme data suggests that NDIS costs are broadly in line with the NDIA's long-term modelling estimates. While more children are entering the scheme than expected and package costs are higher than expected, these factors have been offset by lower levels of utilisation than expected.

However, it is critical that emerging cost pressures are managed as utilisation rates are expected to rise. The Department of Social Services (sub. 146, p. 20) echoed this sentiment, noting that 'better management of cost pressures should reduce the impact of increasing utilisation rates'. That said, if the cost pressures emerging from the trials and transition are not addressed, the financial sustainability of the scheme will be at risk.

The NDIA is tasked with ensuring that the NDIS is delivered within the funding envelope, and this involves identifying and managing emerging cost pressures. The Scheme Actuary compares the experience of the NDIS to projections on an ongoing basis and reports to the Board quarterly. If cost pressures are detected early, management responses can be put in place before problems become entrenched.

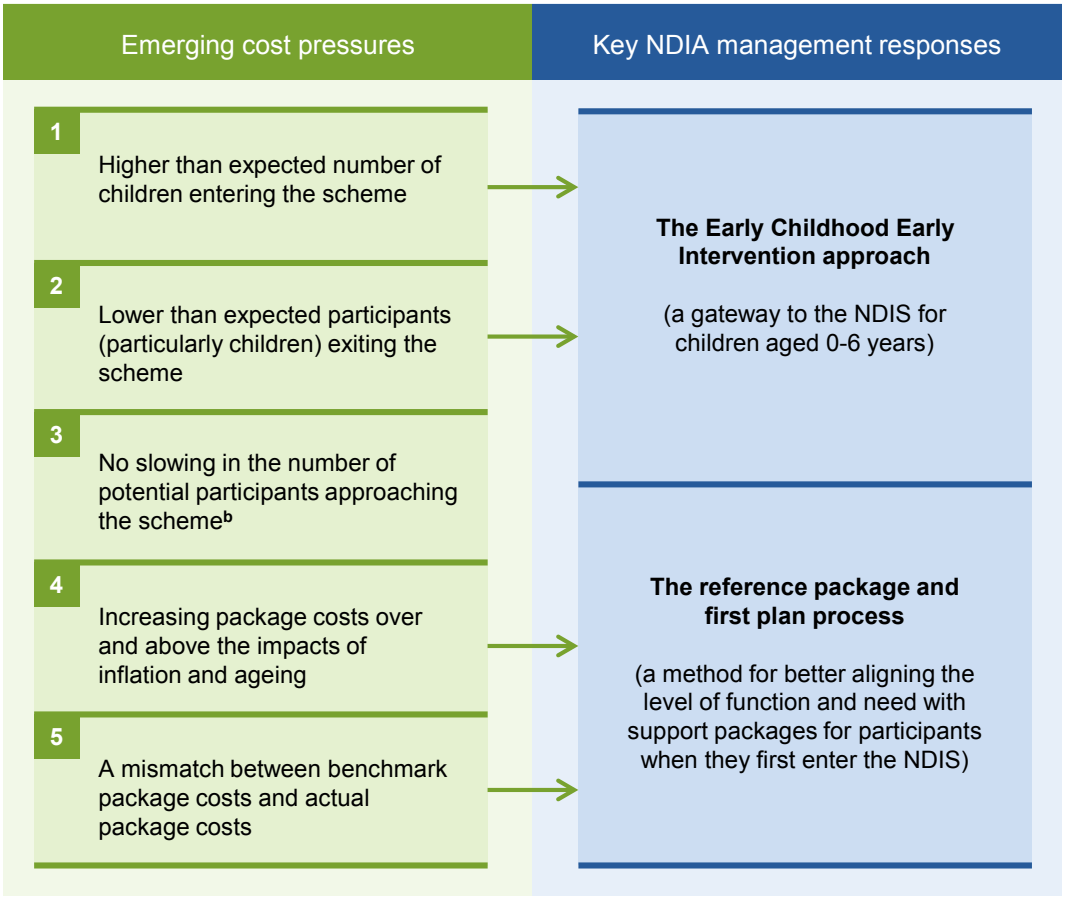
In the NDIA's most recent annual report, the Scheme Actuary identified five cost pressures from the trial sites that need to be managed for the full scheme, including:

- a higher than expected number of children (especially in the trial sites of South Australia, Victoria and the ACT)
- increasing package costs over and above the impacts of inflation and ageing (as plans are reviewed)
- potential participants continuing to approach the scheme (the number of people approaching the scheme in some trial sites that have been operating since 2013 is more than would be expected if only people with newly acquired disabilities were approaching the scheme)
- a lower than expected number of participants exiting the scheme (particularly children who entered the scheme under the early intervention requirements)
- a mismatch between benchmark package costs and actual package costs. There is a greater than expected level of variability in package costs for participants with similar conditions and levels of function (NDIA 2016g, pp. 16, 144).

In line with the insurance approach to identifying risks early and putting in place management responses, the NDIA has put in place initiatives to address these cost pressures

(figure 2.11). The responses include the Early Childhood Early Intervention approach (chapter 3), and the reference package and first plan process (chapter 4) (NDIA 2016g, pp. 16–17, 56–57). It is too early to assess the effectiveness of these initiatives.

Figure 2.11 **The NDIA's responses to emerging cost pressures**[a]



[a] This figure includes the NDIA's two main responses to emerging cost pressures. The NDIA has initiated several smaller projects to address emerging cost pressures, such as an analysis of reasonable and necessary costs across the lifespan of participants. These are detailed in the NDIA's 2015-16 Annual Report (NDIA 2016g, pp. 145–146). [b] Potential participants continuing to approach the scheme is not a cost pressure that can easily be addressed by the NDIA.

Source: NDIA (2016g, pp. 144–146).

DRAFT FINDING 2.3

The National Disability Insurance Scheme, at the end of trial, came in under budget. This was in large part because not all committed supports were used (in 2015-16 the utilisation rate was 74 per cent).

Based on trial and transition data, scheme costs are broadly on track compared to the National Disability Insurance Agency's (NDIA) long-term modelling. At this stage, early cost pressures (such as greater than expected numbers of children and higher than expected package costs) have been offset by lower than expected levels of utilisation.

The NDIA has put in place initiatives to address emerging cost pressures. It is too early to assess the effectiveness of these initiatives.

2.4 Are scheme benefits being realised?

Realising the benefits of the scheme is critical for the wellbeing of people with disability and for ensuring that the community continues to be willing to pay for the NDIS.

Comparing the benefits of the scheme relative to expectations is more difficult than making the same comparison for costs. Some of the benefits are difficult to calculate because they are intangible (for example, the benefits that people with disability receive from having greater choice and control) which makes it more challenging to compare actual and expected benefits.

Outcomes for participants, families and carers

Both the NDIS Outcomes Framework (box 2.8) and an evaluation undertaken by the National Institute of Labour Studies (box 2.9) provide some early insights on outcomes for participants.

- The NDIA has developed a NDIS Short Form Outcomes Framework for measuring the outcomes of scheme participants and their families and carers over time. Most questions ask participants to reflect on their life at the moment to form a baseline for assessment of the ongoing effects of the NDIS. However, there are some questions that ask participants how their life has improved after becoming a participant that can be used to assess scheme benefits to date.
- The intermediate report of the NDIS evaluation undertaken by the National Institute of Labour Studies uses both quantitative (from surveys) and qualitative data (from interviews) to assess the outcomes of the NDIS.

Box 2.8 NDIS Short Form Outcomes Framework

The National Disability Insurance Scheme Short Form Outcomes Framework is an approach to measuring the outcomes of the support experienced by scheme participants and their carers. It includes eight indicators of participant experience (known as participant domains) as well as outcomes related specifically to families (table below). It was piloted in the first three months of 2015 and is now being rolled out scheme wide. (At June 2016, over 23 000 questionnaires had been received — over 13 000 participant surveys and 10 000 family surveys.)

The Framework will allow tracking of participant and scheme progress over time, and demonstrate how participants are faring relative to other Australians and other OECD countries. It will also contribute to an understanding of what types of supports lead to good outcomes for people with disability, their families and carers.

Domain	*Description*
Choice and control	Improved choice and control over participant goals, as well as the planning and delivery of their supports.
Daily activities	Increased ability to undertake daily activities with adequate levels of support.
Relationships	Increased levels of social inclusion and reduced experiences of loneliness.
Home	Improved satisfaction with participants' home environment now and five years into the future.
Health and wellbeing	Improved health and wellbeing and increased ease of access to health services.
Lifelong learning	Increased opportunities to learn new things.
Work	Increased uptake of paid employment opportunities (as well as the associated feelings of social inclusion from being part of the workforce).
Social, community and civic participation	Increased participation in community activities chosen by the participant, and reduced negative experiences associated with being excluded.

Sources: NDIA (2015d, 2016g, p. 60).

Box 2.9 **NDIS Evaluation**

In 2013, the Australian Government Department of Social Services commissioned a consortium led by the National Institute of Labour Studies to conduct an evaluation of the trial of the National Disability Insurance Scheme. The study monitors and evaluates the experience of participants, and their families and carers, service providers and their workforces in the trial sites of the ACT, Victoria, New South Wales, Northern Territory, South Australia and Tasmania.

An initial report, which described how the evaluation was being conducted, was delivered to the Department of Social Services in December 2015.

An intermediate report presented a synthesis of the quantitative and qualitative evidence collected to date and was released in December 2016.

- The qualitative evidence was sourced from in-depth interviews of people with disability, their families and carers (62 interviews), disability service providers (5), disability workforce stakeholder organisations (15) and National Disability Insurance Agency staff (46).
- The quantitative evidence is based on a survey of about 4500 people with disability and about 3500 families. Survey participants are split into two groups — those covered by the NDIS trial and those not covered — and their experiences are compared.

A final report is scheduled to be completed in 2017. It will incorporate an additional wave of survey data. Unless otherwise stated, data presented in this chapter are from the intermediate report.

Source: Mavromaras, Moskos and Mahuteau (2016, p. ix–x, 18).

The NDIS is providing benefits to many

Data from the NDIS evaluation and NDIS Short Form Outcomes Framework suggest that the NDIS has provided a range of benefits to participants, their families and carers. The Commission also received many submissions supporting this finding (box 2.10). The NDIS is:

- providing participants with increased supports (more hours of support, a wider range of support and greater access to equipment) — on average more supports were available than under the previous system.
  - 88 per cent of carers with children aged under five years said the NDIS had improved their child's access to specialist services (NDIA, sub 161, p 36).
  - About two thirds of scheme participants aged 15 years and over said the NDIS had helped with daily living (64 per cent for participants aged 15-24 years and 71 per cent for participants aged 25 years and above) (NDIA, sub 161, p 38).
  - The NDIS evaluation found that 'the majority of respondents receive increased supports as a result of becoming NDIS participants' (Mavromaras, Moskos and Mahuteau 2016, p. xi). The average number of different supports accessed by participants increased from 2.02 to 3.3 under the NDIS (Mavromaras, Moskos and Mahuteau 2016, p. 32).
- improving the wellbeing of scheme participants and their families and carers.

  - 89 per cent of carers with children aged under five years said the NDIS had improved their child's development (NDIA, sub 161, p 36).
  - Almost two thirds of participants aged 15 years and over said the NDIS helped with health and wellbeing (62 per cent of participants aged 15-24 years and 65 per cent of participants aged 25 years and over) (NDIA, sub 161, p 38).
  - 49 per cent of participants said the quality of care had improved with the NDIS (although 15 per cent said quality had declined) (Mavromaras, Moskos and Mahuteau 2016, p. 38).
  - The NDIS evaluation notes that the qualitative evidence 'makes clear that on the whole the NDIS has improved the wellbeing of scheme participants and their family members and carers' (Mavromaras, Moskos and Mahuteau 2016, p. xv). Scheme participants attributed this increase in wellbeing to having better services than previously, and increased independence.
  - Carers reported an 'increased sense of positivity and wellbeing' because their NDIS participants were more involved in activities they enjoyed and were able to participate in wider interests outside of the home. (However, the greater administration burden associated with the NDIS was a cause of stress for some families.) (Mavromaras, Moskos and Mahuteau 2016, p. xv).
- giving participants more choice and control over the supports they receive (the types of supports they receive, the timing of those supports and who provides them).
  - The NDIS evaluation found that 44 per cent of participants surveyed had a greater say over the supports they received, while 46 per cent also had more choice over who provided their supports (Mavromaras, Moskos and Mahuteau 2016, p. 60).
  - The NDIS Short Form Outcomes Framework data suggest that 73 per cent of scheme participants aged 15 years and over had more choice and control over their life (NDIA, sub 161, p 38).
- increasing the social participation of scheme participants and their carers.
  - The NDIS evaluation shows that many participants can now take part in activities independently and are able to follow interests and social activities that had previously been inaccessible (Mavromaras, Moskos and Mahuteau 2016, p. xvi).

Box 2.10 **The NDIS has changed lives**

Anne Hansen:

> … I have seen the life changes in people with disability who now have NDIS funding. They are now accessing community, have a good life and have hope for their futures. The burdens are off the family, some aged carers, and there is job creation. Broken wheelchairs are now being replaced and people who never had wheelchairs, now have and can access the community. I now see happy people. (brief sub. 2)

Lorraine Rodrigues:

> The NDIS to me is knowing that my son will have a future of his own to look forward to if I am unable to care for him for whatever reason. (brief sub. 3)

Merle Searle:

> The NDIS has made such a huge difference to us and our young man on a day to day basis … Please keep up the NDIS it is so appreciated in our households. (brief sub. 17)

Julanne Sweeney:

> The strain on our busy family would be almost unbearable without NDIS … With NDIS help she [granddaughter Isi] is learning skills to equip her for independent living and employment in the future. (brief sub. 21)

Karen Wakely:

> We began implementing our plan in Jan 2016. In a little over 12 months, the change it has facilitated has been extraordinary. For the first time we have been able to access meaningful therapeutic supports. (brief sub. 43)

Lynne Foreman:

> … I can now choose who cares for me, as I now have a choice. I have the hours I need to live my life and also because of flexibility in my plan, I am now an employee … (brief sub. 71)

The stories of Oni and Harry provided by the National Disability Insurance Agency:

> 'I've been working with a speech therapist to get my speech up and it's really helping. I can say a few more words and actually pronounce them properly and all that,' Oni remarked … 'He's only been in one year and the changes have been remarkable. I've seen his confidence improve out of sight. I've heard him be able to speak and say words that we didn't even know he knew,' Chelinay remarked.
>
> 'The NDIS has definitely improved our lives – Harry's and ours as a family,' she said. 'We've been able to get funding to purchase Harry a manual wheelchair … now he can access places he could never in his electric wheelchair, so he now has more flexibility. He was recently able to go the beach with his classmates – something he had never been able to do before!' (sub. 161, pp. 41–43)

But not all are having a positive experience

Some people with disability, however, are experiencing poorer outcomes under the NDIS. And they tend to be some of the most vulnerable people with disability.

Qualitative evidence suggest that some people with disability are experiencing poorer outcomes under the NDIS and are receiving fewer services than previously (Mavromaras, Moskos and Mahuteau 2016, p. xi). According to the NDIS evaluation, participants who were receiving less support are often those who are unable to effectively advocate for services on their own behalf, including those with psychosocial disability, and/or

participants who struggle to understand the sometimes complex NDIS processes (Mavromaras, Moskos and Mahuteau 2016, p. xi).

About 15 per cent of participants reported feeling that they had less choice and control of their supports under the NDIS, while about one quarter of participants are accessing fewer distinct supports (Mavromaras, Moskos and Mahuteau 2016, pp. 60–61). Both the qualitative and quantitative data from the NDIS evaluation indicate that people with psychosocial disability are more likely to report less choice and control over supports since becoming NDIS participants.

The qualitative data also suggested that:

> … vulnerable families, those unable to navigate the NDIA website to find what services and providers were available, and those less able to articulate support needs, are less likely to experience greater choice over their supports. (Mavromaras, Moskos and Mahuteau 2016, p. xiii).

Many participants are not realising the benefits of the NDIS because they are finding it difficult to access disability supports for which they are receiving funding. The NDIS evaluation attributes this to lengthy waiting lists for some providers or types of support, a lack of local providers, and lack of quality provision. Unmet demand is more common for those living in rural and remote areas (15 per cent more likely than those in urban areas), and for older participants (Mavromaras, Moskos and Mahuteau 2016, p. 31).

There has also been a significant fall in participant satisfaction with the scheme since the scheme has entered the transition phase — the percentage of participants reporting they were satisfied or very satisfied dropped from an average of 95 per cent to around 85 per cent between 2015-16 and 2016-17 (first three quarters) (NDIA 2017o, p. 26). This could be linked to changes to planning processes over that period (discussed in chapter 4).

Recent surveys find consistent results

Every Australian Counts and the Melbourne Social Equity Institute have also surveyed participants to gauge the impact of the NDIS (box 2.11). And while the sample sizes are small and less representative than the NDIS Outcomes Framework and NDIS evaluation, the survey conclusions are broadly consistent.

Box 2.11 **Consistent results from recent surveys on the impact of the NDIS**

'NDIS Report Card' — Every Australian Counts

From November 2016 to January 2017, over 2100 Every Australian Counts supporters completed an online survey to gauge their views on the National Disability Insurance Scheme. About 30 per cent of respondents were participants (or carers of participants), while 23 per cent were workers employed in the sector. The remaining participants were either people expecting to be participants in the future (37 per cent) or supporters of the NDIS (11 per cent).

The survey found that:

- 71 per cent of participants and 61 per cent of carers had average or above satisfaction with the NDIS
- 78 per cent of participants and 74 per cent of carers had the same or more support than before the NDIS
- 64 per cent of participants and 61 per cent of carers said their life was the same or better with the NDIS.

Choice, control and the NDIS — Warr et al. (2017)

Researchers interviewed 42 NDIS participants and carers of participants who were part of the Barwon trial. The report found that:

- participants' expectations and experiences of the NDIS were strongly influenced by their circumstances
- resources to help people to exercise choice and control over their support was not always available
- in some cases service users had limited choice over what was available for them to purchase with their funding package, especially in regional areas
- participants feel like their views are often overlooked in planning processes
- participants who do not fully understand the system tend to feel disadvantaged.

Sources: Every Australian Counts (2017); Warr et al. (2017, pp. 7–8).

The broader benefits of the NDIS

The NDIS is expected to generate a number of broader benefits beyond the improved outcomes of people with disability and their families and carers. Based on the Commission's 2011 estimates of benefits, and a number of more recent studies, the NDIA's preliminary estimates suggest that:

- the NDIS will reduce costs for the health system by between $140-$300 million each year (by reducing hospitalisations for people with disability and limiting the need for people with disability to remain in hospital due to a lack of more appropriate arrangements)

- the NDIS will reduce justice system costs by between $350-$850 million each year (by reducing incarceration rates of those with mental disabilities)
- as a result of the NDIS, between 103 000–218 000 people with disability will be able to increase their hours worked or join the workforce
- as a result of the NDIS, between 56 000-104 000 carers will be able to increase their hours worked or join the workforce (sub. 161, pp. 29–31).

At this early stage of the rollout, it is difficult to measure whether these broader benefits are being realised.

The jury is out on economic participation

It is too early to tell whether the NDIS will lead to the economic participation benefits that were expected. While the NDIS evaluation and study participants provided individual examples of scheme participants and their carers entering the workforce (box 2.12), the (limited) quantitative evidence is less rosy. In the Outcomes Framework pilot, 13 per cent of respondents aged 25 to 55 indicated that the NDIS had helped with employment, the lowest of any domain (NDIA 2016g, p. 35).

Box 2.12 The NDIS has helped some scheme participants enter or remain in the workforce

Karene Gravener:

> I have improved physically, emotionally and mentally because of the support of the NDIS. We, as a family, have been able to live life, and pursue our dreams. My husband has been able to be in full-time employment without the stress of being a carer, and we are building our own home. (brief sub. 96)

Lauren McGowan-Slee:

> My condition got worse about seven years ago, and at my worst, I couldn't get out of the house and sometimes even bed. Last week I started full time work, a feat that was once seen as impossible. It's not easy. I get fatigued and crash out most evenings and end up in bed quite early, but I don't mind because I am living a meaningful life!
>
> Because of the NDIS, I have supports that mean I can do a job that works with my disability and have the physical home tasks I can't do taken care of. I can sit and use my brain with no worries, so that is what I do for work, but I struggle to do physical tasks so I get help for that. (brief sub. 52)

Richelle Carta:

> I was struggling to sustain my lifestyle with very minimal funding but due to the NDIS I can continue to be a wife, mum, work full time and have a life with my family by having ongoing funding to provide me with morning and night personal care support seven days a week. (brief sub. 111)

Susanna Goodrich:

> My son Toby is sixteen. He has Down Syndrome. He's had a rough few years with an autoimmune condition … The NDIS has provided funding that has changed Toby's life. His week has opened up from a routine of school, family life and the occasional social event, to a week that looks much like his other teenage brothers: he plays sport, goes out with peers, works in a part time job and will soon be learning how to catch the bus to the local shopping and entertainment hub. (brief sub. 39)

There are a number of reasons why increased economic participation flowing on from the NDIS may take some time.

- NDIS-funded initiatives to engage community and businesses to improve employment outcomes for people with disability have not occurred yet (ILC funding was not part of the NDIS trial).
- The NDIS is most likely to be effective for people entering the system for the first time and will thus have a greater effect as time goes on (PC 2011).[16]

DRAFT FINDING 2.4

Early evidence suggests that the National Disability Insurance Scheme is improving the lives of many participants and their families and carers. Many participants report more choice and control over the supports they receive and an increase in the amount of support provided.

However, not all participants are benefiting from the scheme. Participants with psychosocial disability, and those who struggle to navigate the scheme, are most at risk of experiencing poor outcomes.

16 In 2011, the Commission noted that those who have been in the system for a while often 'have missed opportunities for early intervention, had poor educational experiences, been dogged by low expectations by others, faced a community culture not strongly conducive to their employment and had long breaks from employment that erode skills and confidence'(PC 2011, p. 960).

3 Scheme eligibility

Key points

- The eligibility requirements of the National Disability Insurance Scheme (NDIS), as set out in the *National Disability Insurance Scheme Act 2013* (Cwlth), are consistent with the principles of the scheme.
- However, eligibility is broader than what the Commission recommended in 2011 in two key areas: the inclusion of people with substantially reduced functional capacity to undertake learning or social interaction; and children with developmental delay. This broader criteria have cost implications for the scheme. These groups were not included in the Commission's 2011 costings.
- Data are not available to assess the cost implications of adding learning and social interaction to the eligibility criteria for disability requirements. The National Disability Insurance Agency (NDIA) should improve its data collection in this area.
- Trial site data show that a significant number of children are entering the NDIS with developmental delay.
  - Early intervention for children with developmental delay can yield benefits, which suggests that including these children is consistent with the insurance principles of the scheme. The NDIA should monitor research in this area and build its evidence base on what early intervention supports work for children.
  - The definition of developmental delay, as prescribed in the NDIS Act, sets a high standard for children to be eligible for individualised supports. However, a high proportion of children in the scheme do not have a significant functional deficit relative to their peers.
  - The recently introduced Early Childhood Early Intervention (ECEI) pathway is a tighter gateway in principle, and should result in better enforcement of the eligibility criteria for children aged 0-6 years (in all areas, including developmental delay). However, it is too early to assess the effectiveness of the ECEI approach in practice.
- The Commission is seeking further information on the magnitude of the benefits and risks associated with maintaining lists that allow for automatic entry into the NDIS on the basis of a diagnosis.
- There is broad support for people with psychosocial disability being included in the NDIS. A high proportion of people with psychosocial disability who apply for support under the NDIS have been found to be eligible, despite concerns that demonstrating a condition is permanent could be a barrier to access.
  - The investment approach of the NDIS and the recovery model of treatment are both about building capacity and appear well aligned.
  - Reforms to the planning process should improve the way that people with psychosocial disability engage with the scheme. A specialised psychosocial gateway could be considered if planning reforms are not effective in improving engagement.

For the National Disability Insurance Scheme (NDIS) to deliver cost effective outcomes and remain financially sustainable, it is important that the eligibility criteria are aligned

with the objectives of the scheme. The legislated eligibility criteria, as they currently stand, do appear to target those people with disability who the Commission intended the scheme to cover. That said, the criteria are broader than that proposed by the Commission in 2011 (PC 2011, pp. 174–175), and this has cost implications for the scheme.

There are a number of factors that affect scheme participant numbers, including the:

- size and age profile of the Australian population
- prevalence, incidence, nature and severity of disability within the population
- eligibility criteria
- effectiveness of entry pathways in upholding the eligibility criteria
- effectiveness of exit pathways when people no longer meet the eligibility criteria for individualised supports.

This chapter looks at the eligibility criteria (section 3.1) and entry and exit pathways (section 3.2) — the two factors relevant to the design of the NDIS. One of the key eligibility issues raised in this study was the inclusion of psychosocial disability in the NDIS. This issue is discussed in section 3.3.

3.1 The eligibility criteria

The NDIS is for all Australians. It provides insurance against the costs of support in the event that a person acquires a significant disability. And anyone with, or affected by, a disability can approach the NDIS for information, linkages and capacity building. Individualised supports under the NDIS, however, are targeted at people with permanent and significant disability or those who meet early intervention requirements. In this context, 'eligibility criteria' refers to access to these individualised supports.

The eligibility criteria are critical in an uncapped scheme

The NDIS is a new way of providing disability services. When services were block-funded, governments had tight control of how much money was provided for disability services. Individualised supports provided under the NDIS are uncapped — so long as an individual meets the eligibility criteria, and the supports provided are 'reasonable and necessary' (chapter 4), an individual will receive the support that they need for as long as they need (often for their whole lifetime). This means that from a budgetary perspective, the NDIS is less certain than previous models of disability support.

The eligibility criteria are the main instrument available for determining how many people will receive individualised support through the NDIS. It is important that these criteria are clear, aligned with the objectives of the scheme, and rigorously upheld.

Eligibility differences when compared with the 2011 recommendations

When the Commission designed the NDIS in 2011, it recommended that the eligibility criteria for individualised supports uphold the following principles:

- individuals should have a disability that is, or is likely to be, permanent reflecting the irreversible nature of disabilities; and
- individuals would meet one of the following conditions:
  - have significantly reduced functioning in self-care, communication, mobility or self-management, and require significant ongoing support (restricting access to people with significant, ongoing support needs — rather than anyone with disability — reflects the objective that the NDIS embody a risk-pooled insurance scheme, which focuses on minimising the impact of high cost, low frequency events)
  - qualify for an early intervention group (covering people for whom there is good evidence that early intervention would be safe, cost-effective and significantly improve outcomes — box 3.1) (PC 2011, pp. 13–14).

The Commission also recommended that participants meet residence and age requirements.

Box 3.1 Why early intervention is important

An important recommendation in the Commission's 2011 *Disability Care and Support* inquiry was that individualised supports be available to 'an early intervention group, comprising of individuals for whom there is good evidence that the intervention is safe, significantly improves outcomes and is cost effective' (PC 2011, p. 63).

A key tenet of the NDIS is that it takes a lifetime approach to providing care and support. Early intervention is one way to embody this. Early intervention seeks to incur expenditure during the early stages of a person's disability in order to improve (or maintain) their functioning later on, or reduce the volume of supports that they need later in life.

Providing early intervention support through the NDIS can mean:

- a better quality of life for scheme participants by addressing many of their needs early, and building or maintaining their functional capacity
- a delay in the need for care (or a lower cost of providing care) in later stages of a participant's life, which contributes to a more financially sustainable scheme.

The eligibility criteria for the NDIS (as set out in ss. 21–25 of the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act)) are broadly in line with what the Commission recommended in 2011 (table 3.1). However, there are two key differences:

- a person can receive individualised supports under the disability requirements if they have substantially reduced functional capacity to undertake the activities of *learning or social interaction* — the activities proposed by the Commission were restricted to mobility, self-care, self-management and communication (PC 2011, p. 198)

- a child can receive individualised supports under the early intervention requirements if they have developmental delay.

Table 3.1 **A summary of the NDIS eligibility requirements**[a]

Age requirements	Residence requirements
Aged under 65	• Australian citizen • Permanent resident • Hold a protected special category visa
And meet either:	
Disability requirements	**Early intervention requirements**
Disability attributable to one or more: • intellectual • cognitive • neurological • sensory • physical impairments; or • an impairment attributable to a psychiatric condition; and	• Has one or more identified intellectual, cognitive, neurological, sensory or physical impairments, and likely to be **permanent**; or • Has one or more identified psychiatric conditions, and likely to be **permanent**; or • Is a child who has developmental delay; and
The impairments are, or are likely to be, **permanent**; and	The early intervention support is likely to benefit the person by **reducing the person's futures needs** for supports in relation to disability; and
Impairments substantially reduce **functional capacity** or **psychosocial functioning** to undertake one or more of the following activities: • communication • social interaction • learning • mobility • self-care • self-management	The early intervention support is likely to benefit the person by: • **mitigating or alleviating** the impact of the person's impairment on their functional capacity • **preventing the deterioration** of such functional capacity • **improving** functional capacity • strengthening the **sustainability of informal supports** available to the person, including through building the capacity of the person's carer.

[a] This figure represents an overview of what the Commission considers to be the main aspects of the eligibility criteria. The NDIS Act prescribes that more requirements are met than those outlined here.

Source: NDIS Act, ss 21-25.

Both these differences allow more people to qualify for individualised supports under the NDIS than the Commission included when costing the scheme. The extent to which the less restrictive eligibility criteria is contributing to scheme participation, and consequently, scheme costs, is a key question for this study.

Based on the eligibility criteria proposed in its 2011 report, the Commission estimated that approximately 410 000 people would be eligible for individualised supports under the NDIS (PC 2011, p. 160). Using the Commission's estimates as a basis, the NDIA has increased the estimated number of scheme participants to 460 000 (or 475 000 including those aged over 65 years, as discussed in chapter 2).

Adding learning and social interaction to the disability requirements — what is the effect?

Data are not available to make an assessment about the impact on scheme costs of adding learning and social interaction to the eligibility criteria for the disability requirements. However, Speech Pathology Australia said advice from their members who are NDIS providers is that:

> … they have not been providing services to children whose only disability relates to learning and literacy — thus, it is our conclusion that the increased numbers of people entering the Scheme is not due to the eligibility of people whose *only* functional disability relates to learning and/or social interaction. (sub. 136, p. 15)

It seems reasonable to assume that relationships across domains exists, however, the Commission understands that the NDIA does not collect data specifically on which, or how many, of the six activity domains specified in the Act that scheme participants enter through. This means that assessing the extent to which one particular domain is driving entry into the scheme, or how common it is for scheme participants to have reduced functional capacity across multiple domains, is not possible.

Collecting data at entry on which domains apply to each participant would not only inform what parts of the eligibility criteria are having a large impact on participant numbers (and therefore scheme costs), but also allow for more granular analysis of who is in the scheme and what their needs are likely to be. Such information may also be useful to the NDIA in its monitoring and forecasting roles.

DRAFT RECOMMENDATION 3.1

When determining that an individual is eligible for individualised support through the National Disability Insurance Scheme under the disability requirements, the National Disability Insurance Agency should collect data on which of the activity domains outlined in section 24 of the *National Disability Insurance Scheme Act 2013* (Cwlth) are relevant for each individual when they enter the scheme.

Including developmental delay in the early intervention requirements — what is the effect?

A child has developmental delay if it takes longer for them to reach age-specific milestones than other children. The term developmental delay is used in the absence of a diagnosed condition — that is, there is usually a more specific condition causing the developmental delay, including disability, but this condition is not yet able to be formally identified. This can be because it is difficult to reach an accurate diagnosis given the age and capabilities of the child.

The 'developmental trajectory' of children with developmental delay varies. In some cases, children may 'catch up' to their peers either with or without support. Others may need more substantial support for a longer period, which is often the case if the underlying condition causing the developmental delay is a significant disability.

The effect of including developmental delay as a condition eligible for individualised support was explored in detail by Dyson, Cutter and Moore (2015). The review, which was commissioned by the Department of Social Services (DSS), found that:

- about 11 600 children with developmental delay or global developmental delay would be eligible for support under the scheme (p. 15) (box 3.2), with an estimated annual cost of $155 million
- the vast majority of children in the scheme with developmental delay or global developmental delay could be expected to progress to full scheme participation — in part because of the high access requirements for developmental delay, and in part because developmental delay and global developmental delay is 'often predictive of the future diagnosis of intellectual disability' (p. 87)
- ' … the costs associated with including children correctly identified as having [developmental delay or global developmental delay] is of immaterial consequence to the sustainability of the NDIS' (p. 9)
- given the likelihood that a child with developmental delay would progress to the full scheme, early intervention could reduce costs to the scheme in the longer term by reducing future need (p. 17).

Box 3.2 Developmental delay and Global developmental delay — what is the difference?

Definitions for developmental delay and global developmental delay vary. The Commission looked at many definitions to draw out the key features that tend to define the conditions.

A child has *developmental delay* when they take longer than other children to meet age specific milestones in a specific area (or domain). Since children develop at different rates, and some will inevitably reach a milestone before others, most definitions require that a child be substantially or significantly behind their peers before they are identified as having developmental delay.

In contrast, a child is considered to have *global developmental delay* if they take longer to meet specific milestones across multiple domains. Some definitions require only more than one domain to be affected, while others require all domains to be affected. The definition of global developmental delay published by COAG in 2012, required a delay across a majority (out of five) domains.

Different definitions also outline different domains to be considered. However, they often include:

- motor skills (both gross and fine)
- speech and language skills
- social and/or emotional skills
- cognitive ability.

The definition of developmental delay for the purposes of the NDIS is set out in section 9 of the Act, and is spelled out in full in box 3.4.

Sources: COAG (2012a, p. 4); Disability Services Commission (2011, p. 12); Queensland Government (2017a).

Including developmental delay is consistent with the objectives of the scheme

The evidence base on the effectiveness of early intervention in improving the trajectories for children with developmental delay, or reducing the future costs of their care, is still being developed. Nevertheless, there is general acceptance that for children with developmental delay, access to early intervention leads to improved outcomes (box 3.3).

Such evidence suggests that there is a firm rationale for children with developmental delay to be eligible for individualised supports under the early intervention requirements of the NDIS. In 2011, the Commission recommended that the NDIA build an evidence base on early intervention, in part to inform what forms of intervention are beneficial and therefore warrant potential funding through the scheme (PC 2011, p. 632).

The evidence on early intervention for children with developmental delay should be a particular focus, given the developing evidence base, and given the higher than expected number of children entering (and the fewer than expected number of children leaving) the scheme.

Box 3.3 Evidence supports early intervention for developmental delay

Evidence points to children with developmental delay benefiting from early intervention supports. For example, when summarising the evidence, KPMG said:

> For children already exhibiting developmental delay, effective early intervention strategies can both alter the course of their developmental trajectories and prevent the onset of secondary complications … The earlier a child is identified as having a developmental delay or disability, the more likely they are to benefit from strategies targeted towards their needs. The success of early intervention strategies not only assists families through the provision of extra support for their child, but also decreases costs to schools and community in the later years as children transition to school. (2014, p. 3)

Dr Michael Guralnick — Director of the Center on Human Development and Disability in the University of Washington — presented a similar conclusion:

> Early intervention for children at risk and for those with established intellectual disabilities is now firmly embedded in the context of general early childhood development. An overarching developmental framework has been advanced and has achieved a high level of consensus; one that is relevant to typically developing young children and to those vulnerable to a range of developmental problems, particularly intellectual disability (2005, p. 318).

Guralnick also noted that:

> … long-established intervention science indicating that comprehensive early intervention programmes can, at a minimum, help prevent the substantial decline in intellectual development that generally occurs across the early childhood period for children with developmental delays. (2017, p. 11)

Early intervention for children with developmental disability was also described to be 'of clear benefit' by the Royal Australasian College of Physicians (2013, p. 2), while the World Health Organization (WHO) notes that early intervention for children with disability can enhance developmental competencies, minimise secondary complications and build the effectiveness of support networks (2012, p. 12).

Numbers in the scheme to date

Trial site data (to June 2016) show that just under 4000 individuals (or roughly one-third of the 11 600 estimate by Dyson, Cutter and Moore (2015)) entered the scheme with a primary health condition recorded as being either developmental delay or global developmental delay (NDIA 2016t, table 2.1.11(c)). If the prevalence rate experienced in trial sites was observed nationally, there would be more children with developmental delay in the scheme than Dyson, Cutter and Moore's estimate.

However, trial site prevalence rates may not be reflective of prevalence rates expected on a national level. Further, the NDIA has recently redesigned the entry pathway for children aged 0-6 years with the introduction of the Early Childhood Early Intervention (ECEI) approach (discussed below). This changes how the eligibility of children is assessed, and is designed to better ensure that the eligibility requirements for individualised supports are upheld.

Two possible explanations for higher numbers of children

There are two possible reasons why there may be more children with developmental delay in the scheme to date than expected:

- more children meet the eligibility criteria than expected or
- assessment processes allow children who do not meet the eligibility criteria to enter the scheme.

This section looks at the eligibility criteria for developmental delay. The extent to which assessment processes could be contributing to higher than expected numbers is discussed in the next section.

The definition of developmental delay for the purposes of the NDIS is outlined in box 3.4. A child with developmental delay must meet this definition to be eligible for individualised supports under the early intervention requirements (as well as meeting residency requirements).

Box 3.4 How does the NDIS define developmental delay?

The definition of developmental delay is set out in section 9 of the NDIS Act. It states that developmental delay means a delay in the development of a child under 6 years of age that:

(a) is attributable to a mental or physical impairment or a combination of mental or physical impairments; and

(b) results in substantial reduction in functional capacity in one or more of the following areas of major life activity:

  (i) self-care

  (ii) receptive and expressive language

  (iii) cognitive development

  (iv) motor development; and

(c) results in the need for a combination and sequence of special interdisciplinary or generic care, treatment or other services that are of extended duration and are individually planned and coordinated.

Source: NDIS Act.

Some study participants raised concerns about the adequacy of the developmental delay definition in the NDIS Act. However, most of the evidence presented to the Commission on developmental delay suggests that the current definition requires a significant threshold to be met. For example, Dyson, Cutter and Moore (2015, p. 11) found that the definition of developmental delay prescribed in the NDIS Act sets 'a high access hurdle', particularly the requirements for there to be a substantial reduction in functional capacity, and the exclusion of children who only require uni-disciplinary intervention.

The ACT Government also said that a delay across one domain was in itself generally insufficient to qualify for individualised supports through the NDIS:

> … the NDIA has recently changed the operational guidelines relating to eligibility to the scheme for developmental delay. Specifically, the 'need for a combination and sequence or special interdisciplinary or generic care, treatment or other services that are of extended duration and are individually planned and coordinated' is being interpreted to mean children with only one area of delayed development are not eligible. As a result, the NDIA access team deems children with one area of delay not eligible for the scheme because they do not require interdisciplinary care and these children are no longer receiving (or renewing) packages or early intervention supports. (sub. 156, p. 9)

In making this point, the ACT Government expressed concern that this pushes the cost of providing support to people with a delay in only one area back onto State and Territory Governments. The fact that the NDIS sets a high access hurdle — which the Commission considers to be important — means that some children will require support outside of the scheme. Consequently, there is a need for all governments to work together to ensure that there are supports outside of the NDIS for children who do not meet the eligibility requirements.

Since the criteria that children must meet to qualify for individualised supports under the scheme is high, this suggest that it is the process by which children are entering the scheme (not the eligibility criteria) that is resulting in higher than expected numbers. This is consistent with evidence provided by the NDIA that a significant proportion of children in the scheme to date have little or no reduction in their functional capacity compared to their peers (discussed in the next section).

The number and cost of children with developmental delay in the scheme should continue to be monitored by the NDIA. Should changes to assessment processes be made, but children who do not meet the definition of developmental delay, as outlined in the Act, continue to enter the scheme, there is a strong case for changing the definition of developmental delay in the Act so that it is clearer under what circumstances a child would qualify for individualised supports.

3.2 Are entry and exit pathways effective?

Effective entry pathways are imperative to the successful functioning of the NDIS. They uphold the eligibility criteria of the scheme and only allow people who meet these criteria to qualify for supports. Excessively porous pathways may allow people who do not meet eligibility requirements to access the NDIS, placing cost pressures on the scheme.

There are two main pathways for people to enter the NDIS:

- the Early Childhood Early Intervention (ECEI) pathway for all children aged 0-6, including those with a disability or developmental delay (NDIA 2016i)
- a general pathway for people aged 7-65 years (NDIA 2016i, 2016q).

Entry into the NDIS can be self-initiated, or facilitated by the NDIA (the NDIA contacts people receiving disability services that are being phased into the NDIS when the NDIS becomes available in their area).

The NDIA also has a list of defined programs. People receiving supports through these programs do not need to show that they meet the disability requirements, as the requirements for the programs and the NDIS are considered 'equivalent' (NDIA 2016q). As an entry pathway, these lists are relevant during the transition phase of the scheme.

The Early Childhood Early Intervention pathway

In response to the higher than expected number of children entering the scheme in the trials, the NDIA established the ECEI pathway for children to enter into the scheme (NDIA 2016g, p. 16). Prior to the introduction of the ECEI pathway — which commenced in 2016 and is being rolled out in line with the full scheme — children entered the scheme via the general pathway — through the lodgment of an access request and subsequently an assessment of eligibility and need.

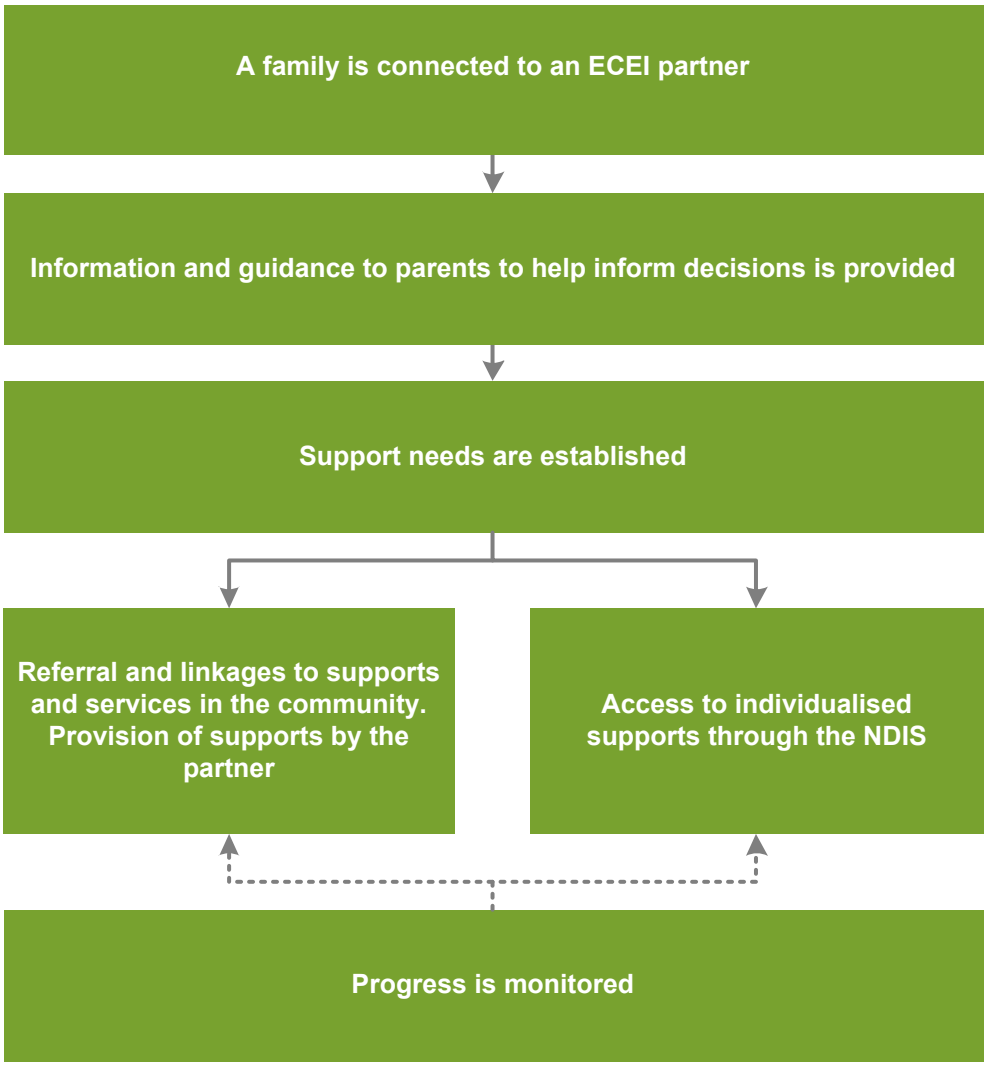
A summary of how the ECEI pathway works is provided in figure 3.1.

Under the ECEI approach, a family with a child with a disability or developmental delay seeking support is connected to an ECEI 'partner' in their local community. To be a partner, an organisation must be approved by the NDIA and have experience in early childhood intervention.

Partners assess the support needs of a child with disability and their family and, based on the assessment, determine the supports and services the child needs. Early childhood partners can provide:

- information and linkages to mainstream supports and services
- 'timely short to medium early childhood early intervention supports'. Examples of these supports include: information, family based education, parenting support services and therapy (DSS 2016a, p. 11)
- access to an NDIS plan. If it is considered that a child is best supported by a NDIS plan, it remains a NDIA delegate who determines whether a child is eligible and approves a plan, although the ECEI partner is responsible for providing information that will inform a decision on access and assisting with plan development (DSS 2016a, pp. 11–18).

Figure 3.1 **The ECEI process**



Source: Adapted from on NDIA (2017c).

On paper, the ECEI approach does not appear to be very different to how people enter the NDIS under the 'general' pathway. However, the specialised nature of ECEI partners, and the fact that they can provide short- and medium-term support, and refer children to mainstream services, means that the ECEI approach places significant emphasis on upholding eligibility while supporting less severe cases outside of the scheme. The ECEI approach seeks to reduce the number of children with milder levels of disability from entering the scheme, thereby reducing cost pressures.

Study participant's views on the likely effectiveness of the ECEI approach are largely positive (box 3.5).

Box 3.5 General support for the ECEI approach, but some concerns

Lifestart Co-operative Limited:

> Over time, if implemented correctly with experienced and well credentialed Early Childhood Partners, outcomes for children, their families and the scheme will be positive. [The ECEI approach] should ensure that children get the right support, in a timely manner and in the right amount. It should see the number of children requiring individualised plans decrease. This trend has emerged with the introduction of ECEI Partners in the Nepean Blue Mountains where Lifestart has provided children with supports and assistance where these children and families were able to be well supported without a plan. (sub. 97, p. 4)

The New South Wales Government:

> NSW believes that the ECEI process represents best practice for children under 7 years … A version of the ECEI approach was part of the early NDIS transition in the Nepean Blue Mountains, which commenced from July 2015 for children and young people under 18 years. Anecdotal evidence from this process suggests the effectiveness of the model in diverting children from specialist disability supports funded by the NDIS to mainstream and community based support options. (sub. 60, pp. 17-18)

National Disability Services:

> NDS … supports the concept of the ECEI approach. The broad gateway of ECEI enables some children with lesser needs to receive short-term assistance … It also allows time to see how a child responds to short-term early intervention before making a decision on eligibility, while still giving immediate access to an NDIS package to those with obvious significant and long-term disability. (sub. 51, p. 4)

The Department of Social Services:

> The early indications are that the inclusion of developmental delay in the NDIS and the Early Childhood Early Intervention (ECEI) gateway approach is effective in supporting children. It is expected a number of these children will meet their development goals and will not require long-term NDIS supports. (sub. 146, p. 3)

Allied Health Professions Australia:

> AHPA and its members support the role of early intervention but note that the early childhood early intervention (ECEI) approach may risk excluding children with a need for support, increasing the burden on other systems and schemes. If the scheme doesn't meet the child's needs there is the risk that this may result in higher levels of support in the future negating the purpose of early intervention programs. (sub. 37, p. 10)

Royal Institute for Deaf and Blind Children:

> Models such as the ECEI have resulted in a cost shift from the Agency to providers, with little specificity around specific abilities. The ECEI process has imposed significant and redundant elements for children with hearing impairment, and if strictly implemented would actually delay access to services. (sub. 95, p. 7)

Prior to the introduction of the ECEI approach, the number of children receiving individualised supports through the NDIS without having a substantial functional deficit relative to their peers was significant. The NDIA pointed to their analysis of PEDI-CAT scores which found that:

> … the aggregated scores indicated that, overall, around 40% of participants had scores of 30 or more ('average') across each of the four domains. *That is, these participants did not seem to have any identified deficits, compared to the normal range for their age.* (sub. 161, p. 78, emphasis added)

Some study participants questioned the appropriateness of the PEDI-CAT tool and how it was applied by the NDIA for some types of disability (chapter 4), and this may go some way to explaining the apparent anomaly. However, to have children with mild or no deficits in the NDIS clearly runs counter to the objectives of the scheme, and depending on the volume of supports that these children receive, could have significant cost and equity implications. As such, a tighter gateway that better assesses eligibility is necessary.

The ECEI approach can be this tighter gateway. Using specialised organisations with experience in identifying and treating developmental delay and childhood disability should result in more accurate assessments of whether children meet the criteria for individualised supports under the NDIS. The emphasis on providing timely short- and medium-term supports and support through mainstream services to children with needs, but not severe enough to warrant entry into the NDIS, is also positive.

However, it is too early to tell if the ECEI approach has been successful in upholding the eligibility criteria of the NDIS, and contributing to beneficial outcomes for children who are ineligible for individualised support. The DSS (sub. 146, p. 13) observed that the 'gateway's actual success will be dependent on services outside the NDIS being available, and the management of family expectations about how children's needs are better met'.

The NDIA has developed an evaluation and monitoring framework for the ECEI approach. In time, this framework should assist with monitoring children's pathways (including entry and exit from NDIS via the gateway) and evaluating the effectiveness of the ECEI approach.

Brotherhood of St Laurence commented on the importance of ECEI being evidenced-based:

> As the initial roll-out of the NDIS nears completion, children with developmental delays will be the largest group of people with disability entering the NDIS. Understanding what works for children who gain access to the NDIS is vital to manage costs. To ensure the NDIS provides value for money and can reduce the life-long impact of developmental delays on children, ECEI needs to be underpinned by a strong evidence-based practice, policy and research agenda. Most importantly, ECEI staff need access to the latest research and evidence to inform service design and practice. This is especially important given the emerging findings that some interventions and/or programs can be harmful and/or have limited evidence regarding their efficacy. (sub 189, p. 12)

The NDIA is also developing an early intervention approach for the 7-14 years cohort (sub. 161, p. 26).

Streamlined entry for early intervention

Under the NDIS Act, when assessing whether a potential participant is eligible for individualised supports under the early intervention requirements, the NDIA must be satisfied that the supports will benefit the child by reducing future need (s. 25(1)(b)) and

benefit the child in one of the ways prescribed in s. 25(1)(c) (table 3.1). If a child has a condition that is on List D (a list maintained under the NDIA's operational guidelines on access (NDIA 2016q)), the presence of the condition is deemed sufficient to satisfy s. 25(1)(b) and s. 25(1)(c).

List D contains about 130 conditions, including global developmental delay (NDIA 2016q). Developmental delay (as defined in the Act) is not contained in the list, however it is effectively given the same streamlined entry arrangements under the *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* (Cwlth) (r. 6.10).

Maintaining such a list represents a trade-off. The appeal of such a list is that it places less onus on families to demonstrate eligibility, reduces the administrative burden on the NDIA, and provides a degree of certainty for the families of children with these conditions.

However, such lists can be problematic. They can affect incentives, or can represent an overly generous entry gateway if set too expansively. Further, making assumptions that children will benefit from early intervention risks providing entry for children who, given their individual circumstances, may not benefit from individualised support — something that runs counter to the concept of early intervention.

A list can also stifle exits from the scheme. If diagnosis, rather than expected benefits, form the basis of early intervention, a child may remain eligible so long as their condition is present even if early intervention has been applied and expected benefits have been realised (or are unlikely to be realised).

The Commission is seeking feedback on the advantages and disadvantages of retaining List D, with a view to determining whether it should continue to be a pathway for children to enter the scheme under the early intervention requirements.

INFORMATION REQUEST 3.1

The Commission is seeking feedback on the advantages and disadvantages of maintaining 'List D — Permanent Impairment/Early Intervention, Under 7 years — No Further Assessment Required' *in the National Disability Insurance Agency's operational guidelines on access. Feedback is sought on the extent to which the list:*

- *reduces the burden on families to demonstrate that their child will benefit from early intervention and/or provides certainty that support will be provided*
- *reduces the burden on the National Disability Insurance Agency of assessing whether children are eligible for early intervention support under the* National Disability Insurance Scheme Act 2013 *(Cwlth)*
- *may be contributing to supports being provided to children who are unlikely to benefit from such supports*
- *may be discouraging or inhibiting exit from the scheme.*

The 'general' pathway

For people aged 7-65 years, entry to the NDIS begins with the lodgment of an access request. This can be lodged through a form, but is increasingly being completed by telephone. In lodging an access request, a potential scheme participant provides information on their age and residency status (the first two components of the eligibility criteria), as well as information about their disability.

To demonstrate their disability, an applicant is typically required to provide evidence of the condition from their treating doctor or specialist. The NDIA may also require evidence from an applicant's health professional on the impact of the disability on the applicant's ability to undertake tasks related to mobility, communication, social interaction, learning, self-care and self-management. For some conditions (contained in a list maintained by the NDIA), the impact of the disability on a person's functional capacity is assumed and further evidence is not required (NDIA nda).

The NDIA has 21 days to either decide whether the prospective participant meets the eligibility criteria, or to request additional information (NDIS Act s. 20). The additional information may require the potential participant being assessed or examined, and the NDIA has the authority to nominate where this occurs (s. 26(1)).

The Commission has been presented with little evidence to suggest that the entry pathway for people under disability requirements is having an undue influence on scheme costs.

The NDIA maintains a list of conditions designed to streamline access for people with disability (List A). If a person has a condition on List A, the permanence of their condition and the impact of their condition on their functional capacity is assumed, and the individual is deemed eligible for individualised supports under the NDIS without further assessment of their eligibility (NDIA 2016q, nda).

Maintaining List A offers benefits to both the NDIA and participants, but there is some risk that, in providing for that streamlining, it effectively lowers the hurdle to access the scheme to a level that is too low.

The Commission would value additional feedback on the effects of List A.

INFORMATION REQUEST 3.2

The Commission is seeking feedback on the benefits and risks of maintaining 'List A — Conditions which are Likely to Meet the Disability Requirements in section 24 of the NDIS Act'. *In particular:*

- *to what extent does List A reduce the burden for people with permanent and significant disability of entering the National Disability Insurance Scheme under the disability requirements?*
- *is there any evidence that people who do not meet the disability requirements are entering the scheme under List A?*

As discussed in chapter 2, a cost pressure identified by the NDIA is the lower than expected rate at which people are exiting the scheme. At the end of March 2017, just under 700 participants had exited the scheme. Over 90 per cent of these exits were people who had permanent disability plans, while only 10 per cent of exits were people with early intervention plans (NDIA 2017a, p. 15). The NDIA is monitoring exit rates and should continue to consider actions that will arrest trends in exit rates that do not appear to be consistent with the aims of the scheme.

3.3 Psychosocial disability and the NDIS

Support for including psychosocial disability in the NDIS is generally high

In 2011, the Commission recommended that people with permanent psychosocial disability with significant long-term support needs be supported through the NDIS (PC 2011, p. 189). The recommendation was made on the basis that:

- the day-to-day support needs for people with significant and enduring psychiatric disability are effectively the same as people who have an intellectual disability or an acquired brain injury
- some important parts of the care that is needed to be provided to people with psychosocial disability — namely community-based supports such as outreach or day programs — are best met through the NDIS
- providing supports to people with psychosocial disability through the NDIS provides them with the wider benefits of the scheme, including personalisation of supports to meet the needs of the individual, more choice over what supports are provided, when and by who, and greater access to early intervention supports (PC 2011, pp. 186–189).

These points remain salient, and lend support to people with psychosocial disability being supported through the NDIS. And, while the Commission heard a range of views about whether the NDIS represents the 'right' vehicle to provide support to people with psychosocial disability, the majority of submissions to this study were optimistic and/or

supportive about the role the NDIS is playing in meeting needs of people with psychosocial disability (box 3.6).

Box 3.6 Strong support for the NDIS from the mental health sector

Flourish Australia:

> Flourish Australia strongly supports the NDIS and the opportunity it provides for greater certainty, choice and control, and economic and social participation for people with disability who require life-long support. We are also strongly supportive of the inclusion of psychosocial disability within the Scheme's remit, and have seen firsthand the benefits of the Scheme for the people we support and their families. (sub. 74, p. 1)

Mental Health Community Coalition of the ACT:

> MHCC ACT views the NDIS with great hope. It holds promises for a better more integrated life for people living with disability. (sub. 135, p. 2)

The National Mental Health Commission:

> The NMHC considers the NDIS to be an important initiative with its promise of individualised care and choice for eligible people with psychosocial disability. It is a potentially very important element in addressing the long standing unmet needs of people with mental illness for effective community and disability supports. (sub. 153, p. 1)

Mental Health Australia:

> The National Disability Insurance Scheme (NDIS) is an historic opportunity to improve the lives of people who have for far too long missed out on the support they need to live contributing lives in the community. Mental Health Australia strongly supports the policy intent underpinning the Scheme, and hopes to work with government over the long term to maximise choice and control for people living with mental illness and psychosocial disability. (sub. 155, p. 3)

The Department of Health:

> There is broad stakeholder support for the inclusion of psychosocial disability in the NDIS, with feedback suggesting that participants are receiving better and more effective support and assistance under the NDIS than what was available to them before accessing the scheme. (sub. 175, p. 2)

That said, there is evidence that some people with psychosocial disability are experiencing less positive outcomes than others in the scheme. For example, people with psychosocial disability are more likely to report less choice and control over supports since becoming a NDIS participant compared to other groups of participants in the scheme (Mavromaras, Moskos and Mahuteau 2016) and are more at risk of experiencing poor outcomes (chapter 2).

Boundaries are important

Several study participants suggested that the requirement that an impairment be permanent is incompatible with the recovery models used in supporting people with mental health conditions. For example, the Royal Australian and New Zealand College of Psychiatrists said that:

> The RANZCP is concerned about the centrality of disability 'permanence' in the eligibility criteria for the NDIS as the language of 'permanence' does not fit with the recovery-oriented

> approach of the mental health sector … Eligibility criteria that relies on permanence may therefore contribute to many individuals not seeking, or opting out of, treatment if that treatment is predicated on their acceptance of the lifelong nature of their illness (sub. 158, p. 2)

The New South Wales Government also said that:

> The recovery focus in contemporary mental health practice does not align neatly with the NDIS requirement that psychosocial disability is considered a permanent disability. (sub. 60, p. 14)

Similar arguments were presented by the Butterfly Foundation (sub. 78, p. 3), Top End Association for Mental Health Inc (sub. 102, p. 9), Anglicare Tasmania (sub 145, p. 24), Mental Health Australia (sub. 155, p. 8) and VICSERV (sub. 169, p. 7).

The Victorian Council of Social Services (sub. 176, p. 11) argued that a recovery framework is widely accepted as best practice, and requiring people to identify as having a permanent psychosocial disability can 'create stigma, distress and limit people's hope and optimism'.

However, others, such as the National Mental Health Commission, argued that that the concepts of permanence and recovery are not necessarily mutually exclusive:

> The NDIS requirement for Tier 3 participants to establish a 'permanent impairment' can appear to be somewhat at odds with the more strengths-based concept of 'recovery' used in mental health. 'Recovery' is not synonymous with the absence of illness. Rather, it means people who are living with, or have experienced, mental illness can nevertheless lead contributing and meaningful lives, in which they feel safe and secure, have connections with community and family, are engaged in social and economic participation (whether paid or not), and are physically and mentally thriving (not just surviving).
>
> From this perspective, recovery is not inconsistent with the philosophical underpinnings of the NDIS that aim to support people with lifelong disability to live an ordinary life so they can engage in education, employment and community activities. (sub. 153, pp. 2–3)

The investment approach of the NDIS and the recovery model of mental health are both about building capacity, and appear to be well aligned.

While demonstrating permanence may be more difficult for people with psychosocial disability than for people with other types of disability, permanence is about the irreversible nature of a disability which may be of a chronic episodic nature. The NDIS Rules and operational guidelines accept that a permanent condition may be episodic in nature, requiring different amounts of support at different times.

Scheme participant numbers show that people with psychosocial disability have been able to demonstrate that their condition is, or is likely to be, permanent. At the end of March 2017, about 5000 people with psychosocial disability had approved plans, accounting for six per cent of scheme participants (NDIA 2017o, p. 18). And data (to December 2016) also indicate that 81 per cent of people with psychosocial disability who lodged an access request to the NDIS have been found eligible for the scheme (although this is a lower acceptance rate compared to other conditions) (NDIA 2016v, p. 56).

The Commission cautions against changing the eligibility criteria to relax or loosen the definition of permanency and how it relates to psychosocial disability. The requirement that a condition be permanent is a key tenet of the NDIS. Removing or relaxing this requirement would represent a significant risk to the financial sustainability of the scheme.

The NDIS is not meant to support everyone with psychosocial disability, and even for those who do qualify for individualised supports, other systems need to play their part (for example, the health system meeting clinical needs). Many people will not meet the eligibility criteria for individualised supports and therefore will need to be supported outside of the scheme. Clarity about the specific services that will be funded and/or provided by all governments once the rollout of the NDIS has been completed is essential (chapter 5).

A 'psychosocial gateway' is an option

Many participants to this study expressed frustration that people with psychosocial disability were subject to phone planning conversations and inconsistent or inequitable outcomes in plans. There were also concerns that a specific assessment tool for psychosocial disability is not being used and planners lack experience in understanding the needs of people with psychosocial disability (chapter 4).

While framed around people with psychosocial disability, these concerns are broadly in line with observations others have made about the planning process more generally. A discussion of planning — including reforms to improve the process — is provided in chapter 4. Such reforms may improve outcomes for people with psychosocial disability, or allay concerns about how the eligibility criteria are being applied.

That said, a case can be made that psychosocial disability is sufficiently different from other types of disability that a unique, specialised gateway could be of value. It was put to the Commission that people with psychosocial disability may not engage with the system effectively, may be hard to reach, may view the system with distrust, or may have particular difficulty identifying and articulating their goals and needs. It was also argued that more beneficial outcomes for scheme participants could be achieved if planners were familiar with psychosocial disability and had greater knowledge of the types of supports that could be provided within and outside of the scheme.

The finding that people with psychosocial disability are more likely than other scheme participants to report less positive outcomes from their involvement in the scheme suggests that the scheme might not be working as well for people with psychosocial disability as it could.

While a specialist gateway provides no guarantee of improved outcomes, it is something that could be explored if wider reforms to the planning process do not result in better engagement with the scheme for people with psychosocial disability.

Reforms to the wider planning process (chapter 4) should be the priority and may be sufficient to improve outcomes for people with psychosocial disability. However, the NDIA could also consider a unique entry pathway for people with psychosocial disability. This could build on the strengths of the ECEI approach, that is, a connection with partners who have considerable expertise in psychosocial disability, and linkages to supports outside of the scheme for people with needs that will not be supported through the NDIS.

4 Scheme supports

Key points

- The National Disability Insurance Scheme (NDIS) is designed to cover individualised disability supports that are reasonable and necessary. This includes supports that help people with disability to pursue their goals, live independently and participate in the community and employment. The NDIS is meant to complement other mainstream or specialist services available to the wider population, not replace them.
- The extent of supports coverage matters — over-coverage of supports could create cost pressures and pose a risk to the financial sustainability of the scheme, but under-coverage could mean that the benefits of the NDIS are not fully realised.
- The overall costs and benefits of the NDIS are affected by the volume of supports covered under the scheme, as well as how supports are allocated — that is, the planning process.
  - The touchstone of what is reasonable and necessary directly impacts the quantity and types of supports funded. The concept of 'reasonable and necessary' is malleable, and allows scheme participants the flexibility to exercise choice and control.
  - The quality of planning processes is a key determinant of the long-term sustainability of the NDIS, because it influences what costs are incurred; the predictability of costs; and the integrity of, and community support for, the scheme as a whole.
- The planning process is about matching scheme participants with supports. It involves conversations between the participant and the National Disability Insurance Agency to determine, for each participant: their goals and aspirations, their level of function and appropriate supports.
- The challenge for the planning process is finding the right balance between individualisation and good outcomes for scheme participants on the one hand, and ensuring equity among participants and the financial sustainability of the scheme on the other.
- Planning processes are not operating well. The speed of transition and performance indicators that focus on participant numbers have placed pressure on the National Disability Insurance Agency to finalise plans quickly, and the quality of plans has been compromised.
  - Planning conversations with scheme participants are said to be rushed and superficial. Most plans are prepared by phone, which limits engagement with participants and can mean that planners do not get the 'full picture'.
  - The planning process is not clear, transparent and accessible. Nor are processes inclusive or sufficiently flexible to accommodate differing needs, particularly for participants with complex needs or from culturally and linguistically diverse backgrounds.
  - There is variability in planner skills, experience and training. Planners often lack knowledge about different types of disability, which can hinder their ability to formulate a good plan. Planner performance could be improved by using specialised planning teams for some disabilities and better leveraging industry expertise.

The quantity and types of supports funded by the National Disability Insurance Scheme (NDIS) are key drivers of scheme costs. Supports are also important for realising many of the benefits of the NDIS (box 4.1) because they help scheme participants:

- pursue their goals, objectives and aspirations and increase their independence
- increase their social and economic participation (and increase the social and economic participation of carers)
- reduce their need for other supports and services
- develop their capacity to actively take part in the community.

For this reason, striking the right balance is crucial: over-coverage of supports could create cost pressures and pose a risk to the sustainability of the scheme, but under-coverage could mean that the benefits of the NDIS are not fully realised.

The overall costs and benefits of the NDIS are also affected by *how* supports are allocated to scheme participants. Good planning processes are important for matching scheme participants with the supports that will result in improved outcomes and help maintain the integrity of, and community support for, the scheme as a whole. Poor planning processes can increase the likelihood of cost blowouts and undermine the accuracy of cost projections, compromising the ability of governments to plan for the future of the scheme.

The *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act) provides for two types of supports for people with disability.

- Specialist disability supports funded by the NDIS are called *reasonable and necessary supports*. The types of supports that may be funded include: assistance with daily personal activities and household tasks; therapeutic supports (such as occupational therapy, speech therapy and behavioural support); mobility equipment; home and vehicle modifications; and services that enable employment and participation in community and social activities (NDIA ndf).
- The National Disability Insurance Agency (NDIA) may also provide *general supports* to people with disability, even if they are not eligible for the NDIS. General supports include: coordination, strategic and referral services and activities, to help people with disability access mainstream services, such as health, education and transport services (Commonwealth of Australia 2013, p. 8).

This chapter is about the specialist supports that are funded under the NDIS — that is, reasonable and necessary supports. The rules governing the scope of supports covered by the NDIS are covered in section 4.1. Section 4.2 gives an overview of the process for allocating supports to individual scheme participants — the planning process. Section 4.3 discusses the key concerns raised by study participants about the planning process and considers what implications these have for scheme sustainability. Section 4.4 looks at the evidence on the effectiveness of supports. The interface between the NDIS and other services is discussed in chapter 5.

Box 4.1 Many of the NDIS's benefits are realised through supports

Brenda Gillett:

> My adult son James (39 years old) who has an intellectual disability, lived at home until almost two years ago, when we then decided it was time for him to try to live as independently as possible without our total support … James just loves his own 'unit' and his new (and much loved) support person who is enabling James to become more independent each day; and is helping him to become more inclusive in his community … James also has used funding specifically set aside for a speech pathology assessment and is looking forward to catching up with the 21st century and the rest of his generation by buying an iPad with which to look at his photos and use a communication app to help him express his needs and wants. (brief sub. 15)

Sally Shackcloth:

> My adult daughter's life has improved in many ways since she was a member of the trial group in Tasmania. An occupational therapist found that her bed was unsafe both for her and for the support workers dressing her. The physio review recommended a hip x-ray because of increasing mobility problems. The result is she is now having preventative treatment so her condition doesn't deteriorate … Very importantly, she is now participating in an ongoing speech pathology program with an expert speech pathologist as she needs a communication system tailored to her needs. Up to now she has no reliable way to communicate. (brief sub. 19)

Karen Wakely:

> For the first time we have been able to access meaningful therapeutic supports. Previously therapy was only once a month, and was inadequate for gaining any momentum. Now we access either psyc or occ therapy every week, and it has been far more effective in developing the social and practical skills needed for independent living. For the first time, my child is beginning to successfully participate in mainstream community activities. (brief sub. 43)

Lauren McGowan-Slee:

> Because of the NDIS I have supports that mean I can do a job that works with my disability and have the physical home tasks I can't do taken care of … I am excited to be a taxpayer again, it fills me with so much pride to be giving back again. With the NDIS I can afford to get to work, the transport contributions mean I don't have to reduce my work days to afford taxis. I have adaptive technology which means I can do things by myself and be safe. I am also blind and I can finally read again and I used funding to get me to a functional level so I could work. … I can afford to buy healthier food and get help preparing it instead of having to buy pre prepared meals so I have had less digestive problems, and I don't see the doctor as often. I have a person who can be with me when I do exercise so I can exercise effectively without being afraid of falling over or getting injured when I lose muscle control. (brief sub. 52)

Graham Lawrence:

> Under her NDIS approved plan, Michelle has the ability to purchase a 5 day/week community access program with a group of her peers, with arranged leisure, craft and life education activities … [this] makes it possible for the Government to save an estimated $300,000 -$400,000 p/a. This is the typical net cost of providing care (equivalent to their own home), for people with the severe levels of disability which Michelle has. (brief sub. 78)

Sonya & Stephanie Nicolaides:

> My Daughter Stephi has been on the NDIS for three months now and it has made a dramatic change to her life. She now has the same life opportunities other Australians take for granted. She is able to have regular physio and hydro therapy now, which helps with all her tight muscles. Stephi seems to be a lot happier within herself and able to move a lot easier without much pain. We were able to get ramps to the front and rear of the house, making it very easy to get Stephi in and out of the house in her wheelchair now. (brief sub. 132)

4.1 What supports are funded under the NDIS?

The NDIS is designed to cover individualised disability supports that are 'reasonable and necessary' (Gillard 2012; PC 2011, pp. 257–261).

This includes supports that help people with disability to:

- pursue their goals and maximise their independence
- live independently and be included in the community as fully participating citizens
- participate in the community and in employment (NDIS Act s. 4(11)).

However, the NDIS is not meant to replace mainstream or other specialist services available to the broader population, and does not fund supports that are covered by other areas of government (including hospital and GP visits, and school teacher aides).

In addition, the NDIS Act s. 34(1) specifies criteria for determining whether supports (general or individualised) may be provided to scheme participants. This includes whether the support:

- will assist the participant in achieving their stated goals and aspirations
- will facilitate the participant's social and economic participation
- represents good value for money
- will (or is likely to) be effective and beneficial for the participant
- should (within reasonable expectations) be provided by families, carers, informal networks or the community
- is most appropriately funded or provided through the NDIS.

The *National Disability Insurance Scheme (Supports for Participants) Rules 2013* (Cwlth) and operational guidelines maintained by the NDIA provide additional rules and guidance for deciding what supports may be approved.

What is reasonable and necessary?

Individualised support funding under the NDIS is bounded by the touchstone of what is reasonable and necessary. However, the concept of 'reasonable and necessary' is not specifically defined in the legislative framework. Notably, the NDIS Act 'does not prescribe the types of supports that would be considered 'reasonable and necessary' across all participants' (EY 2015, p. 9), nor does it provide direct guidance on how to determine whether a support is reasonable and necessary.

As the court in *McGarrigle v National Disability Insurance Agency* observed:

> Although the phrase 'reasonable and necessary supports' is used throughout the legislative scheme, including in the objects and principles provisions, it is not defined. Its meaning can be

> derived from the context in which it is used, especially in my opinion s 4(11), which sets out what reasonable and necessary supports should enable and empower people with a disability to do, read with s 14 which sets out the purposes for which funding for reasonable and necessary supports is provided. ([2017] FCA 308 at [41])

As such, the bounds of what is reasonable and necessary will ultimately be shaped by court and tribunal decisions over time, having regard to the text of the legislation, rules and operational guidelines. These decisions will affect what will be funded under the NDIS, and therefore overall scheme costs. On this basis, the NDIA identified 'decisions by the Administrative Appeals Tribunal (AAT) or court system in interpreting the boundaries of … reasonable and necessary supports' (sub. 161, p. 45) as a policy lever affecting the financial sustainability of the NDIS that is outside of its control (box 4.2).

Box 4.2 **McGarrigle v National Disability Insurance Agency**

Mr Liam McGarrigle is a scheme participant with autism spectrum disorder and intellectual disability. Each week, he attends a group program for three days and is employed for two days. Transport to and from these activities is by taxi or provided by a support worker. As part of his third plan, Mr McGarrigle was allocated $11 850 for 'transport to access daily activities'. This represented about 75 per cent of his total transport costs ($15 850).

Administrative Appeals Tribunal decision

Mr McGarrigle sought a review of this decision in the Administrative Appeals Tribunal, seeking to have his transport costs fully funded. The Tribunal found that, while transport is a reasonable and necessary support for Mr McGarrigle, it was open to the National Disability Insurance Agency (NDIA) to decide to fund less than the full cost of the support. The Tribunal said, 'I am satisfied that the decision to fund 75 per cent of his weekday transport costs strikes an appropriate balance between what is reasonable and necessary for him and the overall financial sustainability of the NDIS' [64].

Federal Court decision

On appeal, the Federal Court of Australia overturned the Tribunal's decision. It reasoned that the imperative language of the NDIS Act (specifically, the words 'will be funded' in s. 33(2)(b)) does not permit partial funding of supports. That is, if a support has been determined to be a reasonable and necessary support, the support must be fully funded. The Court also noted that the Act does not refer to contributions from the participant towards the cost of supports.

Appeal to the Full Federal Court

The NDIA has lodged an appeal of this decision to the Full Federal Court. Mr David Bowen, Chief Executive of the NDIA, said:

> The appeal is an important test case which arises from a set of circumstances in the trial phase of the NDIS. It could affect the future of the whole NDIS … We have, therefore, decided to ask the court for the fullest clarity, given the serious implications for the future sustainability of the Scheme for many thousands of present and future participants.

Sources: *McGarrigle v National Disability Insurance Agency* [2016] AATA 498; *McGarrigle v National Disability Insurance Agency* [2017] FCA 308; NDIA (2017l).

In 2011, the Commission made recommendations about various criteria for determining whether a support is reasonable and necessary (PC 2011, pp. 258–259). These criteria were adapted from the Lifetime Care and Support Scheme in New South Wales and are echoed in the NDIS Act s. 34(1) (discussed above).

However, the NDIS's legislative regime is different to that of the Lifetime Care and Support Scheme — and the scheme contemplated in PC (2011) — in two subtle ways.

- While the NDIS Act repeatedly refers to 'reasonable and necessary supports', it does not explicitly state that individualised supports funded under the NDIS must be or assessed to be 'reasonable and necessary'. (That said, such a requirement may be implied by the text of the legislation.) By contrast, the Lifetime Care and Support Scheme explicitly requires a direct assessment of what treatment and care needs are reasonable and necessary in the circumstances (*Motor Accidents (Lifetime Care and Support) Act 2006* (NSW) ss. 11A, 23).
- The considerations outlined in the NDIS Act s. 34(1) are not framed as criteria exclusively for deciding whether a support is reasonable or necessary. Instead, they are considerations for deciding whether *any* type of support (that is, general *or* individualised) may be provided to scheme participants. The NDIS Act does not explicitly provide a schema for determining whether a support is reasonable and necessary.

On this basis, there may be scope for additional and specific legislative guidance on whether and how the NDIA should apply the 'reasonable and necessary' test.

INFORMATION REQUEST 4.1

Is the National Disability Insurance Scheme Act 2013 *(Cwlth) sufficiently clear about how or whether the 'reasonable and necessary' criterion should be applied? Is there sufficient clarity around how the section 34(1) criteria relate to the consideration of what is reasonable and necessary?*

Is better legislative direction about what is reasonable and necessary required? If so, what improvements should be made? What would be the implications of these changes for the financial sustainability of the scheme?

Putting 'reasonable and necessary' into practice

Some study participants identified issues with operationalising the concept of 'reasonable and necessary'. One particular concern is that there are different perceptions about what supports are reasonable and necessary (Flourish Australia, sub. 74, p. 5; PDA, sub. 38, p. 9). Alzheimer's Australia, for example, said:

> In our experience, there are large variances in what is considered 'reasonable and necessary' in relation to assessment planning. For example, one person with younger onset dementia was

> assessed and given horse riding lessons, while another person was not allowed bathroom aids. There also needs to be an oversight and improvement process that monitors how an assessor or planner determines what is considered 'reasonable and necessary'. (sub. 10, p. 13)

The NDIA (sub. 161, p. 92) also acknowledged that 'there is still confusion within the sector and the community, and to some extent within the NDIA, around the scope of reasonable and necessary supports'.

Flexibility around the concept of 'reasonable and necessary' allows scheme participants to exercise choice and control, and to be innovative in terms of supports. As the NDIA explained:

> Decisions around reasonable and necessary supports require balancing the need to empower participants to explore different ways of achieving increased participation with the need to spend taxpayers' money consistent with legislation and in a way that minimizes risk of misuse or fraud. (sub. 161, p. 92)

However, Physical Disability Australia argued:

> … what is 'reasonable and necessary' also needs to be elucidated with many benchmark examples so that planners and participants can approach planning conversations with similar frames of reference. (sub. 38, p. 8)

The NDIA has operational guidelines, practice guides, work practices and task cards to help planners exercise their judgment about what is reasonable and necessary. The NDIA indicated that it intends to update these to reflect outcomes of court and tribunal decisions and planners' experiences.

4.2 About plans and the planning process

Supports are allocated to scheme participants through a plan, which is prepared through conversations between a planner and the participant. As the NDIS Act (s. 31) states, where practicable, the development of a plan should be individualised, directed by the participant and maximise participant choice and control.

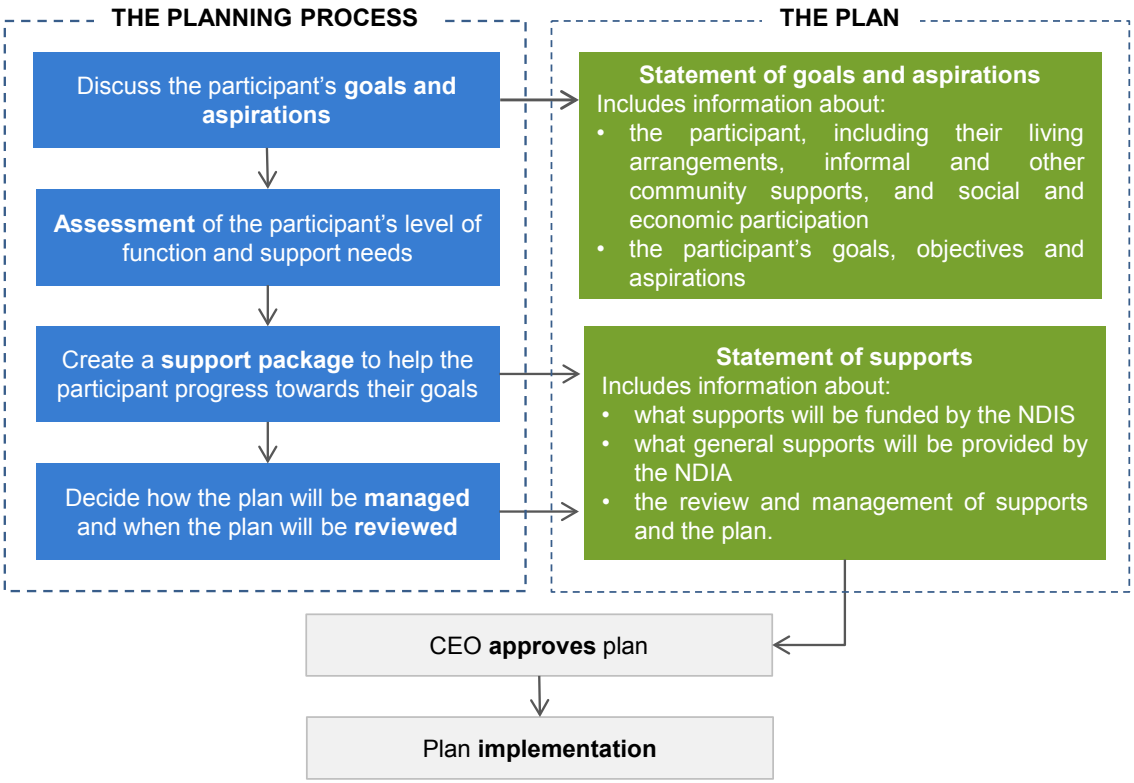
The planning process involves several steps (figure 4.1), designed to elicit information about the scheme participant, which is used to inform the content of the plan.

1. The participant and planner discuss the participant's goals and aspirations. This conversation is used to help put together a statement of goals and aspirations, which includes information about the participant, including: their living arrangements, informal and other community supports, and social and economic participation, as well as their goals, objectives and aspirations.
2. The NDIA conducts or considers assessments of how the participant is performing in different areas of their life ('level of function' or 'functional capacity'), including their 'activity limitations, participation restrictions and support needs arising from [the]

participant's disability' (*National Disability Insurance (Supports for Participants) Rules 2013* (Cwlth) r. 4.1), and identifies areas where the participant requires support.

3. A support package is put together to help the participant progress towards their goals. The support package may include general supports, as well as reasonable and necessary supports, and is set out in a statement of supports.
4. The planner and the participant decide when or under what circumstances the plan will be reviewed. They also decide how the plan will be managed (such as self-management, management by the NDIA, or using a plan management provider), including whether support coordination is required. (Plan management and support coordination are discussed in chapter 8.) This information is also included in the statement of supports.
5. Before the plan is finalised, it must be approved by the CEO of the NDIA (or a delegate).

Figure 4.1 **Making a plan**



For most people, their first plan is completed over the phone, although some planning conversations do take place face to face (NDIA 2016e, p. 1).

Assessment and tools

The assessment process is about evaluating the scheme participant's level of function and identifying the supports that will allow them to progress towards their personal goals and aspirations. Choosing the right tools for the job is challenging, as there is no universally agreed assessment tool for evaluating the care and support needs of people with disability. There are, however, several features that an assessment tool should have (box 4.3).

Box 4.3 Desirable features of assessment tools

To ensure the sustainability of scheme costs, it is important that assessment tools are:

- *valid* — the tools should test what they purport to and provide a basis for accurately identifying the nature, frequency and intensity of a person's support needs. Assessment tools that are not appropriate could threaten scheme sustainability.
- *reliable* — the tools should yield consistent measures across time, individuals and situations; results should not be influenced by when or where the assessment is undertaken, who is undertaking the assessment, or the identity of the individual per se.
- *accurate* — the tools should reduce the risk that assessors and individuals overstate or understate their support needs.
- *efficient* — an efficient tool is one that collects sufficient information to assess support needs in the least costly manner.

Assessment tools also need to be continually monitored and refined to ensure that they remain in line with scheme objectives, and keep pace with evolving best practice and community expectations.

Source: PC (2011, pp. 315–320).

Since the commencement of the NDIS, the NDIA has used several different assessment tools as part of the planning process (box 4.4).

Feedback about the NDIA's use of assessment tools was mixed.

- Some study participants were critical of the NDIA's assessment tools, but it was sometimes unclear which specific tools they were referring to (ABF, sub. 48; Alzheimer's Australia, sub. 10; Belinda Jane, sub. 80; Macarthur Disability Services, sub. 57; Queensland Advocacy Incorporated, sub. 115).
- Other study participants were critical of how certain tools were used, particularly in relation to early childhood and early intervention (chapter 3). For example, the AEIOU Foundation (sub. 32, p. 8) said that PEDI-CAT is not appropriate for children with intellectual disability. The Shepherd Centre (sub. 107, p. 12) made a similar observation about young children with hearing loss. Others questioned whether NDIA staff had been adequately trained to apply the PEDI-CAT tool (Early Intervention Australia Victoria/Tasmania, sub. 129, p. 10; Noah's Ark, sub. 108, pp. 10–11).

Box 4.4 The evolution of NDIS assessment tools

The National Disability Insurance Agency (NDIA) has undertaken significant work to identify appropriate assessment tools for identifying the support needs of scheme participants.

- *Mid-2013*: the NDIA commenced delivering the National Disability Insurance Scheme without an assessment tool, as none was available.
- *Late 2013*: adoption of the Support Needs Assessment Tool (SNAT). The SNAT attempted to identify functional support needs through a planning discussion, and provided the participant with a detailed, personalised support plan. After the first year of trial, it became apparent that the SNAT was not fit for purpose.
- *Late 2014*: further work on identifying appropriate assessment tools. This entailed a survey of functional assessment tools used around the world, and evaluating these tools for relevance, usability and reliability. The cost of acquiring and using these tools was also a crucial consideration. The process included extensive consultation and engagement with key stakeholders and experts across the key disability types, including clinical experts and researchers, and disability associations.
- *Mid-2015*: identification and testing of a new suite of assessment tools. This included different tools for 11 key disability types, and the World Health Organization Disability Assessment Schedule version II (WHODAS II) where no specific tool was identified.
- *Mid-2016*: adoption of the new suite of assessment tools. The NDIA has the capability to administer some of these assessments tools in house, but they can also rely on assessments performed by specialists.

Considerable work around assessment tools remains to be done. For example, the NDIA still has no tool for evaluating the support needs of people with psychosocial disability. Engagement with representatives in the mental health sector on this point is ongoing.

Source: NDIA (sub. 161, pp. 9–11).

But many study participants said that they were unable to obtain information about what assessment tools the NDIA uses (including tools for assessing level of function). Physical Disability Australia said this made it difficult to comment on the appropriateness of assessment tools.

> Information about assessment tools is scarce on the NDIS website … Furthermore, there is no mention of them on the pages dealing with planning processes and planning conversations. It is therefore difficult for [Physical Disability Australia] (or anyone) to comment on them as it is not clear which assessment tools are being used and by whom. (sub. 38, p. 7)

The Centre for Disability Studies also said:

> A major barrier to the on-going improvement and implementation of the NDIS is the lack of access to, or public domain information on the assessment tool(s) in use by the National Disability Insurance Agency … we do not see why the assessment tool itself is not public domain, unless for commercial copyright reasons. Many support needs assessments in use across jurisdictions are in the public domain, or are available upon purchase or enquiry. (sub. 49, p. 2)

The NDIA is required to specify what assessment tools it uses in its operational guidelines (*National Disability Insurance (Supports for Participants) Rules 2013* (Cwlth) r. 4.4), which must be published and kept accurate, up-to-date and complete (*Freedom of Information Act 1982* (Cwlth), ss. 8, 8A, 8B). But, in practice, study participants' knowledge about what assessment tools the NDIA uses appears to be sourced indirectly, through word of mouth or via experiences with the planning process. Information about the role of assessment tools in the planning process could also help participants understand how or to what extent assessment tool results influence the supports that they receive.

The first plan process

As discussed in chapter 2, the NDIA has identified increasing package costs (over and above the impacts of inflation and ageing) as a source of cost pressures. The NDIA developed reference packages to assist with monitoring scheme experience and assessing cost pressures (box 4.5). Reference packages are based on age, disability type and level of function. Reference packages can also help improve equity in the scheme by giving clearer guidance on 'typical' arrangements.

Box 4.5 Reference packages

Reference packages are an 'indicative' support package, developed as a way to identify typical support needs and funding for different cohorts of scheme participants.

The National Disability Insurance Agency currently uses a suite of assessment tools for evaluating scheme participants' level of function, covering 11 key disability types (box 4.4). The reference package cohorts are based, in part, on these 11 disability types. They are also based on age and level of function.

Reference package data were tested and validated using:

- back-captured data — that is, data about previous support packages
- expert groups in each of the 11 disability categories — these groups included academics, consumers and providers.

Back-captured data and the work of expert groups were also used to identify how different variables impact the value of support packages. This information allowed the Scheme Actuary to validate the assessment tools, and develop a basis for determining 'reasonable and necessary' funding at an aggregated level.

Work to refine reference packages is ongoing. For example, no reference package is currently available for people with psychosocial disability. Reference packages also have limited utility where a person has more than one disability and the secondary disability is an important contributor to support needs. As more data are collected, reference packages will become more sophisticated and better informed by actual experience.

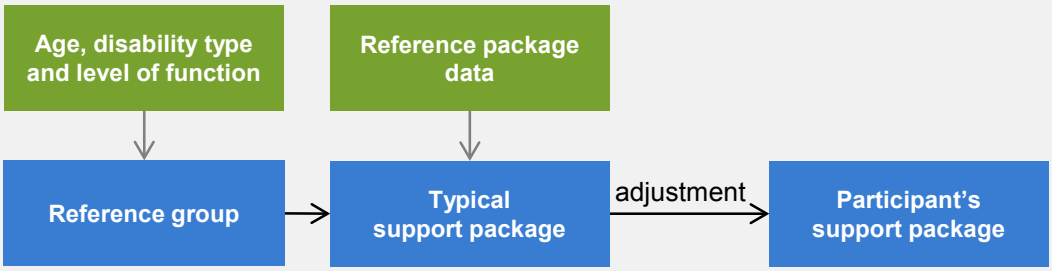
Source: NDIA (sub. 161, pp. 10–11).

Based on the learnings from trial, the NDIA adopted a new approach to determining support packages — the 'first plan process'. The first plan process uses reference package

data to assign scheme participants a 'typical support package' based on their age, disability type and level of function. This is adjusted to account for the individual support needs of participants to create the participant's plan (box 4.6).

Box 4.6 The first plan process

The first plan process was introduced on 1 July 2016. Scheme participants are first allocated a 'typical support package', based on their reference group (which is determined by their age, disability type and level of function). The typical support package may include funding across the following eight core domains: daily activities; social participation; consumables; transport; home modifications; assistive technology; capacity building; and support coordination.



For each participant, the level of funding is adjusted according to the participant's circumstances. This is done using a questionnaire, which asks the participant about each of the domains, including what supports they already have in place and whether these are sufficient and sustainable. For example, where it is reasonable that sustainable informal, community or mainstream supports continue to assist the participant, or where the participant believes that other informal, community or mainstream supports may provide a better outcome, funding is adjusted in the participant's support package.

Source: NDIA (sub. 161, pp. 10–11).

Balancing different considerations

A number of study participants argued that the use of reference package data is at odds with person-centred planning and that it limits choice and control during the planning process (AASW, sub. 124, p. 4; Down Syndrome Australia, sub. 121, p. 7; Flourish Australia, sub. 74, p. 13; Lifestart Co-operative, sub. 97, p. 9). ACT Disability, Aged and Carer Advocacy Service (sub. 87, p. 14) said that the approach 'carries inherent risks that planners (and assessment tools) will overly rely on reference plans as opposed to taking a person-centred approach'.

A person-centred or individualised approach to planning is central to the NDIS. The scheme is about matching participants with the supports that are right for them; however, this needs to be done in the context of the sustainability of the scheme and achieving a consistent approach to funding packages.

During the first year of trial, a highly detailed and person-centred approach was taken to planning, but according to the NDIA it was found not to be fit for purpose.

> [The] Support Needs Assessment Tool (SNAT) was a construct that attempted to identify functional support need and through a planning discussion using the tool to provide the participant with a detailed personalised support plan. The SNAT was used throughout the first year of trial. However, at the end of this period, it had become apparent that the SNAT was not fit for purpose. While the SNAT delivered an individualised outcome, there was no correlation of the SNAT to the reference packages upon which the funding of the Scheme was based. (sub. 161, pp. 9–10)

While some scheme participants expressed greater satisfaction with processes during trial (for example, Down Syndrome Australia, sub. 121), according to the NDIA (sub. 161, p. 10), it led to 'highly prescriptive plans that provided detail at the daily and sometimes the hourly level minimising the flexibility for participants to exercise choice and control'.

The first plan process, introduced in 2016, sought to improve the approach taken at trial by enabling people greater flexibility in how they used their funds against goals and outcomes that they identified. It also sought to address the issues of consistency between support packages by providing guidance to planners about what support packages for different groups should look like.

The challenge for the future of the planning process is to find the right balance between individualisation and good outcomes for scheme participants on the one hand, and ensuring equity among participants and the financial sustainability of the scheme on the other. It is likely to be some time before the right balance is struck.

A dynamic process

As with all insurance-based schemes, the tools and processes for handling and assessing claims are a matter of ongoing refinement. This is necessary to ensure that the insurance scheme remains 'on track' and is viable in the long term. Dynamic processes are also important to allow the scheme to adapt to changing circumstances or incorporate information that becomes newly-available over time.

Part of this process is ongoing monitoring and evaluation (chapter 9). The NDIA undertakes internal monitoring of its processes.

> The first plan process is a dynamic process which will include ongoing refinement as more data and information becomes available. The process allows continuous monitoring of committed support and utilised support, with benchmark costs. As the NDIS moves through transition, the NDIA is continually monitoring and seeking opportunities to enhance the planning process from a participant, provider and staff perspective. The NDIA is currently reviewing the plan review process to streamline the process and ensure it continues to meet the needs of both the participants and Scheme sustainability. (sub. 161 p. 89)

The COAG Disability Reform Council has also undertaken to review the first plan process at the end of June 2017 (DRC 2016). This review should consider whether the first plan process strikes the right balance between individualisation and ensuring equity across participants, and whether the process helps ensure that the scheme is sustainable in the long term.

Information about how the planning process works is important

Many study participants were unsure or unaware of how the first plan process operates. Scope Australia (sub. 72, p. 15) suggested that this was because 'communication from the Agency and its contractors has been inconsistent and at times poor'.

A number of study participants were unsure or mistaken about:

- what the first plan process was
- the rationale for adopting the first plan process
- whether or to what extent support packages were adjusted for individual circumstances
- whether or how supports received under legacy programs were taken into account.

With evolving processes, it is important that scheme participants and their families and carers can access accurate and up-to-date information about the planning process. ACT Disability, Aged and Carer Advocacy Service (sub. 87, p. 14) said, 'we would encourage a transparent and rigorous approach to consideration of benchmarking and reference plan topics'. Clear messaging about how and why things are changing is also important for maintaining the credibility of evolving planning practices.

Plan reviews

Usually, plan reviews occur as part of the planning cycle — that is, at the expiry of a scheme participant's previous plan (usually after 12 months). However, unexpected plan reviews can be triggered if the scheme participant changes their statement of goals and aspirations or requests a plan review (NDIS Act, ss. 47–48). Often plan reviews are initiated by the scheme participant because their supports do not, or cease to, meet their needs or expectations. Changes to a plan may also be required if information in the plan is incorrect or missing.

Currently, any changes to a plan require a full plan review. Several study participants advocated to allow plans to be amended or varied without triggering a full review (Blind Citizens Australia, sub. 130, p. 5; MND Australia, sub. 45, p. 3; Woden Community Service, sub. 159, p. 10).

Full plan reviews can be time-consuming and costly, and scheme participants may also be unable to access the supports they need while they wait for their plan to be reviewed (CPSU, sub. 76). A process for amending or adjusting plans would improve the cost effectiveness of review processes, especially when the proposed changes to the plan are minor (Jacqueline Pierce and Associations, sub. 147, p. 5).

Some also suggested that amendment processes could be used to manage supports for participants when needs change quickly — such as in the case of episodic or degenerative disorders (ABF, sub. 48; MND Australia, sub. 45). However, where there has been a

significant change in the participant's circumstances, it may be most appropriate to undertake a full plan review (provided it is undertaken with sufficient expediency).

The role of Local Area Co-ordinators in the planning process

In some areas, planning discussions are conducted and plans are prepared by Local Area Co-ordinators (LACs). However, under current legislative arrangements, LACs do not have the power to approve plans; that is, plans prepared by LACs must still be approved by the NDIA.

The NDIA (sub. 161) suggested that there may be some benefits to allowing approval functions to be delegated to LACs. This could lead to efficiencies in plan administration as it would reduce double-handling of plans by LACs and the NDIA. The NDIA also said that delegating approval functions could lead to greater certainty for scheme participants.

> More importantly, it would improve the experience of participants by allowing the LAC, while in discussion about support needs and within defined parameters and agreed reporting and monitoring arrangements, to be able to confirm the level of reasonable and necessary funding and move straight to a discussion on plan implementation. (sub. 161, p. 13)

However, there are risks associated with allowing the NDIA to delegate its plan approval functions to LACs.

- Delegating plan approval functions could reduce the NDIA's control and oversight over plans and allocated supports. This could compromise scheme sustainability and the realisation of outcomes within the scheme.
- Transferring additional functions to LACs may limit their capacity to perform other important functions, due to time and resource constraints. It could also lead to conflicts of interest (real or perceived) between different roles — for example, it may compromise LACs' ability to provide impartial pre-planning support.
- Sharing approval functions between the NDIA and LACs may reduce clarity and transparency around roles and responsibilities, particularly if approval functions are delegated to some LACs but not others. There is also a risk that it could reduce or obfuscate the NDIA's accountability for plans and allocated supports.

The Commission is seeking feedback on whether the NDIS Act should be changed to allow the NDIA to delegate plan approval functions to LACs — and, if so, how the risks of doing so might be managed.

INFORMATION REQUEST 4.2

Should the National Disability Insurance Agency have the ability to delegate plan approval functions to Local Area Coordinators? What are the costs, benefits and risks of doing so? How can these be managed?

4.3 How is the planning process tracking?

Good planning processes are essential for the success of the scheme and long-term sustainability, as the quality of the planning process has a bearing on what costs are incurred in the scheme, the predictability of scheme costs and the integrity of the scheme (box 4.7). The Northern Territory Government said it considers the planning process to be one of the most important elements of the scheme.

> The quantity of supports received by participants is a key driver of costs, and therefore a consideration for the ongoing financial sustainability of the Scheme. However, without a high quality planning process which supports participants to identify and work towards their goals and aspirations, choice and control for participants will not be achieved. (sub. 205, p. 3)

The planning process has not been operating well. The Commonwealth Ombudsman (sub. 137, p. 7) reported that the planning process is one of the main sources of complaints to the office.

Participants to this study also expressed dissatisfaction with planning processes. In particular, participants expressed concern about:

- the lack of consultation and engagement with scheme participants
- the accessibility and transparency of processes and planners
- the quality of planners (including LACs undertaking planning functions).

Study participants overwhelmingly considered that poor planning processes have compromised the quality of plans. As a result, plans are not meeting scheme participants' needs or expectations, and sometimes include supports that they do not want or need (Macarthur Disability Services, sub. 57, p. 4). Several study participants also reported that there was considerable variability in plans for scheme participants with similar needs (Macarthur Disability Services, sub. 57, p. 4; Neami National, sub. 63, p. 3; PDA, sub. 38, p. 8; PDCN, sub. 29, p. 3). For example, Brain Injury SA said:

> Brain Injury SA is aware of one household with multiple children with similar needs. Each child had a different planner and each plan provided funding for different services. In another instance, involving twins with developmental delays and similar levels of need, the plan for one child included support coordination while the plan for the other child did not. (sub. 116, p. 5)

The NDIS is a major reform and the NDIA has been given a monumental task under highly ambitious timeframes and a resource-constrained environment. Many of the NDIA's decisions about how to operationalise the planning process have been influenced by bilateral estimates and community expectations around reaching new participants quickly. In addition, planning processes have had little time to mature.

However, there is real concern that some of the practices adopted to address the pressures of rollout will become entrenched in practice and in the culture of the NDIS, with implications for the long-term costs and benefits of the scheme.

Box 4.7 Why are good planning processes important?

Outcomes, benefits and equity

As discussed in chapter 1, financial sustainability is not just about costs. It is also about whether outcomes are being realised, and whether those who are paying for the scheme remain willing to do so (NDIA 2016j).

Poor planning processes can mean that scheme participants are allocated supports that are not right for them. This can mean that many of the benefits of the scheme (such as increased quality of life, greater social and economic participation, and reduced need for other or future supports) are not fully realised. Poor planning processes can also result in greater variability in plans and outcomes for scheme participants with similar needs, compromising equity within the scheme. Together, these factors can undermine the credibility of, and community support for, the scheme as a whole — and hence its long-term sustainability.

Costs associated with reviews

Poor planning processes can result in plans that do not reflect the needs or expectations of scheme participants. This can place greater stress on review processes.

Increased requests for plan reviews can add to the workload of planners. Review processes can also place greater stress on scheme participants and providers. As Occupational Therapy Australia said:

> … reviews can take months to complete, resulting in added frustration for families and potentially affecting the relationship between participant and provider. (sub. 15, p. 5)

Greater use of review processes can increase the administrative costs of the National Disability Insurance Agency, as well as costs in other areas. For example, appeals to the Administrative Appeals Tribunal or the Federal Court of Australia place a greater burden on the justice system (chapter 9).

Certainty about costs

Poor planning can introduce additional uncertainty about scheme costs (New South Wales Government, sub. 60, p. 15; PDA, sub. 38, p. 9).

- Poor planning processes can be unreliable — that is, they do not yield consistent results across time, individuals and situations. This increases the variance in the value of support packages, increasing the unpredictability of scheme costs overall.
- Poor planning increases the likelihood that participants' plans do not match their needs and expectations. This can contribute to underutilisation of plans, driving a wedge between committed and actual support funding.

Greater uncertainty around scheme costs can undermine the accuracy of cost projections, which can make it difficult for governments to plan for the future of the scheme. High variability of scheme costs also increase the risk of cost blowouts.

The following sections discuss the key concerns raised by study participants, and policy options for ensuring poor practices do not become structural issues that continue to affect the operation of the NDIS in the medium and long term.

Engagement with scheme participants

Engaging with scheme participants during the planning process is important not only for ensuring that they receive the supports that are right for them, but also for the long-term success of the NDIS. Physical Disability Australia suggested that engaging with scheme participants is particularly important in the early stages of planning.

> Given that many planners are new to this type of work and may have limited lived experience of disability, the validity, reliability and accessibility of the processes they use to determine what constitutes an appropriate support package depends on deep engagement with participants, their families and supporters. (sub. 38, p. 7)

The planning process needs to be sufficiently 'deep' so that planners can obtain sufficient information about a participant for them to make a decision about reasonable and necessary supports that minimise lifetime costs, while also making the process person-centred and convenient for scheme participants and their carers. Involving families, carers, support workers and advocates in the planning process can also improve understanding of the functional impact of the participant's disability, their needs and the supports that they require (VCOSS, sub. 176, p. 16).

Concerns about rushed planning

The speed of transition, as set out in Bilateral Agreements, has placed a lot of pressure on the NDIA to finalise plans quickly. This has detrimentally affected the quality of the planning process. SCIA Australia said:

> The rush to get new participants into the scheme against bilateral agreements is proving to be a major headache for the Agency and is severely affecting the quality of first plans. (sub. 61, p. 3)

Similarly, United Voice said:

> Workloads and inadequate time to do the job is one of the most often cited concerns of our members. United Voice members are concerned that [planners] do not have time to do their job properly, that they rush from client to client preventing them from providing quality support. (sub. 118, p. 8)

Study participants also reported feeling that planning meetings are rushed (Flourish Australia, sub. 74, p. 3; Hannah Potapczyk, sub. 26, p. 1; Leadership Plus, sub. 128, p. 2; Maurice Blackburn Lawyers, sub. 58, p. 13; New South Wales Government, sub. 60, p. 15; University of Sydney, sub. 55, p. 3). Engagement with scheme participants during the planning process appears to be fairly superficial, and the NDIA accepted that the focus on throughput during the first two quarters of transition has contributed to poorer plans (sub. 161, p. 11).

Phone planning

Most planning conversations are now taking place over the phone, although face to face meetings are accommodated if required. The NDIA (sub. 161, p. 12) explained that this was a deliberate decision to allow people to enter the scheme as quickly as possible, with provision for scheme participants to consider how they will use their supports and amend their goals over the first year.

This decision was based on trial experience that recognised that people want to join the scheme as soon as they can, but also want time to think about their goals, supports and how they will use them. While it is recognised that this approach is not perfect, it was designed as a short-term measure to meet both of these objectives (NDIA, sub. 161, p. 10).

Study participants overwhelmingly expressed dissatisfaction with this approach to planning,[17] and many provided examples of poor experiences (box 4.8).

Carers Australia Victoria also identified issues with:

> … limited access to supporting documentation whilst on the phone; limited time to properly consider goals and aspirations; confusion about who they are being contacted by and for what; whether the plan will be as comprehensive as it could have been if the participant had the opportunity for a face-to-face meeting; the ability for the planner to recognise opportunities for capacity building. (sub. 131, p. 8)

Some felt that phone planning limits engagement with the scheme participant and does not allow the planner to see the full picture. For example:

> [Phone planning] is a transactional and blunt approach at a critical stage of a participant's navigation and interaction with the scheme … We feel utilization of phone-planning also creates assumptions of living situation by planners, who are unable to adequately capture the requirements and considerations of participants and respect the role of family, carers and other persons who are significant in the life of the participant. (Social Support & Precarious Workforce Research Discussion Group, sub. 71, pp. 2–3)

[17] Study participants who were critical of phone planning included: ADACAS (sub. 87); AHPA (sub. 37); Alzheimer's Australia (sub. 10); Brain Injury SA (sub. 116); Carers Australia Victoria (sub. 131); CMHA (sub. 9); ECCV (sub. 31); Flourish Australia (sub. 74); Jacqueline Pierce and Associates (sub. 147); Macarthur Disability Services (sub. 57); Mental Health Community Coalition of the ACT (sub. 135); OTA (sub. 15); PDCN (sub. 29); PDA (sub. 38); The Shepherd Centre (sub. 107); Social Support & Precarious Workforce Research Discussion Group (sub. 71); VCOSS (sub. 176); VMIAC (sub. 167).

Box 4.8 Experiences with phone planning

Alzheimer's Australia:

> Annie called the Parkinson's 1800 support line as she worried about an over the phone NDIS planning session that had taken place earlier that day. Annie's volume and quality of speech has been impaired due to Parkinson's and she also requires longer to respond to questions. She felt rushed and because her response is delayed she felt that the assessor didn't get a clear indication of her needs. Annie and a Parkinson's Nurse Specialist were able to take the time [to] put information together in order to apply for a review for Annie's plan. (sub. 10, p. 8)

Ethnic Communities' Council of Victoria:

> … anecdotal evidence from advocates and providers in the North Eastern Melbourne Region indicates that some participants are not being adequately informed about the purpose of phone contact by the NDIA or their LAC. These participants are having plans being completed without realising that they are engaging in the process or providing informed consent. (sub. 31, p. 1)

Carers Australia Victoria:

> I received a telephone call from an NDIA representative and requested a face-to- face meeting … The planner requested information regarding my son and said there were notes from his case manager which would be used to help create his plan. I inquired about the case manager, as I was not aware my son had one. The name given was of a man I had spoken to about 20 years ago. The planner said they have all his needs documented. I reiterated the need for a face-to-face meeting to discuss our changing circumstances and the support that my son needs to live independently and future support needs. I was offered a meeting three days later, 90 km from my home, which was not possible for me to attend. When I received a follow up call, I thought it was to schedule another time for a meeting, instead it was to tell me that a plan had been created for my son and that I should login to the Portal to see it. A week later I received a copy of the plan in the mail. The plan contained information about my son from over 20 years ago. (sub. 131, p. 9)

And:

> … an assessment completed by phone does not take the person's disability into account and fails to provide the added awareness and accommodation that are possible in a face-to-face meeting. Planners ask questions over the phone, which sometimes assume ability that does not exist. However, this is not evident to the planner because they are not with the person being assessed. They also lack the ability to make observations about the situation of the participant at the time of the phone call, which may involve distractions. (Brain Injury SA, sub. 116, p. 9)

Blind Citizens Australia (sub. 130, p. 3) also said that conducting meetings over the phone 'severely compromises the ability of people who are blind or vision impaired to demonstrate the difficulties they may face with completing tasks like reading, navigating the environment or household chores'.

Others expressed concern that phone planning takes scheme participants by surprise or does not allow participants to be supported by family, carers or advocates (Flourish Australia, sub. 74, p. 12). Physical Disability Council of New South Wales said:

> Phone plans to do not allow for participants to be supported simultaneously by carers or other important parties; physical sharing of important resources such as weekly planners or aspirational plans; equal access for peoples with specific communication needs; or allow

> planners to observe physical cues and surroundings for possible supports or equipment needs. (sub. 29, p. 3)

Phone planning is especially problematic for scheme participants with particular accessibility requirements (discussed below), such as mental illness (CMHA, sub. 11, p. 6; Flourish Australia, sub. 74, p. 3), cognitive impairment and neurodegenerative diseases (Alzheimer's Australia, sub. 10, p. 5) or people of culturally and linguistically diverse backgrounds (ECCV, sub. 31, p. 1; VCOSS, sub. 176, p. 11).

The Commonwealth Ombudsman reported that the bulk of complaints he had received about the planning process were from people who participated in phone planning. The Ombudsman suggested that it would be useful to compare the outcomes, satisfaction and review rates of face to face and phone planning discussions, noting that:

> While phone meetings likely provide the most cost effective method for planning when only simple administrative overheads are considered, there may be merit in considering whether — if participants who have phone meetings are likely to subsequently complain or seek review — the time spent on those subsequent interactions detracts from the cost effectiveness of planning by phone. (sub. 137, p. 8)

Consulting with participants about plan content

Consulting with scheme participants and their family, carers and advocates is essential to the success of the planning process. However, the Commission heard that, in many instances, scheme participants were not consulted about the content of their plan.

In particular, scheme participants were not permitted to view plans before they were finalised. National Disability Services explained:

> During the trial phase of the NDIS, participants were invited to comment on their draft plan before it was finalised. That practice has largely ceased. The consequence is that participants can end up with a plan that doesn't reflect their needs and goals. Some participants receive plans they don't recognise. Consistent with the NDIS's focus on choice and control, participants should always have the opportunity to comment on their plan before it is finalised. (2017a, p. 7)

And Community Mental Health Australia said:

> Clients are generally not permitted to see a plan before it is finalised, which anecdotally providers state is hindering clients understanding of their plan … There are incidents where people don't know what they are going to get until the plan is submitted — and there is currently no opportunity to take time to consider the plan before it is finalised. (sub. 11, pp. 3, 11)

The lack of participant involvement is not confined to first plans. Several study participants said that consultation around subsequent plans was also inadequate, and reported that first plans were simply being 'rolled over' (CPSU, sub. 76, p. 9; Health Services Union,

sub. 132, p. 12). For example, the Summer Foundation recounted a mother's experience with her child's third plan.

> No actual review took place and her daughter received a 'form' letter advising that her plan would continue 'as was' for the next 12 months and if she required any changes to apply for an internal plan review within 3 months of receiving this letter! This letter was not even signed! (sub. 113, p. 21)

Conversely, others said that requests to have a plan rolled over were ignored.

> In February I was contacted by an NDIA employee to have my plan review early. I tried to ask for it to be rolled over as I had not been able to fully activate the plan. I explained about the portal being down for months which was experience[d] by a large number of service providers. This person would not consider this and proceeded to state I was to be reviewed by phone. (Tricia Curley, sub. 140, p. 4)

Under the current timetable, the NDIA is required to complete a large number of plans in a relatively short period of time, and this has influenced how planning processes are undertaken. However, it is essential that the NDIA undertakes its planning function adequately and in a way that does not undermine the objectives of the scheme. An increased focus on the quality of the planning process will no doubt make it more difficult for the NDIA to keep to the timetable set out in the Bilateral Agreements. But if the quality of plans is compromised because of a focus on participant numbers, this will undermine the effectiveness of the scheme and have implications for long-term costs.

For this reason, in the medium to long term, it is important that the NDIA's performance is measured in relation to whether and how effectively it is realising outcomes under the NDIS, rather than participant numbers alone (chapter 9). A greater emphasis on reporting on the quality of planning processes would help shift the focus towards better quality plans and give the NDIA the incentive and latitude to focus on participant experience and outcomes.

Accessibility of the planning process

A lack of clear and transparent information

Study participants expressed frustration about the lack of clarity and transparency around the planning process (Autism Aspergers Advocacy Australia, sub. 178, p. 19; DPO Australia, sub. 165, p. 13; Flourish Australia, sub. 74, p. 11; Mamre Association, sub. 47, p. 1; Mental Health Community Coalition of the ACT, sub. 135, p. 19; Noah's Ark, sub. 108, p. 10; SWAN Australia, sub. 86, p. 1). Limited information is publicly available to help scheme participants and their families, carers and advocates to navigate the system. Noah's Ark, for example, said:

> … there is no information about the planning process and how it is supported in the public domain. There has been a significant change in how plans have been written. These changes have not been documented or an explanation provided. (sub. 108, p. 9)

Mamre Association also identified problems with:

> The lack of consistency with clear, concise and factual information. It is often left up to the general disability sector to try to navigate their way through 'forensic' investigation as to what the information means. There simply is very little capacity within the sector itself to invest in something so time consuming. (sub. 47, p. 1)

Poor information can be especially stressful for scheme participants who do not have the time or capacity to navigate a complex and confusing system.

Scheme participants are also often not aware or informed about their rights and options. For example, some participants did not know that they could request a face to face planning meeting instead of phone planning (ADACAS, sub. 87, p. 15; Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 3).

Participants were also often unaware of their entitlement to have an advocate present at their planning meeting, which can negatively affect outcomes for participants with limited ability to self-advocate (ABF, sub. 48, p. 9; New South Wales Government, sub. 60, p. 15). Brain Injury SA also identified problems with the failure to provide information about review processes.

> … information provided to participants about review is unclear and inadequate. There is minimal information about the process and no information about how or where participants can get help with a review … Further, Brain Injury SA has received anecdotal evidence from parents and guardians that NDIA has not been informing participants of their right to an internal review or external merits review through the [Administrative Appeals Tribunal]. (sub. 116, pp. 9–10)

Planners are not easily reachable

Study participants also felt that planners were not identifiable and accessible to scheme participants (AHPA, sub. 37, p. 14; Disability Services Commissioner, sub. 35, p. 5; OTA, sub. 15, pp. 4–5). The Disability Services Commissioner said:

> Planners are not clearly identifiable and accountable. A participant told us that the planner got his plan wrong and he couldn't call the planner directly to talk about the issue. He raised further concerns that no one at the NDIA records his calls, so he feels he cannot escalate his complaint, as there is no record of his previous contact. (sub. 35, p. 5)

Brain Injury SA also said:

> The 1800 phone number is the only number provided to participants and service providers. Anyone wanting to speak to a planner, even in response to a message that has been left by the planner, must use this number … there is usually a 45 minute wait for calls to be answered. When the call is answered, there is no certainty that the call will be transferred to the relevant office or planner. (sub. 116, p. 10)

Planning processes are not inclusive for all

It is important that planning processes are accessible, inclusive, and sufficiently flexible to accommodate the needs of different scheme participants. This is especially true for participants with complex needs or from culturally and linguistically diverse backgrounds. For example, the New South Wales Government said:

> Many NDIS participants that are participants of other state services (justice, mental health) do not have the capacity or capability to interact with the NDIS without intensive support. They may have no natural supports, like family or friends in their lives; they may have family that do not support their best interests; or they may have limited experience as consumers generally and may not be able to exert their rights as participants in the NDIS. Some people with complex needs may not be able to define their needs or understand what reasonable and necessary supports they would need to support them. (sub. 60, p. 17)

Planning processes also need to be sensitive to the intersection between disability and other social issues, such as homelessness, family violence, and alcohol and other drug use. Study participants also highlighted the importance of providing gender-responsive services (ACT Government, sub. 156, pp. 28–9; DPO Australia, sub. 165, p. 15; Leadership Plus, sub. 128, p. 2; Richard Kennedy, sub. 2, p 2; VCOSS, sub. 176, p. 10; Women with Disabilities Victoria, sub. 111, p. 2).

Needs arising from disability

Many study participants said that planning processes are not inclusive and overlook the needs of people with disability. Sharing Places said:

> People with intellectual disabilities and very high and complex support needs are not understood by NDIA. People with high and complex needs would greatly benefit from a more in depth assessment and planning process. (sub. 53, p. 2)

Communication accessible processes are also important for people with vision or hearing impairment (ABF, sub. 48, p. 9; Deafness Forum of Australia, sub. 127, pp. 16–7; Speech Pathology Australia, sub. 136, pp. 28–9). But Australian Blindness Forum said:

> … participants in the NDIS cannot access any NDIS information in alternative formats. This means that people who are blind or vision impaired cannot independently register themselves with the NDIS or read their own plans. (sub. 48, p. 9)

Planning can also be challenging for people whose needs can change quickly — such as episodic or progressive disorders. Study participants identified psychosocial disability (box 4.9) and degenerative disorders (box 4.10) as particular problem areas.

Box 4.9 Mental illness and psychosocial disability

The National Disability Insurance Scheme is designed to cover disabilities that are permanent, including those of a chronic episodic nature, such as mental illness and psychosocial disability.

> 'Permanent' refers to the irreversible nature of the disability, even though it may be of a chronic episodic nature. For example, this would include people with significant and enduring psychiatric disabilities, who periodically rely exclusively on support from the clinical services of the mental health system, but at other times are able to live in the community provided they have appropriate supports. (PC 2011, p. 14)

However, the episodic nature of mental illness can mean that some scheme participants' needs are unpredictable. To some extent, this runs contrary to the planning process, which, in broad terms, requires a forecast of the participant's support needs over the life of the plan.

This problem is exacerbated by 'inflexibility in changing arrangements in response to fluctuations in support need because of escalating illness' (Mind Australia, sub. 144, p. 8). This can create incentives for participants to overstate their support needs, so that they can be sure that they have access to adequate support during times of high need.

Due to the nature of their disability, people with psychosocial disability may at times find it difficult to articulate or disclose their support needs during the planning conversation (Anglicare Tasmania, sub. 145, p. 32; VMIAC, sub. 167, p. 7; VICSERV, sub. 169, p. 4). For this reason, such participants 'may need more than one meeting to develop plans due to [the] fluctuating nature of conditions' (Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 6).

Box 4.10 Progressive and degenerative disorders

Study participants said that certain progressive or degenerative disorders sat poorly with the 'investment approach' of the scheme. For example, Neurological Alliance Australia said:

> … the progressing and complex needs of people with neurodegenerative diseases have been overlooked due to lack of understanding of these diseases or for the sake of expediency … People with a progressive neurological disease run counter to the 'traditional' trajectory of someone on the NDIS: that is, an ability to enhance independence and re-ablement through a more effective engagement of services. For someone with a neurodegenerative disease, however, care needs inevitably increase over time. (sub. 30, pp. 1–2)

In addition, current planning processes do not account for the changing needs of people with progressive or degenerative disorders. Calvary Health Care Bethlehem said:

> For people with progressive disorders, the person's needs can change more rapidly than expected, so there needs to be sufficient flexibility in the plan being reviewed and amended to accommodate unforeseen needs arising. This needs to happen in a timely manner. (sub. 64, p. 2)

Similarly, MND Australia said:

> Plans are based on the 'now' and do not take account of the rapid and increasing needs caused by the progressive degenerative nature of [motor neurone disease], requiring review planning earlier than is necessary. (sub. 45, p. 9)

MND Australia (sub. 45, p. 7) also reported that between June 2016 and January 2017, all plans for people with Motor Neurone Disease in New South Wales and the ACT required review, primarily due to a poor understanding by planners of degenerative diseases.

Language and cultural barriers

Study participants observed that planning processes do not adequately cater for people of different cultural and linguistic backgrounds (Companion House, sub. 84, p. 2; Jesuit Social Services, sub. 117, p. 7; Neami National, sub. 63, p. 6; Northern Territory Government, sub. 205, p. 7; Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 6; VCOSS, sub. 176, p. 9; VMIAC, sub. 167, pp. 6–7).

For many, language barriers can prevent meaningful engagement with planning processes. Neami National (sub. 63, p. 6) said that 'consumers without English as their first language describe difficulties in participating in planning and in getting plans that they can fully implement on account of their language needs'. This is an issue which disproportionately affects Aboriginal and Torres Strait Islander communities:

> English is a second language for many Indigenous people in remote communities. The majority of participants in Barkly identify as being Aboriginal or Torres Strait Islander and for 67% English is not their first language. Many have limited capacity to understand or read it. This has a significant impact on their ability to have genuine input into the formulation of their plans and also impacts on decision making and choice. (Brain Injury SA, sub. 116, p. 3)

and those of refugee background:

> People with disability from a refugee background are often not well equipped to navigate the NDIS in planning meetings and to negotiate a package of supports from providers. Many have little or no understanding of the context of the broader social support system in Australia. (Companion House, sub. 84, p. 2)

Cultural barriers can also make accessing and interacting with the planning process difficult. In particular, there may be confusion as to the purpose of planning conversations and there is a risk that scheme participants do not communicate their needs due to different cultural or social norms. (Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 6). There may also be greater mistrust of government services or an aversion to sharing personal information (VCOSS, sub. 176, p. 9).

Access can be especially difficult for some Aboriginal and Torres Strait Islander communities. Brain Injury SA said:

> Many Aboriginal people can be transient in nature and to uphold their cultural requirements. Therefore, participants are not in regular receipt of mail or telephone communication. In the Barkly region there is no mail delivery to homes and most people do not regularly check their PO Box. If they do not receive a hard copy of their plan they are advised to go onto the portal and get it online. However, many do not have access to computers, nor the awareness of how to use them. Consequently, many participants do not know they have a plan or, if they do, what is in it. (sub. 116, p. 3)

The Australian Medical Association emphasised the need to have culturally appropriate processes and cited evidence of poor planning practices.

> … we were told that in one Aboriginal community, NDIA assessors did not leave their vehicle, instead they yelled questions of Aboriginal people regarding their disabilities … there was no verification of the person's identity other than to ask their name and conduct a conversation from a driveway. Another reported case was that Aboriginal people with disability were asked to leave their homes and find their way to a waiting vehicle for an assessment; this included an Aboriginal person in a wheelchair. (sub. 120, p. 5)

The role of pre-planning support

For many scheme participants, pre-planning support can assist them in navigating a confusing and complex system. Pre-planning support is directed at helping the participant prepare for the planning conversation, including:

- thinking about their goals and aspirations
- preparing documentation to support the assessment process
- thinking about what supports are available and can help them.

Demand for pre-planning support services is influenced by how accessible and complex planning processes are, as well as the scheme participant's capacity (including their ability, willingness, skills and resources) to navigate those processes (chapter 8). At present, pre-planning support is provided by a range of different organisations, including advocacy groups and service providers.

Several study participants noted that pre-planning assistance is costly to provide (House with No Steps, sub. 104, p. 5; Mamre Association, sub. 47, p. 2). Some participants said that the NDIA should play a greater role in providing pre-planning support (ADACAS, sub. 87, p. 16; CMHA, sub. 11, p. 10; Cohealth, sub. 50, p. 10). Others called for governments to provide additional funds to facilitate pre-planning support (Amaze, sub. 160, p. 5; Cohealth, sub. 50, p. 10; NSW Disability Network Forum, sub. 18, p. 3; Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 9; VICSERV, sub. 169, p. 4).

Providing pre-planning services is one of the core functions of LACs. It was intended that, during transition, LACs would be 'on the ground' in each area six months before the NDIS was rolled out in that area, in part to provide pre-planning support. However, the speed of the rollout has meant that this was not possible and LACs have not been performing their pre-planning functions as envisaged (NDIA, sub. 161, p. 56). The NDIA should also ensure that LACs are able to perform their pre-planning functions properly.

In addition, the Commission considers that there is considerable scope for the NDIA to improve transparency and clarity around planning processes. This includes providing clear and up-to-date information about what to expect during the planning conversation, when it will occur, and how the information gathered during that conversation will be used. There

is also considerable scope for improving the accessibility of planning processes, especially in relation to people with complex needs and those of different cultural and linguistic backgrounds.

These advancements could go a long way to mitigating the need for extensive pre-planning support, and relieve some of the pressure on advocacy groups and service providers to provide such services. It is likely that there will always be some scheme participants for whom more pre-planning support is necessary, and so it may be necessary in the future for government or the NDIA to play a greater role in providing that support. However, the first steps in helping scheme participants navigate the NDIS must be to ensure that LACs are able to properly perform their pre-planning functions and improve the transparency, clarity and accessibility of planning processes.

The NDIA is currently undertaking a review of the participant pathway to identify what changes or improvements should be made to planning processes (while achieving the number of completed plans as specified in Bilateral Agreements) to achieve plans that:

- maximise choice and control for scheme participants and contribute to improved participant outcomes
- are of a high quality in terms of a positive participant experience, compliance with all statutory requirements and consistency
- are financially sustainable so that the aggregate value of all plans remains within the funding envelope (sub. 161, p. 4).

However, the NDIA is operating under demanding time and resource constraints, and there are trade-offs between the quality of planning processes and how quickly the scheme can reach new participants. As noted earlier, better planning processes could involve compromises in terms of participant throughput.

DRAFT RECOMMENDATION 4.1

The National Disability Insurance Agency should:

- implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review
- review its protocols relating to how phone planning is used
- provide clear, comprehensive and up-to-date information about how the planning process operates, what to expect during the planning process, and participants' rights and options
- ensure that Local Area Coordinators are on the ground six months before the scheme is rolled out in an area and are engaging in pre-planning with participants.

Planners

Planners are an essential part of the planning process and exert considerable influence on scheme participants' experiences within the NDIS. Sufficiently skilled and impartial planners can improve the quality of the planning process and outcomes for scheme participants. As ACT Disability, Aged and Carer Advocacy Service said:

> It is crucial that the NDIA continue to recruit planners with the right combination of skills, experience and passion, that they offer good training and that workload pressures for NDIA staff are managed. Planners need the skills to be able to tailor the planning approach, and their communication style to participants with different needs. (sub. 87, p. 13)

Conversely, planners with less experience, skill or training can have a detrimental effect on the quality of plans and outcomes. This is because they may have less knowledge about what supports are appropriate, meaning that plans may include inappropriate supports or fail to include appropriate ones (Brain Injury SA, sub. 116, p. 5).

Impartial planners are also important for scheme participants' experience of the planning process and the quality of plans.

> The planners can have a great impact both positive and negative on the resulting plans. The planners biases also have an impact on both the discussion and resulting plan of a participant. For two years, the planner I had, put me in a box and thought she knew what and how I wanted supports. She would not listen until I had a panic attack in the meeting. It was only then she started listening. (Hanna Potapczyk, sub. 26, p. 1)

Skills, training and knowledge of specific conditions

A number of study participants were critical of the skills, experience and training of planners as a whole (Carers Australia Victoria, sub. 131, p. 12; DAA, sub. 119, p. 3; Matt Burrows, sub. 7, p. 3; Mental Health and NDIS Facebook Support Group, sub. 8, p. 3; Macarthur Disability Services, sub. 57, p. 4). The Public Service Research Group reported feedback that:

> There's not adequate induction support and supervision training provided to the people who are doing the planning … If we can't get the planning right we're not going to get the scheme right. (sub. 56, p. 6)

Others said that there was considerable variability in the skills, knowledge and competency across planners (including LACs undertaking planning functions), leading to uneven outcomes for scheme participants (AHPA, sub. 37, p. 8; Autism Aspergers Advocacy Australia, sub. 178, p. 20; Companion House, sub. 84, p. 2; New South Wales Government, sub. 60, p. 15; OPG, sub. 143, p. 3; Summer Foundation, sub. 113, p. 4; PDCN, sub. 29, p. 3; VCOSS, sub. 176, p. 12; South Australian Government, sub. 203, p. 11). Speech Pathology Australia (sub. 136, p. 28) also noted that information about the level of qualifications and training required of planners is not publicly available.

Study participants overwhelmingly agreed that planners performed better when they understood what needs arise from a person's disability. As Community Mental Health Australia said:

> If a planner understands the depths of a person's disability and what is needed to support the individual, the package developed will suit them over a longer term. This reduces the need for a plan to be amended in the future, thereby reducing administrative burden on the NDIA and building confidence in the process for the consumer. (sub. 11, p. 4)

However, many participants expressed concern about planners' limited disability knowledge.[18] For example, the Australia Physiotherapy Association said:

> Our members report that service planning is being undertaken by staff who have little competence in the specific field of disability relevant to the participant's needs and thus that service plans are at odds with the needs which the NDIS is designed to meet. (sub. 93, p. 13)

In particular, study participants expressed concern that planners had limited knowledge about specific conditions, such as motor neurone disease (MND Australia, sub. 45, p. 8), multiple sclerosis and dementia (Alzheimer's Australia, sub. 10, p. 16), Prader-Willi Syndrome (PWSAA, sub. 112, p. 4), and mental illness and psychosocial disability (CMHA, sub. 11, pp. 9–10; Cohealth, sub. 50, p. 10; Macarthur Disability Services, sub. 57, p. 4; Mental Health Carers Australia, sub. 181, p. 10; Neami National, sub. 63, p. 6). The Commonwealth Ombudsman reported that:

> Some stakeholders have told us about planners who asked parents when their child was likely to 'recover' from a life-long disability, and others who told people with psychosocial disabilities they should 'try to be more positive'. (sub. 137, p. 8)

Others also said that planners had limited knowledge of appropriate supports for certain conditions, such as the role of occupational therapists (Occupational Therapy Australia, sub. 15, pp. 4–5) and podiatry (Australian Podiatry Council, sub. 52, p. 2). For example, VCOSS (sub. 176, p. 12) gave the example of 'a deaf participant with cochlear implants [being] allocated two hearing aids in their package, despite hearing aids being ineffective for people with cochlear implants'. The Commission also heard that planners are ill-equipped to connect scheme participants with employment supports (House with No Steps, sub. 104, pp. 5–6; Round Squared, sub. 170, pp. 5–6).

[18] Study participants who commented on planners' limited knowledge of disabilities included: ABF (sub. 48); ACIA (sub. 141); AHPA (sub. 37); Alzheimer's Australia (sub. 10); Anglicare Tasmania (sub. 145); APA (sub. 93); Australian Podiatry Council (sub. 52); Belinda Jane (sub. 80); Cheryl McDonnell (sub. 79); CMHA (sub. 11); Cohealth (sub. 50); Commonwealth Ombudsman (sub. 137); DPO Australia (sub. 165); Macarthur Disability Services (sub. 57); Macular Disease Foundation Australia (sub. 75); Mental Health Australia (sub. 155); Mental Health Community Coalition of the ACT (sub. 135); Mind Australia (sub. 144); MND Australia(sub. 45); Neami National (sub. 63); OPA (sub. 46); OTA (sub. 15); PWSAA (sub. 112); VMIAC (sub. 167).

Improving planners' performance

Planners should, at a minimum, have a general understanding about different types of disability. Several study participants called for planners to receive more education on specific conditions and supports (Alzheimer's Australia, sub. 10, p. 13; Cheryl McDonnell, sub. 79, p. 2; CMHA, sub. 11, p. 4; Cohealth, sub. 50, p. 5; Neami National, sub. 63, p. 6; PWSAA, sub. 112, p. 4).

Others saw a role for specialised planners, especially for people with psychosocial disability (Cohealth, sub. 50, p. 10). The Office of the Public Advocate argued that these specialised planners should hold professional certifications.

> NDIS planners and support coordinators should be required to hold professional certifications. If assisting a participant with a primary psychosocial disability, for example, planners and coordinators should be trained mental health professionals. (sub. 46, p. 2)

The Commission also considers that there is value in having specialised planning teams for some types of disability. This is in line with industry practice for insurance companies. For example, Allianz Australia (sub. 42, p. 6) submitted that, in the context of workers' compensation claims, it employs specific psychological claims teams, given the unique nature of mental health related claims. However, specialised planners may not be appropriate for all types of disability, especially where:

- the person does not have a diagnosis
- the benefit of having a specialised planner is minimal
- the group affected is small, such that the cost of specialisation is not justified.

An alternative (or complementary) approach would involve leveraging expertise from the disability support sector. Macular Disease Foundation Australia advocated better use of existing resources.

> Whilst it is acknowledged that it is not physically or logistically possible for planners with specialist disability knowledge to be matched with every NDIS participants' disabilities and conditions on a national scale, the NDIS appears to not be effectively leveraging existing expertise from specialist disability organisations. (sub. 75, p. 5)

In many cases, providers may also have valuable knowledge about the scheme participant's needs. Anglicare Australia said:

> Many of our agencies have experienced reluctance from the NDIA to involve sector providers in the planning stage, and believe it is a major weakness that needs to be addressed … Service providers, due to their many years' experience (including vital rapport with scheme participants, particularly necessary for people with a psychosocial disability), are often better placed to accurately identify the scope and cost of an appropriate plan. (sub. 157, pp. 8–9)

Similarly, National Disability Services said:

> The quality of planning would improve if disability service organisations were involved. Providers of specialist supports have deep knowledge of disability – and they know their

> clients. Using this knowledge to inform planning would make sense. This is particularly true for people with complex needs … Planning partnerships between the NDIA and specialist providers should be extended. (2017a, pp. 6–7)

While leveraging expertise from the sector could give rise to potential conflicts of interest, these could be managed or mitigated by ensuring that such organisations only have an advisory role, with final decision-making powers exercised by an impartial planner. This approach would also mean that the NDIA would not need to compete with others in an already thin market to recruit planners with specialist qualifications or experience.

Over the longer term, satisfaction with planners could also be improved through monitoring and assessing their performance (OTA, sub. 15, p. 5; PDA, sub. 38, p. 7). According to the NDIA (sub. 161, pp. 89–90), planner performance is currently monitored through:

- participant satisfaction measures
- complaints, accounting for the volume and substance of complaints
- the National Quality Framework, where monthly audits are conducted on planner records and feedback provided through coaching and supervision.

Regular and public reporting around planner performance could help increase the accountability of planners, and improve community confidence in planners and the planning process.

DRAFT RECOMMENDATION 4.2

The National Disability Insurance Agency should ensure that planners have a general understanding about different types of disability. For types of disability that require specialist knowledge (such as psychosocial disability), there should be specialised planning teams and/or more use of industry knowledge and expertise.

4.4 Linking supports and outcomes

Supports are one of the core mechanisms through which the benefits of the NDIS are realised. In the short term, many of these benefits arise because supports can help address the care and support needs of people with disability (chapter 2).

However, many benefits will only be realised over a longer time horizon. This is due to the NDIS's insurance approach to funding supports, which takes a lifetime view of participant needs and seeks early investment opportunities, in order to optimise long-term outcomes (chapter 1). This includes capacity building for scheme participants to:

- maximise participant independence
- increase social and economic participation (of scheme participants and their carers)

- reduce scheme participants' support requirements.

Examples of capacity building supports include: therapeutic supports; transport to enable participation in community and social activities; and employment supports to help a participant obtain and keep a job.

It is still too early to fully evaluate whether, and to what extent, these long-term benefits will be realised, although the NDIA has developed an Outcomes Framework to allow outcomes of scheme participants, their families and carers to be measured over time (chapter 2). However, the Commission heard that supports directed at capacity building and early investment are under-represented in participants' plans.

In particular, some study participants pointed to early signs that scheme participants are not being supported to work, meaning that economic participation outcomes may not be realised (chapter 2). This is because plans do not include or do not make adequate provision for employment supports. Westhaven Association said:

> The evidence from the plans being produced to date shows NDIA has failed to ensure that NDIS participants are supported to gain productive employment. Without the employment outcomes expected from the scheme, NDIS may not achieve the return originally projected by the Productivity Commission. (sub. 81, p. 2)

And National Disability Services argued:

> A broad spectrum of employment options should be open to people with disability, including Supported Employment Enterprises … More must be done to boost demand for, and access to, NDIS employment supports. NDIS planners and LACs should adopt a 'work first' approach which motivates and assists an increased proportion of NDIS participants to connect with work. (2017a, pp. 8–9)

In part, this stems from community attitudes towards disability and employment embedded in legacy support systems. These attitudes have persisted despite the move to an early investment approach to disability care and support arrangements, and can mean that scheme participants are unaware of or do not seek employment supports. As Epic Employment Service said:

> After four years of the NDIS trial and full scheme roll out, EPIC believes the small amount of plans focusing on employment is due to widely-held beliefs … . We believe the Australian community broadly accepts that NDIS participants will not primarily be seeking employment through their NDIS packages … Furthermore, participants and their families are often led to believe open employment is simply not a viable option. (sub. 70, pp. 2–3)

However, some study participants said that planners do not have a good understanding of what employment supports are appropriate for scheme participants (House with No Steps, sub. 104, pp. 5–6; Roundsquared, sub. 170, pp. 5–6). As a result, scheme participants are not offered employment supports, or encouraged to think about how they might increase their economic participation.

Going forward, the challenge for the NDIA will be to develop a planning process that fosters capacity building, independence, and social and economic participation. Community attitudes about disability and community involvement are unlikely to change without evidence that people with disability can be supported to work and participate in the community. Therefore, as a first step, it will be up to the NDIA and planners to 'lead the way' and encourage scheme participants to think about, and connect them with, capacity building and employment supports that are right for them.

5 Boundaries and interfaces with the NDIS

Key points

- Effective interfaces between the National Disability Insurance Scheme (NDIS), other disability services and mainstream services are essential for good outcomes for scheme participants and the financial sustainability of the scheme. To provide the right incentives, services available to people who just qualify for the NDIS and those who just miss out should be as seamless as possible. This requires coordination of services within and outside of the NDIS.
- The Information Linkages and Capacity Building (ILC) program is a key component of the NDIS. It is a false economy to have too few resources for ILC activities, particularly during transition when it is critical to have structures in place to ensure people with disability are adequately connected with appropriate services.
- For people with disability who are not eligible for the NDIS, the Australian, State and Territory Governments have agreed to provide continuity of support.
  - But in practice, there is confusion and uncertainty about what services will continue to be provided and/or funded outside the NDIS.
  - Governments need to be clearer about their approach on continuity of care, and what disability services they will provide for non-NDIS participants.
- The NDIS is meant to work alongside mainstream services (such as services in health, education, aged care and transport), not replace them.
  - The Bilateral Agreements between the Australian Government and State and Territory Governments delineates responsibilities in terms of which services are to be provided by the NDIS and mainstream services.
  - While it is still too early to identify service gaps, there are emerging issues in a number of areas, including justice, emergency, transport and mental health services.
  - Each COAG Council that has responsibility for a service area that interfaces with the NDIS should have a standing item on their agenda to address the provision of those services and how they interface with NDIS services.
  - Further investment in the *National Disability Strategy* could improve accountability.
  - ILC and Local Area Coordinators can play a role in ensuring mainstream services are better informed about their roles and responsibilities.
- The National Injury Insurance Scheme (NIIS) was envisaged to cover the care needs of individuals who newly acquire a disability through a catastrophic injury or accident. Two of the four streams proposed have been implemented. While the cost implications of the two remaining streams are not large for the NDIS, the States and Territories should bear the cost of participants who were intended to be covered by the NIIS.

People with disability, and their families and carers rely on a wide range of services — including mainstream services, specialist disability services and community supports — for their care needs and to maintain the quality of their lives. For the National Disability Insurance Scheme (NDIS) to work efficiently and effectively, the interface of the scheme with these other services must be as seamless as possible. By design, the NDIS is intended to complement these other supports, not replace them. A requirement of any supports provided through the NDIS is that they are most appropriately funded through the scheme and not by other services.

While the level of funding provided to the NDIS recognised that the aggregate level of funding available to people with disability was inadequate, the NDIS was not expected to fill *all* of the very large gaps in services that existed before the scheme was established. The responsibility to provide services to people with disability remains a shared responsibility between all levels of government.

The interface between all kinds of assistance for people with disability will take time to determine at the coalface, but until these interfaces are settled, it is important that governments do not withdraw from services too quickly, as any gaps that emerge will place added burdens on people with disabilities and their families.

As the interface issues become clearer, it is essential to consider the incentives that are set up where boundaries exist. Most critically, it is important that people with disability do not see the NDIS as an oasis of support, surrounded by a desert, where little or nothing is available. Should such a dynamic develop, the financial pressures on the NDIS could be unsustainable, particularly if people feel the need to test their ability to qualify for the scheme, and/or remain in the scheme for as long as possible, for fear of not gaining access again should the need arise.

This can be compared with a situation where the gap between participants with the lowest needs (and therefore the lowest level of supports), and those outside the scheme, is not large. In such a system, people will not have an incentive to enter the scheme as their needs will be adequately met outside it, and those inside the scheme who are assisted sufficiently to no longer need individualised supports will have little incentive to stay in the scheme longer than necessary.

There is a lot of detail yet to be worked through. Nevertheless, establishing clear and robust boundaries is essential for the fiscal sustainability of the NDIS, and for the surrounding network of supports. When people are accessing the services they need, the system as a whole should be providing supports at the most efficient and cost effective level.

This chapter first looks at bridging and capacity building services provided under the NDIS (section 5.1), then how the NDIS interfaces with other disability services (section 5.2). The interface between the NDIS and mainstream services is examined in section 5.3. How the NDIS interfaces with the aged care sector (section 5.4) and the National Injury Insurance Scheme (section 5.5) are also examined.

5.1 Linking people to the right services

About the Information, Linkages and Capacity Building program

The NDIS is just one part of a wider disability system. While the NDIS will benefit all Australians, only a proportion of people with disability will become scheme participants. Of the 4.3 million Australians with disability just 475 000 (those people with a 'permanent and significant' disability) will receive individualised supports under the NDIS (chapter 1, figure 1.1). As the National Disability Insurance Agency (NDIA) said:

> The NDIS is intended to benefit a wide range of Australians, only a proportion of whom will become participants and receive an individualised plan. … short-term or light touch assistance from the NDIS, in collaboration with a capable and inclusive community and mainstream response, can help them better access mainstream supports, build connections into community supports and strengthen natural supports in order to achieve their outcomes. (sub. 161, p. 53)

The Commission recommended a bridging and capacity building service for anyone with, or affected by, disability (PC 2011, pp. 163–165, 198). The Information, Linkages and Capacity Building (ILC) program, to be provided under the NDIS from July 2017, is a key component of the NDIS. It will provide information, linkages and referrals to people with disability, their families and carers, helping them to connect with appropriate community and mainstream supports (NDIA 2017e). The focus of ILC is community inclusion. According to the NDIA, it is to:

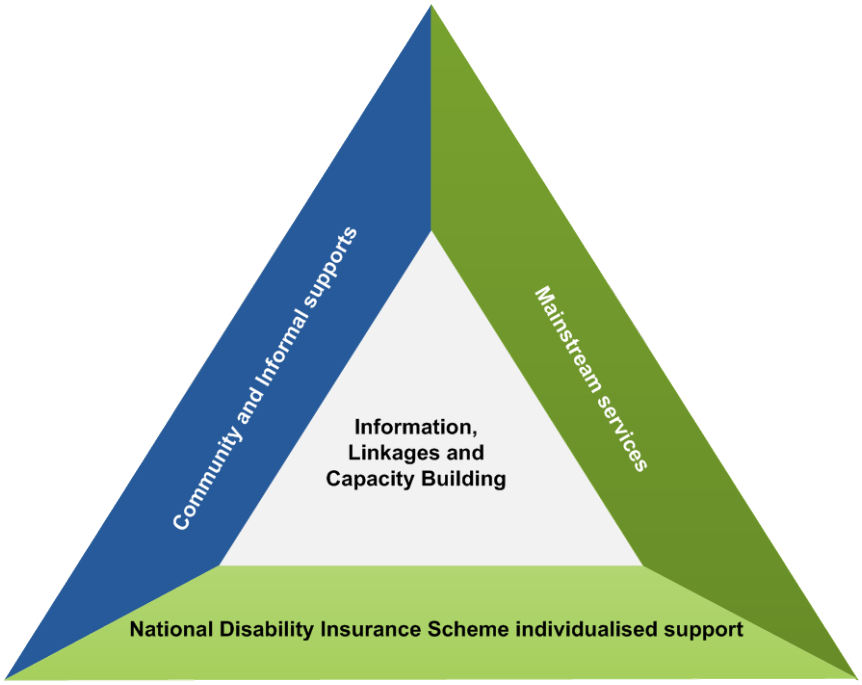
> … build innovative ways to increase the independence, social and community participation of people with a disability. (NDIA 2016d, p. 5)

ILC will also facilitate capacity building support and greater inclusivity by promoting collaboration and partnership with local communities and mainstream services (figure 5.1).

In August 2015, COAG endorsed the ILC Policy Framework (NDIA 2015a). The framework describes five streams to achieve the objective of ILC.

- Information, Linkages and Referrals — connecting people with disability, their families and carers with appropriate disability, community and mainstream supports.
- Capacity building for mainstream services — ensuring people with disability connect with and access mainstream supports.
- Community awareness and capacity building — supporting organisations (such as not-for-profit organisations, local councils and businesses) and people within communities to be inclusive of people with disability, and understand the needs of families and carers.
- Individual capacity building — fostering the principle of choice and control, improving outcomes for people with disability, their families and carers.
- Local Area Coordinators (LACs) — developing relationships between the NDIS, people with disability, their families and carers, and the local community (NDIA 2015a).

Figure 5.1 **Bridging services — Information, Linkages and Capacity Building**



Source: NDIA (2015a, p. 4).

ILC is an important tenet of the NDIS insurance model, and will affect scheme sustainability because it is expected to reduce reliance on NDIS funded support and thus reduce costs over time. ILC is expected to:

- *reduce the demand for individualised packages* — ILC is a lever to divert people from needing to access individualised packages and instead connect them to the appropriate supports for their needs
- *reduce the need for supports within funded packages* — ILC can maximise the ability of participants to access mainstream, community and informal supports, which in turn can reduce the need for funded supports (for example, targeted supports to assist a person to navigate the public transport system can reduce the need for funded taxi travel)
- *make supports more effective at helping people achieve their goals* — many supports are more effective in helping a participant achieve their goals when complemented by informal and community support (for example, a fitness goal is more likely to be achieved if funded support to use gym equipment is complemented by an inclusive gym community or a friend for companionship and motivation) (NDIA, sub. 161, p. 54).

ILC in practice

ILC is still to be rolled out. Grant rounds are completed for ILC activities in the ACT (2017-18) and for national activities (2016-17). ILC activities are expected to begin operating in ACT on 1 July 2017 (NDIA 2017e, 2017h). Only one component of ILC — Local Area Coordinators (box 5.1 and chapter 4) — has been implemented. LACs will be the single largest investment by the NDIA in delivering outcomes for ILC.

Box 5.1 Local Area Coordinators

LACs plays a central role in the delivery of ILC, by ensuring people with disability participate in and contribute to social and economic life, and that people with disability receive appropriate services. LACs connect across each of the first four streams of ILC, including information and linkages and individual capacity building as well as working with mainstream services and communities to better enable access and participation.

LACs also provide support for people with disability to understand their plans and how changes in funding and processes of the scheme are likely to affect them. LACs can help people put their plan into action and help them build capacity to self-manage their plan.

LACs have three primary roles:

- to work directly with people who have an NDIS plan, by connecting them to mainstream services, community activities, and getting their plans into action (chapter 4)
- provide some short-term assistance to non-NDIS plan participants and connect them into mainstream services and community activities
- work with the local community to ensure it is more accessible and inclusive for people with disability.

It is agreed with LAC partners that 20 per cent of their effort (and funding) should be allocated to the delivery of ILC activities.

Sources: NDIA (2015a, 2017k);. NDIA (sub. 161, p. 56).

In November 2016, the NDIA released its ILC Commissioning Framework (NDIA 2016f). The framework reflects the ILC Policy activities and identifies five focus areas which are deemed ‘priority areas’ for funding. These focus areas provide broad indications of the types of services that are eligible to be supported through ILC (table 5.1).

Table 5.1 **ILC Focus Areas**

Focus Area	*Definition*	*Example*
Specialist or expert delivery	Focus on activities that provide specific skills and knowledge in relation to disability — for example, diagnostic specific expertise or expertise in particular models of support or capacity building.	A comprehensive website that provides information about particular disabilities or conditions.
Cohort-focused delivery	Focus on activities for specific groups of people that require detailed cultural or other knowledge to be effective — for example, multilingual activities to assist Aboriginal and Torres Strait Islander peoples or people from culturally or linguistically diverse backgrounds.	A yarning circle (peer group) for Aboriginal women run by local Aboriginal organisations.
Multi-regional activities	Focus on activities that would be inefficient if delivered separately in different local areas – for example, advice or information that is not based on location and could be relevant anywhere.	A community awareness campaign to increase employment opportunities for people with disability.
Remote/rural delivery	Focus on ensuring activities are designed to address local needs, circumstances and conditions in rural and remote locations.	A project that connects young people with disability in a rural area with each other via multimedia or social media.
Delivery by people with disability, for people with disability	Focus on supporting organisations that are run and controlled by people with disability. These are sometimes called user-led organisations.	A telephone information service for people with disability, staffed by people with disability.

Source: NDIA (2016f, p. 18).

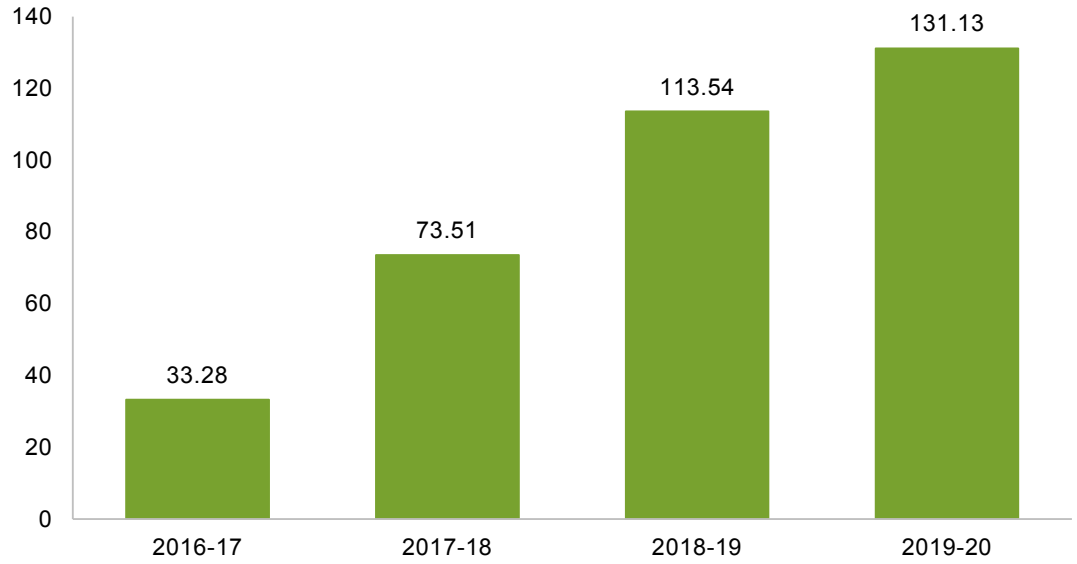
The ILC Commissioning Framework developed five strands of outcomes which programs funded through ILC will be measured against. They include the extent to which people with disability:

- participate in and benefit from, the same community activities as everyone else
- use and benefit from the same mainstream services as everyone else
- have the skills and confidence to participate and contribute to the economy
- have the appropriate information so they can make informed decisions and choices
- contribute to, lead, shape and influence their community (NDIA 2016f, p. 8).

Funding for ILC will gradually increase over the transition period from $33 million in 2016-17 to $131 million in 2019-20 (figure 5.2).

Figure 5.2 **ILC Funding**[a]

$million



[a] These numbers include funding for ILC activities in Western Australia; excluding Western Australia, the budget is about $119 million for 2019-20.

Sources: Australian Treasury (2017b, p. 140); NDIA (2016d).

Tendering processes are staggered across jurisdictions in line with the rollout timeline. Accordingly, the ACT will be the first jurisdiction to have ILC activities (commencing on 1 July 2017) (NDIA 2017e). Some of the successful grants in the ACT include:

- changing the ACT Health Care System to be more inclusive of people with impaired decision making ability
- educating Aboriginal and Torres Strait Islander people about what is meant by the term 'disability'
- establishing a peer support network for people with mild and borderline cognitive disability (NDIA 2017i).

As part of the ILC program, the successful ILC organisations and the NDIA will collect detailed data on ILC activities. The collection of data is important for measuring how effective ILC activities are in achieving outcomes for people with disability. The data will be used by the NDIA to identify and address performance issues, and inform future decisions on the allocation of funds.

Data collected will include the outcome success of activities in the short, medium and long term; quality and effectiveness of the activities; and performance over time. Data will be both qualitative and quantitative (NDIA 2016f, p. 27).

Is the funding for ILC adequate?

It is difficult to measure the adequacy of current ILC funding …

According to the NDIA, the timing of ILC funding has prevented it from investing in ILC activities and delayed the rollout of initiatives which would allow the infrastructure of a national ILC framework.

> The budget for ILC will increase over time and will reach a total budget of approximately A$131 million. This budget allocation severely hampers the NDIA's flexibility to use ILC at the time when the greatest impact could be realised. … The timing of payments means that the NDIA cannot apply ILC to assist the community or people with disability to prepare for the NDIS in advance of the NDIS rolling out in their area. … The timing of funding, linked to State and Territory contributions also prevents the NDIA from rolling out widespread national initiatives which would allow the infrastructure of a national ILC framework to be established. (sub. 161, pp. 54–55)

Many study participants questioned the adequacy of funding for ILC services given the scope outlined in the commissioning framework. For example:

> The PC should consider whether the one per cent cap (of scheme costs) on ILC expenditure should be adjusted to more flexibly accommodate investment in these areas that would generate better participant outcomes. (Victorian Government, sub. 174, p. 11)

> It is a widely reported view from the disability sector that there is a significant under-funding of the ILC in order to meet the needs of people with disability. (Speech Pathology Australia, sub. 136, p. 24)

> It appears that ILC is significantly underfunded and therefore will not deliver on rising community expectations. (Goldfields Individual & Family Support Association, sub. 13, p. 4)

> While some supports may be available through the Information, Linkage and Capacity Building (ILC) framework, it currently is not sufficiently resourced to meet the gaps. (Cohealth, sub. 50, p. 8)

> The total funding package for ILC at full roll out … when split across all types of disability is not adequate. (Mental Illness Fellowship of Australia sub. 122, p. 15)

> The implementation of the [ILC] framework … is dependent on adequate resourcing. Under full roll out, only $132 million is being allocated to the ILC. This is equivalent to approximately $30 to provide services to each person with a disability as well as to support mainstream services in capacity building. (Down Syndrome Australia, sub. 121, p. 12)

> Currently, only $132 million … has been allocated to the ILC. This is not sufficient and means that one of the key foundations on which the NDIS is being built is weak. (Bruce Bonyhady, sub. 100, p. 5)

Others said that the scope of ILC is too narrow to accommodate ILC's intended purpose (box 5.2), particularly in the context of what the Commission proposed would be covered under tier 2 of the NDIS.

Box 5.2 Many participants consider the scope of ILC too narrow

Physical Disability Australia (PDA):

> … it is PDA's understanding that the original tier 2 of the NDIS (that the ILC program replaces) was supposed to boost all non-participants' capacity to access to mainstream services. For example, we envisioned this might involve an 'Access Fund' to support the building of ramps and accessible toilets in the community.
>
> As such, PDA finds the current scope of the ILC (and its proposed budget) to be somewhat disappointing. (sub. 38, p. 6)

Australian Blindness Forum:

> … the range and type of services initially promised to be funded under the ILC program has changed substantially. The original proposal was that ILC would reflect the 'Tier 2' programs including block funding and early intervention programs. The goal of this was to continue to provide disability services to those who were not eligible for the NDIS. Now, the way the ILC program has been developed, it is only tools and awareness programs, delivered by mainstream services for a limited time or on an ad hoc basis. (sub. 48, p. 7)

Belconnen Community Service Board:

> ILC does not appear to cover the apparent lack of low intensity early intervention services needed for people who are not eligible for an NDIS package. The limited amount of funding for ILC and the competitive nature of these resources means people living with low to moderate mental health/psychosocial disabilities will struggle to access the supports required to maintain good mental health. (sub. 39, p. 4)

Woden Community Service:

> For the ILC to be able to make meaningful referrals block funded programs will need to continue in parallel with individually funded arrangements. (sub. 159, p. 11)

Allied Health Professions Australia (AHPA):

> AHPA believes the range and types of services proposed for funding under the Information, Linkages and Capacity Building (ILC) program does not currently fit well with the goals of the NDIS, particularly the intention to create and support small and innovative programs. (sub. 37, p. 12)

Centre for Disability Research and Policy:

> The ILC will be an important tool in developing or enhancing services to meet the needs of people where services do not currently exist. This is particularly important in 'thin markets' and within rural and regional contexts. (sub. 55, p. 4)

Psychiatric Disability Services of Victoria.

> Under the current framework, there is no real benefit to mental health services from the ILC because the funding provided through the framework is so minimal; the ILC simply does not have the capacity to provide for the scope of what existing services deliver, whilst also responding to the needs of people who won't be eligible for the NDIS. (sub. 169, p. 9)

ILC services could be broader than envisaged, at least in New South Wales. Under the New South Wales Bilateral Agreement[19], it has been agreed that the NDIA will establish ILC arrangements to support people who have been in receipt of state-based specialist disability supports but not eligible for the NDIS. The ILC supports will enable the person

[19] The Bilateral Agreements are individual agreements between the Commonwealth Government and each State and Territory Government, covering the roles and responsibilities afforded to each government for the implementation of the NDIS.

to transition to alternative arrangements over time. What this means in terms of funding adequacy is hard to determine, as it is not clear what specific ILC services will be provided (Australian Government and New South Wales Government 2015).

The question of whether the funding for ILC is adequate is difficult to answer for a number of reasons. First, the program is still to be rolled out. Second, there do not appear to be any comparable programs, either within Australia or overseas. Third, it is unclear where gaps may exist in services, or what activities should be funded by ILC. As the New South Wales Government said:

> … there is still a gap in the information presented in relation to the Commissioning Framework not setting out what activities the NDIA will actually fund under the ILC budget for full scheme. (sub 60, p. 18)

Further, without appropriate information, it is too early to pass judgment on whether ILC will reduce the demand to access individualised support and how ILC initiatives will affect individualised support related services. This was noted in a report commissioned by the Department of Social Services which found:

> The evidence … suggests that the existing funding allocation ($120 million per annum) may not be sufficient to achieve intended social outcomes; although it is difficult to determine budget adequacy in terms of either ILC outcomes or avoiding escalation to Individually Funded Packages. (URBIS 2017, p. 11)

… but additional funding is critical in the short term

Although directing additional funds to ILC in transition could crowd out state and territory 'ILC like' activities, the grants process by which organisations receive ILC funding means these activities can be targeted to where they are most needed. There could also be a risk of duplicating services, but the risk of service gaps appears a much more likely prospect under current arrangements, particularly as determining precisely what ILC should cover is unclear at the operational level.

It is a false economy to have too few resources for ILC activities in the transition period when it is critical to have structures in place to ensure that people eligible for the NDIS access the scheme and those who are not eligible can access supports and services outside the NDIS. Withdrawal of existing ILC type activities by State and Territory Governments may also have affected the supports available. The NDIA, in relation to ILC and LACs funding, stated that:

> The success of this [ILC and LACs] strategy will … be heavily reliant on the quality and availability of such supports that largely remain the responsibility of state and territory governments to fund. The experience of trial is that this is not a certain or consistent base upon which the NDIS is building. (sub. 161, p. 53)

The Commission recommends increasing ILC funding by $75 million so that the ILC is resourced with $131 million for each year in the transition period (2017-18 to 2018-19) to

allow a national rollout of ILC activities. This additional funding should come from the program delivery budget.

Data on the effectiveness of programs funded through ILC in improving outcomes for people with disability, or reducing scheme costs by lowering demand for supports through individualised supports will be critical to determining funding in the future. The requirement for organisations to collect data as a condition of receiving an ILC grant will help build this evidence base.

COAG has agreed to a review of NDIS costs in 2023 (Heads of Agreements). This will provide an opportunity to review the performance of the ILC program and the magnitude of any benefits from increasing its funding. It is reasonable to expect that there will be more data on ILC by this time, and many of the transitional issues which may be exacerbating concerns about the adequacy of ILC funding could be resolved.

Given that underfunding ILC carries significant risk for the sustainability of the scheme, the Commission recommends that the funding for ILC continue to be funded at a minimum of $131 million per year until the review in 2023.

DRAFT FINDING 5.1

It is a false economy to have too few resources for Information Linkages and Capacity Building, particularly during the transition period when it is critical to have structures in place to ensure people with disability (both inside and outside the National Disability Insurance Scheme) are adequately connected with appropriate services.

DRAFT RECOMMENDATION 5.1

Funding for Information, Linkages and Capacity Building (ILC) should be increased to the full scheme amount (of $131 million) for each year during the transition. The funds that are required beyond the amounts already allocated to ILC to reach $131 million should be made available from the National Disability Insurance Agency's program delivery budget.

The effectiveness of the ILC program in improving outcomes for people with disability and its impact on the sustainability of the National Disability Insurance Scheme should be reviewed as part of the next COAG agreed five-yearly review of scheme costs. The ILC budget should be maintained at a minimum of $131 million per annum until results from this review are available.

5.2 The NDIS and other disability services

Prior to the NDIS, the delivery and funding of disability services was primarily governed by the National Disability Agreement (NDA). The Agreement, of which the Australian

Government and all State and Territory Governments are signatories, was established in 2009 and revised in 2012. It features clear roles and responsibilities for each level of government and nationally agreed objectives and outcomes for people with disability, their families and carers (COAG 2012c).

The NDA also establishes that the Australian Government is responsible for providing income support and employment services for people with disability. States and territories are responsible for the delivery of specialist disability services such as supported accommodation, respite and community support services, therapy, early childhood interventions, life skills and case management (SCRGSP 2017, p. 15.3).

Other services available to people with disability, prior to the introduction of the NDIS, included (but were not limited to):

- home and community care
- residential aged care (provided to a person under the age of 65)
- taxi and transport subsidy schemes
- psychiatric disability community supports.

While the scope of these services and their eligibility requirements varied by jurisdiction, they typically included programs that covered both people who would be eligible and not eligible for individualised supports under the NDIS. Continuity of service and program interfaces are therefore critical to ensure that people with disability do not 'fall between the cracks' when services are split between NDIS and non-NDIS provision.

How does the NDIS affect other disability services?

As individuals transition to the NDIS, many existing services will be defunded, with previous funds used to offset the cost of the NDIS. Funds transferred from these services to the NDIS are calculated on a predetermined per person basis. The funds move with the individual when they transition to the NDIS, as agreed in the Bilateral Agreements. However, not all individuals will meet the NDIS eligibility criteria and not all services will be funded by the NDIS. Consequently, some services provided under the NDA and other avenues will need to continue.

Unless agreed otherwise, the responsibility of governments to provide services under the NDA remains (part 2, subsection 16 of Bilateral Agreements). The Australian and State and Territory Governments have also agreed in the Bilateral Agreements to continuity of disability support services for:

- people who receive support but do not meet the access requirements outlined in the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act), or are receiving supports that do not meet the definition of reasonable and necessary support in the NDIS Act; and

- funding for supports attributed to a program/service that will cease when the NDIS is introduced.

All states and territories have agreed to provide continuity of support to people in receipt of state and territory administered disability programs/services. The Australian Government is responsible for providing Commonwealth administered disability programs/services (Bilateral Agreements schedule D). As part of annex E of the Continuity of Support Agreement (COAG 2013), the Australian, State and Territory Governments are also obliged to make clear their policy approach to providing continuity of support.

On the basis of the agreements that are in place, if the State, Territory and Australian Governments adhere to their responsibilities there should be few, if any, gaps in disability services for existing users (or at least the funding for these services). People previously receiving a disability service will continue to receive the same level of service — either through the NDIS or from other services funded by the State, Territory and Australian Governments.

Continuity of support is less straightforward in practice

Where programs are transitioning into the NDIS (closing) and there are people not eligible for the NDIS, these clients should receive services under continuity of support arrangements. In practice, however, there is a lot of uncertainty around continuity of support arrangements (box 5.3).

Most states and territories (to date) have not demonstrated how they will deliver on their commitment to provide continuity of support. There is varying detail on what disability support services will continue after the full rollout of the NDIS, and who will fund them. And where it is clear that services will continue, the detail on what will be provided varies. For example, the Queensland Government stated that they will continue providing some disability services (Queensland Government 2017b), while the Department of Social Services (DSS) have made public that 17 DSS and Department of Health programs will be affected by the introduction of the NDIS (DSS 2016e). Beyond this, little information is provided on specific programs that will cease or continue and who may be able to access the services. Those governments that have made public their intentions (the New South Wales and Australian Capital Territory Governments), are ceasing to provide specialist disability services altogether (NDS 2014; NSW Government nd).

Box 5.3 Participants point to uncertainty around continuity of support

Flourish Australia:

> People not eligible for the NDIS are already experiencing uncertainty and confusion. Continuity of support arrangements are still not finalised, so it is unclear whether they will be able to continue to access the services they currently receive, post full Scheme rollout. The concern is that if people currently accessing support in the community have this support 'switched off' at a future point, their needs and circumstances could be exacerbated, pushing up demand for the NDIS. (sub. 74, p. 9)

National Mental Health Commission:

> It is not clear how continuity of support for carers will be addressed through the NDIS. For example, the NDIS does not include direct provision of respite support for carers. Anecdotal evidence indicates that some applicants are being encouraged not to include family support in order to enhance their chances of getting a package. (sub. 153, p. 4)

Department of Health:

> The continuity of support commitment has been raised as a concern by service providers. It is currently unknown the proportion of program clients that will be deemed ineligible for the NDIS. Further information is needed of this cohort to inform continuity of support planning, such as the reasons for the ineligible access decision and the type of supports that individuals are currently accessing. (sub. 175, p. 5)

Rather than having a clear framework around the continuity of support, there seems to be some signs of brinkmanship, with governments holding off implementing policies (perhaps until another jurisdiction acts, or waiting for gaps to emerge before engaging in renegotiations).

While the Commission heard concerns about the quantum and nature of supports that will be provided outside the NDIS across a number of areas, mental health is one area where these concerns were particularly pronounced (box 5.4). In this case, the non-clinical supports that will be available for people with mental health disabilities who are not eligible for the NDIS is very unclear (box 5.4). State and Territory Governments have primary responsibility for mental health services — in 2014-15, state spending on community mental health services accounted for 83 per cent of all spending with the Commonwealth accounting for 17 per cent (DSS, sub. 146, p. 16).

In March this year, the Disability Reform Council agreed to focus on mental health to ensure mainstream systems are effectively supporting people with disability in Australia (DRC 2017, p. 2). In the most recent budget, the Australian Government also allocated $80 million over four years for support services for people with mental health illnesses who do not qualify for the NDIS, contingent on State and Territory Governments matching this contribution (Australian Treasury 2017a, p. 120). This should go some way to addressing support gaps, but continual monitoring will be required to ensure that people with significant needs are not missing out because they do not satisfy the NDIS eligibility criteria.

Box 5.4 Mental health — an area where uncertainty abounds

Many participants to this study raised concerns about people with severe mental illness missing out on services. In 2011, the Commission assumed that around 57 000 people with a psychosocial disability would be eligible for individualised supports under the NDIS (PC 2011, p. 190). The NDIA has since revised this number to 64 000 people (NDIA 2016g, p. 26).

The National Mental Health Commission's report on Mental Health Programs and Services estimated that around 700 000 Australians experience severe mental illness in any one year (and there are estimated to be over three million people in Australia with some sort of mental illness in any one year) (NMHC 2014, p. 5). The Department of Health (sub. 175, p. 4) submitted that through their internal modelling, around 282 000 people aged 0–64 years have a severe psychosocial disability requiring supports, and about 92 000 (aged 18–64 years) would 'most closely align' with the NDIS (although this did not involve modelling against the NDIS eligibility criteria per se).

For those people with a psychosocial disability not eligible for an individualised package under the NDIS, it is intended that mainstream or other disability supports will assist them. However, many submissions to this study pointed to current uncertainty around what services and supports will be provided to individuals with a psychosocial disability outside the NDIS. For example:

Mental Illness Fellowship of Australia said:

> While there have been assurances under the principle of continuity of service, in practice there is no clear indication of who and how the system will provide for those not eligible for the NDIS yet in existing programs, and more generally, those who were never Commonwealth clients to begin with. Members have reported emerging evidence of cost-shifting and ambiguities in responsibility, resulting in program uncertainty. (sub. 122, p. 12)

The National Mental Health Commission submitted:

> A particular concern is that there seem to be many people in existing community mental health programs at the Commonwealth and the State and Territory level who are being found ineligible for the NDIS, and while governments' commitment to continuity of support for existing clients is welcome (subject to the details of how such support is to be provided into the future), there appears to be no clear strategy for dealing with future cohorts of people who would otherwise have accessed such programs but who are not eligible for the NDIS. (sub. 153, p. 6)

And the Mental Health Community Coalition of the ACT said:

> … there is a need for both the NDIS and a mental health system. One is not a substitute for the other. However, since the introduction of the NDIS, the intersection between these systems has become very unclear and difficult; as well as inconsistent between States and Territories.
>
> - States and Territories made different decisions about what was in and out of scope for the NDIS.
> - Further, these decisions were made very early in the process when detail of scheme design was limited — it's fair to say that in many cases decisions would now be different given how the scheme has evolved. (sub. 135, p. 15)

The DSS (sub. 146) also noted that service gaps in this area have been known for some time. The implications of gaps are significant — uncertainty about what supports will be provided is distressing for people who rely on them and places an additional call on the generosity of informal support. They can also threaten the sustainability of the scheme by encouraging scope creep, or by forcing those who are unlikely to meet eligibility requirements to test their access anyway.

The DSS argued that the States and Territories:

> … need to demonstrate they are delivering their undertakings to provide continuity of support to clients not eligible for NDIS. (sub. 146, p. 27)

The DSS also noted that while measurement and reporting of service gaps are difficult, the agreed development of a new reporting framework for the *National Disability Strategy* could assist and better cross-system reporting could make any moves away from those services more obvious (and therefore more difficult to shift costs).

An important first step to ensuring an effective interface between the NDIS and other disability services is for governments to set out what disability services outside the NDIS will be funded, including the value of supports and number of people covered. Without this, it is impossible to work out where the gaps are and where cost-shifting is occurring. Delineation of services at the operational level should be made public immediately. This will help ensure that gaps do not emerge and the burden of these gaps do not fall on people with disability and their family. A schedule setting out the value of supports and number of people covered by disability support programs outside the NDIS should be included in the upcoming bilateral agreements for the full scheme.

The NDIA should also report — as part of the quarterly COAG DRC report — on boundary issues, including the number and value of supports being refused by the NDIS on the grounds that they are best provided by another support system, such as other disability services and mainstream services. The Commonwealth, State and Territory Governments should also publically report on the number of people covered by their disability programs pre and post NDIS, and the value of these services.

The delineation and reporting of disability services at the operational level will encourage discussions between the NDIA and disability service providers (including governments, local communities and businesses), and help identify gaps as they emerge.

ILC programs and LACs should also assist in identifying any gaps and reporting them back to the NDIA.

DRAFT RECOMMENDATION 5.2

The Australian, State and Territory Governments should make public their approach to providing continuity of support and the services they intend to provide to people (including the value of supports and number of people covered), beyond supports provided through the National Disability Insurance Scheme. These arrangements for services should be reflected in the upcoming bilateral agreements for the full scheme.

The National Disability Insurance Agency should report, in its quarterly COAG Disability Reform Council report, on boundary issues as they are playing out on the ground, including identifying service gaps and actions to address barriers to accessing disability and mainstream services for people with disability.

5.3 The interface between NDIS and mainstream services

A key requirement of any support provided under the NDIS is that the support is most appropriately provided and funded by the scheme and not by another service.[20] The NDIS is not designed nor funded to replace mainstream services. But for the NDIS to be successful and financially sustainable, there must be clear lines of responsibility between the mainstream services and the scheme. Also, as people with disability can require supports across a number of service systems, it is essential that service systems work well together.

In theory, the delineation between NDIS and mainstream services is clear cut. The *National Disability Strategy* 2010–2020 sets out the guiding principles around the supports to be provided by mainstream services (box 5.5). The Strategy's Second Implementation Plan (Driving Action 2015–2018) states that:

> While the NDIS is a significant step forward for many people with disability, the strategy remains the key to achieving improvements in access to mainstream services and support for all people with disability, regardless of age or type and level of support required. (COAG 2016b, p. 6)

However, as the NDIA (sub. 161, p. 57) put it, 'the Strategy is an overarching framework rather than a binding agreement for action'. It does not include 'substantial commitments, key performance indicators or targets' and 'there are limited identifiable consequences for governments if there is a lack of action'.

The Australian Government has also entered into Bilateral Agreements with State and Territory Governments to delineate the types of supports to be provided and funded by the NDIS and mainstream services (table 5.2). COAG has endorsed Principles to Determine the Responsibilities of the NDIS and other service systems, which are to be used to determine the funding and delivery responsibilities of the NDIS. The Principles are incorporated into the reasonable and necessary decision making of the NDIA by being incorporated in the *National Disability Insurance Scheme (Supports for Participants) Rules 2013*, Schedule 1.

[20] NDIS Act subsection 34(f).

Box 5.5 National Disability Strategy 2010–2020

The *National Disability Strategy 2010–2020* provides a ten-year national policy framework for improving life for Australians with disability, their families and carers. It represents a commitment by all levels of government, industry and the community to a unified, national approach to policy and program development. The vision of the Strategy is for 'an inclusive Australian society that enables people with disability to fulfil their potential as equal citizens' (COAG 2011b, p. 8).

The Strategy was endorsed by the Council of Australian Governments in February 2011. It guides public policy across all level of governments and aims to bring about change in mainstream services, specialist programs and services, and community infrastructure — to meet the needs of people with disability, their families and carers. It is the first time the Australian, State and Territory Governments have agreed to such a wide range of policy directions for disability. The Strategy sets out six priority policy areas for action. They are:

1. inclusive and accessible communities
2. rights protection, justice and legislation
3. economic security
4. personal and community support
5. learning and skills
6. health and wellbeing.

The first implementation plan, *Laying the Groundwork 2011–2014*, established the foundations to bring about reform in the planning and delivery of both mainstream and disability-specific programs and services. The Strategy's second implementation plan, *Driving Action 2015–18*, outlines new priority actions and builds on ongoing commitments to improving outcomes for people with disability across the Strategy's six policy outcome areas. Additional areas of national co-operation include: NDIS transition to full scheme; improving employment outcomes for people with disability; improving outcomes for Aboriginal and Torres Strait Islander people with disability; and communication activities to promote the intent of the Strategy throughout the community.

In September 2016, the Disability Reform Council reaffirmed its ongoing commitment to the National Disability Strategy.

Sources: COAG (2011b, 2016b); DSS (2017c).

Table 5.2 **What the NDIS covers and what mainstream services provide**

	What the NDIS covers	*What mainstream services provide / what the NDIS does not cover*
Health	Support to enable a person with disability to undertake daily activities, including 'maintenance' supports (from clinically trained or qualified health practitioners) directly associated with the person's disability.	Access to health services, such as diagnosis and clinical treatment of health condition, as required by National Healthcare Agreement and Commonwealth Disability Discrimination Act.
Mental Health	Non-clinical supports that focus on the person's functional ability to undertake daily living.	Clinical support related to mental health and any residential care and rehabilitative care.
Early childhood development	Individualised support or early intervention, specific to a child's disability or developmental delay, targeted at enhancing the child's functionality to engage in daily activities.	Early childhood education and care needs, child and maternal health services and any supports clinical in nature.
Child protection and family support	Support for the child, family and carer as a direct result of the child's disability, to enable participation in the community.	Promoting the safety of children from abuse and neglect, and providing parenting programs, counselling and other supports for families.
School education	Supports related to the functional impact of a student's disability to undertake activities of daily living, such as personal care and transport to and from school.	Personalising learning and support related to educational attainment, including teaching, learning assistance, school building modifications and transport between school activities.
Higher education and vocational education and training	Functional support related to the student's disability to undertake daily activities, including personal care and transport to and from education.	Learning and support needs of students that primarily relate to their educational and training attainment, and transport between education, training and employment venues.
Employment	Assistance to take part in the workforce and support in the person's functional capacity to work, such as training in workplace relationships and communication skills.	Employment services to support people with disability to prepare for, find and maintain a job, and employers to hire people with disability in their workplace (e.g. workplace modification, training and funding assistance).
Housing and community infrastructure	Assist individuals with disability to live independently by building their capacity to maintain tenancy, such as home modifications for accessibility, specific to their disability.	Accommodation for people in need of housing assistance, access to housing and homelessness services and any previous infrastructure responsibilities.
Transport	Funding support to enable independent travel, including aids and equipment and training to use transport. Cover reasonable and necessary costs for those not able to travel independently.	Ensuring transport options are available to people with disability. Other parties are still responsible for transport infrastructure as part of universal service obligation, including managing disability parking.
Justice	Continue to fund the full NDIS support related to the person's disability impairment where the person is not serving a custodial sentence.	Meet the needs of people with disability in line with the National Disability Strategy and existing legal obligations, such as ensuring the system supports accessibility for people with a disability and a secure environment for those in prison.
Aged care	Those under age of 65 can choose to purchase support from an aged care provider and the NDIS will fully meet these 'reasonable and necessary' costs.	Responsible for access to quality and affordable aged care and carer support. Cater for individuals aged over 65 years, unless they qualify to remain in the NDIS.

Source: COAG DRC (2015b).

Interfaces are not so clear at an operational level

At the operational level, the lines of responsibility between the NDIS and mainstream services are not so clear. The NDIA reported that during trial and transition it faced three key challenges in relation to mainstream supports, including:

- lack of clarity around some interfaces
- different understanding of mainstream obligations, by each jurisdiction and the NDIS
- difficulty in holding mainstream services accountable (sub. 161, pp. 59–60).

State governments also pointed to the need for further work on achieving greater clarity. For example, the South Australian Government said:

> There remains a lack of clarity in relation to roles and responsibilities across the NDIS and mainstream services in some areas. South Australia believes that there is still extensive work to be done in defining mainstream interface boundaries. (sub. 203, p. 6)

And the New South Wales Government said:

> Extensive further work is required by the States and the Commonwealth to scope, agree and communicate service boundaries. Any movement of boundaries (existing responsibilities) between the NDIS and other service systems should be implemented with associated resourcing considerations. (sub. 60, pp. 13–14)

A lack of clarity around responsibilities between the NDIS and mainstream services has the potential to impact on NDIS costs, and on the effectiveness and efficiency of service delivery in multiple ways, including scope creep; cost shifting from mainstream provision to the NDIS and vice-versa; gaps in service provision; inconsistent support access decisions; and duplication of services.

An added complexity is in-kind support arrangements (a program may have been agreed as in-kind but some people receiving the program may not be eligible for the NDIS and not all supports within the program may align with reasonable and necessary supports) (chapter 10).

There is some early evidence that interface issues are emerging. The NDIA reports some instances of possible cost-shifting, scope creep and services gaps, including:

- providers trying to extend the amount of therapeutic (health) interventions through use of NDIS funding
- reports that mainstream services are refusing entry to people who are likely to be eligible for the NDIS
- issues around a lack of accessible public transport options, particularly in regional, rural and remote areas, which means NDIS participants seek transport funding through the NDIS despite having the capacity to travel independently were transport options available (sub. 161, pp. 59–60).

State and Territory Governments also reported instances of cost shifting. The South Australian Government said:

> As policies and eligibility have been clarified over the trial/transition period, there are a number of emerging issues which are or are expected to result in costs for the state in areas which were originally assumed to be part of the scheme. … South Australia is keen to ensure that all appropriate costs are met by the NDIS to avoid any potential of states effectively paying twice for services. (sub. 203, pp. 7)

The ACT Government said:

> The ACT has experienced a cost pressure associated with the fact that what is 'in scope' for the NDIS has moved over time. (sub. 156, p. 9)

Some of the examples provided by the ACT Government include:

- a narrowing of the eligibility criteria for Early Intervention meant that some children who were deemed eligible for the scheme and have not implemented plans are being reviewed by the NDIA and referred back to mainstream services
- the lack of clarity from the NDIA about what is considered as parental responsibility and what is reasonable and necessary to fund student transport means that a tightening of scope by the NDIA will shift costs to states and territories
- the NDIA being insistent that supports for people with forensic disability where their behaviour manifests as a public safety issue is the responsibility of mainstream services. The ACT Government did not anticipate that it would be required to meet such costs, given that they relate directly to the participant's ability to live in the community (sub. 159, pp. 9–16).

And while many submissions to this study raised concerns about how the NDIS interface was working with mainstream services, particular concerns were raised in the areas of the justice system (box 5.6) and emergency and health services (box 5.7).

Box 5.6 Interface between the NDIS and justice services: views of study participants

Participants to this study expressed a number of concerns about the interface between the NDIS and mainstream criminal justice disability services. While there are specific NDIS rules that deal with the interface with the justice system (NDIS (Supports for Participants) Rules), there are some concerns that these rules are not clearly defined and that differences in interpretation will create inconsistencies. The Office of the Public Advocate, for example, said:

> On the intersection with the justice system, the COAG principles outline that the NDIS 'will continue to fund the reasonable and necessary supports'; a statement that is vague and subject to differing interpretations. Moreover, some of the responsibilities accorded to the justice system in the COAG principles have seldom been available in the pre-NDIS environment; for example, 'specific interventions to reduce criminal behaviours' and intensive case coordination — both of which are attributed to mainstream services — are not currently provided by the justice system and it is unlikely that they will be under the NDIS. (sub. 46, p. 2)

Participants also expressed concern that delineation between the NDIS and state and territory responsibilities is resulting in the withdrawal of some community justice programs and creating inconsistencies between jurisdictions and gaps in service provision. Disabled People's Organisations Australia submitted:

> There is an assumption that States and Territories are providing the appropriate supports to people with disability through the mainstream or their own specialist disability support systems. In some cases, States and Territories are entirely withdrawing funding and services for disability support while others are retaining a residual role in specialist supports. This creates inequity in programs within different jurisdictions. For example, NSW is ceasing its funding of specialist disability criminal justice programs based on the rationale that this should be the purview of the mainstream criminal justice system. (sub. 165, p. 11)

A further issue was the ability of people in custody to access NDIS support. Sisters Inside, for example, said:

> In our view, the unique and 'complex' needs of women in prison pose a significant challenge for the current NDIS model. We are concerned that most criminalised women will not be eligible for NDIS services. Even if eligible, many criminalised women can be expected to avoid the application process and services provided by mainstream (institutional charity) organisations. (sub. 16, p. 1)

In particular, access to disability services for people moving in and out custody is viewed as problematic. Neami National submitted that an:

> … issue occurs when participants move in/out of justice settings. For example, in preparation for discharge from a forensic mental health unit, extensive preparatory work and relationship building is provided through in-reach of community mental health disability support. This is not funded under the NDIS and will compromise the capacity of justice services to facilitate safe and timely discharge for people, again increasing overall cost pressures on the health and social care systems. (sub. 63, p. 9)

Similarly, Leanne Dowse, Melinda Paterson and Mike Sprange said:

> … as the NDIS implementation is only partially complete in NSW, it is hard to comment on how the interface between the NDIS and mainstream services has been working. What is clear has come from areas where trial implementations of the NDIS have occurred, such as in the Hunter region.
>
> In the area of Justice, there are some reports that the transition out of custodial sentences for people with disability who may be eligible for the NDIS, or even already in it, is problematic. It is likely that in relation to the mainstream area of Justice, many complex issues will arise in the interface. (sub. 114, p. 7)

Box 5.7 Emerging gaps in emergency and health services

Responsibility for funding emergency services

A gap in emergency response funding was identified by a number of study participants. For example, the ACT Government (sub. 156, p. 24) pointed out that there is currently no provision for emergencies, such as accommodation for:

- children with challenging behaviours who may not be able to live with their parents all of the time
- participants being discharged from a psychiatric inpatient unit
- participants unable to leave hospital without a modified or supported accommodation option.

It is unclear whether the NDIS or State and Territory Governments are responsible for funding this service. For example, in the ACT, the government has 'cashed out' on disability services related to emergency care (the ACT is expected to close its doors for 'Disability ACT' on 30 June 2017) under the expectation that the NDIS would fund these services. On the other hand, the NDIA has claimed that providing emergency accommodation falls under the state and territory responsibility of child protection, public housing and health sector respectively.

Based on the Commission's 2011 report, the intention was that crisis and emergency responses would be funded under ILC. However, ILC is yet to roll out and it is not clear whether it will provide such services.

Uncertainty in some health services

There are also cases where individuals are being turned away from specific state funded health services, and there seems to be uncertainty around who should provide these services.

- Audiologists report confusion around the funding of services for people experiencing tinnitus, with one practitioner being told that supports for tinnitus would no longer be funded by South Australia Health as this program would move over to the NDIS. However, young and adult clients with severe tinnitus are being advised that they are ineligible for the NDIS (Allied Health Professions Australia, sub. 37, p. 11).
- The Australian Physiotherapy Association (sub. 93, p. 10) reported feedback from consumers that rehabilitation services have 'closed their books' to NDIS package holders.
- The Australian Physiotherapy Association also noted cases of individuals being discharged early from hospitals:

  > … there are increasing incentives for 'early discharge' from public and private hospitals resulting from the introduction of the NDIS … There is little incentive, for example, for hospitals to ensure optimal pre-discharge functioning of a participant, compared with early hand-off and the transfer of the responsibility for achieving optimal functioning into the hands of the participant, their NDIS budget and community-based providers. (sub. 93, p. 10)

Where to from here?

It is too early to determine whether emerging problems in the interface between the NDIS and mainstream services are transitory or more long-term in nature. However, it is important that steps are taken to clarify NDIS boundaries and a process put in place to identify and address any service gaps, cost shifting, duplication and inconsistencies.

The first step is for State and Territory Governments to agree and finalise the boundaries between NDIS and mainstream services. As the New South Wales Government said:

> … at this early stage, NSW considers reviewing scheme boundaries by the PC to be of limited value given extensive work is still required by governments to define and agree boundaries. (sub. 60, p. 14)

A number of Administrative Appeals Tribunal cases have tested the boundaries of the NDIS (box 5.8), but given the narrow focus of these cases to date, their use in defining boundaries between services is limited. As more decisions are tested through the Tribunal, it can be expected that boundaries may be clarified. Importantly, however, the fact that a support is ruled to be best provided by a mainstream service does not in itself mean that the support will necessarily be provided.

Box 5.8 AAT Cases — whether a support is most appropriately funded by the NDIS

The following are examples of Administrative Appeals Tribunal cases that look at whether the requested NDIS support item is most appropriately funded by the NDIS or mainstream services. The cases have generally focused on specific claims for medical equipment and disability care.

- *Young and the National Disability Insurance Agency* [2014] AATA 401 — Young applied for a portable oxygen concentrator and insulin pump to be funded through the NDIS. The AAT found that the oxygen concentrator and insulin pump were clinical treatments and should be funded or subsidised under the health system.
- *McCutcheon and the National Disability Insurance Agency* [2015] AATA 624 — McCutcheon's NDIS support package did not include chiropractic care, which she appealed. The AAT found that the chiropractic treatment was related to McCutcheon's ongoing functional impairment and was therefore most appropriately funded by the NDIS.
- *Fear by his mother Vanda Fear and National Disability Insurance Agency* [2015] AATA 706 — On behalf of Fear, his parents applied for certain equipment (pulse oximeter and oral suctioning machine) as part of his individual support package under the NDIS, but they were not included in his plan. The AAT found that the oximeter and oxygen suction machines are more closely related to clinical treatment for Mr Fear's health and were the responsibility of the health system.

Interface disputes are an inevitable part of the transition process. Because of this, there needs to be a process to monitor interfaces, and prevent or resolve problems as they emerge.

The Commission considers that the most appropriate vehicle for the discussion and monitoring of mainstream services for this process is COAG. A standing item should be introduced through the COAG Disability Reform Council and at each COAG council that is responsible for services that interface with the NDIS, to discuss how the services interface with the NDIS.

The DSS suggested specific disability reporting across COAG Councils:

> Monitoring and reporting through COAG infrastructure could be strengthened by specific disability reporting across relevant COAG Councils, specifically on the effectiveness of mainstream systems in supporting all people with disability; and improving the interfaces between mainstream services and the NDIS.
>
> DRC could consider proposing this through its regular reporting to COAG, starting with the three agreed priorities for the *National Disability Strategy*:
>
> - mental health services outside the NDIS
> - health services for people with disability
> - over-representation and lack of support for people with disability in the criminal justice system (sub. 146, p. 28).

The *National Disability Strategy* should be strengthened to improve government accountability. There should be more detailed reporting around the boundaries of the NDIS and the implications for mainstream service provision. Specific commitments, key performance targets and outcomes should be set out. This should be pursued through review points of National Agreements and National Partnership Agreements under the Federal Financial Relations Intergovernmental Agreements. (An important commitment by governments under the Disability Reform Strategy was to use the review points of National Agreements and National Partnerships as an opportunity to assess their consistency with the aims and objectives of the Strategy.)

As the DSS said:

> Translating the National Disability Strategy into tangible results for people with disability, their families and carers is a major factor in successful implementation of the NDIS. (sub. 146, p. 5)

ILC and LAC can play a role in ensuring mainstream services are better informed about their roles and responsibilities.

DRAFT RECOMMENDATION 5.3

Each COAG Council that has responsibility for a service area that interfaces with the National Disability Insurance Scheme (NDIS) should have a standing item on its agenda to address the provision of those services and how they interface with NDIS services. This item should cover service gaps, duplications and other boundary issues.

Through the review points of National Agreements and National Partnership Agreements under the Federal Financial Relations Intergovernmental Agreement, parties should include specific commitments and reporting obligations consistent with the National Disability Strategy. The Agreements should be strengthened to include more details around how boundary issues are being dealt with, including practical examples.

5.4 Interface with aged care

An important issue in the design of the NDIS is the interface between the aged care and disability systems. As people with disability age, they are likely to experience age related conditions, such as increasing frailty, or the onset of age related neurological conditions (such as Alzheimer's). At the same time, a person may develop a non-age related disability later in life.

Under the NDIS, a scheme participant:

- under the age of 65 can choose to purchase support from an aged care provider and the NDIS will fully meet these 'reasonable and necessary' individualised support costs
- are free to remain in the NDIS once they turn 65, or they can exit the scheme and enter the aged care system
- ceases to be a participant when they enter a residential care service or start being provided with home based care on a permanent basis, but only after they turn 65 (DRC 2015b, p. 26).

There are incentives for people to stay in the NDIS

There are aspects of the design of the NDIS, and how it interfaces with the aged care system, that create incentives for people to stay in the NDIS after the age of 65, and encourage people nearing the age of 65 to apply for NDIS access (and have their needs met through the scheme, rather than through the aged care system).

There are different objectives and different supports

The NDIS and the aged care systems have different objectives.

The NDIS is designed to provide all eligible participants with a wide set of supports, while the aged care system rations places and the amount of government funding for each place.

- The NDIS is intended to support the independence of people with disability, the *Aged Care 1997 Act* (Cwlth) does not include independence or participation objectives.
- The NDIS aims to provide reasonable and necessary supports to participants, while the aged care system attempts to target limited resources to people within the system.

The NDIS is intended to provide each participant with reasonable care and assistance they need at each stage of their life. The scheme has a strong emphasis on contributing to the participant's independence and ability to participate in all aspects of life (including education, socially and economically). In addition, one of the objectives of the NDIS is to help participants enjoy the same rights as other people in Australia (NDIS Act s. 4(1)).

Aged care may require financial co-contributions. The NDIS does not.

While supports are provided at no cost to NDIS participants, means-tested co-contributions are a feature of the aged care system (My Aged Care 2017b). This means that there is a financial incentive for participants aged 65 years and over to remain in the NDIS, even where their needs could be better met through the aged care system. As noted by one participant (Name withheld, sub. 5, p. 1) as long as the market for providing services to NDIS participants is operating effectively, it is difficult to see why people would choose to transition from the NDIS to aged care.

That said, as noted by the DSS (sub. 146, pp. 14–15), 'for many with lifelong disability, it is unlikely that sufficient assets would have been accumulated for a means tested co-contribution to apply after the age of 65 years'.

However, means testing for aged care services is based on both income and assets, with co-contributions applying to people on an age pension — for example, the basic contribution for at home care costs is 17.5 per cent of the pension (My Aged Care 2017a). Contributions for residential aged care are higher.

It is too early to assess the cost implications

The Australian Government has agreed to fund the full cost of participants in the NDIS scheme aged 65 years or older. As the aged care system is also Commonwealth funded, this means that the cost of supporting older people falls to the Australian Government, whether they are in the NDIS or the aged care system. The additional costs to the Australian Government is the difference in the value of NDIS packages compared to the aged care costs that the same NDIS participants would otherwise have incurred.

If people aged nearly 65 join the NDIS, or those aged 65 or older elect to stay in the NDIS, there is a cost implication — the NDIS is more generous in support provided, and requires no co-contribution. As such people staying in the NDIS rather than moving to the aged care system is likely to result in higher expenditure for the Australian Government. It could also raise questions about equity.

Given the infancy of the NDIS, the interface between the scheme and the aged care system is yet to be tested. There are currently very few participants aged over 65 years in the scheme and the average support costs for this group are lower than expected (DSS, sub. 146, p. 14). However, the higher costs associated with the past few years of life and issues around the interface with the aged care system are unlikely to have materialised as the oldest participants in the scheme are 69 years of age (DSS, sub. 146, pp. 14–15). By 2019-20, however, there are expected to be around 15 000 scheme participants aged 65 years or older (chapter 2).

As part of the NDIS transition arrangements, the aged care system is implementing a new continuity of support program for people aged 65 and over — it is looking at who is

ineligible for the NDIS and who is currently in state specialist disability services. Insights from this program should help inform the aged care system in providing specialist disability supports (DSS, sub. 146). There should be ongoing monitoring as the scheme matures.

5.5 Interface with the National Injury Insurance Scheme

In 2011, the Productivity Commission also recommended a National Injury Insurance Scheme (NIIS) that would operate in parallel to the NDIS. At the time, the Commission considered it a priority to establish a no-fault lifetime care and support scheme for catastrophic injuries, as many Australians acquiring such injuries were receiving poor care and support because they were unable to find an at-fault party to sue.

Under the model proposed by the Commission, the NIIS was to fully fund health, rehabilitation and care and support costs for all newly acquired catastrophic injuries. As such, lifetime care and support needs of people with newly acquired catastrophic injuries would be met through the NIIS and not the NDIS. However, the care and support needs of people with existing catastrophic injuries, and not covered under any no-fault arrangements, would be met through the NDIS.

The NIIS, as proposed by the Commission, was to operate as a federation of individual state-based no-fault insurance schemes. Implementation of the NIIS is overseen by the Australian Treasury and has been undertaken across four streams — motor vehicle accidents, workplace accidents, medical treatment injuries and general accidents (occurring in the home or community).

The Commission, in 2011, recommended that the NIIS be in full operation in 2015, or before the full rollout of the NDIS. This was on the basis that there were well-established schemes in place that could form the blueprint for the design of schemes and the number of people affected was relatively small (around 1000 people a year) (PC 2011, p. 863). This has not happened. Of the four streams, motor vehicle accidents has been completed, and workplace accidents is in the process of being completed — a consultation Regulation Impact Statement has been released and progress is being made towards setting minimum benchmarks.

Progress on the other two streams, medical accidents and general accidents, has been slower. A discussion paper was released in 2015 for the medical treatment injuries stream (Australian Treasury 2016c); however, negotiations for the general accidents stream have not commenced. The DSS (sub, 146, p. 25) noted that over the short to medium term, the medical and general streams may not be implemented, with a number of implementation challenges identified for the medical stream.

As there is no agreement in place by the states and territories to commit to the funding for, or establishment of, the medical and general accident streams, anyone who acquires a

catastrophic injury from a medical or general accident will receive supports through the NDIS. This will have a direct impact on NDIS costs. As the DSS said:

> Contingencies are needed if the full NIIS is not delivered, as this would move costs onto the NDIS. … If the NDIS were to pick up responsibility the funding obligation would sit fully with the States, which have responsibility for implementing the NIIS. (sub. 146, p. 5)

The number of people entering the NDIS, who would otherwise be covered by the medical or general accident streams of the NIIS in any one year is expected to be relatively small — across both streams the Commission in 2011 estimated there to be around 400 people.

But over time, as new people enter each year, there is a cumulative effect. To illustrate, modelling undertaken by the NDIA suggests that the cost to the NDIS of the medical and general schemes not operating would amount to about $23 million in 2018-19, but would increase to about $226 million in 2025-26 and to around $1.3 billion in 2040-41 (table 5.3).

Table 5.3 **Medical and general accidents costs to the NDIS**
$ million

	2018-19	*2019-20*	*2020-21*	*2025-26*	*2030-31*	*2035-36*	*2040-41*	*2045-46*
Medical	1	3	7	33	71	121	186	271
General	4	19	42	193	417	712	1 098	1 597
Total	**5**	**23**	**49**	**226**	**488**	**833**	**1 284**	**1 868**

Source: NDIA modelling.

One of the key goals of the NIIS is to deter high-risk behaviour and reduce local risks that can contribute to accidents. For this reason, in 2011 the Commission argued that premiums and state and territory funding should be used to send price signals and encourage greater incentives for safety.

The Commission acknowledged that the appropriate funding source for no-fault coverage of catastrophic injuries following medical treatment is more complex than for other accidents. A key consideration is to build on existing incentives to minimise risk by:

- motivating the systematic collection and analysis of data that may decrease risks
- varying premiums depending on whether practitioners (or the health sector more broadly) follow best practice protocols and have the appropriate training and credentials (PC 2011, p. 877).

In terms of general injuries, accidents result from a number of causes, such as environmental factors (for example, maintenance of footpaths and safety of play grounds) and the nature of activity being undertaken (such as recreational activities). For this reason local governments (which are devolved powers by the states and territories) are in a better position to implement incentives to minimise the risk of accidents (such as proper signage

around dangerous areas) and are able to collect revenue reasonably efficiently to fund the NIIS, including a potential levy on local government rates.

Because the states and territories have greater control over implementing risk reducing programs (and therefore, indirectly, the costs of the NIIS), they should bear the costs of the NIIS if it remains only partially rolled out for an extended period. A number of participants pointed to the costs to the NDIS.

> Not proceeding with the medical or general streams of the NIIS will have a direct impact on the NDIS by increasing overall Scheme costs. … Any additional cost, not adequately funded by the States, is a risk to the Commonwealth. (DSS sub. 146, p. 26)
>
> The sustainability of the NDIS depends on a complete NIIS that, in providing no fault insurance for catastrophic injury, removes the significant cost drivers of these injuries from the NDIS. (Young People In Nursing Homes National Alliance, sub. 187. p. 4)
>
> Without the NIIS in place, further cost-pressure will be placed on the NDIS. (NDIA sub. 161, p. 113)

The Commission is seeking feedback on a mechanism to ensure that the states and territories bear the cost of participants who were intended to be covered by the NIIS.

INFORMATION REQUEST 5.1

The Commission is seeking feedback on a mechanism to ensure that the States and Territories bear the cost of participants who were intended to be covered by the National Injury Insurance Scheme.

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6 Provider readiness

Key points

- Providers play an important role in meeting the needs and goals of National Disability Insurance Scheme participants, and improving their lives. However, the transition to a market-based system means that providers will need to make substantial changes to the way they provide disability supports. They need to become more efficient, innovative and responsive in the delivery of supports to participants.
- The supply of disability supports affects scheme costs. If there is insufficient supply, scheme costs are likely to be lower in the short term because individualised supports are underutilised, but higher in the long term as participants are unable to access the supports that can reduce their costs of care in the future.
- The National Disability Insurance Agency (NDIA) currently sets the maximum price of disability supports that can be charged by NDIA-registered providers. However, the responsibility to set prices may conflict with the Agency's other responsibilities, including maintaining financial sustainability and its market stewardship role. This potential conflict should be addressed in three stages, by:
  - introducing an independent price monitor to serve as a transparent 'check and balance' on the NDIA's pricing over the transition period
  - transferring the NDIA's power to set prices to an independent price regulator, who would also be responsible for deregulating the prices of supports
  - continuing independent price monitoring following price deregulation.
- While the market-based approach to providing disability supports will increase incentives for providers to deliver supports in areas previously undersupplied, there will still be 'thin markets', where there are few, if any, providers. Arrangements to deal with thin markets (including Provider of Last Resort arrangements) need timely and considered attention because shortages, less competition and poorer outcomes for participants may persist. While there is a range of ways to address access issues (including block-funding), ongoing public reporting, monitoring and evaluation of thin markets is crucial.
- Participants to this study also raised other potential barriers to supply — including moving to fee-for-service, administrative burdens, in-kind services and collaboration in the sector. While these are likely to be transitional issues, ongoing monitoring can ensure that they do not become entrenched or systemic issues.

The ability of the disability support sector to provide disability supports has a direct bearing on National Disability Insurance Scheme (NDIS) costs. If there are not enough providers and workers to deliver the supports allocated by the National Disability Insurance Agency (NDIA) to participants, this will lead to underutilisation of supports, and ultimately lower than expected costs to the scheme in a given year, and poorer outcomes for participants (and their families).

Costs should be considered from a long-term perspective. When reasonable and necessary supports are allocated to participants under the NDIS's insurance-based approach, the package of supports should minimise the long-term cost of care to the community. If these supports are not available, the costs of supporting participants may be higher in the long term — because of more services demanded through the NDIS, through other government services, or through informal carers. There are also costs to participants and their families from reduced wellbeing.

The loss in wellbeing of not being able to access supports for a person with disability will vary by the type of support. For example, not being able to find a carer to provide core supports (like an attendant carer to provide assistance to get out of bed and with personal daily activities) is likely to impose a higher cost on a person with disability than being unable to find a provider for community-engagement activities. Also, the use of the community-engagement support is likely to be contingent on being able to find someone to provide core supports, and vice versa.

The focus of chapters 6-8 is on how ready the market (providers, workers and participants) is to respond to such growth in demand, and how this will ultimately affect scheme costs. This chapter considers how existing and new providers are responding to the increased demand for supports under the NDIS. Section 6.1 provides a snapshot of the current state of the disability support sector and the expected growth required to meet the demands of the NDIS. Section 6.2 examines the pricing of disability supports in the context of market growth to date. Section 6.3 looks at where the market supply for disability supports could be limited and result in 'thin markets'. Section 6.4 discusses other transitional matters affecting provider readiness.

6.1 The disability support sector

People with disability have a range of different wants and needs (including personal care, therapy, and assistance with cleaning and mowing), which require a variety of supports. In turn, the cost of providing a range of services varies by region and the degree of competition. This means that there are a number of submarkets within the aggregate disability support market. As explained by one provider, there are particular characteristics of the disability support market that distinguish it from a traditional market.

> The disability support 'market' is not a normal or 'perfect' market in classical economic terms. It is about providing a range of customised supports, human and technological, paid and unpaid, to meet complex and often poorly-defined human needs and wants. Outcomes are often hard to measure and report. Information is unbalanced. Regional, rural and remote markets are 'thin'. The 'buyers' of services and their local situations are diverse and heterogeneous, not homogeneous. Many are vulnerable. (House With No Steps, sub. 104, p. 1)

It is within this context that the NDIS is driving market-based competition between disability support providers, at a time when the size of the aggregate disability support market needs to increase significantly to meet NDIS demand.

This includes:

- a shift away from a block-funded, welfare model of support to a fee-for-service, market-based approach
- an increase in funding for the sector from about $8 billion in 2015-16 to $22 billion by 2019-20 (SCRGSP 2017)
- assessing and meeting the reasonable and necessary needs of about 475 000 people by 2019-20 (chapter 2)
- about 70 000 additional workers (or about 20 per cent of all new jobs created in Australia) in the three-year transition period to full scheme (Bonyhady 2016, p. 5; chapter 7).

As put by the NDIA:

> In the first year [of transition], to meet projected Scheme demand, growth in supply needs to be around eight per cent. By the second and third year respectively, growth must reach 30-40 per cent, although … the supply needed to meet funded participant demand varies depending on location. (2016k, p. 8)

The market for disability supports is diverse and difficult to characterise in general terms. There is a range of different markets for people with disability. Some providers specialise in providing supports for those with specific disability, while others specialise in providing particular types of supports (such as accommodation or therapeutic supports). Others provide a much broader service. NDIA 2016k, p. 8)

The data on disability support providers are patchy. The most comprehensive data were collected by Martin and Healy in 2010. More recent work by National Disability Services (NDS) and Curtin University's Not-for-profit Initiative contains data on provider characteristics and financial performance.[21]

Notwithstanding the data limitations, a few broad points can be made.

- Many providers are small. About 40 per cent of disability service outlets employed 10 or fewer disability workers (Martin and Healy 2010, p. 122). The NDS estimated that about 58 per cent of providers are either small or very small (with a turnover of less than $5 million) (Gilchrist and Knight 2017, p. 10).
- About 80 per cent of disability providers are not-for-profit (NDS 2016, p. 7).
- Most providers do not exclusively provide disability services. About 57 per cent of providers surveyed by the NDS provided services in other areas, such as aged care, mental health and homelessness (NDS 2016, p. 13).

[21] The National Disability Services' (NDS) State of the Disability Sector Report 2016 is based on the fourth wave of the National Business Confidence Survey of 549 disability service providers, of whom 486 were NDS members and 63 were non-members (NDS 2016, p. 7). The NDS has also undertaken a financial benchmarking project for disability services (NDS nd).

How will the sector need to change under the NDIS?

While a lack of data prevents a complete evaluation of the current state of the sector, envisioning how the future disability sector will look under the NDIS is even more difficult. Some of the supports required by participants will be provided by existing providers who expand, while others will be provided by new entrants. However, it is not certain:

- how many providers will be needed — and the proportion of new and existing providers
- what the proportion of for-profits, not-for-profits and government service providers will be
- whether there will be greater specialisation by disability, type of support, or both
- how long it will take for these changes to occur.

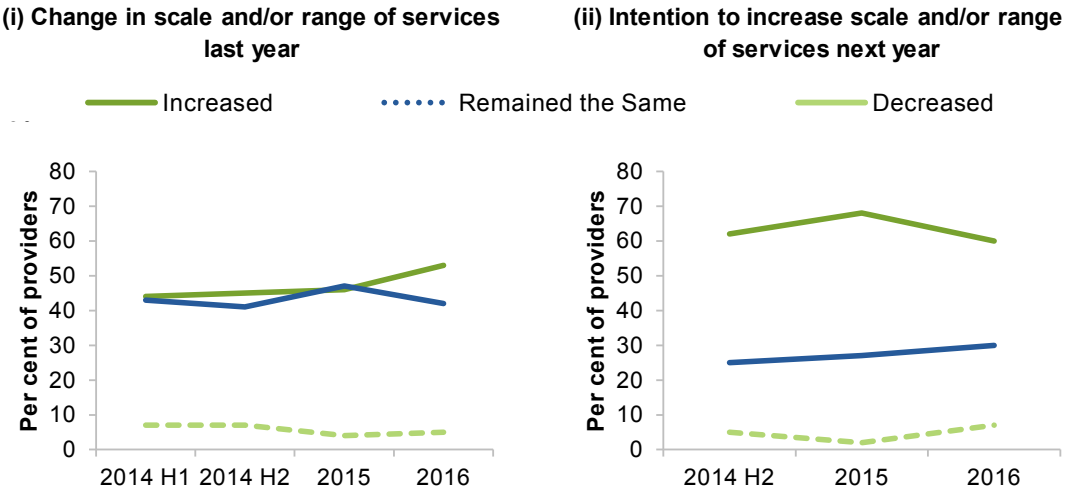
This uncertainty is reflected in estimates on the number of providers needed under the NDIS. The ANAO (2016, p. 68) estimated that between 13 500 and 40 000 providers will be needed by the end of the transition period in 2020. Therefore, understanding how existing providers are responding to, and whether new providers are entering, the NDIS market is important.

The NDS survey of providers gives some insight into how existing providers are responding. The majority of providers surveyed said that they expanded their services last year, and that they intend to expand further next year (figure 6.1). Providers reported increasing their services particularly in the areas of therapy, early intervention, and planning and coordination supports (NDS 2016, p. 11), but the amount of additional supports is unclear. However, some providers also reported plans to reduce or stop supplying services in other areas, and that they are entering new markets (outside of the disability support sector) (NDS 2016, pp. 12–13). The financial position of providers is also variable, and in turn, the strength of existing supply.

It is more difficult to ascertain the size, scope and number of new providers who are entering the market in response to the NDIS. Data are available on the number of providers *registered* with the NDIA to provide supports under the scheme, which includes both existing and new providers (figure 6.2).

While registrations increased by about 30 per cent between the December 2016 and March 2017 quarters, about 54 per cent of registered providers are yet to provide a service, and the top 25 per cent of registered providers currently account for about 80-90 per cent of the value of payments made by the NDIA for participant supports (NDIA 2017o, pp. 38, 41).

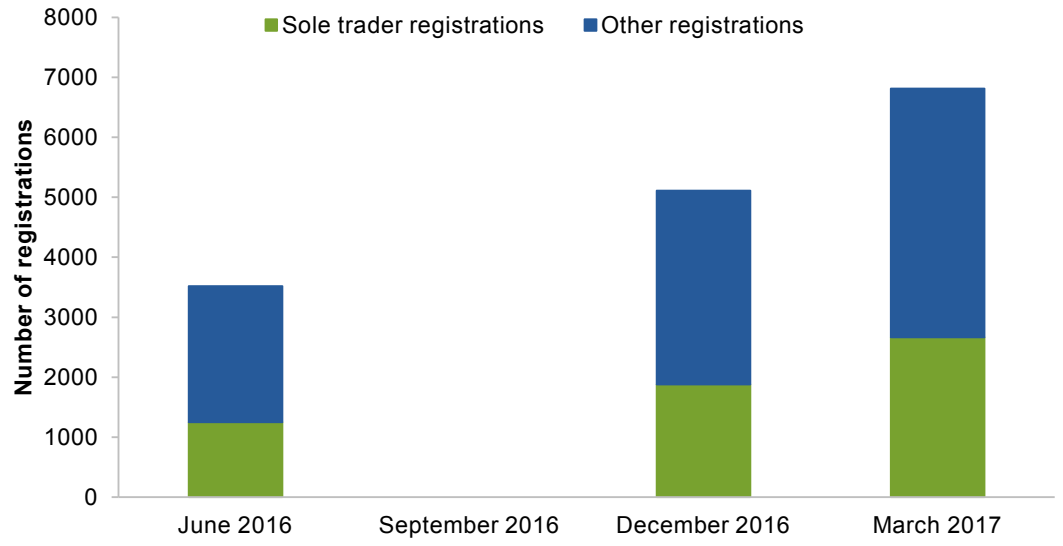
Figure 6.1 **Providers' response and intention to increase supply[a]**



[a] H1 and H2 refer to the first half and second half of the calendar year respectively.

Source: Gilchrist and Knight (2017, p. 16), who surveyed 492 respondents.

Figure 6.2 **Cumulative number of NDIA-registered providers by quarter[a]**



[a] Data for September 2016 are unavailable.

Sources: Commission estimates based on NDIA (2016t, 2016u, 2017o).

This is consistent with NDS data, where 77 per cent of providers surveyed had registered, but only about half had provided services under the NDIS (Gilchrist and Knight 2017, p. 5). One explanation could be that some providers are registering to provide services ahead of the NDIS rollout in their location (NDIA 2017o, p. 41; DSS, sub. 146, p. 36).

Growth in registrations of those providing therapy supports — usually allied health professionals — has been strong, and accounted for 54 per cent of the increase in registrations in the quarter ending 31 March 2017 (NDIA 2017o, p. 40).

While the scale of market growth to date is uncertain, many providers pointed to two challenges to developing the market for disability supports:

- the effect of price controls for supports set by the NDIA
- concerns that some markets will be too small to be profitable for providers to supply.

The next two sections examine these concerns in turn.

6.2 Pricing of disability supports

In a mature market, the choice and control that participants exercise will increasingly be the main factor driving the price of disability supports. Allowing the market to determine the price of supports is an important tenet of the NDIS, as it will contribute to both participant outcomes and the financial sustainability of the scheme.

However, there is a need for the temporary regulation of prices in the disability support sector, as recommended by the Productivity Commission in its 2011 *Disability Care and Support* inquiry (box 6.1).

Box 6.1 Why regulate the price of disability supports?

Governments have historically regulated the price of human services (PC 2016, p. 35), including disability care and support services, on the grounds of equity and efficiency. Absent price regulation, the use and provision of disability supports may be below socially optimal levels for a number of reasons, including ineffective competition and abuse of market power (NDIA 2017a, p. 5).

In particular, there may be too few providers in the market, which is a real risk in the disability support sector. Early data indicate a market concentration of more than 80 per cent in some disability service sub-markets (NDIA 2016p, p. 32, 2016w, p. 29, 2016aa, p. 38; DSS, sub. 146, p. 38). This may result in prices that are too high, and limited access to services for some disadvantaged groups. Others have noted the need to maintain price controls in the foreseeable future, as it may take at least a decade for the new market for NDIS disability supports to develop (ANAO 2016, p. 54; AONSW 2017, p. 5; DSS, sub. 154, p. 39).

The Commission in 2011 recommended that an early — albeit temporary — task for the NDIA was to set efficient prices to allow providers to recover the costs of service provision (including adequate returns for capital investment), and in turn, ensure the supply of disability supports (PC 2011, pp. 51, 412–414). While the NDIA has set prices since the beginning of the NDIS trials in July 2013, the Agency indicated that it does not plan to do so in the long term.

> During transition, the market stewardship role of the Agency will be more active; to facilitate development of the marketplace and as a catalyst for basic market infrastructure. This includes … setting prices and pricing policy …
>
> The setting and reviewing of NDIS prices is a significant market-intervention initiative … for most submarkets, it sees this [price-setting] as a temporary measure to support the marketplace. In the long-term, the NDIA will not set prices to the extent it does now and will instead allow the marketplace to determine the price of supports. (NDIA 2016k, pp. 18, 26)

An important principle of price regulation is that it should not persist unnecessarily, have excessive scope, nor shape the market — such as by benefiting some providers or participants over others.

How are prices set?

The NDIA sets the total value of a participant's support package as part of the planning process (chapter 4). Participants can only purchase supports from NDIA-registered providers if they want the Agency to manage their plan (chapter 8). These supports are subject to a maximum price set by the NDIA — 'a price cap'. Given that about three-quarters of participants are currently subject to these price caps (NDIA 2017o, p. 21), price controls have considerable scope to affect market development.

The NDIA walks a fine line in setting prices.

> The NDIA risks unnecessarily disrupting existing markets through setting prices inaccurately. If price limits are set too high (relative to an efficient benchmark) providers will not face adequate incentives to review practices and operations in an effort to be more efficient. As a result, participants, and the Scheme in general, would not get value for money from expenditure on supports. On the other hand, if price limits were set too low, providers would be

> unable to recover even efficient costs. This could result in a significant share of providers leaving the sector and/or a lack of new investment in disability services. (NDIA 2016r, p. 10)

This is reflected in the rationale of price caps, which is to:

- ensure 'value for money' for participants — as the price of supports may be bid up too quickly in the absence of price caps in the period after funding is allocated to participants, but before the disability support sector grows sufficiently to meet the increased demand
- encourage the market supply of disability supports by giving providers sufficient incentive to grow and enter the NDIS market (NDIA 2016s).

There are also trade-offs associated with price controls. While fixing prices causes scheme costs to be lower in the short term, it may slow the development of the market. Conversely, the deregulation of prices could mean higher short-term costs, but potentially lead to faster growth of the market in the long term.

The NDIA currently sets price caps using a 'reasonable cost model', which seeks to 'define the direct cost elements at a rate that is sufficient to cover the efficient costs of a reasonable quality support provider at a point of time' (NDIA 2014a, p. 2). Prices are intended to reflect an estimate of what the long-term 'efficient' price would be in a competitive, deregulated market, *plus* an additional margin to reflect both the cost and time needed for existing providers to transition to a market-based system, and to entice new providers to enter the disability support market (transitional pricing). To do this, the reasonable cost model makes a number of assumptions about the cost of providing supports, which vary by the support in question (box 6.2).

Prices are currently set by annual reviews conducted by the NDIA. The price review for 2017-18 was recently completed, with prices effective from 1 July 2017 (NDIA 2016a). This price review included an examination of the evidence and methodology used to set prices, with a focus on attendant care (NDIA 2017a, p. 8). The Agency also considered changing the nature of price information provided to firms by introducing 'price bands', which would consist of two components: a benchmark price that reflects the efficient costs of providing a reasonable and necessary level of care, and a price cap *above* the benchmark price reflecting the maximum price that can be charged under the NDIS (NDIA 2017a, p. 17).

Regulating prices is always difficult — regulating a market that is still developing and undergoing significant change is even harder, as the past may offer less guidance to regulators than in a mature market, and there is an increased risk of disruption caused by regulated prices. Prices are also only one of many factors that affect the willingness and ability of providers to supply disability supports.

Box 6.2 The NDIA's reasonable cost model used to set price caps

The reasonable cost model (RCM) uses a range of assumptions that have been developed in consultation with the disability support sector to determine the price cap for a given support type under the NDIS. These price caps are intended to inform providers about the efficiency levels that should be targeted under the market-based system. To date, price caps have included an additional premium to reflect the costs of transitioning existing providers into the scheme, and to give new providers an incentive to enter the sector.

One support subject to a price cap is the cost of an hour of attendant care — one of the most common supports provided under the NDIS. The RCM assumes the following conditions for an hour of attendant care provided in 2016-17.

- The hourly rate of pay is based on the *Social, Community, Home Care and Disability Services Industry Award 2010* pay point 2.3 for employees and 3.2 for managers or supervisors. Pay rates depend on whether the hour worked is on a weekday (6am-8pm or 8pm-12am), Saturday, Sunday, or a public holiday.
- Employees are employed on a full-time or permanent part-time basis. No allowance for shift work or other allowances are included. Leave entitlements are ten days of paid personal leave; four weeks of paid annual leave at 17.5 per cent leave loading; and 17.98 per cent of employees achieve long service leave of 8.67 weeks.

In terms of other costs, including 'on-costs', the RCM assumes:

- loadings for location (18 and 23 per cent for remote and very remote areas respectively) and the complexity of client needs (about 6 per cent)
- that carers spend 95 per cent of paid time with clients, and that managers spend 90 per cent of time with clients, or dealing with client matters. A manager is expected to supervise 15 employees (for standard needs clients)
- that providers operate with a corporate overhead equal to 15 per cent of total salary, management and non-client facing expenses. There is an additional payment for provider travel costs for travelling between clients (maximum 20 minutes).
- superannuation is 9.5 per cent of total salary costs, and workers' compensation insurance is 4 per cent of total salary costs
- a profit margin of 5 per cent of total costs, as well as an additional margin for the transition pricing period.

The RCM, under these assumptions, results in a price cap of about $42 for an hour of attendant daytime weekday care in metropolitan New South Wales, Victoria, Queensland and Tasmania. About a third of this price is for on-costs.

Most of the assumptions and methodology of the model were initially developed in consultation with National Disability Services; however, the parties did not agree on what assumptions were appropriate for the future efficient price (NDIA and NDS 2014, p. 16). Many providers who made submissions to this study argued that the price caps resulting from the RCM are inappropriately low (box 6.3).

Sources: NDIA (2016l, 2016m, 2016n, 2016o, 2016s, 2017a).

However, prices are also important because they affect participant choice and control. What participants want and need should ultimately be the main driver of prices — something that can be most effectively and efficiently achieved in a market *without* price

controls. This is because price caps constrain quality, variety, innovation and ultimately reduce the benefits to participants. It is therefore important that prices are not regulated where it is unnecessary to do so.

Prices affect who providers choose to supply. Although it is difficult to get a complete picture as the scheme is still early in the transition period, a number of providers submitted to this study that they were unable to provide services for participants with complex needs at the prices derived from the reasonable cost model (Anglicare Australia, sub. 157, pp. 11-12, 19; CMHA, sub. 11, pp. 5, 13; Leadership Plus, sub. 128, pp. 3-4; NDS 2017c, p. 4; United Voice, sub. 118, p. 12; VCOSS, sub. 176, pp. 20-21) — an unintended consequence of assumptions in the model of a single complexity loading, base salary rate and supervisory requirements. As put by the Brotherhood of St Lawrence:

> The existing fixed pricing structures pose some problems for both participants and service providers because they fail to take into account the circumstances of activities. By setting a single price, the provider does not have the option to charge less or more for a tailored service. This has the unintended consequence of reducing the choice and control of people with disability. (sub. 189, p. 20)

NDIS transition data tend to suggest greater underutilisation of supports for those with complex needs (as proxied by level of function). While this could indicate problems with plans or participant readiness to navigate the NDIS (chapter 8), many study participants indicated that those with complex needs were experiencing significant difficulties with finding providers willing to provide services to them.[22]

Some concerns about prices may reflect a general inefficiency by providers or a reluctance to change business practices. While a number of study participants raised concerns about the adequacy of prices to provide quality supports (box 6.3), the NDIA submitted that some providers may be finding it difficult to become more efficient under the new fee-for-service model.

> Some providers have raised concerns that NDIS price levels are too low, particularly for personal care and community supports, but have generally not supported these arguments with clear evidence. Other providers have suggested that current price levels are appropriate. These contradictory views within the provider population might be evidence that some are struggling to adjust to a funding model that is based on market principles. There is also evidence of a wide variation in operating costs under pre-NDIS approaches where efficiency was not a key consideration. It also might reflect changes in volume as well as the extent of cross-subsidisation of services that previously existed.
>
> The NDIA effort to set maximum prices has incorrectly been taken by many in the sector to authorise an 'NDIS price' for their services, which is often inflated above actual costs. (sub. 161, p. 101)

[22] Including: ACT Government (sub. 156); Anglicare Australia (sub. 157); Belinda Jane (sub. 80); Disability Services Australia (sub. 9); Disability Services Commissioner Victoria (sub. 35); National Disability Services (sub. 51); Scope Australia (sub. 72); and Victorian Government (sub. 174).

Given that the most recent price review by the NDIA has only just concluded (with new prices to take effect on 1 July 2017), the Commission has not made any findings or recommendations about the adequacy of prices at this stage.

Box 6.3 Study participants' views on NDIS price caps

Many providers gave anecdotal evidence to the study about the NDIS price caps being too low to provide services, with a particular focus on the price cap for an hour of attendant care. Estimates of the shortfall between what was needed against what the cap offered varied considerably.

- House with No Steps (sub. 104, p. 3) indicated a shortfall of about 10 per cent.
- Belconnen Community Service Board (sub. 39, p. 1) indicated a shortfall of between 10.5 and 16.0 per cent.
- Cohealth (sub. 50, p. 11) indicated a shortfall of 98 per cent for those with mental health needs.

The Commonwealth Ombudsman provided an anecdote in relation to wages relative to other care sectors.

> … at a recent consultation a provider told us they could bill around $10 per hour more for providing in-home domestic assistance for aged care clients than they could for providing the same service to an NDIS participant. They suggested it was difficult to understand the rationale for this difference and said it created a risk that service providers would focus their service provision on areas that were more financially sustainable, leaving NDIS participants with even fewer choices. (sub. 137, p. 14)

While these anecdotes are helpful, data and evidence on how the overall market is responding to price caps are limited.

A survey by National Disability Services in partnership with Curtin University found that 67 per cent of respondents reported that they were worried that they would not be able to provide services at the prices being offered under the NDIS. And 46 per cent advised that to provide services at the prices being offered by the NDIA, they would have to reduce the quality of service (NDS 2016, p. 19). Although 55 per cent of disability support organisations reported making a profit, only 40 per cent of respondents budgeted to make a profit in 2016-17 (NDS 2016, p. 14).

Another report applied assumptions in the pricing model that it considered to be more representative of what could be achieved by disability support providers. It found that the price cap on an hour of attendant care would have to increase by approximately 13 and 25 per cent for providers to continue to provide care of a reasonable quality (Samaritans Foundation, in Anglicare Australia, sub. 157, att. 4, p. 1).

Should the NDIA set prices?

Regardless of the effectiveness of the NDIA's price caps to date, a question that needs to be asked is whether the NDIA should be setting prices. Even though it is an independent statutory agency, the NDIA's roles of funder and purchaser of supports, market steward and guardian of financial sustainability mean that it has a potential or perceived conflict when setting prices.

Typically, agencies such as the NDIA are not placed in such a position when managing human services provision. This was noted by the ANAO in its audit of the performance of the DSS' and NDIA's management of the transition of the disability services market.

> … the NDIA's dual roles in the market as both a funder or 'purchaser' on behalf of governments, and as a price 'regulator' presents a conflict of interest which needs to be transparently managed. In other (largely public-provided) sector transformations such as the establishment of the national energy market, governments have progressively taken steps to establish independent pricing regulators, for all or part of the market's operations where public interest concerns remain. In a similar human service delivery market, the Aged Care Financing Authority provides independent advice to government on funding and financing matters.
>
> In the context of entities' analysis of NDIS market arrangements, and advice to governments' on the NDIS market design, the ANAO could find no evidence that the implications of these dual market roles for the NDIA had been actively examined. (2016, p. 30)

This concern was shared by the DSS (sub. 146, p. 39), who suggested that while the NDIA is best placed to continue to set NDIS prices in the short term, consideration should be given to prices being set by an independent pricing authority in the medium term (ideally within the next five years). The New South Wales Government (sub. 60, p. 8) queried whether prices should be set by the NDIA, when the independent regulation of prices has assisted market development in other sectors. The Victorian Government (sub. 174, p. 19) also emphasised the need for prices to be set independently.

Is there a better way to set prices?

A fundamental tenet of the NDIS is for prices to be driven by the market in the long term. While price caps are only meant to be transitional, if set inappropriately, there is the risk that the NDIA's pricing decisions 'make the market', rather than allowing the market to develop in a way that reflects the needs (and goals) of participants. To avoid this outcome, price controls need to be evidence-based, set transparently and determined independently.

Evidence and transparency are essential

As the NDIS disability support market is still developing, the evidence base needed to determine the appropriate price controls is limited. This is reflected in the NDIA's approach, which includes consultation with the disability support sector.

> In the roll-out phase of the NDIS, the NDIA is adopting a cautious approach to price controls in the absence of information on the competitiveness of markets for supports. (NDIA 2017a, p. 5)
>
> Price control decisions are informed by significant input from market stakeholders through regional forums, targeted workshops, individual discussions and responses to discussion papers. (NDIA, sub. 161, p. 100)

This approach is consistent with the Office of Best Practice Regulation's recommendation that the NDIA:

> … continue to make its decisions about the setting of reference prices transparent, continue to work with the NDS to collect information on the costs of providing supports, and continue to monitor the impacts of reference prices on existing providers. (2015, p. 43)

There is some evidence that the NDIA has responded to market circumstances and feedback. For example, the NDIA increased price caps for personal care and community supports by about 10 per cent in 2014 and 2015 at some NDIS trial sites (ANAO 2016, p. 47).

However, some providers argued that they have had no real opportunity to provide feedback on pricing decisions. For example, House with No Steps (sub. 104, p. 4) said that there was a 'lack of real consultation by the NDIA with service providers', and that they had never been formally consulted on any matter (including prices), despite being one of the largest providers nationally.

> Our frustration is that this pricing is relatively easily and transparently modelled in an Award environment. Such modelling, if publicly shared, would move the discussion from the inadequacy of a 'black box' number to an informed discussion around cost drivers such as staffing mix, management spans of control and overhead levels. We understand such modelling has been carried out by the NDIA and independent actuaries and, if so, do not understand why the output of those modelling exercises has not been made public or reflected in NDIA pricing. (sub. 104, p. 3)

These frustrations extend to a lack of usable information about prices needed to provide meaningful feedback.

> The NDIA's process for pricing services of various kinds has been difficult for non-government stakeholders to understand or contribute to … Providers have also been largely unable to provide detailed advice in response to any consultations either during or subsequent to the RCM's development. To build the NDIA's evidence base for 'a market price' for psychological services, Mental Health Australia asked the NDIA to check the assumptions in the model with providers, but to our knowledge this did not occur. (Mental Health Australia, sub. 155, p. 22)

Concerns about a lack of transparency and consultation appear to be shared by many others (not just providers) — including the Health Services Union (sub. 132, p. 10), the ACT Government (sub. 156, p. 27) and the ANAO (2016, p. 13). As part of its most recent price review, the NDIA said that it had received feedback from stakeholders that there was:

> … a lack of transparency on the assumptions and methodology used to calculate price controls (which could affect discussion about how price arrangements relate to other parts of the NDIS, as well as debate about the price controls themselves). (2017a, p. 7)

To address this lack of transparency, the NDIA released additional information about pricing as part of the latest pricing review (NDIA 2017a). That said, the price-setting process remains largely opaque. Submissions to the price review process are not made public, nor is it clear how the material is used. Details about the operation of the RCM are not in the public domain.

The lack of transparency around prices is at odds with the practice of independent price regulators in other sectors.[23] It is also inconsistent with the Commission's 2011 recommendation that the NDIA's recommendations to change prices should be transparent, if the Agency is to set prices (PC 2011, p. 412). Transparency is important to impose discipline and public accountability in setting prices, as well as to increase credibility and certainty of price signals, which assists with forward planning and investment by providers. It also creates greater incentives for new providers to enter the disability support market, and helps build community confidence that the prices for supports are fair and reasonable for providers, participants and taxpayers. A lack of transparency can erode this confidence, and put the scheme at risk.

An independent price regulator

The transition period of the scheme represents an opportunity to resolve concerns about the NDIA's perceived conflict of interest and lack of transparency in price regulation. It is also an opportunity to provide greater certainty to providers about how and when price deregulation will occur, which is a key milestone in moving to a market-driven approach.

The Commission considers that prices for disability supports should be deregulated in three stages. In the first stage, the NDIA would maintain its role of price regulator, and an independent price monitor would be introduced with responsibilities, including to:

- examine how the market is responding to price caps set by the NDIA
- review the NDIA's price caps based on the available evidence, including submissions made to the NDIA's price reviews, and making comparisons with prices in other care sectors (including aged care)
- report publicly on its assessment of the NDIA's price controls with regard to market development and participant outcomes.

This monitor should be put in place immediately to serve as a 'check and balance' on the NDIA's pricing over the crucial transition period. The monitor would improve transparency on how price caps are set, and in turn, lead to greater accountability to participants, providers and the wider community.

The second stage is to shift the NDIA's price-setting powers to a regulator that is an independent statutory authority — an approach consistent with the evolution of other markets for consumer-directed care, such as in the aged care sector. This would allow the NDIA to focus on its core responsibilities of delivering and administering the NDIS; remove any potential conflict of interest; and help address concerns about a lack of transparency in price regulation.

[23] For example, aged care (Aged Care Pricing Commissioner), electricity and telecommunications (Australian Competition and Consumer Commission), minimum wages (Fair Work Commission) and hospitals (Independent Hospital Pricing Authority).

At this time, the Commission envisions that the independent price monitor would be best placed to take over these pricing powers, as it would have developed the knowledge and expertise necessary to understand the disability support market.

The body tasked with price regulation for scheme supports (including the NDIA while it remains the price regulator) should, among other things:

- collect and publicly report data on providers' characteristics and costs — public reporting of this data would provide a benchmark for providers, inform public debate about prices, and facilitate relevant research by external parties
- communicate with disability support providers, participants and the NDIA to transparently set prices at regular intervals, with sufficient time for providers to phase in price changes
- periodically review and publish its price model for transitional and efficient prices in a transparent and comprehensive manner
- send granular and targeted price signals — that is, provide prices at the state and territory level, with an expectation that prices could be set at a more disaggregated regional level where possible
- assess and recommend — on the basis of transparent consultation and evidence — when prices for particular NDIS supports in each region should be deregulated, and evaluate whether there is a need for price controls. To enable efficiencies to be driven by the market wherever possible, the price regulator should presume that it is appropriate for prices to be deregulated — that is, to only have price controls when there is clear evidence that unregulated prices are likely to lead to inflation that would harm participants.

Pricing of NDIS disability supports should be transferred to the independent body by 1 July 2019. This is important for providing certainty to the sector of a transparent pricing regime. There is also an expectation that price regulation will be required for some supports over the medium to long term.

The third and final stage of deregulation will occur when the price of a given disability support is deregulated, but is still subject to subsequent monitoring. The independent price monitor would maintain an ongoing watch on pricing, collect data, and publicly report on emerging market issues that affect the purchasing power of scheme participants. The pricing role of the independent regulator would gradually diminish (and revert to a monitoring role) as the market develops over time.

DRAFT RECOMMENDATION 6.1

The Australian Government should:

- immediately introduce an independent price monitor to review the transitional and efficient maximum prices for scheme supports set by the National Disability Insurance Agency (NDIA)
- transfer the NDIA's power to set price caps for scheme supports to an independent price regulator by no later than 1 July 2019.

The body tasked with price regulation for scheme supports should:

- collect data on providers' characteristics and costs. This should include appropriate funding to continue the business characteristics and benchmarking study currently undertaken by National Disability Services and Curtin University
- determine transitional and efficient prices for supports at a state and territory level
- comprehensively review and publish its price model on an annual basis. This review should be transparent, have public consultation, be evidence-based and evaluate the effectiveness of prices in meeting clearly-defined objectives
- assess and recommend when to deregulate prices for supports, with particular regard to the type of support and region, on the basis that prices should only be regulated as narrowly, and for as short a time, as possible.

6.3 Thin markets

The market-based model for disability supports is designed to encourage the provision of more supports that people with disability want and need than under previous arrangements (PC 2011, pp. 111–156). However, there are still going to be cases when the disability support market remains too small (in terms of the number of providers or participants) to support the competitive provision of services. This outcome is known as a 'thin market'.

There are a number of negative consequences of thin markets. Insufficient supply may lead to higher prices, less variety, lower quality services and unmet demand. In the disability support sector, thin markets can result in poor participant outcomes, increased demand for mainstream services, and greater pressure on informal carers. Scheme costs are also affected — while they may be lower in the short term (due to underutilisation of supports), they may be higher in the long term if participants are not receiving the right supports at the right time. For these reasons, governments often need to — and do — intervene in thin markets to ensure the supply of disability supports for people with disability.

When will thin markets arise in the NDIS?

Thin markets can arise in places or for particular disability supports when demand is limited and the cost of supply is high. The NDIA and COAG Disability Reform Council

both noted that thin markets are most likely to occur in rural and remote areas, and for specialised supports, such as aids and equipment (DRC 2015a, p. 19; NDIA 2016k, p. 15). Participants in this study also identified access problems for particular groups of people with disability, including some participants:

- living in outer regional, remote or very remote areas[24]
- with complex, specialised or high intensity needs, or very challenging behaviours, such as those with psychosocial disabilities[25]
- from culturally and linguistically diverse (CALD) backgrounds (ECCV, sub. 31)
- who are Aboriginal and Torres Strait Islander Australians (GIFSA, sub. 13; OPG of the Northern Territory, sub. 143; VACCHO, sub. 162; and Northern Territory Government, sub. 205)
- who have an acute and immediate need (crisis care and accommodation) (Anglicare Tasmania, sub. 145, pp. 46–47).

Given the early stage of the transition, it is difficult to tell where thin markets may be diminishing, growing or persisting under the NDIS. Even when thin markets do occur, it is not necessarily the case that the NDIS is responsible for them. Thin markets were a feature of disability support arrangements previously, as well as in many other human services (PC 2011, pp. 115–156, 2017). What is important is that the appropriate and timely policies are put in place to minimise their incidence and impact on participants and providers. This is especially the case as the interface with other mainstream services evolves (chapter 5). Thin markets will remain a feature of the provision of some disability supports under the NDIS (box 6.4).

[24] Including: the ADFO (sub. 180); Cheryl McDonnell (sub. 79); Commonwealth Ombudsman (sub. 137); Deaf Australia (sub. 183); Early Childhood Intervention Australia NSW/ACT (sub. 190); GIFSA (sub. 13); Mental Health and NDIS Facebook Support Group (sub. 8); MTHCS (sub. 6); Northern Territory Government (sub. 205); OPA Victoria (sub. 46); OPG of the Northern Territory (sub. 143); Queensland Advocacy Incorporated (sub. 115); RDAMR (sub. 12); and South Australian Government (sub. 203).

[25] Including: Carers Australia Victoria (sub. 131); Department of Health (sub. 175); DSA (sub. 9); and Leadership Plus (sub. 128).

Box 6.4 Evidence of thin markets under the NDIS

Thin markets for disability supports have long been an issue for some groups and in some regions. The structure of these thin markets means that many will persist under the National Disability Insurance Scheme (NDIS). This is particularly the case for people with disability who live in rural and remote areas, and early evidence from the scheme appears to confirm this.

- The NDIA (2016c, p. 34) deemed there to be supply risks for therapy supports (a specialised support) to be more acute in regional areas in southern New South Wales.
- The DSS (sub. 146, p. 37) said that there was early anecdotal evidence of thin markets for personal care support, participants with complex needs, early childhood and employment supports.
- A National Institute of Labour Studies survey found that unmet demand was experienced more by NDIS participants living in rural and remote areas in the Victorian trial site and for older NDIS participants, particularly those living in regional areas (Mavromaras, Moskos and Mahuteau 2016, p. xi).
- In some service regions, the increase in the value of support packages is forecast to grow more quickly than the growth in participants (NDIA 2016p, pp. 10–12, 2016aa, pp. 10–12). This could reflect a lack of supports and more unmet demand for these participants.
- In South Australia, almost one-third of NDIS participants are expected to reside outside of Adelaide (NDIA 2016y, p. 25); however, the NDIA observed that there was a lack of provider choice in remote and very remote areas in South Australia, with participants often dependent on a key support worker (NDIA 2016y, p. 26).
- Participants in the Barkly region in the Northern Territory had the third highest level of unutilised funding — 41 per cent in 2014-15, and 64 per cent in 2015-16 (NDIA 2017m, p. 29). However, underutilisation may be due to a number of factors other than unmet demand (chapter 2).
- In the Northern Territory, there appears to be a shortage of supports for physical disabilities. As at 30 June 2016, only one per cent of active registered providers in the Northern Territory provided physical wellbeing services, but 27 per cent of participants with an approved plan in the Barkly trial region were identified as having a physical disability (NDIA 2017m, pp. 10, 22). The NDIA noted that:

  > Given the much higher level of physical disability in the Territory as compared to … [Victoria and New South Wales], the number of providers registered to provide physical wellbeing supports appears to be low. (2017m, p. 21)

How can thin markets be minimised?

One of the challenges of addressing thin markets is that while they share some common characteristics, often they have very specific and different causes. A ‘one-size-fits-all’ approach will not to be feasible or effective. A more tailored response that considers the complexities of dealing with the wide variety of thin markets is required, taking into account issues such as the presence of CALD and Aboriginal and Torres Strait Islander

communities; quality of infrastructure; weather events and population density.[26] In practice, it means that standardised approaches to pricing may not be effective to encourage supply in some thin markets. This is reflected in the diversity of options that can be used to address thin markets (box 6.5).

There are costs associated with government intervention to minimise under-provision of disability supports in thin markets. In addressing thin markets, it is necessary to balance the trade-off between providing cost-effective service provision, and providing as flexible a service as possible to enable participant choice and control.

The NDIA's recently published Rural and Remote Strategy (NDIA 2016x), and Aboriginal and Torres Strait Islander Engagement Strategy (NDIA 2017b) both reflect the need to provide disability supports in a way that allows for as much choice and control for participants as possible, and to enable innovative methods of service delivery.

Such an approach is also reflected in the Bilateral Agreement between the Northern Territory and Australian Governments on the transition to the NDIS, as the Northern Territory has historically faced particular challenges in providing human services due to thin markets (PC 2017). It was agreed that the Northern Territory's approach to the transition would be guided by the following principles:

- place-based, tailored solutions to planning, market development, access to services and risk management
- a coordinated, client-centred, and tailored approach to the operating model in remote communities, informed by existing effective frameworks that maximise access, engagement and management of risk for individuals
- culturally competent engagement and professional practices
- local planning, market development and risk management strategies informed by timely and appropriate data (Australian Government and Northern Territory Government 2016, p. 4).

[26] For example, scheme participant density in the Northern Territory (except the Darwin urban service region) in 2020 is expected to be less than five participants per 100 square km (NDIA 2017m, p. 14). Despite remoteness price loadings, some providers in Queensland also reported to the NDIA that recent new providers were concentrated in major population centres such as Townsville, Cairns and Mackay (NDIA 2016w, p. 33). The Commonwealth Ombudsman (sub. 137, p. 16) also noted that some existing providers who specialise in providing services for CALD and Aboriginal and Torres Strait Islander people with disability may not be able to make the transition, due to registration barriers and insufficient cash reserves to transition to fee-for-service.

Box 6.5 Different approaches to address thin markets

There are a number of measures that could be used to mitigate the risks of thin markets, including:

- partial or full block-funding to commission or procure services (PC 2011, pp. 521–523). Goldfields Individual and Family Support Association (sub. 13, p. 12) said that removing block-funding would likely result in an 'almost complete loss of services on the very remote Lands.' Many study participants said that block-funding is the most efficient way to ensure that needs are met (Centacare Brisbane, sub. 44; Australian Blindness Forum, sub. 48; Cohealth, sub. 50; and Anglicare Tasmania, sub. 145)
- sharing of infrastructure, knowledge, skills and experience among providers
- facilitating bulk-purchasing arrangements by participants — for example, by pooling of participants' funds (Mallee Track Health and Community Service, sub. 6; PC 2017)
- more collaboration, coordination and integration of services, particularly with local and mainstream service providers — to avoid supply gaps or duplication (CADR 2014, p. 15; RACGP, sub. 200). Providing more hours of support coordination in participants' packages should also be considered, particularly for those with complex needs (Alzheimer's Australia, sub. 10, pp. 9–10). Brain Injury SA (sub. 116, p. 14) emphasised the need for effective coordination of services between State (and Territory) and Australian Government providers
- use of community- or place-based services (PC 2017) — including greater use of the local workforce where possible
- greater use of information technology, including videoconferencing, telehealth and other technologies, particularly for therapeutic supports (NDIA 2016z, p. 28; APA, sub. 93; Amaze, sub. 160)
- the NDIA providing more detailed information on market demand (and unmet demand) to encourage providers to enter thin markets
- cultural training, education and awareness programs (Brain Injury SA, sub. 116; Commonwealth Ombudsman, sub. 137) — including greater funding of translators and interpreters (Goldfields Individual and Family Support Association, sub. 13; Cohealth, sub. 50; SDN Children's Services, sub. 73; and Companion House, sub. 84)
- more support and respite care for informal carers (chapter 7)
- greater engagement with the local community to build trust and relationships.

What is being done to address thin markets?

Based on the experience of the NDIS trial sites (particularly the Barkly trial in the Northern Territory), the NDIA said that it would consider a range of approaches to mitigate the risk of thin markets, including:

- active and deliberate cross-government collaboration — including the use of locally-based workers, and educating the community about the interface between health services and disability supports
- leveraging established community organisations (such as those already operating in health, aged and community care sectors) who may also deliver disability services

- supporting a provider to access supports from business councils, Indigenous Business Australia, or any other organisation in the Aboriginal and Torres Strait Islander business capacity-building sector
- using the hub and spoke model (also known as scaffolded support) — where generalist providers provide support in the rural or remote community, and where needed, can collaborate or seek oversight from an advanced practitioner or specialist centre, either through a visiting clinic or telepresence
- working with existing mainstream providers to expand their services to better meet the needs of participants — such as plan management services by local accounting services and re-purposing underutilised infrastructure (sub. 161, pp. 105–106).

These approaches rely heavily on the commercial decisions of providers (such as the type of workforce, the decision to deliver disability services, and service delivery business models). They also appropriately reflect an attempt to make the market-based, consumer-driven approach succeed where possible — with more interventionist alternatives a last resort.

The NDIA (sub. 161, p. 106) noted that 'some providers are thinking creatively about supply in thin markets', including by diversifying into associated areas to provide additional business income, and forming business relationships between urban and remote businesses.

While the details of how providers are to be encouraged to supply thin markets are not yet clear, the Commission understands that the NDIA and DSS are jointly developing a more detailed Market Intervention Framework to address thin markets, which is being negotiated with each jurisdiction (NDIA 2016k, p. 15, 2016x, p. 26). This framework will be released later in 2017.

Given that the NDIS is already in the transition phase, there is a risk that thin markets will persist or worsen in the absence of timely strategies and intervention by the NDIA. There is a growing need for the NDIA to clarify and implement practical measures to mitigate the risks to participants associated with thin markets, particularly with the withdrawal of in-kind supports by governments (DSS, sub. 146, p. 37).

Interventions need to be tailored to the specific circumstances of each case — such as user characteristics, the broader service landscape, resource constraints and effects on the wider community (PC 2017). The diversity of user needs also means that a 'one-size-fits-all' solution will not be effective in addressing access issues. As a result, it is inappropriate to automatically default to block-funding, direct commissioning or mainstream services (particularly acute or primary health care services). While it is likely that block-funding will be needed in some cases (PC 2011, pp. 521–523), care must be taken to avoid crowding out competition.

Regardless of the approach chosen, there will be a need for strong market stewardship (PC 2017), and collaboration between the Australian, and State and Territory

Governments, given the latter's knowledge and experience as funders and providers to date. Addressing thin markets requires a whole of government approach and community involvement.

As noted by the Commission in 2011, it will not always be possible to match the price, quality and range of services in the major cities (PC 2011, p. 529). Some participants may need to travel (and in some cases, move) to metropolitan areas to access highly specialised services. This highlights the need for complementary services, such as transport to access specialised disability care, to be provided either in a participant's plan or outside of the NDIS where appropriate (chapter 5). Improving access for participants in thin markets is a key objective of the NDIS, but it is an ongoing task requiring constant vigilance, monitoring and evaluation (box 6.6).

DRAFT FINDING 6.1

In a market-based model for disability supports, thin markets will persist for some groups, including some participants:

- living in outer regional, remote and very remote areas
- with complex, specialised or high intensity needs, or very challenging behaviours
- from culturally and linguistically diverse backgrounds
- who are Aboriginal and Torres Strait Islander Australians
- who have an acute and immediate need (crisis care and accommodation).

In the absence of effective government intervention, such market failure is likely to result in greater shortages, less competition and poorer participant outcomes.

Box 6.6 Addressing thin markets requires data and ongoing public reporting

Mitigating the effects of thin markets (and informing associated funding arrangements) will require more transparent identification, reporting and evaluation of thin markets than at present. Planning, evaluation, monitoring and feedback systems (as well as commissioning practices) are discussed in the Commission's current inquiry into Human Services. Specific key performance targets and indicators (both outputs and outcomes) need to be developed, and the relevant data collected, to ensure the equity, effectiveness and efficiency of disability supports and thin market strategies. This was recognised by the Joint Standing Committee on the NDIS for services in rural and remote areas, which recommended that:

> … all options to develop a market that provides choice and control for participants in rural and remote areas be explored, and that any additional funding for disability in the Northern Territory to any provider is conditional on measureable increases in service provision. (2015, p. 78)

The Northern Territory Government also emphasised the need for more granular data.

> The availability of more granular data is particularly important to enable monitoring of the Scheme's roll out in remote regions and thin markets – where the NDIS market-based model is most challenging to implement. Detailed regional level data is also important to inform service providers to enable localised market growth and development (e.g. client base, size of market, and service provider gaps). (sub. 205, p. 3)

As a starting point, the type of information that could be collected in the monitoring of thin markets (including through Local Area Coordinators and current feedback mechanisms in the NDIS) could supplement current reporting to COAG under the National Disability Strategy. In particular, reporting in each thin market could better reflect similar measures reported by the Commission as part of the National Disability Agreement, including:

- participation rates — such as the number of eligible participants; the severity and nature of disabilities; and other participant characteristics. The Joint Standing Committee on the NDIS (2015, pp. 62–67) noted a lack of data for participants who are from culturally and linguistically diverse backgrounds, as well as for Aboriginal and Torres Strait Islander Australians
- access or support use by participants — including utilisation rates; the number of providers, workers and supports; as well as market concentration
- appropriateness of supports — for example, whether supports were delivered in a culturally and linguistically respectful manner in accordance with the NDIA's Aboriginal and Torres Strait Islander Engagement Strategy
- quality of services — such as reporting the satisfaction rate of participants and carers, and any complaints under the NDIS Quality and Safeguarding Framework (and State and Territory Government quality and safeguard regulations in the interim)
- cost per unit of output — including government and NDIA contribution per participant, and forecasts of future costs per participant. This would also be consistent with the insurance-based approach of the scheme
- participant outcomes — such as choice and control; economic or social participation; and use of other services by people with disability (including mainstream services and informal support) (SCRGSP 2017, p. 15.1-15.39).

Timely and ongoing data collection is particularly important as the NDIA's online platform (eMarketPlace) is still being developed (chapter 8).

What if there is no market? The Provider of Last Resort

The NDIA does not directly supply individualised supports to participants, but there are times when it may take a direct role to ensure that services are provided. This might occur in very specific and exceptional circumstances when providers are unwilling or unable to supply disability supports under NDIS policy settings, for example, when:

- participants cannot access disability supports — there is no provider, or the only external provider is likely to fail in circumstances that would leave participants at risk (such as in remote locations)
- supports are not available at reasonable prices — this might be true for participants with highly complex needs or challenging behaviours, or in emergency situations when supports are needed at short notice
- it is difficult to verify that external providers are genuinely achieving good quality outcomes for participants or their carers
- there are significant economies from combining or coordinating several services together, and where the government has an advantage in supplying the package of services ('economies of scope') — this might apply to participants who are Aboriginal and Torres Strait Islander Australians, where governments might have to deal with multiple levels of disadvantage (housing, health, education, urban amenity, employment, transport and disability) (NDIA 2016k, pp. 26–27; PC 2011, p. 409).

The principles that should govern provider of last resort (POLR) arrangements were considered by the Commission in 2011. The Commission noted that POLR needed to be subject to the same regulatory oversight and monitoring as other providers in the scheme, and that block-funding of providers should only be used when fee-for-service was proven to be infeasible to ensure the supply of supports (PC 2011, pp. 523–526).

The Commission also emphasised the need for POLR arrangements to be contestable and at arm's length from the commissioning body, and when block-funding is judged to be the preferred method, that the NDIA should develop standardised tendering, contracting, reporting and acquittal requirements in order to reduce compliance costs (PC 2011, pp. 523, 528). Importantly, it is not the role of the NDIA to support failing providers in thin markets, but to ensure the supply of disability supports for participants in the most effective and efficient way.

The POLR arrangements for the NDIS are still being developed by the NDIA, but appear consistent with the Commission's views in 2011 (box 6.7). However, the delay in formalising these arrangements is resulting in uncertainty for both participants and providers.

The NDS stated that POLR arrangements under the NDIS are:

> … currently poorly articulated and are inadequate. This needs to be addressed, ideally through the NDIA establishing emergency response agreements with a number of disability support providers across the country. (sub. 51, p. 16)

Box 6.7 The NDIA's provider of last resort arrangements

What is the provider of last resort (POLR)?

As a market steward, the NDIA is responsible for POLR arrangements. When there is a significant risk of insufficient market supply; when no provider is available; or in the event of provider failure (for example, if the *only* local provider for a range of disability support services in a remote community goes into administration), the NDIA may directly commission and procure disability supports for scheme participants. Triggers are likely to include:

- insufficient, volatile or uneven supply — in a particular geography, market segment or service type, potentially due to lack of scale or providers being active in that market
- evidence of inappropriate use of market power — for example, constraints to competition or lack of consumers exercising choice
- insufficient quality at a reasonable price
- benefits for greater return on investment from arrangements other than individual commissioning.

A provider contracted as a POLR will need to meet agreed quality standards and ensure that services are delivered in an appropriate and culturally competent way. The provider may also need to leverage existing infrastructure. The NDIA considers POLR arrangements to be a highly interventionist form of market intervention.

Who is responsible for the POLR?

As the transition leads to full scheme, the NDIA will lead an integrated response jointly with the States and Territories. In the interim, the States and Territories lead as POLR, and will continue to do so for providers who they fund during transition (except for the Northern Territory, where the NDIA is responsible for ensuring POLR services even in the transition period pursuant to Schedule K of the Northern Territory Bilateral Agreement). The Agency noted that identification and response to such market failure will require collaboration among all NDIS stakeholders.

What does the POLR involve?

The POLR framework forms part of the NDIA's broader *Market Intervention Framework*. Both are currently being developed by the NDIA and DSS, and negotiated with each jurisdiction. It is expected that in 2016-17, the NDIA will agree to POLR processes, and that by 2018-19, there will be a maturity of POLR capabilities, to potentially include a range of response options, such as panels in relevant jurisdictions or submarkets capable of providing emergency capabilities at extremely short notice.

Sources: NDIA (2016k, 2016x).

Some guidance about POLR arrangements has been included for scheme participants in the Northern Territory. In the Bilateral Agreement between the Australian and the Northern Territory Governments on the transition to the NDIS, it was agreed that the NDIA would

be responsible for ensuring that POLR services are in place for all participants in the Northern Territory (Australian Government and Northern Territory Government 2016, p. 1, Schedule K). The bilateral agreement also includes principles on how these arrangements are to work (risk, transparency, person-centred approach, non-exclusivity, barriers to entry, supply of services and end of service arrangements) (Australian Government and Northern Territory Government 2016, p. 2, Schedule K). It also stipulated that 'solutions will be established to avoid inappropriate default to the acute medical system as the provider of last resort' (Australian Government and Northern Territory Government 2016, p. 2, Schedule K). Some have commented that this detail has not been sufficient to ensure that POLR arrangements are in place (and what they would entail).

> The State Committee is further concerned the POLR [provider of last resort] commitment is behind in its conceptual and operational planning in line with the rollout schedule and ambiguous to members on what these provisions mean in terms of their own business planning and existing services.
>
> We ask that urgent attention be given to clarify the POLR aspect of the NT Bilateral Agreement so as to further mitigate the risk of market failure. (TEAMhealth, sub. 102, p. 22)

The Northern Territory Government (sub. 205, p. 6) said that it is working with the NDIA to develop the POLR framework, which once developed, could have broader application nationally. The need for greater clarity on how POLR and thin market arrangements more generally are to be put into practice is increasing, particularly as governments change their involvement in providing disability and mainstream supports (chapter 5).

The Commission is seeking feedback on when particular measures should be used to provide services in thin markets, when POLR arrangements should be used, and any other information on ways to address thin markets.

INFORMATION REQUEST 6.1

In what circumstances are measures such as:

- *cross-government collaboration*
- *leveraging established community organisations*
- *using hub and spoke (scaffolding) models*
- *relying on other mainstream providers*

appropriate to meet the needs of participants in thin markets? What effects do each have on scheme costs and participant outcomes? Are there barriers to adopting these approaches?

Under what conditions should block-funding or direct commissioning of disability supports (including under 'provider of last resort' arrangements) occur in thin markets, and how should these conditions be measured?

Are there any other measures to address thin markets?

6.4 Other factors affecting provider readiness in transition

The NDIS is a new system for existing providers, and is creating a new market for all participants and providers in the disability support sector. And there are several transitional issues affecting the sector's supply response. These include:

- challenges faced by providers who were previously block-funded
- administrative burdens associated with the scheme
- the effect of supports that are provided 'in-kind' by governments to the scheme
- the scheme's effect on collaboration among providers.

Moving from block-funding to fee-for-service

As detailed in table 1.1, providers received government funding *before* providing certain supports in 'bulk' to participants prior to the NDIS. This usually took the form of lump sum payments for each participant under annual contracts that were paid three months in advance (AONSW 2017, p. 7). Providers now claim reimbursement from the NDIA *after* providing individualised supports to scheme participants. The majority of support items are based on per hour, or 'per instance' of service provided (NDIA 2016l, 2016m, 2016n, 2016o).

Providers face significant challenges to adapt to the new fee-for-service model, and some may not be able to make the transition. Providers bear increased financial risk (such as from non-payment and late payment) and in turn, have a greater need for cash reserves, making it harder to maintain liquidity and solvency (DSS, sub. 146, p. 37). The NDS (2015, p. 17) stated that 'the majority of not-for-profit disability service providers report insufficient cash flow required to transition to the NDIS.' Providers will incur specific fixed costs to restructure and adapt their business to the NDIS market. Costs may relate to unit pricing, IT, accounting, marketing and the provision of individualised supports.

While these costs are likely to be significant given the scale and nature of the required changes (particularly for small providers, and there are many of them in the disability support sector (box 6.8)), they are better addressed by the price received for supports than the payment method (PC 2011, p. 520). In general, the need to cover fixed costs is not a reason for government intervention (PC 2011, p. 523). Fixed costs are also likely to be a transitional issue for a number of reasons.

- The introduction of innovative payment systems by some financial intermediaries may reduce some of the financial risks of the fee-for-service model and help providers adapt to the new system (Eyers 2017).

- Price deregulation will help providers recover their fixed costs, as prices will more accurately reflect the cost of supply, and fixed costs will be driven by consumer preferences (PC 2011, p. 520).
- Providers may be able to use different pricing methods to efficiently recover fixed costs (such as discounts for regular users, or for periods where demand is lower) (PC 2011, p. 521).
- The experience of providers in comparable and adjacent sectors in the economy (including aged care) that moved from block-funding to fee-for-service as part of consumer-directed care reforms also suggests that adjustment can and will take place in the medium to long term. As the NDIA observed:

  > Similarly, aged care providers are undergoing their own reforms related to consumer-directed-care and many businesses are leveraging this experience to build services and products relevant for the disability market. (2016aa, p. 5)

Box 6.8 Small providers can face big challenges to transition

A feature of the disability support sector is that many providers are small (Martin and Healy 2010, p. 122). National Disability Services estimated that about 58 per cent of providers are either small or very small (with a turnover of $5 million or less) (Gilchrist and Knight 2017, p. 10). And about 39 per cent of NDIA-registered providers are individuals or sole traders (NDIA 2017o, p. 38). Small providers may have less capacity to make the transition to the NDIS than larger providers. For example, they face challenges from:

- proportionately higher fixed costs of operating in the NDIS, especially as they must incur new marketing and systems costs
- achieving economies of scale or scope, with total costs spread more thinly across smaller hours of support, particularly with the shift to more individualised or tailored supports.

The scale of these challenges may be inferred by the amount of merger and acquisition activity in response to the challenges of being a small provider. Merger activity and restructuring in the sector provides some indication that this may be the case (NDS 2016, p. 17), although it is unclear whether this has led to an actual increase in services or substantially reduced competition.

The Commission heard that some providers are delaying making changes to their business model and planning decisions (including investment) because of uncertainty and lack of clarity, particularly about the timing of price deregulation and the withdrawal of in-kind services (ANAO 2016, p. 32). About 75 per cent of providers surveyed by the NDS felt that 'the policy environment is uncertain' (NDS 2016, p. 19). One provider surveyed by the NDS commented that:

> The uncertainty around 'how much we will be able to receive' once NDIS is implemented in our region means that the climate for any investment is too uncertain, because we cannot make a reliable business plan. (NDS 2016, p. 10)

The Office of Best Practice Regulation also noted that:

> … ongoing engagement with providers when developing reference prices and maximum prices, particularly for key supports, should help providers during the transition to a fee-for-service based system of disability care. (2015, p. 49)

Better information and communication by the NDIA would assist, as will independent price monitoring (recommendation 6.1).

Administrative burdens

There are a range of regulatory and other costs to provide supports. As the NDIA (2016k, p. 9) noted, there are 'high costs to enter the marketplace'.

Regulatory costs include those to register with the NDIA, and costs associated with ensuring quality and safety of supports. These include professional registration (in the case of specialised services, like therapeutic supports), working with children checks, and police checks. These costs are necessary to ensure safe and high quality support provision for NDIS participants. The recently developed NDIS Quality and Safeguarding Framework (which will only apply to NDIA-registered providers) aims to provide a nationally consistent set of regulations on what providers need to do to provide disability supports (chapter 9). Increased regulatory consistency across jurisdictions should mean lower costs for some providers.

Concerns were also raised by a number of study participants about the NDIA's online payment system and communication issues with the NDIA. As Catholic Social Services Australia said:

> Though CSSA [Catholic Social Services Australia] member agencies have been preparing for transition to the NDIS for a long time, the dysfunctionality and un-preparedness of the NDIA has severely affected its capacity to deliver sustainable services through the NDIS. Complex and ongoing issues with the portal (including the system being taken down for weeks at a time with very little notice) means that providers are finding it very difficult to access the funds for services provided. These cash flow issues have restricted providers' ability to invest, innovate and even operate (for example one agency providing significant disability services in a trial site had $1 million 'stuck' in the portal in December 2016). This has led to cash flow issues and providers withdrawing due directly to pricing or lack of payment. (sub. 166, p. 9)

The problems associated with the online portal have been examined in some depth by others (ANAO 2016, pp. 62–71; Conifer and McKinnon 2017; PwC 2016), and were recognised by the NDIA (sub. 161, p. 119). The Agency indicated that it is reforming its processes to improve the 'provider pathway', including registration and payment arrangements, and is also delivering tailored information sessions for providers.

> The NDIA is working to improve the quality and amount of information available to providers in all elements of the provider pathway (awareness, commercial assessment, registration process (including the impacts of the move to the national arrangements being led by DSS),

> service planning and delivery, payment and claiming outcomes) so that providers are better placed to meet expectations and develop their service offer under the NDIS. (sub. 161, p. 102)

Payments to providers need to be timely so that innovation, entry and the supply of supports are not hampered.

Competition and in-kind services

Under Bilateral Agreements between the Australian, and State and Territory Governments, government funding of the NDIS is a combination of services and cash contributions, with the proportion differing by jurisdiction.

This means that Australian, State and Territory Government programs under existing block-funding arrangements ('in-kind services') continue to exist to ensure continuity of supply in the short term. In practice, this means that governments may continue to remain a service provider,[27] or block-fund a provider to deliver services. Most in-kind services are to be phased out through transition and replaced by cash contributions, though the timing of this varies by jurisdiction (NDIA 2016v, p. 71).

The withdrawal of in-kind services is consistent with the NDIS objective of a more competitive, consumer-driven and market-based system, with services to be delivered by a wider range of private providers. Governments will no longer provide or procure disability services except in limited circumstances, such as in thin markets and under POLR arrangements (section 6.3).

However, there are concerns that the continuation of in-kind services in the meantime may adversely affect the transition by existing providers, market entry (PC 2017), the quality of supports (PDA, sub. 38, p. 13) and overall scheme costs. Providers may also delay adapting to the fee-for-service model due to ongoing block-funding under in-kind service arrangements (Mavromaras, Moskos and Mahuteau 2016, p. 45; NDIA, sub. 161, p. 102). In addition, providers may have less incentive to provide or increase services if they are effectively foreclosed from meeting demand for the entire market due to in-kind services.

> … large parts of the marketplace are subject to in-kind arrangements and therefore, not immediately available to prospective providers … (NDIA 2016k, p. 7)

The risk of deterring private providers may be higher in regional or remote areas, and other thin markets, where governments may be the main provider with few actual or potential competitors.

> Mr Croker from Keep Moving, was concerned that because the NT Government was the only entity that was able to provide services across all of the region, this left his organisation

[27] Host jurisdictions are also likely to provide services in monitoring the overall integrity and effectiveness of the *NDIS Quality and Safeguarding Framework*. For example, approval of restrictive practices by providers will continue to be managed through current State and Territory government processes (DSS 2016c, p. 17).

> effectively in competition with the NT Government and begged the question of 'How do you compete as a private enterprise against government departments?'. (JSCNDIS 2015, p. 68)

Some in-kind services also cannot be bundled by the NDIA and can only be priced as individual line items (JSCNDIS 2015, p. 33), often at prices higher than the NDIA's price caps (NDIA, sub. 161, p. 101). This limits the potential efficiencies and pro-competitive benefits of allowing providers to bundle supports due to economies of scale or scope, and price discrimination.

As in-kind services restrict the development of the disability support market and place upward pressure on scheme costs, they should be phased out as quickly as possible (chapter 10, recommendation 10.3). At the same time, it will be important to monitor and respond to any service gaps arising from cashing out of in-kind services — particularly if they result in or exacerbate thin markets (section 6.3). This is likely to occur when in-kind services comprise a large share of the market. For example, about 45 per cent of disability support accommodation services are provided in-kind in South Australia (South Australian Government, sub. 203, p. 16).

Even if in-kind services are phased out, governments may still provide some disability supports under the NDIS and therefore have an impact on competition. Private providers need to be able to compete with governments on a level playing field to ensure the most efficient provision of disability supports to scheme participants (also known as 'competitive neutrality'). Greater clarity by governments about the application of competitive neutrality in the disability support market would assist in achieving this outcome (PC 2017).

Collaboration in the disability support sector

Some disability supports are provided using collaborative and co-operative arrangements. Some providers were concerned that the increased competitive pressures of a market-based system will reduce collaborative activity (and the associated benefits), and therefore lead to a potential erosion of 'social capital'[28] (Alzheimer's Australia, sub. 10, p. 15; Anglicare Australia, sub. 157, p. 13; and CMHA, sub. 11, p. 14). This could increase provider costs and lead to the withdrawal of some services.

A National Institute of Labour Studies survey found that the introduction of the NDIS had made providers more guarded and that less information was shared due to commercial considerations (which may undermine provider networks), although some collaboration among providers was continuing to occur. One provider who was surveyed commented that:

> I think that's been a sad sort of aspect of the NDIA. When you create a competitive marketplace it's very hard, you know, those old networks that we would have been a part of and shared ideas and things like that have kind of broken down a little bit. (Mavromaras, Moskos and Mahuteau 2016, p. 45)

[28] The relationships and trust that underpin the functioning of society (PC 2010, p. XIX).

Not-for-profit providers may experience lower volunteering and fundraising contributions due to public perception of their perceived greater 'commercial' focus and competitive behaviour, and that the NDIS is fully-funded (ABF, sub. 48, p. 14; Australia Scope, sub. 72, p. 25). The NDS said that:

> Providers are beginning to report that fundraising is dropping as donors believe that the NDIS will provide all people with disability with all the supports they need. This is clearly a misunderstanding but seems to be becoming more pervasive. (sub. 51, p. 14)

While these contributions may be retained within the disability sector (either redirected to other providers or spread more thinly across all providers), they could also be transferred to other human service sectors, and therefore be lost from the disability support sector.

Conversely, providers may have greater incentives for collaboration in order to increase flexibility and responsiveness to participant demand in an increasingly competitive funding environment (NDS and CADR 2015, p. 13). Collaboration may allow providers to offer services at a greater range of times and locations, and achieve economies of scale or scope that would otherwise be difficult to achieve (particularly in thin markets and for small providers). Market stewards (and regulators) need to monitor such arrangements closely to ensure that collaboration does not reduce competition, efficiency and participant wellbeing.

NDS data indicate that in 2015-16, the majority of providers surveyed collaborated to advocate for the sector (68 per cent) or for clients (62 per cent), and had agreements to refer to provide services to clients (55 per cent), despite increased competition for both workers and clients (NDS 2016, p. 17). This appears to be broadly in line with previous results, where providers reported that they were forming alliances and joint working relationships with other organisations to offer services at a greater range of times and locations (NDS 2015, p. 38; NDS and CADR 2015, p. 13). Collaboration would also be consistent with the objectives and mission of not-for-profit providers, which typically promote the interests and wellbeing of NDIS participants. As noted by Centacare Brisbane (sub. 44, p. 3), the degree of collaboration and cooperation between providers under the NDIS will depend on the maturity, interests and skills of each party.

On balance, collaboration is a voluntary and valuable activity undertaken by not-for-profit providers that produces intangible benefits, but has tangible costs when removed. The mixed evidence on the degree of and incentives for collaboration in a more competitive environment suggests that the net effect will depend on whether the increased efficiency of providers offsets the higher costs associated with reduced social capital. The Commission has previously noted that for the not-for-profit sector, efficiency and effectiveness are central to maximising community wellbeing (PC 2010, p. 18).

While it is difficult to assess the change in collaboration (particularly when there are price caps and lack of data), based on the available evidence to date, some collaboration may continue to exist in the NDIS, and will be primarily determined by provider efficiency.

Separating transitional issues from structural issues is difficult

The disability support market is undergoing significant change. The way that participants, providers, workers and governments interact with the demand and supply of supports means that it is difficult to be certain about which challenges faced by providers are transitional, and which may become more entrenched or systemic. This is especially as the NDIA is already responding to some problems faced by providers.

The importance of choice and control for participants means that a diverse range of providers will be necessary for participants to achieve the best outcomes from the scheme. The Commission is seeking further feedback on barriers to new providers entering the market, and existing providers expanding their provision of disability supports. The Commission is also interested in approaches that will promote greater market innovation and responsiveness to demand.

INFORMATION REQUEST 6.2

What changes would be necessary to encourage a greater supply of disability supports over the transition period? Are there any approaches from other consumer-directed care sectors — such as aged care — that could be adopted to make supplying services more attractive?

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7 Workforce readiness

Key points

- The disability care workforce will need to roughly double from its 2014-15 level to meet the increased demand for National Disability Insurance Scheme (NDIS) supports. Such workforce growth will mean that about one in five new jobs forecast to be created in Australia over the transition period will need to be in disability care. While the disability care workforce has grown considerably over the transition period to date, it is unlikely to meet this target under current policy settings.
- There are a number of challenges to growing the disability care workforce. These include: finding carers to meet high participant demand at particular times of the day; ensuring that there are enough qualified carers to provide a reasonable quality of care (including allied health professionals); and increasing rates of retirement of workers from the sector as they age. There are also regional challenges. In some areas, the workforce will need to more than double to meet demand.
- Policy changes that would help to address some of the workforce shortages over the transition period include:
  - taking advantage of the preference of many workers in the disability care sector to work more hours
  - relaxing the rules on informal carers providing paid care to participants, especially in remote and regional areas
  - using a targeted approach to immigration to address persistent skill shortages.
- The way that respite services are provided under the NDIS — requiring participants to include it in their plans, and being subject to caps on the amount of respite — could be creating a disincentive for providers to supply these services. This may reduce the ability of participants' family members and friends to provide informal care. A lack of respite and informal care will increase demand for formal carers and scheme costs.
- There needs to be a clearer delineation of roles and responsibilities for developing workforce policy for a more coordinated response to meeting the workforce needs of the NDIS in the future. Building the evidence base on the number of workers in the sector, their conditions and working arrangements would be a sound investment to develop more effective workforce policies in the future.

As discussed in chapter 6, the state of the disability care market's readiness to deliver National Disability Insurance Scheme (NDIS) supports will affect scheme costs. Market readiness will depend on, among other things, whether there are enough workers to provide NDIS supports.

As recognised by the National Disability Insurance Agency (NDIA), any workforce shortages are a risk to the scheme.

> A major concern for the NDIA is that the speed in growth of demand cannot be met by a commensurate speed in growth of supply. The availability of workforce is a significant factor in the ability of the market to supply the needs of people with disability. (sub. 161, p. 95)

While workforce shortages will have a direct effect on scheme costs, the pricing policies of the NDIA will also have an effect on workforce growth and scheme costs. For example, without price regulation (in the short term), increased competition for care workers could bid up wages and increase scheme costs. However, with price regulation, it may be difficult to build up the workforce fast enough. This could lead to unmet demand for participants, which will put a brake on scheme costs, but could undermine the objectives of the scheme by restricting access to supports that are regarded as reasonable and necessary.

This chapter examines the question — can the disability care workforce grow quickly enough to supply the increasing demand for services under the NDIS? Section 7.1 looks at the current state and characteristics of the disability care workforce. Section 7.2 discusses the size and scope of the workforce that will be needed when the NDIS is fully rolled out. Section 7.3 examines policy options for developing the workforce, and ways to reduce the number of workers required to provide NDIS supports.

7.1 The current disability care workforce

The disability care and support workforce is diverse. It includes disability support workers that provide daily care and allied health professionals that provide specialised care. As the NDIS is rolled out, the size and scope of the workforce will increase further — both to cater for more participants, and to embrace new roles driven by the market-based system as participants exercise greater choice over their supports.

To understand how the workforce will need to change requires an understanding of what it looks like now. It is difficult to measure the disability care workforce by itself, as it is classified with aged care in regularly published statistics (box 7.1). With this in mind, a number of broad conclusions about the disability (and aged care) workforce can be drawn:

- disability care workers are older than the workforce in general (figure 7.1) — about one fifth of workers are aged 55 and older (NDS, sub. 51, p. 9)
- about 80 per cent of employees in the disability care sector are women (compared to about 46 per cent of employees for all occupations)[29]
- about 60 per cent of employees in the disability care sector work part time (compared to about 30 per cent of employees for all occupations)[30]

[29] Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2016).

[30] Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2016).

- the majority of workers in the disability care sector hold a certificate-level qualification (figure 7.2).

Box 7.1 Measurement issues: the disability care workforce

Data on workers in Australia are collected regularly by the Australian Bureau of Statistics based on the of industry of operation (the Australia-New Zealand Standard Industry Classification (ANZSIC)) and the occupation of the worker (using the Australia-New Zealand Standard Classification of Occupations (ANZSCO)) (ABS 2006, 2013). However, neither of these classifications are well suited to identifying those working in the disability care sector, or those working in disability care roles.

For example, the most disaggregated — that is, the level of finest detail — ANZSIC classification that includes disability carers is '8790 Other Social Assistance Services', which also includes aged care assistance services, marriage guidance services, and the operation of soup kitchens. In ANZSCO it is '4231 Aged or Disabled Carer', which again combines aged and disability carers together. Neither of these are ideal for analysing the state of the disability care workforce.

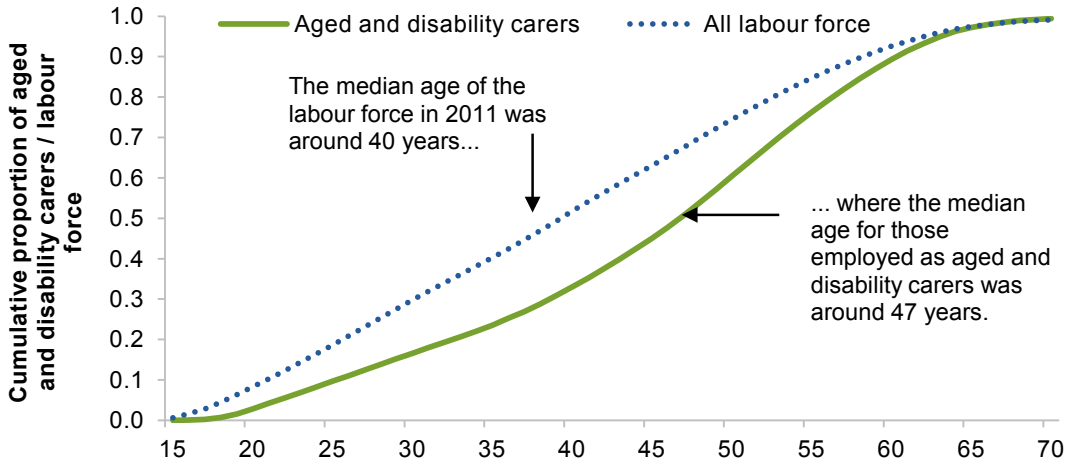
Allied health professionals that work in the disability support sector are similarly hard to identify, as it is difficult to distinguish between those that may provide services occasionally or those that provide them full time to people with disability. The classification of allied health professionals is also contentious and subject to revision.

> There is no one definition which prescribes the disciplines considered as allied health. At the meeting of the Council of Australian Governments in July 2006, agreement was reached to establish NRAS [the National Registration and Accreditation Scheme] for health professionals, beginning with the ten professional groups registered in all jurisdictions, of which seven fall under the allied health banner: chiropractic care, optometry, osteopathy, pharmacy, physiotherapy, podiatry, and psychology. … A further four allied health professions joined NRAS on 1 July 2012: Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists. … Other allied health professions that are not included under NRAS, but are considered in the Commonwealth's health workforce policy planning, include: Audiologists, Counsellors, [Dieticians], Exercise physiologists, Music therapists, Nutritionists, Pathologists, Social workers, Sonographers, Speech pathologists. (Department of Health and Ageing 2013)

Other studies, including the Commission's inquiry into *Disability Care and Support* (PC 2011), relied on 'one-off' surveys and alternative data sources to better understand the disability care workforce. This included a detailed survey by Martin and Healy (2010). This survey remains the most specialised data source for the disability care sector workforce, though is now becoming dated. A forthcoming survey on the disability care workforce may also help solve some unaddressed measurement issues (Cortis nd).

Figure 7.1 **People working in the aged and disability care sector are older than the labour force in general[a]**

2011

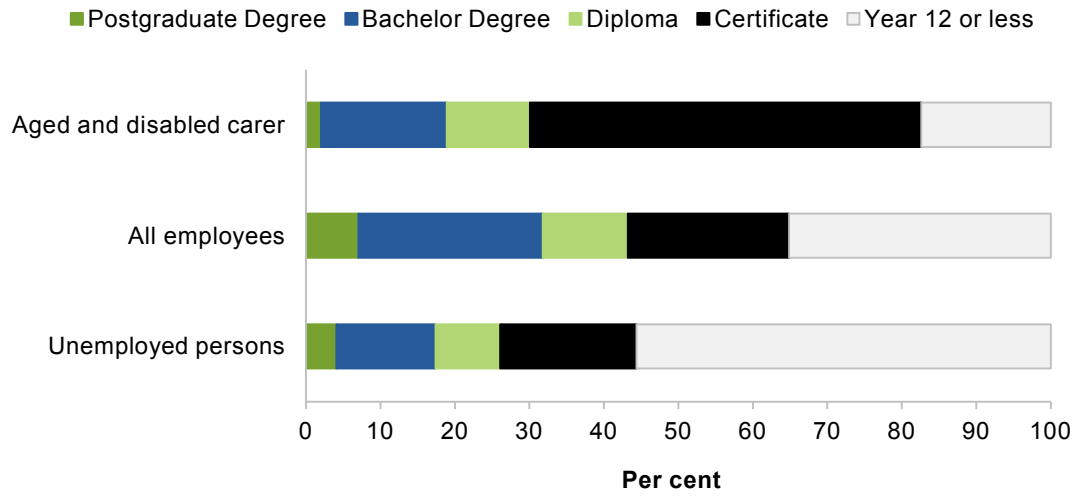


[a] Based on ANZSCO code 4231 'Aged or Disabled Carer'.

Source: Commission estimates based on ABS (*TableBuilder Basic,* 2011 Census).

Figure 7.2 **People employed in aged and disability care roles are more likely to hold certificate-level qualifications[a]**

Highest level of educational attainment, 2016



[a] Aged and disability care roles based on ANZSCO code 4231 'Aged or Disabled Carer'. The Bachelor Degree category includes postgraduate certificate and diploma qualifications.

Source: Commission estimates based on ABS (*TableBuilder,* Education and Work, May 2016).

7.2 What will the size of the workforce need to be by scheme roll out?

While estimates of the number of workers required to deliver supports allocated through the NDIS vary, the consensus is that the workforce will need to increase by between 60 000-90 000 full-time equivalent employees (FTE) — or roughly double in size:

> The workforce will need to increase from approximately 73 600 full-time equivalent (FTE) workers, to an estimated 162 000 FTE workers. (DRC 2015a, p. 19).
>
> The workforce opportunities and challenges as a result of the introduction of the NDIS are very significant. It is expected that the NDIS will generate between 60 000 and 70 000 new jobs on a full-time equivalent basis over the next three years. This represents about 20 per cent of the total number of new jobs forecast to be created in Australia over this period. (Bonyhady 2016, p. 5)

The NDIA's market position statements indicate that about an additional 70 000 FTE workers will be needed from 2015-16 to 2019-20 (NDIA 2016c, 2016p, 2016w, 2016y, 2016z, 2016aa, 2017m).

The evidence to date — admittedly at the very early stage of transition — indicates that the workforce is growing quickly, but not fast enough to meet the overall growth target. For example:

- data collected on the workforce by National Disability Services (NDS), a peak body for disability care providers, indicates that the number of workers in the sector is growing at a rate of about 12 per cent each year (NDS, sub. 51, p. 9)
- the number of people employed in aged and disability care occupations increased by about 27 per cent between 2015 and 2016 according to ABS Labour Force data.[31]

Neither of these sources are on a FTE basis. Based on the proportion of part-time to full-time positions, halving the rates of reported 'headcount' growth allows for a rough approximation of the FTE growth targets. As such, both figures are well short of the average annual growth rate of 18 per cent in FTE employees required to meet the expected workforce needed for the scheme.[32]

Data on allied health professionals, albeit patchy and reported in a period early in the trial phase, also indicate that growth rates in FTE employees are slow (table 7.1). Clearly, there are considerable challenges emerging in scaling up the workforce to meet the needs of NDIS participants.

[31] Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2015 and May 2016).

[32] Commission estimates based on NDIA (2016c, 2016p, 2016w, 2016y, 2016z, 2016aa, 2017m)

Table 7.1 **The number of registered allied health professionals[a]**
2014

Allied Health Category	*Number registered*	*Average hours worked per week*	*FTE equivalent per 100 000 population*	*Average annual growth rate in FTE per 100 000 population (%)*
Psychologists	31 489	32.7	87.4	1.3[b]
Physiotherapists	27 011	34.7	83.3	2.1[b]
Occupational therapists	16 757	33.1	52.2	3.2[c]
Chiropractors	4 902	32.8	15.8	1.3[b]
Podiatrists	4 316	36.2	16.1	4.0[b]
Dental prosthetists	1 223	38.8	4.9	-2.6[b]
Aboriginal and Torres Strait Islander health practitioners	322	40.7	1.2 (76.4 based on Aboriginal and Torres Strait Islander population)	4.4[d]

[a] Only selected allied health professions shown from National Registration and Accreditation Scheme data (box 7.1). No data available for speech therapists and dieticians. [b] 2011 to 2014. [c] 2013 to 2014. [d] 2012 to 2014.

Sources: Commission estimates based on ABS (*Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, 2001 to 2026, Cat. no. 3238.0, series B); AIHW (2014a, 2014b, 2014c, 2014d, 2014e, 2014f, 2014g).

Challenges to reaching the workforce target

While estimates of FTE employees are helpful for providing an overview of the growth required, they mask a wider variation of supply and demand at a more disaggregated level. There are many different workforces that will provide services for NDIS participants, and the challenges — and policy responses to address those challenges — to each will vary. A better way is to consider the disability care workforce across 'role and region'.

- Role covers the types of workers needed to fulfil a NDIS participant's needs, which in turn will depend on individual choice, disability and other family circumstances. In turn, this translates to the skill mix of workers needed, and in turn, the mix of general carers, allied health professionals, and other workers required.
- Region covers the different number and growth in workers required in different locations.

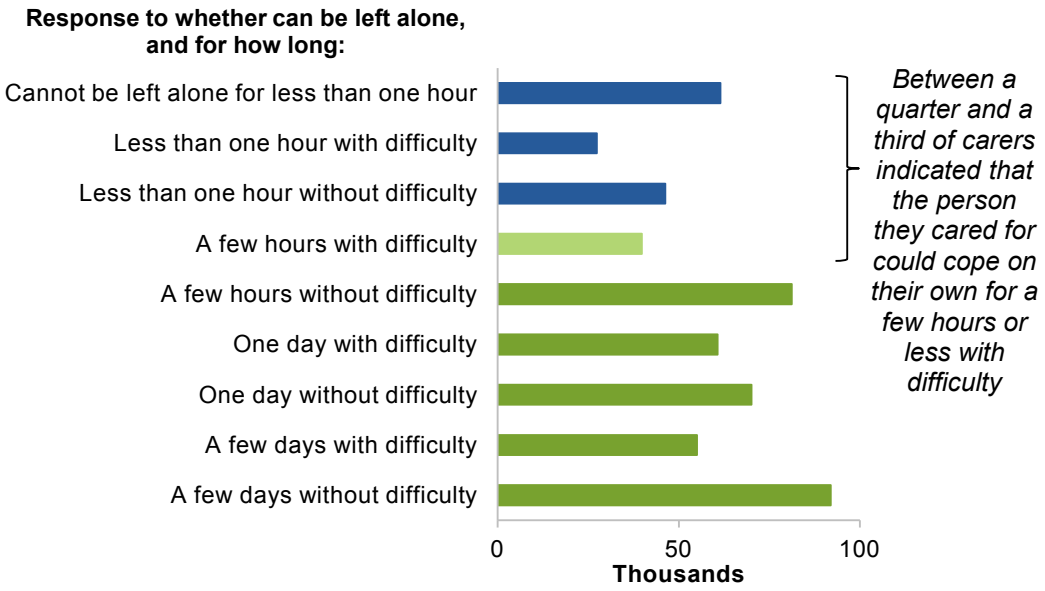
Role challenges

Peak hours

Disability carers are often required for only a few hours per day at 'peak times' — when there is high demand for carers in early mornings and evenings to help people with

disability get in or out of bed, showered and fed (Physical Disability Australia Ltd, sub. 38, p. 11). This is reflected in the Survey of Disability, Ageing and Carers, which indicates that about three-quarters of people with severe or profound disability require attendant care for a few hours a day before encountering difficulties (figure 7.3).

Figure 7.3 **Amount of care required before recipient has difficulties[a]**
2015



[a] Based on the response by the carer for those with severe or profound disability aged 15 years or more.

Source: Commission estimates based on ABS (*Disability, Ageing and Carers Australia: Summary of Findings, 2015,* Cat. no. 4430.0, table 42).

This means that there are times of the day when more carers are needed than on average, which would require a greater headcount than the FTE figures suggest. This has implications for how 'flexible' the workforce needs to be. As the NDIA said:

> Participant demand for care often occurs at 'peak times' or high demand periods which may include 7-9am (breakfast) and 4-8pm (bathing and mealtime) with less demand at late morning or mid-afternoon. This poses challenges for the sector to develop more mature rostering and staff management practices which are emerging in some areas. (sub. 161, p. 98)

One way to address this challenge is to make greater use of a more casualised workforce. This could provide the labour needed in those hours of greatest demand. However, there are also some impediments to such an approach, including:

- minimum shift requirements under the Social, Community, Home Care and Disability Services Industry Award, and the cost of casual loadings and penalty rates for working less desirable hours (such as those outside ordinary hours of work)
- quality concerns, such as whether NDIS participants want a different carer for each instance of care, and issues of reliability of casual labour (Cortis nd, p. 6)

- whether there is the supply of casual labour to allow such an approach
  - this includes the attractiveness to work on a casual basis for prospective workers, and the risk that more experienced and better qualified workers may seek permanent jobs elsewhere given the disincentives associated with less secure work (Independent Inquiry into Insecure Work in Australia 2012, pp. 20–21).

Qualified staff in general

The quality of care provided to NDIS participants will depend, in large part, on the quality and skills of the workers providing disability supports. For many roles, formal qualifications are important, if not mandatory, to provide supports. For other roles, formal qualifications are less important. The available evidence suggests that the 'average' level of formal skills in the disability care workforce will decline over the transition period of the NDIS (box 7.2).

This raises the question — is a formal qualification the most important or necessary characteristic to secure employment as a disability support carer? A survey of firms specialising in disability support by the Department of Employment (2014, pp. 2, 5) found the evidence to be mixed.

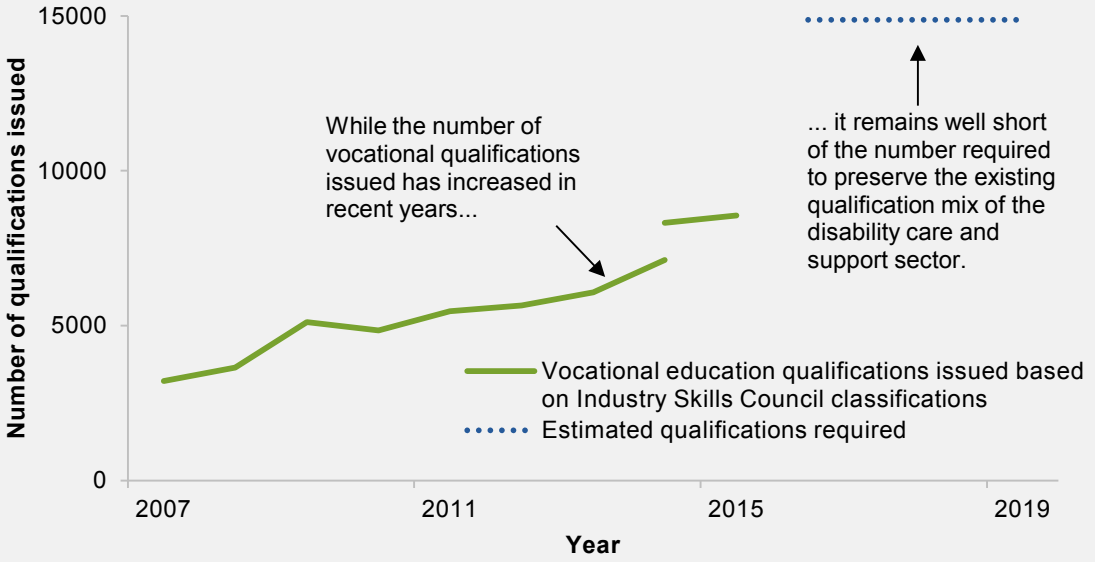
- 89 per cent of providers said that 'personal qualities' were 'important or very important' in terms of the characteristics sought; this compared to 70 per cent for 'relevant experience' and 47 per cent for 'relevant qualifications'.
- 89 per cent of firms said that their minimum requirement for employment was a certificate-level qualification. However, 26 per cent of firms indicated that they regularly employed unqualified workers, suggesting this requirement was not as binding a constraint for some firms.

This mixed story was also reflected in evidence provided to the Commission's 2011 inquiry into *Disability Care and Support*. While some providers argued that a minimum standard or qualification should be mandated for disability support staff, others said that formal qualifications sometimes fell short of providing 'work ready' employees, and that on-the-job training was far more important (PC 2011, p. 740).

Box 7.2 Not enough new trainees to maintain formal qualifications[a]

People employed in aged and disability care roles are more likely to hold a formal qualification than the workforce in general. The most common level of qualification for disability and aged care workers is a certificate III or IV. The number of people completing a qualification against expected workforce targets provides a measure of how the qualification mix of the workforce may look by the end of the National Disability Insurance Scheme transition.

The National Centre for Vocational Education Research dataset on vocational education outcomes (VOCSTATS) indicates that, if workforce targets are met, there will be a smaller proportion (than currently) of workers holding a certificate-level qualification. The figure below shows that about 50 000 certificate or diploma level qualifications were issued in the nine years between 2007 and 2015, while about another 60 000 qualifications would be necessary in the four years between 2016 and 2019 to preserve the same distribution of qualifications observed in the 2011 census.



This indicates that the proportion of workers holding certificate-level qualifications in disability care related studies will fall over the transition period. However, it is not clear what mix of qualifications will be necessary for all National Disability Insurance Scheme participants.

a Estimate is derived by subtracting the expected and current midpoint estimates of FTE disability care and support workers from the NDIA's market position statements and multiplying by a scaling factor of 0.85 to apply the proportion of full-time equivalent workers with a certificate or diploma qualification. This yields a result of 59 500 additional qualified workers, which when apportioned over 4 years requires 14 875 new qualified workers per year. Vocational qualifications are identified using Industry Skills Council classifications that include the term 'disability' in their title (specifically, codes CHC20599, CHC30302, CHC30408, CHC30799, CHC40202, CHC40302, CHC40308, CHC40312, CHC40799, CHC50102, CHC50108, CHC50799, CHC60102, CHC60108, CHC60112, CHC60799). Note that these data are presented in terms of qualifications awarded rather than qualifications used on a full-time equivalent basis. The break in series reflects changes in concordance between previously offered qualifications and current qualifications.

Sources: Commission estimates based on ABS (*TableBuilder,* Education and Work, May 2016) and VOCSTATS (http://www.ncver.edu.au/resources/vocstats.html), extracted on 15 March 2017.

In practice, the benefits of a formal qualification depend in large part on the role that a disability care worker is employed in, and the client's needs. The NDIS will also mean that many workers will need to learn additional skills in the market-based environment for disability supports.

> The NDIS differs considerably from previous reforms as it moves away from 'block funding' programs to a 'fee for service' model. Earlier reforms had little effect on frontline workers. But now workforce models are changing. Frontline workers need to have an understanding of sales, customer service and the ability to work within financial constraints as well [as] being able to adapt and customise service delivery in a person centred model.
>
> Conversations are being held in the sector regarding formal qualifications and whether they are necessary. Some organisations are recruiting workers with no experience and no formal qualifications, with new staff undergoing customised organisational training only. For other organisations, formal qualifications are a pre-requisite. This brings opportunities for a diverse workforce. (Queensland Alliance for Mental Health, in VICSERV & CMHA 2017, p. 46)

It seems reasonable to conclude that the lack of certificate-qualified workers will affect some firms and present a challenge to meeting the workforce target of the NDIS, but the evidence is too limited to say which areas will be most disadvantaged. Also, participants may prioritise attitude and aptitude, and choose to employ less qualified staff who better suit their needs.

Qualified allied health professionals

Allied health roles are very different to attendant care roles. Allied health professionals specialise in a range of different areas, and hold higher level qualifications relative to the disability support workforce in general.

> Allied health professionals are generally educated in the university sector with bachelor degrees, usually three to four years duration. However, in a development common to other health professions, there is an increasing move to postgraduate degrees, for example an initial generic undergraduate science degree followed by a Masters in an individual discipline. (Department of Health and Ageing 2013)

Formal qualifications are almost always a requirement for allied health professionals to practice, which means building up qualified staff can take much longer than for other roles. Constraints in this regard were recognised as part of the *NDIS Integrated Market Sector and Workforce Strategy*.

> It is estimated that the highest rate of increase in the demand for disability workers will be for allied health professionals. The disability sector will need to work closely with related community service sectors, particularly health and aged care, to ensure the demand for allied health professionals is met.
>
> To support the sector and enhance the supply of allied health professionals to the disability sector, the Commonwealth and jurisdictions will work with the sector, education authorities, and professional bodies to ensure that professional education prepares graduates adequately to work in the NDIS. At the same time, to encourage allied health professionals to choose the

> disability sector, the Commonwealth will work with these same stakeholders to strengthen the sector's capacity to provide high-quality placements and support continuing professional development for allied health workers. (DRC 2015a, p. 20)

If the allied health professional workforce does not build quickly enough, then this could lead to unmet demand for participants. It could also lead to a substitution away from using professionals carers to using more general workers instead. This has already been reported in the evaluation of the NDIS, along with the effect this has had on the quality of care provided.

> A perception was expressed in the wave 1 interviews that the pricing structure of the NDIS would bring change to the role of allied health professionals through encouraging the increased use of non-professional staff. By wave 2 a de-professionalisation of the disability workforce was more commonly being reported, with increasing numbers of allied health assistants in the sector. Concerns were raised about the ability and skills of these workers to provide more complex supports and the impact this could have on the quality of care and outcomes for participants. (Mavromaras, Moskos and Mahuteau 2016, p. 48)

And as put by one of the providers interviewed in that study:

> We have employed a number of inexperienced people, but I believe that's starting to backfire … Just the inexperience and the lack of knowledge on how to work with behaviours or understand confidentiality, or things like professional distance and all those types of things. And we're sending inexperienced people out to work individually with people with disabilities. (Mavromaras, Moskos and Mahuteau 2016, p. 48)

Evidence presented to the Commission provides another mixed story about supply and demand for allied health workers in the NDIS. On the one hand, the number of providers registered to deliver allied health services to NDIS participants has grown strongly (NDIA 2016v, p. 44), and in line with the expected number needed by the end of the transition period. However, many who have registered are not yet providing services to scheme participants. This makes it difficult to determine if they are registering in advance of the NDIS rollout or have changed their mind about delivering services.

Many disability service providers indicated that there are a number of allied health roles that are moderately or extremely difficult to fill. For example, more than half of the firms surveyed by National Disability Services indicated that they had experienced difficulties recruiting speech therapists and occupational therapists (NDS 2016, p. 38). The *Intermediate Review of the NDIS* also identified persistent shortages in the provision of speech pathology, occupational therapy and psychology supports (Mavromaras, Moskos and Mahuteau 2016, p. 32), though supply to those who needed such services had increased. As one staff member of the NDIA in the Intermediate Review put it:

> The NDIS has worked twofold. It's increased the amount of service available so people can see other OTs [Occupational Therapists] outside of what they would have been able to. But there's an increased demand. The increased demand is way above the increase of services. (Mavromaras, Moskos and Mahuteau 2016, p. 54)

Some service providers and peak bodies expressed concerns about whether there will be enough allied health providers for NDIS participants, and the consequences for sectors (box 7.3).

Box 7.3 Difficulties faced finding allied health workers

Matthew Burrows:

> The workforce is a wicked problem. … To think that we, as service providers, can just advertise for and employ that many qualified staff (eg therapists) in such a short time is just misguided. Let alone the considerations of balancing a commercial and compassionate culture during this transition time.
>
> At entry to the NDIS in 2012-13 the employment market for therapists relied heavily on internationals supported to work domestically on 457 visas. By 2016-17 the training institutions had geared up and graduates now make up a steady portion of the new recruits. But there remains a gap and that gap is being filled from the full employment market being accessed elsewhere. Australia only has so many therapists and their entry into the NDIS employment field means they are exiting elsewhere. (sub. 7, pp. 3–4)

Disability Services Australia:

> Professional staff, in particular Psychologists and Speech Pathologists are generally difficult to attract (especially in Regional areas) in a very competitive marketplace. This has driven the need to implement creative sourcing strategies such as the hiring of interns for a short term solution. We have also seen significant wages growth in the allied health professions due to labour shortages. (sub. 9, p. 9)

Australian Physiotherapy Association:

> Our members have suggested that increasing the NDIS workforce to that which is projected as being required will not be possible in the current policy settings. They have advised us that demand for services has already stripped supply of providers. (sub. 93, p. 16)

Allied Health Professionals Australia:

> Current demand for services is already exceeding the available supply of allied health providers and there is no evidence of short term changes to this workforce shortage. (sub. 37, p. 16)

A lack of allied health professionals represents a risk that supports of appropriate (and necessary) quality may not be available to some NDIS participants. The time it takes to train an allied health worker — both in terms of formal qualifications and on-the-job training — means that it may be too late to prepare the necessary allied health workforce without either diverting them from other caring sectors, or to seek skilled migrants to fill the workforce gap in the short term. Both approaches involve costs.

An ageing workforce and population presents a greater challenge

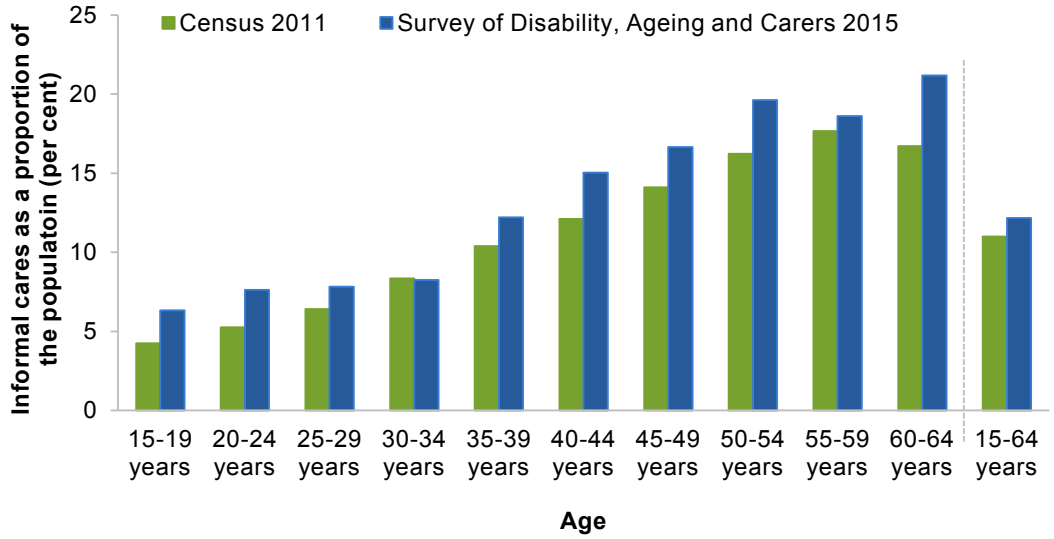
Australia has an ageing population, and this is reflected in the increasing average age of:

- formal carers employed to look after people with disability (figure 7.1)
- informal carers who look after friends and family with a disability
- the general population, which will affect the on demand for carers more broadly.

As noted above, the average age of carers employed in the aged and disability care workforce is higher than for the general workforce. The average age of people employed in aged and disability care is about 47 years, and more than 30 per cent are above the age of 55 years (figure 7.1).[33] An increasing proportion of the care workforce is likely to retire in the coming years, with the average retirement age of those employed in the personal care and assistance occupations being about 55 years in 2014-15.[34] Only about half of those working in disability care intend to still be working in the sector in five years' time (Cortis nd, p. 24).

Informal carers are also ageing. The trend since the 2011 Census has been an increasing proportion people aged 50-64 years providing care for others (figure 7.4). The ability for informal carers to continue providing this care as they age is likely to diminish. As the degree of informal care a NDIS participant receives affects the amount of formal care supports that they are allocated, this suggests that as informal carers age, there will be greater calls on the NDIS to provide more supports and this will require a larger formal workforce.

Figure 7.4 **Informal carers are growing older**



Sources: Commission estimates based on ABS (*TableBuilder Basic,* 2011 Census; *TableBuilder,* Survey of Disability, Ageing and Carers 2015).

The ageing population also means that there will be more intensive demand for carers. While aged carers are not perfect substitutes for disability care workers, there are some roles that cross over, and about one-fifth of disability care providers also provide aged care

33 Commission estimates based on ABS (*TableBuilder Basic,* 2011 Census).

34 Commission estimates based on ABS (*Retirement and Retirement Intentions, Australia, July 2014 to June 2015,* Cat. no. 6238.0, unpublished data).

(NDS 2016, p. 13). This means that even if new carers are trained, they may not be necessarily attracted to the disability care sector as the aged care sector expands. As Disability Services Australia said:

> There is no doubt that as Baby Boomers retire from full time work there will be an overall impact on a range of employment sectors. Whilst there may be some potential for retirees to take on casual disability support or mentoring roles, the ageing population will also create an increase in demand for aged care workers, in direct competition with the recruitment for workers in to disability roles. (sub. 9, p. 9)

Even if the disability sector attracts workers from the aged care sector, there could still be implications for scheme costs. For example, if the quality of aged care services falls as a result of workforce shortages, there could be a stronger incentive for NDIS participants to remain in the scheme past the age of 65 years.

The role of wages in growing the workforce

Most of the payments from the NDIS will be spent on wages, given the labour-intensive nature of disability care. While price caps will have an impact (chapter 6), this is likely to mean more money will be available for workers. From a policy perspective, the question is whether this money will be sufficient to induce more workers to provide disability supports. This depends on how competitive the disability care market is, how responsive care workers are to wages, and in turn, why people work in the disability care sector.

Analysis conducted prior to the introduction of the NDIS suggests that pay is not the primary motivation to work in disability care. For example, a study of community service employees undertaken in 2009 found that only 16 per cent of employees were attracted to work in the disability services sector primarily for the remuneration (Martin and Healy 2010, p. 135). A desire to help others and a desire to do something worthwhile were far more important motivations (nominated by 76 and 68 per cent of workers, respectively) (Martin and Healy 2010, p. 135). As put by one disability support worker:

> I love this industry. It's not about coming into work, doing an 8 hour shift and leaving. It's so much more than that. For some people we can be their eyes, their ears or their hands. (United Voice, sub. 118, p. 2)

However, there is evidence that suggests that higher rates of pay may help to retain workers in disability care roles and to attract new workers to the sector. Just over half of employees who left a disability support provider surveyed by the Department of Employment (2014, p. 17) said that they left for a position that had 'better pay and conditions', and that about 60 per cent of firms used increased remuneration as a means to improve retention. Given the ageing workforce, higher wages to keep workers from retiring may prove to be one of the scheme's strengths, notwithstanding the effects of the NDIA's price controls.

Overcoming the perception that caring jobs do not lead to fulfilling careers may be necessary to enough workers to provide NDIS supports. As noted in the *NDIS Integrated Market, Sector and Workforce Strategy*:

> To meet the increased demand for disability workers, including allied health professionals, it will be necessary to assist suppliers to promote the disability sector nationally as a career. (DRC 2015a, p. 20)

A number of study participants noted that caring roles are seen as unattractive due to the nature and remuneration of the work.

> The nature of the work of disability support staff may not in itself be attractive enough to appeal to many school leavers and those looking for a career change in later life. The work itself can be highly complex and carry significant risk, especially when supporting people with severe challenging behaviours or people with complex medical support needs. Greater provision for training support staff is vitally important at present, providers are limited in the amount of training that can be provided due to cost pressures. (Macarthur Disability Services, sub. 57, p. 8)

> The NDIA has observed over the course of trial and transition that caring jobs are often poorly valued. Common reasons cited for a lack of retention (Department of Employment survey of Personal Care Workers 2014, National Aged Care Workforce Census and Survey) include the low conditions of work and physical and emotional toll of the job. This is regrettable. (NDIA, sub. 161, p. 97)

> That caring roles are poorly [valued] is not perception, it is reality. Caring jobs are poorly valued. Pay rates are mostly minimal. Good or exceptional performance of the role is rarely valued financially. (Autism Aspergers Advocacy Australia, sub. 178, p. 26)

The longer term responsiveness of labour supply to conditions under the NDIS is hard to determine. The nature of the data makes it difficult to understand the number and hours worked by employees of disability care providers. The unprecedented scale of workforce growth required combined with a new market-based approach also mean that historical data on wages and work patterns are less useful to estimate the future. The interaction with other care sectors — especially aged care — will also important. More data will need to be collected to make meaningful wage policy when it comes to NDIS workers.

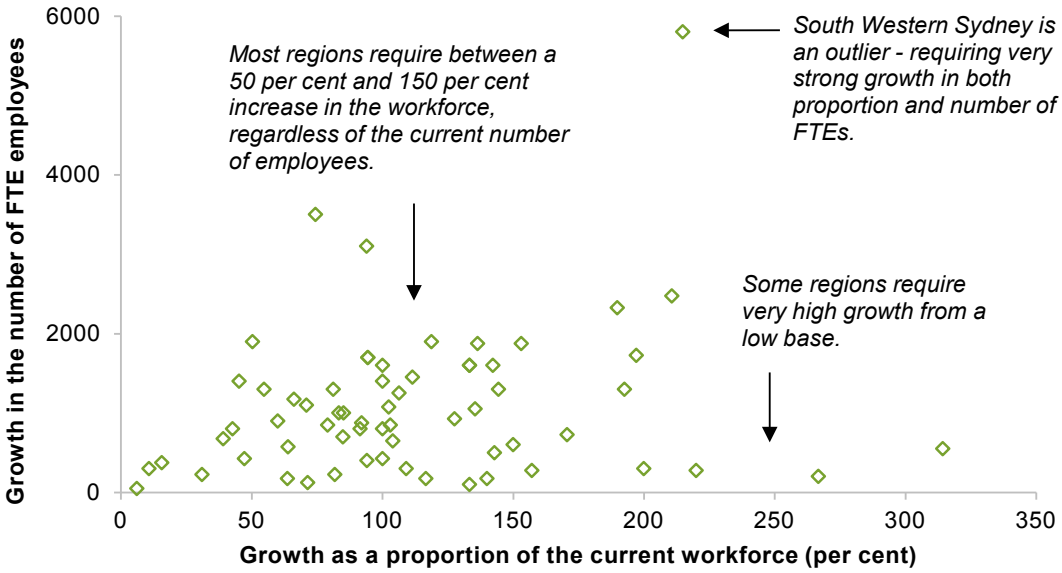
Regional challenges

The disability care workforce needs to double in aggregate, but the scale of growth required in individual regions varies between as little as 5 and over 300 per cent (figure 7.5).[35] Most regions will need to grow their disability care workforce between 50 and 150 per cent. While some of the percentage increases are large, many are based on a very low number of workers to start with. This is especially the case in rural or remote areas where a few workers can represent a doubling of the disability care workforce.

[35] Regions are groups of local government areas, which are the geographical basis for the NDIA's market position statements.

Figure 7.5 **Variation in growth required in different regions[a]**

Each dot represents the growth in the amount of FTE employees needed relative to the current situation, both in terms of the number and proportion, between 2015-16 and 2019-20.



[a] The NDIA's market position statements provide a range of estimates for the number of FTE disability workers at present and what will be needed in the future. To derive these estimates for growth, the midpoints of each range are used. No data are available for Western Australia. Regions are groups of local government areas.

Sources: Commission estimates based on NDIA (2016c, 2016p, 2016w, 2016y, 2016z, 2016aa, 2017m).

Some of the challenges associated with thin markets in remote areas are discussed in chapter 6, but it is worth noting that there are several regions within metropolitan areas where the required growth is about 200 per cent:

- South Western Sydney, where about an additional 5800 FTE workers are needed (growth of 215 per cent)
- Southern Melbourne, where about an additional 2400 FTE workers are needed (growth of 211 per cent)
- Beenleigh, where about an additional 2300 FTE workers are needed (growth of 190 per cent)
- Brimbank Melton, where about an additional 1700 FTE workers are needed (growth of 197 per cent).

These data, as published, do not capture the mix of roles within the FTE positions. For example, they do not distinguish between the hours of care provided by an in-home carer as opposed to those provided by an allied health professional. All of this emphasises the need for policies that seek to mitigate workforce shortages to have a focus at a regional

level, where different policy responses may be more appropriate across different regions and roles.

The bottom line?

The scale of workforce growth required, combined with challenges related to worker roles and regional variation, means that the NDIS workforce targets are unlikely to be met by 2020. As the Intermediate Review of the NDIS noted:

> While the NDIS had led to an increase in the supply of disability supports, the Scheme had also led to an increase in a demand for services (and particularly therapy services); NDIA staff concluded that overall, demand now exceeded supply. (Mavromaras, Moskos and Mahuteau 2016, p. 54)

The trends to date show that providers are already responding to workforce shortages by using less skilled labour. In some cases, this may compromise the quality of care received by participants and could become more widespread as the NDIS is fully rolled out. This, in turn, will reduce the effectiveness of the NDIS, compromise its insurance principles (and increase long-term costs), and in some cases, be a risk to participants' wellbeing.

It is more difficult to make an assessment of how far the workforce will develop beyond the transition given the uncertainties about how yet-to-be implemented policies will affect the supply and demand for workers (such as the implementation of the NDIS Quality and Safeguarding Framework, outcomes from future price reviews, and the implications of the NDIS's market intervention framework).

DRAFT FINDING 7.1

It is unlikely that the disability care workforce will be sufficient to deliver the supports expected to be allocated by the National Disability Insurance Agency by 2020.

7.3 What can be done to improve workforce readiness?

The challenges confronting the readiness of the workforce, if left unaddressed, could create short-term and long-term risks to the sustainability of the scheme and the wellbeing of participants. In the short term, a lack of qualified workers may mean that less qualified staff are used to deliver supports, or there will be unmet demand. This, in turn, erodes the benefits of the insurance approach over the longer term, meaning that the costs to support participants will be higher than necessary.

However, some of these challenges can be addressed relatively quickly, or alternative arrangements employed to mitigate their effects.

Getting the right balance between strategy and action

The responsibility for funding sector and workforce development was allocated to the Australian Government as part of the 2012 *Intergovernmental Agreement for the National Disability Insurance Scheme Launch* (ANAO 2016). The Department of Social Services (DSS) has responsibility for many roles in developing the disability care workforce to meet the needs of the NDIS, including: coordinating and facilitating responses to workforce shortages; coordinating with other Australian Government agencies to build workforce supply; and developing a coordinated response in particularly challenging areas — such as the demand for allied health professionals (Independent Review of the Readiness of NDIS for Transition to Full Scheme 2016).

Australian Government initiatives to foster disability care workforce readiness have focused primarily on a range of frameworks and principles that have been developed in consultation with the NDIA (table 7.2). These have been designed to provide guidance on how the workforce is to develop.

Such a strategic approach to developing a market — especially one so ground-breaking as the NDIS — was appropriate for the trial period. However, as the scheme begins to build up over the transition period, there needs to be more practical implementation of the strategic objectives, particularly to develop the workforce. Relying on strategic policies alone is leading to uncertainty among providers.

> Several strategies have been published (Assistive Technology, Rural and Remote, Market and Workforce). They provide directions but are light on implementation detail. For these strategies to inform the planning and investment decisions of service providers, they need to be underpinned by clear publicly-available plans. (NDS in ANAO 2016, p. 32)

Table 7.2 **Many strategies affect workforce development**

Entity	*Strategy*
NDIA (2013, 2016h)	2013–16 Strategic Plan and 2015–21 Corporate Plan
NDIA (2015b)	Assistive Technology Strategy
NDIA (2016x)	Rural and Remote Strategy
NDIA (2017b)	Aboriginal and Torres Strait Islander Strategy
NDIA (forthcoming)	Provider of Last Resort Strategy
NDIA (forthcoming)	Market Intervention Framework
COAG DRC (DSS 2016c)	Quality and Safeguards Framework
COAG DRC (DRC 2015a)	Integrated Market, Sector and Workforce Strategy
COAG DRC (DSS 2017c)	National Disability Strategy 2010-2020
DSS (2015)	Sector Development Fund Strategy and Operational Guidelines
DSS (2017b)	Integrated Plan for Carer Support Services

The Australian National Audit Office (ANAO), when it examined the market transition under the NDIS, found that the *Integrated Market Sector and Workforce Strategy* lacked the details necessary for the transition.

> While establishing a national approach to the market transition, the Strategy does not provide a clear basis for coordinated actions, as it does not commit jurisdictions to specific deliverables, with agreed timeframes, accountabilities and milestones. DSS advised the ANAO that 'detailed timeframes and accountabilities will likely be captured in a bilateral context going forward, recognising the unique characteristics in each jurisdiction in terms of the market and workforce.' …
>
> Further detail about how the Strategy is to be operationalised, including specific actions and timeframes, would assist stakeholders, particularly service providers who need to make investment decisions. In July 2016, DSS advised the ANAO that it intends to develop a Strategy 'action plan' for 2016-17 and into the future. Publishing this action plan, including key priorities and initiatives, timeframes and milestones, may help to address stakeholder concerns. (ANAO 2016, p. 32)

The Sector Development Fund (SDF), which is funded by the Australian Government with $146 million to support the NDIS market transition between 2012-13 and 2017-18, includes workforce development as one of its objectives. The DSS administers the SDF by allocating grants to organisations and governments to address areas of identified need. However, in its evaluation of the SDF, the ANAO (2016, p. 34) found that the approach to grant-making had not followed the objectives outlined in the strategic documents themselves, and that greater evaluation of SDF projects was necessary . More recently, funding to boost the workforce was allocated as part of the 2017-18 budget.

> The Government will assist service providers in rural, regional and outer suburban areas to provide the workforce required to meet the expected growth in the disability and aged care sectors arising from the introduction of the National Disability Insurance Scheme and an ageing population by investing $33.0 million over three years from 2017-18. (Australian Treasury 2017a, p. 145)

Some State and Territory Governments have already taken action in response to workforce concerns. For example:

- The New South Wales Government spent $5 million to supplement its 'industry development fund', which provides a range of resources for firms to transition to the NDIS and includes materials regarding workforce development (NDS 2017b; Nucleus Group 2015)
- The Victorian Government (sub. 174, p. 18) spent about $26 million (supplemented in part by the Sector Development Fund) on its *Keeping Our Sector Strong* policy, which has the goal of 'developing and growing the disability workforce over the transition to full scheme'
- The South Australian Government has sought independent advice about likely workforce needs at a more detailed level, and has provided grants as part of its *Provider Readiness Program* (SA DCSI 2017)

- The ACT Government has invested in market development, and made a number of direct grants to provider organisations, including some using SDF monies (ACT Directorate of Community Services 2016).

While it is understandable that State and Territory Governments want to address potential workforce shortages, there is a risk that fragmented workforce policies may lead to duplication or unnecessary programs at a time when the scheme can least afford it. As a union that represents many disability carers said:

> Unclear delineation of market development and stewardship responsibilities between the National Disability Insurance Agency (NDIA), the Commonwealth Department of Social Services (DSS) and the States and Territories has resulted in no substantive progress on a workforce development strategy focusing on attraction, retention, skills or quality. (Health Services Union, sub. 132, p. 4)

While the COAG Disability Reform Council has taken steps to clarify responsibilities, the Commission considers that further refinement is necessary. The 'big tent' approach to workforce development remains appropriate, but the responsibilities of different parties should be made public.

- State and Territory Governments should have more responsibility for workforce development issues over the transition period. They have the best experience of where historically unmet need has been and the approaches best suited to solve such issues in particular jurisdictions.
- The Australian Government should retain oversight of the scheme and focus on areas such as tertiary education and immigration, and how increased demand affects and interacts with other care sectors, in particular aged care.
- The NDIA is best placed to provide more information to governments in the form of actuarial and scheme data collected to provide more granular detail on where supply gaps are emerging, or likely to emerge.
- Providers should also be regularly consulted by governments about emerging workforce policy issues, such as where the incentives of the scheme may be affected by other laws and regulations, like minimum standards, conditions of State and Commonwealth awards, and training and development.

The workforce development responsibilities of State and Territory Governments will be less as the NDIA fully rolls out and replaces their existing disability support programs. However, State and Territory Governments should remain 'in the tent' when it comes to workforce policymaking given the interaction between the NDIS and other mainstream services. The Commission seeks feedback on the best way for governments and the NDIA to manage these responsibilities as the scheme rolls out.

DRAFT RECOMMENDATION 7.1

The roles and responsibilities of different parties to develop the National Disability Insurance Scheme workforce should be clarified and made public.

- State and Territory Governments should make use of their previous experience in administering disability care and support services to play a greater role in identifying workforce gaps and remedies tailored to their jurisdiction.
- The Australian Government should retain oversight of workforce development, including how tertiary education, immigration and aged care policy interact and affect the development of the workforce. In doing so, the Australian Government should pay particular attention to immigration policy to mitigate workforce shortages over the transition period.
- The National Disability Insurance Agency should provide State and Territory Governments with data held by the Agency to enable those jurisdictions to make effective workforce development policy.
- Providers of disability supports should have access to a clear and consistent mechanism to alert those tasked with market development about emerging and persistent workforce gaps.

INFORMATION REQUEST 7.1

What is the best way for governments and the National Disability Insurance Agency to work together to develop a holistic workforce strategy to meet the workforce needs of the National Disability Insurance Scheme?

An evidence-based approach to workforce policy is needed

A lack of data makes it difficult for policymakers and market stewards to properly exercise direction and support to the sector for it to develop sustainably. The existing data do not lend itself to measurements of specialisation, or differentiation of caring roles (such as between aged and disability care). Nor is it straightforward to examine labour supply and wage outcomes. This means that tasks that are simple for other industries — like identifying the response in labour supply to an increase in wages — are impossible to undertake with any degree of certainty. As the DSS said:

> A significant limitation to assessing the NDIS market readiness is the availability of market and workforce data. DRC has agreed Market Key Performance Indicators to monitor NDIS market performance and identify emerging market risks and, as the Scheme matures, will assist the NDIA with identifying risk requiring intervention. (sub. 146, p. 34)

These key performance indicators will be drawn from scheme data, which will provide a richer dataset on providers and participants. However, the nature of the data means that it will be less well suited for measuring workforce growth and gaps over the transition period

and over the longer term. The Commission considers that the evidence base on the NDIS workforce needs to be commensurate with the importance of the scheme itself.

More data need to be collected on the supply and demand of disability care workers. On the demand side, the NDIA's market position statements provide the necessary information on when and where workers will be needed, and should be updated regularly. On the supply side, the Australian Bureau of Statistics should be funded to collect policy-relevant data on the disability care workforce.

DRAFT RECOMMENDATION 7.2

The National Disability Insurance Agency should publish more detailed market position statements on an annual basis. These should include information on the number of participants, committed supports, existing providers and previous actual expenditure by local government area.

The Australian Government should provide funding to the Australian Bureau of Statistics to regularly collect and publish information on the qualifications, age, hours of work and incomes of those working in disability care roles, including allied health professionals.

There is some scope to expand the supply of carers in the short term

One short-term policy to bolster the workforce is to make better use of existing disability carers. About 20 per cent of current aged and disability care workers express a desire to work more hours, half of whom wanted to work full-time (figure 7.6). This confirms the observation made by Martin and Healy (2010, p. 146), that frontline disability care workers 'generally wanted a substantial increase of 10 or more hours' of their weekly workload.

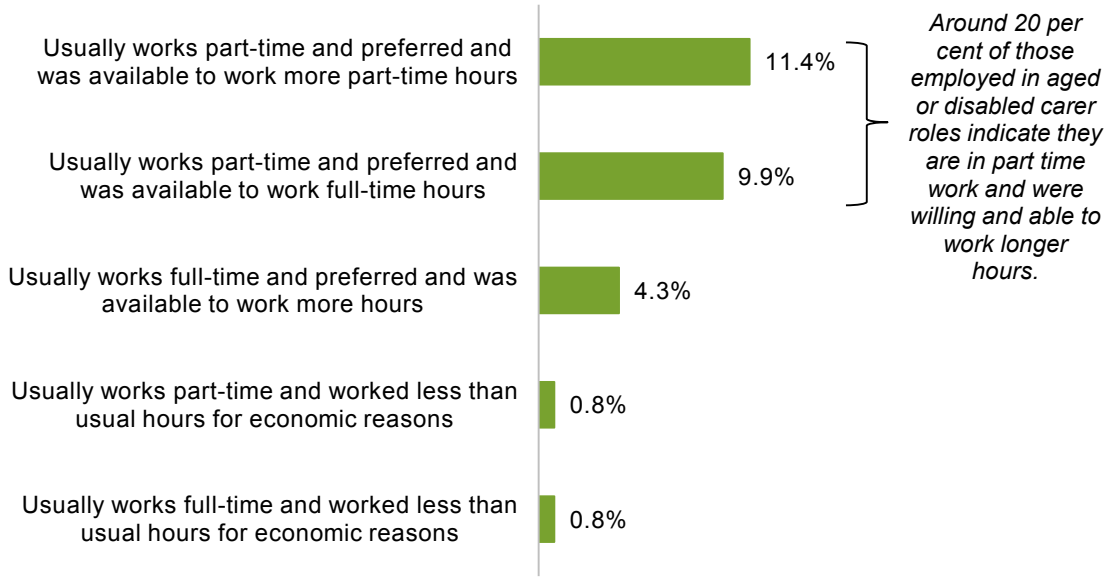
However, a desire to work more hours, does not mean an outcome of working more hours if policy settings and preferences of workers do not align. As put by the South Australian Government:

> Offering additional hours and more full time positions is an effective strategy to increase the size of the workforce, capitalising on the use of existing skilled workers and potentially offering greater security for some, particularly in the short term. However, this should also be balanced with being an employer of choice and offering flexible work arrangements to retain skilled workers in the sector. SA would therefore be interested in analysis being conducted on what level of inducement is provided by the flexibility of work arrangements that part time employment provides. (sub. 203, p. 14)

The Commission agrees, and considers that building the evidence base is key to identifying and addressing further impediments to making the most of the existing workforce. There may also be impediments to working additional hours arising from the price caps set by the NDIA, an issue that would form part of an independent pricing monitor and pricing regulator's duties to assess and respond to, if necessary (chapter 6).

Figure 7.6 **Aged and disabled carers express a desire to work longer hours[a]**

Per cent of aged and disabled carers, based on ANZSCO definitions, 2016



[a] Residual are those who are not underemployed (about 72 per cent of aged and disabled carers). 'Economic reasons' include being stood down or there not being enough work available.

Source: Commission estimates based on ABS (*TableBuilder,* Education and Work, May 2016).

Some informal carers may be able to provide additional care

Workforce shortages will mean that some people with disability will have to continue for some time yet to rely on their informal carers. But there are three constraints on informal carers providing additional hours of care:

- declining ability to care (especially in the case of ageing informal carers)
- other commitments (such as paid employment, or the need to engage in paid work)
- lack of respite.

In terms of the first point, and as mentioned above, the increasing age of informal carers means that there will be many carers who are unable to provide additional care. The most striking example are ageing parents of adult children with disabilities. Many ageing parents contributed to this study (box 7.3). It is clear that their capacity to offer additional care is extremely limited, and should not be relied upon.

Box 7.3 Many parents are currently the 'provider of last resort'

Rosa Miot:

> The NDIS is crucial to my future. I have a 40 year old daughter with an intellectual disability. I have been her full time carer all of her life. … However, I am now 70 years old and I will need the NDIS to provide her with the ongoing supports she will need to be able to remain living in the community as she has done all her life. I would like to be able to concentrate on my own life and health needs and not be overburdened with the caring role. (brief sub. 134)

Evelyn Ware:

> My husband and I are 89 and 82 years old respectively and have a daughter aged 55 with autism and intellectual disability. Although living in the community she requires a considerable amount of support with budgeting, health matters, cooking and general management of her life. … once we are unable to provide the assistance we are now providing she will need to have more support from NDIS, or go into supported accommodation as her disability prevents her from living independently in the community. (brief sub. 137)

Pat van der Beek:

> Our intellectually disabled son is 41 years old this year and my husband and I are 73 and 72 respectively. When the NDIS rolls out in our area in July, we are hopeful that we will have additional resources to enhance his life. His siblings are busy with their own families, careers and lives in general and there is no certainty that they will be able (or willing) to provide the necessary support for their brother when we no longer can. … While we are currently both in reasonable health, there is obviously no guarantee this will continue; inevitably, our son will be without our support in the later years of his life. … We have genuinely done our utmost to give him the best possible life to this point and welcome the introduction of the NDIS which we hope will enhance his future while also lifting some of the responsibility from our shoulders. (brief sub. 70)

However, for others the constraint is less to do with ability and more to do with the forgone wages that caring entails. Alleviating these constraints may allow informal carers to support family members with disability for longer and more intensively.

The simplest option is to allow the payment of informal carers through NDIA-managed plans. The NDIA's operational guidelines do not allow family members to be paid as carers except in exceptional circumstances. Specifically, the NDIA (ndd) 'will not fund a family member to provide personal care or community access supports unless all other options to identify a suitable provider of supports have been exhausted'. In practice, this has been interpreted to mean that family members who are paid to provide supports do not reside at the same location as the participant (NDIA 2014b, p. 5; Queensland Advocacy Limited, sub. 115, p. 15).

Due to slower than expected workforce growth, the Commission considers that it is appropriate for the guidelines concerning payment for informal care to be relaxed over the transition period for core supports (as these supports are critical to the wellbeing of a participant). Specifically:

- any requirement that the paid informal carer not reside at the same location as the participant should be removed

- the need to 'exhaust' all options to identify suitable providers should be more clearly defined, and linked to the NDIA's own data about the number and nature of providers in a region.

It is appropriate for such supports provided by informal carers paid by the NDIS to be reviewed regularly in light of market development, as well as issues about quality, safety and the longer-term objective of the scheme to relieve the burden on informal carers. There are also potential benefits for those in thin markets, including for Aboriginal and Torres Strait Islander participants where a greater use of informal carers could be more culturally appropriate in some circumstances.

> Peak representative group the First People's Disability Network argues there is an existing workforce in many Aboriginal and Torres Strait Islander communities because family members provide support informally. Giving resources to people already providing informal support may help fill capacity gaps in a culturally appropriate way. Additionally, area or community-based cooperatives could be used to develop capacity in Aboriginal and Torres Strait Islander communities. (AONSW 2017, p. 15)

A separate price for the supports provided by informal carers should be determined by the body tasked with setting prices for NDIS supports (chapter 6). It could reflect the opportunity cost of wages or welfare payments forgone, but should, generally speaking, be lower than that of the base hourly wage set in the NDIA price list for formal carers. The methodology used to determine the carers payment could also form a basis for setting the price of supports provided by informal carers.

There remain some administrative difficulties. Carers employed by participants are subject to the same laws about superannuation, occupational health and safety, industrial relations and workers compensation insurance. These arrangements should be the responsibility of participants and their families.

DRAFT RECOMMENDATION 7.3

The National Disability Insurance Agency's (NDIA) guidelines on paying informal carers who live at the same residence as a participant should be relaxed for core supports for the period of the National Disability Insurance Scheme (NDIS) transition. Such payments should be:

- accessible under clearly defined and public guidelines, which make reference to worker shortages in the relevant market using the NDIA's information about providers and supports in the participant's region
- set at a single rate determined by the NDIS price regulator in a transparent manner
- reviewed by the NDIA as part of plan reviews.

Respite plays an important role in facilitating informal care

Respite services can also help informal carers care for longer. A number of submissions to this study argued that respite services are not well catered for in NDIS supports. Specifically:

- the prices for short-term accommodation under the NDIS, which is used for respite, are too low to be sustainable (Cerebral Palsy Alliance, sub. 163, att. 1, p. 4) — an issue of price caps set by the NDIA for some supports (discussed in chapter 6).
- there is a lack of respite supports for family members (Carers Australia Victoria, sub. 131, pp. 37–38).

The shift towards participant-driven demand means that there are few avenues for informal carers to be assured of respite care. For informal carers to receive NDIS-funded respite care, it must form part of a participant's plan. While this maximises choice and control for the participant, it can lead to inappropriate levels of support for informal carers (National Mental Health Commission, sub. 153, p. 4), especially as some block-funded supports for carers are withdrawn. As Anglicare Sydney said:

> … carer needs and supports are not formally recognised as part of NDIS packages. There is no formal assessment of the needs of the carer, no funding package for the carer and no guarantee of involvement in the assessment of the care recipient's needs. … With the closure of carer-specific support services, Anglicare is concerned that carers will no longer receive the same amount of support, let alone improved levels of support, under the new system. (Kemp et al. 2016, p. 10)

The supports for respite under the NDIS are made up of several different options, most of which place a cap on the number of respite days provided per year. These caps have attracted criticism, with some providers claiming that they make the provision of respite services commercially unviable, including for participants with particularly complex needs or challenging behaviour (Cerebral Palsy Alliance, sub. 163, att. 2, p. 1). Some families also indicated that the respite offered in plans is insufficient (Carers ACT 2015, pp. 1–3).

Broader support for carers, including information and linkage about respite, is also to be provided under the DSS' *Integrated Plan for Carer Support Services*, which is yet to be fully implemented. A gap is emerging for respite services both within and outside the NDIS as the scheme transition occurs.

A lack of respite may mean that informal carers are unable to support family members and friends who are NDIS participants. This, in turn, will require more formal and costly supports in their place. It was for this reason that the Commission in its 2011 *Disability Care and Support* inquiry recommended that the needs of carers be considered as part of a participant's individualised supports (PC 2011, p. 340).

However, it is less clear whether a quantity cap (as well as a price cap) for respite services is warranted, and whether it is in the best interests of participants, providers and the

community over the transition period of the scheme where *all* carers are needed. The Commission is seeking further information on these issues.

INFORMATION REQUEST 7.2

How has the introduction of the National Disability Insurance Scheme affected the supply and demand for respite services? Are there policy changes that should be made to allow for more effective provision of respite services, and how would these affect the net costs of the scheme and net costs to the community?

Greater use of skilled migration has costs and benefits

While reducing underemployment for general care workers may bolster supply of some workers, there is practically negligible underemployment in allied health professions.[36] For such workers, the long lead time to train them means that shortages could persist over the shorter term, and potentially beyond the end of the NDIS transition period.

An option to meet a shortfall in the short-term is to make greater use of skilled migrants, which was proposed by the Commission in its 2011 inquiry (2011, p. 721). The Commission considers that the existing policies and regulations for using skilled migrants is appropriate to meet the needs of the NDIS over the transition period, if required.[37] The flexibility of using staff employed on visas over a few years is also of value to the scheme, as participants may have changing preferences over a similar time period.

That said, it should be recognised that using skilled migrants is not an immediate solution. Like any new worker, there is a period of on-the-job training required to become proficient in providing services, and in the case of allied health, it will still be necessary for sufficient mentoring to occur. These issues touch directly on setting the appropriate prices for supports over the transition period to enable a sufficient margin for such training to occur — an issue for the independent price regulator discussed in chapter 6.

36 Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2016).

37 Commission estimates based on ABS Census data from 2011 indicate that about 10 per cent of those working in a group of allied health professional occupations (based on the ANZSCO classes relating to dieticians, optometrists and orthoptists, health therapy professionals (not further defined), occupational therapists, physiotherapists, podiatrists, speech professionals and audiologists) were born overseas and arrived in Australia after 2000, suggesting that avenues for skilled migration are possible. Analysis by the ABS found that the second most commonly reported industries of Skilled Program migrants' employment was in the Health Care and Social Assistance industry division, which includes carers and some allied health professionals (ABS 2010). It is too early to tell if recently announced changes to skilled migration visas (Dutton and Turnbull 2017) may impact on this flexibility.

Not all participants to this study agreed that greater use of skilled migration is an appropriate approach to workforce shortages. For example, Allied Health Professions Australia, while agreeing that skilled migration is one way to increase the number of qualified allied health professionals, said that the time spent to acclimatise skilled migrants to Australian conditions was as intensive as training someone locally.

> … skilled migrants are unlikely to be familiar with local health and social systems and services and may not have specialised skills as required to provide appropriate support to many participants. As a result these skilled migrants are likely to have skills and knowledge at a level that is closer to entry level allied health professionals and requiring mentoring and support. Experience suggests that significant time is required for overseas-trained graduates to learn to navigate the complex interaction of systems and understand the various parties involved in providing support. These factors mean that there will need to be significant investment to ensure that skill[ed] migrants can provide services of equivalent quality and AHPA [Allied Health Professions Australia] submits that it may be more effective to pursue alternatives such as incentivisation of Australian graduates and other workers. (sub. 37, p. 18)

The Commission considers that the time taken to train someone to understand Australian conditions is likely to be shorter than the time taken to achieve the formal qualifications to practice in the first place. This is particularly the case in the transition stage, when the time to train new staff is limited.

Another objection raised was in relation to the precarious nature of skilled migration visas, and that it should not be viewed as a substitute for training local workers. As put by the Australian Services Union and the Disabled People's Organisations of Australia:

> Any migrant worker scheme for the NDIS should provide permanent migration and only be considered after there has been local labour market testing. The NDIS provides a significant opportunity to address high levels of unemployment for many people, including people with disability. While we do not support a precarious, exploitative 457-style visa scheme for NDIS workers, we do support the development of a comprehensive workforce plan to retain and attract new workers locally. (sub. 198, p. 2)

The Commission agrees that skilled migration is a policy response that should focus on meeting the shortfall in specific roles (rather than as a general measure to address all shortages), and considers that more clearly delineating workforce development responsibilities among governments would provide a better platform to train and develop local workers. However, given the risk of shortages in the transition period, greater use of skilled migration appears to have more benefits than costs at present. As previously put by the Commission:

> Overall, the role of immigration as a source of labour must balance the impacts on wages and other strategies for eliciting domestic supply of workers, and the reality that significant labour shortages are still likely, especially during the rapid growth in disability supports during the establishment phase of the NDIS. In that vein, immigration should mainly address acute and persistent shortages. (2011, p. 720)

What remains to be seen is whether the shortfalls persist over the longer term, which is when further review and consideration should be given to changes to workforce

development and immigration policies. This could be facilitated as part of the expected future reviews of the NDIS, including the regular reviews by the Joint Standing Committee on the NDIS.

New technology may reduce demand for workers

A number of submissions to the study indicated that greater use of technology could reduce the need for some disability care workers, and so mitigate a potential shortfall. Understanding the extent that technology could be 'labour-saving' is difficult: the market for disability supports is undergoing major change, and what NDIS participants will demand is still unclear. That said, there is a range of emerging technologies that could significantly reduce the need for workers. As put by the NDIA:

> Technology may reduce the need for formal and informal care as innovations allow participants to partake in more daily living tasks:
>
> - Incorporating smart design into Specialist Disability Accommodation has the potential to reduce reliance on person-to-person supports. For instance, smart alert systems may enable participants to operate their homes better without or with less assistance;
> - The expansion of innovative transport services such as car-sharing into accessible transport options may provide more efficient ways for people with disability to access modified vehicles compared to private ownership; and
> - Creating communities of support and effective use of telepresence technologies for the delivery of paid supports may assist informal carers to maintain and develop their care with the reassurance that they can seek advice or assistance when needed. Communities of support may also help reduce the expectation that therapy/ interventions can only be undertaken in a clinic or practitioner's premises and thus support the NDIA expectation of a diverse workforce.
>
> Appropriate use of assistive technologies (including suitable monitoring/ alert systems) can reduce dependence of participants on carers for routine tasks and appointments (e.g. getting a drink or going to the toilet), and permit care and interventions to target activities or periods that require skilled human input (e.g. preparing a meal or intervention to manage a period of muscle spasm).
>
> Technology advances and innovation in service sectors similar to the disability support sector demonstrate potential future uses of technology:
>
> - Evidence from dementia research has shown that appropriate use of location triggered alerts/alarms can enable greater freedom for people who may wander, without increasing (even lessening) the burden on carers. Similarly, such technologies can also offer protection for carers dealing with participants out of hours or with at risk behaviours; and
> - Recent reports on the use of robot monitors in homes of the elderly to predict falls. While this particular instance is in an aged care setting, there are clearly applications in this technology applicable to disability support services. (sub. 161, pp. 98–99)

Other participants highlighted the values of providing care remotely through 'telepractice' (Allied Health Professions Australia, sub. 37, p. 17; The Shepherd Centre, sub. 107,

pp. 14–15; Speech Pathology Australia, sub. 136, p. 47), which reduces the need for service providers to travel.

Given the scheme is in the early period of transition, it is difficult to tell what technologies will emerge and what effects they will have on the need for workers. The Commission will examine these issues, as well as other impediments to participants making the use of emerging technologies, including issues about internet access and access to telepractice supports in NDIS plans in preparing the final study report.

8 Participant readiness

Key points

- How ready participants are to make the most of their National Disability Insurance Scheme (NDIS) plan will depend on a number of factors, including: an individual's capacity; their network, informal carers and peers; the assistance provided under the NDIS; how ready the market is to provide supports; and the complexity of the scheme.
- Some participants (as well as their carers and families) are finding the NDIS difficult to understand and interact with, particularly in the context of the scheme being a new way to allocate and supply disability supports. Some transitional issues are also making it harder for participants to navigate the scheme.
  - If participants are unable to interact well with the NDIS, then the benefits of the scheme will not be fully realised. This has consequences for the lives of participants and the financial sustainability of the NDIS.
- Supports are provided to some participants to increase their capacity to navigate the scheme and implement their plans — including through support coordination, which makes up about 4 per cent of committed supports (for plans after 30 June 2016). There may be ways to improve the efficiency of support coordination, including through complementary actions directed at building participant readiness.
- The National Disability Insurance Agency is currently responding to participants' concerns about the online portal (through which participants manage and organise payment for supports). It is also developing the eMarketPlace to provide timely information to participants to help them find and purchase supports from disability support providers. The eMarketPlace is critical to supporting participant decision making.
- Intermediary services, which can help participants manage different elements of their plans, can also help to reduce the transaction costs and complexity of the scheme for participants. At this early stage of the scheme rollout, the extent of any barriers to entry for intermediary services is unclear, as well as whether additional safeguards are required to regulate their operations.

The readiness of participants to make the most of their National Disability Insurance Scheme (NDIS) plan is key to the success of the scheme. Understanding how ready participants are to enter the NDIS; to get the plans that they need; to find their supports; and, if they desire, to self-manage their own affairs, is directly linked to the intended outcomes of the scheme.

Participant readiness also has a direct bearing on costs. If people with disability are unable to navigate the scheme, this will lead to lower participation in the scheme and underutilisation of supports. Both outcomes will reduce scheme costs in the short term, but may lead to higher costs (both inside and outside of the NDIS) over the longer term.

This chapter examines participant readiness by looking at how readiness to navigate the NDIS can be considered, and the supports available to participants to assist them to use the scheme (section 8.1). It then discusses options for improving participant readiness (section 8.2). Issues relating to participant engagement in the planning process are discussed in more detail in chapter 4.

8.1 What is participant readiness?

Participant readiness should be considered in the context of the changes that the NDIS is driving for people with disability. Participants are moving from a scheme where they had little choice and control over their supports to a new system, where they have greater opportunities to exercise choice and control. While this empowers participants to take greater control of their lives, it also brings with it challenges that they may have never faced before. This includes: thinking about the best way to achieve their goals; shopping around for providers; and managing more administrative and financial tasks than previously. And they must do this while the scheme is still rolling out and as the disability support market is changing. A study participant said that:

> Telling people they have choice and control, does not give them the skills to find appropriate service providers, which are much harder to find when they are full and simply tell people to go somewhere else if they are not happy with something. There is no information anywhere on how people can choose providers, what to look for in them, the sorts of questions to ask and what sorts of things you might want to consider. Equally when providers are all full, then what options are there. (Belinda Jane, sub. 80, p. 10)

There will be some degree of 'learning-by-doing' as participants spend more time in the NDIS and become more accustomed to the scheme. But at this point in time, it is clear that participants need help to become well-informed consumers who are able to make decisions that provide cost-effective outcomes. This was recognised by the COAG Disability Reform Council.

> … many people with disability will not have had the opportunity to exercise choice. Some people with disability may require additional support to effectively exercise informed choice, especially those with high and complex needs. (2015a, pp. 14–15)

Broadly speaking, there are two main aspects to participant readiness:

- the capacity of participants (and informal carers who they may have to assist them) to navigate the NDIS — including their ability, willingness, skills and resources
- the complexity of the NDIS — including interactions with the National Disability Insurance Agency (NDIA), Local Area Coordinators (LACs) and providers to secure and purchase supports. The more complex the scheme, the more skills that participants require to engage with it.

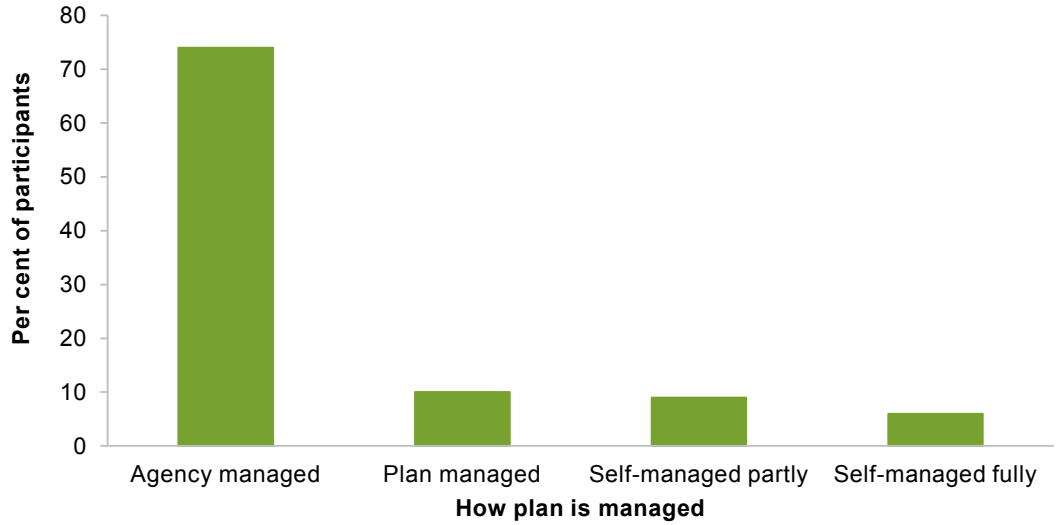
As such, there are two levers that can be used to improve participant readiness: developing the skills (and capacity) of participants, and reducing the complexity of the scheme. While

both approaches have costs and benefits, they are not mutually exclusive, but interdependent and complementary.

What assistance is there for participants?

NDIS participants have access to a range of resources to help them navigate the scheme, and to exercise choice and control over their disability supports. Participants have a range of options in relation to managing their plans (box 8.1). Most participants in the transition period to date have chosen to use a NDIA-managed plan, rather than using a third party or managing their plans themselves (figure 8.1).

Figure 8.1 **How NDIS participants are managing their plans**
For participants joining the scheme between 1 July 2016 and 31 March 2017



Source: NDIA (2017o, p. 21).

Box 8.1 Managing the funding for supports under a participant's plan

The *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act) allows a participant to choose how to manage their funding for supports. Management of funds is defined as:

- purchasing the supports identified in the plan (including paying any applicable indirect costs, such as taxes, associated with the supports)
- receiving and managing any funding provided by the Agency
- acquitting any funding provided by the Agency (s. 42(1)).

A participant with an approved plan (or one that is being prepared) may make a request that funding be managed wholly, or to a specific extent, by one of the following:

- the participant — this is known as 'self-management'
- a registered plan management provider nominated by the participant
- the National Disability Insurance Agency (NDIA)
- the plan nominee nominated by the participant or the CEO of the NDIA (ss. 42(2) and 43).

The NDIS Act does not permit self-management of funds in some circumstances, including when:

- the participant or the plan nominee is an insolvent under administration (s. 44(1))
- self-management would present an 'unreasonable risk to the participant' (s. 44(2)(a)). This is prescribed by the *National Disability Insurance Scheme (Plan Management) Rules 2013* (Cwlth), which includes a range of factors relating to the participant's legal capacity and decision-making ability that the CEO of the NDIA must consider in making the determination (s. 44(3)(a), rr. 3.7 and 3.8)
- the NDIS Rules have prescribed matters that must not be managed by a participant (s. 44(2)(b)).

If a participant does not make a plan management request, the plan is to be managed by the registered plan management provider specified by the NDIA, or by the NDIA itself (s. 43(4)). If this occurs, the CEO of the NDIA 'must, so far as reasonably practicable, have regard to the wishes of the participant in specifying who is to manage the funding for supports under the plan' (s. 43(5)).

General assistance is available for all participants

General assistance to implement and manage a plan is available for all NDIS participants, including via LACs, Information, Linkages and Capacity Building (ILC), and plan managers (sometimes referred to as intermediaries).

LACs link participants to the NDIS, and to information and support in the community. They also work with the local community to make it more inclusive for people with disability. LACs can also help participants understand the NDIS and implement their plan. This involves helping participants to:

- find and start receiving the supports that they need

- self-direct or self-manage their plan
- find mainstream and community services.

However, LACs are still being rolled out. The nature of their services also means that they assist participants with less complex needs (NDIA, sub. 161, p. 107).

ILC-funded projects focus on community inclusion, and making sure that the community becomes more accessible and inclusive for people with disability. This includes:

- personal capacity building — making sure that people with disability and their families have the skills, resources and confidence that they need to participate in the community, or access the same kind of opportunities or services as others
- community capacity building — making sure that mainstream services or community organisations become more inclusive of people with disability (NDIA 2017h).

ILC was not part of the NDIS trial period, but will be progressively rolled out across the country (chapter 5). The NDIA has provided grants to organisations to carry out activities in the community, with further funding rounds open in the second half of 2017 (NDIA 2017h).

Participants can also choose to use an external plan manager for some or all of their supports. A plan manager can take on a range of different tasks for the participant, allowing the participant to effectively 'outsource' the tasks that they feel least comfortable with managing, and in turn, reduce the administrative burden on participants. For example, plan managers can coordinate payments between the participant, provider and the NDIA, but participants retain choice and control over their supports. Plan managers can also take a larger role, such as searching and securing providers to meet a participant's needs — effectively acting as an agent for the participant.

Specialised support coordination is available for some participants

Some participants, including those with complex needs or less capacity to actively manage their affairs, can receive a range of 'support coordination' items as part of their plan. These include: support connection; coordination of supports; participant training in planning and plan management; and specialist support coordination. Support coordination is determined in the same way as any other support in a plan — based on what is reasonable and necessary for the NDIS to provide in meeting a participant's needs or goals.

In practice, support coordinators provide more intensive assistance to help a participant understand their plan, and to help them choose and connect with providers — effectively a more personalised and in-depth service than what LACs would provide (NDIA ndc, nde). Between July 2016 and March 2017, about 55 per cent of scheme participants had some funding for support coordination included in their plans (NDIA 2017o, p. 21).

Other groups can also provide assistance to participants

While LACs, ILC, plan management and support coordination are all provided under the umbrella of the NDIS, there are other groups and representatives who can offer assistance to NDIS participants. These include Disability Support Organisations (DSOs) and peer support groups, advocacy organisations, and trustees. These groups currently play, and will continue to play, an important role in assisting participants and their families to make the most of the NDIS.

DSOs are community organisations that facilitate disability peer support groups, which allow scheme participants and their families to share their experience, information and knowledge with others about issues associated with disability and the scheme (including helping people think about their goals and the supports that they might need). Peer support groups can also provide information on how best to find and arrange supports, and connect with community activities.

Funding through the Australian Government's Sector Development Fund was allocated to 18 DSOs to facilitate up to 20 peer support groups over the life of the project (NDIA 2015c, p. 80). However, peer support groups are also forming naturally (without funding) as the NDIS rolls out (for example, the Mental Health and NDIS Facebook Support Group (sub. 8)).

Advocacy for people with disability (including NDIS participants) can be defined as having an independent person (without a conflict of interest) directly speaking, acting or writing on behalf of the interests of an individual or group. There are a number of different models of disability advocacy, including:

- systemic advocacy — this is aimed at bringing about systematic improvement in policy and practice, and removing discriminatory barriers for people with disability
- individual advocacy — this involves upholding the rights of individuals with disability by working on discrimination, abuse and neglect (DSS 2016b, p. 2).

Advocacy may extend to helping participants find supports; however, it is currently not funded through the NDIS, but shared between the Australian,[38] and State and Territory Governments (except for South Australia). There are also a small number of disability advocacy organisations that are not funded by government (DSS 2016d, p. 2). The Department of Social Services (DSS) is currently reviewing what an updated National Disability Advocacy Program should look like, and how it should work (including funding) in a NDIS environment (DSS 2016d, p. 2). To reflect this, the COAG Disability Reform Council's terms of reference was recently amended to include a review of

[38] National Disability Advocacy Program (NDAP) agencies based in the NDIS sites may have additional roles, such as assisting people through the planning and internal review processes with the NDIA. Australian Government funding has been provided via the NDIS Appeals program to support people with disability who seek an external review of the NDIA's decisions through the Administrative Appeals Tribunal. Funding to current providers of the NDAP has been extended until 30 June 2018 (DSS 2016b).

advocacy arrangements, including roles and responsibilities, by 31 October 2017 (COAG 2017, p. 3).

Trustees can also help participants manage their affairs. For example, public trustees, established by State and Territory Governments, aim to ensure that all members of the community (including people with disability) have access to financial management services in the event that their capacity to make decisions is affected. Public trustees can make decisions on behalf of the person with disability in the best interests of that person (known as 'substitute decision making'), taking into account their needs and views. The *National Disability Insurance Scheme Act 2013* (Cwlth) also allows the CEO of the NDIA to appoint a public trustee as a participant's nominee in order to make decisions on planning and actioning supports.[39]

Navigating the NDIS is difficult for some participants

Some scheme participants are finding it difficult to understand and interact with the scheme, and to exercise choice and control over their supports. Study participants said that they are finding it difficult to understand plans; find, negotiate and coordinate supports with providers; and seek assistance from the NDIA when problems occur.

Study participants mentioned problems with clear communication of the participant pathway in particular. This partly reflects the changing nature of the disability support landscape. Under the previous system, NDIS participants who had access to support programs (typically block-funded) often relied on providers to be the 'first port of call' to seek remedies or changes to services. Under the NDIS, participants now have a range of options to seek information or clarity — including approaching a LAC or the NDIA itself. A lack of fit-for-purpose information means that confusion continues to arise among participants, and that burdens are still being placed on providers.

> There needs to be much more focus on communicating clearly and simply with clients. For instance, at the moment, plans are vague and written in 'government speak'. If the government is concerned about clients overspending, the NDIS needs to give clients clear information on what their funding is for and clear conditions under which it can be spent. (Angela Blakston, brief sub. 168)

> If anything has characterised the NDIS to date it is poor communications performance. It has failed to communicate changes in the Scheme as it has been rolled out to potential participants. Its communications have frequently been heavily jargonised and pitched at a very high level. Even people whose job it is to understand NDIS developments and operations often struggle with exactly what is being communicated. In some cases the NDIA has been successful in

[39] This process is one that is still relatively underutilised, but there are some concerns that nominees may have a narrower ability and responsibility compared to what a public trustee would ordinarily be able to do in the interests of the beneficiary. The Australian Law Reform Commission and participants in this study also noted that there may be a conflict in the duties required of a nominee as defined in the *National Disability Insurance Scheme Act 2013* (Cwlth), and relevant State and Territory legislation (ALRC 2014, pp. 151–152; Financial Services Council, sub. 98, pp. 4-5), but this is yet to be tested in court.

> making elements of the Scheme intelligible to consumers; for example, in a number of their plain English guidelines to supports available under the NDIS. This approach needs to be incorporated into all communications with participants, their carers and providers. (Carers Australia, sub. 195, p. 22)

The time spent by providers in assisting participants and their carers to navigate the complex system is significant, but are often 'unbillable hours' of support. Participants and their carers indicated that they are not able to obtain helpful advice from the Agency or LACs (Macarthur Disability Services, sub. 57, p. 9). The NDIA acknowledged that:

> People with disability and their families and carers have reported that there is continued difficulty in understanding the NDIS and the process of moving through the [participant] pathway. (sub. 161, p. 107)

Reflecting the complexity and variation of needs and circumstances among participants, some participants will be more ready than others. This, in turn, partly reflects the extent of help that they received under previous disability support arrangements. For example, one study participant said that:

> I don't think I will have trouble utilising my plan, because I am overdue some support and will fully appreciate the value of NDIS funding. I've done my research and I know what's available in my area; however, I appreciate that I live in a city area where there is choice of providers and my needs will not be difficult for me to articulate and negotiate around. (Name Withheld, sub. 5, p. 1)

Another study participant commented that:

> As a now plan-managed NDIS participant I find it even harder, if anything, to manage that additional layer of administrative burden and all I really want to do is to go back to the good old days when the MS [Multiple Sclerosis] Society told me what I want and needed and provided it at a reasonable cost. … there are many benefits to it, including being able to shrug off the burden of managing your costs and choices with a reasonably low level of bureaucratic rigidity. In the meantime … I am an 'under-utilisation' risk to the NDIS, with the immediate threat of having my unused funding cut back — not because I don't want and need the features these choices provide, but because I can't get organised to utilise the promised benefits and it's easier to blow my budget RIGHT OUT than navigate the NDIS' portal … (Kirsty Magarey, sub. 150, p. 4)

8.2 How can participant readiness be improved?

The balance between support coordination and other assistance

It was recognised before the implementation of the NDIS that it would be necessary to build the capacity of participants to interact with the scheme.

The NDIA recently implemented a 'participant pathway', which includes additional funding for those participants with less capacity to navigate the scheme.

> The NDIA has designed the participant pathway to include support for participants during the planning and implementation phases … In the implementation phase, the NDIA provides LACs for those with less complex needs and funding for support coordination for the intensive participant groups. … The NDIA has also identified that there is a need for work in the support coordination sector, particularly in some cohorts such as where participants have challenging behaviours, rural and remote areas and where there are gaps in mainstream services that the NDIS cannot fill. Work continues to educate support coordinators on the capacity building role expected of their function which is designed to build the skills of individuals over time to make support decisions themselves. (NDIA, sub. 161, p. 107)

Support coordination is an element of the participant pathway, which is the key means to bolster the readiness of participants with *complex* needs. However, study participants said that there is confusion about the role of support coordinators, and that it is not clear whether they are effective in helping scheme participants find providers, nor whether they are being allocated to the participants who most need such supports.

> We need a step by step guide. A clear list of who is who and who does what. What the heck is a support coordinator and what exactly can they achieve in an hour a week? … Especially at the start of a plan, [a] support coordinator needs to be much more active. (Cheryl McDonnell, sub. 79, p. 3)

> There has been a lack of clarity and guidance around the function, allocation and use of support coordination funding … Providers also report a wide variation in the quality of the support provided. (Early Childhood Intervention Australia Victoria/Tasmania Limited, sub. 129, p. 11)

While it is too early to evaluate the efficacy of support coordination, there is some evidence to suggest that it does help those who receive and use it. For example, participants who are allocated and use support coordination have higher rates of utilisation (the ratio of used to committed supports in a plan) on average than those who are allocated, but do not use, support coordination. While many factors affect a participant's readiness to navigate the NDIS and decision to use supports provided in plans, at face value, this suggests that support coordination does help build a participant's capacity.

Support coordination funding has been significant over the transition period to date. About 4 per cent of committed supports in participant plans after 30 June 2016 have been allocated to support coordination (figure 2.9). If the same proportion were applied to total scheme costs in 2020, then this suggests that support coordination could cost around $900 million each year. (This would assume, however, that support coordination is fully utilised to the same extent as other committed supports, which is not the scheme experience to date.)

Effective support coordination is important to both deliver participant outcomes and contain scheme costs. The Commission is seeking feedback on both possible improvements to support coordination, and any complementary actions that may make support coordination more efficient.

INFORMATION REQUEST 8.1

Is support coordination being appropriately targeted to meet the aims for which it was designed?

How can scheme complexity be reduced?

The Commission received a lot of feedback about the complexity of the NDIS. The two main areas of concern were:

- participants finding providers
- participants (and providers) understanding and using the online portal where plans and payments are managed (box 8.2).

The rapid rollout of the NDIS has led to a number of transitional issues, including the implementation of the online portal. A review of the portal found many shortcomings in its implementation, mainly stemming from the speed of the rollout (PwC 2016). The NDIA said that it accepted the recommendations of the review and is addressing the portal issues.

> Significant difficulties with the implementation of the new ICT system in July 2016 adversely impacted on both participants and providers and caused a loss of community confidence in the NDIA's administration. An assessment of the failures from July 2016 have been documented in the PricewaterhouseCoopers *NDIS MyPlace Portal Implementation Review*. The NDIA accepts the broad thrust of those findings and has now implemented, or is the process of implementing, all of the recommendations from that report. (sub. 161, p. 15)

Given the NDIA's commitment to address portal issues, the Commission has made no finding or recommendation on this matter. However, as participants (and providers) rely heavily on the portal to manage supports and payments, it may be appropriate to examine the operation of the portal in future reviews of the NDIS, as well as closely monitor any issues with the portal to improve accessibility for scheme participants.

Box 8.2 Problems using the NDIS online portal

Syndromes Without A Name Australia said that:

> The portal has a number of plans on it if the plan has been reviewed, causing confusions for clients. The headings are not the same as what is written in the plan, leading to interpretation errors. The portal crashes a number of times and the dates need to be entered a certain way. Some days the portal works better than others. There is no form on the MyGov tab or NDIS website to ask for a correction if you accidently upload a payment request to the wrong category. One family is still waiting 6 weeks later to hear from NDIS re: this issue, after submitting an enquiry regarding this. As there is no way to upload receipts, the portal uploads are open to exploitation. (sub. 86, p. 2)

Mental Health Community Coalition ACT said that:

> Service Providers are often placed in the unenviable position of having to help participants use the MyGov website in order to use their NDIS plans, including by entering passwords – technically this is breaking the guidelines of use, possibly the law. (sub. 135, p. 28)

Summer Foundation said that:

> The current administration of the NDIS creates a high barrier for participation by individuals with complex needs. Young people in RAC [residential aged care] typically have few informal supports and many have cognitive impairment. Most don't have ready access to a computer and/or are not able to navigate the Internet, both of which are required to activate plans and to find and negotiate supports with providers … More accessible and flexible approaches to delivering information and building the capacity of people with disabilities and their families are desperately needed (sub. 113, p. 25)

Timely and useful information can minimise transaction costs for participants

While a functioning portal is important, participants also need information about providers. As the Prader-Willi Syndrome Association of Australia said:

> NDIS participants must have access to information about the performance of providers (e.g. number of complaints against them, participant's budgets running out too early, etc.). (sub. 112, p. 6)

Information that helps participants to exercise informed choice and control can emerge naturally from private sources, such as online comparison sites, connecting services and peer support groups for disability supports. There is evidence that this is already occurring, but the extent is unclear. Some providers also indicated that they will provide more information to participants to make choices (Australian Orthotic Prosthetic Association, sub. 123, p. 8).

That said, the NDIA's role as a market steward means that it has a responsibility to provide information about providers to reduce participant search costs, to increase competition, to better monitor the market, and to reduce information asymmetry (NDIA 2016k, pp. 24–25). This role will become increasingly important as the number of participants and the disability support market increases through transition. This role also reflects a key area for action under the *Integrated Market Sector and Workforce Strategy* (DRC 2015a, p. 15) to enhance the amount of information available to consumers, and the NDIA's (2016k, p. 24)

desire for participants to have easy access to information 'about all possible service providers from which they can choose'.

This is to be achieved, in large part, by the NDIS 'eMarketPlace', which, according to the NDIA (sub. 161, p. 65), will support information discovery, encourage industry innovation, build local community capacity, and provide timely data and analytics to assist with NDIS sustainability (box 8.3). The eMarketPlace is broadly consistent with the Commission's 2011 recommendation that the NDIA should provide a centralised internet database of service providers that indicates the range of products and services, price, availability and links to measures of performance and quality (PC 2011, pp. 486–487).

Box 8.3 The eMarketPlace aims to help participants and providers

The eMarketPlace is a project of the National Disability Insurance Agency (NDIA) to 'support information discovery, encourage industry innovation, and build local community capacity' and to 'provide timely data and analytics to assist with Scheme sustainability' (NDIA, sub. 161, p. 65). This includes the introduction of 'cognitive intelligence capabilities' — a form of artificial intelligence that will allow for easier interaction between participants, providers and the NDIA. For example, participants would be able to ask general and personalised questions about the eMarketPlace and the National Disability Insurance Scheme, rather than contacting the scheme's call centre. The eMarketPlace will be co-designed by the NDIA and people with disability.

The aim of the eMarketPlace is to maximise the benefits of the scheme by making it easier and more efficient for participants to find and access the supports that they need. It will also enable providers, businesses and community organisations to market their products and services. In turn, it will improve the responsiveness of providers to participant demand, and encourage innovation.

The eMarketPlace is expected to reduce transaction costs of both participants and the NDIA. According to the NDIA:

> By introducing an eMarketPlace and eventually automating much of the payments and processing function, the NDIA will reduce the time spent on these activities and consequently the potential costs.
>
> In general contexts, eMarket platforms may be able to reduce unit costs by between 15-30%. In the NDIA context, these cost savings may flow through to participants in some scenarios. Where the NDIS is incentivising participants to shop around, the eMarketPlace will likely result in the best price for support services, in particular homogenous supports, being achieved more often. As well as open price comparison and price competition, the eMarketPlace also adds an additional commissioning channel for the participant. Cost savings realised from eMarketPlace price competition will serve to promote the effectiveness of the eMarketPlace, incentivising eMarketPlace participation, improving the scale of use and the sustainability of the NDIS. (sub. 161, p. 66)

Source: Adapted from NDIA (sub. 161, pp. 65–66).

The NDIA (2016k, pp. 29–31) plans to introduce the eMarketPlace by the end of June 2018, but it is unclear how long this will take in practice (and there are a number of market stewardship activities and projects that are to take place during this period).

The DSS also stated that:

> The NDIA will conduct a 'Request for Information' (RFI) process to gather advice from industry stakeholders about innovative solutions and commercial models to deliver the NDIS eMarket Place to assist providers to reach their participants. (sub. 146, p. 38)

The eMarketPlace, as described, would go a long way towards meeting the needs of participants when it comes to information about providers. It can overcome some existing information gaps, such as the slow updates to existing provider lists, inaccessibility of provider lists, and lack of indicators of consumer satisfaction (particularly on service quality and performance). The eMarketPlace will also supplement other work by the NDIA to develop a range of consumer guides to best practice in areas such as therapeutic supports or equipment (DRC 2015a, p. 15), which are currently being refined. Metrics are also being developed to better understand purchasing patterns and the timing in which participants make decisions (NDIA, sub. 161, p. 107).

For participants to exercise choice and control, they must have access to information about options for supports and providers that is timely, accurate, relevant, clear and accessible. As the New South Wales Government (sub. 60, p. 4) said, 'participants are particularly vulnerable to information asymmetries and/or a differential in bargaining power between themselves and providers'. This is particularly the case for people with disability where quality of service is highly valued (as there are significant negative consequences from the provision of poor service) and switching costs are high.

The Commission considers that the eMarketPlace should be introduced as a matter of priority.

DRAFT RECOMMENDATION 8.1

The National Disability Insurance Agency should implement the eMarketPlace discussed in the *Integrated Market Sector and Workforce Strategy* as a matter of priority.

A greater role for intermediaries?

Directly reducing complexity and building participant capacity can be costly. A more cost-effective (and preferable) option for participants could be outsourcing some or all of the administration of their plans to an intermediary. This can be done by using an intermediary as a plan manager, or even a third party to procure and manage particular supports.

Intermediaries can assist participants who may struggle to deal with the detail necessary to self-manage their affairs, and reduce scheme costs by aggregating participants' purchasing power for common supports. There is evidence that the administrative burden of self-managing a plan is a disincentive for some participants to take full control of their

supports. As put by the National Institute of Labour Studies' Intermediate Evaluation of the NDIS:

> At wave 1 the option of self-managed funding was not always fully understood by NDIS participants; nor was it always discussed in the planning meetings. By wave 2 it was evident that while NDIS participants had a greater understanding of what self-management was there remained very few self-managers. The main reason for this appeared to be a reluctance to take on additional administrative activities. (Mavromaras, Moskos and Mahuteau 2016, p. 72)

Intermediaries can also reduce the stress from dealing with NDIA processes. As noted by Mind Australia Limited:

> … when processes are overwhelming or negotiations are difficult, the impact on an individual's mental health can be devastating. One participant in the choice project said that when she was accepted into the NDIS, she thought that getting good support would mean fewer stays in hospital. In fact, she was admitted to hospital eight times in her first year in the scheme, which she put down [to] the stress of dealing with the NDIS and NDIS processes. Ongoing navigational support is one means to address this situation. (sub. 144, pp. 11–12)

Intermediary-managed plans can help participants with a range of tasks,[40] including to:

- help participants find providers, and take responsibility for the hiring and firing of workers
- take charge of financial administration, including invoicing and budgeting
- assist in dispute resolution with providers and/or the NDIA
- deal with the complexities of hiring particular individuals, by administering superannuation, workers' compensation, and occupational health and safety insurance[41]
- provide assistance dealing with the NDIA and LACs, including during plan reviews.

By coordinating these activities, intermediaries can act as a 'one-stop shop' for NDIS participants, which reduces the complexity faced by participants. They can also provide systemic feedback to the NDIA on any common and recurring issues, which in turn can reinforce the scheme's insurance approach.

40 In some ways, intermediaries could fulfil the roles that the Commission recommended for Disability Support Organisations in its 2011 inquiry (PC 2011, pp. 414–422).

41 An alternative approach that is being used by some self-managing participants is to use independent contractors to provide supports (Home Life Association, sub. 59, p. 9). As contractors must organise their own insurance, superannuation and other administrative matters, the use of contractors may reduce the administrative burden on participants.

Financial and service intermediaries can be funded as line items in approved NDIS plans (NDIA 2016n, p. 48, 2016o, p. 48).

- Financial intermediaries hold funds and manage risk on behalf of participants.
- Service intermediaries provide broader technical assistance, including:
  - assisting participants develop skills with plan management
  - negotiating and coordinating the provision of supports
  - sourcing providers
  - negotiating the method and timing of the delivery of supports
  - negotiating individual requirements as part of support management
  - recruitment, training, support and employment of staff (NDIS IAC nd).

However, the distinction between financial and service intermediaries is somewhat blurred in practice, as the service intermediary role can only be undertaken in conjunction with the financial intermediary role (NDIS IAC nd).

What is less clear, however, are the roles and responsibilities that intermediaries can more effectively and efficiently undertake given the presence of LACs and support coordinators, and whether they should be funded out of participants' plans or elsewhere.

The Commission has been unable to identify any barriers that prevent intermediaries from helping participants manage their supports. Given that it is 'early days', it may be too soon to observe such barriers. Participants may also not be aware that intermediaries are an option, as noted by Blind Citizens Australia.

> Due to the speed of the roll out, we are increasingly concerned that participants are not always being made aware of the full range of options in regards to plan management and support coordination and as such, their plans do not always include the support that will enable them to put their plan into action. (sub. 130, p. 8)

It is also unclear what safeguards or regulations should apply to intermediaries, especially as other parts of the NDIS are implemented or improved. As the Victorian Government put it:

> It is too early to say how well equipped and how well supported NDIS participants will be to exercise informed choice in this new marketplace. As the disability service market matures, it can be anticipated that intermediaries will emerge to facilitate mutually satisfactory transactions between providers and consumers, often aided by new information and communication technologies and tools.
>
> Appropriate regulatory responses for intermediaries will also need to be determined. In the interim, the readiness of participants to exercise choice is likely to rely heavily on NDIA funded initiatives and programs designed to assist participants navigate the disability support sector. Much of this support infrastructure is yet to be fully rolled out. (sub. 174, p. 19)

Intermediaries should be closely monitored over the next few years to ensure that there are no undue barriers to their operation, but also as a means to better identify areas of

complexity that participants are seeking paid assistance to overcome as part of ongoing scheme reform. The activities of intermediaries should also be monitored with an eye to developing any necessary safeguards that may be needed beyond the NDIS Quality and Safeguarding Framework (which is currently being developed by the DSS and yet to commence).

The Commission is seeking feedback on a range of questions relating to intermediaries and disability support organisations, including how they fit within the broader landscape of assistance for participants; whether there are barriers to entry for intermediary services; and what safeguards should apply to them. This includes any safeguards that may be appropriate to address conflict of interest when intermediaries are both plan managers and a disability support provider at the same time.

INFORMATION REQUEST 8.2

Is there scope for Disability Support Organisations and private intermediaries to play a greater role in supporting participants? If so, how? How would their role compare to Local Area Coordinators and other support coordinators?

Are there any barriers to entry for intermediaries? Should intermediaries be able to provide supports when they also manage a participant's plan? Are there sufficient safeguards for the operation of intermediaries to protect participants?

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9 Governance

Key points

- The governance arrangements for the National Disability Insurance Scheme (NDIS) provide a good foundation for the scheme. Some enhancements can be made where the governance arrangements affect, or have the potential to affect, scheme costs and financial sustainability.
- There is a lack of clarity around some roles and responsibilities, including Local Area Coordinators, mainstream services and market development.
- The current arrangements for implementing NDIS Rules need to be relaxed to ensure that they can be amended quickly when there are changing circumstances that could risk the financial sustainability of the scheme.
- Internal review processes have the potential to increase scheme costs and poor planning processes can increase the number of reviews.
- External review processes will clarify the law over time, including the entitlement to reasonable and necessary supports. Outcomes from such reviews could potentially have a significant impact on scheme costs.
- The timeframe to implement the *NDIS Quality and Safeguarding Framework* is ambitious. However, it is important that it be met to ensure quality and safety for scheme participants, to provide clarity and reduce regulatory burden for providers.
- While the Western Australian NDIS is meant to mirror the national scheme in many respects, there is a risk that the governance arrangements could lead to a divergence in participant outcomes. There are also costs associated with setting up parallel schemes. The Commission's preference is for Western Australia to be part of the NDIS.
- Current NDIS performance reporting does not have a sufficient focus on plan quality. Reporting on scheme participants' outcomes and attainment of participants' goals also requires further development.
- The National Disability Insurance Agency's (NDIA) focus on participant intake has compromised the success of the scheme. The NDIA needs to find a better balance between participant intake, the quality of plans, participant outcomes, and the financial sustainability of the scheme during the transition period. Some steps are now being taken by the NDIA to better balance these aspects, but the outcomes are not yet clear.

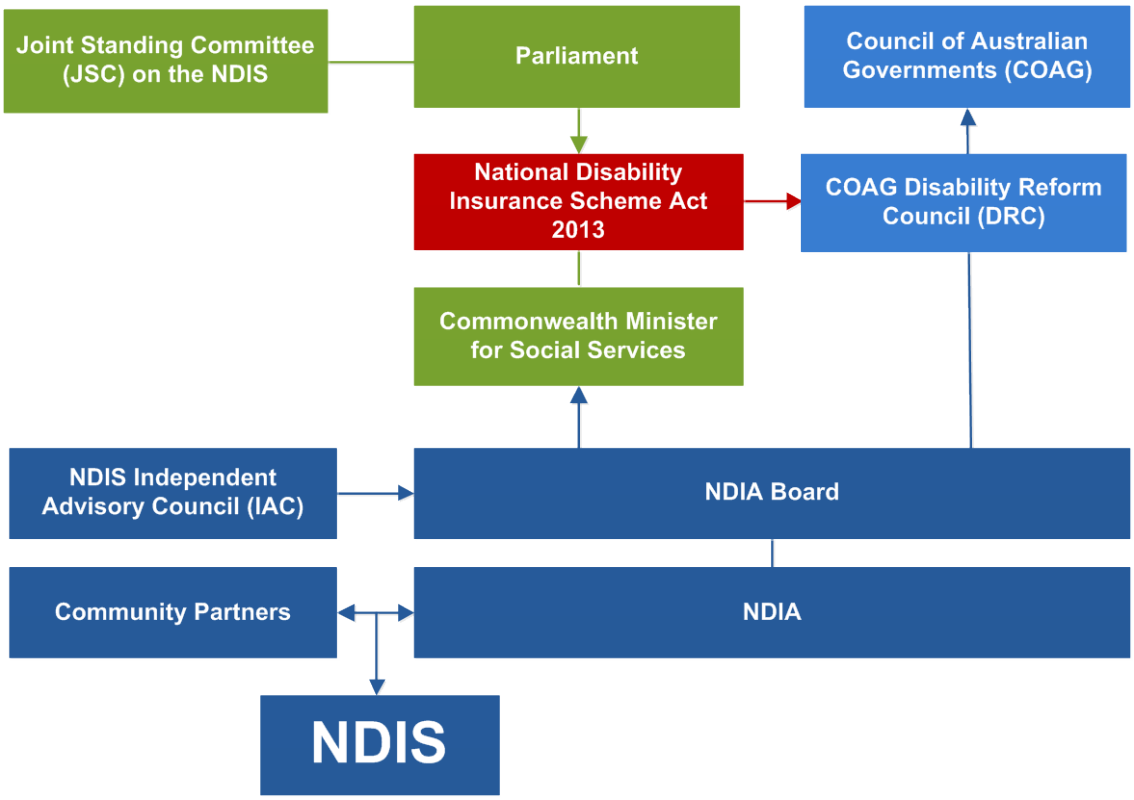
This chapter looks at the National Disability Insurance Scheme (NDIS) governance arrangements in the context of scheme costs and financial sustainability. Section 9.1 provides an overview of the governance arrangements. Sections 9.2 to 9.7 discuss issues with the current governance arrangements including: clarity and transparency around roles, responsibilities and processes; flexibility of the arrangements; the Western Australian

NDIS; review processes; regulation; and performance reporting arrangements. Section 9.8 discusses the timetable for the scheme rollout.

9.1 Overview of governance arrangements

The *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act) sets out the governance arrangements of the NDIS (figure 9.1). The Act is supported by the NDIS Rules, which are legislative instruments that provide more detail on the operation of the NDIS (NDIA 2017j).

Figure 9.1 **Summary of NDIS governance arrangements**



Source: Adapted from NDIA (2016g, p. 127).

The Australian, State and Territory Governments share responsibility for the governance and policy decisions of the NDIS. The Australian Government Minister for Social Services is responsible for administering the NDIS Act, and exercises statutory powers with the agreement of State and Territory Governments. The Minister can (in some cases, with the agreement of State and Territory Governments) make NDIS Rules and issue directions to the NDIA about the performance of its functions (NDIA 2016g, 2017f; NDIS Act).

The COAG Disability Reform Council (DRC) is responsible for NDIS policy and broader disability policy. Its members include the Minister responsible for disability policy and the Minister responsible for the Treasury portfolio from each Australian, State and Territory Government, and a representative from the Australian Local Government Association (DSS 2017a). The DRC:

- considers policy matters relating to the NDIS and the NDIS Act
- advises the Minister for Social Services and makes recommendations to COAG (NDIS Act s. 12)
- oversees the implementation of the NDIS and can make recommendations to COAG on the transition to full scheme
- is responsible for a range of reforms that are to be implemented through the National Disability Agreement and the National Disability Strategy to support people with disability and their families and carers (DSS 2017a).

State and Territory Governments are also responsible for regulating providers in their respective jurisdictions until the *NDIS Quality and Safeguarding Framework* is implemented (DSS 2016c, p. 17).

The NDIA is responsible for managing and delivering the NDIS. It is an Australian Government agency established under the NDIS Act and the *Public Governance, Performance and Accountability Act 2013* (Cwlth) (NDIA 2017f; NDIS Act s. 117). Its main functions include:

- delivering the NDIS to support the independence and social and economic participation of people with disability, and enable them to exercise choice and control in the pursuit of their goals
- managing, advising and reporting on the financial sustainability of the NDIS
- facilitating innovation, research and best practice in the disability sector
- building community awareness of disabilities
- collecting, analysing and exchanging data on people with disability, and the supports provided to them
- undertaking research relating to disabilities (NDIA 2017q; NDIS Act s.118).

The NDIA is governed by a Board, which is appointed by the Minister for Social Services in consultation with State and Territory Governments. The Board is responsible for managing risk and setting the strategic direction of the NDIA. It is also responsible for monitoring and reporting on the performance of the Agency (NDIA 2017n). The Board was expanded from 1 January 2017 'to ensure it has the disability service, financial management, corporate governance and insurance-based expertise needed to guide the $22 billion scheme through its critical three year expansion to 2019-20' (Porter 2016).

The Independent Advisory Council (IAC) provides independent advice to the NDIA Board on how the NDIA performs its functions. The IAC is a panel of experts including people with disability, carers of people with disability, at least one person with expertise on disability in rural or remote areas, and at least one person with expertise in the supply of equipment or provision of disability services. The IAC can provide advice either on its own initiative or at the written request of the Board. The Board must consider all advice and provide the DRC a copy of the advice and its response (NDIA 2017g).

A Parliamentary Joint Standing Committee on the National Disability Insurance Scheme was established in 2013, with the role of reviewing the implementation, administration, performance, governance and expenditure of the NDIS, and other NDIS-related matters referred to it by parliament (JSCNDIS 2017; NDIA 2016g, p. 131). It has provided two progress reports to Parliament on the implementation and administration of the NDIS and is currently undertaking inquiries into hearing services and services for people with psychosocial disabilities related to a mental health condition.

Different arrangements for Western Australia

Western Australia has different governance arrangements for the NDIS to the rest of Australia. While it is intended to provide similar supports as the national scheme, the Western Australian NDIS (WA NDIS) will:

- be administered by the Western Australian Government, not the NDIA
- be funded differently (chapter 10)
- begin rollout one year later than the national scheme (2017-18) (box 9.1).

Are the current governance arrangements effective?

The high-level governance arrangements for the NDIS mostly reflect those recommended by the Commission in its 2011 inquiry on *Disability Care and Support*, including the appointment of an independent body (the NDIA), an independent Board and an Independent Advisory Council.

The NDIS Act and its objectives are also broadly aligned with the Commission's recommendations, including the entitlement to reasonable and necessary supports, eligibility criteria and an obligation to ensure the scheme is financially sustainable (PC 2011).

The governance arrangements provide a good foundation for delivering the scheme and managing financial sustainability.

Box 9.1 The NDIS in Western Australia

In January 2017, the Western Australian and Australian Governments signed a bilateral agreement for the implementation of the WA NDIS. Under this agreement, Western Australia will have a locally administered scheme, but the scheme is to be consistent with the national NDIS. The WA NDIS is expected to begin rollout on 1 July 2017 (one year later than the national scheme).

Unlike the national scheme, the WA NDIS will be managed by the State Government under State legislation. A WA NDIS authority will be established to manage the scheme which, similar to the NDIA, will have a Board and Independent Advisory Committee.

The intention is that the WA NDIS will be consistent with the national scheme in a number of areas, including:

- eligibility requirements
- the core principles, including access to reasonable and necessary supports, choice and control and guaranteed portability
- the application of the National Quality and Safeguarding Framework
- the complaints and appeals process, which will mirror the national process including access to the Administrative Appeals Tribunal
- reporting requirements, including the requirement to report quarterly to the DRC
- other governance arrangements, including relevant Rules under the NDIS Act
- contributions to policy at the national level by the Western Australian Government.

Sources: Australian Government and Western Australian Government (2017); WADSC (2017).

One important difference is the Australian Government minister responsible for the NDIS. The Commission recommended that the Australian Government Treasurer be the responsible Minister for the NDIS because of the proposed commercial focus of the NDIA, and the need to ensure strong cost controls, insurance characteristics, long-run sustainability and appropriate management of funds (PC 2011, p. 432). The Commission also envisaged other ministers, such as the Minister for Social Services, playing a prominent role in disability policy.

However, primary responsibility for the NDIS is with the Australian Government Minister for Social Services. While the Commission has not received any evidence to suggest that the insurance and commercial focus of the scheme is compromised by these arrangements, it is important that the NDIS is managed as an insurance scheme and not as a welfare program.

The following sections discuss areas of concern about the governance arrangements.

9.2 Lack of clarity around roles and responsibilities

While the high-level governance arrangements for the scheme are clearly set out in the NDIS Act, the Heads of Agreement, the Bilateral Agreements and other policy documents, the way the governance arrangements play out in practice, including who is responsible for what, is less clear. For example, there is a lot of confusion about the role of Local Area Coordinators (LACs). For example, DARE Disability Support said:

> DARE's understanding of the role initially envisaged for the LACs, namely frontline problem solving and assistance with plan implementation, appeared to change shortly before transition to planning and the Coordination of Supports for non-complex participants, surely a foreseeable gap in NDIS planning resources. (sub. 182, p. 7)

The confusion is, in part, because the NDIA experimented during the trial with a number of options for delivering LACs' activities. The NDIA ultimately chose to outsource the LAC functions, and this arrangement was put in place for the beginning of the rollout. However, the confusion could also be because LACs have been diverted away from their intended activities towards planning-related tasks. As the NDIA said:

> The need to meet bilateral estimates has also meant that for the first period of transition the NDIA has asked LAC partners to divert their resources into information gathering to facilitate the approval of plans and implementation of plans. (sub. 161, p. 56)

There is also a lack of clarity around the responsibilities of the NDIS and mainstream services, and how governments are approaching continuity of care (chapter 5). As noted by the Department of Social Services (DSS):

> The Council of Australian Governments (COAG) agreed principles to determine the responsibilities of the NDIS and mainstream service systems, which are generally sound, but need clarifying at an operational level. (sub. 146, p. 4)

The Commission is recommending that the National Disability Strategy be strengthened to improve accountability, and a standing item be added to the agenda of the relevant COAG Councils to address mainstream and other disability services and how they interface with the NDIS (chapter 5).

Other areas in need of greater clarity include supply side arrangements, such as the responsibilities for developing the NDIS workforce, the arrangements for provider of last resort and addressing thin markets. The DSS and the NDIA are working on these issues (chapters 6 and 7).

Given the scale and complexity of the NDIS, and the focus on insurance principles — which involves ongoing monitoring and refining of the scheme — changes to roles, responsibilities and processes are expected. However, it is crucial that governments and the NDIA continue to work to ensure clarity and transparency in the governance arrangements so that they do not undermine accountability and put the success of the scheme at risk.

9.3 Flexibility of governance arrangements

The NDIA and governments need to be able to respond quickly when circumstances arise that could threaten the financial sustainability of the scheme. This requires governance arrangements that are sufficiently flexible and that allow changes to be made quickly when required. This is especially important during the transition period of the NDIS, when the compressed timeframes increase the potential for poor arrangements to lead to poorer outcomes in the longer term.

While the NDIA has some flexibility and autonomy in how it operates the scheme, governments also have significant control over its operations. For example, the Minister for Social Services, with unanimous agreement from the State and Territory Governments, is responsible for appointing NDIA Board members and can, by legislative instrument, give directions to the NDIA about the performance of its functions (NDIS Act ss. 121, 127).

Also, as the NDIA operates under legislation, including the NDIS Act and the NDIS Rules, issues that could affect scheme costs or financial sustainability may require changes to legislation. For example, an Administrative Appeals Tribunal (AAT) or Federal Court ruling that was not in line with the original intention of the scheme, and had the potential to significantly increase scheme costs, could require a legislative change.

While the Australian Government is responsible for the NDIS Act, the Australian, State and Territory Governments are jointly responsible for the NDIS Rules. There are four categories of NDIS Rules. The Minister for Social Services has overarching responsibility for making Rules, and making Rules under each Category requires a different level of involvement or agreement from State and Territory Governments (box 9.2). The Minister can also delegate the power to make Rules to the CEO of the NDIA, with the agreement of State and Territory Governments (NDIS Act s. 201).

Most of the Rules currently in force are either Category A or Category B Rules (box 9.2). Category A Rules cover most of the sections of the NDIS Act, including (but not limited to) disability and early intervention requirements, what must be included in plans, and the statement of participants' supports. They require agreement from the Australian Government and each State and Territory Government (NDIS Act s. 209).

Box 9.2 Categories of NDIS Rules

There are four main categories of NDIS Rules.

- Category A — The Australian Government and each host jurisdiction must agree to the Rule.
- Category B — The Australian Government and the specific host jurisdiction that the Rule relates to must agree to the Rule.
- Category C — The Australian Government and a majority of host jurisdictions must agree to the Rule.
- Category D — Each host jurisdiction must be consulted on the Rule (NDIS Act s. 209).

In addition, under sections 125B and 180C of the NDIS Act, the Minister responsible for the *Insurance Act 1973* (Cwlth) can make Rules related to the management of risk and the Scheme Actuary's duties.

Most of the current NDIS Rules are either Category A Rules (requiring unanimous agreement) or Category B Rules (requiring agreement between the Australian Government and the relevant host jurisdiction).

Category A rules

The current Category A Rules cover areas such as:

- rules to assist in determining who can become a participant, including extra details about age, residence and early intervention requirements (*National Disability Insurance Scheme (Becoming a Participant) Rules 2016*)
- requirements in determining representatives for children, and what that child's representative must comply with (*National Disability Insurance Scheme (Children) Rules 2013* (Cwlth))
- nominees, including their appointment, duties and cancellation and suspension (*National Disability Insurance Scheme (Nominees) Rules 2013* (Cwlth))
- how supports in a participant's plan should be specified and how to assess whether it would pose an unreasonable risk for a participant to manage their own plan (*National Disability Insurance Scheme (Plan Management) Rules 2013* (Cwlth))
- criteria for approving registered providers of supports and requirements registered providers of supports must comply with (*National Disability Insurance Scheme (Registered Providers of Supports) Rules 2013* (Cwlth))
- funding of Specialist Disability Accommodation (*National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* (Cwlth)).

Category B Rules

Category B Rules are jurisdiction-specific Rules. They generally relate to the schedules for when areas and people will be phased into the scheme (such as the Rules regarding the preparation of participant plans), or the specific State and Territory laws that prevent a person providing certain information to the NDIA (*National Disability Insurance Scheme (Protection and Disclosure of Information) Rules 2013* (Cwlth)).

Some study participants raised concerns about the governance arrangements for Rule changes. Both the NDIA and the DSS pointed to the length of time it can take to get agreement from the States and Territories on Rule changes.

> The process for amendment of the NDIS Rules requires agreement from a majority or all (depending on the rules) of the States and Territories. Recent experience of seeking amendments to rules is that the process takes considerable time. (NDIA, sub. 161, pp. 48–49)
>
> This has proved cumbersome and complicated for most rules and other actions, such as making appointments and issuing directions, requiring unanimous agreement by the Commonwealth and the States. This can delay the timely sign-off of amendments, and can potentially impact timely direction being provided to the NDIA. (DSS, sub. 146, p. 32)

Both the NDIA (sub. 161, p. 49) and the DSS (sub. 146, p. 32) raised the example of the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* (Cwlth) (Category A Rules), which require unanimous agreement from the Australian, State and Territory Governments. According to the DSS (sub. 146, p. 32), it took about 10 months to implement these Rules. In a transition period of three years, such timeframes could pose significant operational difficulties for the NDIA.

The DSS (sub. 146, p. 32) called for governance arrangements to be changed to enable more streamlined decision making, particularly by the Australian Government. The NDIA argued for a mechanism for efficient and timely amendment of NDIS Rules and suggested that it could be achieved through:

> … legislative amendment that allows some rules to be made that do not require agreement from all jurisdictions, more efficient administrative arrangements to agree changes or by the Minister making a delegation under s.201 of the NDIS Act to the CEO to make legislative instruments in limited circumstances. (sub. 161, p. 49)

State and Territory Governments did not raise this issue specifically in their submissions to this study, and they were generally supportive of the current governance arrangements. For example, the Victorian Government said:

> Victoria reaffirms its support for the governance arrangements outlined in the 2013 Heads of Agreement. This includes a standing council of state and federal ministers as the decision maker on significant NDIS policy issues, COAG as decision maker in relation to scheme costs and implications for mainstream services, and a centralised national NDIA to administer the scheme. (sub. 174, p. 5)
>
> The states must be part of any decision-making process that determines what will be funded under the NDIS. Given the critical interface between the NDIS and state-funded mainstream services, Victoria considers these arrangements as a necessary safeguard against decisions about the scheme's scope which could result in a significant transfer of costs and risks to state-funded services, and poor outcomes for people with a disability. (sub. 174, p. 22)

However, the New South Wales Government said:

> NSW has always been open to considering governance changes, if required, to provide the Commonwealth with greater capacity to effectively administer the scheme, including managing cost risks and ensuring positive outcomes for participants. (sub. 60, p. 13)

While there can be benefits from requiring agreement from all jurisdictions to implement Category A Rules (different perspectives can ensure a better overall outcome is achieved),

there are also costs and risks to delaying changes. The benefits of requiring agreement from all jurisdictions to implement many NDIS Rules, therefore, need to be balanced against the need for the NDIS to be agile and able to adapt to emerging risks within a timeframe that ensures the financial sustainability of the scheme.

The Commission's view is that the risks of delaying implementing or changing Category A Rules in response to risks to financial sustainability are greater than the benefits of requiring unanimous agreement. The requirement for unanimous agreement from the Australian Government and all host jurisdictions for changes to some Rules should be relaxed.

However, any changes to the level of responsibility of governments in making Rule changes need to be considered in light of the risk-sharing arrangements in place, so that incentives can be aligned. This, and possible options for relaxing the Rule making requirements, are discussed in chapter 10.

DRAFT RECOMMENDATION 9.1

The requirement that changes to National Disability Insurance Scheme Category A Rules have unanimous agreement from the Australian Government and all host jurisdictions should be relaxed.

9.4 Western Australian NDIS

As noted above, Western Australia has not signed up to the national NDIS. This section looks at whether the governance arrangements for the WA NDIS will affect costs and financial sustainability. The funding and risk sharing arrangements are discussed in more detail in chapter 10.

Will two schemes affect costs and sustainability?

In 2011, the Commission recommended a single national scheme, and a single national agency, to provide disability care and support across the country (PC 2011, pp. 424, 428). The Commission also recommended that, if a single national scheme could not be achieved, the scheme should still be established, but with its funding and scheme design only applying to participating jurisdictions. The proposed model in Western Australia means that the arrangements in Australia fall somewhere in between these two approaches.

There are costs involved in implementing two systems. There is the cost of two sets of legislation — the NDIS Act and the proposed Western Australian legislation. There are also additional costs associated with setting up a separate agency in Western Australia to administer the WA NDIS (in addition to setting up the NDIA), and any associated loss of economies of scale that could ensue from having a single agency. Also, it is important that

learnings from the transition, such as things that have gone well or poorly, are adopted as quickly as possible in other parts of the scheme. Having two agencies could mean that it takes longer for lessons learned from the national scheme to be adopted in Western Australia and vice versa.

There could, however, be benefits to Western Australia having its own scheme. For example, a WA NDIS could allow increased flexibility and an ability to quickly adapt to changing Western Australian conditions. While the scheme is intended to mirror the national scheme in many aspects, including most parts of the NDIS Act and the NDIS Rules, the fact that the NDIA has its own detailed operational guidelines for its functions suggests that mirroring the legislation allows for significant flexibility. This flexibility could lead to a divergence in the supports provided to scheme participants and participant outcomes between Western Australia and the rest of Australia.

There were two trials of the NDIS in Western Australia — one managed by the NDIA and the other by the Western Australian Government. There are two reviews that have compared the trials in Western Australia. One review identified key features for an effective disability support model for Western Australia, and made a number of recommendations to address gaps in processes. It found that the Western Australian-managed trial required fewer changes in policy and processes to achieve an effective model than the NDIA-managed trial (Stantons International 2016). However, the limitations of this review should be noted. It compared and contrasted the processes related to plan preparation, activation, operation and review. It did not compare actual outcomes of participants in the two trials (this was not feasible due to the timing of the review), nor did it compare the costs of the different approaches.

The WA NDIS and the NDIS scheme actuaries have also undertaken an assessment of the two Western Australian trials. The results of the evaluation are not public.

While the Goldfields Individual and Family Support Association (sub. 13, p. 3) noted it ‘supports a decentralised and localised WA state governance model’, the majority of study participants who commented on the Western Australian model did not support a separate scheme. A key concern was that it will create inequities in specialist disability support (box 9.3).

Under the Bilateral Agreement between the Western Australian and Australian Governments, there are to be regular reviews of the state legislation, the first occurring two years after the commencement of the WA NDIS (Australian Government and Western Australian Government 2017). While the terms of reference for these reviews are yet to be agreed, they will include the extent to which the WA NDIS is achieving consistency with the agreed provisions in the NDIS Act. If the WA NDIS is to proceed as agreed under the Bilateral Agreement, these reviews will be important for ensuring consistency between the two schemes, and that people with disability in Western Australia are not disadvantaged by not being part of the national scheme.

In April 2017, it was reported that the Western Australian Government was undertaking a review of the decision to implement the WA NDIS and that joining the national scheme was still an option (Emerson, Wearne and Carporn 2017).

It is the Commission's view that Western Australia should be in the national NDIS. There are benefits of having a national scheme (as identified in the Commission's 2011 inquiry) and there are additional costs with two schemes. Where there is evidence that different processes in the Western Australian-managed trial have resulted in better outcomes for participants than under the national scheme, these processes should be considered for the national scheme. Given the concerns about the transition timetable, Western Australia could delay joining the national scheme until the national NDIS is at full scheme. However, to minimise uncertainty for participants, providers and governments, any decision to join the national scheme should be made public as soon as possible.

Box 9.3 Study participants' views on the WA NDIS

Down Syndrome Australia:

> Down Syndrome Australia, as a federation of state and territory Down syndrome organisations, has advocated strongly for WA to be part of the national scheme. DSA is very concerned that people with Down syndrome in WA will not get an equitable level of support, nor the choice and control nor long-term certainty of the national scheme. (sub. 121, p. 20)

Disabled People's Organisations Australia:

> DPO Australia is very concerned about the decision by the previous Western Australian Government to establish its own NDIS. Despite a number of nationally consistent provisions in the bilateral agreement, it is concerning that the WA NDIS will have different funding arrangements and accountabilities and a greater focus on service provider control. This is highly likely to prevent market growth and innovation for people with disability in WA and create inequities in the provision of specialist disability support in WA. (sub. 165, p. 10)

Matt Burrows:

> Without WA signed up to a national Scheme, the entire Scheme is at risk. The entire Scheme is not sustainable as a *national* reform unless all States and Territories are signed up to it. (sub. 7, p. 4)

Community Mental Health Australia:

> The announcement that Western Australia (WA) would be implementing its own state-based system has immediately created a situation where there will not be a nationally consistent scheme … (sub. 11, pp. 1–2)

Queensland Advocacy Incorporated:

> [Western Australia's agreement with the Australian Government] undermines that nationally consistent approach and increases state and territory variation. (sub. 115, p. 18)

Department of Social Services:

> An additional risk to consistency and sustainability will arise if a different model is implemented in Western Australia (WA), with the Commonwealth preference for WA to be part of the national NDIS delivery model. (sub. 146, p. 33)

DRAFT RECOMMENDATION 9.2

The Western Australian Government and Australian Government should put in place arrangements for Western Australia to transition to the National Disability Insurance Scheme. Any decision to join the national scheme should be made public as soon as possible.

9.5 Review processes

There are two types of *internal review* processes that can be accessed by those dissatisfied with an NDIA decision.

- *An unexpected plan review* — a scheme participant can request that the NDIA conduct a review of their plan. The NDIA must decide within 14 days whether or not to conduct the review, begin the review within 14 days of that decision, and complete the review as soon as reasonably practicable (NDIS Act s. 48). (This is distinct from the periodic (usually annual) plan review that is discussed in chapter 4.)
- *A review of a decision* — a number of reviewable decisions relating to the NDIA are set out under s. 99 of the NDIS Act, including decisions regarding eligibility, supports provided and registration of providers. When the NDIA makes a reviewable decision, it must give written notice to each person affected by the decision informing them of the option for review. A person then has three months to request a review of the decision. The review must be completed as soon as reasonably practicable (NDIS Act, s. 100).

There are also *external review* processes. If a person is dissatisfied with the outcome from a review of an NDIA decision (not a plan review), they can apply to the AAT to undertake a merit review of the decision within 28 days of the review decision (or apply for an extension of time). And if the person is not happy with the outcome of the external review, they can appeal the AAT's decision in the Federal Court, but only if it is a question of law (NDIA 2017p).[42]

Are the review processes appropriate and effective?

Some study participants argued that the review processes are not as appropriate and effective as they could be. First, there is confusion about the two types of NDIA reviews. The NDIA said that it:

[42] A question of law can include, for example, whether the AAT denied a person procedural fairness, correctly interpreted or applied the NDIS Act, or applied or identified the correct test. This is also known as a judicial review.

> … is aware that there has been confusion around avenues for reviews of decision[s] (especially given the word 'review' is used in the legislation to refer to two different [processes] in relation to planning). (sub. 161, p. 94)

The Commonwealth Ombudsman also commented that:

> … the distinction between an 'internal review' [a review of a decision by the NDIA] and a 'plan review' often seems to be lost on participants and their representatives. This situation was demonstrated in a recent AAT decision, Bridgland and National Disability Insurance Agency, where the applicant had sought an internal review and then, remaining dissatisfied, lodged an appeal with the AAT. The Tribunal found that it did not have jurisdiction to review the matter because the NDIA reviewer had initiated a plan review, resulting in a new plan which attracted internal review rights the applicant had not yet exercised. (sub. 137, p. 12)

This confusion was also noted by Ernst & Young (2015, p. 70) in its review of the NDIS Act, which recommended that the terminology in the Act be amended to make the distinction between the two types of reviews clearer.

Second, there are concerns about the accessibility of the review processes and the adequacy of information provided to scheme participants about review options. Down Syndrome Australia (sub. 121, p. 15) said that 'it appears that people are not well enough informed about their rights to ask for an internal review within the timeframe'. Scope Australia argued that the process is not clear and that the amount of information provided is insufficient.

> … the process for resolving disputes or disagreements is not clear. The Agency rarely provides a contact name for appeals or provides a process by which participants can escalate their concerns. There is only one email address where the information and requests for review can be lodged. This is not customer friendly nor does it encourage participants to best advocate for their rights. (sub. 72, p. 19)

Similarly, Brain Injury SA commented that:

> … the information provided to participants about review is unclear and inadequate. There is minimal information about the process and no information about how or where participants can get help with a review. Brain Injury SA delivers presentations to client communities about the support it can provide to participants wanting a review of an NDIA decision and further appeal rights and support. However, NDIA should provide this sort of information to all participants and be consistent about this approach.
>
> Further, Brain Injury SA has received anecdotal evidence from parents and guardians that NDIA has not been informing participants of their right to an internal review or external merits review through the AAT. (sub. 116, p. 10)

Third, while there is no limit in the Act on how long a review can take, study participants expressed frustration about both the overall length of reviews, and the variability in timeframes. For example, Brain Injury SA (sub. 116, p. 6) said that 'reviews can take between 1 and 8 months'. Others also commented on the delays.

> If people are not satisfied with their plan, they can apply for an internal review of a decision, and if necessary escalate this to the Administrative Appeals Tribunal. However, VCOSS members report this process can be confusing and time-consuming, taking months to resolve. (VCOSS, sub 176, p. 12)
>
> The review process itself is complex and bureaucratic and we have heard of cases where it can take up to 18 months to be completed. Participants who are implementing their second plan are sometimes still waiting for the review of their first plan to be finalized. (Leadership Plus, sub. 128, p. 2)
>
> Although operational guidelines suggest NDIA has 14 days to decide to review a plan, Anglicare Tasmania have examples of cases where reviews have not been resolved for up to seven months. In all cases we have been involved with, timeframes have been very lengthy and involved a huge amount of follow up from families or workers. (Anglicare Tasmania, sub. 145, p. 33)

Governments and the NDIA are working to address concerns about review processes. COAG has agreed to implement the recommendation from Ernst and Young's review of the NDIS Act to review the terminology in the Act to make the distinction between the types of reviews clearer, and to amend the legislation to provide more guidance on the rights of scheme participants to request a review of their plan (COAG 2016a, pp. 4–5). The NDIA (sub. 161, p. 94) also said that it is working to improve its review processes, including working with the Commonwealth Ombudsman to develop service and process improvements.

It is important that the NDIA continues to improve the transparency, clarity and adequacy of the information it provides about reviews and on the timeliness of its reviews.

Are review processes affecting scheme costs?

Review processes can affect scheme costs and financial sustainability in two ways.

- Internal reviews can affect the amount of supports provided or the number of people eligible for the scheme, and thereby affect scheme costs. (But if the review reverses an incorrect decision, there will be benefits, even if it increases scheme costs.)
- Decisions resulting from external review processes will clarify the eligibility requirements and reasonable and necessary supports, which can impact scheme costs.

In addition, poor planning processes can lead to an increase in the number of reviews being requested. This can be costly for the NDIA and scheme participants, and can divert resources away from other, more valuable activities.

Some study participants said that a high number of unexpected plan reviews are being undertaken for certain types of disabilities. For example, MND Australia stated:

> From June 2016 until January 2017 100% of all Plans for people with MND in NSW and the ACT required review. (sub. 45, p. 7)

Publicly available data on the number of unexpected plan reviews being undertaken by the NDIA are limited. Between 1 July 2016 and 31 March 2017, the NDIA had conducted about 26 500 plan reviews that lasted for 30 days or more (NDIA 2017o, p. 15). However, it is not known how many of these were unexpected plan reviews. As such, there is insufficient evidence for the Commission to judge whether the number of unexpected plan reviews is higher than expected, or whether reviews are increasing scheme costs. One way to reduce the number of unnecessary unscheduled plan reviews (and the costs of such reviews), is for the NDIA to implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review. Improving planning processes should also reduce the need for unscheduled plan reviews. This is discussed in more detail in chapter 4.

For internal reviews of decisions, the most recent publicly available data are included in the NDIA's June 2016 quarter report to the DRC (NDIA 2016t, p. 46). At the end of June 2016, the NDIA had conducted 772 reviews of decisions. Of these:

- 262 related to access decisions and 510 to plan decisions
- about 66 per cent of completed reviews where an outcome was recorded (430 reviews) had resulted in the original decision being overturned.

However, there is no information about whether the review decisions have increased scheme costs, for example, by allowing more participants to enter the scheme or additional supports being included in plans.

As at 31 March 2017, there had been 161 external appeals to the AAT (NDIA 2017o, p. 27). Of these, 43 related to access issues, 104 to planning issues and 14 to plan reviews. The NDIA did not report the outcomes of the AAT reviews in its March 2017 quarterly report to the DRC, but it did so in December 2016. Of the 77 (out of a total of 112) appeals that were resolved by 31 December 2016, the NDIA's decision in about half was varied or set aside (the participant was successful) (NDIA 2016v, p. 40). As with the internal reviews of decisions, while participants have successfully appealed many external reviews, it is not clear whether this has led to increased scheme costs.

Two decisions by the AAT have been appealed to the Federal Court. The first case, *Mulligan v National Disability Insurance Agency* [2015] FCA 544, was an appeal of an AAT ruling to affirm the NDIA's decision to decline access to the scheme. The Federal Court set aside the AAT's decision and remitted for another decision by the AAT (NDIA 2017d).

The second case, *McGarrigle v National Disability Insurance Agency* [2017] FCA 308, was an appeal of an AAT decision to affirm the NDIA's decision to partially fund transport to access daily activities (chapter 4). The Federal Court set aside the AAT decision and remitted for another decision by the AAT. The implications of the McGarrigle case are yet to be fully understood, and the NDIA has announced it will appeal the decision (NDIA 2017l).

There is the potential for external review processes to significantly increase costs in the future by expanding eligibility requirements and the scope of supports provided. As the NDIA said:

> Decisions by the AAT (and/or an appeal to the Federal Court) have the potential to vastly increase the scope of both access and reasonable and necessary supports and must be adhered to while in effect, even if the NDIA challenges the decision. (sub. 161, p. 49)

That said, it is important that scheme participants have access to appropriate and effective external review processes. This ensures trust in the scheme, that participants have access to the scheme where appropriate and are receiving the right level of support (even where it increases scheme costs), and that the objectives of the scheme are being fully achieved. As noted by Carers Australia Victoria:

> Internal and external reviews are a vital quality safeguard for participants and carers, enabling them to test the lawfulness and merits of NDIA decisions affecting them. Importantly, they also promote transparency in NDIA decision-making. (sub. 131, p. 14)

As discussed in section 9.3, when external reviews result in outcomes that are not in line with the objectives of the scheme and could significantly increase scheme costs, it is important that governance arrangements allow for timely responses to ensure the financial sustainability of the scheme.

To provide greater clarity and transparency around the effectiveness of the review process and their effect on financial sustainability, the NDIA should undertake more detailed performance reporting on review processes (including on the number of reviews, review timeframes, outcomes of reviews, and participant satisfaction with the review process).

DRAFT RECOMMENDATION 9.3

The National Disability Insurance Agency should publicly report on the number of unexpected plan reviews and reviews of decisions, review timeframes and the outcomes of reviews.

9.6 Regulation and quality assurance arrangements

Regulation and quality assurance arrangements are important for ensuring the quality of the scheme and good outcomes for scheme participants. Currently, the Australian Government and the State and Territory Governments are responsible for regulation and quality assurance in their jurisdictions, and for the programs they fund (Bilateral Agreements, sch. F; DSS 2016c, p. 17).

In December 2016, the DRC endorsed the NDIS Quality and Safeguarding Framework. Under this framework, nationally consistent regulation and quality assurance processes will be implemented from 1 January 2018 (Australian Treasury 2017a, p. 154). The focus

of the framework is on helping scheme participants to exercise choice and control, while ensuring appropriate safeguards are in place.

The Australian Government will be responsible for most of the regulatory functions under the framework, including provider registration, the complaints handling system, serious incident notification, restrictive practice oversight, and investigation and enforcement (box 9.4).

A number of entities will be established to oversee the Australian Government's regulatory functions including the:

- NDIS Complaints Commissioner, which will be responsible for handling complaints, investigating serious incident notifications and investigating potential breaches of the NDIS code of conduct. The Commissioner will refer complaints to the relevant entity where appropriate, including those about provider standards to the NDIS registrar
- NDIS Registrar, which will be responsible for:
  - registering providers
  - managing the NDIS practice standards and certification scheme
  - leading the design and broad policy settings for worker screening
  - monitoring provider compliance
  - monitoring, reviewing and reporting on the effectiveness of the market for supports
- Senior Practitioner, which will be responsible for:
  - overseeing approved behaviour support practitioners and providers
  - providing best practice advice
  - receiving, reviewing and reporting on providers using restrictive practices
  - following up on serious incidents that suggest unmet support needs (DSS 2016c, pp. 16–17).

The State and Territory Governments will be responsible for worker screening and for the authorisation of restrictive practices in their jurisdiction (box 9.4).

The Australian Government has also announced that it will establish an NDIS Quality and Safeguards Commission to implement the framework and to undertake some of the Australian Government's regulatory functions listed above, including provider registration and regulation, complaints, reportable incidents, and behaviour support practices (Australian Treasury 2017a, p. 154; DSS, sub. 146, pp. 6-7). However, there is still a lot of work to be done in terms of implementation design and roll out of the arrangements (DSS 2016c).

Box 9.4 NDIS Quality and Safeguarding Framework

The NDIS Quality and Safeguarding Framework outlines the national approach to regulation and quality assurance for the NDIS. The DRC endorsed the framework in December 2016. The aim of the framework is to 'help empower and support NDIS participants to exercise choice and control, while ensuring appropriate safeguards are in place, and establishes expectations for providers and their staff to deliver high quality supports' (DSS 2017d, p. 1).

The framework embodies a number of principles.

- Measures within the framework are designed to uphold and respect the human rights of people with disability.
- Developmental measures (measures intended to build capacity) are designed to empower and support people with disability to make informed decisions about providers and supports.
- The framework is designed to ensure that people with disability have the same protection, regardless of where they live in Australia.
- The regulatory requirements for workers and providers are tiered to ensure regulation is proportionate to the level of risk associated with the type of support offered and the needs of the participants supported.
- The framework starts from the presumption that all people with disability have the capacity to make decisions and exercise choice and control.
- The framework streamlines requirements so the system is easier for people with disability to navigate, and red tape is reduced for providers.
- The framework is designed to support the development of an efficient and effective market.

The framework includes a range of measures targeted at individuals, the workforce and providers in three domains — developmental, preventative and corrective.

The Australian, State and Territory Governments will share responsibilities under the framework. The Australian Government will be responsible for provider registration, the complaints handling system, serious incident notification, restrictive practice oversight, and investigation and enforcement. State and Territory Governments will be responsible for worker screening and for the authorisation of restrictive practices in their jurisdiction.

The framework also encompasses a range of other functions including:

- advocacy services, which are funded outside of the NDIS
- systems for detecting fraud and related issues associated with the responsibility for paying providers and verifying that supports have been delivered. These will remain the responsibility of the NDIA
- complaints about the NDIA and Local Area Coordinators, which will be addressed through existing measures
- universal complaints and redress mechanisms, including Fair Trading and professional and industry bodies, which will continue to be available to participants
- anti-discrimination and human rights legislation overseen by the Disability Discrimination and Human Rights Commissioners, which will provide additional avenues for raising a complaint.

The Australian Government has committed $209 million to establish a NDIS Quality and Safeguards Commission to implement the framework.

Sources: Australian Treasury (2017a, p. 154); DSS (2016c, 2017d).

Are arrangements for quality and safety affecting scheme costs or sustainability?

The development of the NDIS Quality and Safeguarding Framework is an acknowledgment that the current arrangements will not be satisfactory for the full scheme. Current arrangements are designed around providers being block-funded and people with disability not having the level of choice and control they have now, or will have under the new system.

Although the current arrangements will not be appropriate for full scheme, they will remain in place for the transition. Given the importance to scheme costs and sustainability of having as smooth a transition as possible, ideally the current arrangements would not impede the development of the scheme and would ensure the safety of, and good outcomes for, scheme participants.

However, submissions to this study suggested that the current arrangements pose some risks to the scheme. A concern raised by a number of study participants is the different requirements providers need to meet across jurisdictions. For example, the NDIA (sub. 161, p. 103) argued that having different requirements in each jurisdiction can act as a barrier to entry for new providers. Plan Management Partners argued that:

> The current state based approach in our view is problematic as it is inconsistent in terms of application and requirements between the states. It is important in our view that the National framework (which is being introduced) addresses the current state variability. (sub. 126, p. 13)

And the Australian Rehabilitation Providers Association said:

> Barriers to entry for allied health professionals into the NDIS is high. The variable quality and safety procedures required by each State/Territory places additional costs on businesses employing allied health professionals. (sub. 28, p. 1)

Study participants also raised concerns about the burden of the registration process. Occupational Therapy Australia (sub. 15, p. 6) said that some occupational therapists found the registration process to be quite lengthy, which could deter therapists from registering as providers. Similarly, Allied Health Professions Australia commented that:

> The registration process is slow and complex, which is resulting in costs for practitioners, primarily in the form of significant time outlays required to address the bureaucratic requirements of registration. (sub. 37, p. 5)

Queensland Advocacy Incorporated argued that the registration processes are a particular barrier for smaller providers.

> QAI submits that the requirements for registration as an NDIS service provider will have the effect of squeezing smaller or lower funded organisations out of the marketplace. This will be to the detriment of people with disability and will impact upon the choice and control they have with respect to their services. (sub. 115, p. 16)

Third party verification (TPV) was raised as a concern by some providers. For example, in New South Wales, providers wanting to register to provide specialist disability supports are required to show evidence of full TPV (NDIA, sub. 161, p. 103). The Australian Psychological Society (sub. 19, p. 2) argued that one of the reasons psychologists are choosing not to provide NDIS services is the cost associated with the TPV process. The Australian Rehabilitation Providers Association also argued that:

> … [the TPV] process has imposed an additional layer of regulation and 'red tape' on tertiary educated professionals with rigorous registration requirements already in place. (sub. 28, p. 1)

Unfortunately, the timing of the implementation of the new framework at full scheme means that many regulatory issues will not be addressed until then. It is important that governments working on the implementation design and rollout of the new arrangements take into account current arrangements that are imposing unnecessary regulatory burden on providers. Consistent requirements across jurisdictions at full scheme will reduce the compliance burden for providers who want to provide services across jurisdictions. As the NDIA said:

> The implementation of the new national quality and safeguard framework … will reduce the compliance burden for providers seeking to operate in multiple jurisdictions. The framework will drive consistent approaches to regulating provision of the NDIS funded support. (sub. 161, p. 103)

While there is still work to be done on the implementation design and rollout of the framework, some study participants commented on the framework. Topics raised included the arrangements for psychosocial disability (CMHA, sub. 11, p. 16), children and young people (Centre for Disability Research and Policy, sub. 40), the need for a cultural competence domain (Northern Territory Government, sub. 205, p. 7) and those who provide services to scheme participants who self-manage not being required to register with the NDIA (DSA, sub. 9, p. 12).

Another ambitious timeframe

The NDIS Quality and Safeguarding Framework was only endorsed by the DRC at the end of 2016 which means that the timeframe (like other NDIS timeframes) is ambitious. However, it is important that this timeframe be met to ensure quality and safety for scheme participants, and to provide clarity and reduce the regulatory burden for providers. A number of study participants supported the arrangements being clarified and implemented as soon as possible (for example, Physical Disability Australia, sub. 38, p. 14).

As many of the details of the new arrangements are yet to be worked out, the Commission is not in a position to comment on the detailed regulatory arrangements under the framework.

9.7 Monitoring the performance of the NDIS

Performance reporting requirements can influence scheme costs and financial sustainability. Effective performance monitoring can improve transparency and accountability, and provide incentives for the NDIA and governments to effectively manage the scheme and ensure that the objectives of the scheme are realised.

To be effective, performance reporting indicators should measure performance against the objectives of the scheme and cover both outputs and outcomes. They should also be transparent and ideally released publicly in a timely manner. Some features of good performance indicators are summarised in box 9.5.

Box 9.5 **Features of good performance indicators**

- *Comprehensive* — indicators in a framework should measure performance against all important objectives.
- *Meaningful and understandable* — indicators must measure what they claim to measure and provide a good indication of success.
- *Accurate* — the data should be sufficiently accurate so that the community has confidence in the conclusions drawn from the information.
- *Timely* — the data must be collected at the point in time that aligns with the achievement of the outcome or objective.
- *Comparable* — indicators should allow for comparisons, including over time and between jurisdictions and target groups.
- *Streamlined* — indicators in a framework should be concise.
- *Cost-effective* — the benefits of reporting the indicator should outweigh the costs of collecting and reporting the data.
- *Avoid perverse incentives* — the indicator should not create perverse incentives or lead to unintended consequences.

Sources: Adapted from COAG (2011a, pp. 14–15); SCRGSP (2017).

How is performance currently reported?

The performance of the NDIS is currently monitored and reported through a number of mechanisms, including the:

- Integrated National Disability Insurance Scheme Performance Reporting Framework
- Scheme Actuary's monitoring and reporting on the financial sustainability of the scheme
- NDIA's annual report and corporate plan
- key performance indicators recently agreed by the DRC to monitor NDIS market performance and identify emerging market risks (DSS, sub. 146, p. 34).

Some of these are discussed in more detail below.

The Integrated NDIS Performance Reporting Framework

The main framework used to measure the performance of the NDIS is the Integrated National Disability Insurance Scheme Performance Reporting Framework, which is set out in schedule G in the Bilateral Agreements for the transition between the State and Territory Governments and the Australian Government (schedule H for Western Australia). The Framework comprises three main components:

- *NDIS Performance* — this includes agreed outcomes, key performance indicators and measures designed to assess whether the NDIS is achieving its objectives as set out in the legislation (table 9.1). Requirements at this level are designed to meet the accountability requirements of the DRC. This information is reported annually by the NDIA Board to the DRC.
- *NDIA Operational Performance* — this reporting meets the requirements in the legislation for the NDIA Board to report on expenditure and activities related to the NDIS, and it provides information on various aspects of NDIA operations that contribute directly to the achievement of NDIS outcomes and KPIs. This information is reported quarterly by the NDIA Board to the DRC (table 9.2).
- *NDIS Activity in Jurisdictions* — this reporting provides jurisdictions with the information they need to meet their own individual accountability requirements, such as budget reporting. This information is to be provided monthly by the NDIA to each jurisdiction through the data warehouse.

The NDIA is not yet reporting against all of the performance measures or indicators in the reporting framework, as it has not yet built in to its systems the capability to measure some of the indicators. For example, the NDIA is not yet reporting detailed data on the proportion of participants who attain the goals outlined in their plans, the time between requesting access and receiving support, and the number of participants and other people with disability supported by LACs (NDIA 2016v, 2017o).

In addition, only limited baseline (not longitudinal) data are presented for some indicators, such as the proportion of participants, and their families and carers, who report improved economic and social outcomes (NDIA 2016v, 2017o).

Table 9.1 **NDIS performance outcomes, KPIs & performance measures**

Outcome	*KPIs*	*Performance measures*
1. People with disability lead lives of their choice	1.1. People with disability achieve their goals for independence, social and economic participation	1.1.1. Proportion of participants, and their families and carers, who report improved economic and social outcomes (as measured by the NDIS Outcomes Framework) 1.1.2. Proportion of participants who attain the goals outlined in their plans (as measured by the NDIA's Goal Attainment Scale) 1.1.3. Participant satisfaction
	1.2. Increased mix of support options and innovative approaches to provision of support in response to assessed need	1.2.1. Mix and number of provider services 1.2.2. Proportion of participants with capacity building supports
	1.3. People with disability are able and are supported to exercise choice	1.3.1 Proportion of participants, and their families and carers, who report being able to exercise choice (as measured by the NDIS Outcomes Framework)
2. NDIS is a financially sustainable and insurance-based	2.1. Effective estimation and management of short-term and long-term costs	2.1.1. Comparison of actual expenditure against projected expenditure 2.1.2. Changes in medium- and long-term expenditure projections 2.1.3. Projected expenditure matches projected revenue over the medium and long-term 2.1.4. NDIA operating expenses ratio 2.1.5 Reduction in long-term cost trends against population, price and wages growth 2.1.6. Estimated future lifetime costs of support for current clients (NPV), including disaggregation for new and existing clients by client group
	2.2. Benefits are realised from targeted investment strategies in enhanced disability support	2.2.1. Effectiveness of early intervention in reducing estimated lifetime costs of support measure: • In the short term through case studies which include targeted investment • In the long term through estimated returns from this investment
3. Greater community inclusion of people with disability	3.1. People with disability are able to access support from mainstream services	3.1.1. Referrals to mainstream services for participants and non-participants through Information, Linkages and Capacity Building (ILC) 3.1.2. Proportion of participants accessing mainstream services
	3.2. Community awareness of people with disability	3.2.1 Activities undertaken by the NDIA to increase community awareness of the issues that affect people with disability
	3.3. Effectiveness of Local Area Coordination and other funded community capacity building	3.3.1. Number of people supported through ILC

Sources: Bilateral Agreements, sch. G.

Table 9.2 **NDIA operational performance outcomes, measures and indicators**

Outcome	*Measures*	*Indicators*
1. People with disability lead lives of their choice	1.1. Outcomes for participants and their families	1.1.1. Proportion of participants, and their families and carers who report improved economic and social outcomes (as measured by the NDIS Outcomes Framework)
		1.1.2. Proportion of participants who attain the goals outlined in their plans (as measured by the NDIA's Goal Attainment Scale)
		1.1.3. Participant satisfaction
	1.2. Provision of support in response to assessed need	1.2.1. Number of registered service providers by characteristics and market profile
		1.2.2. Access request to receiving support within different timeframes
2. NDIS is a financially sustainable and insurance-based	2.1. Participant characteristics and their families	2.1.1. Access requests made by outcome
		2.1.2. Eligible participants against bilateral targets, including key characteristics
		2.1.3. Participants with approved plans against bilateral targets
		2.1.4. Trends in plan approvals
		2.1.5. Access request to plan approval within different timeframes
		2.1.6. Ineligible participant numbers and key characteristics
	2.2. Support packages	2.2.1. Committed support
		2.2.2. Actual payments
		2.2.3. Average and median package costs by sub-groups of the population and for all participants compared with the expected averages and medians, including trends
		2.2.4. Details of participants with second plans, including length and value of supports
		2.2.5. Distribution of package costs
	2.3. Projections	2.3.1. Cost of the NDIS in dollar terms and as a percentage of GDP (split by participants aged under 65 years and over 65 years). This measure will include NDIS operating costs
3. Greater community inclusion of people with disability	3.1. Mainstream services	3.1.1. Number of participants accessing mainstream services by service type
	3.2. Local Area Coordination (LAC)	3.2.1. Number of participants and other people with disability supported by LACs by participant characteristics
		3.2.2. Description of activities undertaken on ILC including dollars spent by regions and activities
	3.3. Information, Linkages and Capacity Building (ILC)	3.3.1. Number of participants and other people with disability supported by ILC activities by participant characteristics
		3.3.2. Description of activities undertaken on ILC including dollars spent by regions and activities.

Sources: Bilateral Agreements, sch. G.; NDIA (2016v).

Monitoring and reporting on financial sustainability

Under the NDIS Act, each time an annual report is prepared the Scheme Actuary is to:

- assess financial sustainability and identify risks to financial sustainability, and any trends in the provision of supports to people with disability

- consider the causes of those risks and trends
- estimate the future expenditure of the NDIS
- prepare a report of that assessment, consideration and estimation
- prepare a summary of that report that includes the estimates of future expenditure (NDIS sub. 161, p. 115).

The Scheme Actuary prepares an annual financial sustainability report, which includes detailed data and information on the financial sustainability of the scheme. This report is not released publicly, although a summary is included in the NDIA's annual report (NDIS Act, s. 172). It is through this reporting that cost pressures are identified.

Are performance monitoring and reporting arrangements appropriate?

As the NDIA is still developing its performance reporting against the integrated framework, it is too early to judge whether the performance reporting will be sufficient to shed light on whether the scheme is meeting its objectives. That said, the Commission has identified some gaps in the framework and the current performance reporting against that framework.

As discussed above, there are limited data reported against the outcomes indicators. In addition, there are limited indicators on mainstream services, Information, Linkages and Capacity Building and LACs, and for the indicators that do exist, the NDIA is not yet reporting against some of them (NDIA 2016v, 2017o). Given the importance of understanding the interaction between the NDIS and mainstream services, and the critical role that Information, Linkages and Capacity Building and LACs play in the scheme (chapter 5), data on these activities should be an important component of reporting on NDIS performance.

There is also not a strong enough focus on quality in the framework, including the quality of plans, and review processes (draft recommendation 9.3). Reporting on quality is especially important given that the NDIA's focus on getting people into the scheme to meet the bilateral estimates has compromised the quality of the planning process and participants' plans (chapter 4). Over time, the NDIA intends to develop its monitoring of, and reporting on, outcomes. Evidence of good outcomes will be evidence of good performance and good plans. However, it could be some time until this reporting is of a sufficient standard. Until then, reporting on quality is needed. This could include indicators such as participant satisfaction with their plans and their planning experience, the number of plans completed by phone and face-to-face, and the number and nature of plan reviews.

As discussed earlier, it is also important that performance reporting is transparent to provide incentives to manage and improve performance, and to help to identify problems early. While the quarterly report to the DRC is made available on the NDIA's website, the financial sustainability report is not.

As the performance reporting on the NDIS is still being developed, the framework should be regularly reviewed and refined as needed. The Bilateral Agreements on transition state that the framework is reviewed annually (Australian Government and Queensland Government 2015, sch. G, p. 2).

DRAFT RECOMMENDATION 9.4

The performance of the National Disability Insurance Scheme (NDIS) should be monitored and reported on by the National Disability Insurance Agency (NDIA) with improved and comprehensive output and outcome performance indicators that directly measure performance against the scheme's objectives.

The NDIA should continue to develop and expand its performance reporting, particularly on outcomes, and Local Area Coordination and Information, Linkages and Capacity Building activities. The NDIA should also fill gaps in its performance reporting, including reporting on plan quality (such as participant satisfaction with their plans and their planning experience, plans completed by phone versus face-to-face, and plan reviews).

The *Integrated NDIS Performance Reporting Framework* should be regularly reviewed by the NDIA and the COAG Disability Reform Council and refined as needed.

9.8 The rollout timetable

As discussed throughout this paper, the ambitious timetable for the rollout presents a risk to the success and financial sustainability of the scheme. The speed of the rollout has:

- compromised the quality of plans (chapter 4)
- implications for the development of other parts of the scheme, especially the disability care workforce, which is unlikely to be sufficiently developed by 2020 to deliver the supports the NDIA is expected to allocate (chapter 7)
- imposed challenging timeframes on the development of important structural elements of the scheme — including details in relation to responsibilities at the coalface in services like health and transport (chapter 5); and instituting the new quality and safeguarding arrangements (section 9.6).

Some study participants argued that the rollout should be slowed down (box 9.6). For example, the Mental Health Community Coalition of the ACT (sub. 135, p. 24) argued that slowing down the implementation of the NDIS would mean that you could 'replace costly mistakes with getting it right in the first place'.

However, others argued that the rollout schedule should not be changed. For example, the Australian Federation of Disability Organisations said that slowing down the rollout is unacceptable to people who are waiting for support:

> Some in the sector have responded by arguing for a slow down [to] the roll out and to lengthen the transition period. To AFDO and its members, this would be completely unacceptable. For many people with disability, the wait has already been too long. For people who have had little or no support for many years, the NDIS cannot come quickly enough. Slowing down the roll out is therefore not an option. (sub. 180, p. 8)

Box 9.6 Some argued for a slowing down of the transition timetable

Cerebral Palsy Alliance:

> We would strongly recommend that the Commonwealth and States revise the transition timetable to support a realistic and manageable change management process for all stakeholders — as per NSW Bilateral Agreement - Management of Risk Clauses 48-51 — if the risk of market, sector and system readiness to transition emerges — changes to the participant phasing schedule may be considered by both parties. (sub. 163, attachment 2, p. 1)

David Parkin:

> The rollout to new areas needs to be slowed. Get the current system as right as it can be. There are enough participants now … who are actually using the system to understand where the effort needs to be applied. The NDIS has to listen to people and Providers. (sub. 177, p. 10)

Australian Lawyers Alliance:

> One important response to the challenges ought in our view to be a reconsideration of the rollout schedule. As at the date of this submission, the rollout is less than nine months old, yet the level of dissatisfaction with the scheme, and the clarity with which problems are being identified, are both rapidly escalating. (sub. 54, p. 6)

Australian Physiotherapy Association:

> Our members are concerned that the balance between the speed of the roll-out and its effectiveness needs to be changed, and the roll-out slowed so that the NDIS can properly train its team, manage its workload and provide consistent support to the regions in which the roll-out is occurring. (sub. 93, p. 8)

Maurice Blackburn Lawyers:

> A prudent approach would be to consider a slower roll-out schedule to help minimise the risks associated with the introduction of the scheme. … A revised rollout schedule could involve a complete cessation of the rollout on a regional basis for a specified period, to enable the remedial work to be undertaken, and a fresh analysis of readiness after that period.
>
> Aside from managing financial risks, a roll-out over an extended period would avoid significant frustration and distress for those living with disabilities and their families, and allow lessons learned from the early results to be incorporated into the scheme's final design. (sub. 58, p. 7)

The Commission acknowledges the hardship that has been imposed on some people with disability under the pre-NDIS arrangements that were 'inequitable, underfunded, fragmented and inefficient' (PC 2011, p. 5). Given the problems under the current rollout schedule, however, it may be that it will be in the interests of people with disability to slow down the rollout timetable.

A slowdown would provide the NDIA with more time to deal with planning and system issues. It would also give the market for disability care and support more time to develop, given that it could take at least a decade for a mature disability services market to develop (chapter 6). Governments at all levels would have more time to deal with interface issues at

an operational level, which is essential to ensure gaps do not emerge in a way that sees costs shifted to people with disability and their carers (chapter 5).

The rollout timetable is tied to the schedules set out in the Bilateral Agreements. Given that the numbers of scheme participants in the Bilateral Agreements are estimates and not hard targets, and that the NDIA is already behind on these estimates (chapter 2), there may be some flexibility for the NDIA to slow down the pace of the rollout should that be required.

The Bilateral Agreements for the transition also provide a potential mechanism for implementing a slowdown. For example, clause 50 of the NSW bilateral agreement on transition allows for a change in the participant phasing arrangements in the event of financial or other risks emerging. It requires the party with primary responsibility for the risk to work with other parties, including the NDIA, to develop an agreed strategy, and notes that other strategies must be pursued fully prior to considering changes in phasing agreements.

Any slowdown would have implications for scheme funding arrangements and the disability services provided by the states and territories. These matters would need careful attention should a slowdown be implemented.

The NDIA is aware of the current problems …

The NDIA acknowledges that the scale of the participant intake has affected the quality of participants' and providers' experiences (NDIA, sub. 161). The NDIA is working with participants, providers, peak disability bodies and other stakeholders to identify changes or improvements required to achieve:

- the intake of participants at the rate required by the Bilateral Agreements
- plans that maximise choice and control for participants, and contribute to improved participant outcomes
- plans that are of high quality
- plans that are financially sustainable so that the aggregate value of all plans remains within the funding envelope (sub. 161, p. 4).

While the NDIA's proposed new approach is yet to be tested with participants and providers, at this stage the Agency plans to have a greater focus on outcomes, more active involvement with communities, more face-to-face communications, and improved interaction with providers and disability organisations. The NDIA also plans to make improvements to its call centre and portal to make it easier to navigate (NDIA, pers. comm., 22 May 2017).

However, it will take time to implement the changes and for the changes to be reflected in the performance reporting data. On the information the Commission has received about the changes proposed by the Agency, the Commission is not in a position to form a judgment

about whether a greater focus on participant and provider experiences can be achieved while also meeting the bilateral estimates. A slowdown in the rollout of the scheme may be required. The Commission is seeking feedback on how a slowdown, if required, could be operationalised, and what the implications of a slowdown would be.

DRAFT RECOMMENDATION 9.5

In undertaking its role in delivering the National Disability Insurance Scheme, the National Disability Insurance Agency needs to find a better balance between participant intake, the quality of plans, participant outcomes and financial sustainability.

INFORMATION REQUEST 9.1

The Commission is seeking feedback on the most effective way to operationalise slowing down the rollout of the National Disability Insurance Scheme in the event it is required. Possible options include:

- *prioritising potential participants with more urgent and complex needs*
- *delaying the transition in some areas*
- *an across-the-board slowdown in the rate that participants are added to the scheme.*

The Commission is also seeking feedback on the implications of slowing down the rollout.

… but scheme success and financial sustainability are about more than the rollout

The rollout schedule is only one of the risks to achieving the objectives and financial sustainability of the scheme. A number of the other risks are outside the control of the NDIA (table 9.3). As the NDIA noted, levers that affect NDIS financial sustainability that it cannot control include:

- The responsiveness of the disability support market to changes in demand;
- National quality and safety regulation in the disability support market;
- Decisions by the Administrative Appeals Tribunal (AAT) or court system in interpreting the boundaries of access and reasonable and necessary supports;
- The efficiency of supports provided by mainstream support systems and community and natural supports. (sub. 161, p. 45)

Table 9.3 **Factors that influence financial risks to the scheme**

Outside the NDIA's control	The NDIA has some influence	Factors within NDIA's control
• Participant intake estimates in bilateral agreements • Adequacy of government disability and mainstream services • Continuity of support outside the NDIS • External reviews of decisions • Quality and safeguards regulation • Legislative framework and amendments	• Market development • Linking people to services outside the NDIS • Provider readiness and registration • Participant readiness • Broader disability policy and the National Disability Strategy	• Upholding eligibility criteria • Effective use of Early Intervention • Planning processes • Assessment of reasonable and necessary supports • Administration of supports • Quality of planners • Prices of supports • Information, Linkages and Capacity Building Activities • Local Area Coordination

Making the scheme work is not just the NDIA's responsibility — it is also the responsibility of governments, service providers, community organisations, employers, participants and their families and carers.

10 NDIS funding arrangements

Key points

- When the National Disability Insurance Scheme (NDIS) is fully rolled out in 2019-20, it is expected to cost about $22 billion. This is an increase of just over 150 per cent in funding from the $8.4 billion allocated to funding disability supports in 2015-16.
- The Australian, State and Territory Governments share responsibility for funding the NDIS. There are different funding arrangements for transition and full scheme.
  - During transition, the Australian, and State and Territory Governments will each contribute an agreed amount per participant based on the intake of participants in each state, which equates to around a 40-60 split respectively.
  - At full scheme (from 2019-20), State and Territory Governments will contribute $10.3 billion to the NDIS (escalated at 3.5 per cent each year). The Australian Government will fund the remainder.
- There are four main levers that affect the federal division of funding responsibilities: funding contributions by the Australian and State and Territory Governments; escalation parameters (which can affect funding contribution from the States and Territories over time); responsibility for funding cost overruns; and the approach taken to underspends.
- The Commission is seeking further input on the role of escalation parameters, as the objective is not clear. The 3.5 per cent escalation parameters currently specified in Bilateral Agreements is at the lower bound of a range that would be expected to keep real per capita contributions from the States and Territories constant over time. It is also likely to be too low to keep funding shares between the Australian Government and the States and Territories constant over time (after allowing for those over 65 who age in the scheme, who will be funded entirely by the Australian Government).
- In line with an insurance-based model, establishing a sufficient reserve fund would enable the National Disability Insurance Agency greater capacity to operate the scheme on insurance principles.
- Responsibility for cost overruns among governments should be allocated according to the proportion of risk controlled by each party. This is not the case in transition — the Australian Government bears liability for cost overruns, but important cost drivers are controlled by the State and Territory Governments. At full scheme, arrangements should apportion cost overrun risk and governance responsibility in line with control of risk.
- While in-kind contributions are necessary in the transition period, they risk jeopardising the objectives of the NDIS and should be phased out by the end of the transition period.

Funding for the National Disability Insurance Scheme (NDIS) is shared between the Australian and State and Territory Governments. The NDIS involves a significant increase in funding provided to people with disability. As discussed earlier in this report, when the NDIS is fully rolled out in 2019-20, it is expected to cost about $22 billion. This is an increase in total government spending on disability supports of:

- just over 150 per cent from the $8.4 billion in funding in 2015-16
- about a 200 per cent increase from the $7.1 billion government spending at the time of the 2011 Commission inquiry into *Disability Care and Support* (PC 2011, p. 675; SCRGSP 2017, p. 15.4).

In 2011, the Commission concluded that people with disability required more certainty about getting reasonable supports over their lifetime, and any disability insurance scheme would need a predictable revenue source:

> … revenue must not vary substantially from year to year or be subject to significant risks that future governments will cut it as part of changing budget circumstances. That implies the need for governments to make a binding commitment that makes it very difficult for them to divert the funding subsequently to other areas of spending. (PC 2011, p. 649)

The Commission's preferred funding option in 2011 was for the Australian Government to finance all the costs of the NDIS using its more efficient taxation base (compared to the State and Territory Governments' relatively limited tax options for raising additional revenue).[43] Another option was for all governments to pool funding subject to a long-run arrangement and with pre-specified funding shares (the arrangement that was put in place). As the Victorian Government said:

> The NDIS was developed against the background of a very high degree of vertical fiscal imbalance within the Australian federal system. In recognition of this, the PC originally recommended the Commonwealth take full responsibility for meeting the entire funding needs of the NDIS in part to '….*reflect the Australian Government's unique capacity to raise efficient and sustainable taxes of the magnitude required*' (PC 2011, p. 35).
>
> In the event it was agreed that the Commonwealth would fund the NDIS, with contributions from states as agreed bilaterally. (sub. 174, p. 23)

This chapter examines the current funding arrangements and the funding levers that affect the division of responsibilities between the Australian and State and Territory Governments.

The way the NDIS is funded in transition and at full scheme is examined in section 10.1. Section 10.2 looks at funding issues arising from the interface between Australian and State and Territory Governments' funding responsibilities, including funding shares, escalation parameters and cost overruns. Section 10.3 examines funding from an insurance-based approach, and section 10.4 looks at in-kind contributions.

[43] Chapter 14 of the Commission's Disability Care and Support inquiry report (PC 2011) examined in detail various options for financing the NDIS.

10.1 How is the NDIS funded?

The complex funding arrangements for the NDIS are set out in a range of intergovernmental agreements (box 10.1). The agreements outline, among other things:

- the respective funding responsibilities of the Australian and State and Territory Governments
- how the arrangements will change over time
- the different arrangements for transition and full scheme.

Box 10.1 Funding arrangements as set out in the intergovernmental agreements

Before the *National Disability Insurance Scheme Act 2013* (Cwlth) was passed (December 2012), the Australian Government and all State and Territory Governments signed the *Intergovernmental Agreement for the National Disability Insurance Scheme (NDIS) Launch*. This agreement established high-level funding principles including how underspends and overspends would be treated. More specific Heads of Agreement between the Australian Government and each of the State and Territory Governments (except Western Australia) set out funding details such as:

- responsibility for cost overruns
- the overall funding shares at full scheme, and escalation parameters
- in-kind arrangements.

For the NDIS transition period, the Australian Government and every State and Territory Government also signed Bilateral Agreements that detail:

- the number of participants that will be funded by the State and Territory Governments (participant numbers are capped in each quarter and preference is given to existing clients of State and Territory Government disability services)
- that the Australian, State and Territory Governments will each contribute a fixed amount per participant, based on actual intake of participants — around a 40-60 split respectively.

Sources: Australian Government and Western Australian Government (2017, p. 14); COAG (2012b).

As discussed in chapter 9, Western Australia has opted for a locally administered scheme and has different funding arrangements to the other states and territories (box 10.2).

Box 10.2 Funding arrangements in Western Australia are different

Western Australia has opted not to join the national scheme, but rather to have a separate WA NDIS (chapter 9).

WA NDIS during transition

During the transition period, as in other jurisdictions, the Western Australian Government will contribute 59.4 per cent of care and support package costs for an agreed number of eligible participants each year.

The Western Australian Government will cover a larger proportion of cost overruns than other State and Territory Governments.

- The Australian Government will bear a maximum of 25 per cent of any cost overruns for the WA NDIS when those overruns are due to a higher than expected number of participants or higher package costs.
- Cost overruns due to any other reasons will be funded by the Western Australian Government.
- If there are lower than expected package costs or participant numbers, the remaining funds will be split according to the contributions of each government.

The Western Australian Government and the Australian Government will share equally in the cost of Information, Linkages and Capacity Building grants and Local Areas Coordinators in that state. The Western Australian Government will fund the administrative costs of the WA NDIS. And as in the other states and territories, the Australian Government will fund supports for participants over 65 years old who choose to remain in the scheme, and Indigenous participants over 50 years old.

WA NDIS at full scheme

Limited details about the WA NDIS at full scheme are available, but at full rollout the Australian Government will make a fixed per person contribution towards the cost of the scheme in Western Australia and this amount will escalate at 3.5 per cent per annum.

Source: Australian Government and Western Australian Government (2017, p. 14).

Transition funding arrangements (2016-17 to 2018-19)

During the transition, the Australian Government will cover 40.6 per cent of the costs for participants under 65 years, and 100 per cent for non-Indigenous participants 65 years and over and Indigenous participants over 50 years who decide to remain in the scheme. The State and Territory Governments will fund the remainder (59.4 per cent of an agreed contribution).

The Australian Government will also fund Information, Linkages and Capacity Building (ILC) activities and the National Disability Insurance Agency's (NDIA's) operating expenses.

All cost overruns in the transition period are to be funded by the Australian Government.

Funding arrangements at full scheme

At full scheme, the State and Territory Governments, excluding Western Australia, will contribute about $9 billion[44] (table 10.1). The Australian Government will contribute the remainder. The fixed funding contributions of each State and Territory are based on the New South Wales fixed contribution of $3133 million in 2018-19 pro-rated, based on census population shares (DSS sub. 146, p. 21).

The Heads of Agreement stipulate that the state and territory contributions will increase at a rate of 3.5 per cent per year, subject to the responses to the recommendations of this study.

Table 10.1 **State and Territory funding commitments in 2019-20**

State or Territory	*Contribution ($ millions)*
New South Wales[a]	3 243
Victoria	2 510
Queensland	2 030
South Australia[a]	748
Tasmania	232
Australian Capital Territory	167
Northern Territory	99
Total[b]	9 029

[a] Not stated directly in Bilateral Agreement, instead a figure of $3133 million is given for 2018-19 which was escalated at 3.5 per cent for the 2019-20 figure. The same calculation was performed for SA where a figure of $723 million is given for their contribution in 2018-19. [b] The total excludes WA's contribution if it joined the national scheme.

Source: Heads of Agreement with each of the State and Territory Governments (except Western Australia).

While arrangements for cost overruns at full scheme are still being finalised, the Australian Government in the Heads of Agreement committed to fund at least 75 per cent of these overruns at full rollout subject to the outcomes of this review (Australian Government and New South Wales Government 2012).

It is evident from the above that funding arrangements are highly complex. Given this complexity, it is essential that comprehensive and timely data from the NDIA be made available to relevant Finance and Treasury departments in all jurisdictions to allow for proper oversight of NDIS costs.

[44] Estimated to be $10.3 billion once agreement with Western Australia is reached.

Sources of NDIS funding

Australian Government funding for the NDIS comes from a number of sources:

- funds redirected from previous Australian Government disability service programs to the NDIS
- funds previously provided to State and Territory Governments under the National Disability Agreement and the 2011 National Health Reform Agreement
- a 0.5 percentage point increase in the Medicare Levy on taxable income which provides funding via the DisabilityCare Australia Fund (DCAF) (box 10.3). Around 75 per cent of the revenue from the DCAF goes to the Australian Government — the remainder is allocated to the State and Territory Governments to partially reimburse their contributions to the NDIS
- debits from the soon-to-be-established NDIS Savings Fund (box 10.3), which will source funding from:
  - an additional 0.5 per cent increase in the Medicare Levy on taxable income (subject to legislative passage)
  - underspends and realised savings from the NDIS (through, for example, changes to budget forecasts reflecting cost saving measures by the NDIA)
  - uncommitted funds from the Building Australia Fund and Education Investment Fund.

State and Territory Government contributions are funded through:

- redirected funding previously used for legacy specialist disability services
- about 25 per cent of the funds available from the DCAF — approximately $825 million from 2014-15. This payment will increase by 3.5 per cent each year until 2023-24 (*DisabilityCare Australia Act 2013* (Cwlth), box 10.3)
- consolidated general State Government revenue.

Box 10.3 The DisabilityCare Australia Fund and the NDIS Savings Fund

The Australian Government increased the Medicare Levy by 0.5 per cent from July 2014-15 to provide funding for the NDIS. The funds from the Medicare Levy are credited to the DisabiltyCare Australia Fund (DCAF) to be invested through the Future Fund to provide payments to the Australian, State and Territory Governments to partially meet their funding obligations for the NDIS.

As set out in the *DisabilityCare Australia Fund Act 2013* (Cwlth), from 2014-15, the State and Territory Governments are entitled to credits of $825 million in funding from the DCAF. This amount will increase at 3.5 per cent each year until 2023-24. Over 10 years (ending 2023-24), State and Territory Governments will have access to a total of $9.7 billion between them, which they can use to partially fund their portion of the NDIS contributions.

State and Territory Governments can draw down from the DCAF when they meet key conditions, including agreement to full scheme and when at least 50 per cent of their eligible population is covered by the scheme. Funds not allocated to State and Territory Governments can be used by the Australian Government to fund its portion of the NDIS.

At 31 December 2016, the DCAF had just over $6 billion in assets.

The DCAF is also to be complemented by the recently announced NDIS Savings Fund. The Australian Government's 2017-18 Budget includes plans to increase the Medicare Levy by (a further) 0.5 per cent which will be credited to a new NDIS Savings Fund (separate from the DCAF) alongside other contributions from underspends on NDIS and recommitting funds from the Building Australia Fund and Education Investment Fund. The increased Medicare levy and creation of the NDIS Savings Fund are subject to legislation passing through parliament.

The NDIS Savings Fund will ring-fence — or hypothecate — revenue specifically for use for the NDIS. These funds will not be made available to the NDIA any sooner than they would if the Australian Government had continued funding their contributions from general consolidated revenue.

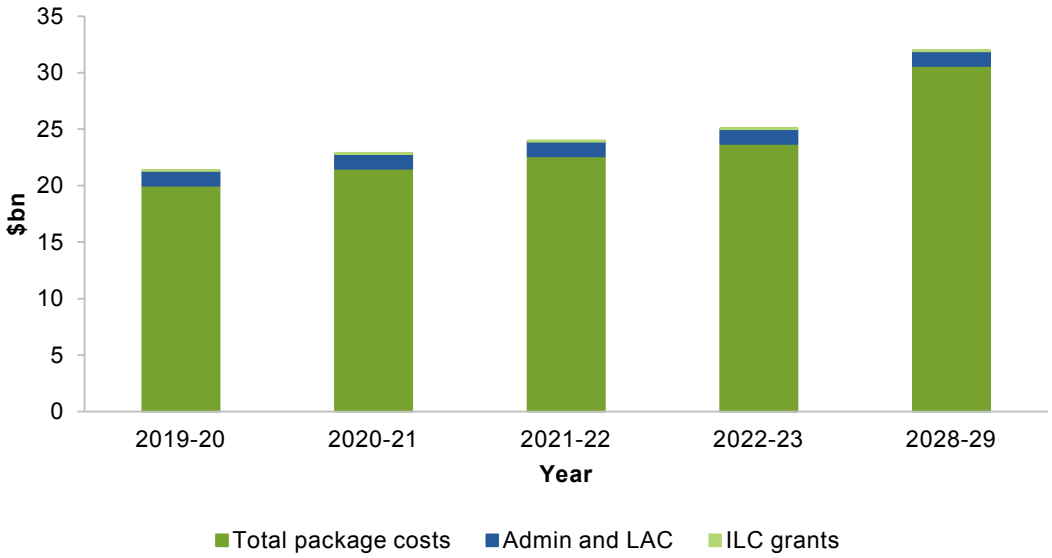
Sources: Australian Government (2012); Australian Treasury (2017c).

The majority of funds are for individualised supports

Individualised support costs make up the majority of the NDIA's funds (around 93 per cent) at full scheme (figure 10.1). The operating budget includes funding for assessment, planning and Local Area Coordination (LAC). The Information, Linkages and Capacity building (ILC) grants program is a separate pillar of the NDIS (Australian Treasury 2017b, p. 140).[45]

[45] ILC will provide information, linkages and referrals to people with disability, their families and carers, with appropriate community and mainstream supports (chapter 5).

Figure 10.1 **Full scheme funding uses over time**[a]



[a] While most chapters in this report use modelling based on NDIA models and data, this chapter uses a funding and costs model provided by the Department of Social Services (DSS). The DSS model is more fit for purpose (than an actuarial model) to examine matters about NDIS costs and funding shares by the Australian, State and Territory Governments. Accordingly, there is a small difference in total scheme costs in this chapter compared to other chapters, reflecting the different purposes of the models and the periods of data used.

Source: Estimates provided by the DSS (sub. 146, p. 17) based on MYEFO 2016-17 data.

10.2 Creating the right incentives in a federal system

As discussed above, Bilateral Agreements define the boundaries of Australian and State and Territory Government responsibility. This section discusses some issues arising out of the interface between Australian and State and Territory Government responsibilities, including:

- escalation parameters
- how any potential large changes to scheme costs might be addressed in the allocation of funding
- how cost overruns are funded and who has control over them.

Escalation parameters and funding shares

As the NDIS is designed to be a no-fault scheme that covers the entire population, the contributions of governments to the NDIS can be thought of as an insurance premium paid by individuals through their taxes. At full scheme, the Australian Government will

contribute an 'insurance premium' to the NDIA on behalf of the citizens in each state. This premium is calculated based on scheme costs and the number of participants in each state.

As discussed above, the State and Territory Governments contribute a fixed amount which escalates at an agreed rate of 3.5 per cent each year from 2019-20 (table 10.2). The escalation parameters are based on:

- the Consumer Price Index (CPI) (midpoint of the long term CPI target Reserve Bank of Australia range (2.5 per cent)) and
- a long term net population growth of one per cent each year (table 10.2).

Table 10.2 **Projections of the funding split over time**[a]

	2019-20	*2020-21*	*2021-22*	*2022-23*	*2028-29*
	$ billion	$ billion	$ billion	$ billion	$ billion
Gross scheme costs	21.5	22.8	24.0	25.1	32.1
- Participant package costs	20.0	21.5	22.0	23.7	30.6
- ILC block grants	0.1	0.1	0.1	0.1	0.1
- Admin and other	1.3	1.3	1.3	1.3	1.3
Commonwealth contributions	11.1	12.0	12.7	13.5	17.9
- % of gross scheme costs	52	52	53	54	56
State and territory contributions	10.3[b]	10.9	12.2	11.6	14.3
- % of gross scheme costs	48	48	47	46	44

[a] While most chapters in this report use modelling based on NDIA models and data, this chapter uses a funding and costs model provided by the Department of Social Services (DSS). The DSS model is more fit for purpose (than an actuarial model) to examine matters about NDIS costs and funding shares by the Australian, State and Territory Governments. Accordingly, there is a small difference in total scheme costs in this chapter compared to other chapters, reflecting the different purposes of the models and the periods of data used. [b] The $10.3 billion estimate of the contribution from the States and Territories in 2019-20 includes the agreement contributions of the State and Territory Governments (excluding Western Australia), plus the estimated contribution from the Western Australian Government once agreement is reached.

Source: DSS (sub. 146, p. 17).

The Heads of Agreement state that, in the event COAG agrees to revise the escalation parameters (based on the advice of this study), escalation parameters will be revised for the State and Territory Governments. There will also be a review every five years (similar to this review), in order to rebase funding per capita based on Census population figures. The first re-basing is expected to occur from 1 July 2023 based on 2021 Census figures.

The objectives of the escalation parameters

The terms of reference for this study ask the Commission to look at changes in the agreed escalation parameters. This was far from straightforward because there is no clearly stated objective for the escalation parameters in the Heads of Agreement. There are also different views about what escalation parameters should be designed to achieve.

Different views among participants

Some participants were of the view that escalation parameters should be used to maintain real per capita contributions to the NDIS by State and Territory Governments. However, others argued that the parameters should be used to increase contributions in line with changes in scheme costs.

The New South Wales Government, for example, argued that the contributions of State and Territory Governments should not increase in line with changes in scheme costs:

> Unlike other sectors like electricity the NDIS is administered under Commonwealth, not State legislation.
>
> In this context, NSW contributed its full disability funding to the NDIS at 2018-19, namely a fixed $3.2 billion per annum plus escalation (3.5%). This is akin to how the Commonwealth provides Specific Purpose Payments to States for health, education, housing and disability. That is, having made a contribution and defined indexation rate the Commonwealth does not vary its payments based on actual costs.
>
> Currently, States are expected to administer state service systems using Commonwealth and State funds. (sub. 60, pp. 12–13)

The Victorian Government also said:

> Current cost and risk sharing arrangements should be maintained as they reflect the reality that the ability of the states to take on any greater financial risk is severely limited. (sub. 174, p. 23)

However, the NDIA observed that scheme costs are likely to increase by more than the current 3.5 per cent escalation parameters and this will mean that funding shares will change:

> The NDIA can observe that wage inflation and the Equal Remuneration Order (ERO) are likely to result in an increase above 3.5 per cent in the short-term, which will result in a skewing of the contributions. Longer-term assumptions should be set considering wage inflation levels, population growth rates, and efficient prices. (sub. 161, p. 114)

The Department of Social Services (DSS) also said:

> The NDIS is currently estimated to cost in the order of $22 billion once fully rolled out in 2020. Over the medium term, this cost is expected to grow above long-term inflation and population growth trends due to the impact of people ageing over 65 in the Scheme. As a result, the cost of the NDIS is expected to increase to more than $32 billion by 2030, with the Commonwealth

> share roughly half of all costs in the short-term, but growing through time as existing participants turn 65 to around 56 per cent by 2030. (sub. 146, p. 17)

And, while the DSS agreed that in the long term, when the scheme has matured, an escalation rate informed by a small number of key economic parameters would be appropriate, it also argued that in the short to medium term:

> … the escalation rate is unlikely to reflect underlying cost growth in the Scheme. This is because the expansion of the market does not lend itself to long-term growth rates in the near future, and it will take some time for the number of participants aged 65 and over in the scheme to stabilise. Instead, a medium- term escalation rate should be developed that considers known transition variables. (sub. 146, pp. 20-21)

The DSS suggested that a medium-term escalation parameter should take into account scheme cost drivers such as social and community services award wages, market development issues, the impact of early intervention, projected disability prevalence rates and observed growth in similar markets or schemes.

The DSS (sub. 146, p. 21) also suggested that the state contribution escalation parameters should be adjusted to take account of the State and Territory Governments' roles and responsibilities, including the extent to which states support and fund mainstream services.

Different arrangements for funding shares between transition and full scheme

Differences in views about the role of escalation parameters reflect tensions about whether current funding shares of the State and Territory Governments should remain the same or change over time. (Noting that the Australian Government is to fund participants over 65 years, and this alone will mean an increasing share of funding will fall to the Commonwealth).

During transition, state and territory funding shares are explicitly tied to scheme costs — the State and Territory Governments make a contribution towards an agreed reasonable average package cost on a per participant basis for up to a set number of participants. But at full scheme, the State and Territory Governments' funding contributions are fixed (escalating at 3.5 per cent per year), which means if scheme costs increase by more than inflation and population then the states contribution share will decline over time.

Some stakeholders suggested to the Commission that escalation parameters should be used, in lieu of adjusting the way funding shares are calculated, to ensure that State and Territory Government contributions increase in line with scheme costs.

The objectives need to be clearer

The way initial funding contributions are calculated and how they increase over time are key determinants of the division of funding responsibilities between the Australian and

State and Territory Governments. (Responsibility for cost overruns and underspends are the other key levers, discussed below.)

The threshold issue for designing the escalation parameters is whether or not State and Territory Government contributions at full scheme and beyond should be designed to keep pace with scheme costs, or simply maintain existing real per capita contributions. The New South Wales Government noted that it did not commit to meeting scheme costs:

> NSW's disability funding was our contribution towards the NDIS, not a commitment to meet actual costs or activity levels as the scheme evolved. This is clear in paragraphs 15 and 16 of the Heads of Agreement between the Commonwealth and NSW Governments. (sub. 60, p. 13)

One argument in favour of State and Territory Governments contributions not increasing in line with scheme costs over time is that they rely on less efficient tax bases and have more limited ability to raise funds than the Australian Government.

However, the Commission also notes that the DCAF is designed to partially fund State and Territory Government contributions via the Medicare Levy, which is administered by the Australian Government. As discussed in box 10.3, the State and Territory Governments will be entitled to $825 million from the DCAF from 2014-15, but are not guaranteed access before 2023-24. This arrangement could overcome inefficiencies in relying more on state tax bases, but it is due to expire after ten years.

If it is agreed that State and Territory Government contributions should keep pace with scheme costs, there are two ways to achieve this.

The first is to rework the way State and Territory Governments' funding shares are calculated, so that they are adjusted over time to explicitly reflect scheme costs. If state and territory funding shares were calculated to explicitly reflect scheme costs over time then the escalation parameters should be calculated to maintain these shares on a constant real per capita basis over time. It is worth noting that the existing escalation parameters of 3.5 per cent per annum seems to be on the lower bound of estimates that would achieve this (box 10.4).

The alternative approach is to leave the State and Territory Governments' funding shares at full scheme as they are and use the escalation parameters to increase state and territory government contributions in line with scheme costs.

This would require the escalation parameters to be calculated using additional variables to account for cost drivers over time. As noted above, the DSS (sub. 146, p. 21) suggested a number of potential cost drivers, including social and community services award wages, market development issues, the impact of early intervention, projected disability prevalence rates and observed growth in similar markets or schemes.

Box 10.4 Different assumptions lead to different escalation parameters

Using recent history as a guide, the low inflation of recent years could imply the agreed escalation parameters of 3.5 per cent seem reasonable. However, the Reserve Bank of Australia expects inflation to return to its range of 2-3 per cent by 2019-20 and the Australian Bureau of Statistics have previously projected population growth to be higher than one per cent well into mid-century. On this basis, escalation parameters in the range of 3.3 per cent to 4.8 per cent (midpoint of about 4 per cent) seem more appropriate than the current 3.5 per cent.

Any changes to the escalation parameters applied to State and Territory Government contributions towards the National Disability Insurance Scheme (NDIS) should also be applied to other NDIS funding factors linked to the escalation parameters — that is, State and Territory Government receipts from the DisabilityCare Australia Fund and the Australian Governments' planned contribution towards WA NDIS post 2020. This would require legislative change.

	Population	*Inflation*	*Implied escalation parameter*[a]
Historical 10 year average annual growth (Sept 2007 to 2016)	1.66	2.36	4.02
Historical 3 year average annual growth (Sep 2014 to 2016)	1.43	1.70	3.13
Medium-term projections (June 2020 to 2023)[b]	1.31-1.83	2-3	3.31-4.83 (midpoint of 4.07)
Long-term projections	1.00	2.50	3.50

[a] Sum of population growth and inflation. [b] The Australian Bureau of Statistics projections have three different scenarios to project population growth. The numbers presented here are the range implied by their estimates.

Sources: ABS (*Australian Demographic Statistics, Sep 2016*, Cat. no. 3101.0; *Consumer Price Index, Australia, Mar 2017*, Cat. no. 6401.0; *Population Projections, Australia, 2012 (base) to 2101*, Cat. no. 3222.0); RBA (2017).

If escalation parameters were used to maintain the State and Territory Governments' funding shares, it would also be necessary to review them periodically. This is because it may be difficult to sufficiently capture all the variables that would maintain the underlying funding shares over an extended period.

Finally, even though funding shares are subject to a five yearly review, reassessing financial contributions every five years does not allow the funding arrangements to be agile enough to address sudden shocks to scheme costs. This could be problematic if any such shocks had significant implications for the financial sustainability of the NDIS. For example, if there was an unforeseen sudden structural shift in labour markets that caused wages and, as a result, package costs to increase, then under transitional arrangements the Australian Government would bear the entirety of this cost until the next five yearly review. Quickly adjusting Bilateral Agreements is not a feasible option in this instance.

One option (considered below) is to allow the NDIA to retain significant reserves. This would allow them to keep windfalls from underspends for later use if there are sudden overruns and so reduce the need for external funding of overruns.

The Commission seeks more information on these issues.

DRAFT FINDING 10.1

The objective of the escalation parameters is not specified in the Bilateral Agreements between the Australian Government and the State and Territory Governments at full scheme.

The existing escalation parameters are unlikely to reflect the full increase in National Disability Insurance Scheme (NDIS) costs over time, which would result in the Australian Government bearing a higher share of NDIS costs over time.

INFORMATION REQUEST 10.1

The Commission is seeking views on the role of the escalation parameters in the Bilateral Agreements between the Australian Government and the State and Territory Governments.

Should escalation parameters be set on the basis of maintaining a constant real per capita contribution to the National Disability Insurance Scheme by State and Territory Governments; or should they be more explicitly tied to scheme costs so that the proportion of funding allocated to the Australian Government and the State and Territory Governments is maintained over time?

Any changes to state and territory funding shares will affect a number of issues discussed in the remainder of this chapter (and in chapter 5), including:

- the level of participation by State and Territory Governments in the scheme's implementation and governance and the implied incentives to fund mainstream services and disability services outside the NDIS
- the incentives for the Australian Government to manage NDIS cost overruns
- how cost overruns are treated in the absence of agreed package costs and participant numbers.

These factors should also be taken into account in considering reallocation of state and territory funding shares and escalation parameters.

Cost overruns: Aligning risk and responsibility

Good risk management requires those who are best placed to manage the risk have responsibility for it. This implies that arrangements for funding cost overruns should be aligned with the ability to control them. This is not the case in the transition period, because the Australian Government bears full responsibility for cost overruns while not having complete control over the factors that contribute to these cost overruns. Two important factors affecting costs that the Australian Government does not have control over are:

- the impact of governance arrangements over NDIS scheme costs such as those contained in the NDIS Rules (box 9.2) or the processes for appointing NDIA Board members
- provision of mainstream services and their interface with the NDIS (chapter 5).

Mainstream services are within the control of the State and Territory Governments. NDIA governance arrangements — such as changing certain NDIS Rules and changing the NDIA Board — require unanimous support from the State and Territory Governments, limiting the ability of the Australian Government to control costs.

There are two options to redress this misalignment — changing the governance arrangements of the NDIS to give the Australian Government more control over cost overruns, or giving the State and Territory Governments some responsibility for cost overruns to reduce their potential incentives to cost shift from mainstream and other disability services outside the NDIS. These options may not be mutually exclusive, given they address different cost control levers.

DRAFT FINDING 10.2

Responsibility for funding National Disability Insurance Scheme (NDIS) cost overruns should be apportioned according to the parties best able to manage the risk. This is not the case in the transition period, as the Australian Government bears all the risk of any cost overruns, but not all the control.

The governance arrangements for the NDIS do not allow the National Disability Insurance Agency to respond swiftly when factors outside its control threaten to impose cost overruns.

Governance and funding arrangements are critical in defining federal-state responsibilities. And incentive issues will exist as long as multiple levels of government have the responsibility for delivering disability and mainstream services.

Giving the states more responsibility for cost overruns

One option is to give the State and Territory Governments more responsibility for NDIS cost overruns. This could reduce incentives to cost-shift from mainstream services to the

NDIS. Incentives to cost-shift under current arrangements were raised as a concern by some study participants. Physical Disabilities Australia, for example, said:

> PDA does not believe the current funding arrangements between the Commonwealth and the State and Territory Governments secure the NDIS' future. Instead, we believe they will threaten the Scheme's viability. Whilst the funding commitments are shared in this way, politicians at all levels will continue to threaten the Scheme's future by claiming the other entities 'aren't paying their fair share' or are 'exploiting [their jurisdiction's] better run economy'. (sub. 38, p. 17)

If cost overruns were to be reallocated, ideally they would be apportioned by calculating the proportion of control over cost overruns held by State and Territory Governments, and the proportion that the Australian Government controls, and allocating responsibility for cost overruns accordingly. As the NT Government said:

> NDIS governance and administrative arrangements post full Scheme should acknowledge the long term shared responsibility and investment of the Commonwealth, states, territories and the NDIA in achieving outcomes, in terms of both service delivery and financial risk. (sub. 205, p. 3)

While it is difficult to calculate such shares accurately, given the State and Territory Governments' responsibility for providing mainstream services (and some disability services), they should bear a share of cost overruns that is significant enough to mitigate any incentives to cost shift onto the NDIS.

Suggestions from participants were that between 25 and 50 per cent of the cost overruns should be borne by the states. Richard Madden, for example, said:

> A minimum of 25% State and Territory share of cost overruns would seem appropriate having regard to the impact of mainstream service provision. (sub. 101, p. 5)

The DSS suggested that the State and Territory Governments need to bear around half of cost overruns:

> Full Scheme risk sharing arrangements need to be equal until the Scheme matures, and this will require State governments to bear 50 per cent of the risk. To manage Scheme risks, agile and streamlined governance is needed, with more control going to those governments that bear the most risk — currently the Commonwealth Government bears full risk. (sub. 146, p. 33)

Decisions about the allocation of cost overruns should also take into account incentives or levers that the Australian Government might have to cost shift to the states. There are currently safeguards against such behaviour (including the requirement for unanimous agreement to make substantive changes to the scheme through the NDIS Rules, adjusting the NDIA Board membership or giving the NDIA specific directives, chapter 9). However, any increase in the cost overruns assigned to the State and Territory Governments should be considered in combination with their governance role.

Giving the Australian Government more control over governance arrangements

There are two changes to governance arrangements that could be made.

One option is to relax the governance arrangements of the NDIS that require unanimous agreement of the Australian, State and Territory Governments to change the NDIS Rules (chapter 9) on the basis that the Australian Government is responsible for cost overruns. As discussed in chapter 9, there could also be operational benefits for the NDIA from taking a more flexible approach to rule changes — including reducing the time taken to make operational decisions, or responding to emerging pressures.

However, the NDIS is not a scheme that operates in isolation — the State and Territory Governments have responsibility for funding mainstream services. The scope of the NDIS (determined by the eligibility requirements set out in the Rules) can also affect the costs borne by the State and Territory Governments. It is therefore important that the State and Territory Governments have some control over changes to the Rules.

Another option is to allow the Australian Government to have a greater influence over the composition of the Board of the NDIA. But again, for incentives to be aligned, the State and Territory Governments should play a role in Board member appointments to the extent that the Board's management of the Agency affects mainstream and non-NDIS disability services. Some stakeholders echoed these concerns. For example, the Victorian Government argued that:

> The states must be part of any decision-making process that determines what will be funded under the NDIS. Given the critical interface between the NDIS and state-funded mainstream services, Victoria considers these arrangements as a necessary safeguard against decisions about the scheme's scope which could result in a significant transfer of costs and risks to state-funded services, and poor outcomes for people with a disability. (sub. 174, p. 22)

A number of options could potentially strike a balance between giving the Australian Government more control over governance while still allowing the State and Territory Governments to have a significant say in the operation of the NDIS. For changes to the Rules, these options could include: a requirement for majority rather than unanimous agreement (including the Commonwealth); relaxing the formalities required to reach agreement to speed up the process; or having a mechanism that lets the majority (including the Commonwealth) be the deciding vote if agreement is delayed past a certain time limit. The Commission is seeking feedback on possible options for reforming governance that achieve this objective.

INFORMATION REQUEST 10.2

The Commission is seeking information on the best way to align the ability to control cost overruns with the liability to fund cost overruns. Possible options include:

- *estimating the proportion of cost overruns that the Australian and State and Territory Governments are responsible for and allocating funding responsibility accordingly*
- *altering the governance arrangements of the National Disability Insurance Scheme to give the Australian Government greater authority to manage the risk of cost overruns, to better reflect their funding liability.*

However, there are no easy answers to reforming funding and governance arrangements, as changes to governance also affect the operation of the NDIA itself. This is discussed further in the next section.

Arrangements in Western Australia

As discussed above, the Western Australian Government has agreed to bear the majority of the cost overruns in the transition to the WA NDIS, with the Australian Government agreeing to contribute no more than 25 per cent over the transition.

Given the role the Western Australian Government has in managing and implementing the WA scheme, it is reasonable for the State Government to bear greater risk.[46] However, Western Australia's separate management of the scheme also poses risks to national consistency of the NDIS (chapter 9).

Should the Western Australian Government choose to join the national scheme, the Commission considers the risk-sharing arrangements between the Australian and Western Australian Governments should be aligned in accordance with the principles applied for the rest of the NDIS.

10.3 Funding an insurance scheme

While the NDIS is an insurance-based scheme, the way the funding and governance arrangements are designed means that it departs from the principles applying to an insurance scheme in a number of areas. As discussed above, the NDIA does not determine its own funding envelope, and as discussed in chapter 9, COAG controls the NDIS scheme's Rules.

46 The WA NDIS Authority, although a Western Australian Government agency, will be governed by an independent Board of seven, with four of the members (including the chair) appointed by the Western Australian Government and the Australian Government appointing the remainder (Australian Government and Western Australian Government 2017).

The NDIA's capped operating costs

At full scheme, the NDIA's operating costs will be capped at 7 per cent of package costs each year. While operating costs made up 33 per cent of scheme costs in 2016, over the transition to full scheme (in 2019-20), this will decrease to a capped 7 per cent target (NDIA 2016g, p. 109).

The 7 per cent operating cost target is similar to that recommended by the Commission in 2011 (PC 2011, p. 776). However, the Commission did not recommend a hard cap. Also, while it was expected that the NDIA would require a workforce of about 10 000 people to deliver the NDIS at full scheme, the NDIA has a full scheme cap of 3000 directly employed staff. The other 7000 people will be outsourced to partner organisations (DSS, sub. 146, p. 24).

The rationale for capping the operating expenses of the NDIA appears to be to encourage administrative efficiencies, and the rationale for the staff cap to encourage the NDIA to enter into community partnerships. The DSS (sub. 146, p. 24) commented that that the 7 per cent cap was 'an aspirational approach designed to encourage best practice and efficient operations'.

However, capping operating expenses could have perverse outcomes in practice.

First, as noted in the NDIA's Annual Sustainability Report, the risks to the scheme's sustainability from the setting of operating expense budgets are clearly asymmetric:

> It is worth noting that a 10% increase in the operating budget may result in additional expenditure of approximately $150 million at full scheme, however an increase in package costs of 10% could result in an additional $2 billion at full scheme (NDIA 2016b, p. 56).

If the NDIA's operating budget is set too tightly, this could hinder its ability to contain package costs (through upfront investments in ICT, LACs, assessors and planners) which could in turn have a significant effect on package costs and scheme sustainability.

A number of study participants argued that the 7 per cent cap is too low (for example, ABF, sub. 48; PDCN, sub. 29; Sotica, sub. 67) and that it is below typical insurance scheme benchmarks.

The Commission notes that achieving a 7 per cent target by full scheme requires the NDIA to cut operating expenditure by 18 per cent ($250 million) between 2018-19 and 2019-20. This seems highly ambitious (box 10.5) without jeopardising the quality of individualised supports (chapter 4).

However, the NDIA (sub. 161, p. 110) said that it expects it can meet the 7 per cent operating cost target at full scheme and effectively manage the NDIS. But, it argued for greater flexibility in its operating costs budget to account for year-to-year fluctuations in operating expenses.

The Commission notes that comparable, more mature schemes operate close to a 7 per cent average, but have significant fluctuations in their annual operating expenses as a proportion of their overall expenses (box 10.5).

Box 10.5 Operating expenses of the NDIA and comparable schemes

NDIS expenses by category

	2015-16 (actual)	*2016-17 (actual)*	*2017-18 (projections)*	*2018-19 (projections)*	*2019-20 (projections)*	*2020-21 (projections)*
Package costs ($m)	859.9	2 973.0	8 045.1	14 267.1	17 855.8	19 165.5
ILC ($m)	10.7	33.3	68.9	105.3	119.3	118.6
Operating expenses ($m)	301.2	704.9	1 033.0	1 393.9	1 143.9	1 096.2
Total scheme costs ($m) [a]	1 171.7	3 711.2	9 147.0	15 766.2	19 119.1	20 380.3
Operating expense ratio (%)[b]	35	24	13	10	6	6

[a] The total cost of the scheme in the budget papers used in this table is less than the $22 billion figure quoted elsewhere because it does not include WA. Elsewhere in this report, estimates are made on the basis of WA being part of the national scheme. [b] The expense ratios differ from NDIA targets and estimates because the NDIA and the Department of Social Services use slightly different projections of scheme costs.

Operating expense ratios[c] of comparable schemes (per cent)

	2010-11	*2011-12*	*2012-13*	*2013-14*	*2014-15*	*2015-16*	*Average*
NZ Accident Compensation Corporation	11.9	6.0	22.9	11.1	7.4	4.9	8.1
NSW Lifetime Care and Support[d]	2.0	3.6	3.6	3.6	4.0	8.4	3.3
VIC Transport Accident Commission	8.5	4.6	11.7	7.4	6.0	4.8	6.4
Disability Care and Support Nationwide	7.6	7.4	6.6	6.5	6.2	6.4	6.8

[c] The ratio of average operating expenses between 2010-11 to 2015-16 to the average total expenses over the same period. [d] The figure for 2015-16 comes from very different reporting standards so may not be comparable with previous years. Further, the number was given in the annual reports without any information about how it was calculated. For this reason it was excluded from the average.

Sources: Accident Compensation Corporation (2011, 2012, 2013, 2014, 2015, 2016); Australian Treasury (2016a, 2017b); Lifetime Care and Support Authority (2011, 2012, 2013, 2014, 2015, 2016); SCRGSP (2016, 2017); and Transport Accident Commission (2011, 2012, 2013, 2014, 2015, 2016).

While the Commission understands the need to create incentives for administrative efficiencies, a hard cap for operating expenses enforced year in, year out does not align with the way an insurance scheme operates. Greater flexibility (including setting an operating budget that sits within a funding target) would allow investments to be made that reduce lifetime costs (for instance, investing in LACs early on to increase participant capacity and readiness which could lower costs in the long-term).

One way to balance flexibility with accountability would be to allow a target range for operating expenses, with the expectation that the Agency would sit at the bottom of this target on average. This would allow the NDIA some flexibility to smooth out year-to-year fluctuations in spending while also placing some limits on administrative spending.

Based on comparable schemes (box 10.5), a target of 7 to 10 per cent appears to be reasonable. Should the NDIA exceed this in a particular year, they should be required to publicly report the reasons why.

DRAFT RECOMMENDATION 10.1

At full scheme, the annual operating budget for the National Disability Insurance Agency should be set within a funding target of 7-10 per cent of package costs with the expectation that, on average, it would sit at the lower end of the band.

The National Disability Insurance Agency should be required, in its annual report, to state reasons why it has not met this target in any given year.

A similar rationale applies to allowing more flexibility around the current staff cap of 3000 people. Because of the cap, the NDIA needs to outsource much of its work. This presents a particular risk when the agency is so new, and therefore needs to build institutional expertise and knowledge.

However, the Commission understands there may be practical limitations to implementing any changes to the staff cap, given the Australian Government's Smaller Government agenda.

DRAFT RECOMMENDATION 10.2

The Australian Government should reconsider the staffing cap on the National Disability Insurance Agency, given the importance of developing internal capability and expertise.

Lack of flexibility in how funds are used

As discussed above, the funds received by the NDIA are allocated to three streams:

- participant supports
- Information, Linkage and Capacity Building grants (chapter 5)
- operating costs (which includes LACs, and 20 per cent of LAC funding is allocated to ILC activities) (NDIA, sub. 161, p. 13).[47]

[47] At full scheme, the Heads of Agreement state that: State and Territory Government funding will pay for participant supports, defined as: individualised support packages for scheme participants, and Local Area Coordinators and other general supports as defined by section 13(2) of the *National Disability Insurance*

Australian Government entities receive their budget in two allocations: one allocation for operating expenses, and a separate allocation for program delivery, divided into different streams (Department of Finance, nd).

Some participants to this study argued that the NDIA should be given more flexibility in how it allocates its funds. For instance, the NDIA commented:

> The funding model of the NDIS quarantines funds that have been provided to the NDIA for reasonable and necessary supports so that they cannot be used for any other purpose. The effect of this in relation to ILC is that, irrespective of the insurance approach and any potential savings to package costs from ILC, funding is strictly limited to what has been made available for operating costs.
>
> This strict split of funding constrains the NDIA's ability to manage Scheme costs by investing in community based activities that may lower the demand for individual packages. (sub. 161, p. 55)

The DSS also expressed a desire for flexibility to be considered as an option to enhance the Agency's insurance approach:

> The initial PC report recommended a small, fixed amount for ILC, but options could be explored, such as giving the NDIA greater flexibility to invest in ILC if linked to reducing overall Scheme costs via its insurance approach. (sub. 146, p. 31)

Private insurance firms have more flexibility in how they allocate their funding, but they are subject to different transparency and accountability requirements than the NDIA (for instance, more stringent reporting requirements).

The Commission recognises the benefits from having the flexibility to make investments,[48] but a better way to achieve this could be by giving the NDIS access to a pool of reserves (discussed below).

To ensure that ILC grants do not encroach on State and Territory Governments' responsibilities, it is important for State and Territory Governments to be involved in decision making about the scope of these grants.

Limited access to a pool of reserves

The NDIS is currently funded on a mostly pay as you go (PAYG) basis, which means that current taxpayers meet the current obligations of the scheme. In transition, underspends of up to three months' worth of support costs can be retained by the NDIA, with amounts

Scheme Act 2013 (Cwlth). Australian Government funding will pay for all additional participant supports, defined as: individualised support packages for scheme participants, and local area coordinators and other general supports. The Australian Government will also pay all administrative costs for the NDIA.

48 For example, New Zealand's Accident Compensation Corporation invests in programs designed to limit the number of catastrophic accidents in a variety of contexts. Their Board has discretion to undertake such activities within their funding envelope.

over this returned to the particular governments in proportion to their contribution. It is not yet certain what the arrangements will be at full scheme.

Retaining three months of reserves appears suitable for the transition period, where reserve amounts may reflect participants who were expected to transition to the NDIS but have not yet done so (and still remain on pre-NDIS services). Longer term arrangements, once funding has moved to a more stable and certain footing, would ideally allow for greater application of, an insurance approach by making sufficient funds available to allow for upfront investments to reduce outlays in future.

In 2011, the Commission (PC 2011, p. 672) recommended the NDIS be established with a large enough reserve fund to smooth out fluctuations and reduce uncertainty. The Commission continues to endorse this approach of having access to a pool of reserves in the longer term.

Providing a substantial pool of reserves has the advantage of providing greater certainty to participants and providers that the scheme will be enduring, enabling them to make long-term decisions (for example, cost pressures will be reduced if people feel they are able to leave the NDIS, knowing that it will be there in the future should they need to return). Absent a pool of reserves, the PAYG arrangement alone more closely resembles a welfare system, as funds are lacking for future looking investments.

In the longer term, the level of reserves should reflect the level of risk that the NDIA is able to manage. In 2011, the Commission suggested that the level of reserves should be determined by:

- partially funding new entrants for the scheme while also collecting enough revenue on a PAYG basis to fund the reasonable and necessary supports for existing participants or
- making an actuarial and economic determination of optimal reserves (PC 2011, pp. 672-673).

Importantly, reserve money should only be used for investments that allow future benefits to accrue, rather than allowing cross-subsidisation between activities such as increasing the operational costs budget.

The Commission is seeking further feedback on the level of reserves needed to enable the NDIS to operate like an insurance scheme, and the method by which this should be achieved.

The Commission is aware of the potential practical difficulties of establishing a reserve fund in the short term, but is also mindful of the potential long-term benefits of doing so — including enabling the NDIS to operate like an insurance scheme not a welfare scheme, and providing certainty in funding that insulates it against the vagaries of year to year budget funding.

One way of building up reserves could be to, each year, redirect a set proportion of the unspent money to a reserve fund, instead of returning it to the Australian and State and Territory Governments (effectively removing the NDIA's cash ceiling). The Commission is seeking feedback on the best way to implement an increased reserve requirement.

INFORMATION REQUEST 10.3

The Commission seeks feedback on the level of a future contingency reserve that would enable the National Disability Insurance Agency to operate like an insurance scheme, and how this would best be implemented, including any transitional arrangements.

10.4 In-kind support

A necessary part of the transition period …

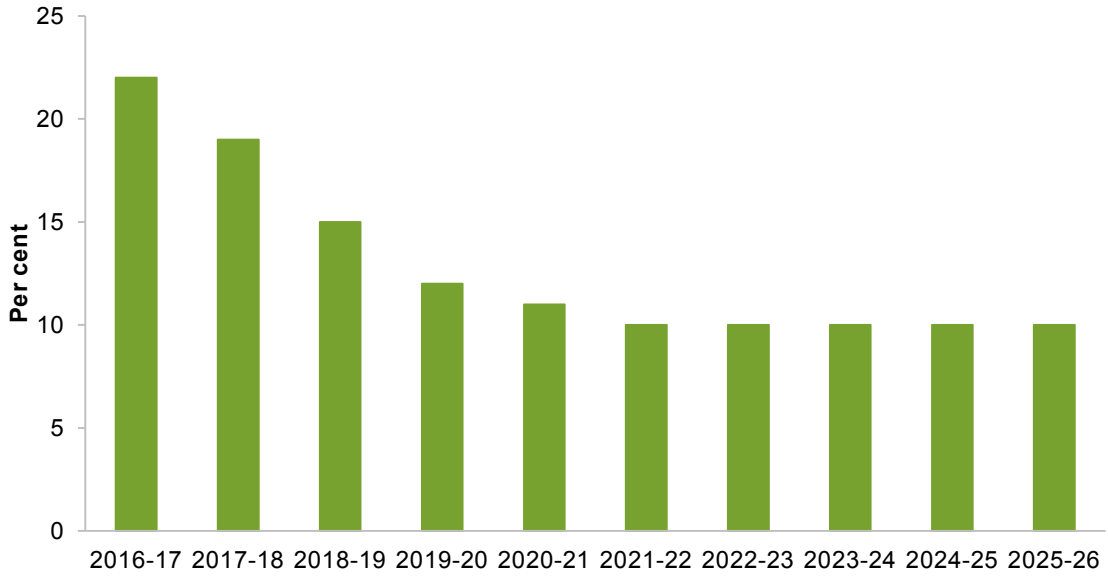
Prior to the NDIS, Australian, State and Territory Governments paid providers to deliver supports to people with disability. This meant that in July 2016 when the transition to full scheme began, governments had in place contracts with existing providers, or had previously made capital investments (like large residential centres or group homes: DSS, sub. 146, p. 22).

Because of these prior arrangements, State and Territory Governments are able to provide 'in kind' services (that is, they can transfer already funded disability supports used by NDIS participants) to the NDIA in lieu of cash contributions towards their funding commitments.

In practice, what this means for scheme participants is that supports in their plans are described specifically as having to be provided by a particular provider (that is, the provider engaged through in-kind arrangements).

In transition, in-kind contributions will account for about 19 per cent of total package costs, and about 10 per cent at the commencement of full scheme (figure 10.2). Over time, and as the assets age, the expectation, as stated in the intergovernmental agreements, is that in-kind contributions will be phased out. According to the DSS (sub. 146, p. 22), all governments are reviewing their in-kind contributions with a view to *minimising* them at full scheme, but 'this is uncertain'.

Figure 10.2 **In-kind supports as a percentage of total package costs**



Source: DSS (sub. 146, p. 23).

… but they reduce choice, increase scheme costs and delay market responses

In-kind contributions reduce choice for participants and, if they are provided at prices above market prices, they can increase scheme costs. A number of study participants pointed out that in-kind contributions undermine the core objectives of the NDIS. The DSS, for example, said:

> The provision of government in-kind contributions as part of NDIS support packages not only reduces participant choice, as in-kind supports must be used to enable the NDIS to be delivered within budget, but adds financial pressure as in-kind contributions are based on current costs to government as opposed to a market-driven efficient price. If maintained, there is a risk inefficient costs from legacy systems will be transferred to the NDIS (sub. 146, p. 21).

Lifestyle in Supported Accommodation commented:

> So much for participant 'choice and control' and 'self managing'. This [in-kind supports] is little different from block-funding. (sub. 3b, p. 2)

Bruce Bonyhady also said that in-kind arrangements:

> … are not consistent with a contestable or competitive market, because they limit control and choice and also lock-in old-style standards and prices above the efficient price (sub. 100, p. 9).

As noted above, in-kind contributions have to be used by participants (*National Disability Insurance Scheme (Plan Management) Rules 2013* (Cwlth) rr. 6.8-6.9) — there is no

ability to opt-out and choose another provider. To the extent that participants would choose another provider if they could, this limits choice.

In-kind contributions may also be of a lower quality than other supports that are more competitively provided. Because providers of in-kind supports do not need to compete for customers there is less incentive to improve the quality and reduce the cost of their services than under more competitive conditions. The NDIA (sub. 161, p. 47) said that one of the challenges to scheme sustainability caused by in-kind supports is they do not encourage innovation.

In-kind supports can also delay market transformation, and the move from a block funded model to a fee-for-service model is a major factor in provider readiness (chapter 6).

And they can result in two-tier pricing, with some participants receiving a higher priced support that is subject to less competition than other participants.

In-kind contributions should be phased out

The Commission recommends that in-kind supports be phased out by the end of the transition period. The NDIS is about developing a functioning disability care and support market that is responsive to the needs of participants and dynamically improves efficiency. The continuation of in-kind arrangements delays the development of such a market.

If in-kind supports are continued into full scheme this would effectively be cost shifting from the State and Territory Governments (who make up the largest share of in-kind contributions) to the Australian Government as well as cost shifting from State and Territory Governments with a large portion of funding provided in-kind to those that do not. As the NDIA put it:

> In-kind is higher than the notional prices, and at present the States and Territories do not carry the financial risk associated with resulting higher package costs. (sub. 161, p. 113)

If in-kind contributions continue beyond transition, jurisdictions should face a financial penalty for doing so.

DRAFT RECOMMENDATION 10.3

In-kind funding arrangements should be phased out by the end of transition and should not form part of the intergovernmental agreements for full scheme funding. Should in-kind funding persist beyond transition, jurisdictions should face a financial penalty for doing so.

A Conduct of the study

The Commission received the terms of reference for this study on 20 January 2017. It subsequently released an issues paper on 22 February 2017 inviting public submissions and highlighting particular matters on which it sought information.

In total, the study received 206 submissions (table A.1). The study also received brief submissions online, including those collected by the organisation Every Australian Counts. All public submissions have been placed on the study's website.

During the study, the Commission held consultations with people with disability, advocacy groups, peak bodies, service providers, disability care and support workers, and government departments and agencies (table A.2).

The Commission thanks all those who contributed to this study.

Data and information

The Commission acknowledges the assistance of the:

- National Disability Insurance Agency in providing unpublished data and information to the study, and allocating a staff member to spend several days in the Commission's Canberra office to provide feedback on analysis conducted by the study. Any errors in the analysis of these data and information in this paper are attributable to the Commission.
- Department of Social Services in providing unpublished data and information to the study.

This paper uses the National Centre for Vocational Education Research's data on vocational education outcomes (VOCSTATS). These data are collected by registered training organisations and state training authorities around Australia. The National Centre for Vocational Education Research is not responsible for errors in the extraction, analysis or interpretation of the data presented herein.

Table A.1 **Public Submissions[a]**

Participant	*Submission number(s)*	
Ability First Australia	62	#
The Able Movement	109	
ACT Council of Social Service	138	
ACT Disability, Aged and Carer Advocacy Service (ADACAS)	87	
ACT Government	156	#
AEIOU Foundation	32	#
Allianz Australia Insurance	42	
Allied Health Professions Australia (AHPA)	37	
Alzheimer's Australia	10	
Amaze	160	
Anglicare Australia	157	#
Anglicare Tasmania	145	#
Annecto	34	
Assistive Technology Suppliers Australasia (ATSA)	33	
Attendant Care Industry Association (ACIA)	141	
Australasian Podiatry Council	52	
Australian Association of Social Workers (AASW)	124	
Australian Blindness Forum (ABF)	48	
The Australian Centre for Social Innovation (TACSI)	65	#
Australian Federation of Disability Organisations (AFDO)	180	
Australian Lawyers Alliance (ALA)	54	
Australian Medical Association (AMA)	120	
Australian Orthotic Prosthetic Association (AOPA)	123	
Australian Physiotherapy Association (APA)	93	
Australian Psychological Society (APS)	19	
Australian Rehabilitation Providers Association (ARPA)	28	
Australian Services Union (ASU)	154	
Australian Services Union (ASU) and Disabled People's Organisations (DPO) Australia	198	
Australian Unity	173	
Autism Aspergers Advocacy Australia	178	
Barnardos Australia	85	
Belconnen Community Service Board	39	
Better Caring	184	
Blind Citizens Australia	130	
Bonyhady, Bruce	100	
Boyle, Michael	27	
Brain Injury SA	116	
Bravo Ability Service	96	#
Broken Rites	204	
Brotherhood of St Laurence	189	*
Burrows, Matt	7	
Bus Association Victoria (BusVic)	1	

(continued next page)

Table A.1 (continued)

Participants	*Submission number(s)*	
Business Council of Co-operatives and Mutuals	91	
Butterfly Foundation	78	#
Calvary Health Care Bethlehem	64	
Capricorn Community Development Association (CCDA)	142	
Carers Australia	195	
Carers Australia Victoria	131	
Catholic Social Services Australia	166	
Centacare Brisbane	44	
Centre for Disability Research and Policy	40, 55	
Centre for Disability Studies (CDS)	43, 49	#
Centre of Research Excellence in Disability and Health	69	
Cerebral Palsy Alliance	163	#
Children and Young People with Disability Australia (CYDA)	188	
Cohealth	50	
Commonwealth Ombudsman	137	#*
Communication Rights Australia, Disability Discrimination Legal Service and Villamanta Disability Rights Legal Service	88	#
Community and Public Sector Union (CPSU)	76	
Community Mental Health Australia (CMHA)	11	
Community Services Industry Alliance (CSIA)	77	
Companion House	84	
Condren, James	66	
Curley, Tricia	140	
DARE Disability Support	182	
Deaf Australia	183	
Deafness Forum of Australia	127	
Department of Health (DoH)	175	
Department of Social Services (DSS)	146	
Dietitians Association of Australia (DAA)	119	
Disability Services Australia (DSA)	9	#*
Disability Services Commissioner	35	
Disabled People's Organisations (DPO) Australia	165	
Down Syndrome Australia	121	
Dowse, Leanne; Paterson, Melinda; and Sprange, Mike	114	
DUO Services Australia	196	
Early Childhood Intervention Australia NSW/ACT	190	
Early Childhood Intervention Australia Victoria/Tasmania	129	
Endeavour Foundation	202	
Epic Employment Service	70	
Ethnic Communities' Council of Victoria (ECCV)	31	
Every Australian Counts	92	
Everyday Independence	133	
Fanning, Vanessa	21	#

(continued next page)

Table A.1 (continued)

Participants	*Submission number(s)*	
Fear, Ross	103	
Financial Services Council (FSC)	98	#*
Flourish Australia	74	
Freedom Key	125	#
Goldfields Individual and Family Support Association (GIFSA)	13	
Health Services Union	132	
Homelife Association	59	
The Hopkins Centre	105	
House with No Steps	104	
Inclusion Australia	185	
Independent Schools Council of Australia (ISCA)	83	
Integra	99	#
Jacqueline Pierce and Associates	147	
Jane, Belinda	80	
Jesuit Social Services	117	
JFA Purple Orange	186	
Jobsupport	191	
Kennedy, Richard	2	
Leadership Plus	128	
Legacy Australia	168	
Lifestart Co-operative	97	
Lifestyle in Supported Accommodation (LISA)	3	#
LINK Community Transport	194	
Lutheran Community Care Queensland	197	
Macarthur Disability Services	57	
Macular Disease Foundation Australia	75	
Madden, Richard	101	
Magarey, Kristy	150	
Mallee Track Health and Community Service (MTHCS)	6	
Maloney, Liza	68	
Mamre Association	47	
Manning, Penny	36	
Martin, Sarah	41	*
Maurice Blackburn Lawyers	58	
McDonnell, Cheryl	79	
Mental Health and NDIS Facebook Support Group	8	
Mental Health Australia	155	#
Mental Health Carers Australia	181	
Mental Health Community Coalition of the ACT	135	
Mental Health Complaints Commissioner	164	
Mental Illness Fellowship of Australia	122	
Milner & Clyde	94	
Mind Australia	144	

(continued next page)

Table A.1 (continued)

Participants	*Submission number(s)*	
MND Australia	45	
Municipal Association of Victoria (MAV)	152	
Name withheld	4	*
Name withheld	5	*
Name withheld	199	*
National Disability Insurance Agency (NDIA)	161	
National Disability Services (NDS)	51	
National Mental Health Commission (NMHC)	153	
NDIS Independent Advisory Council	149	
Neami National	63	
Nelson, Fergus	17	
Neurological Alliance Australia (NAA)	30	
New South Wales Government	60	
Noah's Ark	108	
Northern Territory Government	205	
NSW Council for Intellectual Disability (NSW CID)	193	
NSW Disability Network Forum	18	
NSW Disability Support Organisations	90	#*
Occupational Therapy Australia (OTA)	15	
Office of the Public Advocate (OPA)	46	
Office of the Public Guardian (OPG)	143	
One Door Mental Health	179	
O'Rourke MP, The Hon. Coralee	106	
Parkin, David	177	
Peterson, Frank Lawrence	148	
Physical Disability Australia (PDA)	38	
Physical Disability Council of NSW (PDCN)	29	
Plan Management Partners	126	
Potapczyk, Hannah	26	
Power Housing Australia	139	
Prader-Willi Syndrome Association of Australia (PWSAA)	112	
Psychiatric Disability Services of Victoria (VICSERV)	169	
Public Health Association of Australia	134	
Public Service Research Group	56	
Queensland Advocacy Incorporated	115	
Read, Suzanne	24	
Regional Development Australia Murraylands and Riverland (RDAMR)	12	
Rehab Co	23	
Roundsquared	170	
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	158	
Royal Australian College of General Practitioners (RACGP)	200	
Royal Institute for Deaf and Blind Children (RIDBC)	95	
Royal Society for the Blind (RSB)	82	#

(continued next page)

Table A.1 (continued)

Participants	*Submission number(s)*	
Morton, James	110	
Scope Australia	72	
SDN Children's Services	73	
Sharing Places	53	
The Shepherd Centre	107	
Sisters Inside	16	
Social Support & Precarious Workforce Research Discussion Group	71	
Sotica	67	#
South Australian Government	203	
Speech Pathology Australia	136	
Spinal Cord Injuries Australia (SCIA)	61	
Summer Foundation	113	
Sylvanvale	192	#*
Syndromes Without A Name (SWAN) Australia	86	
Taggart, Michael	89	
Top End Association for Mental Health (TEAMhealth)	102	
Travellers Aid Australia (TAA)	20	
United Voice	118	
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)	162	
Victorian Council of Social Service (VCOSS)	176	
Victorian Government	174	#
Victorian, Queensland, South Australian and ACT Governments	201	
Victorian Healthcare Association (VHA)	172	
Victorian Mental Illness Awareness Council (VMIAC)	167	
Western Australian Local Government Association (WALGA)	151	
Westhaven Association	81	
Wilson, Tony	14	
Windsor & Associates	171	
Woden Community Service	159	
Women with Disabilities Victoria	111	
Yanga, Anna	22	
YFS Ltd	25	*
Young People In Nursing Homes National Alliance	187	
Zemanek, Elizabeth	206	

a An asterisk (*) indicates that the submission contains confidential material NOT available to the public. A hash (#) indicates that the submission includes attachments.

Table A.2 **Stakeholder consultations**

Participants
ACL Disability Services & Gig Buddies Sydney
APM
Australian Council of Social Service
Australian National Audit Office
Australian Services Union and United Voice workers and organisers
Bonyhady, Bruce
CatholicCare Social Services
Catholic Social Services Australia
Centre for Disability Studies
Cerebral Palsy Alliance
Cohen, Dr Martin
Department of Social Services
Disability Discrimination Commissioner (Alastair McEwin)
Disabled People's Organisations Australia
Fenton, Dr Marc
Firstchance
First Peoples Disability Network
House With No Steps
Integra
Karingal
Kevin Stone from Victorian Advocacy League for Individuals with Disability and five parents of participants
LeapFrog Ability
Lifestart
Marymead
Mental Health Australia
Mental Health Coordinating Council of NSW
National Disability Insurance Agency
National Disability Insurance Agency Board members (Helen Nugent and John Walsh)
National Disability Services
Health and Community Services Union workers and organisers
National Disability Insurance Scheme — Scheme Actuary
People with Disability Australia
Physical Disability Council of NSW
SalvoConnect
Victorian Council of Social Service

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Table A.2 (continued)

Teleconference
Australian Capital Territory Community Services Directorate
Australian Capital Territory Chief Minister, Treasury and Economic Development Directorate
Australian Federation of Disability Organisations
Australian Government Actuary
Australian Services Union
Carers Australia
Children and Young People with Disability Australia
Cross, Rebecca
Hogan, Catherine
Department of Finance
Department of Health
Department of Prime Minister and Cabinet
Department of Social Services
Dyson, Dr Maree
Gilchrist, Prof. David (University of Western Australia)
Health and Community Services Union
Mental Health Australia
National Disability Insurance Agency
National Disability Services
National Institute of Labour Studies, Flinders University
National Mental Health Commission
Northern Territory Department of the Chief Minister
Northern Territory Department of Treasury and Finance
Northern Territory Department of Health
New South Wales Department of Family and Community Services
Knight, Dr Penny (Curtin University)
Queensland Department of Communities, Child Safety and Disability Services
South Australian Department for Communities and Social Inclusion
Tasmanian Department of Education
Tasmanian Department of Health and Human Services
Tasmanian Department of Premier and Cabinet
Tasmanian Department of Treasury and Finance
Victorian Department of Health and Human Services
Victorian Department of Premier and Cabinet
Victorian Treasury
United Voice
Western Australia Disability Services Commission
Young People in Nursing Homes

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Working under the NDIS: Insights from a survey of employees in disability services

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Executive Summary

This report analyses information from almost 1,500 disability service workers. It explores their characteristics and perceptions of their working conditions; their experiences of working under the National Disability Insurance Scheme (NDIS); and their concerns about the implementation of the Scheme and its impact on their working lives.

Characteristics of respondents

- 74.1% of respondents were women.
    - Among those working in allied health and in-home care settings, there were higher proportions of women (over 80%). In employment, mental health, and residential/ group home settings, the proportions of women were lower (around 70%).
- Respondents had extensive experience in disability services: a quarter (22.5%) had more than 20 years of experience in the industry.
- 28.5% of respondents supervised other staff in their current role, while about the same number (27.3%) did so sometimes.

Working under the NDIS

- A little over half of respondents (54.7%) were working in an NDIS rollout area or with participants of the NDIS, while 35.8% said they were not, and 9.5% were unsure.
    - Workers in allied health, case management, day settings and in-home care were more likely to report working under the NDIS, while those in mental health, employment and residential/group home settings were least likely.

Impact of the NDIS on participants and families

- Few workers perceive the NDIS to be having a positive impact on participants or their families
    - 24.6% agreed that the NDIS was positive for the participants they work with
    - A minority (14.6%) agreed that families of participants were happy with the scheme, and
    - 15.7% agreed that the NDIS is better than the previous system.

Impact of the NDIS on working life

- Comparisons of respondents working under the NDIS and those who were not shows:
    - Lower proportions of very experienced employees were working under the NDIS, while proportions of staff new to the industry were higher.
    - Among those working under the NDIS, a higher proportion of employees are working for more than one disability service provider.
    - Those working under the NDIS were no more likely to be satisfied with their pay: across all contexts only a minority of respondents were happy with the pay they receive.
- High proportions of staff reported challenges to working under the NDIS:
    - 55.9% reported that they did not have enough time to do their work under the NDIS

- 72.2% were worried about the future of their job
- 52.6% disagreed that the NDIS has been a positive change for them as a worker.

Supervision and the NDIS

- Supervisors working under the NDIS reported supervising higher numbers of staff than others, which made it difficult to provide proper supervision:
  - 20.0% of those in supervisory roles[1] and who were working under the NDIS were supervising more than 14 staff, compared with only 12.0% of supervisors not working under the NDIS.
  - The proportion of supervisors who agreed that they can't provide proper supervision because of lack of time or too many staff rises with the number of supervisees, indicating a major risk for the Scheme.

General comments from disability workers

Among comments from disability workers, the most common concerns were about the adequacy of resources being provided to people with disability under the NDIS, and the impact of the Scheme on the quality of services people with disability would receive. Many explained the frustrations experienced by people with disability and their families, including delayed, inequitable and impersonal planning processes, resulting in inadequate support plans for participants.

Respondents also made a range of comments about how the NDIS was impacting on their working lives. Many linked risks to quality and safety to the use of casual and agency staff, and untrained staff entering the sector. Others expressed concerns about pay and conditions, including coverage of costs of private vehicle use, loss of penalty rates, subcontracting, short shifts, payment for travel time, and roster changes which could result in fewer hours. Respondents also noted that the NDIS was placing pressure on their employment classifications and pay rates, and some raised concerns their work was misclassified. Related, workers' comments attest to their high levels of stress, with many reporting unsustainable workloads and time pressure (including unpaid work) and poor job security, corroborating the other survey findings.

[1] Excluding those who only sometimes supervised staff.

1. Introduction

This report provides insight into the characteristics and experiences of almost 1,500 survey respondents who were working in disability services in early 2017. The survey was designed and administered by the main unions representing workers in the disability services industry, the Health Services Union, Australian Services Union, and United Voice, to help understand disability workers':

- characteristics and perceptions of their working conditions;
- experiences of working under the National Disability Insurance Scheme (NDIS); and
- their concerns about the implementation of the Scheme and its impact on their working lives.

The survey questions asked about respondents' demographic characteristics and how long they had worked in disability services, the settings in which they provided disability services (respondents could select more than one), their perceptions of their pay, their intention to leave or remain in the disability sector and reasons for this. It also asked whether they were a supervisor and if so, explored the characteristics of supervisory roles, including supervisory workloads. Those who were working in an NDIS area or with participants of the NDIS were asked a series of questions about their experience of working under the Scheme, to capture perceptions of time pressure, job security, and the overall impact of the NDIS on clients and their families. Respondents were also given the opportunity to provide open ended comments about working in disability, and any concerns they had about their work in the industry or under the NDIS.

The survey was distributed online via the networks of the three unions, primarily in the Eastern States. As such it is a non-probability based 'opt-in' sample, selected purposively to enable a focus on members of the unions commissioning the survey and to enable insight into experiences of providing disability services in different contexts, and differences among different groups of workers. A particular aim was to explore the impact of working under the NDIS, and to this end, comparison is made between respondents working under the Scheme and those which were not.

As a purposive sample, it may not be perfectly representative of all disability workers in Australia. As the survey was distributed through union networks, workers who are newer to the industry (and less likely to be union members) are under-represented. Further, responses from the Northern Territory and South Australia were not sought. However, while the sample is skewed to older, more experienced workers in the eastern states and should not be considered representative of the whole disability workforce, it does provide important insights into the experiences of working in disability, and differences for workers in different circumstances and settings. To this end, the analysis focused on comparing workers in different circumstances, with cross tabulations used to provide detailed breakdowns of respondents.

2. About respondents

2.1 Gender

Of the 1,477 survey respondents who provided their gender, 1,094 (74.2%) were female. This varied slightly across disability settings, as shown in Figure 2.1. Allied health was most strongly female dominated (87.1%), while mental health, residential, and employment services had proportionally fewer women (around 70%). The gender composition of the sample also differed slightly across the age groups. The largest group of men and women were aged 45 and 54, with this group comprising a third of all respondents (see Figure 2.2). In terms of differences in the age distribution of men and women, a relatively high proportion of men were aged 35 to 44, while a lower proportion of men were aged 45 to 54. Figures were similar across other age ranges.

Figure 2.1 Proportion of respondents in each disability setting who were women

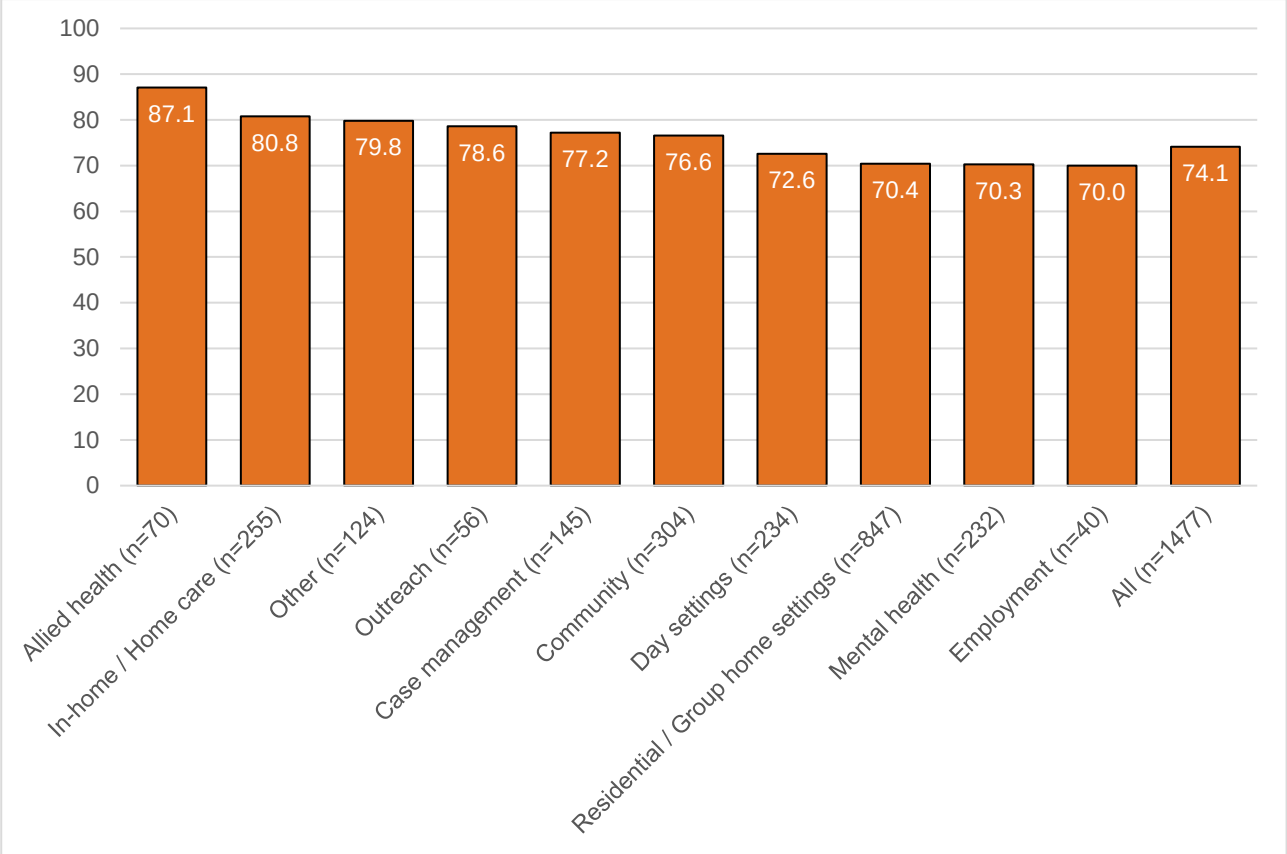
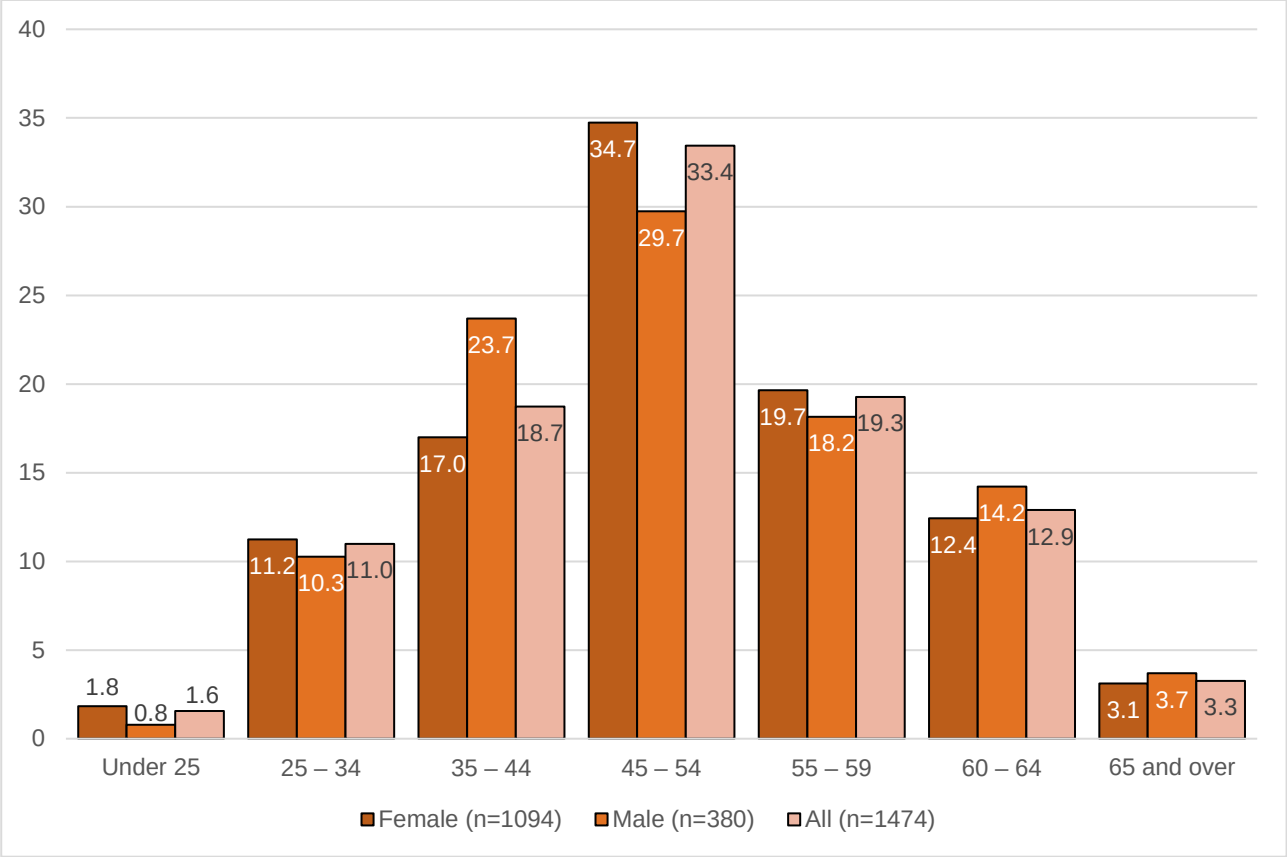


Figure 2.2 Proportion of men and women in each age category (%)



2.2 Experience in disability services

Many respondents were highly experienced in disability services. Almost a quarter (22.5%) had more than 20 years of experience providing disability services, and a further 13.8% had between 16 and 20 years of experience (see Figure 2.3). More than half (54.1%) had more than ten years of experience. Only a minority were new to the sector, with 2.0% having less than 1 year experience and 5.2% having between 1 and 2 years of experience. Although the age distribution of men and women differed slightly, there was little difference in the length of experience of men and women respondents, as shown in Figure 2.3.

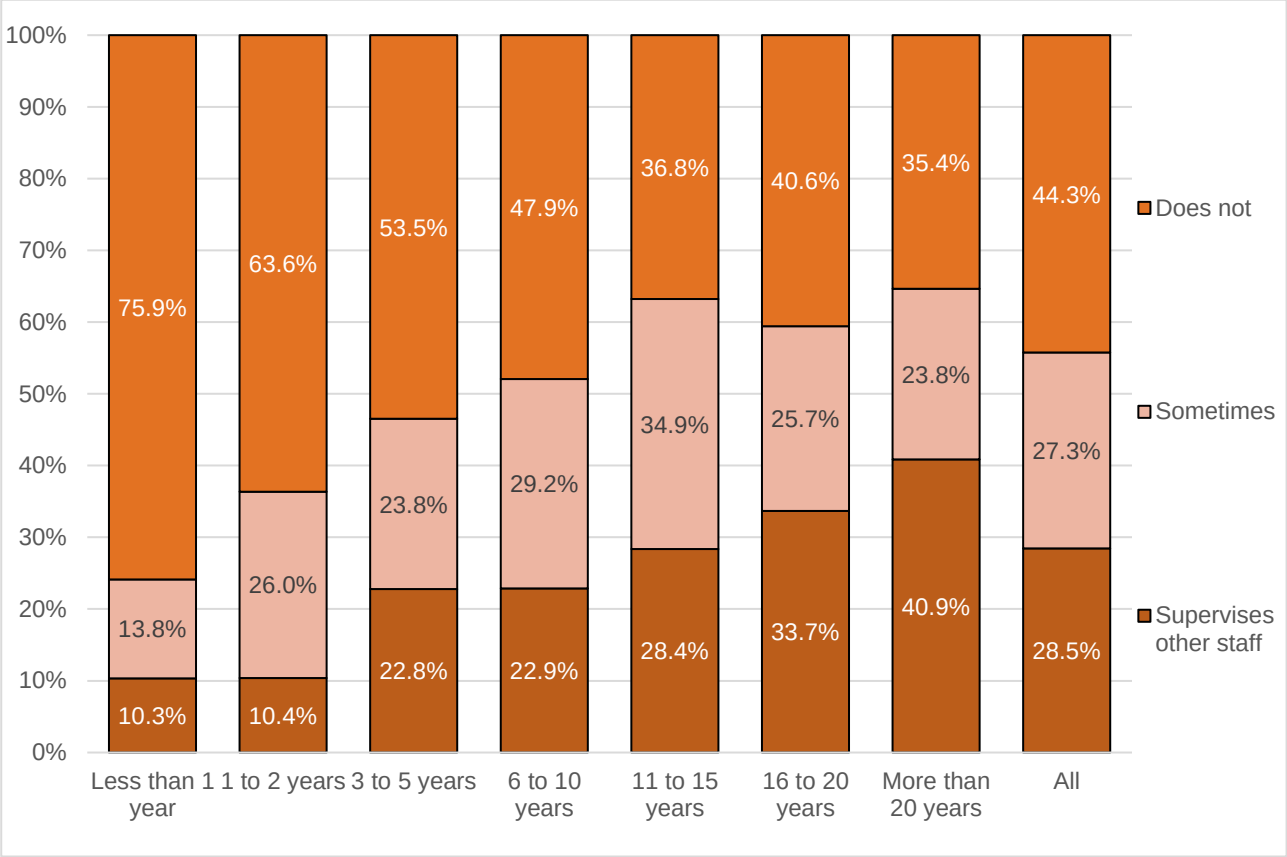
Figure 2.3 Men's and women's experience of working in disability services

	Less than 1 year		1 – 2 years		3 – 5 years		6 – 10 years		11 – 15 years		16 – 20 years		Over 20 years		All	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Male	5	1.3	27	7.1	46	12.0	99	25.9	65	17.0	56	14.7	84	22.0	382	100.0
Female	25	2.3	50	4.6	156	14.3	269	24.6	198	18.1	148	13.5	248	22.7	1094	100.0
All	**30**	**2.0**	**77**	**5.2**	**202**	**13.7**	**368**	**24.9**	**263**	**17.8**	**204**	**13.8**	**332**	**22.5**	**1476**	**100.0**

2.3 Supervisory responsibilities

Figure 2.4 shows that 28.5% of respondents supervised other staff in their current role, while about the same number (27.3%) said they did so sometimes. As would be expected, the proportion of staff supervising others was higher for those with longer experience in the disability services sector: 40.9% of those with more than 20 years of experience were supervisors, compared with around 10% of those with less than 2 years of experience.

Figure 2.4 Proportion of staff which supervised staff in their current role, by length of time working in disability services (n=1,462)



2.4 Residence and NDIS involvement

Most respondents resided in the eastern states, reflecting the networks through which the survey was distributed. Around 2 in 5 respondents (40.7%) resided in Victoria, 37.2% resided in NSW/ACT[2], and 11.8% resided in Tasmania.

Overall, a little over half (54.7%) were working in an NDIS rollout area or with participants of the NDIS, while 35.8% said they did not, and 9.5% were unsure (see Figure 2.5). This differed across the jurisdictions, with relatively high proportions of respondents (more than two thirds) working under the NDIS in NSW/ACT and Tasmania.

[2] A small number (8) were from the ACT, and these are combined with NSW for the purposes of analysis.

Figure 2.5 Respondents from each jurisdiction by whether or not they were working in an NDIS rollout area or with participants of the NDIS

	NDIS		Not NDIS		Not sure		Total	% of total
	n	%	n	%	n	%	n	%
NSW/ACT	356	68.5	121	23.3	43	8.3	520	37.2
QLD	26	37.1	39	55.7	5	7.1	70	5.0
TAS	112	67.9	42	25.5	11	6.7	165	11.8
VIC	224	39.4	277	48.8	67	11.8	568	40.7
WA	45	61.6%	21	28.8%	7	9.6%	73	5.2
Total	**763**	**54.7%**	**500**	**35.8%**	**133**	**9.5%**	**1396**	**100.0%**

2.5 Experience in disability by NDIS involvement

As shown above, over half of respondents were working under the NDIS (54.7%). However, slightly lower proportions of those working under the NDIS had lengthy experience in disability services. As shown in Figure 2.6, among those working under the NDIS, 21.4% of respondents had more than 20 years of experience compared with 26.2% of those not working under the NDIS. Relatively high proportions of those working under the NDIS had 2 years of experience: 8.7% of those working under the NDIS were in this category compared with 4.2% of those not working under NDIS.

The difference between levels of experience of respondents working under the NDIS and others is more apparent for non-supervisor staff (see Figure 2.7). Among staff working under the NDIS, 41.8% of non-supervisory staff had over 10 years of experience and 13.8% had less than 2 years of experience. For those not working under the NDIS the equivalent figures were 53.2% and 5.1% respectively.

Figure 2.6 Number of years worked in the disability sector, by NDIS involvement, supervisors and non-supervisors, n=1,462

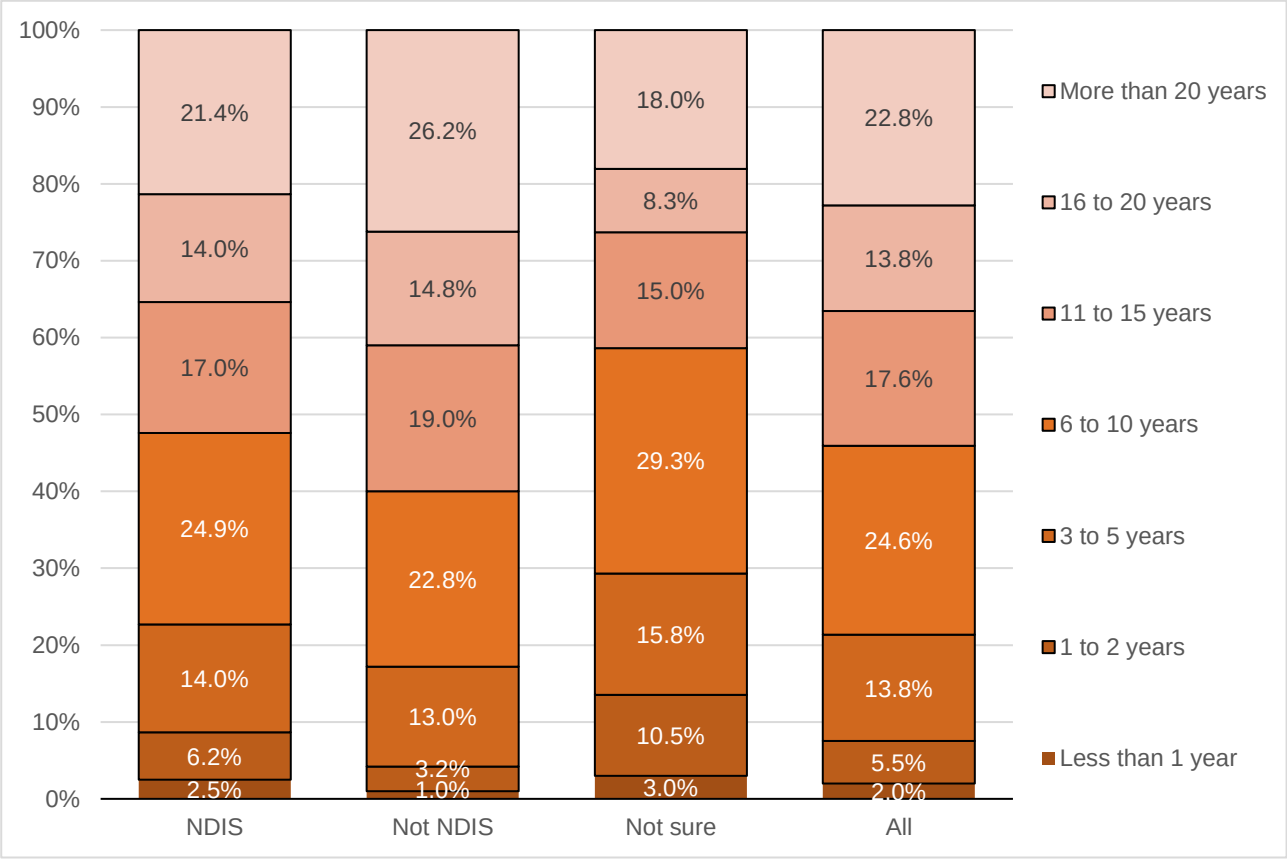
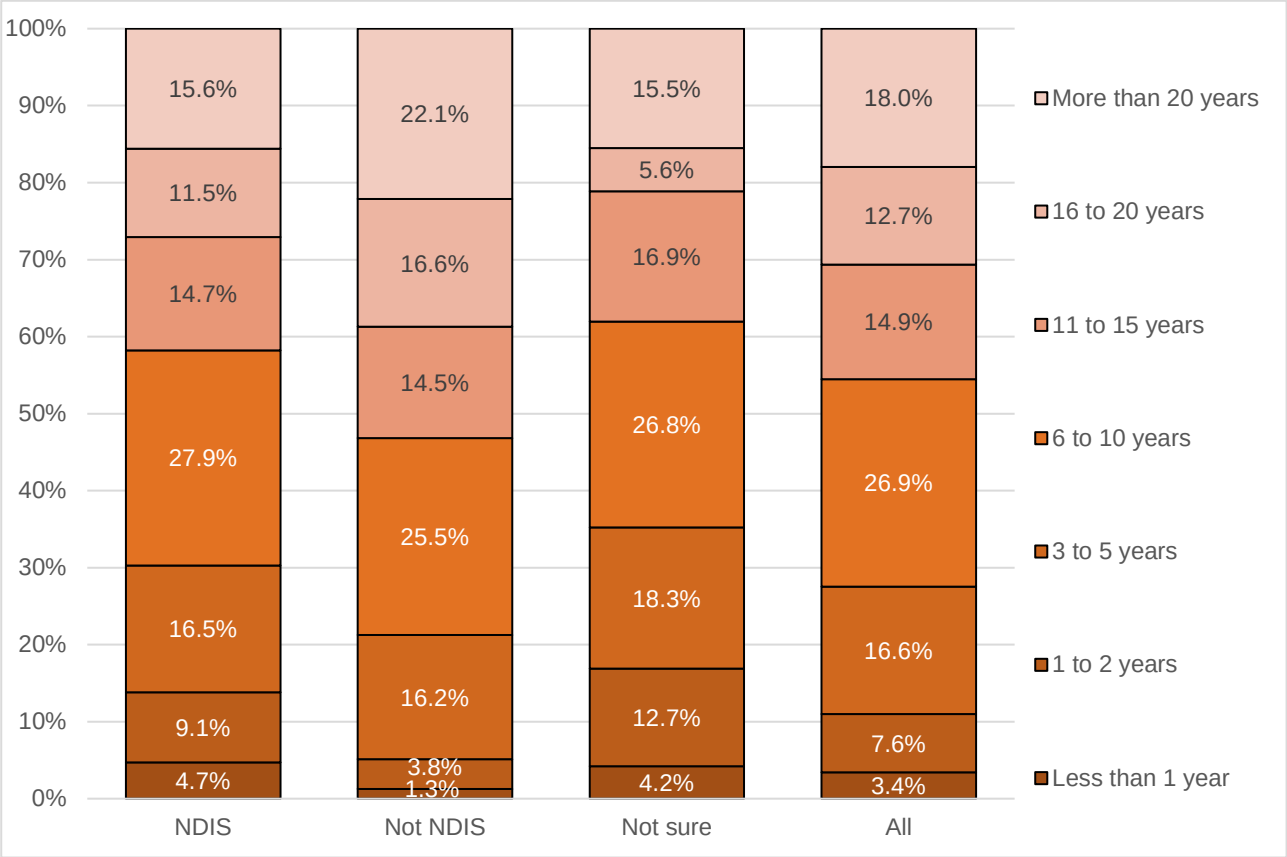


Figure 2.7 Number of years worked in the disability sector, by NDIS involvement, non-supervisory staff only, n=646

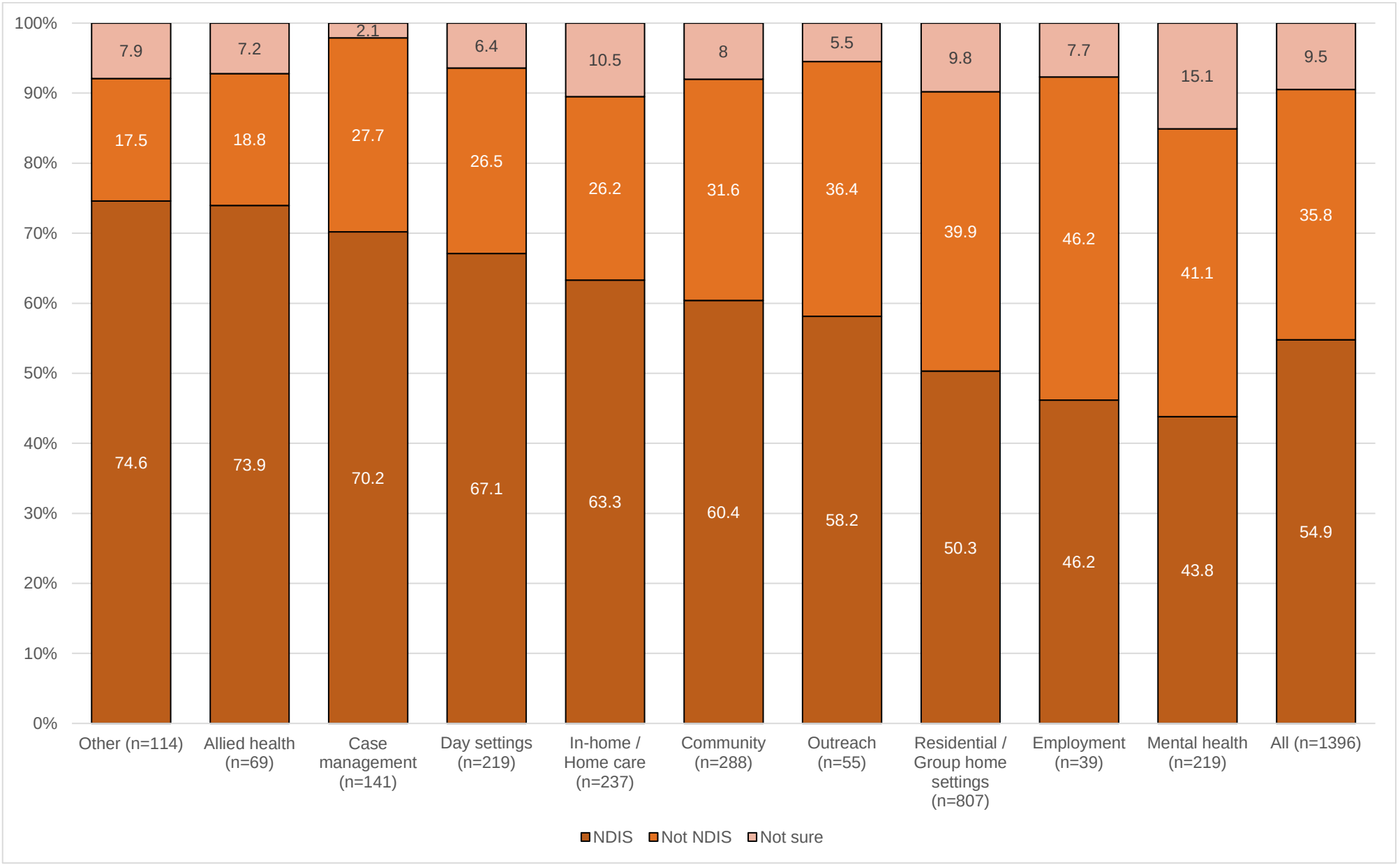


2.6 Disability settings and the NDIS

Figure 2.8 shows the proportions of survey respondents working in various settings who were working under the NDIS. The largest group of respondents were working in residential / group home settings (807, or 54.7%)[3]. A lower than average proportion of respondents in residential settings reported working under the NDIS (50.3%). The highest proportions working under the NDIS were in 'other' settings (not specified) (74.6%), allied health (73.9%), case management (70.2%), day settings (67.1%) and in home settings or home care (63.3%).

[3] Note that many residential workers also said they worked in community settings (20.5%), in-home settings (15.1%), and day settings (13.0%)

Figure 2.8 NDIS involvement for respondents working in the main disability service provision settings



2.7 Multiple job holding

Overall, 11.3% of respondents said they worked for more than one disability service provider or employer. However, this was slightly higher among non-supervisory staff 11.7% were multiple job holders compared with 7.2% of supervisory staff (see Figure 2.9). There was also a slightly higher proportion of staff who held multiple jobs among respondents working under the NDIS. Figure 2.10 shows that 12.8% of those working under the NDIS worked for more than one provider, compared with 8.8% of those who weren't. Further, in some disability settings, very high proportions of respondents worked for more than one disability employer. For example, 23.9% of respondents working in in-home or home care settings worked for more than 1 employer, as did 20.5% of those working in day settings. This is shown in Figure 2.11.

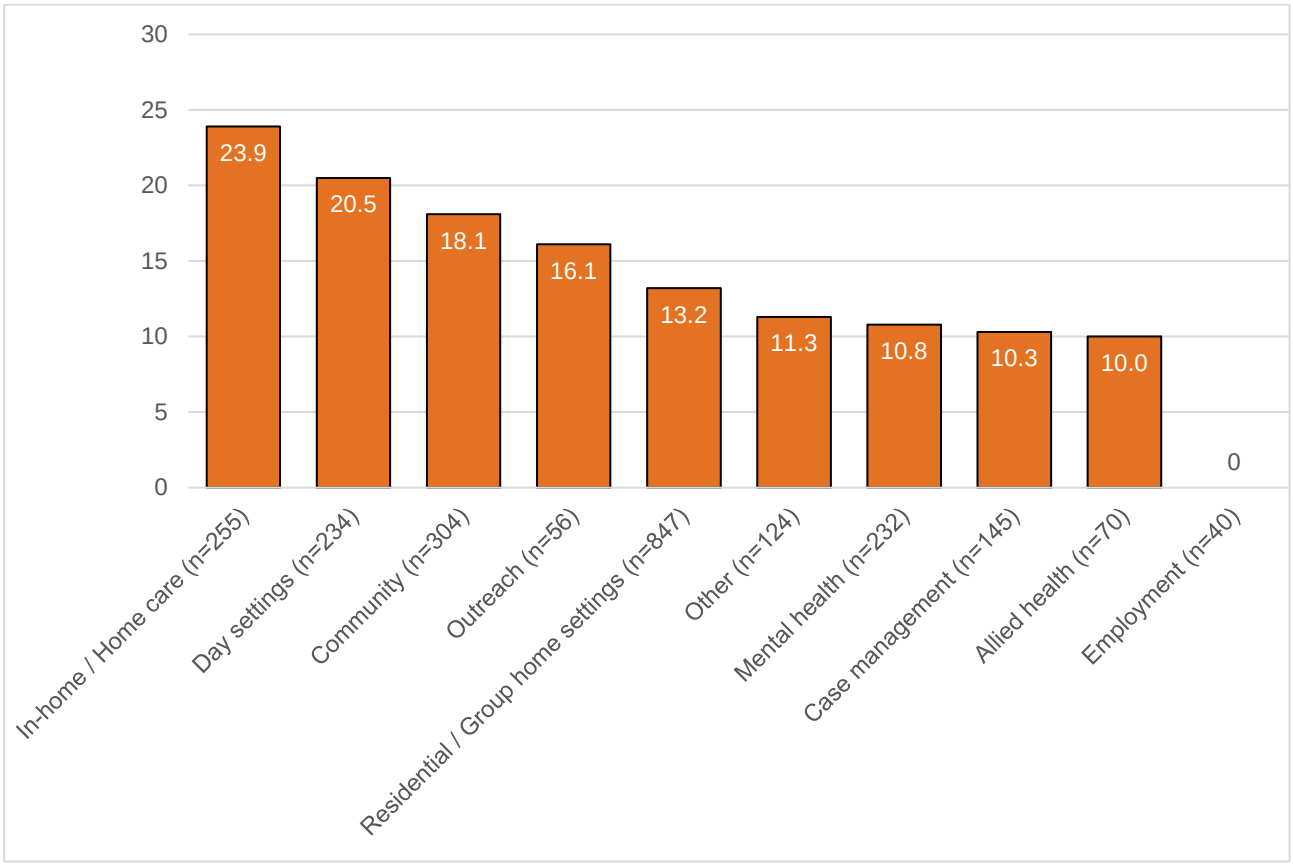
Figure 2.9 Whether respondent worked for more than one provider, by supervisory responsibility

	Works for more than one disability service provider		Works for one disability employer		All	
	n	%	n	%	n	%
Supervises other staff	30	7.2	386	92.8	416	100.0
Does not supervise other staff	76	11.7	571	88.3	647	100.0
Sometimes supervises other staff	59	14.8	340	85.2	399	100.0
All	**165**	**11.3**	**1297**	**88.7**	**1462**	**100.0**

Figure 2.10 Whether respondent worked for more than one provider, by NDIS status

	Works for more than one disability service provider		Works for one disability employer		All	
	n	%	n	%	n	%
Working under NDIS	98	12.8	665	87.2	763	100.0
Not working under NDIS	44	8.8	456	91.2	500	100.0
Not sure	14	10.5	119	89.5	133	100.0
All	**156**	**11.2**	**1240**	**88.8**	**1396**	**100.0**

Figure 2.11 Proportion of respondents in each disability setting who worked for more than one disability provider / employer



3. Perspectives on pay

The survey asked respondents to indicate their level of agreement with the statements "I am paid fairly for the work I do" and "I am satisfied with my overall level of take-home pay". For each of these statements, only a minority of respondents agreed, and this was the case for each statement and in all states (see Figure 3.1 and Figure 3.2). There was little difference between levels of agreement among supervisors and other staff: in both cases and for both statements, only a minority agreed. There were also no significant differences in levels of agreement on either measure between staff working under the NDIS and those who were not; in either context only a minority of respondents were satisfied with their pay.

Figure 3.1 Proportion of respondents who agreed with statement "I am paid fairly for the work I do", by state

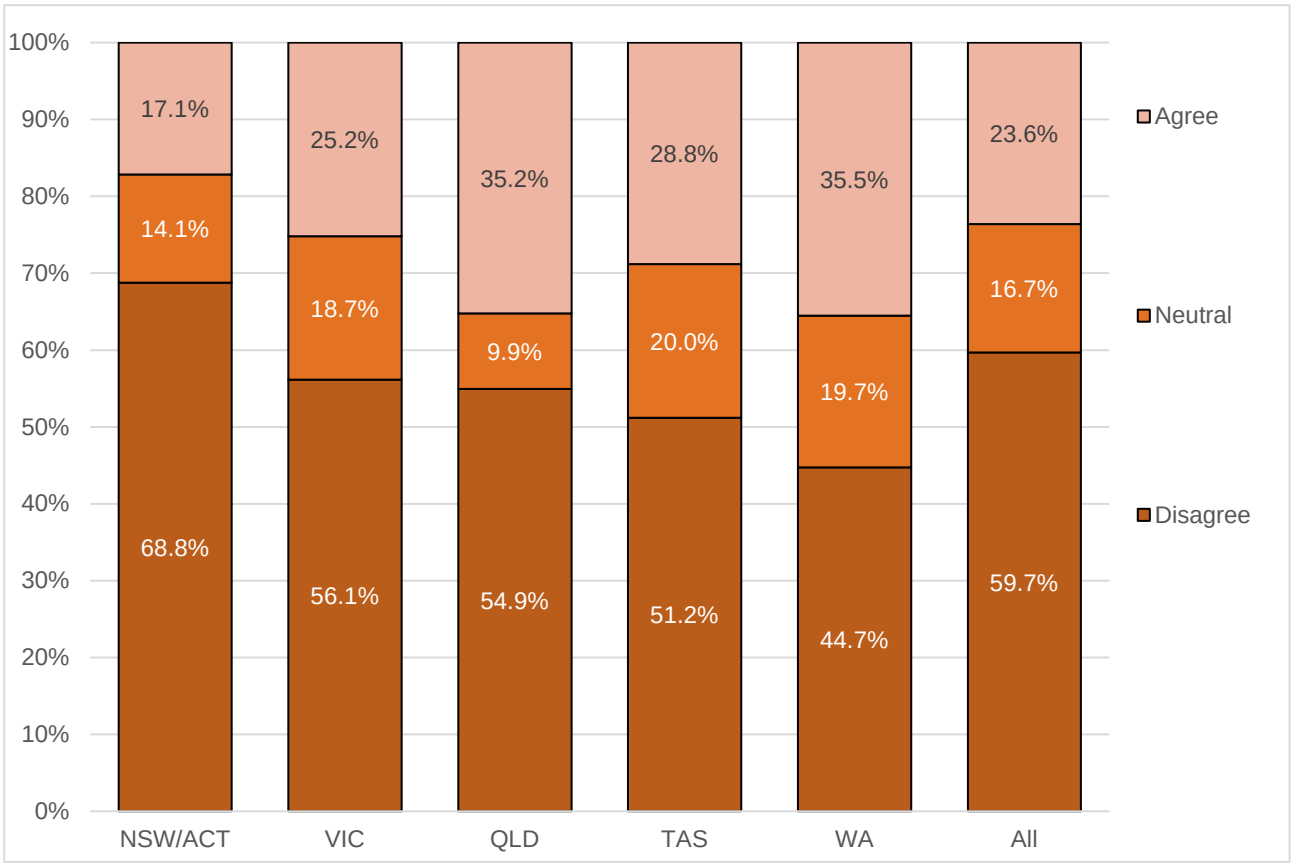


Figure 3.2 Proportion of respondents who agreed with statement "I am satisfied with my overall level of take-home pay", by state

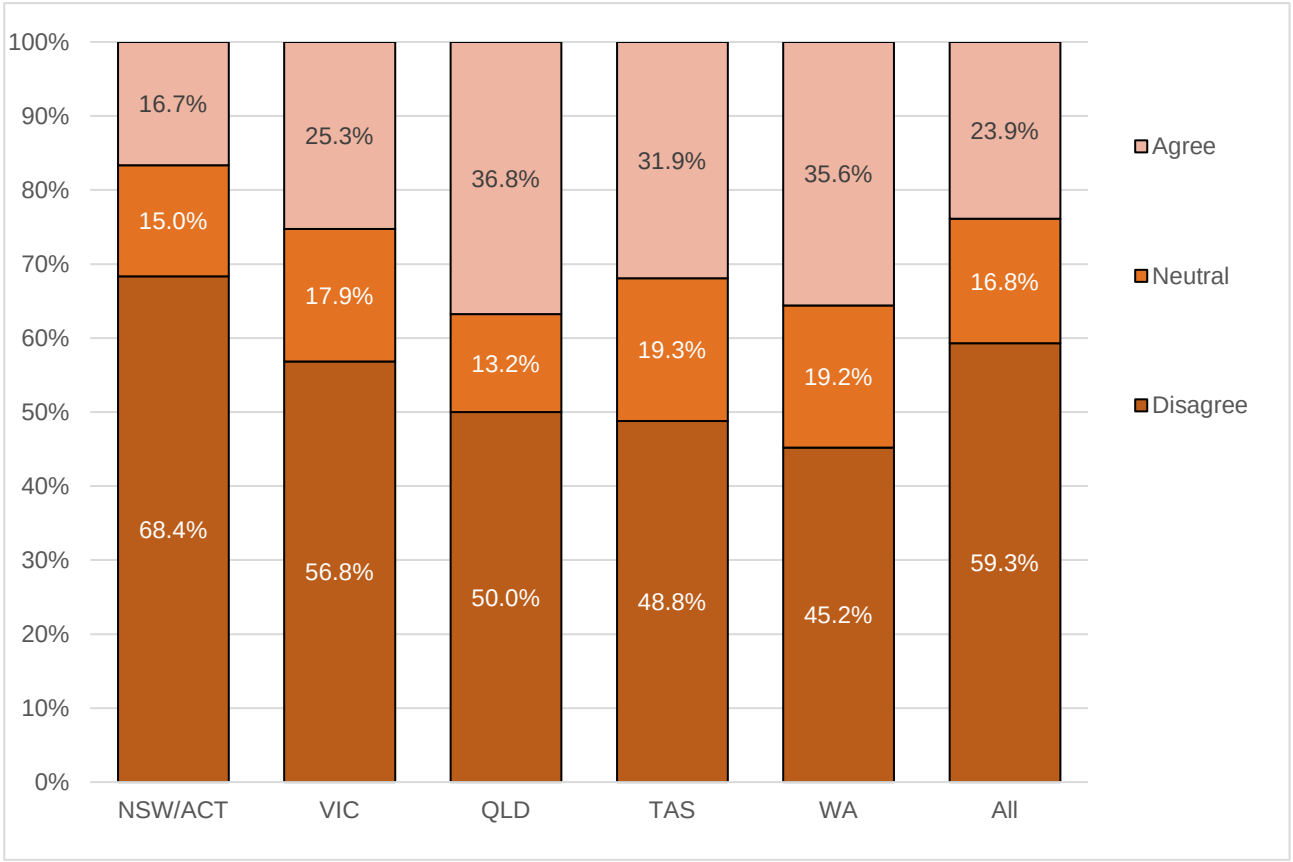


Figure 3.3 “I am paid fairly for the work I do”

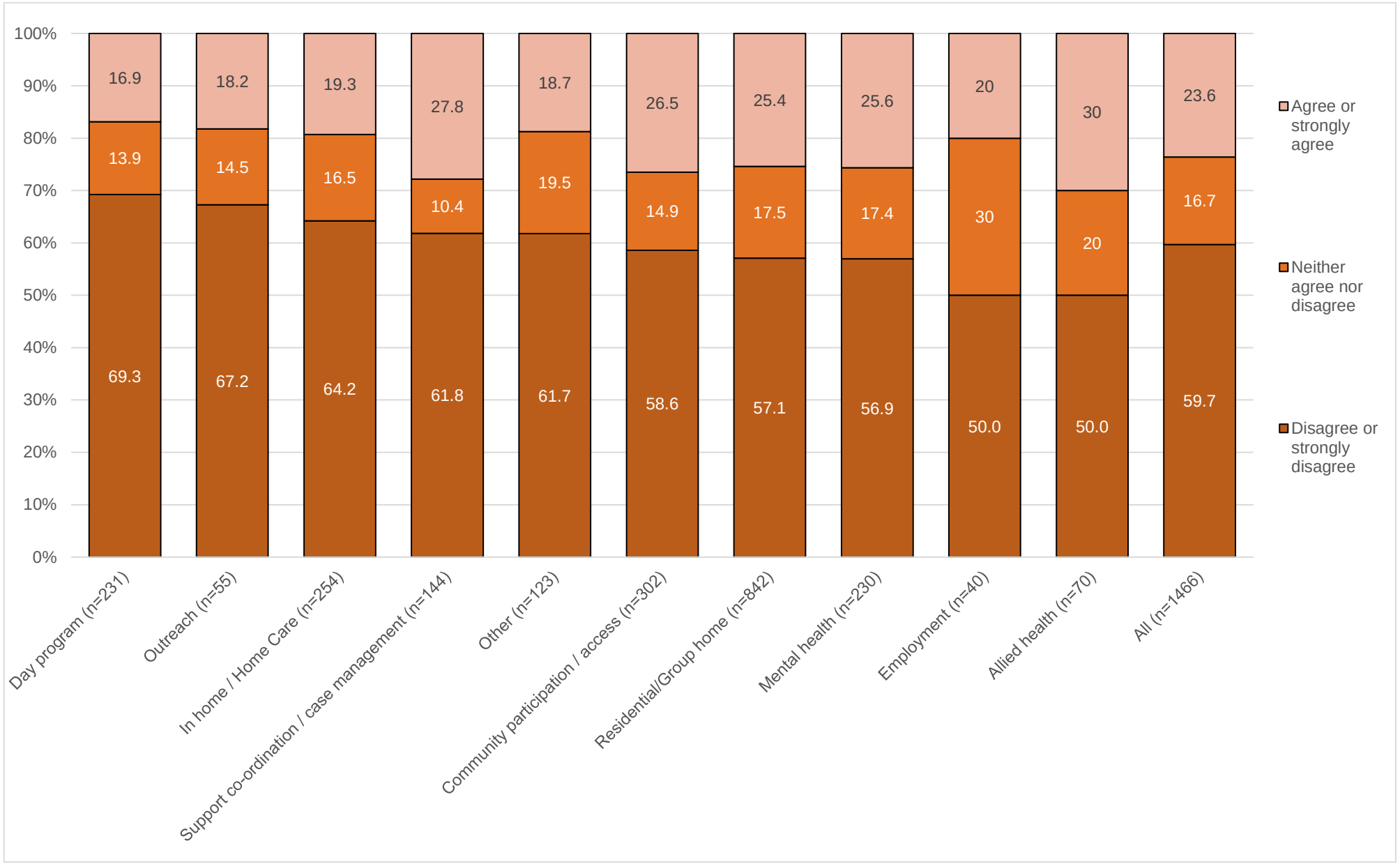
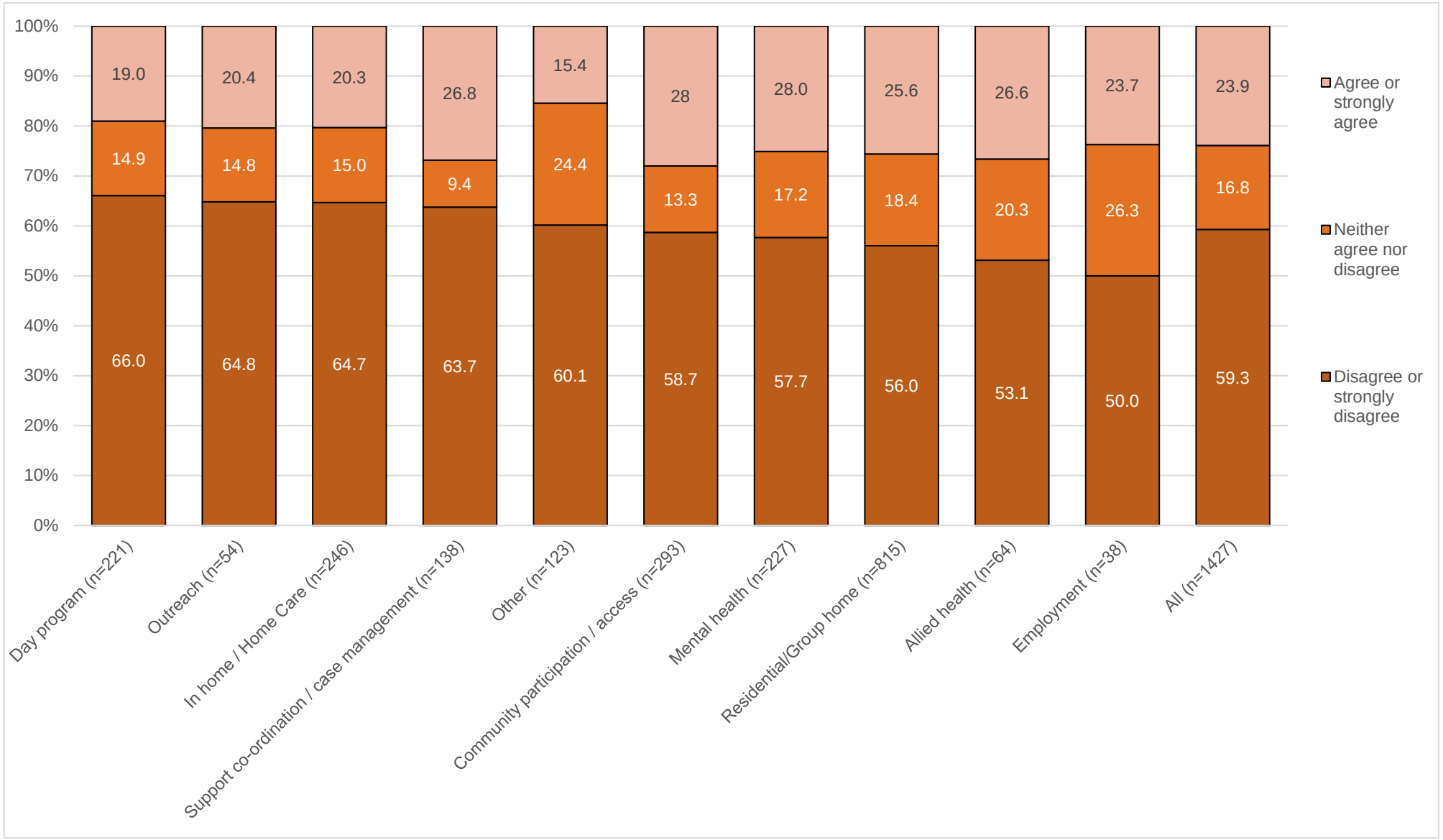


Figure 3.4 “I am satisfied with my overall level of take-home pay”



4. Perceptions of working under the NDIS

The survey captured respondents' perceptions of working conditions under the NDIS, through levels of agreement with three statements:

- Under the NDIS, I don't have enough time to do everything in my job (capturing workload and work intensity)
- Under the NDIS, I worry about the future of my job (capturing job security), and
- Overall, the NDIS has been a positive change for me as a worker (as a summary measure of the impact of the NDIS on working life).

As shown in Figure 4.1, more than half of respondents agreed or strongly agreed that under the NDIS, they don't have enough time to do everything in their job (55.9%), and only a small minority disagreed (11.4%). A larger majority agreed that they worried about the future of their job (72.2%), and 12.4% disagreed. Very few agreed the NDIS was positive for their working lives, with 10.6% agreeing and 52.6% disagreeing. The relatively large proportion who were unsure (36.9%) may have found it difficult to judge, for example if they were new to disability work or if the NDIS was new in their area, or if they had difficulty assessing the mixed impact of the Scheme on their work.

Differences in levels of agreement with the statements reported by workers in different disability settings tended to be small, shown in Figure 4.2. Figure 4.3 shows differences between respondents by their jurisdiction of residence. On all measures and in each jurisdiction, most reported the NDIS was having adverse impacts on their working lives. More detailed insight into experiences of working under the NDIS, in survey respondents' own words, is in Section 8.

Figure 4.1 Percentage of respondents which agreed with statements about working under the NDIS

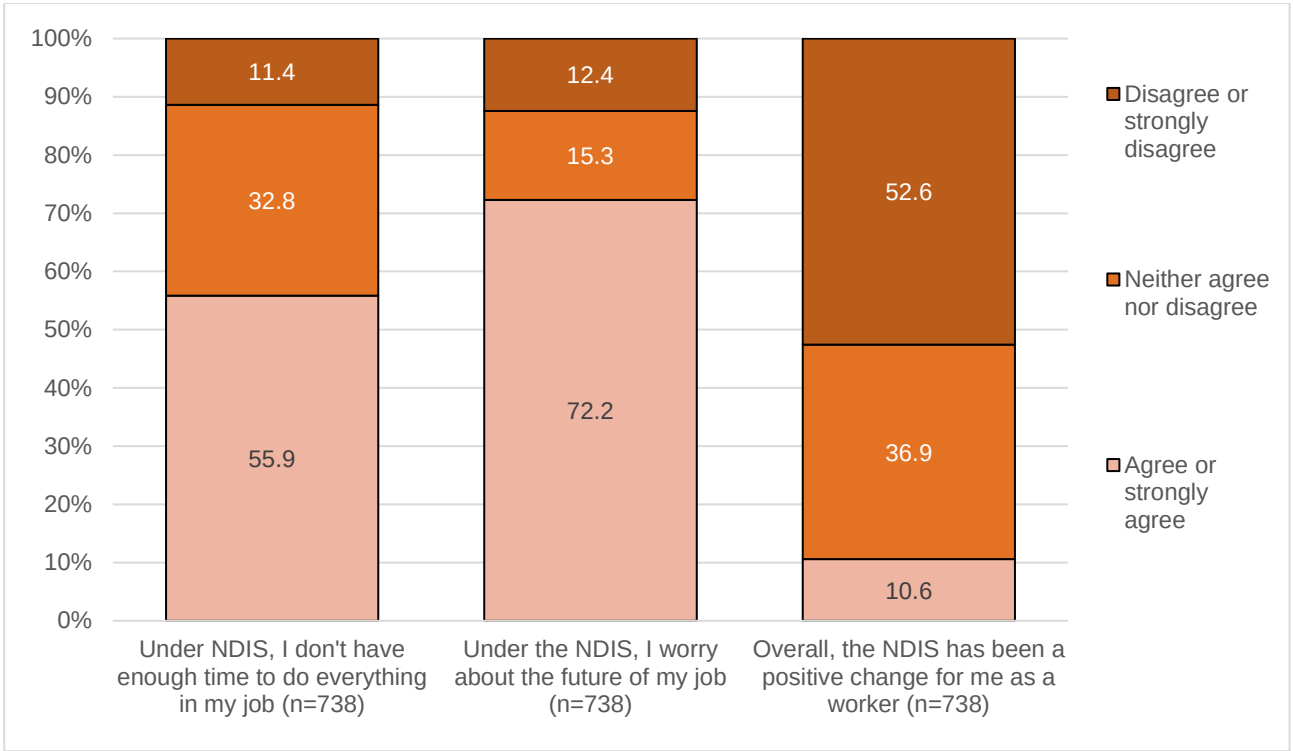


Figure 4.2 Proportion of respondents who agreed or strongly agreed with statements about working under the NDIS, by disability support service setting (%)

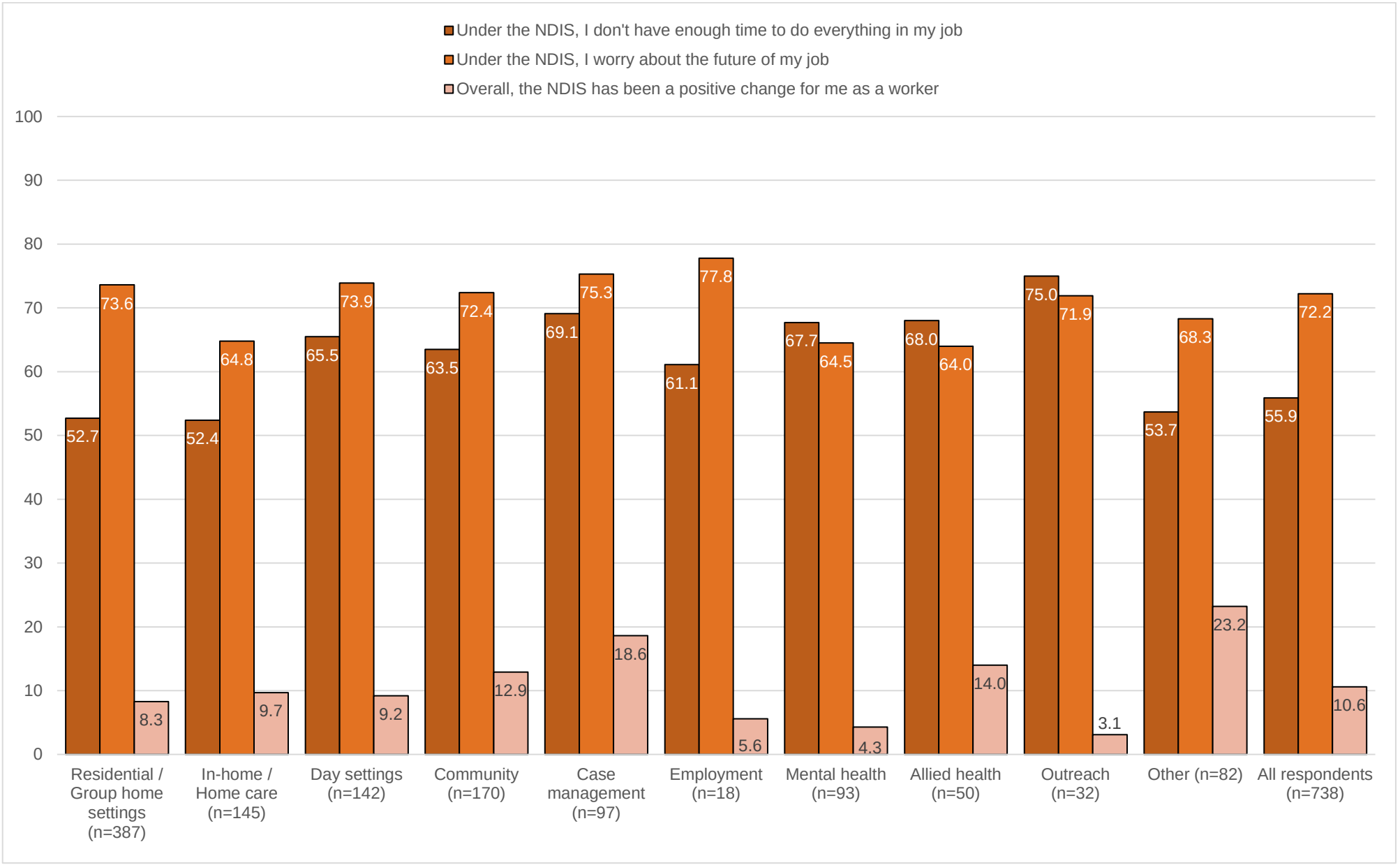
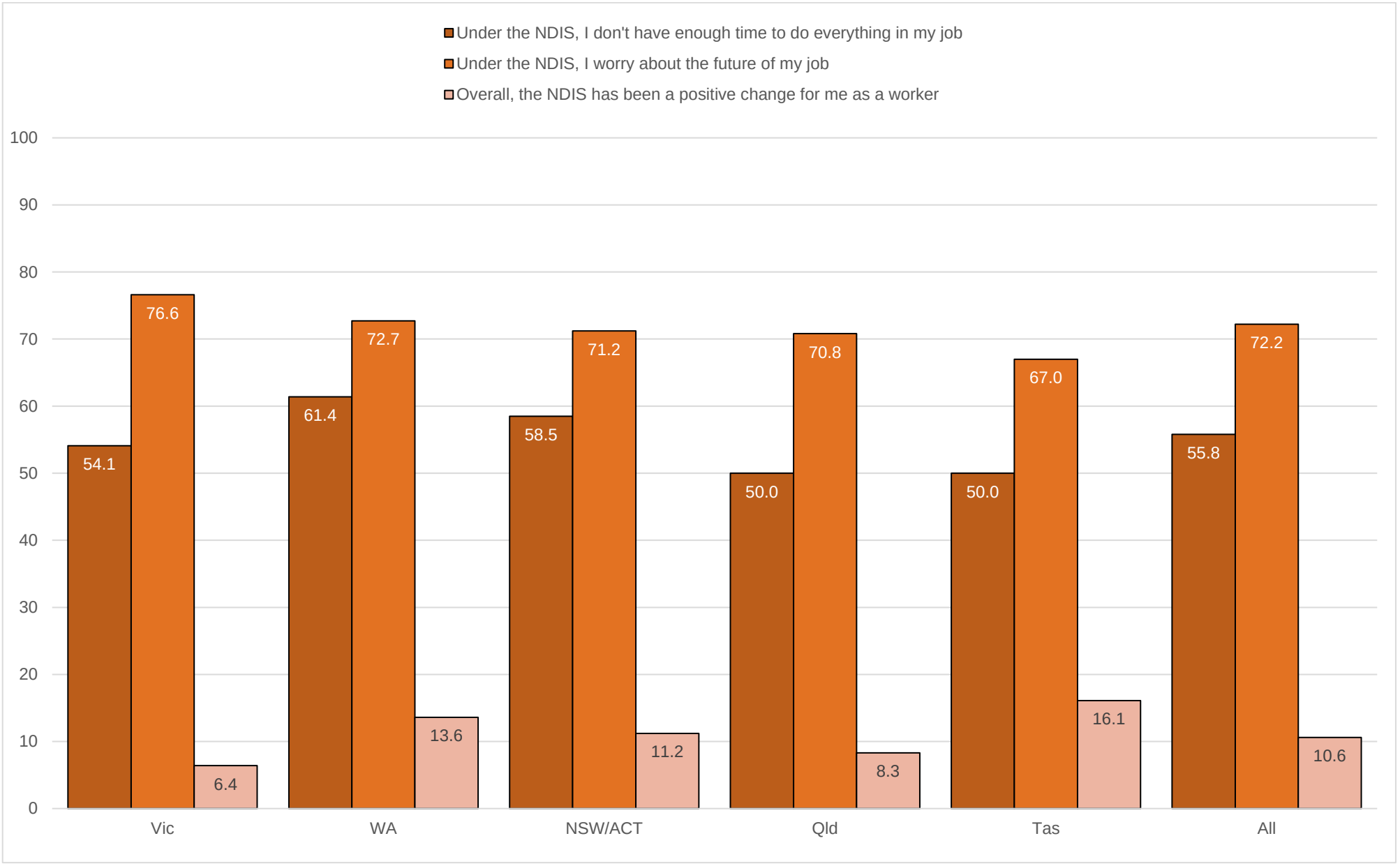


Figure 4.3 Proportion of respondents who agreed or strongly agreed with statements about working under the NDIS, by jurisdiction



5. Perceptions of the impact of the NDIS on participants and families

As well as showing how workers widely perceive the NDIS to be impacting adversely on their working lives, the survey data also shows only a minority reported it was impacting positively on participants and families. Figure 5.1 shows only a quarter (24.7%) agreed or strongly agreed that the NDIS was positive for the participants they work with, and many more disagreed (37.8%). Similarly, only a minority agreed that families of participants were happy with the Scheme (14.6%) and 15.7% agreed that overall, the NDIS is better than the previous system.

Figure 5.1 Percentage of respondents which agreed with statements about impact of the NDIS

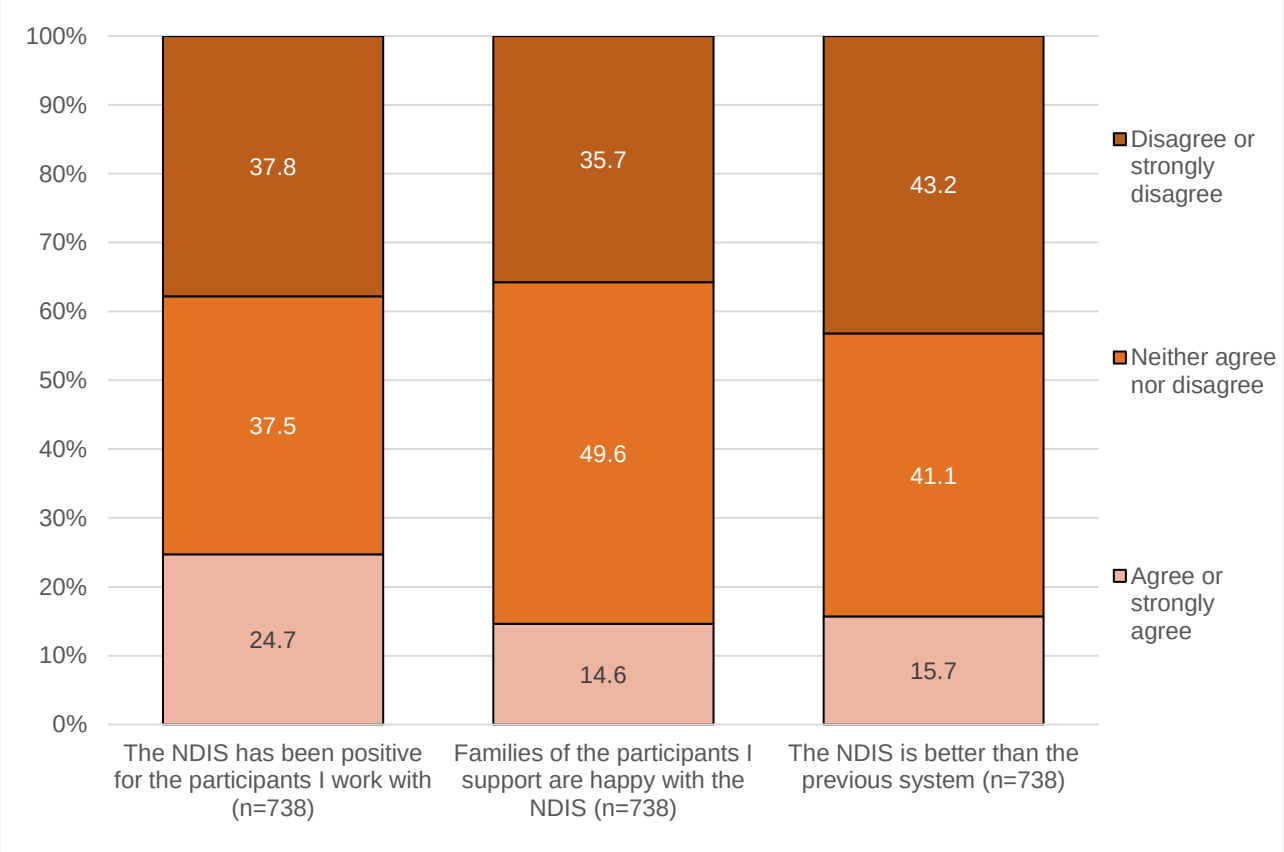


Figure 5.2 shows the proportion of respondents in each disability setting who agreed with the statements about the impact of the NDIS on participants and families. Among those in in-home, community, case management, allied health and 'other' settings, there were relatively high proportions of respondents who agreed the NDIS has been positive for participants, however, this remained a minority in all categories. Fewer agreed with the other statements, with variation by setting shown in Figure 5.2.

Figure 5.3 shows differences among respondents according to their jurisdiction of residence. Higher than average proportions of residents from Tasmania agreed with the statements, while agreement was lower for respondents from Victoria and Queensland.

Figure 5.2 Proportion of respondents which agreed or strongly agreed with statements about the impact of the NDIS on participants and families (%)

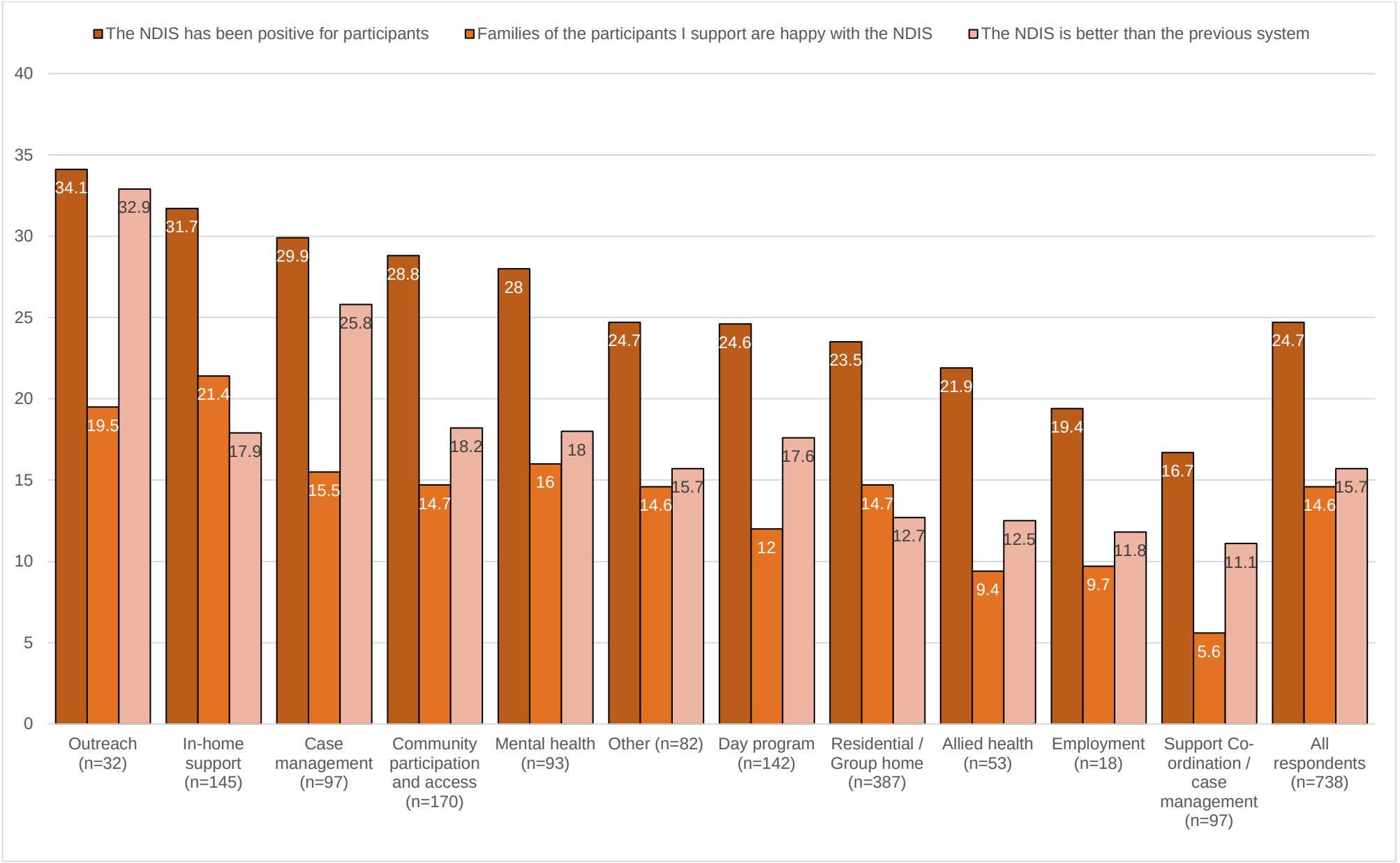
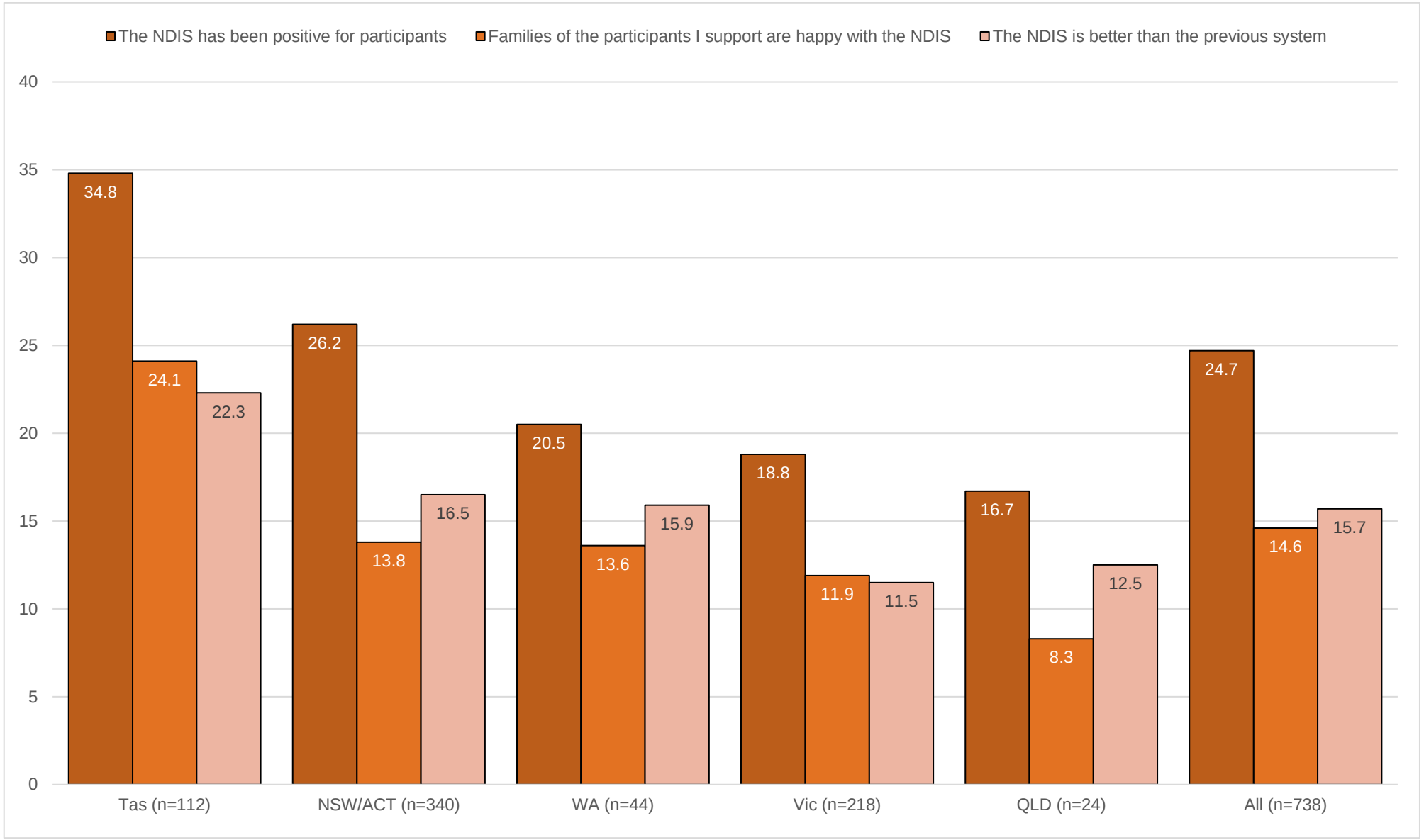


Figure 5.3 Proportion who agreed with statements, by jurisdiction of residence



6. Intention to leave or remain in the disability sector

Respondents were asked "Do you intend to be working in the disability sector in five years' time?" Around half said they did intend to be working in the sector (51.5%), while 15.2% said they did not, and a third (33.3%) were unsure.

The main differences in intention to leave were according to age, with a smaller proportion of those aged 60 or over intending to work in disability in 5 years, presumably due to retirement (see Figure 6.1). Indeed, when those who reported they intended to leave were asked why, retirement was reported by 36.7%. Reflecting dissatisfaction with remuneration discussed in Section 3, 27.6% of those intending to leave said it was because they could get better pay and conditions doing work elsewhere. A further 13.1% pointed to the nature of the work, saying they would leave as the work was too difficult or risky, while 12.7% said they would leave due to limited career development opportunities. Smaller proportions were intending to leave because of the unsociable hours (5.9%).

The main reasons for staying were due to commitment to clients, with 60.7% reporting they intended to continue working in the disability sector as they were 'passionate about supporting people with disabilities' and a further 18.8% said because 'I enjoy the client contact'. 10.9% said they had the flexibility to meet personal and family commitments. A small minority (4.0%) said they receive good pay and conditions, 3.3% said it was the best job available, and 2.3% said they had good career development opportunities.

Figure 6.2 shows the proportion intending to remain in disability services, according to respondents' years of experience in disability, and whether or not they were working under the NDIS The proportion intending to stay was similar for staff working under the NDIS (52.2%) and those who were not (51.4%).

Figure 6.1 Proportion who intend to work in disability services in 5 years, by age group

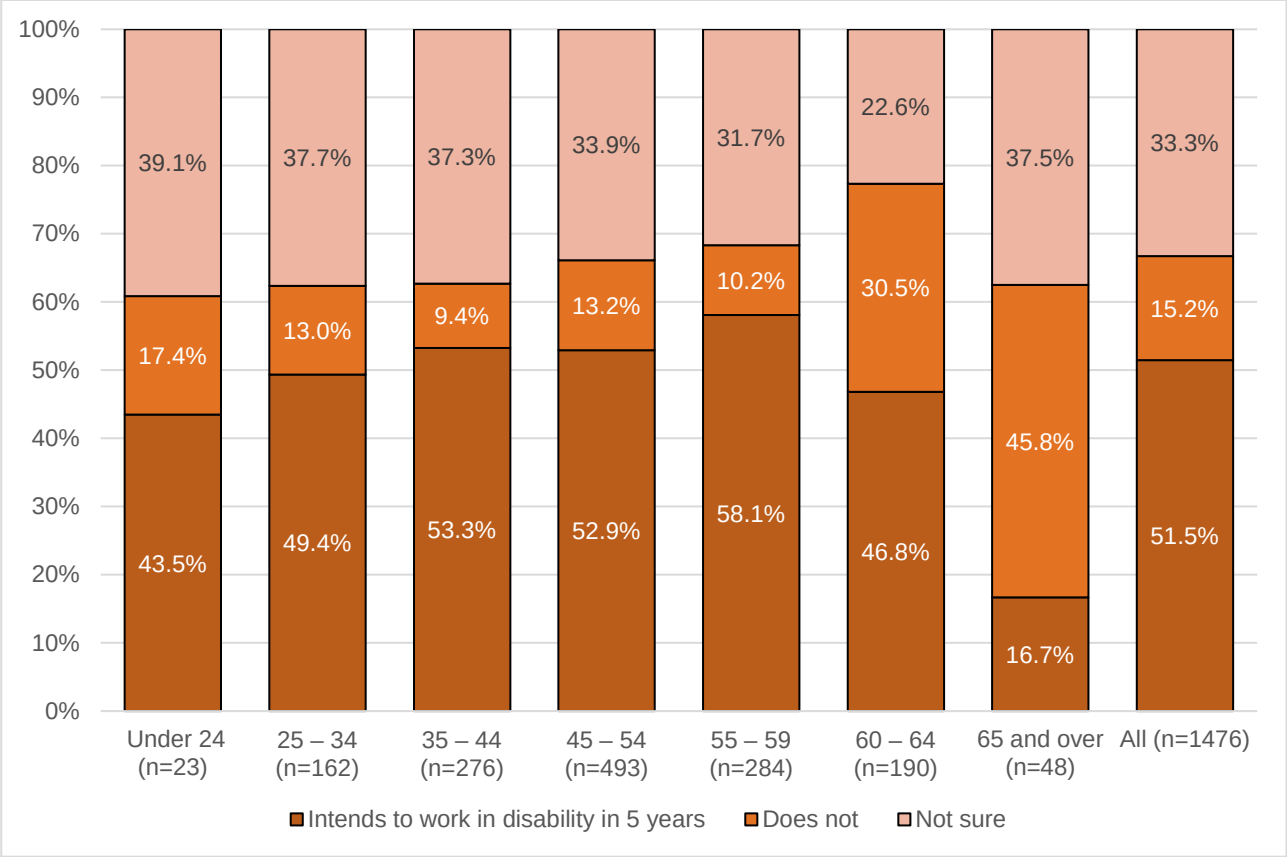
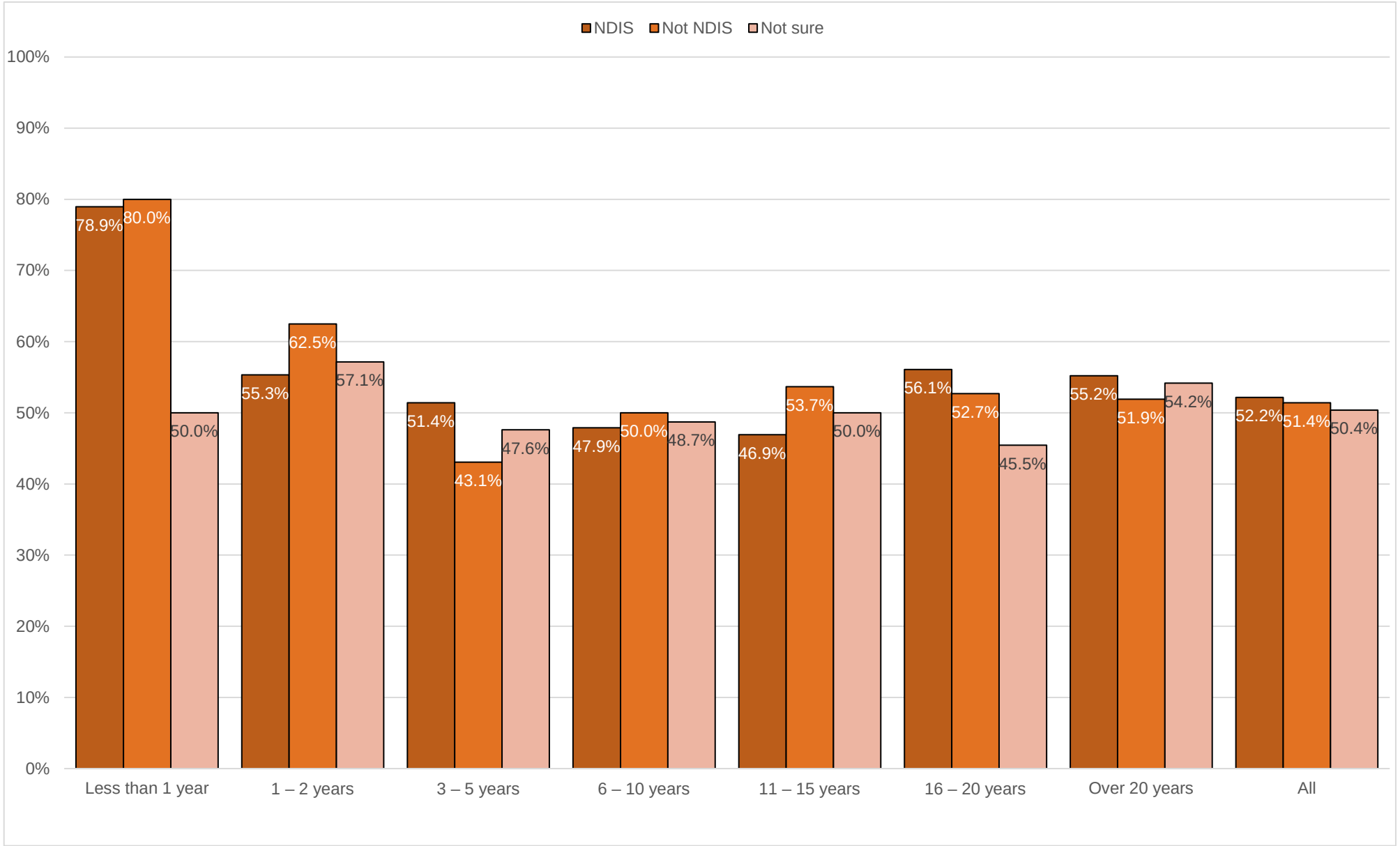


Figure 6.2 Proportion of respondents intending to be working in the disability sector in five years time, by years of experience in disability services and whether they were working under the NDIS



7. A closer look at supervision

As shown in Section 2.3, 28.5% of respondents said they currently supervise other staff, while about the same number (27.3%) did so sometimes. These supervisors (including those who always and sometimes supervised other staff) were asked further questions about the nature of their supervisory responsibilities, including how many people they supervised, and whether they experienced any challenges in providing proper supervision due to lack of time and the number of people they were supervising.

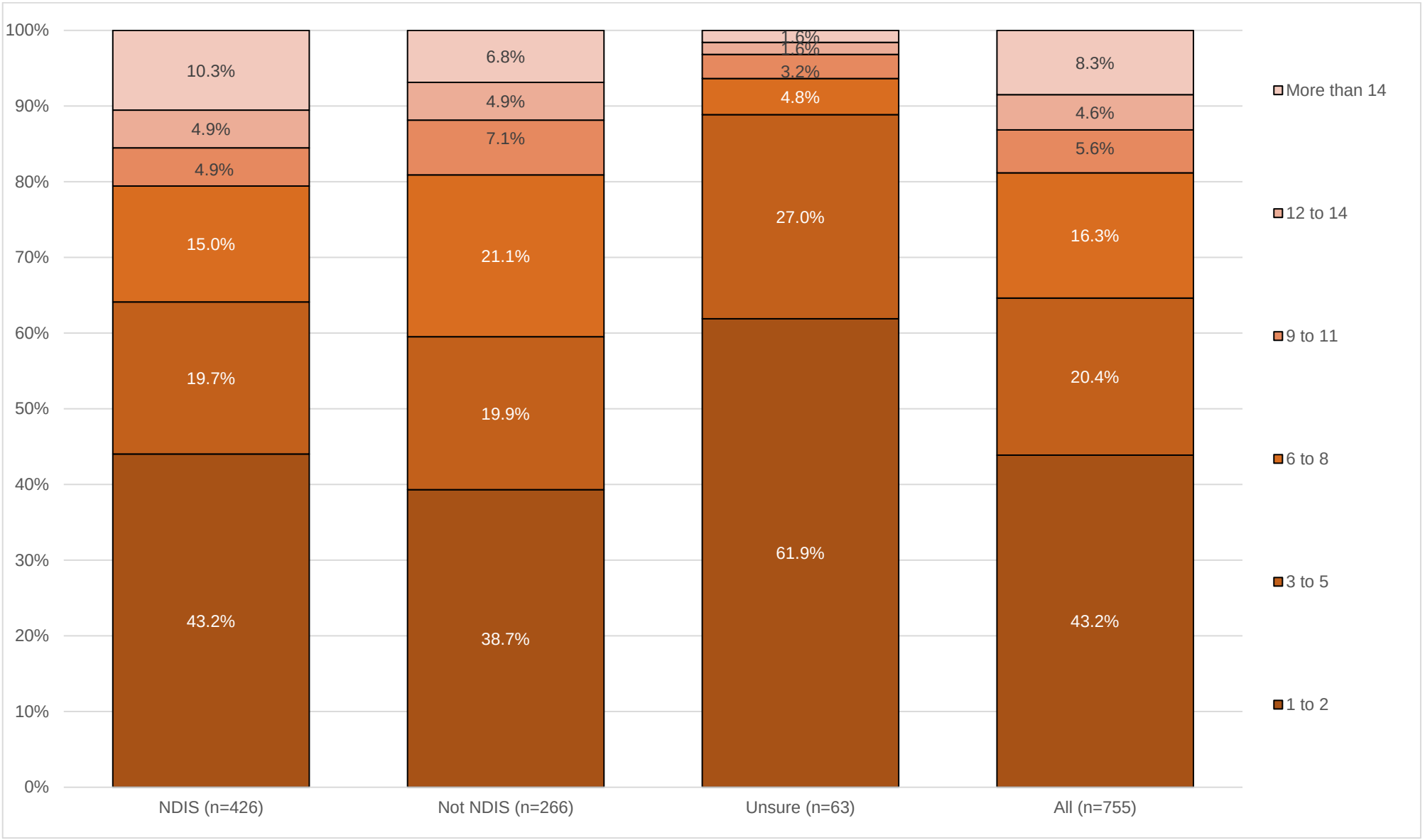
7.1 Numbers of staff supervised

The numbers of subordinates reported by supervisors working under the NDIS, and those who were not, is shown in Figure 7.1 (including information for those who 'sometimes' provided supervision). Overall, most supervisors reported only a few subordinates: 43.2% supervised one or two staff, and a further 20.4% supervised 3 to 5 staff. For this group, only 8.3% of supervisors supervised more than 14 staff[4]. However, this was higher for those under the NDIS, 10.3% of supervisors had more than 14 supervisees, compared with 6.8% of those not working under the NDIS.

Figure 7.2 provides the same indicators but excludes those who reported 'sometimes' supervising other staff. This allows a focus on the numbers of subordinates supervised by staff whose roles consistently involved supervision. For this group, 20.0% of those who worked under the NDIS supervised more than 14 staff, compared with 12.0% of those not under the NDIS.

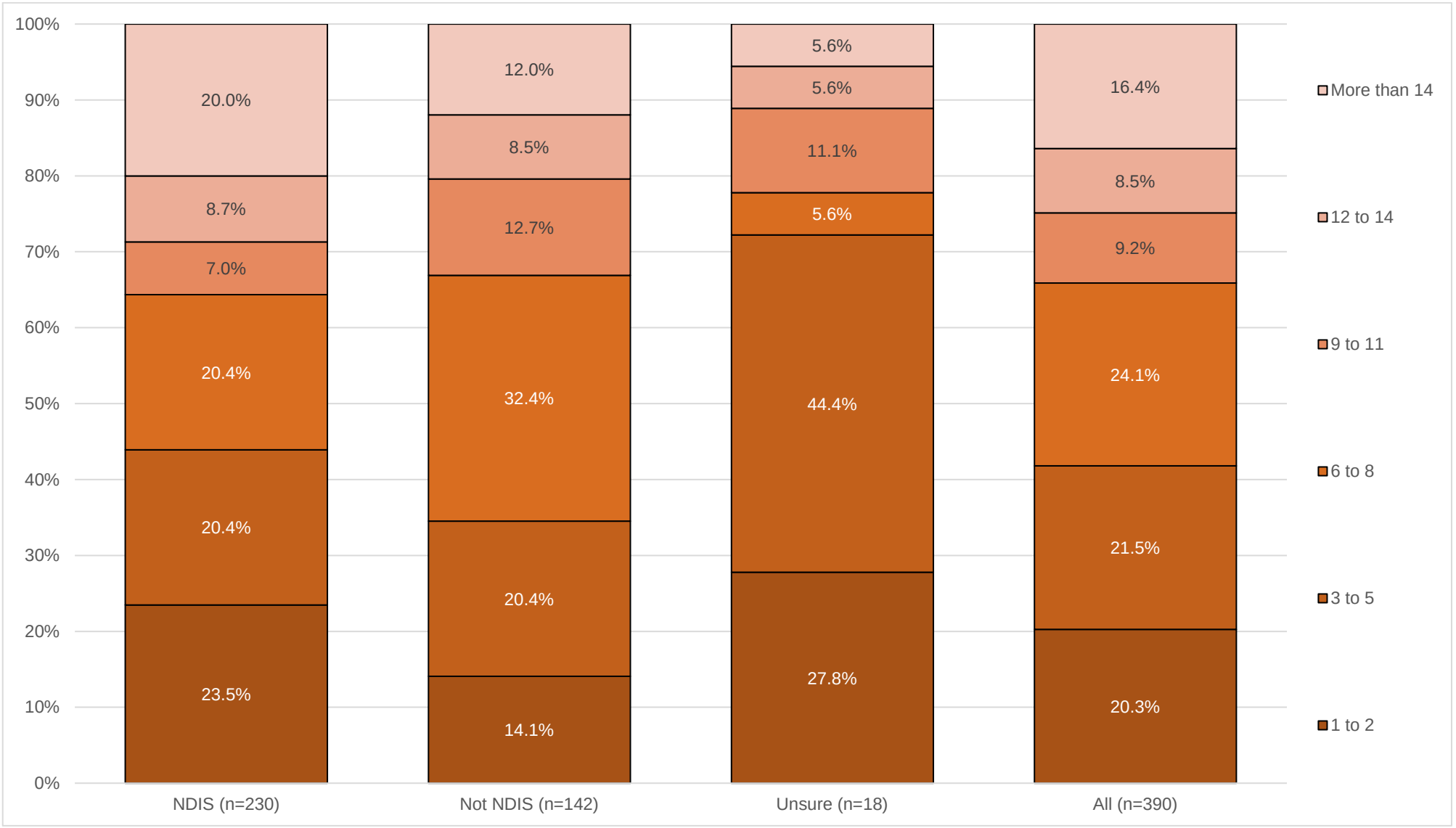
[4] Supervision of more than 14 staff is of interest because the National Disability Insurance Agency's pricing model assumes supervisors directly supervise 15 staff, and provides resources accordingly. See NDIA (2014) NDIA report on the methodology of the efficient price: National Disability Insurance Agency.

Figure 7.1 Number of staff directly supervised, by whether or not respondent was working under the NDIS, all supervisors^ (%)



^NB: This includes supervisors who always or sometimes provided supervision.

Figure 7.2 Number of staff directly supervised, by whether or not respondent was working under NDIS, supervisors^ (%)



^NB: This includes supervisors who always provided supervision only (ie those who sometimes provided supervision are excluded).

7.2 Pressure on supervision

The data shows that supervisors who directly supervise large numbers of staff experience difficulties in providing proper supervision. As shown in Figure 7.3, the proportion of supervisors who agreed that they can't provide proper supervision due to lack of time increased with the number of staff directly supervised. Among those supervising only 1 or 2 staff, 16.7% strongly agreed with the statement, and a further 38.5% agreed. Among those supervising more than 14 staff, many more strongly agreed or agreed: 38.7% and 45.3% respectively. Figure 7.4 shows that similarly, the proportion of supervisors who agreed or strongly agreed with the statement "I can't provide proper supervision because I have too many people to supervise" increased according to the number of supervisees. Well over half of those supervising over 14 staff (58.7%) agreed with the statement. Figure 7.5 and Figure 7.6 shows differences in agreement with the statements according to disability setting. On both measures, higher proportions of supervisors in day, residential and case management settings tended to agree.

Figure 7.3 Agreement with the statement "I can't provide proper supervision due to lack of time", by number of staff directly supervised (n=382)

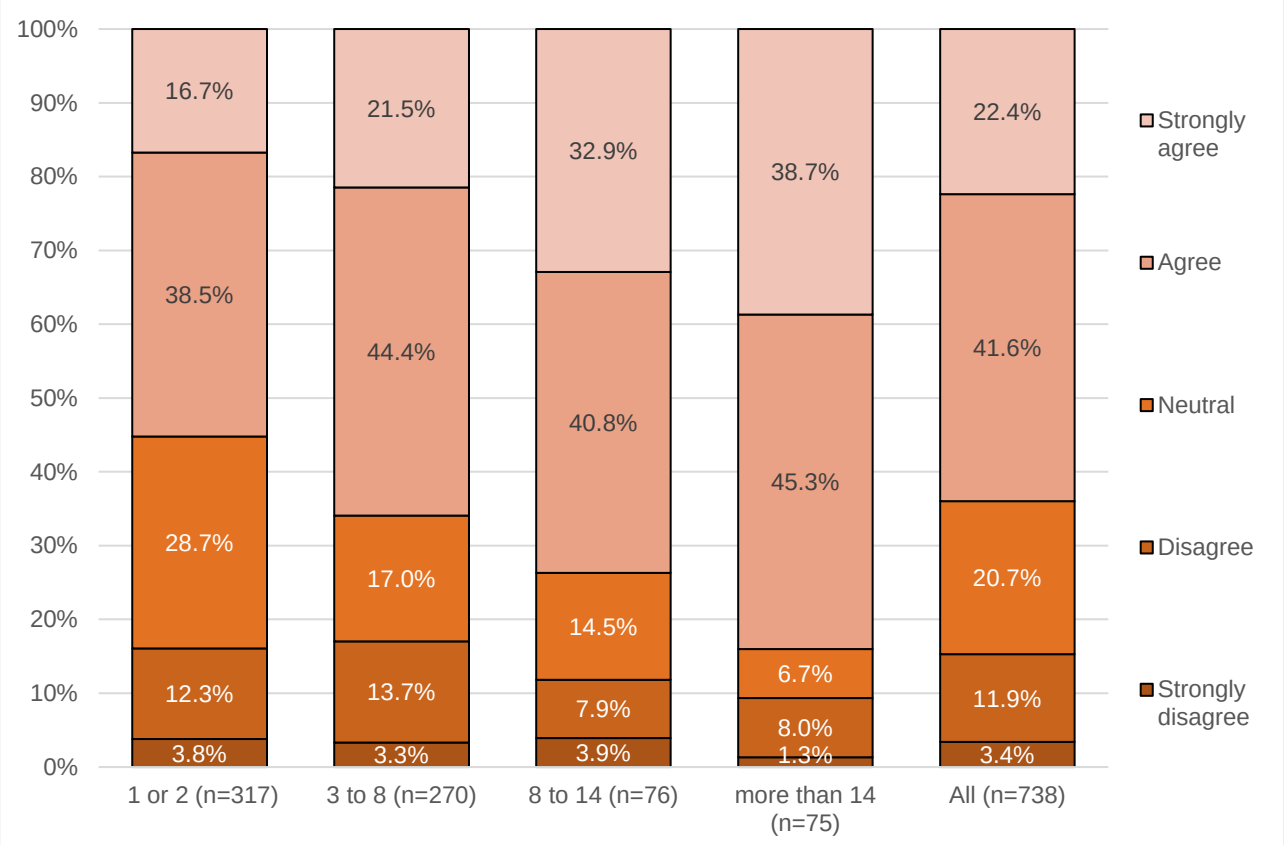


Figure 7.4 Agreement with the statement "I can't provide proper supervision because I have too many people to supervise"

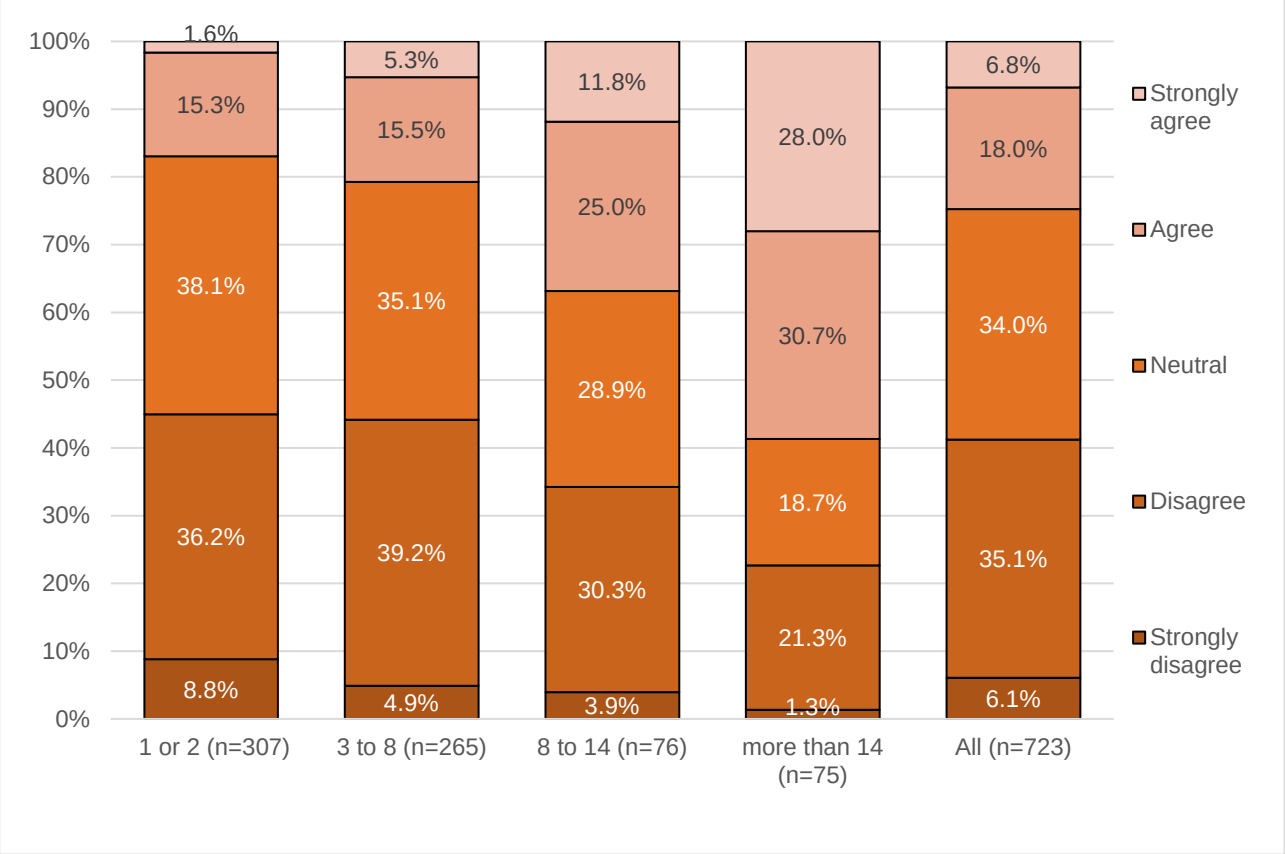


Figure 7.5 Agreement with the statement “I can't provide proper supervision due to lack of time”, by disability setting

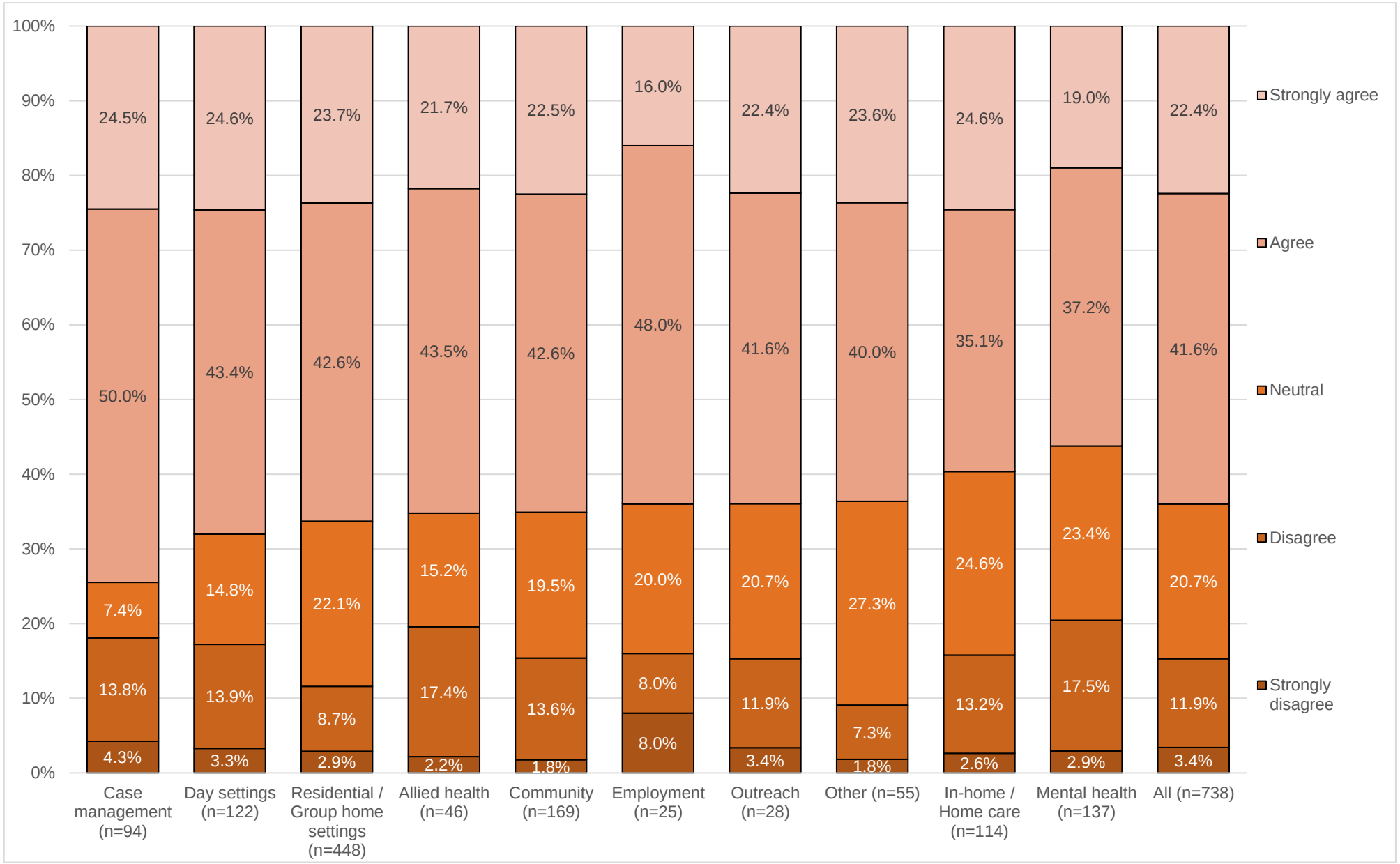
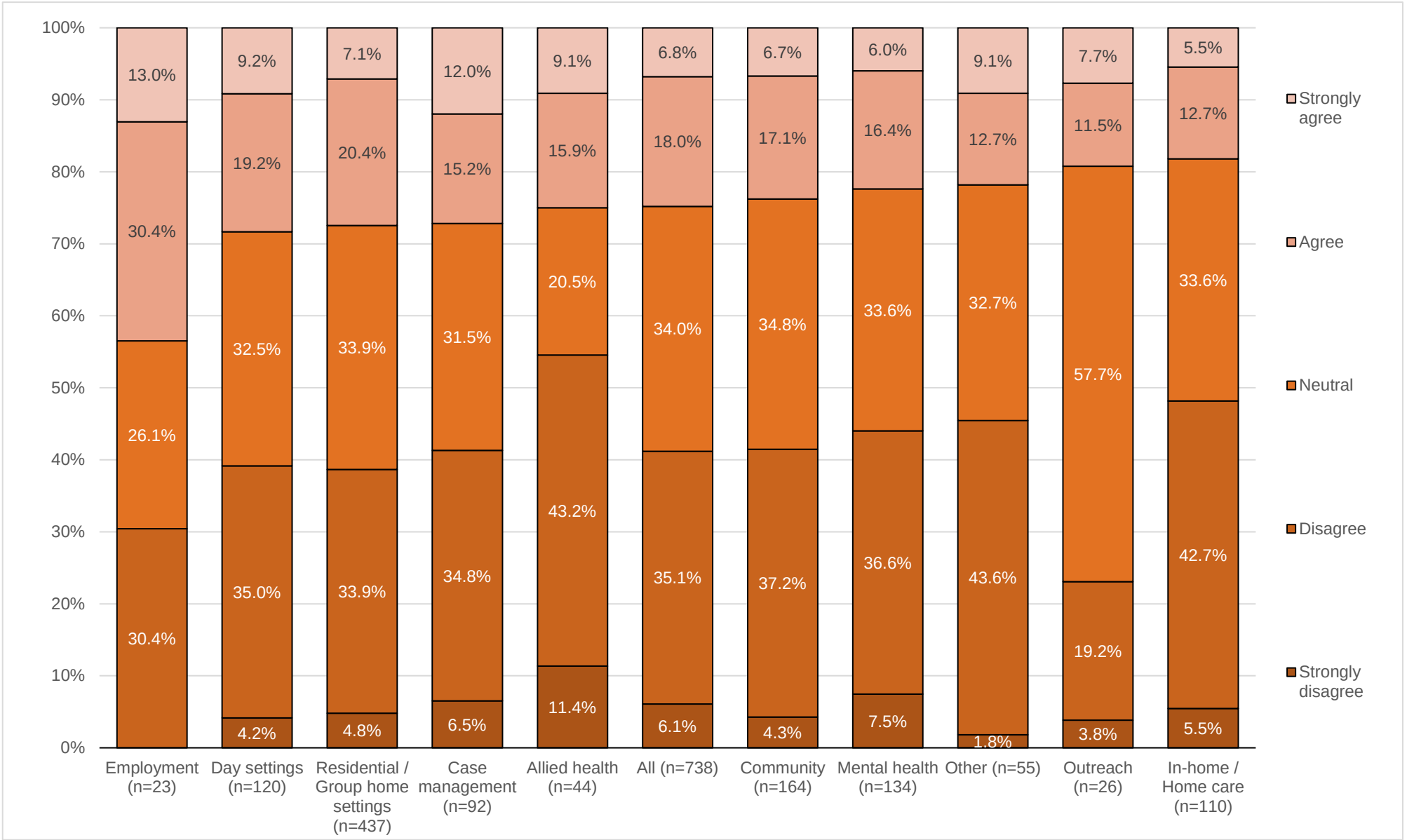


Figure 7.6 Agreement with the statement “I can't provide proper supervision because I have too many people to supervise”, by disability setting



8. Logistic regression

8.1 Understanding the factors affecting impact of the NDIS on participants

To better understand the factors affecting whether or not respondents perceived the NDIS to be positive for participants, multivariate analysis (logistic regression) was used. Logistic regression allows exploration of associations that multiple variables have on a binary categorical (non-numerical) outcome variable. In this case the outcome variable was a binary indicator distinguishing whether respondents agreed (or strongly agreed) with the statement "The NDIS has been positive for the participants I work with" (coded as 1), as opposed to those which did not agree with the statement (coded as 0).

8.2 About the model

The model includes control variables to account for the effects of worker demographics, disability setting, and working conditions, each of which could influence perceptions of the impact of the NDIS on participants. Binary indicators were included to control for the effect of gender, and working in NSW and Tasmania (as higher proportions of respondents in these areas reported the NDIS was positive). It also controlled for disability setting, whether respondents had worked in disability services for less than 2 years, or more than 10 years, and whether the respondent worked for more than one disability provider.

Working conditions were captured with a binary measure of pay justice, job security, time pressure, and capacity to provide quality supervision. Pay justice was constructed as a binary measure which grouped together (and coded as 1) those who agreed (or strongly agreed) with both the statements about pay "I am paid fairly for the work that I do" and "I am satisfied with my overall level of take-home pay". Those who did not agree with both measures were treated as not perceiving pay to be just (and coded as 0). To capture job security, a measure was constructed capturing those who agreed with the statement "Under the NDIS, I worry about the future of my job" compared with those who did not. Similarly, time pressure was captured with those who agreed with the statement "I don't have enough time to do everything in my job" coded as 1 (and the remainder coded as 0). A measure of quality supervision was constructed. Those who disagreed with the statement "I can't provide proper supervision due to lack of time" and "I can't provide proper supervision because I have too many people to supervise" were considered to provide quality supervision, and coded as 1.

8.3 Results

Results (odds ratios) are in Figure 8.1. Odds ratios greater than 1 (and which were statistically significant) indicate the factor was associated with increased odds of reporting the NDIS was positive, while those lower than 1 predict lower odds of doing so. The results show that three factors predict whether or not respondents perceived the NDIS to be positive for participants: state, pay justice, and job security. In particular:

- Residing in NSW and Tasmania were associated with increased odds ratios (of 2.7 and 2.5 times, respectively).

- Perceptions of pay justice also more than doubled the odds of perceiving the NDIS to be positive for participants, with odds ratios of more than 2.4 times.

Poor job security was associated with lower odds of reporting the NDIS had a positive impact on participants:

- Worrying about the future of one's job lowered the odds of reporting the NDIS was positive for participants (Odds Ratio=0.3).

Figure 8.1 Odds ratios: Employees who agreed with the statement "The NDIS is positive for the participants I work with"

	Odds ratios	Standard error
Works for more than 1 provider	.83	0.4
Two years of experience or less in providing disability services	1.8	0.6
More than 10 years of experience	1.4	0.3
NSW	2.7**	0.3
Tas	2.5*	0.4
In-home/home care settings	.8	0.4
Allied health	1.5	0.5
Case management	1.2	0.4
Community settings	1.2	0.3
Perceives pay is just	2.4**	0.3
Provides quality supervision	1.2	0.4
Time pressure	1.1	0.3
Concerned about future of job	0.3***	0.3
Constant	**0.2**	**0.4**

*p<.05 **p<.01 ***p<.001, Nagelkerke r square = .18, Hosmer-Lemeshow chi-square=5.6 (8), p=.685. Reference category is a female employee in 1 job with between 2 and 10 years experience working outside NSW or Tasmania.

9. Comments and concerns about working in the disability sector

Respondents were asked if they had any comments or concerns about their work in the disability sector and / or the NDIS. Overwhelmingly, respondents used the opportunity to comment: 913 workers provided comments (60.0%). The themes below reflect areas of concern. Note that each quote comes from a different person, with quotes selected to exemplify key themes expressed from the group as a whole.

9.1 General concerns about the NDIS

Respondents expressed significant concerns about the working in the disability sector and under the NDIS. Several respondents expressed confusion about the NDIS and the process of change, for example:

> The organisation I'm with are not providing informing us what we employees should be doing to prepare for the roll out in our region, not sure they know what they are doing.

> Everyone feels that they are in the dark about the NDIS, no one knows what's happening, or where they will be standing in the future, whether our jobs or pay will be secure, who knows, because no one is telling us anything

As well as reflecting uncertainty about the process of change, respondents' comments provide insight into the range of adverse impacts workers see the NDIS to have on the quality of services and the quality of jobs. Some explained that although they agreed with the principles of the NDIS, the Scheme did not appear to be implemented in positive ways, as financial considerations were eclipsing the needs of clients. Many expressed concerns about the resource model. They saw funding levels for people with disability to be inadequate, which raised concerns about clients' ongoing and future capacity to purchase the quality and quantity of services required. Examples of this sentiment are in the following statements:

> I fear it is mostly a cost saving scheme for the government. Theoretically it should work well, but at the moment it appears to be underfunded.

> I am concerned that people will not receive adequate packages. I work in respite and there appears to be questionable future funding for this service.

> The NDIS has turned an industry which use to be about caring and nurturing into an industry which only cares about profit for the provider.

Concerns about resourcing of the NDIS centred on the impact on people with disability. One respondent explained:

> The funding for the NDIS needs to meet the needs of people with disabilities. The government needs to take a reality check and they need to remember that they are dealing with the lives of very vulnerable people. If the NDIS is funded correctly it will

> be a fantastic step forward if the funding is not there then people with disabilities will have to take a giant step backward to time before deinstitutionalisation!!!
>
> Many of my clients have wondered why they have to change and what are their choices if they don't go with the NDIS? Many of my clients cannot read or write or are very limited, they have no family and the NDIS was not designed for these types of clients. The NDIS should have been more carefully worked through but all clients have been lumped in the one boat. Many have been very stressed about the change and all that goes with it. They feel they have no choice but to go along with it.

As well as being concerned about the impact of the NDIS on people with disability, workers also expressed concerns about the impact on family members:

> People with high support needs will get less hours of support. There will be pressure for the mothers of people with disabilities in particular to look after their son or daughter for more hours.
>
> I am concerned about vulnerable families and how they will be able to articulate their needs and negotiate the system. Both staff and participants are very confused about how the NDIS will work.

Another respondent, working in a community participation / community access setting, also focused on the impact of the NDIS on parents of children with disability, and described their frustration at discovering plans were unsuitable for meeting their children's needs:

> The NDIS is the worst thing this country has done. I am constantly on the phone with parents, crying out of frustration as they feel that they have lost support, have nowhere to turn for help and basically do not totally understand the scheme as it stands. I have had one parent at the edge of totally giving up and was so concerned with his state of mind that he was referred onto support for himself. The amount of times I have heard families say, "I am so tired of fighting for my child". We have that many families who have appealed their plans as Local Area Coordinators and Planners have been employed with minimal or no experience in the disability sector. How can families receive a plan that suits their needs when the person who is supposed to be guiding them through the process has so little experience?

Other workers also expressed concerns about the quality of the planning process, pointing out how planning was conducted without ensuring support for participants, and without a face to face meeting:

> I feel that anyone changing to the NDIS needs support while being interviewed on the phone. There is no face to face meetings and the people doing the interviewing know nothing about the person being interviewed. This can be very misleading if the person being interviewed does not give a full history of their situation.

Another respondent outlined how the NDIS was reproducing inequalities, as people with disability who had strong family advocates had better access to Scheme resources:

> I have concerns about families not receiving the support they need to navigate the 'system'. From accounts with numerous families I have learned that NDIA support/funding is more likely to be received by families who 'jump up and down', which indicates to me that it is a reactive, not proactive system. For such an amazing concept, I think it is really important for access to the NDIA to provide equality, otherwise the same inequalities that have always been in the disability sector will continue to occur.

Several workers commented that the NDIS was failing particular groups of people with disability, in particular by failing to recognise the complexity of need. As one explained:

> NDIS has been created with a particular set of disabilities in mind, or at least as a priority, but in the case of intellectual disability there is not enough consideration given to the complexities of supporting those with complex care needs. Where participants are unable to self-manage or advocate strongly for themselves, supervisory staff are not being given the resources to properly provide choices and to collect the evidence that quality services are being delivered. What was sold as an opportunity to address the inequalities inherent in the block-funded arrangements has instead delivered a cost-cutting exercise; whether through accident or design, the lofty ideals of the NDIS are not being going to be achieved for a great many participants unless the paucity of funding to provide the best outcomes is rectified.

As well as people with intellectual disabilities, workers also noted the difficulty of engaging with the NDIS for people with mental health or psychiatric needs, older clients, people who were homeless or disconnected from family, and those unable to advocate for themselves.

9.2 Concerns about service quality

In their comments, workers expressed strong concerns about service quality under the NDIS. Perceptions that clients' needs would not be met under the Scheme were widespread, reflected in comments like:

> The only concern that I currently have is that the people that I work with, I'm worried that their needs won't be totally met.

Those working with NDIS participants had witnessed changes in practice which they attributed to the Scheme, while others commented that changes had been made by their organisation in anticipation of the NDIS rollout. Some commented that people with disability were 'treated like numbers' in ways antithetical to the ambitions of personalisation, while others noted high risks, including poor staff training, reductions in staff numbers, and grouping clients together in inappropriate ways. One respondent, who had been a casual worker in an accommodation setting for 10 months and was new to disability services, explained that she had never been shown how to manually assist in moving people in and out of wheelchairs. Another, working in a day program setting explained how services were being organised in ways which raised behaviour-related risks:

> The day programs I work at supports participants with high support need and challenging behaviours. Due to the lack of funding some of these participants receive we are currently grouping the participants up. This can be difficult as some of them do not like to be grouped up and this can cause behaviours which is not

> detrimental to the worker who could be on their own supporting this group but also the other participants in the group.

Risks were also seen to arise relating to the use of temporary casual and agency staff, and staff turnover, which were seen to undermine standards of care:

> Standard of care drops significantly when new, temporary and unfamiliar staff work with residents. The calibre of agency staff is significantly lower than that of ongoing employees. In my team, this is not just a job; it is a career that we are passionate about. We commit to our residents long term for consistent improvement and quality life experiences. I am concerned that NDIS will casualise the workforce, leaving staff disengaged, devalued and bitter, and clients in the care of people who are not committed to positive outcomes.

Others explained:

> There appears to be a trend of more agency and casual pool staff working then permanent employment. This impacts on clients' health and well being. Increased assaults at work results from staff who don't know clients enough to support them especially clients with behaviours of concern. Job security and not being able to retire is impacting staff health and wellbeing. Working on weekends impacts on family togetherness. The pay scales have not increased but the cost of living has and staff are struggling to meet basic living standards.

> The hourly rate payable is so low that we have to take what we get in term of staffing. This is extremely dangerous in a sector that does not require any prerequisite qualifications, skills, or knowledge, and will undoubtedly (especially with such little time to effectively supervise staff) result in people dying either directly or indirectly from staff actions (or lack of action). The NDIA will see a devolution of large residential services, which are filled with trained and qualified medical staff, mental health professionals, psychologists, psychiatrists and social workers. The people from these places are going to NGO's who have untrained and unqualified staff looking after these highly vulnerable and complex people, most of whom have been in the disability sector for a couple of weeks by the time they commence supporting them, coming from fast food/hospitality services, newspapers, and (even scarier) security services where brute force was the preferred option of dealing with people.

The use of untrained staff was seen as a major risk:

> I feel that our ability to support Individuals with mental health concerns has been undermined and negated by the new methodology of the NDIS. New staff that have been employed to fill the newly created gaps, they are not trained and are creating confusion with out supported Individuals. Apparently there is no training funded for these new staff members which I find absolutely horrendous. I have studied for approximately 5 years in this position. I am very worried about how this will impact on the individuals that we support. Also, that the sector will not retain quality staff members.

9.3 Concerns about pay and conditions

Survey respondents expressed significant concerns about their working conditions and remuneration under the NDIS. These concerns are captured in the following statements, which highlight degradation of working conditions in a range of ways, through subcontracting and self-employment, use of private vehicles, unpaid administrative time, loss of hours, and loss of penalty rates:

> I am concerned about changes to my working conditions under the NDIS. Forced to use own vehicle to provide support. Associated costs e.g. business rego and insurance, cleaning, wear and tear. Not paid until I reach the home of my next client. Not paid for admin time. I believe that the NDIS can be beneficial for people with a disability and may offer great opportunities. However the disability support staff seem to be the ones that have to make all of the sacrifices, money, time and workload.

> I am concerned about there being sufficient work available and a possible big drop in pay and working conditions and the possibility the weekend pay rate dropping and the country taking a huge step back in time in terms of pay and workplace conditions and standards.

> I'm concerned that the 'hidden' rort of subcontracting will become the norm and already on the NDIA website there are banners excitedly promoting self-employment opportunities. Standards of care will drop exponentially and the people that will suffer will be the clients. I will not work for peanuts whilst putting myself at risk of physical assault and I think many long-term employees with many years experience will do the same.

Many explained how they had experienced degradation in their work-life balance, and associated work stress, lowering enjoyment of the work:

> In the past year our staffing has been cut back dramatically and the customers are not able to get all goals realised or quality one on one time with staff, also I am finding I am exhausted and on some days rushing aimlessly trying to complete all tasks pertaining to all customers within the daily time frame, it's becoming ridiculous. Starting to hate coming to work, some days. And that's just not who I am, I don't like what's happening to the industry, I hope the changes make work life conditions better once things settle down with the NDIS transition.

Indeed, the challenge of delivering quality services and supports were a reason people were leaving, including this respondent:

> I have just resigned as a NDIS LAC due to over work, lack of management support, focus on KPI's not participants , changing requirements in the job, lack of follow up / time for participants after planning session, huge discrepancies in $$$ attached to plans by NDIA planners for similar situations/disability.

Remuneration

Overwhelmingly, workers considered the pay they received to be inadequate given the level of complexity and risk in performing work in disability services, or were concerned that pay would drop as a result of the NDIS making remaining in the sector untenable:

> The NDIS does not allow employers to offer appropriate wages, especially high risk clients. $22-25 an hour for high personal risk - no way. I'd rather work at Woolworths.

> I enjoy the client contact and believe the pay is fair but would reconsider working in the sector if I was paid any less for what I do.

> The NDIS is only paying award wages and not what I am currently being paid. I fear that I along with many others, will be financially disadvantaged! I fear that quality of care will gradually deteriorate for the clients.

Many comments gave examples of poor employment and work organisation practices, including being employed at low pay grades and on short term or casual contracts. Some explained how changes in rostering had left them worse off, or that they were worried about how shorter shifts would erode their pay, for example:

> I am worried that the hours of work offered will consist of 1 to 2 or 3 hour shifts and hardly worth traveling for once you factor in travel time petrol and time wasted to get to other shifts.

> Recently, I had a roster change, a take it or leave it change even though I was already working a permanent roster, since then my yearly income has reduced by $8000. When I questioned this the coordinator said that [the organisation] doesn't care about penalty rates or your personal life outside of work. We have also been cut on weekends from 2 staff to 1 to look after 5 high support clients. Lack of support is getting worse.

Employment classifications

Several respondents identified how the NDIS had caused their organisation to downgrade their employment classification and freeze their pay rates. As one worker explained:

> I am concerned that the organisation I work for is trying to downgrade mine and co-workers grades by using the NDIS as an excuse to do so. They claim in order to be attractive to families to want to use us that it is better for us to be grade one or two rather than grade three as we are at the moment. I believe they are just in a race to the bottom with only their own company profits as their main focus. I have qualifications in disability as in a Cert 4 but they would prefer to employ people off the street with no experience and no qualifications because they are cheap. What sort of service is that going to be for our clients? It's a disgrace.

Similarly, others explained:

> My employer and many others in our region are reducing pay grades in anticipation of the roll out of the NDIS. For the last two years all new employees are paid at SCHADS 2.2 instead of the previous starting rate of 3.2. By attrition they are

> eroding pay rates in order to shore up their financial position to weather the end of block funding and the introduction of fee for service invoicing under NDIS. There now are almost no new permanent employment contracts and most new contracts are offered on a three month basis at the most.
>
> We have been advised that our hourly rate is higher than what the NDIS rate is so as grade 3 employees, we will be now classed as grade 2. We won't lose pay immediately however we won't be getting a payrise until grade 2 rates catch up to ours. We currently access cars from our organization on leaseback as we use our cars daily for our work. We are losing the cars too. We have also lost our first aid allowance and we no longer get our first aid training paid for by our employer. We are also concerned that we will only be paid per the actual hours spent with clients and not for the travel in between and office time etc. Currently I may only spend 6hrs directly with clients (3 clients at 2hr each) and am paid for my whole day 9am - 5.00pm as that reflects my roster.

Another explained how employers were attempting to save money by reclassifying disability work under the 'homecare' part of the SACS award, to enable shorter shift times:

> The casual nature of the work and the pay/minimum hours is very unsustainable. My employer claims it is legal to pay under the Homecare part of the award for some classifications of clients and therefore legitimise a minimum 1 hour shift. It is also very difficult to come to work (often travelling 30 kilometres) for a 2 hour shift, then having to wait around for the next shift 4-5 hours later. There is little consideration for the impacts on workers - the entire focus for the organisation is on filling shifts and building customer (participant) numbers.

Workloads and stress

As well as pay, many highlighted how their workloads had increased under the NDIS, or in anticipation of NDIS, resulting in high levels of stress:

> As a carer, I feel I am placed in impossible and stressful work situations - there are so few carers available that I feel compelled to accept work hours & travel times (often unpaid) due to a sense of obligation and loyalty to my clients. During many services, there is insufficient time to complete all I need to do and if I exceed the allocated time, I am not paid. I know my clients are very grateful and value my commitment but I feel carers are being taken for granted & have no voice at all.
>
> We are being loaded with more work and less time for the people we support and are told we just have to deal with it as its going to get worse for us support workers as it is now we don't have enough time in a day to do all they expect us to do and from management it is like it or lump it.
>
> I am concerned that our rate of pay will be less and we will be required to support more people eg instead of two per day face to face it may be increased to four, therefore decreasing the quality of support currently being provided. Also it appears that our organisation is going to be a mobile workforce and we will have to use our personal vehicles etc which will increase our personal expenses plus increase isolation of workers where we will not have the opportunity to debrief with each

> other face to face. Many more concerns. However the financial aspect is very concerning.

Many workers who responded to the survey linked their concerns to both transition to the NDIS and the associated privatisation which has occurred or which was pending:

> I am concerned that under NDIS we have to take on more clients as we are now privatised. There is a lot more pressure to take on new clients so that the case load has increased. There is less recognition of mental health issues that impact on our work. Before we could spend extra time if needed with a client in crisis, now it is all about hours and money. The pressure is immense and we are monitored to every minute via a carelink software system and we have to bill everything. I have never felt so pressured as I do now and the pressure is just not the clients but also the system that surrounds NDIS. I worry that whoever provides the cheapest service will get the clients and this it becomes all about money. Certainly the money and hours is what is now pushed and this seems to be the main thing. As a worker this is very disappointing and has changed the face of disability work for the worse.

> Concerned that the residents that I support will have a poor standard of care should [my organisation] privatise. I have supported the same client group for 10 years and know their support requirements, service providers and family well. I would seek different employment opportunities available to me if [my organisation] was privatised.

Concerns about unpaid work

A strong theme within workers' comments about the adverse impact of the NDIS on wages and conditions was the amount of unpaid work required. Employees expressed concerns that expectations of unpaid work were increasing, including for travel and administration which were necessary elements of service delivery. Examples of comments that focused on this are as follows:

> The system does not provide funding for anything other than direct support, therefore all the ancillary tasks such as note writing, documentation, communication with other stakeholders must be done in the employee's own time. In my case I spend at least one hour each day unpaid doing file notes etc. This needs to be looked at as all of this documentation is mandatory.

> My biggest issue has been agency work where you use your own car and do not get paid between jobs. Sometimes I have been paid 1-2 hrs for spending over half a day doing job related activities. I see conditions getting worse under these conditions.

Job security and underemployment

Many employees also expressed significant concerns about job security and the security of their shifts and income, in the disability sector and under the NDIS. One respondents, who provided disability services for more than one employer, explained:

> My jobs feel very insecure, I'm forced to remain a casual as part time jobs are less available and can drop my hourly rate to just $20. In every job I've had we are

> ALWAYS understaffed and torn between multiple employers. Support worker turnover is fast, especially when there are management issues and this is detrimental to the clients and their continuation of care. I love my work but I'm so shocked at how ruthless service providers can be!

Workers perceptions that hours were under pressure, and that shifts were not secure, were reflected in the following comments:

> In one role I am employed in they are not offering part time permanent positions only casuals and they have reduced my rostered time by 1/2 an hour each day.

> I started on a 136 hour a month contract and lowered it to 120 and was told I could always put it up if needed the hours are always there which was not true, they would not let me increase my contract. They have just hired people on a 8 hour a month contract and 30 hour contract and they pick up extra shifts. I have always tried to be a reliable and valued employee but not feeling it now.

> I am concerned that I may lose the stability of the current shifts that I have once the NDIS roll out. For example if the client cancel the support and giving enough notice to the organisation.

Others expressed similar sentiment:

> I am a single parent and am worried that I will not maintain my current level and entitlements and salary which will affect me and my family directly.

> My concerns are job security and my future employment I still have almost 30 years of work ahead of me so it's important now!

> Currently not getting enough hours since the introduction of NDIS because of the 10hrs break in between shift that they just introduced

Together, these responses reflect significant concerns among employees about a wide range of quality and employment issues seen to arise from the NDIS, or which workers were anticipating would arise from rollout in their area.

10. Conclusions

Overall, these findings provide insight into the characteristics and experiences of workers in the disability service sector and in particular, their experiences of working under the National Disability Insurance Scheme. While differences between those working under the NDIS and other disability workers were not consistently evident, the results show a range of quality and workforce risks of the Scheme. While workers' primary concerns were with falling standards of service for people with disability, the survey also shows workforce problems such as high supervisory loads under the NDIS, multiple job holding, and major concerns about job quality, work time and financial security. Moreover, the regression analysis suggests that for this sample of highly experienced workers at least, decent pay and job security are associated with higher perceptions of outcomes for NDIS participants.

The findings indicate the importance of working conditions in the disability sector, and the links between working conditions and the quality of service provision. The results suggest some ways forward, including keeping supervisory loads at reasonable levels, and ensuring experienced workers are retained in the transition to the NDIS. This could be built on with an ongoing and ideally longitudinal program of research, to monitor workforce issues and working conditions in the disability sector through the process of change, and to assess the impact of interventions to improve working conditions and workforce quality and sustainability as a determinant of high quality disability services.

Australian Government
Australian Institute of Health and Welfare

Australia's welfare 2017

AIHW

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The Australian Institute of Health and Welfare is a major national agency whose purpose is to create authoritative and accessible information and statistics that inform decisions and improve the health and wellbeing of all Australians.

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Report designed using art by Moira Nelson. Moira is a Canberra artist who describes herself as a social artist. She likes to produce art within a social and communal setting where she can be 'enlivened and inspired by the diversity of personalities involved'. She creates work that talks about the story of being human, with a particular emphasis on communication. Her interest in this stemmed from a car accident at age 20 which left her with a brain injury impacting on speech and memory. In addition to her own artistry, Moira volunteers and facilitates art programs for disadvantaged and disabled people, children and the wider community.

Please note that there is the potential for minor revisions of data in this report.
Please check the online version at www.aihw.gov.au

Australian Government
Australian Institute of Health and Welfare

AIHW

The Hon Greg Hunt MP
Minister for Health, Minister for Sport
Parliament House
Canberra 2600

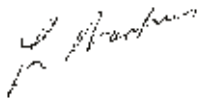
Dear Minister,

On behalf of the Board of the Australian Institute of Health and Welfare, I am pleased to present to you *Australia's welfare 2017*, as required under Subsection 31(1A) of the *Australian Institute of Health and Welfare Act 1987*.

This edition continues the AIHW tradition of delivering high quality evidence and value-added analysis on welfare issues, together with insights into how future data could better meet the needs of policy analysts, researchers and the public.

I commend this report to you as a significant contribution to national information on welfare-related issues, and to the development and evaluation of welfare policies and programs in Australia.

Yours sincerely,



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Preface

In 2017, the Australian Institute of Health and Welfare (AIHW) celebrates a milestone, marking 30 years since the Australian Institute of Health Act came into effect on 1 July 1987. The AIHW gained its 'welfare' role in 1992, and since 1993 has published a biennial flagship report on welfare, the *Australia's welfare* series. *Australia's welfare 2017* is the 13th such report. This year's edition illustrates just how far we have come in producing authoritative statistics on the welfare of Australians since the modest beginnings of the inaugural 1993 report.

The 2017 edition continues the AIHW tradition of delivering quality evidence on welfare issues and, in line with the Institute's new strategic directions, demonstrates the AIHW's core capabilities of being leaders in health and welfare data, drivers of data improvement, expert sources of value-added analysis, champions for open and accessible data and information, and trusted strategic partners.

The AIHW's flagship reports are independent and highly regarded national compendiums on health and welfare: they are compiled from dozens of data sources and draw together a variety of perspectives at both the national and local level. They also serve as 'report cards' on the health and welfare of Australians—they investigate trends and consider how Australians are faring as a nation. Although *Australia's welfare 2017* shows that most of us are doing well, the report highlights the diversity of disadvantage that exists in our communities, including among Indigenous Australians, vulnerable young people, people with disability, Australia's homeless population, and those experiencing family and domestic violence.

Australia's welfare 2017 is framed around 'welfare' in its broadest context. The report is underpinned by the concept that a person's wellbeing results from the interplay of many interrelated individual, societal and environmental factors that extend well beyond the provision of financial assistance and welfare services.

As in previous editions, *Australia's welfare 2017* presents reliable and detailed information on population factors that influence the demand for welfare services, welfare spending and the composition of the community services workforce. It then looks at welfare with respect to various population groups and sectors, including children and youth, education and training, employment, housing, ageing and aged care, and disability. A chapter is dedicated to the welfare of Indigenous Australians, and the report concludes with a comprehensive analysis of welfare indicators based on a framework developed by the AIHW and published for the first time in *Australia's welfare 2015*. This latest edition reports on the 'wellbeing' domain of the framework for the first time, after consideration of Australian and international work in this area.

Australia's welfare 2017 follows a similar structure to recent biennial reports, combining short statistical 'snapshots' with 'feature articles' that explore topical issues in more detail. It considers the factors that help determine welfare from an individual, a family and a community's perspective, and looks at how Australia delivers and funds welfare services. It examines challenges ahead, such as those faced by the welfare workforce. It also looks at opportunities and challenges from a data and information perspective—and how organisations such as the AIHW can best fill gaps in welfare data.

This edition of *Australia's welfare* provides an overview of what we know about family, domestic and sexual violence—an area of signficant community and policy interest in Australia and across the world. The article notes the AIHW's role in this sector, and the work it is doing to bring data sources together.

The report also looks at how to better understand health and welfare data. In today's world of 'big data', governments, businesses, the community and individuals all have an important role to ensure that data are used safely, efficiently and effectively to improve outcomes for all Australians. The report discusses what it means to turn 'big data' into 'smart data', and focuses on the growing need to integrate data sets to produce person-centred data, while protecting privacy. It highlights the gaps in national data, including who needs welfare support, people who face entrenched or persistent disadvantage, and the pathways that people take through the welfare and related systems. It also highlights opportunities for data linkage across national and jurisdictional data sets.

I am pleased to note that *Australia's welfare 2017* includes two feature articles authored by academic experts: 'Persistent disadvantage in Australia: extent, complexity and some key implications' (Professor Alan Hayes and Dr Andrew Hacker) and 'The changing nature of work and worker wellbeing' (Professor Mark Wooden). We extend our thanks to these authors, and also to Associate Professor Judith Yates for her contribution to 'The changing shape of housing in Australia'.

Australia's welfare 2017 is accompanied by an *Australia's welfare 2017—in brief* mini report that summarises key statistics and concepts from the main report, and a variety of online resources.

I would like to thank the many experts who provided the AIHW with valuable advice when drafting this report, and note that their contributions are recognised in the Acknowledgments section.

The AIHW is committed to improving the usefulness and relevance of its flagship reports and welcomes feedback on *Australia's welfare 2017* via flagships@aihw.gov.au.

Barry Sandison
Director

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- Department of Education and Training
- Department of Employment
- Department of the Environment and Energy
- Department of the Prime Minister and Cabinet
- Department of Social Services
- Digital Transformation Agency
- NHMRC National Institute for Dementia Research
- Productivity Commission

Quality assurance

The report content was largely prepared by AIHW staff, and was subject to a rigorous internal review and clearance process. Additional external peer reviewers were used to validate and strengthen the content of the report.

Data sources

The best available information has been used to inform the report, drawn from a range of data sources that are referenced throughout the report. Most of the data sources are national collections managed by the AIHW and the Australian Bureau of Statistics (ABS). These are supplemented by other data collections, as appropriate.

Each of the data sources used in the report has strengths and limitations that affect how the data can be used and what can be inferred from the results. The AIHW takes great care to ensure data are correct and conclusions are robust.

Although this report is published in 2017, many of the statistics refer to 2015 or earlier. This is because some data, such as population-based surveys and the ABS Census of Population and Housing (the Census), are collected every 3–5 years or less often. Given the comprehensive nature of this report, and the time it takes to prepare a compendium report of this scale, it is also possible that some other reports may be released by the AIHW or others with more recent data. For example, due to the timeframes for preparing this report, it was not possible to integrate the 2016 Census data with data presented in *Australia's welfare 2017* (see Box A).

Box A: 2016 Census data—first release and 2016 Census-based population estimates

Data from the 2016 ABS Census of Population and Housing were released on 27 June 2017. Due to the AIHW's drafting timeframes for *Australia's welfare 2017*, it was not possible to include updated Census data within the main body of this report.

There were some notable findings from the 2016 Census that relate to several topic areas covered within the report, as highlighted below. Future iterations of *Australia's welfare* will be able to draw on these data in more detail.

Population estimates

On 27 June 2017, the ABS released preliminary Estimated Resident Population (ERP) re-based on the 2016 Census. Preliminary ERP for Australia was 24.4 million at 31 December 2016. Estimates for 2017 are not yet available but may differ from the projected number of 24.8 million at June 2017 used for this report and based on ABS population projections from the 2011 Census. New age and sex estimates for the total population, and estimates of the Indigenous population, were not available in time for the release of *Australia's welfare 2017*.

Family and household composition

According to the 2016 Census, there were 8.29 million households in Australia on Census night of which 5.9 million were family households, 2 million were lone-person households, and just under 0.4 million were group households. Of family households, 45% were couples with children, 38% were couples without children, and 16% were single parent families. The distribution of household type did not change between 2011 and 2016.

Housing tenure

The 2016 Census data showed a home ownership rate of 66%—comprising 35% with a mortgage and 31% of households that owned their home outright. Home ownership rates have been falling over time. While the overall home ownership rate has declined from 69% in 1991 to 66% in 2016, rates of outright home ownership have seen a larger drop, from 41% to 31% over the 25-year period; by comparison, rates of home ownership with a mortgage have risen from 28% in 1991 to 35% in 2016. Renters make up 31% of households compared with 27% in 1991. See Chapter 6.3 'The changing shape of housing in Australia' for more information.

The rate of home ownership for Indigenous households increased from 36% (25% with a mortgage and 11% without) in 2011 to 38% (26% with a mortgage and 12% without), in 2016.

Overcrowding

In 2016, overcrowding in households, based on those households needing one or more extra bedrooms, was 3.8%, up from 3.4% in 2011. Overcrowding was much higher for Indigenous households at 10.4% (down from 11.8% in 2011).

Additional material online

This edition of *Australia's welfare* has a comprehensive online presence, including links to related web pages and supplementary tables that present the data underlying the charts in each chapter.

Australia's welfare 2017 is available online. Individual PDFs are available for individual articles, for easy downloading and printing.

Visit *Australia's welfare 2017* online at www.aihw.gov.au/reports/australias-welfare/australias-welfare-2017.

Executive summary

Welfare in Australia

- The Australian Government and state and territory governments spent an estimated $157 billion on welfare in 2015–16 (cash payments, welfare services, and unemployment benefits), up from $117 billion in 2006–07. This is an average growth rate (in real terms) of 3.4% per annum.
- Per person expenditure on welfare rose an average of 1.7% a year over the 10-year period in real terms (from $5,663 to $6,566 per Australian resident).
- Welfare spending now accounts for a larger proportion of gross domestic product than before: 9.5% in 2015–16 compared with 8.6% in 2006–07.
- In 2015, the welfare workforce represented 4.1% of the total workforce in Australia, an estimated 478,000 workers. The number of workers has increased by 84% since 2005.

See Chapter 1 for more information.

Vulnerable groups

- About 4.4% (1 in 23) of Australians are estimated to experience deep and persistent disadvantage, as measured by social exclusion. However, this masks much higher rates among some population groups—for example, 24% of people living in public housing (more than 5 times the national average), 15% of people dependent on income support (more than 3 times), and 11% of Indigenous Australians (more than twice) live with deep and persistent disadvantage.
- Children under 15 in single-parent families were more than 3 times as likely to be in relative income poverty as those in two-parent families (41% compared with 13%) in 2013–14.
- About 46,500 children were in out-of-home care as at 30 June 2016. Indigenous children were 10 times as likely to be in out-of-home care (57 per 1,000 children) as non-Indigenous children (5.8 per 1,000) in 2015–16.
- Young people aged 10–17 under youth justice supervision during 2014–15 were 15 times as likely as the general population to be involved with the child protection system in the same year.

continued

Vulnerable groups (continued)

- One in 6 Australian women have experienced physical or sexual violence from a current or former cohabiting partner since the age of 15. This compares with 1 in 19 men.
- Indigenous people living in *Very remote* areas are 1.4 times as likely to be unemployed and 1.5 times as likely to receive a government pension or allowance as their main source of income as Indigenous people living in *Major cities*.

See Chapters 1, 2 and 7 for more information.

Education and employment

- In 2015, 4 in 5 children (78%) starting school were considered to be 'on track' developmentally, slightly higher than in 2009 (76%).
- Results for national literacy and numeracy testing in Years 3, 5, 7 and 9 have largely plateaued for students since 2008, and in the Programme for International Student Assessment test, Australia's 2015 results were significantly lower than those for 2009.
- 2.2 million people aged 15–64 were enrolled in formal study towards a non-school qualification in 2016—1.3 million (59%) were attending a higher education institution such as a university.
- There were 168,800 people commencing apprenticeships and traineeships in 2016—the lowest number since 1998.
- The proportion of Indigenous people aged 20–24 who had attained Year 12 or an equivalent level of education rose significantly from 45% in 2008 to 62% in 2014–15. Progress is on track to halve the gap in Year 12 attainment between Indigenous and non-Indigenous young people by 2020.
- Many more jobs today are part time: 31% of all jobs in 2016 involved part-time hours compared with 10% in 1966.
- The proportion of workers who were underemployed is at its highest level since the late 1970s, accounting for 9.3% of all employed people in 2016.
- The labour force participation rate has more than doubled among people aged 65 and over in the past 30 years, from 5.1% in 1986 to 13% in 2016. This reflects greater life expectancies and delayed retirement compared with previous generations.
- The proportion of lower skilled people (highest qualification Year 10 and below, including Certificate I/II) who were employed fell from 59% in 2008 to 54% in 2016. People whose highest qualification was a Bachelor degree maintained a steady rate of employment over the same period (around 84% employed in 2008 and 2016).
- One in 20 (5.1%) people aged 15–19 were not engaged in any form of education, training or employment in 2016 compared with 7.7% in 2005. By comparison, the rate for people aged 20–24 (around 12%) was similar in both 2005 and 2016.

See Chapters 3, 4 and 7 for more information.

Ageing, disability and informal care

- Australia's population profile is changing. In 2017, an estimated 3.8 million Australians (15% of the population) are aged 65 and over, compared with 2.2 million (13%) in 2007.
- About 4.3 million Australians (18%) have a disability, and about 1.4 million people (5.8%) have a severe or profound core activity limitation. While the overall number of people with disability has increased from 4 million in 2003, the proportion of the population with disability has decreased over time (from 20% in 2003 to 18% in 2015).
- Dementia is a substantial challenge to Australia. Estimates suggest that in 2017, around 365,000 Australians have dementia. This number is projected to more than double to 900,000 people by 2050.
- In 2015, Australia had 2.7 million informal carers, of whom 856,100 were primary carers. One-third of primary carers spent 40 hours or more per week in their caring role, and one-third had spent 10 or more years in this role.

See Chapters 5 and 8 for more information.

Housing and homelessness

- Between 1994–95 and 2013–14, the proportion of Australians who owned their home outright fell from 42% to 31%, and more home owners financed their purchase with a mortgage (rising from 30% to 36%). The 2016 Census confirmed these trends (see Box A).
- Over the same period, the proportion of people renting from private landlords rose from 18% to 26%. Those renters experienced a 62% ($144) rise in average weekly housing costs, after adjustment for inflation.
- A smaller proportion of people aged 25–34 own a home today than 25 years ago—39% in 2013–14, compared with 60% in 1988–89.
- In 2015–16, 38% (106,000) of all clients seeking assistance from specialist homelessness services had experienced family and domestic violence. Of these clients, 92% were women and children, including 31,000 children under 15.
- Compared with other households, Indigenous households are less than half as likely to own their own home, more than twice as likely to rent, more than 7 times as likely to live in social housing, and more than 3 times as likely to live in overcrowded dwellings.

See Chapters 6 and 7 for more information.

How are we faring?

Based on an assessment of trends in the *Australia's welfare* indicators, we are faring well on many aspects of wellbeing:

- Purchasing power has improved over the last 30 years. Australia's net disposable income per capita, adjusted for inflation, has increased by 1.9%, on average, per year.
- Weekly household income rose for all income quintile groups between 1994–95 and 2013–14.
- Education levels among people aged 15–74 have been increasing over time, from 55% holding a non-school qualification in 2009 to 59% in 2016.
- The level of school attendance for young people in youth justice detention rose between 2011–12 and 2015–16 (96% to 98% for students of compulsory school age and 93% to 99% for students of non-compulsory school age).
- The proportion of employees working 50 hours or more per week (in paid employment) dropped between 2004 and 2017—from 26% to 20% for males and 8% to 7% for females.
- We are living longer and enjoying more years without disability: years of life lived without disability rose by 3.9 years for males and 3 years for females between 2003 and 2015.
- Australia enjoys high air quality compared with many other OECD countries and our greenhouse gas emissions have been gradually falling since 2000.
- Crime victimisation rates fell between 2008–09 and 2015–16 for most types of serious crime, such as physical assault and malicious property damage.
- Our perceptions of safety have also improved. More than half of us (52%) reported feeling very safe or safe walking alone in our local area after dark in 2014, compared with 48% in 2006.
- The proportion of Indigenous households living in overcrowded conditions fell from 27% in 2004–05 to 21% in 2014–15.

However, a few aspects of our lives warrant closer attention:

- In 2013–14, 1 in 2 lower income rental households were in housing stress, that is, spending more than 30% of their gross income on housing costs. This is up from 42% in 2005–06.
- While the distribution of income in Australia has shown little change in recent years, income inequality has risen since the mid-1990s as measured by the Gini coefficient.
- Although employment rates have fluctuated over time, there has been an upward trend for youth unemployment rates and for long-term unemployment as a proportion of all unemployment between 2008–2009 and 2017.
- Volunteering rates among adults declined from 36% in 2010 to 31% in 2014.
- Men are more than twice as likely as women to report feeling safe walking alone at night (72% compared with 34% in 2014).

See Chapter 9 for more information.

Chapter 1

Welfare in Australia

1.0 Introduction

Australia is a diverse nation. Its more than 24 million people have diverse cultural, social and economic backgrounds, and live in a variety of communities. Each person has different abilities, resources, experiences and welfare needs. This chapter looks at the major concepts in understanding welfare across the Australian population.

So, what do we mean by a person's welfare? In the broadest sense, welfare refers to the wellbeing of people—being secure, happy, healthy and safe. This is why the terms 'wellbeing' and 'welfare' are often used interchangeably. *Australia's welfare 2017* is underpinned by the concept that a person's wellbeing results from the interplay of many interrelated individual, societal and environmental factors.

Welfare support provided or funded by governments is complex and wide ranging. Many may see it primarily as income support and tax concessions, but policies and programs for wellbeing extend far beyond this. For example, providing universal services for education and health—and targeted support for housing, employment, disability, ageing and aged care (among others)—is critical to the wellbeing of an individual and their family.

The Australian Government and state and territory governments, non-government organisations and individuals all contribute to welfare spending. In 2015–16, the Australian Government and state and territory governments spent more than $157 billion on welfare, up from nearly $117 billion in 2006–07. Welfare spending as a proportion of gross domestic product also increased over the period, from 8.6% to 9.5%.

This chapter profiles the welfare workforce—an estimated 478,000 people who work in early childhood education and care, residential care and a variety of other social support services, such as adoption support and disability assistance. The welfare workforce has grown by 84% (219,000 people) over the past decade. In 2015, it represented more than 4% of the 11.8 million people employed in Australia.

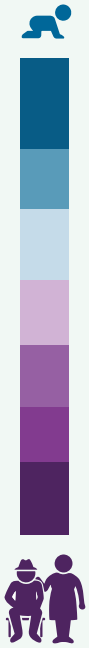
A special feature article commissioned for *Australia's welfare 2017* examines the extent and complexity of persistent disadvantage. It reports that several groups in the community face rates of deep and persistent disadvantage that are 2 to 5 times that of the national average. As the article makes clear, dealing with such disadvantage has potentially profound, positive social and economic effects.

Lastly, this chapter looks at the changing data landscape—in particular, the public data agenda, and the challenges and opportunities presented by 'big data'. It explores the ever growing expectation that organisations such as the AIHW can deliver high-quality information faster, while protecting individual privacy, and profiles the 'person-centred' data model for health and welfare services.

1.1 Who we are

Australia's welfare 2017 draws on a variety of data sources, about people, their wellbeing, and the welfare services they access. Major data sources drawn on are national collections managed by the AIHW and the Australian Bureau of Statistics (ABS).

Based on ABS projections, Australia's population in **June 2017** was around **24.8 million** people, of whom:



4.7 million are aged 0–14

3.2 million are aged 15–24

3.7 million are aged 25–34

3.3 million are aged 35–44

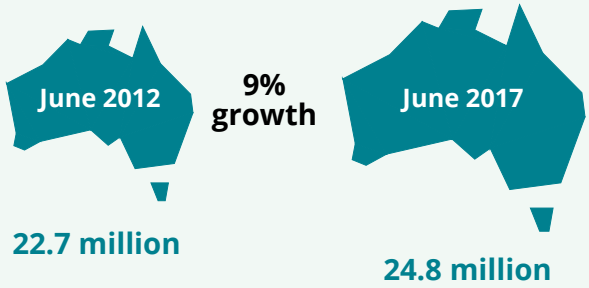
3.2 million are aged 45–54

2.9 million are aged 55–64

3.8 million are aged 65 or older

(ABS 2013).

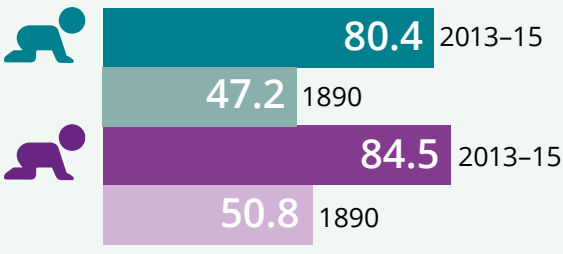
Australia's population has grown



In 2017, an estimated **3.1%** of Australians were Aboriginal and Torres Strait Islander—**761,300 people** (ABS 2014b).

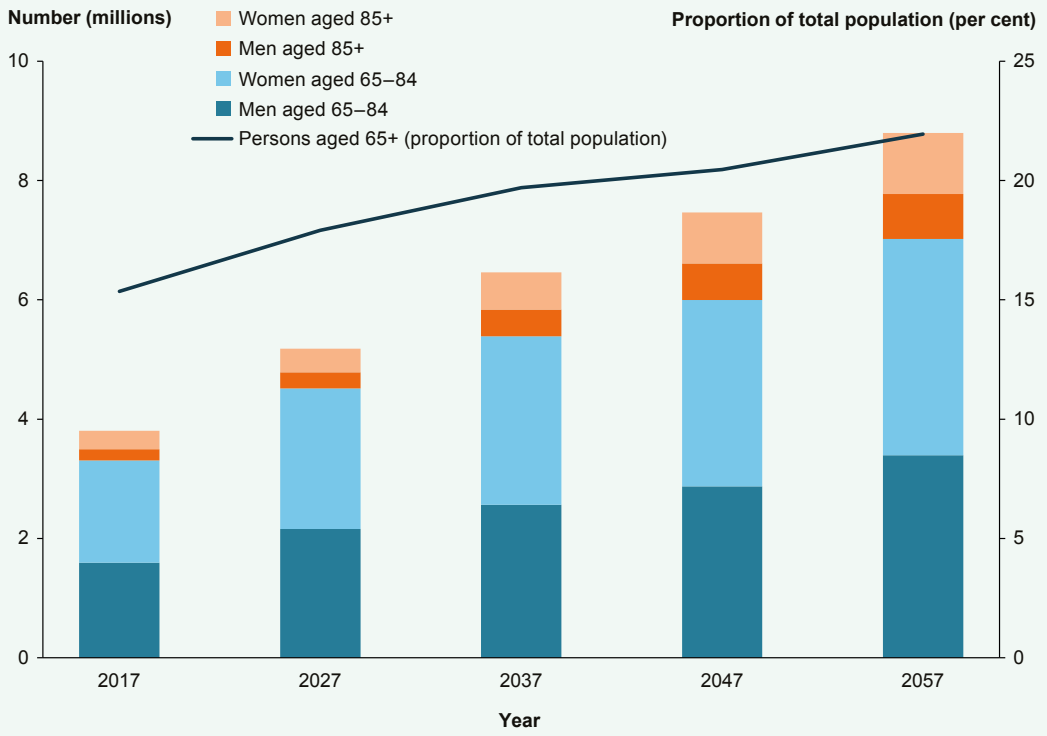
In 2016, **29%** of Australians were born overseas—**6.9 million people** (ABS 2017b).

In 2015–16, **207,325** people permanently migrated to Australia—189,770 (92%) from migration programs and 17,555 (8.5%) from humanitarian programs (Phillips & Simon-Davies 2017).



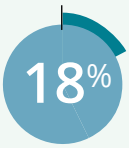
A **boy** born between 2013 and 2015 can expect to live **80.4 years** and a **girl 84.5 years** (ABS 2016c). This compares with 47.2 and 50.8 years, respectively, in 1890 (ABS 2014a).

Australia's population is ageing. Both the number of older Australians and the proportion of Australia's population aged 65 and over are growing. ABS projections for 2017 show that the 3.8 million people in Australia aged 65 and over make up 15% of our total population of 24.8 million. By 2057, the number of people aged 65 and over is projected to more than double to 8.8 million, making up 22% of the total population of 40.1 million. In 2017, there are around half a million very old (aged 85 and over) Australians, making up 2.0% of the population. This proportion is projected to increase to 4.4% by 2057 (Figure 1.1.1) (ABS 2013).



Source: AIHW analysis of ABS 2013.

Figure 1.1.1: Number and proportion of the population aged 65 and over, by age group and sex, 30 June 2017, 2027, 2037, 2047 and 2057



4.3 million Australians—around **18% of our population—had a disability** in 2015, of whom 1.4 million (5.8%) had a severe or profound core activity limitation (ABS 2016a).

In 2016, **31% (more than 1.2 million) of children aged 0–12** attended an approved child care service. Nearly 17,700 approved child care services were offered (Productivity Commission 2017).

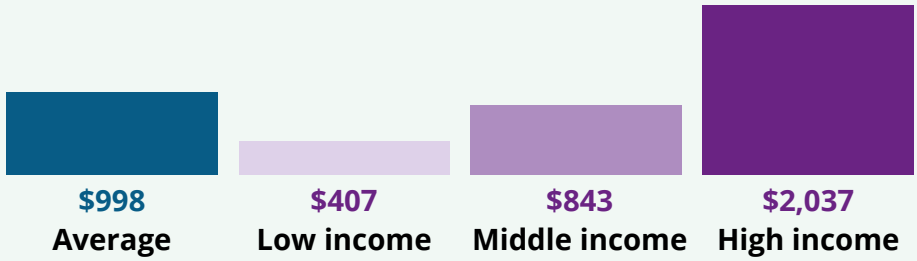
In 2016, nearly **3.8 million students were enrolled in more than 9,400 schools across Australia** with nearly two-thirds of students (65%) in government schools, 20% in Catholic schools and 14% in independent schools (ABS 2017c).

In 2015, **78%** of children starting primary school were **'on track' developmentally**; **22%** were developmentally vulnerable on one or more domains, with this proportion being the same as in 2012, and an improvement on 2009 (24%). The rate of Indigenous children found to be developmentally vulnerable on one or more domains has fallen, from 47% in 2009 to 43% in 2012 and 42% in 2015 (AEDC 2016).

In 2016, around **3.3 million** (31%) of the 10.5 million Australians aged 15–74 with a non-school qualification had a Certificate III/IV and **4.6 million** (44%) **had a Bachelor degree or higher**. The proportion of the total population aged 15–74 holding a Bachelor degree or above has **more than tripled** in the last 30 years, from 7.2% in 1986 to 26% in 2016 (ABS 2016b).

As at April 2017, **77%** of Australians aged 15–64 **were participating in the labour force** (people working and actively looking for work). Almost **1 in 3** (31%) employed people in this age group **worked part time**, compared with 10% in 1966. The unemployment rate was **5.7%**—or an average of 730,000 unemployed Australians in this age group each month (ABS 2017a).

In 2013–14, in real terms, **the average disposable household income** (after adjusting for the number of people in the household) was **$998 per week**, compared with $746 in 2003–04 (in 2013–14 dollars). Low-income households had an income of $407 per week ($323 in 2003–04), middle-income households $843 per week ($657) and high-income households $2,037 per week ($1,432) (ABS 2015).



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1.2 Where we live

Where we live affects our wellbeing. Many of the factors that shape our lives and wellbeing—such as job opportunities, community networks, air pollution and access to clean water and personal safety—are influenced by where we live (OECD 2015).

Most Australians live in capital cities. As at June 2016:

		Growth from 2006
	**71%** lived in *Major cities* **17.2 million people**	**21%**
	**18%** lived in *Inner regional* areas **4.4 million people**	**14%**
	**8.7%** lived in *Outer regional* areas **2.1 million people**	**8.5%**
	**1.3%** lived in *Remote* areas **319,000 people**	**5.2%**
	**0.8%** lived in *Very remote* areas **202,000 people**	**10%**

(ABS 2017b).

Similarly, the majority of Aboriginal and Torres Strait Islander people live in *Major cities* (35%). However, a high proportion of the Indigenous population live in *Inner regional* areas (22%), *Outer regional* areas (22%), *Remote* areas (7.7%) and *Very remote* areas (14%). By comparison, less than 2% of the non-Indigenous population live in *Remote* or *Very remote* areas of Australia (ABS 2013).

Our households and families

According to Australian Bureau of Statistics (ABS) household and family projections, in 2017, the majority (71%, or 6.7 million) of the 9.4 million Australian households are family households, 25% (2.3 million) are single-person households and 4.3% (403,000) are group households (ABS 2015c).

The number of households in Australia is projected to grow by up to 3.3 million over the next 20 years, to between 12.6 million and 12.7 million in 2036. Family households are still expected to be the most common household type over this time—nearly 70% of households in 2036 (up to 8.8 million). But the household type projected to grow most is Australians living alone, increasing by up to 45% over the next 20 years to between 3.3 million and 3.4 million by 2036. This mainly relates to the ageing of the population, as many older Australians live alone (ABS 2015c).

In 2016, the vast majority of families were couple families (84%) and, of these, 44% had dependants living with them (see Box 1.2.1; Figure 1.2.1). Of the nearly 949,000 single-parent families, 65% had dependants living with them (ABS 2017a).

In 2016, there were an estimated 52,400 same-sex couples (0.9% of all couple families), an increase from 39,400 in 2012 (ABS 2017a).

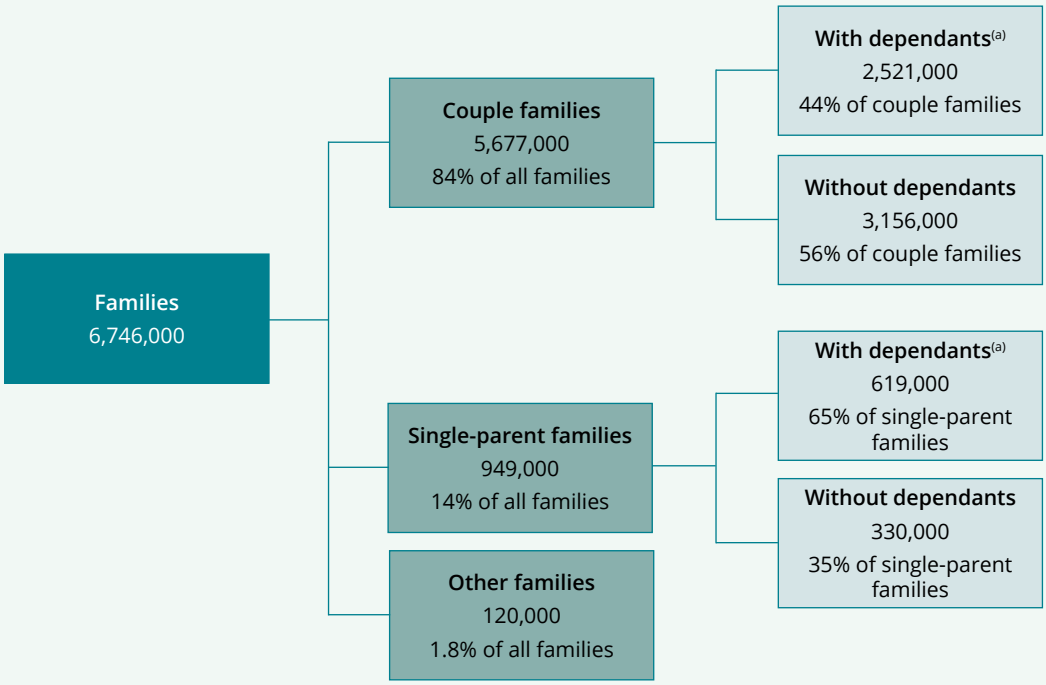
Box 1.2.1: What is a family?

The ABS defines a family as 'a group of two or more persons that are related by blood, marriage (registered or de facto), adoption, step or fostering, and who usually live together in the same household. This includes all families such as newlyweds without children, same-sex partners, couples with dependants, single mothers or fathers with children, and siblings living together. At least one person in the family has to be 15 years or over. A household may contain more than one family' (ABS 2017a).

Families are classed as having, or not having, dependants, and there are two types of dependant: children aged under 15, and students aged 15–24 who are at school or studying full time at a tertiary institution and living with their parents/guardians. Children aged over 15 who are not full-time students are not considered 'dependants' even if they still live at home.

A single-parent family can be classified as 'without dependants'—for example, a 50-year-old woman living with her 30-year-old daughter.

An 'other family' is defined as 'a family of other related individuals residing in the same household. These individuals do not form a couple or parent–child relationship with any other person in the household and are not attached to a couple or one-parent family in the household' (ABS 2015a).



(a) Includes children aged under 15 and dependent students aged 15–24.
Note: Numbers and percentages may not add to totals due to rounding.
Source: ABS 2017a.

Figure 1.2.1: Structure of Australian families, 2016

Indigenous households

According to the 2011 ABS Census, compared with other households, Indigenous households are:

- less likely to be single-person households (14% compared with 25%)
- more likely to consist of 2 or more families (6% compared with 2%)
- more likely to contain 5 or more people (23% compared with 10%).

Families in Indigenous households were more likely than families in other households to include children aged under 15 (59% compared with 38%) and more likely to be single parent families with children aged under 15 (28% compared with 8%) (see Chapter 7.1 'Community factors and Indigenous wellbeing').

Our homes

Fewer Australians own their own home today than 20 years ago. In 2013–14, 67% of Australians owned their home (with or without a mortgage) compared with 71% in 1994–95. Households today are less likely to own their home outright and are more likely to be financing the purchase of their own home with a mortgage (Table 1.2.1) (ABS 2015d).

The proportion of households renting has been increasing over the past 20 years, particularly for those renting from a private landlord (ABS 2015d) (see Chapter 6.3 'The Changing shape of housing in Australia').

Table 1.2.1: Home ownership in Australia

Tenure and landlord type	1994–95 (%)	2013–14 (%)
Own home outright	41.8	31.4
Own home with a mortgage	29.6	35.8
Renting from private landlord	18.4	25.7
Renting from a state or territory housing authority	5.5	3.6

Source: ABS 2015d.

Indigenous home ownership

Data from the National Aboriginal and Torres Strait Islander Social Survey show that, in 2014–15, almost one-third of Indigenous households owned their own home, either with a mortgage (20%), or without (10%). Nearly 7 in 10 Indigenous households were renters—30% lived in social housing, while the remainder (39%) were private renters or rented from another type of landlord.

The rate of home ownership among Indigenous households (30%) was less than half that for other households (68%) and was similar to the proportions in 2012–13 and 2008 (both 32%) (SCRGSP 2016) (see Chapter 7.1 'Community factors and Indigenous wellbeing').

Homelessness

Being homeless can severely affect a person's mental and physical health, education and employment opportunities, as well as their ability to participate fully in social and community life.

On Census night 2011, close to 105,000 Australians were classified as homeless. These people lived as follows:

- 41,400—in severely crowded dwellings (those that require 4 or more extra bedrooms to accommodate the residents)
- 21,300—in supported accommodation for the homeless
- 17,700—in boarding houses
- 17,400—temporarily with other households
- 6,800—sleeping rough
- 700—in temporary lodgings (ABS 2012).

About 279,000 Australians were supported by homelessness agencies in 2015–16—that is, 1 in 85 people in the Australian population. This compares with about 236,000 clients in 2011–12, or 1 in 94 people in the Australian population.

Currently, the single biggest client group for these services is people experiencing family and domestic violence (38% of all clients; 106,000 people). The number of family and domestic violence clients has increased by 33% since 2011–12 (see Chapter 2.7 'Family, domestic and sexual violence').

Specialist homelessness service (SHS) clients with a current mental health issue are the fastest growing client group within the SHS population, growing at an average rate of 13% per year since 2011–12. In 2015–16, 26% of all clients (72,400 people) had a current mental health issue (see Chapter 6.2 'Homelessness').

What is missing from the picture?

Overall, the availability of information on the demographic, social, economic and welfare status of Australians is good, but there are some gaps. For example, there is little information on people who experience homelessness who do not seek help from service organisations. According to the ABS 2014 General Social Survey, two-thirds of people who had experienced homelessness in the last 10 years (about 950,000 people) did not seek assistance during their most recent experience of homelessness, compared with the 476,000 people who did (ABS 2015b).

Statistics on the wellbeing of smaller subgroups of the population and changes to their living circumstances over time can be difficult and/or costly to obtain. For example, further information is needed on pathways in and out of homelessness and the longer term outcomes for service users. Further information about population cohorts using multiple, cross-sector services is also needed.

The AIHW is actively contributing to the knowledge and understanding of the clients of multiple services, such as drug and alcohol treatment services and child protection services, by undertaking data linkage projects using de-identified information about the users of these services. For more information about data linkage, see Chapter 1.7 'Understanding health and welfare data'.

Where do I go for more information?

The ABS collects information on Australia's population through its 5-yearly Census of Population and Housing (the last Census was conducted in 2016). It also has extensive data on a range of welfare-related topics, including housing and income. More information is available on the ABS Census website and the ABS website.

The AIHW's biennial Australia's health and Australia's welfare reports include detailed analyses of Australia's population in the context of these two sectors. The reports are available for free download at the AIHW website.

Extensive information on the welfare of Indigenous Australians is also available on the AIHW website.

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1.3 Understanding welfare

Welfare and wellbeing

In the broadest sense, welfare refers to the wellbeing of people—the state of 'faring well'; for example, being secure, happy, healthy and safe. Hence, the terms 'wellbeing' and 'welfare' are often used interchangeably (Econlib 1999–2012). The Organisation for Economic Co-operation and Development (OECD) (2015a) states that 'well-being is multidimensional, covering aspects of life ranging from civic engagement to housing, from household income to work-life-balance, and from skills to health status'.

A range of interdependent factors can affect wellbeing. At the individual level, these include a person's knowledge, attitudes, behaviours and responses to life events. Factors on a broader scale might include access to education, employment, secure housing, the environment, community networks and safety.

'The circumstances under which people grow, live, work and age, and the systems put in place to deal with illness' (CSDH 2008) help to determine an individual's health, and are important contributors to wellbeing. Many of these elements are shaped by social and economic forces; they are also shaped by government direction (CDSH 2008). Policies at all levels of government can substantially influence the wellbeing of individuals and, hence, the broader population.

Australia's federated governing system sees responsibility for policy, services and assistance shared between different levels of government (see Figure 1.3.3). Adding to this, these government agencies face a range of complex challenges in trying to meet the needs of the population. Challenges include changing population demographics (such as population ageing and decreasing family size), the changing nature of the Australian workforce, housing affordability issues, and government fiscal constraints.

Given this context, welfare support provided or funded by governments in Australia is complex and broad in nature. Some may see 'welfare' as primarily income support and tax concessions. But government policies and programs for wellbeing extend well beyond this. Universal services (such as education and health) and those more specifically focused on support for housing, employment, disability, ageing and aged care (among others) are, together, often critical to the wellbeing of an individual and their family. Mindful of this, governments are increasingly moving toward more comprehensive policies and programs to improve wellbeing overall. This requires coordinated efforts to address the factors that cause disadvantage and inequality (Buckmaster 2009).

Conceptual framework for *Australia's welfare*

The concepts of welfare can be organised in many different ways. Figure 1.3.1 presents the conceptual framework used for this report. It shows the complexity of welfare as a concept—and that wellbeing, in general, results from the interplay of many interrelated factors. See also Chapter 9 'Indicators of *Australia's welfare*', which presents indicators underpinning this conceptual framework.

The framework acknowledges that welfare services and assistance—a large focus of this article—are not the only policy and program areas that governments and others (including non-government and for-profit organisations) adopt to improve wellbeing. Other policy and service areas, such as health and education services, interact with and influence the need or demand for welfare services.

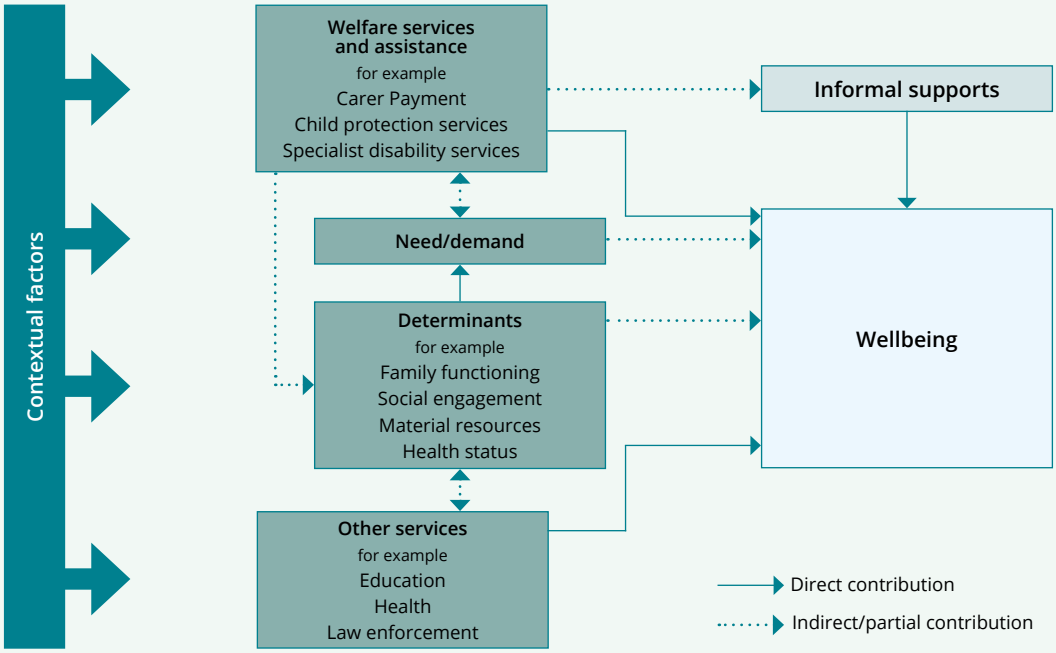


Figure 1.3.1: Conceptual framework for *Australia's welfare*

The framework recognises the overarching importance of contextual factors—such as sociodemographic trends (for example, population ageing and immigration patterns), policy settings and general economic conditions (for example, Gross National Income and labour market efficiency)—which can influence the allocation of welfare expenditure and workforce availability. Contextual factors can help to enable or inhibit people's ability to meet their everyday needs. For example, a neighbourhood with good footpaths and close access to parks, open spaces or recreational facilities can promote healthy behaviours, such as walking and physical activity (NHFA 2009), that affect wellbeing.

The need and demand for services are mediated by informal supports and the availability of welfare and other services—both at the individual and community level. For example, programs that help people with disability to maintain their housing tenancy can lead to more secure long-term housing arrangements and greater independence, and thereby lessen demand for informal and other formal support services.

Determinants play a central role in the framework (Figure 1.3.1). These are factors that can positively or negatively affect a person's wellbeing, and thus increase or decrease the likelihood that he or she will need welfare assistance. For example, a person's health status affects their ability to work, earn an income or contribute to their community. These are all factors that research shows are closely linked to wellbeing. Another example is family functioning: strong family functioning and cohesion contribute directly to wellbeing, and may also protect family members from needing welfare services because the family is a source of support (physical, emotional, financial, and so on). Loss of this support due to family breakdown may lead to a family member's requiring welfare assistance, such as shelter or income supplementation.

For many determinants, the action can be in both directions. For example, having access to social networks is associated with positive benefits like enhanced self-esteem, and access to emotional support; however, negative social interaction is also associated with outcomes such as poorer mental health and psychological wellbeing (Lincoln 2000).

Health, welfare and wellbeing

Health, welfare and wellbeing are strongly interrelated. The World Health Organization (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 1948). This definition recognises that being in 'good health' is linked with having positive wellbeing, and that, conversely, health status is closely linked with an individual's wellbeing status. More recently, the WHO defined positive mental health as being 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO 2001). This later definition recognises the fundamental role of social contribution and engagement to wellbeing (see Chapter 4.1 'The changing nature of work and worker wellbeing'; Chapter 7.1 'Community factors and Indigenous wellbeing'; Chapter 8.2 'Participation in society by people with disability', and Chapter 9 'Indicators of *Australia's welfare*').

Welfare services and assistance

Many people do not need support, or their need for support may vary as their circumstances and life stage change. If support is needed, it can come from a variety of sources—both formal (government and other organisations) and informal (family, friends and community groups)—and vary in nature and extent. This support in times of need can bolster a person's wellbeing. In fact, for people facing major challenges or suffering from long-term hardship, support in the form of welfare services and assistance is likely to be fundamental to wellbeing (see Chapter 1.6 'Persistent disadvantage in Australia: extent, complexity and some key implications' for more information).

As already noted, welfare services and assistance (income support, tax concessions and welfare services) are just one part of a larger network of services and assistance provided by governments and non-government organisations to improve the wellbeing of individuals, groups and, thus, the Australian population.

This report presents a comprehensive picture of available information on welfare services and assistance, with reference to closely related policy and program areas, such as health and education. To begin, a brief overview is provided of the key types of welfare services and assistance in Australia today.

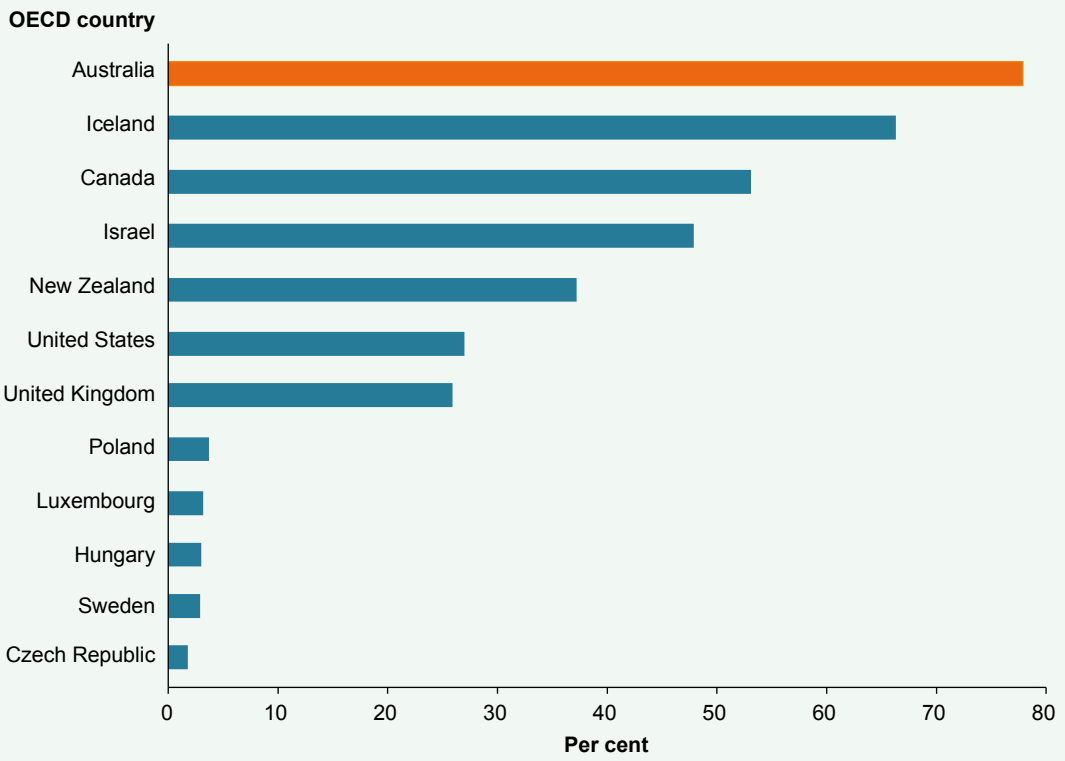
Income support and tax concessions in Australia

Australia's income support payments are financed from government revenue, with no separate social security contributions. This differs from what occurs in many other OECD countries, where employers and employees partly finance the system, and some benefits are tied to past earnings; for example, in parts of Europe, the United States and Japan, people who have earned relatively higher incomes receive more if they need to access benefits (Whiteford 2015).

The income support system redistributes income via the tax system (from people who are well-off to people who are most disadvantaged), and acts as a 'safety net' for people not able to support themselves (DSS 2017b). In Australia, income support payments are subject to means testing, a process used to determine eligibility for benefits. Means testing helps to ensure that resources are focused on supporting people with relatively lower incomes and fewer assets. It plays a more prominent role in Australia than in other countries, particularly in continental Europe. In fact, Australia is the highest means testing country in the OECD, with around 80% of spending on cash benefits (for example, age pensions and veterans' payments) determined by means testing (OECD 2014) (Figure 1.3.2).

Australia's transfer payment system also differs from those in the majority of other OECD countries. Australian Government transfer payments are financed solely from general revenue, rather than relying on contributions via a social security system financed by employers and/or employees. Australia's compulsory superannuation contributions also work to reduce the reliance on the Age Pension over time (Productivity Commission (Australia) 2015) (see also Chapter 1.4 'Welfare expenditure'). Because cash benefit payments in Australia are at a flat rate (not based on prior earnings) and generally means tested, Australia's spending on these benefits is comparatively low compared with spending in other OECD countries. (Australia was the 6th lowest spender in 2014, at 8.6% of Gross Domestic Product, or GDP (Whiteford 2015)).

As well, in 2011, around 42% of social benefits in Australia went to the lowest (or most disadvantaged) quintile of households. This compares with slightly more than 20% of benefits, on average, going to the lowest quintile of households across all OECD countries. Further, only 3.8% went to the highest 20% of households in Australia—the lowest figure of all OECD countries and well below the OECD average of 20% (CEDA 2014; OECD 2014).



Source: Adapted from OECD 2014.

Figure 1.3.2: Public spending on income and means-test benefits as a proportion of public social spending on cash benefits, by selected OECD countries, 2012 or latest year available

Major income support payments

The most commonly accessed income support payment types are the Age Pension, Newstart Allowance and Youth Allowance. The Age Pension is by far the largest income support payment, with the most recipients (2.6 million eligible senior Australians, as at December 2016) (DSS 2017a). However, 2 in 5 (42%) people who received the Age Pension in 2015–16 were on a part rate. This means, that due to means testing, they receive only part of the payment. The proportion of the population receiving a part rate has been increasing over time. This is mostly due to new retirees who reach pension age having higher levels of income and assets than retirees before them, which, in turn, can be largely attributed to the design of Australia's compulsory superannuation system (Productivity Commission (Australia) 2015; DSS 2016b).

There is also a range of supplementary payments. These comprise various additional long- or short-term payments, including those made during transitional periods to help with particular life situations or costs. The Family Tax Benefit A is the supplementary payment type with the largest recipient group (1.5 million families received assistance with the cost of raising children, as at December 2016) (DSS 2017a). Other types of supplementary payment include Paid Parental Leave and the Carer Allowance. There are also many payments accessed less often for people in time of need, such as the Crisis Payment (a one-off payment for people in severe financial hardship), the Bereavement Allowance and the Double Orphan Pension.

Tax exemptions and concessions

Various tax exemptions, deductions, offsets, concessional rates and deferral of tax liabilities are provided for welfare purposes. For example, a taxpayer may be entitled to claim a tax offset when they support a close family member receiving a disability support pension. Offsets are also available for eligible taxpayers who are seniors or pensioners, low-income earners, or beneficiaries of particular payments and allowances (ATO 2016). Governments at all levels, and some private organisations, also issue concession and health cards to eligible Australians. These provide access to discounts—mainly for medication and health services (DHS 2017).

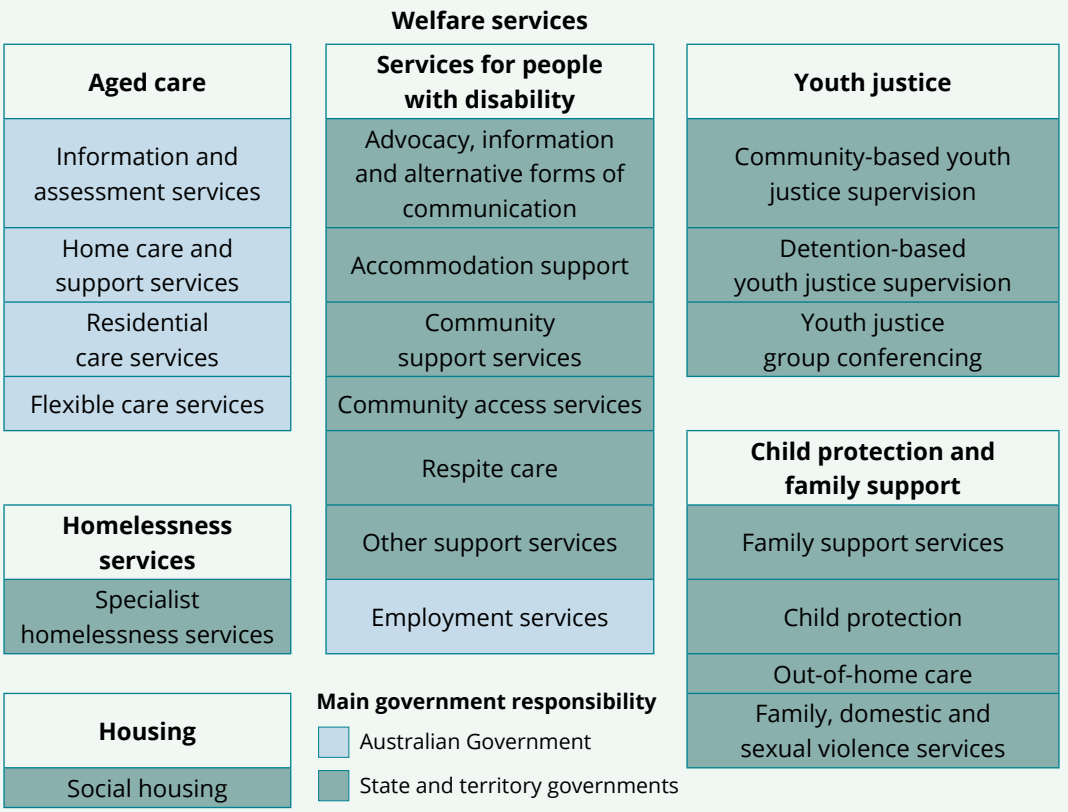
Based on modelled tax expenditures (which are underpinned by a set of assumptions, and may exclude some alternative tax arrangements), tax expenditures in 2015–16 accounted for around 30% of welfare expenditure—up from 27% in 2014–15 (AIHW welfare expenditure database). The Treasury estimated that tax expenditure or concessions by the Australian Government for welfare amounted to $47 billion in 2015–16 (for more information on tax concessions and welfare expenditure, see Chapter 1.4 'Welfare expenditure').

Welfare services

Welfare services (often referred to as 'community services') are provided to vulnerable individuals and families of widely differing ages and social and economic circumstances. As well as helping individuals and families directly, services may also indirectly help others in need. For example, they may help to develop community networks and infrastructure that help to access services.

Some services (such as those for health and education) help to enhance wellbeing for individuals throughout their life. There are also those specifically seen as 'welfare' or 'social' services. These services respond to need across people's lives, aim to encourage participation and independence, and assist in creating a cohesive society (DSS 2015).

Figure 1.3.3 presents a summary of the major welfare service types provided in Australia that are discussed in more detail in this report, together with income support and supplementary payments (described above). These service types closely align with the outcome priorities of the Department of Social Services: social security (financial support), families and children, ageing and aged care, disability and carers, and housing (DSS 2015).



Note: The services listed under 'services for people with disability' are based on current National Disability Agreement categories. The current transition to the National Disability Insurance Scheme, taking place over a 5-year period, will transform the type and nature of disability services, as well as the overall government responsibility (which moves to the Australian Government).

Source: Adapted from SCRGSP 2016.

Figure 1.3.3: Major welfare service types in *Australia's welfare*, by main government responsibility

Delivery of welfare services

The responsibility for funding and managing these services mainly lies with Australian or state and territory governments; however, arrangements for the delivery of welfare services are complex. In many cases, services are delivered by non-government organisations, or NGOs (profit and not-for-profit). These NGOs are predominantly 'approved providers'—meaning they have been formally authorised, contracted and/or funded by government to provide particular services. Further, service delivery can be shared between these NGOs or local governments and state and territory governments. The relative involvement of organisations varies from program to program, and between states and territories. Private investment in welfare services is also a relatively new and growing area (see 'Social investment approaches' later in this article).

It is also worth noting that beneath the high-level services described in Figure 1.3.3 are services that can and do cross service types and sectors. For example, respite care provides a formal break for clients and their families in the context of out-of-home care, disability support services, aged care services, and for young informal carers. Similarly, support for family, domestic and sexual violence may be delivered in specialist homelessness and other service settings, as well as being provided though family support services (see Chapter 2.7 'Family, domestic and sexual violence': Figure 2.7.4). There are also other services that foster wellbeing in, or across, other sectors.

Note that while this report discusses areas of policy and program interest outside of these specific welfare services, its focus is generally on welfare outcomes (for example, entering employment, readiness for school, or attaining school qualifications).

Current and future reforms

Reforms to the delivery of Australian welfare services in recent years have aimed to introduce a more person-centred approach in providing welfare services. The National Disability Insurance Scheme, which is being rolled out at a national level between 1 July 2016 and July 2020, is one example of how this approach has been adopted in the disability sector (see Chapter 8.1 'People with disability'; Chapter 1.7 'Understanding health and welfare data').

Another trend emerging among governments responsible for social policy—both nationally and internationally—is developing new and innovative ways to fund and deliver welfare services.

Social investment approaches

Over recent years, there has been growing interest in a 'social investment' approach to complex welfare issues. In its most general sense, social investment involves spending on programs up front to provide better long-term outcomes for a given population. This has the added benefit of achieving future savings for government, as better outcomes mean reduced future reliance on government services and/or income support. For example, a United States study estimated that the long-term benefits of an early childhood program focused on vulnerable families yielded a return on investment of over 13% per annum, while showing substantial and sustained improvements in outcomes for the families, including in health, education, employment and contact with the criminal justice system (Garcia et al. 2016). Research in the United Kingdom has also shown benefits from prenatal interventions for 'at risk' mothers, with regular visits from a family nurse before and after the birth of a child (and continuing to the child's second birthday) showing a wide range of positive outcomes for both mother and child (EIF 2017).

The major principles behind social investment have been established for some time, with their application expanded in recent years. Internationally, this includes the European Commission's establishment of a social investment package in 2013. It incorporates the development of a strong evidence base to determine what interventions work when aimed specifically at children. This social focus has now been transformed into the European Pillar of Social Rights, which sets out an ambitious agenda across three major reform areas—equal opportunities and access to the labour market, fair working conditions, and adequate and sustainable social protection (European Commission 2016, 2017).

Social impact bonds

The expansion of 'investment' to incorporate privately-funded bonds is relatively new but a rapidly growing initiative. First developed in 2010 by the United Kingdom Government, these 'social impact bonds'—also known as 'social benefit bonds'—are offered to private investors, who provide capital to fund specific projects in return for a future financial return paid on delivery of specific social outcomes.

Australian governments have begun to introduce social impact bonds, with some early successes evident.

- Australia's first social impact bond was the Newpin Social Benefit Bond—a program to reunite families and prevent entry into statutory out-of-home care. The program restored a total 130 children to their families in New South Wales between 2013 and 2016, while delivering an above-target return to investors of 12.2% in 2016 (OOSII 2017).
- In early 2017, the South Australian Government launched Aspire—Australia's first social impact bond to focus on the homeless population. It aims to improve health, employment, justice and housing outcomes for up to 600 individuals over a 4-year period (SVA 2017).
- The Victorian Government has announced its intention to develop its first social impact bond in 2017. It will work collaboratively with an NGO consortium in focusing on improved outcomes for young people leaving out-of-home care (Premier of Victoria 2017).

Welfare investment approaches

Alongside the expansion of social investment has been the introduction of Australia's Priority Investment Approach, modelled on the New Zealand welfare investment model. While 'social investment' and 'welfare investment' are increasingly being used interchangeably, in an Australian and New Zealand context, the latter is more narrowly focused.

Welfare investment refers to specific programs that use detailed actuarial modelling to provide a baseline estimate of individual lifetime welfare costs to guide the targeting of packages of services at the group or individual level. They are set up to project and track actual government savings over the long term, providing information that feeds back into better targeting and more effective services. They also allow innovative approaches to reduce long-term welfare dependency to be tested (OECD 2015b, 2017) (see also Box 1.3.1).

The adoption of welfare investment principles is proving to be applicable at state level. The Victorian Government has drawn on the principles from the New Zealand and Australia-wide models to establish the Victorian Social Investment Integrated Data Resource. This Data Resource—a large, integrated state-wide data set—is intended to be used to identify priority groups for early intervention, create a model of expected future costs, and apply this to develop packages of services that better support people in these groups.

Box 1.3.1: Investment approaches to welfare

A welfare investment model aims to reduce the reliance of a population on government welfare payments. This is done by estimating—via statistical modelling—how many people will be likely to rely on these payments into the future (and for how long), and then developing interventions (investments) to reduce this contact as much as possible.

New Zealand model

New Zealand's welfare investment model introduced a world-first approach by estimating lifetime costs of the working-age population who are, or are likely to be, reliant on social security payments (Taylor Fry 2016). In late 2011, the New Zealand Government announced a welfare package coupled with a baseline valuation report (Taylor Fry 2011), with an overall target of reducing future government liabilities by $NZ 13 billion by 30 June 2018 (SSC 2016).

Australia's Priority Investment Approach

The development of an Australian welfare investment model was a major recommendation of the McClure report into Australia's welfare system (Reference Group on Welfare Reform 2015). It cited the New Zealand model as having substantial potential in an Australian context. In 2015–16, the Australian Government announced funding to implement the Australian Priority Investment Approach. This included an initial actuarial valuation of the Australian Government's social security system. The total future lifetime cost of providing social support for the whole model population was estimated to be $4.8 trillion as at 30 June 2015 (DSS 2016c).

In 2016–17, a further $96.1 million was committed to creating a 'Try, Test and Learn Fund' to finance the development and implementation of innovative targeted early intervention programs. The first tranche (round) of the 'Try, Test and Learn Fund' is focused on three priority groups:

- young carers aged under 25 who started receiving the Parenting Payment at age 18 or under and who are still receiving an income support payment
- young parents aged under 25 who are receiving a Carer Payment or are at immediate risk of going onto the payment
- young students aged under 25 who have moved, or are at risk of moving, from study to an extended period on an unemployment payment.

Trials of new policy responses, which will be developed from a shortlist of ideas, are scheduled to be rolled out in the second half of 2017 (DSS 2016a). The Australian approach differs from the New Zealand model in that it has not set specific targets for cost or recipient reduction. Rather, its overall goals are to: improve lifetime wellbeing through targeted interventions to increase the capacity of people to live independently of welfare (especially through employment), manage the risk of intergenerational welfare dependency, and reduce long-term social security costs. The Australian model also projects future welfare use for the entire Australian resident population, including both current recipients and people not currently in the system.

Some concerns have been raised about the potential of the investment approach to produce unexpected or perverse outcomes. It has been noted that reducing eligibility for some types of benefits could result in the emergence of other social issues (for example, an increase in homelessness) (Productivity Commission (New Zealand) 2015; Taylor Fry 2011). In an Australian context, the Australian Council of Social Service has also noted concerns that the initial focus on young people does not consider the immediate needs of other sections of the population; for example, older jobseekers (ACOSS 2014).

What is missing from the picture?

Many welfare-related data sources are restricted by their focus on a single, specific area, often related to the receipt of a single service at a defined point in time. This limits the ability to analyse and report meaningful information about an individual's wellbeing.

Linking data from multiple sources (data linkage) can provide more information about an individual or institution than one data source alone. In certain cases, this can provide a time sequence, helping to show a 'pathway' (for example, the sequential contact an individual makes with services across systems) and provide insights into cause and effect. The AIHW has undertaken several data linkage projects—for example, linking data from youth justice, child protection and specialist homelessness services to better understand the characteristics of vulnerable young people across all three sectors (see 'Where do I go for more information?'). Further linkage may provide more meaningful data on health and welfare service requirements and outcomes at an individual level (see Chapter 1.7 'Understanding health and welfare data' for further discussion on current data gaps).

Where do I go for more information?

Up-to-date information on payments and allowances for all income support programs, including eligibility criteria, can be sourced from the Department of Social Services and Department of Human Services websites. A guide to Australian Government payments is available on the Department of Human Services website.

Access the DSS website for information on government support for families and children, seniors, communities and vulnerable people, homeless people, people with disability and carers.

AIHW reports on welfare service usage and clients can be found at www.aihw.gov.au. Topics of interest may include:

- Aged care: www.aihw.gov.au/aged-care/
- Child protection: www.aihw.gov.au/child-protection/
- Disability: https://www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/disability/overview
- Homelessness: https://www.aihw.gov.au/reports-statistics/health-welfare-services/homelessness-services/overview
- Housing assistance: https://www.aihw.gov.au/reports-statistics/health-welfare-services/housing-assistance/overview
- Youth justice: https://www.aihw.gov.au/reports-statistics/health-welfare-services/youth-justice/overview

The linkage report: *Vulnerable young people: interactions across homelessness, youth justice and child protection 1 July 2011 to 30 June 2015* is available for free download.

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1.4 Welfare expenditure

The Australian and state and territory governments contribute to welfare spending, as do non-government organisations and individuals. The Australian Government primarily contributes through cash payments relating to its areas of responsibility, as defined in the Australian Constitution (which include family allowances, unemployment benefits and pensions), although it also contributes some expenditure on welfare services. The states and territories focus more on providing welfare services. Government expenditure on cash payments and welfare services is reported in this article as welfare expenditure.

Both the Australian Government and state and territory governments often choose to provide welfare services by funding organisations in the non-government sector to deliver them. The non-government sector also contributes some welfare services expenditure from its own sources, including fees charged to individuals. However, there are limited data available on expenditure by the not-for-profit non-government sector (see Box 1.4.4) and the for-profit non-government sector, such as aged care providers. Expenditure on welfare services by the non-government sector from its own sources (including expenditure by individuals) is therefore not included as welfare expenditure in this article.

At the time of writing, the most recent welfare expenditure data available for state and territory governments and for Indigenous Australians was for 2012–13, as published in the *2014 Indigenous expenditure report* (SCRGSP 2014), and in *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015* (AIHW 2015). State and territory data were estimated for 2011–12 and for 2013–14 to 2015–16 using available trend data. Based on the estimated data, in 2015–16, state and territory governments spent $17.8 billion on welfare, all on services with no expenditure on cash benefits (42.1% of government expenditure on welfare services and 11.3% of government expenditure on welfare overall). This outlay is similar to the proportions in 2012–13, when data sourced from the *2014 Indigenous expenditure report* indicated proportions of 44.4% and 11.7%, respectively. (See also Chapter 7.5 'Income and employment for Indigenous Australians' for more details on the number of Indigenous Australians who receive income support payments and other benefits from the Australian Government.)

Where possible, the welfare expenditure estimates have been developed to be consistent with the AIHW's Welfare Expenditure Series of publications, in which welfare expenditure was last reported in full for the 2005–06 financial year (AIHW 2007). This has been done to maintain a consistent time series with data from 2005–06 and before. As a result, however, these estimates of welfare expenditure may not match the coverage of 'welfare' in other sections in this report or in other AIHW publications.

Cash payments covered are those provided by the Australian Government to assist older people, people with disability, people who provide care for others, families with children, war veterans and their families, and people who are unemployed (see Box 1.4.2).

Welfare services covered include supported accommodation, family support, early intervention programs, outreach services, counselling, youth programs, child care services, home and community care services for older people, and specialist services for people with disability (see Box 1.4.3).

This article covers the amounts spent on financial assistance and welfare services; however, it does not assess the adequacy or effectiveness of this expenditure.

Expenditure is reported in constant prices (that is, adjusted for inflation) except where noted (see Box 1.4.1).

Box 1.4.1: Current and constant prices

'Current price' refers to expenditure reported for a particular year, unadjusted for inflation.

'Constant price' estimates in this article indicate what the equivalent expenditure would have been had 2015–16 prices applied in all years; that is, it removes the inflation effect. The phrase 'real terms' is often used where constant prices are referred to. Constant price estimates for expenditure have been derived using deflators produced by the Australian Bureau of Statistics (ABS). The Consumer Price Index was used for cash payments and the government final consumption expenditure implicit price deflator was used for welfare services.

Trends in welfare expenditure

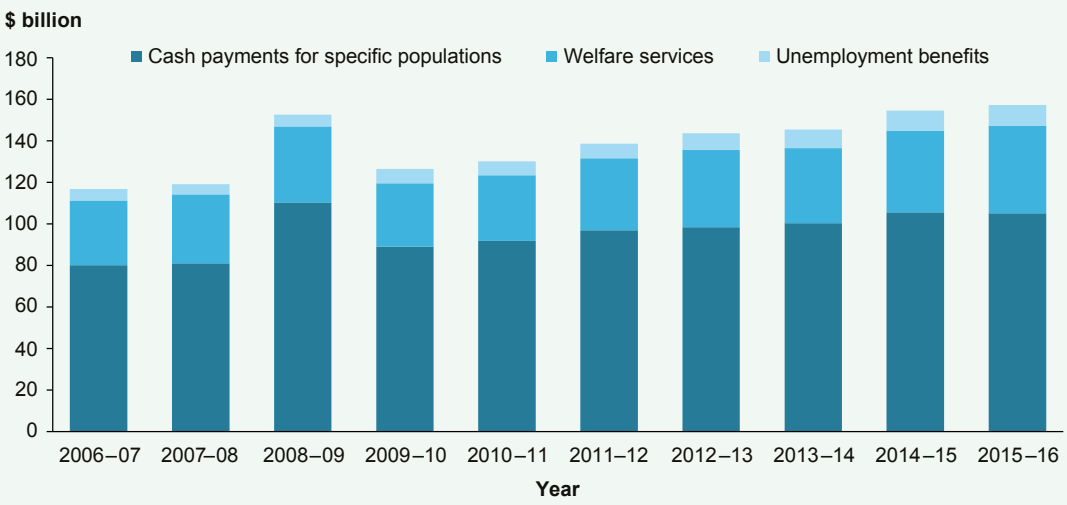
In 2015–16, expenditure by Australian and state and territory governments on welfare was $157.2 billion, up from $116.8 billion in 2006–07 (constant prices—see Box 1.4.1 for information). It included 66.8% ($105.1 billion) in cash payments for specific populations (not including unemployment benefits), 26.9% ($42.2 billion) in welfare services and 6.3% ($9.9 billion) in unemployment benefits (Figure 1.4.1).

Welfare expenditure increased between 2006–07 and 2015–16, with an average annual growth rate of 3.4% in real terms. There was a notable increase in 2008–09, when the Australian Government implemented several initiatives as part of a response to the Global Financial Crisis (GFC). These initiatives increased expenditure substantially in that year.

Expenditure grew faster than the population, which grew at an average of 1.7% a year over the 10-year period. This resulted in per person expenditure rising an average of 1.7% a year over the 10-year period in real terms (from $5,663 to $6,566 per Australian resident) (Supplementary Table S1.4.4).

Welfare expenditure grew more quickly than the overall economy over the same period. Gross Domestic Product (GDP) grew by 2.7% in constant prices each year between 2006–07 and 2015–16, compared with 3.4% annual growth in welfare spending. As a result, welfare expenditure grew from 8.6% of GDP in 2006–07 to 9.5% in 2015–16 (Figure 1.4.2).

As a proportion of taxation revenue, government spending on welfare was 29.3% in 2006–07. It then rose in response to the GFC, contributed to by both increases in welfare spending and slow taxation revenue growth. The spending-to-revenue ratio remained higher in the following years, ending the period at 35.1% of revenue in 2015–16.

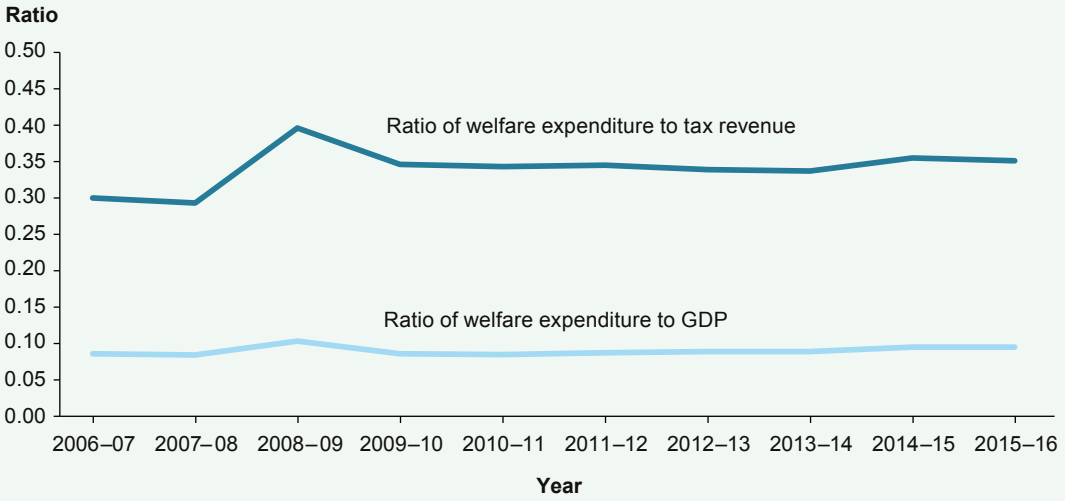


Notes

1. Estimates for states and territories have been modelled for 2011–12 and for 2013–14 to 2015–16.
2. 'Cash payments for specific populations' includes associated Commonwealth Rent Assistance, as well as one-off payments made as part of the Economic Security Strategy in 2008–09.
3. Only expenditure on Newstart Allowance and associated Commonwealth Rent Assistance is included in 'unemployment benefits'.
4. Constant price estimates are expressed in terms of 2015–16 prices (see Box 1.4.1).

Source: AIHW welfare expenditure database.

Figure 1.4.1: Government welfare expenditure, by type of expenditure, constant prices, 2006–07 to 2015–16



Note: Estimates for states and territories have been modelled for 2011–12 and for 2013-14 to 2015-16.

Source: AIHW welfare expenditure database.

Figure 1.4.2: Ratio of government welfare expenditure to tax revenue and GDP, 2006–07 to 2015–16

Cash payments

In 2015–16, the total amount spent by governments on cash payments, excluding unemployment benefits, was estimated at $105.1 billion, down slightly from $105.5 billion the previous year but up from $80.0 billion in 2006–07 (Figure 1.4.3). The contribution of cash payments to total welfare spending was 66.8% in 2015–16, which was relatively unchanged from 2006–07 when it was 68.6%.

Of the estimated $115.0 billion spent on cash payments (including unemployment benefits) in 2015–16, $46.4 billion was for older people, $30.9 billion was for families and children, $26.0 billion for people with disability, $9.9 billion was spent on unemployment benefits, and the rest was on 'other' cash payments (Figure 1.4.3).

Between 2006–07 and 2015–16, spending grew at an average rate per year by 5.7% for people with disability, by 3.5% for older people and by 1.2% for families and children. Spending on 'other' cash payments fell by 3.6% on average per year (Table S1.4.3).

Box 1.4.2: Which cash payments are included?

The estimates of cash payments in this article include expenditure by the Australian Government, such as for the Age Pension, Disability Support Pension, Veterans' Affairs pensions and Carer Allowance.

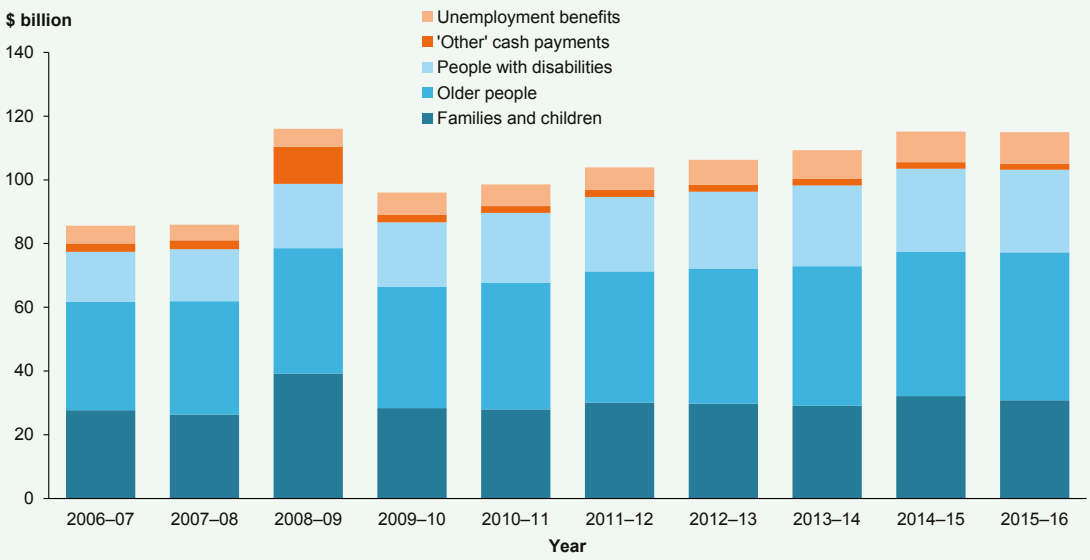
To maintain comparability over time, the Child Care Benefit and Child Care Rebate are included in the estimates of welfare services expenditure (rather than cash payments) since, historically, these payments were paid to the service providers rather than directly to households.

Also, to maintain comparability over time, Youth Allowance, Austudy and ABSTUDY are not included in the estimates in this article (although information on these allowances is included in Chapter 4.2 'Key employment trends').

Youth Allowance (Student) is available to eligible young people aged 16 to 24. It provides financial support for students to participate in full-time education, training or apprenticeships. In 2015–16, $2.4 billion was spent on Youth Allowance for students.

Youth Allowance (Other) is available to eligible young people aged 16 to 21 who are looking for work or undertaking other activities to improve their employment prospects. In 2015–16, $1.0 billion was spent on Youth Allowance (Other) (DSS 2017c).

Austudy provides financial assistance to full-time students and apprentices aged 25 and over ($0.6 billion in 2015–16) and ABSTUDY provides support to Indigenous people who are studying or undertaking a full-time apprenticeship ($0.3 billion in 2015–16) (DSS 2017a).



Notes

1. Estimates for states and territories have been modelled for 2011–12 and for 2013–14 to 2015–16.
2. Constant price estimates are expressed in terms of 2015–16 prices (see Box 1.4.1).
3. Data include associated Commonwealth Rent Assistance.

Source: AIHW welfare expenditure database.

Figure 1.4.3: Government cash payments expenditure, by major area of expenditure, constant prices, 2006–07 to 2015–16

Unemployment benefits

Between 2006-07 and 2015-16, the total amount spent on unemployment benefits (Newstart Allowance) grew from $5.6 billion to $9.9 billion in real terms. There are two main contributing factors. Firstly, there was an increase in the number of unemployed persons; the average annual unemployment rate increased from 4.8% in 2006 to 5.8% in 2016 (See Chapter 4.2 'Key employment trends': Figure 4.2.1). Secondly, there was a large number of Parenting Payment recipients who transferred to Newstart Allowance between 2011–12 and 2013–14 (DSS 2017b) (Table S1.4.4). While it is difficult to directly track this shift in expenditure between categories, there were similar, (though not quite as large) decreases in cash payments to 'Families and children' and 'Other' cash payments in the corresponding period.

In real terms, spending per person on unemployment benefits increased from $270 per Australian resident in 2006–07 to $414 per Australian resident in 2015–16.

Welfare services

In 2015–16, the total amount spent by governments on welfare services was estimated at $42.2 billion, up from $31.2 billion in 2006–07 and $39.4 billion in the previous year (Table S1.4.1). Most spending on welfare services is recurrent, and comprises payments for wages, salaries, operating expenses and running costs. The remainder is capital expenditure. Over the decade to 2008–09, government capital expenditure on welfare services was less than 2% of total welfare services expenditure (AIHW 2011). An estimate of capital expenditure for more recent years is not available.

Due to a lack of state and territory spending data for recent years, it is difficult to be certain what proportion of spending on welfare services was by the states and territories as opposed to the Australian Government. Based on the modelled data, in 2015–16, it is estimated that the state and territory governments were responsible for 42.1% of government expenditure on welfare services.

Box 1.4.3: What does expenditure on welfare services cover?

Welfare services encompass a range of services and programs to support and assist people and the community, such as family support services, youth programs, child care services, services for older people, and services for people with disability.

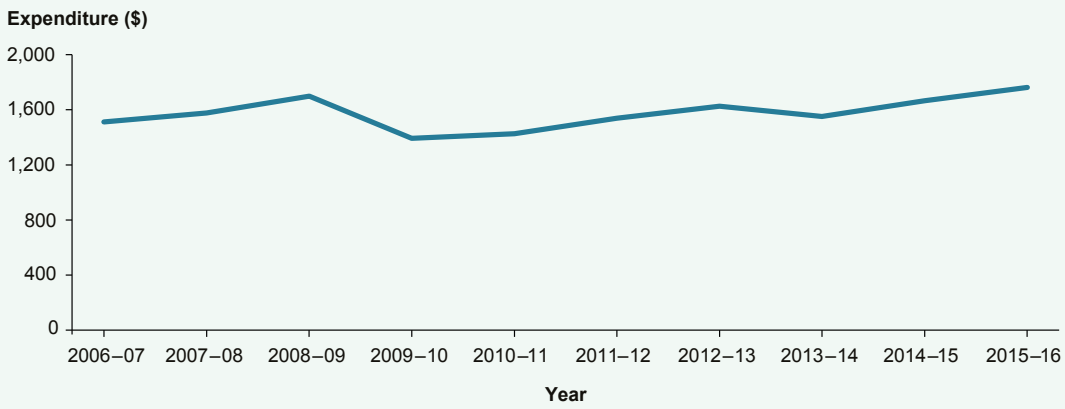
Welfare services expenditure presented in this article is reported for the target groups specified in the ABS Government Purpose Classification for welfare service financial transactions:

- family and child welfare services; for example, youth support services
- welfare services for the aged; for example, home and community care services
- welfare services for people with disability; for example, personal assistance
- welfare services not elsewhere classified (ABS 2005).

The welfare services estimates include government expenditure only (see Box 1.4.4 for information about non-government expenditure).

Welfare spending defined according to these four target groups does not necessarily include all government spending on services that may have a welfare benefit. For example, some programs relevant to people with disability—and that might be considered welfare services—are in the Government Purpose Classification categories of education, health or housing. Some types of welfare services that are covered elsewhere in this report (such as employment services) are also not included.

The average amount spent by governments on welfare services per Australian resident in 2015–16 was $1,763, up from $1,512 in 2006–07 and $1,667 in 2014–15 (Figure 1.4.4). The per person cost represents total spending on welfare services per person in the population. It does not reflect spending for each eligible person or spending per recipient.



Notes

1. Estimates for states and territories have been modelled for 2011–12 and for 2013–14 to 2015–16.
2. Constant price estimates are expressed in terms of 2015–16 prices (see Box 1.4.1).

Source: AIHW welfare expenditure database.

Figure 1.4.4: Government welfare services expenditure per Australian resident, constant prices, 2006–07 to 2015–16

Box 1.4.4: Non-government community service organisations

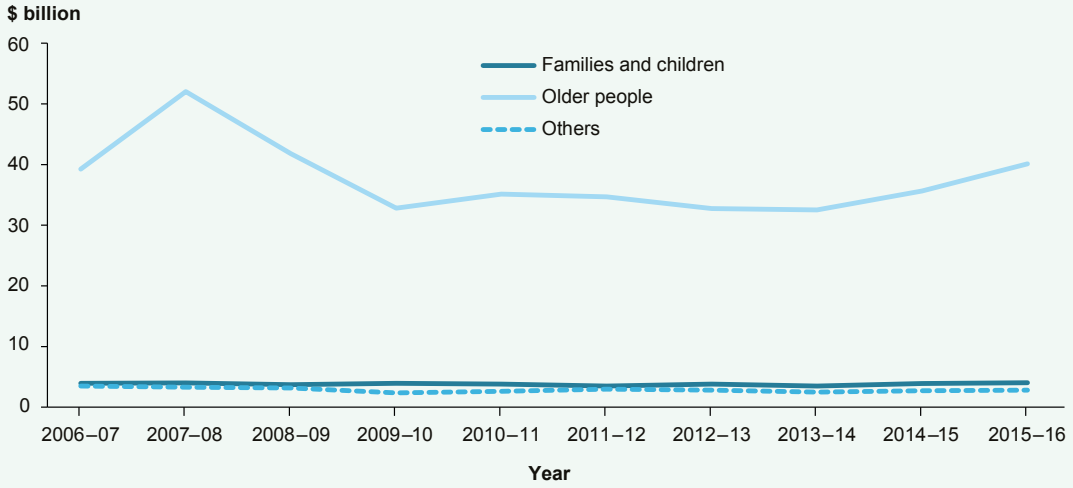
Non-government organisations, particularly non-government community service organisations (NGCSOs), play an important part in delivering welfare services. As indicated earlier, governments fund a large part of the services delivered by NGCSOs. This expenditure is included in the analysis of welfare services expenditure in this article. NGCSO expenditure that comes through fees paid by clients or NGCSOs' own sources, such as fund-raising, is not included. This is because comprehensive information on those sources of funds is not readily available in a way that is consistent and comparable with other information in this article. The most recent year for which comprehensive data for NGCSOs are available was 2008–09 (AIHW 2011), though some data on not-for-profit NGCSOs is available for 2012–13 (ABS 2015).

Tax concessions

Various tax exemptions, deductions, offsets, concessional rates and deferral of tax liabilities are provided for welfare purposes. The Australian Government Treasury estimated that tax expenditure or concessions by the Australian Government for welfare amounted to $47 billion in 2015–16. This does not include any tax expenditures by state, territory or local governments. This amount is not included in the estimates of total welfare spending in this article as it is generally in the form of foregone potential revenue rather than expenditure (Treasury 2017).

Most of the tax concessions total ($35 billion, or 75%) was for concessions for superannuation, which aim to assist people to save for or fund their retirement. Of the remainder, $4.0 billion (9%) was for concessions for families and children (Table S1.4.6). Tax concessions for families and children include exemption from taxation for disaster relief and child care assistance payments.

Australian Government tax concessions for welfare peaked in 2007–08 (Figure 1.4.5). The decline in concessions in 2008–09 and 2009–10 reflects the effects of the GFC, in particular, slower growth in the profits of superannuation funds (Treasury 2012).



Notes

1. 'Others' refers to welfare-related concessions expenditure not specifically aimed at families and children, or older people.
2. Constant price estimates are expressed in terms of 2015–16 prices (see Box 1.4.1).

Sources: Australian Treasury, 2010 to 2017.

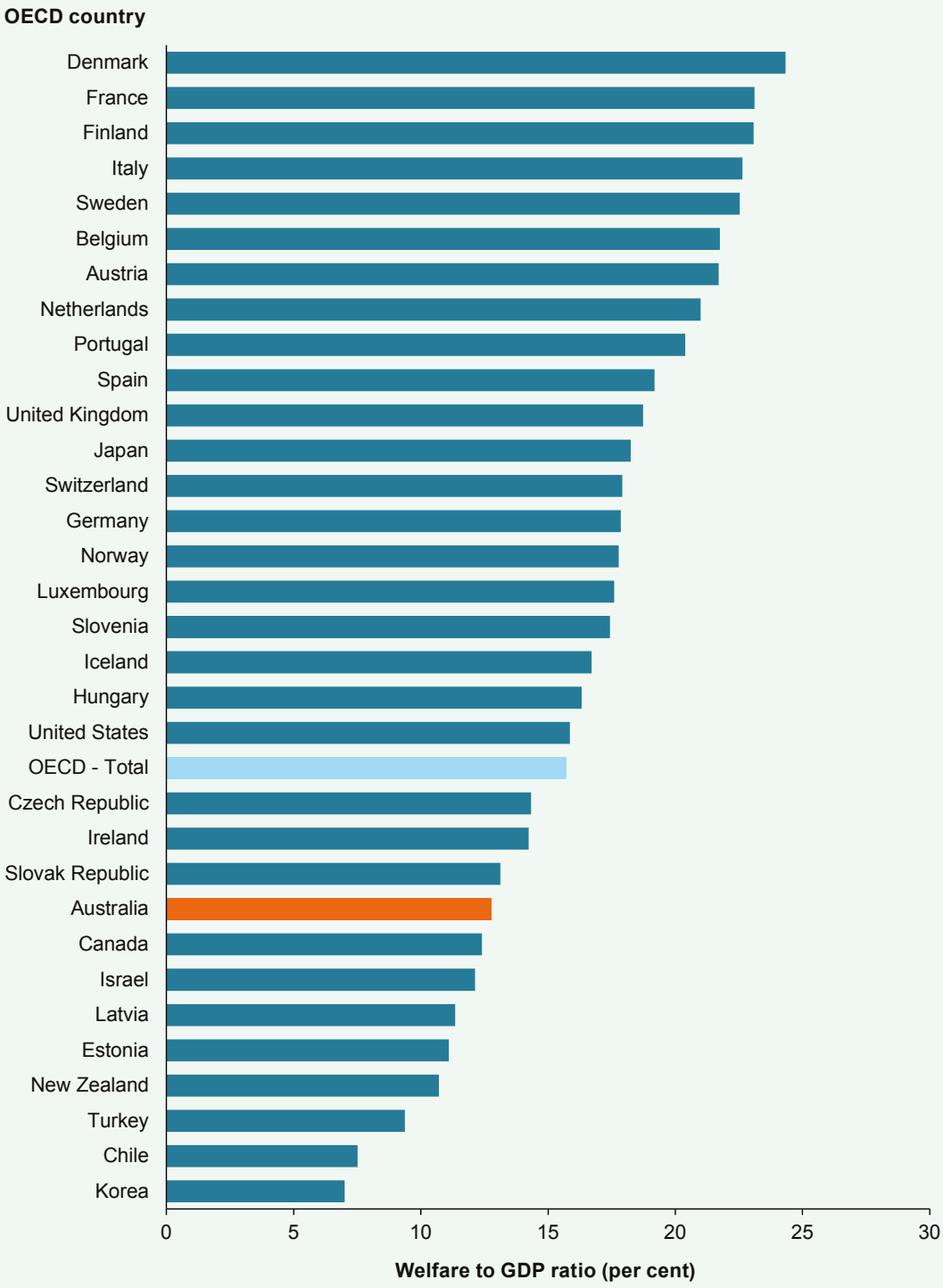
Figure 1.4.5: Tax concessions by the Australian Government for welfare, by type of concession, 2006–07 to 2015–16

International comparisons

There are many difficulties in comparing the welfare spending of different countries. Social support structures in many countries are complex, and not necessarily comparable. Systems generally involve mixtures of:

- government and non-government funding arrangements—including programs funded directly by governments, tax-based systems, employer-focused schemes and fee for service systems
- redistribution models—social support structures in some countries focus on redistribution between sections of the society at particular, but often differing, times. For example, in Australia, unemployment benefits transfer resources via the tax system from the employed to the unemployed. Other schemes act to redistribute resources over the life course (such as through savings and superannuation-based schemes)
- targeted versus non-targeted support arrangements—many countries use means testing to target support, but do it in different ways with different thresholds.

Organisation for Economic Co-operation and Development (OECD) data for 2013 show that welfare expenditure in Australia was 12.8% of GDP (using the OECD methods for calculating expenditure that differ from the methods used for estimates elsewhere in this article). This was lower than the OECD median of 17.1% (Figure 1.4.6) and puts Australia's welfare expenditure in the lowest third of all OECD countries (OECD 2017).



Note: Excludes health, active labour market programs and housing from OECD Social expenditure database. Data for Greece, Mexico and Poland are not yet available.

Source: OECD Social Expenditure database 2017.

Figure 1.4.6: Welfare expenditure as a proportion of GDP, OECD countries, 2013

The Australian social security system differs from those in most countries of Europe and in the United States in several ways, including:

- the benefits are generally more targeted through means testing than being based on factors such as past earnings (see Chapter 1.3 'Understanding welfare')
- the system is largely funded by general government revenue rather than by contributions by employers or insured employees
- benefits are not time limited.

Australia has a different demographic and employment structure than many other OECD countries. For example, the proportion of the population who are aged differs; so do unemployment rates. This drives differences in aged and unemployment pension structures. Whiteford (2014) argues that these differences contribute to making the Australian system relatively efficient in terms of the distribution of benefits to the most needy, suggesting that the below-average spending understates the impact of the spending in terms of its more targeted nature.

What is missing from the picture?

Estimates of non-government expenditure sourced through fees or fund-raising are an important information gap, as are estimates of expenditure on capital. For example, the currently available data do not allow analysis of how expenditure on welfare services by individuals has changed over time. It is unclear whether individuals are now paying a greater proportion of the cost of welfare services or less. It is also unclear how much is being spent on capital—infrastructure and equipment to support welfare provision—and who is paying.

Some important disaggregations (such as between Australian and state/territory government expenditure) have not been included in this article due to a lack of up-to-date data.

Where do I go for more information?

More information can be found in *Welfare expenditure Australia 2005–06* and in the AIHW report: *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015*.

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1.5 Welfare workforce

An estimated 478,000 people were employed in the welfare workforce (see Box 1.5.1) in 2015. This workforce has grown by 84% since 2005 (259,000 employed people in 2005). About 2,000 people per 100,000 population were employed in the welfare workforce in 2015 (an increase of 56% since 2005); of the people employed, about 5 in 6 were female. Overall, the welfare workforce represented 4.1% of the total 11.8 million people employed in Australia in 2015.

Box 1.5.1: Defining the welfare workforce

There is no single definition of the welfare workforce. In this article, it is defined as people who are employed both in a community service industry and a community service occupation, such as an early childhood education and care worker in the preschool education industry.

Community service industries were identified using the Australian and New Zealand Standard Industrial Classification (ABS 2006); community service occupations were identified using the Australian and New Zealand Standard Classification of Occupations (ABS 2013).

The definition excludes some people in a community service occupation who are not employed in a community service industry, such as nurses employed in the health sector (hospitals) or counsellors in the school education sector. Likewise, it excludes some people employed in a community services industry who are not in a community services occupation; for example, accountants, administration staff and tradespeople.

In this article, community service industries have been grouped into three categories:

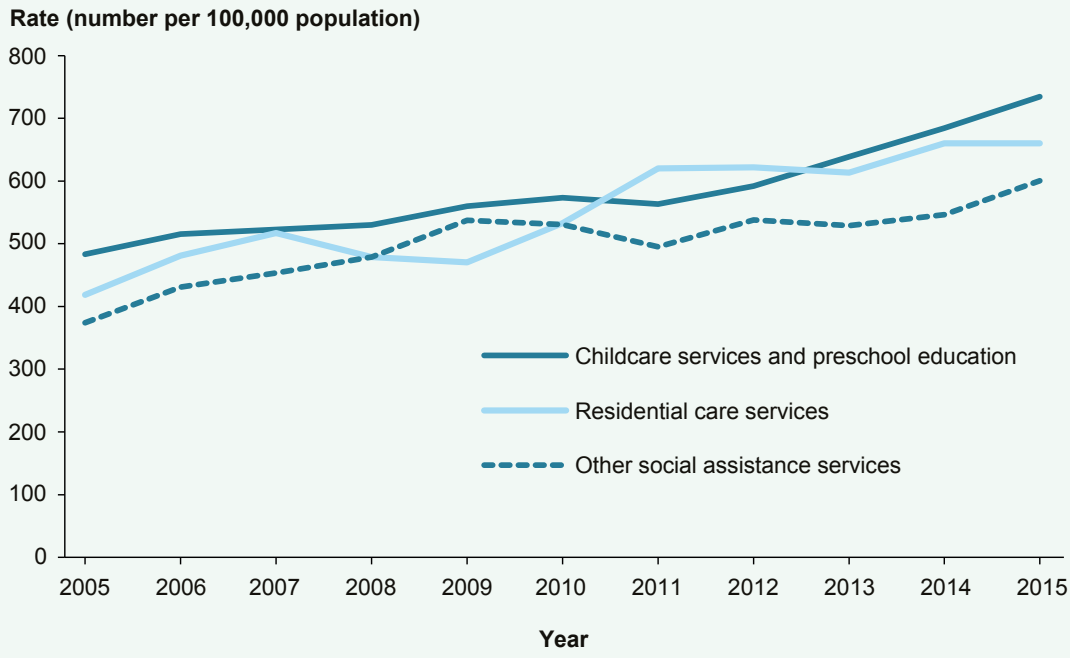
- child care services and preschool education, which includes child care services, operation of nurseries, child-minding services and accredited pre-primary school education
- residential care services, which includes aged care residential services and other forms of residential care services
- other social assistance services, which includes a variety of social support services such as adoption services, adult day care centres, and disability assistance services.

The data source used for information on this workforce is the ABS Labour Force Survey (ABS 2016). This Survey collects information on the number of people employed in occupations and industries and not full-time equivalent staff rates. For this article, 'employed people' refers to a head count of workers.

Community service industries

The industry with the largest welfare workforce in both 2005 and 2015 was the *Child care services and preschool education* industry; however, it varied somewhat throughout the period as the workforce numbers fluctuated (Figure 1.5.1).

The welfare workforce per person rates of all three community service industries (see Box 1.5.1) grew between 50% and 60% over 2005–2015: 52% for the *Child care services and preschool education* industry (from 484 to 734 employed people per 100,000 population), 58% for the *Residential care services* (from 419 to 660) and 60% for the *Other social assistance services* industry (from 374 to 600).



Source: AIHW analysis of ABS Labour Force Surveys 2005 to 2015.

Figure 1.5.1: Number of employed people in the welfare workforce per 100,000 population, by type of community service industry, 2005 to 2015

Community service occupations

Early childhood education and care workers was the largest community services occupation group in the welfare workforce in 2015, at 711 employed people per 100,000 population (Table 1.5.1). *Early childhood education and care workers* were almost exclusively employed in the *Child care services and preschool education* industry in 2015.

The *Aged and disabled carers* occupation group was the second largest group, growing from 196 to 515 employed people per 100,000 population between 2005 and 2015. This group is expected to grow substantially with the rollout of the NDIS, with the Productivity Commission estimating that 1 in 5 new jobs created in Australia over the next few years will need to be in the disability care sector (Productivity Commission 2017).

The number of *Nursing support and personal care workers* also grew, from 132 to 239 employed people per 100,000 population between 2005 and 2015. Of the remaining occupations, Table 1.5.1 shows that half of them experienced growth over the period, while the other half were in decline.

Some occupations were distributed across multiple industries. *Aged and disabled carers*, for example, were distributed mostly between *Residential care services* and *Other social assistance services*. Around 70,000 workers, or 15% of the total welfare workforce, were *Aged and disabled carers* working in the *Other social assistance services* industry (Figure 1.5.2).

Table 1.5.1: Number of employed people in the welfare workforce per 100,000 population, by type of community service occupation, 2005 and 2015

Occupation	2005	2015	Growth (%)
Early childhood education and care workers	453	711	57
Aged and disabled carers	196	515	163
Nursing support and personal care workers	132	239	82
Registered nurses	231	173	–25
Welfare support workers	87	132	51
Social workers	24	60	152
Welfare, recreation and community arts workers	25	49	96
Enrolled and mothercraft nurses	46	27	–41
Counsellors	26	32	24
Psychologists	14	6	–60
Special care workers	6	3	–43

Notes

1. Early childhood education and care workers include child carers, child care centre managers and early childhood (pre-primary school) teachers.
2. Diversional therapists, education aides, special education teachers and Indigenous health workers are included as community service occupations in totals; however, the number of workers in these occupations within community service industries is small and not reported separately.
3. Data shown are the annual average of quarterly data for 2005 and 2015.

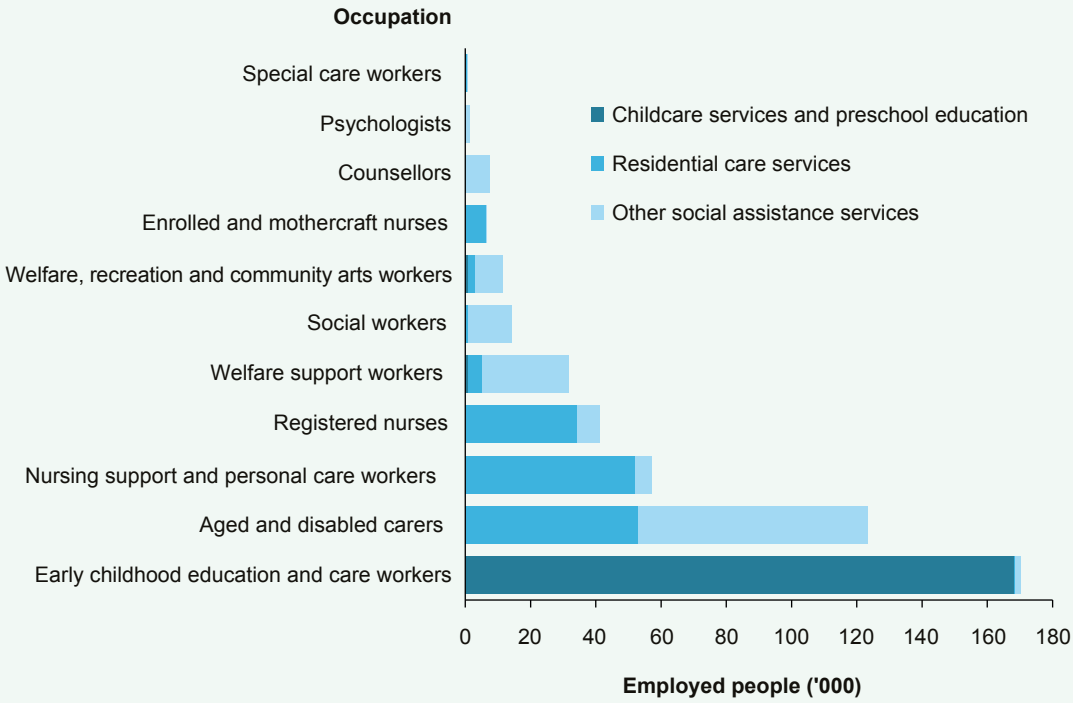
Source: AIHW analysis of ABS Labour Force Survey 2005 and 2015.

What is missing from the picture?

While some information is available from the ABS Labour Force Survey, routine monitoring of details of the welfare workforce, and from the perspective of the whole sector, is limited. In the health sector, there is a mandatory national registration system for certain health professionals, with a range of workforce information updated at the time of annual registration renewal. This type of information is not consistently collected for the welfare workforce but could usefully inform workforce planning.

Where do I go for more information?

More information about the Australian workforce is available from the ABS Labour Force Survey.



Notes

1. Early childhood education and care workers include child carers, child care centre managers and early childhood (pre-primary school) teachers.
2. Diversional therapists, education aides, special education teachers and Indigenous health workers are included as community service occupations in totals; however, the number of workers in these occupations within community service industries is small and not reported separately.
3. Data shown are the annual average of quarterly data for 2015.

Source: AIHW analysis of ABS Labour Force Survey 2015.

Figure 1.5.2: Number of employed people in the welfare workforce per 100,000 population, by type of community service industry and occupation, 2015

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1.6 Persistent disadvantage in Australia: extent, complexity and some key implications

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Why does disadvantage persist for some but not others? And, what might be done about it? This article describes the extent of persistent disadvantage in Australia, examines a range of complex contributing factors, and discusses some key implications for dealing with persistent disadvantage.

Extent of persistent disadvantage in Australia

Australia has had a longstanding focus on disadvantage. This focus gained momentum with Henderson's work on measuring poverty—a distinct but related concept (Commission of Inquiry into Poverty & Henderson 1975; Johnson 1996). Disadvantage is complex, with no universally preferred definition or approach to measurement. Rather, there is a range of approaches to conceptualising it, and various measures can often be complementary (McLachlan et al. 2013). A detailed discussion of each approach is beyond the scope of this article; however, describing some well-established examples may show the difficulties in measuring persistent disadvantage (for more detailed discussions on the different concepts and measures, see McLachlan et al. 2013; Saunders 2011).

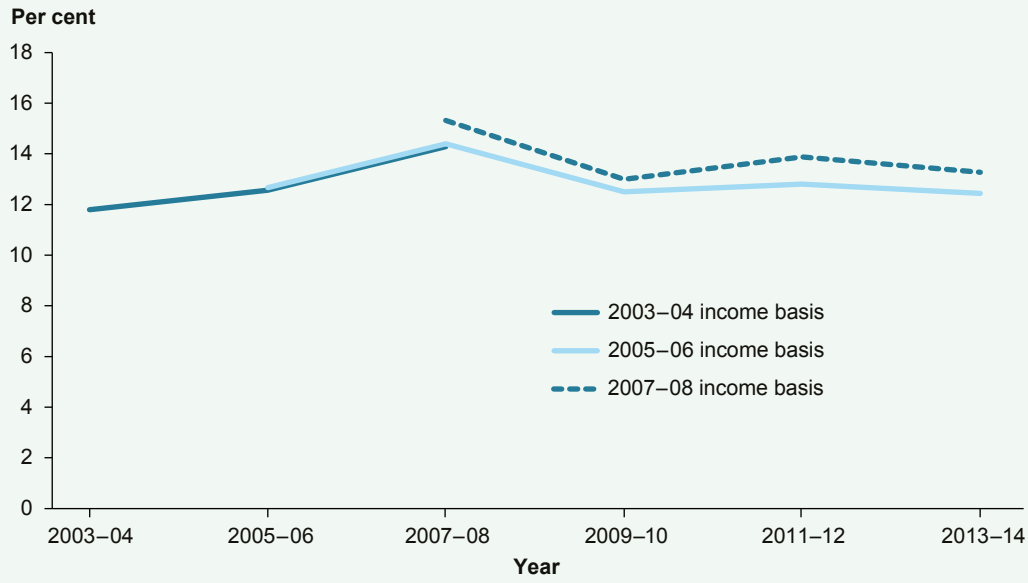
Absolute and relative poverty measures

One common proxy measure for disadvantage is poverty of income, measured in absolute or relative terms (McLachlan et al. 2013). Absolute poverty is commonly defined as not having enough income to cover the cost of a given basket of goods that provides an agreed minimal level of decency (in this sense, the measure is not completely absolute as it is relative to changing views of decency). Based on absolute poverty rates in the Household Income and Labour Dynamics in Australia (HILDA) survey, the proportion of people in absolute income poverty in Australia has been estimated to have dropped from 13% in 2001 to 3.9% in 2014 (Wilkins 2016).

However, the picture is different if considering relative income poverty. In Australia, this measure usually assesses the proportion of households with an equivalised income that is less than 50% of the national median equivalised household income (McLachlan et al. 2013). Considering Australian rates of relative income poverty from 2003–04 to 2013–14, 'the overall

picture on a ten-year trend basis is one of a persistent and entrenched poverty rate around 12%' (Figure 1.6.1) (ACOSS 2016: p.17). Similar analysis by the Melbourne Institute has indicated that, from 2001 to 2014, trends have generally been toward slowly reduced relative poverty in Australia (despite a rapid rise in 2007), but that relative poverty has nonetheless remained between 10.3% and 13.0% (Wilkins 2016). Further, there has been an estimated increase of more than 2 percentage points in the proportion of children living in relative poverty (2004 to 2014), with an estimated 17% of children aged under 15 currently living in households below the poverty line (ACOSS 2016).

The apparent lack of decline in relative poverty in Australia contrasts with absolute poverty reductions and has occurred despite more than 25 consecutive years of economic growth. As an example of economic growth, Australians born in 1991 now have an average household disposable income about twice what it was when they were born, even after accounting for rising prices and population growth (ACOSS 2016).



Note: Figure shows an estimate of the proportion of people living in households with incomes below the poverty line of 50% of national median income.

Source: ACOSS 2016.

Figure 1.6.1: Poverty trend (50% of median, after housing costs), all persons, Australia, 2003–04 to 2013–14

Measures of relative income poverty have been used for international comparisons (Förster & d'Ercole 2009; McLachlan et al. 2013). The Organisation for Economic Co-operation and Development (OECD) has estimated that the proportion of people facing relative income poverty in Australia in 2014 was 12.8% (compared with an OECD average of 11.4%) (ACOSS 2016). This placed Australia fourteenth highest (or among the middle third of countries), despite its relative prosperity compared with other nations in the OECD. While the characteristics of the compared nations certainly differ, the fact that six countries had relative income poverty proportions of 8% or less suggests that reductions in relative income poverty may be possible.

However, these measures of income poverty (whether absolute or relative) are cross sectional snapshots (even if repeated over time). They do not directly indicate how many people are persistently impoverished since individuals can, and do, move in and out of poverty. An alternative is to measure the duration of poverty. The Melbourne Institute analysed HILDA data from 2002 to 2013 for persons aged over 18 who entered poverty, reporting the number of years before they exited it ('poverty spell durations') (Wilkins 2016). While the majority of people entering poverty (61%) had a spell of 1 year, others had spells lasting 2 years (17%), 3 years (7.4%), 4 years (4.4%), 5 years (2.5%) or 6 or more years (8.2%). Wilkins (2016) also provides a second, similar analysis, but using duration of receiving income support payments.

Whether measuring snapshots of absolute or relative poverty or the duration of poverty, all such measures are proxies of disadvantage since they rely on measuring income. Measures based solely on income are limited in assessing disadvantage as they do not account for financial resources other than income (for example, savings or home equity) nor for the range of non-financial factors that may contribute to disadvantage (for example, poor health, low education or limited community participation) (Förster & d'Ercole 2009; McLachlan et al. 2013).

Measuring persistent disadvantage

A multifaceted approach to measuring persistent disadvantage has been employed by the Productivity Commission, using the Social Exclusion Monitor (SEM) (Box 1.6.1). Table 1.6.1 shows estimated proportions of segments of the Australian population facing deep and persistent social exclusion from 2001 to 2010, based on the SEM (McLachlan et al. 2013). The table lists population groups where estimates were at least twice that of the national estimate. Groups with estimates above (but less than twice) the national estimate are not shown, but include single adults (aged 18 to 64), single adults aged over 65, all adults aged over 65, and migrants (from a non-English-speaking background).

Box 1.6.1: Social Exclusion Monitor

The SEM provides a composite measure of disadvantage based on seven dimensions: material resources, employment, education and skills, health and disability, social support, community participation, and personal safety perceptions. Disadvantage (social exclusion) is scored from 0 to 7, with scores of 2 or more defined as deep exclusion and of 3 or more as very deep exclusion (for further details on the SEM, see McLachlan et al. 2013; Scutella et al. 2013). The Productivity Commission estimated that between 2001 and 2010, deep exclusion levels among Australians aged 15–64 affected:

- almost 3% for 5 years or more (465,000 people)
- around 1% for 7 years or more (165,000).

The average duration for deep exclusion was 1.7 years, and 1.4 years for very deep levels of exclusion (McLachlan el al., 2013).

The Productivity Commission also reported on yearly shifts between various levels of social exclusion, from 2001 to 2009. It found that the largest proportion of people facing deep or very deep social exclusion in any given year experienced less exclusion (lower SEM scores) the year after. These findings were consistent with the Melbourne Institute's analysis of durations of poverty (Wilkins 2016) and analyses of the Panel Study of Income Dynamics (PSID) in the United States (for example, Duncan & Vandel 2012; Gottschalk et al. 1994). However, the Productivity Commission also found that, of people who were very deeply socially excluded in any given year, 31% remained so the following year and that, of people who were deeply socially excluded, 37% remained so the following year and 8% moved on to being very deeply socially excluded (proportions being a year-on-year average across the period) (see McLachlan et al. 2013: Table 3.7).

Table 1.6.1: Proportion of people aged 15 and over facing deep and persistent disadvantage, by selected population groups, 2001 to 2010

	Group	Facing deep and persistent disadvantage (%)
	Living in public housing	23.6
	Dependent on income support	15.3
	Unemployed	11.5
	Lone parents	11.3
	With a long-term health condition or disability	11.2
	Indigenous Australians	10.8
	Highest educational attainment Year 11 or below	9.3
	All Australians	4.4

Notes

1. Deep and persistent disadvantage is defined as being an individual aged 15 and over and having a SEM score of 2 or more for 4 or more years between 2001 and 2010.
2. Groups are not mutually exclusive.

Source: McLachlan et al. 2013.

Complexity of persistent disadvantage

Disadvantage is a multifaceted phenomenon with both individual and environmental factors interacting in complex ways to alter its likelihood and persistence.

Individual attributes

The likelihood that external risk factors will result in persistent disadvantage seems to be amplified or mitigated by various individual characteristics. These interactions between environmental and individual characteristics are further complicated given that, while some individual characteristics are largely stable over time (for example, ethnicity and sex), others may or may not change (for example, attitudes) and yet others will certainly change (for example, age, employment status, family status).

Indigenous status

Indigenous Australians (aged 15 and older) had more than twice the prevalence of deep and persistent social exclusion (10.8%) compared with that for all Australians (4.4%) (see Table 1.6.1).

On virtually any measure of disadvantage, Aboriginal and Torres Strait Islander Australians are over-represented, and this disadvantage appears to persist (SCRGSP 2016). For example, while educational attainment for Indigenous Australians is increasing, large educational gaps remain between Indigenous and non-Indigenous people (see Chapter 7.4 'Closing the gap in education'). In 2014–15, 47% of Indigenous people aged 20–64 either had a Certificate level III or above or were studying at any post-secondary level—a 21% increase from 26% in 2002. However, a similar rise of 18% was also seen for non-Indigenous people of the same age, from 52% in 2002 to 70% in 2014–15. So this educational gap has remained largely steady (SCRGSP 2016).

Similarly, the Indigenous employment rate (48%) in 2014–15 was much lower than the non-Indigenous employment rate (73%), and the gap has not changed substantially since 2008 (PM&C 2017). Median equivalised gross weekly household incomes for Indigenous Australians are two-thirds of those for non-Indigenous Australians ($556 vs $831 in 2014–15) (see Chapter 7.5 'Income and employment for Indigenous Australians'). More than 1 in 5 (22%) Indigenous Australians reported experiencing physical or threatened violence in 2014–15, a rate 2.5 times higher than for non-Indigenous Australians (SCRGSP 2016). As at 30 June 2015, Indigenous Australians made up more than one-quarter (27%) of the adult prison population, and the imprisonment rate for Indigenous Australian adults was 13 times that for non-Indigenous adults. In 2014–15, the juvenile detention rate for young Indigenous Australians was 25 times that for their non-Indigenous counterparts (see Chapter 2.6 'Youth justice supervision' and Chapter 7 'Indigenous Australians').

Sex

Research indicates that females are consistently more likely to live in households below the poverty line than males. This is primarily due to their generally lower rates of employment, lower wages and the associated impacts of their greater family caring commitments (ACOSS 2016). Nationally, in 2014, the rates of poverty for females were estimated to be 1 percentage point higher than those for men (13.8% vs 12.8%, respectively) (ACOSS 2016). Similarly, deep and persistent social exclusion has been found to be more prevalent for females (5.2%) than for males (3.7%) (national prevalence: 4.4%) (McLachlan et al. 2013).

Cobb-Clark et al. (2016) explored the relative durations, for females and males, of two key markers of persistent poverty: housing insecurity (for example, living with friends or in a motel) and homelessness (for example, sleeping on the street or in crisis accommodation). They found that, on average, females leave circumstances of housing insecurity around 2 months sooner than males. In contrast, they tended to remain homeless for around 1.4 months longer than males (although this was not statistically significant). The study attributed the longer duration of homelessness for females to their being more likely to enter crisis accommodation (characterised by relatively longer stays) while males were more likely to be sleeping rough (characterised by shorter durations).

Attitudes

Unlike other individual factors such as ethnicity, sex or age, attitudes can be directly influenced by public policy. Changes of attitude may, in turn, alter behaviours, which may change the course of disadvantage. For example, Baron and Cobb-Clark (2010) found that Australian high school students who more strongly believed they could control life events were more likely to complete Year 12 by age 18 and to obtain a university entrance rank. Further, entrance ranks tended to be higher for students reporting stronger beliefs about control. In contrast, a study of the behaviours of Dutch students facing financial disadvantage due to changes to university funding found that students with an 'all-will-be-well' attitude were less likely to act to tackle this perceived concern (Stroebe 2013). This was independent of the perceived extent of the concern, or the perceived effectiveness of action. Similarly, a study in the Midwestern United States found that where low-income mothers attributed their own poverty to romantic relationships or to children, this was positively associated with beliefs about upward mobility, while self-focused attributions were negatively associated with such beliefs (Mickelson & Hazlett 2014).

Age

Data suggest that older age (particularly beyond the traditional age of retirement at 65) somewhat increases the likelihood of poverty (ACOSS 2016). People aged over 65 (at 13%) are more likely to experience poverty than people of typical working age (25–64: 12%) (though less likely than children aged under 15: 17%). Similarly, people aged over 65 have been found to be the least likely to exit poverty (Wilkins 2016), and people aged over 60 represent 'close to two-fifths' of people who are deeply and persistently disadvantaged (McLachlan et al. 2013).

Similar patterns have been observed with homelessness. Cobb-Clark et al. (2016) have reported evidence that the likelihood of people experiencing homelessness or housing insecurity quickly moving to more stable accommodation decreases with age (that is, the older a person, the longer before they secure stable housing). Similarly, while the current proportion of people seeking specialist homelessness services who are older (aged over 55) is relatively small (8% in 2015–16), this group represents one of the fastest growing populations seeking help from specialist homelessness agencies (AIHW 2016b). This group has shown an average annual growth rate of 9.5% since 2011–12, more than twice the rate of the general population seeking specialist homelessness services. This may be of greater concern for such disadvantaged people given the evidence that greater age may be associated with a greater likelihood that disadvantage will persist.

Family characteristics

Family structure and relationships

People living in lone-parent families are more likely to experience disadvantage. As at June 2016, the majority (83%) of the 618,900 one-parent families with dependants in Australia were single mother families (ABS 2017b). Australian children living in lone-parent families are more than 3 times as likely to be in poverty as children in two-parent families (41% vs 13%) (ACOSS 2016). This is consistent with international evidence that, compared with two parent families, poverty tends to be higher for households headed by single parents (Corcoran & Chaudry 1997) and that children living in the absence of fathers are more likely, as adults, to move downward in the income distribution (Hancock et al. 2013).

> ***The prevalence of deep and persistent social exclusion for lone-parents (11%) is more than twice the national prevalence (4.4%) (Table 1.6.1).***

Divorce and separation are associated with greater likelihood of experiencing disadvantage, and evidence suggests the impacts may span multiple generations. Previous research has consistently shown that the likelihood of separation in adulthood is greater for adults whose own parents have separated (D'Onofrio et al. 2007; Wolfinger 2005, 2011). Of the few studies of the effects of divorce on multiple generations, Amato and Cheadle (2005) reported that lower educational attainment and more marital discord among grandchildren may be correlated with divorce among their grandparents. In a study that highlights the complex interactions between life events (such as relationship breakdown) and individual factors (in this case, age and sex), de Vaus et al. (2014) found that females who experienced a relationship breakdown late in life—especially those who did not re-partner—were more likely to move into poverty than males who had a relationship breakdown in their later years.

The quality and type of parenting and nurturing has important impacts on the life chances of children. Being disadvantaged does not necessarily diminish the quality of parenting; however, caregivers need sufficient education, time and support to ensure the health and wellbeing of children (Engle et al. 1999; Harper 2004a). Persistent poverty, exclusion and disadvantage may increase the stresses and strains on caregivers and reduce the resources and supports they need to optimally nurture child development.

Family income and housing

A growing number of international and Australian studies have examined the relationships between the incomes of consecutive generations (Andrews & Leigh 2009; Broom & Jones 1969; Cobb-Clark 2010; Corak 2013; Huang et al. 2016; Leigh 2007; Mendolia & Siminski 2016; OECD 2010). In summary, these studies provide two main findings. First, they suggest that there is a correlation between the income of one generation and the next. Second, they suggest that the strength of this correlation is associated with the income inequality of a country, such that greater income inequality is associated with a stronger correlation between generational incomes—in other words, greater inequality between higher and lower incomes is associated with reduced income mobility between generations, as measured by the Gini coefficient (see Chapter 9.2 'Indicators of *Australia's welfare*'). While estimates of social mobility for Australia have varied over the last decade, all the estimates suggest that Australia has relatively greater social mobility than countries such as Italy, the United States and the United Kingdom, but less than the Nordic countries.

Using PSID data, Duncan et al. (2010) assessed the consequences of child poverty for a range of adult outcomes while controlling for average later childhood and adolescent family incomes as well as a large range of demographic variables. They found that early childhood poverty was associated with both lower earnings and lower work hours in adulthood.

Source of income is associated with disadvantage.

> ***For people dependent on income support, the prevalence of deep and persistent social exclusion (15%) is more than 3 times as high as the national prevalence of such exclusion (4.4%) (Table 1.6.1).***

Analysis by Cobb-Clark (2010) indicates that, relative to young people from families with no income support, people from families with intensive, multi year income support tend to have poorer education and health outcomes, and engage in more risky behaviours. Importantly, however, this study indicated that young people from families with intensive income support also have a decreased sense of control over life events. This was associated with a lower likelihood of completing year 12 and lower university entrance ranks. The study suggests that these attributional and educational attainment factors are likely to be more important mediators of poor education, health and behavioural outcomes than the receipt of welfare payments.

In terms of housing, children who experience homelessness tend to have a lower likelihood of employment as adults, with men being more at risk than women (Cobb-Clark & Zhu 2015).

> ***The highest prevalence of deep and persistent social exclusion was for people living in public housing (24%) (Table 1.6.1).***

Life events

People living in disadvantaged circumstances are more likely to experience multiple adverse life events (Baxter et al. 2012; Moloney et al. 2012). Moreover, adversity is far from randomly distributed, with people in disadvantage experiencing both a higher frequency and higher severity of adverse events, while simultaneously having a lower likelihood of effective protective influences that enable them to bounce back. In short, vulnerability tends to beget further vulnerability (Baxter et al. 2012).

Job loss

Loss of employment is a major life event that has marked impacts on families.

> ***For people aged over 15, the prevalence of deep and persistent social exclusion was more than twice as high among people who were unemployed (11%) as the national prevalence (4.4%) (Table 1.6.1).***

Living in jobless households is associated with children tending to have both poorer social-emotional wellbeing, and health and educational outcomes (Gray & Baxter 2012; Gray et al. 2011), particularly in families where joblessness endures (Gray & Baxter 2011). These effects may extend across multiple generations, with research by Hancock et al. (2013) finding that 'being in a jobless family was also associated with experiences of grandparent joblessness'. Factors that predict future joblessness include current joblessness, along with lower education level and long-term individual health problems (Hérault et al. 2015) (see Chapter 9.2 'Indicators of *Australia's welfare*').

Changes in health

The prevalence of deep and persistent social exclusion for people with a long-term health condition or disability (11%) is more than twice that of the national prevalence (4.4%) (Table 1.6.1).

Good health is a key asset and ill health is the single most widespread hazard affecting poor households (Harper 2004b). Reduced health is a key driver of downward social mobility. This is because reduced health diminishes the workforce participation of individuals and their carers, which alters household dependency ratios. In Australia, data indicate that 81% of people who are deeply and persistently socially excluded have a long-term health condition or disability (McLachlan et al. 2013).

Relationship conflict and violence

Exposure to physical, emotional and/or psychological violence is associated with the intergenerational transmission of poverty. In Australia, domestic violence is the main reason that women and children leave home and is consistently cited among the most common reasons for seeking support from specialist homelessness services (AIHW 2016a; Spinney 2012). Domestic violence has negative impacts on children's educational performance. It is also associated with being more likely to have to repeat grades, discipline problems, and poor child mental health (Aldaz-Carroll & Morano 2001). Where violence leads to family breakdown, it further contributes to persistent intergenerational disadvantage through impacts such as asset loss, inheritance loss, reduced income, and reduced social networks (Bird & Shinyekwa 2005). Johnson et al. (2008) identify domestic violence as one of five 'typical' pathways into homelessness in Australia, along with mental health, substance abuse, youth (first experience of homelessness when aged under 18), and housing crisis pathways (see also Mackenzie and Chamberlain (2001) for domestic violence as a major factor in family breakdown; see Chapter 2.7 'Family, domestic and sexual violence').

Educational opportunity and human capital

A lack of education is associated with greater risks of disadvantage. People with inadequate education are more likely to experience unemployment, low income, poor health and high rates of involvement with the criminal justice system (Vinson 2007). In the United States, persistent poverty is highest among people who have not completed high-school (Bird 2007). Consistent with this, Australian research indicates that 61% of people who are deeply and persistently disadvantaged have low educational attainment (Year 11 or below).

The prevalence of persistent deep disadvantage among Australians with low educational attainment (9.3%) is twice that of the national average prevalence of such disadvantage (4.4%) (Table 1.6.1).

The effects of limited education may also be intergenerational, with household poverty and disadvantage associated with having parents with limited education (Aldaz-Carroll & Morano 2001; Emerson & Souza 2005; Falkingham & Ibragimova 2005; Handa et al. 2004).

In contrast, increased education is widely considered to be a protective factor in later life (Bird 2007). In many countries, schooling correlates strongly with adult earning potential and actual income (Aldaz-Carroll & Morano 2001; Emerson & Souza 2005). Education may also reduce the risk of housing insecurity (Cobb-Clark et al. 2016). Educational opportunities for girls and women are important in interrupting persistent disadvantage, and more educated mothers are more likely to send their children to school (Christiaensen & Alderman 2004; Rose & Dyer 2008) (for more information on education, see Chapter 3 'Education in Australia').

Wider risk factors

As well as factors associated with individuals and their immediate families, circumstances and settings, several wider factors can affect persistent disadvantage. These include the local neighbourhood, and structural economic changes.

Location and disadvantage

Evidence suggests that, relative to urbanised areas, disadvantage is more prevalent (Saunders & Wong 2012) and persistent (Tanton et al. 2012) in regional and remote parts of Australia. However, people experiencing disadvantage can be co-located with others who are more mobile, making it difficult to precisely describe disadvantage in locational terms (McLachlan et al. 2013).

Saunders and Wong (2012) analysed how deprivation and social exclusion among Australian adults varied (based on 2010 Poverty and Exclusion in Modern Australia (PEMA) survey data). They found that people in rural areas or villages experienced the highest prevalence of deprivation, generally higher rates of social disengagement, the highest rates of service exclusion, and higher rates of economic exclusion. In contrast, people living in the inner city experienced the lowest prevalence of deprivation and generally lower rates of social disengagement (for an extended locational analysis of the PEMA data, also see Saunders & Wong (2014)).

Tanton et al. (2012) examined entrenched disadvantage and found that multiple-life-stage-disadvantage is more prevalent in *Remote* and *Very remote* areas of Australia, and not as prevalent in most (though not all) capital cities. Most people living in *Major cities* were in areas that were not designated as 'disadvantaged' for any life-stage. Consistent with Tanton et al. (2012), Vinson and Rawsthorne (2015) provide evidence of the prominence of disadvantaged localities in rural areas and on the fringes of metropolitan areas.

Changes to economic and labour market conditions

Labour markets do change, and certainly have changed in Australia (see Chapter 4.1 'The changing nature of work and worker wellbeing'). For example, in 1966, manufacturing accounted for around one-quarter of all jobs (ABS 2007); as at February 2017, it accounted for 7.5% of jobs (ABS 2017a). In the 1980s, casual employment (that is, employment without entitlement to annual or sick leave) climbed steadily, representing 13% of employees in 1982, and 20% in 1989 (Dawkins & Norris 1990). Since that time, the proportion of casual employees has remained at around 20% (Wooden 2016). The proportion of jobs requiring higher skills and qualifications has grown, possibly associated with the expansion of disruptive technologies such as automation (Department of Employment 2016). Such changes do not necessarily result in disadvantage. However, for people already on a pathway toward disadvantaged circumstances, risks may be even further increased by such economic changes, if they or members of their family do not have the skills, capabilities or qualifications needed to make a shift in line with changing labour market conditions.

Some key implications

Dealing with complex issues such as persistent disadvantage has potentially profound and positive social and economic effects. As a parallel example, Brown et al. (2012) reported on the anticipated benefits of government action to reduce health inequities, concluding that if Australia adopted WHO recommendations to tackle the social determinants of health this would potentially mean:

- some 170,000 extra Australians could enter the workforce, generating $8 billion in extra earnings
- around $4 billion in annual savings in paying welfare support
- around 60,000 fewer people admitted to hospital annually, resulting in savings of $2.3 billion in hospital expenditure
- 5.5 million fewer Medicare services each year, resulting in annual savings of $273 million
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts filled each year, resulting in annual savings of $184.5 million each year.

One key implication of the complexity of persistent disadvantage is to recognise that many of the contributing factors are dynamic and, therefore, amenable to change. Conceptualising disadvantage as a state that can dynamically change over the life course is foundational to public policy in this area since it is these alterable factors—both within and around individuals—that public policy can most directly consider.

Multidimensional approaches to measurement

The complex and dynamic character of persistent disadvantage calls for a multidimensional approach to measurement and monitoring (Martinez & Perales 2015). Such an approach informed the widely adopted SEM, used to estimate the prevalence of deep and persistent disadvantage for various groups highlighted throughout this article. Measures such as the SEM highlight that there may be both clear differences and overlaps in the trends of different dimensions of disadvantage. For example, a recent analysis of HILDA data showed that the domains of health and disability, material resources, social support, and education and skills all contributed to increased disadvantage between 2001 and 2013. However, these were offset by relative decreases in disadvantage over the same period related to safety perceptions, employment, and community participation (Martinez & Perales 2015). Considering the trends and relationships between various dimensions of disadvantage may more fully inform practice.

Australia has extensive data resources, including its existing longitudinal collections (for example, Growing up in Australia, the Longitudinal Study of Australian Children; the Australian Longitudinal Study on Women's Health; the HILDA survey and the Longitudinal Surveys of Australian Youth, along with the collections of the Australian Bureau of Statistics). Australia has also developed longitudinal social security administrative data to support the Priority Investment Approach (see Chapter 1.3 'Understanding welfare'). While bearing in mind issues of ethics and privacy, integrating government administrative data sets via data linkage and/or combining them with other evaluative or research data has the potential to provide better understanding of different forms of disadvantage. This could guide initiatives that target persistent disadvantage in Australia (see Chapter 1.7 'Understanding health and welfare data').

Priority population groups

As indicated in Table 1.6.1, the prevalence of deep and persistent social exclusion is substantially greater than the national average for several identifiable groups:

- public housing tenants
- people dependent on income support
- unemployed people
- lone parents
- persons with a long-term health condition or disability
- Indigenous people
- people with low educational attainment.

These demographic indicators flag segments of the population that may benefit from more focused efforts to reduce disadvantage. Clearly, where individuals fall into multiple categories, further prioritising how best to support them may need to be considered. The wider context also warrants consideration. Rural and remote communities, as well as suburbs on the outskirts of capital cities, may be areas where initiatives to tackle disadvantage could be of benefit (Saunders & Wong 2012; Tanton et al. 2012; Vinson & Rawsthorne 2015).

Possible approaches to reducing disadvantage

The OECD (2010) recommended considering a range of approaches to increasing social mobility. Several of these recommendations focused on education, namely:

- prioritising education that facilitates social and economic mobility
- supporting education 'at both ends' through facilitating both early childhood education and greater completion of secondary schooling
- enabling greater equity of access to tertiary education
- facilitating greater local autonomy to match educational resources to local need
- enhancing teacher quality generally, and particularly encouraging quality teachers to work with school populations from disadvantaged backgrounds.

Surrounding these educational approaches, other approaches recommended for consideration include:

- urban planning that increases the heterogeneity of school populations
- taxation approaches that provide incentives and pathways from welfare to work
- child care arrangements that simultaneously support employment and child education (Duncan et al. 2007; OECD 2010).

Adopting a multi-strategic approach to reducing persistent disadvantage

As discussed, persistent disadvantage is complex. It is both multifaceted and dynamic. A diverse range of individual attributes, family characteristics, life events, and wider geographic and economic factors interact to increase the risk of moving into and remaining in disadvantage.

Recent changes in social policy have focused on better targeting of policy and practice. This change has been influenced by the multi-strategic New Zealand Investment Approach. As reinforced in the McClure Report, this approach has four pillars of welfare reform:

- welfare system simplification
- skill development and ability
- strengthening employer engagement
- incentives and community support through encouragement of philanthropy and volunteering (McClure et al. 2015) (see also Chapter 1.3 'Understanding welfare').

However, as suggested by the range of possible approaches to reducing disadvantage outlined above—covering areas including education, urban planning, taxation and child care—dealing with persistent disadvantage would likely benefit not only from adopting a multi-strategic approach to welfare, but also to tackling issues of public concern more broadly. Problems as complex as persistent disadvantage clearly require a coordinated approach that involves authentic community engagement, shared aspirations and goals, evaluation systems that facilitate strategic learning, prioritising locally effective activities, and facilitating necessary change (Cabaj & Weaver 2016; Kania & Kramer 2011). In Australia, a coordinated approach has been evaluated, with longitudinal outcomes (from 2002 to 2011), providing emerging evidence that such an approach may be able to reduce persistent disadvantage (Homel et al. 2015). From a data perspective, much of this could be facilitated through better integrated data sources—for example, linkage between service data at state/territory and Commonwealth government level.

Given that social and economic disadvantage are dynamic states rather than fixed traits of individuals, the circumstances and contexts that contribute to persistent disadvantage can be directly considered. Multidimensional measures of persistent disadvantage (for example, SEM) can be illuminated by considering the range of factors that contribute to persistent disadvantage, tracking these over time, and identifying demographic indicators around which persistent disadvantage tends to cluster. The value of multidimensional measures could be further enhanced through integration with Australia's existing longitudinal data collections and with administrative data and other collections, including those of the AIHW and the Australian Bureau of Statistics.

Practice models based on coordinated approaches may provide a framework to deal with persistent disadvantage and have an emerging evidence base for their effectiveness. Approaches that prioritise targeted, multi-strategic initiatives to move people from persistent disadvantage carry promise for delivering substantial social and economic benefits.

Where do I go for more information?

More information can be found in key documents at the following websites: AIHW, ACOSS, OECD, from the Productivity Commission, and from several other reports (full details of which are provided in the references): *The cost of inaction on the social determinants of health* (Brown et al. 2012); *Collective impact 3.0: an evolving framework for community change* (Cabaj & Weaver 2016); *A new system for better employment and social outcomes* (McClure et al. 2015); *Deep and persistent disadvantage in Australia* (McLachlan et al. 2013); *Dropping off the edge* (Vinson & Rawsthorne 2015).

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1.7 Understanding health and welfare data

Changing data landscape

In today's world of 'big data', governments, businesses, the community and individuals have access to more data than ever before. 'Big data'—the unprecedented volume, diversity and speed of data generation—is growing at a rapid pace, with the volume of digital data expected to almost triple in size between 2017 and 2020 (Productivity Commission 2017; Reimsbach-Kounatze 2015).

As its 2015 public data policy statement makes clear, the Australian Government is well aware of this trend, and of the pressing need to exploit this 'strategic national resource' (PM&C 2015a). It sees potential benefit in making non-sensitive data 'open by default' by not restricting its use or redistribution. Indeed, there may be substantial economic returns in making 'high-value' data sets (such as detailed geospatial data) more publicly accessible and enabling them to be analysed by a range of freely available tools. While the need to manage 'big data' is clearly evident, the key issue for all data users is to ensure these data are used in the most effective manner; that is, 'smart data'.

The Australian Government's agenda is to improve and, where appropriate, simplify data sharing arrangements (PM&C 2015b). It emphasises the importance of developing partnerships with government and non-government stakeholders, especially researchers (PM&C 2016a). For example, the creation of the new Data Integration Partnership of Australia in the 2017 Budget signals an ongoing commitment to '…improving policy, programs and service delivery through the better use of government data to assist in delivering a more productive economy' (DOF 2017).

There is a growing interest in unstructured data—for example, social media posts and web searches. This is being fostered by the development of machine learning techniques, where computers can track through large amounts of information for meaning, without needing explicit programming.

Privacy, security and social licence

The Australian Government's public data agenda faces substantial challenges. There is ever growing pressure to deliver high-quality, useable information faster, while ensuring that individual privacy is protected. The Productivity Commission's *Inquiry on Data Availability and Use* (Productivity Commission 2017) highlights the critical importance of obtaining 'social licence' from the community. It is suggested that, on the whole, people are willing to make their information available, but on several conditions. They need to trust how it will be handled. They need to feel that they have control over how and who will use it. They also need to see (and ideally directly benefit from) its potential value.

Improved security is becoming more and more important as the volume of digital data expands. People who collect sensitive personal information must keep their security technology up to date. However, these steps, along with tighter privacy legislation, can only go so far to prevent breaches. These are often due to human error and cannot always be foreseen. The Productivity Commission concludes that the best approach is to assess the level of data required for different uses. In other words, risk will be minimised if sensitive information is only collected when necessary. Risk management needs to be a central focus of all data collection activity.

Increased interest in person-centred data

Alongside the mounting volume of data are growing expectations about how these data assets will be used. More emphasis is being put on ensuring that public data will be used to improve outcomes for Australian people. For example, comprehensive data are essential to develop social investment models and evaluate the impacts of programs or policies for various population groups.

Figure 1.7.1 shows the elements of policy and program areas for a person-centred data model. These form much of the 'content' of the evidence base needed to understand the experiences of the population and various cohorts within it. Across these elements, questions can be formed around:

- the characteristics of a population cohort—such as age, sex and geographical location
- determinants of the needs for support, and factors influencing outcomes—covering social, behavioural and individual factors
- interactions with the health and welfare 'system'—for example, eligibility and access, barriers (such as cost or distance), unmet need, pathways through the system
- outcomes from interactions with the system—notably education, employment and social/participation outcomes; and health and general wellbeing
- aspects of the system that can either help or hinder intended outcomes—including policy parameters, funding models, system resources (for example, workforce levels, skills and distribution), system performance (efficiency, integration/coordination, safety/quality, responsiveness), informal carer capacity.

This model recognises that the various components may interact, and that the level of support required will differ according to individual circumstances.

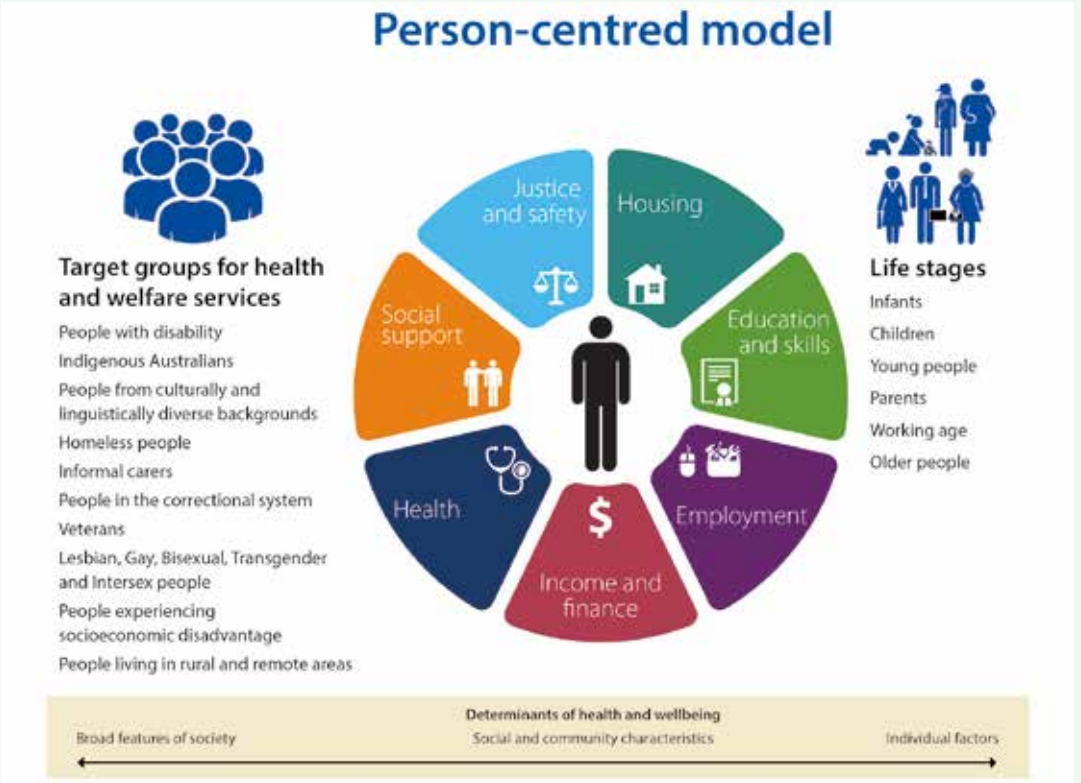

Figure 1.7.1: Person-centred data model

Types of data sources

Broadly speaking, major health and welfare data sources in Australia are either administrative data (such as collected when running a service or program) or survey data (for a targeted sample on a given topic). Each type of data has advantages and disadvantages. Choosing which one to use often comes down to purpose and the capability of each collection to measure what is needed.

The rapid growth of digitally accessible data is likely to allow much broader uses of administrative data sources (as well as to explore the potential of unstructured data). But joining administrative and survey data can provide deeper insights. This technique is used effectively, for instance, in the Business Longitudinal Analytical Data Environment. This data set combines administrative data from the Australian Tax Office with business survey data from the Australian Bureau of Statistics to tell a rich story about the characteristics and outcomes of businesses across Australia (Kalisch 2016).

Data can also be described as cross-sectional or longitudinal. A cross-sectional data source represents a particular population at a specific time. A longitudinal data source collects data on the same subjects repeatedly over time. Most Australian data collections are cross-sectional. But longitudinal studies are becoming more prevalent, as their usefulness in many policy contexts becomes more recognised. They can help governments to understand

how individuals respond to different situations over time; they can also identify individual pathways, and (in some instances) be directly linked to changes and outcomes after specific policy interventions (FaHCSIA 2013). Over the past 20 years, there have been concerted efforts in Australia to collect longitudinal data on a range of populations. Among these efforts was the formation, in 2014, of the National Centre for Longitudinal Data. This Centre promotes further use of longitudinal data in Australia and supports collaborative projects between researchers and policy makers (DSS 2017).

Getting the most out of data

The level and accessibility of data in 2017 is substantial. It needs, however, to be meaningfully used, not only to create evidence that informs decisions, but also to improve outcomes that can be interpreted in a policy context (as above, it needs to be 'smart' data). Data users need the skills to handle and analyse data in general; they also need to be aware of the relevant policies and contextual background (AIHW 2016a). It is essential that work in this regard is framed by strong data governance arrangements that meet legislative requirements and align with community expectations around privacy, confidentiality and data security.

Data standards

Data standards play a critical role in the meaningful use of data. 'Metadata' (data about data) allows users to have a consistent understanding of the meaning and representation of underlying data. It is a key part of making data sources as clear and usable as possible. In fact, a generally accepted principle in statistical collections is that quality metadata leads to better data.

Metadata supports consistent and transparent collection of data across national, state and territory boundaries and, in some cases, across a substantial number of agencies' data systems. For example, the Specialist Homelessness Services Collection draws on data from around 1,500 disparate non-government agencies across Australia. The comparable collation of this information supports the evidence base about people seeking homelessness services.

Data access and data sharing

The Australian Government's public data agenda is still in its early stages. But it offers many opportunities to enhance data access, paying close attention to privacy and data security. It is expected that by making non-sensitive data 'open by default', and creating integrated data sets that are widely accessible, many data gaps can be filled. Having much richer and integrated longitudinal data in future will help to answer more complex research questions. It will also better enable person-centred data to be collected and analysed. Important strategies will be to continue to improve and maximise the use of existing data sets while being proactive in identifying those that could be integrated.

All levels of government see more open data as a priority. For example, data.gov.au has been created as a central access point for a range of public data sets drawn from Australian, state/territory and local government data sets. The growing demand for individuals to control their own data is being acknowledged. This includes knowing which individuals or agencies can access this information (as seen in models such as My Health Record).

Arrangements for data sharing are progressing. One of the first major Australian Government initiatives is the Multi-Agency Data Integration Project. This involves creating an enduring, linked data set that draws information from several government data sources to answer key policy questions that can only be done by linking multiple sources. It is expected that this integrated data set will be made available to researchers via a 'trusted user' model—which allows broad data access while keeping strong privacy provisions (ABS 2016; PM&C 2016b). Some Australian and state/territory governments—Western Australia and New South Wales in particular—have already set up data integration models to answer complex policy questions, setting good examples of how multi-agency data integration models can work (Productivity Commission 2017).

A demonstration project is underway to test the linkage of a data set based on hospitals data routinely provided to the AIHW by jurisdictions with Medical Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) data. The linked data set would be a source of patient-centred information about services provided by Australia's hospitals, medical and other services subsidised through the MBS and pharmaceuticals dispensed under the PBS. This would enhance the ability to examine patient journeys through the Australian health system.

Data linkage

Data linkage (also called data matching, data integration or record matching) is a process that allows users to combine information from multiple databases, while preserving privacy, to tell a much more powerful story than would be possible from a single source (AIHW 2014). As indicated earlier in this article, linking multiple data sources can enable more meaningful person-centred analyses, which cannot be carried out on individual data sets in isolation. Integrating data in this way can help policy makers to improve their understanding of a range of issues. These include patient- or person-centred outcomes, individuals' life courses, and the patterns of a person's interactions with various service sectors. There are many recent examples that show the substantial value that can be gained from linking multiple data sources (see Box 1.7.1 for a selection).

The number and variety of data linkage activities have increased rapidly in recent years. Three Commonwealth Integrating Authorities were set up between 2012–2014 (the AIHW, the Australian Bureau of Statistics and the Australian Institute of Family Studies). These authorities provide a secure environment in which the development of linkage projects can be fostered. Western Australia undertook over 800 projects between 1995–2016 under its WA Data Linkage System (WADLS), while the SA–NT DataLink consortium has delivered results for over 40 projects since it was set up in 2009 (DLWA 2016a, 2016b; University of South Australia 2017). Data linkage is a powerful tool. Yet challenges remain, before its benefit can be maximised. The time taken to gain approvals to use data for linkage is one pressing issue. It can affect the ability of researchers to analyse data and release results in a timely way. Another issue is the re-use of linked data for follow-up projects, a matter that is being widely discussed. Currently, most data linkage projects are funded as one-off activities. They therefore need full re-approval to use data before researchers can carry out further investigations (AIHW 2016c; Productivity Commission 2017).

Box 1.7.1: Selected recent examples of major data linkage projects

Specialist Homelessness Services and Youth Justice clients

An estimated 187,500 young people aged under 18 accessed homelessness services over a 4 year period, or about 30% of all clients. This data source was linked with the Juvenile Justice National Minimum Data Set. From this linkage, it was learned that 5,133 of these young people also had some contact with youth justice supervision. This group, compared with other specialist homeless clients of the same age, had 5 times the rate of drug and alcohol issues, double the rate of mental health issues and an overall need for more intensive support. Governments and service providers can use this analysis to design and provide more targeted responses at an individual level. For example, ensuring that mental health services are available for people exiting youth justice services and seeking homelessness support.

Human papilloma virus (HPV) vaccination program and cervical abnormalities

This study, based on Victorian HPV vaccination and Pap test data, was a world first. It showed that a population-based HPV vaccination program has produced a fall in cervical abnormalities within 5 years of its start.

MBS and the Australian Cancer Database

MBS data on 680,000 computerised tomography (CT) scans were linked to the Australian Cancer Database. This showed that exposure to CT scans in childhood increased the incidence of cancer.

Diabetes care outcomes

This pilot study involved linkage across a range of health data sources to evaluate whether new models of care deliver better quality outcomes for people with diabetes than existing practices. The study enabled several evidence-based recommendations to be developed around the integration of diabetes care and funding mechanisms.

Sources: AIHW 2014, 2016, 2016d; McKinsey and Company 2011.

Major gaps in health and welfare data

Filling data gaps

In the context of health and welfare data gaps, several themes have been identified in recent years. These include gaps in:

- the availability of prevalence data (for example, users of primary health care, and Australians who experience child abuse and neglect)
- the ability to measure meaningful outcomes for people who receive health and welfare services
- the ability to measure and track unmet demand for services
- the availability of data to measure pathways and transitions within and across different service types and across jurisdictions (AIHW 2013, 2015).

Statistical agencies work closely with data users to give priority to filling data gaps across a range of data sources. The broader accessibility of data gives governments the chance to engage with stakeholders more widely and meaningfully than ever before to better ascertain and meet their needs. For example, gaps in information collected at the local level can be determined (along with strategies to fill them) by communicating directly with Primary Health Networks and sharing relevant data with them. This strategy will allow researchers and policy experts to better target groups of interest. It will also enable them to adapt their approaches to produce much more meaningful, outcomes-based information.

Data linkage has enormous potential, but much more needs to be done to fully exploit its benefits. Data gaps in relation to services and outcomes for people with disability provide one example of these potential opportunities, and the challenges faced (Box 1.7.2).

Box 1.7.2: Filling data gaps in the disability sector

People with disability may access a range of specialist disability and mainstream health and welfare services. The creation of the National Disability Insurance Scheme (NDIS) and its subsequent national rollout highlights the opportunity and challenges of producing person centred data about services used by people with disability.

Currently, disability services data are collected at a jurisdictional level. They are collated from state/territory and Australian Government data sources via the National Disability Services National Minimum Data Set (DS NMDS). This data set provides an annual breakdown of people who access specialist disability services funded by Australian and state/territory governments. Information collected includes the characteristics and care needs of people with disability, the type and nature of support provided to them, and the mix of services they have received over the year.

The creation of the NDIS provides a chance to capture more comprehensive and meaningful data about people with disability (including outcomes) as they shift to the new model of service delivery. During the transition period, National Disability Agreement service users will continue to be captured in the DS NMDS.

The challenge from a national data perspective will be, firstly, how to capture important data about people who are ineligible for the NDIS once the rollout is complete. Then it will be a question of how best to fill long-standing gaps in available data on the use of mainstream health and welfare services by people with disability.

Future opportunities

The rapid growth in digital data will continue to accelerate. How to make optimal use of this huge and increasingly unstructured source of information is a major challenge. But it also presents an opportunity to develop better ways to analyse and present data, and to partner with a wider range of collaborators. These are issues yet to be fully dealt with. It will be an iterative process, as the full extent of how data will be used in the coming decades cannot be envisaged. Ensuring that data are used as effectively as possible will require a mix of leadership, trust and openness at all levels of government and beyond.

Where do I go for more information?

Latest news and resources on Australia's public data agenda can be found on the Department of the Prime Minister and Cabinet's Public Data web page. Currently available public data sets are also accessible via http://data.gov.au.

More information on Australia's key longitudinal data sets is available via the Department of Social Services' National Centre for Longitudinal Data.

Further information on the AIHW's data linkage program, including information for prospective researchers, can be found on the AIHW website data linking page, or by contacting the AIHW Data Integration Services Centre (linkage@aihw.gov.au).

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Chapter 2

Children, youth and families

2.0 Introduction

How a family functions—and its social and demographic characteristics—are critical to the health and wellbeing of its members. The adversity faced by many families in Australia can be profound and have widespread repercussions. Challenges might be to secure housing tenure or employment, access social services and support, achieve financial security, develop parenting skills or deal with family conflict and violence. The effects (both positive and negative) on children and young people of their family relationships and interactions, school performance and social interactions, and whether they are safe from harm can be lifelong.

This chapter opens with a discussion of key national statistics in early childhood education and care—both of which play a crucial role in child development. Over three-quarters of 4 year-olds (77%) are enrolled in a preschool program in Australia and nearly half of all children aged under 13 attend some type of child care. The majority of children are 'on track' developmentally when they start primary school, but about 1 in 5 are vulnerable on one or more developmental domains.

This chapter highlights the importance of providing a stable and secure home for the 46,500 children in statutory out-of-home care. About three-quarters of the almost 31,000 children who had been continuously in care for 2 or more years as at 30 June 2016 had experienced more than one placement in their most recent episode of care.

Two groups of vulnerable young Australians are profiled—children in child protection and young people in the youth justice system. Young people who become involved in the youth justice system are more likely than the general population to have been homeless and been under child protection. They are also at risk of continued and more serious involvement in the criminal justice system later in life. Nearly 5,500 young people aged 10 and over are under supervision on an average day in Australia, though that number has fallen over the past 5 years. Despite this, males, Indigenous young people, and young people from low socioeconomic areas continue to be over-represented in youth justice.

This chapter concludes with a feature article that examines family, domestic and sexual violence in Australia. This is an area of heightened community concern and a key priority for all levels of government in Australia. About 1 in 6 Australian women have experienced physical or sexual violence from a current or former cohabiting partner, compared with around 1 in 19 men.

2.1 Children in child care and preschool programs

Early childhood education and care plays an important role in a child's cognitive and social development and supports the workforce participation of parents. Participation in early childhood education programs has been found to improve school readiness, expressive and receptive language, and positive behaviour for all children (Urbis Social Policy 2011). In Australia, early childhood education services are provided by government and non-government organisations in a range of settings, including kindergartens, preschools and child care centres (ABS 2015). Child care can be broadly categorised as either formal or informal (Box 2.1.1).

An early childhood education and care service may offer more than one service type. The most common type of integrated service is preschool delivered within a long day care centre.

Box 2.1.1: Formal and informal child care

Formal child care is regulated care away from the child's home. It is primarily provided to children aged 0–12 through five models:

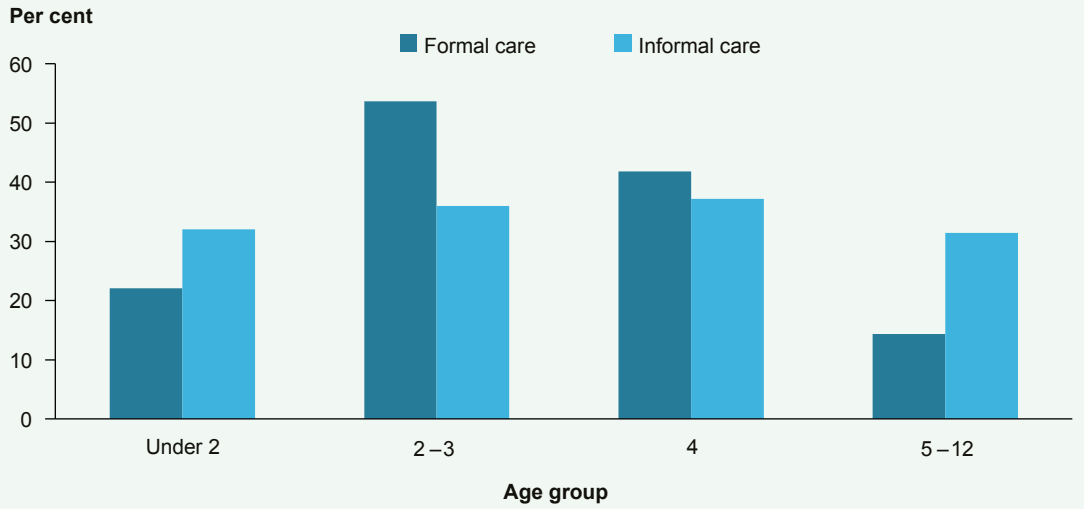
- long day care
- family day care
- occasional care
- outside school-hours care
- preschool.

Informal paid or unpaid care is non-regulated care that is arranged by a child's parent or guardian, either in the child's home or elsewhere (ABS 2015). It comprises care by:

- grandparents
- (step) brothers or sisters
- other relatives (including a parent living elsewhere).

Children in child care

In 2014, 48% (or 1.8 million) of all children aged 0–12 usually attended some type of child care (Box 2.1.1), a decrease from 52% in 2011; 52% 'did not usually attend any care' in 2014. Patterns of use of formal and informal care varied by age. Under the age of 2, 22% of children 'usually attended formal child care' and 32% 'usually attended informal child care'. The highest level of overall care attendance was among 2- and 3-year-olds, of whom 54% usually attended formal child care and 36% attended informal child care (Figure 2.1.1).



Source: ABS 2015.

Figure 2.1.1: Children aged 0–12 who usually attended child care, by care type and age group, 2014

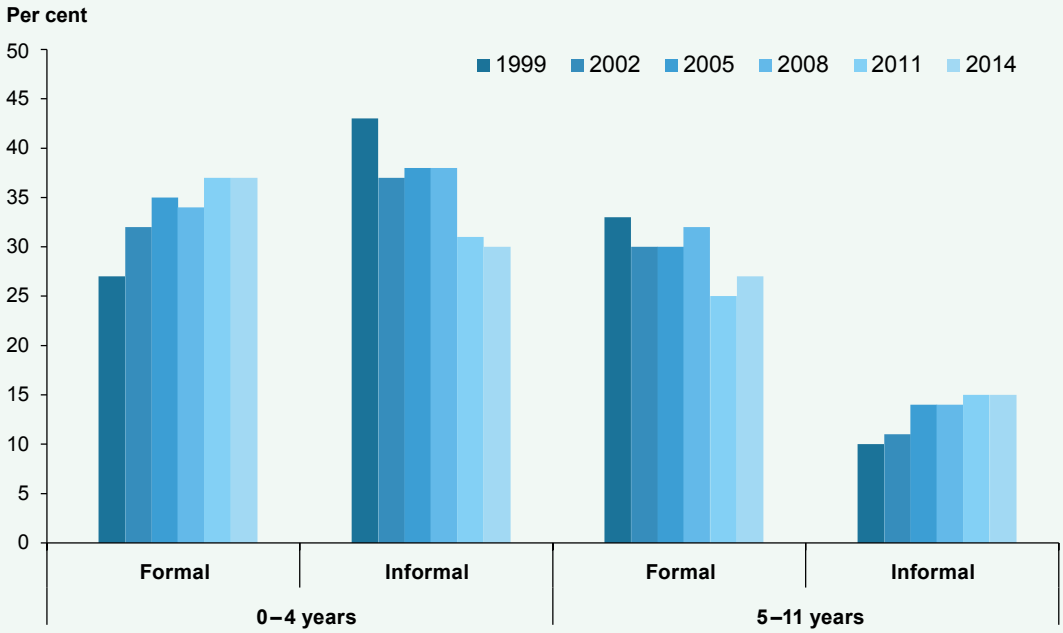
Trends in formal and informal care

Between 1999 and 2014, there was an increase in the proportion of children attending formal care, and a decrease in children being cared for by relatives. This was particularly the case for 0–4-year-olds:

- In 2014, 37% of children aged 0–4 attended formal child care—an increase from 27% in 1999. This period saw an increase in young children attending long day care (from 18% to 31%).
- The proportion of 0–4-year-olds receiving informal care (for example from grandparents or other relatives) decreased between 1999 and 2014, from 43% to 30% (Figure 2.1.2).

For 5–11 year olds, the increase in formal care between 1999 and 2014 was mostly due to an increase in children attending before and/or after school care—up 63%, from 8% to 13% (ABS 2015).

Grandparent care has been the most dominant type of informal care since 1999. In 2014, almost 1 in 4 (23%) 0–4-year-olds and 1 in 6 (16%) 5–11-year-olds were cared for by their grandparents (ABS 2015).



Notes

1. Due to changes in data collection, time series data are not available for (a) type of care attended last week and (b) for children aged 0–11.
2. Formal care does not include preschool for time series analysis.
3. Some children attend both formal and informal care and will be counted in each sector.

Source: ABS 2015.

Figure 2.1.2: Proportion of children aged 0–4 and 5–11 in child care services, by care type—1999, 2002, 2005, 2008, 2011, and 2014

Family characteristics and care type

The proportion of children attending formal child care was similar for children in couple or one parent families (24% and 23%, respectively) (ABS 2015). In 2014, children in one-parent families were more likely to attend informal child care (44%) than children in couple families (30%). Grandparents were the most common source of informal child care (23% in one parent families and 22% in couple families) in 2014 (ABS 2015).

The employment status of children's parents and the composition of their family appear to influence the use of child care. Sixty per cent (60%) of children in couple families where both parents were employed attended child care—32% attended formal care and 40% attended informal care (children could attend more than one type of care). In one-parent families with the parent in employment, 72% of children aged 0–12 attended some type of care—29% attended formal care and 57% attended informal care.

Preschool participation

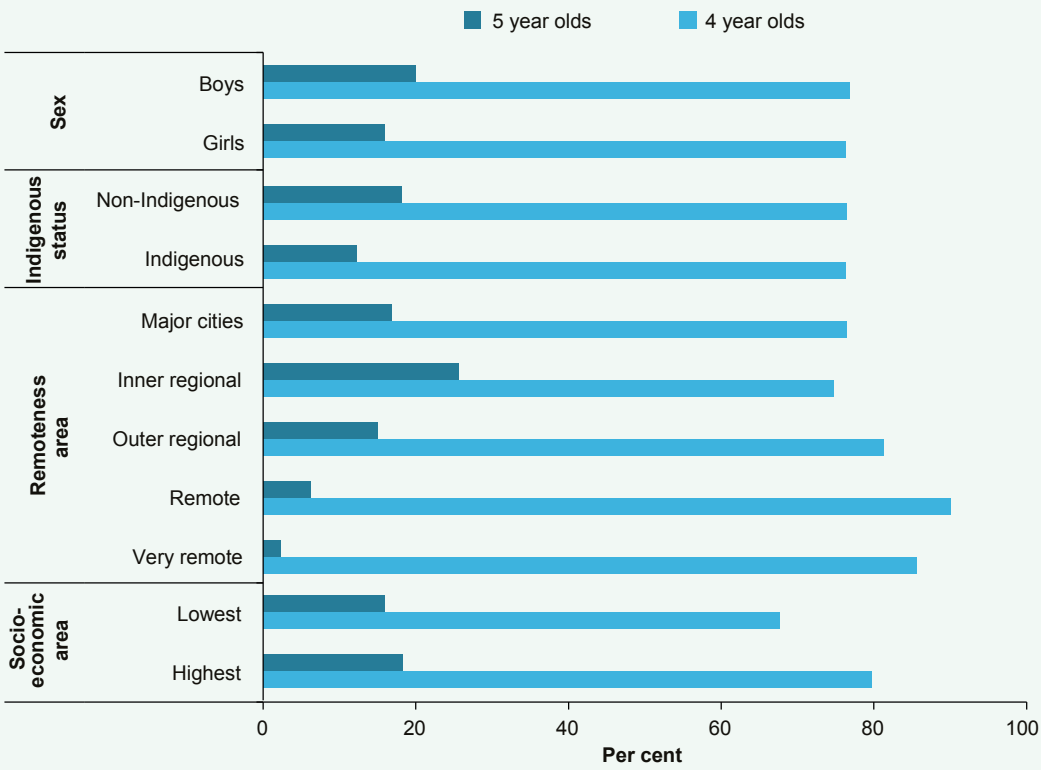
An early childhood education or preschool program is defined as a program delivered in the year before full-time school (YBFS) in a diversity of settings, including long day care centres, stand-alone preschools and preschools that are part of schools. The program is to provide structured, play-based early childhood education delivered by a qualified early childhood teacher in accordance with the Early Years Learning Framework and the National Quality Framework. Preschool programs are tailored to meet the learning needs of younger children.

Since 2008, the Australian Government has provided more than $2.8 billion to assist states and territories achieve universal access to quality early childhood education programs through a series of National Partnership Agreements on Universal Access to Early Childhood Education.

Universal access aims to ensure that all children participate in a quality, early childhood education program in the YBFS, with a focus on participation by Indigenous, vulnerable and disadvantaged children. The program is delivered for 600 hours per calendar year (or 15 hours per week for 40 weeks). Participation in a quality program is a major first step in laying the foundations for future learning, including children's school readiness and transition to full time school, as well as future school success.

In 2016, more than 297,000 children were enrolled in a preschool program in the YBFS (Figure 2.1.3). Of these children, around 243,000 were aged 4, and nearly 55,000 aged 5—representing 77% of all children aged 4 and 18% of all children aged 5. Of all these children, almost 15,000 were Aboriginal and Torres Strait Islander children (76% of Indigenous 4-year-olds and 12% of Indigenous 5-year-olds)(ABS 2017).

Children in couple families were more likely to have participated in a preschool or preschool program (88%) if one or both parent(s) were employed, compared with neither parent being employed (45%). Of children in couple families with one parent employed, 86% attended a preschool or a preschool program. In one-parent families, around three-quarters of children participated in a preschool or a preschool program whether the parent was employed or not (75% and 76%, respectively). More than 1 in 4 preschool program enrolments in Australia were free of fees and over half had out-of-pocket costs ranging between $1 and $4 per hour, on average. Children participated in a preschool for an average of 15 hours per week at an average cost to parents and guardians of $65 per week (ABS 2015).



Source: AIHW analysis using ABS TableBuilder. Source data in TableBuilder was ABS cat. no. 4240.0.55.003—Microdata: preschool education, Australia, 2016.

Figure 2.1.3: Proportion of children aged 4 and 5 participating in a preschool program in the YBFS, by sex, Indigenous status, remoteness area and socioeconomic area, 2016

What is missing from the picture?

While there are data available on the number of enrolments, there are limited reliable data available on actual attendance rates in preschool programs. Data on attendance are collected in the labour force survey during one week of the year, which may not represent the attendance patterns across the year.

Information about the working arrangements used by parents to help care for their child was not available for parents who were out of scope of the labour force survey for any reason (for example, parents who were members of the permanent Defence Force were not included in the survey).

More work needs to be done to evaluate the effectiveness of preschool programs and to investigate ways to increase participation in programs for vulnerable and at-risk children who stand to gain the most from quality preschool.

Data on unmet demand for child care are scarce, including information on reasons for being inaccessible, how long parents are waiting to access child care, and the region where additional care is required. As well, very few child care centres operate outside traditional working hours, and the impact on families who work unusual hours or shift work and require child care is unknown.

Where do I go for more information?

More information on early childhood education is available at www.education.gov.au and www.abs.gov.au. Information on payments available to families can be found on the Department of Human Services website: www.humanservices.gov.au.

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2.2 Transition to primary school

The transition from early childhood education to primary school is a time of potential challenge and stress for children and families. Evidence suggests that children who have a positive start to school are likely to engage well and experience success later in life (Farrer et al. 2007). This transition involves not only how children move into and adjust to new learning environments but also how families and schools interact and cooperate. These are all interlinked for building competencies and preparedness in children, schools and families. The starting age for the first year of school varies between 5 and 6 years across the states and territories.

This article provides an overview of 'school readiness'. It focuses on whether children are developmentally on track, at risk or vulnerable, based on results from the 2015 Australian Early Development Census (AEDC) (Box 2.2.1).

Box 2.2.1: School readiness

The AEDC is a population measure that looks at how young children have developed by the time they start their first year of full-time school. The Australian Government delivers the AEDC in partnership with the states and territories, the Centre for Community Child Health and the Telethon Kids Institute, to examine how young Australian children have developed as they start their first year of full time education.

The AEDC data are collected using a validated instrument to assess development in 5 broad areas (domains): physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge. The AEDC measure of school readiness is defined as the proportion of children developmentally on track on 4 or more (of the 5) domains. School readiness has been demonstrated as a strong predictor of a child's later literacy, numeracy and other cognitive and behavioural outcomes (AEDC 2015).

In the first data collection cycle in 2009, cut-off scores were set for each of the 5 domains:

- children falling below the tenth percentile were categorised as 'developmentally vulnerable'
- children falling between the tenth and twenty-fifth percentile were categorised as 'developmentally at risk'
- all other children were categorised as 'developmentally on track'.

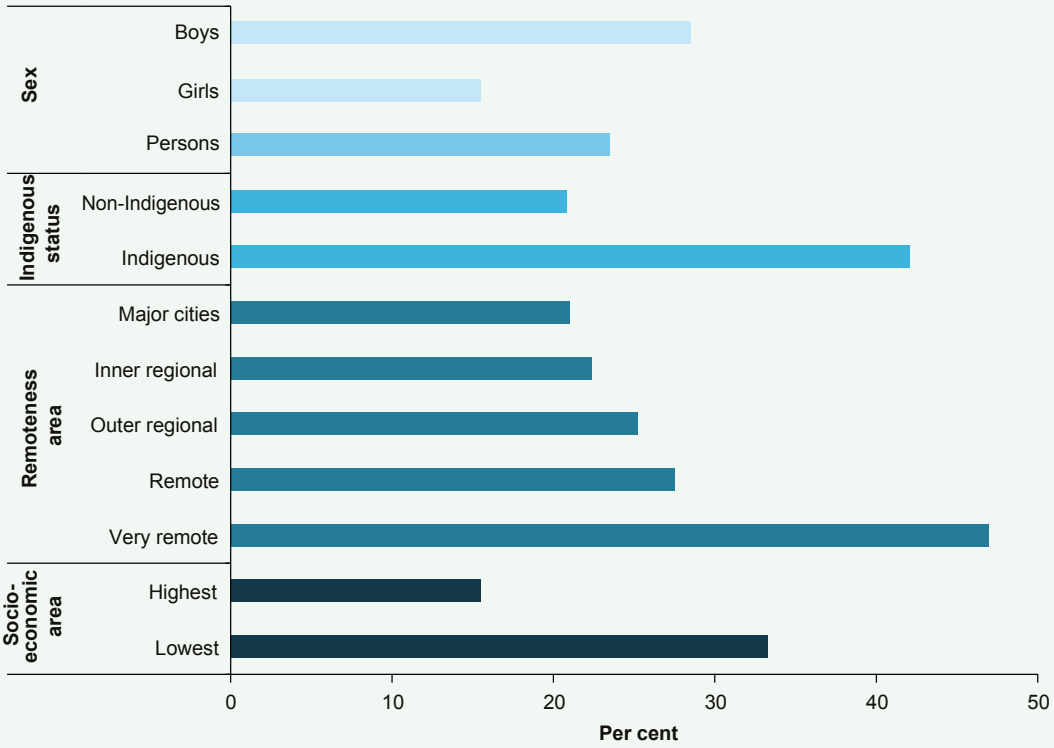
The cut-off scores set in 2009 provide a reference point against which later AEDC results can be compared. These have remained the same across the three collection cycles

Source: AEDC 2016.

Developmental vulnerability

In 2015, 22% of Australian children entering primary school (around 63,000 children) were assessed as vulnerable on 1 or more domains (with 11% vulnerable on 2 or more). The proportions of children assessed as developmentally vulnerable were similar for the social competence (9.9%), emotional maturity (8.4%), communication skills and general knowledge (8.0%), and physical health and wellbeing (9.7%) domains. A smaller proportion of children were considered vulnerable in the language and cognitive skills domain (6.5%).

- In 2015, a higher proportion of boys (29%) were developmentally vulnerable on 1 or more domains than girls (16%) (Figure 2.2.1).
- Developmental vulnerability on 1 or more domains among Indigenous children dropped over the three censuses, from 47% in 2009, to 43% in 2012, and 42% in 2015. It also fell among children with a language background other than English, from 32% in 2009, to 30% in 2012, and 28% in 2015 (AEDC 2016).
- Children living in the lowest socioeconomic areas were around twice as likely to be developmentally vulnerable on 1 or more domains than children living in the highest socioeconomic areas (33%, compared with 16%) (Figure 2.2.1).
- Results differed by state and territory. For example, 37% of Northern Territory students (1,200 students) were vulnerable on 1 or more domains compared with 20% of New South Wales students (18,400) (AEDC 2016).



Source: AEDC 2016.

Figure 2.2.1: Proportion of children assessed as developmentally vulnerable on 1 or more AEDC domain, by sex, Indigenous status, remoteness area and selected socioeconomic areas, 2015

Overall, the proportion of developmental vulnerability reduced between 2009 and 2012. There has been a small decrease in the proportion of children developmentally vulnerable on 1 or more domains (from 24% in 2009 to 22% in 2012) and the proportion of children developmentally vulnerable on 2 or more domains (from 12% in 2009 to 11% in 2012). The proportion vulnerable on 1 or more domains remained stable in 2015, at 22% (AEDC 2016).

Of the 5 domains, the proportion of children who were developmentally vulnerable increased in 2 of the domains between 2009 and 2015.

- The proportion of children who were developmentally vulnerable on the social competence domain increased from 9.5% in 2009 and 9.3% in 2012 to 9.9% in 2015. This change was more pronounced in larger jurisdictions.
- The proportion of children developmentally vulnerable in physical health and wellbeing increased from 9.4% in 2009 to 9.7% in 2015.
- After decreasing from 8.9% in 2009 to 7.6% in 2012, the proportion of children vulnerable in the emotional maturity domain increased to 8.4% in 2015.
- Improvements have been made in children's communication skills and general knowledge, with 8.5% of children developmentally vulnerable on 1 or more domain in 2015—a decrease from 9.0% in 2012 and 9.2% per cent in 2009.
- Gains have also been made in children's language and cognitive skills in 2015 (6.5%), with a decrease in developmental vulnerability from 6.8% in 2012 and 8.9% in 2009 (AEDC 2016).

What is missing from the picture?

Recently the AEDC was linked with the Longitudinal Survey of Australia's Children. Targeted research projects using this data asset would allow examination of the long-term outcomes of early developmental vulnerabilities. Further linking these data with early intervention data could potentially show the most effective ways to ameliorate these vulnerabilities. Establishing data linkage protocols similar to those produced via the numerous SA–NT Datalink projects (https://www.santdatalink.org.au/) could enable greater use of matched data to follow long-term outcomes.

Where do I go for more information?

More information on transition to school in Australia, along with other childhood health, development and wellbeing indicators, is available as part of the Children's Headline Indictors at www.aihw.gov.au/chi/. The now discontinued report, *A picture of Australia's children 2012*, is also available for free download at the AIHW website.

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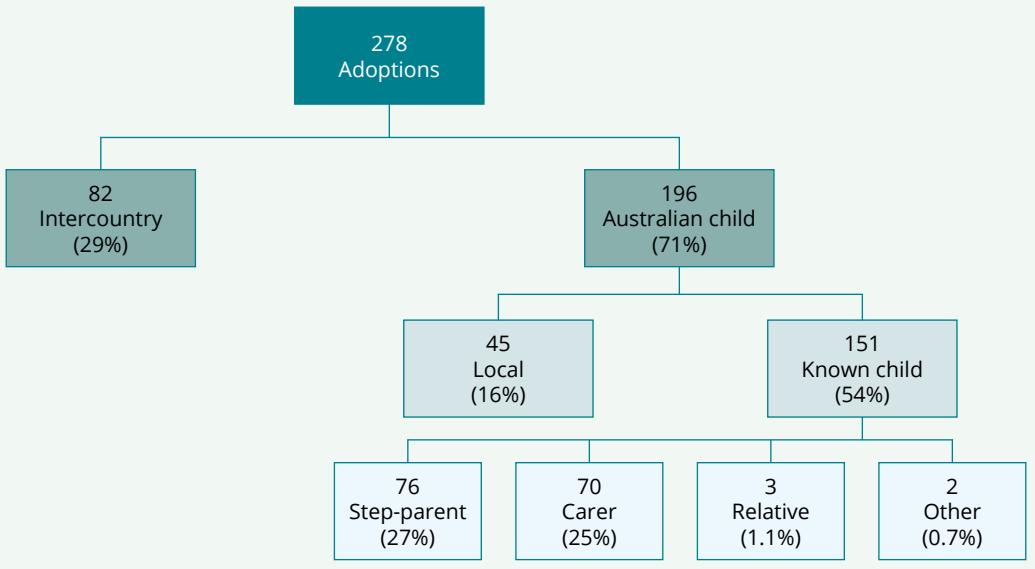
2.3 Adoptions

Adoption is one of the options used to provide permanent care for children not able to live with their families. It is a process where full parental rights and responsibilities for a child are legally transferred from the child's parent/s to his or her adoptive parent/s. Other options for permanent care include long-term care and protection orders (see Chapter 2.5 'A stable and secure home for children in out-of-home care').

Types of adoption

There were 278 adoptions in Australia in 2015–16. An adoption of an Australian child can be either a 'known child adoption' (where the child and the adoptive parent/s were previously known to each other) or a 'local adoption' (where the child and the adoptive parent/s are not known to each other). Children can also be adopted from overseas—an intercountry adoption (Figure 2.3.1). Generally, with intercountry adoptions, the child and the adoptive parent/s are not known to each other.

Among Australian children, there were 151 known child adoptions and 45 local adoptions in 2015–16. Most known child adoptions were by step-parents and foster carers (27% and 25% of all adoptions, respectively). In 2015–16, there were 82 intercountry adoptions, 90% of which were from Asian countries.



Note: Per cents may not add to totals due to rounding.

Figure 2.3.1: Adoptions in Australia, 2015–16

Trends in adoption

Adoptions have declined by 74% over the last 25 years, from 1,052 in 1991–92 to 278 in 2015–16 (Figure 2.3.2). Similar declines have occurred for both Australian child and intercountry adoptions (73% and 76%, respectively). Known child adoptions represent an increasing proportion of all adoptions, as the overall number of adoptions continues to fall. They accounted for 54% of adoptions in 2015–16, compared with 18% in 2006–07. Within known child adoption, adoption by carers (such as foster parents) rose from 21% in 2006–07 to 46% in 2015–16, while step-parent adoption fell from 76% to 50% over the same period.

These changes are due to a complex interplay of factors. These include views on the circumstances in which adoption might be considered appropriate, and the availability of both contraception and legalised abortion, and financial support for single parents. They also include increasing labour force participation of women, reproductive innovations, and efforts to improve the outcomes for children in out-of-home care through alternative legal orders or adoption by carers. Similarly, economic and social changes have enabled children who might otherwise have needed intercountry adoption to remain with their family or be adopted in their country of origin.

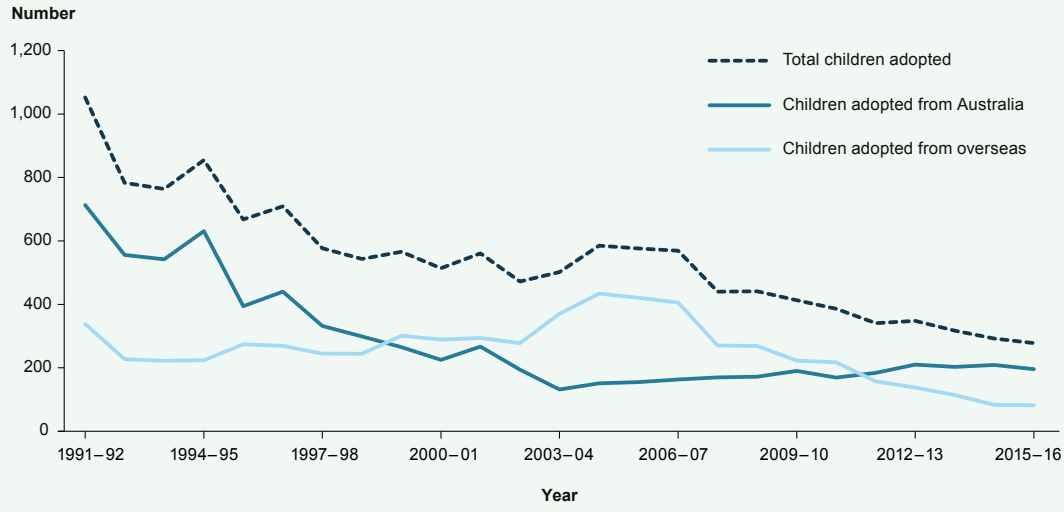


Figure 2.3.2: Number of children adopted in Australia, 1991–92 to 2015–16

Characteristics of adoptees and adoptive parents

In 2015–16, 3 in 5 (60%) adopted children were boys. The difference was more pronounced among children aged under 10 (63% boys), than children 10 and over (55%). The age profiles of adoptees also varied by type of adoption—100% of local adoptees, 71% of intercountry adoptees and 8.6% of known child adoptees were aged under 5. For intercountry adoption, the proportion of infant (aged under 12 months) adoptions declined from 47% in 2005–06 to 8.5% in 2015–16.

The majority of intercountry adoptions in Australia have consistently been from Asia, in line with global adoption trends. In 2015–16, 90% of intercountry adoptions were from Asian countries. The most common countries of origin were the Philippines (24% of intercountry adoptions), Thailand (22%), Taiwan (20%) and South Korea (17%). The main country of origin has changed over time, from China or the Philippines between 2005–06 and 2009–10, to Taiwan or the Philippines since.

The characteristics of adoptive parents also varied with the type of adoption. In 2015–16, 48% of local adoptive parents and more than 80% of intercountry adoptive parents were aged over 40. This proportion increased from 62% in 2006–07 for intercountry adoptive parents but has remained largely unchanged for local adoptive parents (47% in 2006–07).

What is missing from the picture?

Little is known in Australia about the long-term outcomes of adoptions, including the proportion of adoption disruption (breakdown between placement and legal finalisation of adoption) or legal dissolution of adoptions over time.

Data on expatriate adoptions (when an Australian living abroad for 12 months or more adopts a child through an overseas agency) and known child intercountry adoptions (where the child and adoptive parent/s are previously known to each other) are also limited. These types of adoptions are generally excluded from the data for intercountry adoptions described in this section.

Where do I go for more information?

More information on adoption in Australia is available on the AIHW website www.aihw.gov.au/adoptions/. The report *Adoptions Australia 2015–16* is also available for free download.

2.4 Child protection

In Australia, statutory child protection is the responsibility of state and territory governments. Departments responsible for child protection assist vulnerable children who are suspected of being abused, neglected or harmed, or whose parents are unable to provide adequate care or protection.

Children receiving child protection services

Children may receive a combination of child protection services, including 'investigations', 'care and protection orders', and 'out-of-home care'. Investigations can lead to 'substantiations' if there is sufficient reason to believe that a child has been, or is at risk of being, abused, neglected or harmed. Definitions of key terms are available in the Glossary.

In 2015–16:

- About 162,200 (or **1 in 33**) **Australian children** aged 0–17 **received child protection services**.
- **Children receiving child protection services were most likely to be infants** under the age of 1 (38 per 1,000 children) and were least likely to be aged 15–17 (21 per 1,000).
- **Almost three-quarters** (73%) of children receiving child protection services were **repeat clients**. This means that they had previously been the subject of an investigation or were discharged from a care and protection order or a funded out-of-home care placement.
- **Three in 5** (60%) children receiving child protection services **were subject to an investigation only**; that is, their cases had been, or were in the process of being, assessed to determine whether further intervention was required.

Substantiations

In 2015–16, around 45,700 children were the subject of a substantiation—an increase of 21% over a 5-year period, from about 37,800 in 2011–12. The rate at which children were subject to a substantiation rose from 7.4 per 1,000 children in 2011–12 to 8.5 per 1,000 in 2015–16 (Figure 2.4.1).

Emotional abuse was the most common primary type of abuse or neglect substantiated (45%), followed by neglect (25%), physical abuse (18%) and sexual abuse (12%).

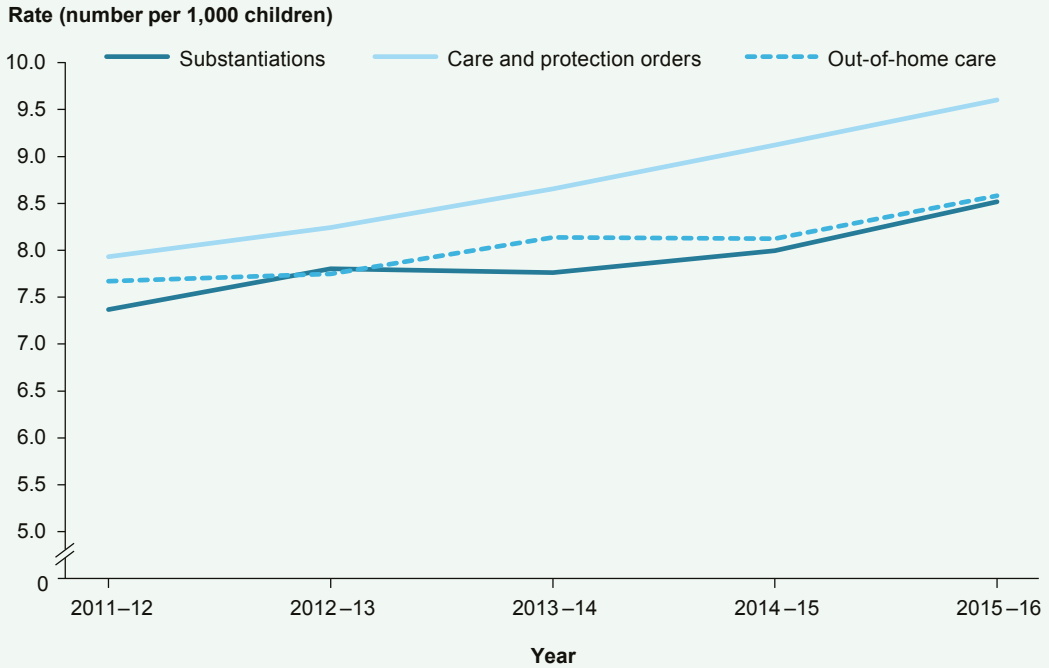
Care and protection orders

About 52,000 children were on care and protection orders as at 30 June 2016—an increase of 27% from around 41,000 as at 30 June 2012. The rate of children on care and protection orders increased over the 5 years to 30 June 2016, from 7.9 to 9.6 per 1,000 children (Figure 2.4.1). Two-thirds (64%) were on finalised guardianship or custody orders (most of which were long term), 19% of children were on third-party parental responsibility orders (again mostly long term), 12% were on interim and temporary orders, and 5.2% were on other types of orders.

Out-of-home care placements and carers

As at 30 June 2016, there were about 46,450 children in out-of-home care—an increase of 17% from 39,600 as at 30 June 2012. There were 7.7 children in out-of-home care per 1,000 children as at 30 June 2012, which rose to 8.6 per 1,000 as at 30 June 2016 (Figure 2.4.1; see also Chapter 2.5 'A stable and secure home for children in out-of-home care').

The vast majority (94%) of children in out-of-home care were in home based care—39% in foster care and 49% in relative/kinship care.



Note: The rates of children who were the subject of substantiation are based on during the year counts, while the rates of children on care and protection orders and in out-of-home care are based on counts as at 30 June.

Figure 2.4.1: Rates of children who were the subject of substantiations, were on care and protection orders or were in out-of-home care, 2011–12 to 2015–16

Some groups are over-represented

Compared with non-Indigenous children, Aboriginal and Torres Strait Islander children were:

- 7 times as likely to be the subject of substantiations
- 9 times as likely to be on care and protection orders
- 10 times as likely to be in out-of-home care.

Compared with children living in *Major cities*, children in combined *Remote* and *Very remote* areas were:

- 4 times as likely to be the subject of substantiations
- 2 times as likely to be in out-of-home care.

What is missing from the picture?

The AIHW is continuing work to enhance national child protection reporting in priority areas identified under the *National Framework for Protecting Australia's Children 2009–2020* (COAG 2009). These efforts include improving data on disability status and cultural and linguistic diversity, and linking to other data sets to measure the health and welfare outcomes for children receiving child protection services. All data which are currently lacking or of unusable quality.

Where do I go for more information?

More information on child protection in Australia is available at www.aihw.gov.au/child-protection/. The report *Child protection Australia 2015–16* is also available for free download at the AIHW website.

Reference

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2.5 A stable and secure home for children in out-of-home care

Some children are not able to live in safety and security with their parents. There are several reasons for this. It may be that children have been, or are at risk of being, abused or neglected and need a more protective environment. It may be that parents are incapable of providing adequate care for them, or that alternative accommodation is needed during times of family conflict. When these situations occur, state and territory departments responsible for child protection may intervene and place children in out-of-home care.

Out-of-home care is overnight care for children aged 0–17, where financial support from state or territory departments responsible for child protection is given or offered to the carer. It can include kinship care (provided by relatives of the child), foster care, family group homes and residential care. During 2015–16, more than 55,600 children (10.4 per 1,000 children) were supported in out-of-home care placements (AIHW 2017). More than one-third (36%) of all children in out-of-home care as at 30 June 2016 were Aboriginal and Torres Strait Islander children and more than half (52%) were boys (AIHW 2017). The number of children in out-of-home care across Australia has increased considerably over recent years—overall, 5,300 more children were in out-of-home care in 2015–16 than in 2012–13 (an increase of 11%) (AIHW 2014, 2017). For more information on child protection, see Chapter 2.4 'Child protection'.

Social and economic impact

The social and economic costs associated with out-of-home care are substantial. There is the personal cost for children and their families. There is also a sizable cost to the community, in providing child protection services at the state and territory level ($4 billion in 2015–16, see Box 2.5.1) and welfare and other services related to the long-term poorer outcomes for many children who have been in care.

Research shows that negative experiences in early life (including child abuse and neglect) increase the likelihood of developmental delays and of difficulties with learning, memory and self regulation (Center on the Developing Child at Harvard University 2016; McLachlan et al. 2013). This can have longer term impacts on health and wellbeing and on a person's ability to be a productive member of society—representing a substantial cost to government in terms of workforce participation, health care and social assistance (Kezelman et al. 2015; McLachlan et al. 2013). Box 2.5.1 presents the recurrent cost of out-of-home care in 2015–16 and recent estimates of the longer term costs associated with negative childhood experiences.

Box 2.5.1: Estimating the cost of abuse and neglect

- In Australia, the national recurrent expenditure on out-of-home care services alone was $2.7 billion in 2015–16—a real increase of $240.2 million (9.7%) from 2014–15 (SCRGSP 2017). The total cost of child protection, including out-of-home care services, was almost $4 billion.
- The longer term cost to government of negative family functioning was estimated to be $5.4 billion per year in 2010 (Access Economics 2010).
- The cost of unresolved trauma from physical, sexual and emotional abuse has been estimated at $6.8 billion per year (Kezelman et al. 2015).

The experience of out-of-home care has been shown to further affect the health and wellbeing of children unable to live with their parents. However, differences between children who experience abuse or neglect and who are later placed in out-of-home care and children who remain at home may contribute to this effect. These differences include the type and severity of the abuse or neglect experienced and socioeconomic characteristics (Berger et al. 2009).

Of particular concern are children who have extended periods in out-of-home care, and who may 'drift in care', moving between multiple home-based placements or between home-based and residential care (Strijker et al. 2008). These circumstances have been linked with negative outcomes in a range of areas, including:

- mental health and wellbeing (Leve et al. 2012; McGrath-Lone et al. 2015; Reilly 2003; Staines 2016)
- educational attainment (Leve et al. 2012; McGrath-Lone et al. 2015; Reilly 2003; Smith & McLean 2013; Staines 2016)
- access to suitable accommodation (Staines 2016)
- employment (Courtney et al. 2001; Reilly 2003; Staines 2016)
- life satisfaction and relational stability (Leve et al. 2012).

The negative outcomes may be severe and include:

- homelessness (Courtney et al. 2001; Reilly 2003)
- disproportionately high rates of substance abuse (Staines 2016)
- over-representation in youth justice systems (Courtney et al. 2001; Reilly 2003; Staines 2016)
- vulnerability to further abuse and violence (Courtney et al. 2001; Reilly 2003)
- premature death (McGrath-Lone et al. 2015).

The Prison Reform Trust in the United Kingdom reported recent findings that there had been little or no improvement in outcomes for children in care in recent years and this was compounded by placement instability (Staines 2016).

Young people who enter the income support system before the age of 18—in particular, young people leaving out-of-home care—are a group requiring support to prevent long-term dependence on income support (Reference Group on Welfare Reform 2015). Australia does not yet have comparable evidence of the outcomes for children in care or changes over time (see 'What is missing from the picture?' at the end of this article). Longitudinal data are critical to understand the outcomes for children in care and the efficacy of policies and systems to support them. Linkage of administrative data sets held by government agencies can maximise the information available to better understand the characteristics and pathways of disadvantaged groups (McLachlan et al. 2013).

Importance of a stable and secure home

Developing secure relationships, including those with non-parent carers, can mitigate or reverse negative outcomes such as those already mentioned (Center on the Developing Child at Harvard University 2016). This is because a 'child who has been subject to trauma and loss requires a deep, meaningful and sustained primary attachment relationship to heal' (McPherson & MacNamara 2014: 224). Therefore, a key aim for children in out-of-home care is to achieve a stable, long-term care arrangement. The processes that state and territory departments responsible for child protection take to achieve this goal are broadly termed 'permanency planning'.

The importance of permanency for children and young people in out-of-home care is widely recognised in Australia and internationally. The concept emerged in the United States in the 1970s, where there was increasing concern that children unable to live with their families were 'drifting in care', with multiple, unstable foster care placements over extended periods (Roth 2013).

In Australia, the impact of out-of-home care on children and young people, as well as the direct and indirect cost to the community, has been examined over many years in parliamentary inquiries, Council of Australian Governments (COAG) reforms and coronial inquests. In 2015, Australia's Senate Inquiry into Out-of-home Care (Senate Community Affairs References Committee 2015) showed heightened policy interest in providing ways to achieve long-term care, with safety of the child and stability of placement as prime objectives. The Inquiry concluded that placement stability and emotional security in the early years are critical to a child's development and important in securing positive outcomes (Senate Community Affairs References Committee 2015). It also recommended that a project be undertaken to develop a nationally consistent approach to legal forms of permanence—including guardianship orders and adoption—and to research improving access to those placements (Senate Community Affairs References Committee 2015).

In November 2016, Community Services ministers of Australian and state and territory governments agreed to develop a set of guiding principles to drive permanency arrangements for children in out-of-home care. These included a focus on permanency and stability, on the timeliness of permanent care decisions and on improving outcomes for Indigenous families and children. Further, it was agreed that reform efforts be directed toward improving consistency in permanent care arrangements across jurisdictions, and to investigating possible schemes for mutual recognition of the suitability of carers.

Permanency planning—what are the options?

Permanency planning, in the context of child protection, is defined as 'the process of making long-term care arrangements for children with families that can offer lifetime relationships and a sense of belonging' (Tilbury & Osmond 2006: 266). Permanency may be understood in terms of both the legal framework for individual care arrangements (for example, a care and protection order or an adoption order), and the actual placement stability achieved. It is important to note, however, that placement stability can occur without a long-term legal order and, conversely, that a long-term legal order does not necessarily result in placement stability.

Legal permanency

The legal framework of permanency is based on the orders that establish long-term care arrangements. For national reporting purposes, short-term care and protection orders (which anticipate reunification with the family) are for 2 years or less. Long-term orders seek to set continuity or stability of care, where the carer and the care arrangements are unchanged over an extended period, once safe reunification with the child's family has been ruled out. However, as noted, not all long-term orders provide placement stability in practice.

Placement stability

Placement stability refers to stability in both the care relationship and residential location. In general, the fewer placements a child has, the greater is his or her stability. However, measures of placement stability are confounded in the available national data by a number of factors. These include placement changes to enhance the child's wellbeing (including reunification attempts), respite provision, sibling co-location efforts, and attempts to find a 'forever home'. Achieving long-term care—particularly when the child is placed outside the kinship network—requires extensive planning. Considerable efforts are made to achieve a match between child and carer to increase safety and security, while reducing the risk of placement disruption.

Permanency planning in practice

There are jurisdictional differences in the approach and terminology used for child protection practices in Australia. Yet, some concepts, both in planning for permanency and in the actions taken to achieve long-term care arrangements, are shared (AIHW 2016c). These can be broadly grouped as:

- reunification with the family of origin
- long-term alternative care on third-party parental responsibility or guardianship/ custody orders
- adoption orders.

These three broad options have very different legal bases and practical outcomes (see Box 2.5.2).

Box 2.5.2: Options for achieving permanency

Reunification

Reunification is a planned process to safely return a child home after a period of time in care to be with their birth parent(s), family or former guardian (and enabling the child to stay); this occurs when it is in the child's best interests, and where it will safeguard his or her long-term stability and permanency (AIHW 2016c). By returning to the family of origin, the child may be deemed to have exited care. Parental rights and responsibilities may resume as normal, although in some cases a care and protection order can remain in place for a period.

Third-party parental responsibility orders

These orders transfer all duties, powers, responsibilities and authority (to which parents are entitled by law) to a nominated person(s) whom the court considers appropriate. The nominated person may be an individual, such as a relative, or an officer of the state or territory department (AIHW 2017).

Guardianship/custody orders

Guardianship orders involve the transfer of legal guardianship to the relevant state or territory department or non-government agency. Custody orders generally refer to orders that place children in the custody of the state or territory department responsible for child protection, or a non-government agency. These orders usually involve the child protection department being responsible for the daily care and requirements of the child, while the parent retains legal guardianship (AIHW 2017).

Guardianship or custody orders can be for specific periods. For national reporting purposes, these are classified as:

- **long-term orders:** transfer guardianship/custody until the child is 18. In some jurisdictions, this may also include orders for a specified period of more than 2 years
- **short-term orders:** transfer guardianship/custody for a specified 'short-term' period of 2 years or less.

Adoption orders

Adoption is a legal process involving the transfer of the rights and responsibilities for the permanent care of a child from the child's parent(s) to his or her adoptive parent(s). The legal relationship between the child and the parent(s) is severed and any legal rights that existed from birth regarding the birth parent(s), such as inheritance, are removed. The legal rights of the adopted child become the same as they would be if the child had been born to the adoptive parent(s) (AIHW 2016a).

Known carer adoption

This is adoption by the foster parent(s) or other non-relative(s) who has been caring for a child in out-of-home care, and been responsible for the daily care and control of the child for the period specified by the relevant state/territory department before the adoption (AIHW 2016c). (In some jurisdictions, adoption from care may not be viewed as part of permanency planning, or, while legally available, it may be rarely used in practice—in particular, for Indigenous children and young people.)

As well, due to the inherent uncertainties in securing permanency, dual planning processes are common. This is especially the case, given the critical importance of age considerations and the need to minimise delays in putting decisions into practice. Jurisdictions may plan for safe reunification while actively seeking to identify potential long-term alternative care.

Permanency planning is not a static process. Children may move from one care and protection order to another and/or from one placement to another. This may be due to efforts to find the most suitable long-term care, or to placement disruption. Further, children who have exited out-of-home care due to reunification or adoption may re-enter out-of-home care at a later stage. This would then require further consideration about how permanency may be achieved.

Challenges in achieving permanency

Children who have experienced abuse and neglect are one of the most vulnerable groups in the community (COAG 2009); those who are subsequently placed in out-of-home care have a broad range of needs (Bath 2015). Caring for these children can be particularly challenging, due to behavioural issues or additional needs arising from disability or developmental delay (Bath 2015; DHS 2016). Some children may also find it hard to form attachments with carers (Meredith Carter & Associates 2015). Carers may thus carry a greater burden of care when parenting children who are unable to live with their birth parents (DHS 2016; Meredith Carter & Associates 2015).

Permanency planning needs to be individualised and must consider all these issues, along with the child's age and whether siblings may be placed together (Murphy et al. 2012; Pritchett et al. 2013; Selwyn et al. 2014). However, permanency decisions also need to be timely; research indicates that a child's age—in particular, age at entry to care—is a strong predictor of placement disruption (Selwyn et al. 2014). The older a child is when adopted, the greater the likelihood of adoption breakdown (Unwin & Mişca 2013).

The challenges to achieving permanency for children in out-of-home care can result from a blend of barriers at the child, family and agency level (seen in 'crisis-driven placements') and difficulties in matching suitable carers with children who already experience health and behavioural issues (Thomson et al. 2016).

Kinship carers report stress, financial strain, health concerns and poor resources as common experiences, with problems compounded by lack of preparation and training (AIFS et al. 2015; Dunne & Kettler 2006; McPherson & MacNamara 2014). Agency level barriers within child welfare systems add to the challenges, including the complexity of processes and the availability of adequate supports and services for children and carers alike (Murphy et al. 2012).

Overall, the availability of out-of-home carers is declining, as the number of children entering care and the complexity of their needs increase (Fernandez 2014; Tregeagle et al. 2014). Together, these challenges potentially increase the average number of placements a child may experience, reflecting a lack of placement choices and the additional placement efforts required (Fernandez & Atwool 2013).

Who are the children needing long-term care?

Reunification (or safe return home) is the policy priority for children in out-of-home care across all states and territories. This will not be achieved for some children, so permanent alternative care arrangements will be needed.

Across all states and territories, policies for permanency planning indicate that children who have been in care for 2 or more years need a decision on their long-term care arrangements (AIHW 2016c) (see the Glossary for relevant out-of-home care definitions).

Almost 31,000 (67%) of the 46,500 children in out-of-home care as at 30 June 2016 had been continuously in care for 2 or more years (AIHW 2017). Of children who have been in 'long-term care' (that is, for 2 or more years):

most (70%) were aged between 5 and 14, with a median age of 10 (see Supplementary Table S2.5.1)

more than one-third (36%) were Indigenous (Table S2.5.2)

94% were living in home-based out-of-home care, including 43% with relatives/kin (Table S2.5.3)

almost three-quarters (74%) had experienced more than 1 placement in their most recent episode of care (Table S2.5.4).

What do we know about the level of permanency achieved for these children?

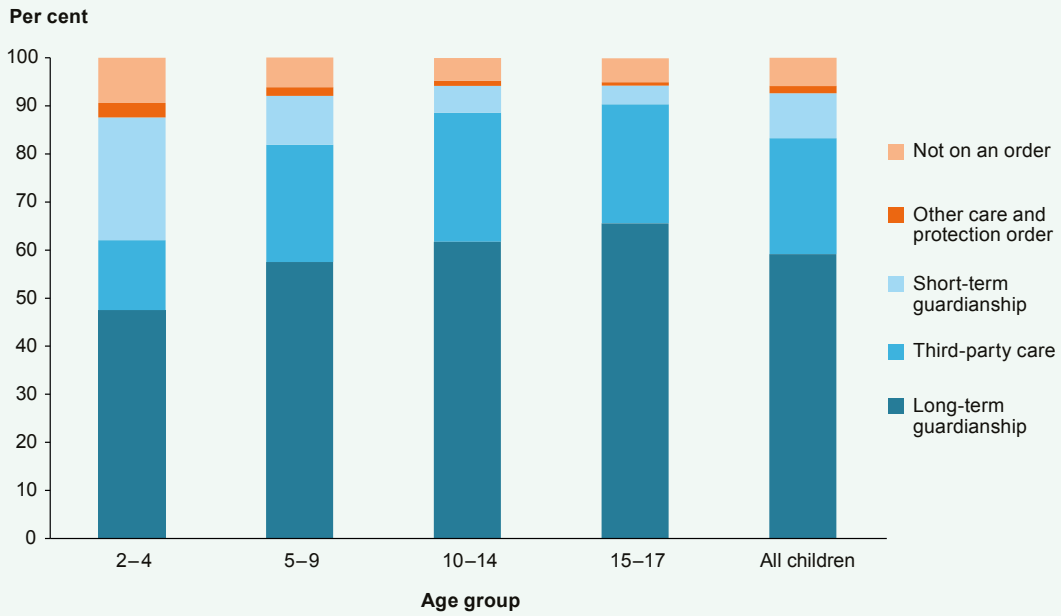
This section presents available data on the long-term care arrangements for children in out-of-home care, and adoption by known carers.

Children remaining in out-of-home care

The available data indicate that most children in out-of-home care for 2 or more years, including children who have had more than 1 care arrangement, achieved some level of stability of care, if not permanency.

Of the children who had been in care for 2 or more years, most (83%) were on a long-term care and protection order:

- one-quarter (24%) were in a third-party parental care arrangement—home-based care where parental responsibility had been transferred to the carer
- around three-fifths (59%) were on long-term finalised guardianship or custody orders (Figure 2.5.1).



Note: This figure includes only children who had been continuously in out-of-home care for 2 or more years as at 30 June 2016.

Source: AIHW Child Protection Collection 2016.

Figure 2.5.1: Children aged 2–17 in long-term out-of-home care, by legal arrangement and age group, 30 June 2016

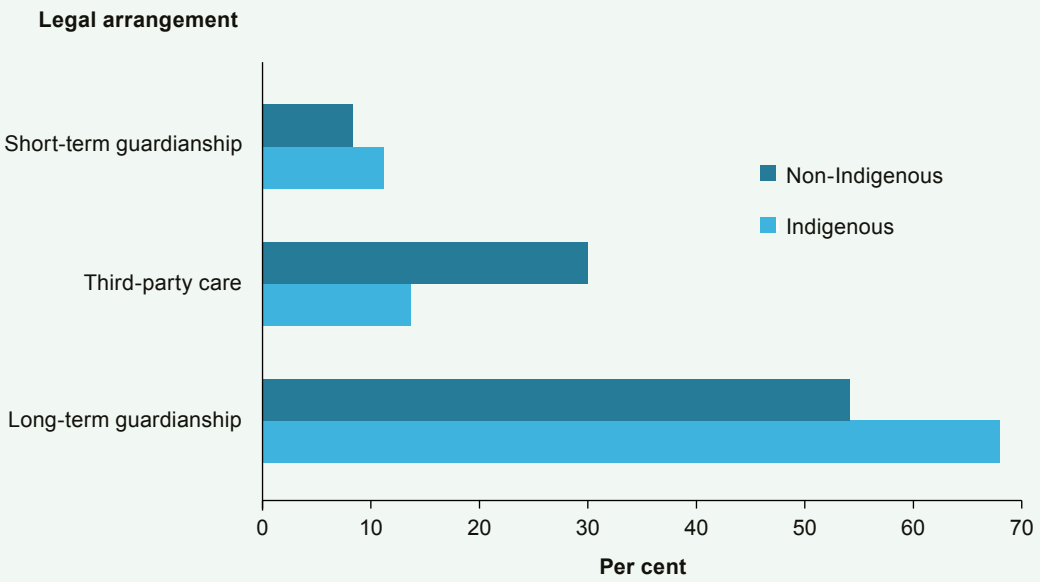
Similar patterns were generally seen across age groups. However, children aged 2–4 were less likely to be on a long-term third-party parental responsibility order and more likely to be on short-term guardianship/custody orders than older children. Young people aged 15–17 were more likely to be on a long-term guardianship order and living in residential care than other children (Table S2.5.5).

Most (88%) children on a long-term guardianship or custody order were living in home-based care with a foster or relative/kinship carer. A smaller proportion (8.1%) were living in residential care or family group homes (Table S2.5.6). Children living in home-based care (that is, in a family setting with a carer) are seen to have better developmental outcomes than children living in residential care with paid, rostered staff (AIFS et al. 2015; Cashmore 2011; DHHS 2014). Residential care may be used for children who have complex needs or to keep large sibling groups together.

Figure 2.5.2 shows that, when compared with non-Indigenous children, Indigenous children were:

- more likely to be on long-term guardianship/custody orders (68% compared with 54%)
- less likely to be in long-term third-party care arrangements (14% compared with 30%).

These findings may reflect a difference in approach to achieving permanency for Indigenous children. Permanence for Indigenous children does not rely on individual relationships but rather to belonging to, and being cared for in, extended family and kin networks; hence, placement with family and community should be considered before other permanent care arrangements (SNAICC 2016).



Notes

1. This figure includes only children who had been continuously in out-of-home care for 2 or more years as at 30 June 2016.
2. This figure excludes children for whom Indigenous status was unknown; children on supervisory, interim and other types of orders or who were on administrative arrangements; and children who were not on a care and protection order as at 30 June 2016.

Source: AIHW Child Protection Collection 2016.

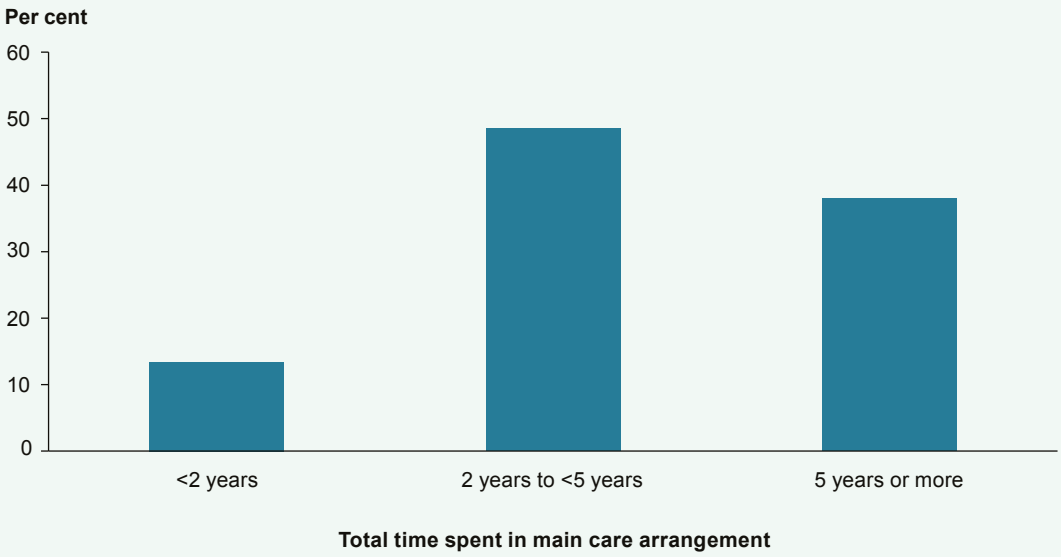
Figure 2.5.2: Children in long-term out-of-home care, by legal arrangement and Indigenous status, 30 June 2016

Most (87%) children who had been in care for 2 or more years had also spent at least 2 years in one main care arrangement (Figure 2.5.3).

This finding is based on the most recently available child protection data, which cover the 2 year collection period 2014–15 to 2015–16. These data include all placements that were open during this collection period, including those that began in a previous collection period. Therefore, time spent in each care arrangement can include time spent outside the 2 year collection period.

Multiple placements are generally viewed as representing instability for a child. However, in the national data, the higher number of placements that some children have experienced can also reflect:

- the use of regular respite care to support an existing long-term placement
- attempts to achieve a more permanent care arrangement (that is, a new placement with relatives/kin or other long-term carer)
- preparation for transition from care (for example, change in placement to independent living or residential care)
- shared care arrangements where children regularly spend a specified number of nights in more than one care arrangement.



Notes

1. This figure includes only children who had been continuously in out-of-home care for 2 or more years as at 30 June 2016.
2. For this analysis, 'main care arrangement' has been selected, based on the longest total duration (the sum of all care periods) spent in a care arrangement.
3. Time spent in the main care arrangement can include placements that began in a previous collection period and therefore can include time spent outside the 2-year collection period.

Source: AIHW Child Protection Collection 2016.

Figure 2.5.3: Children in long-term out-of-home care, by time spent in the main care arrangement, as at 30 June 2016

Views of children in out-of-home care

A recent survey of more than 2,000 children in out-of-home care indicated that 91% felt safe and settled in their current placement, 94% felt close to at least one family group (either the people they lived with, family members, or both) and 97% felt they had an adult who cared about what happened to them, now and in the future (AIHW 2016d).

Two longitudinal surveys currently underway in New South Wales and Victoria will also, in future, provide valuable insights into the experience of children and young people in out-of-home care.

New South Wales Pathways of Care longitudinal study

This large-scale longitudinal study is following a cohort of children and young people who entered out-of-home care for the first time ever between May 2010 and October 2011. Baseline information was collected at entry to out-of-home care and ongoing data are being collected on out-of-home care experiences and developmental wellbeing. These data include those on domains related to physical health, cognitive/learning ability, social–emotional wellbeing and safety. Data on their involvement in child protection, out-of-home care, health care, education and the justice system will be linked and matched to the survey results. The results of the study will be used to inform casework practice and enhance out-of-home care systems to improve outcomes for children in care (NSW FACS 2017).

Beyond 18 longitudinal study in Victoria

This is a study of young people who were aged 16–19 in 2015 and had spent time in out-of-home care in Victoria. Participants are asked to complete three surveys between 2015 and 2018 to document their views on being part of the child protection system and leaving care. Information collected will be related to their out-of-home care and life experiences, health, relationships and education. The study aims to improve the support provided to young people while they are in care, while they make the transition from care and after they leave care (AIFS & DHHS 2017).

Children adopted from out-of-home care

In Australia, 70 children were adopted from out-of-home care ('known carer' adoptions, see Box 2.5.2) in 2015–16. The number of 'known carer' adoptions rose between 2006–07 and 2014–15 (from 22 to 94), before falling to 70 adoptions in 2015–16 (see Chapter 2.3 'Adoptions') (Figure 2.5.4).

Source: AIHW Adoptions Australia data collection.

Figure 2.5.4: Known carer adoptions, 2006–07 to 2015–16

Australian jurisdictions differ in the extent to which they use adoption to achieve permanency for children in out-of-home care (AIHW 2016c; Box 2.5.2). The majority of carer adoptions were finalised in New South Wales, reflecting that state's policies for options to achieve stability.

The recent fall in known carer adoptions is due in part to the application of long-term guardianship orders to children in out-of-home care in New South Wales, from late 2014 (AIHW 2016a).

Placement stability in adoptions

Very little is known in Australia about placement stability in adoptions. Currently, the only Australian national data available are on intercountry adoptions at 12 months after placement of the child with the adoptive family (AIHW 2016a).

Disruption and dissolution of adoptions occur at different points in the adoption process but both result in either the child's return to (or entry into) out-of-home care or placement with new adoptive parents.

- Disruption is an adoption process that ends after the child is placed in an adoptive home but before the adoption is legally finalised.
- Dissolution is an adoption that ends after it is legally finalised.

Studies in the United States have reported disruption (in some cases including dissolution) rates between 6% and 11% (Coakley & Berrick 2008). Studies in the United Kingdom that separate disruption and dissolution report disruption rates of between 4% and 11% (Selwyn et al. 2014).

Changing perceptions of the role of adoption

Adoption of children from out-of-home care has been of increasing interest in recent years. This has been reflected in legislative changes in some jurisdictions. For example, on 1 April 2014, the New South Wales Parliament passed the Child Protection Legislation Amendment Bill 2014. The amendments aim to streamline the process of adopting children and young people in out-of-home care. Amendments in Western Australia (effective late 2012) reintroduced relative adoption as a legislative option and strengthened the carer adoption process (AIHW 2016a).

However, adoption is only one option in permanency planning for children in out-of-home care and is not as widespread in Australia as in England or the United States (Fernandez & Atwool 2013; Ross & Cashmore 2016).

In the United States, the majority of children adopted from out-of-home care were adopted by their foster carers; in the United Kingdom, the majority were 'stranger/matched adoptions' (Selwyn et al. 2014).

The most recent data for the United States indicate that nearly 54,000 children were adopted from foster care in 2014–15. As at 30 September 2015, there were 428,000 children in foster care, of whom more than 110,000 were waiting to be adopted (US Department of Health and Human Services 2016). Over a similar period, in England, more than 5,300 children, of almost 70,000 in care, were adopted (UK Department for Education 2015). This compares with Australia's 94 known carer adoptions for the same period, where 54,000 children were in out-of-home care (AIHW 2015, 2016b).

Opinions differ among legislators, policy makers, practitioners, academics and the community about the use and appropriateness of adopting children from out-of-home care (Ross & Cashmore 2016). This includes a concern not to replicate the Stolen Generations and Forced Adoption, which have been the subject of national apologies (Senate Community Affairs References Committee 2015; SNAICC 2016; Tregeagle et al. 2014).

Adoption may be considered to be in the 'best interests' for some children; however, it is not suitable for all, especially for children who do not wish to be adopted (Bonfili 2015). Some research has estimated that half of the children for whom restoration had been excluded were not suitable for adoption (Tregeagle et al. 2014). This may be due to existing family and/or kinship ties preventing adoption. For children who are placed with relatives/kin, adoption is not generally considered appropriate (AIHW 2016a), while the Aboriginal and Torres Strait Islander Placement Principle (Lock 1997) views the adoption of Indigenous children as a last resort. A child's age, history of abuse, and emotional /behavioural problems may mean that, for some children, long-term out-of-home care with skilled foster parents may be a better permanency option than adoption (Queensland Department of Communities 2011).

The availability of sufficient numbers of carers to adopt children, other than infants, has been questioned (Ainsworth 2016). Many potential adoptive parents prefer to adopt infants and younger children, while children identified as needing adoption may often be older and have had repeated restoration efforts and care placements, sometimes resulting in additional behaviour disorder issues (Tregeagle et al. 2014; Unwin & Mişca 2013). Casework assistance with contact, therapeutic, practical and emotional support, and financial assistance have all been identified as critical to the success of adoption (UCCYPF 2014), but may be reduced or become time limited on adoption (Ross & Cashmore 2016).

What is missing from the picture?

National child protection data are limited in the extent to which they can describe the level of permanency achieved. This is due to the difficulties in determining when a care arrangement has become permanent. The number of children who exited out-of-home care and were reunified with their family cannot be reported using existing national data. Similarly, data are not available on the number of children who experience disruptions to reunification attempts or long-term care arrangements.

National information about permanency-related concepts for children and young people in out-of-home care could be enhanced by the development of:

- nationally standardised definitions of permanency
- national data on the specific reasons children are placed in out-of-home care, including family characteristics
- national data on the reasons for changes in placement, which may help to identify placement changes made to promote permanency
- linked data to support comparisons of outcomes between children who have different experiences of out-of-home care and children who have never entered care
- linked data on the life course of young people exiting care at age 18
- a follow-up survey of children in out-of-home care, including qualitative components, increasing consistency of methodology across jurisdictions
- reportable data on adoption disruption and dissolution
- national data on the types and levels of family support services provided.

What is the AIHW doing?

The AIHW is continuing to work with state and territory departments responsible for child protection to:

- develop and implement an agreed 'reunification/permanency' indicator under Standard 1 of the *National Standards for Out- of-Home Care*
- expand reporting of known carer adoptions to better understand the children for whom this permanency option has been used
- provide a composite view of long-term care in national reports by:
  - reporting on long-term and short-term finalised guardianship/custody orders in *Child protection Australia*
  - reporting on adoption orders as well as care and protection orders in *Child protection Australia*
  - reporting on third-party parental responsibility orders in *Adoptions Australia*, to complement data on known carer adoptions including relevant research.
- improve the availability and comparability of national child protection data, with a focus on the framework for reporting on out-of-home care in Australia.

Linkage of child protection data with youth justice and specialist homelessness services data has been undertaken. The potential for linking out-of-home care data with other data sets related to health and welfare to enable outcomes reporting is also being explored.

Where do I go for more information?

More information about child protection is available at www.aihw.gov.au/child-protection/. The report *Child protection Australia 2015–16* and other recent publications are available for free download.

More information about adoptions is available at www.aihw.gov.au/adoptions/. The report *Adoptions Australia 2015–16* is available for free download.

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2.6 Youth justice supervision

Young people who commit, or allegedly commit, a crime may be dealt with under the youth justice system. In Australia, youth justice is the responsibility of state and territory governments, and each jurisdiction has its own legislation, policies and practices. However, the general processes by which young people are charged and sentenced, and the types of legal orders available to the courts, are similar.

Young people can be charged with a criminal offence if they are aged 10 and older. The upper age limit for treatment as a young person is 17 in all states and territories except Queensland, where it is 16. Some young people aged 18 and older are also involved in the youth justice system. This may be due to the offence being committed when the person was aged 17 or younger, with supervision continuing once they turn 18.

Young people under youth justice supervision

On an average day in 2015–16, 5,482 young people aged 10 and older were under youth justice supervision in Australia, with a total of 11,007 supervised at some time during the year. Among people aged 10–17, this equates to a rate of 21 young people per 10,000 population, or about 1 in every 476 young people being under supervision on an average day.

Most young people under youth justice supervision on an average day were supervised in the community (84%). Although 17% were in detention on an average day (some were supervised in both the community and detention on the same day), more than 2 in every 5 young people (44%) under supervision experienced detention at some time during the year.

Young people may be supervised when they are unsentenced—that is, when they have been charged with an offence and are awaiting the outcome of their court matter, or when they have been found, or have pleaded, guilty and are awaiting sentencing. In 2015–16, more than half (57%) of young people in detention on an average day were unsentenced.

Some groups are over-represented

Compared with non-Indigenous young people, on an average day, Aboriginal and Torres Strait Islander young people were:

- 17 times as likely to be under supervision
- 15 times as likely to be supervised in the community
- 25 times as likely to be in detention.

Compared with young females, on an average day, young males were:

- 4 times as likely to be under supervision
- 4 times as likely to be supervised in the community
- 8 times as likely to be in detention.

Compared with young people living in *Major cities*, on an average day, people in *Very remote* areas were:

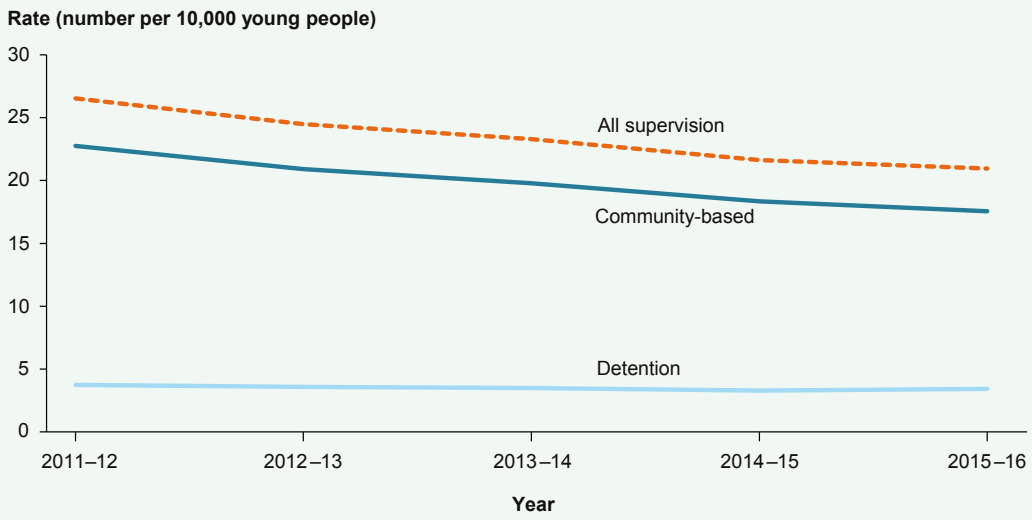
- 10 times as likely to be under supervision
- 10 times as likely to be supervised in the community
- 9 times as likely to be in detention.

Compared with young people living in the highest socioeconomic areas, on an average day, young people living in the lowest socioeconomic areas were:

- 6 times as likely to be under supervision
- 7 times as likely to be supervised in the community
- 6 times as likely to be in detention.

Fewer young people under supervision

Over the 5-year period from 2011–12 to 2015–16, the number of young people aged 10 and over under supervision on an average day fell by 21% (from 6,959 to 5,482), while the rate of those aged 10–17 under supervision fell from 27 to 21 per 10,000 (Figure 2.6.1). The number of young people aged 10 and over in community-based supervision on an average day fell by 23% (from 5,970 to 4,598) while the rate of those aged 10–17 fell from 23 to 18 per 10,000. Among those in detention, the numbers and rates also fell during the 5-year period, although to a lesser degree. The number of young people aged 10 and over in detention fell by 11% (from 1,024 to 914) and the rate among those aged 10–17 went from 4 to 3 per 10,000.



Note: National totals include non-standard data for the Northern Territory.

Figure 2.6.1: Rate of young people aged 10–17 under supervision on an average day, by supervision type, 2011–12 to 2015–16

Time under supervision

When all time spent under supervision is considered, young people who were supervised during 2015–16 spent a total of 182 days—or about 6 months, on average—under supervision. The average length of time under supervision has remained stable over the last 5 years, ranging between 180 and 182 days.

Young people spent more time, on average, under community-based supervision during the year (171 days) than in detention (69 days). For young people in detention, sentenced detention lasted substantially longer (103 days on average) than unsentenced detention (44 days).

Returns to sentenced supervision

Most young people who receive a supervised youth justice sentence serve only 1 sentence, and do not return to sentenced youth justice supervision. Of young people under sentenced youth justice supervision from 2000–01 to 2015-16 and born between 1990–91 to 1997–98, 61% received only 1 supervised sentence before the age of 18.

A sizeable minority of young people who entered sentenced youth justice supervision went on to receive a total of 5 or more supervised sentences before they turned 18. For young people whose first supervised sentence was detention, more than 1 in 4 (27%) received a total of 5 or more supervised sentences, compared with 1 in 7 (15%) of young people whose first supervised sentence was community based.

Involvement with child protection services

Some young people under youth justice supervision are also involved with the child protection system. Young people aged 10–17 under youth justice supervision during 2014–15 were 15 times as likely as the general population to be involved with the child protection system in the same year. Similarly, young people involved with the child protection system were 14 times as likely as the general population to be under youth justice supervision in the same year.

What is missing from the picture?

Data are limited on the health and welfare status and health service use of young people under supervision, and on their health and wellbeing outcomes once they exit youth justice supervision. Information on the pathways between youth justice supervision and adult correctives services is currently not available, due to the current lack of linkable national data on adult corrective services. The Northern Territory did not provide standard data for the Juvenile Justice National Minimum Data Set in 2015–16, but non-standard data have been included in national totals where possible. The AIHW will be working with the Northern Territory to enable the provision of standard data in future years. Non-standard data are not included in some analyses (such as for remoteness or socioeconomic areas) or data linkage studies, due to issues around completeness and comparability with standard data.

Where do I go for more information?

More information on youth justice in Australia is available at www.aihw.gov.au/youth-justice/. Recent youth justice publications, including the *Youth justice in Australia 2015–16* bulletin and state fact sheets are also available for free download at the AIHW Youth justice in Australia 2015–16 page at: http://www.aihw.gov.au/publication-detail/?id=60129558624.

2.7 Family, domestic and sexual violence

Family, domestic and sexual violence is a major health and welfare issue in Australia and globally. The World Health Organization (WHO) estimates that 30% of women who have been in a relationship have experienced physical or sexual violence from an intimate partner since the age of 15 (WHO 2013). Almost 1.5 million Australian women have experienced violence from a current or former partner since the age of 15 (ABS 2013b). Approximately 1 in 6 Australian women have been subjected to physical or sexual violence by a current or former cohabiting partner, compared with 1 in 19 men (ABS 2013b).

This article provides an overview of the available data and research on family, domestic and sexual violence, primarily where the violence involved a female victim and a male perpetrator. This scope is consistent with the focus of recent inquiries and associated policies: the evidence, overwhelmingly, is that women are the victims of family, domestic and sexual violence, and the perpetrators are men.

> If you are experiencing domestic or family violence or know someone who is, please call 1800RESPECT (1800 737 732) or visit the 1800RESPECT website.

What is family, domestic and sexual violence?

Domestic violence is usually defined by a set of violent behaviours between current or former intimate partners: one partner tries to exert power and control over the other through fear. Violent behaviour can include physical, sexual, emotional and psychological abuse. Behaviour toward the victim can include limiting their access to finances, preventing them from contacting family and friends, demeaning and humiliating them, and threatening them or their children with injury or death (COAG 2012).

Family violence is more broadly defined, and refers to violence between family members as well as between current or former intimate partners. For example, it can include acts of violence between a parent and a child. 'Family violence' is the preferred term for experiences of violence between Aboriginal and Torres Strait Islander people, as it covers the broad range of extended family and kinship relationships in which violence may occur (Closing the Gap Clearinghouse 2016) (see Chapter 7.1 'Community factors and Indigenous wellbeing' for more information about the experiences of family violence for Indigenous Australians).

Sexual violence refers to behaviours of a sexual nature carried out against a person's will using physical force or coercion (or any threat or attempt to do so). Sexual violence can be perpetrated by partners in a domestic relationship, former partners, other people known to the victims, or strangers.

Policy context

Family, domestic and sexual violence has become an increased community concern and a key priority for Australian and state and territory governments. There have been several recent national and state and territory inquiries into government responses to it. They all highlight the need to improve the integration of service responses for victims, to invest in prevention and early intervention, and to hold perpetrators more accountable (DPMS 2016; NSW Ministry of Health 2016; Social Development Committee of the Parliament of South Australia 2016; Special Taskforce on Domestic Violence in Queensland 2015; State of Victoria 2016).

The National Plan to Reduce Violence against Women and their Children—2010–2022 (the National Plan) was released in 2011 with a vision that Australian women and their children can live free from violence in safe communities (COAG 2012). The plan focuses on two main types of violence: domestic/family violence and sexual assault. These types of violence mainly affect women. The National Plan aims to achieve a 'significant and sustained reduction in violence against women and their children' (COAG 2012).

The National Plan provides a framework for coordinating governments to deliver on four action plans over the 12 years. Its focus is on the following six outcomes:

- communities are safe and free from violence
- relationships are respectful
- Indigenous communities are strengthened
- services meet the needs of women and their children experiencing violence
- justice responses are effective
- perpetrators stop their violence and are held to account.

The Third Action Plan 2016–19 under the National Plan was launched in October 2016. It outlines what governments, communities, businesses and individuals can do to reduce violence against women and their children through 36 practical actions, across six national priority areas, over the next 3 years.

What do we know?

Prevalence of family, domestic and sexual violence

Based on the Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS) (see Box 2.7.1), since the age of 15:

- 1 in 6 (17%) Australian women, compared with around 1 in 19 men (5.3%) have experienced violence from a current or former cohabiting partner
- 1 in 4 (25%) women have experienced emotional abuse by a current or former cohabiting partner.

In the 12 months before the survey:

- women aged between 18–24 were the most likely age group to experience sexual and/or physical violence by any type of perpetrator (13%)
- women were also more likely to experience violence from a known person (4.0% of all women) than from a stranger (1.7%) (ABS 2013b).

For information on the family, domestic and sexual violence experiences of men in Australia, see Box 2.7.2.

Box 2.7.1: Measuring violence in the ABS Personal Safety Survey

The PSS is designed to provide national level data on the prevalence of, and information about, the most recent experience of violence. Some data refer to partner violence—that is, from a person the respondent currently lives with (or lived with), in a married or de facto relationship. Partner violence does not include violence between intimate partners who were not living together at the time of the incident—this relationship is classified as 'boyfriend/girlfriend or date'. The PSS asks people over the age of 18 about experiences of violence since the age of 15. It also asks about characteristics of their most recent incident of violence. The latest data come from the 2012 PSS, with the 2016 survey due for release late in 2017.

Source: ABS 2013b.

Box 2.7.2: What about male victims of family, domestic and sexual violence?

This article primarily focuses on women and children as victims of family, domestic and sexual violence; however, men can be, too. The 2012 PSS is one of the primary data sources of experiences of men as victims of violence, and how this differs from the experiences of women. This section highlights some of the key findings for male victims, based on reported experience of violence since the age of 15.

Males are more likely to experience violence than women

- Men are more likely to experience physical violence than women. Five in 10 men (or 4.1 million) have experienced some form of physical violence, compared with 1 in 3 women (3 million).
- Men are less likely to experience sexual violence than women, with 1 in 22 men (0.4 million) reporting that they had experienced sexual violence since the age of 15, compared with 1 in 5 women (1.7 million).
- Men are more likely to experience violence from a stranger (36% or 3 million). Women are more likely to experience it from someone they know (36% or 3.1 million).

Violence against men is less likely to be from their partner

- One in 19 (5.3%) men (448,000) have experienced violence from a current or former partner, compared with 17% of women (1.5 million).
- Fourteen per cent (14%) of men (1.2 million) had experienced emotional abuse from a female partner, compared with 25% of women from a male partner.
- Slightly less than half of men who had experienced emotional abuse from a female partner reported feeling anxiety or fear due to the abuse (46% for former partners and 43% for current partners). This compares with 76% of women who felt anxiety or fear due to emotional abuse from a former partner and 63% from a male current partner.

Source: ABS 2013b.

Understanding the prevalence and extent of victims' experiences of violence relies on data collected either through surveys, or for administrative purposes (such as police, health or specialised services data). Use of these data sources to measure the prevalence of family, domestic and sexual violence relies on:

- victims' perception of what constitutes this violence
- victims' willingness to disclose/report the incident
- how the incident is disclosed/reported (ABS 2013a).

Family, domestic and sexual violence can also be disclosed to agencies such as police, health, legal or other specialist services—or just to family and friends. It can also be reported through surveys. The PSS is the most comprehensive source of the experience of interpersonal violence in Australia. However, there are still communities of interest for whom the PSS does not collect detailed information. These include women with disability, women from culturally and linguistically diverse backgrounds, transgender and gender diverse people, and Indigenous peoples (Cox 2015). Dealing with these data gaps will foster a better understanding of experiences of violence for all women and their children.

Risk factors for family domestic and sexual violence

There is no one single cause of family, domestic and sexual violence. It is often a mix of interrelated factors—both individual and interpersonal. Individual factors include personal values and beliefs, mental health, drug and alcohol use. Interpersonal factors include learned patterns of behaviour within relationships. The broad consensus in the literature is that the underlying drivers of this violence reflect inequalities in the distribution of power, resources and opportunity between males and females and the way in which gender roles are formed (OurWatch, ANROWS & VicHealth 2015; VicHealth 2014).

Measures of gender equality can include differences in male and female life expectancy, employment, education, income and representation in political and senior management positions. The 2016 Gender Gap Index (World Economic Forum 2016) ranks Australia in the top third countries included (46th of 144 countries), achieving the highest scores of gender equality for educational attainment, but the lowest for political empowerment (women in parliament or ministerial positions).

Family, domestic and sexual violence can be experienced across all age, socioeconomic and demographic groups. However, there are some common elements associated with raised levels of this type of violence. It is often associated with alcohol and drug use—in 2012, 56% of women who had been physically assaulted by a man reported that alcohol or drugs contributed to the most recent incident of assault (ABS 2013b). As well, victims are commonly:

- young women, particularly women who are inexperienced in relationships or in a relationship where there is a substantial age gap between partners (Flood & Fergus 2008)
- unemployed women (or women who rely on government payments as their main source of income) (ABS 2013b)
- women born overseas (ABS 2013b)
- women with disability (ABS 2013b)

- Indigenous women—in 2014–15, the rate of hospitalisations for assaults related to family violence for Indigenous women was 32 times the rate for non-Indigenous women (SCRGSP 2016)
- women who are pregnant—in 2012, 25% of victims had their first experience of violence from a previous partner during their pregnancy (ABS 2013b).

Attitudes towards violence against women

Communities whose attitudes reflect greater levels of gender equality are more likely to have lower rates of domestic, family and sexual violence (UNIFEM 2010). Attitudes towards violence against women in Australia are measured every 4 years through the National Community Attitudes towards Violence Against Women Survey (NCAS)—the most recent data available are from the 2013 survey (VicHealth 2014). This survey measures community knowledge and attitudes towards violence against women, gender roles and relationships, and responses to violence. It also tracks changes in knowledge and attitudes over time (between 1995, 2009 and 2013). The next NCAS will be conducted by Australia's National Research Organisation for Women's Safety (ANROWS) in 2017.

Overall, the results of the 2013 NCAS were generally positive. Only 4% to 6% of Australians believe that violence against women is justified in certain circumstances (Table 2.7.1). The majority also acknowledge that physical and non-physical violence (such as constant criticism, stalking, intimidation, and controlling social contact) are serious behaviours and a form of violence against women. Almost all Australians (98%) stated that they would intervene if a woman they know was being assaulted. There is room for improvement, though. Twenty-one per cent (21%) agree that the violence can be excused if the perpetrator regrets it, and 18% believe that men should take control and be the head of the household (reflecting attitudes towards gender roles and relationships).

In general, attitudes towards violence against women are fairly consistent across Australia. This is irrespective of location, educational attainment and type of employment. There are particular groups, however, that are more likely to endorse attitudes that support violence against women, and have a poor understanding of what constitutes it. These groups are:

- men in general, particularly young men and men who have experienced multiple forms of disadvantage
- young people aged 16–24
- people from countries where English is not the main language spoken, especially people who have recently arrived in Australia.

Table 2.7.1: Summary of positive and concerning knowledge and attitudes towards violence against women in Australia, 2013

Aspect	Positive findings	Concerning findings
Knowledge of violence	Most Australians recognise that violence against women is more than just physical violence, and can be a wide range of behaviours designed to intimidate and control women. Women were more likely than men to recognise that violence can be non-physical as well as physical.	26% did not believe that someone who tries to control their partner by denying them money is a form of partner violence (34% for males,18% for females). 64% believed the main cause of violence against women is that some men cannot control their anger (65% for males, 64% for females).
Knowledge of the law	96% agree that domestic violence is a criminal offence (94% for males, 98% for females).	Nearly 1 in 10 believe that a woman cannot be raped by someone she is in a relationship with (10% for males, 8% for females).
Patterns and consequences of violence	89% of Australians believe that it is reasonable for the violent partner to be made to leave the family home (87% for males, 91% for females).	78% found it difficult to understand why women stay in a violent relationship (79% for males, 76% for females).
Attitudes for minimising/trivialising the violence	95% of Australians believe that violence against women is a serious issue (94% for males, 96% for females).	38% of Australians believe it is acceptable to track a female partner by electronic means without their consent (43% for males, 32% for females).
Circumstances in which violence can be justified or excused	Only 4% to 6% of Australians believe that violence against women is justified (depending on the scenario).	21% believe that domestic violence can be excused if the violent person regrets it (26% for males, 17% for females).
Responding to family, domestic and sexual violence	98% of Australians are prepared to intervene if a known woman was being assaulted by her partner (98% for males, 97% for females).	Only 57% of Australians would know where to get help for a domestic violence problem (53% for males, 60% for females). This percentage has fallen from 62% in 2009.

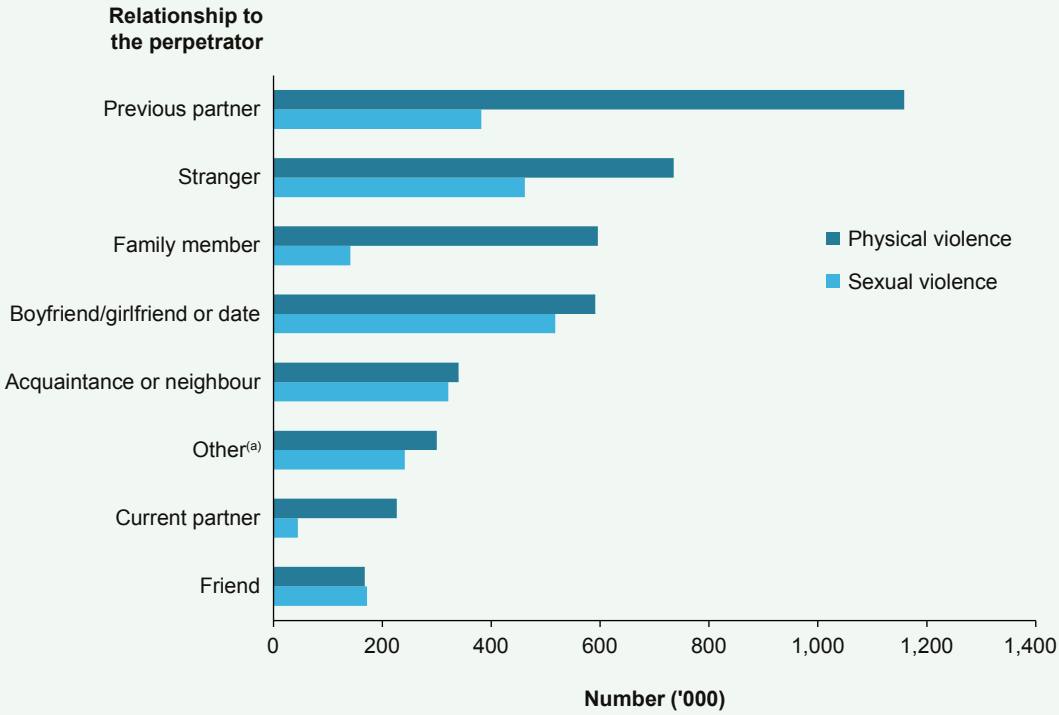
Note: Includes all survey respondents aged 16 and over.

Source: 2013 NCAS (VicHealth 2014).

Relationship to the perpetrator

Women were more likely than men to have experienced physical or sexual violence by a partner. An estimated 17% of all women aged 18 and over (nearly 1.5 million women) and an estimated 5.3% of all men of the same age (around 450,000) had experienced violence from a current or former cohabiting partner since the age of 15. Women were also more likely than men to have experienced violence by a partner in the 12 months before the survey. An estimated 1.5% of all women aged 18 and over had experienced violence by a partner, compared with 0.6% of all men of the same age in the 12 months before the survey (ABS 2013b).

The relationship between the victim and the perpetrator differs for women in cases of physical violence and for women who have ever experienced sexual violence (Figure 2.7.1). Of women who have ever experienced physical violence since the age of 15, the most common type of known perpetrator was a previous partner (1.2 million or 13% of all women). For women who had experienced sexual violence, more than half a million (5.9% of all women) reported that the perpetrator was their boyfriend/girlfriend or date, and almost half a million reported that the perpetrator was a stranger (5.3% of all women) (ABS 2013b).



(a) Includes counsellor/psychologist/psychiatrist, doctor, priest/minister/rabbi, prison officer, ex-boyfriend/ex-girlfriend and any other known persons.

Source: ABS 2013b.

Figure 2.7.1: Women who have experienced violence since the age of 15, by type of violence and relationship to the perpetrator, 2012

Impacts of family, domestic and sexual violence

Family, domestic and sexual violence affects more than just victims: perpetrators, families, workplaces and communities are all impacted in some way. These impacts include economic costs, homelessness, health consequences, and collateral effects on children. Some of these impacts are described in this section.

Economic

Family, domestic and sexual violence can have a major impact on victims and the broader community. It places a substantial workload on specialist services, hospitals and other health services, and the justice system. The cost of violence against women and their children in Australia in 2015–16 was estimated at $22 billion (KPMG 2016). Almost half of this cost ($10.4 billion) is linked to the ongoing health impacts of violence. The direct economic impact on victims of violence can also be substantial.

Women who had experienced violence in the past 2 years were more likely than women who had not to have higher levels of debt, more difficulty in paying bills, insufficient money for food, and to have requested material assistance from welfare agencies (Cortis & Bullen 2016). Further, Indigenous women, pregnant women, women with disability, and women who are homeless are under-represented in the PSS. Taking these groups fully into account may add $4 billion to these costs in 2015–16 (KPMG 2016).

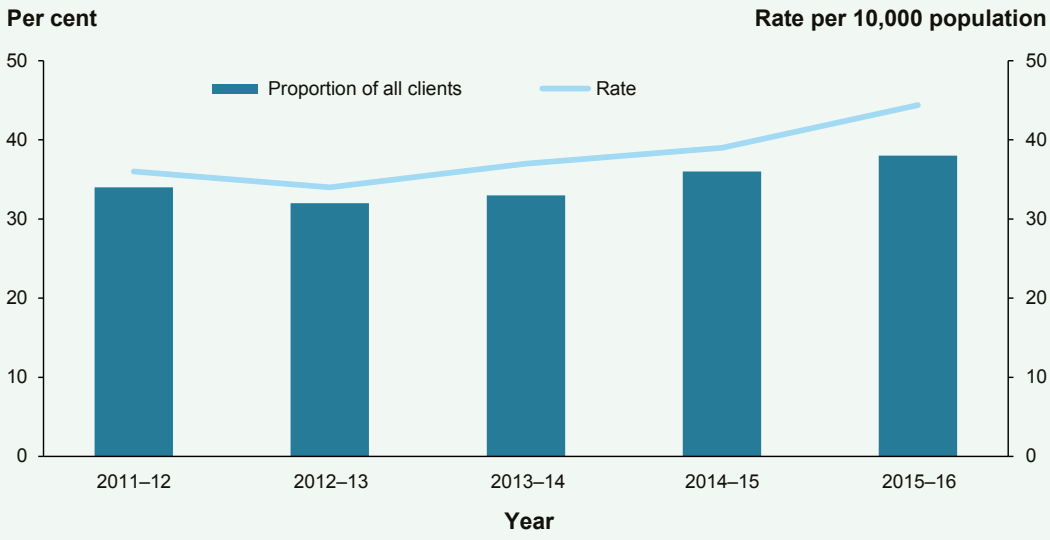
Housing and homelessness

Family, domestic and sexual violence is the leading cause of homelessness and housing instability in Australia (Spinney 2012). It is also consistently one of the most common reasons that clients seek help from specialist homelessness services (SHS) (AIHW 2016a). This sort of violence is most often experienced in the victim's home; hence, escaping it can be very difficult without social and financial support (ABS 2013b; Cortis & Bullen 2016).

SHS offer a range of supports. These include crisis and emergency accommodation, income support, counselling, referrals to legal services, connections to social housing providers, other specialised support, and referrals to specialist providers (AIHW 2016a) (see Chapter 6.2 'Homelessness' for more information about SHS).

In 2015–16, 38% of SHS clients (106,000) had experienced family and domestic violence and 92% of these were women and children (Figure 2.7.2). The number of family and domestic violence clients has increased by 33% since 2011–12 (AIHW 2016a).

In some cases, women can seek support to remain safely in the home with their children while the perpetrator is removed (through criminal justice responses); this option is commonly referred to as 'safe at home' (Breckenridge et al. 2016). Safe at home programs aim to maximise women's safety, allow for integrated service responses, prevent homelessness, and support women's economic security (Breckenridge et al. 2016).



Source: AIHW SHS Collection 2015–16.

Figure 2.7.2: SHS clients who had received assistance for family and domestic violence, 2011–12 to 2015–16

Health

Violence can have a severe impact on the physical, mental and behavioural health of women and children. The effects can be immediate and acute, long-lasting and chronic or, in some cases, fatal (WHO 2013). A study into the burden of disease (including illness, injury and premature death) for adult women who had been exposed to intimate partner violence in their lifetime (using 2011 data) found that:

- 1.4% of the total burden of disease in adult women was attributed to physical/sexual cohabiting partner violence (Ayre et al. 2016)
- anxiety disorders made up 35% of the burden attributed to cohabiting partner violence, followed by depression (32%) and self-inflicted injuries (19%) (Ayre et al. 2016)
- among women aged 25–44, intimate partner violence (includes boyfriend, date or cohabiting partner) was the leading risk factor, responsible for a greater contribution to the disease burden in this age group than alcohol use and tobacco use (Webster 2016).

Injuries leading to hospitalisation or death

Family, domestic and sexual violence can result in serious injury, and may lead to the hospitalisation or death of the victim. In 2013–14, more than 20,000 people (13,800 males and 6,300 females) were admitted to hospital for assault injuries (AIHW 2017b). The overall rate of assault injury among women and girls was 56 cases per 100,000 population, compared with 121 for men. For females hospitalised for assault injuries, 59% of hospitalisations involved a perpetrator who was a spouse or domestic partner (for cases where the perpetrator was specified). 'Parents' (195 cases) and 'other family members' (726 cases) accounted for nearly half of the remaining cases where the type of perpetrator was specified.

Between 2002–03 and 2011–12, there were around 2,600 homicides in Australia, two-fifths of which were classified as domestic or family homicides (Cussen & Bryant 2015). Sixty per cent (60%) of these domestic and family violence homicides were classified as intimate partner homicides (around 650 incidents). Of these intimate partner homicides:

- 75% of the victims were female
- 68% occurred in the victim's home
- 44% involved a prior history of domestic violence
- more than 1 in 3 had alcohol detected in either the perpetrator (36%) or the victim (35%).

Children living with violence

Exposure to family and domestic violence can have a substantial impact on a child's development, physical and mental wellbeing and schooling (Campo 2015). Children exposed to such violence have higher rates of social and emotional and behavioural problems than children with mothers who did not experience it (Shin et al. 2015). Children experiencing family and domestic violence are vulnerable to homelessness, which can further disrupt schooling, social networks and feelings of safety and belonging (AIHW 2016a; Campo 2015).

Evidence suggests that a substantial number of children are exposed to family and domestic violence. For example:

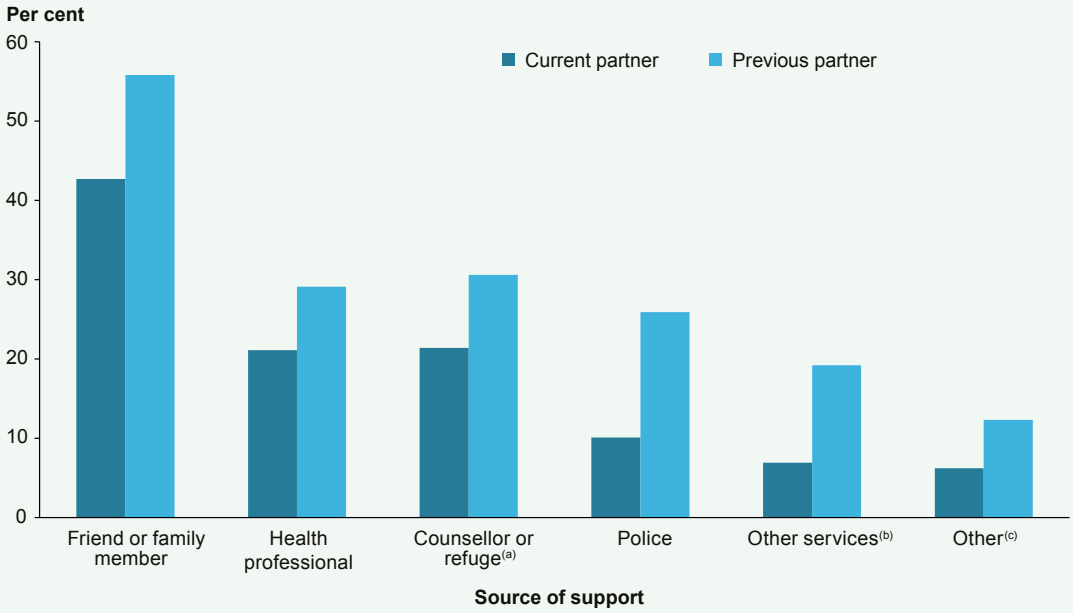
- 6 of 10 (more than 730,000) women who experienced violence from an ex-partner reported that they had children in their care at the time of the violence, and 77% of these women reported that their children had seen and heard the violence (ABS 2013b)
- 29% (about 31,000) of clients who sought assistance from SHS for family and domestic violence were aged 14 or younger (AIHW 2016a)
- emotional abuse (including exposure to family violence) was the primary abuse type for 45% (more than 20,300) of child protection substantiations (AIHW 2017a)
- more than half (54% or about 6,500) of young people who were both clients of SHS and child protection services had experienced domestic and family violence. This was higher than the proportion for SHS-only clients (44%) (AIHW 2016b).

Certain vulnerable groups continue to experience higher levels of violence and disadvantage. These include Indigenous children and young people; people in out-of-home care; people with disability; people who are sexually diverse, transgender, gender diverse and intersex; people from culturally and linguistically diverse backgrounds, and people living in rural and remote areas (AHRC 2016).

Support after family, domestic or sexual violence incidents

After a family, domestic or sexual violence incident, victims might seek support or disclose the incident to informal networks (such as friends and family) or to formal support services (such as health professionals, police, legal services and housing assistance). More than two-thirds (68%) of women who experienced physical violence from a male perpetrator had sought advice or support following the incident (ABS 2013b).

The most common source of support for women was from a friend or other family member (43% for current partner violence and 56% for previous partner violence) (Figure 2.7.3). These networks play a substantial role in helping women who have experienced family, domestic or sexual violence (Meyer 2010). Support services or support networks can assist women who have experienced violence to feel safe and live free of violence (Morgan & Chadwick 2009).



(a) Includes counsellor or support worker, telephone helpline, and refuge or shelter.
(b) Includes legal service, financial service and government housing and community services.
(c) Includes work colleague or boss, priest/minister/rabbi, and other.
(d) Partner violence refers to any incident of sexual assault, sexual threat, physical assault or physical threat by a current and/or previous partner.

Source: ABS 2013b.

Figure 2.7.3: Advice and support-seeking behaviours, women who have experienced partner violence(d) from a current or a previous partner since the age of 15, 2012

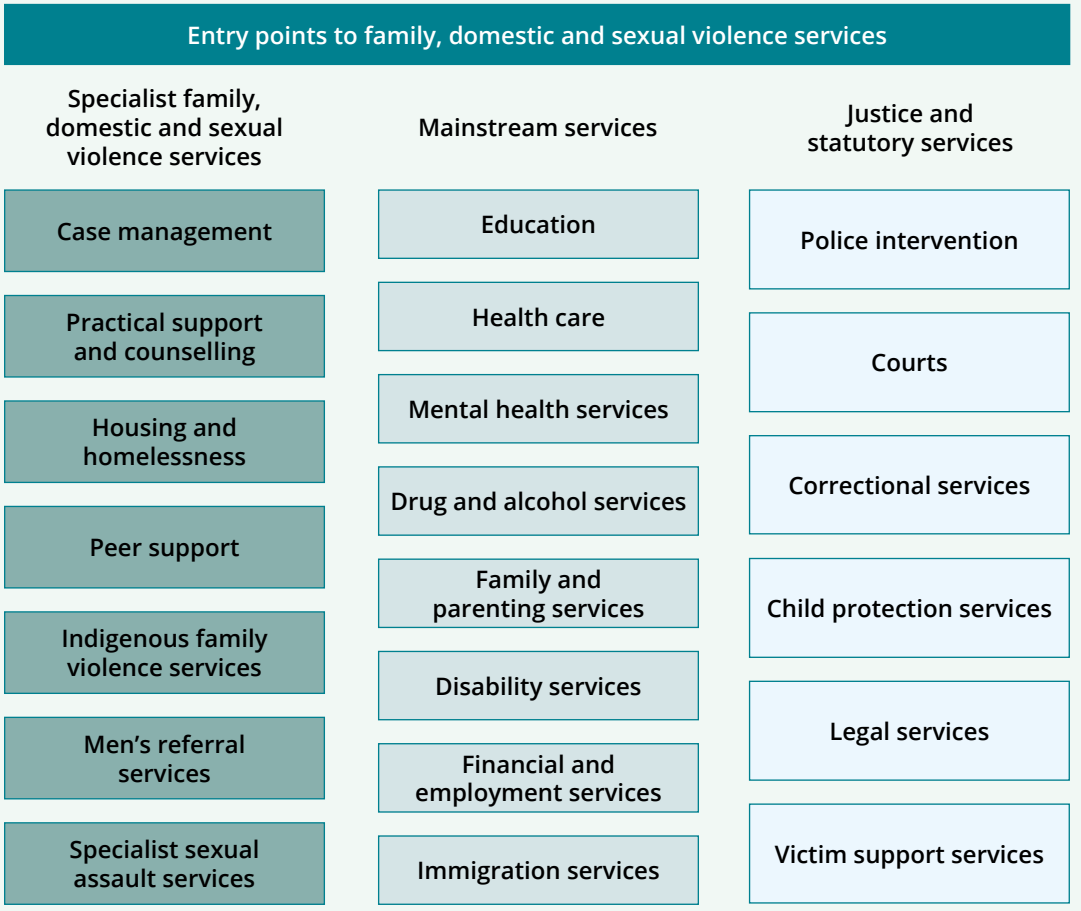
Family, domestic and sexual violence services

Women and their children need to feel safe and have access to appropriate services when reporting family, domestic and sexual violence, and perpetrators should be held to account for their actions. The three main service entry points for people experiencing this violence are:

- specialist domestic and family violence and sexual assault services (including refuges and other housing/homelessness services, crisis services, forensic services, counselling, financial assistance, and perpetrator intervention services)
- mainstream services (including health and education services)
- justice and statutory services (including police, family courts and child protection services) (Figure 2.7.4).

Although multiple entry points into services accommodate the diversity of needs for victims and perpetrators, they can be difficult to access and navigate (State of Victoria 2016).

Family, domestic and sexual violence policy and programs are delivered by government and non-government services across a wide range of sectors; therefore, it is important that service delivery is well integrated. An integrated response requires information and expertise to be shared among agencies to effectively assess risk, enhance efficiency, and improve the data collection to build evidence to deliver services better (PM&C 2016). Effective service integration also reduces the need for victims to have to re-tell their experience to multiple service providers, creating further trauma.



Source: Adapted from DHHS 2012.

Figure 2.7.4: Entry points for family, domestic and sexual violence services

Reporting to police

Police intervention is one of the key entry points into the family, domestic and sexual violence service 'system'. When incidents of such violence are not reported, perpetrators are not held to account for their behaviour by the law, and victims may not get access to the help and services needed to support them (Birdsey & Snowball 2013). Police have the authority to arrest and charge perpetrators, issue interim protection orders for the victims, and coordinate and facilitate referrals to specialist services.

In most cases, there is no specific offence type used for family, domestic and sexual violence. In published police data, such violence may be associated with the following offence types:

- homicide (including murder and attempted murder)
- acts intended to cause injury (including assault and stalking)
- sexual assault
- abduction/harassment/stalking
- property damage
- breach of violence and non-violence orders.

The quality of police data on the number of reported incidents and offences depends on police accurately classifying incidents and associated offences. As there is no consistent process to identify family, domestic and sexual violence across states and territories, caution should be exercised when interpreting such violence from recorded crime data.

According to data reported to police for offences related to family, domestic and sexual violence (for selected states and territories) in 2015–16:

- the most common offence type was *acts intended to cause injury* (ranging from 49% to 80% of all incidents reported)
- there were 4–5 times as many male offenders as female offenders
- the median age of perpetrators ranged between 31 and 34 (ABS 2017b).

Unfortunately, a considerable number of family, domestic and sexual violence incidents are not reported to police. Data from the PSS show that:

- only 20% of women who had experienced physical and sexual violence from a current partner had contacted the police
- only 42% of women who had experienced physical and sexual violence from a previous partner had contacted the police
- women were more likely to report to police if they had experienced more than one incident of partner violence. This was most evident for violence experienced by previous partners. Of the women who had experienced previous partner violence, 6.5% reported it to police after one incident compared with 36% who reported it after more than one incident (ABS 2013b).

Factors affecting reporting to police

In a study of victims attending domestic violence services, only half had reported the most recent incident of violence to police (Birdsey & Snowball 2013). Victims were more likely to report the incident if there was a current apprehended violence order against the perpetrator, if they were physically injured, if there was property damage, or if they thought their children were at risk. The most common reasons for not reporting the incident to police were:

- fear of revenge from the offender/fear of further violence (14%)
- embarrassment and shame (12%)
- thinking that the incident was too trivial/unimportant (12%)
- bad/disappointing experience with reporting previous incidents to police (10%) (Birdsey & Snowball 2013).

Family, domestic and sexual violence perpetrators in criminal courts

Data from the criminal courts show how perpetrators (or defendants) move through the justice system in incidents of family, domestic and sexual violence where criminal charges have been laid by the police. As for police data, there is no consistent process to identify charges related to family, domestic and sexual violence across states and territories. Therefore, caution should be used when interpreting family, domestic and sexual violence reporting from criminal courts data.

According to data reported from selected state and territory magistrates' courts in 2015–16 for offences related to family and domestic violence:

- *acts intended to cause injury* were the most common principal offence related to family and domestic violence
- defendants finalised for one or more offences related to family and domestic violence were more likely to be male than female across all jurisdictions (ranging from 84% to 89% of defendants)
- the majority of defendants were proven guilty (ranging from 72% to 87% of defendants)
- of the defendants proven guilty of *acts intended to cause injury*, the majority (ranging from 64% to 80%) were sentenced to a non-custodial order, except in the Northern Territory where 86% were sentenced to a custodial order (ABS 2017a).

What is missing from the picture?

There is no single source of truth on the prevalence of violence (Cox 2015). The ABS PSS does provide detailed information on specific incidents of violence every 4 years. There is little information, however, on the experiences of persons from culturally and linguistically diverse backgrounds; on people who identify as lesbian, gay, bisexual, trans and/or intersex; on older people (elder abuse); and on people with a disability (Mitra-Kahn et al. 2016). Information on the experiences of Indigenous people are collected in the ABS National Aboriginal and Torres Strait Islander Social Survey, but this is collected only every 6 years (ABS 2016a).

The family, domestic and sexual violence 'system' is diverse. It covers multiple sectors and represents multiple entry or intervention points. For most agencies involved, data collections do not specifically flag family, domestic and sexual violence cases. This represents a major lost opportunity to gain insights into patterns of service use.

Other key data gaps identified include risks and drivers of family, domestic and sexual violence (such as mental health, drug and alcohol use); characteristics of victims and perpetrators; and the outcomes of specialised services and interventions for victims, perpetrators and children.

There is also sparse information on the family, domestic and sexual violence workforce, in terms of its numbers, skills, qualifications and distribution.

What is the AIHW doing?

Family, domestic and sexual violence data are collected through the data systems used to support policing, justice, corrections, health and community services (including SHS). These systems are often not 'linked up', meaning that the individual pathways of women and their children experiencing violence—and of perpetrators—cannot be tracked across systems. This presents a major barrier in determining which interventions are most effective in supporting and protecting women and their children.

Under the National Plan, all governments in Australia are committed to developing a National Data Collection and Reporting Framework (DCRF), being led by the ABS (ABS 2014). This framework is the basis for building a common language and a coordinated and consolidated approach to service-level data collection. Building on the work of the ABS and the DCRF, the AIHW—in partnership with the Department of Social Services, the ABS, ANROWS and several jurisdictions—will develop an initial capability in the form of a national family, domestic and sexual violence data clearinghouse and national report. Subject to ongoing funding, the data clearinghouse is designed to:

- coordinate national reporting of family, domestic and sexual violence data
- provide a platform for improving quality and consistency of existing data collections
- develop a shared understanding of data gaps and priority data developments
- facilitate the linkage of data sets, subject to appropriate protocols
- promote researcher access to individual or linked data sets.

The AIHW has also been assisting the Department of Social Services to develop a set of progress indicators related to the *National Outcome Standards for Perpetrator Interventions* (COAG 2015). It will be preparing annual reports against these indicators, starting with 2015–16 data.

In June 2017, the AIHW participated in a WHO expert group in Geneva on methodological and measurement issues for statistics on violence against women. Data availability, plus identification of data gaps and limitations, need to be addressed for the purposes of national and international monitoring. AIHW is actively contributing in this space, sharing its expertise internationally.

Where do I go for more information?

More information about the PSS and the National DCRF for family, domestic and sexual violence is available from the ABS website at www.abs.gov.au.

Further information on violence against women and their children can be found on the ANROWS website at www.anrows.org.au.

More information about clients experiencing domestic violence in the SHS collection is available at www.aihw.gov.au/homelessness-publications/.

The report *Domestic and family violence and homelessness 2011–12 to 2013–14* and other recent publications are available for free download.

More information about the *National Plan to Reduce Violence against Women and their Children—2010–2022* is available at the Department of Social Services website.

For more information about the National Sexual Assualt, Domestic Family Violence Counselling Service, see the 1800RESPECT website.

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Chapter 3

Education in Australia

3.0 Introduction

Participating and engaging in learning and formal education from an early age are central to a person's development and future ability to lead a productive and fulfilling life. Low school attainment and poor engagement with school can lead to poorer outcomes across the life course, including poverty and social exclusion.

This chapter looks at some of the key aspects of secondary and higher education and training in Australia—from secondary school attendance and completion, to options such as apprenticeships, traineeships and tertiary education. As the chapter shows, education can be a lifelong pursuit and there are many important factors in considering pathways from education to employment. For example, completion of schooling and higher levels of educational attainment (particularly tertiary level qualifications) open up broader employment opportunities and outcomes (such as higher relative earnings) in the future.

In 2016, the proportion of people studying for post-school qualifications was highest among people aged 20–24 (42%), but 15% of 25–34-year-olds, 8.1% of 35–44-year olds and 3.5% of 45–64-year-olds were also enrolled.

All Australian children must attend school until they complete Year 10. Young people must then participate in full-time education, employment or training (or a mix of these) until they are 17. Reflecting this, most (91%) people aged 15–24 were engaged in education and/or employment in 2016. As well, more young Australians aged 20–24 are completing Year 12, or its equivalent, than a decade ago. The Year 12 completion rates for young Aboriginal and Torres Strait Islander people have also risen over the past decade.

Young people not in education, employment or training (often referred to as the 'NEET' group) are seen to be completely disengaged from work and study. In 2016, 8.8% of 15–24-year-olds, 5.1% of 15–19-year-olds and 12% of 20–24-year-olds were not in education, employment or training.

This chapter also reviews how Australian children are faring in education, both at home and internationally. The National Assessment Program—Literacy and Numeracy (NAPLAN) tests are conducted each year for all students across Australia in Years 3, 5, 7 and 9. The results for 2016 were very similar to those for previous years. Big gaps remain for vulnerable groups, including for Indigenous Australians, students whose parents have low levels of education, students whose parents work in unskilled occupations, and children involved in the statutory child protection system.

On the world stage, Australia's performance of late has been mixed. It was one of 72 countries to take part in the 2015 Programme for International Student Assessment—a survey of 15-year-olds' competencies in reading, mathematical and scientific literacy. Although it scored above the average for 35 Organisation for Economic Cooperation and Development countries, Australia's average scores have decreased significantly since 2009 for reading; since 2006 for scientific literacy; and since 2003 for mathematical literacy.

3.1 Pathways through education and training

Education and training are crucial to a person's development and ability to lead a productive and fulfilling life. They promote self-confidence and independence and provide the skills and competencies needed to obtain employment and stay competitive throughout adulthood. Completion of schooling and higher levels of educational attainment (particularly tertiary level qualifications) open up broader employment opportunities and outcomes (such as higher relative earnings) in the future.

In Australia, schooling is compulsory until the completion of Year 10, after which young people must participate in full-time education, employment or training (or a combination of these activities) until the age of 17. After secondary school, young people can enter the workforce, complete further study, or combine both. There are several education and training options available, with many young people continuing their education pathway through higher or vocational education and training (including apprenticeships and traineeships) (see Chapter 3.3 'Apprenticeships and traineeships'; 3.4 'Tertiary education').

However, not all young people are participating in education, employment or training (those who are not are referred to as the 'NEET' group). Non-participation among young people has been linked to future unemployment, lower income and employment insecurity (Pech et al. 2009), placing these young people at risk of social and economic disadvantage and social exclusion.

Transitions

Key milestones

Achieving certain milestones is important if young people are to successfully move on to full-time employment or further study. Evidence has identified the following key transition ages:

- 15—engagement in school, with sufficient literacy and numeracy skills to complete Year 12 or an equivalent vocational qualification (like a Certificate III)
- 19—possessing an initial qualification (or be in the process of completing it)
- 24—being in the process of establishing a career path, having obtained a higher-level vocational qualification or a higher education qualification (for example, a Bachelor degree); young people without an initial qualification at age 19 should have re-engaged with education and training (Liu & Nguyen 2011; Victorian Government 2010).

School completion and transition to further study or work

Students who complete Year 12 tend to have more successful transitions from education to work (Ryan 2011) and are more likely to gain employment and/or continue onto tertiary education. These transitions are established early—for example, over 6 in 10 students establish academic success in early to middle childhood and a similar proportion maintain this through to school completion. Similar proportions are also fully engaged in education or work by their mid-20s (Lamb et al. 2015).

Completion rates have been rising over time, with the proportion of people aged 15–64 who had completed Year 12 (or equivalent) increasing from 65% in 2006 to 76% in 2016 (ABS 2016b) (see Chapter 3.2 'School retention and completion').

Many factors can influence the likelihood that a student will complete their schooling. For example, literacy levels at the age of 15 are a strong indicator for future achievements, including Year 12 completion, university attendance, and university completion. Parental aspirations are also important—secondary students whose parents wish them to attend university are far more likely to complete Year 12 (NCVER 2014).

Australia still has a high number of people who are not completing Year 12 by the time they are 19 (estimated at around 81,000 in 2014) (Lamb et al. 2015). Attending and completing school can be challenging for some young people. Year 12 (or equivalent) completion rates at age 19 are generally lower for people attending school in *Remote* and *Very remote* areas, who live in low socioeconomic areas, who are Indigenous (Lamb et al. 2015) or who have a disability (ABS 2016a).

Optimal pathways

There are many possible pathways through and beyond the education system. There is not one path of 'best fit'. However, certain factors will maximise one's chances of positive outcomes after secondary school.

Longitudinal research that considered the most successful 'paths' (defined as leading to goals to undertake further higher study and/or gain employment) found slightly different results for males and females. While the 'best' path for males differs across a range of desired outcomes, Year 12 completion is a common factor in each. For females, the 'best' pathway was clearly identified as completion of Year 12, followed by university study (Karmel & Liu 2011).

Employment outcomes

In 2016, people with higher levels of educational attainment were more likely to be employed: 80% of people with a Bachelor degree or above and 76% with a Certificate III or IV were employed, compared with 67% of people with Year 12 and 44% of people with Year 11 or below as their highest educational attainment (ABS 2016b). However, while educational attainment has been improving over time (see Chapter 3.2 'School retention and completion'; Chapter 3.4 'Tertiary education'), it is becoming more challenging for young people to find sustainable or full-time employment, even after graduating from higher education (Torii & O'Connell 2017).

The proportion of young people (aged 15–24) in full-time work is decreasing, and the percentage working part time is increasing. This trend is consistent with that for all people of working age (see Chapter 4.1 'The changing nature of work and worker wellbeing'). As at March 2017, 27% of people aged 15–24 worked full time, compared with 35% 10 years ago and 48% 30 years ago. The proportion working part time in 2017 was 31%—increasing from 28% a decade ago and 13% three decades ago (AIHW analysis of ABS 2017).

Understanding employment outcomes and opportunities for young people is complicated by the fact that young people are generally disproportionately affected by tough labour market conditions. Labour market outcomes have not improved for Australians aged 15–29 since 2008 (OECD 2016a)—as reflected in the youth unemployment rate. This rate has continued to rise since the Global Financial Crisis, but has been consistently higher than the overall unemployment rate over many years (13% in 2016 compared with an overall unemployment rate of 5.7%) (see Chapter 4.2 'Key employment trends').

University graduates

In 2016, 71% of university graduates were working full time within 4 months of finishing their undergraduate degree. While this was an increase from 69% for the previous year, it was a large drop from 85% in 2008. Since the Global Financial Crisis, graduates have taken longer to gain a position in the labour market (QILT 2016).

University graduates from more skill/practical based degrees are more likely to succeed in entering the labour market immediately after graduating. For example, Medicine and Pharmacy graduates were the most likely graduates to gain full-time employment (at more than 96% of graduates) in 2016. In contrast, for more generalist degrees in fields such as Creative arts, Communications, and Science and mathematics, less than 62% gained full-time employment immediately (within 4 months) after graduating (QILT 2016).

Apprentices and trainees

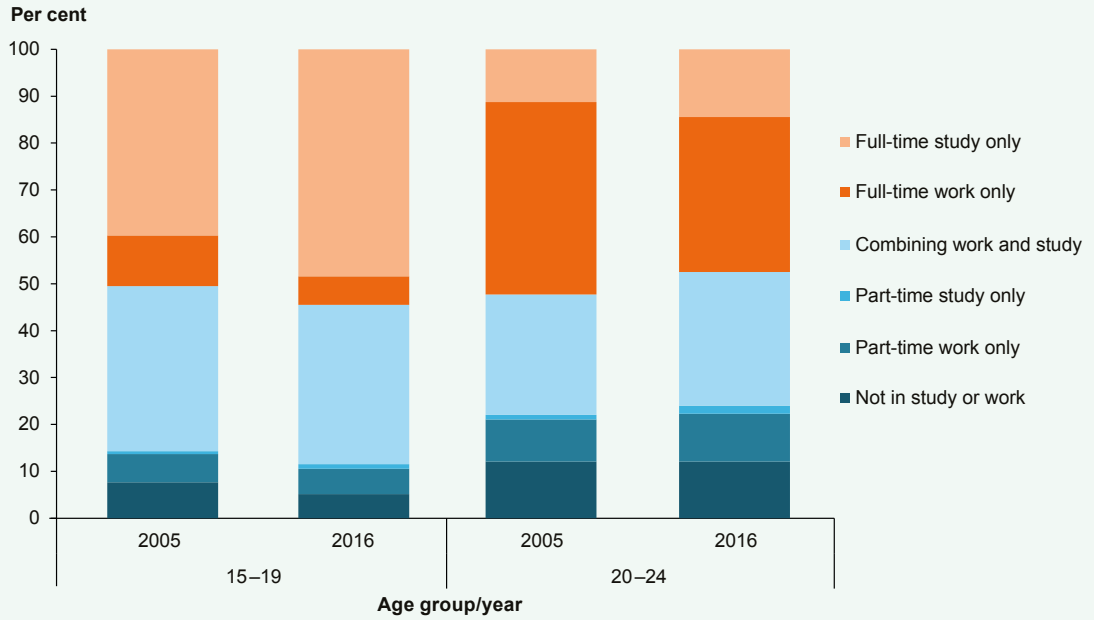
Most people (around 80–90%) who have completed an apprenticeship or traineeship are employed after training (Hargreaves et al. 2017). Older apprentices are more likely than their younger counterparts to be undertaking training at a higher level, and are more likely to complete their training.

There is a continuing growth in the proportion of apprentices undertaking apprenticeships at older ages. These are often workers with established skills, experience and prior qualifications. There is a need for more apprenticeship pathway options (and higher learning options, such as diploma and associate degrees) for this group (see Chapter 3.3 'Apprenticeships and traineeships').

Who is missing out?

Young people who are not in education, employment or training (often referred to as the 'NEET' group, or 'NEETs' for ease of reference) are seen to be completely disengaged from work and study. Low educational attainment and poor literacy and numeracy skills increase young people's risk of being a NEET, with around 40% of NEETs in Australia never having obtained an upper secondary qualification (OECD 2016a; 2016b). Females make up around 60% of the NEET group in Australia—this over-representation is often attributed to their domestic duties and child care obligations. NEET rates are also higher than average among Indigenous youth (making up 10% of the NEET youth, compared with around 3% of the population) and among migrants from non-English-speaking countries (18%) (OECD 2016c).

In 2016, most (91%) people aged 15–24 were engaged in education and/or employment (AIHW analysis of ABS 2016b; customised report). However, 8.8% of people aged 15–24 were not. This varied by age: 5.1% of people aged 15–19 (75,300 people) and 12% of people aged 20–24 (200,400 people) were not engaged in education and/or employment (Figure 3.1.1).



Sources: ABS 2005; AIHW analysis of ABS 2016b, customised report.

Figure 3.1.1: Participation in education and/or employment, people aged 15–24, by age group, 2005 and 2016

Between 2005 and 2016:

- the proportion of 15–19-year-olds not in employment, education or training decreased (from 7.7% to 5.1%, respectively)
- the proportion of 20–24-year-olds not in employment, education or training remained similar (at around 12%)

- the proportion of young people aged 15–19 and 20–24 engaged in full-time work (and not studying) decreased, while the proportion increased for young people engaged in full-time study only
- the proportion of 20–24-year-olds combining work and study increased slightly—from 26% to 29%.

Relative to the international scene in 2015:

- the proportion of Australians aged 15–19 who were not in education or employment was similar to the Organisation for Economic Co-operation and Development (OECD) average (6.0% compared with 6.3%, respectively), with Australia ranked 18th out of 32 OECD countries with available data
- among people aged 20–24, the Australian non-participation rate in 2015 (13%) was lower than the OECD average (17%), and ranked 11th out of 32 OECD countries (OECD 2017).

As already indicated, labour market conditions affect employment opportunities for young people. Several other factors may influence the proportion of the population who are NEETs, such as changed entitlements to Youth Allowance (see later in this article), or perceptions by young people that Year 12 and post-school qualifications are needed to be competitive in the job market (Gilfillan 2016).

Government financial support

The Australian Government offers several payments to support young people undertaking study, training or an apprenticeship. The two main payments are Youth Allowance (Student and Apprentice) and ABSTUDY (Non-living allowance), with around 155,800 and 20,800 recipients, respectively, as at December 2016 (DSS 2017).

The Council of Australian Governments made a commitment to help young people to achieve their educational potential and make the transition to employment through the National Partnership Agreement on Youth Attainment and Transitions (COAG 2009). This agreement outlined that young people who have not attained Year 12 or equivalent must undertake full-time education or training to be eligible for Youth Allowance.

The Australian Government can also assist eligible students with the cost of their tuition fees through subsidised university places, known as Commonwealth Supported Places (CSPs) and the Higher Education Loan Program (HELP). Information about CSPs and HELP loans are available on the Study Assist website at www.studyassist.gov.au.

What is missing from the picture?

While longitudinal data, such as from the Longitudinal Surveys of Australian Youth, can provide substantial insight into educational pathways, a large gap remains in the ability to identify and track individuals over time. Unique student identifiers, which could remove duplicate records and allow tracking of movements across state/territory and educational sectors, would provide a means to do this in future.

The annual Australian Bureau of Statistics Survey of Education and Work provides the most detailed data on youth participation in education and training; however, reliable estimates by Indigenous status and for smaller geographical areas are not available from this survey. Indigenous data are available, less often, from the National Aboriginal and Torres Strait Islander Health Survey and National Aboriginal and Torres Strait Islander Social Survey. Both Indigenous and small level geography data are available every 5 years from the Census.

Where do I go for more information?

More information on youth participation in education and training is available from the ABS Survey of Education and Work and from the National Centre for Vocational Education Research.

For the latest information on available payments and eligibility criteria, see the Department of Human Services website at www.humanservices.gov.au.

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3.2 School retention and completion

Completing Year 12 or an equivalent vocational qualification is seen as a key milestone in the formal development of an individual's skills and knowledge and for improving their economic and social opportunities in life (see Chapter 3.1 'Pathways through education and training').

People with Year 12 qualifications are more likely to continue further study, particularly in higher education, and to enter the workforce. The Australian Government has committed to ensuring that all young people have the opportunity to complete Year 12 or its vocational equivalent. The states and territories are also committed to increasing rates of school completion.

School retention

Most young people stay at school until Year 12. In 2016, the apparent retention rate to year 12 (see Box 3.2.1) was 84%. There has been a gradual increase in the apparent retention rate over the last 6 years (up from 78% in 2010) (ABS 2017).

In 2016, the retention rate was higher for females (88%) than males (81%). This has been the case for many years (for example, rates were 83% compared with 73%, respectively, in 2010).

The apparent retention rate to Year 12 for Aboriginal and Torres Strait Islander students has increased steadily, from 47% in 2010 to 60% in 2016, but it is still lower than the non-Indigenous rate (79% in 2010 and 86% in 2016). However, the gap (between the Indigenous and non-Indigenous rate) has narrowed over the same period (from 32 percentage points to 26 percentage points) (ABS 2017).

Box 3.2.1: Measurement of retention rate

The apparent retention rate to Year 12 is an estimate of the percentage of students who stay enrolled full time in secondary education from the start of secondary school (Year 7 or 8 depending on the state or territory) to Year 12. The term 'apparent' is used because the measure is derived from total numbers of students in each of the relevant year levels, not by tracking the retention of individual students over time. A higher or increasing rate is desirable. This suggests that a larger proportion of students are continuing in school, which may result in improved educational outcomes.

Care needs to be taken, however, in interpreting this measure. It does not take account of factors such as student migration between states and territories, students repeating a year of education or returning to education after a period of absence, or the impact of full fee paying overseas students (SCRGSP 2017).

Completion of Year 12 or equivalent

Completion of Year 12 or its equivalent has risen in recent decades. This is likely to be due to several factors, including the commitment from government to raise the minimum level of education of young people (for example, national agreements for education and Indigenous reform; Box 3.2.2).

Box 3.2.2: Council of Australian Governments: selected education and Indigenous reform agreements

The Council of Australian Governments (COAG) (2016) agreed to the following benchmarks:

- lift the Year 12 or equivalent or Certificate II attainment rate to 90% by 2015 (from 2008)
- lift the Year 12 or equivalent or Certificate III attainment rate to 90% by 2020 (from 2008)
- halve the gap for Indigenous people aged 20–24 in Year 12 attainment or equivalent attainment rates by 2020.

The 2015 COAG benchmark outlined in Box 3.2.2, while close, was not met (completion rate of 88% for Year 12 or a Certificate II or above in 2015, for those aged 20–24).The 2020 target of Year 12 or equivalent Certificate III attainment is on track to be met, with an attainment rate of 87% in 2015 (COAG 2016).

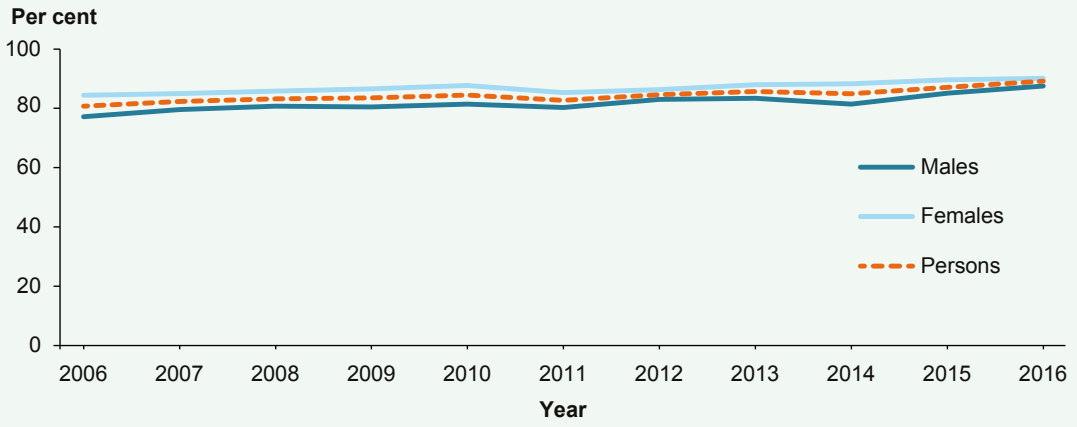
The target to halve the gap between Indigenous and non-Indigenous students in rates of Year 12 or equivalent attainment is also on track to be met by 2020 (COAG 2016). In 2014–15, 62% of Indigenous people aged 20–24 had completed Year 12 or equivalent or above, an increase from 45% in 2008 (SCRGSP 2016), and 'the gap' decreased to 25 percentage points (see Chapter 7.4 'Closing the gap in education').

According to the Australian Bureau of Statistics (ABS) Survey of Education and Work, in 2016:

- 3 in 4 (76%) people aged 15–64 had an educational attainment of Year 12 or equivalent or a non-school qualification at Certificate III level or above, an increase from 65% in 2006. There was no change to this proportion when also including people with a highest qualification of Certificate II (ABS 2016).

Among people aged 20–24 in 2016:

- almost 9 in 10 (89%) had attained Year 12 or equivalent or a non-school qualification at Certificate III level or above, and 90% for Certificate II or above. This is an increase from 81% and 82%, respectively in 2006 (see also Chapter 9.2 'Indicators of *Australia's welfare*')
- females (90%) were slightly more likely to have attained Year 12 or a Certificate III or above than males (88%). This has been the case for many years (Figure 3.2.1)
- attainment of Year 12 or a Certificate III or above generally decreased with remoteness. People aged 20–24 in *Major cities* were most likely to have completed Year 12 or Certificate II or above (92%), while people aged 20–24 in *Outer regional* (76%) and *Remote* and *Very remote* (77%) were least likely (ABS 2016).



Source: ABS 2016.

Figure 3.2.1: Completion of Year 12 or equivalent or a non-school qualification at Certificate III level and above, people aged 20–24, by sex, 2006 to 2016

What is missing from the picture?

Information on apparent retention rates was sourced from the ABS National School Statistics Collection, currently a large aggregate data collection. The retention rate is therefore an estimate (an 'apparent' rate), as individual students cannot be tracked from Year 7/8 through to Year 12. Reasons for this include student migration between states and territories, transfers between school sectors, and students progressing through school slower or faster than expected (for further details, see ABS 2016). To obtain an accurate measurement of student retention rates, and account for these variables, unique student identifiers would ideally be used to track individual students over time.

Where do I go for more information?

More information on youth education is available from the ABS Survey of Education and Work and Schools, Australia.

References

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3.3 Apprenticeships and traineeships

Apprenticeships and traineeships are well-established parts of the vocational education and training system. They integrate on- and off-the-job training, combining training and employment to enable skill development and workforce participation. Australia's apprenticeship and traineeship system offers nationally recognised qualifications in more than 500 occupations. These include traditional trades as well as most sectors of business and industry. Apprentices are trained in a skilled trade (such as electrical, plumbing, cabinet making or automotive trades) or a non-trade (such as hospitality and child care). Trainees are trained in vocational areas, such as office administration, information technology and tourism.

Secondary students of working age may choose to do a school-based apprenticeship. This allows them to gain a formal qualification and earn a wage for their time in the workplace, while completing their school studies (see also Chapter 3.1 'Pathways through education and training').

Key demographics and trends

As at 30 September 2016, there were 278,500 apprentices and trainees in training—a decrease of 5.7% 12 months earlier (NCVER 2017a). In 2015, the majority (74%) of apprentices and trainees aged 15–24 were male, 4.9% were Indigenous, and 1.9% were people with disability (including impairment or long-term condition) (AIHW analysis of NCVER 2016).

Time series analysis by the National Centre for Vocational Education Research (NCVER) shows that for apprenticeships and traineeships in 2016 (as at June 30):

- commencements (in the previous 12 months) had been declining since they peaked in 2012, and were at their lowest since 1998 (168,800 in 2016)
- completions (in the previous 12 months) had been declining since they peaked in 2013, and were at their lowest since 2002 (107,900 in 2016) (NCVER 2017b).

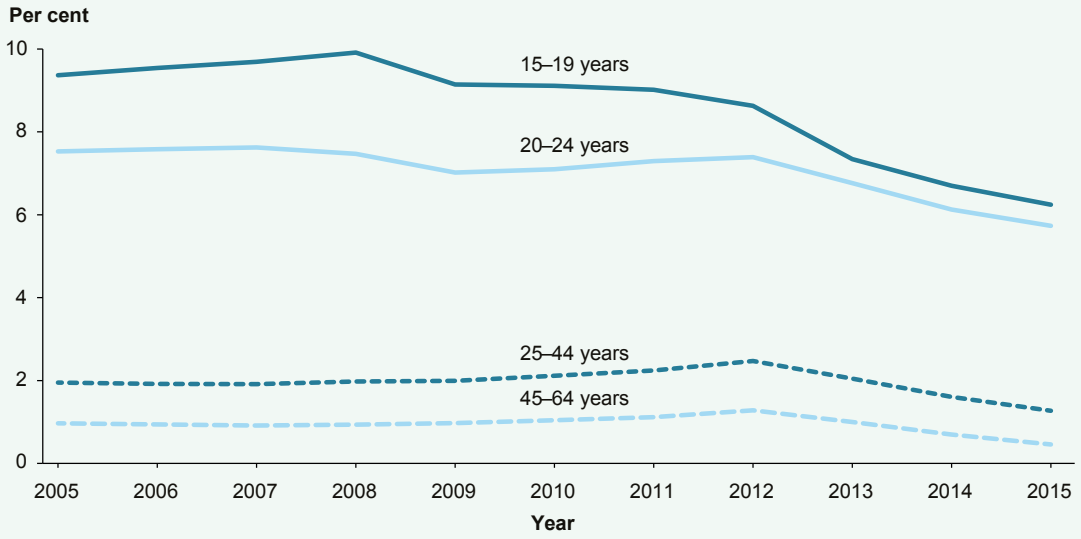
Most of the recent declines were in non-trade occupations. Declines from 2013 coincided with the removal of Australian Government incentive payments for the start and completion of apprenticeships and traineeships not on the National Skills Needs list (Atkinson & Stanwick 2016; Hargreaves & Bloomberg 2015).

Age

While most apprentices are young, the proportion of older apprentices has been increasing over the last few decades. In 2016, apprentices aged 25–64 accounted for 45% of non-trade apprentices (up from 22% in 1996) and 28% of trade apprentices (compared with 8% 20 years before) (Hargreaves et al. 2017).

Analysis by calendar year shows that, in 2015:

- there were around 187,000 apprentices and trainees aged 15–24 in Australia, or 6.0% of the population aged 15–24 (a decline from 258,000, and 8.7% of 15–24-year-olds in 2008) (Figure 3.3.1)
- 15–19-year-olds (6.2% of the population aged 15–19) were slightly more likely to be undertaking an apprenticeship or traineeship than 20–24-year-olds (5.7%); however, this gap has narrowed since 2005 (9.4% compared with 7.5%, respectively)
- 1.3% of the population aged 25–44 were apprentices and trainees, a 32% decrease from 1.9% in 2005
- 0.5% of people aged 45–64 were undertaking an apprenticeship or traineeship, a decrease from 1.0% in 2005
- a greater proportion of apprentices and trainees aged 15–19 were undertaking school based apprenticeships (23%) than in 2008 (17%) (AIHW analysis of NCVER 2016).



Notes

1. Apprentice and trainee data are annual averages of quarterly figures. Population data are the Australian Bureau of Statistics estimated resident population as at 30 June of the respective year.
2. A small number of apprentices and trainees are aged <15 and >64. These people are included with apprentices and trainees aged 15–19 and 45–64, respectively.
3. Data are collected by registered training organisations and state training authorities around Australia.

Source: AIHW analysis of NCVER 2016.

Figure 3.3.1 Apprentices and trainees as a proportion of the population, by age group, 2005 to 2015

Outcomes of apprenticeships

Completion rates for adult trade apprentices have steadily increased over time, while those for younger trade apprentices are on a slow but steady decline (Hargreaves et al. 2017).

Most people who complete an apprenticeship or traineeship are employed after training. In 2016, more than 90% of trade apprentices and almost 80% of non-trade apprentices were employed six months after finishing training, with rates slightly higher for people aged 15–24 than for people aged 25–64. For people who were not employed before they starting training, completing a trade apprenticeship resulted in employment for 84% of 15–24-year-olds and 66% of 25–64-year-olds. Around half of all people who were not employed before starting a non-trade apprenticeship were employed after completing their training (Hargreaves et al. 2017).

Younger apprentices (aged 15–24) were more likely to report job benefits due to their training than older (aged 25–64) apprentices—such as getting a job, or an increase in earnings or promotion at work. Most trade apprentices were employed in the occupation they trained for (Hargreaves et al. 2017).

What is missing from the picture?

Understanding of apprenticeship and traineeship participation and completion is limited. Key data gaps in this area include factors that influence both the start and completion of these qualifications, the destination and outcomes of apprentices and trainees after they exit the system, and the type and level of training being undertaken relative to known industry needs. Future research should respond to shifting consumer demand for online learning.

Where do I go for more information?

Comprehensive, quality data on apprentices and trainees are available from the National Centre for Vocational Education Research National Apprentices and Trainees Collection and the Australian Bureau of Statistics Survey of Education and Work.

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3.4 Tertiary education

Higher levels of educational attainment are associated with higher employment rates and higher relative earnings, more social engagement and better health (OECD 2016).

Tertiary education in Australia can be broadly categorised as either 'higher education' or vocational education and training (VET). Higher education is generally delivered in a university setting, leading to a Bachelor, Master or Doctoral degree. VET focuses on delivering skills and knowledge for a specific industry, leading to Certificate and Diploma qualifications. It is delivered by Registered Training Organisations such as Technical and Further Education (TAFE) institutions. According to the Australian Bureau of Statistics (ABS) Survey of Education and Work, non-school qualifications considered above Year 12 attainment are those at the Certificate III level or above (includes Diploma, Advanced Diploma, Bachelor degree, Post-graduate Diploma, Master degree and Doctorate) (ABS 2016; AQFC 2013).

There were 172 registered higher education providers in Australia as at October 2015, 40 of which were Australian universities (DET 2015). There were 1.4 million students enrolled at Australian higher education institutions during 2015—the vast majority (92%) in universities. Around 74% of higher education students were domestic, 71% were enrolled on a full-time basis, and 55% were female. In 2015, 1.1% of students were from an Aboriginal or Torres Strait Islander background, an increase of 7.1% since 2014 (DET 2016).

In 2015, there were 4,277 VET training providers (including Australian providers operating overseas), with total enrolments of about 4.5 million students during the year. Two-thirds (67%) of all VET students were enrolled with private providers, with a further 21% enrolled in TAFE institutions (NCVER 2016).

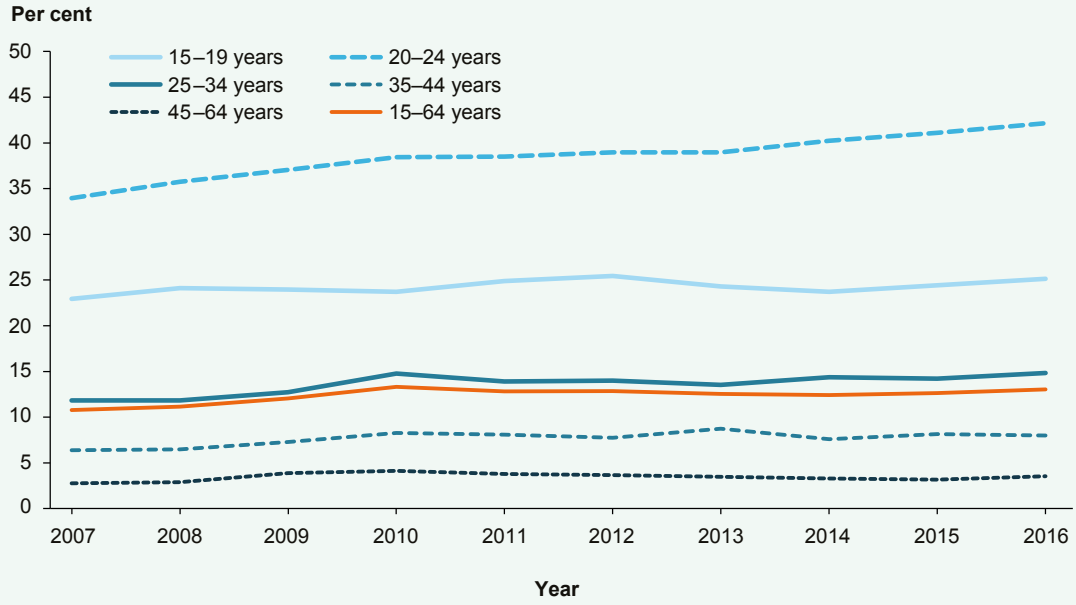
Enrolments in non-school qualifications

According to the ABS Survey of Education and Work, in May 2016, there were 2.2 million people aged 15–64 enrolled in formal study for a non-school qualification. Of these:

- 1.3 million (59%) were attending a higher education institution, such as a university, and 498,800 (22%) were attending a TAFE institution
- two in 5 (42%) were enrolled in a Bachelor degree, while 1 in 5 were enrolled in a Certificate III or IV (19%)
- similar proportions of males (42%) and females (41%) were enrolled in a Bachelor degree. Males (22%) were more likely than females (16%) to be studying for a Certificate III or IV, while females (17%) were more likely to be studying for an Advanced Diploma or Diploma than males (12%)
- the most common fields of study were Management and commerce (24% of people enrolled) and Society and culture (21%). Between 2008 and 2016, the proportion of enrolled students studying Engineering and related technologies fell from 12% to 8.8%, while the proportion studying Health increased from 11% to 14%

- the proportion of people studying for non-school qualifications was highest among people aged 20–24 (42%), followed by those for people aged 15–19 (25%), 25–34 (15%), 35–44 (8.1%) and 45–64 (3.5%) (ABS 2016).

Enrolments for non-school qualifications increased proportionally for all age groups from 2007–2016. The largest increases were seen among people aged 20–24 (from 34% to 42%) and 25–34 (12% to 15%) (Figure 3.4.1).



Sources: ABS 2016; AIHW analysis of ABS 2016, customised report.

Figure 3.4.1: Enrolment in study for a non-school qualification, people aged 15–64, by age group, 2007 to 2016

Attainment of non-school qualifications

As at May 2016, 59% of people (10.5 million) aged 15–74 had attained a non-school qualification. Of these:

- 44% (4.6 million people) had a Bachelor degree or higher qualification
- more than one-quarter (26%) had a qualification above a Bachelor degree level; this proportion has more than tripled since 1986 (when it was 7.2%)
- males (60%) were more likely than females (58%) to have attained a non-school qualification
- people aged 25–34 (73%) and 35–44 (72%) were most likely to hold non-school qualifications, followed by people aged 45–54 (66%), 55–64 (58%) and 65–74 (47%) (ABS 2016).

What is missing from the picture?

The annual ABS Survey of Education and Work provides the most detailed population based data on participation in education and training; however, reliable estimates by Indigenous status and for smaller geographical areas are not available from this survey. Indigenous data are available, less frequently, from the National Aboriginal and Torres Strait Islander Health Survey and the National Aboriginal and Torres Strait Islander Social Survey. Both Indigenous and small level geography data are available every 5 years from the Census. Limited data for Indigenous students are available from the Department of Education and Training's higher education statistics.

Where do I go for more information?

More information on youth education is available from ABS Survey of Education and Work and Schools, Australia.

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3.5 How are we faring in education?

This article looks at Australia's progress in educational engagement and attainment. It presents key statistics on school attendance, literacy and numeracy, and considers some major international comparisons.

School attendance

Attendance rates are the number of days that students attend school as a percentage of all possible school attendance days.

Nationally in 2016:

- the attendance rate for primary school students in Years 1 to 6 was 94%
- attendance rates for students in the compulsory high school years (Years 7 to 10) were generally lower than for younger students, and declined for more senior years (from 93% in Year 7 to 90% in Year 10)
- rates of school attendance were slightly higher for non-government schools than government schools for Years 1 to 6 (94% and 93%, respectively, across all years) and for secondary school students (for example, 94% and 92% for Year 7, and 92% and 88%, respectively, for Year 10 non-government and government schools) (SCRGSP 2017).

Attendance rates have been steady since 2014 (SCRGSP 2017); however, there are some notable variations within the Aboriginal and Torres Strait Islander population (see Chapter 7.4 'Closing the gap in education' for detailed information on school attendance for Indigenous and non-Indigenous students).

Literacy and numeracy

Literacy and numeracy skills are essential for successful learning, healthy child and youth development, active participation in society and, ultimately, the economic productivity and performance of nations (DECD 2013). The National Assessment Program—Literacy and Numeracy (NAPLAN) tests are conducted annually for all students across Australia in Years 3, 5, 7 and 9. The data provide nationally comparable results on the performance of students in the assessment domains of reading, writing, language conventions (spelling, grammar and punctuation) and numeracy (ACARA 2016). Two main measures are used to report achievement: the percentage of students achieving at the agreed national minimum standard (NMS) and the mean score.

The most recent report (ACARA 2016) showed that, at the national level, results had largely plateaued for students since 2008. Exceptions are shown in Table 3.5.1 and represent the few 2016 national results for which differences in achievement at the NMS, or improvements in mean scores, were significantly different from those for 2008.

Table 3.5.1 NAPLAN national results by domain—significant change 2008 to 2016

NAPLAN domain	National results where a significant difference was recorded	Direction of change	2008	2016
Reading	Year 3 achievement at or above the NMS	↑	92.1%	95.1%
	Year 5 mean score	↑	484.4	501.5
Writing	Year 9 mean score	↓	565.9 (in 2011)	549.1
Spelling	Year 3 mean score	↑	399.5	419.8
Grammar and punctuation	Year 3 achievement at or above the NMS	↑	91.7%	95.5%
Numeracy	Year 5 mean score	↑	475.9	493.1

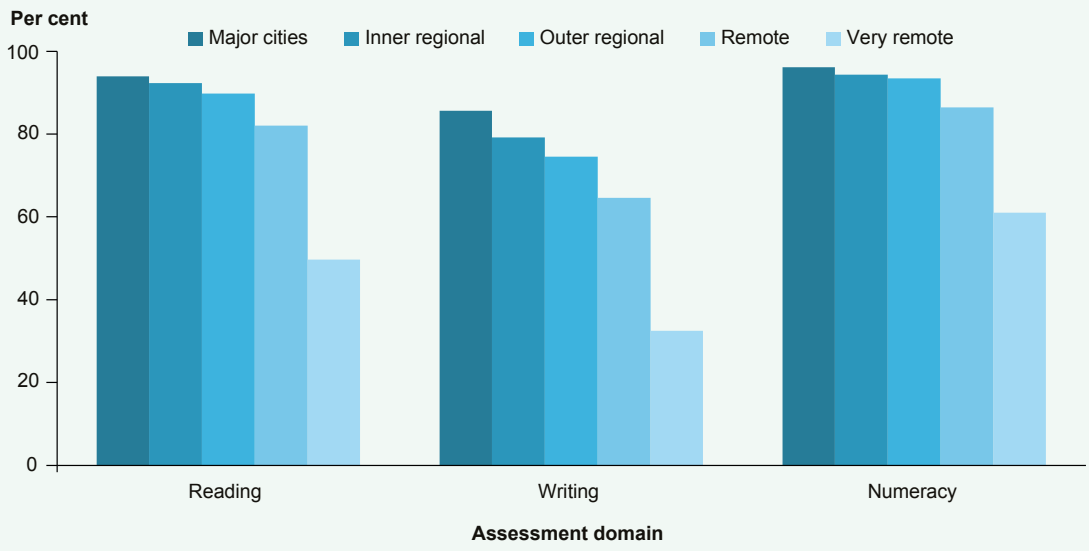
Notes

1. The NMS is the agreed minimum acceptable standard of knowledge and skills without which a student will have difficulty making sufficient progress at school. The mean score refers to the NAPLAN 'scale score'. Any given scale score represents the same level of achievement over time within a domain. For example, a score of 700 in reading in 1 year represents the same level of reading achievement in other testing years (ACARA 2016).
2. The year 9 writing score comparison was based on 2011 as this is the earliest year against which 2016 results can be compared.

Source: ACARA 2016.

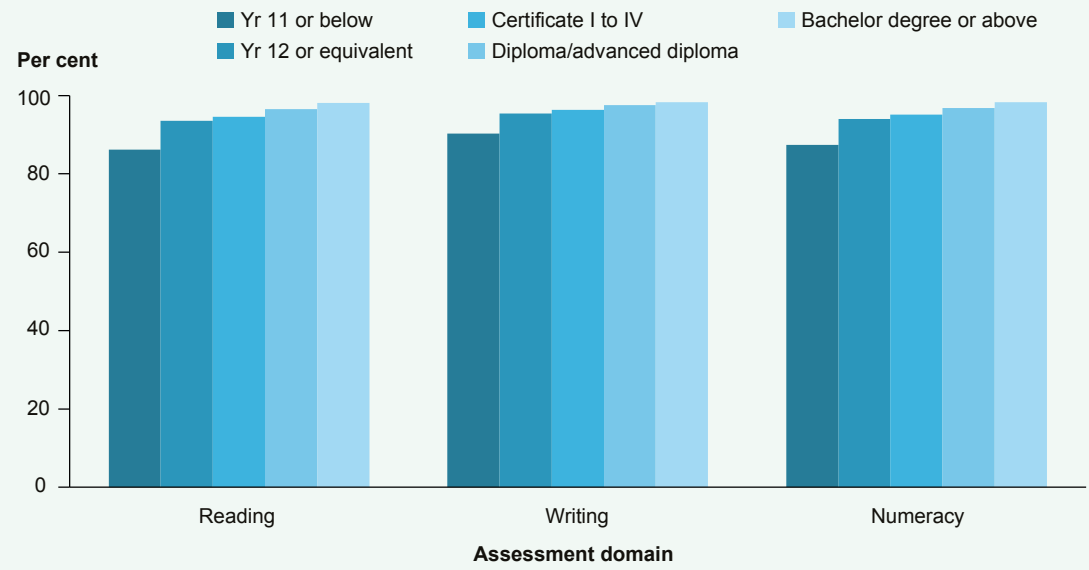
Other points of interest are:

- There were improvements in some domains in each state and territory, particularly for Western Australia and Queensland. The Australian Capital Territory, New South Wales and Victoria have the highest mean achievement across the domains for Years 3, 5 and 7.
- There have been significant improvements for Indigenous students in some domains, but the gap between Indigenous and non-Indigenous achievement is still wide (see Chapter 7.4 'Closing the gap in education').
- Lower levels of achievement persist for disadvantaged groups, including students living in *Very remote* areas (see the example for Year 9 students in Figure 3.5.1), students whose parents have relatively low levels of education (see the example for Year 3 students in Figure 3.5.2), students whose parents work in unskilled occupations (ACARA 2016), and children involved in the statutory child protection system (see AIHW 2015).



Source: ACARA 2016.

Figure 3.5.1: Year 9 achievement at or above NMS, by NAPLAN assessment domain and remoteness area, 2016



Source: ACARA 2016.

Figure 3.5.2: Year 3 achievement at or above NMS, by NAPLAN assessment domain and parental educational level, 2016

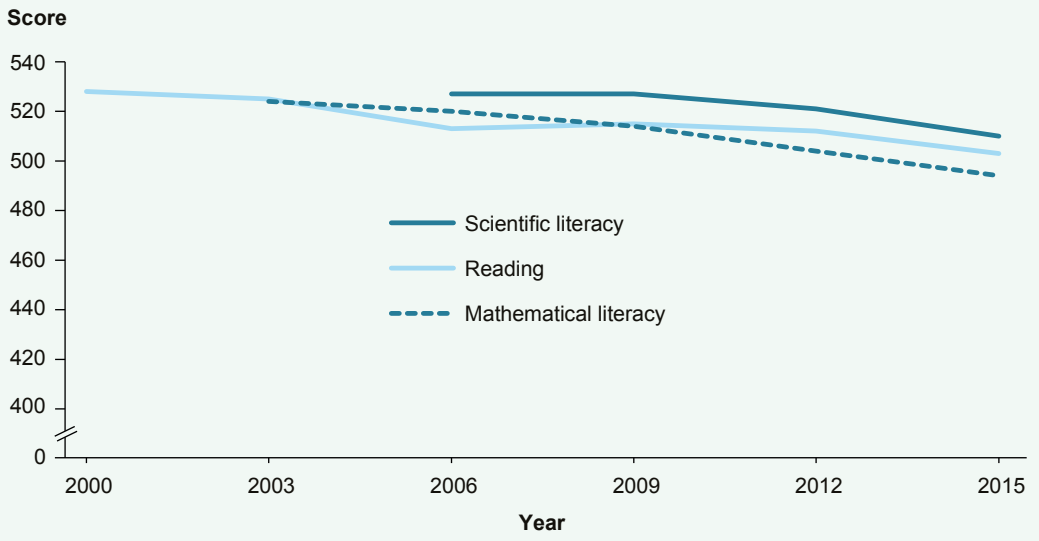
How do we compare internationally?

The Programme for International Student Assessment (PISA) is a survey of the competencies of 15-year-olds in reading, scientific literacy and mathematical literacy. Results from the 2015 PISA show that Australia's recent performance has been mixed. Masters (2016) notes that the ability of Australian students to apply higher order skills and thinking—as indicated by results in the three literacy competency areas—has been declining since 2000.

In 2015:

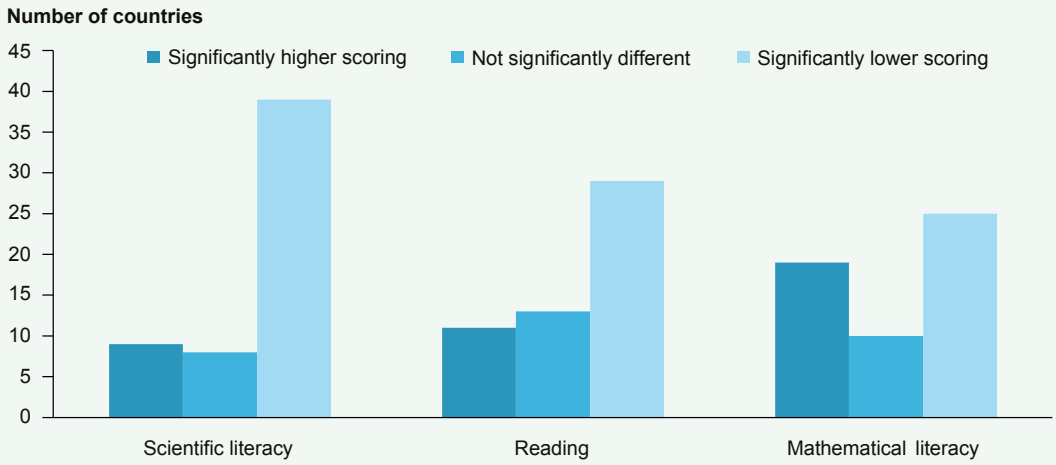
- Australia's average scores had decreased significantly since 2009 for reading; since 2006 for scientific literacy; and since 2003 for mathematical literacy (see Figure 3.5.3)
- the scores for reading (503), scientific literacy (510) and mathematical literacy (494) were still higher than the average scores across the 35 participating Organisation for Economic Co-operation and Development (OECD) countries (out of the 72 participating countries and economies) in each domain (493 for both reading and scientific literacy and 490 for mathematical literacy)
- Australia's performance was significantly below that of 11 countries for reading, 9 countries for scientific literacy and 19 for mathematical literacy (see Figure 3.5.4)
- the national scores on all 3 domains were generally comparable to those of New Zealand and the United Kingdom, but were significantly lower than Canada's, and significantly higher than those for the United States
- Australia's scores were about 1 year of schooling lower for reading, 1.5 years of schooling lower for science and 2.3 years of schooling lower for mathematics than the scores of Singapore, the highest performing country on all three domains in 2015.

See other international comparisons in Box 3.5.1.



Source: Thomson et al. 2016.

Figure 3.5.3: Australia's average performance in PISA and differences over time, 2000 to 2015



Note: Australia is compared with only those countries that achieved an average score that was higher than the lowest performing OECD country.

Source: Thomson et al. 2016.

Figure 3.5.4: How Australia compared with other countries/economies in PISA, by number of countries, 2015

Box 3.5.1: Other international comparisons—TIMSS and PIRLS

The Trends in International Mathematics and Science Study (TIMSS) monitors trends in mathematics and science achievement every 4 years, at the Year 4 and Year 8 levels. TIMSS 2015 was the sixth assessment. TIMSS results consistently show East Asian countries and economies (mainly Singapore, Hong Kong, Chinese Taipei, Korea and Japan) as the highest performers.

Australia was outperformed by 12 countries (out of 39) in Year 8 mathematics and by 21 countries (out of 49) for Year 4 mathematics. Australia's performance in mathematics has not differed significantly since the last survey in 2011. In science, Australia was outperformed by 17 countries (out of 47) for Year 4, and by 14 countries (out of 39) for Year 8. Australia had higher average achievement for Year 4 science than in 2011 and the same level for Year 8.

The Progress in International Reading Literacy Study (PIRLS) has monitored trends in reading achievement at Year 4 level since 2001. It is conducted every 5 years, making 2016 the fourth assessment (results available in December 2017). In 2011, Australia, in its first year of participation, was outperformed by 21 countries (out of 45 participating countries) (Mullis et al 2012).

Source: IEA 2017.

In terms of tertiary education attainment, in 2015, Australia ranked eleventh out of 35 OECD countries for Bachelor degree or above qualifications for those aged 25–64 (32%). Switzerland was ranked first (42%), followed by Belgium (36%). Australia's proportion was slightly lower than that for the United States (34%) and the United Kingdom (33%) but was above that for New Zealand and Canada (both 30%) and the OECD average (28%) (OECD 2016).

What is missing from the picture?

International studies may not discern important factors influencing school achievement in different countries, such as the social, political and cultural environment. To understand a country's academic performance, it is necessary to also consider country-specific data and research, particularly for differing population groups and geographic regions. It is interesting, though, that both domestic and international data, as described here, highlight potential issues with Australia's educational performance. This has implications for its future direction.

Where do I go for more information?

More information about NAPLAN is available at www.nap.edu.au/. For PISA, see www.acer.edu.au/ozpisa/, and for TIMSS and PIRLS, visit https://timssandpirls.bc.edu/.

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Chapter 4

Our working lives

4.0 Introduction

For most of us, paid work plays a big role in our lives. Someone who starts full-time work in their 20s will likely spend at least 70,000 hours at work over the next 40 years.

Work does much more than help to pay our bills; it can be good for our overall health and wellbeing. Unemployment and joblessness increase not only the risk of economic hardship, but also the risk of deprivation and social exclusion.

This chapter examines various aspects of work—from the changing nature of work and the impact this has had on our wellbeing, to the increasing participation of seniors in the workforce. We also consider some recent trends in the labour market and jobless rates. Finally, we discuss the many Australians who work for free—our volunteers.

The Australian labour market has changed considerably over the last half century. The overall employment rate (proportion of the population who are employed) among people aged 15–64 has increased. As well, many more jobs are now held by women. The composition of jobs has also changed: in 1966, manufacturing accounted for about 25% of all jobs, and the services sector for 56%. Today, manufacturing accounts for about 7% of jobs, and service industries for almost 80%. Since 2008, there has been a marked decline in the proportion of lower skilled people who are employed. For instance, the proportion of people whose highest qualification was Year 10 and below who were employed fell by 8.5% between 2008 and 2016.

The notion of a standard-length work week—centred on the 8-hour day, 5-day week—is no longer the norm. As reported in the specially commissioned article in this chapter, the proportion of employed people working part-time has risen substantially; for men, this share has risen more than threefold over the last half century.

Should we be concerned about these changes? The commissioned article presents evidence that it is not the actual number of hours usually worked that matters for worker wellbeing, rather whether the number of hours align with worker preferences.

With increasing life expectancies and improvements in health care, most Australians will grow older and live longer, healthier and more actively engaging lives than any previous generation. For some older Australians, this includes staying longer in the workforce. Over the last 3 decades, the employment rate of Australians aged 65 and over has more than doubled; in fact, it was at an all-time high of 9.1% as at June 2016.

Every day, thousands of Australians work for free, giving their time, services or skills to help others. Volunteers provide a valuable service to the community—the value of their contribution to not-for-profit organisations has been estimated at $17 billion a year. In 2014, an estimated 5.8 million people aged 15 and over did some voluntary work. Australia's volunteer rate fell to 31% in 2014 after several years on the increase; however, we are still above the OECD average.

4.1 The changing nature of work and worker wellbeing

Mark Wooden, Melbourne Institute of Applied Economic and Social Research, University of Melbourne

The Australian labour market has changed markedly over the last half century. While the overall employment rate among the 'working-age population' (people aged 15–64, as defined by the Australian Bureau of Statistics, or ABS), has trended upward—from around 65% as at August 1966 (ABS 2007) to 72% as at August 2016 (ABS 2016c)—the more substantial changes have been in the composition of employment.

First, females account for a much greater proportion of the workforce today than in 1966: 47% of all jobs in 2016 were held by females (ABS 2016c), compared with just 30% in 1966 (ABS 2007).

Second, and associated with the growth in female labour force participation, many more jobs today are part time: 31% of all jobs in 2016 involved part-time hours (ABS 2016c), compared with 10% in 1966 (ABS 2007).

Third, there has been a marked change in the industrial composition of jobs. Manufacturing accounted for about 25% of all jobs in 1966, while what might be loosely described as the 'services sector' (all industries excluding agriculture, mining, manufacturing and construction) accounted for 56% (ABS 2007). In 2016, manufacturing accounted for only around 7% of jobs, while the services sector accounted for almost 80% (ABS 2016d).

Fourth, there has been a marked growth in the proportion of high-skilled jobs, often argued to be driven by a rapid recent growth in disruptive technologies and automation (Department of Employment 2016). This, in turn, has been associated with an increased demand for a more educated and qualified workforce. As a result, around 2 in 3 (66%) people in the labour force in 2016 had a non-school qualification, with 27% having a university (Bachelor degree or higher) qualification (ABS 2016a). In contrast, in the late 1970s, only 36% of the labour force had a post-school qualification, and 6.7% had a degree (see ABS 1979 for a classification of 'post-school qualifications') (ABS 1979).

But are workers necessarily better off? Greater gender equality at work (at least in terms of access to jobs), more jobs that provide opportunities to use skills, and a greater proportion of jobs in industries that are inherently safer and provide more pleasant working environments would all seem to be unequivocally beneficial developments (Safe Work Australia 2002; Skills Australia 2012; WGEA 2016).

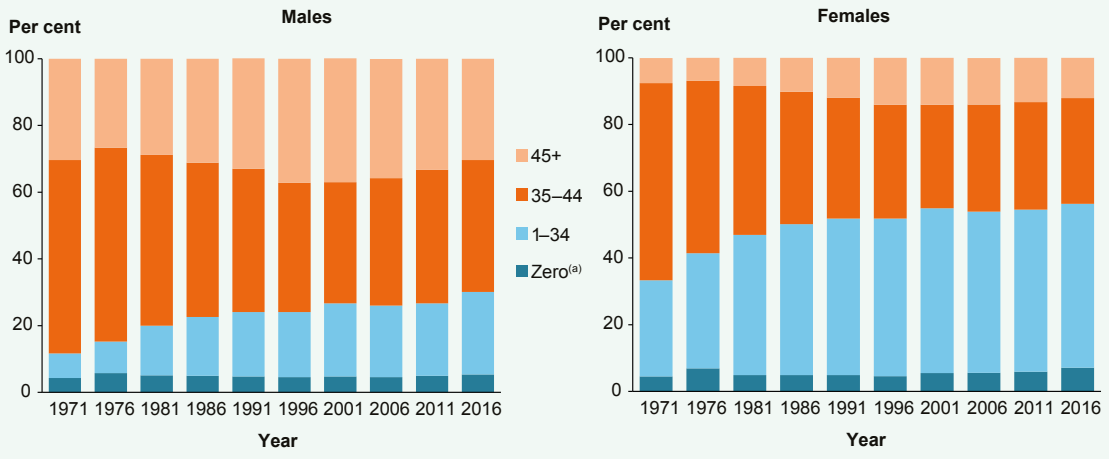
At the same time, though, many commentators have expressed concern that the quality of many jobs has declined. The media, for example, regularly reports stories that emphasise the rise in low-wage, part-time and insecure jobs (Adonis 2016; Cleary 2016; Smith 2014). There is also evidence, both in Australia and internationally, suggesting that many of the new jobs are low quality (for example, Green et al. 2010; Kalleberg 2011; McGovern et al. 2004). In particular, it is widely believed that jobs increasingly require workers to work longer hours and/or more unsocial hours or accept non-standard employment contracts involving either part-time hours or a lack of job security (and often both).

In this article, the question of job quality in Australia is examined. In particular, the article looks at data describing recent trends in working time and the incidence of non-standard employment, and at associations with measures of worker wellbeing.

Working time

Trends

The ABS Labour Force Survey (LFS) is the starting point for any analysis of working time trends in Australia. This survey has long included a question on the number of hours actually worked in all jobs held during the survey reference week. Figure 4.1.1 uses data for selected years from this survey to summarise the changing distribution of working hours since 1971. It shows that the notion of a standard-length work week—centred on the 8-hour day, 5-day week—has not been the norm for a long time. At the start of the period, in 1971, 58% of all employed people reported working between 35 and 44 hours a week, which is roughly equivalent to a standard work week once allowance is made for some modest level of paid overtime. By the end of the period (August 2016), this proportion was slightly less than 40% among males and less than 32% among females.



(a) Includes, for example, people on leave, on strike, and who did not work any hours during the reference week because of shift arrangements.

Sources: 1971–1986: ABS Labour force, Australia (ABS cat. no. 6202.0); 1991–2016: ABS Labour force, Australia, detailed—electronic delivery (ABS cat. no. 6291.0.55.001).

Figure 4.1.1: Composition of employment, by weekly hours actually worked and sex, 1971 to 2016

Figure 4.1.1 shows there has been a marked growth in the proportion of employed people working part-time hours. This is reflected in the rising share of people reporting working fewer than 35 hours during the survey reference week. Among males, this share has risen more than three-fold, from just 7.4% in 1971 to 25% in 2016. Growth has been less rapid among females, but the share is much higher: 49% of employed females in August 2016 worked fewer than 35 hours per week (29% in 1971). However, there has been very little growth in the share of females working fewer than 35 hours since the turn of the century—most of the growth occurred in the 1970s and 1980s.

When data on the incidence of part-time work are examined—as officially measured by the ABS, which defines a part-time worker somewhat differently to other sources (see Box 4.1.1)—there is still evidence that the part-time share among females has continued to rise; albeit at a slower rate in more recent years. As at August 2016, 46% of employed females worked part time compared with 45% 15 years earlier. Among males, however, recent growth has been much more striking. Part-time employment for males rose from 14% in August 2001 to almost 18% in August 2016, with most of this rise occurring since 2009.

Box 4.1.1: Measurement of part-time employment

Thirty-five hours per week is the cut-off point conventionally used to distinguish full time from part-time work in Australia. However, that definition typically requires information on the number of hours usually worked (not just on the number of hours actually worked, which is what is reported in Figure 4.1.1). Therefore, in the LFS, the ABS defines a part-time worker as someone who usually works fewer than 35 hours per week and did so during the survey reference week (ABS 2013).

Very differently, other surveys (for example, the Household, Income and Labour Dynamics in Australia (HILDA) Survey) collect data only on usual hours of work. Hence, the definition of part-time work is solely based on whether usual weekly hours of work are fewer than 35.

The proportion of workers reporting actually working fewer than 35 hours in a specific week will thus overstate the extent of part-time work as it will include some people who usually work full-time hours.

The share of workers in part-time employment in Australia is very high by international standards. While international comparisons are complicated by differences in definitions, data suggest that among Organisation for Economic Co-operation and Development (OECD) countries, only the Netherlands (38%) and Switzerland (27%) employ proportionally more part-time workers than Australia. In 2015, the OECD average proportion of workers in part time employment was 17% (defined by the OECD as people usually working fewer than 30 hours per week in their main job). The most comparable figure for Australia was around 24% (OECD 2016).

Australia is also relatively distinctive in having a workforce where the high incidence of part-time work is accompanied by a relatively high proportion of workers reporting working long hours each week. The OECD ranks Australia tenth out of 38 included member and partner countries for the proportion of its workers (13%) working 'very long hours' (50 hours or more per week as defined by the OECD) (OECD 2015).

As at August 2016, around 12% of females in paid employment reported that they worked long hours (defined here as 45 hours or more a week) during the survey reference week (Figure 4.1.1). This compares with 7.5% of females in 1971. Among employed males, the proportion working long hours is now back to where it was at the start of the period, after rising steadily for 2 decades between the mid-1970s and mid-1990s. Among females, the share of working long hours has been falling over the last 15 years or so.

In summary, the following points are noteworthy:

- The traditional 35- to 40-hour work week is less common today than 50 years ago.
- The main change in working-time patterns is growth in part-time employment.
- Much of the relative growth in part-time employment was concentrated in the 1970s and 1980s. Among males, however, growth in part-time employment has accelerated in recent years.
- During the 1980s and 1990s—and while the part-time employment share was rising—there was also a trend towards long work weeks. This trend stopped, and reversed in the 2000s.

Working-time mismatch

Concerns about the relatively high incidence of both part-time and long work hours are rooted in the notion that the best jobs are those where weekly hours most closely conform to industrial norms. However, there is now strong evidence that it is not the number of hours worked that matter most for worker wellbeing, but whether, and the extent to which, those hours (often driven by employer needs and demands) are aligned with worker preferences.

Survey data consistently show that most part-time workers, and especially females, have strong preferences for part-time work. For example, 2015 HILDA Survey data show that 87% of females in part-time work prefer part-time work (that is, working fewer than 35 hours per week). Among males in part-time jobs, the proportion who prefer part-time hours, while lower than that for females, still represents a sizeable majority (74%).

Studies of job satisfaction have mostly been unable to detect sizeable negative associations with part-time work (for example, Booth & van Ours 2008; D'Addio et al. 2007; Roeters & Craig 2014). Instead, some researchers have focused on the underemployed—part-time workers working fewer hours than desired—arguing that the insufficiency of work among some part-time workers is comparable to unemployment (see Anderson & Winefield 2011). Underemployment, like unemployment, is a source of stress that has the potential to compromise health and wellbeing.

The ABS LFS estimates the number of part-time workers who would prefer more hours. These workers, along with full-time workers who worked fewer than full-time hours during the survey reference week, are defined by the ABS as underemployed workers (see Box 4.1.2). Figure 4.1.2 shows that the (seasonally adjusted) rate of underemployment has trended upward since 1978 for both males and females. It rose steeply during the recession of the early 1990s, but then did not return to pre-recession levels. Since 2011, the rate has climbed steadily upward. In 2016, the underemployment rate was at a record high, accounting for 9.3% of all employed people (or 8.7% of the labour force). This is very different from the trend in the much more well-known unemployment rate, which was 5.6% in 2016, around half its peak of 11% in 1993.

Preferences for working hours

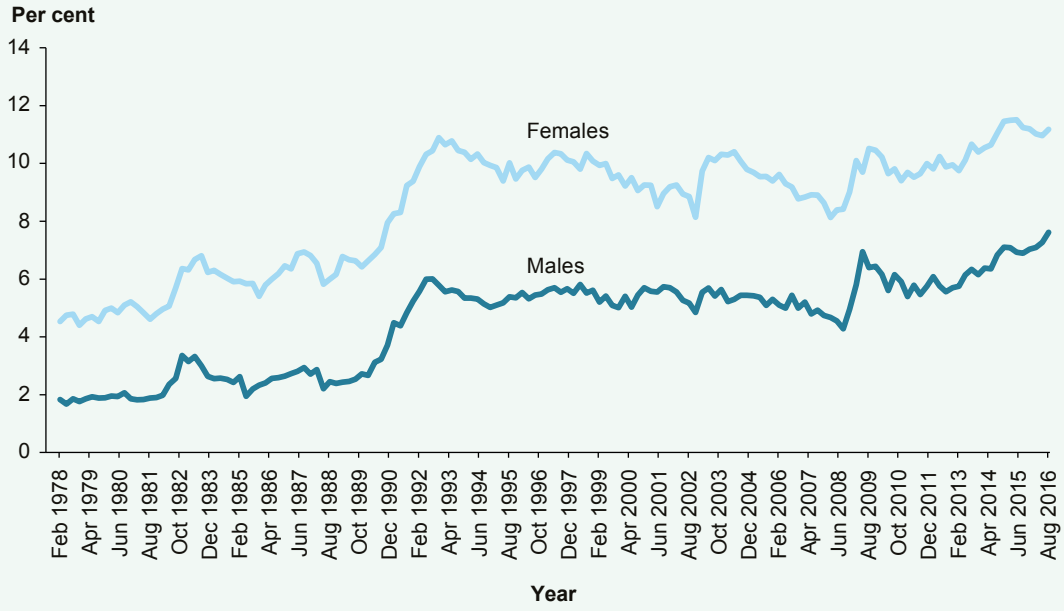
Box 4.1.2: How the ABS defines underemployment

The ABS classifies an employed person as underemployed if they are either:

(i) employed on a part-time basis and want to work more hours (and are available to start work with more hours, either in the survey reference week or in the 4 weeks after the survey), or

(ii) employed full time but worked fewer than 35 hours during the survey reference week for economic reasons.

Source: ABS 2013.



Note: Data are seasonally adjusted.

Source: ABS 2016b, Table 22.

Figure 4.1.2: Underemployment rate in Australia (as a proportion of employed people), by sex, February 1978 to August 2016

The data the ABS collects on working time preferences have limitations. For example, the monthly LFS collects data about preferences for more hours, but not preferences for fewer hours. The likelihood that, at any point in time, the preferences of all workers will coincide with the needs of their employer is very low. For example, the ABS Business Longitudinal Dataset shows the most common response to skill shortages is current employees working more hours at the request of their employer (Healy et al. 2012). Therefore, overemployment can be expected to be especially pronounced when firms face difficulties recruiting additional labour. As well, the LFS is asked on the basis that 'any responsible adult in the household' can respond to the questions. This means that one person in the household answers on behalf of all others, which can be problematic for questions eliciting information about preferences.

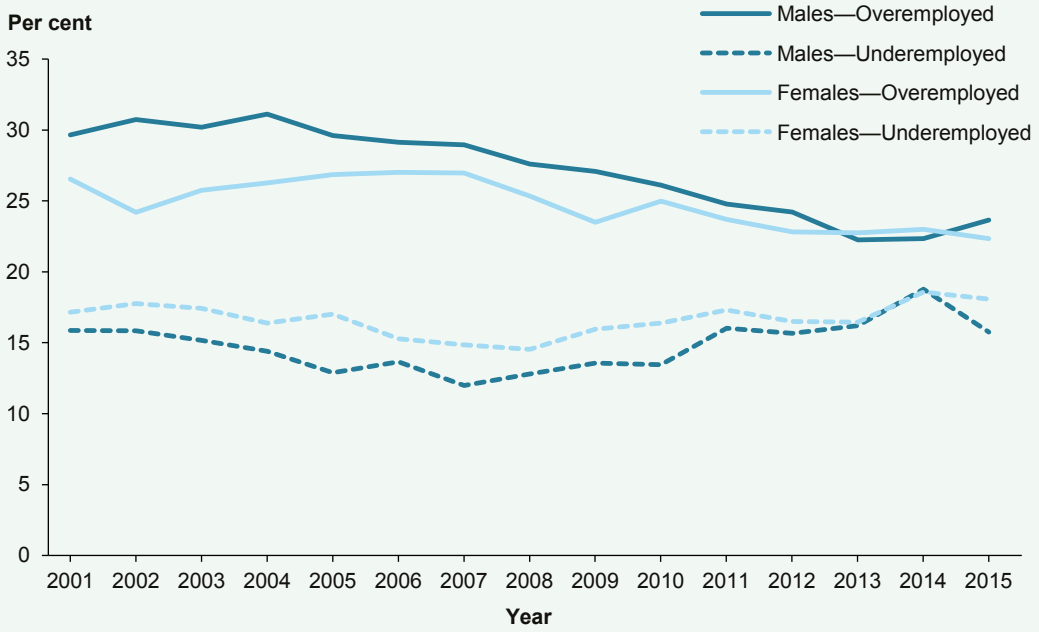
The HILDA Survey is an alternative source of data on working-time mismatch. The annual household panel survey began in 2001. Each year, employed respondents are asked to indicate:

- how many hours they usually work each week, including any paid or unpaid overtime
- whether they would prefer to work fewer, more, or about the same hours as currently (while taking into account how any change would affect income)
- if more or fewer preferred hours are nominated, how many.

Responses to this set of questions provides measures of the incidence of both underemployment and overemployment (that is, employed people who prefer to work fewer hours each week while taking into account any effect on their income), as well as the extent of those mismatches.

Underemployment and overemployment

Data from the HILDA Survey describing trends in the incidence of both underemployment and overemployment are presented in Figure 4.1.3. The figure also shows that there has been a general rise in the level of underemployment in recent years; these levels are much greater than suggested in Figure 4.1.2. This is due, in part, to full-time workers who prefer more hours being included among the underemployed in these data, and because workers have not had to be available to work the additional hours to be classified as underemployed. (The HILDA Survey started collecting data on 'availability to work additional hours' only in 2010.) Even if underemployment had been restricted to people who usually work part time but preferred more hours (and who were available to work those additional hours), the estimated rate of underemployment in 2015 would have been 11%. This is still 2 percentage points higher than the rate derived from the ABS data for this period.



Source: Wooden et al. 2016.

Figure 4.1.3: Underemployed and overemployed workers (as a proportion of employed people), by sex, 2001 to 2015

Figure 4.1.3 also shows that, historically, there have been many more overemployed workers (that is, people who would prefer to work fewer hours) than underemployed workers. At the same time, the incidence of overemployment has been in decline over the last 15 years. Today, the gap between the underemployment and overemployment shares is much smaller than it was at the start of the century.

The combined result of these different trends—rising underemployment but falling overemployment—is that the overall level of mismatch has fallen since 2001. In 2001, around 46% of males and 44% of females workers reported preferred hours that were different from usual hours. In 2015, the comparable proportions were 39% and 40%.

The data also show evidence of a clear time divide, with many part-time workers reporting that they work too little and many full-time workers reporting they work too much (Wooden et al. 2016). Also, the patterns in mismatch are highly gendered: females, who are much more likely to be working part time, are also much more likely to prefer part-time hours; while males, who are more likely to work long hours, are also more likely to prefer long hours.

The numbers presented in both figures 4.1.2 and 4.1.3 are based on a count of heads. As such, they are not necessarily a good guide to the overall level of mismatch. That requires extra information on the extent of mismatch (that is, the size of the difference between preferred and usual hours of work). As noted earlier, this information is collected in the HILDA Survey, with the data indicating that, for most workers reporting mismatch, the extent of mismatch is considerable. For example, in the most recent survey wave (2015), the mean level of mismatch was 13.4 hours per week among males and 12.1 hours per week among females, with mean hours (the difference between hours worked and desired hours) of overemployment slightly higher (by about 1 hour) than mean hours of underemployment. These levels have changed very little over time.

Working time and worker wellbeing

So, does working time—more specifically, working hours that are not in line with worker preferences—affect worker wellbeing? Associations between three indicators of worker wellbeing and usual weekly hours worked, cross-classified by working-time mismatch, were analysed using the HILDA survey (Table 4.1.1).

The three indicators of wellbeing used were:

1. *job satisfaction:* records responses, on a 0 to 10 scale, to the question: 'All things considered, how satisfied are you with your job?'
2. *life satisfaction:* records responses, again on a 0 to 10 scale, to the question: 'All things considered, how satisfied are you with your life?'
3. *mental health:* measured with the Mental Health Inventory, a measure that involves 5 items assessing the frequency of symptoms of anxiety and mood disturbance over a 4 week period. Scores on each item are summed and then transformed to a range from 0 to 100.

Table 4.1.1: Indicators of worker wellbeing (mean scores), by usual weekly hours worked and working-time mismatch, 2001 to 2015 (pooled)

Hours usually worked per week	Well-matched	Underemployed	Overemployed
		Job satisfaction (0–10)	
≤34	8.1	7.3	7.3
35–40	7.8	7.4	7.1
41–49	7.9	7.7	7.1
50+	8.0	7.5	7.2
Total	**7.9**	**7.3**	**7.2**
		Life satisfaction (0–10)	
≤34	8.1	7.7	7.8
35–40	7.9	7.7	7.7
41–49	8.0	7.8	7.7
50+	8.0	7.5	7.6
Total	**8.0**	**7.7**	**7.7**
		Mental health (0–100)	
≤34	76.0	71.7	73.7
35–40	76.3	73.2	73.8
41–49	77.4	75.1	74.7
50+	78.4	73.0	74.7
Total	**76.6**	**72.2**	**74.3**

Note: Observations are drawn from the first 15 waves of the HILDA Survey and pooled, with each observation weighted by the relevant cross section weight.

Source: Wooden et al. 2016.

The data presented in Table 4.1.1 suggest four main conclusions.

- First, worker wellbeing does not vary much with the length of the usual work week. Consider, for example, job satisfaction levels among the group of workers who report that their usual work hours are consistent with preferences (the well-matched). The mean job satisfaction score within this group was 7.9, varying from 7.8 for people working a standard 35–40 work week to 8.1 for part-time workers and 8.0 for people working long work weeks (50 hours or more).
- Second, regardless of the number of hours worked, both underemployed and overemployed workers report lower levels of satisfaction and mental health than well matched workers. In the case of job satisfaction, these differences are quite large, with mean scores of 7.2 and 7.3 for the overemployed and underemployed, respectively, compared with 7.9 for workers who are well matched.

- Third, these differences are most marked with respect to job satisfaction. The differences are smaller when examining the other two wellbeing measures, but nevertheless remain statistically significant (at a 95% confidence level). These smaller differentials for life satisfaction and mental health are to be expected, and reflect the fact that broader measures of wellbeing will depend much more on factors outside work.
- Fourth, these lower levels of wellbeing do not differ much between the underemployed and the overemployed.

In summary, it is not the number of hours worked that matters for worker wellbeing, but whether those hours accord with worker preferences. Further, other more extensive and statistically sophisticated analyses of these data have found that the conclusions reported here are robust when controlling for individual characteristics (for example, Otterbach et al. 2016; Wooden et al. 2009).

Note that very little has been said here about the forces influencing either worker or employer preferences for working hours. This lies largely beyond the scope of this article. It should not be assumed, though, that the factors driving underemployment will be the same as those driving overemployment. Indeed, there may well be very different, if not opposing, forces at work (Reynolds & Aletraris 2006).

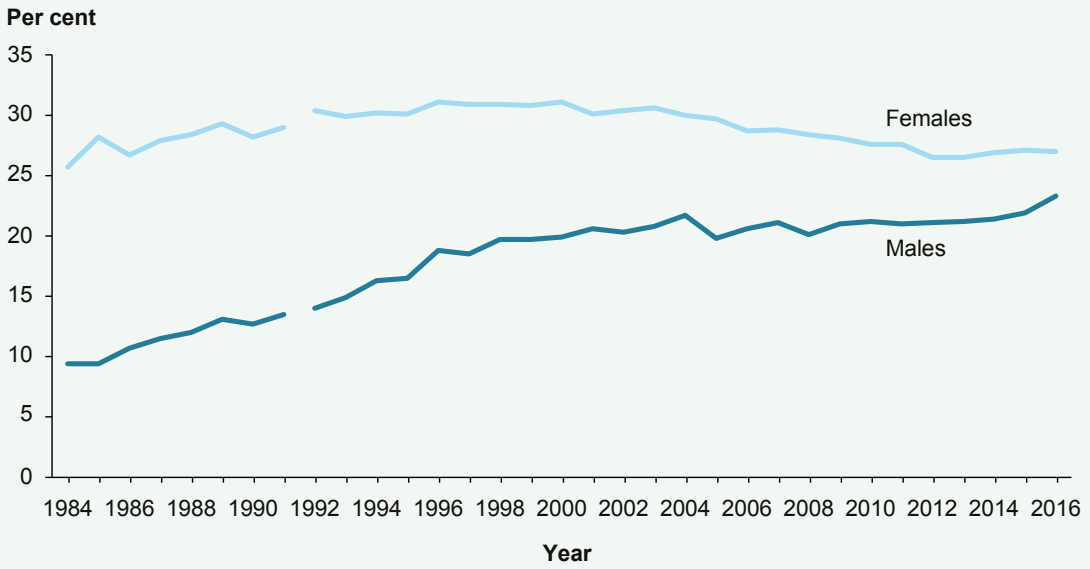
Job security and precarious employment

Another often expressed view is that jobs in Australia today are more insecure than at any other time in Australia's recent (post-World War II) history, and that growth in more precarious non-standard forms of employment (such as casual work, fixed-term contracts, labour hire, and as self-employed contractors) is the major reason for this rise in insecurity (for example, see ACTU 2011). This has important consequences for worker wellbeing, with job insecurity being a source of stress and hence a negative influence on health outcomes (Benach et al. 2014). The potential adverse consequences do not just end with health consequences, however. The greater financial insecurity associated with more insecure forms of work can, for example, also affect the ability of workers to obtain loans or obtain accommodation in the rental market (Independent Inquiry into Insecure Work 2012).

Incidence of, and trends in, non-standard employment

Available data confirm that the incidence of non-standard forms of employment (especially casual employment) is very high in Australia. Still, there is relatively little evidence of significant growth in the share of total employment accounted for by these non-standard jobs over the last 2 decades.

For example, data collected by the ABS on the proportion of employees without either paid annual leave entitlements or paid sick leave entitlements (typically synonymous with casual employment) suggest that most of the growth in the casual employment share occurred before the late 1990s (see Figure 4.1.4 for the trend in this share between 1984 and 2016). The proportion of female employees without paid leave entitlements peaked in 1996, at about 31%, but declined to 27% by 2016. Among male employees, there has been no obvious trend decline, with the proportion reporting no paid leave entitlements fluctuating around 20–21% for most of the period since 2000. However, in 2016, there was a noticeable jump in casual employment levels among male workers (to 23%).



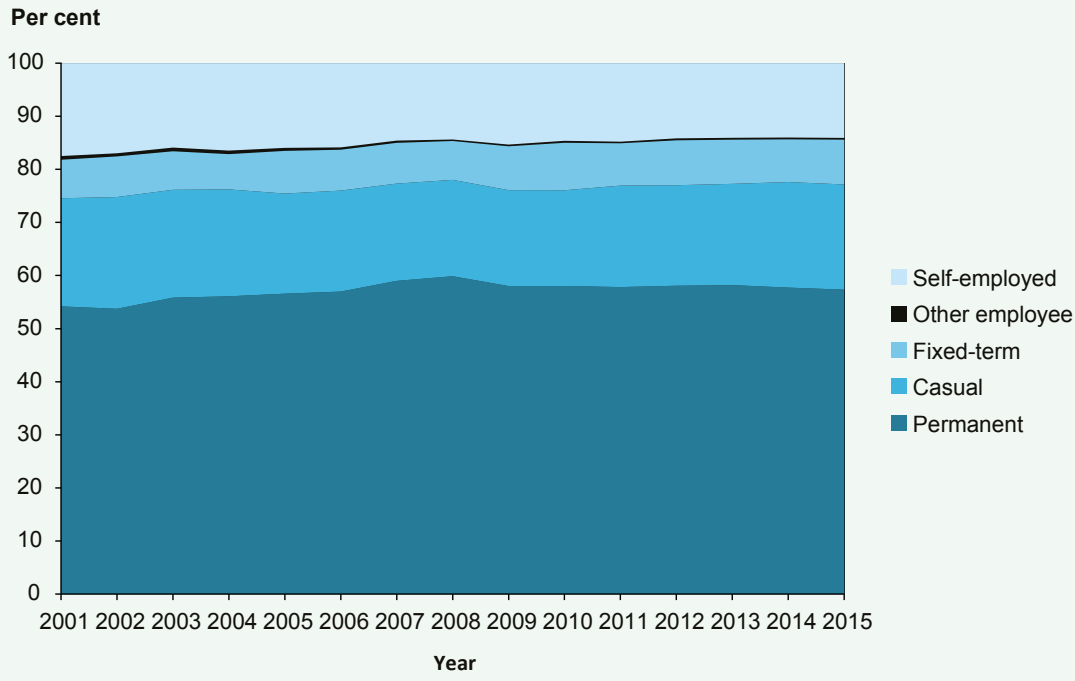
Note: All figures are for the month of August. Figures for 1984 to 1991 include employee managers of incorporated enterprises, and are therefore not directly comparable with figures for other years.

Sources: 1984–1988: Dawkins & Norris 1990; 1988–1992: ABS Employment Benefits, Australia (ABS cat. nos 6334.0 and 6310.0); 1993, 1994 and 1997: ABS Weekly Earnings of Employees (Distribution), Australia (ABS cat. no 6310.0); 1995: ABS 1995; 1996: ABS 1996; 1998–2013: ABS Employee Earnings, Benefits and Trade Union Membership, Australia (ABS cat. no 6310.0); 2014–2016: ABS Labour Force, Australia, Detailed, Quarterly (ABS cat. no 6291.0.55.003).

Figure 4.1.4: Employees without paid leave entitlements (proportion of all employees) by sex, 1984 to 2016

Similarly, there is little evidence that other forms of non-standard employment have been growing relative to more traditional forms of employment—that is, permanent wage and salary earner jobs—in recent years. For example, data collected in the HILDA Survey allow the sorting of employees into one of three main groups based on their employment contract in their main job: fixed-term contract, casual, or permanent/ongoing. Adding the self employed gives the total employed population.

Figure 4.1.5 shows how the composition of the employed workforce by contract type/ employment status has changed over the last 15 years. In 2015, permanent employees accounted for 57% of all employed people—3.1 percentage points higher than in 2001. Virtually all this growth has been offset by a decline in the self-employment share, which has been steadily declining throughout this period; ABS data suggest the decline in the self employment share began in the early 1990s (see Atalay et al. 2014). In contrast, the casual employment share has been fairly stable since 2001, at around 20% of the employed workforce, while the share of workers on fixed-term contracts has increased by only 1.2 percentage points (from 7.2% to 8.4%).



Source: Wooden et al. 2016.

Note: 'Other' employees includes people who could not be categorised elsewhere; this incorporates some apprentices, persons working on probation and some employees working on a commission basis.

Figure 4.1.5: Composition of employment, 2001 to 2015

Almost 1 in 3 employees in Australia have non-standard forms of employment, with casual and fixed-term contract employees combined accounting for 28% of the employed workforce. However, this level is nothing new, with most (if not all) of the growth in the share of non-standard jobs occurring before the turn of the century.

Non-standard employment, job insecurity and worker wellbeing

HILDA Survey data show that non-standard forms of employment (that is, casual employment and fixed-term contract employment) are associated with relatively higher levels of job insecurity. This can be seen in Table 4.1.2, where employment status (and whether working full-time or part-time hours) is cross-classified by a measure of job insecurity—the expected probability of job loss during the next 12 months. The mean probability of job loss among full-time casual employees is almost 20% among males, and more than 15% among females. The comparable proportions among full-time permanent employees are about half this (10% and 8%, respectively). Rates of perceived job loss are also relatively high among fixed-term contract workers. Among females, fixed-term contract jobs are associated with the highest probabilities of job loss. However, there is little evidence of part-time jobs being more insecure than full-time jobs—the mean perceived probability of job loss was noticeably lower among part-time casual employees than among their full-time equivalents.

Table 4.1.2: Probability of job loss, employed people, by employment type and full-time/part-time status and sex, 2001 to 2015 (pooled)

	Mean probability of job loss (%)		Probability of job loss ≥50%	
Employment status	**Males**	**Females**	**Males**	**Females**
Full-time permanent	9.9	7.8	8.9	7.4
Part-time permanent	10.5	7.1	10.1	7.0
Full-time casual	19.8	15.5	24.0	19.2
Part-time casual	13.1	11.9	13.0	12.8
Full-time fixed term	16.0	17.8	16.3	19.8
Part-time fixed term	19.5	17.8	20.8	22.4

Note: The probability of job loss is derived from answers to the question: 'What do you think is the per cent chance that you will lose your job during the next 12 months? (that is, get retrenched or fired or not have your contract renewed.)'. Observations are drawn from the first 15 waves of the HILDA Survey and pooled, with each observation weighted by the relevant cross-section weight.

Source: Wooden et al. 2016.

Except for satisfaction with job security, differences in wellbeing across the different employment types are mostly very small (Table 4.1.3), with no differences for overall life satisfaction. Job satisfaction levels, on the other hand, are slightly lower among males in casual jobs than males in permanent jobs (but this difference is quite small, at 7.4 and 7.6, respectively). More sophisticated statistical analysis of the HILDA Survey data (covering the first 10 survey waves) that controls for other personal characteristics suggests that the difference is greater—perhaps twice as large (Buddelmeyer et al. 2015). This analysis, however, was unable to detect any significant differences in job satisfaction between males in fixed-term contract jobs and males who were permanent employees, nor was there any evidence that the job satisfaction of female workers varies with contract type.

Table 4.1.3: Indicators of worker wellbeing (mean scores), employed people, by employment type and sex, 2001 to 2015 (pooled)

Employment type and sex	Satisfaction with job security (0–10)	Overall job satisfaction (0–10)	Life satisfaction (0–10)	Mental health (0–100)
Males				
Permanent employee	8.1	7.6	7.9	76.7
Casual employee	7.3	7.4	7.9	74.7
Fixed-term contract employee	7.5	7.6	7.9	76.6
Self-employed	7.4	7.7	7.8	77.3
Females				
Permanent employee	8.3	7.7	7.9	74.7
Casual employee	7.6	7.6	7.9	72.2
Fixed-term contract employee	7.0	7.6	7.8	73.3
Self-employed	7.7	8.0	8.0	75.9
All people				
Permanent employee	8.2	7.6	7.9	75.8
Casual employee	7.5	7.5	7.9	73.2
Fixed-term contract employee	7.3	7.6	7.9	75.0
Self-employed	7.5	7.8	7.9	76.8

Note: Observations are drawn from the first 15 waves of the HILDA Survey and pooled, with each observation weighted by the relevant cross section weight.

Source: Wooden et al. 2016.

Both male and female casual employees report lower mental health levels than permanent employees, but the difference is again small. Further, it is not obvious in which direction the causation runs—it may be that mental health issues make it difficult for workers to both obtain and retain permanent work. Other research (also involving the HILDA Survey data) controls for reverse causation and is unable to find any evidence that casual or fixed-term contract employment is harmful for mental health (Richardson et al. 2012).

Recent research undertaken in Europe (Jahn 2015; Origo & Pagani 2009) suggests that it is not employment type that is so critical for worker wellbeing, but perceived job insecurity, which, in turn, may be only imperfectly correlated with employment type. Very few so called permanent jobs are in fact permanent. While rates of job loss are considerably lower for permanent employees than for other types of worker, when permanent employees do lose their job, the cost to those individuals, both economically and psychologically, may be considerable.

Table 4.1.4 shows mean scores on the four wellbeing indicators by employment type, cross classified by a simple measure of job insecurity.

Table 4.1.4: Indicators of worker wellbeing (mean scores), employed people, by employment type and job security, 2001 to 2015 (pooled)

Employment type and job security (% distribution)	Satisfaction with job security (0–10)	Overall job satisfaction (0–10)	Life satisfaction (0–10)	Mental health (0–100)
Permanent—secure (41.1%)	8.8	7.9	8.0	77.1
Permanent—moderately insecure (21.3%)	7.7	7.4	7.7	74.4
Permanent—insecure (5.6%)	5.3	6.7	7.5	71.1
Casual—secure (12.2%)	8.3	7.9	8.1	74.5
Casual—moderately insecure (7.1%)	7.3	7.4	7.8	72.7
Casual—insecure (3.4%)	4.9	6.7	7.4	70.0
Fixed-term contract—secure (4.7%)	8.4	7.9	8.0	76.5
Fixed-term contract—moderately insecure (2.9%)	7.1	7.5	7.7	74.8
Fixed-term contract—insecure (1.8%)	4.5	7.0	7.6	71.2

Note: A secure job is defined as one where the respondents report zero probability of job loss in the next 12 months; a moderately insecure job is one where this probability is non-zero but less than 50%; and an insecure job is one where this probability is 50% or more. Observations are drawn from the first 15 waves of the HILDA Survey and pooled, with each observation weighted by the relevant cross-section weight.

Source: Wooden et al. 2016.

The data reported in Table 4.1.4 clearly show that it is not employment type that matters so much for worker wellbeing but how insecure workers feel in their jobs. Most casual employees in Australia report zero chance of losing their job in the year ahead (54%) and, on average, these workers do not report lower levels of job or life satisfaction than permanent employees. Mental health wellbeing levels are slightly lower among casual employees, but, again, the differences are small. This could reflect a causal process where mental health problems are an obstacle to securing permanent jobs (rather than the result of casual employment).

In contrast, there are marked differences between workers when differentiated based on their reports of expected probability of job loss. Workers in secure jobs (regardless of their contractual arrangement) report not only much higher satisfaction with job security, but also being much better off on each of the three other wellbeing indicators.

So, does this mean non-standard employment is not the problem for worker wellbeing that it is often thought to be? Yes and no. Very clearly, it is job insecurity that is most critical for worker wellbeing. Yet it remains the case that the likelihood of being in an insecure job is much greater when the contract for that job is casual or for a fixed-term.

What is missing from the picture?

When examining working time, the focus has been on the number of hours worked, but equally important may be when those hours are worked (for example, the time of day or week). Data to inform this question may be available from the Australian Time Use Survey (ATUS), but information is dated—the ATUS was last conducted in 2006.

Where do I go for more information?

For a broader review of recent trends in the Australian labour market, see Wilkins and Wooden (2014).

More information about the HILDA Survey, including how to obtain the unit record data file, is available at http://melbourneinstitute.unimelb.edu.au/hilda.

For more detailed analyses of the relationship between working-time mismatch and measures of worker wellbeing that use HILDA Survey data, see Wooden et al. (2009) and Otterbach et al. (2016).

For a more detailed analysis of the relationship between non-standard employment and job satisfaction that uses HILDA Survey data, see Buddelmeyer et al. (2015).

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4.2 Key employment trends

Employment, and the economic resources gained from it, underpins a society's ability to support itself. Having a job helps a person to satisfy their own needs and wants. It also helps them to support their family and their community more broadly. Without employment, some people depend on welfare services and supports, among other society responses. This article provides information on employment trends and on some of the main Australian Government programs that deliver income support and employment services to unemployed people. Box 4.2.1 sets out the main concepts and definitions used when discussing the employment of the population.

Box 4.2.1: Employment concepts and definitions

The 'working age population' in this article is all people aged 15–64.

The 'youth population' in this article is all people aged 15–24.

The 'employment to population ratio' is a measure of the total level of employment. It is the proportion of the total working age population who are employed (that is, the number of working age people employed divided by the total working age population). Data for this measure are based on monthly trend estimates.

The 'unemployment rate' is the number of unemployed people expressed as a percentage of the labour force. The unemployment rate used is an average of monthly rates over a calendar year. To be defined as unemployed, a person must be:

- aged 15 or older
- not currently working and has actively looked for work at any time in the 4 weeks leading up to the end of the survey reference week
- available for work in the survey reference week or waiting to start work in a new job within 4 weeks from the end of the reference week.

Formal definitions of these terms and information on how the data are collected can be found in supporting documentation for the Australian Bureau of Statistics (ABS) Labour Force Survey (ABS 2017).

Long-term employment trends

Over the last 40 years, Australia has generally seen rising levels of employment. This is despite three labour market downturns: in the early 1980s, the early 1990s, and after the Global Financial Crisis (GFC) of 2007–08.

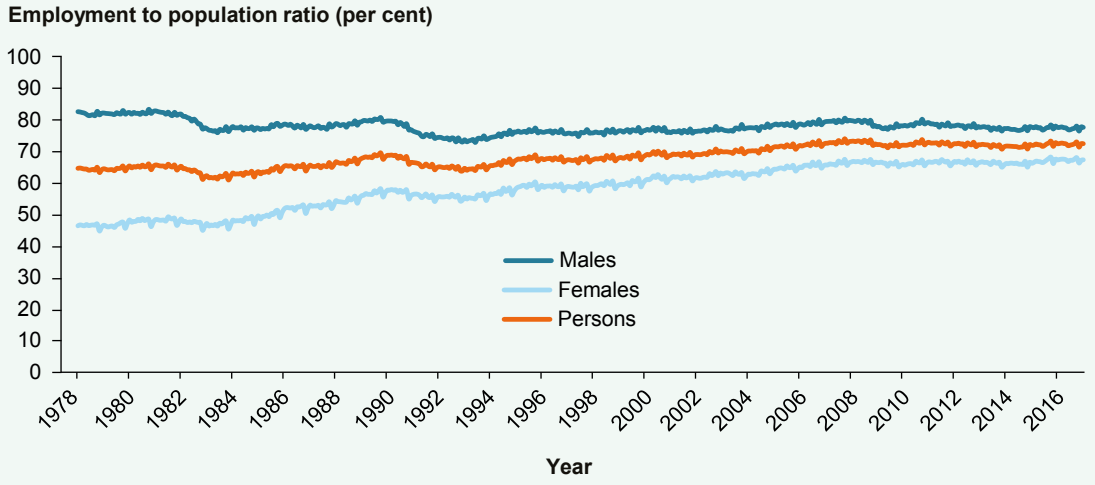
The downturns in the 1980s and 1990s saw a substantial fall in the working age employment to population ratio (see Box 4.2.1) over a few years, after which it grew to surpass pre-event levels. For example, from mid-1981 to mid-1983, the ratio fell from 65% to 62%, but was more than 65% by the end of 1987. The downturn relating to the GFC saw the ratio fall by less than 2 percentage points (73.3% to 71.7%) and last for only 1 year (mid-2008 to mid 2009). Since then, it has been relatively stable, moving between a low of 71.5% and a high of 72.9% (Figure 4.2.1).

Trends for males

Male employment mirrored the overall employment trends up to 2008. Since then, there has been a marked decline in the working age employment to population ratio. It fell from a high of 80% in early 2008 to a low of 77% in mid-2009. Despite bouncing back in 2010–11, the rate has trended downward since the GFC, reaching a 13-year low of 77% throughout most of 2014. It was 77% in March 2017.

Trends for females

The story is more positive for females. Over the course of the last 40 years, the female working age employment to population ratio has been rising. From around 46–47% during the late 1970s, the rate continued to grow until the late 2000s. From the end of 1985, at least half of all working age females were employed; by early 2008, this figure had risen to two-thirds of all working age females. Since 2008, growth in female employment has slowed, although the GFC did not result in a substantial downturn in female employment. Since the start of 2017, the female working age employment to population ratio was 67.3%, which is close to its highest ever level of 67.4% (in early 2016).



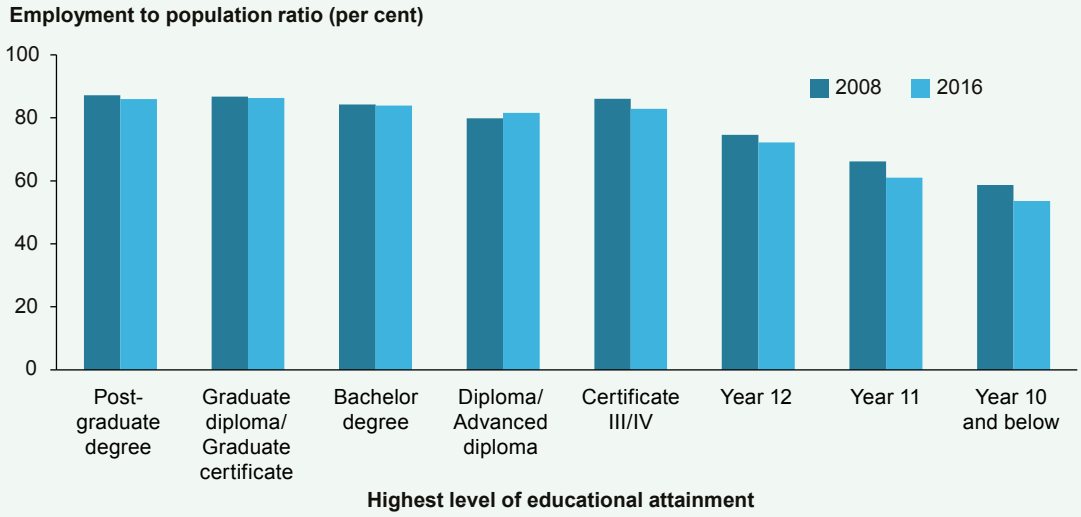
Source: AIHW analysis of ABS 2017.

Figure 4.2.1: Employment to population ratio by sex, March 1978 to March 2017

Education and employment

Since 2008, despite relative stability in employment, there has been a marked decline in the proportion of lower skilled people who are employed. For instance, the proportion of people whose highest qualification was Year 10 and below (including Certificate I/II) who were employed fell from 59% to 54% between 2008 and 2016. By comparison, the proportion of people whose highest qualification was a Bachelor degree who were employed fell only slightly from 84.2% in 2008 to 83.9% in 2016 (Figure 4.2.2).

In general, more than 4 of every 5 people who have a Diploma or higher educational qualification are employed. This compares with just over half (54%) of all people with 'Year 10 and below' (including Certificate I/II) being employed in 2016.



Source: AIHW analysis of ABS 2017.

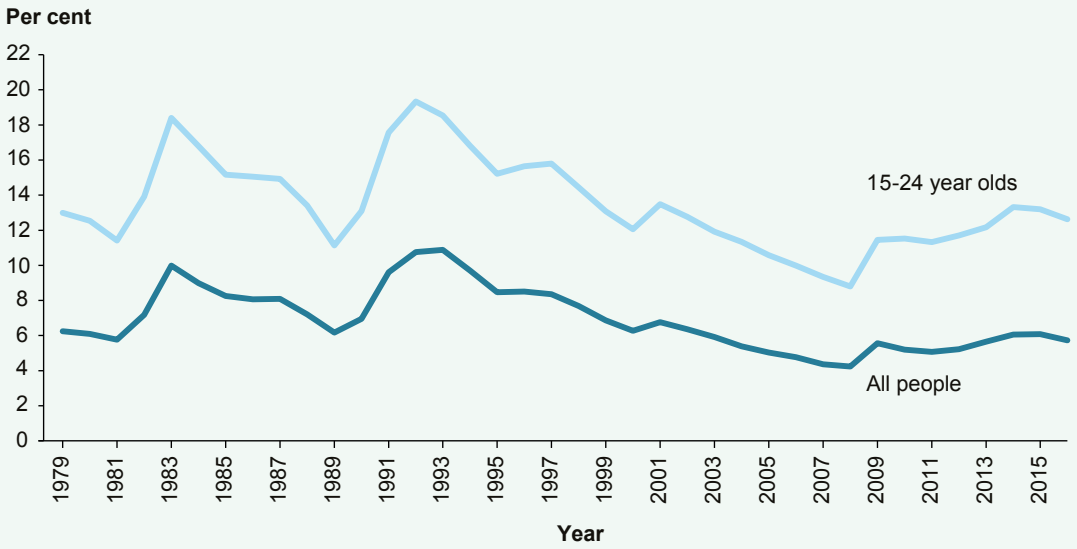
Figure 4.2.2: Employment to population ratio by highest level of education, 2008 and 2016

Youth unemployment

Over the long term, the unemployment rate has showed some variation (Figure 4.2.3). The youth unemployment rate followed a similar pattern to the total unemployment rate, albeit with consistently higher rates.

The two key peaks in youth unemployment align with the recessions of the early 1980s and 1990s—18% (1983) and 19% (1992), respectively. After the second peak, the youth unemployment rate fell to its lowest level of 8.8% in 2008. Unlike the pre-GFC labour market downturns, the youth unemployment rate has continued to rise, as opposed to fall sharply (as was expected), and was 13% in 2016.

The gap between the youth unemployment rate and the total unemployment rate has tended to be more pronounced when total unemployment rates are higher, with the reverse being true when the unemployment rate is lower. This suggests that the unemployment rates in the youth population group are more sensitive to economic changes than they are for the population as a whole.



Source: AIHW analysis of ABS 2017.

Figure 4.2.3: Average annual unemployment rates, 1979 to 2016

Support while looking for work

The Australian Government helps people while they look for work through several payments and services. Financial assistance is available through the following programs:

- Newstart Allowance: provides financial help to people aged 22 or older who are looking for suitable paid work. The benefit covers unemployed people as well as some underemployed people. In 2015–16, the Department of Human Services finalised about 696,000 Newstart Allowance claims, an increase from 671,000 claims in 2014–15 (DHS 2016).
- Youth Allowance (other): available to people looking for work, or undertaking approved activities, who are aged 16–21; full-time students aged 18–24; and apprentices aged 16–24. The benefit has similar rules to those for the Newstart Allowance but notably includes parental income tests, unless independence exemptions are met. In 2015–16, the Department of Human Services finalised about 417,000 Youth Allowance (other) claims, a drop from 424,000 claims in 2014–15 (DHS 2016).
- Job Commitment Bonus: targets job seekers aged 18–30 who have been long-term unemployed (unemployed for 12 months or more). Two payments are made if a job seeker is eligible. The first, of $2,500, is made after 12 months of continuous work and the second, of $4,000, is made for completing a further 12 months of work. In 2015–16, the Department of Human Services processed about 4,300 claims for the first payment (DHS 2016).

The jobactive program is the main Australian Government funded program that supports job seekers in finding employment, linking them with employers. On 1 July 2015, jobactive replaced the Job Services Australia program. The jobactive program supports both job seekers and employers (by delivering employment services). In 2015–16, nearly 350,000 job placements were made through the program (Department of Employment 2016). In 2015–16, 43% of job seekers who had participated in jobactive for 6 months moved off income support, or had substantially reduced their reliance on it (Department of Employment 2016).

People with disability, illness or injury can access Disability Employment Services to find and keep a job. In 2015–16, 31% of participants for this service were employed within 3 months of accessing it (DSS 2016). Australian Disability Enterprises also provides a wide range of supported employment opportunities for people with disability. In 2015–16, just under 19,900 employees were assisted by this agency (DSS 2016).

On 1 July 2015, the Community Development Programme began to support jobseekers in remote Australia. It supports around 35,000 people, 83% of whom identify as being Aboriginal and Torres Strait Islander (PM&C 2017).

What is missing from the picture?

As jobactive has been in existence only since 1 July 2015, there are insufficient data to measure performance over a long-term period for this program.

Where do I go for more information?

More information on labour force data is available from the ABS Labour Force Survey.

More information on support for unemployed people in Australia is available at the Department of Human Services and Department of Employment websites.

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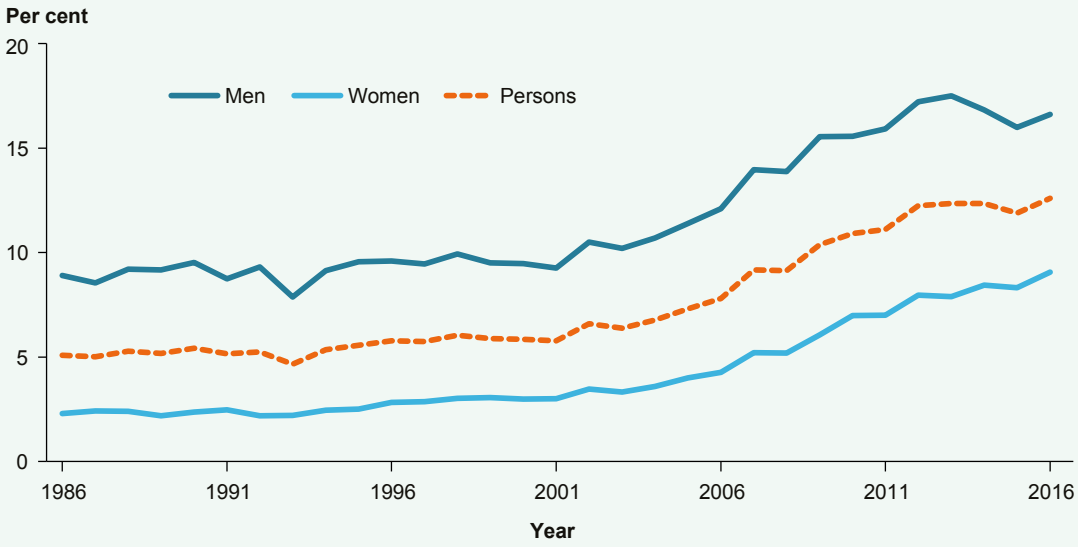
4.3 Seniors in the workforce

Australia's older generation (people aged 65 and over) is continuing to grow. With increasing life expectancies and improvements in health care, more of us will grow older and live longer, healthier and actively engaging lives. This has implications at both the national and individual level, including (but not limited to) those to do with the economic workforce and retirement income planning.

Recent policy changes to meet these challenges include increasing the eligibility age for the Age Pension as well as introducing incentives (such as the Work Bonus and Restart) to encourage seniors back into the workplace, and employers to hire mature-aged workers.

Increasing participation and part-time work

Over the last 3 decades, the employment rate (employment to population ratio) has generally increased among people aged 65 and over, from 5.1% in 1986 to 13% in 2016 (ABS 2016a; (Figure 4.3.1). Over the same period, the unemployment rate for this age group remained relatively stable at around 1.4%.

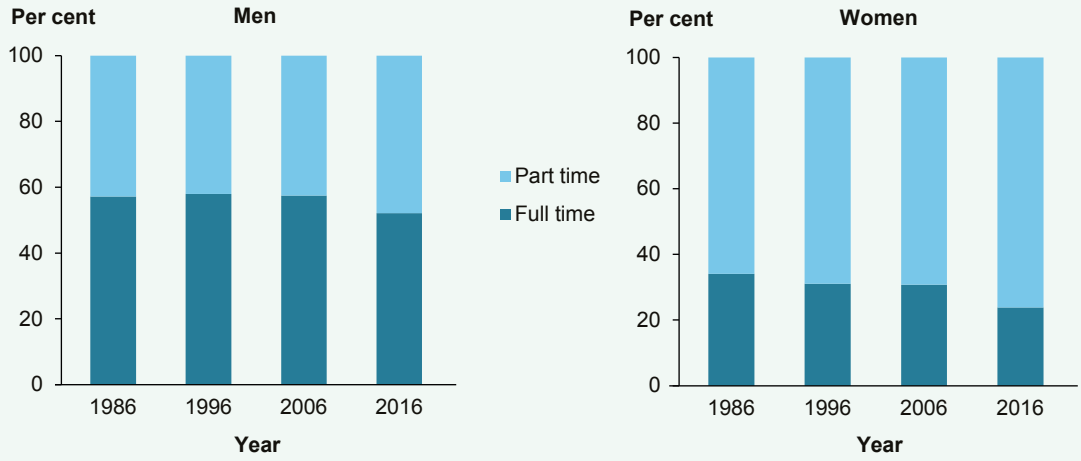


Source: AIHW analysis of ABS 2016a.

Figure 4.3.1: Employment rate, people aged 65 and over, by sex, June 1986 to June 2016

In recent decades, there has been a downward trend in full-time work and an upward trend in part-time work for older Australians. In 1986, a slightly higher proportion of employed older people worked full time (51% compared with 49% working part time) (ABS 2016a). However, the balance between full-time and part-time work shifted in 1997. Since then, there has been a higher proportion in part-time work, steadily increasing to a peak of 59% in 2016.

Employed older women were more likely to work part time than men (Figure 4.3.2). Over the last 3 decades, the majority of employed older women worked part time, with the proportion doing so increasing from 66% in 1986 to 76% in 2016. The proportion of employed older men who worked part time has also increased—though not as much—rising from 43% in 1986 to 48% in 2016.



Source: AIHW analysis of ABS 2016a.

Figure 4.3.2: Proportion of employed persons aged 65 and over working full time and part time, by sex, 1986, 1996, 2006 and 2016, as at June

International comparisons

Labour force data for Australia, relative to that for other countries, suggest that older Australians are faring relatively well against the Organisation for Economic Co-operation and Development (OECD) average (Table 4.3.1). The latest OECD data show that the unemployment rate for Australians aged 65 and over in 2015 was below the OECD average. However, the participation (people working and actively looking for work) and employment rates for people aged 65 and over were just short of the OECD average and well below the rates for New Zealand, Japan and the United States.

Table 4.3.1: Labour force participation, employment rate and unemployment rate, people aged 65 and over, selected OECD countries and OECD average[(a)], 2015

	OECD	Australia	Canada	Japan	New Zealand	United Kingdom	United States
Participation rate (%)	13.8	12.2	13.4	22.1	22.1	10.3	18.9
Employment rate (%)	14.1	12.0	12.8	21.7	21.7	10.1	18.2
Unemployment rate (%)	2.6	1.5	4.5	2.0	1.6	1.9	3.8

(a) International comparisons should be treated with caution as countries have different population profiles. For example, the share of the population in the upper age ranges (80 and over) might vary.

Source: OECD 2017.

Reasons for not working

The most recent data on persons not in the labour force show that, in 2016, there were around 101,100 discouraged job seekers—people available to start work within the next 4 weeks but not actively seeking work (ABS 2016b). Of these people, close to one-third (30% or 30,400) were aged 65 and over. The most commonly reported reason for not actively looking for work among older discouraged job seekers was that they believed they would be considered too old by employers.

In 2014–15, close to 4 in 5 people (79%) aged 65 and over had retired (ABS 2016c). Among men and women, the retirement rate was similar (78% and 80%, respectively). For people who had retired at age 65 and over, reaching retirement age was the most commonly reported reason for leaving their last job (62%). The retirement rate of seniors in 2014–15 was lower than what is was a decade ago (83% in 2004–05).

What is missing from the picture?

Information on Indigenous labour force participation and retirement is limited and is not presented in this article. While the Australian Bureau of Statistics (ABS) publishes labour force data for Indigenous Australians in the National Aboriginal and Torres Strait Islander Social Survey and the Aboriginal and Torres Strait Islander Health Survey, there is no annual measure currently available. Similarly, there are limitations to presenting data on retirement as the ABS Retirement and Retirement Intentions Survey, used in this article, does not include information on the Indigenous status of respondents.

Where to go for more information?

For more information on labour force participation and retirement, see the ABS reports Labour Force and Retirement and Retirement Intentions.

To find out more on the Work bonus and Restart incentives, visit the following sites: Department of Human Services and Department of Employment, respectively.

A paper assessing the changing role of part-time work in Australia was released in 2008 and is available for free download via the Productivity Commission's website. See: www.pc.gov.au/research/supporting/part-time-employment.

The report *Too old to work, too young to retire* overviews seniors in the workforce, providing insight to their experiences, vulnerabilities and future aspirations. For further information on research around age discrimination in the workplace, and the laws in place to prevent this, see the *Willing to Work* report by the Australian Human Rights Commission.

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4.4 Working for free—volunteers in Australia

Australians have a long history of volunteering across many aspects of community life. Volunteers provide an irreplaceable service to the community. Volunteering benefits both the economy and the health and wellbeing of volunteers. In 2012–13, the estimated value of voluntary work in not-for-profit organisations was equivalent to $17 billion (ABS 2015a). Organisations report that volunteers bring new insights, enhance the image of the organisation, increase the efficiencies and volume of operations, and improve effectiveness; volunteering also broadens the networks and professional skills of the volunteers themselves (PwC 2016). Many report that volunteering makes them happier, and provides them with a sense of personal satisfaction, which has flow-on health benefits.

Fewer people are volunteering

The Australian Bureau of Statistics (ABS) General Social Survey (GSS) defines a volunteer as 'someone who is over the age of 15 and, in the previous 12 months, willingly gave unpaid help, in the form of time, service or skills, through an organisation or group' (ABS 2015a). Informal volunteering, such as the care provided by informal carers, is not included under this definition (for information on informal carers, see Chapter 8.3 'Informal carers').

Data from the GSS show that, in 2014:

- an estimated 5.8 million people aged 15 and over (or 31% of the population) participated in voluntary work
- an estimated 748 million hours of voluntary work were provided (or an average of 128 hours per volunteer)
- sport and physical recreation (31%) was the most common type of organisation for which people volunteered
- fundraising or sales (23%) was the most common type of voluntary work undertaken
- the proportion of the population who volunteered was lower than in previous years, and the change between 2010 and 2014 was statistically significant (Figure 4.4.1; ABS 2015b).

Australia's volunteer rate fell for the first time in 2014 after several years on the increase. Yet, it is still above the Organisation for Economic Co-operation and Development (OECD) average. In 2012, the volunteer rate for working-age people (aged 15–64) in Australia was 40%, compared with the OECD average of 34% (OECD 2016). Nevertheless, the decline in the rate of volunteering is concerning as it has links to the economy and health, is thought to be an indicator of wellbeing (for example, by building social connections) and is often highlighted by the World Health Organization as contributing to an age-friendly world (WHO 2015).

Source: ABS 2015b.

Figure 4.4.1: Proportion of people aged 15 and over who undertook unpaid voluntary work in the last 12 months, by sex, 2006, 2010 and 2014

Who volunteers?

In 2014, volunteering was highest among:

- people born in Australia (34%), compared with people born overseas (26%)
- females—who made up 54% of all volunteers
- young people aged 15–17 (42%), followed by people aged 35–44 (39%) and 65–74 (35%)
- people living in *Outer regional* and *Remote* areas (39%), compared with people living in *Major cities* (30%)
- people working part time (38%), followed by people who were unemployed (31%) and people working full time (30%)
- people with a Bachelor degree or above (41%), compared with people without a non-school qualification (25%)
- people living in households in the highest gross household income quintile (39%), compared with people living in the lowest (23%).

(ABS 2015b)

Helping—the main reason to volunteer

According to the GSS, in 2014, helping others and helping the community was the most commonly reported reason for volunteering (64%), followed by personal satisfaction (57%), to do something worthwhile (54%), and personal or family involvement (45%) (ABS 2015a). Around one-third of volunteers reported the reason for being a volunteer was for the social contact (37%), and to use their skills or experience (31%).

What is missing from the picture?

Aboriginal and Torres Strait Islander communities and people from a non-English speaking background undertake large amounts of informal volunteering. As most definitions of volunteering explicitly exclude less structured and informal volunteering, these groups of people are often under-represented in national rates of volunteering. For a deeper understanding of volunteering among these groups, see the report *Giving and volunteering in culturally and linguistically diverse and Indigenous communities*.

Rates of volunteering appear to be in decline. Data on why this is occurring—such as societal factors (including changes in work patterns and living arrangements)—and on the impacts on society (for example, on trust and social cohesion) are not readily available. The associated implications for organisations that rely on volunteers are also unknown. Understanding the demand for, or potential undersupply of, volunteers is hindered by the unavailability of reliable data.

Where do I go for more information?

Information about volunteers in this snapshot is sourced from the ABS General Social Survey.

An entire chapter was dedicated to volunteering in the 2015 edition of the OECD's biennial publication *How's Life?*, which summarises a range of data measuring wellbeing.

See also Chapter 9.2 'Indicators of *Australia's welfare*'.

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Chapter 5

Ageing and aged care

5.0 Introduction

Australia's population profile is changing: we are living longer than ever before. As a result, older Australians now make up a greater proportion of the total population. In 2017, an estimated 3.8 million Australians (15% of the population) are aged 65 and over compared with 2.2 million (13%) in 2007.

This chapter looks at two of the key issues facing older Australians: aged care and dementia.

Many older people are choosing to stay in their home for longer. The clear majority can live independently in households, with or without support. In 2015, only 5.2% of older people lived in cared accommodation, such as nursing homes and aged care hostels.

One in 4 older people aged 65 and over lives alone. Living alone is generally seen as a risk factor for social isolation—a condition that can affect health and wellbeing. Yet, there seems to be minimal differences in social participation between older people who live alone and older people who live with others.

Almost 40% of older people aged 65 and over need help with at least one activity, such as mobility, communication, health care or property maintenance. As might be expected, the older people are, the more likely they are to need help. This assistance may be given informally by family members, friends and neighbours, or formally by a service or organisation. Spouses and partners provide the most informal help for older Australians.

Dementia is a substantial challenge to Australia, particularly as the population continues to age. While it is not caused by age, dementia does primarily affect older people. It is difficult to determine the exact number of people with dementia as there are no national data on how many people are diagnosed. However, estimates suggest that in 2017, around 365,000 Australians had dementia, 99% of whom were aged 60 and over. This number of people affected by dementia is projected to rise considerably, to 900,000 people by 2050.

According to the Australian Bureau of Statistics Survey of Disability, Ageing and Carers (SDAC), around half of people with dementia lived in cared accommodation (such as residential aged care facilities and hospitals, as well as group homes). The other half lived in households (such as private dwellings and self-care units within retirement villages).

Almost all people with dementia have a disability. The majority (95%) of people living in cared accommodation always needed help with at least one core activity (mobility, self-care or communication) compared with 56% of people living in households.

5.1 Ageing and aged care

Australia's older generation are generally classified as people aged 65 and over; that is, people born before 1952. They are commonly called the 'baby boomer generation' or 'baby boomers'. The expectations of baby boomers about the type of aged care they want, and their right to choose, are changing, with many preferring to remain in their home for longer (Productivity Commission 2011).

In 2017, there were an estimated 3.8 million older Australians (equivalent to 15% of the population), an increase from 2.2 million people (13% of the population) 10 years earlier (ABS 2013, 2014). Very old Australians (aged 85 and over) accounted for 2.0% of the population in 2017, with this proportion projected to increase to 4.4% by 2057 (ABS 2013). The increasing number of older people and the changing characteristics of the ageing population are associated with a range of issues. These include the implications for high-level aged care; a need for policies and services that respond to the needs of this population and support healthy, positive ageing; and the potential for social isolation and elder abuse.

1 in 4 older people live alone

In 2015, the vast majority (95%) of older people lived in households, with the remainder (5.2%) living in cared accommodation, such as residential aged care facilities (ABS 2016). More than one-quarter (27%) of older people living in households lived alone and this proportion is projected to remain about the same through to 2036 (ABS 2015). Women were more likely to live alone than men (35% compared with 18%).

Living alone is generally considered to be a risk factor for social isolation (see Box 5.1.1). However, data from the 2015 Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers showed minimal differences overall in social participation between older people who lived alone and people who lived with others. One important sign of social and community participation is contact with family and friends. In 2015:

- 88% of older people who lived alone were visited at home by friends or family in the last 3 months, a slightly lower proportion than for people who lived with others (92%)
- older men who lived alone were less likely to have been visited by family or friends (83%) in the last 3 months than were older men who lived with others (91%); there was little difference between women who lived alone and women who lived with others (91% and 92%, respectively)
- the proportion of older people who went out to visit friends and family in the last 3 months differed little between older people who lived alone (84%) and older people who lived with others (86%).

Box 5.1.1: Social isolation

Social isolation is seen as the objective state of having minimal contact with others; it differs from loneliness, which is a subjective state of negative feelings associated with having a lower level of contact than desired (Wenger et al. 1996). Some recent definitions embed the construct of loneliness within social isolation (Hawthorne 2006), but others argue they are conceptually distinct. Regardless, research has found that social isolation is associated with increased mortality (Steptoe et al. 2013), as well as with poorer health behaviours (smoking and physical inactivity) and biological effects (high blood pressure and inflammation) (Shanker et al. 2011).

Older people are at an increased risk of social isolation due to a number of environmental factors, primarily the loss of physical or mental capacity or the loss of friends and family members (WHO 2016). It is estimated that around 1 in 5 (19%) older Australians are socially isolated, with the highest rates occurring in the largest urban regions and in sparsely populated states and territories (Beer et al. 2016).

Informal providers—the main form of support

Almost 40% of older people aged 65 and over needed assistance with at least one activity in 2015 (ABS 2016). The need for assistance increased with age, from 22% of people aged 65–69 to 89% of people aged 90 and over. Activities with the highest reported need for assistance included:

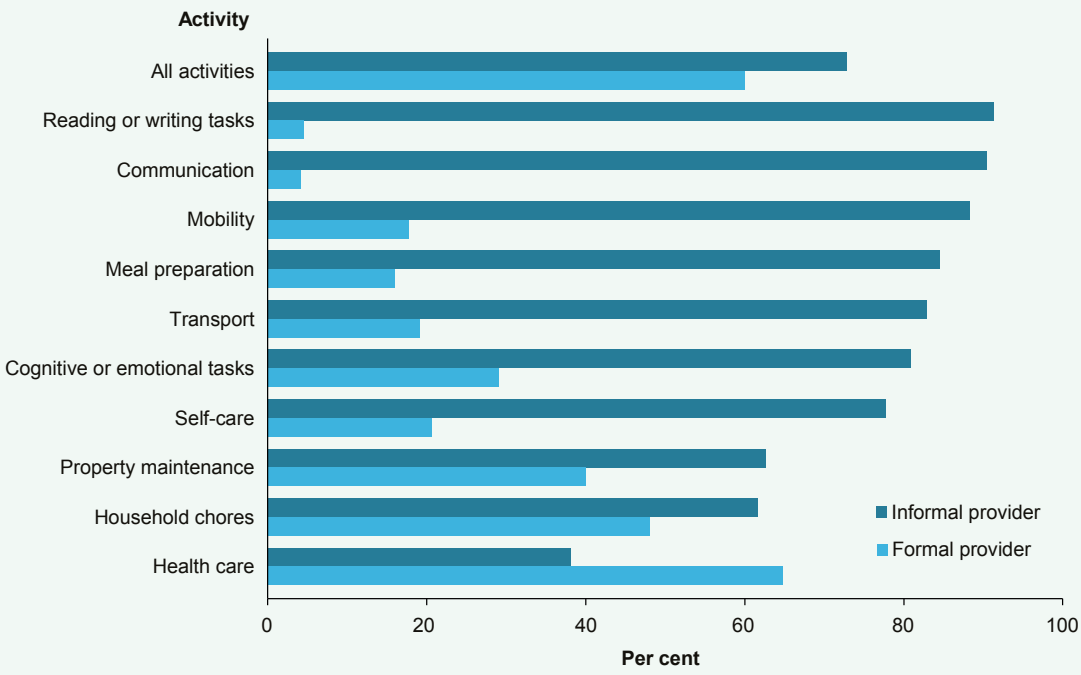
- personal activities (27%)—such as self-care, mobility, communication, cognitive or emotional tasks, and health care
- property maintenance (20%).

The most common types of personal activities for which older people needed assistance were:

- health care (23%)
- mobility (16%)
- self-care (12%).

Both formal and informal providers assist people who live in households. Informal providers are family, friends, neighbours or others who provide help but are not attached to an organisation. Formal providers provide regular paid help and work for an organisation. More than one type of provider may assist older people. Overall, in 2015, 73% of older people who needed assistance were helped by an informal provider, and 60% by a formal provider (ABS 2016). There were some notable differences between the type of activity for which assistance was needed and the provider type (Figure 5.1.1):

- informal providers predominately helped with communication and with reading or writing tasks (more than 90% for each activity)
- health care was the only activity where the majority of care was delivered by formal providers (65%)
- household chores had the most even split between support by informal and formal providers (62% and 48%, respectively).



Source: ABS 2016.

Figure 5.1.1: Australians aged 65 and over living in households who needed assistance, by activity type and provider type, 2015

Spouses and partners provided informal assistance to more than one-third (35%) of all older Australians needing assistance and close to half (48%) of older Australians who received support from an informal provider (ABS 2016). Children were the second most common informal providers for people who needed assistance (21% were daughters and 18% sons).

How many people receive aged care services?

Aged care is currently provided to older people through three main programs:

- the Commonwealth Home Support Programme (CHSP)—provides entry-level support services (such as transport, assistance with food preparation and meals, and personal care) to help older people remain independent and in their homes and communities for longer
- the Home Care Packages Program—offers packages of services at four levels of care to enable people to live at home for as long as possible, with care needs (including clinical services) increasing incrementally for each level of care
- residential aged care—provides a range of care options and accommodation on a permanent or respite basis for older people who are unable to continue living independently in their own homes.

As well as the mainstream programs, flexible care programs provide care for special groups or circumstances in mixed settings. Transition Care is the largest of these, providing support for older people to return home after a hospitalisation.

The use of aged care services is often seen as a progression—from low-level or temporary care to high-level, permanent care; however, this is not necessarily the case. Some people may never use aged care services; if they do, their progression through the care system is not necessarily linear and they may enter at any level.

Aged care is increasingly being provided through community-based programs to support people to remain living at home for longer. In 2015–16, many more people used one of the community-based aged care programs than residential aged care (Table 5.1.1). Some people used more than one program during the year; for example, more than half (52%) of the people who used respite residential aged care during 2015–16 later entered permanent care (DoH 2016).

Table 5.1.1: Number of people accessing aged care programs, by program type, 2015–16

Aged care program	Persons
Commonwealth Home Support Program	640,000
Home and Community Care[(a)]	285,400
Home Care Packages Program	88,900
Residential aged care	
Permanent	235,000
Respite	56,900
Transition Care	24,700

(a) The CHSP was launched in July 2015, incorporating Home and Community Care Program (HACC) and a number of smaller programs. In 2015–16, Western Australia and Victoria had not yet transitioned to CHSP and, in these states, support services to assist people to continue living independently at home were provided under HACC.

Source: DoH 2016.

Elder abuse

Older people who rely on others to help them with their needs may be susceptible to elder abuse. The World Health Organization (WHO) defines elder abuse as 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person' (WHO 2016). Elder abuse can have physical outcomes—death, psychological effects and an increased risk of hospitalisation or residential aged care admission.

The rates of elder abuse in high to middle income countries, as estimated by the WHO, range from 2.0% to 14%, with the most common form of abuse being financial (1.0% to 9.2%) (WHO 2015). Other forms of abuse include neglect, and physical, sexual and psychological abuse. Victims are more likely to be women, have a physical or mental disability, and be care dependent and socially isolated. Rates of abuse may be higher for older people living in institutions than in the community (WHO 2016).

Currently, little data are available on elder abuse in Australia (see 'What is missing from the picture?'). The ageing of the Australian population suggests that the potential for elder abuse may increase in coming years. This makes the need for reliable and nationally standardised data increasingly important in order to measure and monitor progress in this area.

What is missing from the picture?

Individually, many data collections gather information on older Australians and how they use particular services, such as those offered through the aged care or health systems. However, the interactions between these systems are poorly captured—identifying individual people's movements between aged care and hospital, for example, requires data linkage. Such linkage has previously been carried out as part of the AIHW's Pathways in Aged Care (PIAC) work, and could be repeated. For general information on data linkage, see Chapter 1.7 'Understanding health and welfare data'.

Data on the use of aged care by Aboriginal and Torres Strait Islander people may be an underestimation of the true number using aged care programs as Indigenous status may not be accurately collected or people may choose not to identify as Indigenous. For information on the use of aged care services by Indigenous Australians, see Chapter 7.6 'Use of disability and aged care services by Indigenous Australians'.

Data on elder abuse in Australia—including its prevalence, the type of abuse, who carried out the abuse, and in what context or setting abuse may be more likely to occur—are currently not comprehensively collected or reported. Some data are collected in surveys (for example, the ABS Personal Safety Survey) and there is limited mandatory reporting of some forms of elder abuse in residential aged care (in relation to suspected, alleged or witnessed assaults). But there are no data collected for other aged care services (such as community-based aged care programs), and the extent of elder abuse that occurs at home is largely unknown.

An inquiry for the Australian Law Reform Commission (ALRC) on elder abuse was announced in early 2016, with the report *Elder Abuse—A National Legal Response* tabled in June 2017. The report includes 43 recommendations for law reform, with the aim to safeguard older people from abuse. As part of these, the ALRC recommends building the evidence base for elder abuse through a national prevalence study, including the development of standardised measures of elder abuse for consistent data collection (ALRC 2017).

Where do I go for more information?

More information on how ageing affects a person's life and experiences is available in the most recent (2015) ABS Survey of Disability, Ageing and Carers.

For a more detailed analysis of the aged care sector and characteristics of people in aged care, visit the GEN website gen-agedcaredata.gov.au. Previous publications using PIAC, which links data from a number of aged care programs, are also available on this website.

More information on aged care services is available on the My Aged Care website.

The Australian Institute of Family Studies published the research report, *Elder abuse: Understanding issues, frameworks and responses*, which provides insight into elder abuse in the Australian context.

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5.2 Dementia and people's need for help from others

Dementia is not a specific disease. Rather, it is a group of conditions characterised by the gradual impairment of brain function. It commonly affects people's ability to think, remember and reason—and their personality—and impairs other core brain functions, such as language and movement. The condition is degenerative and irreversible. Dementia is the second most common underlying cause of death and it contributes to Australia's burden of disease through years of life lost from death and disability. In 2014, it was the leading underlying cause of death for 12,000 people, with an estimated 33 people dying from dementia each day. People may also die with dementia; it was recorded as an associated cause of death for a further 35,600 deaths in 2014. In 2011, it accounted for 3.4% of the overall burden of disease, and was the leading cause of total burden for females aged 85 and over.

Dementia is a substantial challenge to Australia's care systems, particularly as the population continues to age. While it is not caused by age—and should not be considered as an inevitable consequence of ageing—dementia does primarily affect older people. The AIHW report *Dementia in Australia* indicates that only 1.3% of the estimated 365,000 people with dementia in Australia in 2017 were aged under 60. The number of people affected by dementia is estimated to rise considerably, to 900,000 people by 2050.

People's health generally declines as dementia progresses; they increasingly need help from others, including informal carers and aged care services. Often, as the impacts of dementia worsen, the increasing burden on informal carers such as family members influences care decisions, such as whether to move to residential aged care or stay at home. It is expected that greater numbers of older people in Australia will choose to stay at home for longer (see Chapter 5.1 'Ageing and aged care'). Hence, it will be increasingly important to ensure that informal carers are adequately supported and that people receive an appropriate level of formal care at home. It is similarly important to ensure that people within residential aged care receive care that is appropriate to their needs.

This article focuses on how dementia affects people's functional ability and their need for assistance and how these factors differ, not only between people with dementia in cared accommodation (commonly permanent residential aged care) and people who still live at home, but also between people with and without dementia in permanent residential aged care.

People with dementia

The Australian Bureau of Statistics Survey of Disability, Ageing and Carers (SDAC) estimated that there were more than 194,000 people with dementia in Australia in 2015 (ABS 2016b). This estimate is lower than that produced by the AIHW for the report *Dementia in Australia*. While the SDAC criteria were broadened in 2015 to better identify people with dementia (ABS 2016a), the survey primarily collects information from the perspective of disability and impairment and it may underestimate the prevalence of dementia in the population; for more information, see 'What is missing from the picture?'.

Based on AIHW analyses of the 2015 SDAC, just over half (51%) of people with dementia lived in households (such as private dwellings and self-care units within retirement villages), with the remaining 49% living in cared accommodation (such as residential aged care facilities, hospitals and other institutions that provide care, as well as group homes) (ABS 2016b).

In 2015, people living with dementia in cared accommodation were more likely to be:

- older (62% were aged 85 and over, compared with 28% of people with dementia living in households—the average age of a person with dementia in cared accommodation was 85.3, compared with 77.9 for households)
- women (70%, compared with 53% for men)
- widowed (59%, compared with 29%. This varied further by sex—70% of women living in cared accommodation were widowed, compared with 32% of men) (ABS 2016b).

Overall, people with dementia in cared accommodation were more likely to indicate restrictions in line with common dementia symptoms than people living in households. These included memory problems or confusion (86%, compared with 68% in households), social or behavioural issues (67%, compared with 18%) and partial or complete loss of speech (52%, compared with 9.3%) (ABS 2016b).

Almost all people with dementia identified by the survey had a disability (99% of people with dementia living in cared accommodation, and 94% of people with dementia living in households). As might be expected, the likelihood of needing assistance with core activities was greater for people with dementia living in cared accommodation: 95% of these people always needed assistance with at least one core activity (mobility, self-care or communication) and 16% with all three, compared with 56% and 7.8%, respectively, for people with dementia living in households (ABS 2016b).

Dementia in permanent residential aged care

After people enter permanent residential aged care, their care needs are assessed using the Aged Care Funding Instrument (ACFI). This tool is not a comprehensive assessment, but it does provide some information on people's care needs as they relate to service provision in residential aged care. People are assessed on 12 items that measure care needs on three broad domains—activities of daily living, behaviour, and complex health care.

Almost 92,000 people with dementia were living in permanent residential aged care as at 30 June 2016 (representing 52% of the total). People with dementia were more likely to be rated as requiring a 'high' level of assistance on all three domains (42%, compared with 23% of people without dementia). For many specific items, the differences were even greater (Table 5.2.1).

Table 5.2.1: Proportion of people in permanent residential aged care with/without dementia who were assessed as being most dependent, by ACFI domain[(a)] and individual item[(b)], as at 30 June 2016

	ACFI domain/item	With dementia (%)	Without dementia (%)
	Activities of daily living	**63**	**48**
	Nutrition	26	9
	Mobility	61	56
	Personal hygiene	90	76
	Toileting	77	63
	Continence	86	70
	Behaviour	**80**	**43**
	Cognitive skills	46	9
	Wandering	16	5
	Verbal behaviours	65	50
	Physical behaviours	53	32
	Symptoms of depression[(c)]	14	18
	Complex health care	**61**	**61**
	Taking medications	45	44
	Health-care procedures and activities	33	35

(a) Proportion of people who received the highest rating (H, or high) on a domain based on the ratings on the underlying individual items.

(b) Proportion of people who received the highest rating (D, or most dependent) on an individual item relating to day-to-day care needs (defined by need for assistance, frequency, or degree of impairment/inference in function, as relevant to item).

(c) Fewer than 1 in 6 people were assessed as showing symptoms of depression that caused major interference with their ability to function and participate in activities. However, ACFI data also showed that 2 in 5 (42%) people with dementia had been diagnosed with depression, and slightly more than half (51%) of people without dementia.

Source: AIHW analysis of ACFI data.

Further information on health conditions that affect people's care needs in permanent residential aged care is also available through information collected via the ACFI.

What is missing from the picture?

It can be difficult to determine the exact number of people with dementia. There are no national data or population-based surveys with diagnostic criteria on dementia to identify how many people are diagnosed with dementia—and diagnoses cannot be relied on to accurately capture the number of people with dementia, as the condition may go unrecognised (particularly in its early stages).

Some data on people with dementia are available from administrative data sources, such as those relating to deaths, hospitalisations, aged care assessments and pharmaceutical prescriptions. Each of these sources provide some information on particular groups of people with dementia. However, people with dementia may not be reliably identified as they come into contact with various services; for example, data on how people with dementia use aged care outside of permanent residential aged care are not readily available, although this can be analysed in more detail using the Pathways in Aged Care (PIAC) linkage map. Data linkage could be used to improve our understanding of how different services are used by people with dementia, as well as to improve estimates of the number of people living with dementia in Australia.

Where do I go for more information?

More information about people with dementia is available at www.aihw.gov.au/dementia/, and the report *Dementia in Australia* is available for free download. Recent publications drawing on PIAC linkage work include information on how some people with dementia used aged care—to find out more about PIAC and other aged care data, see GEN.

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Chapter 6

Housing and homelessness

6.0 Introduction

'Having a roof over one's head' is generally seen to be essential to the wellbeing of individuals and families. Access to housing is very important. It is just as important that this housing is safe, affordable and suitable for people's specific needs.

Each night in Australia, more than 105,000 Australians are homeless. They may be spending the night in supported accommodation for the homeless, sleeping in temporary accommodation, 'couch surfing', sleeping on the street, or living in severely crowded dwellings.

Homelessness can profoundly affect a person's mental and physical health, their education and employment opportunities, and their ability to participate fully in social and community life.

This chapter profiles homelessness and social housing in Australia, and examines the changing shape of housing and home ownership.

In 2015–16, homelessness agencies were supporting nearly 280,000 people—or 1 in 85 Australians. These agencies assist not only people who are homeless, but also people who are at risk of becoming homeless (this includes providing generic services to people facing housing crises). Six in 10 clients were female, 1 in 6 were children, and nearly one-third were under the age of 18.

Over the past 3 decades, home ownership rates have fallen in Australia, with younger people being particularly affected. Despite mortgage interest rates being substantially lower (on average) over the last 20 or so years, and the government incentives for first home buyers, the overall home ownership rate has fallen.

Between 1994–95 and 2013–14, the proportion of Australians who owned their home (with or without a mortgage) fell from 71% to 67%. The 2016 Census found similar trends. The pattern of home ownership also changed over this time. The proportion of Australians owning their home outright fell from 42% to 31%, while the proportion financing their purchase with a mortgage rose from 30% to 36%. People aged 25–34 had the steepest decline in home ownership rates over the period.

The gap between household income and house prices in Australia has widened over the past 3 decades, creating a barrier to home ownership for many. As a result, more people are renting. The proportion of Australians in private rental is higher than ever before, with 26% of the population renting in 2013–14 compared with 18% in 1994–95. Half of the estimated 1.3 million lower income rental households were in rental stress in 2013–14, as were 62% of lower income households renting in the private market.

Social housing programs that provide rental housing at below market rates are available for eligible Australians. The programs focus on low-income households in greatest need. These households include Aboriginal and Torres Strait Islander Australians, younger and older Australians, people with disability, people experiencing domestic and family violence, and the homeless. There were 394,000 households living in social housing at 30 June 2016. A further 195,000 were on the waiting list at June 2016.

6.1 Social housing

Social housing is eligible rental housing that is provided by government or non-government (including not-for-profit) organisations, at below market rates. The aim is to alleviate housing pressures. Having access to appropriate and secure housing that is affordable can limit the risk of low-to-moderate income Australians being socially excluded by factors such as homelessness, overcrowding and poor physical and mental health.

Social housing programs

In Australia, there is a range of social housing programs that fall under a regulated funding model (Box 6.1.1).

Box 6.1.1: Main social housing programs and funding, 2015–16

Public rental housing—This is the largest social housing program (Figure 6.1.1). It comprises publicly owned dwellings administered by state and territory governments. Rents are subsidised for eligible low-income tenants so that they generally pay no more than 30% of their gross income on rent.

State owned and managed Indigenous housing (SOMIH)—These dwellings, managed by state and territory governments, are aimed at low-to-moderate income households with at least one member who identifies as being an Aboriginal or Torres Strait Islander Australian (see also Chapter 7.1 'Community factors and Indigenous wellbeing').

Mainstream community housing—This is the second largest social housing program (Figure 6.1.1). Mainstream community housing is generally delivered by not-for-profit organisations to low-to-moderate income or special needs households. Community housing models vary across states and territories. Generally, state or territory governments provide community housing organisations with some assistance, be it direct funding or land and property.

Indigenous community housing—This housing is owned or managed by an Indigenous community housing organisation. These organisations may either directly manage the dwellings they own or sublease tenancy management services to the relevant state/territory housing authority or another organisation. This housing is made available to households with at least one Indigenous tenant (see also Chapter 7.1 'Community factors and Indigenous wellbeing').

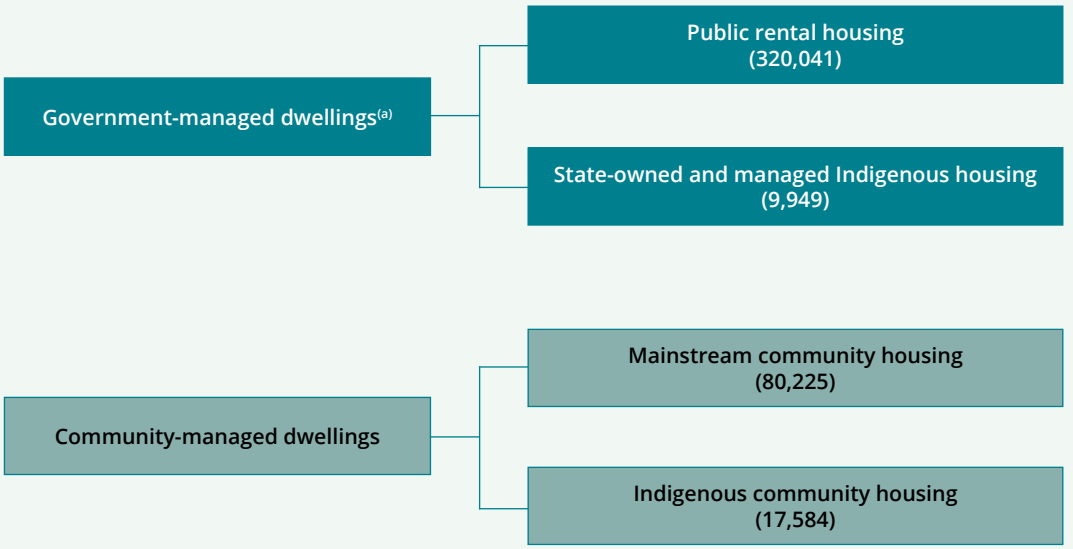
Commonwealth funding for social and affordable housing programs is provided via the National Affordable Housing Specific Purpose Payment and via National Partnerships between the Australian and state and territory governments.

Over the past decade, policy changes have seen a gradual shift in the social housing sector, from government-managed housing programs toward community-managed housing.

In the 9 years from 2007–08 to 2015–16, the total number of social housing dwellings has risen by 5.6% (or 22,800 dwellings) to 432,800:

- The largest rise has been in community-managed housing programs; specifically, for mainstream community housing, where dwelling numbers have more than doubled, from 36,000 to more than 80,000.
- In contrast, dwelling numbers have dropped in government-managed programs; specifically, for public rental housing, where dwellings dropped by nearly 18,000 to 320,000 dwellings.
- Although their numbers have dropped, public housing dwellings continue to make up the majority of social housing (75%) (Figure 6.1.1).

Although the total number of social housing dwellings has risen, this growth rate is not keeping pace with household growth. Therefore, the share of social housing is declining. Over the 9-year period, social share has gradually fallen from 5.1% to 4.7% (see also Chapter 6.3 'The changing shape of housing in Australia').



(a) Excluding government-managed NT remote public housing (5,046 dwellings).

Figure 6.1.1: Main social housing programs in Australia, by total number of dwellings, 30 June 2016

Social housing tenants

As at 30 June 2016, 394,000 households were living in social housing (public rental housing, SOMIH and mainstream community housing)—a 4.0% increase from 379,000 households in 2008. An estimated 845,000 tenants made up these households across Australia. Indigenous households made up 9.4%, or 29,293, of public rental housing households and 7.9%, or 5,377, of mainstream community households while SOMIH and Indigenous community housing programs were focused on Indigenous households.

Social housing tenant characteristics such as the age of the main tenant, main income source and living arrangements can vary across social housing programs (Table 6.1.1).

Table 6.1.1: Ongoing[a] social housing tenants, by selected housing program and selected characteristics, 30 June 2016

	Number of households (% change from 2008)	Sex[b] (%)		Age[b]	Living arrangement	Income
		Male	Female			
Public rental housing	312,000 (–6%)	37	63	54% older Australians (aged 55+)	54% living alone	29% disability support pension
SOMIH	9,700 (–22%)	24	76	64% aged 35–64	36% sole parent with dependent children	32% on other government payments[c]
Mainstream community housing	72,400 (+103%)	41	59	67% aged >45	59% living alone	n.a.

n.a. not available.

(a) 'Ongoing' means that the household's tenancy is not concluded.

(b) Excludes cases where sex or age were 'not stated' (less than 3% in each program).

(c) 'Other government payments' are government payments provided other than set government allowances, pensions or cash incomes.

Social housing has focused on low-income households in greatest need who can also have special needs. This includes Indigenous Australians, young and older Australians, people with disability, people experiencing domestic and family violence, and the homeless. Based on the proportion of newly assisted households in greatest need, these vulnerable households accounted for more than half of all newly housed tenants in the public rental housing, SOMIH and mainstream community housing programs in 2015–16.

The proportion of new public rental housing allocations provided to greatest need households increased from 36% in 2003–04 to 74% of newly allocated households in 2015–16. Over the same period, however, the total number of new public rental housing allocations reduced from 31,000 households to 20,500, in part due to a reduction in public rental housing dwelling stock (Figure 6.1.2).

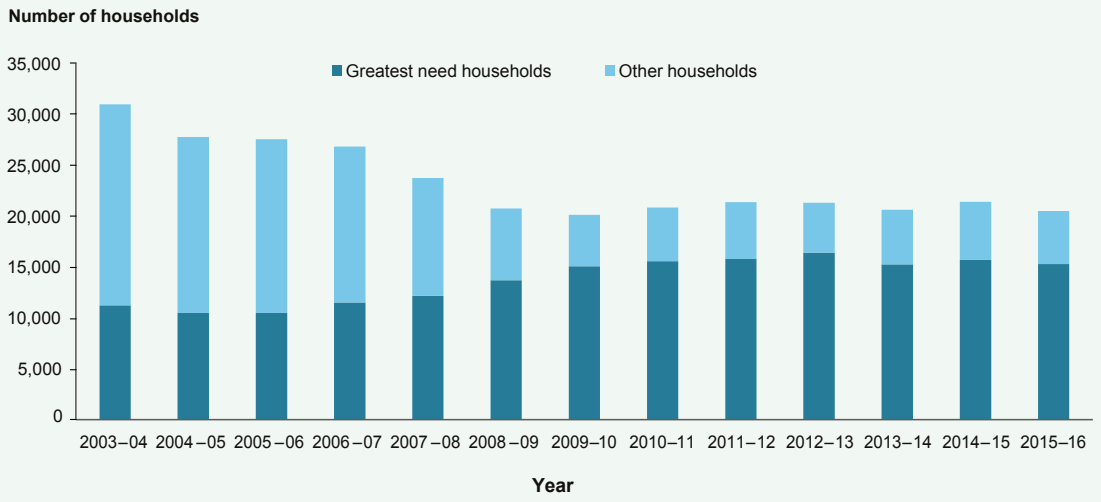


Figure 6.1.2: Number of newly assisted households in public rental housing in greatest need and other households, 2003–04 to 2015–16

Social housing wait lists and prioritisation

Demand for social housing is strong. As at 30 June 2016, there were around 195,000 households on social housing waiting lists. Both the waiting lists themselves, and the wait times for many households, are very long. As at 30 June 2016, 47% of households waiting for public housing had been doing so for more than 2 years. This excludes households considered to be in greatest need, who remain a priority for provision of housing assistance (see also Chapter 9.2 'Indicators of *Australia's welfare*').

Tenant satisfaction

Over time, social housing has been a stable form of tenure for vulnerable tenants. For the allocation of affordable housing to be considered successful, the dwelling must meet the needs of the household. In 2015–16, 2 in 5 (42%) public rental households and 1 in 3 (34%) SOMIH households had been in the same tenancy for over a decade. This low tenant turnover, together with ongoing demand for social housing, poses a challenge when bridging the gap between supply and demand.

The National Social Housing Survey presents a profile of social housing tenants and their satisfaction with services provided by their housing provider (see Box 6.1.2). In 2016, tenants living in mainstream community housing had higher levels of satisfaction (80%) than tenants in other social housing programs (73% for public rental housing and 68% for SOMIH).

Box 6.1.2: Social housing tenant satisfaction

Personal experiences of social housing vary among tenants. To record the influence of individual experiences on social housing satisfaction, the National Social Housing Survey documents tenant comments. These comments reflect both the benefits and the difficulties faced by tenants. Here are two:

> *I thank you for giving me a place when my world fell from under me.*
>
> *I have had several inspections over the years. I have holes in my floor which has* [sic] *been inspected at least 5 times by a housing inspector. No side and back fence. Window can't be open or closed due to termites. Fireplace still full of bricks and falling into lounge room for 6 years now, very dirty, holes in the wall.*
>
> 2014 National Social Housing Survey

What is missing from the picture?

To further support low-income Australians into stable housing, governments across Australia fund services to support people who are homeless or at risk of homelessness, known as Specialist Homelessness Services. Support from these service providers includes assisting social housing tenants to maintain their social housing tenure. More on these services is available through reports linked below and in Chapter 6.2 'Homelessness'.

Where do I go for more information?

For more information about housing assistance in Australia, see reports available online at www.aihw.gov.au/housing-assistance-publications/. The report *Housing assistance in Australia 2017*, the National Social Housing Survey: a summary of national results 2016, Specialist homelessness services 2015–16, and other recent publications are available for free download.

6.2 Homelessness

Homelessness can profoundly affect a person's health (mental and physical), their education and employment opportunities and their ability to participate fully in social and community life.

On Census night in 2011, more than 105,000 men, women and children in Australia were estimated to be homeless (see Glossary for a definition of 'homeless'). This figure included people who were in supported accommodation for the homeless, in temporary accommodation, in severely crowded dwellings (those requiring 4 or more extra bedrooms to accommodate them adequately) and people who were 'sleeping rough'. More than half of these people were male (56%). The majority were aged under 35 (60%, compared with 46% in the general population), 1 in 5 (20%) were in supported accommodation and about 1 in 15 (6.4%) were 'sleeping rough' (ABS 2012).

The rate of homelessness in 2011 was 48.9 people for every 10,000 population. This is an increase of 8.2%, from 45.2 people per 10,000 population in 2006. The estimated number of homeless Australians is expected to rise in the 2016 Census, as the enumeration strategy and methodology used will better capture this population.

Governments across Australia fund a range of services called specialist homelessness services (SHS) to support people who are homeless or at imminent risk of homelessness (Box 6.2.1).

Box 6.2.1: Specialist homelessness services

A number of factors can not only lead to homelessness, but become barriers to ending it. These include domestic violence, diagnosed mental health issues, drug and/or alcohol issues, and release from custodial settings (for example, an adult correctional facility, youth detention or correctional centres, and immigration centres). SHS are geared to meeting the particular needs of these clients.

This article provides an overview of the characteristics of people who access SHS, with more detailed analysis presented for people experiencing mental ill health and leaving custody, as captured by the Specialist Homelessness Services Collection.

Specialist homelessness services—These services are delivered by non-government organisations. They include agencies that specialise in delivering services for specific groups (such as young people, Indigenous people or people experiencing family and domestic violence). They also include agencies that provide more generic services to people facing housing crises. Currently, people experiencing family and domestic violence are the single biggest client group within the Collection (38% of all clients) (for more information, see Chapter 2.7 'Family, domestic and sexual violence').

Specialist Homelessness Services Collection—This national data collection, conducted by the AIHW, contains data collected by homelessness agencies funded under the National Affordable Housing Specific Purpose Payment and the National Partnership Agreement on Homelessness. These data include information on clients receiving the services, the assistance they requested and outcomes achieved. National data from 5 collection years are now available.

More than 800,000 Australians were supported by homelessness agencies between 2011–12 and 2015–16. In 2015–16 alone, 279,196 clients were supported, representing 1 in 85 Australians (1.2% of the total population).

Characteristics of clients

Age and sex

Of clients who sought assistance from homelessness services in 2015–16:

- 6 in 10 were female (59%, or almost 166,000)

- 1 in 6 were children under the age of 10 (16%, or nearly 46,000 clients); there were similar numbers of boys and girls

- nearly 3 in 10 clients were aged under 18 (28%, or nearly 79,000); about half were female (40,000)

- clients aged 25–34 made up the largest age group (19%); 7 in 10 (68%) were female

- about 12,000 older women (55 and over) sought services, a 52% increase since 2011–12

- most commonly, clients were living in single-parent families (34%) when they sought support.

Clients with a current mental health issue

The Australian Government's national approach to reducing homelessness identifies untreated mental health as one of the main pathways into homelessness, and has given priority to this vulnerable group (COAG 2009).

Specialist homelessness agencies support many people with mental health issues, providing a range of health, housing and general services. Clients with a current mental health issue (see Glossary for a definition of clients with a current mental health issue) make up the fastest growing client group in the SHS population. Increased rates of identification, greater community awareness and reduced stigma about mental health have all potentially driven the increase in self-identification and reporting of mental illness among SHS clients. On average, this client group has grown at a rate of 13% per year since 2011–12 (Table 6.2.1). The increase has been faster for females, growing at an average rate of 14% per year since 2011–12. The equivalent growth rate for males over this period was 11%.

The rate of service use by clients with a mental health issue has increased 50% in 5 years, from 20 people per 10,000 population in 2011–12 to 30 people in 2015–16.

Similar to the general SHS population, the majority of clients with a current mental health issue were female (58%) in 2015–16.

Table 6.2.1: SHS clients with a current mental health issue, 2011–12 to 2015–16

	2011–12	2012–13	2013–14	2014–15	2015–16
Number of clients	44,835	48,599	56,281	63,062	72,364
% of all clients	19.0	19.9	22.2	24.7	25.9
Rate (per 10,000 population)	20.1	21.4	24.3	26.9	30.4

Note: Rates are crude rates based on the Australian estimated resident population as at 30 June of the reference year.

Clients leaving custodial arrangements

People who leave custodial settings are seen to be at increased risk of homelessness and they are also less likely to exit homelessness (Johnson et al. 2015). Being able to secure stable housing may reduce the likelihood of their reoffending (Australian Government 2008).

The number of clients who had recently left custodial settings grew, on average, by 11% each year between 2011–12 and 2015–16 (Table 6.2.2). The growth rate is higher for females (15%) than males (10%). In part, at least, this rise is a response to programs that connect people leaving custody with SHS services. The vast majority of clients are leaving adult prisons (84% in 2015–16); another 15% left youth centres.

The rate of service use has also increased for people who have recently left custodial settings, from 2.3 people per 10,000 population in 2011–12 to 3.3 people in 2015–16. However, despite increasing rates of service use, fewer clients in this group are receiving accommodation than before (45% in 2011–12 and 38% in 2015–16). As well, people who are given accommodation stay fewer nights. (The median nights of accommodation per client has fallen from 31 in 2011–12 to 26 in 2015–16.)

The majority of clients who had recently left custodial settings in 2015–16 were male (77%), with most males aged between 25 and 44 (58%).

Table 6.2.2: SHS clients leaving custodial arrangements, 2011–12 to 2015–16

	2011–12	2012–13	2013–14	2014–15	2015–16
Number of clients	5,132	6,399	6,756	6,866	7,804
% of all clients	2.2	2.6	2.7	2.7	2.8
Indigenous (%)	24	23	23	25	27
Rate (per 10,000 population)	2.3	2.8	2.9	2.9	3.3

Notes

1. Rates are crude rates based on the Australian estimated resident population as at 30 June of the reference year.
2. Indigenous proportions include only clients where Indigenous status is known, and consent given. About 10% of clients each year were excluded on these basis.

What is missing from the picture?

To help governments and homelessness service providers to better focus their delivery of services, more information is needed on pathways in and out of homelessness as well as on the longer term outcomes of service users. More information is also needed on individuals who use services across sectors. The AIHW is actively contributing to this knowledge and understanding of clients who use multiple services—such as drug and alcohol treatment services, as well as child protection services and youth justice—by carrying out data linkage projects.

Where do I go for more information?

For more information about SHS in Australia, see reports available online at: www.aihw.gov.au/homelessness-publications/. The report *Specialist homelessness services 2015–16* and other recent publications are available for free download.

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6.3 The changing shape of housing in Australia

Housing, even in its simplest form, meets two basic human needs: shelter and security. Its influence on the welfare of households is substantial, affecting, for example, health and wellbeing, education, employment and social and community participation. So fundamental is housing that the right to it is recognised by a number of international agreements, including the Universal Declaration of Human Rights (article 25.1). Economically, buying a home is often the largest financial investment a household will make, and it provides a means of saving for millions of Australians. It is also a key source of voluntary retirement savings and financial security for a majority of age pension recipients. As well, housing is a vehicle for asset/wealth accumulation for a growing number of households and, relatively more recently, a growing number of investors.

The 'great Australian dream' of owning one's own home is slipping away for some groups of Australians. While aggregate home ownership rates (that is, households with or without a mortgage) have declined modestly in Australia over the past 20 years—from 71% in 1994–95 to 67% in 2013–14—there have been more dramatic falls for younger age groups and lower income groups, suggesting barriers for those groups wishing to buy (ABS 2015a).

The decline in home ownership has not been uniform. Underpinning the national decline is a widening disparity in ownership rates and trends across Australia. Data from the annual Australian household-based panel survey show that since 2001 the largest fall in home ownership rates has been in Victoria (7.8 percentage point decline to 66%) followed by New South Wales (4.3 percentage points) and South Australia (2.5 percentage points), with little net change in Queensland and Western Australia (Melbourne Institute of Applied Economic and Social Research 2016). Globally, the aggregate home ownership rate in Australia ranks twenty-ninth among the 35 countries in the Organisation for Economic Co-operation and Development (OECD).

Since 1945, Australians have enjoyed high rates of home ownership and relatively low housing costs. In the past few decades, however, housing trends in Australia have changed:

- High home ownership rates have been threatened as house price increases have outpaced rises in household incomes.
- Australia has experienced declining housing affordability (both rental and purchase affordability). Affordability issues are particularly affecting younger generations and lower income groups. With these groups having limited opportunities to become home owners, this trend threatens to widen economic inequalities between owners and renters and destabilise wealth transfer between generations.
- Levels of exit from ownership are higher for someone entering home ownership in 2001–10 than for someone who entered it before 2001 (Wood et al. 2013). It is estimated that 1 in 5 (22%) Australians exited home ownership in the decade to 2010, with one-third of these people never re-entering it.

- The focus in providing direct housing and housing assistance has shifted—from lower income working families to the most vulnerable in society, such as people living with disability or experiencing domestic and family violence. The proportion of newly assisted households in greatest need more than doubled in the 12 years to 2015–16 (to 74% in public housing and 56% in state owned and managed Indigenous housing).

These trends have created policy challenges for governments of all levels. Exits from home ownership, as well as delayed and reduced rates of entry across the life course, threaten the high levels of home ownership on which Australian retirement incomes policy is based. This has the potential to place increasing demand on housing assistance, particularly on the Commonwealth Rent Assistance (CRA) scheme (Wood et al. 2013).

Further, Australia's retirement policy is largely based on low housing costs in older age. With fewer Australians tending to own their house outright at retirement, this increases pressure on the welfare system, as a greater proportion of superannuation money will be spent on housing costs. Where increasing numbers of people entering retirement are potentially reliant on social housing or private rental (as a result of their inability to own their own home), costs to government could be reasonably expected to escalate.

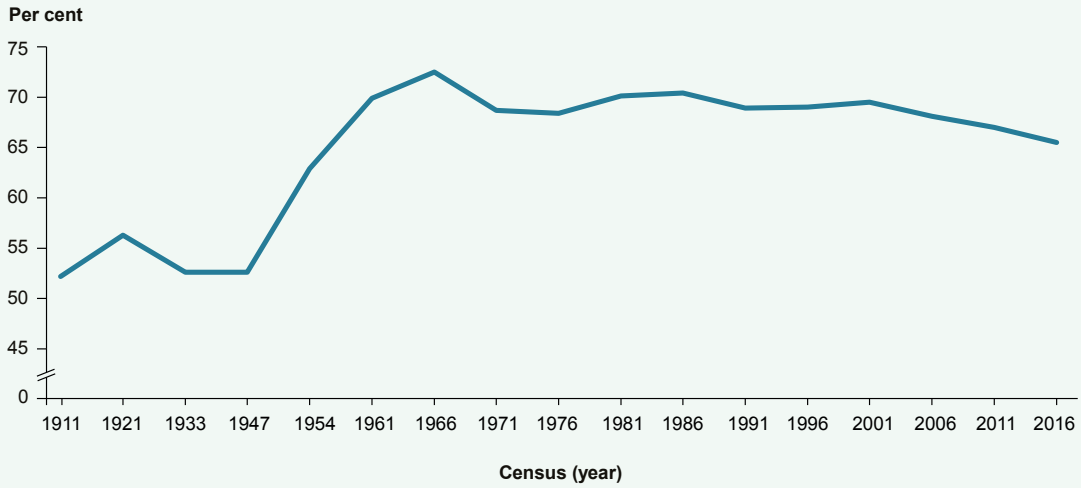
Home ownership and changing trends in housing tenure

Home ownership rates in Australia rose substantially after World War II (Figure 6.3.1). In part, this can be attributed to government policies that promoted home ownership, improving housing affordability and increasing supply, together with rapidly growing household incomes and the lifting of constraints on housing finance.

While aggregate home ownership rates have remained stable in Australia since the mid-1960s, the rates of home ownership for different age cohorts have varied markedly. This variation has been driven by substantial changes in the factors influencing the housing market over the past 20 or so years. For example, until the early 1990s, growth in the housing stock increased at a faster rate than the population. However, in 2011, the shortage of housing, relative to the underlying demand for it, was estimated at 228,000 dwellings (NHSC 2012).

Over this 20 or so year period, steady population growth, combined with other demographic changes—the growth of single-person and single-parent households (for example, as a result of more family breakdowns, and a decline in marriage rates), declining average family size, and an ageing population—placed upward pressure on dwelling stock.

Despite mortgage interest rates being substantially lower, on average, over the last 20 or so years and the government incentives to first home buyers, the overall home ownership rate has declined by 6 percentage points to 66% (Census 2016), its lowest figure since the 1954 Census (Figure 6.3.1).



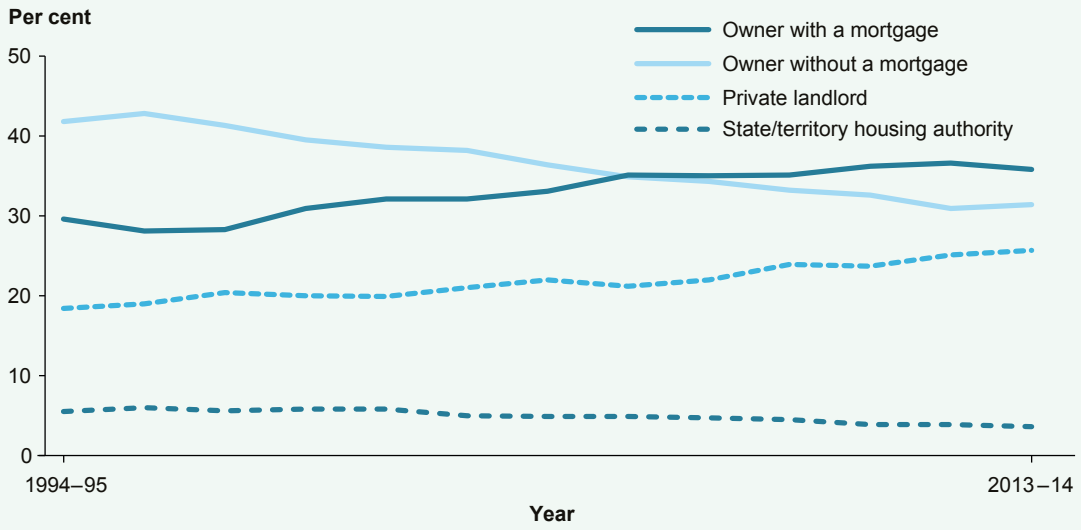
Notes

1. Percentages are of occupied private dwellings, excluding those for which tenure is not stated.
2. Censuses were conducted irregularly until 1961.

Source: ABS Censuses, as charted by Eslake 2013.

Figure 6.3.1: Australian home ownership rates at Censuses, 1911 to 2016

Over the past 20 years, there has also been a major shift in home ownership trends across Australia (Figure 6.3.2). Nationally, the proportion of home owners without a mortgage has continued to fall, while the proportion of renters has increased.



Note: Excludes 'Renter–other landlord type' and 'Other tenure type', which were steady at around 1.5% and 2.5%, respectively.

Source: ABS 2015a.

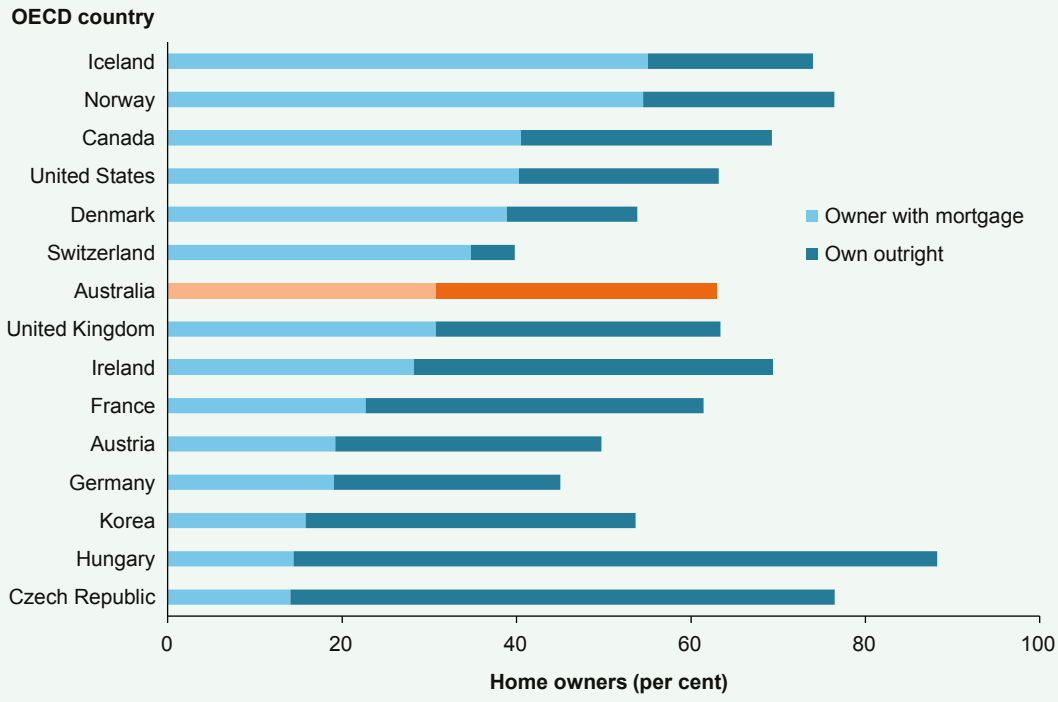
Figure 6.3.2: Changes in housing tenure in Australia, 1994–95 to 2013–14

Between 1994–95 and 2013–14, the proportion of Australians who owned their home outright fell from 42% to 31%. Over the same period, more home owners financed their purchase with a mortgage (increasing from 30% to 36%).

Australians are renting in greater proportions than 2 decades ago. The private market has seen the greatest increase in renter numbers, up 7 percentage points to 26% over 20 years. In contrast, state/territory housing authorities are contributing fewer rental properties in the market, down 1.9 percentage points to 3.6%.

Global trends in home ownership rates

Home ownership is still the most common tenure type in Australia, as it is in many other OECD countries (Figure 6.3.3). However, home ownership rates have tended to increase in many OECD countries over recent decades, unlike the Australian experience (Andrews & Sánchez 2011). Contributing to this trend overseas, at least in part, are changes in the characteristics of households (including population ageing, household structure, and income and education) and policy influences, such as mortgage market innovations (including the relaxation of deposit constraints, increasing home ownership rates among lower income households, and tax reliefs on mortgage debt financing) (Andrews & Sánchez 2011).



Notes

1. Year of collection and method of collection varies across countries and may affect comparisons. Data for Australia are sourced from the Household, Income and Labour Dynamics Survey 2014.
2. Percentage of renter (private and subsidised) and 'Other, unknown' not shown.

Source: OECD 2017b.

Figure 6.3.3: Home ownership distribution in selected OECD countries, 2014 or most recent year

While Australia ranks in the lowest quarter of OECD countries in terms of aggregate home ownership rates (twenty-ninth), it ranks in the top third for home owners with a mortgage (selected OECD countries are shown in Figure 6.3.3). It is similar to Ireland, Spain, Portugal, United Kingdom, Finland and Belgium at around 30%.

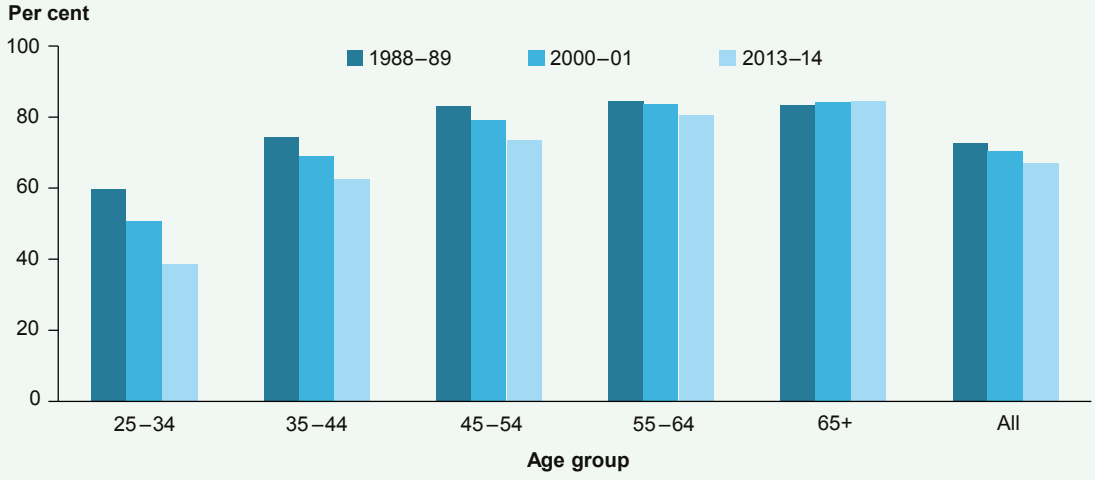
From an international perspective, national housing outcomes and policy challenges are contemporary issues. To help countries measure access to affordable housing and strengthen the knowledge base for policy evaluation, an online OECD Affordable Housing Database has been developed, with support from the European Union.

Home ownership across the generations, and changing housing careers

Housing careers can be thought of as the sequence of housing circumstances an individual or household occupies over their life (Beer et al. 2006). Research shows that Australia is experiencing generational change when it comes to home ownership, with younger households being principally affected by factors such as economic constraints, lifestyle choices and work–home preferences (Burke et al. 2014; Yates 2011).

The steepest decline in home ownership rates across the 25 years to 2013–14 has been for people aged 25–34 (Figure 6.3.4) (see Supplementary table S6.3.1). This is typically the age at which first transitions into home ownership are made. But, fewer and fewer people in this age group are entering home ownership, with a 21 percentage point decline to just 39% in 2013–14 (compared with 60% in 1988–89). Home ownership rates for people aged 35–44 also fell, but not so much (12 percentage points). People aged over 65 (the age of retirement) were the only age group to increase their rate of home ownership and, even then, the increase was marginal.

Census data from 2016 became available just prior to the release of this publication and confirm this trend of diminishing home ownership rates among younger Australians. From 2006 to 2016 Census data reveal the greatest declines in home ownership have been in the 25–34 and 35–44 year age groups (from 51% down to 45% and from 68% to 62%, respectively).

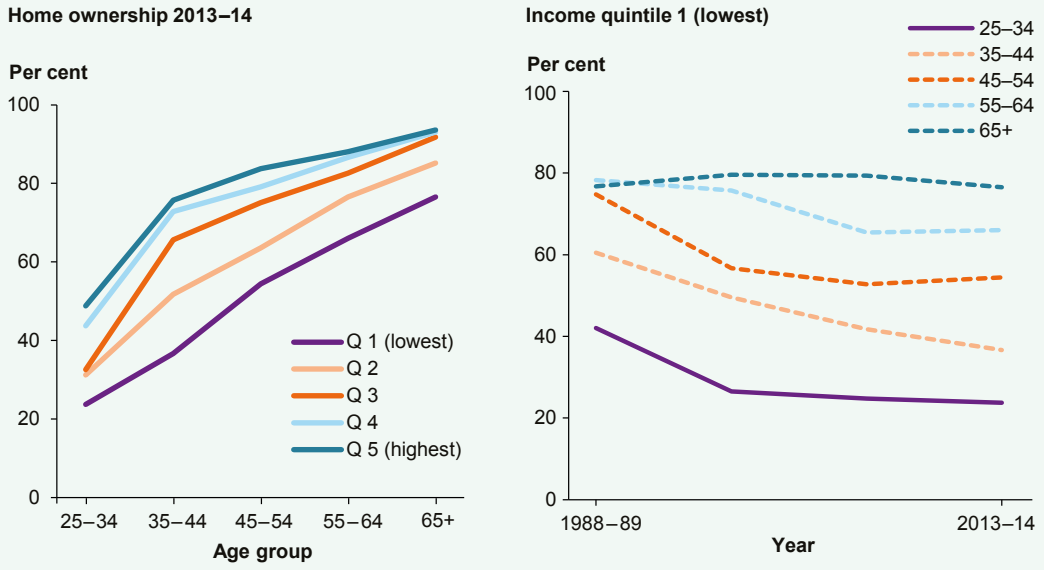


Sources: ABS 4130.0 Housing occupancy and costs 1988–89, 2000–01 and 2013–14.

Figure 6.3.4: Home ownership rates, by age group, 1988–89, 2000–01 and 2013–14

Consistent with a decline in ownership rates among younger Australians is evidence of first home buyers being older than they were a decade ago (ABS 2015a). In 2000–01, 61% of first home buyers were aged between 25–34; by 2013–14, this proportion had dropped to less than half (49.6%). At least in part, the financial impacts of higher education costs and compulsory superannuation contributions on younger generations have been implicated in their deferral into home ownership, as they save for a deposit in a market of increasing house prices (Burke et al. 2014; Yates 2011). In the absence of real income growth, the effect of increased house prices on the time taken to save for a deposit is significant, particularly in Sydney and Melbourne. Estimates reveal that since 2006, the average number of years required to save for a deposit in Sydney increased from 5 to 8 years and in Melbourne, 4 to 6 years (Australian Government 2017).

While lifestyle preferences and choices affect purchasing decisions across all age groups, constraints that strongly impede access of younger households are largely financial. These constraints include the price of dwellings themselves, deposit requirements, and access to mortgages. For each age group, home ownership rates increase notably with household income. Over the past 25 years, however, home ownership rates have declined more steeply for younger Australians earning the least (Figure 6.3.5).



Note: Equivalised disposable household income is household incomes that are adjusted to enable analysis of the relative wellbeing of households of different size and composition, using an equivalence scale.

Sources: ABS 4130.0 Housing occupancy and costs 1988–89, 2000–01, 2009–10 and 2013–14.

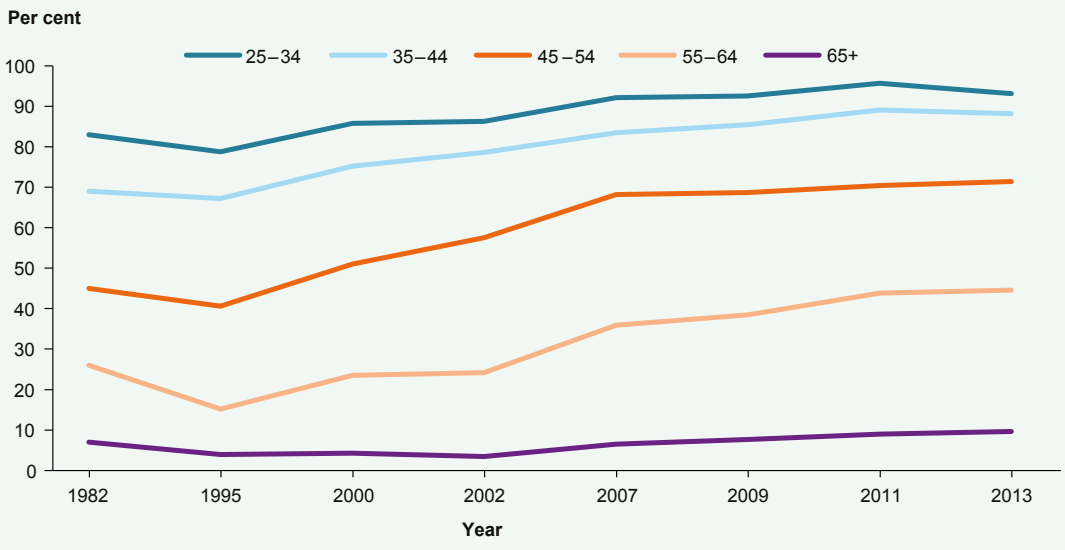
Figure 6.3.5: Home ownership rates, by age group and equivalised disposable income quintile 2013–14; and for equivalised disposable income quintile 1 (lowest), by age group, 1988-89, 2000–01, 2009–10 and 2013–14

Generational changes in mortgage indebtedness

Australian households have adapted to increased affordability pressures by not becoming home owners or, if they are home owners, taking on more debt. This latter option has been enabled both by the willingness of households to take on more debt and lenders changing their practices to offer larger mortgages (Tomlinson & Burke 2012). The current climate of low interest rates has also been an influential factor in household indebtedness.

More than 70% of Australian households had some level of debt during 2013–14, with housing debt a major component of this (ABS 2015b). For those households with a mortgage, more than 4 in 10 (44%) were servicing a total debt that was three or more times their annualised disposable income. This is a 10.5 percentage point increase since 2003–04. This greater level of debt taken on by more Australian home owners with a mortgage makes many of these households vulnerable to economic hardship. Further, repayment affordability may well become an issue for these households should interest rates rise in the future.

Among home owners, the proportion of households with a mortgage has grown across all age groups during the past 3 decades (Figure 6.3.6). This rise in mortgage indebtedness coincided with the house price boom in the late 1990s. The proportion of older mortgagors is climbing most steeply, particularly for people approaching retirement (aged 45–54 and 55–64). In 1982, less than half (45%) of people born during the Depression, from 1928 to 1937 (austerity babies), were financing a mortgage when aged 45–54. By comparison, in 2013, 71% of people born between 1957 and 1966 (mainly baby boomers), were financing a mortgage when aged 45–54. This trend is of particular concern as these households approach retirement without their home and asset base being paid off. For people looking to retire in the next 10 years, 45% of 55–64-year-olds in 2013 were still servicing a mortgage, compared with just 26% in 1982.



Sources: ABS 4130.0 Housing occupancy and costs 1982–83, 1995–96, 2000–01, 2002–03, 2007–08, 2009–10, 2011–12 and 2013–14. Graph based on that published in Ong et al. 2013.

Figure 6.3.6: Proportion of home owners with a mortgage, by age group, selected years

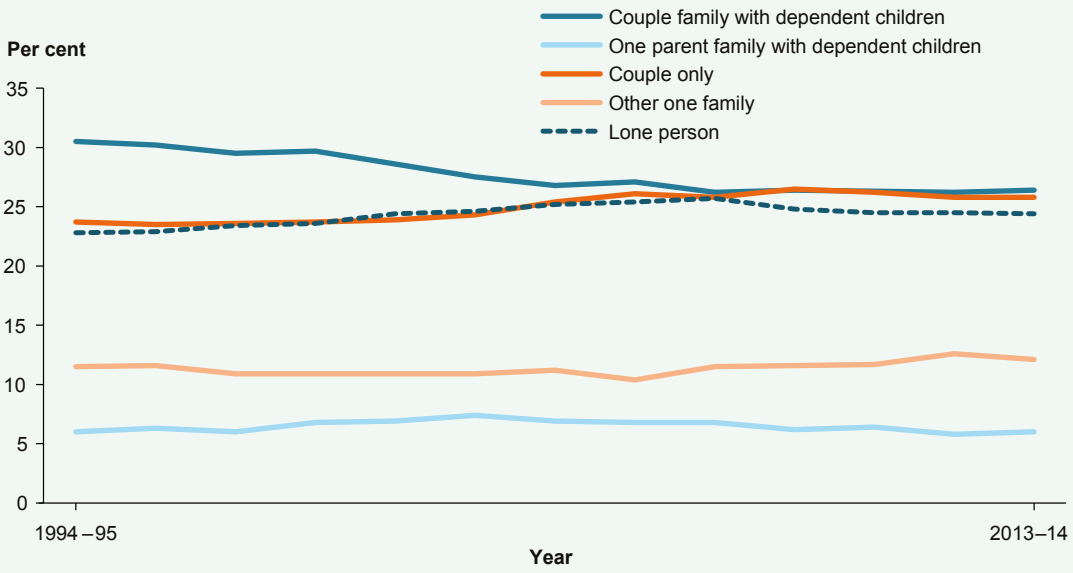
The recent housing boom of the late 1990s has seen house prices rapidly escalate, with corresponding deteriorations in purchase affordability, particularly for people trying to enter the housing market, and those rental households on low incomes. Decreasing levels of housing purchase affordability in Australia have forced many households to adapt by borrowing more, deferring the purchase of a home, moving into more affordable housing (such as apartments and townhouses) and moving to more affordable locations. Despite this, low-income and single-income working age households are increasingly being left out of the home purchase market (Wood et al. 2013).

Australian population—demographic changes and challenges

There is evidence of a decline in household formation since 2006. Between 1994–95 and 2013–14, the Australian population grew by around 31%, with accelerated growth between 2006 and 2013 on the back of increases in overseas migration. Over the same period, the number of households in Australia increased from 6.5 to 8.8 million, a rise of 34% (ABS 2015b). The number of people in these households, on average, has declined steadily for many years; by 2006 it had fallen to its lowest point, 2.5 people per dwelling (ABS 2015b). After this time, households formed at a slower rate than population growth, implying that people were not forming households at the same rate as before. Rising house prices in the face of unaccompanied growth in incomes, a lack of available dwellings (that is, insufficient or mismatched supply) and a lack of affordable dwellings have been proposed as possible reasons for a decline in household formation (AHURI 2016; ABS 2011; Reserve Bank of Australia 2015).

The composition of families is also changing, presenting its own housing challenges (Figure 6.3.7). Family households remain the most common household type, but there have been changes in their composition. Couple families with dependent children have declined from 31% in 1994–95 to 26% in 2013–14, while the proportion of couple-only families (25.8%, up from 23.7%), and multiple-family households (2.3%, up from 1.3%) have all increased.

With family structure changing, so too, are families' housing choices and preferences. The challenge is for housing options to be responsive, flexible and affordable to meet this change. For example, as the numbers of lone-person and couple-only households grow, these households may increasingly seek smaller dwellings. Increases in non-nuclear family households are likely to expose a growing number less likely to have the financial resources, or the need, to buy a large single family home. Other challenges include having sufficient options for older households who may prefer to age in their own home or in alternative appropriate accommodation.



Sources: ABS 4130.0 Housing occupancy and costs, selected years between 1994–95 and 2013–14.

Figure 6.3.7: Family composition of households, 1994–95 to 2013–14

Future projections forecast 4.3 million more households in Australia by 2036, increasing from 8.4 million in 2011 to between 12.6 and 12.7 million in 2036 (ABS 2015c), an increase of between 49% and 51%. There were about 7.8 million Australian households living in private dwellings in 2011, estimated to increase by 49% to 11.6 million by 2031. Family households are projected to have the largest increase over the projection period, remaining the most common household type in Australia.

Housing affordability: trends and distribution

Given current population projections, demand for housing will continue to grow. This increased demand will put pressure on dwelling prices, with a particularly adverse effect for low-income households.

A number of factors influence house prices, and therefore housing affordability (Box 6.3.1).

Box 6.3.1: Determinants of housing affordability in Australia

Demand for housing is influenced by factors such as:

- population growth
- changes in household composition
- economic circumstances, such as household income and the number of income earners in the household
- interest rates and access to affordable finance
- tax settings
- attractiveness to investors (profitability and percentage returns) compared with the asset classes
- rental prices and availability
- consumer preferences, such as the size, location, tenure and quality of housing; the balance between housing costs and the costs of transport; and demand for second/holiday homes.

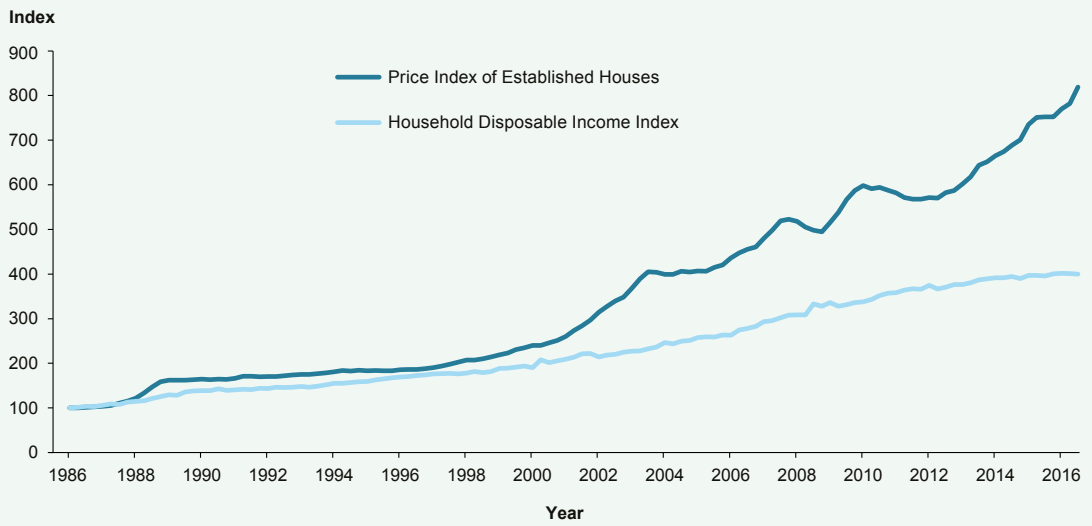
The supply of housing is influenced by a range of factors, such as:

- land availability, such as zoning and restrictions on land tenure that do not readily permit land to be developed, sold, or individually owned
- land release and development processes, including fees and regulation
- the costs of construction and providing essential infrastructure, such as water, power, and sewerage
- the availability of skilled labour in the construction industry
- the level of services (such as public transport) and employment required to attract households into locations
- government taxes and subsidies
- interest rates and access to affordable sources of development finance.

Sources: Adapted from PM&C 2014; Kirchner 2014; NHSC 2009; The Senate Select Committee on Housing Affordability in Australia 2008; URC 2008.

The gap between household income and dwelling prices in Australia has widened over the past 3 decades, creating a barrier to home ownership for many (Burke et al. 2014) (Figure 6.3.8). This gap has been fuelled by rapid house price growth, after the financial system was deregulated, with the total value of Australian housing estimated to be $6.5 trillion (CoreLogic RP Data 2016a).

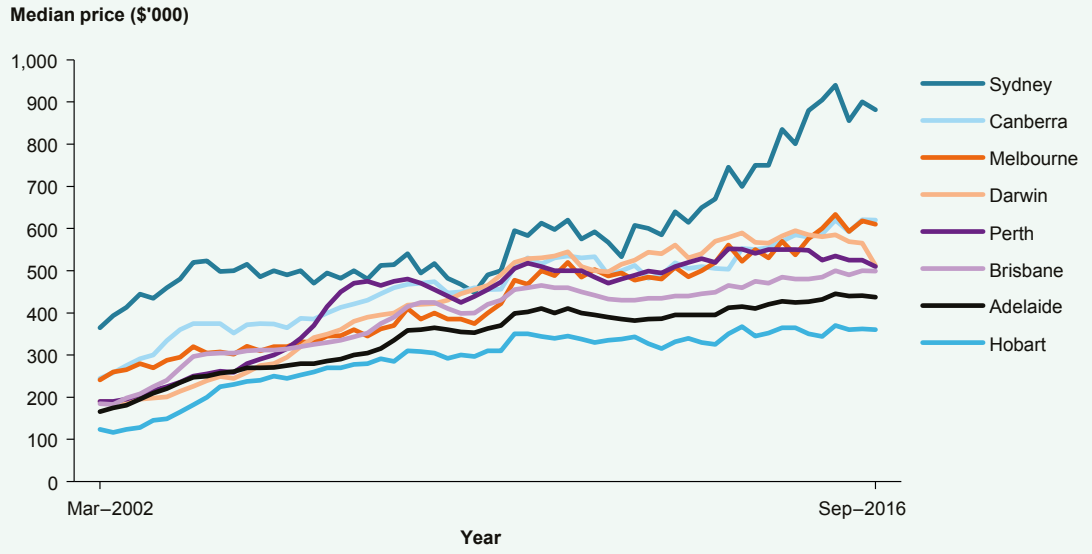
House prices in Australia have increased substantially in recent decades. The OECD noted in its biennial survey that they have reached unprecedented highs in Australia, increasing by 250% in real terms since the 1990s (OECD 2017a). The impact of higher house prices has been partially offset by lower mortgage interest rates, increased credit availability and changes in financial agency practices. These favourable lending conditions and low interest rates have encouraged buyers into the market, despite the growth in house prices themselves.



Sources: ABS cat. no. 5206.0 various years; ABS cat. no. 6416.0 various years. Graph based on that published in Burke et al. 2014.

Figure 6.3.8: Established house prices compared with household disposable income, Australia, 1986 to 2016

As Figure 6.3.9 shows, house price growth has not been uniform across Australian cities. Sydney prices have seen the steepest rises, particularly in the past 5 years, and are the most expensive. By contrast, Hobart has the lowest median house price, currently less than half that of Sydney.

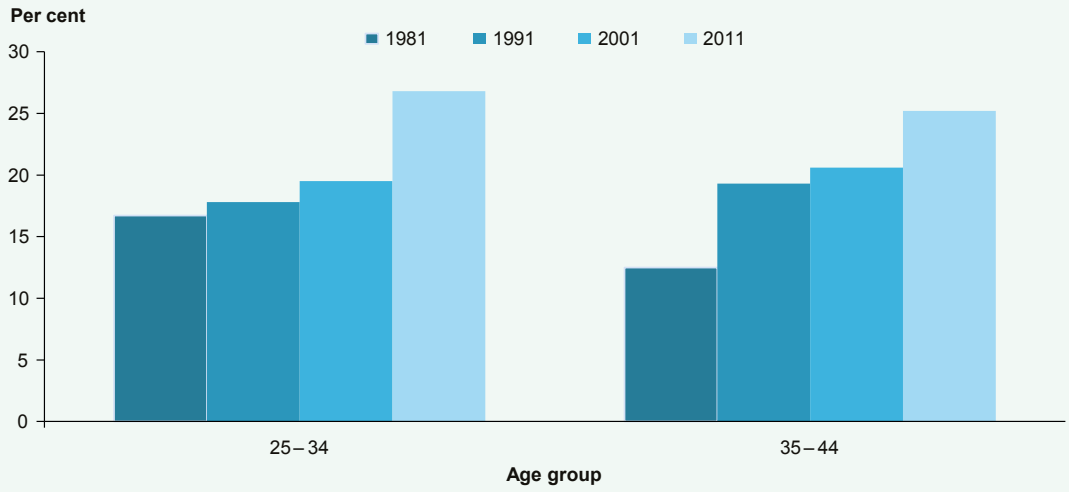


Note: Capital cities have been ordered from highest to lowest median price as at September 2016.

Source: ABS 2016a.

Figure 6.3.9: Median price of established houses, by capital city, March 2002 to September 2016

With house prices outpacing income growth, repayment affordability is affected. The cost of mortgages rose substantially in the 30 years to 2011 (Figure 6.3.10). This rise has been particularly felt by younger home buyers. The proportion of median household income spent on mortgage repayments increased by more than 50% for people aged 25–34 between 1981 and 2011. This proportion more than doubled over the same period for people aged 35–44, with this age group paying around 25% or more of their median household income on mortgage repayments (Burke et al. 2014).



Note: Data are for all purchasers in these age groups.

Source: Burke et al. 2014, based on ABS Census unit record files, various years.

Figure 6.3.10: Median mortgage as a percentage of median household income, by home owners with a mortgage and age group, 1981, 1991, 2001 and 2011

What is affordable, to whom and where?

Generally, measurements of housing affordability focus on quantifying housing stress as a proxy for all housing affordability driven outcomes (Gabriel et al. 2005; Rowley & Ong 2012). Measurements of housing stress primarily focus on the financial aspects of housing affordability, ignoring the wider non-financial impact of housing quality, location, economic participation and social and neighbourhood issues. A key issue with common housing stress measures (for example, house price to income ratio and the 30:40 rule—that is, housing costs below 30% of household income for the bottom 40% of the household income distribution) is that they include buyers and renters, but ignore people trying to enter the housing market.

The concept of affordability means different things to different people and households, and it depends on the housing situation. Affordability for home owners relates to purchase and repayment expenses; for renters, it relates to rental expenses. For the highest income households, affordability is a matter of exercising choice, rather than being restricted in accessing the market. For people with more modest means (with lower income and/or accumulated wealth assets), affordability is, and remains, a major issue and affects their ability to access the housing market.

The level of affordability experienced by buyers is influenced by many factors, including interest rates, asset wealth, dwelling prices, household composition, and the level of household income (Box 6.3.1).

From June 1993 to June 2016, the standard variable interest rate for housing loans fluctuated but trended downward, decreasing from 9.50% to 5.35%. This has helped people with a mortgage, but not renters. House prices have outpaced income growth over the past decade, contributing substantially to the decline in purchase affordability, particularly for lower income renters, and single-income households.

Affordability for rental households

For households renting, affordability is also declining (Hulse et al 2014). Stronger demand for housing generally leads to a tighter rental market, which has a disproportionate impact on lower income private renters.

The proportion of Australians in private rental is higher than ever before, with more than one quarter (26%) of the population renting in 2013–14, compared with just 18% in 1994–95 (ABS 2015a). Over the same period, renters have had a 62% (or $144) increase in average weekly housing costs. This is substantially higher than for owners with a mortgage (42%) or public housing renters (45%) over this time (ABS 2015b).

The number of lower income households renting has also grown; there were an estimated 1.3 million households in 2013–14. The proportion of these lower income rental households in rental stress (spending more than 30% of their gross income on housing costs) (see Chapter 9.2 'Indicators of *Australia's welfare*') has also increased. Half (50%) of the estimated 1.3 million lower income rental households were in rental stress in 2013–14, up from 40% in 2007–08 (ABS 2015a). For lower income households renting in the private market (about 912,500), 62% were in rental stress in 2013–14. The growing population of lower income households who are private renters represents a growing divide in home ownership and wealth inequity in Australia.

Affordability for households entering the market

Research indicates that it is future households that will face major affordability constraints (Eslake 2013; Rowley & Ong 2012). The barriers to purchasing a home are increasingly an issue for younger Australians and lower income households as they try to become home owners.

To highlight the difficulty in entering the housing market, the AIHW analysed a cross section of the community, to examine their opportunity to buy a home in the 2013–14 market. The population included private renter households who did not own a property—an estimated 2.3 million private rental households. An affordable dwelling price was estimated (affordable price point) using median gross household income data applied in a mortgage calculation for particular household or income groups in each Australian capital city (see 'Methods and conventions' section of this report for supplementary technical information related to the purchase affordability indicator; S6.3.1). Income data vary considerably across capital cities and therefore create quite different affordable price points; hence, outcomes are relative for each city. The proportion of dwellings sold in each capital city at or below these price points was calculated, providing an insight into the prospects for people wanting to get into the housing market. This analysis excluded Australians who were housed through social housing programs or who received government subsidised rent, as these households have different financial situations (and incomes) and are less likely to be in a position to buy a house.

Only about 1 in 6 (15%) of all dwellings sold in Australia in 2013–14 could have been bought by private rental households in Australia earning the median household income (CoreLogic RP Data 2016b).

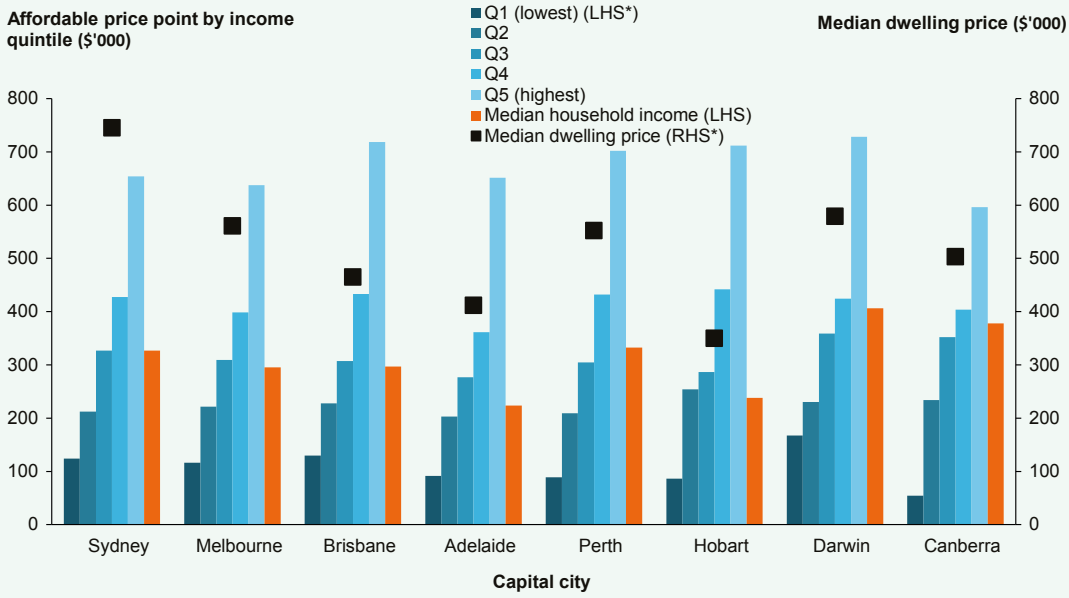
Of the 544,875 dwellings sold in Australia in 2013–14, 71% were in capital cities, with the remaining 29% across the rest of the states/territories. This reflects the distribution of the Australian population.

AIHW analyses of affordable purchase price data show the influence of broad location, income and household composition on the potential of rental populations to buy a dwelling in capital cities in Australia in 2013–14. The analyses reveal a notable degree of 'unaffordability' for these households.

Household income and affordability

Across all capital cities, both the median house and unit price exceeded the calculated maximum affordable dwelling price for the median income rental household.

The gap between the affordable price point for the median rental household income and median dwelling price was most pronounced for households in Sydney, with a median house price of $745,000. This figure is higher than even the affordable price point for the highest income quintile (Figure 6.3.11).



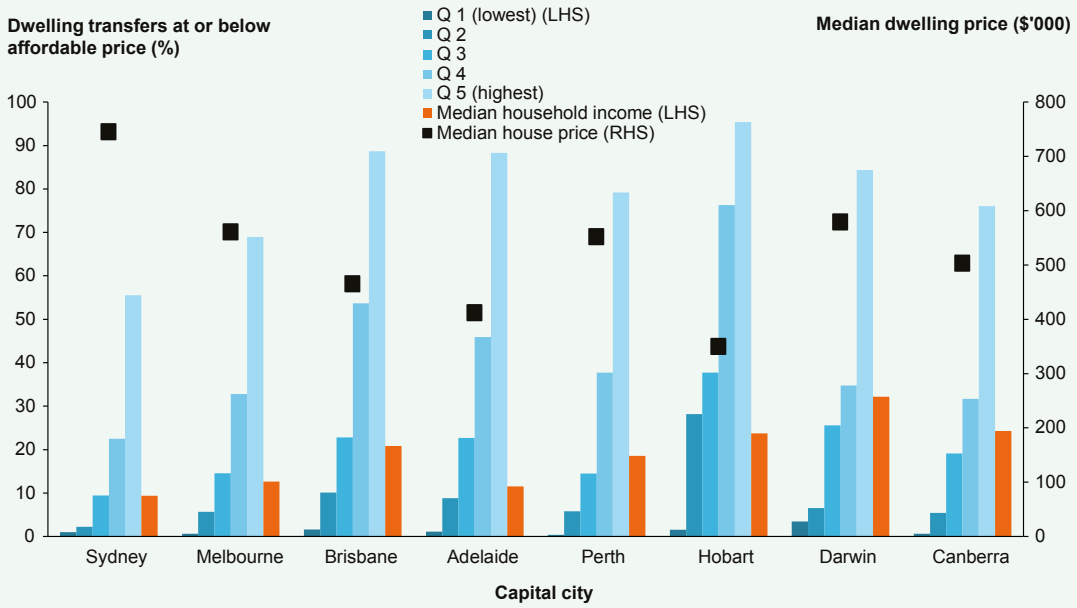
Note: Equivalised disposable household income is household incomes that are adjusted to enable analysis of the relative wellbeing of households of different size and composition, using an equivalence scale.

* LHS = left hand side; RHS = right hand side.

Sources: AIHW analysis of ABS 2016b; CoreLogic RP Data 2016b.

Figure 6.3.11: Median price of established houses and maximum affordable price points, by equivalised disposable income quintile and capital city, 2013–14

Overall, the proportion of dwellings sold that were affordable to the median income rental household across the capital cities ranged from 9.4% in Sydney to around 32% in Darwin (Figure 6.3.12). These locational differences are driven by differences in household incomes and the distribution of the prices of dwellings sold during 2013–14.



Note: Equivalised disposable household income is household incomes that are adjusted to enable analysis of the relative wellbeing of households of different size and composition, using an equivalence scale.

* LHS = left hand side; RHS = right hand side.

Sources: AIHW analysis of ABS 2016b; CoreLogic RP Data 2016b.

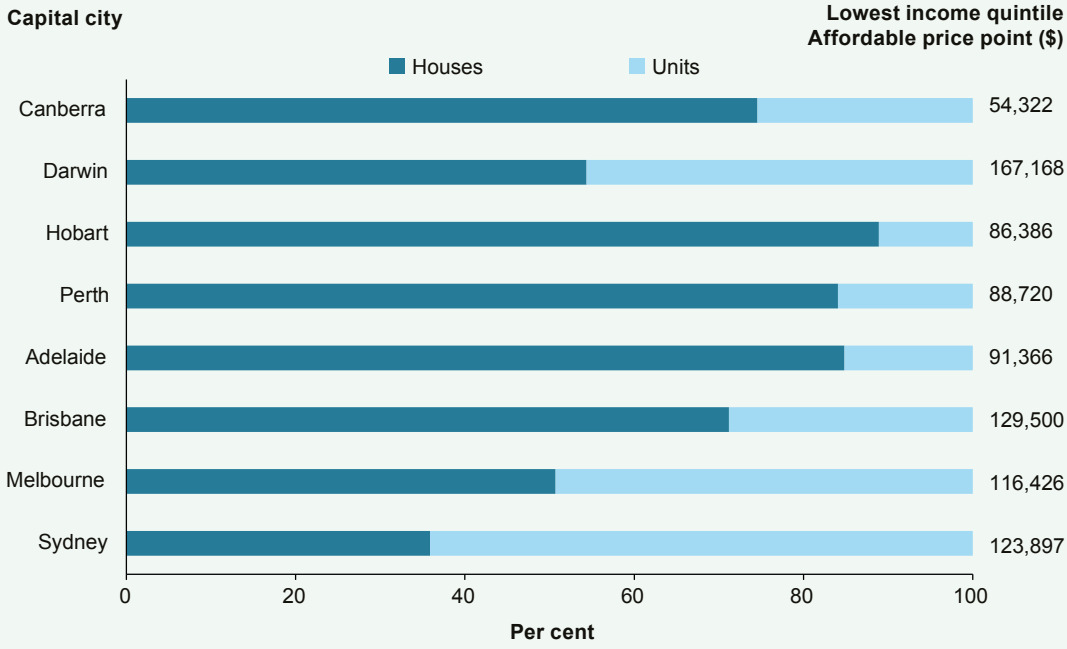
Figure 6.3.12: Median price of established Australian houses and proportion of dwellings transferred at or below the maximum affordable price point, by equivalised disposable income quintile and capital city, 2013–14

For rental households in the lowest equivalised disposable household income quintile (the lowest income earners), there were considerably fewer opportunities to enter the property market. For example, from less than 1% of dwellings sold in Perth to 3.5% in Darwin were affordable for these households (Figure 6.3.12).

By comparison, households in the highest equivalised disposable household income quintile, (the highest income earners) could afford to buy up to 95% of dwellings sold in Hobart and more than 75% of dwellings in all other capital cities, except for Sydney and Melbourne. Only 56% of dwellings sold in Sydney were affordable to the highest income earners and 69% in Melbourne.

There were not only fewer opportunities for financially constrained households to buy an affordable property, but also limited choice in the type of dwelling, depending on location (Figure 6.3.13). Sydney was the only capital city where there were more units than houses transferred below the affordable price point for people in the lowest two income quintiles (quintile 1, 64%; quintile 2, 52%). In Darwin, Melbourne and Brisbane, where the affordable

price point was also high, renters in the lowest income quintile would have had fewer opportunities to buy a house than renters in capital cities with lower affordable price points (Hobart, Adelaide, Perth and Canberra). These analyses imply that, for renters in the lowest income quintile living in capital cities with the highest affordable price points, choice of dwelling type would be constrained.



Note: Equivalised disposable household income is household incomes that are adjusted to enable analysis of the relative wellbeing of households of different size and composition, using an equivalence scale.

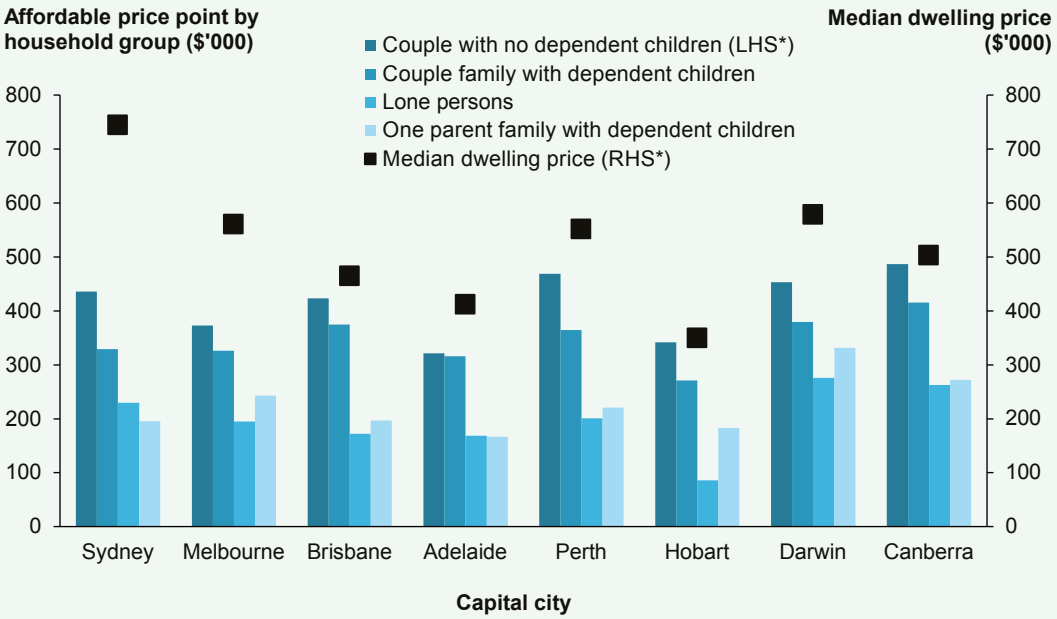
Source: AIHW analysis of CoreLogic RP Data 2016b.

Figure 6.3.13: Proportion of houses and units transferred at or below affordable price points for lowest equivalised disposable income quintile, by capital city, 2013–14

Household composition and affordability

Purchase affordability is influenced not only by household income, but also by the composition of the household itself. Households with a single income and/or dependants have reduced borrowing capacity, while the adequacy of the dwelling is influenced by family size. While calculated affordable price points varied across household types and capital cities, one thing remained constant: the median house price across all capital cities was above the maximum affordable dwelling price point across all household types.

For certain household types, the gap between median income and affordable price point was greater than others (Figure 6.3.14). Across most capital cities, this gap was largest for lone-person households, followed closely by single-parent households with dependent children.



* LHS = left hand side; RHS = right hand side.

Sources: AIHW analysis of ABS 2016b; CoreLogic RP Data 2016b.

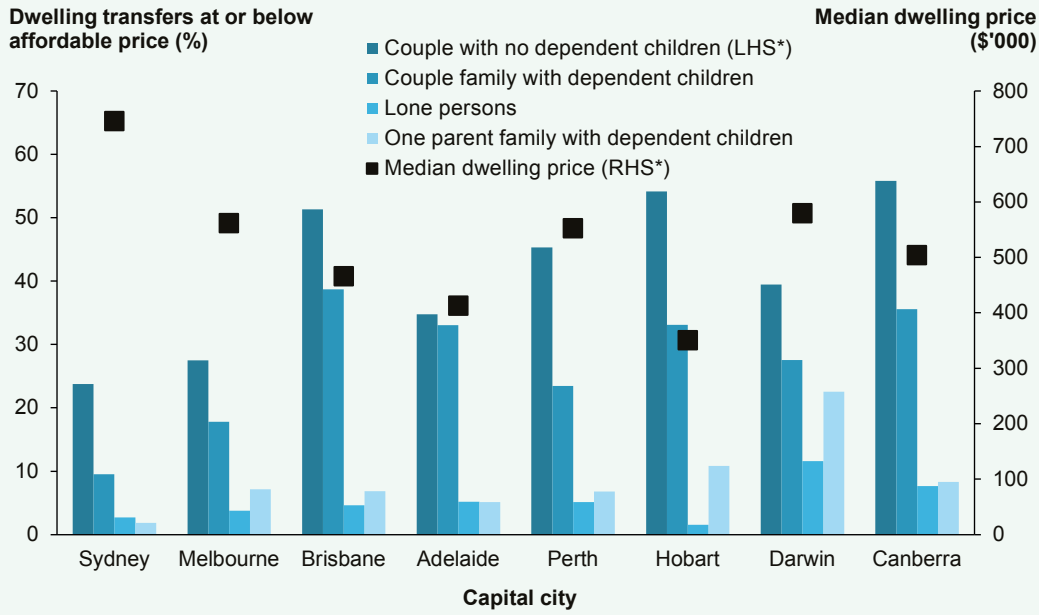
Figure 6.3.14: Median price of established Australian houses and affordable price points, by family composition of household and capital city, 2013–14

The vast majority of affordable dwellings transferred across all Australian capital cities in 2013–14 were not affordable for single-income households; that is, one-parent families with dependent children and lone-person households (Figure 6.3.15).

Sydney was the least affordable capital city. For single-income households, just 1.8% (or 2,144) of dwellings sold in 2013–14 were deemed affordable, and for lone-person households just 2.7% (or 3,180). A similar trend was observed for single-income and lone-person households in the four other capitals, ranging from a 10% in Adelaide to 12% in Perth and Brisbane.

Couples with no dependent children had the greatest opportunity to buy a house across all capital cities. For example, a couple with no dependent children earning the median income could have bought about half of all dwellings sold in Canberra, Hobart, Perth and Brisbane. However, in Sydney, even these households could only have bought around 24% of properties.

These data show that, for most rental households across most income quintiles, median house prices were well above what these households could comfortably afford. Despite this price issue, the Australian housing market continues to grow, with more and bigger houses being bought. Higher income earners accessing bigger and better homes, and investors entering the housing market, have been responsible for some of the economic pressures contributing to rising real house prices.



* LHS = left hand side; RHS = right hand side.

Sources: AIHW analysis of ABS 2016b; CoreLogic RP Data 2016b.

Figure 6.3.15: Median price of established Australian houses and proportion of dwellings transferred at or below the affordable price point, by family composition of household and capital city, 2013–14

Housing assistance

Direct housing assistance

Increasing affordability issues have the potential to increase the number of households in housing stress and hence the demand for direct housing assistance. A range of incentives and programs are available to directly assist low-to-moderate income households and households who are particularly disadvantaged or vulnerable. These include measures to help households pay for housing, to increase the supply of affordable housing and to assist with rental subsidies and the provision of social housing.

Social housing programs are available for lower income Australians who need housing and meet eligibility criteria. Latest figures estimate that Australia has nearly 433,000 social housing dwellings (public rental housing, mainstream community housing, state owned and managed Indigenous housing, Indigenous community housing). This stock, however, is shrinking; it is not keeping up with household growth (4.7% in 2016, down from 5.1% in 2007–08) (AIHW analysis of National Housing Data Repository), effectively reducing the number of social housing dwellings available. The composition of the 'Australian population' accessing social housing assistance has changed over time, with the most disadvantaged groups (for example, the homeless, people with disability, and Indigenous populations) accounting for a growing proportion of people who receive housing assistance (see also Chapter 6.1 'Social housing').

A growing proportion of Australians are renting in the private market, including many lower income households. As social housing dwellings as a proportion of all dwellings decrease, lower income households find themselves having to rent in the private market. Where lower income households remain in the private rental market, they may be helped financially through the CRA scheme. The growth of the CRA over the past 10 years, both in terms of the number of recipients and government expenditure, indicates a growing reliance on this funding in a rental market with increasing rental costs and a growing population of lower income renters. The number of CRA recipients increased by 43% to 1,346,000 income units in 2015–16, while real government expenditure increased to nearly $4.4 billion, up from $2.6 billion over the same period.

An adequate supply of affordable, sustainable rental housing is a key requirement to meet the increasing demand on social housing. The Australian Government has responded to this need by establishing an Affordable Housing Working Group, following a request from state and territory Treasurers at the Council on Federal Financial Relations meeting in October 2015. The Working Group's final report was considered by Treasurers in December 2016. Following this, the Australian Government established an Affordable Housing Implementation Taskforce that is investigating innovative ways to harness private sector investment in the social housing sector including through the National Housing Finance and Investment Corporation (NHFIC). NHFIC will operate an affordable housing bond aggregator to encourage greater private and institutional investment and provide cheaper and longer-term finance to registered providers of affordable housing.

Indirect housing assistance and affordability

Indirect housing assistance provided through so called tax expenditures (for example, capital gains tax and negative gearing) is a major contribution towards housing assistance in Australia.

The value of housing tax expenditures reported for 2015–16 was about $60 billion (Table 6.3.1), an increase of almost 40% since 2005–06. This increase reflects the increase in housing wealth accumulated over this period.

In 2015–16, indirect assistance to owner–occupiers via the capital gains tax exemption on the family home was estimated at almost $55 billion (Table 6.3.1) in the 2015 Tax Expenditures Statement (Treasury 2016b).

The 50% discount on capital gains was estimated to provide up to a further $6 billion to investors in residential property in 2015–16.

These estimates represent an upper bound of the benefits to housing investors, since the data apply to all investments that generate capital gains. The Grattan Institute provided an estimate of about $5 billion in 2011–12 from the capital gains tax discount for investors in residential property, to which it adds about a further $2 billion, considering the negative gearing opportunities provided by the asymmetric treatment of income and expense (Kelly et al. 2013). As at 2011, total quantified tax expenditures were estimated to account for almost 9% of gross domestic product, with housing tax expenditures accounting for around one third of the total (Treasury 2011).

Table 6.3.1: Large housing tax expenditures and capital gains tax 2005–06 to 2015–16 (estimated)

Year	CGT main residence exemption ($b)	CGT discount for individuals and trusts ($b)
2005–06	40	5
2006–07	40	6
2007–08	41	10
2008–09	29	9
2009–10	40	4
2010–11	37	4
2011–12	32	5
2012–13	36	4
2013–14	46	4
2014–15	55	6
2015–16 (estimated)	55	6

* CGT = Capital Gains Tax.

Note: All estimates are based on a revenue foregone approach.

Sources: Treasury 2016b and earlier years.

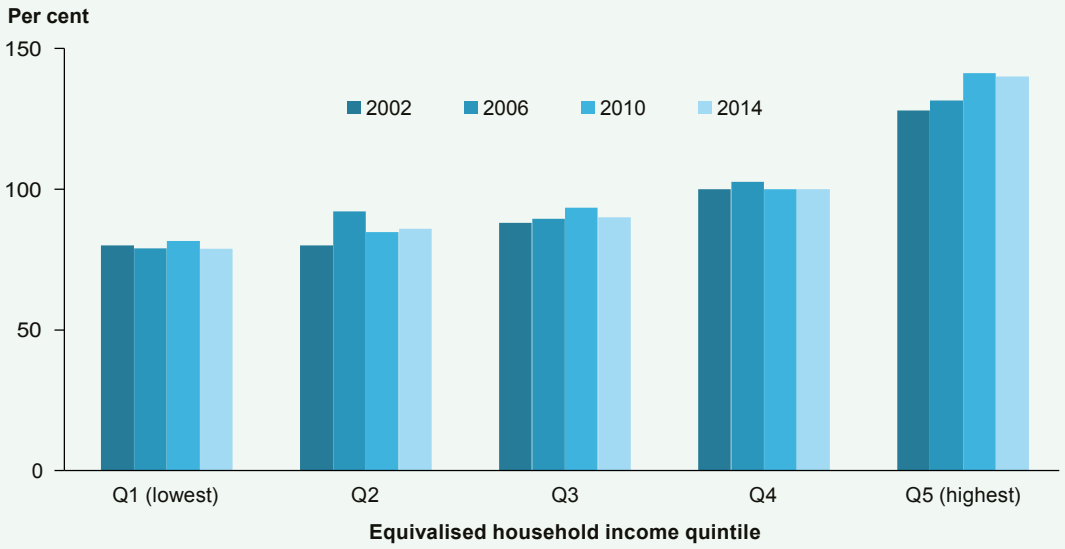
Regardless of what impact measurement issues have on revenue or what tax benchmark is used to identify them, tax expenditures have a substantial impact on the equity and efficiency outcomes of Australia's housing system.

Housing wealth, both in the form of owner-occupied (Figure 6.3.16) and other residential property wealth, has increased more rapidly for households in the highest income quintile over the past decade than it has for households in all lower quintiles. Households in the top income quintile, therefore, have benefited more from the tax concessions accorded to owner-occupied housing and to investment housing than have all other households.

Tax concessions that exempt some or all the income earned from housing—whether this is earned by owner–occupiers or by investors—make investment and speculation in residential property more attractive than it otherwise would be (Treasury 2010).

Investors compete directly with potential home buyers; established owners are encouraged to improve their housing living standards. Both responses add to demand pressures in the housing market. In light of the relatively sluggish supply responses across Australia, they contribute to upward pressures on dwelling prices and to the increasing difficulties faced by would-be home buyers.

Subsidies for home ownership are often justified because of the associated economic and social benefits. Of these, contributions to wealth accumulation and to protection against poverty in older age are central. As increasing proportions of younger, and particularly lower income households, are excluded from home ownership, these arguments become less compelling. As argued almost a decade ago, tax expenditures support home owners, not home ownership (The Senate Select Committee on Housing Affordability in Australia 2008).



Note: Equivalised disposable household income is household incomes that are adjusted to enable analysis of the relative wellbeing of households of different size and composition, using an equivalence scale.

Source: Reserve Bank of Australia statistics, Analysis of Australian Housing and Urban Research Institute data.

Figure 6.3.16: Ratio of quintile median dwelling wealth of primary residence to median dwelling wealth of all households, by equivalised disposable income quintiles, 2002, 2006, 2010 and 2014

Direct housing assistance, such as that provided through CRA, is often justified on equity grounds. This assistance is relatively tightly aimed at lower income households at risk of facing financial stress as a result of high housing costs in the private rental market. Indirect housing assistance, however, is not so focused, with the greatest assistance going to high-income and high-wealth households. This inequitable distribution of assistance has been well documented over the past 25 years.

What is missing from the picture?

With generational changes occurring with home ownership, there is limited information in the following areas:

- the housing aspirations of different population groups—whether by choice or necessity, what trade-offs are individuals and households willing to make when it comes to housing? Population groups of particular interest include, for example, youth, aged people, the homeless, people with disability and Indigenous people. Trade-offs might include increased mortgage repayments during periods of low interest rates, increased indebtedness, tenure options, location, and quality across the life course
- measurements of affordability—these are currently limited to measuring the cost burden on households and do not include, for example, the wider non-financial impact of housing quality or location
- housing stress—this measure examines only the position of households currently in home ownership; it does not quantify, for example, the would-be households who are unable to form.

The supply of housing and drivers of supply are outside the scope of this article.

Where do I go for more information?

More information on housing assistance in Australia is available at: www.aihw.gov.au/housing-assistance/haa/2016/. More information on OECD housing affordability measures is available at: http://www.oecd.org/social/affordable-housing-database.htm.

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Chapter 7

Indigenous Australians

7.0 Introduction

Aboriginal and Torres Strait Islander people are the Indigenous peoples of Australia. They are not one group, but comprise hundreds of groups that each have their own distinct set of languages, histories and cultural traditions.

There were an estimated 761,300 Indigenous Australians, or 3% of the total Australian population, in June 2017. Indigenous communities pass on knowledge, tradition, ceremony and culture from one generation to the next through language, performance, protection of significant sites, storytelling and the teachings of Elders. In 2014–15, 62% of Indigenous Australians aged 15 and over identified with a clan, tribal or language group, and 74% recognised an area as homelands or traditional Country.

As a group, Indigenous Australians experience widespread socioeconomic disadvantage and health inequality. This chapter examines factors affecting their wellbeing, including community safety; closing the gap in Indigenous education; income and employment; and use of disability and aged care services.

Educational achievements of Indigenous children and youth have been improving but substantial gaps remain. The Australian Early Development Census (AEDC) is an assessment of 'school readiness' carried out in a child's first year of full-time schooling, usually at the age of 5. The AEDC results show that the gaps in child development between Indigenous and non-Indigenous children have, on average, developed even at this early age. In all three AEDC collections since 2009, Indigenous children were more than twice as likely as non-Indigenous children to be assessed as developmentally vulnerable. However, there has been encouraging progress: the proportion of Indigenous children assessed as vulnerable on 1 or more of the 5 assessed domains dropped from 47% in 2009 to 42% in 2015—a larger fall than for non-Indigenous children over this period.

Of the three education-related Closing the Gap targets for which trend data are available, only one is on track—the target to halve the gap in Year 12 attainment by 2020.

The gap between Indigenous and non-Indigenous Australians continues into working age. Indigenous Australians aged 15–64 are less likely to be in the labour force than non-Indigenous Australians, on average earn less, and are more likely to receive a government pension or allowance as their main source of income. However, the proportion of Indigenous adults with incomes in the bottom 20% of equivalised gross weekly household incomes has decreased over the past decade.

7.1 Community factors and Indigenous wellbeing

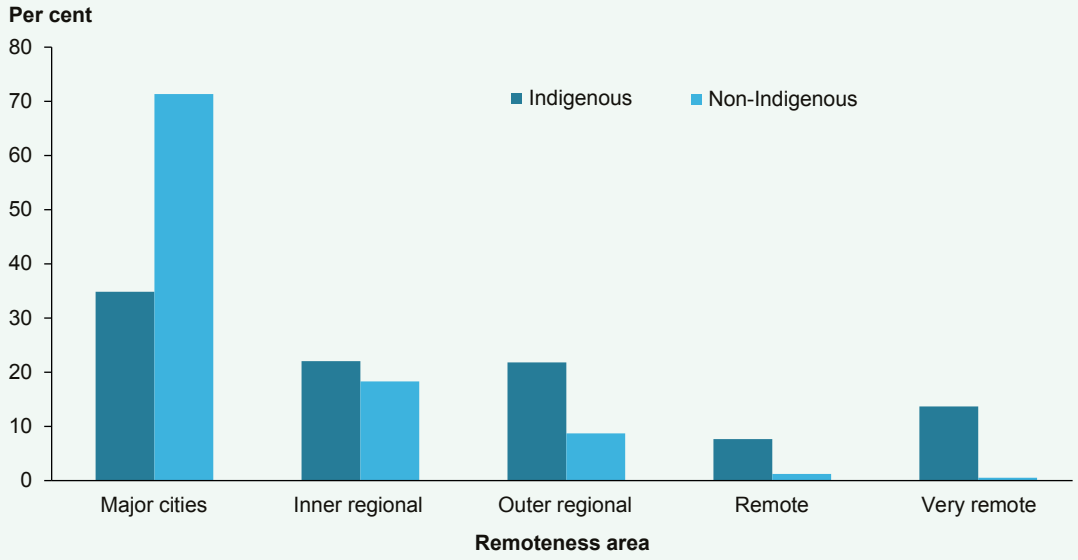
Aboriginal and Torres Strait Islander people are the Indigenous peoples of Australia. They live in all parts of the nation, from major cities to remote tropical and desert areas. Indigenous Australians are not one group, but comprise hundreds of groups that have their own distinct set of languages, histories and cultural traditions.

Indigenous Australians can be of Aboriginal origin, Torres Strait Islander origin, or both. The Australian Government defines Indigenous Australians as people who are of Aboriginal or Torres Strait Islander descent, who identify as being of Aboriginal or Torres Strait Islander origin and who are accepted as such in the communities in which they live, or have lived. In most data collections, a person's Indigenous status is based on the first two parts of this definition.

Indigenous population

As at 30 June 2017, there were an estimated 761,300 Indigenous Australians, who made up 3.1% of the total Australian population (ABS 2014). Indigenous population estimates based on the 2016 Census were not available at the time of writing (see Box A in this report's preliminary pages).The Indigenous population is much younger than the non-Indigenous population, and Indigenous Australians are more likely than non-Indigenous Australians to live outside of the *Major cities* areas.

- In the 2011 Census, 90% of Indigenous Australians identified as being of Aboriginal origin only, 6% as Torres Strait Islander origin only, and 4% as both Aboriginal and Torres Strait Islander origin.
- In June 2011, the median age of the Indigenous population was 21.8 (compared with 37.6 for the non-Indigenous population). Only 3.4% of the Indigenous population was aged 65 or over compared with 14% of the non-Indigenous population (ABS 2013a).
- The majority (79%) of Indigenous Australians live in non-remote areas, with more than one third (35%) living in *Major cities*. 7.7% live in *Remote* areas, with a further 14% in *Very remote* areas (see Glossary for information about the remoteness classification used in this report). By comparison, 1.7% of the non-Indigenous population live in *Remote* or *Very remote* areas of Australia (Figure 7.1.1).
- More than half of all Indigenous Australians live in New South Wales (31%) or Queensland (28%), with a further 13% in Western Australia and 10% in the Northern Territory.
- The Northern Territory has the highest proportion of Indigenous Australians in its population at 30%; in the other jurisdictions, Indigenous people make up 1–4% of the population (ABS 2013a).



Source: ABS 2013a.

Figure 7.1.1: Population distribution, by Indigenous status and remoteness area, as at 30 June 2011

The 2011 Census identified around 209,000 households where at least one Indigenous person was a usual resident (referred to in this section as an Indigenous household).

- Three-quarters (75%) of these were one-family households, 6% consisted of two or more families, 14% were one-person households and 5% were group households.
- Indigenous households were less likely than other households to be single-person households (14% compared with 25%), more likely to consist of 2 or more families (6% compared with 2%) and more likely to contain 5 or more people (23% compared with 10%) (ABS 2012a).

In 2011, there were 181,700 families living in Indigenous households.

- Families in Indigenous households were more likely than families in other households to include children aged under 15 (59% compared with 38%), and more likely to be one parent families with children aged under 15 (28% compared with 7.7%).
- The proportion of families with dependent students was similar in Indigenous and other households (14% and 15%, respectively) (AIHW analysis of ABS 2011 Census (TableBuilder)).

Why focus on Indigenous Australians?

Indigenous Australians experience widespread socioeconomic disadvantage and health inequality. They are more likely than non-Indigenous Australians to be exposed to poverty, unemployment, violence, substance abuse and imprisonment. Indigenous children tend to have poorer educational outcomes than non-Indigenous children (see Chapter 7.4 'Closing the gap in education'), and are more likely to have contact with the child protection and youth justice systems. Given current mortality rates, an Indigenous baby born in 2010–2012 has an expected life span 10 years shorter than that of a non-Indigenous baby (ABS 2013b).

The reasons for these disparities are complex, and include dispossession, marginalisation, and racism, as well as the ongoing and cumulative effect of past policies of forced removal and cultural assimilation (HREOC 1997; SCRGSP 2016a).

The 2008 National Indigenous Reform Agreement (the Agreement) (COAG 2008) commits all Australian governments to actions aimed at closing the gap in Indigenous disadvantage. The Agreement notes that efforts will be directed across seven key platforms: early childhood, schooling, health, economic participation, healthy homes, safe communities, and governance and leadership. It also acknowledges the importance of culture and of eliminating discrimination. The wide range of actions across multiple sectors recognises the complex web of factors involved in creating and perpetuating Indigenous disadvantage, and that the approach to closing the gap must be coordinated and multifaceted. It must involve not just governments but also the corporate sector, non-government organisations and the Indigenous community.

In October 2015, the Australian Government released the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023. The Implementation Plan outlines 106 actions to be taken by the Australian Government, the Aboriginal community controlled health sector, and other key stakeholders to give effect to the vision, principles, priorities and strategies of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023. The Implementation Plan sets a number of goals to be achieved by 2023 for a set of 20 indicators for Indigenous health care processes and outcomes at the national level. These goals complement the existing Council of Australian Governments (COAG) Closing the Gap targets and focus on prevention and early intervention across the life course. For more information on the Implementation Plan, its vision and the context for its goals, see *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (DOH 2015) and the associated technical companion document (AIHW 2015).

This chapter focuses on two of the key factors that support the wellbeing of Indigenous Australians: a well-functioning community and a safe, secure home with working facilities. Information about some of the factors that reduce Indigenous wellbeing (such as exposure to discrimination and violence) and on educational outcomes, employment and income for Indigenous Australians can be found in other parts of Chapter 7.

Indigenous community functioning

Indigenous communities pass on knowledge, tradition, ceremony and culture from one generation to the next through language, performance, protection of significant sites, storytelling and the teachings of Elders. Family and kinship are integral to establishing relationships, positions and obligations within and outside the community (Bourke & Edwards 2004). Having a cohesive and well-functioning community, which provides opportunities for education, employment and recreation, as well as the infrastructure of adequate housing, transport and other services—and where people are empowered to make choices—can help to deal with the social and economic issues that result in social isolation, poor mental wellbeing, and anti-social behaviour (such as violence, crime and drug use) (ABS 2004; Hirschfield & Bowers 1997; Victorian Government 2015).

Functioning in this context is about the things people achieve or experience, consistent with their account of wellbeing. It varies from basic needs (such as being adequately nourished and being free from avoidable disease) to very complex activities or personal states (such as being able to take part in the life of the community and having self-respect). The conversion of capabilities into functioning is influenced by the values and personal features of individuals, families and communities, and by the social and cultural environment in which they live. Different cultures give greater or lesser priority to different types of functioning (Sen 1999, as cited in AHMAC 2015).

In 2008 and 2010, workshops were undertaken to inform the development of community functioning measures for the Aboriginal and Torres Strait Islander Health Performance Framework. These workshops drew together Indigenous people from across Australia, who described the various elements of family and community life essential for high levels of functioning. Six themes central to Indigenous Australian community functioning were identified: Connectedness to Country, land, and history, culture and identity; Resilience; Leadership; Having a role, structure and routine; Feeling safe; and Vitality (AHMAC 2015).

The next few sections present information about some aspects of community functioning that relate to each of these themes. The majority of the data are drawn from the Australian Bureau of Statistics (ABS) National Aboriginal and Torres Strait Islander Social Survey (NATSISS), conducted most recently in 2014–15, with previous surveys conducted in 2008 and 2002. The available data suggest that, in terms of these key themes supporting wellbeing through community functioning, circumstances for Indigenous Australians have either been maintained or have improved since 2008. Comparison data for non-Indigenous Australians is from the ABS 2014 General Social Survey (GSS).

Connectedness to country, land and history, culture and identity

This theme comprises being connected to country, land, family and spirit; strong and positive social networks with Indigenous people; a strong sense of identity and being part of a collective; and sharing, giving and receiving, trust and love, and looking out for others (AHMAC 2015).

In 2014–15:

- 62% of Indigenous Australians aged 15 and over identified with a clan, tribal or language group, and 74% recognised an area as homelands or traditional country
- 18% of Indigenous people aged 15 and over spoke an Australian Indigenous language, with a further 20% speaking some words. Around one-third (34%) of Indigenous people aged 4–14 spoke at least some words of an Indigenous language
- an Indigenous language was the main language spoken at home for 11% of Indigenous Australians aged 15 and over, and for 7.5% of Indigenous children aged 4–14. Speaking an Australian Indigenous language as the main language spoken at home was considerably more common in remote than non-remote areas (41% compared with 2.0% for people aged 15 and over)
- almost two-thirds (63%) of Indigenous Australians aged 15 and over and three-quarters (75%) of Indigenous children aged 4–14 had been involved in Indigenous cultural events, ceremonies or organisations in the previous 12 months (ABS 2016)

- more than 4 in 5 (83%) Indigenous Australians aged 15 and over had weekly face-to-face contact with family or friends living outside their household, a higher proportion than among non-Indigenous Australians (77%) (ABS 2015a; 2016)
- half (50%) of Indigenous Australians aged 15 and over provided support (such as money, food, clothing or transport) to relatives living outside their household (ABS 2016).

These results are all similar to those from the 2008 survey. Comparable data from the 2002 survey indicate that the proportion speaking an Indigenous language (including as a main language spoken at home) was similar in 2014–15 and 2002, while the proportion identifying with a clan or language group was higher in 2014–15 (62% compared with 54% in 2002). However, the proportion of Indigenous Australians who had attended an Indigenous cultural event in the last 12 months was somewhat lower in 2014–15 than in 2002 (63% compared with 68%) (AIHW 2017a).

Resilience

This theme comprises coping with the internal and external world; power to control options and choices; ability to proceed in public without shame; optimising what you have; challenging injustice and racism, standing up when required; coping well with difference, flexibility, and accommodating; ability to walk in two worlds; engagement in decision making; and external social contacts (AHMAC 2015).

In 2014–15 among Indigenous Australians aged 15 and over:

- 62% had not experienced unfair treatment in the previous 12 months
- 86% had not avoided situations in the previous 12 months due to past unfair treatment
- almost all (97%) had participated in sporting, social or community activities in the previous 12 months
- 49% felt able to have a say in their community on important issues at least some of the time. This is similar to the result among non-Indigenous Australians (53%)
- of people who were employed and had cultural responsibilities, their work allowed them to meet these responsibilities in 71% of cases
- most (92%) could get support from outside their household in times of crisis. This is similar to the result among non-Indigenous people (95%) and an increase since 2008 (89%)
- 80% of people who had seen a general practitioner in the previous 12 months felt that their doctor listened carefully to them, and 85% felt that their doctor showed respect
- 81% felt that their doctor could be trusted (ABS 2016)
- more than half (58%) felt that local police could be trusted, an increase from 52% in 2008 (AIHW 2017a).

Leadership

This theme comprises strong Elders in family and community, both men and women; role models, both men and women; strong direction, and vision; and a 'rock', someone who has time to listen and advise (AHMAC 2015).

In 2014–15:

- half (51%) of Indigenous children aged 4–14 in remote areas and almost one-quarter (23%) of Indigenous children in non-remote areas spent at least 1 day with a leader or Elder each week
- most (82%) Indigenous Australians aged 15 and over had someone outside the household in whom they could confide
- half (50%) of Indigenous Australians aged 15 and over living in remote areas felt that their community had strong leadership, and more than half (52%) felt that the leaders in their community had time to listen and give advice (ABS 2016).

Having a role, structure and routine

This theme comprises having a role for self: participation, contributing through paid and unpaid roles; capabilities and skills derived through social structures and experience through non-formal education; knowing boundaries and acceptable behaviours; sense of place—knowing your place in family and society; being valued and acknowledged; and disciplined (AHMAC 2015).

In 2014–15:

- 61% of Indigenous Australians aged 15–64 were in the labour force, with most of these people (79%) being employed. By comparison, 77% of non-Indigenous Australians aged 15–64 were in the labour force in 2014, with 94% of these people being employed (AIHW analysis of ABS 2014–15 NATSISS (TableBuilder) and AIHW analysis of ABS 2014 GSS (TableBuilder))
- 72% of Indigenous Australians aged 15 and over lived in a household where household members had not run out of money for basic living expenses in the previous 12 months, a similar proportion to that in 2008 (AIHW 2017a).

More information about income and employment among Indigenous Australians can be found in Chapter 7.5 'Income and employment for Indigenous Australians'.

Data from the 2011 Census show that:

- families living in Indigenous households were more likely than those in other households to have had some or all residents move house in the previous year (29% compared with 19%) (AIHW analysis of ABS 2011 Census (TableBuilder)).

Feeling safe

This theme comprises lack of physical and lateral violence (see Glossary); safe places; emotional security; cultural competency; and relationships that can sustain disagreement (AHMAC 2015).

In 2014–15 among Indigenous Australians aged 15 and over:

- most (84%) felt safe at home alone after dark, an increase from 80% in 2008
- over half (54%) felt safe walking alone in their local area after dark, similar to the result from 2008 (53%)
- most (87%) had not been a victim of physical violence in the previous 12 months, a similar proportion to that in 2008 (85%) (AIHW 2017a).

More detailed information about safety issues, contact with the criminal justice system and the exposure of Indigenous Australians to violence can be found in Chapter 7.3 'Community safety among Indigenous Australians'.

Vitality

This theme covers community infrastructure, access to services, education, health, income and employment (AHMAC 2015).

In 2014–15:

- 47% of Indigenous Australians aged 15 and over had a non-school qualification—that is, educational attainments other than those of a pre-primary, primary and secondary education. These qualifications may be attained after completing school, or concurrently with obtaining school qualifications. This proportion was significantly higher than that in 2008 (32%)
- 22% of Indigenous Australians aged 15 and over were enrolled in formal study—a significant increase from 19% in 2008
- 39% of Indigenous Australians aged 15 and over were daily smokers, a drop from 45% in 2008 and 49% in 2002, but still almost 3 times the rate among non-Indigenous Australians (ABS 2016)
- the majority (74%) of Indigenous Australians aged 15 and over who had tried to access services in the previous 12 months (such as health care, utilities, employment services and financial institutions) had no problems accessing these services. This was the same as for non-Indigenous Australians (74%) (AIHW analysis of ABS 2014–15 NATSISS (TableBuilder) and AIHW analysis of ABS 2014 GSS (TableBuilder))
- 81% of Indigenous Australians were living in houses of an acceptable standard (AIHW 2017a)
- 40% of Indigenous Australians aged 15 and over rated their general health as very good or excellent, a fall from 44% in 2008 (ABS 2016).

Housing and homelessness

A stable and adequately maintained and serviced home is fundamental for health. As well, it provides a safe and secure environment, and underpins a well-functioning community. Not having affordable, secure and appropriate housing can have negative consequences. These include homelessness, poor health, and lower rates of employment and education participation—all of which can lead to social exclusion and disadvantage.

This section focuses on housing stability (including tenure and housing assistance), housing quality (including facilities and structural soundness) and potential overcrowding. It also looks at homelessness and the use of relevant support services by Indigenous Australians.

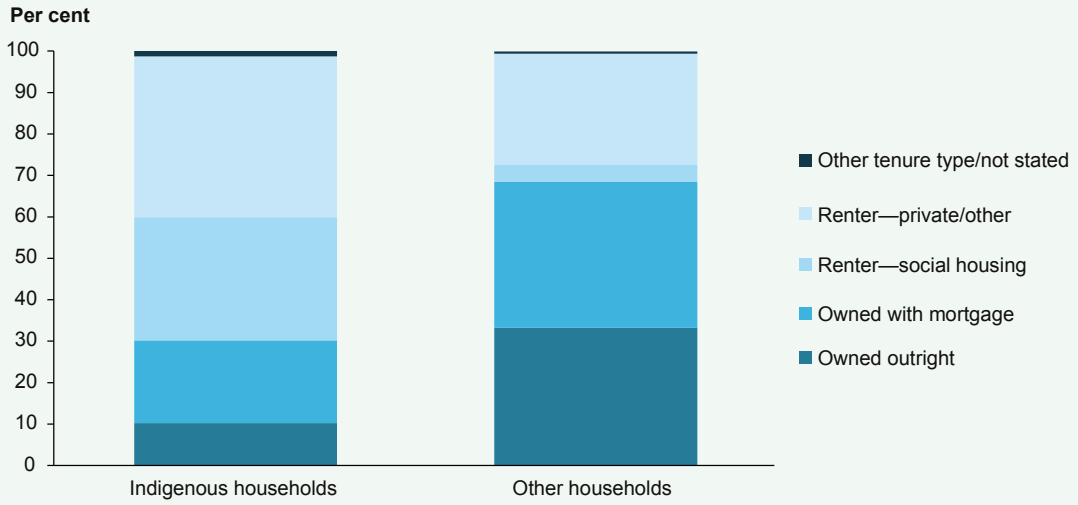
Housing tenure

Housing tenure describes whether a dwelling is owned or rented, or occupied under some other arrangement (see also Box 7.1.1). Survey data from the NATSISS show that, in 2014–15, of the estimated 283,900 Indigenous households:

- 3 in 10 (30%) were home owners—10% owned their home outright (about 29,000 households) and 20% had a mortgage (56,900 households)
- nearly 7 in 10 (69%) were renters—30% lived in social housing (about 84,400 households), while the remainder (39%) were private renters or rented from another type of landlord (110,300 households)
- 1.3% occupied their dwelling under some other arrangement, or did not provide information on household tenure (Figure 7.1.2).

The rate of home ownership among Indigenous households (30%) was less than half that for other households (68%) (Figure 7.1.2).

The proportion of Indigenous households who owned their home with or without a mortgage in 2014–15 (30%) was similar to the proportions in 2012–13 and 2008 (both 32%) (SCRGSP 2016a).



Notes

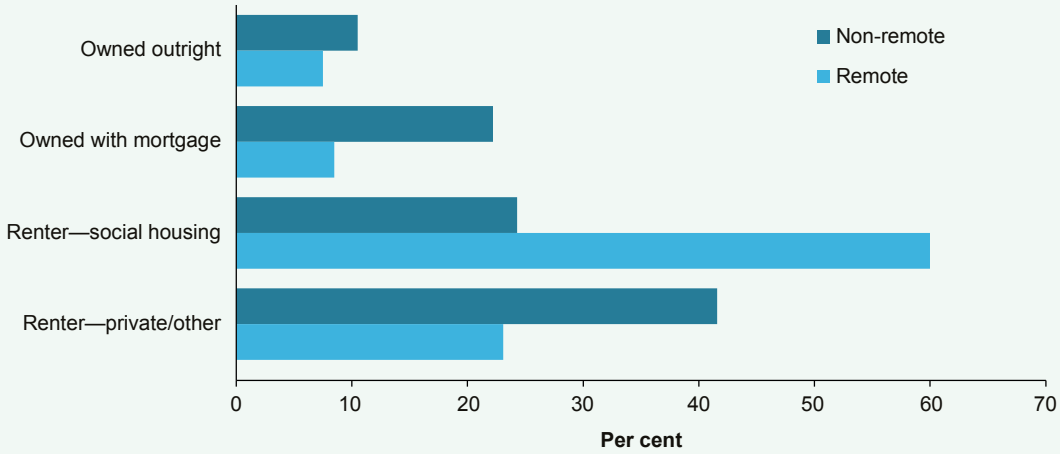
1. Data for 'Other households' are from the 2014 General Social Survey.
2. See Box 7.1.1 for definitions of the tenure types shown.

Source: AIHW analysis of the 2014 General Social Survey (TableBuilder); AIHW analysis of the 2014–15 National Aboriginal and Torres Strait Islander Social Survey (TableBuilder).

Figure 7.1.2: Housing tenure of households, by Indigenous status, 2014–15

There were also differences in tenure type by remoteness area (Figure 7.1.3). In 2014–15:

- Indigenous households in non-remote areas were twice as likely to own their home (with or without a mortgage) as Indigenous households in remote areas —33% compared with 16%
- Indigenous households in remote areas were more than twice as likely to live in social housing as Indigenous households in non-remote areas—60% compared with 24%.



Note: See Box 7.1.1 for definitions of the tenure types shown.

Source: AIHW analysis of the 2014–15 National Aboriginal and Torres Strait Islander Social Survey (TableBuilder)

Figure 7.1.3: Housing tenure of Indigenous households, by remoteness area, 2014–15

Box 7.1.1: About the housing tenure data in this article

Tenure type describes whether a dwelling is owned, rented, or occupied under some other arrangement. For the analyses shown in this chapter, distinctions are made between:

- two types of home owners—people with and without a mortgage. The category 'owned with a mortgage' consists of participants in rent/buy and shared equity schemes and those living in a household in which payments were being made on mortgages or secured loans towards the purchase of the dwelling.
- two types of renters:
  - people renting from social housing providers
  - private/other renters (includes people renting from real estate agents, unrelated persons, relatives, owner–managers of caravan parks, employers and other landlords, and people for whom landlord type was not stated)
- households with some other tenure type (including dwellings being occupied under a life tenure scheme) and households for which information on tenure type was not stated.

Households occupying their dwelling 'rent free'—that is, where the household exchanges no money for lodging and is not an owner of the dwelling—are classified as renters.

Information about housing tenure can be presented about 'households' (see Glossary) or about 'people living in households'. This article presents information about households. Indigenous households are defined as households in which at least one resident (of any age) identified as being of Aboriginal and/or Torres Strait Islander origin.

Housing assistance

Housing assistance aims to relieve the pressures of housing costs, and provide safe and secure housing for many low-income households, particularly households that are disadvantaged or vulnerable (see also Chapter 6.1 'Social housing').

Due to the multiple disadvantages that many Indigenous Australians face in the housing market, they are a priority group for (or focus of) many housing assistance services. This section provides information on the programs that assist the largest number of Indigenous households, namely Commonwealth Rent Assistance (CRA) and social housing (see Box 7.1.2). Note that the data in this section are administrative by-product data, rather than survey data as in the previous section on 'Housing tenure'. Due to differences in the collections, the estimates of the number of households living in social housing differ between the two sources.

Assistance from CRA

CRA is a non-taxable income supplement payable to eligible people who rent in the private or community housing rental markets (see Box 7.1.2). Recipients of CRA are 'income units'—that is, a person or a group of persons within a household, whose command over income is shared (see Glossary).

Data on the recipients of CRA show that:

- as at 26 June 2016, 67,387 income units receiving CRA reported having an Indigenous member (this represents 5% of all CRA recipients of around 1.3 million income units)
- the proportion of Indigenous income units in total CRA income units has increased from 3.6% in 2009 to 5.0% in 2016
- over the period 2009 to 2014, the proportion of Indigenous income units in rental stress, even after receiving CRA, ranged within a narrow band of 29% to 31%; this proportion was slightly higher in 2015 and 2016 (both 33%) (AIHW analysis of AIHW 2014a; SCRGSP 2014, 2015, 2016b, 2017).

While CRA data relate to income units rather than to households, data from the ABS 2013–14 Survey of Income and Housing suggest that, in practice, the clear majority of income units are households. Specifically, data from that survey indicate that, among CRA recipients, there are about 9.3 households for every 10 income units (see the 'Methods and conventions' section of this report for supplementary technical information related to housing assistance data; S7.1.1). Using this information, it can be estimated that 62,900 Indigenous households were receiving CRA in June 2016—equating to one-quarter (25%) of all Indigenous households (see 'Methods and conventions'; S7.1.2). By comparison, an estimated 13% of other households (or about 1.2 million) were receiving CRA. Although an estimated 75% of Indigenous households do not receive CRA, some would receive other forms of housing assistance.

Box 7.1.2: Major housing assistance programs

Social housing: This is rental housing provided by not for-profit, non-government or government organisations to eligible households, with rents set below market rates (based on a percentage of a tenant's income).

There are four main social housing programs in Australia. Of these, two are 'mainstream' programs available to all Australians—public housing and community housing (see Chapter 6.1 'Social housing'). The other two are specifically aimed at Indigenous Australians—state owned and managed Indigenous housing, and Indigenous community housing. As well, from 2008–09, some remote dwellings in the Northern Territory were transferred from Indigenous community housing programs to public housing. These are referred to as 'NT remote public housing'.

Commonwealth Rent Assistance: This is a non-taxable income supplement funded by the Australian Government. It is payable to people who rent in the private housing market and receive an income support payment, or more than the base rate of Family Tax Benefit Part A, and who pay rent above a minimum threshold. CRA is paid at 75 cents for every dollar above a minimum rental threshold until a maximum rate is reached. The minimum threshold and maximum rates vary according to the composition of an income unit's household, including the number of children. CRA may also be payable to people living in mainstream community housing or Indigenous community housing and, in some jurisdictions, to people living in state owned and managed Indigenous housing.

Recipients of CRA are 'income units' not households (see Glossary). Indigenous income units are those in which at least one member has self-identified as being Indigenous.

Social housing assistance

As at 30 June 2016:

- 44,228 Indigenous households lived in social housing managed through either the public housing program, mainstream community housing program or state owned and managed Indigenous housing programs
- almost 18% of Indigenous households were living in social housing managed by one of these three programs, compared with 3.9% of other households
- of these three programs, public housing was the largest provider of social housing to Indigenous households, with 13% of Indigenous households living in this housing
- Indigenous households were 4 times as likely as other households to live in public housing (12% compared with 3.1%, respectively) and 3 times as likely to live in mainstream community housing (2.2% compared with 0.7%) (Table 7.1.1).

Table 7.1.1: Households living in social housing, by Indigenous status, 30 June 2016

	Indigenous households		Other households	
Type of social housing	**Number**	**Rate[a]**	**Number**	**Rate[a]**
Public housing	29,293	11.8	282,926	3.1
Mainstream community housing[b]	5,377	2.2	62,821	0.7
State owned and managed Indigenous housing	9,558	3.8	102	0.0
Total	**44,228**	**17.8**	**345,849**	**3.8**

(a) Per 100 households. See 'Methods and conventions'; S7.1.2 for information on the denominator used.

(b) Total household counts for Mainstream community housing data may not match other published totals due to gaps in detailed information about tenants. Queensland provided partial unit record tenant data for the first time in 2015–16 (unit record data was not available for 3,840 households). Unit record data are not provided for the Northern Territory.

Sources: AIHW analysis of ABS 2015b; AIHW 2017b; AIHW National Housing Assistance Data Repository.

In addition to the dwellings managed by these three social housing programs, Indigenous households also access social housing via the Indigenous community housing program and the Northern Territory remote public housing program. Together, these two programs managed 22,630 dwellings in 2015–16, however information about whether these dwellings are tenanted and the Indigenous status of tenants living in these dwellings is incomplete or not available. For more information on social housing, see Chapter 6.1 'Social housing'.

Housing quality

The 2014–15 NATSISS collected information on basic types of household facilities that are considered important for a healthy living environment, as well as whether the household dwelling had any major structural problems. These data show that in 2014–15:

- 29% of Indigenous Australians (28% of people aged 15 and over and 32% of people aged under 15) were living in a dwelling with major structural problems. Most commonly, these problems were major cracks in the walls or floors, followed by major plumbing problems
- 15% of Indigenous Australians (15% of people aged 15 and over and 14% of people aged under 15) were living in a household in which at least 1 basic facility considered important for a healthy living environment (namely, facilities for preparing food, for washing clothes, for washing people, or sewerage facilities) were not available or did not work
- nearly 1 in 5 (19%) Indigenous people were living in a house that did not meet an acceptable standard; that is, at least one basic household facility was unavailable or there were more than 2 major structural problems (Table 7.1.2).

Indigenous Australians in remote areas were more likely than Indigenous Australians in non-remote areas to be living in a dwelling with major structural problems (37% compared with 27%), that lacked basic household facilities (27% compared with 11%) and that did not meet acceptable standards (31% compared with 16%) (Table 7.1.2).

The proportion of Indigenous adults living in dwellings with major structural problems or in which 1 or more basic facilities were not available was similar in 2014–15 and 2008. Comparable data for non-Indigenous Australians are not available.

Table 7.1.2: Proportion of Indigenous Australians living in dwellings with structural problems or with household facilities that are not available or do not work, by remote and non-remote areas, 2014–15

	Non-remote	Remote	Australia
Major structural problems			
Number of types of structural problem			
1–2	*20.5	*27.7	22.0
3 or more	6.6	8.9	7.1
At least 1 major structural problem	**27.1*	**36.8*	*29.1*
Most common structural problems			
Major cracks in walls / floors	10.8	13.2	11.3
Major plumbing problems	*6.2	*12.1	7.4
Walls or windows that are not straight	*5.8	*10.7	6.9
Major electrical problems	*5.0	*9.9	6.1
Wood rot / termite damage	5.8	6.3	5.9
Household facilities			
Has household facilities that are not available or do not work[(a)]	*11.3	*26.7	14.5
Facilities that do not work			
Facilities for preparing food	*6.8	*18.3	9.1
Facilities for washing clothes or bedding	*5.7	*15.2	7.7
Facilities for washing people	2.1	5.1	2.8
Sewerage facilities	*2.2	*4.2	2.6
Overall housing standard[(b)]			
Not acceptable	*16.1	*31.1	19.3
Total[(c)]	**100.0**	**100.0**	**100.0**
***Total* (number)**	**542,800**	**143,800**	**686,900**

* Statistically significant difference between the proportions for remote and non-remote areas (p<0.05).

(a) Includes facilities such as cooking facilities, a fridge, toilet and bath or shower.

(b) A house was deemed to be of an acceptable standard where it had fewer than 3 structural problems and had working facilities for washing people, for washing clothes or bedding, for preparing food, and working sewerage facilities. A house was deemed to be not of an acceptable standard where any of the these facilities were unavailable or there were more than 2 structural problems.

(c) Total includes 'not stated' responses. Sum of components does not equal the total as households may have reported more than one type of structural problem or lack of access to more than one type of household facility.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (TableBuilder).

Overcrowding

In basic terms, overcrowding occurs when a dwelling is too small for the size and composition of the household living in it. Overcrowding can put stress on household infrastructure, such as food preparation areas, sewerage systems and laundry facilities. It can also adversely affect health, education and family relationships (AIHW 2014b; SCRGSP 2016a).

Various approaches are used to define and measure the extent of overcrowding. This chapter uses the definition currently used by the ABS, which is based on the Canadian National Occupancy Standard (CNOS) (see Glossary). Using this definition, a dwelling is overcrowded if it requires at least one additional bedroom to accommodate the people who usually live there, given their ages, sex, and relationships to each other.

Note that the concept of overcrowding is subjective; Indigenous people—indeed, any Australians—may be defined as living in overcrowded conditions based on a particular standard such as the CNOS, but may themselves not feel that their household is overcrowded (Keys Young 1998; Memmott et al. 2012).

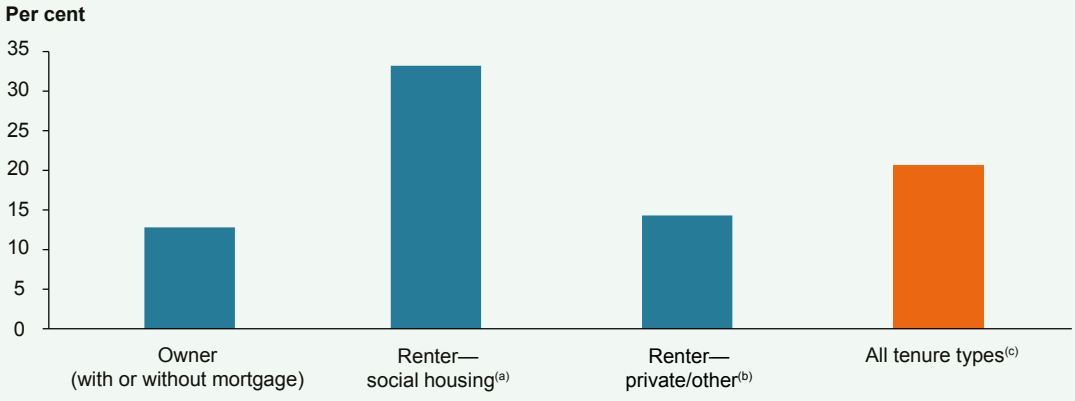
According to data from the 2014–15 NATSISS, 10% of Indigenous households were living in overcrowded dwellings (29,000 households). This was 3 times the rate of overcrowding among other households (3.0% in 2013–14, corresponding to about 258,300 households, based on the ABS Survey of Income and Housing) (ABS 2016).

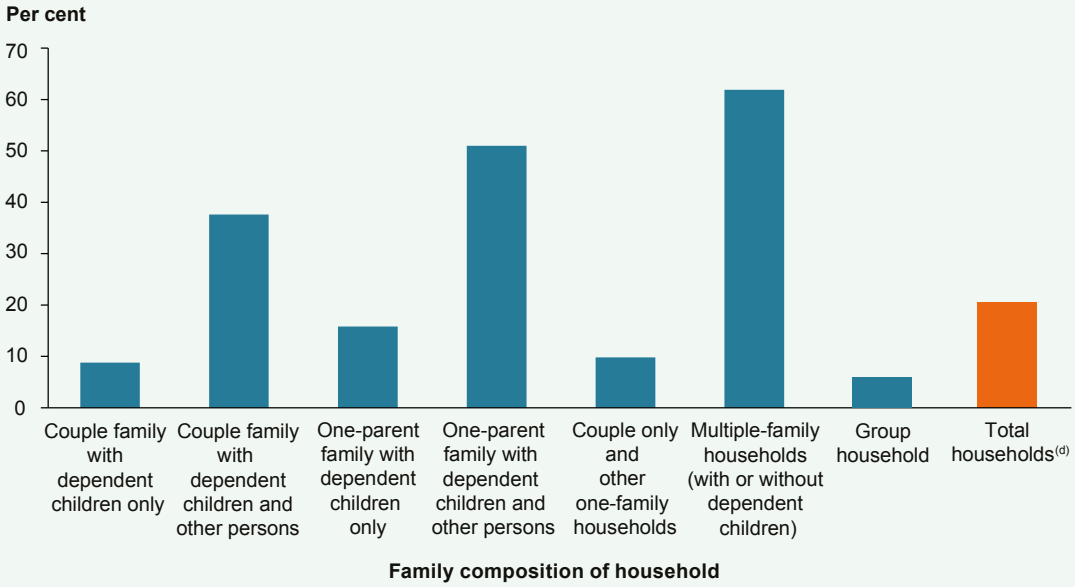
As well as information about Indigenous households, data are also available on the number of Indigenous people living in overcrowded dwellings. Those data show that, in 2014–15:

- 1 in 5 (21%, or 141,400 people) Indigenous Australians were living in overcrowded dwellings
- younger Indigenous Australians were more likely than Indigenous Australians in older age groups to live in overcrowded conditions—about one-quarter of people aged under 15 and aged 15–24 were living in overcrowded conditions (24% and 25%, respectively), compared with 17% of people aged 24–34, 35–44 and 45–54, and 10% of people aged 55 and over
- Indigenous Australians living in remote areas were more than twice as likely to be living in overcrowded conditions as Indigenous Australians in non-remote areas—41% compared with 15%
- across states and territories, the rate of overcrowding was highest in the Northern Territory, where just over half (53%) of Indigenous Australians were living in overcrowded conditions. The rate of overcrowding in the Northern Territory was about double that for the jurisdiction with the next highest rate—Western Australia (25%)
- within the Northern Territory, the rate of overcrowding was highest in *Very remote* areas, where two-thirds (67%) of Indigenous Australians were living in overcrowded conditions (compared with 36% in *Remote* areas, and 31% in non-remote areas)
- the rate of overcrowding varied according to housing tenure, with the highest rate among Indigenous Australians living in social housing (33%), and the lowest among Indigenous Australians living in a home owned outright or with a mortgage (13%)
- the rate of overcrowding also varied according to the family composition of the household (Figure 7.1.4).

Available data suggest a decline in overcrowding over time:

- NATSISS data indicate that the proportion of Indigenous people living in overcrowded conditions decreased from 27% in 2004–05 to 21% in 2014–15 (see Chapter 9.2 'Indicators of *Australia's welfare*'). (SCRGSP 2016a).
- Census data indicate that the proportion of Indigenous households that were living in overcrowded conditions fell from 16% in 2001 to 11% in 2016.





(a) Consists of households renting their dwelling (or occupying it rent free) from a state or territory housing authority, housing co-operative or church group, Indigenous Housing Organisation, community housing or Council.

(b) Consists of households renting their dwelling (or occupying it rent free) from real estate agents, unrelated persons, relatives, owner/managers of caravan parks, employers and other landlords, and those for whom landlord type was not known.

(c) Includes households with other tenure types and households for which tenure type was not stated.

(d) Includes lone-person households.

Source: AIHW analysis of 2014–15 NATSISS (TableBuilder).

Figure 7.1.4: Indigenous people living in overcrowded households, by tenure type, and by family composition of household, 2014–15

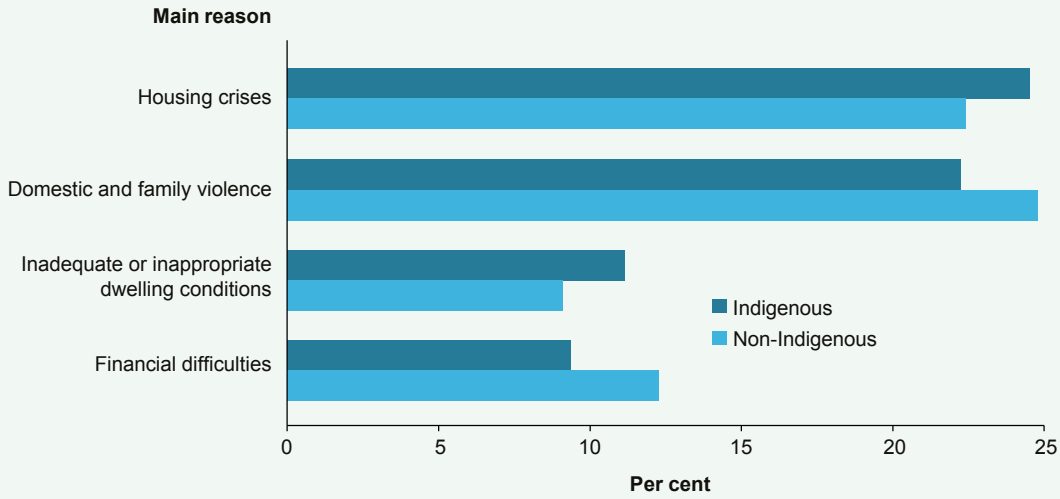
Homelessness

The 2014–15 NATSISS asked Indigenous Australians about experiences of homelessness. Note, however, that the NATSISS did not specifically ask about the experience of living in severely crowded dwellings (households that require 4 or more bedrooms according to the CNOS), which is considered homelessness under the ABS statistical definition (see Glossary). According to NATSISS data:

- 29% of Indigenous Australians aged 15 and over (an estimated 129,000 people) had been homeless at some time in their life. More than 1 in 4 (27%) of these people had been homeless in the previous 2 years. The results were similar for males and females (ABS 2016). By comparison, data from the 2014 GSS suggest that 13% of non-Indigenous Australians aged 15 and over had ever experienced homelessness.

Governments across Australia fund a range of services to support people who are homeless or at risk of becoming homeless. These specialist homelessness services (SHS) are delivered by non-government organisations. These include those that specialise in delivering services to specific groups (such as young people or people experiencing domestic and family violence), as well as those that provide more generic services to people facing housing crises.

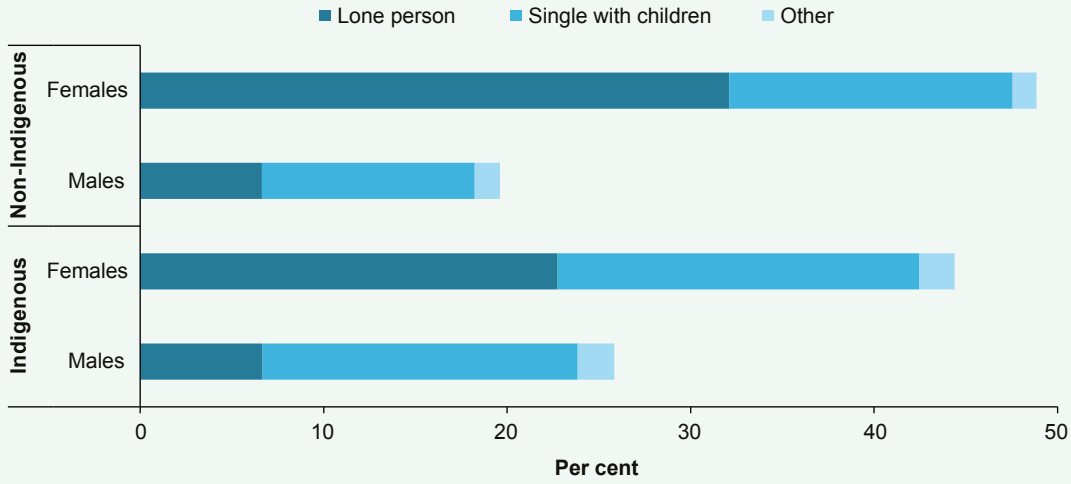
- In 2015–16, an estimated 61,700 Indigenous people accessed SHS.
- Indigenous people made up 24% of people accessing SHS in 2015–16. The rate of use of these services among Indigenous Australians was more than 9 times that for non-Indigenous Australians.
- A total of 61% of Indigenous SHS clients in 2015–16 were female, compared with 58% of non-Indigenous clients.
- Indigenous SHS clients tend to be younger than non-Indigenous clients; in 2015–16, more than half (54%) were aged under 25 compared with two-fifths (41%) of non-Indigenous clients.
- In 2015–16, more than 1 in 5 Indigenous SHS clients (22%) cited domestic and family violence as their main reason for seeking assistance, slightly less than the proportion among non-Indigenous clients (25%) (Figure 7.1.5).
- More than 1 in 3 (37%) Indigenous SHS clients in 2015–16 reported domestic and family violence as a reason for seeking assistance or were assessed by the SHS agency as having a need for domestic and family violence assistance, a similar proportion to that among non-Indigenous clients (37%). Lone females and single clients accompanied by children were more likely than other clients to require domestic and family violence assistance (Figure 7.1.6).
- The proportion of Indigenous clients ending an SHS support period in stable housing (either public or private) increased from 57% in 2012–13 to 64% in 2015–16 (AIHW 2017b).



Note: The four most common reasons given by Indigenous clients for seeking assistance are shown. These were also the four most common reasons for non-Indigenous clients, but in a different order.

Source: AIHW 2017b.

Figure 7.1.5: SHS clients, main reason for seeking assistance, by Indigenous status, 2015–16



Source: AIHW SHS Collection Data Cubes.

Figure 7.1.6: SHS clients citing domestic and family violence as a reason for seeking assistance or being assessed by the SHS agency as requiring such assistance, by Indigenous status, sex, and family type, 2015–16

What is missing from the picture?

Much of what we know about Indigenous Australians and the gap between Indigenous and non-Indigenous outcomes relies on statistics that are calculated using data from the Census, surveys and administrative data from service providers. These data collections rely on people identifying themselves and/or their family members as Indigenous, and this information being accurately recorded and supplied to relevant agencies. The AIHW and the ABS strive to collect and present accurate data, as well as to ensure that service providers are aware of the importance of collecting accurate Indigenous status information. However, they acknowledge that, for various reasons, not all Indigenous people are identified in the different data sets, which can lead to an under-count. For example, it is estimated that around two-thirds of Indigenous Australians have formally identified as such to Medicare either on enrolment or using the Voluntary Indigenous Identifier form. Under-identification of Indigenous people in key data collections makes it difficult to report accurately on the circumstances and experiences of Indigenous Australians, and to assess whether their needs are being met.

The Indigenous estimated resident population (ERP) is derived from the Census counts after adjusting for the under-count and for those records where Indigenous status is unknown. In 2011, the Indigenous under-count was estimated to be 17% (114,000 persons) and about 1 million Census records (4.9%) had an unknown Indigenous status (ABS 2012b). The 2011 Indigenous ERP was 669,881 people—an increase of 152,838 people, or 30% from the 2006 ERP. The increase was due to several factors, including natural population growth, improved Census estimates and changes in Indigenous identification.

Caution is needed when comparing data from two Censuses. For example, Census data show that, in 2006, 4.6% of Indigenous Australians needed help with daily activities due to a disability or health condition, compared with 5.7% in 2011. This could suggest that the proportion of Indigenous people who needed help has increased since 2006. However, the change could be due to more people with a disability being identified as Indigenous in 2011 or due to the population having aged since 2006. While it is likely that all scenarios have contributed, it is often difficult to separate these effects.

Complete information on the use of housing assistance among Indigenous Australians is not currently available. There is a lack of reliable information on the number of households living in social housing and also receiving CRA; hence, it is not possible to derive the number of Indigenous (or other) households receiving assistance from at least one major housing assistance program.

There is a high level of missing information about Indigenous status in some housing assistance data (for example, Indigenous status was missing for 25% of households in public housing in 2015). The coverage of some administrative data collections is also incomplete (for example, data on mainstream community housing in the Northern Territory are not available by Indigenous status).

Available information about the housing aspirations of Indigenous people is limited. Research suggests that most Indigenous Australians aspire to home ownership, with the main motivations being intergenerational asset building for future generations, and housing security (Memmott et al. 2009). Further information about the housing aspirations of Indigenous Australians would be useful in determining the appropriateness of current housing policies.

If successful programs are to be put in place to deal with the myriad of factors underlying and perpetuating Indigenous disadvantage, more information about the effectiveness of existing or newly implemented programs is needed. There has been relatively little robust evaluation of the performance and effectiveness of Indigenous programs and policies (Department of Finance and Deregulation 2009; Productivity Commission 2015). Rigorous evaluation of policies, programs and interventions can provide the evidence for 'what works' and ensure that future efforts are directed at strategies that produce positive outcomes for Indigenous Australians.

Where do I go for more information?

Data on issues covered in this Chapter are available from *The health and welfare of Aboriginal and Torres Strait Islander peoples: 2015*, and the *Aboriginal and Torres Strait Islander Health Performance Framework*.

The AIHW website includes further information on housing assistance programs. The reports *Housing circumstances of Indigenous households: tenure and overcrowding*, *Housing assistance for Indigenous Australians* and other recent publications are available for free download.

Information from the 2014–15 NATSISS is available from the ABS website.

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7.2 Factors affecting the social and emotional wellbeing of Indigenous Australians

Social and emotional wellbeing is strongly linked to the welfare of the individual and community. Stressful life events, recent or past trauma, and experiences of discrimination, bullying or harassment can adversely affect a person's social and emotional wellbeing and contribute to higher levels of psychological distress and poor mental health (Ferdinand et al. 2012; Kelaher et al. 2014; Net Industries 2017). These experiences may reduce people's willingness to contact services, negatively affecting their health and welfare outcomes (Kelaher et al. 2014).

Poor social and emotional wellbeing is also linked to employment: it can be a barrier to finding or keeping a job, stressful events at work can affect mental health, and the loss of a job or inability to find work can cause or increase psychological distress (Harnois & Gabriel 2000; Krueger et al. 2011; Olesen et al. 2013). Problems with finding or keeping employment have broader impacts on income, living conditions and opportunities for the affected individual as well as their family and community (Belle & Bullock 2010).

Social and emotional wellbeing for Aboriginal and Torres Strait Islander Australians is a broad construct that includes mental health as well as factors such as connection to country, culture, spirituality, ancestry, family and community (Gee et al. 2014). Factors linked to poor social and emotional wellbeing among Indigenous Australians include discrimination, grief, past and ongoing child removals and unresolved trauma, social exclusion, economic and social disadvantage, incarceration, experiences of violence, substance use and poor physical health (Zubrick et al. 2014).

Mental and substance use disorders are the largest contributor to the burden of disease in Indigenous people, accounting for 19% of the total burden in 2011 (AIHW 2016). Suicide and self-inflicted injuries accounted for a further 4.5% of the burden. Dealing with the causes of poor social and emotional wellbeing, self-harm and suicide are therefore critical to improving both the health and welfare of Indigenous Australians.

The effects of stressful events on wellbeing are influenced by differences in resilience—that is, how people cope with stress and the resources they have available to make adjustments (Net Industries 2017). These resources may be physical (for example, health status), personal (such as values, self-control, and religious beliefs) or social (such as networks and supports). Resilience is strongly related to an individual's environment, and the ability of their family, community and culture to provide these resources in culturally meaningful ways (First Nations Information Governance Centre 2014; Ungar 2008).

For Indigenous Australians, factors such as family and community connectedness, supportiveness, sharing and leadership have been found to be important in building resilience and strength, and in enhancing social and emotional wellbeing (McLennan 2015; Parker & Milroy 2014). This finding reinforces the importance of a well-functioning community as a key factor in improving the social and emotional wellbeing of Indigenous Australians. More information about community functioning is provided in Chapter 7.1 'Community factors and Indigenous wellbeing'.

This chapter looks at some of the key factors affecting and reflecting the social and emotional wellbeing of Indigenous Australians, including psychological distress and life stressors, experiences of discrimination, substance use, and self-harm and suicide.

Psychological distress and stressors

According to the Australian Bureau of Statistics (ABS) 2014–15 National Aboriginal and Torres Strait Islander Social Survey (NATSISS):

- more than two-thirds (68%) of Indigenous Australians aged 15 and over had experienced at least one personal stressor in the previous 12 months. The most commonly experienced stressors were the death of a family member or close friend (28%), not being able to get a job (19%), serious illness (12%) and work-related stressors (11%)
- more than one-quarter (28%) of Indigenous Australians aged 15 and over and almost one-third (32%) of Indigenous children aged 0–14 lived in a household where household members had run out of money for basic living expenses at least once in the previous 12 months
- one-third (33%) of Indigenous Australians aged 15 or over had experienced high or very high levels of psychological distress in the previous 4 weeks
- Indigenous adults were 2.6 times as likely as non-Indigenous adults to have high or very high levels of psychological distress (ABS 2016).

Experiences of discrimination

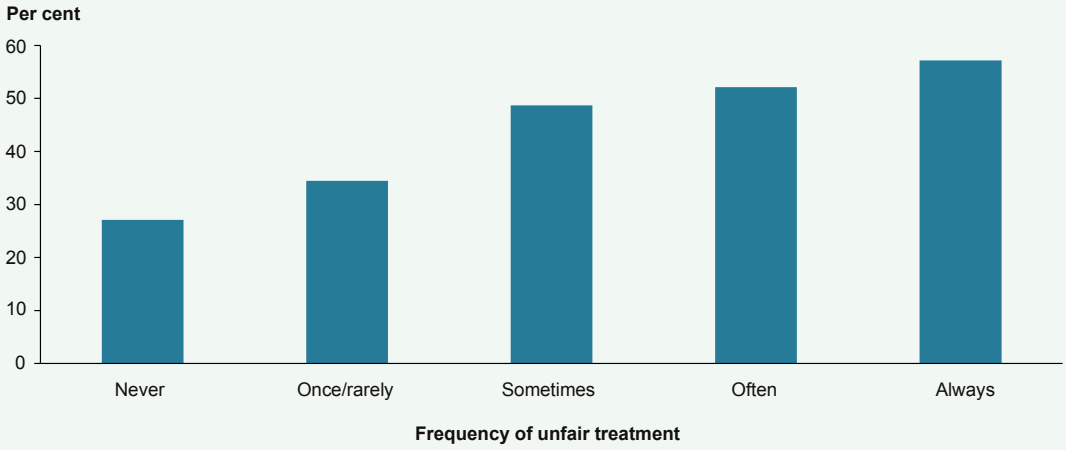
Racism and discrimination affect wellbeing in several ways, both directly and indirectly. They cause psychological distress and increase the risk of mental health issues, such as depression (Ferdinand et al. 2012; Priest et al. 2011). They are also associated with risky behaviours, such as substance use (Paradies 2008). Anticipation of being subject to racism may cause anxiety. Fear of discrimination may lead to avoidance of certain people, places or situations, which can have negative consequences—for example, not seeking health care when it is needed, poor school attendance, or social isolation. This avoidance can have profound effects on socioeconomic outcomes and health status.

A survey of Aboriginal people in Victoria found that the risk of high levels of psychological distress increased as the volume of racism experienced increased (Ferdinand et al. 2012). According to Reconciliation Australia, 46% of Indigenous respondents to its 2016 Reconciliation Barometer survey reported experiencing racial prejudice in the previous 6 months, compared with 18% of general community respondents (Reconciliation Australia 2017).

According to the 2014–15 NATSISS, of Indigenous Australians aged 15 and over:

- one-third (33%, or about 148,400 people) felt that they had been treated unfairly in the previous 12 months because they were Indigenous. The most commonly reported form of unfair treatment was hearing racial comments or jokes (23%), followed by being called names, teased or sworn at (14%), and not being trusted (9.3%)
- 4.8% (21,100 people) reported that discrimination had been a stressor in their lives in the previous 12 months
- 14% (62,300 people) had avoided situations in the previous 12 months due to past unfair treatment (ABS 2016).

Among Indigenous people aged 15 and over who felt they had been treated unfairly in the previous 12 months because they were Indigenous (148,400 people), 44% had high or very high levels of psychological distress. This was 1.6 times the rate of high/very high psychological distress among Indigenous people who had not been treated unfairly in the previous 12 months (27%). The proportion of Indigenous Australians with high or very high levels of psychological distress increased with the frequency of unfair treatment experienced in the previous 12 months—from 34% of people who felt unfairly treated once or rarely to 57% of people who always felt unfairly treated (Figure 7.2.1).



Source: AIHW analysis of 2014–15 NATSISS (TableBuilder).

Figure 7.2.1: Proportion of Indigenous Australians aged 15 and over with high or very high levels of psychological distress, by frequency of unfair treatment in the previous 12 months, 2014–15

Use of alcohol and other drugs

Alcohol and other drugs are the cause of, or contribute to, a wide range of social problems among Indigenous Australians. These include violence, social disorder, family breakdown, child neglect, loss of income or diversion of income to purchase alcohol and other substances, and high levels of imprisonment (Wilkes et al. 2014). See also Chapter 7.3 'Community safety among Indigenous Australians' for information on contact with the criminal justice system and experiences of violence among Indigenous Australians.

Alcohol

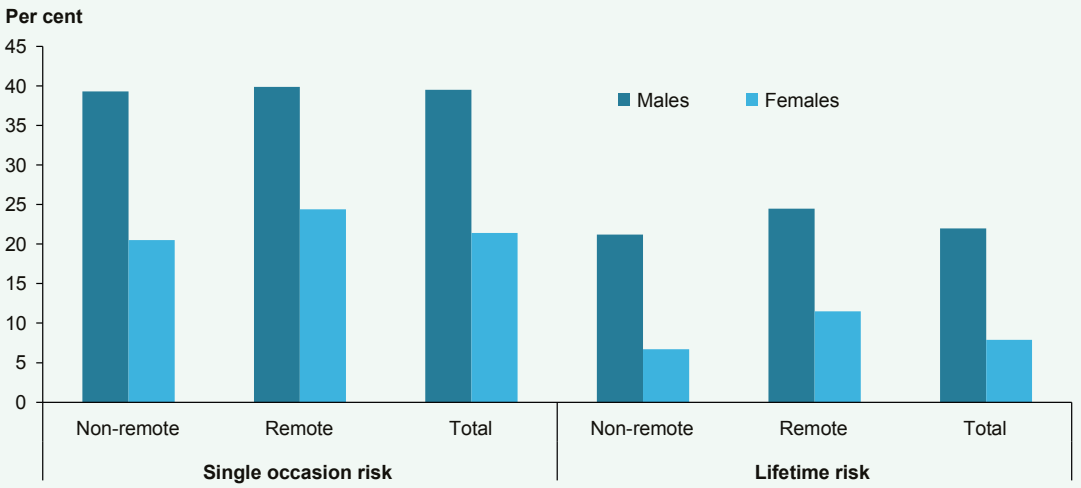
Most Australian adults drink alcohol, and do so at levels that cause few adverse effects. However, a substantial proportion of people drink at levels that increase the risk of alcohol-related harm to themselves and others. As well as the risks to an individual's physical health, harmful use of alcohol is associated with anti-social behaviour, violence, anxiety, depression, self-harm, road traffic accidents, and other unintentional injuries (NHMRC 2009).

According to the 2014–15 NATSISS, among Indigenous Australians aged 15 and over:

- 38% were abstainers (that is, they never consumed alcohol, or had consumed alcohol on 1 day or less in the previous 12 months)
- 15% drank at levels that exceeded the Australian guidelines for lifetime risk of long-term harm (more than 2 standard drinks per day, on average), a decrease from 19% in 2008
- 30% had consumed alcohol at a level that exceeded the Australian guidelines for single occasion risk of harm at least once (more than 4 standard drinks on a single occasion), a decrease from 38% in 2008
- drinking at risky levels was significantly more common among males than females (Figure 7.2.2).

Data from the 2011–12 Australian Health Survey and the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey show that, after adjusting for age:

- Indigenous Australians aged 15 and over were 1.2 times as likely as non-Indigenous Australians of this age to abstain from alcohol
- the proportions of Indigenous and non-Indigenous people aged 15 and over drinking at levels that put them at risk of lifetime harm were similar
- Indigenous Australians aged 15 and over were 1.1 times as likely as non-Indigenous Australians of this age to drink at levels putting them at risk of short-term harm (ABS 2013).



Source: AIHW analysis of ABS 2016.

Figure 7.2.2: Proportion of Indigenous Australians drinking at risky levels, by sex and remoteness area, 2014–15

Other drug use

According to the 2014–15 NATSISS, 30% of Indigenous Australians aged 15 and over had used other drugs (drugs other than alcohol and tobacco) in the previous 12 months, an increase from 22% in 2008. The most commonly used substance was marijuana (19%), followed by analgesics or sedatives used for non-medical purposes (13%). About 1 in 20 (4.8%) Indigenous Australians aged 15 and over had used amphetamines in the previous 12 months. Amphetamines can be used in several forms (for example, powder, tablet or ice); survey data for the total Australian population suggest that the preferred form is ice (or crystal methamphetamine), with half (50%) of recent amphetamine users aged 14 and over in 2013 reporting that they mainly use ice (AIHW 2014).

Data from the 2013 National Drug Strategy Household Survey suggest that Indigenous Australians are more likely than non-Indigenous Australians to report using substances, particularly marijuana and pharmaceuticals used for non-medical purposes (AIHW 2014).

Self-harm and suicide

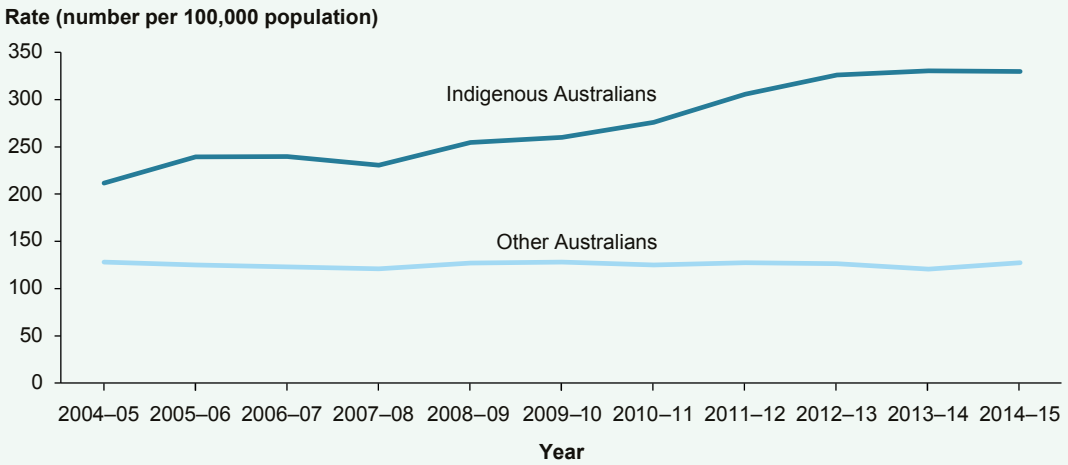
Suicide and self-harm cause great distress and grief in both Indigenous and non-Indigenous communities. Indigenous Australians experience higher rates of self-harm and death from suicide than non-Indigenous Australians. Underlying this is a complex set of factors, including the effects of past trauma; psychological distress; geographic and social isolation and marginalisation; socioeconomic disadvantage; substance abuse; and experiences of violence, abuse and neglect.

In 2014–15, there were more than 2,200 hospitalisations of Indigenous Australians for non-fatal self-harm (that is, a hospitalisation for self-inflicted injury where the patient was discharged alive)—an age-standardised rate of 315 per 100,000 population. This was 2.6 times the rate for non-Indigenous Australians.

- Among both Indigenous and non-Indigenous Australians, females were more likely than males to be hospitalised for non-fatal self-harm.
- The age-standardised rate of hospitalisations of Indigenous Australians for non-fatal self-harm increased by almost 60% between 2004–05 and 2014–15. By comparison, the rate for other Australians remained stable during this period (SCRGSP 2016) (Figure 7.2.3).

Between 2011 and 2015, there were 690 deaths due to suicide among Indigenous Australians in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined—an age-standardised rate of 23 per 100,000 population. This was 2.1 times the rate for non-Indigenous Australians in those jurisdictions.

- Among both Indigenous and non-Indigenous Australians, males were around 3 times as likely as females to die from suicide.
- The suicide death rate was greatest among Indigenous Australians aged 25–34, at 41 per 100,000 population (SCRGSP 2016).
- Between 2006 and 2015, the suicide death rate increased among both Indigenous (from 19 to 26 per 100,000 population) and non-Indigenous Australians (from 10 to 13 per 100,000 population) (Figure 7.2.4).

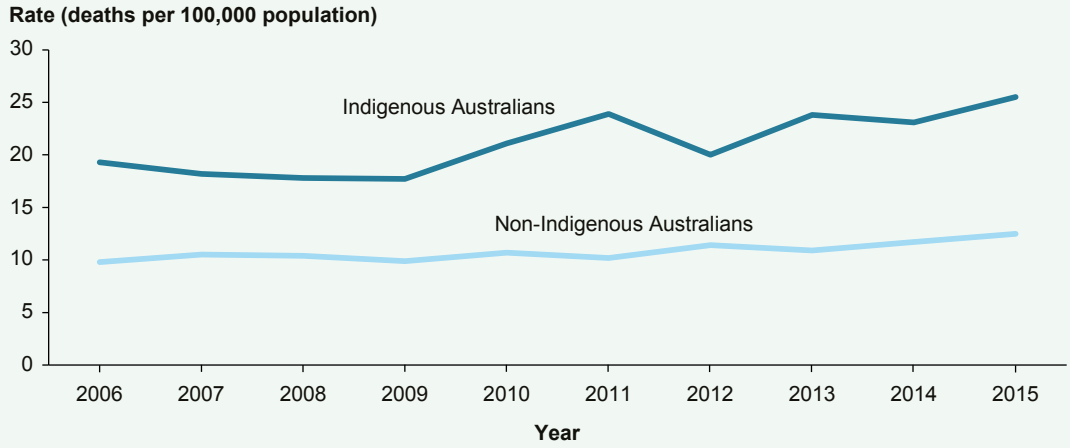


Notes

1. 'Non-fatal' refers to records where the patient was discharged alive. 'Intentional self-harm' refers to a principal diagnosis of injury and poisoning (ICD-10-AM codes S00–T98) and a first reported external cause reported for ICD-10AM codes X60–X84, based on the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification.
2. Rates have been directly age-standardised to the 2001 Australian standard population and are expressed per 100,000 population.

Source: SCRGSP 2016.

Figure 7.2.3: Rate of non-fatal hospitalisations for intentional self-harm, by Indigenous status, 2004–05 to 2014–15



Notes

1. Rates have been directly age-standardised to the 2001 Australian standard population and are expressed per 100,000 population.
2. Suicide includes ICD-10 codes X60–X84 and Y87.0. Causes of death data from 2006 onward are subject to a revisions process. The status of data in this figure is: 2006–2012 (final), 2013 (revised), 2014–2015 (preliminary).

Source: AIHW 2017.

Figure 7.2.4: Suicide rates, by Indigenous status, 2006 to 2015

Being part of a resilient, well-functioning community that includes strong family and community support networks, that minimises exposure to harm, and that provides opportunities for engagement can help to prevent suicide among Indigenous Australians (DoHA 2013). Access to culturally appropriate and coordinated support services, and the involvement of Elders in establishing suicide prevention activities at the community level, is also critical (Dudgeon et al. 2016). Research among First Nations people in Canada has also found that community empowerment, self-determination, and renewal and maintenance of culture protect against suicide (Chandler & Lalonde 2008).

If you or someone you know needs help:

Lifeline **13 11 14** beyondblue **1300 22 4636** Kids Helpline **1800 55 1800**

Where do I go for more information?

Relevant AIHW reports such as *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015* are available for free download from the AIHW website.

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) website contains a range of resources related to suicide prevention in Indigenous Australian communities.

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7.3 Community safety among Indigenous Australians

Many factors can influence community safety and wellbeing for Aboriginal and Torres Strait Islander people. Among the positive influences are being connected to country, land, family and spirit; having strong and positive social networks; and having strong leadership in both the family and the community (see Chapter 7.1 'Community factors and Indigenous wellbeing' for more information about these and other positive influences on community functioning).

This article focuses on contact with child protection services, contact with the criminal justice system, and community experiences of safety and violence. Indigenous Australians are over-represented in Australia's child protection, youth and adult justice systems. They also experience violence (particularly family and domestic violence) at rates well above those of non-Indigenous Australians. Factors contributing to this include past experience of violence and abuse (including in childhood), long-term social disadvantage, use of alcohol and drugs, and the ongoing impact of past dispossession and forced removal policies that have caused psychological trauma and contributed to the breakdown of traditional parenting, culture and kinship practices (SCRGSP 2016).

Contact with child protection services

The child protection system across Australia assists vulnerable children who have been, or are at risk of being, abused, neglected or otherwise harmed, or whose parents are unable to provide them with adequate care or protection. Children may receive a mix of child protection services. These include 'investigations', 'care and protection orders', and 'out-of-home care'. Investigations can lead to 'substantiations' if there is sufficient reason to believe that a child has been, or is at risk of being, abused, neglected or harmed. Definitions of key terms are available in the Glossary (see also Chapter 2.4 'Child protection' and Chapter 2.5 'A stable and secure home for children in out-of-home care').

Factors that may be associated with child abuse and neglect include poverty, substance abuse by parents, marginalisation, social isolation, parental exposure to violence and crime, low levels of parental educational achievement, and inadequate housing (AIHW 2014; Scott 2014). All these factors are more common among Indigenous Australians than non-Indigenous Australians. Protecting Indigenous children requires a multifaceted approach that takes account of these factors, and strengthens and empowers Indigenous families and communities (SNAICC 2015).

- In 2015–16, more than 46,600 Indigenous children aged 0–17 received child protection services and about 12,900 (43.6 per 1,000 population) were the subject of a child protection substantiation—a rate around 7 times that for non-Indigenous children (Figure 7.3.1).
- The most common reasons for substantiations for Indigenous children were emotional abuse and neglect (accounting for 39% and 36% of cases, respectively). By comparison, 47% of substantiations for non-Indigenous children were due to emotional abuse, and 20% due to neglect.
- More than one-third of children (35%) on care and protection orders as at 30 June 2016 were Indigenous despite making up only 5.5% of the Australian population aged 0–17.
- As at 30 June 2016, there were more than 16,800 Indigenous children in out-of-home care, a rate almost 10 times that for non-Indigenous children (Figure 7.3.1).

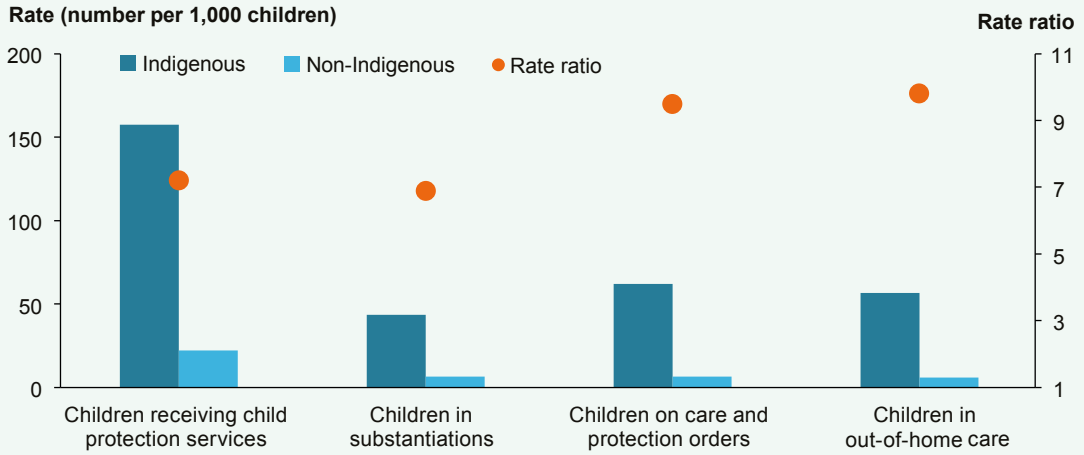


Figure 7.3.1: Children in the child protection system, by Indigenous status, 2015–16

Contact with police and the criminal justice system

In 2014–15, around 1 in 7 (15%) Indigenous people aged 15 and over reported that they had been arrested in the previous 5 years (20% of males and 9.2% of females) and over 1 in 3 (35%) had been formally charged by police at least once in their lifetime (48% of males and 23% of females) (ABS 2016a). Comparable data for the non-Indigenous population are not available.

Youth justice

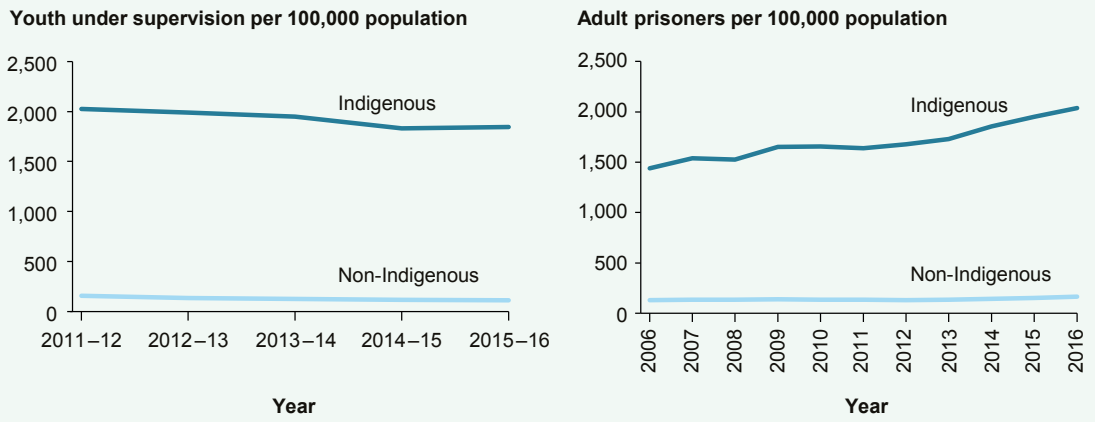
Supervision of young people on legal orders is a major aspect of Australia's youth justice system (see Chapter 2.6 'Youth justice supervision'). On an average day in 2015–16, the majority (84%) of young people under supervision were supervised in the community, with the remainder in secure detention facilities.

- Although only 5.5% of young Australians aged 10–17 are Indigenous, on an average day in 2015–16, nearly half (48%) of people of this age under supervision were Indigenous. Among people aged 10–17 supervised in detention, more than half (59%) were Indigenous.
- For both Indigenous and non-Indigenous Australians, about 4 in 5 people aged 10–17 under supervision on an average day in 2015–16 were male (80% for Indigenous, 83% for non-Indigenous). These proportions were higher among people in detention (89% for Indigenous, 91% for non-Indigenous).
- Between 2011–12 and 2015–16, the rate of Indigenous people aged 10–17 under supervision on an average day fell from 2,026 to 1,845 per 100,000 population (Figure 7.3.2).

Adult imprisonment

Indigenous Australians are greatly over-represented in adult prisons. They are generally younger than non-Indigenous prisoners and more likely to have been imprisoned before.

- As at 30 June 2016, around 10,600 prisoners identified as Indigenous. This accounted for more than one-quarter (27%) of the total Australian prison population. The Indigenous age-standardised imprisonment rate was 13 times that for non-Indigenous Australians (2,039, compared with 163 per 100,000 population) (ABS 2016b).
- Around 1 in 4 (24%) Indigenous prisoners were aged 24 or under, compared with 1 in 7 (14%) non-Indigenous prisoners.
- The majority of Indigenous and non-Indigenous prisoners were men (90% and 93%, respectively).
- Three-quarters (76%) of Indigenous prisoners had been imprisoned before, compared with half of non-Indigenous prisoners (49%).
- Between 30 June 2006 and 30 June 2016, the age-standardised Indigenous imprisonment rate increased by 42% compared with a 24% increase for non-Indigenous Australians (Figure 7.3.2).



Notes

1. Data for youth relate to young people aged 10–17 in detention or community supervision on an average day in the relevant year.
2. Data for adults are age-standardised rates for prisoners aged 18 and over (17 and over in Queensland) as at midnight on 30 June in the relevant year.

Sources: ABS 2016b; AIHW 2016.

Figure 7.3.2: Youth under supervision per 100,000 population, 2011–12 to 2015–16 and adult prisoners per 100,000 population, 2006 to 2016, by Indigenous status

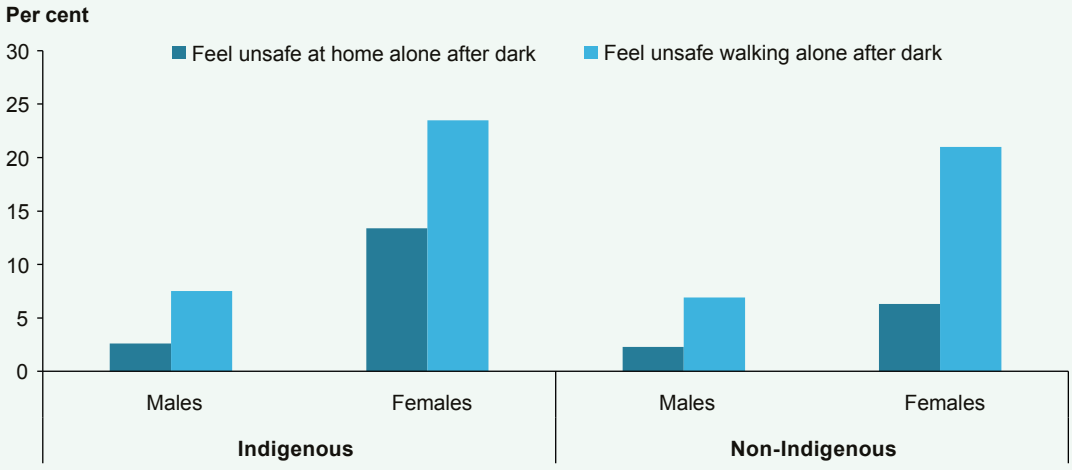
Community experiences of safety and violence

Family violence in Indigenous communities is both a cause and an effect of social disadvantage, intergenerational trauma, poor parenting and substance misuse (see also Chapter 7.2 'Factors affecting the social and emotional wellbeing of Indigenous Australians' for information on the use of alcohol and other drugs by Indigenous Australians). It is likely to be linked to the effects of colonisation and dispossession, and past policies of removal, disempowerment and assimilation (Memmott et al. 2001).

In 2014–15 among Indigenous Australians aged 15 and over:

- 16% felt unsafe walking alone in their local area after dark and 8.1% felt unsafe at home alone after dark. Among both Indigenous and non-Indigenous Australians, females were more likely than males to feel unsafe when alone after dark (Figure 7.3.3)
- in the previous 12 months, 13% had experienced physical violence and 16% had been threatened with physical violence (ABS 2016a)
- more than two-thirds (68%) of people who had experienced physical violence reported that alcohol or other substances contributed to the most recent incident
- almost two-thirds (63%) of women and more than one-third (35%) of men who had experienced physical violence reported that the perpetrator of the most recent incident was a family member (AIHW analysis of ABS 2014–15 National Aboriginal and Torres Strait Islander Social Survey)

- the majority (69%) were aware of there being problems in their neighbourhood or community. The most commonly reported problems were theft (44%), dangerous or noisy driving (41%), alcohol (38%) and illegal drugs (37%) (ABS 2016a)
  - by comparison, 67% of non-Indigenous people aged 15 and over were aware of there being problems in their local area. The problems they most commonly reported were noisy driving (38%), dangerous driving (36%), offensive language/behaviour, rowdy behaviour and noisy neighbours (all 17%) (AIHW analysis of ABS 2014 General Social Survey)
- Indigenous Australians in remote areas were more likely to report neighbourhood or community problems than Indigenous Australians in non-remote areas (82% compared with 65%), and were more than twice as likely to report problems with alcohol, family violence, assault, rape, neighbourhood conflict and gambling (ABS 2016a).



Source: AIHW analysis of 2014 General Social Survey (TableBuilder) and AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (TableBuilder).

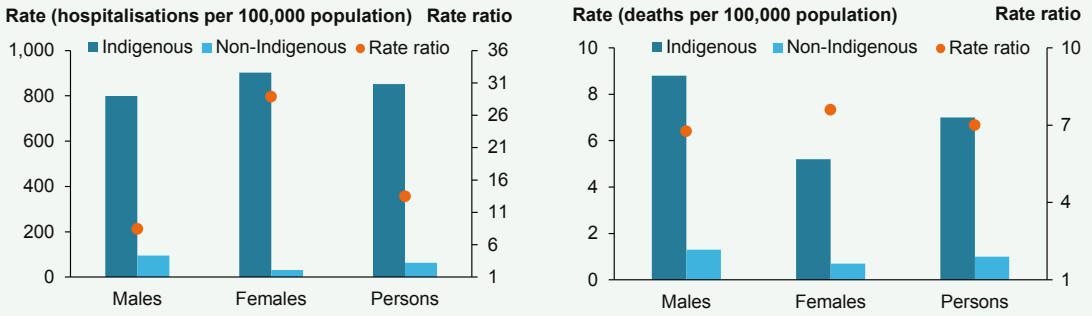
Figure 7.3.3: Feelings of safety when alone after dark, people aged 15 and over, by sex and Indigenous status, 2014–15

Hospitalisations and deaths due to assault

In 2014–15, the Indigenous age-standardised hospitalisation rate for non-fatal assault (that is, hospitalisations for injuries inflicted by another person where the patient was discharged alive) was more than 13 times the rate for non-Indigenous Australians (852 compared with 63 per 100,000 population) (Figure 7.3.4). The ratio was even higher for females (29 times as high) and for people living in *Remote* and *Very remote* areas (19 times as high).

Indigenous Australians are also more likely than non-Indigenous Australians to die from assault. Over the 5-year period 2010–2014 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined:

- there were 192 deaths due to assault among Indigenous Australians. The Indigenous age-standardised rate of deaths from assault was 7 times as high as the rate for non-Indigenous Australians (7.0 compared with 1.0 per 100,000 population) (Figure 7.3.4)
- Indigenous and non-Indigenous males were around twice as likely as their female counterparts to die from assault (age-standardised rate ratios of 1.7 for Indigenous and 1.9 for non-Indigenous) (SCRGSP 2016).



Note: Hospitalisation rates are for Australia. Death rates are for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined.

Figure 7.3.4: Age-standardised hospitalisation (2014–15) and death (2010–2014 pooled) rates for assault, by Indigenous status and sex

What is missing from the picture?

The prevalence of violence in Australia is difficult to determine as not all incidents are reported to police or other authorities. Incomplete identification of Indigenous Australians in relevant data collections also reduces the accuracy of estimates of violence among Indigenous Australians. Determining the prevalence of domestic or family violence is further complicated by the fact that even when incidents are reported, the victim may not disclose that the incident was perpetrated by a family member (ABS 2013). For the hospital separations data on non-fatal assault cited in this article, the relationship of the perpetrator to the victim was recorded in only 51% of cases.

The AIHW is developing reporting capability in the form of a national Family, Domestic and Sexual Violence data clearinghouse. The clearinghouse will coordinate national reporting, and provide a platform for improving data quality and for identifying data gaps and priority data developments. The AIHW may also conduct data linkage and facilitate the access of researchers to data. More information is provided in Chapter 2.7 'Family, domestic and sexual violence'. The collection of more detailed data regarding experiences of violence among Indigenous Australians would provide valuable information to support policy and service responses to this issue.

Where do I go for more information?

More information about community safety for Indigenous Australians is available from the reports *The health and welfare of Aboriginal and Torres Strait Islander peoples* and the *Aboriginal and Torres Strait Islander Health Performance Framework*.

More data on child protection and youth justice can be found on the AIHW website.

Detailed information on prisoners, offenders and victims of reported crime are available from ABS Crime and Justice statistics.

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7.4 Closing the gap in education

Good health and wellbeing throughout life depend to a considerable extent on sound education. For Aboriginal and Torres Strait Islander Australians, in particular, education can provide opportunities to avoid the several disadvantages they face (ABS 2011; Biddle 2006; Biddle & Cameron 2012).

The Council of Australian Governments (COAG) is committed to a number of Closing the Gap targets for education (Box 7.4.1); this article reviews the progress made against these. It also analyses, for Indigenous people, several other aspects of school and tertiary educational attainment and transitions from school to work, as well as education related employment outcomes. In addition, it assesses the patterns of early childhood development and school readiness for Indigenous (and non-Indigenous) children from the most recent 2015 Australian Early Development Census (AEDC).

Box 7.4.1: COAG Closing the Gap targets related to education

- Ensure that 95% of all Indigenous 4-year-olds are enrolled in early childhood education by 2025.
- Close the gap between Indigenous and non-Indigenous school attendance within five years (by 2018).
- Halve the gap for Indigenous children in reading, writing and numeracy achievements within a decade (by 2018).
- Halve the gap for Indigenous Australians aged 20–24 in Year 12 (or equivalent) attainment rates (by 2020).

Source: PM&C 2017.

Of the education related targets, the 2020 target on Year 12 attainment is on track to be met, but not the 2018 target on reading and numeracy; and progress will need to accelerate for the 2018 school attendance target to be met (PM&C 2017). It is too early to properly assess progress on the new 2025 target on early childhood education. The previous 2013 early childhood education target expired unmet (PM&C 2017).

Early childhood development (school readiness)

Indigenous disadvantage has an early onset. Many Indigenous children fall behind, even on the earliest measures of childhood development. This is usually related to Indigenous households generally being in lower socioeconomic areas, with children inheriting the disadvantage of the families into which they are born (Daly and Smith 2005; Guthridge et al. 2016). Indigenous children also face several other unique developmental constraints not generally shared by the wider population. Common among these are multiple early life stressors—from deaths and adult imprisonment occurring more often in their families, from having severe illnesses and accidents, from experiencing discrimination (Shepherd and Zubrick 2012) and from the intergenerational effects of forced separation (Silburn et al. 2006).

A key marker of early childhood development in Australia is available through the AEDC assessments (Box 7.4.2). The AEDC assessments have been validated as a valuable measure of school readiness and have strong potential to predict later-stage school learning outcomes for the individual child (Brinkman et al. 2013).

Box 7.4.2: Australian Early Development Census

- The AEDC is a census type data collection. It has been conducted every 3 years since 2009 for all children in their first year of full-time schooling, usually when aged 5.
- School teachers assess these children on five domains of early childhood development:
  - physical health and wellbeing
  - social competence
  - emotional maturity
  - language and cognitive skills
  - communication skills and general knowledge.
- The assessments are based on teacher observations; the children do not participate in tests.
- For each of the five AEDC domains, children are given a score between 0 and 10. The distribution of scores achieved is quite skewed, with most children receiving high domain scores (towards 10). Such a distribution, with greater sensitivity at the lower end of the scale, is reasonable for a measure focused on levels of vulnerability in child development.
- The numerical scores of the AEDC assessments are used to classify all assessed children into three categories: 'developmentally vulnerable', 'developmentally at risk' and 'developmentally on track'.
- In the first data collection (2009), a series of cut-off scores were set for each of the five domains to convert numerical scores into these three categories. Children falling below the 10th percentile were categorised as 'developmentally vulnerable'. Children ranked between the 10th and 25th percentile were categorised as 'developmentally at risk', and all other children were categorised as 'developmentally on track'.
- The cut-off scores set in 2009 for these classifications remain the same across the three collection cycles.
- Two additional summary assessments of vulnerability are made of whether a child is assessed as developmentally vulnerable on any one or more of the five domain(s), and on two or more domains.
- The AEDC recently introduced a new measure of early childhood development, the Multiple Strength Indicator, that focuses on the more advanced skills and competencies of the assessed children (Gregory and Brinkman 2016a). Results on this Indicator are not presented in this chapter.
- The AEDC data collection instrument has been validated to measure developmental vulnerability for Indigenous children in the Australian context (Silburn et al. 2009).

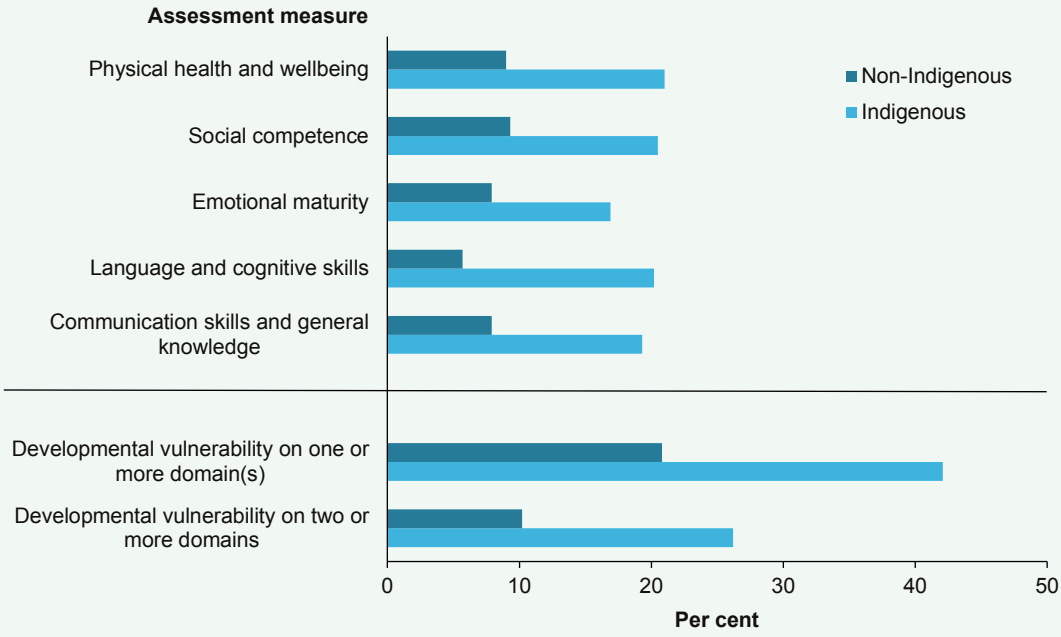
Source: DET 2016b.

The three collections of the AEDC (2009, 2012 and 2015) show that gaps in child development between Indigenous and non-Indigenous children have, on average, formed even at this early age. In all three collections, Indigenous children were more than twice as likely as non-Indigenous children to be assessed as developmentally vulnerable. This was the case for the result on each of the five specific test domains and for both the vulnerability summary indicators used in AEDC data reporting (vulnerable on one or more of the five domain(s), and vulnerable on two or more of the five domains).

2015 AEDC results

The latest AEDC collection (2015) assessed around 302,000 children (of whom about 17,300, or 5.7%, were Indigenous). The results showed that, nationally, around 42% of all Indigenous children were categorised as developmentally vulnerable on one or more of the five AEDC domain(s), compared with 21% of all non-Indigenous children (Figure 7.4.1). As well, 26% of Indigenous children were assessed as vulnerable on two or more of the five domains, compared with the non-Indigenous rate of 10% (DET 2016b).

Figure 7.4.1 also shows the proportion of children assessed as vulnerable on each of the five AEDC domains. The Indigenous rates were at least 2 times higher than the non-Indigenous rates for all domains, with the smallest gap (still 2.1 times as vulnerable) in the emotional maturity domain. The largest gap (3.5 times as vulnerable) was in the language and cognitive skills domain.

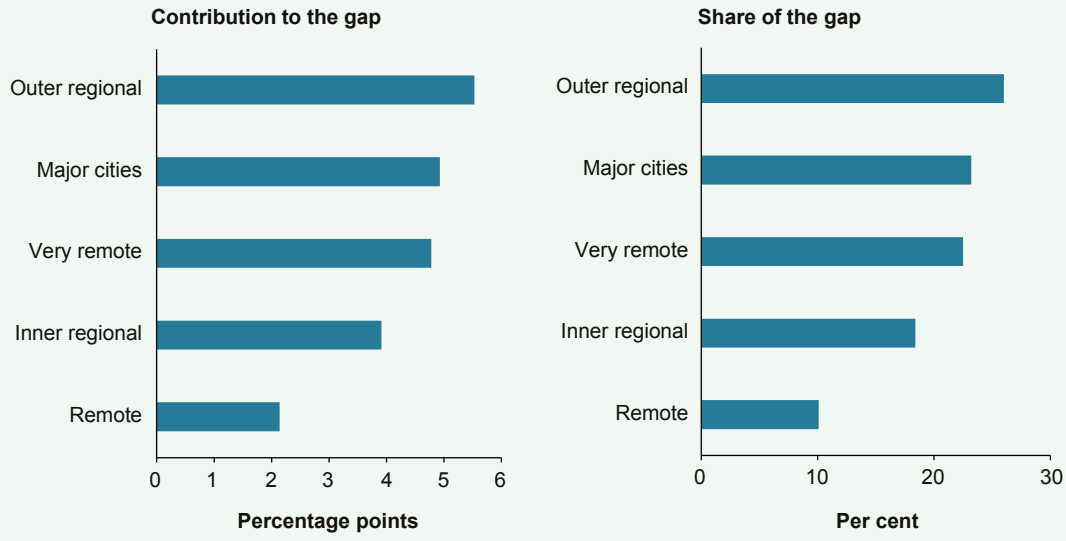


Source: DET 2016b.

Figure 7.4.1: Proportion of developmentally vulnerable children in each of the five domains and on vulnerability summary measures, by Indigenous status, 2015

A contributing factor to the higher vulnerability rate of Indigenous children at the national level is that Indigenous children who live in *Remote* and *Very remote* areas have much higher levels of vulnerability, and more Indigenous children live in these areas, as a share of all Indigenous children, than is the case for non-Indigenous children. In 2015, about two-thirds (66%) of Indigenous children living in *Very remote* areas were assessed as vulnerable on one or more domain(s), as were 52% of Indigenous children in *Remote* areas (AIHW analysis of 2015 AEDC data, unpublished).

The *Very remote* and *Remote* areas jointly contribute to around one-third of the national gap between Indigenous and non-Indigenous children in the proportion vulnerable on one or more domain(s); the *Very remote* areas alone contribute to 22% of the national gap (Figure 7.4.2). The majority of Indigenous children, however, live in *Major cities* and *Inner* and *Outer regional* areas, so these regions contribute to the major share (two-thirds) of the national gap. The highest single-region contribution to the national gap is *Outer regional* areas (26%), followed by *Major cities* (23%) and *Inner regional* areas (18%) (AIHW analysis of 2015 AEDC data, unpublished).



Note: The national gap on this measure is 21.3 percentage points (and the sum of the left horizontal bars equals 21.3).

Source: AIHW analysis of AEDC data, unpublished.

Figure 7.4.2: Contribution to the national gap in vulnerability on one or more domain(s) between Indigenous and non-Indigenous children, by remoteness area, 2015

At the national level, encouraging progress has been made to reduce the gap in early childhood development outcomes between Indigenous and non-Indigenous children. The proportion of Indigenous children assessed as vulnerable on one or more domain(s) decreased from 47% in 2009 to 43% in 2012, and to 42% in 2015. This was a larger decrease than for non-Indigenous children over this period for whom this proportion decreased from 22% in 2009 to 21% in 2015 (DET 2016a).

The AEDC results for Indigenous children also vary by sex. A consistently lower proportion of Indigenous girls were assessed as vulnerable on each of the five domains, and on the two vulnerability summary measures. This pattern was also seen for non-Indigenous children. For instance, in the 2015 AEDC assessments, 34% of Indigenous girls were assessed as vulnerable on one or more of the five domain(s), compared with 50% of Indigenous boys. The biggest relative difference by sex was on the emotional maturity domain: only 10% of Indigenous girls were assessed as vulnerable compared with 24% for Indigenous boys, making boys almost 2.5 times more likely to be assessed as vulnerable on this domain (AIHW analysis of 2015 AEDC data, unpublished).

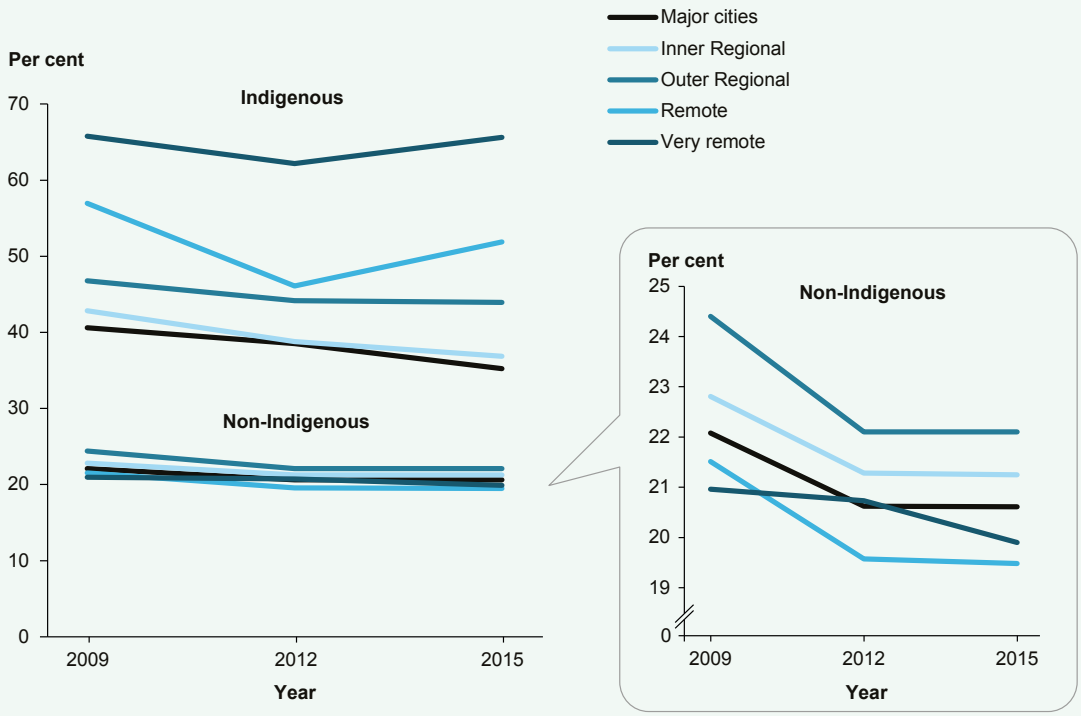
Trends in AEDC results by remoteness areas

The results presented in this sub-section are based on unpublished AIHW analyses of the unit record AEDC data. Over time, changes have been uneven across remoteness areas in the proportion of Indigenous children assessed as vulnerable on one or more domain(s) (Figure 7.4.3). Between 2009 and 2015, this vulnerability rate decreased most in *Inner regional* areas (from 43% to 37%) and in *Major cities* (from 41% to 35%); both changes were significant, based on the critical difference method recommended in Gregory and Brinkman (2016b). However, when comparing changes between the two most recent AEDC collections (2012 and 2015), the vulnerability rate for Indigenous children increased significantly in *Remote* and *Very remote* areas and decreased significantly in *Major cities* and *Inner regional* areas. There was no change for Indigenous children living in *Outer regional* areas.

In *Very remote* areas, the proportion of Indigenous children assessed as vulnerable on one or more domain(s) increased by 3.5 percentage points (from 62% in 2012 to 66% in 2015); the 2015 vulnerability rate was almost the same as in the first collection of 2009, offsetting almost all the decrease observed between 2009 and 2012 (Figure 7.4.3).

Around 18% of all Indigenous children in the 2015 AEDC collection lived in *Remote* or *Very remote* areas (DET 2016b). The uneven pattern in developmental vulnerability across remoteness areas over time means that Indigenous children in *Remote* and *Very remote* areas are falling further behind (increasing gaps) in their early development. This comparison applies not just with non-Indigenous children in these areas, but also with Indigenous children living in *Major cities* and *Inner and Outer* regional areas.

The high rate of developmental vulnerability of Indigenous children in *Remote* and *Very remote* areas is not due mainly to the effect of geographical location. A similar pattern is not observed for non-Indigenous children. A smaller population of non-Indigenous children live in these areas, but their development vulnerability is not higher than in other areas. Indeed, in the 2015 AEDC collection, non-Indigenous children living in *Remote* and *Very remote* areas had the lowest and second lowest rate of vulnerability on one or more domain(s) among all non-Indigenous children (Figure 7.4.3 inset).



Source: AIHW analysis of AEDC data, unpublished.

Figure 7.4.3: Proportion of children vulnerable on one or more domain(s), by Indigenous status and remoteness area, 2009, 2012 and 2015

Progress in the Closing the Gap targets in education (and student achievements in PISA)

Early childhood education

In December 2015, the COAG agreed to a new target on access to quality early childhood education for 4-year-old Indigenous children. The previous target expired unmet in 2013. The new target is to ensure that 95% of all Indigenous 4-year-olds are enrolled in early childhood education by 2025. The new target extends beyond the original focus on Indigenous children living in remote communities; it aims to increase the participation of all Indigenous children in high-quality early childhood programs nationally (PM&C 2017).

This target has two measures of progress:

(a) the proportion of children enrolled in a preschool program in the year before full-time schooling

(b) the proportion of children attending a preschool program in the year before full-time schooling.

Baseline data for this target for 2015 have been recently released, using a revised method to calculate the numerators and the denominators of both measures (SCRGSP 2016a). The revised baseline data are derived from the National Early Childhood Education and Care Collection, which is managed by the Australian Bureau of Statistics. The revised method used in the new baseline takes account of the variation in school starting ages by jurisdiction, and how this interacts with population estimates. Also, the attendance rates reported for measure (b) are calculated as a percentage among children enrolled in a preschool program, rather than as a percentage of the relevant population of children, as was reported previously (SCRGSP 2016a).

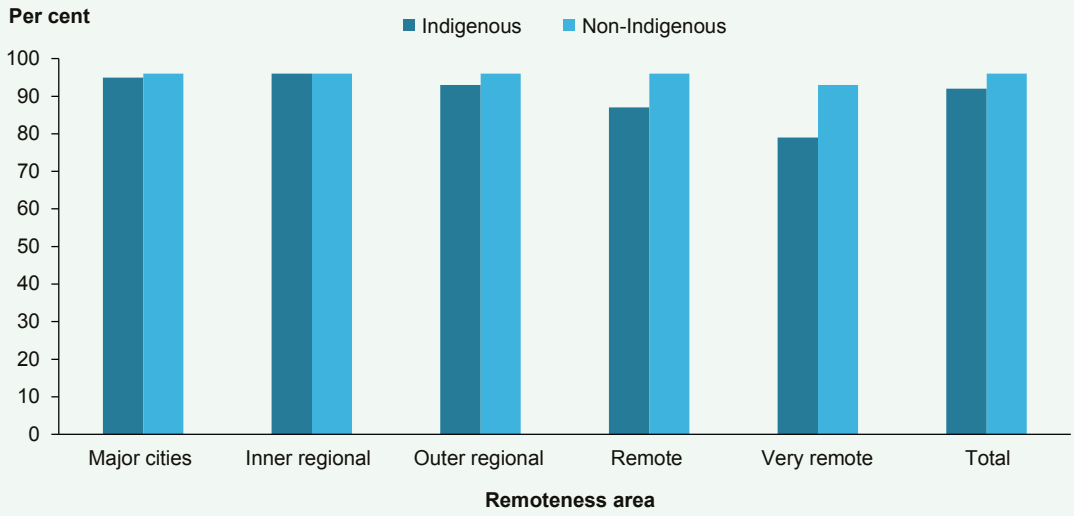
The new baseline data for 2015 are therefore not comparable with previously reported data. Progress against this target should be assessed only in relation to the revised 2015 baseline and using future data releases consistent with the new methodology.

The revised baseline data for 2015 show a total of 14,200 Indigenous children enrolled in a preschool program in the year before full-time schooling. Expressed as a ratio of the potential population of children (taking account of the different rules on school starting ages in each state and territory), this represents a rate of 87% of all Indigenous children enrolled in a preschool program in the year before full-time schooling. The comparable non-Indigenous rate was 98% (SCRGSP 2016a).

The 2015 preschool enrolment rate for Indigenous children in the year before full-time schooling varied considerably across jurisdictions. To highlight some continuing misalignment of the numerator and denominator counts—even within the revised baseline methodology—the enrolment rate for Indigenous children exceeds 100%, as presently computed, in three jurisdictions (Western Australia, South Australian and the Australian Capital Territory). The lowest rate was 77% in New South Wales, followed by 84% in the Northern Territory, 85% in Queensland and 94% in Victoria (SCRGSP 2016a).

For preschool attendance, the revised 2015 baseline data show a total of 12,900 Indigenous children attending at least 1 hour of preschool (in the reference week of the National Early Childhood Education and Care Collection). As a proportion of Indigenous children enrolled in preschool, the national Indigenous preschool attendance rate in 2015 was 92%. The equivalent attendance rate for non-Indigenous children was 96%. There is significant variation across jurisdictions in the estimated preschool attendance rates for Indigenous children (expressed as a proportion of children enrolled) in the year before full-time schooling. Five jurisdictions recorded rates of 95% or higher (New South Wales, Queensland, South Australian, Tasmania and the Australian Capital Territory), with a low of 73% in the Northern Territory, followed by 88% in Western Australia and 92% in Victoria (SCRGSP 2016a).

There was also significant variation across remoteness areas in preschool attendance rates in the year before full-time schooling for Indigenous children (Figure 7.4.4). In 2015, *Major cities* and *Inner regional* areas recorded attendance rates of 95% or higher, and *Very remote* areas had the lowest rate, of 79%. For comparison, preschool attendance rates for non-Indigenous children varied little by remoteness areas, ranging from 93% attendance in *Very remote* areas to 96% attendance in all other areas.



Source: SCRGSP 2016a.

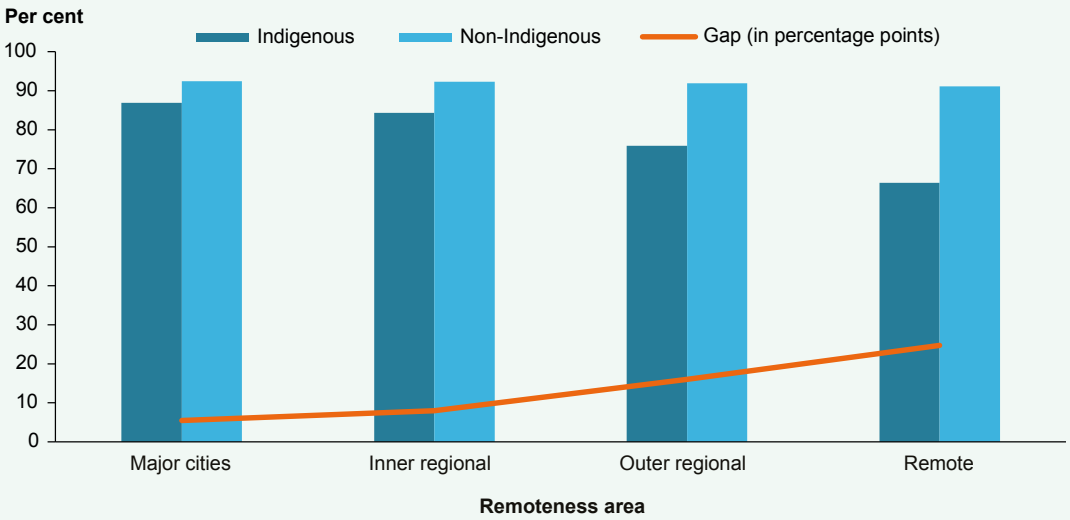
Figure 7.4.4: Proportion of enrolled children attending a preschool program in the year before full-time schooling, by Indigenous status and remoteness area, 2015

School attendance (Year 1 to Year 10)

In May 2014, COAG agreed to a new target to close the gap in school attendance rates between Indigenous and non-Indigenous students by the end of 2018. The baseline data for this new target were developed for 2014. The baseline and progress measures for this target calculate the school attendance rate for Indigenous and non-Indigenous students in each grade from Year 1 to Year 10 (using Semester 1 data), as well as a combined attendance rate for Year 1 to Year 10.

In 2016, the attendance rate for Indigenous students was 83% (about the same rate as in 2014), and for non-Indigenous students, 93%. The gap in attendance rates of 10 percentage points in 2016 was the same as in 2014. Progress will need to accelerate for this target to be met (PM&C 2017).

The overall school attendance rate in 2016 for Indigenous students was highest in *Inner regional* areas (87%) and *Major cities* (86%), declining steadily with increasing remoteness (to 66% in *Very remote* areas) (Figure 7.4.5). Attendance rates for non-Indigenous students varied little across remoteness areas (ranging from 93% in *Major cities* to 91% in *Very remote* areas). The largest gap in attendance rates between non-Indigenous and Indigenous students was in *Very remote* areas (25 percentage points), and the smallest gap was in *Inner regional* areas (5.5 percentage points).



Note: The gap denotes the difference between the non-Indigenous and Indigenous rates, as represented by the heights of the corresponding columns in the figure.

Source: SCRGSP 2016a.

Figure 7.4.5: Student attendance rate in Years 1–10 (combined), by Indigenous status and remoteness area, 2016

The attendance rate for Indigenous students also varies greatly between primary and secondary schools. For instance, in 2016, the average attendance rate for Indigenous students in primary school (Years 1–6) was 86%, and 79% in secondary school (Years 7–10). The lowest attendance rate among all Indigenous students in Years 1–10 was 75%, in Year 10 (SCRGSP 2016a).

The school attendance target has two supplementary measures associated with it:

- proportion of students who attend school 90% or more of the time, by Indigenous status
- number and proportion of schools achieving 90% or more average school attendance, by Indigenous status.

Table 7.4.1 shows data for these additional measures.

Table 7.4.1: Students attending school 90% or more of the time and schools achieving 90% or greater average attendance, by Indigenous status, 2016

	Proportion of students attending school 90% or more of the time (%)	Proportion of schools achieving 90% or greater average attendance (%)
Indigenous students	49	48
Non-Indigenous students	79	86

Note: Government schools in New South Wales are excluded from the additional measure for proportion of students attending school 90% or more of the time due to lack of data.

Sources: PM&C 2017; SCRGSP 2016a.

Literacy and numeracy

The COAG target is to halve the gap in school achievements in reading, writing and numeracy between Indigenous and non-Indigenous students by 2018. The gap is assessed by measuring the difference between the proportion of Indigenous and non-Indigenous students who are at or above the National Minimum Standard (NMS) in the National Assessment Program—Literacy and Numeracy (NAPLAN) test results (see Box 7.4.3 and Box 7.4.4 for further details).

Progress on this measure since the 2008 baseline year has been mixed. Consistent trends are not usually found, due to the variability in the NAPLAN results from year to year for Indigenous students.

Box 7.4.3: About National Assessment Program—Literacy and Numeracy

- The NAPLAN tests are conducted every year for all students across Australia in Years 3, 5, 7 and 9. Each year, over 1 million students nationally sit the NAPLAN tests.
- Assessments are made on three main domains (reading, writing, and numeracy), and two other language-related sub-domains (spelling, and grammar/punctuation).
- The Australian Curriculum, Assessment and Reporting Authority (ACARA) prepares national reports on each year's NAPLAN results. Student achievements are reported in two ways—a scaled score, and in performance bands.
- The scaled scores are constructed so that a given score represents the same level of achievement over time on a domain. This means these scores are consistent across the test for Years 3, 5, 7 and 9. Increases in the scaled score for the same student tested over a period of years (that is, in Years 3, 5, 7 and 9) show comparable improvements in the ability of that student.
- The conversion of scaled scores into performance bands provides an extra indicator of whether a particular child's achievement level on a specific test is at or above a pre-agreed NMS set for each test and year level.
- Every year, a small proportion of students are exempted from the NAPLAN tests.
- Children can also be withdrawn from the NAPLAN testing program at the request of their parent/carer, or be absent on the day of the test.
- Exempt students are included in the count of students participating in the NAPLAN testing program and are assessed to not have met the NMS; but they are excluded from the calculation of the mean scores.
- Withdrawn and absent children are not included in the counts of participating students nor in the calculations of the proportion of students who have met the NMS.
- A higher proportion of Indigenous students are regularly exempted, withdrawn or absent from the NAPLAN tests than non-Indigenous children. The combined proportion of Indigenous students exempted, withdrawn or absent is also generally higher in higher grades (SCRGSP 2016a). This can affect comparability of results for the same group of students over time.

Source: ACARA 2016.

Box 7.4.4: NAPLAN results and methods used to measure progress against the COAG target

- Progress against the Closing the Gap targets in reading, writing and numeracy is assessed using data on increases since the 2008 baseline in the proportion of Indigenous students who are at or above the NMS (not in reference to the mean scaled scores of Indigenous and non-Indigenous students).
- The target to halve the gap by 2018 has been converted into an agreed trajectory between 2008 (the baseline year) and 2018 (the target year) on the proportion of Indigenous students meeting the NMS (COAG 2012).
- The trajectories are a guide to measure progress from baseline performance to achievement of the target. They are, however, only indicative, with the national trajectories developed from those that each state and territory has adopted to measure its own progress.
- Achieving the annual trajectory progress points are neither requirements nor guarantees that the final target point will be reached. Still, it is customary to use the agreed annual trajectory points as a basis for assessing whether the latest calendar year's NAPLAN results are on track to meet the target by 2018.
- The annual trajectory points for assessing progress were developed for the three main NAPLAN test domains (reading, writing and numeracy). The original trajectories for the writing test (COAG 2012), however, are not currently valid, due to changes in the genre of the writing test.
- The NAPLAN writing tests have two alternate genres—narrative writing and persuasive writing. From 2008 to 2010, the test genre was narrative and from 2011 to 2015 it was persuasive. In 2016, the writing test switched back to narrative, and new analytical methods were developed to place scores for the narrative task and the persuasive task on the same scale. Results for both genres of the writing test are therefore comparable over time, but only from 2011 onwards.
- There are no agreed Closing the Gap trajectories for writing using the new combined scale from 2011 onwards. Therefore, assessment of progress against the COAG Closing the Gap target on literacy and numeracy is confined to the NAPLAN reading and numeracy domains, in Years 3, 5, 7 and 9 (a total of 8 test-year and test-domain combinations).
- As well as the COAG endorsed measures of progress against this target, other measures of progress reported on the achievements of Indigenous students are changes over time in their mean NAPLAN test scores, and gains in mean score made by the same cohort of students as they are tested in higher school grades.

Source: ACARA 2016.

Progress against the annual trajectory

The usual way to assess progress against this literacy and numeracy target is to compare the latest calendar year NAPLAN results with the national trajectory points for that year. Among the 8 test-year and test-domain combinations with an agreed trajectory point for 2016 (see Box 7.4.4), the 2016 results on the proportion of Indigenous students meeting the NMS showed that only numeracy in Year 9 was on track to meet the 2018 target.

Figure 7.4.6 tracks the annual performance of Indigenous and non-Indigenous students in the NAPLAN reading and numeracy tests between 2008 and 2016; the agreed trajectory points consistent with meeting the target in 2018 are also shown. In 2016, apart from Year 9 numeracy, the achievement levels by Indigenous students are below the agreed trajectory points for 2016. Achievements below the 2016 trajectory levels signal that progress achieved by 2016 is not on track to meet the 2018 target levels for Indigenous students. (The Year 3 reading achievement in 2016 is very close to the agreed trajectory point, with the deficit being only 1.8 percentage points).

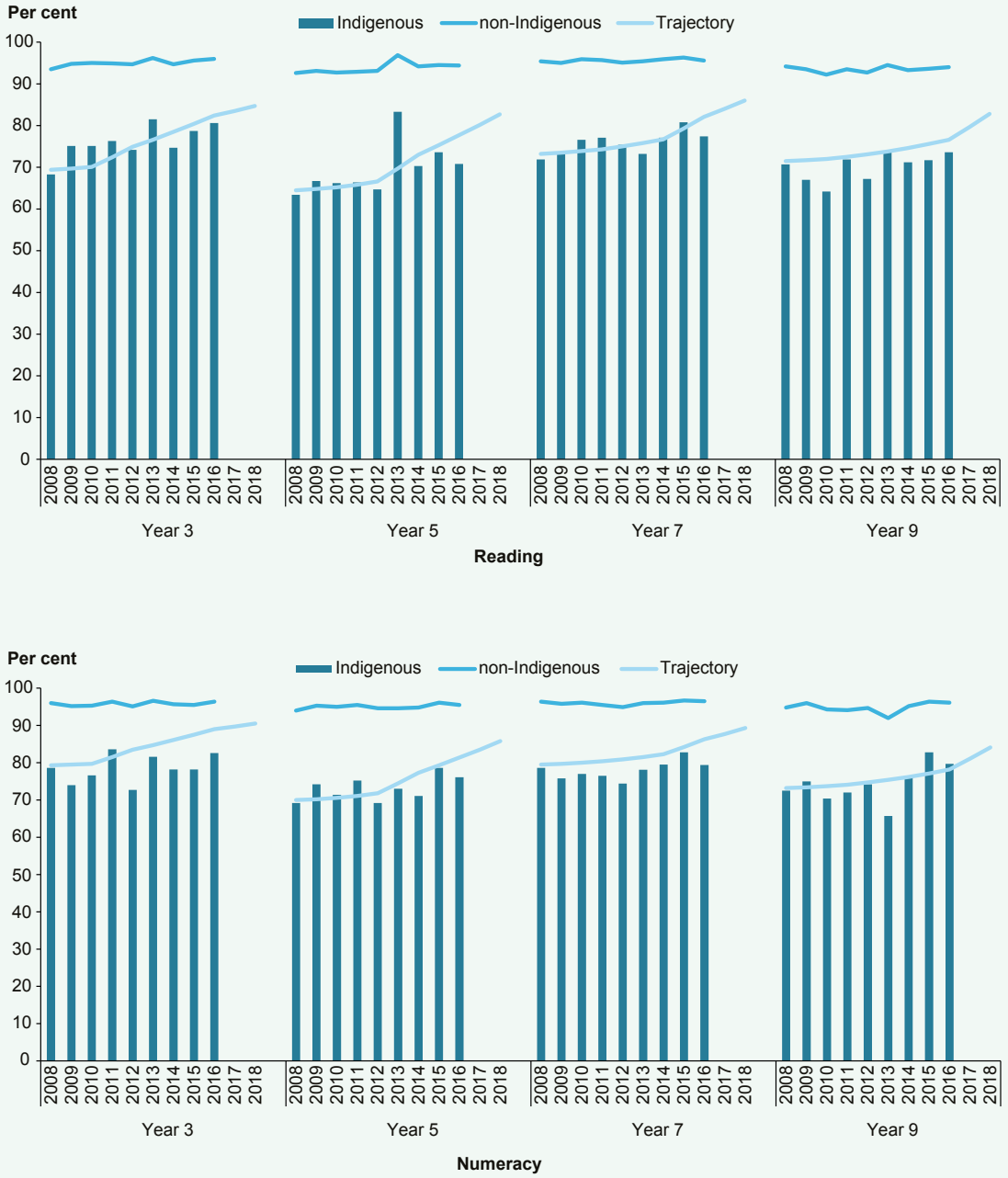
Figure 7.4.6 also shows the large variability in the proportion of Indigenous students who meet the NMS across different calendar years in NAPLAN tests. The NAPLAN tests are designed to be equivalent in difficulty across calendar years so that the scaled scores measure the same level of achievement across different cohorts of children tested. Yet, for Indigenous students, there is unexpected variability in the results on the proportion meeting the NMS across different years, such as the one-off large increase in 2013 Year 5 reading results.

These large and unexplained fluctuations in the Indigenous NMS results across years suggest that, in assessing progress against this target, a narrow focus looking only at the latest calendar year results may not be appropriate. Using the 2015 NAPLAN results for Indigenous children, instead of the latest 2016 results, the assessment of progress against the target is quite different.

The 2015 results for the proportion of Indigenous students meeting the NMS (also in Figure 7.4.6) show that for half of the measures (4 of the 8), progress was on track to meet the 2018 target in Years 5, 7 and 9 numeracy and in Year 7 reading. By the same token, if results in a future year improved, showing an increase in the number of measures on track, the general variability of NMS results for Indigenous students means that they would also need to be treated with some caution.

Indigenous NAPLAN results and gaps by remoteness areas

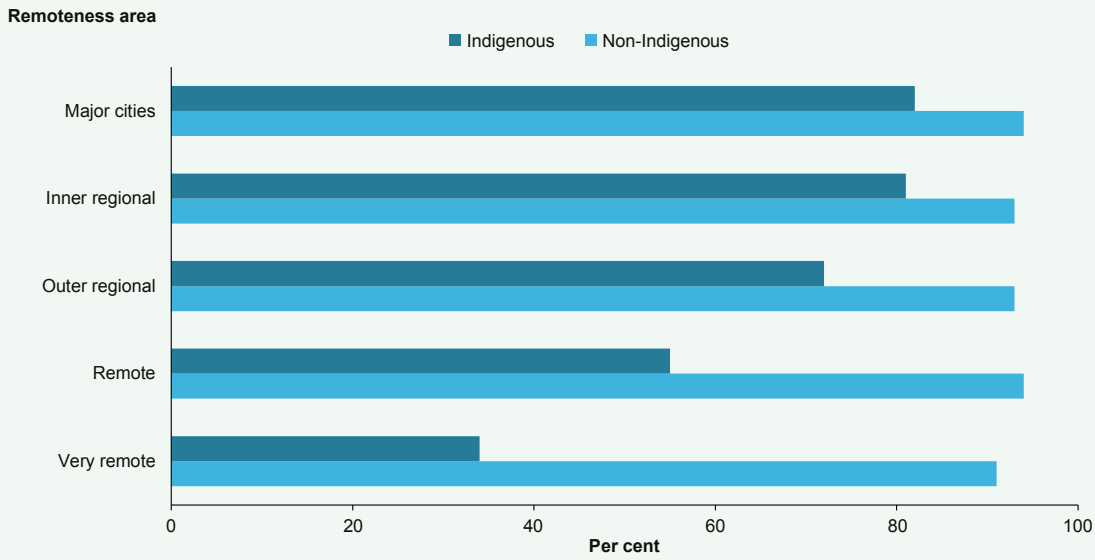
The proportion of Indigenous students who achieve the NMS declines substantially with increasing remoteness, while there is little variation by remoteness for non-Indigenous students. There are large gaps not only between Indigenous and non-Indigenous students but also within Indigenous students by region of residence. For instance, in Year 9 reading in 2016, the gap in the proportion achieving the NMS between Indigenous and non-Indigenous students in *Very remote* areas was 57 percentage points. There was also an almost equally large gap of 48 percentage points in Year 9 reading results between Indigenous students in *Very remote* areas and *Major cities* (Figure 7.4.7).



Note: The annual trajectory points shown are for Indigenous student results. They represent achievements consistent with halving the gap between 2008 and 2018, and were developed through the National Indigenous Reform Agreement process. These trajectory points are given in Schedule G of COAG (2012).

Sources: AIHW analyses of NAPLAN data in ACARA 2016 and previous NAPLAN national reports; COAG 2012.

Figure 7.4.6: NAPLAN performance in reading and numeracy, by Indigenous status and year level, and trajectories for Indigenous achievements (percentage meeting the NMS), 2008 to 2016



Source: AIHW analysis of NAPLAN data in ACARA 2016.

Figure 7.4.7: Proportion of students meeting the NMS in Year 9 Reading, by Indigenous status and remoteness area, 2016

The substantially poorer NAPLAN performance of Indigenous students living in *Remote* and *Very remote* and areas is a major concern as it contributes significantly to the national gap, even though the overwhelming majority of Indigenous students live in non-remote areas. Using data from an earlier 2014 NAPLAN testing round for Year 5 reading, the Productivity Commission (2016) estimated that *Very Remote* areas accounted for one-third of the national gap in the NMS percentage for Year 5 reading. This one-third share in the national gap is substantially disproportionate to the share of Indigenous students in *Very remote* areas (only 12% in 2014) because of the considerably larger gaps in NAPLAN achievements that occur there.

Indigenous students in metropolitan and provincial areas, accounting for a large majority of the Indigenous student population, still contributed more than half (55%) to the national gap in 2014 Year 5 reading. But the contributions of the *Remote* and *Very remote* areas were also significant (adding up to 45%). The Productivity Commission (2016) concluded that, to be effective and equitable, approaches to closing the gap on literacy and numeracy need to improve the educational outcomes of Indigenous students in all regions—metropolitan, provincial, remote and very remote areas (as well as across all states and territories).

Improvements in Indigenous results since the baseline of 2008

Improvements in achieving the NMS

As well as checking if annual trajectory points are met, progress against the reading, writing and numeracy targets is assessed through improved NAPLAN performance of Indigenous students—that is, by comparing the proportion of Indigenous students achieving the NMS in the 2008 baseline year with the latest year of results (point to point comparisons).

Between 2008 and 2016, there were statistically significant increases in the proportion of Indigenous children who achieved the NMS in:

- 4 of 8 measures of the reading and numeracy test domains (reading in Years 3 and 5 and numeracy in Years 5 and 9)
- 4 of 8 measures in the spelling and grammar/punctuation tests in Years 3, 5 and 7 (both tests in Year 3, and grammar/punctuation in Years 5 and 7)
- 1 of 4 measures of the writing results (Year 3, comparing results of 2011 with 2016).

Improvements in mean NAPLAN scores

The NAPLAN annual reports also report the mean scores achieved by Indigenous students in the NAPLAN tests over time. This measure is not formally agreed to by COAG to assess progress against this target.

Using 2008 data as the baseline, almost half (7 of the 16 measures, excluding writing) showed statistically significant increases in the mean NAPLAN test scores achieved by Indigenous students in 2016. These were in Years 3 and 5 in reading; Year 5 in numeracy; Year 3 in spelling; and in Years 3, 5 and 7 in grammar/punctuation. For the writing test, the mean score was not statistically higher in 2016 than the revised baseline of 2011 for any year level.

Gaps in school achievements—perspective from the Programme for International Student Assessment

Australia has participated in the Programme for International Student Assessment (PISA) since its inception. PISA is administered to 15-year-old students (who are usually in Years 9, 10 or 11) (see Box 7.4.5 for further details on the PISA). PISA results are a valuable indicator of the school achievements of Indigenous students, even though the PISA is not a formal measure related to the COAG target on literacy and numeracy.

Like for NAPLAN, PISA results consistently show significant gaps in the average achievements of Indigenous and non-Indigenous students. Several of these gaps have been reduced over time, however, more noticeably in the latest results for 2015, because of declines in the PISA performance of non-Indigenous students. However, the gap in performance of Indigenous students remains substantial. Indigenous students tend to be under-represented at the higher proficiency levels and over-represented at the lower proficiency levels in all domains in PISA tests.

PISA 2015 results

Australia's results from the PISA 2015 show that Indigenous students continue to achieve significantly lower scores than non-Indigenous students in all three major test domains.

In 2015, the mean score achieved by Indigenous students in reading literacy was 435 points, compared with a mean score of 506 points by non-Indigenous students. (This resulted in a gap of 71 points.) This level of difference in the mean scores indicates that Indigenous students, on average, were behind by around 2.3 years of schooling in reading literacy, compared with non-Indigenous students (Thomson et al. 2016).

In 2015, the mean score attained by Indigenous students in mathematical literacy was 427 points, compared with a mean score of 497 points for non-Indigenous students. (This represents a gap of 70 points.) The mean scores in scientific literacy for Indigenous and non-Indigenous students were 437 and 513 points, respectively (that is, a gap of 76 points).

The gap of 70 points in the mean score in mathematical literacy indicates Indigenous students, on average, were behind by around 2.3 years of schooling; correspondingly, the gap of 76 points in scientific literacy indicates they were, on average, behind by around 2.5 years of schooling (Thomson et al. 2016).

Comparisons of PISA results over time

Time trends for the Australian PISA test results on the mean scores of Indigenous and non-Indigenous students on the three core domains show that the gaps in these mean scores have narrowed slightly mainly due to significant declines in the mean performance of non-Indigenous students (Figure 7.4.8).

The starting point for the comparisons in Figure 7.4.8 is the PISA test cycle in which a particular test domain was the major domain for the first time. The recommendation that the most reliable way to establish a trend for PISA results is to compare major domain results (Thomson et al. 2016) could not be followed here as it would severely reduce the number of data points for comparison. Instead, the latest 2015 results (in which scientific literacy was the major domain) are compared with the first instance in which a particular domain was the major domain (2000 for reading, 2003 for mathematical literacy, and 2006 for scientific literacy.) The first full assessment of each domain as the major domain sets the scale of assessment and provides a valid starting point for future comparisons (Thomson et al. 2016).

All three core domains show that for non-Indigenous students the mean scores in 2015 are lower than the first point of comparison with a major domain assessment. For Indigenous students, there was a significant decline in performance in mathematical literacy but no change in results for reading or scientific literacy. In all instances, the relative decline in mean scores for non-Indigenous students has been greater which has led to a small reduction in the gap between Indigenous and non-Indigenous mean scores. In general, though, this is not a desirable way to reduce the school achievement gaps.

Box 7.4.5: About the Programme for International Student Assessment

- PISA is a standardised test of the knowledge and skills administered to 15-year-olds by the Organisation for Economic Co-operation and Development in over 70 countries. It tests young people's ability to apply their knowledge and skills to real-life problems and situations, rather than how well a specific curriculum is learned.
- This means that PISA results can be consistently compared, both across countries and across time (OECD 2015).
- International results from the PISA are used regularly by many participating countries to evaluate the effectiveness of their school education systems.
- The PISA has been administered triennially since 2000. Australia has participated in all cycles of the PISA, and six sets of results for Australian students are now available.
- In 2015, over half a million students (representing 28 million 15-year-olds in 72 countries and economies) took the 2-hour PISA test. Students were assessed against three core domains (scientific, mathematical and reading literacy) as well as in collaborative problem solving. Australian students also took part in an optional assessment of financial literacy.
- Since the first cycle, the PISA has focused on the three core domains, but one domain is selected as the major domain in each test cycle. A substantial part of the total test time is devoted to the major domain.
- The distinction between major and minor domains matters. The recommended most reliable way to establish a trend for results in an assessment domain is to compare results between cycles when that assessment domain was the major domain.
- PISA testing in Australia has consistently ensured that enough Indigenous students are sampled to allow for reliable reporting of results by Indigenous status.
- In Australia, PISA results are reported as mean scores achieved in each of the three domains at the national and jurisdictional level. Results are also reported for each domain by selected demographic groups at the national level.
- In some test cycles, the sample of Australian students who sit for the PISA are also invited to become part of the Longitudinal Surveys of Australian Youth (LSAY), and to be interviewed regularly until age 25. The LSAY is a valuable longitudinal data resource covering the critical periods of school completion and transitions to employment or further education and training (NCVER n.d.).
- PISA test scores are important markers of students' cognitive ability around the end of compulsory schooling. Analyses of LSAY data in the Australian context show that PISA test scores are reliable predictors of later educational and employment outcomes (for example see Mahuteau et al. 2016; Nguyen 2010).

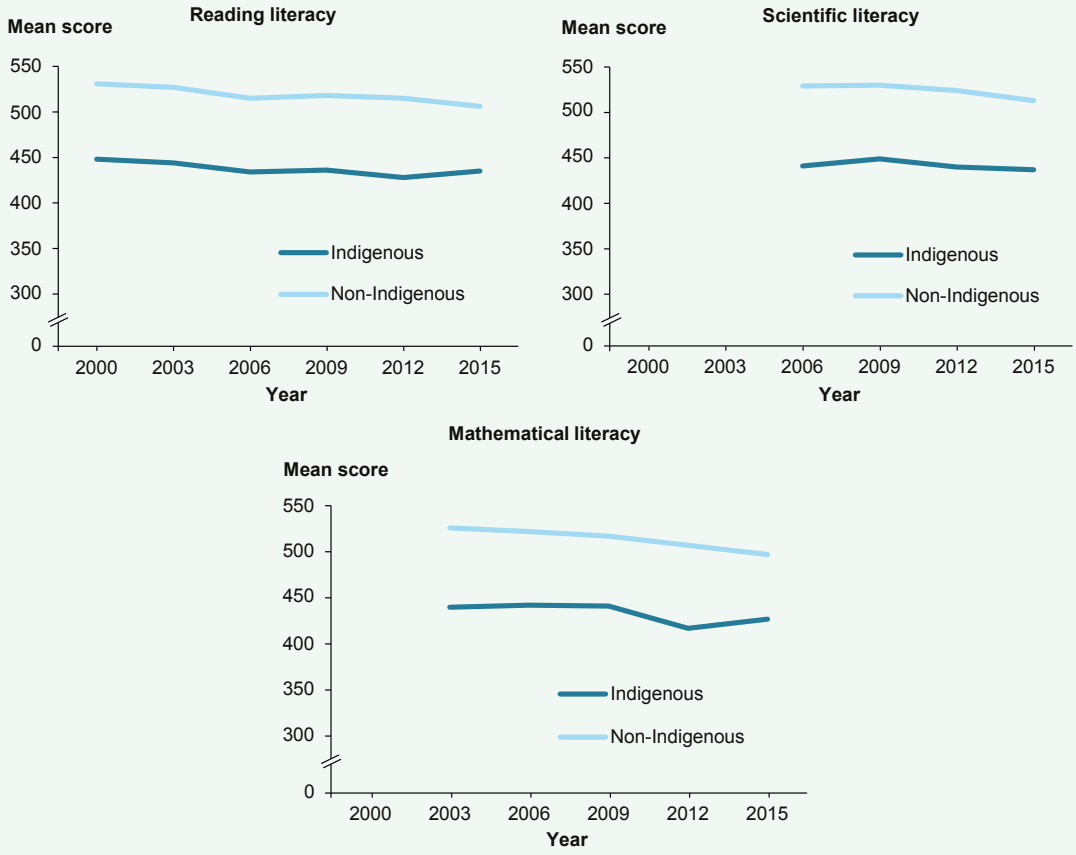
Source: Thomson et al. 2016.

A welcome feature in the trends in Figure 7.4.8 is that the Indigenous mean scores increased in 2015 compared with 2012 in two domains—by 7 points in reading literacy, and by 10 points in mathematical literacy. Both increases are statistically significant.

In reading literacy between 2000 and 2015, there was a 13-point decline in the mean score of Indigenous students (not statistically significant). A larger decline of 25 points in the scores of non-Indigenous students over this period was statistically significant. This results in a reduction in the gap in reading literacy between Indigenous and non-Indigenous students of 12 points (from 83 points in 2000 to 71 points in 2015). (Statistical significance of changes in the gap cannot be readily assessed.)

In mathematical literacy between 2003 and 2015, there also was a 13-point decline in the mean score of Indigenous students (from 440 points in 2003 to 427 points in 2015). This decline is statistically significant. Despite this decline, the gap in mathematical literacy was reduced by 16 points (from 86 points in 2003 to 70 points in 2015), again due to a larger (and statistically significant) decline in the performance of non-Indigenous students.

In scientific literacy since 2006, the mean score of Indigenous students has not changed significantly. It ranges from 441 in 2006 to 437 in 2015. There has, however, been a significant reduction of 16 points in the mean score for non-Indigenous students. The gap in the mean score in scientific literacy between Indigenous students and non-Indigenous students has decreased by 12 points (from 88 points in 2006 to 76 points in 2015).



Note: The starting point for the time series in each domain is the PISA test cycle in which that domain was the major domain for the first time.

Source: Thomson et al. 2016.

Figure 7.4.8: Mean PISA scores for Australian students, by Indigenous status, 2000, 2003, 2006, 2009, 2012 and 2015

PISA results and subsequent education outcomes

Analyses of the longitudinal link between the PISA sample of students and LSAY follow-up till age 25 in some of the Australian PISA test cycles show that PISA test scores are a good predictor of later employment and educational outcomes. Analyses of the 2003 PISA/LSAY cohort found that higher PISA scores in reading and mathematical literacy were linked with higher Year 12 completion and post-school university enrolment for both Indigenous and non-Indigenous students (Nguyen 2010).

A later more detailed analysis (Mahuteau et al. 2016) focusing on the educational outcomes of Indigenous students who participated in the PISA cohorts in 2006 and 2009 showed that:

- there was only a very modest improvement in the PISA results of Indigenous students at age 15 between the 2006 and the 2009 cohorts, once other background characteristics of the students in the two cohorts were controlled for
- a large part of the gap (50% to 63%) in the mean PISA scores of Indigenous and non-Indigenous students in these cohorts could be attributed to differences in their socioeconomic area and other background variables, and to differences in the schools that Indigenous students attend. However, a sizeable part of the gap still remains unexplained by these socioeconomic and school-related factors
- there was no significant difference between the subsequent educational outcomes of Indigenous and non-Indigenous students after taking account of their academic achievement at age 15, as reflected in the PISA scores. For example, the Year 12 completion rate and subsequent university enrolment rates were similar for Indigenous and non-Indigenous students who had similar PISA test scores.

A key implication of this last finding is that remedial efforts to advance Indigenous educational outcomes need to begin much earlier than age 15. At this age, gaps in academic achievement have already been set, and are shown to largely determine future outcomes. This reinforces the well-understood evidence from the international child development literature that early investment in the lives of disadvantaged children will help to reduce inequality in outcomes, in both the short and long term (Cunha and Heckman 2007).

However, it is noteworthy that given the same levels of ability developed by age 15 (as represented by the PISA scores), Indigenous students appear not to be further disadvantaged in subsequent educational outcomes. Indigenous students have the same rate of completing high school and acquiring further educational qualifications as non-Indigenous students with similar levels of PISA test achievements at age 15.

If sustained advances can be made in early childhood development vulnerability and school learning outcomes for future cohorts of Indigenous children, it would be very likely that they can attain the same rates of subsequent educational outcomes as non-Indigenous children—for both Year 12 completion and participation in tertiary education. The international literature on PISA assessments has found that 15-year-old PISA students who had attended at least 1 year of pre-primary school scored better on the PISA tests, particularly for mathematical literacy in 2015, than students who did not go to preschool (Sparks 2017).

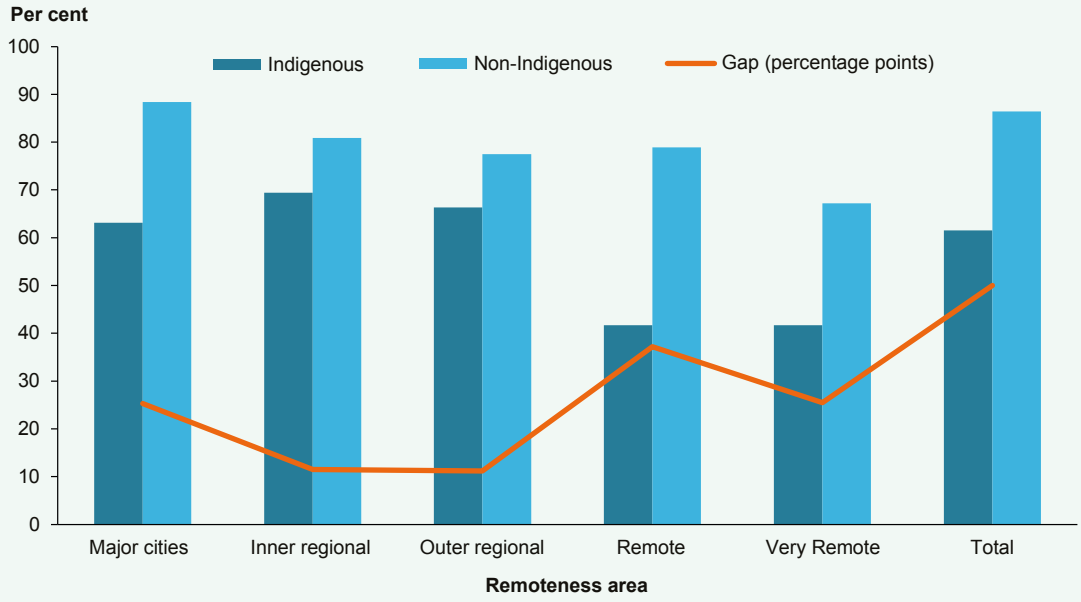
Year 12 attainment

Progress on the Year 12 attainment target can be measured from either Census or survey data. While the Census is the preferred official data source, the most recent Indigenous data for this target are from the 2014–2015 National Aboriginal and Torres Strait Islander Social Survey. Those data show this target is on track to be met (PM&C 2017).

In 2008 (survey baseline data), the Year 12 attainment gap between Indigenous and non-Indigenous 20–24-year-olds was 40 percentage points (attainment rates of 45% and 85%, respectively). The COAG target is to halve that gap by 2020.

The proportion of Indigenous 20–24-year-olds who have attained a Year 12 or equivalent level of education has increased significantly, from 45% in 2008 to 62% in 2014–2015; in 2014–15, the gap between Indigenous and non-Indigenous 20–24-year-olds decreased to 25 percentage points (with 62% and 86% attainment rates, respectively) (PM&C 2017). This shows that in relation to the survey-based estimates of this target measure, about two-thirds of the final reduction of the gap needed by 2020 has already been achieved by 2014-15.

In 2014–15, Year 12 attainment among Indigenous 20–24-year-olds was substantially higher in non-remote areas than in remote areas. It ranged from the highest rate of 69% in *Inner regional* areas to 42% in both *Remote* and *Very remote* areas (Figure 7.4.9).



Note: The gap denotes the difference between the non-Indigenous and Indigenous rates, as represented by the heights of the corresponding columns in the figure.

Source: AIHW analyses of ABS 2014, 2016.

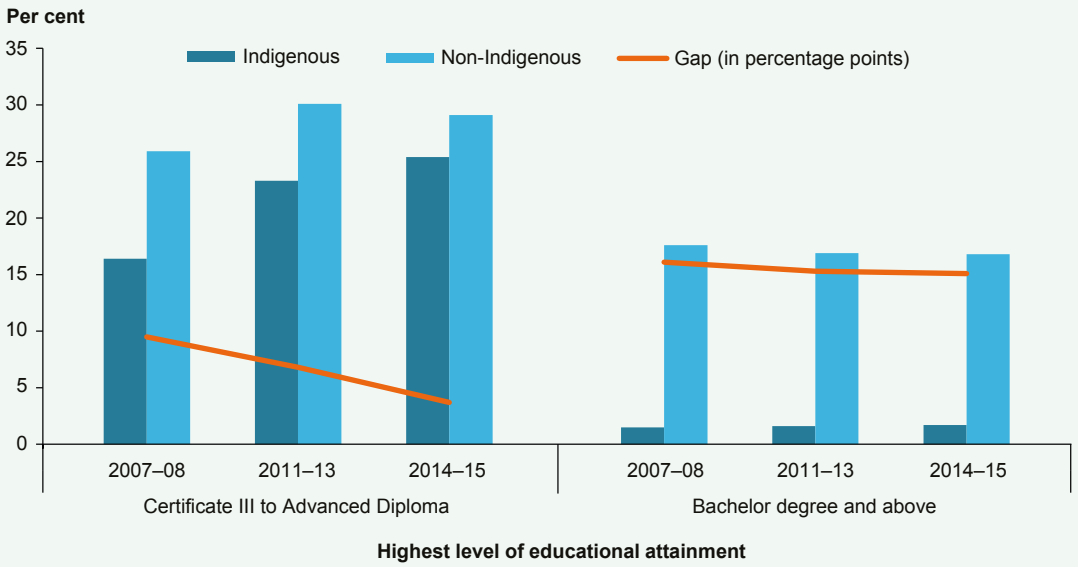
Figure 7.4.9: Proportion of population aged 20–24 with at least Year 12 or equivalent educational attainment, by Indigenous status and remoteness area, 2014–15

Post-school education and training

Post-school qualifications

Post-school qualifications are those obtained through successful completion of vocational education and training and/or higher education at universities. They include postgraduate/bachelor/diploma/certificate degrees from universities, and certificates in vocational education. Post-school qualifications are often classified as Certificate level III or higher in vocational education programs. That convention is adopted for the data reported in this section. Some individuals may complete post-school qualifications without having completed Year 12 in school; and some may take vocational educational courses while still enrolled in school. All of the latter category are excluded from the analyses in this section, irrespective of the Certificate level enrolled in, because they are still in school.

In 2014–15, slightly more than one-quarter (27%) of Indigenous 20–24-year-olds had obtained a post-school qualification (Certificate level III or higher)—double the rate (13%) in 2002 (SCRGSP 2016b). (These proportions exclude individuals still studying at any level). In 2014–15, the majority of Indigenous 20–24-year-olds with a post-school qualification had completed a Certificate III to an advanced diploma (25% of all 20–24-year-olds), and 1.7% had a Bachelor degree or higher. In 2014–15, Indigenous 20–24-year-olds had almost caught up with their non-Indigenous counterparts in attainment rates for a Certificate III to an advanced diploma, but a large gap remained in attaining a Bachelor degree or higher (Figure 7.4.10).



Note: The gap denotes the difference between the non-Indigenous and Indigenous rates, as represented by the heights of the corresponding columns in the figure.

Source: SCRGSP 2016b.

Figure 7.4.10: Post-school qualifications at Certificate III level to Advanced Diploma, and Bachelor degree and above for people aged 20–24, by Indigenous status, 2007–08, 2011–13 and 2014–15

Among all Indigenous persons aged 20–64, in 2014–15, 39% had obtained a post-school qualification—an increase from 18% in 2002 (SCRGSP 2016b). However, over time, there has not been a narrowing of the gap between the Indigenous and non-Indigenous population because post-school qualifications have also increased at about the same pace for the non-Indigenous population of 20–64-year-olds.

The rate of post-school attainment for Indigenous adults aged 20–64 decreases with remoteness area of residence. In *Major cities*, half of Indigenous 20–64-year-olds have attained a Certificate III level or above (including Bachelor and above). This rate decreases progressively with remoteness (50% in *Major cities*, 43% in *Inner regional* areas, 36% in *Outer regional* areas, 28% in *Remote* areas and 19% in *Very remote* areas).

Higher education enrolments

The number of Indigenous students enrolled in higher education has increased steadily over time. Between 2006 and 2015, enrolments increased by more than 80% (from 8,800 to 16,100) (DET 2016c). However, Indigenous students are still under-represented in tertiary enrolments, accounting for only 1.1% of all higher education domestic enrolments in 2015 (DET 2016a).

Participation in vocational education and training

In Australia, a wide range of agencies provide vocational education and training (VET) services. Their funding models vary from being fully publicly funded to fully privately funded. Data collected on Australia's VET services are reported on an annual basis for the total level of VET activity, and quarterly for only government-funded activity. Indigenous trainees feature prominently in both types of data collections.

Total VET activity

In 2015, around 4.5 million students were enrolled in vocational training, with 4,277 Australian providers. Of these students, about 165,500 (3.6%) were reported as Indigenous, 3.7 million (81%) as non-Indigenous and 698,900 (15%) did not report their Indigenous status (NCVER 2016a).

In 2015, there were 170,100 VET program enrolments for Indigenous students. Among these, 89% were in Australian Qualifications Framework (AQF) programs and the rest (11%) in non-AQF programs. These Indigenous students were enrolled in 1.3 million specific VET subjects.

Government-funded VET activity

In the first 9 months to 30 September 2016, there were 1.1 million students enrolled in the government-funded VET system, of whom 69,900 (6.5%) were Indigenous (NCVER 2016b). Indigenous students have a higher share in total enrolment for government-funded VET places than in total VET activity; this share has increased from 5.4% in 2011 (SCRGSP 2017).

The number of Indigenous students undertaking government-funded training in the first 9 months of 2016 increased by 14% over that for the corresponding period in 2015. This was a larger increase than the 4% increase in government-funded VET enrolments for non-Indigenous students over the same period.

Expressed as a proportion of the relevant Indigenous total population, Indigenous participation in government-funded VET has decreased slightly, from 12% in 2011 to 10% in 2015. Among Indigenous 18–24-year-olds, in 2015, almost one-quarter (24%) participated in a government-funded VET program, compared with 16% of non-Indigenous people in the same age group. The Indigenous participation rate in government-funded VET among 18–24-year-olds has, however, decreased slightly from 27% in 2011 (SCRGSP 2017).

Load pass rate of Indigenous students

The VET load pass rate has improved for Indigenous students, from 65% in 2004 to 77% in 2015. The VET load pass rate for Indigenous students has increased 3.5 percentage points since 2011 and 10.7 percentage points since 2006. Accordingly, the gap between Indigenous and non-Indigenous students in the VET load pass rate has reduced by half to 6.5 percentage points in 2015 compared to 13 percentage points in 2006 (SCRGSP 2016b). (The VET load pass rate is the ratio of hours studied by students who passed their subject(s) to the total hours committed to by all students who passed, failed or withdrew).

Transition from school to work

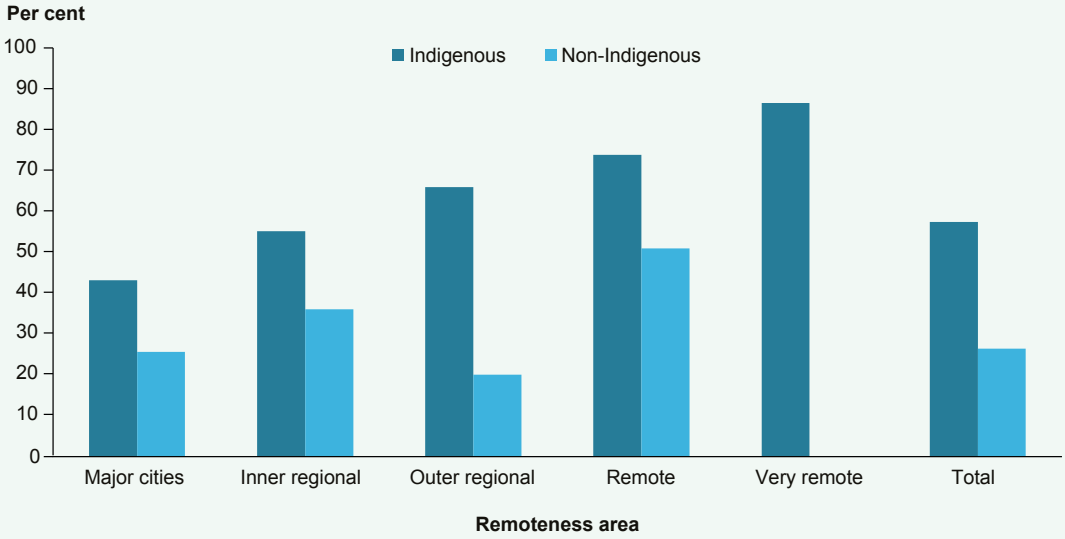
The transition from school to work or further education and training is an important milestone for young people. A commonly used measure of the lack of success in this transition is expressed as the proportion of 17–24 year olds who, after leaving school, are not 'fully engaged' in employment or further education and/or training (that is, the total time spent either separately, or in combination, in employment and further education/training is less than what constitutes a normal 'full-time' basis of involvement; note this is different to 'NEET'; see Chapter 3.1 'Pathways through education and training').

Indigenous young people aged 17–24 are more likely not to be fully engaged than non-Indigenous Australians of the same age. In 2002, more than two-thirds (68%) of young Indigenous Australians were not fully engaged. This proportion declined to 57% in 2014–15. In contrast, the proportion of young non-Indigenous Australians not fully engaged in employment, education and/or training increased slightly over the same period (from near-stable rates of around 25% between 2002 and 2012–13 to 26% in 2014–15) (SCRGSP 2016b). This led to a narrowing of the gap between Indigenous and non-Indigenous 17–24-year-olds between 2002 and 2014–2015 (from 43 to 31 percentage points).

The proportion of young Indigenous people not fully engaged in employment, education and/or training increases with remoteness of residence. In 2014–15, this rate ranged from 43% in *Major cities* to 87% in *Very remote* areas. However, the greatest gap in this rate between Indigenous and non-Indigenous 17–24-year-olds was in *Outer regional* areas (46 percentage points). The gaps in other regions were less than half the gap in the *Outer regional* areas (Figure 7.4.11).

Education and employment outcomes

The educational outcomes for many Indigenous youth and working age adults have generally improved over time. This is likely to continue, but there is still a long way to go before the remaining gap between the Indigenous and non-Indigenous populations for educational outcomes is closed. The gaps in educational qualifications are salient because they often are the sources of later gaps in employment and other socioeconomic indicators and health status (ABS 2011; Karmel et al. 2014).



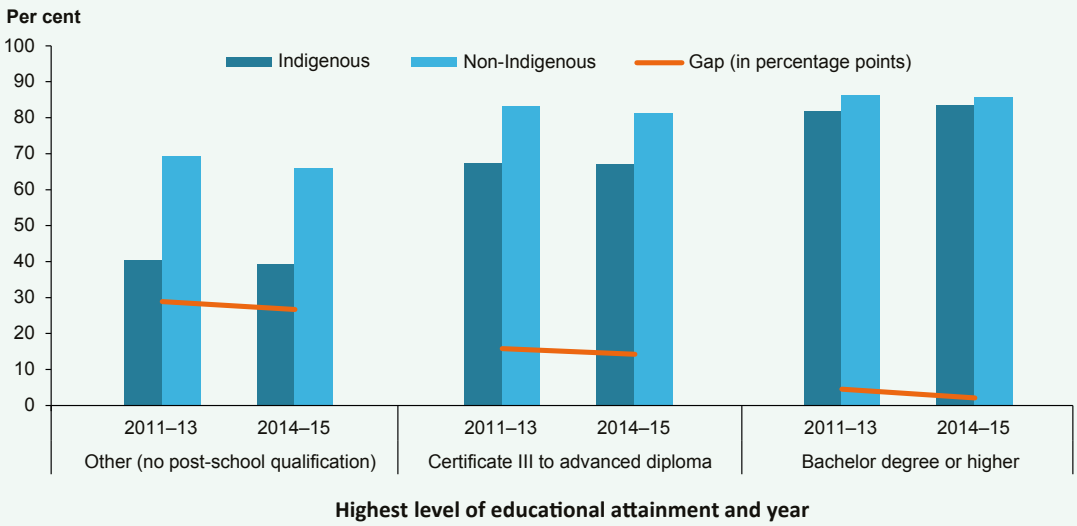
Note: The proportion of non-Indigenous 17–24-year-olds who were not fully engaged in employment, education and/or training in *Very remote* areas was not available for 2014–15. Hence, the gap between the non-Indigenous and Indigenous rates are not separately indicated for any of the remoteness areas.

Source: SCRGSP 2016b.

Figure 7.4.11: Young people aged 17–24 not fully engaged in employment, education and/or training, by Indigenous status and remoteness area, 2014–15

The key role of education as a 'leveler' of some of the other related gaps is clearly shown by the links between the highest level of post-school qualifications and the gaps in employment status. Not many Indigenous people aged 18–64 have a Bachelor degree or higher level of qualification. However, once they achieve that level of qualification, they consistently report high levels of employment (expressed as an employment ratio) of more than 80%. There also are only minimal gaps when compared with the employment to population ratio for non-Indigenous people aged 18–64 who have a Bachelor degree or higher level of qualification.

In 2014–15, the employment to population ratio for Indigenous people aged 18–64 varied greatly by the level of post-school qualifications (Figure 7.4.12). Among people with only a Certificate I or II (or lower), only 39% were employed. The employment ratio increased substantially to 69% for people with a Certificate III to an advanced diploma. The employment ratio increased further to 84% for people with a Bachelor degree or higher. The gap in the employment to population ratio between Indigenous and non-Indigenous persons aged 18–64 with only a Certificate I or II (or lower) was 27 percentage points in 2014–15. This gap was lower by almost half (14 percentage points) for people with a Certificate III to an advanced diploma. The employment ratio gap almost disappears (only 2 percentage points) for people with a Bachelor degree or higher level of qualification.



Notes

1. 'Bachelor degree or higher' comprises Bachelor degree, Graduate Diploma/Graduate Certificate and Postgraduate Certificate; 'Certificate III to advanced diploma' includes Certificate III/IV, Certificate III/IV not further defined and Advanced Diploma/Diploma; and 'Other (no post-school qualification')' comprises Certificate I and II, Certificate I and II not further defined, Certificate not further defined and people who do not have a post-school qualification (includes secondary school educational attainment and no post-school qualification).
2. The gap denotes the difference between the equivalent non-Indigenous and Indigenous rates, as represented by the heights of the corresponding columns in the figure.

Source: SCRGSP 2016b.

Figure 7.4.12: Employment to population ratio, people aged 18–64, by level of highest educational attainment and Indigenous status, 2011–13 and 2014–15

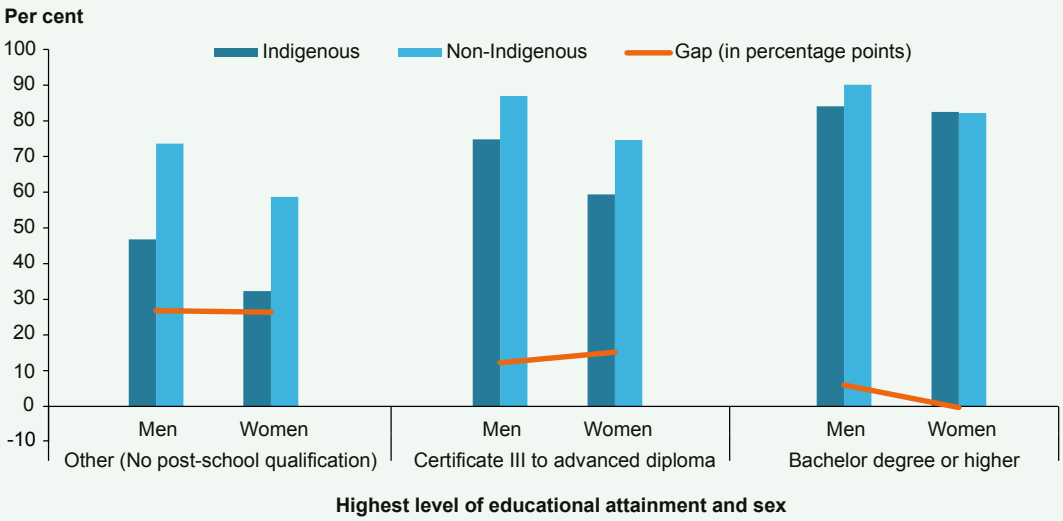
As shown in Figure 7.4.13, the boosts for employment of attaining a Certificate III or above is clear, for both Indigenous men and women.

The employment to population ratio for Indigenous men increased from 47% for men without a post-school qualification to 75% for men with a Certificate III to advanced diploma. This ratio increased further to 84% for Indigenous men with a Bachelor degree or higher.

For Indigenous women, the increases in the employment to population ratio were similar: from 32% for women without a post-school qualification to 59% for women with a Certificate III to advanced diploma, and 83% for women with a Bachelor degree or higher.

The gaps between the proportions of Indigenous and non-Indigenous adults employed are high for both men and women with education levels below Certificate III (shown as 'Other' in Figure 7.4.13). For people with a Bachelor degree or higher, Indigenous employment rates are consistently high (above 80%) for both men and women, and the gaps with non-Indigenous employment are much smaller. A gap does not exist for Indigenous women with a Bachelor degree or higher (both employment rates are between 82% and 83%).

A qualification at the level of Certificate level III is thus seen as the critical threshold level of education that greatly improves the employment prospects of Indigenous workers and reduces the employment gaps between them and equivalently qualified non-Indigenous working age adults. This is a consistent pattern seen in other time periods (Karmel et al. 2014; SCRGSP 2016b).



Notes

1. 'Bachelor degree or higher' comprises Bachelor degree, Graduate Diploma/Graduate Certificate and Postgraduate Certificate; 'Certificate III to advanced diploma' includes Certificate III/IV, Certificate III/IV not further defined and Advanced Diploma/Diploma; and 'Other (no post-school qualification') comprises Certificate I and II, Certificate I and II not further defined, Certificate not further defined and people who do not have a post-school qualification (includes secondary school educational attainment and no post-school qualification).
2. The gap denotes the difference between the non-Indigenous and Indigenous rates, as represented by the heights of the corresponding columns in the figure.

Source: SCRGSP 2016b.

Figure 7.4.13: Employment to population ratio, people aged 18–64, by level of highest educational attainment, Indigenous status and sex 2014–15

What is missing from the picture?

The Closing the Gap agenda and its early learning and education measures have helped to substantially improve our understanding of the early onset of gaps in child development and learning outcomes for many Indigenous children. Family background, school characteristics and remote locations play important contributing roles.

Much less is known, however, about the origins and trends in the development of non-cognitive skills of Indigenous children. The child development literature stresses that cognitive and non-cognitive skills work together to produce successful adult outcomes, and that one helps to develop the other. Further analyses are needed on how Indigenous (and non-Indigenous) children from disadvantaged backgrounds can be helped to acquire non-cognitive skills—such as perseverance, motivation and self-esteem—that are vital in producing successful adult outcomes, including in education. This requires developing further, as well as making greater use of, any existing data on children linked over different services and outcome measures.

Where do I go for more information?

Early learning and care and achievements in school literacy and numeracy are part of the regular reporting by the AIHW on Children's Headline Indicators. These are disaggregated by Indigenous status, remoteness area and socioeconomic area (see AIHW Children's Headline Indicators for more information).

More information about the AEDC results is provided in the national reports prepared for each collection 2015 AEDC National Report, and community level report cards and maps are available online at 2015 AEDC Community Profiles.

Detailed annual national reports on the NAPLAN tests are produced by ACARA; see NAPLAN—National reports by year. As well, trends in NAPLAN results over time by Indigenous status and remoteness area (among others) are available at ACARA NAPLAN time series data.

A fuller discussion of the gaps in educational outcomes and other broader measures related to education are reported regularly in the Overcoming Indigenous Disadvantage Reports prepared by the Steering Committee for the Review of Government Service Provision. The latest report was released in November 2016; see *Overcoming Indigenous Disadvantage: Key Indicators 2016*.

Publication disclaimer

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7.5 Income and employment for Indigenous Australians

One way in which Aboriginal and Torres Strait Islander Australians face socioeconomic disadvantage is through disparity of income. Low income is associated with a wide range of disadvantages, including poor health, shortened life expectancy, poor education, substance abuse, reduced social participation, crime and violence (AHMAC 2015). Income is also closely linked to employment status.

Besides providing income, being employed has important benefits for the health, social and emotional wellbeing of individuals, families and communities. However, job seekers often face many barriers in pursuing employment, including living with a physical or mental illness or disability, or having caring responsibilities. Indigenous Australians have, on average, lower employment rates than non-Indigenous Australians for a range of reasons. These include lower levels of education and training, living in areas with fewer employment opportunities, higher levels of contact with the criminal justice system, experiences of discrimination, and lower levels of job retention (Gray et al. 2012).

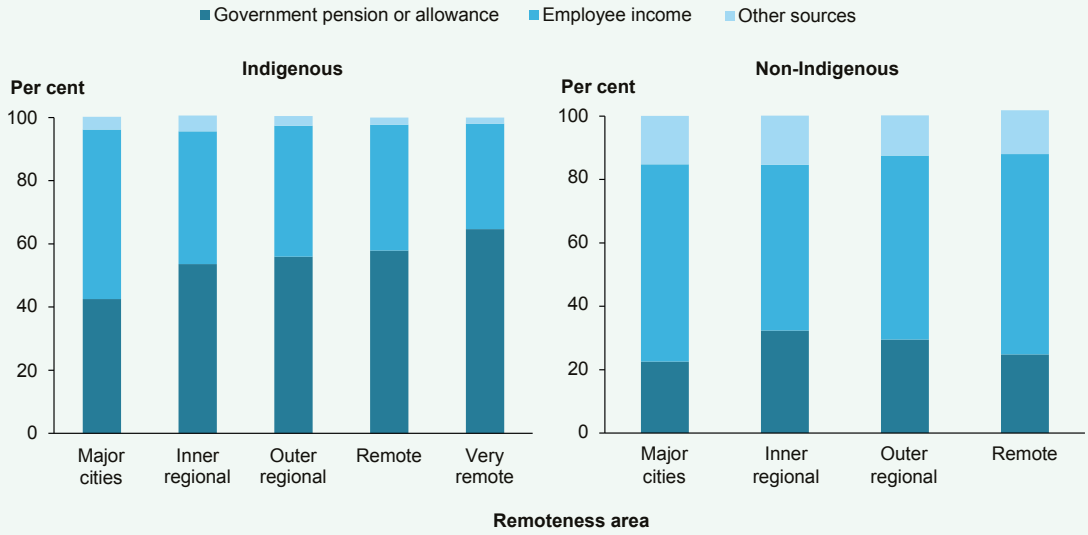
Income

This section looks at income among people aged 15 and over. (People of this age are most likely to be earning or receiving an income, including income support payments and the aged pension). Data for Indigenous Australians are drawn from the Australian Bureau of Statistics (ABS) 2014–15 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), and for non-Indigenous Australians from the 2014 General Social Survey (GSS).

In measuring and comparing income, it is important that the number of people living in a household—particularly children and other dependants—is taken into account. To do this, reported incomes are adjusted to create a comparable measure called equivalised gross household income (see Glossary).

- In 2014–15, an estimated 36% of Indigenous people aged 15 and over had incomes in the bottom 20% of equivalised gross weekly household incomes, compared with 16% of non-Indigenous people in the same age bracket. Comparable trend data are not available for Indigenous people aged 15 and over; however, for Indigenous people aged 18 and over, the proportion with incomes in the bottom 20% of equivalised gross weekly household incomes decreased from 49% in 2008 to 37% in 2014–15. The equivalent proportion for non-Indigenous people in the same age bracket remained relatively stable over time (16% in 2008; 17% in 2014–15) (SCRGSP 2016).
- For people aged 15 and over, the median equivalised gross weekly household income of Indigenous people was lower than that for non-Indigenous people ($556/week compared with $831/week). The median equivalised gross weekly household income for Indigenous people aged 15 and over was also lower in *Very remote* areas ($400/week) than in *Major cities* ($671/week).

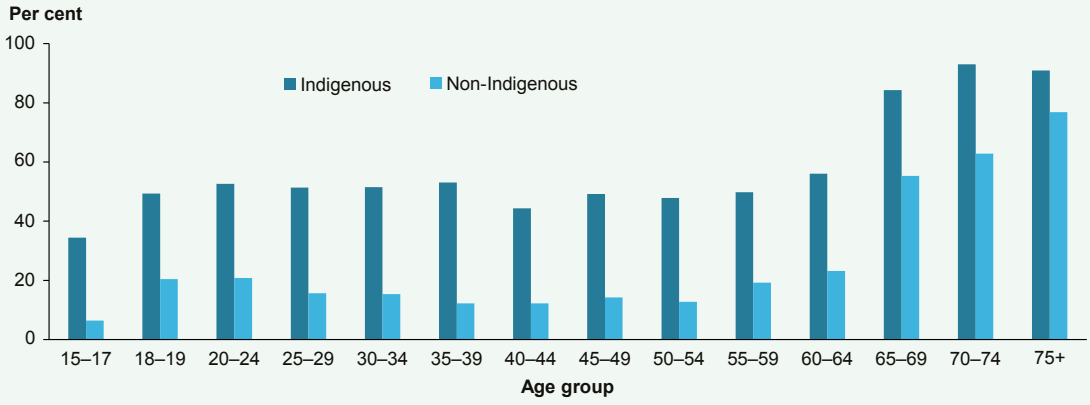
- The proportion of people aged 15 and over whose main source of income was a government pension or allowance increased with remoteness for Indigenous people but showed little variation for non-Indigenous people (Figure 7.5.1).
- A higher proportion of Indigenous people aged 15 and over received a government pension or allowance as their main source of income (52%) compared with non-Indigenous people aged 15 and over (25%). This was the case across all age groups (Figure 7.5.2).



Note: The 2014 GSS did not collect data for *Very remote* areas.

Source: AIHW analysis of ABS 2014 GSS (TableBuilder); AIHW analysis of ABS 2014–15 NATSISS (TableBuilder).

Figure 7.5.1: Main source of income, people aged 15 and over, by Indigenous status and remoteness area, 2014–15



Source: AIHW analysis of ABS 2014 GSS (TableBuilder); AIHW analysis of ABS 2014–15 NATSISS (TableBuilder).

Figure 7.5.2: Government pension or allowance as the main source of income, people aged 15 and over, by Indigenous status and age group, 2014–15

Income support

The Department of Social Services compiles Centrelink data on the number of recipients of various Centrelink income support payments and supplements. These data do not include payments made by the Department of Veterans' Affairs. In this section, 'income support payments' are defined as those that cannot occur concurrently, to avoid double counting. These payments include ABSTUDY, the Age Pension, the Disability Support Pension, The Carer Payment, Newstart Allowance and Youth Allowance. People receiving income support payments may also be receiving other allowances or supplements, such as the Carer Allowance or Family Tax Benefit.

At the end of the June quarter of 2016, around 45% of Indigenous Australians aged 15 and over (220,800 people) were receiving some form of Centrelink income support payment, compared with 26% of non-Indigenous Australians of this age (4.9 million people). Though the number of people receiving support payments has grown—from around 209,000 Indigenous Australians and 4.8 million non-Indigenous Australians at the end of June 2014—the proportions of the Indigenous and non-Indigenous populations receiving payments has not changed over this time (AIHW analysis of ABS 2014; DSS 2016).

The most common income support payments received by Indigenous Australians were Newstart Allowance, the Disability Support Pension and the Parenting Payment (Table 7.5.1).

Table 7.5.1: Main Centrelink income support payments received by Indigenous Australians, June quarter 2016

Income support payment	Number of recipients[a]	% of reference Indigenous population	Reference Indigenous population[a]	
Newstart Allowance	68,500	19.3	354,900	(aged 22–64)
Disability Support Pension	47,400	10.2	447,600	(aged 16–64)
Parenting Payment	44,400	9.6	463,500	(aged 15–64)
Youth Allowance	18,800	13.9	134,800	(aged 16–24)
Age Pension	18,200	58.7	31,000	(aged 65+)
Carer Payment	13,400	2.9	463,500	(aged 15–64)
ABSTUDY (Living Allowance)	8,900	1.9	463,500	(aged 15–64)
Total receiving Centrelink income support payments[b]	**220,800**	**44.6**	**494,500**	**(aged 15+)**

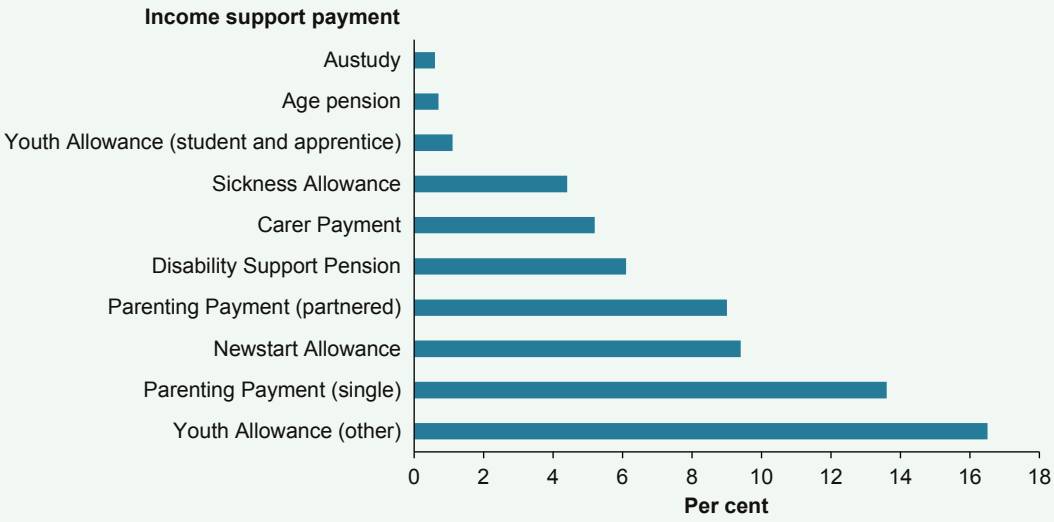
(a) Rounded to nearest hundred.

(b) Columns do not add to total as 'Total receiving Centrelink income support payments' includes other payment types not listed in the table.

Sources: AIHW analysis of ABS 2014; DSS 2016.

Centrelink data on income support recipients confirm that Indigenous Australians are more likely than non-Indigenous Australians to rely on government payments as their main source of income. These data show that almost 17% of recipients of Youth Allowance (other than student/apprentice), almost 14% of recipients of the single Parenting Payment, and around 9% of recipients of the Newstart Allowance and the partnered Parenting Payment were Indigenous Australians (Figure 7.5.3).

The comparatively low proportions of recipients of Austudy and the student and apprentice Youth Allowance who are Indigenous are due to the availability of ABSTUDY, which is an alternative payment specifically for Indigenous students.



Source: DSS 2016.

Figure 7.5.3: Share of Indigenous persons among recipients of specific income support payments, June quarter 2016

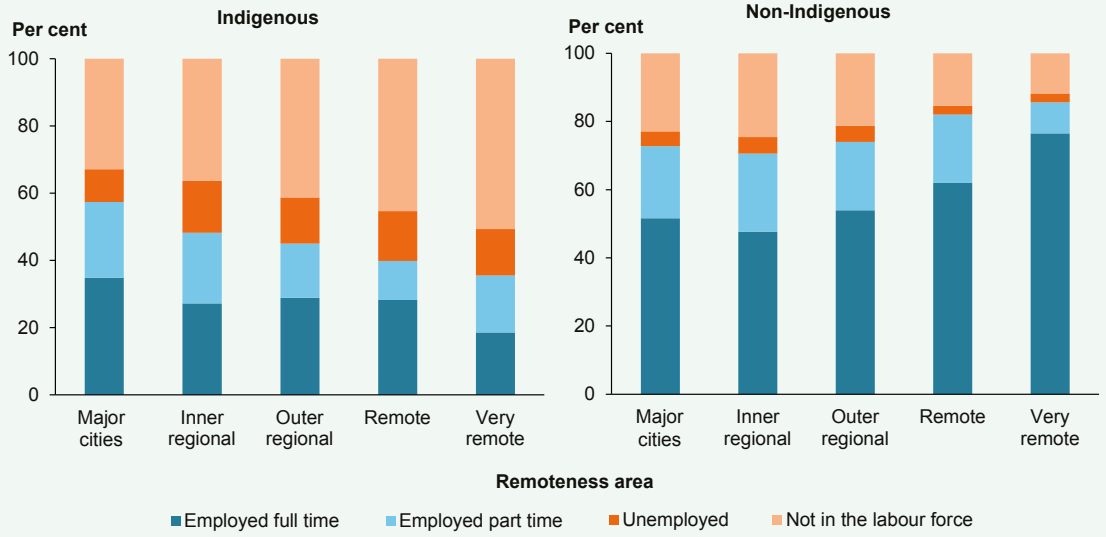
Employment

The labour force comprises all people who are employed (people who have worked for at least 1 hour in the reference week) or unemployed (people who are without work, but have actively looked for work in the last 4 weeks and are available to start work). The remainder of the population is not in the labour force.

According to the ABS 2014–15 NATSISS and the ABS 2014 Survey of Education and Work, among people aged 15–64:

- 61% of Indigenous Australians were in the labour force, compared with 77% of non-Indigenous Australians
- the proportion of employed Indigenous Australians decreased with remoteness, but the proportion of non-Indigenous Australians employed in remote areas was higher than in non-remote areas (Figure 7.5.4)
- the Indigenous unemployment rate (number of people unemployed as a proportion of people in the labour force) was 21% overall—it was lowest in *Major cities* (15%) and highest in *Very remote* areas (28%) (ABS 2016)
- most (92%) Indigenous Australians who were unemployed reported having had difficulties in finding work. The most commonly reported difficulties were that there were no jobs available; there were transport problems; they had no driver's licence; and had insufficient education, training or skills (AIHW analysis of ABS 2014–15 NATSISS (TableBuilder)).

Between 2004–05 and 2014–15, the proportion of Indigenous Australians aged 15–64 in the labour force remained relatively stable (60–65%) (SCRGSP 2016).



Source: AIHW analysis of ABS 2016.

Figure 7.5.4: Labour force status, people aged 15–64, by Indigenous status and remoteness area, 2014–15

Changes in Indigenous community employment programs mean that much of the 2014–15 Indigenous employment information is not comparable with that collected in the 2008 NATSISS (ABS 2016). In 2008, Indigenous people in communities could access the Community Development Employment Projects (CDEP) scheme; they received wages, and were classified in the 2008 NATSISS results as employed. In July 2013, the CDEP was replaced by the Remote Jobs and Communities Program; people accessing this program received income support payments and were classified in the 2014–15 NATSISS results as either unemployed or not in the labour force, depending on whether they were actively looking for work.

Excluding CDEP participants from the 2008 data provides comparable information about the proportion of Indigenous people aged 15–64 who were employed. These data suggest that there has been no change in the Indigenous employment to population ratio, which was 48% in both 2008 and 2014–15.

The Closing the Gap target for employment set by the Council of Australian Governments aims to halve the gap in employment between Indigenous and non-Indigenous Australians within a decade (by 2018). This target is not on track, with Indigenous employment rates (excluding CDEP participants) remaining stable at 48% and non-Indigenous employment rates falling slightly from 75.0% in 2008 to 72.6% in 2014–15 (PM&C 2017).

Main occupations and industry of employment

Data from the 2014–15 NATSISS show that the main occupations of employed Indigenous Australians aged 15 and over were as community and personal service workers (21%), followed by technicians and trades workers (16%), general labourers (16%) and professionals (13%). Only 6.2% listed their occupation in their main job as managers. For the non-Indigenous employed population aged 15 and above, data from the 2014 GSS show that the most common occupation was professionals (22%), followed by clerical and administrative workers (15%), technicians and trades workers (14%) and managers (14%). Less than 20% of employed Indigenous Australians aged 15 and over worked as managers or professionals, compared with 36% of non-Indigenous Australians (AIHW analysis of ABS 2014–15 NATSISS (TableBuilder) and AIHW analysis of ABS 2014 GSS (TableBuilder)).

The main industry or sector of employment for Indigenous Australians aged 15 and over was health care and social assistance (15%), followed by public administration and safety (11%). Three other sectors each had around 9% of total Indigenous employment (construction, accommodation/food services, and retail trade), with the mining sector accounting for a further 3.1% of employed Indigenous persons aged 15 and over in 2014–15 (AIHW analysis of ABS 2014–15 NATSISS (TableBuilder)).

Indigenous participation in the community services workforce

The provision of community services depends on having an adequate, accessible and skilled workforce. The community services workforce comprises people in paid employment who provide services such as personal and social support, child care, and special education services. This is complemented by the assistance of family members, other informal carers, and volunteers.

There is no agreed definition of which occupations make up the community services workforce. This chapter uses the definition outlined in Box 7.5.1, which was developed for *Australia's welfare 2013* in consultation with relevant Australian Government departments.

According to the 2014–15 NATSISS and the 2014 GSS:

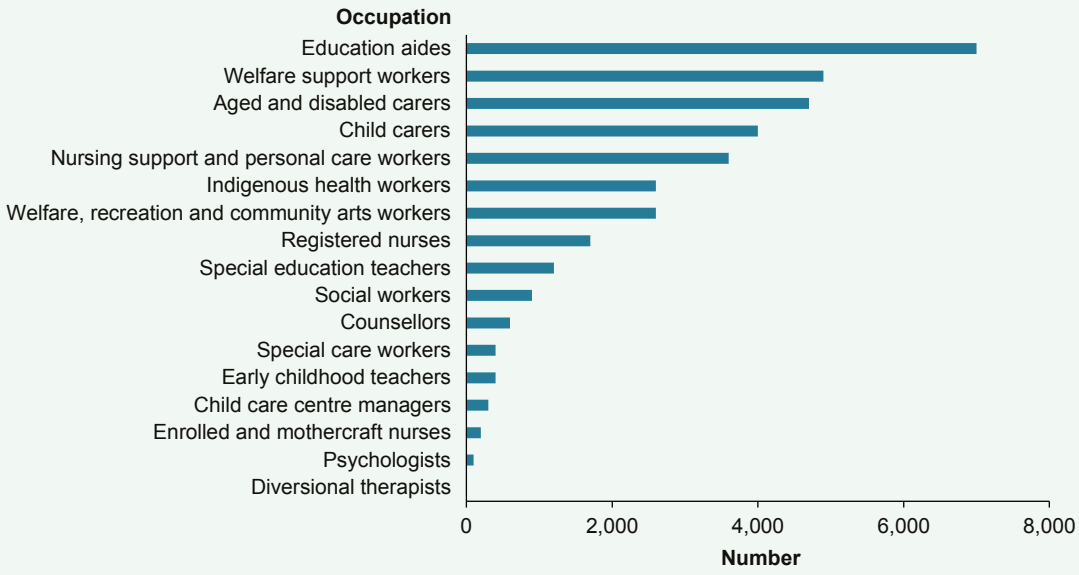
- an estimated 35,200 Indigenous Australians aged 15 or over worked in community services occupations, accounting for 3.7% of all community services workers
- the largest community services occupation group for Indigenous Australians was education aides (an estimated 7,000 workers), followed by welfare support workers (4,900) and aged and disabled carers (4,700) (Figure 7.5.5)
- Indigenous Australians are more likely than non-Indigenous Australians to be employed in the community services workforce. In 2014–15, 7.9% of the Indigenous population aged 15 or over was employed in community service occupations, compared with 5.0% of the non-Indigenous population of this age
- around 1 in 6 (17%) Indigenous Australians who were employed in 2014–15 were part of the community services workforce, compared with around 1 in 13 (7.8%) non-Indigenous employed people (AIHW analysis of ABS 2014–15 NATSISS (TableBuilder) and AIHW analysis of ABS 2014 GSS (TableBuilder)).

Box 7.5.1: Community services occupations

For the purposes of this chapter, 17 occupations are considered to be community services occupations, based on the Australian and New Zealand Standard Classification of Occupations (ANZSCO) (ABS 2013). These are:

- child care centre managers
- child care workers
- education aides
- early childhood (pre-primary school) teachers
- special education teachers
- registered nurses
- enrolled and mothercraft nurses
- nursing support and personal care workers
- Indigenous health workers
- counsellors
- psychologists
- social workers
- welfare support workers
- aged and disabled carers
- special care workers
- welfare, recreation and community arts workers
- diversional therapists.

This definition does not include some relevant occupations due to the absence of relevant categories in the ANZSCO (for example, employment services workers).



Source: AIHW analysis of ABS 2014–15 NATSISS (TableBuilder).

Figure 7.5.5: Indigenous people aged 15 or over employed in community services occupations, by occupation, 2014–15

Where do I go for more information?

Data on income and employment among Indigenous Australians are available in *The health and welfare of Aboriginal and Torres Strait Islander peoples: 2015* and the *Aboriginal and Torres Strait Islander Health Performance Framework*.

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7.6 Use of disability and aged care services by Indigenous Australians

Indigenous Australians with disability

Data from the Survey of Disability, Ageing and Carers (SDAC) show that, in 2015, one quarter (24%, 125,000 people) of Aboriginal and Torres Strait Islander Australians living in households reported living with disability—defined as any limitation, restriction or impairment which restricts a person's everyday activities, and has lasted, or is likely to last, for at least 6 months (see also Chapter 8.1 'People with disability') (ABS 2016a). After adjusting for differences in population age structure, Indigenous Australians were 1.8 times as likely as non-Indigenous Australians to be living with disability. Of Indigenous Australians with disability, 38,100 people (7.3% of the total Indigenous population) had severe or profound core activity limitation, meaning they sometimes or always need help with day-to-day activities related to self-care, mobility and communication (ABS 2016a).

Disability prevalence estimates are available from the 2014–15 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), but only for Indigenous people aged 15 and over. These estimates are markedly higher (45%, 199,800 people) than those from the 2015 SDAC (29%, 101,000 people); however, the scope and collection methodology for these two surveys differed (ABS 2016a, 2016b). For example, the SDAC used a larger set of screening questions, which are more effective in differentiating between people with disability and people with long-term health conditions but no disability; this may have contributed to the higher estimates from the NATSISS (ABS 2016a). As well, the SDAC did not include people living in *Very remote* areas and discrete Indigenous communities. Excluding *Very remote* areas from the NATSISS data, however, does not change the estimated disability prevalence rate among Indigenous people aged 15 and over (45%, 173,200 people). Estimates of Indigenous people aged 15 and over with a profound or severe core activity limitation—which has a much narrower definition than overall disability—are similar across the two surveys (NATSISS—7.7%, 34,300 people; SDAC—7.6%, 26,300 people).

Use of disability support services

Under the National Disability Agreement (NDA), government services are provided to people with disability to assist them with areas of daily living, such as accommodation, community involvement and employment. Data on the use of these services are collected and reported by the AIHW in the Disability Services National Minimum Data Set (DS NMDS).

In 2015–16, around 19,300 Indigenous Australians used disability support services under the NDA, accounting for 5.8% of service users. Indigenous service users were generally younger than non-Indigenous service users, with an average age of 28 compared with 35.

Intellectual disability was the most common primary disability reported by Indigenous and non-Indigenous service users (28% and 25%, respectively), followed by physical disability (19% for both) and psychiatric disability (18% and 20%, respectively).

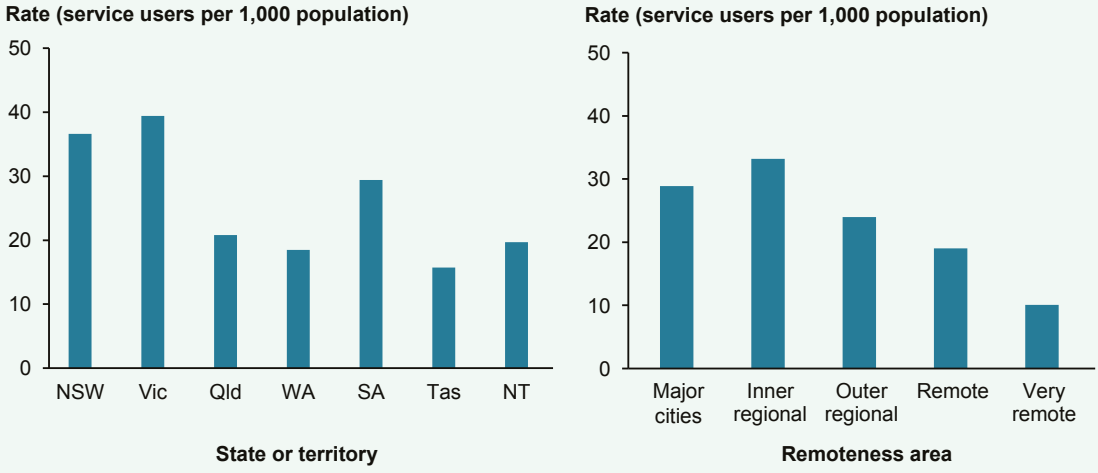
The most common service group used by Indigenous service users was community support (54%), followed by employment (37%), community access (13%), respite (12%) and accommodation support (11%). By comparison, the most common service group used by non-Indigenous service users was employment (46%), followed by community support (44%), community access (15%), accommodation support (12%) and respite (11%).

Almost all service users were aged under 65 (97% of Indigenous and 94% of non-Indigenous service users). After adjusting for differences in population age structure, Indigenous Australians aged under 65 used disability support services at almost twice the rate of non-Indigenous Australians aged under 65 (27 per 1,000 compared with 14 per 1,000 population).

Location

In 2015–16, the rates of Indigenous people using disability support service were highest in Victoria and New South Wales (39 and 37 per 1,000 population, respectively) and lowest in Tasmania (16 per 1,000) (Figure 7.6.1).

The rate at which Indigenous people aged under 65 used disability support services was higher in non-remote areas than in remote areas (Figure 7.6.1).



Note: The Australian Capital Territory Government did not collect DS NMDS data in 2015–16.

Figure 7.6.1: Crude rates (per 1,000 population) of Indigenous people aged under 65 using disability support services, by state and territory and by remoteness area, 2015–16

Labour force

In 2015–16, the proportion of disability support service users aged 15 and over who were in the labour force was similar for Indigenous (68%) and non-Indigenous (70%) people. Among those in the labour force, Indigenous service users were less likely to be employed (21%) than non-Indigenous service users (34%).

National Disability Insurance Scheme

From 1 July 2013, users of disability support services in trial sites began moving to the National Disability Insurance Scheme (NDIS) (see Chapter 8.1 'People with disability' for more information). The NDIS aims to provide Australians aged 65 and under who have permanent and significant disability with the reasonable and necessary support to participate in everyday life (NDIA 2016a). With the progressive roll out of the NDIS across Australia, it is expected that many existing NDA service users will move to it and cease to be counted in the DS NMDS collection over time.

Data on the NDIS are collected by the National Disability Insurance Agency (NDIA) (the independent statutory agency implementing the NDIS) and published in quarterly reports. As at 31 December 2016, Indigenous Australians represented 5.2% (3,200 people) of the 61,200 people with approved plans who are participating in the NDIS (NDIA 2016b). In comparison, of the 4.1 million people with disability living in households in 2015 (based on SDAC data), 3.1% were Indigenous (125,000). Among people with severe or profound disability (1.2 million people), 3.2% were Indigenous (38,100 people) (ABS 2016a).

Aged care services

Aged care support is available to older Australians through three main types of care—the Home Care Packages Program, residential aged care and the Commonwealth Home Support Programme (CHSP) (see Chapter 5.1 'Ageing and aged care' for more information). Data on Indigenous status in the CHSP are not yet available for reporting; for more information see 'What is missing from the picture?' later in this chapter.

Information in this article relates to the use by Indigenous Australians of services in mainstream programs. Flexible care programs are also available, including one specifically aimed at older Indigenous people—the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. As at 30 June 2015, 31 aged care services were funded to deliver 802 aged care places through this program (Department of Health 2015).

Target population

The Indigenous population has a younger age structure and shorter life expectancy than the non-Indigenous population. Conditions associated with ageing may also affect Indigenous Australians earlier. Given these circumstances, the aged care target population comprises Indigenous Australians aged 50 and over and non-Indigenous Australians aged 65 and over.

Of the 3.8 million Australians in the aged care target population in 2016, around 112,000 (3.0%) were Indigenous people.

Home Care

The Home Care Packages Program is designed to provide clients with an individually tailored and coordinated package of services to support them in living independently in the community for as long as possible. Home Care Packages are available at four levels of care. Progressively higher levels of help are offered to support people with basic, low, intermediate, or high care needs.

It should be noted that more than one-third (36%) of home care client records in 2016 did not include Indigenous status (Table 7.6.1). Hence, these data should be used with caution.

As at 30 June 2016, 4.2% of Home Care clients with recorded Indigenous status in client records identified as Indigenous Australians. Of those clients with recorded Indigenous status, 3.9% of those receiving level 1 (basic) care and 5.3% of those receiving level 2 (low) care were Indigenous (Table 7.6.1).

Table 7.6.1: Proportion of people using Home Care Packages, by level of care and Indigenous status, 30 June 2016

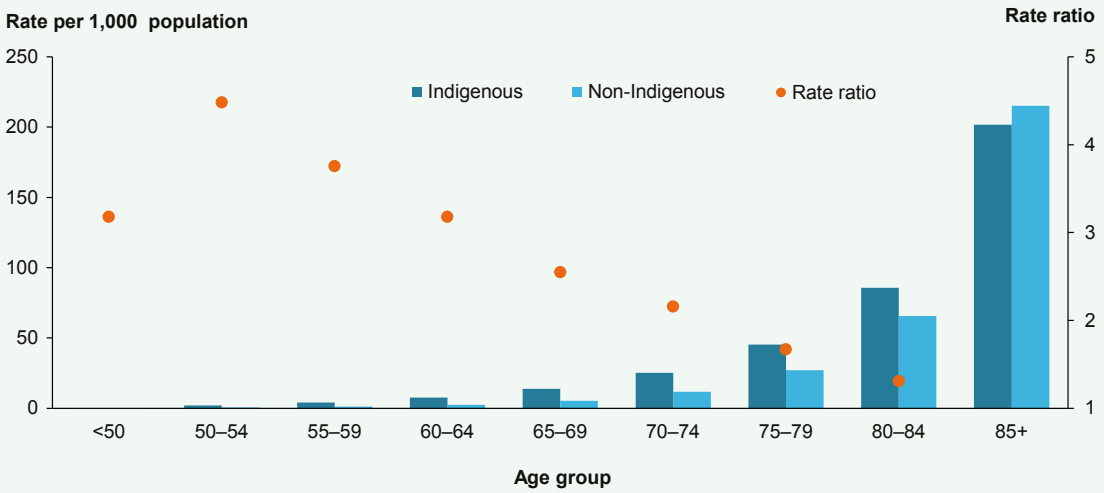
Indigenous status	Home Care levels of care				
	Level 1 (basic care)	Level 2 (low care)	Level 3 (intermediate care)	Level 4 (high care)	Total Home Care
	% of total clients				
Indigenous	1.7	3.3	1.4	1.5	2.7
Non-Indigenous	42.9	58.2	60.3	72.1	61.4
Not stated	*55.3*	*38.6*	*38.3*	*26.3*	*35.9*
All clients	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
	% of clients with recorded Indigenous status				
Indigenous	3.9	5.3	2.2	2.1	4.2
Non-Indigenous	96.1	94.7	97.8	97.9	95.8
Clients with recorded Indigenous status	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Note: Columns may not add to 100% due to rounding.

Residential aged care

As at 30 June 2016, there were 1,531 Indigenous Australians in permanent residential aged care. This represents 0.9% of permanent residential aged care residents and 0.2% of the total Indigenous population.

The age profile of Indigenous people in permanent residential aged care was substantially younger than that of non-Indigenous people. One-quarter (26%) of Indigenous permanent aged care residents were aged under 65 compared with only 3.3% of non-Indigenous aged care residents. Indigenous Australians had higher rates of aged care use in all age groups until age 85 (Figure 7.6.2).



Note: Rate ratio not shown on graph if ratio is less than 1.

Figure 7.6.2: Rate (per 1,000 population) and rate ratio for use of permanent residential aged care, by Indigenous status and age group, as at 30 June 2016

As at 30 June 2016, the rate of Indigenous Australians in permanent residential aged care was highest in *Remote and very remote* areas and lowest in *Major cities* (Figure 7.6.3).

The pattern of aged care residents by remoteness differed for Indigenous and non-Indigenous people, with around one-third (31%) of Indigenous aged care residents in *Major cities*, compared with more than two-thirds (70%) of non-Indigenous residents. The observed patterns of aged care residents by remoteness closely mirrors the corresponding aged care target population patterns (Figure 7.6.3).

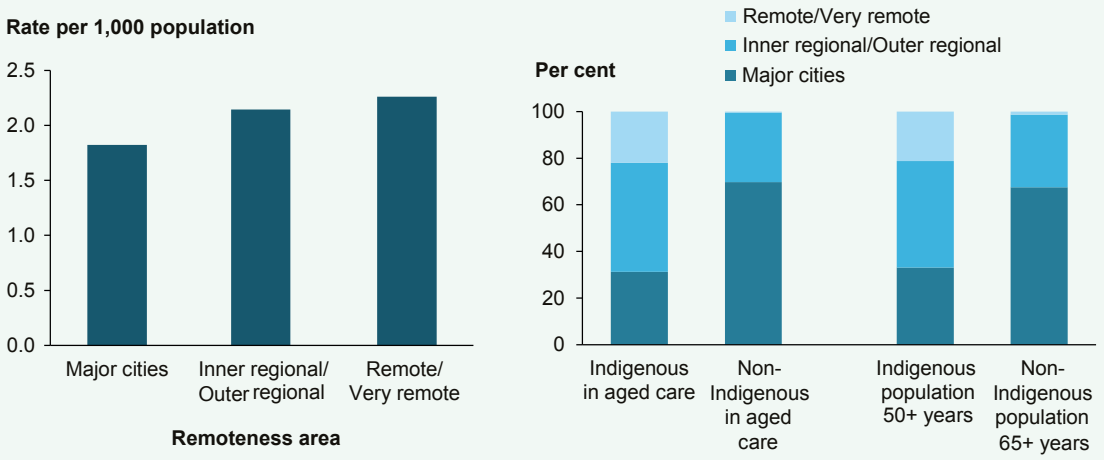


Figure 7.6.3: Crude rate of Indigenous people in permanent residential aged care by remoteness area and proportion of people in permanent residential aged care and proportion of population, by Indigenous status and remoteness area, as at 30 June 2016

What is missing from the picture?

The CHSP was launched in July 2015. It incorporates Home and Community Care (HACC) and several smaller programs, and is the largest of the aged care programs. Because of the transition to a new system some data items, including Indigenous status, were unavailable for reporting in the first year (2015–16).

As self-identifying one's Indigenous status is not compulsory, the number of people presented who identified themselves as being of Aboriginal and Torres Strait Islander origin may be an underestimate of the true number of Indigenous people using these programs.

Information about geographical location (remoteness) is based on the location of the service provider for all programs except HACC. Although the location of care recipients can be inferred from the location of service providers, some care recipients may live outside the geographical areas or jurisdictions of service providers.

Some socio-demographic characteristics of care recipients are recorded when they apply for care; these may have changed by the time recipients are receiving care. These include usual residence status and living arrangements.

Where do I go for more information?

More information about use of disability support services by Indigenous Australians is available from *Disability support services: services provided under the National Disability Agreement 2015-16* and the *Aboriginal and Torres Strait Islander Health Performance Framework*.

More data about the use of aged care services by Indigenous Australians are available from the AIHW National Aged Care Data Clearinghouse.

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Chapter 8

Disability and carers

8.0 Introduction

As has been reported throughout *Australia's welfare 2017*, some Australians face profound disadvantages. These can affect not only their physical and mental health, but also their participation in education, employment and social activities. This chapter profiles Australians living with disability and discusses some of the challenges they face, including being meaningfully involved in everyday life.

Living with disability may limit what a person can do in their daily life, or restrict their participation in other ways. Socioenvironmental factors can add to these difficulties—for instance, availability of services, accessibility of the physical environment, and social attitudes towards people with disability. How people with disability participate in society can also be influenced by the opportunities and help available to them, as well as by the severity of their disability.

About 4.3 million Australians (or 18% of the population) have a disability, and about 1.4 million people with disability have a severe or profound core activity limitation. This means that they sometimes or always need help with everyday activities—self-care, mobility and communication.

While the number of people with disability has increased over time (from 4 million in 2003), the proportion of the population with disability has decreased (from 20% in 2003 to 18% in 2015).

The majority of people with disability live in households; only 4.5% live in some form of cared accommodation. People with disability are about 4 times as likely as people without disability to rely on a government pension or allowance as their main source of income. While around 1.1 million people with disability of working age participated in the labour force in 2015, almost as many (1.0 million) did not.

Almost all people with disability take part in some social activities away from home, but this involvement differs by the severity of disability. People with severe or profound limitation are less likely to leave home to take part in everyday activities as often as they would like.

This chapter also profiles Australia's 2.7 million informal carers—about one-third of whom are primary carers for a person with disability. The time and costs of providing care to another person can present challenges for carers. There may be increased financial stress, limited access to education and employment, and restricted involvement in social and community life. One-third of primary carers spend 40 hours or more per week caring for the recipient of care, and one-third have spent 10 or more years in the caring role.

8.1 People with disability

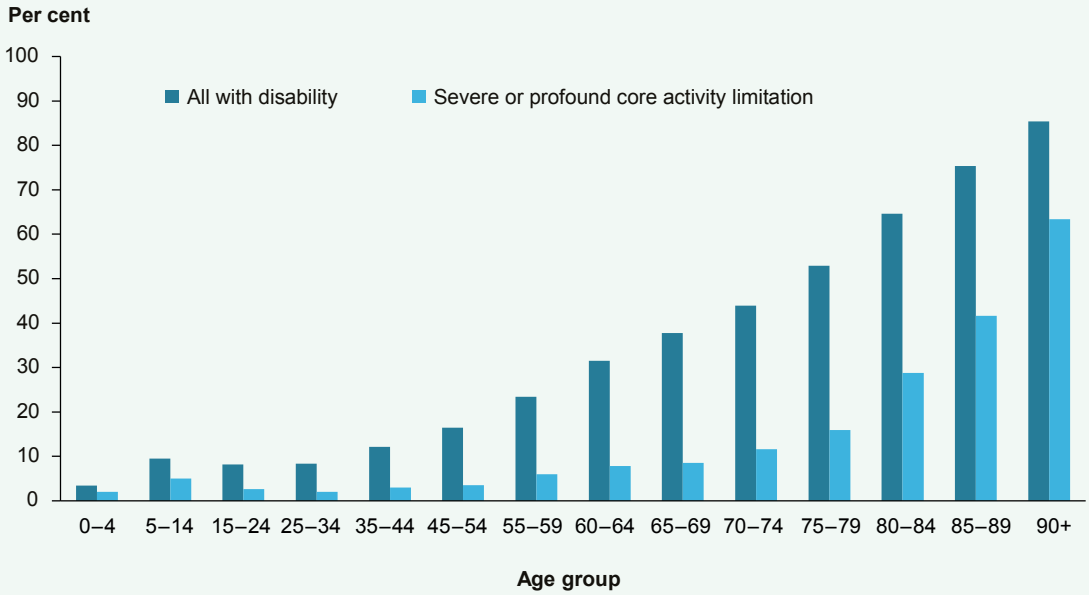
The World Health Organization estimates that 15% of the world's population (1 billion people) have disability, which it defines as any impairment, activity limitation or participation restriction (WHO 2016). The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC) collects information on the wellbeing, functioning and social and economic participation of people with disability in Australia. The SDAC uses a broad construct of disability (Box 8.1.1) designed to align with the WHO's International Classification of Functioning, Disability and Health 2001 (ABS 2016).

Box 8.1.1: Australian Bureau of Statistics definition of disability

The ABS SDAC defines a person with disability as someone who has one or more specified types of limitations, restrictions or impairments that restrict everyday activities, and which has lasted (or is likely to last) for at least 6 months. The severity of disability is further defined by the degree of assistance or supervision required in core activities—self-care, mobility and communication—and grouped for mild, moderate, severe and profound limitation. People can also be identified as having a disability and schooling or employment restriction only, or disability and no restriction or limitation (ABS 2016). The concept 'people with disability' contains all of these definitions, and thus also includes 'people with severe or profound limitation'.

How many Australians have disability?

In 2015, an estimated 4.3 million Australians had disability—nearly 1 in 5 people (18%). While the number of people with disability has increased over time, from 4 million in 2003, the proportion of the population with disability has decreased (from 20% in 2003) (see Chapter 9.2 'Indicators of *Australia's welfare*'). Of the 4.3 million people with disability, about 1.4 million (or 5.8% of the total population) had severe or profound core activity limitation. This means that they sometimes, or always, need help with day-to-day activities related to self-care, mobility and communication. The likelihood of having disability or severe or profound core activity limitation generally increased with age (Figure 8.1.1).



Source: ABS 2016.

Figure 8.1.1: Proportion of the population with disability and severe or profound core activity limitation, by age group, 2015

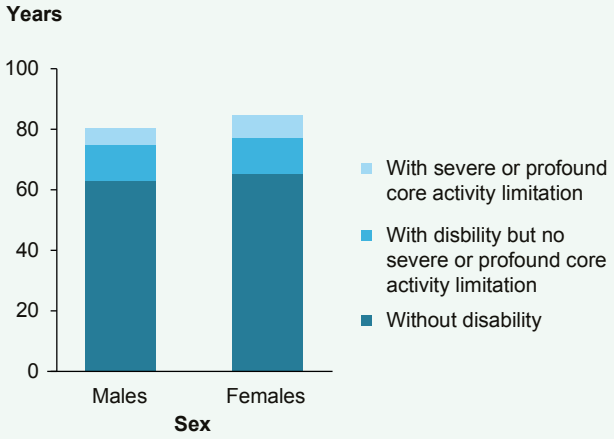
The SDAC also found that, in 2015:

- disability prevalence was similar for males (18%) and females (19%), but females were slightly more likely to report severe or profound core activity limitation (6.4%) than males (5.3%)
- around 8% of people with disability reported having schooling or employment restrictions (see Chapter 8.2 'Participation in society by people with disability' for more information on education and employment for people with disability)
- close to 4 in 5 people (79%) with disability reported a physical condition as their main long-term health condition, with the rest reporting a mental or behavioural disorder (21%). In recent years, there has been a notable increase in people who report mental and behavioural disorders as their main long-term condition—up from 17% in 2009 and 19% in 2012
- the majority of people with disability lived in households—with 75% living with others and 21% living alone. The remaining 4.5% lived in cared accommodation
- a government pension or allowance was the main source of personal income for 42% of people with disability of working age (15–64) living in households, followed by wages or salary (37%). By comparison, wages or salary was the main source of personal income for the majority (68%) of people of working age without disability: fewer than 1 in 10 (8.5%) reported a government pension or allowance as their main source of personal income

- more than half (59%) of people with disability living in households reported needing help with at least 1 of 10 specified activities of daily living. These activities included self-care, mobility, communication, cognitive or emotional tasks, health care, reading or writing tasks, transport, household chores, property maintenance and meal preparation. The most common activity requiring assistance was health care (29%), followed by property maintenance (27%)
- of people who need help with daily activities, 62% reported their needs were fully met, 35% partly met and 2.7% not met at all. The most common activities for which a need for assistance was not fully met were property maintenance (7.7%) and cognitive or emotional tasks (7.5%)
- of people aged 15 and over living in households who received assistance from organised services in the 6 months before the survey, the majority (85%) were satisfied with the quality of service received (where the level of satisfaction could be determined).

How long can we expect to live with and without disability?

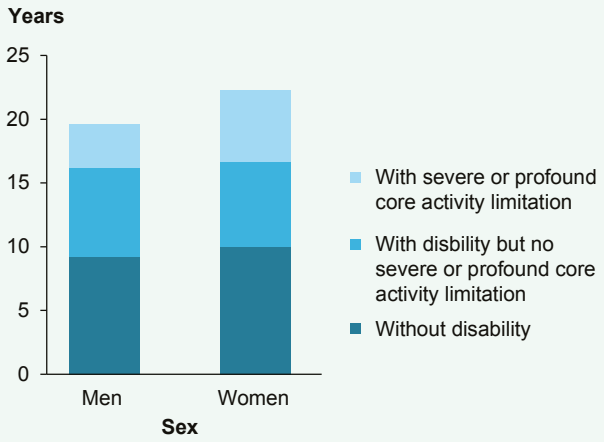
The life expectancy of Australians has continued to increase for both males and females in recent decades. Most of these increases correspond to an increase in disability-free life expectancy, which is the expected number of years living without disability. Between 2003 and 2015, the disability-free life expectancy increased from 59.1 years to 63.0 years for males, and from 62.2 years to 65.2 years for females.



Source: AIHW analysis of unpublished ABS SDAC 2015 data and unpublished ABS abridged Australian life tables 2013–2015.

Figure 8.1.2: Expected number of years of life with and without disability at birth, by sex, 2015

On average, boys born in 2015 could expect to live 63 years without disability and another 17 years with disability, including 5.4 years with severe or profound core activity limitation (Figure 8.1.2). Girls born in 2015 could expect to live an average of 65 years without disability and another 19 years with disability, including 7.5 years with severe or profound core activity limitation.



Source: AIHW analysis of unpublished ABS SDAC 2015 data and unpublished ABS abridged Australian life tables 2013–2015.

Figure 8.1.3: Expected number of years of life with and without disability at age 65, by sex, 2015

Life expectancies at birth are influenced by mortality in early life. Hence, looking at life expectancies at age 65 provides an insight into healthy ageing (Figure 8.1.3). Men aged 65 in 2015 could expect to live, on average, a further 9 disability-free years, followed by 10 years with disability, including 3 years with severe or profound core activity limitation. Women aged 65 could expect to live, on average, a further 10 years without disability and another 12 years with disability, with close to half of those 12 years being with severe or profound core activity limitation.

The disability-free life expectancy estimates of people aged 65 are average estimates for the total population of that age group, including people who already have disability. As such, the number of expected years of life with disability for a person who does not have a disability at age 65 would be fewer than those presented, which average the experience of people both with and without disability at age 65.

Further information on disability-free life expectancy is presented in Chapter 9.2 'Indicators of *Australia's welfare*'.

What support services are available to people with disability?

The disability services environment has changed a lot in recent years. Since 1991, government-funded services for people with disability have been provided under various iterations of the National Disability Agreement (NDA) (see Box 8.1.2). In 2012, the Australian Government introduced the National Disability Insurance Scheme (NDIS) (see Box 8.1.3), which is expected to largely replace the NDA over time.

Both the NDA and the NDIS reflect the intention of the Australian Government to improve the lives of people with disability, their families and carers. This intent is captured in the National Disability Strategy 2010–2020 (DSS 2016b) (see Box 8.1.4).

How many people receive support under the National Disability Agreement?

Under the NDA, government services are provided to people with disability to help them with aspects of daily living, such as accommodation, community involvement and employment.

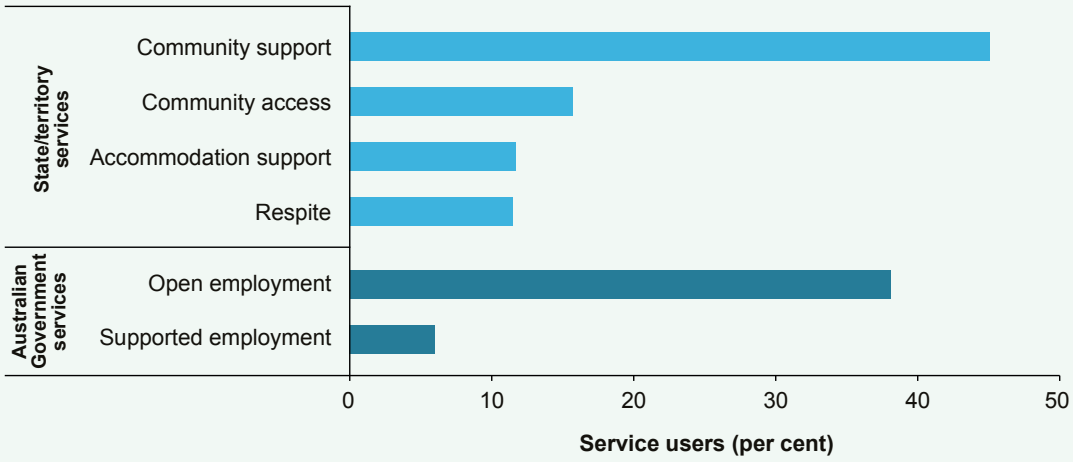
Box 8.1.2: National Disability Agreement

Under the NDA, the Australian and state and territory governments fund a range of disability support services that aim to ensure 'people with disability and their carers have an enhanced quality of life and participate as valued members of the community' (COAG 2009). Eligibility requirements vary between jurisdictions, and the service a person can receive is largely subject to availability (for example, based on the number of available places in certain programs). Services are mainly delivered by 'block-funded' providers, with funding allocated directly to the provider.

Information on the use of services under the NDA is collected and reported by the AIHW in the Disability Services National Minimum Data Set (DS NMDS).

In 2015–16, around 332,000 people used disability support services under the NDA. (Note, however, that this is an underestimate as it excludes data from the Australian Capital Territory Government, which did not collect data in 2015–16.) The average age of service users was 35, and 5.8% were aged 65 or over. More than half (59%) were male and 6.0% were Indigenous. Intellectual disability was the most common primary disability type of service users (25%), followed by psychiatric disability (20%) and physical disability (19%).

Community support services, which support a person with disability in living in a non-institutional setting, were the most commonly used services (45%) (Figure 8.1.4). The next most commonly used services were open employment services (38%), which help people to gain and/or retain employment in the open labour market.



Note: People can use more than one type of service.

Source: Disability Services National Minimum Data Set 2015–16.

Figure 8.1.4: Proportion of disability support service users by service group, 2015–16

Transition of National Disability Agreement service users to the National Disability Insurance Scheme

Although most NDA service users are expected to move to the NDIS as it is rolled out, not all users will be eligible. For example, people aged 65 and over are not eligible to enter the NDIS, but those who turn 65 after becoming an NDIS participant may continue to receive support until they enter the aged care system. As well, some specialist disability support programs, such as open employment services, will not be included in the NDIS and will continue to operate separately. In 2015–16, there were 19,090 NDA service users aged 65 or older, and 126,470 who used open employment services. As not all users of services under the NDA will be supported under the NDIS, governments have set up 'continuity of support' arrangements. These will allow people who do not meet requirements for NDIS entry to continue to receive support services consistent with their current arrangements.

During 2015–16, 3,500 NDA service users were reported in the DS NMDS as having moved to the NDIS, adding to the 9,600 reported to have made the transition since the start of the NDIS. The data published by the National Disability Insurance Agency (NDIA) on people with an approved and active NDIS plan might not match the DS NMDS data on NDA service users who moved to the NDIS (see next section). There are several reasons for this. For instance, the NDIA data include data for people who have not been reported as part of the DS NMDS, such as people referred directly to the NDIS. This is especially the case for very young children and people who meet the early intervention eligibility requirements under the NDIS.

How many people receive support under the National Disability Insurance Scheme?

According to the NDIA, 74,900 people with approved plans were participating in the NDIS (known as 'active participants') as at 31 March 2017 (NDIA 2017b). This excludes 700 people who had received an approved plan but have since exited the scheme, bringing the total number of people who have received support from the NDIS to 75,600. As well, almost 2,400 children have received a referral to the Early Childhood Education Intervention gateway. This initiative is designed to connect children aged 0–6 with early childhood providers to identify needs and provide timely access to information and support.

Box 8.1.3: National Disability Insurance Scheme

The NDIS aims to provide Australians with permanent and significant disability with the reasonable and necessary support needed to participate in everyday life (NDIA 2016). The NDIS is a substantial change to how services are provided to people with disability in Australia. Arrangements under the NDA largely see service providers funded for places in a set number of assistance programs. On the other hand, NDIS participants receive an individualised plan of the support needed to achieve their goals, and a funding package to purchase this support.

The NDIS was introduced through trial sites from 1 July 2013. The transition to the full scheme will occur progressively from 1 July 2016. The roll out of the NDIS varies by state and territory. In some jurisdictions, it is being rolled out geographically: people enter it at different times, according to where they live. In other jurisdictions, people enter it at different times according to their age. Full national roll out is scheduled to be completed by 1 July 2019 in all states and territories except for Western Australia, where roll out will be completed by 1 July 2020 (NDIA 2017a).

The NDIA—an independent statutory agency whose role is to implement the NDIS—collects data on the NDIS, and publishes them in quarterly reports.

NDIS active participants were younger than NDA service users, and more than half of them (52%) were aged 18 and under, as at 31 March 2017 (NDIA 2017b). The majority of participants were male (63%) and 5.1% were Indigenous. Intellectual disability was the most common primary disability group of participants (37%), followed by autism (28%) and psychosocial disability (6.5%).

Once the NDIS is fully implemented, it is estimated that it will support 475,000 people with significant and permanent disability—460,000 aged under 65; and 15,000 aged 65 and over who entered the scheme before turning 65 (Productivity Commission 2017). This represents about 11% of all people with disability in Australia (based on SDAC estimates), and 64% of people with severe or profound disability aged under 65.

Box 8.1.4: The National Disability Strategy

The National Disability Strategy 2010–2020 (DSS 2016b) outlines the shared national vision for improving the lives of Australians with disability, their families and carers. It is an important mechanism to ensure the principles underpinning the United Nations Convention on the Rights of Persons with Disabilities (UN 2006) are incorporated into policies and programs across all levels of government. The Strategy embodies a national approach to inclusive public policy development and to improved access to mainstream services.

The Strategy's first implementation plan, *Laying the groundwork 2011–2014*, set the foundations to drive reform in the planning and delivery of both mainstream and disability specific programs and services. The second implementation plan, *Driving action 2015–2018*, builds on ongoing commitments to improve outcomes for people with disability.

What financial support is available for people with disability?

As well as support services (such as those mentioned in this article that are received under the NDA or through the NDIS), people with disability may be eligible to receive financial assistance to help with activities of daily life. The Disability Support Pension and the Mobility Allowance are two such programs (DSS 2016a). Other financial support, such as to assist with study or housing, may also be available for people with disability.

In 2015–16, close to 782,900 people received the Disability Support Pension. This pension provides financial support for people with a physical, intellectual or psychiatric condition who are unable to work for 15 hours or more per week within the next 2 years because of their impairment and who have participated in a program to help prepare for, find or maintain work; or for people who are permanently blind (DHS 2017; DSS 2016a). The pension is available to people aged between 16 and the age pension age. Pension recipients represent about 18% of the total estimated number of people with disability in 2015 (according to SDAC), and about 36% of people with disability aged 15–64 (the closest comparable age group).

The Mobility Allowance was provided to about 60,000 recipients in 2015–16. This financial support helps with transport costs for people aged 16 and over who cannot use public transport without substantial assistance and who are participating in approved activities, such as work or study.

People with disability may also be eligible for various government concession cards, which provide recipients with access to selected goods and services at a discounted rate (DSS 2017) (see also Chapter 1.3 'Understanding welfare'). People getting the Disability Support Pension will automatically be issued with a Pensioner Concession Card. People who receive the Mobility Allowance but not the Disability Support Pension will receive a Health Care Card. State and territory governments, local governments and private businesses may provide further concessions for health, household costs, education or transport.

Financial support for children with disability is available through payments made to their parents or carers, such as the Child Disability Assistance Payment, which is available to recipients of the Carer Allowance (see Chapter 8.3 'Informal carers').

What is missing from the picture?

It is currently not possible to provide a full picture of the experiences of people with disability in Australia and how these might be changing over time. People with disability interact with every aspect of social policy and programs in Australia. They access both specialist and mainstream services across a wide variety of areas. Although there are many data collections across different agencies that collect information on people with disability (such as the AIHW, the ABS, the Department of Social Services and the NDIA), there is currently no national process to collectively report on available data in a person-centred way, understand data quality issues, or to identify and fill data gaps.

While there is no denying that a comprehensive and consolidated picture of the experiences of, and outcomes for, people with disability is desired, there are challenges involved in doing so. Currently, specialist disability support services are provided through multiple avenues—including under the NDA, NDIS, Basic Community Care, and Disability Employment Services. Hence, the total number of people receiving disability support services, and the extent of overlap of users, is difficult to determine. There are also challenges related to the varying definitions of disability used across different sources of data. Disability is generally defined depending on the type and purpose for which the data were collected. This means that definitions may differ between population surveys as well as in administrative data.

Adding to the challenge, most mainstream services (for example, health and aged care) do not include a way to identify whether a person has disability. So, comprehensive reporting on the use of these services by people with disability, and on the interactions between specialist and mainstream services, is not possible. To help address this, the AIHW has developed a disability 'flag' that can be used to identify records of people with a disability within mainstream data collections. The flag derives from a standard set of questions that assesses a person's level of functioning and need for support in everyday activities. These questions are based on the International Classification of Functioning, Disability and Health, and are broadly consistent with the short disability questions that the ABS uses in a number of its social surveys. Versions of the flag have been implemented in the AIHW's Specialist Homelessness Services Collection and the National Prisoner Health Data Collection, and are in the process of being implemented within other AIHW collections. A wider implementation of the flag would improve the ability to report more comprehensively on people with disability, and to do so in a more person-centred way.

Data linkage is another option that could be used to more comprehensively examine the experiences of people with disability than is possible from a single source. For example, linking disability support services or payments data to national hospital data, the Medicare Benefits Schedule or the Pharmaceutical Benefits Scheme could provide an insight into how people with disability interact with mainstream health services, and how these services complement specialist disability supports. Likewise, linking disability support services data to aged care could help improve understanding of the interactions between these two sectors. Chapter 1.7 'Understanding health and welfare data' explores further the opportunities and challenges associated with using data linkage to fill data gaps, including those related to disability.

Where do I go for more information?

For more information relating to disability and the use of disability support services, see www.aihw.gov.au/disability/. The AIHW reports *Disability support services: services provided under the National Disability Agreement 2015–16* and *Life expectancy and disability in Australia: expected years living with and without disability*, and other recent publications related to disability in Australia are available for free download. Information on people with disability from the most recent ABS SDAC is available from Disability, ageing and carers, Australia: Summary of findings, 2015.

The NDIS website, https://www.ndis.gov.au, provides information about the scheme for people with disability, families and carers, services providers and the wider community.

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8.2 Participation in society by people with disability

The *United Nations Convention on the Rights of Persons with Disabilities* sets out rights for people with disability, one of which protects the right of people with disability to participate fully in all aspects of life (United Nations 2006). However, people with disability often face challenges in doing so, and their rates of participation in education, employment and social activities are generally lower than for people without disability.

Any disability may limit the activities a person undertakes in their daily life (such as tasks relating to self-care, mobility and communication), or restrict their participation in other ways. How people with disability participate in society can also be affected by the opportunities and assistance available to them, and by the severity of their disability.

The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC) uses a broad construct of disability, defining it as any limitation, restriction or impairment that restricts a person's everyday activities, and has lasted, or is likely to last, for at least 6 months (see Chapter 8.1 'People with disability' for more detail). Almost 1 in 5 (18%) Australians—4.3 million people—had a disability in 2015. This represented an increase of 8.7% from 2003, at the same time as the general population increased by almost 19%. Around 1 in 3 people with disability (1.4 million) had severe or profound limitation.

The following article presents key findings from AIHW analyses of the 2003 and 2015 ABS SDAC. More detail is available in the related fact sheets (see 'Where do I go for more information?').

Trends in education and work

School attendance

In 2015, there were 336,000 children and younger people with disability aged 5–20 living in households in the community and attending school or an educational institution. This represents 1 in 14 (7.1%) people in this age group. The number of students with disability increased by 4.0% between 2003 and 2015, growing at a slower rate than the number of people in the same age group in the general population (up by 9.2%). At the same time, the number of students with severe or profound limitation increased by 11%.

For students with disability, common schooling options are special schools (those that enrol only students with special needs), special classes within a mainstream school (those that specifically support students with special needs), or ordinary classes within a mainstream school (where students with disability may receive extra, tailored supports). Between 2003 and 2015, there was a shift towards students with disability attending special schools. The number of students who attended a special school increased by 35% for people with disability, and by 31% for people with severe or profound limitation. In 2015, 15% of children and young people with disability, and 26% of students with severe or profound limitation, attended a special school. At the same time, fewer students attended special classes within a mainstream school environment—decreasing from 2003 by 22% for people with disability, and by 8.0% for people with severe or profound limitation. In 2015, 19% of students with disability, and 22% of people with severe or profound limitation, attended special classes in a regular school.

An increasing number of students with disability also needed assistance in other ways with their schooling. This included help provided by a person, by using special equipment, or through other arrangements such as for access, transport or assessment. The need for part-time attendance at school increased considerably. Between 2003 and 2015, the number of students requiring 1 or more days off school each week increased by 47% for people with disability, and by 79% for people with severe or profound limitation. In 2015, 10% of students with disability and 14% of people with severe or profound limitation attended school part-time.

Employment

Labour force participation

Around 1.1 million working-age people (aged 15–64) with disability living in households participated in the labour force, either by working or looking for work in 2015. Almost as many people with disability did not participate in the labour force (1.0 million), with more than half (57%) of them reporting having an employment restriction that meant they were permanently unable to work.

The number of people with disability in the labour force has fallen by 3.0% between 2003 and 2015. This is similar to the 3.3% fall in the overall number of working age people with disability living in households over that period. At the same time, the number of working age people without disability participating in the labour force increased by 23%.

There has been little change in the overall labour force participation rate for people with disability. Around half of working age people with disability were participating in the labour force (53% in 2003 and 2015), compared with 81% and 83%, respectively, for the overall population. The rate of labour force participation varied by the severity of people's disability. Two-thirds (68%) of people with disability and schooling or employment restrictions only, and one-quarter (25%) of people with severe or profound limitation (down from 30% in 2003), were either employed or looking for work in 2015.

Employment

In 2015, around 580,000 working age people with disability were employed full time, and 453,000 part time. The number of people with disability who were working fell (down by 4.6% from 2003), and considerably fewer people with severe or profound limitation were working (down by 17%). In 2015, half (48%) of working age people with disability, and 22% of people with severe or profound limitation, were employed, compared with 79% of people without disability.

The patterns of work changed between 2003 and 2015, with a trend towards part-time work. Between 2003 and 2015, the number of people with disability working full time dropped by 16%, and the number of people with severe or profound limitation by 41%. At the same time, the numbers of those working part time increased by 14% and 7.4%, respectively. By comparison, the number of people without disability in full-time and part-time employment increased over this period (by 12% and 33%, respectively). In 2015, employed people with disability were more likely to work part-time, compared with employed people without disability—44% of employed people with disability, and 63% of those with severe or profound limitation, were working part-time hours, compared with 32% of employed people without disability (see Supplementary Table S8.2.1 for additional information on employment).

Unemployment

Unemployment rates are calculated as the proportion of people participating in the labour force who were unemployed and looking for work. These rates are thus affected by not only the number of unemployed people but also the size of the labour force. Unemployment rates also showed variation by disability severity. Overall, for all people with disability, the unemployment rate was 10% in 2015 (9% in 2003), 13% for people with a schooling or employment restriction (15% in 2003) and 14% for people with severe or profound limitation (11% in 2003).

For more information, see Chapter 9.2 'Indicators of *Australia's welfare*'.

Social activities

There were 2.1 million people aged 15–64 with disability living in households in 2015. The likelihood of participating in some aspects of community life varied, depending on the severity of a person's disability (Table 8.2.1). The differences in general measures of participation were small. For example, in 2015, most people with disability and people with severe or profound limitation had participated in at least one social activity at home (96% and 93%, respectively) and away from home (94% and 89%) in the previous 3 months. On some specific measures, such as internet use, the difference was greater. Overall, four-fifths (81%) of people with disability had used the internet in the previous 3 months; among people with severe or profound disability, the proportion was lower (68%) (Table 8.2.1).

Table 8.2.1: Participation rates in selected social activities for people aged 15–64 with disability or with disability and severe/profound limitation living in households, 2015

Participation type	Disability (%)	Severe/profound limitation (%)
Had a driver's licence[(a)]	84.2	64.0
Destination of last trip was shopping[(b)]	30.0	32.6
Participated in social activities at home[(c)]	96.0	93.4
Visits from friends/relatives	*89.8*	*88.5*
Telephone calls from friends/relatives	*92.8*	*86.6*
Used the internet[(c)]	80.9	68.0
For online banking	*64.7*	*47.2*
For social networking	*72.7*	*70.2*
Left home as often as would like	70.0	48.0
Participated in social activities away from home[(c)]	94.0	89.0
Visited friends/relatives	*92.8*	*90.2*
Went out with friends/relatives	*74.1*	*65.3*
Attended a cultural venue[(d)]	69.0	57.4
Movies	*55.2*	*42.1*
Library	*30.4*	*24.0*
Felt safe/very safe at home after dark	81.1	69.5
Able to find support from others in times of crisis outside of members of own household	90.9	86.3
Difficulty with access[(e)]	26.7	31.6
Avoided community situations due to disability[(d)]	41.3	61.9
Experienced discrimination due to disability	13.8	21.8

(a) Excludes people aged under 17.
(b) People who took a trip in the previous 2-week period.
(c) At least once in the previous 3-month period.
(d) At least once in the previous 12-month period.
(e) Had difficulty with mobility/communication and difficulty accessing community facilities/buildings in the previous 12-month period.

Source: AIHW analysis of ABS 2015 Survey of Disability, Ageing and Carers (TableBuilder).

What is missing from the picture?

With currently available data, it is not possible to provide a full picture of the experiences of people with disability in Australia. The SDAC is a valuable source of information for estimating the number of people with disability and the nature of their disability, but information from other data sources is needed to provide a consolidated picture of the experiences and outcomes of people with disability as they engage in various aspects of life in Australia. For more information, see Chapter 1.7 'Understanding health and welfare data' and Chapter 8.1 'People with disability'.

The SDAC has been conducted regularly since 1981, with changes over the years. Many items, particularly for social and community activities, are either recently introduced, or not comparable across the years, and some items are only applicable to specific subgroups. For example, questions on participation in social and community activities are only asked of people with disability living in households, rather than of all people with disability or people without disability (although these questions are asked of carers and people aged 65 and over). Some populations are also outside of the survey's scope: while data are collected for Indigenous people with disability, the SDAC excludes people who live in *Very remote* areas and discrete Indigenous communities, and the resulting data may not be representative of the prevalence or experience of disability for all Indigenous people.

Where do I go for more information?

More information about people with disability is available at www.aihw.gov.au/disability/. The factsheets for *Disability in Australia: changes over time in inclusion and participation in community living*, *employment* and *education* are available for free download, as well as other recent publications such as *Disability support services: services provided under the National Disability Agreement 2015–16* and *Life expectancy and disability in Australia*.

The ABS also provides information on people with disability through a Summary of findings and supporting data from each Survey of Disability, Ageing and Carers.

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8.3 Informal carers

Informal carers provide care to others who need help or support due to disability, health conditions or ageing, outside the formal care sector (where paid care is provided by trained professionals). Often, informal carers are people close to the person in need, such as family and friends. Informal care covers a wide range of activities, such as personal care, transport assistance and medical care. It may be provided alongside formal care, or shared with other informal carers. Informal carers play an important role in assisting people who need help in their daily lives, with an estimated 1.9 billion hours of unpaid care provided in 2015 (Deloitte Access Economics 2015).

This article focuses on carers of people with disability, health conditions, or frailty due to old age, and not on the large number of Australians who provide informal care for children (Box 8.3.1).

Box 8.3.1 Informal carers of children

Other people beside parents or guardians may care for children on an informal basis. Grandparents are the most common informal carers for children aged 12 and under (ABS 2015). Other informal carers may be (step) brothers or sisters, other relatives (including a parent living elsewhere) or other (unrelated) people such as friends, neighbours, nannies or babysitters.

In 2014, 1 in 5 (22%) children aged 12 and under usually received care from a grandparent; grandparents provided an average of 10 hours of care per week—almost all (98%) of their care was unpaid (ABS 2015).

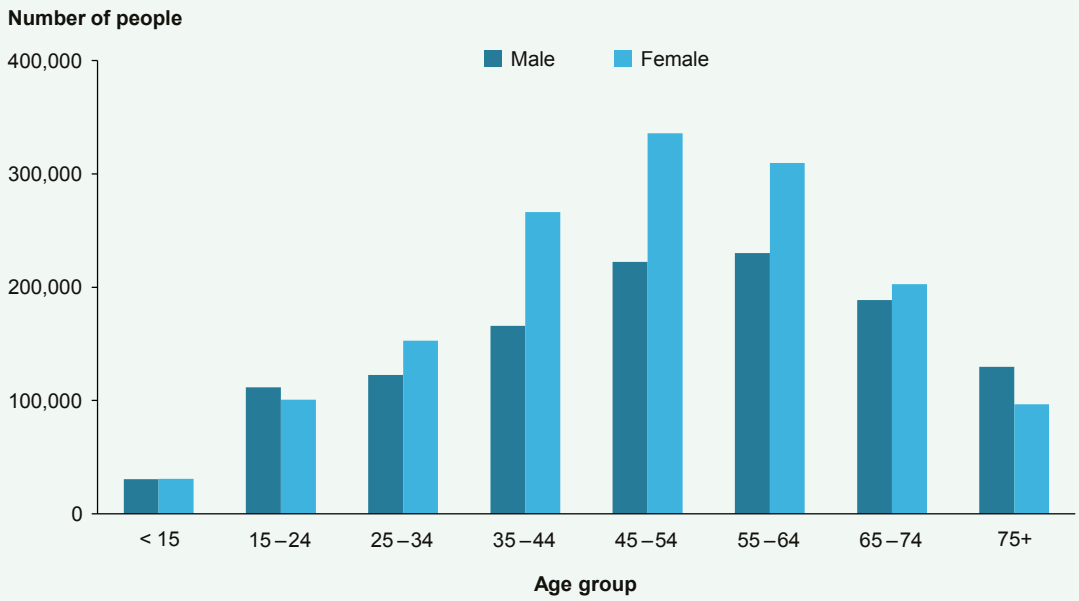
For more information on formal and informal child care in Australia see Chapter 2.1 'Children in child care and preschool programs'.

Being an informal carer can be rewarding, but challenging. Informal carers may experience social isolation, physical and emotional strain and restricted education and employment opportunities. Recent research has shown that carers who provided a high level of care and were employed in the workforce were most likely to be adversely affected (Kenny et al. 2014).

How many informal carers are there in Australia?

In 2015, 1 in 9 Australians (2.7 million people) were informal carers according to the Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC). The SDAC collects information about people who provide informal care in Australia—their health, wellbeing and participation in the community and workforce. In particular, information is collected about primary carers (the main caregivers): people aged 15 and over who live in the same household as the person with disability and provide them with the most help. In 2015, there were an estimated 856,100 primary carers in Australia, representing 3.7% of the population.

In 2015, more than half of informal carers were female (56%). There were significantly more female carers than male carers aged 35–64 (Figure 8.3.1). One in 10 (10%) carers were aged under 25, and more than 2 in 10 (23%) were aged 65 and over.



Source: ABS 2016.

Figure 8.3.1: Number of carers, by age group and sex, 2015

Between 2009 and 2015, the number and proportion of carers in Australia has remained steady, with an estimated 2.6 million carers in 2009 and 2.7 million in 2015, representing 12% of the population in both years. Over the same period, the number of primary carers increased from 771,400 (3.6%) to 856,100 (3.7%), although the proportion of primary carers in the population remained similar. Primary carers now make up 32% of all carers, compared with 29% in 2009.

The 2015 SDAC found that:

Almost all (96%) primary carers care for a **family member**.

Two-thirds (67%) of primary carers stated **'family responsibility'** as their reason for taking on a caring role.

2 in 5 (38%) primary carers reported having **disability**, with 1 in 5 (21%) experiencing severe or profound core activity limitation.

40+

One-third (33%) of primary carers spend **40 hours or more each week** caring for their main recipient of care.

10+

One-third (33%) of primary carers have spent **10 or more years** caring for their main recipient of care.

What challenges do carers face?

The time and costs associated with providing care to another person can be challenging for carers, particularly for the primary carer. The caring role may create increased financial stress, limit the carer's access to education and employment, or restrict their participation in social and community life. Table 8.3.1 shows differences in income, employment and education between primary carers, other (non-primary) carers and non-carers.

Table 8.3.1: Income, employment and education levels for primary carers, other (non-primary) carers and non-carers, 2015

Measure	Primary carers	Other (non-primary) carers	Non-carers
Median gross personal weekly income[(a)]($)	520	813	900
Government pension or allowance as main source of income[(a)](%)	42.7	18.0	11.3
Unemployment rate[(b)](%)	7.3	6.4	5.4
Workforce participation rate[(b)](%)	43.3	63.9	69.2
Educational attainment of Year 12 or higher[(b)](%)	63.2	69.0	71.3

(a) People aged 15–64 years.
(b) People aged 15 and over.

Source: ABS 2016.

In 2015, in the 3 months before the survey, most (94%) primary carers had participated in a social or community activity away from home, such as visiting friends or relatives or taking part in sport or physical recreation. Three-quarters (76%) of primary carers took part in such activities without the person they cared for. Primary carers who spent, on average, 40 hours or more caring per week were less likely to participate in social and community activities outside the home without the person they cared for (65%), compared with primary carers who spent fewer than 20 hours on average providing care (86%).

Young carers

Young carers are people aged under 25 who provide informal care for another person, often a parent or family member. According to the 2015 SDAC, there were an estimated 272,200 young carers in Australia, including 59,100 aged under 15 (ABS 2016). This equated to around 1 in 12 (8.3%) people aged under 25 in Australia being carers. About 20,700 carers aged 15–24 were primary carers, and the majority (61%) of these were caring for a parent.

Aspects of the caring role can be enjoyable and rewarding. But an intensive caring role may affect the ability of young carers to participate in life—such as in education, employment and social activities—to the same extent as other young people. Analysis of the SDAC indicates that primary carers aged 20–24 were less likely to have completed Year 12 or equivalent (32%) than both non-primary carers (72%) and non-carers (80%) of the same age (ABS 2016). Primary carers aged 15–24 were also less likely to be employed (43%) than non-primary carers (56%) and non-carers (60%). However, most (97%) young primary carers (aged 15–24) had participated in a social or community activity away from home without the recipient of care in the last 3 months.

Older carers

Older carers are people aged 65 and over who provide informal care for another person, often their spouse or partner, their child, or their own parent. There were an estimated 618,000 older carers in Australia in 2015, representing close to 1 in 5 people (18%) aged 65 and over (ABS 2016). More than one-third of older carers were primary carers (234,100 people). The majority cared for their partner (76%), with a smaller proportion caring for their child (9.1%) or parent (8.1%).

As well as the challenges faced by all carers, older carers may experience increased stress and anxiety over the decline of their own health, or the future care of their care recipient when they are no longer able to provide care (Bellamy et al. 2014). Close to 1 in 5 (19%) older carers reported often feeling worried or depressed due to their caring role, while more than 2 in 5 (44%) reported that their main recipient of care did not have a fall-back informal carer. Many older carers are long-term carers, with 2 in 5 (41%) having been a primary carer for their current recipient of care for 10 years or more. Long-term care may amplify the social, emotional, physical and economic challenges faced by carers (Carers Australia 2010). However, it is important to note that caring can also provide many positive benefits for both the carer and recipient of care, with 40% of older carers reporting that their caring role contributed to a closer relationship with the person they cared for.

Carers of people with autism

People with autism spectrum disorder and their carers are a growing population, in Australia and around the world (WHO 2016). Analysis of the SDAC indicates that, in 2015, an estimated 164,000 people had autism spectrum disorders in Australia (ABS 2016). This number has more than doubled since 2009, when 64,400 people were identified as having autism (ABS 2014). This increase has been mirrored by an increase in the number of people who provide care to someone with autism who is living in their household, from 35,000 primary carers in 2009 to 79,900 primary carers in 2015.

In 2015, there were 69,700 primary carers whose main recipient of care reported autism as their main condition (that is, the condition that causes the most difficulty in daily life). Close to two-thirds (65%) of these carers were women aged 35–54. Compared with primary carers for people with other conditions, primary carers of people with autism were more likely to work part time, care for 60 hours or more per week, and to have reported needing further support in their caring role (Table 8.3.2). Primary carers of people with autism were as likely to be employed full time as other primary carers. These findings, particularly those relating to employment, may be partly related to the age profile of primary carers of people with autism.

Table 8.3.2: Primary carers of people with autism as their main condition compared with primary carers of people with other main conditions, 2015

Measure	Primary carers of people with autism as main condition (%)	Primary carers of people with other main conditions (%)
Employed working full time	16.4	15.1
Employed working part time	38.6	19.0
Provides care for 60 hours or more per week	46.8	31.5
Has suffered financially because of their caring role, through a decrease in their income or an increase in expenses	80.6	52.3
Has lost touch (or is losing touch) with existing friends	37.3	23.6
Has experienced a change in their physical or emotional wellbeing because of their caring role	56.4	38.5
Needs further support to assist in their caring role	58.1	36.4

Source: AIHW analysis of ABS 2015 Survey of Disability, Ageing and Carers (TableBuilder).

What support is available for carers?

A variety of government-funded services and financial support programs are available to assist carers with their caring responsibilities.

Support services

Non-financial support services for carers include counselling, information and advice, and respite care (short-term alternative care arrangements to provide a break for both the carer and the person being cared for). In 2015, 14% of carers reported they had used respite care for their main recipient of care. Female carers were more likely to have used respite care than male carers.

Under the National Disability Agreement, respite services are also available to people with disability, their families and carers. In 2015–16, more than 38,200 people with disability were provided with respite services under this Agreement (excludes data from the Australian Capital Territory Government, which did not collect data in 2015–16; see the AIHW report *Disability support services: services provided under the National Disability Agreement 2015–16* for more information). Most of this group (91%) reported having a primary carer.

The Young Carers Respite and Information Services Program also supports young people with a substantial caring role to complete their secondary education or vocational equivalent (DSS 2016d). The program helps carers who need support due to the demands of their caring role by way of respite care, education support services and information, referral and advice. Respite and education support services are delivered by the national network of 54 Commonwealth Respite and Carelink Centres; information, referral and advice are delivered by Carers Australia and state and territory carers' associations. Respite services will move to the National Disability Insurance Scheme (NDIS) as the scheme rolls out, to be accessed through the care recipient's plan. For more information on the NDIS, see Chapter 8.1 'People with disability'.

Several local and national organisations provide counselling and information services for carers. In 2015–16, Carers Australia, the national peak body representing carers, provided counselling for more than 8,000 carers, and helped more than 60,000 people with information and advice (Carers Australia 2016).

Financial support

Carers may receive financial payments, depending on their caring arrangements and the needs of the person they care for (DSS 2016b). In 2015–16, close to 605,800 people received the Carer Allowance. This is a supplementary payment for carers who provide a certain level of daily care and attention to a person with disability or a severe medical condition (excluding carers whose care recipient qualified for a Health Care Card only) (DSS 2016a). This represents more than two-thirds (71%) of the estimated number of primary carers in 2015 (from SDAC). The number of people receiving the Carer Allowance has increased in recent years, up from around 590,200 recipients in 2013–14 and almost 601,400 recipients in 2014–15 (DSS 2016a). In June 2016, 70% of Carer Allowance recipients were aged 45 and over (DSS 2016c). Carers aged under 25 accounted for 2.0% of recipients.

In 2015–16, financial support was also provided, through the Carer Payment, to almost 260,600 carers who were unable to support themselves through substantial paid employment because of their caring responsibilities (DSS 2016a). As well, there were about 629,000 recipients of the Carer Supplement and around 154,400 recipients of the Child Disability Assistance Payment. (Both these payments depend on recipients receiving specific qualifying payments, such as the Carer Allowance.) Carers may also be eligible for other forms of financial assistance, such as support for education, housing or access to Health Care Cards.

What is missing from the picture?

At present, it is difficult to gain a consolidated picture of the experiences of carers in Australia. While some self-reported information is available from the Survey of Disability, Ageing and Carers, detailed data about the use of support services is limited. Carers may receive support through a number of government and non-government programs across a wide variety of areas, including the disability, aged care and health systems. In addition to specific programs targeted at carers, carers are also affected by the support provided to the person they care for. There is a lack of comprehensive data on the support services used by carers (such as counselling and information services), including interactions with mainstream and specialised services, pathways through these services, and the outcomes of these interactions (including how the type and level of support provided to care recipients impacts carers' lives). This is particularly an issue for groups such as young carers, who face unique challenges because of their age. Data linkage, such as between carer payments and health or education datasets, could enable a better understanding of the experiences of carers in Australia, their interactions with services, and their associated outcomes, providing a clearer evidence base for policy decisions.

The introduction of the NDIS presents an opportunity to collect better data on informal carers of people with disability. From 1 July 2013, people with disability who met eligibility requirements started the transition to the NDIS to receive formal assistance with everyday life (see Chapter 8.1 'People with disability'). Carers of NDIS participants may be involved in planning and implementing a person's care plan. The NDIS reports some information on families and carers of participants, including baseline outcome indicators covering financial support, workforce participation, social participation and health (NDIA 2017). However, detailed information on the carers of NDIS participants, such as their relationship to the participant and the extent of their caring responsibilities (for example, the number of hours spent caring per week, the type of caring activities undertaken) is not currently available. Such information would also be limited to carers of NDIS participants, meaning a gap will remain around those who care for people who are not eligible for the NDIS, such as older Australians.

Where do I go for more information?

For more information on informal carers, see www.aihw.gov.au/informal-care-ageing. Information on carers of people with disability who access disability support services under the National Disability Agreement is available in the bulletin *Disability support services: services provided under the National Disability Agreement 2015–16*, which is available for free download from the AIHW website. Information on carers from the most recent ABS Survey of Disability, Ageing and Carers is available from Disability, ageing and carers, Australia: Summary of findings, 2015.

The Carer Gateway is a national website and phone service launched in December 2015. It provides information and advice to carers, and can connect carers with suitable services in their local area.

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Chapter 9

Indicators of *Australia's welfare*

9.0 Introduction

Indicators are commonly used to assess the performance of policies, programs or services, and to meet accountability and transparency requirements. Ideally, they provide information on change in outcomes, and inform quality improvements of services and programs. Indicators are useful in highlighting particular results in an area of interest and in helping people to ask questions about why the result is as it is.

Indicators are simple statistics, such as numbers or rates, that summarise issues that are often complex; therefore, they should not be used in isolation. Contextual information should always be used to interpret and use indicator results.

The AIHW has been reporting on indicators of *Australia's welfare* as part of its biennial welfare flagship reports since 2003. Following a review, the 2015 edition of *Australia's welfare* included a new conceptual framework and a framework for these indicators (see Chapter 8 of *Australia's welfare 2015* for a discussion of the developmental work).

The indicator framework is designed to measure and report on the key components of the conceptual framework guiding the *Australia's welfare 2017* report (see Chapter 1.3 'Understanding welfare' Figure 1.3.1). In doing so, it aims not only to summarise the performance and outcomes of Australia's welfare services but also to provide insight into what determines the demand for them. It also includes several measures relating to the overall wellbeing of the Australian population. The wellbeing domain indicators are reported for the first time in 2017, and their development is discussed in Chapter 9.1 'The *Australia's welfare* indicator framework'. Chapter 9.2 'Indicators of *Australia's welfare*' presents data for 53 indicators across all five domains of the framework, including first results for 14 new wellbeing indicators.

9.1 The *Australia's welfare* indicator framework

The indicator framework for *Australia's welfare* has three core domains—wellbeing, determinants, and welfare services performance (Figure 9.1.1). Two additional domains—contextual factors, and other factors—recognise the role of other influences, such as access to primary care practitioners, population growth and economic conditions. Each component in the framework represents an area for which it is useful to assess progress and which can inform service improvement.

Data were reported against four of the five domains in *Australia's welfare 2015*, but were not presented for the wellbeing domain pending further conceptual development and scoping. A discussion of the wellbeing domain follows.

This 2017 edition of *Australia's welfare* has 61 indicators, including updated or newly reported results for 39 indicators and first results for 14 new wellbeing indicators. See Table 9.2.2 in Chapter 9.2 'Indicators of *Australia's welfare*' for the complete set of indicators across all domains. More information on definitions and context can be accessed online at www.aihw.gov.au/reports/australias-welfare/australias-welfare-2017/related-material.

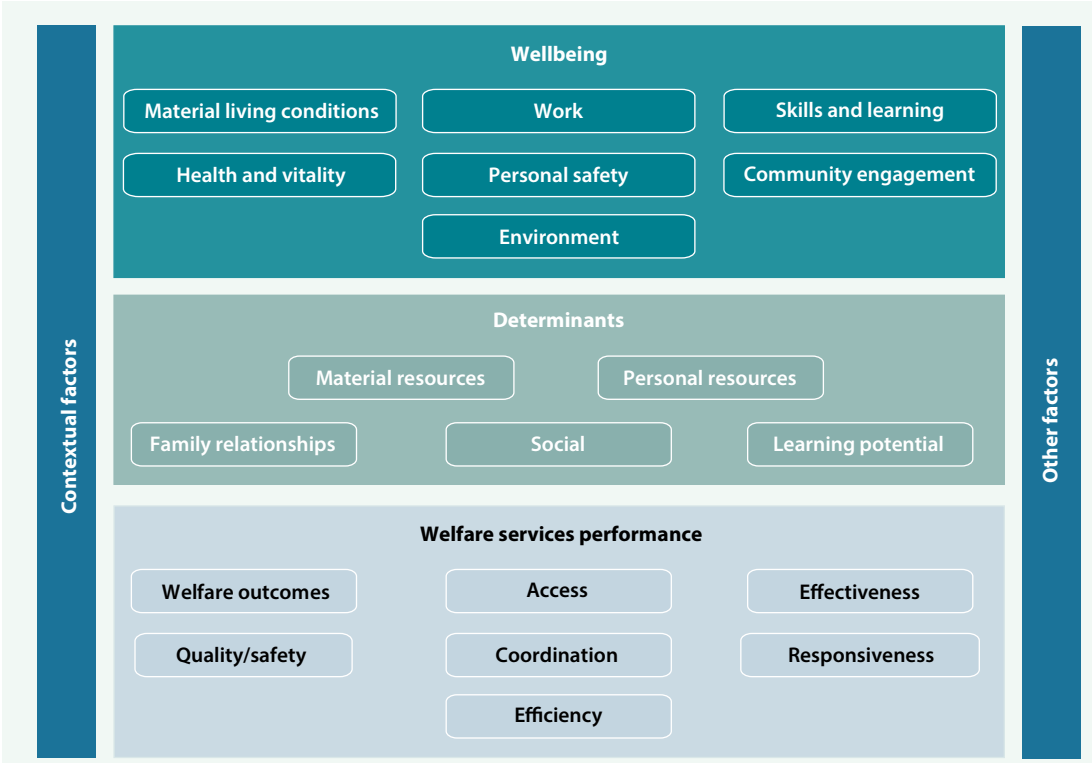

Figure 9.1.1: Indicator framework for *Australia's welfare*

Developing the wellbeing domain for the indicator framework

As discussed in Chapter 1.3 'Understanding welfare', wellbeing is a complex synthesis of factors that influence happiness or satisfaction with our lives. It can be highly individual and subjective, with different meanings for different people, and can change across the life course. Some people place more importance on financial wealth, others on their physical and/or mental health. In reality, wellbeing is a product of many, often interrelated, factors. Measuring wellbeing at the population level therefore presents a range of challenges. This section presents information on current national and international measurement of wellbeing and introduces the wellbeing indicators selected by the AIHW for the indicator framework shown in Figure 9.1.1.

The measurement of the wellbeing of communities and nations has become increasingly widespread, driven, in part, by a growing recognition that traditional high-level summary economic measures such as Gross Domestic Product (GDP) are, at best, partial measures of a nation's progress. Some studies have shown that countries with higher GDPs are well down the list in rankings, based on subjective wellbeing measures, suggesting that factors other than income can matter for wellbeing (Helliwell et al. 2016).

Several national and international wellbeing indicator sets and frameworks were investigated in developing a wellbeing domain for *Australia's welfare*, and are briefly outlined here. They represent just a small subset of work that is being conducted in this field. Composite indexes of wellbeing are used by some organisations. Others use a set of indicators, without any attempt to aggregate or average results to a single number.

The AIHW's approach to the selection of themes for the wellbeing domain has been to initially map existing national and international frameworks sourced from a desktop review. This draws on the extensive body of research in the area. A strong focus is placed on topics that are relevant to the Australian welfare context and to the *Australia's welfare* report series. In selecting the detailed indicators, the availability of Australian data sources was considered, particularly where the data can be disaggregated sub-nationally, or lend themselves to trend reporting.

Wellbeing measurement and reporting in Australia

Australia's interest in investigating national wellbeing and progress is reflected in a variety of frameworks and measures that have been developed for the Australian context.

The Australian Bureau of Statistics (ABS) was a frontrunner in this respect. It published *Measures of Australia's progress* every 2–4 years between 2002 and 2013, with the 2013 report reflecting a major revision undertaken during 2011–12. The framework covers four domains—society, economy, environment, and governance—and provides a useful set of indicators to inform conceptual thinking and to show whether life in Australia is getting better (ABS 2013). The ABS also has a framework for social statistics more broadly, which considers individual and societal wellbeing, and the influences and actions that can have an impact on and change the state of wellbeing (ABS 2015a).

The first *The Australia we want* report of the Community Council for Australia (2016) presented initial findings on how Australia is performing against a set of measures selected by a group of 60 leaders in the Australian charity and not-for-profit sector. The measures define the Australia that these leaders aspire to live in, and how well we are doing in realising these goals across the nation. The indicators for the reporting framework are grouped into four domains or principles: Just, fair, safe; Inclusive, equal opportunity, united, authentic; Creative, confident, courageous, optimistic; and Generous, kind, compassionate. Results are presented at both the national and state/territory level.

The Department of Social Services (DSS), responsible for national social policy and management of welfare services funded by the Australian Government, uses a conceptual wellbeing framework to guide its policy planning and program development. The framework identifies long-term priorities for improving the lifetime wellbeing of people and families in Australia. It is structured around four wellbeing domains that lend themselves to performance measurement and monitoring—independence, life readiness, family functioning, and strong communities—and two cross-cutting domains of access to opportunity and individual risk factors (DSS 2016).

Several Australian states and territories have also invested in developing wellbeing frameworks to govern planning and policy. See Box 9.1.1 for an example of one state's outcomes framework for welfare services that incorporates wellbeing concepts.

Box 9.1.1: Human Services Outcomes Framework of the New South Wales Department of Family and Community Services

The New South Wales Department of Family and Community Services has developed a framework based around the question: *What matters for an individual over the course of their life?* It identifies the factors that have an impact on the life course and, particularly, the interconnectedness of these factors. The framework provides a conceptual underpinning and structure for the department's services and outcomes.

The framework has seven domains of wellbeing: home, health, education and skills, economic, safety, social and community, and empowerment. The department explains that its first application of the framework has been to social housing, which:

> *'…helps focus our collective effort on using social housing assistance to improve outcomes for tenants and users of our services. It makes transparent the continuum from what we deliver to how people benefit and what outcomes they ultimately achieve…'*
>
> NSW Department of Family & Community Services 2016

A number of wellbeing indexes have also been developed or are under development in Australia. Examples include the Australian National Development Index (ANDI) and the Scanlon Foundation's Scanlon-Monash Index (SMI) of social cohesion. The ANDI is a composite index, based on a conceptual framework that encompasses 12 social, economic, health and environmental domains, and is described as 'a holistic measure of national progress and wellbeing' (ANDI 2017). The SMI of social cohesion incorporates five domains: belonging, worth, social justice and equity, political participation, and acceptance/rejection. While these domains are not all directly related to wellbeing, indicators touch on many of the themes seen in other wellbeing measures, such as income equality, community participation, trust, and life satisfaction (Markus 2016).

International wellbeing measurement and reporting

The fifth Organisation for Economic Co-operation and Development (OECD) World Forum on Statistics, Knowledge and Policy in 2015 included a strong focus on the measurement of wellbeing. This reflects the topic's current acceptance in mainstream policy discussions at the highest level (OECD 2015a). Three approaches to the measurement of wellbeing are discussed here—an indicator set approach, a subjective measure and an objective measure.

Since 2011, the OECD has been reporting on wellbeing in *How's life? Measuring well-being*. The report documents a wide range of wellbeing outcomes, with comparative and trend data for OECD countries. It is part of the OECD Better Life Initiative, which aims to promote 'better policies for better lives'. The *How's life* framework has three conceptual areas: material conditions, quality of life, and sustainability. Eleven domains—each with a concise set of relevant indicators—capture these conceptual areas: income and wealth, jobs and earnings, work life balance, housing, environmental quality, health status, education and skills, social connections, civic engagement and governance, personal security, and subjective wellbeing (OECD 2015b).

Countries can be ranked by indicator but there is no overall summary index. Recent findings show that OECD countries ranking in the top third for GDP per capita—such as Australia, Canada, the United States and Norway, among others—do well overall in terms of material resources, such as income. However, these same countries may have weaknesses in other areas, such as in work–life balance, and housing affordability. This shows that all countries have areas for improvement. Australia does not perform particularly well on some measures, such as employees working long hours, and perceived personal safety. The *How's life* report also notes something that is useful to keep in mind when viewing the indicator data in Chapter 9.2: that different groups within a country's population can have very different wellbeing outcomes (OECD 2015b).

The fifth World Happiness Report was published in 2017, ranking more than 150 countries by their happiness (also referred to as subjective wellbeing) levels, based on a global survey in which participants are asked to rate the quality of their current lives on a scale of 0 to 10. The authors use six key variables—GDP per capita, social support (having someone to count on in times of trouble), healthy life expectancy, social freedom (freedom to make life choices), generosity (donations in the previous month) and perceived absence of corruption—to explain most of the variation in subjective wellbeing between countries. Australia was ranked ninth with Norway the highest ranked. New Zealand, the United States and United Kingdom came in at eighth, fourteenth and nineteenth, respectively (Table 9.1.1) (Helliwell et al. 2017).

The United Nations produces the Human Development Index (HDI), which is a summary measure across the dimensions of: a long and healthy life (measured by life expectancy), being knowledgeable (measured by mean years of schooling), and having a decent standard of living (measured by gross national income per capital). The scores of these three dimensions are aggregated into a composite index. The HDI is reported for up to 188 countries, most recently in 2014. Australia was ranked second, after Norway. The United States, Canada and New Zealand were ranked eighth, ninth and tenth, respectively, and the United Kingdom came in at fourteenth (Table 9.1.1) (United Nations 2016).

On each of the above measures, Australia and similar countries generally perform relatively favourably. There are advantages and disadvantages of each type of measure. It can be hard to obtain a holistic view when multiple indicators are used, however, summary measures can also be difficult to interpret as, in isolation, they provide no underlying information as to the composition of the ranking score. For the wellbeing domain in the *Australia's welfare* indicator framework, as described further in this chapter, AIHW chose to follow an approach similar to that of the OECD's *How's life*, with a small set of key indicators rather than an index or aggregate score. An important purpose of the AIHW's wellbeing indicators is the ability to consider them together with indicators in other parts of the indicator framework. For example, trust, perceptions of safety and life satisfaction can be coupled with social connectedness and volunteering in the determinants domain; and indicators of financial and employment stress in the welfare services performance domain. While international rankings are of interest, they are not the main purpose of the AIHW's wellbeing domain.

Table 9.1.1: Country ranks for wellbeing summary measures, selected countries and years

Measure	Year	World best	Australia	New Zealand	Canada	United States	United Kingdom
World happiness report[(a)]	2017	Norway	9	8	6	14	19
UN Human Development Index	2014	Norway	2	10	9	8	14

(a) Ranks are based on national average scores when people are asked to evaluate the quality of their lives on a scale of 0 to 10.

Sources: Helliwell et al, 2017; United Nations 2016.

Themes and indicators for the AIHW wellbeing domain

While there are different views on which measure best represents wellbeing, there is much consensus on what makes us satisfied with our lives, and what is considered human progress (OECD 2015b). There is close alignment across frameworks on such topics as the economy and jobs, education and skills, health, social engagement, personal safety, the environment, and overall life satisfaction or happiness.

As shown in the previous sections on measurement and reporting, wellbeing measures can stand alone; however, in the context of *Australia's welfare*, it is the interrelationships between wellbeing and the other domains of the framework that are of interest. For example, the data should help to assess how the outcomes of welfare service support contribute to achieving and maintaining satisfying and fulfilling lives at the individual, family and community levels. Outcomes measured by indicators in the other domains may influence our wellbeing. In turn, though, our wellbeing will have an impact on our opportunities and choices in life and, to some extent, determine when and how we might interact with the welfare system. The complexity of these interactions means that the placement of indicators within particular domains can be somewhat arbitrary—that is, some indicators could sit just as easily in one domain as another. The AIHW has focused on coverage and completeness of the indicator set as a whole, and encourages readers to view the indicators on the same basis.

The authors' scoping and review resulted in seven themes being selected for the wellbeing domain in the Australia's welfare indicator framework: material living conditions, work, skills and learning, health and vitality, personal safety, community engagement, and environment. Some themes, such as personal relationships, were not included in the wellbeing domain but are represented by indicators in other domains, such as the determinants domain. Fifteen indicators were identified for the wellbeing domain which, together, can meaningfully, usefully and concisely provide a picture of Australia's wellbeing now and into the future (Table 9.1.2). Including a customised wellbeing domain has allowed the AIHW to select the themes, indicators and data for the Australian context, while drawing on global and scientific experience.

The detailed indicators within each theme and indicator area of the wellbeing domain were selected based on standard indicator criteria of relevance, understandability, ability to be actioned/sensitivity to change, feasibility of measurement, and technical robustness. This resulted in 14 indicators being defined. One indicator, for lifelong learning, could not be defined (see Box 9.1.2). As well as this data gap, several gaps remain within other domains of the indicator framework, as set out in the next section.

Table 9.1.2: Indicators for the wellbeing domain

Theme	Indicator number	Indicator summary form	Context
Material living conditions	1	Purchasing power	Measure of national economic wellbeing reflecting real standard of living
	2	Income inequality	Indicator of inequality in the distribution of income in society which is associated with disparities in both health and wellbeing outcomes.
	3	Adequate housing	Indicator of adequate housing which is essential to meet basic needs for shelter, and is a protective factor for health and childhood development.
Work	4	Employment to population ratio	Indicator reflecting a person's resource base as having a job helps protect the household from poverty, and is a major contributor to personal wellbeing.
	5	Employees working 50 or more hours	Measure of [lack of] work–life balance, which reflects complexity of life and residual resources to engage in social interactions.
Skills and learning	6	Non-school qualification	Measure of higher education level which is associated with better material living conditions, better health and greater civic involvement.
	7	Lifelong learning	Indicator of a society that promotes and provides infrastructure for further learning, which is associated with greater wellbeing.
Health and vitality	8	Disability-free life expectancy	Derived measure combining life expectancy with disability prevalence: better reflects aggregate human capacity than life expectancy.
	9	Life satisfaction	Subjective indicator of wellbeing, reflecting the notion that people are their own best judge of their wellbeing. Counterbalances objective measures.
Personal safety	10	Crime victimisation	Measure of safe environment, which is essential to overall mental and physical wellbeing.
	11	Perceptions of safety in the community	Subjective indicator of personal safety, and associated with confidence and social engagement. Counterbalances objective measure.
Community engagement	12	Level of generalised trust	Indicator of, or proxy for, social capital, which is an important contributor to wellbeing directly, and signals other aspects of social participation.
	13	Voter enrolment	Indicator of take-up of basic human right to have a political voice.
Environment	14	Air quality	Indicator of environmental quality. Poor air quality can have a major impact on health, the environment and the economy and can exacerbate conditions such as asthma and other respiratory disorders.
	15	Greenhouse gas emissions	Indicator of environmental sustainability. Increasing greenhouse gas concentrations have an impact on global temperatures and the earth's climate, with consequences for ecosystems and human settlements.

What is missing from the picture?

Inevitably, there will be some compromise between the ideal set of indicators and those that are reportable in practice. In the *Australia's welfare* indicator framework, data gaps have been kept to a minimum, and proxy indicators have been selected in some instances. Remaining data gaps are outlined in Table 9.1.3 and further explored below.

Table 9.1.3: Data gaps—*Australia's welfare* indicator framework

Domain: sub-domain	Indicator number	Indicator (summary form)	Context	Comment
Wellbeing: Skills and learning	7	Lifelong learning	Indicator of a society that promotes and provides infrastructure for further learning, which is associated with greater wellbeing.	No indicator defined. See Box 9.1.2.
Determinants: Material resources	18	Housing security	Indicator of the ability to maintain tenancy in housing of a satisfactory standard which contributes directly to wellbeing, and reflects adequate financial resources.	No data; no proxy.
Welfare system performance: Welfare outcomes	38	Safe return home for children in out-of-home care	Measure of long-term outcome for children in out-of-home care. For some of these children, the best long term outcome is for them to return home after their parents' skills and capacity to care for them have improved.	No data; no proxy. This indicator could be complemented by an indicator for stable permanent placement.
Welfare system performance: Efficiency; sustainability	43	Cost per service output (by sector)	Cost per unit output is a simple measure of the efficiency of service delivery: the aim is to reduce costs without compromising quality.	Data not reported in 2017 due to interpretation issues around the meaning/ desired direction of trends.
	44	Management expense ratio (by sector)	The administrative costs associated with delivering services are a measure of efficiency—and to some extent, indicate sustainability.	No data are available, as, for most programs, the administrative costs are spread over program components, and not separately reportable. While aggregate measures may be possible to compile, they are not readily available.
Welfare system performance: Coordination	50	No indicators identified		

Housing security

When considering how to develop an indicator for housing security, areas such as housing tenure (for example, home owners, renters), affordability, homelessness, and housing mobility might be considered (AIHW 2010). Information about housing tenure is presented in Indicator 58, affordability in Indicator 30, and homelessness in Indicators 29, 41 and 49 (see Chapter 9.2 'Indicators of *Australia's welfare*').

An indicator on housing mobility could be considered as a proxy for housing security (AIHW 2010). Existing data show that renters are more than 6 times as likely as home owners (with or without a mortgage) to have moved at least 4 times in the last 5 years, and people in private rental accommodation are 2 times as likely as people living in state/territory housing to have moved at least 4 times in the last 5 years (ABS 2009, 2015b).

While this could provide some useful information, not moving from a residence does not mean that the residence is satisfactory; there could be issues with housing condition, overcrowding (see Indicators 3 and 31 in Chapter 9.2 'Indicators of *Australia's welfare*') or personal safety. More work is needed to define this indicator.

Safe return home for children in out-of-home care

There are no data currently available to report on this indicator. However, work has been undertaken to facilitate future reporting. The AIHW, in consultation with state and territory departments responsible for child protection, has developed indicator specifications for reporting on the number of children who return home, or for whom alternative permanent care arrangements have been provided. A field test was undertaken as part of the 2015–16 National Child Protection data collection. Data are expected to be reported under the National Standards for Out-of-Home Care, following an assessment of data availability/quality and subject to approval (AIHW 2016).

Efficiency indicators: Cost per service output, and Management expense ratio by sector

Data for Indicator 43, Cost per service output, were included in *Australia's welfare* 2015 but have not been reported in this report due to interpretation issues. There is lack of clarity around which components are included in the costs (for example, administrative costs, rebates and subsidies) and therefore what the desired direction of change should be.

Management expense ratios aim to measure administrative costs, such as overheads as a proportion of total program costs, and are a measure of efficiency. The Report on Government Services (RoGS) has several efficiency output indicators in its community sector performance indicators: for example, *Administrative expenditure as a proportion of total recurrent expenditure* (in the disability services sector), *Expenditure per head of target population* (aged care services), *Expenditure per placement* and *Cost per child in out of home care* (child protection services). However, each sector has different measures and, within sectors, there are issues to do with comparing data, due to different policies in states and territories.

Both indicators will be reviewed for future editions. Readers are referred to the RoGS website for further information on efficiency output indicators by sector: http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/community-services.

Welfare system performance: coordination

This remains a data gap in the framework, but its importance is highlighted in many sectors. For example, the Victorian Royal Commission into Family Violence highlighted the need for better integration of services, including among the justice sector, health services, homelessness services, victim support services, and others (State of Victoria 2016). More work is needed to define 'coordination' and to explore indicators that might measure this concept. This is challenging but measuring and reporting what is important can often lead to increased efforts being directed toward an area.

Lifelong learning

An indicator for *Lifelong learning* in the Wellbeing domain could not be defined (see Box 9.1.2 for further discussion). Although no single indicator seems to adequately measure the complex and expansive concept of lifelong learning, readers are directed to the results of various indicators in the *Australia's welfare* framework—such as Non-school qualification (Indicator 6), Year 12 attainment (Indicator 28), Work–life balance (Indicator 5), Volunteering (Indicator 25), and Access to the internet (Indicator 26)—for insight into factors that contribute to and reflect aspects of lifelong learning.

Box 9.1.2: Lifelong learning

As the term implies, lifelong learning occurs throughout the life course. It is learning that goes beyond traditional schooling or formal study and is flexible, diverse and available in different times at different places. Delors (1996) described four pillars of lifelong learning:

- **Learning to know**—mastering learning tools rather than acquisition of structured knowledge
- **Learning to do**—equipping people for the types of work needed now and in the future, including innovation and adaptation of learning to future work environments
- **Learning to live together, and with others**—peacefully resolving conflict; discovering other people and their cultures; fostering community capability; individual competence and capacity; economic resilience; and social inclusion
- **Learning to be**—education contributing to a person's complete development: mind and body, intelligence, sensitivity, aesthetic appreciation and spirituality.

It is unlikely that any one indicator can capture lifelong learning. Canada uses a measure of progress in this area known as the Composite Learning Index (CLI). The CLI is constructed from 15 indicator areas and 26 specific measures.

Canada's Composite Learning Index—pillars and indicator areas

Learning to know	**Learning to do**
Youth literacy skills	Availability of workplace training
High school dropout rate	Participation in job-related training
Participation in post-secondary education	**Learning to be**
University attainment	Exposure to media
Learning to live together	Learning through sports
Participation in social clubs and organisations	Learning through culture
Learning for other cultures	Access to broadband internet
Volunteering	Access to learning opportunities
	Social and economic outcomes

Source: Lifelong Learning Council Queensland Inc. 2016.

A similar index, the European Lifelong Learning Indicators (ELLI) Index, is constructed from 17 indicators and 36 specific measures organised under the same four pillars as the CLI. It is used to generate a lifelong learning score for European Union member states (Hoskins et al. 2010).

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9.2 Indicators of *Australia's welfare*

The *Australia's welfare* indicator framework aims to summarise the performance of Australia's welfare services, track individual and household determinants of the need for welfare support, and provide insight into the nation's wellbeing status more broadly. The framework brings together an overview of key topics and data presented in *Australia's welfare*, and enables many aspects of welfare to be considered in an objective and holistic way. Box 9.2.1 presents some key findings.

Box 9.2.1: Key results

- Nearly two-thirds of us rate our overall life satisfaction as high.
- We are living longer without disability—years of life lived without disability have risen by 3.9 years for males and 3.0 years for females since 2003.
- Crime victimisation decreased between 2008–09 and 2015–16 for most types of serious crime, such as physical assault and malicious property damage. Our perceptions of safety have also improved.
- Around 86% of families report good to excellent family cohesion.
- A total of 89% of 20–24-year-olds in 2016 had completed Year 12 or at least a Certificate III, up from 80% in 2005.
- One in 5 men (20%) and 1 in 14 women (7%) in paid employment were working 50 hours or more per week in 2017; however, these rates have dropped from 26% and 8% respectively in 2004.
- The proportion of Indigenous households living in overcrowded conditions fell from 27% in 2004–05 to 21% in 2014–15.
- In 2013–14, 1 in 2 (50%) lower income rental households spent more than 30% of their gross income on housing costs, an 8 percentage point increase from 2005–06.
- While the distribution of income in Australia has shown little change in recent years, income inequality has risen since the mid-1990s as measured by the Gini coefficient.
- While rates have fluctuated over time, there has been an upward trend for youth unemployment rates and the long-term unemployment ratio (long-term unemployment as a proportion of all unemployment) since 2008–2009.
- There were 1.4 million jobless families in Australia in 2016, representing 22% of all families—similar to rates in 2012 (20%).

Chapter 9.1 'The *Australia's welfare* indicator framework' focused on the concepts underpinning the indicator framework, and the development of its wellbeing domain. This chapter presents the indicator data. The first results for the wellbeing domain and updated results for the other four domains—determinants, welfare services performance, other sectors and context—are reported here. A diagram of the indicator framework depicting its five domains and associated sub domains is included in Chapter 9.1 'The *Australia's welfare* indicator framework'. Table 9.2.1 presents a summary of the status of all indicators.

Table 9.2.1: Indicator status *Australia's welfare 2017*

Indicator status	Number of indicators
Updated since *Australia's welfare 2015*	38
First time reportable (Indicator 41: Unmet demand for homelessness services)	1
New indicators (wellbeing)	14
Not able to be updated (Indicator 29: Homelessness rate; Indicator 23: Partner violence)	2
Not reportable[(a)]	6
Total	**61**

(a) Not reportable: Lifelong learning (Indicator 7), Housing security (18), Safe return home for children in out-of-home care (38), Cost per service output (43), Management expense ratio (44), and Coordination (50).

Information on indicators not reported in 2017 and work in progress to meet the data gaps is provided in Chapter 9.1 '*Australia's welfare* indicator framework'. New in this edition is an assessment of trends for the indicator set (Table 9.2.2), and an explanation of how trends were assessed follows.

Data for some indicators are disaggregated by population subgroups, such as age, sex, Indigenous status, or income quintile. Other indicators are presented as time series. Decisions around how data are presented largely depend on what data are available, the quality of these data, and what will be most informative for the reader. Maintaining consistency of data presentation over time is also a priority.

Indicator results

Table 9.2.2 provides an overview of all indicators and an assessment of trends. Indicator results are then presented by domain, together with a summary of key results.

Assessment of trends

Trend data are presented in the figures wherever possible. Where a trend series is not provided, the commentary usually includes a reference to earlier years' data if this is meaningful.

Where 5 years or more of good-quality trend data are available for at least 3 data points, Table 9.2.2 lists trends as being favourable, unfavourable or unchanged. 'Good quality data' should meet, as far as possible, minimum criteria for accuracy, completeness and comparability (see the AIHW's Metadata Online Registry for more information on data quality: http://meteor.aihw.gov.au/content/index.phtml/itemId/480742).

A favourable trend contributes to greater wellbeing and might mean that the indicator is declining (such as homelessness rates). Where there is a longer time series, it is used in the assessment. So, a trend may appear as favourable or unfavourable in the short term, but be given a contrary assessment in the table, based on a longer time series.

Where sufficient data are available, but the trend direction cannot be confidently determined (due to data quality or other issues), an assessment of 'no clear trend' is made. Changes in definitions can be problematic for determining trends. Further, changes in government policies and programs may mean that some comparisons cannot be made with earlier years.

If sufficient good-quality trend data are not available, an assessment of 'no data/insufficient data' is made.

Table 9.2.2: Indicators of Australia's welfare—trend assessment

Domain/ sub-domain	Indicator number	Indicator	Time period for trend assessment	Trend[a]
WELLBEING				
Material living conditions	1	Purchasing power	1987–2016	Favourable
	2	Income inequality	2003–04 to 2013–14	Unfavourable
	3	Adequate housing	2007–08 to 2013–14	No change
Work	4	Employment to population ratio	1997–2017	No clear trend[b]
	5	Employees working 50 hours or more	2004–2017	Favourable
Skills and learning	6	Non-school qualification	2009–2016	Favourable
	7	Lifelong learning	..	..
Health and vitality	8	Disability-free life expectancy	2003–2015	Favourable
	9	Life satisfaction	..	No data/ insufficient data
Personal safety	10	Crime victimisation	2008–09 to 2015–16	Favourable[c]
	11	Perceptions of safety in the community	2006–2014	Favourable
Community engagement	12	Level of generalised trust	2006–2014	No change
	13	Voter enrolment	2010–2016	Favourable

continued

Table 9.2.2 (continued): Indicators of Australia's welfare—trend assessment

Domain/ sub-domain	Indicator number	Indicator	Time period for trend assessment	Trend[a]
Environment	14	Air quality	1998–2015	Favourable
	15	Greenhouse gas emissions	2000–2016	Favourable
DETERMINANTS				
Material resources	16	Household income	1994–95 to 2013–14	Favourable
	17	Access to emergency funds	..	No data/ insufficient data
	18	Housing security	..	..
Personal resources	19	Psychological resilience	2001 to 2014–15	No change[d]
	20	Self-assessed health status	2004–05 to 2014–15	No change
	21	Functional status	2003–2015	Favourable
Family relationships	22	Family cohesion	..	No data/ insufficient data[e]
	23	Partner violence	..	No data/ insufficient data[f]
Social engagement	24	Social connectedness	2006–2014	No change
	25	Adults who volunteer	2006–2014	Unfavourable
	26	Internet access	2006–07 to 2014–15	Favourable
Learning potential	27	School readiness	2009–2015	Favourable
	28	Year 12 attainment	2005–2016	Favourable
WELFARE SERVICES PERFORMANCE				
Welfare services outcomes	29	Homelessness	2001–2011	No clear trend
	30	Lower income rental households in housing stress	2005–06 to 2013–14	Unfavourable
	31	Indigenous households living in overcrowded conditions	2004–05 to 2014–15	Favourable
	32	Labour force participation for people with disability	2003–2015	No change
	33	Social participation for people with disability	2003–2015	No change
	34	Jobless families	2005–2016	No change
	35	Long-term unemployment ratio	2004–2017	Unfavourable
	36	Youth unemployment rate	2004–2017	Unfavourable

continued

Table 9.2.2 (continued): Indicators of Australia's welfare—trend assessment

Domain/ sub-domain	Indicator number	Indicator	Time period for trend assessment	Trend[a]
	37	Older people with care needs supported	2003–2015	Favourable
	38	Safe return home for children in out-of-home care	..	..
Access	39	Waiting times for social housing	..	No data/ insufficient data[g]
	40	Difficulty accessing child care	..	No data/ insufficient data[h]
	41	Unmet demand for homelessness services	2011–12 to 2015–16	No clear trend[i]
Responsiveness	42	Satisfaction with services	..	No data/ insufficient data
Efficiency	43	Cost per service output	..	..
	44	Management expense ratio	..	..
Safety and quality	45	Compliance with service standards	..	No data/ insufficient data
	46	Safety and security of children and young people in out-of-home care	2010–11 to 2015–16	No change
Effectiveness	47	Job seekers off benefits after participation in employment services	..	No data/ insufficient data[j]
	48	Young people in detention attending education/training	2011–12 to 2015–16	Favourable
	49	Repeat periods of homelessness	..	No data/ insufficient data[k]
Coordination	50	No summary indicators defined	..	..
OTHER SECTORS				
	51	Police operational staffing levels	2009–10 to 2015–16	No change
	52	Access to primary care practitioners	2011–2015	Favourable
	53	Young people not in education, employment or training	2005 to 2016	No clear trend[l]
	54	Emergency services response time	..	No data/ insufficient data

continued

Table 9.2.2 (continued): Indicators of Australia's welfare—trend assessment

CONTEXT[m]	
55	Population size and growth
56	Population ageing and dependency ratio
57	Overseas born population
58	Housing tenure
59	Government welfare expenditure
60	Welfare workforce
61	Economic conditions

(a) Favourable = trend moving in desired direction; Unfavourable = trend moving contrary to desired direction; No change = no movement in the trend; No clear trend = sufficient data are available to assess a trend but the trend cannot be determined with confidence due to potential data quality or confounding issues; No data/insufficient data = trend not assessed due to no trend data being available or insufficient data points over at least 5 years; .. = not applicable.

(b) Continuing a trend that was evident in the late 1970s, the employment to population ratio has risen for women and fallen for men. Overall, there is little change, with a slightly unfavourable trend for all people over the last 10 years and a slightly favourable trend over the last 20 years.

(c) The crime victimisation rate is declining for most types of serious personal and household crime.

(d) Trend is an age-standardised rate for high or very high levels (combined) of psychological distress.

(e) The family cohesion variable in the Longitudinal Survey of Australian Children is not recommended for trend analysis.

(f) Partner violence data for 2016 are expected to be available in late 2017.

(g) Trend data on waiting times for social housing are impacted by state and territory variation in wait list management over time which, together with changes to core systems in 2014–15, impact comparability of data between years.

(h) Comparison with previous surveys for the variable additional days of child care required in the ABS survey of Childhood education and care is not recommended.

(i) Interpretation of the trend is difficult due to changes in service delivery models in some jurisdictions.

(j) Changes in employment programs impact on the comparability of trend data.

(k) A trend assessment cannot be made due to data quality issues with data prior to 2012–13.

(l) The trend is favourable for 15–19-year-olds but unfavourable for 20–24-year-olds.

(m) No trend assessment is made for context indicators.

Wellbeing domain—indicator results

This domain presents indicators of our national wellbeing, reflecting the breadth and complexity of this concept. Over time, the domain will indicate, it is hoped, our progress towards better lives and greater happiness. The domain will highlight our collective strengths and weaknesses and point to areas for improvement. See Box 9.2.2 for key findings from the wellbeing domain.

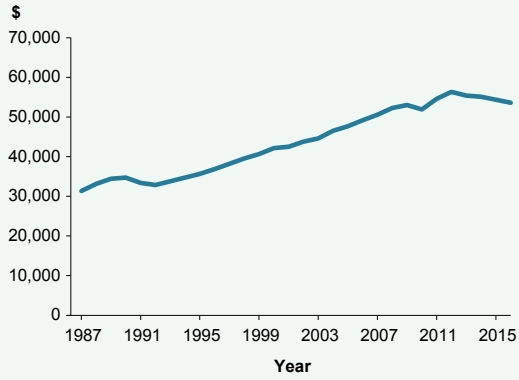
Box 9.2.2: Key results—wellbeing domain

Results from the initial measurement of wellbeing against the new indicator set show that:

- Real net national disposable income per capita rose steadily over the 30 years to June 2016 but has dropped since 2012.
- While the distribution of income in Australia has shown little change in recent years, income inequality has risen since the mid-1990s as measured by the Gini coefficient.
- Achieving a healthy work–life balance can be difficult: 20% of men and 7% of women in paid employment worked 50 hours or more per week in 2015. The rates have declined from 26% and 8%, respectively, in 2004 but are high compared with rates in some European and Nordic countries.
- Nearly two-thirds of Australians rate their overall satisfaction with life as high. Internationally, in 2016, Australia ranked 9th out of 38 Organisation for Economic Co-operation and Development (OECD) countries on life satisfaction.
- Australians are living longer without disability—years of life lived without disability in 2015 had increased since 2003 by 3.9 years for males, to 63 years, and by 3.0 years for females, to 65.2 years.
- Crime victimisation fell between 2008–09 and 2015–16 for most types of serious crime, such as physical assault and malicious property damage. Rates for malicious property damage more than halved over the period (11.1% down to 4.8%). Sexual assault rates have not changed since 2009.
- Our perceptions of safety have improved, although there are still substantial differences between the sexes. In 2014, 72% of men reported they felt safe walking alone in their local area after dark compared with just 34% of women.
- Education and skill levels have been increasing over time in the population, particularly for women. The proportion of women aged 35–44 with non-school qualifications increased from 61% in 2009 to 73% in 2015.
- Our air quality is relatively high. The concentration of fine particulate matter in Australia's atmosphere is lower than the OECD average and has been dropping gradually over time.
- More than 1 in 4 of us (28%) somewhat or strongly disagree that most people can be trusted.

Material living conditions: Purchasing power

Definition: Real net national disposable income (RNNDI) per capita.



Note: Chain volume measures; annual, original series.

Source: ABS 2016b.

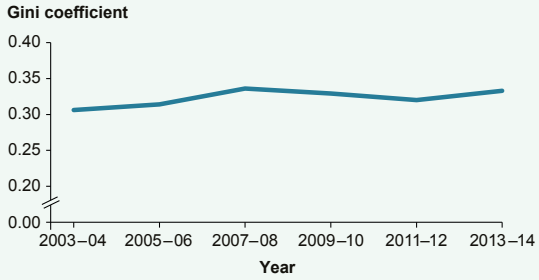
Indicator 1: Real net national disposable income per capita, June 1987 to June 2016

- RNNDI per capita rose from $31,340 in 1987 to $53,630 per annum in 2016.
- Over the 30 year period, RNNDI grew at 1.9% per annum on average.
- RNNDI peaked at $56,330 in June 2012 and then dropped by 1.2% per annum on average, returning to 2009 levels.

See also Indicator 61 'Economic conditions'.

Material living conditions: Income inequality

Definition: The Gini coefficient.



Notes

1. The Gini coefficient is a summary measure of inequality of income distribution, representing the income distribution of a nation's population. It has a score range between 0 and 1. The closer to 1, the higher the income inequality.
2. Estimates from 2007–08 are not directly comparable with those for prior years.

Source: ABS 2015c.

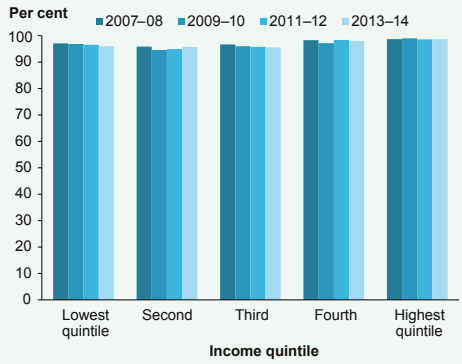
Indicator 2: Gini coefficient—income, 2003–04 to 2013–14

- Australia's Gini coefficient fluctuated around 0.32 for the decade to 2013–14. In 2013–14, the coefficient was 0.333, an increase from 0.306 in 2003–04.
- Australia's income distribution appears to have become more unequal since the mid 1990s, reflected in a slight upward trend in the Gini coefficient (Dollman et al 2015).
- OECD data for 2014 show that the Gini coefficient for Australia (0.337) was similar to that of New Zealand (0.333) and lower than that of the United Kingdom (0.358) and the United States (0.394). It was higher than the OECD average (0.318), which was rescribed in late 2016 as being the highest on record since the mid-1980s (OECD 2016).

See also Indicator 16 'Household income'.

Material living conditions: Adequate housing

Definition: Households that do not require extra bedrooms (%)—Housing utilisation (measured using the Canadian Occupancy Standard) by equivalised disposable household income.



Notes

1. Data are for households who either do not require any extra bedrooms or that have at least one bedroom spare.

Source: ABS 2015d.

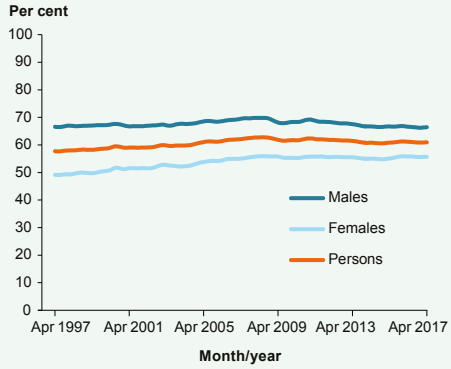
Indicator 3: Households that do not require extra bedrooms, by equivalised disposable household income quintiles, 2007–08 to 2013–14

- In 2013–14, most households had enough bedrooms. However, households in lower income quintiles were less likely to have enough or spare bedrooms (96% for the first, second and third quintiles; 98% for the fourth quintile; and 99% for the highest income quintile).
- This situation has changed little over the 7 years to 2013–14.
- In 2013–14, renter households were less likely than households that owned or were buying their own home to have enough or spare bedrooms (94% compared with 98%).

More information: Chapter 6.1 'Social housing' and Chapter 6.3 'The changing shape of housing in Australia'.

Work: Employment to population ratio

Definition: The number of employed persons expressed as a percentage of the Australian population aged 15 and over.



Note: Trend is a smoothed, seasonally adjusted series of estimates. Denominator is the population aged 15 years and over and includes the employed, unemployed and people not in the labour force.

Source: ABS 2017b.

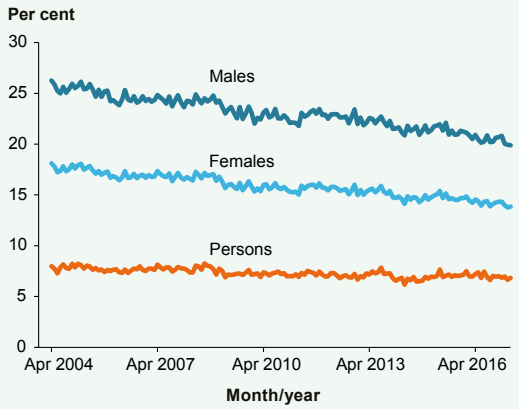
Indicator 4: Employment to population ratio, Australia, 1997 to 2017

- Over the last 20 years, the percentage of the Australian population that is employed has risen slightly, from 58% to 61%.
- The employment to population ratio has changed little for men, at 67%. By contrast, it rose for women from 49% to nearly 56% between 1997 and 2017.
- The ratio peaked at 63% in mid-2008. The highest rate for men was 70% and for women, 56%, both recorded in 2008.
- The employment to population ratio is a high-level summary measure. It does not reflect hours worked, types of employment, employment preferences, or job security.

More information: Chapter 4.2 'Key employment trends'.

Work: Employees working 50 hours or more

Definition: Hours usually worked—proportion of employees working 50 or more hours per week, people aged 15 and over.



Note: Employed persons who usually worked 50 hours or more in all jobs.

Source: ABS 2017d.

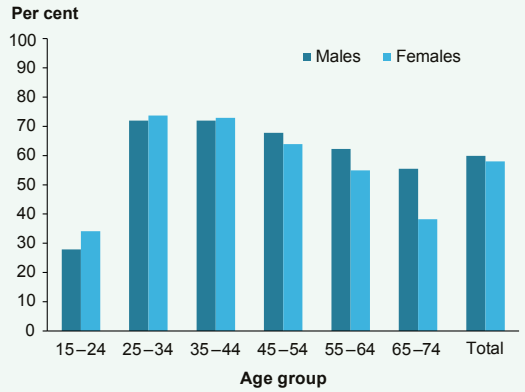
Indicator 5: Employed people 15 years and over working 50 hours or more per week, 2004 to 2017

- Working 50 hours or more per week may affect wellbeing. So, too, can underemployment and a mismatch between desired and actual hours worked.
- About 14% of the population were working 50 hours or more per week in April 2017. One in 5 (20%) males and 1 in 14 (7%) females were working these hours.
- The rates have decreased over time, from 26% for males and 8% for females in January 2004.
- OECD data show that Australia has one of the highest rates for this indicator. It is similar to the rates for New Zealand and the United Kingdom, but lower than Japan. Rates are much lower in many European and Nordic countries, and in Canada (OECD 2017b).

More information: Chapter 4.1 'The changing nature of work and worker wellbeing'.

Skills and learning: Non-school qualification

Definition: The proportion of people aged 15–74 with non-school qualifications.



Source: ABS 2016d.

Indicator 6: People aged 15–74 with a non-school qualification, by age group and sex

- In 2016, 59% of the Australian population aged 15–74 held a non-school qualification, such as a university degree or vocational education certificate.
- The percentage was slightly higher for males (60%) than females (58%).
- Education levels have been rising gradually over time in the population. Between 2009 and 2016, for example, the proportion of the population aged 15–74 with non-school qualifications increased by 3.9 percentage points.
- The gains have been more marked for females. The largest differences over time were for females aged 35–44, 12 percentage points, from 61% in 2009 to 73% in 2016.

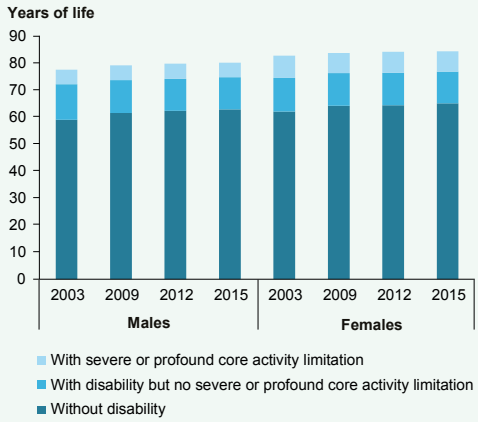
More information: Chapter 3.4 'Tertiary education'.

Skills and learning

Indicator 7: Lifelong learning—no indicator defined. See Chapter 9.1 'The *Australia's welfare* indicator framework', Box 9.1.2 for more information.

Health and vitality: Disability-free life expectancy

Definition: Disability-free life expectancy at birth.



Source: AIHW 2017.

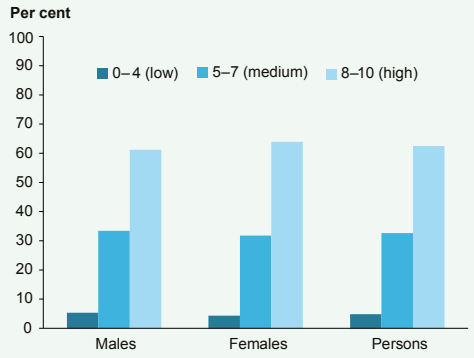
Indicator 8: Expected years of life at birth, by sex, 2003, 2009, 2012, 2015

- A boy born in 2015 can expect to live, on average, 80.4 years and a girl, 84.5 years. This is 2.6 and 1.7 extra years for males and females, respectively, compared with 2003.
- On average, boys born in 2015 can expect to live about 63 years without disability, 11.9 years with disability (but no severe or profound core activity limitation), and a further 5.4 years with severe or profound core activity limitation.
- The equivalent figures for girls born in 2015 are 65.2, 11.8 and 7.5 years.
- Years of life lived without disability have increased by about 2% for both males and females since 2003 (3.9 years for males and 3.0 years for females).

More information: Chapter 8.1 'People with disability'.

Health and vitality: Life satisfaction

Definition: Overall life satisfaction scores for people aged 15 and over (%).



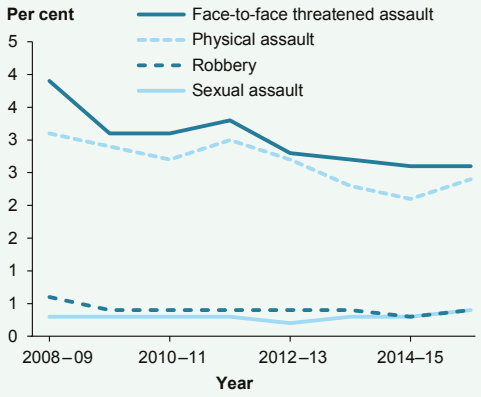
Source: ABS 2015b.

Indicator 9: Overall life satisfaction score in score ranges, people aged 15 and over, by sex, 2014

- In 2014, similar proportions of males and females rated their overall life satisfaction as low (5.3% and 4.3%, respectively); medium (33% and 32%) or high (61% and 64%).
- The average life satisfaction score on a scale of 0 to 10 was 7.6.
- People aged 75 and over were more likely to rate their life satisfaction as high (72%) than people aged 15–24 (63%).
- In 2016, Australia ranked ninth out of 35 countries on this measure, and higher than the OECD average. Australia's average score changed little over 2013–2016 (OECD 2017a).

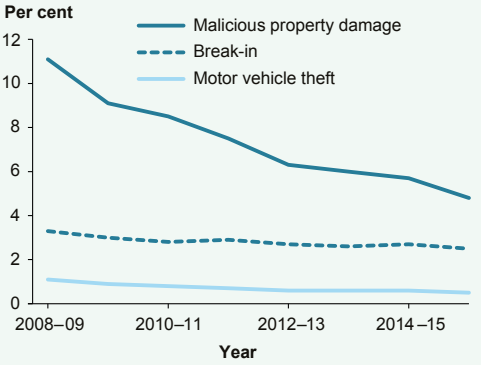
Personal safety: Crime victimisation

Definition: Rate (%) who experienced selected personal and household crime in the last 12 months, people aged 15 and over.



Source: ABS 2017a.

Indicator 10a: Victimisation rate, selected personal crimes, 2008–09 to 2015–16



Source: ABS 2017a.

Indicator 10b: Victimisation rate, selected household crimes, 2008–09 to 2015–16

- Household and personal crime victimisation rates generally fell between 2008–09 and 2015–16. However, the sexual assault rate did not, remaining stable over the period (0.3%).
- Rates for malicious property damage more than halved over the period (11.1% down to 4.8%).
- Data from the ABS General Social Survey also show a drop in crime victimisation rates. In the 12 months leading up to the survey, rates fell from 11% in 2006 to 8.0% in 2014 for threatened or actual physical violence, and from 9.4% in 2006 to 7.1% in 2014 for attempted or actual break-in (ABS 2015b).

Personal safety: Perceptions of safety in the community

Definition: The proportion of adults who report feeling very safe or safe walking alone after dark/alone at home after dark.

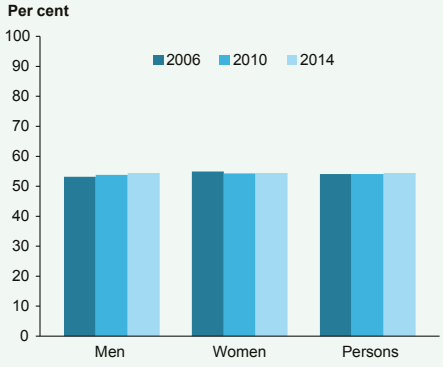
Source: ABS 2015b.

Indicator 11: Adults who report feeling very safe or safe walking alone after dark/being alone at home after dark, 2006, 2010 and 2014

- Perhaps reflecting the results for Indicator 10, adults reported feeling safer in their community in 2014 than in earlier years. More than half (52%) reported feeling very safe or safe walking alone in their local area after dark, compared with 48% in 2006.
- Similarly, the rates for feeling very safe or safe at home alone after dark also improved, from 86% in 2006 to 89% in 2014.
- While improvements were seen for both sexes, men feel much safer in their community than women. In 2014, 72% of men reported that they felt safe walking alone in their local area after dark compared with just 34% of women.

Community engagement: Level of generalised trust

Definition: Proportion of adults who somewhat agree or strongly agree that most people can be trusted.



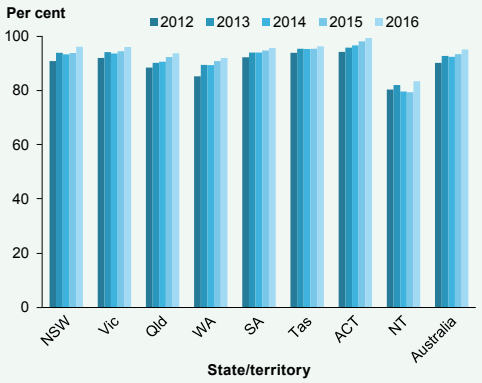
Source: ABS 2015b.

Indicator 12: Adults who somewhat agree or strongly agree that most people can be trusted, by sex, 2006, 2010 and 2014

- Levels of generalised trust did not change between 2006 and 2014, with about 54% of adults strongly agreeing or somewhat agreeing that most people could be trusted.
- Rates were similar for men and women.
- More than one-quarter (28%) of adults in 2014 somewhat or strongly disagreed that most people could be trusted.

Community engagement: Voter enrolment

Definition: Proportion of eligible Australian adults enrolled to vote.



Note: As at 30 June each year.

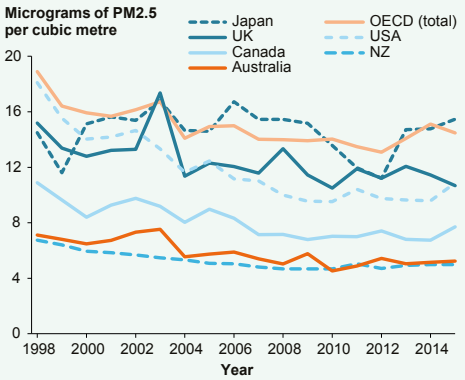
Source: AEC 2017.

Indicator 13: Eligible Australian adults enrolled to vote, by state and territory, 2012 to 2016

- The proportion of eligible Australians aged 18 and over who are enrolled to vote has risen since 2012, from 91% to 95% in 2016.
- The increase was seen in all jurisdictions, with the ACT having the highest enrolled population (99%) and the NT the lowest (84%) in 2016.
- Federal elections in 2013 and 2016 may explain higher rates of increase in those years.
- As at 31 December 2016, more than 800,000 eligible Australian citizens were not on the electoral roll.
- Nationally, the proportion of adults enrolled to vote is higher for women (51%) than men (49%).

Environment: Air quality

Definition: Mean population exposure to PM2.5 micrograms per cubic metre.



Notes

1. PM2.5 is fine particulate matter that is less than 2.5 microns in diameter. The major components of particulate matter are sulphate, nitrates, ammonia, sodium chloride, black carbon, mineral dust and water.
2. The underlying PM2.5 concentrations estimates have been derived using satellite observations and chemical transport models, calibrated against ground-based measurements.

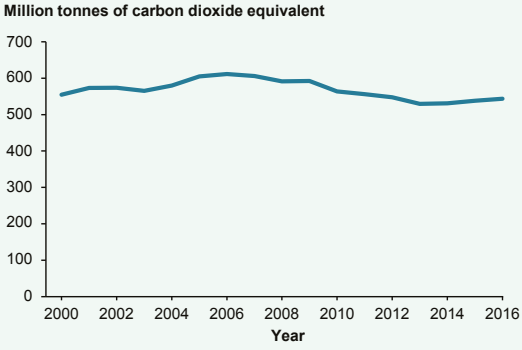
Source: OECD 2017b.

Indicator 14: Micrograms of PM2.5 per cubic metre, 1998 to 2015

- Australia has comparatively good air quality compared with selected OECD countries and the OECD as a whole.
- Australia's concentration of PM2.5 per cubic metre in 2015 (5.2 micrograms) was about one third that of the OECD average (15 micrograms).
- While there have been some fluctuations, the concentration of PM2.5 has dropped in Australia since 1998, from 7.1 to 5.2 micrograms of PM2.5 per cubic metre in 2015.
- All Australia's capital cities have very good air quality, based on assessment of PM2.5, according to findings of the State of the Environment 2016 report (Department of the Environment and Energy 2017a).

Environment: Greenhouse gas emissions

Definition: Greenhouse gas emissions—million tonnes of carbon dioxide equivalent (Mt CO2-e).



Notes

1. National inventory total (including the land sector).
2. Estimates are based on the Kyoto Protocol classification system (Cancun Agreement quantified economy-wide emission reduction target (QEERT)) and are used to track progress towards Australia's 2020 emission reduction target. See also Department of the Environment and Energy 2017b.

Source: Department of the Environment and Energy 2017b.

Indicator 15: Greenhouse gas emissions, million tonnes of carbon dioxide equivalent, 2000 to 2016

- Australia's greenhouse gas emissions have dropped by 2% since 2000 to 543.3 million tonnes (Mt) of carbon dioxide equivalent (CO2-e) in the year to December 2016.
- In the year to December 2016, the energy sector contributed most emissions (79%), followed by agriculture (13%), industrial processes and product use (6%), and waste (2%) (Department of the Environment and Energy 2017b).
- Australia's emissions per capita and per dollar of gross domestic product (GDP) have declined over the last 27 years, reducing by 24% and 39% respectively since 2000 (Department of the Environment and Energy 2017b).

Determinants domain—indicator results

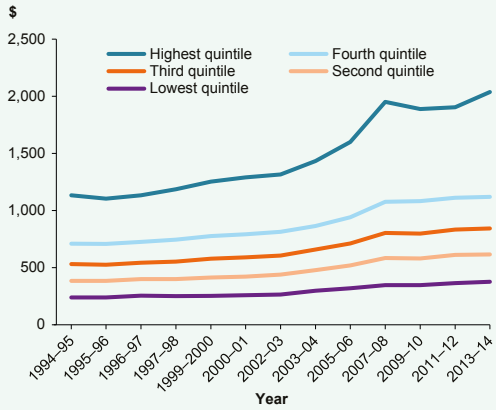
The determinants domain focuses on those factors that influence health and welfare and, potentially, demand for welfare services; that is, they can be risk factors for needing welfare support. The determinants indicators are closely related to the wellbeing indicators. See Box 9.2.3 for key findings from the determinats domain.

Box 9.2.3: Key results—determinants domain

- The prevalence of disability has decreased for all types of disability, from 20% in 2003 to 17% in 2015, as well as for disability with severe and profound core limitation (from 6.2% to 5.4%) (age standardised rates).
- In terms of social connectedness, 95% of the adult population could get support in times of crisis, and 85% could get access to emergency funds in a hurry.
- About one-third of people living in the lowest income households reported they could not get access to emergency funds quickly compared with 2% of people living in the highest income households.
- Around 86% of families report good to excellent family cohesion.
- In 2016, 89% of 20–24-year-olds had completed Year 12 or Certificate III, up from 80% in 2005, and 85% in 2012.
- Household internet access has been increasing over time, and is now at about 86%.
- One in 5 children were developmentally vulnerable on one or more domains in 2015. There is improvement for Indigenous children but the rates are still twice as high as for non-Indigenous children.
- A gradient towards increased disadvantage with increasing remoteness persists. Completion rates for Year 12 decline with increasing remoteness, as does internet access.

Material resources: Household income

Definition: Average weekly household income adjusted for the number of household members.



Note: Intervals between surveys have varied over time so trends should be interpreted with caution. From 2005–06, the survey of income and housing was run every 2 years. Prior to that, it was generally run every year.

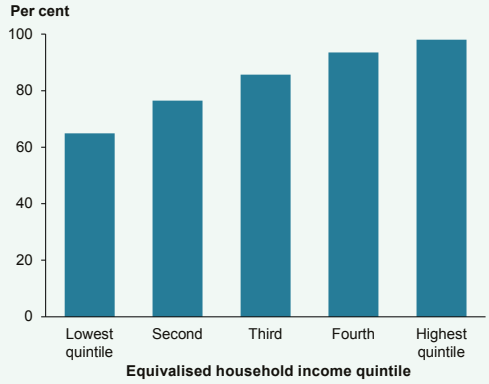
Source: ABS 2016e.

Indicator 16: Equivalised weekly household income, by income quintile, 1994–95 to 2013–14 (constant 2013–14 dollars)

- Equivalised weekly household income has risen for every quintile since 1994–95.
- The highest quintile had the highest growth of 80%, from 1994–95 to 2013–14.
- The growth rates for all other quintiles showed similar trends over the same period; however, since 2003–04, the gap has widened somewhat between each quintile level.
- The difference between the highest quintile and the lowest quintile nearly doubled between 1994–95 and 2013–14.

Material resources: Access to emergency funds

Definition: The proportion of people aged 18 and over able to raise $2,000 in a week for something important.



Source: AIHW analysis of ABS 2014–15 National Health Survey (TableBuilder).

Indicator 17: Ability to raise $2,000 in a week for something important, people aged 18 and over, by equivalised household income quintile, 2014–15

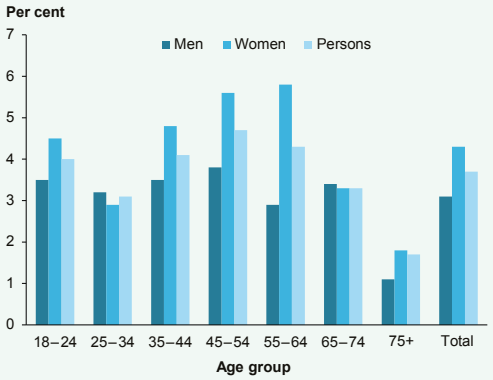
- Based on questions asked in the ABS 2014–15 National Health Survey, 85% of people aged 18 and over could raise $2,000 in a week for something important.
- In contrast, lower income households reportedly had more difficulty in raising emergency funds at short notice. About one-third (35%) of people living in the lowest income households reported they could not do so. This compares with just 2% of people living in the highest income households.
- Similar results were reported for 2011–12. This suggests that the level of financial vulnerability for low-income households has not changed substantially in 4 years.

Material resources: Housing security

Indicator 18: No indicator defined. See Chapter 9.1 'The *Australia's welfare* indicator framework' for more information.

Personal resources: Psychological resilience

Definition: [Proxy used] The proportion of adults with very high levels of psychological distress as measured by the Kessler Psychological Distress Scale—10 items (K10).



Note: The K10 is a scale of non-specific psychological distress based on 10 questions about negative emotional states in the 4 weeks before being interviewed.

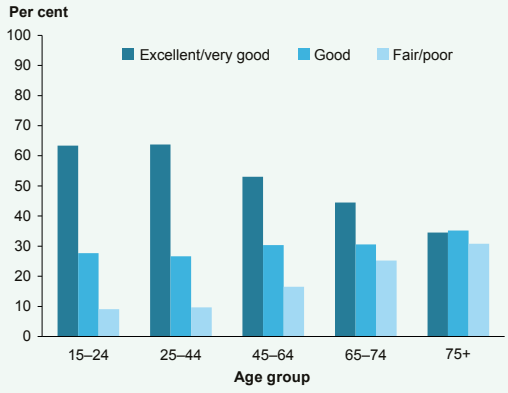
Source: AIHW analysis of ABS 2015e.

Indicator 19: Adults with very high levels of psychological distress, by age group and sex, 2014–15

- In 2014–15, 3.7% of adults had very high levels of psychological distress.
- Women (4.3%) were more likely than men (3.1%) to have very high levels of psychological distress, with women aged 55–64 having the highest rate (5.8%).
- Age-standardised rates of high or very high levels of psychological distress (combined) have not changed significantly between 2001 (13%) and 2014–15 (12%).
- Rates of high or very high psychological distress were more than twice as high for adults living in low socioeconomic areas (18%) than for adults in high socioeconomic areas (7%) (ABS 2015f).

Personal resources: Health status (self-assessed)

Definition: The proportion of people aged 15 and over who self-assess their health as excellent or very good.



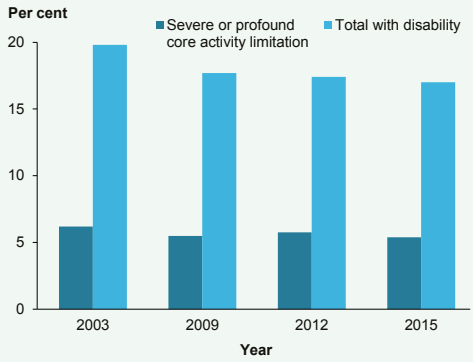
Source: ABS 2015e.

Indicator 20: Self-assessed health status, by age group, 2014–15

- In 2014–15, 56% of Australians aged 15 or over described their health as excellent or very good.
- Younger people were more likely than older people to rate their health as excellent or very good—63% of people aged 15–24 compared with 35% of people aged 75 or over.
- The proportion of people who described their health status as excellent or very good in 2014–15 was similar to the rate in 2004–05.
- Self-assessed health status was slightly higher for females (58%) than males (55%).

Personal resources: Functional status

Definition: [Proxy used] Disability prevalence rate (expressed as age-standardised rate).



Notes

1. Rates have been directly age-standardised to the Australian population as at 30 June 2001.
2. The change between the 2003 and 2009 surveys, being a six year period, should be compared with caution with change between the later surveys run at 3 year intervals.

Source: ABS 2016c.

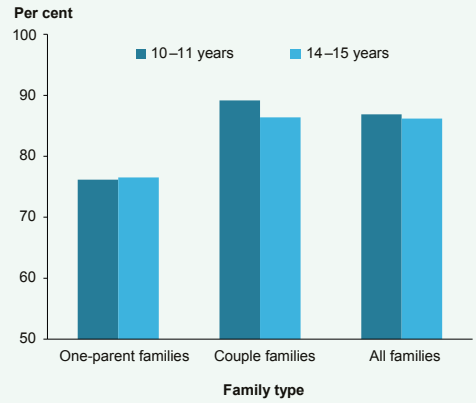
- After adjusting for age structure changes, the proportion of people with disability fell from 20% in 2003 to 17% in 2015.
- Over the same period, the proportion of people with severe or profound core activity limitation also fell, from 6.2% to 5.4%.
- Total disability prevalence was the same for males and females (17%). For people with severe or profound core activity limitation, the rates were 5.2% for males and 5.6% for females.

More information: Chapter 8.1 'People with disability'.

Indicator 21: Age-standardised prevalence of severe or profound core activity limitation, and all with disability, 2003, 2009, 2012 and 2015

Family relationships: Family cohesion

Definition: The proportion of families with children aged 10–11 and 14–15 who reported 'good', 'very good' or 'excellent' family cohesion.



Note: Family cohesion is a measure of family functioning and is defined in the Longitudinal Study of Australian Children as the ability of family members to get along with one another. The primary carer answers the relevant survey question on behalf of the family.

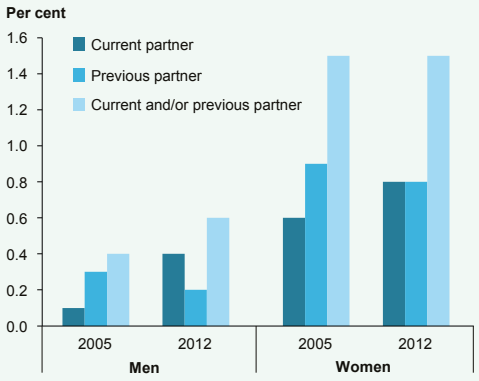
Source: AIHW analysis of DSS, AIFS & ABS 2016.

- According to *Growing up in Australia: The Longitudinal Study of Australian Children* (Wave 6), family cohesion was 'good', 'very good' or 'excellent' in the majority of families with children of both age groups—87% for families with children aged 10–11 and 86% for families with children aged 14–15.
- These results are very similar to those reported for 2012–13.
- A higher proportion of couple families than one parent families reported high levels of family cohesion (89% versus 76% for families with children aged 10–11 and 86% versus 77% for families with children aged 14–15).

Indicator 22: Families with good, very good or excellent family cohesion, families with children aged 10–11 and 14–15, by family type, 2014–15

Family relationships: Partner violence

Definition: The proportion of people who experienced any incident of sexual assault, sexual threat, physical assault or physical threat by a current and/or previous partner in the previous 12 months.



Source: ABS 2013a.

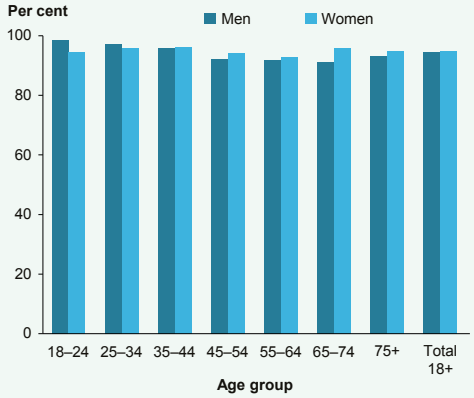
Indicator 23: Experience of partner violence in previous 12 months, by partner status and sex, 2005 and 2012

- Women are more likely than men to have experienced partner violence: in 2012, an estimated 1.5% of women and 0.6% of men aged 18 and over had experienced violence by a current and/or previous partner in the 12 months before the survey.
- Despite appearances, there were no statistically significant changes between 2005 and 2012 in the proportion who reported experiencing partner violence in the 12 months before the survey, for either men or women.
- Partner violence data for 2016 are expected to be available in late 2017.

More information: Chapter 2.7 'Family, domestic and sexual violence'.

Social engagement: Social connectedness

Definition: The proportion of adults who could get support in a time of crisis from people living outside the household.



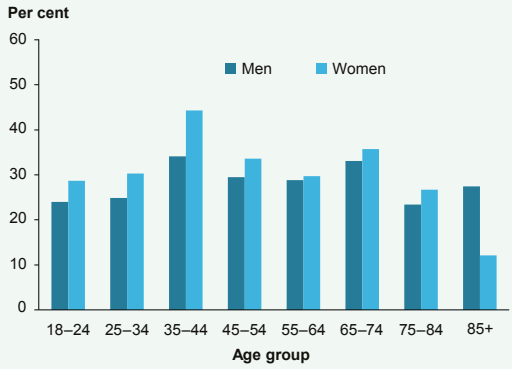
Source: AIHW analysis of ABS 2014 General Social Survey confidentialised unit record file.

Indicator 24: People who could get support in a time of crisis from outside the household, by age group and sex, 2014

- In 2014, 95% of people aged 18 and over indicated that they could get support in a time of crisis from people living outside their own household.
- Women aged 35 and over were slightly more likely than men to be able to get support; the opposite was true for people aged 18–34.
- Family members were the most commonly reported source of support (for 79% of adults), followed by friends (66%) and work colleagues (23%).
- The overall proportion of people able to get support outside the household has stayed much the same, at 93% in 2006 and 95% in 2014.

Social engagement: Adults who volunteer

Definition: The proportion of people who performed voluntary work at least once in the year.



Note: Voluntary work is unpaid help, willingly provided to an organisation or group.

Source: AIHW analysis of ABS 2015b.

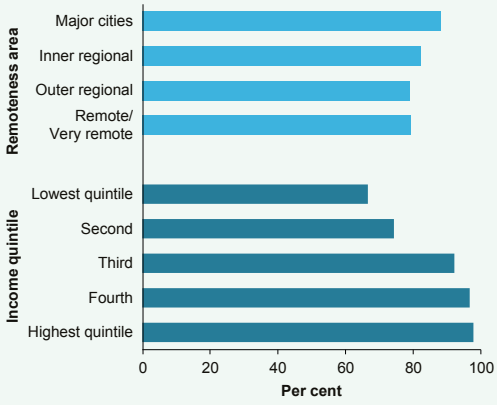
Indicator 25: Adults who volunteer, by age group and sex, 2014

- In 2014, about 5.4 million people aged 18 and over (31% of adults) worked voluntarily for an organisation in the previous 12 months.
- This rate has declined since 2010 (36%) and is lower than in 2006 (34%).
- There were slightly more female than male volunteers (33% and 29%, respectively). Rates were higher for women than men in every age group, except for people aged 85 and over (27% males and 12% females).
- The proportion of people who did voluntary work was highest among people aged 35–44 (39%). Rates for men and women were also highest in this age group (34% and 44%, respectively).

More information: Chapter 4.4 'Working for free—volunteers in Australia'.

Social engagement: Internet access

Definition: [Household access is used as a proxy for personal access.] The proportion of households that have internet access at home.



Note: Estimates presented for 2014–15 are not directly comparable with estimates for previous surveys which allowed the identification of the type of internet connection.

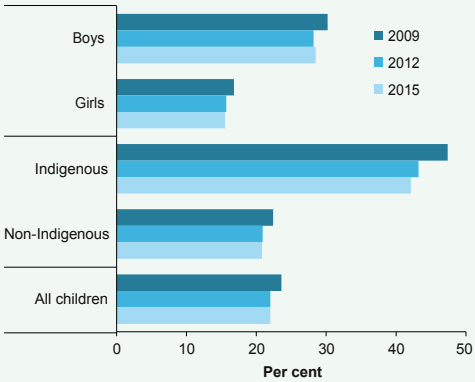
Source: ABS 2016f.

Indicator 26: Households with internet access at home, by remoteness area and by equivalised disposable household income, 2014–15

- Nearly 86% of Australian households had internet access at home in 2014–15, up from 67% in 2007–08.
- Access was higher in *Major cities* (88%) and *Inner regional* areas (82%) than in the more remote parts of Australia (79% for both *Outer regional* and *Remote/Very remote* areas).
- Internet access at home has generally increased for all Australians. However there is still a sharp gradient in access across household income levels. It ranges from 67% among households in the lowest equivalised disposable income quintile to 98% among households in the highest quintile.

Learning potential: School readiness

Definition: The proportion of children developmentally vulnerable on one or more domains of the Australian Early Development Census (AEDC).



Source: DET 2016.

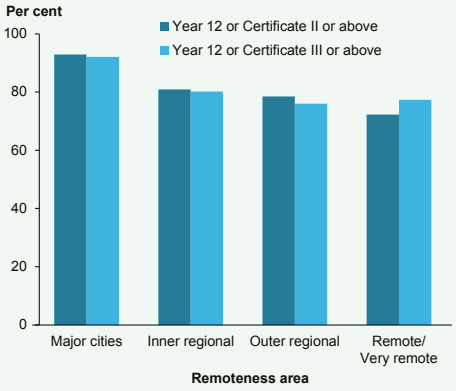
Indicator 27: Children developmentally vulnerable on one or more domains of the AEDC, by sex and Indigenous status, 2009, 2012 and 2015

- In 2015, about 1 in 5 (22%) children were developmentally vulnerable on one or more domains. This was the same as in 2012 and a small improvement on 2009 (24%).
- Boys were almost twice as likely to be developmentally vulnerable on this measure (around 29%) as girls (around 16%).
- Indigenous children were twice as likely to be developmentally vulnerable on one or more domains as non-Indigenous children (around 42% compared with around 21%, respectively).
- The rate of developmental vulnerability of Indigenous children has fallen, from 47% in 2009 to 42% in 2015.

More information: Chapter 2.2 'Transition to primary school' and Chapter 7.4 'Closing the gap in education'.

Learning potential: Year 12 attainment

Definition: The proportion of young people aged 20–24 who have completed Year 12 or gained a qualification at the Australian Qualifications Framework Certificate II/III or above.



Source: ABS 2016d.

Indicator 28: Completion of Year 12 or Certificate II/III or above, people aged 20–24, by remoteness area, 2016

- In 2016, 90% of people aged 20–24 had completed Year 12 or Certificate II or above, and 89% had completed Year 12 or Certificate III or above. These percentages were up from 81% and 80% in 2005, and 86% and 85% in 2012, respectively.
- Completion rates were higher for women than for men—92% compared with 89% for attainment of Year 12 or Certificate II or above and 90% compared with 87% for attainment of Year 12 or Certificate III or above.
- Completion rates decreased with increasing remoteness, from 93% and 92% in *Major cities* for attainment of Year 12 or Certificate II or above, and Year 12 or Certificate III or above, to 72% and 77% in *Remote/Very remote* areas.

More information: Chapter 3.2 'School retention and completion' and Chapter 7.4 'Closing the gap in education'.

Welfare services performance domain—indicator results

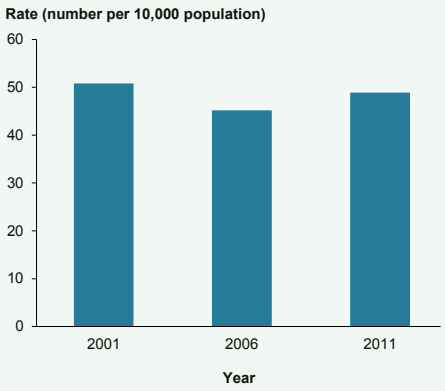
A role of welfare payments and services is to provide a 'safety net' for people who experience disadvantage on a short- or long-term basis. This domain reports on the extent to which the major services, supports, payments and interventions contribute to providing an adequate level of support and achieving better welfare outcomes for Australians. The pathways between welfare support and long-term outcomes are not direct; therefore, these indicators can provide only high-level insights about likely impacts on individuals. See Box 9.2.4 for key findings from the determinants domain.

Box 9.2.4: Key results—welfare services performance

- In 2015, most people (94%) aged 15–64 with disability had participated in social activities away from home in the last 3 months. The majority of people with disability aged 65 and over reported that their needs were fully met (67%) in 2015.
- More than 98% of young people in youth justice detention were in education and/or training. The level of school-aged attendance for this population group increased over the period from 2010–11 to 2014–15.
- The proportion of Indigenous households living in overcrowded conditions dropped from 27% in 2004–05 to 21% in 2014–15, with improvements seen across all remoteness areas.
- Satisfaction with particular services ranged from 67% for clients of Centrelink to 80% for community housing clients.
- After a period of improving rates between 2004 and 2008, there has been an upward trend for the male and female long-term and youth unemployment rates from late 2008/early 2009.
- There were 1.4 million jobless families in Australia in 2016, representing 22% of families. Over half a million children aged under 15 (13% of all children in this age group) were living in jobless families.
- One in 2 (50%) lower income rental households were spending more than 30% of their income on housing in 2013–14, with this figure rising since 2005–06 (42%).

Welfare services outcomes: Homelessness

Definition: The number of homeless people per 10,000 population.



Source: ABS 2012.

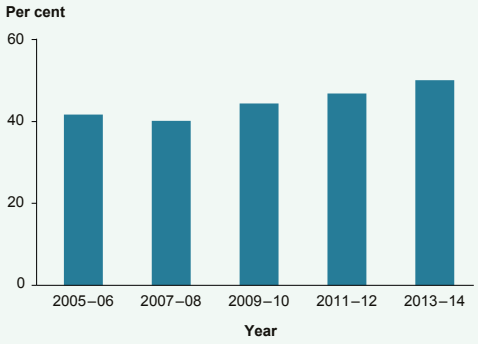
Indicator 29: Homelessness rate, number per 10,000 population, 2001, 2006 and 2011

- In 2011, the homelessness rate was 49 people per 10,000 population as enumerated in the Census.
- The 2011 rate increased by 8% from 45 per 10,000 in 2006, but decreased from 51 per 10,000 in 2001.
- The increase between 2006 and 2011 was due to the increase in people considered to be living in severely overcrowded conditions.
- Specialist Homelessness Services (SHS) client numbers have increased, from 236,429 clients in 2011–12 to 279,196 in 2015–16. Nearly half (47%) of these clients in 2015–16 had sought assistance during the previous 4 years.
- The number of SHS clients who were homeless on presenting to an SHS agency increased from 70,580 (41%) in 2011–12 to 108,570 (44%) in 2015–16 (AIHW 2016a).

More information: Chapter 6.2 'Homelessness'.

Welfare services outcomes: Lower income rental households in housing stress

Definition: The proportion of lower income rental households in housing stress (spending more than 30% of their gross income on housing costs).



Notes

1. Lower income households have 38% of people with equivalised disposable household income (EDHI) between the 3rd and 40th percentiles of EDHI.
2. Excludes households with nil or negative total income.
3. Excludes lower income 'owners without a mortgage' and 'owners with a mortgage'.

Source: ABS 2015d.

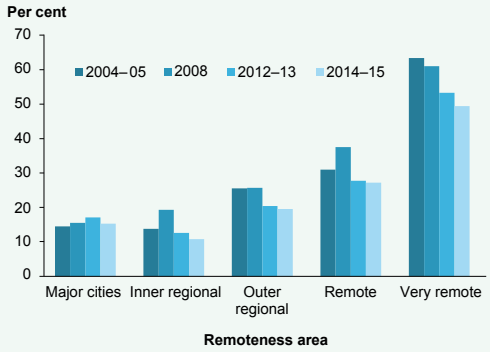
- In 2013–14, 1 in 2 (50%) lower income rental households spent more than 30% of their gross income on housing costs. This is an 8 percentage point rise from 42% in 2005–06.
- The proportion of lower income rental households in housing stress rose steadily between 2007–08 and 2013–14.
- For lower income households renting privately, the proportion in housing stress continued to rise, from 54% in 2011–12 to 62% in 2013–14.

More information: Chapter 6.3 'The changing shape of housing in Australia'.

Indicator 30: Proportion of lower income rental households spending more than 30% of their gross income on housing costs, 2005–06 to 2013–14

Welfare services outcomes: Indigenous households living in overcrowded conditions

Definition: The proportion of Indigenous households that require one or more extra bedroom(s) to accommodate usual residents, based on the Canadian National Occupancy Standard.



Note: See Glossary for 'overcrowding'.

Source: SCRGSP 2016.

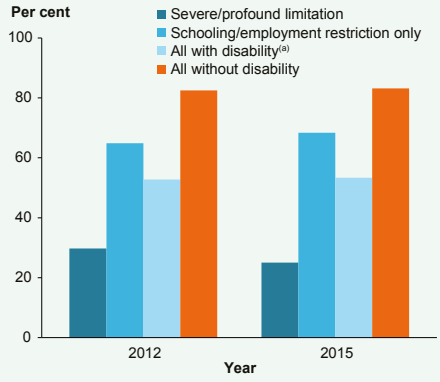
Indicator 31: Overcrowding in Indigenous households, by remoteness area, 2004–05, 2008, 2012–13 and 2014–15

- Between 2004–05 and 2014–15, the proportion of Indigenous households living in overcrowded conditions dropped from 27% to 21%.
- Improvements were seen across each of the remoteness areas, with the greatest change in *Very remote* areas.
- However, a three-fold difference remains in the rate of overcrowding in *Very remote* areas (49% in 2014–15) compared with *Major cities* (15%).

More information: Chapter 7.1 'Community factors and Indigenous wellbeing'.

Welfare service outcomes: Labour force participation for people with disability

Definition: The proportion of people aged 15–64 who are working or looking for work, by disability status.



(a) Includes people with severe/profound limitation and schooling/employment restrictions.

Sources: AIHW analyses of ABS 2012 and 2015 Surveys of Disability, Ageing and Carers.

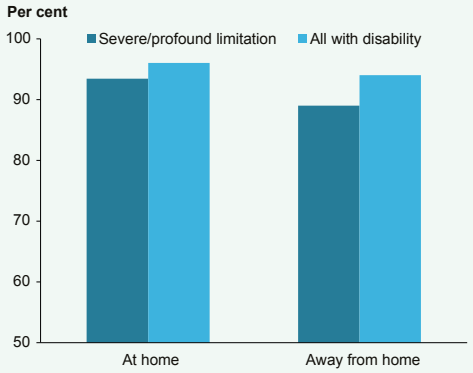
Indicator 32: Labour force participation for people aged 15–64, by disability status, 2012 and 2015

- In 2015, labour force participation was lower for people with disability and severe or profound limitation (25%) than for people with schooling or employment restriction only (68%), or for all people with disability (53%) and people without disability (83%).
- Participation declined slightly for people with severe or profound limitation from 30% in both 2003 and 2012 to 25% in 2015.
- Participation remained steady for people without disability in 2015. However, it rose for people with disability and schooling or employment restriction(s) only (65% in 2012), returning to its 2003 level (68%).

More information: Chapter 8.2 'Participation in society by people with disability'.

Welfare services outcomes: Social participation for people with disability

Definition: The proportion of people aged 15–64 with disability living in households who engaged in social activities at home or away from home in the last 3 months.



Source: AIHW analysis of ABS 2016c.

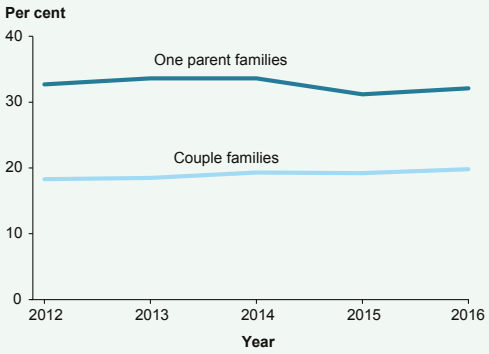
Indicator 33: Participation in social activities, people aged 15–64 with disability, by disability severity, 2015

- In 2015, most people (94%) aged 15–64 with disability had participated in social activities away from home in the last 3 months.
- The proportion was slightly lower for people with disability and severe or profound limitation (89%).
- The difference was less marked for participation in social activities at home (93% for people with severe or profound limitation, and 96% for all people with disability).
- These rates have changed little since 2003.

More information: Chapter 8.2 'Participation in society by people with disability'.

Welfare service outcomes: Jobless families

Definition: The proportion of households where no-one in the family aged 15 and over is employed, including dependants.



Note: A jobless family is a family where no person usually resident in the family (including dependants) is employed.

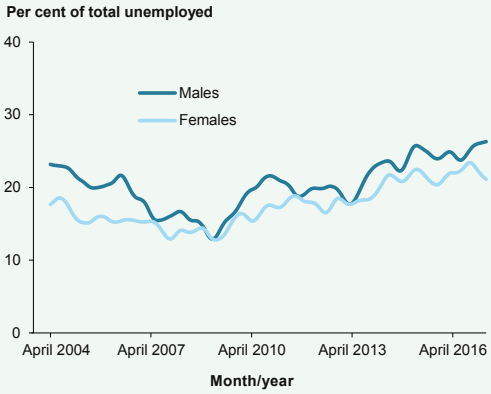
Source: ABS 2017c.

Indicator 34: Jobless families, by family type, 2012 to 2016

- In June 2016, there were 1.4 million jobless families in Australia (22% of all families).
- Of these, around 1.1 million were couple families and around 304,400 were one parent families.
- Eleven percent (127,600) of jobless couple families and 70% (213,900) of jobless one parent families had dependants.
- There were 580,000 children aged 0–14 living in jobless families (13% of all children aged 0–14). This proportion has changed little since 2012.

Welfare services outcomes: Long-term unemployment ratio

Definition: The number of long-term unemployed persons (unemployed for 52 weeks or more) expressed as a percentage of the total unemployed population aged 15 and over.



Note: Figure presents ABS 'trend' series, which is a smoothed seasonally adjusted series of estimates.

Source: ABS 2017d.

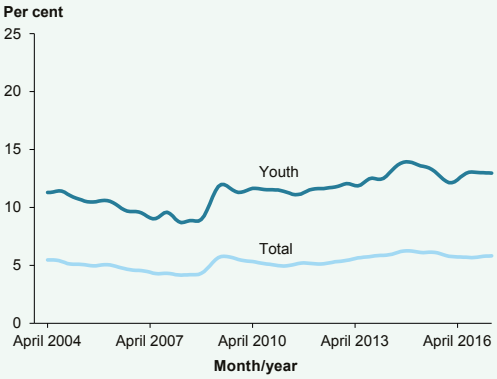
Indicator 35: Long-term unemployment ratio, people aged 15 and over, by sex, 2004 to 2017

- One in 4 (24%) unemployed people had been unemployed for 52 weeks or more, as at April 2017.
- The long-term unemployment ratio was generally higher for males than females from April 2004 to April 2017.
- There has been an upward trend for the male and female long term unemployment ratios since early 2009.
- The difference between the male and female long-term unemployment ratio has fluctuated over the period. As at April 2017, the difference was 5.2% (26.3% for males, and 21.1% for females).

More information: Chapter 4.2 'Key employment trends'.

Welfare services outcomes: Youth unemployment rate

Definition: The number of unemployed people aged 15–24, expressed as a percentage of the total number of people aged 15–24 in the labour force.



Note: Figure presents ABS 'trend' series, which is a smoothed seasonally adjusted series of estimates.

Source: ABS 2017b.

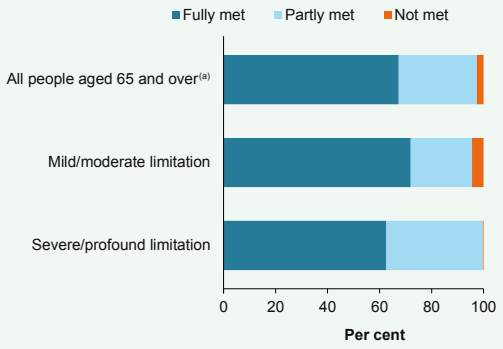
Indicator 36: Youth (aged 15–24) and total unemployment rates, 2004 to 2017

- Between April 2004 and April 2017, the youth unemployment rate was higher than the total unemployment rate.
- The difference in rates between 2004 and 2017 was largest in October 2014, when it was 7.7 percentage points.
- While rates have fluctuated over time, there has been an upward trend in the youth unemployment rate since October 2008, with the rate peaking in October 2014 at 14%.
- At April 2017, the youth unemployment rate was 13% (14% for males, and 12% for females).

More information: Chapter 4.2 'Key employment trends'.

Welfare services outcomes: Older people with care needs supported

Definition: The proportion of people aged 65 and over living in households whose need for assistance was fully met.



(a) Includes people with and without disability.

Source: AIHW analysis of ABS 2016c.

Indicator 37: People aged 65 and over living in households, by extent to which need for assistance was met and disability status, 2015

- The majority of people aged 65 and over had their needs fully met (69%). This is a small improvement since 2003 (64%).
- The proportion of people who reported their needs were fully met was higher among people with mild or moderate core activity limitation than among people with severe or profound core activity limitation (72% and 63%, respectively).
- People with mild or moderate core activity limitation were most likely to report not having their needs met at all (4%).

More information: Chapter 5.1 'Ageing and aged care'.

Welfare services outcomes: Underemployment of parents receiving child care benefits

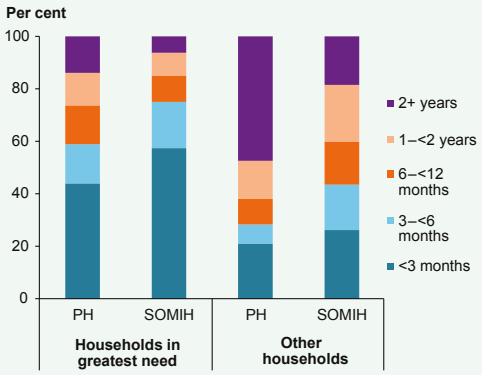
Note this indicator was reported in *Australia's welfare 2015* using proxy data. However a re-assessment of the value of the available data resulted in the decision to remove this indicator from the indicator set.

Welfare services outcomes: Safe return home for children in out-of-home care

Indicator 38: No indicator defined. See Chapter 9.1 'The *Australia's welfare* indicator framework' for more information.

Access: Waiting times for social housing

Definition: The length of time households in greatest need wait to be allocated social housing.



Note: PH = public housing. SOMIH = state owned and managed Indigenous housing.

Source: AIHW—National Social Housing Assistance Data Repository.

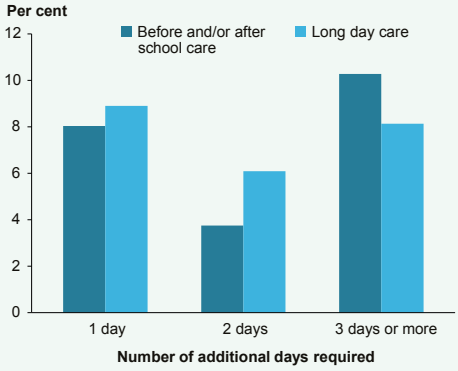
Indicator 39: Waiting time for social housing, households in greatest need and other households, by social housing program, 2015–16

- A total of 14% of households in greatest need for public housing waited 2 years or more to be allocated housing—similar to 2013–14 (15%). 47% of other households also waited 2 years or more.
- For households in greatest need for SOMIH, 6% waited over 2 years to be allocated housing, compared with 19% of other households.
- The proportion of housing allocations made to those in greatest need has remained relatively stable for public housing and SOMIH over the past 5 years (around 75% for public housing and 58% for SOMIH).

More information: Chapter 6.1 'Social housing' and Chapter 6.3 'The changing shape of housing in Australia'.

Access: Difficulty accessing child care

Definition: Proportion of children aged 0–12 attending formal child care who require additional days of care.



Source: ABS 2015a.

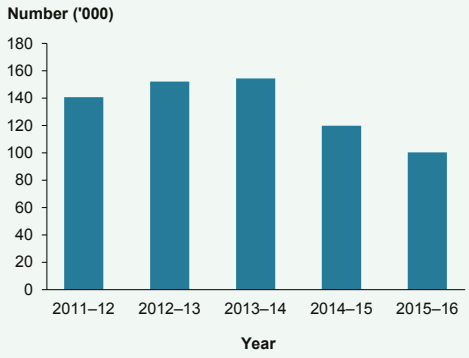
Indicator 40: Proportion of children aged 0–12 attending formal child care who require additional days of care, by number of days and care type, 2014

- In 2014, parents reported that additional formal care was required for 250,800 children aged 0–12 (27% of all children attending formal care; 7% of all children aged 0–12).
- The greatest need was for 3 or more extra days of care in before and/or after school care (10% of children attending before and/or after school care).
- The most common reason parents needed care was for work-related purposes (153,300 children).

More information: Chapter 2.1 'Children in child care and preschool programs'.

Access: Unmet demand for homelessness services

Definition: [Proxy used] Number of unassisted requests for specialist homelessness services (SHS).



Notes

1. Unassisted requests for specialist homelessness services (SHS) assistance relate to people who were not able to be offered any services by an SHS organisation or agency.
2. An unassisted request can relate to one or more people seeking SHS assistance. These people may have approached more than one agency or returned to the same agency another day.
3. Previously published data for 2011–12 have been revised.
4. The 2011–12 data exclude those for South Australia.

Source: Specialist Homelessness Services Collection, 2011–12 to 2015–16.

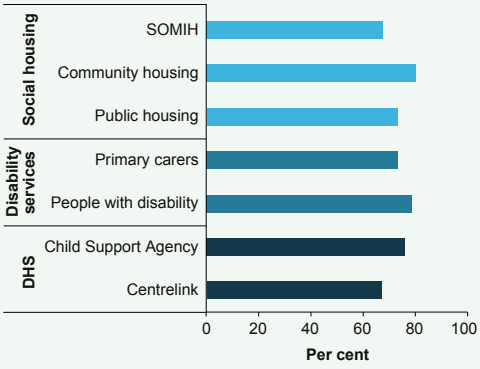
Indicator 41: Number of unassisted requests for SHS, 2011–12 to 2015–16

- Between 2011–12 and 2015–16, nearly 700,000 requests for SHS could not be met by SHS agencies.
- The total number of unassisted requests gradually increased, from 140,700 in 2011–12 to 154,400 in 2013–14.
- The decrease in unassisted requests recorded from 2014–15 was, in part, due to the introduction of new service delivery models in the sector.

More information: Specialist homelessness services annual report, 2015–16.

Responsiveness: Satisfaction with services

Definition: The proportion of clients satisfied with the service received (within specific programs/sectors).



Notes

1. SOMIH = state owned and managed Indigenous housing.
2. Department of Human Services (DHS) data are for financial year 2015-16; disability services data are for calendar year 2015; social housing data are for calendar year 2016.

Sources: DHS 2016; SCRGSP 2017.

Indicator 42: Client satisfaction with service provision, selected services, 2016 (or nearest available year)

- For the services included here, satisfaction ranged from 68% for clients of SOMIH services to 73% for clients of public housing, and 80% for community housing clients.
- There was a 10 percentage point increase in SOMIH client satisfaction, from 58% in 2014 to 68% in 2016.
- A total of 79% of people with disability and 73% of primary carers were satisfied with services received. This was not significantly different from what it was in 2012.
- Client satisfaction with Centrelink was steady in 2015–16 (67%) compared with 2013–14 (68%); however, it had decreased for the Child Support Agency, from 84% to 76%.

More information: Chapter 6.1 'Social housing' and Chapter 6.3 'The changing shape of housing in Australia'.

Efficiency: Cost per service output

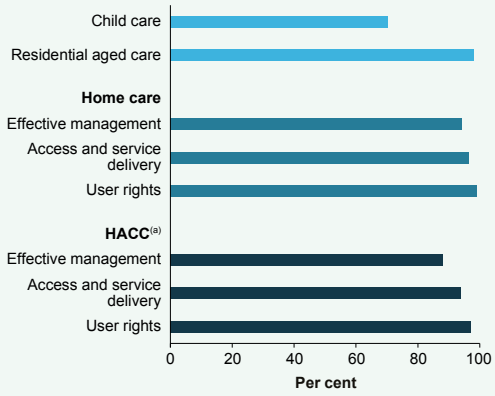
Indicator 43: Data not reported. See Chapter 9.1: 'The *Australia's welfare* indicator framework'.

Efficiency: Management expense ratio

Indicator 44: No indicator defined. See Chapter 9.1: 'The *Australia's welfare* indicator framework'.

Safety and quality: Compliance with service standards

Definition: The proportion of services that comply with applicable service standards (by sector).



(a) In most jurisdictions, Home and Community Care (HACC) has been consolidated into Home Care; therefore, HACC figures here are only for Western Australia.

(b) For information on programs included, see online data tables and SCRGSP 2017.

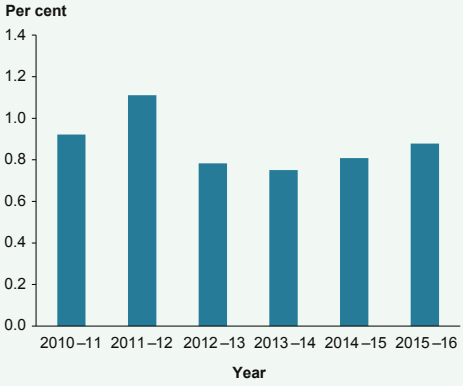
Source: SCRGSP 2017.

Indicator 45: Compliance with service standards, selected sectors(b), 2015–16

- As at 30 June 2016, 70% of approved child care services with a quality rating achieved an overall rating that met or exceeded National Quality Standards, slightly higher than for the previous year (67%).
- In 2015–16, 98% of residential aged care services held 3-year accreditation, similar to results for the previous year.
- Community aged care services are assessed against three service standards. In 2015–16, the proportion of Home Care services meeting the standards ranged from 94% to 99%. For HACC services (Western Australia only), the proportion ranged from 88% to 97%. Figures are not comparable with those for previous years.

Safety and quality: Safety and security of children and young people in out-of-home care

Definition: [Proxy used]: Children in out-of-home care who were the subject of a child protection substantiation and the person responsible was living in the household.



Notes

1. Children in out-of-home care include young people up to 17 years.
2. Excludes the Northern Territory for all years and South Australia for 2014–15 and 2015–16, as data were not available for this indicator.

Source: SCRGSP 2017.

Indicator 46: Children in out-of-home care who were the subject of a child protection substantiation and the person responsible was living in the household, 2010–11 to 2015–16

- In 2015–16, less than 1.0% of children in out-of-home care were the subject of a child protection substantiation where the person responsible was living in the household.
- Over the period from 2010–11 to 2015–16, the number of children in this group has varied slightly, with a low of 365 children (0.8%) in 2013–14 and a high of 522 children (1.1%) in 2011–12.
- The 2015 national pilot survey on the views of children and young people in out-of-home care found that 91% reported feeling both safe and settled in their current placement (AIHW 2016b).

More information: Chapter 2.4 'Child protection'.

Effectiveness: Job seekers off benefits after participation in employment services

Definition: The proportion of job seekers off benefits after participation in employment services.

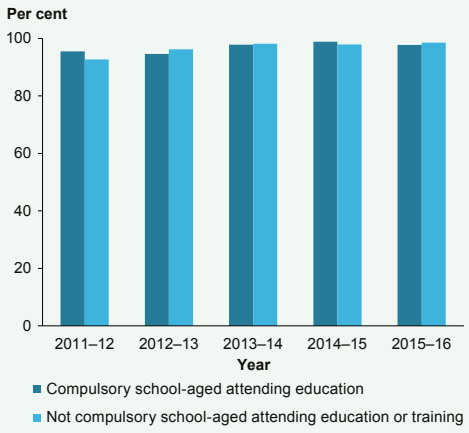
- On 1 July 2015, Job Services Australia was replaced with a new employment program, jobactive. Six months of data were collected for job seekers participating in jobactive from 1 July 2015 to 31 December 2015. Their income support status was measured six months later between 1 January 2016 and 30 June 2016.
- The results showed that 43% of job seekers moved off income support or substantially reduced their reliance on income support 6 months after participation in the jobactive program.

Source: Department of Employment 2016.

Indicator 47: Proportion of job seekers off benefits after participation in employment services

Effectiveness: Young people in detention attending education/training

Definition: The proportion of young people in detention attending education/training.



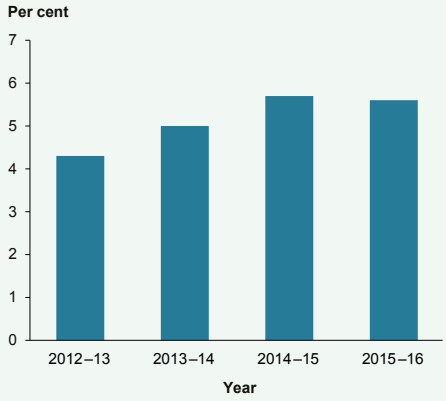
Source: SCRGSP 2017.

Indicator 48: Young people in youth justice detention attending education/ training, by school age, 2011–12 to 2015–16

- The vast majority (almost 98%) of young people in youth justice detention were in education and/or training.
- There were very similar results for both compulsory school-aged and non-compulsory school-aged young people in youth justice detention.
- The level of compulsory and non-compulsory school-aged attendance rose over the period from 2011–12 to 2015–16 (96% to 98% for compulsory education; 93% to 99% for non-compulsory education).

Effectiveness: Repeat periods of homelessness

Definition: The proportion of homelessness services clients who had more than one period of homelessness within the reporting period.



Source: Specialist Homelessness Services Collection, 2012–13 to 2015–16.

Indicator 49: Clients experiencing repeat periods of homelessness, 2012–13 to 2015–16

- During 2015–16, 5.6% of clients receiving specialist homelessness assistance had more than one period of homelessness.
- On average, 1 in 20 clients of specialist homelessness services had more than one period of homelessness in a year.
- The proportion of clients experiencing repeat homelessness increased between 2012–13 and 2015–16 (7% annual growth on average).

More information: Chapter 6.2 'Homelessness'.

Coordination: no indicators identified

Indicator 50: No indicator defined. See Chapter 9.1: 'The *Australia's welfare* indicator framework'.

Other sectors domain—indicator results

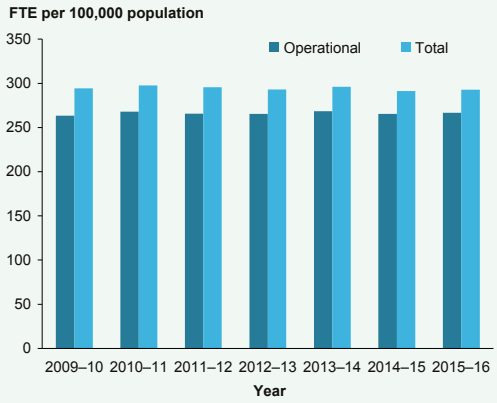
This domain recognises the contribution of other sectors to the determinants of wellbeing, and outcomes of welfare services. The four indicators presented here are not intended to provide a comprehensive summary of each sector. They are included to acknowledge the many complexities that have an impact on welfare and wellbeing. See Box 9.2.5 for key findings from the other sectors domain.

Box 9.2.5: Key results—other sectors

- Young people not in education, employment or training are at risk of social exclusion, and more likely to require welfare support. Rates have reduced slightly since 2013; however, in 2015, 5.1% of people aged 15–19 and 12% of people aged 20–24 were not working or studying.
- The highest rate for full-time equivalent (FTE) general practitioners in 2015 was in *Remote/Very remote* areas, with 136 FTE general practitioners per 100,000 population. Rates increased in all remoteness areas between 2011 and 2015.

Other sectors: Police operational staff levels

Definition: The number of operational full-time equivalent police staff per 100,000 population.



FTE = full-time equivalent

Note: Estimated resident population as at 30 June each year.

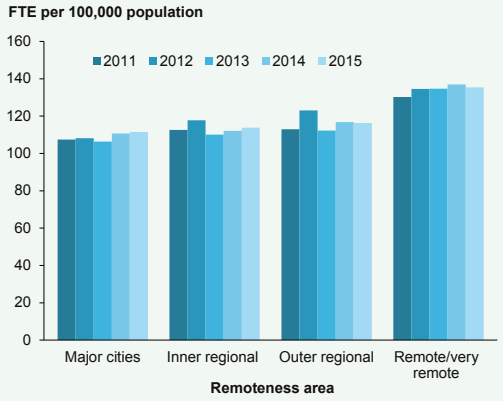
Sources: ABS 2016a; SCRGSP 2017.

- The rate of FTE operational police staff has been steady over the 7 years to 2015–16, at around 266 police per 100,000 population.
- The proportion of operational to total police staff has also been steady over the period, at about 90%.
- Around 75% of the population were generally satisfied with police services.

Indicator 51: Operational and total police staff per 100,000 population, 2009–10 to 2015–16

Other sectors: Access to primary care practitioners

Definition: The number of full-time equivalent general practitioners per 100,000 population.



Notes

1. FTE = full-time equivalent
2. The FTE number is based on total weekly hours worked. A standard working week is 40 hours.
3. Data cannot be compared with data presented in *Australia's welfare 2015* that were based on Medicare data which only take into account MBS-billable work.
4. From 2013 the survey directs Australian General Practice Training program trainees to select Specialist in training rather than General practitioner.

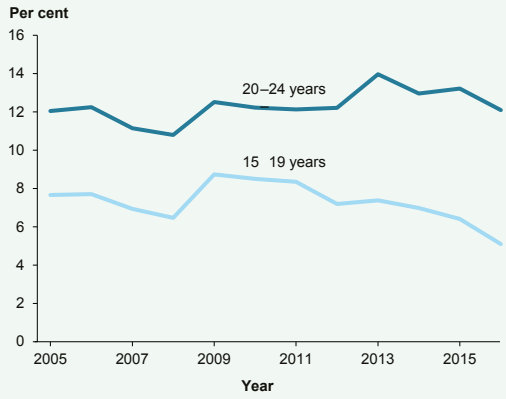
Source: National Health Workforce Data Set medical practitioners 2015.

- In 2015, the highest general practitioner (GP) FTE rate was in *Remote/Very remote* areas, with 136 FTE GPs per 100,000 population. The lowest FTE rate was in *Major cities*, at 112 FTE per 100,000 population.
- Although there were some fluctuations, GP FTE rates increased in all areas between 2011 and 2015.
- The National Health Workforce Data Set used here captures total hours worked, including hours not billed to Medicare. This is particularly relevant for rural and remote GPs who may do a broader scope of work than their urban counterparts, including work that would not normally be considered primary care.

Indicator 52: General practitioners per 100,000 population, 2011 to 2015

Other sectors: Young people not in education, employment or training

Definition: The proportion of young people (aged 15–24) not engaged in education, employment or training.



Source: AIHW analysis of ABS 2016d.

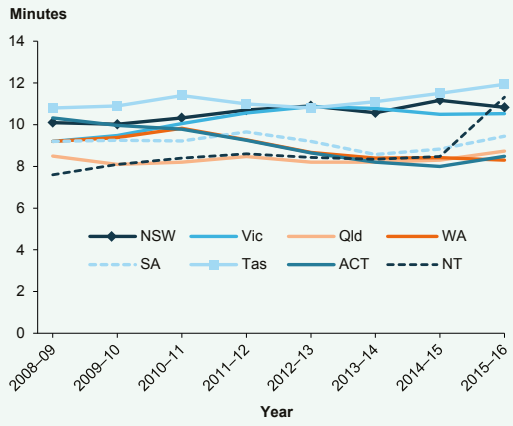
Indicator 53: Young people not in education, employment or training, by age group, May 2005 to May 2016

- After peaking at 8.7% in May 2009, the rate of people aged 15–19 who were not in education, employment or training fell to 5.1% in 2016.
- The rate for people aged 20–24 peaked in 2013 at 14% and then fell to 12% in 2016, equivalent to the rate in 2005.

More information: Chapter 3.1 'Pathways through education and training'.

Other sectors: Emergency services response time

Definition: [Proxy used] The time taken between the arrival of the first responding ambulance resource at the scene of an emergency in code 1 situations (emergency—immediate response under lights and sirens required), and the initial receipt of the call for an emergency ambulance at the communications centre, in urban centres.



Note: Data cannot be aggregated to a national total.

Source: SCRGSP 2017.

Indicator 54: Median ambulance response time to emergency incidents, capital cities, by jurisdiction, 2008–09 to 2015–16

- In 2015–16, ambulance services nationally made 1.85 million emergency responses, a rate of 77 per 1,000 population.
- The median ambulance response time for emergency (or code 1) incidents ranged from 8.3 minutes in Perth to 11.9 in Hobart.
- Response times varied across the states and territories, with the Australian Capital Territory and Western Australia showing decreases in response time since 2008–09. Trends should be interpreted with caution due to changes in reporting methods.

Context domain—indicator results

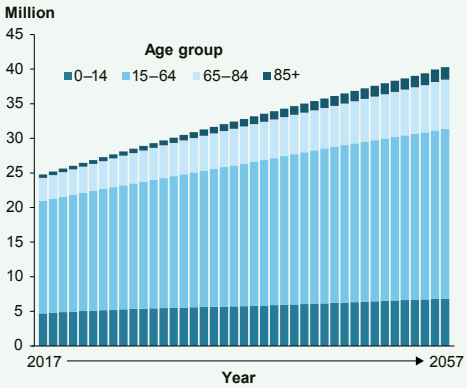
This domain provides broad contextual information that is expected would aid in the interpretation of other indicators, and overall performance. It covers major sociodemographic factors, such as population ageing and migration, and general economic conditions. See Box 9.2.6 for key findings from the context domain.

Box 9.2.6: Key results—context domain

- Australia's population is projected to grow from 24.8 million in 2017 to 40.1 million in 2057.
- The 85 and over age group is projected to grow from around 500,000 people in 2017 to 1.8 million in 2057. This age group is expected to grow at the fastest rate of all age groups.
- The total dependency ratio for Australia is expected to increase from 52 dependants per 100 working-aged people in 2017 to 64 per 100 in 2057.
- The proportion of home owners without mortgages has declined by 25% and the proportion of private renter households has increased by 7 percentage points over 1994–95 to 2013–14.
- Gross Domestic Product has risen since 2010 in line with other OECD countries.

Context: Population size and growth

Definition: The projected number of usual residents.



Note: Series B projections. Population projections make assumptions about future fertility and mortality patterns and net overseas migration. The ABS Series B projections make modest assumptions about each of these components.

Source: ABS 2013b.

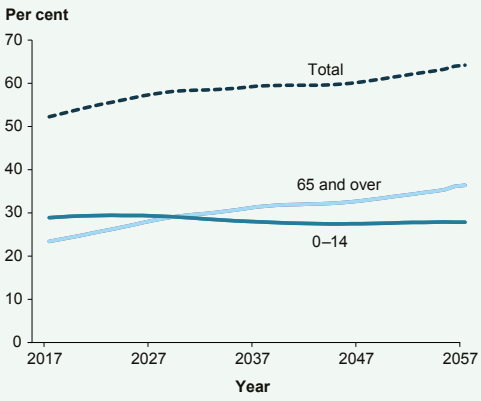
Indicator 55: Projected population, by age group, 2017 to 2057

- Australia's population is projected to grow from 24.8 million in 2017 to 40.1 million in 2057.
- The 85 and over age group is projected to grow at 3.2% per year, from around 500,000 people in 2017 to 1.8 million in 2057. It is the fastest growing age group, followed by people aged 65 to 84.
- The 0–14 age group has the slowest annual growth rate (0.9%) of all the age groups.

More information: Chapter 1.1 'Who we are'.

Context: Population ageing and dependency ratio

Definition: The number of people aged under 15 and the number of people aged 65 and over, divided by the number of people aged 15–64, expressed as a percentage.



Note: Series B projections.

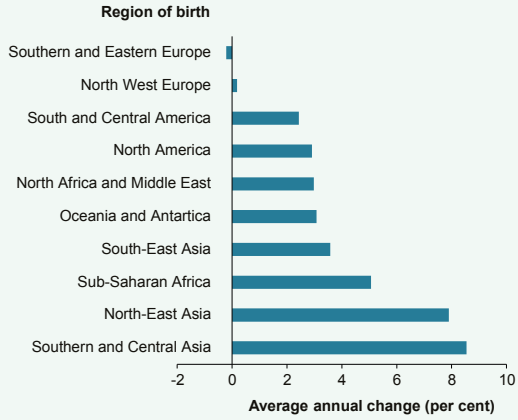
Source: ABS 2013b.

Indicator 56: Projected dependency ratio, by age group, 2017 to 2057

- The total dependency ratio for Australia is expected to increase from 52 dependants per 100 working-aged people in 2017 to 64 per 100 in 2057.
- This is mostly driven by the increase in the 65 and over dependency ratio, from 23% in 2017 to 36% in 2057. This is consistent with the rapid increase in the number of people at older ages compared with people aged under 65.
- Although the 0–14 dependency ratio is expected to drop slightly over this period, the smaller size of the child population and slower growth relative to the older age population means the effect is minimal on the total dependency ratio.

Context: Overseas born population

Definition: The change in the number of people usually resident in Australia who were born overseas.



Source: AIHW analysis of ABS 2017e.

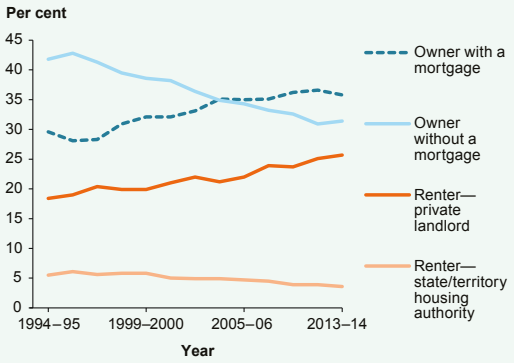
Indicator 57: Average annual change in estimated resident population, by region of birth, 1992 to 2016

- Over the period 1992 to 2016, the proportion of the total Australian population born overseas has increased from 23% to 29%.
- The number of Australian residents born in Southern and Central Asia has risen the most rapidly, from 112,000 in 1992 to 803,000 in 2016 (a rate of 8.5% per year). Immigrants from North-East Asia and Sub-Saharan Africa had the next highest growth rates for the period, at 7.9% and 5.1%, respectively.
- Compared with 1992, the number of residents in 2016 born in Southern and Eastern Europe has declined.

More information: Chapter 1.1 'Who we are'.

Context: Housing tenure

Definition: The proportion of total households by housing tenure.



Notes

1. Housing tenure refers to the nature of the legal right to occupy the dwelling in which the household members reside.
2. Excludes 'Renter—other landlord type' and 'Other tenure type', which were steady at around 1.5% and 2.5%, respectively.

Source: ABS 2015c.

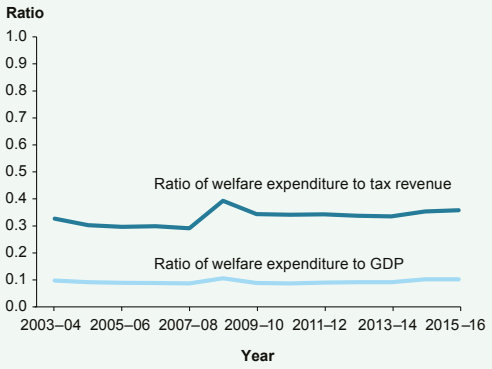
Indicator 58: Housing tenure, by selected tenure types, 1994–95 to 2013–14

- About two-thirds (67%) of all households were home owners in 2013–14 (36% with a mortgage; 31% without).
- Owners with a mortgage made up the majority of household tenures—after a 25% decrease, since 1994–95, of owners without mortgages.
- Private renter households increased by 7.3 percentage points between 1994–95 and 2013–14.

More information: Chapter 6.3 'The changing shape of housing in Australia'.

Context: Government welfare expenditure

Definition: The ratio of government welfare expenditure to tax revenue and to Gross Domestic Product (GDP).



Note: Estimates for states and territories have been modelled for 2011–12.

Source: AIHW welfare expenditure database.

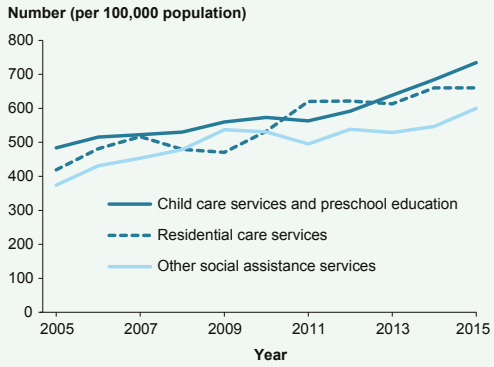
Indicator 59: Ratio of government welfare expenditure to tax revenue and GDP, 2003–04 to 2015–16

- Since 2008–09, the ratio of welfare expenditure to tax revenue and welfare expenditure to GDP have remained relatively stable (at around 0.34 and 0.09, respectively).
- The peak in both ratios in 2008–09 coincides with the GFC. The GFC had a negative impact on both tax revenues and GDP. The government's response included short-term increases in spending.

More information: Chapter 1.4 'Welfare expenditure'.

Context: Welfare workforce

Definition: The number of people employed in the welfare workforce per 100,000 population.



Source: AIHW analysis of ABS Labour Force Surveys 2005 to 2015.

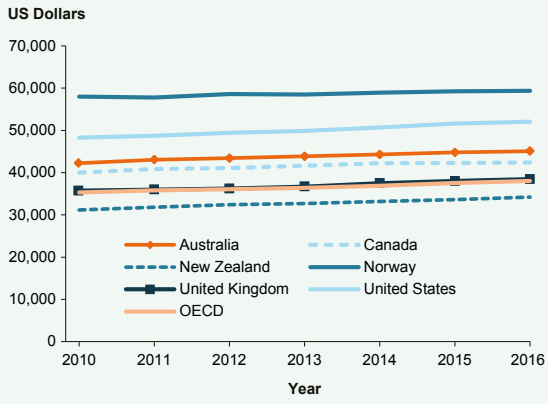
Indicator 60: Number of employed people in the welfare workforce per 100,000 population, by type of community service industry, 2005 to 2015

- The number of people in community service occupations employed in community service industries (the welfare workforce) generally rose between 2005 and 2015.
- The child care services and preschool education industry increased from 484 employed people per 100,000 population in 2005, to 734 per 100,000 in 2015.

More information: Chapter 1.5 'Welfare workforce'.

Context: Economic conditions

Definition: Gross Domestic Product (GDP) per capita (US Dollars (USD), constant prices, constant Purchasing Power Parities (PPPs)).



Note: Countries are compared on a constant price basis, with constant PPPs and using a common base year of 2010. See OECD 2017d for more information on PPPs.

Source: OECD 2017c.

Indicator 61: GDP per capita Australia, selected OECD countries and OECD total, 2010 to 2016

- Australia's GDP per capita in 2016 was USD 45,083. This was higher than New Zealand (USD 34,211) and the OECD average (USD 38,019) but lower than the USA (USD 52,066).
- Norway had the highest GDP per capita among selected OECD countries at USD 59,366 and New Zealand had the lowest at USD 34,211.
- GDP per capita in Australia rose from USD 42,239 to 45,083 over the period, an average annual increase of 1.1%.
- Average annual growth was highest in New Zealand (1.6%) and lowest in Norway (0.4%).

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Glossary
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Glossary

Aboriginal or Torres Strait Islander: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander. See also **Indigenous**.

absolute income poverty: A state of poverty where a person does not have enough income to cover the cost of a given basket of goods that provides an agreed minimal level of decency.

accommodation support: Services that provide accommodation to people with disability, and services that provide support to enable a person with disability to remain in their existing accommodation or to move to more suitable or appropriate accommodation.

administrative data collection: A data set that results from the information collected for the purposes of delivering a service or paying the provider of the service. This type of collection is usually complete (that is, all in-scope events are collected), but it may not be fully suitable for population-level analysis because the data are collected primarily for an administrative purpose.

adoption: The process by which a person legally becomes a child of the adoptive parent(s) and legally ceases to be a child of his/her existing parent(s). Intercountry adoptions are of children from countries other than Australia who are legally able to be placed for adoption, but who generally have had no previous contact or relationship with the adoptive parents.

age pension age: The age at which a person becomes eligible to receive the age pension (subject to income, asset and residency requirements). The age pension age has changed over time and depends on a person's date of birth. Between 1 July 2013 and 30 June 2017 the age pension age was 65 years. From 1 July 2017, the qualifying age increased to 65 years and six months, and will increase by 6 months every 2 years to reach 67 years by 1 July 2023.

The age pension age is also used to determine eligibility for other payments, such as the Disability Support Pension, for which recipients must be aged between 16 and the age pension age.

age structure: The relative number of people in each age group in a population.

aged care services: Regulated care delivered in either residential or community settings, including the person's own home. Most formal care is funded through government programs but may also be purchased privately.

age-specific rate: A rate for a specific age group. The numerator and denominator relate to the same age group.

age-standardisation: A method of removing the influence of age when comparing populations with different **age structures**. This is usually necessary because the rates of many diseases vary strongly (usually increasing) with age. The age structures of the different populations are converted to the same 'standard' structure, and then the disease rates that would have occurred with that structure are calculated and compared.

age-standardised rate: A rate for which the influence of age is removed by converting the age structures of the different populations to the same 'standard' structure. This provides a more valid way to compare rates from populations with different age structures.

apparent retention rate: The percentage of full-time students who remain in secondary education from the start of secondary school (Year 7 or 8, depending on the state or territory) to a specified year (usually Year 10 or Year 12).

apprentice: A person aged 15 to 64 who enters into a legal contract (training agreement or contract of training) with an employer, to serve a period of training to attain tradesperson status in a recognised trade.

attendance rate (school): The number of actual full-time equivalent student-days attended by full-time students in Years 1 to 10 as a percentage of the total number of possible student days attended over the period.

Australian Standard Geographical Classification (ASGC): Common framework defined by the Australian Bureau of Statistics for collecting and disseminating geographically classified statistics. The ASGC was implemented in 1984 and the final release was in 2011. It has been replaced by the **Australian Statistical Geography Standard** (ASGS).

Australian Statistical Geography Standard (ASGS): Common framework defined by the Australian Bureau of Statistics for collecting and disseminating geographically classified statistics. The ASGS replaced the **Australian Standard Geographical Classification** (ASGC) in July 2011.

average day: A measure that reflects the number of people within a service on a typical day during the year. It takes into account the number of people, the number of contacts and the duration of each contact.

Bachelor degree or higher: An undergraduate or post-graduate qualification at a university.

big data: There is no single, agreed definition, but the term is commonly used to describe the relatively recent global growth in the number of very large data sets, and the growing volume of unstructured data emerging from the increasing digital transfer of information.

Canadian National Occupancy Standard: A standard used to assess overcrowding in households, based on the number, sex, age, and relationships of household members.

capital expenditure: Expenditure incurred for goods and services with a life equal to or longer than a year. Compare with **recurrent expenditure**.

care and protection order: Legal order or arrangement that gives child protection departments some responsibility for a child's welfare. The level of responsibility varies with the type of order or arrangement. These orders include guardianship and **custody orders**, third-party parental responsibility orders, supervisory orders, interim and temporary orders, and other administrative arrangements.

casual worker: Employed person who generally works irregular hours, usually fewer than a full-time worker, and is not entitled to paid leave.

Centrelink: A program of the Department of Human Services. Centrelink delivers a range of government payments and services for retirees, the unemployed, families, carers, parents, people with disability, Indigenous Australians, and people from diverse cultural and linguistic backgrounds at times of major change.

children receiving child protection services: Children who are the subjects of an **investigation** of a notification; on a **care and protection order**; and/or in **out-of-home** care.

civilian population: All usual residents of Australia aged 15 and over, except members of the permanent Defence Force, certain diplomatic personnel of overseas governments customarily excluded from Census and estimated population counts, overseas residents in Australia, and members of non-Australian defence forces (and their dependants) stationed in Australia.

clients exiting custodial arrangements (specialist homelessness services): Specialist homelessness service clients are counted as leaving a custodial setting if, in their first support period during the reporting period, either in the week before or at presentation:

- their dwelling type was: adult correctional facility, youth or juvenile justice detention centre or immigration detention centre, or
- their reason for seeking assistance was: transition from custodial arrangements, or
- their source of formal referral to the agency was: youth or juvenile justice detention centre, or adult correctional facility.

Some of these clients were still in custody when they began receiving support.

Children aged under 10 identified as exiting from adult correction facilities or youth/juvenile justice detention centres have been excluded because of concerns about the quality of the data; children aged under 10 cannot be charged with a criminal offence in any jurisdiction in Australia.

clients with a current mental health issue (specialist homelessness services): A specialist homelessness service client was identified as having a current mental health issue if they provided any of the following information:

- at the start of a support period, they were receiving services or assistance for their mental health issues, or had in the past 12 months
- their formal referral source to the specialist homelessness agency was a mental health service
- 'mental health issues' was a reason for their seeking assistance
- their dwelling type either a week before presenting to an agency, or when presenting to an agency, was a psychiatric hospital or unit
- they had been in a psychiatric hospital or unit in the last 12 months
- at some stage during their support period, a need was identified for psychological services, psychiatric services or mental health services.

This analysis does not include clients aged under 10.

community access: Services designed to provide opportunities for people with disability to gain and use their abilities to enjoy their full potential for social independence.

community-based supervision: Supervision of a young person in the community by a juvenile justice agency while that person is waiting either for an initial court appearance for an alleged offence or for a court hearing or outcome, or completing an order after the finalisation of a court case. It includes supervised bail, probation, community service orders, suspended detention and parole.

community living: A living arrangement where the place of usual residence is a private or non-private dwelling, as distinct from **residential aged care**, a hospital or other type of institutional accommodation. Community settings include private dwellings (a person's own home or a home owned by a relative or friend) and certain types of non-private dwellings; for example, retirement village accommodation.

community support: Services that provide the support needed for a person with disability to live in a non-institutional setting.

constant prices: Estimates that indicate what expenditure would have been if prices for a given year had applied in all years (that is, removing the inflation effect). Changes in expenditure in constant prices reflect changes in volume only. An alternative term is 'real expenditure'. Compare with **current prices**.

core activity: Term used in discussions of disability, referring to the basic activities of daily living; namely, self-care, mobility and communication.

core activity limitation: A limitation where someone needs help with—or is having difficulty in using aids and equipment for—self-care, mobility and/or communication. See also **disability**, **severe or profound core activity limitation** and **mild or moderate core activity limitation**.

couch surfer: A person who is homeless and who typically moves from household to household intermittently, who is not regarded as being part of those households, and who does not have any form of leased tenure over any accommodation.

couple family: A **family** comprising two people in a registered or de facto marriage and who are usually living in the same household. A couple family may be with or without children, and may or may not include other related individuals.

current prices: Expenditures reported for a particular year, unadjusted for inflation. Changes in current price expenditures reflect changes in both price and volume.

custody orders: Orders that place children in the custody of the state or territory department responsible for child protection, or a non-government agency. These orders usually involve the child protection department being responsible for the daily care and requirements of the child, while the parent retains legal guardianship. Custody alone does not bestow any responsibility regarding the long-term welfare of the child.

data linkage: The bringing together (linking) of information from two or more different data sources that are believed to relate to the same entity; for example, the same individual or the same institution. This linkage can provide more information about the entity and, in certain cases, provide a time sequence, helping to 'tell a story', show 'pathways' and perhaps unravel cause and effect. The term is used synonymously with 'record linkage' and 'data integration'.

dementia: A general term for disorders characterised by worsening mental processes (such as Alzheimer disease or vascular dementia). Symptoms include impaired memory, understanding, reasoning and physical functioning.

dependency ratio: The number of people likely to be 'dependent' on others due to not being in the labour force, compared with the number in the **labour force** and therefore potentially able to provide support.

dependent child: A person who is either a child aged under 15, or a **dependent student**. Note, this definition applies to the Australian Bureau of Statistics Census of Population and Housing and may differ somewhat the definitions in other collections. See also **non-dependent child**.

dependent student: A natural, adopted, step or foster child who is aged 15 to 24 and who attends a secondary or tertiary educational institution as a full-time student and for whom there is no identified partner or child of his/her own usually resident in the same household. Note, this definition applies to the Australian Bureau of Statistics Census of Population and Housing and may differ somewhat from the definitions in other collections. See also **dependent child**.

detention: Supervision of a young person in a remand or detention centre by a juvenile justice agency while he/she is waiting for either an initial court appearance for an alleged offence or for a court hearing or outcome, or completing an order after the finalisation of a court case. It includes remand and sentenced detention.

disability: An umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation. Disability is a multidimensional concept, and is considered as an interaction between health conditions and personal and environmental factors. See also **core activity limitation** and **severe or profound core activity limitation**.

disability-free life expectancy: An indication of how long a person can expect to live without disability. See also **life expectancy**.

Disability Support Pension (DSP): A pension that provides financial support for people aged between 16 and **age pension age**, with a physical, intellectual or psychiatric condition, who:

- are unable to work for at least 15 hours per week at or above the relevant minimum wage, or
- be re-skilled for such work, for more than 2 years because of their disability, and have participated in a program to help prepare for, find or maintain work, or
- are permanently blind.

domestic violence: A set of violent behaviours between current or former intimate partners, where one partner aims to exert power and control over the other through fear. Domestic violence can include **physical violence**, **sexual violence**, **emotional abuse** and **psychological abuse**.

dwelling: A structure or a discrete space within a structure intended for people to live in, or where a person or group of people live. Thus, a structure that people live in is a dwelling regardless of its intended purpose, but a vacant structure is only a dwelling if intended for human residence. A dwelling may include one or more rooms used as an office or workshop, provided the dwelling is in residential use.

early childhood education and care worker: A category of workers that includes child carers, child care centre managers and early childhood (pre-primary school) teachers.

early intervention: In the childhood development sector, this describes programs used to improve health and developmental outcomes among children aged 0 to 6 who have, or are at risk of, developmental delay or disability. Programs may include physiotherapy, speech therapy, occupational therapy and special education. The term 'early childhood intervention' is sometimes used to distinguish these from other forms of early intervention.

elder abuse: A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.

emotional abuse (children): Any act by a person having the care of a child that results in the child suffering any kind of significant emotional deprivation or trauma. Children affected by exposure to family violence would also be included in this category.

emotional abuse from a partner: Abuse between current or former cohabiting partners that occurs when a person is subjected to behaviours or actions (often repeatedly) aimed at preventing or controlling their behaviour, with the intent to cause them emotional harm or fear through manipulation, isolation or intimidation.

employed: Describes people aged 15 and over who, during the reference week of the Australian Bureau of Statistics Labour Force Survey, worked for 1 hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm, or worked for 1 hour or more without pay in a family business or on a farm (that is, contributing family workers). This includes employees who had a job but were not at work and were away from work for less than 4 weeks up to the end of the reference week, or away from work for more than 4 weeks up to the end of the reference week and received pay for some or all those 4 weeks. It also includes those who were away from work as a standard work or shift arrangement, on strike or locked out, on workers' compensation and expected to return to their job, or were employers or own account workers, who had a job, business or farm, but were not at work. Note, this definition applies to the Australian Bureau of Statistics Labour Force Survey and may differ somewhat from the definitions in other collections. Compare with **unemployed**. See also **labour force**.

employment restriction: A restriction determined for persons aged 15 to 64 with one or more disabilities if, because of their disability, they: were permanently unable to work; were restricted in the type of work they can or could do; needed or would need at least 1 day a week off work on average; were restricted in the number of hours they can or could work; required or would require an employer to provide special equipment, modify the work environment or make special arrangements; required assistance from a disability job placement program or agency; needed or would need to be given ongoing assistance or supervision; or would find it difficult to change jobs or get a better job. Note, this definition applies to the Australian Bureau of Statistics Survey of Disability, Ageing and Carers and may differ somewhat from other collections' definitions. See also **schooling restriction**.

employment to population ratio: The number of employed people in a specified group expressed as a percentage of the **civilian population** in the same group.

enrolled: Describes a person's status who is registered for a course of study at an educational institution.

episode of care: The period during which a child remains in **out-of-home care**. During this period, a child may have one or more different out-of-home care placements, including placements lasting fewer than 7 days. If a child has a return home or a break of less than 60 days before returning to the same or different placement, he or she is considered to be continuously in care during this period.

equivalised household income (disposable or gross): An indicator of the economic resources available to a standardised household. For a lone-person household, it is equal to income received. For a household comprising more than one person, equivalised income is an indicator of the household income that a lone-person household would require to enjoy the same level of economic wellbeing as the household in question. Equivalised *disposable* household income is based on income after essential costs are deducted, as opposed to *gross* (that is, total) income, or *net* (that is, after-tax) income.

estimated resident population (ERP): The official Australian Bureau of Statistics estimate of the Australian population. The ERP is derived from the 5-yearly Census counts, and is updated quarterly between Censuses, based on births, deaths and net migration. It is based on the usual residence of the person. Rates are calculated per 1,000 or 100,000 mid-year (30 June) ERP.

family: Two or more persons, one of whom is aged at least 15, who are related by blood, marriage (registered or de facto), adoption, step or fostering, and who are usually living in the same household. Each separately identified couple relationship, lone parent to child relationship or other blood relationship forms the basis of a family. Some households contain more than one family.

family day care: Comprises services provided in the carer's home. The care is largely aimed at children aged 0 to 5, but primary school children may also receive care before and after school, and during school vacations. Central coordination units in all states and territories organise and support a network of carers, often with the help of local governments.

family group home: A home for children provided by a department or community-sector agency that has live-in, non-salaried carers who are reimbursed and/or subsidised for providing care.

family violence: Includes violence between family members as well as current or former intimate partners. For example, family violence can include acts of violence between a parent and a child. Family violence is the preferred term used to identify experiences of violence for Indigenous people as it encompasses the broad range of extended family and kinship relationships in which violence may occur.

finalised guardianship orders: Orders involving the transfer of legal guardianship to the relevant state or territory department or non-government agency responsible for child protection. These orders involve considerable intervention in the child's life and that of their family, and are sought only as a last resort. Guardianship orders convey responsibility for the welfare of the child to the guardian (for example, regarding the child's education, health, religion, accommodation and financial matters). They do not necessarily grant the right to the daily care and control of the child, or the right to make decisions about the daily care and control of the child, which are granted under **custody orders**.

formal aged care: Regulated care delivered in either residential or community settings, including the person's own home. Most formal care is funded through government programs, but may also be purchased privately.

formal child care: Regulated care away from the child's home. The main types of formal care are before and/or after school care, **long day care**, **family day care** and occasional care.

foster care: A form of **out-of-home care** where the caregiver is authorised and reimbursed (or was offered but declined reimbursement) by the state/territory for the care of the child. (This category excludes relatives/kin who are reimbursed.) There are varying degrees of reimbursement made to foster carers.

full-time employees: Permanent, temporary and casual employees who normally work the agreed or award hours for a full-time employee in their occupation and received pay for any part of the reference period. If agreed or award hours do not apply, employees are regarded as full time if they ordinarily work 35 hours or more a week. Note this definition applies to the Australian Bureau of Statistics Survey of Employee Earnings and Hours and may differ somewhat from the definitions in other collections.

full-time workers: Employed people who usually worked 35 hours or more a week (in all jobs) and those who, although usually working fewer than 35 hours a week, worked 35 hours or more during the reference week of the ABS Labour Force Survey. Note, this definition applies to the Australian Bureau of Statistics Labour Force Survey and may differ somewhat from the definitions in other collections. Compare with **part-time workers**.

greatest need (pertaining to housing): Households that, at the time of allocation, are either homeless or at risk of homelessness, in housing inappropriate to their needs, in housing placing them at risk or in housing with very high rental costs.

gross domestic product: A statistic commonly used to indicate national income. It is the total market value of goods and services produced within a given period after deducting the cost of goods and services used up in the process of production, but before deducting allowances for the consumption of fixed capital.

home-based out-of-home care: Care provided for a child who is placed in the home of a carer, who is reimbursed (or who has been offered but declined reimbursement) for the cost of care of that child. Home-based out-of-home care includes care provided by relatives/kin who are reimbursed, foster care, third-party parental care and other home-based out-of-home care.

homeless: As defined by the Australian Bureau of Statistics, people who do not have suitable accommodation alternatives and their current living arrangement:

- is in a **dwelling** that is inadequate (is unfit for human habitation and lacks basic facilities such as kitchen and bathroom facilities)
- has no tenure, or if their initial tenure is short and not extendable
- does not allow them to have control of, and access to, space for social relations (including personal or household living space, ability to maintain privacy and exclusive access to kitchen and bathroom facilities).

hospitalisation: Synonymous with admission and separation; that is, an episode of hospital care that starts with the formal admission process and ends with the formal separation process. An episode of care can be completed by patients being discharged, transferred to another hospital or care facility, or dying, or by a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation).

household: A group of two or more related or unrelated people who usually reside in the same dwelling, and who make common provision for food or other essentials for living. Can also be a single person living in a dwelling who makes provision for his or her own food and other essentials for living, without combining with any other person.

household composition: The grouping of people living in a **dwelling**. Household composition is based on couple and parent–child relationships. A household is a *single-family* type if it contains a main tenant, and if that main tenant lives with a partner and/or the main tenant's children. *Group households* consist of two or more tenants aged 16 or over, who are not in a couple or parent–child relationship. *Mixed households* are households not described by the other two types; for example, multiple single-family households.

housing affordability: The cost of housing compared with the financial situation of households. This term is generally used to refer to housing across major cities, states or nationally, as opposed to individual households. Housing affordability is often measured using the proportion of households in a given area in **housing stress**.

housing stress: A measure of **housing affordability**, where the proportion of household income spent on basic housing costs (that is, rent or mortgage) is calculated. Low-income households spending 30% or more of their income on housing are considered to be in housing stress.

impairment: Any loss or abnormality of psychological, physiological or anatomical structure or function.

improvised dwelling: A **dwelling** that was not designed for human habitation or is considered unfit for human habitation. This may include shacks, sheds, cabins, boats or tents.

income support payments: A range of pensions and benefits paid by Australian Government to support people who have little or no private income, or to help with particular costs such as those associated with raising children or caring for a person with severe disability or illness. This comprises a range of income support payments and supplementary payments.

income unit: An income unit may consist of:

- a single person with no dependent children
- a sole parent with one or more dependent children
- a couple (married, registered or defacto) with no dependent children
- a couple (married, registered or defacto) with one or more dependent children.

A non-dependent child living at home, including one who is receiving an income support payment in his or her own right, is regarded as a separate income unit. Similarly, a group of non-related adults sharing accommodation are counted as separate income units.

Index of Relative Socio-Economic Disadvantage: One of the set of **Socio-Economic Indexes for Areas** for ranking the average socioeconomic conditions of the population in an area. It summarises attributes of the population such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations.

Indigenous: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander. See also **Aboriginal or Torres Strait Islander**.

Indigenous household: A household that contains one or more **Indigenous** people.

Indigenous status: Whether a person identifies as being of **Aboriginal or Torres Strait Islander** origin.

informal carer: A person of any age who provides any informal assistance, in terms of help or supervision, to people with disability or long-term conditions, to children, or to people aged 65 and over. This assistance must be ongoing, or likely to be ongoing, for at least 6 months. See also **primary carer**.

informal child care: Non-regulated care, arranged by a child's parent or guardian, either in the child's home or elsewhere. It comprises care by (step) brothers or sisters, care by grandparents, care by other relatives (including a parent living elsewhere) and care by other (unrelated) people, such as friends, neighbours, nannies or babysitters. In the context of the ABS Childhood Education and Care Survey, it may be paid or unpaid.

International Classification of Functioning, Disability and Health: The World Health Organization's internationally accepted classification of functioning, disability and health. The classification was endorsed by the World Health Organization in May 2001.

investigation: The process whereby the relevant child protection department obtains more detailed information about a child who is the subject of a **notification** received. Departmental staff assess the harm or degree of harm to the child and their protective needs. An investigation includes sighting or interviewing the child where it is practical to do so.

labour force: People who were **employed** or **unemployed** (not employed but actively looking for work) during the reference week of the ABS Labour Force Survey. Note, this definition applies to the ABS Labour Force Survey and may differ somewhat from the definitions in other collections. See also **not in the labour force**.

labour force participation rate: For any group, the **labour force** expressed as a percentage of the civilian population aged 15 and over in the same group.

lateral violence: Violence that is directed at one's peers or community members. It may include bullying behaviours such as gossip, intimidation, shaming, backstabbing and attempts to cause social isolation, as well as physical violence. It is a learned behaviour where an oppressed or powerless person or group directs their anger at those around them, instead of at their oppressors. It is believed to occur worldwide in minorities, and particularly Aboriginal peoples.

life expectancy: An indication of how long a person can expect to live, depending on the age they have already reached. Technically it is the average number of years of life remaining to a person at a particular age if age-specific death rates do not change. The most commonly used measure is life expectancy at birth.

lone parent: A person who has no spouse or partner usually living in the household but who forms a parent-child relationship with at least one child usually resident in the household.

long day care: Comprises services aimed primarily at children aged 0 to 5, which are provided in a centre usually by a mix of qualified and other staff. Educational, care and recreational programs are provided based on the developmental needs, interests and experience of each child. In some jurisdictions, primary school children may also receive care before and after school, and during school vacations. Centres typically operate for at least 8 hours per day on normal working days.

long-term unemployed: People aged 15 and over who have been **unemployed** for 52 weeks or more.

long-term unemployment ratio: The number of **long-term unemployed** people, expressed as a percentage of the total unemployed population.

Longitudinal data: A data source that collects data from the same sample of subjects multiple times over a given time.

main tenant: The tenant who is party to the residential tenancy agreement. Where this is not clear, it is the person who is responsible for rental payments.

median: The midpoint of a list of observations that have been ranked from smallest to largest.

median age: For a given measure, the age at which half the population is older and half is younger.

mild or moderate core activity limitation: A person who needs no help but has difficulty with core activities (moderate) or has no difficulty (mild) with core activities, but uses aids or equipment, or has one or more of the following limitations:

- cannot easily walk 200 metres
- cannot walk up and down stairs without a handrail
- cannot easily bend to pick up an object from the floor
- cannot use public transport
- can use public transport but needs help or supervision
- needs no help or supervision but has difficulty using public transport.

See also **disability**, **core activity limitation**, and **severe or profound core activity limitation**.

mortality rate: The number of deaths in a given period, adjusted to take account of population age structure, expressed per 1,000 population.

neglect: Any serious acts or omissions by a person having the care of a child that, within the bounds of cultural tradition, constitute a failure to provide conditions essential for the healthy physical and emotional development of a child.

net overseas migration: The number of incoming international travellers minus the number of outgoing international travellers, where the movement to or from Australia is for 12 months or more.

non-dependent child: A natural, adopted, step or foster child of a couple or lone parent usually resident in the household, who is aged 15 or over and is not a full-time student aged 15 to 24, and who has no identified partner or child of his/her own usually resident in the household. Note, this definition applies to the Australian Bureau of Statistics Census of Population and Housing and may differ somewhat from definitions in other collections. See also **dependent child**.

non-Indigenous: People who have indicated that they are not of **Aboriginal or Torres Strait Islander** descent.

non-school qualification: Educational attainments other than those of pre-primary, primary and secondary education. They include qualifications at the following levels: Post-graduate degree, Graduate Diploma and Graduate Certificate, Bachelor degree, Advanced Diploma and Diploma, and Certificates I, II, III and IV. Non-school qualifications may be attained concurrently with school qualifications. See **post-school qualification**.

Notification (child protection): Contact made to an authorised department by people or other bodies alleging child abuse or neglect, child maltreatment or harm to a child.

not in the labour force: People who are not **employed** and not **unemployed**. See also **labour force**.

occasional care: A type of formal care (see **formal child care**) provided mainly for children who have not started school. These services cater mainly for the needs of families who require short-term care for their children. Compare with **out-of-school hours care**.

older household: A **household** with a **reference person** aged 65 and over.

older person: For the purposes of this report (unless noted otherwise), a person aged 65 or over.

one-parent family: A family consisting of a lone parent with at least one **dependent** or **non-dependent child** (regardless of age) who is also usually living in the **household**. Examples of one-parent families include a parent aged 25 with dependent children, and a parent aged 80 living with a child aged 50.

Organisation for Economic Co-operation and Development (OECD): An organisation of 35 countries (including Australia) that are mostly developed but some are emerging (such as Mexico, Chile and Turkey); the organisation's aim is to promote policies that will improve the economic and social wellbeing of people around the world.

other family: A family of other related individuals living in the same household. These individuals do not form a couple or parent-child relationship with any other person in the household and are not attached to a couple or a one-parent family in the household.

out-of-home care: Overnight care for children aged 0–17, where the state makes a financial payment or where a financial payment has been offered but has been declined by the carer. See also **residential care**, **family group homes**, **foster care**, **relative/kinship care**, independent living, other out-of-home care.

out-of-school-hours care: Services provided for school-aged children (that is, aged 5 to 12) outside school hours during term and vacations. Care may be provided on student-free days and when school finishes early. Compare with **occasional care**.

outside-school-hours care: See **out-of-school-hours care**.

overcrowding: Describes a situation in a dwelling where one or more additional bedrooms are required to adequately house its inhabitants, according to the **Canadian National Occupancy Standard**. Compare with **underutilisation (housing)**.

over-representation: The likelihood of occurrence for one population compared with another population. This may be expressed as a rate ratio and may be calculated as: population A rate divided by population B rate. See also **rate ratio**.

owner (of dwelling): A household in which at least one member owns the dwelling in which the household members usually live. Owners are divided into two categories:

- owner without a mortgage—if there is no mortgage or loan secured against the dwelling
- owner with a mortgage—if there is any outstanding mortgage or loan secured against the dwelling.

participation: The **International Classification of Functioning, Disability and Health** defines participation in terms of involvement in life situations, from basic learning and applying knowledge, through general tasks and demands, to domestic life, relationships, education and employment, and community life.

participation rate: See **labour force participation rate**.

partner violence: A set of violent behaviours a respondent experienced from a person they currently live with, or lived with at some point; does not include violence by a boyfriend/girlfriend or date.

part-time worker: Employed person who usually worked fewer than 35 hours a week (in all jobs) and either did so during the reference week of the ABS Labour Force Survey, or was not at work in the reference week. Note this definition applies to the ABS Labour Force Survey and may differ somewhat from definitions in other collections. Compare with **full-time workers**. See also **employed**.

Persistent disadvantage: In this report, a measure derived using the Social Exclusion Monitor (SEM). The SEM is a composite measure that considers the seven domains of material resources, employment, education and skills, health and disability, social support, community participation, and personal safety perceptions. Disadvantage (social exclusion) is scored from 0 to 7, with scores of 2 or more defined as *deep exclusion* and of 3 or more defined as *very deep exclusion*.

physical abuse: Any non-accidental physical act inflicted upon a child by a person having the care of a child.

post-school qualification: See **non-school qualification**.

preschool: Services licensed and/or funded by state or territory governments to deliver preschool services at a particular location. Preschool comprises a structured educational program provided by a qualified teacher in a variety of settings, usually aimed at children in the year before they start formal schooling.

primary carer: A person who provides most of the informal assistance, in terms of help or supervision, to a person with one or more disabilities or aged 65 and over in one or more of the core activities (communication, mobility and self-care). The 2015 Survey of Disability, Ageing and Carers included as carers people aged 15 and over who identified themselves as carers or were nominated by a care recipient as a carer. See also **informal carer**.

projection (population): Is not a forecast but instead illustrates changes that would occur if the stated assumptions were to apply over the period in question.

psychological abuse: Behaviours including limiting access to finances, exclusion from contacting family and friends, demeaning and humiliation, and any threats of injury or death directed at the victim or their children.

quintile: A group derived by ranking a population according to specified criteria (for example, income) and dividing it into five equal parts. The term can also mean the cut-points that make these divisions—that is, the 20th, 40th, 60th and 80th percentiles—but the first use is the more common one. Commonly used to describe socioeconomic groups based on **socioeconomic position**. Also used to describe income groups.

rate: One number (the numerator) divided by another number (the denominator). The numerator is commonly the number of events in a specified time. The denominator is the population 'at risk' of the event. Rates (crude, age-specific and age-standardised) are generally multiplied by a number such as 100,000 to create whole numbers.

rate ratio: A rate ratio shows the relative difference between two rates and may be calculated as: the rate for population A divided by the rate for population B. Rate ratios are commonly used to compare rates between:

(i) two points in time for the same population, or

(ii) between different populations at the same point in time.

A rate ratio of 1 indicates no difference between the rates. A rate ratio less than 1 indicates that rates have decreased over time (use i), or that the rate for population A is lower than that for population B (use ii). A rate more than 1 indicates an increase over time or that the rate for population A is higher than that for population B.

recurrent expenditure: Expenditure incurred for goods and services with a life of less than 1 year. Compare with **capital expenditure**.

reference person: The reference person for each **household** is chosen by applying, to all household members aged 15 and over, the selection criteria below, in the order listed, until a single appropriate reference person is identified:

- one of the partners in a registered or de facto marriage, with **dependent children**
- one of the partners in a registered or de facto marriage, without dependent children
- a lone parent with dependent children
- the person with the highest income
- the eldest person.

This definition applies to the ABS Survey of Income and Housing and may differ somewhat from definitions in other collections.

Relative income poverty: The proportion of households with an equivalised income that is less than 50% of the national median equivalised household income. (Note that there is more than one measure for relative income poverty, and therefore this definition may differ somewhat from definitions in other reports).

relative kinship care: A form of out-of-home care where the caregiver is a relative (other than parents), considered to be family or a close friend, a member of the child or young person's community (in accordance with their culture), or who is reimbursed by the state/territory for the care of the child (or who has been offered but declined reimbursement). For Aboriginal and Torres Strait Islander children, a kinship carer may be another Indigenous person who is a member of their community, a compatible community or from the same language group. See also **out-of-home care**.

remoteness classification: A classification that divides each state and territory into several regions based on their relative accessibility to goods and services (such as general practitioners, hospitals and specialist care) as measured by road distance. These regions are based on the **Accessibility/Remoteness Index of Australia (ARIA)** and defined as Remoteness Areas by either the **Australian Standard Geographical Classification (ASGC)** (before 2011) or the **Australian Statistical Geographical Standard (ASGS)** (from 2011 onwards) in each Census year.

residential aged care: Care provided to a person in an Australian Government-approved aged care home, including accommodation (bedding and other furnishings, meals, laundry, social activities), personal care (bathing/showering, toileting, dressing, eating, moving about), and nursing and allied health services if required. Residential aged care can be provided on a permanent basis, or a short-term basis for respite or emergency support. Before July 2014, care was provided at a 'high' or 'low' level, relative to the resident's care needs; however, since July 2014, there is no distinction among permanent residents as needing high or low care.

residential care (aged care and younger people with disability): See **residential aged care**.

residential care (out-of-home care): A type of out-of-home care where the placement is in a residential building whose purpose is to provide placements for children and where there are paid staff.

respite services: Services that support community living by people receiving assistance from informal carers. Direct respite is respite care where the primary purpose is to meet carer needs by providing them with a break from their caring role; this may be delivered in the person's home, in a day centre or community-based overnight respite unit, and in residential aged care homes. Indirect respite is the 'respite effect' achieved by relieving the carer of other tasks of daily living, which may or may not be directly related to their caring responsibility.

restriction: A person has a restriction if he/she has difficulty participating in life situations, needs assistance from another person or uses an aid.

retirement: People are considered to have retired when they have previously worked for 2 weeks or more; have retired from work, or from looking for work; and are not intending to look for, or take up, work in the future.

schooling restriction: A restriction determined for people aged 5 to 20 who have one or more disabilities if, because of their disability, they were unable to attend school, a special school or special classes at an ordinary school; needed at least one day a week off school on average; or had difficulty at school. Note, this definition applies to the ABS Survey of Disability, Ageing and Carers and may differ somewhat from definitions in other collections. See also **employment restriction**.

severe or profound core activity limitation: A person who needs help or supervision *always* (profound) or *sometimes* (severe) to perform activities that most people undertake at least daily—that is, the core activities of self-care, mobility and/or communication. See also **core activity limitation** and **disability**.

severely crowded dwelling: A dwelling that requires four or more extra bedrooms to accommodate the usual residents of that dwelling, according to the **Canadian National Occupancy Standard**. Note, this definition applies to the ABS Census and may differ somewhat from definitions in other collections.

sexual abuse: Any act by a person, having the care of a child that exposes the child to, or involves the child in, sexual processes beyond his or her understanding or contrary to accepted community standards.

sexual violence: Behaviours of a sexual nature carried out against a person's will using physical force or coercion (or any threat or attempt to do so). Sexual violence can be perpetrated by partners in a domestic relationship, former partners, other people known to the victims, or strangers.

sleeping rough: The state of sleeping with no shelter on the street, in a park or in the open, or in a motor vehicle. See also **homeless**.

social exclusion: The opposite of **social inclusion**.

social housing: Rental housing that is funded or partly funded by government and is owned or managed by the government or a community organisation and let to eligible persons. This includes public rental housing, state owned and managed Indigenous housing (SOMIH), mainstream and Indigenous community housing and the Crisis Accommodation Program.

social housing programs: Social housing is rental housing funded, or partly funded by government, that is owned or managed by the government or a community organisation. There are four main social housing programs in Australia:

- public rental housing
- state owned or managed Indigenous housing (SOMIH)
- mainstream community housing
- Indigenous community housing.

social impact bonds: An approach for financing social service programs. They are offered to investors, who provide capital to fund specific projects—which are expected to result in improved social outcomes and public sector savings—in return for a future financial return paid on delivery of those specific social outcomes. They are also known as 'social benefit bonds'.

social inclusion: According to the former Social Inclusion Board, an inclusive society is one in which all members have the resources, opportunities and capability to learn, work, engage with and have a voice in the community. See also **social exclusion**.

social investment: An investment activity that has an expected social outcome (or improvement) and a financial return (or savings). More generally, it is spending on programs up front to provide better long-term outcomes for a given population.

socioeconomic position: An indication of how 'well off' a person or group is. In this report, socioeconomic groups are mostly reported using the **Socio-Economic Indexes for Areas**, typically for five groups (quintiles), from the most disadvantaged (worst off or lowest socioeconomic group) to the least disadvantaged (best off or highest socioeconomic group).

Socio-Economic Indexes for Areas (SEIFA): A set of indexes, created from Census data, that aim to represent the **socioeconomic position** of Australian communities and identify areas of advantage and disadvantage. The index value reflects the overall or average level of disadvantage of the population of an area; it does not show how individuals living in the same area differ from each other in their socioeconomic group. This report generally uses the **Index of Relative Socio-Economic Disadvantage**.

specialist disability services: Services provided under the National Disability Agreement for people with intellectual, psychiatric, sensory, physical or neurological impairments that manifest before 65 years of age, and which result in a need for assistance with one or more core activities of life. Services currently include accommodation support, community support, community access, respite and employment.

specialist homelessness service: Assistance provided specifically to people who are experiencing homelessness or who are at risk of homelessness.

substantiations (child protection): Substantiations of notifications received during the current reporting year are child protection notifications made to relevant authorities between 1 July and 30 June, which were investigated and the investigation was finalised by 31 August of the reporting period, and where it was concluded that there was reasonable cause to believe that the child had been, was being, or was likely to be, abused, neglected or otherwise harmed. Substantiation does not necessarily require sufficient evidence for a successful prosecution and does not imply that treatment or case management was provided. Substantiations may also include cases where there is no suitable caregiver, such as when children have been abandoned or their parents are deceased.

superannuation: Money set aside over a person's lifetime to provide for their retirement. It can be accessed when a person reaches eligible age (between 55 and 60, depending on year of birth) and retires, or when they turn 65. Access can be through pension payments or a lump sum.

Survey data collection: A data set that results from sampling individual units from the population. No sample will ever be fully representative of the population, but if carefully designed and implemented, samples will be highly representative for drawing conclusions about characteristics of the whole population.

tertiary education: Tertiary education in Australia can be broadly categorised as either 'higher education' or vocational education and training (VET). Higher education is generally delivered in a university setting, leading to a Bachelor, Master or Doctoral degree. VET focuses on delivering skills and knowledge for a specific industry, leading to Certificate and Diploma qualifications. It is delivered by Registered Training Organisations such as Technical and Further Education institutions.

traditional working age: In this report, refers to the ages of 15 to 64.

underemployed: Employed persons aged 15 and over who want, and are available for, more hours of work than they currently have. They comprise people employed part time who want to work more hours and are available to start work with more hours, either in the reference week or in the 4 weeks after the survey; and persons employed full time who worked part-time hours in the reference week for economic reasons (such as being stood down or insufficient work being available). Note, this definition applies to the ABS Labour Force Survey and may differ somewhat from definitions in other collections.

underemployment rate: The number of underemployed workers expressed as a percentage of the labour force.

underutilisation (housing): Occurs where a dwelling contains one or more bedrooms surplus to the needs of the **household** occupying it, according to the **Canadian National Occupancy Standard**. Compare with **overcrowding**.

unemployed: Describes people aged 15 and over who were not employed during the reference week of the ABS Labour Force Survey, and had actively looked for full- or part- time work at any time in the previous 4 weeks, or were waiting to start a new job within 4 weeks of the end of the reference period. Note, this definition applies to the ABS Labour Force Survey and may differ somewhat from definitions in other collections. Compare with **employed**.

unemployment rate: The number of **unemployed** people, expressed as a percentage of the **labour force**.

usual resident: Refers to all people, regardless of nationality, citizenship or legal status, who usually live in Australia, except foreign diplomatic personnel and their families. It includes usual residents who are overseas for less than 12 months over a 16-month period. It excludes overseas visitors who are in Australia for less than 12 months over a 16-month period.

victimisation rate (crime): The total number of people/households who experienced a crime type, expressed as a percentage of all people/households. This is a measure of how prevalent a crime type is in a given population.

volunteer: Someone who, in the previous 12 months, willingly gave unpaid help, in the form of time, service or skills, through an organisation or group.

volunteer rate: The number of volunteers as a percentage of the relevant population.

working-time mismatch: When the number of hours a week an employed person works does not align with their preferences for working hours.

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACARA	Australian Curriculum, Assessment and Reporting Authority
ACFI	Aged Care Funding Instrument
ACT	Australian Capital Territory
AEDC	Australian Early Development Census
AIHW	Australian Institute of Health and Welfare
ALRC	Australian Law Reform Commission
ANDI	Australian National Development Index
ANROWS	Australia's National Research Organisation for Women's Safety
ANZSCO	Australian and New Zealand Standard Classification of Occupations
AQF	Australian Qualifications Framework
ATUS	Australian Time Use Survey
Aust	Australia
CDEP	Community Development Employment Projects
CHSP	Commonwealth Home Support Programme
CLI	Composite Learning Index
CNOS	Canadian National Occupancy Standard
COAG	Council of Australian Governments
CRA	Commonwealth Rent Assistance
CSP	Commonwealth Supported Place
CT	computerised tomography
DCRF	Data Collection and Reporting Framework
DS NMDS	Disability Services National Minimum Data Set
EDHI	equivalised disposable household income
ERP	estimated resident population
FTB	Family Tax Benefit
FTE	full-time equivalent
GDP	gross domestic product
GFC	global financial crisis
GSS	General Social Survey
HELP	Higher Education Loan Program
HACC	Home and Community Care
HDI	Human Development Index
HILDA	Household, Income and Labour Dynamics in Australia
HPV	human papilloma virus
K10	Kessler Psychological Distress Scale—10 items
LFS	Labour Force Survey
LGBTI	lesbian, gay, bisexual, transgender and intersex
LSAY	Longitudinal Surveys of Australian Youth

MBS	Medicare Benefits Schedule
NAPLAN	National Assessment Program—Literacy and Numeracy
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCAS	National Community Attitudes towards Violence Against Women Survey
NDA	National Disability Agreement
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NEET	not in education, employment or training
NGCSO	non-government community service organisation
NGO	non-government organisation
NMS	national minimum standard
NSW	New South Wales
NT	Northern Territory
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PEMA	Poverty and Exclusion in Modern Australia
PH	public rental housing
PIRLS	Progress in International Reading Literacy Study
PISA	Programme for International Student Assessment
PSID	Panel Study of Income Dynamics
PSS	Personal Safety Survey
Qld	Queensland
RNNDI	real net national disposable income
RoGS	Report on Government Services
SA	South Australia
SDAC	Survey of Disability, Ageing and Carers
SEM	Social Exclusion Monitor
SHS	Specialist Homelessness Services
SMI	Scanlon-Monash Index
SOMIH	state owned and managed Indigenous housing
TAFE	Technical and Further Education
Tas	Tasmania
TIMSS	Trends in International Mathematics and Science Study
VET	vocational education and training
VHC	Veterans' Home Care
Vic	Victoria
WA	Western Australia
WADLS	WA Data Linkage System
WHO	World Health Organization
YBFS	year before full-time school

Methods and conventions

Age-standardisation

This is a method of removing the influence of age when comparing populations with different age structures—either different populations at 1 time or the same population at different times. For this report, the Australian estimated resident population as at 30 June 2001 has been used as the standard population. The same population was used for males and females to allow valid comparison of age-standardised rates between the sexes (see Table A1).

Two different methods of age-standardisation can be used: direct and indirect. Direct age-standardisation has been used in this report.

Direct age-standardisation

This is the most common method of age-standardisation, and is used in this report for prevalence, hospitalisations and most deaths data. This method is generally used when the populations under study are large and the age-specific rates are reliable. The calculation of direct age-standardised rates has 3 steps:

Step 1: Calculate the age-specific rate for each age group.

Step 2: Calculate the expected number of cases in each age group by multiplying the age-specific rate by the corresponding standard population for each age group.

Step 3: Sum the expected number of cases in each age group and divide this sum by the total of the standard population to give the age-standardised rate.

Table A1: Age composition of the Australian population at 30 June 2001

Age group (years)	Australia, 30 June 2001
0	253,031
1–4	1,029,326
5–9	1,351,664
10–14	1,353,177
15–19	1,352,745
20–24	1,302,412
25–29	1,407,081
30–34	1,466,615
35–39	1,492,204
40–44	1,479,257
45–49	1,358,594
50–54	1,300,777
55–59	1,008,799
60–64	822,024
65–69	682,513
70–74	638,380
75–79	519,356
80–84	330,050
85 and over	265,235
Total	**19,413,240**

Source: ABS 2003.

Average annual rates of change

Average annual rates of change or growth rates have been calculated as geometric rates:

$$\text{Average rate of change} = \left(\left(\frac{P_n}{P_o} \right)^{\frac{1}{N}} - 1 \right) \times 100$$

where P_n = value in later time period

P_o = value in earlier time period

N = number of years between the two time periods.

Data linkage

Data linkage, also known as data integration and record linkage, is a powerful statistical tool both for identifying multiple appearances of individuals within a data set and for integrating client information across data sets.

There are two main types of data linkage:

- Probabilistic linkage—in which the linkage of records in two (or more) files is based on the probabilities of agreement and disagreement between a range of match variables. Probabilistic matching allows for variation in reported characteristics by deriving a measure of similarity across variables used to identify matches, called the match weight. This is then used to decide whether a particular pair-wise comparison between records on two data sets is accepted (high weight) or rejected (low weight) as a match, or link.
- Deterministic key-based linkage—in which the linkage of records is based on exact agreementof match variables, or a statistical linkage key. Linkage using a single match key cannot allow for variation in reporting. However, algorithms can be constructed that can, and the AIHW has developed a stepwise key-based linkage algorithm that allows for ariation in reported data linkage items.

The method used for a particular linkage process depends on both the data items and resources available to undertake the linkage.

Data subject to revision

This report draws data from a range of administrative and survey data sets, all of which are subject to change. For example, data may be updated on a regular annual cycle or revised due to discovered errors or anomalies.

Wherever possible, the latest version of a data set has been used; in cases where the data change frequently, the date of the release is noted in the text or table.

Effects of rounding

Entries in columns and rows of tables may not add to the totals shown, because of rounding. Unless otherwise stated, derived values are calculated using unrounded numbers. Percentage distributions may not always sum exactly to 100 due to rounding. Where numbers are rounded to whole numbers or one decimal place, the number is rounded down for values 0–4 and rounded up for values 5–9. As a general rule, single-digit numbers are rounded to one decimal place. Numbers over 10 are rounded to whole numbers unless accuracy to one decimal place is required for differentiation.

Supplementary technical information

This section contains technical information related to the purchase affordability indicator in Chapter 6.3 'The changing shape of housing in Australia' (S6.3) and the housing assistance data presented in Chapter 7.1 'Community factors and Indigenous wellbeing' (S7.1).

S6.3.1 Purchase affordability indicator

Affordable dwelling: A dwelling sold in the reference year where mortgage repayments represent up to 30% of gross household income, assuming a home loan of 100% of the value of the dwelling, a term of 25 years, and the standard variable housing loan rate of banks as reported by the Reserve Bank, averaged out over the financial year (5.97% in 2013–14).

Computation:

1. Median gross household income was estimated for the following household groups, within each equivalised disposable household income quintile and within household (composition) groups (couple with no dependent children, couple family with dependent children, lone persons, one parent family with dependent children) within each housing market. Data were sourced from the 2013–14 Survey of Income and Housing (ABS 2016).
2. These income data were applied in a mortgage calculation to determine the maximum dwelling price that was affordable to particular household groups (equivalised disposable household income quintiles and household composition groups).
3. The proportion of dwellings sold in each location at or below each of these maximum prices was then calculated. Data were sourced from CoreLogic RP-data (CoreLogic RP-Data 2016).

S7.1.1 Converting income units to household numbers

Recipients of Commonwealth Rent Assistance (CRA) are 'income units', rather than households. More than one person/group within a household can receive CRA. To derive an estimate of the rate of Indigenous households receiving CRA, data at the income unit level must be converted to the household level.

Because the Australian Bureau of Statistics (ABS) 2011–12 Survey of Income and Housing (SIH) collects information about both income units and households, information from this survey can be used to derive a conversion factor. Those data suggest that, among CRA recipients, there are an estimated 93.4% as many households as income units in Australia (unpublished data from the ABS SIH).

To enable estimates of rates of households receiving CRA to be derived for this paper, this conversion factor was applied to the data about CRA income units. For example, for Indigenous income units:

(a) 67,387 Indigenous income units received CRA as at 26 June 2016

(b) applying the conversion factor of 93.4% provides an estimated number of Indigenous households receiving CRA of 62,939.

A conversion factor by Indigenous status is not available and how the conversion factor may differ between Indigenous households and other households is not clear; thus, the one factor is applied to both Indigenous and other income units. Note also:

- the proportion of households to income units is an estimate calculated from a survey sample

- methods to collect information about income units vary between the CRA data collection (which are administrative data pertaining to a specific day) and the SIH (self-reported survey data collected throughout a yearly cycle)
- care should be taken when comparing data from different data sources due to the different methodologies used (AIHW 2014).

S7.1.2 Estimating number of households

Chapter 7.1 'Community factors and Indigenous wellbeing' presents information on the proportion of Indigenous households receiving assistance from the various social housing programs and CRA in June 2016.

To calculate these proportions, information is required on the total number of households in Australia in 2016, by Indigenous status. ABS produces projections of household growth (ABS 2015); however, these are not published by Indigenous status. Hence, to estimate the number of Indigenous and other Australian households, information from the 2011 Census has been used. To derive such estimates for 2016, the proportion of Indigenous households as enumerated in the 2011 Census was applied to the total projected number of households for 2016 (using series II—the middle range of the three different projection scenarios).

An example of the process is set out here, using the number of Indigenous households across Australia:

(a) the number of households with an Indigenous member, as enumerated in the 2011 Census count, was 209,048—representing 2.7% of all households enumerated (7,760,322) (AIHW analysis of 2011 Census TableBuilder)

(b) according to the ABS series II household projections, the total number of households in 2016 was 9,241,497

(c) applying the (unrounded) Census-derived proportion of the number of households that are Indigenous provides an estimated count of 248,948 Indigenous households in 2016.

This estimated count was then used as the denominator when calculating rates of usage of social housing and CRA by Indigenous households at the national level.

The approach assumes that the proportion of households with an Indigenous member as identified in the 2011 Census accurately reflects the proportion of households with an Indigenous member in 2016. While there is likely to be some under-identification of Indigenous households in the Census, this issue is mitigated to some degree as there is also under-counting in administrative data on the number of all households living in social housing. In other words, there is some degree of under-counting in both the numerator and the denominator of the social housing rates presented, but the extent of such under-counting is not known.

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CoreLogic RP Data 2016. Customised data request.

Symbols

$	Australian dollars, unless otherwise specified
—	nil or rounded to zero
%	per cent
’000	thousands
n.a.	not available
n.d.	no date
. .	not applicable
n.p.	not published due to small numbers, confidentiality or other concerns about the quality of the data
>	more than
<	less than
≥	more than or equal to
≤	less than or equal to

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Article

Wage theft, underpayment and unpaid work in marketised social care

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Abstract
Marketised models of social care provision in Australia are placing pressures on service providers and driving changes in work organisation and employer practices, with potential to degrade social care jobs. While international experience of marketised social care has demonstrated the vulnerability of social care workers to wage theft and other violations of employment laws, Australia's relatively strong industrial relations safety net might be expected to be better able to protect these low-paid workers. Nevertheless, there is emerging evidence of negative impacts on the pay and entitlements of frontline workers in the expanding community support and homecare workforce. This study investigates the paid and unpaid work time of disability support workers under Australia's new National Disability Insurance Scheme. The research takes a novel approach combining analysis of working day diaries and qualitative interviews with employees to expose how jobs are being fragmented and work is being organised into periods of paid and unpaid time, leaving employees paid below their minimum entitlement. The article highlights the role of social care policy along with inadequate employment regulation.

JEL Codes: J390, J81, J88

Keywords
Employment conditions, NDIS, social care, wage theft, working time

Introduction

This article reports on research investigating underpayment of wages of low-paid social care workers under Australia's new National Disability Insurance Scheme (NDIS). As a

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'cash-for-care' scheme, the NDIS individualises and marketises disability support and shifts the location of much care and support work from public organisational settings to more diverse settings, including private households, as well as introducing new demands for flexibility, for very short working hours and for travel between multiple work locations (Macdonald and Charlesworth, 2016). Similar pressures and arrangements in adult social care in the United Kingdom have seen social care workers become highly vulnerable to wages underpayment (Low Pay Commission, 2016).

This study explores working time arrangements and pay of disability support workers (DSWs) in the context of employment regulation and the new disability support arrangements. It addresses the following questions: what regulatory gaps contribute to any wages' underpayments and what roles (if any) do the design and management of the social care system (the NDIS) play in this?

Rubery et al. (2015) suggest a homecare worker's comment 'it's all about time' encapsulates 'the central importance of time in the management and employment arrangements in home care work' (p. 756). This phrase also encapsulates our findings that the tight control of time as a contested resource in disability support in the home and community underlies wage theft, underpayment and low pay. Underpayment of workers is made possible by various gaps in employment regulation, in addition to inadequate enforcement. While the regulatory deficiencies are not new, the changing industry structure under the new marketised social care arrangements may be exacerbating the issues.

Beginning with a short overview of the regulatory context for wages underpayment and minimum wage compliance in Australia, we then review relevant international literature on working time and wages in social care. We then outline the changing industry and regulatory context of disability support work in Australia. After outlining our method and framework for analysing paid and unpaid work, we present key findings from (1) analysis of disability support work 'working day' time diaries and (2) interviews with DSWs about their jobs and working time. We end with a reflection on the funding and regulatory frameworks that contribute to wages underpayment, and point to some possible responses.

Background

Wage theft, underpayment and employment regulation in Australia

Wage theft refers to the non-payment or underpayment of the full wages to which employees are legally entitled (Galvin, 2016: 325; Milkman et al., 2010; Vosko et al., 2017). Thus, wage theft is seen as arising from non-compliance with employment laws, and multiple types of wage theft reflect different kinds of violations. While violation of minimum wages regulation is the most 'blatant' type of wage theft (Wilson, 2011: 6), others include overtime violations, rest break violations, time 'off-the-clock' violations and illegal employer deductions (Milkman et al., 2010).

There has been little research into the extent of minimum wage non-compliance in Australia (Maconachie and Goodwin, 2010; Nelms et al., 2011). Historically, with wide workforce coverage, union recognition and union membership preference provisions, the centralised industrial arbitration system has been characterised by relative ease of

enforcement of standards, with trade unions playing a significant role (Johnstone et al., 2012: 27). In addition, a feature of the system has been a comparatively wide array of minimum employment standards contained in industry or occupation-based industrial awards including working time arrangements such as standard working times, minimum and maximum shifts, shift and overtime penalty payments, minimum call-back times and other rostering arrangements.

However, changes in the labour market and organisation of work and significant de-regulation and de-collectivisation of industrial relations (Quinlan and Sheldon, 2011) have seen more employment likely to be affected by 'gaps' in regulation. Unchecked non-compliance with employment laws resulting in wage theft can be seen as arising from a regulatory gap whereby evasion is made possible by limits in enforcement. Other forms of regulatory gaps have contributed to the growth of employment forms with inferior rights and benefits, including lower payment for comparable work, although there may not be any violation of employment laws. Taking the range of protections of terms and conditions for full-time permanent employees as a normative standard, regulatory gaps exist for most workers outside this form of employment. Different forms of regulatory gaps contribute to inferior employment. Special rules and exemptions in employment regulation establish some forms of employment with diminished conditions and benefits (e.g. casual employment), while limits in regulatory scope leave some workers, such as self-employed contractors, entirely outside all or most employment law (Pocock et al., 2004). An additional regulatory gap involves the absence of legal mechanisms for ascribing responsibility for pay and conditions to network lead organisations that, while not being the direct employer, control the way work is organised (Johnstone et al., 2012). All these types of regulatory gaps are relevant to the underpayment of social care workers' wages, including wage theft through non-compliance.

Employment regulation is one important element in the broader institutional context in which wage theft and underpayment occur. Other social institutions also have significant influence. In the next section, we review some of the international evidence relating to working time in social care. This review highlights that employer practices leading to underpayments (including wage theft) are also strongly shaped by gendered norms of unpaid care work and the design of public social care systems.

Social care work, working time and underpayment of wages

International comparative research has shown there are real differences in social care systems in developed economies in regard to outcomes for social care workers (Simonazzi, 2009). However, in general, workers are low-paid and have poor working conditions (Cristiano et al., 2016; Razavi and Staab, 2010). In the context of pressures to cut care costs, there is also convergence between care systems, to more home-based care, private provision and cash transfers for care recipients. From the developing international literature on working time and pay in social care we draw three insights especially relevant to our Australian study. First, analysis of the organisation of work shows work time has been excised from paid time, embedding unpaid time in home-based care work (Boivin, 2016; Hayes, 2017; McCann, 2016). Second, the gendered nature of care work and strong norms of unpaid time combine with employer strategies and worker resistance to contribute to

overwork and high levels of unpaid work (Baines et al., 2017; Hayes, 2017; Palmer and Eveline, 2012). Third, public authorities and funding bodies maintain significant control over the organisation of work and over care workers' pay and conditions, using time as the main control mechanism (Atkinson and Crozier, 2016; Boivin, 2016; Rubery et al., 2015).

Of particular relevance is the UK experience, as social care systems across Britain share many features with Australia's developing individualised and marketised disability support system (Macdonald and Charlesworth, 2016). Social care workers have been identified as at greater risk than other UK workers of not receiving the National Minimum Wage (NMW) (Low Pay Commission, 2016: xxvii), and it has been estimated that about half of social care companies have not met their minimum wage obligations (HM Revenue and Customs, 2013). Homecare workers – who provide care and support to frail aged and people with disability in private homes and the community – are particularly vulnerable to underpayment with one estimate that 60% of such workers are underpaid (Bessa et al., 2013: 27–28).

In particular, the social care workforce experience in England highlights how, by paying workers for only some of the time they work, 'nominal' wages may be above the statutory minimum wage but 'effective' wages can be much lower (Koehler, 2014: 5). In England, homecare workers have typically been paid only for contact time with care recipients and have not been paid for much of the work they perform, including the time they travel between private residences where they provide care (Hayes, 2017: 135–138; Rubery et al., 2015). This has been considered to be wage theft (Hayes, 2014) and recent legal challenges to the practice have strengthened regulation specifying that travel between work assignments must be paid (United Kingdom Government, 2017).

Similarly, until recently, homecare and DSWs in New Zealand were not paid for time spent travelling between 'clients', with Briar et al. (2014) arguing this brought the employees' hourly wages below the national minimum wage. Following a long-running campaign and a legal case pursued by the Public Service Association (PSA), a sector-wide arrangement for payment of travel time has now been introduced (New Zealand Parliament, 2015). In Europe, recent legal cases under the European Working Time Directive have also challenged the non-payment of homecare workers' time spent travelling between home visits (McCann, 2016).

Despite some ambiguity about travel as 'work' (McCann, 2016), much other unpaid overtime undertaken by social care workers is undoubtedly work (comprising face-to-face client care and support, administration and communication). Non-payment of work time is underpinned by unfair job design with extremely tight specification of time and tasks and no provision at all for some aspects or for any variability in the work (Hayes, 2017; Moore and Hayes, 2017: 103). In addition, work scheduling techniques that 'drain waged-time from the working day' and the devolution to workers of the risks of variable client demand result in fragmented, often varying and unpredictable work schedules: short periods of paid time (invariably face-to-face contact time with care recipients) are interspersed with other also fragmented, variable and unpredictable periods of unpaid 'non-work' time (McCann, 2016: 44–45; Rubery et al., 2015). So, workers have long work days for little recompense, contributing to low pay. Gaps of unpaid time in the day may not be work but neither are they available to the worker as personal time (Boivin, 2016: 301).

Non-payment of social care work is supported by the gendered legacy of care work as women's work (Hayes, 2017; Palmer and Eveline, 2012). With care work continuing to

be mainly performed unpaid by women in the family, it is often regarded as performed for altruistic reasons and as unskilled and not deserving of decent pay. These norms have a powerful role in social care, influencing employer strategies and also workers' preparedness to perform unpaid work. Furthermore, much social care work is performed in not-for-profit agencies that have long traditions and strong norms of volunteering that contribute to pressures on workers (Baines et al., 2017).

A final insight from the international literature concerns the role funding models and commissioning practices play in determining care workers' pay and conditions. The UK and Canadian studies have identified the use of time as a control mechanism by public funding and commissioning bodies (Atkinson and Crozier, 2016; Boivin, 2016; Rubery et al., 2015). These bodies have no direct responsibility for the employment of care workers but nevertheless determine many aspects of care provision, including the organisation of work. They tightly specify 'care quality' and work on the basis of time and tasks, leaving employers with little scope in relation to workforce strategy. They determine the duration and scheduling of work and, through tight hourly based funding, they also determine pay.

The multiple factors underpinning the underpayment of homecare workers, including marketised, poorly funded care systems which build on a gendered legacy of care work as non-work, are now more visible in the Australian context of disability support work.

Social care, the NDIS, working time and pay in Australia

The Australian care workforce is predominantly female and the work of frontline social care workers is low-paid (Martin and Healy, 2010). Some 70,000 people were employed in specialist disability support services before the NDIS (Martin and Healy, 2010: 109) and the effective full-time disability support workforce is predicted to more than double by 2019–2020 (Buckmaster and Dunkley, 2017). In 2017, this workforce comprised 43% permanent part-time, 41% casual and only 12% permanent full-time employees (National Disability Services (NDS), 2017: 4).

The gendered undervaluation of social care work is reflected in the historical development of working conditions standards for social care workers in Australia (Charlesworth, 2012). The growth of the paid workforce was accompanied by a long struggle for industrial recognition, and it was not until 1990s that most social care workers gained industrial award coverage, providing them with minimum wage rates and employment conditions that were already available to 'over 90% of the Australian workforce' (Briggs et al., 2007: 498). Recently, some recognition of the gendered undervaluation of care work has been achieved with the success of an equal pay case acknowledging this undervaluation (Macdonald and Charlesworth, 2013).

In comparison to the UK, employees in Australia might be expected to be protected by this country's much more comprehensive set of minimum standards for pay and conditions. However, as Charlesworth and Heron (2012) have argued – specifically drawing on the case of social care work – inferior conditions are established for 'non-standard' part-time and casual employees in both the statutory National Employment Standards and in industrial awards, and this regulatory gap has a gendered impact due to women's concentration in these forms of employment. These authors document a range of inferior working time standards for employees covered by the Social Community Home Care and Disability

Support (SCHADS) award compared to employees covered by the Manufacturing Award. Such regulatory gaps include the absence of minimum engagement periods for part-time employees and of provisions for notice of changes to rostered work time and silence on the question of pay for time spent travelling between work assignments (Charlesworth and Heron, 2012). Based on overseas experience, it could be expected that these regulatory gaps are now more significant to the working conditions of care workers under the NDIS than under previous block-funding contracts for disability services.

The publicly funded disability support system in Australia has undergone significant reform with a national system, the NDIS, replacing multiple piecemeal services provided by states and territories. Services are now allocated and funded on an individual basis and provided through the market. Traditional service providers are now competing with new providers, including private for profits. A national agency, the NDIS, manages the market, assessing eligibility, determining individual support packages, setting prices and funding supports. Funding for the personal support provided by DSWs is determined on the basis of an hourly price, varied in some circumstances. Recent study suggests this fee has been set too low to enable the minimum SCHADS Award conditions to be met for DSWs (Cortis et al., 2017). The study also found that the pricing model did not reflect existing employees' classification levels and provided inadequate allowance for training, workers' time not spent providing face-to-face support (3 minutes an hour), travel between clients (providers can include a 20-minute journey but without any adjustment for support to be provided), and supervision (both levels and workloads). These assessments are supported by findings of an employer survey in which two-thirds of respondents disagreed with the statement 'NDIS prices enable us to meet our industrial obligations' (Cortis and Blaxland, 2017: 3).

Here, we report on a qualitative case study of DSWs' paid and unpaid work time. Our findings shed light on the ways in which social care work may be organised under the various pressures and within the regulatory context outlined above and on some of the impacts this can have on employees and their pay.

Method

Qualitative research combined collection of data from 'working day' diaries and semi-structured interviews with DSWs employed under the new NDIS arrangements. The purpose of collecting diary data was to explore working time arrangements and any unpaid work associated with DSWs' jobs. Interviews explored employees' experiences and views of their jobs, working time arrangements and pay.

Participants were recruited through advertisements in newspapers and job websites and through snowballing. We interviewed 22 employees providing home and community-based support services to people with disability. This article reports on analyses of interviews and working day diaries for 10 DSWs: a total of 20 interviews and 30 self-completed diaries. The 10 women all provided support and care under the NDIS. They were employed by 10 different service providers: four for-profit, five not-for-profit and one government provider. All worked in the same region that was one of the first NDIS implementation sites. At the time of the fieldwork in late 2016, the NDIS had been in place in the region for 3 years. The other 12 participants who are not reported on in this article were not providing NDIS services.

The 10 DSWs cannot be seen as representative of all DSWs working under the NDIS. However, this study can provide valuable insights into some of the ways in which work

is being organised under the NDIS and impacts on employees. Despite the small sample size, our interviews were approaching saturation (Morse, 1995), with issues raised in interviews highly consistent across the 10 participants. While there was considerable dissimilarity in paid and unpaid work patterns recorded in diaries, common issues and themes emerged from all 10 workers' diaries. The issues are also similar to those identified in recent surveys of DSWs and providers examining NDIS workforce issues (Cortis et al., 2017; NDS, 2016). Nevertheless, the data we present is indicative only and our findings warrant further investigation through a larger study.

Each DSW participated in two individual face-to-face semi-structured interviews with one of the researchers. In the first interview, each participant was asked about what her job/s involved, the support she provided, working time arrangements, rates of pay and likes and dislikes. At the end of the interview, the participant was given a paper 'diary' on which she was asked to record time, duration and a brief description of each work-related activity and 'breaks' for the next three work days. At the second interview (1–4 weeks later), the researcher went through the diary with the participant seeking additional details and views of the 'diarised' time use. Informed consent in writing was obtained from all participants. Participants were given retail vouchers in recognition of their time and in lieu of payment for any expenses incurred.

Analytic framework

To identify and quantify any apparent underpayment of employees' work time, we categorised time recorded in the diaries as follows:

a. Paid work time.
b. Unpaid overtime comprising: *support work and administrative work* (paperwork, communications and meetings with supervisors, support recipients and families).
c. Unpaid travel directly between support recipients (for a single employer).
d. *Other unpaid time in the work day* comprising: unpaid travel between the employee's home and work during and at the beginning and end of the work day; and unpaid 'breaks' between work-related activities.

We also recorded the *length of the work day* (e), defined as the duration of time from when the worker first left home in the morning until she returned home from her last shift for the day.

On the basis of our literature review, we considered that, on the face of it, time spent on (b) unpaid overtime and (c) unpaid travel directly between support recipients should undoubtedly be paid work time. In this article, we focus on these categories to investigate underpayment of wages for the DSWs. It is much more difficult to ascertain the extent of any wrongful underpayment for time in category (d) and, as it would require considerably more space to do so, we have largely excluded this time from our analysis. This time is, nevertheless, critical to the structuring of employees' work days and pay as workers are often expected to travel long distances from home for very short shifts and can have their work scheduled so that they experience long periods of 'dead' time between shifts.

Here, we have space to provide detail of this time only where it sheds light on the overall organisation and time structure of the work.

Findings

Overview of employees' work and pay

In total, 9 of the 10 DSWs were multiple job holders: five worked in two or three different DSW jobs. Other jobs included aged care and residential support. The main reason women gave for holding multiple jobs was that their main job provided insufficient income. In their main job, seven women were permanent part-time and three were casual employees. Part-time employees had contracts specifying minimum hours, although these minimums were as low as 2 hours a fortnight. All employees had highly variable daily and weekly hours and all were regularly 'expected' to do additional work, often at very short notice. Part-time employees' hourly rates ranged from AUD19.80 to AUD25 and casuals' from AUD25 to AUD29, rates consistent with employment at or just above the relevant classifications in the SCHADS Award. Nine DSWs said they were paid penalty rates for weekend and evening work. The 10th said her employer told her she was paid penalties only when they were included in her clients' NDIS support plans.

Only two DSWs (both employees of the same long-established and large service provider) were paid for time spent travelling between clients. However, seven DSWs (including those two), received a per-kilometre reimbursement for using their own cars when travelling between clients. Notably, the industrial award specifies employees must receive this reimbursement 'where required and authorised by their employer to use their motor vehicle *in the course of their duties*' (our emphasis) (SCHADS Award 2010:: cl 20.5(a)). All DSWs were reimbursed for using their cars to transport clients, as long as the distance was within the kilometre range specified in the client's NDIS funding package.

Employees' paid work time was primarily spent in direct contact with clients, providing in-home assistance, personal care and/or support for community and social participation. All 10 workers said they enjoyed or even loved many aspects of the work; they valued making a difference in people's lives and enjoyed spending time with clients. However, most were unhappy with their pay and conditions and several were seeking other employment. The work aspect identified as a serious problem by all 10 workers was the way their working time was structured. Many frequently worked long days, 6 or even 7 days a week to try to earn an adequate income; yet many spoke of their difficulties earning enough to pay their bills. The women's jobs often left them exhausted and with little time for friends and families.

The working day: The time diaries

The working day diaries documented a total of 30 working days (comprising 3 diarised days for each of the 10 DSWs). They reveal four important aspects of DSWs' working days.

First, the diaries show that the DSWs' days were typically made up of several relatively short paid work 'shifts' spent with support recipients, interspersed with often long periods of unpaid time. Over the 30 days, the 10 DSWs worked between one and five

separate shifts per day. The shortest recorded shifts of paid work were around 30 minutes and the longest was over 10 hours. Most paid work periods were 2 hours or less. Second, the DSWs' working days (from first departure from home for work to last arrival home from work) were long. Two-thirds of the 30 diarised days were 10 hours or longer. Third, though days were often very long, the proportion of the total working day that was paid work was often small. On 17 of the 30 work days, employees were paid for 5 or fewer hours' work in the context of a long span of working hours. As an example, one day in DSW9's diary showed that she left home at 8:45 am and finished her day 13.5 hours later, at 10:15 pm, having completed four shifts and earned only 5 hours' pay. This pattern of paid work was not uncommon: the diaries showed that for each worker, on average over their 3 working days, paid work time was between 27% and 73% of the working day (Table 1). Fourth, the diaries showed very substantial periods of the working day consumed by unpaid activities, structured and often occupied by work.

In the presentation of findings below our focus is on the unpaid work time employees spend travelling between clients and undertaking support and administrative work, time that apparently should be paid work time. However, the organisation of disability support work often renders unusable as 'free' or 'personal' time much other time in a worker's day. For example, workers spent time travelling back and forth from home to work in breaks between periods of paid work, and they often found themselves too far from home to make it worthwhile returning so they simply waited somewhere near their next client's home.

Turning to the unpaid work that clearly directly contributes to underpayment, all 10 DSWs undertook unpaid work either travelling between clients or unpaid overtime (administration and face-to-face support), or both, over the 3 diarised days. For individual workers, the total amount of such unpaid work undertaken over the 3 days ranged from 22 minutes to over 6 and a quarter hours. For some DSWs, unpaid work time was equivalent to a third or more of paid work time in a single day and comprised up to 25% of the duration of the working day (Table 1). If all travel between clients and overtime had been paid, these employees would have received between 2% and 27% more pay than they actually received for the 3 days. In the discussion that follows, this unpaid work and the factors driving it are examined in detail.

Unpaid work: Travel between clients

Travel to clients' homes is an essential part of home and community-based disability support work. The amount of unpaid travel directly between clients varied considerably among the 10 employees on the 3 diarised days. The two women who were paid for the time they spent travelling directly between clients had paid travel time in their enterprise agreement with the same long-standing service provider. Our interviewees informed us, and it was later confirmed, that this provider had ceased providing disability support services because they could not afford to do so under the NDIS. For other DSWs unpaid travel between clients was equivalent to between 1% and 15% of the employee's paid time over the 3 days, and as much as 25% in a single day. One DSW spent an hour and a half travelling directly between clients in a single day. A total of 15 of the diarised days showed no unpaid travel directly between clients, but this was often because employees had large unpaid gaps between paid work periods and went home before travelling to the next client.

Table 1. Disability Support workers' paid and unpaid work time for 3 days[w].

DSW ID	Disability support workers									
	1[x]	2	3[y]	4	5	6[x,y,z]	7[x,y]	8[y]	9[x,z]	10[x]
Day 1 (no. engagements)	5	2	2	3	1	10	1	1	5	2
Paid time (a)	10:00	2:00	1:06	4:36	10:00	7:58	8:00	1:07	6:30	7:00
Unpaid overtime (b)	1:14	0:15	0:19	0:22	0:30	0:35	0:00	-0:02	0:00	1:10
Unpaid travel directly between clients (c)	0:25	0:00	0:00	0:06	0:00	0:00	0:00	0:00	0:15	0:00
All unpaid work (b + c)	1:39	0:15	0:19	0:28	0:30	0:35	0:00	-0:02	0:15	1:10
Length of work day (e)	15:15	6:00	3:30	9:37	11:30	10:00	9:00	1:21	13:30	10:45
All unpaid work/all work time ((b + c)/(a + b + c)) (%)	14	11	22	9	5	7	0	-3	4	14
Paid time/work day (a/e) (%)	66	33	31	48	87	80	89	83	48	65
Day 2 (no. engagements)	4	3	4	1	3	5	2	3	4	4
Paid time (a)	5:00	3:00	3:36	8:05	8:05	6:20	5:00	2:58	5:00	7:00
Unpaid overtime (b)	1:19	0:35	-0:01	-0:06	0:58	0:19	0:00	0:08	0:07	0:30
Unpaid travel directly between clients (c)	0:30	0:00	0:55	0:00	0:20	0:00	0:00	0:00	0:00	1:30
All unpaid work (b + c)	1:49	0:35	0:54	-0:06	1:18	0:19	0:00	0:08	0:07	2:00
Length of work day (e)	15:45	11:15	15:15	8:41	13:40	12:30	7:20	13:24	13:30	9:50
All unpaid work/all work time (b + c)/(a + b + c)) (%)	27	16	20	-1	14	5	0	4	2	22
Paid time/work day (a/e) (%)	32	27	24	93	59	51	68	22	37	71
Day 3 (no. engagements)	5	2	3	2	2	6	4	3	3	2
Paid time (a)	8:20	2:50	5:06	1:56	7:30	10:36	3:36	2:35	3:10	2:25
Unpaid overtime (b)	1:49	0:00	0:24	0:05	1:10	0:04	-0:06	0:18	0:00	0:01
Unpaid travel directly between clients (c)	1:00	0:25	0:35	0:00	0:40	0:15	0:30	0:00	0:00	0:00
All unpaid work (b + c)	2:49	0:25	0:59	0:05	1:50	0:19	0:24	0:18	0:00	0:01
Length of work day (e)	11:15	4:20	8:55	6:26	10:05	14:42	7:45	9:52	3:35	8:50
All unpaid work/all work time ((b + c)/(a + b + c)) (%)	25	13	16	4	20	3	10	10	0	1
Paid time/work day (a/e) (%)	74	65	57	30	74	72	46	26	88	27

Table 1. (Continued)

DSW ID	Disability support workers									
	1[x]	2	3[y]	4	5	6[x,y,z]	7[x,y]	8[y]	9[x,z]	10[x]
Total: Days 1 to 3	14	7	9	6	6	21	7	7	12	8
Paid time (a)	23:20	7:50	9:48	14:37	25:35	24:54	16:36	6:40	14:40	16:25
Unpaid overtime (b)	4:22	0:50	0:42	0:21	2:38	0:58	-0:06	0:24	0:07	1:41
Unpaid travel directly between clients (c)	1:55	0:25	1:30	0:06	1:00	0:15	0:30	0:00	0:15	1:30
All unpaid work (b + c)	6:17	1:15	2:12	0:27	3:38	1:13	0:24	0:24	0:22	3:11
Total all work days [e]	42:15	21:35	27:40	24:44	35:15	37:12	24:05	24:37	30:35	29:25
All unpaid work/all work time ((b + c)/(a + b + c)) (%)	21	14	18	3	12	5	2	6	2	16
Paid time/work day (a/e) (%)	55	36	35	59	73	67	69	27	48	56

DSW: disability support worker.
[w]Times are reported in hours and minutes.
[x]DSW employed by more than one disability support provider.
[y]Administration time adjusted as one employer paid for 30 minutes a week.
[z]DSW paid for travel between clients by one employer.

Most interviewees raised the issue of unpaid travel time as a major shortcoming of the job, particularly when paid work periods were short and the ratio of unpaid to paid working time was high. Women's gave a variety of explanations for undertaking shifts that involved at lot of unpaid travel and little paid work. For some it was a sense of responsibility to clients, a manager or both. Fear of jeopardising further work opportunities was often cited as a strong motivator for not refusing shifts. One DSW who had been in her job under 6 months was very conscious of the impact of travel time on her effective pay rate and also found the driving stressful:

> … but a big part, as you know, is driving for the job. So I think at the end of the day I'm so knackered, so tired because I'm thinking, I've just been stressed all day worrying about the traffic, whether I'm going to have a prang, just trying to get to these places on time. All for what? For say 3 hours' work. (DSW2)

Yet this employee was unwilling to complain about her pay and conditions as it had been difficult for her to find work. This sense of vulnerability may have been well-placed: another DSW, who had consistently refused to take certain poor shifts, believed she had been punished by having work taken away. By comparison, a very experienced worker reported resisting or refusing shifts where the ratio of paid to unpaid work was too low:

> I don't do any less than an hour. … [Employer B] don't do less than an hour. [Employer A] try to get you to do half hour ones like for medication runs or things like that but, no to me it's not worth it especially when you have to drive like half an hour there, get paid half an hour and a half an hour back and you don't get paid for travelling. (DSW1)

However, this DSW spent nearly 2 hours travelling directly between clients over the 3 days, unpaid and without a car allowance.

Unpaid work: Overtime providing support and undertaking administration

A second type of unpaid work was the additional time DSWs spent providing support to clients and undertaking administrative tasks. Five of the ten employees accrued 50 minutes or more of such unpaid work over the 3 days. For four workers, this was equivalent to 10% or more of the time they were paid for work.

This form of unpaid work appeared endemic. Six of the ten employees provided unpaid support on 29 occasions over the 30 recorded days. Though often only for short periods this unpaid work added up to between 15 and 50 minutes over the three days. Employees' fragmented work schedules meant that this additional work was often absorbed into unpaid time between scheduled support for clients – rendering it invisible to the employer. Contributors to unpaid support included unexpected events (e.g. client illness), unpredictable behaviours, client requests for extra supports; new/unfamiliar clients; family carers returning home late, and mismatches between client needs and funded supports, as described here:

> Sometimes when the support team goes out to a client's home or interviews them, [or] interview them over the phone, they may think 'Oh this is only going to take half an hour' but they haven't actually done it [the work]so they might guestimate that it's half an hour where it's a bit longer. [DSW4]

Administration work was a further significant component of unpaid overtime. Eight of the ten employees completed multiple, often small, amounts of unpaid overtime every day. The range of unpaid administrative tasks included: completing client notes and incident reports, communicating with supervisors about client needs, organising rosters and extra shifts and completing travel forms and timesheets. Most tasks were central to client care and/or the organisation of work. While one organisation paid employees 30 minutes a week for administration, DSWs were not otherwise allocated paid time for these tasks which often consumed considerable amounts of time and could be highly disruptive to personal time. One employee, who had many serious concerns about her clients, spent nearly 4 and a half hours over the 3 days writing up client notes, usually very late at night. This unpaid administration was equivalent to almost 20% of her paid work time. Another seven employees undertook between 10 minutes and just under 2 hours of unpaid administration over the 3 days. Two employees did no unpaid administration work at all.

DSWs gave two main reasons for undertaking unpaid work. Many workers did so out of a personal commitment to providing good quality, and usually essential, care. This included one employee who said she and colleagues arranged staff meetings in unpaid time to induct new staff and discuss clients' support needs. Most employees linked their unpaid overtime to job insecurity and some reported responding to pressure to complete additional unpaid tasks at clients' request because they feared losing shifts if a client requested a different support worker.

In theory employees could claim pay for some of their unpaid overtime while in practice it was often difficult or impractical to do so. One employee commented: 'I mean I guess if we specifically rang our boss and we're like "hey, this ran 15 minutes over, I'm going to put it on my timesheet," and they knew, then we would. But if it happens every single day, I don't think that many of us really ring her every single day. And she's very hard to contact as well' [DSW10]. Nevertheless, employees sometimes accepted responsibility for not claiming time:

> I: Do you get paid for that extra ten minutes, when (the family carer's) late?
>
> P: No. Well, that's my fault; I'm not going to ring something like that in.
>
> I: No. When would you ring it in? How many minutes late would they have to be for you to call in?
>
> P: Half an hour, twenty minutes, half an hour, it depends. This is a nice lady, she doesn't mean to be home [late]. [DSW6]

In some cases, explicit organisational arrangements required employees to absorb unpaid work without remuneration. Further, employees articulated it was in their best interests to undertake this work in order to have better outcomes for clients. For example, one employee (DSW5) explained that it was in her position description to arrive at work 10 minutes before the commencement of her paid work. While she considered this 'a nuisance' it also enabled her to talk with the client's family carer and get any issues 'sorted'.

Finally, workers' sense of insecurity and lack of support in challenging their working conditions was often evident in their explanations for undertaking unpaid work. One employee feared losing shifts if she 'rock[ed] the boat' (DSW2), another said she was afraid of 'making ripples' and risking confrontation (DSW5), and others reported they

had been 'punished' with removal of shifts for attempting to challenge an employer (DSW1) and for refusing to take poor shifts (DSW8). In contrast the two employees of the large long-established and highly unionised service provider reported numerous instances of challenging management to improve conditions for workers.

The financial cost to employees of the unpaid work of travel between clients and overtime was significant, even for those who undertook relatively little unpaid work. For five of the ten employees, 2%–6% of their work over the 3 days was unpaid. On the basis of the standard hourly rate each DSW was paid (i.e. disregarding any penalty rates), we estimate those five employees were underpaid by between AUD8.84 and AUD30.42 over the 3 days. The other five DSWs were not paid for 12% or more of their work time, including one who was not paid for 21%. That employee, who had both the highest number and proportion of unpaid work hours, was underpaid by around AUD180 over 3 days. The remaining four employees were underpaid by between AUD24.75 and AUD92.08 over 3 days.

Discussion and conclusion

Our case study findings demonstrate some of the ways in which disability support work is being organised under NDIS implementation, leaving employees underpaid for significant amounts of their working time. While it is not possible to generalise from the experiences of this small sample it is worth noting that underpayment for travel and overtime was experienced by employees of nine of the ten different employers in this study. Further, we argue that the significance of this study, beyond mapping the dimensions of wage theft and underpayment for a small group of workers, is its analysis of how the funding and regulatory environments facilitate systemic non-payment of working time for homecare workers – an analysis which is broadly applicable to the many workers employed in the same context.

In part, underpayment of the DSWs was rendered invisible by the gendered norms of care work. The findings of this study echo those of Hayes (2017) that in the UK 'homecare workers who wish to provide care in a way which is compatible with self-respect must do so on an unpaid basis' (p. 127). The underpayment of wages was hidden and ambiguous, owing to the regulatory gaps which supported it. Non-payment for travel time was apparently enabled by the absence of a specific entitlement in the industrial award, while the absence of a minimum engagement period for part-time employees saw work periods reduced to as little as 20 minutes. Employers appear to have actively exploited the lack of clear minimum standards: paying vehicle allowances for travel between assignments suggests acceptance of this activity as work – while not paying wages for this time.

Inferior benefits and conditions for social care workers were established in Australian employment regulation long before the introduction of the NDIS. However, our findings support the view that the NDIS is further institutionalising employment practices that produce wages underpayment. Notably, in the context of identified under-pricing of personal support services under the NDIS, the only employees in our study who were paid for travel time lost work as their employer's disability services provision was deemed not viable under the new funding model. Also notably, in this workplace, employees had gained their superior benefits through collective bargaining, while union organisation and representation were less apparent for other employees in our study.

Addressing deficiencies in employment minimum standards is one strategy for resolving some of the problems of underpayment for social care workers. Embedding gender equality objectives in award review processes is potentially a way of achieving this (Macdonald and Charlesworth, 2013). More fundamentally, addressing underpayment of wages of social care workers is likely to require acknowledgement of the limitations of regulation fashioned around the normative standard of full-time permanent employment and the binary employment relationship. In this regard there is a variety of innovative regulatory responses that target network lead or top of supply chain organisations, including in Australia's textile, clothing and footwear industry (Johnstone et al., 2012). Safeguarding and quality regulation under the NDIS could be framed to ensure disability workers are paid fairly and all participants in the supply chain take responsibility, as was previously done in the road transport sector (Johnstone et al., 2015). The fact that the government is effectively the top of the supply chain body in publicly funded social care systems such as the NDIS highlights the need for embedding accountability for labour standards in public policy more generally.

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Dear Providers

This letter provides an update on the Independent Pricing Review (IPR).

In response to market feedback that, in some areas, price limits set by the NDIA required more detailed consideration, the National Disability Insurance Agency (NDIA) Board engaged McKinsey & Company in June 2017 to undertake an Independent Pricing Review for the National Disability Insurance Scheme (NDIS). As the NDIS is rolled out across Australia, the establishment of the IPR reflected the NDIA's commitment to developing a vibrant provider sector that can provide reasonable and necessary supports to NDIS participants to help them live a better life.

As part of this independent process, McKinsey & Company consulted with over 1000 individuals, held ten open forums, nine webinars, and 45 one-on-one meetings in the second half of 2017.

The IPR was commissioned recognising the important role that price plays as a key driver of value for participants, particularly during transition. In commissioning the review, it was acknowledged that prices paid to providers must be sufficient to create adequate supply to meet the short and longer term needs of participants. To that end, the IPR undertook detailed analysis of provider economics, market development, and Scheme and sector data, resulting in a deeper understanding of the complex environment in which providers operate.

In March 2018, the full IPR and the NDIA Response were published, including in principle endorsement of the report's 25 recommendations. The NDIA response also outlined that additional work was required prior to implementation for some of the more complex recommendations.

The disability sector has welcomed the IPR's message that close attention must be paid to price, and in particular that action was needed to support providers during their transition to the participant centred funding approach that is integral to the NDIS . The NDIA has continued to engage and consult with providers about the impact of the IPR's recommendations, and has committed to communicate with providers and implement the IPR recommendations in a thorough and timely way. Following those initial soundings, the NDIA provided an update to the market in April, 2018 revising those recommendations that would be progressed immediately and those where further work was required.

The NDIA now confirms the specific IPR recommendations that will be implemented for 2018/19 from 1 July 2018. These changes will give providers immediate support to meet the challenges of transitioning to the participant centred NDIS funding approach.

Price limits for most supports will increase. For standard intensity attendant care supports, price limits will include a new 2.5% loading, following the IPR recommendation to give providers temporary support for their overhead costs (TSO). 'Attendant care' refers both to assistance with daily personal activities and assistance with community participation.

The initial IPR recommendation was that this should be put in place for one year. However, the NDIA Board has decided that this TSO measure will remain partially in place (at 1.25%) in 2019/20, rather than be removed after 12 months as originally recommended. While this

TSO loading is in place, the NDIA will continue to work to deliver initiatives which will reduce provider administrative costs and deliver a better NDIS provider experience. Significant progress has been made, with the NDIA delivering provider portal enhancements, payments process improvements, and continuous development of helpful tools such as the provider finder. The NDIA has clear initiatives for delivery over the coming financial year, which will build on this work, and will also work with providers to help improve their efficiency.

New price limits will also take full account of growth in wage costs under the Social, Community, Home Care and Disability Services Industry Award and the Equal Remuneration Order. The cumulative impact of both is 5.14%. When combined with the TSO of 2.5% for the year, this means that the price limit for standard attendant care supports will increase by 7.6% from 1 July 2018.

Group community participation supports will be converted to a new, consistent structure in the NDIS support catalogue, to give providers and participants more clarity and flexibility. Providers will also benefit from new price limits that recognise per-person costs when delivering group supports, and include an allowance for capital costs when these supports are delivered in a specialist centre.

New, more flexible arrangements for provider travel and appointment cancellations will also be introduced from 1 July 2018.

To ensure that participants are not adversely impacted by this price increase and that they can purchase their reasonable and necessary supports, the 1 July 2018 price limit changes will be accompanied by automatic updates to participant budgets and service bookings. These adjustments will reflect the additional costs that each individual participant will face as a result of the increases in price limits. Other changes, such as for cancellation and travel cannot readily be adjusted, but will be monitored closely for individual participants to ensure they are not adversely affected.

Full details of all price limit changes are being published at the same time as this advice is provided.

As advised in April, some other changes—originally envisaged to be implemented on July 1—will be delayed pending further consultation.

Specifically, this applies to therapy support. Therapy support is crucial for many participants, and providers are responding to the opportunity that the roll-out of the NDIS provides. For instance, while variations in growth rates occur among states and territories, in the year to 30 March 2018, the number of registered providers across Australia offering therapeutic supports more than doubled from 3560 to 7161. Therapy providers are the single largest group of registered providers in all states, other than Western Australia where many are expected to register now that the NDIS is fully national.

However, based on therapy provider feedback since the IPR; the interrelationship of therapy prices with the IPR's recommendations in relation to pricing for complexity; and Western Australia's decision to join the NDIS, the NDIA has asked McKinsey & Company to ensure the appropriateness of its therapy price control recommendations. The NDIA was particularly eager to ensure that initial IPR recommendations captured differences among states, including those with a substantial number of participants in remote areas, along with differentiation by therapy types. For this reason, adjustments to therapy prices will only be implemented after this work is complete and fully considered.

This approach reflects the NDIA's commitment to working collaboratively with the sector to deliver a strong, vibrant and innovative market for quality disability supports.

Following implementation of the first set of IPR recommendations, the NDIA will move immediately to finalise the next set of recommendations, including therapy price limits and complexity. Consultation with provider groups and experts from the sector in relation to these recommendations will occur before implementation. We expect the outcomes of the important work on therapy and complexity to be implemented in late 2018.

You can find more information relating to the implementation of IPR recommendations on the NDIS website: https://www.ndis.gov.au/providers/independent-pricing-review.html.

Regards

Robert De Luca
Chief Executive Officer
National Disability Insurance Agency

IPR Implementation

The NDIA confirms that the Independent Pricing Review (IPR) recommendations that will be implemented for 2018/19, taking effect on 1 July 2018 are as follows:

- 4 - Regional Travel
- 9 – High intensity loading for centre-based activities
- 10 - Short Term Accommodation
- 14 - Temporary Support for Overheads (TSO)
- 15 - Cancellation policy for core supports
- 16 - Group supports
- 18 - Therapy Assistants (phase one)
- 19 - Therapy travel (phase one)
- 20 – Cancellation policy for therapy
- 21 – Reports requested by the NDIA

Full details of these changes are available in the link to the 2018-19 NDIS Price Guide. Key changes, to take effect on 1 July 2018, include the following:

- A TSO loading of 2.5 per cent will be applied to all standard intensity attendant care price limits in the 2018-19 Price Guide.
  - This measure will provide temporary financial relief for providers as they transition to the NDIS funding approach of individualised participant packages.
  - Half of this loading (1.25%) will remain in place during 2019-20.
  - The loading will be removed in 2020-21, as an adjustment to the annual price review.
  - While the TSO loading is in place, the NDIA will continue to work on pathway initiatives that will provide ongoing cost reductions and an improved and easier experience for disability support providers.. Initiatives already underway or completed include improvements to the provider portal, provider payments systems, and helpful tools such as the provider finder.

Standard needs attendant care price limit per hour	Without TSO	TSO for 12 months	Decision - extended TSO
2017/18	$44.72	$44.72	$44.72
2018/19	$47.02	$48.14	$48.14
2019/20*	$49.44	$49.44	$50.02

*The 2019/20 figures are projections only, assuming a 3.5% growth in Modern Award wage levels on 1 July 2019.

- As in previous years, price limit increases for attendant care take full account of growth in wages under the *Social, Community, Home Care and Disability Services Industry (SCHADS) Award* as well as the Equal Remuneration Order (ERO) by Fair Work Australia. This results in the following adjustments.

	Component	Cumulative
ERO 1 December 2017	2.27%	
SCHADS wage growth 1 July 2018	3.50%	5.14%*
TSO (applies to standard intensity supports)	2.50%	7.64%

* See Appendix A for further detail.

- Combined with annual 'indexation' adjustments to account for growth in provider costs, this means that price limits will increase in 2018/19 by:
  - 7.64% for standard intensity attendant care supports (including TSO),
  - 5.14% for high intensity attendant care supports (TSO does not apply – see Appendix A), and
  - 2.1% for capacity-building supports, including therapy, based on growth in the national Wage Price Index (these supports are delivered by highly skilled workers, for whom the SCHADS award is not an appropriate reference).
- Based on provider feedback, a new price limit will be added for Short Term Accommodation (STA) to allow for a 1:3 support worker to participant ratio. The new limit will be consistent with existing STA price limits, and will provide more flexibility to providers and participants in making support arrangements.
- Providers will be able to charge 90 per cent of the service booking price for short notice cancellations, up to a maximum of 12 cancellations per year for core supports and 6 hours per year for therapy.
- New price limits will be introduced for both standard and high intensity community-based group supports, to allow for support ratios of 1:4 and 1:5 (i.e. worker:participant ratio).
- A capital allowance will be included in the price limits for centre-based group care.
- Therapy travel recommendations that will benefit providers will also be introduced from 1 July 2018 (i.e. allowing providers to charge up to 45 minutes of travel time in rural areas). More specific travel claiming arrangements for remote areas that were flagged in the IPR (allowing travel costs on a quote basis) will be implemented as soon as possible. In the meantime, travel cost arrangements for remote areas can still be claimed, subject to explicit agreement by the participant in advance.

The implementation schedule for the remaining IPR recommendations remains as outlined in the 24 April update (https://www.ndis.gov.au/news/ipr-implementation-update.html).

The NDIA is committed to ensuring that providers are supported as they transition from block funding to the participant-led NDIS, and the eventual creation of a deregulated market for services.

Participant Plans will be adjusted to match the indexation increases in price limits for disability supports, ensuring participants will maintain their purchasing power for reasonable

and necessary supports. The specific impact on each participant's budget will vary, according to the mix of supports that are reasonable and necessary for each individual.

Changes to the group support price limit tiers and cancellation and travel policies will not be adjusted in participant plan budgets. While these changes will have a positive impact on individual participants through increased flexibility, changes to support arrangements between providers and participants will only come into effect through an individual participant's choice, making it difficult to make broader adjustments. The NDIA will monitor cancellation practices, particularly in areas with high risk of cancellations and heavy reliance on provider travel (e.g. participants living in regional areas). The NDIA will consider targeted action if there is a risk to the delivery of reasonable and necessary supports, without the need for a plan review.

The 'Supported Independent Living (SIL) tool', used to determine reasonable and necessary support budgets for participants in shared accommodation arrangements, will be updated before 1 July 2018. The new version, for use in 2018/19, will include specific changes to provide for an 'indexation' adjustment of 5.14% to account for growth in wages. Consistent with the IPR recommendation, the TSO will not apply to SIL calculations. Because the SIL tool will be in use from July 1, there is no requirement for SIL benchmarks, and they will be removed from the NDIS Price Guide.

Nonetheless, existing service bookings between providers and participants for SIL will be updated as appropriate in the following ways:

- The NDIA understands that SIL providers will experience the same wage cost growth on 1 July 2018 as other providers of attendant care supports, but may not have factored this growth into their original quotes. For this reason, the NDIA is taking steps to make sure that any SIL service bookings (and participant budgets) that continue into the 2018/19 financial year are adjusted appropriately.
- In future years, SIL service bookings will not be subject to automatic updates to account for inflation. Instead, the NDIA expects that SIL providers will use the updated SIL tool to anticipate wage growth during the course of their service bookings and factor in indexation as part of their quote.

APPENDIX A

Price limits increase in the NDIS line with the increase in costs that providers face in delivering different supports. For attendant care, most of the cost is driven by wages of support workers, who are employed under the *Social, Community, Home Care and Disability Services Industry* (SCHADS) Award. Their wages increase in line with national minimum wage decisions and the Equal Remuneration Order (ERO). Some other costs that providers face, such as overheads, increase at a different rate, typically in line with general measures of inflation such as CPI. Combining these increases for different costs results in an indexation adjustment to attendant care price limits of 5.14% in 2018-19. The following table explains this calculation in detail.

<table>
<tr><th colspan="3">Components of cost growth</th><th>Cost growth</th><th>Estimated proportion of costs</th><th>Weighted average cost growth</th></tr>
<tr><td rowspan="2">Labour cost</td><td>ERO 1 December 2017</td><td>2.27%</td><td rowspan="2">A. 5.8%</td><td rowspan="2">C. 82%</td><td rowspan="3">5.14%
A * C + B * D</td></tr>
<tr><td>SCHADS wage growth 1 July 2018</td><td>3.5%</td></tr>
<tr><td>Other Cost</td><td>CPI</td><td>1.9%</td><td>B. 1.9%</td><td>D. 18%</td></tr>
</table>

Combined with annual ‘indexation’ adjustments to account for growth in provider costs, this means that price limits will increase in 2018/19 by:

- 7.64% for standard intensity attendant care supports (including TSO),
- 5.14% for high intensity attendant care supports (high intensity supports will be addressed by more specific IPR recommendations, so the IPR recommended that the TSO apply to standard intensity supports only), and
- 2.1% for capacity-building supports, including therapy, based on growth in the national Wage Price Index (these supports are delivered by highly skilled workers, for whom the SCHADS award is not an appropriate reference).

NDIS Price Guide 2019-20

Valid from: 1 July 2019

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Contents

Scope of the NDIS Price Guide

Where possible, the National Disability Insurance Agency (NDIA) utilises market mechanisms to deliver the level of supply required by the National Disability Insurance Scheme (NDIS) to meet participant demand and deliver the correct mix of goods/services, produced at market clearing (efficient) prices. However, in underdeveloped or non-existent markets, reliance on a deregulated market mechanism may not meet participant demands; may not deliver adequate supply; may not deliver the correct mix of disability supports and may not produce efficient prices. To address these issues, the NDIA has a role, as market steward, to create an efficient and sustainable marketplace through a diverse and competitive range of suppliers who are able to meet the needs of a consumer driven market.

As part of its market stewardship role, the NDIA imposes price controls on some supports by limiting the prices that registered providers can charge for those supports and by specifying the circumstances in which registered providers can charge participants for supports. Price controls are in place to ensure that participants receive value for money in the supports that they receive. In the short to medium term, price controls are required for some disability supports because the markets for disability goods and services is not yet fully developed. The longer-term goal of the NDIA is to remove regulatory mechanisms from the markets for disability supports.

This Price Guide is a summary of NDIS price limits and the associated pricing arrangements that will apply from 1 July 2019 as set by the NDIA. It is designed to assist participants and disability support providers, both current and prospective, to understand the way that price controls for supports and services work in the NDIS. The price limits within this Price Guide are the maximum prices that Registered Providers can charge NDIS participants for specific supports. There is no requirement for providers to charge at the maximum price for a given support or service. Participants and providers are free to negotiate lower prices.

Currently, the NDIA varies its approach to the regulation of prices, depending on market conditions, between:

- **No regulation** (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.
- **The imposition of price limits**: these represent a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for attendant care.
- **Quotable supports**: in which participants are expected to obtain quotations from suppliers to provide to the NDIA, which will verify that the prices are fair and reasonable. This approach is typically used in the case of highly specialised, differentiated supports that may not have a high level of competition – for example, assistive technology. They are also used in cases, such as supported independent living, where a bundle of supports is being purchased.

This Price Guide is principally concerned with NDIS supports that are subject to price limits. A comprehensive list of all NDIS supports (“the Support Catalogue”) is at

https://www.ndis.gov.au/providers/price-guides-and-information. The Support Catalogue includes item descriptors to assist providers to claim payments using a “best-fit” approach, and to assist participants in engaging and negotiating with service providers.

The NDIA publishes separate price guides for:

- Assistive Technology at https://www.ndis.gov.au/providers/essentials-providers-working-ndia/providing-assistive-technologies-and-home-modifications
- Specialist Disability Accommodation at https://www.ndis.gov.au/providers/essentials-providers-working-ndia/specialist-disability-accommodation

Application of this Price Guide

The price limits and other arrangements in this Price Guide must be followed when supports are delivered to NDIS participants who have either an agency-managed plan or a plan manager.

A provider of supports to a participant with an agency-managed plan (or of a support that is agency managed):

- must be a registered provider with the NDIS;
- must declare relevant prices to participants before delivering a service, including any notice periods or cancellation terms;
- must adhere to the arrangements in the Price Guide, including ensuring that their prices do not exceed the price limits prescribed in the Price Guide

Plan managers can purchase supports on behalf of participants from either registered or unregistered providers, but they are registered providers themselves, and therefore responsible for ensuring that prices paid for supports on behalf of their participants adhere to the arrangements in the Price Guide, including price limits.

Self-managing participants can use registered or unregistered providers and are not subject to the pricing arrangements in the Price Guide.

In addition, all registered providers, regardless of whether funding for the support is managed by the participant, managed by a registered provider, or managed by the NDIA, must not add any other charge to the cost of the supports they provide, including credit card surcharges, or any additional fees including any ‘gap’ fees, late payment fees or cancellation fees.

Support Purposes, Categories and Line Items

This section describes the way that the NDIS categorises disability supports. These categories can be relevant to rules for participants about how they can spend their support budgets, and for providers when seeking payment for delivered supports.

Support Purpose Types

NDIS participant budgets can be allocated to three separate types of support purpose:

1. CORE – Supports that enable participants to complete activities of daily living. Participant budgets often have a lot of flexibility to choose specific supports with their core support budgets, but cannot reallocate this funding for other support purposes (i.e. capital or capacity building supports).
2. CAPITAL – Investments, such as assistive technologies - equipment, home or vehicle modifications, or for Specialist Disability Accommodation (SDA). Participant budgets for this support purpose are restricted to specific items identified in the participant's plan.
3. CAPACITY BUILDING - Supports that enable a participant to build their independence and skills.

Support Categories aligned to the NDIS Outcomes Framework

Participant budgets are allocated at a support category level and must be used to achieve the goals set out in the participant's plan.

Support categories are aligned with the NDIS Outcomes Framework, which has been developed to measure goal attainment for individual participants and overall performance of the Scheme. There are eight outcome domains in the Framework, which help participants think about goals in different areas of their life and assist planners explore where supports in these areas already exist and where further supports are required. These domains are:

1. Daily Living	5. Work
2. Home	6. Social and Community Participation
3. Health and Wellbeing	7. Relationships
4. Lifelong Learning	8. Choice and Control

NDIS service providers should be aware that all supports and services for NDIS participants must contribute to the achievement of their individual goals as outlined in the participant's plan. Support purpose categories are designed to align with the Outcomes Framework and the 15 support categories (listed below). This helps participants choose supports that help them achieve their goals, and providers to understand how the supports they provide contribute to the participant's goals. The following table shows the links between support purpose types, domains in the Outcomes Framework and support categories.

SUPPORT PURPOSE	OUTCOME DOMAINS in FRAMEWORK	SUPPORT CATEGORY
CORE	Daily Living Daily Living Daily Living Social & Community Participation	Assistance with Daily Life Transport Consumables Assistance with Social & Community Participation
CAPITAL	Daily Living Home	Assistive Technology Home Modifications and Specialised Disability Accommodation (SDA)
CAPACITY BUILDING	Choice & Control Home Social and Community Participation Work Relationships Health & Wellbeing Lifelong Learning Choice and Control Daily Living	Support Coordination Improved Living Arrangements Increased Social and Community Participation Finding and Keeping a Job Improved Relationships Improved Health and Wellbeing Improved Learning Improved Life Choices Improved Daily Living Skills

Support Line Items

Each support category has many specific supports and services that are recognised in the NDIS payment system. These are referred to as 'support line items' and are, in most cases, not prescribed in participant plans.

Providers should claim payments against a support line item that most closely aligns to the service they have delivered.

Each support line item has a unique reference number, according to the following structure:

For example:

01_013_0107_1_1 - Assistance With Self-Care Activities - Standard - Saturday

Support Category	Sequence Number	Registration Group	Outcome Domain	Support Purpose
1	013	0107	1	1

Units of Measure

The NDIS payment system includes units of measure to suit each support line item as follows:

• Each	• Hour	• Daily
• Week	• Month	• Annual

Claiming supports and services

Registered Providers can make a claim for payment for a support once that support has been delivered or provided. Where price limits apply, prices charged to participants must not exceed the price limit prescribed for that support in this Guide. Providers cannot add any other charges to the cost of the support, including credit card surcharges, or any additional fees including any 'gap' fees, late payment fees or cancellation fees unless otherwise stated in this Price Guide.

When claiming, it is the responsibility of the provider to ensure that the claim accurately reflects the supports delivered, including the frequency and volume of supports. Falsifying claims for any aspect of supports delivered, is a serious compliance issue and may result in action against the provider. Providers are also required to keep accurate records of claims, which are subject to audit at any time.

Providers should claim payments against a support line item that most closely aligns to the service they have delivered.

Service Agreements

A Service Agreement is a formal agreement between a participant and provider. They help to ensure there is a shared understanding of:

- expectations of what supports will be delivered and how they will be delivered; and
- the respective responsibilities and obligations of the provider and the participant and how to resolve any problems that may arise.

Service Bookings

Service bookings are used to set aside funding for an NDIS registered provider for a support or service they will deliver. Each service booking sets out the specific supports or support domains agreed to be provided and the length of time that agreement is applicable within the current participant plan dates. Service bookings are not the same as 'service agreements', which set out the terms and conditions negotiated with the participant.

The Agency recommends that service bookings are created at the category level, where possible. This allows providers and participants to negotiate or access supports on a more flexible basis, especially for on-the-spot assessments or less predictable support needs. This is preferable to having to edit existing service bookings or create another service booking for that item at a later date or have funds locked into a support line item that may not eventuate, which restricts funding for alternate services.

See the 'NDIS Myplace Provider Portal Step-by-step guide' on the Provider Toolkit for further information.

Special NDIS Pricing Arrangements

Regional, Remote and Very Remote Areas

The NDIA uses the Modified Monash Model (MMM) to determine regional, remote and very remote areas using a scale based on population size and locality (see Table below).

	Zones	MMM	Inclusion
Metropolitan	MMM 1-3	1	All areas categorised as Major Cities of Australia.
		2	Areas categorised as Inner Regional Australia or Outer Regional Australia that are in, or within 20km road distance, of a town with population >50,000.
		3	Areas categorised as Inner Regional Australia or Outer Regional Australia that are not in MM 2 and are in, or within 15km road distance, of a town with population between 15,000 and 50,000.
Regional	MMM 4-5	4	Areas categorised as Inner Regional Australia or Outer Regional Australia that are not in MM 2 or MM 3, and are in, or within 10km road distance, of a town with population between 5,000 and 15,000.
		5	All other areas in Inner Regional Australia or Outer Regional Australia.
Remote	MMM 6	6	All areas categorised Remote Australia that are not on a populated island that is separated from the mainland and is more than 5km offshore.
Very Remote	MMM 7	7	All other areas – that being Very Remote Australia and areas on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.

Further details on the MMM can be found on the Department of Health's DoctorConnect website, which contains a resource to look up the MMM area for particular locations[1].

Participants located in MMM4 and MMM5 areas are classified as 'Regional', MMM6 as 'Remote', and MMM7 as 'Very Remote'. In general, price limits are 40% higher in remote areas and 50% higher in very remote areas. There is no additional loading applied for supports in regional areas.

Providers should refer to support price limits based on where the support is delivered, which is not necessarily where the participant lives. For example, if a participant living in a Remote location visits a therapist in their capital city, the therapist should not attempt to claim a price that is higher than the price limit for the support in that city. On the other hand, if the therapist was to visit the participant in their local area to deliver the support, then the therapist could claim a price that is within the limit set by the 'Remote' Price Guide.

If local providers are not available, the NDIA may enter into arrangements (and at times contracts) with specific providers for provision of services to more remote regions. The contract with a service provider will specify the cost of travel and any other associated expenses in these areas.

Temporary Transformation Payment (TTP)

Providers of attendant care and community participation supports who meet the eligibility criteria set out below will have access to a higher price limit through a Temporary

[1] www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

Transformation Payment (TTP). This conditional loading will assist providers to continue transforming their businesses in the move towards a more competitive marketplace. This replaces the Temporary Support for Overheads.

In order to access the higher TTP price limits, providers will have to:

- publish their service prices;
- list their business contact details in the Provider Finder and ensure those details are kept up-to-date; and
- participate annually in an Agency-approved market benchmarking survey.

TTP Providers will have to until 31 December 2019 to meet these requirements, and to include in their contractual arrangements with their participants that they are entitled to use the TTP support items (and price limits) because they are compliant with the TTP terms.

That is, in the first year, providers can commence making claims using the TTP items from 1 July 2019, and will have until 31 December 2019 to meet the three compliance requirements. In later years, providers will need to be complaint by the start of the financial year, noting that the Benchmarking Requirement is met up until 31 December of any year by the provider's intention to take part in the next Benchmarking Survey, and after that date by actual participation in the most recent Benchmarking Survey.

Providers who become non-compliant during a financial year should not claim for TTP items while they are non-compliant.

Every support item in scope of the TTP has two support line items and two price limits. The non-TTP item should be used by providers who are not compliant with the TTP conditions. The TTP item should be used by providers who are compliant with the TTP conditions, an example is given in the following Table.

01_011_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Daytime
01_011_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Daytime - TTP

There will be no formal registration process for TTP. Providers will be required to acknowledge compliance to the TTP terms when submitting a payment request through the myplace Provider Portal. By claiming TTP items through the NDIA payment system, or from a plan manager, providers are warranting that they have complied with the TTP conditions, or intend to comply with the TTP conditions by the relevant time.

Plan managers will not be responsible for ensuring providers are TTP compliant – that is, they will be able to accept the claim for a TTP support item by a provider as proof of TTP compliance.

Billing for non-direct services

Provider Travel

Providers can only claim travel costs from a participant in respect of the delivery of a support item if the Support Catalogue indicates that providers can claim for Provider Travel in respect of that support item.

Providers who intend to claim travel costs from a participant must have the agreement of the participant in advance (i.e. the service agreement between the participant and provider should specify the travel costs that can be claimed).

Where a worker is travelling to provide services to more than one participant in a 'region' then the provider can apportion that travel time between the participants equally as long as they have the agreement of each participant in advance.

Where a provider is permitted to claim for travel time then they can only claim for travel time if either:

- the provider is required to pay the worker delivering the support for the time they spent travelling as a result of the agreement under which the worker is employed; or
- the provider is a sole trader and is travelling from their usual place of work to or from the participant, or between participants.

Where a provider claims for travel time in respect of a support then the maximum amount of travel time that they can claim for each participant (for each eligible worker) is 30 minutes in MMM1-3 areas; and 60 minutes in MMM4-5 areas. (Note the relevant MMM classification is the classification of the area in which the participant lives.)

Claims for travel in respect of a support need are made separately to the claim for the support using the line item for the support and the code "Provider Travel".

When claiming for travel in respect of a support a provider can use the same hourly rate as they have agreed with the participant for the support for the basis of calculating the claimable travel cost.

Cancellations

Where a provider has a short notice cancellation (or no show) they are able to recover 90% of the fee associated with the activity, subject to the terms of the service agreement with the participant.

A cancellation is a short notice cancellation (or no show) if the participant has given

- less than 2 clear business days' notice for a support that is less than 8 hours continuous duration and worth less than $1000; and
- less than 5 clear business days' notice for any other support.

There is no limit on the number of short notice cancellations (or no shows) that a provider can claim in respect of a participant.

However, providers have a duty of care to their participants and if a participant has an unusual number of cancellations then the provider should seek to understand why they are occurring.

The NDIA will monitor claims for cancellations and may contact providers who have a participant with an unusual number of cancellations.

NDIA Reporting

Providers will be expected to provide progress reports to the participant and NDIS at agreed times. A provider may charge for the time taken to write a therapy report (including functional assessment) that is requested by the NDIA, and claim this against the appointment at the hourly rate for the relevant support item. A report requested by the NDIA is considered a report that is required at the commencement of a plan which outlines plan objectives and goals, and at plan review which measures functional outcomes against the originally stipulated goals. Providers are also expected to make recommendations for ongoing identified needs (informal/community/mainstream and/or funded supports). Providers may charge for any other NDIA-requested therapy report that is stipulated as being required in a participant's plan.

Non-Face-to-Face Supports

Non face to face activities are billable if:

- the activities are part of delivering a specific disability support item to that participant (rather than a general activity such as enrolment, administration or staff rostering),
- the provider explains the activities to the participant, including why they represent the best use of the participant's funds (i.e. explains the value of these activities to the participant),
- the proposed charges for the activities comply with the NDIS Price Guide, and
- the participant agrees to pay for the activities (preferably in a formal service agreement).

For example, the Assistance with Self Care support items are described as covering activities "Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible". Therefore, time spent on non-face to face activities that assist the participant - for example, writing reports for co-workers and other providers about the client's progress with skill development – could be charged against this support item.

On the other hand, time spent on administration, such as the processing of NDIS payment claims for all clients, is outside the description of the support item and should not be claimed against an individual participant's budget. The NDIS price controls include an allowance for overheads, so that providers can fully recover the efficient costs, including the costs of administration tasks.

The method of charging is as hours of support time against the relevant support item, rather than a separate fee. Service agreements with each client can ‘pre-authorise' these activities, but providers should only charge a participant for delivering a support item if they have completed activities that are part of the support for that participant. Charging a fee that is not linked to completed activities would not be appropriate.

It is not appropriate to charge all participants an average additional fee. The additional fee must be worked out in each case and related specifically to the non-face-to-face services delivered to the particular participant. This is not to say that the same additional fee might end up being charged to a number of participants, but it must be worked out separately.

Administrative activities, even if they can be attributed to individual clients, are not billable. These are covered by the overhead component of the price, such non-billable activities include:

- Pre-engagement visits
- Developing and agreeing Service Agreements
- Entering participant details into system
- Making participant service time changes
- Staff / participant travel monitoring and adjustment
- Ongoing NDIS plan monitoring
- Completing the Quoting tool
- Making service bookings
- Ending participant services in the system

Other Payment Considerations

This section outlines various other considerations that may be relevant to participants and providers. These should be reviewed when entering into a new Service Agreement or if there is a significant change in the participant’s circumstances.

Medicare and insurance

Some elements of a participant’s care may be covered by funds outside the NDIS. These expenses are commonly medical, including those covered by private health insurance or Medicare. These medical expenses are not funded under the NDIS, even if they are related to, or a symptom of the disability. These expenses should be claimed under the relevant health care scheme or insurance policy. Some providers (e.g. therapists) may need to distinguish between the health services and disability supports that they provide to a single client, and make separate payment claims (e.g. claim payments from Medicare for health services, and the NDIS for disability supports).

Prepayments

Registered Providers can make a claim for payment once that support has been delivered or provided. Prepayment is not permitted unless the NDIA has given prior approval in writing to the Registered Provider. This will only occur in exceptional circumstances such as for certain assistive technologies, home modifications and remote area servicing where this has been agreed to by the participant.

Co-Payments for Capital items, including assistive technology

Co-Payments by the participant are not required; however, where the participant would like a customisation to a support or assistive technology that is not considered reasonable or necessary, they are required to pay for this themselves. These may include an aesthetic customisation to an assistive technology or modifications to a vehicle that are additional to the assistive components.

Goods and Services Tax (GST)

Most items are GST-Free, as per Australian Tax Office information about GST and NDIS and the application of section 38-38 of the GST Act[2]. For a small number of items where GST is applicable (for example, delivery fees and building materials), the price is inclusive of GST.

Other fees (Commissions and exit fees)

Participants are not required to pay exit fees, even when changing providers part way through a plan. A core principle of the NDIS is choice and control for participants, allowing them to change providers without expense. Further information on establishment fees claimable by the incoming provider can be found below under *Establishment fee for personal care/community access*.

[2] http://www8.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/antsasta1999402/s38.38.html

Core – Assistance with Daily Life (includes Supported Independent Living)

This support category relates to assisting with and/or supervising personal tasks of daily life to enable the participant to live as autonomously as possible. These supports are provided individually to participants and can be provided in a range of environments, including but not limited to, the participant's own home.

Daily Personal Activities, including High Intensity Daily Personal Activities

A hierarchy of price controls applies to this group of supports, based on:

A) The time of day that the support is delivered;

B) The day of week that the support is delivered;

C) Whether the support is Standard Intensity or High Intensity;

D) If the support is High Intensity then whether it is a Level 1(Standard), Level 2 (High Intensity) or Level 3 (Very High Intensity) support; and

E) Whether the provider is eligible for the Temporary Transformation Payment.

Time of day

In determining which price control is applicable to a support, providers should note that a support is considered to be:

- A Daytime Support is it is delivered between 6 am and 8 pm;
- An Evening Support if it is delivered after 8 pm and before 12 midnight; and
- An Overnight Support is it is delivered between 12 midnight and 6 am.
- Overnight is where the support finishes after 12 midnight and before 6am.

Day of week

In determining which price control is applicable to a support, providers should note:

- A weekday is Monday to Friday;
- The extra rates paid for Saturday, Sunday and Public holidays are in substitution for, and not cumulative upon, the shift premiums payable for evening and overnight supports.
- The extra rates for Saturday/Sunday/Public holidays do not increase further when the support finishes after 8pm.

High intensity

A support is considered a high intensity support if the participant requires assistance from a support worker with additional qualifications and experience relevant to the participant's complex needs. The high intensity price limits may be considered when:

- Frequent (at least 1 instance per shift) assistance is required to manage challenging behaviours that require intensive positive behaviour support; and/or
- Continual active support is required due to high medical support needs (such as unstable seizure activity or respiratory support)

In determining which price limit for High Intensity Supports should apply to a given support, the provider should consider the skills and experience of the worker delivering the support. In general, the Level 2 price limit applies to most high intensity supports. However, if the particular instance of support is delivered by a worker who does not have the skills and experience to deliver a high intensity support then the Level 1 price limit should be applied. If the particular instance of the support is delivered by a more highly skilled or experienced worker then the provider can consider applying the Level 3 price cap, with the participant's prior agreement.

Other matters

Provisions for 'shadow shifts'

Shadow shifts may be considered where the participant has complex individual support needs that are best met by introducing a new worker to the participant before it is reasonable that they commence providing the support independently. These are considered where the specific individual support needs include:

- Very limited communication;
- Behaviour support needs; and/or
- Medical needs/procedures such as ventilation or home enteral nutrition.

Where the individual would require shadow shifts to assist with the introduction of new workers, and this is the desired method by the participant or their family, the provider may claim for up to 6 hours of weekday support per year.

Introducing new workers is not designed to replace formal, recognised training that will be provided by an employer to their workforce, such as Shadowing (or "Buddying") less experienced staff or new staff with experienced workers or informal carers to help build knowledge and social capital (worker retention), which is not claimable under the NDIS.

Establishment fee for personal care/community access

This fee applies to all new NDIS participants in their first plan where they receive at least 20 hours of personal care/community access support per month. This payment is to cover non-ongoing costs for providers establishing arrangements and assisting participants in implementing their plan. The establishment fee is claimable by the provider who assists the participant with the implementation of their NDIS Plan, delivers a minimum of 20 hours per month of personal care/community access support and has made an agreement with the participant to supply these services.

The establishment fee will operate as follows:

- Providers can charge $500 against a plan if assisting a new participant, who is new to NDIS and new to the provider.
- A provider can charge $250 when they are maintaining an existing client of theirs who is commencing as a participant of the NDIS.
- Should a participant wish to change providers on commencing their first NDIS plan, $250 is available to the new provider. This is to assist the participant in changing providers.
- A budget of $750 is included in the first plan for NDIS participants, in case they need this type of assistance from providers to design and implement support arrangements.

Assistance with household tasks

These support items enable participants to maintain their home environment. This may involve undertaking essential household tasks that the participant is not able to undertake.

Preparation and delivery of meals

This support item is for the preparation and delivery of food to participants who are unable to do this themselves, and are not in receipt of other supports that would meet the same need. The cost of the food itself is not covered by the NDIS. The cost of this support will vary based on the number of meals prepared and the deliveries required.

Assistance in Shared Living Arrangements – Supported Independent Living

Supported Independent Living (SIL) is the assistance with and/or supervising tasks of daily life in a shared living environment, with a focus on developing the skills of each individual to live as autonomously as possible. The support is provided to each person living in the shared arrangement in accordance with their need.

SIL does not include rent, board and lodging or other day to day usual living expenses such as food and activities. It also does not include the capital costs associated with a participant's accommodation.

SIL does not have fixed price limits, and providers can quote for the specific SIL service that they offer to each participant. To assist providers with quoting, the NDIA has developed a Provider SIL Pack[3]. The Provider SIL Pack contains templates that assist providers in developing an individualised quote. The purpose of this quote is to identify:

- The individual supports that will be available for the person, focused on maximising the person's capacity to be as independent as possible with household decision making, personal care and domestic tasks,
- The typical roster of supports that is shared between participants to maximise the efficient use of resources, and

[3] https://www.ndis.gov.au/providers/essentials-providers-working-ndia/supported-independent-living

- What supports are available to all residents to ensure the smooth operation and running of the household.

Once a quote is received, the NDIA uses a 'SIL Tool' to analyse provider quotes and to make sure that they represent value for money. In some cases, negotiation between the NDIA and providers will be necessary to agree appropriate prices for SIL.

Short Term Accommodation and Assistance

From time to time, participants may require temporary supports that are different from their usual arrangements. These are non-typical days and may include short stays in a group-based facility (short term accommodation), or the purchase of additional in-home support.

For the purposes of this Price Guide, the 'short term accommodation' price limit includes all expenses in a 24 hour period including assistance with daily personal activities, accommodation, food and negotiated activities. Typically, this type of support would be used for short periods of up to 14 days at a time. For longer term arrangements, other options are likely to be more appropriate (e.g. Supported Independent Living).

In cases where a participant will receive substantially less than 24 hours of assistance with daily personal activities, it may be appropriate for the participant and provider to negotiate a lower price than the maximum price specified in this Guide, based on the actual support provided. This situation might arise, for example, if a participant enters a short term accommodation facility in the evening, and exits again early the following morning. Also, where a participant enters accommodation late in the day, it may be appropriate to claim the daily rate for the day of the week that the majority of the support is provided. In each case, support arrangements, including price, should be **agreed with participants in advance**.

Short term accommodation price limits vary according to the support needs of the participant and the day of the week the support is provided. Providers claiming at the rates for high intensity (i.e. ratio of 1 support worker for 2 participants) or 1:1 support must deliver assistance with daily personal activities at those support ratios for the duration of the participant's stay.

CORE - Transport

Transport enables participants to access disability supports outside their home, and to pay for transport that helps them to achieve the goals in their plan. Transport supports generally do not have price controls; however, participants should use the least expensive transport that meets their needs. Transport funding is paid fortnightly in advance to self-managed participants. Funding transport assistance is limited to those who cannot use public transport due to their disability. If the participant has questions about their transport support, providers may direct them to the NDIS factsheet available on the NDIS Website[4].

Accompanying participants for community access

Providing community access supports may, at the request of a participant, involve a worker accompanying a participant on a community outing and/or transporting a participant from their home to the community. In these situations, the worker's time can be claimed at the hourly rate for the relevant support item for the total time the worker provides support to one or more participants, including time spent accompanying and/or transporting the participant. Where a provider is transporting two or more participants on the same trip, the worker's time should be claimed at the appropriate group rate for the relevant support.

Contribution towards costs of transport itself

If a provider incurs costs, in addition to the cost of a worker's time, when accompanying and/or transporting participants in the community (such as cost of ticket for public transport), they may negotiate with the participant for them to make a reasonable contribution towards these costs. A participant's support budget may include funding for transport, and this funding can be used for these types of contributions, which should be clearly specified in the service agreement.

[4] https://www.ndis.gov.au/participants/creating-your-plan/plan-budget-and-rules/transport-funding

CORE - Consumables

Consumables are a support category available to assist participants with purchasing everyday use items. Supports such as continence and home enteral nutrition (HEN) products are included in this category. More information on these supports can be found in the *Assistive Technology and Consumables Code Guide* on the Assistive Technology webpage[5].

[5] https://www.ndis.gov.au/providers/essentials-providers-working-ndia/providing-assistive-technologies-and-home-modifications

CORE - Assistance with Social and Community Participation

These supports enable a participant to engage in community, social or recreational activities. They may be provided in a centre or in community settings at standard or higher intensity rates. If arranged in advance with participants, providers may charge up to 4 hours for each plan period to document proposed supports and expected outcomes. Price limits vary according to the support needs of the participant and the day of the week the support is provided.

Providers should not claim payment for:

- Expenses related to recreational pursuits, such as event tickets for the participant, as they are not covered by the NDIS.
- The cost of travel or entry for a paid support worker to attend a social or recreational event.

A hierarchy of price controls also applies to this group of supports, based on:

A) The time of day that the support is delivered;

B) The day of week that the support is delivered;

C) Whether the support is Standard Intensity or High Intensity;

D) If the support is High Intensity then whether it is a Level 1(Standard), Level 2 (High Intensity) or Level 3 (Very High Intensity) support; and

E) Whether the provider is eligible for the Temporary Transformation Payment.

(See the definitions and notes in the Assistance with Daily Living Support Category.)

Community and social activity costs

This support is included in a participant's plan to enable them to pursue recreational activities and engage in the community when associated with a participant's disability and goals. Participants may use this funding for activities such as camps, vacation and outside school hours' care, course or membership fees. More information can be found in the Operational Guidelines[6]

Where appropriate, funded hours in a Community Access budget may be converted to a fee and claimed by a provider for these purposes.

Group based supports

Assistance to access community, social and recreational activities is often provided in a group setting, either in the community or in a centre.

A hierarchy of price controls applies to group based supports, based on:

[6] https://www.ndis.gov.au/about-us/operational-guidelines/including-specific-types-supports-plans/including-specific-types-6

A) The time of day that the support is delivered;

B) The day of week that the support is delivered;

C) Whether the support is Standard Intensity or High Intensity (complex);

D) Whether the provider is eligible for the Temporary Transformation Payment;

E) The size of the group and ratio of staff to participants; and

F) Whether the support is provided in a Centre or in the community.

(See the definitions and notes in the Assistance with Daily Living Support Category.)

For support ratios that are not stated in this Guide (e.g. two workers for three participants), participants and providers should discuss and agree the most appropriate line item to be used for payments, and the appropriate price to be paid (which might be lower than the price limit for that line item).

Capital – Assistive Technology

This support category includes all aids or equipment supports that assist participants to live independently or assist a carer to support the participant. It also includes related delivery, set-up and some training support items. Usually, providing independent advice, guidance, trials, set-up and training (not bundled with sale of an item) is funded through a capacity building support.

More detailed information on assistive technologies and consumables codes can be found in the *Assistive Technology and Consumables Guide* on the Assistive Technology webpage[7].

Vehicle Modifications

Vehicle modifications include the installation of, or changes to, equipment in a vehicle to enable a participant to travel safely as a passenger or to drive.

A participant is free to choose a more expensive option at their own expense, where the more expensive option is not considered to be reasonable and necessary. An example of this situation would be where a vehicle modification has been approved for a participant, but the participant would like cosmetic or personalised fittings that are not related to their disability or are more expensive than others that have an equivalent function. In this situation, the NDIA will cover the reasonable and necessary component of the modification, and the participant will pay the additional cost.

[7] https://www.ndis.gov.au/providers/at/supplying-at.html

Capital – Home Modifications and Specialist Disability Accommodation

This support category includes home modifications and Specialist Disability Accommodation (SDA) supports.

Home Modifications

Home modifications include design, construction, installation of or changes to equipment or non-structural components of the building, and installation of fixtures or fittings, to enable participants to live as independently as possible or to live safely at home. All home modifications in excess of $1,500 are quotable.

A participant is free to choose a more expensive option or modification that achieves the same outcome at their own expense, where the more expensive option is not reasonable and necessary. For example, where a home modification has been approved for a participant, but the participant would like cosmetic or personalised fittings that are not reasonable and necessary, the NDIA will provide funding for the reasonable and necessary component of the modification, and the participant will pay any extra costs.

Specialist Disability Accommodation (SDA)

SDA funding is intended for participants who require a specialist dwelling that reduces their need for person-to-person supports, or improves the efficiency of the delivery of person-to-person supports. SDA funding will only be provided for participants who meet the eligibility criteria. Participants who meet the eligibility criteria will have an extreme functional impairment and/or very high support needs.

SDA does not refer to the support services, but the homes in which these are delivered. SDA may include special designs for people with very high needs or may have a location or features that make it feasible to provide complex or costly supports for independent living.

SDA payments are an adjusted contribution to the cost of capital required for the land and physical building required for SDA needs. Importantly, SDA funding is not intended to cover personal support costs, which are assessed and funded separately by the NDIS. SDA also does not cover accommodation costs where these are not linked to a person's disability or where specialist accommodation with integrated supports is not required. SDA is a separate support category and does not replace Supported Independent Living (SIL) or any other support. Participants receiving SDA could also be eligible for SIL supports in their package.

All providers who are registered with the NDIA for the Registration Group 'Specialist Disability Accommodation' will also be required to declare and ensure that the infrastructure meets the NDIA's specialist built form requirements and the relevant legislation and standards applicable to the state in which the accommodation is situated. These individual sites/locations must also be enrolled with the NDIA.

Due to the nature of the support, the identification of maximum SDA prices and the process by which providers can claim for SDA are more complex than for most other supports. Providers should refer to the Specialist Disability Accommodation section of the NDIS

website for detailed information about maximum prices that can be charged, dwelling enrolment and participant assessments[8].

SDA has two support line items: Specialist Disability Accommodation and SDA person-specific adjustments.

Each SDA dwelling has a unique maximum price, based on a standard set of factors. There are also limits on the amount that providers of SDA can charge participants in addition to the SDA price, for rent and other board-like services provided. Providers should refer to the SDA section of the NDIS website for detailed guidance on maximum prices[9]. Participants are able to choose to move between SDA dwellings, as long as the SDA dwelling is commensurate with their SDA budget.

SDA person specific adjustments

In certain limited circumstances, the NDIA will continue to make SDA payments on behalf of a participant who has moved out of an enrolled SDA dwelling. Provided all conditions are met in section 6.3 of the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016*, vacancy payments may continue to be made for a period of up to 90 days if the dwelling is enrolled to house four or five residents, or up to 60 days if the dwelling is enrolled to house two or three residents[10]. Vacancy payments will not be made where a dwelling is only enrolled to house one resident. Vacancy payments will only be payable if the vacancy is available to another NDIS participant and the NDIA has been notified.

[8] https://www.ndis.gov.au/providers/essentials-providers-working-ndia/specialist-disability-accommodation
[9] https://www.ndis.gov.au/providers/price-guides-and-information/sda-pricing-and-payments
[10] https://www.legislation.gov.au/Details/F2017L00209

Capacity Building - Support Coordination

Support Coordination (if required) is included in the Capacity Building budget. This is a fixed amount for strengthening participant's abilities to coordinate and implement supports in their plans and to participate more fully in the community.

There are three items in the NDIS Price Guide that describe different layers of support coordination activity.

Level 1: Support Connection

Assistance for participants to implement their plan by strengthening the ability to connect with the broader systems of supports and understand the purpose of the funded supports and participant in the community Support Connection will assist a participant to understand their NDIS plan, connect participants with broader systems of supports, and provide assistance to connect with providers. Support Connection will assist participants to achieve effective utilisation of their NDIS plan.

Support Connection will increase a participant's capacity to maintain (or in some cases change) support relationships, resolve service delivery issues, and participate independently in NDIA processes.

Where a participant aged 0-6 years is receiving assistance from Partners in the Community (PITC) delivering Early Childhood Early Intervention (ECEI) services, linking the family to a service provider/s (under ECEI best practice principles, a service provider operating under the key worker approach) and support through changes in circumstance will be delivered through Partner arrangements.

Where a participant aged 7 and over is receiving assistance from Partners in the Community (PITC) delivering Local Area Coordination (LAC) services, plan implementation and monitoring support will be delivered by a Participant's Local Area Coordinator.

Level 2: Coordination of Supports

The delivery of Coordination of Supports is to assist strengthening a participant's ability to design and then build their supports with an emphasis on linking the broader systems of support across a complex service delivery environment. Coordination of Supports is to focus on supporting participants to direct their lives, not just their services. This involves working together to understand the funding, identify what participants expect from services, and how participants want this designed. Coordination of Supports also includes coaching participants, and working with participants to develop capacity and resilience in their network.

Support coordinators are focused on assisting participants to build and maintain a resilient network of formal and informal supports.

It is generally expected participants will develop their capacity to implement and manage their supports and network more independently over time. Some participants, however, will require Coordination of Supports funding in subsequent plans to support ongoing capacity

building or manage the complexity within the participant support environment and/or circumstances. This is to be identified in the plan review process.

Over time, as a participant's capacity is strengthened, this support may be replaced by Support Connection or the introduction of a Local Area Coordinator or Early Childhood Early Intervention Partner in subsequent plans.

Level 3: Specialist Support Coordination

Specialist Support Coordination is delivered utilising an expert or specialist approach, necessitated by specific high complex needs or high level risks in a participant's situation. Specialist Support Coordination is delivered by an appropriately qualified and experienced practitioner to meet the individual needs of the participant's circumstances such as a Psychologist, Occupational Therapist, Social Worker, or Mental Health Nurse. Specialist Support Coordination will address highly complex barriers impacting on the ability to implement their plan.

Specialist support coordination is expected to address complex barriers impacting a participant's ability to implement their plan and access appropriate supports. Specialist support coordinators assist participants to reduce complexity in their support environment, and overcome barriers to connecting with broader systems of supports as well as funded supports.

Specialist support coordinators are expected to negotiate appropriate support solutions with multiple stakeholders and seek to achieve well-coordinated plan implementation. Specialist support coordinators will assist stakeholders with resolving points of crisis for participants, assist to ensure a consistent delivery of service and access to relevant supports during crisis situations.

Specialist support coordination is generally delivered through an intensive and time limited period necessitated by the participant's immediate and significant barriers to plan implementation. Depending on individual circumstances, a specialist support coordinator may also design a complex service plan that focuses on how all the stakeholders in a participant's life will interact to resolve barriers and promote appropriate plan implementation. Once developed a specialist support coordinator will continue to monitor the plan, but it may be maintained by one of the participant's support workers or other care supports.

In some instances, depending on the individual circumstances, a participant may have specialist support coordination, as well as Coordination of Supports, funded in the same plan; for instance, when immediate complex barriers have been addressed and the participant still requires more general coordination of supports for the remainder of their plan period. For others, they may have specialist support coordination in one plan, and Coordination of Supports in subsequent plans.

Capacity Building and Training in Plan and Financial Management by a Support Coordinator

This reasonable and necessary support focuses on strengthening the participant's ability to undertake tasks associated with the management of their supports. This includes:

- Building financial skills
- Organisational skills
- Enhancing the participant's ability to direct their supports
- Develop self-management capabilities

Plan and Financial Capacity Building providers are expected to assist the participant to develop their skills for self-management in future plans, where this is possible. As a part of this capacity building support, providers are to assist the participant to build capacity in the overall management of the plan including engaging providers, developing service agreements, paying providers and claiming payment from the NDIA and maintain records.

Capacity Building - Improved Living Arrangements

Support is provided to guide, prompt, or undertake activities to ensure the participant obtains and/or retains appropriate accommodation. This may include assisting to apply for a rental tenancy or to undertake tenancy obligations in line with the participant's tenancy agreement.

Capacity Building - Increased Social and Community Participation

This support category involves supports for participation in skills-based learning to develop independence in accessing the community.

Skills Development and Training

These support items are price controlled. Providers of these supports can also claim for: Provider Travel; Cancellations, NDIA Report Writing and Non Face to Face supports.

The group rate is based on a staff/participant ratio of 1:3. If the group size differs, providers should claim at the rate applicable for the group size. A higher staff ratio for groups may be indicated when a participant has challenging behaviour or high medical support needs, which require additional assistance from another worker and this is referred to as a higher intensity support.

Innovative Community Participation

This support item is not price controlled. It is designed to allow providers to offer new and innovative services to NDIS participants. Any standards applicable to the industry in which the provider operates would need to be met.

Community Participation Activities

These support items are not price controlled. They are designed to enable providers to claim for tuition fees, art classes, sports coaching and similar activities that build skills and independence. Camps, classes and vacation activities that have capacity building components. These may include assistance to establish volunteer arrangements in the community, mentoring, peer support or individual skill development.

All supports funded under these items need to be determined as reasonable and necessary given the participant's plan goals and could include, but are not limited to:

- Universal recreational activities: A limited number of lessons could be funded to enable a participant to try out an activity and test their capability and interest in further pursuing this activity – such as horse riding, art, dance or singing classes
- Funding to attend a "camp" or groups that build a person's relationship skills and offer a range of activities and opportunities to explore wider interests.
- Other items or adjustments such as customised tools required because of the person's disability could also be funded.

Capacity Building - Finding and Keeping a Job

Workplace assistance

These supports provide workplace assistance that enables a participant to successfully obtain and/or retain employment in the open or supported labour market.

School Leaver Employment Supports (SLES)

School Leaver Employment Supports (SLES) is a support for school leavers to assist them to transition from school into employment. Some students may already be engaged with the mainstream Disability Employment Services (DES) Eligible School Leaver (ESL) program during Year 12 and therefore not require SLES.

These support are designed to plan and implement a pathway to inclusive employment, focusing on capacity building for goal achievement. With appropriate supports, it is expected that the majority of SLES participants will transition to DES to undertake the job seeking, placement and post placement support phases of their pathway.

Supports will have an individualised approach, with a strong emphasis on “try and test” work experience opportunities, (generally in work places that would pay award wages). Capacity building should focus on hard and soft skill development.

Supports, more generally, should facilitate positive experiences that contribute to developing an understanding of work capability and confidence to step into employment. SLES should also help inform the level and nature of future supports needed to obtain and sustain employment.

Capacity Building - Improved Relationships

This support category is the provision of specialised assessment where the participant may have complex or unclear needs, requiring long term and/or intensive supports to address behaviours of concern.

Behaviour support requires a behaviour support plan to be developed that aims to limit the likelihood of behaviours of concern developing or increasing once identified. This plan outlines the specifically designed positive behavioural support strategies for a participant, their family and support persons that will achieve the intended outcome of eliminating or reducing behaviours of concern.

This support category includes specialist behavioural intervention support, which is an intensive support for a participant, intending to address significantly harmful or persistent behaviours of concern.

Capacity Building - Improved Health and Wellbeing

Physical Wellbeing Activities

These activities support, maintain or increase physical mobility or well-being through personal training or exercise physiology. Physical well-being activities promote and encourage improved physical capacity and health.

Dietetics

These supports provide individual advice to a participant on managing diet for health and wellbeing due to the impact of their disability.

Capacity Building - Improved Learning

This support is for provision of skills training, advice, assistance with arrangements and orientation to assist a participant moving from school to further education.

Capacity Building - Improved Life Choices

Plan Management – Financial Administration

Plan Management – Financial Administration funding applies to registered providers who undertake financial administration of a plan on behalf of a participant.

Plan Management – Financial Administration funding includes a setup fee to establish the payment arrangements with providers and a monthly processing fee. This support assists a participant by:

- Giving increased control over plan implementation and utilisation with plan financial assistance
- Managing and monitoring budgets over the course of the plan
- Managing NDIS claims and paying providers for delivered service
- Maintaining records and producing regular (at least monthly) statements showing the financial position of the plan
- Providing access to a wider range of service providers, including non-registered providers whilst remaining in line with the price limits contained within this Guide.

A Plan Management – Financial Administration provider will possess bookkeeping / accounting skills and qualifications with have systems in place for efficiently processing payments on behalf of a participant.

Capacity Building and Training in Plan and Financial Management by a Plan Manager

This reasonable and necessary support focuses on strengthening the participant's ability to undertake tasks associated with the management of their supports. This includes:

- Building financial skills
- Organisational skills
- Enhancing the participant's ability to direct their supports
- Develop self-management capabilities

Plan and Financial Capacity Building providers are expected to assist the participant to develop their skills for self-management in future plans, where this is possible. As a part of this capacity building support, providers are to assist the participant to build capacity in the overall management of the plan including engaging providers, developing service agreements, paying providers and claiming payment from the NDIA and maintain records.

Funding for this capacity building support where reasonable and necessary will be included in the plan an hourly rate.

Capacity Building - Improved Daily Living

This support category includes assessment, training, strategy development and/or therapy (including Early Childhood Intervention) supports to assist the development or increase a participant's skills and/or capacity for independence and community participation. Supports can be delivered in groups or individually.

Therapy Services (over 7 years)

In the NDIS, therapy supports are for participants with an established disability, where maximum medical improvement has been reached, to facilitate functional improvement. For people who access the Scheme as 'early intervention' NDIS participants, reasonable and necessary supports are likely to be a blend of medical and disability therapies, but should be predominantly disability therapy supports. Therapy in this context must be aimed at adjustment, adaption and building capacity for community participation.

For NDIS participants whose medical condition, illness or disease requires a particular treatment to maintain the functioning of a body part, or slow/prevent the deterioration, the NDIS may fund reasonable and necessary training for non-skilled personnel to undertake this intervention as part of the usual daily personal care. For participants where such treatment can only be met through skilled rather than non-skilled care, this treatment is to be funded through medical funds, not the NDIS.

Ongoing funding for therapy is subject to a detailed support plan that is designed to deliver progress or change for the participant. Providers develop this plan with the participant and it should clearly state the expected therapy outcomes and demonstrate a link to the participant's goals, objectives and aspirations.

Massage Therapy (over 7 years)

Massage, delivered directly to impact a body part or body system, is more appropriately provided by the health system and is therefore not funded by the NDIS.

Maintenance Therapy (over 7 years)

Where maintenance therapy is reasonable and necessary, it is funded as part of ongoing direct support hours (delivered by carers who are or can be trained in this if required), and is not funded as ongoing therapy.

For participants whose medical condition or disability requires a particular regime to maintain functioning of a body part, or to slow the deterioration of a medical condition or body part, the NDIS will fund reasonable and necessary training for non-qualified personnel to assist the individual as part of usual daily care.

Where a skilled therapist is involved in establishing a therapy program for a participant, funding can include the development of a plan and training for a therapy assistant, informal or funded carers, as part of usual care. Building capacity with family and carers to undertake therapy or exercises under the supervision of a skilled therapist can deliver ongoing benefit to NDIS participants.

Group Supports for Therapy

The NDIA prefers to allow participants and providers flexibility in negotiating arrangements, so there may not be price controls or support items for specific group ratios beyond what is currently in place.

For support ratios that are not stated in this Guide (such as one therapist to two participants, or one therapist to four participants), the NDIA encourages participants and providers to discuss arrangements both parties agree to, including price. Therapy delivered in a group may be claimed using the relevant therapy support line item but with lower prices than the price limit as agreed between provider and participant. This arrangement for support ratios is intended to allow providers to offer a range of services and discuss with participants about more flexible arrangements which both parties prefer.

Early Childhood Intervention Supports (under 7 years)

Early childhood intervention (ECI) provides specialised support and services for infants and young children with disability and/or development delay and their families, to help their development, well-being and participation in family and community life.

The aim of ECI is to ensure that parents and other important adults in the child's life can provide young children with disability and/or developmental delay, with experiences and opportunities that help them gain and use the skills they need to participate meaningfully in their everyday lives.

Families know their child best and will continue to be involved in their child's life. Family centred ECI services understand that parents and caregivers have the most powerful influence on their child's development. ECI services partner with families to ensure that family life and family priorities and choices drive what happens in planning and intervention.

We know that children learn best in everyday situations with familiar people. ECI is about encouraging and supporting everyday learning to naturally build on opportunities for learning and development already being provided at home, childcare, preschool, playgroups and in the community such as parks and shopping.

Early intervention is much more effective if the adults who have the deepest relationships and spend the most time with the child, are skilled to provide intervention through the child's everyday activities and daily routines.

This category includes supports provided in small groups or to individual families by an ECI provider. It can also include supports provided by an allied health assistant under the supervision of a therapist and/or any other combination of ECI supports.

Eligible participants will have budgets built by Early Childhood Partners to reflect the child and family individual needs, applying the reasonable and necessary criteria as per the Early Childhood Early Intervention (ECEI) approach. Budgets will allow flexibility in service delivery by ECI providers to reflect the changing needs of the participant.

The provision of supports under ‘capacity building supports for early childhood’ are expected to deliver outcomes for the child that will enable them to participate meaningfully in everyday

life. Each child's NDIS plan will focus on functional, participation based goals and will summarise the outcomes expected from early intervention and will be reviewed at regular intervals.

These supports are price controlled. Providers of these supports can also claim for: Provider Travel; Cancellations, NDIA Report Writing and Non Face to Face supports.

Multidisciplinary Team Intervention (over 7 years)

This support item enables a coordinated multidisciplinary approach to be delivered to participants beyond the age covered by the Early Childhood Early Intervention approach. All team members will claim against a single support item, thereby increasing flexibility in service delivery to reflect the changing needs of a participant. This support item is not price controlled.

ATTACHMENT A

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FAIR WORK COMMISSION

AMENDED DRAFT DETERMINATION OF HSU

Fair Work Act 2009

Part 2-3, Div 4 – 4 Yearly reviews of modern awards

Social, Community, Home Care and Disability Services Industry Award 2010

(ODN AM2014/285) MA000100

Health and Welfare

<<PLACE, MONTH, YEAR>>

Review of modern awards to be conducted.

A. Further to the Full Bench decision issued by the Fair Work Commission on DD MM YYYY, the above award is varied

[1] By deleting clause 10.4 (c), and inserting a new clause 10.6:

The minimum engagement for employees under this award will be 3 hours

[2] By amending the current clause 26 by deleting the following words:

and the casual loading prescribed in clause 10.4(b)

[3] By deleting the current clause 25.6 and replacing it with the following:

25.6 Broken Shifts

(a) This clause only applies to:

(i) social and community services employees when undertaking disability services work; and

(ii) home care employees.

(b) For the purposes of this clause, broken shift means a shift worked by a casual or part-time employee that includes no more than one break (other than a meal break) and where the span of hours is not more than 12 hours.

(c) A broken shift may only be worked where there is mutual agreement between

the employer and employee.

*(d) Where an employee works a broken shift, they shall be paid at the appropriate rate for the reasonable time of travel from the location of their last client before the break to their first client after the break, and such time shall be treated as time worked. The travel allowance in clause **20.5** also applies.*

(e) The minimum period of engagement specified in clause 10.6 shall apply to each period of work in a broken shift.

(f) In addition to the rates at 14.4(d) penalty rates and shift allowances in accordance with clause 20.2 – Shiftwork and clause 19 – Overtime apply.

(g) Shift allowances will be determined by the starting or finishing time of the broken shift, whichever allowance is higher. The allowance will apply across both parts of the shift.

(h) All work performed beyond the maximum span of 12 hours for a broken shift will be paid at 200% of the minimum hourly rate.

(i) An employee must receive a minimum break of 10 hours between broken shifts rostered on successive days.

[4] By deleting clause 25.8 – 24 hour care and renumbering clause 25.9 as clause 25.8

[5] By deleting the words *'a 24 hour care shift pursuant to clause 25.8 or'* in clause 25.7.

[6] By inserting a new provision at clause 20.3 and renumbering the current 20.3-20.9 accordingly

20.3 Damaged clothing allowance

(i) Where an employee, in the course of their employment suffers any damage to or soiling of clothing or other personal effects (excluding hosiery), upon provision of proof of the damage, employees shall be compensated at the reasonable replacement value of the damaged or soiled item of clothing.

(ii) This clause will not apply where the damage or soiling is caused by the negligence of the employee.

[7] By deleting the current clause 20.6 and replacing it with

20.7 Telephone allowance

Where the employer requires an employee to use a mobile phone for any work related purpose, the employer will either:

(a) provide a mobile phone fit for purpose and cover the cost of any subsequent charges; or

(b) refund the cost of purchase and subsequent usage charges on production of receipts

[8] By inserting a new clause 26.1:

Saturday and Sunday work

(a) Casual employees will receive their casual loading in addition to the Saturday and Sunday rates at clause 26

(b) The rates are:

(i) in substitution for and not cumulative upon the shift premiums prescribed in clause 29 —Shiftwork; and

(ii) not applicable to overtime worked on a Saturday or a Sunday.

[9] By inserting a new clause 34.2(c):

(c) A casual employee will paid the casual loading under clause 10.4(b) in addition to the public holiday penalty rate at clause 34.2(a)

[10] By inserting a new clause 20.5(c):

First aid refresher

(i) Where an employee is required to maintain first aid certification, the employer will pay the full cost of the employee updating their first aid certification by:
a. reimbursing the employee's registration and attendance expenses; or
b. paying the registration and attendance costs.

(ii) Attendance at first aid refresher courses will be work time and paid as such.

[11] By deleting clause 28.1(b)(ii), and replacing it with the following:

28.1(b)(ii) All time worked by part-time or casual employees which exceeds 8 hours per day, will be paid at the rate of time and a half for the first two hours and double time thereafter, except on Sundays when overtime will be paid for at the rate of double time, and on public holidays at the rate of double time and a half.

[12] By deleting clause 28.1(b)(iii), and replacing it with the following:

28.1(b)(iii) All time worked by part-time employees which exceeds the hours agreed in clause 10.3(c) will be treated as overtime and paid at the rate of time and a half for the first two hours and double time thereafter, except on Sundays when overtime will be paid for at the rate of double time, and on public holidays at the rate of double time and a half.

[13] By deleting the words "by 5.00 pm the day prior" in clause 25.5(f)(i) and replacing them with the words "*at least 48 hours in advance*".

[14] By deleting the words *"minimum specified hours"* in clause 25.5(f)(ii) and replacing them with the words *"rostered hours for that visit".*

[15] By renumbering the text appearing below the heading of clause 28.4 with "(a)".

[16] By inserting the following after clause 28.4(a):

b. Where an employee is required to perform work from home after leaving the employer's or client's premises, including:

i. Responding to phone calls, message or emails;
ii. Providing advice ("phone fixes")
iii. Arranging call out/rosters of other employees; and
iv. Remotely monitoring and/or addressing issues by remote telephone and/or computer access;

the employee will be paid for a minimum of one hours' work at the overtime rate for each time recalled.

[17] By replacing clause 25.7(c) with the following:

(c) The span for a sleepover will be a continuous period of eight hours. Employees will be provided with:
(i) a separate and securely lockable room with a peephole or similar in the door, a bed and a telephone connection in the room; and
(ii) suitable sleeping requirements such as a lamp and clean linen;
(iii) use of appropriate facilities (including staff facilities where these exist), and
(iii) free board and lodging for each night when the employee sleeps over.

[18] By inserting, at the end of clause 20.5(a) the following:

Disability support workers and home care workers shall be entitled to be so reimbursed in respect of all travel:

(a) from their place of residence to the location of any client appointment;
(b) to their place of residence from the location of any client appointment;
(c) between the locations of any client appointments on the basis of the most direct available route.

B. This determination will come into operation from DD MM YYYY.

Fair Work Commission
Four Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award
Matter No: AM2014/285 and AM2018/26

SUBMISSIONS OF HEALTH SERVICES UNION – FOUR YEARLY REVIEW – SUBSTANTIVE ISSUES

OVERVIEW

1. These submissions are made by the Health Services Union (HSU), in accordance with the Directions of President Ross, dated 13 November 2018.

2. The *Fair Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Act* 2018 was assented to on 11 December 2018. That Act repealed the parts of the *Fair Work* Act 2009 (FW Act) providing for the conduct of 4 yearly reviews of modern awards. However, Schedule 4, Application and transitional provisions, of that Act preserved the operation of the relevant provisions in the FW Act in respect of reviews of modern awards conducted as part of 4 yearly reviews of modern awards, if such review was commenced, but not completed, prior to 1 January 2018.

3. The present review was commenced by the FWC in February 2014. Accordingly, the review may continue pursuant to the provisions of the FW Act notwithstanding their repeal.

4. The task of the Fair Work Commission (**FWC**) in conducting the present review is to review the *Social, Community, Home Care and Disability Services Industry Award* (**the Award**) by reference to the modern awards objective in s.134. That section provides:

What is the modern awards objective?

(1) The FWC must ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions, taking into account:

(a) relative living standards and the needs of the low paid; and

(b) the need to encourage collective bargaining; and

(c) the need to promote social inclusion through increased workforce participation; and

(d) the need to promote flexible modern work practices and the efficient and productive performance of work; and

(da) the need to provide additional remuneration for:

(i) employees working overtime; or

(ii) employees working unsocial, irregular or unpredictable hours; or

(iii) employees working on weekends or public holidays; or

(iv) employees working shifts; and

(e) the principle of equal remuneration for work of equal or comparable value; and

(f) the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden; and

(g) the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards; and

(h) the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.

HSU Claims

5. The HSU makes claims for variation of the Award to ensure that it achieves the modern awards objective by:

a) providing that all employees, whether full-time, part time or casual are entitled to a minimum engagement of three hours in all sectors covered by the award (clause 10; Exposure Draft (**ED**) clauses 8-11) – S10;

b) varying the broken shifts clause to ensure that broken shifts can only be worked by agreement and short shifts are not broken (clause 25.6; ED clause 13.6**) –** S35;

c) amending the "Travelling, transport and fares" clause, to ensure that employees are compensated appropriately for the cost of travel required to perform their duties – (clause 20.5; ED 16.3(c)) - S19;

d) varying the overtime clause to ensure it applies to all employees, including part-time and casual employees, when working beyond their rostered hours, and that overtime is paid for shifts greater than 8 hours (clause 28.1(b); ED clause 18.1(b)) – S50;

e) ensuring that casual loading is paid in addition to weekend and public holiday rates (clause 10.4(b); ED clause 11.2) – S13, S48;

f) amending the telephone allowance to reflect the requirement to have a mobile phone for work-related purposes (clause 20.6; ED clause 16.3(d)) – S19;

g) amending the uniform allowance to ensure that a uniform is provided or an allowance is paid; and providing a new entitlement for replacement of damaged clothing (clause 20.2; clause 16.3(a)) – S19;

h) amending the existing first aid allowance to provide for payment of an allowance for first aid certificate renewal and CPR training (clause 20.4; ED clause 16.2) – S19;

i) deleting the 24-hour care clause (clause 25.8; ED clause 13.8) – S43;

j) varying the recall to work provisions to ensure that workers who respond to work calls or emails out of hours receive compensation for the performance of such work (clause 20.9; ED clause 16.2(d)) – S22;

k) varying the cancellation provisions to ensure that adequate notice is given to home care workers of changes of shift as a consequence of client changes or cancellations (clause 25.5(f); ED clause 13.5(g)) – S29;

l) amending the Sleepover clause to ensure appropriate facilities are provided (clause 25.7; ED 13.7) – S38.

6. The HSU submits that the proposed amendments provide for the safety net of terms and conditions established in the Award to be fair and relevant and thereby enable the Award to meet the modern awards objective.

7. Annexed to these submissions are **draft orders** with the HSU's proposed variations.

HSU Evidence

8. The HSU relies on the evidence of a number of witnesses in support of its claims. The HSU has filed, along with these submissions, witness statements of:

    a) Dr. Fiona Macdonald, Senior Research Fellow and Australian Research Council Discovery Early Career Research Award Fellow at the School of Management, RMIT University;

    b) Mark Farthing, Senior Policy Advisor for the Health Services Union (**HSU**) Victoria No. 2 Branch;

    c) James Eddington, Legal and Industrial Officer at HSU Tasmanian Branch;

    d) William Elrick, Area Organiser for the Health Services Union (**HSU**) Victoria No. 2 Branch;

    e) Rob Sheehy, Manager Aged Care and Disabilities at the Health Services Union NSW/ACT/QLD Branch;

    f) Christopher Friend, Bargaining Officer at the Health Services Union NSW/ACT/QLD Branch;

    g) Pamela Wilcock, Community Care worker for Hammond Care on the Central Coast of NSW;

    h) Heather Waddell, Community Care worker for Hammond Care in Nowra (NSW);

    i) Thelma Thames, Support Worker employed by Uniting (NSW)

    j) Bernie Lobert, Disability Support Worker (Victoria).

9. The HSU also relies on the following research papers and reports, which have been filed along with these submissions:

a) Cortis, Natasha, *Working under the NDIS: Insights from a survey of employees in disability services* (Report prepared for Health Services Union, Australian Services Union and United Voice, June 2017), Social Policy Research Centre, University of New South Wales, Sydney.

b) Cortis, Natasha et al, *Reasonable, necessary and valued: Pricing disability services for quality support and decent jobs* (SPRC Report 10/17, June 2017), Social Policy Research Centre, University of New South Wales, Sydney.

c) McKinsey & Company, *Independent Pricing Review: National Disability Insurance Agency* (Final Report, February 2018)

d) National Disability Services, *Australian Disability Workforce Report* (Report, February 2018).

e) National Disability Services, *State of the Disability Sector Report* (Report, 2018).

f) Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs* (Study Report, October 2017), Canberra.

g) Australian Government Department of Health, *The Aged Care Workforce, 2016,* March 2017, Canberra.

h) NDIS Price Guide for Victoria, 1 July 2018.

i) NDIS 2018-2019 Price Guide Update Summary

OVERVIEW OF INDUSTRY

10. The Award covers employees falling within its classifications in the following sectors:

a) crisis assistance and supported housing sector;
b) social and community services sector;
c) home care sector;
d) family day care scheme sector;

11. The two largest sectors are the social and community services sector and the home care sector, which include, respectively, disability support work (including such work provided under the National Disability Insurance Scheme) and aged care and dementia care delivered in the home.

12. Casual workers made up about 42% of the disability support workforce as at September 2017[1]. Of the permanent workforce of disability support workers, part-time work is the dominant, and increasing, mode of employment, rising from about 65% of the permanent workforce in September 2015 to 81% in September 2017[2]. Over that same period, the average weekly hours per worker have decreased from about 26 to about 20 hours per week.

13. Similar trends are evident in the home care sector of the aged care workforce.

14. The approach of providing aged care in the home is growing in scope in part due to an increasing preference amongst aged persons for such care, which is reflected in both policy and funding arrangements. In 2016, some 86,000 workers (or 66% of the home care and home support aged care workforces) were employed in direct care roles, or which some 72,000 were community care workers[3].

15. In the period since the establishment of the Award, there has been an increase in the proportion of direct care workers employed for fewer hours[4].

16. The pattern of increasing use of part-time workers (evident in respect of both the above sectors) is not one which is evident across the labour market in general[5].

17. The evidence of the HSU shows that a concern about getting enough hours of work is a significant one amongst both part-time and casual workers employed under the Award, who are amongst some of the lowest paid members of the workforce. Those concerns, and the above workforce trends are relevant when the Commission comes to consider the degree of flexibility currently available to employers under the Award, and the appropriate safety net for such workers.

THE HSU'S CLAIMS

18. The HSU's claims, and its arguments in support of its claims are dealt with in turn below.

Minimum Engagement – clause 10; ED clauses 8-11

[1] p11, National Disability Services, *Australian Disability Workforce Report* (Report, February 2018)
[2] p22, National Disability Services, *Australian Disability Workforce Report* (Report, February 2018)
[3] p69, Australian Government Department of Health, *The Aged Care Workforce, 2016,* March 2017, Canberra
[4] Ibid, p70
[5] p28, National Disability Services, Australian Disability Workforce Report (Report, February 2018)

19. The HSU seeks a minimum engagement of three hours for all workers.

20. The Award presently provides no minimum engagement for full-time and part-time employees in any of the sectors it covers. This issue is of particular concern for part-time workers. The provisions regarding rostering and span of hours mean this issue is of less import for full-time workers.

21. For casual employees, minimum engagement depends on the sector in which they work. For home care workers, the minimum engagement is one hour. For SACS employees (except disability support workers) the minimum is three hours. For all other casual employees it is two hours (clause 10.4; ED clause 11.3).

22. The union contends that the minima in respect of casual workers are inadequate (except in respect of SACS workers who are not disability support workers).

23. The rationale for minimum engagement periods is:

> *"to ensure that the employee receives a sufficient amount of work, and income, for each attendance at the workplace to justify the expense and inconvenience associated with that attendance by way of transport time and cost, work clothing expenses, childcare expenses and the like. An employment arrangement may become exploitative if the income provided for the employee's labour is, because of very short engagement periods, rendered negligible by the time and cost required to attend the employment. Minimum engagement periods are also important in respect of the incentives for persons to enter the labour market to take advantage of casual and part-time employment opportunities (and thus engage the consideration in paragraph (c) of the modern awards objective in s.134)".*[6]

24. It is striking (and counter-intuitive), having regard to that rationale, that the least protection by way of minima in respect of casual employees, applies to home care and disability support workers, about whom it might reasonably be concluded the expense and inconvenience associated with each shift of work is greatest. It is also striking that no minimum engagement applies in respect of part-time employees.

25. The question of minimum engagement periods did not receive any systematic consideration in the award modernisation process[7], and the *Casual and Part-Time Employment Case* rejected the adoption of a consistent minimum across awards[8]. Having regard to the changes in the industries covered by this Award since modernisation: the marketisation of service delivery, the proliferation of part-time

[6] *Casual and Part-Time Employment Case* [2017] FWCFB 3541 at [399]
[7] Ibid, at [402]
[8] Ibid, at [406]

employment on decreased hours (as set out above), and the evidence as to working arrangements in the industry, it is timely for the Commission to consider the issue.

26. Part-time employees are strictly entitled, under clause 10.3(c) to have an agreed written pattern of hours and days of work. However, that obligation appears to have little relevance, with the requirement either not being observed, or honoured, or not operating due to the existence of enterprise agreements with contrary provision[9]. At the time of engagement employees are least able to advocate for a fair pattern of hours. In any event, the evidence before the Commission will show that in the particular circumstances of much of the industry operating under the present Award, clause 10.3(c) does not operate (as would be wished) to ameliorate the unfairness associated with the absence of fair minimum engagement periods for part-time employees, disability support workers and home care workers.

27. Whilst the Award envisages part-timers have set patterns of work, they are commonly asked to work, and do in fact perform, work additional to their agreed hours[10]. Given the trends of increasing numbers of workers performing increasing numbers of hours the evidence points to a level of underemployment within the industry, leaving employees with less bargaining power. The absence of any penalty or loading associated with the performance of additional hours by part-timers creates a structural incentive to enter arrangements with part-timers with less hours than are likely to be required, and to use part-time employees like a pool of casual workers.

28. It is a common feature of employment, particularly amongst disability support workers and home care workers, that employees are not performing work at the same location every day. Rather, their work locations are the homes of their clients and/or the communities in which the employer's client lives. Those locations change a number of times during the course of the day. Employees may not therefore count on travelling the same route to and from the workplace on every work day, have any certainty about how long travel will take and may not practicably, rely on public transport to travel to and from work and between clients. Employees are either explicitly required to provide their own vehicle to travel between work locations (and to transport clients) or are compelled by the nature of the work to provide such vehicle themselves. The mental burden of planning and navigating such trips should not be gainsaid. This feature of the work warrants particular consideration when the minimum engagement period is

[9] Waddell [6]; Wilcock [3] – [4]; Thames [1], [9], [11]; Eddington [25]; Friend [11] – [14]
[10] Friend [20]; Wilcock [4]; Thames [21] – [22]

considered. Relative to workers attending the same workplace every time, the above workers make a greater investment of time and effort for the performance of each shift.

29. The evidence to be called by the HSU will show it is commonplace within the industry for employees to be "rostered" to perform very short shifts – sometimes less than an hour, and often corresponding with the period of an appointment with a client of the service – interspersed with unpaid breaks between such periods of work/appointments. During the break in shift employees are required to travel (sometimes considerable distances) between clients in their own vehicles.

30. The impact of those practices is compounded by the fact that within the industry the majority of workers are employed on Award rates only. Few workers receive above Award rates as a consequence of contractual arrangements or enterprise agreements. For the small cohort of workers covered by enterprise agreements, rates of pay exceed Award minimum rates only modestly. In effect, the *minimum* rates in the Award are *paid rates.*

31. Workers are accordingly spending many hours, and travelling considerable distances, in pursuance of their employment, only to be paid minimum award rates in respect of part only of the overall time expended.

32. The absence of appropriate minimum engagement provisions means that the Award fails to provide a fair and relevant minimum safety net of terms and conditions for the employees it covers. Those workers are some of the lowest paid and vulnerable workers in the modern award system – those performing care work for vulnerable clients including the elderly, those with dementia or people with disabilities, in their homes.

33. The HSU's proposed variation to the award provides for a minimum engagement of three hours for all employees. The utility of the provision would be defeated if shifts of the minimum period were able to be broken. To make a minimum engagement clause effective in the circumstances of the industry, broken shifts should not be available for the minimum engagement.

Broken shifts - clause 25.6; ED clause 13.6

34. The broken shift clause in the Award applies only to social and community services employees undertaking disability services work and home care employees.

35. The only current restraint on the utilisation of broken shifts is that the shift may not span more than 12 hours (cl 25.6(a)).

36. Such provision is manifestly open to exploitation when it operates in the absence of a minimum engagement provision (as is the case for part-time workers), or where there are short minima (as is the case for casual employees).

37. Under the existing provisions, a home care worker could be required to work two blocks of one hour (or less) broken by a period of 10 hours. The capacity to have more than one break during the shift can mean that an employee may be required to work three or more separate periods of work over the course of many hours in order to generate a reasonable amount of earnings. The evidence of the HSU's witnesses shows that a disturbing trend has emerged in the industry for disability support workers and home care workers to have their shifts "broken" by the time between successive clients, meaning that they are paid for a proportion only of the time that is expended in performing the work required by their employer. That circumstance also leaves some employees in the invidious position of deciding whether to incur the costs of driving home and back to the next client in the "break", or to endure stretches of dead or waiting time in the vicinity of the next client's house during the course of the day[11].

38. The broken shift clause should contain provisions to prevent exploitation of employees.

39. The relevant restrictions should be:

    a) that the shift may only be broken once and not multiple times;
    b) that the minimum period of engagement should be applied to each period of work in a broken shift; and
    c) that the employee is paid, as if working, for the time necessary to travel between clients required to be undertaken during any break in the shift.

[11] Eddington [20] – [22], [31]-[32]; Sheehy [7] – [9]; Friend [47] – [48]; Waddell [11]-[12]; Thames [15]; see also McDonald et al, Wage theft, underpayment and unpaid work in marketized social care (2018) Vol 29(1), Economic and Labour Relations Review, 80-96, at p88.

Travelling, transport and fares – (clause 20.5; ED 16.3(c))

40. The Award currently provides that an employee required or authorised by their employee to use their motor vehicle in the course of their duties is entitled to be reimbursed at a rate of $0.78 per kilometre.

41. The evidence of the HSU discloses that disability support workers and home care workers are as a matter of course required to travel considerable distances during the course of their working days in order to perform their work for their employers, particularly in regional areas. The evidence suggests employers regard the travel to the first client and from the final client of the day as not travel which occurs in the course of the employee's duties. If that were correct, there would be a perverse incentive for employers to schedule the furthermost clients at the start and finish of each day. The evidence indicates this approach is already being taken by some employers. Such travel is a fundamental part of the duties performed by those workers. It is necessary in order to perform the principal caring duties, and well exceeds the usual travel engaged in by employees to and from their workplaces.

42. The HSU's evidence demonstrates that the existing broken shift provision in the Award, combined with the absence of minimum shifts for part-time workers, enables employers to engage employees to perform a series of periods of work over the course of a day, with the expectation that the "break" in the shift will be used to travel on to the next client. Where such arrangements are utilised, workers are required to travel significant distances in the course of a day, on their own time, and in many cases, because the travel is not regarded as occurring in the course of duties because it occurs during a break in the shift, without any compensation.[12]

43. Dr Macdonald and her fellow authors dealt with these trends in the article annexed to her witness statement: *Wage theft, underpayment and unpaid work in marketized social care* (2018) Vol 29(1), Economic and Labour Relations Review, 80-96. In that article, the authors analyse the impact of marketisation of the provision of disability support care in Australia in light of international experience, and consider the efficacy of labour market regulation in protecting the low paid workers engaged in social care. The article notes the greater demands for flexibility, for shorter working hours and travel between multiple locations associated with the NDIS. Unpaid travelling time formed a

[12] Eddington [20] – [22]

significant part of the working days of many of the disability workers analysed in the article.

44. It is no part of the modern awards objective to have employees incurring substantial costs for the benefit of the employer without recompense. The Award should be amended accordingly.

Overtime - clause 28.1(b); ED clause 18.1(b)

45. The way in which overtime functions under the Award for part-time employees does not meet the Modern Award Objective, which recognises (at s.134(da)), the need to provide additional remuneration for employees working overtime; or employees working irregular or unpredictable hours.

46. Part-time employees only receive payment of the overtime rate for hours which exceed 10 in any shift, 38 in a week or 76 in a fortnight. Part-time employees should be entitled to overtime for work beyond their rostered hours. The absence of any penalty associated with the performance of such work creates a structural incentive to underestimate the hours of work required of a part-time employee at the time of engagement and/or rostering, and to utilise part-time workers like a pool of casual employees. The evidence above suggests the increasing tendency towards engagement of part-time employees in both home care and disability support work, with such employees working less hours.

47. Overtime for casual and part-time workers should be paid for shifts longer than 8 hours rather than 10. Work performed by carers in private homes and in the community providing personal or domestic assistance for elderly clients or clients with a disability is both physically and mentally taxing,[13] which is compounded by the (often unrecognised and unpaid) travel involved in the performance of the work. During long shifts there may be little opportunity, or appropriate facility, for workers to take proper breaks and rest.[14]

Casual loading - clause 10.4(b); ED clause 11.2

48. Casual loading should be paid in addition to any overtime, weekend and public holiday penalty. That approach is consistent with the function of casual loading, which is to

[13] Thames [6] – [7]; Lobert [21]
[14] Thames [13] – [17]

compensate casual employees for the paid leave entitlements available to permanent employees which are forgone by reason of their less secure position. It is consistent with the "default approach" discussed by the Full Bench in the *Penalty Rates Decision* [2017] FWCFB 1001 (at [338]), which has the advantage of being simple and easy to understand, consistent with s134(1)(g).

49. The Full Bench in the *Penalty Rates Decision* noted, in considering the *Hospitality Award*, the distinct purposes of penalty rates and casual loadings, observing that:

> [889] *As we have mentioned, the [Productivity Commission] Final Report makes reference to the interaction of penalty rates and casual loadings and concludes that:*
>
> > *'For neutrality of treatment, the casual loading should be added to the penalty rate of a permanent employee when calculating the premium rate of pay over the basic wage rate for weekend work.'*
>
> [890] *There is considerable force in the Productivity Commission's conclusion.*
>
> [891] *Casual loadings and weekend penalty rates are separate and distinct forms of compensation for different disabilities. Penalty rates compensate for the disability (or disutility) associated with the time at which work is performed.*

50. The Full Bench went on to hold that under the *Hospitality Industry (General) Award*, casual loading should be added to the Sunday penalty rate, because clause 13.1 in that award, concerning casual loading, did not state that the loading was intended to compensate employees for Sunday work. The Full Bench found that:

> [895] *The distinct purpose of the casual loading is made clear from clause 13.1 of the Hospitality Award: 'The casual loading is paid as compensation for annual leave, personal/carer's leave, notice of termination, redundancy benefits and other entitlements of full-time or part-time employment'*
>
> [896] *Importantly, the casual loading is not intended to compensate employees for the disutility of working on Sundays.*
>
> [891] *In our view, the casual loading should be added to the Sunday penalty rate when calculating the Sunday rate for casual employees. We propose to adopt the Productivity Commission's 'default' method. Accordingly, the Sunday rate for casual employees in the Hospitality Award will be 25 + 150 = 175 per cent.*

51. Clause 10.4(b) of the Award is relevantly identical to the corresponding provision in the Hospitality Award. It provides that: *'A casual employee will be paid per hour calculated at the rate of 1/38th of the weekly rate appropriate to the employee's classification. In addition, a loading of 25% of that rate will be paid instead of the paid leave entitlements accrued by full-time employees.*

52. It is clear from the terms of the clause that the casual loading is paid in substitution for the leave entitlements otherwise available to permanent employees and does not operate to compensate for any other aspect of the work, or its performance, including the inconvenient or unsociable time at which the work is performed.

53. For casual employees covered by the Award, the loss of a client or of a regular engagement presents an ongoing threat to the security of their employment and hours of work. Such employees take steps such as working more than one job in the industry to hedge against that risk.[15]

54. Clause 28.1(b)(iv**)**, (see clause 18.1(b), exposure draft) provides that: '*Overtime rates payable under this clause will be in substitution for and not cumulative upon:*

(A) the shift premiums prescribed in clause 29—Shiftwork; and
(B) the casual loading prescribed in clause 10.4(b),
and are not applicable to ordinary hours worked on a Saturday or a Sunday.

55. Clause 26 provides:

Saturday and Sunday work
'Employees whose ordinary working hours include work on a Saturday and/or Sunday will be paid for ordinary hours worked between midnight on Friday and midnight on Saturday at the rate of time and a half, and for ordinary hours worked between midnight on Saturday and midnight on Sunday at the rate of double time. These extra rates will be in substitution for and not cumulative upon the shift premiums prescribed in clause 29 – Shiftwork and the casual loading prescribed in clause 10.4(b), and are not applicable to overtime hours worked on a Saturday or a Sunday.'

56. Clause 34.2 provides that:

(a) An employee required to work on a public holiday will be paid double time and a half of their ordinary rate of pay for all time worked.

(b) Payments under this clause are instead of any additional rate for shift or weekend work which would otherwise be payable had the shift not been a public holiday.

57. The HSU contends against the adoption of the above clauses in those terms, to the extent they operate to subsume casual loading within other penalties.

[15] Lobert [17]

58. Neither overtime rates, weekend penalties, nor public holiday penalties are designed to compensate casual workers for the loss of leave entitlements. Casual employees should not be denied such compensation because they receive a payment in respect of another feature of the work.

Telephone allowance - clause 20.6; ED clause 16.3(d)

59. The current telephone allowance clause – as worded in both the exposure draft and current award – is outdated. The language of the clause refers to a landline telephone. The Commission would safely conclude that the vast bulk of employees now have mobile phones and that they are available to them during the course of their work.

60. Employers frequently require or expect care workers to be contactable by mobile phone when performing their duties. Employees commonly need to use smart phones to check their rosters, make notes on clients, take photographs, log onto company apps or portals, call ambulances or supervisors in emergencies, as well as answer calls about their availability for shifts, often at the last minute.[16] Any employees required to use a phone for work in this way should receive a telephone allowance which reflects the cost of maintaining and using such mobile phone. Employees required to use a smart phone should be reimbursed for the cost of purchasing one if such purchase is necessary.

Uniform allowance and damaged clothing allowance - clause 20.2; clause 16.3(a)

61. Clause 20.2 of the Award provides for payment of an allowance for uniforms and their laundering. The reality of work in the industry, particularly for home carers and disability support workers, is that employees are not provided with uniforms, but wear their own clothes to work, which are at risk of being soiled or damaged in the course of their duties[17].

62. The award should include a damaged clothing allowance, which takes into account that employees' clothing will frequently become damaged, soiled or worn given the nature of the work they do. Where such damage occurs, upon provision of proof of the damage, employees should be compensated at the reasonable replacement value of the damaged or soiled item of clothing.

[16] Thames [23]; Waddell [33] – [34]; Wilcock [22] – [23]; Lobert [18] – [20]
[17] Wilcock [11]; Waddell [36]

First aid certificate renewal - clause 20.4; ED clause 16.2

63. The evidence shows many employees engaged in disability support or home care roles are required to hold a current first aid certificates in their roles. Even where such qualification is not explicitly required, the holding of such qualification is likely to be beneficial for the employer in that the employee is better equipped to deal with a medical emergency. Where an employee is required to maintain their first aid certification, that they should be entitled to be reimbursed the costs of maintaining their certification by their employer.

24 hour care - clause 25.8; ED clause 13.8

64. The 24 hour care clause is unclear and rarely used. It should be removed, and extended periods of care dealt with in accordance with the provisions otherwise in the Award.

65. The clause leaves employees open to exploitation as:

a) it does not compensate employees for the entire time they are required to be available for the performance of their duties. It is a fundamental principle of employment law that *"they also serve who only stand and wait".* Where an employee is required by the employer and is not free to get on with their own chosen activities, they should be compensated for that as work;
b) it does not specify what would happen if an employee works more than 8 hours in a 24 hour period;
c) the sleepover clause provides that a sleepover span must be a continuous period of eight hours, and provides that if an employee's sleep is interrupted and they are required to perform work, they are required to be paid overtime rates;
d) there are no provisions under this clause for the employee to be provided a continuous number of hours for sleep, or what happens if the employee's sleep is broken;
e) it provides that a bed in a private room will be provided 'where appropriate' but it is not clear when it would not be appropriate for an employee working a 24 hour shift to not be provided with such a bed.

66. The clause does not meet the modern award objective. It provides for remuneration at a discounted rate during a period where an employee is required to be available for work.

Cancellation - clause 25.5(f); ED clause 13.5(g))

67. The Award enables home care workers to have their shifts cancelled or changed at 5.00 p.m. the day before a rostered shift without the employer being required to pay wages in respect of that cancelled shift.[18] The brevity of the notice has the capacity to be disruptive for employees seeking to arrange other responsibilities around work commitments.

68. The capacity to cancel on such terms undermines the entitlement of part-time workers to regular and guaranteed days and hours of work. Employees should receive greater notice than that currently provided.

Recall to Work Overtime - clause 20.9; ED clause 16.2(d)

69. The Award provides (at clause 20.9) for payment of an on call allowance for employees who are required to be available for recall to duty.

70. Clause 28.4 regulates the payment for when an employee is recalled to work. Where an employee is recalled to work overtime after leaving the work, the employee is paid for a minimum of two hours work at the appropriate rate for each recall, but must be released if the work is completed within that period.

71. The award does not clearly identify whether employees required to perform additional work without attending the place of work are entitled to compensation. Many employees are now able to perform valuable work for the employer outside the employer's premises connecting remotely with employer systems. Such work should be compensated appropriately.

72. The HSU contends the Award should be amended to make clear that employees required to perform work out of hours should be compensated, with a minimum payment of one hour attached to such work.

[18] Waddell [16] – [21]; Thames [11]

Sleepover – clause 25.7; ED clause 13.7

73. The clause should be amended to ensure appropriate facilities are provided when employees are required to perform a sleepover shift. Such shifts are compensated modestly.

74. The HSU initially foreshadowed a claim for review of the rate paid, as well as other substantive amendments, in respect of the performance of such shifts. No such claim is currently pressed, however, the HSU anticipates it will likely advance such a claim outside the scope of the 4-Year review process in future, and reserves its rights in that respect.

15 February 2019

From: Rachel Liebhaber [mailto:rachell@hsu.net.au]
Sent: Thursday, 18 April 2019 12:40 PM
To: Chambers - Ross J
Cc: Brent Ferguson; Kyle Scott; Lisa Doust; Leigh Svendsen; mrobson@asu.asn.au; Natalie Dabarera; 'nicola.shaw@afei.org.au'; peggms24@gmail.com; thalls@ja.com.au; Ruchi Bhatt
Subject: AM2018/26 SCHCDS Award

AM2018/26
4 yearly review of modern awards
Social, Community, Home Care and Disability Services Award

Dear Casey,

At the hearing yesterday in the above matter, the Full Bench raised questions about NDIS pricing structures. In response, I write to draw their attention to pages 36 – 38 of the 2018 NDIS Price Guide which was filed with the HSU's submission as report (h). These tables outline how the price caps vary depending on when the support is delivered (afternoon, night, Saturday, Sunday, public holiday) and the complexity of the client being supported (Level 1, 2 or 3).

I also attach the media release referred to by our witness, Mr Farthing, which was requested by the Full Bench. The detail, including the 2019 increased price caps for weekday, afternoon, night, Saturday, Sunday, and public holiday shifts are listed on the NDIA website at this page: https://www.ndis.gov.au/annual-price-review.

Regards,
Rachel

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THE HON PAUL FLETCHER MP

Minister for Families and Social Services

THE HON SARAH HENDERSON MP

Assistant Minister for Social Services, Housing and Disability Services

MEDIA RELEASE

30 March 2019

NDIS price increases for a sustainable and vibrant disability services market

The Morrison Government has today announced an increase to price limits for therapy, attendant care and community participation under the National Disability Insurance Scheme (NDIS), effective 1 July 2019. These price increases will inject more than $850 million into the NDIS market in 2019-20 so that NDIS participants can access the quality and innovative services and supports that meet their individual needs.

Minister for Families and Social Services, Paul Fletcher, and Assistant Minister for Social Services, Housing and Disability Services, Sarah Henderson said the new prices include a minimum increase of almost $11 per hour for therapists and up to a 15.4 percent price increase to the base limit for attendant care and community participation.

“We are committed to the development of a vibrant disability services market that enables NDIS participants to have genuine choice and control over the services and supports they need,” Mr Fletcher said.

“We have consulted widely with participants, providers and the sector to inform and implement these changes.

“These changes form part of the National Disability Insurance Agency’s (NDIA) annual price review to update prices that reflect market trends, costs in wages and other influences. It also responds to regular monitoring of markets and responding to emerging issues.

“These processes have identified the need to increase prices for attendant care and community participation and we are responding to that.

“Substantial increases to the hourly rates for therapy also follow a comprehensive review of the price control arrangements and other market settings for therapy services through December 2018 to March 2019.

“These price increases are part of an overarching pricing strategy and commitment to review and respond to pricing evidence as required, and will encourage the development of a disability services market of appropriate size, quality and innovation,” Mr Fletcher said.

Ms Henderson said providers of attendant care would also be eligible for an additional pricing boost through a temporary transformation payment.

“The Government recognises the transition to a competitive market may be difficult for some providers and the changes we are announcing today complement a broad range of initiatives to support that transition,” Ms Henderson said.

“With the NDIS well under way, demand for disability services is growing rapidly, with more than 90,000 new jobs to be created over the next five years.

“The changes are part of ongoing pricing considerations that will be communicated to the sector in coming months, including the outcomes from the WA Market Review, in the lead up to the implementation of the new 2019-20 prices, effective 1 July 2019,” Ms Henderson said.

Graeme Innes, one of two independent members of the NDIA’s Pricing Reference Group and the former Australian Disability Discrimination Commissioner, explained that the pricing changes were considered by the Pricing Reference Group over a number of meetings and were supported by a strong body of evidence.

“We endorse the changes because we are satisfied that the increases are reflective of the adjustment that is needed to address sector concerns and ensure participants continue to be supported in achieving their goals,” Mr Innes said.

In addition to the support of the NDIA Pricing Reference Group, Andrew Rowley, a member of the NDIA’s Industry Reference Group and Managing Director and CEO of Ability First Australia (AFA), a not for profit strategic alliance between 14 of Australia’s leading disability service providers also welcomed the price increases.

“AFA expects this will help encourage investment in attendant care and therapy supports amongst the members of Ability First Australia,” Mr Rowley said.

The NDIA’s Pricing Reference Group guides NDIS price regulation activities and decisions to support NDIS objectives during the transition to a competitive market place. The NDIA would continue to improve market and price settings, using benchmarking methodologies to guide the process.

For further information about these prices changes please visit the NDIS website.

ENDS

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Additional Information

From 1 July 2019:

- Price limits for therapy supports (excluding psychology and physiotherapy) will increase by almost $11 per hour (/hr), from $179 to $190.
- Psychologists and physiotherapists will also see increases based on the location in which these supports are delivered.

  Psychology:

  - In the Australian Capital Territory, New South Wales, Queensland and Victoria psychology support price limits will increase from $179 to $210/hr.
  - In the Northern Territory, South Australia, Tasmania, and Western Australia, psychology support price limits will increase from $179 to $230/hr.

  Physiotherapy:

  - In the Australian Capital Territory, New South Wales, Queensland and Victoria physiotherapy support price limits will increase from $179 to $190/hr.
  - In Northern Territory, South Australia, Tasmania, and Western Australia physiotherapy support price limits will increase from $179 to $220/hr.
- Attendant care and community participation will increase from between 5.6 per cent and 15.4 per cent dependent on variables such as location, times and days of shifts, and level of worker;

Providers of attendant care will also be eligible for a temporary transformation payment to assist providers to cover the costs associated with transitioning to the NDIS. In 2019-20, this conditional loading will be set at 7.5 per cent. It will reduce 1.5 per cent each year thereafter.

From 1 July, the combined effect of the increased price limits and the temporary transformation payment is an increase of between 10.9% and 20.4%, dependent on variables such as location, times and days of shifts, and level of worker. Increases will be further indexed for wage inflation and the Fairwork Commission's Equal Remuneration Order prior to implementation.

Funding in participant plans will be automatically adjusted to reflect the changes in the price limits for therapy, attendant care and community participation, effective from 1 July 2019 as part of the annual indexation of plans.

Other initiatives designed to assist providers to transition to a competitive NDIS market include an online NDIS Demand Map (at blcw.dss.gov.au) which provides data on the demand for NDIS supports and services by region, to help providers understand opportunities for their business.

NDIS providers and organisations can now also apply for up to $20,000 of tailored business support to help them transition to the NDIS under the $5.6 million Transition Assistance Funding program. Providers can apply for Transition Assistance Funding by firstly completing a readiness assessment at blcw.dss.gov.au/readiness

HSU NATIONAL

IN THE FAIR WORK COMMISSION

AM2018/26
S 156 - Four Yearly Review of Modern Awards - Group 4 Awards
Social, Community, Home Care and Disability Services Industry Award 2010

SUBMISSION OF THE HEALTH SERVICES UNION

1. The Health Services Union (**HSU**) make these submissions in response to the Directions of the Full Bench dated 1 May 2019 (**the Directions**), in relation to the four yearly review of the Social, Community, Home Care and Disability Services Industry Award (**SCHCDS Award**).

2. These submissions are made in response to the questions raised by the Full Bench in paragraph F of the Directions, which are as follows:

> *In the Part-time employment and casual employment decision the Full Bench described the operation of the NDIS at paragraphs [554] and [630] – [633]. Do the parties take issue with any of the observations made at those paragraphs? Is there any more up to date information?*

3. The HSU does take issue with some of the observations made at paragraphs [554] and [630]-[633] for the reasons outlined below. We also provide some up-to-date information on the operation of the NDIS.

Paragraph [554]

4. We take issue with the following contention of Australian Business Industrial and the NSW Business Chamber (**ABI**) which was summarised in paragraph [554] of the Part-time and Casual decision[1]:

> *ABI contends that the NDIS is radically changing the disability support services sector, in that employers have lost a large degree of control over when work is required to be performed, and accordingly require much greater flexibility in the allocation of working hours to part-time employees so that they can operate in a way which is responsive to client demand.*

5. Whilst it is true that the nature of the funding system has changed, the needs of people with disabilities have not changed because of the NDIS. For example, NDIS participants requiring personal care during the morning and evening will still predominantly need that support during the morning and evening. Claims from

[1] [2017] FWCFB 3541

ABI that the NDIS has and will lead to radical changes on a daily basis are incorrect.

6. We also note that paragraph [554] by no means represents the concluded view of the Full Bench on the operation of the NDIS. The paragraphs fall under the heading '*5.1 ABI and NSWBC claim*' and represents a summary of ABI's claim and characterisation of how the NDIS operates.

7. In fact, the Full Bench rejected ABI's characterisation of the NDIS later in the decision, particularly in paragraphs [636] - [640].

8. Relevantly, the Full Bench found at [636] that:

> *The evidence makes it clear that there remains considerable uncertainty as to how the NDIS will operate and what will be the pattern of service demand from participants once the NDIS is fully implemented. We consider it to be likely that this uncertainty is a major reason for the current degree of preferment for casual employment, and that once the NDIS has been fully implemented and its operation becomes more certain and stable, part-time employment will be maintained as a substantial feature of the sector.*[2]

9. It found at [639]:

> *The basic elements of the NDIS lend themselves to reasonably predictable workforce planning. Many of the forms of support that are funded in individualised NDIS plans are (as Mr Bowden said) regular and predictable. The service agreement between the participant and the provider of a support service allows for providers to deal with participants in a structured and consistent way, with requirements for cooperation and communication as to when services are provided, notice periods for cancellations, payment where insufficient notice of a cancellation is provided, and notification to the NDIA for a review of the plan if cancellations become excessive. Ultimately an agreement may be terminated by the provider if it becomes impracticable and financially unviable.*

10. It found at [640]:

> *Fourth, we consider it unlikely that the market for disability support services which the NDIS is establishing will give participants the degree of market power that some of the employer witnesses implicitly suggested it would. It is clear that for many types of supports, participants value support workers who provide a high quality and amenable service, and they also value having continuity in the personnel who provide the service. In that context, we cannot envisage that participants will be in a position to demand from providers as a matter of course the disability service worker they prefer at whatever time they may choose to nominate from week to week. The massive expansion in the number of participants which will occur as the NDIS is rolled out, and the*

[2] [2017] FWCFB, [636]

concomitant expansion in the workforce which will be required in order to service these participants, tend to indicate that providers will need to, and will be in a position to, limit the extent to which participants can demand the provision of services on a discretionary and unplanned basis.

Paragraph [630]

11. For accuracy, the second sentence in paragraph [630] should read '*Participants in the scheme (and/or their carers) are required to prepare an NDIS plan…'* [amended text underlined].

12. We say that the 3rd and 9th sentences in paragraph [630] are inaccurate. These state:

Supports may be fixed – that is, regularly required at a fixed time each day or week – or be flexible, which means the participant has scope to rearrange the supports to suit themselves within the overall budget.

…

The example plan required each identified support to be purchased as described, and prohibited swaps from one item to another.

13. An NDIS plan has 3 overall categories of supports: (i) core supports; (ii) capital supports, and; (iii) capacity building supports. The significant majority of funded NDIS supports are core supports. Core supports are generally fully flexible within the category, and not as prescriptive as the discussion of the example plan suggests. Only capacity-building and capital supports would identify prohibits on swaps.

14. We do not agree with the second from last sentence of paragraph [630]:

In pricing items, the NDIA has been aggressive in trying to set the absolute minimal cost so as to control the cost to government of the NDIS as a whole.

15. Recently, there have been significant pricing increases announced. The NDIA has not publicly released the reference formulas for the new prices that have been announced but not yet come into effect (they will on 1 July 2019).

16. The NDIA is not simply concerned with keeping costs at a minimum; it also aims to set prices at what it deems to be high enough to encourage supply. This is apparent in the recent NDIA Quarterly Report, dated 31 March 2019,[3] which states the following in relation to NDIS pricing:

The NDIA is acutely aware of its role as market steward and the need to set prices that encourage market development, particularly in thin markets.

[3] National Disability Insurance Agency (NDIA), *COAG Disability Reform Council Quarterly Report* (31 March 2019).

Supplementing the work of the Independent Pricing Review, which is currently being implemented, and the Western Australia Market Review, the NDIA has undertaken extensive consultation on therapy prices and pricing for attendant care. That work, initiated and promoted by the NDIA, has been rigorous and fact-based, using extensive data not previously available to the Independent Pricing Review.

As a consequence, it was announced towards the end of the quarter that from 1 July 2019 significant price increases will be made for both therapy and attendant care.

…

In relation to attendant care, increases of between 5.6% and 15.4% to the base price for attendant care, depending on location, times and days of shifts, and skill level will be available from 1 July 2019. In addition, a Temporary Transformation Payment of 7.5% will also be made to providers, reducing by 1.5% each year over 5 years. This conditional loading will assist providers continue to transform their businesses as the market evolves.

Overall, the increases will help ensure the availability of supply in the attendant care and therapy markets, thereby assisting participants to achieve their goals.[4]

17. Additionally, the NDIA indexes prices on an annual basis to take into account wage inflation (the minimum wage order and the equal remuneration order) and non-wage inflation (CPI).

18. Furthermore, a significant area of NDIS supports, known as '*Supported Independent Living (SIL)*' is not subject to price caps of any kind.

Paragraph [631]

19. Paragraph [631] is inaccurate in its characterisation of self-managed compared with agency managed NDIS plans.

20. We outline the categories of plans below. The statistics are taken from the NDIA Quarterly Report.[5]

21. At the plan approval stage, participants can opt to manage their funding in three different ways (or a combination of each)

Agency-Managed Funding

[4] Ibid, 45.
[5] Ibid, 85.

22. The first option is to have an agency-managed plan. This means that the National Disability Insurance Agency (NDIA) pays disability service providers on behalf of participants. NDIS participants who select this option can only purchase NDIS-funded services from service providers who are registered with the NDIA. As at 31 March 2019, 47% of NDIS participants had agency-managed funding.

Plan-Managed Funding

23. The second option is plan management, where the NDIA will fund a financial intermediary (a Plan Manager) who will pay providers for purchased supports and manage financial reporting. NDIS participants who use plan-managed funding can use both registered and unregistered providers. As at 31 March 2019, 27% of Victorian NDIS participants had plan-managed funding.

Self-Management

24. The third option is self-managed funding, where the NDIA provides funds directly to the NDIS participant who is responsible for managing their own plan. Self-managing NDIS participants can use registered or unregistered providers and directly employ their own staff (or engage them as independent contractors). As at 31 March 2019, 15% of NDIS participants were fully self-managing their funding, with another 11% partly self-managing. Self-managing participants are not subject to the price caps contained in the NDIA Price Guide.

25. Paragraph [631] refers to an example of a 'service agreement'. Service Agreements are contracts between an NDIS service provider and an NDIS participant. Certain rules are imposed, which are articulated by the NDIA's Terms of Business and Price Guide.[6] It's important to state that providers will generally set the terms of a service agreement. The provisions in the example of a service agreement listed in dot points under paragraph [631], particularly around the participant informing the provider about certain changes, are not standard across the sector.

Paragraph [632]

26. The second sentence of paragraph [632] states:

> *The full implementation rollout began in July 2016, but it is not expected to be completed until 2019.*

27. This statement is out of date. The rollout targets have not been met and it can be expected that rollout will continue well into 2020.

28. The data in paragraph [632] is generally out of date. According to the NDIA Quarterly Report, as at 31 March 2019:

[6] 'Terms of Business for Registered Providers'
https://providertoolkit.ndis.gov.au/sites/g/files/net3066/f/ndis_terms_of_business.pdf

(i) There were 277,155 NDIS participants. Of these 85,489 were receiving support for the first time.[7]

(ii) The total number of registered providers was 20,208. Of this 57% (11,418) were "active" on 31 March 2019. "Active" means that they had claimed a payment from the NDIA for delivering a service. Of the total number of providers, 45% are individual/sole traders.[8]

29. The '*data collected and benchmarked by NDS*' referred to in paragraph [633] will have changed since 2017. Moreover, the data appears to refer to the NDS 'Workforce Wizard' data. This data is collected through self-reporting of NDS members. It is therefore not rigorous or accurate in the same way as ABS data, for example, would be.

Health Services Union
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[7] National Disability Insurance Agency (NDIA), *COAG Disability Reform Council Quarterly Report* (31 March 2019), 18.
[8] Ibid,43.

Fair Work Commission
Four Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award
Matter No: AM2018/26

SUBMISSIONS IN REPLY OF HEALTH SERVICES UNION

OVERVIEW

1. These submissions in reply are made by the Health Services Union (**HSU**), in accordance with paragraph (2) of the amended directions of the Full Bench, dated 2 September 2019.

2. The HSU has also filed the Further Statement of Mark Farthing dated 16 September 2019 and relies on that statement in support of the arguments below.

3. These submissions are in response to:
    a) the proposed variations in the draft determination filed by the Australian Business Lawyers and Advisors Pty Ltd (**ABL**) on 2 April 2019**,** on behalf of Australian Business Industrial (**ABI**) the NSW Business Chamber (**NSWBC**), Aged & Community Services Australia (**ACSA**) and Leading Age Services Australia (**LASA**);
    b) the submissions filed in support of the abovementioned draft determination, consisting of:
        i. the submissions of ABL of 2 July 2019 on behalf of ABI, NSWBC, ACSA and LASA, including the witness statements of Scott Harvey dated 2 July 2019, Joab Darbyshire dated 28 June 2019 and Graham Shanahan dated 28 June 2019**;**
        ii. the submissions of National Disability Services **(NDS)** of 2 July 2019, including the witness statement of Steven Miller dated 28 June 2019;

iii. the submissions of the Australian Federation of Employers and Industries (**AFEI**) of 4 July 2019, which provide no evidence in support of the variations.

4. These submissions also respond in part to the submissions of the Australian Industry Group (**AIG**) insofar as they are relevant to ABL's claims as set out in their draft determination of 2 April 2019 and their submissions of 2 July 2019. AIG has not explicitly stated its support of ABL's claims, and has provided no evidence in support of the variations.

5. For ease of reference these submissions refer collectively to the parties supporting ABL's submissions, including ABI, NSWBC, ACSA, LASA, NDS, AFEI and AIG as '**the employers'**.

6. Consistent with the understanding at the conclusion of the discussion of the parties concerning the remote response allowance in the conciliation conferences before Commissioner Lee in August and September 2019, no submission is made herein in respect of that matter. The HSU reserves its right to make further submissions about that issue subject to the outcome of the discussions in respect of that matter.

VARIATIONS PROPOSED BY THE EMPLOYERS

7. In seeking to ensure a 'stable' system of modern awards, in accordance with the modern awards objective, in particular s 134(1)(g), the Full Bench held that where a '*significant change*' to a Modern Award is proposed in the four yearly review process, '*it must be supported by a submission which addresses the relevant legislative provisions and be accompanied by probative evidence properly directed to demonstrating the facts supporting the proposed variation*'.[1]

8. The employers' proposed variations, and the HSU's response to each submission, are dealt with in turn below.

Variation 1: ordinary hours of work in clause 25.1 (clause 13.1 in Exposure Draft (ED))

9. The employers propose to delete 25.1. That clause currently provides:

25.1 Ordinary hours of work

[1] [2014] FWCFB 1788, [23].

(a) The ordinary hours of work will be 38 hours per week or an average of 38 hours per week and will be worked either:

(i) in a week of five days in shifts not exceeding eight hours each;

(ii) in a fortnight of 76 hours in 10 shifts not exceeding eight hours each; or

(iii) in a four week period of 152 hours to be worked as 19 shifts of eight hours each, subject to practicality.

(b) By agreement, the ordinary hours in clause 25.1(a) may be worked up to 10 hours per shift.

10. The employers propose to replace clause 25.1 with the following:

25.1 Ordinary hours of work

(a) The ordinary hours of work will be 38 hours per week or an average of 38 hours per week over the employee's roster period, up to a maximum of four weeks.

(b) Subject to clause 25.1(c), the maximum ordinary hours that can be worked per shift is 8.

(c) By agreement between an employer and an individual employee, ordinary hours may be worked up to 10 hours per shift.

11. The HSU opposes the proposed variation. No imperative or proper basis for the variation is demonstrated.

12. The proposed change to clause 25.1 is not a '*minor or technical variation'* as ABI contends[2]. A significant amendment of the current wording is proposed.

13. No evidence demonstrating the erroneous or otherwise undesirable operation of the current clause is produced. It is not apparent what roster arrangements ABI says should be facilitated, but which are impeded by the current clause. No concrete alternative roster arrangement appears to be contemplated by any of ABI's witnesses. ABI has filed witness statements from:

    a) Scott Harvey, whose organisation Connectability does not employ any workers in direct support roles on a full-time basis[3], and who does not identify any rostering difficulties concerning full time workers in other roles;

[2] ABI Submissions, 2 July 2019, para 4.9
[3] Witness Statement of Scott Harvey dated 2 July 2019 [20]

b) Joab Darbyshire, whose organisation Macleay Options Incorporated employs 50 full-time employees in classifications which are not identified and in respect of whose rostering, no evidence is given[4];

c) Graham Shanahan, from Coffs Coast Health and Community Care Pty Ltd, which employs 6 full-time employees, whose classifications and rosters are not disclosed[5];

d) Jeffery Wright, from HammondCare, which employs 798 full-time employees in classifications which are not identified[6]. Mr Wright's statement does not identify any impediment posed by clause 25.1 to the sensible and efficient rostering of those staff;

e) Andrew Collins, from the Benevolent Society, which employs 812 full-time employees in classifications which are not identified[7]. Mr Collins' statement also does not identify any impediment posed by clause 25.1 to the sensible and efficient rostering of those staff;

f) Deb Ryan, from Community Care Options, which employs 23 full time employees in classifications which are not identified[8]. Ms Ryan's statement does not identify any difficulties in respect of the the rostering of such full-time staff;

g) Therese Adami, from Catholic Healthcare Limited, which employs 546 full-time employees in classifications which are not identified. Ms Adami's statement does not address the rostering of those employees[9];

h) Wendy Mason, from Baptist Care NSW & ACT, which employs 555 full-time employees including 176 such employees in its Home Services (home care) division. Ms Mason's statement does not address the rostering of such employees[10].

14. NDS supports the claim but has provided no evidence to demonstrate the necessity either the wisdom or necessity of this proposed amendment. It has filed a witness

[4] Statement of Joab Darbyshire, 28 June 2019, [10]
[5] Statement of Graham Shanahan, 28 June 2019 (**Shanahan**), [16].
[6] Statement of Jeffery Wright, 12 July 2019 (**Wright**) [14].
[7] Statement of Andrew Collins, 12 July 2019, [20].
[8] Statement of Deb Ryan, 12 July 2019, [21].
[9] Statement of Therese Adami, 12 July 2019.
[10] Statement of Wendy Mason, (undated) July 2019.

statement from Steven Miller from the Endeavour Foundation, which employs 236 full-time employees.[11] However, nothing in Mr Miller's evidence touches on the organisation's rostering practice, let alone demonstrates why any proposed change to clause 25.1 is necessary and consistent with the Modern Awards objective.

15. Contrary to the ABL Submission at [4.7], not all the *key elements* of the clause as currently drafted would be retained if the amendment were made. The amendment would remove the entitlement (albeit condition) of employees on a four week roster to a rostered day off. The employers' evidence does not address the question of rostered days off at any point.

16. The Commission should decline to make the change sought.

Variation 2: 'period of work' in clause 25.4(a) (clause 13.4 in Exposure Draft)

17. The employers propose to vary clause 25.4(a). Clause 25.4 currently provides:

> ***25.4 Rest breaks between rostered work***
>
> *(a) An employee will be allowed a break of not less than 10 hours between the end of one shift or period of work and the start of another*
> *(b) Notwithstanding the provisions of subclause (a), by agreement between the employee and the employer, the break between:*
> *i. the end of a shift and the commencement of a shift contiguous with the start of a sleepover; or*
> *ii. a shift commencing after the end of a shift contiguous with a sleepover may not be less than eight hours.*

18. The employers propose that the clause be amended to read as follows:

> ***25.4 Rest breaks between rostered work***
>
> *(a) An employee will be allowed a break of not less than 10 hours between the end of one shift and the start of another*
> *(b) Notwithstanding the provisions of subclause (a), by agreement between the employee and the employer, the break between:*
> *i. the end of a shift and the commencement of a shift contiguous with the start of a sleepover; or*

[11] Statement of Steven Miller, 28 June 2019 [11].

ii. a shift commencing after the end of a shift contiguous with a sleepover may not be less than eight hours.

19. The effect of the proposed variation would be to remove the words "period of work" from clause 25.4(a) and thereby diminish the scope of the protection for employees that is contained in that clause. The HSU opposes the proposed variation.

20. The term "period of work" has a meaning that is broader than the term "shift". It includes sleepovers (as the qualification in clause 25.4(b) demonstrates) and excursions. Whilst not characterised as "shifts" under the Award, they are nonetheless periods of work, from which an employee should be entitled to recover before commencing further work. The elimination of the phrase from the clause would significantly impact its operation, and would shorten the period of rest between periods of work.

21. No evidence demonstrating the presently erroneous or otherwise undesirable operation of the current clause is produced. Indeed, nothing in the employer evidence addresses this issue at all. No basis for the variation is demonstrated.

Variation 3: change in roster - sub-clause 25.5(d)(ii) (clause 13.5(f) in Exposure Draft)

22. The employers propose to delete sub-clause 25.5(d)(ii).

23. Clause 25.5(d) currently provides:

(d) Change in roster

(i) Seven days' notice will be given of a change in a roster.

(ii) However, a roster may be altered at any time to enable the service of the organisation to be carried on where another employee is absent from duty on account of illness, or in an emergency.

(iii) This clause will not apply where the only change to the roster of a part-time employee is the mutually agreed addition of extra hours to be worked such that the part-time employee still has four rostered days off in that fortnight or eight rostered days off in a 28 day roster cycle, as the case may be.

24. The employers propose that sub-clause 25.5(d) should be varied as follows:

(i) Seven days' notice will be given of a change in a roster.

(ii) However, a roster may be altered at any time:

A. by agreement between the employer and relevant employee, provided the agreement is recorded in writing;

B. to enable the service of the organisation to be carried out where another employee is absent from work on account of personal/carer's leave, compassionate leave, community service leave, ceremonial leave, leave to deal with family and domestic violence, or in an emergency; or

C. where the change involves the mutually agreed addition of hours for a part-time employee to be worked in such a way that the part-time employee still has four rostered days off in that fortnight or eight rostered days off in a 28 day roster cycle.

25. The proposed variation would:

    a) facilitate the change of rosters at any time where the employee has agreed to such variation; and

    b) expand the circumstances where a unilateral variation may be effected beyond illness or emergency.

26. The HSU opposes the proposed variation.

27. There is no evidence demonstrating the necessity for such a variation, nor that there is any proper case for such a variation in this industry. Amendments to the *Nurses Award* are inapposite. It is not appropriate to carry over on a piecemeal basis, provisions from awards that contain a raft of different conditions for employees and which have application in different circumstances.

28. So far as part-time employees are concerned, the amendment appears designed to undermine a fundamental protection: the entitlement to a regular pattern of work which appears in clause 10.3(c). Given that employees under this Award (unlike nurses) have no entitlement to an overtime loading until their hours of work exceed 10 in a day, 38 in a week or 76 in a fortnight[12], any dilution of the effect of clause 10.3(c) should not be regarded by the Commission as fair.

[12] Clause 28.1(b)

29. The evidence before the Commissions shows a high incidence of part-time work within the industries covered by the Award, and a high incidence of underemployment of those employees. The employer evidence indicates employers organisation their operations on the assumption that part-time workers will want to work additional shifts[13]. The absence of any penalty for doing so creates a structural incentive to do so. The employers' proposed variation to allow change of roster where there is agreement is unlikely to provide any real and substantial protection for employees. The facility to make changes by agreement should remain limited to changes to perform additional shifts.

Variation 4: client cancellation in clause 25.5(f) (clause 13.5(g) in Exposure Draft)

30. The employers propose to delete sub-clause 25.5(f).

31. Clause 25.5(f) currently provides:

> *(f) Client cancellation*
>
> *(i) Where a client cancels or changes the rostered home care service, an employee will be provided with notice of a change in roster by 5.00 pm the day prior and in such circumstances no payment will be made to the employee. If a full-time or part-time employee does not receive such notice, the employee will be entitled to receive payment for their minimum specified hours on that day.*
>
> (ii) *The employer may direct the employee to make-up time equivalent to the cancelled time, in that or the subsequent fortnightly period. This time may be made up working with other clients or in other areas of the employer's business providing the employee has the skill and competence to perform the work.*

32. The employer's proposed clause reads:

> *(f) Client cancellation*
>
> *(i) This clause applies where a client cancels or changes a scheduled home care or disability service which a full-time or part-time employee was rostered to provide.*
>
> *(ii) Where a service is cancelled by a client under clause 25.5(f)(i), the employer may either:*

[13] Wright [35] – HammondCare offered 14,000 additional hours above contract hours in May 2019, or the equivalent of 92 FTE positions; Shanahan [30] – Coffs Coast Health offered an additional 902 hours of work to its 31 part-time employees in May 2019, an average of about 30 hours each or 7.5 hours per week.

A. direct the employee to perform other work during those hours in which they were rostered; or
B. cancel the rostered shift.

(iii) Where clause 25.5(f)(ii)(A) applies, the employee will be paid the amount payable had the employee performed the cancelled service or the amount payable in respect of the work actually performed, whichever is the greater.

(iv) Where clause 25.5(f)(ii)(B) applies, the employer must either:
A. pay the employee the amount they would have received had the shift not been cancelled; or
B. subject to clause 25.5(f)(v), provide the employee with make up time in accordance with clause 25.5(f)(vi).

(v) The make up time arrangement cannot be utilised where the employee was notified of the cancelled shift after arriving at the relevant place of work to perform the shift. In these cases, clause 25.5(f)(iv)(B) applies.

(vi) Where the employer elects to provide make up time:
A. the make up time must be rostered in accordance with clause 25.5(a);
B. the make up time must be rostered to be performed within 3 months of the date of the cancelled shift;
C. the employer must consult with the employee in accordance with clause 8A regarding when the make up time is to be worked prior to rostering the make up time; and
D. the make up shift can include work with other clients or in other areas of the employer's business provided the employee has the skill and competence to perform the work.

33. The HSU opposes the proposed variation.

34. The HSU agrees with primary position of United Voice that there should be no cancellation provision in this Award. If there is to be a cancellation clause, it should be on strictly limited terms. The employers' submissions and draft variation concede, implicitly, the inequity of the current position of not paying workers for a shift that has been cancelled the evening before it is to be performed. That inequity is glaring in an award in which the certainty of days and hours of work of part-time workers has been said to compensate for the absence of an entitlement to overtime penalties within ordinary full time hours.

35. The employers have neither demonstrated:

    a) a proper basis on the evidence for the extension of cancellation provisions to the disability worker stream; nor

b) that its proposed variation would establish a fair safety net for workers.

36. As to the former issue, the position for employers has improved considerably with the changes to the NDIS cancellation rules effective 1 July 2019. These changes are articulated in the NDIS Price Guide 2019-20, p. 17 available from the NDIS website: https://www.ndis.gov.au/media/1455/download. In his further statement concerning the pricing mechanisms under the NDIS[14], Mark Farthing summarises the extensive pricing changes which took effect at the commencement of the present financial year. Those changes include both substantial increases to service rates compared to increases to wages over a comparable period as well as significant increases to loadings and the like.

37. Significantly, the rules around cancellation provide greatly expanded scope for services to recoup their costs in the event of cancellation. The updated cancellation rules provide for the following:

    a) a provider can charge an NDIS participant for a "short-notice" cancellation up to 90% of the fee associated with the scheduled activity/service. Such fee well exceeds the total labour costs of the service;
    b) a "short-notice" cancellation is defined as such if the participant:
        i. does not show up for a scheduled support within a reasonable time, or is not present at the agreed place and within a reasonable time when the provider is travelling to deliver the support (i.e. a "no-show"); or
        ii. has given less than 2 clear business days' notice for a support that meets both of the following conditions:
            - the support is less than 8 hours continuous duration; AND
            - the agreed total price for the support is less than $1,000; or
        iii. has given less than 5 clear business days' notice for any other support.
    c) There is no limit on the number of short notice cancellations (or no shows) that a provider can claim in respect of a participant.

38. The claims made by ABI regarding the operation of the cancellation provisions under the NDIS in paragraphs 5.12 and 5.13 of its submissions are incorrect.

39. The revised cancellation rules in the updated NDIS Price Guide provide a generous mechanism for service providers to recoup the costs of service cancellations.

[14] Statement of Mark Farthing, 16 September 2019

40. The suggestion by Mr Harvey[15], that the circumstances in which short notice cancellations may be claimed are "*very specific"* is obtuse and misleading. Rather than limiting the scope for such payment, the change to the provisions has greatly expanded the scope for such payment. The requirements now operate to ensure either 2 full business days' notice of cancellation or 90% payment (for most ordinary attendances) and 5 full business days' notice or 90% payment for appointments of greater length and cost. In those circumstances it is unclear how it may be posited[16] that client short notice cancellations give rise to hours that are unable to be billed. Rather, given the generosity of the notice required, it is likely employees may be deployed usefully or lucratively for the period of the cancelled service.

16 September 2019

[15] Statement of Scott Harvey, 2 July 2019 (**Harvey**) at [45]
[16] Harvey [47]

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FURTHER STATEMENT OF MARK FARTHING

1. I am employed as the National Campaigns and Projects Officer at the Health Services Union (**HSU)**. I have been employed in this position since September 2019.
2. I was previously employed as a Senior Policy Advisor for the Health Services Union (**HSU**) Victoria No. 2 Branch, also known as the Health and Community Services Union (**HACSU Victoria**) from March 2016 until September 2019.
3. I have substantial research experience in the health and community services sector, with particular expertise in disability services and the National Disability Insurance Scheme (NDIS), as well as more broadly in industrial and workforce research and policy.
4. Between 2013 to 2016 I was employed as the Senior National Project Officer in the Health Services Union National Office.
5. My work background is set out further in my previous witness statement dated 15 February 2019.

Overview of Changes to NDIS Price Guide

6. The National Disability Insurance Agency (NDIA) is responsible for setting price limits and policies relating to the delivery of NDIS-funded supports.
7. This function of the NDIA is achieved through the production of a document known as the “Price Guide”.
8. Price Guides typically operate for a full financial year (1 July to 30 June).
9. At least once per year, usually just prior to the end of the financial year, the NDIA revises the Price Guide to account for wage rises and general inflation. However, in some years more substantial variations to prices are implemented, either at that time or otherwise

because of Commonwealth Government policy decisions and/or at the behest of the NDIA Board.

10. In the 2019-20 Price Guide, which came into operation on 1 July 2019 and is in operation as at the time of the making this statement, significant changes were made to several price categories and policies. In summary these were:

    a. General price increases and significant above-inflation increases for therapists and attendant care and community participation supports. For example, the price for attendant care and community participation supports delivered during the daytime on a weekday to a standard needs participant was increased from the previous financial year by 9.78% (or 18.01% when the TTP Payment is taken into account). The rates were as follows:

       Assistance With Self-Care Activities – Standard – Weekday Daytime (Level 1) [01_011_0107_1_1]

       2018-19 = $48.14

       2019-20 = $52.85/$56.81 TTP

    b. The introduction of a Temporary Transformation Payment (TTP), which is a conditional loading calculated at 7.5% of Level 1 (standard needs) prices, but applicable in respect of Level 2 and Level 3 supports as well. The TTP will reduce each subsequent year by 1.5%. Providers can claim the higher TTP prices as long as they publish their service prices, list and keep up-to-date their business contact details in the NDIA's "Provider Finder" and participate in an annual NDIA-approved market benchmarking survey.

    c. A doubling of the remote and very remote loadings from 20% to 40%, and from 25% to 50%, respectively, of the price of the scheduled attendance. The rates for attendant care and community participation supports delivered during the daytime on a weekday to a standard needs participant are as follows:

       Assistance With Self-Care Activities – Standard – Weekday Daytime (Level 1) [01_011_0107_1_1]

       Metro = $52.85/$56.81 TTP

       Regional = $73.99/$79.53 TTP

       Rural = $79.28/$85.22 TTP

    d. Increases to the length of time that providers can claim for the time spent travelling to participants from 20 to 30 minutes within city areas, and from 45 to 60 minutes in regional areas.

e. Clearer rules around charging for non face-to-face time, with the NDIA stipulating that these activities are billable if they are part of delivering a disability support item to a participant such as writing a report about the participant's progress (rather than a general activity such as staff rostering).

f. A revised cancellation policy which abolishes the limit on the number of cancellations or "no shows" that be charged per year (see section below for more detail on client cancellation policy changes)

Response to AiG Submission

11. In paragraph 76 of its submissions dated 13 July 2019, the AiG suggests that the only increase applied in the 2019-20 Price Guide was the 4.5% increase relating to the Commission's Annual Wage Review decision and the operation of the Equal Remuneration Order. This overlooks the increases announced by the Commonwealth Government on 30 March 2019, the key elements of which I refer to in paragraph 10 above, and which were incorporated into the 2019-20 Price Guide in addition to the 4.5% increase.

12. In paragraph 77 of its submission the AiG suggests that *"the information published by the NDIA to date does not suggest that the assumptions underpinning the pricing arrangements have been changed or that any additional funding has been released to address broader concerns previously expressed by employers about the inadequacy of the funding to cover the various costs associated with providing the relevant services, including labour costs."*

13. While the NDIA has not released materials explicitly identifying the methodology underpinning price limits for supports in the 2019-20 Price Guide, it does not necessarily follow that prior published pricing methodologies and assumptions are still correct, for the reasons I set out below.

14. In section 5.3 of its submission, the AiG refers to the NDIA's "Reasonable Cost Model" (**RCM**) and the report published by the University of NSW in June 2017 titled *"Reasonable, necessary and valued: pricing disability services for quality support and decent jobs".* (**UNSW Report**)

15. The HSU along with the ASU and United Voice commissioned this report. I was intimately involved in working with the research team during the production of this report and was identified as such in the acknowledgements section prefacing the report, and am in a position to comment on the parameters of that research.

16. The UNSW report examined NDIS prices as they were in the NDIA's 2016-17 Price Guide, with the focus of analysis on the "base hourly rate" for standard needs, weekday, daytime support at $42.79 per hour, specifically the support item: *Assistance With Self-Care Activities - Standard - Weekday Daytime*

17. In the 2019-20 Price Guide the price limit for *Assistance With Self-Care Activities - Standard - Weekday Daytime* is $52.85 ($56.81 with the Temporary Transformation Payment (**TTP**) loading). This represents a 23.51% increase (32.76% with the TTP) compared with the 2016-17 price limit.

18. The 2016-17 rate for a SACS 2.3 worker was $24.70 per hour, whilst the current (2019-20) rate for the same worker is $28.44. This represents a 15.14% increase over the same period. These wage rates are inclusive of the ERO component.

19. The NDIS price item has increased at a rate which is substantially greater than the increase in wages for the average level disability support worker. The price limits in the 2019-20 Price Guide therefore do not reflect the assumptions that were contained in the NDIA's original RCM, which was the focus of the UNSW report.

20. The AiG's claim in Paragraph 151 that *"there is nothing to suggest that the fundamental problems identified in the UNSW Report with the RCM will be alleviated by the funding increases"* appears to disregard the fact that the price increases and additional payments set out above well and truly outstrip wage growth, provide some significant new bases of entitlement to payment and presupposes that the assumptions contained in the RCM are still built into the price structure.

21. The UNSW report also critiqued a number of NDIA policies contained within the 2016-17 Price Guide which have subsequently been addressed in the 2019-20 Price Guide. These include:

    a. Increasing the intensity loading for more complex participants, from two levels (standard and high-intensity) in 2016-17, to three levels Level 1 (standard), Level 2 (high intensity/complex) and Level 3 (higher intensity/more complex) supports in 2019-20;

    b. A doubling of the remote and very remote loadings from 20% to 40%, and from 25% to 50% respectively of the price of the scheduled attendance.

    c. Updates to the length of time that providers can claim for the time spent travelling to each participant to 30 minutes within city areas and 60 minutes in regional areas. This is an increase from 20 and 45 minutes, respectively.

d. Clearer rules around charging for non face-to-face time, with the NDIA stipulating that these activities are billable if they are part of delivering a disability support item to a participant such as writing a report about the participant's progress (rather than a general activity such as staff rostering).

e. A revised cancellation policy which abolishes the limit on the number of cancellations or "no shows" that be charged per year (see section below for more detail on client cancellation policy changes)

22. In summary, the AiG submission relies heavily on the UNSW report, which is predicated on an analysis of NDIS prices in the 2016-17 Price Guide. In light of the significant changes to both price limits and pricing policies contained in the 2019-20 Price Guide, much of the analysis in the UNSW report is no longer relevant.

Client Cancellation

23. The NDIA has significantly revised its cancellation rules in recent Price Guides.

24. In the 2015-16, 2016-17, 2017-18 Price Guides, the NDIA allowed providers to charge a participant the full amount of a scheduled personal care or community support up to 8 times per year when there was a short-notice cancellation or a "no show" by a participant. A short-notice cancellation was defined as such if the participant advised the provider after 3pm the day before the scheduled service.

25. In the 2018-19 Price Guide, the NDIA revised its cancellation rules which increased the number of times a provider could charge a participant for a short-notice cancellation or "no show" from 8 to 12 times per year, however, it reduced the amount that a provider could charge from 100% of the cost of the scheduled personal care or community support to 90%.

26. The 2018-19 Price Guide did not set 12 cancellations per year as a hard limit, instead specifying that "beyond this threshold, the NDIA will require the provider to demonstrate they are taking steps to actively manage cancellations."

27. In the 2019-20 Price Guide, which came into operation on 1 July 2019 and is in operation as at the time of the making this statement, the NDIA revised its cancellation rules again.

28. The revised cancellation rules provide for the following:

a. A provider can charge an NDIS participant for a "short-notice" cancellation up to 90% of the fee associated with the scheduled activity/service.

b. A "short-notice" cancellation is defined as such if the participant:

i. does not show up for a scheduled support within a reasonable time, or is not present at the agreed place and within a reasonable time when the provider is travelling to deliver the support (i.e. a "no-show"); or

ii. has given less than 2 clear business days' notice for a support that meets both of the following conditions:

- the support is less than 8 hours continuous duration; AND
- the agreed total price for the support is less than $1,000; or

iii. has given less than 5 clear business days' notice for any other support.

c. There is no limit on the number of short notice cancellations (or no shows) that a provider can claim in respect of a participant.

29. By way of example, a participant who had booked 2-hours of standard-needs community access between 9am to 11am on a Thursday at a cost of $125.38 who cancelled any time after 9am on the Tuesday prior could be charged $112.84 by their provider. Whereas a participant who had booked a full-day stay at a respite facility on a Thursday to receive 1:1 supports at a cost of $1,546.39 who cancelled anytime after 9am Friday the prior week could be charged $1,391.75.

30. In summary, the 2019-20 Price Guide provides significantly more flexibility and certainty to providers by abolishing the limit on the number of cancellations that may be charged per year and extending the definition of a "short notice" cancellation from 3pm the day before the scheduled service to less than 2 clear business days before the scheduled support.

31. The claims made by ABI in paragraphs 5.12 and 5.13 are therefore no longer correct in light of the 2019-20 Price Guide.

32. The revised cancellation rules in the 2019-20 Price Guide provide a significantly expanded capacity for service providers to recoup the costs of service cancellations.

Mark Farthing

16 September 2019

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SUPPLEMENTARY SUBMISSIONS IN REPLY OF HEALTH SERVICES UNION

OVERVIEW

1. These submissions in reply are made by the Health Services Union (**HSU**) in response to the claim, by Australian Business Lawyers and Advisors Pty Ltd (**ABL**) on behalf of Australian Business Industrial (**ABI**) the NSW Business Chamber (**NSWBC**), Aged & Community Services Australia (**ACSA**) and Leading Age Services Australia (**LASA**) (referred to herein as **the employers)** to insert a remote response work clause in the *Social, Community, Home Care and Disability Service Award* (**the Award**).

2. That claim is contained in the submission of ABL dated 2 July 2019 and its draft determination of 2 April 2019.

3. The Commission will recall that in its submissions of 15 February 2019 in support of its Draft Determination dated 15 February 2019, the HSU contended that remote work should be compensated by a one hour minimum payment at the overtime rate.

4. In its Reply submission dated 16 September 2019, the HSU deferred its response to the employers' claim and the ABL submissions in keeping with the understanding of the parties following the conciliation of the issue in August and September 2019. In that submission the HSU reserved its rights to respond to the employer claim.

REMOTE RESPONSE ALLOWANCE

5. The employers' claim implicitly concedes that the issue of employees working from home is one which is appropriate to be addressed in the current review, and should, in

accordance with the Modern Awards objective, be addressed by a variation to the Award. The HSU embraces that implicit concession. It contends that work performed remotely by employees after ordinary hours should be remunerated under the Award.

6. The difference between the parties does not appear to be one of principle, rather the principal differences between the parties are as to the scope of work to be covered by such a clause, and as to the approach to be taken in determining and regulating payment of the remuneration for such work.

7. The HSU notes that the employers' claim is the subject of submissions by the Australian Services Union (**ASU**) dated 23 September 2019. Those submissions contain a number of observations about the employer claim, with which observations the HSU broadly agrees, namely:

   a) At [3(a)], the ASU contends that the definition of "remote response duties" does not describe work in the SCHCDS Industry. The HSU adopted similar language in its draft variation of 15 February 2019. However, that description was an *inclusive* one. The HSU did not intend for that description to be an exhaustive one which performed the function of excluding from an entitlement to remuneration any other type of work required of employees outside of normal hours remote from their workplace, such as administrative work. Rather, the HSU's intention was to make clear that the types of work described were included as remunerated work in circumstances where such work is frequently required of employees outside ordinary hours, and performed, without remuneration;

   b) At 3(b), the ASU observes that the proposed variation would appear to entitle an employer to direct an employee to perform work outside of their ordinary hours contrary to the reasonable hours limitation in s.62 of the FW Act. The HSU shares that concern and contends that at the very least, the employers' proposed clause may be perceived to have that effect;

   c) At 3(c) and (d), the ASU notes the impact the employers' proposed clause would have on the current regulation of "on-call" work. The ASU's proposed variation deals with that issue by having a greater minimum payment for such work when required of an employee who is not "on call". The HSU agrees that such a distinction would create an incentive for more efficient management of the performance of work out of hours, and sets a fair and reasonable minimum standard for the performance of such work. Where an employee is not on-call and

thereby on notice as to the prospect of additional work out of hours, the disruption and disutility associated with a recall to perform work is likely to be greater.

8. As set out in the HSU's draft determination dated 15 February 2019, remote response work should be compensated at the overtime rate.

9. The HSU adopts the ASU Submissions at 3(f), (g) and (h), which address the operation of the employer's proposed clause, and the ASU's responses to the ABL Submissions at [5]. It endorses the principled approach to this issues set out at [7] of the ASU's Submissions.

Health Services Union

2 October 2019

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SUPPLEMENTARY SUBMISSIONS IN REPLY OF HEALTH SERVICES UNION

OVERVIEW

1. These submissions in reply are made by the Health Services Union (**HSU**) in response to:

   a) Reply Submission dated 12 July 2019 of Australian Business Lawyers and Advisors Pty Ltd (**ABL**) on behalf of Australian Business Industrial (**ABI**) the NSW Business Chamber (**NSWBC**), Aged & Community Services Australia (**ACSA**) and Leading Age Services Australia (**LASA**) (referred to herein as **the employers)** regarding the HSU's Claims (the outstanding matters identified in Attachment C to the directions issued on 13 May 2019) (**ABL Submission**);

   b) AIG Submission in Reply dated 13 July 2019 (**AIG Submission**);

   c) National Disability Services dated 12 July 2019 (**NDS Submission**);

   d) Business SA Submission in Reply dated 12 July 2019 (**Business SA Submission**);

   e) Australian Federation of Employers and Industries Submission dated 23 July 2019 (**AFEI Submission**);

   f) Reply Submission dated 13 September 2019 of **the employers** regarding the Unions' travel time claims (**ABL September Submission**);

g) Reply Submission dated 16 September 2019 of AIG regarding the Unions' travel time claims (**AIG September Submission**);

h) Reply Submission dated 16 September 2019 of NDS regarding the Unions' travel time claims (**NDS September Submission**);

i) Reply Submission dated 16 September 2019 of AFEI regarding the Unions' travel time claims (**AFEI September Submission**);

2. Save where something in the HSU's Submissions of 15 February 2019 is expressly disavowed, the HSU relies on its earlier submissions.

3. The HSU does not contest the FWC's *Legislative framework relevant to the Review* dated 12 April 2019, and adopts the analysis contained therein in these submissions.

The Social, Community, Home Care and Disability Services Industry

4. In Section 4 of the ABL Submission, ABL describes the "work arrangements" covered by the Award as falling into two categories: work that is stable, consistent and certain, and work that is *dynamic, variable and difficult to predict* due to client driven factors that cause the working arrangements to be subject to regular change.

5. The HSU does not accept the ABL's characterisation.

6. It is true that some of the work performed under the Award is work that may be performed at a single location and at regular times. It is also true that the services provided to clients by disability and home care workers are likely to be required at a range of locations over the course of any day or week, and that the timing and nature of that work required to be performed by an employer will be significantly determined by client demand.

7. However, it does not follow for those reasons that the *working arrangements* need be subject to regular change. Nor is it the case that employers are lacking in any power or means to manage the timing and the performance of the work they require in a way that makes sensible and efficient use of the time of employees. The evidence and submissions of ABL in this regard display a disturbing passivity in that regard.

8. At 4.13, ABL contends that *the nature of this work is also often characterised by short segments of work.* The HSU does not accept that description. The evidence shows that in order to deliver any service, a home care or disability worker will initially be required

to travel some distance in order to attend upon the client. They must then either travel on to the next appointment, or return from the appointment. All such travel is carried out for the purpose of performance of the employer's work and should be regarded and remunerated as such, as is the case for employees in other industries. Further, the period between directly "productive" tasks is also work, as in any other industry where a worker stands in readiness for the next task. It wouldn't be suggested that a retail worker should only be paid for the moments when they are receiving money from customers. ABL's contention seeks to redefine "work" as only that time when the worker is in direct contact with the client. Given the funding provided under the NDIS for travel, its definition doesn't even extend to the entire period during which the worker is generating income for the employer. When the direct client contact time, and associated travel and waiting time is considered, it is clear that the periods of work performed by employees are considerable, and easily sufficient to meet a minimum engagement.

9. The circumstances of home care and disability workers are at the centre of the present proceeding. The evidence from workers in the industry, and from experts whose reports have been filed by the unions, shows an expanding and underemployed workforce, rarely earning any more than Award minima, spending hours criss-crossing the catchment areas of their employer organisation to perform services for clients without being fairly compensated for the entire time they are required to devote to the performance of the work of their employers. The HSU's claims in respect of minimum engagement, broken shifts and travel allowance are, taken together, directed to avoiding the unfairness and exploitation which are made possible by the provisions of the Award as they currently stand.

10. So far as ABL points to the prices that employers may charge for such services being fixed by Government, the HSU relies on the *Further Statement of Mark Farthing* dated 16 September 2019 which details the recent significant increases to the prices which may be charged by organisations for NDIS funded services. Those price increases were effected in a 30 March 2019 announcement, and in the changes in the NDIA 2019 – 2020 Price Guide, and significantly outpaced wage increases.

11. So far as ABL points to the *significant financial pressure* on employers in the industry at 4.18, it does not substantiate that assertion in the evidence it has filed. The Commission could not make the finding urged on it at 4.19(f) of the ABL submission based on the evidence before it.

12. NDS also makes some observations about the nature of the industry. At [29] of its Submission, NDS refers to the personal preferences of clients regarding reallocation of their workers.

13. The FWC should not proceed in its consideration of this matter on the basis that in the utilisation of services under the NDIS clients have, at every point in their relationship with an organisation, an entitlement to be afforded their first preference as to the service they receive. The reality that preferred workers will have days off sick, or on leave is one with which clients are, not unreasonably, required to grapple. The vast bulk of appointments carried out by any organisation are carried out as scheduled; cancellations represent a small proportion of those appointments. It is not unreasonable for clients to have to deal with the occasional frustration of not having their preferred provider if a cancellation gives rise to a need to reshuffle workers.

14. The assertion at [37] of the NDS Submission as to the enhanced negotiating power of the individual client is unsupported by any evidence of client flight, or any evidence of organisations attempting to negotiate arrangements in a way that protects the interests of their workers.

15. In its Submission at page 33 and following, AIG deals with the NDIS, and the funding arrangements associated with that scheme. The HSU relies on the analysis contained in the *Further Statement of Mark Farthing* dated 16 September 2019 in respect of those funding arrangements.

ABL Submission - Section 5 – Summary of ABL Position

16. The ABL contends, at 5.2, that if the unions' claims are granted there will be a *significant deleterious impact on the viability of most businesses in the sector.*

17. That assertion is unsupported by cogent and reliable evidence. There is not a proper basis to urge such a finding on the Commission.

18. If made, the variations sought by the HSU will create an incentive for employers to review their approach to the rostering and scheduling of their services and their workers. The financial impact of the changes will depend, in any case, on the extent to which those the employer deploys management strategies to meet them.

19. The suggestion that the changes sought by the unions *would likely have a material adverse impact on the businesses' ability to deliver services to vulnerable members of the community* is unsupported by any evidence as to the financial position of the

organisations, from clients in receipt of services, or any cogent evidence as to the impossibility of managing work to meet the proposed changes. The Commission would reject this hyperbole.

20. So far as the ABL sets out its position at 5.9 and following, the HSU notes ABL implicitly concedes the necessity for minimum engagements for part-time employees at 5.9 and 5.10.

Minimum Engagements

21. Both AIG and ABL refer to the decision in the *Casual and Part-Time Employment Decision*[1]. Although it rejected the ACTU's universal claim in that case, the Full Bench made this observation about the purpose of minimum engagement periods, which is particularly apposite in the current matter (at [399]):

> *Minimum engagement periods in awards have developed in an ad hoc fashion rather than having any clear founding in a set of general principles. However their fundamental rationale has essentially been to ensure that the employee receives a sufficient amount of work, and income, for each attendance at the workplace to justify the expense and inconvenience associated with that attendance by way of transport time and cost, work clothing expenses, childcare expenses and the like. An employment arrangement may become exploitative if the income provided for the employee's labour is, because of very short engagement periods, rendered negligible by the time and cost required to attend the employment. Minimum engagement periods are also important in respect of the incentives for persons to enter the labour market to take advantage of casual and part-time employment opportunities (and thus engage the consideration in para (c) of the modern awards objective in s 134).*

22. The Full Bench set out evidence before it concerning work in the disability sector. In the case of Ms Potoi, the work involved the performance of a one and a half hour shift which involved the same amount of time again spent on travel, and in the case of Mr Quinn, the working of shifts between half an hour in length and 4 hours in length. The Full Bench characterised that evidence as showing the working of short shifts in the disability sector in a manner which *verged on being exploitative*[2].

23. The HSU has obtained, and filed in the present matter, the Witness Statement of Mr Scott Quinn which was admitted into evidence in those earlier proceedings. It has also obtained a Supplementary statement from him which updates his earlier statement.

[1] (2017) 269 IR 125
[2] At p 312 [406]

24. The observations of the Full Bench invite a consideration of the time and cost expended by employees for the performance of any particular shift of work, in order to weigh whether the income is rendered negligible. In the HSU's submission, to undertake that weighing process in the case of disability services and home care workers requires consideration of (at least) the following matters:

    a) the length of "shifts" offered;

    b) the capacity of employers to break shifts;

    c) the time and cost expended in travelling to attend shifts;

    d) whether such time and cost are remunerated and reimbursed;

    e) the "dead time" lost by employees as a consequence of broken shifts.

25. To the extent it is suggested, at 6.28 of the ABL Submission, that the Full Bench is bound by the conclusions reached by the Full Bench when the Award was made, that submission misstates the task now required of the Commission. The establishment of the 4 Yearly Reviews contemplated that the making of the Modern Award in 2010 was a starting point, rather than an end point.

26. The HSU also relies upon, in support of this claim, the evidence in the Statement of Steven Miller dated 28 June 2019. Mr Miller's statement, at [25] and following shows the peaks and troughs of demand for services during the course of weekdays and weekends, with identifiable and extended periods of consistent demand. The task of arranging work and shifts of a reasonable minimum length in those circumstances should not be beyond employers in this industry. The observation at [53] in the Statement of David Moody dated 12 July 2019[3], that NDIS participants receiving assistance with daily living require assistance of 2-3 hours, provides a basis for optimism that a 3 hr minimum engagement may be readily accommodated by employers.

27. The HSU notes the concession by ABL, at 6.43, that it is commonplace in the industry that employees are rostered to perform very short shifts. It rejects the contention thereafter, that such approach is the inevitable consequence of the nature of the services offered by employers.

[3] Filed by National Disability Services

28. The ABL's contention, at 6.45, that it is particularly challenging in regional, rural and remote areas to effectively *bundle* a number of engagements to produce a shift of sufficient length betrays an underlying assumption that the extensive travel to, from, and between such appointments is not regarded as forming a part of a worker's shift. Contrary to the ABL's submission, it is the fact that the performance of each shift of work involves such travel that makes a fair minimum engagement necessary.

29. At clause 6.48, ABL contends for a one-hour minimum engagement for home care employees. The HSU submits such a minimum engagement is exploitative, in keeping with the comments of the Full Bench in the Casuals and Part-Time Case. This is particularly the case where the Award would enable an employer to break a single hour shift. The two hour minimum engagements ABL otherwise contends for barely rise above the level of the verging on exploitative shift of Ms Potoi considered by the Full Bench.

30. Business SA appears to concede that there is a proper and principled basis for the introduction of a minimum engagement clause for part-time workers ([34]).

31. As with the ABL's submissions, the Business SA contention that the industry is one which of necessity requires short shifts (at [37]ff) is based on an assumption that travel to and from client appointments and waiting time between appointments is not work. Those assumptions are wrong as a matter of principle, and encourage an exploitative model of employment.

32. As to [47] of the Business SA Submission, the HSU repeats the observations it has made above about the significant increases to NDIS funding in 2019.

33. At [69] of its submission, AFEI bemoans the prospect of employer liability to pay for *"hours"* in which *no productive work is being performed.* As set out above, this submission is based on a fundamental misunderstanding or mischaracterisation of the nature of "work". Entitlement to wages is not conditioned on being "productive". Many types of employment involve workers having differing levels and periods of productivity over the course of a period of engagement. The submissions of the employer in this respect seek simply to define themselves out of the obligation to pay wages whilst having workers ready and available to perform the work they require.

34. At [113] AFEI repeats submissions it made in the Award Modernisation process. That submission referred to a single hypothetical example in a small community. The FWC would not centre that scenario in its approach to dealing with the matter before it. As

set out elsewhere herein, the evidence about peaks of demand at the start and end of the day make it apparent the HSU's claim for minimum engagements in each part of the broken shift one which is able to be accommodated.

35. To the extent the AFEI submission refers to the increased costs to providers as a consequence of allowing the union claims, that submission:

    a) does not appear to acknowledge the significant NDIS Price Guide increases in 2019-2020; and

    b) fails to credit employers with the capacity to adapt to changes in work conditions by reviewing their approaches to rostering and scheduling of appointments.

36. The issue of minimum engagements was considered by the Full Bench in the *Aged Care Decision* [2019] FWCFB 5078.

37. In that decision, the Full Bench said:

> *[182] In considering the merits of the claim, it is useful to look first at the rationale for minimum engagement provisions in modern awards.*
>
> *[183] The question of minimum engagement terms did not receive any systematic consideration during the award modernisation process which led to the current modern awards and largely preserved the predominant provisions concerning minimum engagements contained in pre-reform awards. As explained by the Full Bench in Re Victorian Employers' Chamber of Commerce and Industry:*
>
> > *'The Award Modernisation Full Bench of the Australian Industrial Relations Commission (AIRC) did not address the question of minimum engagements in any of its decisions and statements made in connection with the award modernisation process. This is because minimum engagements did not emerge as a significant issue during that process. Minimum periods of engagement have been a common feature of State and Federal awards for a very long period. The rationale for minimum periods of engagement is one of protecting employees from unfair prejudice or exploitation. Given the time and monetary cost typically involved in an employee getting to and from work, it has long been recognised that employees, especially casual employees, can be significantly prejudiced if a shift is truncated by the employer on short notice (as would otherwise be lawful in a typical casual engagement) or the employee can be pressured into accepting unviable short shifts in order to*

retain access to longer shifts. The inclusion of a minimum engagement period in a modern award invariably reflected the fact that such provisions were to be found in a sufficient proportion of the pre-reform awards and NAPSAs that are operated within the coverage of the modern award.' (emphasis added)

[184] Similar observations were made by the Full Bench in the Metals Casual Decision.

> *'the minimum income from a casual engagement determines whether or not people who rely on social security or who have children will accept the job. Travel costs, child care expenses erode savagely any earnings. Any reduction in the expected length of a daily engagement has a severe impact on an already disadvantaged employee, and most heavily so for intermittent casual workers. The difficulties in balancing the requirements of the social welfare Newstart program with an offer of casual work are often too great to make the job worth the extra trouble'*

[185] The Full Bench in the Casuals and Part-time Employment Decision, 137 observed that the rationale for minimum engagement periods in modern awards was as follows:

> *'to ensure that the employee receives a sufficient amount of work, and income, for each attendance at the workplace to justify the expense and inconvenience associated with that attendance by way of transport time and cost, work clothing expenses, childcare expenses and the like. An employment arrangement may become exploitative if the income provided for the employee's labour is, because of very short engagement periods, rendered negligible by the time and cost required to attend the employment. Minimum engagement periods are also important in respect of the incentives for persons to enter the labour market to take advantage of casual and part-time employment opportunities (and thus engage the consideration in paragraph (c) of the modern awards objective in s.134.' 138*

[186] The short point to be extracted from the decisions referred to is that minimum periods of engagement protect employees from exploitation by ensuring that they receive a minimum payment for each attendance at their workplace in order to justify the cost and inconvenience of each such attendance.

[187] The interpretation of clause 22.8 advanced by ABI and AFEI would allow a casual or part-time employee to be engaged to perform work on two or more occasions in a day and an engagement may be for less than an hour. Indeed there would be no minimum duration for an individual engagement provided the sum of the engagements (or broken shifts) on a particular day exceed 2 hours in total. It seems to us that such an outcome is antithetical to the purpose of a minimum engagement term, such as clause 22.7 in the Aged Care Award.

[188] We note that ABI (and AFEI) point to a number of what are said to be 'safeguards' in relation to the use of broken shift, namely:

> *1. Broken shifts can only be worked by casual and permanent part-time employees.*
>
> *2. A broken shift can only be worked where the employee agrees to work the broken shift.*
>
> *3. The breaks within a broken shift cannot total more than four hours.*
>
> *4. The span of hours of a broken shift cannot exceed 12 hours.*
>
> *5. Part-time employees have the certainty of their pattern of work having been agreed in advance (in writing), including the number of hours to be worked each week, the days of the week to be worked, and the starting and finishing times of each day.*
>
> *6. The existing minimum engagement provisions ensure that employees receive a minimum payment of two hours' pay when working a broken shift.*

[189] We are not persuaded these 'safeguards' are adequate and nor do we consider that in its current form, clause 22.8 is a fair and relevant safety net term. The fact that broken shifts can only be worked by 'mutual agreement' does not provide sufficient protection, particularly for casual employees.

[190] It is relevant to note that the Full Bench in the 2017 Casual and Part-time Employment decision considered (and rejected) an Ai Group proposal to vary the Fast Food Industry Award 2010 to allow an employer and a casual employee to agree on an engagement of less than the 3 hour minimum provided in clause 13.4 of that award. In rejecting the claim the Full Bench said:

> *'The actual award variation advanced by the Ai Group may be criticised in the same way as the NRA proposal was criticised by Vice President Watson in his 2010 decision – namely that it "does not address the balance that is required with award provisions of this type to provide reasonable safeguards for employees against unfair engagement practices". The general concept of casual employees agreeing to reduced minimum engagement periods is itself problematic, since the continued engagement of casuals at all is dependent upon them agreeing to the terms of each engagement (subject only to any applicable award obligations binding on the employer). Ai Group's proposed provision does not require any minimum engagement period to be agreed in substitution for the standard 3 hour period at all, meaning that it would facilitate the complete removal of minimum engagement periods and thus open the door to the exploitation of casual employees.'*

[191] Later in that decision, the Full Bench rejected the proposition that provisions which allow employees, voluntarily and at their initiative, to work additional hours at ordinary rates would represent a tangible benefit for employees, noting that:

> *'Where a casual is engaged on a daily basis, the employer has the capacity under any facilitative provision, to dictate the terms of engagement, so that any employee who did not volunteer in writing to work additional hours at ordinary time rates would not be engaged.' 141*

[192] Further, in the Modern Awards Review 2012 – Award Flexibility Decision the Full Bench rejected applications which sought to include minimum engagement periods within the scope of the model flexibility term:

> *'We are not persuaded that it is appropriate to include 'minimum engagement periods' within the scope of the model flexibility term. As we have noted these provisions relate to minimum wages and for many employees are an important aspect of the modern award safety net. As Vice President Watson observed in Secondary School Students case:*
>
> > *"There is a long history of minimum engagement periods for part time and casual employees providing protection for employees from employer expectations of working short periods where the cost and inconvenience of attending the workplace outweighs the benefits received from the engagement."*

Any variation to minimum engagement periods in modern awards should only be by application to vary the relevant modern award or by enterprise agreement. This will ensure that the variation is subject to appropriate scrutiny. It is not appropriate to permit such variations by IFAs, which are effectively self-executing. In our view, the inclusion of such terms within the scope of the model flexibility term would not be consistent with the modern awards objective.'

[193] To the extent that clause 22.8 permits casual and part-time employees to be engaged (and paid for) for a portion of a broken shift which is less than 2 hours it does not provide a fair safety net.

[194] In relation to the s.134 considerations:

- *the 'needs of the low paid' (s.134(1)(a)) weighs in favour of the proposed variation;*

- *the variation of the clause in the manner proposed by the HSU would not 'encourage collective bargaining', it follows that the consideration in s.134(1)(b) does not provide any support for the variation;*

- *as to ss.134(1)(d) and (f), we accept that the variation proposed by the HSU may have an adverse effect on business – it is likely to increase costs and reduce flexibility. But the extent of the adverse impact is not likely to be substantial as the material before us suggests that split shifts are relatively uncommon and the incidence of such shifts has declined over time; and*

- *the consideration in s.134(1)(da)(e)(g) and (h) are not relevant.*

[195] The modern awards objective is to 'ensure that modern awards, together with the NES, provide a fair and relevant minimum safety net of terms and conditions', taking into account the particular considerations identified in paragraphs 134(1)(a)–(h). We have taken into account those considerations, insofar as they are relevant to the matter before us, and have decided to vary the Aged Care Award in the manner proposed by the HSU.

Broken Shifts

38. The issues of broken shifts, minimum engagements and travel provisions are interconnected. As set out by the HSU here and elsewhere, the existing provisions are

ripe for exploitation, and many workers have experienced periods between client interaction treated as breaks between their shifts. This approach is enabled where there is no minimum engagement, and no limit on the number of breaks in a shift. It is particularly egregious where it affects employees who work on a part-time basis.

39. The claim by ABL, at 7.26, of a need to have employees *work a broken pattern of work across the course of a day to meet customer needs* is in essence a demand to have employees in harness for an extended day, being paid for but small parts of that day. Nothing in the ABL submission acknowledges the disutility resulting from that approach to rostering.

40. The HSU accepts that it is appropriate in this industry for full-time workers to work broken shifts by agreement. It accepts that its draft variation dated 15 February 2019 inadvertently excludes that possibility.

41. The HSU maintains, however, that part-time disability and home care workers should have no more than one break to their shift.

Travel Time and Travel Allowance

42. The HSU rejects the employers' view that the Award currently does and should permit that '*employees are not entitled to any payment in respect of the non-work time which falls between the portions of work-time in a broken shift*'.[4]

43. As we have stated above, the HSU rejects the assumptions inherent in the submissions of the employer parties that travel to, from and between client appointments, and that time between appointments is not work.

44. The HSU has read the submissions of United Voice (**UV**) of 3 October 2019, and adopts its response to the employer replies to the union parties' travel time claims.[5] The UV submission clearly sets out the inequities associated with treating travel as an allowance rather than as time worked.

45. A further inequity arising from dealing with travel purely as an allowance is the fact that such time does not count for the purpose of calculating the entitlement to overtime payment. The nature of work in the industry means that employees can, over a span of

[4] ABL September Submissions, [4.10]-[4.12], and [8.2]-[8.25].
[5] United Voice Further Submission in Reply dated 3 October 2019, [6]-[19].

many hours druring the course of a day, spend many hours devoted to the performance of the employer's work: travelling, attending appointments and waiting.[6]

46. If travel between clients were to be considered an allowance rather than time-worked, employees working long days with multiple clients would rarely be entitled to overtime, save for when working beyond the 12 hour span for a broken shift, notwithstanding that they devote many hours to the employer's business.

47. Finally, we note that AIG has criticised the 'workability' of the HSU's and other unions claims at paragraphs [49] to [66] of their September Submissions, but have filed no evidence in support of their arguments and have never identified in these proceedings which clients in the industry they in fact represent. AIG's failure to comprehend how 'reasonable travel time' might be assessed displays either disingenuousness or a lack of engagement in and knowledge of the sector. Employers must have some idea of the time it takes to travel between clients, else they could not roster their workers. Employers, just like everyone else with internet access, know how to use Google Maps.[7]

Telephone Allowance

48. The HSU's claim in this regard was conditioned upon an employee being required by their employer to use a mobile phone for work purposes.

49. In that event, it is difficult to see how it can be asserted that the employer should not bear the costs associated with such usage.

50. Business SA appears to concede the prima facie entitlement to recompense for telephone costs incurred for the purpose of work.

Overtime for Part-Time Employees

51. At [41], AFEI appear to contest the HSU Submission that the Award creates a structural incentive to underestimate the work required of part-time employees.

52. The HSU's submission to that effect is supported by the evidence of employer organisations filed on behalf of ABL. Several of those witnesses averred, in terms which are strikingly similar, as to the frequency with which part-time employees are offered work additional to their contracted hours.

[6] Supplementary Statement of Scott Quinn, dated 3 October 2019, [24]-[26], [30], Annexure A.
[7] See, eg, Quinn [10], [14]-[20].

Cancellation

53. At [29] of its Submission, NDS refers to the personal preferences of clients regarding reallocation of their workers.

54. The HSU opposes the extension of cancellation arrangements to disability workers. There is no warrant at all for any diminution of the conditions of this workforce.

55. As to [33] of the NDS Submission, it is significant that NDS does not identify the number or proportion of cancellations that occur between 2 and 7 days out from an appointment. In any event, it must be conceded that with such an amount of notice, the capacity of an employer to rearrange workers and schedules is significantly greater than cancellations with lesser notice.

Health Services Union

3 October 2019

Fair Work Commission
Four Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award
Matter No: AM2014/285 and AM2018/26

STATEMENT OF DR. FIONA MACDONALD

1. I am a Senior Research Fellow and an Australian Research Council DECRA (Discovery Early Career Research Award) Fellow in the School of Management, RMIT University.
2. I have worked as a researcher in academic, government and non-government roles since 1994. My research work over this period has largely centred on the changing nature of employment and the role of work in people's lives. A copy of my Curriculum Vitae is **attached as FM-1** to this statement.
3. Since 2014, when I commenced at the School of Management at RMIT University, my research has focussed on the work and employment arrangements of frontline disability support workers under the National Disability Insurance Scheme.
4. Since 2016 this research has been supported by an Australia Research Council grant.
5. I employ a range of qualitative and quantitative methodologies in my research including in-depth interviews, labour market and organisational case studies, and socio-legal analysis.
6. I am a member of the Executive Committee of the Association of Industrial Relations Academics of Australia & New Zealand, the ILO Regulating for Decent Work network and the International Carework network. I am a member of the editorial advisory board of the International Journal of Care and Caring.
7. **Attached as FM-2** to this statement is an article I co-authored, titled 'Wage theft, underpayment and unpaid work in marketised social care,' which was published in 2018 in *The Economic and Labour Relations Review*. The article reports on the findings of a recent research project undertaken by me and two colleagues about the paid and unpaid work time of disability support workers.

[redacted]

Dr Fiona Macdonald

15 February 2019

FM-1

Fiona Macdonald

My professional experience as a researcher commenced over 20 years ago and my research over this period has largely centred on the changing nature of employment and the role of work in people's lives. Since 2014 my research has focussed on work and employment arrangements of frontline disability support workers under the National Disability Insurance Scheme. Since 2016 this research has been supported by an Australia Research Council grant. I employ a range of qualitative and quantitative methodologies in my research including in-depth interviews, labour market and organisational case studies, and socio-legal analysis. I am a member of the Executive Committee of the Association of Industrial Relations Academics of Australia & New Zealand, the ILO Regulating for Decent Work network and the International Carework network. I am a member of the editorial advisory board of the International Journal of Care and Caring.

Qualifications

2012	PhD (Political Science), University of Queensland
2001	Master of Social Science (Social Policy), (awarded with distinction) RMIT University.
1991	Graduate Diploma in Counselling Psychology, RMIT University
1982	Bachelor of Behavioural Science (Psychology), Latrobe University.

Employment

2016-	*Senior Research Fellow & ARC DECRA Fellow,* School of Management, RMIT University
2015-2016	*Vice-Chancellor's Senior Research Fellow,* School of Management, RMIT University (four year appointment, deferred in July 2016 to take up ARC DECRA Fellowship.
2014-2015	*Research Fellow,* (project position) School of Management, RMIT University.
2012-2014	*Research Fellow, Gender Equality and Decent Work* (project position), Centre for Work + Life, University of South Australia.
2009-2012	*Panel Member*, Victorian State Services Authority Panel of Grievance Review and Workplace Investigations Officers and *Independent Chair*, Victorian Public Service Tripartite Work Review Panels (self-employed consultancy roles).
2007-2012	*Self-employed research consultant*
2007	*Research Associate (project contracts)*, School of Political Science, University of Queensland; Centre for Applied Social Research, RMIT University; and Centre for Citizenship and Human Rights, Deakin University.
2005-2006	*Senior Researcher and Organisational Consultant*, URCOT, Melbourne.
2001-2004	*Executive Director, Equity Research Centre Inc.* industry advisory body to Victorian Government on equity and diversity in vocational education and training.
1994-2001	*Research and Policy Projects Manager* (from 1998) and Officer, Future of Work Research Project, Social Action and Research Division, Brotherhood of St Laurence, Melbourne.
1987-1994	*Vocational counsellor* and sessional lecturer, Social Science, RMIT; secondments to Industry Liaison Officer, TAFE Industry Research Unit, and Research Officer, Equal Opportunity Unit.

Awards

2018	Research Excellence Award, School of Management, RMIT University
2017	Vice-Chancellor's Award for Research Impact – Early Career Researcher Award, RMIT University
2016	Early Career Researcher Research Excellence Award, College of Business, RMIT University

2015 2016-2019 Australian Research Council Discovery Early Career Researcher Award

2008 Vic Taylor Award for Best Paper awarded by the Association of Industrial Relations Academics of Australia and New Zealand (AIRAANZ) for Charlesworth, S and Macdonald, F. 'The Unpaid Parental Leave Standard: What Standard?' 21st Conference of AIRAANZ, Melbourne, 6-8 February.

Recent funded research

2018 'Where Secure Employment meets Client Needs' Workforce Innovation Project for Greenacres Disability Services. Role: Sole researcher.

2018 *Disability Skills Portfolio Project,* for National Disability Services. With Assoc. Prof. Darryn Snell and Assoc. Prof. Victor Gekara, RMIT. Role: Joint Chief Investigator.

2017 *Scoping review on informal care, social protection and gender: policy implications for countries in the WHO Western Pacific Region, particularly in relation to low to middle income countries*, World Health Organisation Western Pacific Region.
Role: Lead Chief Investigator.

2017 *NDIS Workforce research,* Health and Community Services Union, United Voice and Australian Services Union. With Natasha Cortis (UNSW), Bob Davidson (Macquarie University) Role: Joint Chief Investigator.

2016 *Discovery Early Career Researcher Award,* Australian Research Council. 'Workforce challenges under cash-for-care models: Regulating for quality jobs in flexible care systems, Australia's NDIS in comparative perspective. Sole chief Investigator. (3 years).

2012 *Economic Abuse Research Project,* Good Shepherd Youth & Family Services and Kildonan UnitingCare. Role: Sole Chief Investigator.

Publications

Refereed journal articles

2018 Delaney, A, and **Macdonald, F** 'Thinking about informality: gender (in) equality (in) decent work across geographic and economic boundaries' *Labour & Industry* 28(2): 99-114. doi:10.1080/10301763.2018.1475024

2018 **Macdonald, F** and Charlesworth, S 'Failing to live up to the promise: the politics of equal pay in 'new' workplace and industrial relations institutions' Australian journal of Political Science, accepted 16 June 2018, doi: 10.1080/10361146.2018.1502256.

2018 Byrne, L, Roennfeldt, H O'Shea, P and **Macdonald, F** 'Taking a gamble for high rewards? Management perspectives on the value of mental health peer workers *International Journal of Environmental Research and Public Health* 15(4), 746-758. doi:10.3390/ijerph15040746.

2018 **Macdonald, F**, Bentham, E and Malone, J 'Wage theft, underpayment and unpaid work in marketised social care' *The Economic and Labour Relations Review*, 29(1): 80-96.

2016 **Macdonald, F** and Charlesworth, S 'Cash for care under the NDIS: Shaping care workers' working conditions? *Journal of Industrial Relations*, 58(5): 627-646.

2015 Charlesworth, S and **Macdonald, F** 'The Decent Work Agenda and the advancement of gender equality: For emerging economies only?' *International Journal of Comparative Labour Law and Industrial Relations*, 31(1): 5-26.

2015 Charlesworth, S and **Macdonald, F** 'Women, work and industrial relations in Australia in 2014: The year in review', *Journal of Industrial Relations*, 57(3): 366-382.

2014 Charlesworth, S and **Macdonald, F** 'Australia's gender pay equity legislation: How new, how different, what prospects?' *Cambridge Journal of Economics*, 39(2): 421-440.

2014 Charlesworth, S and **Macdonald, F** 'Women, work and industrial relations in Australia 2013' *Journal of Industrial Relations* 56 (3): 382-397.

2013 **Macdonald, F** and Charlesworth, S 'Equal pay under the Fair Work Act 2009: mainstreamed or marginalised?' *UNSW Law Journal*, 36(2): 1-24.

2012 Bailey, J, **Macdonald, F** and Whitehouse, G 'No leg to stand on: the moral economy of Australian industrial relations changes' *Economic and Industrial Democracy*, 33(3): 441-461.

2008 Pocock, B, Elton, J, Preston, A, Charlesworth, S, **Macdonald, F**, Baird, M. Cooper, M and Ellem, B (2008) 'The impact of Work Choices on women in low paid employment in Australia: a qualitative analysis' *Journal of Industrial Relations*, 50 (3): 475-488.

Scholarly book chapters and monographs (peer reviewed)

Forthcoming

Campbell, I**, Macdonald, F** and Charlesworth, S 'On-demand work in Australia' in M O'Sullivan et al. (eds.) *Zero-Hours and On-Call Work in Anglo-Saxon Countries*, Berlin, Springer Press.

2018 **Macdonald, F**. Charlesworth, S and Brigden, C 'Low-paid workers and collective bargaining; the issues in B Creighton, A Forsyth and S McCrystal (eds) *Collective Bargaining under the Fair Work Act: Evaluating the Australian Experiment in Enterprise Bargaining*. Federation Press, Sydney.

2018 **Macdonald, F** and Pegg, M 'Contracting out public services, marketisation and wages' in Hardy, T, Stewart, A and Stanford, J (eds) *The Wages Crisis in Australia: What It Is and What to Do About It,* University of Adelaide Press, Adelaide.

2017 Charlesworth, S and **Macdonald, F** 'Employment regulation and worker-carers: Reproducing gender inequality in the domestic and market spheres?' Chapter 6 in D Peetz and G Murray (eds) *Women, Labor Segmentation and Regulation*, Routledge.

2001 **Macdonald, F** and Holm, S 'Employment for 25 to 34 year-olds in the flexible labour market: a generation excluded?' in L Hancock, B Howe, M Frere and A O'Donnell (eds.) Future Directions in Australian Social Policy: New Ways of Preventing Risk, Council for Economic Development of Australia (CEDA), Melbourne:16-24. ISBN 0 85801 254 5.

2000 **Macdonald, F** and Siemon, D 'Families, work and welfare', Chapter 10 in P Saunders (ed.) Reforming the Australian Welfare State, AIFS, Melbourne, pp. 206-223. ISBN 0 642 39474 1.

1999 McClelland, A and **Macdonald, F** 'Young adults and labour market disadvantage?' in Dusseldorp Skills Forum (DSF), Australia's Young Adults: The Deepening Divide, DSF, Sydney, 117-134. ISBN 0 958 529 329.

1999 Probert, B and **Macdonald, F** 'Young women: poles of experience in work and parenting', in Dusseldorp Skills Forum, Australia's Young Adults: The Deepening Divide, DSF, Sydney, 135-158.

1998 McClelland, A, **Macdonald, F** and MacDonald, H (1998) 'Young people and labour market disadvantage', in Dusseldorp Skills Forum, Australia's Youth: Reality and Risk, DSF, Sydney, 103-128, ISBN 0 958293 0-2.

Published commissioned research reports (from 2006)

2017 Cortis, N, **Macdonald, F**, Davidson, B and Bentham, E *Reasonable, Necessary and Valued: Pricing Disability Services for Quality Support and Decent Jobs*, SPRC UNSW, Sydney.

2008 Charlesworth, S and **Macdonald, F** *Hard Labour: Pregnancy, Discrimination and Workplace Rights*, Victorian Office of the Workplace Rights Advocate, Melbourne.

2007 Charlesworth, S and **Macdonald,** F *Going Too Far: WorkChoices and the Experiences of 30 Victorian Workers in Minimum Wage Sectors*, Industrial Relations Victoria, Melbourne.

2007 **Macdonald, F,** Whitehouse, G and Bailey, J *Tipping the Scales: A Qualitative Study of the Impact of Work Choices on women in low-paid employment in Queensland*, Department of Employment and Industrial Relations, Brisbane.

2007 Whitehouse, G, Haynes, M, **Macdonald, F** and Arts, D 'Re-assessing the "family-friendly workplace": Trends and influences 1998-2004', *Employment Relations Research Series* No. 76, Department of Business, Enterprise and Regulatory Reform, United Kingdom.

2006 **Macdonald, F** 'Best practice in employment services for disadvantaged jobseekers', URCOT, Melbourne (commissioned by the Australian Committee of Officials on Employment for the Ministerial Council on Employment, Education, Training and Youth Affairs).

Refereed conference papers

2008 Charlesworth, S and **Macdonald, F** 'The unpaid parental leave standard: What standard?' Refereed paper published in the *Proceedings of Workers, Corporations and Community: Facing Choices for a Sustainable Future*, 22nd Conference of The Association of Industrial Relations Academics of Australia and New Zealand, Melbourne, 6-8 February. **Awarded Vic Taylor prize for best paper.*

2008 **Macdonald, F** 'Dependent self-employment and some consequences of changing employment relationships in household services', Refereed paper in *Proceedings of the 26th International Labour Process Conference*, University College, Dublin, 18-20 March.

2007 **Macdonald, F** Entrepreneurs or precarious workers: what do we know about women's self-employment?' Refereed paper published in the *Proceedings of the Our Work Our Lives: Women and Industrial Relations Conference*, Adelaide, 20-21 September.

Professional leadership and community engagement

Professional leadership and engagement

International research partner, UK ESRC-funded international 'Sustainable Care: connecting people and systems' project (2017-2021), led by Prof Susan Yeandle, Professor of Sociology, and Director of CIRCLE (Centre for International Research on Care, Labour & Equalities), Sheffield University, England.

Member, Executive Committee, Association of Industrial Relations Academics of Australia and New Zealand (2017-).

Fellow, Future Social Service Institute, VCOSS & RMIT University (2017-present)

Member, Editorial Advisory Board, International Journal of Care and Caring (2016-present)

Graduate Member, Australian Institute of Company Directors (GAICD) (2016).

Research Collaborator, 'Gender, Migration and the Work of Care' International Research project led by Professor Ito Peng, Director, Centre for Global Social Policy, University of Toronto Canada (2013-present).

Member, Work &Family Policy Roundtable (W+FPR) comprising 30 researchers from 18 universities and research institutions to promote research to inform good evidence-based public policy in Australia.

Co-convenor, Gender Inequality Research Network (2016-present), RMIT University.

Research Theme Leader 'Working Lives: Uncertainties and Futures', Centre for People, Organisation and Work, College of Business, RMIT University (2016-present)

Member, School of Management Research Committee & Convenor, Grants Working party (2016-2017)

Community and industry leadership

2012-current	Member, Board of Directors, Brotherhood of St Laurence.
2006-2011	Member, Board of Directors and Chair, Services and Policy Sub-Committee (2008-2011), Wesley Mission Victoria.
2002-2004	Member, Board of Directors, AFL SportsReady Group Training Company.
2002-2004	Member, Community Advisory Panel on Equity and Diversity to the Secretary, Department of Education and Training, Victoria.
1999-2000	Member, Advisory Panel, Victorian Government Social Indicators Project.
1998–2004	Member, Board of Directors, Victorian Welfare Rights Unit.

Recent invited keynote and other addresses to industry

2018 Quality, marketised funding and the future of the community sector workforce: Panel Speaker, to Job Australia National Conference, Melbourne, 3-5 October.

2017 'The regulation, organisation and experience of disability support work in the NDIS, a qualitative study', invited presentation to the National Institute of Labour Studies, Flinders University, Adelaide, 12 September.

2016 'The impact of personalisation on the care sector workforce experience', Invited address to the Jobs Australia National Conference, Gold Coast, 18-20 October.

2015 'Women, work and family: policy and politics', Keynote address to the Australian Education Union National Women's Conference, South Melbourne, November.

ELRR

Article

Wage theft, underpayment and unpaid work in marketised social care

The Economic and Labour Relations Review
2018, Vol. 29(1) 80–96

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Abstract
Marketised models of social care provision in Australia are placing pressures on service providers and driving changes in work organisation and employer practices, with potential to degrade social care jobs. While international experience of marketised social care has demonstrated the vulnerability of social care workers to wage theft and other violations of employment laws, Australia's relatively strong industrial relations safety net might be expected to be better able to protect these low-paid workers. Nevertheless, there is emerging evidence of negative impacts on the pay and entitlements of frontline workers in the expanding community support and homecare workforce. This study investigates the paid and unpaid work time of disability support workers under Australia's new National Disability Insurance Scheme. The research takes a novel approach combining analysis of working day diaries and qualitative interviews with employees to expose how jobs are being fragmented and work is being organised into periods of paid and unpaid time, leaving employees paid below their minimum entitlement. The article highlights the role of social care policy along with inadequate employment regulation.

JEL Codes: J390, J81, J88

Keywords
Employment conditions, NDIS, social care, wage theft, working time

Introduction

This article reports on research investigating underpayment of wages of low-paid social care workers under Australia's new National Disability Insurance Scheme (NDIS). As a

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'cash-for-care' scheme, the NDIS individualises and marketises disability support and shifts the location of much care and support work from public organisational settings to more diverse settings, including private households, as well as introducing new demands for flexibility, for very short working hours and for travel between multiple work locations (Macdonald and Charlesworth, 2016). Similar pressures and arrangements in adult social care in the United Kingdom have seen social care workers become highly vulnerable to wages underpayment (Low Pay Commission, 2016).

This study explores working time arrangements and pay of disability support workers (DSWs) in the context of employment regulation and the new disability support arrangements. It addresses the following questions: what regulatory gaps contribute to any wages' underpayments and what roles (if any) do the design and management of the social care system (the NDIS) play in this?

Rubery et al. (2015) suggest a homecare worker's comment 'it's all about time' encapsulates 'the central importance of time in the management and employment arrangements in home care work' (p. 756). This phrase also encapsulates our findings that the tight control of time as a contested resource in disability support in the home and community underlies wage theft, underpayment and low pay. Underpayment of workers is made possible by various gaps in employment regulation, in addition to inadequate enforcement. While the regulatory deficiencies are not new, the changing industry structure under the new marketised social care arrangements may be exacerbating the issues.

Beginning with a short overview of the regulatory context for wages underpayment and minimum wage compliance in Australia, we then review relevant international literature on working time and wages in social care. We then outline the changing industry and regulatory context of disability support work in Australia. After outlining our method and framework for analysing paid and unpaid work, we present key findings from (1) analysis of disability support work 'working day' time diaries and (2) interviews with DSWs about their jobs and working time. We end with a reflection on the funding and regulatory frameworks that contribute to wages underpayment, and point to some possible responses.

Background

Wage theft, underpayment and employment regulation in Australia

Wage theft refers to the non-payment or underpayment of the full wages to which employees are legally entitled (Galvin, 2016: 325; Milkman et al., 2010; Vosko et al., 2017). Thus, wage theft is seen as arising from non-compliance with employment laws, and multiple types of wage theft reflect different kinds of violations. While violation of minimum wages regulation is the most 'blatant' type of wage theft (Wilson, 2011: 6), others include overtime violations, rest break violations, time 'off-the-clock' violations and illegal employer deductions (Milkman et al., 2010).

There has been little research into the extent of minimum wage non-compliance in Australia (Maconachie and Goodwin, 2010; Nelms et al., 2011). Historically, with wide workforce coverage, union recognition and union membership preference provisions, the centralised industrial arbitration system has been characterised by relative ease of

enforcement of standards, with trade unions playing a significant role (Johnstone et al., 2012: 27). In addition, a feature of the system has been a comparatively wide array of minimum employment standards contained in industry or occupation-based industrial awards including working time arrangements such as standard working times, minimum and maximum shifts, shift and overtime penalty payments, minimum call-back times and other rostering arrangements.

However, changes in the labour market and organisation of work and significant de-regulation and de-collectivisation of industrial relations (Quinlan and Sheldon, 2011) have seen more employment likely to be affected by 'gaps' in regulation. Unchecked non-compliance with employment laws resulting in wage theft can be seen as arising from a regulatory gap whereby evasion is made possible by limits in enforcement. Other forms of regulatory gaps have contributed to the growth of employment forms with inferior rights and benefits, including lower payment for comparable work, although there may not be any violation of employment laws. Taking the range of protections of terms and conditions for full-time permanent employees as a normative standard, regulatory gaps exist for most workers outside this form of employment. Different forms of regulatory gaps contribute to inferior employment. Special rules and exemptions in employment regulation establish some forms of employment with diminished conditions and benefits (e.g. casual employment), while limits in regulatory scope leave some workers, such as self-employed contractors, entirely outside all or most employment law (Pocock et al., 2004). An additional regulatory gap involves the absence of legal mechanisms for ascribing responsibility for pay and conditions to network lead organisations that, while not being the direct employer, control the way work is organised (Johnstone et al., 2012). All these types of regulatory gaps are relevant to the underpayment of social care workers' wages, including wage theft through non-compliance.

Employment regulation is one important element in the broader institutional context in which wage theft and underpayment occur. Other social institutions also have significant influence. In the next section, we review some of the international evidence relating to working time in social care. This review highlights that employer practices leading to underpayments (including wage theft) are also strongly shaped by gendered norms of unpaid care work and the design of public social care systems.

Social care work, working time and underpayment of wages

International comparative research has shown there are real differences in social care systems in developed economies in regard to outcomes for social care workers (Simonazzi, 2009). However, in general, workers are low-paid and have poor working conditions (Cristiano et al., 2016; Razavi and Staab, 2010). In the context of pressures to cut care costs, there is also convergence between care systems, to more home-based care, private provision and cash transfers for care recipients. From the developing international literature on working time and pay in social care we draw three insights especially relevant to our Australian study. First, analysis of the organisation of work shows work time has been excised from paid time, embedding unpaid time in home-based care work (Boivin, 2016; Hayes, 2017; McCann, 2016). Second, the gendered nature of care work and strong norms of unpaid time combine with employer strategies and worker resistance to contribute to

overwork and high levels of unpaid work (Baines et al., 2017; Hayes, 2017; Palmer and Eveline, 2012). Third, public authorities and funding bodies maintain significant control over the organisation of work and over care workers' pay and conditions, using time as the main control mechanism (Atkinson and Crozier, 2016; Boivin, 2016; Rubery et al., 2015).

Of particular relevance is the UK experience, as social care systems across Britain share many features with Australia's developing individualised and marketised disability support system (Macdonald and Charlesworth, 2016). Social care workers have been identified as at greater risk than other UK workers of not receiving the National Minimum Wage (NMW) (Low Pay Commission, 2016: xxvii), and it has been estimated that about half of social care companies have not met their minimum wage obligations (HM Revenue and Customs, 2013). Homecare workers – who provide care and support to frail aged and people with disability in private homes and the community – are particularly vulnerable to underpayment with one estimate that 60% of such workers are underpaid (Bessa et al., 2013: 27–28).

In particular, the social care workforce experience in England highlights how, by paying workers for only some of the time they work, 'nominal' wages may be above the statutory minimum wage but 'effective' wages can be much lower (Koehler, 2014: 5). In England, homecare workers have typically been paid only for contact time with care recipients and have not been paid for much of the work they perform, including the time they travel between private residences where they provide care (Hayes, 2017: 135–138; Rubery et al., 2015). This has been considered to be wage theft (Hayes, 2014) and recent legal challenges to the practice have strengthened regulation specifying that travel between work assignments must be paid (United Kingdom Government, 2017).

Similarly, until recently, homecare and DSWs in New Zealand were not paid for time spent travelling between 'clients', with Briar et al. (2014) arguing this brought the employees' hourly wages below the national minimum wage. Following a long-running campaign and a legal case pursued by the Public Service Association (PSA), a sector-wide arrangement for payment of travel time has now been introduced (New Zealand Parliament, 2015). In Europe, recent legal cases under the European Working Time Directive have also challenged the non-payment of homecare workers' time spent travelling between home visits (McCann, 2016).

Despite some ambiguity about travel as 'work' (McCann, 2016), much other unpaid overtime undertaken by social care workers is undoubtedly work (comprising face-to-face client care and support, administration and communication). Non-payment of work time is underpinned by unfair job design with extremely tight specification of time and tasks and no provision at all for some aspects or for any variability in the work (Hayes, 2017; Moore and Hayes, 2017: 103). In addition, work scheduling techniques that 'drain waged-time from the working day' and the devolution to workers of the risks of variable client demand result in fragmented, often varying and unpredictable work schedules: short periods of paid time (invariably face-to-face contact time with care recipients) are interspersed with other also fragmented, variable and unpredictable periods of unpaid 'non-work' time (McCann, 2016: 44–45; Rubery et al., 2015). So, workers have long work days for little recompense, contributing to low pay. Gaps of unpaid time in the day may not be work but neither are they available to the worker as personal time (Boivin, 2016: 301).

Non-payment of social care work is supported by the gendered legacy of care work as women's work (Hayes, 2017; Palmer and Eveline, 2012). With care work continuing to

be mainly performed unpaid by women in the family, it is often regarded as performed for altruistic reasons and as unskilled and not deserving of decent pay. These norms have a powerful role in social care, influencing employer strategies and also workers' preparedness to perform unpaid work. Furthermore, much social care work is performed in not-for-profit agencies that have long traditions and strong norms of volunteering that contribute to pressures on workers (Baines et al., 2017).

A final insight from the international literature concerns the role funding models and commissioning practices play in determining care workers' pay and conditions. The UK and Canadian studies have identified the use of time as a control mechanism by public funding and commissioning bodies (Atkinson and Crozier, 2016; Boivin, 2016; Rubery et al., 2015). These bodies have no direct responsibility for the employment of care workers but nevertheless determine many aspects of care provision, including the organisation of work. They tightly specify 'care quality' and work on the basis of time and tasks, leaving employers with little scope in relation to workforce strategy. They determine the duration and scheduling of work and, through tight hourly based funding, they also determine pay.

The multiple factors underpinning the underpayment of homecare workers, including marketised, poorly funded care systems which build on a gendered legacy of care work as non-work, are now more visible in the Australian context of disability support work.

Social care, the NDIS, working time and pay in Australia

The Australian care workforce is predominantly female and the work of frontline social care workers is low-paid (Martin and Healy, 2010). Some 70,000 people were employed in specialist disability support services before the NDIS (Martin and Healy, 2010: 109) and the effective full-time disability support workforce is predicted to more than double by 2019–2020 (Buckmaster and Dunkley, 2017). In 2017, this workforce comprised 43% permanent part-time, 41% casual and only 12% permanent full-time employees (National Disability Services (NDS), 2017: 4).

The gendered undervaluation of social care work is reflected in the historical development of working conditions standards for social care workers in Australia (Charlesworth, 2012). The growth of the paid workforce was accompanied by a long struggle for industrial recognition, and it was not until 1990s that most social care workers gained industrial award coverage, providing them with minimum wage rates and employment conditions that were already available to 'over 90% of the Australian workforce' (Briggs et al., 2007: 498). Recently, some recognition of the gendered undervaluation of care work has been achieved with the success of an equal pay case acknowledging this undervaluation (Macdonald and Charlesworth, 2013).

In comparison to the UK, employees in Australia might be expected to be protected by this country's much more comprehensive set of minimum standards for pay and conditions. However, as Charlesworth and Heron (2012) have argued – specifically drawing on the case of social care work – inferior conditions are established for 'non-standard' part-time and casual employees in both the statutory National Employment Standards and in industrial awards, and this regulatory gap has a gendered impact due to women's concentration in these forms of employment. These authors document a range of inferior working time standards for employees covered by the Social Community Home Care and Disability

Support (SCHADS) award compared to employees covered by the Manufacturing Award. Such regulatory gaps include the absence of minimum engagement periods for part-time employees and of provisions for notice of changes to rostered work time and silence on the question of pay for time spent travelling between work assignments (Charlesworth and Heron, 2012). Based on overseas experience, it could be expected that these regulatory gaps are now more significant to the working conditions of care workers under the NDIS than under previous block-funding contracts for disability services.

The publicly funded disability support system in Australia has undergone significant reform with a national system, the NDIS, replacing multiple piecemeal services provided by states and territories. Services are now allocated and funded on an individual basis and provided through the market. Traditional service providers are now competing with new providers, including private for profits. A national agency, the NDIS, manages the market, assessing eligibility, determining individual support packages, setting prices and funding supports. Funding for the personal support provided by DSWs is determined on the basis of an hourly price, varied in some circumstances. Recent study suggests this fee has been set too low to enable the minimum SCHADS Award conditions to be met for DSWs (Cortis et al., 2017). The study also found that the pricing model did not reflect existing employees' classification levels and provided inadequate allowance for training, workers' time not spent providing face-to-face support (3 minutes an hour), travel between clients (providers can include a 20-minute journey but without any adjustment for support to be provided), and supervision (both levels and workloads). These assessments are supported by findings of an employer survey in which two-thirds of respondents disagreed with the statement 'NDIS prices enable us to meet our industrial obligations' (Cortis and Blaxland, 2017: 3).

Here, we report on a qualitative case study of DSWs' paid and unpaid work time. Our findings shed light on the ways in which social care work may be organised under the various pressures and within the regulatory context outlined above and on some of the impacts this can have on employees and their pay.

Method

Qualitative research combined collection of data from 'working day' diaries and semi-structured interviews with DSWs employed under the new NDIS arrangements. The purpose of collecting diary data was to explore working time arrangements and any unpaid work associated with DSWs' jobs. Interviews explored employees' experiences and views of their jobs, working time arrangements and pay.

Participants were recruited through advertisements in newspapers and job websites and through snowballing. We interviewed 22 employees providing home and community-based support services to people with disability. This article reports on analyses of interviews and working day diaries for 10 DSWs: a total of 20 interviews and 30 self-completed diaries. The 10 women all provided support and care under the NDIS. They were employed by 10 different service providers: four for-profit, five not-for-profit and one government provider. All worked in the same region that was one of the first NDIS implementation sites. At the time of the fieldwork in late 2016, the NDIS had been in place in the region for 3 years. The other 12 participants who are not reported on in this article were not providing NDIS services.

The 10 DSWs cannot be seen as representative of all DSWs working under the NDIS. However, this study can provide valuable insights into some of the ways in which work

is being organised under the NDIS and impacts on employees. Despite the small sample size, our interviews were approaching saturation (Morse, 1995), with issues raised in interviews highly consistent across the 10 participants. While there was considerable dissimilarity in paid and unpaid work patterns recorded in diaries, common issues and themes emerged from all 10 workers' diaries. The issues are also similar to those identified in recent surveys of DSWs and providers examining NDIS workforce issues (Cortis et al., 2017; NDS, 2016). Nevertheless, the data we present is indicative only and our findings warrant further investigation through a larger study.

Each DSW participated in two individual face-to-face semi-structured interviews with one of the researchers. In the first interview, each participant was asked about what her job/s involved, the support she provided, working time arrangements, rates of pay and likes and dislikes. At the end of the interview, the participant was given a paper 'diary' on which she was asked to record time, duration and a brief description of each work-related activity and 'breaks' for the next three work days. At the second interview (1–4 weeks later), the researcher went through the diary with the participant seeking additional details and views of the 'diarised' time use. Informed consent in writing was obtained from all participants. Participants were given retail vouchers in recognition of their time and in lieu of payment for any expenses incurred.

Analytic framework

To identify and quantify any apparent underpayment of employees' work time, we categorised time recorded in the diaries as follows:

a. Paid work time.
b. Unpaid overtime comprising: *support work and administrative work* (paperwork, communications and meetings with supervisors, support recipients and families).
c. Unpaid travel directly between support recipients (for a single employer).
d. *Other unpaid time in the work day* comprising: unpaid travel between the employee's home and work during and at the beginning and end of the work day; and unpaid 'breaks' between work-related activities.

We also recorded the *length of the work day* (e), defined as the duration of time from when the worker first left home in the morning until she returned home from her last shift for the day.

On the basis of our literature review, we considered that, on the face of it, time spent on (b) unpaid overtime and (c) unpaid travel directly between support recipients should undoubtedly be paid work time. In this article, we focus on these categories to investigate underpayment of wages for the DSWs. It is much more difficult to ascertain the extent of any wrongful underpayment for time in category (d) and, as it would require considerably more space to do so, we have largely excluded this time from our analysis. This time is, nevertheless, critical to the structuring of employees' work days and pay as workers are often expected to travel long distances from home for very short shifts and can have their work scheduled so that they experience long periods of 'dead' time between shifts.

Here, we have space to provide detail of this time only where it sheds light on the overall organisation and time structure of the work.

Findings

Overview of employees' work and pay

In total, 9 of the 10 DSWs were multiple job holders: five worked in two or three different DSW jobs. Other jobs included aged care and residential support. The main reason women gave for holding multiple jobs was that their main job provided insufficient income. In their main job, seven women were permanent part-time and three were casual employees. Part-time employees had contracts specifying minimum hours, although these minimums were as low as 2 hours a fortnight. All employees had highly variable daily and weekly hours and all were regularly 'expected' to do additional work, often at very short notice. Part-time employees' hourly rates ranged from AUD19.80 to AUD25 and casuals' from AUD25 to AUD29, rates consistent with employment at or just above the relevant classifications in the SCHADS Award. Nine DSWs said they were paid penalty rates for weekend and evening work. The 10th said her employer told her she was paid penalties only when they were included in her clients' NDIS support plans.

Only two DSWs (both employees of the same long-established and large service provider) were paid for time spent travelling between clients. However, seven DSWs (including those two), received a per-kilometre reimbursement for using their own cars when travelling between clients. Notably, the industrial award specifies employees must receive this reimbursement 'where required and authorised by their employer to use their motor vehicle *in the course of their duties*' (our emphasis) (SCHADS Award 2010:: cl 20.5(a)). All DSWs were reimbursed for using their cars to transport clients, as long as the distance was within the kilometre range specified in the client's NDIS funding package.

Employees' paid work time was primarily spent in direct contact with clients, providing in-home assistance, personal care and/or support for community and social participation. All 10 workers said they enjoyed or even loved many aspects of the work; they valued making a difference in people's lives and enjoyed spending time with clients. However, most were unhappy with their pay and conditions and several were seeking other employment. The work aspect identified as a serious problem by all 10 workers was the way their working time was structured. Many frequently worked long days, 6 or even 7 days a week to try to earn an adequate income; yet many spoke of their difficulties earning enough to pay their bills. The women's jobs often left them exhausted and with little time for friends and families.

The working day: The time diaries

The working day diaries documented a total of 30 working days (comprising 3 diarised days for each of the 10 DSWs). They reveal four important aspects of DSWs' working days.

First, the diaries show that the DSWs' days were typically made up of several relatively short paid work 'shifts' spent with support recipients, interspersed with often long periods of unpaid time. Over the 30 days, the 10 DSWs worked between one and five

separate shifts per day. The shortest recorded shifts of paid work were around 30 minutes and the longest was over 10 hours. Most paid work periods were 2 hours or less. Second, the DSWs' working days (from first departure from home for work to last arrival home from work) were long. Two-thirds of the 30 diarised days were 10 hours or longer. Third, though days were often very long, the proportion of the total working day that was paid work was often small. On 17 of the 30 work days, employees were paid for 5 or fewer hours' work in the context of a long span of working hours. As an example, one day in DSW9's diary showed that she left home at 8:45 am and finished her day 13.5 hours later, at 10:15 pm, having completed four shifts and earned only 5 hours' pay. This pattern of paid work was not uncommon: the diaries showed that for each worker, on average over their 3 working days, paid work time was between 27% and 73% of the working day (Table 1). Fourth, the diaries showed very substantial periods of the working day consumed by unpaid activities, structured and often occupied by work.

In the presentation of findings below our focus is on the unpaid work time employees spend travelling between clients and undertaking support and administrative work, time that apparently should be paid work time. However, the organisation of disability support work often renders unusable as 'free' or 'personal' time much other time in a worker's day. For example, workers spent time travelling back and forth from home to work in breaks between periods of paid work, and they often found themselves too far from home to make it worthwhile returning so they simply waited somewhere near their next client's home.

Turning to the unpaid work that clearly directly contributes to underpayment, all 10 DSWs undertook unpaid work either travelling between clients or unpaid overtime (administration and face-to-face support), or both, over the 3 diarised days. For individual workers, the total amount of such unpaid work undertaken over the 3 days ranged from 22 minutes to over 6 and a quarter hours. For some DSWs, unpaid work time was equivalent to a third or more of paid work time in a single day and comprised up to 25% of the duration of the working day (Table 1). If all travel between clients and overtime had been paid, these employees would have received between 2% and 27% more pay than they actually received for the 3 days. In the discussion that follows, this unpaid work and the factors driving it are examined in detail.

Unpaid work: Travel between clients

Travel to clients' homes is an essential part of home and community-based disability support work. The amount of unpaid travel directly between clients varied considerably among the 10 employees on the 3 diarised days. The two women who were paid for the time they spent travelling directly between clients had paid travel time in their enterprise agreement with the same long-standing service provider. Our interviewees informed us, and it was later confirmed, that this provider had ceased providing disability support services because they could not afford to do so under the NDIS. For other DSWs unpaid travel between clients was equivalent to between 1% and 15% of the employee's paid time over the 3 days, and as much as 25% in a single day. One DSW spent an hour and a half travelling directly between clients in a single day. A total of 15 of the diarised days showed no unpaid travel directly between clients, but this was often because employees had large unpaid gaps between paid work periods and went home before travelling to the next client.

Table 1. Disability Support workers' paid and unpaid work time for 3 days[w].

DSW ID	Disability support workers									
	1[x]	2	3[y]	4	5	6[x,y,z]	7[x,y]	8[y]	9[x,z]	10[x]
Day 1 (no. engagements)	5	2	2	3	1	10	1	1	5	2
Paid time (a)	10:00	2:00	1:06	4:36	10:00	7:58	8:00	1:07	6:30	7:00
Unpaid overtime (b)	1:14	0:15	0:19	0:22	0:30	0:35	0:00	-0:02	0:00	1:10
Unpaid travel directly between clients (c)	0:25	0:00	0:00	0:06	0:00	0:00	0:00	0:00	0:15	0:00
All unpaid work (b + c)	1:39	0:15	0:19	0:28	0:30	0:35	0:00	-0:02	0:15	1:10
Length of work day (e)	15:15	6:00	3:30	9:37	11:30	10:00	9:00	1:21	13:30	10:45
All unpaid work/all work time ((b + c)/(a + b + c)) (%)	14	11	22	9	5	7	0	-3	4	14
Paid time/work day (a/e) (%)	66	33	31	48	87	80	89	83	48	65
Day 2 (no. engagements)	4	3	4	1	3	5	2	3	4	4
Paid time (a)	5:00	3:00	3:36	8:05	8:05	6:20	5:00	2:58	5:00	7:00
Unpaid overtime (b)	1:19	0:35	-0:01	-0:06	0:58	0:19	0:00	0:08	0:07	0:30
Unpaid travel directly between clients (c)	0:30	0:00	0:55	0:00	0:20	0:00	0:00	0:00	0:00	1:30
All unpaid work (b + c)	1:49	0:35	0:54	-0:06	1:18	0:19	0:00	0:08	0:07	2:00
Length of work day (e)	15:45	11:15	15:15	8:41	13:40	12:30	7:20	13:24	13:30	9:50
All unpaid work/all work time (b + c)/(a + b + c)) (%)	27	16	20	-1	14	5	0	4	2	22
Paid time/work day (a/e) (%)	32	27	24	93	59	51	68	22	37	71
Day 3 (no. engagements)	5	2	3	2	2	6	4	3	3	2
Paid time (a)	8:20	2:50	5:06	1:56	7:30	10:36	3:36	2:35	3:10	2:25
Unpaid overtime (b)	1:49	0:00	0:24	0:05	1:10	0:04	-0:06	0:18	0:00	0:01
Unpaid travel directly between clients (c)	1:00	0:25	0:35	0:00	0:40	0:15	0:30	0:00	0:00	0:00
All unpaid work (b + c)	2:49	0:25	0:59	0:05	1:50	0:19	0:24	0:18	0:00	0:01
Length of work day (e)	11:15	4:20	8:55	6:26	10:05	14:42	7:45	9:52	3:35	8:50
All unpaid work/all work time ((b + c)/(a + b + c)) (%)	25	13	16	4	20	3	10	10	0	1
Paid time/work day (a/e) (%)	74	65	57	30	74	72	46	26	88	27

Table 1. (Continued)

DSW ID	Disability support workers									
	1[x]	2	3[y]	4	5	6[x,y,z]	7[x,y]	8[y]	9[x,z]	10[x]
Total: Days 1 to 3	14	7	9	6	6	21	7	7	12	8
Paid time (a)	23:20	7:50	9:48	14:37	25:35	24:54	16:36	6:40	14:40	16:25
Unpaid overtime (b)	4:22	0:50	0:42	0:21	2:38	0:58	-0:06	0:24	0:07	1:41
Unpaid travel directly between clients (c)	1:55	0:25	1:30	0:06	1:00	0:15	0:30	0:00	0:15	1:30
All unpaid work (b + c)	6:17	1:15	2:12	0:27	3:38	1:13	0:24	0:24	0:22	3:11
Total all work days [e]	42:15	21:35	27:40	24:44	35:15	37:12	24:05	24:37	30:35	29:25
All unpaid work/all work time ((b + c)/(a + b + c)) (%)	21	14	18	3	12	5	2	6	2	16
Paid time/work day (a/e) (%)	55	36	35	59	73	67	69	27	48	56

DSW: disability support worker.
[w]Times are reported in hours and minutes.
[x]DSW employed by more than one disability support provider.
[y]Administration time adjusted as one employer paid for 30 minutes a week.
[z]DSW paid for travel between clients by one employer.

Most interviewees raised the issue of unpaid travel time as a major shortcoming of the job, particularly when paid work periods were short and the ratio of unpaid to paid working time was high. Women's gave a variety of explanations for undertaking shifts that involved at lot of unpaid travel and little paid work. For some it was a sense of responsibility to clients, a manager or both. Fear of jeopardising further work opportunities was often cited as a strong motivator for not refusing shifts. One DSW who had been in her job under 6 months was very conscious of the impact of travel time on her effective pay rate and also found the driving stressful:

> … but a big part, as you know, is driving for the job. So I think at the end of the day I'm so knackered, so tired because I'm thinking, I've just been stressed all day worrying about the traffic, whether I'm going to have a prang, just trying to get to these places on time. All for what? For say 3 hours' work. (DSW2)

Yet this employee was unwilling to complain about her pay and conditions as it had been difficult for her to find work. This sense of vulnerability may have been well-placed: another DSW, who had consistently refused to take certain poor shifts, believed she had been punished by having work taken away. By comparison, a very experienced worker reported resisting or refusing shifts where the ratio of paid to unpaid work was too low:

> I don't do any less than an hour. … [Employer B] don't do less than an hour. [Employer A] try to get you to do half hour ones like for medication runs or things like that but, no to me it's not worth it especially when you have to drive like half an hour there, get paid half an hour and a half an hour back and you don't get paid for travelling. (DSW1)

However, this DSW spent nearly 2 hours travelling directly between clients over the 3 days, unpaid and without a car allowance.

Unpaid work: Overtime providing support and undertaking administration

A second type of unpaid work was the additional time DSWs spent providing support to clients and undertaking administrative tasks. Five of the ten employees accrued 50 minutes or more of such unpaid work over the 3 days. For four workers, this was equivalent to 10% or more of the time they were paid for work.

This form of unpaid work appeared endemic. Six of the ten employees provided unpaid support on 29 occasions over the 30 recorded days. Though often only for short periods this unpaid work added up to between 15 and 50 minutes over the three days. Employees' fragmented work schedules meant that this additional work was often absorbed into unpaid time between scheduled support for clients – rendering it invisible to the employer. Contributors to unpaid support included unexpected events (e.g. client illness), unpredictable behaviours, client requests for extra supports; new/unfamiliar clients; family carers returning home late, and mismatches between client needs and funded supports, as described here:

> Sometimes when the support team goes out to a client's home or interviews them, [or] interview them over the phone, they may think 'Oh this is only going to take half an hour' but they haven't actually done it [the work]so they might guestimate that it's half an hour where it's a bit longer. [DSW4]

Administration work was a further significant component of unpaid overtime. Eight of the ten employees completed multiple, often small, amounts of unpaid overtime every day. The range of unpaid administrative tasks included: completing client notes and incident reports, communicating with supervisors about client needs, organising rosters and extra shifts and completing travel forms and timesheets. Most tasks were central to client care and/or the organisation of work. While one organisation paid employees 30 minutes a week for administration, DSWs were not otherwise allocated paid time for these tasks which often consumed considerable amounts of time and could be highly disruptive to personal time. One employee, who had many serious concerns about her clients, spent nearly 4 and a half hours over the 3 days writing up client notes, usually very late at night. This unpaid administration was equivalent to almost 20% of her paid work time. Another seven employees undertook between 10 minutes and just under 2 hours of unpaid administration over the 3 days. Two employees did no unpaid administration work at all.

DSWs gave two main reasons for undertaking unpaid work. Many workers did so out of a personal commitment to providing good quality, and usually essential, care. This included one employee who said she and colleagues arranged staff meetings in unpaid time to induct new staff and discuss clients' support needs. Most employees linked their unpaid overtime to job insecurity and some reported responding to pressure to complete additional unpaid tasks at clients' request because they feared losing shifts if a client requested a different support worker.

In theory employees could claim pay for some of their unpaid overtime while in practice it was often difficult or impractical to do so. One employee commented: 'I mean I guess if we specifically rang our boss and we're like "hey, this ran 15 minutes over, I'm going to put it on my timesheet," and they knew, then we would. But if it happens every single day, I don't think that many of us really ring her every single day. And she's very hard to contact as well' [DSW10]. Nevertheless, employees sometimes accepted responsibility for not claiming time:

> I: Do you get paid for that extra ten minutes, when (the family carer's) late?
>
> P: No. Well, that's my fault; I'm not going to ring something like that in.
>
> I: No. When would you ring it in? How many minutes late would they have to be for you to call in?
>
> P: Half an hour, twenty minutes, half an hour, it depends. This is a nice lady, she doesn't mean to be home [late]. [DSW6]

In some cases, explicit organisational arrangements required employees to absorb unpaid work without remuneration. Further, employees articulated it was in their best interests to undertake this work in order to have better outcomes for clients. For example, one employee (DSW5) explained that it was in her position description to arrive at work 10 minutes before the commencement of her paid work. While she considered this 'a nuisance' it also enabled her to talk with the client's family carer and get any issues 'sorted'.

Finally, workers' sense of insecurity and lack of support in challenging their working conditions was often evident in their explanations for undertaking unpaid work. One employee feared losing shifts if she 'rock[ed] the boat' (DSW2), another said she was afraid of 'making ripples' and risking confrontation (DSW5), and others reported they

had been 'punished' with removal of shifts for attempting to challenge an employer (DSW1) and for refusing to take poor shifts (DSW8). In contrast the two employees of the large long-established and highly unionised service provider reported numerous instances of challenging management to improve conditions for workers.

The financial cost to employees of the unpaid work of travel between clients and overtime was significant, even for those who undertook relatively little unpaid work. For five of the ten employees, 2%–6% of their work over the 3 days was unpaid. On the basis of the standard hourly rate each DSW was paid (i.e. disregarding any penalty rates), we estimate those five employees were underpaid by between AUD8.84 and AUD30.42 over the 3 days. The other five DSWs were not paid for 12% or more of their work time, including one who was not paid for 21%. That employee, who had both the highest number and proportion of unpaid work hours, was underpaid by around AUD180 over 3 days. The remaining four employees were underpaid by between AUD24.75 and AUD92.08 over 3 days.

Discussion and conclusion

Our case study findings demonstrate some of the ways in which disability support work is being organised under NDIS implementation, leaving employees underpaid for significant amounts of their working time. While it is not possible to generalise from the experiences of this small sample it is worth noting that underpayment for travel and overtime was experienced by employees of nine of the ten different employers in this study. Further, we argue that the significance of this study, beyond mapping the dimensions of wage theft and underpayment for a small group of workers, is its analysis of how the funding and regulatory environments facilitate systemic non-payment of working time for homecare workers – an analysis which is broadly applicable to the many workers employed in the same context.

In part, underpayment of the DSWs was rendered invisible by the gendered norms of care work. The findings of this study echo those of Hayes (2017) that in the UK 'homecare workers who wish to provide care in a way which is compatible with self-respect must do so on an unpaid basis' (p. 127). The underpayment of wages was hidden and ambiguous, owing to the regulatory gaps which supported it. Non-payment for travel time was apparently enabled by the absence of a specific entitlement in the industrial award, while the absence of a minimum engagement period for part-time employees saw work periods reduced to as little as 20 minutes. Employers appear to have actively exploited the lack of clear minimum standards: paying vehicle allowances for travel between assignments suggests acceptance of this activity as work – while not paying wages for this time.

Inferior benefits and conditions for social care workers were established in Australian employment regulation long before the introduction of the NDIS. However, our findings support the view that the NDIS is further institutionalising employment practices that produce wages underpayment. Notably, in the context of identified under-pricing of personal support services under the NDIS, the only employees in our study who were paid for travel time lost work as their employer's disability services provision was deemed not viable under the new funding model. Also notably, in this workplace, employees had gained their superior benefits through collective bargaining, while union organisation and representation were less apparent for other employees in our study.

Addressing deficiencies in employment minimum standards is one strategy for resolving some of the problems of underpayment for social care workers. Embedding gender equality objectives in award review processes is potentially a way of achieving this (Macdonald and Charlesworth, 2013). More fundamentally, addressing underpayment of wages of social care workers is likely to require acknowledgement of the limitations of regulation fashioned around the normative standard of full-time permanent employment and the binary employment relationship. In this regard there is a variety of innovative regulatory responses that target network lead or top of supply chain organisations, including in Australia's textile, clothing and footwear industry (Johnstone et al., 2012). Safeguarding and quality regulation under the NDIS could be framed to ensure disability workers are paid fairly and all participants in the supply chain take responsibility, as was previously done in the road transport sector (Johnstone et al., 2015). The fact that the government is effectively the top of the supply chain body in publicly funded social care systems such as the NDIS highlights the need for embedding accountability for labour standards in public policy more generally.

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Author biographies

Fiona Macdonald is Senior Research Fellow in the School of Management and Centre for People, Organisations and Work (CPOW) at RMIT University. Her research is investigating workforce challenges of marketised social care systems, through an examination of the organisation of work and changes to disability support workers' jobs and employment arrangements under Australia's NDIS, in international comparison.

Eleanor Bentham is a researcher in the School of Management and CPOW at RMIT University. She has 10 years' experience researching disadvantage in labour markets and education, and has spent the past 2 years investigating the impact of the NDIS on disability support work.

Jenny Malone is a researcher in the School of Management and CPOW at RMIT University. She is researching dimensions of care work, including the ways in which gender, migration and the organisation and regulation of care work intersect to shape working conditions.

Fair Work Commission

Four Yearly Review of Modern Awards

Social, Community, Home Care and Disability Services Industry Award

Matter No: AM2014/285 and AM2018/26

STATEMENT OF MARK FARTHING

1. I am employed as a Senior Policy Advisor for the Health Services Union (**HSU**) Victoria No. 2 Branch, also known as the Health and Community Services Union (**HACSU Victoria**).
2. I have been employed with HACSU Victoria since March 2016.
3. I have substantial research experience in the health and community services sector, with particular expertise in disability services and the National Disability Insurance Scheme (NDIS), as well as more broadly in industrial and workforce research and policy.
4. Between 2013 to 2016 I was employed as the Senior National Project Officer in the Health Services Union National Office.
5. Prior to that I worked as a Senior Project Officer – Research for Service Skills Australia, which involved producing research for the purposes of advising the Commonwealth Minister for Industry and the Australian Workforce and Productivity Agency. I also worked as a Junior Policy Associate for the China Studies Centre at the University of Sydney.
6. I hold a Bachelor of Arts with First Class Honours in History and Politics.
7. In my current role I deal with Victorian employers providing disability support services. These employers are largely not-for-profit organisations, with one very large public-sector employer (with over 6,500 employees), the Victorian Department of Health and Human Services (**DHHS**). I have compiled a table of the employers in the non-government, not-for-profit disability support services sector, with which the union has dealings on behalf of members appears below. I have had the most in-depth

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experience dealing with Scope, EW Tipping Foundation/House with No Steps, and Genu.

Business Name	Trading Name	Services Provided	Operating Region
Araluen Centre	Araluen	Disability services for adults with disabilities including day programs, supported accommodation, community participation, respite and support coordination.	Victoria, north-east metropolitan Melbourne
Scope (Aust) Ltd	Scope	Disability services for adults and children with disabilities, including supported accommodation, community participation, in-home support, allied health, day programs, respite and support coordination.	Victoria (Statewide)
Kindilan Society	Focus Individualised Support Services	Disability services for adults with disabilities, including supported accommodation, respite, in-home support, community participation, day programs and support coordination.	Victoria, Mornington Peninsula
Wallara Australia Ltd.	Wallara	Disability services for adults with disabilities, including supported accommodation, in-home support, community participation, day programs and support coordination.	Victoria, south-eastern Melbourne
The Tipping Foundation Ltd.	EW Tipping	Disability services for adults and children with disabilities, including supported accommodation, community participation, in-home support, day programs and support coordination.	Victoria (Statewide), note that The Tipping Foundation has merged with House with No Steps recently which has operations in NSW, QLD and SA.
Colac Otway Disability Accommodation Incorporated	Colac Otway Disability Accommodation Inc. (CODA Inc.)	Disability services for adults with disabilities including supported accommodation, community participation and in-home support.	Victoria (Cola-Otway region)
Connect GV	ConnectGV	Disability services for adults with disabilities including supported accommodation, day programs, community participation and in-home support.	Victoria (Goulburn region)
Knoxbrooke Incorporated	Knoxbrooke Incorporated	Disability services for adults with disabilities including day programs, community participation and in-home support.	Victoria (Outer Eastern Melbourne)
Mawarra Centre Inc	Mawarra	Disability services for adults with disabilities including day programs, community participation and in-home support.	Victoria (Gippsland region)

Melba Support Services Inc	Melba Support Services	Disability services for adults with disabilities including supported accommodation, respite, community participation and in-home support.	Victoria (Southern and Eastern Melbourne)
Monkami Centre Inc	Monkami Centre	Disability services for adults with disabilities including supported accommodation and day programs.	Victoria (Outer Eastern Melbourne)
Murray Human Services Inc	Vivid	Disability services for adults with disabilities including supported accommodation, day programs, respite, community participation and in-home support.	Victoria (Echuca, Kyabram, Swan Hill and Kerang)
Nadrasca Ltd	Nadrasca	Disability services for adults with disabilities including supported accommodation, day programs, respite, community participation and in-home support.	Victoria (Outer Eastern Melbourne)
Northern Support Services Inc	Northern Support Services	Disability services for adults and children with disabilities including supported accommodation, respite, community participation, support coordination and in-home support.	Victoria (North-East metropolitan Melbourne)
Pinarc Disability Support Inc	Pinarc Disability Support	Disability services for adults and children with disabilities including, respite, community participation, support coordination, day programs and in-home support.	Victoria (Ballarat – Grampians/Central Highlands)
OC Connections Limited	OC Connections	Disability services for adults and children with disabilities including supported accommodation, respite, community participation, support coordination, day programs and in-home support.	Victoria (Outer Eastern Melbourne)
Statewide Autistic Services Ltd	Statewide Autistic Services – SASI	Disability services for adults and children with disabilities including supported accommodation, respite, community participation and day programs.	Victoria (Statewide)
Uniting (Victoria and Tasmania) Limited	Wesley Mission Victoria	Disability services for adults and children with disabilities, including supported accommodation, community participation, in-home support, allied health, day programs, respite and support coordination.	Victoria (Statewide)
Woodbine Inc	Woodbine	Disability services for adults and children with disabilities, including supported accommodation, community participation, in-home support, day programs and respite.	Victoria (Wimmera/Mallee)
Melbourne City Mission	Melbourne City Mission	Disability services for adults and children with disabilities, including supported accommodation, community participation, in-home support, allied health, day programs, respite and support coordination.	Victoria (Statewide)
Karingal St Laurence Limited	genU	Disability services for adults and children with disabilities, including supported accommodation, community participation, in-home	Victoria (Geelong and Barwon region)

		support, allied health, day programs, respite and support coordination.	
DPV Health Ltd	DPV Health	Disability services for adults and children with disabilities, including supported accommodation, community participation, in-home support, allied health, day programs, respite and support coordination.	Victoria (Outer Northern Metro Melbourne)

8. Most of the above providers operate under enterprise agreements which were made prior to the introduction of modern awards in 2010, and which are based on the pre-modern *Residential and Support Services (Victoria) Award* 1999. The pay rates in these agreements broadly align with the *Social, Community, Home Care and Disability Services Industry Award* (**the Award**) Schedule B (SACS) classifications, ranging from Level 1 to Level 4 of the Schedule.

Wage rates for disability support workers

9. Based on my experience in bargaining in this sector in Victoria, wage increases in enterprise agreements are always the same as the Award, or phrased as "3% or the minimum award increase if greater", or words to that effect.

10. The only enterprise agreement I have come across in this sector with higher wages than the award is the public sector one with the DHHS.

11. The ERO has largely precluded any above award increases as wages have been going up by about 5% a year with the ERO in place.

SCHCDSI Award and disability workers

12. The vast majority of HSU members employed in the disability support sector in Victoria are "social and community services sector" (**SACS**) employees as defined in the Award.
13. With the exception of employees employed by some large public-sector employers, almost all disability support workers are paid minimum Award rates.
14. The introduction of the National Disability Insurance Scheme (NDIS) has further entrenched minimum Award rates of pay as the standard for wages in the sector as employers cannot charge participants more than the National Disability Insurance Agency (NDIA) price-cap, which is calculated on the basis of Award wage rate assumptions. This cap, coupled with the unique characteristics of the disability sector—a sector almost entirely reliant on government funding with minimal or limited co-contributions/co-payments by the service recipients—largely precludes bargaining above Award wage outcomes.

15. While bargaining does occur in the sector, the focus of bargaining is predominantly on non-monetary items such as consultation, hours of work, rostering and training.
16. Since 2012, the Equal Remuneration Order has substantially lifted Award rates of pay, however, with the final ERO payment due on 1 December 2019, the disability sector workforce will again be reliant on minimum wage case decisions to secure wage increases.

Minimum Engagement under SACS and Home Care classifications

17. Clause 10.4(c) of the Award (Exposure Draft – clause 11.3) provides for minimum shift engagements for casual employees. This provides for three hours for casual SACS employees who are not undertaking disability services work, one hour for casual home care employees, and two hours for all other employees, including disability support workers.

18. This distinction between SACS and home care casual employees creates a perverse incentive to misclassify Schedule B workers as Schedule E workers. It creates additional flexibility for employers in the rostering and scheduling of work if they can characterise workers as falling under the Home Care classifications in Schedule E of the Award.

National Disability Insurance Scheme (NDIS)

19. The National Disability Insurance Agency (NDIA) caps the price that providers can charge NDIS participants for particular service types.

20. The current NDIS Price Guide for NSW, QLD, VIC and TAS (published on 1 February 2019 and applying to 30 June 2019) has been filed by the HSU along with its material in this matter

21. Below is a table I have created which provides a summary of the elements of the NDIS capped price for 1-hour of standard needs, weekday support, with a supervision ratio of 1:15. The first column of the table describes what data is contained in the second, third and fourth columns. The second column uses the SACS (Schedule B) 2.3 hourly wage rate as at 1 December 2018 as the basis of calculating labour and on-costs. The third column uses the Home Care (Schedule E) 3.1 hourly wage rate as at 1 December 2018 as the basis of calculating labour and on-costs. The fourth column provides some further details on the assumptions used in different rows of the table.

	SACS 2.3	HC 3.1	Notes on Assumptions
Hourly Rate (1 December 2018)	$ 27.61	$ 22.04	*SACS 2.3 is level agreed by the NDIA as forming the basis of the capped unit price. Homecare 3.1 is the closest equivalent to the skill level and duties of the SACS 2.3 classification.*
Annual Leave	$ 2.12	$ 1.69	*4-weeks of annual leave.*
Leave Loading	$ 0.37	$ 0.30	*17.5% leave loading on annual leave.*
Personal Leave	$ 1.06	$ 0.85	*10 days of personal leave per annum and all 10 days are taken. This is assumed by the NDIA.*
Long Service Leave	$ 0.08	$ 0.07	*NDIA assumes 8.67 weeks of long service leave after 10-years and*
Superannuation	$ 2.62	$ 2.09	*9.5% superannuation guarantee*
Workcover	$ 1.22	$ 0.98	*NDIA assumption is 4% (based on NSW industry average)*
Payroll Tax	$ 1.48	$ 1.18	*Victorian Payroll Tax rate (metropolitan employers)*
Total Labour Cost	$ 36.58	$ 29.20	
NDIS Price Cap	$ 48.14	$ 48.14	
Total Labour Cost	$ 36.58	$ 29.20	
Supervision 1:15	$ 2.68	$ 2.28	*Calculations are based on classification levels SACS 3.3 and HC 5.1. The total labour costs are then divided by 15 to create the supervisory span of 1:15 FTE*
Remaining (Overhead and Margin)	$ 8.88	$ 16.66	
Overhead and Margin as % Price Cap	18.4%	34.6%	

NDIS Price Increases

22. At least once per year the NDIA increases price caps to account for wage growth and/or general inflation. For the 2018-19 financial year the NDIA adjusted prices used for attendant care supports to take into account the 1 July 2018 3.5% minimum wage increase and the ERO adjustment from 1 December 2017, calculated by the NDIA as 2.27%, plus CPI of 1.9%. For attendant care supports, this equated to an increase of 5.14%. This can be seen in the NDIS 2018-2019 Price Guide Update Summary, which has been filed by the HSU along with its material in this matter.

Client Cancellation

23. The current NDIS Price Guide for NSW, QLD, VIC and TAS (published on 1 February 2019 and applying to 30 June 2019) sets rules around how much and how frequently a provider can charge an NDIS participant for a short-notice cancellation.

24. The NDIA defines a short-notice cancellation as, "after 3pm the day before the service." (see Price Guide, p. 18)

25. Providers can charge a participant a fee of up to 90% of the agreed price of a short-notice cancellation for personal care and community access supports.

26. This fee can be charged up to 12 times per year without pre-authorisation from the NDIA. A provider may still be able to charge cancellation fees in excess of 12 times per year, however the NDIA will require the provider to demonstrate they are taking active steps to manage cancellations.

24 hour shifts

27. In my experience the 24 hour clause is not used by employers. Based on my discussions with employees and employers in the sector and officers of the HSU, employers are not requiring employees to work 24 hour shifts.

28. In terms of work value, the compensation provided for by the clause does not represent the value of the work. The worker is not compensated for the entire period of time they are required to be present at the workplace, nor are they compensated for the inconvenience and unsociability of working extended hours under fatigue away from their homes and families. When you compare the compensation paid to what a worker would be entitled to under the alternative provisions in the award, such as overtime, shift penalties and sleepover allowance, it is substantially less.

29. In-home respite is not a discrete line item in the NDIS price guide. Instead, NDIS participants are able to use a range of line items in the price guide to engage a support worker to deliver in-home respite such as "assistance with self-care activities – daytime, evening, Saturday, Sunday and Public Holiday" and "Assistance with self-care – Night-Time Sleepover and Active Overnight." These line items allow the delivery of in-home respite over a 24-hour period, with support workers being paid using a combination of ordinary time earnings, shift allowances and the sleepover allowance.

Mark Farthing

15 February 2019

Fair Work Commission

Four Yearly Review of Modern Awards

Social, Community, Home Care and Disability Services Industry Award

Matter No: AM2014/285 and AM2018/26

STATEMENT OF WILLIAM ELRICK

1. I am employed as an Area Organiser for the Health Services Union (**HSU**) Victoria No. 2 Branch, also known as the Health and Community Services Union (**HACSU Victoria**).

2. I have been employed with HACSU Victoria since March 2016. My previous roles at HACSU Victoria have included Project Organiser, HACSU Assist Organiser and Administrative Assistant.

3. HACSU Victoria primarily deals with members and employers working in the Social and Community Services (**SACS**) sector, as defined in clause 3 of the *Social, Community, Home Care and Disability Services Industry Award* (**the Award**). A far smaller number of our members are classified under the Home Care sector, as defined in clause 3 of the Award.

4. As an Area Organiser I am regularly required to visit worksites and engage with members about issues they are experiencing at work. I also often represent members during disciplinary matters and prosecute disputes through the Fair Work Commission. As a HACSU Assist Organiser I regularly received industrial based calls and emails from members seeking advice. My roles have required an in-depth understanding of the Award and being able to interpret and apply the Award to issues members are dealing with at their workplaces.

5. Prior to working for HACSU Victoria, I held a number of roles in the SACS sector.

6. Between 2012 to 2016 I was employed as a Disability Development and Support Officer for the Department of Health and Human Services. This role involved supporting clients with their activities of daily living, such as personal care, transport, assistance with eating and drinking, community outings, regular grocery shopping and

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other community-based activities. In this position I was responsible for development and completion of individual care plans, which involved engagement with community stakeholders and family members.

7. Between 2009 to 2011 I was employed as a Personal Support Worker for Karingal Support Services. This role involved providing complex care to adults with severe physical disabilities in relation to all aspects of daily living activities. Shifts varied between one to two-hour home visits, and seven to nine-hour respite days assisting clients while family members worked or were otherwise absent. I also undertook active night shifts, where I assisted clients overnight whilst family members slept. I often assisted clients over mealtime; this involved preparing meals for clients and general household duties. I was also trained and competent in feeding clients through PEG (percutaneous endoscopic gastrostomy) tubes. Many of my shifts involved primary care for clients whilst they were undertaking social and community activities. I was responsible for their care and transport in varied situations such as shopping, going out for meals, attending movies and other activities as requested.
8. Between 2009 to 2010 I was employed as a Respite Support Worker for Gateways Support Services Geelong. In this role I was often responsible for transporting clients within the Geelong area, such as driving primary school age clients from school to home. I would frequently be involved in providing respite for families with young members who are mentally disabled. This would involve transporting and caring for the clients during recreational activities such as swimming, visits to parks and walks on beaches as requested. My duties included all aspects of clients' personal care such as hygiene, toileting and feeding plus dealing with physical aids such as wheelchairs. I was responsible for communicating with families and my supervisors as to the care provided during my shifts and the clients' responses and needs.

Coverage of members under SCHCDS Award

9. The majority of the members I have supported in my role at HACSU Victoria are classified under the SACS stream of the SCHCDS Award.
10. It is not always a straightforward task to advise about the appropriate classification for a particular worker, often because organisations engage in activities which overlap classification boundaries. For example, in one instance I received a referral from our HACSU Assist member advice line, about a member who was unsure of their classification in a role which mainly involved working in a client's home.
11. I spoke with the member, who detailed their role as largely involving cleaning and who worked for an organisation that was largely staffed by former council workers. To the

best of my recollection, neither the employment contract nor payslips correctly referred to their classification.

12. I advised that she was indeed a Home Care employee, as defined in clause 3, as she didn't undertake any plan driven support work and mostly undertook domestic duties.

13. There were rare occasions where the member took the client out to do shopping, which would in my view be SACS work. However, the member was concerned about the requirement to perform those duties and sought advice about approaching the employer to stop those duties.

14. The majority of employers I deal with in the SACS sector are medium to large, not-for-profit disability service providers.

15. I have never dealt with a small business (according to the *Fair Work Act* definition). I do not think it would be economical to operate a disability service with less than 15 employees.

16. The providers I regularly organise within include: Yooralla, Scope, The Tipping Foundation, Jewish Care, Focus, Statewide Autistic Services, Autism Spectrum – Aspect, Connect GV, PALS, Melba, Life Without Barriers, Villa Maria, GenU and Melbourne City Mission (MCM).

17. With the exception of disability support workers in public sector roles, the vast majority of disability support workers are paid award wages only. Bargaining in the sector isn't common. However, many workers are on enterprise agreements that have long expired and were developed during the "Work Choices" period. When new enterprise agreements are negotiated, wages are almost always in line with the rates in the Award. The HSU has been successful in bargaining with a couple of organisations for a term providing for the greater of a 2.5% increase or the annual minimum wage increase. Thus far, the minimum wage increase has always been greater.

Minimum Engagement

18. Some of the most common issues of concern for workers we deal with who are covered by the Award are around rostering issues and lengths of shift.

19. Because there is no minimum engagement for part-time and full-time employees under the Award, the HSU sees a lot of cases of 0-hour contracts and 30-minute shifts. The shortest shift I've heard of is 15 minutes, although in that case the worker was paid for 45 minutes. In that particular workplace the employer would often pay a rate of 45 minutes or 30 minutes for a short shift. Some of the larger employers have a minimum two hour engagement policy, but this is not always adhered to.

Broken shifts

20. Broken shifts are very common in this sector.

21. Some workers enjoy working broken shifts, as they provide them with the ability to undertake personal tasks during the breaks.

22. However, many workers strongly dislike them. This is especially the case for workers living some distance from work, as the transportation to and from home becomes very tedious.

23. In group homes workers will often do a morning and afternoon shift, such as 7am – 10am and then 3pm – 10pm. In-home support workers generally have a more fragmented working pattern and may be required to do several shifts in a day. For example, rosters of 7am - 9am, 11am - 1pm, and then 5pm – 7pm are common. These shifts are normally for the purposes of providing meal assistance and personal care to clients.

Sleepovers

24. As a disability support worker, I would regularly be rostered to work sleepovers. There are many pros and cons to sleepovers, the biggest positive is for the client who is able to be supported overnight in a manner that supports less restrictive practice. As a worker, considering most sleepovers have several hours of work either side, sleepovers provide an opportunity to work significant hours in one stint, allowing more days off work. Sleepovers also allow for reduced travel time in between shifts, this is particularly advantageous if the worker regularly has short shifts.

25. Nonetheless, sleepovers can have an impact on a worker's wellbeing, productivity, and employment satisfaction. Firstly, my colleagues and I use to always say you'd "have to sleep with one eye open", this was due to the perceived risk that incidents could happen overnight. When working with clients who are suffering medical issues it is only natural that many workers will have anxiety or concerns and will be alert to the point where they are unable to get a regular night's sleep. There are other issues that can occur overnight that result in workers irregular night's sleep, such as, some clients can soil themselves over night and not be able to communicate this to the sleeping worker. Sleeping through a client who has soiled themselves can cause health impacts for client and take up time during the morning routine to assist in cleaning the client.

26. The allowance for sleepovers and the disturbance clause don't sufficiently remunerate for the work done overnight. The SCHADS rate of $47.04 works out to be $5.88 an hour, while I understand that it is an allowance and not an hourly rate, a sleepover is

still 8 hours away from your own home and loved ones. It isn't uncommon to be woken up overnight whilst on sleepover for reasons that most workers wouldn't claim for remuneration, such as, a client getting up to use the toilet and slamming doors, clients who knock on the door for no reason, and various other matters that don't require direct support. All the aforementioned can result in the worker being too tired to pick up additional shifts the next evening, or having to sleep through the day when they return home.

27. Lastly, the sleepover arrangements in many workplaces aren't conducive to a good sleep. For a period while I was undertaking sleepovers where bed was located in the office. The head of the bed was coming out of the cupboard that had the doors removed, the office had hums from the computer and fax, along with a bright light from the handset of the house phone. I have had reports from other members who have had to sleepover with the sleepover door open, having to deal with uncomfortable beds, and various other issues that result in poor sleep.

24 hour care

28. I am unaware of any workers being rostered for 24-hour shifts or being paid under the 24 hour care provision in the Award.

29. I have myself worked more than 24 hours straight when I was working in the industry. I am also aware of other workers who have worked such hours, usually including a sleepover as per the award clause, however, this is normally not a rostered 24 hour shift, but overtime which is required due to an emergency. For example, an employee may be about to finish a 12-hour shift after 8-hour sleepover, but the client is suddenly required to be rushed to hospital. In that case the employee may be required to go to hospital with a client and isn't able to leave. I've never come across an employee who has been engaged according to this clause.

Telephone allowances

30. Generally speaking, most workers will only use their personal phone for the purposes of being contacted for shifts, and not during work.

31. However, there is a growing trend amongst employers in the industry to have 'bring your own device' practices or policies that require employees to complete notes and other work-related duties using on-line apps on their personal phones. This is a problem because it isn't uncommon for workers in this sector not to have "smart" phones.

32. HACSU Victoria has recently prosecuted a dispute in the Fair Work Commission about the employer PALS ('Providing All Living Supports') requiring employees to use their personal phone for work duties. The employer had intended to compensate their employees with just $5 per month, without any extra money for those who needed to upgrade their phones to a smart phone.

33. Part of supporting people with disabilities requires research for social activities, making reservations, and sending emails to stakeholders. In group home settings, many houses only have one computer that is primarily for the group home managers. Some employers such as Scope do not let their workers access the computer at all. As computers are often inaccessible, many workers will use their personal phones to carry out the necessary research and communications.

Travel

34. Our members working in in-home support and day services are required to do a great deal of driving in their own vehicles between shifts and worksites.

35. In group homes, many worksites will have a van for transporting clients. However, some employers have suggested to me that they won't be keeping those vans in the future.

36. Where an employee is required to use their vehicle for work, they will often be required to have comprehensive business insurance. This can come at a large cost for workers and they generally aren't compensated for the added insurance costs by the employer.

37. There is also the problem for employees working with clients with behaviors of concern that their vehicle may be damaged.

Clothing

38. When supporting a person with a disability it is best to be dressed casually as it creates less barriers between the client and support worker, and makes clients feel comfortable and at ease, it assists in avoiding unwanted attention in the public. inclusion. I'm only aware of a few disability services employers who require uniforms to be worn.

39. Uniforms are common in the home care services which undertake a cleaning heavy practice.

40. For employees in disability services in the SACS sector, a damaged clothing allowance is more appropriate than a uniform allowance.

41. Clients with behaviors of concern will often damage clothing to the point they need replacing.

42. There are other ways a worker's clothing also suffers greater wear and tear in the course of work. If you are cleaning you may spill or splash cleaning products on your clothes which causes fading and a breakdown of the clothing. In services that require medical supports, a worker will often want to have two separate wardrobes, one for work and one for personal. Work clothes will often be looser fitting for ease during manual handling, and washed more regularly due to close proximity with bodily fluids.

43. Some employees will have extra pairs of shoes that they use while showering clients. The additional pair of shoes are just a pair that can get wet and be dried out over the shift, to avoid having to wear wet shoes all days.

44. Many worksites will provide surgical booties although these aren't always effective of stopping water from a shower.

First aid allowances

45. The cost of renewing first aid qualifications is something that is often raised by members as an issue. First Aid and CPR are essential to work in disability services. Without a first-aid certificate, an employee can't work this sector. Costs vary depending on the training provider, but, for example, St John Ambulance Australia charges $159 for a one-day refresher course for those who hold a current first aid certificate less than 2 years old, and $75 for a CPR course.

WILLIAM ELRICK

14 February 2019

Fair Work Commission
Four Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award
Matter No: AM2014/285 and AM2018/26

STATEMENT OF ROBERT SHEEHY

1. I am employed as the Manager Aged Care and Disabilities at the Health Services Union NSW/ACT/QLD Branch (**HSU NSW Branch**). I have been in this role since November 2015.

2. In my current role I manage a team of 8 organisers, develop and manage campaigns and provide strategic direction within the HSU NSW Branch in relation to Aged Care.

3. In my role I deal with members and employers covered by the *Social, Community, Home Care and Disability Services Industry Award* (**the Award**) in the Home Care sector. The Home Care sector classifications are contained Schedule E of the Award.

4. Most of the organisations I deal with are not-for-profit organisations, and include both larger home care provides (for example, Uniting), and smaller or medium sized not-for-profits.

5. Our members in the home care industry are predominantly carers working with clients in aged care or dementia care, but can also include schedulers, coordinators, maintenance workers, assessors, leisure and lifestyle workers, administrative assistants, health professionals and some support services (for example, workers with cleaning or gardening roles).

6. Some of the most common issues of concern arising from the Award for our members are around shifts and rostering, particularly: compensation for travel time; minimum engagements; broken shifts; client cancellations; low hour contracts; and unpaid work.

Split Shifts and Travel Time

7. Broken shifts are a very common occurrence in the home care sector. It is very common to have at least one split to the shift during the course of the work day, but I

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know of instances where workers have had two splits to their shifts in a day. That is, the workers have had 3 separate periods of work during the course of the day, with breaks between each period.

8. The periods of work often occur with the same client, with the member providing assistance at different times of the day. I am aware of one member who was rostered to work three separate periods of one or one and a half hours over the course of a day with the same client.
9. The inconvenience and inequity associated with working such patterns is compounded by the requirement for workers to travel, sometimes long distances, to the work location which is the client's residence. I am aware of cases where members are required to travel up to 50 kilometres to the client's home before they are regarded as commencing their shift of work. From my discussions with members, employers are scheduling the work at the most distant locations for the first and/or final appointment of the day, minimising the extent to which the time taken to travel to, from and between client homes counts as paid work.

24 hour care

10. I am not aware of any workers being engaged to provide 24-hour care in a person's home, as contemplated in clause 25.8 of the Award. As far as I am aware this clause is not used by employers in the aged care sector.

Telephone allowance

11. It is very common amongst our members working in home care to be required to have a mobile or smart phone, to be able to be contactable out of hours and when they are on the job, to log in to rostering or work allocation schedules, for use in writing reports on their clients, or to otherwise carry out their work functions.
12. Nearly all our home care worker members either have been provided with a phone or are required to have their own phone. A smart phone in particular is required and is required because rosters, change in rosters and all work related communication is done through the phone, including email and texts, often utilizing an app.
13. Many of the aged care employers are now providing phones to employees. But there are still some who don't, yet require employees to have a smart phone to communicate and log onto their company's app.

Clothing

14. Some employers in the industry do not provide any, or sufficient uniforms to their employees working in home care. For example, some employers will insist on a dress

code which is practically a uniform (for example, black pants, black shoes, white shirt), but will neither provide these clothes nor reimburse workers for them.

15. Other employers will provide only one t-shirt a year. This is not adequate when the nature of the work home carers do means that clothes become damaged, dirty or worn quickly.
16. Workers in the industry are performing all types of personal care – getting people dressed, showering, preparing food, feeding clients and dealing with bodily fluids. I've had members talk to me about being asked to pick up dog faeces and clean up after pets.

First aid certificate renewal

17. The cost of renewing first aid certificates is an issue commonly raised with me and my organisers by members.
18. It is commonly required of our members in aged care to have a first aid certificate, and then to maintain the certification with regular, updated training. Some enterprise agreements stipulate that the company will pay for it, but often not.
19. For aged care workers who are low paid, the costs of obtaining and maintaining a first aid certificate is a significant amount of money

Employers altering rosters to avoid public holiday entitlements

20. Our branch has run a number of disputes for members where employers have altered rosters to avoid paying employees public holiday entitlements.
21. It's not uncommon for employers to change the roster shortly before a public holiday, with the consequence that the employee is not paid for that day. For example, an employee may work every Monday but will be taken off that Monday for the two week period where the public holiday falls. Often employers will cite client cancellation as the reason for changing an employee's roster.

ROBERT SHEEHY

15 February 2019

[redacted]

27/2/19

Fair Work Commission
Four Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award
Matter No: AM2014/285 and AM2018/26

STATEMENT OF CHRISTOPHER FRIEND

1. I am employed as a Bargaining Officer for the Health Services Union NSW Branch (**HSU NSW**). I have been working in this role for 1 year. Prior to this role, I was an Organiser with the HSU NSW Branch for approximately 1 year, and prior to that I was employed by the Australian Services Union for approximately 8 years, representing members in the social and community sector, state government utilities and local government.
2. The HSU NSW represents members in NSW, ACT and Queensland.
3. My primary role is representing the HSU NSW in enterprise agreement negotiations with employers in the aged care sector, under the *Fair Work Act* 2009 (**the Act**). Within that sector are employees in the home care sector, who fall within the classifications in Schedule E of the *Social, Community, Home Care and Disability Services Industry Award 2010* (**the Award**), or within equivalent classifications in an enterprise agreement underpinned by the Award.
4. In NSW and the ACT, the HSU is covered by 234 enterprise agreements made under the *Fair Work Act* 2009 with various employers in the aged care sector. Of these agreements, 190 have coverage of home care worker roles.
5. Save in respect of the Award provision requiring that part-time employees be given a regular pattern of work at the time of engagement, the terms and conditions as contained in the Award are seldom varied significantly in enterprise agreements.
6. As a consequence, many of the industrial issues that arise for HSU members in home care roles involve the interpretation and application of terms and conditions of the Award, whether because the Award applies directly to them, or because a corresponding provision in an enterprise agreement in the same or similar terms has application.
7. Based on my work and discussions with HSU delegates and members, the primary industrial issues affecting members in home care are:

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a. inconsistent and precarious rostering, leading to insecure employment;
b. extremely low, or non-existent, minimum engagements;
c. a prevalence of broken shifts, with little or no compensation; and,
d. high levels of unpaid work-related travel.

Rosters

8. Employers in the home care sector overwhelmingly engage part-time employees. Amongst the material filed by the HSU in these proceedings is an Australian Government Department of Health Publication entitled "The Aged Care Workforce, 2016". That report shows that some 79% of employees in the aged care home care workforce are part-time, 5.3% are full-time and 15.3% are casual.
9. HSU members report being offered employment contracts with very low minimum hours, such as 15 hours per fortnight. Commonly, the minimum number of hours is about 20 hours per fortnight.
10. The rostering practices in many organisations leave staff vulnerable and open to exploitation.
11. In my experience, the requirement for a regular pattern of work hours for part-time employees in clause 10.3 (c) of the Award is one which is rarely observed.
12. Some of the employers in the home care sector may not have an enterprise agreement, and therefore rely on the Award as their primary industrial instrument.
13. Of the 190 enterprise agreements that the HSU is covered by, which contain provisions for staff to be employed in home care roles, none of the agreements contain specific provisions that guarantee a particular pattern of shifts, in the manner provided in clause 10.3(c) the Award.
14. Where enterprise agreements are in operation in the sector, the Award requirement is often diluted. Most commonly enterprise agreements in the sector contain a provision in the following (or similar) terms:

    'Before commencing part-time employment, the Employer and the Employee will agree in writing on the minimum number of hours to be worked and the rostering arrangements which will apply to those hours.'

15. Where such terms apply, in practice, they mean that prior to employment, a prospective employee is required to identify the days and times they are available to work, and are then rostered within those periods. New employees are not well-placed to demand limitations on the hours in which they are rostered.
16. Members report that changing or reducing their availability is viewed negatively by management and many say that they are fearful of repercussions were this to occur.

17. When I have raised this issue during enterprise agreement negotiations, employers have responded that it is often too difficult to accommodate changes to an employee's availability.
18. One employer has told me in enterprise bargaining negotiations that if an employee requests to change their availability, they reserve the right to refuse the request, potentially leading to termination as a result.
19. Alternatively if an employee requests to reduce their availability, they can expect the minimum hours in their contract of employment to be reduced, proportionally with the reduction in their availability.
20. Most HSU members work additional hours, in excess of their minimum number of contract hours.
21. Classifying work as 'additional hours', rather than regularly rostered hours, means that Award provisions such as consultation about roster changes (8.2) or notice about roster changes (25.5 (d)) do not apply.
22. Staff who have extremely low guaranteed hours per week are in a weak negotiating position to refuse the hours or to request changes to any additional hours offered.
23. Many members report feeling pressured to accept additional hours, even if the hours offered do not suit the staff member.
24. Members commonly say that if they do not accept additional hours that are offered, they will not be offered additional hours in the future.
25. One member said that when she declined to work additional hours, she was told that she would be rostered on the hours anyway and that she would now need to apply for annual leave if she did not want to work them.
26. Many staff rely on working 'additional hours' and could not survive on the extremely low minimum contracted hours, so are forced to accept whatever additional hours are offered.
27. This gives the employer little incentive to avoid short-notice roster changes and provides them with a group of staff that are willing to accept almost any shift that is offered to them.
28. By providing employment contracts with extremely low minimum hours, employers maximise their flexibility, minimise their liability and create a significant power imbalance by giving employees very little job security.
29. For staff members who do have regularly rostered shifts, they may still be changed at very short notice.
30. Changes are often caused by clients cancelling, or altering, their visits.
31. The Award provision regarding client cancellation (25.5 (f)) is replicated in most enterprise agreements.

32. This provision enables employers to change any upcoming shifts, up to 5pm on the day before a shift, if the client cancels or requests a change in time.
33. That means that employees, who may have been scheduled to work a morning shift close to their home, can be redirected to work an afternoon shift far away from their home, with less than 24 hours of notice.
34. Worse still, in the case of employees who are rostered to work 'additional hours' which are then subject to client cancellation, there is simply no obligation on the employer to provide alternate work and fulfil the shift that has been rostered.
35. So employees working high numbers of 'additional hours' are subject to far more precarious employment when it comes to client cancellation.
36. Our members also report changes to the roster on the day of shifts being worked, without any notice or consultation.
37. Most enterprise agreements make a provision similar to the Award condition 25.5 (d) (ii) that says:

    (ii) However, a roster may be altered at any time to enable the service of the organisation to be carried on where another employee is absent from duty on account of illness, or in an emergency.

38. In the case of home care employees, what constitutes an 'emergency' is often given a very wide interpretation by an employer.
39. Our members report that it is not uncommon for a roster to be changed on the same day, in some cases while en route to a client visit, and this being deemed an 'emergency' change by the employer.
40. Our members are then directed to change their shift pattern for the day, with no regard for any other plans or responsibilities the employee may have made, based on the scheduled roster.
41. If the member complains or refuses to work the altered shift, but the change is within the employees originally agreed 'availability roster', members report being told that they will not be paid as they are refusing work.
42. The cumulative effect of rostering patterns that change from cycle to cycle, along with frequent, short-notice changes within a cycle, is a highly destabilised workforce that is vulnerable to exploitation.

Minimum engagements

43. While casual home care employees have a 1 hour minimum engagement under the *Social, Community, Home Care and Disability Services Industry Award 2010*, there is

no such minimum engagement for part-time home care employees who make up the overwhelming majority of care staff in the home care industry.

44. Given the above issues with rostering, part-time employees are open to exploitation in the form of extremely small minimum engagements.
45. There is no provision in the Award that prevents a minimum engagement for a part-time home care employee of less than 1 hour, for example 30 minutes or even 15 minutes.
46. Some enterprise agreements do provide a minimum number of hours per shift.
47. However, some employers take the view that a shift may be made up of any number of 'engagements' (i.e. the periods of work) within that shift. For example, the employee could be 'engaged' to work for 30 minutes, then be on the 'break' part of a broken shift for 3 hours, before commencing another 30 minute 'engagement' of work, to complete a 1 hour shift for the day.
48. By having no minimum engagement for part-time employees – in terms of 'total hours per shift' or 'per work period within a broken shift' - the Award effectively provides no limit on the ways work could be divided in any given period, except for limiting such period to 12 hours.

Broken Shifts

49. Broken shifts are commonplace within the home care sector in New South Wales.
50. Issues related to broken shifts are one of the most regularly raised problems from union members.
51. The Award does not provide strong protection for an employee to refuse a broken shift, when directed to work by their employer.
52. The Award provides no compensation to an employee for the inconvenience of working a broken shift. A shift of two hours performed over two hours is compensated the same as a shift of two hours performed over a span of eight hours.
53. The Award does not regulate the length of 'break' between periods of work, except indirectly by the span of 12 hours or limit the number of 'breaks' in a broken shift.
54. Members commonly report having 1 or 2 hour breaks within broken shifts, which do not give them sufficient time to undertake other constructive activities in between periods of work, particularly when travel between clients is factored in.
55. Members also regularly report having to wait in their car or a public space, for their next period of work to commence.
56. Members in regional areas often report that the distance between home and their clients makes it unfeasible to return home between periods of work and have a proper

break (eat a meal for example) and then return to the next client engagement, making the broken shift inefficient for them.

57. Some members have reported having a high number of 'breaks' in any one shift, for example up to four or five breaks, in between short periods of work in worst cases.
58. Members have reported to me that they are effectively tied up for full days performing work or waiting to attend their next client, but only being compensated for a portion of their work due to multiple 'breaks' on their broken shift.
59. Many employers do not pay travel costs for travel at the start or finish of a shift. The effect of that approach is compounded where the shift is broken – the employee gets no compensation for the drive on to the next client engagement undertaken during the break in the shift.

Work related travel

60. At clause 20.5, the *Social, Community, Home Care and Disability Services Industry Award* provides that:

    (a) Where an employee is required and authorised by their employer to use their motor vehicle in the course of their duties, the employee is entitled to be reimbursed at the rate of $0.78 per kilometre.
61. Most home care employees in New South Wales do not work from the employer's business, but move between their own home and the clients' homes in the course of their work.
62. Most home care employees in New South Wales are not provided with a company vehicle to undertake their duties, but are required by their employer to use their own vehicle in the course of their duties, in order meet the requirements set by their employer.
63. A vehicle is necessary to perform home care work to carry necessary equipment and supplies, and to take clients on trips and outings.
64. Employees could not fulfil their role adequately without using their personal vehicle to undertake their duties and most employers structure the rosters of home care employees on the assumption that the worker will drive their own vehicle from client to client.
65. Our members regularly travel significant distances in order to meet the requirements of role.
66. In regional areas, this can include regular travel of 30km-40km, in order to make a single home care visit to a client.

67. Some members report being asked to in excess of 70km in order to make a home care visit.
68. While our members are ordinarily paid for travel between consecutive clients, they usually receive no allowance to use their vehicle in order to get to or from a client, if it is their first or last client of the day.
69. In some cases, it may be their only client for the day.
70. Further, it is commonplace for employers not to pay any kilometre allowance when an employee is travelling on a broken shift.
71. This means that home care employees may be required use their vehicle to service a client, then break for several hours, before commencing a visit another client, without receiving any kilometre allowance for the use of their private vehicle to undertake any of that work.
72. Some enterprise agreements go further than the Award to explicitly prohibit any payment for travel, in either circumstance.
73. Our members do not have a regular place of work, do not work a regular pattern of work and required their employer to use their own private vehicle to undertake their work.
74. As a result, our members report significant financial disadvantage due to this allowance not being paid for all work-related travel, including to and from all clients and while traveling on a broken shift.

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CHRISTOPHER FRIEND

15 February 2019

Fair Work Commission
Four Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award
Matter No: AM2014/285 and AM2018/26

STATEMENT OF PAMELA WILCOCK

1. I am employed as a Community Care worker for Hammond Care. I have been working in this role for three years. I cover the central coast of NSW.
2. I am a member of the Health Services Union NSW, ACT and QLD Branch. I am the union delegate at my workplace.
3. I am covered by the *HammondCare HammondAtHome Care Worker Enterprise Agreement* 2015.
4. I am a permanent part-time employee. I am contracted for 40 hours per fortnight, but can average over 50 hours per fortnight. These can be worked in my available hours, which are
5. Saturday, Sunday and Monday are my busiest days. On Saturday and Sunday, I generally see up to 4 to 5 clients in the morning between 8am to 1pm. Then I usually will have a break for 2 or 3 hours. In the afternoon, I will generally have 2 to 3 clients, sometimes 4 clients. This is generally in a period of between one and a half of three hours.
6. On Monday I generally work about 8 and a half hours between about 9am until about 5:30pm, and see on average about 4 clients.
7. Tuesday and Wednesday are generally my short days. On a Tuesday, I usually work between 10:30am and 4:00pm, with a break of about 10-20 minutes in between. Wednesdays I tend to only see two clients, one for a half hour and one three hour.
8. My role involves helping out clients with personal care including showers, toileting, applying creams. We are allowed to dispense medication if it is from a Webster pack. When we do, we have to check the medication and document what the client has taken. If the client declines to take the medication, we have to report that straight away to the manager. If they have antibiotics in a separate packet, for example, we're only allowed to

prompt them to take it themselves. I regularly take clients to appointments, shopping, or sometimes they just want to go for a drive.

9. My role sometimes involves respite care. With respite care your role is to be there with the client so that their family member can have time off and assist the client with any needs their carer would normally assist with. In my time with the company, I have worked five-hour long visits for clients needing respite care.

10. Showering clients can be very difficult. I often tell people to think about their own bathrooms and how they're set out. We're trying to assist people in and out of showers often in a tight space. Our client's bathrooms aren't like those in a nursing home where you have a lot of room to manoeuvre, equipment and extra staff at hand. It's also where a lot of injuries can happen if a client falls in the bathroom. We could become trapped in a bathroom if a client falls in front of the door. A small number of clients will have lifting equipment to help them in and out of their bed, chairs and into the shower. But the vast majority of clients don't have such equipment in their homes.

11. Sometimes clients cancel appointments with short notice because they have to go to hospital or for some other reason, and this can mean I don't make my 40 hours per fortnight minimum hours, as per my contract. When this happens I have to make up my hours at another time that fortnight. I generally make up my hours at one of Hammond Care's respite cottages or facilities. I have also seen other care workers in the head office doing administrative or filing work as part of their make up hours .

Cleaning

12. My role involves a lot of cleaning. We also make our clients' beds, and sometimes they request us to make up other beds in the house as well.

13. When cleaning we have to use whatever cleaning products the client has in their home. We usually end up using harsh chemicals like bleach. Using those products can ruin our clothes. Hammond Care does provide us with protective clothing and gloves.

14. We also have to often have to clean bodily fluids or urine. Often we're not dealing just with clients but with their pets as well, and I've had to clean urine and faeces from a dog that the client isn't able to care for.

Travel

15. The main concern for myself, and my fellow care workers (as best I can understand as the union delegate) is the travel we are required to do in the course of our work. We don't go to the same workplace day to day, rather, each work day we can go to the homes of a number of different clients. This can involve driving long distances.

16. We cannot plan our days much in advance as the schedule can be changed at any time up to the start of the shift, and sometimes even during the shift.

17. Our vehicles are our tools of trade. You cannot be a community care worker if you do not have a car. We need our cars to meet the schedules set by the employer, and also to carry out our duties when we need to take a client to an appointment or for a drive. We often have to put clients' wheelchairs and walkers in the cars and that can be difficult at times. When clients have misplaced their disabled parking permits, we can have difficulty finding parking and manoeuvring clients safely in and out of the car. The amount of driving required is such that it forms a large part of the working day. Some workers are available for shifts between 6am-9pm. Combined with the burden of driving, that length of work day can leave workers very fatigued.

18. A few workers have had accidents in their cars. But costs such as vehicle insurance and excess payments have to be covered by us. All these added costs weigh on our wages.

Phone use

19. We are given a phone by the company. That is common these days because we rely on our phone for work. We our phones for emails for work purposes, risk plans, amongst other things.

20. Our work schedule is issued through an app on the phone and it can be changed by management as required. It is common for our shift times and the location of our work to be changed at very short notice, including on the day of our work.

Rostering

21. I am a permanent part-time employee. But, while we are meant to have a roster fortnightly in advance, our roster is often changed at short notice based on the hours we've said we would be available.

22. My availability is from 8am to 6pm Saturday, Sunday, Monday and Wednesday. On Tuesdays my availability is from 9am to 4pm. This means that I can be rostered to work a minimum of 40 hours a fortnight during these available hours. My roster can be changed at short notice. On one occasion, I finished a client and had no other clients rostered on for the day, so I logged off from the app and went home. Then I got a call asking me to log back into the app and do another client visit.

23. This means employees are virtually on call for lengthy periods with no allowance. Employees are often asked to do a shift at short notice and expected to do so during the period of their "availability".

24. What this means is that it is difficult to make other plans or to leave the area during those “availability” periods. If you do so and then are not in a position to take a shift at short notice, that is frowned upon.

25. I’ve spoken to a lot of community care workers working for different employers, and from my understanding all of them work according to a similar system. That is, if you say you’re available between 8am to 6pm, you have to be available then. Your roster might have you finish at 3pm, but if the employer then calls you and asks you to do another shift at 4pm, you have to work, because you said you were available until 6pm.

Public holidays

26. Our employer offers us to sign a form to say if we do not want to be rostered to work on a public holiday. If we sign this form, we then don’t get paid for the public holiday. If we don’t sign the form, and say we’re available to work the public holiday, then we have to be available to work it, though we may not know whether we’re rostered on until the last minute.

27. The problem is that we never know whether we are working a public holiday or not until two days beforehand, or sometimes at even shorter notice. Your roster on the mobile phone app can can show that you don’t have any clients, but this can change at the last minute. It means you can’t plan anything. You can’t leave the local area in case your roster changes. If we complain about being rostered on a public holiday at short notice we’re told ‘but you said you were available to work’. This is also a problem in general, not just on public holidays.

28. We had a big discussion about this during bargaining for our enterprise agreement.

PAMELA WILCOCK

15 February 2019

Fair Work Commission

Four Yearly Review of Modern Awards

Social, Community, Home Care and Disability Services Industry Award

Matter No: AM2014/285 and AM2018/26

STATEMENT OF HEATHER WADDELL

1. I am employed as a Community Care worker for Hammond Care in the Shoalhaven area of New South Wales. I have been working in this industry for over 10 years.

2. I work mainly in aged care and with dementia patients. Most of the clients I provide care for are frail or aged, some clients are younger people with early onset dementia.

3. Hammond Care train their workers and are committed to looking after people in need of care. I enjoy my role as a care worker and gain satisfaction from knowing that I have made a difference to peoples' lives by assisting them to remain at home for as long as possible.

4. As a Community Care worker, my role involves assisting clients with all their daily activities of living, including socialisation and personal care and home maintenance This includes showering, dressing, administering medication from their Webster packs, house cleaning and cooking shopping and caring for their pets, leisure activities and community engagement.

5. I am a member of the Health Services Union. I am on the Aged Care Committee for the NSW/ACT/QLD Branch.

6. I am covered by the *HammondCare HammondAtHome Care Worker Enterprise Agreement* 2015. We have recently negotiated a new Enterprise Agreement for 2018 that is in the process of being ratified.

7. I am a permanent part-time employee. I am engaged to work a minimum of 20 hours per week, 40 hours per fortnight. According to our enterprise agreement, this 20 hours can be rostered any time within my available hours that I provided to my employer. My availability is from 7am to 7pm, 5 days a week. I don't work on Fridays or Wednesdays.

8. I am not always rostered on for my full 20 hours, in which case I have to make up hours in the following week.

9. As a Community Care worker I am required to supply my own registered, insured and clean vehicle to attend to clients as directed and transport them as necessary along with their wheelchairs or walkers on their various outings

Travel

10. The regional head office of Hammond Care in the Shoalhaven district is in Nowra. We have 3 teams, North team and South team and Ulladulla team I live about 32 kilometres south of the head office. I am part of the "South" team. We cover an area that stretches approx 100kms plus. We are sometimes rostered to cover clients in the North Team, and regularly the Ulladulla team's clients.

11. I sometimes have to travel long distances to visit clients. For example, I visit clients in Ulladulla, which is approximately 50 kilometres south of where I live. The furthest south I personally have travelled is to Kiola / Bawley Point (80km). The furthest North is Gerringong (63km). The furthest west is Kangaroo Valley and Budgong (54km) (which in my opinion you need a 4 wheel drive to get in and out of.) I have worked days where I have travelled 250 km in a day for 4 or 5 hours of paid work. I have been required to travel 50 kilometres to my first client, perhaps attend other clients in the area, then have a long break after having only performed a few hours of work, attend to other clients then travel 50km home.

12. On days like that, I would have to weigh up whether I should wait for hours in my car to save money on travel, or drive home during my breaks. Even though going home involves a long drive it is often the case that there is very little else useful I can do with my time in the areas around client homes. Driving 50 kilometres back home and then back out for the next part of your shift doesn't work out to be economical. But the other option is to be away from home for 13 hours for only 4 or 5 hours work which is emotionally uneconomical.

13. The employer doesn't pay for travel to the first client in a shift or back home from the last client, or travel time and kilometres in a broken shift. For home carers like me this can mean travel of great distances without being paid for the time spent undertaking that travel. We can ask our manager to get paid for kilometres or the time. But we have to make the request in advance, and it's only given at the manager's discretion and if our shift is less than 3 hours. I work on weekends – so late on Friday afternoon my roster can change and I'm travelling up to Ulladulla next day so I can't get prior approval before I go.

14. Driving such long distances in the country and driving home involves the risk of accidents. I've had incidents where I've run out of fuel while on the highway, and I've had to walk back up the highway up the hill to get reception on my phone to call someone to help me. I've hit three kangaroos in my time, and at least one was while driving for work. On that occasion, a kangaroo jumped on my car while I was driving between clients. I had to call for a tow truck and Native Wildlife Rescue to put the animal out of its misery and my partner to allow me to drive to next client whilst he waited for the other agencies to come. That

made me late for my client and distressed. Another occasion, coming home from a client, in Ulladulla, my back tyre blew on a bend at Jerrawangala and I came off the highway and into the ditch on the other side of the road. I went careering across the highway. Luckily no one was coming in the other direction. I had to phone for my partner to come and assist me.

Rosters

15. The clients we are rostered to visit can change at short notice. We have to check after 5pm the night before to see where we're rostered on the next day. The after hours schedulers may phone you between 5pm and 9pm and then again from 6am to change your roster.

16. I have found myself rostered 50 kilometres away at short notice and had no fuel in my car. I have then had to scramble to find money just for the fuel to get there.

17. In December 2018 I didn't RSVP for our work Christmas party on a Saturday, because I was rostered to work. On Friday my roster was changed. I would have been able to attend the Christmas party after all, but it was too late to change my RSVP. It's very difficult to make plans when your roster changes like that.

18. Sometimes the roster will change instantly due to emergencies. Normally, if you decline a job during a time you said you were available, the company will reduce your hours for that fortnight and you end up losing pay.

19. I've had my roster changed at the last minute when I've been rostered to work on public holiday. For example, I said I would be available to work on the Australia Day public holiday, but I didn't have anything on my roster. Then, in the late afternoon the day before, I saw I had two clients added to my roster, a total of one and half hours work. Both of these were clients I'd never worked with before, and one client needed their stoma bag changed.

20. It is hard to plan a holiday or break if you don't know whether or not you will working on a public holiday until shortly before.

Minimum Engagement and Broken Shifts

21. The minimum client visit at Hammond Care is half an hour. Often we are rostered on back to back, one client to the next, because each client visit is short.

22. The shortest shift I've worked is half an hour. A lot of the shifts we get are just half an hour.

23. Work is usually rostered around client meal times, so shifts tend to be around morning, lunch and evening. Generally shifts are broken with breaks in between those times being paid at $21 flat.

24. In our most recent Enterprise Agreement, we negotiated for a two hour minimum engagement. Previously we had a one hour minimum engagement.

25. But with broken shifts, the employer takes the minimum to mean two hours per day, not 2 hours per shift

Overtime

26. While shifts are usually short ones, there have been times I've worked much longer days.

27. On one occasion I recall working a nine hour straight shift. I drove to a client in Ulladulla and was there from 7am to 4pm, and was with the client the whole time.

28. I had no time to take a lunch or tea break, just to quickly eat the lunch I brought whilst caring for the individual.

29. There was no overtime paid on this shift because it was within my available hours and the shift wasn't over 10 hours.

30. I have been paid overtime when I've worked past 7pm, that is, over my available hours or over the 10 hours.

Telephones

31. The company supply us with a phone. We clock on and off with each client with an app on our phone. There are no hard copy paper rosters. We work on our own so our phone is our only contact with our employer, supervisor or other colleagues. We're asked to have our phone on our person at all times (though this can be difficult, for example, in wet areas while showering clients). Using the phone for emails, photos and apps is essential. I use the camera on the phone to take photos of client's wounds, which I send to my manager who is a clinical nurse, who will then advise how to dress it. We take pictures of our clients when they're out having a nice time on a social visit, and are added to their file for their families. We also take photos of clients to have on our records for our paperwork

32. My employer's primary form of contact is via an app. It is used for rostering, emails, communication with schedulers etc. Every night after our last client, or at 5:30pm, we have to log out of the app, then log back in to see what you're doing for the next day.

Clothing

33. We don't get uniforms at our work so we have to wear our own clothes. These get damaged and worn out very quickly with the kind of work we do. With cleaning we have to use the cleaning products the client wants us to use or has available. Often this is harsh chemicals like bleach that can splash and ruin our clothes. Clothing can also get spoiled with bodily fluids.

34. Hammond Care does provide single use aprons and goggles that we can use, for example when dealing with bodily fluids. These are kept at head office and we'd need to drive to head office before our shift to pick them up if we are rostered to them. I don't do this because the head office is usually in the opposite direction of my clients, and it doesn't work out economically to make that trip

[redacted]

Heather WADDELL

15 February 2019

Fair Work Commission

Four Yearly Review of Modern Awards

Social, Community, Home Care and Disability Services Industry Award

Matter No: AM2014/285 and AM2018/26

STATEMENT OF THELMA THAMES

Introduction

1. I am employed as a support worker by Uniting, which is an Aged Care provider based in NSW and the ACT. The company was previously called Uniting Care, but rebranded a few years ago. I am covered by the Uniting Aged Care Enterprise Agreement (NSW) 2017.
2. I have been working for the company for some 13 years. I started working with the company in 2006 as an enrolled nurse. Since 2009 I have been working in my current role in community care. I am the union delegate for our workplace.
3. My role involves assisting clients in aged care. A lot of my clients are in their 90s. Other are in their 70s or 80s. One of my clients is younger, in their 60s, but they have a medical problem which makes them less mobile.
4. The title of my role has changed over the years from 'carer' or 'care worker' to 'support worker'. The roles are very similar but the main difference is that being a care worker involves mainly personal care. That is, for example, showering clients, getting them in and out of bed, and assisting with medication. As a support worker we have a much broader duty statement.
5. The service is based on what the client's package allows for in their care plan. This may include:
    - personal care, which includes assisting with showering and toileting, for example
    - meal preparation
    - medication assistance
    - transportation to appointments, or errands such as the bank or hairdresser.

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- domestic assistance, for example making beds, vacuuming and mopping floors, cleaning the toilet and bathroom, laundry, shopping for groceries and discarding old food in the fridge (after asking the client)
- social support, such as taking a client out for lunch or coffee, or another activity to give respite for themselves and their family

6. A lot of my work now is domestic assistance. The employer tells us this is because clients now get more choice in their aged care packages and these are the tasks the clients want us to do. I find domestic assistance to be more physically demanding, wearing on the body and tiring than personal care. A few years ago, the domestic assistance shifts would be limited to 3 a week. Now we usually have 3 domestic assistance shifts a day.
7. Our shifts are broken up into 'microshifts' according to the client's care plan. For example, a one hour shift might be broken up into two microshifts, which could include 9 to 9:30, meal preparation, and from 9:30 to 10:00 domestic assistance. In a lot of cases, the entire shift is dedicated to domestic assistance, as per the client request. Another might be a three hour shift, and the microshifts will include personal care, medication assistance, meal preparation, domestic assistance and social support.
8. It also depends on the individual carer. For example, my clients know I can cook, so in my case, meal preparation means I will make them poached eggs, for example.

Rostering and hours of work

9. I am a permanent part-time employees, and contracted to work a minimum of 20 hours a week. I work these hours over four days per week. I'd like to have more hours. I'm not close to retiring and 20 hours a week is a semi-retired wage. Most weeks I work more than 20 hours a week, taking into account meetings and travel time.
10. On Mondays and Tuesdays I work full days, sometimes with a break for an hour. Wednesdays and Thursdays are usually short days.
11. The roster is very fluid, it can go up and down. You can access the roster in the company portal online two weeks in advance, and see the previous two weeks, but your shifts can be cancelled at any time. A client can cancel in less than 24 hours. I've been on the way to a job and the client has cancelled, and suddenly your four hour day is now two hours.
12. In the past, I have had some half hour shifts. I haven't had one in a while, but some employees do get these. Usually these are at the end of a day to help a client with meal preparation or their medications.

Travel and arrangement of work

13. Generally, breaks between clients longer than 10 minutes are called 'gaps' and are unpaid. Breaks an hour or longer are called broken shifts. We get an allowance of $10.74 for each broken shift.

14. The amount of travel I do varies. Some days I drive 50km in a day, other days 30km, some days it is only 10km. I work in the Sydney metropolitan area, so Sydney traffic can be a problem and cause delays.

15. When I have a gap or broken shift, I usually sit and wait in my car for my next client. Sometimes, if I have the time and I'm close to home, I will go home in this break. But often I will be waiting for an hour in my car for the next client, sometimes longer. The $10.74 we receive for a broken shift isn't much compensation when you have to sit in your car twiddling your thumbs for an hour and a half. It's been extremely hot in Sydney over summer, so sitting in your car can be very uncomfortable.

16. We don't get paid any travel time or a travel allowance for travelling to our first client in morning, and from the last client at the end of the day. We regularly have to travel 12 -15 kms to our first clients. Because we don't have the same place of work day to day this distance can be fluid. The company often roster the furthest away client on either end of our shifts, because they're not paying for travel. Traffic-wise, this can be difficult, especially in peak hour.

17. When I started working for my employer, we had two teams – east Sydney and west Sydney. I live in the East and requested to work in the East. But recently this has changed. I now cover what my employer calls 'Sydney Central', which means I work further out.

18. I live in Bondi, but am currently staying in Maroubra. I have been rostered to see clients in Camperdown, Lilyfield, Newtown, Balmain, Petersham, Dover Heights and Rose Bay.

19. As the union delegate I sometimes get calls from other employees, who'll call me to complain that they've been rostered to travel from the eastern suburbs where they love to South Strathfield, Beverly Hills and Bellfield to see clients.

Overtime

20. Occasionally, where necessary, my employer will extend my hours on a temporary basis. I may be required to work from 9am to 5pm, instead of 9am to 4pm on one day, for example. When this occurs, I do not receive overtime rates. We are only paid ordinary rates for the hours we work over and above our rostered or available hours.

21. One week earlier this year I worked an extra day, on Sunday, which I don't usually work. The client requested that someone be there the whole day, from 10am – 6:30pm. Last year there was another day I ended up working a whole extra day on Friday, which wasn't my usual day either. I didn't receive overtime for working these extra days either.

Telephones

22. My employer provides us all with a smart phone. We are required to use the online portal, called 'Care Link mobile', as our timesheet. For example, you use it to put in the time you start and finish with a client, and then you get the client to sign at the end of the service, before you log off. We also use something called 'Care Link portal' to access our rosters.

First aid

23. I hold a first aid certification. My employer pays for us to do the training through Red Cross. First aid is essential for employees doing the work we do. I used to be an enrolled nurse so have some nursing experience. That training comes in handy when working with our clients.

THELMA THAMES

19 February 2019

Fair Work Commission

Four Yearly Review of Modern Awards

Social, Community, Home Care and Disability Services Industry Award

Matter No: AM2014/285 and AM2018/26

STATEMENT OF BERNIE LOBERT

1. I am a disability support worker employed in that role on a casual basis by three different organisations:
    a. **Morcare Services** which is a company based in Wantirna South in Eastern Melbourne. The people I support are Transport Accident Commission (**TAC**) clients who have acquired brain injuries.
    b. **EACH** is a company limited by guarantee. The people I support have intellectual disabilities.
    c. **Possability** is a company limited by guarantee which is based in Tasmania but has recently branched into Victoria and now manage a number of TAC funded facilities. I work doing one-on-one community access.
2. I started working as a disability support worker in June 2012. Before that I was a Community Development Officer at a local council. I was made redundant in my 50s, so I moved into this sector, and then I realised that I really liked the work.
3. Initially what I liked about the work was the people and making a difference in peoples' lives. Now I also like that you don't have to take the work home with you, and that working one on one, you're only responsible to the person you're working with.
4. I am employed under the *Social, Community, Home Care and Disability Services Award* (**the Award**) for Morcare and Possability. EACH has an old 2009 Enterprise Bargaining Agreement, which is still current, but our pay and all of our conditions now come from the Award. Employees have been paid most of the conditions under the Award since 2016 because the Award rates were higher than the EBA. At the end of

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last year, EACH introduced casual loading, a first aid allowance and increased mileage rates. EACH has told employees that it wants to terminate the old EBA.

5. I work mainly in the East and South East of Melbourne. My furthest clients are in Frankston in one direction, and in Lilydale in the other direction. I work in suburbs including Glen Waverly, Ferntree Gully and Bayswater.
6. Including the time it takes me to travel home and back each day, and the driving I do with my clients, I end up travelling about 1000km a week. I keep a log of all the travel I do on my phone.
7. I mainly work in one-on-one community access; that is, supporting the client to participate in their community in the ways they decide they want to.
8. Activities I do with my clients include:
    a. Driving clients to programs organised by the disability service provider, such as cooking or woodwork programs;
    b. Taking clients on outings for coffees, to the movies, shopping, the gym, or other activities;
    c. Taking clients to medical appointments with their doctors, or with podiatrists, physiotherapists and hydrotherapy sessions.
9. The activities you do will change depending on the client. For example, one of my client likes to go shopping, so I will do a lot of driving with them to different shops across different suburbs, sometimes travelling 50km or 60km in a day.

Hours of work and travel

10. I work Monday to Friday and every second weekend.
11. My shifts are generally between 5 hours and 7 and a half hours in length.
12. My first employer was Melba Support Services. I was engaged as a casual employee, and completed my training with them. But wasn't given any shifts for about 3 months after I started. So I started looking elsewhere.
13. When I started out in the industry I generally worked shorter shifts. I did two hour shifts and some one hour shifts. At that time I was desperate to get into work and took whatever shifts I could take. My very first shift was a two hour shift in Carnegie. This was a good 45 minutes from where I live in Belgrave South. I spent 45 mins driving there and back.
14. After a few years I refused to do anything below 3 hours, as it's really not worth it. Whether you work 1, 3 or 7 hours, you still have to get ready for work, shower, get dressed, travel to your client, travel back home, and pay for fuel.
15. I prefer to work longer shifts because I didn't get paid for the time spent travelling between clients for my shorter shifts. I used to have a client in Ferntree Gully and

then another in Burwood East, so I could claim a per-kilometre allowance for the distance travelled between them (approximately 12 or 13km) but not for the approximately 20 minutes I spent driving from the first client to the next.

16. If you use your own car as a disability support worker, you're also required to have comprehensive car insurance.
17. I work for three different employers because I work casually, and I feel I need to spread the risk, given the work can be unpredictable and insecure. In the past I have had regular hours of work dealing with the same client or clients for years, and have those hours change suddenly because there are changes with the client's situation or in the organisation. For example, one client I worked for passed away, in another instance one moved into a facility. To spread the risk I worth for 3 different employers.

Telephones

18. My employers don't provide their employees with a phone, but we are expected to have a phone for the work we do. One company I used to work for, Melba Support Services, used an internet portal and they required employees to sign on and off for every shift using that portal within a half hour of the start or finish time. Because of this time limit, you couldn't do this from home; you needed to use a phone.
19. One company uses text messages to notify all employees when a shift is available. They'll regularly send out message to all employees with the date, time, suburb and shift length, for example, 1 February, 9am to 11am, Wantirna, and if you want that shift you click on the link to confirm your availability.
20. I'll also use my phone during the course of my work. I may need to call the ambulance if the client has a medical emergency, call doctors or podiatrists on behalf of the client, use the calendar to keep track of appointments, or look up movie times or other information during the course of working with clients. I may need to call my coordinator at times. For example, I've had to call my coordinator when I received a call from an Occupational Therapist about changing the gym hours for the person I support. On another occasion I had to call the after-hours coordinator when a person I supported had a fall, and I'd had to call the ambulance. I also use my phone to keep a log of my hours and the kilometres I drive. One of my clients also gets a monthly allowance from his provider, so I use my phone to keep track of how much we spend each visit.

Shift length and overtime

21. Most of my shifts are between five and seven and a half hours long. I don't generally work shifts that are any longer than that. It can be difficult working one on one with someone with a disability for 7 hours or more. Because the work is one on one, you can't have a break, you can't get away and you can't switch off.

First aid renewal

22. As a disability support worker you are required to have a current first aid certification, otherwise you can't get work. You need a CPR update every year and a new first aid certificate every three years. It costs approximately $100 for the first aid training once every three years, and $60 for the CPR training once a year. That works out to a cost to the employee of roughly $90 dollars a year.

BERNIE LOBERT

15 February 2019

Fair Work Commission
Four Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award
Matter No: AM2014/285 and AM2018/26

STATEMENT OF JAMES EDDINGTON

1. I have worked as the Legal and Industrial Officer at HACSU, Tasmania Branch since October 2010. In that role I am responsible, amongst other things, for bargaining for enterprise agreements, reviewing enterprise agreements, filing associated documentation with the FWC and representing members that have disputes with employers.

2. As our branch has members in the social and community and home care sectors, my work in respect of those two streams in the *Social, Community Home Care and Disability Services Industry Award* (**the Award**) represents a significant portion of my work. I was involved in the negotiation of a 2011 Tasmanian multi-employer agreement in the disability services sector and have played a significant role in negotiating enterprise agreements for homecare, disability services and community service employers in Tasmania.

Overview of Industry

3. The Social, Community, Home Care and Disability Services (**SCHCDS**) Industry in Tasmania consists of three broad sectors:

    a. Disability Sector, which consists of about 22 employers employing about 2,950 employees.

    b. The Home Care Sector, which consists of about 15 employers employing about 2,000 employees.

    c. The Social and Community Sector, which consists of about 130 employers employing about 3,000 employees.

Disability Sector

4. There are approximately 22 providers of disability services in Tasmania. There are about 5 large employers with more than 200 employees; 6 medium sized with 100 – 200 employees; and 11 smaller employers (fewer than 100 employees).
5. Across the sector, the staff of disability support providers consists predominantly of disability support workers (**DSWs**). Although the employment profile changes from service to service, DSWs make up in excess of 90% of the workforce (including team leaders, managers and co-ordinators). Administrative or clerical employees make up around 5% of the industry. In addition to those two categories of employment other employees in disability service organisations consist of:
    a. senior management,
    b. in some of the larger services, maintenance, groundskeeping, domestic and service staff;
    c. in some of the larger, facility based services, nurses and medical staff.
6. The 5 largest employers of disability support workers, and the approximate numbers of such workers they employ, are:
    a. Anglicare – 250 DSWs
    b. Possability – 422 DSWs
    c. St. Giles – 218 DSWs
    d. Liviende Veranto – 194 DSWs
    e. Mosaic – 250 DSWs
    f. Life Without Barriers – 175 DSWs
7. I have gleaned the numbers of DSWs employed by the organisations from organising in the sector, F17 forms lodged at the Fair Work Commission and other published materials.

Home Care Sector

8. There are 6 major home care providers in Tasmania who provide services utilising funding through the Home and Community Care (**HACC**) and Commonwealth Home Support Programme (**CHSP**) funding programs. They, and their approximate number of home care workers are:
    a. Anglicare – 200 home carers
    b. Community Based Support – 300 home carers

c. Independent Health Care Service – 300 home carers

d. Integrated Living – 300 home carers

e. Family Based Care North West – 122 home carers

f. South East Community Care – 75 home carers

9. Again, as with the disability services industry described above, I have gleaned the numbers of home carers employed by the organisations from organising in the sector, F17 forms lodged at the Fair Work Commission and other published materials.

Community Services Industry

10. The community services industry is vast in its breadth. There are approximately 130 different community organisations in Tasmania performing a wide range of community services. Broadly the community services provided by each are designed to assist the social inclusion, safety, wellbeing and health of recipients. Organisations include those that provide for:

a. Mental health (eg. Richmond Fellowship Trust;);

b. Physical wellbeing and health (eg. Arthritis Tasmania);

c. Shelters and protection from violence and assault (eg. Launceston Women's Shelter);

d. Housing and homeless support (eg. Colony 47);

e. Community houses (eg. Derwent Valley Community Houses);

f. Drug and alcohol counselling and education (eg. Holyoake Tasmania);

g. Family and relationship support (eg. Family Relationship Centre);

h. Legal support (eg. Women's legal service);

i. Work and training (eg. Work Solutions Australia);

j. Charity (eg. St. Vincent de Paul);

k. Aboriginal assistance and support (eg. SETAC Primary Health Care & Wellbeing).

11. The largest providers of community services in Tasmania are Anglicare, with approximately 275 community service (as distinct from disability and home care workers and excluding administration and home care staff) employees; and Catholic Care which has 300 support workers providing child and family assistance and housing.

12. Other large providers include:

l. Richmond Fellowship Trust – 80 support workers working in group homes for residents requiring mental health support;

m. Colony 47 – 104 support workers providing housing and homeless support, mental health services, and education and employment services;

n. Mission Australia – 69 support workers assisting in homelessness, alcohol and drug counselling, mental health and employment, skills and training, youth services and family and children services.

13. The majority of community service providers in Tasmania are small (between – 10-40 staff). For instance, The Link Youth Health Service has 22 support workers and 4 administration staff. EACH, which provides counselling and family violence services and a children's contact service has 10 staff made up of 7 support workers and 3 administration staff.

14. Increasingly Award employers have shown a desire to employ both home care and disability services staff. In negotiating enterprise agreements, organisations that traditionally only operated in home care have sought to expand into disability services. Similarly, employers that have historically only provided disability services have now sought to expand into home care. Almost every aged care provider in Tasmania has sought to expand their service from a facility-based service to a home care service. An example of employers proposing that one employee may have multiple functions based on different Award classification descriptors is the negotiation of the *Liviende Veranto Enterprise Agreement* 2016 [2016] FWCA 4686. This employer historically has only been a disability service provider. They sought to branch into home care. The parties included in the enterprise agreement Cl. 13.6, a clause that allowed employees to be employed in multiple positions (ie. as both a disability support worker and home care worker) provided the employee voluntarily applied for a second role and the total ordinary hours would be an average of 38 per week over two weeks. Similarly, in negotiating the recently approved *South Eastern Community Care Community and Disability Support Workers Enterprise Agreement* 2018 [2018] FWCA 7646, the employer, an organisation that traditionally only provided home care services sought for a change of scope and classifications to include disability support work.

Rates of pay

15. The very large majority of disability service providers in Tasmania pay staff at Award rates only. When we negotiate enterprise agreements in the sector wage rates are almost universally at Award rates including the rates determined in the Equal Remuneration Order.

16. Negotiated home care rates in EBAs (because the ERO has not applied to home carers) may be slightly higher than the Award (approximately 2% higher).

17. Social and Community sector wages rates (other disability services) are commonly at Award rates but may be above Award for occupations requiring higher qualifications.

18. There are 22 disability services and 6 home care organisations in Tasmania that are covered by enterprise agreements and for which we bargain replacement agreements.

19. There are 6 larger employers (eg. Anglicare, Richmond Fellowship Trust, Colony 47) providing community services that have enterprise agreements and that we bargain for. As that sector has approximately 130 small employers it is difficult to bargain effectively across the sector.

Scheduling of work, minimum engagement and broken shifts

20. The most common issue of concern for employees in the home care sector is the scheduling of work and length of minimum engagement. In Tasmania home care employers have taken the approach that travel to any engagements beyond one hour apart is not travel 'in the course of duties'. This means employees must bear the cost of travelling from one client to another if there is a break of more than one hour between engagements. It is reported to me by members that there are often breaks of more than 1 hour between engagements or that engagements that are significant distance from an employee's home are rostered as the first engagement.

21. Often home carers in Tasmanian are required to travel significant distances to work for clients. I am aware of employees having to travel between 30 and 50 kilometres to client homes. If an employee has to pay for their own travel to attend to clients for work and then only have an engagement of 1 hour (or, in the case of part-time employees 15 minutes or 30 minutes) it is uneconomical to work. That is, the cost of travel to and from the client may exceed or be approximately the same as wages received for the hour of work performed. Members have informed me that they tolerate such economic inequity because they feel a sense of duty and obligation to their clients and that if they refuse such shifts they will no longer get any work at all.

22. There is no minimum engagement for part-time employees pursuant to the Award. I am aware of employees being asked to work shift lengths as little as 15 minutes. Commonly engagements are 1 hour, which is the current minimum engagement for casual employees.

23. Broken shifts are relatively common in both home care and disability services in Tasmania. Historically, pursuant to the state Tasmanian Disability Service Providers Award,

employees were paid an allowance when required to work a broken shift. This allowance partly ameliorated the inconvenience and expense associated with having a break between shifts.

Experiences of HSU members

24. The home care industry is a difficult one to organise, because employees don't have a workplace as such. As a union official, I can't just call a member meeting at a workplace to ascertain views on various issues because there is no common workplace. Whilst home care organisations often do have an office, home carers themselves do not often frequent it. Organising in this sector usually involves a lot of individual conversations.

25. In the course of preparing this statement, I spoke to a number of our members working in home care or disability support work about the conditions of their employment. These employees did not wish to reveal their names or the names of their employers, as they were fearful that their employment would be adversely affected, such as by having their hours reduced by their employers. Most employees in this sector in Tasmania are underemployed, and are always seeking extra shifts to make ends meet. They therefore feel constrained about speaking out about their employers.

26. Because of this, I have provided de-identified information about these members and employers below. I refer to the employees as Employee A, B, C, D, E and F. I refer to the Employers as Employer X and Y. This information is based on conversations I had with our members, and the notes I took from these conversations.

Employee A

27. A works as a home carer for Employer X. The applicable instrument is the Award. A is employed at Home Care level 3.2 of the Award and paid at the rate applicable to that level (that is, $22.70 per hour). A has worked for employer X for 14 months and is a permanent part-time employees. A works 30 hours per week.

28. Like most employers in the sector, the employer is funded for home care services through either the Commonwealth Home Support Program (CHSP), the Tasmanian Home and Community Care program (HACC) or through Home Care Packages (HCP). The HACC program provides funding for home and community care services that support persons who are under 65 years or Aboriginal and Torres Strait Islander people aged less than 50 years of age living with disabling conditions. HACC services are targeted towards people who need assistance for independent living. The Commonwealth (CHSP) program provides funding for persons over the age of 65, or Aboriginal and Torres Strait Islander people that are 50 years or older.

29. Despite the Award (Cl. 25.5) requiring that a roster will be posted at least two weeks before the commencement of the roster period, employer X posts rosters 3 days before the roster period commences. I am aware that this Award clause is commonly breached by home care employers in Tasmania.

30. Employer X at times rosters sizeable breaks between seeing clients. They have determined that any break of greater than one hour between clients means that the travel between clients is not in the 'course of duties.' This means that an employee is responsible for their own travel costs, subject to the radius limit described below) when travelling between clients if the break between those visits is more than 1 hour.

31. In late 2018, every Wednesday, A worked the following work day:

    a. Leave home in Legana at 7.20am to beat school traffic for first client at Youngtown. Travel of 22 km. A is responsible for her travel costs for this leg. The work at Youngtown was for 1 hour.

    b. A then left Youngtown to go to next client at Newnham. The time between the work at Youngtown and Newnham was one hour. The distance travelled was 15 km. The employer paid the cost of travel (.78c per kilometre) as the break between shifts was one hour or less). A would, however, sit in her car on the side of the road waiting for her work at Newnham to commence. The work at Newnham was also 1 hour in length.

    c. A then left Newnham to drive to her next client at Beauty Point. The distance between Newnham and Beauty Point is 51km. The break between these work engagements was 1.5 hours. The work at Beauty Point is 2 hours in length. As the break between the Newnham work and Beauty Point work is 1.5 hours (beyond 1 hour) the travel in between is not considered in the 'course of duties'. As such A had to pay for their own travel although X have a policy that an employee is only responsible for the first 25 km (if rostering is done in Tasmania) or 30 km of travel (if rostering is done in Melbourne). That is, a 51 km trip will see the employee pay 30km and X will pay travel (ie. the Award travel allowance of .78 pe kilometre for 21 km.

    d. After finishing the two hours of work at Beauty Point A then drove home to Legana (36 km). This travel is not in the 'course of duties' and thus A is responsible for the first 25 km of travel (if rostering is done in Hobart) or 30km (if rostering is done in Melbourne).

32. In summary, on Wednesdays in 2018, A left home for her first client at 7.20am and returned home from her last client at approximately 3.30pm: Approximately 8 hours. In that time, she was paid for 2 x 1 hour shifts ($22.70 per hour) and 1 x 2 hour shift; ie. a total of 4 hours work. She travelled 124km. Of that, she was responsible for 88km of travel and the employer paid her (at the Award rate of .78km) for 36km.

33. A informs me that there has been one improvement in the rostering in 2019 in that a half hour unpaid meal break can be allocated in the day. If X requests that meal break to be allocated between her Newnham and Beauty Point work the break between those work engagements is reduced to an hour and therefore the employer will pay the cost of travel between the Newnham and Beauty Point engagements. She indicates that the unpaid meal break is normally scheduled at the end of the day so she has to have it changed to best accommodate her work schedule.

34. In the past, A has worked a similar shift requiring that A travel between a client in Youngtown and a client in Deloraine (again 50 km apart). The shift was for two hours. The payment of travel arrangements was the same as above. That is, A had to pay for 30km of the 50km travel.

35. Recently, A has been asked to work a shift that finishes at 12.15pm in Newnham in Northern Tasmania. A is then rostered to work for 15 minutes at 4.15pm in Mowbray. Newnham to Mowbray is 6km. Because the break between engagements was more than one hour she has to meet the travel cost to work the 15 minute engagement. A has the choice of driving 30 km each way (60km round trip) to get home from the 12.15pm Newnham engagement. This means A either travels 60km at her own expense for a 15 minute client visit or sits around after 12.15pm in the car until the 4.15pm job starts.

Employee B

36. Employee B also works as a home carer for X. B is a casual. The applicable instrument is the Award. B is employed at level 3 of the Award. B has worked for employer X for 2.5 years and is a casual employee.

37. B has been rostered on for one hour shifts by X. In December 2018, B was asked to work a one hour engagement in Westbury, which involves travelling from Perth. The time between engagements is beyond one hour, so the employee is responsible for their own travel costs for the first 25 or 30km one way. The round trip is 78km. Therefore, the employee will pay for 50km of travel and the business will pay for 28km. The travel cost is $39 based on a travel allowance of 78c per kilometre. It is understood the travel allowance rate takes into account factors such as the cost of fuel, wear and tear, depreciation of vehicle and higher insurance costs. B is not paid for the time spent travelling. Effectively,

B loses money to work the one hour engagement. B indicated that it is very difficult to refuse shifts because refusing shifts will result in not being rostered for other shifts.

38. In the weeks preceding the making of this statement B obtained some other part-time work and is thus in a position to refuse shifts which require uneconomic travel; ie. the cost of travel is the same or greater than the cost of remuneration for the work performed.

Employee C

39. Employee C is a permanent part-time home carer in Northern Tasmania and works for Employer Y. C has worked for Y for 15 years. Approximately half of the workforce are covered by an old Enterprise Bargaining Agreement (EBA) - the Family Based Care Association (Northern Region) Inc. Direct Care Worker Employee Collective Agreement 2009-2012 - that has never been terminated. Newer employees are covered by the SCHCDS Award.

40. C is covered by the old EBA. C is rostered to work shifts of half an hour in duration. The Award has no minimum engagement for part-time home carers.

41. The old EBA provides that employees are entitled to claim 60 cents per kilometre where kilometres are incurred for work purposes; and also claim 60 cents per kilometre for all kilometres beyond 15 km to and from the first and last client per day (ie. the employee is responsible for the first 15 kilometres).

42. C has a job on Saturdays that C effectively performs for little remuneration. C travels from Prospect to Hillwood (a distance of 37km) to work with a client for one hour. C must meet the first 15 km of the travel costs each way, meaning C is only compensated for 44 kilometres of 74 kilometres travelled. C is paid at $27.35 per hour.

43. C retains the client as C does not want to let the client down.

Employee D

44. D works as a permanent part-time employee for Employer Y. D is covered by the Award. They are contracted to work 40 hours a fortnight.

45. D lives in Scottsdale, and was asked to work a one-hour shift in Labrinya (36km away) as their first client. Y asks employees to pay for the first 35km of travel unless the travel is between jobs. If the time between jobs is more than 1 hour then travel will no longer be in ‘course of duties’ and the employee will have to be responsible for the first 35 km of travel.

46. In another instance, D was asked to work a 1.5 hour shift in Bridport, which is 25 kilometres away. This would mean that D has to bear the cost of the travel.

Employee E

47. E works for Employer X and is covered by the old EBA described above.

48. E is a permanent part-time employee.

49. Like employee C above, E is rostered to work on half hour shifts.

50. E has been required to work a shift involving travel from Deddington to Norwood in Northern Tasmania (approximately 38km) for a half hour shift with one client, than travel from Norwood to Perth (approximately 16km) for another half hour shift, then from Perth to Kingsmeadows (approx. 14km).

24 hour care

51. To my knowledge, the 24 hour care provision in the Award is not frequently used in Tasmania. I am aware of one employer that includes the Award 24 hour care provision as a term in their enterprise agreement (*Community Based Support Enterprise Agreement 2014* [2014] FWCA 8298).

52. The 24 hour care clause became an issue in bargaining when the FWC sought that employers include the clause in enterprise agreements by way of undertaking at the approval stage of the *South Eastern Community Care Community and Disability and Support Workers Enterprise Agreement* 2018 (AG2018/2506) and at the approval stage of the variation to the *Liviende Veranto Enterprise Agreement* 2016 (AG2018/3439).

53. The HSU made submissions to the FWC that a 24 hour clause should not be included in the above EBAs by way of undertaking because, in both cases, the parties had negotiated a maximum hours for a shift or day clause and time worked in excess of those hours was to be paid as overtime. This resulted in a far more beneficial arrangement for employees than an arrangement whereby they may be available for 24 hours (perhaps in its entirety at work) and only paid at 155% for 8 hours. A 24 hour clause is not financially more beneficial for employees, and the inclusion of such a clause subsequent to an Agreement being made would represent a substantial detrimental change to the Agreement negotiated. The FWC ultimately accepted the HSU's submissions and did not proceed with its initial request to the employers to provide undertakings regarding the 24 hour clause.

54. 24 hour care shifts are strongly opposed by our membership. They result in an overall paltry rate of pay given the employee may be at work and unable to engage in other pursuits or perform other responsibilities, such as family responsibilities for 24 hours. The Award 24 hour care clause is uncertain and ambiguous because:

    a. it is not clear as to what is meant by *'be available for duty in a client's home'*. The HSU's interpretation is that to be available for duty may not mean actually being

present in the client's home but being *'available'* to be. This position is supported by 25.8(b) which states an employee *'will normally have an opportunity to sleep during a 24 hour care shift and, where appropriate, a bed in a private room will be provided'*. Given that an employee would be expected to sleep at some stage in a 24 hour period the absence of compulsion to provide a bed suggests the *'availability for duty'* does not necessarily mean *'present for duty'*;

b. pursuant to the 24 hour shift clause an employee is required *'to provide no more than 8 hours of care'*. The issues of how the 8 hours care are to be recorded and the activities that constitute 'care' are contentious. In circumstances of 24 hour care, the maintenance of an accurate record of "caring" time is likely to be difficult. A question also arises as to the pay arrangements if the 8 hours of 'care' have been provided and the employee is then asked to do further care tasks? If an employee is present over a 24 hour care shift it appears unlikely they will reasonably be able to refuse to provide care if they have already provided 8 hours care.

Telephone Allowance

55. I am aware employees in the SCHCDS sector require a telephone to be contactable regarding direction to work shifts or fill shortfalls due to alterations in the roster. In home care particularly there is high degree of fluidity regarding employees being or making themselves available for certain shifts and thus are very regularly contacted on their personal phone in their own time by their employer. If there is an issue with certain clients employers will also contact employees on their personal phone in their personal time.

Overtime

56. There is an inconsistency in the overtime provision of the Award in that part-time employees are only paid overtime after 10 hours worked in a day yet full-time employees are paid overtime for work in excess of 8 hours per day (rostered ordinary hours). Cl. 25.1 provides that the maximum ordinary hours of work for a shift shall not exceed 8 hours (this applies to all employees including full-time and part-time employees). By agreement, the ordinary hours may be worked up to 10 hours per shift. If a part-time employee is directed to work in excess of the stipulated maximum hours per shift (8) then they will not be paid overtime for doing so (until they work in excess of 10). There should be alignment between the maximum hours per shift and overtime provision.

First aid allowance

57. The First Aid Allowance (cl. 20.4), as currently drafted, has no practical application for home care employees. Home care employees in Tasmania work on their own almost exclusively. They travel from client to client doing tasks such as performing respite care, personal care and domestic duties. Employers in Tasmania mandatorily require home carers to hold a first aid certificate if they provide personal care (as opposed to just domestic services) to clients. However, given home carers do not commonly work with fellow employees they will not be required by their employer *'to be responsible for the provision of first aid to employees employed by the employer.'* They may be required by their employer, however, to provide first aid at their workplace (which is clients' homes). In that event, however, they will not, unlike disability support workers and SACS workers with the same requirement, be entitled to the allowance.

JAMES EDDINGTON

15 February 2019

Fair Work Commission
Four Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award
Matter No: AM2018/26

FURTHER STATEMENT OF MARK FARTHING

1. I am employed as the National Campaigns and Projects Officer at the Health Services Union (**HSU)**. I have been employed in this position since September 2019.
2. I was previously employed as a Senior Policy Advisor for the Health Services Union (**HSU**) Victoria No. 2 Branch, also known as the Health and Community Services Union (**HACSU Victoria**) from March 2016 until September 2019.
3. I have substantial research experience in the health and community services sector, with particular expertise in disability services and the National Disability Insurance Scheme (NDIS), as well as more broadly in industrial and workforce research and policy.
4. Between 2013 to 2016 I was employed as the Senior National Project Officer in the Health Services Union National Office.
5. My work background is set out further in my previous witness statement dated 15 February 2019.

Overview of Changes to NDIS Price Guide

6. The National Disability Insurance Agency (NDIA) is responsible for setting price limits and policies relating to the delivery of NDIS-funded supports.
7. This function of the NDIA is achieved through the production of a document known as the “Price Guide”.
8. Price Guides typically operate for a full financial year (1 July to 30 June).
9. At least once per year, usually just prior to the end of the financial year, the NDIA revises the Price Guide to account for wage rises and general inflation. However, in some years more substantial variations to prices are implemented, either at that time or otherwise

because of Commonwealth Government policy decisions and/or at the behest of the NDIA Board.

10. In the 2019-20 Price Guide, which came into operation on 1 July 2019 and is in operation as at the time of the making this statement, significant changes were made to several price categories and policies. In summary these were:

    a. General price increases and significant above-inflation increases for therapists and attendant care and community participation supports. For example, the price for attendant care and community participation supports delivered during the daytime on a weekday to a standard needs participant was increased from the previous financial year by 9.78% (or 18.01% when the TTP Payment is taken into account). The rates were as follows:

       Assistance With Self-Care Activities – Standard – Weekday Daytime (Level 1) [01_011_0107_1_1]

       2018-19 = $48.14

       2019-20 = $52.85/$56.81 TTP

    b. The introduction of a Temporary Transformation Payment (TTP), which is a conditional loading calculated at 7.5% of Level 1 (standard needs) prices, but applicable in respect of Level 2 and Level 3 supports as well. The TTP will reduce each subsequent year by 1.5%. Providers can claim the higher TTP prices as long as they publish their service prices, list and keep up-to-date their business contact details in the NDIA's "Provider Finder" and participate in an annual NDIA-approved market benchmarking survey.

    c. A doubling of the remote and very remote loadings from 20% to 40%, and from 25% to 50%, respectively, of the price of the scheduled attendance. The rates for attendant care and community participation supports delivered during the daytime on a weekday to a standard needs participant are as follows:

       Assistance With Self-Care Activities – Standard – Weekday Daytime (Level 1) [01_011_0107_1_1]

       Metro = $52.85/$56.81 TTP

       Regional = $73.99/$79.53 TTP

       Rural = $79.28/$85.22 TTP

    d. Increases to the length of time that providers can claim for the time spent travelling to participants from 20 to 30 minutes within city areas, and from 45 to 60 minutes in regional areas.

e. Clearer rules around charging for non face-to-face time, with the NDIA stipulating that these activities are billable if they are part of delivering a disability support item to a participant such as writing a report about the participant's progress (rather than a general activity such as staff rostering).

f. A revised cancellation policy which abolishes the limit on the number of cancellations or "no shows" that be charged per year (see section below for more detail on client cancellation policy changes)

Response to AiG Submission

11. In paragraph 76 of its submissions dated 13 July 2019, the AiG suggests that the only increase applied in the 2019-20 Price Guide was the 4.5% increase relating to the Commission's Annual Wage Review decision and the operation of the Equal Remuneration Order. This overlooks the increases announced by the Commonwealth Government on 30 March 2019, the key elements of which I refer to in paragraph 10 above, and which were incorporated into the 2019-20 Price Guide in addition to the 4.5% increase.

12. In paragraph 77 of its submission the AiG suggests that *"the information published by the NDIA to date does not suggest that the assumptions underpinning the pricing arrangements have been changed or that any additional funding has been released to address broader concerns previously expressed by employers about the inadequacy of the funding to cover the various costs associated with providing the relevant services, including labour costs."*

13. While the NDIA has not released materials explicitly identifying the methodology underpinning price limits for supports in the 2019-20 Price Guide, it does not necessarily follow that prior published pricing methodologies and assumptions are still correct, for the reasons I set out below.

14. In section 5.3 of its submission, the AiG refers to the NDIA's "Reasonable Cost Model" (**RCM**) and the report published by the University of NSW in June 2017 titled *"Reasonable, necessary and valued: pricing disability services for quality support and decent jobs".* (**UNSW Report**)

15. The HSU along with the ASU and United Voice commissioned this report. I was intimately involved in working with the research team during the production of this report and was identified as such in the acknowledgements section prefacing the report, and am in a position to comment on the parameters of that research.

16. The UNSW report examined NDIS prices as they were in the NDIA's 2016-17 Price Guide, with the focus of analysis on the "base hourly rate" for standard needs, weekday, daytime support at $42.79 per hour, specifically the support item: *Assistance With Self-Care Activities - Standard - Weekday Daytime*

17. In the 2019-20 Price Guide the price limit for *Assistance With Self-Care Activities - Standard - Weekday Daytime* is $52.85 ($56.81 with the Temporary Transformation Payment (**TTP**) loading). This represents a 23.51% increase (32.76% with the TTP) compared with the 2016-17 price limit.

18. The 2016-17 rate for a SACS 2.3 worker was $24.70 per hour, whilst the current (2019-20) rate for the same worker is $28.44. This represents a 15.14% increase over the same period. These wage rates are inclusive of the ERO component.

19. The NDIS price item has increased at a rate which is substantially greater than the increase in wages for the average level disability support worker. The price limits in the 2019-20 Price Guide therefore do not reflect the assumptions that were contained in the NDIA's original RCM, which was the focus of the UNSW report.

20. The AiG's claim in Paragraph 151 that *"there is nothing to suggest that the fundamental problems identified in the UNSW Report with the RCM will be alleviated by the funding increases"* appears to disregard the fact that the price increases and additional payments set out above well and truly outstrip wage growth, provide some significant new bases of entitlement to payment and presupposes that the assumptions contained in the RCM are still built into the price structure.

21. The UNSW report also critiqued a number of NDIA policies contained within the 2016-17 Price Guide which have subsequently been addressed in the 2019-20 Price Guide. These include:

    a. Increasing the intensity loading for more complex participants, from two levels (standard and high-intensity) in 2016-17, to three levels Level 1 (standard), Level 2 (high intensity/complex) and Level 3 (higher intensity/more complex) supports in 2019-20;

    b. A doubling of the remote and very remote loadings from 20% to 40%, and from 25% to 50% respectively of the price of the scheduled attendance.

    c. Updates to the length of time that providers can claim for the time spent travelling to each participant to 30 minutes within city areas and 60 minutes in regional areas. This is an increase from 20 and 45 minutes, respectively.

d. Clearer rules around charging for non face-to-face time, with the NDIA stipulating that these activities are billable if they are part of delivering a disability support item to a participant such as writing a report about the participant's progress (rather than a general activity such as staff rostering).

e. A revised cancellation policy which abolishes the limit on the number of cancellations or "no shows" that be charged per year (see section below for more detail on client cancellation policy changes)

22. In summary, the AiG submission relies heavily on the UNSW report, which is predicated on an analysis of NDIS prices in the 2016-17 Price Guide. In light of the significant changes to both price limits and pricing policies contained in the 2019-20 Price Guide, much of the analysis in the UNSW report is no longer relevant.

Client Cancellation

23. The NDIA has significantly revised its cancellation rules in recent Price Guides.

24. In the 2015-16, 2016-17, 2017-18 Price Guides, the NDIA allowed providers to charge a participant the full amount of a scheduled personal care or community support up to 8 times per year when there was a short-notice cancellation or a "no show" by a participant. A short-notice cancellation was defined as such if the participant advised the provider after 3pm the day before the scheduled service.

25. In the 2018-19 Price Guide, the NDIA revised its cancellation rules which increased the number of times a provider could charge a participant for a short-notice cancellation or "no show" from 8 to 12 times per year, however, it reduced the amount that a provider could charge from 100% of the cost of the scheduled personal care or community support to 90%.

26. The 2018-19 Price Guide did not set 12 cancellations per year as a hard limit, instead specifying that "beyond this threshold, the NDIA will require the provider to demonstrate they are taking steps to actively manage cancellations."

27. In the 2019-20 Price Guide, which came into operation on 1 July 2019 and is in operation as at the time of the making this statement, the NDIA revised its cancellation rules again.

28. The revised cancellation rules provide for the following:

a. A provider can charge an NDIS participant for a "short-notice" cancellation up to 90% of the fee associated with the scheduled activity/service.

b. A "short-notice" cancellation is defined as such if the participant:

i. does not show up for a scheduled support within a reasonable time, or is not present at the agreed place and within a reasonable time when the provider is travelling to deliver the support (i.e. a "no-show"); or

ii. has given less than 2 clear business days' notice for a support that meets both of the following conditions:

- the support is less than 8 hours continuous duration; AND
- the agreed total price for the support is less than $1,000; or

iii. has given less than 5 clear business days' notice for any other support.

c. There is no limit on the number of short notice cancellations (or no shows) that a provider can claim in respect of a participant.

29. By way of example, a participant who had booked 2-hours of standard-needs community access between 9am to 11am on a Thursday at a cost of $125.38 who cancelled any time after 9am on the Tuesday prior could be charged $112.84 by their provider. Whereas a participant who had booked a full-day stay at a respite facility on a Thursday to receive 1:1 supports at a cost of $1,546.39 who cancelled anytime after 9am Friday the prior week could be charged $1,391.75.

30. In summary, the 2019-20 Price Guide provides significantly more flexibility and certainty to providers by abolishing the limit on the number of cancellations that may be charged per year and extending the definition of a "short notice" cancellation from 3pm the day before the scheduled service to less than 2 clear business days before the scheduled support.

31. The claims made by ABI in paragraphs 5.12 and 5.13 are therefore no longer correct in light of the 2019-20 Price Guide.

32. The revised cancellation rules in the 2019-20 Price Guide provide a significantly expanded capacity for service providers to recoup the costs of service cancellations.

Mark Farthing

16 September 2019

BEFORE THE FAIR WORK COMMISSION

MATTER NO. AM2014/196 & AM2014/197

Part-time Employment

Casual Employment

Filed on behalf of:	**Health Services Union**		
Filed by:	Leigh Svendsen Senior National Industrial Officer	**Mobile:**	[redacted]
Address:	54 Victoria St, Carlton VIC 3053		
Phone:	03 9020 1870	**Email:**	leighs@hsu.net.au

Statement of Scott Quinn

I, Scott Graeme Quinn, Disability Support Worker at Community Based Support, of [redacted] Tasmania say:

1. I am a member of the Health Services Union, Tasmania Branch, and a delegate of the Union within my workplace.

2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. I was born on 17 January 1970.

4. I am married.

5. My wife and I care for our two infant children aged 18 months and 1 month.

Work History

6. I have worked in disability services/aged care since about July 2006.

7. I have Certificate III in disability and a Certificate IV in Home and Community Care

8. I have worked at Community based Support Tasmania (CBS) since entering this sector in 2006.

9. Before working at CBS I was on a disability Support Pension, due to an earlier workplace injury where I had a severely injured knee.

10. Before surviving on a disability Support Pension I worked at Bennetts Patroleum in a fuel supply role, servicing homes and business and machinery; I fell from a ladder at work, which originally was a workers compensation claim after smashing my knee.

Current Work

11. In approximately July 2006, I commenced work with Community Based Support (CBS) as a part time employee, this was under an Australian Workplace Agreement (AWA). I worked between 120 and 130 hours per fortnight at that time.

12. There was a 15% loading, only applicable to hours worked outside of 6am to 10pm; this loading also applied from 10pm Friday until 6am Monday.

13. In 2010 my employment conditions were greatly improved with the introduction of the modern Awards. This facilitated the Negotiated Enterprise Agreement at CBS.

14. I am employed under (Community Based Support Inc (AG2014/9677)) COMMUNITY BASED SUPPORT ENTERPRISE AGREEMENT 2014. This is predominantly based on the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS). I am classified under the Agreement as a LVL 2B Grade 2; this is the effective equivalent as a Home Care Employee LVL 3 PP2, under the SCHADS Award.

15. I currently work an average of 37 to 40 hours worked per week; but I am only contracted for 60 hours per fortnight.

16. I work varying hours over a seven day period, including early morning starts and later night finishes.

17. I work a few night shifts as part of 'patient sitting' with patients in hospital.

18. Normally I have every Thursday off and every second weekend off. Occasionally I am asked to work on those days.

19. I have no permanent clients, although I do often see the same people for their personal care needs.

20. My shifts (appointments between 30 minutes and 4 hours) can vary from day to day or hour to hour.

21. We have moved to 'smart phone' rostering; in general terms we get 6 days advance notice of shifts. We are entitled to 7 days' notice.

22. Our shifts can be changed with very little notice.

23. Notice for changes is normally given via text message but sometimes you get no notice and your duty has changed when you check your shifts (appointments) in your phone.

24. Travel time between shifts is normally given and shifts can have a "Time Band" applied so it isn't time critical to attend that shift exactly as scheduled.

25. Some "time bands" are short others are larger; it's client dependent.

26. I work Public Holidays as well.

27. A typical day of shifts are 12pm-1pm, 3pm-5pm, 5:30pm-6:30pm and 8pm-9pm. So over a 9 hour period I work 5 hours, plus travel time between clients, usually 10 to 15 minutes each. In this example it would be approximately 40 minutes travel.

28. I receive travel and time from each location to the next; but for example in the 1pm to 3pm window I would likely return home, but not be compensated for the petrol or time between clients and my home; just the distance and time between clients.

29. I would travel to and from work approximately 30 times a week, as the gaps between duties are staggered as such to have normally 2 to 3 occasions per working day where I would return home between shifts.

30. If the clients are close together, physically, I can lose a lot of my own petrol etc returning home, especially if that travel time from the client to home is large.

31. Attached and marked **Annexure A** are copies of my diary entries about my rosters for the period 1 July 2014 to 31 August 2014.

32. Attached and marked **Annexure B** are copies of my diary entries about my rosters for the period 1 July 2015 to 2 September 2015.

The Impact of Short Shifts

33. When shifts are cancelled then the employer will normally give us additional work within the same pay period.

34. Our agreement states as per the *Social, Home Care and Disability Services Industry Award* [SCHCDS] Award that it could be the following fortnight too;

however the employer has no easy way of tracking this so it's impracticable and not common practice for hours to flow from one pay period to the next.

35. Most Part Time employees work above their minimum contracted hours, so normally lost hours are absorbed into the hours otherwise allocated as additional hours.

36. Variations occur all the time day to day, hour by hour. It becomes difficult to make plans or appointments when you working on a given day.

37. I have a good relationship with the rostering department and only occasionally have it been stated that I have refused a shift because I was unable to attend due to appointments otherwise booked when I wasn't working.

38. I am aware of other employees who don't have this good relationship so lose out on pay for not being available when they have been assigned alternate work on a day with little to no notice.

39. There is no minimum client engagement or shift length for Part Time or Full Time staff.

40. If a shift is cancelled in the middle of other duties it can become problematic and expensive as you lose travel time, and sometimes have no real alternative other than to return home for long periods where you would normally have expected to work continuously.

41. We receive a split shift allowance where the break between duties in excess of 1 hour after travel time; this is a single payment of $7.50 per break. As per paragraph 27 I would have received 2 split shift payment on that day. This normally covers the petrol expenses for returning home and back to a client.

42. I understand that under the current SCHCDS Award the split shift payment is not provided for, the impact of this would make working multiple short shifts on a given day untenable.

43. The biggest problem with working short shifts is the length of time it takes on a given day to work a 'full days work'. For example on 5/7/14 I started work at 7:30am and worked through until just after midnight (12:03am). I had no splits that

day and only accrued 9 hours and 53 minutes work but I didn't finish work until 16 hours after beginning my working day.

44. I have an arrangement with CBS to take 3 months off every year where I work at another job, making Christmas Cakes. This supplements my income greatly as I work significant hours in those 3 months; whilst it is hard physical work, I get paid for all the hours I spend at work.

Income and Expenses

45. Attached and marked **Annexure C** are copies of my pay slips for the period 24 June 2013 to 21 June 2015.

46. In an average week I earn $1900 Net. About 30% of my weekly take home pay comes from penalty rates.

47. My wife is currently on Paid Parental Leave.

48. The average weekly expenses of my household are approximately $850, comprised of:

Rent/mortgage payments:	$300
Household bills (utilities, telephone, internet):	$150
Groceries:	$150
Transport (petrol, tickets):	$160
Other household expenses (health, school, etc):	$90
Total:	$850

Impact of working definite hours

49. I rarely under take social activities on days of work, it is difficult to rely on having a set time on or off. However there are usually time to undertake personal appointments between work engagements.

50. Compared to my previous work, where I permanently worked 7am to 3pm 5 days per week; this type of work is more difficult to manage overall.

51. My petrol expenses are higher than my previous jobs because of all the travel to and from home, however costs are relatively neutral as my split shift payments can cover the majority of this extra cost.

Witness Signature

Scott Quinn

Witness Name (printed)

Date: 16/12/15

Annexure A

No. Tues

Date 1.7.14

10.20 – 11.50 Andrew

12.05 – 1.10 mike

1.37 – 2.50 Emelia.

3.00 – 4.30 Bus Run

5.30 – 6.30 Kevin.

8.00 – 9.00 Mike

9.15 – 10.20 John.

543 min

No. Wed.

Date 2.7.14

7:00 – 5:00 Ben

8:20 – 9:20 Andrew

9:50 – 10:50 MT Stewart.

12:00 – 1:00 Andrew H.

3:00 – 5:00 mathew

5:30 – 6:30 Andrew.

500 min

No. Friday.

Date 4.7.14

11.35] Peter
12.05]

12.14] mike
1.24]

1.44] John
2.57]

3.06] mathew
5.06]

5.43] John.
7.15]

8.00] mike
9.30]

9.45] John
10.45]

625 min.

No. ~~Last~~ Sat.

Date 5.7.14

7:30] John
10:03]

10:17] Andrew
11:47]

12:12] John
12:42]

1:04] Andrew H
2:04]

2:26] John
3:26]

3:47] mike
5:51]

6:10] Andrew H.
7:20]

&

8:00] Justin.
12:03]

953 min.

1st of 4 weeks

No. Mon

Date 7 : 7 14

8.01] Andrew H.
9.20

9.39] mike
10.49

11.45] mike
1.03

1.18] Andrew H.
2.12

5.05] stephen.
5.05

No. Payweek

Date

Tues	10 hour	Holiday	8-7-14
Wed	10 hour	Holiday	9-7-14
Friday	10 hour	Holiday	11-7-14.

Sat 12-7-14

9.00] Andrew
10.30]

10.45] John.
11.15]

Sun 13-7-14

9.45] Andrew
11.15]

11.30] John
12.00]

No. Mon

Date 14-7-14

9:29 } mike
10:33

12:15 } mike
1:30

5:05 } stephen
8:05

No. T.03

Date 15-7-14

10.45] Andrew
11.45]

12.02] mike
1.08]

1.48] Emelia
2.48]

3.00] R.Rd Bus Run
4.30]

5.30] Kevin.
6.30]

8.00] mike
9.04]

9.30] John.
10.30]

No. Wed

Date 16.7.14.

8.00] Ben.
9.00]

1.00] Andrew H.
2.30]

3.00] mathew.
5.00]

No. Fri.

Date 18 7 14

11.58] mike
1.10

1.40] John
2.43

3.00] mathew
5.02

5.29] John.
6.59

8.06] mike.
9.14

9.26] John.
10.26.

No. Sat.

Date 19. 7. 14

7.30 – 10.00 John

10.15 – 11.40 Andrew

12.07 – 12.37 John

1.55 – 3.03 John

3.17 – 5.06. mike.

No. mon .

Date 21 . 7 . 14

9.30 } mike.
10.30 }

12.00 } mike
1.00 }

5.00 } stephen.
8.00 }

No. 1 of 2

Date 22-7-14

10.15] Andrew
11.45]

12.50] mike
1.00]

3.00] Bus Run
4.30]

5.30] Kevin
6.30]

8.00] mike
9.00]

9.15] John.
10.15]

No. Wed

Date 23.7.14

8.00 } Ben
9.00 }

9.10 } Andrew
10.40 }

10.56 } John
11.56 }

pay week.

No. Friday

Date 25 7.14

12.06 } mike
1.13 }

152 } John.
252 }

3.00 } mathew
5.00 }

5.28 } John
6.58 }

8.00 } mike
9.00 }

9.14 } John.
10.14 }

No. Mon

Date 28 / 14

8.00 } Ben
9.00 }

~~9.00~~

9.40 } mike
10.40 }

11.56 } mike
1.06 }

5.00 } stephen.
8.00 }

No. Friday

Date 1 · 8 · 14

9:30 } Andrew
11:00 }

11:18 } Peter
11:48 }

12:00 } mike
1:05 }

1:20 } Andrew lit.
2:30 }

3:00 } mathew
5:00 }

5:30 } Kevin.
6:30 }

7:30 } mike (sick).
8:00 }

No. Sat

Date 2.8.14

10:15 } Andrew
11:45

3:00 } mtc.
5:00

No. Sun

Date 3.8.14

10.16] Andrew
11.46]

12.03] mike
1.05]

1.21] Andrew H.
2.48]

3.03] mike
5.14]

No. Mon.

Date 4.8.14

8.00] 13m
9.00]

9.32] mike
10 35]

10.50] ~~Bill~~ Lillian Noble
11.55]

12.12] mike. 3.50m.
1.18]

200 min

29th July started with John.
2009. 5 years

No. Tues

Date 5 · 8 14

8·30] Andrew H.
10·00]

10·15] Andrew
11·45]

12·00] mike
1·07]

2.9

3·00] RRd Bs Run
4·30]

2.0

5·30] Kevin
6·30]

4 27 m

8·00] mike
9·00]

Pay week

No. Wed

Date 6-8-14

6:30] Roger
7:50

8:00] Ben
9:00

9:05] Andrew
10:35

11:11] Danuta
1:11

1:39] Sylvia
2:41

3:00] Mathew
5:00

610 m

No. 8-8-14

Date Frid

11.06] John 133
11.57]

12.08] mike
1.19]

3.20] mathew
5.20]

5.42] Keith 330
7.26]

7.53] mike
8 51] 463m

No. Mon

Date 11-8-14

8:00] Ben
9:00]

9:30] mike
10:30]

10:45] Lillian
11:45]

12:00] mike
1:00]

480

5:04] stephen
8:04]

No. 1005

Date 12-8-14

10.18] Andrew
11.48]

180

12.03] mike
1.16]

1.53] Emelia
2.53]

153

3.00] RRJ Bus
4.30]

5.30] Kevin
6.30]

453m

130

7.55] mike
8.55]

No. Ned

Date 13-8-14

8.00 } Ben
9.00 }

9.10 } Andrew
10.40 }

10.54 } John
2.31 }

451

3.00 } Mathew
5.00 }

No. Friday

Date 15.8.14

9.14] John
10.01]

10.20] Peter
10.45]

11.04] Luke
11.48]

12.00] mike
1.22]

1.36] Sandra
2.36]

530

3.05] Mathew
5.05]

8.05] mike
9.05]

No. Sat

Date 16-8-4

8.59 } Robert
9.49 }

10.15 } Andrew
11.45 }

295

3.09 } mike
5.19

4 hour missing.

No. Sun

Date 17. 8. 14

10.15] Andrew
11.45]

12.00] mike
1.00]

1.25] Andrew H.
2.55]

3.00] mike.
5.00]

No. Mon

Date 18-8-14

8.00] David young
9.00]

9.30] mike
10.30]

10.45] Lillian Noble
11.45]

12.00] mike
1.00]

5.00] stephen.
8.00]

No. Tue

Date 19-8-14

8.30] Andrew H.
10.00

10.16] Andrew
11.46

12.01] mike
1.09

3

3.00] RRJ Bus Run
4.30

5.30] Kevin
6.30

8.05] mike.
9.12

No. wed

Date 20-8-14

7.20] Ben
8.20]

8.41] Bus Run
10.16]

11.30] Kevin
12.30]

1.47] Sylvia
2.52]

3.05] Bus Run.
4.35]

No. Friday

Date 22 8 14

9.00] Andrew
10.30]

10.58] John
11.43]

12.00] mike
1.10]

1.25] Andrew H
2.55]

3.24] mike
5.24]

5.31] Kevin.
6.34]

7.59] mike.
9.13]

No. Sat

Date 23 Aug 14

9:08] mike
12:10

12:26] Justin
5:23]

No. Mon

Date 25-8-14

8:00] David
9:00

9:30] mike
10:38

10:54] Lillian
11:57

12:15] mike
1:45

5:00] stephen
8:00

No. Tues

Date 26 8 14

9.15] mike
11.15]

11.45] mike
12.45]

~~1200~~

1.49] Emelia
2.49

3.00] Bus Run
4.30]

5.30] Kevin
6.30]

7.48] mike.
9.13]

No. Wed

Date 27 8:14

7.58] Ben
8.58]

9.10] Andrew
10.41]

11.30] Kevin
12.30]

3.00] mathew
5.00]

5.30] Kevin.
6.30]

No. Sat

Date 30 8.14

10.15 } Andrew
11.45 }

12.00 } mike
1.00 }

3.00 } mike.
5.00 }

8.00 } Sushi SNC.
11.45 }

No. Sun

Date 31. 8. 14

8.30] Wayne SNC.
9.30]

10.21] Andrew
11.57]
11.57] mike
1.17]
1.34] Andrew H
3.13]
3.32] mike.
5.42]

Annexure B

Wed 31-7-15 Date _____

3.00 - 5.00 mathew. 3hours Sick Pay

Frid 3-7-15

11.27 - 11.58 margaret

12.19 - 1.55 mike.

3.00 - 5.00 mathew.

5-10 - 6.10 Ben

split

7.40 - 9.40 mike.

Sat 4-7-15

8.00 - 9.00 Roger
split

10.15 - 11.45 Andrew.

split.

3.20 - 5.20 mike

5-30 - 6.30 Kevin.

Sun 5-7-15 Date _____

8:30 - 9:30 Roger

10:15 - 11:45 Andrew

12:00 - 1:15 mike.

Split

3:00 - 5:15 mike.

Mon 6-7-15

8:00 - 9:00 Ben

9:40 - 10:10 mike

10:30 - 12:00 Harold Smart.

12:20 - 1:35 mike

Split

3:00 - 4:30 Bus Run

5:02 - 8:02 Stephen.

Tues 7-7-15.

10:15 - 11:45 Andrew

12:00 - 1:45 Mike

Split

3:00 - 4:30 Bus Run SNC

5:30 - 6:30 Kevin

Wed 8-7-15 Date _____

8:00 - 9:00 Ben

9:35 - 10:35 Andrew

10:00 - 12:30 Andrew H.

split

3:00 - 5:00 mathew.

Frid 10-7-115

9:00 - 11:00 mike

11:30 - 12:30 Kevin

12:40 - 1:40 mike

2:00 - 4:00 Andrew H.

4:20 - 5:20 Ben

split

7:00 - 9:00 mike.

Mon 13-7-15

5 1/2 Hours Sick PAY.

Date

Tues 14-7-15

10.15 - 11.45 Andrew

12.00 - 1.00 mike

1.15 - 2.15 Emelia

3.00 - 4.30 Boo Run SNC. Split ?

5.30 - 6.30 Kevin

Wed 15-7-15

8.00 - 9.00 Ben

9.05 - 10.35 Andrew 15

11.00 - 12.30 Andrew H. 16

Split

3.00 - 5.00 mathew.

Fri 17-7-15

3.00 - 5.00 mathew

Split

8.00 - 9.30 mike.

Date _____

Sat 18-7-15

8.00 - 9.00 Roger

Split

10.15 - 11.45 Andrew

Split

2.30 - 5.20 mike.

5.30 - 6.30 Kevin.

Sun 19-7-15.

8.30 - 9.30 Roger

10.15 - 11.45 Andrew

12.00 - 1.30 mike

Split

8.00 - 5.15. Mike.

Mon 20-7-15

8.00 - 9.00 Ben

9.10 - 10.10 mike.

split
11.27 - 12.27 Kevin

12.40 - 2.10 Larraine Scoles.

3.00 - 5.00 mathew

5.15 - 8.15 Stephen

Date

Tues 21-7-15

10.15 - 11.45 Andrew

12.00 - 1.30 mike

Split

3.15 - 5.15 mike

5.30 - 6.30 Kevin

Wed 22-7-15

8.00 - 9.00 Ben

9.05 - 10.35 Andrew

11.00 - 2.30 Andrew H

Split

3.00 - 5.00 mathew.

Frid 24-7-15

9.00 - 11.00 Andrew H.

Split

3.00 - 5.00 mathew

Split

7.30 - 9.00 mike.

Sat 25-7-15 Date _____

10.45 - 12.45 mike

Mon 27-7-15

8.17 - 9.15 ~~xxxx~~ Con

9.35 - 10.35 mike.

split

12.00 - 105 mike

1.24 - 3.24 Andrew. H.

3.45 - 4.45 Ben.

5.05 - 8.35 stephen

~~25~~ Tues 28-7-15

10.15 - 11.45 Andrew

12.00 - 1.00 mike

1.15 - 2.15 Emelia

3.15 - 5.15 mike

5.30 - 6.30 Kevin.

Wed 29-7-15 Date

8.00 - 9.00 Ben

9.05 - 10.55 Andrew

10.55 - 12.25 Andrew H.

Split

3.00 - 5.00 mathew.

Fri. 31-7-15

12.30 - 2.30 Andrew H.

3.00 - 5.00 mathew.

5.10 - 6.10 Ben

Split

8.00 - 9.30 mike.

Sat 1-8-15

8.00 - 9.00 Roger

Split

10.15 - 11.45 Andrew

Split

3.20 - 5.20 mike

5.30 - 6.30 Kevin.

Date _____

Sun 2-8-15

7.45-8.45 Roger

9.00-10.30 mike.

10.40-12.10 Andrew

12.20-1.20 mike

split

3.00-5.30 mike.

Mon 3-8-15

8.00-9.00 Ben

9.15-10.45 mike.

split

12.00-1.00 mike.

1.20-3.20 Andrew M.

split

5.05-8.05 stephen

Tues 4-8-15

7 hours Sick Pay.

Wed 5-8-15 Date _____

8:00-9:00 Ben

9:05-10:35 Andrew

10:55-12:25 Andrew H.

Split

3:00-5:00 mathew.

Frid 7-8-15

9:30-11:30 Andrew H

12:00-1:30 mike.

Split

3:00-5:00 mathew

Split

8:00-9:15 mike.

Mon 10-8-15

8:00-9:00 Ben SNC.

9:32-10:47 mike

Split

12:01-1:36 mike

Split.

5:11-8:11 stephen.

Date _____

Tues 11-8-15

10:15 - 11:45 Andrew

11:55 - 1:15 mike.

1:29 - 2:29 Emelia

~~2:50 - 5:20~~

2:50 - 5:20 mike

5:30 - 6:30 Kevin

Wed 12-8-15

7:55 - 8:55 Con

9:16 - 10:46 Andrew

11:05 - 12:35 Andrew H.

split

3:00 - 5:00 mathew.

Fri 14-8-15

6 hours sick pay.

Sat 15-8-15 Date _____

3.00 - 9.00 Roger

Split

10.15 - 11.45 Andrew.

Split

3.20 - 5.20 mike

5.30 - 6.30 Kevin.

Sun 16.8-15

8.30 - 9.30 Roger

10.15 - 11.45 Andrew.

12.00 - 1.30. mike.

Split

3.00 - 5.00 mike.

Mon 17-8-15

9.45 - 10.45 mike

Split

12.00 - 1.00 mike

1.30 - 3.30 Andrew H.

Split

5.07 - 8.07. stephen.

Date _____

Tues 18-8-15

10.15 - 11.45 Andrew

12.00 - 1.00 Mike

Split

3.20 - 5.20 Mike

5.30 - 6.30 Kevin.

Wed 19-8-15

7.55 - 8.55 Con

9.15 - 10.45 Andrew.

11.00 - 1230 Andrew H.

~~1.30~~ split

1.55 - 3.10 15 min MOT.

3.00 - 5.00 Mathew SNC. 1.45 hrs left.

Friday 21-8-15

10.05 - 10.35 Mike.

split

11.45 - 1.12 Mike.

split

3.00 - 5.00 Mathew

split

8.00 - 9.00 Mike.

Date

Mon 24-8-15

9.45 - 10.45 mike

Split

12.00 - 1.00 mike

split

5.11 - 8.11 Stephen

Tues 25-8-15

10.15 - 11.45 Andrew

12.00 - 1.00 mike

1.45 - 2.45 Emelia

3.20 - 5.20 mike

5.30 - 6.30 Kevin 15 min mt

Wed 26-8-15

~~10.15~~ - ~~11.45~~

9.00 - 10.30 Andrew

10.53 - 12.22 Andrew H *

Split

3.00 - 5.00 mathew.

241

Fri 28-8-15 Date _____

10.20 - 11.50 Andrew

12.00 - 1.00 mike.

split

3.00-5.00 mathew

split

8.00 - 9.00 mike.

Sat 29-8-15

8.00-9.00 Roger

split

~~10~~ 10.20 - 11.50 Andrew

Split

3.20 - 5.20 mike

5.30 - 6.30 Kevin.

Sun 30-8-15

8.30 9.30 Roger

10.20 - 11.50 Andrew

12.03 - 1.03. mike

Split

3.00 - 5.00 mike.

Date _____

Mon 31-8-15

8.05 - 9.05 Con

9.20 - 10.20 mike

Split

12.00 - 1.00 mike

~~5.06~~ Split

5.06 - 8.06. Stephen.

Tues 1-9-15

10.15 - 11.45. Andrew

1200 - 1.00 mike

Split

3.20 - 5.20 mike

5.30 - 6.30 Kevin.

WED 2-9-15.

9.05 - 10.35 Andrew

Split

1200 - 1.30 Andrew H. *

Split

3.01 - 5.01 mathew.

Fair Work Commission

Four Yearly Review of Modern Awards

Social, Community, Home Care and Disability Services Industry Award

Matter No: AM2018/26

SUPPLEMENTARY STATEMENT OF SCOTT QUINN

1. I made a Statement in the casual and part-time employment four yearly review matter (matter numbers AM2014/196 and AM2014/197) dated 16 December 2015.

2. This is a supplementary statement to that earlier statement.

Current work

3. I am a member of the Health Services Union, Tasmania Branch, and a delegate of the Union within my workplace.

4. I have worked in disability services/ aged care since about July 2006.

5. I have a Certificate III in Individual Support (Disability) and a Certificate IV in Home and Community Care.

6. I have worked for Community Based Support Inc, known as Community Based Support Tasmania (**CBS**) since entering this sector in 2006.

7. I am employed under the *Community Based Support Enterprise Agreement* 2018 (AG2019/602) (**the Agreement**). This is predominantly based on the Social, Community, Home Care and Disability Services Industry Award 2010 (**the Award**). I am classified under the Agreement as a Level 2B Grade 2; this is the effective equivalent as a Home Care Employee Level 3 Pay Point 2, under the Award.

8. I am only contracted to work 60 hours per fortnight, but I usually work an average of 37 – 40 hours per week, sometimes more.

9. My work involves attending to clients of CBS in their homes or at other locations to assist them with anything from assisting clients with showering, preparing meals, social support such as taking them to do shopping, domestic assistance such as changing the bed, mopping and laundry, or social support, such as taking them out to a concert.

If they have mobility issues we might help get the client into bed or out of bed. Generally the role is assisting clients to do what they can't do for themselves in their every day lives.

10. On a work day, my schedule is as follows:

    a. Leaving my home in Glenorchy, which is about 10km from Hobart, and driving to the home of my first client. Occasionally I will call into the office in Hobart on the way past if there is something I need to pick up, but normally I will go straight to my first client.

    b. My work locations vary between 1 and 20 kilometres from my home. Normally I see clients anywhere between Taroona in the South (approximately 20km from home) Bridgewater in the North (approximately 15km from home). On the odd occasion I will travel further than 20 kilometres. Travel to for my first appointment varies between 5 minutes and 45 minutes;

    c. I am not paid travel time or a kilometre allowance for the travel to my first appointment;

    d. My first appointment usually lasts for a minimum of one hour;

    e. At the end of my first appointment, I will then either drive back home for a short gap, or drive on to my next appointment;

    f. Unless the time between the end of the appointment and the start of the next appointment coincides with the Google Maps estimate of time taken to travel between the two locations, my shift will break, and I will have unpaid time prior to the next appointment. That period can be between 5 minutes and 5 hours, but normally my breaks are not longer than 2 hours. I set out below how the Google Maps arrangement operates;

    g. I continue with that process each day until my final appointment;

    h. My return trip home from my final appointment is not paid.

11. Attached and marked **Annexure A** to this statement are copies of my diary entries which show my rosters from 3 June 2019 to 8 September 2019.

12. There is a typo on the first page of Annexure A. The first date listed reads '3-6-18'. It should read '3-6-19'.

13. In my diary I have recorded the times of my shifts and breaks. For most days I have calculated the hours worked (not including breaks or travel time) and added them up on the side. Where I have recorded kilometres these indicate the kilometres I drove

with clients or for clients, for example taking them to the shops or doing other errands for them. I have marked as 'split' where the split shift allowance is payable for a break. Where I have written 'SNC' this indicates the shift was a short-notice cancellation.

Broken shifts and travel time

14. CBS pays for travel time and a travel allowance per kilometre. CBS calculates travel time using Google Maps.

15. For example, in the second entry in my diary, dated 4 June 2019, I have a 15 minute gap between my first and second client, and my second and third client, and a 45 minute gap between my third and fourth client. I am not paid for all this time, only the time it takes to travel between clients according to Google Maps. So, if CBS have calculated on Google Maps that it only takes 10 minutes to travel between those clients, that extra 5 or 35 minutes is unpaid, it is dead time.

16. As far as I understand it, CBS calculates travel time by putting in the address of the first client in, for example, Moonah, and the second client in, for example, Newtown. Google Maps will display the best route and the time and kilometres between the locations, and the company will use that to calculate the travel time and kilometre allowance we are paid.

17. We are not told in advance how much travel time is allowed between clients. The rosters do not always reflect the amount of time needed to travel between clients. When this happens I try and manoeuvre my client appointments around to make the roster work and will let my clients know.

18. Sometimes it might take you longer to travel between clients than what Google Maps says, if there are road works, for example. When this happens, you need to ring up work and let them know that travel took longer because of road works, or whatever the reason. They make a note that you rang in and that you should be paid 45 minutes instead of 25 minutes, for example.

19. As per the Agreement, I receive a split shift allowance of $7.50 per break, where the break between duties is in excess of one hour after travel time into account.

20. If the break is one hour, but including travel time, then the split shift allowance is not paid. For example, my roster on 12 July 2019 has a one hour break between my first and second clients. I would be paid the time it takes to travel between these clients, according to Google Maps, and the kilometre allowance, but no split shift allowance for that day. In that case, my first two client appointments were each around 10 minutes drive from my home. In the hour gap between the first two appointments I

travelled 10 minutes home, and had about 25 minutes at home, before having to leave to travel to the next client.

21. During breaks like these, if the kids are home, I might muck around with them. I am working on renovations on my home, which I can sometimes do on my breaks, but 25 minutes isn't long enough to start a task. Often I will just sit down and do nothing.

22. My third client appointment was in Taroona, which is about 20 kilometres and about a half hour drive from my home, so I most of that time in my roster would have been spent travelling to and from that client.

23. I have marked in my diary 'split' for the breaks between clients for which I am paid the split shift allowance.

24. For example, on 17 July 2019, I worked from 8am-9am, 11am-12pm, 2pm to 5pm and 6:30pm to 7:30pm. So over an 11.5 hour day I worked 6 hours, with two breaks of two hours and one break of 1.5 hours. I received the split shift allowance for the three breaks. I also receive travel time for the time it takes to travel from one client to the next, according to Google Maps.

25. In that case, I travelled about 2 kilometres from my home to my first client in Glenorchy, then home for my first break, then roughly 7 kilometres or 15 minutes to my second client in North Hobart, then home for my second break, then about 6 kilometres or 15 minutes to my third client in Lenah Valley, then home for my third break, then about 2 kilometres or 5 minutes to my final client in Derwent Park, then home.

26. In total I spent approximately 34 kilometres and one hour 20 minutes travelling back and forth between clients and my home that day. However I was only paid for 14 kilometres and 30 minutes for the travel time between clients.

27. If I have a split shift but am not required to travel, then I am not paid any travel time or kilometres for that client. For example, I have one client out in Berriedale whom I see for a 12pm-1pm lunch shift, and then a 3pm-5pm tea shift. The time between 1pm and 3pm is a split shift. Berriedale from home is about 5 to 6 kilometres and a 10 minute drive from home. There's never anything I need to do out in Berriedale so I just go back home during that time. I am paid the $7.50 split shift allowance for this time, but no more, even though practically there is nothing else for me to do but to drive home and drive back in that time.

28. Where I have a split shift or dead time in my roster, I usually return home. If it's not practical for me to return home I might go to the client early to see if I can start earlier.

29. Travelling between clients and home all the time can get costly, as I am not compensated for all of the kilometres I have to travel or for time spent travelling between clients and my home where there is a long break between appointments, only the distance and time between clients. But there is usually little else useful I can do with that time.

Overtime

30. I am often required to work overtime. For example, in the first entry in Annexure A dated 3 June 2019, I worked a total of 9.75 hours with clients. But I did an additional 1 hour and 30 minutes travel time between clients that day, as my client Scott lives in Taroona, which is about a half hour drive each way from the clients on either side. So I was paid for eleven hours of work, with one hour and a quarter at overtime, in that example.

Shift changes and cancellations

31. Our shifts can be changed with very little notice.

32. Notice for when your roster has been changed or a shift added is normally given via an alert in your phone. But sometimes you get no notice and you just find out your duty has changed when you check your roster.

33. For example, although I see a fairly regular set of clients, I have checked my phone in the morning and noticed that I have two extras rostered in there.

34. If a shift is cancelled in the middle of other duties it can become problematic and expensive as although I am paid for the appointment, I am not paid for the kilometres and travel time connected with the appointment. If the cancellation opens up a big gap in time, I will have no real alternative other than to return home, which involves incurring the extra petrol costs of returning home and then travelling out again for the next client. An example of this is on 19 August 2019 in my roster. I had a short notice cancellation from 11am – 12:30pm, which left a gap in my roster between 10:30am and 12:45pm, during which I wasn't entitled to any compensation for travel, even though there would have been nothing for me to do but travel home and back.

35. We generally need to carry our phones with us because rosters or other circumstances may change at short notice. On one occasion I arrived at a client's home in North Hobart for a shift, only to find out he had moved to Claremont. I checked my roster again but his address hadn't been changed on the system. I had to call up the office to find the new address.

SCOTT QUINN

3 October 2019

Annexure A

mon 3-6-18.

9.30 - 10.30 Paul
split
12.00 - 2.00 maria 20km
2.15 - 3.15 ELLIE
3.45 - 4.45 Scott
5.15 - 10.00 stephen 20km

9.75

Tues 4-6-19.

7.45 - 8.45 Jenny
9.00 - 10.00 Gary
10.15 - 2.15 Thomas.
3.00 - 4.45 Mike

7.75

Wed 5-6-19.

8.00 - 9.00 Kevin
split
10.30 - 11.30 maria
split
1.30 - 4.30 Thomas
split
6.30 - 7.30 Jenny.

6.

7-6-19 Fri.

8.00 - 9.00 Kevin

9.15 - 2.00 Paul 30km. (9.75)

2.15 - 4.15 ELLIE

4.30 - 6.30 Bianca Clark.

31.2

Mon 10-6-19

9.30 - 10.30 Paul (6.25)

11.00 - 12.00 Scott

Split

5.15 - 9.30 Stephen. 20km

Tues 11-6-19.

7.30 - 8.30 Jenny

8.45 - 10.45 maria 15km

11.00 - 3.00 Thomas

3.15 - 4.45 mike

Wed 12.6-19

8.00 - 9.00) Kevin 20km

9.00 - 2.00

2.15 - 5.15 Thomas

Fri 14-6-19.

6.45 - 7.45 Ikem

8.00 - 10.00 mike

10.30 - 12.30 Scott 15km.

1.00 - 3.00 ELLIE

Split

6.30 - 7.30 Jenny.

Sat 15-6-19.

8.00 - 9.00 Jenny

9.15 - 10.45 Andrew

Split

12.00 - 1.00 mathew

~~Split~~ 1.15 - 1.45 Clems Rowe 1km

Split

3.00 - 4.30 mike

Split

6.30 - 7.30 Jenny.

Sun 16-6-19

8.00 - 9.00 Jenny

Split

10.15 - 11.45 Andrew

1200 - 100 mike

Split

3.00 - 4.45 mike.

mon 17-6-19.

9.30 - 10.30 Paul.
split
12.00 - 2.00 maria 15 km
2.15 - 3.15 ELLIE
3.45 - 4.45 Scott
5.15 - 9.30 stephen 20 km

Tues 18-6-19.

7.00 - 8.00 Jenny. Double Tim
8.15 - 9.15 DAve Hanolin
9.30 10.30 Gary
10.45 - 2.45 Thomas
3.00 - 4.30 mike

wed 19-6-19.

8.00 - 9.00 Kevin
9.45 - 10.45 maria
11.00 - 12.00 Jozsef Ferenez.
12.30 - 1.30 Scott 20 km
2.00 - 5.00 Thomas.
split
6.30 - 7.30

Thurs 20-6-19.
9.00 - 12.00 TRAINING.

Frid 21-6-19

8.00 - 9.00 Kevin

9.15 - 1.15 Paul 20km

split

2.30 - 4.30 ELLIE

mon - 24 - 6 - 19.

9.30 - 10.30 Paul.

split

11.45 - 12.15 Ivey. 10 km

12.30 - 2.30 maria 15 km

300 - 4.00 Scott

5.15 - 10.00 Stephen 20km

Tues 25 - 6 - 19.

9.00 - 10.00 Jerry.

10.15 - 2.15 Thomas.

3.00 - 5.00 mike.

5.15 - 5.45 Lola Lorraine.

Wed 26 - 6 - 19

8.00 - 2.00 Kevin

215 - 5.15 Thomas

5.30 - 7.30 Kai 3 km

Fri 28-6-19.
6.45-7.45 Kevin
8.00 - 10.00 mike.
10.30 - 12.30 scott 15 Km
split
2.30-4.30 ELLIE

Sat 29-6-19.
7.45 - 8.45 Jenny
9.00 - 10.30 Andrew
10.45 - 11.45 Paul
split
3.00 - 4.30 mike
split
6.30-7.30 Jenny.

Sun 30-6-19
7.00 - 7.30 mike
7.45-8.45 Jenny
split
1015 - 11.45 Andrew
12.00 - 1.00 mike.
split
3.00 - 4.45 Mike

Wed 17-7-19.
11.

Mon 1-7-19
9.30 - 10.30 Paul
Split
12.00 - 2.00 Maria 15km
2.15 - 3.15 ELLIE
3.45 - 4.45 Scott 15km
5.15 - 10.00 stephen 20km

9.75

Tues 2-7-19
9.30 - 11.30 Mathew
Split
1.00 - 2.00 Gary
3.00 - 5.00 mike

5

Wed 3-7-19.
8.00 - 9.00 Kevin
~~11.15~~ -Split
11.15 - 12.15 Maria
12.30 - 1.30 Mathew
1.45 - 4.45 Thomas
Split
6.30 - 7.30 Jenny.

7

Frid 5-7-19.

9.00 - 9.00 Kevin

9.15 - 2.00 Paul 20 Km (8.75)

2.15 - 4.15 ELLIE

split

6.30 - 7.30 Jenny

Mon 8-7-19

9.30 - 10.30 Paul

split

12.00 - 2.00 maria 15 km (5).

2.30 - 3.30 Scott 15 km

split

6.30 - 7.30 Jenny

Tues 9-7-19

7.30 - 8.15 Rohan Hills. (5.5)

split

9.30 - 11.30 mathew

split

12.45 - 1.45 mathew

split

300 - 4.45 mike.

Wed 10-7-19.

6.00-9.00 Kevin

9.00-2.00 Kevin

2.15-5.15 Thomas

(9)

Fri 12-7-19.

8.00-9.00 Kevin

10.00-11.00 Peter Brittain

11.30-1.30 Scott williams.

2.00-4.00 ELLIE.

(6)

Sat 13-7-19.

8.00-9.00 Jenny

9.15-10.45 Andrew

11.00-12.00 Paul

Split

3.00-4.45 mile

Split

6.30-7.30 Jenny.

6.25

Sun 14-7-19

7.45 - 8.45 Jenny
9.00 - 10.00 mike
10.15 - 11.45 Andrew
12.00 - 1.00 mike
1.15 - 2.15 mathew
3.00 - 4.30 mike.

(7).

mon 15-7-19.

9.30 - 10.30 paul
split
12.00 - 2.00 maria 15 km
2.30 - 3.30 scott
4.00 - 5.00 ELLIE

(5)

Tues 16-7-19.

9.30 - 11.30 mathew
11.45 - 12.45 Gary
split
3.00 - 5.15 mike.
weights

(5.25)

Wed 17-7-19.

8.00-9.00 Kevin
Split

11.00-12.00 maria (6)
Split

2.00-5.00 Thomas
Split

6.30-7.30 Jonny.

Frid 19-7-19

8.00-9.00 Kevin
9.15-1.15 Paul 7km (8)
1.45-2.45 Scott
3.15-5.15 ELLIE

Sun 21-7-19

12.00-1.00 mike
Split (3.5)
4.00-6.30 MIKE

Mon 22-7-19

9.30 - 10.30 Paul.

Split

12.00 - 2.00 Maria 15km (8.25.)

2.30 - 3.30 Scott

Split

5.15 - 9.30 Stephen 20 km

Tues 23-7-19

9.30 - 11.30 Mathew (5)

12.00 - 1.00 Mike.

Split

3.00 - 5.00 Mike

Wed 24-7-19

8.00 - 9.00 Kevin

9.00 - 2.00 Kevin (10)

2.15 - 5.15 Thomas

Split

7.00 - 8.00 Mike.

Fri 26-7-19

7.00 - 8.00 Kevin
8.15 - 9.45 Andrew
10.15 - 12.15 Scott 11.5 km (9.5)
12.45 - 1.45 mike
2.00 - 4.00 ELLIE
Split
6.00 - 7.00 Jenny
7.15 - 8.15 mike

Sat 27-7-19

8.00 - 9.00 Jenny
9.15 - 10.45 Andrew
11.00 - 12.00 Paul (6)
Split
3.00 - 4.30 mike
split
6.30 - 7.30 . Jenny

Sun 28-7-19.

7.45 - 8.45 Jenny
9.00 - 10.00 mike
10.15 - 11.45 Andrew (7).
12.00 - 100 mike.
1.15 - 2.15 Mathew
3.00 - 4.30 mike.

Mon 29-7-19.

9.30 - 1030 Paul
split (9.75)
12.00 - 2.00 maria 15km
2.15 - 3.15 ELLIE
3.45 - 4.45 Scott 15km
5.15 - 10.00 stephen 20km

Tues 30-7-19

9.30 - 11.30 mathew
11.45 - 12.45 Gary (4.5)
split
3.00 - 4.30 mike.

Wed 31-7-19

8.00 - 9.00 Kevin

9.15 - 10.00 Rick Lette 6km.

10.15 - 11.15 maria

Split

(6.75)

1.30 - 4.30 Thomas

Split

6.30 - 7.30 Jenny

Frid 2-8-19

7.30 - 8.30. Kevin

9.15 - 1.45. Paul 20 1km (10.5)

2.15 - 3.15 Scott 15 1km

3.45 - 5.45 ELLIE

6.30 - 7.30 Jenny

7.45 - 8.45 mike.

Mon 5-8-19

9.30 - 10.30 Paul

Split

(8.75)

11.00 - 3.00 maria 15 1km

3.30 - 4.30 Scott

5.15 - 10.00 Stephen 20 1km

Tues 6-8-19

8.00 - 9.00 Paul 15km

9.30 - 11.30 Mathew (3)

3.4.30 - Sick Pay

Wed 7-8-19

8.00 - 9.00 Kevin

9.00 - 2.00 Kevin 25km (11.5)

2.15 - 5.15 Thomas.

5.30 - 7.00 Mathew

7.15 - 8.15 Jenny.

Fri 9-8-19

7.30 - 8.30 Kevin

8.45 - 10.45 Laurie Cairns 3km

11.15 - 1.15 Scott 15km (8)

Split

3.00 - 5.00 ELLIE

Split

6.30 - 7.30 Jenny

Sat 10-8-19

8.00 - 9.00 Jenny
9.15 - 10.45 Andrew
11.00 - 12.00 Paul (6.5)
Split
3.00 - 5.00 mike
split
6.30 - 7.30 Jenny

Sun 11-8-19

7.45 - 8.45 Jenny
9.00 - 10.00 mike
10.15 - 11.45 Andrew (6)
12.00 - 1.00 mike
split
3.00 - ~~4~~ 3.30 mike

Mon 12-8-19

9.30 - 10.30 Paul (9.25)
SPlit
1200 - 2.00 maria 15 km
2.15 - ~~3~~ 3.15 ELLIE
3.45 - 4.45 Scott
5.15 - 9.30 Stephen 20km

Tues 13-8-14

9.30 - 11.30 mathew
11.45 - 12.45 Gary (5.25)
1.00 - 2.00 mathew
3.00 - 5.15 mike

Wed 14-8-14

8.00 - 9.00 Kevin
split
11.00 - 12.00 maria
split (6.5)
2.00 - 5.00 Thomas
5.15 - 5.45 Elvie Radcliffe.
6.30 - 7.30 Jenny.

Frid 16-8-14

800 - 900 Kevin
9.15 - 2.15 Paul 20km. (8)
2.30 - 4.30 ELLIE TOM DIED. Sun

mon 19-8-19.

9.30 - 10.30 Paul.
11.00 - 12.30 Joshua stokes SNC.
12.45 - 2.45 maria 15 1km
3.15 - 4.15 scott 15 1km (9.75)
5.15 - 9.30 stephen 20 1km.

Tues 20-8-19

9.30 - 11.30 mahew
split (4)
3.00 - 5.00 mike

wed 21-8-19

8.00 - 9.00 Ikevin
900 - 2.00 Ikevin (7.5)
split
4.00 - 5.30 Alan Thors 10km

Frid 23-8-19

7.00 - 8.00 Ikevin
9.00 - 9.30 mike (8.5)
10.00 - 12.00 Trent Gordon
12.30 - 2.30 Scott 15 1km
3.00 - 5.00 ELLIE.
5.00 - 6.00 Trent SNC.

Sat 24-5-19.

8:00 - 9:00 Jenny
9:15 - 10:45 Andrew.
11:00 - 12:00 Paul.
Split
3:00 - 4:45 mike
split
6:30 - 7:30 Jenny.

6.25

Sun 25-8-19.

7:45 - 8:45 Jenny
9:00 - 10:00 mike
10:15 - 11:45 Andrew
12:00 - 1:00 mike
Split
3:00 - 4:45 mike.

6.25

Mon 26-8-19

9:30 - 10:30 Paul
Split
12:00 - 2:00. Maria 15 km
2:15 - 3:15 ELLIE
3:45 - 4:45 Scott 15 km
5:15 - 9:30 Stephen 20 km.

9.25

Sun 8-9-19.

Tues 27-8-19.

9.30 - 11.30 mathew
11.45 - 12.45 mike (6)
1.00 - 2.00 Gary
3.00 - 5.00 mike.

Wed 28-8-19.

8.00 - 2.00 Kevin
2.15 - 3.15 maria (9)
split
5.00 - 6.00 Trent
6.15 - 7.15 Jenny

Frid 30-8-19.

8.00 - 9.00 Kevin
9.15 - 1.15 Paul 6km (7)
1.30 - 3.30 ELLIE

Mon 2-9-19.

9.30 - 10.30 Paul
Split
1.00 - 3.00 maria 15km (8.25)
3.30 - 4.30 Scott
5.15 - 9.30 Stephen 20km

TUE 3-9-19

9.30 - 11.30 Mallow (4.)
split
3.00 - 5.00 mike

Wed 4-9-19.

8.00 - 2.00 Kevin
2.15 - 4.15 ELLIE (9)
5.00 - 6.00 Trent

Frid 6-9-19.

6.45 - 7.45 Kevin (5.25.)
8.00 - 10.05 mike
10.45 - 12.45 Scott 15km

Sat 7-9-19.

8.00 - 9.00 Jenny
9.15 - 10.45 Andrew. (6.25.)
11.00 - 12.00 Paul
split
3.00 - 4.45 mike
split
6.30 - 7.30 Jenny.

Sun 8-9-19

7.45 - 8.45 Jenny.

9.00 - 10.00 mike

10.15 - 11.45 Andrew

12.00 - 1.00 mike

Split

3.00 - 4.30 mike.

6

Working under the NDIS: Insights from a survey of employees in disability services

Prepared for:
Health Services Union, Australian Services Union and United Voice

June 2017

Natasha Cortis

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Contents

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Executive Summary

This report analyses information from almost 1,500 disability service workers. It explores their characteristics and perceptions of their working conditions; their experiences of working under the National Disability Insurance Scheme (NDIS); and their concerns about the implementation of the Scheme and its impact on their working lives.

Characteristics of respondents

- 74.1% of respondents were women.
    - Among those working in allied health and in-home care settings, there were higher proportions of women (over 80%). In employment, mental health, and residential/ group home settings, the proportions of women were lower (around 70%).
- Respondents had extensive experience in disability services: a quarter (22.5%) had more than 20 years of experience in the industry.
- 28.5% of respondents supervised other staff in their current role, while about the same number (27.3%) did so sometimes.

Working under the NDIS

- A little over half of respondents (54.7%) were working in an NDIS rollout area or with participants of the NDIS, while 35.8% said they were not, and 9.5% were unsure.
    - Workers in allied health, case management, day settings and in-home care were more likely to report working under the NDIS, while those in mental health, employment and residential/group home settings were least likely.

Impact of the NDIS on participants and families

- Few workers perceive the NDIS to be having a positive impact on participants or their families
    - 24.6% agreed that the NDIS was positive for the participants they work with
    - A minority (14.6%) agreed that families of participants were happy with the scheme, and
    - 15.7% agreed that the NDIS is better than the previous system.

Impact of the NDIS on working life

- Comparisons of respondents working under the NDIS and those who were not shows:
    - Lower proportions of very experienced employees were working under the NDIS, while proportions of staff new to the industry were higher.
    - Among those working under the NDIS, a higher proportion of employees are working for more than one disability service provider.
    - Those working under the NDIS were no more likely to be satisfied with their pay: across all contexts only a minority of respondents were happy with the pay they receive.
- High proportions of staff reported challenges to working under the NDIS:
    - 55.9% reported that they did not have enough time to do their work under the NDIS

- 72.2% were worried about the future of their job
- 52.6% disagreed that the NDIS has been a positive change for them as a worker.

Supervision and the NDIS

- Supervisors working under the NDIS reported supervising higher numbers of staff than others, which made it difficult to provide proper supervision:
  - 20.0% of those in supervisory roles[1] and who were working under the NDIS were supervising more than 14 staff, compared with only 12.0% of supervisors not working under the NDIS.
  - The proportion of supervisors who agreed that they can't provide proper supervision because of lack of time or too many staff rises with the number of supervisees, indicating a major risk for the Scheme.

General comments from disability workers

Among comments from disability workers, the most common concerns were about the adequacy of resources being provided to people with disability under the NDIS, and the impact of the Scheme on the quality of services people with disability would receive. Many explained the frustrations experienced by people with disability and their families, including delayed, inequitable and impersonal planning processes, resulting in inadequate support plans for participants.

Respondents also made a range of comments about how the NDIS was impacting on their working lives. Many linked risks to quality and safety to the use of casual and agency staff, and untrained staff entering the sector. Others expressed concerns about pay and conditions, including coverage of costs of private vehicle use, loss of penalty rates, subcontracting, short shifts, payment for travel time, and roster changes which could result in fewer hours. Respondents also noted that the NDIS was placing pressure on their employment classifications and pay rates, and some raised concerns their work was misclassified. Related, workers' comments attest to their high levels of stress, with many reporting unsustainable workloads and time pressure (including unpaid work) and poor job security, corroborating the other survey findings.

[1] Excluding those who only sometimes supervised staff.

1. Introduction

This report provides insight into the characteristics and experiences of almost 1,500 survey respondents who were working in disability services in early 2017. The survey was designed and administered by the main unions representing workers in the disability services industry, the Health Services Union, Australian Services Union, and United Voice, to help understand disability workers':

- characteristics and perceptions of their working conditions;
- experiences of working under the National Disability Insurance Scheme (NDIS); and
- their concerns about the implementation of the Scheme and its impact on their working lives.

The survey questions asked about respondents' demographic characteristics and how long they had worked in disability services, the settings in which they provided disability services (respondents could select more than one), their perceptions of their pay, their intention to leave or remain in the disability sector and reasons for this. It also asked whether they were a supervisor and if so, explored the characteristics of supervisory roles, including supervisory workloads. Those who were working in an NDIS area or with participants of the NDIS were asked a series of questions about their experience of working under the Scheme, to capture perceptions of time pressure, job security, and the overall impact of the NDIS on clients and their families. Respondents were also given the opportunity to provide open ended comments about working in disability, and any concerns they had about their work in the industry or under the NDIS.

The survey was distributed online via the networks of the three unions, primarily in the Eastern States. As such it is a non-probability based 'opt-in' sample, selected purposively to enable a focus on members of the unions commissioning the survey and to enable insight into experiences of providing disability services in different contexts, and differences among different groups of workers. A particular aim was to explore the impact of working under the NDIS, and to this end, comparison is made between respondents working under the Scheme and those which were not.

As a purposive sample, it may not be perfectly representative of all disability workers in Australia. As the survey was distributed through union networks, workers who are newer to the industry (and less likely to be union members) are under-represented. Further, responses from the Northern Territory and South Australia were not sought. However, while the sample is skewed to older, more experienced workers in the eastern states and should not be considered representative of the whole disability workforce, it does provide important insights into the experiences of working in disability, and differences for workers in different circumstances and settings. To this end, the analysis focused on comparing workers in different circumstances, with cross tabulations used to provide detailed breakdowns of respondents.

2. About respondents

2.1 Gender

Of the 1,477 survey respondents who provided their gender, 1,094 (74.2%) were female. This varied slightly across disability settings, as shown in Figure 2.1. Allied health was most strongly female dominated (87.1%), while mental health, residential, and employment services had proportionally fewer women (around 70%). The gender composition of the sample also differed slightly across the age groups. The largest group of men and women were aged 45 and 54, with this group comprising a third of all respondents (see Figure 2.2). In terms of differences in the age distribution of men and women, a relatively high proportion of men were aged 35 to 44, while a lower proportion of men were aged 45 to 54. Figures were similar across other age ranges.

Figure 2.1 Proportion of respondents in each disability setting who were women

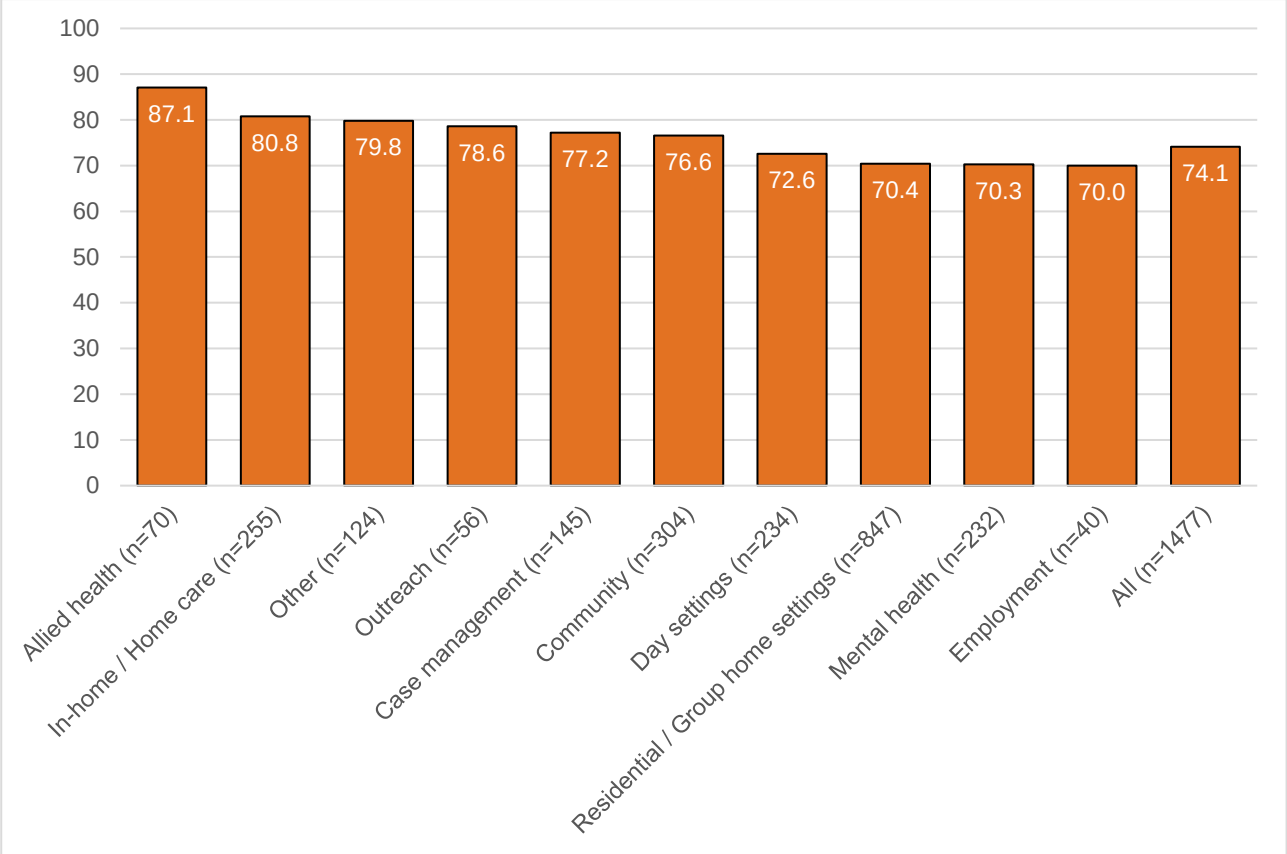
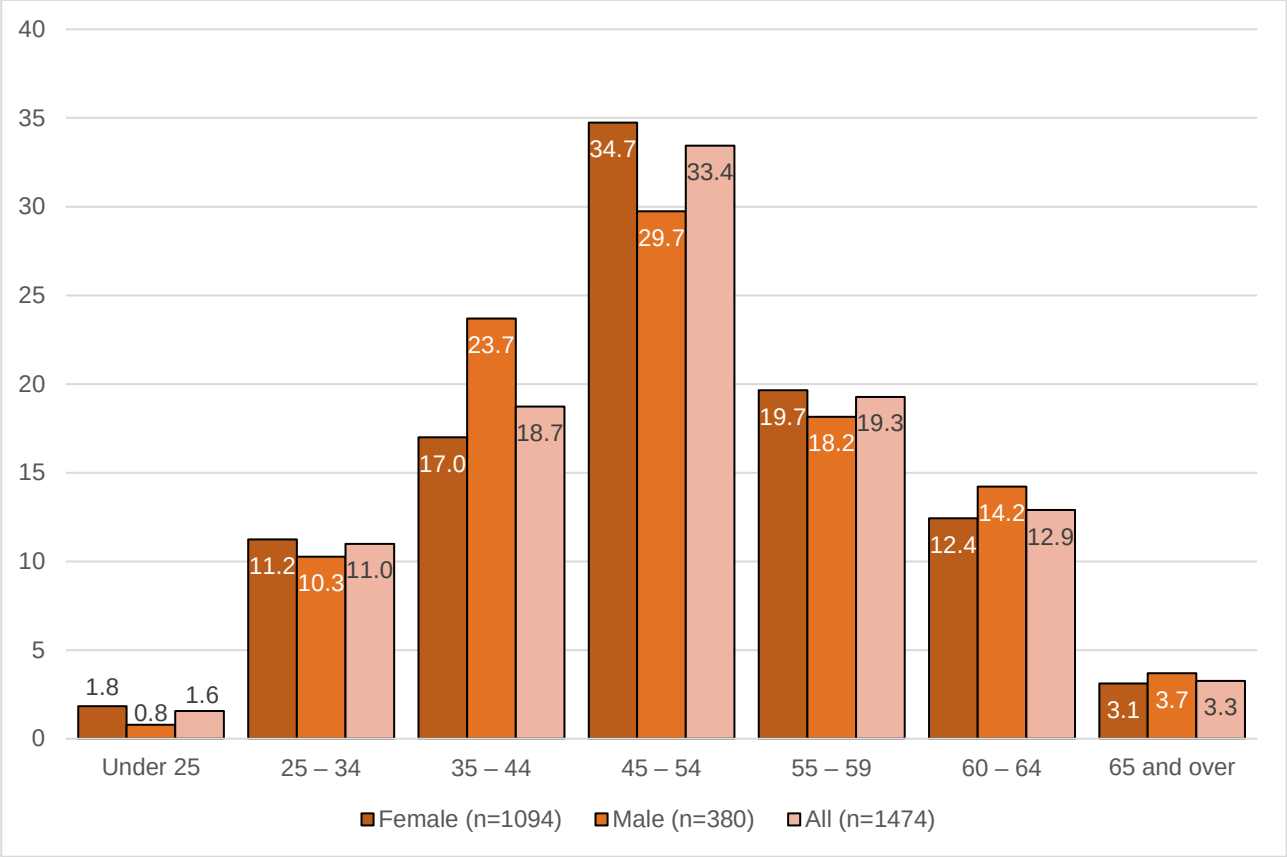


Figure 2.2 Proportion of men and women in each age category (%)



2.2 Experience in disability services

Many respondents were highly experienced in disability services. Almost a quarter (22.5%) had more than 20 years of experience providing disability services, and a further 13.8% had between 16 and 20 years of experience (see Figure 2.3). More than half (54.1%) had more than ten years of experience. Only a minority were new to the sector, with 2.0% having less than 1 year experience and 5.2% having between 1 and 2 years of experience. Although the age distribution of men and women differed slightly, there was little difference in the length of experience of men and women respondents, as shown in Figure 2.3.

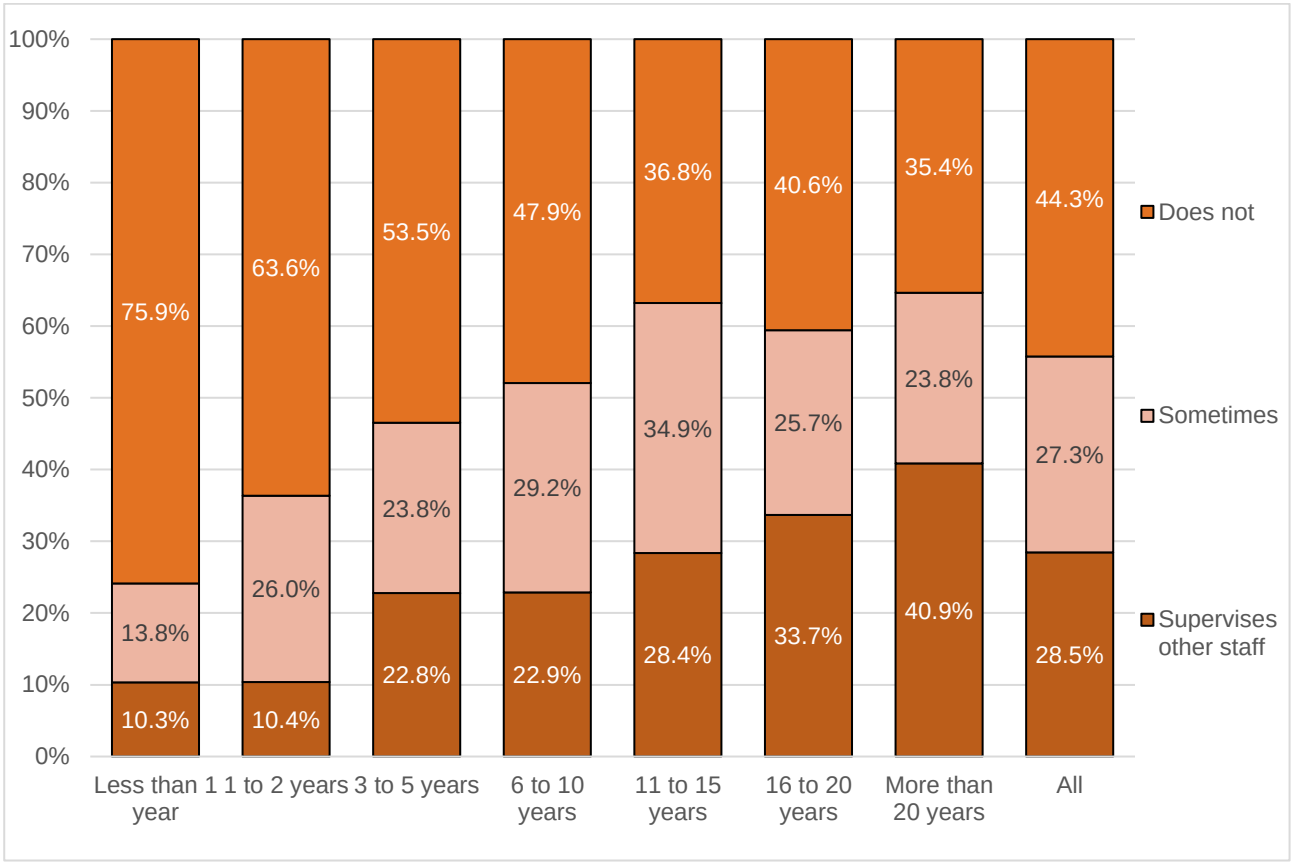
Figure 2.3 Men's and women's experience of working in disability services

	Less than 1 year		1 – 2 years		3 – 5 years		6 – 10 years		11 – 15 years		16 – 20 years		Over 20 years		All	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Male	5	1.3	27	7.1	46	12.0	99	25.9	65	17.0	56	14.7	84	22.0	382	100.0
Female	25	2.3	50	4.6	156	14.3	269	24.6	198	18.1	148	13.5	248	22.7	1094	100.0
All	**30**	**2.0**	**77**	**5.2**	**202**	**13.7**	**368**	**24.9**	**263**	**17.8**	**204**	**13.8**	**332**	**22.5**	**1476**	**100.0**

2.3 Supervisory responsibilities

Figure 2.4 shows that 28.5% of respondents supervised other staff in their current role, while about the same number (27.3%) said they did so sometimes. As would be expected, the proportion of staff supervising others was higher for those with longer experience in the disability services sector: 40.9% of those with more than 20 years of experience were supervisors, compared with around 10% of those with less than 2 years of experience.

Figure 2.4 Proportion of staff which supervised staff in their current role, by length of time working in disability services (n=1,462)



2.4 Residence and NDIS involvement

Most respondents resided in the eastern states, reflecting the networks through which the survey was distributed. Around 2 in 5 respondents (40.7%) resided in Victoria, 37.2% resided in NSW/ACT[2], and 11.8% resided in Tasmania.

Overall, a little over half (54.7%) were working in an NDIS rollout area or with participants of the NDIS, while 35.8% said they did not, and 9.5% were unsure (see Figure 2.5). This differed across the jurisdictions, with relatively high proportions of respondents (more than two thirds) working under the NDIS in NSW/ACT and Tasmania.

[2] A small number (8) were from the ACT, and these are combined with NSW for the purposes of analysis.

Figure 2.5 Respondents from each jurisdiction by whether or not they were working in an NDIS rollout area or with participants of the NDIS

	NDIS		Not NDIS		Not sure		Total	% of total
	n	%	n	%	n	%	n	%
NSW/ACT	356	68.5	121	23.3	43	8.3	520	37.2
QLD	26	37.1	39	55.7	5	7.1	70	5.0
TAS	112	67.9	42	25.5	11	6.7	165	11.8
VIC	224	39.4	277	48.8	67	11.8	568	40.7
WA	45	61.6%	21	28.8%	7	9.6%	73	5.2
Total	**763**	**54.7%**	**500**	**35.8%**	**133**	**9.5%**	**1396**	**100.0%**

2.5 Experience in disability by NDIS involvement

As shown above, over half of respondents were working under the NDIS (54.7%). However, slightly lower proportions of those working under the NDIS had lengthy experience in disability services. As shown in Figure 2.6, among those working under the NDIS, 21.4% of respondents had more than 20 years of experience compared with 26.2% of those not working under the NDIS. Relatively high proportions of those working under the NDIS had 2 years of experience: 8.7% of those working under the NDIS were in this category compared with 4.2% of those not working under NDIS.

The difference between levels of experience of respondents working under the NDIS and others is more apparent for non-supervisor staff (see Figure 2.7). Among staff working under the NDIS, 41.8% of non-supervisory staff had over 10 years of experience and 13.8% had less than 2 years of experience. For those not working under the NDIS the equivalent figures were 53.2% and 5.1% respectively.

Figure 2.6 Number of years worked in the disability sector, by NDIS involvement, supervisors and non-supervisors, n=1,462

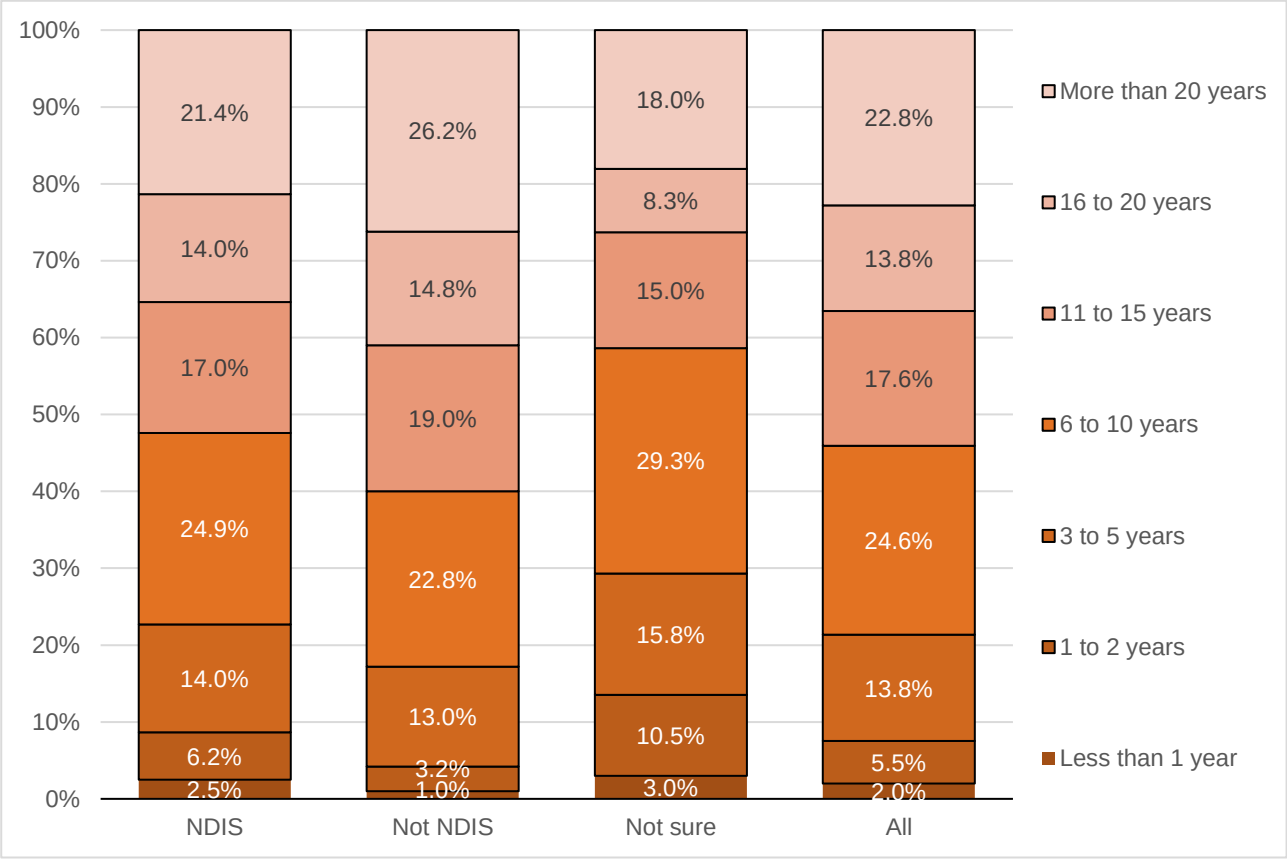
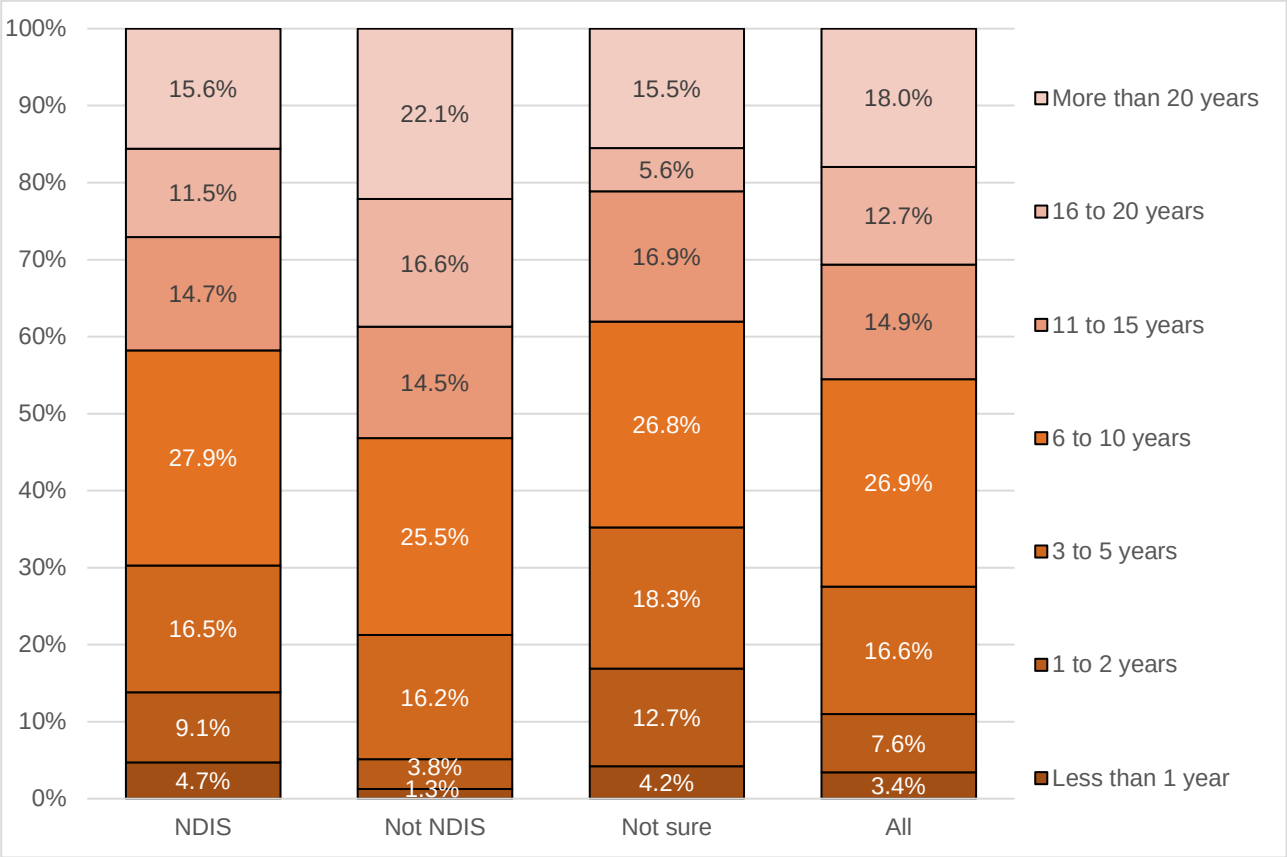


Figure 2.7 Number of years worked in the disability sector, by NDIS involvement, non-supervisory staff only, n=646

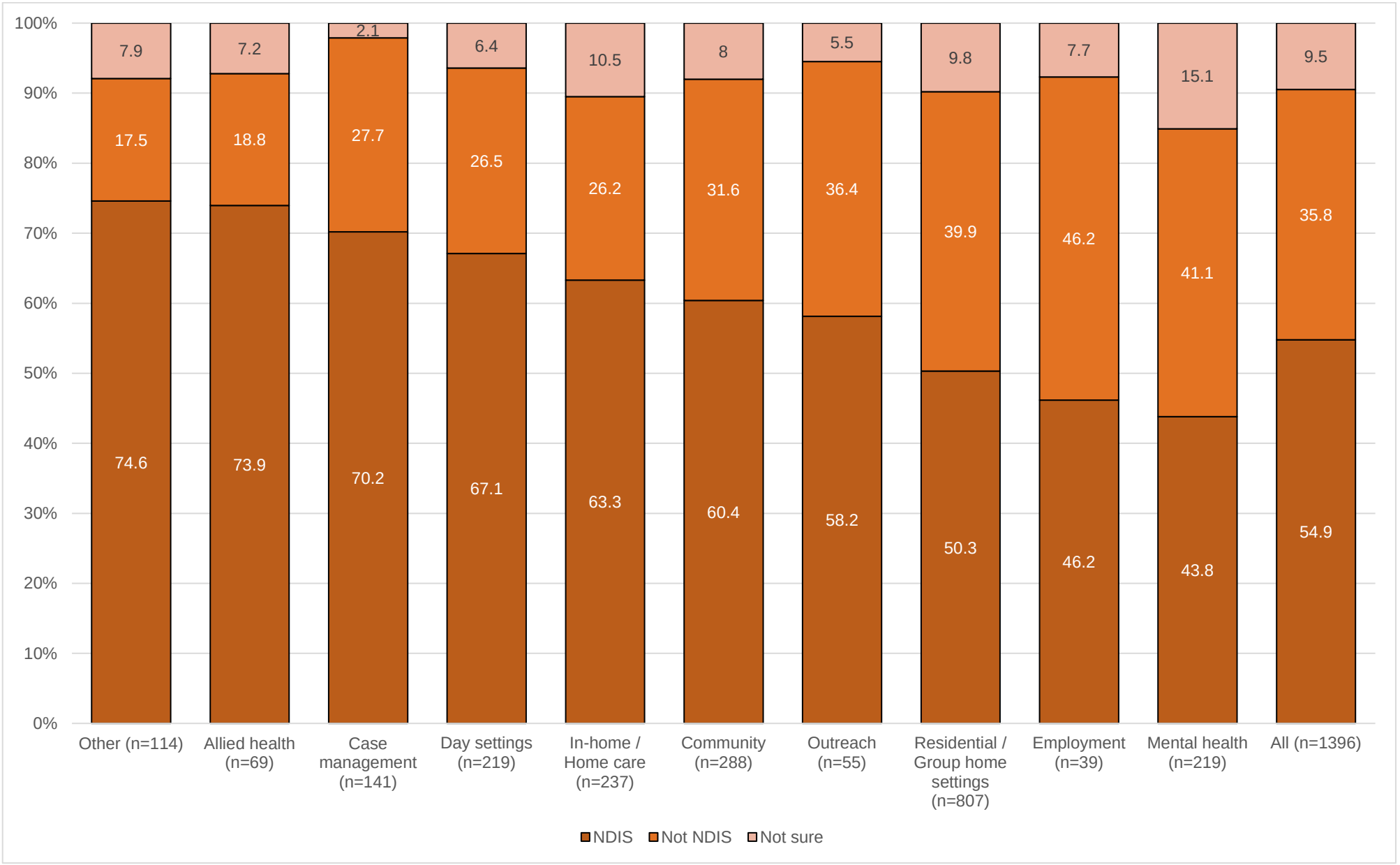


2.6 Disability settings and the NDIS

Figure 2.8 shows the proportions of survey respondents working in various settings who were working under the NDIS. The largest group of respondents were working in residential / group home settings (807, or 54.7%)[3]. A lower than average proportion of respondents in residential settings reported working under the NDIS (50.3%). The highest proportions working under the NDIS were in 'other' settings (not specified) (74.6%), allied health (73.9%), case management (70.2%), day settings (67.1%) and in home settings or home care (63.3%).

[3] Note that many residential workers also said they worked in community settings (20.5%), in-home settings (15.1%), and day settings (13.0%)

Figure 2.8 NDIS involvement for respondents working in the main disability service provision settings



2.7 Multiple job holding

Overall, 11.3% of respondents said they worked for more than one disability service provider or employer. However, this was slightly higher among non-supervisory staff 11.7% were multiple job holders compared with 7.2% of supervisory staff (see Figure 2.9). There was also a slightly higher proportion of staff who held multiple jobs among respondents working under the NDIS. Figure 2.10 shows that 12.8% of those working under the NDIS worked for more than one provider, compared with 8.8% of those who weren't. Further, in some disability settings, very high proportions of respondents worked for more than one disability employer. For example, 23.9% of respondents working in in-home or home care settings worked for more than 1 employer, as did 20.5% of those working in day settings. This is shown in Figure 2.11.

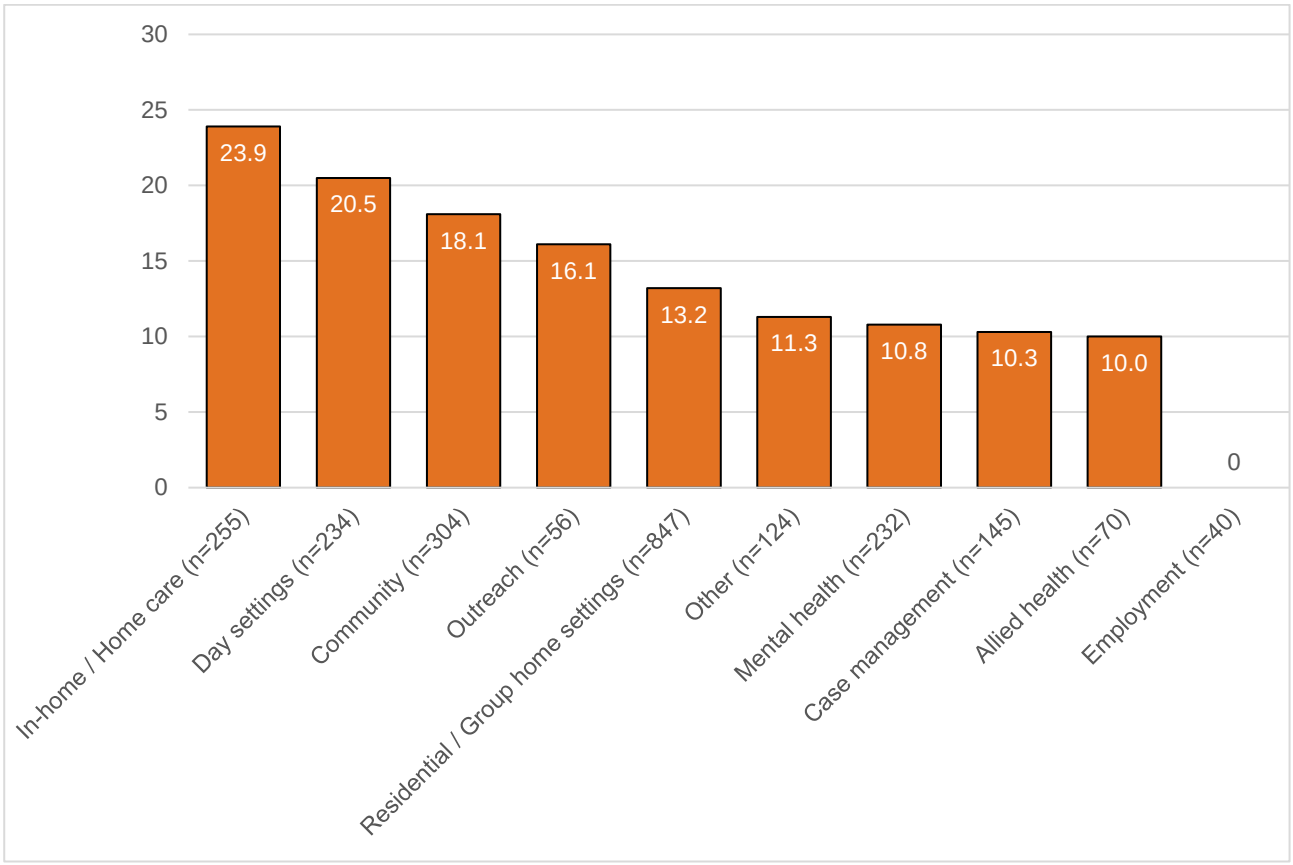
Figure 2.9 Whether respondent worked for more than one provider, by supervisory responsibility

	Works for more than one disability service provider		Works for one disability employer		All	
	n	%	n	%	n	%
Supervises other staff	30	7.2	386	92.8	416	100.0
Does not supervise other staff	76	11.7	571	88.3	647	100.0
Sometimes supervises other staff	59	14.8	340	85.2	399	100.0
All	**165**	**11.3**	**1297**	**88.7**	**1462**	**100.0**

Figure 2.10 Whether respondent worked for more than one provider, by NDIS status

	Works for more than one disability service provider		Works for one disability employer		All	
	n	%	n	%	n	%
Working under NDIS	98	12.8	665	87.2	763	100.0
Not working under NDIS	44	8.8	456	91.2	500	100.0
Not sure	14	10.5	119	89.5	133	100.0
All	**156**	**11.2**	**1240**	**88.8**	**1396**	**100.0**

Figure 2.11 Proportion of respondents in each disability setting who worked for more than one disability provider / employer



3. Perspectives on pay

The survey asked respondents to indicate their level of agreement with the statements "I am paid fairly for the work I do" and "I am satisfied with my overall level of take-home pay". For each of these statements, only a minority of respondents agreed, and this was the case for each statement and in all states (see Figure 3.1 and Figure 3.2). There was little difference between levels of agreement among supervisors and other staff: in both cases and for both statements, only a minority agreed. There were also no significant differences in levels of agreement on either measure between staff working under the NDIS and those who were not; in either context only a minority of respondents were satisfied with their pay.

Figure 3.1 Proportion of respondents who agreed with statement "I am paid fairly for the work I do", by state

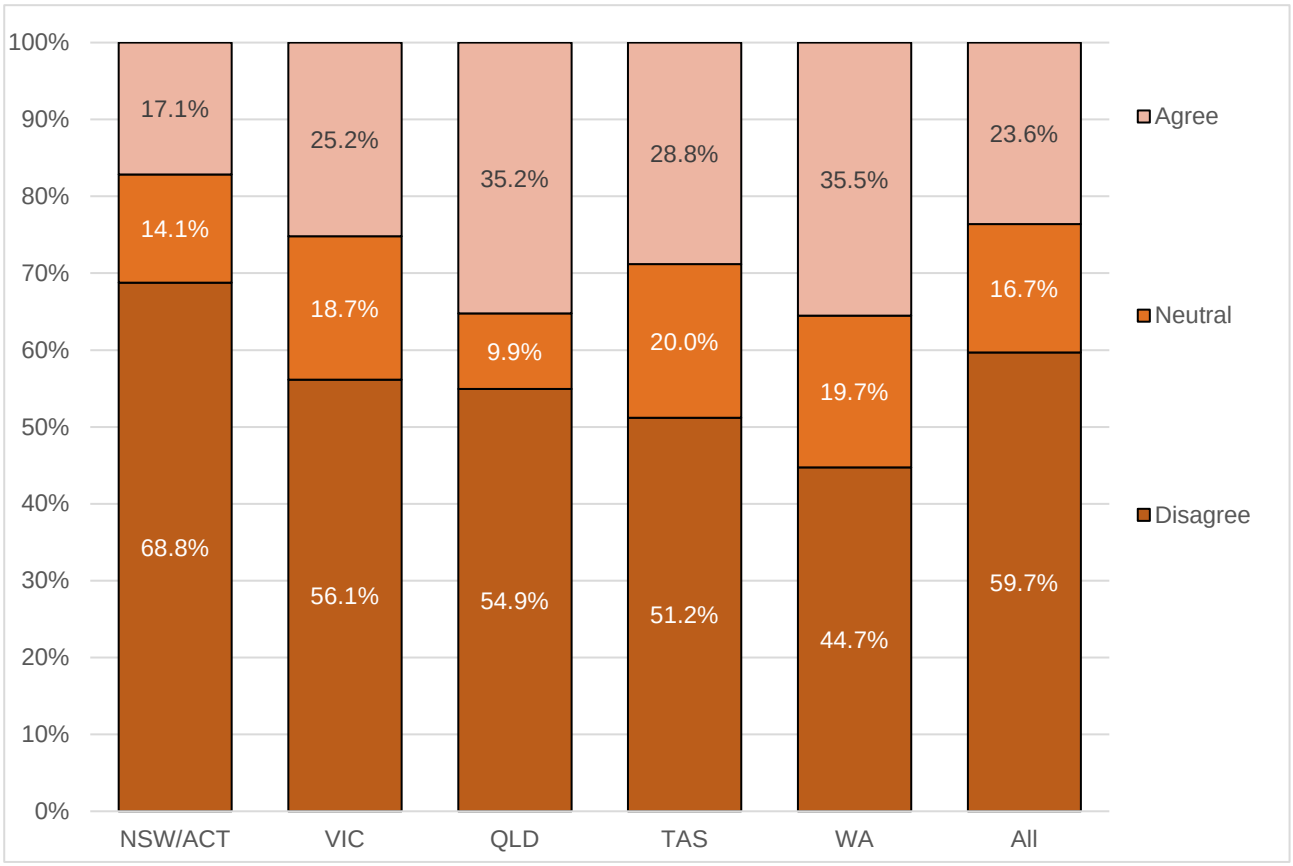


Figure 3.2 Proportion of respondents who agreed with statement "I am satisfied with my overall level of take-home pay", by state

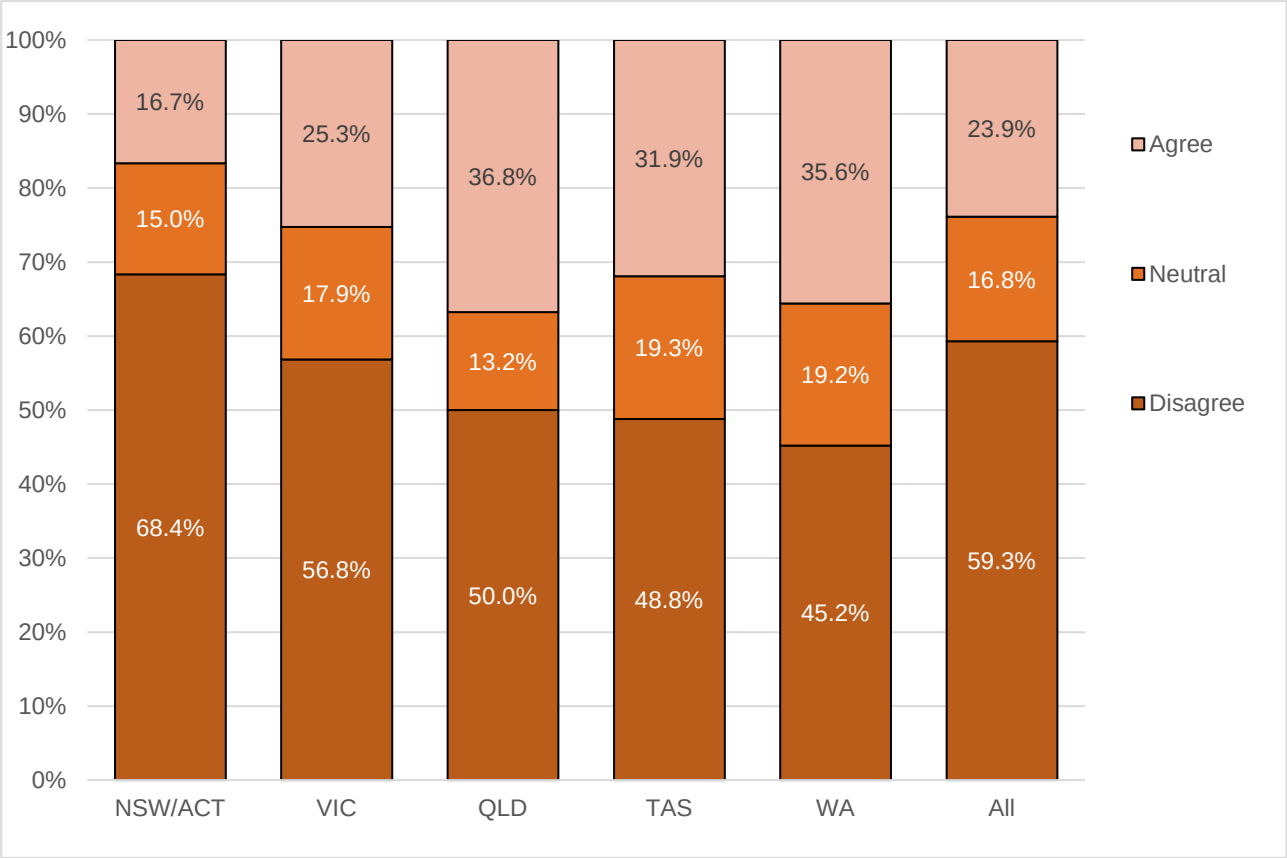


Figure 3.3 “I am paid fairly for the work I do”

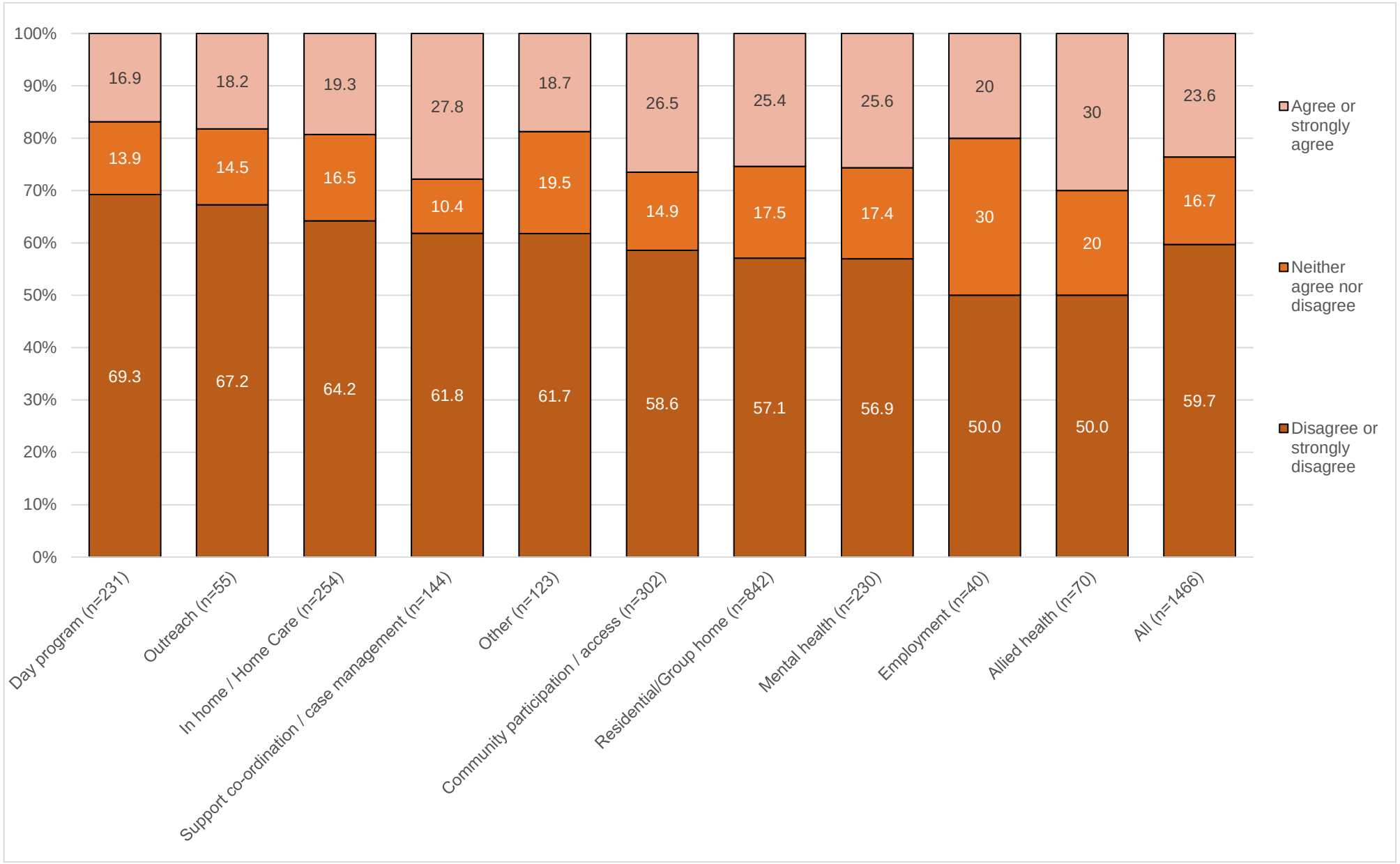
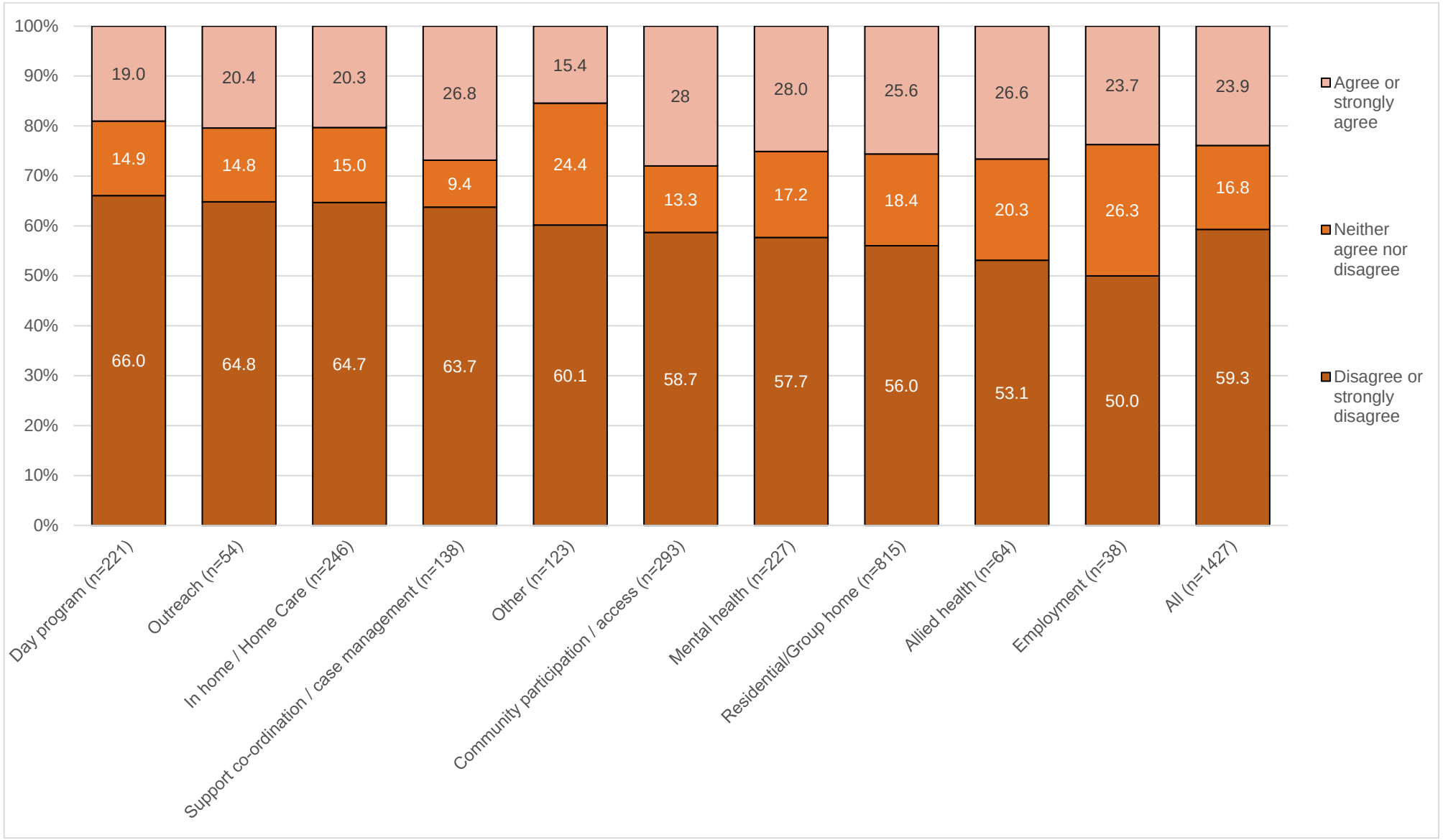


Figure 3.4 “I am satisfied with my overall level of take-home pay”



4. Perceptions of working under the NDIS

The survey captured respondents' perceptions of working conditions under the NDIS, through levels of agreement with three statements:

- Under the NDIS, I don't have enough time to do everything in my job (capturing workload and work intensity)
- Under the NDIS, I worry about the future of my job (capturing job security), and
- Overall, the NDIS has been a positive change for me as a worker (as a summary measure of the impact of the NDIS on working life).

As shown in Figure 4.1, more than half of respondents agreed or strongly agreed that under the NDIS, they don't have enough time to do everything in their job (55.9%), and only a small minority disagreed (11.4%). A larger majority agreed that they worried about the future of their job (72.2%), and 12.4% disagreed. Very few agreed the NDIS was positive for their working lives, with 10.6% agreeing and 52.6% disagreeing. The relatively large proportion who were unsure (36.9%) may have found it difficult to judge, for example if they were new to disability work or if the NDIS was new in their area, or if they had difficulty assessing the mixed impact of the Scheme on their work.

Differences in levels of agreement with the statements reported by workers in different disability settings tended to be small, shown in Figure 4.2. Figure 4.3 shows differences between respondents by their jurisdiction of residence. On all measures and in each jurisdiction, most reported the NDIS was having adverse impacts on their working lives. More detailed insight into experiences of working under the NDIS, in survey respondents' own words, is in Section 8.

Figure 4.1 Percentage of respondents which agreed with statements about working under the NDIS

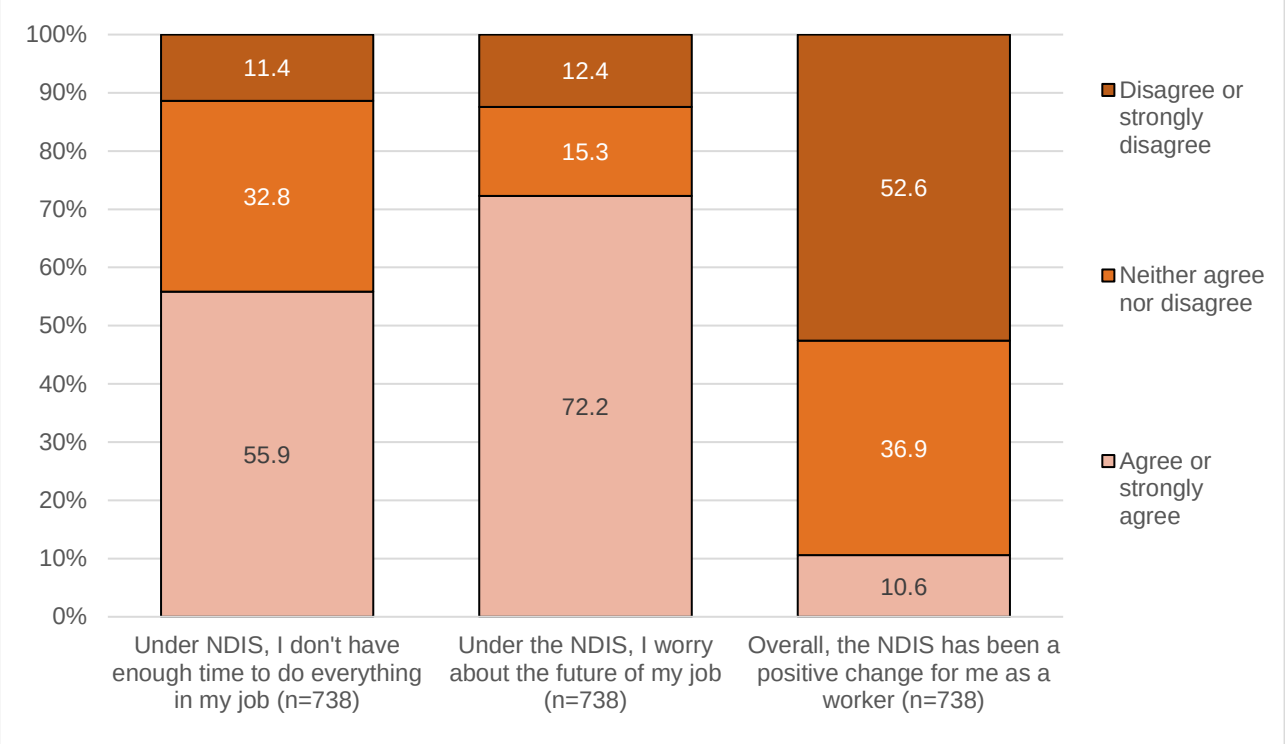


Figure 4.2 Proportion of respondents who agreed or strongly agreed with statements about working under the NDIS, by disability support service setting (%)

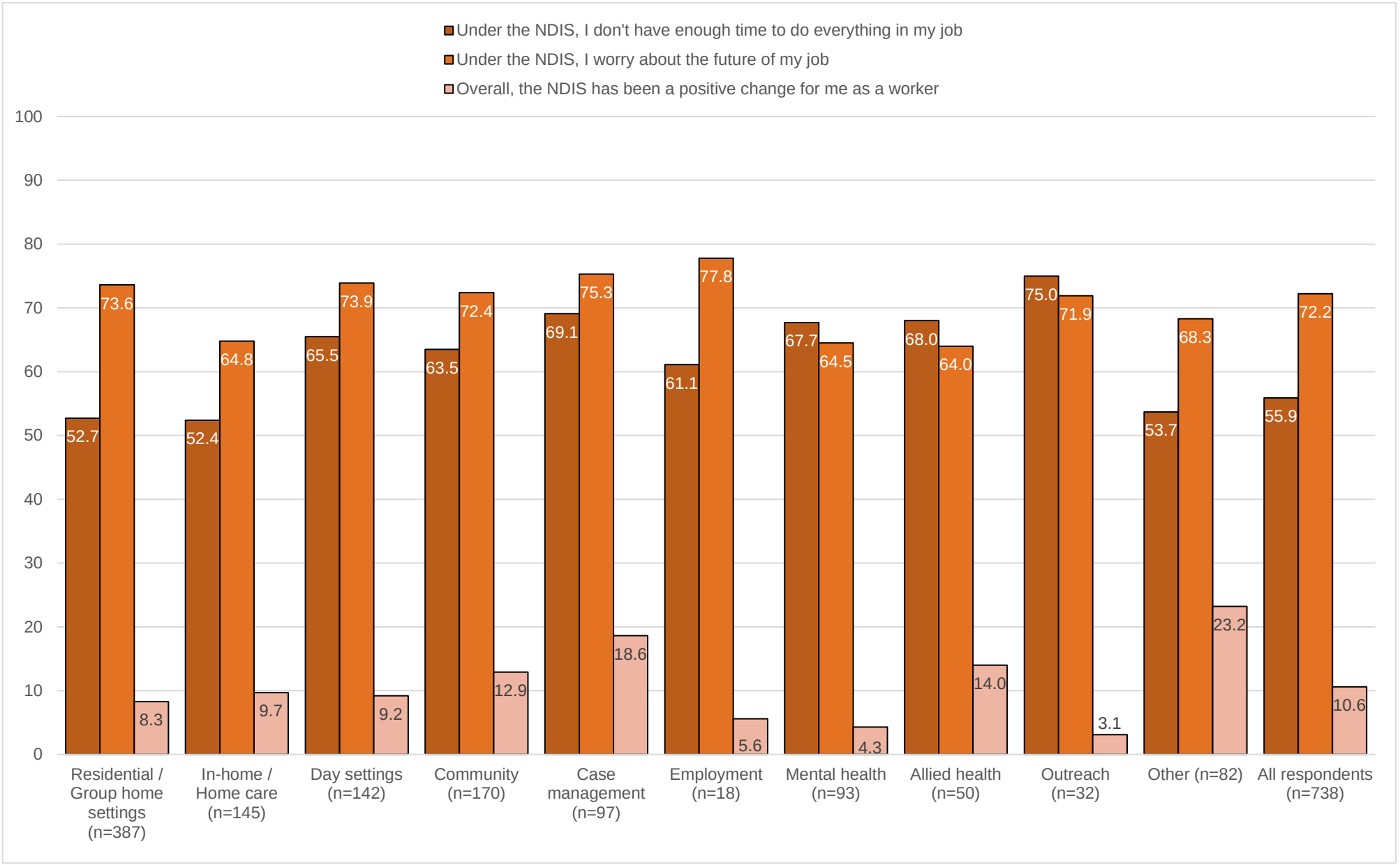
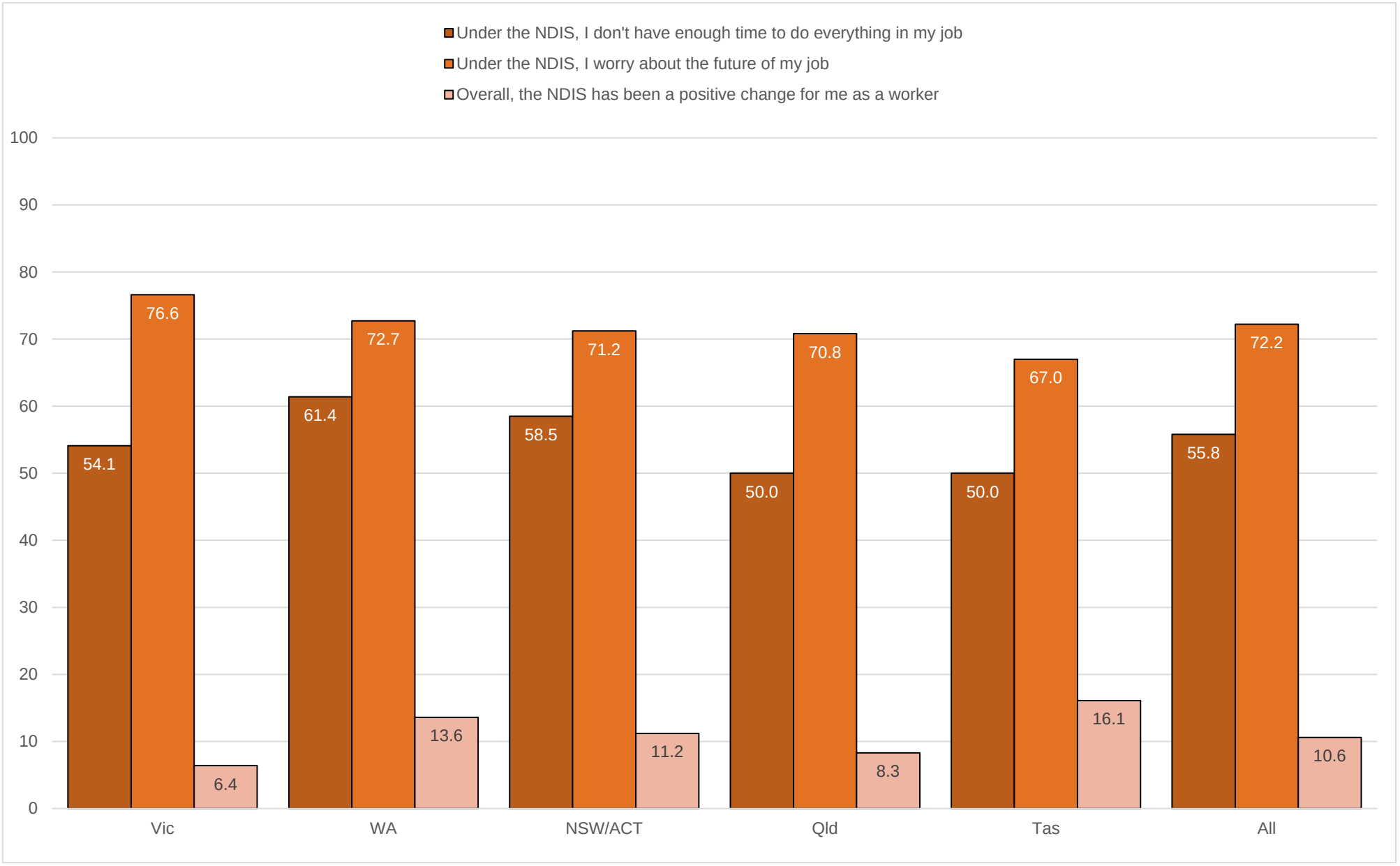


Figure 4.3 Proportion of respondents who agreed or strongly agreed with statements about working under the NDIS, by jurisdiction



5. Perceptions of the impact of the NDIS on participants and families

As well as showing how workers widely perceive the NDIS to be impacting adversely on their working lives, the survey data also shows only a minority reported it was impacting positively on participants and families. Figure 5.1 shows only a quarter (24.7%) agreed or strongly agreed that the NDIS was positive for the participants they work with, and many more disagreed (37.8%). Similarly, only a minority agreed that families of participants were happy with the Scheme (14.6%) and 15.7% agreed that overall, the NDIS is better than the previous system.

Figure 5.1 Percentage of respondents which agreed with statements about impact of the NDIS

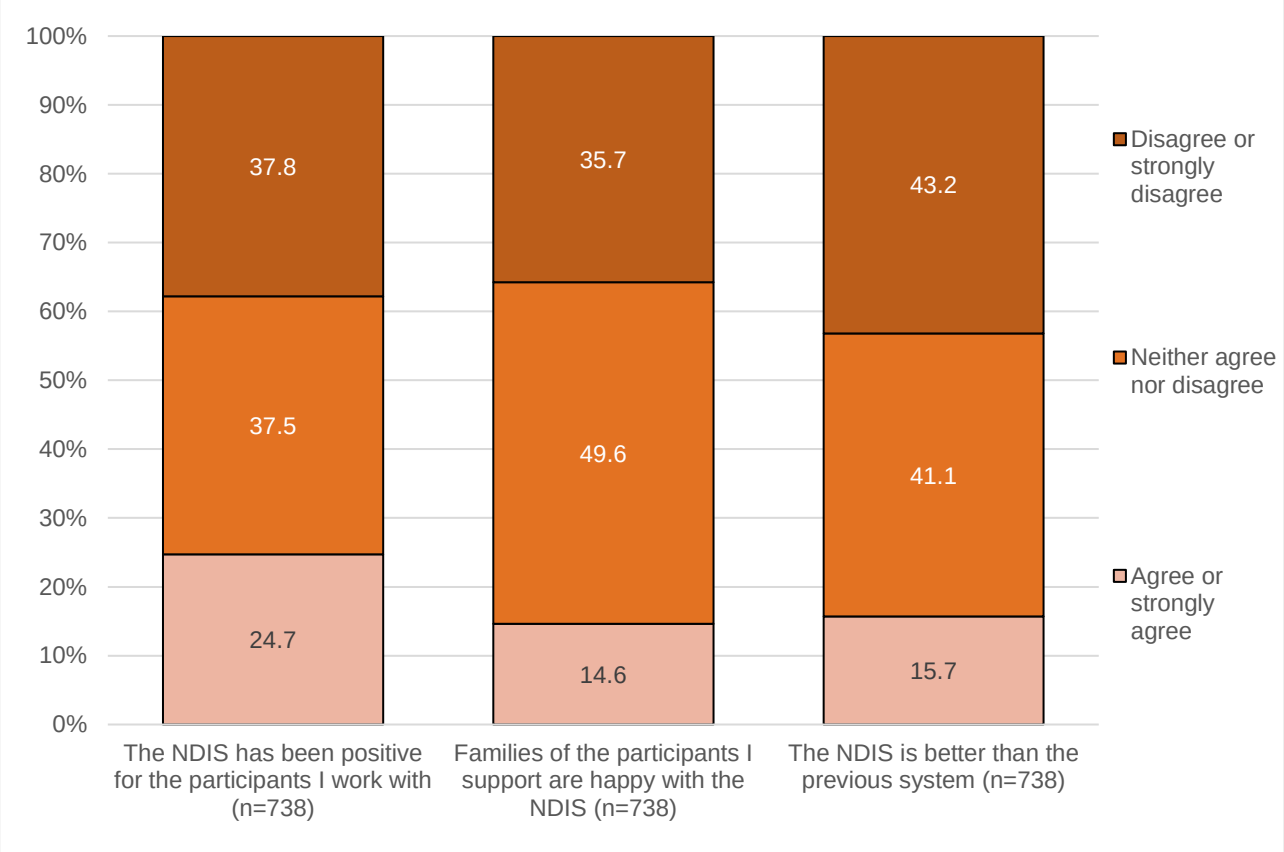


Figure 5.2 shows the proportion of respondents in each disability setting who agreed with the statements about the impact of the NDIS on participants and families. Among those in in-home, community, case management, allied health and 'other' settings, there were relatively high proportions of respondents who agreed the NDIS has been positive for participants, however, this remained a minority in all categories. Fewer agreed with the other statements, with variation by setting shown in Figure 5.2.

Figure 5.3 shows differences among respondents according to their jurisdiction of residence. Higher than average proportions of residents from Tasmania agreed with the statements, while agreement was lower for respondents from Victoria and Queensland.

Figure 5.2 Proportion of respondents which agreed or strongly agreed with statements about the impact of the NDIS on participants and families (%)

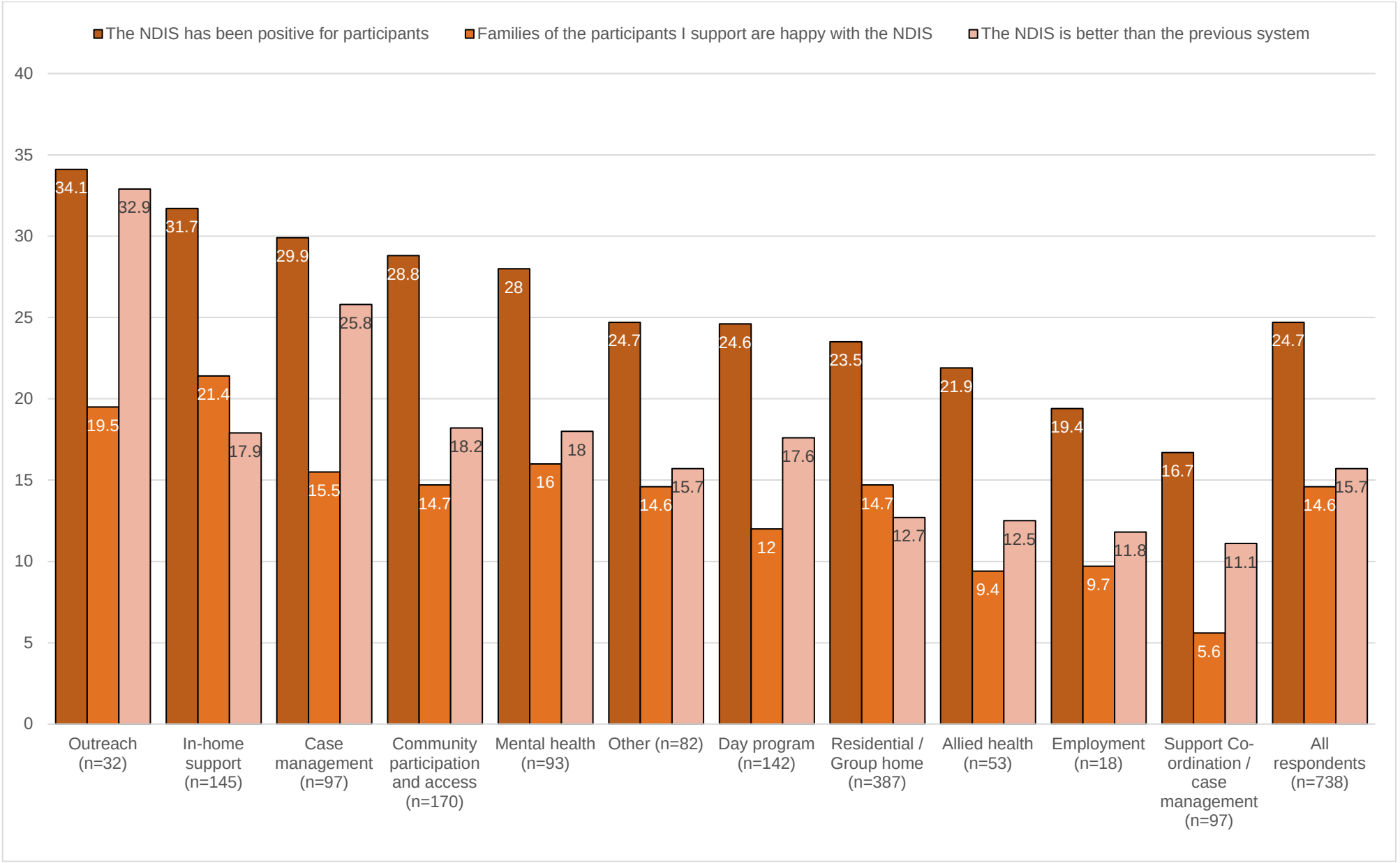
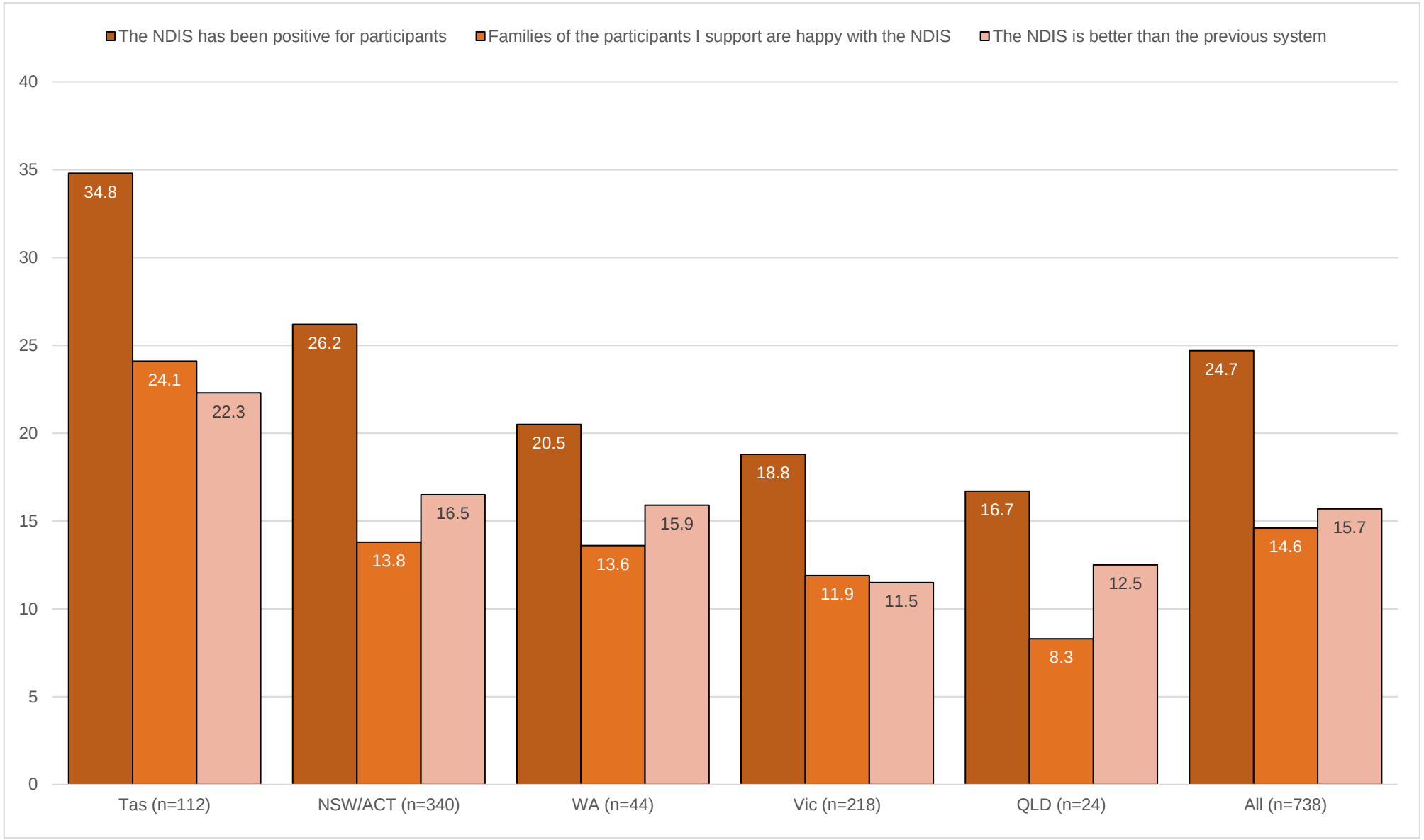


Figure 5.3 Proportion who agreed with statements, by jurisdiction of residence



6. Intention to leave or remain in the disability sector

Respondents were asked "Do you intend to be working in the disability sector in five years' time?" Around half said they did intend to be working in the sector (51.5%), while 15.2% said they did not, and a third (33.3%) were unsure.

The main differences in intention to leave were according to age, with a smaller proportion of those aged 60 or over intending to work in disability in 5 years, presumably due to retirement (see Figure 6.1). Indeed, when those who reported they intended to leave were asked why, retirement was reported by 36.7%. Reflecting dissatisfaction with remuneration discussed in Section 3, 27.6% of those intending to leave said it was because they could get better pay and conditions doing work elsewhere. A further 13.1% pointed to the nature of the work, saying they would leave as the work was too difficult or risky, while 12.7% said they would leave due to limited career development opportunities. Smaller proportions were intending to leave because of the unsociable hours (5.9%).

The main reasons for staying were due to commitment to clients, with 60.7% reporting they intended to continue working in the disability sector as they were 'passionate about supporting people with disabilities' and a further 18.8% said because 'I enjoy the client contact'. 10.9% said they had the flexibility to meet personal and family commitments. A small minority (4.0%) said they receive good pay and conditions, 3.3% said it was the best job available, and 2.3% said they had good career development opportunities.

Figure 6.2 shows the proportion intending to remain in disability services, according to respondents' years of experience in disability, and whether or not they were working under the NDIS The proportion intending to stay was similar for staff working under the NDIS (52.2%) and those who were not (51.4%).

Figure 6.1 Proportion who intend to work in disability services in 5 years, by age group

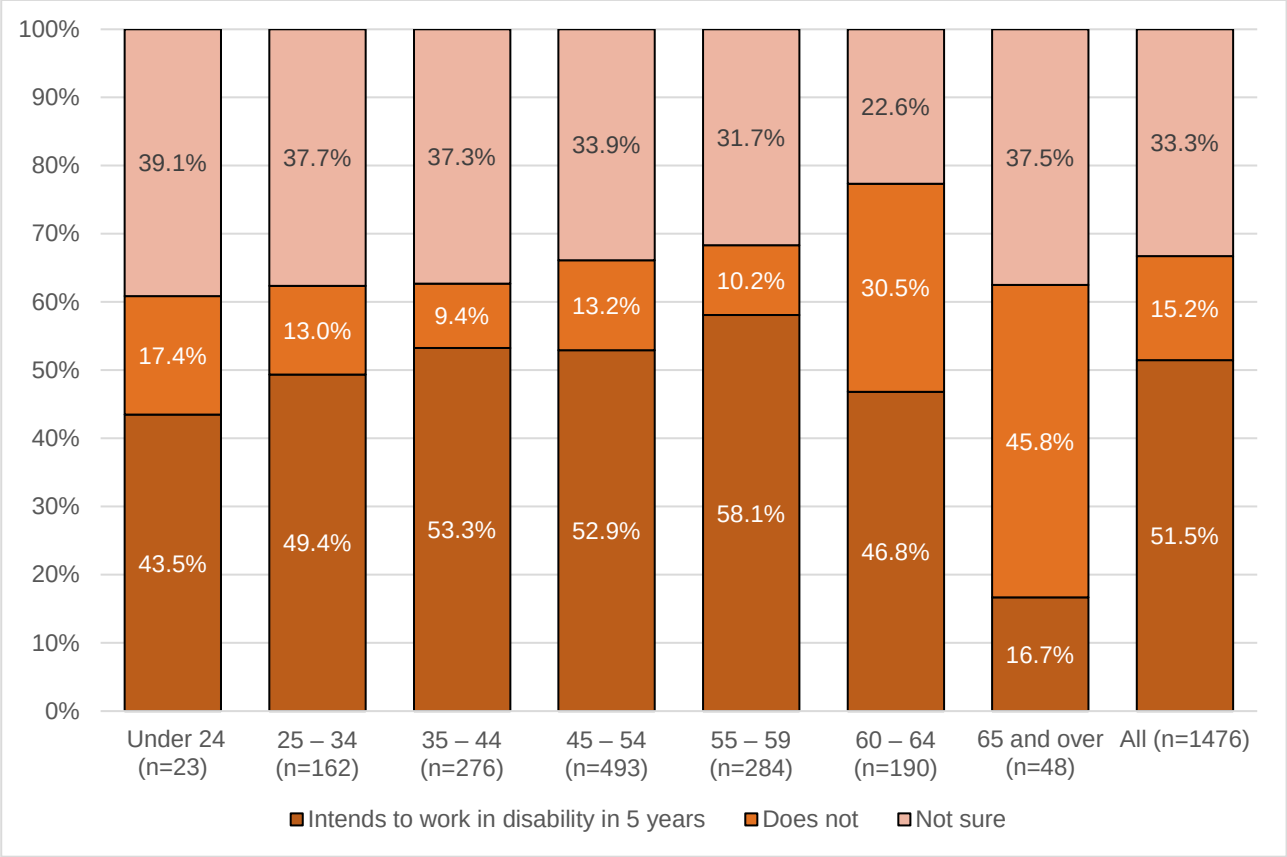
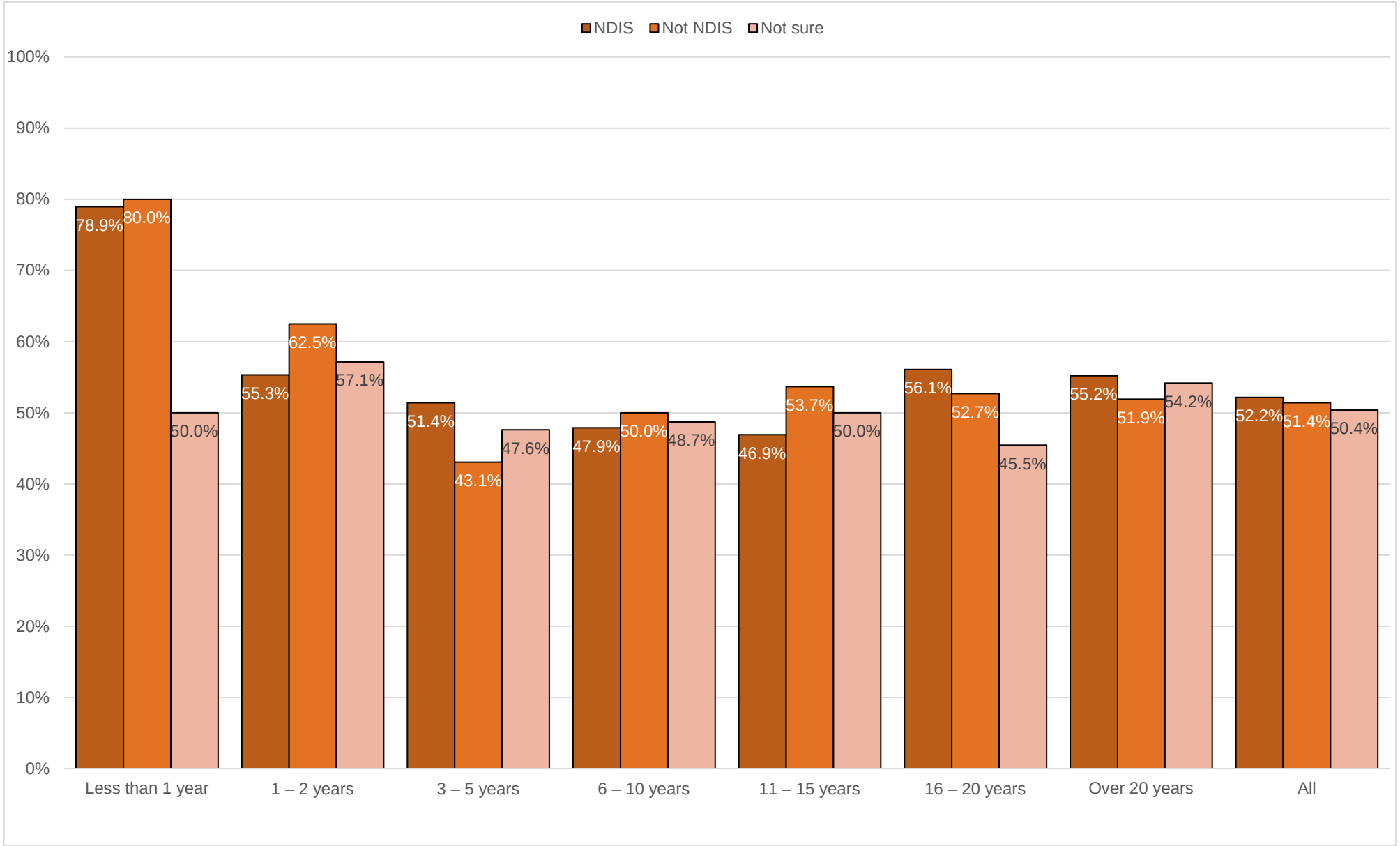


Figure 6.2 Proportion of respondents intending to be working in the disability sector in five years time, by years of experience in disability services and whether they were working under the NDIS



7. A closer look at supervision

As shown in Section 2.3, 28.5% of respondents said they currently supervise other staff, while about the same number (27.3%) did so sometimes. These supervisors (including those who always and sometimes supervised other staff) were asked further questions about the nature of their supervisory responsibilities, including how many people they supervised, and whether they experienced any challenges in providing proper supervision due to lack of time and the number of people they were supervising.

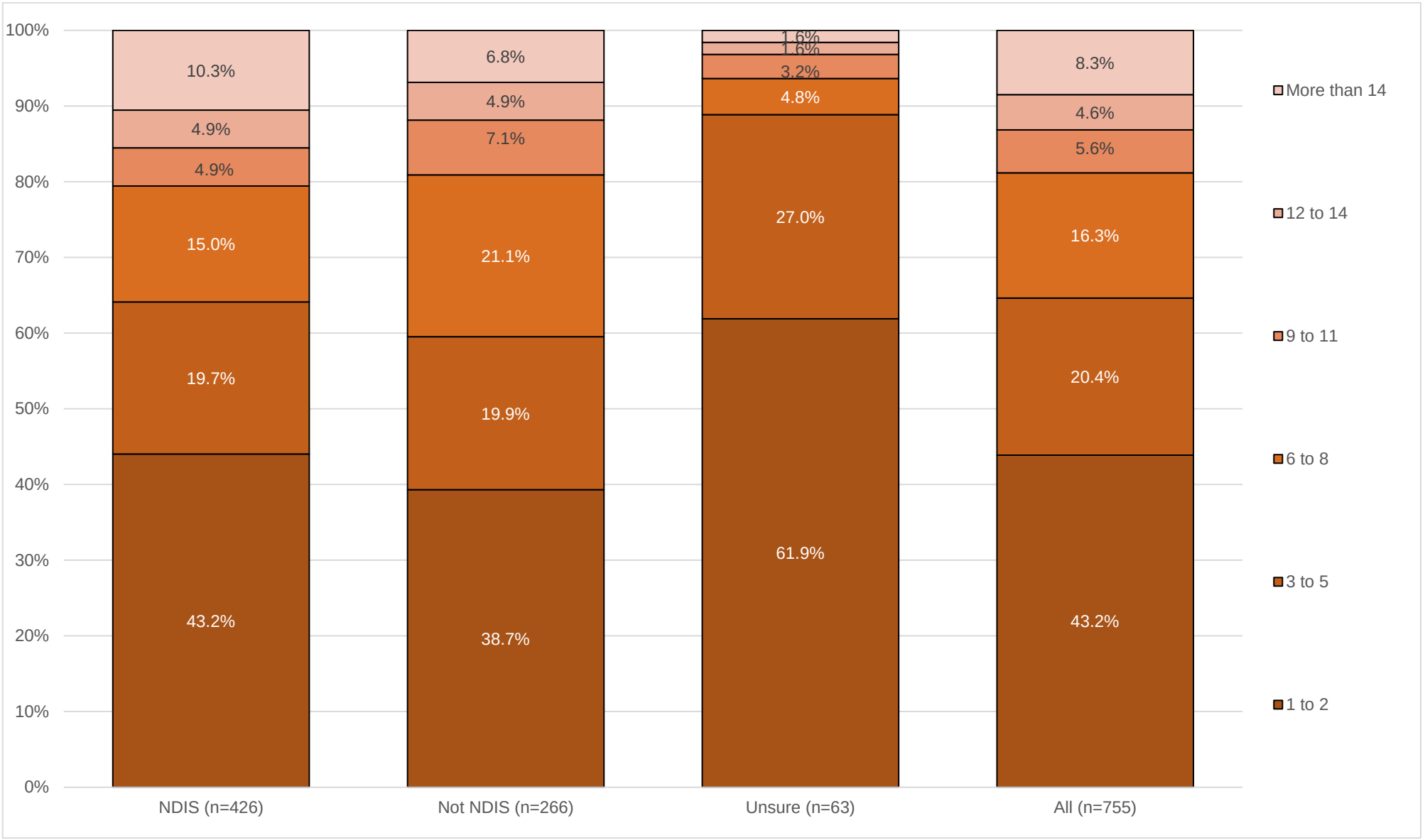
7.1 Numbers of staff supervised

The numbers of subordinates reported by supervisors working under the NDIS, and those who were not, is shown in Figure 7.1 (including information for those who 'sometimes' provided supervision). Overall, most supervisors reported only a few subordinates: 43.2% supervised one or two staff, and a further 20.4% supervised 3 to 5 staff. For this group, only 8.3% of supervisors supervised more than 14 staff[4]. However, this was higher for those under the NDIS, 10.3% of supervisors had more than 14 supervisees, compared with 6.8% of those not working under the NDIS.

Figure 7.2 provides the same indicators but excludes those who reported 'sometimes' supervising other staff. This allows a focus on the numbers of subordinates supervised by staff whose roles consistently involved supervision. For this group, 20.0% of those who worked under the NDIS supervised more than 14 staff, compared with 12.0% of those not under the NDIS.

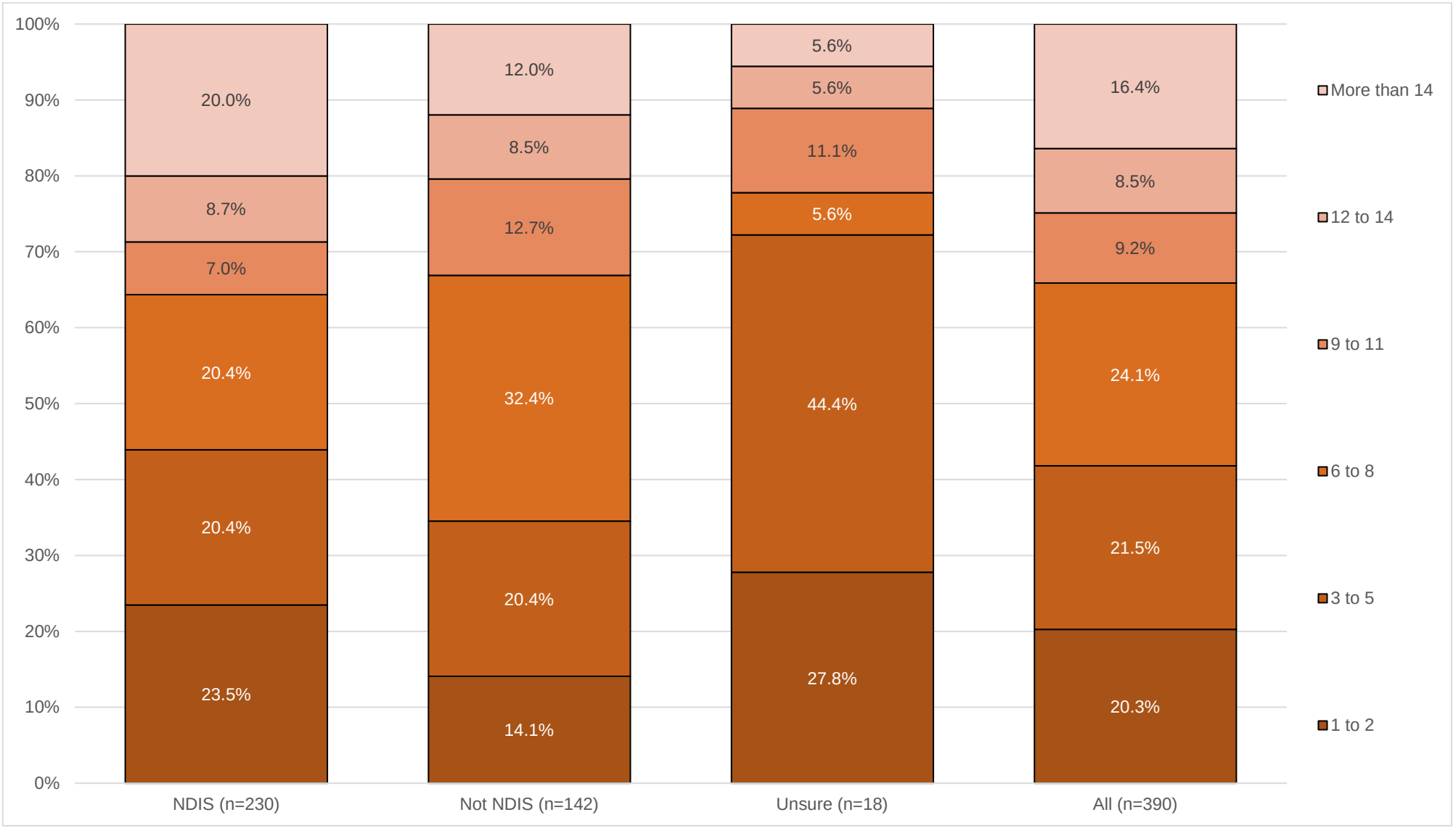
[4] Supervision of more than 14 staff is of interest because the National Disability Insurance Agency's pricing model assumes supervisors directly supervise 15 staff, and provides resources accordingly. See NDIA (2014) NDIA report on the methodology of the efficient price: National Disability Insurance Agency.

Figure 7.1 Number of staff directly supervised, by whether or not respondent was working under the NDIS, all supervisors^ (%)



^NB: This includes supervisors who always or sometimes provided supervision.

Figure 7.2 Number of staff directly supervised, by whether or not respondent was working under NDIS, supervisors^ (%)



^NB: This includes supervisors who always provided supervision only (ie those who sometimes provided supervision are excluded).

7.2 Pressure on supervision

The data shows that supervisors who directly supervise large numbers of staff experience difficulties in providing proper supervision. As shown in Figure 7.3, the proportion of supervisors who agreed that they can't provide proper supervision due to lack of time increased with the number of staff directly supervised. Among those supervising only 1 or 2 staff, 16.7% strongly agreed with the statement, and a further 38.5% agreed. Among those supervising more than 14 staff, many more strongly agreed or agreed: 38.7% and 45.3% respectively. Figure 7.4 shows that similarly, the proportion of supervisors who agreed or strongly agreed with the statement "I can't provide proper supervision because I have too many people to supervise" increased according to the number of supervisees. Well over half of those supervising over 14 staff (58.7%) agreed with the statement. Figure 7.5 and Figure 7.6 shows differences in agreement with the statements according to disability setting. On both measures, higher proportions of supervisors in day, residential and case management settings tended to agree.

Figure 7.3 Agreement with the statement "I can't provide proper supervision due to lack of time", by number of staff directly supervised (n=382)

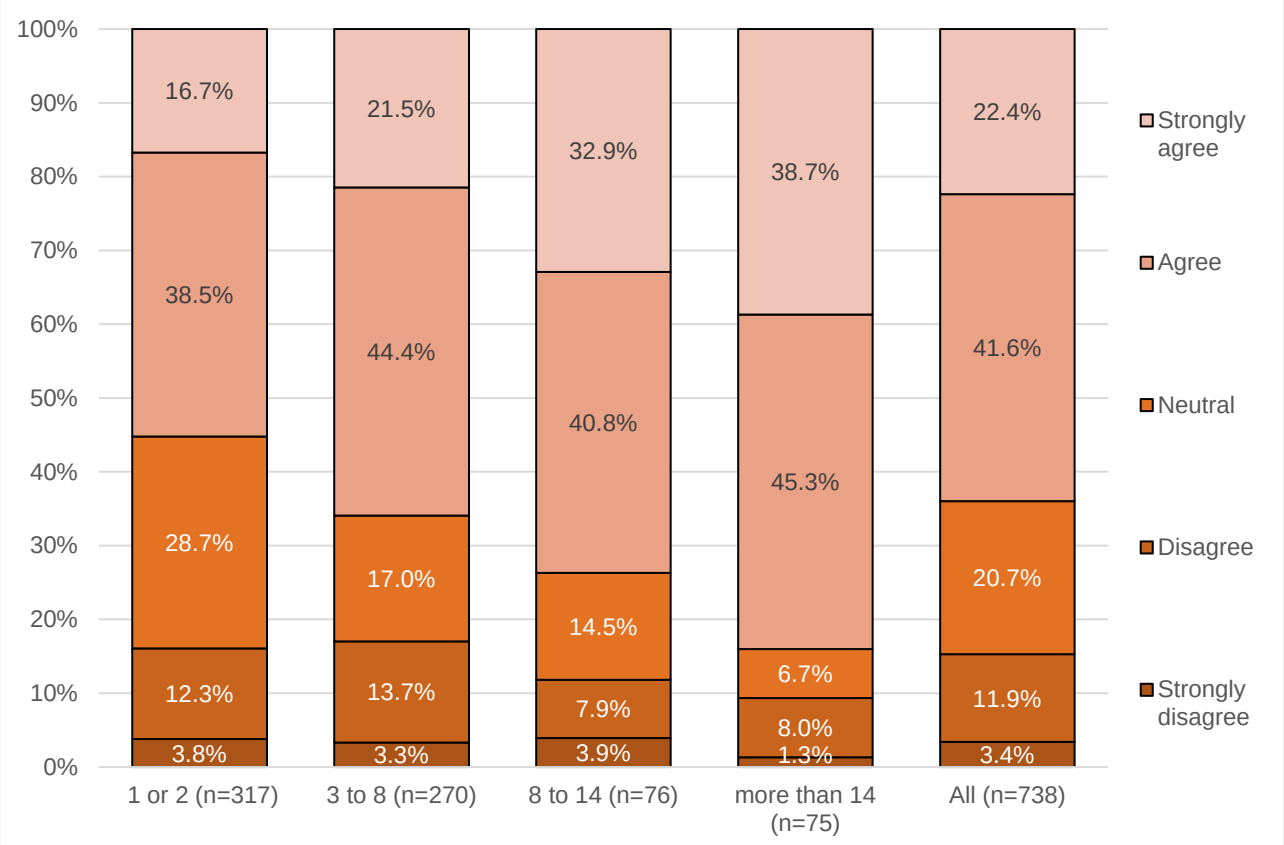


Figure 7.4 Agreement with the statement "I can't provide proper supervision because I have too many people to supervise"

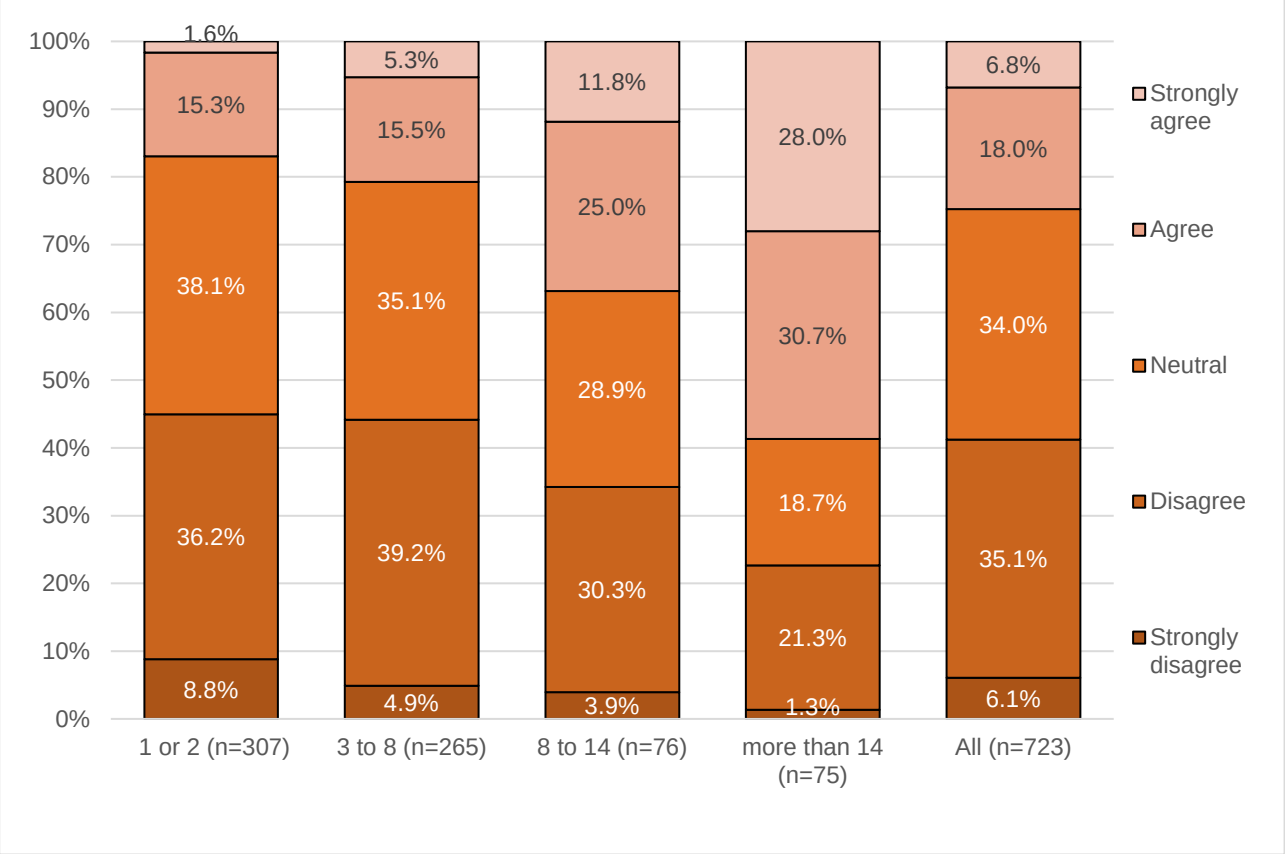


Figure 7.5 Agreement with the statement “I can't provide proper supervision due to lack of time”, by disability setting

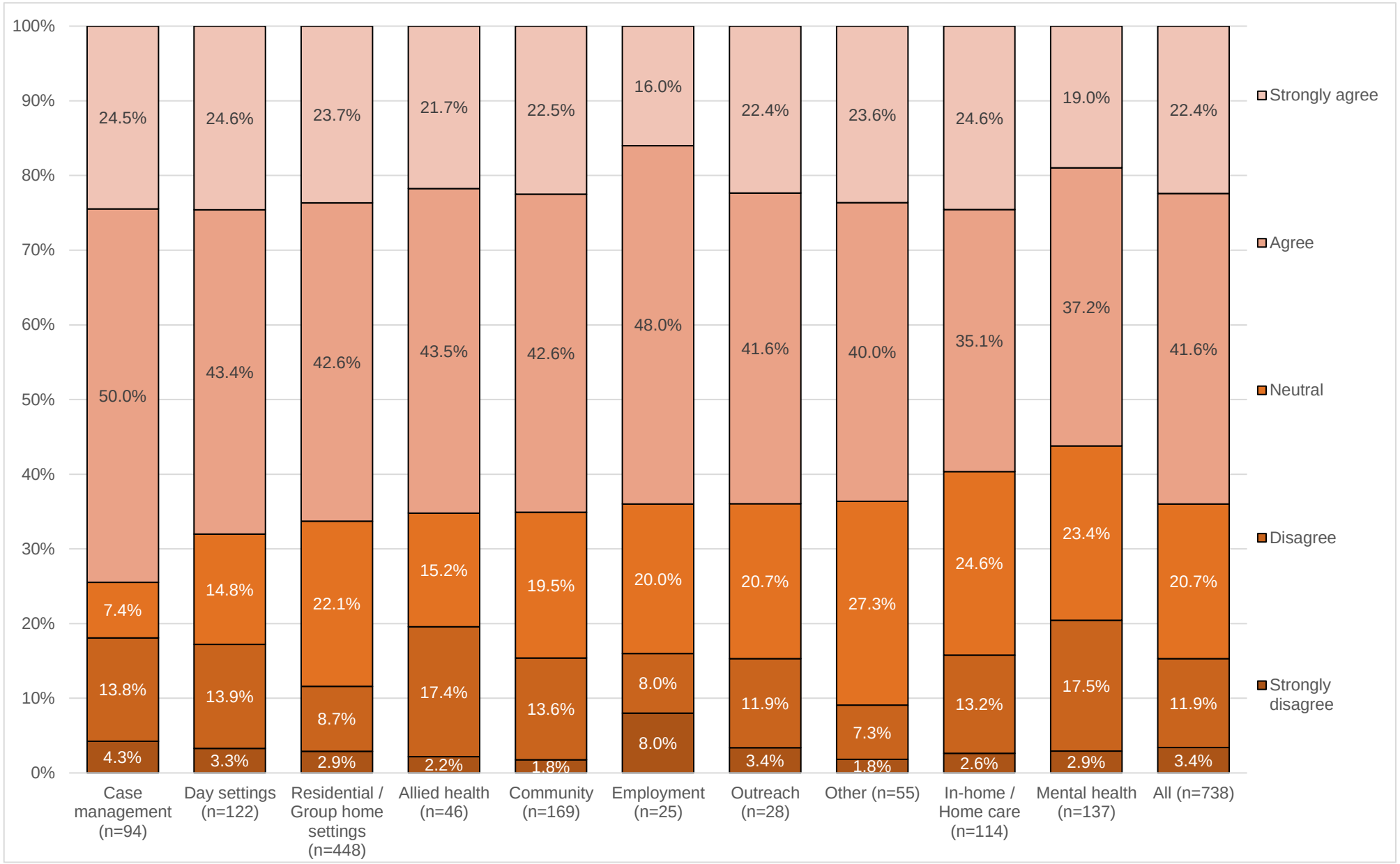
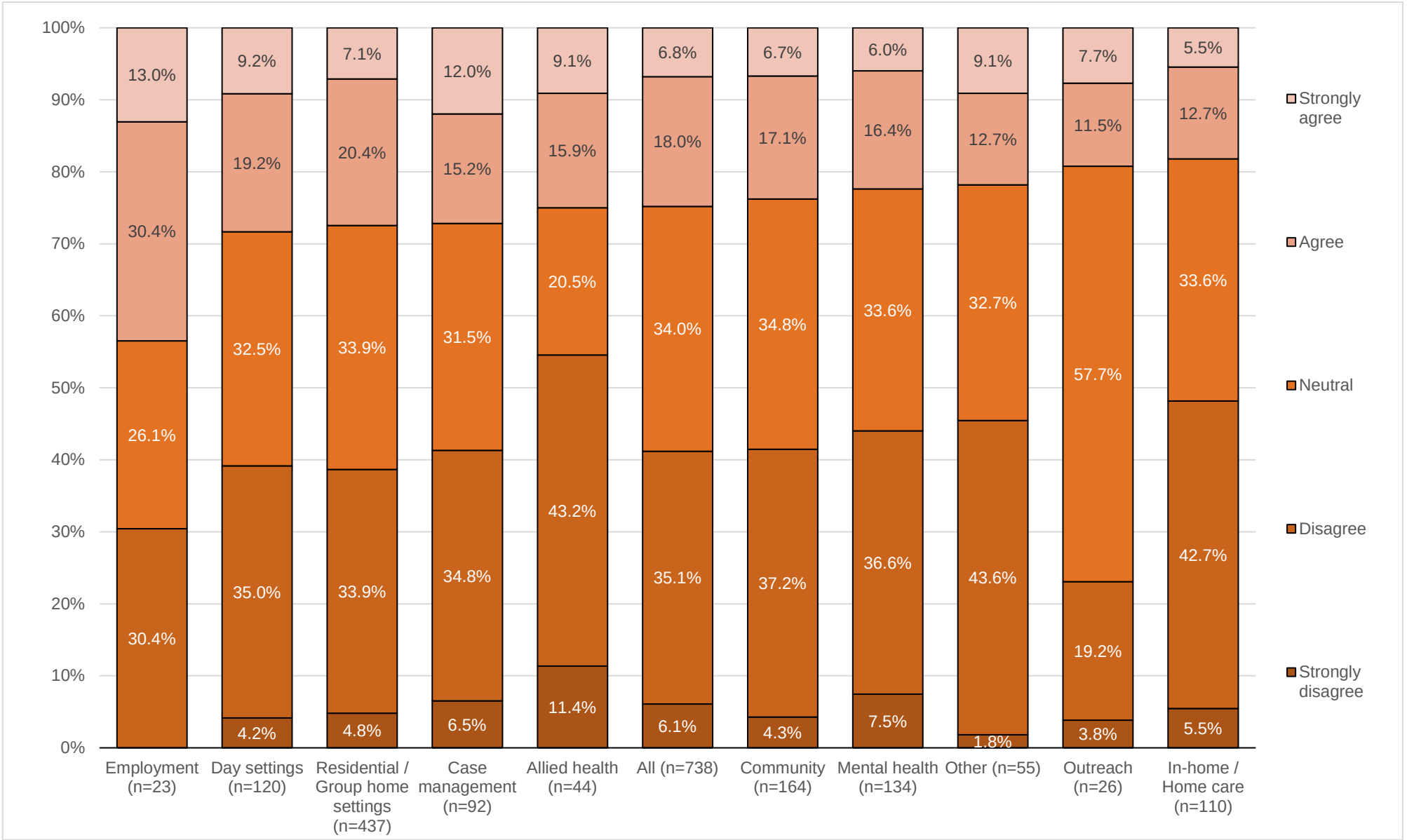


Figure 7.6 Agreement with the statement “I can't provide proper supervision because I have too many people to supervise”, by disability setting



8. Logistic regression

8.1 Understanding the factors affecting impact of the NDIS on participants

To better understand the factors affecting whether or not respondents perceived the NDIS to be positive for participants, multivariate analysis (logistic regression) was used. Logistic regression allows exploration of associations that multiple variables have on a binary categorical (non-numerical) outcome variable. In this case the outcome variable was a binary indicator distinguishing whether respondents agreed (or strongly agreed) with the statement "The NDIS has been positive for the participants I work with" (coded as 1), as opposed to those which did not agree with the statement (coded as 0).

8.2 About the model

The model includes control variables to account for the effects of worker demographics, disability setting, and working conditions, each of which could influence perceptions of the impact of the NDIS on participants. Binary indicators were included to control for the effect of gender, and working in NSW and Tasmania (as higher proportions of respondents in these areas reported the NDIS was positive). It also controlled for disability setting, whether respondents had worked in disability services for less than 2 years, or more than 10 years, and whether the respondent worked for more than one disability provider.

Working conditions were captured with a binary measure of pay justice, job security, time pressure, and capacity to provide quality supervision. Pay justice was constructed as a binary measure which grouped together (and coded as 1) those who agreed (or strongly agreed) with both the statements about pay "I am paid fairly for the work that I do" and "I am satisfied with my overall level of take-home pay". Those who did not agree with both measures were treated as not perceiving pay to be just (and coded as 0). To capture job security, a measure was constructed capturing those who agreed with the statement "Under the NDIS, I worry about the future of my job" compared with those who did not. Similarly, time pressure was captured with those who agreed with the statement "I don't have enough time to do everything in my job" coded as 1 (and the remainder coded as 0). A measure of quality supervision was constructed. Those who disagreed with the statement "I can't provide proper supervision due to lack of time" and "I can't provide proper supervision because I have too many people to supervise" were considered to provide quality supervision, and coded as 1.

8.3 Results

Results (odds ratios) are in Figure 8.1. Odds ratios greater than 1 (and which were statistically significant) indicate the factor was associated with increased odds of reporting the NDIS was positive, while those lower than 1 predict lower odds of doing so. The results show that three factors predict whether or not respondents perceived the NDIS to be positive for participants: state, pay justice, and job security. In particular:

- Residing in NSW and Tasmania were associated with increased odds ratios (of 2.7 and 2.5 times, respectively).

- Perceptions of pay justice also more than doubled the odds of perceiving the NDIS to be positive for participants, with odds ratios of more than 2.4 times.

Poor job security was associated with lower odds of reporting the NDIS had a positive impact on participants:

- Worrying about the future of one's job lowered the odds of reporting the NDIS was positive for participants (Odds Ratio=0.3).

Figure 8.1 Odds ratios: Employees who agreed with the statement "The NDIS is positive for the participants I work with"

	Odds ratios	Standard error
Works for more than 1 provider	.83	0.4
Two years of experience or less in providing disability services	1.8	0.6
More than 10 years of experience	1.4	0.3
NSW	2.7**	0.3
Tas	2.5*	0.4
In-home/home care settings	.8	0.4
Allied health	1.5	0.5
Case management	1.2	0.4
Community settings	1.2	0.3
Perceives pay is just	2.4**	0.3
Provides quality supervision	1.2	0.4
Time pressure	1.1	0.3
Concerned about future of job	0.3***	0.3
Constant	**0.2**	**0.4**

*p<.05 **p<.01 ***p<.001, Nagelkerke r square = .18, Hosmer-Lemeshow chi-square=5.6 (8), p=.685. Reference category is a female employee in 1 job with between 2 and 10 years experience working outside NSW or Tasmania.

9. Comments and concerns about working in the disability sector

Respondents were asked if they had any comments or concerns about their work in the disability sector and / or the NDIS. Overwhelmingly, respondents used the opportunity to comment: 913 workers provided comments (60.0%). The themes below reflect areas of concern. Note that each quote comes from a different person, with quotes selected to exemplify key themes expressed from the group as a whole.

9.1 General concerns about the NDIS

Respondents expressed significant concerns about the working in the disability sector and under the NDIS. Several respondents expressed confusion about the NDIS and the process of change, for example:

> The organisation I'm with are not providing informing us what we employees should be doing to prepare for the roll out in our region, not sure they know what they are doing.

> Everyone feels that they are in the dark about the NDIS, no one knows what's happening, or where they will be standing in the future, whether our jobs or pay will be secure, who knows, because no one is telling us anything

As well as reflecting uncertainty about the process of change, respondents' comments provide insight into the range of adverse impacts workers see the NDIS to have on the quality of services and the quality of jobs. Some explained that although they agreed with the principles of the NDIS, the Scheme did not appear to be implemented in positive ways, as financial considerations were eclipsing the needs of clients. Many expressed concerns about the resource model. They saw funding levels for people with disability to be inadequate, which raised concerns about clients' ongoing and future capacity to purchase the quality and quantity of services required. Examples of this sentiment are in the following statements:

> I fear it is mostly a cost saving scheme for the government. Theoretically it should work well, but at the moment it appears to be underfunded.

> I am concerned that people will not receive adequate packages. I work in respite and there appears to be questionable future funding for this service.

> The NDIS has turned an industry which use to be about caring and nurturing into an industry which only cares about profit for the provider.

Concerns about resourcing of the NDIS centred on the impact on people with disability. One respondent explained:

> The funding for the NDIS needs to meet the needs of people with disabilities. The government needs to take a reality check and they need to remember that they are dealing with the lives of very vulnerable people. If the NDIS is funded correctly it will

> be a fantastic step forward if the funding is not there then people with disabilities will have to take a giant step backward to time before deinstitutionalisation!!!
>
> Many of my clients have wondered why they have to change and what are their choices if they don't go with the NDIS? Many of my clients cannot read or write or are very limited, they have no family and the NDIS was not designed for these types of clients. The NDIS should have been more carefully worked through but all clients have been lumped in the one boat. Many have been very stressed about the change and all that goes with it. They feel they have no choice but to go along with it.

As well as being concerned about the impact of the NDIS on people with disability, workers also expressed concerns about the impact on family members:

> People with high support needs will get less hours of support. There will be pressure for the mothers of people with disabilities in particular to look after their son or daughter for more hours.
>
> I am concerned about vulnerable families and how they will be able to articulate their needs and negotiate the system. Both staff and participants are very confused about how the NDIS will work.

Another respondent, working in a community participation / community access setting, also focused on the impact of the NDIS on parents of children with disability, and described their frustration at discovering plans were unsuitable for meeting their children's needs:

> The NDIS is the worst thing this country has done. I am constantly on the phone with parents, crying out of frustration as they feel that they have lost support, have nowhere to turn for help and basically do not totally understand the scheme as it stands. I have had one parent at the edge of totally giving up and was so concerned with his state of mind that he was referred onto support for himself. The amount of times I have heard families say, "I am so tired of fighting for my child". We have that many families who have appealed their plans as Local Area Coordinators and Planners have been employed with minimal or no experience in the disability sector. How can families receive a plan that suits their needs when the person who is supposed to be guiding them through the process has so little experience?

Other workers also expressed concerns about the quality of the planning process, pointing out how planning was conducted without ensuring support for participants, and without a face to face meeting:

> I feel that anyone changing to the NDIS needs support while being interviewed on the phone. There is no face to face meetings and the people doing the interviewing know nothing about the person being interviewed. This can be very misleading if the person being interviewed does not give a full history of their situation.

Another respondent outlined how the NDIS was reproducing inequalities, as people with disability who had strong family advocates had better access to Scheme resources:

> I have concerns about families not receiving the support they need to navigate the 'system'. From accounts with numerous families I have learned that NDIA support/funding is more likely to be received by families who 'jump up and down', which indicates to me that it is a reactive, not proactive system. For such an amazing concept, I think it is really important for access to the NDIA to provide equality, otherwise the same inequalities that have always been in the disability sector will continue to occur.

Several workers commented that the NDIS was failing particular groups of people with disability, in particular by failing to recognise the complexity of need. As one explained:

> NDIS has been created with a particular set of disabilities in mind, or at least as a priority, but in the case of intellectual disability there is not enough consideration given to the complexities of supporting those with complex care needs. Where participants are unable to self-manage or advocate strongly for themselves, supervisory staff are not being given the resources to properly provide choices and to collect the evidence that quality services are being delivered. What was sold as an opportunity to address the inequalities inherent in the block-funded arrangements has instead delivered a cost-cutting exercise; whether through accident or design, the lofty ideals of the NDIS are not being going to be achieved for a great many participants unless the paucity of funding to provide the best outcomes is rectified.

As well as people with intellectual disabilities, workers also noted the difficulty of engaging with the NDIS for people with mental health or psychiatric needs, older clients, people who were homeless or disconnected from family, and those unable to advocate for themselves.

9.2 Concerns about service quality

In their comments, workers expressed strong concerns about service quality under the NDIS. Perceptions that clients' needs would not be met under the Scheme were widespread, reflected in comments like:

> The only concern that I currently have is that the people that I work with, I'm worried that their needs won't be totally met.

Those working with NDIS participants had witnessed changes in practice which they attributed to the Scheme, while others commented that changes had been made by their organisation in anticipation of the NDIS rollout. Some commented that people with disability were 'treated like numbers' in ways antithetical to the ambitions of personalisation, while others noted high risks, including poor staff training, reductions in staff numbers, and grouping clients together in inappropriate ways. One respondent, who had been a casual worker in an accommodation setting for 10 months and was new to disability services, explained that she had never been shown how to manually assist in moving people in and out of wheelchairs. Another, working in a day program setting explained how services were being organised in ways which raised behaviour-related risks:

> The day programs I work at supports participants with high support need and challenging behaviours. Due to the lack of funding some of these participants receive we are currently grouping the participants up. This can be difficult as some of them do not like to be grouped up and this can cause behaviours which is not

> detrimental to the worker who could be on their own supporting this group but also the other participants in the group.

Risks were also seen to arise relating to the use of temporary casual and agency staff, and staff turnover, which were seen to undermine standards of care:

> Standard of care drops significantly when new, temporary and unfamiliar staff work with residents. The calibre of agency staff is significantly lower than that of ongoing employees. In my team, this is not just a job; it is a career that we are passionate about. We commit to our residents long term for consistent improvement and quality life experiences. I am concerned that NDIS will casualise the workforce, leaving staff disengaged, devalued and bitter, and clients in the care of people who are not committed to positive outcomes.

Others explained:

> There appears to be a trend of more agency and casual pool staff working then permanent employment. This impacts on clients' health and well being. Increased assaults at work results from staff who don't know clients enough to support them especially clients with behaviours of concern. Job security and not being able to retire is impacting staff health and wellbeing. Working on weekends impacts on family togetherness. The pay scales have not increased but the cost of living has and staff are struggling to meet basic living standards.

> The hourly rate payable is so low that we have to take what we get in term of staffing. This is extremely dangerous in a sector that does not require any prerequisite qualifications, skills, or knowledge, and will undoubtedly (especially with such little time to effectively supervise staff) result in people dying either directly or indirectly from staff actions (or lack of action). The NDIA will see a devolution of large residential services, which are filled with trained and qualified medical staff, mental health professionals, psychologists, psychiatrists and social workers. The people from these places are going to NGO's who have untrained and unqualified staff looking after these highly vulnerable and complex people, most of whom have been in the disability sector for a couple of weeks by the time they commence supporting them, coming from fast food/hospitality services, newspapers, and (even scarier) security services where brute force was the preferred option of dealing with people.

The use of untrained staff was seen as a major risk:

> I feel that our ability to support Individuals with mental health concerns has been undermined and negated by the new methodology of the NDIS. New staff that have been employed to fill the newly created gaps, they are not trained and are creating confusion with out supported Individuals. Apparently there is no training funded for these new staff members which I find absolutely horrendous. I have studied for approximately 5 years in this position. I am very worried about how this will impact on the individuals that we support. Also, that the sector will not retain quality staff members.

9.3 Concerns about pay and conditions

Survey respondents expressed significant concerns about their working conditions and remuneration under the NDIS. These concerns are captured in the following statements, which highlight degradation of working conditions in a range of ways, through subcontracting and self-employment, use of private vehicles, unpaid administrative time, loss of hours, and loss of penalty rates:

> I am concerned about changes to my working conditions under the NDIS. Forced to use own vehicle to provide support. Associated costs e.g. business rego and insurance, cleaning, wear and tear. Not paid until I reach the home of my next client. Not paid for admin time. I believe that the NDIS can be beneficial for people with a disability and may offer great opportunities. However the disability support staff seem to be the ones that have to make all of the sacrifices, money, time and workload.

> I am concerned about there being sufficient work available and a possible big drop in pay and working conditions and the possibility the weekend pay rate dropping and the country taking a huge step back in time in terms of pay and workplace conditions and standards.

> I'm concerned that the 'hidden' rort of subcontracting will become the norm and already on the NDIA website there are banners excitedly promoting self-employment opportunities. Standards of care will drop exponentially and the people that will suffer will be the clients. I will not work for peanuts whilst putting myself at risk of physical assault and I think many long-term employees with many years experience will do the same.

Many explained how they had experienced degradation in their work-life balance, and associated work stress, lowering enjoyment of the work:

> In the past year our staffing has been cut back dramatically and the customers are not able to get all goals realised or quality one on one time with staff, also I am finding I am exhausted and on some days rushing aimlessly trying to complete all tasks pertaining to all customers within the daily time frame, it's becoming ridiculous. Starting to hate coming to work, some days. And that's just not who I am, I don't like what's happening to the industry, I hope the changes make work life conditions better once things settle down with the NDIS transition.

Indeed, the challenge of delivering quality services and supports were a reason people were leaving, including this respondent:

> I have just resigned as a NDIS LAC due to over work, lack of management support, focus on KPI's not participants , changing requirements in the job, lack of follow up / time for participants after planning session, huge discrepancies in $$$ attached to plans by NDIA planners for similar situations/disability.

Remuneration

Overwhelmingly, workers considered the pay they received to be inadequate given the level of complexity and risk in performing work in disability services, or were concerned that pay would drop as a result of the NDIS making remaining in the sector untenable:

> The NDIS does not allow employers to offer appropriate wages, especially high risk clients. $22-25 an hour for high personal risk - no way. I'd rather work at Woolworths.

> I enjoy the client contact and believe the pay is fair but would reconsider working in the sector if I was paid any less for what I do.

> The NDIS is only paying award wages and not what I am currently being paid. I fear that I along with many others, will be financially disadvantaged! I fear that quality of care will gradually deteriorate for the clients.

Many comments gave examples of poor employment and work organisation practices, including being employed at low pay grades and on short term or casual contracts. Some explained how changes in rostering had left them worse off, or that they were worried about how shorter shifts would erode their pay, for example:

> I am worried that the hours of work offered will consist of 1 to 2 or 3 hour shifts and hardly worth traveling for once you factor in travel time petrol and time wasted to get to other shifts.

> Recently, I had a roster change, a take it or leave it change even though I was already working a permanent roster, since then my yearly income has reduced by $8000. When I questioned this the coordinator said that [the organisation] doesn't care about penalty rates or your personal life outside of work. We have also been cut on weekends from 2 staff to 1 to look after 5 high support clients. Lack of support is getting worse.

Employment classifications

Several respondents identified how the NDIS had caused their organisation to downgrade their employment classification and freeze their pay rates. As one worker explained:

> I am concerned that the organisation I work for is trying to downgrade mine and co-workers grades by using the NDIS as an excuse to do so. They claim in order to be attractive to families to want to use us that it is better for us to be grade one or two rather than grade three as we are at the moment. I believe they are just in a race to the bottom with only their own company profits as their main focus. I have qualifications in disability as in a Cert 4 but they would prefer to employ people off the street with no experience and no qualifications because they are cheap. What sort of service is that going to be for our clients? It's a disgrace.

Similarly, others explained:

> My employer and many others in our region are reducing pay grades in anticipation of the roll out of the NDIS. For the last two years all new employees are paid at SCHADS 2.2 instead of the previous starting rate of 3.2. By attrition they are

> eroding pay rates in order to shore up their financial position to weather the end of block funding and the introduction of fee for service invoicing under NDIS. There now are almost no new permanent employment contracts and most new contracts are offered on a three month basis at the most.
>
> We have been advised that our hourly rate is higher than what the NDIS rate is so as grade 3 employees, we will be now classed as grade 2. We won't lose pay immediately however we won't be getting a payrise until grade 2 rates catch up to ours. We currently access cars from our organization on leaseback as we use our cars daily for our work. We are losing the cars too. We have also lost our first aid allowance and we no longer get our first aid training paid for by our employer. We are also concerned that we will only be paid per the actual hours spent with clients and not for the travel in between and office time etc. Currently I may only spend 6hrs directly with clients (3 clients at 2hr each) and am paid for my whole day 9am - 5.00pm as that reflects my roster.

Another explained how employers were attempting to save money by reclassifying disability work under the 'homecare' part of the SACS award, to enable shorter shift times:

> The casual nature of the work and the pay/minimum hours is very unsustainable. My employer claims it is legal to pay under the Homecare part of the award for some classifications of clients and therefore legitimise a minimum 1 hour shift. It is also very difficult to come to work (often travelling 30 kilometres) for a 2 hour shift, then having to wait around for the next shift 4-5 hours later. There is little consideration for the impacts on workers - the entire focus for the organisation is on filling shifts and building customer (participant) numbers.

Workloads and stress

As well as pay, many highlighted how their workloads had increased under the NDIS, or in anticipation of NDIS, resulting in high levels of stress:

> As a carer, I feel I am placed in impossible and stressful work situations - there are so few carers available that I feel compelled to accept work hours & travel times (often unpaid) due to a sense of obligation and loyalty to my clients. During many services, there is insufficient time to complete all I need to do and if I exceed the allocated time, I am not paid. I know my clients are very grateful and value my commitment but I feel carers are being taken for granted & have no voice at all.
>
> We are being loaded with more work and less time for the people we support and are told we just have to deal with it as its going to get worse for us support workers as it is now we don't have enough time in a day to do all they expect us to do and from management it is like it or lump it.
>
> I am concerned that our rate of pay will be less and we will be required to support more people eg instead of two per day face to face it may be increased to four, therefore decreasing the quality of support currently being provided. Also it appears that our organisation is going to be a mobile workforce and we will have to use our personal vehicles etc which will increase our personal expenses plus increase isolation of workers where we will not have the opportunity to debrief with each

> other face to face. Many more concerns. However the financial aspect is very concerning.

Many workers who responded to the survey linked their concerns to both transition to the NDIS and the associated privatisation which has occurred or which was pending:

> I am concerned that under NDIS we have to take on more clients as we are now privatised. There is a lot more pressure to take on new clients so that the case load has increased. There is less recognition of mental health issues that impact on our work. Before we could spend extra time if needed with a client in crisis, now it is all about hours and money. The pressure is immense and we are monitored to every minute via a carelink software system and we have to bill everything. I have never felt so pressured as I do now and the pressure is just not the clients but also the system that surrounds NDIS. I worry that whoever provides the cheapest service will get the clients and this it becomes all about money. Certainly the money and hours is what is now pushed and this seems to be the main thing. As a worker this is very disappointing and has changed the face of disability work for the worse.

> Concerned that the residents that I support will have a poor standard of care should [my organisation] privatise. I have supported the same client group for 10 years and know their support requirements, service providers and family well. I would seek different employment opportunities available to me if [my organisation] was privatised.

Concerns about unpaid work

A strong theme within workers' comments about the adverse impact of the NDIS on wages and conditions was the amount of unpaid work required. Employees expressed concerns that expectations of unpaid work were increasing, including for travel and administration which were necessary elements of service delivery. Examples of comments that focused on this are as follows:

> The system does not provide funding for anything other than direct support, therefore all the ancillary tasks such as note writing, documentation, communication with other stakeholders must be done in the employee's own time. In my case I spend at least one hour each day unpaid doing file notes etc. This needs to be looked at as all of this documentation is mandatory.

> My biggest issue has been agency work where you use your own car and do not get paid between jobs. Sometimes I have been paid 1-2 hrs for spending over half a day doing job related activities. I see conditions getting worse under these conditions.

Job security and underemployment

Many employees also expressed significant concerns about job security and the security of their shifts and income, in the disability sector and under the NDIS. One respondents, who provided disability services for more than one employer, explained:

> My jobs feel very insecure, I'm forced to remain a casual as part time jobs are less available and can drop my hourly rate to just $20. In every job I've had we are

> ALWAYS understaffed and torn between multiple employers. Support worker turnover is fast, especially when there are management issues and this is detrimental to the clients and their continuation of care. I love my work but I'm so shocked at how ruthless service providers can be!

Workers perceptions that hours were under pressure, and that shifts were not secure, were reflected in the following comments:

> In one role I am employed in they are not offering part time permanent positions only casuals and they have reduced my rostered time by 1/2 an hour each day.

> I started on a 136 hour a month contract and lowered it to 120 and was told I could always put it up if needed the hours are always there which was not true, they would not let me increase my contract. They have just hired people on a 8 hour a month contract and 30 hour contract and they pick up extra shifts. I have always tried to be a reliable and valued employee but not feeling it now.

> I am concerned that I may lose the stability of the current shifts that I have once the NDIS roll out. For example if the client cancel the support and giving enough notice to the organisation.

Others expressed similar sentiment:

> I am a single parent and am worried that I will not maintain my current level and entitlements and salary which will affect me and my family directly.

> My concerns are job security and my future employment I still have almost 30 years of work ahead of me so it's important now!

> Currently not getting enough hours since the introduction of NDIS because of the 10hrs break in between shift that they just introduced

Together, these responses reflect significant concerns among employees about a wide range of quality and employment issues seen to arise from the NDIS, or which workers were anticipating would arise from rollout in their area.

10. Conclusions

Overall, these findings provide insight into the characteristics and experiences of workers in the disability service sector and in particular, their experiences of working under the National Disability Insurance Scheme. While differences between those working under the NDIS and other disability workers were not consistently evident, the results show a range of quality and workforce risks of the Scheme. While workers' primary concerns were with falling standards of service for people with disability, the survey also shows workforce problems such as high supervisory loads under the NDIS, multiple job holding, and major concerns about job quality, work time and financial security. Moreover, the regression analysis suggests that for this sample of highly experienced workers at least, decent pay and job security are associated with higher perceptions of outcomes for NDIS participants.

The findings indicate the importance of working conditions in the disability sector, and the links between working conditions and the quality of service provision. The results suggest some ways forward, including keeping supervisory loads at reasonable levels, and ensuring experienced workers are retained in the transition to the NDIS. This could be built on with an ongoing and ideally longitudinal program of research, to monitor workforce issues and working conditions in the disability sector through the process of change, and to assess the impact of interventions to improve working conditions and workforce quality and sustainability as a determinant of high quality disability services.

Reasonable, necessary and valued: Pricing disability services for quality support and decent jobs

Prepared for:

Health Services Union, Australian Services Union, and United Voice

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Abbreviations

ACNC	Australian Charities and Not-for-Profits Commission
ASU	Australian Services Union
CPOW	Centre for People, Organisation and Work, RMIT University
DSW	Disability support worker
HSU	Health Services Union
NCOSS	NSW Council of Social Service
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Services
RCM	Reasonable Cost Model
SACS	Social and Community Services
SCHADS Award	Social, Community, Home Care and Disability Services Industry Award 2010
SIL	Supported Independent Living
SPRC	Social Policy Research Centre, UNSW Sydney

Executive Summary

Research aims

This report is concerned with prospects for quality services and decent jobs under Australia's National Disability Insurance Scheme (NDIS). Specifically, it examines how the prices set by the National Disability Insurance Agency (NDIA) are:

- affecting disability support workers;
- enabling employers of disability support workers to meet their industrial obligations; and
- supporting development of a skilled, high-quality, and decently remunerated disability support workforce.

Data sources

To understand and assess NDIS pricing arrangements, data was collected from several sources:

- Government policy documents, industry submissions and reports were used to understand the structure of NDIS prices relevant to disability support work, and the assumptions underpinning price setting.
- These documents, along with findings from a survey of CEOs of not-for-profit organisations registered to provide NDIS services in NSW, were used to understand how pricing arrangements are shaping employers' decisions about the types of employment opportunities and services on offer.
- Interview and survey data from employees helped capture the experiences and perspectives of workers providing disability services under the NDIS. This enabled assessment of how pricing arrangements are affecting working arrangements and disability support workers' capacity to deliver quality services under the Scheme.

Key findings

Together, the data shows the range of ways that disability support work has been under-priced in the NDIS. Prices for disability support work set by the NDIA according to the 'Reasonable Cost Model' do not enable minimum Award conditions to be met, and prevent employers who offer above-Award conditions from meeting their legal obligations. Prices do not account for what is required to deliver high quality services, and arrangements are not fully enabling disability support workers to deliver services which are personalised, co-ordinated, responsive or safe. Quality is likely to diminish in the process of NDIS expansion. Particular issues include:

- Prices do not recognise the time needed to deliver quality services to NDIS participants. As a result, disability support workers are under pressure to work intensely in their jobs and have inadequate time to build relationships with participants, follow up on participants' needs, co-ordinate and communicate with supervisors and other workers, complete paperwork, debrief,

and handover between shifts, all resulting in lower quality support and increased risks for participants.

- Prices are not covering the induction and training required to enable staff to address the health and other complex needs and behaviours of participants, raising the risks that NDIS participants' needs will not be met. Some staff have been required to train in unpaid time or to personally cover the costs of mandatory training.
- Prices are limiting the pay and career progression of support workers and supervisors. Prices assume low Award classifications and do not account for the remuneration levels required to attract experienced staff or to encourage upskilling.
- Many disability support workers have very fragmented working time. Multiple very short shifts with unpaid time between them results in long working hours and inadequate time for rest. Unpredictable working time is also contributing to poor work-life balance.
- Pay for disability support work is low, exacerbated by under-classification and underemployment from short shifts. Low pay is undermining efforts to expand the workforce.
- Casualisation is contributing to financial insecurity for staff and worker turnover, disrupting services and exacerbating risks for participants.
- Physical injuries, exhaustion, stress and other negative psychological impacts arise from combinations of unsafe working conditions, high work intensity, overwork, lack of support, and workers' recognition that participants are not receiving the quality of supports they deserve.

Impact of NDIS prices for disability support work

While the NDIA will increase prices for 2017-18 in line with minimum wage and cost of living increases, these changes do not overcome underlying problems in the structure of prices, which are shifting the costs of provision onto workers and undermining quality. Although disability support workers' commitment to NDIS participants means they frequently perform unpaid work to compensate for under-resourcing, the level of under-pricing is such that the quality of supports is inevitably diminished.

Pricing is undermining quality in a range of ways, including through the loss of co-ordinated team approaches to support, lack of time for communication among workers and supervisors, reduced oversight and safeguarding, and increased casualisation. Promoting choice and control of people with disabilities is an important policy principle. However, to put these principles into practice requires that frontline staff have access to the resources needed to build strong relationships and tailor services to individual needs.

A disability support system predicated on cost-shifting onto low-paid workers is unsustainable. Under current conditions, it will be difficult to expand the disability services workforce, placing the supply of quality services at risk. Prices need to properly recognise and value frontline workers, and provide incentives for service providers to employ, support and retain a workforce capable of providing high quality services and supports.

1. Introduction

This report provides new evidence of how NDIS prices are contributing to service quality and workforce risks. It is structured as follows.

- The first section provides background information about the NDIS (Section 1.1), and explains the significance of NDIS prices (Section 1.2) and our focus on the prices for services and supports involving disability support workers (Section 1.3). We then outline the evidence on which the work builds (Section 1.4), and explain the multiple methods used in the study (Section 1.5).
- Section 2 shows evidence of the general pressures experienced by employees (Section 2.1) and employers (Section 2.2), arising from NDIS pricing arrangements.
- Having established that prices are causing difficulties for disability support workers and providers, we then turn to examine NDIS pricing in detail, outlining the base hourly price and circumstances under which it is varied (Section 3), followed by a more detailed analysis of the assumptions made in setting prices for the services and supports provided by disability support workers (Section 4).
- Section 5 then outlines evidence collected from workers and employers to show the impact of the NDIS and in particular, how pricing arrangements are failing to recognise the time support workers need to complete the mandatory and essential aspects of their work, as well as for co-ordination, relationships and professional development.

Overall, this shows that although many disability workers compensate for under-resourcing by performing unpaid work to ensure participants' needs are met, the systematic under-pricing of disability work in the NDIS contributes to high levels of risk in the service system (discussed in Section 6).

1.1 About the NDIS

The National Disability Insurance Scheme (NDIS) has been repeatedly described as Australia's largest social reform since the introduction of universal national healthcare (Gilchrist, 2016; NDIA, 2016b; Productivity Commission, 2017). It follows decades of activism underlining the importance of self-determination for people with disability, and the inadequacies of underfunded, paternalistic and inequitable models of support provision (Productivity Commission, 2011). The NDIS seeks to overcome the inadequacies of previous arrangements by promoting client choice and control through a market model, broadly following examples of consumer-based reforms in other liberal welfare states (Riddell et al., 2005; Ungerson, 2004; Wilberforce et al., 2011).

Rather than directly providing services or contracting commercial or not-for-profit providers to provide services to NDIS participants, the government, through the NDIA, funds individual packages of supports for eligible people with disability, to meet their individual needs. Once

allocated a plan, NDIS participants[1] are assigned a budget to meet the service and support needs which were deemed 'reasonable and necessary' by the NDIA, and contained in their individual plan. Providers are paid from consumers' allocated funds on invoice at rates currently set by the NDIA, although some items require approval of the NDIA following a quote. The majority of Scheme costs are arising from meeting participants' needs for assistance with daily living (NDIA, 2017c) and, as such, the rates set for this set of supports are particularly important for participants, providers and the ongoing sustainability of the Scheme.

The Scheme is ambitious in scale, with the individualised fee for service model intended to replace most programs which were previously block funded by the Australian Government or the States and Territories. The program will support an estimated 460,000 people by 2020, including many people with previously unmet needs (Buckmaster, 2017). It is expected to create 20 percent of all new jobs in Australia in the process of transition to the Scheme (Productivity Commission, 2017, p. 22, citing Bonyhady, 2016, p5.). Associated, the cost to governments is projected to increase from $4.2 billion in 2016-17 to $22 billion in 2019-20 (Buckmaster, 2017) and, although the intention was that participant plans be fully funded, cost containment is quickly becoming the dominant Scheme priority (Productivity Commission, 2017).

A managed market

Essentially the NDIS establishes a managed market, shaped through the activities of government. The NDIA, as the statutory agency responsible for implementing the Scheme, effectively 'constructs' the market through:

- Demand levers, including:
    - determining eligibility using parameters set under the NDIS Act;
    - working with participants to assess their needs and form a plan; and
    - funding participants' packages at particular levels; and
- Supply levers, including:
    - registering organisations and individuals able to provide support to NDIS participants[2]; and
    - setting the maximum prices that registered providers can charge for supports, which shapes providers' viability and decisions about supply.

In future, the market will also be shaped by additional quality and safeguarding arrangements, with the NDIS Quality and Safeguards Commission planned for 2018 intended to handle complaints and investigate incidents, with worker screening left to the States and Territories (DSS, 2016).

How the NDIA, as market manager, uses these levers establishes the resource environment for the NDIS and shapes the extent to which the Scheme can achieve goals of independence and

[1] We use NDIA term 'participant' to refer to someone who is receiving services under the NDIS. The term 'client' or 'service user' is used in the report where it has been used by others, such as service providers or workers in interviews, or to refer to people using disability services but not as part of the NDIS.

[2] Note however, that participants who self-manage are not required to use registered providers, so can source services and supports from organisations which are not NDIS registered or bound by NDIS prices.

wellbeing for participants. As with social care in the UK and elsewhere, there are risks of rationing and under-provisioning arising from restrictions to eligibility, poor quality planning and cost containment through price controls (Lewis & West, 2014). Indeed, Australian evidence is emerging that NDIS plans can be highly variable and may not necessarily fully or fairly recognise participants' support needs (Browne, 2017; Warr et al., 2017). On the supply side, providers may avoid providing less lucrative services or operating in areas in which they are less viable, contributing to 'thin markets' (Senior Officials Working Group for the Disability Reform Council, 2015). Quality risks may arise from registration of unscrupulous or otherwise low quality providers, or from poorly developed accountability and enforcement arrangements. Setting prices too high risks enabling profiteering and low value for money for participants, while setting them too low will make it difficult for service providers and workers to deliver services at acceptable levels of quality (NDIA, 2017a; Productivity Commission, 2017).

1.2 The significance of NDIS prices

Although risks to quality can also arise from other elements of the NDIS model, we are concerned with how NDIS prices are shaping the supply of disability services and supports, and impacting on disability support workers and the quality of support they are able to provide.

NDIS prices are significant as they are the prime means of determining the levels of funding allocated to participants to purchase the services and supports deemed ‘reasonable and necessary’ in their plan. They also set a limit on what providers can charge, although in some circumstances providers may obtain NDIA approval to fund supports over these levels. The NDIA claims that it sets prices to maximise value for money for participants, and to give providers flexibility, reduce risk of business failure and attract new providers to the sector (NDIA, 2017a). To do this, the intention is that price caps strike a balance for consumers and providers, being ‘as low as possible (but still achievable by providers)’, yet higher than a ‘theoretically efficient level’ to be achieved in the future (NDIA, 2017a).

A series of lengthy documents set out prices for different kinds of services and supports that can be provided under the NDIS. Prices for ‘core’ supports such as assistance with self-care, daily living and accessing the community are derived from a base hourly price, which is varied in some circumstances according to geography, intensity, time of day and week, number of people being assisted and the specific type of service (NDIA, 2016c, 2016d). The base hourly price is derived from the NDIA’s ‘Reasonable Cost Model’ (RCM), developed by a Joint Working Group comprising the NDIA, National Disability Services (the peak body for not-for-profit service providers) and consultants. The RCM has been described as a ‘bottom-up’ model (NDIA and NDS, 2014, p. 10) or ‘ground-up’ model (NDIA, 2014, p. 2), in that it was developed by seeking to identify and quantify all of the costs involved in providing eligible people with disability with assistance with self-care activities and assistance to access the community (NDIA and NDS, 2014, p. 2). The RCM consists of a range of components, each based on a series of assumptions. It claims to set prices at levels ‘sufficient to cover the efficient costs of a reasonable quality support provider’ (NDIA, 2014). Indeed, prices are intended to cover the full costs of providing supports deemed ‘reasonable and necessary’ in participants’ plans, so that user co-payments will not be required, and so that providers can grow capacity (NDIA, 2016c).

The NDIA regards the current prices to be transitional, and its role in price review[3] and price setting to be temporary, as part of a phase of change leading to a fully deregulated market[4]. The NDIA proposes to eventually deregulate prices, although price setting looks set to remain a feature of the Scheme for a decade post full Scheme rollout (DSS, 2017). [5] The vision is that ultimately the NDIA will not play a price setting role, as the 'mature' marketplace will determine the prices of supports.

1.3 Focusing on NDIS prices for disability support work

This report focuses on prices for disability support work, and explores how these prices affect prospects for decent working conditions and for support workers' capacity to work with participants in co-ordinated, responsive and respectful ways. Disability support workers are important as they work at the frontline, providing direct support and assistance to people with disability to meet daily living needs, and participate in the community. Disability support workers are also numerically significant in the disability service workforce, and financially significant to the Scheme. Indeed, most funding for NDIS plans is associated with assistance with daily living, which involves the direct care and support that disability support workers provide: 69.3% of funds in the Barwon trial site and 78.9% of funds in the Hunter site were dedicated to this set of supports (NDIA, 2017c).

1.4 Building on existing evidence

Material in this report builds on existing evidence about the place of the workforce in consumer-centred reform of human services and how frontline disability workers are faring in the process of change. Prior to the NDIS launch, research highlighted possible workforce risks associated with individualised funding models (Cortis, Meagher, Chan, Davidson, & Fattore, 2013). That review pointed out how few studies have captured the perspectives of workers, despite their central place in delivering services and implementing change, and despite accumulating evidence associating individualised funding models with risks for workers. These risks relate to service continuity and job security, income security, skill development, health and safety, and rights to voice and representation.

In the last few years, there does not appear to have been a significant expansion of the Australian or international literature; however, there has been considerable public focus on outcomes for support and care workers of the market-based social care system in the United Kingdom under very tight financial constraints (e.g. House of Commons, 2017). Although some research has identified links between pricing and workforce risks (e.g. Mavromaras, Moskos, & Mahuteau, 2016) relatively little scholarly attention has been specifically dedicated to the detail of this interface.

[3] Various reviews include: Personal Care and Community Participation 2016-17 Price Review - Discussion Paper (NDIA, 2016d); Context for 2016-17 NDIS Pricing Decisions (NDIA, 2016a); Summary of new and updated price arrangements for 2016-17 (NDIA, 2016e) . Further reviews are underway or planned.

[4] Recent changes include: in 2016, the hourly price for one-to-one support was increased by 3.9% in eastern states and 1.9% in other states and territories. Remote and very remote loadings increased to 18% and 23% and supported independent living prices in all areas were increased by 3.9%. Prices for most other supports increased by 2%. Prices were deregulated for participants who were self-managing their plans (around 8% of participants as at 30 June 2016 (COAG Disability Reform Council, 2016).

[5] The NDIA has stated its transitionary 'glide path' to an 'efficient' and eventually deregulated price allows for Equal Remuneration Order adjustments but no cost increases above this (NDIA, 2016e).

Since the review by Cortis et al (2013) the literature continues to highlight how individualised funding can shift risk from employers to workers. Macdonald and Charlesworth (2016) point out how employment outcomes under the NDIS depend on the underlying cost containment agenda and how services are regulated and monitored. Mladenov, Owens, and Cribb (2015) point out that although personalisation and consumer based funding embody ideals of both social justice and marketization, priorities of marketization can over-run social justice considerations. In relation to recent experience in the United Kingdom (UK) they suggest personalisation has been used as an ideological cover for austerity. The UK experience has continued to highlight the employment risks associated with low prices for adult social care services including disability support (Equality and Human Rights Commission, 2013; Rubery, Grimshaw, Hebson, & Ugarte, 2015) and inadequate employment regulation (Hayes, 2015), with poor quality jobs for support and care workers going hand in hand with increased risks for the quality of support provided to consumers (Commission on Dignity in Care, 2012; HM Government, 2012). Australian service providers have also recently identified job quality as a risk for service quality under the NDIS (NDS, 2016, p. 29).

In their review Cortis et al. (2013) identified uncertainty of demand, increased demand at short notice, increased administrative burden and higher transaction costs as some of the pressures likely to adversely affect workers as organisational costs and risks are passed on. The pressures on providers of the low price for one-on-one personal support under the NDIS (NDS, 2016, p. 26) can be added to these pressures, although to date there has not been any detailed scholarly analysis of the shortcomings of different elements of the price.

This report also builds on overseas research showing how, under consumer-based funding, providers have shifted risks and costs onto workers. This has been well illustrated in examples of two Scottish not-for-profit providers documented in recent case studies (Cunningham, 2015, 2016). In moving to personalised social care (and facing effective cuts to service funding of up to 25%) the organisations reported losing money on delivering services or having to subsidise service delivery from organisation resources. Both organisations closed some services but also responded to these pressures by reducing staff numbers or demoting staff to lower skill and pay levels, cutting pay rates, hiring new staff at lower skill levels, increasing the use of casual and zero-hours contracts, introducing split shifts, reducing paid leave and pension conditions, intensifying work, increasing full-time weekly hours, reducing training and/or charging employees for training, and reducing supervisory and management positions. The impacts on social care workers included reduced morale, reduced real and nominal pay rates, longer working hours, reduced leave, more fragmented work days and weeks, reduced training and development opportunities, reduced career prospects and greater employment insecurity.

These types of organisational responses and consequences for workers can be seen more generally in the adult social care sector in England. Cost pressures underlie the failure of some social care providers to pay social care workers the national minimum wage. Indeed, up to 220,000 social care workers have been estimated to be earning less than the minimum wage (Hussein, 2011). Key contributors include unpaid travel time, unpaid time spent in training and supervision, unpaid time assisting service users in emergencies, and overrun in support time beyond that which is recognised in hourly prices (Hayes, 2015). An investigation into 80 providers (HM Revenue and Customs, 2013) found that almost half (47%) were not compliant with National Minimum Wage regulations, while the Low Pay Commission (2016, p. xxvii) recently singled out social care workers

as particularly at risk due to employer non-compliance with minimum wage regulation. Social care work in England has very high levels of employment on ‘zero hours contracts’ meaning workers do not have stable hours or stable incomes; in 2016 it was estimated that almost a quarter (24%) of adult social care workers and a half (49%) of domiciliary (homecare) workers were employed on zero-hours contracts (Skills for Care, 2016, p. 28).

Early findings from the evaluation of the NDIS pilot sites suggest that the low NDIS price may be leading to the emergence of similar issues in Australia. The interim evaluation found increased use of casual and contract staff by providers in trial sites compared with non-trial sites (Mavromaras et al., 2016). In interviews, service providers reported difficulties in meeting industrial relations responsibilities due to low prices; increased use of casual and contract arrangements for support workers; reclassification of support roles at lower pay and skill levels; increased staff workloads; and increased problems with recruitment and retention including the loss of skilled staff. Providers were delivering less training and supervision than they had been at the beginning of the trial. Together, these factors were reported to be resulting in concerns about the declining quality of support.

1.5 Methods

To build on this evidence and assess whether NDIS pricing arrangements enable providers to meet their industrial obligations and provide decent employment opportunities, information was drawn from a range of sources.

Review of pricing arrangements

Reports from the NDIA, Productivity Commission and other government agencies were collated and analysed to understand the design of pricing arrangements, and their underlying assumptions. Explanation of the NDIS Reasonable Cost Model (RCM) is primarily contained in the key documents published in 2014 when the RCM was established (NDIA 2014, NDIA & NDS 2014). Subsequent NDIA documents explain changes in assumptions and variables in the RCM (NDIA, 2016e) including detailed annual Price Guides issued by the NDIA (NDIA, 2016c, 2016d). Primarily drawing on these documents, an analysis of the RCM was conducted to identify in detail the elements of the model and the assumptions and data used to generate the base hourly rate and the current price guides, with a particular focus on prices for disability support work.

Alongside analysis of pricing arrangements, we analysed reports and submissions of service providers and their peak bodies, including National Disability Services (NDS).[6] These reports and policy documents helped deepen understanding of the assumptions underpinning NDIS pricing arrangements and their impacts, and to identify any evidence about employment issues and challenges evident under current pricing arrangements.

Interviews with workers providing disability services

To explore how NDIS pricing arrangements are shaping workers’ experiences and perceptions of delivering disability services, the research analysed interview data from 20 disability support

[6] Documents included providers' submissions to the NDIA's *Personal Care and Community Participation 2016-17 Price Review Discussion Paper*, obtained under Freedom of Information.

workers—including some team leaders and supervisors—delivering services in the NDIS trial sites of Barwon, Victoria and in the Hunter, NSW.

Of the 20 interviewees, 8 were workers providing support to people participating in day activity centres, group homes, and providing personal support in the community or working as support co-ordinators. These interviews were conducted in February and March 2017 with interviewees recruited with the assistance of the unions commissioning the project. The other 12 interviews were undertaken between November 2016 and February 2017 by RMIT researchers. These interviews were with workers providing personal support and assistance to people with disability in the community and in private homes. Discussion of these 12 interviews draws on a working paper presenting work in progress by Bentham and Macdonald (2017) (attached to this report as Appendix A: CPOW Working Paper 2017-1).

Interviews centred on what workers thought was needed to ensure good quality support for people with disability who accessed their services and how they saw the NDIS impacting on the quality of support they and other support workers are able to provide, and on their job quality. While the interviewees identified positive changes for some people with disability as a result of the NDIS they also identified significant problems, many of which relate to NDIS pricing.

Interviews were audio-recorded and transcribed. Key themes, and excerpts of the interviews which illustrate them, are presented in this report. Case studies are used to give more in depth information about how individual interviewees experienced their work. More information about the methods are in Appendix B and Appendix C.

Survey of disability workers

A survey of disability services workers was conducted by the three unions, and findings were provided to the research team for analysis and inclusion in the report. Responses came from 1476 people working with people with disability. Of these 74% were female, and around a third were aged over 55. Around a quarter said they supervise other staff in their current role. As the survey asked if workers deliver services in an NDIS area or to NDIS participants, perceptions can be compared for those working under NDIS providers and others. A little over half of respondents (54.7%) were working in an NDIS rollout area or with participants of the NDIS.

Further details about the methodology, key characteristics of the sample, and supplementary data are provided in Appendix F. Additional analysis is available in Cortis (2017). Some material from this survey was also reported by Health Services Union (2017).

Survey of employers

Information about providers' experiences was drawn from a survey of CEOs of not-for-profit community service providers in NSW, conducted in February 2017 (Cortis and Blaxland, 2017). This is supplemented by information from policy submissions and other public documents. Of the 398 organisations whose CEOs responded to the survey, 135 (33.9%) were registered to provide services under the NDIS. These registered providers were asked specific questions about perceptions of NDIS pricing arrangements. These survey items were followed with the open-ended question ‘Do you have any other comments on what NDIS means for your organisation and staff’. Full findings are reported in Cortis and Blaxland (2017). This information was used to understand

how organisational leaders were experiencing the pricing model, and any differences in perspectives among different types of NDIS providers. Supplementary tables are in Appendix G.

2. Experiences of delivering services under NDIS

This section presents an overview of how employers and employees are experiencing the NDIS and observing that problems are arising from current pricing arrangements. First, data from employees shows that, despite their high commitment to people with disability and to principles of consumer rights and control, many disability workers are finding it difficult to achieve what they consider to be acceptable standards of quality under the NDIS model, and do not see it as positive for people with disability or their families (Section 2.1). Providers are also experiencing difficulties operating under NDIS pricing arrangements (Section 2.2). This material highlights how both employees and employers are finding it difficult to work under current arrangements. It provides a basis for our closer examination of the design of the pricing model and the assumptions underpinning it, in Sections 3 and 4. The adequacy of these pricing arrangements is then assessed, based on the experiences of service providers and employees who have been working under the NDIS (Section 5).

2.1 Employees' experiences of service delivery under NDIS

Both the interviews and the data from the employee survey show that employees are finding it difficult to deliver quality services under the NDIS. The interviews show how frontline disability services workers are very positive about the key focus of their jobs: providing support and assistance to people with disability. All employees spoke of the satisfaction of working closely with people and supporting them to gain independence and to live fulfilling lives. They also spoke of enjoying many of the challenges of their work that required them to be creative and to resolve problems to best support the people they worked with. The fulfilling nature of working closely with people with disability and helping them achieve milestones in their lives is explained by this interviewee:

> I find it immensely rewarding that, through my work, I can support someone and achieve maybe a small milestone.. …And it's just, it keeps you on your toes that you've got to think beyond the box, well okay, if that's not going to work maybe we should try that and in that I find that challenging. You get someone to laugh or you get someone to (achieve a personal milestone), it just seems to, it just gives me a fulfilment, I suppose. (Employee 1)

That workers valued making a difference in the lives of people with disability lives was also highlighted in Bentham and Macdonald (2017), for example:

> (I)t's good to wake up every morning and think that you have the opportunity to influence somebody's life today and that you can choose to make that a positive influence, and help someone with their goals that otherwise without you they wouldn't have been able to do. (DSW22, Bentham and Macdonald, 2017)

When asked about the qualities necessary for providing good support to people with disability, workers identified the importance of skills acquired through training and preparation for the specific needs of the individuals they were working with; being able to respond to individual needs and

goals; and having respect for clients and for their independence. However, the interviewees also explained how it was difficult to provide services in ways that met their ideals of quality support under the NDIS. Many pointed to lack of time to develop familiarity and trust which are well recognised in practice scholarship as the basis through which clients and workers attune to each other to negotiate individual-centred support (Denton et al., 2015; Rugkasa et al, 2014). Interviewees also identified a lack of consistency and co-ordination in teams, lack of flexibility and spontaneity to address clients' needs, and lack of safeguards.

Exemplifying several of these themes, a support co-ordinator with almost 20 years' experience in the disability sector explained how she observed difficulties meeting the needs of people with disability under the NDIS, largely because of a presumption that participants can access kin-based care and because of time pressure and fragmentation between systems and workers:

> Whereas previously there's been a lot of time to work with people in a more person-centred way, get to really know them, what their goals are, how we're going to help them, and support them to achieve those goals. …(Now) (t)here are a lot of participants out there that you feel really concerned about because their family may not have capacity to provide for their disability support needs, and you're working a really complex system I suppose where there's lots of different isolated systems, trying to work together to support somebody and it doesn't always work very well... (Employee 5)

When asked about the impact of the NDIS on participants, workers noted that increased choice was benefiting some people with disability. However, experienced employees who had been working in the NDIS trial sites highlighted some negative impacts on the quality of support and assistance provided. They felt there was reduced scope to provide quality support, and that the pricing model was a key contributor. When asked about the quality of support that participants were receiving under the NDIS, one interviewee expressed concerns that were typical: that although staff were trying their hardest, the resources available under the NDIS and the emphasis on economic efficiency precluded quality provision:

> I suppose there were a lot of people who weren't getting supports (prior to NDIS), and we were very aware of that. And to be honest, for some people the NDIS has been the best thing that's ever happened. … (But) If you want to provide a quality service, you can't provide it for the hourly rate that the NDIS has determined… I mean I know from working in this organisation that we do absolutely the best we can as far as providing an excellent quality service. But I think it's problematic where maybe there's too much counting of money. And an unwillingness to be flexible, and creative, and yeah, it's just really challenging. I can't see it as being a positive thing, really, to tell you the truth. It's really quite depressing. (Employee 4)

Employees identified only negative impacts of the NDIS on the quality of disability support jobs. Many of the negative impacts they experienced relate to funding and the pricing of disability support work, which reduced resources available, fragmented service delivery arrangements and increased the prevalence of short hours and casual positions staffed by people with little experience or training. Of the 20 workers interviewed seven said they were taking active steps to

leave their current jobs—including six who said they were leaving disability work altogether—while several others were thinking about leaving.

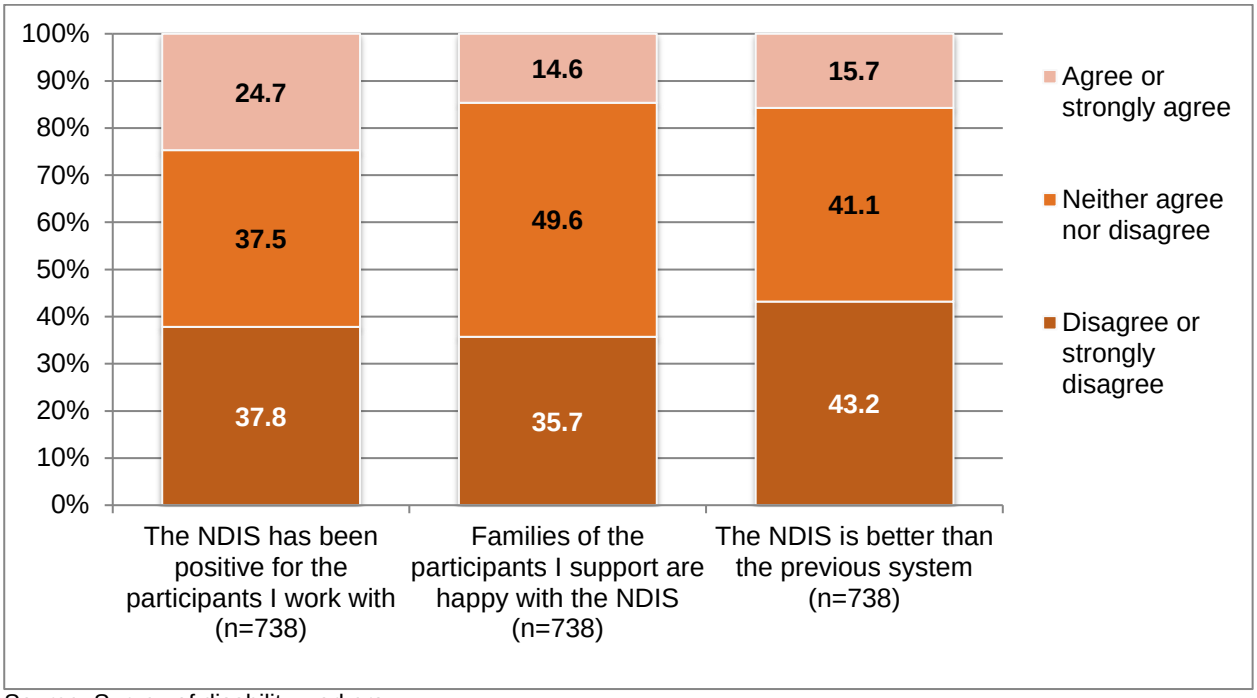
As well as low pay and underpayment, employees highlighted interlinked problems of extended and fragmented working days and weeks, including: unsocial hours and weekend working; a lack of days off; unpaid work; inadequate or no training; poor supervision and/or organisational support (especially for new employees); increased work intensity and overwork (often unpaid); casualisation; stresses caused by a decline in the quality of supports and risks to participants' safety; and additional health and safety issues for staff. These factors contributed to workers' intentions to leave. One support worker described how the combination of stresses related to seeing the decline in quality of support for her clients, together with all the other negative aspects of the job, made it difficult to stay even though—and largely because—she was deeply committed to her clients:

> I'm waiting to see how things pan out but, and I know a lot of staff are anxious about how (the NDIS) is going to work for our clients. But if it really goes downhill, and it breaks my heart to see what's happening with our clients, I don't know that I could stay. The stress would be too hard. I have actually looked at what, how much people at Safeway and Big W get paid, I have actually looked into that. *Interviewer: And what did you think?* Oh well you go to work… you do your job and that's it. You can leave it all at work. You're not ringing up and saying how's such and such doing and, when you come back in the next day, well how did that all work out, what did the doctor say about this, what's the policies and procedures we're following now, signing for medication, signing for money… you walk in, you walk out. (Employee 1)

Data from the survey of disability workers corroborates the concerns expressed by the interviewees. While many respondents working in NDIS rollout areas or with NDIS participants were unsure or neutral about the impact of the Scheme, only a minority agreed it was generally having positive impacts on participants (see Figure 2.1). Around a quarter agreed or strongly agreed that 'the NDIS has been positive for the participants I work with', but many more (37.8%) disagreed. Around half of respondents were unsure or neutral on the issue of whether families of participants were happy with the Scheme, but many more disagreed than agreed (35.7% compared with 14.6%). Similarly, 43.2% disagreed with the statement that 'The NDIS is better than the previous system', while 15.7% agreed.

A breakdown by service type, which shows that across all service types more respondents disagreed than agreed, is provided in Appendix F: Details and supplementary data from worker survey.

Figure 2.1 Percentage of respondents who agreed with statements about the impact of the NDIS on participants and their families



Source: Survey of disability workers

2.2 Employers' difficulties operating under NDIS prices

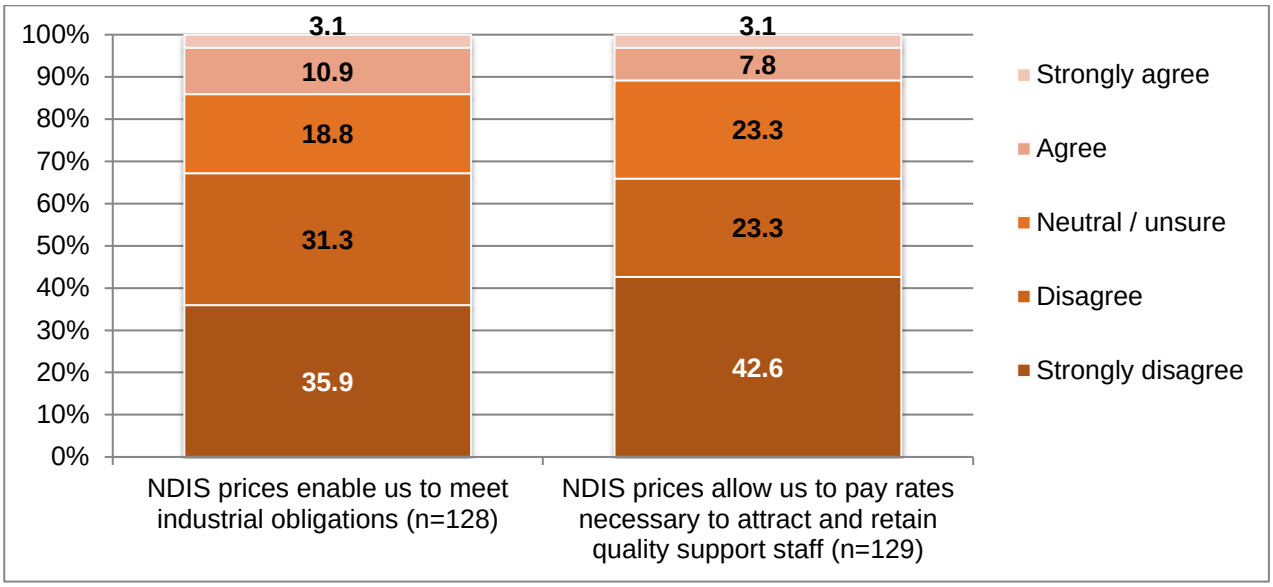
Like the employees interviewed and the workers who took part in the survey, employers have also reported that approaches to NDIS prices are not conducive to quality service provision. The peak body for not-for-profit disability service providers, National Disability Services (NDS), has argued the NDIA's approach places too much emphasis on managing disability markets through price setting, with low prices for disability support causing providers to carry the burden of cost-containment (NDS, 2017). National Disability Services has argued that prices are too low to cover providers' overheads and the margin necessary to cover future costs, and, as such, the pricing mechanism precludes existing providers from developing the additional service capacity required to meet demand (NDS, 2017). Based on surveys of their members in 2016, they found two in three providers agreed or strongly agreed that they would be unable to provide services at the prices offered under the NDIS (NDS, 2016, p. 15). Close to half of providers (46%) agreed or strongly agreed that quality would need to fall in order to provide services at the prices offered (NDS, 2016).

National Disability Services also found that, in 2016, aligning NDIS prices with the actual costs of supply were the highest priorities for 58% of NDS members (NDS, 2016). They have articulated the need to increase one-to-one support prices, establish a mechanism to set more appropriate prices for services delivered to participants in groups, change prices to more accurately reflect jurisdictional and geographical differences in costs, and set prices that better reflect complexity of support (NDS, 2016, p. 24). They have also reiterated the Auditor-General's concerns that the design of the Scheme failed to consider possible conflict of interest between the NDIA's role as both funder and price regulator; that is, that low price setting could be used to achieve funding goals of containing costs, rather than recognising the costs of service provision and providing adequate resources (Auditor-General, 2016; NDS, 2017).

The arguments of NDS and employers, however, have not closely focused on the link between price levels and workforce issues. To explore this in more depth, specific questions were asked about workforce management under NDIS pricing arrangements in the survey of not-for-profit CEOs conducted in NSW as part of a larger survey that is reported in more depth in Cortis and Blaxland (2017). Figure 2.2 shows that overwhelmingly, employers delivering services under the NDIS are finding that NDIS prices are undermining their capacity to operate as 'good' employers:

- 2 in 3 (67.2%) CEOs disagreed with the statement ‘NDIS prices enable us to meet our industrial obligations’ and only 14.0% agreed. 18.8% were neutral or unsure, showing that a substantial proportion are uncertain about pricing adequacy.
- 2 in 3 (65.9%) CEOs disagreed with the statement ‘NDIS prices allow us to pay rates necessary to attract and retain quality support workers’ and only 10.9% agreed. Almost 1 in 4 (23.2%) were neutral or unsure, again showing a high level of uncertainty about the operating environment.

Figure 2.2 Registered providers' perspectives on pricing (%)



Source: Survey of Employers, see Cortis and Blaxland (2017)

In the open-ended survey question, there was some recognition that pricing arrangements depend on the type of service and practitioner employed. In general, pricing was most problematic for organisations employing support workers, as those employing allied health practitioners received prices more attuned to actual costs. Several organisations made general comments on the difficulties they faced in managing and developing their workforce under the NDIS, for example:

> There is still considerable uncertainty in relation to how we can best manage our workforce under an NDIS - balancing choice and control for participants

> whilst still meeting industrial and professional obligations under existing NDIS pricing. (CEO of medium sized non-metropolitan service[7])

Others delved deeper to focus on particular areas of difficulty arising from the price. These respondents focused on the amount of activity required of the organisation which was not paid for under the NDIS (including administration and travel time), the difficulty of skilling staff, and the need to subsidise provision from other sources. Typical comments included:

> An enormous amount of backoffice work that is not paid for by the NDIS (CEO of small non-metropolitan service)

> Covering travel cost is a major concern as most of the clients we support live in rural remote areas. Without adequate funding to cover travel, our service may not be able to continue to provide support to clients in these areas. There are no other services in some of the areas we provide support in. (CEO of medium sized non-metropolitan organisation)

> Low NDIS prices are causing staff to be employed on lower wages, making it difficult to attract and retain quality staff. This will lead to decrease in quality services provided to people with disability. Staff will receive less training to the detriment to the people with disability. (CEO of medium sized non-metropolitan organisation)

Providers' comments were, however, imbued with commitment to the principles of choice and control underlying the NDIS, mixed with disappointment about the Scheme and uncertainty about prospects for future provision. For example:

> Whilst we agree that the NDIS is the greatest social reform since Medibank, it is chaotic, underfunded, poorly priced and with almost daily changes in rules and policy. We fear that it will lead to a deskilling of our workforce and we cannot yet identify how the pricing will permit the essential back office operations. We have been providing NDIS services for over two years, but almost every package has to be subsidised from our diminishing equity. (CEO of very large multi-state organisation)

Many linked the NDIS, and NDIS prices, in particular, with a range of workforce challenges:

> The hourly rate is unsustainable and does not allow funds for training or CPD[8] or staff meetings or supervision. This all is covered by the org as a commitment to maintaining quality. Hours cannot be guaranteed so we look to a casual workforce in our regional areas, we cannot meet demand with staffing and are constantly short staffed. Travel is a nightmare in regional

[7] Organisations with less than 20 staff are described as small, those with 20 to 50 staff are described as medium, those with over 50 are described as large, and those with over 200 staff are described as very large.

[8] Continuing Professional Development

> areas with agencies needing to pay mileage as well as travel time. (CEO of medium sized non-metropolitan based)

Another focused on the failure of NDIS prices to reflect providers' industrial requirements:

> The lack of alignment between how NDIS is funded and employers obligations under the Modern Award (particularly in NSW with higher rates under transitional arrangements) make it incredibly difficult to attract and retain quality staff and operate at a level of efficiency and quality that is sustainable (Human resource manager in very large multi-state organisation)

Another explained how the NDIS had diverted the organisation from its focus on quality, to its focus on market share:

> Competition between other providers and an unspoken message that staff needed to try and ‘win’ business to secure their own work changes the nature of our organisations focus from providing quality services to splitting attention to having to ‘capture’ business. I believe this may have counterproductive consequences to the overall industry and depersonalisation of our sector in the future. (Senior manager in large multi-service, multistate organisation)

As the data presented so far shows, both employers and employees note a range of difficulties of working under the NDIS and of the NDIS pricing arrangements. To explore these issues in more depth, the remainder of the report introduces the design of NDIS prices (Section 3) then details the assumptions underpinning prices for disability support work (Section 4). We more closely explore the adequacy of pricing arrangements in Section 5.

3. NDIS prices for services requiring Disability Support Workers

Having shown that employers and workers are experiencing difficulties working under NDIS in Section 2, Section 3 provides an overview of the design of NDIS prices for services requiring disability support workers, as a basis for systematically assessing the adequacy of prices. Prices for disability support work are the major component of Scheme costs and are expected to increase as full Scheme rollout increases demand for support workers. Section 3.1 outlines 2016-17 prices for services provided by disability support workers, with further detail about the structure of prices in Section 3.2. Section 4 examines the assumptions underpinning the base hourly rate for disability support work, and grounds for variation according to geography, intensity and other factors (Section 4.7).[9] Section 5 assesses the adequacy of prices for disability support work, using data collected from disability support workers and leaders of service provider organisations.

3.1 2016-17 Prices

Prices for services provided by disability support workers are set out in four Price Guides.[10] These guides set out prices for three major 'support purposes' (Core, Capital, and Capacity building). Each contain a number of 'support categories', which contain support items ('line items'). Two support categories are relevant to disability support workers:

- Assistance with Daily Living (containing 43 relevant support items)[11], and
- Assistance with Social and Community Participation (containing 27 support items).

Figure 3.1 shows the structure of these categories. Appendix D sets out their 70 items and their prices. Together, prices for these Support Categories are important because they set the amount of funding allocated to participants to access assistance from disability support workers, and because they are the main components of Scheme costs (NDIA, 2017c). Assistance with daily living, and with social and community participation are also critical to Scheme costs given the prevalence of disability types among NDIS participants: 30% of NDIS participants in Barwon were people with intellectual disability (29% in Hunter), and almost a quarter of participants were people with autism and related disorders (22% in Barwon and 23% in Hunter) (NDIA, 2017c, p. 95). People with these types of disabilities are likely to require assistance with daily living and with social and community participation, and so can be expected to draw on disability support workers (NDIA, 2017c, p. 95).

[9] Analysis is based on 2016-17 prices and the best available information about how these were developed. However, at the time of writing, a complete account of how prices were determined is not in the public domain.

[10] The four guides for 2016-17 have identical structures and definitions, but refer to different areas: non-remote areas in the four eastern states (NDIA, 2016b) and other jurisdictions (NDIA, 2016c), plus separate guides for remote areas, and very remote areas. Differences in prices between each guide are shown in Appendix D, and the sources of the differences are explained below. Other than actual prices, any citations in this report for NDIA (2016c) are identical for the other Price Guides.

[11] There are three service types under Assistance with Daily Life that do not use Disability Support Workers (Figure 4.2).

Figure 3.1 NDIS Services, by Support Purpose and Support Category

PURPOSE	CATEGORY
Core	**1. Assistance with Daily Living** 2. Transport 3. Consumables **4. Assistance with Social & Community Participation**
Capital	5. Assistive Technology 6. Home
Capacity building	7. Coordination of Supports 8. Improved Living Arrangements 9. Increased Social and Community Participation 10. Finding and Keeping a Job 11. Improved Relationships 12. Improved Health and Wellbeing 13. Improved Learning 14. Improved Life Choices 15. Improved Daily Living Skills

Source: NDIA 2016c, p.5

1. Assistance with daily living	Number of support items
• **Assistance with self-care activities: day**	10
• **Assistance with self-care activities: overnight**	4
• **Centre Based Group**	4
• **Assistance with Daily Life**	4(*)
• **Supported Independent Living (SIL)**	18
• **Assistance in a shared living arrangement**	3
TOTAL	**43**

4. Assistance with Social & Community Participation	Number of support items
• **Assistance to access community, social and recreational activities**	10
• **Group-based community, social and recreational activities**	16
• **Assistance with Daily Life (community, social and recreational activities)**	1(*)
TOTAL	**27**

Source: Derived from NDIA 2016c, pp.24-33. Note (*): There are some items that are not necessarily provided by disability support workers, e.g house maintenance, linen, meals.

3.2 The structure of NDIS prices

The NDIS prices relevant to 'Assistance with Daily Living' and 'Assistance with Social and Community Participation', and which therefore underpin prices for disability support work, are derived from three main elements:

1. First, the **base hourly rate,** is paid for services provided (a) in a non-remote area (b) on a weekday in the daytime (c) on a one-to-one basis (d) with a participant who does not have complex (high intensity) needs. The base hourly rate has been derived using the NDIA's Reasonable Cost Model (RCM), based on a set of assumptions and data concerning six factors: the level of disability support workers, the time-allocation of disability support workers, the level and workload of supervisors, staffing on-costs, corporate overheads, and a 'return on capital' margin.[12] The assumptions underpinning the base hourly rate are detailed in Section 4.

2. Second, a number of factors may be applied to vary the base hourly rate to take account of differences in participants and service situations. These **variation factors** relate to geographic location, the intensity (or complexity) of the support needs of a participant, the time of the day or week that the service is provided, and the number of participants being supported. These factors are also based on various assumptions (discussed in Section 4.7).

3. Third, there are a number of relevant Support Items where the prices have apparently been based on **benchmarks** established by the NDIA on the basis of empirical data from a small sample of providers, rather than being directly derived from the base hourly rate and four variation factors (although some take into account the number and/or level of need of participants). The most significant of these services is Supported Independent Living (SIL). These prices are not the key focus of our analysis.

Figure 3.2 summarises this structure, showing that of the 70 relevant prices, 37 are directly derived from the base hourly rate, combined with the four variation factors. The NDIA has stated that these are 'cross-checked against rates under schemes covering similar services, such as the Transport Accident Commission (TAC) in Victoria (NDIA, 2017a, p. 7).

Since the pricing methodology was introduced in July 2014 (NDIA and NDS, 2014), prices have been periodically adjusted upward from the initial base hourly rate of $38.78, but the underlying methodology has been not been substantially amended. However, the NDIA is currently reviewing its underpinning assumptions (NDIA, 2017a), and the intention is to align rates across the two sets of state and territory jurisdictions. In 2016-17 the base hourly rate for daytime self-care was $42.79 in the four eastern states (NDIA 2016c), $43.58 in the other four jurisdictions (NDIA, 2016d), and higher in remote and very remote areas (see Appendix D). Appendix D also shows how current prices vary according to the time service delivery, the number of participants and other features of the service.

[12] The term 'base hourly rate' was not used in the original Joint Working Group report (NDIA and NDS, 2014). That report uses the term 'hourly rate' to refer to this concept), but the term 'base hourly rate' has now been adopted by the NDIA (NDIA, 2017b). This ensures that the concept is not confused with the large number of hourly rates used for the various Support Items.

Additional points relevant to understanding the context of pricing arrangements are in Appendix E, including that prices were set using the Social, Community, Home Care and Disability Services Industry Award 2010 (the SCHADS Award) (also discussed in Section 4), indexation arrangements, assumptions about provider characteristics, the vision for an efficient price, and levels of transparency in price setting arrangements. Next, in Section 4, we more closely examine the assumptions underpinning current prices, before assessing these in Section 5.

Figure 3.2 Services provided by disability support workers by basis for deriving the price

BASIS OF PRICE	SUPPORT TYPE	Number of SUPPORT ITEMS
Base Hourly Rate • **Level of disability support workers** • **Time-allocation of disability support workers,** • **Level & workload of supervisors** • **Staffing on-costs** • **Corporate overheads** • **Return on capital (margin)**	• Assistance with self-care activities: day • Assistance to access community, social and recreational activities • Group-based community, social and recreational activities • Assistance with Daily Life (specialised home-based assistance for a child) **TOTAL**	10 10 16 1 **37**
Four Variation Factors • **Geographic location** • **Intensity (need) of participant** • **Time the service is provided** • **Number of participants**		
Other Bases for Prices • **Primarily derived from benchmarking based on the empirical experience of a small sample of providers**	• Assistance with self-care activities: overnight • Centre Based Group • Assistance with Daily Life • Supported Independent Living • Assistance in a shared living arrangement **TOTAL**	4 4 4 18 3 **33**

4. Detailed assumptions underpinning pricing arrangements

This section outlines the assumptions underpinning the 2016-17 price arrangements based on the Reasonable Cost Model (RCM) in more detail, to provide a foundation for assessing the extent to which they recognise the full costs of disability support work (in Section 5). Specifically, we explore the assumptions underlying six major components of the RCM:

- The classification of disability support work at a particular pay-point under the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award) (Section 4.1);
- how disability support workers spend their time (Section 4.2);
- supervisors' time and workloads (Section 4.3); and
- staffing on-costs (Section 4.4), corporate overheads (Section 4.5) and margin (Section 4.6).

4.1 Classification levels of disability support workers

The RCM assumes that disability support workers are employed at SACS (Social and Community Services) Level 2.3 of the SCHADS Award (NDIA and NDS, 2014, p. 2). The NDIA deemed this level to be a 'reasonable direct staff pay-point, qualification or experience level' for Disability Support Workers (NDIA, 2014, p. 2). Earlier statements indicated this level was chosen as 'the reasonable minimum qualification and experience level' for disability support workers (NDIA, 2014, p. 3). However, more recently (NDIA, 2017a, p. 10) the NDIA has described this level as an *average* rather than minimum, indicating that some workers could be expected to be employed below Level 2.3, as well as above it. The 2016-17 rate for a SACS 2.3 level disability support worker is $24.70 per hour (which represents 58% of the base hourly rate of $42.79 in the four eastern states).

4.2 The time allocations of disability support workers

The base hourly rate assumes that disability support workers spend less than 5% of their paid non-leave time away from participants. This derives from the assumption in the RCM that 85% of a worker's paid time *including* leave is 'client-facing' or spent with participants, and that 95% of a worker's paid time *excluding* leave is with participants. This has been described by the NDIA as a 'minimum utilisation rate' (2014, p. 3). Thus, under the RCM, only 10% of a disability support worker's paid time is deemed to be leave[13], leaving only 5% of time 'on duty' but not with participants or travelling between participants (equivalent to 3 minutes per hour). There does not appear to be any publicly available data or detailed analysis about the extent to which these

[13] NDIA (2017a, p. 10) sets out the NDIA's assumptions underlying the figure of 10% of a disability support worker's paid time is leave: staff are entitled to 10 days paid personal leave and all 10 days are used; staff are entitled to 4 weeks paid annual leave and all 4 weeks are taken each year; there is a 17.5% leave loading for the 4 weeks annual leave; and staff are entitled to 8.67 weeks long service leave after a 10-year tenure, and 17.98% of employees qualify for long service leave.

assumptions reflect the time demands on disability support workers arising from the range of essential tasks required of workers when they are not with participants, and whether administration, handover and communication between disability support workers, supervision, training, team meetings, breaks, and other requirements are accounted for.

The NDIA has previously indicated that the assumed time that disability support workers are not with participants could be reduced in future: 'Staff utilisation rates are a key lever in the cost of disability support services and for a more competitive supply of such services. The current industry utilisation rates and the efficient utilisation frontier may be materially different.' (NDIA, 2014, p. 3). More recently, it has indicated that it 'is considering expanding on the assumptions relating to utilisation' (NDIA, 2017a, p. 11).

4.3 The levels and workloads of supervisors

The RCM assumes that supervisors are employed under the Award at SACS Level 3.2, seen as 'an average pay-point and experience level for program management and administration' (NDIA, 2014, p. 3). As it is assumed to be an *average*, it could be expected that some supervisors will be employed below it (NDIA, 2017a, p. 10). The RCM also assumes a 'supervision span' of 1 supervisor for 15 staff (1:15). As noted above, the original assumption (NDIA and NDS, 2014, p. 12) was that the 1:15 ratio applied for both standard and more complex (high intensity) support, but more recently the NDIA has implied the 1:15 ratio is only for 'standard needs' (NDIA, 2017a, p. 1). The NDIA has also said that increasing the supervision span from 1:15 to 1:18 is one of the major means by which the transition to an 'efficient' price will be achieved (NDIA, 2014, p. 4).[14]

4.4 Staffing on-costs

Common practice is to include a loading of 25-30% for staff on-costs, which is broadly the amount outlined by the Joint Working Group on Pricing (NDIA and NDS, 2014, p. 12). The NDIA has stated that the RCM allows for staffing on-costs that include superannuation and workers' compensation (NDIA, 2014; NDIA and NDS, 2014, p. 3). It has also noted the specific assumptions for superannuation (9.5% of total salary costs) and workers' compensation (4%) (2017a, p.11). However, it is not clear from public documents precisely how this element of the RCM was calculated, and which other costs, if any, were included, making it difficult to assess its adequacy.[15]

4.5 Corporate overheads

Corporate overheads are normally assumed to include the costs of governance, back office support, service and staff development and quality assurance, logistics for organising service sessions (e.g. IT rostering software), and business development activities. The RCM assumes an

[14] As part of a current review of pricing, the NDIA is considering whether this assumption 'is appropriate for the current state of the NDIS, …[and how it] may vary according to the complexity of need.' (NDIA, 2017a, p. 11).

[15] Table 1 in NDIA and NDS (2014, p. 12) shows on-costs of $8.76 which represents 38% of the 'salary cost including client-facing time' of $22.56 per hour that is shown in the table. There may be various reasons for this high number, for example if it also includes the on-costs for supervisors and program management/administration staff as well as Disability Support Workers (NDIA, 2014, p. 3), and/or some allowance for staff development. Alternatively, the $8.76 is 23% of the total 'per hour price of $38.78 shown in that table, which is unduly low, and 27% of the sum of the salary cost and on-costs ($31.32).

allowance of 15% for 'reasonable infrastructure and overhead costs' while acknowledging 'that providers can choose to run their operations in any number of different ways' (NDIA, 2014, p. 4). The 15% is based on the 'total salary, management, and non-client-facing expenses' (NDIA 2017a, p.11). In setting the rate of 15%, the 2014 Joint Working Group considered benchmarks and data from the NSW and Victorian NDIS trial sites; from health, aged care and mental health providers; and from earlier benchmarking studies (NDIA, 2014, p. 4). In July 2014, the NDIA proposed that the movement to the 'efficient' price' should include a reduction in the allowance for corporate overheads (NDIA, 2014).

4.6 Return on capital (margin)

The RCM assumes a margin of 5% as a 'return on capital'. The 5% (presumably applied on top of the staffing, supervision and overhead costs detailed above) is intended to ensure sufficient working capital (cash flow) for daily operational needs, and to meet a number of future expenses (e.g. replacing depreciated assets, new investment and innovations, and major unforeseen contingencies). The 5% does not appear to include provision for the payment of dividends to owners or shareholders, but such payments are not explicitly excluded.

Ensuring that providers have adequate working capital is especially important at present, as NDIS providers adjust to receiving their revenue from individual participants after the services are provided, rather than through block funding in advance of service provision. In deciding to use 5%, NDIA stated that 'there is no real benchmark information available for Australian disability suppliers' and presented data on a number of relevant measures of return to providers from other human service sectors, before concluding that:

> While NDIA is not in the business of dictating return characteristics of suppliers we believe that an overall net profit below 4% is likely to be problematic. Below 4% most organisations struggle to keep pace with inflation let alone replacing critical assets or business innovation. The working group agreed to 5% [but this] should be regularly reviewed against relevant aged care and community health results for reasonableness. (NDIA, 2014, p. 5)

4.7 Variation to the base hourly rate

Sections 4.1 to 4.6 have outlined the assumptions underlying the base hourly rate for disability support work. This price can then be varied in recognition of the diversity of participants and circumstances in which NDIS services are provided. The pricing model involves the application of *four variation factors* to address differences in:

- the geographical location of the service;
- the intensity (complexity) of the participant's support needs;
- the time when the support is provided; and
- the number of participants being supported.

These factors are applied variously to the different service types. Along with the assumptions underpinning the base hourly rate, assumptions about these variations also affect the funding

allocated to participants to access services provided by disability support workers. A brief outline of these variation factors are below, with the resulting differences in 2016-17 prices shown in Appendix D.

Geographic location

NDIS prices vary according to jurisdiction and remoteness. A number of the prices for the four eastern states are slightly less than for the other four jurisdictions.[16] These differences are gradually being removed, as the NDIA intends to align the prices across jurisdictions in coming years. In addition, there are loadings for remote areas (18%) and very remote areas (23%). These loadings, which are based on the Modified Monash Model[17] are applied to the (higher) base hourly rate for the non-eastern state jurisdictions ($43.58 in 2016-17). For the 2017-2018 financial year, these loadings will be increased to 20% (remote) and 25% (very remote). At the time of writing the rationale for this is not clear.

Intensity (complexity) of participant support needs

Participants are assessed by NDIA as having standard or high intensity support needs[18] For participants with high needs, a loading is applied. The various pricing documents recognise that 'high intensity [support] requires additional experience, risk management, and supervision' (NDIA and NDS, 2014, p. 12), and that the higher rate for supports 'may be considered when 'frequent (at least 1 instance per shift) assistance is required to manage challenging behaviours… [and] continual active support is required due to high medical support needs.' (NDIA, 2016d, p. 17).

However, additional demands of high intensity participants recognised in the above statements are not reflected in the loading. The original formulation of the RCM noted that 'higher intensity support in the model is built from the same support worker pay-point with lower utilisation, but this mix may not reflect the actual reality of the cost of providing these supports' (NDIA and NDS, 2014, pp. 10-11). In fact, the price loading for more intense needs only takes account of the additional worker time required away from participants. Thus the prices for supports for high intensity participants assume 'client-facing time, *including* leave' is 80%, not 85% and that 'client-facing time, *excluding* leave' is 90%, not 95%.

Time when the support is provided

NDIS prices for a number of service types requiring disability support workers vary by the time of day and/or the day of the week when the service is provided. Depending on the particular service type, there are up to six periods for which prices may be set, namely (i) daytime (6am-8pm) (ii) weekday evening (8pm-12am) (iii) Saturday (iv) Sunday (v) public holiday (not used for group programs), and (vi) overnight. The reasons for differences in prices between these periods are not

[16] This is relevant for 32 of 65 support items (5 of the 70 in total are by quote only).

[17] http://www.health.gov.au/internet/main/publishing.nsf/content/modified-monash-model

[18] There is also a category of 'low' intensity, which is only used for Supported Independent Living, based off benchmark prices, rather than the RCM. Note that from July 2014 the NDIA had used the term 'Intensity' to refer to the level and complexity of the support needs of a participant. NDIA (2017a) has used 'complexity' while 'intensity' has not been used at all in that document. This report primarily uses 'intensity', as this is the term used in the current Price Guides.

completely apparent but they appear to reflect the shift loadings and penalty rates in the SCHADS Award at the time the RCM was developed.

Number of participants

This factor applies to 'Group based community, social, and recreational activities', with separate prices for two or three participants. A provider only receives in total the base hourly rate ($42.79) for each activity, with the cost allocated equally between the number of participants. In effect, this assumes that there are substantial economies of scale, with no extra costs arising from each additional person. Where there are more than three participants in any group activity, an additional disability support worker should attend, such that the ratio of participants to disability support workers should never be more than 3:1. Centre-Based Group and Supported Independent Living (SIL) services also each have different prices depending on the number of participants in the group or residence, but the prices for these services are not based on the base hourly rate.[19]

4.8 Other aspects of NDIS pricing

Other services provided by disability support workers

In addition to the prices for the 37 Support Items that are determined using the RCM (including the four variation factors) there are another 33 Support Items for services requiring disability support workers where the price does not derive (at least not directly) from the RCM and the four variation factors.[20] These services, which include supported independent living and assistance in shared living arrangements are shown in Appendix D. In most cases these are considered 'benchmark prices' whereby a provider can either accept that price or submit a quote (and seek NDIA approval) where its costs are higher than the benchmark prices. This arrangement contrasts with other prices, where the price is a firm cap (Australian Senate, 2016). The bases of the prices for these services are not clear from the public documents, but in general they appear to have been derived by seeking to establish 'benchmarks' based on the empirical experience of a small number of providers, especially those in the NDIS trial sites.

Other costs for services requiring disability support workers

There are also costs which the NDIA will cover which are not part of the RCM or variation model nor paid according to quote. These include the travel of workers, cancellation fees, and

[19] In some cases, prices appear based on assumptions that there are economies of scale, while in others, they do not. For centre-based group supports for example, the same rate per participant is charged regardless of the number of participants, assuming no economies or diseconomies of scale. For supported independent living on the other hand, the indicative price per participant declines as the number of people assumed to be sharing accommodation increases. Thus, 'returns to scale' are assumed for supported independent living, presumably achieved through some 'sharing' of Disability Support Workers by participants (NDIA, 2016d, p. 12).

[20] Only 28 of these 33 Items actually have a price. The other five require a quote or are listed as 'Varies.'

establishment fees[21], shadow shifts[22], and case management[23]. For disability support workers, the most significant of these is travel. Rather than providing a separate amount for travel, providers can use up to 20 minutes of the first hour of support to travel between participants, for services of less than four hours. In 2016-17, the Price Guide states that for travel to provide personal care and community access:

> the time that a worker spends travelling from home to the workplace (or first participant) and from the workplace (or last participant) to home cannot be claimed at the hourly rate for the relevant support item [but] where a worker travels from one participant appointment to another, up to 20 minutes of time can be claimed against the second appointment at the hourly rate for the relevant support item. (NDIA, 2016c, p. 13)

The NDIS website clarifies that although the first 20 minutes of a service may be for travel, it is expected that the outcomes required in the delivery of support will still be met (NDIA, 2017b).

4.9 Future developments in NDIS pricing

There are a number of possible changes to future prices arising from measures that have been announced by the NDIA or about which the NDIA has expressed a view, including proposed price reviews (NDIA, 2016a), the move to 'efficient prices' by 2019-20 which would be aligned across jurisdictions, and eventual price deregulation (NDIA and NDS, 2014). A current review (NDIA, 2017a) is focusing on:

- the levels of price controls for supports under the categories of 'assistance with self-care activities' and 'assistance to access community, social and recreational activities';
- simplification of shared care price controls; and
- other specific updates to pricing arrangements.

Assessing the pricing model

Section 4 has provided a detailed account of the structure of NDIS pricing and the assumptions underlying the base hourly price, and other aspects of pricing arrangements. The next section builds on this by examining the appropriateness of the assumptions that underpin the various elements of the NDIS pricing model, using empirical data.

[21] Details of cancellation and establishment fees are detailed in service agreements between participants and providers, however the NDIA will only pay a provider for 8 cancellations per participant, per year. (NDIA, 2016b).

[22] Case management is charged as either 'Support connection' ($56.61 per hour in 2016-17), or as 'Coordination of supports' ($92.27) for participants with high needs and more complex situations. These supports are listed under a different Support Category from the Service Types that are the focus of this report, and are not typically provided by disability support workers (although in practice, some disability workers may carry out aspects of co-ordination to ensure continuity of services for participants).

[23] Providers can claim up to 6 hours of weekday support for the purposes of 'shadow shifts', which allow a new worker to accompany an existing worker to participants before they provide support on their own. These are considered necessary where participants have limited communication, or high medical or behaviour support needs (NDIA, 2016b). It doesn't cover 'buddying' of new staff in usual circumstances.

5. Assessing NDIS prices for disability support work

This section draws on data from employees (disability support workers) and from provider organisations to assess the adequacy of assumptions on which NDIS prices for disability support are based, and the challenges emerging from pricing arrangements.

The analysis shows the range of ways that disability service provision is under-priced under NDIS, as prices have been set based on assumptions which have failed to recognise the nature and value of disability support work. The level of under-pricing is such that NDIS prices do not enable minimum award conditions to be met without diverting resources from other functions. As the material shows, NDIS prices are predicated on:

- under-classification of support workers and supervisors;
- under-estimation of the time needed by both disability support workers and their supervisors to deliver quality services to NDIS participants, especially participants with more complex needs; and
- under-estimation of a range of other costs that providers must incur to develop and maintain quality staff and services.

Inadequate prices are having adverse effects on disability support workers, on providers, and on services received by NDIS participants, and contributing to the problems described in Section 2. For workers, access to training and induction are under pressure and levels of risk are high. Staff are performing unpaid work to compensate for systemic under-resourcing. Providers wishing to meet their basic industrial obligations are having to divert resources from other functions. In turn, these pressures on workers and providers are affecting the quality, responsiveness, equity, efficiency, and stability of services, and the overall sustainability of the NDIS.

This section examines each of the elements underpinning NDIS prices, which were outlined in Sections 3 and 4, and shows the adverse impact of the 2016-17 pricing model on workers and services. The elements of the base hourly rate are explored in Sections 5.1 to 5.6, while Section 5.7 considers the variation factors and other elements of NDIS pricing.

5.1 Classification levels of disability support workers

Assumptions made in the RCM about the skills requirement and award classification level of disability support workers is a key means through which the work is under-priced. [24] Specifically, the RCM assumes employment is at Level 2.3 of the SACS classification of the SCHADS Award. [25]

[24] Moreover, the actual amounts that are calculated for all but one of the other assumptions underpinning the base hourly rate are essentially mark-ups on the rate payable for the assumed level of support workers. The exception is the level and workload of supervisors, but under-pricing of that factor also has similar effects on the other assumptions.

[25] In earlier statements by the NDIA, SACS Level 2.3 was described as a minimum level (NDIA, 2014). If set as a minimum, employment costs of current long-term staff, and the progression of new staff above this level will not be covered. However, the most recent statement from the NDIA indicates it is an average (NDIA, 2017a).

There is no allowance made for above award wages, for example those provided under an enterprise agreement.
The SCHADS Award sets out that an employee at Level 2 performs personal care services or 'elementary tasks within a community service program', involving functions which are defined by established routines. Level 2 staff are not expected to engage in problem solving and have only a 'limited scope to exercise initiative', working under general guidance and assistance which is 'readily available'.[26] Under the Award Level 2.2 is the *minimum* pay point for an employee with an appropriate Certificate level qualification, while Level 3.3 is the commencement level for graduates with a three-year degree.

Evidence from employers and from workers also shows that the classification level assumed for disability support work is too low. NDS for example, has stated that Level 2.3 is lower than the sector pays (NDS, 2017). Problematically, some employers have downgraded or 'frozen' staff classifications at this level as a result of NDIS prices. An employee explained in the survey:

> We have been advised that our hourly rate is higher than what the NDIS rate is so as grade 3 employees, we will be now classed as grade 2. We won't lose pay immediately however we won't be getting a pay-rise until grade 2 rates catch up to ours.

Similarly, an interviewee highlighted how the classification assumed in pricing arrangements had precluded career progression in her organisation:

> Our company argues that anyone on 2.4 is already costing us money and that's not true, but it's a really good stopgap for the company to say, 'Stop whingeing.' (Employee 2)

Level 2.3 is also too low, given the tasks performed by disability support workers. As shown in Bentham and Macdonald (2017) workers deploy a range of skills in the course of the working day, applying their knowledge across a wide spectrum of advanced skills, including knowing how to respond to complex health needs such as epilepsy, PEG feeding, calming people with dementia; responding to medical emergencies or violence; managing demanding workloads under time pressure including accommodating unforeseeable events; deploying negotiation and strategic skills to achieve the best for their clients; and working across agencies. Disability support workers often work on their own and perform these functions with minimal levels of support, with supervisors only available remotely, for example, over the phone or days later in planned supervision meetings.

Several of the workers we interviewed described the risks inherent in over-reliance on inexperienced staff members particularly in the NDIS context where training has been cut. For example, one supervisor spoke of her concern for participants because untrained casuals were being left to perform PEG feeding (in which a tube is inserted through the abdomen directly into the stomach to enable feeding):

[26] Corroborating this, the assumption that supervisors will be overseeing the work of between 15 and 18 staff (discussed below, under 'The level and workload of supervisors' suggests general guidance and assistance is unlikely to be readily available.

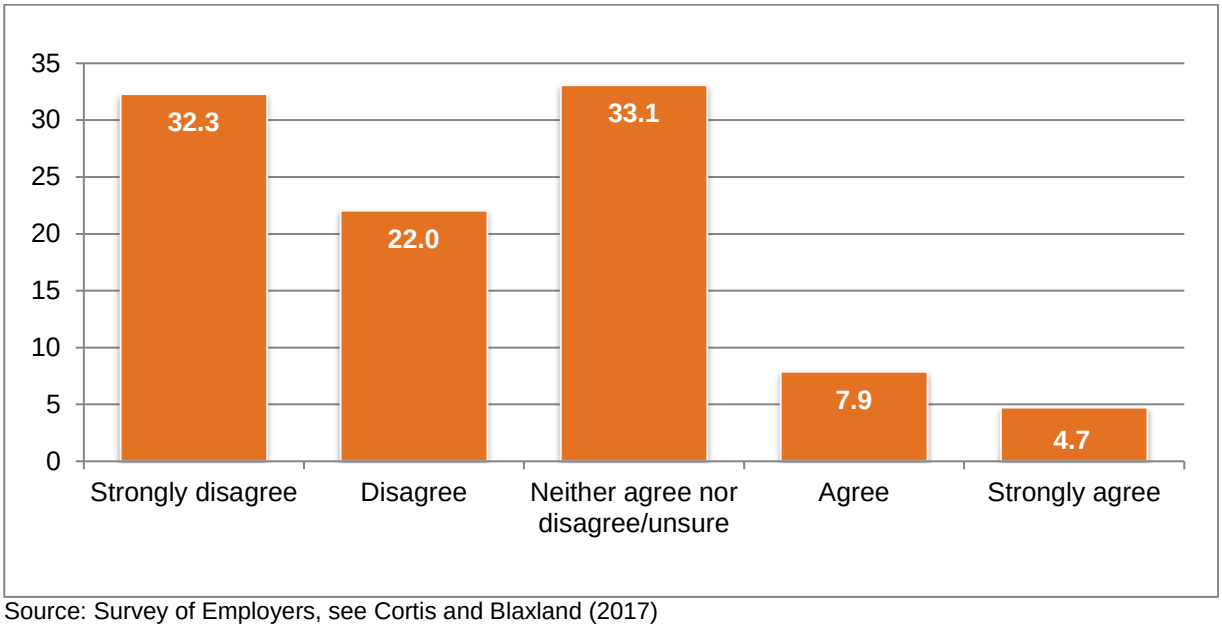
> I've had staff members say that to me, 'Oh, how does she drink this?' …(W)hen I started with this company I had weeks of training before I was supervised to do that …[and transporting groups of people], now, it's, 'Off you go, get in the bus, have a good day, we'll see you when you get back… (Employee 2)

Additional evidence of the problematic nature of assuming employment at Level 2.3 comes from the survey of employers in NSW. Indeed, in their comments, employers described Level 2.3 as 'entry level', and described how they instead needed to employ experienced staff and ensure they could advance through the organisation and be retained. This is reflected in the statement of a leader of a registered provider in NSW, who explained that Level 2 was not a classification they used, whilst also describing several other challenges arising from pricing arrangements. This CEO described the NDIS as:

> A huge change as the NDIS hourly rates for direct care work barely cover entry level positions only (Level 2 SCHADS whereas we currently use level 3) so no room for any advancement. (CEO of medium sized metropolitan organisation)

The survey data shows that many employers shared the view that career advancement was restricted under NDIS. The employer survey asked for the level of agreement or disagreement with the statement 'Under NDIS, the organisation can provide pathways for staff to advance their careers'. More than half of organisation leaders (55.3%) disagreed or strongly disagreed, reflecting how the pricing assumptions are recognised to restrict career progression (see Figure 5.1).

Figure 5.1 Percentage of registered providers who agreed with the statement 'Under NDIS, the organisation can provide pathways for staff to advance their careers' (n=127)



Source: Survey of Employers, see Cortis and Blaxland (2017)

Based on comparison with definitions in the SCHADS Award, and on employer and disability worker accounts, Level 2.3 is considered entry level, and under-classifies disability support workers. This component of the price is misaligned to the actual profile of the workforce, creating

incentives to hire less qualified, competent and permanent staff. As expectations of the disability support workforce grow, and new skills demands arise from individualisation and quality and safeguarding measures (DSS, 2016), the assumption that workers will, on average, be employed at Level 2.3 provides a disincentive to organisations to support upskilling and career progression.

5.2 The time allocations of disability support workers

Evidence from disability workers and employers shows NDIS prices for disability support do not allow adequate time for quality support. For example, there is too little allowance made for legal requirements such as breaks for workers, and for essential tasks such as administration and co-ordination, or for the development of workers through training and time for supervisor and peer support.

Employees expressed high commitment to performing their jobs well, and pointed out how pressure on their time meant they undertook significant amounts of unpaid work. This is a common feature of under-funded support and care delivery. Rubery et al. (2015), for example, point out that arrangements in home care work in the UK have relied on workers' altruism. They observe

> Current practices rely on care staff's goodwill to work more hours than they are paid for even when their hourly pay rate is already close to the minimum wage, to fund their own travel, and to constantly reschedule their times to maintain earnings. (Rubery et al., 2015, p. 769).

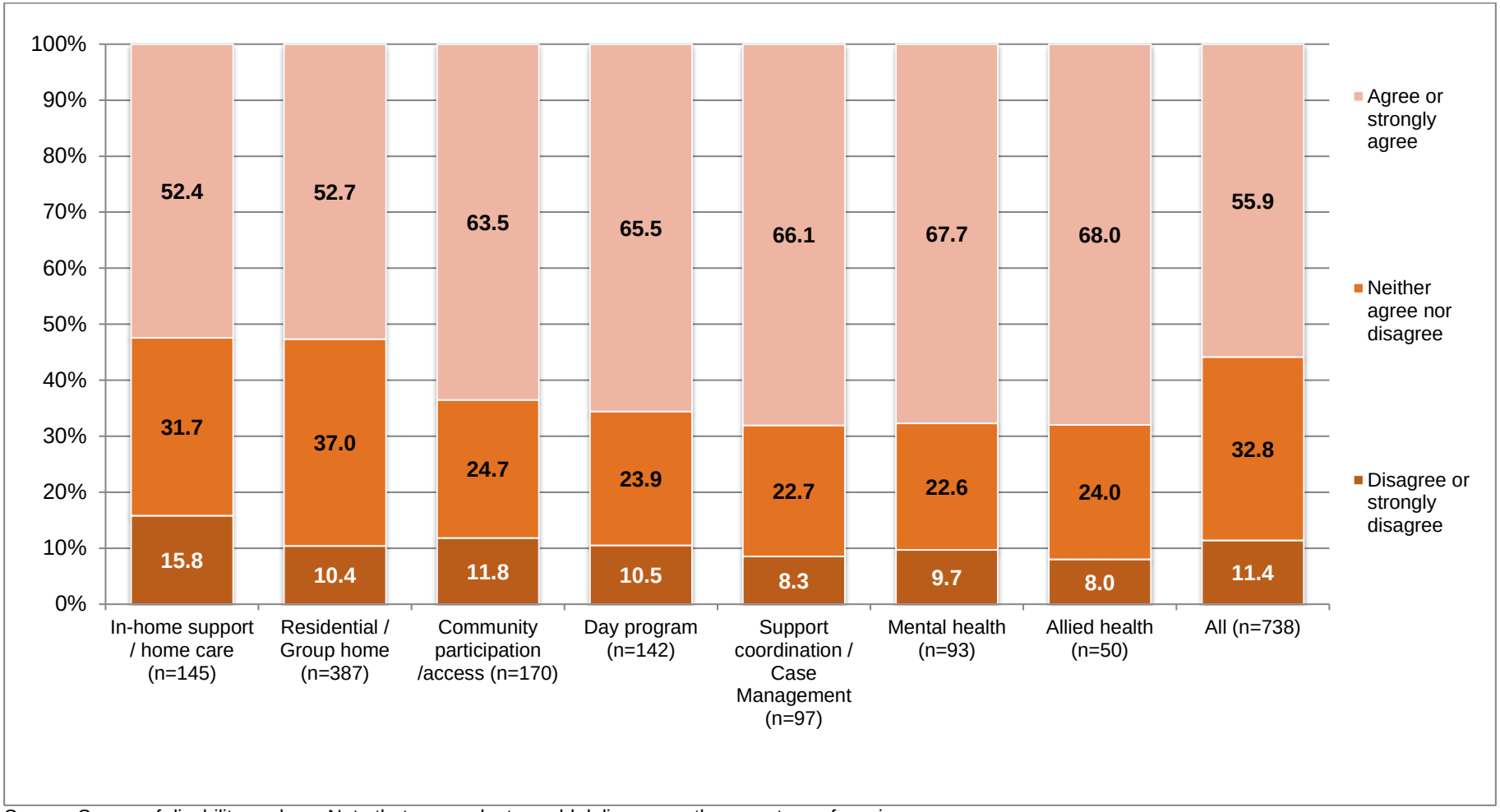
However, where employees contribute additional unpaid time, while cost pressures may be offset, evidence also shows the quality of services is inevitably affected.

Analysis of the pricing model in the context of the SCHADS Award shows prices do not adequately account for non-client facing time, including breaks. The pricing model assumes that just 3 minutes per hour of workers' time is not spent either with participants or travelling between them (Section 4.2). This allows for little more than the 10 minute paid tea break required every four hours under the SCHADS Award, leaving minimal time for other non-client facing activities.

The failure to fully recognise the time demands on workers places workers under pressure. In the survey of disability workers more than half of respondents (55.9%) agreed or strongly agreed with the statement 'Under NDIS, I don't have enough time to do everything in my job' and only 11.4% disagreed. This is shown in Figure 5.2. In open ended comments respondents elaborated on this, underlining how their work takes place under increasing time pressure under NDIS, for example:

> There is a lot more pressure to take on new clients so that the case load has increased… …Before we could spend extra time if needed with a client in crisis, now it is all about hours and money.

Figure 5.2 Percentage of disability workers who agreed with the statement 'Under NDIS, I don't have enough time to do everything in my job'



Source: Survey of disability workers. Note that respondents could deliver more than one type of service.

Similarly, the disability support workers who were interviewed for this study reported they had inadequate time in their jobs to do what was necessary to maintain participants' safety and well-being and/or to do the job as their employer required them, and this resulted in a high level of work intensity and hours of unpaid overtime. This was a major source of frustration and distress for frontline disability support workers. Support co-ordinators also experienced this problem:

> The time you have allocated to each person is a huge factor in what sort of a service you can provide. And if you're a support coordinator … there's a bigger responsibility to make sure that people have maximum, I suppose, support around understanding their plan and implementing it. But I still think there's a lot of restrictions around [that] because of all the aspects of the job that we have to fulfil, it's not just the direct contact, it's all the admin side of stuff, it's about the rostering of the time, it's all that sort of stuff that makes it I suppose less user friendly. I don't know. That's how I feel. …And I haven't had any training [since commencing this role] and what I keep asking for is I just want, I really want someone from the NDIS to come here and just explain this scheme to us, so it's not so mystical. [But that hasn't happened] and then you're sort of, you're told that the best way to keep up to date is to read the NDIS, go on their webpage and read all the updates. But in reality I don't, I honestly don't have time. (Employee 5)

A worker in a residential setting who responded to the employee survey described staff as 'under the pump':

> Responsibilities seem to be getting greater, as clients age and have more health problems. When this happens clients need more staffing hours, and therefore more funding, especially when chronic health issue need constant care. I notice a lot of staff under the pump, some working over hours for no pay at times to get things done, and generally being taken advantage of. It is hard to provide the levels of good quality support that is expected and anticipated, when the staff to client ratio is so low in some group homes.

Others identified a range of risks arising from the time pressures under NDIS. Another survey respondent summed up their experience under NDIS, which capture how time pressures were reducing scope to personalise services:

> Clients going without more outings without rapport being built with the client. Less opportunities /funding for clients being treated as a number without existence. Clients being rushed or misunderstood without a carer that understands the client. e.g non verbal client / behavioral. Client being rushed on 1 hour outings rather than being able to take their time e.g unstable on their feet, cognitive issue / behavioral client. Less contact with staff whom the client know and have built rapport with. Strangers taking the clients for appointments. Client becoming house bound, as they don't feel comfortable with unknown services / staff. Client not getting heard! as the NDIS appointments are so rushed.

The failure of the RCM to adequately address the time demands upon disability support workers has had the effect of preventing workers and their supervisors from effectively carrying out all of

their essential tasks. This can be seen in relation to time available for communication between staff, administration, travel, training, and other activities integral to performing disability work.

Lack of time and opportunity for communication

A particular concern among disability support workers, and a source of risk, was the inadequate time allowed under the NDIS for handovers between support workers, for communication (including with office staff), and for support workers to complete required paperwork. Inadequate time for staff handovers was made worse by high levels of staff turnover and use of casual staff. Direct support workers interviewed said it was much more difficult under the NDIS arrangements to pass on important information to other support workers, even when that information was vital to participant wellbeing or service operations or recording was mandatory. As one respondent in the employee survey explained:

> The system does not provide funding for anything other than direct support, therefore all the ancillary tasks such as note writing, documentation, communication with other stakeholders must be done in the employee's own time. In my case I spend at least one hour each day unpaid doing file notes etc. This needs to be looked at as all of this documentation is mandatory.

Many commented that communication was more difficult under the NDIS as, often, staff were not paid to attend team meetings. In some cases this was because their employer now allocated less or no time for team meetings. In other cases, more complex communication was required under the NDIS, as the 'team' supporting an individual now comprised multiple (and changing) individual support workers from several organisations, requiring more extensive cross-agency communication than previously. While the separation of different support services to different providers was seen to make it logistically difficult to communicate, in these workers' experiences the difficulties were worse because time for even basic communication, such as 'handover', was not funded. Any opportunity for support workers to share knowledge with workers from different organisations was severely restricted due to minimal time for support workers to do anything other than provide face-to-face support to participants. Several workers in residential services spoke of not wanting to use up too much of the small amount of time participants had in their NDIS packages for participation in community activities. One interviewee explained:

> … and as much as we try to give a handover to the [other service provider] staff, there's a, if a client's only got 2 hours [a week] to get out into the community, you've got to be very short, quick [in your handover]. [For example, you might need to explain] 'this person needs clear boundaries, you can't fluff around, they don't cope well with open-ended questions, you need to say do you want a chicken sandwich or a ham sandwich because otherwise it's just not going to work. You need to get in the backseat of the car because they can't, they're too distracted with all the stuff that's in the front seat of the car'. There's a lot to handover. (Employee 1)

Workers felt quality was also undermined as they had insufficient time to give information to other support workers, or to receive information from other support workers, especially at the changeover of shifts. This communication is essential to ensure continuity of support and to maintain a good awareness of participants' needs and well-being. Interviewees also felt quality was

undermined where they were not receiving the information they needed from other support workers:

> ...[support workers] basically bring the client in, well some of them don't even bring the client in, they just drop them off at the front door and drive off. …So, but they'll say, they'll turn around and go 'Joe Blow had a good time', Well what does that mean? What did you do? ... Well some clients are capable of [telling you], but not all clients are capable of doing that (Employee 1).

Time for administration

Workers also reported that increased paperwork associated with the NDIS had also increased their workloads causing spillover into unpaid work time. Bentham and Macdonald (2017) explain how one worker listed the tasks she had to complete in extra unpaid time at the end of a week and sometimes at the end of a shift. These included: recording any extra shifts in her diary; printing up her roster; fill out a claim form for her client's travel kilometres; making notes about any issues with clients; going into the office to deliver paperwork; discussing issues regarding clients with managers; discussing new clients with managers; correcting errors in rosters; and making appointments for clients.

In the other interviews, in which workers were asked if the NDIS had changed anything, one worker said: '...in some respects I see it's given more choices and more opportunities for people with disabilities'. She also said:

> Our workload's increased, because we have to justify everything we do. Simply taking the ([participants out], because their goal might be to access the community more. …We then have to justify in this, in these particular forms, every single time we take them out…. …They say we should be able to get case notes and shift records and all our paperwork done within half an hour. It takes two staff half an hour to get it done and sometimes you still need longer. (Employee 6)

This worker felt in a dilemma about completing administration, as she needed to cut short her client's activities in order to complete her paperwork in her paid time:

> … we've got to get all of this [paperwork] done. [For example] you're looking at your time because you're out on an outing where your client's having an absolute ball. You've got to be back by quarter past one because you finish at 2 o'clock. You know? So, you're potentially pulling a client out of an activity that [took] three hours to get them to be comfortable to be accessing the community, and now you're here, she doesn't want to leave, but you've got to go. (Employee 6)

Others also pointed out how the additional administration had been created by the NDIS. An interviewee in a service co-ordination role explained how she was struggling with the combination of a very high workload and the need to balance the needs of a large number of clients. Added to this she was now required to account for her work time in 15 minute slots that were allocated to individual clients' funding:

> …I'm finding that this position is … overwhelming and distressing … *Interviewer: Okay. So what do you find distressing about it?* Probably the workload I guess, it's an incredible amount of work involved with each person. There's a lot of administrative kind of work that needs to be done. I have to account for every 15 minutes of my day, as far as rostering my time, and making sure that I'm using my time effectively. … So there's a lot of kind of record keeping around making sure that I'm being fair and making sure that I'm using people's time wisely I suppose and if I am working with a particular person, because I could work up to 15 people a day I could be supporting, in that time I've got to be able to work out how many minutes did I work with that particular person, how many minutes did I work with the other person. (Employee 5)

This support co-ordinator, who was considering if she would stay in her job, said she used to spend time researching to support her clients but she no longer did due to the stress of overwork:

> [I was doing this in] my personal time [but now] I really don't want to be going home from work and reading about the NDIS. Whereas in the past I didn't feel as overwhelmed, and I was able to, I was really interested in research, really interested in reading articles and looking up different service providers, and what they offered, and getting a really sound understanding of the system. But I think in this system it's just you feel so overwhelmed all the time. (Employee 5)

These sentiments were echoed in comments in the employee survey:

> I have concerns about the viability of the NDIS. We have been told there is not allocated funds for administration however the administration requirements have significantly increased. In order to provide a plan that is individualized a provider needs to be flexible [and] to do this costs money. Each time a person chooses to make changes to their goals or planning it takes time and therefore money.

They also echo concerns raised in the evaluation of the NDIS (Mavromaras et al., 2016), in which staff raised concerns about their increasing administrative workloads.

Case Study 1: Jessica's unpaid administration

Jessica has worked in disability support for around twenty years. She is a permanent part-time disability support worker in a community residential unit with five residents. Several times each fortnight Jessica works unpaid overtime to complete work that is supposed to be undertaken during shifts. Here Jessica describes her typical sleepover and morning shift which often results in her undertaking unpaid work:

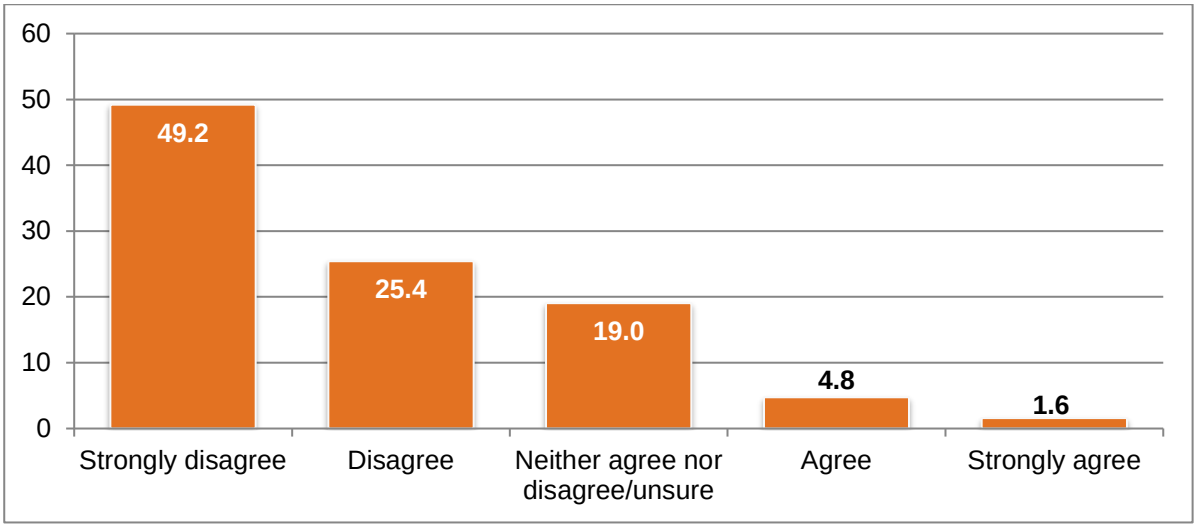
> So you sleep over, so you wake up and you're on shift at 6:30am and you finish at 8:30am. Our second staff member or the first day shift [worker] is 7:15, they come in and the second day staff person comes in at 8:15. …(S)o from 7:15 til 8:30 we've got to get the medication, all medication must be administered by 8:30am and we have a lot of creams and … 'cause we've lots of personal care, we've got creams, we've got pad changes, we've got tablets. …(S)o we've got any personal care that needs to be done in that period of time, which is often a couple of pad changes, …[one resident] has seizures so these are all factors that come into our morning but there might be a seizure, there might be a fall, there might be … and it happens, it does happen quite frequently. Then we also have, we have case notes to write up. So this is all in that first hour and 15 minutes, so it's medication, any personal care, attending to anything, if the residents are having showers, then we need to attend to those. Then we've got the case notes that we have to do on CareLink and then we have the shift records that we have to do on the computer system itself. I've also then got to write up any incident reports, that may have happened on the morning because I'm the sleepover, so I've got to finish them. And then potentially if one of these two staff members are new, they will have done an induction to the house so (…) they've already been to the house and done a bit of a run-through but on this first shift I go through and say, 'Okay, well in this folder, this is where you'll find this information, this is here, this is here.' A rundown, give them the protocol folder to read (…), communication book and diary.
>
> And also while giving them a handover of what may need to be done that day. So, 8:45 the second staff member comes in and then I walk out at nine o'clock and all of that has to happen before I walk out the door. [However] it's rare for me to be walking out that door at 9:00 normally, it's closer to 9:30 and occasionally it'll be a ten o'clock. (Employee 6)

Travel time

Pricing of workers' time spent travelling between clients under the NDIS is a vexed issue. Service providers, and the NDIA recognised that prices in the reasonable cost model did not account for travel time of workers between participants (NDIA and NDS, 2014), and arrangements were subsequently changed to allow payment for 20 minutes between clients. However, travel time remains a major issue for employers, reflected in their survey responses. As Figure 5.3 shows,

around half of CEOs in registered not-for-profit providers in NSW 'strongly disagreed' that NDIS pricing covers the full costs of staff travelling between clients, and a further 25.4% disagreed. Very few agreed or strongly agreed.

Figure 5.3 Percentage of CEOs of registered providers who agreed with the statement 'NDIS pricing covers the full cost of staff travelling between clients' (n=126)



Source: Employer survey (Cortis and Blaxland, 2017)

In their comments, survey respondents explained:

> Covering travel cost is a major concern as most of the clients we support live in rural remote areas. Without adequate funding to cover travel, our service may not be able to continue to provide support to clients in these areas. There are no other services in some of the areas we provide support in. (CEO of medium sized non-metropolitan organisation)

> We are [in] a rural and remote area, NDIS has no concept of what this means in relation to travel times. All adult clients are over 20 minutes away and we are the closest provider. One person who we used to provide services to the driveway was 20 minutes from an unsealed road. Travel needs to be reassessed (CEO of small non-metropolitan service)

> We are transitioning at the moment and our client base are quoted on for service provision - they are outside the NDIS benchmarks. The transition has not been smooth and it is hard to make favourable comment at this stage. We know the costs, NDIS acknowledges the costs - we do not know if they will be met. We are a charity 90% of our costs are staffing. NDIS has not allowed for client travel and transport costs in a rural setting- a major problem (CEO of medium sized non-metropolitan service)

Travel time is also a serious concern for disability support workers who explained it is a major source of unpaid work. A survey respondent explained how her payment for travel had changed under NDIS:

> I do drop in support. We used to get paid when traveling to the next client as well as our kilometres. Now we only get kilometres our days are longer with the same pay. I'm worried that our penalties will be cut as it's the penalties that make our job worthwhile.
>
> I am worried that the hours of work offered will consist of 1 to 2 or 3 hour shifts and hardly worth traveling for once you factor in travel time petrol and time wasted to get to other shifts
>
> We are also concerned that we will only be paid per the actual hours spent with clients and not for the travel in between and office time etc. Currently I may only spend 6hrs directly with clients (3 clients at 2hr each) and am paid for my whole day 9am - 5.00pm as that reflects my roster Currently I'm perm part time 26hrs/week over 4 days.

Bentham and Macdonald (2017) show that employers' treatment of travel differs, but where shifts are short, unpaid travel time is often seen to make it not worth working. Indeed, unpaid travel time between home and work for very short shifts is a key contributor to very low pay experienced by support workers:

> And it's like, I'm driving forty minutes out there for a forty-five minute job; I'm getting paid like seventeen, eighteen dollars– and that sounds really cold and callous, because it's not all about the money – but in the end, nah, doesn't make sense.' (DSW11) (Bentham and Macdonald, 2017)
>
> The shortest (shift) I do is half an hour. …I've got one this week. It's a 9:30 to 10:00 shift at night. And it's …about 25 minutes [from my home]. And it's only a half hour shift, and then 25 minutes home again. (DSW04 Bentham and Macdonald 2017)
>
> …But the hours are really hard. We've got to sort of keep ourselves open for a 13-hour day …and we only work five hours of that. (DSW19 Bentham and Macdonald 2017)
>
> …oftentimes I will have just that one shift that's half an hour away and I won't have anything for another hour or two which means that I don't get paid to go there or back, and essentially it's like the money that I get paid for the shift is covering the petrol to get there and back and it's probably like $5 left over for the actual work once you take that into account. (DSW22 Bentham and Macdonald 2017)

Case Study 2: Marlene's short shifts and unpaid travel

Marlene is a disability support worker with around ten years' experience, a Certificate IV in disability support and an additional diploma-level specialist qualification. She works for two service providers, casually in one job and as a permanent part-time worker in the other.

Marlene works extended days and weeks providing support to people in their homes. Although she usually works only 30 paid hours a week Marlene works on most days and has only one weekend off a fortnight. Due to her work being organised in multiple short shifts she has many days in which she has periods of one to two hours or more between work shifts and she spends a lot of time travelling to and from home to work for which she receives no pay.

Three days a week Marlene works for a non-profit service provider, starting around 9am and finishing 13 hours later at around 10pm. Marlene is paid only for the time she spends working directly with clients, which consists of between 4 and 6 separate shifts. Usually, these shifts amount to between 5 and 6.5 hours of paid time. In addition, Marlene usually spends about 1.5 hours each day travelling back and forth from her home to work between shifts. She travels around 100 km per day excluding her first and last trips. She is not paid for any of this travel time nor does her employer reimburse her for costs associated with the use of her own car to undertake the travel. Marlene must also complete administration for her work that is unpaid.

Unpaid work comprises a very substantial proportion of Marlene's work time. The first day of Marlene's work diary shows that she is not paid for 21% of her work time. On the second day she is not paid for 24% of her time. Marlene says she is 'tired' and feels that she doesn't 'have a life' because she is always working or waiting between shifts:

> You can't go out for dinner, you can't do this, you can't do that, cos it's time to go back to work.
>
> My ideal would be 9-5 so I could have a life, like any normal working person.
>
> (DSW19) (Bentham & Macdonald, 2017)

Time for training

Employees we interviewed also reported that time for training was squeezed under NDIS.[27] For example, one interviewee was adamant about the importance of disability support workers having some knowledge of new participants as they came to the support service and she said she read new participant files to ensure she could provide a good service. Asked if she had time to do this in

[27] This may relate to both under-accounting for employees to spend time in professional development in the pricing model, or to provide for sufficient overheads to cover it. As such, it is considered here, and also later in assessing the pricing model's assumption in relation to corporate overheads.

her job she said she was not given any time, so she did so in her own time. She also said her employer had removed access to training under NDIS:

> No. Not now. We used to, but before NDIS. Since NDIS, no. We have no training, we used to have it …, we would have a total day where no clients/customers had service that day, where all staff came in, we had training for the full day or shift, which would be some upgrading of mental health training, manual handling, clients, new client inductions so staff would have a general awareness of who a new person was coming in, and enough details to at least get past. You would have team meetings for people who have one-on-one direct support, that all their staff could get together during the week and have a chat and see what was working, what wasn't working, come up with new plans. …NDIS came in and we stopped doing that because the company assumes, designates that nobody's going to pay for me to sit around and learn. I as a worker, and I as a parent – I'm a parent of a child with a disability, I would rather have a well-trained staff than somebody who was just flying by the seat of their pants. ….. When I started with this company we had a really well-trained, committed team of people and now we have a lot of people … doing a couple of hours a week here, nothing against them, but the company's training is nothing. Literally nothing. ...It's a very grey area about training at the moment, and I think it's leading to poor service (Employee 2)

Asked if new employees received training or induction, this interviewee described:

> Well the company would say, 'Yes,' but I have yet to see anyone in the last three years have proper inductions, of any sort. …If you were to come in as a new staff member today and I put you with Justin Bieber, let's call him Justin Bieber. You've walked in at nine o'clock this morning and [we've said to you] 'you're working with Justin Bieber.' You're literally then walked around the building to [be] shown where the toilets, kitchen, staffroom is, shown where the file room is, had five seconds or a quick verbal about Justin, and then, off you go, get in the car, and have a good day with Justin. Oh, by the way, he has [difficult] behaviours. By the way, he has epilepsy. By the way, he has medication … we have people that have never had any training, and certainly no certificates, some who haven't even had lived experience that have been employed, have not been trained by this company, who are delivering medication. (Employee 1)

She described how lack of training, or inadequate training carried extremely serious risks for participant health and safety:

> We've had staff arrive at the centre with no brake on the wheelchair, which is, you stop, you're stopping to look in the window, it's mandatory you put the brake on, it's automatically a thing that you do without thinking now. But no brake on the chair, no straps on, and they've driven maybe for half an hour in that vehicle, and that's my fear that, as I said, you hit the brakes because someone cut you off or there's a red light ahead, that continues, flying through a hole with, and a lot of those people … are non-verbal, some of them are silent, so they can't even make a noise that they've been frightened or that they're choking. (Employee 2).

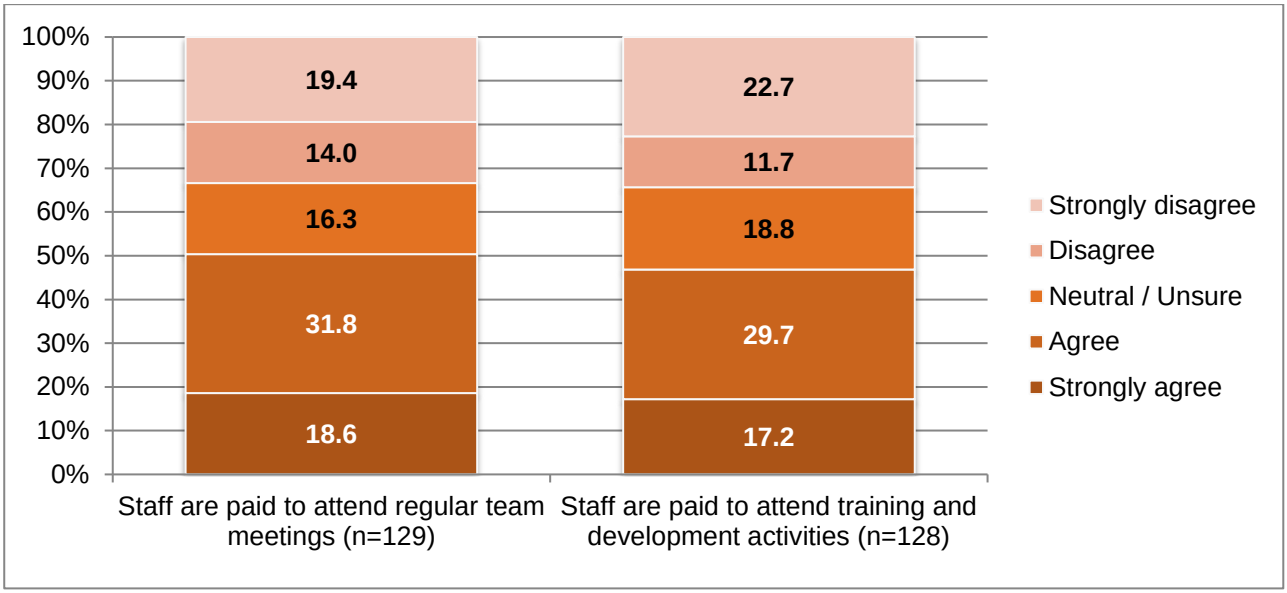
This employee explained the importance of the formal and on-the-job training she had undertaken prior to the NDIS and she described how training, along with experience working consistently with and getting to know individual clients, was important for enabling her to ensure participants' health and safety:

> So I would look at the five people that I'm putting on my bus and go, 'Well, you're sitting here sweetie where I can see you in my rear vision mirror, because you're my choking hazard,' I would look at who was sitting in the front because maybe they had some behaviours or maybe they were epileptic, and I would rather have you right next to me in the front seat of the car where I can see what's going on, or pick [a seizure] as it's coming and pull over as opposed to you're right down the back behind a wheelchair and two other people, and what's that noise, that hitting against, and oh, that's your head smashing on the window. (Employee 2)

A further account from this employee demonstrating systemic lack of training for epilepsy is included as part of Case Study 3.

Employers corroborated employees' reports that staff were not provided with adequate training with many reporting that under the NDIS support staff were not paid for their time to attend training and development. Indeed, 1 in 3 survey respondents reported that support staff delivering NDIS services were not paid to attend training and development activities (34.4%), and the same proportion (33.4%) disagreed that staff were paid to attend regular team meetings (Figure 5.4).

Figure 5.4 Percentage of CEOs of registered providers who agreed that staff are paid for meetings and training and development



Source: Survey of Employers, see Cortis and Blaxland (2017)

Case Study 3: Jessica and Michelle's training for epilepsy

Jessica was responsible for supporting a participant who had epileptic seizures. However, because of understaffing in the residential unit, she was not given training in how to administer the drugs required in the event of a seizure. At the time, high turnover, staff on sick leave and high use of casuals meant many of her co-workers were new and also untrained:

> I was started in the house in February. So for eight months, approximately seven, eight months, I didn't have Medaz training for our client who needed it. So if she had a seizure, I would have to ring an ambulance or hope that someone with Medaz training was on shift…. …. We were getting casuals coming and going… Then we had people leaving and people coming and it [training] just never happened. We had a team leader leave, we had [our new team leader] come. And it was her pushing for it that we finally got [the training]. (Employee 6)

Michelle, working in a different setting, also explained lack of training around epilepsy:

> It's not just this company, I've had friends that work in other companies and it's exactly the same in their company too. Some are still doing better training and working their training a lot better around taking small groups of staff off direct support and training them repeatedly, like that's four or five people out of 55 people, once a month, I think, they go through theirs. Which is better than nothing, don't get me wrong. But in the same sense, if you've got five people that are really well-trained in epilepsy …and then they might be working with people for the next four months that have no epilepsy training but are working with people who have epilepsy. (Employee 2)

Leave required under the SCHADS Award

The RCM assumes that 10% of workers' paid time will be taken as leave. Against this however, the NDIA has also assumed that support workers take 10 days personal leave and four weeks annual leave each year, which in total represents 11.54% of the year (i.e. 6 out of 52 weeks) (NDIA, 2017a, pp. 10-11). This does not reflect leave entitlements. Where employees work more than four hours on ten weekends a year, they are classified as shift workers, and entitled to an additional week's annual leave, which is not accounted for in the RCM's assumptions.

In addition, the NDIA assumes that 17.98% of Support Workers are eligible for 8.67 weeks of long service leave every 10 years, which represents a further 0.16 weeks of leave per annum across all Support Workers (NDIA, 2017a, pp. 10-11).[28] However, these assumptions are incorrect. Long service leave entitlements differ across Australia, with the ACT for example having a portable long service leave scheme leading to higher eligibility. There are also instances in which higher long service leave entitlements result from expired enterprise agreements which were maintained in

[28] That is, each year over a 10-year period, there would, on average, be 10% of 17.98% of Support Workers taking 8.67 weeks long service leave. That is [0.1 x 0.1798 x 8.67] = 0.16 weeks.

transition to the modern award. Thus, the assumption that 10% of workers' paid time will be taken as leave does not fully account for industrial requirements.

5.3 The level and workload of supervisors

Assumptions about supervision also contribute to the under-pricing of disability support work. Good supervision is a key element of quality service provision, but one which is poorly recognised under NDIS pricing arrangements. In Australia there have been some concerns, including prior to the NDIS, of poor skills and knowledge among disability support workers, exacerbated by poor supervision (Commonwealth Senate Community Affairs References Committee, 2015; Iacono, 2010; Mitic, 2013; Office of the Public Advocate, 2016; Parliament of Victoria, 2016). While good supervision will boost morale and staff retention, insufficient or inadequate supervision will raise quality risks and contribute to unpaid overtime (Cookson, 2013, p. 44; Gray & Muramatsu, 2013; Judd, Dorozenko, & Breen, 2017; Larsen & Hewitt, 2012).

The RCM assumes a ratio of one supervisor to 15 workers (1:15), and the NDIA's intention is that increasing the span of control to 18 workers (1:18) will be a source of efficiency which allows the price to drop. However, these ratios do not appear to be based on existing practice or any model of good practice, and do not recognise how disability support work is organised. In the employer survey, for example, a respondent stated this pricing assumption was misguided:

> The expected [supervision] ratio per staff member is 1:15 whereas we currently operate on 1:10. (CEO of medium sized metropolitan organisation)

Further, there is a strong link between the level of support workers (discussed above) and the supervision span. If all workers were employed at SACS Level 2, as per the pricing level, the span would need to be much less than 1:15. However, as Level 2.3 is assumed to be the average for support workers (with some employed at higher levels and some lower), in order to make 1:15 acceptable, supervisors would need to be employed at SACS Level 4 or higher, rather than at Level 3.2 as assumed in the RCM. The SCHADS Award stipulates that Level 3.2 staff 'supervise a limited number of lower classified employees'. The assumed level of supervisors, at Level 3.2, is below the commencement level of a graduate with a three-year degree (Level 3.3). Under the SCHADS Award a characteristic of Level 4, is that positions may involve a 'substantial component of supervision'. This would more plausibly reflect supervision spans of 1:15, than the 'limited number' stipulated at Level 3. Further, larger supervisory spans (such as the 1:18 envisaged in future) require higher levels of responsibility and employment of supervisors at higher levels, and are poorly aligned with the description of responsibilities at Level 3.2.

Empirical data shows supervisory spans of 1:15 and 1:18 are much higher than is common practice. Data from the survey of disability workers shows that among disability workers with supervisory responsibilities, 2 in 3 were supervising 8 or fewer staff (66% of supervisors). Only 16.4% of supervisors reported supervising over 14 staff, although the figure was higher for those working under NDIS (20%) compared with those who were not (12%). This is shown in Figure 5.5 and also contained in Cortis (2017).

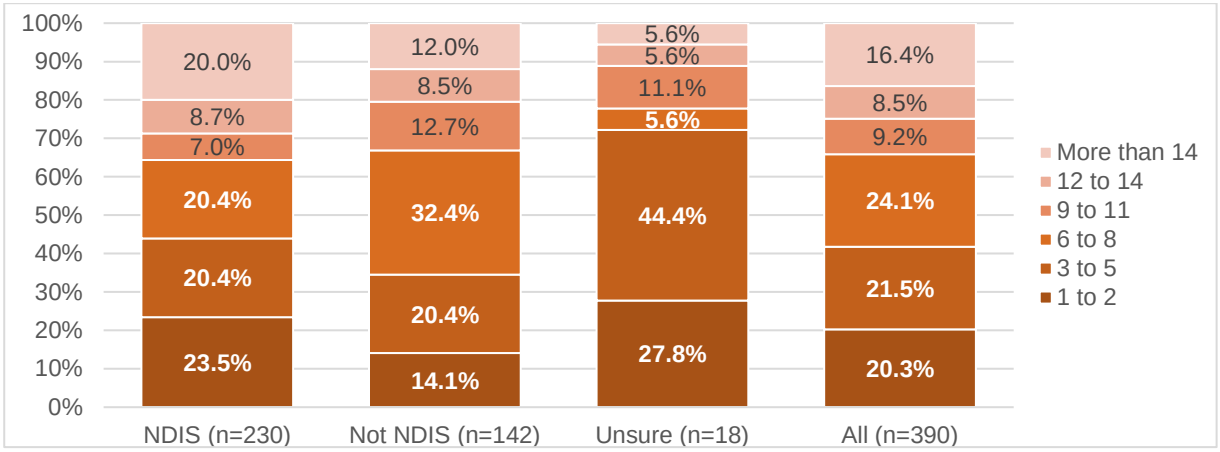
The proportion of supervisors overseeing over 14 staff was higher for workers in in-home settings and case management (each 26%) and community settings (24%), while it was low in outreach

(8%), allied health (11%) and residential/ group home settings (16%). These data are contained in Appendix F.

These data underline how the pricing model has assumed a larger supervision span than accords with the SCHADS Award classifications or than is common practice. Supervision of 15 staff as per the pricing model would entail significant (and unrealistic) change to the design of supervisory roles, and would intensify supervisory workloads for around 83% of supervisors in the survey.

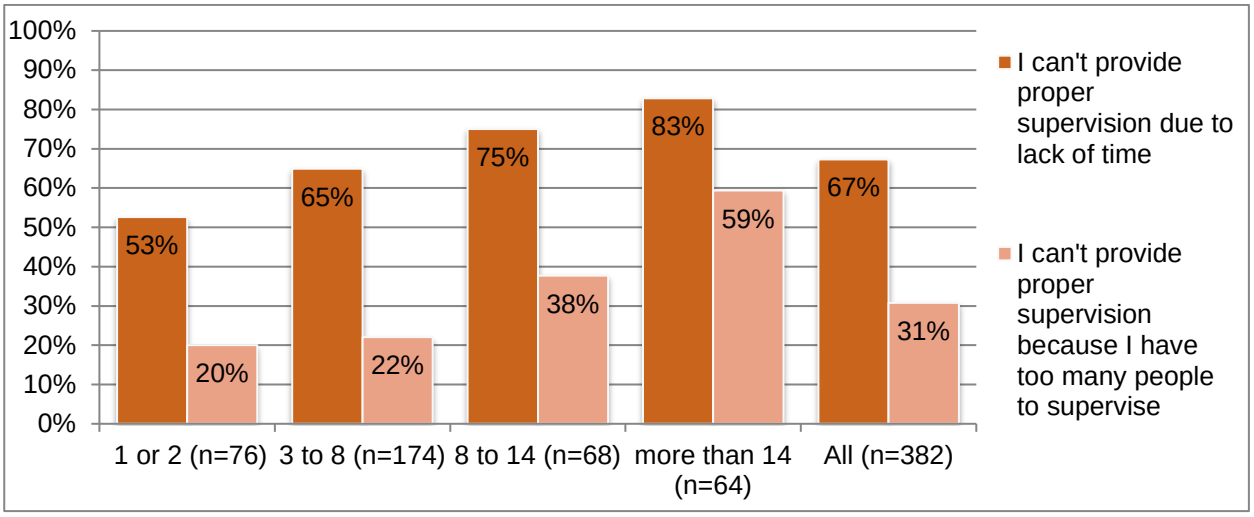
Further, supervisors with high numbers of supervisees are struggling to provide proper supervision. As the survey of disability workers showed, 83% of supervisors who supervise more than 14 staff (the level assumed in the NDIS pricing model) agree or strongly agree that they can't provide proper supervision due to lack of time, and 59% agree or strongly agree that they can't provide proper supervision because they have too many people to supervise (see Figure 5.6). This underlines how increasing the number of supervisees to levels assumed by the pricing model is predicated on poor quality supervision.

Figure 5.5 Number of staff directly supervised, by whether or not respondent was working under NDIS, supervisors (%)



Source: Survey of Disability Workers, 2017

Figure 5.6 Percentage of respondents who agreed with statements on supervision, by number of staff directly supervised



Source: Survey of Disability Workers, 2017

A respondent to the employee survey commented on the difficulties of supervision under the NDIS, and the Scheme's failure to recognise the time requirements for the type of supervision required to support choice and quality assurance:

> It appears that the NDIS has been created with a particular set of disabilities in mind, or at least as a priority, but in the case of intellectual disability there is not enough consideration given to the complexities of supporting those with complex care needs. Where participants are unable to self-manage or advocate strongly for themselves, supervisory staff are not being given the resources to properly provide choices and to collect the evidence that quality services are being delivered. What was sold as an opportunity to address the inequalities inherent in the block-funded arrangements has instead delivered a cost-cutting exercise; whether through accident or design, the lofty ideals of the NDIS are not being going to be achieved for a great many participants unless the paucity of funding to provide the best outcomes is rectified.

Loss of supervision and support for workers was identified as something that had occurred with the NDIS and was felt directly by many workers, mainly in that they—as qualified, trained and experienced workers—were relied on to support new, inexperienced casuals. For example one disability support worker who did not have formal supervisory responsibilities for other staff described needing to step in to supervise less experienced staff:

> When you're working with casuals, because you're attached to the house as a staff member, you're the most senior person there on staff so depending on what needs to be done, then you're directing staff to do that. I'm also the OH&S rep and the union delegate. So in those roles I'm supporting staff. Not so much supervising, but supporting them to make sure that we're all doing A, the same thing and we're all doing it the correct way. *Interviewer*: So how often would you have to be working with casuals? … *Interviewee*: I'd say every second shift I'm working with a casual. (Employee 1)

A broader perspective was offered by a support-co-ordinator who observed new service providers in her region were not putting resources into supervision and support and this was impacting on the quality of support for people with disability. In her own organisation she had seen training and supervision cut to an extent that she believed was having a negative impact on quality of support, particularly for one-on-one personal support. She said:

> … there's a lot of agencies that have started up in…. [and] they don't have that sort of supervision and governance with their direct care support staff. And direct care support staff can get themselves into some tricky situations I suppose around boundaries and that sort of thing. So I see that because I support other people to engage with other agencies, so I see when the problems arise. (Employee 4)

Interviews with disability support workers suggest a combination of reductions in training and support for disability support workers, increased use of inexperienced casual employees and increased supervisor workloads are creating unsustainable pressures on supervisory staff. For example, one supervisor reported that she was working at least 10 to 15 hours unpaid overtime a

week undertaking essential work such as keeping up-to-date with participants' medical needs to try to ensure a safe, good quality service and a safe workplace:

> I'm not getting any training ... So who's to say I'm doing things the right way and showing you how to do things? That worries me. That terrifies me, that I show someone, or explain something to someone, and it's completely wrong. I put someone at risk of, at best, an emotional outburst, at worst of physical violence and psychological injury, because I've told you to do things this way, or such-and-such and it's completely wrong. And that terrifies me. That eats my soul. Which is probably why I do the 10 hours extra [unpaid], making sure that I know what I'm talking about and who I'm talking about and I'm reading people's plans and I'm seeing if anything's been updated in their plans, their diagnosis, their medication. (Employee 2)

5.4 Staffing on-costs

The adequacy of provision for staffing on-costs is difficult to assess, and data was not specifically collected on this theme in the survey or interviews. It appears that the types of costs usually included as staffing on-costs, such as superannuation and workers compensation, have been included in the RCM. However, the actual amounts in the RCM (based on the calculations used in NDIA and NDS, 2014) are inevitably much less than what is necessary, because on-costs are a percentage mark-up on direct wage costs, which, as shown above, are significantly under-stated, based on the under-classification of workers and supervisors, and under-estimates of the time required to provide disability support (as detailed in 5.1, 5.2 and 5.3).

5.5 Corporate overheads

Low allowance for overhead expenses in contracts with governments (or donors) is a problem for not-for-profit financing, as it feeds a cycle of under-investment (Lecy & Searing, 2015). Lecy and Searing (2015) identify how the excessive pursuit of administrative efficiency has caused a steady, self-perpetuating practice of cost-cutting in organisations, which in turn harms not-for-profits and their service users. Reductions in overheads can cause a myriad of behaviours which are detrimental to the long run productive capacity of not-for-profits, including cutting expenses relating to personnel development. Low overheads also place organisations at risk of financial shock, and have long term consequences by depleting organisational capacity, through starving organisations of funds to invest in skilled and efficient management, and training and development. Low overheads result in burned out staff, under-maintained capital, out of date programs, and other manifestations of poor quality.

It is difficult to assess the appropriateness of NDIS prices for corporate overheads, given the diversity of providers' operational models. Indeed, Lecy and Searing (2015) caution against a simple rule of thumb for all not-for-profits, and instead show that organisations have different levels of overheads depending on their size, subsector and stage of growth. However, it is pertinent that disability service providers report that NDIS pricing arrangements do not adequately cover overheads. One CEO explained, how under NDIS, there is:

> Very little face to face time, eg for supervision, meetings and training and it is inadequate and we will have to reduce all 3. We will be cutting back on our regular 3 full training days a year. We will initially be putting people on casual now as we will be unable to determine ongoing employment. The pricing may cause viability issues for us and is a poor outcome for our staff. (CEO of medium sized metropolitan organisation)

Commonly, inadequate provision for overheads was seen to impact on employers' capacity to cover staff development and training:

> The pricing is not appropriate and for many of our participants it is not reasonable or necessary for them to live an ordinary life. The apparently arbitrary allocation of service costs at 12% or 15% does not allow for staff development or training. The NDIS is squeezing organisations and promoting casualisation of the workforce and skills atrophy of staff. It is great in theory, and I really love the concept, but the implementation and understanding by government, the NDIA Board and the NDIA staff is poor. (CEO of large metropolitan organisation)

> The pricing structure for NDIS means that opportunities for training, professional development are being called into question and how/what type of training can be delivered. Individual plans are also not covering the cost of clinical services and requisite training to staff to deliver particularly in relation to behaviour management. Also the cost of team meetings is not being covered. In many cases the plans for supported independent living do not cover even the direct support needs of people with disabilities (CEO in large non-metropolitan organisation)

> It is challenging to maintain quality and an appropriate level of L & D[29] and supervision under the NDIS. This is particularly important as we deal with quite complex cases that require this support. Also the qualifications of people who can deliver different supports has meant an entire organisation restructure and recruitment to ensure our employees can deliver the required supports…. …Also, there has been great pressure on employees to deliver NDIS work efficiently when they have to learn new systems as well as work under dual systems of current funding and NDIS funding. (CEO of small metropolitan organisation)

As discussed in Section 5.2, workers also identified the loss of paid time for training as something that had occurred with the NDIS with negative impacts on workers' ability to their jobs, and negative impacts on job satisfaction as they observed declining capacity and service quality. Workers we interviewed had experienced their organisations significantly cutting back on support for induction and training of support workers, and for supervision and team meetings. Impacts on service quality were very apparent as there were often many new support workers and many more casual and short hours' part-time workers in their services than previously. As Bentham and

[29] Learning and development

Macdonald (2017) found, workers reported their ability to deliver quality, safe support to clients was often compromised. As one stated:

> …I know one new girl who buddied up with me once, she said, '[our employer] gave me a box of gloves and said, off you go'. (DSW12, Bentham and Macdonald, 2017)

Many other workers reported having inadequate information about the people they were supporting; for example one worker said:

> … [The person was] the most complex client I have ever been sent to …there were no written notes. …I wasn't told that he self-harms, but he does self-harm. So the most crucial information wasn't provided. (DSW07, Bentham and Macdonald, 2017)

She also said that the strict routine required by one person she worked with who had high support needs required around '30 different steps in a one hour [shift]. …And I was expected to know this routine after maybe two shifts.' (DSW07, Bentham and Macdonald, 2017)

Workers said they highly valued staff meetings, as these were important opportunities for workers to share information and ideas to improve support strategies for individual clients. However, several reported that their organisations did not have meetings for support workers at all. One worker said that support staff had asked for meetings but had been told the organisation didn't have funding for staff meetings. Some workers felt so strongly that meetings were essential, they organised and conducted them in their own unpaid time:

> Usually when something arises in the team – because you put it to the office [that we should have a staff meeting], 'Oh, no, we can never find time,' or 'it doesn't allow for that in their NDIS package' or something – so we'll just meet for coffee. Probably every two-three months, or if someone new comes onto the team, we'll sort of have a get-together with coffee and sort of discuss some of the behaviours, and strategies we use and things like that …because as I said before, for a team to work, you all have to be on the same wavelength. (DSW01, Bentham and Macdonald, 2017)

Another support worker connected the lack of support and supervision she was receiving with the move to the NDIS:

> When I now say a 'team leader', look, really there is no team. They say that there's a team, we're in the complex team, …program, but we never get together. Like there's no meetings, there's no supervision. ... Previously there was just that sense of you were a part of a team, and a team that cared about those people, the clients within that team. At the moment it's so scattered that we're all fragmented, it doesn't feel like a team at all. [Previously] you run past things with people, you get other ideas. It's like, you know, a whiteboard and you've got all these different ideas coming at you and you're going, 'Oh yeah, look, I didn't think of that.' You know, like it's reflection, it's feedback, it's all those things that, [now] who are you going to talk to? I'm not going to go home and talk to my husband and say, 'Hey listen, what do you think of this?' You need that, you do, you need that sense of support around

> you as a worker. And, I don't know, I guess it's a feeling of belonging, of belonging to an organisation that really cares and nurtures and all that sort of thing. Had that before; don't have that now.' (DSW20, Bentham and Macdonald, 2017)

Some employers also pointed out how under NDIS, organisational overheads were higher, given both the need to spend time negotiating with service users, and the high costs of working with the NDIA:

> NDIS requires both of our organisation and our staff to be more flexible in terms of meeting the more frequently changing needs and demands of clients. It will also increase our administrative cost because our staff members will spend more time in negotiating with clients before they use our services and after they discharge from our services. (Human Resource Manager in large metropolitan service)

> At the moment, we still have great confusion among some of our clients and their plans. Even so, there are plans in place, they cannot always be accessed for the service we provide or the client has used up funds in one category but then has difficulties to access another part. To ring NDIA it takes often up to a hour on hold to get to talk to someone, who then in turn cannot always help with a solution. For a small organisation like us NDIS is nearly not worth the hassle. We have to pay our staff, but have delays in getting paid. We have one admin staff, who cannot spent hours trying to solve all the issues. Fees do not cover cost of the professional provider and admin cost. We find NDIS very heavy on administrative cost, which is hard to manage for a small organisation like us. We hope with time this gap will significantly reduce and make servicing NDIS clients more viable for us. (CEO of small non-metropolitan organisation)

5.6 Return on capital (margin)

An appropriate margin would allow organisations to ensure sufficient working capital and to accumulate a small reserve to meet future expenses, which can help ensure future capacity to pay staff (Calabrese, 2013). The interviews and survey data collected for this study did not specifically explore the appropriateness of the 5% allowance for a margin in the NDIS pricing model, making it difficult to assess its adequacy. However other sources suggest this may be a little low, especially for a period of transition, where providers have high costs of adjusting to new models and need to invest to expand capacity.

Some evidence of the margins achieved by registered NDIS providers comes from NDS (2016). Around 1 in 5 organisations reported no surplus in the last financial year, and 46% had a margin between -3% and +3%. Around a third (32%) reported margins which were above this level. Another source of information comes from the financial reports made to the Australian Charities and Not-for-Profits Commission (ACNC) by 14,896 charities which listed people with disabilities among their beneficiaries in 2015, the average margin (net income as a percentage of total income) was 6.3%. When limited to the 7,963 registered charities who listed people with disabilities

as a beneficiary group and were in the sectors relevant to NDIS, charities had an average margin of 5.2%.[30]

While the employer survey did not indicate the exact margins organisations needed, it shows that, under current pricing arrangements, providers are under pressure. For example:

> Under the NDIS rates we are being asked to provide the same hours of work for a lot less money (around 1/3) - something must give. … We have not accumulated surpluses…. How do you maintain safety, probity, supervision, training with such low margins- I guarantee each organisation will be cutting corners somewhere. (CEO of large non-metropolitan service)

The evidence about the adequacy of the pricing assumptions relating to margins is fairly thin and requires further research. It may appear that the pricing model allowance for margins is a little too low and that the 5% margin is likely to be unachievable by most providers in the context of underfunding of the other elements of the price.

5.7 Variation to the base rate, and other NDIS pricing issues

As discussed above, NDIS pricing is contributing to under-classification, time pressure, and unpaid work among disability support workers, primarily because of under-pricing through the base hourly rate. Less evidence is available about the adequacy of variation arrangements, such as the geographic and time of day loadings, and other aspects of NDIS pricing, although some conclusions can be drawn.

To assess the adequacy of geographic loadings in 2016-17, and the increases scheduled for 2017-2018, would require more focused research on providers' costs and practices across the full range of geographic contexts, while the time of day loadings similarly require assessment against the full range of industrial entitlements, including those in enterprise agreements.

However, the evidence does however show the loading for intensity is far too limited, as it fails to take account of the range and cost of strategies that are essential to assist participants with complex support needs, in particular the need for more senior workers and the frequent need for more than one worker to work with participants. The loading only takes (inadequate) account of additional non-client time required of workers, with a 5% reduction allowed from the proportion assumed in the base hourly rate. Under current arrangements, the higher rate of supports can be considered where assistance to manage challenging behaviour is required at least once per shift or where continual active support is required, but it is the case that some participants have more intermittent complex support needs. Case Study 4 shows how prices need to take into account that

[30] These figures come from an online analysis tool at australiancharities.acnc.gov.au, and were calculated using a subset of charities which listed people with disability among their beneficiaries and whose main activities were in the ACNC's categories of social services, health, law and advocacy, development and housing, and culture and recreation. This excluded those in the categories of education and research, environment, international, other, religion, and philanthropic intermediaries, which are unlikely to deliver NDIS services. Note that it is not clear how many of these were actually delivering NDIS, rather the figures are indicative of the margins of disability charities more broadly.

in some cases, more than one worker will be required to work with participants with complex needs, or for reasons of worker health and safety

In terms of variation for numbers of participants, prices for Group based, Community, Social and Recreational Activities assume substantial economies of scale, in that a provider is paid the base hourly rate for providing support to a single participant when providing support to 2 or 3 participants. For Centre-based Care, the same price is charged for each participant, and thus prices assume there are no economies or diseconomies of scale. For Supported Independent Living (SIL), the price per participant reduces as the number of participants increases, and thus prices assume there are economies of scale. There does not appear to be any publicly available explanation of the reasons why the NDIA made the various assumptions about the nature of the economies of scale in each of the three cases, nor why the assumptions are different in each case. As for the other variation components, further information is needed for a full assessment.

Case Study 4: Jane's experiences of under-staffing

Jane, a disability support worker described health and safety problems that placed workers and participants at risk. Due to understaffing Jane has been required to use a hoist to lift a person on her own, despite this being unsafe for her and or the person she was supporting:

> Every single person that works there has had to hoist him by themselves, one time or another because of [they are working on their own when there should be two support workers assisting the person]. …This is a very stressful situation to be in.

Lack of enough staff in the organisation has meant Jane and her colleagues work shifts when they are unwell even when there may be health risks for themselves and a risk of exposing participants with weak immune systems to illness:

> Say that a carer got sick and they rang up to say, 'We can't go to this client's house today because I'm sick,' then oftentimes, like often she's said to me, 'Well, I'll have to tell him that nobody's coming then,' because they rang everybody else and because there's so little of us if everybody else said no there's not really much you can do.' And sending us in is not a good idea because you don't want the client to get sick, so yeah…
>
> (S)ometimes we still go to work even if we really shouldn't. There's a [co-worker] that was told not to go to work for a month because she hurt her knee, and they didn't want her to be walking on it or hoisting on it or doing anything, but she still had to go to work because there's so little of us that there's nobody else to cover her shift. (DSW22)

6. Concluding discussion

This final section summarises the overall impact of inadequate prices on NDIS services and the staff employed to deliver them, and suggests some ways forward.

6.1 Summary of inadequacies in pricing arrangements

Drawing on data from disability support workers and employers, this report has shown a range of problems arising from the assumptions embedded in the RCM. Overwhelmingly, the evidence shows that NDIS prices are not covering the full costs of disability service provision or supporting quality services. Under-pricing of services is inherent in the key assumptions underpinning the NDIS pricing model.

Prices have been set with little transparency, which appears inappropriate given the Scheme's high public costs, and the significant implications prices have for provider viability and supply, workers' financial security and participants' quality of life. More transparency about all the NDIA's assumptions and decision making is required. Principles of transparent, evidence-based pricing should guide the operations of the NDIA or any independent price regulator.

Major problems with the NDIS pricing models and prices include:

- The assumed average level of workers at SACS 2.3 is acting as a cap at entry level, and does not reflect the actual profile of the level of workers. It is creating incentives to hire less qualified and less competent staff, and is limiting career paths and progression, and prospects for staff retention. Level 3 would be more appropriate.
- Pricing arrangements fail to recognise the costs of supervision. The assumed classification level of supervisors at Level 3 is low, and the supervision level and span does not align with either the assumed level of support workers who are supervised, evidence of current supervisory practices, or the classification descriptions contained in the SCHADS Award. Level 4 would be more appropriate.
- The assumed amount of non-client time involved in disability support work (5%, or 21 minutes in a 7 hour day) is inadequate. While there appears to be large variation between service types and providers, administration and co-ordination demands have increased under NDIS. Disability support workers are experiencing excessive time pressure which is unsustainable, and antithetical to supporting participants' needs in individualised ways.
- Development and co-ordination activities, such as training, peer support and team meetings are not adequately funded under current prices. As a result, there are greater risks to participants, where disability support workers are not properly trained, where supports are poorly co-ordinated, and where workers lack the capacity to provide supports in individualised ways.
- While more research is necessary to assess price variation, the variations based on intensity are inadequate. The 'discount' of non-client facing time does not adequately recognise what is required to assist clients with high support needs, such as the need for more than one support worker, or the employment of more highly skilled workers. If the costs of working with

participants with high support needs are not available under NDIS, there are real risks that providers will avoid supplying these participants. Similarly there may be other gaps in the overall supply of NDIS services and supports if the other variation factors do not fully cover the costs across the range of places and circumstances that the NDIS is supposed to serve.

Overall, the data shows how provider organisations are finding it difficult to be 'good employers' and to meet their industrial obligations and cover required pay rates and conditions. Many are reconsidering whether they are likely to be able to provide services in viable ways in the future. Further evidence of employers' difficulties covering the costs of staffing are reflected in the substantial proportion of CEOs who report that their organisation cannot provide staff with regular hours, and their low likelihood of offering an expanded number of permanent positions in the future. Reports from employees confirm that some employers are adopting workforce strategies to minimise labour costs, reducing support workers' pay and employment conditions and, in some cases, undercutting legal minima.

This context creates real risks for the future of the NDIS, and for NDIS participants. Pricing is predicated on under-classification of workers and insufficient time for workers and supervisors to do their jobs well, problems which are exacerbated for participants with more complex needs. Prices are not supporting thorough induction and training, contributing to high levels of risk. Workers are compensating for under-resourcing with unpaid work. Under these arrangements, attracting and retaining the additional disability support workers necessary to meet projected demand is unlikely. Indeed, even retaining the current workforce is a matter of concern.

6.2 Building alternatives

Any review of NDIS costs and the factors affecting Scheme design need to recognise that current prices and price setting processes are inadequate. Urgent intervention is required to develop more realistic assumptions and ensure prices are based on evidence of what is required to deliver good quality services, and the importance of a well-supported and reasonably remunerated workforce. Although prices are being indexed upwards for 2017-2018 to account for cost of living, minimum wage and ERO increases, these increases leave the underlying structure of prices intact. These arrangements are unsustainable, as the effect of under-pricing is to shift the costs of provision onto frontline staff, undermining quality support and prospects for decent jobs for support workers.

Prices are incentivising cost-cutting and creating imperatives for low quality provision. Fairer pricing arrangements would recognise that providers require access to resources which enable them to attract, train and retain high quality staff, and to employ staff in decent jobs that provide adequate hours and earnings, safe workplaces, job security, and a reasonable work-life balance. Dedicated funding for training, and a loading to cover employment of support workers above entry level, would help to provide career pathways and aid in staff retention and workforce expansion. The NDIS quality and safeguarding framework should be enhanced over time to ensure quality disability support is underpinned by a well-trained and qualified workforce, through mandating or creating incentives for minimum requirements, such as qualifications at Certificate IV level.

The NDIA has repeatedly promoted the ideal of a mature NDIS market within which competition will drive prices down. In light of the evidence showing service provision is under-priced, this vision seems unrealistic. The NDIA has stated expectations that movement to an efficient price will be

driven by reduction in corporate overheads, expanding the supervision span, and increasing staff 'utilisation' (time with clients), but has given little indication of why or how this will happen, except for generalised claims about the impact of 'competition'. These changes seem unrealistic in the context of current pressures on organisations, existing supervisory practices and the very limited amount of non-client facing time currently allowed. Any lowering of NDIS prices is likely to reduce the quality of services further below acceptable minima, and work against the achievement of NDIS objectives.

A more realistic vision, based on robust evidence of the nature of quality service provision and measures of quality, would help guide reform in ways that avoid a race to the bottom. Pricing should be informed by research about the ways disability work is performed, and the experiences of those who perform it, and recognition of the links between employment arrangements and outcomes for people with disability. Measurement of participant satisfaction and health and wellbeing outcomes which are linked to job quality measures could help assess the contribution of different employment models, and could be used to evaluate any future changes to prices, and the ongoing process of reform.

Principles of transparency in price determination are also vital to enable all stakeholders to assess the adequacy of prices in relation to the full costs of provision. As well as transparency of NDIA decision making, consideration should be given to requiring providers to report workforce information, to demonstrate the integral position of workers in the logic of implementing the NDIS and supporting participants to achieve outcomes. It could become a requirement of NDIS registration, for example, to publicly report specific workforce data, including the numbers of qualified and experienced workers, and workers employed on a permanent basis. The National Minimum Dataset for Social Care (NMDS-SC) [31] in the UK provides an excellent model for workforce monitoring, enabling time series analysis of the social care workforce as a whole over time, whilst also providing more granular information for particular areas or service types, to inform research, benchmarking and quality assurance (Hussein, 2009; Hussein & Manthorpe, 2012).

[31] See https://www.nmds-sc-online.org.uk/

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Appendix A: CPOW Working Paper 2017-1

Disability support work under the NDIS: Initial analysis of workers' experiences

Eleanor Bentham and Fiona Macdonald

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Disability support work under the NDIS: Initial analysis of workers' experiences

April 2017

CPOW Working Paper 2017-1

Centre for People, Organisation and Work, RMIT University

Melbourne, Australia

Report contents

This working paper presents preliminary findings from an initial analysis of some of the data collected for the *Day in the Life of a Care and Support Worker* research project led by Fiona Macdonald and Sara Charlesworth with Eleanor Bentham and Jenny Malone as part of three larger research projects . All three projects have received funding from the Australian Research Council: *From Margins to Mainstream: Gender Equality and Decent Work* (DP110102963), *Prospects for Quality Work and Gender Equality in Frontline Care Work* (FT120100346) and *Paid Work in Cash-for-Care: Australia in Comparative Perspective* (DE 160100543).

Overview of research and summary of findings

The research

This working paper explores some of the experiences of people employed to provide personal support and assistance to people with disability under the National Disability Insurance Scheme (NDIS). It presents a preliminary analysis of semi-structured interviews conducted in late 2016 and early 2017 with 12 Disability Support Workers (DSWs) for the *Day in the Life of a Support and Care Worker* research project. In this work in progress paper we focus on aspects of workers' experiences that are affected by NDIS funding and pricing arrangements.

Summary of findings

Workers were very positive about their roles supporting people with disability work. Nevertheless, six of the 12 workers were taking active steps to leave their jobs as disability support workers. This working paper examines what is behind this apparent contradiction, It reports on workers' experiences of disability support work under the NDIS and identifies that most of the negative aspects of work for these disability support workers are not inherent to the work but are the result of the ways in which the work is organised and the limited funding, training and support associated with their jobs. Workers experienced poor training and support, low earnings, excessive unpaid work time, and extended working days and weeks as significant negative aspects of their jobs.

The research and the research participants

The 12 disability support workers (DSWs) whose experiences are reported in this paper were among a larger group of workers who participated in two individual face-to-face semi-structured interviews with researchers in which they were asked about their jobs, and their employment and working time arrangements. In between the first and second interviews each of the research participants completed a ‘diary’ outlining their working time over three days. The analysis presented in this report is drawn primarily from the worker interviews.

Research participants were recruited for the research through advertisements in a local newspaper and also through snowballing, with some people passing on the invitation to participate in the research to their colleagues. Interviews were conducted in public locations offering privacy (e.g. in private rooms in community centres and public libraries) and with permission from participants were audio-taped.

The 12 research participants were women aged from early 20s to over 60 years. Nine of the 12 were aged over 40, most of them in their 50s or 60s. Five of the 12 DSWs were employed by two or more organisations to provide support to people with disability. Three workers held other jobs in addition to their disability support roles. Some also worked as homecare workers providing personal assistance to aged people in their homes (This work is not discussed in this analysis).

The women were employed by not-for-profit, for-profit and public sector organisations with several of these organisations providing a range of support, care and other services in addition to services provided to people with disability as part of individual support packages under the NDIS (for example home and community care to elderly people). Four workers were employed by more than one type of provider.

Almost all the disability support workers provided personal care and assistance to a number of NDIS participants, working with adults or children with physical and intellectual disability or cognitive impairment. Two provided support to people with mental health issues.

One worker was employed full-time on a fixed-term contract. Five others were permanent part-time employees (some working full-time hours) and six were casual employees, mostly working part-time hours.

Workers’ years of experience in their current roles or in similar work ranged from five months to 30 years. Most of the workers were either the main or sole breadwinner in their household or were joint earners with a partner.

Preliminary findings

Disability Support Workers' skills and responsibilities

The disability support workers reported providing support to a variety of people including some with complex support needs. Most of their work involved providing support to people in their homes; typically the workers were working on their own, or with one other worker, and often without immediate access to a team leader or supervisor. Workers spoke of having to deploy a range of skills in the course of the working day, including the following examples:

- applying knowledge across a wide spectrum of advanced practical skills, such as: knowing how to do PEG feeding[32] or safely use a hoist to lift someone; knowing how to respond when someone has an epileptic seizure; and knowing what routine or intervention will prevent someone from self-harming or keep a client with challenging behaviours happy and calm;
- monitoring and assessing participants' wellbeing and health, and taking appropriate steps to address problems, for such things as a person not eating; having unexplained bruises; or having their health deteriorate requiring action;
- responding to urgent situations, such as medical emergencies or violence;
- using interpersonal skills to lift a depressed client's mood, provide an enjoyable experience for a child, calm a distressed client with dementia, or support a terminally ill client and their grieving family;
- working with people to help them achieve their short- and long-term goals;
- managing a demanding workload under time pressure, including frequently accommodating unforeseeable events within a tight schedule;
- understanding and working in compliance with requirements of the various legal, regulatory, funding and healthcare systems applying to their roles; and
- negotiating with their employers and other health and support agencies to achieve the best for their clients.

Supporting people with disability: The positive aspect of the work

Disability support workers were overwhelmingly positive about the key aspect of their work: supporting people with disability. All the workers said they enjoyed working with people and making a difference in their lives.

> There's certainly a bit of everything in this job. That's what I love about it. …And I love that you build an attachment to people, although you're not supposed to. I

[32] PEG is an abbreviation for percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach to enable feeding directly into the stomach.

> shouldn’t say an attachment; you build a friendship. You’re not supposed to; it’s a big no-no. But that’s totally unrealistic. I mean, you’re a carer, you’re going to care. (DSW11)

> (I)t’s good to wake up every morning and think that you have the opportunity to influence somebody’s life today and that you can choose to make that a positive influence, and help someone with their goals that otherwise without you they wouldn't have been able to do. (DSW22)

> I love it. I’m really enjoying the experience, yes. I love it. …Every day’s different. …Yeah, I’m enjoying it. Because it’s still quite new, it’s different and I’m enjoying it, the difference. But yeah, all my clients are just lovely. And sometimes I go into a home and I work with a person and they’re just lovely. And I just go away thinking, oh, that was such a pleasure to do that job. (DSW04)

The difficulties of disability support work

While all 12 workers said they liked or loved their work, all also readily named aspects of their jobs they found very difficult. Workers talked about their work being physically, mentally and emotionally tiring or exhausting; and they spoke about the stress of trying to provide essential support without having enough time to do so. Some experienced verbal and physical abuse from people they supported. Many workers spoke about the stressful elements, and emotional strain of their work: some described experiencing distress working with people with degenerative diseases and about their grief when long-standing clients passed away, and others spoke of the difficulties they experienced supporting people who had limited social contact:

> …when you go into someone’s home, they may not have a support network around them. So I think it is a lot more emotional for me (than working in a group setting). Because I take on people and their worries and their problems.

> You always have them in the back of your mind. It’s that kind of industry. …It’s really hard not to think about your clients when you’re not with them. (DSW04)

The negative aspects of disability support workers’ jobs

While some of the difficult aspects workers identified were largely inherent to the work, disability support workers spoke to us about many more problems with their jobs that were not, and that multiplied the difficulties identified above. These were: inadequate training, inadequate supervision and organisational support, low pay, and working time problems associated with split shifts, unsocial working hours, extended work days and weeks, and casual conditions.

Inadequate training and support to do the job well

Despite not being explicitly asked in interviews about training and support, half of the workers raised lack of training and/or supervision and management support as serious problems, and only a few described good training and support.

Supports that workers wanted but reported not receiving included: ready access to supervisors who could be contacted in an emergency and who were familiar with the clients; regular meetings with supervisors and colleagues to develop improved support strategies for clients; timely provision of essential information about clients necessary to keep themselves and their clients safe; training and support to ensure workers' safety when working with potentially dangerous clients; supervisors and managers who would follow up on concerns about client wellbeing raised by workers; and the opportunity to gain familiarity with individual clients' needs, personalities and interests through regular consistent shifts with the same clients and on-the-job training.

Several workers contrasted their current negative experiences of work with the good-quality training and support they had received previously, either with government providers or prior to the NDIS. For example, one worker spoke highly of the training and support offered by her government employer, compared with the lack of support she received from the not-for-profit she now also worked for:

> …we have one-on-one meetings every six weeks. …They are for any grievances you might have – if your roster's too full, if you're not getting enough hours, if you want to change something around, if you have a problem with a particular client – just whatever's going on with you workwise. And we also have team meetings every four weeks, which is great, and then for an hour and a half we often have guest speakers. And we just finished a workshop on (a specialist topic), which was really interesting. And again, you can bring something up that's relevant to everybody else in the room, and we can kind of brainstorm: 'Well this is how I chose to deal with it, I don't know if that's always going to work,' …and they offer counselling services and physio services. (DSW11)

By comparison, she said of her not-for-profit employer:

> you don't have anything to do with them. …I know one new girl who buddied up with me once, she said, (the employer) gave me a box of gloves and said, off you go. (DSW11)

Many workers said that the lack of training and support meant that their ability to deliver quality, safe support to clients was compromised, or that their own health and safety was compromised. Many also reported having inadequate information about the people they were supporting; for example another woman said:

> … she was the most complex client I have ever been sent to …there were no written notes. …I wasn't told that she self-harms, but she does self-harm. So the most crucial information wasn't provided.

> This woman also said that the strict routine required by this client to manage their behaviour required '[dozens of] different steps in a one hour (shift). …And I was expected to know this routine after maybe two shifts.' (DSW07)

Workers said they highly valued staff meetings, as these were important opportunities for workers to share information and ideas to improve support strategies for individual clients. However, several reported that their organisations did not have meetings for support workers at all. One worker said that support staff had asked for meetings but had been told the organisation didn't have funding for staff meetings. Some workers felt so strongly that meetings were essential, they held them in their own unpaid time:

> Usually when something arises in the team – because you put it to the office (that we should have a staff meeting), 'Oh, no, we can never find time,' or 'it doesn't allow for that in their NDIS package' or something – so we'll just meet for coffee. Probably every two-three months, or if someone new comes onto the team, we'll sort of have a get-together with coffee and sort of discuss some of the behaviours, and strategies we use and things like that …because as I said before, for a team to work, you all have to be on the same wavelength. (DSW01)

> We did mention yesterday that we need to maybe meet out in the community sometimes once a fortnight or something like that. (We would) just organise it ourselves, because (Not-for-profit Provider) is not interested in doing it. It feels like they're just interested in getting the hours paid for, getting the numbers and getting the hours paid for. (DSW20)

A worker, employed by a large not-for-profit provider, said that team meetings were 'non-existent'. (DSW07) Another said that she had had little contact with colleagues since 'my induction, that was when I first started. And so I've barely seen people at (not-for-profit provider) after that'. (DSW04) One support worker who was working with clients who had very complex conditions connected the lack of support and supervision she was receiving with the move to the NDIS:

> when I now say a 'team leader', look, really there is no team. They say that there's a team, we're in the complex team, …program, but we never get together. Like there's no meetings, there's no supervision. ... Previously was just that sense of you were a part of a team, and a team that cared about those people, the clients within that team. At the moment it's so scattered that we're all fragmented, it doesn't feel like a team at all. (Previously) you run past things with people, you get other ideas. It's like, you know, a whiteboard and you've got all these different ideas coming at you and you're going, 'Oh yeah, look, I didn't think of that.' You know, like it's reflection, it's feedback, it's all those things that, (now) who are you going to talk to? I'm not going to go home and talk to my husband and say, 'Hey listen, what do you think of this?' You need that, you do, you need that sense of support around you as a worker. And, I don't know, I guess it's a feeling of belonging, of belonging to an organisation that really cares and nurtures and all that sort of thing. Had that before; don't have that now.' (DSW20)

One worker employed by a small organisation said that her supervisor, was ‘very hard to contact’. She went on to say:

> Yeah, so you kind of pick and choose what you ring her for, because it’s like she’s not going to answer anyway. One time …they hadn’t covered (a) shift for the night. So, there’s meant to be two people and there was only me, and I tried ringing her like x amount of times. She didn’t answer. So I started ringing the other workers, and asking if anyone can come help, because the boss isn’t answering and it’s like a normal thing for us. So that happens quite a bit. (DSW22)

One worker said that employees with her employer had expressed a desire for more training, but had not received it. She said she was willing to offer her time unpaid to receive training, including some ‘basic’ information about the organisation’s directions and the NDIS:

> I think it’d make a great difference if staff were included and …even training sessions, perhaps more refresher training sessions that could be held at the office, where there’s a big conference room there. So staff could be invited in there, I’m not saying necessarily to be paid to be there, but as a choice for them, perhaps, to go in and maybe the supervisors could say, explain to us how the systems work, how the communication moves around ..with the NDIS as well as them. And also give us the heads up about any new things that maybe going to be implemented, like different programs, give us some options too. (DSW08)

This worker also reported that her employer did not give them support to identify community activities to take clients to; the service provider was instead relying on individual workers to use their own, unpaid time to find out about suitable activities:

> If we have …a client who we’re with and we have to structure their day, (I’d like my employer to) give us some guidance as to what’s available within the community. At the moment I have to find those things out myself. And I really don’t have the time. (DSW08)

Several workers reported they had not received adequate support from supervisors when experiencing difficulties with clients. One worker said she had been verbally abused by a client and the client’s family, but had had little support from the manager. She said:

> (I)t makes me unhappy going there because I never know how he’s going to treat me when I walk in the door. I’ll be dreading going there in case his (relative) is there. (DSW22)

Another worker described how under the NDIS funding model, allocation of case management support had become less personalised, meaning that some clients with complex needs had inadequate levels of case management support:

> I find a lot of the client’s case managers are too busy and like especially since NDIS have come in, like they’re only allotted, I think it’s like an hour a week, to do everything per client. (I)f you get a difficult client an hour a week would be one phone call with some of their issues, whereas they don’t sort of see each client as

> an individual and like some of them would probably need five hours a week and some wouldn't even need that hour. So yeah they don't see them as individuals. (DSW01)

Fragmented working time: very short shifts and extended working weeks

Many workers spoke of working regular shifts of less than the two hours' minimum engagement period in the SCHADS Award, and some spoke of working shifts of less than the one hour minimum engagement for homecare workers. In addition, almost all workers complained that they had long periods of empty time between (often short) paid shifts. This fragmented working schedule resulted in workers having to work very long days, across six or seven days a week (sometimes in multiple jobs), to earn an adequate income. A significant number were underemployed, despite being available for more work and sometimes or always working extended weeks of six or seven days.

One woman reported that her shortest shift was 30 minutes and another said she had refused to 'do shifts less than 45 minutes' (DSW13). Another worker said she had regularly been working 14 one-hour shifts a week, along with 14 two-hour shifts, working from breakfast through to the bed-time shift. Others said:

> The shortest (shift) I do is half an hour. …I've got one this week. It's a 9:30 to 10:00 shift at night. And it's …about 25 minutes (from my home). And it's only a half hour shift, and then 25 minutes home again. … You're taking all day to make up three or four hours. It's quite time consuming. I don't mind the travel where a lot of people don't like the travel. But it is a big day for very little benefit, financial benefit. (DSW04)

> I can start at quarter to eight in the morning and I can finish at four o'clock at night and I only have done five hours. That's the worst part – any carer will tell you that's the worst part of this job. (DSW11)

> Yeah I love it. But the hours are really hard. We've got to sort of keep ourselves open for a 13-hour day …and we only work five hours of that. (DSW19)

Many said that they would prefer to work full days – even long days – without multiple breaks:

> I'd much rather have full days. All the days that I'm working I'd rather them all be full (DSW04)

One woman was new to direct support work and said she was prepared to accept short shifts and long days in the short term. However, she was also planning to leave this provider in search of longer shifts.

> It's a big day, and at the end of the day I could have been doing a lot more stuff than spending all that time to get an hour's work. But I'm still new, I'm still putting my foot in the water, still testing the water, and slowly I'm picking up other shifts, getting more. But even though it's only an hour it's still an hour's pay, it's still money in my pocket. And it's, I'm learning, I'm meeting people. (DSW04)

Some workers were working extended weeks or days because employers could not find other workers to take shifts. One DSW reported that she had just completed three weeks without a break, doing days that started around 8am and finished around 11 or 11:30pm, after which she sometimes had to complete notes.

We asked DSWs what their ideal working week would look like. Almost all of them said that they would prefer to work weekdays during the day, except for those who said that they wanted to work weekends because of the extra pay they received, or who said they would continue to do a single weekend or evening shift just to support a particular client.

> I would also like the weekends off because I work most weekends, the majority of the weekend, and I don't really get to socialise or see my family or my partner as much as I would like to. (DSW22)

Working time: Short notice, unpredictability and one-way flexibility

All of the DSWs said that they regularly received messages asking them to do extra shifts. It was not unusual for this to be at extremely late notice. One woman said 'I could get a ten-minute notice.' She also said this had occurred, 'In the last two months, probably about five times.' (DSW08). Another woman said that every week she had been taking two or three extra shifts at one or two days' notice to fill weekend shifts.

DSWs found it difficult to assert their rights to say no to last-minute shifts. Most of the workers reported feeling pressure to work when they didn't want to, either because they feared losing work altogether, or because they felt responsible for clients' wellbeing. Some felt their supervisors exploited their vulnerability:

> …like often (the supervisor's) said to me, 'Well, I'll have to tell (the client) that nobody's coming then…' (DSW22)

> When you cross (my employer), he punishes you by taking shifts away. …the guilt trips, especially if it's after hours, and you say no. 'Oh, but what will the client do without you? How will they cope?' …(The) guilt trips are horrific. (DSW01)

Workers often experienced flexibility to be only one-way. If a client cancelled at a day's notice workers would not get paid :

> …under our policies at (not-for-profit provider), a client can cancel the day before and not be liable for any fee. Right. But a support worker probably has to give something like six weeks' notice to get out of a shift. Because even though that shift won't be allocated probably until the day or two before, we're still told you're not allowed to do it, which is really extremely difficult to know six weeks in advance. (DSW07)

One worker said she felt angry that the NDIS system did not provide incentives for service providers or participants to consider workers' needs in relation to scheduling. She said her employer accepted that participants could change their support times for what she considered to

be trivial reasons. However the worker received no compensation for the loss or change of shift at short notice and the employer would not ask the participant to consider the worker's interests:

> (The participant) can ring, maybe I'm due there in an hour and a half, and he can ring and say 'Oh no, tell (me) to come an hour later'. I get the call 'Go an hour later'. … 'Well hang on, that's going to make me an hour later finishing'. 'Oh well this is what the client has requested and he is your client, he's on your roster. That's what we have to do'. …
>
> It's not so much the money part of it, it's the assumption being that my time is so flexible that I can change it within an hour, an hour and a half …I don't get an explanation as to why, but generally …it'll come up in conversation (with the participant): 'I was out having lunch with friends and we were having such a good time, didn't realise the time', that sort of thing. And I don't think that's terribly fair.' (DSW08)

When workers received their rosters with very little notice—a common occurrence—they found it extremely difficult to either schedule shifts for their second jobs or to plan their own lives. For example, one DSW said she usually received her roster for the week beginning Monday:

> …(i)n between Friday and Sunday; sometimes it could be 8 pm on Sunday night. It just depends what my boss is up to. …it's hard to organise anything else during the week until I know when I'm working, and I can't accept shifts with (another provider) until I know when I'm working with that agency, so to find out so late just puts everything else on hold. (DSW22)

Other workers spoke of late changes to their rosters and the expectation they would work with little notice as making it very difficult to plan their lives:

> I'm sick of making (personal health-related) appointments thinking I'm free, and then something crops up and you've got to cancel your own personal stuff to fit in with work. (DSW01)
>
> …quite often I have my medical appointments in the spaces in between and I need to maintain a regular gym routine as well because I've got (a health condition) and I find that that's the only way I can really keep on. And also for my mental health that's really my outlet. And it is quite difficult to organise it all.' (DSW07)

Fluctuating incomes and low wages

A number of workers reported that they found it difficult to plan financially, due to substantial fluctuations in the hours they were allocated. Several workers employed on a casual basis said they would prefer to have certainty of income if they could get permanent part-time work and have guaranteed minimum hours even though it would mean working for a lower hourly rate.

However, even workers employed on a permanent part-time basis were not protected from dramatic fluctuations in weekly hours and earnings; some had minimum guaranteed hours of only one or two hours' work per week. Five of the 12 workers said they worked in second jobs because of insufficient hours and pay in their main disability support work jobs. Workers' earnings also varied due to work hours being cut with very little notice.

One worker who said she was guaranteed 2.5 hours per week as a casual also said:

> I'd prefer the permanent part-time because …I need to basically know what kind of money's coming in so I can go 'Right, I can afford to pay my gas bill this week or I can afford to put some extra money on the mortgage because I know what money's coming in'. (DSW04)

Unpaid work: travel time

Like most workers, DSWs are not paid, or reimbursed, for travel time and costs between home and work. However, many DSWs providing direct support services are doing very short shifts, of as little as one hour then having to return home again:

> oftentimes I will have just that one shift that's half an hour away and I won't have anything for another hour or two which means that I don't get paid to go there or back, and essentially it's like the money that I get paid for the shift is covering the petrol to get there and back and it's probably like $5 left over for the actual work once you take that into account. (DSW22)

> The one that I was doing in (another suburb) it's half an hour drive, half an hour work, half an hour drive home. So there's an hour and a half to earn half an hour, plus costing in your petrol. (DSW04)

Most of the workers we spoke to were not paid at all for the time they spent travelling; most were merely reimbursed a per-kilometre rate for the costs they incurred using their own cars. One worker who was not reimbursed was told by her employer to claim the expense on tax. Workers described regularly travelling 20- to 45-minute journeys four or five times in a day, often to do short shifts of less than one hour up to two hours. For example, one DSW said that on several days a week, she drove four return journeys from her home to a client who lived 20 minutes away. As a result (excluding her first and last trips to/from home) she drove at least 100km each day, spending a total of one hour and 45 minutes' unpaid travel time to undertake 5-6 hours' paid work.

Another DSW said, 'I can remember one weekend with (Provider E) I did a hundred and eighty-nine kilometres' (DSW11)

The long distances workers travelled resulted in some being paid for less than half of the time they spent at work. For example, one worker said that her employer would sometimes ask her to do a 45-minute weekday evening shift that required a total of 80 minutes' driving:

> And it's like, I'm driving forty minutes out there for a forty-five minute job; I'm getting paid like seventeen, eighteen dollars– and that sounds really cold and callous, because it's not all about the money – but in the end, nah, doesn't make sense.' (DSW11)

Disability support work case study: Short shifts and unpaid travel

Marlene is a disability support worker with around ten years' experience, a Certificate IV in disability support and an additional diploma-level specialist qualification. She works for two service providers and is employed casually in one job and as a permanent part-time worker in the other.

Marlene works extended days and weeks providing support to people in their homes. Although she usually works only 30 paid hours a week Marlene works on most days and has only one weekend off a fortnight. Due to her work being organised in multiple short shifts she has many days in which she has periods of one to two hours or more between work shifts and she spends a lot of time travelling to and from home to work for which she receives no pay.

Four days a week Marlene works for one service provider, starting around 9 am and finishing 13 and a half hours later at around 10:30 pm. In her job with this employer (a not-for-profit service provider) Marlene is paid only for the five to six hours she spends with clients over four or five separate shifts. In addition to this Marlene spends about an hour and 45 minutes travelling back and forth from her home to work between shifts, travelling a total of 100 km per day excluding her first and last trips. She is not paid for any of this travel time, nor does her employer reimburse her for costs associated with the use of her own car to undertake the travel.

This unpaid travel time between shifts, along with unpaid administration work associated with her job, add up to about 8 hours over the 4 days, an additional 26% of the 30 hours' work Marlene is paid for. Marlene says she is "tired" and that she doesn't have a life because she is always working or on a break:

> You can't go out for dinner, you can't do this, you can't do that, cos it's time to go back to work.
>
> My ideal would be 9-5 so I could have a life, like any normal working person.
>
> (DSW19) (Bentham & Macdonald, 2017)

Other unpaid work

Many support workers reported spending considerable time, unpaid, at the end of the day completing notes on clients or completing required paperwork. While some workers had been told by employers they should finish ten minutes early to write up notes or to contact the supervisor with any issues or concerns, they also said this was difficult or just not possible. Some said it was clients' expectation that the worker would use the full hour supporting them. Others said it was just not possible to complete their work in less than an hour:

> Because you don't get time - like, in the perfect world, they tell you to do (the paperwork) at the end of each shift, but you don't get time, because you're running off to the (next) client. You're supposed to take off from your client, say, 10 minutes earlier and just go sit in your car and do them. But some clients you can't leave early. … Because their needs haven't been met. So you know, they allow you an hour, (leaving early could mean) maybe not, you know, giving them a proper breakfast maybe, if it's a morning. Yeah. Just not doing what you get paid to do. (DSW01)

> …it's all your own time, …you can't do a monitoring form while you're on shift. (DSW07)

Some workers said that a lack of support from their employers forced them to spend additional unpaid time to ensure that their clients received support they felt was essential:

> 'Usually with progress notes, with (provider), you just hand them in with your timesheets once a fortnight. But I don't think that's good enough. To me, if there's a concern that needs immediate help, I will ring them up as soon as I finish the shift and tell them. But then, also when I get home, I will put it in an email as well, because sometimes when you ring you get the impression that their mind's concentrating on 20 million things and sometimes you don't get a response. …And I always ask for a read receipt too, so I know when they've read it. And if they haven't got back to me within, say, half a day, I'll ring up and nag. (DSW01)

> One worker listed the tasks she had to complete in extra unpaid time at the end of a shift or week. These included: recording any extra shifts in her diary; printing up her roster; fill out a claim form for her client's travel kilometres; making notes about any issues with clients; going into the office to deliver paperwork; discussing issues regarding clients with managers; discussing new clients with managers; correcting errors in rosters; and making appointments for clients. (DSW08)

Many said that they did not claim overtime when they were kept late for some reason, because the provider's processes made it so difficult to do so. One worker said a client's informal carer was late back from work on a fairly regular basis:

> 'But I would have to ring the office and ask them for approval to stay. I simply cannot stay without their approval. And I can't leave. …(T)here is an after-hours call centre, but it is an appalling situation there. Because they use an agency so they

> screen, this after calls service screens the calls that come in and then they decide where the call has to go, whether it's going to go to a supervisor who may be doing the after-hours shift. The process that that involves, giving your name, where you are, the client you're with, and it's all done in (the city), so they don't know the areas. …That could take up to five to eight minutes.' (DSW08)
>
> One worker with a large organisation said, 'We get paid for half an hour of work to do admin kind of thing.' However, she said she usually spends an additional 40 minutes or more on top of that 30 minutes per week, despite working less than 20 hours per week. (DSW13)

Casuals can spend a considerable time sorting out problems with rosters, completing and submitting timesheets (some agencies require that they be submitted in person) and responding to requests to take or cancel shifts. 'So (from) 9:50 to 10:06, (I) answered texts about shifts' (DSW13, reading from her time-use diary)

Completing the paperwork required to be paid wages, or reimbursed for travel, could take considerable amounts of time. One worker said she regularly took around 90 minutes a week on this:

> '(M)y regular hours are printed out and then it might take me 20 minutes to half an hour to add in all my extras, all the ones that I've picked up, so I fill in a (time)sheet for them. … It could take me maybe an hour (per week) to fill in my petrol allowance travel claim form, and then I've got to drop those two bits of paperwork in at the office. …They said to me that I don't need to claim my petrol because they know what petrol I'm doing, but when I have a client, two of my clients I transport them but we do stuff together. (The administrative staff) don't know how far I've driven with (that client).' (DSW04)

Risks to clients' health and safety

Many workers expressed unhappiness with impacts on their clients' quality of care. Some reported that their providers forced working practices on them that put their clients' health and safety at risk. For example, more than one worker reported being asked to, or having to, use a hoist alone, despite regulations requiring that two workers always undertake hoisting, for the safety of both clients and workers. One reported being pressured to go to work even when ill, due to understaffing, despite the risks to clients.

Disability support work case study: Understaffing leading to health and safety risks to workers and participants

Jane, a disability support worker we interviewed, described health and safety problems that placed both workers and participants at risk. Due to understaffing Jane has been required to use a hoist to lift a person on her own, rather than with a co-worker, despite this being unsafe for her and or the person she is supporting:

> Every single person that works there has had to hoist him by themselves, one time or another because of (understaffing)…
>
> This was, she said, 'a very stressful situation to be in.'

Lack of enough staff in the organisation has meant Jane and her colleagues work shifts when they are unwell, even when there may be health risks for themselves and a risk of exposing participants with weak immune systems to illness:

> Say that a carer got sick and they rang up to say, 'We can't go to this client's house today because I'm sick,' then oftentimes, like often she's said to me, 'Well, I'll have to tell him that nobody's coming then,' because they rang everybody else and because there's so little of us if everybody else said no there's not really much you can do.' And sending us in is not a good idea because you don't want the client to get sick, so yeah…
>
> [S]ometimes we still go to work even if we really shouldn't. There's a [co-worker] that was told not to go to work for a month because she hurt her knee, and they didn't want her to be walking on it or hoisting on it or doing anything, but she still had to go to work because there's so little of us that there's nobody else to cover her shift. (DSW22)

Risks to workers' health and safety

Some workers had injuries from their work. Many others spoke of being exhausted by their work, citing long days, extended working weeks and not having full days off to rest as well as coping with the physical and emotional intensity of the work.

> I was really stressed, really stressed all the time; I was tired all the time, my back was hurting all the time, … And I was just running myself ragged. I didn't know how to say no, and these people, like I used to think, but if I don't go, maybe they can't find someone else to do it – as if they can't – like I thought I was quite indispensable. No, I didn't think that; I just thought, well I don't want to let anybody down. And so I put my own health at risk, and would do everything that was asked

> of me, and get paid peanuts, and come home buggered. Pay the bills, and off I'd go again the next day. (DSW11)

Several workers also reported musculoskeletal injuries serious enough to require treatment and surgery, which they attributed to the physical aspects of the work such as moving clients, and long hours of repetitive movement required with house cleaning, particularly vacuuming and mopping of floors. (DSW01; DSW11; DSW19)

Work/life problems

Many DSWs described the conflicts with their personal and family life, caused by the extended and unsocial hours they worked:

> I know I've got to cut back, because some fortnights you work 14 days straight, and I know, my partner's complaining as it is, we never sort of have days anymore to go do our own stuff, and the kids are complaining, 'Oh, you don't see the grandkids much or anything. (DSW1)

> I didn't have a life. Even my friends would come around and say, you're never home – no, I'm working. And I'd say, I've got Friday and Saturday off, and they'd go, all day Friday and Saturday? Oh no, well I'm working Friday night and Saturday, and they'd go, well then you haven't got it off, and it was just silly.'(DSW11)

> I've got friends … that I quite often go up and visit and I'll go up and stay the night, so it means that if I go to visit them it's a short trip up and a short trip back, because I can't stay the night because I might have a shift the next morning. And if I want to go and have a social drink with them I'm not going to have a social drink because I'm working the next morning. So, yeah, it does affect my social life a little bit.

> …most of my friends have weekends off. They work weekdays and have weekends off. (DSW04)

> '…because I work a morning shift and come home for one hour, and then go back to work for another three hours, and come home for one hour, it's like you can't really fit social things into those one hour slots in between shifts. So it's always a struggle to have a social life while working my job.' (DSW22)

Intentions to leave

Our interviews did not canvass DSWs' intentions to stay in or leave disability support work. However, a surprising number offered, unprompted, the information that they were planning to leave the industry.

None of our interviewees said that they were planning to leave because they didn't enjoy the work. On the contrary, all expressed very positive feelings about the work itself. However, as one DSW put it, while the work was great, the job itself was not.

One young worker found the stress of working unsupported in physically and emotionally difficult conditions so great, she was actively taking steps to find work in another field. Others spoke of leaving because of emotional and physical exhaustion exacerbated by excessively long days and weeks, despite only having part-time hours and part-time (low) pay::

> … apparently, there's jobs out there that you can earn money the same as what I'm earning while I'm working days and nights. (I am) applying for jobs left right and centre.' (DSW11)

> I do enjoy (disability support work), but it's more just, because of the time gap, so like today, I've got 11:30, then a gap until 3:30, then a gap from 4:30 to 8:00. (DSW13)

An additional reason for leaving offered by three workers was feeling they could not provide good-quality support under the NDIS.

Appendix B: Details of interviews

Data comes from interviews from two data collection exercises.

- 8 union member interviews

The first eight employees interviewed were among union members contacted by the unions commissioning this project who were invited to email a member of the research team if they were interested in finding out more and participating in the research. We conducted interviews with the first eight employees who emailed us and agreed to an interview. In recognition of their time we gave each interviewee a token shopping voucher to the value of $50.

The employees participating in the interviews were five direct support workers, two support co-ordinators and one support services manager. Four of them were employed by one of two government service providers and the other four were employed by not-for-profit service providers, with services including disability activity, personal support and accommodation services. All were permanent employees and worked full-time, although one was employed on a part-time basis.

All the employees are women and their ages range from early 30s to late 50s. One worker had seven years' experience working in disability services and the others all had 15 or more years' experience. Seven of the eight All of the employees had a qualification in disability services ranging from one with a Certificate III, others with Certificate IV or Diploma qualifications and two with Advanced Diplomas.

In the interviews we asked workers about their experiences working in disability services and about their experiences of any changes working under the NDIS arrangements. The interviews ranged from 40 minutes to an hour and 20 minutes in length. With participants' consent the interviews were audio-taped and transcribed by a professional transcription service.

- Data collected from Bentham and Macdonald (2017), see Appendix A: CPOW Working Paper 2017-1.

Appendix C: Interview topics

Worker background and motivation: Motivations for working in the disability sector; pathway to current role; qualifications or training; multiple job holding

Worker's current role: Usual tasks, types of service users, examples of work done in a typical day, supervisory responsibilities, any aspects of work liked and disliked, any aspects of job difficult, how this is dealt with.

Working under NDIS: How job changed under NDIS, whether employer requirements have changed, whether nature of service to client has changed. View of quality clients receive, what makes a good service, barriers to providing good service, how NDIS affects quality for clients. Perceptions of capacity to respond flexibly to client needs under NDIS, timeliness and adequacy of information and plans; expectations of worker time for work tasks, adequacy of training, time to complete case notes.

Client relationships: Number of clients, whether they are the same each week, whether time with clients is sufficient, relationships with families, and barriers to maintaining good relationships with clients and families.

Worker relationships: Regular meetings with line manager, support from co-workers, opportunities to meet with workers from other services used by clients.

Working conditions: Flexibility with rostering, de-briefs and responding to issues for clients, nature and amount of training, skill requirements in the role

Working time: Usual working hours, full-time/part-time, ongoing/fixed term/casual, suitability of schedule, whether NDIS has changed any aspect of working time, adequate breaks / rests, underemployment, long work days, fragmented working time, predictability of shifts, other work-life issues.

Pay, health and safety: Classification, hourly rate, casual loading, travel time & expenses, paid leave, super. Costs associated with work you have to meet yourself. Unpaid overtime, unpaid administrative work. Safety of work environment. Whether these have changed under NDIS.

Progression, career and aspirations: Intention to leave job and organisation, opportunities for career progression, future career plans.

What would improve employment: Anything that needs to be done to improve jobs for disability support workers, anything that needs to be done to improve service quality under NDIS.

Appendix D: 2016-17 prices of services and supports requiring disability support workers

No	Indivi-dual or group	Service Type	Intensity (Client need)	Time of Service	Number of partici-pants	Other Features of the service	Price unit	Basis of price	Price Eastern	Price Other	Price Re-mote	Price Very re-mote
									$	$	$	$
1	Indivi-dual	Self-Care Daytime	Standard	Weekday Daytime	One		Hour	RCM	42.79	43.58	51.43	53.61
2				Weekday Evening	One		Hour	RCM	46.93	47.68	56.26	58.65
3				Saturday	One		Hour	RCM	59.36	59.94	70.73	73.72
4				Sunday	One		Hour	RCM	75.96	76.28	90.01	93.83
5				Public Holiday	One		Hour	RCM	92.53	92.63	109.30	113.93
6			High	Weekday Daytime	One		Hour	RCM	45.17	46.58	54.96	57.29
7				Weekday Evening	One		Hour	RCM	49.53	50.72	59.84	62.38
8				Saturday	One		Hour	RCM	62.66	63.15	74.51	77.67
9				Sunday	One		Hour	RCM	**80.17**	**80.17**	94.60	98.61
10				Public Holiday	One		Hour	RCM	**97.68**	**97.68**	115.26	120.15
11	Indivi-dual	Self Care Overnight			One	Monitoring	Each	Quote	**Quote**	**Quote**	Quote	Quote
12					One	Sleepover	Each	Other	**186.40**	**186.40**	219.95	229.27
13			Standard		One	Active	Hour	Other	47.75	48.49	57.22	59.65
14			High		One	Active - High intensity	Hour	Other	50.42	51.54	60.82	63.4
15	Indivi-dual	Social & Community	Standard	Weekday Daytime	One		Hour	RCM	42.79	43.58	51.43	53.61
16			Standard	Weekday Evening	One		Hour	RCM	46.93	47.68	56.26	58.65
17			Standard	Saturday	One		Hour	RCM	59.36	59.94	70.73	73.72
18			Standard	Sunday	One		Hour	RCM	75.96	76.28	90.01	93.83
19			Standard	Public Holiday	One		Hour	RCM	92.53	92.63	109.30	13.93
20			High	Weekday Daytime	One		Hour	RCM	45.17	46.58	54.96	57.29

No	*Indivi-dual or group*	*Service Type*	*Intensity (Client need)*	*Time of Service*	*Number of partici-pants*	*Other Features of the service*	*Price unit*	*Basis of price*	*Price Eastern*	*Price Other*	*Price Re-mote*	*Price Very re-mote*
21				Weekday Evening	One		Hour	RCM	49.53	50.72	59.84	62.38
22				Saturday	One		Hour	RCM	62.66	63.15	74.51	77.67
23				Sunday	One		Hour	RCM	**80.17**	**80.17**	94.60	98.61
24				Public Holiday	One		Hour	RCM	**97.68**	**97.68**	115.26	120.15
25	Group	Social & Community	Standard	Weekday Daytime	Two		Hour	RCM	21.39	21.80	25.72	26.81
26				Weekday Evening	Two		Hour	RCM	23.46	23.84	28.14	29.33
27				Saturday	Two		Hour	RCM	29.68	29.98	35.38	36.87
28				Sunday	Two		Hour	RCM	37.98	38.14	45.01	46.91
29			Standard	Weekday Daytime	Three		Hour	RCM	14.27	14.53	17.15	17.87
30				Weekday Evening	Three		Hour	RCM	15.65	15.90	18.76	19.55
31				Saturday	Three		Hour	RCM	19.78	19.98	23.58	24.58
32				Sunday	Three		Hour	RCM	25.32	25.42	30.00	31.27
33			High	Weekday Daytime	Two		Hour	RCM	**28.47**	**28.47**	33.59	35.02
34				Weekday Evening	Two		Hour	RCM	**31.24**	**31.24**	36.87	38.43
35				Saturday	Two		Hour	RCM	39.51	41.05	48.43	50.49
36				Sunday	Two		Hour	RCM	50.56	54.72	64.57	67.31
37			High	Weekday Daytime	Three		Hour	RCM	**18.98**	**18.98**	22.40	23.35
38				Weekday Evening	Three		Hour	RCM	**20.83**	**20.83**	24.58	25.62
39				Saturday	Three		Hour	RCM	26.34	27.36	32.28	33.65
40				Sunday	Three		Hour	RCM	33.71	36.48	43.05	44.87
41	Group	Centre-Based Care		Weekday Daytime	>1		Hour	Other	**19.37**	**19.37**	22.85	23.82
42				Weekday Evening	>1		Hour	Other	**21.26**	**21.26**	25.08	26.15
43				Saturday	>1		Hour	Other	**28.39**	**28.39**	33.49	34.91
44				Sunday	>1		Hour	Other	**36.31**	**36.31**	42.85	44.67

No	*Indivi-dual or group*	*Service Type*	*Intensity (Client need)*	*Time of Service*	*Number of partici-pants*	*Other Features of the service*	*Price unit*	*Basis of price*	*Price Eastern*	*Price Other*	*Price Re-mote*	*Price Very re-mote*
45	Indivi-dual	Assist Daily Life			One	Live-in carer	Hour	Other	**Quote**	**Quote**	Quote	Quote
46					One	Domestic	Hour	Other	40.60	42.79	51.43	53.61
47					One	For a child	Hour	RCM	42.79	43.58	51.43	53.61
N/A					One	House/yard maintenance	Hour	Other	**42.05**	**42.05**	49.62	51.73
48					One	Cleaning +	Hour	Other	37.70	42.81	50.62	52.66
N/A					One	Linen	Each	Other	**Varies**	**Varies**	Varies	Varies
N/A					One	Meal prepn & delivery	Each	Other	**11.11**	**11.11**	13.11	13.67
49					One	Community & Social	Annual	Other	**Varies**	**Varies**	Varies	Varies
50	Group	Supported Indep. Living	Lower		Two		Week	Other	**2160.78**	**2160.78**	2549.72	2657.76
51					Three		Week	Other	**1878.94**	**1878.94**	2217.15	2311.09
52					Four		Week	Other	**1866.49**	**1866.49**	2202.46	2295.78
53					Five		Week	Other	**1814.43**	**1814.43**	2141.02	2231.74
54					Six		Week	Other	**1676.33**	**1676.33**	1978.07	2061.89
55					Seven		Week	Other	**1676.33**	**1676.33**	1978.07	2061.89
56			Standard		Two		Week	Other	**3712.61**	**3712.61**	4380.88	4566.51
57					Three		Week	Other	**3065.16**	**3065.16**	3616.89	3770.15
58					Four		Week	Other	**2374.71**	**2374.71**	2802.15	2920.89
59					Five		Week	Other	**2273.97**	**2273.97**	2683.28	2796.98
60					Six		Week	Other	**2203.78**	**2203.78**	2600.46	2710.65
61					Seven		Week	Other	**2203.78**	**2203.78**	2600.46	2710.65

No	*Indivi-dual or group*	*Service Type*	*Intensity (Client need)*	*Time of Service*	*Number of partici-pants*	*Other Features of the service*	*Price unit*	*Basis of price*	*Price Eastern*	*Price Other*	*Price Re-mote*	*Price Very re-mote*
62			High		Two		Week	Other	**4807.14**	**4807.14**	5672.43	5912.78
63					Three		Week	Other	**4163.10**	**4163.10**	4912.45	5120.61
64					Four		Week	Other	**3305.12**	**3305.12**	3900.04	4065.3
65					Five		Week	Other	**2905.56**	**2905.56**	3428.56	3573.84
66					Six		Week	Other	**2605.61**	**2605.61**	3074.63	3204.91
67					Seven		Week	Other	**2605.51**	**2605.51**	3074.63	3204.91
68	Indivi-dual	Shared Living			One	Short-term	Day	Other	**480.11**	**480.11**	566.53	590.54
69			High		One	Complex needs person	Each	Quote	**Quote**	**Quote**	Quote	Quote
70					One	With alternative family	Day	Quote	**Quote**	**Quote**	Quote	Quote

Appendix E: Other aspects of the design of NDIS prices

Other relevant aspects of the design of NDIS prices include:

- **SCHADS Award:** In general, where relevant, the NDIS Prices for the services requiring disability support workers are based on the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award). No allowance was made to cover employment on enterprise agreements (EAs) that provide better pay or conditions.
- **Indexation***:* Since the current pricing system was introduced in July 2014, prices have been regularly increased to take account of cost increases, and the implementation of the Equal Remuneration Order (ERO) relevant to disability support workers employed under the SCHADS Award. The NDIA has stated that 'it will update prices on at least an annual basis, effective 1 July each year taking account of national trends, changes in costs and wage rate.'[33] At this stage, it has not been proposed to use a specific index or weighted set of indices. Rather, the NDIA will determine the basis for indexation year-by-year, considering the consumer price index and wage price index.
- **Transitional and Efficient Prices:** The NDIA regards the basis on which it currently sets prices to be transitional. Its aim is to move to lower 'efficient prices' nationally by 2019-20, along a 'transitional glide path', before eventually moving to a situation where most prices are deregulated. The decision to use transitional prices from July 2014 was based on recognition of limitations of available data and the need for further research; and the need to ensure providers can adjust from block funding to payments made by individual participants based on prices set for each service (NDIA & NDS 2014, pp.15-17).
- **Diversity of providers:** There is much diversity between NDIS service providers, especially in relation to their structural dimensions (e.g. ownership, scale, service scope, geographical spread, longevity), their motivations, their suite of services, and their service delivery models. Thus, an important implicit factor in the design of NDIS prices concerns the assumptions that have been made about the dimensions and operations of a 'typical provider' that underpin the explicit assumptions about cost factors that are in the RCM. NDIA (2017c) specifies that at least one pricing assumption is based on 'a typical medium sized provider, employing between 40 and 100 staff'.[34]
- **Transparency of pricing:** There is no comprehensive and detailed explanation of the basis on which the NDIS prices have been constructed available in the public domain, making it difficult to identify all assumptions underlying price setting and current prices. Although much of the rationale and calculations for pricing can be pieced together from publicly available documents,

[33] https://www.ndis.gov.au/providers/pricing-and-payment

[34] This is the assumption that one manager supervises fifteen staff members. As a broad approximation, providers employing between 40 and 100 staff would be likely to have an annual turnover of $4M-$10M. The ABS define a small business as having less than 20 full-time equivalent employees, which Davidson (2015, pp. 429-430) shows is broadly consistent with the ATO definition of a small business as having a turnover of less than $2M per annum.

there is no publicly available formula that enables replication of the original base hourly rate (as shown in NDIA and NDS (2014, p. 12) or the variation factors; and there is minimal public information showing the sources of various assumptions about elements of the RCM, or the sources of prices for services not based on the RCM. A more comprehensive account may emerge from the current review of NDIS prices (NDIA, 2017a).

Appendix F: Details and supplementary data from worker survey

Notes on method

The survey of workers was developed by the HSU, ASU and United Voice, and distributed online through the networks of these unions (in all states except for SA and NT). As such, it is a non-probability based 'opt-in' sample. This approach was taken to enable a focus on members of the relevant unions, and to compare experiences and perceptions of those working under the NDIS and those who were not. As a result of the distribution method, workers newer to the industry (who are less likely to be union members) are under-represented, but it nonetheless provides important insights into the experiences of working in disability and differences in experiences and perceptions among workers in different circumstances and settings.

Table F.1 Age of respondents to employee survey

	n	%
Under 25	23	1.6
25 – 34	162	11.0
35 – 44	276	18.7
45 – 54	493	33.4
55 – 59	284	19.2
60 – 64	190	12.9
65 and over	48	3.3
Total	*1476*	*100.0*

Table F.2 Employees' state of residence

	n	%
ACT	9	0.6
NSW	546	37.0
QLD	72	4.9
TAS	174	11.8
VIC	599	40.6
WA	77	5.2
Total	1477	100

NB: Responses were not sought from NT and SA.

Table F.3 Gender of respondents to employee survey

	n	$
Female	1094	74.1
Male	380	25.7
Other	2	0.1
Total	1476	100

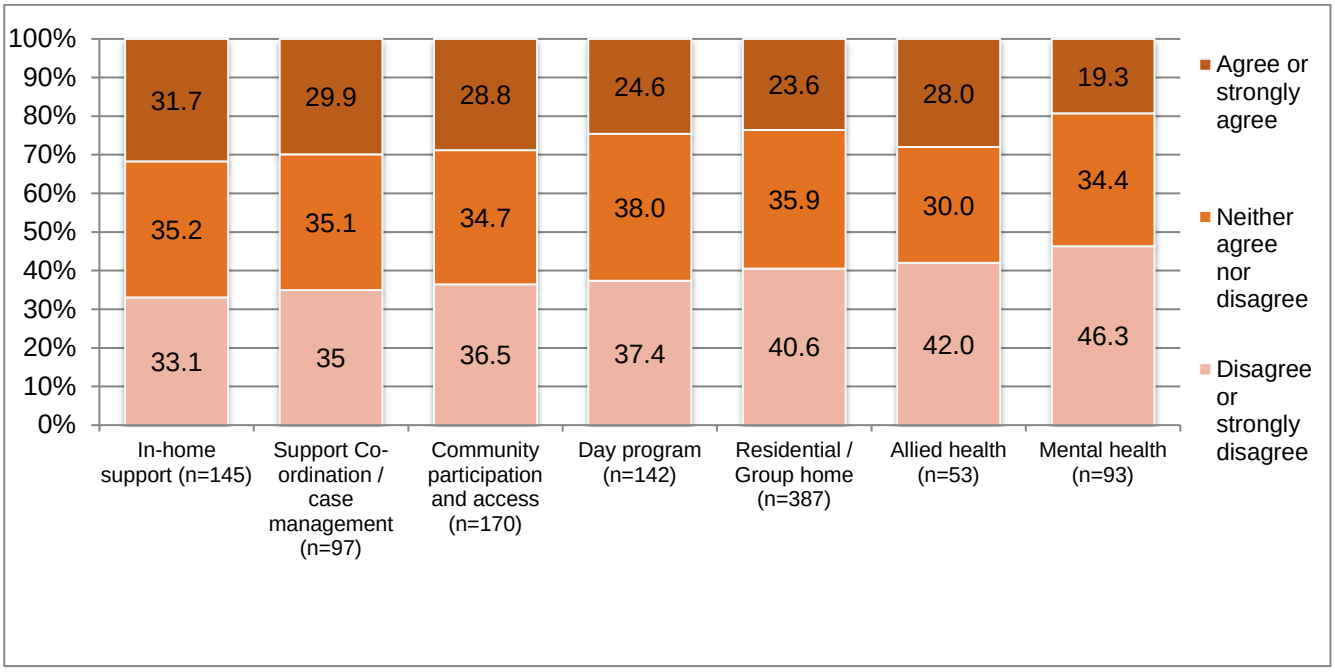
Table F.4 Years of experience working in disability

	n	%
Less than 1 year	30	2.0
1 – 2 years	77	5.2
3 – 5 years	202	13.7
6 – 10 years	369	25.0
11 – 15 years	263	17.8
16 – 20 years	204	13.8
Over 20 years	332	22.5
Total	1477	100.0

Table F.5 Proportion of supervisors supervising more than 14 subordinates, by setting

	1 or 2	3 to 8	9 to 14	More than 14
Case management (n=65)	4.6	43.1	26.2	26.2
In-home / Home care (n=43)	16.3	39.5	18.6	25.6
Community (n=78)	17.9	41	16.7	24.4
Other (n=32)	6.3	46.9	25	21.9
Employment (n=14)	21.4	42.9	14.3	21.4
Day settings (n=60)	21.7	31.7	26.7	20
Mental health (n=77)	24.7	42.9	14.3	18.2
Residential / Group home settings (n=210)	20	46.2	17.6	16.2
Allied health (n=28)	42.9	42.9	3.6	10.7
Outreach (n=13)	23.1	46.2	23.1	7.7

Figure F.1 Percentage of respondents which agreed or strongly agreed that 'The NDIS has been positive for the participants I work with', by type of service



Source: Survey of disability workers. Note that workers could nominate more than one service type.

Appendix G: Supplementary data from employer survey

Figure G.1 Percentage of respondents which agreed with the statement 'Under NDIS, the organisation can provide workers with regular hours (n=129)

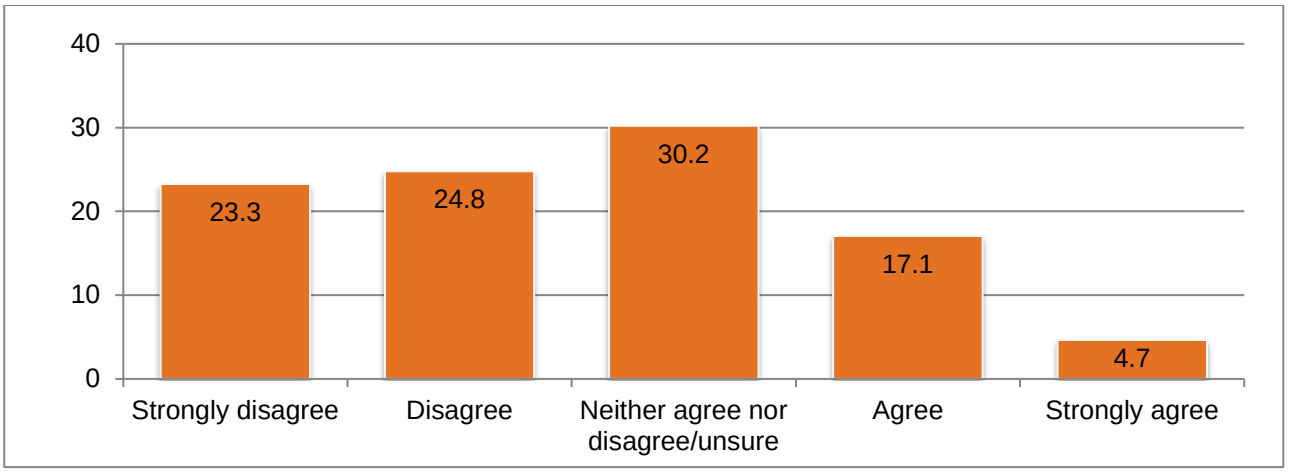
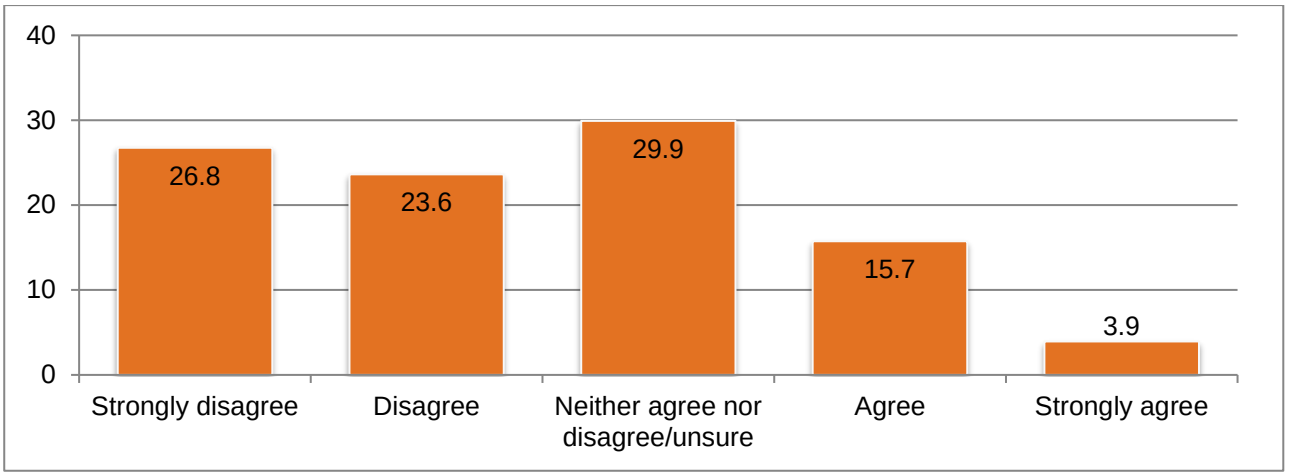


Figure G.2 Percentage of respondents which agreed with the statement 'We plan to offer more permanent employment under NDIS (n=127)



McKinsey&Company

Independent Pricing Review

NATIONAL DISABILITY INSURANCE AGENCY

Final Report | February 2018

Contents

Executive Summary

THE NDIS AND PRICING

The National Disability Insurance Scheme (NDIS) is a new way of providing support for 460,000 Australians with permanent and significant disabilities ('participants'). It represents a fundamental shift in how disability support is delivered. Under the NDIS, participants can exercise choice and control by purchasing their supports directly from providers. This means funding of disability supports will no longer take place through block funding for providers, but rather through individualised support funding for participants.

Once the NDIS reaches maturity, it is intended that the market itself will set the price of supports. However, temporary price controls are needed to ensure participants can access affordable supports, while the market is still growing. The National Disability Insurance Agency (NDIA) uses price caps on many supports and services to regulate price, but striking the right balance is challenging. If prices are set too high, this will encourage the supply of supports, but reduce the purchasing power of participants and negatively impact the sustainability of the NDIS. If prices are set too low, this could lead to a supply shortfall in the market and compromise participant outcomes.

Some providers of disability supports and other stakeholders have expressed views that current price caps are too low and are hindering market development. These issues have been raised in submissions by providers to the NDIA, as part of the NDIA FY2017/18 Price Review, as well as to the Productivity Commission as part of the review of NDIS costs.

THE INDEPENDENT PRICING REVIEW PROCESS

In June 2017, the Board of the NDIA commissioned McKinsey & Company to undertake an Independent Pricing Review (IPR) to investigate the appropriateness of the NDIA's pricing strategy and approach, and the suitability of current price levels for supports and services. The scope of the IPR was defined by the NDIA Board in the Terms of Reference (TOR):

1. Provide recommendations in relation to improved pricing effectiveness, including but not limited to:
   - National versus regional pricing
   - Pricing of services with different levels of complexity
   - Pricing of respite services
   - Thin and undersupplied markets, particularly in regional and remote areas
   - Relative provider efficiencies, including overheads
   - Adequacy of provider returns
   - Effectiveness of the Hourly Return approach used to set prices

2. Provide recommendations in relation to the potential early deregulation of price in more mature sub-markets and the glide path for the eventual deregulation of price more generally.

Over the last six months the IPR team has conducted its review, including extensive consultations with stakeholders – providers, peak bodies, the NDIA, academics, and state and territory governments. Through the provider consultation process, the IPR team engaged with over 1000 individuals across Australia through 10 open forums, 9 webinars and 45 one-on-one interviews, to understand how providers have been responding to current price settings. The IPR team also undertook detailed analyses of provider economics, market development and NDIA data. This report provides a summary of the evidence gathered by the IPR team, and 25 recommendations for changes to the NDIA's pricing approach and policies. Recommendations are grouped by the items in the Terms of Reference.

FEEDBACK FROM CONSULTATION

Key issues raised by providers and other stakeholders in submissions and during the consultation process were:

- The NDIS requires a significant change in providers' operating models and there are administrative costs associated with transition; as well as opportunities to improve the efficiency of the NDIA's systems and processes, for example, the online portal.
- Current loadings for complex participants do not fully reflect the additional costs of serving these participants, such as higher wages for a more skilled workforce, additional time required for training and reporting, and higher supervision ratios. In addition, there is no clear definition of what constitutes 'complex', and as a result the high intensity loading is applied inconsistently.
- Current travel allowances do not adequately cover the costs of provider travel and participant transport in regional areas and isolated communities.

Other issues were raised in relation to specific support types:

- In attendant care, some providers, who have historically been funded by state-administered block funding, are struggling to adjust their business models to operate under the NDIS unit-funding model and the current level of price caps. To operate profitably within the price caps requires improved levels of utilisation and overheads; and better matching of skills to participant needs.
- In therapy, the existing single price point does not reflect the diversity in therapy supports and the travel allowance is insufficient for some participants in regional areas. In addition, limiting therapists to recover the costs from a maximum of 2 hours of cancellations per year is imposing additional costs on some therapists.

Additionally, issues regarding the price setting process and the opportunity for innovative price setting were raised, including:

- The price setting process could be more transparent, and providers would appreciate earlier communication of changes to price level and/or structure to refresh service agreements and adapt operating models.

- Some providers and participants expressed the desire for the NDIA to explore outcomes-based approaches to pricing on the basis that would create better incentives to improve outcomes than the current hourly rate approach.

KEY FINDINGS AND SUPPORTING EVIDENCE

To address the issues raised by providers and other stakeholders during consultation, and to assess whether current price caps are adequate, the IPR team looked at three sources of evidence: evidence of market development/supply shortages; provider economics and operating models; and benchmarks of comparable schemes.

The key findings of the IPR are:

- While there is not yet evidence of generalised supply shortages, data on market development is mixed and there are certain markets for which undersupply is a risk in the future:
  - Across support types, provider entry and exit data suggests market growth is keeping pace with demand and utilisation data does not provide compelling evidence of supply shortages:
    - The rate of growth of month-to-month provider registration outpaced the rate of growth of participant registration throughout 2017.
    - Utilisation data from the trial sites suggests lower than expected utilisation was driven by participants being unfamiliar with the NDIS and how to use their supports, rather than a supply shortage.
  - In the attendant care market, there is not yet compelling evidence of participants being unable to access supports, but there are signals that are concerning, including a significant proportion of providers that currently have unprofitable operating models.
  - There are cohorts of participants for which supply shortages are high-risk due to the increased cost of service provision and limited availability of workforce, including those who: are in outer regional, remote or very remote areas; have complex needs; are from culturally and linguistically diverse backgrounds; are Aboriginal and Torres Strait Islander Australians; or have acute care needs such as in crisis situations.
- While some providers have operating models that are profitable at current price points, many are struggling, particularly traditional providers delivering attendant care supports:
  - In the attendant care market, there is significant variation (from <$40 to $55+ per hour) in the cost of service delivery between providers. There are examples of low cost models that are profitable at current price points, including the online platform model and lean-operating model. However, many traditional providers are struggling to operate profitably at current price points. This is attributable to a combination of factors: higher overheads; challenges in adapting to unit pricing and NDIA systems improvement opportunities; lower utilisation of workers; and higher labour costs.
  - In therapy, the single price point is working for some providers, such as physio and speech therapy providers and many sole traders. However, it is not working so well for some others, such as psychological therapy for more complex participants.

  - In Supported Independent Living (SIL), Support Coordination and Plan Management, feedback indicates that most providers can operate profitably at current price caps/benchmarks for lower complexity participants. However, the rollout of a more accurate SIL pricing process may make it more challenging for providers to cross-subsidise other supports in the future.

- Benchmarking of NDIA support price caps against comparable schemes highlighted that the NDIA price is broadly aligned with prices of accident compensation schemes, including the Transport Accident Commission and WorkSafe, although market prices for some similar aged care services are higher.

RECOMMENDATIONS

Ultimately, the test of whether the price caps set by the NDIA are adequate is whether participants can access the quality supports and services required to achieve their goals. While there is not yet evidence of widespread supply gaps occurring, the Scheme is in a state of transition and rapid growth, and the situation could change quickly. Further, the absence of supply gaps does not diminish the fact that the current price caps are challenging, and many providers are unable to operate profitably within those price caps. Providers and participants have raised concerns that where providers are unable to supply services at a given price level, new supply will not be made available quickly enough to ensure that participants have access to an adequate level of support.

To proactively manage the key risk of supply gaps, the IPR team proposes three steps for the NDIA to undertake. Firstly, the NDIA should collect and analyse a broader set of indicators of market development and participant outcomes to both better monitor the risk of supply gaps and build institutional capacity to avert supply challenges through market intervention.

Secondly, the NDIA should implement appropriate amendments to price loadings and policies, to improve the economics of efficient providers and reduce the risk of supply shortages in high-risk markets – particularly rural and remote, and highly complex participants. Those changes include:

- Adding a third tier to the complexity loading of 10%, to account for higher level of skills/experience of workers and additional training required.
- Allowing providers to charge up to 45 minutes of travel time in rural areas, and quote for services in isolated regions.
- Changing the cancellation policy to allow providers to charge participants for cancellations after 3pm on the day before the service.
- Removing the $1000 travel cap for therapy supports and aligning the travel policy with attendant care travel policy.
- Changing the therapy prices to better reflect different therapy types, and introducing a second tier of pricing for therapy assistants.
- Addressing specific NDIA systems and processes, such as portal functionality and quoting, to enable providers to reduce administrative tasks and overhead costs.

Finally, the NDIA should assess the implementation of a temporary price supplement to the attendant care price cap to address short-term issues with provider economics. The IPR team's assessment is that while generalised supply gaps have not occurred to date, there is a material risk of gaps emerging over the next year. Demand will continue to rapidly increase as new participants enter the Scheme, and many providers are struggling to operate a surplus at the price cap with their current operating model. There is a risk that profitable providers will not grow quickly enough to supply the services required. The IPR team proposes a model of Transitional Support for Overheads (TSO) in the form of a 2-3% increase in the price cap of 1:1 attendant care for the next 12 months. This would apply in addition to the normal annual indexation of the price cap. This adjustment reflects what the IPR team believes are reasonable cost improvement assumptions for most providers to achieve in the near term. The exact quantum of the TSO should be a policy decision the NDIA makes in view of other more targeted interventions government will undertake in the next 12 months to mitigate the risk of supply shortages. There should be a review in 12 months to determine whether any level of temporary support is required for a further period. The expectation is that 12 months is a reasonable timeframe for providers to make the necessary changes to their business models, and for the NDIA to assist and encourage the development of efficient and effective alternative supply options (e.g. e-marketplaces), so that the TSO would not need to be renewed.

Longer term, the development of a competitive marketplace should enable changes to the Scheme's current pricing model of price caps and fee-for-service. The IPR team's recommendations include actions that the NDIA can take to pilot and prepare for different pricing models. Firstly, the NDIA should conduct a trial of outcomes-based pricing. This is an appealing alternative to input-based pricing as it encourages providers to maximise outcomes, rather than the volume of services provided. However, it is significantly more complex and requires strong baseline data and measurement systems. A trial would provide valuable learnings on how this approach might be implemented in some supports.

Deregulation of pricing remains an appropriate goal, but there is not yet a clear path towards reaching it. To better prepare the market and the NDIS for deregulation, the IPR team proposes strengthening and monitoring provider and participant readiness, including investing in key infrastructure, such as an e-market. Trialling price deregulation in one geography or support type market will also help the NDIA collect more detailed information on the impact of deregulation on market development and participant outcomes.

IMPLICATIONS

In developing its recommendations, the IPR team has sought to address provider concerns in a way that best balances potential trade-offs between participant outcomes, market development and Scheme sustainability. The effectiveness and efficiency of pricing mechanisms and levels was considered, subject to available data. Some recommendations go directly to changing the effective price, such as Temporary Support for Overheads (TSO) and a new complexity loading for very complex participants; some target root causes of the problems, such as changes to cancellation and travel policies; and some propose stronger market monitoring and intervention capabilities. Each of these recommendation types will have different impacts on the three Scheme aspirations: better participant outcomes; a growing market with innovative supports; and a financially sustainable scheme.

In the aggregate, the IPR team estimates that the above recommendations will have a potential financial impact of ~$250-420m per annum over the next 12 to 24 months, will alleviate some of the financial pressure currently placed on some providers, and will improve participant outcomes by addressing challenges that are impacting some providers' abilities to deliver quality services. Cost estimates have been made on the best data available. However, data will remain incomplete until the Scheme becomes more mature. As a result, the IPR has made a number of assumptions leading to a wide range of estimates.

Beyond the next 24 months, the IPR team believe it is possible to implement the IPR recommendations and manage the Scheme so that it is financially sustainable and within the current budget estimates. Approximately 50% of the total cost implication of the IPR recommendations is temporary and will therefore not have an adverse impact on the Scheme's longer-term financial sustainability. Also, as the Scheme matures, the NDIA should be able to offset any financial impact of these recommendations by appropriately assessing their effectiveness and efficiency. For example, as evidence develops as to which interventions are most effective in reducing costs associated with complexity, it should be possible to reduce the number of complex participants and provider costs and prices. It should also be possible to encourage more local providers in rural and remote areas that will assist in reducing travel costs. There should also be some savings from introducing tiered therapy pricing.

1 Introduction

1.1 OVERVIEW OF THE NDIS AND NDIA

The National Disability Insurance Scheme (NDIS) is a new scheme designed to change the way supports and services are provided to Australians with significant and permanent disabilities ('participants'). By 2020, the NDIS will provide about 460,000 people with the reasonable and necessary supports they need to live an ordinary life. The NDIS is currently in the transition period, with participants entering the Scheme according to an agreed phasing plan.

The National Disability Insurance Agency (NDIA) is the statutory authority responsible for administering the NDIS. The NDIA has three external aspirations (NDIA aspirations):[1]

1. Facilitate outcomes of economic and social independence and deliver an exceptional service for participants, and their families, carers and providers ('better participant outcomes').
2. Work with participants and other stakeholders to facilitate the growth of a market of adequate size, quality and innovation ('a growing market with innovative supports').
3. Deliver a financially sustainable scheme based on insurance principles within agreed funding ('a financially sustainable Scheme').

1.2 THE ROLE OF PRICE

The NDIS represents a fundamental shift in the way disability supports are provided. Under the NDIS, people with disability will be able to exercise choice and control over the supports they receive. This way of providing supports and services requires a transition from a prior model of block funding for providers, to individualised funding for supports for participants.

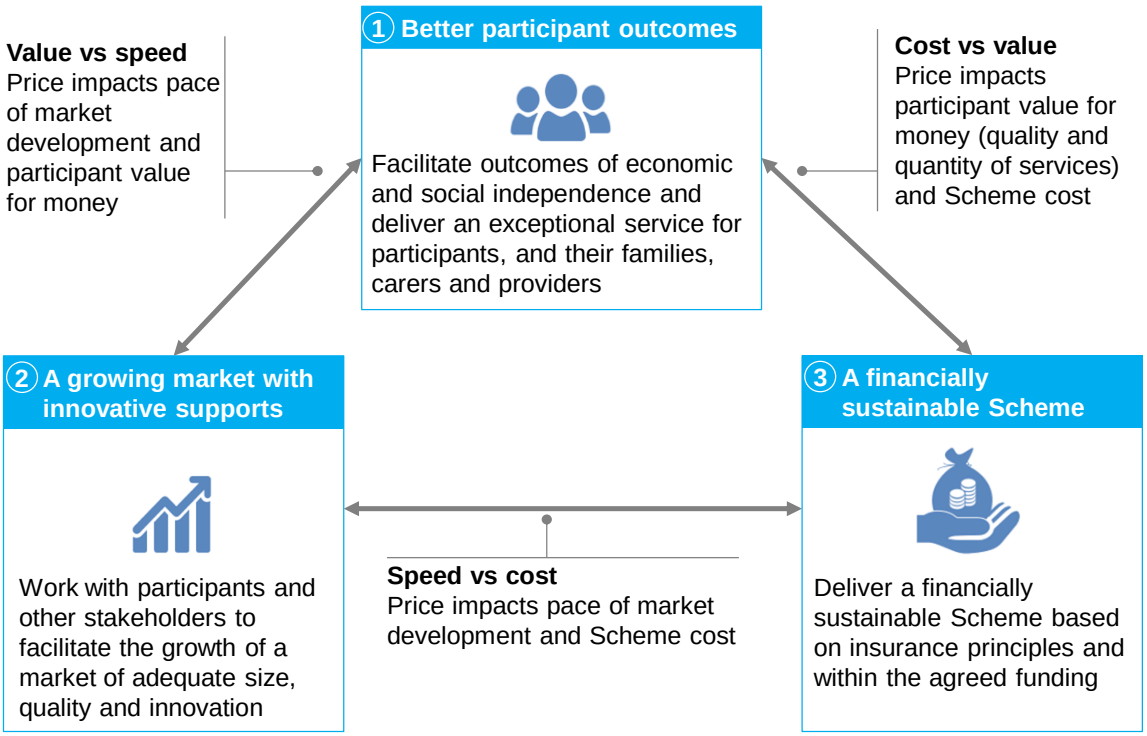
In a mature market, participants exercising choice and control will drive the price of supports, and in turn drive competition and innovation among providers. This is an important feature of the NDIS. However, where the market is not sufficiently mature and where there is an imbalance in bargaining power between participants and providers, price regulation helps ensure value for money for participants.

The NDIA sets price caps for many supports. The price of supports has implications for the NDIA aspirations, and trade-offs may be required among them (see Exhibit 1). For example, higher prices may encourage the supply of supports, but reduce the purchasing power of participants and negatively impact Scheme sustainability, whereas lower prices may increase value for money but lead to a supply shortfall in the market. Ultimately, the test of whether the price caps set by the NDIA are adequate is whether participants can access quality supports and services required to achieve their goals.

[1] NDIA: *Corporate Plan 2017-21*. The Corporate Plan outlines four aspirations for the NDIA: three 'external aspirations' and one 'internal aspiration', which is to build a high performing NDIA.

EXHIBIT 1

Impact of price on three Scheme aspirations



SOURCE: NDIS Corporate Plan 2017-21

1.3 BACKGROUND AND SCOPE OF THE IPR

Some providers of disability supports and other stakeholders have expressed concerns that some of the current price caps are constraining market development and outcomes for participants. These concerns were raised in submissions to the NDIA, as part of the NDIA FY2017/18 Price Review, as well as to the Productivity Commission as part of its review of NDIS costs. In June 2017, the Board of the NDIA commissioned McKinsey & Company to undertake an Independent Pricing Review (IPR) to understand the significance of provider concerns, and create an evidence base to inform decision making and help to mitigate the risk of future supply shortages as the NDIS transitions to full scheme. The objective of the IPR was to investigate the appropriateness of NDIA's current pricing strategy and approach, and assess the suitability of current price levels for supports and services.

The scope of the IPR was defined by the NDIA Board in the Terms of Reference:

1. Provide recommendations in relation to improved pricing effectiveness, including but not limited to:
   - National versus regional pricing
   - Pricing of services with different levels of complexity
   - Pricing of short-term accommodation (respite) services

- Thin and undersupplied markets, particularly in regional and remote areas
- Relative provider efficiencies, including overheads
- Adequacy of provider returns
- Effectiveness of the Hourly Return approach used to set prices

2. Provide recommendations in relation to the potential early deregulation of price in more mature sub-markets and the glide path for the eventual deregulation of price more generally.

Pricing of specialist disability accommodation (SDA) was excluded from the scope of the IPR on the basis that there was separate work being undertaken by the NDIA on this topic.

This report provides a summary of the evidence and findings from provider consultation and analysis conducted by the IPR team (Sections 2 and 3), and presents recommendations against each item of the IPR Terms of Reference (Section 4).

1.4 PHASES OF THE IPR

Phase 1 (Jul-Aug 2017): Review of submissions and NDIA documents and initial assessment of provider economics

The first phase of work consisted of reviewing and analysing the NDIA's market stewardship role, building a provider economics/cost model, and analysing supply challenges likely to emerge at the sub-market level. Submissions to the NDIA and the Productivity Commission were reviewed and documented, to identify priority issues for further consultation.

The IPR team also conducted analysis of comparable schemes, e.g. Accident Compensation, Aged Care, and State-funded disability – to assess NDIA prices versus other relevant sectors.

Phase 2 (Sep-Oct 2017): Provider consultation and evaluation of options

Phase 2 focussed on engaging with providers and other stakeholders. The IPR team held ten provider forums in: Adelaide (SA), Townsville (QLD), Melbourne (VIC) (2), Darwin (NT), Canberra (ACT), Sydney (NSW) (2), Newcastle (NSW) and Campbell Town (TAS), with ~800 individuals attending in total. In addition, nine online forums were held, with a total of 270 individuals joining from across Australia.

The IPR team engaged individually with 45 NDIS and aged care providers, and participated in working groups with providers, peak bodies, advisory groups, and state and territory governments. This included multiple consultations with the Independent Advisory Council (IAC) representing participants.

Though no formal written submissions were requested, many providers chose to submit supporting evidence/documentation to the IPR. In total ~20 written submissions were received from across the sector; this was in addition to the submissions made to the Productivity Commission and NDIA FY2017/18 Price Review.

Phase 3 (Oct-Nov 2017): Development of draft recommendations

The third phase of work focused on summarising findings, conducting further analysis and developing draft recommendations. The consultation phase highlighted examples of providers operating profitably at current price points, as well as examples of providers who find the current price points very challenging. Phase 3 involved collecting data on different operating models to identify features of models that are working, and key drivers of cost in models that are not. The IPR team engaged with providers to identify options for solutions that would help improve provider economics.

In considering solution options, the IPR assessed the appropriateness of options in achieving NDIA's three aspirations- better participant outcomes, a growing market with innovative supports, and a financially sustainable scheme. Implications of the recommendations were assessed, and the effectiveness and efficiency of pricing mechanisms and levels were considered, subject to available data.

Phase 4 (Dec 2017): Syndication and refinement of recommendations and preparation of final report

The final phase of the IPR involved testing of recommendations with providers and other stakeholders and preparation of the final report. The implications of recommendations were identified and quantified, where possible, in terms of impact on the three NDIA aspirations. Estimates of costs were made based on the best information available. Given a lack of appropriate data as the Scheme matures, the IPR made several assumptions to inform estimates of costs, leading to wide ranges in estimates presented in this report.

1.5 ACKNOWLEDGEMENTS

The IPR team is grateful for the cooperation of many providers and representatives of peak bodies, member groups and state and territory governments, who generously gave up their time to meet with the team and provide input to the IPR. The IPR would like to especially thank the 45 providers who met one-on-one with the IPR team and shared detailed financial information, modelling and analysis, as well as the IAC that invited the IPR to join four of its meetings.

The IPR team would also like to acknowledge the many individuals within the NDIA who shared their expertise and helped the team understand current practices related to pricing and work underway in the NDIA.

Further, the IPR team would like to thank AlphaBeta Advisors who provided support to McKinsey & Company throughout the entirety of the IPR.

2 Input from submissions and consultation

The IPR team examined input from various sources, including:

- Written submissions to the Productivity Commission report on NDIS Costs; the NDIA FY2017/18 Price Review; and the IPR team.
- Face-to-face consultation with providers to the NDIS; providers in adjacent sectors such as aged care; peak bodies including the Independent Advisory Council (IAC) representing participants; state and territory governments; and academics.

Provider submissions to the Productivity Commission report on NDIS Costs and the NDIA FY2017/18 Price Review had different areas of focus. The Productivity Commission sought responses on pricing with a holistic view of the disability market, whereas the NDIA FY2017/18 Price Review sought responses focused on specific modelling assumptions detailed in the *2017 Price Review – Discussion Paper*.

The objective of consultation undertaken through the IPR was to identify a comprehensive list of issues and challenges faced by providers that the IPR team could test for significance and impact on the NDIA aspirations: improving participant outcomes, growing a market with innovative supports, and a financially sustainable scheme. To do this, the IPR team consulted with over 1000 provider representatives through provider forums; and consulted individually with 45 providers that are broadly representative of the disability market, including providers across NDIS support types, large and small providers, providers with new service models, providers delivering services in regional and remote areas, and new entrants with potential to scale in size.

This section of the report records the challenges and opportunities raised by stakeholders – as was committed to do during consultation, prior to testing their significance on the NDIA aspirations. Actions being taken to address some of these challenges, as advised by the NDIA, are also recorded. Section 3, *Key findings and supporting evidence*, details evidence the IPR team sought to test, challenge and validate opportunities, including those raised by providers, that are within the scope of the TOR. Section 4, *Recommendations*, outlines the IPR team's recommendations to address the challenges and opportunities raised by providers and other stakeholders, underpinned by further analysis and data to support how these recommendations assist the NDIA in achieving its three aspirations.

The IPR team recognises that not all challenges and opportunities raised by providers are specifically within the scope outlined in the TOR. However, where these challenges are likely to have a flow on impact on provider economics, they have been noted below. Other challenges that are less likely to impact on provider economics, but could assist the NDIA to improve participant outcomes, will be raised separately with the NDIA.

Feedback received during consultation can be summarised into four areas:

- Increasing price loadings to adequately cover the cost of service delivery for rural and remote geographies, participant cohorts, and support types (see Section 2.1 below).
- Reducing the cost of administration for providers by improving the NDIA's provider-facing systems and processes (see Section 2.2).

- Increasing the emphasis on policies that support the development and growth of the market, including a greater focus on participant outcomes (see Section 2.3).
- Improving aspects of participant planning quality and consistency that would assist provider economics as well as participant outcomes (see Section 2.4).

While discussions with providers centred around challenges they are facing, most expressed their strong support for the reforms and objectives of the NDIS, and aspirations of the NDIA, as well as the positive work underway by the NDIA to achieve these aspirations and address provider challenges. Several providers were also excited about their success in developing new business models that could work successfully in helping participants achieve their objectives, and improve their outcomes, in a financially sustainable way.

The remainder of this section summarises provider and other stakeholder feedback on the following topics:

- 2.1 Provider economics
- 2.2 NDIA processes and systems
- 2.3 Market growth and development
- 2.4 Planning process.

2.1 PROVIDER ECONOMICS

Many providers raised challenges with the assumptions included in the NDIA's *2017 Price review – Discussion Paper*, which detailed the input assumptions to be used by the NDIA to model the price of attendant care (a combined category comprising Assistance with Daily Living and Assistance with Social and Community Participation). In Section 3 – *Key findings and supporting evidence*, the IPR team tests these challenges by benchmarking against other schemes, and examining effective models that are working in the market, as well as those that are not working.

These providers considered that the NDIA should continue to refine the following assumptions:

- The wage assumption. The NDIA assumes that the disability support worker will be employed at a level 2.3 under the Social, Community, Home Care and Disability Services Industry Award (SCHADS Award). Some providers believe the assumption is low and does not allow for career progression. Other providers commented that they pay higher wages due to Enterprise Bargaining Agreements (EBA) or a more mature workforce. By way of contrast, some providers commented that they are successfully operating in a consistent way with the wage assumption, utilising different mixes of part-time/full-time employee models, casual employment and accessing new talent pools.
- The utilisation assumption for support workers. The NDIA assumes a utilisation level of 95% for disability support workers. Some providers believe this level of utilisation is difficult to achieve. Some providers that consulted with the IPR reported that 80-85% utilisation of direct support staff is typical. By way of contrast, some are achieving 95% to 100% utilisation.

- The utilisation assumptions for supervisors. The NDIA assumes a 1/15 supervision ratio, and a utilisation level of 95% for supervisors. Some providers believe this level of supervision is difficult to achieve, and that it does not allow sufficient time to undertake quality/compliance requirements and support worker management. Others are finding that they do not require the level of supervision of 1/15 to offer quality support to the participants they serve.
- The overhead assumption. The NDIA assumes an overhead level of 10%, which equates to 15% if a provider is not subject to payroll tax. Some providers are finding it difficult to achieve this level of overheads, particularly those with higher expenditure on training, reporting and participant engagement during transition. While the Department of Social Services (DSS) and states and territories have provided funding to support transition, some providers claim this is insufficient – given that the participant-driven service model requires most providers to make new investments in areas such as training, IT, marketing, and recruiting. Further, some providers noted that NDIS processes contribute to higher overheads, e.g. through lost administration time associated with information and communication technology (ICT) challenges. By way of contrast, some providers reported that they are currently able to achieve an overhead level of 10%.

Providers also raised issues related to the higher cost of service provision for certain cohorts of participants. This includes participants living in remote areas, with complex needs, and those requiring Assistive Technology (AT). More specifically, they considered that the NDIA should consider the following:

- Remote loadings are not sufficient for some remote areas where there are high costs-to-serve due to factors including extra travel time, lack of infrastructure and facilities, and the cost of deploying/housing a workforce. In some cases, such as for communities in the Northern Territory, air travel and overnight accommodation is necessary to reach participants, and this cannot be claimed from the NDIA.
- Travel is also a concern in some regional areas, as providers are not being fully remunerated for travel in all circumstances.
- The differentiation in price levels for support workers serving participants with complex needs is not sufficient to cover the costs of a higher skilled worker with increased qualifications or experience, which some providers believe are required to provide high quality support to these participants. Some providers expressed a view that the current price could discourage providers, both existing and new entrants, from serving participants with complex needs and instead focus on those that can be served with a lower cost support model.

The NDIA has recently announced the development of an independent provider benchmarking function to generate important strategic information both for providers and the NDIA. The initiative seeks to collate and share market knowledge on the cost structures and pricing of providers. Participating providers will receive information that enables them to understand how they are performing relative to their peers, and where there are specific opportunities for organisational improvement. The data generated by the project will be at an aggregate and anonymised level, and will provide government with a clearer sense of what is happening in the sector, and where intervention by the NDIA may be necessary.

2.2 NDIA PROCESSES AND SYSTEMS

Providers raised challenges relating to additional overhead costs associated with operating in the NDIS, which they believe are partly attributable to NDIA processes and systems. Opportunities identified by providers for the NDIA to improve system and processes include:

- Reducing the administrative load when providers interact with the NDIS, including the one-time costs associated with pre-planning and quoting (where applicable) when a participant enters the NDIS, and ongoing administration such as billing, invoicing, and reporting. For example:
  - Improve the functionality and efficiency of the Provider Portal, as they consider errors are still occurring and can be time consuming to resolve.
  - Increase the speed at which SIL quotes can be created and processed. Some providers commented that they have submitted reports between 100-200 pages in length as part of the additional information they consider is required for 'above benchmark' SIL quotes, while other providers reported that they have waited up to 3 months to receive a response from the NDIA on SIL quote outcomes.
  - The quoting process for Assistive Technology and home modifications can disadvantage the provider developing the initial quote, as they are required to spend more time and effort to develop a quote together with a participant, typically in-home, and often an assessor, usually an occupational therapist. As the NDIA requires at least 3 quotes, additional providers are sent the initial quote to develop their own quote in isolation from the participant and assessor. This advantages subsequent providers by giving them the opportunity to undercut the initial quote due to the reduced cost of quote development.
- Improving the clarity and consistency in communication of policies to providers. Some providers commented that they spend significant amounts of time contacting the NDIA, and become frustrated with the inconsistency of responses from NDIA staff. Others commented that they're increasingly satisfied with NDIA staff responses.
- Increasing the transparency of the price setting process, and the timeliness of communications relating to price changes, to allow providers sufficient time to update service agreements prior to pricing changes coming into effect.

The NDIA has advised the IPR team that they have made several improvements in the design and functionality of the Provider Portal in the last 12-18 months in response to feedback from providers. However, the NDIA also recognises there are opportunities to further improve functionality and provider experience, and will continue focusing on this as part of its ongoing work. The NDIA also has two projects underway to address the challenges providers are facing relating to SIL: the SIL Tool project, and the SIL Redesign project. Data from the NDIA shows the SIL Tool has reduced the processing time for SIL quotes by up to 50%, however additional improvements will be required for the NDIA to achieve its target of a 14-day turnaround time.

2.3 MARKET GROWTH AND DEVELOPMENT

Providers raised issues about price levels inhibiting the growth and development of a skilled workforce. Some providers believe there is a risk of supply shortage as demand increases towards Full Scheme, and there are anecdotal reports that some providers are choosing to reduce their services or not grow beyond their existing service levels due to pricing constraints. Some providers believe there is also potential that new participants and participants with complex needs could have difficulty finding a service provider if the market is not growing at the necessary rate to meet demand. At the same time, these providers recognise there are also new providers entering the market and some other existing providers are expanding their services. Providers suggested:

- Setting prices at a point that allows providers to attract and retain a more skilled workforce to care for participants with complex needs. Some providers serving participants without complex needs also raised this as an issue, as they are having difficulty attracting highly skilled workers necessary for some categories of service.
- Explicitly allowing a provision for training, as some providers believe the utilisation assumption used in modelling is not sufficient to cover enough time for training, in addition to other non-client facing activities such as incident management, administration and reporting. This issue is more pronounced for providers serving participants with complex needs.
- Developing market infrastructure to increase the ability for the market to grow. For example, there is no functioning e-market, and participants vary in their abilities to exercise choice and control.

Some participants and providers suggest that the hourly rate approach to pricing does not provide sufficient incentives to improve outcomes and consistent adherence to insurance principles. Specifically, they requested the NDIA to consider the following:

- An approach to pricing consistent with an outcome focus. Prices are currently focused on units of care in hours. The IAC and some providers would like to see an incentive in the pricing structure for providers to reduce a participant's support needs over time. While the focus on units of care helps to ensure participants receive a defined number of service hours, it can also inhibit innovation by limiting flexibility in how participant packages can be spent.
- A more consistent adherence to insurance principles that focuses on early investment to reduce participant needs over time and reduce their lifetime cost to the NDIS. Participant plans should be looked at more holistically to understand how a greater investment in capital supports such as Assistive Technology and home modifications could reduce the need for other supports. Looking at capital supports in combination with opportunities to reduce other supports, and focusing on quality as well as price could improve outcomes for participants, as well as assist the sustainability of the NDIS.

The NDIA has advised the IPR team that it has identified initiatives to expand its monitoring and support of market development. It is developing a market assessment framework, which seeks to bring together disparate data sources and metrics into a coherent assessment process. It is also investing in a benchmarking function to share market knowledge and identify opportunities for providers to improve their businesses. The NDIA is also focused on

increasing its understanding of how the NDIS is affecting participant outcomes through regular surveys and participant consultation. For example, the Short-form Outcomes Framework questionnaire has helped the NDIA build a baseline understanding of participant outcomes during the NDIS transition period.

2.4 PLANNING PROCESS

The planning process is not formally within the scope of the IPR, as defined in the TOR. During consultation, issues were raised by providers about how the quality and consistency of plans could be improved to positively impact both participant outcomes and provider economics, both initial plans and plan reviews:

- Improving the planning process to support NDIA planners and Local Area Coordinators (LACs) to consistently capture all the needs of a participant to deliver quality plans for participants. This can reduce the time and resources providers invest to help some participants rectify issues with their plans such as correcting plan errors and submitting additional documentation to justify the need for additional funding in participant budgets. It can also help reduce the time providers spend educating participants and their families on how to engage with the NDIA and LACs, including how to utilise their plans with providers. These improvements will benefit participant outcomes by ensuring they have sufficient funds for specific functions. It is recognised by providers that there will always be more opportunities to improve plans, and the role of the NDIA is to improve the capabilities of its planners over time in identifying and planning for all needs of participants and how to improve outcomes.
- Improving the consistency in timing and communications for plan reviews, to make sure providers are aware reviews are taking place. This would help providers understand when they may need to update service agreements with participants, and alert them to when there could be service continuity issues if there are changes to a participant's funding allocation across different supports.

The NDIA has advised the IPR team that significant improvements are underway to the planning process to address many of the challenges raised by providers, and are currently being implemented as part of the Participant and Provider Pathways Review. Piloting has commenced in Victoria in December 2017, with improvements including:

- A significantly re-designed planning process to make it easier for participants to see how their goals have been recorded and linked to community, other government services and funded supports.
- Face-to-face planning meetings with an LAC, an NDIA planner and a participant to improve plan quality and educate participants and their families on how to utilise participant packages.
- Participants being able to see a working version of their plan as it is developed and the opportunity to ask questions and provide feedback during the planning meeting, to allow for any queries to be discussed and addressed before the plan is finalised.
- The use of simple language to improve communication.

Some providers argue that the challenges described in this section are having an impact on their abilities to operate at a sufficient surplus in the sector. In Section 3 – *Key findings and supporting evidence*, and Section 4 – *Recommendations*, the IPR team has worked with the providers, the NDIA and other stakeholders to explore the challenges raised by providers that are within the scope of the TOR, to provide a sufficient evidence base to justify the need for action, and propose recommendations relating to pricing that can be adopted by the NDIA to address these challenges.

3 Key findings and supporting evidence

To address the issues raised by providers and other stakeholders during consultation, and to assess whether current price caps are adequate, the IPR team looked at three sources of evidence:

- **3.1. Evidence of market development and shortages in supply,** including analysis of the available market data such as utilisation rates, rates of market entry and exit, and market surveys.
- **3.2 Provider economics and models,** including detailed bottom-up analysis of providers' costs-to-serve and comparison with the hourly rate model.
- **3.3 Benchmarks from other schemes,** including comparison of NDIS prices to state accident compensation schemes and the Commonwealth's aged care and veterans' support programs.

3.1 MARKET DEVELOPMENT

Close to 11,000 service providers have been approved to cater to participants in the NDIS, with approximately 5,000 service providers already active in supplying support services.[2] Many of these service providers are small suppliers, with 60% of active providers catering to fewer than 10 clients each. The larger providers account for most of the Scheme expenditure to date. Approximately 70% of NDIS payments have been to providers which cater to 100 or more participants each.[3]

The IPR team recognises that the provider market landscape is likely to change significantly in response to providers shifting to a new consumer-driven, unit funded environment. For example, the current provider landscape for in-home attendant care, a significant support type in the Scheme, is dominated by not-for-profits and medium to large providers.[4] Going forward, new providers, many of whom are likely to be for-profit organisations, and could leverage technology innovatively, are expected to enter the market, having identified a profitable niche or operating model. Some existing providers will exit the support category because they cannot adjust to this new market landscape, while providers who successfully adjust their operating models are likely to expand to meet demand. It is unclear how quickly this market adjustment and new provider entry will occur. A dynamic and responsive approach to monitoring the market will be critical to ensuring there is sufficient and quality supply to allow participants to continue to receive safe and quality supports.

The key test of whether current prices are adequate is whether participants can access the quality supports and services needed to achieve their goals, as defined and funded in their

[2] National Insurance Disability Agency: *National Insurance Disability Scheme COAG Disability Reform Council Quarterly Report* (30 September 2017).

[3] Analysis based on NDIS payment data.

[4] Not-for-profits consist of 62% of the disability sector, while 88% of in-home attendant care service volume in 2016-17 was delivered by medium to large providers.

plans. Market data on participant and provider behaviour and intent offers the most direct evidence of whether current prices are consistent with this test. Analysis of provider entry and exit rates, utilisation rates, and participant outcomes reveals a market that is, to date, providing the supply required to match demand. However, this evidence is not unequivocal. Gaps in the available data and the volatility of a transitional and rapidly growing market mean that this data does not yet provide certainty as to whether participants will be able to continue to access the supports they need into the future.

The remainder of this section examines the available data sources on market development:

Provider entry and exit data

Provider entry and exit data offer evidence of a market that is growing to meet demand. The number of registered providers more than doubled in FY16/17. The rate of growth of quarter-to-quarter provider registration has outpaced the rate of growth of participant registration throughout 2017. In the latest quarter, provider registrations grew by 21%, with a total of 10,507 providers currently registered in the Scheme.[5]

In the trial regions, less than 15% of providers decreased or ceased supply during the trial, whereas 30% of providers increased supply or entered after the trial began (FY13/14 to FY15/16).[6] The existence of some provider exits is also not in itself an indication of inappropriate prices. It is to be expected that as providers adjust to the NDIS, some will be unable to make enough changes to their business models and operations to supply services at an efficient price, while others will choose to specialise in some supports but exit other supports. It is also important to recognise that providers may have been willing to invest in the trial to test whether they could develop an effective model, so limited exits during trial may also not be predictive of future provider behaviour.

Participant utilisation data

Another key data point – utilisation – also does not provide compelling evidence of supply shortages. The utilisation rate is the share of a participant's budgeted supports that has been used. The average utilisation rate across the Scheme in FY16/17 was 66%, which is well below the expected utilisation of the Scheme at maturity of 85-95%.[7] However, the available evidence suggests that it is more likely caused by participants being unfamiliar with the Scheme and how to use their supports, rather than a supply shortage. In the trial sites, the average utilisation rate also started low, at 64%, but increased to 75% in the final year, reaching 80% in some sites. This change occurred without a reduction in the average size of plans, discounting the possibility that individual plans simply became more restrictive, despite the number of participants increasing as the trial progressed. Evidence from transition also indicates that the utilisation rate increases as participants spend more time in the Scheme and move onto their second and subsequent plans. The share of participants with high utilisation rates (>75%) almost doubles from first to subsequent plans. There is little participant survey

[5] National Insurance Disability Agency: *National Insurance Disability Scheme COAG Disability Reform Council Quarterly Report* (30 September 2017).

[6] Analysis based on NDIS payment data.

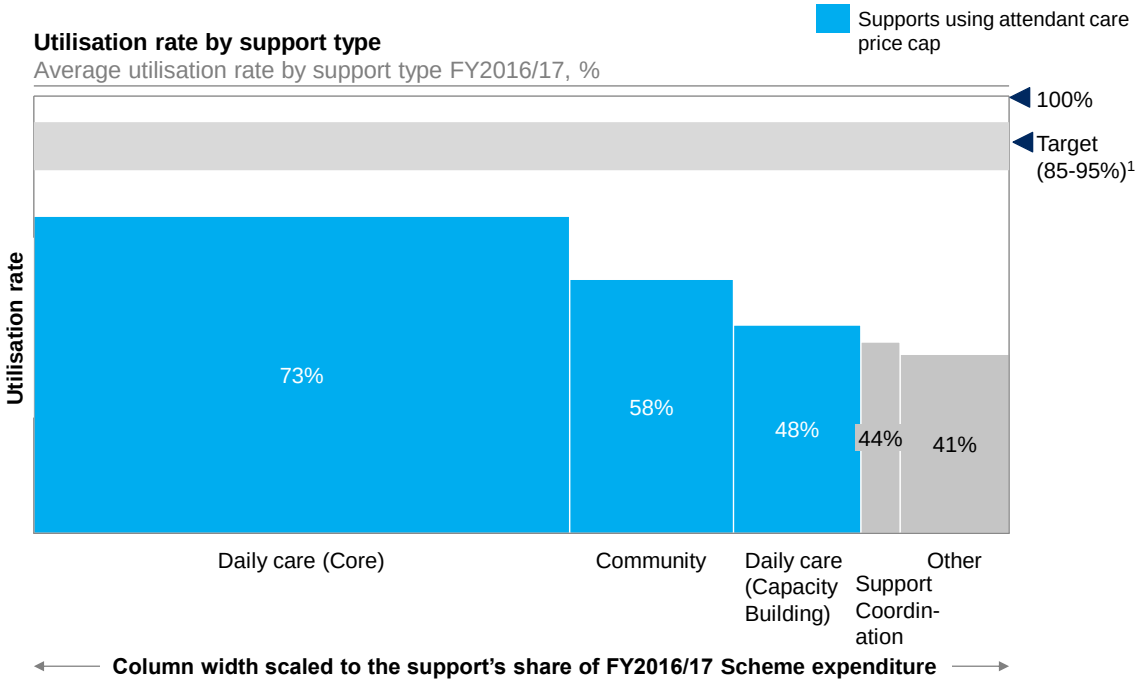
[7] Average utilisation rate for FY16/17 as at December 2017. Utilisation rates continue to increase after the end of the period being measured due to delays in claims and payment processing, so it is likely the final average utilisation rate for FY16/17 will be higher.

data to understand the drivers of this utilisation rate. Surveys during the NDIS trial showed that 27% of NDIS participants had at least some difficulty in accessing supports for which they had funding. More recently, baseline outcomes performance reported quarterly by the NDIA shows that 68% of participants nominate having no difficulty in accessing health services they require. However, a similar metric for NDIS services is not reported.

Analysis of utilisation by support type shows utilisation rates are highest in the largest support types and supports using attendant care, with the category of core daily care support services having a utilisation rate of 73% (Exhibit 2). This category includes support services such as assistance with daily living. Other support types reliant on attendant care, like assistance with social and community participation ('Community') and support for capacity building daily activities, have the next highest utilisation rates. The lowest utilisation rates are in capital and intermediary supports, which are of concern but are less likely to represent an imminent shortfall in critical supports.

EXHIBIT 2

Average utilisation of daily care (core) supports was higher than any other support type



1 Target utilisation rate estimated based on consultation with the NDIA and review of annual budget papers.
SOURCE: Scheme Actuary, FY17 utilisation data by support category

Aggregate analysis of firm entry/exit and utilisation data is complemented by anecdotal evidence of new private sector investment and innovation. For example, firms such as HireUp and BetterCaring[8] have made large investments to build new digital infrastructure to provide services in the disability services market. Such upfront investments offer evidence of the private sector's willingness to invest in this market. Similarly, the state government in New South Wales sold its Home Care business for $114 million, indicating the willingness of private capital to enter the disability services market.

Participant survey data

An evaluation of the NDIS trial by the National Institute of Labour Studies (NILS) revealed most participants found supports for which they had funding. This survey was initiated in 2014 and therefore covers more of the early experience of the Scheme. Approximately 73% of participants responded that they were able to access all supports for which they had funding. The average number of different supports accessed by participants has increased to 3.3 from 2.2 since the introduction of the Scheme, and 44% of participants report having greater choice and control over the supports they do receive since their enrolment in the NDIS. [9]

More recent measurement of participant outcomes reveals that 71% of participants believe that the NDIS has helped the level of choice and control they experience. 75% of participants identify the NDIS as having helped their daily living conditions, and 63% identify that it has helped their social, community, and civic participation.[10]

Evidence of provider intent

Other factors point to significant challenges as the Scheme continues to grow. The Productivity Commission acknowledged several studies that point to a potential future shortfall in supply to meet projected demand, with current workforce growth rate estimated between 6-13% versus a required growth rate of 18%. However, this can partly be explained by the ramp-up in demand that is expected, i.e. future growth rates are expected to be higher than current growth rates. The Productivity Commission also identified several participant cohorts for which a shortfall in supply is a risk. These included participants in remote and very remote areas and participants with complex needs. While there is not yet evidence of a shortfall in supply occurring across the Scheme, this is a risk that needs to be closely monitored.

Furthermore, some providers reported to the IPR team during its consultation process that they were drawing on surpluses and other funding sources, and cross-subsidising some support types, to continue to serve participants while they transition. They are concerned as to whether they can achieve a sustainable operating model in the future. Some major providers also reported that due to challenging economics operating in the Scheme, they are not accepting new participants for some services and are planning to reconsider their support

[8] Better Caring is not a registered provider under the NDIS, but has a profitable operating model in the disability services market supporting self-managed participants.

[9] National Institute of Labour Studies: *NDIS Survey of people with disability, their family and carers* (2014 – 2017), available at http://ndisevaluation.net.au/information/ndis-survey.cfm

[10] National Insurance Disability Agency: *National Insurance Disability Scheme COAG Disability Reform Council Quarterly Report* (30 September 2017).

offerings in 2018. Ongoing close market surveillance and liaison with providers will be essential for identifying the intention of large providers to exit or reduce services.

3.2 ANALYSIS OF PROVIDER ECONOMICS

The financial sustainability of providers in the NDIS is critical to ensuring ongoing supply of supports to participants. While providers may be able to absorb losses for a period, operating in the NDIS needs to be attractive in the long term for enough providers to meet the growth in demand.

To understand the economics of providers in the NDIS, the IPR team gathered evidence from various sources, including a detailed cost-to-serve analysis of a sample of NDIS providers. The IPR team is grateful for the cooperation of many providers, who generously shared detailed financial information to enable the team to analyse their costs-to-serve.

The remainder of this section examines the evidence available on the following:

- 3.2.1 Cost of transitioning to the NDIA
- 3.2.2 Overview of provider economics across support types
- 3.2.3 Provider economics in attendant care

3.2.1 Cost of transitioning to the NDIS

For providers across all support types, the cost of transitioning to the NDIS and interacting with the NDIA's systems and processes added materially to their cost base and affected their short term financial position.

Moving to a unit-funded, consumer-driven environment has required providers to employ new staff to process payments and invest in IT systems and marketing. Some providers estimate that these costs have added 1.5% to their annual expenditure.[11] This is detailed further in Section 4.6.1.

Improving the NDIA's systems and processes related to the portal and planning as articulated in Section 4.6.2, would reduce administrative costs and cash flow risk. Anecdotal evidence indicates that these improvements could amount to ~0.5% of total annual expenditure for some providers.[12] Anecdotal evidence also indicates that the cumulative effect of unapproved SIL quotes, unresolved portal errors and expired plans has resulted in cash flow risk for some providers; one large provider submitted that at one point they were owed ~10% of their total revenue in services unclaimed. The IPR team has been advised by the NDIA that substantial improvements to the portal have been made in the last 12-18 months, and the NDIA currently has a significant program of work underway, the Provider Pathway Project, to review and address the issues noted above.

[11] Based on 45 one-on-one interviews with providers in September 2017, in which three large providers (revenue > 50 million in FY16/17) gave detailed evidence of these costs.

[12] Based on 45 one-on-one interviews with providers in September 2017, in which three large providers (revenue > 50 million in FY16/17) gave detailed evidence of these costs.

3.2.2 Overview of provider economics across support types

Across all support types there were examples of providers operating profitably, and examples of providers struggling (see Exhibit 3).

EXHIBIT 3

Provider cohorts where pricing is working economically versus where it is challenging

Support type[1]	Working economically	Challenging
Assistance with daily life and social/ community participation (36.1%)	▪ Tech-enabled for-profit providers serving participants with lower complexity needs or strong informal supports ▪ Some incumbents with economies of scale ▪ New entrants with lean operating models	▪ Providers serving complex participants or operating in low density areas ▪ Providers with more qualified, specialist or experienced workforces ▪ Providers with EBAs that are more generous than the Award
Short term accommodation (1.7%)	▪ (Limited) Providers serving less complex participants with lower care ratios	▪ Providers serving complex participants ▪ Providers operating on weekends/ holiday periods/ overnight
Therapy (5.0%)	▪ Some therapy providers (e.g. sole traders in physio, speech) ▪ Providers in high density, metro areas	▪ Remote/rural areas where lots of travel is required ▪ Some psychotherapy service providers
Life skills and support coordination (5.3%)	▪ Support coordination and plan management providers for low complexity participants ▪ Some employment service providers	▪ Providers serving complex participants, where plans do not adequately cover coordination activities undertaken
Supported independent living (39.0%)	▪ Some SIL providers, as SIL is a quoted item	▪ Providers serving complex participants with onerous quoting requirements ▪ Emergency/crisis situations

1 Numbers in brackets represent percentage of Scheme spend in FY17, based on payments data provided bythe NDIA
SOURCE: Provider Consultation, Sep-Oct 2017

In Supported Independent Living (SIL), Therapy, Support Coordination and Plan Management, analysis indicated that most providers can operate profitably at current price points/benchmarks. However, the costs involved in meeting quoting requirements and delays in approving quotes in SIL are impacting provider overheads.[13] In addition, the rollout of the new SIL pricing process may reduce surpluses that providers are generating, and reduce their ability to cross-subsidise other services.

In attendant care, there was a higher proportion of providers who submitted they were unable to operate profitably. Given the emphasis from providers on the challenges associated with profitably delivering attendant care, the IPR team conducted detailed analysis of provider economics for this support type.

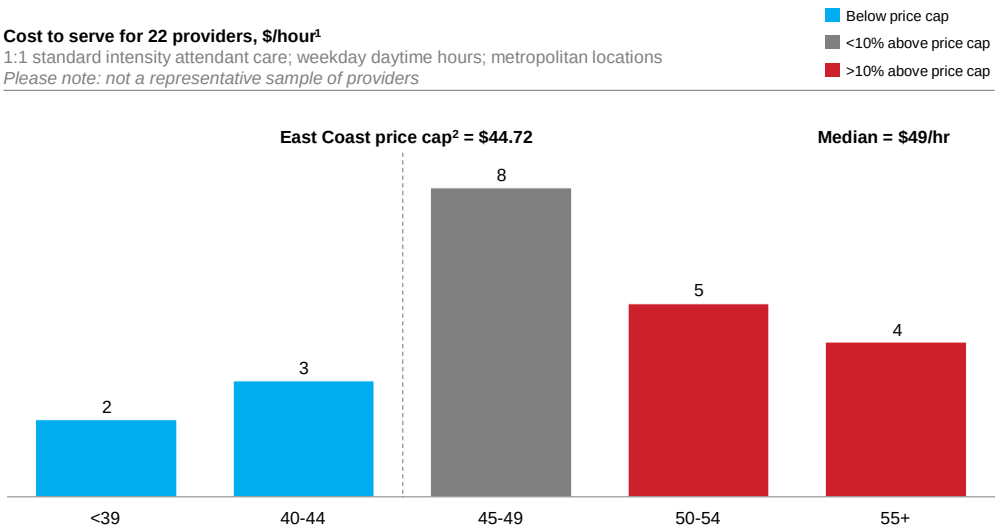
13 Anecdotal evidence from provider consultation indicates that SIL quoting requirements can be onerous: some providers have submitted reports of 100-200 pages in length to justify above benchmark quotes. NDIA data indicates that the average time to approve a SIL quote in Jul-Sept 2017 was 40 days, down from 107 days pre-July 2017.

3.2.3 Provider economics in attendant care

There is significant variation in the cost of service delivery for attendant care between providers. For the 22 providers who shared their financials, costs-to-serve ranged from under $40 to $55+ per hour for standard intensity weekday support (see Exhibit 4).[14]

EXHIBIT 4

Distribution of provider costs-to-serve for attendant care



1 Based on 22 providers who provided costings information for 1:1 standard intensity attendant care as part of the IPR or the 17/18 Price review. Some providers submitted a cost to serve based on actual data that represented their actual workforce mix. Where a provider submitted a cost to serve that assumed an 100% permanent or 100% casual workforce, and where the IPR had information about their workforce mix of permanent v casual staff, the IPR team adjusted their costings to reflect their true workforce mix. 2 Price cap for VIC, NSW, QLD and TAS. The 'East Coast' price cap is shown here as this is the cap that applies to most providers on this chart. The price cap for ACT, SA, WA and NT is $45.54.

This variation is attributable to differences in operating models and different cost structures across providers:

- For providers with more mature and formally highly qualified workforces, or who are bound by more generous working conditions and pay scales compared to the SCHADS award and pay scale, base labour wages were a key differential cost driver.
- For providers with heavier supervision structures, the cost of supervision was a key differentiating cost driver.
- For providers in regional geographies, travel was often a key cost driver.
- For providers with predominantly casual workforces, workforce utilisation was significantly easier to manage.

14 While the IPR's sample of 22 medium to very large providers was not comprehensive or representative of the market, the IPR was limited by the information providers were able to provide.

- There was significant variation in the cost of corporate or indirect overheads between providers, with expenditure on corporate overheads as a percentage of direct labour costs ranging from less than 10% to over 20%.[15]

For a more detailed summary of key drivers of differences in costs between providers, see Appendix A.

Participant characteristics can also influence provider economics. Margins were more compressed (or negative) for providers operating in areas with low density of participants, e.g. rural, remote and very remote areas, and for those serving participants with complex needs. On the other hand, the profitability of some providers can be in part attributed to their focus on specific participant segments. Providers who serve participants at the lowest end of the complexity spectrum often have lower labour and supervisory costs. These providers submitted that it is not necessary to pay a highly qualified or trained worker to deliver attendant care supports to participants that are not medically or behaviourally complex, for whom the risk of incidents is extremely low. Rather what they focussed on ensuring was that they had support workers with the right mindset, compassion and soft skills to deliver high quality support.[16] Providers who serve participants with predictable and high volumes of care are also able to operate profitably in attendant care, because workforce rostering and utilisation is easier to manage.

While a substantial number of providers assessed are not yet able to operate profitably at the current price cap, there are some providers who submitted they are able to deliver 1:1 standard intensity attendant care at a sustainable surplus, while complying with their award or enterprise agreement obligations. These providers often have lean operating models, leverage technology successfully, or are sole traders. Some of these providers have operated in the sector for some time, while others are new providers that entered the disability space in response to the NDIS opportunity.

- **Traditional providers with lean operating models:** Some traditional providers who run extremely efficient operations and have achieved a degree of scale are able to operate profitably. These providers exhibited some, or all, of the following characteristics: lean corporate overheads facilitated by effective investments in IT systems; effective rostering systems and a mix of casual and permanent staff to maximise staff utilisation; and/or a supervision model where supervisors only focus on quality assurance and co-ordination, while rostering work is done by a separate team. Providers in this group submitted they can achieve corporate overheads of ~10% of direct labour costs. Providers in this group who hire predominantly casual workers can maximise the amount of time their workers perform client-charging work and achieve 95+% workforce utilisation rates. These

[15] Data based on information from 22 providers who provided detailed financial information to the IPR. Corporate overheads refers to costs that are not directly attributable to client care (e.g. IT, HR, rent, marketing, business development, senior management salaries).

[16] This is particularly relevant in the context that there will be more than 100,000 people who receive NDIS funding who did not previously receive disability funding, A segment of the 100 000 new participants will have a psychosocial disability and may need highly qualified workers to support them. A segment of the new participants whom will have lower packages relative to participants who were existing recipients of State block funding, are likely to be at the lower complexity end of the spectrum. For these participants, a support worker with the right mindset may be more appropriate than a highly qualified worker.

working models provide insights on tactics that can be used by struggling traditional providers to improve their financial performance.

- **Tech-enabled providers**: These providers serve participants via online platforms, which allow participants to book and manage their own care schedule directly, reducing the work required to be completed by a provider and minimising corporate overheads. Support workers are typically casual, allowing providers to achieve high utilisation levels, as staff will only work when there is known demand from a participant. These providers estimate their cost of service delivery is up to ~20% lower than the current price cap. These providers also leverage technology to manage quality and safety: customers are able provide feedback after every shift online and an algorithm helps detect potential problems with service quality or customer satisfaction. However, this operating model relies on participants or their carers having the capacity and desire to manage their own supports. These providers currently only serve a small proportion of the market, and while this model appears to hold significant potential, it is unclear as yet what percentage of the standard intensity attendant care market this model will be able to serve at full Scheme.
- **Sole traders:** Sole traders can deliver attendant care significantly below the current price cap. This is because a self-employed support worker does not incur the supervisory or corporate overhead expenses of a small provider. While sole traders currently deliver less than 1% of service volume in in-home attendant care market, the emergence of e-marketplaces connecting self-employed care workers and participants could see a significant growth in this group of providers.[17]

The IPR believes these profitable and successful operating models offer valuable lessons to learn from for other providers who are struggling.

3.3 BENCHMARKING WITH COMPARABLE SCHEMES

There are several other State and Commonwealth schemes in Australia that offer comparable supports to their participants, including state accident compensation schemes and the Commonwealth's aged care sector. There is also significant overlap in the provider markets that service these other schemes. For example, ~90% of providers in one of the benchmarked schemes are also registered NDIS providers.[18]

To assess the adequacy of NDIS price caps for various supports, the IPR team benchmarked prices against available prices in the other schemes. The IPR team undertook detailed benchmarking for attendant care and therapy supports. Attendant care was chosen given the large proportion of Scheme spend attendant care represents, and given the recent scrutiny on the price cap for 1:1 attendant care (see Section 4.6.3.1). Therapy supports was chosen

[17] NDIA data. Sole-traders that are registered NDIS providers can serve all NDIS participants, whereas sole traders that are not registered NDIS providers cannot serve Agency-managed participants.

[18] McKinsey analysis, conducted by checking providers in the comparable scheme with NDIS registration data.

because the single NDIS price cap for therapy appeared to be inconsistent with the multiple price levels, and structure, of other comparable schemes.

3.3.1 Attendant care

Benchmarking the unit price of 1:1 attendant care under the NDIS with comparable schemes is complicated by a variety of factors: each scheme has a different funding model, different cohorts of clients, different business rules associated with care delivery (e.g. travel rules, cancellation policy, funding for training), and different fee structures (e.g. weekly price cap versus hourly price caps, composite versus time differentiated price caps). For instance, the Transport Accident Commission (TAC) and Worksafe have composite price caps in which the price cap for 1:1 care does not vary for time of the day or day of the week. By way of contrast, the NDIS rates are specific to the time of the day and day of the week. While TAC and Worksafe attendant care standard price caps do not vary for complex participants, the NDIS price caps differentiate for 'higher intensity' and 'standard intensity' prices.

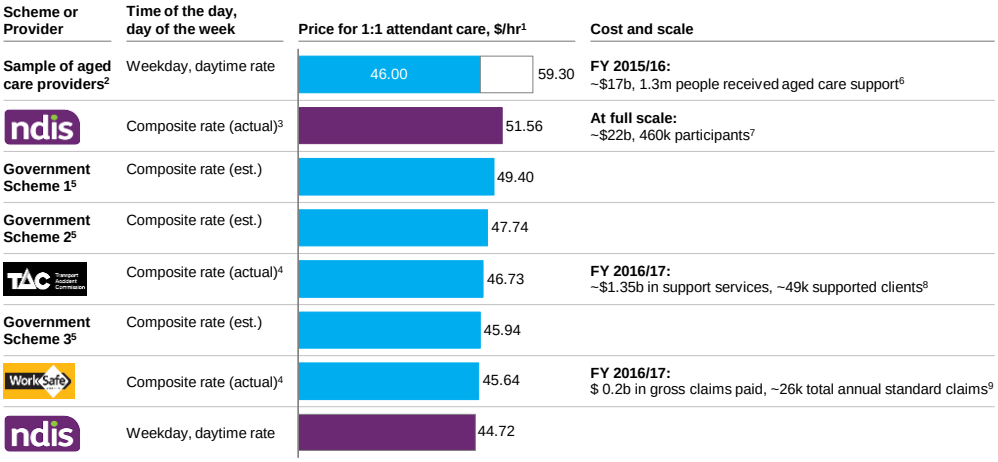
It is also important to recognise that other government schemes such as the TAC and Worksafe are significantly smaller than the NDIS, and revenue from these schemes is less likely to be the primary source of revenue for providers. Further, providers under other government schemes such as Worksafe are often guaranteed they will serve a participant for a set amount of time, and this demand certainty allows providers to manage their business and workforce planning more efficiently.

Despite these limitations in comparing across schemes, benchmarking is nonetheless useful to understand whether NDIS prices are broadly aligned with prices of other schemes. This benchmarking highlighted that the NDIS prices for standard intensity attendant care are in fact broadly aligned with prices of the accident compensation schemes, although market prices for many aged care services are higher (see Exhibit 5). While the NDIS composite price is higher than the composite rate for other schemes, other schemes provide more generous conditions associated with the delivery of care.[19] For example, TAC and WorkSafe offer establishment fees of ~$1200, compared to $500 in the NDIS. TAC also reimburses providers for training at a rate of $43.10 per hour, compared to no specific provision for training reimbursement under the NDIS.

[19] The NDIS composite rate is a weighted average of the various NDIS standard intensity time of the day and day of the week price caps.

EXHIBIT 5

The NDIS attendant care price cap is aligned with comparable compensation schemes, although market prices for aged care appear higher



1. Benchmarking the unit price of 1:1 attendant care under the NDIS with comparable schemes is difficult for a variety of factors: each Scheme has a different funding model, serve different cohorts of clients, different business rules associated with care delivery (travel rules, cancellation policy, funding for training etc) and fee schedules with different fee structures (e.g. weekly price cap vs hourly price caps, composite vs time differentiated price caps). 2. We sampled a range of aged care home care providers in metro regions in Sydney and Melbourne for their weekday daytime attendant care prices. These rates were private rates, meaning they are not necessarily fully government subsidised. 3. NDIScomposite rate for Eastern States, based on actual distribution of service volume between time of the day and day of the week;. 4.IQRS accredited rate. 5. For these Government Schemes, we estimated the composite rate. Where the Government Scheme provided a weekly cap, we divided this cap by the recommended number of hours of care per week. Where the Government Scheme provided different rates for time of the day and day of the week, we estimated the distribution of service volume to calculate a composite rate. 6. 2015/16 Report on the Operation of the AgedCare Act 1997, p9 and 10. 7. NDIA 2017 Corporate Plan, p11. 8. TAC 2017 Annual report, p6. 9. Worksafe Victoria Annual Report 2017, p57 and 15

3.3.2 Therapy

The NDIA has a single price cap in place for all therapy supports delivered by a qualified therapist under the NDIS. The price cap allows therapists to charge participants up to $175.57/hr for the delivery of services in a participant's own environment, which for a child could be in their home or at school, or in a therapist's office.[20] When a participant requires therapy supports to be delivered in their own environment, a therapist can make a separate claim for travel against a participant's package to reimburse them for the costs they incur. The NDIA has created a separate allowance in participant packages for therapy travel, which is capped at $1000 each year per therapy support type. The current travel policy allows therapists to claim travel time at the hourly rate of the service being delivered for travel over 10km.[21]

Other comparable insurance schemes in Australia offer different therapy prices dependent on the number and complexity of the conditions experienced by the participant. Examples include the TAC, WorkSafe, Department of Veterans Affairs (DVA), and NSW State Insurance Regulatory Authority (SIRA). The categorisation of the number and complexity of conditions vary by scheme. To simplify, the IPR team has named them Level 1, Level 2, and Level 3, with the number of conditions and/or complexity of the support increasing with each level (see

[20] NDIA: *2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017)*, p. 61
[21] NDIA: *2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017)*, p. 15

TABLE 1). Price ranges to equate each level of therapy support were observed both across schemes and within schemes for common types of physical therapy including physiotherapy, speech therapy, and occupational therapy. These schemes are typically associated with physical disabilities, but each include psychological therapy as a reimbursable support. When benchmarking to comparable schemes, it is important to recognise that travel policies specifically for therapy services vary across different schemes, and the NDIS travel policy is more generous than other schemes. For example, the TAC does not pay any travel allowance above the hourly rate for out-of-room care, and the DVA pays an allowance for every kilometre travelled above 10km of $0.90/km excluding GST.[22]

For physical therapy, three discrete levels of therapy support exist, each with a different range of prices (see TABLE 1).

TABLE 1: BENCHMARK PRICES FOR PHYSICAL THERAPY SUPPORTS[23,24,25,26,27]

Level of support	Benchmark price range ($/hr)	NDIS price cap ($/hr)	Description
Level 1	$90 - $130	$175	Includes treatment on a one-on-one basis and focused on treatment of a single physical condition
Level 2	$120 - $160	$175	Includes treatment of multiple (2-3) entirely separate injuries or conditions, where treatment applied to one condition does not affect the symptoms of the other injury
Level 3	$170 - $200	$175	Includes treatment related to complex pathology and clinical presentation (including complicated injuries involving multiple joints and tissues, spinal cord injuries, head injuries, major trauma)

[22] Department of Veteran Affairs: *Occupational Therapist Schedule of Fees (Effective 1 November 2013)*, p. 5

[23] Transport Accident Commission: *Fee Schedules* (2017), Government of Victoria, available at http://www.tac.vic.gov.au/providers/invoicing-and-fees/fee-schedules

[24] Worksafe: *Fees and Policies* (2017), Government of Victoria, available at https://www.worksafe.vic.gov.au/health-professionals/fees-and-policies

[25] Department of Veterans Affairs: *Dental and Allied Health Fee Schedules* (2017), Government of Australia, available at https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules

[26] State Insurance Regulatory Authority: *Physiotherapy, Chiropractic, Osteopathy Fees Order* (2017), Government of New South Wales, available at https://www.sira.nsw.gov.au/__data/assets/pdf_file/0019/112870/Physiotherapy,-chiropractic-and-osteopathy_Fees-Order-2017.pdf

[27] Comcare: *Allied Health Rates* (2017), Government of Australia, available at https://www.comcare.gov.au/claims_and_benefits/benefits_and_entitlements/fees,_rates_and_reimbursements/allied_health_rates

For psychological therapy, the entry level of support is at a higher level of complexity than Level 1 physical therapy, and more equivalent to Level 2 physical therapy (see TABLE 2).

TABLE 2: BENCHMARK PRICES FOR PSYCHOLOGICAL THERAPY SUPPORTS

Level of support	Benchmark price range ($/hr)	NDIS price cap ($/hr)	Description
Level 1	$160 - $180	$175	Includes psychological therapy on a one-to-one basis focused on treatment of a psychological disability in a low risk environment
Level 2	$190 - $240	$175	Complex psychological therapy requiring a very skilled and experienced clinical professional, often necessary where a participant poses a high risk to themselves or others because of their disability

The findings outlined in this section form the basis of the suite of recommendations detailed in the following section. Recommendations are grouped by the items of the Terms of Reference. Under each item, further detail is also provided on the issues and evidence relevant to the topic.

4 Recommendations

As outlined in Section 3.1, the fundamental test of whether price caps are adequate is whether participants can access quality supports and services. There is not yet compelling evidence of supply shortages occurring, other than what was recently observed in short term accommodation and has now been addressed through price changes. However, there is still a risk of future supply shortage, particularly for participants in rural, remote and very remote areas and those with complex needs. The IPR team's analysis also identified a significant number of providers that have not yet developed a profitable operating model, particularly in the service category of attendant care.

To improve provider economics and confidence in the NDIS, minimise the risk of supply shortages in the future, and assist the NDIA to achieve its aspirations, the IPR team has made 25 recommendations, detailed in this section. These recommendations are designed to target the root cause of issues identified through consultation and further analysis.

Together, these recommendations will have a positive impact on provider economics, improving overall industry margins by 2% to 4%, with even higher margin improvements for providers serving participants with complex needs or in rural, remote and very remote areas. Examples of these recommendations that will have a direct impact on provider economics are:

- Adding a third tier to the complexity loading of 10%, to account for higher level of skills/experience of workers and additional training required.
- Allowing providers to charge up to 45 minutes of travel time in rural areas.
- Allowing providers to quote on the delivery of services in isolated regions.
- Changing the cancellation policy to allow providers to charge participants for cancellations. after 3pm on the day before the service.
- Removing the $1000 travel cap for therapy supports and align the travel policy with attendant care travel policy.
- Changing the therapy prices to better reflect different therapy types, and introduce a second tier of pricing for therapy assistants.
- Continuing to improve NDIA systems and processes (e.g. portal functionality, quoting) to enable providers to reduce administrative tasks and reduce costs.
- Introducing temporary overhead assistance equivalent to a 2% to 3% loading on the price for providers delivering attendant care for the next 12 months.

The recommendations in this section have been grouped according to items in the IPR's Terms of Reference (see Section 1.4). There were some issues raised during the consultation phase that were outside the scope of this review. These issues have been captured and will be raised separately with the NDIA.

The structure of this section is as follows:

- Section 4.1: Approach to price setting, covering Recommendations 1 to 2
- Section 4.2: National versus regional pricing, covering Recommendations 3 to 5

- Section 4.3: Pricing of services with different levels of complexity, covering Recommendations 6 to 9
- Section 4.4: Pricing of short-term accommodation (respite) services, covering Recommendation 10
- Section 4.5: Thin and undersupplied markets, covering Recommendations 11 to 12
- Section 4.6: Provider efficiencies and adequacy of provider returns, covering Recommendations 13 to 21
- Section 4.7: Price deregulation, covering Recommendations 22 to 25

4.1 APPROACH TO PRICE SETTING

The NDIA sets price caps for an hour of service for most support services supplied in the NDIS. The price caps are reviewed annually and a new price guide is published, though the NDIA has also twice amended prices outside the annual review process. In assessing the approach to price setting used by the NDIA, the IPR considered both the process for setting price caps, and the way in which price caps are applied as an hourly (or other time-based) rate.

Section 4.1 covers the following topics:

- 4.1.1 Determining appropriate price caps
- 4.1.2 Alternatives to an hourly rate

The use of price ranges and deregulated pricing are considered separately in Section 4.7.

4.1.1 Determining appropriate price caps

Issues and evidence

The NDIA has amended prices through its annual price reviews as well as interim changes where required. The current price caps are a result of the NDIA FY2017/18 Price Review concluded in June 2017 and a change to short term accommodation price caps from 30 October 2017. The NDIA FY2017/18 Price Review was based on an assessment of the underlying methodology used to estimate the hourly costs of personal care and community supports, feedback from the disability services sector including 82 provider submissions directly in response to the annual review process, new economic data such as increases in the Wage Price Index, and an assessment of the impact of proposed changes by external consultancy HoustonKemp. The annual price adjustment also accounted for changes in the national minimum wage and the operation of the Equal Remuneration Order (ERO).[28] This led to several changes. For example, base prices for the support type 'Assistance with daily living' were increased by 4.5%, loadings for remote and very remote areas were increased, and the

[28] The Equal Remuneration Order is an order made by the Fair Work Commission in 2012 which required wages in the social and community services industry to be increased regularly to 2020. The ERO increases occur each December according to a prescribed formula.

cancellation policy of therapy services was amended. The NDIA published the amended Price Guide on 12 June 2017 before it took effect on 1 July 2017. These changes were then followed by a tailored change to price caps for short term accommodation services, announced on 18 October this year, with the new prices being revealed a week later and taking effect two weeks later, on 30 October.

The NDIA does not yet have a comprehensive evidence base to inform its regular pricing decisions, but it has been increasing its scope of data collection. For example, the NDIA does not keep a collated record of supply shortfalls identified by LACs and regional offices, nor does it directly survey participants on whether they experienced shortages in supply of supports for which they had funding.[29] However, it has developed and implemented a Short-form Outcomes Framework questionnaire which measures participant outcomes and it is deploying a benchmarking survey of providers to understand evolving cost structures across the NDIS. The NDIA is also working with DSS to develop a set of metrics to monitor market development, as well as developing a market intervention strategy to identify and respond to instances in which prices have been unable to attract sufficient supply.

Recommendations

1: The NDIA should include a broader set of indicators of participant outcomes and market development in its price setting process, and clarify its methodology for implementing price setting decisions.

The NDIA's current process for setting prices and ensuring provision of services for participants can be enhanced. The IPR team recommends a four-step process (see Exhibit 6). This process should apply to the annual price reviews, as well as any interim adjustments which may be necessary in response to changing market conditions. The IPR team recommends that the NDIA considers the following four steps as it develops its market intervention strategy:

1. Continuous market monitoring
2. Focused data collection on at-risk markets
3. Data analysis and policy decision
4. Implementation of decision

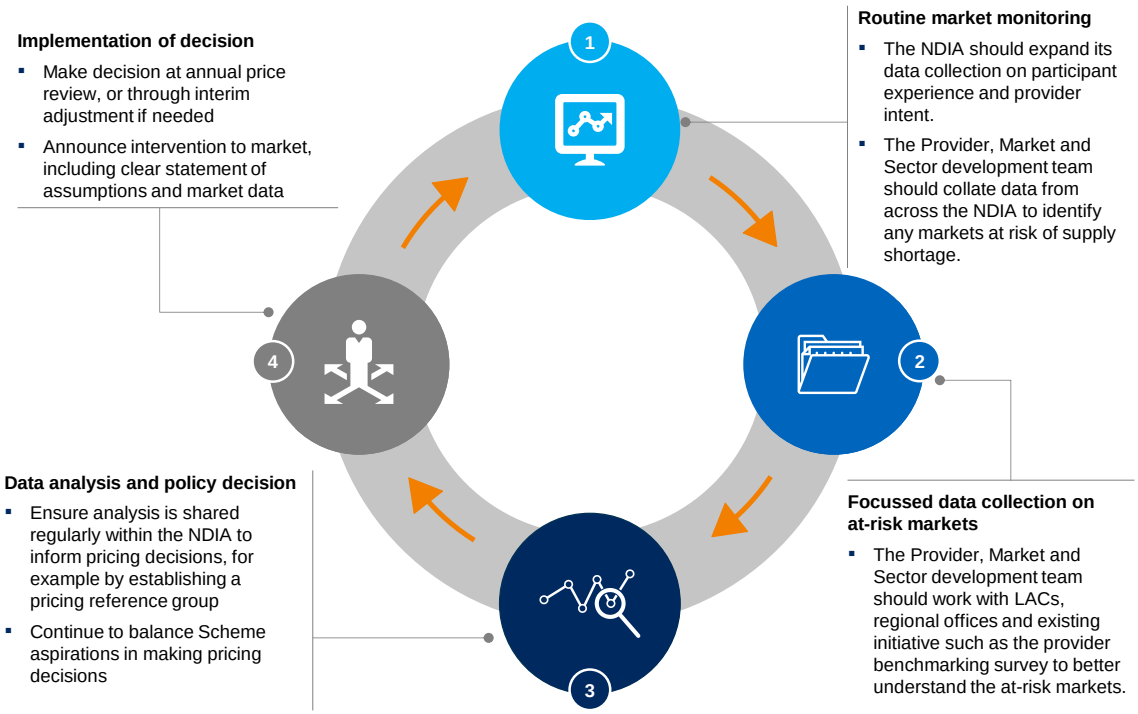
The most significant departure of this prescribed process from NDIA's current practice is to include a more thorough assessment of the risk of supply shortages, including a more comprehensive analysis of alternative supply options and the range and distribution of costs to serve of providers. The driving question should be whether participants are able to access all the services for which they have funding. In the case of an existing provider no longer being able to offer services, participants will require options to access alternative providers. Where there are signals that participants are at risk of not being able to access services, the NDIA should assess options to intervene through evaluating impact on the NDIA aspirations.

[29] The NDIA does monitor the number and broad category of complaints lodged by participants, as well as tracking the overall participant satisfaction rate, which has consistently been above 85%. However, neither of these are directly related to observations of supply gaps in the Scheme.

It is important that the price-setting process continually balances the NDIA aspirations, which can involve trade-offs. This is because in an immature and developing market, price caps not only regulate provider competition but also act as a signal of efficient prices, enable value-for-money for participants, and affect the long-term development of the NDIS.

EXHIBIT 6

The process for testing whether to amend price caps should incorporate thorough market monitoring and transparent decision making



Step 1: Routine market monitoring

The NDIA should complement its existing initiatives to advance its market monitoring capabilities through three additional initiatives: collecting data on the share of participants affected by supply gaps, extending its provider consultation and feedback processes, and collating market data and sharing internally to all relevant decision-makers.

The NDIA should collect more comprehensive data on the ability of participants to find the supports they require across each geographical region and support type. The most desirable way to collect this information is regular surveying of participants. This could be done through a new survey, or by expanding the existing participant assessment in the Short-form Outcomes Framework.

Secondly, the NDIA should establish proactive and regular consultations with providers, including surveys, to assess provider experience and intent. The NDIA should construct a representative sample of new and mature providers to gauge their financial sustainability, intent for growth, self-assessment of ability to cater to demand, and knowledge of any current or emerging supply gaps. Whilst some of this data is currently collected by other

organisations, the NDIA should have access to a more regular and reliable source of data that it can rely on for its own decision making.

The above sources of data should be part of a regular monitoring framework which also incorporates existing market data such as utilisation rates and evidence of provider entry or exit (see Exhibit 7). See Section 4.5.1 for a detailed discussion of the relevant metrics.

Finally, all relevant market information should be collated and analysed by the Provider, Market and Sector development team. Regional offices, LACs, the Scheme Actuary and other parts of the NDIS should share the relevant data with this team. The data and analysis should then be regularly reported to key stakeholders within the NDIA such as the Chief Executive Officer (CEO) and the Board. This will enable rapid identification of any markets that may be at high risk of undersupply and a consistent flow of information within the NDIA.

If this market monitoring process reveals any markets that are at risk of developing supply gaps, the NDIA should take immediate steps to collect more focussed data on those at-risk markets.

EXHIBIT 7

Supply in Scheme markets can be evaluated through considering a mix of indicators from surveys, utilisation rates and entry/ exit data

Indicator and relevant metrics		Data Source	Discussion on limitations
1 Participant experience	**1.1**: Share of participants with funding who had difficulty or were unable to find services	▪ Participant survey, e.g. "In the past year, did you have difficulty or were you unable to access supports because of a lack of suppliers in your market?" ▪ Compare across respondent region and support type	▪ Broad surveys may be too expensive or time-consuming to be sufficiently representative and timely ▪ Consider focusing on "at-risk" markets which show other indicators of supply shortages, such as low rates of market entry or poor utilisation rates
	1.2: Share of participants who are unsatisfied with quality of services accessed	▪ Participant survey, e.g. "Were you satisfied with the quality of supports you have received in the past year?" ▪ Compare across region and support-types of respondents	
2 Provider intent	**2.1**: Share of providers intending to grow/ shrink number of participants served	▪ Provider survey, e.g. "Are you intending to serve more participants in the next year than you did in the last?" ▪ Compare across respondent region and support type.	▪ Provider intent may be informed by non-Scheme features ▪ However, reason for withdrawal/ expansion is not as relevant as identifying the outcomes that are consistent with existing price settings
	2.2: Share of providers intending to expand into/ withdraw from support types/ regions.	▪ Provider survey, e.g. "Are you intending to expand the number of regions in which you operate? ▪ Compare across respondent region and support type.	
3 Utilisation rate	**3.1**: Level of utilisation by support type and geography ("utilisation rate")	▪ NDIA planning and claims data ▪ Share of funds allocated in participant plan which were disbursed in the relevant time period ▪ Compare relative averages and distribution across markets	▪ Utilisation rates are affected by many non-supply factors, e.g. plan quality ▪ However, comparing to average utilisation rates and measuring change over time can help to determine markets in which persistent low utilisation is likely to be due to insufficient supply.
	3.2: Change in utilisation rate over time by support type and geography	▪ NDIA planning and claims data ▪ Percentage point change in utilisation rate from one time period to the next	
4 Rates of market entry/ exit	**4.1**: Number and share of providers which withdrew from current markets.	▪ NDIA payment and claims data ▪ Number of providers who sought payments from fewer regions/ support types in this year than last	▪ Benchmark entry/ exit rates are difficult to establish due to volatility in transitioning markets ▪ However, the data can be used to identify outlier markets which warrant further investigation
	4.2: Number and share of providers which expanded into new markets.	▪ NDIA payment and claims data ▪ Number of providers who sought payments from more regions/ support types in this year than last	

Step 2: Focussed data collection on at-risk markets

More focussed data collection on specific markets should include investigating the causes of participants being unable to access supports, through LAC feedback and qualitative research with participants. It may also include assessing the economic performance of providers to

understand whether the supply gap is likely to worsen over time. If this data confirms that providers are struggling to provide the required supports in a financially sustainable fashion, and supply gaps are likely to continue, the NDIA should proceed to evaluate the effectiveness of different interventions to address this risk of supply shortage.

In some cases, this market monitoring process will identify instances where participants require a more immediate solution than amendments to price controls or related policies. This is discussed in further detail in Section 4.5 (*Thin and undersupplied markets*).

Step 3: Policy decision

The data collected by the NDIA should inform its annual price review, but also inform any interim price or non-price interventions that may be required. Interim interventions should be used where there is an immediate market concern, as was the case with the change of short term accommodation prices in October 2017. Once the NDIA has assessed markets that need intervention, it should identify intervention options which may involve targeted adjustments to specific policies or terms of business (e.g. travel or remoteness policies), non-price levers such as changes to the planning process or NDIA's systems and processes, or changes to prices.

The identified policy options should be assessed against each of the NDIA aspirations, to test which options will have the most favourable impact on all aspirations while ensuring that participants are able to access all the services for which they have funding. This should be done with input from all relevant parts of the NDIA, so that information on how the options will affect each of participant outcomes, market development, and Scheme sustainability can be fully considered. The assessment of policy options should be coordinated by the Provider, Market and Sector development team and made available to all relevant decision makers, including the CEO and the Board.

The NDIA should consider the addition of new organisational mechanisms to support this stronger internal collaboration and ensure proper governance of the pricing process. It may be appropriate to establish a pricing reference group with participation from all relevant parts of the NDIA, such as the Scheme Actuary, senior management, the Provider, Market and Sector development team etc. For pricing decisions which affect a smaller part of the market or Scheme spend, the NDIA may consider authorising the CEO or the Provider, Market and Sector development team to make policy decisions. Regardless of the model chosen, the NDIA should be satisfied that holistic information is available on the rationale and consequences of changes in price levels or other policies.

Step 4: Implementation of decision

The NDIA should give providers sufficient notice of price changes that result from the annual price reviews. The IPR team recommends that this notification period be one month for core and capacity building supports. A notification period of a month will allow organisations to calculate the impact of new prices and make informed business decisions. It will also allow providers to communicate and advocate for their new prices to participants. Price changes should also be scheduled to take effect at the beginning of the financial year to align with the corporate planning procedures of providers. The NDIA should also make clear the reasoning for price decisions and disclose relevant market data.

For interim price adjustments where a single support service or market is being affected, a shorter notice period of two weeks would be acceptable. This is because by their nature interim pricing decisions need to be implemented more rapidly, and are likely to affect a smaller proportion of the Scheme.

4.1.2 Alternatives to an hourly rate

Issues and evidence

It is important to differentiate between the funding model and the pricing approach of the NDIS. The NDIS funds individual supports for participants, to help them achieve their goals and desired outcomes. Under the previous block-funding model, providers were funded to deliver a range of services to a participant over a quarter or year.

The predominant mechanism for setting prices across the NDIS is a cap on the hourly (or other time-based) rate that can be charged for providing the relevant support service. Under this approach, providers are paid for their 'inputs'.

Input-based pricing, sometimes referred to as fee-for-service, rewards providers for work done, and creates a transparent price that can be used to stimulate provider efficiency. However, this form of pricing is sometimes criticised for creating incentives for providers to increase volume of services, rather than focusing on how to improve outcomes.

Outcome-based pricing is an alternative method which remunerates service providers based on an agreed improvement in the service user's outcomes resulting from the provision of services. For example, employment services could be priced based on whether users of the services are able to obtain and maintain stable employment. An example of such a payment model for providers is the Federal Government's jobactive program. Outcome-based pricing encourages innovation by prioritising the delivery of the desired outcomes at the lowest cost. It encourages providers to find more productive ways to deliver services, rather than rewarding providers who simply provide the highest volume of services. However, this method requires outcomes which are able to be clearly defined and monitored so that the improvements can be measured and an appropriate price established. The method also requires careful design choices so that providers are not encouraged to deliver short-term measurable outcomes at the expense of more sustainable, long-term improvements in a participant's welfare.

Recommendations

2: The NDIA should continue to use an hourly rate approach, but trial outcomes-based pricing

The current measures of participant outcomes are not yet sufficiently defined or tested to support an outcomes-based pricing model. Currently the NDIA is measuring progress of participants against multiple outcomes through the Short-form Outcomes Framework questionnaire, and as part of participant plan reviews. However, many of these outcomes are broadly defined such as increased choice and control or community participation. Given that many participants are receiving different supports from a range of providers, it will be difficult to attribute improvements in outcomes to a specific support. In addition, there are not yet clear

outcomes baselines for most services, or alignment on evidence-based approaches to test and monitor improvements in outcomes. As a result, outcomes-based pricing approaches will require further development and testing before becoming a viable alternative to the current hourly rate approach.

The NDIA should start to build its capability to design and manage outcome-based pricing through a trial for a support service which is amenable to outcomes measurement. Services which are most amenable to outcome measurements include employment services, learning supports, and some types of physical or behavioural therapy. For example, the NDIA could pay providers of employment supports a bonus based on their ability to find stable employment for participants. To encourage long-term improvements in outcomes, such bonuses could be paid out in part at the time of placing a participant in a job, and in part at the 12-month mark if the participant continues to be in work. For behavioural supports, the NDIA could reward providers based on their ability to reduce the incidence of certain behaviours or behavioural interventions such as restrictive practices. Before commencing any trial, the NDIA will need to be satisfied that it has a good understanding of baseline outcomes in that market, and the capability to both monitor and price outcomes going forward. A trial would develop the NDIA's capacity in designing outcomes-based pricing systems, offer useful insights on whether the NDIA is able to sufficiently monitor outcomes, test whether providers can adjust to this model of service provision, and provide evidence for whether such a system improves participant outcomes.

4.2 NATIONAL VS REGIONAL PRICING

One of the questions posed for the IPR team was whether there are significant differences in the costs of serving participants within and across states and territories.

Within states and territories, the cost of service provision varies by geography due to travel and other service delivery costs associated with remote and very remote areas. For example, in very remote areas providers often incur higher wages, higher accommodation and food costs and higher staff turnover. To compensate providers for these costs, the NDIA applies loadings to prices of 25% in very remote areas and 20% in remote areas.

Once travel and remoteness are accounted for, there is little difference in cost structures within a state. In the disability sector, approximately 80% of the cost of service provision is labour, and labour costs are typically based on the SCHADS Award.[30] Most providers pay their workers in line with these award rates or their EBAs, with no further adjustments for the location of service provision.

Across states, labour costs vary a little due to some small differences in award rates. These differences are minor (under 3%) and will converge by 2020.[31] The NDIA currently has two

[30] Estimate based on independent modelling of the IPR, consultation with providers and comparison with modelling of comparable Schemes. The NDIA's current pricing methodology makes a similar assumption as to share of labour costs.

[31] See Appendix C for further detail on SCHADS Awards by state. Convergence of national awards is a result of the Equal Remuneration Order (ERO) made by the Fair Work Commission in 2012. For full detail on the ERO and SCHADS Awards rates, see: https://www.fairwork.gov.au/pay/minimum-wages/social-and-community-services-industry-pay-rates.

price guides – one for Eastern states (NSW, VIC, QLD, TAS) and one for Western states (ACT, NT, SA, WA). The difference in prices between these guides does not correlate with differences in SCHADS Awards or other cost differences between those states. The current disparity between these price guides appears to be based on legacy arrangements among jurisdictions, rather than any direct correlation with regional costs.

Section 4.2 covers the following topics:

- 4.2.1 Service provision in remote and very remote regions
- 4.2.2 Service provision in rural areas
- 4.2.3 Single national price

4.2.1 Service provision in remote and very remote regions

Issues and Evidence

The NDIS operates in several regions which are located far from existing providers and workforces. These regions are categorised as remote or very remote, depending on classification systems that assess a combination of population size and distance factors. The NDIA is currently changing the classification system it uses from 'Remoteness Areas' (RA),[32] which ranges from category 1 to 5 by increasing remoteness, to the 'Modified Monash Model' (MM), which ranges from category 1 to 7 in the same way.[33]

'Remote' regions are those classified as 'MM 6' and are broadly comparable to RA – 4. Examples include the Central Highlands region in Queensland and Western NSW. 'Very remote' regions are those with the 'MM 7' classification and are broadly comparable to RA – 5. Examples of the most remote regions catered to by the NDIS include the unincorporated regions of far western NSW, the Central Desert region in the Northern Territory, and the Central Highlands region in Queensland.

The cost of service provision in remote and very remote areas is often higher than in other regions due to travel and other service delivery costs – for example, higher wages, higher accommodation and food costs, and higher staff turnover. To compensate providers for these costs, the NDIA applies loadings to prices of 25% in very remote areas and 20% in remote areas. These percentages are based on loadings developed by the Independent Hospital Pricing Authority (IPHA). Some providers stated that the remoteness loadings are inadequate in situations where air travel or long-distance road travel is required to serve isolated communities, or where local market infrastructure is limited.

In the absence of local supply, providers sometimes need to resort to fly-in, fly-out (FIFO) or drive-in, drive-out (DIDO) service models to reach isolated communities that may be located tens to hundreds of kilometres from the nearest town (e.g. Palm Island). Furthermore, the cost of running and maintaining off-road vehicles is very high. Providers have reported to the IPR

[32] Remoteness Area classifications are based on the Accessibility/Remoteness Index of Australia (ARIA) and the Australian Statistical Geography Standard (ASGS).

[33] See National Disability Insurance Agency: *Rural and Remote Strategy 2016 – 2019* (February 2016) for more detail on how the NDIA classifies areas according to remoteness.

team that they could spend up to $2,000 per vehicle per month for leasing (or depreciation) and operational costs. Due to the remote areas that they cater to, there are few opportunities for economies of scale and some providers maintain fleets with tens of vehicles. Many of these costs can be avoided if service delivery was instead conducted by more local workforces but this is difficult in the short term.

Many isolated communities are discrete Indigenous communities. In these communities, service provision must account for a range of cultural factors such as: gender matching for workforce and clients, family-based decision making, differences in conceptualisation of disability, and travel challenges for participants that may result in unexpected cancellations.

Providers indicated that catering to remote and very remote areas often requires an investment to build up foundational market infrastructure. For example, participants in the region might not yet have been identified by the NDIA, nor is there an understanding within the community of the value of disability support services. One provider consulted by the IPR team illustrated this issue with recent experience. The provider described a market in remote North Queensland with a population of approximately 1,000 people (60% of whom were of CALD background) where just one NDIS participant had been identified, even though a greater need for support existed. The provider worked with health care providers and the local community to identify a further dozen people in need of disability supports and facilitated their introduction to the NDIS. This provider has been able to introduce sustainable services in these regions but the market is unlikely to be large enough for two providers, and the provider is unlikely to be able to invest in developing other new markets without some support for the upfront investment that is required.

Recommendations

3: In very remote/isolated areas, the NDIA should work with other community services and providers to support local workforce development to deliver services in the most efficient way possible. In regions with limited local supply, allow providers to quote on cost of delivering NDIS services in the short term to ensure supply.

The challenges described above are not unique to the NDIS. Many other government services, such as health and education, have faced similar challenges in providing services to remote and very remote communities. While price is one lever that can help encourage supply, a more holistic approach is needed.

The NDIA should prioritise identifying areas and individuals that constitute either thin markets at risk of under-supply or underpenetrated markets with unmet demand. Analysis to identify these markets should leverage data on participant residences and support requirements, provider office locations and support offerings, and plan utilisation. Many of the isolated communities falling into this category will be discrete Indigenous communities (including ATSI participants) that will require a coordinated and culturally sensitive approach to service provision.

The NDIA should then work with other community services and providers to support local workforce development that increases the reliability and quality of care while driving down the cost of supply. This could include working with the Aboriginal Medical Services (AMS) to deliver services in predominantly Indigenous communities. Extending the reach of the AMS

may be preferable to new providers who have little experience working with Indigenous communities.

Whilst development of a local workforce is preferable, there will be some regions where this is not possible in the short term and where cost of service provision is high. In these areas, the NDIA should establish a quoting system by which providers can bid for supplying services to underserved areas. In some regions, it may be feasible to establish panels of providers to quote on service delivery, to streamline the procurement process. While the quoting method is bureaucratically more demanding, other policy options are unlikely to address the lack of supply in these areas. For example, adjustments to the price loadings for remote areas (20%) and very remote areas (25%) are unlikely to cater to the full spectrum of challenges that providers face. The variability in cost of service provision and the non-price challenges that must be overcome (e.g. engaging with local communities) require a coordinated effort from the NDIA, other mainstream services, and providers.

Implications

Participant outcomes and market development will be improved at lower cost if the NDIA successfully works with existing health service providers and communities to develop local capacity. However, this may not be able to be achieved immediately.

In the short term, establishing the operational capacity to manage a quoting process will be important. It is expected that higher prices are likely to result from this process in isolated areas, but given the small proportion of participants in these regions, Scheme expenditure will not increase significantly. This process is likely to lead to more sustainable coverage of these areas and improvement in participant outcomes, including ATSI communities.

4.2.2 Service provision in rural areas

Issues and evidence

Some of the challenges associated with service provision in remote/very remote areas are relevant to providers serving rural areas as well. While price loadings exist for MM 6 and MM 7 areas, providers serving individuals and communities in ‘outer regional’ or ‘rural’ areas, which correspond anecdotally to MM 4 and MM 5 areas, cite geographic spread and high travel costs as contributing to higher costs. As a result, it appears that some providers have terminated services to participants living more than a certain distance away from offices or have expressed plans to withdraw services from rural communities.

MM4 areas are defined as areas in Remoteness Area 2 (RA2) and Remoteness Area 3 (RA3), per the Australian Standard Geographical Classification, that are not in MM3, and are within 10 km road distance of a town with population between 5,000 and 15,000 people. MM5 areas are all other areas in RA2 and RA3. Provider travel times to and between participants in MM 4 and MM 5 areas exceed 20 minutes, the current limit on time that attendant care providers can charge for travel between participants, in a significant number of cases. Providers cite averages that are often closer to 30-45 minutes due to low participant density and geographic spread of rural farms and communities. In extreme cases, providers in rural areas take an hour to several hours to reach the site of support service provision. In practice, many providers absorb all travel costs, inclusive of the first 20 minutes of travel, due to a reluctance

to reduce service levels, as plans are often insufficient to cover travel times while still ensuring that clients receive necessary supports. Participants may also expect to be charged for and receive a full hour of service due to unclear communication and insufficient participant education.

Several providers have instituted policies that stipulate a radius outside of which they are no longer able to provide service. For example, upon transitioning to the NDIS, a provider in regional Victoria has chosen to no longer serve clients located more than 10 kilometres from its office, while a provider in regional New South Wales has chosen to only serve participants located within 30 minutes from an office. Travel costs often compound other challenges of rural service delivery including lack of appropriate facilities and extreme weather, and inefficient staff rostering. Some providers consulted by the IPR team expressed an intent to withdraw from such areas due to these location-specific costs of service. For example, a provider in Queensland identified that supports in the Charters Towers regions (MM 4) were financially unsustainable as it involved costs associated with servicing regional areas which were not adequately recognised by the current NDIS pricing arrangements. These difficulties are currently challenging to identify or diagnose, as travel expenses are not monitored as a separate line item in the NDIA payments system. It is instead included as a part of the care provided. There is therefore no ongoing record of providers' travel times.

It is important to note that as the Scheme matures, development of local workforces will help alleviate this problem. It is expected that participants in rural areas – in particular in MM4, which is defined as being within 10km of a town of 5,000-15,000 people – will be served by local providers. However, the IPR recognises that development of these local workforces takes time, and there needs to be a mechanism to ensure that participants in these areas are not disadvantaged in the short term, by compensating providers for costs incurred.

Recommendations

4: The NDIA should clearly define rural areas and lift travel allowance from 20 minutes to 45 minutes for providers serving a participant located in MM5 (or ARIA equivalent) and MM4 in the short term. Adjust participant plans to account for travel and track travel as a separate line item.

While the NDIA released a Rural and Remote Strategy in February 2016, some providers noted continued ambiguity over the official definition of 'rural'. Thus, 'rural' areas should first be formally defined with reference to a consistent geographical category. This classification could rely on either the Modified Monash Model (likely Levels 4 and 5), or on Remoteness Areas calculated with reference to the Accessibility/Remoteness Index of Australia (ARIA).

Once this definition is in place, adjustment to the provider travel policy would be the most direct and cost-effective way to support supply. To compensate providers for high travel times in rural areas, the NDIA should increase the 20-minute travel cap for providers of eligible supports, and should align this travel policy with that of therapy (see Section 4.6.4 for recommendations relating to travel for therapy supports). The IPR believes a travel cap of 45 minutes is more appropriate.

The IPR team recognises the risk that more generous compensation of travel costs may create an incentive for some providers to use travelling workforces rather than the more efficient model of building local workforces, which is a core aspiration for the NDIA. However,

workforce development in small towns of less than 15,000 people can often be challenging in the short term. Therefore, the IPR recommends that this change in policy be applied to participants in MM4 and MM5 in the near term, but changed in the medium term (3 to 4 years) to apply only to participants in MM5. A travel cap of 45 minutes is unlikely to cover all costs of travel to participants in MM5. Providers will need to look for opportunities to cluster participants and coordinate service provision to reduce travel times.

This policy does not remove the commercial incentive for participants to choose providers who are able to provide services without the additional expense of travel costs. As such, the IPR team believes this travel adjustment is an acceptable balancing of competing priorities In the medium term, the NDIA could explore mechanisms to reduce the incentive for providers to travel, such as planning processes that only allow providers to charge for travel where there are no local alternatives.

An alternative option would be to add a price loading to rural areas, as is done with remote and very remote areas. The Health system, via the General Practice Rural Incentives Program, and Aged Care system, via the viability supplement and home care subsidy rates, currently provide additional compensation for service in MM 4-5 areas. However, it is mainly travel driving the increased cost of service to participants in rural areas. More than doubling the travel time allowed to be claimed by providers would provide a more targeted and effective intervention than a broad price loading, which does not account for the specific amount of travel a provider undertakes.

Travel should be tracked as a separate line item in NDIA payment data. This will allow the NDIA to monitor travel costs and better understand how providers and participants are allocating the costs of travel. Such monitoring will also allow the NDIA to understand whether more generous travel pricing provides a perverse incentive for providers to travel long distances rather than invest in local workforce development, or to encourage participants to attend the provider premises. This monitoring and better understanding of travel behaviour might then pave the way for the deregulation of travel costs. Removing travel caps to allow complete fungibility of travel versus direct service funding would enable providers to charge for any amount of travel (subject to agreement with participants), affording participants maximum choice and control and requiring providers to reduce travel costs to remain competitive. In some areas with high participant density and sufficient supply, travel deregulation may be appropriate provided participants can make informed choices between providers located at varying distances from their residence. Participants, planners, and LACs would require education to understand the availability of supply for each participant as well as the outcome implications of trading off travel and direct service. The NDIA should maintain travel caps in the near term, including an expanded cap for travel in rural areas, with the option of exploring travel deregulation as the NDIS matures.

Service provision in rural areas can also be affected by restrictions on the ability of participants to transport themselves to and from support services. This was an issue highlighted by providers during the IPR team’s consultation process (see Section 2). However, this issue is beyond the remit of the IPR. The NDIA could work with LACs, planners as well as the states and other local authorities to understand if a participant has public transport available to them and the capability to utilise the service. The IPR team recognises that solutions to transport will have implications for the adequacy of supply and support access in remote and rural areas.

Implications

The short-term implications of this change in travel policy for Scheme expenditure is difficult to estimate with precision as the NDIA does not currently track travel as a separate item. For instance, a provider who charges for an hour of service provision may have had no travel, or have used the full travel entitlement of 20 minutes and provided 40 minutes of care.

The IPR has made a number of assumptions to estimate potential costs, based on available information. Assuming a quarter of the participants who receive supports in regional areas (MM 4 and MM 5) are now provided services which attract additional travel entitlements, and that 45 minutes of travel is charged for approximately every four hours of support provided, the additional annual cost to the NDIS would be approximately $75 million.

Increasing the amount of travel time providers can charge will require planning process adjustments. Participants living in rural areas who require providers to travel to them, and who can only be served by providers requiring more than 20 minutes travel, should be given proportionally larger plan allocations to account for the cost of travel within these areas. As with other changes to price caps which affect how plans are constructed, participant education initiatives and additional coordination of support should be offered in parallel, to ensure that participants are able to factor in provider travel times when exercising choice and control.

As the Scheme matures and local workforces develop, the NDIA should review this policy and assess whether other incentives may be more appropriate to encourage local supply and reduce the incentive for providers to travel long distances to deliver supports.

4.2.3 Single national price

Issues and evidence

The NDIA currently has two different price guides, with typically lower prices in Eastern states (NSW, VIC, QLD, TAS) and higher prices in Western states (ACT, NT, SA, WA). For example, the price for ‘assistance with self-care activities during daytime weekdays’ differs by 1.8% between the two guides. In the ACT, NT, South Australia or Western Australia, providers can charge $45.54, while in the remaining states the cap is $44.72. The differences between other prices range from 0-12%. For example, higher intensity group care on Sundays is capped at $57.18 in ACT and the western states and territories, while it is capped at $52.84 in the other states.

There is no clear rationale for maintaining separate price guides. Current disparity between the Eastern and Western price guides appears to be based largely on legacy arrangements between jurisdictions, rather than on a direct correlation with regional costs. Whilst there is currently some minor variation in labour costs between states, it is not correlated to the division of price guides. Analysis of labour costs other than award wages, such as payroll tax, leave entitlements and workers compensation requirements, does not show a consistent difference between the eastern states and western states.[34]

[34] See Appendix C for more details on differences in award rates between States and analysis of other cost differences.

Recommendations

5: The NDIA should converge the two Price Guides and move toward a single national price guide by 2021.

In the absence of stronger justification for differentiated price guides across states, the NDIA should progressively converge prices to promote pricing simplicity, ease of communication, and systems efficiency for providers operating across multiple states. This price convergence should occur by 2021.

It is the IPR team's view that the NDIA should not attempt to capture the price differences between each state through tailored state-specific price guides, as this is likely to lead to significant pricing complexity and may also fracture a national market. Cost differences within states, driven for example by remoteness of a region, are more important factors, and these are accounted for through specific policies (see Sections 4.2.1 and 4.2.2 above).

Implications

Transition to a single national price guide will need to occur over the next three years. This can be done by adjusting the relative rates of annual inflation between the eastern and western price guides such that the two price guides converge over time. Once implemented, providers operating nationally will benefit from the simplicity of one national price guide.

4.3 PRICING OF ONE-TO-ONE SERVICES WITH DIFFERENT LEVELS OF COMPLEXITY

The NDIA recognises participants entering the NDIS will have a range of disability types, levels of functional impairment, and requirements of a support worker to meet their needs. A two-tiered pricing structure is in place to allow a high intensity rate to be charged by a provider. The high intensity rate is set at 5.5% higher than the standard rate, applicable where a participant's complex needs require assistance from a support worker with a higher skill level. Support workers serving participants with complex needs are sometimes exposed to a higher level of safety risk, which can be to a participant or to themselves, and the higher skill levels and pay rates ensure the support worker is fit to provide quality services to participants in these environments. Examples of environments with greater safety risk could include a support worker serving a participant with medical needs where health-related intervention is a core component of service delivery, or serving a participant with behaviours of concern that could result in the participant attempting to self-harm or harm the support worker.

The key concerns raised by providers related to the quantum of the high intensity loading being insufficient to cover the cost of employing a higher skilled worker, and the loading not accounting for the additional time required to service participants with complex needs, including team meetings, report writing, training, and more frequent incident management. Additional concerns included the inconsistent application of high intensity loading across Core Support Items in the Price Guide. Examples include centre-based care having no high intensity rate, and not allowing for increased carer ratios, and the inconsistent allocation of the high intensity loading across participants. Currently, responsibility falls on a provider to agree with a participant that a high intensity loading is necessary for them to receive the level of care that will help them achieve their desired outcomes.

This section covers the following topics:

- 4.3.1 Definition of complexity and quantum of the high intensity rate
- 4.3.2 Participants with extreme behaviours of concern
- 4.3.3 Consistency of pricing for participants with complex needs across core supports

4.3.1 Definition of complexity and quantum of the high intensity rate

Issues and evidence

There is no simple definition communicated to the sector of what complexity means in a pricing context, and as a result, the term complexity is used inconsistently. Providers link complexity to the ratio of care a participant requires i.e. the number of carers, the number of hours of care a participant has allowance for in their plans, also referred to as 'intensity of care', and more subjectively, to how difficult a provider believes it is to serve a participant. There are cohorts of participants that require support workers with specific skillsets above the level of a typical support worker, which cost providers more to employ. Providers are not consistently receiving a high intensity loading to serve these participants due to the lack of clarity in the definition of complexity. The link between a participant's needs, the cost drivers of a provider, and price is not clear, which leads to inconsistent application of the high intensity price loading. The policy placing the responsibility on providers to determine whether a participant should be charged a high intensity rate exacerbates the issue, as providers each have their own definition of complexity.

Provider submissions to the IPR showed that many providers employ support workers serving participants without complex needs between SCHADS Level 2.2 to Level 2.4. This is consistent with NDIA expectations and the responsibilities outlined in the Award for a Social and Community Services Employee Level 2.[35] To serve participants with complex needs, providers often employ support workers at a base wage level between a SCHADS 2.4 and 3.3 to match the workers increased level of skill and experience. There is evidence of some providers employing workers up to and above SCHADS Level 4. For participants classified as having complex needs because of a medical condition, additional skills of a support worker can include the ability to recognise the need for health-related intervention, and administer medication by injection, or feeding through a nasogastric tube. For participants classified as having complex needs because of behaviours of concern, additional skills of a support worker can include the ability to recognise symptoms or presentations of mental illness and intervene to de-escalate violent behaviours. To serve participants with complex needs resulting from medical or behavioural presentations, support workers are required to exercise judgement based on prior knowledge and experience to determine the course of action necessary to

[35] The Award states the responsibilities of a Level 2 employee are: *'(k) implementing client skills and activities programmes under limited supervision either individually or as part of a team as part of the delivery of disability services'* and *'(l) supervising or providing a wide range of personal care services to residents under limited supervision either individually or as part of a team as part of the delivery of disability services'.* The Fair Work Commission: *Social, Community, Healthcare and Disability Services Industry Award 2010 (updated 29 July 2017), p. 52*

address the situation. These attributes closely align to the characteristics necessary of a Level 3 employee.[36]

The high intensity loading of 5.5% is intended to provide additional funds where a participant requires assistance from a support worker with additional skills or experience relevant to a participant's complex needs. The loading provides enough funding to allow an employer to pay a support worker between a SCHADS 2.4 and 3.1, which is at the lower end of the wage level currently being paid by providers, assuming a base level of SCHADS 2.3, which is consistent with the rate paid by many providers for participants without complex needs. This could be adequate in some situations such as feeding through a nasogastric tube in a standard environment. However, where a participant has very serious behaviours of concern, or a combination of medical needs and behaviours of concern, a worker with a higher level of skill may be required.

Many providers raised concerns about the high intensity loading not taking into consideration the incremental ongoing training and development requirements for support workers serving complex participants. Submissions to the IPR indicated providers are conducting approximately 3-4 hours of additional training for these support workers each quarter. These training sessions often bring together groups of support workers and other professionals to discuss individual client situations and techniques that have been used or developed to deliver improved outcomes. As the sessions are often internal, the costs incurred by providers are for support worker time, with no opportunity to recover the cost for the delivery of the training.

Providers serving participants with complex needs reported that they spend more time on incident management and reporting than other providers, due to the nature of the disabilities of the participants cohorts they serve. One small provider estimated spending over 200 hours per year on incident management, with an average of one incident per fortnight, and each incident requiring a review, report, care team meetings, and a response plan. This was estimated to have up to a 2-3% impact on the provider's overall margin. While not all incidents are avoidable, providers are expected to have effective internal processes to prevent and respond to incidents.

[36] The Award states the characteristics of a Level 3 employee include: *'General features of this level involve solving problems of limited difficulty using knowledge, judgment and work organisational skills acquired through qualifications and/or previous work experience. Assistance is available from senior employees. Employees may receive instruction on the broader aspects of the work. In addition, employees may provide assistance to lower classified employees.'* The Fair Work Commission: *Social, Community, Healthcare and Disability Services Industry Award 2010 (updated 29 July 2017)*, *p. 54*

Recommendations

6: The NDIA should develop a definition for complexity linked to the skills required to meet participant's needs, and use its specialised planning resources to classify what skills are required, and which participants require higher skilled support workers.

The NDIA should develop a definition for what complexity means in a pricing context and communicate it to the sector. The definition must create a clear link between a participant's needs and the cost drivers for a provider, that can be translated into price. To serve participants with complex needs, providers employ support workers with additional skills and experience, and are required to compensate them with a higher base wage level. The increased cost of employing these support workers should be translated into the price. The NDIA can leverage most of the existing definition for high intensity supports in the Price Guide, but the focus should be on skill level rather than on qualifications, as in some cases additional qualifications may not develop the specific skills necessary to serve a participant's complex needs.

This revised definition should include a clear link between a participant and their needs, and the relevant and most significant cost driver of a provider being support worker wages. Examples of participants that would be defined as complex in a pricing context include participants that exhibit rapid, severe and frequent escalation of violent or self-harm behaviour, including some participants in the psychosocial and cognitive disability participant cohorts, and participants that require health-related intervention as part of ongoing support. In both situations, participants may require a support worker with additional skills to serve them. The skill level required to service a participant increases with the severity of a participant's complex needs, and there should be different tiers of pricing to match the different levels of skills needed.

The NDIA should use the specialist team of planners it is developing as part of the Participant Pathway project to develop a set of criteria to determine whether a participant's requirements are complex for the purposes of pricing. The objective of the criteria should be to determine whether a participant requires a higher skilled or qualified support worker for their needs.

The NDIA should assign the responsibility of classifying participants with complex needs for the purposes of pricing to the specialist planning team. Planners have visibility into participant records and complexity classifications throughout the participant pathway (see Appendix D – Existing definitions of complexity that exist within the NDIA), and under the revised pathway should have face to face interactions with participants to understand their needs and goals. Each of these sources of information should allow a planner to determine if a participant requires a support worker with additional skills or experience, and hence a price loading.

As the specialist team builds capability, it should develop and refine the service models used for participants with complex needs, both health and behaviour related, to make sure participants receive plans that meet their needs and deliver the best possible outcomes. It may be difficult for the planning team to build expertise quickly, and in the short-term the NDIA should consider leveraging industry experts for support until the team is able to manage most of the cases in-house. The team could continue to reach out to outside experts for advice in very difficult cases which are outside its area of expertise.

7: The NDIA should add an additional tier to the high intensity loading to allow a provider to recover the cost of a support worker with a higher level of skill than can be procured with the current high intensity loading.

The current loading may be sufficient to employ a higher skilled support worker for some complex needs, such as health-related intervention in a standard environment. However, it may be less suitable for situations where a participant has serious behaviours of concern, or a combination of medical needs and behaviours of concern. A third tier classification of 'Very Complex', should allow a provider to employ a mix of support workers at SCHADS Level 3.1 or Level 3.2. The loading should also take into consideration the incremental ongoing training and development necessary for support workers serving very complex participants estimated at 1%. The specialist planning team should be responsible for assessing and classifying participants considered to be Very Complex. The IPR team recognises that there is a small number of participants for whom it is very difficult develop prices due to the nature of their disabilities and the environments necessary to deliver their services, and believe a quoting process is the most appropriate mechanism to ensure they receive the supports required to meet their needs (see Section 4.3.2). TABLE 3 describes the characteristics of participants that would be classified as Standard, Complex, Very Complex, and Quoted.

Incidents are more likely to occur for providers serving participants with complex needs. Providers incur costs associated with incidents such as the time spent on team briefing meetings and incident report writing. Providers are expected to have effective internal processes to prevent and respond to incidents, but it is recognised that not all incidents are avoidable.

The introduction of the NDIS Quality and Safeguarding Framework will have some implications for providers on the scope of incident reporting requirements. Given the operational implications of this are not yet known, the IPR recommends that the NDIA revisits this recommendation in the future to evaluate if providers need to be compensated for the costs of incident reporting – for example by introducing an incident reporting line item in the Price Guide to allow for providers to charge for time spent on this activity.

TABLE 3: DESCRIPTION OF PROPOSED LEVELS FOR PARTICIPANTS WITH COMPLEX NEEDS

Classification	Participant characteristics
Standard (no price loading)	■ No health-related intervention needs (e.g. feeding through a nasogastric tube, ventilation support) ■ None or mild behaviours of concern
Complex (5.5% price loading)	■ Health-related intervention needs (e.g. feeding through a nasogastric tube, ventilation support) ■ Mild-moderate behaviours of concern (e.g. infrequent rapid escalation of challenging behaviour)
Very Complex (10% price loading)	■ Combination of health-related intervention needs and mild-moderate behaviours of concern ■ Severe behaviours of concern (e.g. rapid, severe and frequent escalation of challenging behaviour)
Quoted	■ Extreme behaviours of concern – see Section 4.3.2 for further details

Implications

The NDIA has commenced work to establish specialist planning teams as they develop the new participant pathway. The specialist team will need to be trained to categorise participants with complex needs as informed by the tool/set of criteria defined by the NDIA. It is important that the team monitors the outcomes of their categorisations to help improve accuracy and consistency over time.

An improved definition of complexity and allocation process will ensure providers are able to charge a higher rate to participants that require a higher skilled support worker. This will allow providers to recover the increased cost of direct supports required to service the complex participant cohort. It will be important to engage with the relevant segments of the sector, both participant and provider representatives, when developing the final set of characteristics to be used during the complexity classification. This will limit the number of times providers request the NDIA to review participant categorisations. In a situation where a provider challenges a participant's categorisation, a process needs to be put in place to allow individual cases to quickly be reviewed by the NDIA if a provider can provide evidence to show the categorisation is not correct. It should be noted that it is possible some participants are currently being charged the high intensity rate that would not apply under a new definition. To reduce the financial impact on providers, the definition should be phased in for participants already in the NDIS as their plans come up for review.

The expected cost of the additional tier of price loading for participants with complex needs is between $100m-$140m, which represents 0.5%-0.7% of costs at Full Scheme[37]. The IPR team expects the costs to be at the lower end of the range, as the improved definition and classification process for participants with complex needs will limit the number of participants that receive the price loading to only those that require a support worker with additional skills. It is possible the price increase could be absorbed by the utilisation levels within participant budgets, meaning there could be no impact on the funding envelope. The suggested approach is to fix each of the definition and classification issues related to complexity before adjusting the price. This will ensure price loadings are only applied to participants considered to have complex needs under the improved definition of complexity.

4.3.2 Participants with extreme behaviours of concern

Issues and evidence

Participants with extreme behaviours of concern include participants that are subject to orders under the justice system, also referred to as forensic disability participants, and previous offenders no longer subject to orders. Participants with extreme behaviours of concern are not explicitly recognised in NDIS pricing. Forensic disability participants are typically individuals with cognitive impairments that have committed criminal offences in the past, but are unable to be institutionalised due to their condition. They often fall at the extreme end of the spectrum of behaviours of concern. Providers have historically served this participant cohort with a very

[37] Based on 12% of participants qualifying for the complex level (a 6% loading) and 10% of participants qualifying for the very complex level (a 10% loading), with a margin of error of +/- $20m, and assuming all participant plans are adjusted to compensate for the change in policy

skilled workforce, such as tertiary educated support workers, and it is not possible for them to recover costs at the high intensity rate set in the Price Guide.

There is legislation in place that details the responsibilities of the NDIS to participants that have been offenders under the criminal justice system. The NDIS (Supports for Participants) Rules 2013, made for the purposes of Sections 33 and 34 of the National Disability Insurance Scheme Act 2013, outline that forensic disability services are to be funded and delivered as part of the NDIS.[38] Services to be provided to this participant cohort are legislated under a number of state-based Acts related to the nature of the offence and disability of the participant.[39] A provider requires extensive knowledge of the legislative environment to deliver services to this participant cohort, who often need intensive supports and services, delivered by very skilled and experienced professionals. As the services necessary for a participant can vary significantly from one circumstance to another, it is very difficult for the NDIA to develop pricing schedules and plans that meet the needs of participants while also adhering to state-specific legislation.

Providers serving forensic disability participants, often referred to as forensic providers, are exposed to increased risk compared to providers focused on other participant cohorts. NDIA policy does not allow providers to deliver all support items from the Support Coordination support category, to mitigate the risk of a conflict of interest. There are cases of forensic service providers pulling out of Support Coordination or refusing to provide the services to participants not in their care to minimise risk, where they are not in full control of a participants care. This puts the specific sub-market at risk of supply shortages.

The NDIA has put rules in place for the Support Coordination support category to mitigate the risk of conflicts of interest, specifically for Local Area Coordinators (LACs), which are included in the NDIS Partners in the Community Program: Program Guidelines (August 2016).[40] There are three Support Items within the Support Coordination support category relevant to the discussion: Support Connection, Coordination of Supports, and Specialist Support Coordination. Participants that are classified as Supported or General during the pre-planning phase, meaning it is easier for the planning team to engage with a participant throughout the participant pathway, receive Support Connection. Support Connection is delivered by LACs, and it is not possible for LACs to deliver Support Connection and provide services to the participant. Participants classified as Intensive or Super Intensive during the pre-planning phase, meaning it is more difficult to engage with a participant throughout the participant

[38] Section 7.23 explains the meaning of a person not in custody: '*person not in custody means a person who is subject to the justice system (including relevant elements of the civil justice system), but is not in a custodial setting (for example, a person on bail, a person under a community based order that places controls on the person to manage risks to the individual or to the community, a former prisoner on parole, or a person in home detention)'*. Section 7.24 goes on to explain the NDIS responsibilities for a person not in custody *'The NDIS will be responsible for: (a) in relation to a person not in custody –reasonable and necessary supports on the same basis as all other persons'. National Disability Insurance Scheme Act 2013* (the Act): *National Disability Insurance Scheme (Supports for Participants) Rules 2013, Section 7.23 and 7.24, p. 20*

[39] In Victoria, this can include Supervision Orders under the Serious Sex Offender and Detention Supervision Act 2009 and the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, Parole Orders (and Bail Conditions) under the Crimes Act 1958 and Corrections Act 1986, and Community Treatment Orders under the Mental Health Act (2014).

[40] Section 4.1.1.3 states 'An Applicant which applies to deliver LAC Services, must not be a Registered Provider of Supports as defined under section 9 of the NDIS Act'. NDIA: NDIS Partners in the Community (Round One) – Program Guidelines, Section 4, p. 9

pathway, receive Coordination of Supports and/or Specialist Support Coordination. These Support Items are delivered by providers, not by LACs. It is possible for a provider to deliver Coordination of Supports and/or Specialist Support Coordination and be a participant's service provider, but the provider must ensure they proactively manage conflicts of interest, as per the Terms of Business for Registered Providers (July 2016).[41]

The NDIA is currently addressing cases of participants with extreme behaviours of concern out of their regional offices, and providers have communicated that in some cases they have been allowed to develop quotes to deliver services to this participant cohort. However, there are examples of providers being advised that they need to follow the Price Guide, and price according to the high intensity rate. There is not yet a consistent approach for addressing the needs of this participant cohort.

Recommendations

8: The NDIA should develop a consistent process for participants with extreme behaviours of concern that acknowledges the specialised needs of the participant cohort, and the environment providers operate in. Providers serving this cohort should quote on the delivery of services to these participants, and be allowed to deliver all services they require to be adequately supported i.e. all Support Coordination items.

The quotes, which would include a detailed support plan for a participant, would be submitted directly to the specialist planning team (see Section 4.3.1) for review and approval. A quoting mechanism will be most effective for this participant cohort given that the number of participants in this cohort is very small, the number of providers servicing the participant cohort is also very small, effectively making it a thin market, and the services necessary to support participants will vary significantly from one individual to another.

Allowing providers to deliver all Support Coordination services will ensure individuals in this participant cohort receive the services they require to be adequately supported, and help to eliminate the risk of supply shortages leading to participants not being able to procure services. Detailed reviews of the quotes submitted to the specialist planning team to ensure participants are only receiving the supports required to meet their needs can help the NDIA protect against conflicts of interest.

Implications

The NDIA will need to set up a quoting process to allow providers to submit quotes for review and approval. For the NDIA to review and approve quotes, the capability of the specialist planning team needs to be place with a clear understanding of the needs of the forensic disability participant cohort as well as of the legislative environment in which forensic service providers operate. To speed up the quoting process and ensure forensic disability participants can move into a care environment as quickly as possible, the NDIA may identify a list of preferred providers in each state that can be contacted at short notice.

[41] The Terms state *'Registered Providers must ensure that they proactively manage perceived and actual conflicts of interest, including through development and maintenance of organisational policies'* NDIA: *Terms of Business for Registered Providers (effective 18 April 2016)*, p. 3

From a participant perspective, allowing forensic service providers to deliver all supports to them could be considered as a conflict that limits choice and control. Considering the legislative environment providers operate in, it is unlikely a participant will receive a range of services from multiple providers. It is a better outcome for the participants to have the services available to them than not at all due to providers not wanting to take on additional risk.

4.3.3 Consistency of pricing for participants with complex needs across core supports

Issues and evidence

There are inconsistencies with the application of high intensity loadings and care ratios across different core supports. Support items including 'Assistance with self-care activities' and 'Assistance to access community, social/recreational activities' allow providers to charge a high intensity loading where assistance is required from a support worker with additional skills or experience relevant to the participant's complex needs. The support items also allow providers to charge different prices dependent on the care ratio necessary to support a participant. This can either be a lower care ratio, such as 1:2 or 1:3, where a single support worker can service multiple participants at the same time, or higher care ratio, such as 2:1 or 3:1, where multiple support workers are required to serve a single participant.

The support item 'Group based activities in a centre', does not allow providers to charge a high intensity loading, meaning providers cannot be compensated for the additional cost they incur for a highly skilled support worker if a participant with complex needs chooses to utilise the service. This support item is also set at a price between the 1:2 and 1:3 care ratio for Assistance with self-care activities and Assistance to access community, social/recreational activities, and does not provide the flexibility to providers to either increase or decrease the price based on the number of participants in the group.

Recommendations

9: The NDIA should update the pricing structure for the core support item 'Group based activities in a centre', to allow providers to charge a high intensity loading where a more skilled worker is required to serve a participant, and set prices consistent with the care ratio required to serve a participant.

The NDIA should ensure pricing for 'Group based activities in a centre' adopts the same approach used for other core supports, including Support Items 'Assistance with self-care activities' and 'Assistance to access community, social/recreational activities'. This recommendation is not designed to encourage a participant to lead a life with a high intensity of support. Rather, it is expected that as the Scheme matures and evidence develops, providers and the NDIA will be able to assess which interventions are most effective in supporting participants with complex behaviours and needs to achieve improved outcomes and, in some cases, no longer require high intensity support.

Implications

Participants with complex needs utilising 'Group based activities in a centre' will be required to pay a higher price for the service. They will need to choose whether they would like to

continue utilising the services at the higher price, or if their funding can be used more effectively with a different mix of services.

4.4 PRICING OF SHORT TERM ACCOMMODATION SERVICES

The NDIA recognises participants may at times have periods where their support arrangements need to be different from the regular level of support they receive. Short-term accommodation (STA), also known as Respite, is a Core Support available to participants to provide third-party care in a group based facility or in-home support. The service is often used by participants whose regular support is delivered at home by family members, allowing family members the opportunity to have some time off from being the primary care giver. It also gives participants the opportunity to socialise with peers in a safe environment.

At the time of the provider consultation phase of the IPR, a flat price of $501.71/day[42] was in place for STA, and most concerns by providers related to the lack of price differentiation. The key concern voiced by providers was that a single price for the STA support item did not reflect variations in the cost of service delivery by the day of the week, or by the care ratio necessary to serve a participant. Providers also raised the issue that there was no allowance in the price to compensate them for the capital invested in the facilities. After the completion of the consultation phase of the IPR, the NDIA announced price changes effective 30 October 2017 to address issues related to the STA price.

Issues and evidence

Under a single price point, many providers found it difficult to operate economically on weekends and public holidays, when they were required to pay penalty rates to support workers, and when participants required higher care ratios such as one-on-one support. As a result, providers began to withdraw services from the market, either by closing their facilities on specific days of the week, by no longer providing services to participants that required high care ratios, or by shutting down their short-term accommodation services completely. Recently, this issue became acute in the ACT, where providers Duo and Carers ACT closed their short-term accommodation services, and Marymead, the only other provider, signalled they were going to follow, having already restricted services to participants that required low care ratios on specific days of the week that did not involve substantially higher labour costs.

The NDIA responded to the market reaction and revised the price of STA, releasing a new price schedule, effective 30 October 2017. The NDIA adjusted the price, basing it on the price of attendant care, to better reflect the variable costs of service delivery on different days of the week and at different care ratios for participants, and capital employed in facilities. The revised pricing schedule includes differentiated prices for weekdays, weekends, and public holidays, as well as for care ratios of 1:4, 1:2, and 1:1 support needs. Each of the prices also includes a capital allowance. The NDIA has established a process for participants who are fully utilising their plans to review participant budgets and ensure participants are not disadvantaged by the price increases.

[42] NDIA: *2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017)*, p. 40

Recommendations

10: The NDIA should continue to refine the assumptions for high intensity rates, active overnight, and capital allowances used to develop the new STA price schedule, to ensure they reflect the cost of service delivery.

The IPR team agrees with the approach used by the NDIA to develop a differentiated price schedule based on the price of attendant care, that is more reflective of the cost of service delivery for providers. Assumptions around provider operating models have been used to develop the new pricing schedule, and the NDIA should continue to refine each of these to reflect an efficient provider's costs.

The NDIA has applied the high intensity loading to each care ratio to build up the new STA pricing schedule. This high intensity loading should only be used where a participant requires assistance from a support worker with additional skills or experience relevant to the participant's complex needs. Participants with complex needs are less likely to be served under low care ratios. The NDIA should consider using the standard intensity rate for lower care ratios (1:4 and 1:2), and in those special cases have two prices for a 1:1 care ratio, one price based on the standard rate (for participants with high physical disabilities) and one price based on the high intensity rate for participants with complex needs.

For each care ratio, the assumption made in the price is that the support worker will be required to work 8 hours of an active overnight shift, meaning the support worker is required to be awake and active throughout the night. Provider consultation raised the point that this should only be necessary in extreme cases, and it would be reasonable to assume that for participants without complex needs, a support worker works a night-time sleepover shift, with up to two hours of active overnight hours to allow for disruptions during the night. The NDIA should consider using an overnight shift with up to two hours of active overnight for low care ratios, and an active overnight shift only when a high care ratio is required for a participant with highly complex behavioural needs.

An accommodation allowance of $200 per night has been included to cover board and meals throughout the new pricing schedule. The $200 figure is the average cost of i) accommodation costs for a day of respite in aged care facilities ($140), based on rates set by the Australian Government for My Aged Care, and ii) accommodation costs for a day in acute care or a hospital setting ($260), as sourced from the Independent Hospital Pricing Authority (IHPA). The NDIA should continue to refine the capital allowance by reviewing the operating costs of providers. A review of the financials of providers that made submissions related to STA indicated accommodation and other overhead costs could be below $100 per day. This is from a small sample of providers, but it indicates that the operating costs are much less comparable to hospitals, and the aged care comparison of $140 per day could be a more reasonable assumption.

4.5 THIN AND UNDERSUPPLIED MARKETS

A 'thin' or 'undersupplied' market is one in which there is a persistently low level of supply relative to demand. This is often due to structural features of the market that makes it expensive or difficult for providers to compete effectively. Thin markets are a key policy concern for the NDIS as the presence of thin and undersupplied markets can compromise participant outcomes in that region.

While price caps may have an impact on thin and undersupplied markets, other policy considerations can often be more important. Once a market has been assessed as thin or undersupplied, increasing prices can be a way to attract new suppliers and investment. However, some structural features cannot be overcome by price alone. This includes when the suppliers do not have the capacity to cater to some specialised markets, or when the market has structural features such as geographical isolation which make it difficult for providers to operate in these areas.

The NDIA should bolster its market evaluation framework to identify thin markets before they develop, invest in market development infrastructure, and make pricing changes where necessary.

Section 4.5 covers the following topics:

- 4.5.1 Process to identify thin and undersupplied markets
- 4.5.2 Addressing emerging thin and undersupplied markets

4.5.1 Process to identify thin and undersupplied markets

Issues and evidence

The NDIS is too young and the available data too incomplete to make a definitive assessment of whether certain markets are at risk of being thin or undersupplied. The NDIS has only been in operation for more than 12 months in a few geographic regions. 79% of supports committed in the latest financial year were in NSW, ACT and Victoria, with the NDIS yet to be rolled out in much of Queensland, Tasmania and the western states and territories. NDIS expenditure on support services in FY 2016/17 was 15% of the projected annual expenditure by 2021. Not only is the NDIS in its early stage, there are also some limitations to the current data on market supply. For example, comprehensive surveys of participants and providers are limited to the trial sites or have only just been initiated in other parts of the Scheme. More discussion of this evidence is presented in Section 3.1 – Market Development. It is too early to form definitive assessments about which markets are likely to emerge as thin or undersupplied, as any evidence of supply gaps may be a product of temporary transitional pressures, or reflect gaps in data collection.

The NDIA is currently designing a market analysis and intervention strategy to identify thin and undersupplied markets. It is also developing a strategy to maintain critical supports which will support its efforts to identify short-term responses to supply gaps. These strategies are yet to be finalised and implemented. The NDIA does not currently have a framework with clearly identified metrics and data sources to ensure that its monitoring strategies are more comprehensive and transparent.

Recommendations

11: As part of its market intervention strategy, the NDIA should adopt a clear set of metrics to more comprehensively identify and respond to risks of thin markets emerging.

The NDIA should include a clear set of metrics and data sources within a robust evaluation framework to test markets for potential undersupply. The IPR team recommended above the

adoption of a clear and robust market evaluation and decision-making process to set appropriate price levels (see Section 4.1.1). The foundation of this process is a comprehensive understanding of market indicators to understand whether there is sufficient supply in each Scheme market. The following section identifies the key metrics that the NDIA should monitor, the data sources it can rely on, and the teams within the NDIA that should have responsibility for collection and analysis of these metrics.

The IPR team recognises that no single set of Scheme-wide indicators can offer a definitive answer on whether supply challenges are likely to occur in each rapidly changing market. Therefore, the focus of the monitoring framework should be on identifying the markets that most warrant further investigation. The NDIA should err on the side of caution when identifying thin markets. Identifying the markets 'most at risk', rather than whether they are currently undersupplied or not, will position the NDIA well to respond to emerging supply challenges.

Participant survey data

The NDIA should have a regularly updated awareness of the share of participants who are unable to access supports for which they have a budgeted plan, and the share of participants who are satisfied with the quality of supports to which they have access. This can be constructed through a participant survey, as well as by accessing informal information flows from LACs and planners. As NDIS-wide participant surveys may be more difficult to update continuously, the NDIA can target participant surveys in markets that demonstrate other indicators of supply shortages.

The NDIA currently conducts a regular participant survey through its Short-form Outcomes Framework assessment. The NDIA should include in this survey a question as to whether participants were able to access supports for which they had funding, and if not, if this was due to a lack of available providers. The NDIA currently reports on the share of participants who identified having difficulty in accessing health services, but this question is not specific to either NDIS-supported services or difficulty caused by a lack of adequate supply. The NDIA should also collate instances of participants contacting their LACs to report an inability to find providers. The results of these queries should be included by the Provider, Markets and Sector development team in its regular assessment of markets and reported to senior management.

Provider intent

Understanding whether providers intend to expand services to a new market, continue in current markets, or withdraw from the markets in which they provide support services, is a good leading indicator of the adequacy of supply in the future. The NDIA can monitor this intent through provider surveys and regular consultation with providers. Where indications exist of provider exit, more thorough consultation should be conducted to inform the NDIA's understanding of provider economics, participant demand, and Scheme performance in that area. This will inform whether the prices in that market should be changed, including through interim pricing adjustments.

The provider benchmarking initiative currently being developed by the NDIA will give some indirect indication of provider economics and intent.[43] The NDIA also manages relationships with providers through its regional offices and LAC network. However, standardised and regular reporting of provider intent should be part of its permanent market monitoring framework.

Utilisation rate

The utilisation rate is the share of a participant's budgeted plan that has been used to purchase services. It is calculated annually and, since services provided in one year may not be claimed for reimbursement until some months later, updated retrospectively. If a participant were unable to find providers of sufficient quality to meet their needs as specified in their plan, it would be reflected in the utilisation rate, and could signpost a lack of appropriate supply in that market.

Utilisation rates should be used by comparing changes in relative levels to overcome some of the metric's shortfalls. Absolute levels of utilisation rates are less informative because they may be affected by many factors other than supply. The most important of these is the content of the plans themselves; a utilisation rate might appear high simply because the plans catered for inadequate supports in the first place. Similarly, plans that provide for more services than required in a support category may appear underutilised, even though the participants are accessing all the high-quality support they require. Some plan managers who were consulted by the IPR team reported that their participants sometimes had spare allocations for capital equipment in case some of it was damaged and needed to be replaced. Such items are only intended to be used infrequently and could account for low utilisation rates in some support markets.

Despite these alternate explanations for any given level of a utilisation rate, observing the relative rates across markets, and the change in rates over time, will give some indication of which markets may be experiencing supply shortfalls.

The Scheme Actuary currently collects and shares utilisation data quarterly. The IPR team proposes the Provider, Markets and Sector development team should identify quarterly markets in the Scheme with low levels of relative utilisation using more tailored samples of participant utilisation rates, e.g. support type by geography, or a subset of participant characteristics within a geography. Markets with utilisation rates that are persistently lower than other markets can be investigated using surveys and interviews, through working with LACs, regional offices, participants and providers in that market.

Rates of market entry and exit

Rates of market entry and exit are a basic measure of the willingness of providers to supply disability support services in the NDIS at existing price levels. A combination of registration and payment data can help inform this measure. Registration data indicates instances where firms enter or exit the NDIS, but a provider can register while not actively providing supports and stop providing supports without deregistering. Analysis of payment data to identify provider activity offers the most direct observation of market supply. It is recognised that provider entry and exit rates will be affected by many commercial (and other) factors that are

[43] National Disability Insurance Agency: *Overview of benchmarking project,* available at https://www.ndis.gov.au/providers/market-information-useful-links/benchmarking-Project-Overview

not a result of just the price level. However, significant variations in provider entry or exit rates in some markets should serve as a trigger for further investigation.

The Scheme Actuary currently collects and reports payment data which shows rolling averages of provider entry and exit. This should be reviewed monthly by the Provider, Market and Sector development team, who should work with the Scheme Actuary to identify the markets by support type or geography which are experiencing the highest net declines in provider activity. This should be a trigger for further investigation in the relevant markets.

4.5.2 Addressing emerging thin and undersupplied markets

Issues and evidence

Provider submissions to the IPR during the consultation process for this review identified some markets as being at risk of undersupply due to the additional expense and difficulty in catering to them. These included markets for participants in remote regions and those with complex needs. These markets were also identified by the Productivity Commission as potential thin or undersupplied markets.[44]

Remote and very remote areas account for 3-5% of the current committed supports in the Scheme. Provider consultation and market data suggest a risk of undersupply in these markets. The non-financial obstacles to providing services in remote and very remote areas, include insufficient information about the participants in that region, limited Scheme infrastructure such as LACs, and the lack of a local workforce. Providers also revealed difficulties in travel to and from these areas which made service provision unsustainable (see Section 4.2.1).

Participants with very complex needs are defined here to include those that most require assistance from a support worker with additional skills and experience due to a medical need or challenging behaviour (see Section 4.3 for further detail). Based on the current application of ‘high intensity’ loadings, this cohort is estimated to comprise approximately 4% of participants enrolled in the Scheme but 13% of expenditure in the latest financial year.[45] Service provision to these participants is highly specialised and the participant density is low, creating a risk of undersupply that should be monitored and addressed (see Section 4.3.3).

Across all markets, as the Scheme transitions, the current assessment of market supply will change. Participants will change their demand patterns, new suppliers will come online while others leave, and Scheme infrastructure will be developed that helps participants and providers find each other – through LACs, and events at which providers can present their services, for example. These changes can continually affect the adequacy of supply in the market and must be proactively monitored by the NDIA.

[44] Productivity Commission: *National Disability Insurance Scheme (NDIS) Costs* (19 October 2017) , pp. 268 – 270.

[45] Share of participants who have been assessed as Level 13 – 15 according to the Disability Severity Indicator. It should be noted that this current definition of complexity does not adequately capture all participants with complex needs (see Section 4.3.1).

Recommendations

The supply challenges faced by the markets identified above can be addressed in part through changes to pricing and related policies. These changes are briefly outlined below, and discussed in more detail in the relevant other sections of this report:

- In very remote areas, including isolated Indigenous communities, the NDIA can work with providers to develop local workforces, and allow providers to quote on services to ensure supply in the short term (see Section 4.2.1).
- In rural areas, the NDIA can amend travel policies to enable providers to recoup costs associated with delivering services to participants in these areas (see Section 4.2.2).
- For participants with complex needs, the NDIA should more clearly define these participants, and adopt a more appropriate tiered pricing structure to reflect the costs of providing services for these participants (see Section 4.3).

In some cases, thin and undersupplied markets will require immediate intervention to ensure the provision of critical supports. For example, participants with daily care needs may require assistance in locating providers if a major provider in an already thin market were to withdraw. The NDIA is undertaking an initiative to ensure access to critical supports at any time, and facilitating a provider of last resort solution to address this scenario. In these circumstances, a price solution alone may not address the short-term requirements of participants, and LACs will likely play a significant role to help participants find suitable providers.

12: The NDIA should invest in Scheme infrastructure such as an e-market tool, which would empower participants in thin or undersupplied markets to find suitable providers.

One of the priorities for the NDIA as the NDIS has developed has been ensuring participants can connect with providers. To assist in this, the NDIA is establishing a ‘Provider Finder’, which enables a participant to search by postcode for a provider in his or her area. This is a useful tool for identifying providers, but does not yet let participants compare prices or transact directly through the platform. As the market grows, an e-market tool with this functionality will empower participants and increase price transparency and competition amongst providers. In addition to helping the NDIA address thin and undersupplied markets, easier identification of services and prices could support a faster transition towards deregulated prices (see Section 4.7).

An e-market would enable a participant to search by support type or features of the provider, such as location, price-range, or quality rating, and could also allow participants and providers to book support services on the platform. The e-market will not be a suitable solution for all providers and participants, for example where there are difficulties in accessing the internet or navigating an online portal. As such, the NDIA through its regional offices and LAC network should also continue experimenting with other forms of Scheme infrastructure, such as physical market fairs where participants can come to one place to meet providers and compare offerings.

In addition to its own activities, the NDIA can speed up the process of delivering an e-market by allowing private firms to develop and compete on online marketplace platforms. There are firms that are already providing similar products, but some are not registered in the NDIS,

meaning Agency-managed participants cannot access supports on these platforms. The NDIA should explore options to incentivise private providers to build e-market tools.

4.6 PROVIDER EFFICIENCIES AND ADEQUACY OF PROVIDER RETURNS

Section 3 of this report included analysis on provider economics and benchmarking with other schemes. The IPR team found that across all support types there were examples of providers operating profitably, as well as examples of providers struggling (see Exhibit 3). The successful models provide inspiration for how the market can innovate and drive efficiencies, while providing high quality services to participants that meet their needs. However, some providers, particularly those providing attendant care services, are struggling to make the transition to the NDIS.

The IPR team has focused on the adequacy of provider returns for attendant care and therapy. Attendant care was chosen given the large proportion of Scheme spend it represents, and given the recent scrutiny on the price cap for 1:1 attendant care. Therapy supports was chosen because the single NDIS price cap for therapy appeared to be inconsistent with the multiple price levels, and structure, of other comparable schemes.

Section 4.6 covers the following topics:

- 4.6.1 Costs of transitioning to the NDIS that impact provider returns
- 4.6.2 Administrative costs related to operating within the NDIS
- 4.6.3 Attendant care adequacy of provider returns and efficiencies
- 4.6.4 Therapy adequacy of provider returns and efficiencies

4.6.1 The cost of transitioning to the NDIS

Section 4.6.1 provides context for all of Section 4.6 by outlining the transitional costs and organisational challenges providers across all supports face as they move to a unit-funded, consumer-driven environment under the NDIS. It also provides an overview of federal and state and territory government spending to date to support NDIS transition, specifically as it relates to supporting provider readiness.

4.6.1.1 Changes providers must adapt to under the NDIS

Transitioning to the NDIS requires existing providers to develop new organisational capabilities and make significant changes and innovations to their systems and process. This requires significant investment by providers. This was recognised by DSS in a 2015 document.

'A substantial proportion of existing service providers are unlikely to operate effectively in the new environment without significant transformation…Providers long accustomed to block funding will require support to transition to business models responsive to individualised funding, and to diversify their service offerings to meet the support requirements of NDIS participants'.

Anecdotal evidence from provider consultations indicated that the cost of transition could amount to 1.5% of total annual expenditure for a provider.[46] The four biggest transitional changes to which providers must adapt are: a shift from block funding to unit funding; adapting to a consumer-driven service environment; a shift from payment in advance to payment in arrears; and compliance with a new quality and safeguards framework. Many providers have invested in IT, organisational capability, and organisational restructures.

Shift from block funding to unit funding

The shift from receiving and reporting against block funding every quarter, to claiming and reporting against individual units of service, has created challenges for providers.

First, many providers are struggling to manage the additional administrative burden of unit-funding. Anecdotal evidence from consultation suggests many providers have hired new corporate staff to manage payments and invoicing, increasing corporate overhead costs.

Second, providers have had to invest to understand whether they can deliver services under NDIS pricing. The unit costing regime requires providers to accurately measure each component of their service delivery, including on-costs and corporate overheads. Anecdotal evidence suggests many providers of disability support services did not understand their unit cost to serve prior to the NDIS. Nor did they possess data or organisational capability to measure unit costs, and therefore did not understand whether they could deliver services profitably within NDIS price caps. Not understanding whether they could deliver services within the price caps, or whether they had the short-term financial resilience to cope with transition, was a significant source of stress for many organisations. Many larger organisations hired external consultants to help them understand their unit costs to serve, while the federal government and state governments have also funded programs to help develop this capability in the sector.

Adapting to a consumer-driven service environment

In a new consumer-driven, competitive service delivery environment, providers must develop marketing capabilities to attract and retain customers. There is broad recognition amongst providers that this capability is underdeveloped in this sector, and many providers are investing significantly in their direct-to-customer marketing capabilities:

- One industry expert states: ‘There is a low level of sophistication in understanding the marketing funnel and the sequence of events through the activities of reaching, engaging, converting and servicing customers’.
- In transitioning to the NDIS, one provider invested in 10 full-time equivalent (FTE) staff to perform sales and relationship management functions at a cost of $750 000 per year, and incurred marketing and other new costs of $250 000. This represents an increase of over 1% to their total annual expenditure.

[46] Based on data from 3 large providers with revenue of over 50 million in FY16/17. Included spending on IT, new business teams and NDIS transition teams.

The empowerment of participants to choose not only their supports and providers, but also to have a greater say in when these are received, has also been challenging for providers. There is greater pressure to ensure that service times meet the needs of the participant, rather than the rostering requirements of the provider. This means providers are required to manage more peaks and troughs in demand between days of the week and hours of the day, making it more difficult to plan consecutive client bookings. Some providers have introduced a new human resources role to manage these new challenges, while others have invested in workforce rostering systems. Many providers have moved towards more casualised workforces to manage this challenge.

Shift from payment in advance to payment in arrears

Prior to the introduction of the NDIS, most disability organisations were paid by state and territory governments in advance on a quarterly basis. The switch from payments in advance to payments in arrears has represented a short-term cash flow challenge for providers, who now need to fund salaries and other expenses for a period in transition before they receive payments.

Compliance with a new quality and safeguarding framework

The NDIS Quality and Safeguarding Framework, released by the Council of Australian Governments Disability Reform Council in February 2017, introduces a nationally consistent system for regulating the safety and quality of disability services in Australia.[47]

The new framework will, among other things, introduce a new risk-based provider registration system. Registered providers whose registration group is deemed to be lower risk will only undergo a simple, periodic verification process while providers delivering higher-risk supports will be required to gain third party quality assurance certification.[48] In addition, all providers and workers will be required to comply with a new code of conduct, registered providers and their employees will be required to undertake a mandatory compulsory orientation module, and registered providers will be required to have effective internal complaints arrangements.[49]

In the short term, the new framework represents an added compliance cost for providers, who will have to adapt internal systems and processes to comply with these new standards. In the longer term, the framework may represent a cost efficiency for national providers – who will only need to comply with one set of standards, as opposed to one in each jurisdiction.

[47] Department of Social Services: *NDIS Quality and Safeguarding framework, factsheet for providers*, available at https://www.dss.gov.au/sites/default/files/documents/04_2017/ndis_quality_and_safeguarding_framework_fact_sheet_for_providers_final_2.pdf

[48] Department of Social Services: *NDIS Quality and Safeguarding framework, factsheet for providers*, available at https://www.dss.gov.au/sites/default/files/documents/04_2017/ndis_quality_and_safeguarding_framework_fact_sheet_for_providers_final_2.pdf

[49] Department of Social Services: *NDIS Quality and Safeguarding framework, factsheet for providers*, available at https://www.dss.gov.au/sites/default/files/documents/04_2017/ndis_quality_and_safeguarding_framework_fact_sheet_for_providers_final_2.pdf

4.6.1.2 Federal and state and territory government funding for provider readiness to date

To date, federal and state and territory governments have committed significant funds to support the NDIS transition. At the federal level, the Sector Development Fund (SDF), a pool of $146 million administered by DSS from 2012/13-2017/18,[50] has funded provider readiness projects under the primary outcome area of 'building disability sector capacity and service provider readiness'.[51] At the state and territory level governments have also invested significantly in the transition, often over and above the money they have received via SDF funding. For instance, the NSW Government spent over $30 million between 2009-2016 on NDIS sector development and capacity building.[52]

Of the money dedicated to provider readiness, some has been used to fund publicly accessible education tools that give providers practical business advice to assist the transition to the NDIS world, and some has been used to provide direct individualised provider support, financial and non-financial. It is unclear how much of this funding has been provided as funding to support provider education, versus direct financial assistance to providers.

Examples of provider readiness initiatives funded by federal and state and territory governments include:

- **Education tools for all providers:** The SDF funded a 'Unit Costing Tool Project' in New South Wales, which developed a suite of resources to help providers develop the capability to operating in a unit-funded NDIS world.[53]
- **Direct individualised non-financial assistance:** The SDF funded contractors to give providers in South Australia one-on-one support in helping them transform their business models, including assistance with financial and costing analysis, bookkeeping, IT and data management integration, and marketing and communication.[54]
- **Direct individualised financial assistance:** The NSW Government's Round 1 Transition Assistance Program (TAP), launched in 2016, provided over $ 4 million in financial assistance to small and medium providers regional areas. Providers with less than $3 million in annual turnover were offered up to $35,000 to help with readiness activities like updating business plans or purchasing software.[55] In TAP Round 2,

[50] The Fund was administered by the NDIA between 2013-2014.

[51] This is one of five outcome areas funded by the SDF. It is unclear at the time of writing this report, how much of the $146 million to date has been committed to this outcome area. The SDF is now closed for new applications.

[52] Audit Office of New South Wales: *New South Wales Auditor-General's Report Performance Audit: Building the readiness of non-government sector for the NDIS* (February 2017), available at http://www.audit.nsw.gov.au/news/building-the-readiness-of-the-non-government-sector-for-the-ndis

[53] National Disability Insurance Agency: *State and Territory Government SDF activities,* available at https://www.ndis.gov.au/sdf_state_territory.html

[54] National Disability Insurance Agency: *State and Territory Government SDF activities,* available at https://www.ndis.gov.au/sdf_state_territory.html

[55] NSW Government Department of Family and Community Services: *Funding boost to help regional NSW to get NDIS-ready* (19 July 2016), available at https://www.facs.nsw.gov.au/about_us/media_releases/media_release_archive/funding-boost-to-help-regional-nsw-get-ndis-ready

launched in 2017, the NSW Government awarded a further $600,000 in grants to providers.[56]

The effectiveness of this spending is not yet clearly established. Two audits have noted that these interventions have not been systematically evaluated. [57] Therefore, there is an opportunity for federal and state and territory governments to review the effectiveness of spending on provider readiness to date where possible, to evaluate the effectiveness of future interventions, and to assess whether any further support for provider readiness is required.

4.6.2 Costs of interacting with the NDIA

Issues and evidence

In addition to the expected costs associated with transition to the NDIS, consultation with providers revealed opportunities for the NDIA to improve its systems and processes, and reduce the administrative costs and cash flow risk of providers. Sections 2.2 and 2.4 summarised the provider feedback relating to the portal, NDIA responsiveness and planning raised in consultation, while Section 3.2 quantified the potential impact of these issues on provider financials based on a small sample of provider submissions. This sample indicated that the Agency could reduce provider costs by ~0.5% of total annual expenditure through improvements to its systems and processes.[58]

This section highlights a measures the NDIA should prioritise to address key provider feedback relating to NDIA systems and processes raised in consultation. The focus of the IPR is pricing and these recommendations are made in the context of the relative emphasis placed on these issues in consultation, and through an assessment of relative impact of these issues on provider economics.

The IPR team has been advised by the NDIA that there are multiple initiatives currently underway as part of the Participant and Provider Pathway Reviews that go to addressing the issues outlined in Sections 2.2 and 2.4, or to implementing some of the recommendations below.

[56] Consultation with the NSW Government Department of Family and Community Services.

[57] The Australian National Audit Office's audit of the Management of Transition of the Disability Services Market (November 2016) found *'limited evidence of evaluation of some higher cost projects'* funded by the SDF. Australian National Audit Office: *National Disability Insurance Scheme – Management of Transition of the Disability Services Market* (November 2016), available at https://www.anao.gov.au/work/performance-audit/national-disability-insurance-scheme-transition-disability-services. The NSW Audit Office's performance audit on *'Building the readiness of the non-government sector for the NDIS*' (February 2017) found the overall impact of the NSW Department of Family and Community Services spending on provider capability was not clear, as baseline information on provider capability was not collected and targets for improvement in provider capability were not set. Audit Office of New South Wales: *New South Wales Auditor-General's Report Performance Audit: Building the readiness of non-government sector for the NDIS* (February 2017), available at http://www.audit.nsw.gov.au/news/building-the-readiness-of-the-non-government-sector-for-the-ndis

[58] Based on 45 one-on-one interviews with providers in September 2017, in which three large providers (revenue > 50 million in FY16/17) gave detailed evidence of these costs.

Recommendations

13: The NDIA should prioritise the implementation of measures to continue to improve its portal, responsiveness and communication as part of the Participant and Provider Pathway Reviews.

Portal

- **Allow for automatic notification of plan review commencement, if participant consent is provided:** The NDIA has advised the IPR team that as of December 2017, changes to the portal will allow providers to view relevant sections of a participant's plan, including plan start and end dates, given the participant has a current service booking with the provider and the participant has provided their consent. The IPR team recommends the Agency also consider allowing providers to receive an automatic notification through the portal that a plan review has been triggered, given the participant has a current service booking with the provider and the participant has provided their consent.
- **Provide more detailed descriptions of claim rejection reasons:** The NDIA should consider providing a more detailed description of the cause of payment rejection in the portal.
- **Improve provider education tools:** The NDIA should continue simplifying and improving tools (like the provider toolkit) that educate providers how to navigate and troubleshoot portal issues. In the medium term, the NDIA should consider setting up a dummy portal that peak bodies and the NDIA can use to train providers on how to use the portal. This recommendation should be considered after changes in the provider pathway project have been implemented, and the new portal has been standardised.
- **Consult with providers when designing portal improvements:** The NDIA should consider making future improvements to the portal by consulting with a representative group of providers. The NDIA advised the IPR that this is already underway.

Agency responsiveness and communications

- **Stream call centre inquiries:** The NDIA should upskill call centre staff and stream call centre inquiries to specialist teams, to ensure that most provider inquiries are resolved by staff with the knowledge and the authority to resolve the issue. The IPR has been advised by the NDIA that there are current initiatives underway to address these issues.
- **Improve response times for SIL quote approvals:** The NDIA should aim to further reduce the average time it takes to process a SIL quote, building on its success to date in reducing the time required. The NDIA's current target is 14 days.
- **Improve communication of policy and process changes:** The NDIA should build on recent improvements such as the provider toolkit to clearly communicate all planned policy and process changes to providers, as far ahead of time as possible, and preferably through a single touchpoint. The IPR has been advised that the NDIA is aware of these issues and has recently implemented initiatives to address them e.g. the provider e-newsletter has been recently revised to include more 'need to know' information that is valued by providers.

Planning

The IPR team will not make any recommendations relating to the planning process as this is outside of the IPR's TOR. Moreover, the NDIA has advised the IPR team that most of the planning issues raised in Section 2.4 are being considered and addressed as part of the Participant and Provider Review projects.

4.6.3 Attendant care supports

Attendant care refers to 'Assistance with daily living' and 'Assistance with social and community participation'. 'Assistance with daily living' involves assisting with, and/or supervising personal tasks of daily life to develop the skills of the participant to live as independently as possible. 'Assistance with social and community participation' involves the provision of support to enable a participant to independently engage in community, social and recreational activities. Together these supports account for 45% of committed scheme spend at full Scheme. Attendant care can be provided by one carer to one participant (one to one) as well as by one carer to more than one participant in the case of 'Assistance with social and community participation' (group care).

Pricing for 'Supported Independent Living' (SIL) is derived from the price cap for attendant care. If SIL is included together with all other supports involving attendant care, together they are estimated to account for 75% of committed scheme spend at full scheme.[59]

This section covers the following topics:

- 4.6.3.1 Base price for one to one attendant care
- 4.6.3.2 Cancellation policy for attendant care
- 4.6.3.3 Group price for attendant care

4.6.3.1 Base price for one to one attendant care

Issues and evidence

Attendant care supports are currently subject to price caps. There are different price limits for the provision of these supports:

- At different times of day i.e. daytime, evening
- At different days of the week i.e. weekdays, Saturdays, Sundays and public holidays
- By the complexity of the care required i.e. standard and higher intensity
- By the location of the service i.e. metropolitan, remote or very remote.

The base price of one to one (1:1) attendant care (daytime, weekday, standard intensity, metropolitan location) is subject to a price limit set by the NDIA of $44.72 in the 2017/18 Price Guide for Victoria, New South Wales, Queensland and Tasmania, and $45.54 in the

[59] Source: NDIA Scheme Actuary.

Australian Capital Territory, Northern Territory, South Australia and Western Australia. The NDIA also sets service definitions, payment rules and terms of business that affect the cost of service delivery for this support.

The price of 1:1 attendant care has come under recent scrutiny.

- The price of 1:1 attendant care was the focus of the NDIA's FY2017/18 Price Review. The NDIA published a discussion paper '2017 Price Controls Review' in March 2017 and invited providers to give feedback on questions related to the price setting process and the adequacy of pricing for attendant care.
  - The NDIA found that 'divergent facts and views were presented' with some providers submitting that 'existing prices did not allow for recovery of costs', and some participants submitting that 'providers were overpricing supports in some categories'.[60]
  - In June 2017, the NDIA increased the base price of attendant care by 4.5% to $44.72, reflecting the increase in the national minimum wage, the Equal Remuneration Order and the impact of inflation.[61]
- More broadly, the NDIA's view on the pricing of attendant care is reflected in its March 2017 submission to the Productivity Commission Costs Paper, which states that '*Contradictory views in the provider population might be evidence that some are struggling to adjust to a funding model that is based on market principles. There is also evidence of a wide variety in operating costs under pre-NDIS approaches where efficiency was not a key consideration'*.[62]
- The Productivity Commission in its NDIS Costs Paper (October 2017) noted, based on anecdotal evidence from provider submissions, that attendant care price caps may be too low to achieve safe and quality outcomes, with estimates of the shortfall as a percentage of the current price cap varying considerably.[63]

One objective of the NDIS is to develop an efficient market of providers while providing safe and high quality supports for participants.

In assessing the price of 1:1 standard intensity attendant care, the IPR team examined evidence of supply shortages, benchmarked NDIA price caps against comparable schemes, and consulted with providers about their unit cost to serve. Detailed findings relating to these

60 National Disability Insurance Agency: *Letter from David Bowen to providers outlining the outcome of the FY17-18 Review* (12 June 2017), available at https://www.ndis.gov.au/news/letter-to-ndia-registered-providers.html

61 The 4.5% increase was based on the rise in the national minimum wage (3.3% from 1 July 2017) and the application of the Equal Remuneration Order (1.7% in some disability roles from 31 December 2016) for labour costs, and inflation (2.1% for the 12 months to 31 March 2017) for non-labour costs. Labour costs and non-labour costs were assumed to constitute 80% and 20% of the cost base for attendant care respectively. National Disability Insurance Agency: *Letter from David Bowen to providers outlining the outcome of the FY17-18 Review* (12 June 2017), available at https://www.ndis.gov.au/news/letter-to-ndia-registered-providers.html

62 National Disability Insurance Agency: *NDIA Submission to Productivity Commission Issues Paper on NDIS Costs* (March 2017), p. 101, available at https://www.pc.gov.au/__data/assets/pdf_file/0013/216031/sub0161-ndis-costs.pdf

63 Productivity Commission: *National Disability Insurance Scheme (NDIS) Costs* (October 2017), p. 300, available at https://www.pc.gov.au/inquiries/completed/ndis-costs/report/ndis-costs.pdf

are presented in Section 3. The IPR team recognises the limitations of each of these evidence sources.

The IPR team found no conclusive evidence of general supply shortages in the standard intensity attendant care market, with the NDIS price caps for attendant care being comparable to similar government funded schemes. The IPR team also found that some providers with different operating models currently deliver attendant care at a profit, but many providers in the market are struggling to make an adequate return. Based on a sample set of 22 providers who shared detailed operating cost breakdowns with the IPR team, the median cost to serve was ~$49 per hour, or ~10% higher than the current price cap (see Exhibit 4), with some providers stating they are cross-subsiding the loss on this support from other NDIS or non-NDIS funding sources, including state and territory government block funding.[64]

Many providers with profitable operating models in attendant care have recently started their business and specifically designed it to work for the NDIS, or are for-profit organisations, while many providers who are finding it difficult to deliver services under NDIS unit prices are incumbents or more traditional providers.

While there is no single model of care that will work for all providers and participants, and acknowledging the substantial investment providers have already made in transforming their organisations, the significant variation in cost to serve across the market indicates there are opportunities to innovate and lessons to be learned from operating models that are working well in standard intensity attendant care. Providers will generally need to achieve corporate overheads of 10-15% and improve workforce utilisation rates to above 90% to make a profit while complying with SCHADS award obligations. To do this, most existing providers will be required to adjust their operating models, driving efficiencies and innovation through technology and other operational improvements.

While this transformation will be challenging, examples of providers who are delivering quality supports at a profit suggest that it is achievable. Appendix E provides examples of strategies employed by some providers that have operating models that work under current prices. The NDIA's recently announced independent provider benchmarking function will also be a key reference point for providers as they make this transformation. In its first phase, this provider benchmarking project, run by an independent third-party survey manager, will survey providers for detailed information about their input costs for delivering attendant care, as well as for provider (e.g. provider scale, workforce mix, industrial agreements) and client characteristics (e.g. client complexity, location). The customised reports produced for participating providers will benchmark providers' input costs against similar providers in the sector. This will be an important piece of strategic information in helping providers understand how they are performing relative to their peers, potential drivers in variations in their input costs, and in identifying where there are specific opportunities to for improvement.

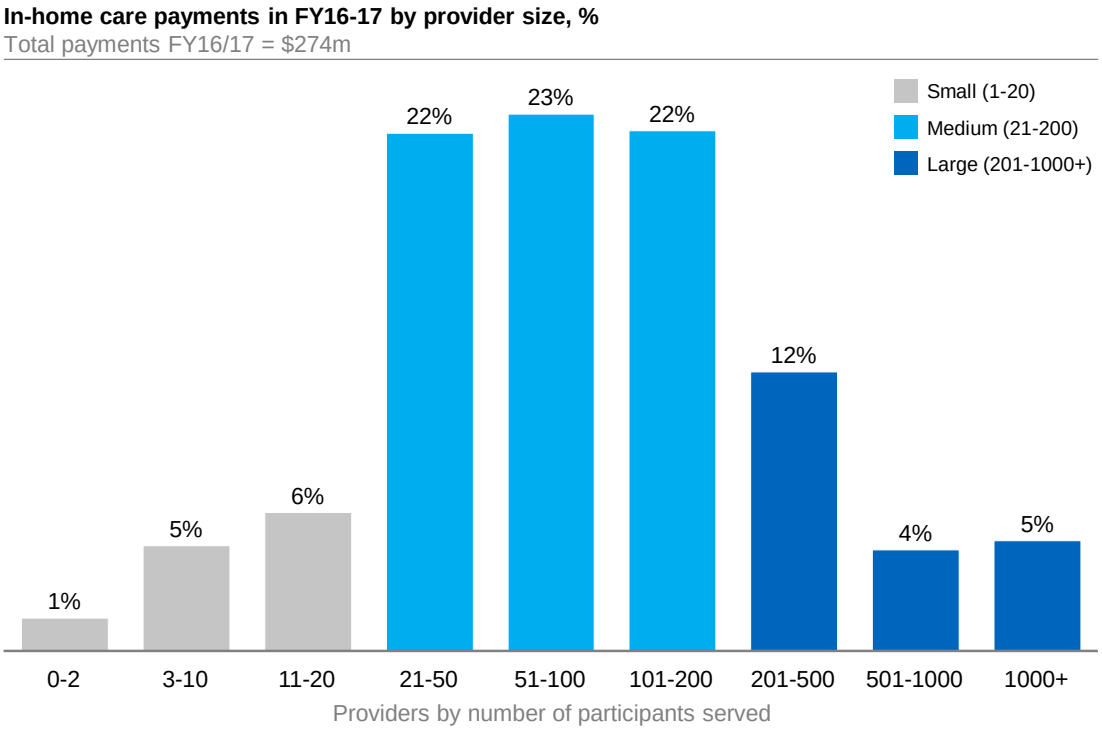
The IPR team also recognises that provider adjustment will take time: 88% of in-home care service volume under the NDIS is delivered by medium and large providers (see Exhibit 8)

[64] Data based on information from 22 providers who provided detailed financial information to the IPR. While the IPR's sample of 22 providers was not comprehensive or representative of the market, the IPR was limited by the information providers were able to provide.

who are less agile by nature of their size, while new entrants – although growing rapidly – have yet to capture a material share of the market.

EXHIBIT 8

Distribution of providers by size for in-home attendant care



SOURCE: Scheme Actuary, distribution of FY17 NDIS payments by provider size (in terms of number of participants served)

Recommendations

14: The NDIA should implement 'temporary support for overheads' (TSO) in the form of a temporary increase to the price cap for standard intensity attendant care. Government should offer business planning support for large providers that would otherwise exit and create the risk of supply shortages.

While the IPR team has not seen evidence of generalised supply shortages in attendant care to date, the IPR team's assessment is that there is a future risk of this occurring given rapidly increasing demand and supply side uncertainty. On the demand side, there will be rapid growth in demand for attendant care, as funding for disability doubles from $11 billion per annum prior to the NDIS, to more than $22 billion per annum at full Scheme. On the supply side, the market is undergoing significant adjustment. Some traditional providers, new technology-based entrants and sole traders can deliver attendant care support profitably under the price cap. However, many existing providers are not at the operating efficiency required to operate at a surplus under the price cap, and achieving the necessary efficiencies will take some more time.

The IPR team also notes the evidentiary difficulty of detecting how quickly the market is adjusting in a timely way, as articulated in Section 3.1. Critically, there is not one or a set of leading indicators that currently conclusively predict future generalised supply shortages.

In this uncertain context, and given the essential daily support that attendant care provides participants, the IPR team believes it is prudent to act cautiously and pre-emptively using a combination of price and non-price instruments to mitigate the risk of market failure.

The IPR team recommends the NDIA implement 'temporary support for overheads' (TSO) in the form of an increase of 2-3% in the price cap of 1:1 attendant care for 12 months. The TSO should apply in addition to ordinary annual indexation of the price. The presumption should be that the TSO is a one-off measure and will not be extended. The IPR believes that 12 months is a reasonable time frame for providers to implement changes to operating models to reduce overhead costs, and for the NDIA to assist and encourage the development of efficient and effective alternative supply options, such as e-marketplaces. At the end of the 12 months, the loading would be removed by reducing the annual indexation of the price by the TSO amount of 2-3%.

Before the end of this 12 months, there should be a review that examines the progress providers have made in transforming their business models and the ongoing risk of supply shortages. The expectation should be that providers have improved their performance sufficiently that they no longer require the TSO. Government should also consider using non-price instruments such as business planning support for providers to address the risk of supply shortages in attendant care, if further funding becomes available for this purpose.

In developing this recommendation, the IPR considered several alternatives including funding providers for specific activities (e.g. training, IT investments) and by-application support for providers. Given there is no legislative mechanism for NDIA to fund providers directly, and that a policy that advantaged one provider over another was unfavourable, the TSO was selected as the most appropriate option.

The specific quantum of the TSO increase should be a policy decision the NDIA makes in view of other more targeted interventions government will undertake to mitigate the risk of supply shortages. Based on current information, a 2-3% TSO adjustment reflects what the IPR team believes are reasonable assumptions for providers to achieve in the short term. While no one model of care will work for the entire market, if a 3% TSO is applied, providers will be able to achieve a ~5 % margin under the price cap if they can meet the following benchmarks:[65]

- **Labour costs (including supervisors):** SCHADs 2.3 support worker; 1:15 span of control, SCHADs 3.2 supervisor
- **Workforce mix:** 80% full-time or part-time workforce, 20% casual workforce

[65] Assumes the midpoint where an assumption range was provided. Analysis assumes labour costs in NSW as of November 2017, and the $44.72 price cap for attendant care in the Victoria, New South Wales, Queensland and Tasmania. The IPR recognises that on 1 December 2017 pay rates under the SCAHDS award were adjusted to reflect an increase from the Equal Remuneration Order (ERO). This will compress provider margins by ~2% for 6 months, until the Agency's July 2018 price increase, which should adjust the new price to reflect the 1 December 2017 ERO increase.

- **Workforce utilisation**: 90-95% utilisation of full-time and part-time workforce, 100% utilisation of casual workforce
- **Corporate overheads:** 10-15% corporate overheads as a % direct of labour costs.

These benchmarks should be achievable, as some providers are demonstrating they are able to operate more efficiently than these benchmarks, as described in Section 3.2. Some of these providers have already reduced corporate overheads to 10% and below. Improvements in utilisation above 90% should be realised as providers improve their rostering and adjust their workforce mix; and, labour costs can be reduced by creating different workforce pools for standard and high intensity participants. While achieving these efficiencies will be challenging for some providers, existing providers demonstrate they are attainable.

The IPR team recommends that the government fund business planning services for large providers who deliver high volumes of service in attendant care that are at risk of ceasing service provision, but who have the willingness to develop and implement an action plan to deliver attendant care profitably in the future. This focus on providers who deliver high volumes of service reflects the fact that the exit of these providers would increase the risk of supply shortages.

The TSO adjustment should not be made available to SIL. The high volume and certainty of demand for SIL allows providers to manage their business and workforce planning more effectively, and reduces the need for SIL providers to undergo large scale business model changes to adapt to the NDIS.

Implications

The quantum and the timing of the TSO balances the need to ensure the market has sufficient support to adjust, with the aspiration to achieve an efficient, high quality market of providers. The TSO will relieve some pressure on providers as they transform their operating models, while any targeted planning support will help protect against identified supply risks.

Implementing the TSO in conjunction with other recommendations relating to attendant care will improve the margins of providers, recognising that the TSO willonly last for 12 months. The other recommendations that will improve margins both in the short and long term, are the addition of a very high intensity rate for the most complex participants, adjustments to travel and cancellation policies, and the NDIA's ongoing work to improve the design of its systems and processes. The aggregate effect of these recommendations is that providers who were previously making a small loss on attendant care will now be able to provide the service at a profit while they adjust and improve their business models.

4.6.3.2 Cancellation policy for attendant care

Issues and evidence

Under the Price Guide, a provider can charge a maximum of 8 booking cancellations a year against a participant's plan for assistance with self-care activities and assistance to access community, social and recreational activities. A provider can only charge a booking cancellation if there are unforeseen circumstances, and the participant agrees that they (the participant), did not comply with the agreed requirements in the service agreement. The

NDIA's Price Guide does not distinguish between cancellations made far in advance and those made at short notice. The Price Guide also stipulates that providers are expected to have business arrangements in place to minimise the risk of participant cancellations, no shows or late changes.

Providers submitted that this policy does not reflect the frequency at which cancellations occur in this sector, particularly for medically or behaviourally complex participants. They submitted that where more than 8 cancellations occur per participant, this policy can be loss-incurring given providers' obligation under the SCHADS award to pay full-time and part-time employees as if they had worked a cancelled shift, if notification is not provided prior to 5pm the day before the scheduled service.

Recommendations

15: The cancellation policy for attendant care should be amended so that up to a certain threshold, providers can charge against a participant's plan for up to 90% of the entire duration of the scheduled service if the participant makes a short notice cancellation. Above this threshold, providers will need to demonstrate they are actively working with participants to minimise the risk of cancellations in order to continue charging for cancellations.

The Price Guide should distinguish between short-notice cancellations and other cancellations.

For short-notice cancellations, the cancellation policy for attendant care should be amended so that providers can charge against a participant's plan for up to 90% of the entire duration of the scheduled service.[66] A short-notice cancellation should be defined as occurring where the participant provides notice of cancellation after 3pm on the day before the scheduled service. This amended policy is designed to bring the NDIA's cancellation policy in line with providers' obligations under the SCHADS award. The 3pm cut-off time recognises that providers need time to redeploy a support worker or to give them notice of a cancelled shift before 5pm on the day before the scheduled service, as required under the SCHADS award for a full-time or part-time employee. Limiting providers to charging 90% provides an incentive to redeploy the worker if possible to recover overheads. It also provides an incentive for the provider to work with participants to reduce the volume of cancellations to the extent possible. If the worker can be redeployed by the provider, the provider should not charge the cancelling participant.

For other cancellations, where the participant has provided notice of cancellation prior to 3pm the day before the scheduled service, no cancellation fee should be able to be charged against a participant's plan. This is because providers are not obligated under the SCHADS award to pay full-time and part-time employees for a cancelled shift if notification is provided prior to 5pm the day before the scheduled service.

Additionally, the NDIA should introduce a new core support line item in the Price Guide for short-notice cancellations. This will allow the NDIA to monitor the volume of short-notice cancellations for two purposes. The first purpose is to provide better information on which participant cohorts have a defensible and higher risk of cancellations from their condition, for

[66] The terms of each provider's cancellation policy should be clearly laid out in the service agreement between the provider and the participant.

example a high risk of hospitalisation. The Scheme Actuary already factors in a level of cancellations into plan packages, but a line item would provide better information and may allow for a reduction in planned cancellations for certain cohorts of participants. The second purpose is that data on cancellations will allow the NDIA to detect anomalies in the volume of cancellations, and work with providers and participants to reduce the level of cancellations as appropriate.

The NDIA should also introduce a policy that above a specific threshold, providers will not be able to charge for short-notice cancellations unless they submit a report to the NDIA outlining the circumstances of each above-threshold cancellation, and actions taken to work with participants to minimise the risk of their short-notice cancellations. This threshold could be defined by the number of short-notice cancellations per participant per provider, or the percentage of short notice cancellations per participant per provider. The NDIA should consult with experienced practitioners in the disability sector to determine what a reasonable threshold should be.

Implications

This revised policy minimises the financial loss incurred by providers on short-notice cancellations and recognises that while providers should work with participants to minimise short notice cancellations, providers should also not bear financial risk for these incidents. It also incentivises positive behaviour by all actors in the market: participants are incentivised to give sufficient notice, while providers are incentivised to work with participants and implement processes to minimise risk of cancellations.

It is not expected that this change in policy will have an adverse impact on participant outcomes or Scheme costs. In most cases, the cost of cancellations will be absorbed by participants' budgets. If the nature of a participant's disability makes him or her more susceptible to cancellations, then the participant's budget should be increased accordingly. It is expected this will be a small proportion of participants.

4.6.3.3 Group pricing for attendant care

Issues and evidence

The NDIS has separate pricing schedules in place for the delivery of group-based community, social and recreational activities; and centre-based group care.

The current price schedule for group-based community, social and recreational activities assumes the price per participant is inversely proportionate to the number of participants in a group. The price per participant for a group of 1 support worker to 2 participants (1:2 care ratio) is half the price of a 1:1 care ratio. The price per participant for a group of 1 support worker to 3 participants (1:3 care ratio) is one third price of a 1:1 care ratio. For example, using the current price for attendant care of $44.72/hr[67], a provider will receive the same total of $44.72 whether a support worker delivers one hour of care to one participant, or a group of two or three participants.

[67] NDIA: 2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017), p. 29

Some providers believe the pricing of group care in the community does not consider the incremental fixed costs they incur when an additional participant is added to a care setting. These fixed costs include overhead costs for scheduling and invoicing, and the costs associated with completing case notes or outcome journals for a participant. Providers believe that in a 1:1 care setting it is possible to complete case notes during a consultation, however in group sessions this is difficult as there are greater demands on a support workers time due to the increased number of participants they are caring for. Some providers also believe that delivering care in a group setting requires a more highly skilled worker, because they need the skills and experience to manage multiple participants at the same time. For group-based community, social and recreational activities, it is possible to charge a high intensity rate when serving participants with complex needs. However, some providers believe that even for participants without complex needs, a higher skilled worker is required for group settings.

Providers that deliver care to large group sizes believe the Price Guide should include prices for groups larger than 3 participants to 1 support worker. The Price Guide displays prices for groups of up to 3 participants per support worker, but there are no prices indicated for groups of 4 or 5 participants per support worker. Some providers told the IPR team that because they do not believe the prices for group supports are correct, they stopped delivering care to small groups and only deliver care to groups of 4 or 5 participants, and charge them the price for a group size of 3 participants to 1 support worker. This results in their receiving more than $44.72 per hour as each of the 4 or 5 participants pays one third of the hourly rate. The NDIA is aware of this practice by providers, and is allowing it to take place because there is no policy that mandates providers need to charge a price below the 1:3 rate for groups with more than 3 participants.

The pricing schedule for centre-based group care is different to the pricing schedule for group care in the community, and some providers delivering centre-based group care believe it is difficult for them to operate with a surplus at the current price cap. The Price Guide has a flat hourly rate for centre based group care, and providers are not able to vary the price paid per participant based on the number of participants in a group, or to reflect the cost of a higher skilled support worker when they are caring for participants with complex needs (see Section 4.3.2). Some providers also believe the price does not consider the incremental fixed costs incurred when an additional participant is added to a care setting, as discussed for group based community, social and recreational activities, as well as the costs of operating a facility, and the capital providers have invested to make the facilities fit-for-purpose for participants, such as investment in modifications.

Some providers also raised the issue of cancellations impacting their ability to operate with a surplus. When a single participant in a group cancels, it is not possible for a provider to charge a higher rate to the other participants in a group to compensate for the difference in revenue. This results in the provider receiving less revenue than was expected if they delivered the support to the remaining participants in the group.

Recommendations

16: The NDIA should implement a new pricing schedule for group care (both community based and centre based) outlined in Table 4 that allows providers to recover additional costs incurred for groups, while still retaining the incentives and efficiencies of group based care. It should also assess whether a capital allowance should be provided for centre based care based on whether there is demand to increase the number of centres.

The price schedule of group based community, social and recreational activities should reflect the additional overhead costs for scheduling and invoicing, the additional administrative time required to write case notes/populate outcome journals, and consider an allowance for a higher skilled or experienced worker if it is determined to be appropriate for participants without complex needs. The price schedule should maintain high intensity loadings which can be applied above the standard rate for participants with complex needs. Section 4.3.1 includes a discussion on price loadings for participants with complex needs. This recommendation is not designed to encourage a participant to lead a life with a high intensity of support. Rather, it is expected that as the Scheme matures and evidence develops, providers and the NDIA will be able to assess which interventions are most effective in supporting participants with complex behaviours and needs to achieve improved outcomes and, in some cases, no longer require high intensity support.

TABLE 4 shows a comparison of the current price per participant without complex needs for 1:2, 1:3, and 1:4 care ratios compared to price ranges calculated using assumptions for the incremental fixed costs discussed above. Using data from a small sample of providers for the share of overheads scheduling and invoicing account for (10-20%), the amount of time spent per participant writing notes (3-5 mins/hr), and the SCHADS level of support workers for group care ratios (Level 2.3-3.1). The NDIA should conduct further work to refine the cost driver assumptions used to develop the new group prices. Once the assumptions have been refined by the NDIA, it can create a pricing schedule for group sizes larger than 1 support worker to 3 participants, up to a level deemed to be appropriate for a single support worker to be able to manage. This pricing schedule should be included in the Price Guide. TABLE 4 indicates prices for group based community, social and recreational activities for groups of up to 4 participants per support worker.

To support centre based group care, the NDIA should remove the flat pricing schedule that currently exists and adopt the same approach proposed for group based community, social and recreational activities. It should also assess whether a capital allowance is required based on whether there is demand to increase the number of centres. This should involve an assessment of the future demand for these services relative to the current supply.

TABLE 4: EXAMPLE OF PRICING SCHEDULE FOR GROUP BASED COMMUNITY, SOCIAL, AND RECREATIONAL ACTIVITIES

Care ratio	Current price per participant	Price per participant (without complex needs) including incremental fixed costs
1 staff – 1 participant	$44.72/hr	$44.72/hr
1 staff – 2 participants	$22.36/hr	$25.04/hr - $29.07/hr
1 staff – 3 participants	$14.91/hr	$16.76/hr - $19.68/hr
1 staff – 4 participants	No price - providers use $14.91/hr	$12.97/hr - $15.20/hr

Care ratio	Current price per participant	Price per participant (without complex needs) including incremental fixed costs
1 staff – 5+ participants	No price - providers use $14.91/hr	NDIA to determine the largest group size they will set prices for.

Implications

Increasing the price of group based care to reflect the incremental costs of service delivery could result in more supply of group care entering the market. This could be beneficial to participants, particularly for those with higher needs that cannot be cared for in large group sizes. By giving participants greater opportunity to access group care, they could choose to spend more of their budget on group care rather than 1:1 care, giving them more funds to utilise on other supports.

Once the NDIA has finalised a new pricing schedule for group care, they will need to ensure providers adopt the new prices and discontinue the current practice of charging the price of 1 staff to 3 participants for groups of 4 or more. The NDIA should consider including audits of group care delivery in their existing provider audit process to help enforce the use of the updated pricing schedule.

4.6.4 Therapy supports

The NDIA recognises therapeutic supports may be necessary for many participants to help build capacity to participate in the broader community. For example, for young participants (0-6 years), early intervention in the form of medical and disability therapy supports may help build their capacity to become more independent.

In therapy supports, participants, providers and other stakeholders identified an opportunity to differentiate pricing for different types of services to better match market rates for services, and enable the NDIS to provide better value for money to participants. This was supported by the IPR's benchmarking with other comparable schemes described in Section 3.3.2 above. Some providers delivering specialised therapy, for example clinical psychology, believe the price is not adequate for their participants. Other providers also raised the issue that the current description for therapy assistants does not reflect the activities undertaken, and that the price is not adequate to recover their costs, which leads them to serve participants with qualified therapists when the support could have been delivered by a therapy assistant at a lower price. Providers also raised issues relating to travel and cancellation policies, and NDIA-required report writing.

This section provides recommendations and rationale for:

- 4.6.4.1 Differentiated pricing for therapy supports delivered by a qualified therapist
- 4.6.4.2 Pricing for therapy supports delivered by therapy assistants
- 4.6.4.3 Travel policy
- 4.6.4.4 Cancellation policy
- 4.6.4.5 NDIA-required report writing

4.6.4.1 Differentiated pricing for therapy supports delivered by a qualified therapist

Issues and evidence

Providers, participant bodies, and other stakeholders raised issues associated with the single price of therapy. Some providers consider that the current price is more than adequate for many therapy supports, but where more complex therapy is required, for example complex psychological therapy delivered by a clinical psychologist, the price is not adequate. Participant bodies and other stakeholders have raised issues about the single price being too high where standard therapy is required. For example, for a typical physiotherapy consultation, participants are being charged a price higher price than the market rate for the service.

While the NDIA has a single price for therapy supports, other comparable insurance schemes in Australia have differentiated pricing. Examples include the TAC, WorkSafe, Department of Veterans Affairs (DVA), and NSW State Insurance Regulatory Authority (SIRA). Section 3.3, *Benchmarking with comparable schemes*, indicates that there is opportunity to differentiate the price of therapy supports based on the type of therapy being delivered, and level of service a participant requires to meet their needs.

Recommendation

17: The NDIA should develop differentiated price levels for physical therapy and psychological therapy based on price levels being paid in comparable schemes.

Physical therapy should be differentiated across three levels of care, and psychological therapy across two levels of care (TABLE 5 and TABLE 6).

TABLE 5: RECOMMENDED PRICES FOR PHYSICAL THERAPY SUPPORTS

Level of support	Proposed price ($/hr)	Description
Level 1	$110 - $120	The delivery of therapy for a single physical condition (which can result in multiple symptoms) in a low risk environment. An example is occupational therapy to develop the balance of a child with low level cerebral palsy that has a low level of severity on the Gross Motor Function Classification System (GMFCS).
Level 2	$140 - $150	The delivery of therapy for multiple physical conditions where treatment of one condition does not affect symptoms from another condition e.g. occupational therapy for a child with a middle level of severity on the GMFCS that results in multiple physical conditions; can also include treatment of a single physical condition if a participant also has mild-moderate behaviours of concern.
Level 3	$180 - $190	The delivery of therapy to participants with extreme presentations, e.g. occupational therapy for a child with cerebral palsy that has a high level of severity on the GMFCS, that results in physical conditions such as convulsions or spasms or swallowing difficulty such as dysphagia; can also include a combination of physical disabilities and severe behaviours of concern.

TABLE 6: RECOMMENDED PRICES FOR PSYCHOLOGICAL THERAPY SUPPORTS

Level of support	Proposed price ($/hr)	Description
Level 1	$160 - $170	The delivery of therapy focused on treatment of a psychological disability in a low risk environment. Typically administered by a registered psychologist.
Level 2	$210 - $220	The delivery of therapy focused on the treatment of a complex psychological disability where a very skilled and experienced clinical professional is necessary. Often necessary where a participant poses a high risk to themselves or others due to their disability. Typically administered by a clinical psychologist.

For each level of care in physical therapy and psychological therapy, the NDIA will need to define the characteristics of the type of therapy support a participant should expect to receive, and a provider should expect to deliver. The NDIA should work with therapy providers and the broader therapy market to develop these characteristics.

Implications

Providers of Level 1 and 2 therapy will have price caps lower than the current NDIA price cap. Providers of Level 3 therapy will be able to charge prices higher than the existing price cap for participants that require a high level of support due to their disability. When using the increased prices, providers will need to justify that the higher level of service is necessary to serve a participant. The NDIA will need to reflect the changes to therapy prices in the packages developed for participants. These changes should consider a participant's physical and psychological conditions, and reflect their likelihood to need a higher proportion of one level of therapy compared to another.

4.6.4.2 Differentiated pricing for therapy supports delivered by a therapy assistant

Issues and evidence

The current Price Guide describes therapy assistants as *'Program to empower participants & improve interactions between participants & their social networks. Assistance to engage effectively in the community through a group approach to help achieve goals, gain insight into their lives & make informed decisions*' and prices these supports at $41.71/hr[68]. Consultation with providers suggests that this description does not accurately reflect the role of therapy assistants, and that the price for a therapy assistant should be at least the same as the price of attendant care because therapy assistants, at a minimum, require the same level of skill as a standard level support worker. They believe the price of a therapy assistant should reflect the cost of a higher skilled support worker due to the increased difficulty of the support being delivered.

Providers believe they can utilise therapy assistant in two ways. The first is to have a therapy assistant to help deliver therapy supports, for example to help deliver hydrotherapy by

[68] NDIA: 2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017), p. 61

supporting a participant to stand in the water, while a physical therapist instructs a consultation. The second is in situations where a consultation could be delivered independently and in full by a therapy assistant with adequate qualifications (such as an exercise scientist). This might occur in the case of a physical therapy consultation where a treatment schedule has been developed by a physiotherapist with input from an exercise scientist, but can be delivered independently by the exercise scientist. The Price Guide does not currently allow for these two types of roles, and as a result there are examples of providers serving participants with physiotherapists at $175.57/hr[69] when an exercise scientist could be delivering the consultation at a much lower rate.

Recommendations

18: The NDIA should amend the description for therapy assistants and introduce two tiers of prices for therapy assistants – one that is comparable to the attendant care price, and a second that is for the delivery of therapy supports by a professional with a lower level of skill than a qualified therapist.

A Level 1 therapy assistant could support the delivery of therapy services and be priced in the range of $44.72-$49.20/hr. The activities performed by this type of therapy assistant is comparable to those performed by a disability support worker, but with a focus on capacity building. The relevant benchmark is therefore the attendant care price, and this is consistent with the price set by other similar schemes such as the Transport Accident Commission (TAC). The low end of the price range reflects the current price of attendant care, and the high of the range reflects the price proposed for a highly skilled support worker delivering care to a participant with very complex needs. This is the current price of attendant care plus an additional 10% price loading, and should be the absolute upper bound of the price of a Level 1 therapy assistant. This price is aligned with external benchmarks for a Level 1 therapy assistant. The TAC prices Allied Health Assistants at $37.04/hr and prices therapy supports for Independently Reviewed against Quality Standards (IRQS) Providers at $46.73/hr.

A Level 2 therapy assistant should deliver therapy supports where a qualified therapist has developed a treatment plan with input from an exercise scientist, and a consultation can be delivered by a qualified professional that is not a qualified therapist. This could be an employee with a qualification in exercise science or human movement that has the skill and knowledge to deliver a treatment plan they have helped develop at a high level of quality. The price of a Level 2 therapy assistant should be above the price of a Level 1 therapy assistant ($44.72-$49.20/hr) and below the proposed price of Level 1 physical therapy ($110-$120/hr). The market for the delivery of some therapy supports by professionals such as exercise scientists is new and growing, therefore data on pricing is limited. Discussions with some therapy providers and an observation of a small sample of private market rates suggest the price of a Level 2 therapy assistant should be between $70-90/hr, however the NDIA should conduct further analyses to refine and validate the price, and verify the relevant benchmark.

[69] NDIA: 2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017), p. 61

Implications

Increasing the price of a standard therapy assistant to be comparable to the price of attendant care will allow providers to recover the costs of employing workers with the same level of skill as a support worker. Introducing a second tier to the therapy assistant price could allow participants to receive some therapy supports at a lower price when the support is not required to be delivered by a qualified therapist, and can be delivered with a high level of quality by a professional with a lower skill level. This could represent value for money for some participants, as they could utilise Level 2 therapy assistants where they were previously seeing a qualified therapist, and redirect the funds they save to other supports.

4.6.4.3 Travel policy for therapy supports

Issues and evidence

Many providers believe the $1000 travel cap for therapy supports and the approach defined by the NDIA to calculate travel costs are appropriate for participants that are located close to a therapist or do not require frequent support. However, when a participant requires a provider to travel a reasonable distance on a frequent basis, the therapy travel policies can make it difficult for some providers to profitably serve participants, even in a metropolitan area.

For attendant care supports, there is no monetary cap on the amount a provider can charge a participant for travel. It is a different case for therapy as a $1000 per annum cap exists, and in situations where a moderate amount of travel is required, the therapy travel cap can run out quickly, as it equates to less than 6 hours of travel that a provider can charge over a year at the current therapy price cap of $175.57/hr[70].

Separating therapy support funding from therapy travel has positive and negative consequences. Placing a limit on the amount a therapist can charge for travel incentivises participants to receive supports from providers where less travel is needed to reach them. However, there are examples of providers ceasing to serve participants that have funds remaining in their plans for therapy supports, because they have exhausted the $1000 allowance that providers can charge for travel.

The policy providers are required to follow to charge for travel is also making it difficult for providers, as the calculation does not allow providers to charge for the first 10km of travel. Beyond 10km providers can charge up to the hourly rate of therapy supports based on the distance travelled, with the assumption being that the average speed of travel is always 60km/hr. For core supports such as attendant care, providers can charge the first 20 minutes of travel between participants (excluding travel to the first participant).

An effective travel policy should encourage participants to find services that require less travel where adequate supply is available, and discourage providers from serving participants where more travel is required if there are closer options available. The policy should also acknowledge that there are situations where travel is necessary, and allow providers to be

[70] NDIA: 2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017), p. 61

remunerated for a reasonable amount of travel. However, the policy should only apply where the participant cannot travel to the provider.

Recommendations

19: The NDIA should align the travel policy for therapy supports to the travel policy for attendant care by removing the $1000 travel cap, allowing providers to charge up to 20 minutes at the hourly rate when travelling between participants.

The travel policy for therapy should be consistent with the travel policy for attendant care, where there is no travel cap or separate travel allowance, and a provider can charge the first 20 minutes of travel between participants. The policy should also follow the approach suggested in Section 4.2.2, where providers serving participants located in rural areas (MM 4 and MM 5) can charge up to 45 minutes at the hourly rate when travelling between participants.

Implications

The NDIA will need to communicate with participants receiving therapy supports in-home that they will no longer have a separate budget for provider travel, and that a provider will be able to charge travel against their combined therapy budget with no maximum set by the NDIA. Participants will need to take this into consideration when they select a provider. If the preference of the participant is to receive supports from a therapist located far from their home they may receive less supports, as the provider will be able to charge up to 20 minutes in a metro area (45 minutes in rural areas) each time they travel to the participant.

The NDIA will need to communicate with providers that there are limitations on the amount of travel time they can be reimbursed for each time they visit a participant. If a provider chooses to serve a participant located outside of the area they can service based on the time caps set for metro and rural areas, they will not be reimbursed for the incremental travel time.

4.6.4.4 Cancellation policy for therapy supports

Issues and evidence

The therapy cancellation policy limits the number of hours a provider can charge to a maximum of 2 cancelled hours per year, compared to a maximum of 8 booking cancellations per year for core support items including Assistance with self-care activities and Assistance to access community, social/recreational activities. Providers believe 2 hours is insufficient as many participants cancel more than 2 hours of services per year. For example, participants with health-related needs may cancel due to hospitalisation due to their condition, and participants with behaviours of concern may cancel due to sudden escalations of behaviour. Currently providers are often required to absorb the cost of cancellations over 2 hours, even where they are short-notice, as it is typically very difficult to substitute in another patient on short notice, especially when services are delivered in-home.

Recommendations

20: The cancellation policy for therapy should be amended so that up to a certain threshold, providers can charge against a participant's plan for up to 90% of the scheduled service if the participant makes a short notice cancellation. A cancellation line item should be created as a governance mechanism for the NDIA.

The cancellation policy for therapy should follow the same approach as that suggested for attendant care (see Section 4.6.3.2). A short notice cancellation should be defined as occurring where a participant provides notice of cancellation after 3pm the day before the scheduled service. A cancellation line item should be introduced in the Price Guide to enable the NDIA to monitor the volume of cancellation by providers, which will help build an understanding of participant cohorts with higher risks of cancellations, and help detect anomalies in the volume of cancellations. Providers should not charge a cancellation where they have been able to substitute another customer.

The NDIA also should introduce a policy that above a specific threshold, providers will not be able to charge for cancellations unless they submit a report to the NDIA outlining the circumstances of each above-threshold cancellation, and actions taken to work with participants to minimise the risk of their cancellations.

Implications

As discussed in Section 4.6.3.2 the proposed policy minimises the financial loss incurred by providers on short-notice cancellations and recognises that while providers should work with participants to minimise short notice cancellations, providers should also not bear the financial risk for this occurring.

4.6.4.5 NDIA-required reports for therapy supports

Issues and evidence

Some providers indicated they were confused about whether they could be reimbursed for the time they spend developing reports for participants. The NDIA has set the expectation that providers are required to develop progress reports for participants, the Price Guide states *'Therapists will be expected to provide progress reports to the participant and NDIS at agreed times'.*[71] Currently there are some therapy providers that believe they can be reimbursed for report writing, and charge the time against a participant's package. However, there are other providers that do not believe it is possible to charge a participant for report writing, and they are absorbing the cost of the time to develop a report.

There are two types of reports therapists typically write: end-of-session notes and progress reports. Therapists write end-of-session notes to capture what has taken place during an individual consultation. This is a standard activity and should be considered as being included in the hourly rate for the support. Therapists write progress reports upon request, often by a third party, where information is sought to understand how a participant's condition is

[71] NDIA: 2017/18 NDIS Price Guide VIC-NSW-QLD-TAS (version release date July 2017), p51

improving due to their therapy. This is not considered a standard activity and therefore should be reimbursed separately.

Comparable schemes such as SIRA, TAC, and Worksafe each reimburse providers for reports, and have discrete line items in their fee schedules for reports requested by the insurers. SIRA has a single line item for report writing, and TAC and Worksafe have multiple line items for the development of the initial treatment plan, and also for treatment reviews. For each of the schemes, they will only allow a provider to charge for the reports if they have been specifically requested by an agent within insurer.

To provide therapy supports in the NDIS there are two types of reports that a provider must deliver to help the NDIA track a participant's progress: 1) at the commencement of supports, the NDIA requires a report to be submitted including the assessment of a participant, their goals, and the care plan developed to achieve those goals; and 2) as a participant progresses through their care plan, the NDIA requires a therapist to submit one or more reports per year to the NDIS to communicate the progress a participant has made against their goals, including evidence of specific areas of improvement and outcomes that have been achieved. The progress reports also include recommendations from a therapist on what they believe a participant's new or revised goals should be based on their progress at the time, and a proposal for a new or revised care plan to support a participant to achieve those goals.

Recommendations

21: The NDIA should allow providers to charge participants for the time spent writing reports that are requested by the NDIA. A new line item should be introduced for tracking purposes.

The time that a therapist can charge does not include time spent at the end of a consultation writing notes, which is factored into the rate paid for the consultation. However, for additional reports mandated by the NDIA, providers should be allowed to charge for time spent developing these reports at the same rate as a regular consultation, as they are an essential part of the service being delivered to a participant. This should be communicated to the market to ensure there is consistent application across all therapy providers.

Implications

The impact on participants of allowing therapists to be reimbursed for the development of NDIA-required progress reports is expected to be small, as it should occur no more than once or twice a year. Adding a separate line item in the Price Guide for NDIA-required reports will allow the NDIA to track therapists that are charging participants for report writing, to make sure it is only occurring when they have requested a report to be written by a therapist.

4.7 PRICE DEREGULATION

The deregulation of NDIS prices offers some compelling advantages for providers and participants operating in a mature market. The effect of current NDIS price controls is that nearly all transactions take place at the specified price cap. Forcing the market to a single regulated price introduces the risk that the market will be undersupplied (if the price is too low), or that participants will not be able to achieve value for money (if the price is too high). In

a market like disability services, regulated prices also restrict the ability of providers to offer a range of different service types and thereby limit participants' ability to choose the best mix of quality and price that suits their needs for any service. Deregulation also has the benefit of reducing bureaucracy, making it easier for participants and providers to interact with the NDIS. However, price deregulation comes with risks if implemented in an underdeveloped market. In particular, it may result in providers charging higher prices and participants receiving less value for money.

To navigate this choice, the NDIA should collect more information to understand the likely impact of deregulation of prices, prepare participants and providers for deregulation, and undertake trial(s) before deregulating prices across large portions of the market.

This section covers the following topics:

- 4.7.1 Developing more information and insights on self-managed participants
- 4.7.2 Assessing and advancing participant and provider readiness for de-regulation
- 4.7.3 Conducting a deregulation trial

4.7.1 Developing more information and insights on self-managed participants

Issues and evidence

There is currently limited information to understand how the NDIS would operate if prices were deregulated. One source of possible insight is the experience of self-managed participants, who operate in a commercial environment that is broadly comparable to a deregulated market. These participants are allocated a budgeted plan through the same process as all other participants. However, the providers they choose and manage are not bound by the NDIA's price caps in providing support services to them[72]. This is therefore somewhat comparable to the experience of participants in a deregulated market.

According to the latest NDIA data, 18% of Scheme participants have at least partially self-managed plans[73]. Anecdotal evidence from participants who self-manage their supports suggests there are many benefits of self-managing, including much greater flexibility in how funds are used across support categories. However, further analysis is required to understand whether this experience is likely to be replicated across the Scheme as a result of broader price deregulation.

There is currently only partial data available on the experience of self-managed participants. Through auditing processes, the NDIA has the potential to gather data on how self-managed participants allocate funds within their budgeted plans. The NDIA also collects participant outcomes data which can be used to track the performance of self-managed participants against those of Agency-managed or plan-managed participants.

[72] Note: providers serving both self-managed and NDIA-managed participants typically charge both groups of participants at the price cap. Therefore, only a small part of the self-managed market is effectively operating as per a deregulated market.

[73] Source: Scheme Actuary

Recommendations

22: The NDIA should collect and analyse information on the experience of self-managed participants to help inform its assessment of price deregulation.

A better understanding of the outcomes of self-managed participants can help the NDIA understand the opportunities and challenges of potential price deregulation.

The NDIA should collect information on:

- The pricing of support services provided to self-managed participants, including prices relative to the rest of the Scheme, the distribution of prices within the market for self-managed participants, and the responsiveness of prices to competitive pressure.
- Outcomes for self-managed participants.
- The supply response to price changes for supports catering to self-managed participants.

This information can be gathered through existing sources, as well as through new initiatives. Data on outcomes of self-managed participants can be gathered by categorising responses to the Short-form Outcomes Framework survey. Comparing self-managed participants with Agency-managed participants may be affected by some sampling bias, as self-managed participants are likely to have better support structures around them, which could lead to better outcomes. Therefore, it will be more useful for the NDIA to compare changes within cohorts over time, rather than across cohorts.

Some general scheme data, such as utilisation rates, are also already being collected by the NDIA and could be monitored by the participant's type of support management. The NDIA is planning to collect more thorough data on which supports are being accessed by self-managed participants, and for what prices, as part of its assurance process for self-managed participants.

Implications

The NDIA will need to collate the information it has on self-managed participants from the Scheme Actuary, the Provider, Market and Sector Development team, and its quality and safeguards assurance processes.

The NDIA will also need to expand its data collection and analysis efforts in some instances, including amending the Short-form Outcomes Framework survey or other participant consultation as necessary. The NDIA should also include queries specific to self-managed participants in its regular consultation with providers, including through LACs, its annual request for submissions into the pricing process, and ad hoc consultations throughout each year.

4.7.2 Assessing and advancing participant and provider readiness

Issues and evidence

Deregulated markets will allow providers and participants to transact freely without being bound by price caps. The NDIS marketplace is yet to be guided by a clear set of pre-conditions which would need to be satisfied for such transactions to function effectively. Price

controls cannot be relinquished until the NDIA is satisfied that such pre-conditions have been articulated and satisfied.

A broad review of provider and participant capacity makes clear that it remains too early for the Scheme to pursue price deregulation across markets at this point in time. Most providers and participants have spent under a year in the Scheme, and the Scheme continues to grow rapidly from quarter to quarter. As such, there is little stable evidence to evaluate the performance and capabilities of participants and providers in the Scheme. Even in existing competitive and well-supplied markets like those for some forms of therapy, it is important to observe participant and provider behaviour over a longer timeframe.

The NDIA supports the capability development of participants and providers through various initiatives. This ranges from core elements of the NDIS such as LACs, through to the release of market information such as the Market Position Statements. Others, such as support coordinators or online marketplaces, also work to expand the capacity of participants and providers to locate and compare with each other.

Recommendations

23: The NDIA should collect information on and assess the readiness of participants and providers for price deregulation.

The NDIA can test the readiness of the market for price deregulation by considering the commercial and other characteristics required to operate in a deregulated market. Before deregulating a market, the following conditions should be met:

- Participants must first have a thorough awareness of their supports and prices in their market.
- Participants must have the ability to exercise choice and control by switching between providers as required. The development of the e-market would support this by giving participants greater information about alternative providers and greater transparency on the range of prices charged in the market.
- Providers must have the commercial capacity to make efficient pricing decisions.
- Providers must have the ability to provide sufficient supply to drive competition and moderate price fluctuations.

The required information can be collected through participant and provider consultation, analysis of existing market and NDIA data, and by collating NDIA experience from its network of LACs and regional offices. This assessment of the readiness of markets for deregulation should consider specific markets and not just the Scheme in aggregate. Different markets within the Scheme – be they geographic regions or various support types – will be ready for deregulation at different times. Deregulation should, therefore, not be considered as a single event to be rolled out across the Scheme, but rather as a process to be introduced to markets as they become sufficiently mature.

24: The NDIA should provide more comprehensive market data to support the development of provider and participant capacity.

The NDIA should make available more detailed market information on participants' demand for services, and the available supply of support services. In addition to market overviews

presented in its Market Position Statements, the NDIA can provide further evidence of what support services participants are demanding and accessing in each market – defined by support type and geographic region – and the state of supply in those markets. This could take the form of more detailed Market Position Statements, the Provider Finder, or e-markets (see Section 4.5). Market information can also be disseminated through the NDIA's existing LACs and regional office network, as well as through support coordinators. Information on where participants are located, their patterns of demand, and the current state of service provision in a given market are very relevant to providers making pricing or supply decisions. Ensuring that such market data is available will likely lead to increased competition in the market, and improve the readiness for price deregulation.

Implications

Ensuring timely access to detailed market data will promote participant outcomes in the short term. It will also support market development in the medium to long term, with the potential to accelerate readiness for price deregulation across markets.

4.7.3 Conducting a deregulation trial

Issues and evidence

It is essential that price deregulation begins with a trial, given the limited information currently available on how the disability support services market in Australia would operate in a deregulated pricing environment, as well as the lack of directly comparable markets elsewhere.

A trial will allow the NDIA to collect more detailed information on the impact of deregulation. This information can help the NDIA confirm its assessment of the readiness of markets for deregulation, and help refine the design choices to be made in implementing deregulation. A deregulation trial would involve the removal of price caps in a specified market, defined by support type or region.

Recommendations

25: The NDIA should pursue a trial of price deregulation in one market, once the preconditions for deregulation have been satisfied.

The market chosen for deregulation should have well-equipped participants and providers as identified in Section 4.7.2, as well as meet three additional criteria:

- The chosen market should have been active in the Scheme for at least 2 years. This will allow the NDIA to assess whether the information collected about that market reflects a stable state.
- The chosen market should be clearly defined and demarcated from the remainder of the Scheme. For geographies, this would mean that the defined area is aligned to other boundary definitions affecting how businesses operate (e.g. state borders, remoteness thresholds).
- The market should be one in which the NDIA is satisfied that it has monitoring capacity and a good understanding of Scheme and market performance to date.

Some therapy supports and well-defined geographical areas such as the ACT have been identified to the IPR team by providers and other Scheme stakeholders as potential candidates for deregulation. These do not yet appear to be ready for deregulation as the Scheme is still in its early stages and there is insufficient evidence that providers and participants have the capacity to navigate a deregulated market. The NDIA should monitor the progress of these and other markets against the above criteria to identify a suitable market for a deregulation trial.

The NDIA could consider transitioning toward the trial by replacing prescriptive price caps with suggested price ranges as a way of testing market capacity for price competition. To do this, a price guide for that market would identify two prices for a given support item, a lower price which is nominated as the suggested efficient price, and a higher price which acts as the price cap. Even though the current price is only a price cap for most support services, the great majority of providers charge at this price point, and there is no way to indicate an efficient price using a single price cap.

The introduction of deregulated pricing in a chosen trial market should be accompanied by enhanced safeguards and monitoring in that area. The NDIA should be able to identify risks of supply shortages or where providers are charging well above their cost to serve to the detriment of participants' ability to secure plan outcomes.

Implications

Designing and delivering a deregulation trial will require an investment of resources from the NDIA in the medium term. However, a well delivered deregulation trial will provide a lower risk way to test the proposed preconditions for deregulation of prices and ultimately, promote a more innovative and sustainable Scheme.

Appendix A: Differences in cost drivers between attendant care providers

Summary of key differences in cost drivers between attendant care providers

The following table summarises some differences in cost drivers between providers, and explains the significant variation in cost to serve between different attendant care providers.

TABLE 7:

Issue	Provider feedback
Labour costs	■ Some providers found it difficult to manage labour costs under the current price. This was particularly true for providers who had a mix of complex and standard intensity clients, and therefore had more qualified or mature workforces. For instance, for some providers, the average worker had a Cert IV qualification and was paid at SCHADS 2.3. By contrast providers who focus on participants at the lowest end of the complexity spectrum submitted it was neither necessary nor proportionate to pay a highly qualified worker to deliver attendant care; rather it was the support worker's mindset that was important. ■ Under the SCHADS Award, employers pay casual workers a 25% loading on the base salary of an FTE. The more expensive base wage of and fixed cost of onboarding and training a casual worker is offset by a various factors: first, casual workers have lower on-costs as they are not entitled to annual or sick leave; second, it is easier to manage the utilisation rates of casual workers; finally, anecdotal evidence suggests employers with heavily casualised workforces tend to pay lower base salaries. Depending on the difference in utilisation and base salary paid to casual workers vis a vis FTEs, casual workers can be either more or less expensive to hire.
Workforce utilisation	■ Factors that make workforce utilisation difficult to manage include: unchargeable time spent travelling to clients, particularly in regional and remote areas; the frequency of cancellations in the sector; and, the time required for care co-ordination (e.g. team meetings, debriefing) and reporting, particularly for behaviourally and medically complex participants. Utilisation is particularly challenging to manage in areas of lower population density and for providers with less casualised workforces. ■ Utilisation was significantly easier to manage for providers with highly casualised workforces, as staff are only rostered when there is known demand. However, because casual workers are paid a 25% loading under the SCHADs award (which is only partially offset by the lower on-costs associated with casual workers), whether a casual worker is more expensive to employ than a permanent employee depends on how well an employer can utilise its casual workers relative to its permanent workforce.
Supervision structures	■ Some providers had heavy supervision structures, reflecting the complex participants in their client mix. For instance, some providers have 2 layers of supervision consisting of a supervisor and a team leader. Providers who only serviced lower complexity participants with strong informal supports had minimal supervision in their operating models, rather relying on instant customer feedback to detect potential risks to service quality.
Corporate overheads	■ This was a key differentiating cost driver between providers. Traditional providers that had achieved relatively efficient overheads had typically invested in IT and had achieved a degree of scale. Online platform providers also leveraged

Issue	Provider feedback
	technology to minimise overhead costs, while sole traders incurred very low overhead costs.
Other issues	■ *Training:* While there are currently no legislative requirements for disability support workers to undergo specific trainings, some providers, particularly those with complex participants in their client mix, require their staff to complete a mandatory training as a matter of internal policy.[74]

74 Some of these trainings include: First Aid, Manual Handling, Corporate Induction, Medication and infection control; CPR; Epilepsy; Diabetes; Bowel care; Oxygen Training; Management of PEG feeding.

Appendix B: Summary of IPR recommendations

Below is a summary of the IPR team's recommendations, as well as an assessment of the potential impact of these recommendations on the NDIA's three aspirations. Cost estimates have been made on the best information available. Where information is incomplete due to immaturity of the Scheme, the IPR has made a number of assumptions, which has led to wide ranges in estimates. In the aggregate, the IPR team estimates that the recommendations made in this report will have a potential financial impact of ~$250-420m per annum over the next 12 to 24 months, but will alleviate some of the financial pressure currently placed on some providers, and will improve participant outcomes by addressing challenges that are impacting some providers' abilities to deliver quality services.

Beyond the next 24 months, the IPR team believe it is possible to implement the IPR recommendations and manage the Scheme so that it is financially sustainable and within the current budget estimates. Approximately 50% of the total cost implication of the IPR recommendations is temporary and will therefore not have an adverse impact on the Scheme's longer-term financial sustainability. Also, as the Scheme matures, the NDIA should be able to offset any financial impact of these recommendations by appropriately assessing their effectiveness and efficiency. For example, as evidence develops as to which interventions are most effective in reducing costs associated with complexity, it should be possible to reduce the number of complex participants and provider costs and prices. It should also be possible to encourage more local providers in rural and remote areas that will assist in reducing travel costs. There should also be some savings from introducing tiered therapy pricing.

EXHIBIT 9

Summary of recommendations (1/3)

Positive impact
Potential minor negative impact
Neutral/No impact
Potential significant negative impact
E.g. <$50m for Scheme sustainability
E.g. >$50m for Scheme sustainability
Short term = < 1 year
Medium term = 1-2 years
Long term = 3+ years
($Xm) = Value used by IPR team to calculate the total financial impact of recommendations if different from range provided by the Scheme Actuary

	Recommendation	Direct impact on NDIA aspirations: Participant outcomes	Direct impact on NDIA aspirations: Market development	Direct impact on NDIA aspirations: Scheme sustainability	Implications: Implementation timeframe
Price-setting process	1 Include a broader set of indicators of participant outcomes and market development in its price setting process, and clarify the methodology for making price setting decisions.				Short-term
	2 Continue to use an hourly rate approach, but trial outcomes-based pricing.				Medium-term
National vs regional pricing	3 In very remote/isolated areas, work with other community services and providers to support local workforce development to deliver services in the most efficient way possible. In regions with limited local supply, allow providers to quote on cost of delivering NDIS services in the short term to ensure supply.				Medium-term
	4 Clearly define rural areas and lift the travel allowance from 20 mins to 45 mins for providers serving a participant located in MM5 (or ARIA equivalent) and MM4 in the short term. Adjust plans to account for travel and track as a separate line item.			$26-75m[1]	Short-term
	5 Converge the two Price Guides and move toward a single national price guide by 2021.				Long-term
Comp-lexity	6 Develop a definition for complexity linked to the skills required to meet participant's needs, and use specialised planning resources to classify what skills are required, and which participants require higher skilled support workers.				Medium-term
	7 Add an additional tier to the high intensity loading to allow a provider to recover the cost of a support worker with a higher level of skill than can be procured with the current high intensity loading.			$100m – $140m[2]	Medium-term (require definition first)
	8 Develop a consistent process for participants with extreme behaviours of concern that acknowledges the specialised needs of the participant cohort, and the environment providers operate in. Providers serving this cohort should quote on the delivery of services to these participants, and also be allowed to deliver them all of the services they require to be adequately supported (i.e. all Support Coordination items).				Short-term
	9 Update the pricing structure for the core support item 'Group based activities in a centre' to allow providers to charge a high intensity loading where a more skilled worker is required to serve a participant, and set prices consistent with the care ratio required to serve a participant.				Short-term

1 $26m assumes 25% of participants in ARIA-outer regional get the additional loading and the impact of the loading is only 10% (i.e. 45 mins hr travel for every 6.75 hrs of care). $75m assumes 25% of participants in MM4 and MM5 receive a loading and the impact of the loading is 20%. If all participants in MM4 and MM5 received the additional loading (and impact was 20%), this would equate to a cost of $296m. The IPR does not believe this to be a likely scenario.
2 Based on 12% of participants qualifying for the complex level (a 6% loading) and 10% of participants qualifying for the very complex level (a 10% loading), with a margin of error of +/- $20m to account for uncertainty in data, and assuming all participant plans are adjusted to compensate for the change in policy

EXHIBIT 10

Summary of recommendations (2/3)

Positive impact
Potential minor negative impact
Neutral/No impact
Potential significant negative impact
E.g. <$50m for Scheme sustainability
E.g. >$50m for Scheme sustainability
Short term = < 1 year
Medium term = 1-2 years
Long term = 3+ years
($Xm) = Value used by IPR team to calculate the total financial impact of recommendations if different from range provided by the Scheme Actuary

	Recommendation	Direct impact on NDIA aspirations: Participant outcomes	Direct impact on NDIA aspirations: Market development	Direct impact on NDIA aspirations: Scheme sustainability	Implications: Implementation timeframe
STA	10 Continue to refine the assumptions for high intensity rates, active overnight, and capital allowances used to develop the new STA price schedule, to ensure they reflect the cost of service delivery				Short-term
Thin markets	11 Adopt a clear set of metrics to more comprehensively identify and respond to risks of thin markets emerging.				Short-term
	12 Invest in Scheme infrastructure such as an e-market tool, which would empower participants in thin or undersupplied markets to find suitable providers.				Medium-term
Relative provider efficiencies and ade-quacy of provider returns	13 Prioritise the implementation of measures to continue to improve the NDIA's portal, responsiveness and communication as part of the Participant and Provider Pathway Reviews.				Long-term
	14 Implement 'temporary support for overheads' (TSO) in the form of a temporary increase to the price cap for standard intensity attendant care. Government should offer business planning support for large providers that would otherwise exit and create the risk of supply shortages.			$130-190m[1]	Short-term
	15 Amend the cancellation policy so that up to a certain threshold, providers can charge against a participant's plan for up to 90% of the entire duration of the scheduled service if the participant makes a short notice cancellation. Above this threshold, providers will need to demonstrate they are actively working with participants to minimise the risk of cancellations in order to continue charging for cancellations.				Short-term
	16 Implement a new pricing schedule for group care (both community based and centre based) that allows providers to recover additional costs incurred for groups, while still retaining the incentives and efficiencies of group based care. Also assess whether a capital allowance should be provided for centre based care based on whether there is demand to increase the number of centres.				Short-term
	17 Develop differentiated price levels for physical therapy and psychological therapy based on price levels being paid in comparable schemes.				Short-term
	18 Amend the description for therapy assistants and introduce two tiers of prices for therapy assistants – one that is comparable to the attendant care price, and a second that is for the delivery of therapy supports by a professional with a lower level of skill than a qualified therapist.				Short-term

1 $130m assumes 2% TSO for the 12 months in FY18/19, $190m assumes 3% TSO for the 12 months in FY18/19. Assumes TSO is applied to attendant care supports only (excludes SIL).

EXHIBIT 11

Summary of recommendations (3/3)

Positive impact
Neutral/No impact
Potential minor negative impact
Potential significant negative impact
E.g. <$50m for Scheme sustainability
E.g. >$50m for Scheme sustainability
Short term = < 1 year
Medium term = 1-2 years
Long term = 3+ years
($Xm) = Value used by IPR team to calculate the total financial impact of recommendations if different from range provided by the Scheme Actuary

	Recommendation	Direct impact on NDIA aspirations			Implications
		Participant outcomes	Market development	Scheme sustainability	Implementation timeframe
Relative provider efficiencies and adequacy of provider returns	19 Align the travel policy for therapy supports to the travel policy for attendant care by removing the $1000 travel cap, and allowing providers to charge up to 20 minutes at the hourly rate when travelling between participants.				Short-term
	20 Amend the cancellation policy for therapy so that up to a certain threshold, providers can charge against a participant's plan for up to 90% of the scheduled service if the participant makes a short notice cancellation. Create a cancellation line item as a governance mechanism for the NDIA				Short-term
	21 Allow providers to charge participants for the time spent writing reports that are requested by the NDIA. Introduce a new line item for tracking purposes.				Short-term
Price deregulation	22 Collect and analyse information on the experience of self-managed participants to help inform NDIA's assessment of deregulation.				Medium-term
	23 Collect information on and assess the readiness of all participants and providers for deregulation.				Medium-term
	24 Provide more comprehensive market data to support the development of provider and participant capacity				Medium-term
	25 Pursue a trial of price deregulation in one market, once the preconditions for deregulation have been satisfied				Medium-term

Appendix C: Variation in attendant care cost drivers across jurisdictions

EXHIBIT 12

SCHADS awards are broadly comparable across states and territories

STATE	Relevant Award (adjusted to 2016/17 per Equal Remuneration Order)	Hourly pay rate of full or part time worker at Level 2.3	Hourly pay rate of full or part time worker at Level 3.2
NSW	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services Employee (State) Award [AN120505] (NSW)	$25.52 (Grade 1) $25.97 (Grade 2)	$28.21
ACT	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Social and Community Services (ACT) Award 2001 [AP808334]	$25.52	$27.68
Victoria	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services – Victoria – Award 2000 [AP796561]	$25.52 (Youth or welfare worker) – $26.11 (Community development worker)	$27.35 (Youth or welfare worker) $27.59 (Social worker)
South Australia	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services Award [AN150140] (SA)	$25.71	$27.68
Western Australia	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services – Western Australia Award 2002 [AP815319]	$25.52	$27.35 – $27.68 (Depending on experience)
NT	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services Industry – Community Services Workers – Northern Territory Award 2002 [AP817216]	$25.75	$27.76
Queensland	Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services (Queensland) Award 2001 [AP808848]	$25.52	$27.35

Source: Social, Community, Home Care and Disability Services Industry Award 2010, accessed in November 2017.

Labour costs make up 80% of the costs of attendant care services (which account for approximately 75% of NDIS expenditure)[75]. There is currently some variation in labour costs between states, but they are not correlated to the differences in prices between the Eastern Price Guide and Western Price Guide. For example, New South Wales and Victoria are covered by the same Price Guide but include Award provisions for Level 2.3 workers with slightly different pay rates. Similarly, the ACT and Western Australia have the same Award rate for Level 2.3 workers despite being covered by different Price Guides.

Analysis of other labour costs such as payroll tax, leave entitlements and workers compensation requirements does not show a consistent difference between the eastern states versus the western states. For example, the payroll tax rate in South Australia and Victoria (which are administered by different price guides) is similar at just under 5% annual rate and annual threshold of approximately $600,000. Meanwhile, the ACT and Western Australia are

administered by the same guide but the former has a payroll tax rate 1.35 percentage points higher and an annual threshold $1.15 million higher. Similarly, the qualifying period for long service leave is 15 years in Victoria and WA (again, there are different price guides), while it is 10 years in NSW which is regulated by the same price guide as Victoria. Finally, workers compensation premiums are higher in the ACT and Tasmania, while Western Australia has much lower premiums than South Australia. Non-labour components of cost such as utilities, rent, and cost of goods vary within states as much as they do vary between states.

Appendix D: Existing definitions of participant complexity within the NDIA

The NDIA currently uses three discrete approaches to categorise participants with complex needs through the pre-planning, planning, and plan implementation phases of the participant pathway. There is no relationship between any of the three approaches, and they are used in isolation. This means specific characteristics relating to a participant's level of need that surface during pre-planning or planning phases are not always used to inform whether they receive a high intensity loading during plan implementation.

During the pre-planning phase participants are segmented based on 'streaming factors' that are designed around workflow, to help the NDIA understand the amount of time required to keep a participant engaged in the participant pathway. These factors include behaviours of concern, involvement in multiple service systems (e.g. the justice system or Child Protection), and the level of informal supports. Participants are streamed into four categories – General, Supported, Intensive, and Super Intensive, with the greater the intensity the more time/effort required to be spent on participant.

As participants progress to the planning phase, they are assessed using a Disability Severity Indicator, which measures of the impact of the disability on the participant's day-to-day life, to determine their level of functional impairment. The level of functional impairment, together with to the participant's age and location, are used to determine the level of funding a participant receives. Participants are allocated a rating between 1-15 describing their level of functional impairment, as follows: 1-5 Low level of disability-high functional capacity; 6-10 Medium functional capacity; (11-15) High level of disability-low functional capacity.

Once a participant receives a plan and selects the providers to deliver their services, providers assess the participant based on a range of additional factors, such as disability type, budget, personal/family situation, to determine if they should be charged at a standard intensity rate or a high intensity rate. The Price Guide notes that a provider can charge a high intensity rate where a participant requires assistance from a support worker with additional qualifications or experience relevant to the participant's complex needs. High intensity rates can be considered when assistance is required to manage challenging behaviours, or when active support is required due to high medical support needs, such as unstable seizure activity or respiratory support.

Appendix E: Opportunities for attendant care providers to innovate

The IPR team has identified three broad areas where traditional providers of attendant care can innovate and drive efficiency, based on the information it received in provider consultation.

Going forward, the new benchmarking project should provide tailored and strategic information to providers to help them understand how their input costs benchmark against their peers, and where there are specific opportunities to drive efficiency. In the longer term, the aspiration of this benchmarking project is to link data collected on provider input costs, to information about service quality and participant outcomes. This will build a more wholistic picture of how the sector can drive better participant outcomes with greater efficiency.

A. Achieve efficiencies in corporate overheads

The significant variation in provider cost to serve from the sample of cost inputs submitted to the IPR team indicates that, there is significant opportunity for some providers to improve their corporate overhead efficiencies.

Medium to large providers should be investing in technology (for attendance, online booking, automation, rostering) to achieve efficiencies in indirect overheads, while smaller providers should consider using shared services.

B. Optimise staff mix and staff rostering

Workforce planning and support worker utilisation is critical under the NDIS now that providers are only for funded for units of direct client service. Providers are facing a heightened need to maximise the time staff spend performing-chargeable activities. In response, providers should improve their ability to predict demand for services, and use this information to optimise their workforce mix (e.g. full-time, part-time and casual workers) and workforce rostering.

The IPR team notes that predicting and optimising staff mix and staff rostering may be particularly difficult in the current NDIS context for a number of reasons: first, providers may not have the data and capability to analyse historical demand for services; second, even if providers had this data, the transition to full Scheme will means historical demand may not be the best predictor of future demand; finally, in rostering staff, providers of disability staff need to optimise for many variables (including participant needs, participant preferences, staff skill, staff available, staff preference, and staff geography) to ensure it can supply adequate and high quality services.

While these workforce utilisation challenges exist in many other industries, the relatively fragmented nature of disability care means many traditional providers do not have the financial capacity or the scale to justify investing in digital solutions that could assist providers improve workforce.

C. Segment service lines based on participant needs

Many providers currently maintain the same staff pool and supervision structures across all their participants. This is often driven by rostering, which is easier to do if all staff are

capable of serving the most complex participants the provider serves, that is they are trained to the highest common denominator.

Providers should identify participant segments and design customer-centric operating models to ensure staffing and supervision structures are commensurate with the participant segment's needs.

The level of staff qualification, training, experience, and supervision, and therefore the labour costs involved in delivering safe and high quality care varies significantly between participants at different points on the complexity spectrum: At the lowest end of the spectrum, soft skills rather than formal certifications are more important to delivering a high quality service; At the highest end of the spectrum, formal qualifications and experience are needed to deliver supports safely to medically and behaviourally complex participants. This was recognised by the Quality and Safeguarding Framework.

These changes will be easier to implement for smaller providers with defined customer segments and new entrants into the market who focus on specific customer segments. Large providers should also have sufficient scale in a geography to better design service models around different participant segments, although the challenge and time taken for transformation is not underestimated.

Glossary and Abbreviations

TABLE 8:

Abbreviation	Meaning
AMS	Aboriginal Medical Services
ARIA	Accessibility/Remoteness Index of Australia
Assistive Technology	Any device or system using a device that allows individuals to perform tasks that would otherwise be more difficult, unsafe or not possible. It does not include items for treatment, mainstream technology without modifications.
ATSI	Aboriginal and/or Torres Strait Islander
Attendant Care	Refers to all supports which are either assistance with daily living or assistance with social and community participation.
Award	Regulatory instrument which outlines the minimum pay rates and conditions of employment for a particular industry and/or occupation.
Board	The corporate governing board of the National Disability Insurance Agency
CALD	Culturally and linguistically diverse
CEO	Chief Executive Officer of the National Disability Insurance Agency
COAG	Council of Australian Governments
DIDO	Drive-in, drive-out; refers to services provided by non-local workforces who are required to drive to/from a separate town or region.
DVA	Department of Veterans Affairs
DSS, or 'the Department'	The Commonwealth Department of Social Services
Eastern Price Guide	*NDIS Price Guide Victoria, New South Wales, Queensland Tasmania* released by the NDIA, the latest of which is valid from 1 July 2017
EBA	Enterprise Bargaining Agreement
ECEI	Early Childhood Early Intervention [x]
NDIA Aspirations	The three external aspirations of the NDIA as identified in its *Corporate Plan 2016 – 2021*: better participant outcomes, a growing market with innovative supports ('market development'), and a financially sustainable scheme ('Scheme sustainability').
FIFO	Fly-in, fly-out; refers to services provided by non-local workforces who are required to fly to/from a separate town or region.
FTE	Full-time equivalent
Full Scheme	Refers to the fully implemented state of the NDIS, estimated to operate from 2020.
FY	Financial Year
IAC	Independent Advisory Council
ICT	Information and communication technology
IHPA	Independent Hospital Pricing Authority
IPR	Independent Pricing Review
IT	Information Technology

Abbreviation	Meaning
LAC	Local Area Coordinator
Modified Monash Model, including 'MM 4', 'MM 5' etc.	A geographical classification system predominantly used to estimate health workforce needs, based on the population size and proximity of each geographical region.
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NILS	National Institute of Labour Studies
Participant and Pathway Review	A review of the process by which participants are enrolled into and managed within the NDIS, finalised in late 2017.
Price cap or price level	The applicable maximum price that can be charged by a provider registered under the NDIS for a particular support service, as identified in the relevant Price guide.
Price guide	One or all of the Eastern price guide, Western price guide, *NDIS Price Guide Very Remote* or *NDIS Price Guide Remote*
Portal	A secure website that enables registered providers to transact online with the NDIA.
QSC	Quality and Safeguards Commission
Quality and Safeguarding Framework	Refers to the content in the following document – Department of Social Services: *NDIS Quality and Safeguarding Framework* (9 December 2016)
Quoting	A price-setting process by which the supplier of a good or service states the price required to supply a particular support service to be assessed by the purchaser.
SCHADS Award, or SCHADS	*Social, Community, Home Care and Disability Services Award 2010* [MA000100] or its applicable state or territory equivalent
Scheme Actuary	A Board-appointed person whose duties are set out in section 180B of the *National Disability Insurance Scheme Act 2013* (Cth)
SDA	Specialist Disability Accommodation
SDF	Sector Development Fund
SIL	Supported Independent Living
SIRA	NSW State Insurance Regulatory Authority
STA	Short term accommodation
TAC	Transport Accidents Commission
TAP	Transition Assistance Program
TOR	Terms of Reference
TSO	Temporary Support for Overheads
Western Price Guide	*NDIS Price Guide Australian Capital Territory, Northern Territory, South Australia, Western Australia* released by the NDIA, the latest of which is valid from 1 July 2017

National Disability Services

Australian Disability Workforce Report

February 2018

WORKFORCE WIZARD

care careers

Findings from Workforce Wizard and carecareers – the best sources of disability workforce data in Australia

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About this report

This is the second edition of a twice yearly publication. It was prepared by Dr Ian Watson, Freelance Researcher and Caroline Alcorso, NDS. The next edition will be published in July 2018.

About National Disability Services

National Disability Services ('NDS') is the peak body for non-government disability services. Its purpose is to promote quality service provision and life opportunities for people with disability. NDS's Australia-wide membership includes more than 1000 non-government organisations, which support people with all forms of disability. NDS provides information and networking opportunities to its members and policy advice to state, territory and federal governments.

National Disability Services

Contents

Executive summary

The second edition of **Australian Disability Workforce Report** revisits the issues first identified in our mid-2017 edition. The richness of nine quarters of Workforce Wizard data covering between 35,000 and 38,000 people each quarter significantly deepens our understanding of front-line disability and allied health professional work.

The analysis presented confirms the distinctive character of the of the disability workforce: a majority female, mainly part-time group of workers, over two-fifths of whom are casually employed.

Trends and features that appear to be associated with the way the sector is responding and adapting to the National Disability Insurance Scheme are also becoming clearer as the rollout gathers pace.

Changes in support worker employment as the NDIS rolls out

Since 2015, casual work has been increasing slightly, and now accounts for 42 per cent of all workers. Most employment gains appear to be coming from casual employment growth. This trend is mainly driven by small and medium organisations, where casual employment at the end of 2017 formed close to half of their workforce.

Two potential downsides to this high casual employment, however, are revealed elsewhere in the data analysis. First is the very high turnover rate of casual workers – a two-year average of nearly 9% per quarter (equal to 35% per annum). This is a significant cost and administrative burden for providers. Second, detailed investigation of NDS carecareers job board data shows job applicants have a clear preference for permanent over casual roles. In the competition for talented people, offering casual jobs only or mainly is likely to be a liability.

Part-time work has also been growing; but unlike casual employment large organisations are also contributing to this tendency. It appears that both large and small/medium organisations are seeking to achieve flexibility in their staffing, but have chosen different strategies. Again, the NDS carecareers job board data offers useful insights. Most job applicants want part-time rather than full-time work, so this growth in the sector is partly driven by worker preferences.

Allied health professionals facing an uncertain environment

Allied health professional employment offers a stark contrast to that of disability support workers. Instead of being majority part-time, the allied health workforce is split almost evenly between people who work full and part time. Three-quarters are permanent workers. But around 16% of applied health professionals were employed as fixed term (on short term contracts) over the last two years and this rose to above 20% during some quarters.

Again, different strategies to minimise risk in an uncertain environment are being used with this young, mainly female professional workforce.

Spotlight topics of interest suggested by Workforce Wizard users

The two spotlight topics featured in this edition of **Australian Disability Workforce Report** are staff absences and industrial instrument coverage.

This is the first time we have reliable data on the use of personal and carers' leave in disability: well over ten days per year. The data is important to achieving fair prices since these figures run counter to the figures assumed by the NDIA.

The disability sector also has an above-average proportion of workers on enterprise agreements than the labour market average, although we know that many of these are due to be renegotiated.

Workforce Wizard and carecareers data continue to fill a major gap

Despite government's legitimate concern about the sector's capacity to scale up as quickly as NDIS participants need, no publicly funded workforce data collection process exists. ABS classifications continue to merge disability workers with other groups, making it impossible to obtain regular labour force analysis.

NDS thanks the many regular Workforce Wizard users whose quarterly data entries allow us to fill this pressing information gap.

1 Introduction

This is the second edition of the **Australian Disability Workforce Report**, an NDS publication that documents current trends in the disability workforce. The features of this workforce is a key question for the sustainability of the National Disability Insurance Scheme (NDIS), and the disability sector as a whole.

Disability's key workforce metrics are reported and discussed in this and every edition. A primary focus is how the workforce is changing (or not) with the introduction of the NDIS.

Australia's capacity to provide a workforce that is of sufficient quantity and quality to meet the increasing workload that the NDIS demands will be crucial to the success of the scheme.

Where does the data come from?

Since ABS labour force data is not classified in a way that allows us to pinpoint the disability workforce, the **Australian Disability Workforce Report** relies on data from NDS's purpose-built two-way workforce metrics application, Workforce Wizard.

Workforce Wizard (www.workforcewizard.com.au) is a free online tool into which disability service providers enter data quarterly. An important design element of Workforce Wizard is that it is short and simple, making it convenient for users. Once the data period closes, benchmark reports are quickly generated showing the organisation's workforce characteristics benchmarked against the sector.

Organisations enter data based on workforces of their own defining. For the purposes of this report, if an organisation entered data for more than one workforce, those workforces were consolidated into one organisational result. This is to avoid multiple counts of a single organisation with more than one (and sometimes duplicate) workforces. When the unit 'organisation' is used in this report, it needs to be understood that the real life organisation may have other streams of activity, such as aged care, plus other staff (eg back office staff) who are not included in our analysis.

The data sample used in this report is nine quarters of data entered up to the end of the September quarter in 2017. Roughly 35,000 to 38,000 disability support workers and allied health professionals data were entered each quarter, from across Australia. Considering the significant coverage of the sector that Workforce Wizard provides, aggregate results have been mainly used.

A longitudinal 'balanced panel' has also been created of organisations that have entered data across the seven consecutive quarters between March 2016 and September 2017. The longitudinal nature of this panel means the disability support worker results from each quarter are more truly comparable to each other, and can confirm trends.

There is no separate longitudinal analysis for the allied health workforce, as most participants of this sample are consistently engaged with Workforce Wizard and therefore constitute a longitudinal panel.

Data on jobseekers

The second major source of data used in this report comes from carecareers (www.carecareers.com.au). This is NDS's job board where employers advertise for disability sector and aged care staff. The data from this job board spans about five years, from the end of 2012 to the beginning of 2018, and is a rich source of information on what is happening in the disability job market. Around one million people use this site every year to find disability and aged care jobs.

A more detailed discussion of Workforce Wizard and carecareers data and our methodology can be found in the first edition of the **Australian Disability Workforce Report**, which can be found at www.nds.org.au/workforce-hub.

What's in this report

In the next three chapters, the Report presents data on the key metrics Workforce Wizard collects about disability support workers:

- types of employment
- organisation growth
- turnover rates
- working hours; and
- age and gender distribution.

Chapter Six analyses these same workforce trends among allied health workers.

Chapter Four reports on our newly introduced special topics, so-called Spotlight Topics, which shed light on important policy issues in the sector. These issues are generated by users and reflect their concerns and interests. One or two additional questions are asked each quarter about these subjects, on a one-off basis.

In this edition, the topics covered are:

- Number of staff absences
- Industrial instrument use in the organisation.

carecareers data analysed in Chapter Five concerns the number of views and applications made by jobseekers for each advertisement.

Throughout the report there are hyperlinks (in blue) to various other parts of the text, to all the figures, and to the tables in the appendix. These tables provide the data which sit behind all the figures. Clicking on these links will take you directly there, and clicking on the Back Button in your PDF Reader will take you back to where you were reading.

2 How are workers employed?

The disability workforce is quite distinctive. About 70% of disability support workers are women, compared to a figure of 46% in the wider Australian workforce.[1] Disability support workers are also slightly older than the Australian workforce: some 44% are aged 45 years or more. In the workforce more generally, the figure is 39%.

Over time, as the disability sector grows strongly, these features may change. More men and more younger workers may enter the sector. At present these features pose challenges that many services are overcoming as they broaden their recruitment targets. On the other hand, there are two areas where the characteristics of the sector pose considerable ongoing challenges. These arise around the forms of employment—whether workers are permanents or casuals—and the hours of work.[2] The disability sector is quite unique in both these areas and the steady growth of casual employment and the increased use of part-time hours raises important issues about the viability of the sector's workforce. Will the disability workforce of the future be a stable, highly-skilled and well-motivated workforce? Or will we see the emergence of pockets of heavily casualised and part-time work, where high turnover, low morale and inconsistent standards prevail?

It is still early days in the rollout of the NDIS, but the sector needs to be alert to developments in the disability workforce which may undermine the positive outcomes promised by the scheme. By focusing on changes in forms of employment and hours of work, NDS is drawing attention to issues that industry, government and service users need to solve collaboratively.

1. It is important to stress that this gender characteristic is shared by other community sector workers, such as carers and aides (the group which includes child-care aged-care workers) where the proportion is 85%.
2. See the discussion of these concepts in the Appendix, on page A1.

Overview

Most disability support workers are employed as permanent or casual workers. Very few are fixed-term workers.[3] In September 2017 the proportion of permanent workers in the disability workforce was 55%; the proportion of fixed-term workers was 3%; and the proportion of casual workers was 42%. Figure 1 shows these proportions in each of the quarters over last two years.

The largest group in the disability workforce are permanent workers ...

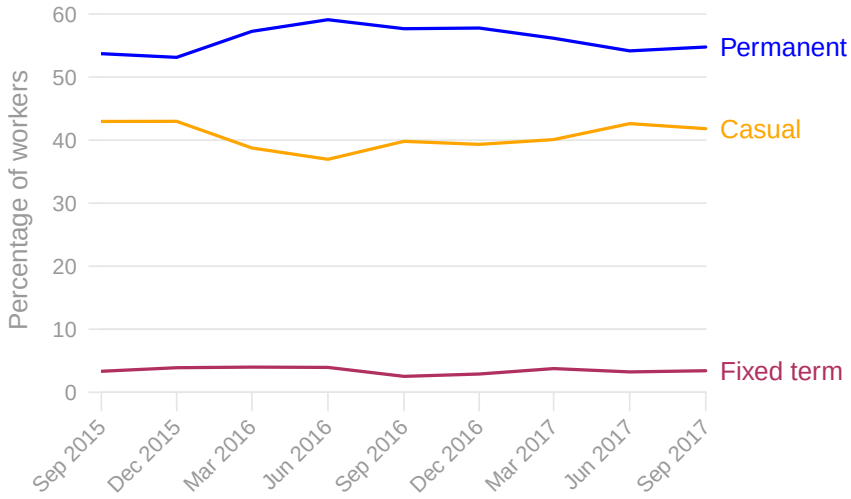


Figure 1: Forms of employment

Notes: Details in Table A10

The figures for September 2017 are close to the overall averages for this two-year period, though the permanent proportion is somewhat lower and the casual proportion somewhat higher, suggesting that the share of casual employment may be slowly increasing. The analysis of workforce growth (page 14 onward) does indeed suggest that casual employment is increasing in the sector.

... but casual workers make up two-fifths of the workforce, a share which has been increasing over the last 18 months

3. Permanents are employed with an expectation of on-going employment; fixed-term workers have a termination date in their contracts; and casuals have no expectation of any ongoing employment and can, in theory, be terminated at short notice.

Does organisational size make a difference?

While the overall trend towards increased casualisation is only slight, when we look more closely at the different organisational sizes in the disability sector, it becomes apparent that small and medium organisations are definitely engaging more casuals. This is shown in Figure 2. In both cases, the proportion of casuals among their disability support workers is now greater—or about to become greater—than the share of permanents. Only for large organisations is the gap between the share of casuals and permanents not closing.[4]

Permanent employment is increasingly the preserve of large organisations ...

In the September 2017 quarter the proportion of permanent disability support workers in large organisations was 57%, while the proportion of casuals was 40%. By contrast, in small organisations permanents made up just 44% and casuals had reached 47%, while in medium organisations the figures were 49% permanents to 48% casuals.

... and casual employment is becoming dominant in small and medium size organisations

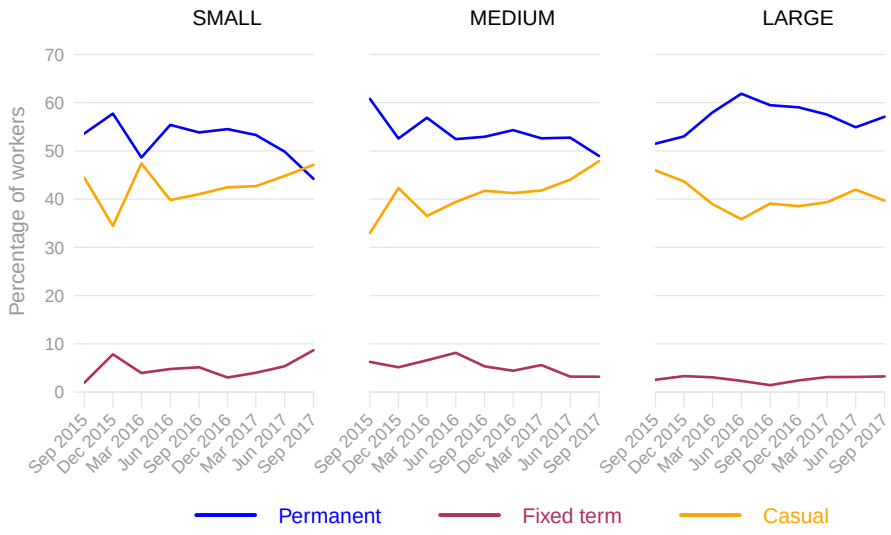


Figure 2: Forms of employment by size of organisations

Notes: Details in Table A11

4. We categorise organisational size on the basis of the number of disability support workers in the organisation: Small: less than 50 workers; Medium: 50 to 199 workers; and Large: 200 or more workers.

Is there a gender story?

There is also a striking pattern according to the gender of the workforce. We saw in the last chapter that women make up the majority of the workforce—averaging around 70 percent—so this makes it difficult to define organisations by their gender proportion. Nevertheless, by pooling the data from all quarters, we have a sufficient number of observations to define four categories based on the ratio of female to male staff, that is, the percentage of women within each organisation's workforce.[5]

By comparing the forms of employment across these four categories we find a distinctive result: organisations with higher female-to-male ratios have higher levels of casual employment and lower levels of permanent employment. Indeed, there is an almost linear relationship: as the proportion of women increase in organisations, so too does the proportion of casuals (see the red line in Figure 3.)

> As the proportion of women increase in organisations, so too does the proportion of casuals

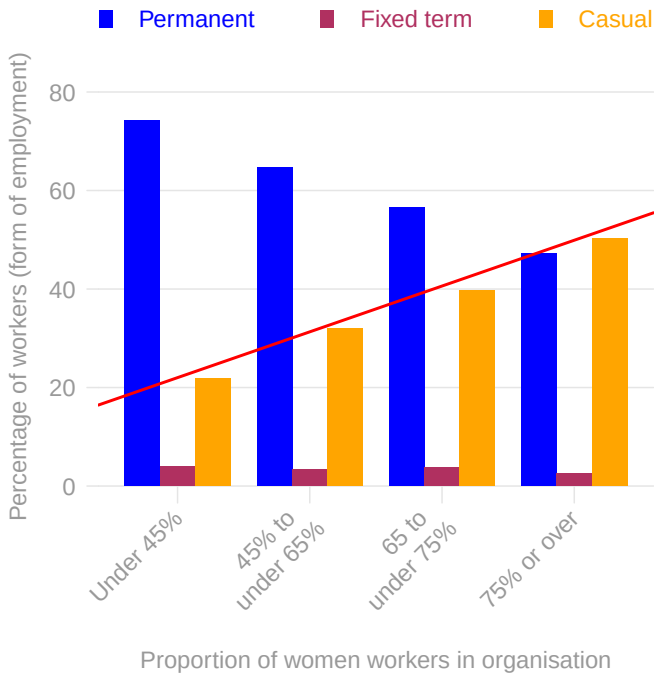


Figure 3: Forms of employment by the proportion of women employed

Notes: Note that data is pooled over all quarters. Details in Table A12.

In organisations which are clearly majority male—that is, where

> Permanent employment is dominant in organisations where there are a large majority of male workers

5. These categories are: Under 45% women; 45% to under 65% women; 65% to under 75% women; 75% or over women.

male workers make up 55% or more of the staff—the proportion of permanents in those organisations is 74% and the proportion of casuals is just 22%. By way of contrast, in organisations where women make up three quarters of the staff—only slightly above the overall average—we find almost equal proportions of permanents (47%) and casuals (50%).

The growth in the workforce

One of the most striking aspects of the disability workforce is the strong growth taking place. As the NDIS rollout proceeds, new organisations have arisen and existing organisations have expanded their staff to cope with the increased demand for services. During 2016 the Australian workforce as a whole increased by about 1.6% per year, but the workforce in the broader social assistance / personal assistance / residential care sectors grew much more strongly, by 9.5% per year.[6] In the case of the disability sector the growth, as measured by Workforce Wizard, has been even stronger: 11.1% per year (averaged over the two year period).

It is possible to examine workforce growth in the disability sector by analysing the numbers of workers who leave an organisation and the numbers who are recruited in each quarter. The difference between these is a measure of 'net change' in the workforce. These figures are collected by Workforce Wizard for permanent and casual staff, and an overview of these data are shown in Figure 4.

Employment losses come from permanent workers leaving ... and the gains come from increased recruitment of casuals

It appears that employment losses in the sector tend to come from permanent workers departing and that most of the employment gains are, in absolute terms, from increased employment of casuals. Given that casuals make up just under half of the disability support workforce one might expect that the net change would also reflect a similar ratio. Clearly, this is not the case, and the increased propensity for organisations to recruit more casuals is evident in Figure 4.

If we want to look at this in percentage terms, the permanent growth rate was 1.3% per year. The casual growth rate, on the other hand, was 26% per year.[7]

6. Figures from Australian Bureau of Statistics, *Characteristics of Employment*, 2016, Cat. No. 6333.0.
7. There is considerable quarterly variability in these percentages, so the figures given here are averaged over the two year period. A different approach to calculating growth rates, based on a balanced panel, is discussed below on page 18.

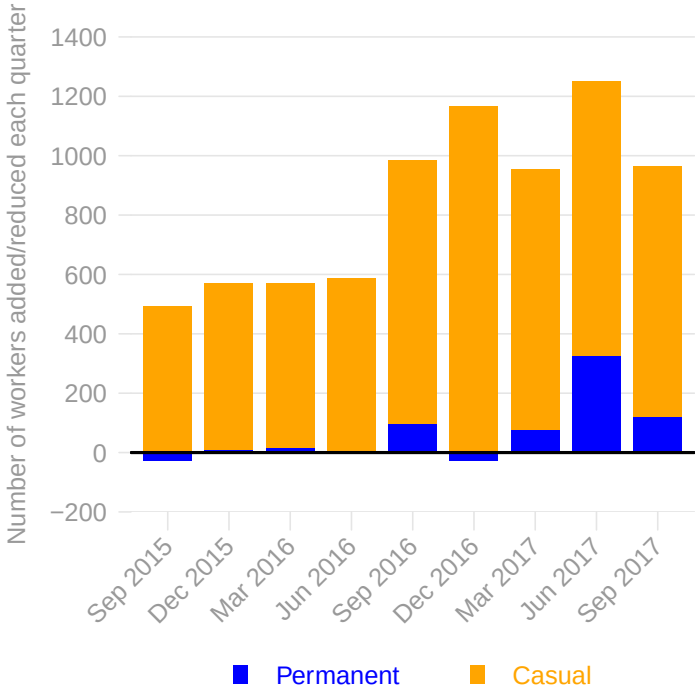


Figure 4:
Net change in permanent and casual staff

Notes: Details in Table A13

We saw earlier (page 12) that in both small and medium size organisations the proportion of casual staff was growing strongly, and becoming the dominant form of employment. For medium size organisations, this picture is confirmed in Figure 5, which shows the net change in permanent and casual staff across medium and large organisations (with trend lines shown in black). In large organisations the **ratio** between permanent and casual net changes in staff appears reasonably stable over time—both are growing together at the same rate.

In large organisations permanent and casual employment are growing at the same rate ...

By contrast, in medium size organisations, the net change in casual staff is growing rapidly, while the net change in permanent staff shows a downward trend.

... but in medium organisations casual employment is growing strongly while permanent employment is declining

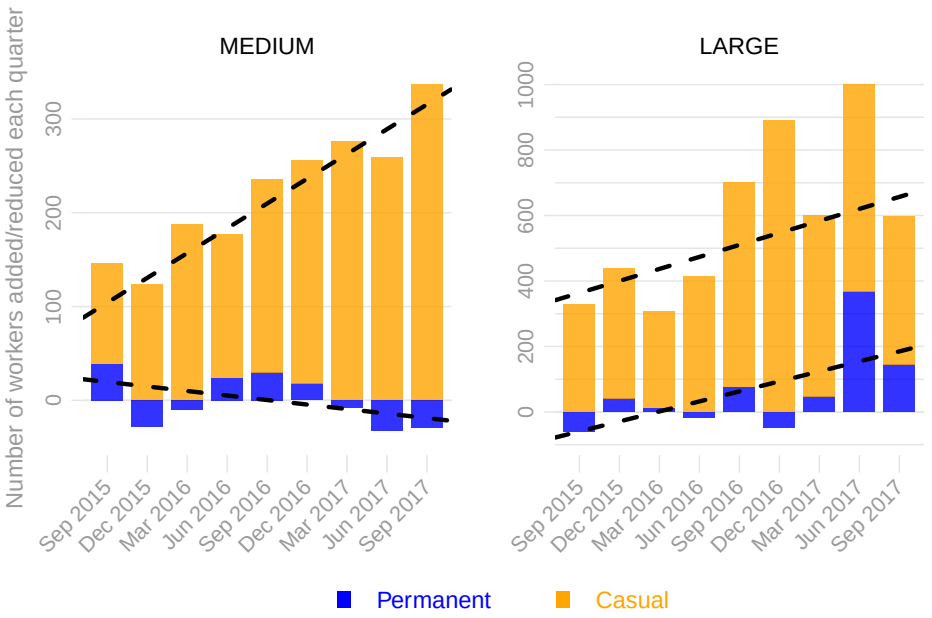


Figure 5:
Net change in permanent and casual staff, by organisational size

Notes: Details in Table A14

What do these changes mean? Essentially, over time a downward trend in the net change of permanent staff means that the sector is diluting its permanent workforce, and that in the long term the share of jobs in the sector held by casual workers will steadily increase. While large organisations are 'holding the line' and not contributing to this potential problem, the drivers of this transition lie in the medium size organisations.

Another perspective on these changes in employment entails categorising organisations by how their permanent and casual staffing profile changed during the quarter. We can define three categories: where a particular type of workforce is declining, where it is stable, and where it is increasing. (The definitions of these categories, and the detailed data for them, are shown in the appendix, see Table A17).

Looking first at the casual staffing profile, about 71% of organisations have had a stable casual workforce in each quarter. Only a small proportion of organisations—an average of 3%—had seen their casual workforce decline during the quarter. By contrast, 25% of all organisations experienced an increase in their casual workforce.

25% of all organisations experienced an increase in their casual workforce ...

... but the majority of organisations maintained a stable permanent workforce

In the case of permanent workers, about 85% of organisations had a largely stable workforce during the quarter. Another 7% of organisations had seen their permanent workforce decline. The remaining 8% of organisations had seen their permanent workforce increase. This organisational approach to the issue of forms of employments is important because it emphasises the **stability**, as well as the changes, in the sector.

As the sector grows rapidly, more of the increased recruitment of workers takes place through the creation of casual jobs

While the losses in employment which do take place are largely in permanent jobs—as we saw earlier—the magnitude of this is relatively small. The strong growth in casual employment may not represent a 'conversion' of permanent work into casual work. Rather, it suggests that as the sector grows rapidly, more of the increased recruitment of workers takes place through the creation of casual jobs.

Workforce turnover

Workforce turnover is an important measure of the amount of 'churn' in an organisation. High levels of labour turnover lead to instability, as experienced workers with good organisational knowledge depart and are replaced with less experienced workers. High labour turnover can signal problems with the organisation, such as low worker morale, or uncompetitive wages or working conditions. On the hand, turnover rates which are too low may leave an organisation without fresh ideas, and the organisations may suffer from routines which reflect old habits no longer suited to the organisation. For the clients, turnover which is too high disrupts continuity in their access to supports; turnover which is too low may leave them deprived of the new ideas which new recruits might bring.

About one quarter of the disability workforce changed jobs every year

The turnover rate is measured as the number of workers who leave an organisation during a quarter, expressed as a percentage of the average total number of workers for that quarter and the previous quarter. Thus the all-worker turnover rate, shown in Figure 6, was 6.5% in the September 2017 quarter; the permanent turnover rate was 4.9% and the casual turnover rate

was 8.6%. In annual terms, about one quarter of the disability workforce changed jobs every year.

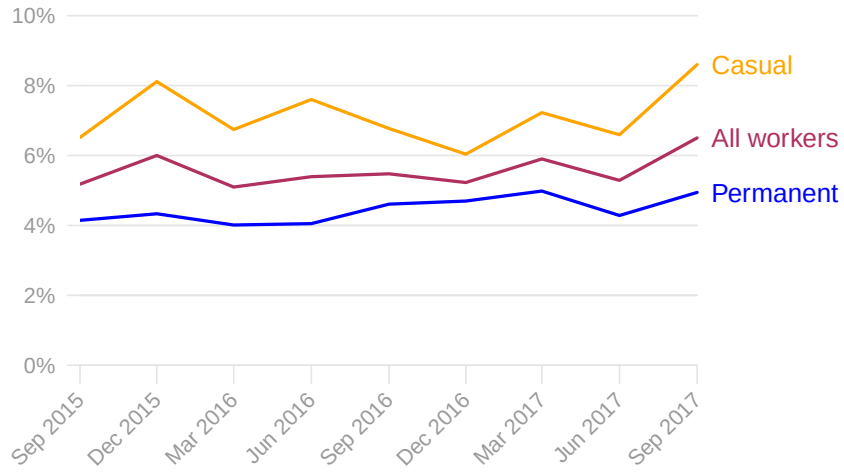


Figure 6: Quarterly turnover rates by forms of employment

Notes: Details in Table A18

The turnover rate for all workers averaged 5.6% per quarter over the last two years, so the 6.5% figure for September 2017 represents a small rise. The turnover rate for permanent workers has fluctuated between 4.1% per quarter and 5% per quarter over the last two years, and has averaged 4.4% per quarter for the period. In the case of casuals, the turnover rate has been even more erratic, ranging from a low of 6% per quarter through to a high of 8.6% per quarter, with the average for the last two years being 7.1% per quarter. The rate for the last quarter—at 8.6%—is above this longer-term average.

Casual workers have 1.6 times the turnover rate of permanent workers

In summary, the turnover rate for casuals has averaged about 1.6 times as high as the permanent rate over the last two years and appears to be increasing. This reinforces the observation made at the start of the chapter: organisations gain apparent flexibility by employing more casual staff but the cost is a greater increase in labour turnover in their workforce, and a consequent drop in the quality of the service provision for their clients.

Another look at growth in the workforce

The information provided by Workforce Wizard on departures and recruitment is valuable in looking at growth and turnover rates. There is, however, an issue around compositional change in the Workforce Wizard sample. As new organisations join the Workforce Wizard, and others drop out, the composition of the workforce

represented by all these organisations may change. To capture a more enduring picture of the workforce we can create what is called a 'balanced panel', a longitudinal sample made up of the same organisations.[8]

Using this balanced panel, we look at where the growth in the workforce came from with respect to forms of employment (see Table A15 for details). In overall terms, most quarters saw growth in numbers (with the exception of the March 2017 quarter) with the strongest growth taking place in the June and December quarters of 2016 (Figure 7).

We can also look at these data in terms of growth rates, that is, the percentage change in numbers in each quarter. Figure 8 shows that the quarterly growth rate for the permanent workforce is consistently lower than the growth rates for casuals (except for the last quarter). In annual terms, and averaging across all quarters, the growth rate for permanents was about 4% percent and for casuals it was 15.2%. The growth in the workforce overall was 8.4%.[9]

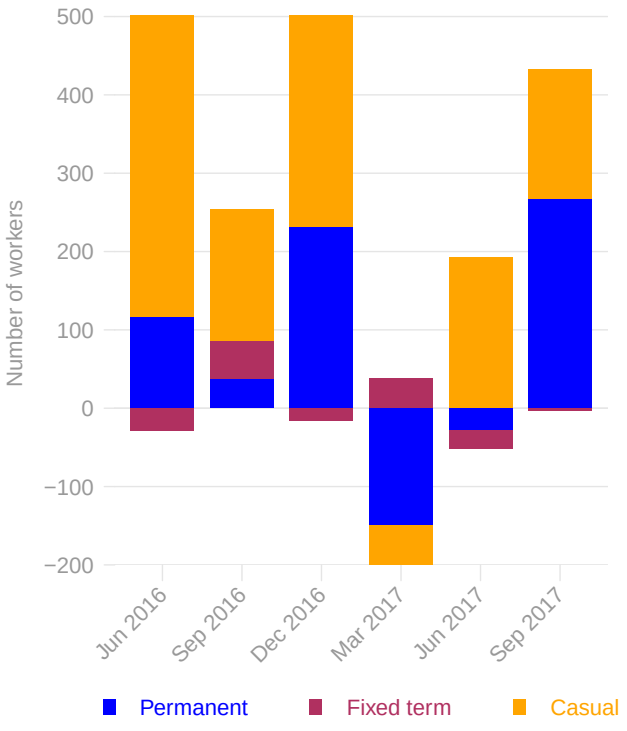


Figure 7: Growth in disability support workforce by forms of employment (counts)

Notes: Details in Table A15

8. In this case, we have selected only those organisations with complete data in Workforce Wizard for all of the seven previous quarters. While this reduces the size of the sample considerably, the numbers are still adequate for our analysis.
9. Growth rates for fixed-term workers are not shown because they are so erratic, based as they are on very small counts. The average growth rate across all quarters for fixed-term workers is 1.1%.

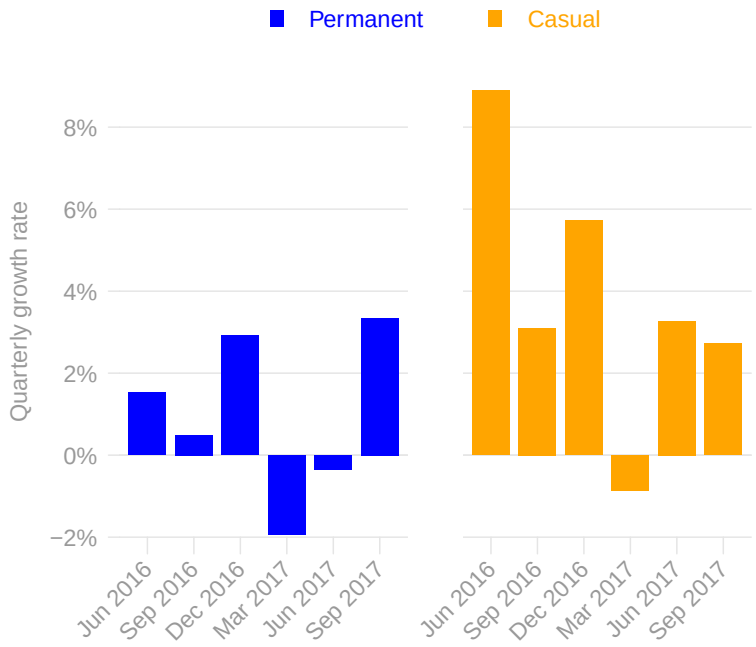


Figure 8: Growth in disability support workforce by forms of employment (quarterly growth rates)

Notes: Details in Table A16

Both these figures show that the majority of the growth in the sector's workforce was through the increased employment of casuals, with only the most recent quarter breaking from this pattern. This analysis confirms the overall picture shown earlier: that casual employment is overwhelmingly driving employment growth in the sector but that in the last quarter (September 2017) permanent employment fared much better. Additional quarters of Workforce Wizard will indicate if this is the beginning of a new trend.

Casual employment has driven employment growth ... but permanent employment has begun to fare better

How does the sector compare?

In 2016 the proportions of casuals, permanents and fixed-term workers in disability, compared with the labour market more generally were as follows:

Permanent: 58% (disability) to 67% (in general);
Casual: 40% (disability) to 23% (in general);
Fixed term: 3% (disability) to 10% (in general).

This comparison shows that casual employment in the disability sector is considerably higher than in the labour market more generally. At the same time, fixed-term employment is much lower.

Casual employment in disability is much higher than in the labour market more generally

If we look at the ABS category of ‘carers and aides’—which includes child care, aged care and disability—this difference in casualisation rates shrinks considerably: some 33% of carers are casuals. The full details of these comparisons can be found in the appendix (Table A6).

In summary, casual employment is much higher in the disability sector than in the Australian workforce more generally. But if we compare the sector to other similar sectors, then the comparison is less stark, though these higher casualisation rates are still exceptional.

3 What hours are worked by disability workers?

Overview

Flexibility in the hours of employment is important for both employers and workers. The former often need to manage varying demand for staff, while workers often need flexibility to juggle their work and non-work lives. In this chapter we look at the hours patterns in the permanent workforce: mainly the split between part-time (under 38 hours per week) and full-time (38 hours or more). We also look at the average hours worked each week.

The disability sector shares in what has been a national trend towards increased part-time work. Within the disability sector, part-time work is dominant and also increasing (see Figure 9). In the September 2017 quarter, the proportion of the permanent workforce who worked part-time was 81%. Full-time workers made up the remaining 19%.

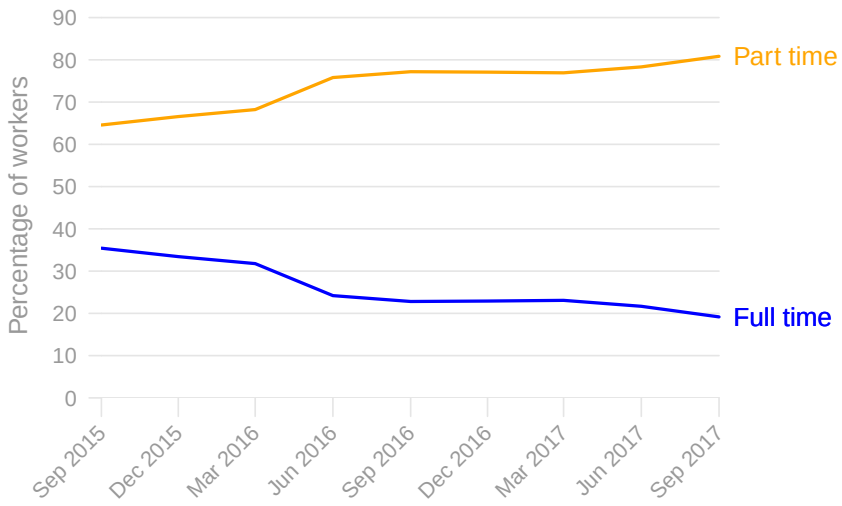


Figure 9: Full-time and part-time workers: overview (%)

Notes: Details in Table A19

The permanent workforce is dominated by part-time work, and this is growing strongly

Over the last two years part-time work has grown strongly among permanent disability support workers. In September 2015 part-time workers made up 65% of this workforce (with full-timers making up the remaining 35%). The part-time workforce (among permanent workers) has thus grown by 16 percentage points in just two years.

Does organisational size make a difference?

Large organisations have increased their part-time workforce ... and now have the highest proportion of part-time workers

Over the last two years large organisations have been steadily increasing their part-time workforce. As Figure 10 on page 24 shows, at the start of the period part-timers made up 62% of their workers. By the end of the period the figure was 83%, an increase of 21 percentage points. From being behind small and medium organisations in their employment of part-timers back in 2015, by late 2017 large organisations now have the highest proportion of part-timers.

In both small and medium organisations the proportion of part-timers has remained reasonably stable over the period (with more volatility in small organisations). By the end of the period medium organisations had slightly higher proportions of part-timers than did small organisations (74% to 68%).

Both large and small/medium organisations aim for workforce flexibility ... but have chosen different strategies

Because the analysis discussed here applies to the **permanent** workforce, a number of inferences can be drawn. First, this high proportion of part-timers in large organisations is predominantly **permanent part-time**. Secondly, the slightly lower proportion of part-timers in small and medium organisations needs to be seen in the context of higher levels of casual workers in those organisations. In other words, both large and small/medium organisations have sought to achieve flexibility in their staffing, but have chosen different strategies.

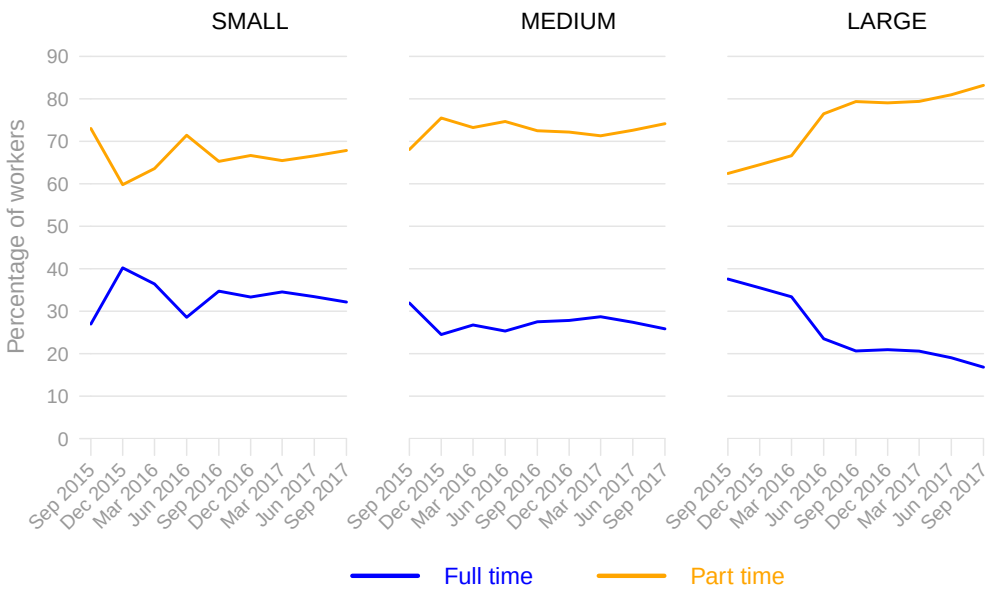


Figure 10:
Full-time and part-time workers by size of organisation

Notes: Details in Table A20

Average hours worked by each worker

Does the increased use of part-time workers also mean a reduction in the average hours worked by each worker within the disability sector? In general, the answer appears to be yes. There is a downward trend over the last two years in overall average hours of work, as shown by the red line in Figure 11.

There is a long-term downward trend in average hours of work ...

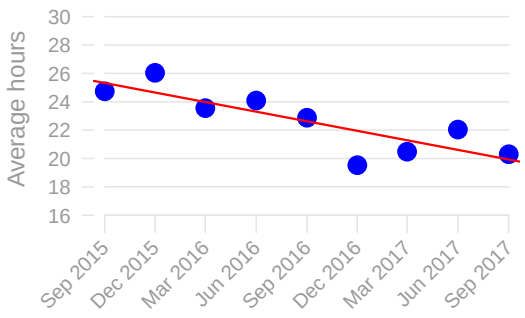


Figure 11:
Average hours of work per week per worker

Notes: Details in Table A21

If we look at the size of the organisations we can see that this is driven by the medium and large organisations (see Figure 12). In small organisations, average hours of work are stable whereas in both medium and large organisations they are declining steadily. This last result is not surprising: given

... and this is most pronounced in medium and large organisations

the increased use of part-time workers by large organisations, it follows that their average hours per worker will be declining.

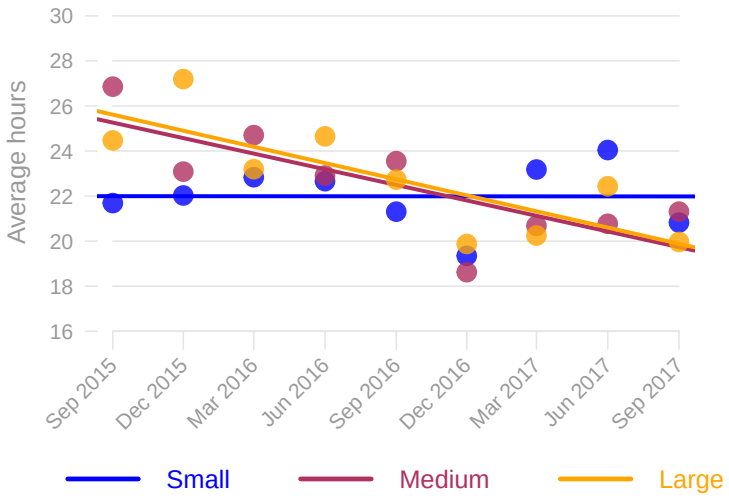


Figure 12:
Average hours of work per week per worker by organisational size

Notes: Details in Table A22

Both the level and the decline in average hours worked are a cause for concern. The decline appears unusual, and departs from the general pattern in the labour market. The level—averaging 22.6 hours per week over the last two years—is considerably lower than elsewhere in the labour market. For example, in workforces with similarly large proportions of part-time workers the figure is closer to 26 hours per week.[10] In the last quarter, the average hours worked by disability support workers had actually fallen to just 20 hours per week. Such low average hours raise important questions about sustainable growth for the sector's workforce: how does one earn a living wage without taking on a second job, or leaving the sector for a better paid position elsewhere?

Gender and hours of work

Is there a gender effect with full-time and part-time work, as there is with forms of employment? Using the same definitions as before, we look at whether organisations with higher concentrations of female disability support workers are also more likely to have higher proportions of part-time workers.

10. This is a ten year average for the general category of 'carers and aides', which includes aged-care workers as well as disability workers. Based on HILDA data.

There is no clear linear relationship between gender and hours of work

Figure 13 suggests that unlike forms of employment, there is no clear linear relationship. Until one looks at those workplaces with the highest concentrations (three quarters or more women) the proportion of part-time workers shows no distinct pattern. However, in those organisations with these large concentrations of women, there is a distinctly higher proportion of part-time workers: some 84% working part-time compared with an average of about 75% across the other categories.

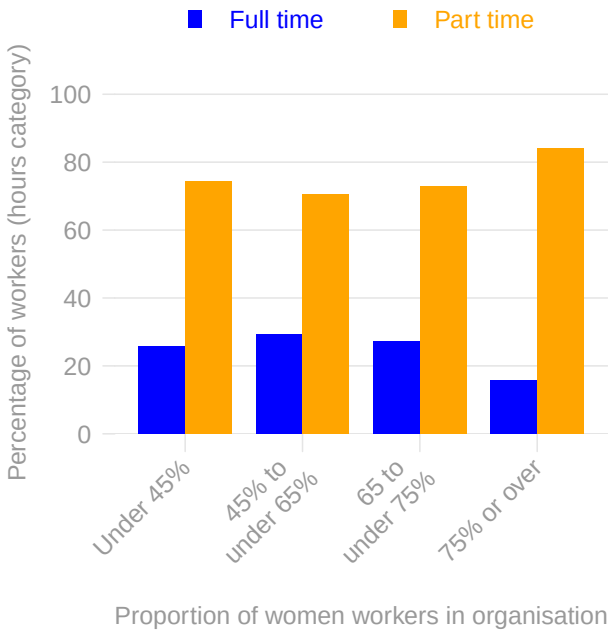


Figure 13: Full-time and part-time workers by the gender composition of the organisation

Notes: Note that data is pooled over all quarters. Details in Table A23.

Hours of work and workforce growth

Employment gains come from increases in part-time workers ... job losses are from declines in full-time workers

We saw earlier that workforce growth was strongly driven by an increased employment of casual workers. Using the same approach, with a balanced panel (see page 14), we analyse the composition of workforce growth according to the full-time and part-time status of the workers entering and leaving organisations. While the totals are smaller—because this full-time / part-time analysis is restricted to the permanent workforce—it seems clear that the growth in employment is largely driven by the increased employment of part-time workers. At the same time most of the job losses have been for full-time workers. Only in the September 2016 quarter did growth in full-time workers exceed growth in part-time workers. Figure 14 illustrates these findings.

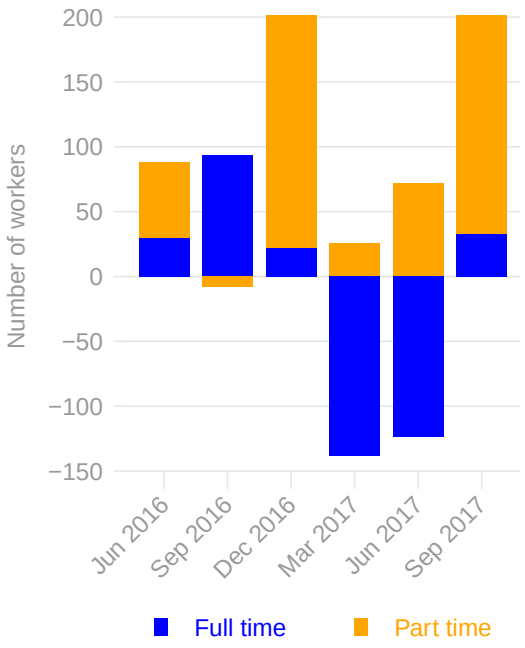


Figure 14: Growth in disability support workforce by full-time and part-time work (counts)

Notes: Details in Table A24

How does the sector compare?

We conclude this chapter by looking at how disability support workers compare with other workers. A more detailed comparison is in the appendix (see Table A7). It needs to be kept in mind that the population here is the permanent workforce and the comparisons are for September 2016.

The high levels of part-time employment in disability appear exceptional

In the September quarter of 2016 about 23% of disability workers within the permanent workforce were full-time; the remaining 77% were part-time. By comparison, the figures for the labour market as a whole are vastly different: 69% full-time and 31% part-time. In other words, in its use of part-time employees, the disability sector appears quite exceptional. However, this seems to be a feature of this type of sector, since the occupational category of 'carers and aides'—which includes the aged-care sector—has similar proportions: here some 30% are full-time and 70% part-time.

The strong growth of part-time work in disability over the last two years is a departure from the general trend

Is the growth in part-time employment which this chapter has illuminated part of a wider development in the labour market, or is it

somewhat unique to the disability sector? Over the last 15 years, part-time employment has grown steadily among permanent employees, rising from 26% of the workforce in 2001 to 30% in 2016. However, this growth has been uneven: and the figure of 30% has been largely stable since 2011 suggesting that the strong growth of part-time work in disability over the last two years is a departure from the general trend, and is likely to be NDIS-related.

If we again look at the broad category of 'carers and aides'—keeping in mind that it includes aged-care workers as well as disability support workers—the 15 year-trend is largely static: 72% were part-time in both 2001 and 2016. However, in the period since 2011, the proportion has been dropping, from a high of 75% down to 72%. While these figures need to be treated with caution (given the small sample size on which they are based), they confirm the earlier impression: the increasing use of part-time work in the disability sector is not shared more widely in the labour market.

4 Spotlight topic: absences

Introduction

Each quarter the Workforce Wizard contains an additional 'spotlight topic', a topic which throws light on important policy issues within the sector. It is not essential that these topics be collected every quarter. They will be repeated every two years and thereby provide the sector with a long-term perspective on these crucial issues.

In the March 2017 quarter the topic was recruitment trends and difficulties, and the results for this topic were discussed in the previous **Australian Disability Workforce Report**. In June 2017 the topic was workforce absences, specifically personal and carers' leave and leave without pay. Since these conditions were only available to the permanent workforce, they were only collected by Workforce Wizard for workers engaged as permanent or fixed term.

Personal and carers' leave and leave without pay

The Workforce Wizard collected the actual **number** of days workers were absent, but to take account of the fact that large organisations have a larger numbers of workers, we need to analyse leave as a **ratio**: the number of days taken per worker per quarter. Using this figure we compare averages across the states (with some of the smaller areas grouped with their neighbour to make the numbers adequate for analysis).

Workers took an average of about 6 days of personal and carers' leave per person per year

During the June quarter of 2017 disability support workers took an average of 1.8 days of personal and carers' leave per person during the quarter (see Table 1). Using the median, which removes more extreme values, the average was 1.2 days. Based on these figures, an annual estimate is that workers took about 6 days of personal and carers' leave per person per year.[11]

11. This is based on multiplying by 4 the mid-point figure of 1.5 days.

Personal and carers' leave was highest in Queensland (2.9 days per quarter) and New South Wales / ACT (2.5 days per quarter), and lowest in Victoria / Tasmania (1 day per quarter) and in organisations that were spread across states (0.8 day per quarter).

Leave without pay was much less common. The national average was 0.5 day, which in annual terms equated to 2 days of leave without pay. The highest figures were just 0.7 day per quarter in Queensland and South Australia / Northern Territory. The lowest figures (0.3 day per quarter) were again in the multi-State organisations.

> Workers took an average of 2 days of leave without pay per person per year

While there is no discernible pattern in the leave without pay figures according to the size of the organisation, there is when it comes to personal and carers' leave. Those disability support workers employed by large organisations accessed about half of the amount of leave compared to those employed by small and medium organisations. Those in large organisations took 1.1 days per quarter, while those in small organisations took 2 days and those in medium organisations took 2.1 days.

Table 1: Average number of days per worker per quarter, personal and carers' leave and leave without pay, by State

	Personal and carers' leave		Leave without pay		
State	**Mean**	**Median**	**Mean**	**Median**	**n**
Queensland	2.5	1.3	0.4	0.0	33
Multi-state	1.0	1.1	0.5	0.2	47
Victoria / Tasmania	2.9	1.8	0.7	0.0	31
Western Australia	1.3	1.2	0.7	0.0	30
New South Wales / ACT	1.6	1.2	0.4	0.0	34
South Australia / NT	0.8	0.4	0.3	0.0	18
National average	1.8	1.2	0.5	0.0	193

Notes: Population is permanent and fixed term workers only. n is number of organisations in the sample. *Source*: Workforce Wizard

The National Employment Standards for a full-time employee provide for 10 days per year for personal and carers' leave. This minimum figure feeds into the pricing assumptions of the NDIS. Yet the disability sector figure of 6 days for each worker, in a workforce where over 80% of workers are **part time**, equates to a much higher number, well over 10 days. While it is well-known that workers in stressful and emotionally demanding jobs have higher sickness rates, this is the first time we have data on the actual use of personal and carers' leave entitlements in disability.

Industrial instruments covering the workforce

In the September quarter of 2017 the spotlight topic was the type of industrial instrument which covered the workforce for which that organisation was entering data. The industrial instrument provided the basis for wages and conditions for a defined group of employees. There were two main instruments:

1. Awards: which are negotiated by trade unions and often operate at an industry level. They usually provide a 'floor' to both wages and conditions in that industry, though individual organisation may sometimes provide 'over-award' pay or conditions.
2. Enterprise agreements: these are based on bargaining outcomes within the organisations between the union or workers and the management. They usually provide better pay and conditions than the award, but may also involve 'trade-offs' on the part of the workers in return for these advantages.

Traditionally, many disability organisations have undertaken enterprise bargaining, but this may be changing in the new market environment and this spotlight topic will assist in monitoring such changes.

Nearly 60% of organisations were covered by awards, about 40% by enterprise agreements

Overall about 59% of organisations were covered by awards and the remaining 41% were covered by agreements. However, the variation across states was considerable. As Table 2 shows, the coverage of awards was much higher in New South Wales / ACT and Queensland: 87% and 73% respectively. It was lowest in South Australia / NT (just 25%) and somewhat lower in Victoria / Tasmania (49%).

Table 2: Industrial instruments operating in organisations, by state (%)

State	Award	Agreement	Total	n
New South Wales / ACT	87	13	100	30
Victoria / Tasmania	49	51	100	37
Queensland	73	27	100	22
South Australia / NT	25	75	100	16
Western Australia	54	46	100	26
Multi-state	56	44	100	16
Total	59	41	100	147

Notes: Population is organisations and coverage refers to disability support workers. n is number of organisations in the sample. *Source*: Workforce Wizard

These figures for industrial coverage are for **organisations** in the disability sector, but it is also possible to calculate coverage for the **workforce** by taking account of the number of workers in each organisation. Table 3 shows the patterns in industrial coverage for some 31,000 disability support workers in Australia.

Workers are split evenly between award coverage and enterprise agreements

Overall, workers are split almost evenly between award coverage (51%) and enterprise agreements (49%). The state patterns, however, are quite diverse. New South Wales / ACT and Queensland are again the States with the highest proportion of workers under the award (82% and 63%), and South Australia / NT is again much lower. An interesting difference is evident in the figures for Victoria / Tasmania. Award coverage for organisations is 49%, but for the workforce the figure is half this at 25%.

Table 3: Industrial instruments for the workforce, by state (%)

State	Award	Agreement	Total	n
New South Wales / ACT	82	18	100	6,658
Victoria / Tasmania	25	75	100	5,008
Queensland	63	37	100	2,911
South Australia / NT	17	83	100	3,429
Western Australia	44	56	100	5,999
Multi-state	58	42	100	6,819
Total	51	49	100	30,824

Notes: Population is the disability support workforce. n is number of workers covered by the organisations in the sample. *Source*: Workforce Wizard

Historically, enterprise bargaining has been more common in large organisations, while smaller organisations have often stayed on the award. To some extent, this pattern is confirmed in the Workforce Wizard data, particularly for the workforce figures. In the case of organisational coverage, some 46 percent of large organisations have enterprise agreements, slightly higher than the average (41%) but considerably higher than small organisations (35%). Turning to workforce coverage, some 53% of workers in large organisations are covered by enterprise agreements compared with just 35% of the workforce found in small organisations.

Table 4: Industrial instruments for organisations and for the workforce, by organisational size (%)

	Organisations				Workers			
Org size	Award	Agree-ment	Total	n	Award	Agree-ment	Total	n
Small	65	35	100	40	65	35	100	1,083
Medium	59	41	100	66	61	39	100	6,757
Large	54	46	100	41	47	53	100	22,984
Total	59	41	100	147	51	49	100	30,824

Notes: Population in first panel is organisations; in second panel the workforce. n in first panel is number of organisations; in second panel, number of workers covered. *Source*: Workforce Wizard

The disability sector has a higher proportion of workers on enterprise agreements than the labour market average

How do these figures compare with the industrial relations situation more generally? The Australian Bureau of Statistics collects workplace information on methods of setting pay and it's data for May 2016 provides an overall estimate of 37% of employees[12] on enterprise agreements, with the balance split between award coverage and individual arrangements.[13] This suggests that the disability sector has a higher proportion of workers (49%) on enterprise agreements than in the labour market more generally.

However, if we look at the broad industry category of 'health care and social assistance', the figures are much closer to the disability sector figures in Workforce Wizard. These ABS estimates show that 53% of employees were employed on enterprise agreements. This industry finding mirrors the findings in other chapters, where if we focus more closely on occupational groups such as carers and aides, the disability sector appears much less exceptional.

12. The data come from ABS, *Employee Earnings and Hours*, Australia, May 2016, Cat.No. 6306.0 (Spreadsheet: 63060DO007_201605). Note that the population for these estimates is full-time non-managerial employees. The all-employee data combines awards and collective agreements and is therefore of no use in this particular comparison.
13. The ABS has always distinguished between award coverage and individual arrangements but this overlooks two issues. First, individual arrangements are 'underpinned' by the award, so the low figures given for award coverage are mislead-ing. Secondly, the number is further reduced because 'over-award' payments are also classified as individual arrangements. For these reasons, it is best to just focus on the figures for enterprise agreements, which the ABS terms collective agreements.

5 What are workers looking for?

The job market is where employers in the disability sector look for workers and where people interested in working in the sector seek out jobs. The **carecareers** website which is run by NDS accepts advertisements for jobs ('job ads') from employers where they currently have vacancies. People who land on the website scan this 'job board' looking for suitable employment, and when they find a position which interests them, they may click on the 'view details' button and continue by clicking on an 'apply' button.

The data from this job board spans about 5 years, from the end of 2012 to the beginning of 2018, and is a rich source of information on what is happening in the disability jobs market. In this chapter we look at the job applications posted by individuals who transact with the carecareers job board. These people—termed 'job seekers'—may be already working, and looking around for a different job; they may be unemployed; or they may be outside the labour force and contemplating entering or returning to the workforce. We don't have information on their situation, but we can look in some detail at the kinds of jobs for which they are looking.

We use the data from 2013 to 2017 because it is complete for each year. Through to end of June 2016 NSW employers (accounting for over 50% of the total advertiser base) were able to list ads for free, so there is a steady growth in jobs over the period. However, during 2017—once employers were required to pay a (modest) amount for listing ads—the number of job ads declined. It is important to keep this decline in mind. It does not imply a decline in the availability of work in the sector and the decline in ads does not weaken the useful of the various comparative measures used here.

All the jobs examined here are only those applying to the disability sector (carecareers posts a much larger range of jobs in other areas of the community sector) and we also analyse the occupational groupings which apply to these jobs.[14]

14. The definitions of the occupational groupings used here are to be found in the appendix. See Table A26. The combined disability sector jobs include some health professional, and allied health professional jobs, but for sampling reasons the occupational groupings omit all of the health jobs.

What interests job seekers?

One measure of what people look for when they transact on the jobs board of carercareers is whether they click to find out more details about the job. We calculate **the ratio of views to each listing** to gauge the 'popularity' of listings over the period from 2013 to 2017. These data are shown in Figure 15 and suggest that in the first full year of operation, each listing on the jobs board for direct support workers was 'viewed' on average by more than 450 potential workers.[15]

These popularity ratios fell in 2014, but then grew steadily from then on, and the pattern was generally repeated across most occupational groups. One interpretation of these data is that the initial year represented heightened interest in a new job-seeking platform available on the internet, and that subsequent years reflected the underlying growth of interest in these jobs. What seems particularly notable about the listings for direct support workers is the reduction in listings during 2017 did not lead to a diminishing level of interest by job seekers. The ratio (of over 400) held up during 2017, despite fewer jobs on offer on the platform.

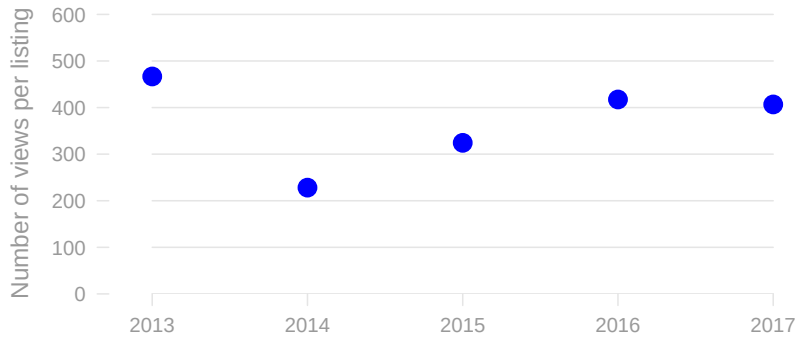


Figure 15:
Views of job listings for direct support workers

Source: carecareers job board

15. We need to keep in mind that actual job listings were only shown for a month, so this figure is an average based on dividing the total number of views in a year by the total number of listings, broken down by the occupational grouping.

Job applications

A much stronger measure than viewing the details for job ads is making an application. While there are some difficulties in knowing whether job seekers follow through completely with their online applications, there is no reason to assume that systematic patterns will influence this outcome. With this in mind, we examine information on forms of employment and hours of work to see what kinds of jobs disability workers are looking for. We plot the data as monthly counts and then fit trend lines to illuminate the overall pattern. As we did in earlier chapters, we focus on both forms of employment (permanent and casual jobs) as well as hours of work (full time and part time jobs). The latter distinction is only applicable to job ads for permanent positions.

As Figure 16 shows, most job seekers preferred permanent jobs over casual jobs. The growth in the latter category remained almost flat from 2016 onward, whereas growth in applications for permanent jobs grew strongly until early 2017, when applications began to fall.

Most job seekers preferred permanent over casual jobs ...

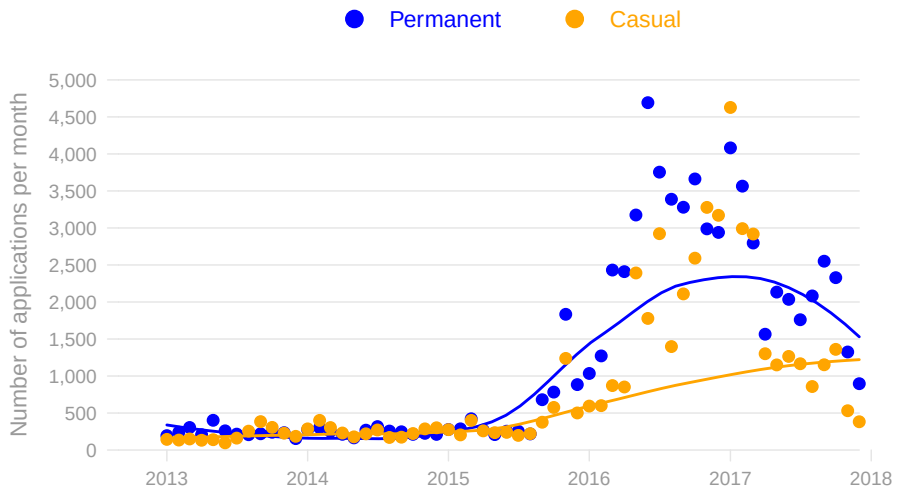


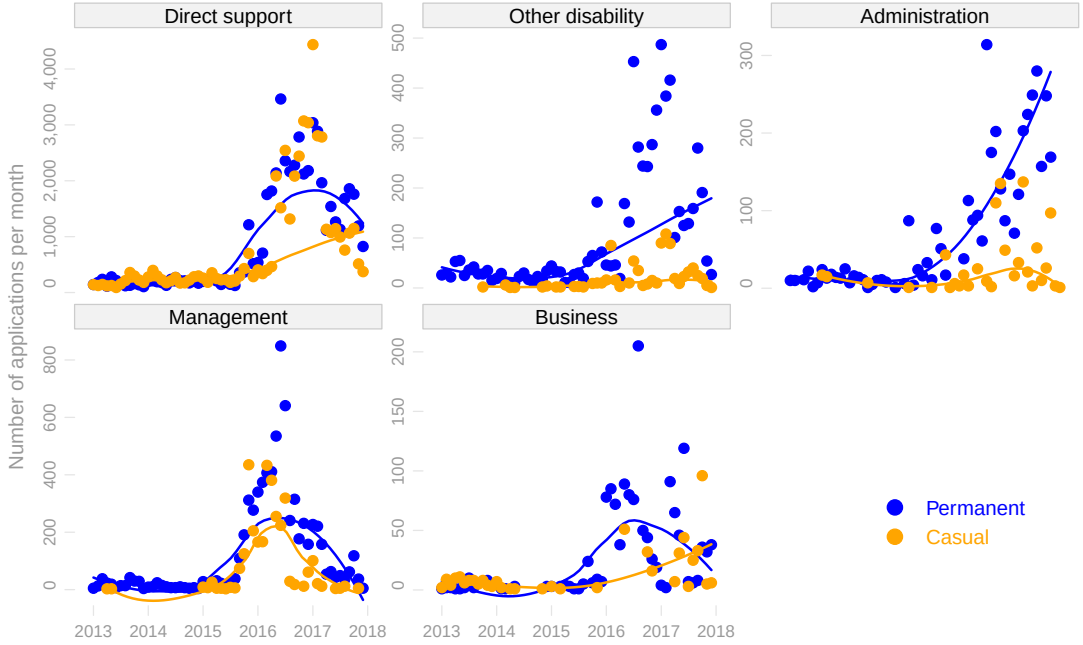
Figure 16: Monthly applications for disability jobs, by forms of employment

Source: carecareers job board

Because 80% of the applications were for direct support workers, the occupational breakdown for this group closely matched the overall patterns. That is, direct support workers had a much stronger preference for permanent jobs over casual jobs (see Figure 17). This carried through to the other occupational groups with some minor variations. For example, while casual jobs barely

featured in administration, they were more common in the management occupations, with applications split evenly between permanent and casual jobs during the middle of 2016.

Figure 17: Number of job applications per month, by forms of employment and by occupational grouping (*Source:* carecareers job board)



When we turn to hours of work, a very different picture emerges. Not only did part-time applications outnumber full-time applications across the period, but they continued to grow strongly during 2017 when full-time applications were falling away (Figure 18). This is quite a striking difference to the picture which emerges with forms of employment. Again, because of the dominance of direct support workers in this population, the breakdown by occupational groups reinforces this general pattern of a strong preference for part-time work. There is, however, is one interesting variation. While full-time applications were more common than part-time ones in administrative occupations, the numbers were very close and there was strong growth in both during 2017 (Figure 19).

... but workers preferred part-time jobs over full-time jobs

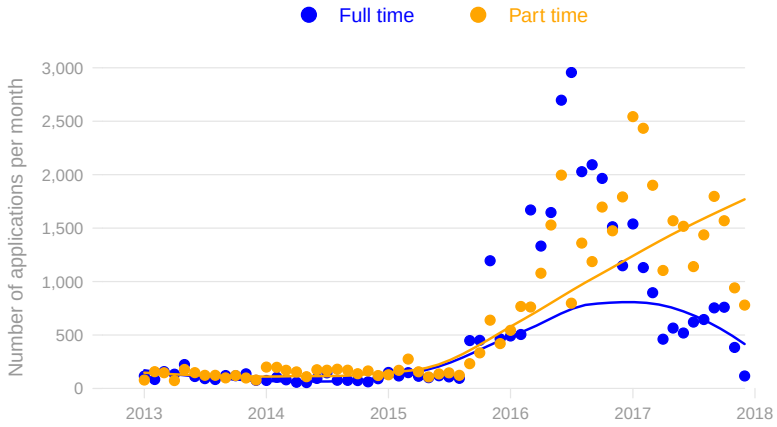
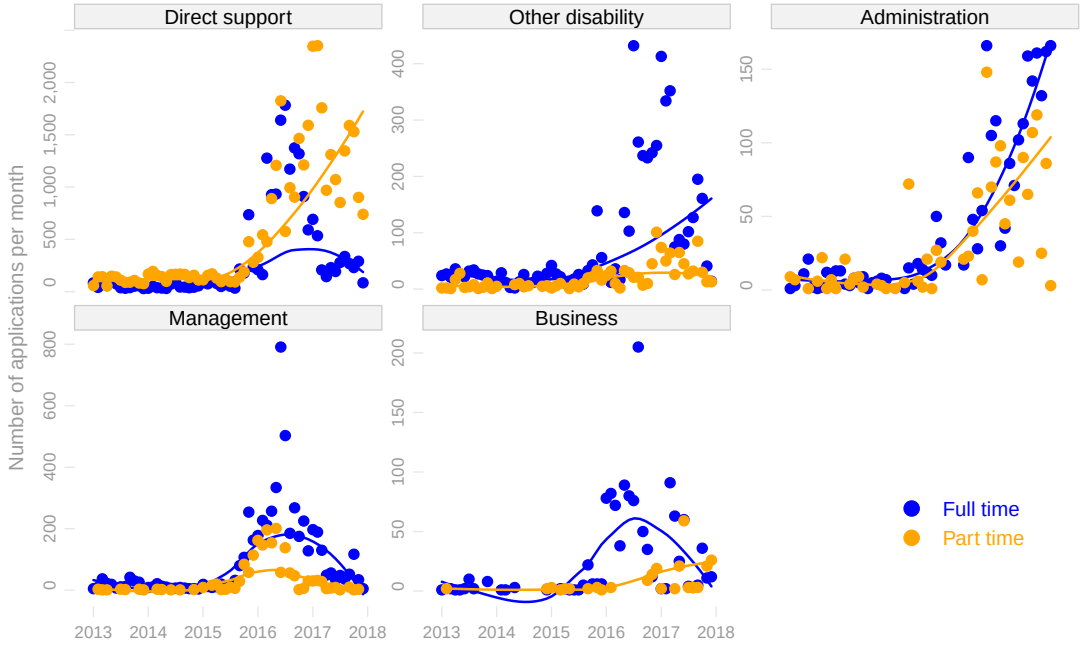


Figure 18: Monthly applications for disability jobs, by hours of work

Source: carecareers job board

Figure 19: Number of job applications per month, by hours of work and by occupational grouping (*Source:* carecareers job board)



One of the enduring questions posed by the growth of part-time employment in the Australian labour market is whether this growth is mainly driven by what employers offer, or by what workers are looking for. The high levels of **underemployment**[16] in some sectors of the labour market suggests that many of the part-time jobs are all that is on offer. Nevertheless, some sectors have large numbers of female workers and students who seek out part-time work because of its suitability for work-life balance.

16. This is where part-timers wish to work more hours than are provided by their employers.

The job applications data for the disability sector provides some insights into this enduring question. When it comes to offering jobs for direct support workers, carecareers employers appear to be offering both permanent and casual jobs in roughly comparable numbers. Similarly, when it comes to whether the permanent jobs on offer are full-time or part-time jobs there is some variability over the period, but the overall pattern in the proportions are also close to even.

Most job seekers want permanent jobs in preference to casual jobs, and part-time jobs in preference to full-time jobs

However, when we turn to look at the data on what interests job seekers, we find that workers are more interested in applying for the permanent jobs. And within those permanent jobs, they are more interested in the part-time positions. This is particularly so among workers looking for direct support jobs and for jobs in administration.

6 What does the allied health workforce look like?

Demographic aspects

The allied health workforce in the disability sector is much smaller than the disability support workforce, but is quite a distinctive group of workers. It is made up of allied health professionals such as occupational therapists, physiotherapists and speech pathologists, as well as nurses.

The workforce is overwhelmingly made up of women. In the September quarter of 2017, 92% of allied health professionals were women. In very few organisations (about 12%) is the female-to-male ratio of the allied health workforce less than 80%. Indeed, in more than one fifth of disability organisations, the whole of their allied health workforce is female. These figures compare starkly with the disability support workforce, where the female proportion in the September quarter of 2017 was 70%.

Similarly, the age profile of allied health workers stands out: they are a much younger workforce. Some 65% were in the middle years of 25 to 44, compared with a figure of 44% among disability support workers. As we saw earlier, the latter group had more older workers—about 21% were older than 55 years—whereas in the allied health workforce only 11% were in this age group.

Forms of employment

Three quarters of the allied health workforce were permanent workers

Unlike disability support workers, an important aspect of employment among allied health workers is the dominance of permanent employment and the relatively larger role played by fixed-term appointments. Whereas casual employment is a striking feature of the disability support workforce, among allied health workers it is

insignificant: only about 7% of workers were employed in this way over the period.[17] By contrast, some 16% were employed as fixed-term and this figure had moved above 20% during some quarters. Most importantly, an average of three quarters of the allied health workforce were employed as permanent employees.

If we look at this in terms of workforce density within organisations, we see that both casual and fixed-term employment is not prominent. As Table 5 shows, 47% of organisations with allied health workers employ none of these worker as casuals, and 44% employ none as fixed-term workers. Only about 10% of organisations had densities of more than 30% for these forms of employment, and these were overwhelmingly the smaller organisations.

Table 5: Organisations by casual and fixed-term density: allied health workers

	Casual employment		Fixed-term employment	
Density	**No.**	**%**	**No.**	**%**
None	91	47	85	44
10% or less	46	24	31	16
Between 10% and 30%	35	18	58	30
More than 30%	23	12	21	11
Total	195	100	195	100

Notes: Data has been pooled over all quarters. *Source*: Workforce Wizard

Hours of work

The allied health workforce is split almost evenly between full-time and part-time workers.[18] In the September quarter of 2017 49% were employed full-time and 51% were employed part-time. This situation is, however, the culmination of a steady increase in part-time workers over the two year period. At the start of the period part-time workers made up 45% of the workforce.

Consistent with this development, the average hours of work seem to have been declining over the period. As Figure 20 shows, despite the fluctuations, the longer-term trend appears to be downward.[19]

17. The data for the last quarter shows a threefold increase in the proportion of casuals (from 6.6% to 18.7%), but because of the small number of organisations in the Workforce Wizard sample, one needs to treat this figure with considerable caution. The average of 7% for the period excludes this outlier. Including it only moves the average higher by one percentage point.
18. The population for this is both permanent and fixed-term workers. Unlike the situation with disability support workers, fixed-term employment is significant in allied health, and is thus included in the analysis.
19. One needs to be cautious with these quarterly figures for the allied health work-

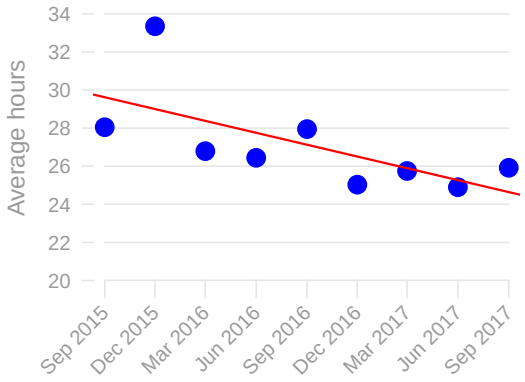


Figure 20: Average hours per week: allied health professionals

Notes: Details in Table A25

Spotlight topics

Like the disability support workers, the allied health professionals also answered question about absences and industrial relations. In the case of personal and carers leave, allied health professional took an average of 2 days leave per person during the quarter. This was a slightly higher figure than that taken by disability support workers (1.8 days).

Allied health workers use of leave without pay was low: 0.7 days per quarter. Again, this figure was slightly higher than the comparable figure for disability support workers (0.5 days).

In nearly two-thirds of organisations the industrial coverage for allied health professionals was an industrial award, with the remainder of organisations using enterprise agreements (63% to 37%). This figure for award coverage was slightly higher than for organisations with disability support workers (59%).

force because the number of observations are quite small. See Table A25 for these counts.

Appendix

Important concepts

Workers may be engaged by employers as permanent, fixed term, or casual, a mode of engagement referred to as the **form of employment**. The first two categories are characterised by the workers having access to holiday and sick leave, while those in the third category have neither of these. Permanents are also employed with an expectation of on-going employment; fixed-term workers have a termination date in their contracts; and casuals have no expectation of any ongoing employment and can, in theory, be terminated at short notice.[20]

Fixed term workers are often used to fill a gap, such as when staff are on parental leave or long service leave. Because the number of fixed-term disability support workers is very small, we mostly combine permanent and fixed-term workers and refer to them as the permanent workforce. Only in Chapter 2, the chapter which deals with forms of employment, do we report on all three categories.

One of the key issues for workforce planning in the disability sector is the extent of casualisation. As we will see, the sector has a higher proportion of casual workers than most other sectors in the workforce and it is growing over time. There are a number of important policy issues raised by this development. While casuals offer apparent flexibility to employers in meeting their staffing needs, the downside is the higher staff turnover which results, and a more uneven mix in their workforce when it comes to quality (such as skills, experience and qualifications). For workers, these jobs offer a 'casual loading' in their wages, which they may be reluctant to forgo in favour of the increased security which permanent jobs might bring. The main downside for workers is that casual employment is insecure: there is no guarantee of the job continuing, nor how much income they may earn and institutions such as banks will often not make large loans to those in casual employment.

20. The casual category is a complicated one, since industrial tribunals have modified the rights of employers to terminate casuals at short notice. The labour market is also characterised by large numbers of 'permanent casuals' who have worked in that form of employment with the same employer over many years.

The **hours** an employee works, whether full-time or part-time, is a different matter to the **form of employment**, but in popular usage the term 'casual' is often taken to mean part-time. In the case of the disability workforce, we distinguish full-time and part-time only for the combined permanents category (that is, permanents and fixed term workers). In the case of casuals, disability services do not systematically record data on their hours of work, so we are not in a position to discuss levels of part-time work among the casual workforce.

Comparisons

In this section of the appendix we look in more detail at how disability support workers compare with other workers, and how the Workforce Wizard data compare with other data sources (in this case the HILDA data).[21] The comparison for forms of employment is summarised in Table A6. We need to keep in mind the difficulties of lining up disability support workers with occupational and industry categories available in other data sources.[22] There is no clear one-to-one correspondence. The occupational category which is the closest analogy for these workers is **carers**, so this comparison is the best one for comparing the data as such.[23] The other comparisons in this table illuminate how the workforce in this sector differs from other workforces.

Table A6: Comparisons for forms of employment (%)

Category	Casual	Fixed term	Permanent
Disability service workers (Workforce Wizard)	40	3	58
Carers (HILDA)	33	9	58
Community Sector (HILDA)	19	11	70
All males (HILDA)	20	9	70
All females (HILDA)	25	11	64
All persons (HILDA)	23	10	67

Notes: The data for Workforce Wizard come from the September quarter of 2016, the closest period in time to when the HILDA data was collected. *Source*: Workforce Wizard and unpublished data from HILDA, Release 16

21. The Household, Income and Labour Dynamics in Australia (HILDA) Survey is a longitudinal survey of Australian households which has been conducted annually since 2001. It is carefully sampled to be representative of the Australian population and collects information on households, and on individuals living in those households. It is managed by the Melbourne Institute of Applied Economic and Social Research.
22. For more details see NDS and Windsor and Associates 2014, *Roadmap to a Sustainable Workforce: Improving the quality of disability workforce data*, Report for DSS Project Report 1, Sydney: National Disability Services.
23. Carers are defined as ANZSCO [42] Carers and Aides. This category also includes childcare workers, education aides and aged care workers.

The most notable difference shown here is the remarkably high incidence of casual employment among organisations in the Workforce Wizard. The comparison with carers has the smallest gap: 40% compared to 33%. Compared to the community sector as an industry category,[24] the difference is stark: 40% compared to 19%. A similar gap is evident for the workforce more generally: 40% to 23%.

However, part of the explanation for these differences lies with the category of fixed-term employment. What is notable about the occupational comparison is that the incidence of permanent employment is identical between Workforce Wizard and carers, at 58%. The difference in casualisation is solely due to the differences in fixed-term employment: Workforce Wizard organisations have a far smaller proportion of fixed-term workers than is the case for carers. A similar difference is evident with the community sector. Here the gap in permanent employment between that sector (70%) and the disability sector (58%) is narrower than is the gap in casual employment between that sector (19%) and the disability sector (40%).

Turning now to a comparison with hours, Table A7 summarises the results. It needs to be kept in mind that the population here is the permanent workforce, and this applies to the HILDA data as well as to the Workforce Wizard figures.

Table A7: Comparative split between part-time and full-time permanent workers (%)

Category	Part time	Full time
Disability service workers (Workforce Wizard)	77	23
Carers (HILDA)	70	30
Community Sector (HILDA)	56	44
All males (HILDA)	16	84
All females (HILDA)	47	53
All persons (HILDA)	31	69

Notes: Population is non-casual workforce for both Workforce Wizard and HILDA data. The data for Workforce Wizard come from the September quarter of 2016, the closest period in time to when the HILDA data was collected. *Source*: Workforce Wizard and unpublished data from HILDA, Release 16

As with forms of employment, Workforce Wizard organisations are closer to the category of carers: about 7 percentage points difference in the incidence of part-time workers: 77% to 70%. As noted earlier this occupational category is probably the closest match for disability support workers so these similar figures suggest

24. The community sector is defined as ANZSIC [86] Residential Care Services and [87] Social Assistance Services.

the Workforce Wizard data is reasonably representative of the sector.

The broader comparison is quite stark. For all the other comparisons in this table the gap is particularly large. There is a 21 percentage point gap with the community sector more broadly, and a 46 percentage point gap with the general workforce. Given the high incidence of female employment in the sector, a fairer comparison for the latter would be with the female workforce more generally and the gap here is 30 percentage points: 77% to 47%. Clearly, the incidence of part-time employment within the permanent workforce in the disability sector is remarkable.

Acknowledgements

This report uses unit record data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey. The HILDA Project was initiated and is funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and is managed by the Melbourne Institute of Applied Economic and Social Research (MIAESR). The findings and views reported in this report, however, are those of the author and should not be attributed to either FaHCSIA or the MIAESR.

Additional tables

Table A8: Age profile of staff of disability support workers (%)

Quarter	Under 25 year	25 to 44 years	45 to 54 years	55 years and over	n
Sep 2015	10.1	42.2	25.7	22.0	123
Dec 2015	9.7	42.0	25.3	23.1	132
Mar 2016	10.2	42.6	24.7	22.5	157
Jun 2016	11.5	43.6	24.0	20.9	167
Sep 2016	10.3	42.9	24.2	22.6	182
Dec 2016	10.6	43.6	24.0	21.8	183
Mar 2017	10.9	43.5	23.7	21.9	189
Jun 2017	11.2	44.3	22.9	21.5	193
Sep 2017	11.5	44.2	22.9	21.4	165

Notes: n is number of organisations in the sample. *Source*: Workforce Wizard

Table A9: Gender profile of disability support workers (%)

Quarter	Female	Male	n
Sep 2015	71.0	29.0	123
Dec 2015	71.5	28.5	132
Mar 2016	70.5	29.5	157
Jun 2016	66.6	33.4	167
Sep 2016	70.6	29.4	182
Dec 2016	70.8	29.2	183
Mar 2017	70.6	29.4	189
Jun 2017	70.2	29.8	193
Sep 2017	69.8	30.2	165

Notes: n is number of organisations in the sample. *Source*: Workforce Wizard

Table A10: Forms of employment: overview (%)

Quarter	Permanent	Fixed term	Casual	n
Sep 2015	53.7	3.3	43.0	123
Dec 2015	53.1	3.9	43.0	132
Mar 2016	57.3	4.0	38.8	157
Jun 2016	59.1	3.9	37.0	167
Sep 2016	57.7	2.5	39.8	182
Dec 2016	57.8	2.9	39.3	183
Mar 2017	56.2	3.8	40.1	189
Jun 2017	54.2	3.2	42.6	193
Sep 2017	54.8	3.4	41.8	165

Notes: n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A11: Forms of employment by organisational size (%)

Quarter	Size	Permanent	Fixed term	Casual	n
Sep 2015	Small	53.6	1.9	44.4	50
Sep 2015	Medium	60.8	6.2	33.0	44
Sep 2015	Large	51.5	2.5	46.0	29
Dec 2015	Small	57.7	7.8	34.4	46
Dec 2015	Medium	52.6	5.1	42.3	51
Dec 2015	Large	53.0	3.3	43.7	35
Mar 2016	Small	48.6	4.0	47.4	53
Mar 2016	Medium	56.9	6.6	36.5	66
Mar 2016	Large	58.0	3.1	39.0	38
Jun 2016	Small	55.4	4.8	39.8	55
Jun 2016	Medium	52.4	8.1	39.4	75
Jun 2016	Large	61.9	2.3	35.8	37
Sep 2016	Small	53.8	5.1	41.0	56
Sep 2016	Medium	52.9	5.3	41.7	78
Sep 2016	Large	59.5	1.4	39.1	48
Dec 2016	Small	54.5	3.0	42.5	53
Dec 2016	Medium	54.3	4.4	41.3	83
Dec 2016	Large	59.0	2.4	38.6	47
Mar 2017	Small	53.3	4.0	42.7	55
Mar 2017	Medium	52.6	5.6	41.8	87
Mar 2017	Large	57.5	3.1	39.3	47
Jun 2017	Small	49.8	5.3	44.8	55
Jun 2017	Medium	52.8	3.2	44.0	92
Jun 2017	Large	54.9	3.1	42.0	46
Sep 2017	Small	44.2	8.7	47.1	44
Sep 2017	Medium	49.0	3.2	47.9	75
Sep 2017	Large	57.1	3.2	39.7	46

Notes: Size of organisation is based on the number of employees: Small = Less than 50; Medium = 50 to 199; Large = 200 or over. n is number of organisations in the sample. *Source*: Workforce Wizard

Table A12: Forms of employment by the gender composition of the organisation (%)

Female % of workforce	Permanent	Fixed term	Casual	n
Under 45%	74.1	4.0	21.8	54
45% to under 65%	64.6	3.4	32.0	372
65 to under 75%	56.5	3.8	39.8	542
75% or over	47.2	2.6	50.2	519

Notes: Data has been pooled over all quarters. n is number of organisations in the sample. Workforce refers to all disability support workers in that organisation.*Source*: Workforce Wizard

Table A13: Net change in permanent and casual staff

	Permanent staff			Casual staff			
Quarter	Depart	Recruit	Net change	Depart	Recruit	Net change	n
Sep 2015	458	431	-27	559	1,054	495	123
Dec 2015	603	611	8	891	1,452	561	132
Mar 2016	635	651	16	704	1,258	554	157
Jun 2016	702	697	-5	801	1,389	588	167
Sep 2016	892	990	98	877	1,763	886	182
Dec 2016	1,000	972	-28	839	2,005	1,166	183
Mar 2017	995	1,071	76	1,000	1,878	878	189
Jun 2017	824	1,151	327	976	1,902	926	193
Sep 2017	912	1,034	122	1,179	2,022	843	165

Notes: Population is all organisations.
n is number of organisations in this sample. *Source*: Workforce Wizard

Table A14: Net change in permanent and casual staff by organisational size

		Permanent staff			Casual staff			
Quarter	Size	Depart	Recruit	Net change	Depart	Recruit	Net change	n
Sep 2015	Small	26	19	-7	35	96	61	50
Sep 2015	Medium	131	170	39	93	200	107	44
Sep 2015	Large	301	242	-59	431	758	327	29
Dec 2015	Small	31	25	-6	20	59	39	46
Dec 2015	Medium	147	119	-28	147	271	124	51
Dec 2015	Large	425	467	42	724	1,122	398	35
Mar 2016	Small	27	42	15	36	106	70	53
Mar 2016	Medium	204	194	-10	177	365	188	66
Mar 2016	Large	404	415	11	491	787	296	38
Jun 2016	Small	34	23	-11	57	77	20	55
Jun 2016	Medium	165	189	24	271	424	153	75
Jun 2016	Large	503	485	-18	473	888	415	37
Sep 2016	Small	41	33	-8	41	95	54	56
Sep 2016	Medium	178	208	30	249	455	206	78
Sep 2016	Large	673	749	76	587	1,213	626	48
Dec 2016	Small	26	26	0	44	82	38	53
Dec 2016	Medium	193	211	18	232	470	238	83
Dec 2016	Large	781	735	-46	563	1,453	890	47
Mar 2017	Small	52	89	37	59	107	48	55
Mar 2017	Medium	209	201	-8	244	520	276	87
Mar 2017	Large	734	781	47	697	1,251	554	47
Jun 2017	Small	26	18	-8	62	96	34	55
Jun 2017	Medium	235	202	-33	301	560	259	92
Jun 2017	Large	563	931	368	613	1,246	633	46
Sep 2017	Small	23	30	7	41	94	53	44
Sep 2017	Medium	165	136	-29	248	585	337	75
Sep 2017	Large	724	868	144	890	1,343	453	46

Notes: Size of organisation is based on the number of employees: Small = Less than 50; Medium = 50 to 199; Large = 200 or over.
n is number of organisations in this sample. *Source*: Workforce Wizard

Table A15: Growth in disability support workforce by forms of employment (counts)

Quarter	Permanent	Fixed term	Casual	Total	n
Jun 2016	117	-29	467	555	64
Sep 2016	38	48	168	254	64
Dec 2016	231	-16	329	544	64
Mar 2017	-150	38	-50	-162	64
Jun 2017	-28	-24	193	141	64
Sep 2017	268	-3	165	430	64

Notes: Counts refer to the change in the number of employees from the previous quarter. Sample is longitudinal sample limited to seven quarters where each organisation is present in every quarter (a balanced panel). n is number of organisations in this sample. *Source*: Workforce Wizard

Table A16: Growth in disability support workforce by forms of employment (quarterly growth rates %)

Quarter	Permanent	Fixed term	Casual	Total
Jun 2016	1.5	-6.0	8.9	4.1
Sep 2016	0.5	9.0	3.1	1.9
Dec 2016	2.9	-3.1	5.7	3.8
Mar 2017	-1.9	6.8	-0.9	-1.2
Jun 2017	-0.4	-4.5	3.3	1.0
Sep 2017	3.3	-0.6	2.7	2.9
Average	1.0	0.3	3.8	2.1
Annual average	4.0	1.1	15.2	8.4

Notes: Sample is longitudinal sample limited to seven quarters where each organisation is present in every quarter (a balanced panel). Number of organisations in this sample is the same as for Table A15.
Source: Workforce Wizard

Table A17: Categorisation of organisations according to workforce changes, by forms of employment

		Percentages in each category			
Quarter	**Forms emp**	**Decline**	**Stable**	**Increase**	**n**
Sep 2015	Permanent	7	89	4	123
Dec 2015	Permanent	8	83	8	132
Mar 2016	Permanent	7	85	8	157
Jun 2016	Permanent	7	86	7	167
Sep 2016	Permanent	8	81	11	182
Dec 2016	Permanent	9	83	8	183
Mar 2017	Permanent	8	85	7	189
Jun 2017	Permanent	4	89	8	193
Sep 2017	Permanent	7	83	10	165
Sep 2015	Casual	2	72	25	123
Dec 2015	Casual	3	76	21	131
Mar 2016	Casual	6	73	21	157
Jun 2016	Casual	5	76	19	167
Sep 2016	Casual	3	71	26	182
Dec 2016	Casual	1	70	29	183
Mar 2017	Casual	3	67	30	189
Jun 2017	Casual	3	70	26	193
Sep 2017	Casual	4	67	29	165

Notes: These definitions are based on: **decline**: where the net change in staff (in each form of employment) in that organisation has fallen by more than 5 workers during the quarter; **stable**: where the net changes lie between a fall in 5 workers and a rise in 5 workers; and **increase**: where the net changes are greater than 5 workers increasing.
n is number of organisations in the sample. *Source*: Workforce Wizard

Table A18: Turnover rates: all workers, permanents and casuals

Quarter	**Permanent**	**Casual**	**All workers**	**n**
Sep 2015	4.1	6.5	5.2	123
Dec 2015	4.3	8.1	6.0	132
Mar 2016	4.0	6.7	5.1	157
Jun 2016	4.1	7.6	5.4	167
Sep 2016	4.6	6.8	5.5	182
Dec 2016	4.7	6.0	5.2	183
Mar 2017	5.0	7.2	5.9	189
Jun 2017	4.3	6.6	5.3	193
Sep 2017	4.9	8.6	6.5	165

Notes: Turnover rate is the number of workers in organisations who leave during the quarter, expressed as a percentage of the average total number of workers for that quarter and the previous quarter. All workers refers to the sum of permanents and casuals (ie. excludes fixed-term workers). n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A19: Full-time and part-time workers: overview (%)

Quarter	Full time	Part time	n
Sep 2015	35.4	64.6	123
Dec 2015	33.4	66.6	132
Mar 2016	31.8	68.2	157
Jun 2016	24.2	75.8	167
Sep 2016	22.8	77.2	182
Dec 2016	22.9	77.1	183
Mar 2017	23.1	76.9	189
Jun 2017	21.7	78.3	193
Sep 2017	19.2	80.8	165

Notes: Population is the non-casual workforce. n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A20: Full-time and part-time workers by size of organisations (%)

Quarter	Size	Full time	Part time	n
Sep 2015	Small	27.0	73.0	50
Dec 2015	Medium	31.9	68.1	44
Mar 2016	Large	37.6	62.4	29
Jun 2016	Small	40.2	59.8	46
Sep 2016	Medium	24.5	75.5	51
Dec 2016	Large	35.5	64.5	35
Mar 2017	Small	36.4	63.6	53
Jun 2017	Medium	26.8	73.2	66
Sep 2017	Large	33.4	66.6	38
Sep 2015	Small	28.6	71.4	55
Dec 2015	Medium	25.3	74.7	75
Mar 2016	Large	23.5	76.5	37
Jun 2016	Small	34.7	65.3	56
Sep 2016	Medium	27.5	72.5	78
Dec 2016	Large	20.6	79.4	48
Mar 2017	Small	33.3	66.7	53
Jun 2017	Medium	27.8	72.2	83
Sep 2017	Large	20.9	79.1	47
Sep 2015	Small	34.5	65.5	55
Dec 2015	Medium	28.7	71.3	87
Mar 2016	Large	20.6	79.4	47
Jun 2016	Small	33.4	66.6	55
Sep 2016	Medium	27.4	72.6	92
Dec 2016	Large	19.0	81.0	46
Mar 2017	Small	32.2	67.8	44
Jun 2017	Medium	25.8	74.2	75
Sep 2017	Large	16.8	83.2	46

Notes: Population is the non-casual workforce. Size of organisation is based on the number of employees: Small = Less than 50; Medium = 50 to 199; Large = 200 or over. n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A21: Average hours of work per week per worker

Quarter	Average hours	n
Sep 2015	24.7	97
Dec 2015	26.0	109
Mar 2016	23.6	128
Jun 2016	24.1	149
Sep 2016	22.9	165
Dec 2016	19.5	161
Mar 2017	20.5	166
Jun 2017	22.0	172
Sep 2017	20.3	147

Notes: n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A22: Average hours of work per week per worker by organisational size

Quarter	Organisational size	Average hours	n
Sep 2015	Small	21.7	40
Sep 2015	Medium	26.9	32
Sep 2015	Large	24.5	25
Dec 2015	Small	22.0	41
Dec 2015	Medium	23.1	40
Dec 2015	Large	27.2	28
Mar 2016	Small	22.8	45
Mar 2016	Medium	24.7	53
Mar 2016	Large	23.2	30
Jun 2016	Small	22.7	54
Jun 2016	Medium	22.9	63
Jun 2016	Large	24.6	32
Sep 2016	Small	21.3	53
Sep 2016	Medium	23.5	70
Sep 2016	Large	22.7	42
Dec 2016	Small	19.3	50
Dec 2016	Medium	18.6	74
Dec 2016	Large	19.9	37
Mar 2017	Small	23.2	49
Mar 2017	Medium	20.7	76
Mar 2017	Large	20.2	41
Jun 2017	Small	24.0	52
Jun 2017	Medium	20.8	81
Jun 2017	Large	22.4	39
Sep 2017	Small	20.8	41
Sep 2017	Medium	21.3	67
Sep 2017	Large	20.0	39

Notes: Size of organisation is based on the number of employees: Small = Less than 50; Medium = 50 to 199; Large = 200 or over. n is number of organisations in the sample. *Source*: Workforce Wizard

Table A23: Full-time and part-time workers by the gender composition of the organisation (%)

Female % of workforce	Full time	Part time	n
Under 45%	25.7	74.3	54
45% to under 65%	29.3	70.7	372
65 to under 75%	27.2	72.8	542
75% or over	15.9	84.1	519

Notes: Data has been pooled over all quarters. n is number of organisations in the sample. Workforce refers to all disability support workers in that organisation. *Source*: Workforce Wizard

Table A24: Growth in disability support workforce by full-time and part-time work (counts)

Quarter	Full time	Part time	Total	n
Jun 2016	30	58	88	64
Sep 2016	94	-8	86	64
Dec 2016	22	193	215	64
Mar 2017	-138	26	-112	64
Jun 2017	-124	72	-52	64
Sep 2017	33	232	265	64

Notes: Population is the non-casual disability service workforce. Counts refer to the change in the number of employees from the previous quarter. Sample is longitudinal sample limited to seven quarters where each organisation is present in every quarter (a balanced panel). n is number of organisations in this sample. *Source*: Workforce Wizard

Table A25: Average hours of work per week per worker: allied health professionals

Quarter	Average hours	n
Sep 2015	28.0	15
Dec 2015	33.3	14
Mar 2016	26.8	14
Jun 2016	26.4	17
Sep 2016	28.0	20
Dec 2016	25.0	21
Mar 2017	25.8	24
Jun 2017	24.9	23
Sep 2017	25.9	19

Notes: n is number of organisations in the sample. *Source*: Workforce Wizard.

Table A26: Definitions of occupational groups

Occupational group	Detailed occupation
Direct support	Professional Support Workers
Direct support	Support Workers
Other disability	Case Manager
Other disability	Service Co-ordinators
Other disability	Employment Consultant
Administration	Accounting & Finance
Administration	Administration
Administration	Facilities & Maintenance
Administration	Legal
Administration	Payroll
Administration	Trades & Services
Administration	Transport
Management	Executive
Management	Human Resources
Management	Management
Management	Service Managers
Business	Business Development
Business	Call Centre & Customer Service
Business	Education & Training
Business	Fundraising & Marketing
Business	Graduate
Business	Hospitality, Tourism & Travel
Business	Information Technology
Business	Marketing & Communications
Business	Sales
Omitted	Occupational Therapist
Omitted	Physiotherapist
Omitted	Speech Pathologist

Source: carecareers job board

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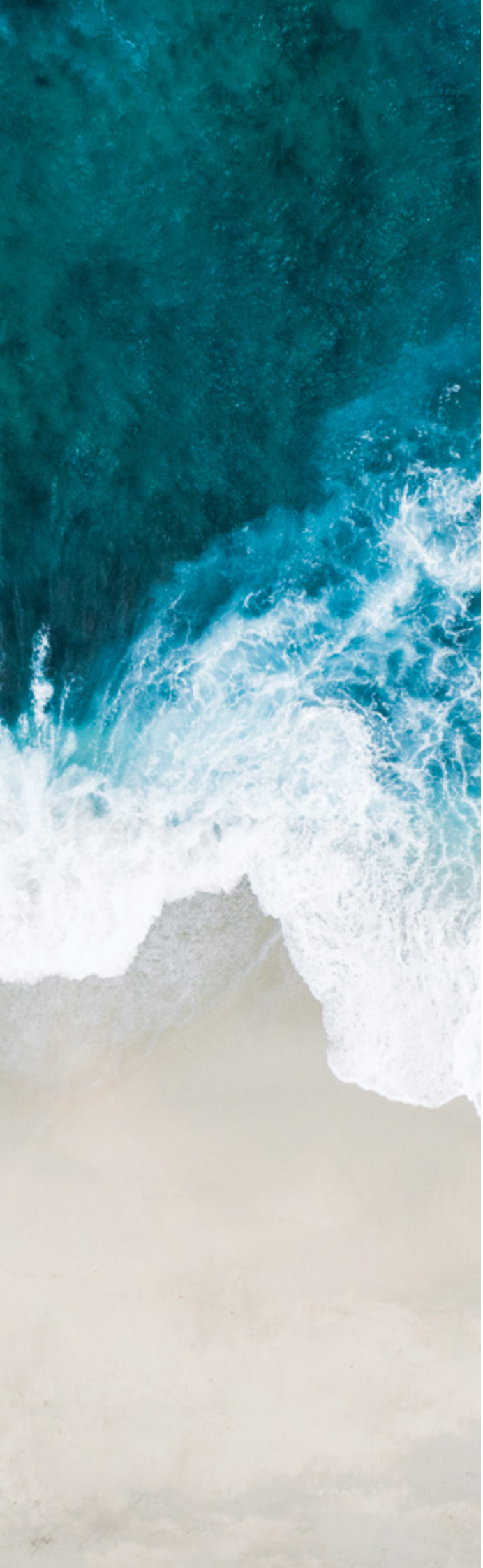
NDS National Disability Services

National Disability Services

STATE OF THE DISABILITY SECTOR REPORT 2018

The NDIS has ushered in a new era for disability service providers. It can be like an ocean; sometimes stormy, with a dangerous undertow; at other times extending our horizons and carrying us forward. The challenge before us is how we navigate this journey of change and collectively create the best possible NDIS.

Centre for Applied Disability Research
An Initiative of National Disability Services



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The State of Play

The disability sector is immersed in complex, difficult and large-scale reform. The major part of that is the National Disability Insurance Scheme (NDIS), but Disability Employment Services (DES) – which sit outside the NDIS – are also in the midst of significant change.

Disability service providers support the NDIS reform principles. They welcome the major boost in funding in response to the chronic unmet need for services, the expansion of choice and control for people with disability and their families, the investment in early intervention, and the goal of equitable access to services across Australia.

However, the road to reform is rough, and many service providers are under stress. Their sense of uncertainty is exacerbated by frequent process changes, inconsistent advice, new regulations and difficulty getting the market data they need to make growth decisions.

At the core of NDS's 2018 State of the Disability Sector Report are findings from a survey of 626 service providers. They include providers of all sizes, from every state and territory, that collectively span the full range of disability service provision.

Providers' experiences of the NDIS are mixed, but more than half see the operating conditions in the disability sector as worsening: 80 per cent say that the disability policy environment is uncertain.

NDIS red tape imposes costs

Providers are frustrated with NDIS systems and processes. Over the past year, many have experienced long delays in payments; the NDIS portal is not user-friendly; and the quality of NDIS plans is uneven.

Providers are expending unpaid effort on untangling red tape, resolving payment issues and helping people with disability to get plans that properly reflect their needs and goals. All of this imposes costs on providers at a time when they are under pressure to reduce their costs.

The impact of very tight NDIS prices on service quality is a significant concern. Some of the prices stretch supervision ratios and don't allow for investment in staff training. They impede the recruitment and retention of experienced and qualified staff.

Some solutions are emerging

NDS is working with the National Disability Insurance Agency (NDIA) on solutions to these problems, and incremental improvements are occurring. While we remain critical of inadequate NDIS prices, the price increases announced following the Independent Pricing Review provided some relief. Further work is under way to set higher prices to support people with complex needs. Having been a strong critic of the planning process and the NDIS portal, we are pleased to see improvements coming to the planning process (albeit gradually) and fixes to the portal (although more are needed).

Accelerating these and other solutions should be a priority. While problems persist, the NDIS will not deliver on its great promise to Australians with disability.

Employment is lagging

Many Australians with disability want to work, yet the employment rate of Australians with disability is low and static. This must change. The exclusion of people with disability from the workforce is bad for the Australian economy and a cause of poverty and social isolation.

Economic participation is a goal of the NDIS, but only a tiny proportion of participant plans currently include employment supports. In NDS's view, all participants of working age should have employment in their plan unless they specifically refuse it.

Stronger disability employment support is a key part of the answer to the low employment rate of people with disability. Reforms to Disability Employment Services, introduced in July 2018, expand choice and competition; but they also apply a new and untested funding model that appears to be disadvantaging some cohorts of job seekers. Whether the new DES program boosts employment outcomes for job seekers is yet to be seen.

Disability Enterprises provide employment to 21,000 Australians with significant disability. Their future depends on resolving the financial uncertainty they face. This will require a satisfactory outcome to the long-running dispute over wage-setting before the Fair Work Commission, a viable funding and pricing model under the NDIS, and

increased commercial income boosted by government procurement of goods and services.

Social inclusion strategy requires renewal

The National Disability Strategy is due to expire in 2020. It is a 10-year strategy, signed off by the heads of all Australian governments, that is designed to give practical effect to the United Nations Convention on the Rights of Persons with Disabilities. The Strategy's ambitions are admirable, but its capacity to drive change has been very limited. The Strategy is a critical companion of the NDIS and it needs reinvigoration.

As well as bringing issues, such as those outlined above, to the attention of government, NDS is committed to working with government to find answers. We are determined to do all we can to make the NDIS work for all stakeholders, to increase employment opportunities for people with disability, and to inject new life into the National Disability Strategy.

Solutions must include drawing more on the great passion, expertise and experience that lies in the disability community among service providers, people with disability and their families and carers. This should extend to policy advice, the identification and testing of process changes before they're introduced, and the provision of some key functions. For example, we believe the quality of plans would improve if participants and their families could choose to construct their plans with service providers and with Disabled Persons Organisations, not just with Local Area Coordinators.

A Federal Parliamentary report on the NDIS released in October 2018 recommended additional resources to assist the disability sector to implement the large-scale reforms that are under way. NDS agrees. Increasingly, governments are turning to the non-government sector to deliver disability services, and there are good reasons for this. Boosting the capacity of the sector to deliver services when and where they are required – and in ways that are responsive to people's needs, goals and differences – is an essential investment.

THE WAY FORWARD

Proposals we'd like to see implemented

1 A fully-funded NDIS
Governments have committed funding to the NDIS, but this must be renewed annually and reflect evolving evidence of costs of disability support.

2 Prices to stimulate growth and quality
Prices set by the NDIA are insufficient to sustain some services and threaten quality. Prices should reflect realistic costs and be progressively deregulated.

3 Market stewardship that responds to warning signals of market failure
Pricing, workforce shortages and uncertainty are impeding growth of NDIS supports. To prevent market failure, improved data, clarity about market interventions and a systematic response to emergencies are needed.

4 NDIS processes informed by experience
Providers are under pressure to reduce costs, but they can only be as efficient as NDIA systems allow. Participants should be able to develop their plans with people who have knowledge of disability supports.

5 Flexibility that reflects national diversity
NDIS planning, funding and service models must respond to local conditions, particularly in rural and remote Australia.

6 Complex design problems resolved
The NDIS is struggling with complex design problems, such as employment, transport and the interface with other service systems. Solutions can be found by working closely with the sector.

7 Sector development that supports transition and progress
A reform as large as the NDIS needs significant investment in workforce development and service capacity, including an industry assistance fund.

8 Investment in quality and safeguarding
Investment in organisational cultures and staff development is critical to complement the new NDIS quality and safeguarding regulations.

9 More open employment opportunities
Action should be taken to ensure that no job seekers are disadvantaged by the new Disability Employment Services model of risk-adjusted funding.

10 Extended school-to-work support
Connecting young people at school with jobs vastly improves their chances of working post-school. NDIS School Leaver Employment Supports should be open to people before they finish Year 12.

11 More jobs in supported employment
The government must work with the sector to resolve the wage determination dispute, develop a viable supported employment funding model, and expand procurement from Disability Enterprises.

12 Renew National Disability Strategy
A renewed National Disability Strategy must have strong performance measures, access to resources, a prominent public profile and ownership across government and the disability community.

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The State of the Operating Environment

About the Annual Market Survey

The following data is produced from the sixth wave of NDS's Annual Market Survey. The survey was conducted by the Centre for Social Impact at the University of New South Wales in partnership with NDS's Centre for Applied Disability Research (CADR).

Who responded to the survey

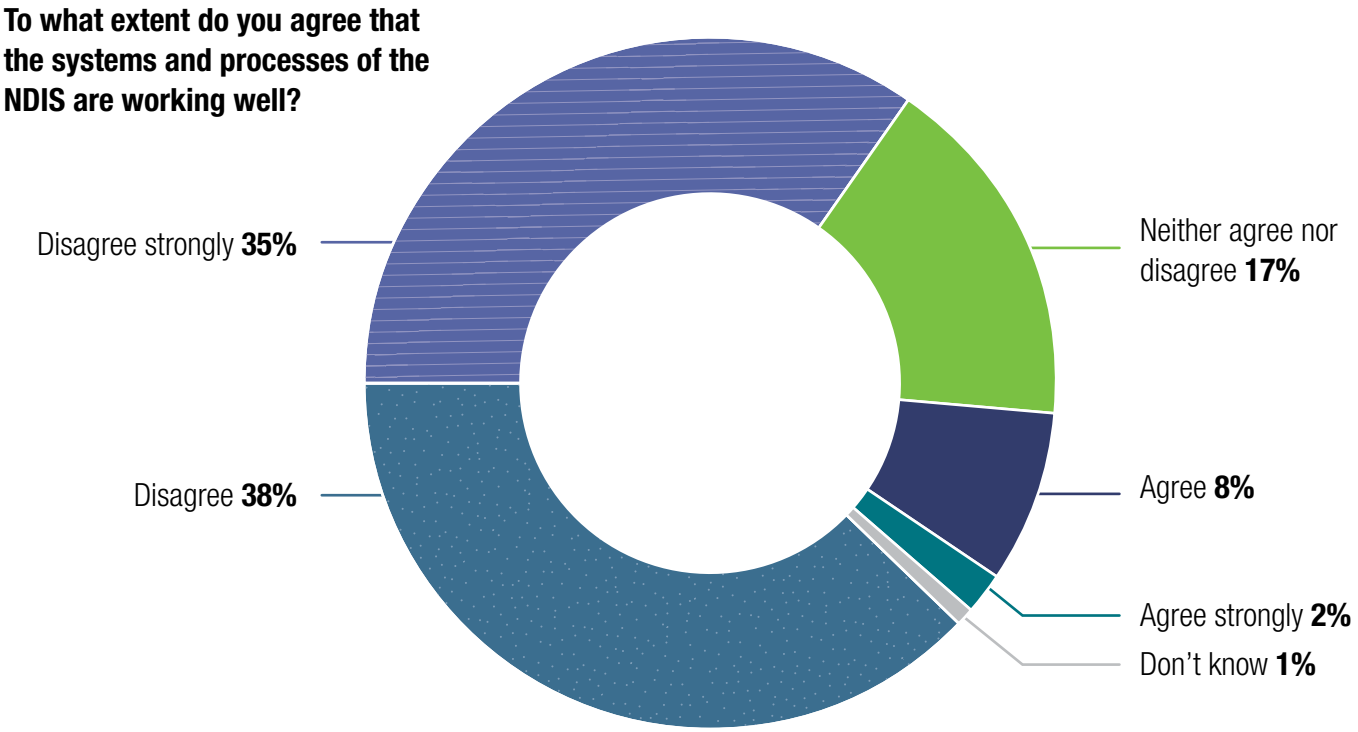
626 disability service providers responded to this wave of the survey. Forty-two per cent had income of less than $1M, 23 per cent between $1M and $5M, 20 per cent between $5M and $20M and 14 per cent had income of $20M or more. Twenty-three per cent were sole traders, up from 12 per cent in 2017. The inclusion of this cohort did not skew results, except where noted. Seventy-three per cent of respondents were not-for-profit organisations and 24 per cent were for-profit organisations. Three per cent were not classified.

Ninety-seven per cent of respondents were registered NDIS providers and 90 per cent were registered and currently provide services under the NDIS.

NDIS policy environment remains uncertain

Service providers continue to be frustrated with NDIS systems and processes. Nearly three quarters (73 per cent) of respondents either disagreed or strongly disagreed that the systems and processes of the NDIS were working well.

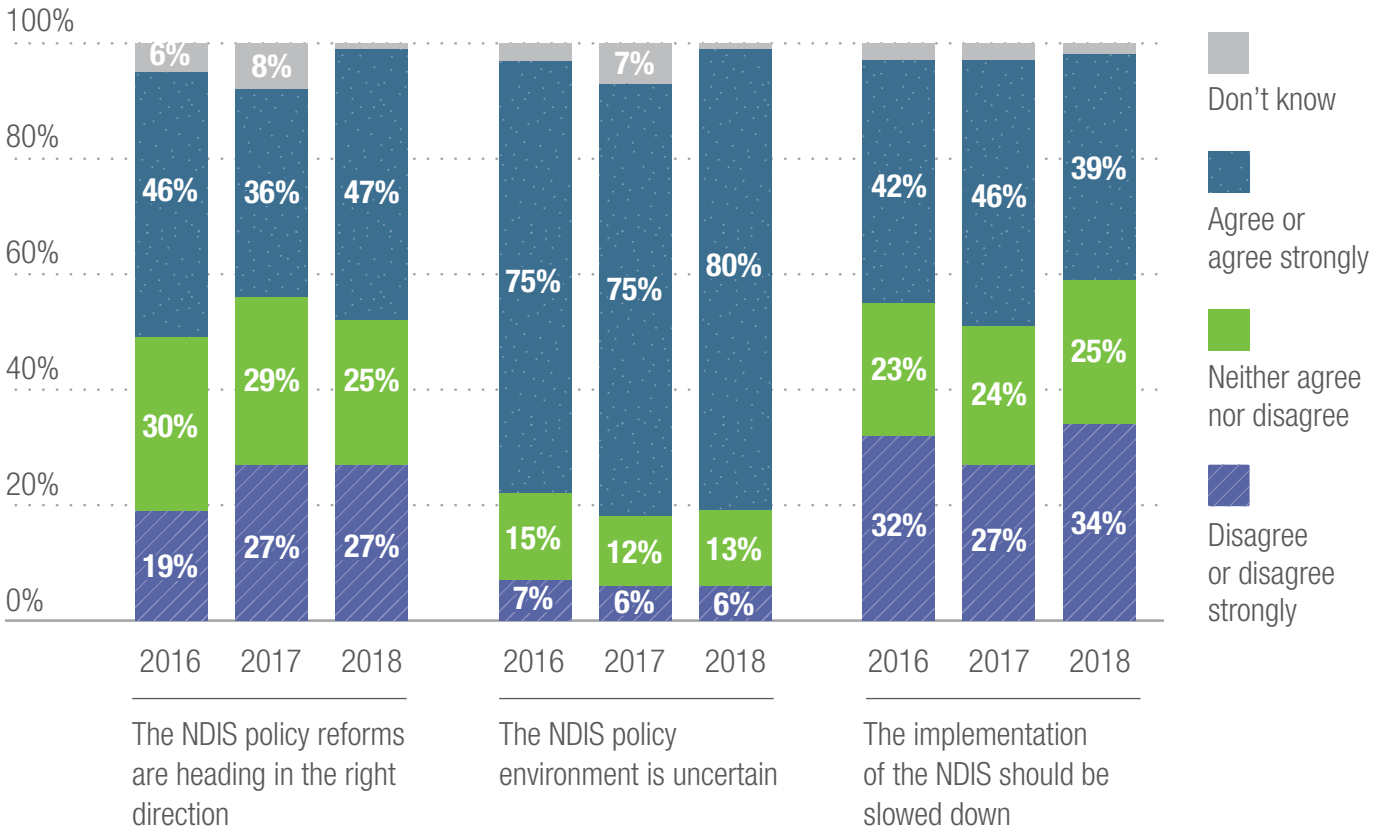
Figure 1 NDIS systems and processes



Comments about NDIS systems and processes reflect key concerns about policy uncertainty, lack of meaningful service provider engagement by government, and pricing and administrative burdens. Provider views on NDIS policy directions and implementation remain consistent. This year, responses were split over whether NDIS implementation should be slowed down – 39 per cent agreed or strongly agreed and 25 per cent were neutral. This represents a decrease from the 2017 survey, where 46 per cent of the providers who responded felt implementation should be slowed. As NDIS implementation proceeds, nearly half (47 per cent) feel that policy implementation is heading in the right direction. However, a significant majority (80 per cent) continue to agree that the NDIS policy environment is uncertain. This number has increased since 2016 and 2017.

Figure 2 Satisfaction with policy and implementation

To what extent do you agree with the following statements?

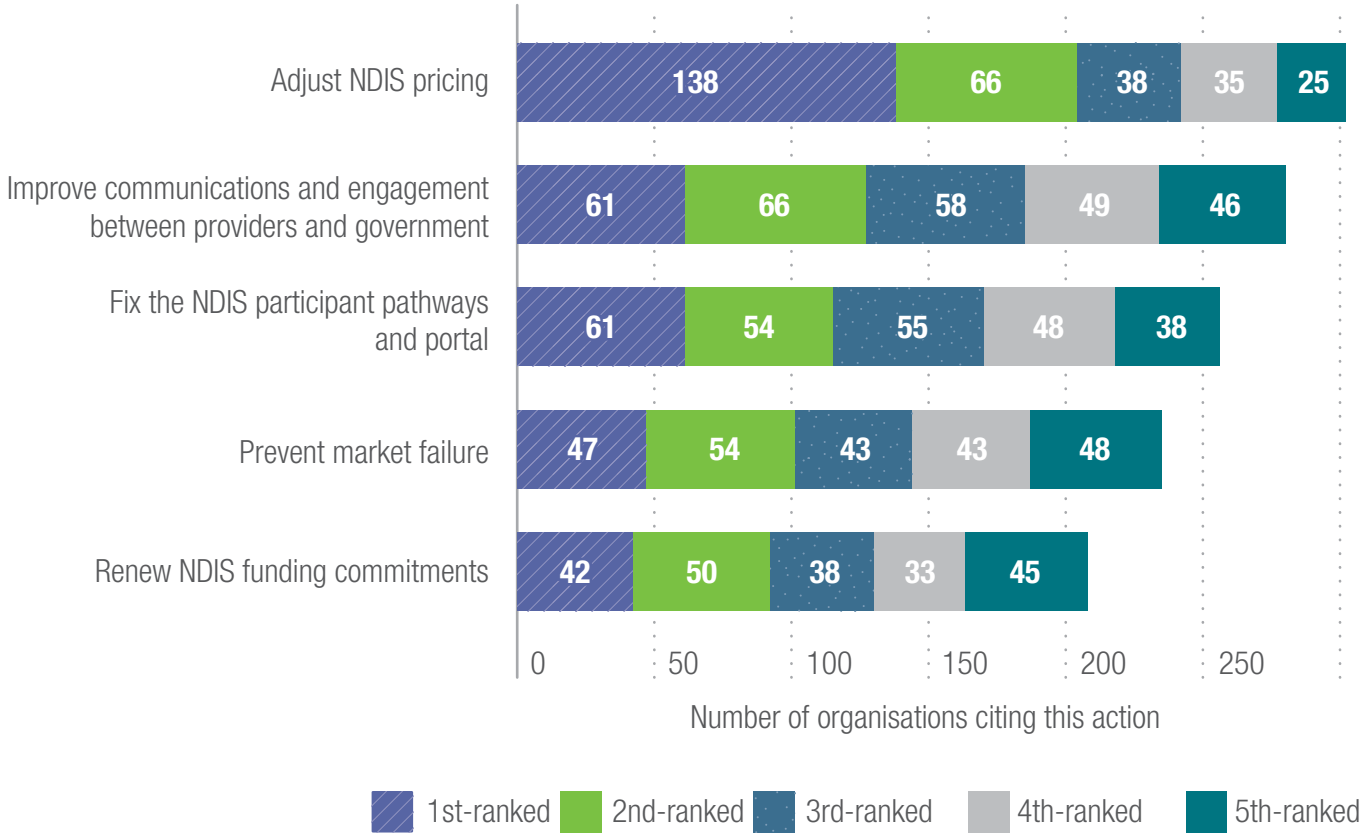


There is consensus among providers about which actions by the government would have the greatest positive impact on their organisation's capacity to deliver good services in the next year:

1. Adjust NDIS pricing
2. Improve communications and engagement between providers and government
3. Fix the NDIS participant pathways and portal

Figure 3 Top five market stewardship priorities for government

Which of the following actions by government would have the greatest positive impact on your organisation's capacity to deliver good services in the next year?



Pricing concerns generated the most comments and 46 per cent ranked 'Adjust NDIS pricing' as their top action for government. Two major themes emerged from the survey: providers' views that central price setting is disconnected from service delivery realities; and concern that financial losses will lead to market failure.

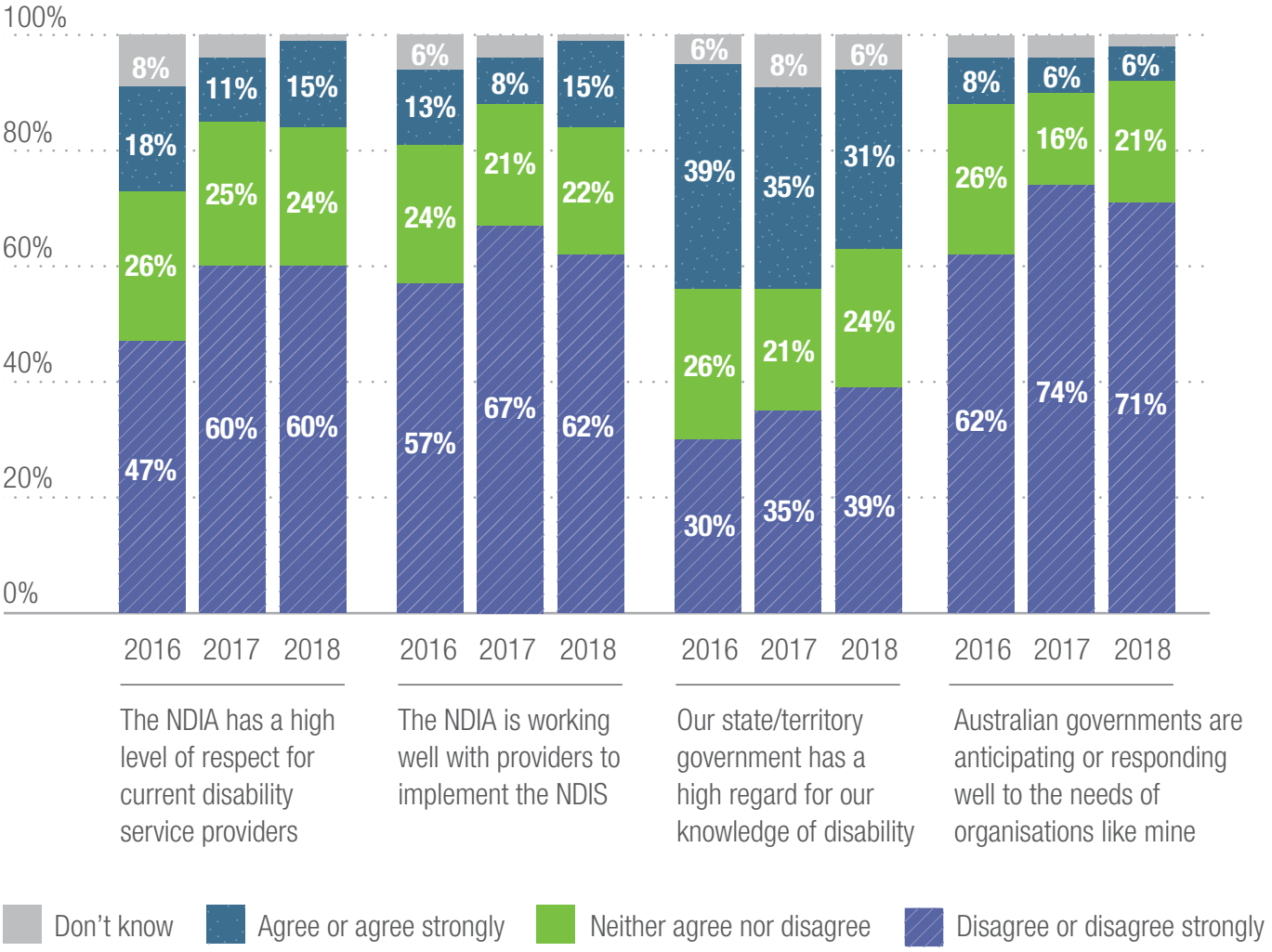
> "It is challenging to continue to conduct a profitable enterprise when [the NDIS] sets the fee for our company's services – particularly without any prior knowledge of the services we provide and associated costs involved. Not all services are created 'equal'."

> "No matter the size of a [participant's care] package there is significant time invested into case development, review, maintenance, and provision which is in excess of an hour's support for capacity building."

Service providers appeared to be largely dissatisfied with their relationship with the NDIA. Only 15 per cent said they agreed or agreed strongly that the NDIA is working well with the sector to implement the NDIS. Similarly, 15 per cent agreed or agreed strongly that the NDIA has a high level of respect for service providers. Most (71 per cent) said they disagreed or disagreed strongly that Australian governments are anticipating or responding well to the needs of organisations such as theirs.

Figure 4 Provider views on government relations

To what extent do you agree with the following statements?



> "NDIS keep changing the rules and there is no consistency between planners, areas and local offices."

> "Incorrect information given to participants by planners and LACs is compromising service delivery and problems are then blamed on providers."

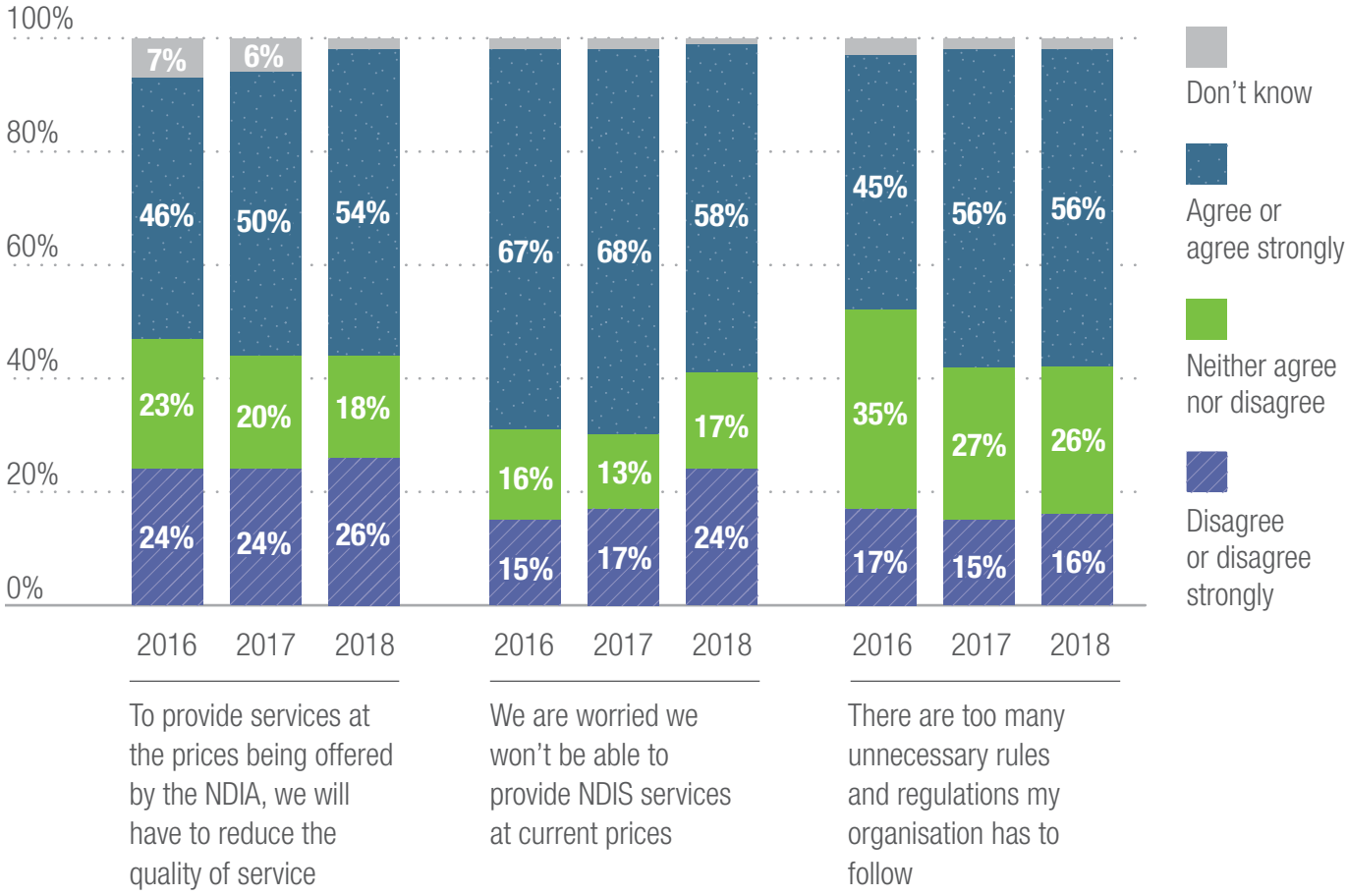
> "Despite the length of time we have been delivering services via NDIS funding there is still an incredible inconsistency in the planning processes that clients/families are attempting to manage."

Fifty-eight per cent of disability service providers agreed or agreed strongly that they were worried they wouldn't be able to provide NDIS services at their current prices. Just under one in four respondents (24 per cent) disagreed or disagreed strongly with this statement. Service providers expressed concern at the costs of compliance with regulation and costs to properly support families and clients beyond the funded service transaction:

> "It costs money to be able to meet all the requirements of government, but we aren't able to set the actual pricing to be able to recover the true cost of support. We are a price taker, and government set all the rules and processes that are administratively burdensome … Providers can't actually charge what it really costs to deliver good services."

Figure 5 Pricing, service quality and administrative burden

To what extent do you agree with the following statements?



Over half of respondents (54 per cent) said that they either agreed or agreed strongly with the statement 'In order to provide the services at the prices being offered by the NDIA, the quality of care would have be reduced'. For some services, prices were regarded as being too low to continue service delivery.

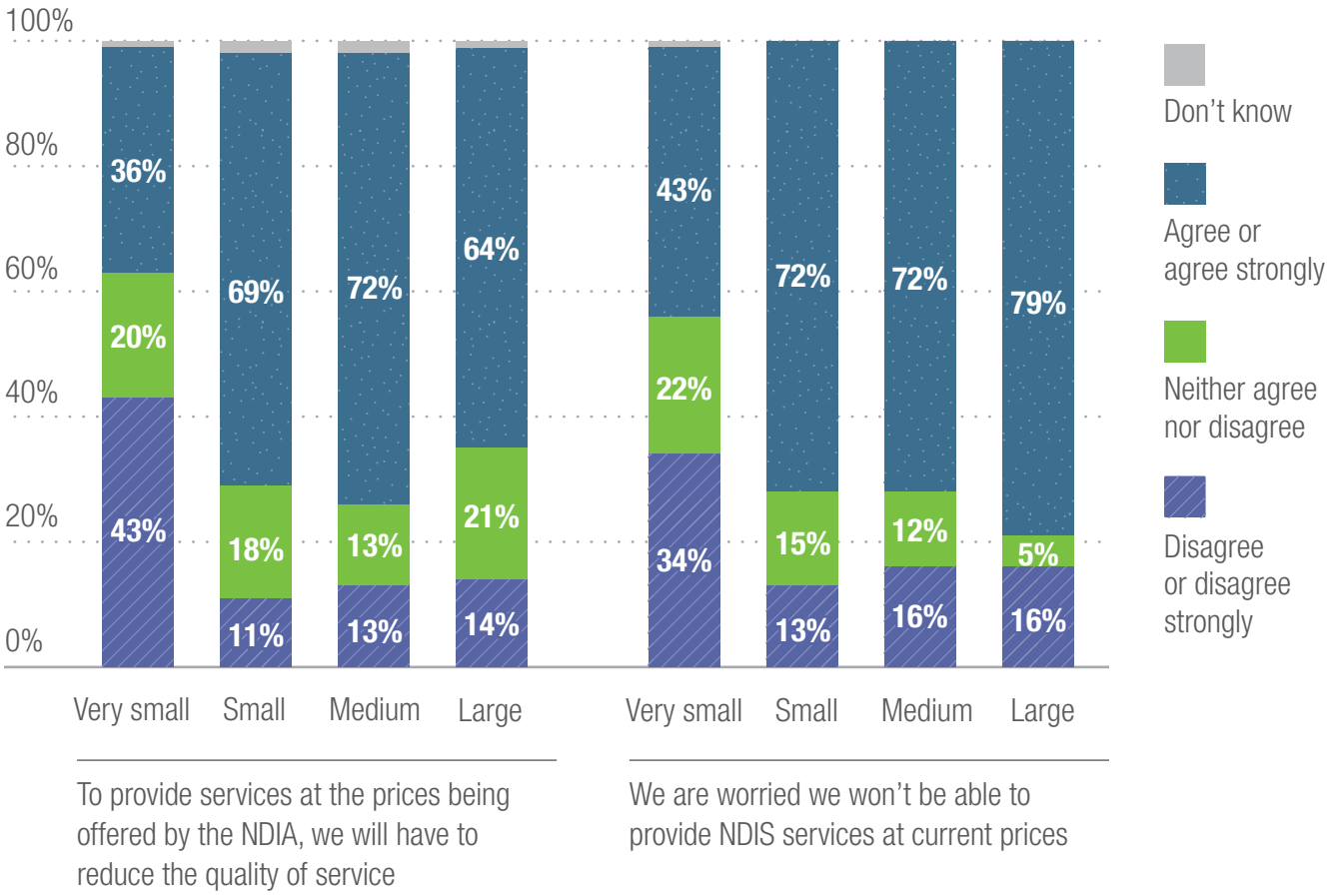
Respondents were acutely concerned with the emergence of thin markets and the impact for NDIS participants, noting this posed a particular threat for groups with complex needs.

> "Market failure is a current reality. We are having to restrict community access services delivered one-on-one, even though demand is growing. Some participants are only being offered supports in groups with a 1:5 support ratio, even though they could benefit from supports delivered in smaller groups or 1:1. This is undermining choice and control."

Concerns about pricing and its impact on services varied by provider size (financial turnover). Very small service providers (less than $1M last financial year - including a high proportion of sole traders) were significantly less likely to agree that they would have to reduce the quality of service to provide services at the prices being offered by the NDIA.

Figure 6 Concerns about NDIS pricing by organisation size (financial turnover)

To what extent do you agree with the following statements?



Organisational size classified by annual income:
Very small* – Less than $1M
Small – Less than $5M
Medium – Less than $20M
Large – More than $20M

*These results could reflect a high proportion of sole traders.

Disability service providers were asked to identify operational areas for improvement or where additional support and investment are required. Key areas for improvement were consistent with previous years and related to administration (information, communications and technology; HR strategy; costing and pricing; and market research). Providers continue to struggle with costing and pricing (and related financial controls); back office systems and data about opportunities to make a difference.

Table 1 Business capability areas for improvement

Which of the following business capability areas does your organisation need to improve most in the next 12 months?

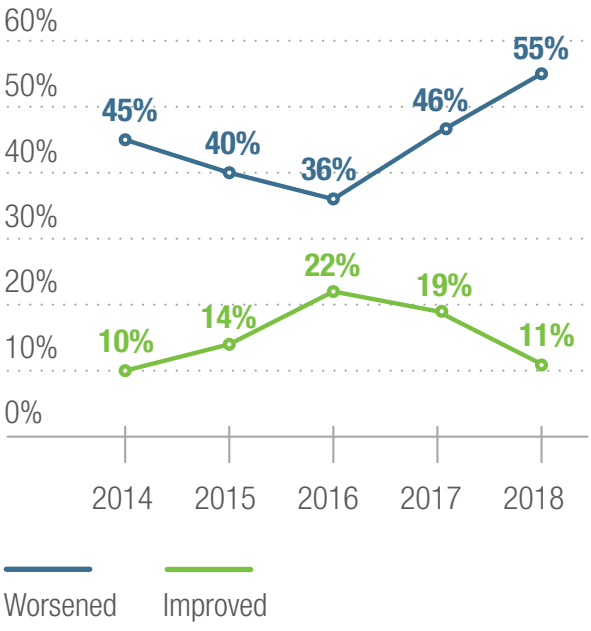
2016	2017	2018
1. Costing and pricing	1. Costing and pricing	1. Information, communications and tech strategy
2. Information, communications, and tech strategy	2. Marketing practice	2. Costing and pricing
3. Marketing practice	3. HR strategy and workforce planning	3. HR strategy and workforce planning

Operating conditions remain tough

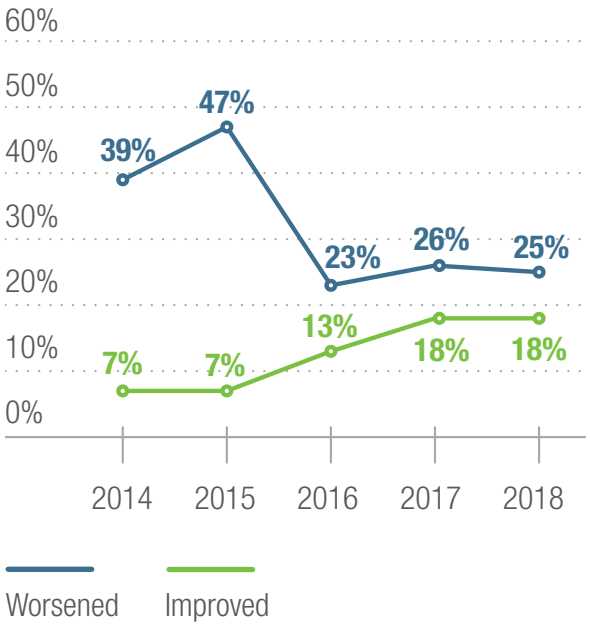
Since 2016, there has been a sharp decrease in the perceived operating conditions of the disability sector – in 2018, 55 per cent of respondents said that they perceived conditions to have worsened. In contrast, the broader economic environment was seen as stable for the past two years.

Figure 7 Perceptions of disability sector operating conditions and wider Australian economy

Over the last 12 months, do you believe that the overall operating conditions of the disability sector have changed?



Over the last 12 months, do you believe that the overall operating conditions of the Australian economy have changed?



As in previous years, providers were asked to indicate whether they had any plans to change the range and scale of services offered. The overall picture remains one of growth, with most providers indicating an intention to increase their service volume.

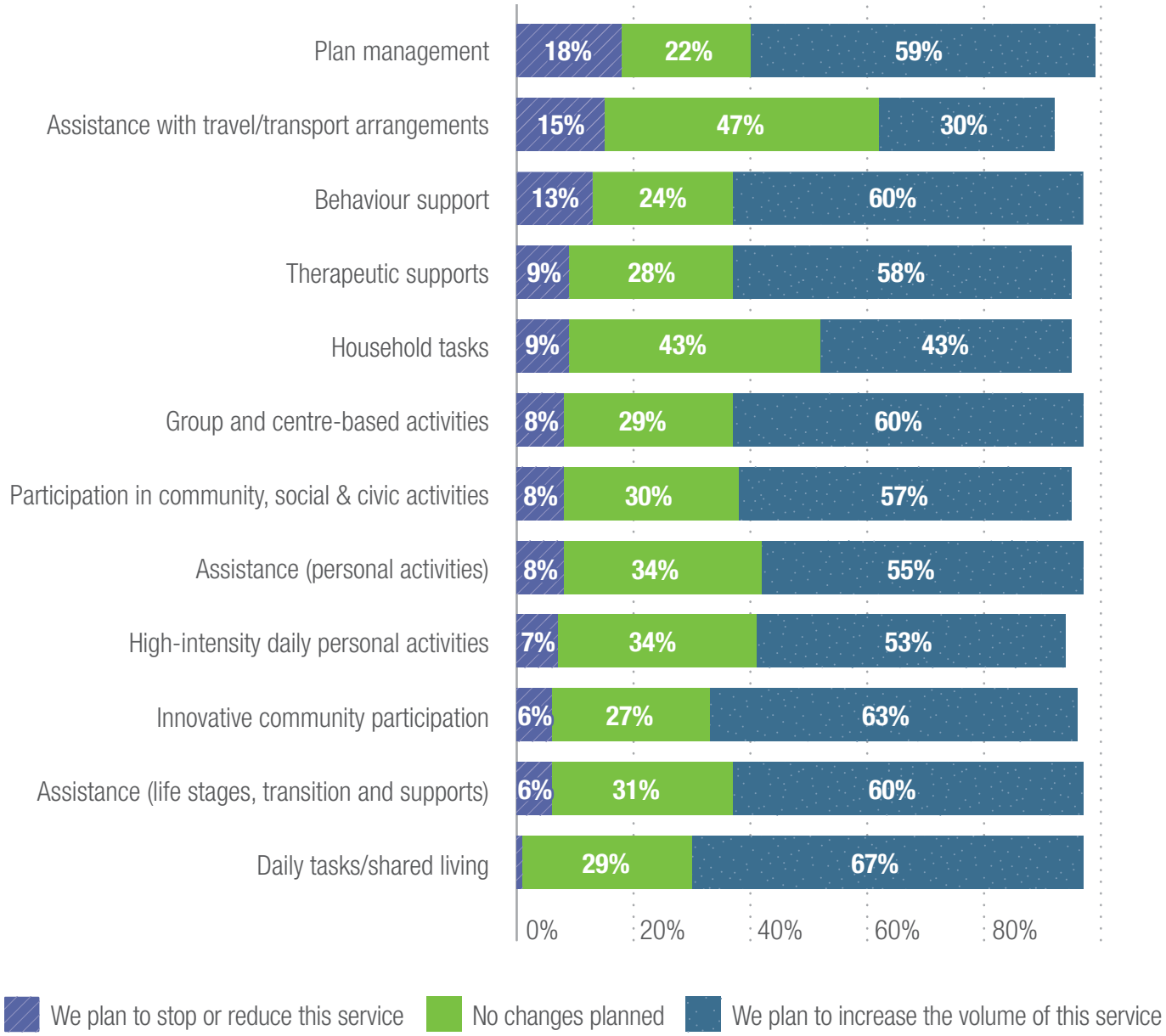
> "NDIS has provided opportunities for clients who could not manage to fund their needs before the NDIS."

> "While the NDIS can at times be difficult to navigate, our experience is that if you establish positive working relationships you can generally get a positive outcome for participants."

The most commonly-cited service types that service providers indicated they were planning to reduce or stop providing were plan management, assistance with travel and transport arrangements, and behaviour support.

Figure 8 Intentions to change service volume

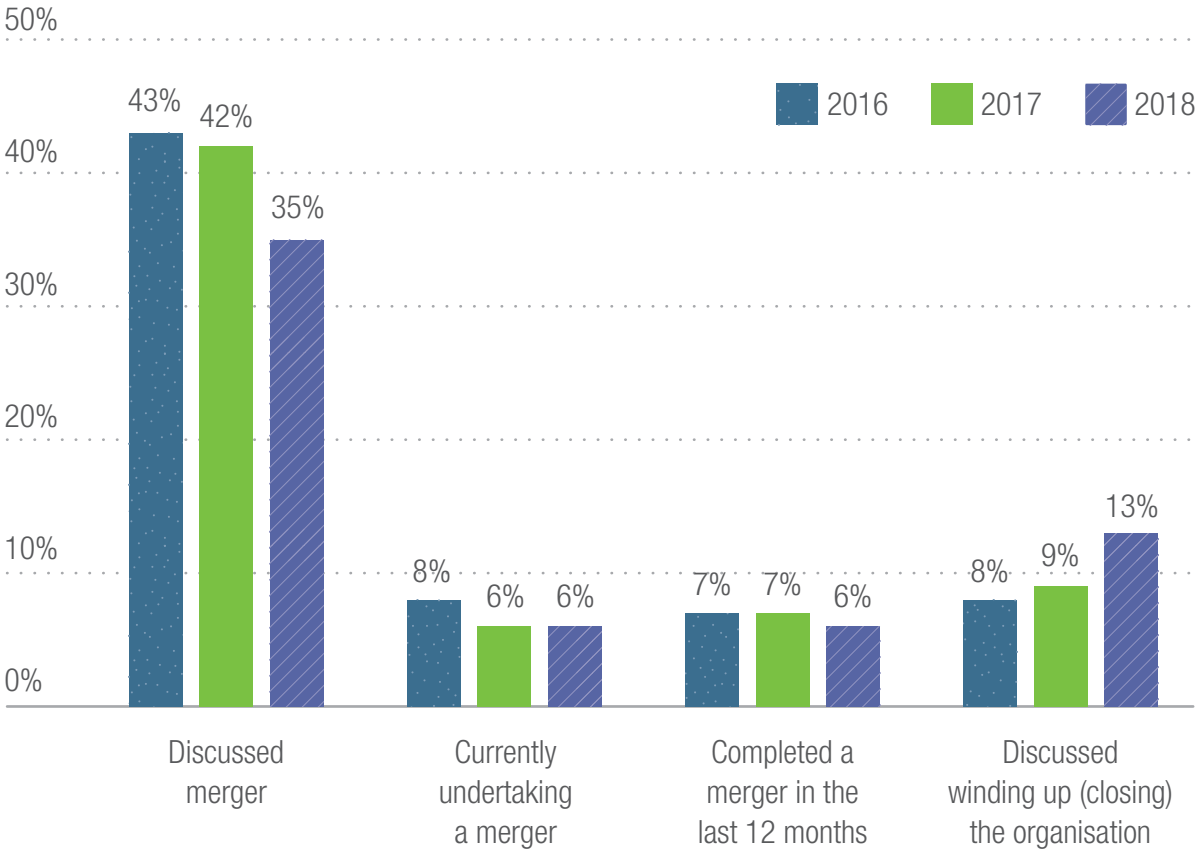
In the next 12 months, do you plan to stop providing, reduce, increase the volume of services or make no changes to your services?



Providers were asked to indicate plans to introduce new NDIS-funded services in the next 12 months. Less than 10 per cent of the providers that responded indicated they planned to do so.

Merger activity remains significant over the three-year period for which data has been collected. Of the providers that responded, close to three in 10 organisations indicated that merger discussions had occurred in the last 12 months.

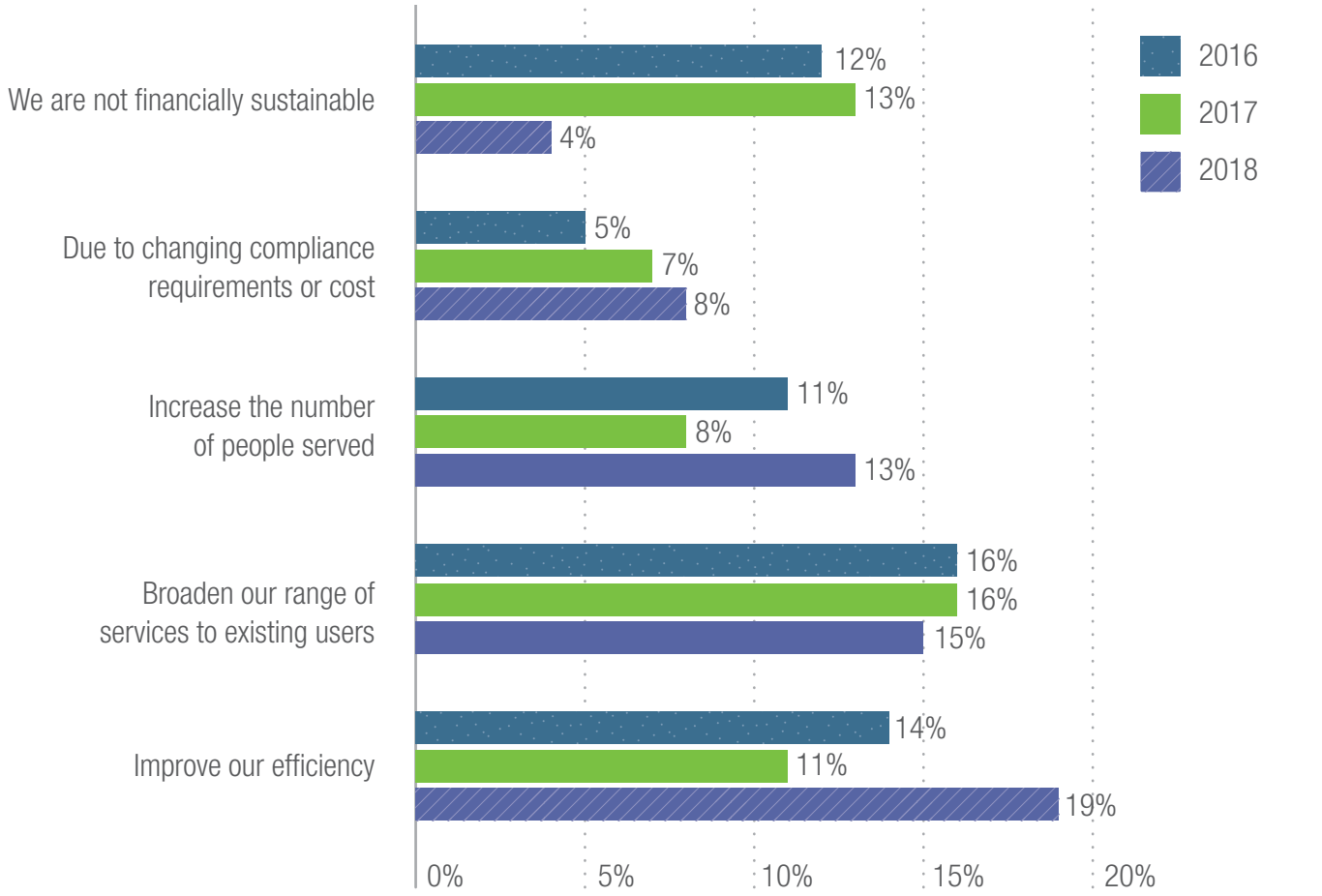
Figure 9 Mergers and market exits



Of the providers that had indicated they had discussed or were currently undergoing a merger, their most-cited reasons for doing so include improving service efficiency and broadening the range of services available to clients.

Figure 10 Reasons for mergers

Why did your organisation choose to merge? Or why might it choose to merge?

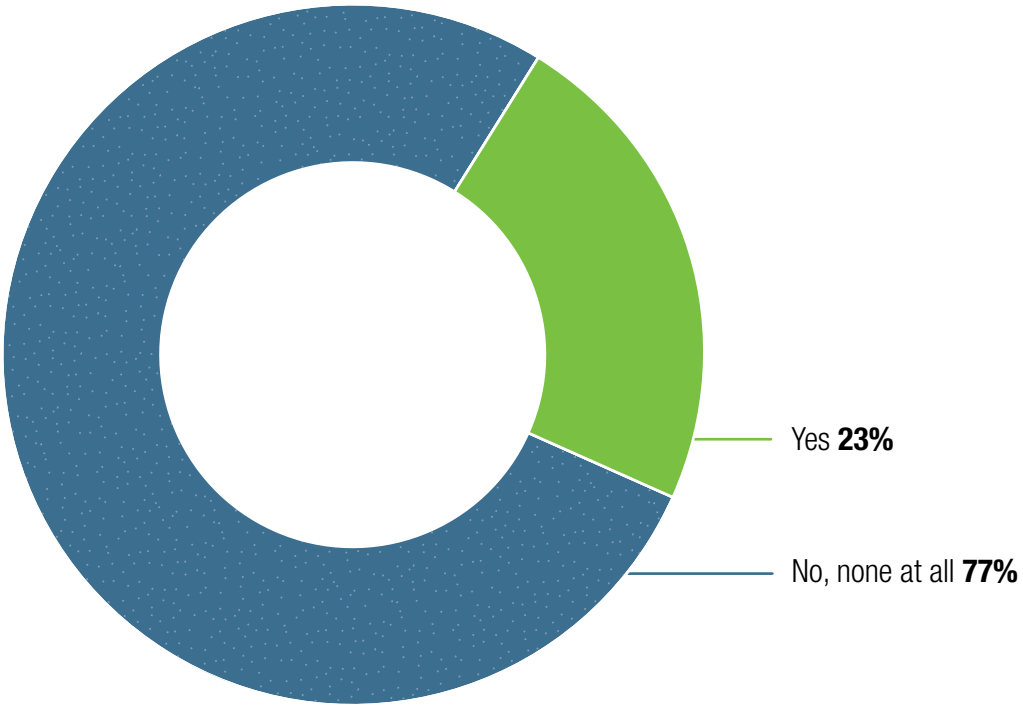


Close to 80 per cent of providers reported that they were not receiving any monetary, organisational, or other help from other disability service providers. This could reflect a lack of connection and collaboration with other services – consistent with international research which shows that as competition for services increase, collaboration across services decreases. Providers seem to be disconnected from each other rather than working together for mutually-agreed goals.

This also reflects research on changes to the sector since the implementation of the NDIS. A recent report from the Centre for Social Impact on collaboration in the sector found that organisations were collaborating and sharing information less as implementation rolled out. This warrants further investigation.

Figure 11 Are disability service providers helping each other?

In the last 12 months, have you received any help (monetary, organisational) from other disability service providers?



According to our survey, 28 per cent report operating at a loss, up from the previous year, and close to half (48 per cent) reports operating at a profit. However, for many, this profit was not meaningful in terms of its relation to Consumer Price Index or CPI (2.1 per cent according to the Australian Bureau of Statistics between 2017-18).

Figure 12 Financial sustainability

In the most recent financial year, did your organisation make a loss, break even, or make a profit?

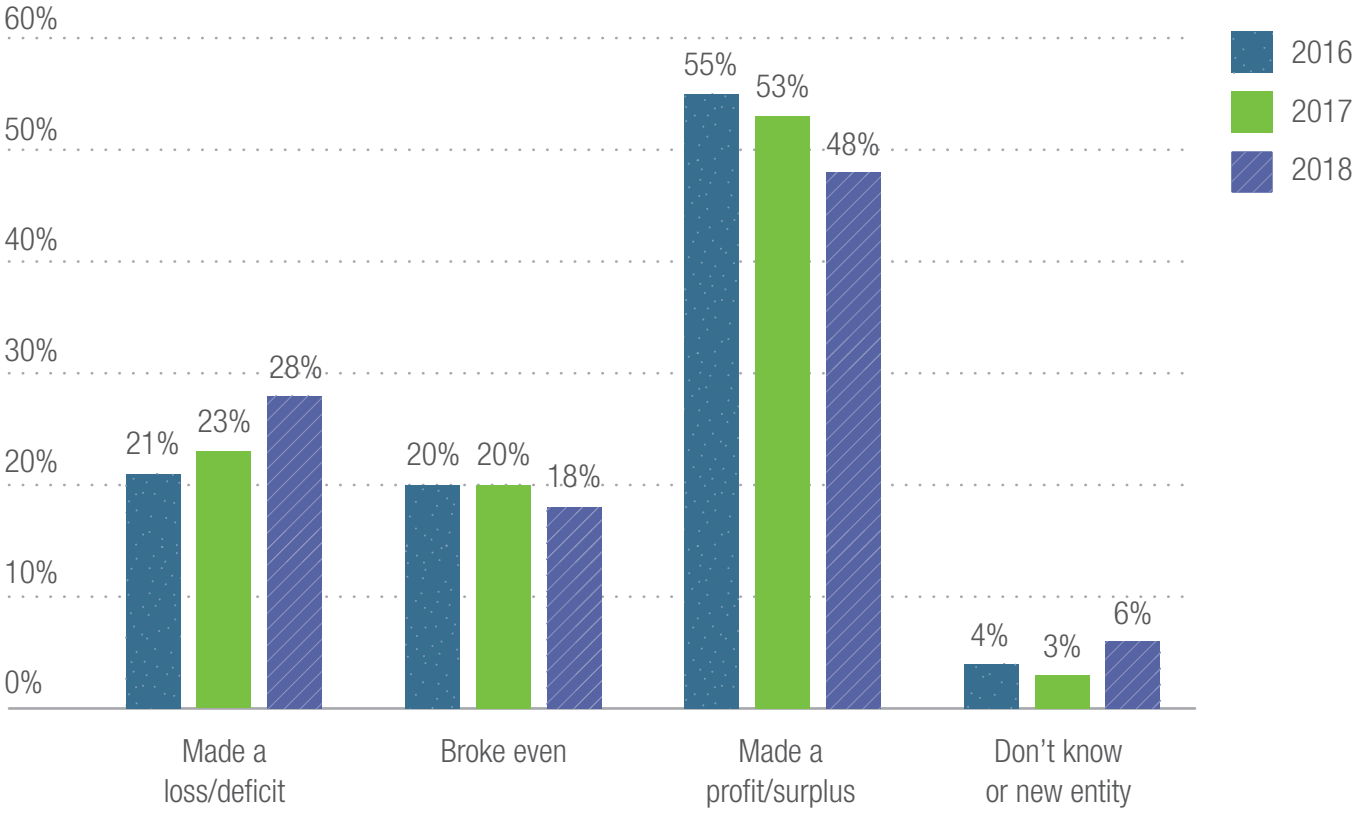
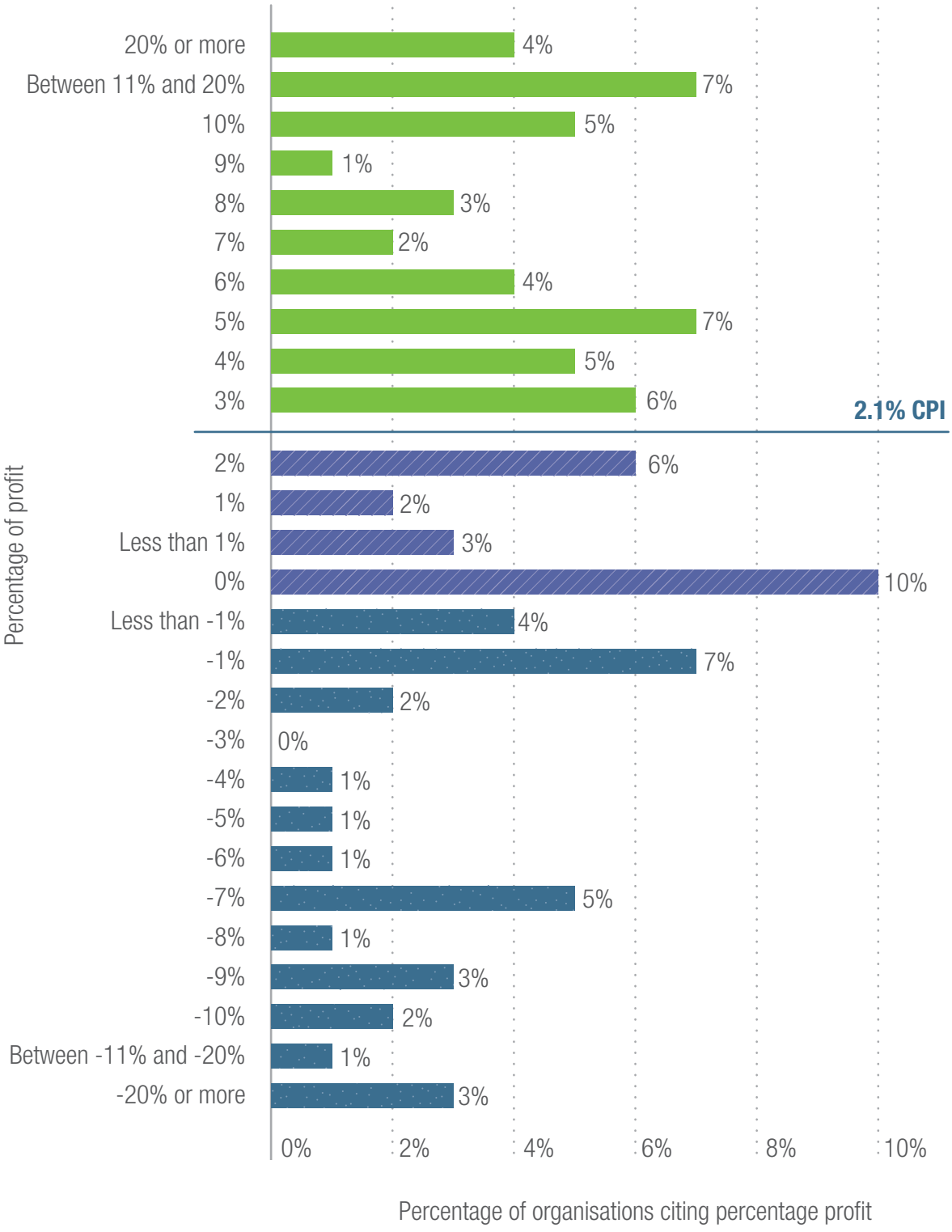


Figure 13 Past year financial performance

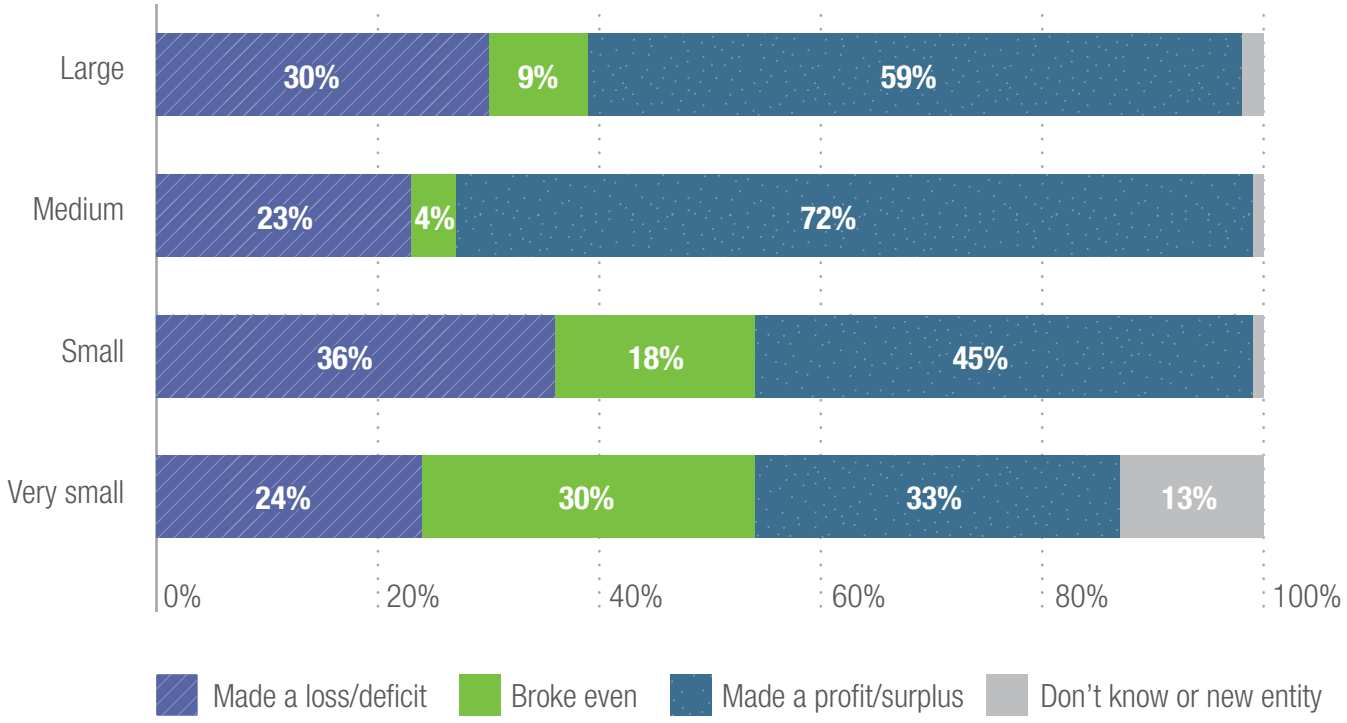
In the most recent financial year, did your organisation make a loss, break even, or make a profit?



Looking at profit margins by organisation size, significantly more medium and large organisations reported making a profit with their disability services in the last 12 months compared to very small and small organisations. A higher proportion (13 per cent) of very small organisations responded that they don't know/were a new entity, which likely reflects the growth in small organisations offering disability services.

Figure 14 Financial sustainability by organisation size

In the most recent financial year, did this organisation make a loss, break even, or make a profit?

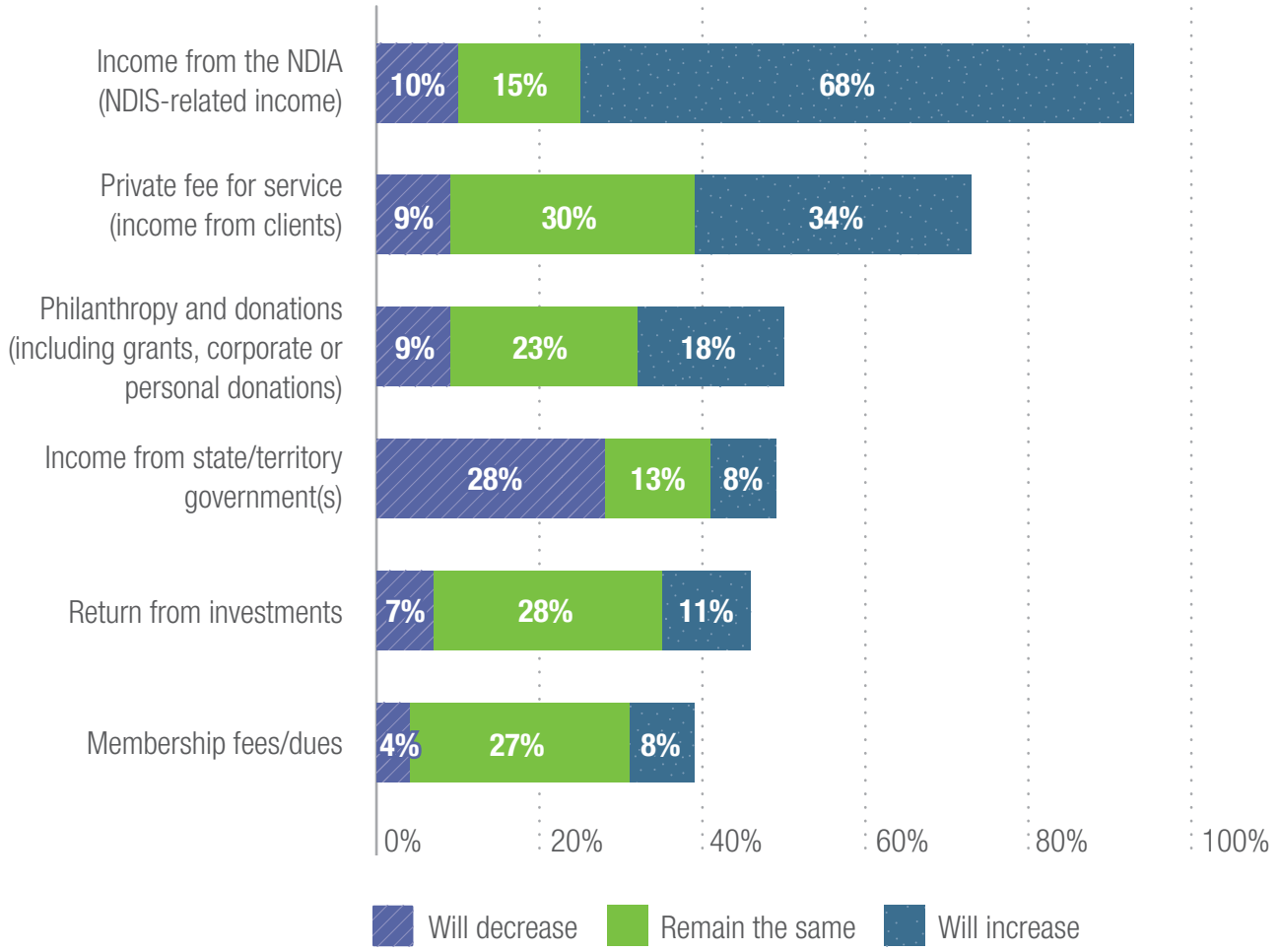


Change in net assets in the last financial year varied by organisation size. Very small providers (less than $1M) were significantly more likely to indicate that their organisation's net assets had not changed in the last year, while significantly more medium-sized organisations reported that their net assets had increased.

With regards to changes in organisational income, the majority of providers (68 per cent) anticipated that their income from the NDIA would increase in the coming financial year. Thirty-four per cent of providers anticipated that their income from private fees for service would also increase.

Figure 15 Income expectations

In this current financial year do you expect your organisation's income from these sources to change or remain the same?



Although sources of funding were not predicted to change drastically, disability service providers are concerned about the costs of their organisation's service provision. Close to half (42 per cent) of providers said that they thought direct labour expenses would grow at a rate faster than service volume growth, and 50 per cent said the same about administration expenses.

Research contact

For details about the survey data, please contact:

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Tasmania

Case study

Mark Jessop

CEO, Nexus

Tell us a bit about Nexus.

Nexus started out because of the wave of deinstitutionalisation in Tasmania in the late 1980s. It was formed in 1998 when two smaller services merged. We then perfected our craft of running group homes and introduced things like Active Support in the mid-2000s. This was all in a fairly traditional model of accommodation and day service providers 'sharing' support of people with disability within a tightly-managed block funding model. Most of our clients had congenital conditions with strong intellectual and physical support needs.

How has the NDIS transition affected your operations?

I joined Nexus as CEO in 2013, just as the NDIS trial for younger people started in Tasmania. I've been hanging onto the dragon ever since and we are slowly coming to an accommodation on how to ride it! We went from a static group of 36 clients for 15 years to ending up with close to 200 clients today – and the NDIS is not yet fully rolled out here. I remember saying to the Board that we'd need to try hard not to grow over the next few years, but I didn't really think it would be quite the ride we are having.

What's been your greatest achievement this year?

Transitioning all of our group homes into Supported Independent Living (SIL). The sector had been planning on a gradual age-based roll out, but at the beginning of the year, we were told by the state that it was all in this year! Not only did we have to wait for the SIL quoting tool to be rolled out by the NDIS, but we really needed to accelerate the knowledge of our key workers and team leaders. It was a great opportunity to go back to person-centred planning principles and look at what people needed and what evidence we had. It was a bit of a scramble, but we got there with a week to spare and all were approved with only minor negotiations. At the end of the process, we were able to offer over 1,000 hours a month extra support under NDIS funding than under the state model – a great win for clients. My role was making sure I had the team ready to 'think NDIS' and put together really meaningful SIL quotes – a great team effort.

What's the most valuable lesson you've learned?

There are so many. All the lessons about change and managing staff reactions to change have been really important. I was lucky to have spent a few years consulting in this area so I've seen a lot of good and bad change processes. Lesson one has been: "Take staff on your journey, too." The other big lesson has been about corporate decision-making and backing your well-researched judgment. There is no doubt that the changes with the introduction of the NDIS have forced providers to make high-risk decisions. At the end of the day, I looked into the crystal ball, got as much insight as I could, and then just made the decision. (There are still people looking into the crystal ball waiting for the fog to clear.) A good example of this decision-making was moving to a new integrated client management and finance IT package. Had we not done that, we would be absolutely stuck now, but when I did it, I was committing to a best guess of least $250K when I knew we had less than $100K in equity.

If you could go back in time, what would you do differently?

From one perspective, we've done reasonably well, but it's been such a rollercoaster ride, with changing models and systems – I don't think there's any wrong way of doing it! It's such a dynamic change in the sector. To think that there's one path to go down would be a mistake. I think we've taken each day at a time, we've anticipated what we could and we've adjusted on an ongoing basis.

Can you share a case study where you achieved a positive outcome for one of your service users?

During the trial, we were approached by the NDIS and Housing Choices Tasmania who had some units they wanted to fill. Because only younger people had come into the NDIS at this stage, we developed a model to support young people moving out of home, who would have been destined for SIL or group home models. We were able to work with this group, and, of the original four who came into the program, two moved to more independent living models and two moved into low support shared housing. We have since expanded the model to different sites and achieved about 15 units for people wanting to make a transition to a more independent lifestyle. It's been full of challenges, but great to take the journey to adulthood and independence with people.

What are your NDIS goals for the next few years?

There are four main goals. We still need to grow to have a sustainable business, particularly with the Quality and Safeguarding costs. Tasmania has had a fairly laissez-faire standards model so many in the sector here will need to ramp up our evidentiary processes, and this will cost. We still need to reduce our transactional costs – doing business with the NDIS is still clunky, much better than 12 months ago, but still too expensive. We need to become a more visible organisation in the new NDIS marketplace, which is a skillset many not-for-profits struggle with, so a bit of thinking is needed for it. Finally, I really want to push the NDIS's potential to its limits. The Agency talks about fostering innovation, but it seems that, whenever you try to be innovative, they struggle to fit it into a line item. We are just not clicking with the Agency in this innovation area, so I want to come up with lots of examples to give my colleagues in the Agency a headache!

3,879 NDIS plans approved in Tas
91% of bilateral estimate

8% NDIS participants are Indigenous
2% Culturally and linguistically diverse

1,159 registered disability service providers

Key issues

Providers struggling under centralised payment centre of the NDIS

Providers in Tasmania are now joining long queues with other, larger states (notably New South Wales and Victoria). Where payment delays were improving in Tasmania comparatively, they have begun to blow out again, causing service providers to carry the costs of continuing to provide supports without being able to claim for their provision. This must be addressed to ensure their ongoing financial viability.

Inadequate prices for travel

Given the limited number of allied health professionals in Tasmania, funding the travel of workers continues to be a problem for providers. The introduction of up to 45 minutes of travel for therapists to provide services in MM4 and 5 regions assists but does not cover all travel costs. This issue requires urgent resolution so that people with disability living in regional and remote areas are not disadvantaged.

Addressing the housing crisis

Shortages of accommodation mean that even those who receive funding for supported living need to join the community housing queue. The State Government has committed $20M to disability housing for Tasmania. Unfortunately, that is projected to be inadequate. Considerable work is still required to improve the supply and diversity of accessible and affordable housing for people with disability.

Western Australia

Case study

Marina Re

CEO, IdentityWA

Tell us a bit about IdentityWA.

IdentityWA has been providing services to people with disabilities in Western Australia for over 40 years. We provide a range of services including Supported Independent Living, family support, and a whole range of other individual supports.

How has the NDIS transition affected your operations?

The Western Australian experience has been a little different. We've had both the national NDIS and the WA NDIS. At one stage, we had two pilot programs operating with trial sites, so that added a level of complication, because we were working with the national, working with the state, and we had the existing disability services that were provided through the state government.

Transition to the NDIS has been quite challenging in terms of that level of complexity. We're now involved in the roll out of the national NDIS across WA, and also the transfer of people involved in the WA NDIS to the national program. There are challenges around financial arrangements, reporting requirements, providing individuals and families with good, clear information – that hasn't always been available – and then, of course, working with our staff to ensure that they're well-trained and up-to-date to be able to deliver what they want to deliver.

What's been your greatest achievement this year?

One of the most important things for service providers is workforce, and ensuring that we have a workforce that's able to deliver what individuals and families want. We're currently in partnership with LaTrobe University, delivering a series of research projects around person-centred active support, and that's been very successful in improving the ability of our staff to be focused on achieving great outcomes for the people we support.

What's the most valuable lesson you've learned?

The most valuable lesson is that our support workers are great people with really good values. With exposure to excellent training opportunities, they're able to move from being good support workers to excellent support workers.

If you could go back in time, what would you do differently?

I don't know that we'd do anything differently. The environment has been so full of change that all we can aspire to do is be responsive and continuously looking at our operations to ensure that we're offering the best opportunities to the people we support. From a WA perspective, it's really only been in the last 12 months that we've had any clarity on how the Scheme would roll out here.

Can you share a case study where you achieved a positive outcome for one of your service users?

The work that we're doing around citizenship, in particular, is really important. We're implementing a citizenship framework throughout the organisation, which draws on Simon Duffy's key principles. That means that we're challenging our staff to look at all of those domains when

they're working with individuals. [Simon Duffy's keys to citizenship include: freedom, direction, money, home, help, life and love.] There are a number of examples within that of people being supported to access TAFE, get their driver's licence, be able to live independently – a whole range of things. That support has further developed the culture of the organisation, and the way that framework is being implemented is having a much broader impact on the lives of the people we support rather than just focusing on any one aspect.

What are your NDIS goals for the next few years?

As an organisation, we think the NDIS provides lots of challenges but also lots of opportunities. The goal is to look at how we go forward, particularly around how we develop some partnerships both within the sector and across sectors to further benefit the people we support. Our goal is to maintain high-quality services while being able to scale up to meet the future demands coming through the NDIS.

> "At the end of the day, service providers work in partnership with families, so the emphasis on co-design and being responsive to what individuals and families are telling us they want is absolutely critical."

For many agencies, there's a huge focus on maintaining operations and being able to sustain the quality of services they're providing within a very tight financial framework. What I think is equally important, going forward, is trying to maintain the focus on innovation. Those relationships with universities and industry partnerships and whatever else are absolutely key in terms of building up that capacity, moving forward.

At the end of the day, as service providers, we work in partnership with families, so the emphasis on co-design and being responsive to what individuals and families are telling us they want in terms of future design of services is absolutely critical.

4,508 NDIS plans approved in WA
78% of bilateral estimate

4% NDIS participants are Indigenous
7% Culturally and linguistically diverse

1,048 registered disability service providers

Key issues

NDIS transfer and transition

In December 2017, a Bilateral Agreement was announced for WA to transition to the nationally-administered NDIS. The challenge of transfer and transition is compounded by geographical issues associated with regional, remote and very remote communities. It is critical that service disruption and detrimental outcomes for people with disability are minimised and that sustainable support services are delivered and built over the bilateral transition period.

Rural and remote communities

WA has distinct characteristics that mean regional strategies in other locations may not be readily transferable. This includes very long distances between communities, diverse language groups, competition for staff from diverse sectors and significant regional differences in the availability of other services or infrastructure. NDIS pricing for disability supports must be based on the current costs of delivering supports in regional, remote and thin markets and also consider the cost of delivering supports to people with high and complex needs.

Building workforce capacity

While the State Government's funding of $20M for NDIS transition announced in May 2018 is a welcome down payment, more investment is needed in workforce development, given that the sector workforce is expected to double over the next three years. Additional investment should focus on implementing strategic initiatives of the WA Disability Services Sector Industry Plan.

The State of the NDIS

Transition to the full NDIS started in mid-2016 and is due to be completed by 2020. Now – more than half way through the transition period – disability service providers are still bearing a heavy burden associated with systems that are not well-designed for the large volume of plans and payments that the NDIS must process.

Inadequate prices are threatening the supply of some supports and there is a paucity of information on some critical services such as providers of last resort.

Ongoing negotiation between NDS and the NDIA has resulted in progress on a range of issues, but more is needed.

Pathways and portal developments

After frequent feedback about the shortcomings of NDIS plans, the participant pathway was redesigned and trialled in three regions of Victoria. The revised pathway, now being implemented progressively across Australia, offers all participants face-to-face planning meetings and increases the focus on pre-planning and on post-plan implementation. An increase in the NDIA's staffing cap is supporting this initiative.

For providers, pathway improvements have included the establishment of a National Provider Payments Team to try to resolve payment delays; the introduction of an improved quoting tool for Supported Independent Living; and enhancements to the Provider Finder function.

Over recent months, a number of improvements to the portal have eased some of the pain experienced by providers. NDS anticipates further changes over the coming year.

Pricing progress amid the pain

Some NDIS prices have improved over the past year. From July, the price limits for standard intensity assistance with daily personal activities and community access increased by 7.64 per cent. This welcome increase included a 2.5 per cent loading as a temporary support for overheads (TSO), which reduces to 1.25 per cent in 2019-20.

The TSO is a welcome but insufficient addition to the prices for standard intensity supports and partial recognition of the high costs of operating within the NDIS. Substantial improvements to NDIS systems and processes must be seen over the next two years. NDS is urging the NDIA to apply the TSO to higher-intensity supports.

The NDIA has not yet completed its research on defining complexity and pricing supports for participants with the most complex support needs.

NDS continues to argue that a substantial and permanent increase to the one-to-one attendant care support price is necessary (and the group prices that flow from it). There are worrying signs that a growing number of providers are reducing – or not growing – their provision of community access supports. The possibility of some market failure is emerging.

A pilot project on pricing and service delivery in remote areas has begun and a review of pricing in Western Australia is planned.

From July, the price limits for standard intensity assistance with daily personal activities and community access increased by 7.64%.

Market stewardship is lacking

In two reports over the past year, the Federal Parliament's Joint Standing Committee on the NDIS has been critical of the flawed approach taken by the Department of Social Services (DSS) and the NDIA to support transition to the NDIS and the lack of market stewardship. Drawing heavily from NDS's input, the reports call for the immediate development of an NDIS market stewardship strategy, the establishment of a disability sector assistance fund and the transfer of responsibility for NDIS price-setting to an agency that is independent of the NDIA.

The Committee was concerned to hear of the inability of many service providers to operate at even modest profit levels and that inadequate pricing was resulting in providers discontinuing services to some participants. As argued by NDS, the Committee called for the

immediate release of information on provider of last resort arrangements.

The lack of a systematic approach to market stewardship should be a concern to all NDIS stakeholders – governments, the NDIA, the NDIS Quality and Safeguards Commission, disability service providers, and participants and their families and carers. Over the coming year, stewardship activities need to be implemented and their effectiveness ensured.

Participant transport and provider travel are inadequately supported

Assisting participants with moving around in their communities is a support that many providers are struggling to sustain. Portal limitations mean that some participants are not able to use their core funds flexibly to purchase additional transport support, even if that is their wish. Removing this portal limitation is one of several recommendations that NDS has issued in a policy paper on transport and the NDIS.

A welcome development is the new travel guide that allows providers to charge up to 45 minutes of travel time between clients in rural areas (up from 20 minutes). While this is an improvement, NDS has continued to alert the NDIA to situations where provider transport is inadequately covered (such as being the sole provider of a specialist support located in a major city but having a participant residing hundreds of kilometres away). Providers in remote and very remote areas are still not adequately compensated for the travel they incur.

The new travel guide allows providers to charge up to 45 minutes of travel time between clients in rural areas (up from 20 minutes). While this is an improvement, NDS has continued to alert the NDIA to situations where provider transport is inadequately covered.

Work in progress: The NDIS Quality and Safeguards Framework

The NDIS (Quality and Safeguards) Commission commenced operations in NSW and SA in July 2018. Its main aim is to achieve a nationally consistent approach to quality and safeguards. Until the NDIS Commission is in place in their jurisdiction, NDIS participants, providers and workers will continue to be covered by their state or territory's existing quality and safeguards systems, and providers remain registered with the NDIA. Early feedback from service providers in NSW and SA highlights the following issues:

- The unknown cost of compliance associated with the quality and safeguards framework. Until national consistency is achieved, this is the case especially for providers that are operating across multiple jurisdictions.
- There will be additional costs in ensuring that all workers are familiar with the new NDIS Codes of Conduct and the mandatory worker orientation program.
- Ensuring that there is a sufficient supply of suitably trained and experienced quality auditors that are familiar with the new NDIS Practice Standards, especially the new emphasis on proportionate treatment of evidence.
- Lack of clarity on the arrangements for the reduction and elimination of restrictive practices. The NDIS Commission confirmed in early October that the national competency framework for behaviour support remains under development.

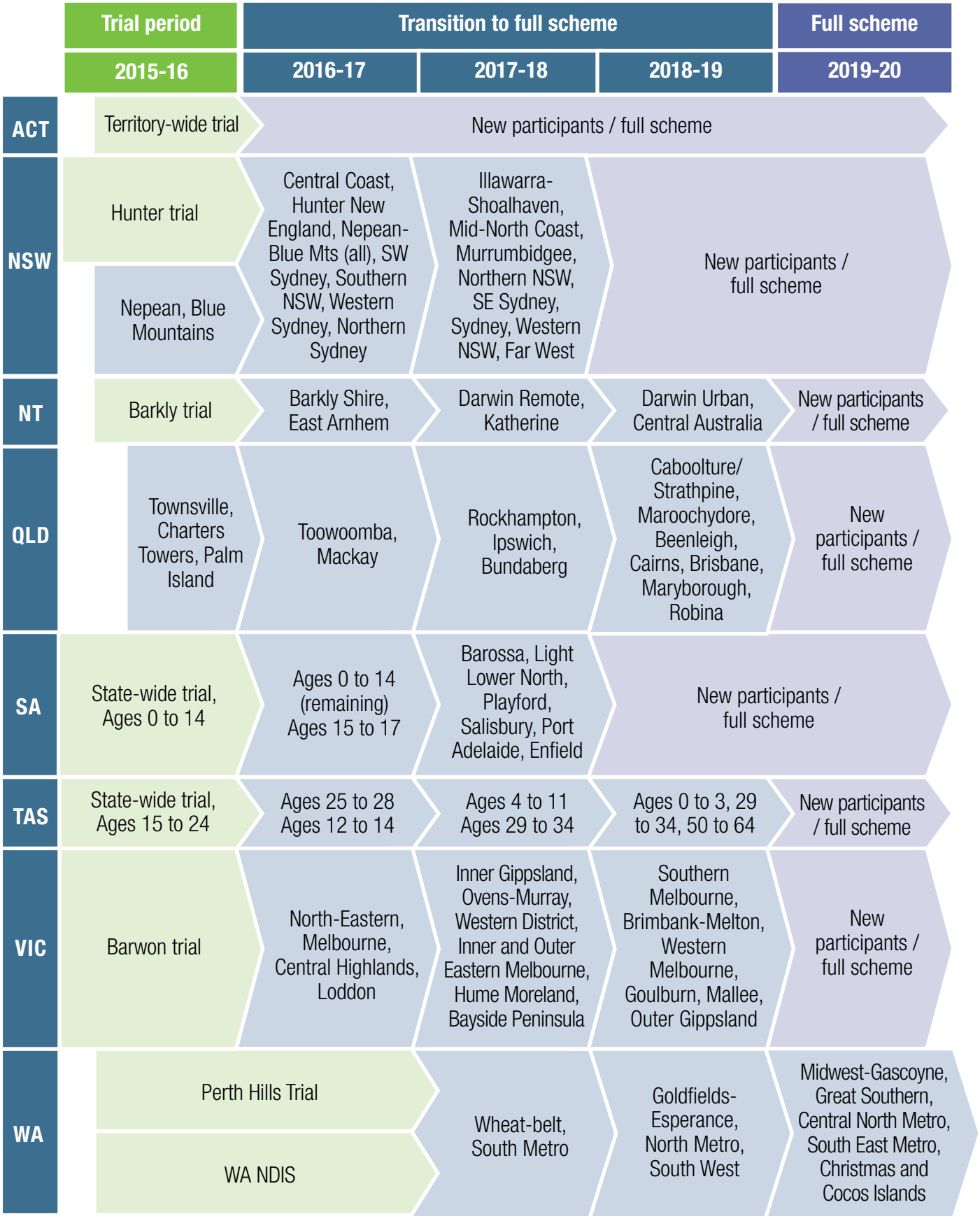
In order to build confidence in the new arrangements, the NDIS Commission must move quickly to assess the efficacy of its regulatory instruments, ensure consistent advice and guidance are available to service providers, and engage all key stakeholders – especially NDIS participants, their families and carers – in an assessment of the impact of the Quality and Safeguards Framework.

Until the NDIS Commission is in place in their jurisdiction, NDIS participants, providers and workers will continue to be covered by their state or territory's existing quality and safeguards systems, and providers remain registered with the NDIA.

How NDS is taking action:

- Presenting arguments to government about the critical need for market stewardship
- Advising the NDIA on how complexity should be defined and funded
- Assisting providers to understand the requirements of the NDIS Quality and Safeguards Commission
- Collecting and analysing workforce data through the NDS Workforce Wizard survey
- Raising sector concerns about inadequate funding for worker travel and participant transport by providing examples to the NDIA
- Negotiating portal enhancements with the NDIA
- Informing the NDIA about providers exiting parts of the market
- Giving providers, people with disability and their families an opportunity to voice concerns at the Make It Work community forums in partnership with Every Australian Counts
- Hosting provider forums and communities of practice to share information and support the spread of good practice in quality and safeguarding
- Launching an ongoing series of webinars, webcasts and podcasts on matters relating to quality and safeguarding
- Providing tools and resources to support effective and efficient quality management systems, including the Standards and Performance Pathways standards assessment tool
- Established the national NDS Helpdesk to accelerate answers to questions about the NDIS
- Submitted a paper to the Joint Standing Committee on the NDIS inquiry into the ICT system
- Urged the NDIA to streamline quoting for Supported Independent Living
- Published ‘Getting Transport on Track’ and ‘Making Employment a Priority’; the first in a series of NDIS Essential Issues papers
- Provided information to disability service providers at the NDIS Essential Briefing series in every capital city
- Put forward evidence for re-pricing community access (for one-to-one and group supports)
- Establishment of positions at NDS at the national and state level with specific focus on building organisational capability on quality and safeguards

NDIS transition arrangements



Australian Capital Territory

Case study

Mary-Ann Kal

Program Manager, Sharing Places

Tell us a bit about Sharing Places.

Sharing Places is a specialist organisation in the ACT that provides services to adults with high and complex support needs to participate in community, social and recreational activities. We assist people to work towards their personal goals and improve their quality of life through the development of daily living and life skills, communication strategies and positive behaviour supports, promoting a person-centred culture.

We are currently supporting around 160 people across the ACT, ranging in age from 18 to 65 years.

How have you found the NDIS so far?

In the ACT, with the transition from trial to full Scheme, there has been less flexibility, and the reality of 'reasonable and necessary supports' has decreased funding in many people's plans. There are still inconsistencies in the plans.

The back office pressure has increased to capture all the information for invoicing, processing claims and ensuring we stay within budgets as agreed in the individual's Service Agreement; keeping on top of outstanding payments and chasing payments from the NDIS. There are still gaps between plans and shortfalls in funding.

> "We have seen a growth in our service, welcoming many new people who previously didn't have funds for social and community participation, as well as young adults who have graduated from school."

What has been the greatest challenge in the NDIS?

The people we support have lifelong disability and many were told they would only need to tell their story once. However, we are asked over and over again to provide evidence for the supports they need in order to access community, social and recreational activities. As a result, the annual reviews were often very taxing for families – constantly having to identify deficits in people to justify funding. The fact that this process doesn't focus on a person's strengths is very tough.

What has been your greatest achievement this year?

Maintaining the level of high-quality service, and remaining financially viable. We have seen a growth in our service welcoming many new people who previously didn't have funds for social and community participation, as well as young adults who have graduated from school.

What's been a valuable lesson for your organisation?

The resilience of families and the people we support, and the commitment and dedication of our staff through changing and often uncertain times. [We have also learnt that] the operating environment continues to change, so you can't become complacent. We are constantly reviewing our financial position and making adjustments accordingly.

Looking back, is there anything you would do differently?

Even with organisational pre-planning and implementation of safeguards and strategies with sound business practices, the impact on our resources such as maintaining our vehicle fleet and our capacity to continue to provide home transport and a range of programs was under threat. We should have realised sooner that our fleet of vehicles could not be maintained once all the subsidies we previously had were gone. Now, we have 100 per cent cost recovery for vehicles and activities.

"Now, it's great to see that the students have their own resources, such as their own walking or standing frames. They're also having therapies introduced much sooner. Previously, waiting lists could be years-long."

Can you share any positive stories that have come about since the NDIS?

There are many positives. Before the NDIS, there were a lot of people with undermet needs sitting in accommodation. That has been addressed. In addition, many people graduating from school used resources that were owned by their schools. Now, it's great to see that the students have their own resources, such as their own walking or standing frames. They're also having therapies introduced much sooner. Previously, waiting lists could be years-long.

What are your NDIS goals as an organisation?

We need to continue to watch the vital signs of the organisation and actively adjust resources. Although we are a not-for-profit organisation, we need to look at how to continue to cost recover and monitor non-claimable absences and work within our budget. Being one of the only organisations that provides supports to people with high and complex needs in the ACT, we also need to consider how big we can grow. We need to gather regular data of school leavers with disability and review our capacity. Something we'd like to do is expand services into the Gungahlin area, which is in the outskirts of the ACT. Finally, we need to keep actively engaging with the NDIA, NDS and other stakeholders.

6,759 NDIS plans approved in ACT
134% of bilateral estimate

4% NDIS participants are Indigenous
10% Culturally and linguistically diverse

1,352 registered disability service providers

Key issues

Inadequate pricing

As the first jurisdiction to fully transition to the NDIS, the cumulative impact of inadequate pricing is increasingly being felt by ACT providers. A closer examination of service types that require additional funds in order to remain viable is required. Inadequate NDIS prices pose a risk not only to individual disability service providers, but to the Scheme as a whole.

Better data to track participant movement away from areas of market stress

Participants requiring one-to-one and community access supports are increasingly unable to access these services and may be substituting them with other service types (e.g., in-home day supports) that do not meet all the needs identified in their plans. Better tracking of participant movement between service models is required to identify areas where the current market can not deliver on participant plan outcomes.

NDIS payment portal

Ongoing process issues and inefficiencies in the NDIS claiming system continue to create an unnecessary administrative burden for providers. Response times from the NDIA need to be shorter if providers are expected to absorb these costs. A co-design approach – with providers and participants – needs to be adopted to ensure that portal improvements are user-centred and tested prior to roll out.

New South Wales

Case study

Monique Cardon

CEO, Fairhaven

Tell us a bit about Fairhaven.

Fairhaven was established in 1962. We have three major streams of business. The majority of our service users work in supported employment. We also have a residential and active business community unit.

How has the NDIS affected the way you work?

Individuals now have money to spend on things they didn't before, which has opened up new opportunities and new worlds to them. We are having great fun trying to help them realise this. Our aim at the moment is to make sure we offer enough variety in our supported employment. Our major Australian Disability Enterprise (ADE) is CoPack, a packaging facility, but we also have ReCreate, an upcycling furniture and homewares-making social enterprise, as well as opportunities to work in our cafe and op-shop. We really want to provide people with choice.

Do you have a positive NDIS case study to share?

One of our guys who works at our Point Clare site wanted to learn to drive a forklift. He used his Coordination of Supports money to have somebody work with him to understand the questions on the driver's licence test. He could already drive a forklift, so it was about getting support to complete the test. I saw him recently after he got his license and he pulled it out of his wallet to show me with such pride. It was wonderful to see. Without that funding, he wouldn't have been able to access the people he needed to make that happen. We also have a similar story from someone from Tuggerah, who really wanted to learn to drive. He also used his Coordination of Supports money to arrange driving lessons and organise people to support him to complete the test. He ended up getting his provisional licence.

What have you learned by working through the transition process?

Understand your unit costs and understand your margins. When you're in human services, it's easy to keep delivering – but you just can't. The most difficult transition for us was to go from block funding where you had a certain amount of money and staff, to a new situation of understanding individual budgets and making Service Agreements based on those. It's tough on staff who have come from that old case management model, especially because you still want to help everybody.

Your entire leadership team recently went on a residential course. How was this experience?

It was an NDS event called 'Leading the NDIS Transformation'. My General Manager and I looked at it and saw that it was two days in the Hunter Valley, which is really close by and very cost-effective, so we went along. We really liked that it followed a peer-support model and involved other organisations. It was fantastic and we really enjoyed ourselves. We got to know people we wouldn't ordinarily connect with. When the course was run again

"Understand your unit costs and understand your margins. It's easy when you're in human services to keep delivering – but you just can't."

in Ballina, we decided to send the rest of our leadership team so that they would be exposed to the same sort of thinking and ideas.

We all really enjoyed getting insights into our own leadership practices, and came back with a great phrase: "You're either on the dancefloor or on the balcony." It was a nice reminder that, when you're busy with the day-to-day, you also need to spend time looking at your organisation in order to work on it – not just in it. It taught us to be really agile, and that you just can't do things using the old ways anymore. It's about choice and control for [the people we support]. I think everybody's starting to get that now.

"When you're busy with the day-to-day, you also need to look at your organisation in order to work on it – not just in it."

Is there anything you would do differently if you could go back in time?

I've been with Fairhaven less than two years, but I think we could have focused more on staff education. I think we've also taken the focus off what our families understand. A lot of work was done with families before the NDIS came in, but once it came in, there was an assumption that they knew what they were doing. As an organisation, we're still working through things but have probably taken our eye off what our families understand. So we are planning to do some 'NDIS 101 information' sessions so families are not left in the dark. I run a family reference group meeting which is always really interesting because there's great peer support and opportunities to help each other.

What's something you're proud of having achieved at Fairhaven?

We went through an important rebranding exercise. Fairhaven is a 56-year-old organisation with a strong local history, but also legacy issues. The rebrand has given everyone a sense of renewal and hope that we are a contemporary and exciting organisation that can attract new people. If we can touch more people and give them opportunities to live an ordinary life, we'll know we have done our job.

86,044 NDIS plans approved in NSW
78% of bilateral estimate

6% NDIS participants are Indigenous
9% Culturally and linguistically diverse

8,485 registered disability service providers

Key issues

Interface between the NDIS and mainstream services

It remains unclear how the NDIS will interface with mainstream services. There are many examples of participants and providers being stuck between the NDIS and mainstream service providers. Provider consultation is essential to resolving these complex cross-service system issues.

Role of Community Partners in NSW

The lack of capacity of Local Area Coordinators to provide plan implementation is concerning. In many cases, the burden of assisting participants is falling on providers. The Early Childhood Early Intervention (ECEI) approach was rolled out very late and quickly in NSW. There are concerns that eligible families have been waiting significant periods of time for plans to be developed.

Leasing arrangements

The leasing arrangement proposed by the NSW Government for providers operating properties under licence from Family and Community Services (FACS)/ Land and Housing Corporation assumes every property will be fully occupied by participants eligible for Specialist Disability Accommodation (SDA). This fails to take into account that many of the properties will be unsuitable for participants eligible for SDA or that there will be participants requiring Supported Independent Living (SIL) who are not eligible for SDA.

The State of Broader Policy Environment

Few DSP recipients are in work

The number of Disability Support Pension (DSP) recipients reporting wage earnings has continued to decline. The number of DSP recipients decreased from 758,911 to 756,960 over the 12-month period to 30 June 2018. The proportion of DSP recipients reporting wage earnings was 7.95 per cent in June 2018, down from 8.2 per cent in June 2017.

Other four pillars of policy need work

While the NDIS dominates the disability policy environment, it is only one of five pillars designed to support the social and economic participation of Australians with disability. The other pillars are the National Disability Strategy; the National Arts and Disability Strategy; the Disability Discrimination Act; and the National Disability Agreement.

The 10-year National Disability Strategy, signed by the heads of all Australian governments, focuses on six areas:

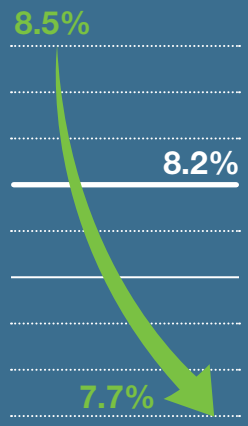
1. Inclusive and accessible communities
2. Rights protection, justice and legislation
3. Economic security
4. Personal and community support (which includes the NDIS)
5. Learning and skills
6. Health and wellbeing

Progress in most of these areas has been uneven and slow. The Strategy is currently under review and NDS believes that a renewed one should include annual reporting to parliaments on key measures to give it visibility and stimulate investment in the changes needed.

The National Arts and Disability Strategy, due to expire next year, is also under review. Arts and cultural ministers from across Australia have agreed to develop a new strategy to assist people with disability to participate in cultural life.

The Disability Discrimination Act protects people with disability against discrimination in public life. Standards have been made under the Act in relation to Public Transport, Education, and Access to Premises. In general, the standards are well-crafted, but their effectiveness is weak. National auditing of compliance with the standards should be strengthened. The Public Transport Standards are under review.

The National Disability Agreement is a high-level Council of Australian Governments (COAG) agreement that defines the roles and responsibilities of the Commonwealth and the states and territories in relation to disability services. The NDIS has rendered parts of this Agreement redundant. However, in NDS's view, a revised Agreement could better connect the other pillars of disability policy and define responsibilities for key policy areas. We have made this point to the Productivity Commission's review of the National Disability Agreement.



In June 2011, the proportion of DSP recipients reporting wage earnings was 8.5%. The March 2018 figure of 7.7% was the first time the proportion of wage earners on DSP had fallen below 8.2% over that period.

How NDS is taking action:

- Advising governments on interface issues between the NDIS and mainstream services, based on the experience of members
- Providing submissions and evidence to national policy reviews
- Developing resources, such as the Zero Tolerance initiative, to help prevent abuse and neglect
- Hosting information sessions on the NDIS Quality and Safeguarding system
- Urging governments to develop continuity of support arrangements for people with disability who are ineligible for the NDIS

South Australia

Case study

Maggie Dowling

CEO, Bedford Group

Tell us a bit about the Bedford Group.

Bedford has been in operation for nearly 70 years. We currently support around 1,500 people with disability, 1,300 of whom access supported employment. The balance is day options and a small amount of residential services. I've been at Bedford for around eight months [as of October 2018].

What is Bedford's furniture business and how has it been adapted to suit your supported employees?

Bedford is known for its flat pack furniture that is marketed throughout Bunnings stores. It has our own branding and is available nationally. The offering includes wardrobes, bedside cabinets and laundry furniture, and we are currently looking at an outdoor kitchen range to be launched into Bunnings very soon. It's one of our largest commercial businesses that our supported employees work in and generates about 44 per cent of our non-funding revenue. Our revenue is about $72M and around $18M of that is funding and the balance is revenue generated by our commercial businesses. We have five furniture manufacturing sites across South Australia, which includes metro and regional areas.

Work, Health and Safety (WHS) is a very strong focus of ours. A lot of companies that don't have supported employees look at what we do and consider it a good idea as we provide a very safe environment for manufacturing.

"Employment isn't just having a job – it's about quality of life. It is waking up in the morning and knowing that you are contributing to society like anyone else. [It provides] socialisation, social inclusion, economic benefits from income, improved health and wellbeing, independence and respite and support for families."

How has the NDIS transition affected your organisation?

The cost of transformation is very evident. Just to transition our 1,500 existing clients, we've had to invest significant resources of around $1.8M in additional staff to have pre-planning meetings with families to ensure they understand the need to put 'finding and keeping a job' in plans. A lot of families are getting a first plan and it's not complete as they haven't understood what the categories are. That extra investment is only to retain our existing funding, without generating any additional revenue, so it's significant. And like other organisations, we are still in the long, arduous journey of systems modifications to suit the new business model.

What's something you're proud of having achieved?

We have some residential accommodation, where about 80 clients live. Because there are a lot of people in one place, it's the sort of housing that the State Government didn't deem as 'independent living'. Because of this, we were getting very marginal funding. My team there worked really hard with the NDIS. The Supported Independent Living (SIL) funding we now have for those clients is

amazing. The team at the NDIA were really helpful and worked through it with us. There's one family in particular, whose son would always send his washing home and get home-cooked meals as he didn't like the cooking at his accommodation. SIL funding has given him much better flexibility. We have numerous stories like this where we've seen very positive outcomes.

What's the most valuable lesson you've learnt through overcoming NDIS challenges?

I came as a relatively new CEO into a risky financial environment. I've seen the move from systems that didn't have to be single-client dependent under the block funding model, to something that needs to identify client-specific data across a range of services. That integration of information about clients is an administrative task that can cause serious financial issues. I think we need to be down in the weeds in relation to transition. Once we're through to the other end of it, we won't need to operate at that level. But I think there's a need in the meantime at the executive, CEO and board level to be driving deep into transition challenges as that's where financial risk is high.

What do you think Bedford has done well through the transition process?

I think the support we've put in to support families absolutely returns value. That won't stop though. While families are still in transition, there will be a continuing requirement for support. It certainly won't be a short-term resource investment – I can see it will be ongoing for some time. High-quality client services where families and people with disability feel supported are going to be key to success as we go through the transition process.

What are your NDIS goals in the coming years?

We want to maintain our focus on ensuring that there is an employment-first focus in NDIS plans so people have the opportunity to work. Supported employment is what we are and we strongly believe in it. Employment isn't just having a job – it's about quality of life. It is waking up in the morning and knowing that you are contributing to society like anyone else. Being employed gives benefits of socialisation, social inclusion, economic benefits from income, improved health and wellbeing, independence and, of course, it provides respite and support for families.

18,460 NDIS plans approved in SA
72% of bilateral estimate

4% NDIS participants are Indigenous
6% Culturally and linguistically diverse

1,960 registered disability service providers

Key issues

Pace of NDIS roll out

Providers are finding that the full roll out of the NDIS in South Australia, which has already been delayed by six months, is proceeding very slowly and is almost at a standstill in some regional centres. The slowdown means that some providers continue to operate with two funding models, which adds to the complexity and cost of administration. It will continue to impact on the growth plans of organisations.

The speed of transition for people with disability is also of concern, with many disability service providers finding that participants who should have transitioned over 12 months ago are still waiting for approved plans.

Inconsistent advice on SIL

Local advice is at times inconsistent with national advice on Supported Independent Living (SIL) from the NDIA. Consistent, prompt and transparent messaging is needed.

High cost of Quality and Safeguarding audits

There is a growing concern in SA around the cost of Quality and Safeguarding audits, with some disability service providers receiving quotes of around $5,000 per day. This needs to be addressed to ensure that audits are cost-effective and not a financial burden for providers.

Queensland

Case study

Brett Adams

Manager Partnership and Performance
– Community Solutions Subsidiary, Endeavour Foundation

Tell us a bit about Community Solutions.

Community Solutions, which is predominantly an employment and workforce-funded not-for-profit, amalgamated with the Endeavour Foundation around five years ago. The biggest part of my role is to connect government-funded services with industry. We work mainly in the employer space so we can support organisations with their workforce issues and get employment outcomes. We also look after mental health and NDIS services which are all growing. However, 75 per cent of our revenue comes from employment and workforce-related services.

How has the NDIS affected what you do?

It's been interesting. The employment services space had already started to move to a market-driven model prior to the NDIS being rolled out. Fortunately, this meant that we were already very much in the NDIS space five to 10 years ago, and our staff were already in the mindset of what the NDIS would bring. As the NDIS has been rolled out, we've been able to position all of the employment services to align with the needs of the Scheme.

Can you explain the concept of a shared labour pool and how it works?

Sure. We've had access to existing funded services such as disability employment services, Jobactive and Group Training for a while. All of this helped us take that step into trying a shared workforce model. What we're trying to achieve is to be a one-stop shop for providers and employers. We want to help them employ the workforce they need through our various pipelines, including a unique labour hire and mainstream recruitment offering. It's still relatively early days, but we're trying to position ourselves for the disability and human services market.

What's the main benefit of a shared labour pool?

We believe that a shared model is how the market needs to work together. The idea is that, through sharing a workforce, there's efficiency of costs (recruitment, training, HR and admin), better ways of getting people into the sector, and any employers that are accessing that shared workforce can handpick the best people and eventually make decisions to permanently employ those people. Ultimately, we are specialists at maximising government-funded services, getting new people into the sector, and doing it smarter.

> "We want to see more collaboration, which I believe can go beyond traditional employment models to a more contemporary and future-proofed model of workforce strategy and management."

What has the response from providers been?

They typically like the idea. When it comes to the nuts and bolts of making it work, it can be more challenging. Using a contingent workforce is new to the sector, but other industries have proven the effectiveness and need in a market-driven environment. It takes a bit of time to understand everyone and how their services are different,

but we can always overcome this. The key will be cost savings from the services we offer.

Can you share a positive outcome from working with a provider?

We worked with a disability provider where we accessed both state and federal funding. We created a program called 'Host to Hire' which allowed providers to trial new workers in the industry through our shared workforce model. We were able to cover recruitment and training costs to get people into jobs whilst engaging successful job seekers through our third party and host candidates with interested providers. The cost savings for employers were significant, and they were able to trial new staff for six months at a heavily-subsidised rate. The job seekers got training, experience and confidence within the disability industry as support workers.

In one particular region in Queensland, there was a cost saving of over $100,000 in recruitment, training and wage costs in six months. The provider went on to employ over 80 per cent of the people that went through the program on a permanent employment basis. One candidate went from being unemployed as a single mother to successfully gaining a management position. This is something we were extremely proud of. And the disability provider had a whole new way of thinking about their workforce and how they attracted and employed staff.

Looking ahead, what are your NDIS goals?

We've had some great successes of organisations being able to collaborate using our services. We want to see more collaboration, which I believe can go beyond traditional employment models to a more contemporary and future-proofed model of workforce strategy and management. We want to continue being proactive problem solvers around NDIS workforce issues. We need to continue using technology too. As an example, we use video interviews for support workers to make the hiring process more efficient for both hiring managers but also the customer experience. We are proud that we can bring these sorts of ideas and solutions to the sector, and we will continue to support the future workforce and community engagement opportunities that the sector will bring.

16,524 NDIS plans approved in Qld
55% of bilateral estimate

10% NDIS participants are Indigenous
3% Culturally and linguistically diverse

3,559 registered disability service providers

Key issues

Delay in NDIS roll out

Under the bilateral agreement between the Commonwealth and Queensland, two thirds of the state's NDIS participants are scheduled to enter the Scheme in 2018-19. The transition process for partners in community contracts, including Local Area Coordination and Early Childhood Early Intervention, was planned to take place prior, but ended up being delayed. This has caused confusion, inconsistency and uncertainty for both Scheme participants and service providers. To ensure successful transition, greater certainty around timelines is required.

Responding to the needs of remote and regional communities

The challenges of thin markets, inadequate pricing and lack of a local workforce have made it difficult to cater to the needs of remote communities. These challenges are even more acute in Indigenous communities. A local and targeted response is needed to ensure that these communities are not further marginalised.

Lack of market data

To date, the NDIS roll out has not met the volume of participants forecast in Queensland's Market Position Statement. Lack of data by location is hampering evidence-based planning and the ability of both existing and new organisations to meet market need in an effective and efficient manner. In addition, providers may be unable to meet participant needs without winding up in precarious financial positions.

The State of Disability Employment

Make employment a priority

Increasing the rate of employment participation of people with disability should be a key objective of the NDIS. The NDS policy paper, Making Employment a Priority, identifies constructive measures that would ensure that the NDIS actively supports participants to enter the workforce.

Recent data demonstrates the urgent need to enhance and streamline the provision of employment supports. As of June 2018, only 2.0 per cent of NDIS supports for people over 25 years and 5.2 per cent of supports for people 15 to 24 years were for employment.

The NDIS should make 'finding and keeping a job' an NDIS core support, rather than a capacity building support, for participants of workforce age. This employment-first approach should also allow participants to automatically receive ongoing funded supports when a participant can commence work. This would alleviate the need for a plan review and the attendant delays that may prevent a participant gaining a job.

Job seekers with disability who are testing their eligibility for a Disability Support Pension (DSP) should have access to supported employment and/or Disability Employment Services (DES). This is currently restricted as they are ineligible to be paid pro rata wages.

Transition to work programs for school students with disability should be provided from age 15 and assist them to gain work experience and build their workforce confidence and career aspirations.

Finally, the interface between DES and the NDIS should be simplified, and the latter allowed a wider brief to provide complementary supports that will sustain employment for participants.

Open employment undergoing significant change

From 2010 to December 2017, DES providers assisted 415,543 people to start a job and 249,282 people to keep a job for at least 26 weeks.

The new DES contract commenced on 1 July 2018. Providers are experiencing a number of challenges as the new arrangements are bedding down. It is an extremely competitive market, with the number of contracts expanding from 800 nationally to over 2,000 licences nationally. Competition in each Employment Service Region is tight, with providers competing for the same participants and employment opportunities.

The new risk-adjusted funding model was designed to improve outcomes for job seekers who have more barriers to employment; through clearer fee differentiation and a higher level of support. However, the model – which is based on the probability of somebody achieving employment – does not account for the support required. Some cohorts of DES participants that require extensive levels of upfront support in order to be placed and supported in employment are not receiving adequate funding at the front end of the program. This affects, in particular, Eligible School Leavers, job seekers aged under 25, individuals with an intellectual or learning disability, and people on the Autism spectrum.

Job placements for people in these cohorts were previously at relatively high levels due to the extensive supports that could be provided with greater funding. A reduction in the levels of funding for these participants will inevitably lead to poorer job placement rates.

In addition, providers have expressed concern about the introduction of additional compliance obligations when assisting participants that require ongoing support. Providers are adamant that these compliance obligations misallocate their resources and the program's funding and reduce the amount of support that can be provided to

> Sixty-nine per cent of DES providers that responded to the Annual Market Survey said that the introduction of the new DES framework had increased the administrative burden on their organisation either a little or a lot. At least half also expressed dissatisfaction with the current DES policy and operating environment. They disagreed that the policy reforms were heading in the right direction, that the Commonwealth processes were working well, and that the operating environment for DES is more certain.

ensure people with disability maintain their employment.

The problems with the risk-adjusted funding model and the new ongoing support obligations are exacerbating the decline in participants with intellectual disability being placed and supported in jobs. As at June 2018, only 7,634 of DES/ESS (Employment Support Service) participants had an intellectual disability, barely seven per cent of the current caseload.

Only **2%** of NDIS supports for people over 25 years and **5.2%** of supports for people 15 to 24 years are for employment.

Supported employment design discussions continue

The Fair Work Commission (FWC) made an important and very welcome decision in April 2018 following the review hearings for the Supported Employment Services (SES) Award. The application by the advocates and several unions that sought the abolition of all wage tools except the Supported Wage System (SWS) was rejected. The decision proposed a new wage assessment method that factors in both the complexity and scope of a job and an employee's productive output. Existing wage assessment tools (including the SWS) are to be phased out of the Award.

The FWC requested that parties involved in the Award review provide input into the development of a new Classification Structure for Grades 1, 2 and 3 of the Award, specifically covering supported employees.

NDS convened a wage determination working group and has completed some important preliminary work including a set of definitions and a description of the methodology that might be used to assess the complexity and scope of a supported employee's job. The FWC's final decision is expected to provide further guidance on the design of the classification structure. A member of the Full Bench will also preside over a conferral process assisting the Award review parties to design the classification structure.

In another welcome development, the Federal Government made a further strong commitment to the Disability Enterprise sector, announced by then Social Services Minister Dan Tehan at NDS's Disability at Work Conference 2018. The package provides $5.3M in support for organisations paying their employees under the SWS, and $1.5M for sector consultation and trials to inform the development of the new wage assessment mechanism. A key consideration for government will be whether to provide an ongoing subsidy for wage increases that may arise due to decisions made by the FWC, the rate of any subsidy and how it would be administered.

Following the initial round of public consultations by the Department of Social Services, NDS will continue its active involvement in the future design of supported employment, including assisting in the design of longer-term pricing and funding arrangements, to be implemented under the NDIS from mid-2019. NDS has recommended that any sustainable model of supported employment pricing must include the cost of ongoing support, the cost recovery shortfall arising from employees with reduced rates of productive output, and a capital replacement subsidy. NDS is of the view that any wage increase subsidy should be indefinite and paid by DSS, as it is not a reasonable and necessary support as defined by the NDIS.

NDS's BuyAbility initiative continues to promote the social and economic benefits of supported employment. The BuyAbility Social Impact Measurement Tool (independently-verified) shows that, for every dollar of funding expended by government on disability enterprises, the net economic benefit is $3.66.

In the Annual Market Survey, 52 ADEs provided feedback on the current operating environment. More than half of these services disagreed or strongly disagreed that policy reforms were heading in the right direction, that Commonwealth processes impacting ADEs were working well, that the operating environment for ADEs was more certain than 12 months ago, and that the transition to the NDIS had enhanced their performance.

School-to-work transition remains a crucial area of focus

Young people with disability continue to be severely underrepresented in the Australian workforce, however work is being done to change this.

Connecting young people at school with jobs vastly improves their chances of working post-school. NDS's Centre for Applied Disability Research (CADR) has released a Research to Action Guide that identifies the six key elements of effective transitions from school to work for young people. These include building work expectations, stakeholder collaboration, meaningful work participation, skills development, family involvement and early transition planning. All of these elements have been successfully utilised in NDS's Ticket to Work initiative, which is assisting significant numbers of students with disability to achieve their work and career aspirations.

Ticket to Work recently conducted a pilot designed to support students to participate in after-school jobs. An after-school job is a rite of passage for many adolescents and students with disability should be no exception. Ticket to Work uses a longitudinal approach to measure the benefits of work for school students and its positive impacts on their economic and social participation. Ticket to Work networks recently celebrated the creation of over 1,000 jobs for young people with disability. The Ticket to Work traineeship/apprenticeship completion rate is well above the general population.

How NDS is taking action:

- Negotiated supported employment design and providing informed advocacy to government on its future
- Shaped a number of the policy directions – in particular, the granting of an invitation to treat for 3-star and above providers – in the design of the new DES program
- Calling for an employment-first approach that makes 'finding and keeping a job' an NDIS core support
- Securing $33.492M in contracts, with 1,511 supported employee roles engaged across 62 disability enterprises, since the launch of the BuyAbility initiative in 2017
- Supporting 2,000 young people with disability to access career development opportunities while at school through NDS's Ticket to Work initiative
- Influencing the review of the Performance Framework, including determining which data would be incorporated in the 2018 Star Ratings
- Releasing a policy paper, Making Employment a Priority, which identifies constructive measures that would ensure the NDIS actively supports participants to enter the workforce
- Development of the The BuyAbility Impact Tool V2.0; now the pre-eminent social and economic impact measurement tool for supported employment

Victoria

Case study

Ross Coverdale

CEO, Araluen

Tell us a bit about Araluen.

Araluen is based in three local government areas in metro Melbourne. We've been a fairly traditional service, with strong loyalty from our participants and their support networks. We've enjoyed a strong 10 years leading into the NDIS, in which we've been able to attract good staff. We're the only adult day service in the country that has the international gold standard of Autism Accreditation. We support people aged over 18 in the traditional day service model, but also other innovative support initiatives including creating vocational opportunities; individualising support; skills development and the like. We provide group housing, and we're specialising in moving people out of the family home, where they typically live with ageing carers, and into community integrated living.

How has the NDIS transition affected your operations?

We've found ourselves in a growth phase. Our income has gone up significantly since the NDIS started in our area, and more participants now want more support from us. We went through a period in which we thought we might struggle to stay in business, but we've comfortably done that. Our issue now is to have the internal capacity to respond to participant demand and probably double in size. We're forever recruiting. We have to invest in Araluen's structure and people to grow it, and to grow the quality. We're not interested in growing just for the sake of numbers. It has to be about impact, and we have to impact people's lives in a positive way. We exist to help people have great lives. How do we improve growth, quality and culture? That's a different struggle to staying afloat, but it's a struggle. That's our struggle now, and it's not the one we thought we were going to have.

What is the most valuable lesson you've learned?

What we've done best is had good managers and we've sat together and asked: "What do you understand?" and "How does this work?" We've been honest and open with each other. Initially, we believed everything the NDIA told us... But what we found is that we know our business better than anybody. We've had consultants come in, we've listened to a lot of different advice, but we've got a good idea of our business operations, what our capacity is, and what our systems are. And we've sat down together with blank pieces of paper and asked: "How can we make this work?"

The second thing is that we've listened very closely to our customers. We've put a lot of effort into pre-planning. Before families go and have their planning meeting with the NDIA, they've met with us and we've discussed what they'd like and how we can support them through that process. That's gone very well. So we're enjoying high trust levels from participants and their families.

What has been your greatest achievement this year?

One of the best things we've done – which was more than a year's work – is becoming a leader in Investigating Housing Solutions (IHS), moving people with disability out into the community. We've developed a process

and a housing roadshow, and moved 32 people into community living. We've got research partners and a process, and I think that's been some of the most exciting work that we've done. We also started our third café. And that's funded through individualised support and skills development.

Can you share a case study where you achieved a positive outcome for one of your service users? Who were they and what happened?

There's a young man – Fred [not his real name] – who lives with his mum, who has other children. Fred's behaviour was becoming difficult for the family, and his mum wasn't coping. So we began to plan the process for Fred to move out of home. Fred has Autism and doesn't always enjoy the company of others. So rather than put him in a group home that may have resulted in conflict, we were able to upskill Fred and move him into his own unit, and find him a volunteer role in the community. He doesn't have paid support during the day, but has visiting support at home that assists him to live the life that he chooses. Fred has an IHS coordinator that has really helped him out. He has had to work through issues of resilience and expressing appropriate relationships, and we've helped him with those. With the NDIS, we're spending a fraction of what it would have cost in a group home.

If you could go back in time, what would you do differently?

I think we would have worried less. I would say that a lot of the information we gleaned about the NDIS was actually wrong, or wasn't relevant to our context. When we ran all of our pricing scenarios, the actual outcome was far more positive than what we were being told. The thing we should have done is believe in our own abilities and our own capacity more.

What are your NDIS goals for the next few years?

What we now know is that, at this stage, we're still able to attract good staff. So our big goal right now is to embrace the growth. In Melbourne, we're on the edge of what's known as the Whittlesea growth corridor. We're seeking to become a premium provider in that municipality. In that context, we're going to develop all sorts of new models for supporting adults. They won't be traditional models. And that will probably lead us to double our organisation.

39,180 NDIS plans approved in Vic
83% of bilateral estimate

2% NDIS participants are Indigenous
7% Culturally and linguistically diverse

4,923 registered disability service providers

Key issues

Ongoing support from NDS's Sector Development Program

With funding from the Victorian Government's Transition Support Project, NDS will continue providing disability service providers with the advice they need to support their transition to the NDIS throughout the 2018-19 year. We are keen to ensure that funding to support sector transition continues to be available after June 2019.

A voluntary Disability Worker Accreditation and Registration Scheme

NDS was successful in making the case for a voluntary rather than mandatory Victorian Disability Worker Accreditation and Registration Scheme in the 2017-18 year. We were concerned that a mandatory scheme would act as a barrier to workers entering the sector at a time when it needs to grow. NDS continues to undertake project work and advocacy to support the growth of, and quality of services provided by, the Victorian workforce.

Disability transport difficulties

NDS members report challenges in providing transport services under NDIS prices. NDIA restrictions around provider travel claims and scarcity of funding for participant transport in NDIS plans exacerbate this. NDS continues to work with the Victorian Government to address these issues, including advocating for the Victorian Mobile Passenger Transport Program to be extended to NDIS participants beyond June 2019.

Northern Territory

Case study

Kim McRae

Tjungu Team Manager, NPY Women's Council

Tell us a bit about NPY Women's Council.

NPY Women's Council provides a range of services and advocacy for people living in the remote cross-border region of the Northern Territory, Western Australia and South Australia. In the disability space, we've been receiving disability funding under the Tri-State Disability Agreement since 2005 – providing case management, flexible respite, and transport associated with that respite. We work with people with disability and their families and we support people to continue living on country, with kin, connected to culture, for as long as they are able to. Our big focus is keeping people on country, and we do that by supporting the whole family, because the family provides the care out there.

How has the NDIS affected your operations?

It's been incredibly time-consuming trying to attend all the NDIA information sessions; trying to get staff trained to move away from the case management model that we have previously used for people out in communities and more into the support coordination model… There are quite significant differences there, so it's been a big issue in terms of advocacy.

The amount of time we've had to spend advocating to the NDIA about what people in remote communities actually want in terms of disability supports has been significant too. Material poverty is a huge issue for people out there… Often food, shelter and safety are the big issues for our families. The NDIS can't particularly purchase food, or swags and blankets for people – which is what our families often ask for because they're highly-mobile and often don't have a bed. The NDIA has an Aboriginal and Torres Strait Islander Communities Engagement Strategy, but the reality of how that's being applied out in community is different. How can we support the whole family to maintain the care for that person? Those kinds of concepts aren't really supported well by the current structure of services through the NDIS.

What's been your greatest achievement this year?

I think one of our biggest achievements has been maintaining stable staffing in an environment where there's no guarantee what's going to happen tomorrow; and where we're dealing with declining levels of block funding because of the NDIS. We've invested heavily in trying to maintain our existing staff. And that's important, because working in Aboriginal communities, the work you do is based on having trusting relationships with clients and families. Those relationships take a long time to build. We want those staff members to stay here and continue those relationships.

What's the most valuable lesson you've learned?

We have to be very careful to look after ourselves, because burnout is a huge risk in the environment we're in. Also, trying to reassure our clients and families that they'll continue to receive supports even though there are going to be changes. I've become more focused on what it is we're going to be able to provide for people with disabilities and their families under the NDIS – focusing on trying to maintain the quality of services despite the

cost pressures. That remains the most important issue for us. We don't want to compromise on that because of NDIS pricing. What that might mean is that the range of supports we provide might decrease, because we're trying to focus on what we can do well, within that pricing structure.

I've also learned how important it is to keep raising issues and negotiating with the NDIA around things like remote travel. The cost of remote travel in our communities is very high, and we have to be upfront about that. We've had to be prepared to say 'no' if they don't come to the party. If they're not willing to pay what it costs, we can't do it. We've had to stand up and speak out about what's required, and be prepared for the fact that we may have to stop doing some things.

If you could go back in time, what would you do differently?

Because we've come from an environment of block funding, you kind of felt obliged to go along with the NDIA and try and accommodate the way they do business. But what I've realised – particularly in the past 12 months – is that I just need to challenge that at every opportunity. You've got to be upfront. If you don't get the answer you want from one person in the NDIA, try 10 others that you know. You have to be really frank and fearless, because the issues are so important for people with disability living out in those remote areas. To keep those people out there, we're going to have to fight a very good fight. Otherwise, a lot of people are going to be forced to live in town in supported accommodation because of the lack of services out in the community. And with a little flexibility on the part of the NDIA, they could have the choice to continue living out on country.

What are your NDIS goals for the next few years?

We've kind of lived in a survival mode for the past few years where we're not sure when our block funding is going to end. The big picture, in my mind, is people still living out on country; still with their families; in their communities; doing the things that they want to do every day; being part of the culture and the community, with better services than are available now – because the services out there need to improve.

843 NDIS plans approved in NT
52% of bilateral estimate

78% NDIS participants are Indigenous
38% Culturally and linguistically diverse

602 registered disability service providers

Key issues

Thin and failing markets

Thin and failing markets are continuing areas of concern in the Northern Territory. Of the $197M that has been committed in participant plans to June 2018, only $67.3M has been paid. This represents around 34 per cent; significantly lower than the national average of 64 per cent. Investment in industry development is needed, as well as access to a quarterly market opportunity report by region from the NDIA.

Workforce challenges

Difficulty accessing qualified and experienced staff is already being felt in the NT during NDIS transition, particularly in regional and remote areas. There is anticipated required growth of around 1,300 additional staff to meet the demand at full Scheme in the NT. Investment in workforce planning and development is urgently needed to support continued market growth.

Transport shortages and challenges

Transport in the NT is very limited and expensive. In the place of current funding tiers, an alternative approach to funding remote transport is required to address the challenges and to enable Indigenous participants to return to country without impacting on their core supports. It is imperative that both NDIS prices and engagement models are sufficiently flexible to reflect the cultural norms and costs of delivering services in isolated and Indigenous communities.

The State of the Workforce

Economic and labour market conditions have been improving in most parts of Australia over the past year.

Recent Australian Bureau of Statistics (ABS) data reveals a more vibrant labour market, with more people employed and higher labour force participation. Job vacancies have increased significantly across all industries. Seventy-eight per cent of 15 to 64-year-olds are now in the labour force; the highest rate on record (ABS, August 2018).

In the disability sector, growth has been particularly rapid. NDS workforce data for June 2018 showed a net growth rate for disability support workers of 2.5 per cent, which is equivalent to 10 per cent annually. This compares to an all-industry figure of 2.5 per cent over the past year.

Recruiting disability support workers is becoming more difficult

The challenge of recruiting disability support workers has become greater this year.

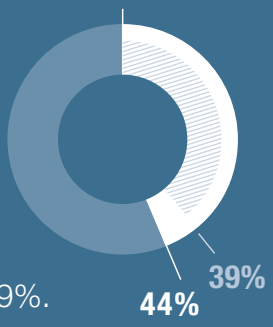
- Nearly two thirds of respondents (63 per cent) reported extreme or moderate difficulty in recruiting disability support workers, up from 42 per cent in 2017.
- Managers and supervisors moved into the 'difficult-to-recruit' category this year for over half of respondents, compared to around one third in 2017.

The most acute recruitment difficulties reported in 2018, as in the two previous years, were for allied health positions.

- Psychologists, physiotherapists, speech therapists and occupational therapists were the top four hardest-to-recruit occupations, with a majority of those responding to this question reporting 'extreme' or 'moderate' difficulty. (See table on p56.)
- Although these were also hard-to-recruit professions in 2016 and 2017, it has become more difficult to recruit as the NDIS rolls out.

Specific skill shortage occupations identified this year include music therapists, pedorthists, custom medical grade shoe-makers, people with a mental health speciality, social workers and, as in 2017, psychologists.

Disability support workers are slightly older than the average Australian worker: Some 44% are aged 45 years or more. In the workforce more generally, this figure is 39%.



Providers getting better at facing challenges

At the same time, nearly two fifths of providers said that it was 'easy' or 'not hard to recruit' support workers. Comments suggested that some organisations feel they are getting better at meeting the challenges of attracting and retaining suitable people:

> "We have very actively tackled our workforce issues. We have been able to recruit and retain better than other organisations in our sector … but it's still difficult, especially for our rural locations."

> "Our workforce is older and, to retain, we are having to reduce hours and offer greater flexibility."

Retention difficulties may also be lessening, with the number of respondents saying they were finding it 'extremely or moderately difficult' to retain disability support workers falling by nearly 10 percentage points from 2017, suggesting employers may be learning what it takes:

> "We have a very high emphasis on the non-financial benefits of working with us - great culture, passion, flexible working, etc."

The hardest-to-retain groups were again the major allied health professionals.

Recruiters tailoring to demand

Providers consistently emphasise that, as the NDIS roll out vastly increases demand, recruitment and selection have become more challenging.

Employers say that they are now recruiting more reactively

to demand, seeking to match new clients to staff with:

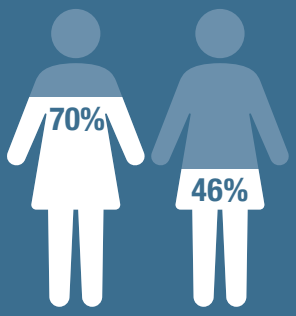
- specific job skills or experiences (e.g. behaviour support)
- personality or demographic characteristics that match customer preferences
- the ability to work flexible hours in order to fit the shifts clients want

> "Finding the right skills and competencies of support workers to match client interests/needs is becoming more difficult, particularly in regional areas where the pool of good and available staff is smaller."

> "The rate of pay and security of employment (guaranteed hours) make it difficult to recruit and retain support workers."

> "Stress has escalated due to the constant cycle of helping families prepare for planning (they are stressed), getting inappropriate plans and poor/ incorrect advice about managing them … and then trying to provide a decent service with insufficient funding. This makes working in this field so much less interesting and sustainable."

About 70% of disability support workers are women, compared to a figure of 46% in the wider Australian workforce.



Remote, rural and regional areas the hardest

As in previous years, recruitment and retention difficulties are exacerbated in remote rural and regional areas. Organisations that cover both metro and rural areas commented on the contrast:

> "It's completely different in rural areas. We simply do not have the numbers to keep up with demand. Too isolated from bigger areas to access some professionals. Transport limited to travel to other services for provision."

Providers see risks associated with workforce pressures

In addition to recruitment, Annual Market Survey respondents highlighted several ongoing workforce issues of concern. Foremost are risks to clients and safety, and risks associated with insufficient time to induct, train and facilitate staff development, undermining the principles of the NDIS:

> "The inability to provide more than very basic training for staff represents a huge risk to the entire sector."

> "We are having to employ people with lower skill and competency levels than we would like due to the low payments from the NDIS. This means less choice for the participants."

How NDS is taking action:

- Offering job board and recruitment tools specifically for the disability sector via carecareers.com.au
- Providing training programs and modules via NDS Learn and Develop
- Offered online workforce benchmarking tool, Workforce Wizard, to help disability organisations track workforce trends
- Providing a one-stop-shop of disability workforce tools and resources at the NDS Workforce Hub
- Launched 'Purpose and People', a national network which meets regularly to support service providers interested in self-organising teams to re-design their workforce
- Managing The Innovative Workforce Fund, an Australian Government-funded initiative designed to encourage the development of innovative workforce practices to support the roll out of the NDIS. So far, NDS has supported 30 projects nationally to identify new ways to engage, develop and use their workforce.
- Developed 'People Search', a searchable database available on carecareers.com.au that enables job seekers to post their profiles and employers to find potential employees
- Publishing the Australian Disability Workforce Report, which documents trends in the disability support and allied health workforces

Table 2 In the past financial year, how easy or difficult has it been to **recruit** competent staff in the following categories?

Occupation category	Percentage of respondents that answered 'extremely or moderately difficult'
Psychologist	83%
Physiotherapist	76%
Speech therapist	75%
Occupational therapist	73%
Local Area Coordinator/ Planner	64%
Disability support worker	63%
Dietitian	63%
Managers/supervisors of disability support	55%
Support Coordinator	50%
HR/Workforce Development	38%
Marketing/business development	38%
Information Technology	37%
Finance/Accounting	32%

Table 3 In the past financial year, how easy or difficult has it been to **retain** competent staff in the following categories?

Occupation category	Percentage of respondents that answered 'extremely or moderately difficult'
Psychologist	53%
Speech therapist	40%
Physiotherapist	38%
Dietitian	33%
Disability support worker	33%
Occupational therapist	32%
Support Coordinator	27%
Local Area Coordinator/ Planner	26%
Marketing/business development	23%
HR/Workforce Development	23%
Managers/supervisors of disability support workers	23%
Finance/Accounting	17%
Information Technology	17%

“

NDS is determined to do all we can to make the NDIS work for all stakeholders, to increase employment opportunities for people with disability, and to inject new life into the National Disability Strategy.

”

Publisher
National Disability Services

Chris Tanti
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About National Disability Services
National Disability Services is Australia's peak body for non-government disability service organisations, representing about 1,100 service providers. Collectively, NDS members operate several thousand services for Australians with all types of disability.

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Productivity Commission

National Disability Insurance Scheme (NDIS) Costs

Productivity Commission Study Report

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The Productivity Commission

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Further information on the Productivity Commission can be obtained from the Commission's website (www.pc.gov.au).

Foreword

The National Disability Insurance Scheme (NDIS) is a new scheme designed to change the way that support and care are provided to people with permanent and significant disability.

This study is a review of NDIS costs. The Heads of Agreement between the Australian and State and Territory Governments on the NDIS stated that the Productivity Commission would undertake a review of NDIS costs in 2017, to inform the final design of the full scheme prior to its commencement.

The Commission, and this study, benefited from discussions and submissions from people with disability, advocacy groups, peak bodies, disability care and support workers and government. We are grateful for the valuable contribution of all those who contributed to this study.

Angela MacRae
Commissioner

Richard Spencer
Commissioner

October 2017

Terms of reference

REVIEW OF NATIONAL DISABILITY INSURANCE SCHEME COSTS

I, Scott Morrison, Treasurer, pursuant to Parts 2 and 4 of the *Productivity Commission Act 1998*, hereby request that the Productivity Commission (the Commission) undertake a study into the National Disability Insurance Scheme (NDIS) costs.

Background

The Heads of Agreement between the Commonwealth and the States and Territories (States) on the NDIS stated that the Commission would undertake a review of scheme costs in 2017. This review is intended to inform the final design of the full scheme, prior to its commencement.

Scope of the study

The Commission should address the following issues identified in the Heads of Agreement for the review of scheme costs:

- the sustainability of scheme costs;
- jurisdictional capacity;
- cost pressures (including wages pressures);
- changes in the agreed escalation parameters;
- if efficiencies have been achieved within the scheme;
- whether there has been any impact on mainstream services; and
- examine the most appropriate levers to manage any potential cost overruns.

In addressing these issues, the Commission should consider:

1. Commonwealth and State funding and governance arrangements for the NDIS, including financial contributions and risk-sharing;
2. the interaction with, and role of, other services in meeting reasonable and necessary support for people with severe and profound disability; and

3. whether there are any issues with the scheme's design, including the application of market and insurance principles, in ensuring the best possible outcomes for people with severe and profound disability.

In conducting the analysis, the Commission should take into account its 2011 report into disability care and support and subsequent agreements between governments for the implementation of the NDIS. The Commission will be provided with all the data on scheme rollout it considers necessary for the analysis.

Process

The Commission is to consult broadly, including with the Australian, State and Territory Governments.

The Commission will report within eight months of receipt of the terms of reference, or by 15 September 2017, whichever is later.

Scott Morrison
Treasurer

[Received 20 January 2017]

Letter of extension

TREASURER

Peter Harris AO
Chairman
Productivity Commission
Locked Bag 2, Collins St East
Melbourne VIC 8003

Dear Mr Harris Peter

I agree to your request to extend the final reporting date of the Productivity Commission's study on National Disability Insurance Scheme (NDIS) Costs from 20 September 2017 to 11 October 2017.

I trust that the extension will give the Commission enough time to incorporate feedback from stakeholders, and refine the Commission's recommendations on the areas outlined in the terms of reference and any issues identified in the consultation process.

Yours sincerely

The Hon Scott Morrison MP
24 / 7 / 2017

Parliament House Canberra ACT 2600 Australia
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Contents

Abbreviations

AAT	Administrative Appeals Tribunal
ABS	Australian Bureau of Statistics
ACC	Accident Compensation Corporation
ACFI	Aged Care Funding Instrument
AIHW	Australian Institute of Health and Welfare
ALNSW	Ability Links NSW
ANAO	Australian National Audit Office
ANZSCO	Australia-New Zealand Standard Classification of Occupations
ASIC	Australian Securities and Investments Commission
CALD	Culturally and linguistically diverse
CEO	Chief Executive Officer
COAG	Council of Australian Governments
CSIRO	Commonwealth Scientific and Industrial Research Organisation
DCAF	DisabilityCare Australia Fund
DES	Disability Employment Service
DRC	COAG Disability Reform Council
DSO	Disability Support Organisation
DSS	Department of Social Services
ECEI	Early Childhood Early Intervention
ELNSW	Early Links NSW
FTE	Full-time equivalent
FWC	Fair Work Commission
GDP	Gross Domestic Product
HRM	Hourly Rate Model
IAC	Independent Advisory Council
ICT	Information and communication technology
ILC	Information, Linkages and Capacity Building

LAC	Local Area Coordinator
LCAS	Lifetime Care and Support
MS	Multiple Sclerosis
NDA	National Disability Agreement
NDAP	National Disability Advocacy Program
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Services
NEC	National Efficient Cost
NEP	National Efficient Price
NIIS	National Injury Insurance Scheme
OECD	Organisation for Economic Cooperation and Development
PC	Productivity Commission
PEDI-CAT	Paediatric Evaluation of Disability Inventory-Computer Adaptive Test
PGPA	Public Governance, Performance and Accountability
POLR	Provider of last resort
QSC	Quality and Safeguards Commission
SDAC	Survey of Disability, Ageing and Carers
SDF	Sector Development Fund
SLES	School Leaver Employment Support
SNAT	Support Needs Assessment Tool
SSA	Shared Supported Accommodation
TAC	Transport Accident Commission
VET	Vocational Education and Training
WA NDIS	Western Australian National Disability Insurance Scheme

OVERVIEW

Key points

- The National Disability Insurance Scheme (NDIS) is a complex and highly valued national reform. If implemented well, it will substantially improve the wellbeing of people with disability and Australians more generally.
- The level of commitment to the success and sustainability of the NDIS is extraordinary. This is important because 'making it work' is not only the responsibility of the National Disability Insurance Agency (NDIA), but also that of governments, participants, families and carers, providers, and the community.
- The scale, pace and nature of the changes that the NDIS is driving are unprecedented in Australia. To reach the estimated 475 000 participants in the scheme by 2019-20, the NDIA needs to approve hundreds of plans a day and review hundreds more. The reality is that the current timetable for participant intake will not be met. Governments and the NDIA need to start planning now for a changed timetable, including working through the financial implications.
- Based on trial and transition data, NDIS costs are broadly on track with the NDIA's long-term modelling, but this is in large part because not all committed supports are used. While some cost pressures are emerging (such as higher numbers of children entering the scheme), the NDIA has put in place initiatives to address them. The benefits of the NDIS are also becoming apparent. Early evidence suggests that many (but not all) NDIS participants are receiving more disability supports than previously, and they have more choice and control.
- In the transition phase, the NDIA has focused too much on quantity (meeting participant intake estimates) and not enough on quality (planning processes), supporting infrastructure and market development. For the scheme to achieve its objectives, the NDIA must find a better balance between participant intake, the quality of plans, participant outcomes, and financial sustainability.
  - Greater emphasis is needed on pre-planning, in-depth planning conversations, plan quality reporting, and more specialised training for planners.
- A significant challenge in the transition phase is developing the supply of disability services and growing the disability care workforce. It is estimated that 1 in 5 new jobs over the next few years will need to be in disability care, but workforce growth remains way too slow.
  - Emerging shortages should be addressed by independent price monitoring and regulation, more effective coordination among governments to develop markets (including intervening in thin markets), a targeted approach to skilled migration, and equipping participants to exercise choice.
- The interface between the NDIS and other disability and mainstream services is critical for participant outcomes and the financial sustainability of the scheme. Some disability supports are not being provided because of unclear boundaries about the responsibilities of the different levels of government. Governments must set clearer boundaries at the operational level around 'who supplies what' to people with disability, and only withdraw services when continuity of service is assured.
- NDIS funding arrangements should better reflect the insurance principles of the scheme. Governments need to allow flexibility around the NDIA's operational budget and commit to establishing a pool of reserves.

Overview

1 About the National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is a new scheme designed to change the way that support and care are provided to people with permanent and significant disability (a disability that substantially reduces their functional capacity or psychosocial functioning). The NDIS is currently being rolled out across Australia. At full scheme, about 475 000 people with disability will receive individualised supports, at an estimated cost of $22 billion in the first year of full operation.

The NDIS is based on the premise that individuals' support needs are different, and that scheme participants should be able to exercise choice and control over the services and supports they receive. The scheme differs from previous approaches in a number of ways:

- it adopts a person-centred model of care and support
- it is an insurance-based scheme — it takes a long-term view of the total cost of disability to improve participant outcomes and to meet the future costs of the scheme (box 1)
- funding is determined by an assessment of individual needs (rather than a fixed budget)
- it is a national scheme.

The NDIS funds reasonable and necessary supports for Australians with permanent and significant disability. Reasonable and necessary supports are those that help participants live as ordinary a life as possible, including care and support to build their skills and capabilities, so they can engage in education, employment and community activities.

The NDIS also funds supports for people who meet early intervention criteria. This covers cases where early intervention can significantly improve an individual's outcomes and is cost effective. The focus on early intervention reflects the lifetime approach of the scheme (which is consistent with insurance principles, box 1).

Individuals eligible for the scheme are assessed, and individualised support packages are developed and funded for them. NDIS access, planning and payments are managed by the National Disability Insurance Agency (NDIA). (In Western Australia, arrangements are different, but intended to be consistent with the NDIS.)

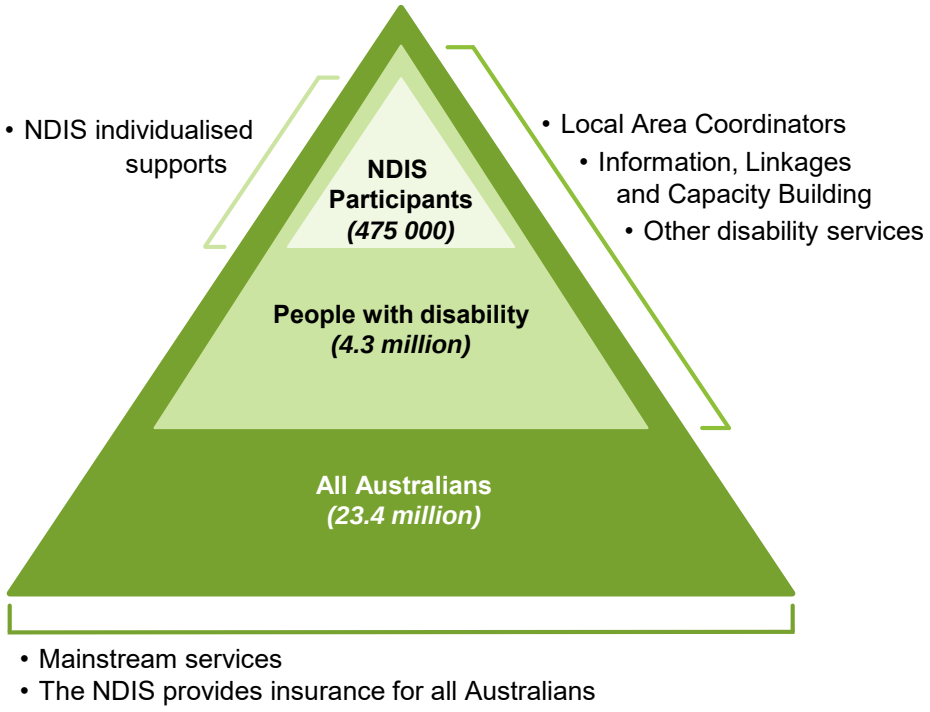
Information, Linkages and Capacity Building (ILC) services are also provided under the NDIS. ILC services provide information about, and referrals to, community and mainstream services (including health, education, employment, transport, justice and housing). These services are available to the 4.3 million people with disability in Australia (figure 1).

Box 1 The NDIS is based on insurance principles

The National Disability Insurance Scheme provides universal coverage by pooling risk across all Australians and taking the risk of disability support costs away from individuals. It is based on four insurance principles.

1. Actuarial estimates of long-term costs — updated to reflect the experience of the scheme, and used to help ensure the scheme is financially sustainable and continuously improved.
2. A long-term view of funding requirements — takes a lifetime view of participant needs and seeks early investment and intervention for people in order to maximise their independence and social and economic participation, and reduce their long-term support requirements.
3. Investment in research and innovation — to encourage and build the capacity and capability for innovation, outcome analysis and evidence-based decisions on early intervention.
4. Investment in community participation and building social capital — to make the community accessible and inclusive for people with disability, and provide participants and non-participants with necessary supports outside the scheme, through: mainstream services; Information, Linkages and Capacity Building initiatives; and education programs.

Figure 1 The NDIS is part of a broader system of supports[a]



[a] Number of Australians and those with disability are based on 2015 data. NDIS participants are the projected number of people eligible in 2020.

The governing legislation for the NDIS is the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act). The Act establishes the NDIA, the independent statutory agency responsible for administering the NDIS. The NDIS Rules and Operational Guidelines set out the operational details of the NDIS. Funding for the NDIS is shared by the Australian, and State and Territory Governments.

Some background to the scheme

The Commission's inquiry in 2011 on *Disability Care and Support* found that Australia's system of disability support was inequitable, underfunded, fragmented, inefficient, and gave people with disability little choice and no certainty of access to appropriate supports. The Commission recommended a new national scheme to provide insurance cover to all Australians in the event of significant disability. This recommendation was based on the finding that such a scheme would generate substantial net benefits, including:

- improved wellbeing of people with disability (and their families and carers)
- better options for people with disability for education, employment, independent living and community participation
- efficiency gains and cost savings in the disability support system and savings to other government services.

The Commission's recommendations on the national scheme were largely accepted by Australian governments. The *Intergovernmental Agreement for the NDIS Launch* was signed by the Australian and State and Territory Governments in December 2012.

2 What we were asked to do and our approach

In the Heads of Agreement on the NDIS signed by the Australian and the State and Territory Governments in 2012 and 2013, it was agreed that the Productivity Commission would review NDIS costs in 2017 to inform the final design of the full scheme prior to its commencement.

The terms of reference for this study ask the Commission to look at:

- the sustainability of scheme costs, including current and future cost pressures, and how to manage any potential cost overruns
- whether jurisdictions have the capacity to deliver disability care and support services as the scheme expands
- how the NDIS impacts on, and interacts with, mainstream services
- whether efficiencies have been achieved within the scheme

- whether there are any issues with scheme design, including the application of market and insurance principles, in ensuring the best possible outcomes for people with profound or severe permanent disability
- funding and governance arrangements, including escalation parameters.

What factors drive scheme costs?

The majority (about 90 per cent) of NDIS costs are for individualised supports, but there are also the costs of operating the scheme and funding ILC activities. Key factors driving scheme costs include the:

- number and characteristics of participants
- scope of supports covered by the scheme
- quantity of supports received by participants
- proportion of supports in a plan that is utilised by a participant
- price paid for supports under the scheme
- costs associated with operating the scheme.

Scheme culture is also an important driver of costs. Moving away from the welfare culture of current disability systems to one of providing reasonable and necessary supports, and managing down the total cost of disability over a participant's lifetime, will be critical for the financial sustainability of the scheme.

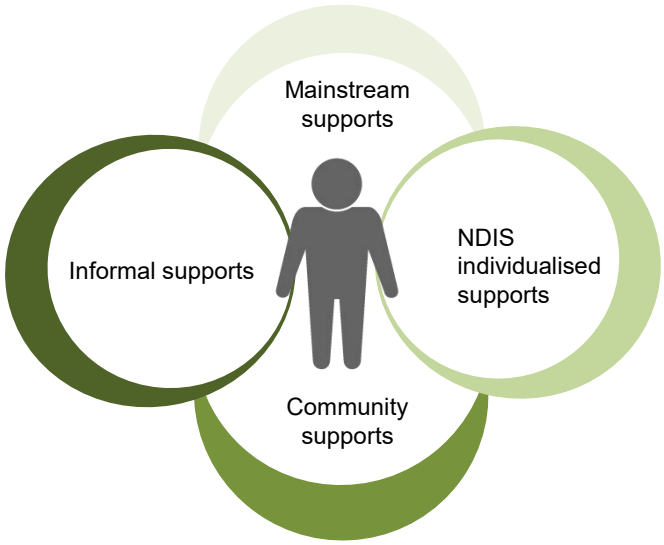
Other support systems can also affect scheme costs. The NDIS, as a person-centred approach to providing disability supports, relies on supports and services outside the scheme, including informal supports (family, friends and neighbours), community supports (sporting, social and interest groups), and mainstream supports (public transport, health and education), to help people with disability to live ordinary lives (figure 2). If these supports are not available, people with disability could seek NDIS funding to fill the gap, and this could pose a risk to scheme costs.

Costs are one side of the equation — benefits are just as important

While the focus of this study is on scheme costs and the financial sustainability of the scheme, the Commission examined costs in light of the benefits and impacts of the scheme on the lives of people with disability, and Australians more generally, using a wellbeing framework.

The NDIS was introduced because it has potential to improve the lives of people with disability and the community more generally (by providing insurance for all Australians and lowering future costs of providing disability support). It is therefore essential that the costs to the community are considered in the context of scheme outcomes.

Figure 2 **A person-centred approach relies on supports beyond the NDIS**



Taxpayers' willingness to fund the NDIS will depend on their perception of value for money, in terms of:

- people with disability experiencing better lives as a result of the scheme
- the scheme making it easier for families and carers to play a supporting role
- the way the scheme invests in people with disability
- the confidence taxpayers have that the NDIS will be available to cover their care needs (or those of their loved ones) should a disability be acquired in the future
- the supports that are funded (and the evidence base to support what is funded)
- efficiency gains and cost savings in the disability support system and other government services.

While the NDIS is sometimes described as an 'uncapped scheme', the ultimate cap — and test of financial sustainability — is taxpayers' continuing willingness to pay for it. In line with this, the NDIA defines financial sustainability for the NDIS as:

- the scheme is successful on the balance of objective measures and projections of economic [and] social participation and independence, and on participants' views that they are getting enough money to buy enough high-quality goods and services to allow them reasonable access to life opportunities — that is, reasonable and necessary support; and
- contributors think that the cost is and will continue to be affordable, under control, represents value for money and, therefore, remain willing to contribute.

The NDIA's actuarial estimates of long-term costs (which reflect the experience of the scheme and management responses to cost pressures) play an important role in

demonstrating to the Australian community that the scheme is sustainable. Governments also need to demonstrate that the NDIS funds are dollars well spent.

Financial sustainability of the NDIS also needs to be considered in the context of the efficiency and effectiveness of the NDIA, the readiness of participants and providers, and the integration of the scheme with mainstream and other disability services. Only a system that is integrated and holistic in its focus will bring the benefits that the scheme is expected to deliver.

3 An enormous challenge

The NDIS is a major, complex national reform — the largest social reform since the introduction of Medicare. It will:

- involve a shift away from a block-funded welfare model of support, to a fee-for-service market-based approach
- increase funding in the sector from about $8 billion per year to $22 billion in 2019-20
- involve assessing the reasonable and necessary needs of about 475 000 people
- require about 70 000 additional disability support care workers (or about 1 in 5 of all new jobs created in Australia over the transition period)
- substantially improve the wellbeing of people with disability and Australians more generally (if implemented well).

It is therefore no surprise that the NDIS is described as ‘ground-breaking’ and a ‘once-in-many-generation reform’.

The level of commitment to the NDIS is extraordinary

There is an extraordinary level of commitment to the success and sustainability of the NDIS (and to preserving the core principles of the scheme) shared by governments, people with disability and their families and carers, providers of disability services and disability advocates (box 2). As the Australian Disability Discrimination Commissioner said:

> Yes — the NDIS is big, it is complex, and it changes everything, but it is the change that we need. And when we think about what life might be like for people with disability without the NDIS, I think it becomes clear that it is the change we cannot afford to prevent. … If we want real and lasting change for people with disability, we cannot absolve ourselves of our responsibility to make the NDIS work.

Box 2 **There is overwhelming support for the NDIS**

NSW Council for Intellectual Disability:

> … we have been strong supporters of the development of the NDIS and we continue to see [the] scheme as having a fundamental capacity to improve the lives of people with disability around Australia.

Flourish Australia:

> … strongly supports the NDIS and the opportunity it provides for greater certainty, choice and control, and economic and social participation for people with disability who require life-long support.

JFA Purple Orange:

> … the NDIS is a major, once-in-many-generations opportunity to invest in the life chances of people living with disability, to achieve a fair go, so that people living with disability take their rightful place as … valued active members of Australian community life and the economy.

National Disability Services:

> The principles on which the NDIS is founded remain compelling and inspiring.

Australian Federation of Disability Organisations:

> We want to begin … by emphasising our unwavering support for the NDIS. AFDO and its members regularly hear from people with disability and their families about the difference the NDIS is making to their lives. People who now have the dignity of appropriate and timely support, the opportunity to be more involved in their communities, the chance to move out of home, the economic freedom of a new job. These are the kinds of differences the NDIS is making.

Anglicare Australia:

> … strongly believes that the establishment of the NDIS is a major achievement. Our member agencies are already witnessing the transformative power of the scheme for participants, and finding that reconfiguring services to reflect their needs and aspirations is creating opportunities to reimagine and create better outcomes in people's lives.

New South Wales Government:

> The NSW Government is a strong advocate of the National Disability Insurance Scheme (NDIS). The improvement in the lives of people with disability, as outlined by the Productivity Commission (PC) in its 2011 inquiry report into Disability Care and Support, is a goal embraced by NSW.

The rollout schedule

The NDIS was trialled from 2013 in different jurisdictions across Australia in four trial sites (including two whole-of-state age cohort trial sites, table 1). The Bilateral Agreements between the Australian and the State and Territory Governments set out the timeframes, and the estimated number of people who will become participants in the scheme, for the transition to full scheme in each jurisdiction. The full scheme is scheduled to be rolled out nationally by 2019-20, but some jurisdictions are scheduled to move to full scheme earlier.

Table 1 **NDIS transition arrangements by jurisdiction**

	Trial period			Transition to full scheme			Full scheme
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
NSW	Hunter area trial			Transition to full scheme (by region)		Full scheme	
			Early Transition in Nepean Blue Mountains area (children aged 0–17 years)				
Vic	Barwon area trial			Transition to full scheme (by region)			Full scheme
Qld				Transition to full scheme from July 2016 (by region). Early Transition from January 2016 in Townsville, Charters Towers and Palm Island			Full scheme
SA	Statewide trial (children aged 0–14 years)			Transition to full scheme (by age and region)		Full scheme	
Tas	Statewide trial (people aged 15–24 years)			Transition to full scheme (by age)			Full scheme
NT		Barkly region trial		Transition to full scheme (by region)			Full scheme
ACT[a]		Territorywide trial		Full scheme			
WA[b]		Perth Hills area trial		Transition to locally administered NDIS			
		MyWay trial					

[a] The Bilateral Agreement for the NDIS launch between the Australian Government and the ACT Government notes that from 2016-17 the ACT will be in 'transition to full scheme'. This transition has been categorised as 'full scheme' because all residents who meet the eligibility criteria will have access to the scheme. [b] In February 2017, the Australian Government and Western Australian Government signed a Bilateral Agreement for a nationally consistent, but locally administered, NDIS.

Transition — a unique and challenging period in the life of the scheme

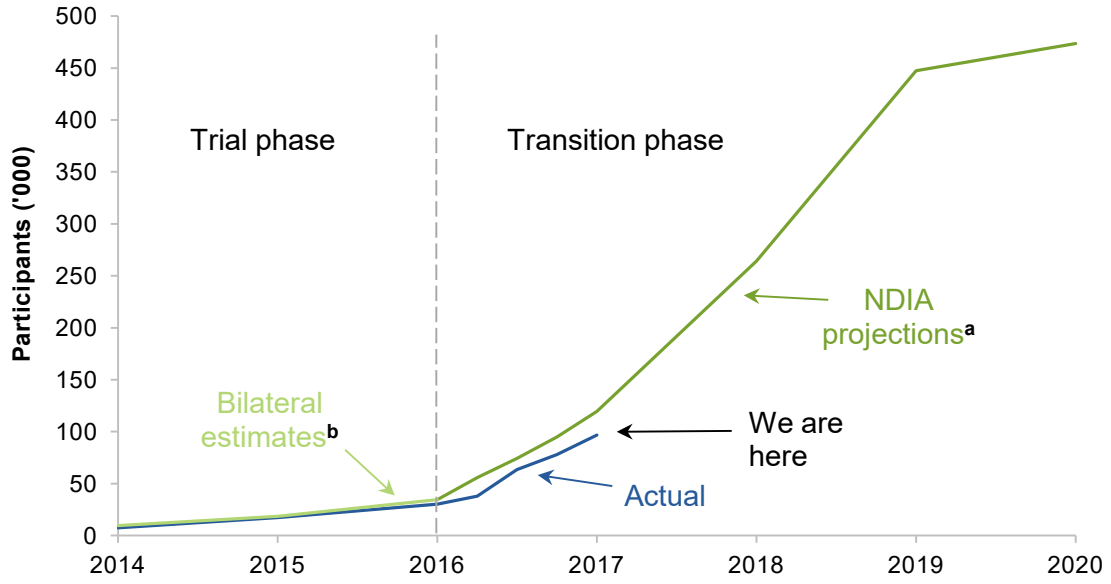
The transition period is a unique period in the life of the scheme. Never again will:

- the number of new participants be entering the NDIS over such a compressed timeframe
- so many disability support service providers be facing the challenge of transitioning from a block-funded model of support to a fee-for-service market-based approach
- so many new scheme participants be learning how to navigate a new scheme where they have choice and control over disability supports (making the change from passive recipients of supports to informed consumers).

Participant intake

The NDIA has been given an extremely difficult task — the rollout schedule is highly ambitious given the magnitude of the reform. To reach the estimated 475 000 participants at full scheme by 2019-20 (figure 3), the NDIA needs to approve hundreds of plans a day.

Figure 3 **Participant numbers will increase substantially over the next three years[a]**



[a] Scheme participant projections are based on projections prepared by the Scheme Actuary for the NDIA's 2015-16 Annual Financial Sustainability Report using data at 30 June 2016. The Commission adjusted the projected number of participants for the four quarters of 2016-17 to be consistent with the bilateral estimates reported in the latest NDIA quarterly report. [b] Bilateral estimates based on the NDIA's quarterly reports.

In the June 2017 quarter, the NDIA approved about 15 000 plans, or roughly 165 plans a day. In 2018-19 (the final year of transition), the NDIA will need to approve about 500 plans a day, while also reviewing hundreds more.[1]

One study participant described the transition arrangements as 'a tsunami of new participants' that will need to be processed into the scheme over the next two years. A number of study participants questioned whether the intake timetable could, or should, be met. And many raised concerns about the NDIA's focus being on participant numbers with little attention on planning processes. House with No Steps, for example, said:

> … the Scheme has aggressive ramp-up targets. These are putting pressure on the NDIA's capacity to develop quality plans for participants. Unfortunately, the need to achieve high growth in participant numbers appears to be outweighing considerations of plan quality and consistency.

The intake of participants with approved plans is already falling behind the expected pace. If the trend of delivering about 80 per cent of the bilateral estimates continues (figure 3), it will take an additional year before all eligible participants are in the scheme. (And this delay could be longer if the scheme falls further behind when the participant intake ramps up in 2017-18.)

1 Based on NDIA modelling.

The reality is that the rollout timetable for participant intake will not be met.

This means that 'full scheme' (the time when everyone eligible to enter the NDIS will be able to do so and have an approved plan) will be delayed beyond 2019-20 — that is, beyond the date anticipated in the Bilateral Agreements. Governments need to start planning now for a new participant intake timetable, including working through the financial implications.

NDIA's focus on participant intake has compromised the quality of plans and participant outcomes. Quality plans are critical, not only for participant outcomes but also for sending the right signals to providers about demand for supports and containing long-term costs of the scheme. The Commission makes several recommendations in this report on the quality of planning and participants' experiences with the NDIA (section 7). Implementing these recommendations will increase the NDIA's workload, at least in the short term, making the timetable even more ambitious. But without these changes the objectives of the scheme will not be achieved.

Supply of disability supports and demand pressure from participants

Another significant transition challenge is developing the disability support market — both in terms of the scale and scope of services — so there are enough providers and workers to meet the increased demand for disability supports (section 9). The large increase in funding and considerable unmet need in the disability support sector means that the number of workers and providers will need to grow quickly over the transition period.

Prices are critical for market development and participant outcomes. But there is a risk that demand for disability supports will exceed supply, creating inflationary and quality pressures in the market. The Commission recommends independent price monitoring and regulation, as well as more effective coordination among governments to develop markets (including intervening in thin markets).

It will also take time for scheme participants to exert the influence and control over their supports that will bring about the kind of competitive pressures that characterise mature markets. Participants need the skills and information to exercise informed choice. It is essential that participants get the supports they need to navigate the scheme (section 9).

Ensuring continuity of support

There is also evidence of service gaps (section 8). Some disability supports are not being provided because of unclear boundaries. Clearer boundaries must be set at the operational level around 'who supplies what' to people with disability, and services only withdrawn when continuity of service is assured. All governments need to work together to better manage the integration of the NDIS and other services.

Transitional issues, if not addressed, will pose risks to the scheme

Each of these transitional issues is challenging in its own right, but in combination, the task as currently planned, becomes even more difficult. And all this is against a backdrop of significant change in governance and funding arrangements (with some arrangements still to be bedded down). The arrangements are also tied to insurance-based principles that do not fit easily within the existing model of government oversight. The newly established Agency also needs to find and skill staff, while developing operational guidelines from scratch under circumstances where legislation is untested.

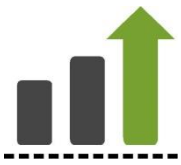
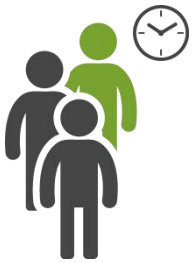
The transition period is going to be more protracted than previously expected. Based on evidence to date:

- the participant intake will not match the estimates in the Bilateral Agreements — adjustments need to be made now on a state-by-state basis
- supply shortages will persist for some time
- many participants will need more time and assistance to be equipped to exert the influence and control over their supports that will bring the kind of competitive pressure that characterises mature markets
- underutilisation will continue for some time — while this will keep scheme costs in check, it will mean poorer outcomes for some participants.

Recommendations made by the Commission to deal with the challenges and risks are outlined in table 2 and discussed in more detail in the sections below.

Scheme costs are discussed in the next section.

Table 2 **National Disability Insurance Scheme rollout challenges**

	The change	*The challenge*	*PC recommendations*
	Move from block-funded welfare model of support to a fee-for-service, market-based approach. Give scheme participants choice and control over disability supports.	Build the capabilities of providers and participants to engage in a market-driven scheme. Some participants do not have the capacity to navigate the new market. Some providers can struggle to adapt to a market-driven scheme.	Ensure participants get the supports they need to navigate the scheme, including information about providers and services. Provide stronger price incentives to encourage providers to deliver supports.
	Assess the reasonable and necessary needs of 475 000 people with disability based on insurance principles and individualised planning.	Assess eligibility and develop plans for a large number of participants within short timeframes (to meet bilateral estimates). Build a planning workforce with sufficient skills to administer the plans over scheme transition. Plans will be rushed or completed by planners without experience in disability – leading to a lack of supports for participants.	Rebalance the focus from numbers to better quality plans (the right plans will lead to the correct signals to the supply side of the market). Greater focus on pre-planning. More specialisation of planners. Allow NDIA more flexibility over its staffing arrangements.
	Increase funding to the sector from $8 billion per year to $22 billion in 2019-20.	Ensure funding arrangements do not create incentives for cost-shifting by jurisdictions. Ensure funding arrangements are based on insurance principles.	Clearly delineate what supports are provided to participants, and what are not. Establish clear boundaries around ‘who’ provides ‘what’. Establish a reserve fund to allow the scheme to take a long-term approach to participant needs.
	Build the supply side of the scheme — both in terms of the scale and scope of provider services, and the size of the workforce to deliver supports.	The supply side of the scheme may not respond fast enough to meet participant demand.	Implement independent price monitoring and regulation to get the right price signals to encourage supply. Bolster market stewardship through better collaboration among governments, providers and the NDIA.

4 Modelling the costs of the scheme

In 2011, the Commission estimated that a national disability insurance scheme would cover 411 000 participants and cost $13.6 billion (gross) at maturity. The NDIA's current projections are that the NDIS will cover 475 000 participants and cost $22 billion at full scheme commencement.[2]

The NDIA's estimates are based on a more refined costing methodology than that used by the Commission in 2011, and are broadly consistent with the Commission's 2011 modelling after accounting for wage and population growth. Of the $8.9 billion difference between the Commission's original estimates and the NDIA's current estimate, $6.4 billion is due to pay rises awarded to social and community services employees by the Fair Work Commission in 2012. Adding population changes and the cost of participants aged over 65 years (who were not included in the Commission's estimates), the estimates come within one per cent of each other (table 3).[3]

Table 3 **Comparing the Commission's and the NDIA's costings**

	Participant numbers	*Scheme costs ($ billions)*
Productivity Commission estimates 2011[a]	**411 250**	**12.82**
Population projections to 2019-20	49 544	1.54
Inflation in disability sector (wages)	..	6.38
Participants aged 65 years and older	15 285	1.09
Updated Productivity Commission estimates 2017	**476 079**	**21.84**
The NDIA's projections for participants 2017[b]	**473 653**	**21.76**
Difference (%)	2 426 (0.5%)	0.08 (0.4%)

[a] Excluding operating costs and offsets associated with the National Injury Insurance Scheme and assumed efficiency dividends. [b] Excluding operating costs ($1.5 billion), offsets associated with the National Injury Insurance Scheme ($0.7 billion) and assumed efficiency dividends ($0.3 billion). .. Not applicable.

It is too early and the data are too limited for new cost projections

In terms of reliable cost data, it is still very early days in the transition to full scheme. And while the transition experience should inform estimates of full scheme costs, the NDIA has decided that, at this early stage, the data have too many limitations to update the prevalence and package cost assumptions. Important limitations include small and unrepresentative trial

2 While the gross cost of the NDIS is estimated to be $22 billion in 2019-20, the scheme is expected to reduce the funding required for a range of government programs. A review by the Australian Government Actuary in 2011 estimated that these offsets were about $11 billion.

3 Participants must be aged under 65 years to *enter* the NDIS but can remain in the scheme after they reach 65 years.

populations, and concerns about the integrity of transition data. Approaches to planning and assessments were also changed at the beginning of the transition period (July 2016).

The Commission supports the NDIA's approach to projecting scheme costs, including the decision to delay integrating data from the trial and transition. We therefore did not revise the projections of scheme costs for this study. However, it is imperative that new data are incorporated into the NDIA's assessment of longer-term costs as soon as possible. The Commission's assessment is that, in the absence of major new data reliability issues, there should be sufficient data for the NDIA to update the estimates of scheme costs based on scheme experience for the 2017-18 Annual Financial Sustainability Report.

5 Insights from the trial and transition period

Costs in the trial phase aligned with expectations

Given the uncertainties around the costings of the scheme before it commenced, an important rationale for trial sites was to inform more reliable estimates of full scheme costs (and for testing and refining the scheme). At the end of the trial phase:

- the number of participants with an approved plan (30 281) was 83 per cent of bilateral estimates (36 307) (there were 35 695 people who had been determined eligible but who did not necessarily have an approved plan)
- the average annualised package cost was $36 049.

The scheme, at the end of the trial, also came in under budget — there was a surplus of about 1.5 per cent of the funding envelope over the three years. However, this was in large part because not all committed supports were used — in 2015-16, 76 per cent of committed supports were used.

Transition — the latest data

Post-trial data are also available. At the end of June 2017, an additional 86 000 people were eligible for the scheme, taking the total number of participants to 122 065. About 90 000 participants are currently active[4] and have an approved plan. Some insights from the transition data are presented in figure 4.

4 Participants who have not exited the scheme.

Figure 4 **Key insights from the transition data**
Data at 30 June 2017

[a] Psychosocial disability is the next most common disability, accounting for about 6 per cent of participants. [b] The annualised average level of committed support for packages after 1 July 2016. For participants with multiple plans over the time period, the latest plan is used. [c] NDIA modelling projects that the percentage of scheme participants who are aged 14 years and under will decrease to 30 per cent by 2019-20.

Emerging cost pressures

The Commission compared trial and transition data with the assumptions in the NDIA's modelling. Noting the limitations of the data, scheme costs are broadly on track compared to expectations.

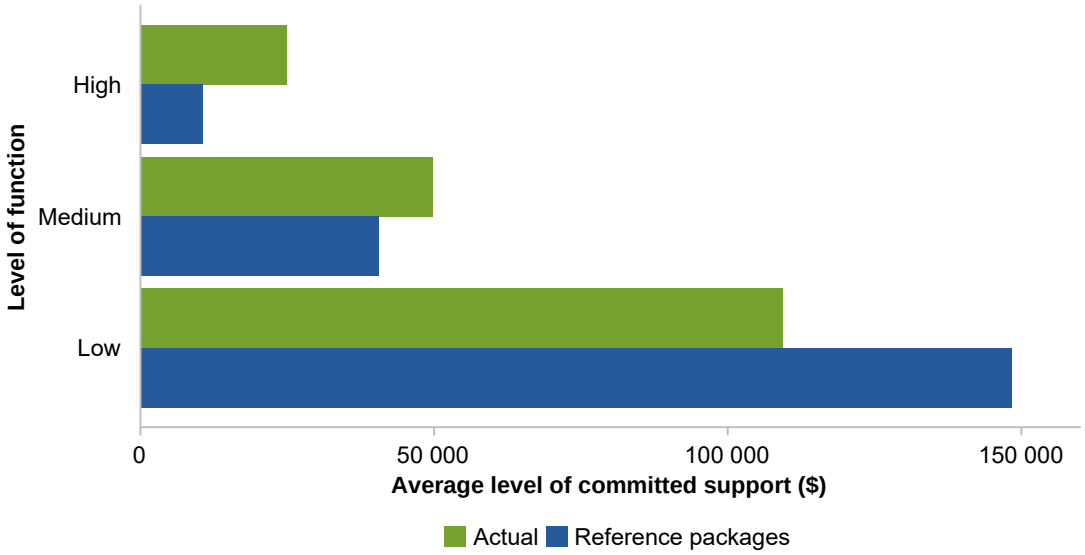
- For most disabilities, participant numbers broadly match the modelling assumptions for all but the largest disability groups. However, there are more children with autism and intellectual disability than expected.
- Average package costs (for plans effective from 1 July 2016) are broadly in line with modelling assumptions (after accounting for disability, age and level of function).[5] However, there are differences when the data are disaggregated by level of function. The average package cost for participants:
  - with low levels of function is $40 000 less than expected
  - with medium levels of function is $9000 higher than expected
  - with high levels of function are higher on average by $14 000 (figure 5).

5 For the position paper, the Commission conducted the same analysis with data from the first three quarters of transition, and found that package costs were higher than modelling assumptions.

- Utilisation rates — the proportion of committed supports that are used by participants — are lower than expected. Underutilisation is currently more than offsetting the increase in scheme costs attributable to higher prevalence rates for children.

Figure 5 **Average annualised committed support compared with reference packages, by level of function[a,b]**

Plans effective from 1 July 2016



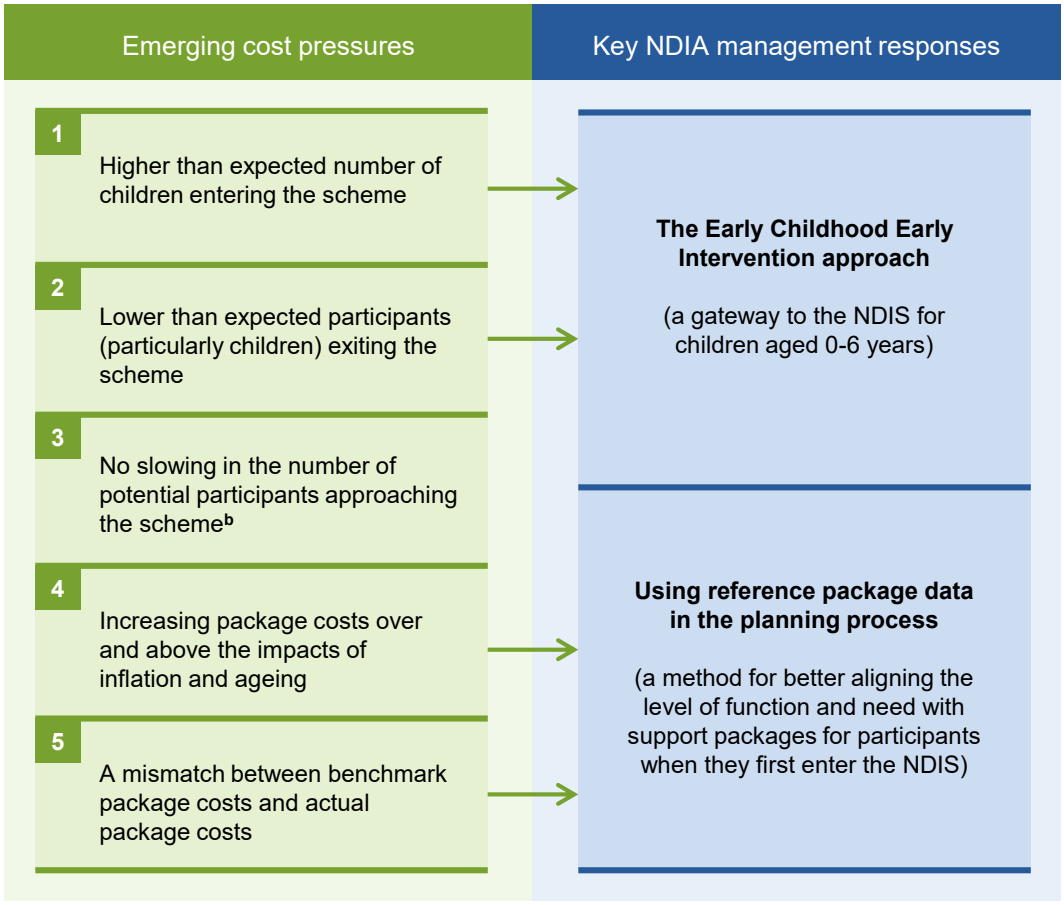
[a] Reference packages are the average package cost assumed in the NDIA's long-term modelling based on age, disability and level of function. They *are not* what an individual should expect to receive in an individualised funded package at any given time. [b] For participants with multiple plans over the time period, the latest plan is used.

The NDIA is tasked with ensuring the NDIS is financially sustainable. The insurance approach involves identifying and managing emerging cost pressures. The NDIA has identified five early cost pressures that need to be managed for the full scheme going forward (figure 6).

- The number of children entering the scheme is higher than expected.
- The number of people approaching the scheme in trial sites that have been operating the longest (since 2013) is higher than would be expected if only people with newly acquired conditions were approaching the scheme.
- The number of participants exiting the scheme is lower than expected (particularly for children entering under the early intervention requirements).
- Levels of committed support tend to increase as participants move to their second and third plans (over and above the impacts of inflation and ageing).
- There is greater than expected variability in package costs for participants with similar conditions and levels of function (suggesting inconsistencies in planners' decisions).

While the NDIA has not updated its baseline cost projections to reflect these cost pressures, it has put in place initiatives to address them. These include the Early Childhood Early Intervention (ECEI) approach for children aged 0–6 years (section 6, box 3), and the use of reference package data in the planning process to reduce variability in the level of support provided to participants (section 7, box 4).

Figure 6 **The NDIA's responses to emerging cost pressures**[a]



[a] The NDIA's two main responses to emerging cost pressures. The NDIA has also initiated several smaller projects to address emerging cost pressures, such as an analysis of reasonable and necessary costs across the lifespan of participants. [b] Potential participants continuing to approach the scheme is not a cost pressure that can easily be addressed by the NDIA.

While it is too early to conclusively assess the effectiveness of these initiatives, there are some signs from 2016-17 data that the new planning process may be helping to alleviate cost pressures related to package costs.

Benefits are already being realised

Realising the benefits of the scheme is critical for the wellbeing of people with disability and for ensuring that the community continues to be willing to pay for the scheme. However, at this early stage, only some of the benefits are being realised.

The NDIS Outcomes Framework and a National Institute of Labour Studies evaluation of the NDIS provide some early insights (based on trial data) into the scheme's benefits. Both find that the NDIS has:

- increased supports — more hours of support, a wider range of supports and greater access to equipment — than under the previous system
- on average, improved wellbeing of NDIS participants and their families and carers
- given people more choice and control over their supports
- increased social participation for some scheme participants and their carers.

The Commission also received numerous submissions supporting these findings. As one disability advocate said:

> … I have seen the life changes in people with disability who now have NDIS funding. They are now accessing community, having a good life and have hope for their futures. The burdens are off the family, some aged carers, and there is job creation. Broken wheelchairs are now being replaced and people who never had wheelchairs, now have and can access the community. I now see happy people.

However, not all are reporting improved outcomes under the NDIS. The groups at risk of having a less positive experience include those with psychosocial disability, complex and multiple disabilities, and language and cultural barriers, as well as people with disability transitioning into the community from the criminal justice system, the homeless and the socially isolated.

Participants reporting that they were satisfied or very satisfied with the scheme has also fallen since the scheme entered the transition phase — from 95 per cent in 2015-16 to 84 per cent in 2016-17. This could be linked to the speed of the rollout, and changes to the planning process (discussed below).

6 Scheme eligibility

The eligibility criteria are the main instrument available to influence how many people will be able to access individualised supports through the NDIS. It is important that these criteria are clear, aligned with the objectives of the scheme, and rigorously upheld.

When the Commission designed the national disability insurance scheme, it recommended that, to be eligible for the scheme, individuals should:

- have a disability that is or is likely to be permanent
- have significantly reduced functioning in self-care, communication, mobility or self-management and require significant ongoing support, or be in an early intervention group where there is good evidence that the intervention is safe, significantly improves outcomes and is cost effective
- meet residence and age requirements.

The eligibility criteria for the NDIS are broadly in line with what the Commission recommended, with two exceptions — the inclusion of supports to undertake activities of *learning* or *social interaction*, and the inclusion of developmental delay in the early intervention criteria. Both these criteria allow more people to qualify for individualised supports under the NDIS than the Commission included when costing the scheme.

Adding learning or social interaction — what effect?

The Commission was unable to assess the effect of adding learning or social interaction to the eligibility criteria, because the NDIA does not collect data on which (or how many) of the six activity domains are relevant to each participant when they enter the NDIS. Speech Pathology Australia, however, said that their members who are NDIS providers are not providing services to children whose *only* disability relates to learning and literacy.

The NDIA should collect data at entry on the domains to provide information on the impact of each part of the eligibility criteria on participant numbers (and therefore scheme costs). This information would also allow for more granular analysis of who is in the scheme and what their needs are likely to be (and could also be used by the NDIA in its monitoring and forecasting roles).

Adding developmental delay — what effect?

The evidence suggests that providing individualised supports for children with developmental delay can improve outcomes for individuals and reduce costs — it is therefore consistent with the early intervention insurance principles of the scheme.

A review undertaken for the Department of Social Services (DSS) estimated that about 11 600 children with developmental delay or global developmental delay would be eligible for support under the scheme at a cost of $155 million each year. While no definitive data are available to test this estimate, trial site data (which may not be reflective of full scheme prevalence rates) suggest higher prevalence rates than the estimate provided to the DSS.

For children with developmental delay to be eligible for individualised supports, they need to have a delay across multiple domains. This suggests that the eligibility criteria set an

appropriately high hurdle. However, the NDIA tested a sample of children who entered the NDIS during trial with the PEDI-CAT assessment tool and found that 40 per cent of the children did not have any identified deficits compared to the normal range for their age.

The NDIA's recently introduced ECEI approach (box 3), put in place in response to the higher than expected number of children entering the scheme in the trials, should tighten the entry pathway for children aged 0–6 years, and help ensure that only children who meet the eligibility criteria receive supports through the scheme. The NDIA is also developing an early intervention approach for the 7–14 years cohort.

Box 3 Early Childhood Early Intervention

The Early Childhood Early Intervention (ECEI) approach is designed to be a 'gateway' to the National Disability Insurance Scheme for children aged 0–6 years. It aims to ensure that only those children who meet the eligibility criteria of the NDIS become participants of the scheme. Under the ECEI approach, families meet with an early childhood intervention service provider to discuss the needs of their child. The provider then identifies appropriate supports for the child and family, and whether the supports should be provided through the NDIS or through mainstream services. As the National Disability Insurance Agency put it, 'the ECEI approach aims to ensure children are provided with the right level of support at the right time for the right length of time'.

The ECEI approach is also aimed at ensuring early intervention supports are effective and result in the exits expected in the 0–6 years cohort. The National Disability Insurance Agency plots a child's progress against development milestones and supports the child to access mainstream supports when NDIS supports are no longer required.

It is too early to gauge the success of the ECEI in upholding the eligibility criteria of the NDIS and to assess its effectiveness in supporting children who are not eligible for individualised supports. However, given that children receiving early intervention supports are one of the largest groups in the scheme, it is critical that the NDIA builds an evidence base to inform the types of intervention that are most beneficial and should be funded. The NDIA has developed an evaluation and monitoring framework for the ECEI approach, but the effectiveness of this framework is yet to be tested.

The role of diagnostic lists

The NDIA maintains a list (List D in the latest NDIA operational guidelines) that allows for streamlined entry into early intervention supports for children who have a condition on this list. List D contains about 130 conditions, including Global Developmental Delay.

Maintaining such a list represents a trade-off. The appeal of such a list is that it places less onus on families to demonstrate eligibility, reduces the administrative burden on the NDIA and provides a degree of certainty for the families of children with these conditions. However, the list can also affect incentives, and can be an overly-generous entry gateway if set too expansively. Also, if diagnosis forms the basis of early intervention, a child would remain eligible for early intervention supports so long as their condition is present, even if

the expected benefits from early intervention have been realised (or are unlikely to be realised).

The NDIA also maintains a list of conditions (List A) that allows for streamlined entry into the NDIS through the disability requirements.

While there is little evidence that these lists are resulting in people entering the scheme who would not meet the wider eligibility criteria, the NDIA did point to Autism Spectrum Disorders as potentially representing a difficulty for List A:

> … there is evidence to suggest that use of the diagnosis process for autism may differ from the process's intent (resulting in access to the Scheme where eligibility requirements would not otherwise be met).

Because the lists are a key entry pathway, monitoring them is essential to ensure they work as intended. A process for quickly changing the lists as new information comes to light is necessary, as is transparency about what is on the lists and why changes are made.

Psychosocial disability and the NDIS

In 2011, the Commission recommended that people with psychosocial disability (the term used to describe disabilities that can arise from mental health issues) be supported through the NDIS. This was on the basis that:

- the day-to-day support needs of people with significant and enduring psychosocial disability are often the same as people who have an intellectual disability or an acquired brain injury
- some important parts of the care requirements of people with psychosocial disability — namely community supports — are best met through the NDIS
- providing supports to people with psychosocial disability through the NDIS provides them with the wider benefits of the scheme, including individualised supports and more choice in what supports are provided, when and by whom.

These points remain salient, and lend support to people with psychosocial disability being supported through the NDIS. And, while the Commission heard a range of views about whether the NDIS is the 'right' vehicle to provide support to people with psychosocial disability, most stakeholders supported its inclusion.

Concerns were also raised about the need for permanency under the NDIS Act being incompatible with the recovery models used in supporting people with psychosocial disability. However, the investment approach of the NDIS and the recovery model of mental health are both about building capacity, and appear to be well aligned. The NDIS Rules and operational guidelines accept that a permanent condition may be episodic requiring different levels of support at different times.

Scheme participant numbers suggest that people with psychosocial disability are able to demonstrate that their condition is, or is likely to be, permanent. At the end of June 2017, about 6000 people with psychosocial disability received individualised supports. And data to December 2016 shows just over 80 per cent of people with psychosocial disability who lodged an access request to the NDIS were eligible for the scheme.

While the Commission does not support changing the eligibility criteria to relax the definition of permanency and how it relates to psychosocial disability, it does recommend a change in the way that people with psychosocial disability engage with the scheme. A psychosocial gateway, involving specialised staff, designed in consultation with experts in mental health, has the potential to improve how the scheme engages with people with psychosocial disability at an operational level.

Estimating the number of people with psychosocial disability eligible for the scheme is difficult because a robust and comprehensive database from which to draw is lacking. While there are estimates by a number of stakeholders and agencies, they vary greatly. It would be beneficial for the different methodologies to be made transparent, so they can be used to better project the numbers of participants with psychosocial disability at full scheme.

Concerns about gaps in support for people with psychosocial disability not eligible for the NDIS are discussed in section 8.

7 Supports and plans

Scope of supports

The NDIS is designed to cover specialist disability supports that are reasonable and necessary. This includes supports that help people with disability to:

- pursue their goals and maximise their independence
- live independently and be included in the community as fully participating citizens
- participate in the community and in employment.

The extent of support coverage directly impacts the costs and benefits of the NDIS — too little will result in lost benefits within the scheme, but too much could create cost pressures and pose a risk to the financial sustainability of the scheme.

The scope of supports covered by the NDIS is governed by legislation, rules and guidelines and, over time, will be shaped by court and tribunal decisions. What legislation and case law say about reasonable and necessary supports is important because it sets parameters for how the NDIA can operationalise support allocation. It also provides future courts and tribunals with a framework for evaluating whether decisions about supports have been properly made.

Ongoing monitoring and evaluation can help ensure that the body of law around reasonable and necessary supports is operating in a way that is consistent with community expectations and the objectives of the scheme. The review of the NDIS Act scheduled for 2021, agreed to by COAG, should look at the impact of court decisions on the content of the law as well as other issues raised in this study relating to the drafting of the NDIS Act.

About plans and the planning process

The planning process is about matching scheme participants with supports. It involves conversations between the participant and the NDIA to ascertain each participant's goals and aspirations, level of function and appropriate supports. The NDIS Act requires that a plan is developed and, where possible, is individualised, directed by the participant, and maximises participant choice and control.

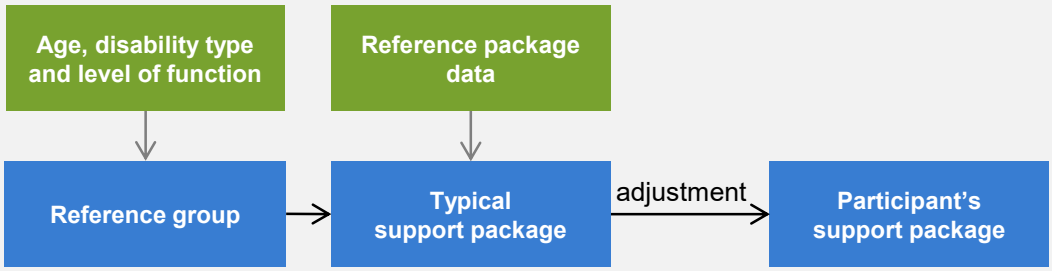
The quality of planning processes is a key determinant of the success and long-term sustainability of the NDIS — it influences what costs are incurred; the predictability of costs; the market for disability supports; outcomes for participants; and the integrity of, and community support for, the scheme.

Participants need to understand the planning process

The planning process has changed significantly since the NDIS commenced in 2013. At the beginning of the transition period the NDIA introduced a new process for determining participants' support packages, using reference package data (box 4). This approach has resulted in more plans being in line with benchmark costs (compared to the trial period). As with all insurance-based schemes, the tools and processes for handling claims and assessing entitlements are a matter of ongoing refinement. This is necessary to ensure that the insurance scheme remains 'on track' and is viable in the long term. Dynamic processes are also important to allow the scheme to adapt to changing circumstances or incorporate information that becomes available over time.

Box 4 **Using reference package data in planning**

Participants are first allocated a 'typical support package', based on their reference group (which is determined by their age, disability type and level of function). The typical support package may include funding across the following eight core domains: daily activities; social participation; consumables; transport; home modifications; assistive technology; capacity building; and support coordination.



For each participant, the level of funding is adjusted according to the participant's circumstances. This is done using a questionnaire, which asks the participant about each of the domains, including what supports they already have in place, and whether these are sufficient and sustainable. For example, where it is reasonable that sustainable informal, community or mainstream supports continue to assist the participant, or where the participant believes that other informal, community or mainstream supports may provide a better outcome, funding is adjusted in the participant's support package.

In light of this, it is important that stakeholders can access accurate and up-to-date information about planning processes. Clear messaging about how and why things are changing is also important to maintain the credibility of evolving planning practices.

The NDIS planning process is complex and confusing, and often lacks clarity and transparency. It is difficult to access information about assessment tools that are used by the NDIA and how support allocation is determined. There is also limited information to help scheme participants and their families, carers and advocates navigate the planning system. Scheme participants are often not aware of their rights and options, such as their entitlement to request a face-to-face meeting or have an advocate present during the planning meeting.

There needs to be greater transparency and clarity around the NDIA's planning processes. There also needs to be clear and up-to-date information about what participants should expect during the planning conversation, when it will occur, and how the information gathered during the conversation will be used.

Phone planning

The move to transition saw a shift from face-to-face to phone planning. The NDIA adopted this approach to allow people to enter the scheme as quickly as possible, with the intention of adjusting and improving plans over time. During trial, people indicated that they wanted to join the scheme as soon as they could. The speed of the transition placed a lot of pressure on the NDIA to finalise plans quickly and phone planning was part of the solution.

But there is a lot of dissatisfaction with phone planning (box 5). A number of participants said they felt rushed during their planning meetings. As one study participant put it:

> … the transition time pressures [appear] to have resulted in a reduction in the time available to assist people to resolve their plan; in some cases this is reported to have reduced to a 30 minute phone call. This could not be further removed from the feature of a 'person centred model of care and support' that is meant to distinguish the NDIS from previous approaches.

Box 5 Dissatisfaction with phone planning

Social Support & Precarious Workforce Research Discussion Group:

> … some participants are not fully aware that the phone conversation occurring with the NDIS staff member is actually their planning process occurring. This confusion is also evident in the NDIS marketing of phone-planning as a 'planning conversation', where the suggestion is you will 'talk-about' the plan whereas the reality is that it is a full and structured assessment and plan procedure.

The Disability Services Commissioner:

> Planners are not providing clear and accessible information about the planning process including when and how planning will take place. A sister of a participant said that someone from NDIA had rang her while she was in the car. They advised that they were 'only collecting answers' and it would 'only take a minute'. Following that conversation, her sister received a plan for approval from the NDIA, with less funds than she had previously received.

Alzheimer's Australia:

> Annie called the Parkinson's 1800 support line as she worried about an over the phone NDIS planning session that had taken place earlier that day. Annie's volume and quality of speech has been impaired due to Parkinson's and she also requires longer to respond to questions. She felt rushed and because her response is delayed she felt that the assessor didn't get a clear indication of her needs. Annie and a Parkinson's Nurse Specialist were able to take the time [to] put information together in order to apply for a review for Annie's plan.

Blind Citizens Australia:

> [Phone planning] severely compromises the ability of people who are blind or vision impaired to demonstrate the difficulties they may face with completing tasks like reading, navigating the environment or household chores.

The Commission also heard (on numerous occasions) that participants were called with no forewarning of the planning conversation, or were not informed that the call was a planning conversation (so the person was not prepared and could not have an advocate present).

An individualised approach to planning is a key feature of the NDIS and sufficient time is required to match participants with the supports that are right for them. Phone planning can mean that planners do not 'get the full picture'. For example, the living environment of participants may not be adequately reviewed (which means issues such as accessibility, safety and appropriate assistive technology can be difficult to identify).

Phone planning is not appropriate for some participants, including those with particular accessibility requirements, mental illness, cognitive impairment and neurodegenerative diseases, and people of culturally and linguistically diverse backgrounds. However, it may be appropriate for others, particularly if there is adequate pre-planning. The Commission

recommends that the NDIA review its protocols relating to phone planning. The NDIA recently said that, in response to feedback from scheme participants, it intends to use face-to-face planning as a default approach.

Pre-planning

The pre-planning phase of the planning process has not received adequate attention. As a result, many participants are ill-prepared for planning, and this is affecting the quality of plans. The NDIA acknowledged that, because of the speed of the transition, it was not able to engage Local Area Coordinators (LACs) in time to provide participant and community development during the pre-planning stages.

A greater focus on pre-planning should make phone planning suitable for a larger pool of participants. LACs need to be in place six months in advance in the areas in transition to assist with pre-planning. This is a better (and potentially less costly) approach than trying to 'fix' plans over time. It will also mean that participants are better able to exercise choice and control (and this is more likely to induce a provider response).

Planners need more disability knowledge

Planners' limited disability knowledge is a real concern (box 6). Many advocacy groups said that planners do not have sufficient knowledge of particular disabilities or the impact that particular conditions have on people's lives, and they often do not know what supports are most effective for the participant's disability. Alzheimer's Australia, for example, reported that a person with Multiple Sclerosis (MS) was asked by the LAC at a planning meeting, 'How long will MS last?'.

Planners should, at a minimum, have a general understanding about different types of disability. There should be specialised planning teams for some types of disability, including psychosocial disability. The NDIA should also make better use of expertise from within the industry, including by getting specialist disability organisations or service providers more involved in the planning process. A risk-based approach to managing potential conflicts of interest that could arise from such arrangements should be adopted by the NDIA. This would also mean that the NDIA would not need to compete with others in an already thin market to recruit planners with specialist qualifications or experience.

Box 6 **Planners — not enough disability knowledge**

MND Australia:

> LAC's do not have the expertise to support people with [motor neurone disease]. … They have no understanding of MND and the disability it creates. They attempt to plan via a telephone conversation, when speech and communication can be one of the early losses created by MND.

Alzheimer's Australia:

> Peter, the carer of a woman with younger onset dementia, felt unprepared when he and his wife attended their first NDIS planning session. … The NDIS planner had no understanding of dementia and the needs of people living with dementia and as a result the planning session focused on physical needs and solutions … Feedback from people with progressive neurodegenerative diseases has revealed that [LACs] have also shown insufficient knowledge of their disease, the impact of that condition on their lives, the most effective service interventions and the degenerative and fatal nature of their disease.

Amaze:

> Amaze's 2017 survey found: 65% of respondents rated their planner's knowledge and understanding of autism as none to moderate a level (with the remainder rating the planner's knowledge as high). … given 30% of participants identify autism as their primary diagnosis, a high level of ongoing training in autism will be a necessity to developing and maintaining their capacity to reliably develop plans.

New South Wales Government:

> … planner knowledge and capability is highly varied, as is their interpretation of reasonable and necessary supports and understanding of interim working arrangements with mainstream services. Approved supports are less likely to be based on a participant's needs and more on a planner's knowledge of the disability and/or how effectively the participant or their carer advocate for certain supports.

8 Boundaries and interfaces — the NDIS and services outside the scheme

People with disability, their families and carers rely on a wide range of services — including mainstream services, specialist disability services and community supports. For the NDIS to work efficiently and effectively, the interface of the scheme with these other services must be as seamless as possible.

While the level of funding provided to the NDIS recognised that the aggregate level of funding available to people with disability was inadequate, it was not expected that the NDIS would fill *all* the service gaps that predated the scheme. Providing services to people with disability remains a shared responsibility between all levels of government.

The interface between supports for people with disability will take time to clarify, but in the meantime it is important that governments do not prematurely withdraw from services, as any gaps that emerge will place added burdens on people with disability and their families. As the interface issues become clearer, it is important that incentives do not exist for individuals to prefer one system over another. Most critically, the NDIS should not be seen as an oasis of support, surrounded by a desert where little or nothing is available.

While there is much detail yet to be worked through, establishing clear and robust boundaries (and appropriately tailored supports) is essential to the fiscal sustainability of the NDIS, and for the surrounding network of supports.

Linking people to the right services

The Commission's 2011 report recommended a bridging and capacity building service for people with, or affected by, a disability (known as Tier 2 supports). The ILC program is a key component of the NDIS. It is designed to provide information, linkages and referrals to people with disability, their families and carers, with community and mainstream supports. The focus of ILC is on individual development and community inclusion.

ILC will be important for scheme sustainability. It is expected to reduce reliance on NDIS funded support over time by:

- reducing the demand for individualised supports and the need for supports within funded packages
- making supports more effective at helping people achieve their goals.

In July 2017, the NDIA began rolling out the ILC program. Funding for ILC will gradually increase over transition (from $33 million in 2016-17 to $131 million in 2019-20). The timing of ILC funding is determined by governments (it starts with a small budget that increases over time) and has prevented the NDIA from investing in ILC activities and rolling out a national ILC framework. At the same time, State and Territory Governments are withdrawing from existing ILC-type activities.

It is a false economy to have too few resources for ILC activities in the transition period — it is critical to have structures in place to ensure that people eligible for the NDIS can access the scheme, and those who are not eligible can access supports and services outside the NDIS.

ILC funding should be increased to the full scheme amount ($131 million) for each year during the transition and be focused on national ILC activities. The effectiveness of the ILC program in improving the outcomes for people with disability and its impact on the sustainability of the NDIS should be assessed as part of the 2023 review of NDIS costs, when data on ILC activities will be available.

Interface with mainstream services is not clear at an operational level

The Australian Government has entered into bilateral agreements with State and Territory Governments to delineate the types of services to be provided and funded by the NDIS and mainstream services. Schedule 1 of the *National Disability Insurance Scheme Rules (Supports for Participants) 2013* (Cwlth) sets out the rules to determine whether the NDIS or another system is most appropriate to fund specific supports for individuals.

COAG has accountability for the NDIS and the *National Disability Strategy,* and through its Disability Reform Council (DRC), receives reports and advice on progress and risks. While the principles agreed to by COAG on the boundaries between the NDIS and mainstream services are clear, greater clarity is required at the operational level. This will prevent duplication, gaps and cost shifting by the NDIA, and the Australian, State and Territory Governments.

The boundary issues are yet to be tested. However, the *National Disability Strategy* should be strengthened to include more detail around boundaries (based on challenges faced when seeking to operationalise boundaries), and greater accountability. At review points of National Agreements and National Partnership Agreements under the Intergovernmental Agreement on Federal Financial Relations, parties should agree to specific commitments and reporting obligations that are consistent with the Strategy. As the DSS said:

> Translating the National Disability Strategy into tangible results for people with disability, their families and carers is a major factor in successful implementation of the NDIS.

Adding a standing item to the agenda of each COAG council that is responsible for services that interface with the NDIS to discuss any gaps in service provision would also help build clarity around what services governments will provide, and ensure ongoing monitoring and solutions for potential future gaps. The Councils should put forward issues to be resolved and suggested actions to the DRC.

Concerns that some people with disability may be left without services

Many are concerned that, as disability support programs are rolled into the NDIS, people using these services (including those not eligible for the NDIS) may no longer receive continuity in support. This is a key risk to the financial sustainability of the NDIS — and one that the NDIA has little control over.

Mental health services are an area of particular concern. The National Mental Health Commission's report on Mental Health Programs and Services estimated that about 700 000 Australians experience a severe mental illness in any one year. According to the NDIA, about 64 000 people with primary psychosocial disability are expected to be eligible for individual packages in the NDIS at full scheme.

Clearly, there needs to be support for people with mental health illnesses outside of the scheme — a responsibility that remains (largely) with State and Territory Governments. However, governments are withdrawing their funding for a number of mental health support programs and using this funding to offset part of their contribution to the NDIS. At this stage, it is unclear what supports will be available for people with a mental illness who do not meet the NDIS eligibility criteria. This should be clarified as a matter of urgency.

The implications of this are significant. Not only is uncertainty distressing for those with mental illness, any gap in support places an additional call on the generosity of informal support. Gaps could also place pressure on the financial sustainability of the NDIS if they

encourage scope creep, or force those who are unlikely to meet the eligibility criteria to test their access for fear of having few supports should they not qualify for the scheme. Mental health and psychosocial disability are a key priority of the DRC, but more clarity is required.

While the Australian and State and Territory Governments have agreed to provide continuity of support for disability services outside the NDIS, in practice there is confusion and uncertainty about what services will continue to be provided and/or funded. Governments need to be clearer about how they will approach continuity of care, and transparent about what disability services they will continue to provide for people who are not eligible for the NDIS.

Gaps in disability services need to be quickly identified (possibly with the assistance of ILC and LACs) and managed, to ensure the sustainability of the overall scheme. The NDIA and the Australian and State and Territory Governments should report regularly to the DRC on boundary issues.

9 Market readiness

The market-based approach of the NDIS means that there will be significant changes in the way that supports are demanded by, and provided to, participants. This disruption of the disability supports market is designed to maximise the choice and control of participants, while also giving providers incentives to efficiently and effectively deliver the supports that participants want and need.

While the scheme will drive efficiencies, the increase in funding and considerable unmet need in the disability support sector means that the number of workers and providers will need to grow quickly over the transition period. For example, the NDIS workforce will need to more than double from 2014-15 to 2019-20. The scale, scope and capacity of providers will also need to expand substantially. As the success of the NDIS relies on providing the right supports to participants, market readiness will affect costs during transition and beyond.

Providers face challenges to be ready for the NDIS

To meet the needs of NDIS participants, there must be a significant increase in the quantity, quality, range and responsiveness of disability supports.

In making the transition to a market-based system for disability supports, providers are facing the prospect of workforce shortages and coming to grips with operating in a market that will, for some time, be characterised by price caps. The shift in the business model, from a block-funded to a fee-for-service environment, is highly challenging for many.

Prices are critical for market development and participant outcomes

Participants exercising choice and control will increasingly drive the price of disability supports. And these prices will drive providers to supply the supports that participants most value, and encourage competition and innovation among providers. Allowing the market to determine the price of supports is an important tenet of the NDIS — it will contribute to both participant outcomes and the financial sustainability of the scheme.

However, prices are currently regulated. The NDIA sets maximum prices ('price caps') for many of the supports provided by NDIA-registered providers to:

- ensure value for money for participants — as the price of supports may be bid up too quickly before the sector grows sufficiently to meet the increased demand
- encourage the market supply of disability supports.

In practice, the NDIA must balance these two objectives. If prices are set too high, this will encourage the supply of supports, but reduce the purchasing power of participants. If prices are set too low, this could lead to a shortage of particular supports. Striking the right balance is difficult. From a long-term perspective, price regulation should not linger for years, have excessive scope, nor skew the market (such as by benefiting some providers or participants over others).

The Commission heard from many stakeholders that the NDIA's pricing methodology has, in some cases, led to perverse incentives, poor participant outcomes and hindered market development — especially for supports required by participants with complex needs. According to the NDIA, existing providers (many who previously relied on block-funding) are finding it difficult to adjust to the fee-for-service model.

The NDIA, on completing its 2017-18 price review, commissioned McKinsey & Company to review its pricing approach. The report will be completed at the end of 2017.

The Commission agrees with the NDIA's findings from recent reviews that the communication, transparency and timeliness of the pricing process needs to be improved. Price regulation of NDIS supports should be administered by a body with relevant capabilities and necessary resources. Prices of supports should be regulated as narrowly and for the least time possible, as well as be:

- transparent, with wide public consultation and publicly available information, including all assumptions used in any pricing models
- more granular and targeted by setting prices for supports at the state and territory level, with an expectation that price signals could be set at a more disaggregated regional level where possible
- evidence-based, with the collection of data and public reporting on providers' characteristics and costs
- supported by clear and limited legislative authority

- timely (giving providers sufficient time to phase in changes and be responsive to market conditions) and reviewed on a regular basis
- used only when there is clear evidence that unregulated prices are likely to lead to inflation that would harm participants.

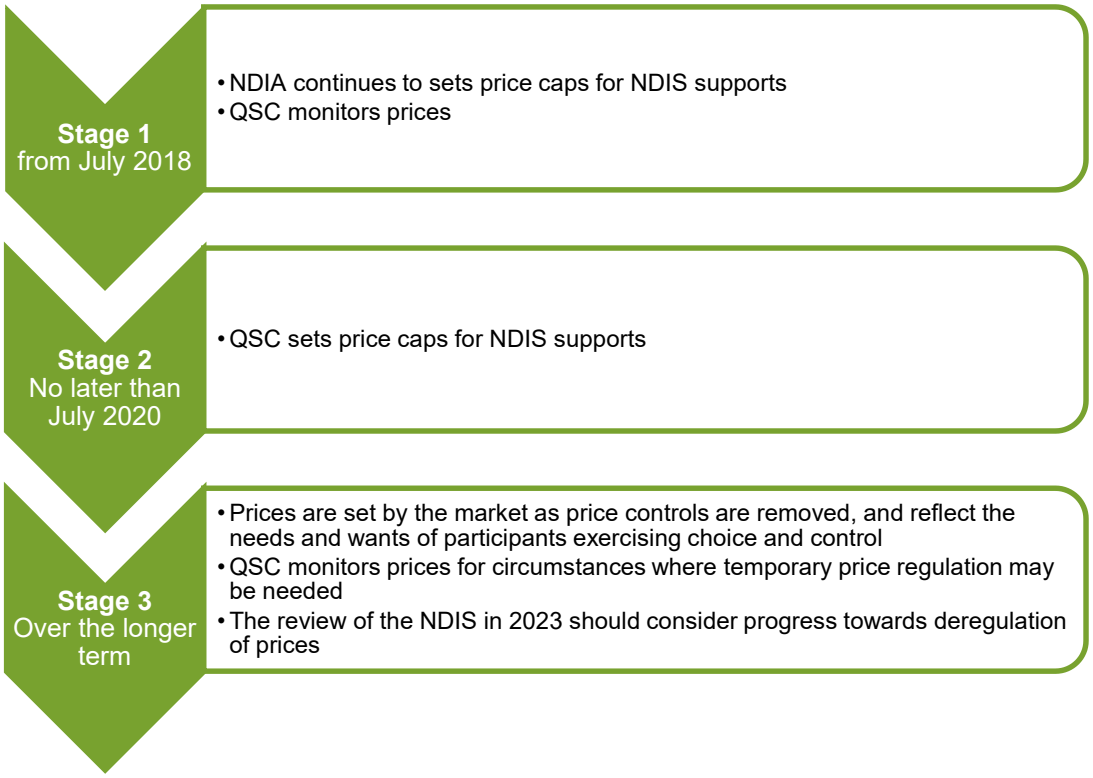
The Commission is concerned that while ever the price-setting mechanism is held within the NDIA, there is an incentive for it to be used to offset budget pressures. Prices should be set with market development as the primary focus. To better reflect the above principles, the Commission proposes moving towards the deregulation of prices in three stages (figure 7).

- The first stage reflects the current situation: the NDIA continues to set price caps for NDIS supports. But to provide additional oversight and improve the transparency of price-setting, the NDIS Quality and Safeguards Commission (QSC) should begin monitoring prices from its commencement in July 2018, particularly to highlight price settings it considers to be inconsistent with longer-term market development.
- The second stage (following the end of transition) addresses the greater need (see above) to ensure strong and competitive markets that provide a sufficient quantity of supports to meet the demand from 475 000 participants. To that end, the QSC should take over the role of price regulator no later than July 2020.
- The third stage is characterised by the longer-term removal of price controls by the QSC as markets for disability supports become more fully developed (which will occur at different times in different jurisdictions). The review of NDIS costs in 2023 should consider the state of market development including progress towards deregulation of prices. Following deregulation, there will still be need for the QSC to monitor prices to ensure that participant outcomes are being achieved through the ongoing provision of safe and quality supports.

It is undeniable that the supply response to the scheme is less than what will be required to deliver supports to participants.

The NDIA's cautious approach in setting prices was commensurate with the uncertainties around cost pressures early in the scheme, but the pace and growth of market development now needs to be accelerated. Vesting price regulation powers in the QSC will ensure that market development (and participant wellbeing) receives the focus that it needs, and reflects its increasing importance over time as the scheme rolls out.

Figure 7 **The PC's recommended path for NDIS price deregulation**



Without better oversight and transparency of price signals in the near term to achieve the required significant increase in supply, the benefits of the NDIS will not be fully realised. These concerns were raised by numerous stakeholders, including many of the governments funding the scheme. The Victorian Government, for example, said:

> It is important to separate the price-setting function from the NDIA and then clarify the role and accountability to be retained by the NDIA. Victoria considers that there is also an immediate need to consider areas where NDIS pricing may be inhibiting market growth or risking provider failure (particularly in areas or services in which there are thin markets). In some areas, the NDIA appears to have applied flawed assumptions to its calculation of prices. Examples include low allowances to train, supervise and recruit direct support staff, unrealistic assumptions around the amount of time staff need to spend undertaking non-client facing functions, and low assumptions around the proportion of overall costs devoted to overheads (particularly during the transition period). Victoria considers that these areas should be corrected as soon as possible.

Independent price monitoring and regulation will benefit participants, providers, and the community. Participants will be assured that quality and safety standards are considered in the pricing of NDIS supports. Providers will have greater certainty that price setting will be transparent and evidence-based. And the community can be confident that the funds they have contributed to the scheme will be spent in a way that best balances the needs of market development and the interests of participants.

Thin markets need more attention

When creating a new market for disability supports, there is a risk that, in some areas, or for some types of supports, the market (the number of providers or participants) will be too small to support the competitive provision of services ('thin market'). Thin markets are not new — they have been, and will continue to be, a persistent feature of the disability support sector.

In the absence of government intervention, there will be greater shortages, less competition, and ultimately poorer outcomes for participants. Participants at most risk are those who:

- live in outer regional, remote or very remote areas
- have complex, specialised or high intensity needs, or very challenging behaviours
- are from culturally and linguistically diverse backgrounds
- are Aboriginal and Torres Strait Islander Australians
- have an acute and immediate need (crisis care and accommodation).

The NDIA has not, to date, developed a Provider of Last Resort policy, or its Market Intervention Framework, and this has led to concerns about continuity of services. These policies should be published as soon as possible.

More flexible funding, service delivery and other measures tailored to specific circumstances are also needed. The NDIA should consider the widest range of approaches, including block-funding.

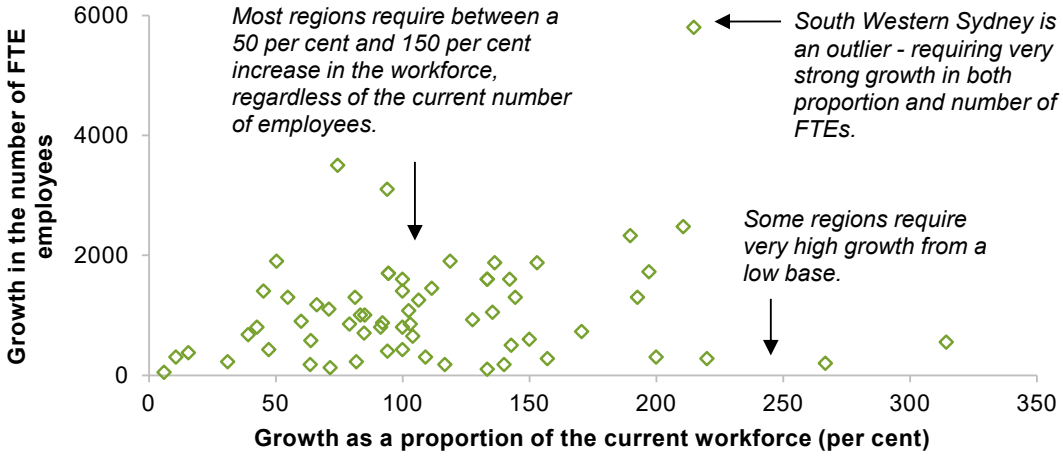
The NDIA should also collect and publicly release granular data, feedback and reports on thin markets, including when Provider of Last Resort arrangements are used. This will help inform the appropriateness and effectiveness of market interventions. Regardless of the approach chosen, there is a need for transparent reporting and evaluation of thin market arrangements, and collaboration between the Australian and State and Territory Governments.

The workforce is not growing fast enough

As the NDIS provides more individualised supports for people with disability, the workforce needed to provide those supports will need to both increase and become more diverse. There is broad consensus that the number of full-time equivalent positions will need to roughly double over the transition period — at a local level, some regions will need to triple their workforce or more to meet demand (figure 8).

Figure 8 **Variation in workforce growth required in different regions[a]**

Each dot represents the growth in the amount of full-time equivalent (FTE) employees needed relative to the current situation, both in terms of the number and proportion, between 2015-16 and 2019-20.



[a] The NDIA's market position statements provide 'low and high' estimates for the number of FTE disability workers at present and what will be needed in the future. To derive these estimates for growth, the midpoints of each range are used. No data are available for Western Australia. Regions are areas consisting of several local government areas.

Several policy changes are recommended to mitigate the potential workforce shortage over the short term, including:

- meeting the desires of many existing workers — who are qualified and experienced, and usually work part-time — to work additional hours
- trialling different approaches to help fund volunteer organisations to provide participant supports
- allowing for skilled migration where residual shortages remain persistent.

Building the workforce is a long-term exercise

While these measures will help to address workforce shortages in the transition period, more attention also needs to be paid to the longer-term development of the workforce.

The responsibility for workforce development is currently shared jointly between the DSS and the NDIA — with the former having 'oversight' of workforce development and the NDIA allocated the task of 'market steward'. The DRC also plays a role in workforce development issues, along with the relevant State and Territory Government departments.

The current fragmented landscape of roles and responsibilities for workforce development is understandable given the breadth and reach of the scheme, and the speed of implementation, but is unacceptable. The risk is that a fragmented workforce policy may

lead to inaction, or result in duplication or unnecessary programs at a time when the scheme can least afford it. While some progress is being made to better coordinate the activities of different jurisdictions, much more needs to be done.

A 'big tent' approach to workforce development remains appropriate, but the roles and responsibilities of different parties should be clarified and made public. This is a big task, and is not yet being given the attention it needs.

- State and Territory governments should have more responsibility for workforce development issues over the transition period, as they have the best experience of where there has been historically unmet need and the approaches best suited to solve such issues in particular jurisdictions.
- The Australian Government should retain oversight of the scheme, and focus on areas that affect the supply and demand of care workers from an economy-wide perspective, including the interaction of the NDIS with other care sectors (such as aged care) and monitoring trends in the supply of skilled workers through tertiary and vocational education.
  - The Australian Government should adjust immigration policy where necessary to address workforce shortages.
- The NDIA is best placed to provide more granular detail to governments on where supply gaps are emerging, or likely to emerge.
- Governments should also regularly consult with providers on emerging workforce policy issues, such as where the incentives of the scheme may be affected by other laws and regulations like minimum standards, conditions of State and Commonwealth awards, and training and development.

Over the long term, the workforce development responsibilities of State and Territory Governments will diminish as the NDIS is fully rolled out and supplants their existing disability support programs. Even then, State and Territory Governments should remain 'in the tent' when it comes to workforce policymaking given the interaction between the NDIS and other mainstream services.

Building the evidence base is also important

Existing data on the size and scope of disability care workers and the organisations they are employed by are poor, and not commensurate with the importance of the NDIS. The DSS (the agency currently tasked with market development oversight) said that 'a significant limitation to assessing the NDIS market readiness is the availability of market and workforce data'. To address this deficiency, the Australian Government should fund the collection of more fit-for-purpose data by the Australian Bureau of Statistics and the university sector.

Participants need help to make the most of the NDIS

The NDIS is about giving participants more choice and control over their supports. While some participants will be ready to manage and work with the NDIS to implement their plans, others will be less so, and may find it difficult to get the most out of the scheme. This in turn will reduce the overall benefits and financial sustainability of the scheme.

How ready participants are to make the most of their plan will depend on a number of factors, including: an individual's capacity; their network of informal carers and peers; the assistance provided under the NDIS; how ready the market is to provide supports; and the complexity of the scheme. As participants spend more time in the NDIS, there will also be some degree of 'learning by doing'.

However, some scheme participants are finding it hard to understand and interact with the NDIS, particularly because the scheme is a new way of allocating and supplying disability supports. There is a lack of useful information about providers and their services. Providing timely, accessible and useful information to participants about providers will help people with disability access their NDIS supports, and better exercise choice and control.

Supports provided in plans give some assistance to participants to implement their plans, including through support coordination (a key means to bolster the readiness of participants with complex needs). However, there is some evidence that support coordination is being provided to participants for only a fixed period of time. The NDIA should allocate support coordination based on need, rather than time.

Intermediaries can also help participants navigate the NDIS, as they can provide tailored supports to participants to manage their plans, including helping to pay providers and hire workers. Intermediaries are especially important for those who may struggle to deal with the administrative burden of managing their own affairs (while allowing participants to retain choice and control). They can also reduce scheme costs by reducing the administrative burden for the NDIA and aggregating participants' purchases of common supports.

However, the take-up rate of intermediaries to date has been slow. Only 11 per cent of participants in the transition period are using intermediaries. To encourage greater use of intermediaries, the NDIA should provide more information to participants and planners about the roles and use of intermediaries. Intermediaries should also be closely monitored to ensure that safeguards are in place to protect participants and providers. And the NDIA should continue to assess the capacity of participants to self-manage on a case-by-case basis.

Disability advocates also play an important role and help participants in a way that NDIS supports cannot. They can help participants get better plans, find supports, navigate the new scheme with its new jargon and complexities, and provide systemic advocacy about difficulties faced by people with disability. However, many State and Territory Governments have reduced or ceased funding for disability advocacy — rolling it into NDIS funding of supports instead. As advocacy remains important over the transition period, the Commission

recommends that funding be restored by jurisdictions that have ceased or reduced funding, and data collection and evaluation of disability advocacy be increased.

More effective government stewardship of the market is needed

As discussed above, there are substantial challenges developing the market supply of disability supports. While some progress is being made, there are still difficulties in growing the number of providers and the disability care workforce, as well as helping participants to become informed and effective consumers (figure 9). This is occurring at a time when the rapid pace of the rollout — and growth in demand for supports — is at its greatest. Based on experience to date, there will be a shortage of disability supports under the scheme.

Many of these challenges could have been anticipated. This highlights the need for more effective market stewardship by governments (including by the NDIA). As the Agency said:

> Market stewardship recognises that when governments implement policies to increase consumer choice and adopt market-based delivery, they must also oversee how the marketplace develops.

Just as providers, workers and participants need to change their approach to disability supports, so too must governments.

The responses from jurisdictions have varied, and their effectiveness is unclear. Although some of the variation reflects jurisdictional differences (including the rollout timetable), it also highlights the uncertainties around the roles and responsibilities of governments under the NDIS. In practice, this has led to gaps, duplication and shifting of responsibilities. This is a risk to the scheme, and to the wellbeing of participants and their families.

While the bilateral agreements provide some level of detail about 'who is responsible for what', more rigorous communication, public reporting and coordination of market stewardship activities are needed. The DRC should immediately clarify and publish the specific and practical delineation of market stewardship roles, responsibilities and accountability arrangements of Australian, State and Territory Governments. Where governments, their agencies and/or the NDIA are responsible for a market stewardship task, there should be clear and transparent reporting about the specific outcomes they are to achieve, the timeframe in which it is meant to occur, and progress towards that goal. Governments should also coordinate their market stewardship actions across all sectors, particularly with other care sectors and mainstream services.

Coordination among market stewards is important, but the release of timely, market-relevant data are also needed urgently. The Australian, State and Territory Governments should, with the NDIA and QSC, collect and publish disaggregated, tailored and forward-looking market data. This includes provider and workforce data, as well as qualitative information and feedback from liaison with market participants. A better evidence base would enable a deeper understanding of the market and in turn, inform risk-based market stewardship responses.

Figure 9 **The main actors, actions and Commission's recommendations affecting market readiness**

Key issue	Provider readiness: Price Signals	Provider readiness: Non-Price Signals	Workforce readiness	Participant readiness
Responsible stakeholders	Price regulator (currently NDIA)	Provision of market information (NDIA)	Coordination of workforce development activities by Governments, DSS and NDIA	Assistance in plans (NDIA)
Main current actions	McKinsey & Company price review initiated by the NDIA	Changes arising from the NDIA provider pathway review	Sector Development Fund Workforce action plan developed by DSS	Changes arising from the NDIA participant pathway review
Commission recommends	Principles-based pricing Independent price monitor and regulator (NDIS Quality and Safeguards Commission)	NDIA to release more frequent and granular data on participant demand NDIA to make public its Provider of Last Resort policy and Market Intervention Framework	Better coordination between governments, providers and the NDIA to develop the workforce Appropriate data collection Trialling use of volunteers	Implement objectives of the eMarketPlace Clarifying the supports that help participants Encouraging use of intermediaries Continue funding disability advocacy

All of the market readiness issues suggest that market stewardship needs improvement

Clarify and make public the roles and responsibilities for each party
Require transparent and regular reporting against outcomes
Collect and make public disaggregated, tailored and forward-looking market data
Coordinate market stewardship actions across all sectors

10 Governance

The governance arrangements for the NDIS are complex and reflect the shared responsibility of the scheme between the Australian and State and Territory Governments. While the NDIS is administered by an Australian Government Authority (the NDIA) under Commonwealth legislation and under the direction of an Australian Government Minister, it is designed and funded by the Australian, State and Territory Governments.

In 2011, the Commission recommended a single national scheme, and a single national agency, to provide disability care and support. The Commission considers that this is still the best model, and that Western Australia, the sole jurisdiction to remain outside the NDIS, should be in the national NDIS. The possibility of Western Australia joining the scheme is currently under consideration by the Western Australian Government.

NDIS rules

Under the current governance arrangements, State and Territory Governments play a significant role in setting NDIS policy. For example, while the Minister for Social Services is responsible for creating NDIS Rules, Category A Rules require unanimous agreement from the Australian Government and each host jurisdiction.

There have been cases where NDIS rules have taken considerable time to implement. The process for implementing or amending Category A NDIS Rules should be streamlined, to ensure that swift changes can be made in response to developments that threaten the financial sustainability of the scheme. The Commission does not recommend that the requirement for agreeing to Category A NDIS Rules be changed from unanimous agreement. Instead, the process should be changed to encourage timely agreement to Rules without diluting the control of State and Territory Governments. This could be done, for example, by requiring governments to state whether they agree or disagree to a proposed rule introduction or change within a certain amount of time. No response could be taken as agreement to the proposal.

The NDIA's operating costs and staff cap

The NDIA needs sufficient autonomy to manage the NDIS as an insurance-based scheme.

The NDIA is subject to a cap on operating costs. At full scheme the cap is set at 7 per cent of package costs. While capping operating costs could encourage efficiency, if the cap is set too low it could hinder the NDIA's ability to effectively manage the scheme. While similar types of schemes operate close to a 7 per cent average when they are close to maturity, they also typically have significant fluctuations in their annual operating expenses as a proportion of their overall expenses. A target of 7 to 10 per cent, with the expectation that the NDIA would sit at the bottom of this range, would give the NDIA the flexibility to smooth year-to-year fluctuations in spending, while still encouraging efficiency.

The NDIA also has a full scheme cap of 3000 directly employed staff. Capping staff levels could lead to poorer outcomes, especially early in the scheme's life when the agency is building capacity and institutional knowledge, and developing first plans for many participants. The number of employed staff (and in-house skills) required will depend on the model adopted to undertake planning, and is likely to change as the scheme matures. The NDIA, as a corporate Commonwealth entity, should be given the independence to determine the most effective and efficient number of staff to deliver the scheme.

Monitoring the performance of the NDIS

Performance reporting is important for ensuring outcomes are realised and that there is accountability when they are not. It is also an important component of the insurance approach. The performance of the NDIS is currently monitored and reported through a number of reports, including the quarterly report to the DRC and the Annual Financial Sustainability Report.

While the NDIA is still developing its performance reporting, there are some gaps in the framework and the reporting against the framework, especially around quality. As reporting on outcomes develops, evidence of good outcomes will be evidence of good quality plans, processes and experiences. However, this could take many years. In the meantime, reporting on measures and indicators of quality is needed, and should begin by June 2018.

There is also a need for improved public reporting of review processes. The NDIA should publicly report on the numbers of reviews, review timeframes, outcomes of reviews, and participant satisfaction with the review process. This would improve clarity, transparency and accountability around the effectiveness of the review process.

11 Funding

To ensure that the integrity of the NDIS' objectives are maintained, the funding arrangements for the NDIS need to provide funding certainty and allow the scheme to operate in line with insurance principles. This requires:

- sufficient funding for the NDIA to take a lifetime approach to participant supports
- predictable funding that gives people with disability (and their families and carers), and those that may acquire a disability later in life, certainty that they will receive reasonable and necessary supports over their lifetime
- incentives for the NDIA to efficiently and effectively operate the scheme
- incentives for governments to take a collaborative approach to mainstream interfaces and other disability services.

The current funding arrangements

In 2011, the Commission's preferred funding option was for the Australian Government to be the single funder of the NDIS. This option was preferred on the basis that it would:

- provide certainty and clear lines of funding responsibility
- avoid the inefficiencies of the Commonwealth-State 'blame game' that can afflict shared funding arrangements
- reflect the Australian Government's capacity to raise efficient and sustainable taxes of the magnitude required.[6]

The Commission also recommended that the Australian Government direct payments from consolidated revenue into a National Disability Insurance Premium Fund using a legislated formula that provided stable revenue to meet the actuarially-assessed reasonable needs of the NDIS and included funding for adequate reserves.

The funding arrangement for the NDIS (expected to cost $22 billion in 2019-20) is a pooled approach (this was the Commission's second, less preferred option), with funding from Australian and State and Territory Governments. In the first year of full scheme, the State and Territory Governments (assuming Western Australia joins the national scheme) will contribute a combined $10.3 billion to the NDIS, and the Australian Government will pay the remainder. The arrangements are governed by a range of bilateral agreements that are to be revisited every five years. The NDIA does not have a reserve to manage fluctuations in expenditure.

DisabilityCare Australia Fund arrangements should be phased out

A 0.5 percentage point increase in the Medicare levy provides some funding for the NDIS via the DisabilityCare Australia Fund (DCAF). The DCAF is managed by the Future Fund and is subject to management fees. A maximum of $9.7 billion over 10 years will be credited to the State and Territory Governments to partially reimburse their NDIS contributions, with the remainder available to the Australian Government (at least 75 per cent of the revenue).

The Australian Government's 2017-18 Budget also included plans to increase the Medicare levy by (a further) 0.5 percentage point and credit it to the yet to be established NDIS Savings Fund (alongside other redirected savings, contributions from NDIS underspends returned to the Australian Government, and recommitted funds from the Building Australia Fund and Education Investment Fund (subject to legislation)). The NDIS Savings Fund is a special account ring-fenced within consolidated revenue and is not subject to management fees.

6 This option was subject to the State and Territory Governments reducing their taxes to avoid increasing the tax burden on Australians beyond what is necessary to provide additional funding to the NDIS.

The DCAF arrangements will become less appropriate over time as State and Territory Government withdrawals become more frequent and the 'churn' of funds increases. The Commission recommends that the DCAF arrangements be discontinued after 2023-24[7] and that the Medicare levy funds for the NDIS be put into the proposed NDIS Savings Fund.

Escalation parameters

As the NDIS is designed to be a no-fault scheme that covers the entire population, the contributions of governments to the NDIS can be thought of as an 'insurance premium' paid by individuals through their taxes. The current Bilateral Agreements provide that the State and Territory Government contributions will increase by 3.5 per cent each year (the 'escalation parameters') until 2023, subject to the outcomes of this study.

The current escalation parameters of 3.5 per cent are based on the long-term annual projections of the consumer price index of 2.5 per cent and a net population growth rate of 1 per cent. The threshold issue for escalation parameters is whether or not State and Territory Government contributions at full scheme and beyond should keep pace with scheme costs or maintain existing real per capita contributions.

The argued benefit of State and Territory Government contributions tracking scheme costs is to give them some 'skin in the game' to control costs. However, there are a number of factors that contribute to increasing scheme costs, and most of these are not within the control of the State and Territory Governments. State and Territory Government tax bases are also less efficient than the Australian Government's, which means it is more costly for them to raise funds than it is for the Australian Government.

The Commission recommends keeping State and Territory Government NDIS contributions constant on a real per capita basis over time, as it is reasonable to expect that their tax revenue will grow with inflation and population.

On the basis of current projections of population and price growth post 2019-20, the currently agreed escalation parameters of 3.5 per cent are at the lower end of the likely range of values based on reasonable assumptions. An escalation parameter of 4 per cent would be more appropriate over the short to medium term, until they are reviewed in 2022-23.

Funding an insurance-based scheme

Insurance schemes typically prepare actuarial forward estimates of costs over a period of time and adjust their insurance premiums in line with long-term actuarial projections of future scheme costs. Premiums are usually set at a level to allow reserves to build up to manage year-to-year fluctuations in costs and to set aside money for claims not yet finalised.

7 Governments have not negotiated payments to the State and Territory Governments after 2023-24.

Having access to reserves also allows insurance companies to make upfront investments aimed at reducing scheme costs over the longer term.

For the NDIS to operate as an insurance-based scheme, the NDIA needs to have the autonomy to manage the lifetime risk of participant costs and to manage discrepancies between actual and estimated costs in any given year. The NDIA, rather than the Australian Government, is best placed to manage the costs of the scheme and risk of cost overruns because it has the best information to do so.

Increasing funding contributions in line with cost increases, with a buffer for risk, would provide the NDIA with sufficient certainty and flexibility to manage the costs of the scheme, rather than having to rely on injections of cash from the Australian Government (which should be rare in a well-run insurance scheme) under the current cost overrun arrangements. It would also provide greater certainty to governments about future contribution obligations.

Allowing the NDIA access to a pool of reserves could also result in improved lifetime outcomes for participants (as the NDIA could focus more on long-term investments) and provide assurance to the community that the scheme is insulated (to some extent) from the vagaries of the budget cycle. Governments should commit now to establishing a pool of reserves for the NDIA. The reserve entitlement should be calculated based on an actuarial and economic analysis of the optimal reserve amount and allowed to gradually accrue over time.

12 Data

The NDIA collects data on participants when they access the scheme, when plans are developed, at plan implementation and at plan review. At full scheme, there will be data on about 475 000 scheme participants. And while the longitudinal dataset to support actuarial analysis of the scheme will take time to build (little data are currently available), as one study participant said, 'the NDIA is building the most comprehensive population-based longitudinal database on disability in the world'.

The NDIA's information and communication technology system needs to be fit for purpose to undertake the longitudinal data analysis, reporting and monitoring required to support the insurance approach of the NDIS. And there are some issues with the current system not being capable of extracting all the information required. Progress on enhancing the information and communication technology needs to be monitored by the NDIA.

It is also imperative that access to the longitudinal dataset is made available to other researchers. The NDIA has a legislative basis for allowing others to use the NDIS data, but it is yet to establish policies for data sharing. A data sharing policy should be established.

But not all data relevant for assessing the effectiveness of the NDIS will be (or should be) collected within the scheme. A number of stakeholders raised concerns about data collections outside the NDIS discontinuing as State and Territory Governments wind down

disability support services. It is important that data are available to examine the interface between the NDIS, other disability supports and mainstream services. The Australian, State and Territory Governments should commit to the ongoing funding of the Survey of Disability, Ageing and Carers and an expanded Disability Services National Minimum Data Set.

Recommendations and findings

How is the scheme tracking?

FINDING 2.1

The scale and pace of the National Disability Insurance Scheme (NDIS) rollout to full scheme is highly ambitious, and will not be delivered as scheduled in terms of participant intake. The rollout schedule risks the National Disability Insurance Agency (NDIA) not being able to implement the NDIS as intended and it poses risks to the financial sustainability of the scheme. The NDIA is cognisant of these risks.

FINDING 2.2

The Productivity Commission supports the National Disability Insurance Agency's (NDIA's) approach to projecting scheme costs and the decision to delay integrating data from the trial and transition period to date. As such, the Commission has not revised its own projections of scheme costs.

However, it is imperative that new data are incorporated into the NDIA's assessment of longer-term costs as soon as possible. The Commission's assessment is that, in the absence of major new data reliability issues, there should be sufficient data for the NDIA to update the estimates of scheme costs on the basis of scheme experience for the 2017-18 Annual Financial Sustainability Report.

FINDING 2.3

The National Disability Insurance Scheme, at the end of trial, came in under budget. But of concern to the Productivity Commission is that this was in large part because not all committed supports were used (in 2015-16 the utilisation rate was 76 per cent). While lower than expected levels of utilisation means lower scheme costs, it also implies poorer outcomes for participants.

Based on trial and transition data, scheme costs are broadly on track compared to the National Disability Insurance Agency's (NDIA's) long-term modelling. At this stage, early cost pressures (such as greater than expected numbers of children in the scheme) are being more than offset by lower than expected levels of utilisation.

The NDIA has put in place initiatives to address emerging cost pressures. It is too early to assess the effectiveness of these initiatives.

Scheme benefits

FINDING 3.1

Early evidence suggests that the National Disability Insurance Scheme is improving the lives of many participants and their families and carers. Many participants report an increase in the amount of support provided, more choice and control over the supports they receive, improvements in their quality of care, greater independence and an increase in overall wellbeing.

FINDING 3.2

Not all participants are benefiting from the National Disability Insurance Scheme. The groups at risk of having a less positive experience include those with psychosocial disability, complex and multiple disabilities, and language and cultural barriers, as well as people with disability transitioning into the community from the criminal justice system, the homeless and the socially isolated.

RECOMMENDATION 3.1

The National Disability Insurance Agency should collect and publish data on whether or not participants eligible for individualised supports through the National Disability Insurance Scheme have employment restrictions. Data should be collected in a format similar to data collected on employment restrictions by the Australian Bureau of Statistics Survey of Disability, Ageing and Carers.

Scheme eligibility

RECOMMENDATION 4.1

When determining that an individual is eligible for individualised supports through the National Disability Insurance Scheme under the disability requirements, the National Disability Insurance Agency should collect data on which of the activity domains outlined in section 24 of the *National Disability Insurance Scheme Act 2013* (Cwlth) are relevant for individuals when they enter the scheme.

RECOMMENDATION 4.2

The National Disability Insurance Agency should remove the Performance Indicator Target placed on Early Childhood Early Intervention partners that seeks to ensure that less than 50 per cent of children who connect with the partner are referred for access to the National Disability Insurance Scheme.

RECOMMENDATION 4.3

The National Disability Insurance Agency should make public a process for changing the conditions listed in List A and List D of the operational guidelines on access to the National Disability Insurance Scheme, including identifying under what circumstances a change in the lists may be considered.

RECOMMENDATION 4.4

The National Disability Insurance Agency should implement a psychosocial gateway. The gateway should be the primary pathway that people with psychosocial disability enter the National Disability Insurance Scheme.

The gateway should:

- use specialised staff
- operate on a face-to-face basis to the greatest extent possible
- consider models of outreach to engage people with psychosocial disability who are unlikely to approach the scheme
- provide linkages to both clinical and non-clinical services and supports outside the scheme
- collect data on both entrants into the scheme and people linked to services and supports outside the scheme.

Scheme supports

RECOMMENDATION 5.1

The National Disability Insurance Agency (NDIA) should implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review.

If required, the Australian Government should amend the *National Disability Insurance Scheme Act 2013* (Cwlth) to enable the NDIA to implement such a process.

RECOMMENDATION 5.2

The National Disability Insurance Agency should:

- review its protocols relating to how phone planning is used
- provide clear, comprehensive and up-to-date information about how the planning process operates, what to expect during the planning process, and participants' rights and options
- ensure that Local Area Coordinators are on the ground six months before the scheme is rolled out in an area and are engaging in pre-planning with participants.

RECOMMENDATION 5.3

The National Disability Insurance Agency should ensure that planners have a general understanding about different types of disability. For types of disability that require specialist knowledge (such as psychosocial disability), there should be specialised planning teams and/or more use of industry knowledge and expertise.

Boundaries and interfaces with the NDIS

FINDING 6.1

It is a false economy to have too few resources for Information, Linkages and Capacity Building, particularly during the transition period when it is critical to have structures in place to ensure people with disability (both inside and outside the National Disability Insurance Scheme) are adequately connected with appropriate services.

RECOMMENDATION 6.1

Funding for Information, Linkages and Capacity Building (ILC) should be increased to the full scheme amount of $131 million for each year during the transition.

The effectiveness of the ILC program in improving outcomes for people with disability, the adequacy of its funding, and its impact on the sustainability of the National Disability Insurance Scheme should be reviewed as part of the next COAG agreed review of scheme costs in 2023. The ILC budget should be maintained at a minimum of $131 million per annum until results from this review are available.

RECOMMENDATION 6.2

The Australian, State and Territory Governments should make public — through the COAG Disability Reform Council (DRC) — their approach to providing continuity of support and the services they intend to provide to all people with disability (including the value of supports and number of people covered), beyond supports provided through the National Disability Insurance Scheme. Arrangements for continuity of support should be made clear before full scheme implementation.

The National Disability Insurance Agency should report annually to the DRC on boundary issues as they are playing out on the ground, including identifying service gaps and actions to address barriers to accessing disability and mainstream services for people with disability. The reporting should be used for ongoing monitoring, evaluation and improvements.

RECOMMENDATION 6.3

Each COAG Council with responsibility for a service area that interfaces with the National Disability Insurance Scheme (NDIS) should have a standing item on its agenda to address how these services interface with NDIS supports. The standing item should cover service gaps, duplication and other boundary issues, including ways to improve outcomes for people with disability. Each Council should put forward issues and proposed solutions to the Disability Reform Council for action.

At review points of National Agreements and National Partnership Agreements under the *Intergovernmental Agreement on Federal Financial Relations*, parties should agree to specific commitments and reporting obligations that are consistent with the *National Disability Strategy*. The Agreements should be strengthened to include more details around how boundary issues are being dealt with, including practical examples.

RECOMMENDATION 6.4

If the medical and general accident streams of the National Injury Insurance Scheme are not implemented, then State and Territory Governments should bear the additional costs borne by the National Disability Insurance Scheme because of the absence of these streams.

Provider readiness

FINDING 7.1

In a market-based model for disability supports, thin markets will persist for some groups, including some participants:

- living in outer regional, remote and very remote areas
- with complex, specialised or high intensity needs, or very challenging behaviours
- from culturally and linguistically diverse backgrounds
- who are Aboriginal and Torres Strait Islander Australians
- who have an acute and immediate need (crisis care and accommodation).

In the absence of effective government intervention, such market failure will result in greater shortages, less competition and ultimately poorer participant outcomes.

RECOMMENDATION 7.1

The National Disability Insurance Agency should address thin markets by:

- considering a range of approaches, including block-funding
- publicly releasing its Provider of Last Resort (POLR) policy and Market Intervention Framework discussed in the *NDIS Market Approach: Statement of Opportunity and Intent* as a matter of urgency
- collecting and making publicly available disaggregated data, feedback and reports on thin markets, including when POLR arrangements are used.

RECOMMENDATION 7.2

Bilateral agreements regarding the full rollout of the National Disability Insurance Scheme should only include in-kind funding arrangements for services that are required to ensure continuity of support for existing clients. For in-kind services that persist past transition, a timetable for when they will be ‘cashed out’ should be included in bilateral agreements.

Pricing of disability supports

FINDING 8.1

The National Disability Insurance Agency's approach to setting price caps to date has hindered market development by discouraging the provision of some disability supports. In some cases, it has led to poor participant outcomes, especially for those with complex needs. The benefits of the National Disability Insurance Scheme will not be fully realised if the Agency continues with its current pricing approach.

RECOMMENDATION 8.1

The body responsible for regulating the price of supports under the National Disability Insurance Scheme should have relevant capabilities and the necessary resources to set price caps in a manner that is:

- transparent, with wide public consultation and publicly available information, including all assumptions used in any pricing models
- evidence-based
- supported by clear and limited legislative authority
- independent
- timely, particularly in giving providers sufficient time to phase in changes and be responsive to market conditions.

RECOMMENDATION 8.2

The Australian Government should amend the *National Disability Insurance Scheme Act 2013* (Cwlth) to require the National Disability Insurance Scheme Quality and Safeguards Commission (QSC), upon its commencement in 2018, to monitor, review and report on the price caps for scheme supports set by the National Disability Insurance Agency (NDIA). This should include appropriate funding for the QSC to undertake price monitoring of scheme supports, and to continue the business characteristics and benchmarking study currently undertaken by National Disability Services and the University of Western Australia.

The Act should require the NDIA to provide any relevant data and information that is required by the QSC in its price monitoring functions. The NDIA should make public a summary of the report of the 2017 McKinsey & Company price review upon completion, and provide the full report to the QSC.

RECOMMENDATION 8.3

The Australian Government should amend the *National Disability Insurance Scheme Act 2013* (Cwlth) to transfer the National Disability Insurance Agency's (NDIA) power to set price caps for scheme supports to the National Disability Insurance Scheme Quality and Safeguards Commission (QSC) by no later than 1 July 2020. The Act should require the NDIA to provide any relevant data and information that is required by the QSC in its price regulation functions.

Prices should only be regulated as narrowly and for as short a time as possible. As part of its price regulation functions, the QSC should:

- collect, de-identify and publicly release data on providers' characteristics, including the price, profits, costs and quality of services
- set price caps for supports at least at a state and territory level, which should be made public no less than 60 days before prices take effect
- comprehensively review and make public its price model on at least an annual basis. This review should be transparent, have wide public consultation, be evidence-based and evaluate the effectiveness of prices in meeting clearly defined objectives
- determine when to deregulate prices for supports, with particular regard to the type of support and region.

Progress towards price deregulation should be considered by the independent review of scheme costs in 2023.

Workforce readiness

FINDING 9.1

The disability care workforce will not be sufficient to deliver the supports expected to be allocated by the National Disability Insurance Agency by 2020.

RECOMMENDATION 9.1

The roles and responsibilities of different parties to develop the National Disability Insurance Scheme (NDIS) workforce should be clarified and made public by the beginning of 2018.

- State and Territory Governments should rely on their previous experience in administering disability care and support services to play a greater role in identifying workforce gaps and remedies tailored to their jurisdiction.
- The Australian Government should retain oversight of workforce development, including how tertiary education and aged care policy interact and affect the development of the workforce.
- The National Disability Insurance Agency should provide State and Territory Governments with data and analyses held by the Agency to enable those jurisdictions to make effective workforce development policy.
- Providers of disability supports should have access to a clear and consistent mechanism to alert the National Disability Insurance Agency, the NDIS Quality and Safeguards Commission, and the Australian, State and Territory Governments about emerging and persistent workforce gaps.

RECOMMENDATION 9.2

The National Disability Insurance Agency should publish more detailed market position statements on an annual basis. These should include information on the number of participants, committed supports (disaggregated at a level of detail consistent with the guides used to set price caps), existing providers and previous actual expenditure by local government area.

The Australian Government should provide funding to the Australian Bureau of Statistics to regularly collect and publish information on the qualifications, age, hours of work and incomes of those working in disability care roles, including allied health professionals.

RECOMMENDATION 9.3

The Australian Government should adjust immigration policies where necessary to address National Disability Insurance Scheme workforce shortages.

RECOMMENDATION 9.4

Some volunteer organisations are finding it difficult to provide supports to eligible scheme participants. There is merit in the National Disability Insurance Agency:

- considering whether volunteer organisations should be funded to cover both the initial costs of connecting participants with volunteers and ongoing costs of volunteer management. The Agency should consider whether this is best done through line items for scheme participants or through a more direct funding arrangement with volunteer organisations
- trialling different funding arrangements to cover ongoing costs of volunteer management and collecting data on the outcomes of participants that use such services to better evaluate the costs and benefits of volunteer organisations providing scheme supports over the longer term.

RECOMMENDATION 9.5

The National Disability Insurance Agency should collect data on the number of participants who make use of paid informal carers to deliver scheme supports, including the costs associated with such payments and their length of use.

RECOMMENDATION 9.6

The National Disability Insurance Agency should:

- ensure planners take into account the amount of respite care that is reasonable and necessary under an individualised support package, based on the amount of informal care that is expected to be provided by informal carers
- label short-term accommodation supports provided in participants' plans in a way that makes it clear that these supports can be used for respite
- better inform participants and their informal carers that core supports provided in individualised support packages can be used to fund additional in-home care or support in shared facilities to provide respite
- include specific measures to ensure a supply of respite services in its provider of last resort policies.

Participant readiness and market stewardship

RECOMMENDATION 10.1

The National Disability Insurance Agency should:

- clarify to scheme participants and the community the role of support coordinators in relation to Local Area Coordinators, plan managers, mainstream services and advocates
- allocate support coordination to participants in their plans on the basis of need (and not for a fixed time period) in determining whether it is a reasonable and necessary support, pursuant to section 34 of the *National Disability Insurance Scheme Act 2013* (Cwlth).

RECOMMENDATION 10.2

The National Disability Insurance Agency should provide accessible information to participants and the public about the providers available in the market and indicators of participant satisfaction with those providers. This information should be updated in as close to real-time as possible, and be consistent with the stated objectives of the eMarketPlace discussed in the *Integrated Market, Sector and Workforce Strategy*. It should be provided no later than 1 July 2018.

RECOMMENDATION 10.3

The National Disability Insurance Scheme Quality and Safeguards Commission, upon commencement, should closely monitor the operation of intermediary services under the National Disability Insurance Scheme, and make changes to safeguarding rules and codes of conduct as necessary to ensure that intermediaries act in the best interests of participants.

The National Disability Insurance Agency should provide clear and timely information about the option for participants to self-manage their plans, and the role that intermediaries can play to assist them to undertake different tasks on their behalf. The Agency should continue to assess the capacity of participants to self-manage on a case-by-case basis, consistent with the provisions of the *National Disability Insurance Scheme Act 2013* (Cwlth).

RECOMMENDATION 10.4

The Australian, State and Territory Governments should continue to fund disability advocacy organisations. State and Territory Governments should fund disability advocacy to 2019-20 by an amount that at least matches the per capita contribution of disability advocacy funding announced by the Australian Government.

The Australian, State and Territory Governments should also collect data from funded disability advocacy organisations about people with disability who use their services, and their outcomes. This data should be in a format that can be linked with data held by the National Disability Insurance Agency, and be made publicly available. The Department of Social Services should undertake an independent evaluation of advocacy funding at the beginning of 2020 to inform future funding arrangements, and thereafter periodically evaluate disability advocacy. These reports should be made public.

FINDING 10.1

The supply of disability supports in the short to medium term will not be able to meet participant demand resulting from the National Disability Insurance Scheme. This is due to a combination of factors, including rapid intake of the scheme, difficulties faced by participants to navigate the new markets for disability supports, difficulties by providers to adjust quickly to a new market-based model of service delivery, and underdeveloped market stewardship.

RECOMMENDATION 10.5

The COAG Disability Reform Council should immediately clarify and make public the roles and responsibilities of the Australian, State and Territory Governments with respect to market stewardship (those actions required to define and support the effective functioning of sustainable and enduring markets for participants and providers). This should include clear and transparent reporting of the specific actions and outcomes they are to achieve (including costs, benefits and risks), timeframes and progress towards goals.

The Australian, State and Territory Governments should:

- with the National Disability Insurance Agency and the National Disability Insurance Scheme Quality and Safeguards Commission, collect and make publicly available disaggregated, tailored and forward-looking market data, including provider and workforce data on supply gaps
- coordinate their market stewardship actions across all sectors, particularly with other care sectors and mainstream services.

Governance

RECOMMENDATION 11.1

The *National Disability Insurance Scheme Act 2013* (Cwlth) should be amended to change the process for agreeing to Category A Rules to reduce the time it takes to implement or amend those rules.

The amendment should not change the requirement that there be unanimous agreement among the Australian Government and the host jurisdictions for implementing or amending Category A Rules.

RECOMMENDATION 11.2

At full scheme, the annual operating budget for the National Disability Insurance Agency should be set within a funding target of 7–10 per cent of package costs with the expectation that, on average, it would sit at the lower end of the band.

The National Disability Insurance Agency should be required, in its annual report, to state the reasons why it has not met this target in any given year.

RECOMMENDATION 11.3

The Australian Government should remove the cap on staff employed directly by the National Disability Insurance Agency.

RECOMMENDATION 11.4

The Western Australian Government and Australian Government should put in place arrangements for Western Australia to transition to the National Disability Insurance Scheme. Any decision to join the national scheme should be made public as soon as possible.

RECOMMENDATION 11.5

The National Disability Insurance Agency should publicly report on the number of unscheduled plan reviews and reviews of decisions, review timeframes, outcomes of reviews and stakeholder satisfaction with the review process.

RECOMMENDATION 11.6

The *NDIS Quality and Safeguarding Framework* and associated regulatory arrangements should be examined as part of the first five-yearly review into National Disability Insurance Scheme costs in 2023.

RECOMMENDATION 11.7

The National Disability Insurance Agency (NDIA) should continue to develop and expand the performance reporting against the *Integrated NDIS Performance Reporting Framework*, including on outcomes, and Local Area Coordination and Information, Linkages and Capacity Building activities.

The NDIA should also fill gaps in its performance reporting, including reporting on plan quality (such as participant satisfaction with their plans and their planning experience, plans completed by phone versus face-to-face, and plan reviews). This work should be made a priority. The NDIA should begin reporting on measures and indicators of quality by June 2018.

The *Integrated NDIS Performance Reporting Framework*, and any additional reporting outside this framework included in the Quarterly report to the COAG Disability Reform Council (DRC), should be regularly reviewed by the DRC and refined as needed.

RECOMMENDATION 11.8

The National Disability Insurance Agency should better balance participant intake, the quality of plans and participant outcomes. This rebalancing should be explicitly tied to quality indicators that are publicly reported on (as per recommendation 11.7).

RECOMMENDATION 11.9

The Australian, State and Territory Governments should immediately start planning for a changed timetable for participant intake for the National Disability Insurance Scheme.

In doing so, the Australian, State and Territory Governments should ensure that adequate continuity of support arrangements are in place and assess whether additional resources are required to ensure the scheme meets its objectives. The issue of resourcing disability services under the changed timetable should be dealt with by the Treasurers and Ministers responsible for the disability portfolio in each jurisdiction, at the next COAG Disability Reform Council meeting.

Funding arrangements

RECOMMENDATION 12.1

The DisabilityCare Australia Fund (DCAF) should be discontinued after 2023-24. All the Medicare levy funds hypothecated for the National Disability Insurance Scheme (NDIS) should be put in the proposed NDIS Savings Fund.

The reimbursement arrangements that currently apply under the DCAF should not be continued after 2023-24. If necessary, the impact of such reimbursements should be reflected directly in reduced contributions from the State and Territory Governments.

RECOMMENDATION 12.2

From full scheme, the escalation parameters that determine the growth of State and Territory Government financial contributions to the costs of the National Disability Insurance Scheme should be set on the basis of population growth and inflation. This will maintain constant real per person contributions from the State and Territory Governments.

The Commission's assessment of projections of population and inflation over the period 2019-20 to 2023-24 suggests the escalation parameters should be set at 4 per cent, rather than the currently agreed 3.5 per cent.

The escalation parameters should be reassessed for the period beyond 2023-24, at 5 yearly intervals, based on the most contemporary projections of population and inflation at that time. The funding shares among the States and Territories should also be rebased according to the most contemporary census population data available at that time.

FINDING 12.1

If funding contributions to the National Disability Insurance Scheme increase in line with projected scheme costs and there is an actuarially-assessed buffer for risk, then cost overruns in a mature scheme will only occur where cost increases are sudden and difficult to predict.

RECOMMENDATION 12.3

From full scheme, the Australian Government should explicitly factor projected increases in scheme costs, based on the provision of reasonable and necessary supports, into the calculation of its contributions to the National Disability Insurance Scheme.

If cost overruns occur from full scheme, they should be funded by the Australian Government.

RECOMMENDATION 12.4

Governments should commit now to providing a pool of reserves for the National Disability Insurance Agency. The pool should build up gradually over time, with the target amount based on an actuarial and economic analysis of the optimal level of reserves.

Data and evidence

RECOMMENDATION 13.1

Australian, State and Territory Governments should commit, by June 2018, to fund (on an ongoing basis) the Australian Bureau of Statistics Survey of Disability, Ageing and Carers, so it can be conducted every three years.

RECOMMENDATION 13.2

The Australian, State and Territory Governments should agree to expand the data collection for the Disability Services National Minimum Data Set to include supports to people with disability that are provided or funded by governments outside the National Disability Insurance Scheme (NDIS).

The data collected should include services provided to NDIS participants, but not provided by the NDIS.

A decision on the data to be collected should be made by June 2018, with the broader data to be included in the 2018-19 Disability Services National Minimum Data Set.

FINDING 13.1

There are benefits from allowing researchers to have access to National Disability Insurance Scheme unit record data. Access could be provided by creating a de-identified longitudinal dataset and by allowing approved researchers access to bespoke and more detailed data sets on a case-by-case basis.

FINDING 13.2

The National Disability Insurance Agency should adopt a risk-based approach to sharing and release of data. A risk-based approach could include:

- open data that are able to be publicly released because they are non-sensitive
- a synthetic dataset that is more disaggregated but also non-sensitive, that is readily provided to researchers
- secure sharing of more sensitive data to researchers in an environment such as SURE
- better sharing of data with other relevant agencies such as the Australian, State and Territory Governments, with secure access and storage procedures put in place.

There are likely to be benefits, particularly in the early years of its operation, from drawing on the capability and expertise of more mature organisations such as the Australian Institute of Health and Welfare and Data61.

RECOMMENDATION 13.3

The National Disability Insurance Agency (NDIA) should engage with stakeholders on how data access will be operationalised. By July 2018, the NDIA should issue a statement outlining the organisation's goals for data sharing and an intended timeline for operationalising data sharing by the NDIA.

1 About this study

The National Disability Insurance Scheme (NDIS) is a new scheme designed to change the way that support and care are provided to people with permanent and significant disability. It is currently being rolled out across Australia and is expected to be fully implemented in all states and territories by mid-2019.

This study is a review of NDIS costs. It looks at the sustainability of scheme costs in light of the benefits and impacts of the scheme on the lives of people with disability, and Australians more generally. The study will help inform the final design of the scheme.

Some background to the study

In 2011, a Productivity Commission inquiry into *Disability Care and Support* found that Australia's system of disability supports was inequitable, underfunded, fragmented, inefficient and gave people with disability little choice and no certainty of access to appropriate supports (PC 2011, p. 5). The Commission recommended that a national disability insurance scheme be established to change the way that support and care are provided to people with significant disability, and to provide insurance cover to all Australians in the event of such a disability. The recommendation was based on the finding that such a scheme would generate substantial community-wide benefits, including improving the lives of people with disability and their families and carers.

The Commission's recommendation was accepted by Australian governments and on 7 December 2012, COAG signed an Intergovernmental Agreement for the launch of the NDIS (COAG 2012b). In the Heads of Agreement between the Australian Government and the State and Territory Governments, it was agreed that the Productivity Commission would review NDIS costs in 2017, to inform the final design of the scheme ahead of its full rollout. The terms of reference for this study were received on 20 January 2017.

1.1 About the NDIS

The NDIS is based on the premise that individuals' support needs are different, and those participating in the scheme should be able to exercise choice and control over the services and support they receive. The objectives of the NDIS (as outlined in the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act)) include:

- supporting the independence and social and economic participation of people with disability

- providing reasonable and necessary supports, including intervention supports
- enabling people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports
- facilitating the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability
- promoting the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community
- raising community awareness of issues that affect people with disability.

The NDIS operates under the NDIS Act, and is administered by the National Disability Insurance Agency (NDIA). Funding for the NDIS is shared by the Australian and State and Territory Governments.

The NDIS provides individualised supports to assist people with permanent and significant disability to participate in economic and social life.[8] This report refers to people who are eligible for individualised supports as 'participants' of the scheme.

For each participant, the NDIS funds 'reasonable and necessary' supports related to their disability. Reasonable and necessary supports are those that help participants live as ordinary a life as possible, including care and support to build skills and capabilities, so that they can engage in education, employment and social and community activities.

Supports are also available to those who meet early intervention criteria. This covers cases where early intervention can significantly improve outcomes and is cost effective. The focus on early intervention reflects the lifetime, insurance-based approach of the scheme.

Individuals eligible for the scheme are assessed, and individual support packages are developed and funded. Access, planning and payments are managed by the NDIA. (In Western Australia, arrangements are different, but intended to be consistent with the NDIS (Porter, Barnett and Faragher 2017).)

The individualised supports provided to participants account for the vast majority of scheme costs and therefore references to 'the scheme' (including in this report) often refer to these supports.

However, the NDIS is broader than just supports for eligible participants. Information, linkages and capacity building (ILC) services are also provided under the NDIS to help all people with disability (not just scheme participants), and their families and carers, with information and referrals to community and mainstream services (including health, education, employment, justice, transport and housing) (NDIA 2016b). ILC will also

[8] Permanent and significant disability is defined in this report as a disability that permanently and substantially reduces a person's functional capacity or psychosocial functioning. This is in line with the eligibility criteria contained in the NDIS Act (s. 24).

facilitate greater social cohesion by promoting awareness and acceptance of disability in the wider community.

More detail on the scheme, including eligibility criteria, planning processes and governance arrangements, is provided throughout this report.

The NDIS is part of a broader system of support

The NDIS is part of a wider disability system. It is one component of the broader *National Disability Strategy 2010–2020*, which was endorsed by COAG in February 2011 and provides a ten-year national policy framework for improving the lives of Australians with disability, their families and carers (COAG 2011; DSS 2016c).

Only a proportion of people with disability will become scheme participants and receive individualised supports. There are approximately 4.3 million people with disability in Australia (figure 1.1). Once fully implemented, the NDIS will provide individual packages to about 475 000[9] people — those people with a permanent and significant disability.

Supports for people with disability (both NDIS participants and non-NDIS participants) are also provided through other Australian and State and Territory Government funded disability services and mainstream services, such as health and education.

1.2 The benefits of the NDIS

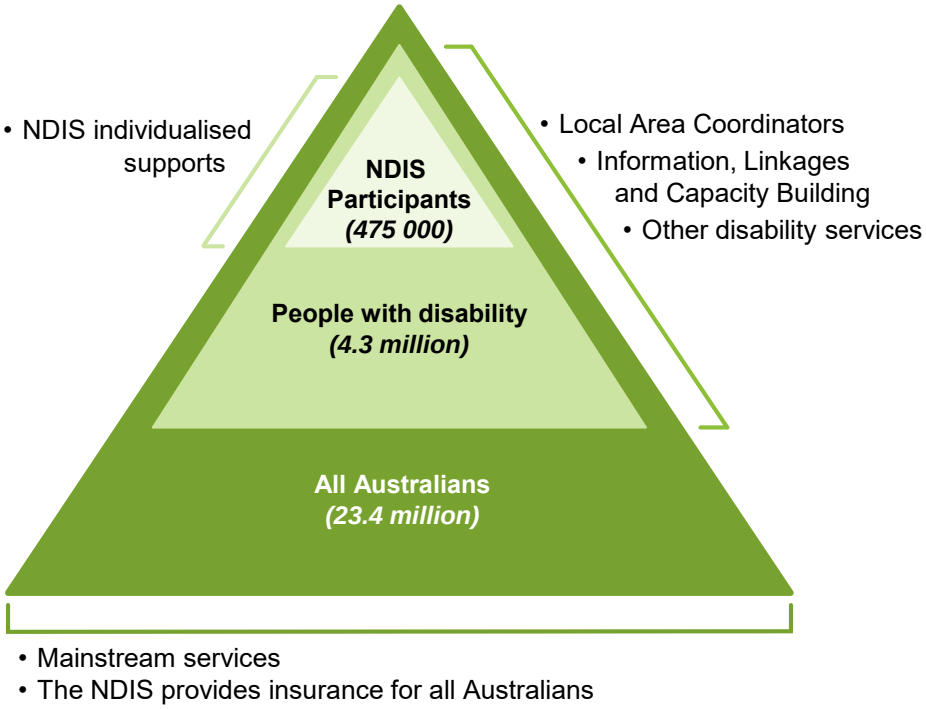
The Commission recommended a national disability insurance scheme in 2011 on the basis of the substantial net benefits it would generate in the long term from:

- improved wellbeing for people with disability and their families and carers through increased care and support, and more choice and control over the supports they receive. This was identified as the area of largest benefit with more, and better targeted, support for participants leading to greater social participation and independence
- efficiency gains in the disability sector — through increased competition and innovation, and better value for money
- savings to other government services — by better supporting people with disability and reducing their reliance on mainstream services
- increased economic participation for people with disability — by overcoming obstacles to employment for those with disability through direct interventions, like school leaver employment programs, and through changes to community attitudes. The Commission estimated that employment of people with disabilities could increase by 100 000 by 2050 (catching up to OECD rates), resulting in $8 billion in additional gross domestic product in that year alone

9 460 000 participants under the age of 65 years and 15 000 aged 65 years and over (chapter 2).

- increased economic participation for informal carers — the Commission estimated that an additional 7500 carers could re-enter the workforce (PC 2011).

Figure 1.1 **The NDIS is part of a broader system of supports[a]**



[a] Number of Australians and those with disability are based on 2015 data. NDIS participants are the projected number of people eligible in 2020.

Sources: Commission estimates based on unpublished NDIA data; ABS *(Disability, Ageing and Carers, Australia: Summary Findings, 2015, Cat. no. 4430.0)*.

A new approach to disability care and support

The scheme is designed to change the way that participants and disability support providers interact, and the way that supports are funded. Two of the key changes from previous approaches include a more market-based, person-centred approach to care and support, and a scheme based on insurance principles.

A more market-based approach aims to create incentives that better provide participants with the quantity, quality and variety of services they desire in an efficient way. It is expected to overcome many of the previous system's shortcomings (table 1.1), including by providing participants more choice and control over their supports and services, and encouraging innovation by service providers through increased competition. The market will, nevertheless, continue to have significant government oversight, as in other administered markets such as health and education.

Table 1.1 **Intended effects of the NDIS on the disability services system**

Features of pre-NDIS disability services system	*Features of a more market-based system*
• Largely 'block-funded', with funding provided in advance of service delivery and little freedom to innovate.[a]	• Predominantly fee-for-service paid on invoice. In principle, prices for services are set by the competitive market, and there is innovation by service providers attracting and retaining consumers.
• Services often limited and priorities for families in immediate crisis, rather than for early intervention. Consumers have little control over the services they receive and limited choice of provider.	• Funding to meet the reasonable and necessary support needs for each NDIS participant. Consumers have choice and control regarding the services received and providers used.
• The primary relationship is between the service provider and the funder, with consumers often described as 'passive' recipients of services.	• The primary relationship is between the consumer and service provider. Intermediaries and access to information about provider quality, performance and pricing help consumers exercise choice.
• Providers are subject to various statutory provisions (at all levels of government) regarding quality. The system is complex, difficult to navigate and not well integrated nationally.	• Compliance with a national quality framework. A nationally consistent and navigable system.
• High transaction costs for both consumers and providers.	• Lower transaction costs for consumers and service providers. There is adequate depth and resilience in the market to underpin financial sustainability.

[a] Block funding refers to the process where governments purchase a 'block' of services from a provider, which is to be delivered to clients who meet certain criteria, or are referred to those providers as part of an individualised plan.

Sources: Adapted from ANAO (2016, p. 20), which is based on analysis by PC (2011); DRC (2015a); and NDIA presentations on the market transition.

As an insurance-based scheme, the NDIS takes a lifetime approach to a participant's support needs and life goals (box 1.1). It is intended to provide assurance to both those with permanent and significant disability, and those who may acquire such disability in the future, that they will receive the support they require. In other words, there is essentially no cap on funding — anyone who meets the eligibility criteria is guaranteed to receive funding for supports and services. The scheme also focuses on early intervention investment in people with disability so that their outcomes can be improved later in life, and costs minimised over the long term, even if that involves more spending upfront. The insurance-based approach also allows for ongoing monitoring and refinement of the scheme.

This contrasts with the previous system which operated on an annual capped amount and did not tailor supports to individuals, leading to short-term planning, limited choice, higher long-term support needs, unmet demand and adverse outcomes for some (PC 2011).

Box 1.1 **The NDIS is an insurance-based scheme**

The insurance approach of the NDIS takes a long-term view of the total cost of disability in order to improve participant outcomes and meet the future costs of the scheme. Key elements of the approach include:

- universal coverage by pooling risk across all Australians and taking the risk of disability support costs away from individuals
- creating an innovative and competitive market for disability support, through which participants can exercise choice and control over the planning and delivery of their supports
- a long-term view of the total future social cost of disability for all people who are insured and yet to be insured
- the NDIA — in its role as the social insurance manager — managing the total cost of disability over a participant's lifetime and incentivising short-term investment in participants to reduce long-term costs.

The NDIA identifies four principles for the way that the insurance approach is operationalised.

1. Actuarial estimates of long-term costs — updated to reflect the experience of the scheme, and used to help ensure the scheme is financially sustainable and that the scheme is continuously improved.
2. A long-term view of funding requirements — takes a lifetime view of participant needs and seeks early investment and intervention for people in order to maximise their independence and social and economic participation, and reduce their support requirements in the long term.
3. Investment in research and innovation — to encourage and build the capacity and capability for innovation, outcome analysis and evidence-based decisions on early intervention.
4. Investment in community participation and building social capital — to make the community accessible and inclusive for people with disability, and provide participants and non-participants with necessary supports outside the NDIS, through mainstream services, ILC initiatives and education programs.

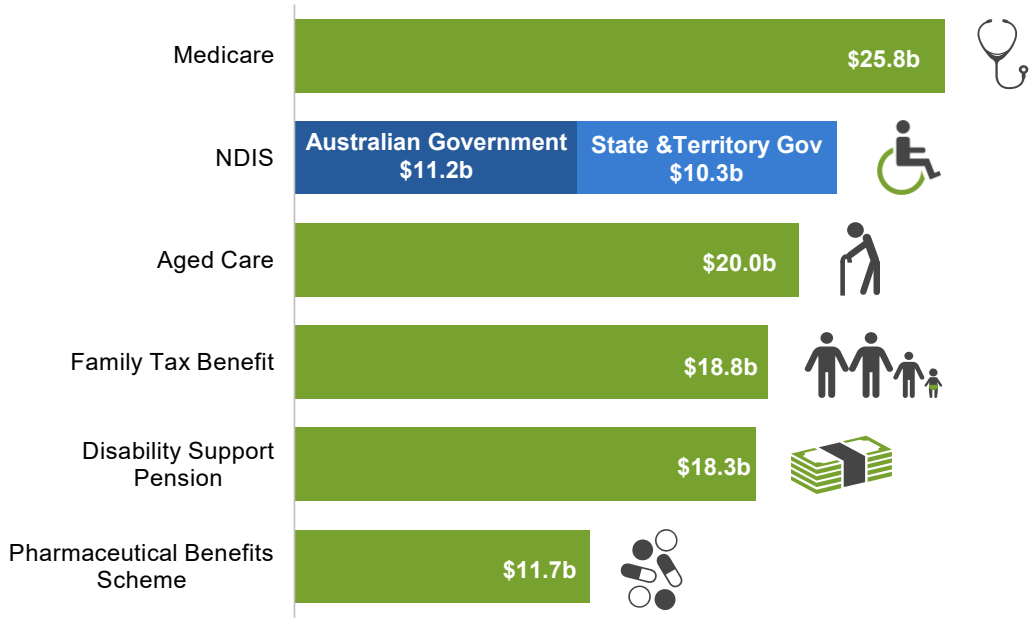
Source: NDIA (sub. 161, pp. 22–26).

1.3 The NDIS is a major reform

The NDIS is a major reform. As the NDIA (2016i, p. 7) said, the scheme is 'on a scale not previously contemplated in Australia and is designed to address un-met need'. The NDIS will be the largest social reform since the introduction of Medicare. At a currently estimated annual cost of about $22 billion when fully implemented, government expenditure on the NDIS will exceed that on aged care and will be almost double that spent on the Pharmaceutical Benefits Scheme (figure 1.2).

At full rollout, the NDIS is expected to cover 475 000 people with disability. This is almost 200 000 more people than were covered under the previous system (NDIA 2016i, p. 8). To meet this increased demand, the disability workforce will need to more than double (chapter 9).

Figure 1.2 **Projected NDIS expenditure compared with other Australian Government programs, 2019–20[a]**



[a] The NDIS amount is based on Department of Social Services modelling and is sourced from the 2016-17 Australian Government budget (the 2017-18 budget estimate excludes the cost of the Western Australian scheme).

Source: Australian Treasury (2016, 2017c, 2017d).

Introducing a scheme of this scale and nature is a challenging task and it is inevitable that it will take many years before the scheme is fully established and operating smoothly. The enormity and significance of the task was acknowledged by many study participants. For example, the ACT Disability, Aged Carer and Advocacy Service said:

> The NDIS is monumental reform for Australia: a grand scheme (akin to the introduction of Medicare) that has the potential to make vast differences in the life experiences of an array of people with disability, their families and carers both now and in decades to come. (sub. 87, p. 1)

Richard Madden, from the Centre for Disability Research and Policy at University of Sydney, said:

> The NDIS has been introduced quickly, and involves a large increase in public expenditure, and inevitably some uncertainty as long standing support arrangements change. The change effort has been huge for all involved. Inevitably, there have been issues to be addressed, and some delay in ambitious timetables. These issues, while important, must not detract from the achievements made and the opportunities that exist. (sub. 101, p. 3)

And the National Mental Health Commission said:

> … the NDIA has been given an extremely difficult task. Implementing a reform of the scale and nature of the NDIS was always going to be challenging; implementing it with a curtailed timetable, reduced resourcing and under shared accountability arrangements where different governments have different expectations. (sub. PP319, p. 5)

There is overwhelming support for the scheme

While many stakeholders commented on the scale and complexity of the reform, there is an extraordinary level of commitment to the success and sustainability of the NDIS (and to preserving the core principles of the scheme as set out by the Commission). This commitment is shared by governments, people with disability and their families and carers, providers of disability services and disability advocates (box 1.2). For example, Mental Health of Young People with Developmental Disabilities said:

> The NDIS is a ground-breaking social reform that is to be commended and supported. … Designing the NDIS as an insurance scheme with benefits paid to individuals is an empowering move. For too long people with disabilities have not been able to exercise control over their lives as able-bodied and minded Australians do. 'Choice and control' is the right of every person with disabilities and that of their primary carers. (sub. PP269, p. 2)

It is also acknowledged that 'making the scheme work' is not just the responsibility of the NDIA, but also of governments, providers and participants (and their families and carers). As the Australian Disability Discrimination Commissioner said:

> Yes — the NDIS is big, it is complex, and it changes everything, but it is the change that we need. And when we think about what life might be like for people with disability without the NDIS, I think it becomes clear that it is the change we cannot afford to prevent. … ensuring the sustainability and success of the NDIS is not only the responsibility of the NDIA or its board — it is the responsibility of all governments, service providers, participants, their families and carers. If we want real and lasting change for people with disability, we cannot absolve ourselves of our responsibility to make the NDIS work. (McEwin 2017)

Box 1.2 There is overwhelming support for the NDIS

Australian Federation of Disability Organisations:

> We want to begin … by emphasising our unwavering support for the NDIS. AFDO and its members regularly hear from people with disability and their families about the difference the NDIS is making to their lives. People who now have the dignity of appropriate and timely support, the opportunity to be more involved in their communities, the chance to move out of home, the economic freedom of a new job. These are the kinds of differences the NDIS is making. (sub. 180, p. 6)

Anglicare Australia:

> Anglicare Australia strongly believes that the establishment of the NDIS is a major achievement. Our member agencies are already witnessing the transformative power of the scheme for participants, and finding that reconfiguring services to reflect their needs and aspirations is creating opportunities to reimagine and create better outcomes in people's lives. (sub. 157, p. 4)

Women with Disabilities Victoria:

> WDV is a strong supporter of the NDIS. We agree with its fundamental principles, including a human rights approach, choice and control for participants and a clear focus on outcomes for individuals. (sub. PP282, p. 3)

JFA Purple Orange:

> … the NDIS is a major, once-in-many-generations opportunity to invest in the life chances of people living with disability, to achieve a fair go, so that people living with disability take their rightful place as valued active members of Australian community life and the economy. (sub. 186, p. 4)

National Disability Services:

> The principles on which the NDIS is founded remain compelling and inspiring. Doubling the funding for disability support to rectify the chronic under-supply of services, choice and control for people with disability and their families, an insurance approach that focuses on early intervention and building the capacity of individuals and families and increased equity across Australia. (2016, p. 3)

Occupational Therapists Australia:

> OTA is a strong supporter of the NDIS and the scheme's focus on providing individualised support for participants with informed choice and control over their plans. Occupational therapists worked across all NDIS launch sites and contributed to the design and implementation of the scheme during its trial period. They are continuing to support participants as the scheme transitions to full rollout. (sub. PP285, p. 2)

Scope Australia:

> Scope is fully committed to the implementation of the National Disability Insurance Scheme. The Scheme creates a paradigm shift in social policy and recognises the rights of all Australians to live an ordinary life. It has enhanced the lives of more than 60,000 participants and their families and for the first time fully recognises the rights of people with a disability to live their lives as empowered and equal citizens. (sub. 72, p. 29)

Northern Territory Government:

> The NT Government is a strong supporter and advocate of the NDIS which will support Territorians with disability achieve life goals through choice and control. (sub. PP359, p. 9)

New South Wales Government:

> The NSW Government is a strong advocate of the National Disability Insurance Scheme (NDIS). The improvement in the lives of people with disability, as outlined by the Productivity Commission (PC) in its 2011 inquiry report into Disability Care and Support, is a goal embraced by NSW. (sub. 60, p. 2)

Transitional issues can become entrenched problems

It is no surprise, given the size, speed and complexity of the reform, that there are transitional issues with the rollout of the NDIS. All major reforms are followed by a (sometimes protracted) period of disruption and adjustment. Flourish Australia, while strongly supporting the NDIS, said it:

> … as with any reform of such a substantial scale, there can be unintended consequences, implementation issues and uncertainty, especially during the transition phase. We are particularly mindful of the impact of this on the people we support. (sub. 74, p. 1)

Most transitional issues are expected to be ironed out as the scheme rollout is completed and the scheme matures. And the NDIA said that resources are being devoted to addressing implementation issues:

> The NDIS is still in its infancy and delivering the Scheme will evolve and improve over time. The NDIA is intent on learning from experience and improving systems, processes and practices as quickly as possible to ensure the success of the Scheme. (sub. 161, p. 16)
>
> Work to improve the participant and provider pathways … is well underway and, in close consultation with stakeholders, is focusing on reforms that will make processes more responsive and flexible to participant and provider needs, and more focused on outcomes across participant lifetimes. (sub. PP327, p. 10)

However, if transitional issues are not dealt with quickly and effectively, they can become entrenched problems that endure in the longer term and affect the success and sustainability of the scheme. As Blind Citizens Australia said:

> Blind Citizens Australia recognises the NDIS represents the single largest reform Australia has seen since the introduction of Medicare. As such, it is understandable that there are still a number of operational and interfacing difficulties that remain outstanding. The challenge is in ensuring these matters are promptly responded to and resolved. (sub. PP351, p. 14)

1.4 The Commission's approach to the study

This study is a review of NDIS costs. The Commission was asked to look at:

- the sustainability of scheme costs, including current and future cost pressures, and how to manage any potential cost overruns
- whether jurisdictions have the capacity to deliver disability care and support services as the scheme expands
- how the NDIS impacts on, and interacts with, mainstream services
- whether efficiencies have been achieved within the scheme
- whether there are any issues with scheme design, including the application of market and insurance principles, in ensuring the best possible outcomes for people with permanent and significant disability

- funding and governance arrangements, including financial contributions, risk-sharing, and the 'escalation parameters', which define the annual increase in funding required by different jurisdictions.

Costs are one side of the equation — benefits are just as important

A number of stakeholders expressed concern that the Commission would focus on costs and not take into account the intent of the scheme and the potential impact that it could have on the lives of people with disability (box 1.3). As the Australian Federation of Disability Organisations said:

> A focus on costs should not be at the expense of a focus on outcomes for the very people the scheme is intended to support. Any decisions made in the interests of ensuring sustainability should also be consistent with improving outcomes for people with disability. (sub. 180, p. 6)

Box 1.3 Stakeholders said the focus should not be solely on costs

Anglicare Australia:

> … measures of the financial sustainability of the NDIS should not be narrowly held and applied solely within the scheme itself. Although such measures are of course essential, questions regarding the overall worth of the scheme that capture the cost and benefit to Australian society should be included … (sub. 157, p. 21)

Community Mental Health Australia:

> … [CMHA] believes that the Commission in assessing whether or not the NDIS is financially sustainable must investigate how the scheme is being implemented and how this is being managed. (sub. 11, p. 2)

Australian Blindness Forum:

> The financial sustainability of the NDIS should be defined and measured by the standard that all people with disability can access and participate in the community. (sub. 48, p. 17)

New South Wales Government:

> Any review of costs and sustainability isn't necessarily about minimising short term costs. Costs must be considered in relation to the objectives of the NDIS (reasonable and necessary support; choice and control; increased social and economic participation). (sub. 60, p. 9)

Victorian Government:

> The PC rightly highlights the cost risks for the NDIS, as financial sustainability is one of the central tenets of the scheme and crucial for it to operate as intended. However, Victoria considers that the risks of the scheme should be conceived more broadly and over a longer time horizon; successful implementation of the scheme must consider participant outcomes, use an insurance based approach and give greater consideration to market development. (sub. PP298, p. 5)

SDN Children's Services:

> SDN believes that a drive for financial sustainability must not be disconnected from a drive for quality, effective practices. (sub. 73, p. 2)

Autism Aspergers Advocacy Australia:

> Maybe 'sustainability' is the wrong notion. It is more about benefit versus cost, and people having a reasonable standard of living in our community. (sub. 178, p. 36)

While the focus of this study is on scheme costs, costs cannot be considered in isolation of the benefits. The Commission's approach (consistent with the *Productivity Commission Act 1998* (Cwlth)) is to examine costs in light of the benefits and impacts of the scheme on the lives of people with disability, and Australians more generally, using a wellbeing framework (figure 1.5). This is consistent with the insurance approach of the NDIS, which is about 'maximising outcomes for participants and their families/carers at the lowest possible sustainable cost' (NDIA, sub. 161, p. 26). It is also consistent with the objectives of the NDIS (choice and control, independence, social and economic participation, reasonable and necessary support), which are seen by the Commission as integral to the analysis of scheme costs.

What are the factors driving scheme costs?

Assessing the sustainability of scheme costs, including current and future cost pressures, involves examining the factors that drive scheme costs. Key factors include:

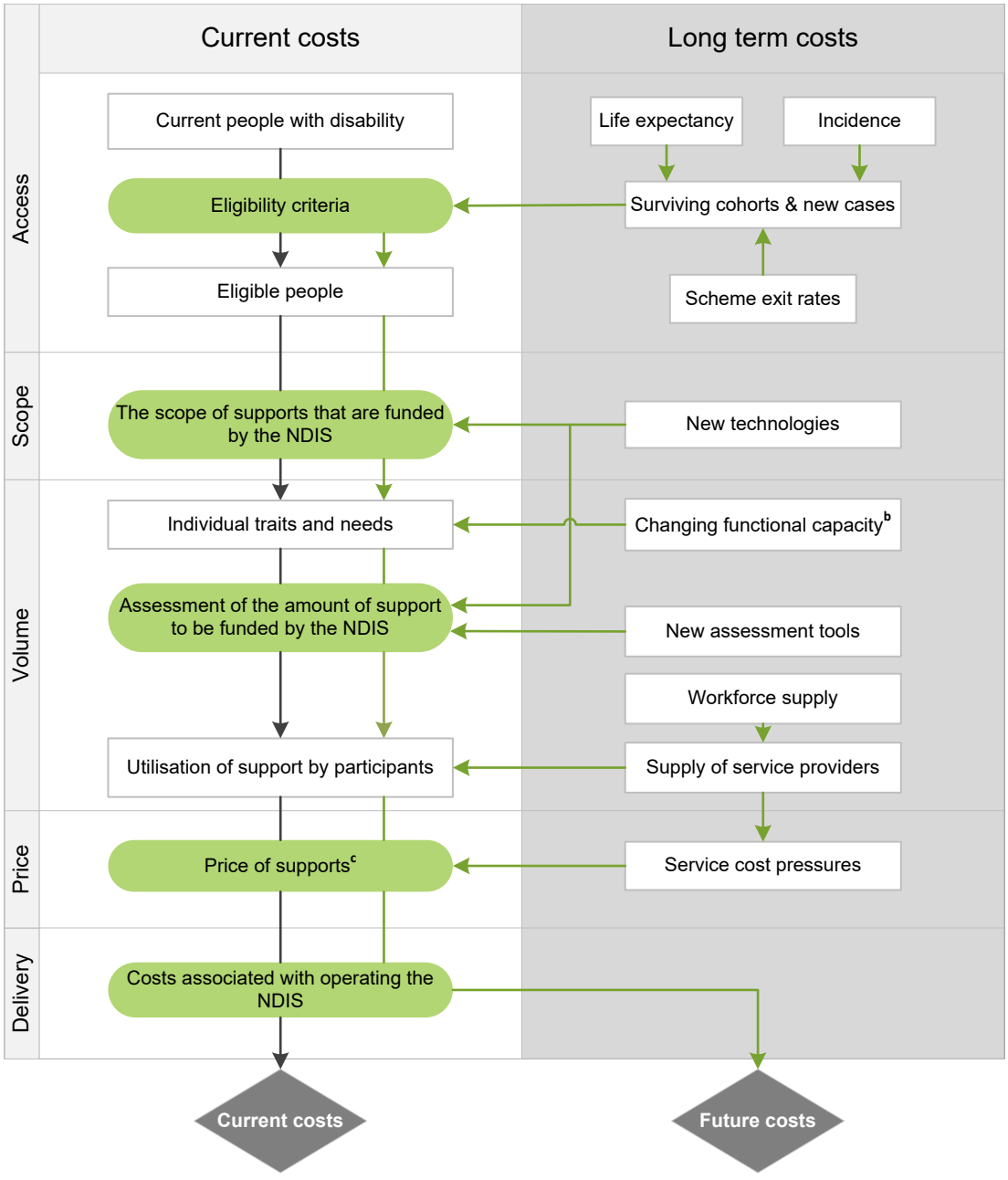
- access — the number and profile (age, sex, disability type, disability severity) of participants in the scheme
- scope — the scope of supports provided to participants in the scheme
- volume — the quantity of supports in a participant's plan and the proportion of supports in a plan that are utilised by a participant
- price — the price paid for supports under the scheme
- delivery — the costs associated with operating the scheme (figure 1.3).

Scheme culture will also be an important driver of costs. Moving away from the welfare culture of current disability systems to one of seeking reasonable and necessary supports and managing down the total cost of disability over a participant's lifetime (in line with an insurance approach) will be critical for the financial sustainability of the scheme. As noted by Bruce Bonyhady, the former Chair of the NDIA Board:

> Importantly, the NDIS cannot be allowed to be turned into a Centrelink-type entitlement model, because under this approach costs would continually escalate. (sub. 100, p. 2)

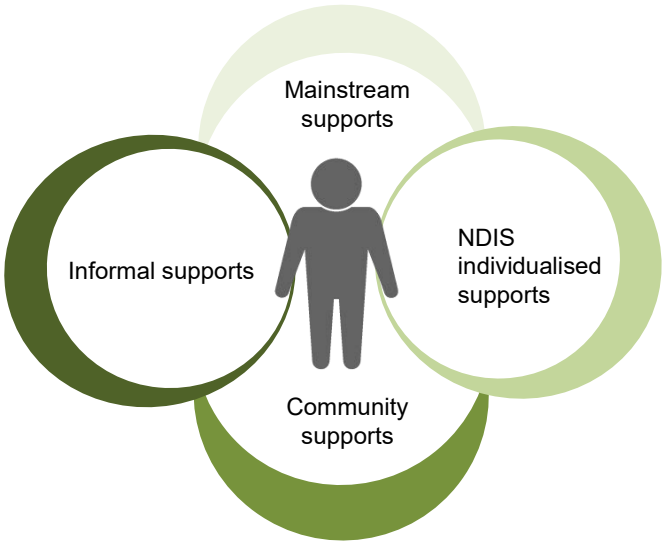
Other support systems can also affect scheme costs. The NDIS, as a person-centred approach to providing disability supports, relies on supports and services outside of the NDIS (including informal, community and mainstream supports) to be in place to help people with disability to live ordinary lives (figure 1.4). If these supports are not available, people with disability could seek NDIS funding to fill the gap, and this could pose risks to scheme costs.

Figure 1.3 **What drives scheme costs?[a]**



[a] Green cells denote cost drivers that the NDIA and/or governments have *direct* control over. Grey cells are cost drivers that can only be *indirectly* influenced by the NDIA and governments. [b] This includes changes in participants' functional capacity attributable to early intervention. [c] Price caps of disability supports are currently set by the NDIA.

Figure 1.4 **A person-centred approach relies on supports beyond the NDIS**



Source: Adapted from NDIA (sub. 161, p. 22).

Sustainability — interpreted as financial sustainability

The Commission interprets scheme sustainability to mean 'financial sustainability'. This is in line with the NDIS Act. Under the Act, the NDIA manages, advises and reports on the financial sustainability of the NDIS. While financial sustainability is not defined or listed as one of the explicit objectives of the Act, the Act (s. 3) does state that 'regard is to be had to … the need to ensure the financial sustainability of the National Disability Insurance Scheme'.

The insurance approach to the scheme and financial sustainability are inextricably linked. For a commercial insurer, financial sustainability is about balance sheet adequacy — there needs to be enough capital to meet some proportion of future expected liabilities by way of cash claims (as set out in prudential standards by the Australian Prudential Regulation Authority) (NDIA 2016h).

However, the financial risks inherent in the NDIS are unique. The NDIS is currently funded on a cash-flow basis — annual contributions meet the cash claims expense — so a balance sheet approach to financial sustainability is not applicable (though there are good reasons for moving closer to funding arrangements that better reflect insurance principles — chapter 12). And because there is no annual capped amount (as there was in previous disability support systems), the financial risk associated with satisfying all valid claims for reasonable and necessary support needs to be managed. As the NDIA explained:

> … unlike traditional disability systems, it is not open to the NDIA to refuse to fund reasonable and necessary supports for a participant who has been found to be eligible on the basis that the

> 'budget has been exhausted'. The NDIS, therefore, faces significant financial risks in the same way that an insurer does and these risks must be managed. Indeed, the NDIS Act explicitly requires the Agency to manage the financial risk that goes with a regime under which any valid claim has to be satisfied. However, the NDIS is still concerned with people rather than claims, and outcomes as well as financial result. (2016h, p. 6)

In light of this, the NDIA defines financial sustainability for the NDIS as:

- the scheme is successful on the balance of objective measures and projections of economic [and] social participation and independence, and on participants' views that they are getting enough money to buy enough high-quality goods and services to allow them reasonable access to life opportunities — that is, reasonable and necessary support; and
- contributors think that the cost is and will continue to be affordable, under control, represents value for money and, therefore, remain willing to contribute. (2016h, p. 18)

Based on the NDIA's definition, achieving financial sustainability requires continuous monitoring of both participants' outcomes and costs. It is not about minimising costs or maximising benefits, but rather balancing the two in a way that ensures there is a net benefit over time. As the NDIA put it:

> … while cost efficiency will be of prime importance to an insurer it will not be the sole focus of the NDIS. Rather, good participant outcomes will be an ongoing objective and, so, finding the right balance between participant outcomes and cost will be critical. (2016h, p. 12)

And as pointed out by the New South Wales Government, financial sustainability must be considered against a long-term (not a short-term) view of costs:

> The lifetime costs for supporting participants must be considered and an investment approach taken. Early intervention principles are appropriate (including beyond just early childhood), and may increase costs in the short term before delivering lower lifetime costs. The alternative is immediate cost reductions that deliver worse social or economic outcomes for participants or the need for acute responses later in life: this is not an improvement to financial sustainability.
>
> … Financial sustainability must be considered with reference to a suite of indicators, with a long-term view, and with consideration of broader impacts elsewhere. (sub. 60, pp. 9–10)

The Department of Social Services supported the NDIA's definition of financial sustainability, and said that:

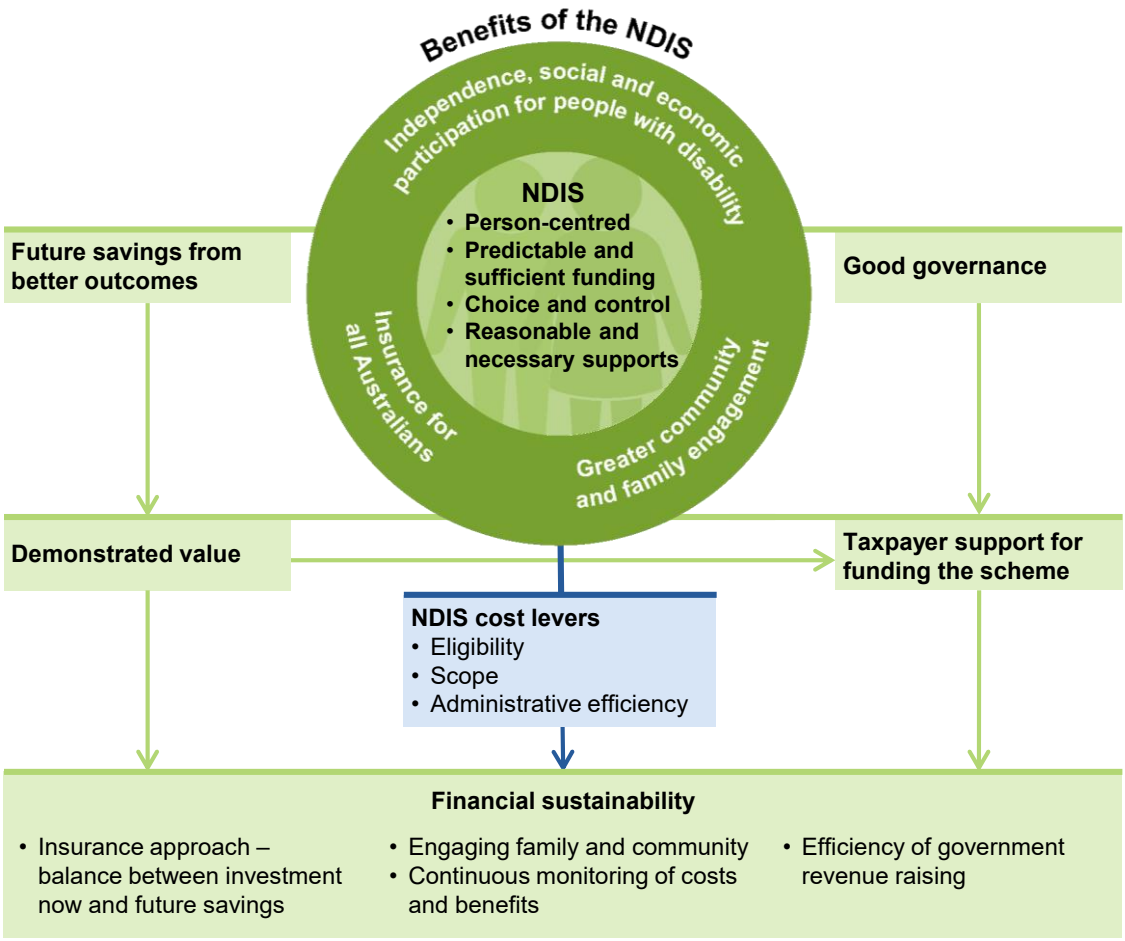
> Considerations of NDIS sustainability need to weigh the success of the Scheme in improving economic and social outcomes and the value-for-money proposition for contributors. (sub. 146, p. 17)

As outlined above, financial sustainability is a difficult concept to define in a unique scheme like the NDIS, but the Commission supports the definition used by the NDIA. The definition provides a clear link between scheme costs, benefits and support from taxpayers.

A wellbeing framework for considering costs and benefits

The Commission examined scheme costs and the financial sustainability of the scheme in light of the benefits to people with disability and Australians more generally using a wellbeing framework (figure 1.5).

Figure 1.5 **Wellbeing framework for considering costs and benefits**



The NDIS aims to improve not only the lives of current scheme participants, but also of future participants. This will only be the case if the scheme is financially sustainable. Financial sustainability is also essential if scheme participants are to consistently receive reasonable and necessary care while they remain in the scheme. Cost overruns could jeopardise the level of care and support participants receive, or result in a return to some of the less desirable features of the previous system (including, for example, an inequitable rationing of support services).

While the NDIS is sometimes described as an 'uncapped scheme', the ultimate cap — and test of financial sustainability — is taxpayers' continuing willingness to pay for it. Unlike

other insurance schemes that rely on premiums to fund costs, the NDIS will only be funded as long as taxpayers consider it is a good use of taxes. Taxpayers' willingness to fund the NDIS will depend on their perception of value for money in terms of:

- people with disability experiencing better lives as a result of the scheme
- the scheme making it easier for families and carers to play a supporting role
- the way the scheme invests in people with disability
- the confidence taxpayers have that the NDIS will be available to cover their care needs (or those of their loved ones) should a disability be acquired in the future
- the supports that are funded (and the evidence base to support what is funded)
- efficiency gains and cost savings in the disability support system and other government services.

Cost overruns could lead to pressure to reduce the scope and certainty of care and supports provided under the NDIS, or require governments to provide more funding at the expense of other programs.

The NDIA's actuarial estimates of long-term costs (which reflect the experience of the scheme and management responses to cost pressures) play an important role in demonstrating to the Australian community that the scheme represents value for money.

Perceptions about the effectiveness of governance arrangements for the NDIS are also important. For example, the community expects planning processes to be in line with the objectives of the scheme and services to meet quality standards. Governments also need to demonstrate that the funds for the NDIS are dollars well spent from a limited tax revenue bucket, and that funding the scheme is not to the detriment of other important expenditures.

Assessing the financial sustainability of the NDIS also involves looking at interrelated systems. This includes, but is not limited to, the efficiency and effectiveness of the NDIA, the readiness of participants, the readiness of providers, and the integration of the NDIS with mainstream services. Only a system that is integrated and holistic in its focus will bring the benefits to people with disability that the scheme is expected to deliver.

It is still early days

While significant benefits are expected to result from the new system of disability care and support, the Commission is aware that, like any major reform, it will be many years before the full extent of the benefits are realised or reflected in objective measures.

Even once the scheme is fully implemented, the transition to a mature market will be gradual, and participants, carers and providers will need time to adjust to the new system. According to an Australian National Audit Office report (ANAO 2016, p. 19), the disability services

market under the NDIS is expected to take up to ten years to develop, and perhaps longer in some market segments. The NDIA, in its Market Approach Statement 2016–2019, said that:

> Developing a strong, contestable marketplace for disability supports is a long term project. All stakeholders in the marketplace will require time to build capability, confidence and systems to support the market mechanisms. Participants, possessing greater consumer power, are learning to make choices and explore different service options. Providers are building an understanding of their customer base and preferences, positioning service offers and transforming their operations. (2016k, p. 12)

And, because the scheme is not yet fully rolled out and there are some transitional issues, the experience to date may not be reflective of the underlying long-term outlook. (Chapter 2 discusses in more detail the limitations of the trial and transition data.)

1.5 A guide to this report

This report outlines the Commission's findings and recommendations on NDIS costs. In conducting this study, the Commission drew on a range of evidence. It consulted widely, including with NDIS participants, advocacy groups, peak bodies, service providers, disability care and support workers and academics. It also met with Australian and State and Territory Government departments and agencies, including extensive liaison with the NDIA and the Department of Social Services. There have also been a number of other reviews of various aspects of the NDIS since the trial began and the Commission drew on these where relevant.

The Commission released an issues paper for this study on 22 February 2017 and a position paper on 14 June 2017. The Commission used the information and evidence provided in the 372 submissions and 185 brief submissions it received in response to these papers (a full list of submissions and consultations is provided in appendix A). The Commission wishes to thank study participants for their input.

Structure of this report

The next two chapters look at how the scheme is performing. Chapter 2 examines how scheme costs are tracking and chapter 3 looks at the evidence, to date, on scheme benefits.

Chapters 4 and 5 discuss two of the key cost drivers for the scheme — eligibility (which determines the number of participants in the scheme), and what supports scheme participants receive (as determined by the rules relating to support coverage and the planning process). Chapter 6 looks at how the NDIS interfaces with non-NDIS disability services and mainstream services and the ways in which this impacts on the financial sustainability of the scheme.

Chapters 7 to 9 look at the supply side of the equation. Chapter 7 assesses whether providers will be able to meet demand for disability services; chapter 8 examines price caps for the NDIS; and chapter 9 considers workforce issues. Chapter 10 looks at whether participants can successfully engage with the scheme.

The last three chapters of the report cover governance arrangements (chapter 11), funding (chapter 12) and data and evidence (chapter 13).

2 How is the scheme tracking?

Key points

- Tracking scheme costs and participant outcomes (and making adjustments in response to scheme experience) is critical to ensuring that the National Disability Insurance Scheme (NDIS) achieves its objectives and is financially sustainable.
- The speed of the launch and the scope of the trial phase meant that some aspects of the NDIS were being developed during trial, including assessment tools and ICT systems.
- To reach the estimated 475 000 participants at full scheme, the National Disability Insurance Agency (NDIA) will need to approve hundreds of plans a day — in 2018-19, about 500 plans will need to be approved and hundreds more reviewed, each day.
  - The intake of participants is already falling behind the expected pace, indicating that the bilateral estimates are unlikely to be met.
- It is inevitable that there will be transitional issues with the rollout of the NDIS given the size, speed and complexity of the reform, but already there are signs that a focus on meeting the bilateral estimates risks the NDIA not being able to implement the NDIS as intended.
  - The focus on getting participants into the scheme has come at the expense of the quality of plans. Some key planning supports for participants are not in place and this has affected participant readiness.
- The NDIA's projection of full scheme costs ($22 billion) is broadly consistent with the Commission's 2011 modelling.
- While the transition experience should inform estimates of full scheme costs, the NDIA considers that, at this early stage, the data have too many limitations to update assumptions on prevalence rates and package costs.
  - In the absence of any new major data reliability issues, there should be sufficient data for the NDIA to update the estimates of scheme costs on the basis of scheme experience for the 2017-18 Annual Financial Sustainability Report.
  - The Commission did not revise its own projections of scheme costs. This is because it broadly agrees with the NDIA's approach to projecting scheme costs and the decision to delay integrating data from the trial and transition.
- Based on trial and transition data, NDIS costs are broadly on track with the NDIA's long-term modelling. While there are more children entering the scheme than expected, this is more than offset by lower levels of utilisation than expected. But while lower than expected levels of utilisation means lower scheme costs, it also implies poorer outcomes for participants.
  - In the first three quarters of 2016-17, the scheme experienced higher than expected package costs, but this improved in the last quarter.
- The NDIA has put in place initiatives to address emerging cost pressures, including the Early Childhood Early Intervention approach and the use of reference package data in the planning process to reduce variability in the level of support provided to participants.

Tracking scheme costs and participant outcomes is critical to ensuring that the National Disability Insurance Scheme (NDIS) achieves its stated objectives and is financially sustainable over the longer term. In 2011, when the Commission estimated full scheme costs for a national disability insurance scheme, it said that insights from the early experience of the scheme should be used to provide a more precise estimate of the long-term scheme costs, given the uncertainties at the time around the costings of the scheme (PC 2011, p. 932).

The National Disability Insurance Agency (NDIA) estimates that at full scheme about 475 000 participants will have individualised supports and the scheme will cost $22 billion in the first year of full operation (NDIA 2016a, p. 18, 2017y, p. 6). The number of participants is higher than what is reported in the NDIA's publications because the NDIA only reports the number of scheme participants under the age of 65 years.[10]

These estimates are consistent with the Commission's 2011 estimates of scheme costs (discussed further below). For this study, the Commission did not update its estimate of long-term scheme costs, however, it did review the NDIA's updates and improvements to the Commission's 2011 estimates. At this stage there are too many limitations with the early scheme data to update the modelling assumptions (though early scheme data can be used to assess where cost pressures may be emerging).

The first section (section 2.1) of this chapter looks at the NDIS rollout schedule. Section 2.2 looks at the assumptions that drive the NDIA's long-term estimates of scheme costs. Section 2.3 provides an overview of scheme participants and costs to date, and looks at how they compare with the NDIA's assumptions.

2.1 The rollout of the scheme so far

The NDIS was trialled from 2013 in different jurisdictions across Australia. Trials commenced in New South Wales, Victoria, South Australia and Tasmania in July 2013 (table 2.1). The trial sites varied in size and scope. For example, the trial sites in:

- South Australia and Tasmania covered the whole jurisdiction but were restricted to certain age groups (children aged 0–14 years for South Australia and 15–24 years in Tasmania)
- Victoria and New South Wales were limited geographically (the Barwon and Hunter regions) but had no age restrictions (apart from the NDIS-wide restriction that participants must be aged under 65 years to enter the scheme).

The transition to full scheme began in all States and Territories in July 2016, with the exception of Western Australia (which began transitioning to a locally administered, but nationally consistent NDIS in July 2017). The Bilateral Agreements between the Australian and State and Territory Governments set out the timeframes for the transition in each

[10] The NDIA projects that in 2019-20, the NDIS will include 460 000 participants under the age of 65 years and 15 000 participants aged 65 years and over. The NDIA reports 460 000 participants in its publications.

jurisdiction, including quarterly estimates of the number of participants who will enter the scheme. Jurisdiction-specific Heads of Agreements signed by the Australian and the State and Territory Governments outline that the full scheme is scheduled to be rolled out nationally by 2019-20, with the timeframes for the transition to differ across jurisdictions (NDIA ndb) (table 2.1).[11]

Table 2.1 **NDIS transition arrangements by jurisdiction**

	Trial period			Transition to full scheme			Full scheme
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
NSW	Hunter area trial		Early transition in Nepean Blue Mountains area (children aged 0–17 years)	Transition to full scheme (by region)		Full scheme	
Vic	Barwon area trial			Transition to full scheme (by region)			Full scheme
Qld				Transition to full scheme from July 2016 (by region). Early transition from January 2016 in Townsville, Charters Towers and Palm Island			Full scheme
SA	Statewide trial (children aged 0–14 years)			Transition to full scheme (by age and region)		Full scheme	
Tas	Statewide trial (people aged 15–24 years)			Transition to full scheme (by age)			Full scheme
NT		Barkly region trial		Transition to full scheme (by region)			Full scheme
ACT[a]		Territorywide trial		Full scheme			
WA[b]		Perth Hills area trial MyWay trial		Transition to locally administered NDIS			

[a] The Bilateral Agreement for the NDIS launch between the Australian Government and the ACT Government notes that from 2016-17, the ACT will be in 'transition to full scheme'. This transition has been categorised as 'full scheme' because all residents who meet the eligibility criteria will have access to the scheme. [b] In February 2017, the Australian Government and Western Australian Government signed a Bilateral Agreement for a nationally consistent, but locally administered, NDIS.

Sources: Adapted from ANAO (2016, p. 79); NDIA (ndb); Porter, Barnett and Faragher (2017).

The speed of participant intake is creating problems

In 2011, the Commission recommended that the NDIS commence in July 2014 in two geographic regions (PC 2011, p. 938).[12] With the benefit of hindsight, the schedule recommended by the Commission was highly ambitious and was unlikely to have been met.

[11] The Bilateral Agreements covering the trial phase (signed between 2012 and 2014) included the planned intake of participants and the balance of cash and in-kind contributions to the scheme. A second set of Bilateral Agreements cover the arrangements for transitioning the NDIS to full scheme. These were signed in 2015 and 2016. The ACT reached full scheme at the completion of the trial period so a second bilateral agreement was not required.

[12] The Commission also recommended that the scheme would be national by July 2015 and reach full scheme by 2018-19.

But the scheme was launched a year earlier than even that ambitious timetable, and the scope of the trials was broadened significantly. The changed timing and scope of the trials compressed the planning phase for the scheme and exacerbated some of the issues faced by the scheme. Some aspects of the scheme were being built and tested over the trial, for example:

- the NDIS commenced without an assessment tool to help determine reasonable and necessary supports and had to build one over the first three months of operation (NDIA, sub. 161, p. 3). The Commission acknowledged that there was no ideal assessment tool for the NDIA to use, but also said that the scheme should not be delayed in the absence of 'perfect' tools (PC 2011, pp. 338–339)
- the ICT system used during trial was an interim system that would not scale to full scheme (NDIA, sub. 161, p. 3). The new system, put in place in 2016 for full scheme, has also had a number of issues (chapter 13).

A review of the capabilities of the NDIA described the Agency as being 'like a plane that took off before it had been fully built and is being completed while it is in the air' (Whelan, Acton and Harmer 2014, p. 7).

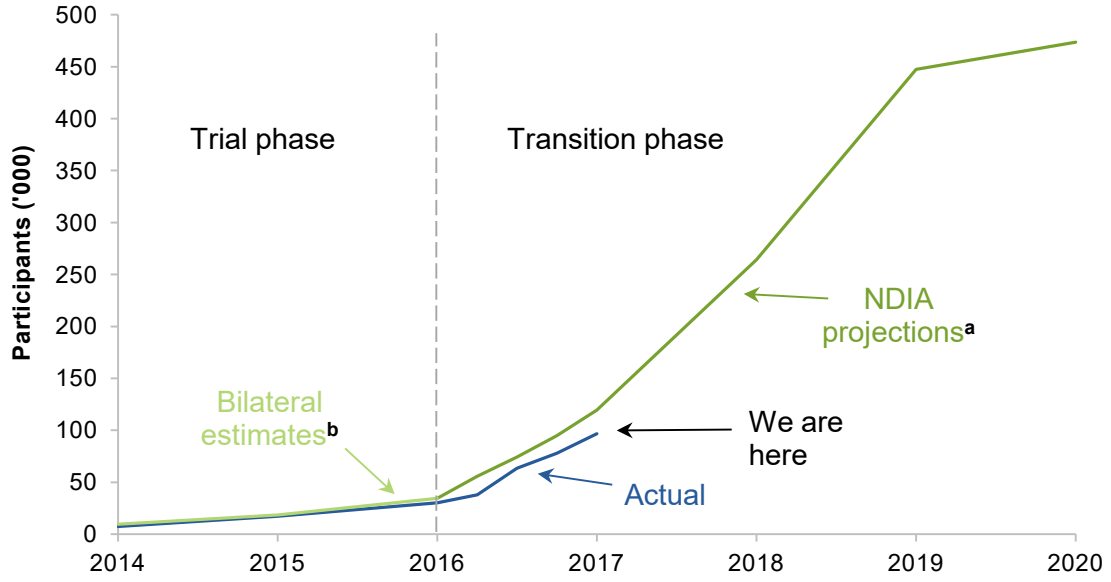
The participant intake schedule is highly ambitious given the magnitude of the reform. To reach the estimated 475 000 participants at full scheme by 2019-20, the NDIA will need to approve hundreds of plans a day (figure 2.1). In the June 2017 quarter, the NDIA approved about 15 000 plans, or roughly 165 plans a day (NDIA 2017y, p. 13). In 2018-19 (the final year of transition), NDIA modelling indicates that about 500 plans will need to be approved, and hundreds more reviewed, each day.

As JFA Purple Orange (sub. 186, p. 7) said the NDIS transition arrangements 'mean a tsunami of new participants will be processed into the scheme over the next two years'. Associate Professor Helen Dickinson of the Public Service Research Group at the University of New South Wales (2017) also recently commented that 'this vast reform is being implemented at break-neck speed'.

The NDIA is already struggling to keep up with the participant numbers included in the Bilateral Agreements — at the end of June 2017, there were 97 000 participants with approved plans, which was just 83 per cent of the bilateral estimates (table 2.2).[13] If the number of people approved to enter the scheme but awaiting a plan (26 000) are added to scheme participant numbers, then the bilateral estimates have only just been reached.

[13] The 97 000 participants with an approved plan reported by the NDIA includes 6 314 children who have entered the Early Childhood Early Intervention pathway but who *do not* have an approved plan. It also includes participants aged 65 years and over (however, the bilateral estimates only include participants aged 0 to 64 years).

Figure 2.1 **Growth in number of participants in the scheme[a]**



[a] Scheme participant projections are based on projections prepared by the Scheme Actuary for the NDIA's 2015-16 Annual Financial Sustainability Report using data at 30 June 2016. The Commission adjusted the projected number of participants for the four quarters of 2016-17 to be consistent with the bilateral estimates reported in the latest NDIA quarterly report. [b] Bilateral estimates based on the NDIA's quarterly reports.

Source: Commission estimates based on NDIA (2016a, 2017y).

Table 2.2 **NDIS participants and bilateral estimates**

	Participant cohort with approved plans[a]				*Bilateral estimate*[b]	*Per cent of estimate*
	Existing disability service clients	*New*	*ECEI*[c]	*Total*		
End of 2015-16	15 308	14 973		30 281	34 545	88
End of 2016-17 Q1	20 652	17 214		37 866	54 811	69
End of 2016-17 Q2	37 715	23 489	2 267	63 471	73 070	87
End of 2016-17 Q3	47 703	27 857	2 439	77 999	93 385	84
End of 2016-17 Q4	58 400	32 238	6 134	96 772	116 555	83

[a] This includes participants who at one point had an approved plan but who have since exited the scheme. [b] The bilateral estimates presented in this table are for participants aged 0–64 years. [c] ECEI denotes the number of children who have entered the Early Childhood Early Intervention pathway but who *do not* have an approved plan.

Source: NDIA (2017y, p. 17).

The NDIA, commenting on the bilateral estimates before the Commission's position paper, said:

> The transition to full scheme commenced on 1 July 2016 and immediately there were problems. The new systems and process, coupled with the scale of intake and issues with the ICT portals saw the NDIA fall behind both in terms of the bilateral estimates and the quality of the participant and provider experience.
>
> The NDIA was able to recover against the bilateral estimates, but problems emerged during this time with the quality of plans and concerns were expressed about aspects of the planning process and the impact on the participant experience. These are matters that the NDIA is now actively addressing. (sub. 161, p. 4)

There also appears to be fewer clients in existing programs transitioning to the NDIS than the national minimum data set suggested, and compared with the estimated number of transitioning participants in the Bilateral Agreements (noting that the numbers in the Bilateral Agreements are estimates, not hard targets). The NDIA said:

> The original estimates of the expected presentation rate were based on demographic data available at the time (e.g. geography, age and the scope and nature of the previous State and Territory client bases). The early Transition experience indicates that other 'real-time' factors are also determinants of the actual participant presentation rate (e.g., participant readiness to join or phase into the Scheme, and difficulties contacting participants due to multiple sources of contact data of varying quality). (sub. PP327, p. 10)

Despite the lower than expected participant intake to date, at this stage the NDIA has not revised the overall expected number of participants in full scheme (sub. 161, p. 76). It has, however, indicated that the lag associated with participants presenting to the scheme is likely to persist (sub. PP327, p. 10).

If the current trend continues, it will take an additional year (2020-21) before all 475 000 participants will be in the scheme (though this delay could be longer if the scheme falls further behind the bilateral estimates when the participant intake ramps up in 2017-18, or if participants do not apply to enter the scheme as soon as they are eligible — something that is already being observed in some jurisdictions).

It is the Commission's view that the current timetable for participant intake will not be met.

Transition to full scheme is a unique stage in the life of the scheme

Given the size, speed and complexity of the reform, it is inevitable that there will be transitional issues with the rollout of the NDIS. It needs to be recognised that the scheme is still in its infancy and it will take time to get it right. A number of study participants noted that the transition period is a unique period in the life of the scheme. The Australian Federation of Disability Organisations, for example, said:

> We acknowledge that there have been many issues during trial and the transition to full scheme implementation. But we also recognise that this is a unique period in the life of the NDIS. Never

> again will the scheme have to grapple with the multiple challenges posed by bringing in a large number of participants in such a short period of time. Once this period of transition is over, growth will be limited to a small number of new participants. AFDO understands that there are significant operational challenges in ensuring hundreds of thousands of people enter the scheme in a short period of time. (sub. 180, p. 8)

Mental Health Australia also said:

> The Transition period is a unique period in the life of the NDIS. Never again will large numbers of people be required to move into the Scheme in such a short period of time. Difficulties were to be expected given the numbers of people involved and the complexity of the task at hand. (sub. PP321, p. 19)

But already there are signs that the rollout schedule is compromising the NDIA's ability to implement the NDIS as intended, and risking the financial sustainability of the scheme — and the number of participants entering the scheme is only just starting to ramp up. Many of the concerns raised with the Commission in this study relate to the rollout schedule and the risks of focusing on participant numbers (box 2.1). The NDIA is also aware of the risks, noting that:

> … bilateral estimates can and do impact upon the way in which the Scheme is delivered. This can put sustainability at risk and impact on the way in which early intervention and investment initiatives are implemented in the short term. It may also have adversely impacted the quality of plans. (sub. 161, p. 109)[14]

While the NDIA has been set a challenging task of generating plans for tens of thousands of participants each quarter, it is important that it also undertakes the planning process in a way that achieves the objectives of the scheme (chapter 5).

A further problem resulting from the participant intake schedule is that parts of the supporting infrastructure that are essential to the objectives of the scheme are not operating as intended. For example, Local Area Coordinators (LACs), which play a key role in delivering information and linking individuals to disability services, were supposed to be 'on the ground' in rollout areas six months before participants joined the scheme (chapter 5). But this did not occur and some areas were still without a LAC months after they joined the scheme. The need to meet bilateral estimates also resulted in LACs being asked to divert resources away from Information, Linkages and Capacity Building (ILC) tasks to undertake planning-related activities. ILC is important for containing scheme costs and reducing reliance on individualised supports (chapter 6).

[14] The NDIA rightly notes that actual participant numbers lagging behind bilateral estimates does not in itself present 'a risk to the financial sustainability of the Scheme' as fewer participants equates to lower costs (NDIA, sub. PP327, p. 10). However, a focus on the meeting the bilateral estimates at the expense of plan quality does have the potential to increase scheme costs in the long term.

Box 2.1 Risks from the rollout schedule are highlighted

House with No Steps:

> … the Scheme has aggressive ramp-up targets. These are putting pressure on the NDIA's capacity to develop quality plans for participants. Unfortunately, the need to achieve high growth in participant numbers appears to be outweighing considerations of plan quality and consistency. (sub. 104, p. 5)

Community Mental Health Australia:

> If the focus purely becomes about signing as many people up as quickly as possible and preventing cost-overruns, then the intent of what the NDIS was actually meant to deliver starts to become lost. (sub. 11, p. 2)

Maurice Blackburn Lawyers:

> We believe the roll-out timeline of the NDIS is highly ambitious and increases the serious risk of inadequate delivery of services to participants. It also poses significant financial risks to the scheme as a whole. (sub. 58, p. 6)

Blind Citizens Australia:

> While we understand the agency is under intense pressure to meet the targets that have been agreed upon under the bilateral agreements between state and territory governments, meeting these targets should not come at the expense of the basic rights and freedoms of people with disability. (sub. 130, pp. 2–3)

Australian Federation of Disability Organisations:

> The need to bring in a large number of participants into the scheme to meet bilateral targets has during transition led to practices which have not always been consistent [with] the original vision of the scheme. (sub. 180, p. 5)

Young People in Nursing Homes Alliance:

> Trying to meet the very demanding targets in the bi-lateral agreements has been torturous for both the scheme and for its partners. The NDIS has had to divert resources away from core commitments to manage these urgent imperatives … (sub. 187, pp. 26–27)

Plan Management Partners:

> … the volume of plans to be completed in order for the scheme to achieve its milestone rollout targets is ultimately generating more work for LACs and plan reviewers due to the variability in quality of resultant plans. (sub. 126, p. 11)

Catholic Social Services Australia:

> The speed of the NDIS rollout will put considerable pressure on processing participants' eligibility, assessment and planning. This pressure will be exacerbated by annual plan reviews that are required for those already in the scheme. (sub. 166, p. 7)

The Department of Social Services:

> … there are risks arising from the scale and pace of roll-out that has potential to place strain on the NDIA, and on agreed transition timeframes. (sub. 146, p. 24)

Mental Health Australia:

> At this time, the NDIA is being judged on volume, on time and on budget. … In the headlong rush to meet both time and volume commitments outlined in bilateral agreements, as the CEO of the [NDIA] recently conceded, insufficient attention appears to have been paid to quality … Processes that are ill-suited to people with psychosocial disability are compromising outcomes for individuals. Consequently, the vision of the Scheme and public confidence in its effectiveness are undermined. (sub. PP321, p. 19)

The NDIA (sub. 161, p. 16) acknowledged that its 'systems and processes are not at peak efficiency and are not ideal in terms of dealing with the speed and scale of the intake challenge'. Also that:

> While the NDIA remains committed to meeting the bilateral estimates, it recognises that the systems and processes that underpin delivery must continue to improve to meet the scale of the challenge while delivering appropriate high quality individual outcomes. The achievement of the bilateral estimates must be done in a manner that maintains the commitment in all jurisdictions to quality, safety, improved outcomes and sustainability. (sub. 161, p. 16)

The rollout schedule has also meant that the market for disability care and support (including providers, workers and participants and their families) has had very little time to adjust to the new scheme (chapters 7–10). As One Door Mental Health said:

> The speed with which the roll-out has occurred has placed significant financial strain on providers, particularly small providers, as a result of needing to move from the relative stability of block-funding arrangements to the uncertainty of unknown revenue through fee-for-service. (sub. 179, p. 11)

Without time to allow for the demand side to become better informed and active, and for the supply side to adjust and grow, there is a risk that participants will be unable to use their supports, either because the services are simply not there, or because participants are not sufficiently well equipped to navigate the scheme.

A number of participants agreed with the Commission's assessment of the risks to the scheme from the ambitious participant intake schedule. For example, Legal Aid NSW said:

> In our experience, the timing and pace of the NDIS rollout has led to poor outcomes for many participants. The focus on participant numbers has compromised the quality of the planning process, and often, participants are left frustrated and dissatisfied with their plans. (sub. PP245, p. 3)

Queensland Government:

> The Queensland Government agrees that the timeframes are ambitious and shares concerns regarding the NDIA's ability to implement the scheme as intended including its ability to manage the increased workload as it approaches full scheme rollout. (sub. PP345, p. 3)

And Catholic Social Services Australia said:

> CSSA agrees with the Commission's finding that the speed of scheme rollout has put considerable pressure on the capacity of the NDIA … leading to compromises in the planning process, lack of support for participants and inadequate communication with providers. (sub. PP278, p. 2)

The NDIA, in response to the Commission's position paper, re-emphasised that the Agency is actively working to mitigate the risk associated with the participant intake schedule. The

NDIA noted the planning process as the most pressing challenge to scheme rollout and stated that significant work is being undertaken to improve the scheme's operation.

> The quality of participant outcomes is the NDIA's primary consideration relative to the speed of the rollout. (sub. PP327, p. 10)

Chapter 5 makes recommendations designed to improve the quality of the planning process. Chapter 11 explores whether additional changes are required to mitigate the risks that the rollout schedule presents to the sustainability of the scheme.

FINDING 2.1

The scale and pace of the National Disability Insurance Scheme (NDIS) rollout to full scheme is highly ambitious, and will not be delivered as scheduled in terms of participant intake. The rollout schedule risks the National Disability Insurance Agency (NDIA) not being able to implement the NDIS as intended and it poses risks to the financial sustainability of the scheme. The NDIA is cognisant of these risks.

2.2 Projections of scheme costs

One of the NDIA's insurance principles is to develop actuarial estimates of long-term costs (chapter 1). Actuarial estimates are compared with the actual scheme experience, so that the NDIA can identify cost pressures, and track and monitor responses put in place to address those pressures.

However, estimating future scheme costs presents a number of challenges. For example, while there is information on the number of potential participants who are currently receiving support from existing State and Territory Government programs, there are only survey data (which are subject to sampling error) on the number of potential participants not receiving support from government programs.

There is also uncertainty about the support needs of potential participants. While there are comprehensive data on the catastrophic injuries that are covered by compensation schemes (mostly spinal cord, brain and burn injuries), for most disabilities, comprehensive data on the level of funding required to achieve good long-term outcomes are not available. The NDIA has constructed reference packages for different disabilities with the help of expert reference groups (chapter 5). These packages will be refined over time as data are collected from the NDIS on the effectiveness of different supports and their cost.

In 2011, the Commission estimated a national disability insurance scheme would cover 411 000 participants at a gross cost of $13.6 billion at full scheme (PC 2011) (box 2.2).

Box 2.2 The Commission's modelling approach in 2011

In its 2011 report on *Disability Care and Support*, the Commission estimated that a national disability insurance scheme would cover 411 000 participants and would have a gross cost of $13.6 billion (and a net cost of $6.5 billion) at full scheme. The costings were based on three calculations:

- the number of people who would be eligible for the scheme
- the level of support that these people would require
- the average per person cost associated with each level of support — four types of support were costed: care and support; aids and appliances; home modifications; and transport.

No single data source contained all the information required.

- The primary data source for numbers of people and level of support was the 2009 ABS Survey of Disability, Ageing and Carers. The number of participants entering with psychosocial disability was calculated by consulting with experts who had previously examined the prevalence of enduring psychiatric disability.
- A variety of sources were used to estimate the average per person costs for different types of support, including data from the Victorian Transport Accident Commission, the New South Wales Lifetime Care and Support Scheme, and the Multiple Sclerosis Longitudinal Study.

The Commission also estimated that when the scheme matured (around 2050), the *net* cost would be $4.4 billion. The long-term savings were attributable to assumptions regarding early interventions and community capacity building (for example, more people with disability are able to live in the community with intensive supports rather than in supported accommodation).

A further offset of about $720 million was assumed when the national injury insurance scheme matured.

The Commission recognised that there were significant uncertainties about the cost estimates because of the nature and quality of the data, and undertook a number of sensitivity analyses to explore these uncertainties.

Source: PC (2011, pp. 748–780).

The NDIA (2017y, p. 6) projected that by 2019-20 the NDIS will cover 475 000 participants and cost about $22 billion each year.[15] These estimates are broadly consistent with the Commission's 2011 modelling after taking into account inflation (including the effects of pay rises awarded to social and community services workers by the Fair Work Commission in 2012), population changes, and costs associated with participants aged 65 years and over (who enter the scheme prior to 65 years) (box 2.3).

[15] Both the Commission's and the NDIA's projections of scheme costs include Western Australia. While the gross cost of the NDIS is estimated to be $22 billion in 2019-20, the scheme is expected to reduce the funding required for a range of government programs. A review by the Australian Government Actuary in 2011 estimated these offsets to be about $11 billion (NDIA, sub. 161, p. 29).

Box 2.3 Comparing the NDIA's estimates and the Commission's 2011 estimates

While the NDIA uses a different methodology to that used by the Commission in 2011 to estimate costs, the differences in projected costs are mainly attributable to incorporating population projections, industry-specific wage increases and costs associated with participants aged 65 years and older (table below).

Population

Between 30 June 2012 and 30 June 2020, Australia's residential population aged under 65 years is projected to increase by 12 per cent. Applying this increase to the Commission's estimate of 411 250 scheme participants (aged under 65 years) results in 461 000 participants aged under 65 years — this is in line with the 458 368 participants estimated by the NDIA. Incorporating population projections adds about $1.5 billion to the Commission's estimates of scheme costs.

Wage increases in the disability sector

In February 2012, the Fair Work Commission found that employees in the community and disability sectors were underpaid compared to public service workers doing similar jobs. The subsequent Equal Remuneration Order applies adjustments ranging from 23 per cent (for employees at the lowest level) to 45 per cent (for employees at the highest level) in nine instalments between December 2012 and December 2020. These adjustments are applied on top of increases from the annual wage review undertaken by the Fair Work Commission.

The NDIA's modelling of scheme costs assumes that average cost of care in the disability sector will increase 29 per cent between 30 June 2014 and 30 June 2020. If Australian Government Actuary assumptions regarding cost increases from the Department of Social Services' funding model are applied between 2011-12 and 2013-14, the total increase in average costs to 2020 is 44 per cent. The NDIA assumptions imply an increase in average costs from $31 183 to $45 018 per participant. These cost increases would add about $6.4 billion to the Commission's estimates of scheme costs.

Participants aged 65 and older

The NDIA modelling projects that there will be 15 000 participants aged 65 years and over in 2019-20 and that they will add an extra $1.09 billion to scheme costs (with an average cost of $71 000 per participant). The Commission's 2011 estimates of costs did not include participants 65 years and over on the basis that they did not represent a net increase in costs to the Australian Government (as their support was funded under the aged care system).

	Participant numbers	*Scheme costs ($b)*
Productivity Commission estimates 2011[a]	**411 250**	**12.82**
Population projections to 2019-20	49 544	1.54
Inflation in disability sector (wages)	..	6.38
Participants aged 65 years and older	15 285	1.09
Updated Productivity Commission estimates	**476 079**	**21.84**
NDIA projections for participants[b]	**473 653**	**21.76**
Difference (%)	2 426 (0.5%)	0.08 (0.4%)

a Excluding operating costs and offsets associated with the National Injury Insurance Scheme and assumed efficiency dividends. **b** Excluding operating costs ($1.5 billion), offsets associated with the National Injury Insurance Scheme ($0.7 billion) and assumed efficiency dividends ($0.3 billion). **..** Not applicable.

Sources: Commission estimates; NDIA unpublished estimates; PC (2011); Fair Work Australia (2012).

The NDIA's methodology is more refined than that used by the Commission in 2011 (the NDIA gave the Commission its long-term cost projection model used to produce the 2015-16 Annual Financial Sustainability Report). The key differences between the NDIA's model and the Commission's 2011 model are:[16]

- participant numbers are modelled for 14 separate disability groups (apart from psychosocial disability, there was no distinction between disabilities in the Commission's 2011 modelling)
- average package costs assumptions are based on reference package data developed by expert reference groups (the Commission in 2011 used data from injury and accident schemes that operate in Australia)
- epidemiological data on incidence and mortality rates for different disabilities were used to model participant numbers over time (the Commission did not explicitly model entry and exit rates in 2011).

Some key assumptions behind the NDIA's cost projections

There are a number of key assumptions that drive the NDIA's long-term projections.

- *Prevalence and incidence rates* — the estimate of participant numbers at full scheme (prevalence) is derived using the ABS Survey of Disability, Ageing and Carers and epidemiological data. Estimates of entry (incidence) and exit rates used to make long-term projections also use these data.
- *Long-term prices* — inflation of 4.3 per cent per year is assumed in the short term based on current wage rates (including the Social, Community, Home Care and Disability Services Award), with a long-term assumption of 4 per cent per year.
- *Utilisation* — there is no explicit assumption regarding underutilisation in the NDIA's projections. The projections assume that participants are allocated, and completely spend, a reference package of supports (the expected level of support required by participants given their age, disability and level of function).
- *Early intervention and early investment* — the NDIA's projections assume that early investment will reduce costs by 0.35 per cent per year. This assumption was originally developed for the Commission's modelling in 2011.
- *Technology* — advances in technology can both increase and decrease costs. The NDIA does not make any assumptions about the effect of technological advances on scheme costs.

[16] The Commission understands that further improvements to the modelling approach will be made for the 2016-17 Annual Financial Sustainability Report.

Participants aged 65 years and over

The proportion of NDIS costs that is attributable to participants aged 65 years and over will increase over time. The NDIA's modelling projects that in 2029-30, almost 20 per cent of scheme costs will be linked to participants aged 65 years and over compared to about 5 per cent in 2019-20 (table 2.3). This suggests that the share of total NDIS funding provided by the Australian Government will increase substantially over time as it is responsible for the funding of all participants aged 65 years and over (and all Indigenous participants aged over 50 years). This does not necessarily mean that there will be a sizable net cost to the Australian Government, as it also has primary funding responsibility for the aged care system (chapter 6).

Table 2.3 **NDIS costs attributable to participants aged 65 years and over**

Year	*Scheme costs (all participants)*	*Scheme costs (65 years and over)*[a]	*Proportion of total costs (65 years and over)*
	$b	$b	Per cent
2019-20	22.3	1.2	5.2
2024-25	30.6	4.1	13.4
2029-30	40.9	8.2	19.9
2039-40	70.2	19.3	27.5
2049-50	113.6	34.1	30.0

[a] This includes operating costs associated with participants aged 65 years and over.

Source: Unpublished NDIA modelling estimates.

The magnitude of the projected increase in the costs associated with participants aged 65 years and over is influenced by a number of assumptions relating to ageing in the scheme, including:

- the exit rates of participants aged 65 years and over, which can be disaggregated into:
  - mortality exit rates — these are based on epidemiological data and are disability specific
  - exit rates for participants entering the aged care system. Participants are assumed to enter the aged care system (and exit the NDIS) when they enter residential aged care (chapter 6).[17] These exit rates are based on (limited) data on the rates of transition to residential aged care and are disability specific
- the average package costs for participants aged 65 years and over:

[17] NDIS participants aged 65 years and over can choose to transition to the aged care system or remain in the NDIS. However, the financial incentives are such that there is little incentive for participants to make this transition (chapter 6). When a scheme participant enters residential aged care, they cease to be an NDIS participant.

- average package costs for those aged 65 years and over are assumed to be higher than for participants aged 55–64 years for about half of the primary disability groups — in 2019-20, the difference is assumed to be 20 per cent
- for the disability groups just identified, average package costs for older participants are also assumed to increase at a faster rate (an additional 1 per cent above economic inflation for every year between 2019-20 and 2044-45) than for participants aged under 65 years (i.e. in 2044-45, average package costs are an *extra* 25 per cent higher than for participants aged under 65 years, or 50 per cent higher in aggregate).[18]

More on utilisation rates…

Utilisation rates during the transition period are likely to remain significantly lower than the utilisation rate expected at full scheme. While data integrity issues make it difficult to develop precise projections on support utilisation at full scheme (2019-20), trial and transition data suggest a utilisation rate of about 75–85 per cent is plausible by the end of the transition phase (section 2.3).

Beyond 2019-20, utilisation rates are expected to rise as the market for supports matures. However, they are unlikely to reach 100 per cent — the NDIA noted that experience in other schemes suggests a utilisation rate of between 80 and 95 per cent could be expected (NDIA, sub. 161, p. 70).

Future updates to the projections of scheme costs

The NDIA has made some adjustments to their long-term cost projections using some trial data, but it has not made more extensive changes to cost projections based on all trial and transition data. Early scheme data deviate from some of the assumptions included in the NDIA's projections (section 2.3), but these data have too many limitations to update assumptions about prevalence and package costs. The data also reflect a period of the scheme prior to management responses implemented by the NDIA to address early cost pressures (discussed below).

As a number of study participants noted, it could be some time before conclusions can be made about the financial sustainability of the scheme. For example, the Victorian Government said:

> The Review is being undertaken at a very early state in the transition to full scheme and the market is at an early stage of its development — too soon to arrive at any conclusions about the scheme's ongoing costs or sustainability.
>
> It may be several years before total costs and lifetime costs are known. Little data is currently available and further experience is required to understand how the application of insurance principles can vary costs over a participant's lifetime. (sub. PP298, p. 1)

[18] The aggregate difference is 50 per cent not 45 per cent (20 per cent plus 25 per cent) due to compounding.

The New South Wales Government also said:

> Transition experience should inform estimates of full scheme costs, but must not be automatically extrapolated. Costs during transition must be considered with reference to the expected costs during this period (not with reference to full scheme costs). (sub. 60, p. 10)

The NDIA indicated that as the scheme rolls out, the transition data collected will be used to better inform estimates of full scheme costs, and to assess the effectiveness of the NDIA's responses to address cost pressures — in its latest quarterly report, the NDIA said that it is undertaking ongoing work to 'verify the longer-term cost of the NDIS based on scheme experience to date' (NDIA 2017y, p. 6).

It is imperative that new data are incorporated into the assessment of longer-term costs as soon as possible. Given the low levels of utilisation that the scheme has experienced in the transition to date (section 2.3), and the fact that underutilisation is likely to continue in the short to medium term (with funding implications), it is particularly important that utilisation assumptions are incorporated into the modelling. In the absence of any major data reliability issues, there should be sufficient scheme data to update estimates of scheme costs based on scheme experience for the 2017-18 Annual Financial Sustainability Report.

From time to time, the NDIA's costings of the scheme may need to be updated to reflect policy changes that alter the scope of the NDIS. For example, changes to the scope of the National Injury Insurance Scheme would impact on the cost of the NDIS and need to be reflected in the estimates of scheme costs (chapter 6).[19] It is important that any policy changes are incorporated quickly into the NDIA's costing of the scheme and that the changes attributable to the policy change are clearly articulated to preserve the public's confidence in the scheme's financial sustainability.

The Commission did not revise its own projections of scheme costs. This is because the Commission broadly agrees with the NDIA's approach to projecting scheme costs and the decision to delay integrating data from the trial and transition (but stress that these data should be incorporated as soon as practicable). It is the Commission's view that the NDIA's projections of scheme costs should inform the Australian Government's budget estimates for the NDIS (chapter 12).

In any case, point estimates of total scheme costs do not tell the whole story. Financial sustainability is about both costs and benefits, and risks to financial sustainability cannot always be easily modelled, or identified from scheme data. A long-term focus, both within and outside the NDIS, is therefore important. While the NDIA is responsible for monitoring scheme costs and responding to the cost pressures that it can control, all governments have a responsibility to ensure the success of the scheme and its financial sustainability.

[19] Another example is the cost risk around specialist school transport services. If Governments decide that the NDIS should cover the costs of specialist school transport services, this would add between $300–$600 million each year to the cost of the scheme. This is a cost risk being considered by the NDIA, but it is not included in the Agency's cost modelling or financial sustainability reporting for the full scheme. (NDIA, sub. PP370, p. 10)

FINDING 2.2

The Productivity Commission supports the National Disability Insurance Agency's (NDIA's) approach to projecting scheme costs and the decision to delay integrating data from the trial and transition period to date. As such, the Commission has not revised its own projections of scheme costs.

However, it is imperative that new data are incorporated into the NDIA's assessment of longer-term costs as soon as possible. The Commission's assessment is that, in the absence of any major data reliability issues, there should be sufficient data for the NDIA to update the estimates of scheme costs on the basis of scheme experience for the 2017-18 Annual Financial Sustainability Report.

2.3 Key insights from trial and transition data

While it is early days, there are some insights from the early experience of the NDIS (from trial and transition data — July 2013 to June 2017). This section looks at participant characteristics, package costs, and utilisation of supports. These three factors determine the year to year costs incurred by the NDIA on individualised supports.

Trial and transition data need to be interpreted with caution

The first point to note is that data from the trial and transition phase need to be interpreted with caution. This is because:

- differences in trial sites and phasing schedules mean that the data cannot necessarily be used as a guide to anticipate full scheme experience (for example, the average level of committed support by a jurisdiction will reflect the trial cohorts for each jurisdiction)
- early scheme data are often subject to small sample sizes — minimal weight should be placed on disaggregated results where sample sizes are small
- the number of scheme participants in a region is likely to be an underestimate of the full scheme number because it takes time for potential participants to approach and gain access to the scheme. (On the other hand, the number of exits due to successful early intervention are likely to be lower in the first years of the scheme as it can take some years for the benefits of early intervention to accrue.)
- it can be difficult to determine whether observed cost pressures are transitional or whether they are likely to persist
- during transition, about 20 per cent of committed support is expected to be provided in-kind (Australian, State or Territory Government programs delivered under existing block-funding arrangements) (DSS, sub. 146, p. 22) and these supports tend to be more expensive than standard supports (NDIA, sub. 161, p. 101)

- data integrity may impact on the analysis, arising in part as a result of the NDIA transitioning to a new ICT system in July 2016. Some concern remains, despite the NDIA making manual adjustments where known data integrity concerns exist.

What do the early data tell us about participants?

At the end of the trial phase in June 2016, the number of participants with an approved plan (30 281) was 83 per cent of bilateral estimates (36 307) (NDIA 2016b, p. 42). (There were another 5400 participants who had been determined as eligible, but who did not yet have an approved plan.)

At the end of June 2017 (the most recent quarterly report), an additional 86 000 people had been found eligible for the scheme. This took the total number of scheme participants who had ever been active to 122 065 (NDIA 2017y, p. 15). About 97 000 active participants have an approved plan (NDIA 2017y, p. 15).

Participants by disability

Almost two-thirds of current scheme participants either have an intellectual disability (37 per cent) or autism (29 per cent) as their primary disability (figure 2.2). Psychosocial disability is the next most common disability, accounting for about 6 per cent of scheme participants.[20]

Participants with disabilities such as stroke and multiple sclerosis tend to be older, while participants with autism and other sensory/speech disabilities are relatively young (figure 2.2).

Most participants with autism enter the scheme under early intervention requirements (and early intervention is most effective at younger ages). In recent years there has been an increase in the number of autism diagnoses — likely in part due to a growing awareness of autism and more sensitive screening tools leading to higher prevalence rates for younger ages (Gothe-Snape 2017).

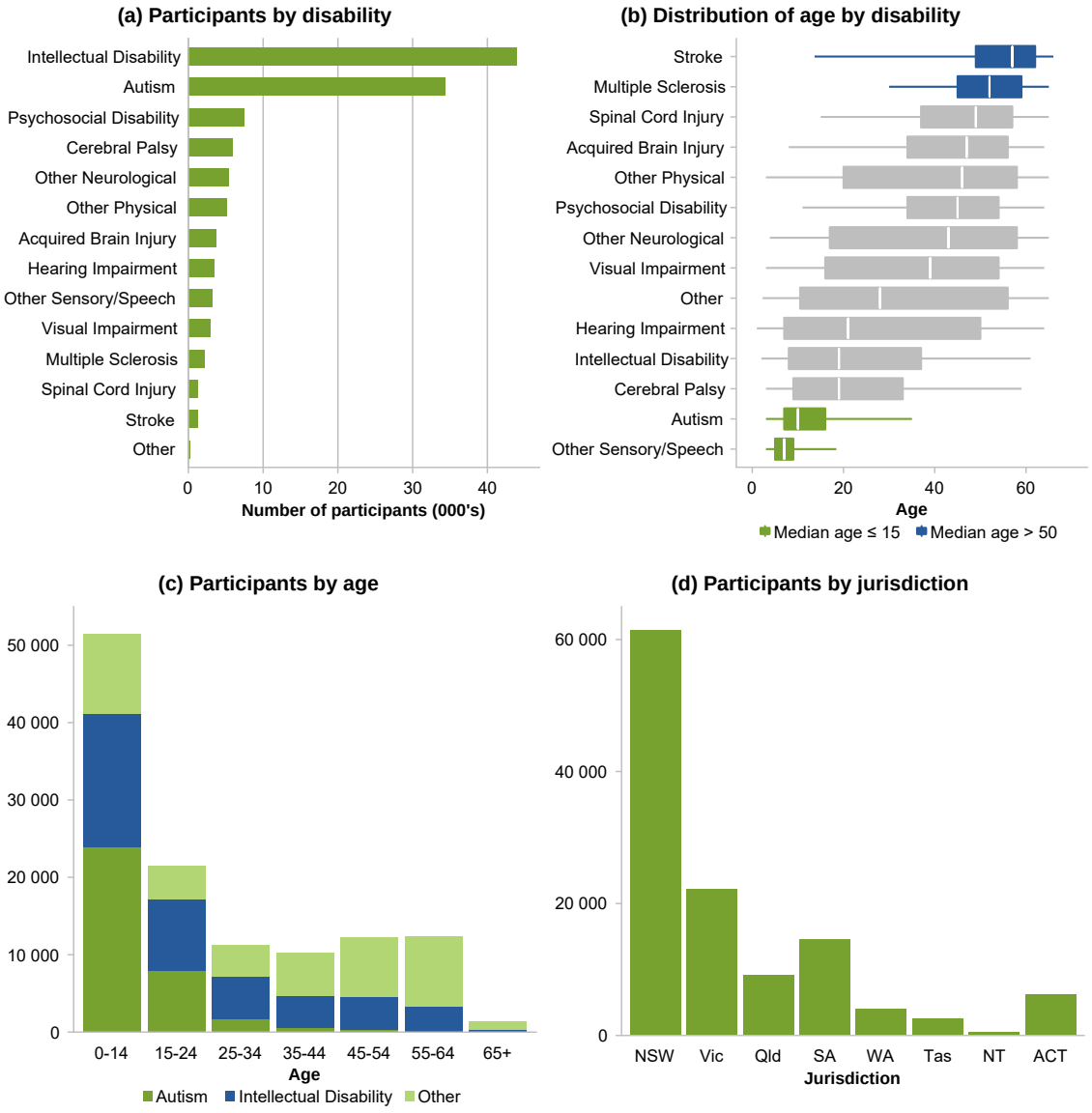
Disability-specific prevalence rates at the Barwon and Hunter trial sites broadly match those assumed in the NDIA's long-term modelling for all but the largest disability groupings (box 2.4) (figure 2.3). Prevalence rates were higher than the NDIA's long-term modelling assumptions for:

- autism, where prevalence rates were significantly higher in both trial sites (the NDIA implemented initiatives in response, discussed below)

[20] In addition, about 4 per cent of participants have a psychosocial disability that is not considered their primary disability (NDIA, sub. 161, p. 82).

- intellectual disability, where prevalence rates were much higher in the Barwon region, but not the Hunter region. The higher prevalence rate for intellectual disability in the Barwon region was most pronounced in participants aged under 18 years.

Figure 2.2 **Some insights: NDIS participants[a,b,c]**



[a] All figures include data on active eligible participants at 30 June 2017. [b] Figure (b) shows box plots of the distribution of the age of participants for different disability groups. The vertical line represents the median age of participants with that disability and the box shows the interquartile range (quartiles 1 and 3). The box plot tails show the 2.5 and 97.5 percentiles. [c] In figure (d), the number of participants in Western Australia includes the Perth Hills NDIS trial site, but not the Western Australia NDIS MyWay trial.

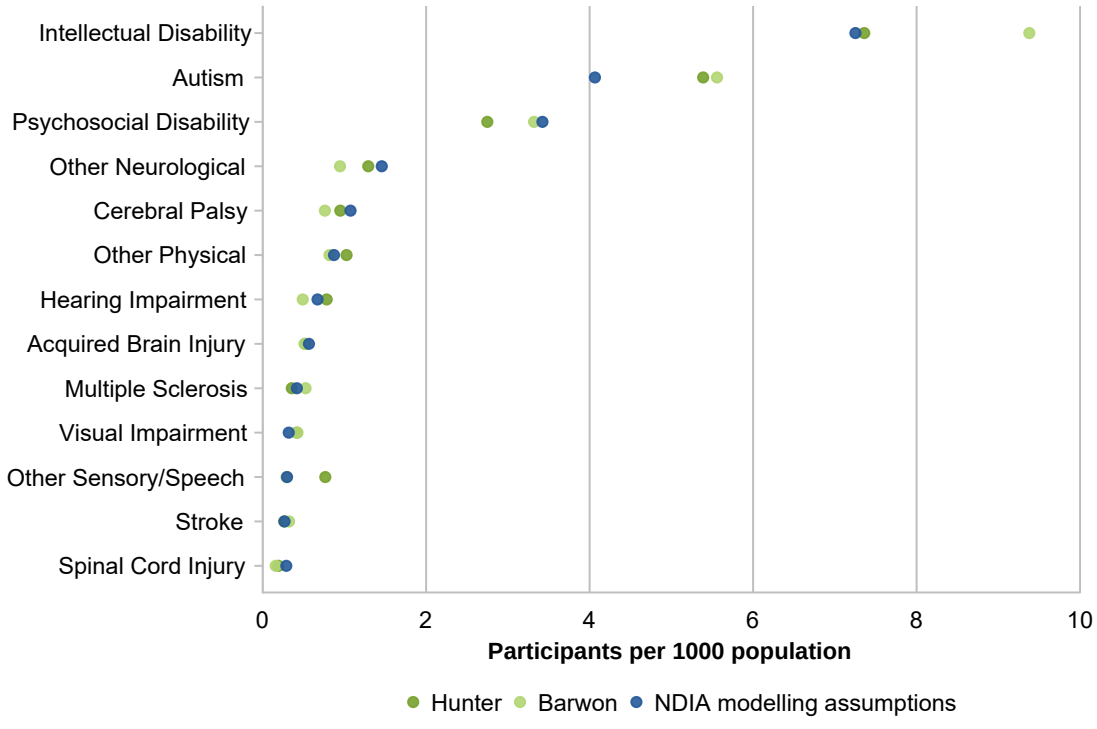
Source: Commission estimates based on unpublished NDIA data.

Box 2.4 Calculating prevalence rates

It is difficult to assess how participant numbers are tracking compared to the NDIA's long-term modelling assumptions, as it takes time for potential participants to approach and gain access to the scheme. To address this issue, the Commission used data from the Barwon and Hunter trial sites. Both these sites have been in operation since July 2013 and are open to everyone under the age of 65 years.

One significant limitation of this approach is that these trial sites may not be representative of the broader Australian population. Another limitation is that the NDIA has found that participants are continuing to approach the scheme at mature trial sites at a rate that is above that expected if only participants with newly acquired disabilities were approaching the scheme (though this latter factor would suggest prevalence may be even higher relative to the modelling assumptions than the numbers so far collected would indicate). Similarly, the number of exits from the scheme due to successful early intervention is likely to be lower than would be expected at full scheme, as it can take some years for the benefits of early intervention to accrue.

Figure 2.3 Prevalence rates by disability — trial compared to the NDIA's long-term estimates[a]



[a] Prevalence rates for a region are calculated as the number of active eligible participants with the selected disability per 1000 of the population aged 0–64 years at 30 June 2016. Data on the population for the Barwon and Hunter trial regions were sourced from the 2016 ABS Census of Population and Housing.

Source: Commission estimates based on unpublished NDIA data.

There is a lot of uncertainty around the number of participants with psychosocial disability at full scheme.

- Modelling work undertaken by the Department of Health (sub. 175, p. 4) in 2016, using the National Mental Health Service Planning Framework, estimated that about 92 000 people (18–64 years) have severe and complex psychosocial disorders that would closely align with the NDIS eligibility criteria for individualised supports.
- David McGrath Consulting estimated that 'approximately 289 000 people with a severe mental illness will need individualised, intensive 'NDIS-like' community supports in any 12-month period' in work conducted for Mental Health Australia in 2015 (Mental Health Australia, sub. 155, p. 10).
- The NDIA (2016b, p. 26) expects there will be about 64 000 participants with a primary disability of psychosocial disability in the scheme in 2019-20. According to the NDIA, at this stage of the rollout, the number of participants with psychosocial disability is tracking broadly in line with the modelling assumptions in mature trial sites (Scheme Actuary 2016).

Estimating the number of people with psychosocial disability eligible for the scheme is difficult because a robust and comprehensive database from which to draw is lacking. However, given there are a range of estimates prepared by stakeholders and agencies, it is essential that the methodology used is fully transparent, so that the estimates can be assessed and considered in relation to projections of numbers of participants with psychosocial disability at full scheme.

Participants by age

The largest share of participants in the scheme are children aged 14 years and under (about 51 000 or 43 per cent of total participants at the end of June 2017) (figure 2.2). About 47 per cent of children in the scheme have autism, and 33 per cent have an intellectual disability (including developmental delay).

The number of children in the scheme is higher than originally expected — this is even after accounting for the fact that the number of children in the scheme is skewed by the South Australian trial site, which was only for children.

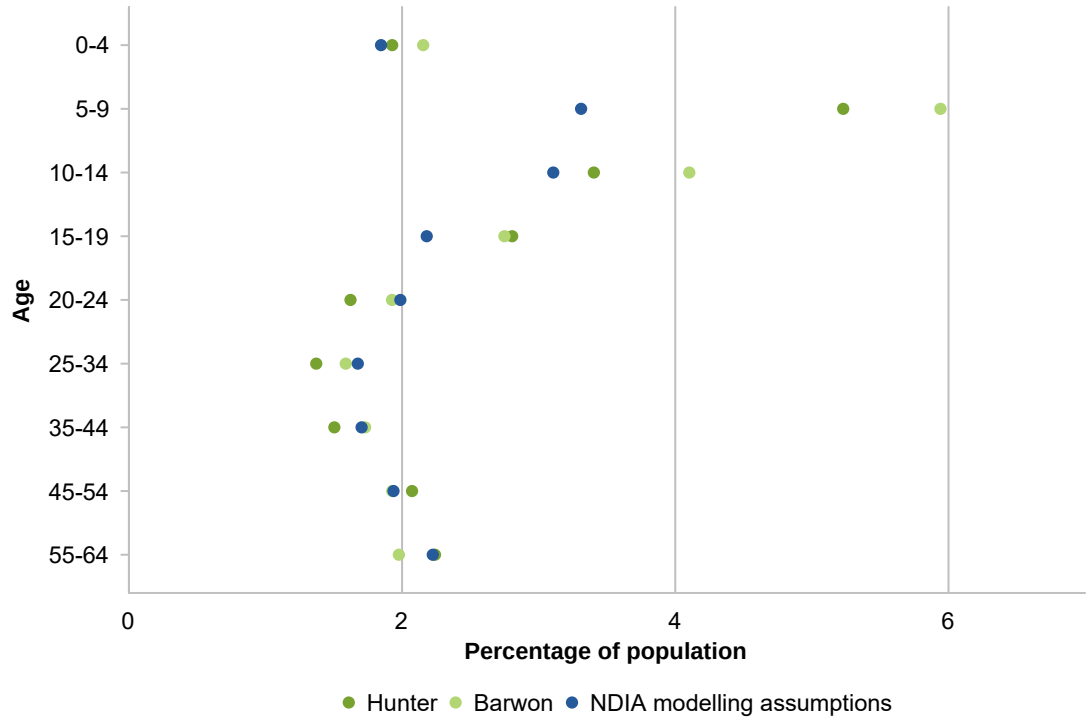
An analysis of the experience of trial sites by the NDIA (sub. 161, p. 78) found that the prevalence rates for children aged 0 to 6 years:

- exceeded the Commission's 2011 estimates in South Australia, Barwon and the ACT trial sites
- were in line with the Commission's 2011 estimates in Western Australia and the Hunter trial sites.

Looking at the data from the Barwon and Hunter trial sites, the Commission reached a similar conclusion. The largest gaps between actual and expected prevalence rates (based on the

NDIA's long-term modelling) are for children aged 5–9 years followed by children aged 10–14 years and young people aged 15–19 years. There are larger gaps for the Barwon region than the Hunter region (figure 2.4).

Figure 2.4 **Prevalence rates by age group — trial compared to the NDIA's long-term estimates[a]**



[a] Prevalence rates for a region are calculated as the number of active eligible participants in a given age group per 1000 of the population in the age group at 30 June 2016. Data on the population for the Barwon and Hunter trial regions was sourced from the 2016 ABS Census.

Source: Commission estimates based on unpublished NDIA data.

Participants by level of function

Participants are assessed for their level of functional capacity when they enter the scheme (box 2.5). Level of function data have been collected since July 2016 and data are available for almost 85 000 participants. At the end of June 2017, of those participants who have been assessed:

- 38 per cent had a high level of function
- 38 per cent had a medium level of function
- almost a quarter had a low level of function.

Box 2.5 Assessing level of function

As part of the planning process, the NDIA assesses each participant's level of function. This is one of many pieces of information that it uses to develop plans to help participants progress towards their personal goals and aspirations.

The National Disability Insurance Agency currently uses different assessment tools for 11 key disability types and the World Health Organisation Disability Assessment Schedule version II (WHODAS II) (for adults) and the Paediatric Evaluation of Disability Inventory-Computer Adaptive Test (PEDI-CAT) (for children) where no specific tool is identified. The scores of each assessment tool are mapped to a scale of 1 (high functional capacity) to 15 (low functional capacity), which provides a common measure across different types of disability.

To simplify its analysis, the Commission aggregated levels of function into three groups: high (levels 1–5), medium (levels 6–10) and low (levels 11–15).

Source: NDIA (sub. 161, p. 10).

Compared to the NDIA's long-term modelling assumptions, the distribution of participants by level of function to date is more heavily weighted towards the medium and low levels of function. This difference reflects, in part, the scheme's phasing schedules — participants with the greatest support needs are typically the first to enter the scheme in a region (figure 2.5). This is supported by the fact that the distribution of level of function for mature trial sites (Barwon and Hunter) is closer to the modelling assumptions.[21] (The distribution of level of function for the Hunter trial site is not expected to match modelling assumptions as it included a number of large residential facilities.)

That said, scheme costs will be higher than estimated if the early distribution of participants with lower levels of function persists at full scheme.

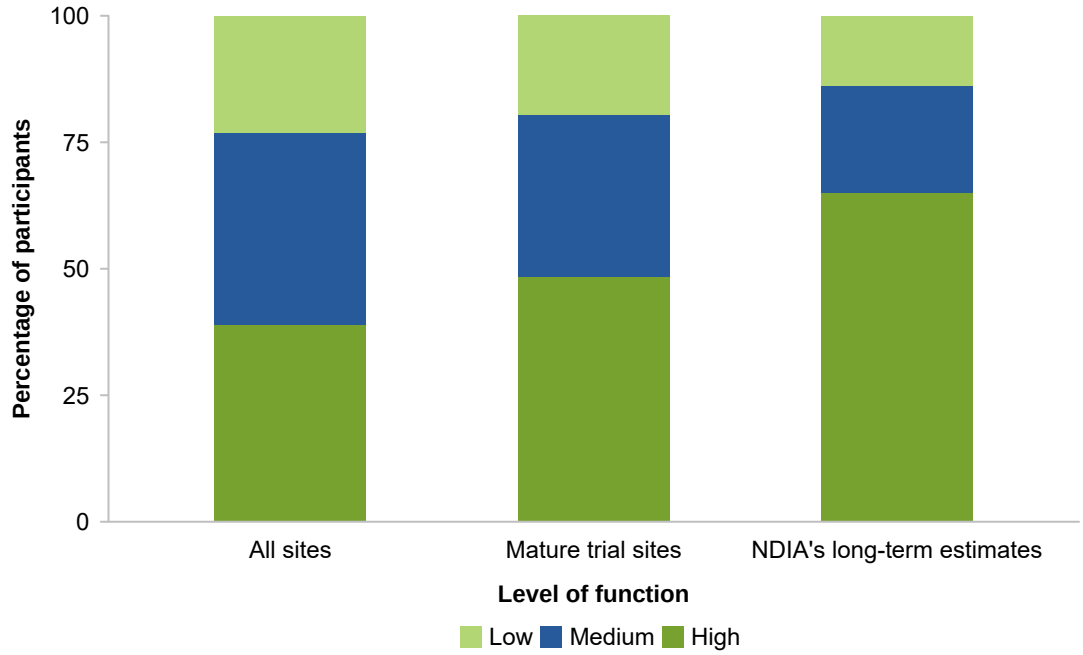
Participants by jurisdiction

About half of current NDIS participants are located in New South Wales (figure 2.2) — in comparison, the state accounts for 32 per cent of Australia's total population. This overrepresentation is because New South Wales had two trial sites while other jurisdictions had one. New South Wales is also further along the transition to full scheme (New South Wales is scheduled to reach full scheme by July 2018 — a year earlier than all the jurisdictions except South Australia and the ACT) (table 2.1).

[21] Data on level of function have not yet been collected for all trial participants.

Figure 2.5 **Distribution of participants by level of function compared to the NDIA's long-term estimates[a]**

At 30 June 2017



[a] 'All sites' denote all eligible scheme participants at 30 June 2017 for whom level of function data are available. 'Mature trial sites' denotes all eligible scheme participants at 30 June 2017 who were trial participants at the Barwon and Hunter trial sites and for whom level of function data are available. 'NDIA's long-term estimates' denote the distribution of level of function implicitly assumed in the NDIA's projections of scheme costs.

Source: Commission estimates based on unpublished NDIA data.

Participants by Indigenous and CALD status

The number of NDIS participants who identify as Aboriginal and Torres Strait Islander is broadly in line with estimates of disability prevalence for Aboriginal and Torres Strait Islander Australians. Aboriginal and Torres Strait Islander people represent 3 per cent of the population (ABS 2017a), and estimates of disability prevalence range from between 1.5 to 2 times the prevalence of the non-Indigenous population (ABS 2016a, 2016b; AIHW 2016). The NDIS data indicate that about 5 per cent of NDIS participants identify as Aboriginal and Torres Strait Islander.

However, some caution is warranted as it is not clear how the rollout schedule has influenced the number of Aboriginal and Torres Strait Islander participants in the scheme and there are some factors that may make it difficult for the NDIS to engage with Aboriginal and Torres Strait Islander people (many Aboriginal and Torres Strait Islander people with disability are reluctant to identify as people with disability and have only had a limited interaction with the disability service system (FPDN 2016)).

The NDIA does not report the number of culturally and linguistically diverse (CALD) participants as the data are not currently collected. That said, in the June 2016 quarterly report, the NDIA found that 4 per cent of participants in the trial were classified as CALD and that this was lower than expected (though again it is difficult to account for possible phasing schedule impacts) (NDIA 2016p, p. 34).[22]

The NDIA (2016t, p. 3) has developed a CALD strategy to support people from CALD backgrounds in accessing the services of the NDIS. CALD participants also have difficulties interacting with the planning process (chapter 5).

What do the early data tell us about package costs?

The scheme, at the end of the trial, came in under budget — there was a surplus of about 1.5 per cent of the funding envelope over the three years. However, this was in large part because not all committed supports were used (discussed further below).

The level of committed support (or a participant's package cost) is the dollar amount of support in a participant's plan. However, it is not necessarily the amount of support that a participant receives — there are a range of reasons why supports may be underutilised (discussed below). Over the course of the trial, the average annualised package cost was $36 049.[23] This is slightly below long-term modelling assumptions of average package costs ($38 360 in 2015-16 dollars).

However, making this comparison is of limited value because it does not account for the composition of participants included in the trial. Notably, the trial included a higher proportion of children (who typically receive less funded support than other participants because they receive more informal care). While participants with lower levels of function typically entered the scheme first during the trial — which would increase package costs — this was more than offset by the number of children entering the scheme.

To address this limitation, the Commission compared annualised package costs to the reference package amounts for each participant where level of function data were available. Reference packages represent the average expected package amount for a participant given their age, disability and level of function, and are a building block for the NDIA's modelling of scheme costs (box 2.6). Importantly, the package cost of a single participant is *not* expected to be equal to the reference package amount (factors such as scope for informal support and requirements for aids are important inputs into a participant's plan and can

[22] The NDIA (2017y, p. 7) identifies a participant as CALD if their country of birth is not Australia, New Zealand, the United Kingdom, the United States of America, Canada or South Africa, or their primary language spoken at home is not English.

[23] This figure excludes the cost of three large residential centres — Stockton and Kanangra (in the Hunter trial site) and Colanda (in the Barwon trial site) — which include a high concentration of high-cost participants in one geographical area. The average annualised package cost increases to $39 065 when they are included (NDIA 2016b, p. 46).

generate large differences between individual packages and reference package amounts), but package costs can be compared to reference packages at an aggregate level.

Box 2.6 Reference packages — fundamental to assessing financial sustainability, not individual packages

To acquit the study's terms of reference, it is necessary to examine the assumptions of the NDIA's financial sustainability modelling, and to consider the reference packages used to project costs for different cohorts of people with different disabilities over the long term.

Reference packages form a key part of understanding long-term costs, and whether the scheme is 'on track' in aggregate. That said, reference packages (and the data presented in this chapter) should not be conflated with what an individual might expect to receive in an individualised funded package at any given time. This is because a package received by an individual is determined by much more than a reference package (chapter 5), and the reference package amount does not account for an individual's particular goals, nor what supports may be reasonable or necessary in a particular individual's circumstances.

Comparing annualised package costs to the reference package amounts is further complicated by participants in Shared Supported Accommodation (SSA). SSA is accommodation for people who require specialist housing solutions and intensive support needs. SSA is designed for participants with extreme functional impairment. As such, package costs for participants in these facilities are substantially higher than other scheme participants (typically about $200 000).

At the end of June 2017, 8 per cent of participants with plans approved from July 2016 were in SSA. While the Commission's estimates include participants in SSA, there are reasons why the package costs of these participants may be lower as the scheme matures.

- There are a number of participants with relatively high levels of function in SSA who will potentially require significantly less support if they receive appropriate capacity building supports early in their lives.
- SSA services are currently delivered under in-kind arrangements and as such are likely to be priced on the high side. State and Territory Governments determine the price of in-kind services (chapter 7).

There are also some data integrity issues around data on committed supports for the transition period linked to the use of the NDIA's ICT system. The NDIA has made adjustments to the data provided to the Commission (and to the data that the NDIA publishes to meet its reporting requirements) to address a number of the identified issues.

For its position paper, when it compared annualised package costs with reference package amounts, the Commission found that the average annualised cost of packages was higher

than expected given the characteristics of participants ($60 000 compared to $56 000) for the period 1 July 2016 to 31 March 2017.[24]

However, after including data for the June 2017 quarter, the average annualised cost of packages has decreased and is now in line with expectations given the characteristics of participants ($54 000 compared to $55 000). A large part of this change can be attributed to the noticeable decrease in the proportion of participants who are in SSA that has occurred over this time period (11 per cent compared to 8 per cent).[25]

Packages by disability

Scheme participants with spinal cord injuries have the highest annualised average level of committed support ($114 000), followed by those with cerebral palsy and acquired brain injury (both $91 000) (figure 2.6). If participants in SSA are excluded, the averages fall to $109 000, $72 000 and $71 000 respectively.

There is significant variation in the amount of committed support received by participants with high-cost disabilities. The distribution of committed support for these disabilities is skewed towards some very high-cost participants, many of which are in SSA (figure 2.6). Disabilities with lower average levels of committed support (like autism and visual and hearing impairment) exhibit less variation in costs. Some participants with high-cost packages may have comorbidities that increase the level of support required, but are classified into a single disability group for reporting purposes.

Average annualised package costs are significantly lower than the NDIA's long-term modelling assumptions for seven of the high-level disability groupings (figure 2.7). However, package costs for participants with intellectual disability (the most common disability grouping) and visual impairments are higher than long-term modelling assumptions (though the number of participants with visual impairment is much lower than the number with intellectual disability so the aggregated impact is much lower). Average annualised package costs are broadly in line with long-term modelling assumptions for the remaining disabilities.

Packages by level of function

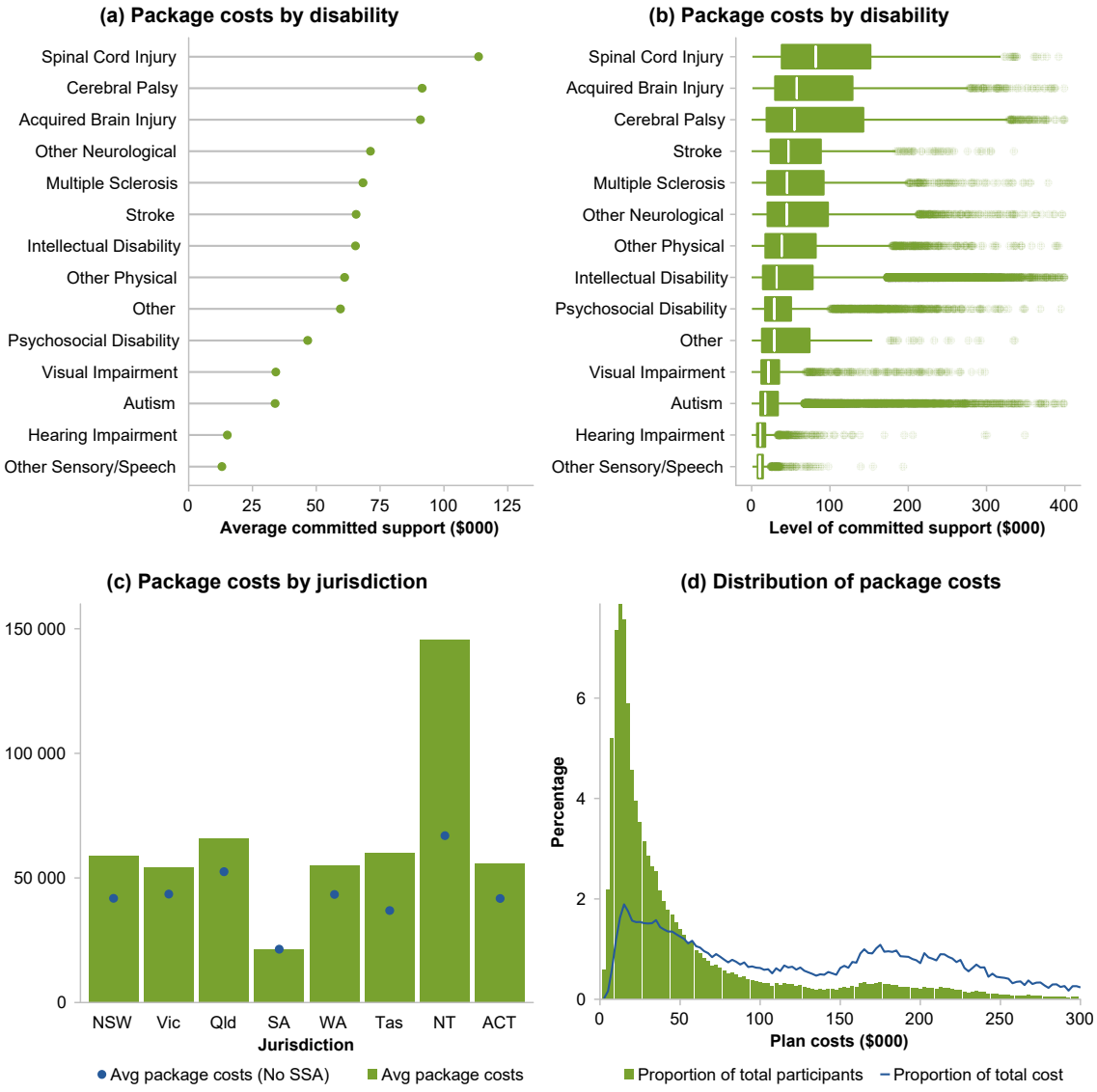
As expected, the average annualised package cost is highest for participants with the lowest level of function (figure 2.8). The average level of committed support for plans associated with low levels of function is almost $110 000, just over four times the amount for participants with high levels of function (about $26 000).

[24] Unless otherwise stated, the Commission has used plans effective after 1 July 2016 when analysing package costs.

[25] This trend brings the proportion of scheme participants who are in SSA towards the NDIA's long-term estimates of SSA prevalence (about 7 per cent).

Figure 2.6 **Some insights on annualised package costs[a,b,c]**

Plans effective from 1 July 2016

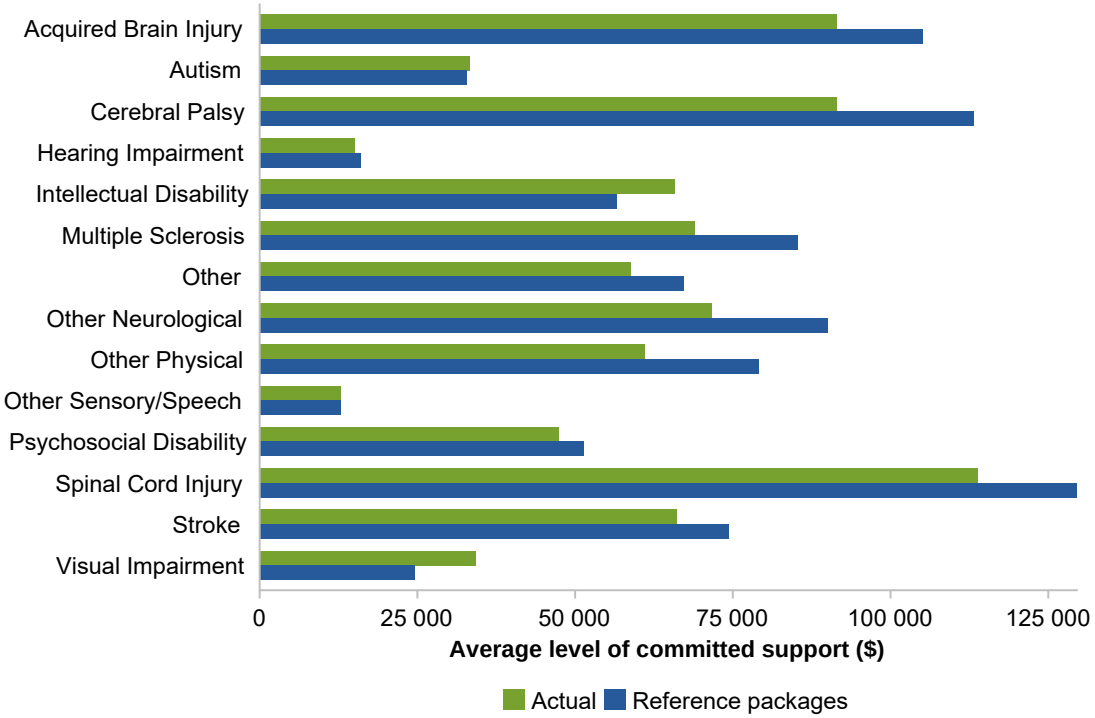


[a] For participants with multiple plans over the time period, the latest plan is used. [b] Figure (b) shows box plots of the distribution of the level of committed support for different disability groups. The white dash represents the median and the box shows the interquartile range (quartiles 1 and 3). The box plot tails show the minimum and maximum observations (though points that deviate by more than 1.5 times the interquartile range from the box are considered outliers and are denoted by a dot point). [c] In figure (c), Western Australia includes the Perth Hills NDIS trial site but not the WA NDIS MyWay trial.

Source: Commission estimates based on unpublished NDIA data.

Figure 2.7 **Average annualised level of committed support compared to reference packages, by disability[a,b,c]**

Plans effective from 1 July 2016



[a] Reference packages are the average package cost assumed in the NDIA's long-term modelling based on age, disability and level of function. They *are not* what an individual should expect to receive in an individualised funded package at any given time. [b] For participants with multiple plans over the time period, the latest plan is used. [c] Reference packages are linked to assessment tools. Therefore, participants who are assessed using the generalised assessment tools (including all participants with psychosocial disability) are linked to a 'generalised' reference package.

Source: Commission estimates based on unpublished NDIA data.

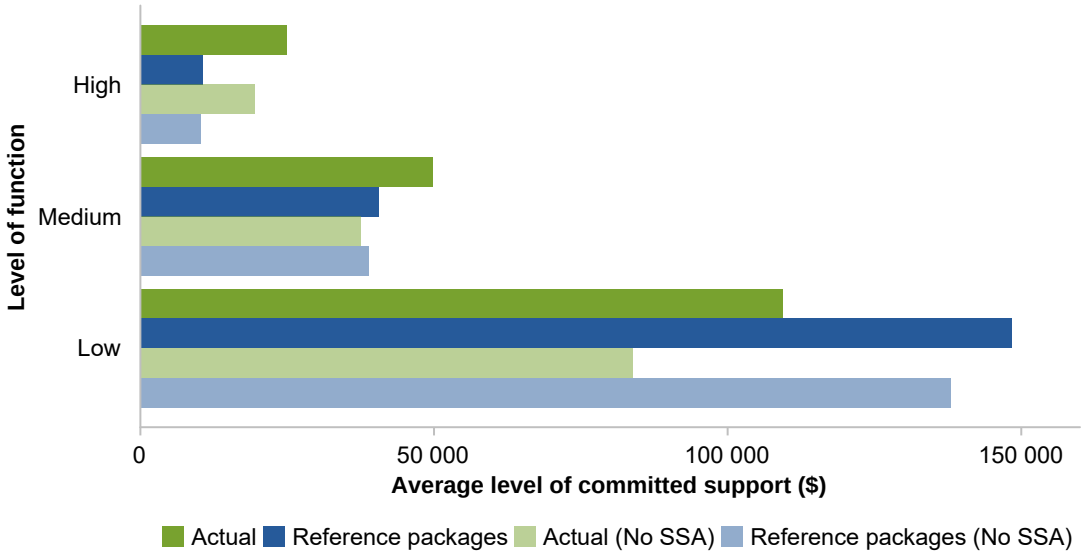
There are significant differences between average annualised packages costs and the NDIA's long-term modelling assumptions by level of function (figure 2.8).

- The average level of committed support for participants with low levels of function (who require more support) is less than expected (about $109 000 compared to $148 000). One explanation for this result may be that reference packages are underestimating the amount of informal support provided by families and carers.
- The average level of committed support for participants with medium levels of function is higher than modelling assumptions ($50 000 compared to $41 000).
- Participants with high levels of function (who require less support) are obtaining higher value packages on average than the modelling assumes ($25 000 compared to

$11 000).[26] The NDIA suggested that fewer participants than expected entering the scheme with small package amounts (less than $10 000) is in part due to problems with planning processes (NDIA 2016a, p. 40).

Figure 2.8 **Average annualised level of committed support compared to reference packages, by level of function[a,b]**

Plans effective from 1 July 2016



[a] Reference packages are the average package cost assumed in the NDIA's long-term modelling based on age, disability and level of function. They *are not* what an individual should expect to receive in an individualised funded package at any given time. [b] For participants with multiple plans over the time period, the latest plan is used.

Source: Commission estimates based on unpublished NDIA data.

Participants in SSA are a significant driver of average costs for the high and medium levels of function cohorts (figure 2.8). Given that SSA is designed for people with low levels of function, this suggests issues with how SSA was managed in the past. Historical experience suggests that investing in capacity building supports early to keep participants with high and medium levels of function out of SSA is critical for minimising scheme costs in the future.

Packages by jurisdiction

Participants in the Northern Territory have the highest average package costs ($150 000) followed by those in Queensland ($66 000). Participants in South Australia have the lowest average package costs ($21 000) (figure 2.6(c)).

[26] The average annualised package cost for participants with high levels of function ($29 000) only includes participants for whom reference package data are available. The average annualised package cost is $31 000 when all participants with high levels of function are included.

The average package cost differences are driven by the phasing schedules.

- About 39 per cent of Northern Territory participants with an approved plan are in SSA with an average package cost of $320 000.[27]
- The NDIS only began operating in Queensland at the beginning of 2016 and therefore has a disproportionate number of participants with low levels of function.
- Because of the scope of the South Australian trial, almost all the scheme participants in that state are children who generally have lower levels of committed support than older participants.

The distribution of total committed supports

The distribution of committed supports is heavily weighted to low cost packages with the most common package costing between $10 000–$15 000 (figure 2.6(d)).

The distribution of committed supports weighted by total cost of packages is flatter, peaking at $10 000–$15 000 and $175 000. The second of these peaks is attributable to participants in SSA. High cost participants account for a significant proportion of scheme costs — the top 20 per cent of packages (those over $80 000) account for 62 per cent of total committed supports.

Types of support provided

Most (over half) of the committed supports are earmarked to help scheme participants with their daily life — support for daily activities (box 2.7) (figure 2.9).[28] Social and community programs make up about 19 per cent of committed support and supports to improve daily living skills about 13 per cent. Employment supports make up about 2 per cent of committed support (discussed further in chapter 3).

[27] Scheme participants in SSA in the Northern Territory tend to be in the most complex types of SSA.

[28] Participants have some control over how they allocate their support budget depending on the support category (that is, they do have some scope to deviate from the support described in their plan).

Box 2.7 Types of support

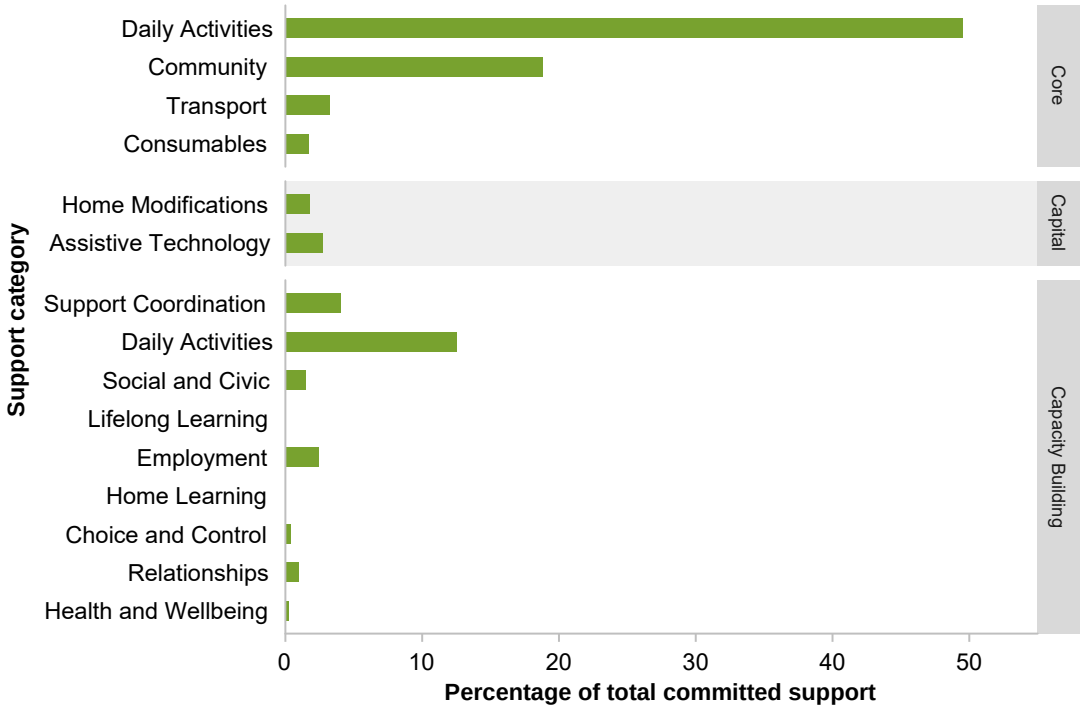
Supports provided under the NDIS fall into one of fifteen *support categories,* which in turn can be grouped into three *support purpose categories*:

- Core supports — support that enables participants to complete activities of daily living, and enables them to work towards their goals and meet their objectives.
- Capital supports — an investment, such as assistive technologies, equipment, home or vehicle modifications, and funding for capital costs associated with specialised housing.
- Capacity building supports — support that enables participants to build their independence and skills.

Source: NDIA (2016o).

Figure 2.9 Committed supports provided by support category[a]

Plans effective from 1 July 2016



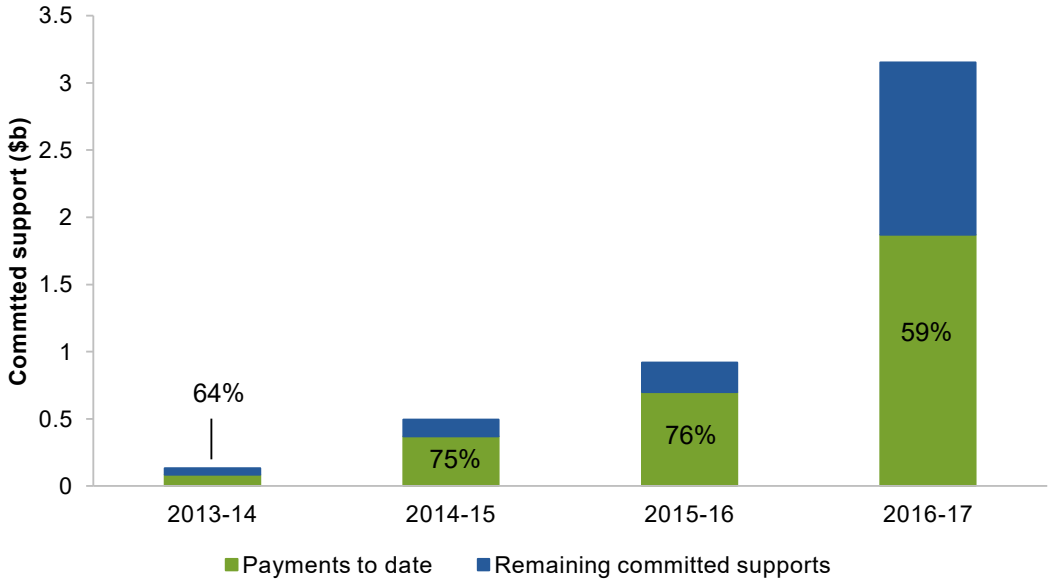
[a] For participants with multiple plans over the time period, the latest plan is used.

Source: Commission estimates based on unpublished NDIA data.

Utilisation

Participants are not using all their packages — for the final year of the trial (2015-16) just 76 per cent of committed supports were used (figure 2.10).[29] As discussed above, low utilisation is the reason why there was a surplus of about 1.5 per cent of the funding envelope at the end of the trial, despite higher than expected levels of committed support (NDIA 2016b, p. 144).

Figure 2.10 **Utilisation of committed supports**[a]



[a] Invoices for some payments for 2016-17 have not yet been received. The NDIA have indicated that the utilisation rate is likely to increase to 70 per cent once all invoices are received (NDIA 2017y, p. 37).

Source: NDIA (2017y, p. 37).

The utilisation rate for 2016-17 was substantially lower — 59 per cent of committed supports have been used to date. The lower rate is in part because not all services have been invoiced. Actuarial modelling undertaken by the NDIA indicates that the utilisation rate is likely to increase to 70 per cent once all invoices are received (NDIA 2017y, p. 37). The remaining difference can be attributed to the significant intake of participants in the first year of transition — new participants tend to have lower utilisation rates when they first enter the scheme (discussed below).

[29] This figure is based on payments that have been made to date. There can be a lag between the date a service was provided and the date that it was invoiced.

According to the NDIA (and supported by comments from other study participants), on-the-ground experience indicates that the reasons for the utilisation rates being below full utilisation vary by the individual and their circumstances. Some reasons include:

- insufficient supply of supports to meet demand, especially for specific supports (such as short-term accommodation) and in particular markets (such as remote and very remote areas) (Commonwealth Ombudsman, sub. 137; Inclusion Australia, sub. PP357; Macarthur Disability Services, sub. 57; APA, sub. 93; PDCN, sub. 29; Public Service Research Group, sub. 56; VICSERV, sub. PP284)
- participants experiencing difficulties navigating the system, which can mean they are unable to implement a plan once it has been approved (ABF, sub. 48; CSSA, sub. 166; Macarthur Disability Services, sub. 57; PDA, sub. 38; Vision Australia, sub. PP210)
- scheme participants not needing all the supports they are entitled to (planners overestimating the amount of funded support that will be needed, or including supports that do not meet the needs of participants) (Macarthur Disability Services, sub. 57; Vision Australia, sub. PP210)
- the market for plan supports (such as support coordination and plan management) being relatively immature and therefore limiting the help that participants can obtain (Anglicare Australia, sub. 157)
- some participants cannot easily access information about how much of their supports are available (Public Service Research Group, sub. 56).

Some underutilisation of supports is expected in the early stages of the scheme — as participants and providers adapt to a new system for providing disability care — but utilisation rates are expected to rise over time. In fact, utilisation rates did increase over the period 2013-14 to 2015-16, before dropping when a substantial number of new participants entered the scheme in 2016-17 (figure 2.10).

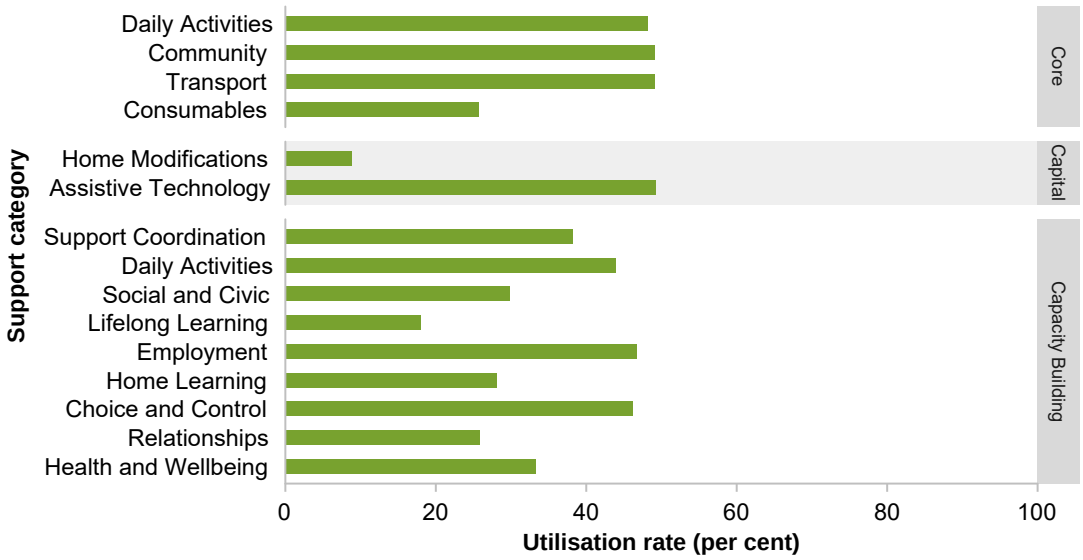
The NDIA (sub. PP327, p. 12) said that 'participant utilisation rates have increased as participants spend more time in the Scheme'. While the NDIA's estimates of scheme costs implicitly assume that all committed supports are spent when the scheme is fully implemented, the NDIA (sub. 161, p. 70) said that 'in a person-centred system the utilisation rate will never be 100%'. The NDIA also noted experience in other schemes suggests a utilisation rate of between 80 and 95 per cent could be expected.

Utilisation by support type

While there are data on utilisation rates disaggregated by support type, it needs to be interpreted with caution as it is not possible to incorporate claims data relating to in-kind supports (these data need to be sourced directly from jurisdictional reconciliations of in-kind supports). This means that disaggregated utilisation rates will be lower than the overall figure.

Keeping that caveat in mind, there are clear differences between the utilisation rates of committed supports for some support categories (figure 2.11). In 2016-17, the transport, assistive technology and social and civic support categories had the highest utilisation rates (each at 49 per cent) and the home modifications support category had the lowest (9 per cent utilisation rate).

Figure 2.11 **Utilisation rates by support type[a]**



[a] There are two reasons why the utilisation rates presented in this figure will be an underestimate: claims data relating to in-kind supports are not included, and invoices for some payments for 2016-17 have not yet been received. However, this is unlikely to have a significant impact on the relativities between support categories.

Source: Commission estimates based on unpublished NDIA data.

Utilisation in subsequent plans

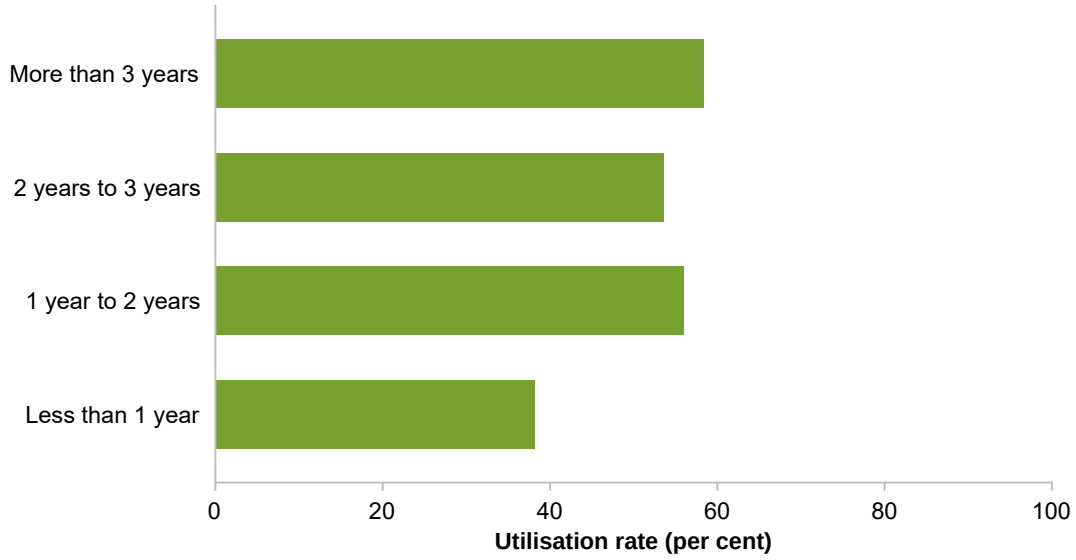
Utilisation rates are higher for participants who have been in the scheme for more than a year compared with those in their first year in the scheme (figure 2.12). But there are no significant differences in the utilisation rates for participants who have been in the scheme for more than a year (about 56 per cent). After adjusting for missing in-kind payments (about 13 per cent)[30] and the payments that have not yet been received (about 11 per cent),[31] and recognising the data integrity issues that impact the calculation of utilisation rates, the

[30] The utilisation rate for 2016-17 data provided to the Commission is 46 per cent, 13 percentage points lower than the reported utilisation rate in the latest NDIA quarterly report (NDIA 2017y, p. 37).

[31] The latest NDIA quarterly report notes that the utilisation rate is likely to eventually rise to 70 per cent once all invoices are received (NDIA 2017y, p. 37)

utilisation rate for participants who have been in the scheme for more than a year would be 80 per cent in 2016-17.

Figure 2.12 **Utilisation rates in 2016-17 by time in scheme[a]**



[a] There are two reasons why the utilisation rates presented in this figure will be an underestimate: claims data relating to in-kind supports are not included, and invoices for some payments for 2016-17 have not yet been received. However, this is unlikely to have a significant impact on the relativities between different lengths of time in scheme.

Source: Commission estimates based on unpublished NDIA data.

Some emerging cost pressures

Bringing the analysis of these three components of scheme costs together, the early scheme data suggest that NDIS costs are broadly in line with the NDIA's long-term modelling estimates.

While more children are entering the scheme than expected, this has been *more* than offset by lower levels of utilisation than expected. If the rollout of the scheme also remains behind the bilateral estimates, it is highly likely that scheme costs in 2019-20 will be lower than the NDIA's projections (this will be because fewer people than expected are accessing support).

However, it is critical that emerging cost pressures are managed as utilisation rates are expected to increase. The Department of Social Services (sub. 146, p. 20) echoed this sentiment, noting that 'better management of cost pressures should reduce the impact of increasing utilisation rates'. That said, if the cost pressures emerging from the trials and transition are not addressed, the financial sustainability of the scheme over the longer term will be at risk.

The NDIA is tasked with ensuring that the NDIS is financially sustainable, and this involves identifying and managing emerging cost pressures. The Scheme Actuary compares the experience of the NDIS to projections on an ongoing basis and reports to the Board quarterly. If cost pressures are detected early, management responses can be put in place before problems become entrenched.

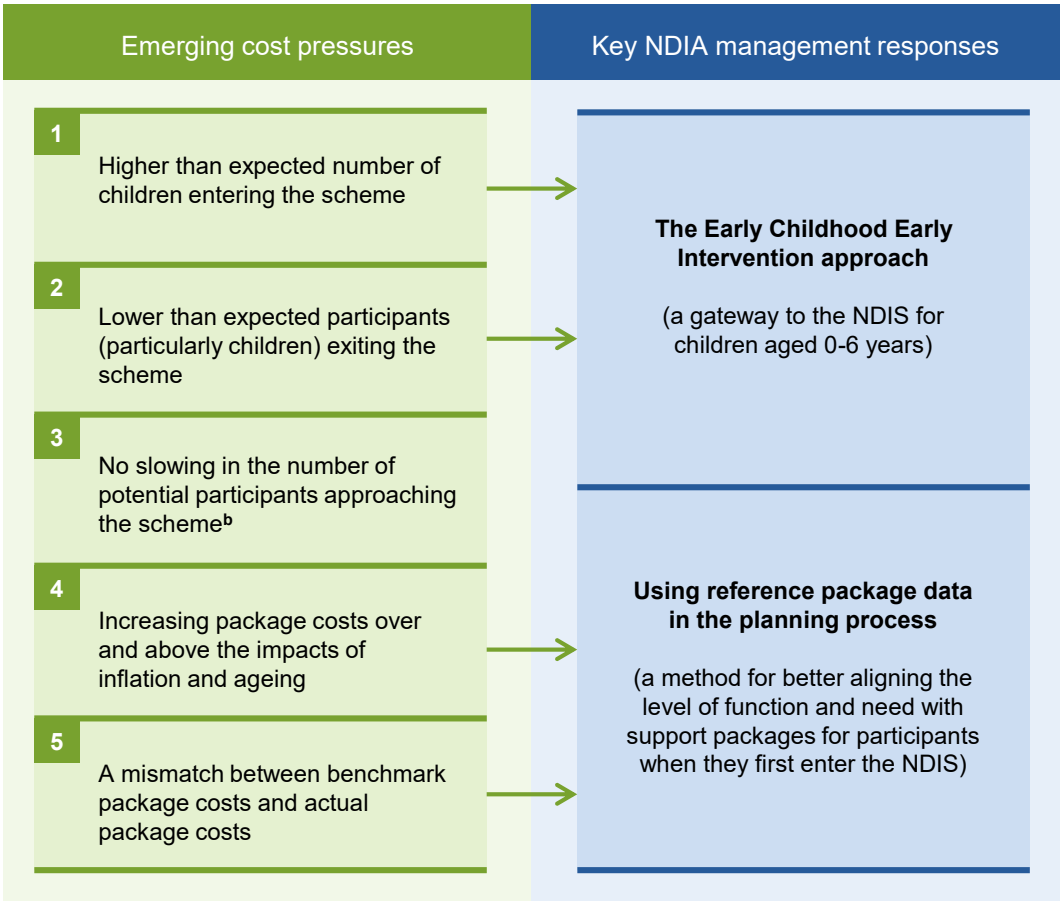
In the NDIA's most recent annual report (released in October 2016), the Scheme Actuary identified five cost pressures from the trial sites that need to be managed for full scheme, including:

- a higher than expected number of children (especially in the trial sites of South Australia, Victoria and the ACT)
- increasing package costs over and above the impacts of inflation and ageing (as plans are reviewed)
- potential participants continuing to approach the scheme (the number of people approaching the scheme in some trial sites that have been operating since 2013 is more than would be expected if only people with newly acquired disabilities were approaching the scheme)
- a lower than expected number of participants exiting the scheme (particularly children who entered the scheme under the early intervention requirements)
- a mismatch between benchmark package costs and actual package costs. There is a greater than expected level of variability in package costs for participants with similar conditions and levels of function (NDIA 2016b, pp. 16, 144).

In line with the insurance approach to identifying risks early and putting in place management responses, the NDIA has put in place initiatives to address these cost pressures (figure 2.13). The responses include the Early Childhood Early Intervention approach (chapter 4), and the use of reference package data in the planning process (chapter 5) (NDIA 2016b, pp. 16–17, 56–57).

While it is too early to conclusively assess the effectiveness of these initiatives, data for 2016-17 may indicate that the new planning process is helping to mitigate the cost pressures related to package costs (table 2.4). (Uncertainty about the effect of phasing schedules make strong conclusions difficult.)

Figure 2.13 **The NDIA's responses to emerging cost pressures**[a]



[a] This figure includes the NDIA's two main responses to emerging cost pressures. The NDIA has initiated several smaller projects to address emerging cost pressures, such as an analysis of reasonable and necessary costs across the lifespan of participants. These are detailed in the NDIA's 2015-16 Annual Report (NDIA 2016b, pp. 145–146). [b] Potential participants continuing to approach the scheme is not a cost pressure that can easily be addressed by the NDIA.

Source: NDIA (2016b, pp. 144–146).

Table 2.4 **The latest information on NDIS cost pressures**

Cost pressure	*2016-17 update*
Higher than expected numbers of children	The prevalence of 0–6 year olds did not significantly change in 2016-17, but the prevalence of 7–14 year olds and 15–18 year olds increased.
Lower than expected participants exiting the scheme	Few participants exited the scheme in 2016-17.
No slowing in the number of potential participants approaching the scheme	This trend continued in 2016-17 (though there was some reduction in New South Wales and the ACT).
Increasing package costs over and above the impacts of inflation and ageing	The rate of increase in package costs between plans increased in the first three quarters of 2016-17. In the last quarter, the rate decreased but it remains above expected levels.
A mismatch between benchmark package costs and actual committed support	This cost pressure improved in 2016-17, especially in the last quarter.

Source: NDIA (2017y, p. 39).

FINDING 2.3

The National Disability Insurance Scheme, at the end of trial, came in under budget. But of concern to the Productivity Commission is that this was in large part because not all committed supports were used (in 2015-16 the utilisation rate was 76 per cent). While lower than expected levels of utilisation means lower scheme costs, it also implies poorer outcomes for participants.

Based on trial and transition data, scheme costs are broadly on track compared to the National Disability Insurance Agency's (NDIA's) long-term modelling. At this stage, early cost pressures (such as greater than expected numbers of children in the scheme) are being more than offset by lower than expected levels of utilisation.

The NDIA has put in place initiatives to address emerging cost pressures. It is too early to assess the effectiveness of these initiatives.

3 Scheme benefits

Key points

- The costs of the National Disability Insurance Scheme (NDIS) need to be considered in the context of the benefits the scheme is expected to generate.
- The NDIS is expected to generate substantial economic benefits that will significantly exceed the additional costs of the scheme. Expected benefits include:
  - improved wellbeing for NDIS participants, their families and informal carers
  - increased economic participation for NDIS participants and their informal carers
  - broader efficiency gains and cost savings in the disability support system
  - savings to other government services.
- It is too early to assess whether the expected benefits of the NDIS are being realised — current outcomes data are based on trial site data and many benefits from the scheme are expected to be realised over the long term.
- That said, there is early evidence that the NDIS is changing lives — reported benefits include improved wellbeing, more supports, and greater choice and control for many scheme participants, their families and informal carers.
- But some people with disability report poorer outcomes under the NDIS when compared with previous disability services.
- The particular groups at risk of having a less positive experience with the NDIS include people with psychosocial disability, complex and multiple disabilities, and language and cultural barriers, as well as people with disability transitioning into the community from the criminal justice system, the homeless and the socially isolated.
- The NDIS has helped some participants and their carers enter or remain in the workforce, but there are concerns that employment supports are not being considered in many plans.
  - About one in five NDIS participants over the age of 15 years currently have employment support included in their plans (and for some age groups it is higher).
- There is a need for better data and reporting (to enable better analysis) on why many participants are not accessing employment supports.

The focus of this report is on National Disability Insurance Scheme (NDIS) costs, but costs need to be considered in the context of the benefits the scheme is expected to generate. The NDIS holds the promise of transforming the lives of people with disability, their families and carers with flow-on benefits for all Australians. It also provides insurance cover for all Australians. Realising the benefits of the NDIS is critical, not only for the wellbeing of people with disability and their families and carers, but also so the community continues to be willing to pay for the NDIS.

This chapter looks at the evidence to date (noting that it is still very early days) on the benefits of the NDIS. Section 3.1 provides a brief summary of the expected benefits and discusses some of the challenges with measuring the benefits. Section 3.2 looks at early outcomes for participants, families and carers. Section 3.3 examines employment outcomes. Section 3.4 looks at early indicators of the broader economic and social benefits of the NDIS.

3.1 Expected benefits and measurement of outcomes

The NDIS is expected to generate substantial benefits that are expected to significantly exceed the additional costs of the scheme (PC 2011, p. 56). The benefits are expected from:

- improved outcomes for NDIS participants, their families and informal carers
- increased economic participation (employment outcomes) for both NDIS participants and their informal carers
- broader efficiency gains and cost savings in the disability support system and savings to other government services.

Support for the NDIS (chapter 1) is based on the potential benefits from the scheme. Every Australian Counts, for example, spoke about the NDIS giving back to the economy.

> At its heart, the NDIS is about people. The Scheme is a once-in-a-lifetime change to the way disability support is delivered in Australia. It is going to affect millions of Australians. … Long-term, the NDIS will give back to the economy. Indeed, it would cost far more not to implement it. The NDIS will create jobs in the sector; improve long-term outcomes for people with disability, families and carers; and decrease reliance on health care and welfare. (sub. 92, p. 2)

And the Mental Health Community Coalition of the ACT said that it:

> … views the NDIS with great hope. It holds promises for a better more integrated life for people living with disability. It offers flow on benefits that will affect all Australians. But we must take care to ensure that we get it right. This requires time, investment, flexibility and persistence. (sub. 135, p. 2)

Tracking the benefits

Comparing the benefits of the scheme relative to expectations is difficult (and arguably more difficult than making the same comparison for costs). Some of the benefits are difficult to calculate because they are intangible (for example, the benefits to people with disability from greater choice and control). This was acknowledged by the Australian Federation of Disability Organisations.

> Some economic outcomes are easily captured and quantified — investment in capacity building or home modifications or equipment can reduce support costs in the long term. And if an NDIS participant is supported to move into employment, or a family carer re-enters the workforce, the economic impact of that change can be measured.
>
> But other, just as important outcomes, are not only more difficult to capture, they are more difficult to assign value. What value can we assign, for example, to increased inclusion? To increased independence? To increased dignity? (sub. PP325, p. 6)

But while it can be challenging to measure intangible outcomes, they can make a significant difference to the lives of people and need to be considered.

Many NDIS outcomes — such as the benefits of early intervention (chapter 4), efficiency gains in the disability sector, savings to government services and increased workforce participation (and the resulting fiscal savings) — will only be realised over the long term. This in part reflects the scheme's adoption of insurance principles that allow for upfront investments where these have the potential to yield future benefits. As the Victorian Government said:

> The NDIS' financial sustainability will critically depend on effective application of insurance principles to drive early investment that will save future costs by improving outcomes for people with disabilities, including their capacity to live independently and participate in social and economic life. This will also reduce the longer term reliance of people with disabilities and their carers on mainstream services and income support. (sub. 174, p. 14)

Data that can be used to assess the benefits of the NDIS are limited at this early stage of the scheme rollout. There are two main sources of data that provide some early insights.

- The NDIS Short Form Outcomes Framework (box 3.1).
- The intermediate report of the NDIS evaluation undertaken by the National Institute of Labour Studies (box 3.2).

Because of limited data, this chapter also relies on anecdotal information from stakeholders (in comments, submissions and consultations) to gain insights on benefits and areas where benefits could be at risk of not being realised. The limitation of anecdotal evidence is that it provides no information about the frequency that particular anecdotes (including issues) arise. Going forward, it is important that the right data are collected to ensure that benefits can be more comprehensively tracked as the scheme is fully rolled out and over the long term. Data issues are discussed in more detail in chapter 13.

Box 3.1 The NDIS Short Form Outcomes Framework

The National Disability Insurance Scheme (NDIS) Short Form Outcomes Framework is an approach to measure the outcomes of NDIS support. It includes eight indicators of participant experience (known as participant domains) as well as outcomes related specifically to families and informal carers (table below). It was piloted in the first three months of 2015 and is now being rolled out scheme wide.

The Framework will allow tracking of participant and scheme progress over time, and demonstrates how participants are faring relative to other Australians and to other OECD countries. It will also contribute to an understanding of what types of supports lead to good outcomes for people with disability, their families and carers.

Between November 2015 and July 2016, the NDIA collected data from existing participants to provide an early indicator of participant progress under the NDIS. More recent data mostly reflect participants' lives when joining the NDIS to form a baseline that can be used to assess the benefits of the scheme.

Participant domains
Choice and control — improved choice and control and planning and delivery of supports
Daily activities — increased ability to undertake daily activities with adequate levels of support
Relationships — increased levels of social inclusion and reduced experiences of loneliness
Home — improved satisfaction with home environment now and five years into the future
Health and wellbeing — improved health and wellbeing and increased ease of access to health services
Lifelong learning — increased opportunities to learn new things
Work — increased uptake of paid employment (and the associated social inclusion)
Social, community and civic participation — increased participation in community activities chosen by the participant, and reduced negative experiences associated with being excluded
Family and carer domains
Families have the support they need to care
Families know their rights and advocate effectively for their family member with disability
Families are able to gain access to desired services, programs, and activities in their community
Families have succession plans
Parents enjoy health and wellbeing

Sources: NDIA (2015d; sub. 161, pp. 27–36).

Box 3.2 **NDIS Evaluation**

In 2013, the Australian Government Department of Social Services commissioned a consortium led by the National Institute of Labour Studies to conduct an evaluation of the trial of the National Disability Insurance Scheme. The study monitors and evaluates the experience of participants, and their families and carers, service providers and their workforce in the trial sites of the ACT, Victoria, New South Wales, Northern Territory, South Australia and Tasmania.

An initial report, that described how the evaluation was being conducted, was delivered to the Department of Social Services in December 2015.

An intermediate report, based solely on trial site data, presented a synthesis of the quantitative and qualitative evidence collected to date and was released in December 2016.

- The qualitative evidence was sourced from in-depth interviews of people with disability, their families and carers (123 interviews), disability service providers (49), disability workforce stakeholder organisations (29) and National Disability Insurance Agency staff (87).
- The quantitative evidence is based on a survey of about 4400 people with disability and about 3400 families. Survey participants were split into two groups — those included in the NDIS trial and those outside the NDIS trial — and their experiences compared.

A final report is scheduled to be completed later in 2017. It will incorporate an additional wave of survey data.

Source: Mavromaras, Moskos and Mahuteau (2016, p. ix–x, 18).

3.2 Outcomes for participants, families and carers

Generally, people with disability and their families face social and financial challenges and, as a group, are among the most disadvantaged in Australia (PC 2011, p. 112). People with disability are more likely to experience relatively poor health, lower levels of participation in education, training and employment, social exclusion, lack of access to goods, services and facilities and ongoing discrimination (COAG 2011, p. 12).

The NDIS is designed to deliver much needed support to improve outcomes for participants, their families and carers. Personalised supports are one of the main ways the benefits of the NDIS are realised (discussed in chapter 5, box 5.1).

The NDIS is improving lives

The NDIS is improving lives. Reported NDIS benefits include improved wellbeing, access to more supports, and improved choice and control for many scheme participants, their families and carers.

Participants and carers report improvements in wellbeing

One of the prime motives behind the NDIS is to improve the wellbeing of people with disability. Wellbeing is expected to improve under the NDIS via better quality of care, increased independence, and increased engagement in the economic and social life of the community.

When outcomes for NDIS participants are improved there are flow-on benefits to their families and informal carers. For example, reasonable and necessary care for participants may result in increased opportunity for informal carers to increase their social and economic participation.

Many submissions and comments received as part of this study spoke about the NDIS improving the lives of participants, their families and carers (box 3.3).

The NDIS evaluation found that many NDIS participants, their families and informal carers have experienced improvements in quality of care, independence and overall wellbeing.

- 49 per cent of participants said the quality of care had improved with the NDIS.
- Many participants can now take part in activities independently and are able to follow interests and social activities that had previously been inaccessible.
- Carers reported an 'increased sense of positivity and wellbeing' because their NDIS participants were more involved in activities they enjoyed and were able to participate in wider interests outside of the home.
- The evaluation also reported that qualitative evidence 'makes clear that on the whole the NDIS has improved the wellbeing of scheme participants and their family members and carers' (Mavromaras, Moskos and Mahuteau 2016, pp. xv, xvi, 38).

The NDIS Short Form Outcomes Framework (based on data collected from existing participants over the period November 2015 to July 2016) also reported:

- about two-thirds of scheme participants aged 15 years and over said the NDIS had helped with daily living (64 per cent for participants aged 15–24 years and 71 per cent for participants aged 25 years and above)
- almost two-thirds of participants aged 15 years and over said the NDIS helped with health and wellbeing (62 per cent of participants aged 15–24 years and 65 per cent of participants aged 25 years and over)
- 89 per cent of carers with children aged under five years said the NDIS had improved their child's development (NDIA, sub. 161, pp. 36, 38).

Box 3.3 **The NDIS — changing lives of participants, their families and carers**

APC Prosthetics:

> … the participant outcomes from the scheme have been overwhelmingly positive. Many participants are enjoying improved mobility and improved quality of life outcomes that were simply not available through the existing State-based treatment pathways. (sub. PP244, p. 1)

Anne Hansen:

> … I have seen the life changes in people with disability who now have NDIS funding. They are now accessing community, having a good life and have hope for their futures. The burdens are off the family, some aged carers, and there is job creation. Broken wheelchairs are now being replaced and people who never had wheelchairs, now have and can access the community. I now see happy people. (brief sub. 2)

Kerrie Newton:

> My NDIS plan has given me funding for someone to come into the home to help. This has taken an enormous amount of pressure off my family so they can live a more normal life. I also received some transport funding and for the first time in four years I have been able to leave the house independently. I am feeling more positive about my future. (brief sub. 154)

Lorraine Rodrigues:

> The NDIS to me is knowing that my son will have a future of his own to look forward to if I am unable to care for him for whatever reason. (brief sub. 3)

The stories of Oni and Harry provided by the National Disability Insurance Agency:

> 'I've been working with a speech therapist to get my speech up and it's really helping. I can say a few more words and actually pronounce them properly and all that,' Oni remarked … 'He's only been in one year and the changes have been remarkable. I've seen his confidence improve out of sight. I've heard him be able to speak and say words that we didn't even know he knew,' Chelinay remarked.
>
> 'The NDIS has definitely improved our lives – Harry's and ours as a family,' she said. 'We've been able to get funding to purchase Harry a manual wheelchair … now he can access places he could never in his electric wheelchair, so he now has more flexibility. He was recently able to go the beach with his classmates – something he had never been able to do before!' (sub. 161, pp. 41–43)

The NDIS is providing more supports to many participants

Early indications are that most NDIS participants are accessing more supports under the NDIS than under the previous disability system, including more hours of support, a wider range of support and greater access to equipment.

- The NDIS evaluation found that 'the majority of respondents receive increased supports as a result of becoming NDIS participants' (Mavromaras, Moskos and Mahuteau 2016, p. xi).
  - The average number of different supports accessed by participants increased from about 2 to 3 under the NDIS (Mavromaras, Moskos and Mahuteau 2016, p. 32).
- The Every Australian Counts online survey reported that 78 per cent of participants and 74 per cent of carers said they had the same or more support than before the NDIS (Every Australian Counts 2017).

- The NDIS Short Form Outcomes Framework reported that 88 per cent of carers with children aged under five years said the NDIS had improved their child's access to specialist services (NDIA, sub. 161, p 36).

Many participants to this study also said that they are accessing increased supports under the NDIS. For example, Merle Searle said:

> The NDIS has made such a huge difference to us and our young man on a day to day basis as we are in the older age bracket i.e. over 70 and now because of the extra funding he has support workers that can take him into the community. (brief sub. 17)

Karen Wakely said:

> We began implementing our plan in Jan 2016. In a little over 12 months, the change it has facilitated has been extraordinary. For the first time we have been able to access meaningful therapeutic supports. (brief sub. 43)

The NDIS is giving many participants more choice and control over supports

In addition to improved wellbeing and more supports, a key marker of the success of the NDIS is whether the scheme is providing more choice and flexibility in the timing of supports and who provides them.

The NDIS evaluation found that 44 per cent of participants surveyed had a greater say over the supports they received, and 46 per cent had more choice over who provided their supports (Mavromaras, Moskos and Mahuteau 2016, p. 60). However, the NDIS Short Form Outcomes Framework data suggest that the percentage of people benefiting from more choice and control under the NDIS is significantly larger — 73 per cent of scheme participants aged 15–24 years stated that they had more choice and control over their life (NDIA, sub. 161, p 36).

A number of submissions to this study also commented on the NDIS providing greater choice and control. For example, Robert Altamore said:

> The NDIS has changed my life because it has given me the ability to set my own goals, exercise my choices and given me control of my money to spend on the adaptive technology and the training I need to change my life and participate in the general community. (brief sub. 36)

And Helen Harrop said:

> My son has been a NDIS participant since August 2016. He is 26 years old, … the benefits to my son within this short time span have been terrific. For the first time in his life he has control. Within his plan he has more opportunity to get out and experience many different options so he can enjoy life. (Every Australian Counts, sub. 92, p. 14)

FINDING 3.1

Early evidence suggests that the National Disability Insurance Scheme is improving the lives of many participants and their families and carers. Many participants report an increase in the amount of support provided, more choice and control over the supports they receive, improvements in their quality of care, greater independence and an increase in overall wellbeing.

But not all are having a positive experience

Some people with disability report poorer outcomes under the NDIS when compared with previous disability services. The NDIS evaluation found that:

- about 16 per cent of participants reported feeling that they had less choice and control of their supports under the NDIS
- about one-quarter of participants are accessing fewer distinct supports (Mavromaras, Moskos and Mahuteau 2016, pp. 60–61).

A Melbourne Social Equity Institute survey (42 NDIS participants and carers who were part of the Barwon trial) reported that:

  - participants' expectations and experiences of the NDIS were strongly influenced by their circumstances
  - resources to help people exercise choice and control over their support were not always available
  - in some cases, service users had limited choice over what was available for them to purchase with their funding package, especially in regional areas
  - participants feel like their views are often overlooked in planning processes
  - participants who do not fully understand the system tend to feel disadvantaged. (Warr et al. 2017, pp. 7–8)

The NDIA (2017y, p. 28) also found a fall in participant satisfaction with the scheme since it entered the transition phase — the percentage of participants describing satisfaction with the Agency as good or very good dropped from an average of 95 per cent in 2015-16 (quarter 4) to 84 per cent in 2016-17 (quarter 4). This may be linked to the speed of the rollout and changes to planning processes over that period (chapter 5).

In some cases, participants are not realising the benefits of the NDIS because they are finding it difficult to access disability supports (chapter 2 discusses underutilisation of supports). The NDIS evaluation attributes this to lengthy waiting lists for some providers or types of support, a lack of local providers, and lack of quality provision. Unmet demand for supports is more common for those living in rural and remote areas (15 per cent more likely than

those in urban areas), and for older participants (Mavromaras, Moskos and Mahuteau 2016, p. 31). This is discussed further in chapter 7.

Some of the most vulnerable are at risk of not realising NDIS benefits

Early evidence suggests that people experiencing poorer early outcomes under the NDIS tend to be some of the most vulnerable people with disability.

According to the NDIS evaluation, participants who are receiving less NDIS support are often those who are unable to effectively advocate for services on their own behalf, and participants who struggle to understand the sometimes complex NDIS processes (Mavromaras, Moskos and Mahuteau 2016, p. xi).

> … vulnerable families, those unable to navigate the NDIA website to find what services and providers were available, and those less able to articulate support needs, are less likely to experience greater choice over their supports. (Mavromaras, Moskos and Mahuteau 2016, p. xiii).

In particular, both the qualitative and quantitative data from the NDIS evaluation indicate that people with mental health and psychosocial disability are more likely to report less choice and control over supports since becoming NDIS participants (Mavromaras, Moskos and Mahuteau 2016, p. xiii).

Study participants also identified a number of groups who appear to be at risk of having a less positive experience with the NDIS. These include people with psychosocial disability, complex and multiple disabilities, and language and cultural barriers, as well as people with disability transitioning into the community from the criminal justice system, the homeless and the socially isolated (box 3.4).

It is important to monitor the utilisation of NDIS supports to identify gaps where vulnerable groups may be 'falling through the cracks'. This study identifies a number of areas where support for vulnerable people with disability could be improved.

- Chapter 4 recommends a specialised psychosocial gateway to improve how the scheme engages with people with psychosocial disability.
- Chapter 5 looks at planning and the use of specialised planning teams.
- Chapter 6 discusses the role of Local Area Coordinators and interface issues between the NDIS and mainstream services.
- Chapter 7 discusses provider of last resort arrangements.
- Chapter 10 considers support coordination.

Box 3.4 Concerns that for some the NDIS experience is less positive

Health Services Union:

> Increasingly, social policy theorists and researchers are positing that the NDIS has 'been constructed predominantly with people with physical and sensory disabilities in mind. For this constituency, who have less difficulty in negotiating the world, the [scheme's] emphasis on individual autonomy and agency makes the most sense. For those with complex and multiple disabilities, and for people with cognitive and intellectual impairment, in contrast, the benefits are less clear, and an individual approach can be counterproductive.' HSU members have echoed these sentiments. (sub. 132, p. 20)

Cohealth:

> It is [also] anticipated that the capacity for outreach will be significantly diminished due to the NDIS pricing structure. The most marginalised and vulnerable groups (eg homeless, CALD [culturally and linguistically diverse] communities, young people, Aboriginal and Torres Strait Islanders), and those who are particularly unwell, often need assertive and active outreach to engage. …
>
> With a framework based on individual choice and control, consumers who don't have knowledge of the NDIS, the ability to advocate for themselves or connections with support services (eg people who are homeless or socially isolated) may miss out on the benefits of the NDIS. It is critical that existing services and supports continue to be funded to ensure supports are provided to the most vulnerable groups. (sub. 50, p. 13)

Early Childhood Intervention Australia Victoria/Tasmania:

> ECIA members report lower numbers of children and families from some backgrounds accessing the NDIS system. In particular, there are fewer families from culturally and linguistically diverse (CALD) backgrounds, fewer Aboriginal and Torres Strait Islander families and fewer vulnerable children and families. Providers largely attribute this to the many hours of extra support required in pre-planning to facilitate access for these families to the scheme. (sub. 129, p. 8)

Psychiatric Disability Services of Victoria:

> … as implementation of the NDIS is rolled out across our State, we are becoming increasingly concerned that the design and functionality of the NDIS does not appropriately align with the needs and requirements of people living with a mental illness. (sub. 169, p. 2)

Butterfly Foundation:

> Concern has been expressed, by a number of key organisations in the mental health sector, consumers and carers that the NDIS may not deliver on promised benefits for Australians living with complex mental illnesses, such as eating disorders. There is a fundamental tension between the NDIS' aim to support those with permanent and incapacitating conditions, and the belief that recovery from mental illness is possible. (sub. 78, p. 3)

Prader-Willi Syndrome Association of Australia:

> Even though some people with PWS can read, and speak quite well, their other cognitive limitations means they cannot take up the level of choice and control anticipated by the NDIA. People with PWS struggle with abstract concepts like a service level agreement, and cannot plan to monitor, or comprehend under-performance by providers, never mind dismiss them. They cannot understand invoicing or budgeting on an NDIS scale, nor the criticality of completing multiple layers of administration to ensure service delivery. (sub. PP228, pp. 2–3)

Public Health Association of Australia:

> Successful navigation of, and interaction with, a complex service environment at a time of rapid change and stress, such as release from prison, is likely beyond the capacity of most individuals with cognitive disability without support. Any gaps in the support and care from the lack of integration between the criminal justice system and disability systems will likely magnify the disadvantage for this vulnerable population. (sub. 134, p. 8)

FINDING 3.2

Not all participants are benefiting from the National Disability Insurance Scheme. The groups at risk of having a less positive experience include those with psychosocial disability, complex and multiple disabilities, and language and cultural barriers, as well as people with disability transitioning into the community from the criminal justice system, the homeless and the socially isolated.

3.3 Employment outcomes

For all individuals, the benefits of working in paid employment include increased economic security and improved wellbeing. For people with disability, the benefits of employment can also include feeling valued, useful and included in everyday life (NDIA 2017u, p. 4). As Michael Boyle commented:

> Work is important to the health and wellbeing of everyone but especially to those who are ill or have a disability and suffer consequent lack of self-esteem or possess limited opportunities for socialisation. Work helps in dealing with isolation and depression which add to the problems and difficulties of those with a disability and may be reflected in demands for further NDIS assistance. (sub. 27, p. 7)

For the community, greater workforce participation of people with disability can mean savings to government budgets (reduced welfare payments and increased taxable income). Epic Employment Services said:

> Throughout EPIC's 27 year life, we have seen time and time again the importance of helping someone find a job. The economic and social benefits that accompany employment for both the individual and the community cannot be overstated. Through employment, people have a reduced reliance on income support, make greater tax contributions and become consumers of more goods and services. (sub. 70, pp. 1–2)

But there can be barriers for people with disability participating in employment. The NDIS evaluation found that workforce barriers include:

- a person's health and disability
- a lack of opportunities
- employers' opinions of people with disability
- difficulties with transport and parking
- difficulties using facilities or equipment
- lack of schooling, training or experience (Mavromaras, Moskos and Mahuteau 2016, p. 78).

People with disability have lower labour force participation rates and higher unemployment rates than those without disability. In 2015, about 53 per cent of working-age Australians

with a reported disability were in the labour force and 10 per cent were unemployed. For those with a profound or severe core activity limitation, the labour force participation rate was significantly lower at 25 per cent and the unemployment rate higher (almost 14 per cent). This compares with an unemployment rate of about 5 per cent and a labour force participation rate of about 83 per cent for people of working-age without disability (ABS 2016a).

However, with the right supports, employment barriers can be surmountable for many people with disability. The story of Ben Hunter (box 3.5) is one example of how well targeted, individualised supports can lead to rewarding work opportunities and increased social inclusion.

Box 3.5 Reaching employment goals, the story of Ben Hunter

Ben is 21 years old, has Down Syndrome and is non-verbal. He is also the front man for the baking business, Ben & Co, Bakers with Purpose.

> … with Ben's NDIS funding, and with his career front of mind, Carolyn [Ben's mum] left her job as a primary school teacher, employed support workers and started Ben & Co, Bakers with Purpose. Selling produce at regular market stalls, the family business's focus is to now provide opportunities for young people with intellectual disability — to fill the gap they identified with Ben. …
>
> Carolyn said. 'Often when young people with intellectual disability leave high school they fall through the cracks. Many struggle to find purpose and direction in their lives. Most are relegated to non-customer-service type work where they don't get as many opportunities to regularly interact with the general public. We want to help change this'.
>
> She said their aim was to provide employment and mentoring experiences through Ben & Co. to help support young people with intellectual disability to acquire and further develop their social skills, alongside their hospitality and retail skills. (The Queensland Times 2017)

While Ben & Co started as a way to increase opportunities for Ben, it has grown into an enterprise helping young people of all abilities find their social independence and participate in the local economy (NDIA 2017e, p. 18).

Caring for a person with disability also impacts on employment. In 2015, the labour force participation rate for primary carers (56 per cent) and other carers (77 per cent) was lower than that for non-carers (80 per cent). Carers were also less likely to be employed (66 per cent) compared with non-carers (76 per cent)[32] (ABS 2016a).

The NDIS is expected to increase employment by:

- providing more appropriate support that allows participants to manage their disability in the workforce

[32] Participation and employment rates for carers aged 15 to 64 years. Primary carers are the main providers of informal care to people of any age with disability. Other carers provide informal assistance (but not the main care) to people of any age with disability and to older people (aged 65 years and older) without disability.

- making it easier to obtain care through providers, thereby freeing up informal carers to enter the workforce or increase their hours worked (NDIA, sub. 161, p. 30).

Estimates of potential employment benefits under the NDIS are presented in box 3.6.

Box 3.6 Potential employment outcomes from the NDIS

Increased participation of people with disability

- The Productivity Commission (2011, pp. 960–963) estimated that if Australia were to reach the average OECD relative employment rate for people with mild to profound disabilities, employment would rise by 100 000 people by 2050. And this, in turn, would increase Australia's GDP by an estimated 0.2 percentage points, or $8 billion in 2050. (The Commission also estimated that broader Disability Support Pension reforms could increase employment by an additional 220 000 people).
- PwC (2011, p. 26) estimated that if Australia realised disability employment ratios comparable to the top eight OECD economies, the employment increase could be 50 000 higher than the Productivity Commission's estimate.
- National Disability Services worked with State and Territory Governments to model the potential employment impact of the NDIS. In New South Wales a potential employment uplift of between 7800 and 12 400 people with disability has been identified (NDIA, sub. 161, p. 30).
- The NDIA (sub. 161, p. 31) estimated that the fiscal impact would be between $2.1 billion and $4.4 billion per year if between 103 000 and 218 000 people with disabilities are able to increase their hours of work or join the workforce (noting that the upper bound is based on the impacts of broader Disability Support Pension reforms).

Increased participation of informal carers

- The Productivity Commission (2011, p. 966) estimated that there were 120 000 unemployed, co-resident primary carers of people with disabilities who would be eligible for funded supports by the NDIS. If a conservative half of these unemployed carers returned to work, Australia's GDP was estimated to increase by $750 million annually.
- PwC (2011, p. 25) estimated that about 80 000 disability carers could enter the workforce or increase their hours worked as a result of the NDIS.
- National Disability Services work (with State and Territory governments) identified that 10 700 carers (on a full-time equivalent basis) in New South Wales and 4000 carers in Western Australia could return to the workforce as a result of the NDIS (NDIA, sub. 161, p. 31).
- The NDIA (sub. 161, pp. 31–32) estimated that the fiscal impact would be between $0.9 billion and $1.7 billion per year if between 56 000 and 104 000 carers could increase their hours worked as a result of the NDIS.

The NDIS has improved employment outcomes for some

The NDIS has helped some participants and their informal carers enter or remain in the workforce (box 3.7).

Box 3.7 Some participants report improved employment outcomes

Karene Gravener:

> I have improved physically, emotionally and mentally because of the support of the NDIS. We, as a family, have been able to live life, and pursue our dreams. My husband has been able to be in full-time employment without the stress of being a carer, and we are building our own home. (brief sub. 96)

Lauren McGowan-Slee:

> My condition got worse about seven years ago, and at my worst, I couldn't get out of the house and sometimes even bed. Last week I started full time work, a feat that was once seen as impossible. It's not easy. I get fatigued and crash out most evenings and end up in bed quite early, but I don't mind because I am living a meaningful life!
>
> Because of the NDIS, I have supports that mean I can do a job that works with my disability and have the physical home tasks I can't do taken care of. I can sit and use my brain with no worries, so that is what I do for work, but I struggle to do physical tasks so I get help for that. (brief sub. 52)

Richelle Carta:

> I was struggling to sustain my lifestyle with very minimal funding but due to the NDIS I can continue to be a wife, mum, work full time and have a life with my family by having ongoing funding to provide me with morning and night personal care support seven days a week. (brief sub. 111)

Lynne Foreman:

> … I can now choose who cares for me, as I now have a choice. I have the hours I need to live my life and also because of flexibility in my plan, I am now an employee … Most of us now feel we can take part in the community, and I know some because of the NDIS have part-time jobs. We are healthy in our mind and that's a good thing in its self. (brief sub. 71)

Susanna Goodrich:

> My son Toby is sixteen. He has Down Syndrome. He's had a rough few years with an autoimmune condition … The NDIS has provided funding that has changed Toby's life. His week has opened up from a routine of school, family life and the occasional social event, to a week that looks much like his other teenage brothers: he plays sport, goes out with peers, works in a part time job and will soon be learning how to catch the bus to the local shopping and entertainment hub. (brief sub. 39)

But some concern that participation benefits will not be fully realised

Some stakeholders argued that a more concerted effort is needed to realise the expected benefits of increased economic participation under the NDIS. National Disability Services, for example, said:

> Increasing the employment participation of people with disability and carers is fundamental to the financial sustainability of the NDIS. … The Productivity Commission anticipated that the then proposed NDIS would generate profound economic benefits and that a key source of these benefits would be 'increased economic participation for people with disabilities … and their informal carers'. … To date, the proportion of NDIS plans with employment supports is disturbingly low … (sub. 51, p. 3)

In 2016-17, the NDIA reported that:

- 16 per cent and 26 per cent of NDIS participants aged 15 to 24 years and 25 years and over respectively were in paid employment

- 30 per cent of family members/carers of participants aged 25 years and over were working in a paid job (about 45 per cent for carers of participants aged 0–24 years)
  - of those that had a paid job, 76 per cent of family members/carers of participants aged 25 years and over were permanently employed (74 per cent and 73 per cent for carers of participants aged 0–14 and 15–24 years, respectively)
- 57 per cent of family members/carers of participants aged 25 years and over said they were able to work as much as they wanted (42 per cent and 47 per cent for carers of participants aged 0–14 and 15–24 years, respectively)
  - of those unable to work as much as they want, over 80 per cent cite their family member with disability as a barrier to working more and about 30 per cent cited insufficient flexibility of jobs as a barrier to working more (NDIA 2017y, pp. 26–27).

Confusion around what employment supports are provided by NDIS

Employers, employment services and the NDIS all have a role in supporting the employment of NDIS participants (box 3.8).

Submissions to this study raised concerns about a lack of awareness of what employment supports are available in the community. Legacy Australia, for example, said:

> For many people with disability, getting a job is near impossible. Another simple but very important issue is that both those responsible for providing facilities and services and those in need of assistance are often unaware of the resources that are already available in the community. For example, many employers (including Government agencies) are not aware of programs such as 'Job Access'. There is a need to put more effort into ensuring that the extensive resources that are available in the community are communicated to those who need to know. (sub. 168, p. 3)

Others said there is confusion between what employment supports are available under the NDIS as opposed to mainstream services. Deafness Forum of Australia said:

> There is likely to be disagreement or confusion between existing programs and the NDIS in relation to which program is responsible for the cost of providing support to people who qualify for assistance through several programs. For example, an NDIS participant requiring particular technology or an Auslan interpreter to support them in the workplace might reasonably expect to have those needs met in their NDIS plan. However there is also the option to access technology and Auslan interpreters through the Job Access Employment Assistance Fund. This appears to be duplication in service provision that could lead to double dipping, or more likely, lead to the person not being able to access the support they need in a timely way if the NDIS and Job Access dispute which program is responsible for funding the supports. (sub. 127, p. 15)

Box 3.8 Employers, employment services and the NDIS

Employers

Employers are responsible for:

- making reasonable adjustments to enable people with disability to access their workplace
- employment-specific aids and equipment such as computers and modified desks
- reasonable adjustments to buildings, such as installing ramps
- transportation for work activities, such as attending a meeting (NDIA 2017o).

Employment services

Employment services and programs (including both disability-targeted and open employment services) are responsible for providing advice and support to:

- people with disability to prepare for, find and maintain jobs
- employers to encourage and assist them to hire and be inclusive of people with disability in the workplace (including support, training and resources, funding assistance to help employers make reasonable adjustments, and incentives for hiring people with disability, such as wage subsidies).

Disability Employment Service (DES), and Job Services Australia (JSA) providers are the primary source of assistance to prepare for, find and maintain employment (NDIA 2017o).

The NDIS

The NDIS funds supports to assist participants with employment where these are beyond the requirements of employment services and employers. The scheme also funds supports that participants would require regardless of the activity being undertaken. The scheme does not fund the cost of education, such as course fees. These remain the responsibility of the education system and individuals. NDIS employment supports include:

- assisting participants (who are not eligible for DES or JSA assistance) to build their skills and capacity to participate in employment, as well as assistance to find and maintain employment
- personal care or assistance with transport where the participant requires these supports regardless of the activity they are undertaking
- assistive technology devices such as wheelchairs and personal communication devices
- supported employment, such as services offered by Australian Disability Enterprises (NDIA 2017o).

The NDIS also provides School Leaver Employment Support (SLES), a reasonable and necessary support for Year 12 school leavers, to assist them to transition from school and reach their employment goals. SLES was introduced because the NDIA identified a need for employment support to ‘start young to set up expectations for employment’ as a strategy to address a culture of low employment expectations (from participants, families, planners and the community) for people with disability. SLES is tailored to meet participants individual goals and includes work experience, job skills training, travel training and links to ongoing support such as DES (De Natris and Battersby 2016).

An effective interface between NDIS employment supports, and other mainstream employment services is essential for achieving good outcomes for NDIS participants. Spinal Cord Injuries Australia stressed the importance of a well-integrated system of employment supports.

> … emphasis should be put on assisting people into the workforce through targeted support and designed in a way that works flexibly with mainstream employment assistance — the two areas should not work in isolation but [be] integrated across service provision. (sub. 61, p. 4)

And there must be clear boundaries between the responsibilities of the NDIS and mainstream employment services for the NDIS to be financially sustainable.

Employment supports are one of a number of disability support areas where interface issues are emerging between the NDIS and mainstream services. Interface problems and the role of Information, Linkages and Capacity Building in providing linkages to other services (including employment services) are discussed in chapter 6.

Concern that participants are not accessing NDIS employment support

There is concern that many NDIS participants (that could benefit from the opportunity to work) do not have employment supports included in their plans. For example, Westhaven Association said:

> The evidence from the plans being produced to date shows NDIA has failed to ensure that NDIS participants are supported to gain productive employment. Without the employment outcomes expected from the scheme, NDIS may not achieve the return originally projected by the Productivity Commission. (sub. 81, p. 2)

Some stakeholders said that planners do not have a good understanding of what employment supports are appropriate for scheme participants (House with No Steps, sub. 104, pp. 5–6; Roundsquared, sub. 170, pp. 5–6) and as a result, scheme participants are not offered employment supports, or encouraged to think about how they might increase their economic participation.

A number of stakeholders suggested that planners and LACs should be more focused on employment outcomes. National Disability Services, for example, said:

> A broad spectrum of employment options should be open to people with disability, including Supported Employment Enterprises … More must be done to boost demand for, and access to, NDIS employment supports. NDIS planners and LACs should adopt a 'work first' approach which motivates and assists an increased proportion of NDIS participants to connect with work. (2017a, pp. 8–9)

Similarly, Milner & Clyde said:

> We understand that one of the fundamental premises upon which the sustainability of the NDIS has been built is that increased levels of labour force participation by people with disability, and also by carers, will result in lower support and income replacement costs and liabilities. Currently, there is little evidence that there is a focus on workability. … We therefore believe

> that the introduction of a focus in participant plans on work participation is urgently required and should be actively monitored. (sub. 94, p. 2)

Qualitative evidence from the NDIS evaluation found that while there was an increase in participation in employment related activities over time, only a few NDIS participants were undertaking volunteer work, work experience, supported employment and paid work. Further, the evaluation reported that:

> Increased economic participation amongst people with disability was considered a long term process, with time needed to develop job-readiness skills, create programs to support both participants and employers, and to change cultural beliefs about employability and opportunities for employment for people with disability. It was argued that more needed to be done to develop effective guidance, supports and linkages to employers in order to open up labour market opportunities for people with disability. (Mavromaras, Moskos and Mahuteau 2016, p. xvi)

Recent unpublished NDIA data[33] indicate that $108 million — 2.4 per cent of NDIS funding for committed supports — is committed to employment supports (chapter 2, figure 2.9). While some stakeholders consider this to be a relatively small amount for a support that is expected to generate significant benefits, what is more important (than comparing funding of employment supports with other supports under the NDIS) is to look at whether the funding for employment supports is meeting its objectives.

About 9000 NDIS participants (or 19 per cent of participants over the age of 15 years) currently have employment supports in their plans. And for some age groups it is higher:

- 32 per cent for NDIS participants aged between 19 and 24 years
- 22 per cent for those aged 25 to 34 years.

On average, participants received $12 000 committed funding for employment support (table 3.1), however, some plans have over $35 000 of committed employment support funding.

Employment support varies by type of disability and level of function. The disability groups most likely to have employment supports in their plans are those with intellectual disability (28 per cent) and autism (24 per cent). By level of function, 23 per cent of NDIS participants with a relatively high or medium level of function have employment support in their plans, compared with 9 per cent of participants with a relatively low level of function (table 3.1).

[33] Commission estimates based on unpublished NDIA data on participants with plans from July 2016.

Table 3.1 **NDIS employment support, participants 15 years and older**

Group	*Number with NDIS employment support*	*Percentage of group with employment support*	*Average support ($)*
Disability Group			
Intellectual Disability	5 044	28	12 783
Autism	1 728	24	12 785
Psychosocial disability	798	15	8 582
Cerebral Palsy	326	13	12 307
Acquired Brain Injury	268	12	10 704
Other Physical	219	7	8 913
Other Neurological	205	7	10 033
Visual Impairment	163	11	9 103
Hearing Impairment	128	9	7 953
Spinal Cord Injury	31	4	5 476
Multiple Sclerosis	31	2	3 469
Sensory/Speech	19	18	9 715
Stroke	22	2	5 545
Other	14	12	9 480
Age Group			
15–18 years	1 151	16	12 553
19–24 years	2 497	32	13 996
25–34 years	1 668	22	10 475
35–44 years	1 362	19	10 643
45–54 years	1 450	17	11 327
55–64 years	821	10	11 124
65+ years	47	4	12 847
Level of function[a]			
High	2 747	23	11 958
Medium	5 105	23	12 046
Low	1 139	9	11 521
Total	**8 996**	**19**	**11 953**

[a] This excludes 5 participants whose function is listed as not applicable.

Source: Commission estimates based on unpublished NDIA data, participants with plans from July 2016.

There are a number of reasons why increased economic participation flowing on from the NDIS may take some time.

- NDIS-funded initiatives to engage community and businesses to improve employment outcomes for people with disability are still being rollout out (Information, Linkages and Capacity Building funding was not part of the NDIS trial, chapter 6).

- The NDIS is most likely to be effective for people entering the system for the first time and will thus have a greater effect as time goes on.[34]

There is some early evidence that employment support is increasingly being included in plans, but the number of plans (with employment support being considered) that have been reviewed is relatively small.[35]

There is a need for better data and reporting (to enable better analysis) on why many participants (currently about 80 per cent of participants over the age of 15 years) are not accessing employment supports. In particular, work prospects vary by level of disability and some NDIS participants, such as those with a profound or severe core activity limitation, may never have the capacity to work. The NDIA should collect data on whether or not participants eligible for individualised supports through the NDIS have a disability that limits their capacity to work.

The ABS *Survey of Disability, Ageing and Carers* collects data on employment restrictions including whether a person with disability:

- is permanently unable to work
- restricted in the type of work they can or could do
- needs, or would need, at least one day a week off work on average
- is restricted in the number of hours they can, or could, work
- requires special equipment, a modified work environment or special arrangements
- needs ongoing assistance or supervision
- would find it difficult to change jobs or get a preferred job
- needs assistance from a disability job placement program or agency (ABS 2016a).

NDIA employment data should be collected in a format similar to this to enable the comparison of NDIS employment outcomes with ABS data on the outcomes of people with disability outside of the NDIS.

[34] In 2011, the Commission noted that those who have been in the system for a while often 'have missed opportunities for early intervention, had poor educational experiences, been dogged by low expectations by others, faced a community culture not strongly conducive to their employment and had long breaks from employment that erode skills and confidence' (PC 2011, p. 960).

[35] Commission estimates based on unpublished NDIA data (of participants with at least two plans and where the previous plan was at least 6 months old) indicate that of the participants with employment support in at least one plan, 25 per cent of participants gained employment support when the plan was reviewed, 57 per cent maintained employment support and 17 per cent no longer had employment support included in their plan.

The NDIA should also consider collecting and publishing information on other reasons why NDIS participants may not be accessing employment support. For example, a participant may:

- be permanently retired from the workforce
- already be employed and not in need of employment support
- be receiving all necessary support from mainstream employment services
- have low expectations of finding employment
- be unaware that employment supports are available under the NDIS.

RECOMMENDATION 3.1

The National Disability Insurance Agency should collect and publish data on whether or not participants eligible for individualised supports through the National Disability Insurance Scheme have employment restrictions. Data should be collected in a format similar to data collected on employment restrictions by the Australian Bureau of Statistics Survey of Disability, Ageing and Carers.

3.4 The broader benefits of the NDIS

As discussed throughout this chapter, the NDIS is expected to generate a number of broader economic and social benefits beyond the improved outcomes of people with disability and their families and carers.

In particular, the scheme is expected to replace funding from a range of other government programs. Examples include:

- the National Disability Agreement
- Home and Community Care
- residential and community aged care
- aids and appliance schemes
- transport taxi subsidy schemes
- psychiatric disability community supports (PC 2011, p. 779).

A review by the Australian Government Actuary in 2011 estimated these offsets to be worth about $11 billion in 2018-19 (AGA 2012, p. 26).

Beyond government program offsets, the NDIS is expected to have a range of additional indirect fiscal impacts. These include a reduced burden (and therefore cost savings) on the health and justice systems and reductions in the lifetime cost of disability as a result of early

investment and intervention. The NDIA's preliminary estimates (sub. 161, p. 29) suggest that the NDIS will reduce:

- costs for the health system by between $140-$300 million each year (by reducing hospitalisations for people with disability and limiting the need for people with disability to remain in hospital due to a lack of more appropriate arrangements)
- justice system costs by between $350-$850 million each year (by reducing incarceration rates of those with mental disabilities)
- supported accommodation costs by between $1.2-$1.6 billion each year (as a result of the increased ability for people with disabilities to live independently).

At this early stage of the rollout, it is difficult to measure whether these broader benefits are being realised. Chapter 13 discusses in more detail how benefits should be tracked over the longer term.

4 Scheme eligibility

Key points

- The eligibility requirements of the National Disability Insurance Scheme (NDIS), as set out in the *National Disability Insurance Scheme Act 2013* (Cwlth), are consistent with the principles of the scheme.
- However, eligibility is broader than the Commission recommended in 2011 in two key areas: the inclusion of people with substantially reduced functional capacity to undertake learning or social interaction; and children with developmental delay. These broader criteria have cost implications for the scheme. These groups were not included in the Commission's 2011 costings of the scheme.
- Data are not available to assess the cost implications of adding learning and social interaction to the eligibility criteria for disability requirements. The National Disability Insurance Agency (NDIA) should improve its data collection in this area.
- Trial site data show that a significant number of children are entering the NDIS with developmental delay.
  - Early intervention for children with developmental delay can yield benefits. This suggests that including these children is consistent with the insurance principles of the scheme. The NDIA should monitor research in this area and build its evidence base on what early intervention supports work for children.
  - The definition of developmental delay, as prescribed in the NDIS Act, sets a high standard for children to be eligible for individualised supports. However, during the scheme's trial, a high proportion of children in the scheme were found to not have a significant functional deficit relative to their peers. This partly reflected the transition arrangements for clients transitioning from state and territory schemes.
  - The recently introduced Early Childhood Early Intervention (ECEI) pathway is a tighter gateway in principle, and should result in better enforcement of the eligibility criteria for children aged 0-6 years (in all areas, including developmental delay). However, it is too early to assess the effectiveness of the ECEI approach in practice.
- While there is value in maintaining diagnostic lists that streamline access to the NDIS, the NDIA should make public the process for changing the conditions in these lists, including under what circumstances a change may be considered.
- There is broad support for people with psychosocial disability being included in the NDIS. That said, many concerns were raised about how some aspects of psychosocial disability align with the design and operation of the scheme.
  - The boundaries of the scheme are important, and should not be changed. However, a specialised psychosocial gateway should be introduced to improve how the scheme engages with people with psychosocial disability on an operational level.

For the National Disability Insurance Scheme (NDIS) to deliver cost effective outcomes and remain financially sustainable, it is important that the eligibility criteria are aligned with the objectives of the scheme. The legislated eligibility criteria, as they currently stand, target those people with disability who the Commission intended the scheme to cover. However, the criteria are somewhat broader than that proposed by the Commission in 2011 (PC 2011, pp. 174–175), and this has cost implications for the scheme.

There are a number of factors that affect scheme participant numbers, including the:

- size and age profile of the Australian population
- prevalence, incidence, nature and severity of disability within the population
- eligibility criteria
- effectiveness of entry pathways in upholding the eligibility criteria
- effectiveness of exit pathways when people no longer meet the eligibility criteria for individualised supports.

This chapter looks at the factors from this list that are relevant to the design of the NDIS — the eligibility criteria (section 4.1) and entry and exit pathways (section 4.2). One of the key eligibility issues raised in this study was the inclusion of psychosocial disability in the NDIS. This issue is discussed in section 4.3.

4.1 The eligibility criteria

The NDIS is for all Australians. It provides insurance against the costs of support in the event that a person acquires or is born with a significant disability. And anyone with, or affected by, disability can approach the NDIS for information, linkages and capacity building. Individualised supports under the NDIS, however, are targeted at people with permanent and significant disability or those who meet early intervention requirements. In this context, 'eligibility criteria' refers to access to these individualised supports.

The eligibility criteria are critical in an uncapped scheme

The NDIS is a new way of providing disability supports. When services were block-funded, governments had tight control of how much money was provided for disability services. However, individualised supports provided under the NDIS are uncapped — so long as an individual meets the eligibility criteria, and the supports provided are 'reasonable and necessary supports' (chapter 5), an individual will receive the support that they need and for as long as they need (often for their whole lifetime). This means that from a budgetary perspective, the NDIS is less certain than previous models of disability support.

The eligibility criteria are the main instrument available for determining how many people will receive individualised support through the NDIS. It is important that these criteria are clear, aligned with the objectives of the scheme, and rigorously upheld.

Eligibility differences when compared to PC 2011 recommendations

When the Commission designed the NDIS in 2011, it recommended that the eligibility criteria for individualised supports uphold the following principles:

- individuals should have a disability that is, or is likely to be, permanent reflecting the irreversible nature of disabilities; and
- individuals would meet one of the following conditions:
  - have significantly reduced functioning in self-care, communication, mobility or self-management, and require significant ongoing support (the recommendation to restrict access to people with significant, ongoing support needs — rather than anyone with disability — reflects the objective that the NDIS embody a risk-pooled insurance scheme, which focuses on minimising the impact of high cost, low frequency events)
  - qualify for an early intervention group (covering people for whom there is good evidence that early intervention would be safe, cost-effective and significantly improve outcomes — box 4.1) (PC 2011, pp. 13–14).

The Commission also recommended that participants meet residence and age requirements.[36]

Box 4.1 Why early intervention is important

An important recommendation in the Commission's 2011 *Disability Care and Support* inquiry was that individualised supports be available to 'an early intervention group, comprising of individuals for whom there is good evidence that the intervention is safe, significantly improves outcomes and is cost effective' (PC 2011, p. 63).

A key tenet of the NDIS is that it takes a lifetime approach to providing care and support. Early intervention is one way to embody this. Early intervention seeks to incur expenditure during the early stages of a person's disability in order to improve (or maintain) their functioning later on, or reduce the volume of supports that they need later in life.

Providing early intervention support through the NDIS can mean:

- a better quality of life for scheme participants by addressing many of their needs early, and building or maintaining their functional capacity
- a delay in the need for care (or a lower cost of providing care) in later stages of a participant's life, which contributes to a more financially sustainable scheme.

[36] In 2011, the Productivity Commission proposed that the NDIS would not cover people acquiring a disability over the age pension age (PC 2011, p. 14). At that time, the age pension age was 65 years.

The eligibility criteria for the NDIS (as set out in ss. 21–25 of the *National Disability Insurance Scheme Act 2013* (Cwlth)) are broadly in line with what the Commission recommended in 2011 (table 4.1). However, there are two key differences:

- a person can receive individualised supports under the disability requirements if they have substantially reduced functional capacity to undertake the activities of *learning or social interaction* — the activities proposed by the Commission were restricted to mobility, self-care, self-management and communication (PC 2011, p. 198)
- a child can receive individualised supports under the early intervention requirements if they have developmental delay.

Table 4.1 **A summary of the NDIS eligibility requirements**[a]

Age requirements	Residence requirements
Aged under 65	• Australian citizen • Permanent resident • Hold a protected special category visa
And meet either:	
Disability requirements	**Early intervention requirements**
Disability attributable to one or more: • intellectual • cognitive • neurological • sensory • physical impairments; or • an impairment attributable to a psychiatric condition; and	• Has one or more identified intellectual, cognitive, neurological, sensory or physical impairments that are, or likely to be, **permanent**; or • Has one or more identified psychiatric conditions that are, or likely to be, **permanent**; or • Is a child who has developmental delay; and
The impairments are, or are likely to be, **permanent**; and	The early intervention support is likely to benefit the person by **reducing the person's future needs** for supports in relation to disability; and
Impairments substantially reduce **functional capacity** or **psychosocial functioning** to undertake one or more of the following activities: • communication • social interaction • learning • mobility • self-care • self-management.	The early intervention support is likely to benefit the person by: • **mitigating or alleviating** the impact of the person's impairment on their functional capacity • **preventing the deterioration** of such functional capacity • **improving** functional capacity • strengthening the **sustainability of informal supports** available to the person, including through building the capacity of the person's carer.

[a] This figure represents an overview of what the Commission considers to be the main aspects of the eligibility criteria. The NDIS Act prescribes that more requirements are met than those outlined here.

Source: NDIS Act, ss. 21–25.

Both these differences allow more people to qualify for individualised supports under the NDIS than the Commission included when costing the scheme. The extent to which the less restrictive eligibility criteria are contributing to scheme participation, and consequently, scheme costs, is a key question for this study.

Based on the eligibility criteria proposed in its 2011 report, the Commission estimated that approximately 410 000 people would be eligible for individualised supports under the NDIS (PC 2011, p. 160). Using the Commission's estimates as a basis, the NDIA has increased the estimated number of scheme participants to 460 000 (or 475 000 including those aged over 65 years, as discussed in chapter 2). This change in expected numbers was mostly attributable to population increases and participants aged over 65 years.

Adding learning and social interaction to the disability requirements — what is the effect?

Data are not available to make an assessment about the impact on scheme costs of adding learning and social interaction to the eligibility criteria for the disability requirements. However, Speech Pathology Australia said advice from their members who are NDIS providers is that:

> … they have not been providing services to children whose only disability relates to learning and literacy — thus, it is our conclusion that the increased numbers of people entering the Scheme is not due to the eligibility of people whose *only* functional disability relates to learning and/or social interaction. (sub. 136, p. 15)

It seems reasonable to assume that relationships across domains exist. However, the NDIA does not collect data specifically on which, or how many, of the six activity domains specified in the Act that scheme participants enter through. This means that assessing the extent to which one particular domain is driving entry into the scheme, or how common it is for scheme participants to have reduced functional capacity across multiple domains, is not possible.

Collecting data at entry on which domains apply to each participant would not only inform what parts of the eligibility criteria are having a large impact on participant numbers (and therefore scheme costs), but also allow for more granular analysis of who is in the scheme and what their needs are likely to be. Such information may also be useful to the NDIA in its monitoring and forecasting roles.

RECOMMENDATION 4.1

When determining that an individual is eligible for individualised supports through the National Disability Insurance Scheme under the disability requirements, the National Disability Insurance Agency should collect data on which of the activity domains outlined in section 24 of the *National Disability Insurance Scheme Act 2013* (Cwlth) are relevant for individuals when they enter the scheme.

There was broad support for the collection of these data, including from Legal Aid NSW (sub. PP245, p. 4), Flourish Australia (sub. PP246, p. 2), Multiple Sclerosis Australia (sub. PP283, p. 5), Bruce Bonyhady (sub. PP333, p. 9) and the Queensland Government (sub. PP345, p. 5).

The NDIA — in response to the Commission's position paper — agreed that collecting data at entry about which domains apply to each participant would provide useful information on the drivers of scheme costs (sub. PP327, p. 16). The NDIA also said that collecting specific data on the activity domains will require data definitions and response formats to be developed, and suggested that the information begin to be published from the commencement of the full scheme (1 July 2019) (sub. PP327, p .17). This timeframe is reasonable.

Including developmental delay in the early intervention requirements — what is the effect?

A child has developmental delay if it takes longer for them to reach age-specific milestones than other children. The term developmental delay is used in the absence of a diagnosed condition — that is, there is usually a more specific condition causing the developmental delay, including disability, but this condition is not yet able to be formally identified. This can be because it is difficult to reach an accurate diagnosis given the age and capabilities of the child.

The 'developmental trajectory' of children with developmental delay varies. In some cases, children may 'catch up' to their peers either with or without support. Others may need more substantial support for a longer period, which is often the case if the underlying condition causing the developmental delay is a significant disability.

The effect of including developmental delay as a condition eligible for individualised support was explored in detail by Dyson, Cutter and Moore (2015). The review, which was commissioned by the Department of Social Services (DSS), found that:

- about 11 600 children with developmental delay or global developmental delay would be eligible for support under the scheme (p. 15) (box 4.2), with an estimated annual cost of $155 million
- the vast majority of children in the scheme with developmental delay or global developmental delay could be expected to progress to full scheme participation — in part because of the high access requirements for developmental delay, and in part because developmental delay and global developmental delay is 'often predictive of the future diagnosis of intellectual disability' (p. 87)
- ' … the costs associated with including children correctly identified as having [developmental delay or global developmental delay] is of immaterial consequence to the sustainability of the NDIS' (p. 9)

- given the likelihood that a child with developmental delay would progress to the full scheme, early intervention could reduce costs to the scheme in the longer term by reducing future need (p. 17).

Box 4.2 Developmental delay and global developmental delay – what is the difference?

Definitions for developmental delay and global developmental delay vary. The Commission looked at many definitions to draw out the key features that define the conditions.

A child has *developmental delay* when they take longer than other children to meet age specific milestones in a specific area (or domain). Because children develop at different rates, and some will inevitably reach a milestone before others, most definitions require that a child be substantially or significantly behind their peers before they are identified as having developmental delay.

In contrast, a child is considered to have *global developmental delay* if they take longer to meet specific milestones across multiple domains. Some definitions require only more than one domain to be affected, while others require all domains to be affected. The definition of global developmental delay published by COAG in 2012, required a delay across a majority (out of five) domains.

Different definitions also outline different domains to be considered. However, they often include:

- motor skills (both gross and fine)
- speech and language skills
- social and/or emotional skills
- cognitive ability.

The definition of developmental delay for the purposes of the NDIS is set out in section 9 of the Act, and is spelled out in full in box 4.4.

Sources: COAG (2012a, p. 4); Disability Services Commission (2011, p. 12); QDCCSDS (2014, pp. 4–5).

Including developmental delay is consistent with the objectives of the scheme

The evidence base on the effectiveness of early intervention in improving the trajectories for children with developmental delay, or reducing the future costs of their care, is still being developed. Nevertheless, there is general acceptance that for children with developmental delay, access to early intervention leads to improved outcomes (box 4.3).

Such evidence suggests that there is a firm rationale for children with developmental delay to be eligible for individualised supports under the early intervention requirements of the NDIS. In 2011, the Commission recommended that the NDIA build an evidence base on early intervention, in part to inform what forms of intervention are beneficial and therefore warrant potential funding through the scheme (PC 2011, p. 632). As discussed later in the chapter, the NDIA is working on developing the evidence base on early interventions for children.

The evidence on early intervention for children with developmental delay should be a particular focus, given the developing evidence base, and given the higher than expected number of children entering (and the lower than expected number of children leaving) the scheme.

Box 4.3 Evidence supports early intervention for developmental delay

Evidence points to children with developmental delay benefiting from early intervention supports. For example, when summarising the evidence, KPMG said:

> For children already exhibiting developmental delay, effective early intervention strategies can both alter the course of their developmental trajectories and prevent the onset of secondary complications … The earlier a child is identified as having a developmental delay or disability, the more likely they are to benefit from strategies targeted towards their needs. The success of early intervention strategies not only assists families through the provision of extra support for their child, but also decreases costs to schools and communities in the later years as children transition to school. (2014, p. 3)

Dr Michael Guralnick — now the Director of the Center on Human Development and Disability in the University of Washington — presented a similar conclusion:

> Early intervention for children at risk and for those with established intellectual disabilities is now firmly embedded in the context of general early childhood development. An overarching developmental framework has been advanced and has achieved a high level of consensus; one that is relevant to typically developing young children and to those vulnerable to a range of developmental problems, particularly intellectual disability. (2005, p. 318)

Guralnick also noted the:

> … long-established intervention science indicating that comprehensive early intervention programmes can, at a minimum, help prevent the substantial decline in intellectual development that generally occurs across the early childhood period for children with developmental delays. (2017, p. 211)

Early intervention for children with developmental disability was also described to be 'of clear benefit' by the Royal Australasian College of Physicians (2013, p. 2), while the World Health Organisation notes that early intervention for children with disability can enhance developmental competencies, minimise secondary complications and build the effectiveness of support networks (WHO 2012, p. 27).

The Victorian Government submitted that:

> Access to high quality early childhood intervention services has been demonstrated to improve outcomes for children with disabilities and their families. For families, the earlier the interventions begin, the easier it will be for them to adapt to the challenges they face when their children are identified with a disability or developmental delay. (sub. 174, p. 9)

Numbers in the scheme to date

Trial site data (to June 2016) show that just under 4000 individuals (or roughly one-third of the 11 600 estimate by Dyson, Cutter and Moore (2015)) entered the scheme with a primary health condition recorded as being either developmental delay or global developmental delay (NDIA 2016p, p. 58, table 2.1.11(c)). If the prevalence rate experienced in trial sites was observed nationally, there would be more children with developmental delay in the scheme than Dyson, Cutter and Moore's estimate.

However, trial site prevalence rates may not be reflective of prevalence rates expected on a national level. Further, the NDIA has recently redesigned the entry pathway for children aged 0–6 years with the introduction of the Early Childhood Early Intervention (ECEI) approach (discussed below). This changes how the eligibility of children is assessed, and is designed to better ensure that the eligibility requirements for individualised supports are upheld.

Two possible explanations for higher numbers of children

There are two possible reasons why there may be more children with developmental delay in the scheme to date than expected:

- more children meet the eligibility criteria than expected or
- assessment processes allow children who do not meet the eligibility criteria to enter the scheme.

This section looks at the eligibility criteria for developmental delay. The extent to which assessment processes could be contributing to higher than expected numbers is discussed in the next section.

The definition of developmental delay for the purposes of the NDIS is outlined in box 4.4. A child with developmental delay must meet this definition to be eligible for individualised supports under the early intervention requirements (as well as meeting residency requirements).

Box 4.4 How does the NDIS define developmental delay?

The definition of developmental delay is set out in section 9 of the NDIS Act. It states that developmental delay means a delay in the development of a child under 6 years of age that:

(a) is attributable to a mental or physical impairment or a combination of mental or physical impairments; and

(b) results in substantial reduction in functional capacity in one or more of the following areas of major life activity:

  (i) self-care

  (ii) receptive and expressive language

  (iii) cognitive development

  (iv) motor development; and

(c) results in the need for a combination and sequence of special interdisciplinary or generic care, treatment or other services that are of extended duration and are individually planned and coordinated.

Source: NDIS Act.

Some study participants raised concerns about the adequacy of the developmental delay definition in the NDIS Act. However, most of the evidence presented to the Commission on developmental delay suggests that the current definition requires a significant threshold to be met. For example, Dyson, Cutter and Moore (2015, p. 11) found that the definition of developmental delay prescribed in the Act sets 'a high access hurdle', particularly the requirements for there to be a substantial reduction in functional capacity, and the exclusion of children who only require uni-disciplinary intervention.

The ACT Government also said that a delay across one domain was in itself generally insufficient to qualify for individualised supports through the NDIS:

> … the NDIA has recently changed the operational guidelines relating to eligibility to the scheme for developmental delay. Specifically, the 'need for a combination and sequence of special interdisciplinary or generic care, treatment or other services that are of extended duration and are individually planned and coordinated' is being interpreted to mean children with only one area of delayed development are not eligible. As a result, the NDIA access team deems children with one area of delay not eligible for the scheme because they do not require interdisciplinary care and these children are no longer receiving (or renewing) packages or early intervention supports. (sub. 156, p. 9)

In making this point, the ACT Government expressed concern that this pushes the cost of providing support to people with a delay in only one area back onto State and Territory Governments. The fact that the NDIS sets a high access hurdle — which the Commission considers to be important — means that some children will require support outside the scheme. Consequently, all governments need to work together to ensure that there are supports outside the NDIS for children who do not meet the eligibility requirements.

Because the criteria that children must meet to qualify for individualised supports under the scheme is high, this suggests that it is the process by which children are entering the scheme (not the eligibility criteria) that is resulting in higher than expected numbers. This is consistent with evidence provided by the NDIA that a significant proportion of children who entered the scheme during the trial stage appeared to have little or no reduction in their functional capacity compared to their peers (discussed in the next section).

The number and cost of children with developmental delay in the scheme should continue to be monitored by the NDIA. Should changes to assessment processes be made, but children who do not meet the definition of developmental delay (as outlined in the Act) continue to enter the scheme, there is a strong case for changing the definition of developmental delay in the Act so that it is clearer under what circumstances a child would qualify for individualised supports.

4.2 Are entry and exit pathways effective?

Effective entry pathways are imperative to the successful functioning of the NDIS. They uphold the eligibility criteria of the scheme and only allow people who meet these criteria to qualify for NDIS supports. Excessively porous pathways may allow people who do not meet eligibility requirements to access the NDIS, placing cost pressures on the scheme.

There are two main pathways for people to enter the NDIS:

- the Early Childhood Early Intervention (ECEI) pathway for all children aged 0–6, including those with developmental delay (NDIA 2016g)
- a general pathway for people aged 7–65 years (NDIA 2016m).

Entry into the NDIS can be self-initiated, or facilitated by the NDIA (this includes the NDIA contacting people receiving disability services that are being phased into the NDIS when the scheme becomes available in their area).

The NDIA also has a list of defined programs (run by governments prior to the introduction of the NDIS). People receiving supports through these programs do not need to show that they meet the disability requirements, as the requirements for the programs and the NDIS are considered 'equivalent' (NDIA 2016m).

The NDIA said that these defined programs could be a contributing factor to the higher than expected number of children entering the scheme:

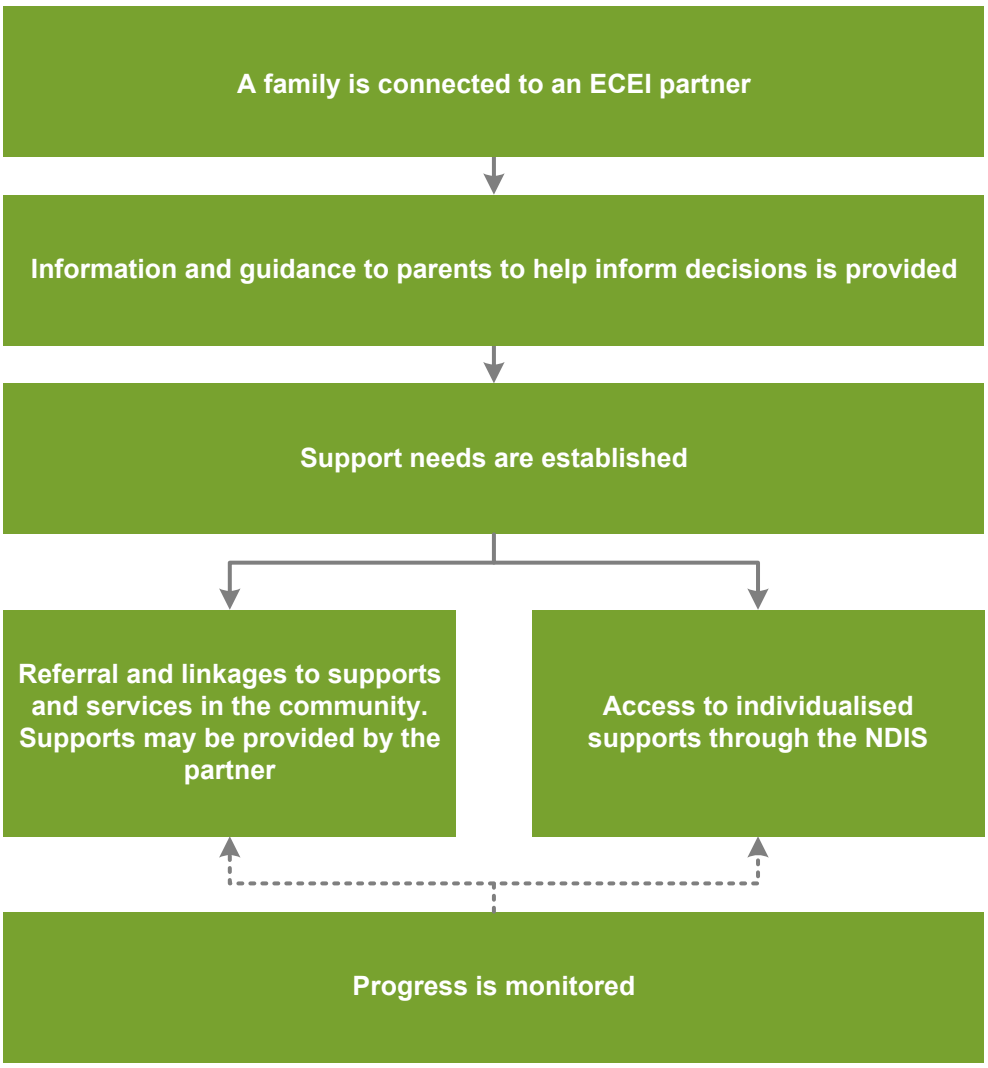
> The NDIA has observed that the change to the access criteria around developmental delay in conjunction with the diagnostic entry criteria for Commonwealth, State and Territory programs to support children with autism has led to increased numbers. (sub. 161, p. 75)

However, as an entry pathway, these lists are relevant during the transition phase of the NDIS, but will become largely redundant at full scheme.

The Early Childhood Early Intervention pathway

In response to the higher than expected number of children entering the scheme in the trials, the NDIA introduced the ECEI pathway for children to enter into the scheme (NDIA 2016b, p. 16). Prior to the ECEI pathway — which commenced in 2016 and is being rolled out in line with the full scheme — children entered the scheme via the general pathway — through the lodgment of an access request and subsequently an assessment of eligibility and need. Figure 4.1 summarises how the ECEI pathway works.

Figure 4.1 **The ECEI process**



Source: Adapted from NDIA (2017f).

Under the ECEI approach, a family with a child with disability or developmental delay seeking support is connected to an ECEI 'partner' in their local community. To be a partner, an organisation must be approved by the NDIA and have experience in early childhood intervention.

Partners assess the support needs of a child with disability and their family and, based on the assessment, determine the supports and services the child needs. Early childhood partners can provide:

- information and linkages to mainstream supports and services
- 'timely short to medium early childhood early intervention supports' — examples of these supports include: information, family based education, parenting support services and therapy (DSS 2016b, p. 11)
- access to a NDIS plan. If it is considered that a child is best supported by a NDIS plan, it remains a NDIA delegate who determines whether a child is eligible and approves a plan, although the ECEI partner is responsible for providing information that will inform a decision on access and assisting with plan development (DSS 2016b, pp. 11–18).

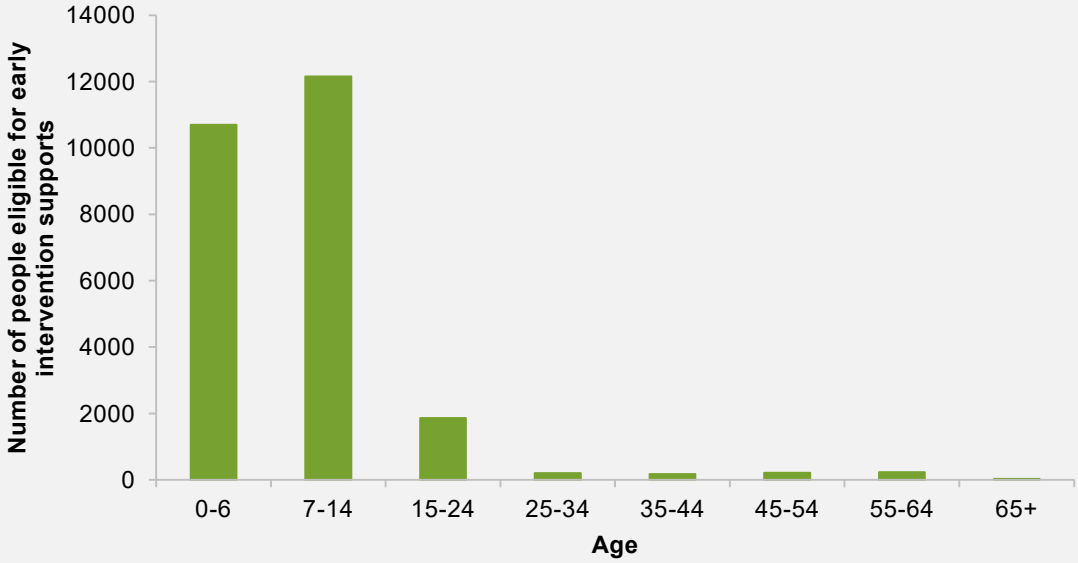
On paper, the ECEI approach does not appear to be very different to how people enter the NDIS under the 'general' pathway. However, the specialised nature of ECEI partners, and the fact that they can provide short- and medium-term support, and refer children to mainstream services, means that the ECEI approach places significant emphasis on upholding eligibility while supporting less severe cases outside of the scheme. The ECEI approach seeks to reduce the number of children with milder levels of disability from entering the scheme, thereby reducing cost pressures.

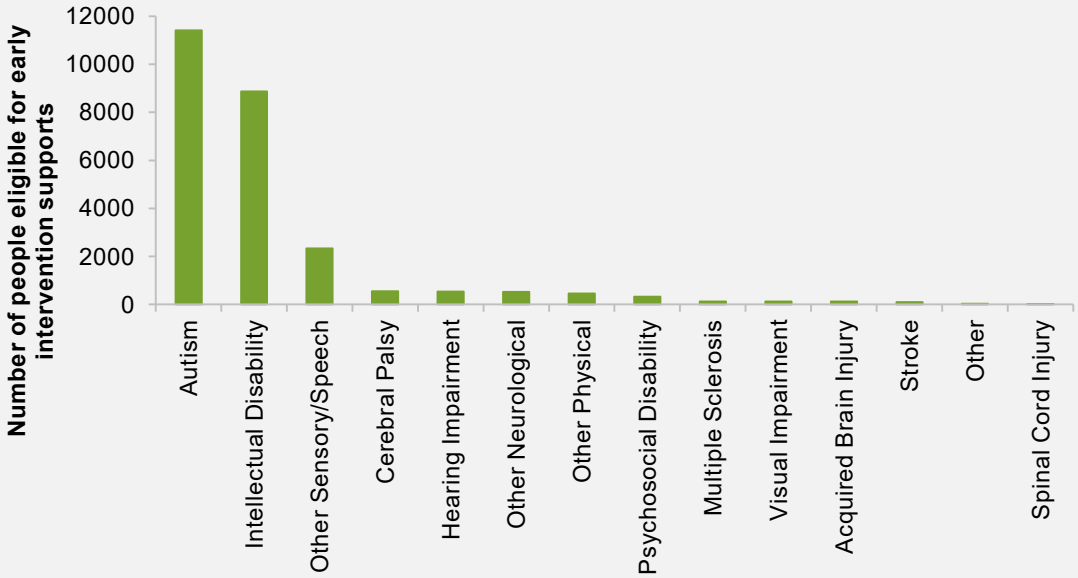
NDIA data on 'who' qualifies for early intervention through the legislated early intervention criteria show that almost 90 per cent are children, and are participants with autism or intellectual disability (box 4.5).

Box 4.5 Who is eligible for NDIS early intervention?

NDIA data provide insights on the main groups who qualify for early intervention in the scheme. Most (about 90 per cent) of those who entered the scheme under the early intervention criteria outlined in the NDIS legislation are children (aged under 15 years of age) and most have either autism or intellectual disability (based on access decisions between 1 July 2013 and 30 June 2017).

People who entered the NDIS by the early intervention criteria, by age and disability





For plans effective from July 2016, the average annual committed support for people who entered under the early intervention requirements was just over $18 100. For people receiving early intervention supports for autism and intellectual disability, the average annualised committed packages were about $17 700 and $17 100 respectively.

Source: NDIA, unpublished data.

What study participants had to say about the ECEI approach

In general, study participants were positive about the likely effectiveness of the ECEI approach (box 4.6). The New South Wales Government, for example, said 'the ECEI process represents best practice for children under 7 years' (sub. 60, p. 17).

Box 4.6 General support for the ECEI approach, but some concerns

Lifestart Co-operative Limited:

> Over time, if implemented correctly with experienced and well credentialed Early Childhood Partners, outcomes for children, their families and the scheme will be positive. [The ECEI approach] should ensure that children get the right support, in a timely manner and in the right amount. It should see the number of children requiring individualised plans decrease. This trend has emerged with the introduction of ECEI Partners in the Nepean Blue Mountains where Lifestart has provided children with supports and assistance where these children and families were able to be well supported without a plan. (sub. 97, p. 4)

National Disability Services:

> NDS … supports the concept of the ECEI approach. The broad gateway of ECEI enables some children with lesser needs to receive short-term assistance … It also allows time to see how a child responds to short-term early intervention before making a decision on eligibility, while still giving immediate access to an NDIS package to those with obvious significant and long-term disability. (sub. 51, p. 4)

The Department of Social Services:

> The early indications are that the inclusion of developmental delay in the NDIS and the Early Childhood Early Intervention (ECEI) gateway approach is effective in supporting children. It is expected a number of these children will meet their development goals and will not require long-term NDIS supports. (sub. 146, p. 3)

Allied Health Professions Australia:

> AHPA and its members support the role of early intervention but note that the early childhood early intervention (ECEI) approach may risk excluding children with a need for support, increasing the burden on other systems and schemes. If the scheme doesn't meet the child's needs there is the risk that this may result in higher levels of support in the future negating the purpose of early intervention programs. (sub. 37, p. 10)

However, some study participants expressed concerns about how the ECEI approach is working for particular disability types, including children with hearing impairments (Deafness Forum of Australia, sub. 127, p. 13, The Shepherd Centre, sub. 107, p. 4). For example, the Royal Institute for Deaf and Blind Children said:

> Models such as the ECEI have resulted in a cost shift from the Agency to providers, with little specificity around specific abilities. The ECEI process has imposed significant and redundant elements for children with hearing impairment, and if strictly implemented would actually delay access to services. (sub. 95, p. 7)

While children with hearing and other sensory disabilities are likely to make up a small proportion of the children who access the ECEI approach, this underscores the need for the ECEI approach to be versatile enough to accommodate all disability types, particularly as it is intended to represent the primary entry pathway into the scheme for children aged 0–6.

Before the ECEI approach was introduced, the number of children receiving individualised supports through the NDIS without having a substantial functional deficit relative to their peers was significant. The NDIA pointed to their analysis of PEDI-CAT scores for a sample of children who entered the scheme during trial which found that:

> … the aggregated scores indicated that, overall, around 40% of participants had scores of 30 or more ('average') across each of the four domains. That is, these participants did not seem to have any identified deficits, compared to the normal range for their age. (sub. 161, p. 78)

To provide additional context around this statement, in its submission in response to the position paper, the NDIA noted that children who entered the scheme through the trial were assessed on the basis of a medical diagnosis. The 40 per cent figure was found by back testing a sample of children who entered during trial with the PEDI-CAT assessment tool (sub. PP327, pp. 19-20).

A small number of study participants questioned the appropriateness of the PEDI-CAT tool and how it was applied to certain types of disability (chapter 5). The Commission is not in a position to comment on the validity or accuracy of the PEDI-CAT tool. However, it is a common tool used by the NDIA to assess the severity of disability in children (a factor in determining eligibility for the scheme), and to have such a significant proportion of children in the scheme with mild or no identifiable deficits relative to their peers points to the importance of having a tight and rigorous entry gateway.

Children with mild or no deficits in the NDIS clearly runs counter to the objectives of the scheme, and depending on the volume of supports that these children receive, could have significant cost and equity implications. As such, a tighter gateway that better assesses eligibility is necessary.

The ECEI approach can be this tighter gateway. Using specialised organisations with experience in identifying and treating developmental delay and childhood disability should result in more accurate assessments of whether children meet the criteria for individualised supports under the NDIS. The emphasis on providing timely short- and medium-term supports as well as support through mainstream services to children with needs, but not severe enough to warrant entry into the NDIS, is also positive.

A version of the ECEI approach (for children and young people under 18 years) was part of the early NDIS transition in the Nepean Blue Mountains. According to the New South Wales Government, 'anecdotal evidence from this process suggests the effectiveness of the model in diverting children from specialist disability supports funded by the NDIS to mainstream and community based support options' (sub. 60, p. 18).

However, it is too early to tell if the ECEI approach has been successful in upholding the eligibility criteria of the NDIS, and contributing to beneficial outcomes for children who are ineligible for individualised support. And as the DSS observed, the 'gateway's actual success will be dependent on services outside the NDIS being available, and the management of family expectation about how children's needs are better met' (sub. 146, p. 13).

The NDIA has developed an evaluation and monitoring framework for the ECEI approach. In time, this framework should assist with monitoring children's pathways (including entry and exit from the NDIS via the gateway) and evaluating the effectiveness of the ECEI approach.

The Brotherhood of St Laurence commented on the importance of ECEI being evidenced-based:

> As the initial roll-out of the NDIS nears completion, children with developmental delays will be the largest group of people with disability entering the NDIS. Understanding what works for children who gain access to the NDIS is vital to manage costs. To ensure the NDIS provides value for money and can reduce the life-long impact of developmental delays on children, ECEI needs to be underpinned by a strong evidence-based practice, policy and research agenda. Most importantly, ECEI staff need access to the latest research and evidence to inform service design and practice. This is especially important given the emerging findings that some interventions and/or programs can be harmful and/or have limited evidence regarding their efficacy. (sub. 189, p. 12)

Mental Health of Young People with Development Disabilities also pointed to the potential harm that can result from interventions that are not evidence-based:

> Non-evidence based intervention, even if delivered by well-meaning therapists and service providers, have significant potential to do more harm than good, advance behavioural and emotional problems and limit a child's ability to develop. … It is imperative the NDIA has a mechanism to ensure that all stakeholders of the NDIS — participants and their families and carers, professional staff developing plans with participants, and practitioners and organisations delivering services — receive clear and empowering information regarding the high value of evidence-based interventions, supports and programs. (sub. PP269, p. 3)

The NDIA is also developing an early intervention approach for the 7–14 years cohort (sub. 161, p. 26).

Concerns about the ECEI approach KPIs

One of the 'Performance Indicator Targets' that applies to ECEI partners is that '<50% of children who connect with the Partner are referred for access to the NDIS' (DSS 2016a, p. C-6). Amaze (sub. PP281, p. 10) submitted that this target is inappropriate in an entitlement-based scheme and could be affecting the practices of ECEI partners.

The Commission is also concerned. One of the key features of the NDIS, compared with previous models of disability support, is that it is not rationed — anybody who meets the eligibility criteria can and should receive support. Whether a child meets the eligibility criteria should be the driver of access.

As such, the Commission considers that a target that seeks to ensure that less than 50 per cent of children who approach ECEI partners are referred for NDIS access is not appropriate. It is an unacceptable outcome if ECEI partners were to not recommend NDIS access for an

eligible child because they were required to meet a target. And there could be instances when more than half of the children who approach an ECEI partner will meet the eligibility criteria to qualify for access to the NDIS.

The target should be removed.

RECOMMENDATION 4.2

The National Disability Insurance Agency should remove the Performance Indicator Target placed on Early Childhood Early Intervention partners that seeks to ensure that less than 50 per cent of children who connect with the partner are referred for access to the National Disability Insurance Scheme.

The 'general' pathway

For people aged 7–65 years, entry to the NDIS begins with the lodgment of an access request. This can be lodged through a form, but is increasingly being completed by telephone. In lodging an access request, a potential scheme participant provides information on their age and residency status (the first two components of the eligibility criteria), as well as information about their disability.

To demonstrate their disability, an applicant is typically required to provide evidence of the condition from their treating doctor or specialist. The NDIA may also require evidence from an applicant's health professional on the impact of the disability on the applicant's ability to undertake tasks related to mobility, communication, social interaction, learning, self-care and self-management. For some conditions (contained in a list maintained by the NDIA), the impact of the disability on a person's functional capacity is assumed and further evidence is not required (NDIA nda).

The NDIA has 21 days to either decide whether the prospective participant meets the eligibility criteria, or to request additional information (NDIS Act s. 20). The additional information may require the potential participant being assessed or examined, and the NDIA has the authority to nominate where this occurs (s. 26(1)).

The Commission was presented with little evidence to suggest that the entry pathway for people under disability requirements is having an undue influence on scheme costs.

The role of diagnostic lists

The NDIA maintains lists — List A and List D — that allow streamlined access to the NDIS for people with certain conditions. Broadly speaking, these lists mean that, if someone has a condition on the list, they automatically meet certain parts of the eligibility criteria (box 4.7).

Box 4.7 **List A and List D**

List A

If an individual has a condition outlined in List A, the National Disability Insurance Agency (NDIA) 'will be satisfied that the person meets the disability requirements without further assessment', meaning in effect, the permanence of an individual's condition, and its impact on their functional capacity, is assumed (residence and age requirements still must be met). List A contains about 30 conditions. For some listed conditions, a specified level of severity must be met in order for the streamlined entry arrangements to apply.

List D

Under the NDIS Act, when assessing whether a potential participant is eligible for individualised supports under the early intervention requirements, the NDIA must be satisfied that the supports will benefit the person by reducing future need (s. 25(1)(b)) and benefit the person in one of the ways prescribed in s. 25(1)(c) (table 4.1).

However, if a child (aged under seven years) has a condition that is on List D, the NDIA 'is satisfied that the child meets the early intervention requirements without further assessment'. List D contains about 130 conditions, including global developmental delay.

Developmental delay (as defined in the Act) is not contained in the list, however it is given streamlined entry arrangements under the *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* (Cwlth) (r. 6.10) that states that the CEO is taken to be satisfied that a child satisfies s. 25(1)(b) and s. 25(1)(c) if 'one or more of the child's impairments is a mental or physical impairment which, by itself or in combination with other mental or physical impairments, results in developmental delay' (p. 14).

Sources: NDIA (2016m, nda).

These lists represent a tradeoff. The appeal of the lists is that they:

- place less of an onus on a potential participant to demonstrate eligibility
- provide a degree of certainty for people with these conditions and their families that they will be supported through the NDIS
- reduce the administrative burden on the NDIA.

However, the lists can affect incentives. They can also be an overly generous entry pathway if set too expansively.

In the case of List D, which applies only to early intervention entry for children under 7 years, the presence of a diagnostic list can run counter to the insurance principles if it leads to the entry of children who are unlikely to benefit from individualised support. The list could also conceivably inhibit exits from the scheme — if diagnosis, rather than expected benefits form the basis of early intervention, a child may remain eligible so long as their condition is present, even if the participant has received early intervention and the expected benefits have been realised (or are unlikely to be realised).

While many post position paper submissions commenting on the lists acknowledged the tradeoff of maintaining these lists, the vast majority considered the benefits to outweigh potential risks.[37] The NDIA also supported maintaining the lists, noting that with List D:

> The NDIA is of the opinion that List D does not result in supports being provided to children who are unlikely to benefit from them. (sub. PP327, p. 18)

In arguing for maintaining List A, the NDIA said there was 'little evidence to suggest that entry pathways for people under the disability requirements is putting pressure on scheme costs' (sub. PP327, p. 19). However, the Agency did identify that:

> Autism Spectrum Disorders may represent a difficulty for List A, and there is evidence to suggest that use of the diagnosis process for autism may differ from the process's intent (resulting in access to the Scheme where eligibility requirements would not otherwise be met). (sub. PP327, p. 19)

Given the broad support for the lists, and little evidence that the lists are leading to people entering the scheme who would not meet the wider eligibility criteria, there seems to be value in maintaining the lists. However, because the lists are a key entry pathway, they should be monitored to ensure they work as intended.

There also needs to be an expedient process to change the lists if new information becomes available (for example, there may be new evidence that people with a particular condition respond differently to early intervention than previously thought) or if there is evidence that the lists are providing an entry pathway for people who would not meet the wider eligibility requirements (as the NDIA suggests might be emerging with respect to Autism Spectrum Disorders).

Given that the lists sit in the NDIA's operational guidelines, rather than the more formal NDIS Rules, there should be fewer barriers to the NDIA modifying lists as required. There is, however, limited transparency about the process by which the lists may be changed — something that was noted by some study participants (Children and Young People with Disability Australia, sub. PP358, p. 4 and National Disability Services, sub. PP295, p. 2). National Disability Services, for example, said in relation to List D:

> It is not clear why some conditions with widely varying degrees of severity are listed and others (such as autism) are omitted. The reasons for inclusion on the list or exclusion should be transparent. (sub. PP295, p. 2)

[37] Study participants who supported maintaining List A and/or List D included: Legal Aid NSW (sub. PP245, pp.4-5); Youngcare (sub. PP253, p. 3); ACT Disability, Aged and Carer Advocacy Service (sub. PP260, p. 3); Victorian Council of Social Service (sub. PP264, p. 3); EACH (sub. PP276, p. 5); Speech Pathology Australia (sub. PP303, p. 5); Amaze (sub. PP281, p. 8); National Disability Services (sub. PP295, p. 2); Early Childhood Intervention Australia Vic/Tas (sub. PP301, p. 2); and the Benevolent Society (sub. PP334, p. 6).

The Commission considers that there are benefits from increased transparency about the process by which the content of List A and List D may be changed. Greater transparency would:

- help the public to understand the purpose of the lists and why some conditions are included on the lists and others not
- impose a level of discipline on the NDIA to ensure that the lists do not remain static, but rather are adjusted to reflect new evidence, or to address concerns that people with listed conditions who are entering the scheme may not meet the wider eligibility criteria.

RECOMMENDATION 4.3

The National Disability Insurance Agency should make public a process for changing the conditions listed in List A and List D of the operational guidelines on access to the National Disability Insurance Scheme, including identifying under what circumstances a change in the lists may be considered.

There is limited information on exits

As discussed in chapter 2, a cost pressure identified by the NDIA is the lower than expected rate at which people are exiting the scheme. At the end of June 2017, just over 1000 participants had exited the scheme, with most of these exits being people who had permanent disability plans, rather than early intervention plans (NDIA 2017y, p. 16).

In its most recent Annual Financial Sustainability Report (2015-16), the NDIA stated that its baseline actuarial model assumes an exit rate of 2.1 per cent of participants each year. However, observed exit rates (as of 30 June 2016) were lower (1.2 per cent per annum). Exit rates of children are particularly low — 0.7 per cent per annum for children aged 0–6 years and 0.3 per cent for children aged 7–14 years (NDIA 2016a, pp. 36–37).

The exit rates included in the NDIS model are long term assumptions. It may take some years before participants — particularly children — receiving capacity building supports through the early intervention requirements are in a position to leave the scheme. The NDIA is monitoring exit rates and should continue to consider actions that will arrest trends in exit rates that do not appear to be consistent with the aims of the scheme.

4.3 Psychosocial disability and the NDIS

Support for including psychosocial disability in the NDIS …

In 2011, the Commission recommended that people with permanent psychosocial disability with significant long-term support needs be supported through the NDIS (PC 2011). The recommendation was made on the basis that:

- the day-to-day support needs for people with significant and enduring psychiatric disability are effectively the same as people who have an intellectual disability or an acquired brain injury
- some important parts of the care that is needed to be provided to people with psychosocial disability — namely community-based supports such as outreach or day programs — are best met through the NDIS
- providing supports to people with psychosocial disability through the NDIS provides them with the wider benefits of the scheme, including personalisation of supports to meet the needs of the individual and more choice over what supports are provided, when and by whom (PC 2011, pp. 186–189).

These points remain salient, and lend support to people with psychosocial disability being supported through the NDIS. And, while the Commission heard a range of views about whether the NDIS represents the 'right' vehicle to provide support to people with psychosocial disability, most submissions to this study were optimistic and/or supportive about the role the NDIS is playing in meeting needs of people with psychosocial disability (box 4.8).

That said, as discussed in chapter 3, there is evidence that some people with psychosocial disability are experiencing less positive outcomes than others in the scheme. For example, people with psychosocial disability are more likely to report less choice and control over supports since becoming a NDIS participant compared with other groups of participants in the scheme (Mavromaras, Moskos and Mahuteau 2016, pp. xi–xiii) and are more at risk of experiencing poor outcomes.

Box 4.8 Strong support for the NDIS from the mental health sector

Flourish Australia:

> Flourish Australia strongly supports the NDIS and the opportunity it provides for greater certainty, choice and control, and economic and social participation for people with disability who require life-long support. We are also strongly supportive of the inclusion of psychosocial disability within the Scheme's remit, and have seen firsthand the benefits of the Scheme for the people we support and their families. (sub. 74, p. 1)

Mental Health Community Coalition of the ACT:

> MHCC ACT views the NDIS with great hope. It holds promises for a better more integrated life for people living with disability. (sub. 135, p. 2)

The National Mental Health Commission:

> The NMHC considers the NDIS to be an important initiative with its promise of individualised care and choice for eligible people with psychosocial disability. It is a potentially very important element in addressing the long standing unmet needs of people with mental illness for effective community and disability supports. (sub. 153, p. 1)

Mental Health Australia:

> The National Disability Insurance Scheme (NDIS) is an historic opportunity to improve the lives of people who have for far too long missed out on the support they need to live contributing lives in the community. Mental Health Australia strongly supports the policy intent underpinning the Scheme, and hopes to work with government over the long term to maximise choice and control for people living with mental illness and psychosocial disability. (sub. 155, p. 3)

The Department of Health:

> There is broad stakeholder support for the inclusion of psychosocial disability in the NDIS, with feedback suggesting that participants are receiving better and more effective support and assistance under the NDIS than what was available to them before accessing the scheme. (sub. 175, p. 2)

… but there are some concerns about how well it fits in the scheme

While there is broad support for psychosocial disability to be included in the NDIS, several study participants identified parts of the scheme's design that are challenging for people with psychosocial disability. For example, the requirement that an impairment be 'permanent', was identified as being incompatible with recovery models used to support people with psychosocial disability. It was also suggested that the requirement could preclude people with significant needs from seeking or receiving support from the scheme. The Royal Australian and New Zealand College of Psychiatrists said that it was concerned about:

> … the centrality of disability 'permanence' in the eligibility criteria for the NDIS as the language of 'permanence' does not fit with the recovery-oriented approach of the mental health sector … Eligibility criteria that relies on permanence may therefore contribute to many individuals not seeking, or opting out of, treatment if that treatment is predicated upon their acceptance of the lifelong nature of their illness. (sub. 158, p. 2)

Mental Illness Fellowship of Australia Inc also said that it:

> … maintains that the criteria for permanency in the context of psychosocial disability is inappropriate, as it is not based in prognostic evidence, is incongruent with recovery-orientated practice, and is unnecessary for ensuring the NDIS supports those most in need. (sub. PP338, p. 2)

And the New South Wales Government:

> The recovery focus in contemporary mental health practice does not align neatly with the NDIS requirement that psychosocial disability is considered a permanent disability. (sub. 60, p. 14)

Similar arguments were presented by the Butterfly Foundation (sub. 78, p. 3), Top End Association for Mental Health Inc (sub. 102, p. 9), Anglicare Tasmania (sub. 145, p. 24), Mental Health Australia (sub. 155, p. 8) and VICSERV (sub. 169, p. 7), amongst others. Some stakeholders suggested that, for psychosocial disability, the permanent requirement should be amended. However, others, such as the National Mental Health Commission, argued that that the concepts of permanence and recovery are not necessarily mutually exclusive:

> The NDIS requirement for Tier 3 participants to establish a 'permanent impairment' can appear to be somewhat at odds with the more strengths-based concept of 'recovery' used in mental health. 'Recovery' is not synonymous with the absence of illness. Rather, it means people who are living with, or have experienced, mental illness can nevertheless lead contributing and meaningful lives, in which they feel safe and secure, have connections with community and family, are engaged in social and economic participation (whether paid or not), and are physically and mentally thriving (not just surviving).
>
> From this perspective, recovery is not inconsistent with the philosophical underpinnings of the NDIS that aim to support people with lifelong disability to live an ordinary life so they can engage in education, employment and community activities. (sub. 153, pp. 1–2)

The DSS made a similar point:

> The investment approach of the NDIS and the recovery model of mental health are both about building capacity, and are well aligned. In the NDIS context, recovery is about achieving an optimal state of personal, social and emotional wellbeing, as defined by each individual, whilst living with or recovering from mental health issues. Recovery approaches acknowledge that the effects of illness and subsequent psychosocial disability may or may not diminish over time. This means that while some people may recover to the point they do not require any mental health or disability supports, others will always require supports to assist and maintain their recovery, ongoing community participation and social inclusion. Similarly, the idea of permanence is about the irreversible nature of a disability, regardless of whether it is chronic or episodic. Therefore the eligibility criteria should not be changed in relation to people with psychosocial disability. (sub. PP318, p. 12)

Concerns about how permanency relates to psychosocial disability are not new. The issue was examined in detail by EY as part of its *Independent Review of the NDIS Act*. The review found ' … there is currently not a case to amend the NDIS Act to address concerns about the

concept of permanency in the context of mental illness' (p. 36), citing a number of reasons (box. 4.9).

Box 4.9 The independent review of the NDIS Act and the concept of permanency in the context of psychosocial disability

In July 2015, the Australian Government commissioned EY to conduct an independent review of the NDIS Act. The review recommended that the need for an impairment to be permanent in the context of mental illness should not be changed. The review provided four reasons to substantiate this.

- The concept of permanency is 'neither minor nor tangential, but central to the design of the NDIS' (p. 36). The review noted that amendments to permanency provisions could (even unintentionally) widen the scope of the scheme, with potential cost implications.
- The legislative framework already accommodates some of the concerns that stakeholders expressed to that review, such as allowing impairments to fluctuate or vary in intensity, or by allowing for the prospect that a person's functional capacity, including their psychosocial functioning, may improve.
- The available evidence at the time did not suggest that permanency provisions were dampening participation in the scheme for people with mental illness.
- The NDIS had 'invested considerable effort in attempting to enhance the responsiveness of the NDIS to people with mental illness' (p. 38).

Source: EY (2015, pp. 34–38).

The Commission supports including people with psychosocial disability in the NDIS. The evidence suggests that a significant number of people with psychosocial disability are eligible and are successfully engaging with the scheme.

- At the end of June 2017, there were about 6000 active participants with psychosocial disability with approved plans, accounting for seven per cent of scheme participants (NDIA 2017y, p. 19).
- Data (to December 2016) also indicate that 81 per cent of people with psychosocial disability who lodged an access request to the NDIS are eligible for the scheme, although this is a lower acceptance rate compared with most other conditions[38] (NDIA 2016r, p. 56).

Scheme boundaries are important, and as the scheme matures and people become more familiar with the scheme, these should become clearer. The Commission cautions against changing the eligibility criteria to relax or loosen the definition of permanency and how it relates to psychosocial disability. Requiring that a condition be permanent is a key tenet of

[38] Across all disability types, about 93 per cent of access determinations found the applicant eligible. The conditions with the highest proportion of successful access requests were autism and cerebral palsy (99 per cent) and the conditions with the lowest were 'other' (67 per cent) and 'other physical' (73 per cent) (NDIA 2016r, p. 56).

the NDIS. Removing or relaxing this requirement would represent a significant risk to the financial sustainability of the scheme.

And while demonstrating permanence may be more difficult for people with psychosocial disability (than for people with other types of disability), permanence is about the irreversible nature of disability which may be of a chronic, episodic nature. The NDIS Rules and operational guidelines accept that a permanent condition may be episodic requiring different amounts of support at different times.

That said, the Commission accepts that some aspects of psychosocial disability do not sit that well in the NDIS, given the design of the scheme and how it operates. In the position paper, the Commission explored the idea of a specialised entry gateway for people with psychosocial disability. Study participants were generally supportive of the idea (box 4.10).

Box 4.10 Participant support for a specialised gateway

Mental Health Australia:

> The development of a psychosocial gateway should commence in tandem with the NDIA's reforms to the wider planning process. Early work on the key design features of a psychosocial gateway should be done with consumers and carers, providers and peak advocacy organisations. (sub. PP321, p. 20)

Victorian Government:

> Current access processes for these people are not operating satisfactorily, evidenced by the high (and growing) number of plan cancellations in Victoria particularly affecting persons with psychosocial needs. Victoria supports the PC's suggestion for a dedicated psychosocial gateway and would welcome the opportunity to be involved in determining its optimal design. (sub. PP298, p. 2)

VICSERV:

> We also note that the Commission raised the concept of a specialised 'gateway' as a unique entry pathway for people with psychosocial disability. Such a pathway would help forge a connection with organisations that already have considerable expertise in psychosocial disability, and would provide linkages to supports and services for individuals with severe and persistent mental illness, but who are ineligible for an NDIS package. (sub. PP284, p. 5)

The Victorian Council of Social Service (VCOSS):

> VCOSS believe the option of a specialist psychosocial gateway has potential to improve people's access to the scheme. (sub. PP264, p. 3)

Why a specialised gateway is needed

There are particular challenges with effectively engaging people with psychosocial disability who may — for example — be hard to reach, or may be distrustful of attempts to provide them with support. As Flourish Australia said:

> … people with a lived in experience of a mental health issue that results in psychosocial disability can also be distrustful of, or find it difficult to navigate government bureaucracies and programs. Some may require time, additional support and/or the chance to hear first-hand from peers about their experience, before they are prepared to give something a go. (sub. 74, p. 6)

A similar point was made by the Mental Health Community Coalition of the ACT:

> Many potential NDIS participants with PSD [psychosocial disability] have a long history of interaction with government services. Over the course of this journey they have been let down many times; made to feel like 'the other'; and spent many hours of time pursuing things that produce little benefit. They have felt judged and demeaned in the process. They are, understandably, suspicious of government as a result. They are not necessarily keen then, to engage with yet another long and involved government initiative that invades their privacy; and another degrading experience of having someone they have no relationship with making such important judgements about them. These are the hurdles faced by service providers in getting many people with PSD to engage in the NDIS. (sub. 135, p. 15)

These characteristics of psychosocial disability present significant challenges for the scheme, particularly in engaging, assessing and planning for people with psychosocial disability. A number of stakeholders suggested that these processes are not functioning well (chapter 5). For example, the Mental Illness Fellowship of Australia pointed out that current assessment and planning practices may be anxiety inducing or traumatic for people with psychosocial disability:

> Having to re-contact a range of people to gather evidence on the history of illness, as well as the experience of being 'interviewed' and assessed, can be experienced as extremely invasive and in some cases, triggering. Symptoms related to psychosocial disability itself can present barriers to access, such that those with anxiety and trauma may require significant support to prepare and attend assessment appointments in which they are exposed to strangers and may feel threatened, judged or vulnerable. Practices by the NDIA or its agents such as calling transitioning participants without fore-warning, conducting telephone interviews, and/or failing to communicate regularly with applicants has exacerbated participants' anxiety and caused considerable distress. (sub. 122, p. 9)

The Joint Standing Committee on the National Disability Insurance Scheme also noted problems with the planning process for people with psychosocial disability:

> Overall, the committee believes the planning process has not been operating well for people with psychosocial disability and has resulted in many cases with less than satisfactory experiences and outcomes for participants … Given the episodic nature of mental health conditions, an agile planning and review process is crucial to ensuring that participants have continuity of appropriate support. (JSCNDIS 2017c, p. 34)

And Neami National pointed to reasons why the planning process may need to be different for people with psychosocial disability:

> Within the NDIS, planning is comprehended as a relatively simple process of information gathering and interpretation, with needs converted into actions through a plan that will last 12 months. This works for some but not all people with a psychosocial disability. For some people planning is a process, dependent on an interactive relationship developed over time, with needs revealed through this relationship, and required actions negotiated between the consumer and planner over time. … The current NDIS process does not accommodate this more interactive approach to planning that has been a strength of community provided mental health services, in particular in meeting the needs of people who are disengaged or marginalised. (sub. 63, p. 6)

One Door Mental Health also said:

> Of critical importance when engaging consumers and carers is that engagement must occur on the participant's terms in a manner appropriate to their individual circumstances. There should be no underlying assumption of readiness for any phase of access to the NDIS. Cold-calling potential participants asking if they need support, with no insight into the support the person needs, is both distressing and ineffective. (sub. PP266, p. 8)

Specialisation is one way to overcome the unique challenges around successfully engaging people with psychosocial disability in the NDIS. One of the key concerns raised by study participants was the knowledge, skills and experience of planners in relation to psychosocial disability. Neami National, for example, said:

> A significant proportion of people with mental illness and related psychosocial disability experience conditions that can present as complex due to factors including: the fluctuating and episodic nature of their condition; difficulties engaging in assessment or service provisions; cognitive deficits that are not necessarily apparent. To ensure effective planning occurs, planners require specific knowledge, skills and experience in engaging and working with people with mental illness and related psychosocial disability. (sub. PP347, p. 5)

One Door Mental Health argued that this is one area where leveraging industry expertise and establishing relationships with potential participants has been underutilised. One suggestion put forward was for the NDIA to discuss the situation of potential scheme participants with current program managers to better understand the individual (sub. PP266, p. 8).

Using more specialised staff — through experience and/or training — should improve the way the scheme connects to and communicates with people with psychosocial disability. Given the current lack of a specific assessment tool and reference package for psychosocial disability, having staff who have a degree of specialisation to assess psychosocial disability is particularly critical.

The value of specialised staff was recognised by the Joint Standing Committee on the National Disability Insurance Scheme:

> Given that participants with psychosocial disability as their primary disability are expected to account for about 13.9 per cent of all NDIS participants by 2019-20, the NDIA should consider having a specialised team of NDIS planners for people with psychosocial disability. This would ensure better plan outcomes for participants, less need for reviews and ultimately contribute to the sustainability of the Scheme. (JSCNDIS 2017c, p. 34)

The NDIA has previously considered the case for a 'new' gateway for people with psychosocial disability, but identified a 'preferred' option of improving the current pathway (National Mental Health Sector Reference Group 2017, p. 2). However, given that people with psychosocial disability are one of the groups at risk of experiencing poorer outcomes in the scheme (chapter 3), the Commission's view is that a psychosocial gateway is a reform worth pursuing.

What features should a psychosocial gateway have?

While the NDIA is best placed to design a psychosocial gateway (in consultation with key stakeholders such as participants, peak bodies, providers and experts in mental health), there are number of key features that the Commission considers the gateway should have.

The first is specialised staff.

Ensuring assessment and planning is undertaken by specialised staff should facilitate better outcomes for scheme participants (because they understand the nature of psychosocial disability and are familiar with appropriate supports). It also ensures that staff are well placed to make appropriate referrals for alternative supports for people who are not eligible for support through the NDIS.

One option for the specialist gateway is to use partner organisations, similar to the ECEI approach. However, other approaches may also be effective — for example, the NDIA could foster specialisation by nominating and training planners to be used exclusively for the gateway.

The second important feature — given widespread concerns about the effectiveness of phone planning for people with psychosocial disability (chapter 5) — is face to face engagement where possible.

Neami National suggested a more iterative planning process for people for whom single-event planning is challenging. This could involve short term plans for high level support coordination, with the goal of developing a longer term plan that is aligned with the person's complex needs (sub. 63, p. 7). Planning and assessment processes should utilise existing information where possible.

Third, the gateway should consider models of outreach to improve engagement for people with psychosocial disability who are unlikely to approach the scheme. Several submissions — including Mental Health Australia (sub. PP321, p. 25), the Victorian Government (sub. PP298, p. 11) and Orygen (sub. PP254, p. 3) — emphasised the value of outreach in improving engagement for people with psychosocial disability.

The cost effectiveness of different outreach approaches need to be considered, with models selected that are expected to yield high benefits relative to the cost of establishing and maintaining them.

Fourth, the gateway should provide a 'soft entry' point for people with psychosocial disability. While the gateway would undertake an assessment of, and assist with plan development for, scheme participants, it also should have a linkage and referral function to other services and supports (like the ECEI approach) for those found to be ineligible for the scheme.

The ability of the gateway to act as an effective linkage and referral service will depend on the adequacy of services and supports provided outside of the scheme. The NDIS is not meant to support everyone with psychosocial disability, and even for those who do qualify for individualised supports, other systems will be critical to their support and care needs (for example, the health system meeting clinical needs). Many people will not meet the eligibility criteria for individualised supports and therefore will need to be supported outside of the scheme.

At present, what supports will be available for people with psychosocial disability who are not eligible for the scheme is unclear, and needs to be addressed (this issue is discussed further in chapter 6).

Finally, the gateway should have a data collection function. At a minimum, data should be collected on:

- the number of people approaching the gateway, and the number of people assessed for scheme eligibility
- basic demographic information about people who approach the gateway (such as gender, age and postcode of residence)
- information on a person's psychosocial disability, including diagnosed mental health conditions and any assessments of severity or impact on functionality that have been undertaken
- the actions taken by the gateway (for example, applying for scheme entry, or linkage to non-scheme services).

The data should be collected, used and disseminated in accordance with the principles outlined in chapter 13 of this report.

RECOMMENDATION 4.4

The National Disability Insurance Agency should implement a psychosocial gateway. The gateway should be the primary pathway that people with psychosocial disability enter the National Disability Insurance Scheme.

The gateway should:

- use specialised staff
- operate on a face to face basis to the greatest extent possible
- consider models of outreach to engage people with psychosocial disability who are unlikely to approach the scheme
- provide linkages to both clinical and non-clinical services and supports outside the scheme
- collect data on both entrants into the scheme and people linked to services and supports outside the scheme.

5 Scheme supports

Key points

- The National Disability Insurance Scheme (NDIS) is designed to cover individualised disability supports that are reasonable and necessary. This includes supports that help people with disability to pursue their goals, live independently and participate in the community and in employment. The NDIS is meant to complement other mainstream or specialist services available to the wider population, not replace them.
- The extent of support coverage matters — under-coverage could mean that the benefits of the NDIS are not fully realised, but over-coverage of supports could create cost pressures and pose a risk to the financial sustainability of the scheme.
- The overall costs and benefits of the NDIS are affected by the volume of supports funded under the scheme, as well as how supports are allocated — that is, the planning process.
  - The touchstone of what is reasonable and necessary directly impacts the quantity and types of supports funded. The concept of 'reasonable and necessary' is malleable, and allows scheme participants the flexibility to exercise choice and control.
  - The quality of planning processes is a key determinant of the success and long-term sustainability of the NDIS — it influences what costs are incurred; the predictability of costs; outcomes for participants; and the integrity of, and community support for, the scheme as a whole.
- The planning process is about matching scheme participants with supports. It involves conversations between the participant and the National Disability Insurance Agency to determine, for each participant: their goals and aspirations, their level of function and appropriate supports.
- The challenge for the planning process is finding the right balance between individualisation and good outcomes for scheme participants on the one hand, and ensuring equity among participants and the financial sustainability of the scheme on the other.
- Planning processes are currently not operating well. The speed of transition and performance indicators that focus on participant numbers have placed pressure on the National Disability Insurance Agency to finalise plans quickly, and the quality of plans has been compromised.
  - Planning conversations with scheme participants are said to be rushed and superficial. Most plans are prepared by phone, which limits engagement with participants and can mean that planners do not get the 'full picture'.
  - The planning process is not clear, transparent and accessible. Nor are processes inclusive or sufficiently flexible to accommodate differing needs, particularly for participants with complex needs or from culturally and linguistically diverse backgrounds.
  - There is variability in planner skills, experience and training. Planners often lack knowledge about different types of disability, which can hinder their ability to formulate a good plan. Planner performance could be improved by using specialised planning teams for some disabilities and better leveraging industry expertise.

The quantity and types of supports funded by the National Disability Insurance Scheme (NDIS) are key drivers of scheme costs. Supports are also important for realising many of the benefits of the NDIS (box 5.1) because they help scheme participants:

- pursue their goals, objectives and aspirations and increase their independence
- increase their social and economic participation (and increase the social and economic participation of carers)
- reduce their need for other supports and services
- develop their capacity to actively take part in the community.

For this reason, striking the right balance is crucial: over-coverage of supports could create cost pressures and pose a risk to the sustainability of the scheme, but under-coverage could mean that the benefits of the NDIS are not fully realised.

The overall costs and benefits of the NDIS are also affected by *how* supports are allocated to scheme participants. Good planning processes are important for matching scheme participants with the supports that will result in improved outcomes and help maintain the integrity of, and community support for, the scheme as a whole. Poor planning processes can increase the likelihood of cost blowouts and undermine the accuracy of cost projections, compromising the ability of governments to plan for the future of the scheme.

The *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act) provides for two types of supports for people with disability.

- Specialist disability supports funded by the NDIS are called *reasonable and necessary supports*. The types of supports that may be funded include: assistance with daily personal activities and household tasks; therapeutic supports (such as occupational therapy, speech therapy and behavioural support); mobility equipment; home and vehicle modifications; and services that enable employment and participation in community, social economic and daily life activities (NDIA ndf).
- The National Disability Insurance Agency (NDIA) may also provide *general supports* to people with disability, even if they are not eligible for the NDIS. General supports include: coordination, strategic and referral services and activities, to help people with disability access mainstream services, such as health, education and transport services (Commonwealth of Australia 2013b, p. 8).

This chapter is about the specialist supports that are funded under the NDIS — that is, reasonable and necessary supports. The rules governing the scope of supports covered by the NDIS are covered in section 5.1. Section 5.2 gives an overview of the process for allocating supports to individual scheme participants — the planning process. Section 5.3 discusses the key concerns raised by study participants about the planning process and considers what implications these have for scheme sustainability. The interface between the NDIS and other services is discussed in chapter 6.

Box 5.1 Many of the benefits of the NDIS are realised through supports

Brenda Gillett:

> My adult son James (39 years old) who has an intellectual disability, lived at home until almost two years ago, when we then decided it was time for him to try to live as independently as possible without our total support … James just loves his own 'unit' and his new (and much loved) support person who is enabling James to become more independent each day; and is helping him to become more inclusive in his community … James also has used funding specifically set aside for a speech pathology assessment and is looking forward to catching up with the 21st century and the rest of his generation by buying an iPad with which to look at his photos and use a communication app to help him express his needs and wants. (brief sub. 15)

Sally Shackcloth:

> My adult daughter's life has improved in many ways since she was a member of the trial group in Tasmania. An occupational therapist found that her bed was unsafe both for her and for the support workers dressing her. The physio review recommended a hip x-ray because of increasing mobility problems. The result is she is now having preventative treatment so her condition doesn't deteriorate … Very importantly, she is now participating in an ongoing speech pathology program with an expert speech pathologist as she needs a communication system tailored to her needs. Up to now she has no reliable way to communicate. (brief sub. 19)

Karen Wakely:

> For the first time we have been able to access meaningful therapeutic supports. Previously therapy was only once a month, and was inadequate for gaining any momentum. Now we access either psyc or occ therapy every week, and it has been far more effective in developing the social and practical skills needed for independent living. For the first time, my child is beginning to successfully participate in mainstream community activities. (brief sub. 43)

Lauren McGowan-Slee:

> Because of the NDIS I have supports that mean I can do a job that works with my disability and have the physical home tasks I can't do taken care of … I am excited to be a taxpayer again, it fills me with so much pride to be giving back again. With the NDIS I can afford to get to work, the transport contributions mean I don't have to reduce my work days to afford taxis. I have adaptive technology which means I can do things by myself and be safe. I am also blind and I can finally read again and I used funding to get me to a functional level so I could work. … I can afford to buy healthier food and get help preparing it instead of having to buy pre prepared meals so I have had less digestive problems, and I don't see the doctor as often. I have a person who can be with me when I do exercise so I can exercise effectively without being afraid of falling over or getting injured when I lose muscle control. (brief sub. 52)

Graham Lawrence:

> Under her NDIS approved plan, Michelle has the ability to purchase a 5 day/week community access program with a group of her peers, with arranged leisure, craft and life education activities … [this] makes it possible for the Government to save an estimated $300,000 – $400,000 p/a. This is the typical net cost of providing care (equivalent to their own home), for people with the severe levels of disability which Michelle has. (brief sub. 78)

Sonya & Stephanie Nicolaides:

> My Daughter Stephi has been on the NDIS for three months now and it has made a dramatic change to her life. She now has the same life opportunities other Australians take for granted. She is able to have regular physio and hydro therapy now, which helps with all her tight muscles. Stephi seems to be a lot happier within herself and able to move a lot easier without much pain. We were able to get ramps to the front and rear of the house, making it very easy to get Stephi in and out of the house in her wheelchair now. (brief sub. 132)

5.1 What supports are funded under the NDIS?

The NDIS is designed to cover individualised disability supports that are 'reasonable and necessary' (Gillard 2012; PC 2011, pp. 257–261).

This includes supports that help people with disability to:

- pursue their goals and maximise their independence
- live independently and be included in the community as fully participating citizens
- participate in the community and in employment (NDIS Act s. 4(11)).

However, the NDIS is not meant to replace mainstream or other specialist services available to the broader population, and does not fund supports that are covered by other areas of government (including hospital and doctor visits, and school teacher aides).

In addition, the NDIS Act s. 34(1) specifies criteria for determining whether supports (general or individualised) may be provided to scheme participants. This includes whether the support:

- will assist the participant in achieving their stated goals and aspirations
- will facilitate the participant's social and economic participation
- represents good value for money
- will (or is likely to) be effective and beneficial for the participant
- should (within reasonable expectations) be provided by families, carers, informal networks or the community
- is most appropriately funded or provided through the NDIS.

The National Disability Insurance Scheme (Supports for Participants) Rules 2013 (Cwlth) and operational guidelines maintained by the NDIA provide additional rules and guidance for deciding what supports may be approved.

What is reasonable and necessary?

Individualised support funding under the NDIS is bounded by the touchstone of what is reasonable and necessary. However, the concept of 'reasonable and necessary' is not specifically defined in the legislative framework. Notably, the NDIS Act 'does not prescribe the types of supports that would be considered 'reasonable and necessary' across all participants' (EY 2015, p. 9), nor does it provide direct guidance on how to determine whether a support is reasonable and necessary.

As the court in *McGarrigle v National Disability Insurance Agency* observed:

> Although the phrase 'reasonable and necessary supports' is used throughout the legislative scheme, including in the objects and principles provisions, it is not defined. Its meaning can be

> derived from the context in which it is used, especially in my opinion s 4(11), which sets out what reasonable and necessary supports should enable and empower people with a disability to do, read with s 14 which sets out the purposes for which funding for reasonable and necessary supports is provided. ([2017] FCA 308 at [41])

As such, the bounds of what is reasonable and necessary will ultimately be shaped by court and tribunal decisions over time, having regard to the text of the legislation, rules and operational guidelines. These decisions will affect what will be funded under the NDIS, and therefore overall scheme costs. On this basis, the NDIA identified 'decisions by the Administrative Appeals Tribunal (AAT) or court system in interpreting the boundaries of … reasonable and necessary supports' (sub. 161, p. 45) as a policy lever affecting the financial sustainability of the NDIS that is outside of its control (box 5.2).

Box 5.2 McGarrigle v National Disability Insurance Agency

Mr Liam McGarrigle is a scheme participant with autism spectrum disorder and intellectual disability. Each week, he attends a group program for three days and is employed for two days. Transport to and from these activities is by taxi or provided by a support worker. As part of his third plan, Mr McGarrigle was allocated $11 850 for 'transport to access daily activities'. This represented about 75 per cent of his total transport costs ($15 850).

In the Administrative Appeals Tribunal

Mr McGarrigle sought a review of this decision in the Administrative Appeals Tribunal, seeking to have his transport costs fully funded. The Tribunal found that, while transport is a reasonable and necessary support for Mr McGarrigle, it was open to the National Disability Insurance Agency (NDIA) to decide to fund less than the full cost of the support. The Tribunal said, 'I am satisfied that the decision to fund 75 per cent of his weekday transport costs strikes an appropriate balance between what is reasonable and necessary for him and the overall financial sustainability of the NDIS' [64].

In the Federal Court

On appeal, the Federal Court of Australia overturned the Tribunal's decision. It reasoned that the imperative language of the NDIS Act (specifically, the words 'will be funded' in s. 33(2)(b)) pointed to the fact the scheme intends that supports will be fully funded. The Court also noted that the Act does not refer to contributions from the participant towards the cost of supports.

The NDIA lodged an appeal of this decision to the Full Federal Court. It argued that the CEO of the NDIA could refuse to fund a support on the grounds of 'financial sustainability'. The Full Court did not consider this argument because it was a new argument and therefore not a permissible grounds of appeal. The Full Court dismissed the appeal on 21 August 2017.

Sources: *McGarrigle v National Disability Insurance Agency* [2016] AATA 498; *McGarrigle v National Disability Insurance Agency* [2017] FCA 308; *National Disability Insurance Agency v McGarrigle* [2017] FCAFC 132, Victoria Legal Aid (sub. PP367).

Is additional clarity required?

In the position paper, the Commission asked whether there is sufficient clarity around how and whether the 'reasonable and necessary' criterion should be applied and whether better legislative direction about what is reasonable and necessary is required. The feedback was mixed.

Clarity for scheme participants and planners

The majority of responses addressed the question of whether 'reasonable and necessary' is sufficiently clear from the perspective of planners and scheme participants. Study participants identified issues with operationalising the concept of 'reasonable and necessary'. A particular concern is that there are different perceptions about what supports are reasonable and necessary (Flourish Australia, sub. 74, p. 5; PDA, sub. 38, p. 9; MIFA, sub. PP338, p. 9; NDS, sub. PP295, p. 3). Alzheimer's Australia, for example, said:

> In our experience, there are large variances in what is considered 'reasonable and necessary' in relation to assessment planning. For example, one person with younger onset dementia was assessed and given horse riding lessons, while another person was not allowed bathroom aids. There also needs to be an oversight and improvement process that monitors how an assessor or planner determines what is considered 'reasonable and necessary'. (sub. 10, p. 13)

Some study participants also said that planners' lack of knowledge about different types of disability impacts their ability to identify what supports are reasonable and necessary for different scheme participants (AASS sub. PP330. pp. 4–5; ABF, sub. PP263, p. 4; MND Australia, sub. PP255, p. 4; MS Australia, sub. PP283, p. 5; RIDBC, sub. PP259, p. 6). The issue of planner knowledge is discussed further in section 5.3.

The NDIA (sub. 161, p. 92) also acknowledged that 'there is still confusion within the sector and the community, and to some extent within the NDIA, around the scope of reasonable and necessary supports'.

Views were split on whether this problem should be addressed through further legislative direction. Some study participants thought that legislative reform could help clear up confusion around how to operationalise the concept of reasonable and necessary supports (CMHA, sub. PP270, p. 3; Disability Services Australia, sub. PP256, p. 2; One Door Mental Health, sub. PP266, p. 6; VICSERV, sub. PP284, p. 3).

But others disagreed (AASS sub. PP330. pp. 4–5; Anglicare Australia, sub. PP339, p. 3; Mental Health Coalition of South Australia, sub. PP308, p. 3; Women with Disabilities Victoria, sub. PP282, p. 5). A key concern was that greater legislative clarity would impose greater restrictions, reducing flexibility and choice for scheme participants (NSW Government, sub. PP230, p. 3; OPA, sub. PP241, p. 1; VALID, sub. PP332, p. 3; YDAS, sub. PP262, p. 3).

The Commission agrees that amending the legislation is not appropriate for clarifying, for scheme participants and planners, what specific supports will or should be funded by the NDIS. Rather, additional guidance, where required, should be contained in rules, operational guidelines or other policy documents. As the Queensland Government said:

> [It is] appropriate for high level principles on 'reasonable and necessary' to be contained in the Act, with more detailed guidance and examples in subordinate legislation and/or … operational guidelines to facilitate consistency of decision making and expectation management. (sub. PP345, p. 7)

The NDIA has operational guidelines, practice guides, work practices and task cards to help planners exercise their judgment about what is a reasonable and necessary support. This allows for greater flexibility and individualisation, and gives scheme participants choice and control over their supports. As the NDIA explained:

> Decisions around reasonable and necessary supports require balancing the need to empower participants to explore different ways of achieving increased participation with the need to spend taxpayers' money consistent with legislation and in a way that minimizes risk of misuse or fraud. (sub. 161, p. 92)

However, as argued by a number of study participants, greater transparency and better communication is required to help scheme participants understand what supports are covered by the NDIS (Amaze, sub. PP281, p. 12; DAA, sub. PP292, p. 3; EarlyEd, sub. PP290, p. 2; Vision Australia, sub. PP252, p. 5; Women with Disabilities Victoria, sub. PP282, p. 5; YPINH, sub. PP326, pp. 2–3). Publishing examples or benchmarks of what is a reasonable and necessary support could help (AASS sub. PP330. pp. 4–5; MIFA, sub. PP338, p. 9; RIDBC, sub. PP259, p. 6; PDA, sub. 38, p. 8).

Clarity for courts and tribunals

What legislation says about reasonable and necessary supports is important because it provides courts and tribunals with a framework for evaluating whether decisions about those supports have been properly made.

In 2011, the Commission made recommendations about various criteria for determining whether a support is reasonable and necessary (PC 2011, pp. 258–259). These criteria were adapted from the Lifetime Care and Support Scheme in New South Wales and are echoed in the NDIS Act s. 34(1) (discussed above). However, the NDIS's legislative regime is different to that of the Lifetime Care and Support Scheme — and the scheme contemplated in PC (2011) — in two subtle ways.

No explicit requirement to assess whether supports are reasonable and necessary

First, while the NDIS Act repeatedly refers to 'reasonable and necessary supports', it does not explicitly state that individualised supports funded under the NDIS must be, or are assessed to be, 'reasonable and necessary'. By contrast, the New South Wales Lifetime Care

and Support Scheme explicitly requires a direct assessment of what treatment and care needs are reasonable and necessary in the circumstances (*Motor Accidents (Lifetime Care and Support) Act 2006* (NSW) ss. 11A, 23).

That said, a requirement for such an assessment may be implied by the text of the legislation. The Second Reading Speech for the NDIS Act also exhibits an intention to require an assessment of what is reasonable and necessary:

> The scheme will give people the care and support that is objectively assessed as being reasonable and necessary over the course of their lifetime. (Gillard 2012)

It also appears that the NDIA (sub. PP327, p. 23) considers itself obligated to assess whether a support is reasonable and necessary.

However, these considerations are not determinative of how a court would interpret the NDIA's obligations, and there is a risk that the legislation could be interpreted in a manner contrary to lawmakers' intentions. One way of minimising this risk would be to redraft the NDIS Act s. 34 to explicitly state that individualised supports funded under the NDIS must be, or are assessed to be, reasonable and necessary in the circumstances (Legal Aid NSW, sub. PP245, p. 7).

No explicit criteria for assessing whether supports are reasonable and necessary

Second, the NDIS Act does not explicitly provide a schema for determining whether a support is reasonable and necessary. The considerations outlined in the NDIS Act s. 34(1) are not framed as criteria exclusively for deciding whether a support is reasonable or necessary. Instead, they are considerations for deciding whether any type of support (that is, general or individualised) may be provided to scheme participants. As the court in *McGarrigle v National Disability Insurance Agency* observed:

> Although s 34 is headed 'reasonable and necessary supports', it in fact expressly deals with both general supports … and reasonable and necessary supports … ([2017] FCA 308 at [39])

Despite this, the court went on to suggest that what is a reasonable and necessary support is related to or coincides with the criteria in s. 34(1), as well as other (as yet unidentified) factors.

> Whether a support is 'reasonable' requires a different assessment to whether a support is 'necessary' … the concept of necessity would appear to tie one aspect of the CEO's assessment to an evaluation of the kinds of factors set out in [some parts of s. 34(1)]. The word 'reasonable' would appear to be directed at factors such as those set out in [other parts of s. 34(1)]). That is not to say the meaning of each word is exhausted by the factors set out in s 34(1): rather, it is to illustrate the different work that each concept does as an adjective in the phrase 'reasonable and necessary supports'. ([2017] FCA 308 at [91])

Victoria Legal Aid (sub. PP314, p. 4) considered the legislation, together with the judicial commentary in *McGarrigle v National Disability Insurance Agency*, to provide sufficient direction about what is reasonable and necessary. Other study participants also expressed a

preference that additional clarity, where required, to come from court and tribunal decisions, rather than legislative change (AFDO, sub. PP325, p. 13; Maurice Blackburn, sub. PP309, p. 6).

On the other hand, some study participants saw merit in clarifying the nature of the connection between the concept of 'reasonable and necessary' and the criteria in s. 34(1). This could be achieved by:

- framing the criteria in s. 34(1) as considerations for determining whether a support is reasonable and necessary (Legal Aid NSW, sub. PP245, p. 7)
- defining 'reasonable and necessary supports' as supports that satisfy the criteria in s. 34(1) (Dr Kylie Burns, sub. PP315, p. 3).

Ongoing evaluation and review

In 2015, an independent review of the NDIS Act found that stakeholders were generally 'supportive of how the legislative framework defines the concept of reasonable and necessary supports' (EY 2015, p. 49). The NDIA (sub. PP327, p. 23) also advised that it is not currently seeking change to s. 34(1). That said, in the 2015 review, some stakeholders raised concerns about specific elements of s. 34(1) (EY 2015, pp. 49–54). Some participants to this study also raised similar types of concerns (Dr Kylie Burns, sub. PP315, pp. 3–4; Legal Aid NSW, sub. PP245, p. 7; YPINH, sub. PP326, p. 3).

It is still early in the operation of the NDIS Act. At this stage, it is unclear what 'gaps' will emerge in the legislative framework over time and how case law will develop to fill those gaps. However, based on feedback to this study, it appears that calls for better legislative direction are stronger now than at the time of the independent review of the Act in 2015.

On this basis, there is a case for ongoing monitoring and evaluation of whether the body of law (including legislation and case law) around reasonable and necessary supports is operating in a manner that is consistent with community expectations and what is intended for the scheme. This will be particularly important in the early years of full scheme.

In 2016, COAG agreed to conduct a further review of the NDIS Act (COAG 2016, p. 7), and on 16 June 2017, the COAG Disability Reform Council agreed that the review should occur in 2021 (DSS, sub. PP318, p. 8). The Commission agrees that a further review of the legislation under full scheme should proceed. That review should consider, amongst other things, the issues relating to the drafting of the NDIS Act raised in this study, as well as the impact of court decisions on the content of the law.

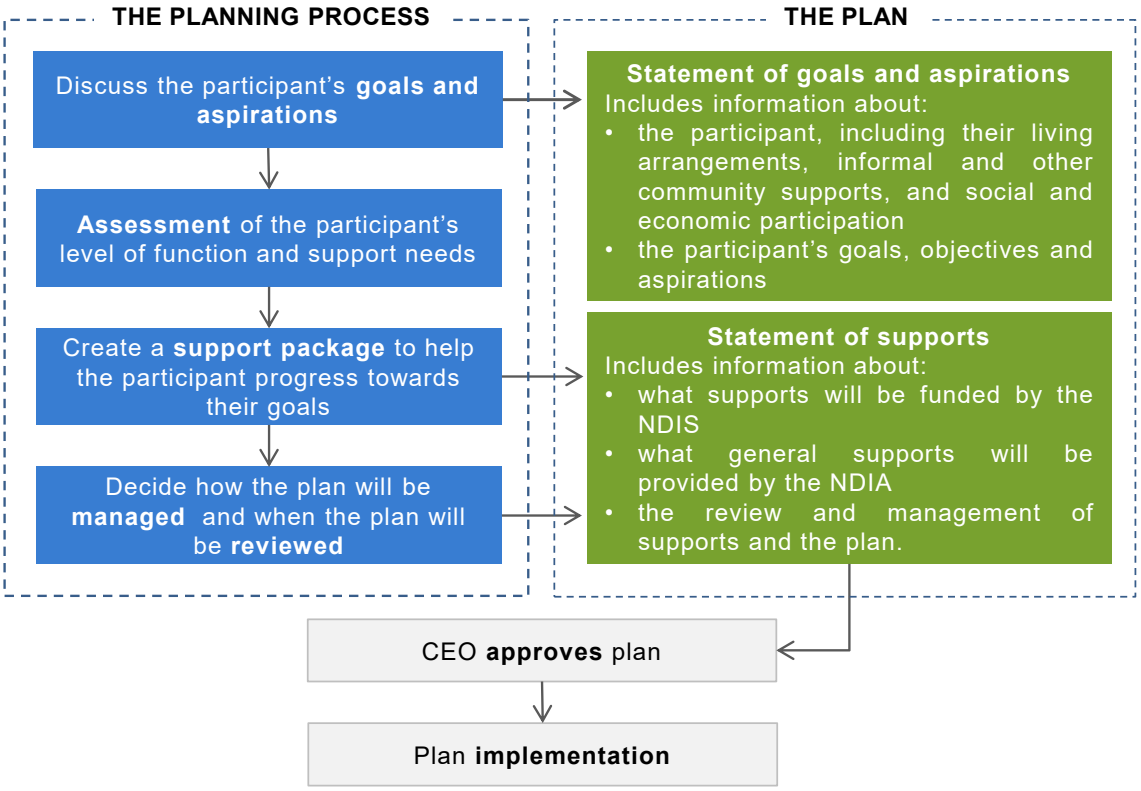
5.2 About plans and the planning process

Supports are allocated to scheme participants through a plan, which is prepared through conversations between a planner and the participant. As the NDIS Act (s. 31) states, where

practicable, the development of a plan should be individualised, be directed by the participant and maximise participant choice and control.

The planning process involves several steps (figure 5.1), designed to elicit information about the scheme participant, which is used to inform the content of the plan.

Figure 5.1 **Making a plan**



1. The participant and planner discuss the participant's goals and aspirations. This conversation is used to help put together a statement of goals and aspirations, which includes information about the participant, including: their living arrangements, informal and other community supports, and social and economic participation, as well as their goals, objectives and aspirations.
2. The NDIA conducts or considers assessments of how the participant is performing in different areas of their life ('level of function' or 'functional capacity'), including their 'activity limitations, participation restrictions and support needs arising from [the] participant's disability' (*National Disability Insurance (Supports for Participants) Rules 2013* (Cwlth) r. 4.1), and identifies areas where the participant requires support.
3. A support package is put together to help the participant progress towards their goals. The support package may include general supports, as well as reasonable and necessary supports, and is set out in a statement of supports.

4. The planner and the participant decide when or under what circumstances the plan will be reviewed. They also decide how the plan will be managed (such as self-management, management by the NDIA, or using a plan management provider), including whether support coordination is required. (Plan management and support coordination are discussed in chapter 10.) This information is also included in the statement of supports.
5. Before the plan is finalised, it must be approved by the CEO of the NDIA (or a delegate).

For most people, their first plan is completed over the phone (NDIA 2016e, p. 1), although some planning conversations do take place face to face. In its submission following the position paper, the NDIA (sub. PP327, p. 25) said it intends moving towards using face-to-face planning as a default approach.

Assessment and tools

The assessment process is about evaluating the scheme participant's level of function and identifying the supports that will allow them to progress towards their personal goals and aspirations. Choosing the right tools for the job is challenging, as there is no universally agreed assessment tool for evaluating the care and support needs of people with disability. There are, however, several features that an assessment tool should have (box 5.3).

Box 5.3 Desirable features of assessment tools

To ensure the sustainability of scheme costs, it is important that assessment tools are:

- *valid* — the tools should test what they purport to and provide a basis for accurately identifying the nature, frequency and intensity of a person's support needs. Assessment tools that are not appropriate could threaten scheme sustainability.
- *reliable* — the tools should yield consistent measures across time, individuals and situations; results should not be influenced by when or where the assessment is undertaken, who is undertaking the assessment, or the identity of the individual per se.
- *accurate* — the tools should reduce the risk that assessors and individuals overstate or understate their support needs.
- *efficient* — an efficient tool is one that collects sufficient information to assess support needs in the least costly manner.

Assessment tools also need to be continually monitored and refined to ensure that they remain in line with scheme objectives, and keep pace with evolving best practice and community expectations.

Source: PC (2011, pp. 315–320).

Since the NDIS commenced, the NDIA has used several different assessment tools as part of the planning process (box 5.4).

Box 5.4 The evolution of NDIS assessment tools

The National Disability Insurance Agency (NDIA) has undertaken significant work to identify appropriate assessment tools for identifying the support needs of scheme participants.

- *Mid-2013*: the NDIA commenced delivering the National Disability Insurance Scheme without an assessment tool, as none was available.
- *Late 2013*: adoption of the Support Needs Assessment Tool (SNAT). The SNAT attempted to identify functional support needs through a planning discussion, and provided the participant with a detailed, personalised support plan. After the first year of trial, it became apparent that the SNAT was not fit for purpose.
- *Late 2014*: further work on identifying appropriate assessment tools. This entailed a survey of functional assessment tools used around the world, and evaluating these tools for relevance, usability and reliability. The cost of acquiring and using these tools was also a crucial consideration. The process included extensive consultation and engagement with key stakeholders and experts across the key disability types, including clinical experts and researchers, and disability associations.
- *Mid-2015*: identification and testing of a new suite of assessment tools. This included different tools for 11 key disability types, and the World Health Organization Disability Assessment Schedule version II (WHODAS II) where no specific tool was identified.
- *Mid-2016*: adoption of the new suite of assessment tools. The NDIA has the capability to administer some of these assessments tools in house, but they can also rely on assessments performed by specialists.

Considerable work around assessment tools remains to be done. For example, the NDIA still has no tool for evaluating the support needs of people with psychosocial disability. Engagement with representatives in the mental health sector on this point is ongoing.

Source: NDIA (sub. 161, pp. 9–11).

Feedback about the NDIA's use of assessment tools was mixed.

- Some study participants were critical of the NDIA's assessment tools, but it was sometimes unclear which specific tools they were referring to (ABF, sub. 48, p. 10; Alzheimer's Australia, sub. 10, p. 10; Belinda Jane, sub. 80, pp. 5–6; Macarthur Disability Services, sub. 57, p. 6; QAI, sub. 115, p. 11).
- Other study participants were critical of how certain tools were used, particularly in relation to early childhood and early intervention (chapter 4). For example, the AEIOU Foundation (sub. 32, p. 8) said that PEDI-CAT is not appropriate for children with intellectual disability. The Shepherd Centre (sub. 107, p. 12) made a similar observation about young children with hearing loss. Others questioned whether NDIA staff were adequately trained to apply the PEDI-CAT tool (ECIA Victoria/Tasmania, sub. 129, p. 10; Noah's Ark, sub. 108, pp. 10–11).

Many study participants said that they were unable to obtain information about what assessment tools the NDIA uses (including tools for assessing level of function). Physical

Disability Australia said this made it difficult to comment on the appropriateness of assessment tools.

> Information about assessment tools is scarce on the NDIS website … Furthermore, there is no mention of them on the pages dealing with planning processes and planning conversations. It is therefore difficult for [Physical Disability Australia] (or anyone) to comment on them as it is not clear which assessment tools are being used and by whom. (sub. 38, p. 7)

The Centre for Disability Studies also said:

> A major barrier to the on-going improvement and implementation of the NDIS is the lack of access to, or public domain information on the assessment tool(s) in use by the National Disability Insurance Agency … we do not see why the assessment tool itself is not public domain, unless for commercial copyright reasons. Many support needs assessments in use across jurisdictions are in the public domain, or are available upon purchase or enquiry. (sub. 49, p. 2)

The NDIA is required to specify what assessment tools it uses in its operational guidelines (National Disability Insurance (Supports for Participants) Rules 2013 (Cwlth) r. 4.4), which must be published on a website and kept accurate, up-to-date and complete (*Freedom of Information Act 1982* (Cwlth), ss. 8-8B, 8D). But, in practice, study participants' knowledge about what assessment tools the NDIA uses appears to be sourced indirectly, through word of mouth or via experiences with the planning process. The Commission was also unable to determine what assessment tools are used by the NDIA, based on information in the public domain. Information about the role of assessment tools in the planning process could help participants understand how or to what extent assessment tool results influence the supports that they receive.

Using reference packages in planning

As discussed in chapter 2, the NDIA has identified increasing package costs (over and above the impacts of inflation and ageing) as a source of cost pressures. The NDIA developed reference packages to assist with monitoring scheme experience and assessing cost pressures (box 5.5). Reference packages are based on age, disability type and level of function. Reference packages can also help improve equity in the scheme by giving clearer guidance on 'typical' arrangements.

Based on the learnings from trial, the NDIA adopted a new approach to determining support packages on 1 July 2016 — this was called the 'first plan process'. This approach uses reference package data to assign scheme participants a 'typical support package' based on their age, disability type and level of function. This is adjusted to account for the individual support needs of participants to create the participant's plan (box 5.6).

Box 5.5 Reference packages

Reference packages are an 'indicative' support package, developed as a way to identify typical support needs and funding for different cohorts of scheme participants.

The National Disability Insurance Agency currently uses a suite of assessment tools for evaluating scheme participants' level of function, covering 11 key disability types. The reference package cohorts are based on these 11 disability types, age and level of function.

Reference package data were tested and validated using:

- back-captured data — that is, data about previous support packages
- expert groups in each of the 11 disability categories — these groups included academics, consumers and providers.

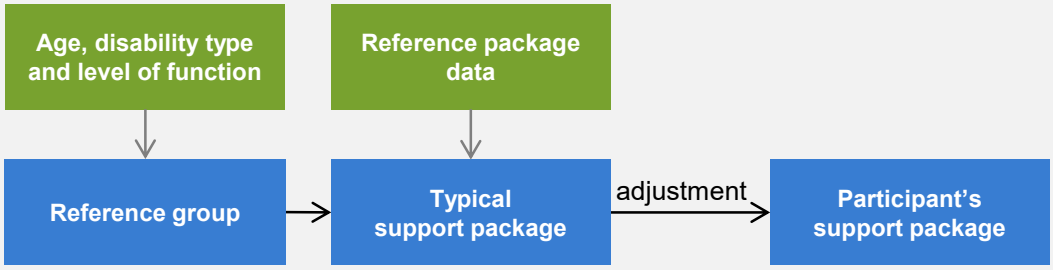
Back-captured data and the work of expert groups were also used to identify how different variables impact the value of support packages. This information allowed the Scheme Actuary to validate the assessment tools, and develop a basis for determining 'reasonable and necessary' funding at an aggregated level.

Work to refine reference packages is ongoing. For example, no reference package is currently available for people with psychosocial disability. Reference packages also have limited utility where a person has more than one disability and the secondary disability is an important contributor to support needs. As more data are collected, reference packages will become more sophisticated and better informed by actual experience.

Source: NDIA (sub. 161, pp. 10–11).

Box 5.6 Using reference package data in planning

Scheme participants are allocated a 'typical support package', based on their reference group (which is determined by their age, disability type and level of function). The typical support package may include funding across eight core domains: daily activities; social participation; consumables; transport; home modifications; assistive technology; capacity building; and support coordination.



For each participant, the level of funding is adjusted according to their circumstances. This is done using a questionnaire, which asks about each of the domains, including what supports the participant already has in place and whether these are sufficient and sustainable. For example, where it is reasonable that sustainable informal, community or mainstream supports continue to assist the participant, or where other informal, community or mainstream supports may provide a better outcome, funding is adjusted in the participant's support package.

Source: NDIA (sub. 161, pp. 10–11).

Balancing different considerations

A number of study participants argued that the use of reference package data is at odds with person-centred planning and that it limits choice and control during the planning process (AASW, sub. 124, p. 4; Flourish Australia, sub. 74, p. 13; Lifestart Co-operative, sub. 97, p. 9). ACT Disability, Aged and Carer Advocacy Service (sub. 87, p. 14), for example, said that the approach 'carries inherent risks that planners (and assessment tools) will overly rely on reference plans as opposed to taking a person-centred approach'.

A person-centred or individualised approach to planning is central to the NDIS. The scheme is about matching participants with the supports that are right for them; however, this needs to be done in the context of the sustainability of the scheme and achieving a consistent approach to funding packages.

During the first year of trial, a highly detailed and person-centred approach was taken to planning, but according to the NDIA it was found not to be fit for purpose.

> [The] Support Needs Assessment Tool (SNAT) was a construct that attempted to identify functional support need and through a planning discussion using the tool to provide the participant with a detailed personalised support plan. The SNAT was used throughout the first year of trial. However, at the end of this period, it had become apparent that the SNAT was not fit for purpose. While the SNAT delivered an individualised outcome, there was no correlation of the SNAT to the reference packages upon which the funding of the Scheme was based. (sub. 161, pp. 9–10)

While some expressed greater satisfaction with processes during trial (for example, Down Syndrome Australia, sub. 121, p. 13), according to the NDIA (sub. 161, p. 10), it led to 'highly prescriptive plans that provided detail at the daily and sometimes the hourly level minimising the flexibility for participants to exercise choice and control'.

The first plan process, introduced in 2016, sought to improve the approach taken at trial by enabling people greater flexibility in how they used their funds against goals and outcomes that they identified. It also sought to address the issues of consistency between support packages by providing guidance to planners about what support packages for different groups should look like.

The challenge for the future of the planning process is to find the right balance between individualisation and good outcomes for scheme participants on the one hand, and ensuring equity among participants and the financial sustainability of the scheme on the other. It is likely to be some time before the right balance is struck.

A dynamic process

As with all insurance-based schemes, the tools and processes for handling and assessing claims are a matter of ongoing refinement. This is necessary to ensure that the insurance scheme remains 'on track' and is viable in the long term. Dynamic processes are also

important to allow the scheme to adapt to changing circumstances or incorporate information that becomes newly available over time.

Part of this process is ongoing monitoring and evaluation (chapter 11). The NDIA undertakes internal monitoring of its processes.

> The first plan process is a dynamic process which will include ongoing refinement as more data and information becomes available. The process allows continuous monitoring of committed support and utilised support, with benchmark costs. As the NDIS moves through transition, the NDIA is continually monitoring and seeking opportunities to enhance the planning process from a participant, provider and staff perspective. The NDIA is currently reviewing the plan review process to streamline the process and ensure it continues to meet the needs of both the participants and Scheme sustainability. (sub. 161, p. 89)

In December 2016, the COAG Disability Reform Council agreed to review the first plan process at the end of June 2017 (DRC 2016). This review should consider whether the first plan process strikes the right balance between individualisation and ensuring equity across participants, and whether the process helps ensure that the scheme is sustainable in the long term.

Information about how the planning process works is important

Many study participants were unsure or unaware of how the first plan process operated. Scope Australia (sub. 72, p. 15) suggested that this was because 'communication from the Agency and its contractors has been inconsistent and at times poor'.

A number of study participants were unsure or mistaken about:

- what the first plan process was
- the rationale for adopting the first plan process
- whether or to what extent support packages were adjusted for individual circumstances
- whether or how supports received under legacy programs were taken into account.

With evolving processes, it is important that scheme participants and their families and carers can access accurate and up-to-date information about the planning process. Dr. Kylie Burns explained the importance of transparency for scheme participants:

> The use of reference packages which are not transparent and available to applicants may also create confusion and resentment in participants who legitimately understand the planning process to be highly individualised based on the provisions of legislation and the NDIS rules (which do not make reference to reference packages). (sub. PP315, p. 5)

ACT Disability, Aged and Carer Advocacy Service (sub. 87, p. 14) said, 'we would encourage a transparent and rigorous approach to consideration of benchmarking and reference plan topics'. Clear messaging about how and why things are changing is also important for maintaining the credibility of evolving planning practices.

Plan reviews

Usually, plan reviews occur as part of the planning cycle — that is, at the expiry of a scheme participant's previous plan (usually after 12 months). However, unexpected plan reviews can be triggered if the scheme participant changes their statement of goals and aspirations or requests a plan review (NDIS Act, ss. 47–48). Often plan reviews are initiated by the scheme participant because their supports do not, or cease to, meet their needs or expectations. Changes to a plan may also be required if information in the plan is incorrect or missing.

Currently, any changes to a plan require a full plan review. Several study participants advocated to allow plans to be amended or varied without triggering a full review (BCA, sub. 130, p. 5; MND Australia, sub. 45, p. 2; Woden Community Service, sub. 159, p. 10).

Full plan reviews can be time-consuming and costly, and scheme participants may also be unable to access the supports they need while they wait for their plan to be reviewed (AOPA, sub. PP294, pp. 3–4). A process for amending or adjusting plans would improve the cost effectiveness of review processes, especially when the proposed changes to the plan are minor (Jacqueline Pierce and Associations, sub. 147, p. 5).

Some also suggested that amendment processes could be used to manage supports for participants when needs change quickly — such as in the case of episodic or degenerative disorders (ABF, sub. 48, p. 3; MND Australia, sub. 45, p. 2). However, where a participant's circumstances change significantly, it will be more appropriate to undertake a full plan review (provided it is undertaken with sufficient expediency).

A process for allowing minor amendments or adjustments to plans without triggering a full plan review was supported by many participants (box 5.7). The NDIA (sub. PP327, p. 25) indicated that it is currently undertaking work to streamline the process for making small plan changes.

However, the NDIS Act s. 37 does not permit variations to a plan once it has come into effect, meaning that the implementation of an amendment process could require legislative change. As Legal Aid NSW explained:

> In our view, this change would require legislative amendment, not just a new NDIA process. Section 37(2) of the NDIA Act states that a participant's plan 'cannot be varied after it comes into effect, but can be replaced under Division 4'. Under Division 4, a participant may request a review of his or her plan at any time and may revise the participant's statement of goals and aspirations at any time, which results in the replacement of the plan. (sub. PP245, p. 8)

If this is the case, the Australian Government should amend the NDIS Act to allow the NDIA to implement a process for making minor amendments or adjustments to plans without triggering a full plan review.

Box 5.7 Many support minor amendments to plans without a full review

Early Childhood Intervention Australia:

> ECIA agrees that the NDIA should implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review. Currently, where there have been minor errors such as plan management choice, a full review is required. … . Due to growth spurts, children can outgrow a piece of equipment such as a wheelchair or orthotics that should be replaced as needed without the full review process. (sub. PP249, p. 4)

Parkinson's Australia:

> Due to progressive nature of Parkinson's there is often the need to frequently adjust plans as the illness progresses, this is particularly important for some of the atypical Parkinson's conditions, such as Multiple System Atrophy, Progressive Supra Nuclear Palsy and Cortico Basal Degeneration, which can progress rapidly. Parkinson's Australia considers that facilitating minor amendments or adjustments to plans to reflect changes in a participant circumstances or changes in the service provision environment would remove unnecessary bureaucracy and assist in the smooth operation of the scheme. (sub. PP232, p. 8)

Australian Orthotic Prosthetic Association:

> Given the issues inherent with the current planning process, plans for orthotic/prosthetic consumers are commonly inadequate and require amendment. … if a plan does not include the necessary supports that would enable a participant with limb-loss to receive a prosthetic limb, an entire review is implemented. This often requires a significant time delay, during which a participant is unable to access the necessary supports and services. For consumers of orthotic and prosthetic services, this may mean a significant period of time without the ability to access the community, mobilise and remain independent. … the current plan review process may take up to three months. (sub. PP294, pp. 3–4)

Prader-Willi Syndrome Association of Australia:

> Plan reviews must be more responsive, to avoid a costly crisis. (sub. PP228, p. 4)

MJD Foundation:

> Because of the inconsistent quality between planners, it would be sensible to have a process whereby plans can be revised without the need for a formal request for a review. (sub. PP233, p. 7)

Young People in Nursing Homes:

> The planning system must be changed to enable adjustments without the need for a full review and replacement plan to be developed. This 'dynamic plan' model should be the default position and criteria need to be developed to guide decisions about when a new plan is needed. (sub. PP326, p. 4)

Early Childhood Intervention Australia Victoria/Tasmania:

> Simplifying the review process for minor amendments will reduce costs and minimise delays for participants accessing services and supports. (sub. PP301, p. 3)

RECOMMENDATION 5.1

The National Disability Insurance Agency (NDIA) should implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review.

If required, the Australian Government should amend the *National Disability Insurance Scheme Act 2013 (Cwlth)* to enable the NDIA to implement such a process.

The role of Local Area Coordinators in the planning process

In some areas, planning discussions are conducted and plans are prepared by Local Area Coordinators (LACs). However, under current legislative arrangements, LACs do not have the power to approve plans — that is, plans prepared by LACs must still be approved by the NDIA.

In its initial submission, the NDIA (sub. 161, p. 13) said that there may be some benefits to allowing approval functions to be delegated to LACs, including increased efficiencies due to reduced double-handling of plans by LACs and the NDIA. The NDIA also said that delegating approval functions could lead to greater certainty for scheme participants.

> More importantly, it would improve the experience of participants by allowing the LAC, while in discussion about support needs and within defined parameters and agreed reporting and monitoring arrangements, to be able to confirm the level of reasonable and necessary funding and move straight to a discussion on plan implementation. (sub. 161, p. 13)

A small number of study participants supported changes to the NDIS Act to allow the NDIA to delegate plan approval functions to LACs (Disability Services Australia, sub. PP256, p. 2; South Australian Government, sub. PP354, p. 4; VICSERV, sub. PP284, p. 3). Some also said that delegation would be appropriate if it could be shown that LACs had sufficient capacity and training (CMHA, sub. PP270, p. 6; MS Australia, sub. PP283, p. 6, Speech Pathology Australia, sub. PP303, p. 9; Parkinson's Australia, sub. PP232, p. 8). The Queensland Government (sub. PP345, p. 8) also said there might be a case for 'rapid or limited approvals for participants supported by LACs engaged by the NDIA who cover very remote areas, for example, the Torres Strait Islands'.

However, the majority of study participants were opposed to allowing delegation, [39] driven mainly by concerns about:

- the risk to plan quality as a result of the NDIA having reduced control and oversight over plans and the planning process
- the capacity of LACs to perform additional functions, due to time and resource constraints
- conflicts of interest (real or perceived) between different roles — for example, giving LACs plan approval functions could compromise their ability to provide impartial pre-planning support
- reduced accountability, clarity and transparency around roles and responsibilities.

[39] Study participants who opposed the delegation of approval functions to LACs included: ADACAS (sub. PP260); AEIOU Foundation (sub. P277); AFDO (sub. PP325); Anglicare Australia (sub. PP339); ABF (sub. PP263); APS (sub. PP229); Bruce Bonyhady (sub. PP333); CPSU (sub. PP310); Flourish Australia (sub. PP246); HSU (sub. PP316); Legal Aid NSW (sub. PP245); MIFA (sub. PP338); NSW Government (sub. PP230); One Door Mental Health (sub. PP266); PWSAA (sub. PP228); RIDBC (sub. PP259); and Vision Australia (sub. PP252).

On balance, it does not appear that legislative change to enable the delegation of plan approval functions to LACs is warranted at this stage. In response to the position paper, the NDIA (sub. PP327, p. 24) also advised that it 'is not currently seeking legislative change to allow the delegation of plan approval to LAC partners'.

5.3 How is the planning process tracking?

Good planning processes are essential for the success of the scheme and long-term sustainability, as the quality of the planning process has a bearing on what costs are incurred in the scheme, the predictability of scheme costs and the integrity of the scheme (box 5.8). The Northern Territory Government said it considers the planning process to be one of the most important elements of the scheme.

> The quantity of supports received by participants is a key driver of costs, and therefore a consideration for the ongoing financial sustainability of the Scheme. However, without a high quality planning process which supports participants to identify and work towards their goals and aspirations, choice and control for participants will not be achieved. (sub. 205, p. 3)

The planning process is not operating well. The Commonwealth Ombudsman reported that the planning process is one of the main sources of complaints to the office (sub. 137, p. 7).

Participants to this study also expressed dissatisfaction with planning processes. In particular, participants expressed concern about:

- the lack of consultation and engagement with scheme participants
- the accessibility and transparency of processes and planners
- the quality of planners (including LACs undertaking planning functions).

A real concern is that poor planning processes are compromising the quality of plans. The Commission heard that plans often do not meet scheme participants' needs or expectations, and sometimes they include supports that are not wanted or needed (Macarthur Disability Services, sub. 57, p. 4). Several study participants also reported considerable variability in plans for scheme participants with similar needs (Neami National, sub. 63, p. 8; PDA, sub. 38, p. 8; PDCN, sub. 29, p. 3). For example, Brain Injury SA said:

> Brain Injury SA is aware of one household with multiple children with similar needs. Each child had a different planner and each plan provided funding for different services. In another instance, involving twins with developmental delays and similar levels of need, the plan for one child included support coordination while the plan for the other child did not. (sub. 116, p. 5)

Box 5.8 Why are good planning processes important?

Outcomes, benefits and equity

As discussed in chapter 1, financial sustainability is not just about costs. It is also about whether outcomes are being realised, and whether those who are paying for the scheme remain willing to do so (NDIA 2016h).

Poor planning processes can mean that scheme participants are allocated supports that are not right for them. This in turn can mean that many of the benefits of the scheme (such as increased quality of life, greater social and economic participation, and reduced need for other or future supports) are not fully realised. Poor planning processes can also result in greater variability in plans and outcomes for scheme participants with similar needs, compromising equity within the scheme. Together, these factors can undermine the credibility of, and community support for, the scheme as a whole — and hence its long-term sustainability.

Costs associated with reviews

Poor planning processes can result in plans that do not reflect the needs or expectations of scheme participants. Increased requests for plan reviews can add to the workload of planners. Review processes can also place greater stress on scheme participants and providers. As Occupational Therapy Australia said:

> … reviews can take months to complete, resulting in added frustration for families and potentially affecting the relationship between participant and provider. (sub. 15, p. 5)

Greater use of review processes can increase the administrative costs of the National Disability Insurance Agency, as well as costs in other areas. For example, appeals to the Administrative Appeals Tribunal or the Federal Court of Australia place a greater burden on the justice system (chapter 11).

Certainty about costs

Poor planning can introduce additional uncertainty about scheme costs (New South Wales Government, sub. 60, p. 15; PDA, sub. 38, p. 9).

- Poor planning processes can be unreliable — that is, they do not yield consistent results across time, individuals and situations. This increases the variance in the value of support packages, increasing the unpredictability of scheme costs overall.
- Poor planning increases the likelihood that participants' plans do not match their needs and expectations. This can contribute to underutilisation of plans, driving a wedge between committed and actual support funding.

Greater uncertainty around scheme costs can undermine the accuracy of cost projections, which can make it difficult for governments to plan for the future of the scheme. High variability of scheme costs also increase the risk of cost blowouts.

Market development

The supply of disability supports needs to grow significantly to meet the needs of NDIS participants. Plans specify what supports will be funded by the NDIS, which directly impacts the demand for different types of supports. This, in turn, encourages certain types of supports to be supplied in the market. Good planning processes are necessary to ensure that the signals sent to the market are those that lead to the supply of the supports that best meet the needs of people with disability.

The NDIS is a major reform and the NDIA has been given a monumental task under highly ambitious timeframes (chapter 2). Many of the NDIA's decisions about how to operationalise the planning process are influenced by bilateral estimates and community expectations around reaching new participants quickly. In addition, planning processes have had little time to mature.

However, there is real concern that some of the practices adopted to address the pressures of rollout will become entrenched in practice and in the culture of the NDIS, with implications for the long-term costs and benefits of the scheme.

The following sections discuss the key concerns raised by study participants, and policy options for ensuring that poor practices do not become structural issues that continue to affect the operation of the NDIS in the medium and long term.

Engagement with scheme participants

Engaging with scheme participants during the planning process is important not only for ensuring that they receive the supports that are right for them, but also for the long-term success of the NDIS. Physical Disability Australia suggested that engaging with scheme participants is particularly important in the early stages of planning.

> Given that many planners are new to this type of work and may have limited lived experience of disability, the validity, reliability and accessibility of the processes they use to determine what constitutes an appropriate support package depends on deep engagement with participants, their families and supporters. (sub. 38, p. 7)

The planning process needs to be sufficiently 'deep' so that planners can obtain sufficient information about a participant for them to make a decision about reasonable and necessary supports that minimise lifetime costs, while also making the process person-centred and convenient for scheme participants and their carers. Involving families, carers, support workers and advocates in the planning process can also improve understanding of the functional impact of the participant's disability, their needs and the supports that they require (VCOSS, sub. 176, p. 16).

Concerns about rushed planning

The speed of transition, as set out in Bilateral Agreements, has placed a lot of pressure on the NDIA to finalise plans quickly. This has detrimentally affected the quality of the planning process. SCIA Australia said:

> The rush to get new participants into the scheme against bilateral agreements is proving to be a major headache for the Agency and is severely affecting the quality of first plans. (sub. 61, p. 3)

Similarly, United Voice said:

> Workloads and inadequate time to do the job is one of the most often cited concerns of our members. United Voice members are concerned that [planners] do not have time to do their job properly, that they rush from client to client preventing them from providing quality support. (sub. 118, p. 8)

Study participants also reported feeling that planning meetings are rushed (Flourish Australia, sub. 74, p. 3; Hannah Potapczyk, sub. 26, p. 1; Jennifer Smith-Merry, sub. 55, p. 2; Leadership Plus, sub. 128, p. 2; Maurice Blackburn Lawyers, sub. 58, p. 13; New South Wales Government, sub. 60, p. 15). Engagement with scheme participants during the planning process appears to be fairly superficial, and the NDIA (sub. 161, p. 11) accepted that the focus on throughput during the first two quarters of transition has contributed to poorer plans.

Phone planning

Most planning conversations are now taking place over the phone, although face-to-face meetings are accommodated if required. The NDIA (sub. 161, p. 12) explained that this was a deliberate decision to allow people to enter the scheme as quickly as possible, with provision for scheme participants to consider how they will use their supports and amend their goals over the first year.

This decision was based on trial experience that recognised that people want to join the scheme as soon as they can, but also want time to think about their goals, supports and how they will use them. While it is recognised that this approach is not perfect, it was designed as a short-term measure to meet both of these objectives (NDIA, sub. 161, p. 12).

Study participants overwhelmingly expressed dissatisfaction with this approach to planning,[40] and many provided examples of poor experiences (box 5.9).

Carers Australia Victoria also identified issues with:

> … limited access to supporting documentation whilst on the phone; limited time to properly consider goals and aspirations; confusion about who they are being contacted by and for what; whether the plan will be as comprehensive as it could have been if the participant had the opportunity for a face-to-face meeting; the ability for the planner to recognise opportunities for capacity building. (sub. 131, p. 8)

[40] Study participants who were critical of phone planning included: Activ (sub. PP302); ADACAS (sub. 87); AFDO (sub. PP325); AHPA (sub. 37); ALA (sub. PP257); Alzheimer's Australia (sub. 10; sub. PP313); Australian Red Cross (sub. PP258); The Benevolent Society (sub. PP334); Brain Injury SA (sub. 116); Carers Australia Victoria (sub. 131); CMHA (sub. 9); ECCV (sub. 31); ECIA (sub. PP301); Flourish Australia (sub. 74); Inclusion Melbourne (sub. PP207); Legal Aid NSW (sub. PP245); Macarthur Disability Services (sub. 57); Maurice Blackburn (sub. PP309); Mental Health Community Coalition of the ACT (sub. 135); OPA (sub. PP241); OTA (sub. 15; sub. PP285); PDCN (sub. 29); PDA (sub. 38); SAL Consulting (sub. PP304); The Shepherd Centre (sub. 107); Social Support & Precarious Workforce Research Discussion Group (sub. 71); SUFY (sub. PP242); VALID (sub. PP332); VCOSS (sub. 176); Vision Australia (sub. 252); VMIAC (sub. 167); YDAS (sub. PP262); and YPINH (sub. PP326).

Box 5.9 Experiences with phone planning

Alzheimer's Australia:

> Annie called the Parkinson's 1800 support line as she worried about an over the phone NDIS planning session that had taken place earlier that day. Annie's volume and quality of speech has been impaired due to Parkinson's and she also requires longer to respond to questions. She felt rushed and because her response is delayed she felt that the assessor didn't get a clear indication of her needs. Annie and a Parkinson's Nurse Specialist were able to take the time [to] put information together in order to apply for a review for Annie's plan. (sub. 10, p. 8)

Ethnic Communities' Council of Victoria:

> … anecdotal evidence from advocates and providers in the North Eastern Melbourne Region indicates that some participants are not being adequately informed about the purpose of phone contact by the NDIA or their LAC. These participants are having plans being completed without realising that they are engaging in the process or providing informed consent. (sub. 31, p. 1)

Carers Australia Victoria:

> I received a telephone call from an NDIA representative and requested a face-to- face meeting … The planner requested information regarding my son and said there were notes from his case manager which would be used to help create his plan. I inquired about the case manager, as I was not aware my son had one. The name given was of a man I had spoken to about 20 years ago. The planner said they have all his needs documented. I reiterated the need for a face-to-face meeting to discuss our changing circumstances and the support that my son needs to live independently and future support needs. I was offered a meeting three days later, 90km from my home, which was not possible for me to attend. When I received a follow up call, I thought it was to schedule another time for a meeting, instead it was to tell me that a plan had been created for my son and that I should login to the Portal to see it. A week later I received a copy of the plan in the mail. The plan contained information about my son from over 20 years ago. (sub. 131, p. 9)

Some felt that phone planning limits engagement with the scheme participant and does not allow the planner to see the full picture. For example:

> [Phone planning] is a transactional and blunt approach at a critical stage of a participant's navigation and interaction with the scheme … We feel utilization of phone-planning also creates assumptions of living situation by planners, who are unable to adequately capture the requirements and considerations of participants and respect the role of family, carers and other persons who are significant in the life of the participant. (Social Support & Precarious Workforce Research Discussion Group, sub. 71, pp. 2–3)

And:

> … an assessment completed by phone does not take the person's disability into account and fails to provide the added awareness and accommodation that are possible in a face-to-face meeting. Planners ask questions over the phone, which sometimes assume ability that does not exist. However, this is not evident to the planner because they are not with the person being assessed. They also lack the ability to make observations about the situation of the participant at the time of the phone call, which may involve distractions. (Brain Injury SA, sub. 116, p. 9)

Blind Citizens Australia (sub. 130, p. 3) also said that conducting meetings over the phone 'severely compromises the ability of people who are blind or vision impaired to demonstrate

the difficulties they may face with completing tasks like reading, navigating the environment or household chores'.

Others expressed concern that phone planning takes scheme participants by surprise or does not allow participants to be supported by family, carers or advocates (Flourish Australia, sub. 74, p. 12). Physical Disability Council of New South Wales said:

> Phone plans … do not allow for participants to be supported simultaneously by carers or other important parties; physical sharing of important resources such as weekly planners or aspirational plans; equal access for peoples with specific communication needs; or allow planners to observe physical cues and surroundings for possible supports or equipment needs. (sub. 29, p. 3)

Phone planning is especially problematic for scheme participants with particular accessibility requirements (discussed below), such as mental illness (CMHA, sub. 11, p. 6; Flourish Australia, sub. 74, p. 3), cognitive impairment and neurodegenerative diseases (Alzheimer's Australia, sub. 10, p. 5) or people of culturally and linguistically diverse backgrounds (ECCV, sub. 31, p. 1; VCOSS, sub. 176, p. 9).

The Commonwealth Ombudsman reported that the bulk of complaints he had received about the planning process were from people who participated in phone planning. The Ombudsman suggested that it would be useful to compare the outcomes, satisfaction and review rates of face-to-face and phone planning discussions, noting that:

> While phone meetings likely provide the most cost effective method for planning when only simple administrative overheads are considered, there may be merit in considering whether — if participants who have phone meetings are more likely to subsequently complain or seek review — the time spent on those subsequent interactions detracts from the cost effectiveness of planning by phone. (sub. 137, p. 8)

The Northern Territory Government also said that better outcomes were achieved when face-to-face planning was used.

> In the NT, the planning processes negotiated through the Bilateral Agreement between the Commonwealth and NT to transition the NDIS allow for a more … intimate planning process, with NDIA planning meetings occurring face-to-face and with a representative from the participant's service provider. This also ensures a comprehensive handover and in remote parts of the NT, particularly in remote Aboriginal communities, this approach has been working well. (sub. PP359, p. 6)

Some study participants argued that phone planning should only be used at the request of the scheme participant (Amaze, sub. PP281, p. 6; CMHA, sub. PP270, p. 5; Cohealth, sub. PP261, p. 2; Parkinson's Australia, sub. PP232, p. 3; YDAS, sub. PP262, p. 3). In its submission, the NDIA (sub. PP327, p. 25) stated that it is moving towards using face-to-face planning as a default approach, in response to feedback from scheme participants.

Consulting with participants about plan content

Consulting with scheme participants and their family, carers and advocates is essential to the success of the planning process. However, the Commission heard that, in many instances, scheme participants were not consulted about the content of their plan.

In particular, scheme participants were not permitted to view plans before they were finalised. Community Mental Health Australia said:

> Clients are generally not permitted to see a plan before it is finalised, which anecdotally providers state is hindering clients understanding of their plan … There are incidents where people don't know what they are going to get until the plan is submitted — and there is currently no opportunity to take time to consider the plan before it is finalised. (sub. 11, pp. 3, 11)

Several study participants said that scheme participants should be able to view and comment on their draft plans before they were finalised (CSSA, sub. PP278, p. 3; Family Advocacy, sub. PP346, p. 7; Inclusion Melbourne, sub. PP207, p. 12, Vision Australia, sub. 252, p. 3). National Disability Services explained:

> During the trial phase of the NDIS, participants were invited to comment on their draft plan before it was finalised. That practice has largely ceased. The consequence is that participants can end up with a plan that doesn't reflect their needs and goals. Some participants receive plans they don't recognise. Consistent with the NDIS's focus on choice and control, participants should always have the opportunity to comment on their plan before it is finalised. (2017a, p. 7)

It may be the case that calls for scheme participants to see draft plans are symptomatic of broader concerns about a lack of consultation during the planning process. Poor consultation and communication appear to have resulted in scheme participants being surprised by, or confused about, the content of their final plan. Sufficiently deep consultation practices need to be built into the NDIA's planning process, so that plans adequately meet participants' support needs.

A formal process for allowing scheme participants to view and comment on draft plans could mitigate some of the issues arising from inadequate consultation, but would not address the problem directly. A more direct approach could be to improve consultation and communication with participants during the planning process. This should be accompanied by a process for making minor amendments or adjustments to draft plans (recommendation 5.1), so that errors can be easily corrected.

There also appears to be limited consultation about the length of plans. At present, plans typically run for 12 months, with only a small number of plans made for more than a year. For many scheme participants, shorter plans represent an opportunity to frequently assess whether their allocated supports are in line with their needs. But longer plans may be appropriate for participants whose needs are relatively stable and predictable. Some study participants expressed a preference for longer plans (Autism Association of Western Australia, sub. PP219, p. 11; Name withheld, sub. PP215, p. 4). Greater consultation and flexibility around the length of plans would promote individualisation and choice and control

in the planning process. Decisions about when a plan should be reviewed should take into account the participant's preferences and circumstances, including the stability and predictability of their needs.

The lack of participant involvement is not confined to first plans. Several study participants said that consultation around subsequent plans was also inadequate. Some reported that first plans were simply being 'rolled over' (CPSU, sub. 76, p. 9; HSU, sub. 132, p. 12). For example, the Summer Foundation recounted a mother's experience with her child's third plan.

> No actual review took place and her daughter received a 'form' letter advising that her plan would continue 'as was' for the next 12 months and if she required any changes to apply for an internal plan review within 3 months of receiving this letter! This letter was not even signed! (sub. 113, p. 21)

Others, however, said that requests to have a plan 'rolled over' were ignored.

> In February I was contacted by an NDIA employee to have my plan review early. I tried to ask for it to be rolled over as I had not been able to fully activate the plan. I explained about the portal being down for months which was experience[d] by a large number of service providers. This person would not consider this and proceeded to state I was to be reviewed by phone. (Tricia Curley, sub. 140, p. 4)

Under the current timetable, the NDIA is required to complete a large number of plans in a relatively short period of time, and this has influenced how planning processes are undertaken. However, it is essential that the NDIA undertakes its planning function adequately and in a way that does not undermine the objectives of the scheme. An increased focus on the quality of the planning process will no doubt make it more difficult for the NDIA to keep to the timetable set out in the Bilateral Agreements. But if the quality of plans is compromised because of a focus on participant numbers, this will undermine the effectiveness of the scheme and have implications for long-term costs.

For this reason, it is important that the NDIA's performance is measured based on whether and how effectively it is realising outcomes under the NDIS, rather than just participant numbers (chapter 11). A greater emphasis on reporting on the quality of planning processes will help shift the focus towards better quality plans and give the NDIA the incentive and latitude to focus on participant experience and outcomes.

Accessibility of the planning process

A lack of clear and transparent information

Study participants expressed frustration about the lack of clarity and transparency around the planning process.[41] Noah's Ark, for example, said:

> … there is no information about the planning process and how it is supported in the public domain. There has been a significant change in how plans have been written. These changes have not been documented or an explanation provided. (sub. 108, p. 9)

Mamre Association also said there is a lack of consistency with clear, concise and factual information.

> It is often left up to the general disability sector to try to navigate their way through 'forensic' investigation as to what the information means. There simply is very little capacity within the sector itself to invest in something so time consuming. (sub. 47, p. 1)

And Family Advocacy (sub. PP346, p. 10) said scheme participants experienced difficulties understanding their plans because they were filled with jargon and not available in plain English. Vision Australia argued for better online information:

> The NDIS planning process, even with the new resources rolled out in the past few months, is opaque. Providers who already engage with the system and have a good understanding still struggle to explain it to participants. The NDIA website is confusing: something as simple as a '*the Six Steps to NDIS Success'* would be hugely beneficial, as the lack of a clear process or flowchart hampers participant understanding. (sub. PP252, p. 1)

Scheme participants and their carers need access to relevant, current and accurate information about the planning process that they can easily understand. But there appears to be limited information available to help scheme participants and their families, carers and advocates navigate the system. This is particularly problematic for scheme participants who do not have the time or capacity to navigate a complex and confusing system.

Scheme participants are also often not aware or informed about their rights and options. For example:

- some participants did not know that they could request a face to face planning meeting instead of phone planning (ADACAS, sub. 87, p. 15; Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 3)
- others were unaware of their entitlement to have an advocate present at their planning meeting — not having an advocate present can negatively affect outcomes for

[41] Participants who expressed concern about the lack of clarity and transparency around the planning process included: Autism Aspergers Advocacy Australia (sub. 178); DPO Australia (sub. 165); Flourish Australia (sub. 74); Inclusion Melbourne (sub. PP207); Mamre Association (sub. 47); Mental Health Community Coalition of the ACT (sub. 135); Name withheld (sub. PP215); Noah's Ark (sub. 108); SWAN Australia (sub. 86); and Tandem (sub. PP212).

participants with limited ability to self-advocate (ABF, sub. 48, p. 9; New South Wales Government, sub. 60, p. 15; Vision Australia, sub. PP252, p. 3).

A lack of information about review processes was also identified as an issue (Legal Aid NSW, sub. PP245, p. 9). For example, Brain Injury SA said:

> … information provided to participants about review is unclear and inadequate. There is minimal information about the process and no information about how or where participants can get help with a review … Further, Brain Injury SA has received anecdotal evidence from parents and guardians that NDIA has not been informing participants of their right to an internal review or external merits review through the [Administrative Appeals Tribunal]. (sub. 116, pp. 9–10)

The NDIA (sub. PP327, p. 26) acknowledged that 'participants have expressed the desire for greater transparency in the planning process and what is required of them'.

Planners are not easily reached

The Commission heard that planners were not identifiable and accessible to scheme participants (AHPA, sub. 37, p. 14; Family Advocacy, sub. PP346, p. 9; OTA, sub. 15, pp. 4–5). The Disability Services Commissioner said:

> Planners are not clearly identifiable and accountable. A participant told us that the planner got his plan wrong and he couldn't call the planner directly to talk about the issue. He raised further concerns that no one at the NDIA records his calls, so he feels he cannot escalate his complaint, as there is no record of his previous contact. (sub. 35, p. 5)

Brain Injury SA also said:

> The 1800 phone number is the only number provided to participants and service providers. Anyone wanting to speak to a planner, even in response to a message that has been left by the planner, must use this number … there is usually a 45 minute wait for calls to be answered. When the call is answered, there is no certainty that the call will be transferred to the relevant office or planner. (sub. 116, p. 10)

Planning processes are not inclusive for all

It is important that planning processes are accessible, inclusive, and sufficiently flexible to accommodate the needs of different scheme participants. This is especially true for participants with complex needs or from culturally and linguistically diverse backgrounds.

As the New South Wales Government said:

> Many NDIS participants that are participants of other state services (justice, mental health) do not have the capacity or capability to interact with the NDIS without intensive support. They may have no natural supports, like family or friends in their lives; they may have family that do not support their best interests; or they may have limited experience as consumers generally and may not be able to exert their rights as participants in the NDIS. Some people with complex needs

> may not be able to define their needs or understand what reasonable and necessary supports they would need to support them. (sub. 60, p. 17)

Planning processes need to be sensitive to the intersection between disability and other social issues, such as homelessness, family violence, and alcohol and other drug use. Study participants also highlighted the importance of providing gender-responsive services (ACT Government, sub. 156, pp. 28–9; DPO Australia, sub. 165, p. 14; Leadership Plus, sub. 128, p. 2; Richard Kennedy, sub. 2, p 2; VCOSS, sub. 176, p. 10; Women with Disabilities Victoria, sub. 111, p. 2).

Needs arising from disability

Many study participants said that planning processes are not inclusive and overlook the needs of people with disability. Sharing Places said:

> People with intellectual disabilities and very high and complex support needs are not understood by NDIA. People with high and complex needs would greatly benefit from a more in depth assessment and planning process. (sub. 53, p. 2)

Communication accessible processes are also important for people with vision or hearing impairment (ABF, sub. 48, p. 9; Deafness Forum of Australia, sub. 127, pp. 16–7; Speech Pathology Australia, sub. 136, pp. 28–9). But Australian Blindness Forum said:

> … participants in the NDIS cannot access any NDIS information in alternative formats. This means that people who are blind or vision impaired cannot independently register themselves with the NDIS or read their own plans. (sub. 48, p. 9)

Vision Australia (sub. PP210, p. 7) called for plans, information and forms to be made available in a wider range of formats, including braille, to ensure that information is accessible for scheme participants.

Planning can also be challenging for people whose needs can change quickly — such as episodic or progressive disorders. Study participants identified psychosocial disability (box 5.10) and degenerative disorders (box 5.11) as particular problem areas.

Language and cultural barriers

Study participants observed that planning processes do not adequately cater for people of different cultural and linguistic backgrounds (Companion House, sub. 84, p. 2; Jesuit Social Services, sub. 117, p. 3; Neami National, sub. 63, p. 6; Northern Territory Government, sub. 205, p. 7; Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 6; VCOSS, sub. 176, p. 9; VMIAC, sub. 167, pp. 6–7).

Box 5.10 Mental illness and psychosocial disability

The National Disability Insurance Scheme is designed to cover disabilities that are permanent, including those of a chronic episodic nature, such as mental illness and psychosocial disability.

> 'Permanent' refers to the irreversible nature of the disability, even though it may be of a chronic episodic nature. For example, this would include people with significant and enduring psychiatric disabilities, who periodically rely exclusively on support from the clinical services of the mental health system, but at other times are able to live in the community provided they have appropriate supports. (PC 2011, p. 14)

However, the episodic nature of mental illness can mean that some scheme participants' needs are unpredictable. To some extent, this runs contrary to the planning process, which, in broad terms, requires a forecast of the participant's support needs over the life of the plan.

This problem is exacerbated by 'inflexibility in changing arrangements in response to fluctuations in support need because of escalating illness' (Mind Australia, sub. 144, p. 8). This can create incentives for participants to overstate their support needs, so that they can be sure that they have access to adequate support during times of high need.

Due to the nature of their disability, people with psychosocial disability may at times find it difficult to articulate or disclose their support needs during the planning conversation (Anglicare Tasmania, sub. 145, p. 32; VMIAC, sub. 167, p. 7; VICSERV, sub. 169, p. 4). For this reason, such participants 'may need more than one meeting to develop plans due to [the] fluctuating nature of conditions' (Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 6).

Box 5.11 Progressive and degenerative disorders

Study participants said that certain progressive or degenerative disorders sat poorly with the 'investment approach' of the scheme. For example, Neurological Alliance Australia said:

> … the progressing and complex needs of people with neurodegenerative diseases have been overlooked due to lack of understanding of these diseases or for the sake of expediency … People with a progressive neurological disease run counter to the 'traditional' trajectory of someone on the NDIS: that is, an ability to enhance independence and re-ablement through a more effective engagement of services. For someone with a neurodegenerative disease, however, care needs inevitably increase over time. (sub. 30, pp. 1–2)

In addition, current planning processes do not account for the changing needs of people with progressive or degenerative disorders. Calvary Health Care Bethlehem said:

> For people with progressive disorders, the person's needs can change more rapidly than expected, so there needs to be sufficient flexibility in the plan being reviewed and amended to accommodate unforeseen needs arising. This needs to happen in a timely manner. (sub. 64, p. 2)

Similarly, MND Australia said:

> Plans are based on the 'now' and do not take account of the rapid and increasing needs caused by the progressive degenerative nature of [motor neurone disease], requiring review planning earlier than is necessary. (sub. 45, p. 9)

MND Australia (sub. 45, p. 7) also reported that between June 2016 and January 2017, all plans for people with Motor Neurone Disease in New South Wales and the ACT required review, primarily due to a poor understanding by planners of degenerative diseases.

For many, language barriers can prevent meaningful engagement with planning processes. Neami National (sub. 63, p. 6) said that 'consumers without English as their first language describe difficulties in participating in planning and in getting plans that they can fully implement on account of their language needs'. This is an issue which disproportionately affects Aboriginal and Torres Strait Islander communities:

> English is a second language for many Indigenous people in remote communities. The majority of participants in Barkly identify as being Aboriginal or Torres Strait Islander and for 67% English is not their first language. Many have limited capacity to understand or read it. This has a significant impact on their ability to have genuine input into the formulation of their plans and also impacts on decision making and choice. (Brain Injury SA, sub. 116, p. 3)

And those of refugee background:

> People with disability from a refugee background are often not well equipped to navigate the NDIS in planning meetings and to negotiate a package of supports from providers. Many have little or no understanding of the context of the broader social support system in Australia. (Companion House, sub. 84, p. 2)

Cultural barriers can also make accessing and interacting with the planning process difficult. In particular, there may be confusion about the purpose of planning conversations and there is a risk that scheme participants do not communicate their needs due to different cultural or social norms. (Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 6). There may also be greater mistrust of government services or an aversion to sharing personal information (VCOSS, sub. 176, p. 9).

Access can be especially difficult for some Aboriginal and Torres Strait Islander communities. Brain Injury SA said:

> Many Aboriginal people can be transient in nature and to uphold their cultural requirements. Therefore, participants are not in regular receipt of mail or telephone communication. In the Barkly region there is no mail delivery to homes and most people do not regularly check their PO Box. If they do not receive a hard copy of their plan they are advised to go onto the portal and get it online. However, many do not have access to computers, nor the awareness of how to use them. Consequently, many participants do not know they have a plan or, if they do, what is in it. (sub. 116, p. 3)

The Australian Medical Association emphasised the need to have culturally appropriate processes and cited evidence of poor planning practices.

> … we were told that in one Aboriginal community, NDIA assessors did not leave their vehicle, instead they yelled questions of Aboriginal people regarding their disabilities … there was no verification of the person's identity other than to ask their name and conduct a conversation from a driveway. Another reported case was that Aboriginal people with disability were asked to leave their homes and find their way to a waiting vehicle for an assessment; this included an Aboriginal person in a wheelchair. (sub. 120, p. 5)

The role of pre-planning support

Pre-planning support can help participants navigate a confusing and complex system. Pre-planning support is directed at helping the participant prepare for the planning conversation, including:

- thinking about their goals and aspirations
- preparing documentation to support the assessment process
- thinking about what supports are available and can help them.

Demand for pre-planning support services is influenced by how accessible and complex planning processes are, as well as the scheme participant's capacity (including their ability, willingness, skills and resources) to navigate those processes (chapter 10). Pre-planning support is provided by a range of different organisations, including advocacy groups and service providers.

Several study participants noted that pre-planning assistance is costly to provide (House with No Steps, sub. 104, p. 5; Mamre Association, sub. 47, p. 2; VICSERV, sub. 169, p. 4). Some argued that the NDIA should do more in the area of pre-planning support (ADACAS, sub. 87, p. 16; CMHA, sub. 11, p. 10; Cohealth, sub. 50, p. 10). Others called for governments to provide additional funds to facilitate pre-planning support (Amaze, sub. 160, p. 5, sub. PP281, p. 7; Cohealth, sub. 50, p. 10; NSW Disability Network Forum, sub. 18, p. 3; Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 9).

Pre-planning services are one of the core functions of LACs. During transition, LACs were meant to be 'on the ground' in each area six months before the NDIS was rolled out in that area, in part to provide pre-planning support. However, the speed of the rollout has meant that this was not possible and LACs have not undertaken the pre-planning functions as envisaged (NDIA, sub. 161, p. 56). The NDIA needs to have LACs in place so they can provide pre-planning support.

There is also scope for the NDIA to improve transparency and clarity around planning processes. This includes providing clear and up-to-date information about what to expect during the planning conversation, when it will occur, and how the information gathered during that conversation will be used. The planning process could also be made more accessible, especially for people with complex needs and those with different cultural and linguistic backgrounds.

These changes could reduce the need for extensive pre-planning support, and relieve some of the pressure on advocacy groups and service providers to provide such services.

The NDIA is currently undertaking a review of the participant pathway to identify what changes or improvements should be made to planning processes (while achieving the number of completed plans as specified in Bilateral Agreements) to achieve plans that:

- maximise choice and control for scheme participants and contribute to improved participant outcomes
- are of a high quality in terms of a positive participant experience, compliance with all statutory requirements and consistency
- are financially sustainable so that the aggregate value of all plans remains within the funding envelope (sub. 161, p. 4; sub. PP327, p. 22).

However, the NDIA is operating under demanding time and resource constraints, and there are trade-offs between the quality of planning processes and how quickly the scheme can reach new participants. As noted earlier, better planning processes could involve compromises in terms of participant throughput.

RECOMMENDATION 5.2

The National Disability Insurance Agency should:

- review its protocols relating to how phone planning is used
- provide clear, comprehensive and up-to-date information about how the planning process operates, what to expect during the planning process, and participants' rights and options
- ensure that Local Area Coordinators are on the ground six months before the scheme is rolled out in an area and are engaging in pre-planning with participants.

Planners

Planners are an essential part of the planning process and exert considerable influence on scheme participants' experiences within the NDIS. Sufficiently skilled and impartial planners can improve the quality of the planning process and outcomes for scheme participants. As ACT Disability, Aged and Carer Advocacy Service said:

> It is crucial that the NDIA continue to recruit planners with the right combination of skills, experience and passion, that they offer good training and that workload pressures for NDIA staff are managed. Planners need the skills to be able to tailor the planning approach, and their communication style to participants with different needs … (sub. 87, p. 13)

Conversely, planners with less experience, skill or training can have a detrimental effect on the quality of plans and participant outcomes. This is because they may have less knowledge about what supports are appropriate, meaning that plans may include inappropriate supports or fail to include appropriate ones (Brain Injury SA, sub. 116, p. 5).

Impartial planners are also important for scheme participants' experience of the planning process and the quality of plans. As one study participant said:

> The planners can have a great impact both positive and negative on the resulting plans. The planners biases also have an impact on both the discussion and resulting plan of a participant. For two years, the planner I had, put me in a box and thought she knew what and how I wanted supports. She would not listen until I had a panic attack in the meeting. It was only then she started listening. (Hanna Potapczyk, sub. 26, p. 1)

Skills, training and knowledge of specific conditions

A number of study participants were critical of the skills, experience and training of planners as a whole (Carers Australia Victoria, sub. 131, p. 12; DAA, sub. 119, p. 3; Legal Aid NSW, sub. PP245, p. 9; Matt Burrows, sub. 7, p. 3; Mental Health and NDIS Facebook Support Group, sub. 8, p. 3). The Public Service Research Group reported feedback that:

> There's not adequate induction support and supervision training provided to the people who are doing the planning … If we can't get the planning right we're not going to get the scheme right. (sub. 56, p. 6)

Speech Pathology Australia (sub. 136, p. 28) also noted that information about the level of qualifications and training required of planners is not publicly available. And many participants expressed concern about planners' limited disability knowledge.[42] For example, the Australia Physiotherapy Association said:

> Our members report that service planning is being undertaken by staff who have little competence in the specific field of disability relevant to the participant's needs and thus that service plans are at odds with the needs which the NDIS is designed to meet. (sub. 93, p. 13)

In particular, the Commission heard concerns that planners had limited knowledge about specific conditions (box 5.12), such as motor neurone disease, multiple sclerosis and dementia, Prader-Willi Syndrome, autism and Parkinson's Disease.

The Commonwealth Ombudsman reported that:

> Some stakeholders have told us about planners who asked parents when their child was likely to 'recover' from a life-long disability, and others who told people with psychosocial disabilities they should 'try to be more positive'. (sub. 137, p. 8)

[42] Study participants who commented on planners' limited disability knowledge included: AASS (sub. PP330); ABF (sub. 48); ACIA (sub. 141); AHPA (sub. 37); Alzheimer's Australia (sub. 10, sub. PP313); Amaze (sub. PP281); Anglicare Tasmania (sub. 145); APA (sub. 93); APodC (sub. 52); Belinda Jane (sub. 80); Cheryl McDonnell (sub. 79); CMHA (sub. 11); Cohealth (sub. 50); Commonwealth Ombudsman (sub. 137); DPO Australia (sub. 165); Macarthur Disability Services (sub. 57); Macular Disease Foundation Australia (sub. 75); Mental Health Australia (sub. 155); Mental Health Community Coalition of the ACT (sub. 135); Mind Australia (sub. 144); MJD Foundation (sub. PP233); MND Australia (sub. 45); Neami National (sub. 63); OPA (sub. 46); OTA (sub. 15); Parkinson's Australia (sub. PP232); PWSAA (sub. 112); VICSERV (sub. PP284); Vision Australia (sub. PP210); and VMIAC (sub. 167).

Box 5.12 Concerns about planners' limited knowledge of specific disabilities

MND Australia:

> LAC's do not have the expertise to support people with MND [motor neurone disease] … They have no understanding of MND and the disability it creates. They attempt to plan via a telephone conversation, when speech and communication can be one of the early losses created by MND … Several people in Victoria had plans developed by the LAC planner that did not include assistive devices — even though the participant was sitting in a wheelchair at the time! … Face to Face meeting with NDIS planner with experience in complex neurological conditions is imperative. (sub. 45, pp. 8–9)

Alzheimer's Australia:

> NDIS planners, while eager to assist, have very limited knowledge of younger onset of dementia and Alzheimer's disease, and minimal information on what services a client with progressive functional decline may need. They also lack the capacity to estimate the number of hours of support and appropriate resourcing that would be required. (sub. 10, p. 16)

Amaze:

> Concern has been expressed to Amaze about planners and LACs lack of understanding of how a participant's autism may impact on their engagement in the planning process, for example by limiting their capacity to comprehend long verbal advice in planning meetings, to understand the specific intent/meaning of questions asked and provide appropriate and complete answers. (sub. PP281, p. 11)

Prader-Willi Syndrome Association of Australia:

> Anyone acting as a Planner for a person with PWS should be properly informed about the complexity of the condition, *plus the types of risks likely to arise within the planning process*. (PWSAA, sub. 112, p. 4)

Autism Advisory and Support Service:

> Most planners come from an administrative background and have no educational experience or lived experience of what disabilities are (we are often asked what is Autism by planners) nor understand relevant questions to ask in order to extract meaningful data from participants or their families. (sub. PP330, p. 4)

Mental illness and psychosocial disability were also areas of concern among study participants (CMHA, sub. 11, pp. 9–10; Cohealth, sub. 50, p. 10; Macarthur Disability Services, sub. 57, p. 4; Mental Health Carers Australia, sub. 181, p. 10; Neami National, sub. 63, p. 6) and the Joint Standing Committee on the NDIS found that planners had insufficient knowledge about psychosocial disability (JSCNDIS 2017c, p. 26).

Planners, according to a number of study participants, also have limited knowledge of appropriate supports for certain conditions, such as the role of occupational therapists (OTA, sub. 15, p. 4), prosthetics (AOPA, sub. PP294, p. 2), specialist disability accommodation (Quality Living Options Bendigo, sub. PP220, p. 1) and podiatry (APodC, sub. 52, p. 2). VCOSS gave the example of:

> … a deaf participant with cochlear implants [being] allocated two hearing aids in their package, despite hearing aids being ineffective for people with cochlear implants. (sub. 176, p. 12)

The Commission also heard that planners are ill-equipped to connect scheme participants with employment supports (House with No Steps, sub. 104, pp. 5–6; Round Squared, sub. 170, p. 3).

Study participants overwhelmingly agreed that planners performed better when they understood what needs arise from a person's disability. As Community Mental Health Australia said:

> If a planner understands the depths of a person's disability and what is needed to support the individual, the package developed will suit them over a longer term. This reduces the need for a plan to be amended in the future, thereby reducing administrative burden on the NDIA and building confidence in the process for the consumer. (sub. 11, p. 4)

Australian Lawyers Alliance (sub. PP257, p. 8) suggested that planners being familiar with disabilities can speed up the planning process while also better meeting participants' needs.

Improving planners' performance

Planners should, at a minimum, have a general understanding about different types of disability. Several study participants called for planners to receive more education on specific conditions and supports (Alzheimer's Australia, sub. 10, p. 13; Cheryl McDonnell, sub. 79, p. 2; CMHA, sub. 11, p. 4; Cohealth, sub. 50, p. 5; CPSU, sub. PP310, p. 5; Neami National, sub. 63, p. 6; NSW Government, sub. PP230, p. 4; PDA, sub. PP306, p. 3; PWSAA, sub. 112, p. 4; Vision Australia, sub. PP210, pp. 3, 8).

Specialised planners

Study participants also saw a role for specialised planners,[43] such as for people with psychosocial disability. For example, Mental Health Australia said:

> Mental Health Australia supports … a specialised planning team for psychosocial disability. This should be well supported by improved training for planners and oversight of the planning process to ensure consistency and improved outcomes. (sub. PP321, p. 22)

Similarly, Parkinson's Australia argued that scheme participants with progressive neurological conditions would also benefit from specialised planning teams.

> To offer true choice and control [to scheme participants with Parkinson's], NDIS planners must have knowledge of the condition, understand its disabling impact on participants so the unique needs of people living with Parkinson's can be addressed in individual plans. It is strongly recommended that participants with progressive neurological condition[s], such as Parkinson's and atypical Parkinson's conditions, be managed by specialised planning teams that have a good

[43] Study participants who supported planner specialisation included: AASS (sub. PP330); ABF (sub. PP263); Allianz Australia Insurance (sub. PP265); Amaze (sub. PP281); Anglicare Australia (sub. PP339); ALA (sub. PP257); CSSA (sub. PP278); Cohealth (sub. PP261); DAA (sub. PP292); Legal Aid NSW (sub. PP245); Mental Health Australia (sub. PP321); MND Australia (sub. PP255); Noah's Ark (sub. PP328); Neami National (sub. PP347); OPA (sub. PP241); Parkinson's Australia (sub. PP232); Speech Pathology Australia (sub. PP303); Summer Foundation (sub. PP293); Tandem (sub. PP212); Tasmanian Government (sub. PP247); VALID (sub. PP332); VCOSS (sub. PP264); Women with Disabilities Victoria (sub. PP282); and YPINH (sub. PP326).

> knowledge and understanding of these conditions and the support and care that is required. (sub. PP232, p. 9)

MND Australia (sub. PP255, p. 7) observed that planners specialising in progressive neurological conditions were used at Victorian trial sites for some time, and believed that this approach worked well.

It is the Commission's view that there is value in having specialised planning teams for some types of disability. This approach is in line with industry practice for insurance companies. For example, Allianz Australia Insurance (sub. 42, p. 6) submitted that, in the context of workers' compensation claims, it employs specific psychological claims teams, given the unique nature of mental health related claims.

The NDIA said that it is currently undertaking work to:

> … enhance workforce capability over the short, medium and longer term. This will include ensuring an enhanced understanding of a wider array of disabilities, as well as employing specialists to work with participants in areas such as intellectual and psychosocial disabilities and degenerative conditions. (sub. PP327, p. 27)

Specialised planning teams will require significant upfront investment, in terms of both the time and resources needed to upskill the planning workforce. However, specialised planning teams have the potential to improve the efficiency of the planning process and lower costs in the medium and long term (in terms of more appropriate supports for participants and fewer unexpected plan reviews from poor planning), especially if appropriate triage processes are put in place. Allianz Australia Insurance said:

> The personal injury sector manages [specialised planning teams] through expertise in triage processes which allow reasonable consideration for the allocation of resources and treatment for an injured claimant. For example, within personal injury claims, insurers may have a team to fast track the management of low touch, minor injuries or a specialist psychological team to streamline the management of resources in an efficient and effective manner … With proper application of triage, the NDIA will benefit from effective resource allocation … (sub. PP265, p. 5)

Matching scheme participants with planners who are suitably trained and knowledgeable about their support needs should also result in better outcomes for participants.

Leveraging industry knowledge

An alternative (or complementary) approach is to leverage expertise from the disability support sector, including specialist disability organisations and service providers. National Disability and Carer Alliance said:

> Consumer-led organisations that specialise in particular disabilities have invaluable experience and expertise that currently remains under-utilised by the NDIA. The NDIA should draw on this expertise in both the development and implementation of training for planners. But beyond planning, this experience could be invaluable in resolving implementation issues more generally

> — such as the development of reference packages, in the development [of] further guidance on reasonable and necessary in the operational guidelines, or in effective communication to particular groups of participants. (sub. PP344, p. 7)

And National Disability Services said:

> The quality of planning would improve if disability service organisations were involved. Providers of specialist supports have deep knowledge of disability — and they know their clients. Using this knowledge to inform planning would make sense. This is particularly true for people with complex needs … Planning partnerships between the NDIA and specialist providers should be extended. (2017a, pp. 6–7)

There are a number of ways that sector involvement could be incorporated into planning processes, including:

- having industry and peak bodies provide input or general advice during the planning process (AOPA, sub. PP294, p. 1; Tandem, sub. PP212, p. 9)
- engaging specialist organisations to conduct seminars for planners and NDIA staff about different disability types and supports (APC Prosthetics, sub. PP244, p. 3)
- contracting specialist disability organisations to conduct specialist disability assessments (Macular Disease Foundation Australia, sub. PP243, pp. 2–3)
- greater sector involvement in the development of planning templates or reference packages and the review of assessment tools (Alzheimer's Australia, sub. PP313, p. 5; AOPA, sub. PP294, p. 2).

Leveraging industry knowledge will be especially useful where it is not feasible or cost-effective for the NDIA to develop in-house specialist knowledge (APC Prosthetics, sub. PP244, p. 3; Macular Disease Foundation Australia, sub. 75, p. 5). Such an approach would also mean that the NDIA would not need to compete with others in an already thin market to recruit planners with specialist qualifications or experience.

However, some study participants said that the NDIA was reluctant to involve service providers in the planning process (Anglicare Australia, sub. 157, p. 8; VICSERV, sub. PP284, p. 4). One reason for this reluctance was potential conflicts of interest. For example, APC Prosthetics said that they:

> … offered their services to conduct, free of charge, a half-day seminar for NDIA staff during the Hunter Trial. The offer was not accepted on the grounds of a possible conflict of interest. (sub. PP244, p. 3)

Several study participants also emphasised the importance of ensuring that sound processes for identifying and managing conflicts of interest are in place (Vision Australia, sub. PP252, p. 8; Women with Disabilities Victoria, sub. PP282, p. 6).

It is the Commission's view that the NDIA could make greater use of industry knowledge and expertise. The NDIA should adopt risk-based strategies for leveraging industry knowledge and expertise. This means that measures taken to manage conflicts of interest

should be proportionate to the probability and impact of the risks associated with those conflicts materialising.

A risk-based approach requires a flexible and innovative approach to sector involvement. This might mean that, in some instances, sector involvement is limited — but it also means that bypassing sector involvement is not an appropriate default approach. The overarching consideration for whether and how the sector should be involved should be how it affects outcomes for scheme participants.

Leveraging industry knowledge is relatively common in comparable schemes, such as the Lifetime Care and Support Scheme in New South Wales and the implementation of the NDIS in Western Australia. In many instances, the risks arising from conflicts of interest could be managed by ensuring that the process for involving industry players is transparent and that final decision-making powers are retained by the NDIA.

Performance monitoring

Over the longer term, satisfaction with planners could also be improved through monitoring and assessing their performance (OTA, sub. 15, p. 5; PDA, sub. 38, p. 7). According to the NDIA (sub. 161, pp. 89–90), planner performance is currently monitored through:

- participant satisfaction measures
- complaints, accounting for the volume and substance of complaints
- the National Quality Framework, where monthly audits are conducted on planner records and feedback provided through coaching and supervision.

Regular and public reporting around planner performance could help increase the accountability of planners, and improve community confidence in planners and the planning process.

RECOMMENDATION 5.3

The National Disability Insurance Agency should ensure that planners have a general understanding about different types of disability. For types of disability that require specialist knowledge (such as psychosocial disability), there should be specialised planning teams and/or more use of industry knowledge and expertise.

6 Boundaries and interfaces with the NDIS

Key points

- Effective interfaces between the National Disability Insurance Scheme (NDIS), other disability services and mainstream services are essential for good outcomes for scheme participants and the sustainability of the scheme. To provide the right incentives, services available to people who just qualify for the NDIS, and those who just miss out, should be as seamless as possible. This requires coordination of services within and outside of the NDIS.
- The Information Linkages and Capacity Building (ILC) program — designed to connect people with disability to appropriate services — is a key component of the NDIS. It is a false economy to have too few resources for ILC activities, particularly during transition when it is critical that people with disability (including those not eligible for the NDIS) are connected to services.
- For people with disability previously receiving support who are not eligible for the NDIS, the Australian, State and Territory Governments have agreed to provide continuity of support. In practice, there is confusion and uncertainty about what services will continue to be provided and/or funded outside the NDIS. Governments need to be clearer about their approach on continuity of care, and what disability services they will provide for non-NDIS participants.
- The NDIS is meant to work alongside mainstream services, not replace them.
  - The Bilateral Agreements delineate responsibilities for services to be provided by the NDIS and mainstream services.
  - While it is still too early to identify service gaps, there are emerging issues in a number of areas, including justice, emergency, transport and mental health services.
  - Each COAG Council with responsibility for a service area that interfaces with the NDIS should have a standing item on their agenda to address how these services interface with NDIS services.
  - ILC and Local Area Coordinators can play a role in ensuring mainstream services are better informed about their roles and responsibilities.
- There are aspects of the design of the NDIS, and how it interfaces with the aged care system, that create incentives for people to stay in the NDIS after the age of 65 years, and encourage people nearing the age of 65 years to apply for the NDIS. This raises some issues that will need to be addressed, but given the complexity involved, this should be done with the benefit of data from experience at full scheme. It should be reviewed as part of the review of scheme costs in 2023.
- The National Injury Insurance Scheme (NIIS) was envisaged to cover the care needs of individuals who newly acquire a disability through a catastrophic injury or accident. Two of the four streams proposed have been implemented. The contributions by the States and Territories should reflect the cost to the NDIS of participants who were intended to be covered by the NIIS — these will grow over time from a small base.

People with disability, and their families and carers rely on a wide range of services — including mainstream services, specialist disability services and community supports — for their care needs and to maintain the quality of their lives. For the National Disability Insurance Scheme (NDIS) to work efficiently and effectively, the interface between the scheme and other services need to be as seamless as possible. By design, the NDIS is intended to complement these other supports, not replace them. A requirement of any supports provided through the NDIS is that they are most appropriately funded through the scheme and not by other services.

While NDIS funding recognises that previously funding for people with disability was inadequate, the NDIS is not expected to fill *all* of the large service gaps that existed before the scheme was established. Providing services to people with disability remains a shared responsibility between all levels of government.

The interface between all services for people with disability will take time to clarify, but until these interfaces are settled, it is important that governments do not prematurely withdraw from services, as any gaps that emerge will place added burdens on people with disability and their families.

As interface issues become clearer, it is essential that incentives do not exist for individuals to prefer one system over another. It is important that people with disability do not see the NDIS as an oasis of support, surrounded by a desert, where little or nothing is available. Should such a dynamic develop, the financial pressures on the NDIS could be unsustainable, particularly if people feel the need to test their ability to qualify for the scheme, and/or remain in the scheme for as long as possible.

There is still a lot of detail to be worked through. That said, establishing clear and robust boundaries is essential for the financial sustainability of the NDIS and other services. When people are accessing the services they need, the system as a whole should be providing supports at the most efficient and cost effective level.

This chapter first looks at bridging and capacity building services provided under the NDIS (section 6.1), then at how the NDIS interfaces with other disability services (section 6.2). The interface between the NDIS and mainstream services is examined in section 6.3. How the NDIS interfaces with the aged care sector (section 6.4) and the National Injury Insurance Scheme (section 6.5) are also examined.

6.1 Linking people to the right services

About the Information, Linkages and Capacity Building program

The NDIS is just one part of a wider disability system. While the NDIS will benefit all Australians, only a proportion of people with disability will become scheme participants. Of the estimated 4.3 million Australians with disability, about 475 000 (those people with a

'permanent and significant' disability) will receive individualised supports under the NDIS (chapter 1, figure 1.1). As the National Disability Insurance Agency (NDIA) said:

> The NDIS is intended to benefit a wide range of Australians, only a proportion of whom will become participants and receive an individualised plan. … short-term or light touch assistance from the NDIS, in collaboration with a capable and inclusive community and mainstream response, can help them better access mainstream supports, build connections into community supports and strengthen natural supports in order to achieve their outcomes. (sub. 161, p. 53)

The NDIS is just one part of a broader suite of services relevant to people with disability (others include health, housing, education, transport, employment and justice).

Information and referral services are therefore vital to people with disability, their families and carers. For this reason, in 2011, the Commission recommended a bridging and capacity building service, known as Tier 2 supports, to assist anyone with (or affected by) disability, to connect to relevant disability, community and mainstream services (PC 2011, pp. 163-165, 198).

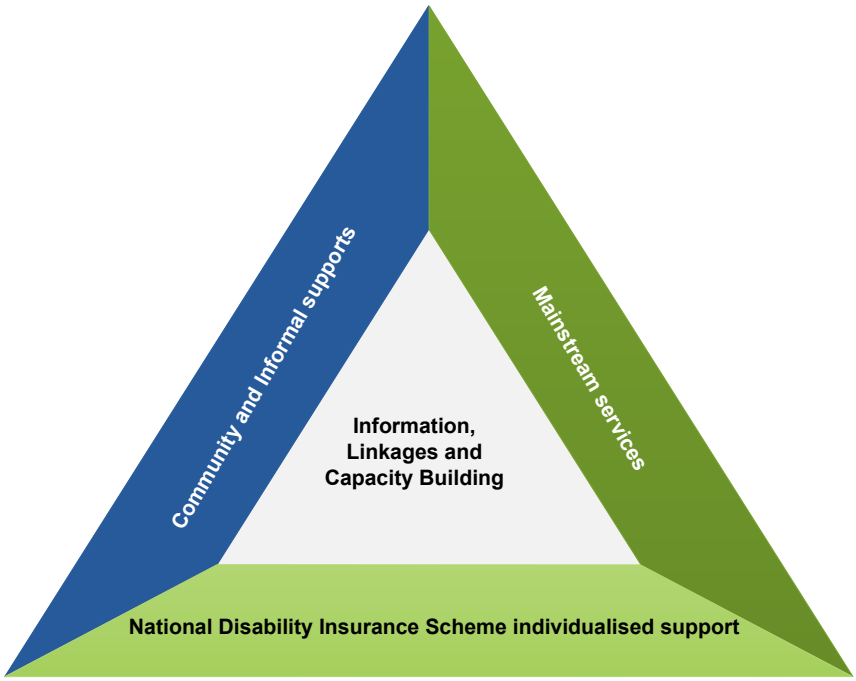
The main goal of Tier 2 supports was to strengthen the links between the community and people with disability. Some examples of Tier 2 supports envisaged by the Commission in 2011 included Local Area Coordinators (LAC) helping to link people with disabilities to local community groups (such as a sailing club), and web services to provide information and educate people about specific disabilities and where to seek help (PC 2011, pp. 13, 163-164).

In July 2017, the NDIA began rolling out the Information, Linkages and Capacity Building (ILC) program (effectively Tier 2 supports). ILC will provide information, linkages and referrals to people with disability, their families and carers, and help them connect with appropriate community and mainstream supports (NDIA 2017h). The focus of ILC is individual development and community inclusion. The NDIA said it is to:

> … build innovative ways to increase the independence, social and community participation of people with a disability. (2016d, p. 5)

ILC will also facilitate capacity building support and greater inclusivity by promoting collaboration and partnership with local communities and mainstream services (figure 6.1).

Figure 6.1 **Bridging services — Information, Linkages and Capacity Building**



Source: NDIA (2015a, p. 4).

ILC is designed to work with individualised supports. As the NDIS Community Inclusion and Capacity Development Program Guidelines put it:

> The NDIS has two parts:
>
> - Individualised NDIS plans for people with permanent disability has a significant impact on their ability to take part in everyday activities; and
> - Information, Linkages and Capacity Building (ILC).
>
> Both parts work together to support people with disability. It is important not to see ILC as something separate to the … success and sustainability of the NDIS. Ensuring people are connected into their communities, using the same services and participating in the same activities as everyone else will mean that, over time, people will rely less on specialist disability support. ILC also has an important role to play in supporting people with disability who do not have an NDIS plan. By providing appropriate support in the community, it will help make sure people only move into the scheme when necessary. (2016d, p. 4)

ILC is an important tenet of the NDIS insurance model, and is expected to reduce costs over time by:

- *reducing the demand for individualised supports* — ILC is a lever to divert people from needing to access individualised packages and instead connect them to the appropriate supports for their needs

- *reducing the need for supports through individualised supports* — ILC can maximise the ability of participants to access mainstream, community and informal supports, which in turn can reduce the need for funded supports (for example, targeted supports to assist a person to navigate the public transport system can reduce the need for funded taxi travel)
- *making supports more effective at helping people achieve their goals* — many supports are more effective in helping a participant achieve their goals when complemented by natural (informal) and community support (for example, a fitness goal is more likely to be achieved if funded support to use gym equipment is complemented by an inclusive gym community or a friend for companionship and motivation) (NDIA, sub. 161, p. 54).

In August 2015, COAG endorsed the ILC Policy Framework (NDIA 2015a). The framework describes five streams to achieve the objective of ILC.

- Information, Linkages and Referrals (activity 1) — connecting people with disability, their families and carers with appropriate disability, community and mainstream supports.
- Capacity building for mainstream services (activity 2) — ensuring people with disability connect with and access mainstream supports.
- Community awareness and capacity building (activity 3) — supporting organisations (such as not-for-profit organisations, local councils and businesses) and people within communities to be inclusive of people with disability, and understand the needs of families and carers.
- Individual capacity building (activity 4) — fostering the principle of choice and control, improving outcomes for people with disability, their families and carers.
- LAC (activity 5) — developing relationships between the NDIS, people with disability, their families and carers, and the local community (NDIA 2015a, pp. 9–13).

In November 2016, the NDIA released its ILC Commissioning Framework to provide guidance around the type of activities ILC will fund and how these will be funded (NDIA 2016f). The framework reflects the ILC Policy activities and identifies five focus areas which are deemed ‘priority areas’ for funding (table 6.1).

Table 6.1 **ILC Focus Areas**

Focus Area	*Definition*	*Example*
Specialist or expert delivery	Focus on activities that provide specific skills and knowledge in relation to disability — for example, diagnostic specific expertise or expertise in particular models of support or capacity building.	A comprehensive website that provides information about particular disabilities or conditions.
Cohort-focused delivery	Focus on activities for specific groups of people that require detailed cultural or other knowledge to be effective — for example, multilingual activities to assist Aboriginal and Torres Strait Islander peoples or people from culturally or linguistically diverse backgrounds.	A yarning circle (peer group) for Aboriginal women run by local Aboriginal organisations.
Multi-regional activities	Focus on activities that would be inefficient if delivered separately in different local areas — for example, advice or information that is not based on location and could be relevant anywhere.	A community awareness campaign to increase employment opportunities for people with disability.
Remote/rural delivery	Focus on ensuring activities are designed to address local needs, circumstances and conditions in rural and remote locations.	A project that connects young people with disability in a rural area with each other via multimedia or social media.
Delivery by people with disability, for people with disability	Focus on supporting organisations that are run and controlled by people with disability. These are sometimes called user-led organisations.	A telephone information service for people with disability, staffed by people with disability.

Source: NDIA (2016f, p. 18).

The ILC Commissioning Framework developed five strands of outcomes that programs funded through ILC will be measured against. They include the extent to which people with disability:

- participate in, and benefit from, the same community activities as everyone else
- use and benefit from the same mainstream services as everyone else
- have the skills and confidence to participate and contribute to the economy
- have the appropriate information so they can make informed decisions and choices
- contribute to, lead, shape and influence their community (NDIA 2016f, p. 10).

ILC funding

Funding for ILC is made through the Community Inclusion and Capacity Development (CICD) Program. The program consists of grants to support two types of activities:

- ILC Jurisdictional Based Grants — targeted at State and Territory level activities.

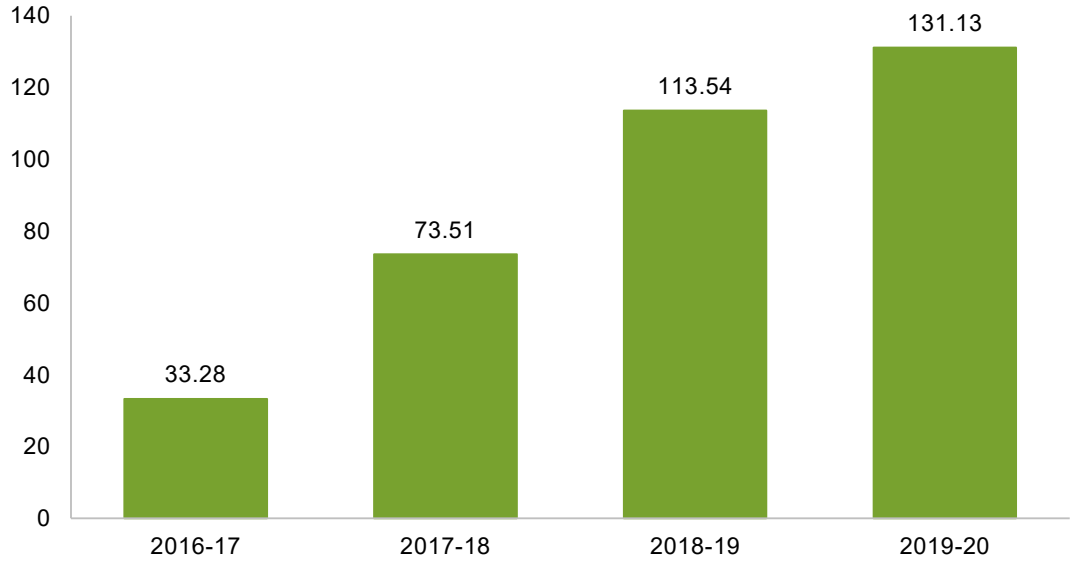
- ILC National Readiness Grants — targeted at activities that can be implemented in multiple jurisdictions or nationally. (NDIA 2016d, pp. 5–6)

The NDIA is taking a staged approach to providing grants in each jurisdiction (full funding across all jurisdictions will apply from 1 July 2019). As part of transitioning to ILC, the NDIA has worked with the Australian, State and Territory Governments to understand what activities currently untaken by the jurisdictions align with the ILC Policy.

Total funding for the CICD Program (which excludes the ILC stream provided by LACs) is $351 million over four years. The funding gradually increases over the transition period from $33 million in 2016-17 to $131 million in 2019-20 (figure 6.2).

Figure 6.2 **ILC Funding**[a]

$ million



[a] These numbers include funding for ILC activities in Western Australia (excluding Western Australia, the budget is about $119 million for 2019-20), but do not include LAC funding for ILC activities in any jurisdictions.

Sources: Australian Treasury (2017d, p. 140); NDIA (2016d, p. 7).

LACs (box 6.1 and chapter 5) are funded separately from the first four ILC activities (through the NDIS Partners in Community Program and with NDIA resources). It is expected about $100 million (or 20 per cent) of LAC funding each year will be for ILC activities.

Box 6.1 Local Area Coordinators

Local Area Coordinators (LACs) play a central role in the delivery of ILC by ensuring people with disability participate in and contribute to social and economic life, and that people with disability receive appropriate services. LACs connect across each of the first four streams of ILC.

LACs also provide support for people with disability to understand their plans and how changes in funding and or the scheme itself are likely to affect them. LACs can help people put their plan into action and help them build capacity to self-manage their plan.

LACs have three main roles:

- to work directly with people who have a NDIS plan by connecting them to mainstream services and community activities, or by helping them put their plans into action (chapter 5)
- provide some short-term assistance to non-NDIS participants and connect them into mainstream services and community activities
- work with the local community to ensure it is more accessible and inclusive for people with disability.

Agreements with LAC partners include that 20 per cent of their effort (and funding) is allocated to the delivery of ILC activities. This is to ensure anyone who approaches a LAC, whether they are eligible for the NDIS or not, are directed to appropriate services (a part of the 'no wrong door' approach, and individual development and community inclusion objectives).

Sources: NDIA (2015a, pp. 13–15, 2017n); NDIA (sub. 161, p. 56).

At the beginning of 1 July 2017, the activities to be funded by ILC Australia-wide and in the ACT were announced (NDIA 2017h, 2017k). The funding allocated to these activities was $14 million and $3 million respectively (NDIA 2017y, p. 45). Some of the successful grants in the ACT included:

- changing the ACT Health Care System to be more inclusive of people with impaired decision making ability
- educating Aboriginal and Torres Strait Islander people about what is meant by the term 'disability'
- establishing a peer support network for people with mild and borderline cognitive disability (NDIA 2017l).

Building the evidence base

As part of the ILC program, the organisations that receive grants — and the NDIA — are required to collect detailed data on ILC activities. This will be important for measuring how effective ILC activities are in achieving outcomes for people with disability. The data will be used by the NDIA to identify and address performance issues, and inform future decisions on the allocation of ILC funds.

Data collected will include: the outcomes and success of activities in the short, medium and long term; the quality and effectiveness of the activities; and performance over time. Data

will be both qualitative and quantitative (NDIA 2016f, p. 27). The data collected will also form part of the ongoing assessment of the broader delivery of NDIS and other disability services (chapter 13).

Is the funding of ILC adequate?

It is difficult to assess the adequacy of current ILC funding …

The adequacy of funding for ILC services was questioned by many study participants given the scope outlined in the ILC Commissioning Framework. For example:

> The PC should consider whether the one per cent cap (of scheme costs) on ILC expenditure should be adjusted to more flexibly accommodate investment in these areas that would generate better participant outcomes. (Victorian Government, sub. 174, p. 11)
>
> It is a widely reported view from the disability sector that there is a significant under-funding of the ILC in order to meet the needs of people with disability. (Speech Pathology Australia, sub. 136, p. 24)
>
> It appears that ILC is significantly underfunded and therefore will not deliver on rising community expectations. (Goldfields Individual & Family Support Association, sub. 13, p. 4)
>
> While some supports may be available through the Information, Linkage and Capacity Building (ILC) framework, it currently is not sufficiently resourced to meet the gaps. (Cohealth, sub. 50, p. 8)
>
> The total funding package for ILC at full roll out … when split across all types of disability is not adequate. (Mental Illness Fellowship of Australia sub. 122, p. 15)
>
> The implementation of the [ILC] framework … is dependent on adequate resourcing. Under full roll out, only $132 million is being allocated to the ILC. This is equivalent to approximately $30 to provide services to each person with a disability as well as to support mainstream services in capacity building. (Down Syndrome Australia, sub. 121, p. 12)
>
> Currently, only $132 million … has been allocated to the ILC. This is not sufficient and means that one of the key foundations on which the NDIS is being built is weak. (Bruce Bonyhady, sub. 100, p. 5)

Others said that the scope of ILC is too narrow to accommodate ILC's intended purpose (box 6.2), particularly in the context of what the Commission proposed would be covered under Tier 2 supports.

Box 6.2 Many participants said the scope of ILC is too narrow

Physical Disability Australia (PDA):

> … it is PDA's understanding that the original tier 2 of the NDIS (that the ILC program replaces) was supposed to boost all non-participants' capacity to access to mainstream services. For example, we envisioned this might involve an 'Access Fund' to support the building of ramps and accessible toilets in the community. As such, PDA finds the current scope of the ILC (and its proposed budget) to be somewhat disappointing. (sub. 38, p. 6)

Australian Blindness Forum:

> … the range and type of services initially promised to be funded under the ILC program has changed substantially. The original proposal was that ILC would reflect the 'Tier 2' programs including block funding and early intervention programs. The goal of this was to continue to provide disability services to those who were not eligible for the NDIS. Now, the way the ILC program has been developed, it is only tools and awareness programs, delivered by mainstream services for a limited time or on an ad hoc basis. (sub. 48, p. 7)

Belconnen Community Service Board:

> ILC does not appear to cover the apparent lack of low intensity early intervention services needed for people who are not eligible for an NDIS package. The limited amount of funding for ILC and the competitive nature of these resources means people living with low to moderate mental health/psychosocial disabilities will struggle to access the supports required to maintain good mental health. (sub. 39, p. 4)

Woden Community Service:

> For the ILC to be able to make meaningful referrals block funded programs will need to continue in parallel with individually funded arrangements. (sub. 159, p. 11)

Allied Health Professions Australia (AHPA):

> AHPA believes the range and types of services proposed for funding under the Information, Linkages and Capacity Building (ILC) program does not currently fit well with the goals of the NDIS, particularly the intention to create and support small and innovative programs. (sub. 37, p. 12)

Centre for Disability Research and Policy:

> The ILC will be an important tool in developing or enhancing services to meet the needs of people where services do not currently exist. This is particularly important in 'thin markets' and within rural and regional contexts. (sub. 55, p. 4)

Psychiatric Disability Services of Victoria:

> … there is no real benefit to mental health services from the ILC because the funding provided through the framework is so minimal; the ILC simply does not have the capacity to provide for the scope of what existing services deliver, whilst also responding to the needs of people who won't be eligible for the NDIS. (sub. 169, p. 9)

Vision Australia:

> The original proposal by the Productivity Commission for Tier 2 services was comprehensive, and offered a meaningful level of supports for people not eligible for the full NDIS. The current ILC program fails to meet this standard, and leaves major gaps in service delivery. One of the key intentions of the original proposal was to address the problems of 'thin markets' — remote, rural and regional areas, and in particular specialist services. (sub. PP210, p. 5)

Macular Disease Foundation Australia:

> … the ILC was intended to fund 'Tier 2' programs including block funding and early intervention programs. The goal of this was to provide access to disability and mainstream services for those who were ineligible for NDIS Individually Funded Packages. (sub. PP243, p 3)

In 2011, the Commission described Tier 2 supports as 'information and referral services (as distinct from funded support)', and said an important role for such supports would be 'to strengthen voluntary links between the community and people with disability — to stimulate 'social capital''[44] (PC 2011, pp. 12–13). The intention was that Tier 2 activities would increase, rather than crowd out existing formal and informal arrangements.

The Commission also said that it would be critical to provide any referral and information services cost-effectively, with strict cost limits, noting that 'the population of potential 'customers' would be very high, but that the overall costs would be small' (PC 2011, p. 12). The Commission suggested $200 million for capacity building (including Tier 1 and Tier 2[45] and Disability Support Organisation funding) (PC 2011, pp. 777, 788).

The question of whether the funding for ILC is adequate is difficult to answer for a number of reasons.

First, the program is still to be fully rolled out. The NDIA said that the timing of ILC funding (as determined by governments) has prevented it from investing in ILC activities and delayed the rollout of initiatives which would allow the infrastructure of a national ILC framework.

> The budget for ILC will increase over time and will reach a total budget of approximately A$131 million. This budget allocation severely hampers the NDIA's flexibility to use ILC at the time when the greatest impact could be realised. … The timing of payments means that the NDIA cannot apply ILC to assist the community or people with disability to prepare for the NDIS in advance of the NDIS rolling out in their area. … The timing of funding, linked to State and Territory contributions also prevents the NDIA from rolling out widespread national initiatives which would allow the infrastructure of a national ILC framework to be established. (sub. 161, pp. 54–55)

According to mapping undertaken by the NDIA of existing programs prior to the introduction of the NDIS, the Australian State and Territory Governments were funding an estimated $200 million of activities that align or mostly align with the ILC Policy. The mapping also showed that these 'legacy' programs were mainly concentrated in activity 1, with gaps in activities 2 to 4 (NDIA, pers. comm., 3 October 2017). Although the NDIA is not obligated to fund legacy programs, some ILC grants will be used to fund these programs. As the NDIA said:

> The effectiveness of ILC funding as an innovative means to increase inclusion of people with disability in the community is constrained by the need to also use this funding for legacy programs to ensure continuity of service delivery (i.e., the funding is also being used to provide transitional funding to States and Territories for existing ILC-like activities in each jurisdiction).

[44] Social capital relates to the social norms, networks and trusts that facilitate cooperation within or between groups. It can generate benefits to the whole community by reducing transaction costs, promoting cooperative behaviour, diffusing knowledge and innovations, and through enhancements to personal wellbeing and associated spillovers (PC 2011, p. 207).

[45] In 2011, the Commission referred to Tier 1 as covering all Australians (as the scheme provides insurances to everyone against the costs of supports in the event that they or a family member acquired significant disability). Tier 2 covered all Australians with, or affected by, disability (PC 2011, pp. 161–5).

> As a result, the full innovative benefits of ILC funding will take time to measure. (sub. PP327, p. 29)

Second, there do not appear to be any comparable programs, either within Australia or overseas, against which the volume of funding can be assessed. A report prepared by URBIS for the Department of Social Services said:

> The fact that the NDIS is a 'world first' model means there are limited learnings from other jurisdictions as to the level of funding required to achieve intended ILC outcomes. (URBIS 2017, p. 1)

Third, to date there is some uncertainty about exactly what activities are to be funded by ILC. As the New South Wales Government said:

> … there is still a gap in the information presented in relation to the Commissioning Framework not setting out what activities the NDIA will actually fund under the ILC budget for full scheme. (sub. 60, p. 18)

And fourth, there is little evidence on the extent to which ILC is effective in improving outcomes for people with disability who are not eligible for individualised supports, nor if ILC is effective in reducing demand for individually funded packages.

The New South Wales Government pointed to the NSW Ability Links program (box 6.3) as a 'successful, cost effective model of innovation, community based supports to assist people with disability to live independently of specialist supports' (sub. PP230, p 4).

Box 6.3 Ability Links NSW and Early Links NSW

Ability Links NSW (ALNSW) supports people with disability, their families and carers to connect with their local community, to achieve their goals and aspirations, and to live enriched and fulfilled lives. ALNSW 'aims to have a light touch on the people it has contact with, with the locus of control lying firmly with the person with disability'.

ALNSW commenced operation from 1 July 2013 in Hunter (NSW) to coincide with the launch of the NDIS, and was made available state wide from 1 July 2014. The NSW Government has committed funding for ALNSW until 30 June 2018.

Early Links NSW (ELNSW) supports families of children with disability up to eight years old. ELNSW was launched in 2009 (as the Early Start Diagnosis Support Program) and in 2013, steps were taken to align the ALNSW and ELNSW. ELNSW has similar components and objectives to ALNSW — in particular, both programs focus on local area coordination to improve outcomes for children with disability, their families and carers.

The latest URBIS benefit and costs analysis, commissioned by the NSW Government, found that over the 2015-16 period there were a number of economic benefits from ALNSW and ELNSW, including increased participation in education and employment (such as work experience and volunteering), new business activity, and increased welfare for carers through a reduction in carer hours required. URBIS also identified some social benefits (such as greater links to, and participation in the community, leading to improved self-esteem and social networks).

Source: (URBIS 2016).

Other evaluations of LAC programs (including in Western Australia, the United Kingdom, Scotland and New Zealand)[46] also found improvements for individuals and families in terms of access to information about services, ensuring people and families have the help and support they need, greater choice, capacity building and increased awareness of disability.

But the evidence base is very thin. With regard to ILC, upon reviewing the available evidence, Urbis concluded that:

> Due to the lack of a comparable case study which incorporates both individualised funding and ILC-type activities in the same system; it has not been possible to explore, in depth, the concept of ILC as a 'safety net' (for those who are not eligible for more intensive support). The evidence suggests that funding directed to Activity Areas 2 and 3 will further enhance outcomes for individuals. Over time, this may even reduce the required funding for Activity Area 5 (Local Area Coordination). (URBIS 2017, p. 6)

… but additional funding is critical in the short term

It is a false economy to have too few resources for ILC activities in the transition period. It is critical to have structures in place to ensure that people eligible for individualised supports can access the NDIS, and those not eligible can access supports outside the scheme. As the NSW Disability Network Forum said:

> … the level of resources allocated to the ILC is not commensurate with the demands on the ILC. Simultaneously, Local Area Coordinators are not fulfilling their community development functions due to the demands of planning work. … This approach will increase cost pressures on the NDIS as people who are unable to access information and capacity building in the ILC will need to include capacity building as part of reasonable and necessary support in their NDIS plan, thereby increasing package size. In addition, there is concern that the lack of widely available capacity building support to those who are not NDIS participants may ultimately lead to an increase in the number of people eligible to become NDIS participants. (sub. 18, p. 4)

The NDIS Independent Advisory Council also noted that:

> The risk for the sustainability of the Scheme is that the lack of capacity building opportunities through the ILC will spill over into increased demand for capacity building as part of reasonable and necessary support, thereby increasing package size. There is also concern that the lack of widely available capacity building support may ultimately lead to an increase in the number of participants eligible to become participants. (sub. 149, p. 10)

State and Territory Governments withdrawing from ILC type activities may have an impact on the supports available. In relation to ILC and LACs funding, the NDIA stated that:

> The success of this [ILC and LACs] strategy will … be heavily reliant on the quality and availability of such supports that largely remain the responsibility of state and territory governments to fund. The experience of trial is that this is not a certain or consistent base upon which the NDIS is building. (sub. 161, p. 53)

[46] See (Kingfishers 2015; Stalker et al. 2007; Western Australia Disability Services Commission 2003).

Although directing additional funds to ILC in transition could crowd out State and Territory 'ILC like' activities, the grants process by which organisations receive ILC funding means these activities can be targeted to where they are needed most. There could also be a risk of duplicating services, but the risk of service gaps appears a much more likely prospect under current arrangements, particularly as determining precisely what ILC should cover is unclear at the operational level.

In the position paper, the Commission recommended funding for ILC be increased to the full scheme amount of $131 million each year during transition. Many stakeholders supported this recommendation (box 6.4). The accelerated funding should be geared towards National ILC activities, to ensure that all people with disability have access to adequate information and are better equipped to gain access to disability services as the NDIS rolls out in their region.

Some study participants suggested greater flexibility around what ILC can fund. The National Mental Health Commission, for example, said:

> There are … concerns about the scope and function of the ILC as it is currently designed and deployed. If the ILC is to succeed in one of its key objectives — ie to reduce pressure on 'Tier 3' individually funded supports — it needs to have a much stronger role in funding services that provide outreach and engagement with people affected by disability … (sub. PP319, p. 3)

And the DSS said:

> The NDIA may require a greater degree of flexibility around how much of the current ILC and participant plan budget is spent on ILC to improve early outcomes for people with disability through an early intervention approach and reduce longer term Scheme costs. (sub. PP318, p. 9)

However, without an evidence base, it is hard to determine what ILC should fund. As the DSS pointed out:

> … ILC investment needs to be targeted to areas that have a strong evidence base for greatest effectiveness, while being careful not to replace mainstream services which are a State responsibility. (sub. PP318, p. 9)

An evidence base needs to be built and used to inform future decisions on the activities to be funded through ILC. The evidence base should provide information on how effective, and by how much, ILC activities improve the outcomes for people with disability and reduces their need for, or reliance on, individualised supports. This information can then be used to better fund activity areas where there is a shortfall in services, and where it is best value for money.

Box 6.4 Participants support increasing ILC funding in the transition period

South Australian Government:

> SA supports this draft recommendation [5.1], recognising the importance of Information, Linkages and Capacity Building (ILC) to Scheme sustainability over time and in promoting community inclusion and participation for all people with disability. Given that only 20% of LAC funding is for ILC activities, it is important that the other four ILC activity streams are adequately funded to build the capacity of people with disability, families, communities and mainstream services. (sub. PP354, p. 5)

The Department of Social Services:

> DSS agrees ILC is an important insurance element of the Scheme to assist all Australians with disability and their families and carers, including those people moving into the NDIS. Monitoring of the level of ILC funding required will continue as part of standard budget processes for the Commonwealth. (sub. PP318, p. 9)

National Disability Insurance Agency:

> … the NDIA supports the Commission's view that it is a 'false economy' to have too few resources for ILC activities during Transition. A well-functioning ILC program should help improve participant outcomes, while contributing to Scheme sustainability. (sub. PP327, p. 6)

Parkinson's Australia:

> An accelerated and enhanced rollout of the Information, Linkages and Capacity Building Program (ILC), including an increase to the full ILC amount of $131m, is strongly supported. (sub. PP232, p. 11)

Women with Disabilities Victoria:

> [Women with Disability Victoria] strongly endorses the Commission's view that ILC funding should be accelerated and maintained until the scheme is fully established and a proper review can take place. (sub. PP282, p. 7)

Early Childhood Intervention Australia:

> ECIA fully supports the recommendation that the ILC funding be increased to the full scheme amount of $131 million for each year during transition and form part of the next COAG review in five years time. (sub. PP249, p. 5)

Orygen:

> Orygen supports the Productivity Commissions Recommendation 5.1 that funding for the ILC should be increased to the full scheme amount during transition as this could potentially improve outcomes. (sub. PP254, p. 5)

The requirement for organisations to collect data as a condition of receiving an ILC grant will help build this evidence base. The NDIA said:

> While the evidence base for the choice of effective ILC intervention is still evolving, it is clear that the absence of ILC infrastructure poses a Scheme sustainability risk, and the NDIA is committed to ensuring this evidence is developed and reflected in future ILC expenditure decisions. (sub. PP327, pp. 29–30)

The agreed review of NDIS costs in 2023 — as outlined in the Heads of Agreement — provides an opportunity to review the effectiveness of the ILC program, including the scope of the ILC Policy and Commissioning Frameworks, and the magnitude of any benefits from increasing its funding. It is reasonable to expect that there will be more data on ILC by this

time, and that many transitional issues which may be exacerbating concerns about the adequacy of ILC funding will be resolved.

FINDING 6.1

It is a false economy to have too few resources for Information, Linkages and Capacity Building, particularly during the transition period when it is critical to have structures in place to ensure people with disability (both inside and outside the National Disability Insurance Scheme) are adequately connected with appropriate services.

RECOMMENDATION 6.1

Funding for Information, Linkages and Capacity Building (ILC) should be increased to the full scheme amount of $131 million for each year during the transition.

The effectiveness of the ILC program in improving outcomes for people with disability, the adequacy of its funding, and its impact on the sustainability of the National Disability Insurance Scheme should be reviewed as part of the next COAG agreed review of scheme costs in 2023. The ILC budget should be maintained at a minimum of $131 million per annum until results from this review are available.

6.2 The NDIS and other disability services

Prior to the NDIS, the delivery and funding of disability services was primarily governed by the National Disability Agreement (NDA). The NDA, of which the Australian Government and all State and Territory Governments are signatories, was established in 2009 and revised in 2012. It features clear roles and responsibilities for each level of government and nationally agreed objectives and outcomes for people with disability, their families and carers (COAG 2012c).

The NDA also establishes that the Australian Government is responsible for providing income support and employment services for people with disability. States and Territories are responsible for the delivery of specialist disability services such as supported accommodation, family support and community support services, therapy, early childhood interventions, life skills and case management (SCRGSP 2017, p. 15.3).

Other services available to people with disability, prior to the introduction of the NDIS, included (but were not limited to):

- home and community care
- residential aged care (provided to people under the age of 65 years)
- taxi and transport subsidy schemes
- psychiatric disability community supports.

While the scope of these services and their eligibility requirements varied by jurisdiction, they typically included programs that covered both people eligible and not eligible for individualised supports under the NDIS. Continuity of service and program interfaces are therefore critical to ensuring that people with disability do not 'fall between the cracks' when services are split between NDIS and non-NDIS provision.

How does the NDIS affect other disability services?

As individuals transition to the NDIS, many existing services will be defunded, with previous funds used to offset the cost of the NDIS. Funds transferred from these services to the NDIS are calculated on a predetermined per person basis. The funds move with the individual when they transition to the NDIS, as agreed in the Bilateral Agreements. However, not all individuals will meet the NDIS eligibility criteria and not all services will be funded by the NDIS. Consequently, some services provided under the NDA and other avenues will need to continue.

Unless agreed otherwise, the responsibility of governments to provide services under the NDA remains (part 2, subsection 16 of Bilateral Agreements). The Australian, State and Territory Governments have also agreed in the Bilateral Agreements to continuity of disability support services for:

- people who receive support but do not meet the access requirements outlined in the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act), or are receiving supports that do not meet the definition of reasonable and necessary support in the NDIS Act
- funding for supports attributed to a program/service that will cease when the NDIS is introduced.

All State and Territory Governments agreed to provide continuity of support to people receiving state and territory administered disability programs/services. The Australian Government is responsible for providing Commonwealth administered disability programs/services (Bilateral Agreements schedule D). As part of annex E of the Continuity of Support Agreement (COAG 2013), the Australian, State and Territory Governments are also obliged to make clear their policy approach to providing continuity of support.

On the basis of the agreements that are in place, if the Australian, State and Territory Governments adhere to their responsibilities there should be few, if any, gaps in disability services for existing users (or at least the funding for these services). People previously receiving a disability service will continue to receive a similar level of service — either through the NDIS or from other services funded by the Australian, State and Territory Governments.

Continuity of support is less straightforward in practice

In practice, access to continuity of support varies.

Continuity of support for people shifting to the NDIS

Continuity of support means that people who meet the eligibility criteria for the NDIS will, at a minimum, continue to receive support that enables them to achieve the same outcomes as their previous support — this could be through the NDIS alone, or through a combination of the NDIS and other services.

However, the NDIS supports need to be reasonable and necessary (chapter 5). This means the supports that a scheme participant receives through the NDIS, and what they received prior to entering the scheme, may not necessarily 'match' one to one.

There is no continuity of support arrangements for new scheme participants (that is, those who were not receiving specialised disability services prior to the introduction of the NDIS), as they will be receiving disability care and support for the first time.

Continuity of support for people not in the NDIS

Where programs are transitioning into the NDIS and there are people on these programs not eligible for the NDIS, these clients should receive services under continuity of support arrangements. However, there is significant uncertainty about how continuity of support arrangements will operate in practice (box 6.5). And what supports will be available for people who newly require disability care and supports is even less clear. Further exacerbating the problem is that funds saved from transitioning services will be used to offset the costs of the NDIS, and so each jurisdiction's willingness, and/or capacity to provide additional services may be reduced.

Box 6.5 Participants point to uncertainty around continuity of support

Flourish Australia:

> People not eligible for the NDIS are already experiencing uncertainty and confusion. Continuity of support arrangements are still not finalised, so it is unclear whether they will be able to continue to access the services they currently receive, post full Scheme rollout. The concern is that if people currently accessing support in the community have this support 'switched off' at a future point, their needs and circumstances could be exacerbated, pushing up demand for the NDIS. (sub. 74, p. 9)

National Mental Health Commission:

> It is not clear how continuity of support for carers will be addressed through the NDIS. For example, the NDIS does not include direct provision of respite support for carers. Anecdotal evidence indicates that some applicants are being encouraged not to include family support in order to enhance their chances of getting a package. (sub. 153, p. 4)

Department of Health:

> The continuity of support commitment has been raised as a concern by service providers. It is currently unknown the proportion of program clients that will be deemed ineligible for the NDIS. Further information is needed of this cohort to inform continuity of support planning, such as the reasons for the ineligible access decision and the type of supports that individuals are currently accessing. (sub. 175, p. 5)

Mental Health Australia:

> All governments are nominally committed to providing continuity of support to clients of programs that are being rolled into the NDIS. Implementation of that commitment is impeded by a number of factors, including … a failure to recognise that many existing programs do not 'map' to the NDIS, … a lack of reliable and publicly available data on the number of clients affected in each program, at both levels of government … and a lack of transparency about funding flows as programs wind back (sub. PP321, p. 13).

There is varying detail on what disability support services will continue after the full rollout of the NDIS, and who will fund them. The New South Wales and ACT Governments — signalled that they intend to cease providing specialist disability services (ACT Government 2017; New South Wales Government nd).

Where it is clear that services will continue, the detail on what will be provided varies. For example:

- the Queensland Government said that they will continue providing some disability services (Queensland Government 2017)
- the Department of Social Services (DSS) stated publicly that 17 DSS and Department of Health programs will be affected by the introduction of the NDIS (DSS 2016g).

Rather than having a clear framework around the continuity of support, there seems to be some signs of brinkmanship, with governments holding off implementing policies (perhaps until other jurisdictions act, or waiting for gaps to emerge before engaging in renegotiations).

In addition to disability care and support, all individuals will continue to have access to mainstream services, regardless of which system they fall under. However, the interface between mainstream services and the NDIS must function well and this is often not the case. Boundary issues between the NDIS and mainstream services are discussed in section 6.3.

While the Commission heard concerns about the quantum and nature of supports that will be provided outside the NDIS across a number of areas, mental health is an area where concerns were particularly pronounced (box 6.6). In this case, the non-clinical supports that will be available for people with mental health disability who are not eligible for the NDIS is very unclear (box 6.6). State and Territory Governments have primary responsibility for mental health services — in 2014-15, state spending accounted for 83 per cent of all spending on community mental health services, with the Commonwealth accounting for 17 per cent (DSS, sub. 146, p. 16).

In March this year, the Disability Reform Council (DRC) agreed to focus on mental health to ensure mainstream systems are effectively supporting people with disability in Australia (DRC 2017a, p. 2). In the most recent budget, the Australian Government also allocated $80 million over four years for support services for people with mental health illnesses who do not qualify for the NDIS, contingent on State and Territory Governments matching this contribution (Australian Treasury 2017b, p. 120). This should go some way to addressing support gaps, but continual monitoring will be required to ensure that people with significant needs are not missing out because they do not satisfy the NDIS eligibility criteria. Through COAG, Health Ministers have also agreed to establish a working group to:

> … progress the Commonwealth's National Psychosocial Supports program. This will have the objective of developing bilateral agreements to support access to essential psychosocial supports for persons with severe mental illness resulting in psychosocial disability who are not eligible for the NDIS. (COAG Health Council 2017, pp. 2–3)

The Commission's recommendation to establish a psychosocial gateway (recommendation 4.4) seeks to provide both a dedicated entry pathway into the NDIS for those eligible for the scheme and to direct people who are not eligible to other relevant services. The gateway should also help to identify gaps in service provision that need to be addressed.

Box 6.6 Mental health — an area where uncertainty abounds

Many participants to this study raised concerns about people with severe mental illness missing out on services. In 2011, the Commission assumed that about 57 000 people with psychosocial disability would be eligible for individualised supports under the NDIS (PC 2011, p. 190). The NDIA has since revised this number to 64 000 people with a primary disability of psychosocial disability (NDIA 2016b, p. 26).

The National Mental Health Commission's report on Mental Health Programs and Services estimated that about 700 000 Australians experience severe mental illness in any one year (and there are estimated to be over three and a half million people in Australia (aged 16 to 85 years) with some sort of mental ill-health in any one year) (NMHC 2014, p. 5). The Department of Health (sub. 175, p. 4) submitted that through their internal modelling, about 282 000 people aged 0-64 years have severe psychosocial disability requiring supports, and about 92 000 (aged 18-64 years) would 'most closely align' with the NDIS (although this did not involve modelling against the NDIS eligibility criteria per se).

For people with psychosocial disability not eligible for an individualised package under the NDIS, it is intended that mainstream or other disability support will assist them. However, many submissions to this study pointed to current uncertainty around what services and supports will be provided to individuals with psychosocial disability outside the NDIS. For example, Mental Illness Fellowship of Australia said:

> While there have been assurances under the principle of continuity of service, in practice there is no clear indication of who and how the system will provide for those not eligible for the NDIS yet in existing programs, and more generally, those who were never Commonwealth clients to begin with. Members have reported emerging evidence of cost-shifting and ambiguities in responsibility, resulting in program uncertainty. (sub. 122, p. 12)

The National Mental Health Commission:

> A particular concern is that there seem to be many people in existing community mental health programs at the Commonwealth and the State and Territory level who are being found ineligible for the NDIS, and while governments' commitment to continuity of support for existing clients is welcome (subject to the details of how such support is to be provided into the future), there appears to be no clear strategy for dealing with future cohorts of people who would otherwise have accessed such programs but who are not eligible for the NDIS. (sub. 153, p. 6)

And the Mental Health Community Coalition of the ACT said:

> … there is a need for both the NDIS and a mental health system. One is not a substitute for the other. However, since the introduction of the NDIS, the intersection between these systems has become very unclear and difficult; as well as inconsistent between States and Territories.
>
> - States and Territories made different decisions about what was in and out of scope for the NDIS.
> - Further, these decisions were made very early in the process when detail of scheme design was limited — it's fair to say that in many cases decisions would now be different given how the scheme has evolved. (sub. 135, p. 15)

The DSS (sub. 146, p. 16) also noted that service gaps in this area have been known for some time. The implications of gaps are significant — uncertainty about what supports will be provided is distressing for people who rely on them and places an additional call on the generosity of informal support. Service gaps can also threaten the sustainability of the scheme by encouraging scope creep, or by forcing those who are unlikely to meet eligibility requirements to test their access.

Continuity of support arrangements need to be made public

The DSS called for the States and Territories to demonstrate that they are delivering on continuity of supports:

> As governments refocus significant proportions of their disability expenditure towards funding the NDIS, there is the potential for services that are expected to remain in the mainstream to be withdrawn, creating service gaps for people who are not eligible for the NDIS. The States need to demonstrate they are delivering their undertakings to provide continuity of support to clients not eligible for NDIS. (sub. 146, p. 27)

While the DSS recognised that measuring and reporting on service gaps is difficult, and that the agreed development of a new reporting framework for the *National Disability Strategy* could assist, it also argued for better cross-system reporting to make any moves away from services more obvious (and therefore more difficult to shift costs).

An important first step to ensuring an effective interface between the NDIS and other disability services is for governments to set out what disability services outside the NDIS they will fund, including the value of supports and number of people covered. Without this, it is impossible to understand where the gaps are and where any cost-shifting may be occurring.

In the position paper, the Commission proposed that a detailed schedule of continuity of support arrangements (including the value of supports and number of people covered) be included in the upcoming full scheme Bilateral Agreements. Responses to this proposed recommendation were mixed.

The Queensland Government considered it reasonable that information about continuity of support services be provided in the Bilateral Agreement for full scheme (sub. PP345, p. 11). The DSS also said that the disclosure of continuity of support arrangements will help people understand what governments will provide (sub. PP318, p. 9).

The South Australian Government argued that it is difficult to accurately quantify continuity of support requirements until existing clients' transition into the scheme (sub. PP354). Similarly, the Tasmanian Government said:

> [W]hether continuity of support is required outside the NDIS may be subject to the NDIA's decisions on reasonable and necessary supports and may not be able to be predicted before an individual accesses the scheme and undergoes planning. … It therefore may not be possible to fully describe or anticipate continuity of support arrangements in full scheme agreements as proposed by the [Productivity Commission], especially where interface issues are still being tested and detailed policy is yet to be determined. (sub. PP247, p. 7)

Arrangements for the continuity of supports need to be made clear by governments — and before the full rollout of the NDIS — to ensure there is certainty about supports for those not eligible for the NDIS. It is the Commission's view that high level commitment to the continuity of support arrangements should remain in the Bilateral Agreements for full scheme. However, rather than constrain the Australian, State and Territory Governments to

fixed values and supports, reporting at the operational level should sit outside the Bilateral Agreements. To ensure continuity of support arrangements are made public, and for a centralised discussion to occur, governments should report their operational level arrangements to DRC.

To assist in identifying gaps as they emerge or cost shifting behaviour occurring, there should also be better data collection at the operational level, and ongoing reporting and evaluation. The data will allow for analysis in trends and the ability to identify where future funds can most efficiently and effectively be allocated. Reporting of disability services at the operational level will encourage discussions between the NDIA, mainstream and disability service providers (including governments, local communities and businesses).

The Commission therefore recommends that the NDIA should collect and report regularly to DRC information on boundary issues. The Australian, State and Territory Governments should also collect data on, and publicly report to DRC, the number of people covered by their disability programs pre and post NDIS, and the value of these services (state and territory's responsibilities are further discussed in section 6.3 and recommendation 6.3). The data will form part of the broader collection of disability data across Australia (chapter 13).

ILC programs and LACs could also assist in identifying any gaps and report them to the NDIA, the Australian, State and Territory Governments and DRC.

In the position paper, the Commission recommended reporting of boundary issues be made quarterly to DRC, however the NDIA argued that annual reporting is more appropriate (sub. PP327, p. 31). The Commission does not have a strong view about whether reporting should be done on a quarterly or annual basis. What is more important is that the reporting is perpetual and made publicly available, and that the first series is made available as soon as reasonably practicable.

RECOMMENDATION 6.2

The Australian, State and Territory Governments should make public — through the COAG Disability Reform Council (DRC) — their approach to providing continuity of support and the services they intend to provide to all people with disability (including the value of supports and number of people covered), beyond supports provided through the National Disability Insurance Scheme. Arrangements for continuity of support should be made clear before full scheme implementation.

The National Disability Insurance Agency should report annually to the DRC on boundary issues as they are playing out on the ground, including identifying service gaps and actions to address barriers to accessing disability and mainstream services for people with disability. The reporting should be used for ongoing monitoring, evaluation and improvements.

6.3 The interface between NDIS and mainstream services

A key requirement of any support provided under the NDIS is that the support is most appropriately provided and funded by the scheme and not by another service or system.[47] The NDIS is not designed nor funded to replace mainstream services. For the NDIS to be successful and financially sustainable, there must be clear lines of responsibility between mainstream services and the scheme. Also, as people with disability can require supports across a number of service systems, it is essential that service systems work well together so that people receive the right services and achieve the best possible outcomes.

In theory, the boundary between the NDIS and mainstream services is clear. The *National Disability Strategy 2010–2020* sets out the guiding principles around the supports to be provided by mainstream services (box 6.7). The Strategy's Second Implementation Plan (Driving Action 2015–2018) states that:

> While the NDIS is a significant step forward for many people with disability, the strategy remains the key to achieving improvements in access to mainstream services and support for all people with disability, regardless of age or type and level of support required. (DSS 2016c, p. 6)

However, as the NDIA (sub. 161, p. 57) stated, 'the Strategy is an overarching framework rather than a binding agreement for action'. It does not include 'substantial commitments, key performance indicators or targets' and 'there are limited identifiable consequences for governments if there is a lack of action'.

The Australian Government has also entered into bilateral agreements with State and Territory Governments. These agreements delineate the types of support to be provided and funded by the NDIS and mainstream services (table 6.2). COAG has endorsed *Principles to Determine the Responsibilities of the NDIS and other service systems*, which are to be used to determine the funding and delivery responsibilities of the NDIS. The Principles provide guidance on decisions about what constitutes 'reasonable and necessary' by the NDIA by being incorporated in the *National Disability Insurance Scheme (Supports for Participants) Rules 2013* (Schedule 1).

[47] NDIS Act subsection 34(f).

Box 6.7 National Disability Strategy 2010–2020

The *National Disability Strategy 2010–2020* provides a ten-year national policy framework for improving the lives of Australians with disability, their families and carers. It represents a commitment by all levels of government, industry and the community to a unified, national approach to policy and program development. The vision of the Strategy is for 'an inclusive Australian society that enables people with disability to fulfil their potential as equal citizens' (COAG 2011, p. 8).

The Strategy was endorsed by the Council of Australian Governments in February 2011. It guides public policy across all level of government and aims to bring about change in mainstream services, specialist programs and services, and community infrastructure to meet the needs of people with disability, their families and carers. It is the first time the Australian, State and Territory Governments have agreed to such a wide range of policy directions for disability. The Strategy sets out six priority policy areas for action. They are:

- inclusive and accessible communities
- rights protection, justice and legislation
- economic security
- personal and community support
- learning and skills
- health and wellbeing.

The first implementation plan, *Laying the Groundwork 2011–2014*, established the foundation for reform in the planning and delivery of both mainstream and disability-specific programs and services. The Strategy's second implementation plan, *Driving Action 2015–18*, outlines new priority actions and builds on ongoing commitments to improving outcomes for people with disability across the Strategy's six policy outcome areas. Additional areas of national co-operation include: NDIS transition to full scheme; improving employment outcomes for people with disability; improving outcomes for Aboriginal and Torres Strait Islander people with disability; and communication activities to promote the intent of the Strategy throughout the community.

In September 2016, the Disability Reform Council reaffirmed its ongoing commitment to the *National Disability Strategy*.

Sources: COAG (2011); DSS (2016c, p. 2, 2017d).

Table 6.2 **What the NDIS covers and what mainstream services provide**

	What the NDIS covers	*What mainstream services provide / what the NDIS does not cover*
Health	Support to enable a person with disability to undertake daily activities, including 'maintenance' supports (from clinically trained or qualified health practitioners) directly associated with the person's disability.	Access to health services, such as diagnosis and clinical treatment of health condition, as required by National Healthcare Agreement and Commonwealth Disability Discrimination Act.
Mental Health	Non-clinical supports that focus on the person's functional ability to undertake daily living.	Clinical support related to mental health and any residential care and rehabilitative care.
Early childhood development	Individualised support or early intervention, specific to a child's disability or developmental delay, targeted at enhancing the child's functionality to engage in daily activities.	Early childhood education and care needs, health system, child and maternal health services and any supports clinical in nature.
Child protection and family support	Support for the child, family and carer as a direct result of the child's disability, to enable participation in the community.	Promoting the safety of children from abuse and neglect, and providing parenting programs, counselling and other supports for families.
School education	Supports related to the functional impact of a student's disability to undertake activities of daily living, such as personal care and transport to and from school.	Personalising learning and support related to educational attainment, including teaching, learning assistance, school building modifications and transport between school activities.
Higher education and vocational education and training	Functional support related to the student's disability to undertake daily activities, including personal care and transport to and from education.	Learning and support needs of students that primarily relate to their educational and training attainment, and transport between education, training and employment venues.
Employment	Assistance to take part in the workforce and support in the person's functional capacity to work, such as training in workplace relationships and communication skills.	Employment services to support people with disability to prepare for, find and maintain a job, and employers to hire people with disability in their workplace (e.g. workplace modification, training and funding assistance).
Housing and community infrastructure	Assist individuals with disability to live independently by building their capacity to maintain tenancy, such as home modifications for accessibility, specific to their disability.	Accommodation for people in need of housing assistance, access to housing and homelessness services and any previous infrastructure responsibilities.
Transport	Funding support to enable independent travel, including aids and equipment and training to use transport. Cover reasonable and necessary costs for those not able to travel independently.	Ensuring transport options are available to people with disability. Other parties are still responsible for transport infrastructure as part of universal service obligation, including managing disability parking.
Justice	Continue to fund the full NDIS support related to the person's disability impairment.	Meet the needs of people with disability in line with the *National Disability Strategy* and existing legal obligations, such as ensuring the system supports accessibility for people with disability and a secure environment for those in prison.
Aged care	Those under age 65 can choose to purchase support from an aged care provider and the NDIS will fully meet these 'reasonable and necessary' costs.	Responsible for access to quality and affordable aged care and carer support. Cater for individuals aged over 65 years, unless they qualify to remain in the NDIS.

Source: COAG DRC (2015b).

Interfaces are not so clear at an operational level

At the operational level, the lines of responsibility between the NDIS and mainstream services are not clear. The NDIA reported that during trial and transition it faced three key challenges in relation to mainstream supports, including:

- lack of clarity around some interfaces
- different understanding of mainstream obligations, by each jurisdiction and the NDIA
- difficulty in holding mainstream services accountable (sub. 161, pp. 59–60).

State governments also pointed to the need for further work on achieving greater clarity. For example, the South Australian Government said:

> There remains a lack of clarity in relation to roles and responsibilities across the NDIS and mainstream services in some areas. South Australia believes that there is still extensive work to be done in defining mainstream interface boundaries. (sub. 203, p. 6)

The New South Wales Government said:

> Extensive further work is required by the States and the Commonwealth to scope, agree and communicate service boundaries. Any movement of boundaries (existing responsibilities) between the NDIS and other service systems should be implemented with associated resourcing considerations. (sub. 60, pp. 13–14)

A lack of clarity around responsibilities between the NDIS and mainstream services has the potential to impact on NDIS costs, and on the effectiveness and efficiency of service delivery in multiple ways, including: scope creep; cost shifting from mainstream services to the NDIS and vice-versa; gaps in service provision; inconsistent support access decisions; and duplication of services.

An added complexity is in-kind support arrangements (a program may have been agreed as in-kind but some people receiving the program may not be eligible for the NDIS and not all supports within the program may align with reasonable and necessary supports) (chapter 7).

Some emerging interface issues

Interface issues are starting to emerge. The NDIA reported instances of possible cost-shifting, scope creep and service gaps, including:

- providers trying to extend the amount of therapeutic (health) interventions through use of NDIS funding
- reports that mainstream services are refusing entry to people who are likely to be eligible for the NDIS
- issues around a lack of accessible public transport options, particularly in regional, rural and remote areas, which means NDIS participants seek transport funding through the

> NDIS despite having the capacity to travel independently where transport options are available (sub. 161, pp. 59–60).

State and Territory Governments also reported instances of cost shifting. The South Australian Government, for example, said:

> As policies and eligibility have been clarified over the trial/transition period, there are a number of emerging issues which are, or are expected to result in costs for the state in areas which were originally assumed to be part of the scheme. … South Australia is keen to ensure that all appropriate costs are met by the NDIS to avoid any potential of states effectively paying twice for services. (sub. 203, pp. 7)

The ACT Government also said:

> The ACT has experienced a cost pressure associated with the fact that what is 'in scope' for the NDIS has moved over time. (sub. 156, p. 9)

Some of the examples provided by the ACT Government include:

- a narrowing of the eligibility criteria for Early Intervention has meant that some children who were deemed eligible for the scheme and have not implemented plans are being reviewed by the NDIA and referred back to mainstream services
- the lack of clarity from the NDIA about what is considered as parental responsibility and what is reasonable and necessary to fund student transport means that a tightening of scope by the NDIA will shift costs to States and Territories
- the NDIA being insistent that supports for people with forensic disability[48] where their behaviour manifests as a public safety issue is the responsibility of mainstream services. The ACT Government did not anticipate that it would be required to meet such costs, given that they relate directly to the participant's ability to live in the community (sub. 159, pp. 9–16).

While many submissions to this study raised concerns about how the NDIS interface was working with mainstream services, particular concerns were raised in the areas of the justice system (box 6.8) emergency and health services (box 6.9) and transport (box 6.10).

[48] A forensic disability client is an individual who has an intellectual or cognitive disability who has been ordered to be detained for treatment or care (Forensic Disability Act 2011(Qld) s. 10).

Box 6.8 Interface between the NDIS and justice services: views of study participants

Participants to this study expressed a number of concerns about the interface between the NDIS and mainstream criminal justice disability services. While there are specific NDIS rules that deal with the interface with the justice system (NDIS (Supports for Participants) Rules), there are some concerns that these rules are not clearly defined and that differences in interpretation will create inconsistencies. The Office of the Public Advocate, for example, said:

> On the intersection with the justice system, the COAG principles outline that the NDIS 'will continue to fund the reasonable and necessary supports'; a statement that is vague and subject to differing interpretations. Moreover, some of the responsibilities accorded to the justice system in the COAG principles have seldom been available in the pre-NDIS environment; for example, 'specific interventions to reduce criminal behaviours' and intensive case coordination — both of which are attributed to mainstream services — are not currently provided by the justice system and it is unlikely that they will be under the NDIS. (sub. 46, p. 2)

Participants also expressed concern that delineation between the NDIS and State and Territory responsibilities is resulting in the withdrawal of some community justice programs and creating inconsistencies between jurisdictions and gaps in service provision. Disabled People's Organisations Australia submitted:

> There is an assumption that States and Territories are providing the appropriate supports to people with disability through the mainstream or their own specialist disability support systems. In some cases, States and Territories are entirely withdrawing funding and services for disability support while others are retaining a residual role in specialist supports. This creates inequity in programs within different jurisdictions. For example, NSW is ceasing its funding of specialist disability criminal justice programs based on the rationale that this should be the purview of the mainstream criminal justice system. (sub. 165, p. 11)

A further issue was the ability of people in custody to access NDIS support. Sisters Inside, for example, said:

> In our view, the unique and 'complex' needs of women in prison pose a significant challenge for the current NDIS model. We are concerned that most criminalised women will not be eligible for NDIS services. Even if eligible, many criminalised women can be expected to avoid the application process and services provided by mainstream (institutional charity) organisations. (sub. 16, p. 1)

In particular, access to disability services for people moving in and out custody is viewed as problematic. Neami National submitted that an:

> … issue occurs when participants move in/out of justice settings. For example, in preparation for discharge from a forensic mental health unit, extensive preparatory work and relationship building is provided through in-reach of community mental health disability support. This is not funded under the NDIS and will compromise the capacity of justice services to facilitate safe and timely discharge for people, again increasing overall cost pressures on the health and social care systems. (sub. 63, p. 9)

Similarly, Leanne Dowse, Melinda Paterson and Mike Sprange said:

> … as the NDIS implementation is only partially complete in NSW, it is hard to comment on how the interface between the NDIS and mainstream services has been working. What is clear has come from areas where trial implementations of the NDIS have occurred, such as in the Hunter region.
>
> In the area of Justice, there are some reports that the transition out of custodial sentences for people with disability who may be eligible for the NDIS, or even already in it, is problematic. It is likely that in relation to the mainstream area of Justice, many complex issues will arise in the interface. (sub. 114, p. 7)

Box 6.9 Emerging gaps in emergency and health services

Responsibility for funding emergency services

A gap in emergency response funding was identified by a number of study participants. For example, the ACT Government (sub. 156, p. 24) pointed out that there is currently no provision for emergency supports, such as accommodation, for:

- children with challenging behaviours who may not be able to live with their parents all of the time
- participants being discharged from a psychiatric inpatient unit
- participants unable to leave hospital without a modified or supported accommodation option.

It is unclear whether the NDIS or State and Territory Governments are responsible for funding this service. For example, in the ACT, the government has 'cashed out' on disability services related to emergency care (the ACT Government (2017) wound up 'Disability ACT' on 30 June 2017) under the expectation that the NDIS would fund these services. On the other hand, the NDIA has claimed that providing emergency accommodation falls under the State and Territory responsibility of child protection, public housing and health sector respectively.

Uncertainty in some health services

There are also cases where individuals are being turned away from specific state funded health services, and there seems to be uncertainty around who should provide these services.

- Audiologists report confusion around the funding of services for people experiencing tinnitus, with one practitioner being told that supports for tinnitus would no longer be funded by South Australia Health as this program would move over to the NDIS. However, young and adult clients with severe tinnitus are being advised that they are ineligible for the NDIS (Allied Health Professions Australia, sub. 37, p. 11).
- The Australian Physiotherapy Association (sub. 93, p. 10) reported feedback from consumers that rehabilitation services have 'closed their books' to NDIS package holders.
- The Australian Physiotherapy Association also noted cases of individuals being discharged early from hospitals:

  > … there are increasing incentives for 'early discharge' from public and private hospitals resulting from the introduction of the NDIS … There is little incentive, for example, for hospitals to ensure optimal pre-discharge functioning of a participant, compared with early hand-off and the transfer of the responsibility for achieving optimal functioning into the hands of the participant, their NDIS budget and community-based providers. (sub. 93, p. 10)

Box 6.10 Taxi subsidy scheme varies across jurisdictions

As part of the transition to the NDIS, some State and Territory Governments, such as South Australia, Tasmania and Queensland, have cashed out their taxi subsidy scheme for NDIS participants, on the expectation that transport requirements for people with disability will be covered by the scheme.

Since the rollout of the NDIS, some scheme participants have received less transport assistance than they did under the previous taxi subsidy scheme. Some State Governments argue that the NDIA is not providing sufficient transport support. As Queensland's Minister for Disability Services Coralee O'Rourke said:

> Together with other jurisdictions, we have been making representations to the Commonwealth Government since earlier this year, expressing concern that people are not getting sufficient provision for transport in their plans from the NDIA. (Bailey and O'Rourke 2017)

The South Australian and Tasmanian Governments have announced they will temporarily reinstate the taxi subsidy scheme for NDIS participant (Mullighan 2017; TDSG 2017), while continuing to provide a cash transfer to the NDIA. The Queensland government reinstated their taxi subsidy scheme for the remainder of the transition period. This will be treated as an in-kind contribution, replacing what was a cash contribution (Bailey and O'Rourke 2017).

There appears to be discrepancies in services received by individuals, depending on which jurisdiction they live in and how their government interprets their responsibilities – this is not desirable in a system striving to be nationally consistent.

While the Commission considers these interface concerns are highly significant, it is not in a position to review the boundaries per se (though it has devised a process to address these issues going forward — discussed below). As the New South Wales Government said:

> … at this early stage, NSW considers reviewing scheme boundaries by the PC to be of limited value given extensive work is still required by governments to define and agree boundaries. (sub. 60, p. 14)

A number of Administrative Appeals Tribunal (AAT) cases have tested the boundaries of the NDIS (box 6.11), but given the narrow focus of these cases to date, their use in defining boundaries between services is limited. As more decisions are tested through the AAT, it can be expected that boundaries may be clarified. Importantly, however, the fact that a support is ruled to be best provided by a mainstream service does not always mean that the support will necessarily be provided.

Box 6.11 **AAT Cases — whether a support is most appropriately funded by the NDIS**

The following are examples of Administrative Appeals Tribunal cases that look at whether the requested NDIS support item is most appropriately funded by the NDIS or mainstream services. The cases have generally focused on specific claims for medical equipment and disability care.

- *Young and the National Disability Insurance Agency* [2014] AATA 401 — Young applied for a portable oxygen concentrator and insulin pump to be funded through the NDIS. The AAT found that the oxygen concentrator and insulin pump were not clinical treatments, and are most appropriately provided by the health system.
- *McCutcheon and the National Disability Insurance Agency* [2015] AATA 624 — McCutcheon's NDIS support package did not include chiropractic care, which she appealed. The AAT found that the chiropractic treatment can amount to good practice for the purposes of NDIS Act s 34(1)(d). The AAT found that the chiropractic treatment was related to McCutcheon's ongoing functional impairment and was therefore most appropriately funded by the NDIS.
- *Fear by his mother Vanda Fear and National Disability Insurance Agency* [2015] AATA 706 — On behalf of Fear, his parents applied for certain equipment (pulse oximeter and oral suctioning machine) as part of his individual support package under the NDIS, but they were not included in his plan. The AAT found that the oximeter and oral suction machines are more closely related to clinical treatment for Mr Fear's health and were the responsibility of the health system.

Interface issues require ongoing action

While there are various governments involved in delivering services to people with disability, there will be interface issues. It will take considerable effort and goodwill to resolve these issues, and as programs for people with disability continue to evolve, interface issues will never be fully 'resolved'.

It is therefore essential that robust processes are in place to clarify interface issues between the NDIS and mainstream services before they appear (if possible — but some issues will only become apparent through experience), or as they arise. The Commission is aware that governments are undertaking substantial work to clarify these issues, but this is complex and will take time. A more formal process is therefore needed to maintain the momentum for this critical work.

The Commission considers that the most appropriate vehicle for the discussion and monitoring of NDIS and mainstream service interfaces is COAG. A standing item should be introduced for each COAG Council that is responsible for services that interface with the NDIS, so that there is a regular discussion, and actions devised, on how best to address the interface of mainstream services with the NDIS.

There were mixed reactions to this recommendation in the position paper. Some study participants were supportive, for example:

> … Victoria would support a standing item on the agenda of each COAG Council that interfaces with the NDIA (Draft Recommendation 5.3). A necessary first step is to put in place public reporting on how the scheme as a whole is progressing. This would identify whether there is a need for further reporting by the states that can be efficiently and effectively progressed through existing COAG avenues. (Victorian Government sub. PP298, p. 22)

> NDIS should be a standing item on the agenda of every COAG ministerial council that has responsibility for services that interface with the NDIS. This would help foster regular discussions to resolve uncertainties about service gaps, duplications and other boundary issues. (National Disability Services sub. PP295, p. 5)

The New South Wales Government, however, raised concerns about this resulting in fragmented decision making:

> NSW does not consider it appropriate for other COAG Councils to resolve boundary or interface issues with the NDIS. Devolving this responsibility to separate COAG Councils will potentially result in a fragmented approach to decision making, and decisions being made without reference to broader NDIS design/impacts. Rather, the Disability Reform Council should have responsibility for considering and agreeing NDIS boundary and interface issues in consultation with other COAG Councils. (sub. PP230, p. 5)

And the DSS suggested that the standing item agenda should be broadened to include a discussion on improving outcomes for people with disability:

> The COAG DRC now lists the NDS as a standing agenda item for its ordinary meetings, Should this option be more broadly pursued it would be important that the standing agenda item be extended to include a broader focus on improving outcomes for people with disability, consistent with the Strategy, to help drive improved outcomes for all people with disability, including those who will not be NDIS participants. (sub. PP318, p. 11)

The Commission agrees broadly with these views and recommends that the standing item for each COAG Council (that is responsible for services which interface with the NDIS) should put forward issues and proposed solutions to the DRC, rather than having each COAG Council resolve interface issues directly. The discussions on boundary issues should also consider how interactions between services affect outcomes for people with disability.

The DSS suggested specific disability reporting across COAG Councils:

> Monitoring and reporting through COAG infrastructure could be strengthened by specific disability reporting across relevant COAG Councils, specifically on the effectiveness of mainstream systems in supporting all people with disability; and improving the interfaces between mainstream services and the NDIS.
>
> DRC could consider proposing this through its regular reporting to COAG, starting with the three agreed priorities for the *National Disability Strategy*:
>
> - mental health services outside the NDIS
> - health services for people with disability

- over-representation and lack of support for people with disability in the criminal justice system. (sub. 146, p. 28)

The *National Disability Strategy* should be strengthened to improve government accountability. There should be more detailed reporting around the boundaries of the NDIS and the implications for mainstream service provision. Specific commitments, key performance targets and outcomes should be established. This should be pursued through review points of National Agreements and National Partnership Agreements under the Federal Financial Relations Intergovernmental Agreements.[49]

As the DSS said:

> Translating the National Disability Strategy into tangible results for people with disability, their families and carers is a major factor in successful implementation of the NDIS. (sub. 146, p. 5)

RECOMMENDATION 6.3

Each COAG Council with responsibility for a service area that interfaces with the National Disability Insurance Scheme (NDIS) should have a standing item on its agenda to address how these services interface with NDIS supports. The standing item should cover service gaps, duplication and other boundary issues, including ways to improve outcomes for people with disability. Each Council should put forward issues and proposed solutions to the Disability Reform Council for action.

At review points of National Agreements and National Partnership Agreements under the *Intergovernmental Agreement on Federal Financial Relations*, parties should agree to specific commitments and reporting obligations that are consistent with the *National Disability Strategy*. The Agreements should be strengthened to include more details around how boundary issues are being dealt with, including practical examples.

As the system evolves, and providers of services to people with disability better understand the NDIS and its interfaces, staff will be better able to work collaboratively, identify gaps or duplications and re-direct people with disability to the most appropriate services. A number of study participants said that cross-system co-ordination is poorly implemented and more needs to be done in this area (box 6.12).

Cross-system co-ordination differs to that of support co-ordination (chapter 10) — rather than connecting scheme participants with complex needs to appropriate services, cross-system co-ordination will ensure that service providers themselves are better equipped to work with one another, and that the best outcome is achieved for *all* people with disability.

Having better co-ordination can help, but of course only if responsibilities are clearly delineated. ILC and LAC can also play a role in ensuring mainstream services and the NDIS

[49] An important commitment by governments under the Disability Reform Strategy was to use the review points of National Agreements and National Partnerships as an opportunity to assess their consistency with the aims and objectives of the Strategy.

are better informed about their roles and responsibilities, and help identify problems and solutions.

Box 6.12 **A need for better cross-service co-ordination**

Victorian Healthcare Association:

> In some cases the roll out of the NDIS has led to fragmented management of care recipients by creating artificial barriers between 'health' needs and 'disability' needs — rather than treating clients holistically and providing integrated care. (sub. 172, p. 4)

Victorian Council of Social Services:

> To help people with disability achieve their aspirations, they need to be treated holistically and receive coordinated support. This is particularly the case for NDIS participants who face a range of complex issues such as experiencing chronic health conditions, homelessness, family violence, child and family services and substance abuse.
>
> There is a role for state and federal governments to better coordinate mainstream systems with the NDIS and to meet their commitment under the National Disability Strategy 2010–2020. (sub. 176, p. 25)

National Mental Health Commission:

> For people living with mental illness, the service landscape is complex and fragmented, as services are both cross-sectoral (health and disability, as well as other sectors such as housing) and cross-jurisdictional (Commonwealth and state/territory). To meet the needs of people with a psychosocial disability, coordination across these sectors and jurisdictions is required to ensure no gaps in services emerge from the implementation of the NDIS. (sub. 153, p. 7)

Flourish Australia:

> To ensure an integrated system that takes a holistic approach and is responsive to the differing needs of people with mental health issues, it is important that the NDIS has strong links to and collaborates with other parts of the system. From our perspective, it would appear that the priority at the moment is the rollout of the Scheme, not smooth transition, collaboration or integration with other relevant service systems. This is problematic. (sub. 74, p. 9)

6.4 Interface with aged care

An important issue in the design of the NDIS is the interface between the aged care and disability systems. As people with disability age, they are likely to experience age-related conditions, such as increasing frailty, or the onset of age-related neurological conditions (such as Alzheimer's). At the same time, a person may develop a non-age related disability later in life.

Under the NDIS, a scheme participant:

- under the age of 65 years can choose to purchase supports from an aged care provider and the NDIS will fully meet these 'reasonable and necessary' individualised support costs

- has the choice to stay in the NDIS, or transition to the aged care system, once they turn 65 years old
- ceases to be a participant when they enter a residential care service or start being provided with home based care on a permanent basis, but only after they turn 65 years old (DRC 2015b, p. 26).

There are aspects of the design of the NDIS, and how it interfaces with the aged care system, that create incentives for people to stay in the NDIS after the age of 65, and encourage people nearing the age of 65 to apply for NDIS access (and have their needs met through the scheme, rather than through the aged care system). For example, there are differences in the objectives, financial contributions, and the level of supports provided under the two systems (box 6.13).

Box 6.13 Incentives to remain in, or seek access to, the NDIS

Varying objectives

The NDIS is intended to support the independence of people with disability, provide reasonable and necessary support and has an insurance based focus of lifetime care for the participant. In contrast, the aged care system focuses on minimising a person's loss of autonomy, and acknowledges that 'if you live long enough, you will need some form of care and support because of frailty' (PC 2011b, p. 147).

This can result in different supports provided by the two systems.

Financial incentives

A NDIS participant is provided care and support at no cost, whereas a person accessing the aged care system may be subject to a means tested co-contribution. As noted by one participant (Name withheld, sub. 5, p. 1) as long as the market for providing services to NDIS participants is operating effectively, it is difficult to see why people would choose to transition from the NDIS to aged care.

Aged care is capped and rationed

The NDIS provides all eligible participants a package of supports which is uncapped, provided these supports are deemed to be reasonable and necessary. In contrast, the aged care system has a limited number of places, and packages have a capped amount of government funding. For example, an NDIS participant with a spinal cord injury has an annual average package of about $109 000 (excluding shared supported accommodation — chapter 2), whereas the largest Home Care and Residential Care packages (excluding supplements) are about $50 000 and $80 000 per year, respectively (Department of Health 2017a).

These incentives raise some issues that need to be addressed. However, given the infancy of the NDIS, and in the absence of adequate data on the characteristics of people aged 65 years and over in the scheme, it is too early to determine the best approach to take.

Some of the policy options that could be worth exploring (as more data become available) include:

- changing the NDIS entry cut-off age — possibly to align with changes in the age pension age (transitioning from 65 to 67 years by July 2023)
- removing the NDIS entry cut-off age altogether — some participants suggested that an age cut off is inequitable and discriminatory (Disabled People's Organisations Australia sub. 165, pp. 11–12 and Motor Neurone Disease Australia sub. 45, p. 7)
- introducing a co-contribution for people aged over 65 years in the NDIS (this was suggested by the PC in 2011)
- better aligning the aged care and NDIS systems.

The Commission considers that, in light of new information, the Australian Government should review the interface between the NDIS and the aged care system as part of the 2023 review of NDIS costs.

6.5 Interface with the National Injury Insurance Scheme

In 2011, the Productivity Commission also recommended that a National Injury Insurance Scheme (NIIS) be established and operate in parallel to the NDIS. At the time, the Commission considered it a priority to establish a no-fault lifetime care and support scheme for catastrophic injuries, as many Australians acquiring such injuries were receiving poor care and support because they were unable to find an at-fault party to sue. (PC 2011, pp. 851-854)

Under the model proposed by the Commission, the NIIS was to fully fund health, rehabilitation and care and support costs for all newly acquired catastrophic injuries. As such, lifetime care and support needs of people with newly acquired catastrophic injuries would be met through the NIIS and not the NDIS. However, the care and support needs of people with existing catastrophic injuries, and not covered under any no-fault arrangements, would be met through the NDIS.

The NIIS, as proposed by the Commission, was to operate as a federation of individual state-based no-fault insurance schemes. It was recommended that the NIIS be in full operation in 2015, or before the full rollout of the NDIS. This was on the basis that there were well-established schemes in place that could form the blueprint for the design of schemes and the number of people affected was relatively small (about 1000 people a year) (PC 2011, p. 863).

Implementation of the NIIS is overseen by the Australian Treasury (2017f) and has been investigated across four streams:

- motor vehicle accidents
- workplace accidents

- medical treatment injuries
- general accidents (occurring in the home or community).

Of the four streams, motor vehicle accidents is complete, and workplace accidents is in the process of being completed — a consultation Regulation Impact Statement has been released and progress is being made towards setting minimum benchmarks (Australian Treasury 2015).

Progress on the other two streams — medical accidents and general accidents — has been slower. In June 2017, COAG agreed not to proceed with the medical accident stream. COAG is also seeking advice from Treasurers, in consultation with the DRC, on a general accident stream of the NIIS (COAG 2017, p. 3).

As there is no agreement in place by the State and Territory Governments to commit to the funding for — or establishment of — the medical and general accident streams, anyone who acquires a catastrophic injury from a medical or general accident will receive supports through the NDIS. This will have a direct impact on NDIS costs.

A number of study participants pointed to the costs to the NDIS.

> Not proceeding with the medical or general streams of the NIIS will have a direct impact on the NDIS by increasing overall Scheme costs. … Any additional cost, not adequately funded by the States, is a risk to the Commonwealth. (DSS sub. 146, p. 26)
>
> The sustainability of the NDIS depends on a complete NIIS that, in providing no fault insurance for catastrophic injury, removes the significant cost drivers of these injuries from the NDIS. (Young People In Nursing Homes National Alliance, sub. 187. p. 4)
>
> Without the NIIS in place, further cost-pressure will be placed on the NDIS. (NDIA sub. 161, p. 113)

The DSS argued that the funding obligation should sit with State and Territory Governments:

> Contingencies are needed if the full NIIS is not delivered, as this would move costs onto the NDIS. … If the NDIS were to pick up responsibility the funding obligation would sit fully with the States, which have responsibility for implementing the NIIS. (sub. 146, p. 5)

And:

> The States should bear the consequential NDIS costs if the NIIS remains only partially implemented. This is consistent with the *Intergovernmental Agreement for the National Disability Insurance Scheme (NDIS) Launch* and the transition agreements between governments, reflecting the original intent of the NIIS to reduce the cost of the NDIS. (sub. PP318, p. 11)

However, a number of State Governments disagreed. For example, the Queensland Government said:

> The terms of Queensland's 2013 Heads of Agreement with the Australian Government do not require implementation of NIIS streams for medical or general accidents. The recent COAG

> decision to not proceed with a medical NIIS at this time should not put Queensland at risk for liabilities of NDIS participants who might otherwise have been covered by a NIIS. (sub. PP345, p. 12)

And the South Australian Government said:

> Negotiations regarding the establishment of a NIIS for medical and general injuries are occurring between the Commonwealth and the states and both levels of government have recommended to COAG that the medical NIIS not proceed at this time. … The NDIS cost implications arising from a failure to establish NIIS arrangements are not clearly a state responsibility, given states' lack of involvement in these fields of insurance, the joint decision making process underway between both levels of government to assess feasibility and the relatively stronger ability of the Commonwealth to raise revenue from efficient taxes. (sub. PP354, p. 7)

The cost implications to the scheme may be lessened by the NDIA's ability to seek compensation from other parties (chapter 5 of the NDIS Act).[50] The NDIA can seek a share of compensation from medical indemnity and public liability payouts related to disability care and support. The NDIA's CEO can also require a person take action to obtain compensation if another party is at fault.

The number of people entering the NDIS, who would otherwise be covered by the medical or general accident streams of the NIIS in any one year is expected to be relatively small — across both streams the Commission (PC 2011, p. 793) estimated there to be about 400 people.

But over time, as new people enter each year, there is a cumulative effect. To illustrate, modelling undertaken by the NDIA suggests that the cost to the NDIS of the medical and general schemes not operating would amount to about $23 million in 2018-19. But, would increase to about $226 million in 2025-26 and to about $1.3 billion in 2040-41 (table 6.3). These numbers take into account the NDIA seeking compensation.

[50] In Western Australia, the motor vehicle accident stream allows participants to take their benefits as a lump sum. This has raised some concerns about its potential impact on NDIS costs should Western Australia join the NDIS. For example, if a participant exhausts their lump sum they could access the NDIS. Queensland's motor vehicle NIIS contains provisions of similar effect to that of Western Australia, whereby a participant can seek a lump sum compensation through common law. However, *National Injury Insurance Scheme (Queensland) Act 2016* (Qld) s. 17(4) allows a person to further seek compensation from NIIS Queensland should they exhaust their funds after five years. This means there is minimal impact on NDIS costs. If Western Australia joins the NDIS, a similar provision of NIIS Queensland Act would need to be included in Western Australia's *Motor Vehicle (Catastrophic Injuries) Act 2016* (WA) to negate the impact on the NDIS costs.

Table 6.3 **Medical and general accidents costs to the NDIS**
$ million

	2018-19	*2019-20*	*2020-21*	*2025-26*	*2030-31*	*2035-36*	*2040-41*	*2045-46*
Medical	1	3	7	33	71	121	186	271
General	4	19	42	193	417	712	1 098	1 597
Total	**5**	**23**	**49**	**226**	**488**	**833**	**1 284**	**1 868**

Source: Commission estimates based on NDIA modelling.

One of the key goals of the NIIS is to deter high-risk behaviour and reduce local risks that can contribute to accidents. For this reason, in 2011 the Commission argued that premiums and State and Territory funding should be used to send price signals and encourage greater incentives for safety (PC 2011, p. 865).

The Commission acknowledged that the appropriate funding source for no-fault coverage of catastrophic injuries following medical treatment is more complex than for other accidents. A key consideration is to build on existing incentives to minimise risk by:

- motivating the systematic collection and analysis of data that may decrease risks
- varying premiums depending on whether practitioners (or the health sector more broadly) follow best practice protocols and have the appropriate training and credentials (PC 2011, p. 877).

For general injuries, accidents can have a range of causes, such as environmental factors (for example, maintenance of footpaths and safety of play grounds) and the nature of activity being undertaken (such as participating in riskier recreational activities). Local governments are in the best position to put in place incentives to minimise the risk of accidents (such as proper signage around dangerous areas) and to collect revenue to fund the NIIS (including, for example, a levy on local government rates).

Because the States and Territories have greater control over implementing risk reducing programs (and therefore, indirectly, the costs of the NIIS), they should bear the costs of the NIIS if it remains only partially rolled out for an extended period.

To provide incentives for State and Territory Governments to take steps to reduce the incidence of catastrophic accidents, the mechanism chosen to determine funding for the NDIS (to account for the NIIS being only partially operational) would need to ensure governments with lower rates of accidents pay less than governments with higher rates of accidents. Such a mechanism would be complex and it may be difficult to secure unanimous agreement to the parameters that would be involved. The NDIA provided a possible approach, including ways to collect data and apportion costs (box 6.14).

Alternatively, some kind of base adjustment could be made to the general contributions to the NDIS from the States and Territories. Under this approach, the adjustment should reflect

an estimate of the costs incurred by the NDIS in respect of each jurisdiction as a result of the NIIS not being fully operational. Such an adjustment would have the benefit of simplicity (the value of transparent funding arrangements is discussed in chapter 12), but the incentives for risk reduction by the States and Territories would be lost relative to the option discussed above.

Box 6.14 The NDIA's proposed approach to account for partial NIIS

The NDIA's proposed approach to recoup the costs of providing care to people who otherwise would be covered by a fully functioning NIIS involves three steps:

- *Collecting sufficient data:* appropriate data is required to calculate costs intended to be covered by the NIIS, such as past and new compensations as well as data on participants who enter the scheme with a catastrophic injury
- *Apportioning the costs*: using the data collected, the NDIA can apportion costs accordingly (such as accounting for compensation, the injury stream and which state they originate from), and project future injuries and the cost implication on the NDIS.
- *Paying the costs*: as the full scheme funding mechanism is yet to be determined by the Commonwealth, States and Territories, an additional annual or monthly amount could be paid to the NDIA (sub. PP327, pp. 33–34).

The funding mechanism to account for the cost impact on the NDIS of the NIIS not becoming fully operational will be a matter for negotiation between the Australian, State and Territory Governments.

RECOMMENDATION 6.4

If the medical and general accident streams of the National Injury Insurance Scheme are not implemented, then State and Territory Governments should bear the additional costs borne by the National Disability Insurance Scheme because of the absence of these streams.

7 Provider readiness

Key points

- Providers play an important role in meeting the needs and goals of National Disability Insurance Scheme (NDIS) participants, and improving their lives. However, the transition to a market-based system means that providers need to change the way they provide disability supports. To survive in this new environment, providers need to become more efficient, innovative and responsive to participants.
- Scheme costs are affected by the supply of disability supports. Insufficient supply will mean scheme costs are lower in the short term because participants' supports are underutilised, but higher in the longer term because timely supports can reduce participants' costs of care over their lifetimes.
- While the market-based approach will increase providers' incentives to deliver supports in areas previously undersupplied, there will continue to be 'thin markets' where there are few, if any, providers. Arrangements to deal with thin markets (including Provider of Last Resort arrangements) need timely and considered attention because shortages, less competition and poorer participant outcomes may persist.
- Given the individualised needs of participants and specific circumstances that can lead to thin markets, no approach (including block-funding) should be ruled out by the National Disability Insurance Agency (NDIA) when seeking to address situations where the market is not supplying reasonable and necessary supports. Ongoing public reporting, monitoring and evaluation of thin markets are also crucial.
- Services provided 'in-kind' by the Australian, State and Territory Governments can hinder market development, and reduce choice and control for participants. However, some in-kind services are necessary for continuity of support. Careful, cooperative and consistent approaches between the NDIA and governments are needed to end in-kind services as quickly as practicable.
- Study participants pointed to barriers to providing NDIS supports, including: the cost of moving to fee-for-service; the administrative burden of the NDIS; and the risk of less collaboration between providers. While these are likely to be transitional issues, ongoing monitoring can ensure that they do not become entrenched or systemic issues.

National Disability Insurance Scheme (NDIS) costs are affected by the supply of disability supports. If there are not enough providers and workers to deliver the supports allocated by the National Disability Insurance Agency (NDIA) to participants, this will lead to underutilisation of supports, lower than expected costs to the scheme in the short term, but poorer outcomes for participants and their families.

Costs should be considered from a long-term perspective. When reasonable and necessary supports are allocated to participants under the NDIS's insurance-based approach, the

package of supports should minimise the long-term cost of care to the community. If supports are not available, the costs of supporting participants may be higher in the long term — because of more services demanded through the NDIS, through other government services, or through informal carers. There are also costs to participants and their families from reduced wellbeing.

The impact on the wellbeing of a person with disability from not being able to access supports will vary by support type. For example, not being able to find a carer to provide core supports (like an attendant carer to provide assistance to get out of bed and with personal daily activities) is likely to impose a higher cost on a person with disability than not being able to find a provider for community-engagement activities. The use of the community-engagement support is also likely to be contingent on being able to find someone to provide core supports, and vice versa.

The focus of chapters 7–10 is on how ready the market (providers, workers and participants) is, and how this will affect scheme costs. This chapter looks at how existing and new providers are responding to the increased demand for supports under the NDIS.

- Section 7.1 provides a snapshot of the current state of the disability support sector and the expected growth required to meet the demands of the NDIS.
- Section 7.2 looks at where the market supply for disability supports could be limited and result in 'thin markets'.
- Section 7.3 examines the effect of in-kind services.
- Section 7.4 discusses other transitional matters affecting provider readiness.
- Chapter 8 considers the pricing of disability supports.

7.1 The changing disability support market

People with disability have different wants and needs (including personal care, therapy, community participation, and assistance with cleaning and household chores), which require a variety of supports. And the cost of providing supports varies by region and the degree of competition. This means that there are a number of submarkets within the aggregate disability support market. As explained by one provider, there are particular characteristics of the disability support market that distinguish it from a conventional market.

> The disability support 'market' is not a normal or 'perfect' market in classical economic terms. It is about providing a range of customised supports, human and technological, paid and unpaid, to meet complex and often poorly-defined human needs and wants. Outcomes are often hard to measure and report. Information is unbalanced. Regional, rural and remote markets are 'thin'. The 'buyers' of services and their local situations are diverse and heterogeneous, not homogeneous. Many are vulnerable. (House With No Steps, sub. 104, p. 1)

It is within this context that the NDIS is driving market-based competition between disability support providers, at a time when the size of the aggregate disability support market needs to significantly increase to meet NDIS demand. These changes include:

- a shift away from a block-funded, welfare model of support to a fee-for-service, market-based approach
- an increase in funding for the sector from about $8 billion in 2015-16 to at least $22 billion by 2019-20 (SCRGSP 2017; chapter 12)
- assessing and meeting the reasonable and necessary needs of about 475 000 people by 2019-20 (chapter 2)
- about 70 000 additional workers (or about 20 per cent of all new jobs created in Australia) in the three-year transition period to full scheme (Bonyhady 2016, p. 5; chapter 9).

As the NDIA said:

> In the first year [of transition], to meet projected Scheme demand, growth in supply needs to be around eight per cent. By the second and third year respectively, growth must reach 30-40 per cent, although … the supply needed to meet funded participant demand varies depending on location. (2016i, p. 8)

The market for disability supports is diverse and difficult to characterise in general terms. Some providers specialise in providing supports for those with specific disability, while others specialise in providing particular types of supports (such as accommodation or therapeutic supports). Others provide a much more general service.

The data on disability support providers are patchy. The most comprehensive data were collected by Martin and Healy (2010). More recent work by National Disability Services (NDS) and Curtin University's Not-for-profit Initiative contains data on provider characteristics and financial performance.[51] Notwithstanding the data limitations, the data provide some insights.

- Many providers are small.
  - About 40 per cent of disability service outlets employed 10 or fewer disability workers (Martin and Healy 2010, p. 122).
  - The NDS estimated that about 58 per cent of providers are either small or very small (with a turnover of less than $5 million) (Gilchrist and Knight 2017a, p. 10).
- Most disability providers (about 80 per cent of survey respondents) are not-for-profit (NDS 2016, p. 7).

[51] The National Disability Services' (NDS) State of the Disability Sector Report 2016 is based on the fourth wave of the National Business Confidence Survey of 549 disability service providers, of whom 486 were NDS members and 63 were non-members (NDS 2016, p. 7). The NDS has also undertaken a financial benchmarking project for disability services (NDS nd). This work was commenced by Curtin University and is now being done in partnership with the University of Western Australia (Gilchrist and Knight 2017b).

- Most providers do not just provide disability services.
  - About 57 per cent of providers surveyed by the NDS provided services in other areas, such as aged care, mental health and homelessness (NDS 2016, p. 13).

How will the sector need to change under the NDIS?

While a lack of data prevents a comprehensive evaluation of the current state of the sector, envisioning how the future disability sector will look under the NDIS is even more difficult. Some of the supports required by participants will be provided by existing providers who expand, while others will be provided by new entrants. However, what is not certain is:

- how many providers will be needed — and the proportion of new and existing providers
- what the proportion of for-profits, not-for-profits and government service providers will be
- whether there will be greater specialisation by disability, type of support, or both
- how long it will take for these changes to occur.

This uncertainty is reflected in estimates on the number of providers needed under the NDIS. The Australian National Audit Office (2016, p. 68) estimated that between 13 500 and 40 000 providers will be needed by the end of the transition period in 2020. Understanding how existing providers are responding to, and whether new providers are entering, the NDIS market is therefore important.

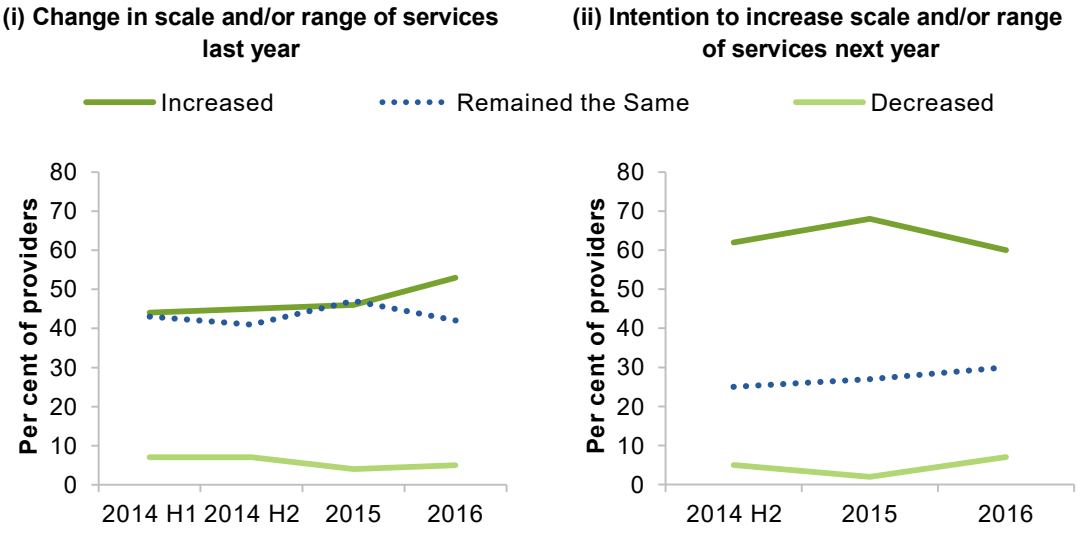
The NDS survey of providers gives some insight on how existing providers are responding. The majority of providers surveyed in September 2016 reported that they had expanded their services last year, and that they intended to expand in 2017 (figure 7.1). Providers reported increasing their services, particularly in the areas of therapy, early intervention, and planning and coordination supports (NDS 2016, p. 11), but the amount of additional supports is unclear.

However, some providers reported plans to reduce or stop supplying services in other areas, and that they are entering new markets (outside of the disability support sector) (NDS 2016, pp. 12–13). The financial position of providers is also variable, and in turn, the strength of existing supply (NDS 2016, pp. 14–15).

It is more difficult to determine the size, scope and number of new providers who are entering the market in response to the NDIS. Data are available on the number of providers *registered* with the NDIA to provide supports under the scheme, which includes both existing and new providers (figure 7.2).

While registrations increased by about 30 per cent between the March 2017 and June 2017 quarters, about 54 per cent of registered providers are not yet active, and the largest 25 per cent of active registered providers currently account for about 80–90 per cent of the value of payments made by the NDIA for participant supports (NDIA 2017y, p. 41).

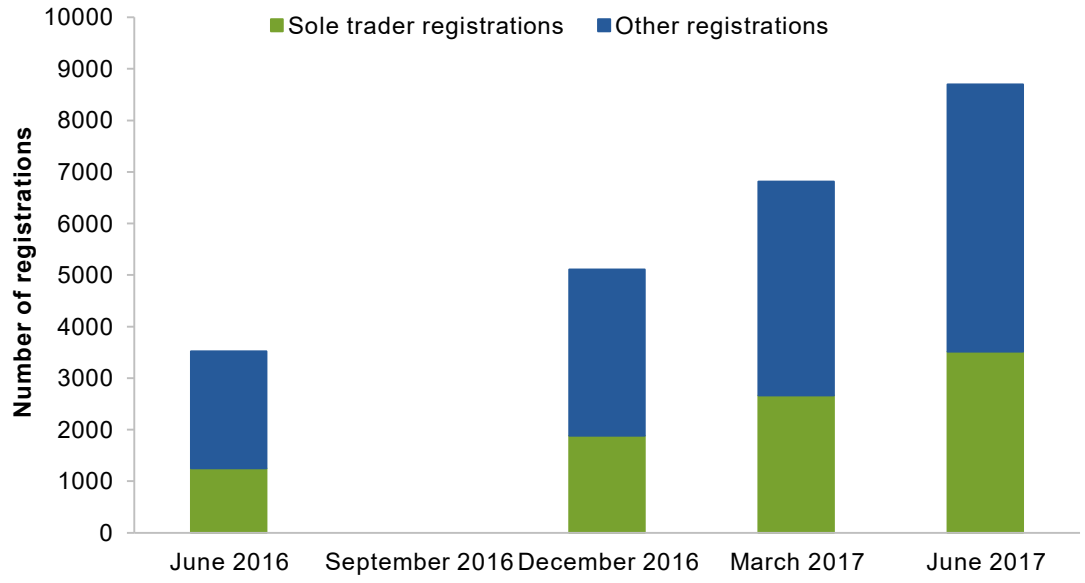
Figure 7.1 **Providers' response and intention to increase supply[a]**



[a] H1 and H2 refer to the first half and second half of the calendar year respectively.

Source: Gilchrist and Knight (2017a, p. 16), who surveyed 492 respondents.

Figure 7.2 **Cumulative number of NDIA-registered providers by quarter[a]**



[a] Data for September 2016 are unavailable.

Sources: Commission estimates based on NDIA (2016p, 2016q, 2017y, 2017z).

This is consistent with NDS data, where 77 per cent of providers surveyed had registered, but only about half had provided services under the NDIS (Gilchrist and Knight 2017a, p. 5).

One explanation could be that some providers are registering to provide services ahead of the NDIS rollout in their location (NDIA 2017y, p. 43; DSS, sub. 146, p. 36).

Growth in registrations of those providing therapy supports — usually allied health professionals — has been strong. In the quarter ending 30 June 2017, allied health professionals accounted for about half (48 per cent) of the increase in registrations (NDIA 2017y, p. 43).

While the scale of market growth to date is uncertain, many providers who made submissions to this study identified the main challenges to developing the market for disability supports as:

- the effect of price controls for supports set by the NDIA (chapter 8)
- concerns that some markets will be too small to be profitable
- government-provided disability services
- other transitional issues affecting provider readiness.

7.2 Thin markets and the Provider of Last Resort

The market-based model for disability supports under the NDIS is designed to encourage greater supply of the supports that people with disability want and need compared with previous arrangements (PC 2011, pp. 111–156). However, there continue to be cases when the disability support market remains too small (in terms of the number of providers or participants) to support the competitive provision of services. This outcome is known as a 'thin market'.

There are a number of negative consequences of thin markets. Insufficient supply may lead to higher prices, less variety, lower quality services and unmet demand. In the disability support sector, thin markets can result in poor participant outcomes, increased demand for mainstream services, and greater pressure on informal carers. Scheme costs are also affected — while they may be lower in the short term (due to underutilisation of supports), they may be higher in the long term if participants are not receiving the right supports at the right time. For these reasons, governments often need to — and do — intervene in thin markets to ensure the supply of disability supports for people with disability.

When will thin markets arise under the NDIS?

Thin markets can arise in places or for particular disability supports when demand is limited and the cost of supply is high. Some have noted that thin markets are most likely to occur in rural, regional and remote areas, for Indigenous and culturally and linguistically diverse (CALD) cohorts, and for specialised supports, such as aids and equipment (DRC 2015a,

p. 19; NDIA 2016i, p. 15). Study participants also identified access problems for particular groups of people with disability, including for some participants:

- living in outer regional, remote or very remote areas[52]
- with complex, specialised or high intensity needs, or very challenging behaviours, such as those with psychosocial disability or who require 24-hour care[53]
- from CALD backgrounds (ECCV, sub. 31)
- who are Aboriginal and Torres Strait Islander Australians[54]
- who have an acute and immediate need (crisis care and accommodation).[55]

Given the early stage of the transition, it is difficult to tell *where* thin markets are under the NDIS, and whether they are diminishing, persisting or growing. And where there are thin markets, it is not necessarily the case that they are occurring because of the NDIS. Thin markets were a feature of the previous disability support arrangements, and are a feature of many other human services (PC 2011, pp. 115–156, 2017b). What is important is that the policies are put in place in a timely manner to minimise their incidence and impact on participants and providers. This is especially the case as the interface with other mainstream services evolves (chapter 6). Thin markets will remain a feature of some disability supports under the NDIS (box 7.1).

52 For example: the AFDO (sub. 180); APC Prosthetics (sub. PP244); Australian Red Cross (sub. PP258); The Benevolent Society (sub. PP334); Cheryl McDonnell (sub. 79); Commonwealth Ombudsman (sub. 137); CTO (sub. PP280); Deaf Australia (sub. 183); EACH (sub. PP276); ECIA NSW/ACT (sub. 190); GIFSA (sub. 13); MAV (sub. PP343); Mental Health and NDIS Facebook Support Group (sub. 8); MND Australia (sub. PP255); MTHCS (subs. 6 and PP222); Northern Territory Government (sub. 205); OPA Victoria (sub. 46); OPG (sub. 143); QAI (sub. 115); Quality Living Options Bendigo (sub. PP220); Queensland Government (sub. PP345); RDAMR (subs. 12 and PP231); and South Australian Government (sub. 203).

53 For example: ABF (sub. PP263); Carers Australia Victoria (sub. 131); Cohealth (sub. PP261); Department of Health (sub. 175); DSA (subs. 9 and PP256); Leadership Plus (sub. 128); Legal Aid NSW (sub. PP245); MHCSA (sub. PP308); Neami National (sub. PP347); NSWCID (sub. PP234); PWSAA (sub. PP228); Tandem (sub. PP212), VALID (sub. PP332); Vision Australia (sub. PP252); Women with Disabilities Victoria (sub. PP282); and Youngcare (sub. PP253).

54 For example: Anglicare NT (sub. PP340); First Peoples Disability Network Australia (sub. PP355); Flourish Australia (sub. PP246); GIFSA (sub. 13); Northern Territory Government (sub. 205); MJD Foundation (sub. PP233); OPG (sub. 143) and VACCHO (subs. 162 and PP223).

55 For example: Anglicare Tasmania (sub. 145, pp. 46–47); DSA (sub. PP256, p. 3); MS Australia (sub. PP283, p. 8); and Youngcare (sub. PP253, p. 2).

Box 7.1 Evidence of thin markets under the NDIS

Thin markets for disability supports have long been an issue for some groups and in some regions. The structure of these thin markets means that many will persist under the National Disability Insurance Scheme (NDIS). For example, the DSS (sub. 146, p. 37) said that there was early anecdotal evidence of thin markets for personal care supports, supports for participants with complex needs, early childhood supports and employment supports. In particular, thin markets are likely to exist for people with disability who live in rural and remote areas, which appears to be confirmed by early evidence from the scheme.

- The NDIA (2016c, p. 34) deemed the supply risks for therapy supports (a specialised support) to be more acute in regional areas in southern New South Wales.
- A National Institute of Labour Studies survey found that unmet demand was experienced more by NDIS participants living in rural and remote areas in the Victorian trial site and by older NDIS participants, particularly by those living in regional areas (Mavromaras, Moskos and Mahuteau 2016, p. xi). These findings were similar to those of a survey of participants living in the Victorian trial site by the Melbourne Social Equity Institute. It found that underutilisation of supports was particularly evident among participants living in regional areas, or those needing highly specialised services and supports (Warr et al. 2017, pp. 30–31).
- In some service regions, the increase in the value of support packages is forecast to grow more quickly than the growth in participants (NDIA 2016l, pp. 10–12, 2016x, pp. 10–12). This could reflect a lack of supports and more unmet demand for these participants.
- In South Australia, almost one-third of NDIS participants are expected to reside outside of Adelaide (NDIA 2016u, p. 25); however, the NDIA observed that there was a lack of provider choice in remote and very remote areas in South Australia, with participants often dependent on a key support worker (NDIA 2016u, p. 26).
- Participants in the Barkly region in the Northern Territory had the third highest level of unutilised funding — 41 per cent of committed supports in 2014-15, and 64 per cent in 2015-16 (NDIA 2017v, p. 29). However, underutilisation may be due to a number of factors other than unmet demand (chapter 2).
- In the Northern Territory, there appears to be a shortage of supports for physical disabilities. At the end of June 2016, only one per cent of active registered providers in the Northern Territory provided physical wellbeing services, but 27 per cent of participants with an approved plan in the Barkly trial region were identified as having 'other physical disabilities' (NDIA 2017v, pp. 10, 22). The NDIA noted that:

  > Given the much higher level of physical disability in the Territory as compared to … [Victoria and New South Wales], the number of providers registered to provide physical wellbeing supports appears to be low. (2017v, p. 21)

How should thin markets be addressed?

One of the challenges of addressing thin markets is that while they share some common characteristics, often they have very specific and different causes. A 'one-size-fits-all' approach will not to be feasible or effective. A more tailored response that considers the complexities of dealing with the wide variety of thin markets is required, taking into account issues such as the presence of CALD and Aboriginal and Torres Strait Islander communities,

quality of infrastructure, weather events and population density.[56] In practice, it means that standardised approaches to pricing may not be effective to encourage supply in some thin markets. This is reflected in the diversity of options that can be used to address thin markets (box 7.2).

However, there are costs associated with government intervention to minimise underprovision of disability supports in thin markets. To address thin markets, it is necessary to balance the trade-off between providing services that are not only cost-effective, but also as flexible as possible to enable participant choice and control. For example, the NDIA's Rural and Remote Strategy (NDIA 2016t), and Aboriginal and Torres Strait Islander Engagement Strategy (NDIA 2017b) both reflect the need to provide disability supports in a way that allows for as much choice and control for participants as possible, and to encourage innovative methods of service delivery.

Such an approach is also reflected in the Bilateral Agreement between the Northern Territory and Australian Governments on the transition to the NDIS, as the Northern Territory has historically faced particular challenges in providing human services due to thin markets (PC 2017b). It was agreed that the Northern Territory's approach to the transition would be guided by the following principles:

- place-based, tailored solutions to planning, market development, access to services and risk management
- a coordinated, client-centred, and tailored approach to the operating model in remote communities, informed by existing effective frameworks that maximise access, engagement and management of risk for individuals
- culturally competent engagement and professional practices
- local planning, market development and risk management strategies informed by timely and appropriate data (Australian Government and Northern Territory Government 2016, p. 4).

It is too early to assess how these principles have been implemented in practice, how effective they have been in addressing thin markets, and whether such approaches are appropriate for other jurisdictions. The NDIS Evaluation Consolidated Report, which is to be released in the latter half of 2017, may provide useful guidance on this issue (Mavromaras, Moskos and Mahuteau 2016, p. 18).

[56] For example, scheme participant density in the Northern Territory (except the Darwin urban service region) in 2020 is expected to be less than five participants per 100 square kilometres (NDIA 2017v, p. 14). Despite remoteness price loadings, some providers in Queensland also reported to the NDIA that recent new providers were concentrated in major population centres such as Townsville, Cairns and Mackay (NDIA 2016s, p. 33). The Commonwealth Ombudsman (sub. 137, p. 16) also noted that some existing providers who specialise in providing services for people with disability who are CALD and Aboriginal and Torres Strait Islander Australians may not be able to make the transition, due to registration barriers and insufficient cash reserves to transition to fee-for-service.

Box 7.2 Different approaches to address thin markets

There are a number of measures that could be used to mitigate the risks of thin markets.

- Partial or full block-funding to commission or procure services (PC 2011, pp. 521–523). Goldfields Individual and Family Support Association (sub. 13, p. 12) said that removing block-funding would likely result in an 'almost complete loss of … services on the very remote Lands'. Many study participants said that block-funding is the most efficient way to ensure that needs are met (Centacare Brisbane, sub. 44; Australian Blindness Forum, sub. 48; Cohealth, sub. 50; Anglicare Tasmania, sub. 145; and Department of Health, sub. PP360).
- Sharing infrastructure, knowledge, skills and experience among providers.
- Facilitating bulk-purchasing arrangements by participants — for example, by pooling participants' funds (Mallee Track Health and Community Service, sub. 6; PC 2017b).
- More collaboration, coordination and integration of services, particularly with existing local and mainstream service providers, community organisations (including Indigenous organisations) — to avoid supply gaps or duplication (CADR 2014, p. 15; RACGP, sub. 200). Providing more hours of support coordination in participants' packages should also be considered, particularly for those with complex needs (Alzheimer's Australia, sub. 10, pp. 9–10). Brain Injury SA (sub. 116, p. 14) and the First Peoples Disability Network Australia (sub. PP355, p. 10) emphasised the need for effective coordination of services among the Australian, State, Territory and local Governments.
- Use of community- or place-based services (PC 2017b) — including greater employment and training of the local workforce where possible. Aboriginal community controlled organisations could also have a role in building community capacity in delivering disability services for Aboriginal and Torres Strait Islander participants living in rural and remote locations (VACCHO, sub. 162, PP223; AMSANT, sub. PP336; JSCNDIS 2017c, p. 46).
- Greater use of information technology — including videoconferencing, telehealth and other technologies, particularly for therapeutic supports (NDIA 2016w, p. 28; APA, sub. 93; Amaze, sub. 160; Livecare Australia, sub. PP217).
- The NDIA providing more detailed and frequent information on market demand (and unmet demand) to encourage providers to enter thin markets. The NSW Government (sub. PP230, p. 7) said that more information on location, type and quantum of demand is required.
- Cultural training, education and awareness programs (Brain Injury SA, sub. 116; Commonwealth Ombudsman, sub. 137) — including greater funding of translators and interpreters (GIFSA, sub. 13; Cohealth, sub. 50; SDN Children's Services, sub. 73; and Companion House, sub. 84).
- More support and respite care for informal carers (chapter 9).
- Greater engagement with the local community to build trust and relationships — including consideration of community feedback on provider performance (PC 2017b) and the development of community plans (First Peoples Disability Network Australia, sub. PP355, p. 9).

What is being done to address thin markets?

Based on the experience of the NDIS trial sites (particularly the Barkly trial in the Northern Territory), the NDIA said that it would consider a range of approaches to mitigate the risk of thin markets, including:

- active and deliberate cross-government collaboration — including the use of locally-based workers, and educating the community about the interface between health services and disability supports
- leveraging established community organisations (such as those already operating in health, aged and community care sectors) that may also deliver disability services
- supporting providers to access supports from business councils, Indigenous Business Australia, or any other organisation in the Aboriginal and Torres Strait Islander business capacity-building sector
- using the hub and spoke model (also known as scaffolded support) — where generalist providers provide support in the rural or remote community, and where needed, can collaborate or seek oversight from an advanced practitioner or specialist centre, either through a visiting clinic or telepresence
- working with existing mainstream providers to expand their services to better meet the needs of participants — such as plan management services by local accounting services and re-purposing underutilised infrastructure (sub. 161, pp. 105–106).

These approaches rely heavily on the commercial decisions of providers (such as the type of workforce, the decision to deliver disability services, and service delivery business models). They also reflect an attempt to make the market-based, consumer-driven approach succeed where possible — with more interventionist alternatives a last resort (such as directly commissioning or providing supports). The NDIA (sub. 161, p. 106) noted that 'some providers are thinking creatively about supply in thin markets', including by diversifying into associated areas to provide additional business income, and forming business relationships between urban and remote businesses.

Study participants had mixed views on the NDIA's proposed approaches, particularly in relation to greater reliance on mainstream providers.

- The NSW Government (sub. PP230, pp. 6–7) cautiously supported the idea of using mainstream providers, but emphasised that 'mainstream government service providers should be the exception, not the norm', as it could stifle the development of a competitive market. It argued that there needed to be a clear strategy and actions to encourage non-government providers to supply services to people with disability.
- Vision Australia (sub. PP252, p. 11) agreed that reliance on mainstream services may be practical and cost-effective. However, it noted that ensuring quality of service would be challenging and that funding through Information, Linkages and Capacity building grants to provide training and support for mainstream providers may be a useful trial.

- Inclusion Australia (sub. PP357, p. 21) was also sceptical about the responsiveness of mainstream providers to the needs of people with disability, given their 'poor track record' in responding to these needs.
- The MJD Foundation (sub. PP233, p. 10) argued that the reliance on mainstream providers has so far not been achievable, and that cross-government collaboration has generally not been successful to improve outcomes for Aboriginal and Torres Strait Islander participants in remote communities.

While the details of how providers are to be encouraged to supply thin markets are not yet clear, the NDIA and DSS are jointly developing a more detailed Market Intervention Framework to address thin markets, which is being negotiated with each jurisdiction (NDIA 2016i, p. 15, 2016t, p. 26). The Commission understands that the NDIA is developing a more detailed Market Intervention Strategy to support the establishment of a more developed NDIA market monitoring system and to facilitate the NDIA's decision-making on market interventions (DSS and NDIA, pers. comm., 4 October 2017). This strategy is expected to be completed in late 2017 (DSS and NDIA, pers. comm., 4 October 2017).

Given that the NDIS is already more than 12 months into the transition phase, there is a risk that thin markets will persist or worsen in the absence of clear and timely strategies and intervention by the NDIA. The NDIA needs to clarify and implement practical measures to mitigate the risks to participants associated with thin markets, particularly with the withdrawal of government-provided disability services (DSS, sub. 146, p. 37; NSWCID, sub. PP234, p. 5). As the Victorian Government said:

> Greater certainty surrounding market intervention and provider of last resort arrangements is also required as thin markets and provider viability could compromise the scheme's capacity to deliver choice to participants … The NDIA is ultimately the market steward: there are significant risks to participants, providers and states if its capability to identify and intervene in thin markets is not in place by full scheme. (sub. PP298, p. 15)

While acknowledging the NDIA's Rural and Remote Strategy, the Joint Standing Committee on the NDIS recommended that:

> … the NDIA in collaboration with the Australian, State and Territory Governments develops a strategy to address the service gaps that exist for rural and remote communities. (2017c, p. 50)

Interventions also need to be tailored to the specific circumstances of each case — such as user characteristics, the broader service landscape, resource constraints and effects on the wider community (PC 2017b). The diversity of user needs means that a 'one-size-fits-all' solution will not be effective to address access issues. And it is inappropriate to automatically default to block-funding, direct commissioning or mainstream services (particularly health and aged care services) unless it is necessary. While it is likely that block-funding will be needed in some cases (PC 2011, pp. 521–523) — such as for services that benefit many people with disability and when isolating the individual cost is difficult (National Mental Health Commission, sub. PP319, p. 12) — care must be taken to avoid crowding out competition.

There is a need for collaboration between the Australian and State and Territory Governments, given the latter's knowledge and experience as funders and providers of disability services. Anglicare South Australia noted that the Exceptional Needs Unit in the Disability SA division of the SA Government Department for Communities and Social Inclusion was a practical example of when block funding, specialisation and government collaboration were appropriate for one thin market — people with disability who have complex needs and comorbidities in South Australia (Anglicare Australia, sub. PP339, p. 7).

Addressing thin markets requires a whole-of-government approach and community involvement, but some experiences to date suggest that this is not occurring in some instances (Anglicare Australia, sub. PP339, p. 9). For example, Anglicare NT reported a lack of collaboration between government departments in aged care and disability, even though in some remote communities they may be the same providers and the same workers.

> The further one moves out from any regional centre into a remote community in Central Australia or the Top End, the greater is the probability that the services for people with a disability and older people will be provided by the same service provider and indeed the same staff! Yet there is little interface between the two Commonwealth Departments that are responsible for funding these services and driving these reforms. Clearly a place based whole of government approach that works to build up a community's capacity is what is required at this time. (sub. PP340, p. 4)

Government and community collaboration are important to provide services in remote Indigenous communities (MJD Foundation, sub. PP233, p. 10; PC 2017b). The Steering Committee for the Review of Government Service Provision's most recent report on *Overcoming Indigenous Disadvantage* noted that the set of 'success factors' include:

- cooperative approaches between Aboriginal and Torres Strait Islander Australians and government — often with the non-profit and private sectors as well
- community involvement in program design and decision-making — a 'bottom-up' rather than a 'top-down' approach
- good governance — at organisation, community and government levels
- ongoing government support — including human, financial and physical resources (2016a, p. 3.18).

The MJD Foundation said that:

> The way forward is to build on established community organisations that have a successful track record in delivering services and who have existing good relationships with families and communities in the remote areas. Collaboration and not control should be the focus (sub. PP233, p. 10).

It will not always be possible to match the price, quality and range of services in the major cities (PC 2011, p. 529). Some participants may need to travel (and in some cases, move) to metropolitan areas to access highly specialised services. This highlights the need for complementary services, such as transport to access specialised disability care, to be provided either in a participant's plan or outside of the NDIS where appropriate (chapter 6).

Improving access to supports for participants in thin markets is a key objective of the NDIS, but it is an ongoing task requiring constant vigilance, monitoring and evaluation (box 7.3).

Box 7.3 Addressing thin markets requires data and ongoing reporting

Mitigating the effects of thin markets (and informing associated funding arrangements) requires more transparent identification, reporting and evaluation of thin markets. Planning, evaluation, monitoring and feedback systems (as well as commissioning practices) are discussed in the Commission's current inquiry on Human Services (PC 2017b). Specific key performance targets and indicators (both outputs and outcomes) need to be developed, and the relevant data collected, to ensure the equity, effectiveness and efficiency of disability supports and thin market strategies. This was recognised by the Joint Standing Committee on the NDIS for services in rural and remote areas. The Committee recommended that:

> … all options to develop a market that provides choice and control for participants in rural and remote areas be explored, and that any additional funding for disability in the Northern Territory to any provider is conditional on measureable increases in service provision. (2015, p. 76)

The Northern Territory Government also emphasised the need for more granular data.

> The availability of more granular data is particularly important to enable monitoring of the Scheme's roll out in remote regions and thin markets — where the NDIS market-based model is most challenging to implement. Detailed regional level data is also important to inform service providers to enable localised market growth and development (e.g. client base, size of market, and service provider gaps). (sub. 205, p. 3)

Information on thin markets (including through Local Area Coordinators and current feedback mechanisms in the NDIS) could supplement current reporting to the DRC under the National Disability Strategy. In particular, reporting in each thin market could better reflect similar measures reported by the Commission as part of the National Disability Agreement, including:

- participation rates — such as the number of eligible participants; the severity and nature of disabilities; and other participant characteristics (as well as their trends and drivers). The Joint Standing Committee on the NDIS (2015, pp. 62–67) noted a lack of data for participants who are from CALD backgrounds, as well as for Aboriginal and Torres Strait Islander Australians
- access or support use by participants — this would map use of existing and future services, such as: plan activation; the frequency and scope of plan reviews; utilisation rates; the number of providers, workers and supports; as well as market concentration
- appropriateness of supports — for example, whether supports were delivered in a culturally and linguistically respectful manner in accordance with the NDIA's Aboriginal and Torres Strait Islander Engagement Strategy
- quality of services — such as reporting the satisfaction rate of participants and carers, and any complaints under the NDIS Quality and Safeguarding Framework (and State and Territory Government quality and safeguard regulations in the interim)
- cost per unit of output — including government and NDIA contribution per participant, and forecasts of future costs per participant (this is consistent with an insurance-based approach)
- participant outcomes — such as choice and control, economic or social participation, and use of other services by people with disability (including mainstream services and informal supports) (SCRGSP 2017, p. 15.1–15.39).

Timely and ongoing data collection is particularly important as the NDIA's online platform (eMarketPlace) is still being developed (chapter 10).

Regardless of the approach taken, it is clear that there is an need for strong market stewardship by governments, as well as a consistent framework against which actions are taken to mitigate thin markets (PC 2017b; NSW Government, sub. PP230, p. 7; chapter 10).

FINDING 7.1

In a market-based model for disability supports, thin markets will persist for some groups, including some participants:

- living in outer regional, remote and very remote areas
- with complex, specialised or high intensity needs, or very challenging behaviours
- from culturally and linguistically diverse backgrounds
- who are Aboriginal and Torres Strait Islander Australians
- who have an acute and immediate need (crisis care and accommodation).

In the absence of effective government intervention, such market failure will result in greater shortages, less competition and ultimately poorer participant outcomes.

What if there is no market? The Provider of Last Resort

The NDIA does not directly supply individualised supports to participants, but there are times when it may take a direct role to ensure that services are provided (for example, by providing or commissioning services). This might occur in very specific and exceptional circumstances when providers are unwilling or unable to supply disability supports under NDIS policy settings, such as when:

- participants cannot access disability supports — there is no provider, or the only external provider is likely to fail in circumstances that would leave participants at risk (such as in remote locations)
- supports are not available at reasonable prices — this might be true for participants with highly complex needs or challenging behaviours, or in emergency situations when supports are needed at short notice
- it is difficult to verify that external providers are genuinely achieving good quality outcomes for participants or their carers
- there are significant economies of scope from combining or coordinating several services together, and when the government has an advantage in supplying the package of services — this might apply to participants who are Aboriginal and Torres Strait Islander Australians, where governments might have to deal with multiple levels of disadvantage (income, housing, health, education, urban amenity, employment, transport and disability) (NDIA 2016i, pp. 26–27; PC 2011, p. 409).

The principles that should govern provider of last resort (POLR) arrangements were considered by the Commission in 2011. The Commission said that the POLR should be subject to the same regulatory oversight and monitoring as other providers in the scheme,

and that block-funding of providers should only be used when fee-for-service was proven to be infeasible to ensure the supply of supports (PC 2011, pp. 523–526).

The Commission also emphasised the need for the POLR arrangements to be contestable and at arm's length from the commissioning body. And, when block-funding is judged to be the preferred method, that the NDIA should develop standardised tendering, contracting, reporting and acquittal requirements in order to reduce compliance costs (PC 2011, pp. 523, 528). It is not the role of the NDIA to support failing providers in thin markets, but to ensure that disability supports for participants are provided in the most effective and efficient way. The overriding aim of the POLR arrangements is to ensure continuity of support and to protect the wellbeing of participants.

The POLR arrangements for the NDIS are still being developed by the NDIA and DSS, but appear broadly consistent with the Commission's views in 2011 (box 7.4). The Commission understands that the NDIA is currently developing participant-centred operational processes to replace the previous POLR system of grants and programs for complex or very complex NDIS participants (DSS and NDIA, pers. comm., 4 October 2017). The NDIA is working with States and Territories to deliver position statements to replace existing POLR arrangements. This phase of the project is due to be completed in December 2017 (DSS and NDIA, pers. comm., 4 October 2017). However, the delay in formalising these arrangements is resulting in some uncertainty for participants, providers and governments. For example:

- The Tasmanian Government (sub. PP247, p. 8) said that the NDIA's POLR arrangements have not yet been negotiated for Tasmania.
- The Victorian Government (sub. PP298, p. 15) reported that work has commenced to construct a range of NDIS market risk scenarios to inform how market risks and crises will be managed under the POLR framework and broader Market Intervention Framework. However, the operational details for Victoria are yet to be worked out.
- The ACT Government (sub. PP312, p. 7) noted that to date, the issue of the POLR had not been addressed in the ACT. In its view, the NDIA had taken an individualised, rather than a systematic, approach to concerns it had raised, particularly in relation to participants with very high needs and challenging behaviours that concern all elements of the human services system.

The NDS stated that the POLR arrangements under the NDIS are:

> … currently poorly articulated and are inadequate. This needs to be addressed, ideally through the NDIA establishing emergency response agreements with a number of disability support providers across the country. (sub. 51, p. 16)

More recently, the Joint Standing Committee on the NDIS emphasised the importance of continuity of support for participants, and recommended that:

> … the NDIA provides details how it is ensuring a provider of last resort is available for all NDIS participants unable to find a suitable service provider, regardless of their location, circumstances and types of approved supports. (2017c, p. 50)

Box 7.4 The NDIA's Provider of Last Resort arrangements

What is the Provider of Last Resort (POLR)?

As a market steward, the NDIA is responsible for the POLR arrangements. When there is a significant risk of insufficient market supply; when no provider is available; or in the event of provider failure (for example, if the *only* local provider for a range of disability support services in a remote community goes into administration), the NDIA may directly commission and procure disability supports for scheme participants. As the NDIA said:

> If local providers are not available, the NDIA may enter into agreements (and at times contracts) with specific providers for provision of services to more remote regions. The contract with a service provider [will] specify how the cost of travel and any other associated expenses in these areas. (2017q, p. 16)
>
> The NDIA is prepared to act to reinforce thin markets where intervention is necessary to ensure market supply, and to act as a Provider of Last Resort where the market fails to provide this supply. (sub. PP327, p. 40)

Triggers are likely to include:

- insufficient, volatile or uneven supply — in a particular geography, market segment or service type, potentially due to lack of scale or lack of providers being active in that market
- evidence of inappropriate use of market power — for example, constraints to competition or lack of consumers exercising choice
- insufficient quality at a reasonable price
- benefits for greater return on investment from arrangements other than individual commissioning.

A provider contracted as a POLR will need to meet agreed quality standards and ensure that services are delivered in an appropriate and culturally competent way. The provider may also need to leverage existing infrastructure. The NDIA considers the POLR policy to be a highly interventionist form of market intervention.

Who is responsible for the POLR?

As the transition leads to full scheme, the NDIA will lead an integrated response jointly with the States and Territories. In the interim, the States and Territories lead as the POLR, and will continue to do so for providers who they fund during transition (except for the Northern Territory, where the NDIA is responsible for ensuring the POLR services even in the transition period pursuant to Schedule K of the Northern Territory Bilateral Agreement). The Agency noted that identification and response to such market failure will require collaboration among all NDIS stakeholders.

What does the POLR involve?

The POLR framework forms part of the NDIA's broader Market Intervention Framework. Both are currently being developed by the NDIA and DSS, and negotiated with each jurisdiction. It was expected that in 2016-17, the NDIA would agree to the POLR processes, and that by 2018-19, there will be a maturity of the POLR capabilities to potentially include a range of response options (such as panels in relevant jurisdictions or sub-markets capable of providing emergency capabilities at extremely short notice) (NDIA 2016i, p. 15, 2016t, p. 26).

Sources: NDIA (2016i, 2016t, 2017q, p. 16).

There is some guidance about the POLR arrangements for scheme participants in the Northern Territory. In the Bilateral Agreement between the Australian and the Northern

Territory Governments on the transition to the NDIS, it was agreed that the NDIA would be responsible for ensuring that the POLR services are in place for all participants in the Northern Territory (Australian Government and Northern Territory Government 2016, Schedule K).

The Bilateral Agreement also includes principles on how these arrangements are to work where there is a 'significant risk of service failure' (Australian Government and Northern Territory Government 2016, Schedule K). These principles include considering risk, transparency, a person-centred approach, non-exclusivity, barriers to entry, supply of services and end of service arrangements. It also stated that 'solutions will be established to avoid inappropriate default to the acute medical system as the provider of last resort' (Australian Government and Northern Territory Government 2016, p. 2, Schedule K).

Some study participants commented that this detail is not sufficient to ensure that the POLR arrangements are in place (nor what they would mean in practice).

> The State Committee is further concerned the POLR commitment is behind in its conceptual and operational planning in line with the rollout schedule and ambiguous to members on what these provisions mean in terms of their own business planning and existing services. We ask that urgent attention be given to clarify the POLR aspect of the NT Bilateral Agreement so as to further mitigate the risk of market failure. (TEAMhealth, sub. 102, p. 22)

> In January 2017, participants in the East Arnhem region commenced transition to the NDIS. It is concerning that the rollout commenced without a clear framework for the Provider of Last Resort (POLR) … Schedule K does not define what constitutes 'service failure' or how it will be recognized or measured by the NDIA, nor when it is necessary for the Provider of Last Resort (POLR) arrangement to be put in place … in 2014–2015 participants in the Barkly region in the NT had the third highest level of unutilised funding – 41 percent. At what point is this recognized as service failure and the need for market intervention? (Anglicare NT, sub. PP340, pp. 1–2)

The Northern Territory Government (sub. PP359, p. 15) said that it is working with the NDIA to develop the POLR framework, which once developed, could have broader application nationally. The Northern Territory Government (sub. PP359, p. 4) also recommended that the POLR include a panel of emergency service providers, and options for short-term block or direct funding arrangements until more permanent arrangements can be established.

There is an increasing need for greater clarity on how the POLR and thin market arrangements more generally are to be put into practice, particularly as governments change their involvement in providing disability and mainstream supports (section 7.3 and chapter 6).

It is critical for the NDIA to clarify how the POLR arrangements are to operate, and how the Agency intends to intervene in the market more generally, by publishing the relevant policies and strategies immediately.

RECOMMENDATION 7.1

The National Disability Insurance Agency should address thin markets by:

- considering a range of approaches, including block-funding
- publicly releasing its Provider of Last Resort (POLR) policy and Market Intervention Framework discussed in the *NDIS Market Approach: Statement of Opportunity and Intent* as a matter of urgency
- collecting and making publicly available disaggregated data, feedback and reports on thin markets, including when POLR arrangements are used.

7.3 In-kind services

Under Bilateral Agreements between the Australian and State and Territory Governments, government funding of the NDIS is a combination of 'in-kind' services and cash contributions, with the proportion differing by jurisdiction. In-kind services are Australian, State and Territory Government programs under existing block-funding arrangements that continue to exist to ensure continuity of support in the short term, and may also partly reflect the long-term contracts involved.

In practice, this means that governments may continue to remain a service provider, or block-fund a provider to deliver services. Under the Bilateral Agreements, most in-kind services will be phased out during transition and replaced by cash contributions where possible, though the timing of this varies by jurisdiction. At the commencement of transition, in-kind contributions accounted for about 19 per cent of total package costs, and at commencement of full scheme, they are expected to account for about 10 per cent (DSS, sub. 146, pp. 22–23).

The withdrawal of in-kind services is consistent with the NDIS objective of a more competitive, consumer-driven and market-based system, with services to be delivered by a wider range of private providers. Governments will no longer provide or procure disability services except in limited circumstances, such as in thin markets and under the POLR arrangements (section 7.2).

In–kind services have many disadvantages …

There are concerns that the continuation of in-kind services may adversely affect:

- the transition by existing providers
- market entry (PC 2017b)
- the quality of supports (PDA, sub. 38, p. 13)
- overall scheme costs.

Providers may delay adapting to the fee-for-service model due to ongoing block-funding under in-kind service arrangements (Mavromaras, Moskos and Mahuteau 2016, p. 45; NDIA, sub. 161, p. 102). In addition, providers may have less incentive to provide or increase services if they are effectively prevented from providing supports to participants where there are in-kind services (NDIA 2016i, p. 7).

The risk of deterring private providers may be higher in regional or remote areas, and other thin markets, where governments may be the main provider with few actual or potential competitors.

> Mr Croker from Keep Moving, was concerned that because the NT Government was the only entity that was able to provide services across all of the region, this left his organisation effectively in competition with the NT Government and begged the question of 'How do you compete as a private enterprise against government departments?'. (JSCNDIS 2015, p. 68)

In-kind services can also hinder innovation and restrict participants' choice and control, as these services must be used where they are provided and available to participants (NDIA, sub. 161, p. 47; *National Disability Insurance Scheme (Plan Management) Rules 2013* (Cwlth), rr. 6.8-6.9). Some in-kind services also cannot be bundled by the NDIA and can only be priced as individual line items (JSCNDIS 2015, p. 33), often at prices higher than the NDIA's price caps (NDIA, sub. 161, p. 101). This limits the potential efficiencies and pro-competitive benefits of allowing providers to bundle supports due to economies of scale or scope. As the NDIA said:

> The NDIA considers that in-kind funding arrangements are limiting choice and control for participants, imposing additional burdens on the NDIA, and may also be limiting growth in certain parts of the market. (sub. PP327, p. 67)

In-kind services also raise broader funding issues, including cost- and risk-shifting between the Australian and State and Territory governments (chapter 12). Funding issues are compounded by a lack of data and transparency on the true, like-for-like cost of providing in-kind services between government and private providers.[57]

… but in-kind services may be necessary in some circumstances

While in-kind services have drawbacks in terms of market development and participant choice, some argued that in-kind services are necessary — in some cases beyond transition — to ensure continuity of support to people with disability. This is particularly the case for those in thin markets and with complex needs. Some study participants, particularly State and Territory Governments, argued that in-kind services may need to persist in a range of circumstances, including where:

[57] Bilateral Agreements between the Australian and State and Territory Governments contain estimates of a jurisdiction's in-kind contribution, and a requirement that in-kind contributions during transition be based on the current cost of delivering services. The price and value of any in-kind contributions at full scheme will be separately agreed by June 2018.

- there is no provider (especially for participants with complex needs)
- the cost of in-kind services reflect economies of scale, or higher quality supports (based on greater supervision, lower casualisation and better training) than what can be supplied in the market
- in-kind services can complement other services to be provided in the scheme, which encourages entry by new providers of those services. (For example, where government housing (provided in-kind) and attendant care (provided by the market) combine to provide supported independent living for participants under the scheme.)
- in-kind services support other people with disability (who are not NDIS participants), or are not easily separated from other service systems
- the administrative costs of dismantling in-kind services are large.[58]

However, some of these arguments are not good reasons to continue in-kind services. Providing services to non-scheme participants is important (chapter 6), but should not be cost-shifted to the scheme through in-kind funding arrangements. Nor should in-kind funding arrangements be used to unnecessarily preserve the high — and potentially inefficient — administrative costs of such services.

The lack of a market, and the nature of the in-kind service provided compared to what is provided in the market, are more complicated — and arguably valid — reasons to continue in-kind supports. This is more likely to be an issue 'in the eye of the beholder', as governments and the NDIA may not agree on whether the market can provide the quality and quantity of supports that are being provided in-kind. The lack of a POLR policy adds complexity about whether governments can phase out in-kind services with confidence that there is continuity of support for participants.

The pace of the rollout is also contributing to concerns about whether the market can supply enough supports while in-kind services are withdrawn. This concern has apparently led the NDIA, in some cases, to request that governments slow down their withdrawal of in-kind services, such as transport and personal care services provided in schools (Tasmanian Government, sub. PP247, p. 11; Queensland Government, sub. PP345, p. 27). The Queensland Government also argued that in-kind services need to continue when the NDIS is unable to manage the transition of a service due to a range of factors, including market and workforce issues in the NDIS.

> … it is important to acknowledge that in some instances in-kind may be required as an extended interim option to maintain services post-transition while longer term and more permanent solutions are being developed and complexities are being addressed. (sub. PP345, p. 27)

[58] HSU (sub. PP316, pp. 9–10); New South Wales Government (sub. PP230, pp. 12–13); NMHC (sub. PP319, p. 17); Northern Territory Government (sub. PP359, pp. 8–9); Queensland Government (sub. PP345, p. 27); South Australian Government (sub. 203, p. 16) and Tasmanian Government (sub. PP247, p. 11).

In-kind services need to be phased out carefully

There are strong grounds to phase out in-kind services, but the phasing out must be done with care and cooperation.

- Care must be taken to ensure continuity of support for participants currently using in-kind services, and that there are arrangements to transfer participants to private providers (in consultation with participants, their families and providers).
- Cooperation between governments and the NDIA is necessary to identify where in-kind services can be safely withdrawn (in the context of a market with sufficient supply to meet participants' needs).

The Commission recommends that in-kind services be phased out as quickly as possible, subject to the following considerations.

- Where there are services that need to be provided in-kind to assure continuity of support, there should be greater public reporting and transparency of the costs and use of these services.
- Governments should publicly report on the cost and quality of services being provided in-kind, publish their reasons and provide evidence on why in-kind services cannot be provided by the market, and a timetable for when in-kind services will end.
- The NDIA should also closely monitor in-kind services and co-operate with governments where the Agency's market intelligence indicates that in-kind services can be 'cashed out' where market supply is available.

RECOMMENDATION 7.2

Bilateral agreements regarding the full rollout of the National Disability Insurance Scheme should only include in-kind funding arrangements for services that are required to ensure continuity of support for existing clients. For in-kind services that persist past transition, a timetable for when they will be 'cashed out' should be included in bilateral agreements.

7.4 Other factors affecting provider readiness in transition

As the NDIS is a new system and is creating a new market, there are several transitional issues affecting the sector's supply response. These include:

- challenges faced by providers who were previously block-funded
- administrative burdens associated with the scheme
- the scheme's effect on collaboration among providers.

Moving from block-funding to fee-for-service

Prior to the NDIS, providers received government funding *before* providing certain supports in 'bulk' to participants (table 1.1). This usually took the form of lump sum payments for each participant under annual contracts that were paid three months in advance (AONSW 2017, p. 7). Providers now claim reimbursement from the NDIA *after* providing individualised supports to scheme participants, unless the NDIA has given prior written approval for prepayments.[59] The majority of support items are based on per hour, or per instance of service provided (NDIA 2017q, 2017r, 2017s, 2017t). This affects the capacity of providers to deliver disability supports under the NDIS.

Providers face significant challenges to adapt to the new fee-for-service model, and some may not be able to make the transition. The shift to the competitive provision of disability services may create upward pressure on production costs for a wide variety of reasons. Providers bear increased financial risk (such as from non-payment and late payment), and in turn, may have a greater need for cash reserves, making it harder to maintain liquidity and solvency (DSS, sub. 146, p. 37). The NDS (2015, p. 17) stated that 'the majority of not-for-profit disability service providers report insufficient cash flow required to transition to the NDIS'. Providers will incur fixed costs to restructure and adapt their business to the NDIS market. Costs may relate to unit pricing, ICT, accounting, advertising, the provision of individualised supports, labour and other input costs.

While these production costs are likely to be significant given the scale and nature of the required changes (particularly for small providers, of which there are many in the disability support sector (box 7.5)), they are better addressed by the price received for supports than the payment method (PC 2011, p. 520).

In general, the need to cover fixed costs is not a reason for government intervention (PC 2011, p. 523). Fixed costs are also likely to be a transitional issue for a number of reasons, and be offset against any eventual gain in efficiency.

- The introduction of innovative payment systems by some financial intermediaries may reduce some of the financial risks of the fee-for-service model and help providers adapt to the new system (Eyers 2017).
- Price deregulation will help providers recover their fixed costs in the longer term, as prices will more accurately reflect the cost of supply, and fixed costs will be driven by consumer preferences (PC 2011, p. 520).
- Providers may be able to use different pricing methods to efficiently recover fixed costs (such as discounts for regular users, or for periods when demand is lower) (PC 2011, p. 521).

[59] Prepayment will only occur in exceptional circumstances such as home modifications and remote area servicing. The NDIA may also approve prepayment for certain assistive technologies where this has been agreed by the participant (NDIA 2017q, pp. 11, 18, 2017r, pp. 12, 19, 2017s, pp. 12, 19, 2017t, pp. 12, 19).

- The experience of providers in adjacent sectors in the economy (including aged care) that moved from block-funding to fee-for-service as part of consumer-directed care reforms also suggests that adjustment can and will take place in the medium to long term (although differences between disability and other sectors make direct comparisons difficult). As the NDIA observed:

  > … aged care providers are undergoing their own reforms related to consumer-directed-care and many businesses are leveraging this experience to build services and products relevant for the disability market. (2016x, p. 5)

Box 7.5 Small providers can face big challenges to transition

A feature of the disability support sector is that many providers are small (Martin and Healy 2010, p. 122). National Disability Services estimated that about 58 per cent of providers are either small or very small (with a turnover of $5 million or less) (Gilchrist and Knight 2017a, p. 10). About 40 per cent of NDIA-registered providers are individuals or sole traders (NDIA 2017y, p. 42). Small providers may have less capacity to make the transition to the NDIS than larger providers. For example, they face challenges from:

- proportionately higher fixed costs of operating in the NDIS, especially as they must incur new marketing and systems costs
- achieving economies of scale or scope, with total costs spread more thinly across fewer hours of support, particularly with the shift to more individualised or tailored supports
- potentially lower and variable revenue from the fee-for-service model, which may require providers to diversify their revenue sources (such as public contributions in the form of volunteering, donations and sponsorships), or services. For example, Riding for the Disabled of the ACT (Pegasus — a provider of horse therapy and equestrian services for people with disability) said that in 2016-17, it received about $18 000 in NDIS revenue. This compared with about $250 000 in annual block-funding from the ACT Government in previous years. As a result, under the NDIS, Pegasus has become more reliant on donations and sponsorship support. Pegasus is also planning on expanding their services to new cohorts (Connery 2017; Riding for the Disabled of the ACT (Pegasus), pers. comm., 28 September 2017).

The scale of these challenges may be inferred by the amount of merger and acquisition activity in response to the challenges of being a small provider. Merger activity and restructuring in the sector provides some indication that this may be the case (NDS 2016, p. 17), although it is unclear whether this consolidation has led to an actual increase in services or substantially reduced competition.

The Commission heard that uncertainty and lack of clarity — particularly about the timing of price deregulation and the withdrawal of in-kind services (ANAO 2016, p. 32) — are causing some providers to delay (or be discouraged from) making changes to their business model, planning and investment. About 75 per cent of providers surveyed by the NDS felt that 'the policy environment is uncertain' (NDS 2016, p. 19). One provider who was surveyed by the NDS commented that:

> The uncertainty around 'how much we will be able to receive' once NDIS is implemented in our region means that the climate for any investment is too uncertain, because we cannot make a reliable business plan. (NDS 2016, p. 10)

The Office of Best Practice Regulation also noted that:

> … ongoing engagement with providers when developing reference prices and maximum prices, particularly for key supports, should help providers during the transition to a fee-for-service based system of disability care. (2015, p. 49)

Better information and communication by the NDIA would assist, as will independent price monitoring and regulation (recommendations 8.2 and 8.3). That said, there are still risks that some existing providers may be unable to transition to a fee-for-service model without some additional assistance in the short term. There could be merit in the NDIA or governments providing short-term targeted assistance where the risks of providers exiting (and a resulting lack of supply) could lead to greater costs to the scheme and participants over the longer term.

Administrative burdens

There is a range of regulatory and other costs to provide NDIS supports. As the NDIA (2016i, p. 9) noted, there are 'high costs to enter the marketplace'. Regulatory costs include the cost of registering with the NDIA, and costs associated with ensuring quality and safety of supports for people with disability. These include:

- professional registration (in the case of specialised services, like therapeutic supports)
- working with children checks
- third-party verification (such as for the safety of new specialist disability accommodation)
- police checks.

These costs are necessary to ensure safe and high quality supports for NDIS participants. The recently developed NDIS Quality and Safeguarding Framework (which will largely only apply to NDIA-registered providers) aims to provide a nationally consistent set of regulations on what providers need to do to provide disability supports (chapter 11). Increased regulatory consistency across jurisdictions should mean lower compliance costs for some providers than under previous arrangements.

Concerns were also raised by a number of study participants about the NDIA's online payment system and communication issues with the NDIA. As Catholic Social Services Australia said:

> Though CSSA [Catholic Social Services Australia] member agencies have been preparing for transition to the NDIS for a long time, the dysfunctionality and un-preparedness of the NDIA has severely affected its capacity to deliver sustainable services through the NDIS. Complex and ongoing issues with the portal (including the system being taken down for weeks at a time with very little notice) means that providers are finding it very difficult to access the funds for services provided. These cash flow issues have restricted providers' ability to invest, innovate and even operate (for example one agency providing significant disability services in a trial site had

> $1 million 'stuck' in the portal in December 2016). This has led to cash flow issues and providers withdrawing due directly to pricing or lack of payment. (sub. 166, p. 9)

The problems associated with the online portal have already been examined in some depth by others (ANAO 2016, pp. 62–71; Conifer and McKinnon 2017; PwC 2016), and were acknowledged by the NDIA (sub. 161, p. 119). The Agency indicated that it is reforming its processes to improve the 'provider pathway', including registration and payment arrangements, and is also delivering tailored information sessions for providers.

> The NDIA is working to improve the quality and amount of information available to providers in all elements of the provider pathway (awareness, commercial assessment, registration process (including the impacts of the move to the national arrangements being led by DSS), service planning and delivery, payment and claiming outcomes) so that providers are better placed to meet expectations and develop their service offer under the NDIS. (sub. 161, p. 102)

Payments to providers need to be timely so that innovation, entry and the supply of disability supports are not hampered. Equally important is for the Agency to maintain open and clear lines of communication with providers to minimise the administrative burden on them. Other schemes, such as NSW Lifetime Care and Support (now part of icare), take a collaborative approach to dealing with providers. This includes: regularly seeking feedback from providers through meetings; workshops and forums; proactive management of provider issues; and having designated staff who deal with any specific problems that arise (icare, pers. comm., 28 September 2017). A relationship of mutual trust, respect and cooperation between providers and the NDIA is needed for the effective operation of the scheme.

Collaboration in the disability support sector

Some disability supports are provided using collaborative and cooperative arrangements, often to ensure better outcomes for people with disability. Some providers were concerned that the increased competitive pressures of a market-based system will reduce collaborative activity (and the associated benefits), and therefore lead to a potential erosion of 'social capital'[60] (Alzheimer's Australia, sub. 10, p. 15; Anglicare Australia, sub. 157, p. 13; and CMHA, sub. 11, p. 14). This could increase provider costs and lead to the withdrawal of some services.

A National Institute of Labour Studies survey found that the introduction of the NDIS had made providers more guarded and that less information was shared due to commercial considerations (which may undermine provider networks), although some collaboration among providers was continuing to occur. One provider who was surveyed commented that:

> I think that's been a sad sort of aspect of the NDIA. When you create a competitive marketplace it's very hard, you know, those old networks that we would have been a part of and shared ideas and things like that have kind of broken down a little bit. (Mavromaras, Moskos and Mahuteau 2016, p. 45)

[60] The relationships and trust that underpin the functioning of society (PC 2010, p. XIX).

A study participant said that:

> There is absolutely no cooperation between providers anymore. They kick out complex clients, saying they do not support clients like that. They do not talk to each other, saying it is not their problem. (Belinda Jane, sub. 80, p. 10)

At the same time, not-for-profit providers may experience lower volunteering and fundraising contributions, due to public perception of their perceived greater 'commercial' focus and competitive behaviour, and that the NDIS is fully-funded (ABF, sub. 48, p. 14; Scope Australia, sub. 72, p. 25). The NDS said that:

> Providers are beginning to report that fundraising revenue is dropping as donors believe that the NDIS will provide all people with disability with all the supports they need. This is clearly a misunderstanding but seems to be becoming more pervasive. (sub. 51, p. 14)

While these contributions may be retained within the disability sector (either redirected to other providers or spread more thinly across all providers), they could also be transferred to other human service sectors, and be lost from the disability support sector.

Conversely, providers may have greater incentives for collaboration in order to increase flexibility and responsiveness to participant demand in an increasingly competitive funding environment (NDS and CADR 2015, p. 13). Collaboration may allow providers to offer services at a greater range of times and locations, and achieve economies of scale or scope that would otherwise be difficult to achieve (particularly in thin markets and for small providers). Market stewards (and regulators) need to monitor such arrangements closely to ensure that collaboration does not reduce competition, choice, efficiency and participant wellbeing.

The NDS data indicate that in 2015-16, the majority of providers surveyed collaborated to advocate for the sector (68 per cent) or for clients (62 per cent), and had agreements to refer or provide services to clients (55 per cent), despite increased competition for both workers and clients (NDS 2016, p. 17). This appears to be broadly in line with previous results, where providers reported that they were forming alliances and joint working relationships with other organisations to offer services at a greater range of times and locations (NDS 2015, p. 38; NDS and CADR 2015, p. 13).

Collaboration is also consistent with the objectives and mission of not-for-profit providers, which typically promote the interests and wellbeing of people with disability. As noted by Centacare Brisbane (sub. 44, p. 3), the degree of collaboration and cooperation between providers under the NDIS will depend on the maturity, interests and skills of each party.

On balance, collaboration is a voluntary and valuable activity undertaken by not-for-profit providers that produces intangible benefits, but has tangible costs when removed. The mixed evidence on the degree of and incentives for collaboration in a more competitive environment suggests that the net effect will depend on whether the increased efficiency of providers offsets the higher costs associated with reduced social capital. The Commission

has previously noted that for the not-for-profit sector, efficiency and effectiveness are central to maximising community wellbeing (PC 2010, p. 18).

While is difficult at this early stage to know how many collaborative arrangements will end and form, the available evidence suggests that some provider collaboration will continue to exist in the NDIS, and is likely to be primarily determined by provider efficiency. Uncertainty about the degree of provider collaboration in the future (and its effect on participant outcomes) highlights the need for strong governance of the NDIA (chapter 11), policy-relevant data collection (chapter 13), monitoring and effective market stewardship (chapter 10).

8 Pricing of disability supports

Key points

- In a mature market, participants' choice and control will determine the price of disability supports. However, temporary price controls are needed to ensure that participants have access to affordable disability supports in the transition period, when the supply of supports is still growing to meet increased demand.
- The National Disability Insurance Agency (NDIA) currently sets the maximum price of disability supports that can be charged by NDIA-registered providers. The NDIA's 2017-18 price review recently concluded. The Agency has also commissioned McKinsey & Company to review its pricing methodology, which will report to the NDIA Board by the end of 2017.
- The NDIA's approach to setting price caps to date has hindered market development and resulted in providers withdrawing from the market for some disability supports. In some cases, the price caps have led to poor participant outcomes, especially for people with complex needs. The benefits of the National Disability Insurance Scheme (NDIS) will not be fully realised if the Agency continues with its current pricing approach.
- NDIS price caps should be set by a body that has relevant capability and necessary resources, and in a manner that is transparent, evidence-based, supported by clear and limited legislative authority, independent and timely.
- To better reflect these pricing principles and ensure that market development receives the necessary attention over the longer term, the Commission recommends that NDIS price caps be deregulated in three stages by:
  - mandating that the NDIS Quality and Safeguards Commission (QSC), when it commences in July 2018, act as an independent price monitor. This will be a 'check and balance' on the NDIA's pricing decisions over the transition period, and should assist with the transparency of pricing — a problem that the NDIA has only partially addressed to date
  - transferring the NDIA's pricing power to the QSC by no later than July 2020. The QSC would also be responsible for determining when supports would no longer be subject to price caps
  - continuing independent price monitoring by the QSC following price deregulation.

Prices of disability supports are a key part of the National Disability Insurance Scheme (NDIS).

- Prices reflect the preferences and relative value that participants place on different supports, which in turn signal to providers the supports to supply. Put another way, prices are signals that are sent to the market when participants exercise choice and control over their packages of individualised supports. Prices affect participant choice, competition, quality, variety, efficiency and innovation.

- Prices affect the purchasing power of participants — the higher the price, the fewer supports participants can purchase using a given package (unless participants can substitute for lower cost supports for a given support type).
- Prices affect the total costs of the NDIS and therefore its financial sustainability.

Prices also affect the allocation of scarce resources and efficiency in the economy — the higher the NDIS price relative to other sectors, the more the NDIS will attract resources from these sectors. Prices can also have spillover effects by driving efficiencies, innovation and growth in the broader economy.

How prices are determined under the NDIS therefore has a direct bearing on participants' (and their families') welfare, provider profitability, scheme costs and the wellbeing of the community.

The National Disability Insurance Agency (NDIA) currently determines 'price caps' or maximum prices that can be charged by registered providers for many NDIS supports.

This chapter examines how prices affect market development, and the choice that participants have over their supports. It focuses on how existing and new providers are responding to the NDIS price of disability supports. Section 8.1 looks at how the NDIA currently sets price caps. Section 8.2 examines the effect of these price caps on the supply of disability supports. Section 8.3 considers whether the NDIA should continue to set prices. Section 8.4 concludes with a discussion of how NDIS pricing could be improved to benefit participants and their families, providers and the wider community.

8.1 How does the NDIA set prices?

The price of disability supports directly affects the supply of quality supports to scheme participants. In a mature market, the choice and control that participants exercise will, and should increasingly, be the main factor determining the price of disability supports. Allowing the market to determine the price of supports is an important feature of the NDIS, as prices affect participant outcomes and the financial sustainability of the scheme. However, temporary regulation of prices in the disability support sector is necessary, and was one of the Commission's recommendations in its 2011 *Disability Care and Support* inquiry (box 8.1).

Box 8.1 Why regulate the price of disability supports?

Governments have historically regulated the price of human services (PC 2016, p. 35), including disability care and support services, on the grounds of equity and efficiency. Without price regulation, the supply of disability supports may be below socially optimal levels for a number of reasons, including ineffective competition and abuse of market power (NDIA 2017a, p. 5).

In particular, there may be too few providers in the market. This is a real risk in the disability support sector. Early data indicate a market concentration of more than 80 per cent in some disability service sub-markets (NDIA 2016l, p. 32, 2016s, p. 29, 2016x, p. 38; DSS, sub. 146, p. 38). This may result in prices that are too high, and limited access to services for some disadvantaged groups. Others have noted the need to maintain price controls in the foreseeable future, as it may take at least a decade for the new market for National Disability Insurance Scheme (NDIS) disability supports to develop (ANAO 2016, p. 54; AONSW 2017, p. 5; DSS, sub. 146, p. 39).

In 2011, the Commission recommended that an early — albeit temporary — task for the National Disability Insurance Scheme Agency (NDIA) would be to set efficient prices to allow providers to recover the costs of providing services (including adequate returns for capital investment), and in turn, ensure the supply of disability supports (PC 2011, pp. 51, 412–414).

While the NDIA has set prices since the beginning of the NDIS trials in July 2013, the Agency said that it does not plan to do so in the long term.

> During transition, the market stewardship role of the Agency will be more active; to facilitate development of the marketplace and as a catalyst for basic market infrastructure. This includes … setting prices and pricing policy …
>
> The setting and reviewing of NDIS prices is a significant market-intervention initiative … for most submarkets it [the NDIA] sees this [price-setting] as a temporary measure to support the marketplace. In the long-term, the NDIA will not set prices to the extent it does now and will instead allow the marketplace to determine the price of supports. (2016i, pp. 18, 26)

An important principle of price regulation is that it should not be distortionary — that is, it should not persist unnecessarily, have excessive scope, or shape the market — such as by benefiting some providers or participants over others.

Given that at least 84 per cent of participants have supports that are subject to NDIS price caps (NDIA 2017y, p. 21), these price controls affect market development. The NDIA acknowledged that it walks a fine line when setting prices.

> The NDIA risks unnecessarily disrupting existing markets through setting prices inaccurately. If price limits are set too high (relative to an efficient benchmark) providers will not face adequate incentives to review practices and operations in an effort to be more efficient. As a result, participants, and the Scheme in general, would not get value for money from expenditure on supports. On the other hand, if price limits were set too low, providers would be unable to recover even efficient costs. This could result in a significant share of providers leaving the sector and/or a lack of new investment in disability services. (2016n, p. 10)

This is reflected in the rationale of price caps, which is to:

- ensure ‘value for money’ for participants — as the price of supports may be bid up too quickly in the absence of price caps in the period after funding is allocated to participants,

but before the disability support sector has grown sufficiently to meet the increased demand

- encourage the market supply of disability supports by giving providers sufficient incentive to grow and enter the NDIS market (NDIA 2016o).

There are also trade-offs with price controls. Fixing prices could mean lower scheme costs in the short term, but also slower market development and support shortages. On the other hand, deregulating prices could mean higher short-term costs, but faster market growth. In the short term, the trade-off is between potential shortages and disability support price inflation.

The price cap for attendant care is particularly important because attendant care is one of the most common supports used by participants in the scheme. The NDIA currently sets price caps for attendant care using its 'Hourly Rate Model' (HRM).[61] The model seeks to 'define the direct cost elements at a rate that is sufficient to cover the efficient costs of a reasonable quality support provider at a point of time' (NDIA 2014a, p. 2). Prices are intended to reflect an estimate of what the long-term 'efficient' price would be in a competitive, deregulated market, plus an additional margin to reflect both the cost and time needed for existing providers to transition to a market-based system, and to entice new providers to enter the disability support market (transitional pricing). To do this, the HRM makes a number of assumptions about the cost of providing supports, which vary by support (box 8.2).

Prices are currently set by annual reviews conducted by the NDIA. The most recent review was completed in June 2017.

The NDIA's 2017-18 Price Review

The most recent price review was undertaken by the NDIA in the first half of 2017. This was the first price review to include a discussion paper that invited feedback from the public on the validity of the assumptions used in the HRM to calculate prices. The NDIA also considered submissions to this study for the price review.[62] While the NDIA intended to publish the updated price guides in late May 2017 (NDIA 2017a, p. 18), they were released on 28 June 2017, just three days before they took effect.

[61] This model is also referred to as the 'Hourly Return Model' (Bowen 2017a). It was previously called the 'Reasonable Cost Model' (RCM) (NDIA 2014a). Many study participants provided submissions that refer to it under these different names, and as the underlying assumptions of the model appear to have remained largely unchanged, the names are largely interchangeable.

[62] A number of confidential submissions were made to this study that had a direct bearing on pricing, including detailed arguments and analysis about the validity of price assumptions. As these submissions were not public, they were not used by the NDIA in its deliberations.

Box 8.2 The NDIA's Hourly Rate Model

The hourly rate model (HRM) uses a range of assumptions to determine the price cap for a given support type under the National Disability Insurance Scheme (NDIS). The price caps are meant to inform providers about the efficiency levels that should be targeted under the market-based system. To date, price caps have included an additional premium to reflect the costs of transitioning existing providers into the scheme, and to give new providers an incentive to enter the sector.

One support subject to a price cap is the cost of an hour of attendant care — one of the most common supports provided under the NDIS. The HRM assumes the following conditions for an hour of attendant care provided in 2017-18:

- the hourly rate of pay is based on the Social, Community, Home Care and Disability Services Industry Award 2010 pay point 2.3 for employees and 3.2 for managers or supervisors. Pay rates depend on whether the hour worked is on a weekday (6am-8pm or 8pm-12am), Saturday, Sunday, or a public holiday
- employees are employed on a full-time or permanent part-time basis. No allowance for shift work or other allowances are included. Leave entitlements are ten days of paid personal leave; four weeks of paid annual leave at 17.5 per cent leave loading; and 17.98 per cent of employees achieve long service leave of 8.67 weeks.

In terms of other costs, including 'on-costs', the HRM assumes:

- loadings for location (20 and 25 per cent for remote and very remote areas respectively) and the intensity of client needs (about 6 per cent)
- that carers spend 95 per cent of paid time with clients, and that managers spend 90 per cent of time with clients, or dealing with client matters. A manager is expected to supervise 15 employees (for standard needs clients)
- that providers operate with a corporate overhead equal to 15 per cent of total salary, management and non-client facing expenses. There is an additional payment for provider travel costs for travelling between clients (maximum 20 minutes)
- superannuation is 9.5 per cent of total salary costs, and workers' compensation insurance is 4 per cent of total salary costs
- a profit margin of 5 per cent of total costs, as well as an additional margin for the transition pricing period.

The HRM, under these assumptions, results in a price cap of about $45 for an hour of attendant daytime weekday care in metropolitan New South Wales, Victoria, Queensland and Tasmania, and about $46 in metropolitan ACT, Northern Territory, South Australia and Western Australia. About a third of this price is for on-costs.

Most of the assumptions and methodology of the model were initially developed in consultation with National Disability Services; however, the parties did not agree on what assumptions were appropriate for the future efficient price. Many providers who made submissions to this study (and to the National Disability Insurance Scheme Agency's (NDIA) 2017-18 price review) argued that the price caps resulting from the HRM are too low to provide quality supports. The HRM was to be reviewed by the NDIA in the 2017-18 price review. The model is being reviewed by McKinsey & Company (who will report to the NDIA Board by the end of 2017).

Sources: Bowen (2017a); NDIA (2017a, 2017q, 2017r, 2017s, 2017t); NDIA and NDS (2014, p. 16).

The prices announced were designed to keep the price caps of most supports in line with inflation.[63] However, other tasks that the pricing review was to undertake were not completed, such as examining the evidence, assumptions and methodology used to set prices, with a focus on attendant care (NDIA 2017a, p. 8).

Instead, the NDIA announced that it had commissioned a pricing review by McKinsey & Company to gain a better understanding of pricing, including the pathway to deregulation. The review commenced in June 2017, with the final report to the NDIA Board due by the end of 2017 (Bowen 2017a). The review's terms of reference directs McKinsey & Company to:

- Provide recommendations in relations to improved pricing effectiveness, including but not limited to:
  - National versus regional pricing;
  - Pricing of services with different levels of complexity;
  - Pricing of short stay support, and for emergency and crisis supports;
  - Thin and undersupplied markets, particularly in regional and remote areas;
  - Relative provider efficiencies (including overheads);
  - Adequacy of provider returns; and
  - Effectiveness of the Hourly Return approach used to set prices.
- Provide recommendations in relation to the potential early de-regulation of price in more mature sub-markets and the glide path for the eventual de-regulation of price more generally. (Bowen 2017a)

8.2 What is the effect of the NDIA's prices on the market?

Regulating prices is always difficult — regulating a market that is transitioning, still developing and undergoing significant change is even harder, as the past offers little guidance to regulators, and there is an increased risk of disruption caused by regulated prices. Prices are also only one of many factors affecting the willingness and ability of providers to supply disability supports.

63 The outcomes from the 2017-18 price review included: increasing the price of supports for personal care and community participation by 4.5 per cent to reflect both wage and consumer price inflation; increasing the price of other supports (including those related to capacity building) by 1.94 per cent to account for wage inflation; increasing the price of capital-related supports by 2.1 per cent to account for consumer price inflation; and increasing loadings for remote and very remote areas by 2 percentage points to 20 and 25 per cent respectively (consistent with the loading changes made by the Independent Hospital Pricing Authority). There was no change in the price of therapy services, as data from competing sectors examined by the NDIA indicated that no change was required. However, the NDIA changed the cancellation policy to allow providers of therapy services to charge for up to two participant cancellations per year, when it was previously prohibited (Bowen 2017a; NDIA 2016o, 2017ac).

As mentioned earlier, there are trade-offs with price controls. Allowing participants' wants and needs to drive prices, and therefore the supply of supports, is important for participant choice and control, and ultimately, participant outcomes. However, without price controls, a lack of supply could put upward pressure on prices, erode participant's packages and have adverse consequences for participants. Therefore, prices should only be regulated where the benefits outweigh the costs.

Many submissions to this study raised concerns about the prices set by the NDIA. Most concerns were about the assumptions of the model used by the Agency. The NDIA's assumptions around complexity of needs, attendant care and short-term accommodation ranked high among the concerns raised. The Commission heard that the price caps in these areas were creating perverse incentives for providers, and leading to poor outcomes for participants.

The cost of supports for people with complex needs is not well reflected in prices

Under the NDIA's price caps, there is single loading when providing attendant care to participants with complex needs (people who have or are likely to have multiple, episodic or high support needs over their lifetime).

Many study participants commented that people with complex needs are struggling to find providers willing and able to provide services to them (box 8.3).[64] A number of providers also said that they could not provide services to participants with complex needs at the prices derived from the HRM (Anglicare Australia, sub. 157, pp. 11–12, 19; CMHA, sub. 11, pp. 5, 13; Leadership Plus, sub. 128, pp. 3–4; NDS 2017b, p. 4; United Voice, sub. 118, p. 12; VCOSS, sub. 176, pp. 20–21). And this was a consequence of the single complexity loading, base salary rate and supervisory requirements. As the Brotherhood of St Laurence said:

> The existing fixed pricing structures pose some problems for both participants and service providers because they fail to take into account the circumstances of activities. By setting a single price, the provider does not have the option to charge less or more for a tailored service. This has the unintended consequence of reducing the choice and control of people with disability. (sub. 189, p. 20)

[64] Including: ACT Government (sub. 156); Anglicare Australia (sub. 157); Belinda Jane (sub. 80); Disability Services Australia (sub. 9); Disability Services Commissioner Victoria (sub. 35); National Disability Services (sub. 51); Scope Australia (sub. 72); and Victorian Government (sub. 174).

Box 8.3 Study participants' concerns about the complexity loading

Victorian Council of Social Services:

> VCOSS members report pricing limitations are particularly inadequate to meet the costs of delivering services to participants with complex and high support needs … Without adequate resourcing, the NDIS risks creat[ing] disincentives for providers to assist participants with complex needs. This could mean services 'cherry pick' participants and leave some people with disability without services. (sub. 176, pp. 20–21)

Disability Services Australia:

> The premium for complexity is insufficient, and there is a strong risk of market failure in the area of service delivery for complex customers — this includes those with challenging behaviours, and those that require centre-based services. (sub. 9, p. 10)

The ACT Government:

> Providers have also reported 'cherry picking' of service types which are better paid and have 'easier' clients, which opens up market gaps for other services.
>
> These pricing issues are very serious … particularly in the areas of … intensive personal support and support for participants with complex needs … The risk to participants in the ACT from providers who currently support people with complex needs withdrawing from the market is high. (sub. 156, p. 30)

Anglicare Australia:

> … The system is designed with low level personal care as the basis for the pricing and consequently the higher skill and responsibility levels for staff who need to care for those with [psychosocial] disabilities is essentially ignored. (sub. 157, p. 12)

Belinda Jane:

> They [providers] kick out complex clients, saying they do not support clients like that. (sub. 80, p. 10)

National Disability Services:

> Providers are also reporting a growing reluctance to support people with complex conditions (in all service types). The NDIS has some higher prices for complexity but they are inadequate. Without a price increase, a high needs group of participants will increasingly not get the supports they need. (sub. 51, p. 12)

Mental Health Australia:

> Since rollout commenced, mental health providers have repeatedly highlighted that the price of supports is set well below the hourly rate for psychosocial support work currently delivered by suitably qualified people. There is no hourly price for psychosocial support services in the NDIS Price Guide … (sub. PP321, p. 37)

This appears to be especially the case for providers that deliver supports to people with psychosocial disability. Many study participants (including CMHA, sub. 11, pp. 4–5; Mental Health Australia, sub. PP321, p. 37; National Mental Health Commission, sub. PP319, pp. 10–11) argued that the single complexity loading did not sufficiently accommodate the different degrees of complexity of need for people with psychosocial disability, and the need

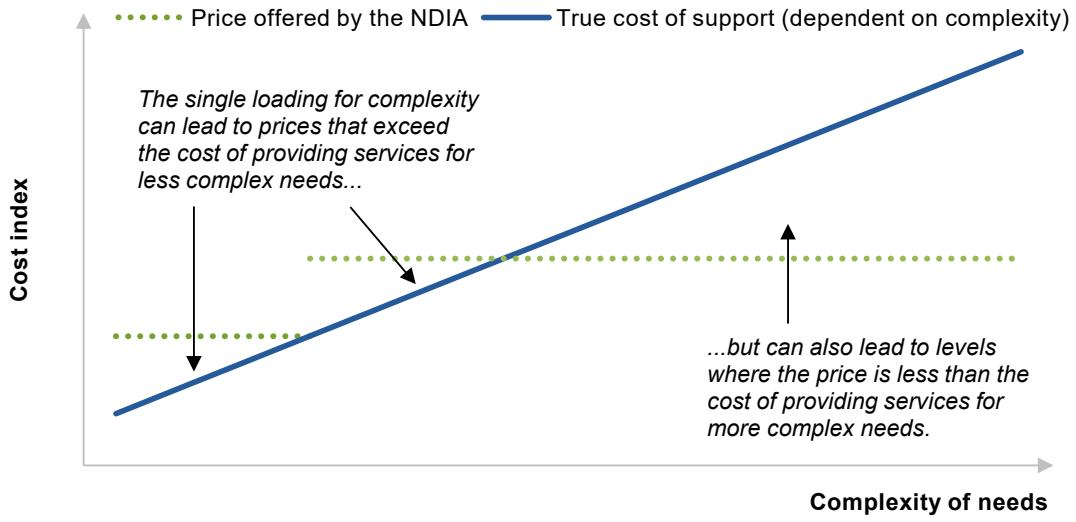
for quality services provided by skilled and qualified mental health workers. For example, the Mental Health Coalition of South Australia said that:

> The cohort for psychosocial disability are at the most complex end of need, yet the Reasonable Cost Model is based on level 2.3 of the SACS award. Skilled mental health peer and support workers attract at least level 3 and often 4. (sub. PP308, p. 3)

It is the bluntness of the single complexity loading that can cause these problems, as it is based on the average, rather than the actual, cost of services. Figure 8.1 shows that as the complexity of needs rises, the actual cost of supplying the support also increases. Yet the price of supports is fixed at two levels — one that includes the complexity loading and one that does not. This creates incentives for providers to provide supports for participants with less complex needs, but a strong disincentive to provide supports to those with more complex needs — resulting in a shortage of supports for these participants.

Given that the cost of supplying supports increases with complexity of needs, a 'one-size-fits-all' approach is not appropriate in the pricing of services for participants with complex needs. A single loading approach is also not consistent with the approaches taken in some other human services, including aged care and public hospital services (box 8.4).

Figure 8.1 **A stylised representation of a single complexity loading**



Box 8.4 Measuring the complexity of human services user needs

Users of human services have needs of varying complexity and intensity. In turn, the cost of delivering services to users will differ depending on the complexity of their needs.

In the aged care sector, the Australian Government pays approved providers a residential care subsidy for each care recipient. The basic subsidy amount is determined by the Aged Care Funding Instrument (ACFI), which consists of 12 questions about assessed care needs, some of which are supported by specified assessment tools and two diagnostic sections (Department of Health 2017b). These questions are rated by the aged care home on a four-point scale of A, B, C or D, which are then used to determine an individual's ACFI rating (Department of Health 2017b). The ACFI consists of three funding categories: activities of daily living, behaviour and complex health care (DHS 2017). Funding in each of these domains is provided at four levels — nil, low, medium or high. This means that there are 55 different rates corresponding to different ACFI classifications (DHS 2017).

The Australian Government also funds public hospital services, jointly with State and Territory Governments. Major determinants of the level of funding are the National Efficient Price (NEP) and National Efficient Cost (NEC) as determined by the Independent Hospital Pricing Authority (IHPA). The NEP also provides a price signal or benchmark for the efficient cost of providing public hospital services (IHPA 2017a). The NEP Determination is used to calculate activity-based funding for in-scope public hospital services, while the NEC Determination covers block-funded services (IHPA 2017c, p. 7). In practice, NEC is higher than NEP, because NEC is for hospitals with activity levels that are too low to be suitable for funding on an activity basis, such as small rural hospitals (IHPA 2017c, p. 34).

In determining the NEP, the IHPA uses classification systems to classify types of patients, their treatment and associated costs. The IHPA then groups patients who have similar conditions and cost similar amounts per episode together (IHPA 2017c, p. 13). Currently, there are six patient service categories — admitted acute care, subacute and non-acute care, non-admitted care, mental health care, emergency care, and teaching, training and research (IHPA 2017c, pp. 13-19). For example, admitted acute care is classified according to the Australian Refined Diagnosis Related Group (AR-DRG) patient classification system. The AR-DRG consists of about 800 patient classes with each patient being classified based on their diagnoses, interventions and other routinely collected data (IHPA 2017b).

Attendant care price caps may be too low to achieve safe and quality outcomes

Many providers presented anecdotal evidence to this study about NDIS price caps for an hour of attendant care being too low. Estimates of the shortfall between what was needed and what the cap offered (as a percentage of the current price cap) varied considerably. For example:

- House with No Steps (sub. 104, p. 3) said that there was a shortfall of about 10 per cent against what it considered to be a more sustainable price cap. This is equivalent to a shortfall of about 11 per cent against the current price cap
- Belconnen Community Service Board (sub. 39, p. 1) suggested a shortfall of between 10.5 and 16 per cent

- Cohealth (sub. 50, p. 11) said that there was a shortfall of 49 per cent for those with mental health needs.

While there is a wide range of views on the pricing of attendant care, more thorough analysis of the assumptions underpinning the HRM highlight the challenges faced by providers to supply supports.[65]

- The Samaritans Foundation applied alternative assumptions that they considered were more reflective of existing practices and the efficiency gains that they believed could be realised in the disability care sector. It found that the price cap on an hour of attendant care would have to increase by between 13 and 25 per cent for providers to continue to provide reasonable quality care (Samaritans Foundation, in Anglicare Australia, sub. 157, att. 4, p. 1).
- A survey of 129 registered NDIS providers and 738 disability support workers examined how the pricing model affected disability support workers. It found that the NDIS price of attendant care under the NDIA's Reasonable Cost Model did not enable minimum Award conditions to be met, and prevented employers who offer above-Award conditions from meeting their legal obligations. The researchers found that the pricing model under-classified support workers and supervisors; underestimated the time needed to deliver quality and safe services to NDIS participants, especially to participants with complex needs; and underestimated a range of other costs that providers must incur to develop and maintain quality staff and services (Cortis et al. 2017).

Short-term accommodation is another area of concern

Short-term accommodation is a core support that provides integrated support for self-care, accommodation, food and activities in a centre or group residence, for people with disability for short periods (NDIA 2017q, pp. 27, 40). It can involve irregular days and may include funding to provide substitute support 'respite' in a group-based facility or in-home support.[66] As respite is important to maintain the ability of informal carers to provide support to participants (chapter 9), short-term accommodation for people with disability is vital to participants, their carers, and the financial sustainability of the scheme. Currently, the price cap for short-term accommodation applies on a flat day rate, which includes all expenses in a 24-hour period with no additional loading (NDIA 2017a, p. 16).

[65] The Commission did not make any findings or recommendations on the prices of particular supports, though some study participants suggested that there would be merit in the Commission doing so (for example, HSU, sub. PP316, p. 6 and Victorian Government, sub. PP298, p. 23). The NDIA provided the Commission's study with a copy of its HRM, but it was provided too late for the study to examine in detail. That said, many of the assumptions in the HRM that was provided to the Commission appear similar or identical to those stated in the NDIA's Price Controls Review 2017 Discussion Paper and 2017-18 Price Guide.

[66] Some participants in this study said that the term 'respite' is pejorative and preferred the term 'family care'. The Commission is sensitive to this issue, but has used the term 'respite' for clarity — both because it is included in the NDIS Price Guide (NDIA 2017q, p. 28) and most study participants, including people with disability, used the term in their submissions.

Some study participants argued that the price of short-term accommodation has several flaws. These include: the flat daily rate that does not allow for any complexity loading or penalty rates for weekends or public holidays; and the NDIA's assumptions about the occupancy rate (NDS, sub. PP295, pp. 8–9; Cerebral Palsy Alliance, sub. 163, att. 1, p. 4).

These assumptions are beginning to shape market supply responses.

- The CSSA (sub. PP278, p. 5) reported members not opening on public holidays; long wait times; large providers withdrawing services; and cherry picking participants — leaving vulnerable participants with complex needs without adequate and timely support.
- According to the NDS (sub. PP295, pp. 8–9), some providers are considering shutting down these services (and converting them to Specialist Disability Accommodation). An emerging risk is that more participants will move into full-time Supported Independent Living (a more expensive option) or Specialist Disability Accommodation.
- The HSU (sub. PP316) said that it had received reports of providers refusing to provide services on weekends and public holidays.
- Some providers are reducing or closing down their respite services in response to NDIS price caps. For example:
  - Marymead, an ACT provider, initially announced that from 26 October 2017, it would significantly reduce its overnight respite services to young people with disability with high needs (Bourchier 2017; Groch 2017a, 2017b). On 3 October 2017, Marymead announced that an agreement had been reached with the NDIA, with the support of the ACT Office of Disability, to allow Marymead to charge for its respite services at a price higher than the NDIS price cap for the next six months (Groch 2017c). As a result, Marymead (2017) said that it would continue to provide these services to scheme participants.
  - Disability Trust, the last remaining provider of overnight respite care for young people with disability in the ACT, indicated that it was reviewing its services, and could not guarantee respite services after Christmas (Groch 2017a)
  - CatholicCare Sydney is no longer providing respite care and short-term accommodation because in its view, the NDIS flat daily rate does not reflect penalty rates and other costs (Morton 2017).

The view more broadly

Most, if not all, of the concerns about pricing raised by study participants related to the assumptions of the HRM,[67] and the limited opportunity for providers (and participants) to have input to the pricing process.

[67] The Commission also had access to 46 of the 84 submissions to the NDIA's 2017-18 Price Review. These submissions expressed similar concerns about the assumptions in the NDIA's price model, as did many of the submissions made to this study.

In response, the NDIA said that:

> Some providers have raised concerns that NDIS price levels are too low, particularly for personal care and community supports, but have generally not supported these arguments with clear evidence. Other providers have suggested that current price levels are appropriate. These contradictory views within the provider population might be evidence that some are struggling to adjust to a funding model that is based on market principles. There is also evidence of a wide variation in operating costs under pre-NDIS approaches where efficiency was not a key consideration. It also might reflect changes in volume as well as the extent of cross-subsidisation of services that previously existed.
>
> The NDIA effort to set maximum prices has incorrectly been taken by many in the sector to authorise an 'NDIS price' for their services, which is often inflated above actual costs. (sub. 161, p. 101)

The NDIA acknowledged that there remain divergent views on pricing.

> More generally, divergent facts and views were presented. Some providers argued that existing prices do not allow adequate recovery of their costs, impeding their ability to make a return and acting as a barrier to market growth. On the other hand, some participants argued that providers are overpricing supports in some categories. More detailed work is required to gain a deeper understanding of these divergent perspectives. (Bowen 2017a)

While further work is required to arrive at an appropriate pricing model, it is clear that some prices are having a negative effect on the sector. A survey by the NDS, in partnership with Curtin University (now conducted with the University of Western Australia), found that:

- 67 per cent of respondents were worried that they would not be able to provide services at the prices being offered under the NDIS
- 46 per cent said that to provide services at the prices being offered by the NDIA, they would have to reduce the quality of service (NDS 2016, p. 20).

While 55 per cent of disability support organisations reported making a profit in 2015-16, only 40 per cent of respondents budgeted to make a profit in 2016-17 (NDS 2016, p. 14).

Evidence presented to this study also suggests that other care sectors are beginning to look more attractive than the disability support sector. For example, the ACT Government said that:

> The current Fixed Pricing Structure for NDIS services has affected the overall development of sustainable business models. There appear to be services that are not, or are perceived to not be financially viable. … others have begun to diversify and others have made decisions about withdrawing from (or not entering) the disability services market. ACT providers have also expressed concern that fixed pricing is compounded by the extensive administrative burden and delays when dealing with the NDIA. Some providers have made a decision to leave disability service provision and will instead focus on aged care. (sub. PP312, pp. 7–8)

The Commonwealth Ombudsman also reported that:

> … at a recent consultation a provider told us they could bill around $10 per hour more for providing in home domestic assistance for aged care clients than they could for providing the same service to an NDIS participant. They suggested it was difficult to understand the rationale for this difference and said it created a risk that service providers would focus their service provision on areas that were more financially sustainable, leaving NDIS participants with even fewer choices. (sub. 137, p. 14)

The NDS called for the NDIA to immediately review its prices, and not wait for the McKinsey & Company review.

> Providers are making these decisions now, to get out of certain disability services, and the (NDIA) needs to respond now rather than wait for that review. (Baker in Morton 2017)

This sentiment was echoed by the Victorian Government, which called for the NDIA to urgently review its prices.

> Victoria considers that there is also an immediate need to consider areas where NDIS pricing may be inhibiting market growth or risking provider failure (particularly in areas or services in which there are thin markets). In some areas, the NDIA appears to have applied flawed assumptions to its calculation of prices. Examples include low allowances to train, supervise and recruit direct support staff, unrealistic assumptions around the amount of time staff need to spend undertaking non-client facing functions, and low assumptions around the proportion of overall costs devoted to overheads (particularly during the transition period). Victoria considers that these areas should be corrected as soon as possible. (sub. PP298, p. 3)

Divergent perspectives on the adequacy of prices are currently leading to uncertainty and low confidence within the sector. This is not conducive to the scale and scope of market development (and increase in provider capacity) that is needed to provide supports for NDIS participants.

There is a serious risk that both existing and potential disability support providers will choose to provide their services elsewhere. Some providers in the ACT have said that they have deregistered with the NDIA (or are considering doing so) as a result of the NDIA's price caps (Hermant 2017). Some participants with particularly complex needs may not be catered for under the scheme. This may result in an inappropriate increased reliance on carers, Provider of Last Resort services (including crisis supports), in-kind services and other mainstream services. Under the NDIA's current pricing approach, the benefits of the NDIS scheme will not be fully realised.

FINDING 8.1

The National Disability Insurance Agency's approach to setting price caps to date has hindered market development by discouraging the provision of some disability supports. In some cases, it has led to poor participant outcomes, especially for those with complex needs. The benefits of the National Disability Insurance Scheme will not be fully realised if the Agency continues with its current pricing approach.

8.3 How should price caps be set?

Prices must send a clear signal to the market to encourage the supply of supports, promote competition and innovation. Without this, many of the problems experienced under the previous system — unmet demand, unclear decision-making and unfair allocations of supports — will continue or reoccur, and lead to poor participant outcomes. In the context of the NDIS, the challenge for the price regulator is to find the right balance between market development, the financial sustainability of the scheme and participant outcomes. It is this balance that the NDIA currently aspires to in setting price caps (NDIA, sub. PP327, pp. 36-7).

The Commission's concern is that the NDIA has not achieved the right balance. Comments by the NDIA (sub. PP327, p. 36) that price setting is inseparable from financial sustainability, and by the former Chair of the Agency (Bonyhady, sub. PP333, p. 13) that 'the NDIA's 'efficient prices' … are calibrated to the expected full costs of the NDIS of $22 billion', suggest that financial sustainability could be prioritised over other objectives.

If the financial sustainability of the scheme is given priority over the other objectives of market development and participant outcomes, then the scheme's objectives will not be achieved. As pointed out by Victorian Legal Aid (sub. PP367, p. 3), 'the scheme cannot function predictably, transparently or fairly if financial sustainability looms large over every decision', and it is difficult to reconcile such a position with the scheme's objective to provide reasonable and necessary supports for participants.

Others suggested that one body attempting to achieve this balance of multiple objectives through pricing is not possible or desirable. For example, both the Harper Competition Review and the OECD emphasised the value of having regulators — including price regulators — being at arm's length from other decision-making and functions (Harper et al. 2015, pp. 227–229; OECD 2014, p. 47). Many State and Territory Governments[68] — funders of the scheme — also suggested that price-setting should be more independent than is presently the case. The Department of Social Services (DSS) (sub. 146, p. 39) also indicated that there could be merit in moving price regulation to an independent body, albeit not immediately. The Australian National Audit Office (ANAO) (2016, pp. 30–31) raised the concern that the NDIA could be conflicted in its dual market roles as both price-setter and purchaser of supports.

Regardless of whether there is a conflict, or how a balance is to be achieved, it is clear that the current pricing approach needs to be improved quickly.

At its heart, pricing policy should reflect the objectives of the scheme and address the concern that without price regulation for a period, participants will be adversely affected by unaffordable support costs. Value for money for participants needs to be considered with financial sustainability of the scheme in the short term, but with an eye to market

[68] See for example: Northern Territory Government (sub. PP359, p. 2); Queensland Government (sub. PP345, p. 13); Tasmanian Government (sub. PP247, p. 8); and Victorian Government (sub. PP298, pp. 3, 22–4).

development to render price controls unnecessary over the longer term. If price caps are set inappropriately, there is a risk that pricing decisions will distort or 'make the market', rather than allowing the market to develop in a way that reflects the needs (and goals) of participants.

To realise the benefits of the scheme for participants, NDIS price caps should be legislated to be evidence-based, set transparently, and determined independently (box 8.5).

Box 8.5 Best practice principles for price regulators

The UK National Audit Office observed that government authorities setting prices for public services in markets should adhere to eight principles for value for money. They should:

- understand national supply and demand and intervene to remedy problems
  - this includes: the patterns of regional variation (including levels of spare capacity); the likely impact of policy reforms; and possible future scenarios
- understand the national market structure and intervene in the event of market failure
  - this understanding should include: market size and concentration (including 'difficult to replace' providers); degree of exposure to publicly funded users; and price and quality variations and trends
- understand the role of, and work with, the competition authorities and relevant quality and sector regulators to raise awareness, standards and enforce rules and the right market behaviour
- understand the authority's impact on local public and private markets as a purchaser of services, and how to encourage the right market behaviour
- know the costs of service provision
- ensure the price sustains supply at acceptable levels
- ensure quality is acceptable
- ensure users are well informed about quality (NAO 2013).

More generally, the OECD's seven principles for good governance of regulators are:

- role clarity
- preventing undue influence and maintaining trust
- decision making and governing body structure for independent regulators
- accountability and transparency
- engagement
- funding
- performance evaluation (OECD 2014).

Evidence and transparency are essential, but lacking

As the NDIS disability support market is still developing, the data and information needed to determine the appropriate price controls are limited. This is reflected in the NDIA's approach, which includes consulting with the disability support sector.

> In the roll-out phase of the NDIS, the NDIA is adopting a cautious approach to price controls in the absence of information on the competitiveness of markets for supports. (NDIA 2017a, p. 5)

> Price control decisions are informed by significant input from market stakeholders through regional forums, targeted workshops, individual discussions and responses to discussion papers. (NDIA, sub. 161, p. 100)

This approach is consistent with the Office of Best Practice Regulation's recommendation that the NDIA should:

> … continue to make its decisions about the setting of reference prices transparent, continue to work with the NDS to collect information on the costs of providing supports, and continue to monitor the impacts of reference prices on existing providers. (2015, p. 43)

There is some evidence that the NDIA has responded to market circumstances and feedback. For example, the NDIA increased price caps for personal care and community supports by about 10 per cent in 2014 and 2015 at some NDIS trial sites (ANAO 2016, p. 47). However, some providers argued that to date, they have not had any real opportunity to provide feedback on pricing decisions.

House with No Steps (sub. 104, p. 4) said that there was a 'lack of real consultation by the NDIA with service providers', and that (prior to the 2017-18 price review) they had never been formally consulted on any matter (including prices), despite being one of the largest providers nationally.

> Our frustration is that this pricing is relatively easily and transparently modelled in an Award environment. Such modelling, if publicly shared, would move the discussion from the inadequacy of a 'black box' number to an informed discussion around cost drivers such as staffing mix, management spans of control and overhead levels. We understand such modelling has been carried out by the NDIA and independent actuaries and, if so, do not understand why the output of those modelling exercises has not been made public or reflected in NDIA pricing. (sub. 104, p. 3)

Similarly, Interaction Disability Services was concerned about the Agency's lack of engagement with providers on pricing issues.

> Our most significant concern is that the NDIA has developed non-contextual pricing. In our view, this has happened because of what we believe is a failure to engage wholly with service providers on planning and pricing. This is a misplaced philosophical position based on assumptions that service providers will inflate prices. These assumptions have never been tested. (sub. PP213, p. 1)

These frustrations extend to a lack of usable information about prices needed to provide meaningful feedback.

> The NDIA's process for pricing services of various kinds has been difficult for non-government stakeholders to understand or contribute to … Providers have also been largely unable to provide detailed advice in response to any consultations either during or subsequent to the RCM's [Reasonable Cost Model] development. To build the NDIA's evidence base for 'a market price' for psychosocial services, Mental Health Australia asked the NDIA to check the assumptions in the model with providers, but to our knowledge this did not occur. (Mental Health Australia, sub. 155, p. 22)

The lack of transparency has also led some providers to question the NDIA's independence. For example, Autism Association of Western Australia said that:

> Given the lack of transparency and evidence surrounding the populating of the RCM [Reasonable Cost Model], it is more accurate to describe it as a funding tool rather than a pricing tool with all that this would imply in relation to market-based evidence. (sub. PP219, p. 3)

Concerns about a lack of transparency and consultation were shared by many others (not just providers) — including the HSU (sub. 132, p. 10), the ACT Government (sub. 156, p. 27) and the ANAO (2016, p. 13). For example, the DSS said that:

> … greater transparency, appropriate benchmarking and independence are required in price regulation under the Scheme. Better communication is required to improve stakeholder understanding and provide greater market certainty, particularly about the pre-conditions for price deregulation. (sub. PP318, p. 14)

As part of its most recent price review, the NDIA said that it had received feedback from stakeholders that there was:

> … a lack of transparency on the assumptions and methodology used to calculate price controls (which could affect discussion about how price arrangements relate to other parts of the NDIS, as well as debate about the price controls themselves). (2017a, p. 7)

To address this lack of transparency, the NDIA (2017a) released additional information about pricing as part of the latest pricing review. The NDIA Board also commissioned a pricing review by McKinsey & Company.

> Reflecting the NDIA's market stewardship role, the NDIA has also commissioned McKinsey and Company to undertake an independent Price Review which will provide the evidence and transparency to ensure that any future price settings for supports and services underpin the critical objectives of the NDIS. (Bowen 2017b)

That said, the NDIA's price-setting process remains largely opaque. Submissions to the price review are not made public, nor is it clear how the material is used or assessed. And details about the operation of the HRM are not in the public domain.

The lack of transparency around prices is at odds with the practice of independent price regulators and authorities in other sectors.[69] It is also inconsistent with the Commission's 2011 recommendation that the NDIA's recommendations to change prices should be transparent, if the Agency is to set prices (PC 2011, p. 412).

As a first step to improve transparency, the NDIA should make public a summary of the McKinsey & Company price review, once it is completed. The NDIA should also use existing work, such as the provider benchmarking study currently being run by the NDS and the University of Western Australia.

Transparent price controls are important to impose discipline and public accountability in setting prices, as well as to increase credibility and certainty of price signals, which assists with forward planning, investment and entry by providers. There are reports that some new providers (including aged care providers) may be delaying entry to the sector because of ongoing uncertainty regarding price deregulation and profitability (Whyte 2017).

A number of State and Territory Governments agreed that independent, transparent and evidence-based price controls are necessary to facilitate market development (for example, Tasmanian Government, sub. PP247, p. 8). As the NSW Government pointed out:

> A well-functioning market requires a robust and transparent pricing framework. This provides certainty in relation to revenue potential for providers, which, in turn, provides an incentive for investment in service offerings (if prices are set at the right level). This work must be prioritised. (sub. PP230, p. 5)

Transparent price controls are particularly important for providers of Specialist Disability Accommodation, as large upfront capital investment ('patient capital') is required, which may be debt-funded and is usually recovered over a 20-year investment period (NDIA 2016v, p. 19; NSW Government, sub. PP230, p. 5). Transparency around price controls also extends to disseminating relevant market information ('non-price signals') to complement and improve the effectiveness of price signals. Power Housing Australia commented on the lack of data on disability housing demand from NDIS participants across Australia.

> … there is little transparency about where people with disabilities and those needing Specialist Disability Accommodation tend to live, and what types of disability housing are needed across Australia … To ensure affordable housing with appropriate modifications are available into the future, information about current and future projections around the location, types of disability, and housing required for NDIS participants is recommended … (sub. 139, p. 6)

Transparency creates greater incentives for new providers to enter the disability support market, and helps build community trust and confidence that the prices for supports are fair

[69] For example, aged care (Aged Care Pricing Commissioner and Aged Care Financing Authority), electricity and telecommunications (Australian Competition and Consumer Commission), energy (Australian Energy Regulator), minimum wages (Fair Work Commission), public hospitals (Independent Hospital Pricing Authority), and the Independent Pricing and Regulatory Tribunal NSW.

and reasonable for providers, participants and taxpayers. A lack of transparency can erode this confidence, and put the scheme at risk.

Clear and limited statutory authority to regulate prices

Transparent price regulation also requires that the legal authority for price regulation is clearly defined and stated in legislation. Having clearly specified objectives ensures that the regulator has 'sufficient context to establish priorities, processes and boundaries for its work' (OECD 2014, p. 31). In other words, clearly defined statutory limits are necessary for pricing powers to be exercised transparently, predictably, independently and fairly.

Clearly defined roles for price regulation also promote public accountability and the rule of law, by ensuring that regulators only operate within the scope of powers given to them by the legislature. This means that the regulator's objectives, functions and powers should be made clear to the regulator's staff, regulated entities, citizens and other stakeholders (ideally through principle-based legislation) — with regulators not being assigned competing or conflicting objectives or functions (OECD 2014, pp. 32–38). A regulator with clear roles is more effective in achieving desired policy objectives, and fosters public trust and confidence in its decision making, resulting in greater certainty and stability. A lack of clarity can impair a regulator's performance and lead to poor community outcomes.

Currently, the NDIA's power to set prices is not expressly specified in the NDIS legislative framework (the *National Disability Insurance Scheme Act 2013* (Cwlth) and NDIS Rules). Nor are the objectives or functions of its price regulation powers clearly stated in the legislation (making administrative review of its decisions difficult). This is notably different to the legislative arrangements for other price regulators.[70]

Without clear limits set on price regulation, there is a risk that the NDIA could exercise its pricing powers inappropriately (for example, constraining scheme costs to the detriment of market development). Unless pricing functions, powers and objectives are clearly specified, the Agency may also have less incentive to act transparently, particularly if it is not empowered or required by law to act transparently in the exercise of these functions.

Strong support for independent price regulation

The transition period of the scheme provides an opportunity to consider a number of issues, including any concerns around how the NDIA balances different objectives of the scheme, the lack of transparency in how price caps are set, as well as the need to define the price-setting role in legislation. It is also an opportunity to provide greater certainty to

[70] For example, the Independent Hospital Pricing Authority's objectives, functions and powers (including matters that the Authority must consider) to determine the national efficient cost and price for health care services provided by public hospitals are specified in the *National Health Reform Amendment (Independent Hospital Pricing Authority) Act 2011* (Cwlth).

providers about how and when price deregulation will occur, which is a key milestone in moving to a market-driven approach.

Most study participants agreed with the need for an independent price regulator (box 8.6).

There was support across a range of stakeholders, including people with disability, providers, community organisations and governments.[71]

However, the NDIA (sub. PP327, pp. 35–9) argued that an independent price regulator would put the scheme at risk. The Agency (sub. PP327, pp. 35–6) perceived its situation not as a conflict of interest, but a 'necessary and deliberate' tension between promoting participant outcomes, market development and financial sustainability.

Balancing the objectives of the scheme, including market development and financial sustainability is important, but does not preclude moving to an independent price regulator. Just as in other price-regulated industries, and like any other stakeholder, the NDIA would be able to make public submissions to a regulator on how price changes could affect the scheme's financial sustainability and other scheme objectives (and include any confidential market data held by the NDIA about relative efficiencies and benchmark costs of service provision), and be able to recommend its own set of prices to the regulator to inform the latter's decision making.

The NDIA (sub. PP327, pp. 36–7) also said that if its pricing powers were moved to an independent price regulator, the Agency would no longer be able to perform its market stewardship role effectively. But the responsibility for effective market stewardship and the management of market risks is already shared among a number of governments (and does not always require price controls). The Agency would still be able to influence market development by providing information and other resources to the market. Delivering better quality plans (chapter 5), supporting participants to navigate the market, and achieving the outcomes of the proposed eMarketPlace (chapter 10) will shape demand, and in turn, the supply response in the disability support sector.

[71] Including: Activ (sub. PP302); ADACAS (sub. PP260); AFDO (sub. PP325); Anglicare Australia (sub. PP339); APC Prosthetics (sub. PP244); ABF (sub. PP263); AOPA (sub. PP294); Australian Unity (sub. PP273); Autism Association of WA (sub. PP219); BCCM (sub. PP329); Carers Australia (sub. PP224); cohealth (sub. PP261); CSIA (sub. PP251); CSSA (sub. PP278); CYDA (sub. PP358); Flourish Australia (sub. PP246); HSU (sub. PP316); HSU, AU and UV (sub. PP272); Jenny Harrison (sub. PP236); Legal Aid NSW (sub. PP245); MAV (sub. PP343); Mental Health Australia (sub. PP321); MIFA (sub. PP338); MJD Foundation (sub. PP233); MS Australia (sub. PP283); NDCA (sub. PP344); NHMC (sub. PP319); Neami National (sub. PP347); NDS (sub. PP295); Noah's Ark (sub. PP328); Northern Territory Government (sub. PP359); OTA (sub. PP285); One Door Mental Health (sub. PP266); Prader-Willi Syndrome Association of Australia (sub. PP228); PDA (sub. PP306); Queensland Government (sub. PP345); Richard Madden (sub. PP307); Summer Foundation (sub. PP293); Tasmanian Government (sub. PP247); VALID (sub. PP332); VCOSS (sub. PP264); VHA (sub. PP337); Victorian Government (sub. PP298); and Vision Australia (sub. PP252).

Box 8.6 Many study participants support independent price regulation

Autism Association of Western Australia:

> For the sake of the sustainability of the Scheme, and the quality of services delivered to participants, pricing needs to be undertaken by an independent umpire who is not conflicted in their approach; and who has no other interest but to set objective prices based on true market conditions for the work under consideration. Only in this way will the Scheme be scalable and sustainable. (sub. PP219, p. 6)

Flourish Australia:

> Integral to the long-term success of the NDIS is the need to get pricing right. Available evidence suggests that a significant number of providers are struggling under the current regime. In the lead-up to deregulation, the price setting process requires specialist expertise, a robust methodology, independence and transparency, and comprehensive consultation with and input from service providers. (sub. PP246, p. 7)

Australian Federation of Disability Organisations:

> … would like to see independence and transparency for such issues as setting the pricing cap that an independent pricing regulator would enable. This is vital in the context of providing a degree of financial certainty … which may allow for more providers to enter the marketplace or existing providers to develop sustainable business models … AFDO is aware of sector wide concern that the financial realities of disability service provision are not given the weight they should. (sub. PP325, p. 17)

Australian Unity:

> … supports the establishment of an independent pricing regulator … Australian Unity is concerned that the current pricing formula does not sufficiently recognise the core costs associated with providing services under the NDIS. We agree that the establishment of an independent pricing regulator is likely to enhance current arrangements, and will ensure that the pricing arrangements for the NDIS align with other parts of the human services sector. (sub. PP273, p. 2)

National Mental Health Commission:

> … acknowledges that the NDIA has been given an extremely difficult task. Implementing a reform of the scale and nature of the NDIS was always going to be challenging; implementing it with a curtailed timetable, reduced resourcing and under shared accountability arrangements where different governments have different expectations. For these reasons the NMHC supports … the separation of the pricing function from the Agency. (sub. PP319, p. 5)

Queensland Government:

> There is merit in introducing an independent price regulator to avoid a potential conflict of interest with the NDIA both setting prices and being responsible for the financial sustainability of the scheme. (sub. PP345, p. 13)

Catholic Social Services Australia:

> … strongly supports … the establishment of an independent price monitor to conduct an immediate review of NDIA price caps, transitioning to an independent price regulator … (sub. PP278, p. 4).

Victorian Government:

> More confidence in NDIA pricing is required as soon as possible to encourage growth in supply and incentivise market transition. Victoria welcomes the recommendation to move to an independent price regulator … (sub. PP298, p. 22).

The NDIA (sub. PP327, p. 38) argued that a new body would result in additional costs, increased fragmentation and inefficiency, and any regulator would hold less useful data and information than the Agency. On access to data, there do not appear to be any significant

barriers to the data sharing between the Agency and the private firms engaged to assist the Agency with its pricing response (for example, the McKinsey & Company price review). The Agency also shared data and information with the Commission for this study. And in terms of additional costs, these will be minimised if the NDIA's pricing powers are transferred to an existing body, particularly if pricing functions are relevant and complementary to its existing functions relating to the NDIS.

Moving towards independent price regulation

As with any price regulator, there are costs and benefits to its operation, and the need for open channels of communication between the regulator, regulated firms, consumers and others affected by such regulations. There is a compelling case to legislate for an independent price regulator that can set price caps independently, transparently and in an evidence-based manner. This will give providers and the community greater certainty (and participants certainty that they will receive the services that they need), and in turn, encourage new and existing providers to supply disability supports. The ultimate objective is for the supply of supports, innovation and efficiency to be driven by price signals that reflect participants' wants and needs through the exercise of their choice and control.

To achieve this, the Commission recommends that price deregulation should occur in three stages (figure 8.2).

In the first stage, the NDIA would temporarily maintain its role of price regulator (given that it is not possible to set up a new price regulator immediately), but an independent price monitor would be introduced with responsibilities, including to:

- examine how the market is responding to price caps set by the NDIA
- review the NDIA's price caps based on the available evidence, including submissions made to the NDIA's price reviews, and making comparisons with prices in other care sectors (including aged care)
- report publicly on its assessment of the NDIA's price controls with regard to market development and participant outcomes.

This monitor should be put in place quickly to serve as a 'check and balance' on the NDIA's pricing decisions over the transition period. The monitor will improve transparency around how price caps are set, and in turn, lead to greater accountability to participants, providers and the wider community.

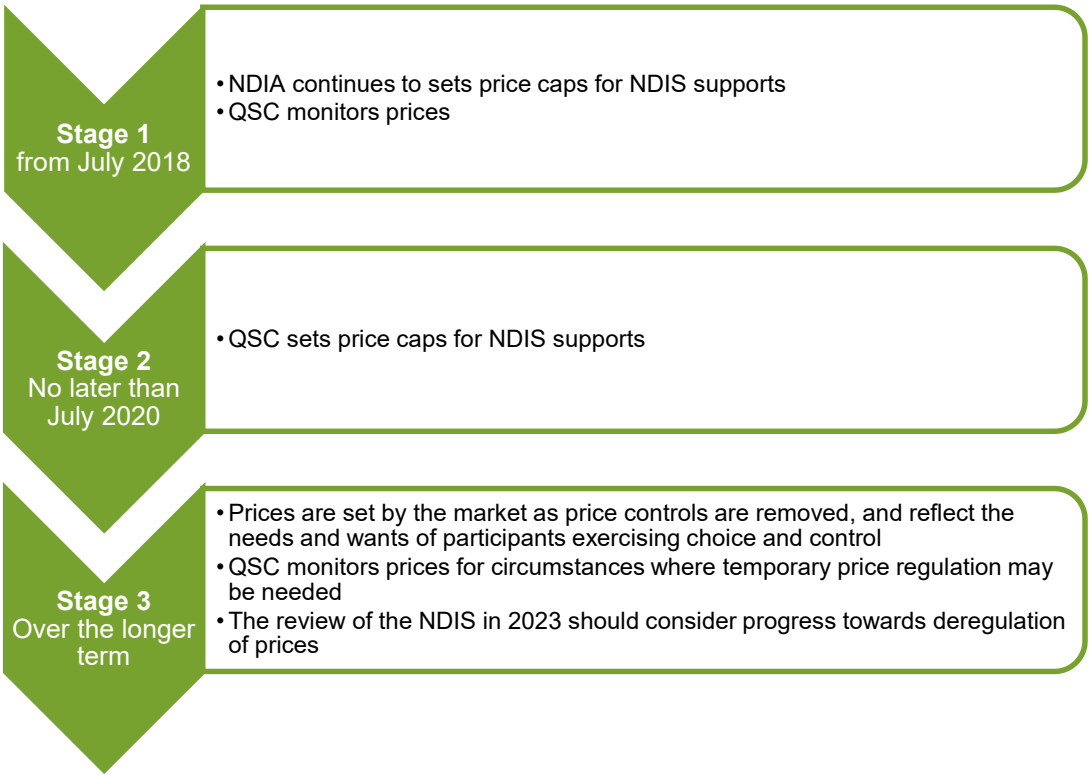
The Commission considers that the NDIS Quality and Safeguards Commission (QSC) (box 8.7) is an appropriate body to *monitor* NDIS prices in the first stage. The QSC's role will include the assessment and enforcement of quality and safety standards to protect participants — which itself will have a strong bearing on prices. Put simply, price and quality are intertwined in the NDIS. The QSC will also have regular communication with

stakeholders, including providers and the NDIA, as part of its provider registration, quality and safety regulation functions.

The QSC should begin price monitoring when it commences in July 2018 to enhance the transparency of the NDIA's price setting over the short term. The full report of the McKinsey & Company price review should be provided to the QSC when it is completed.

The second stage is to transfer the NDIA's price-setting powers to the QSC in July 2020. This would allow the NDIA to focus on its core responsibilities of delivering and administering the NDIS, and remove any concerns about a conflict of interest or how the Agency balances its objectives. It will also help address concerns about a lack of transparency in price regulation. Given the expectation for price regulation to persist for at least the next decade (ANAO 2016, p. 54), it will be necessary to place increasing emphasis on market development to deliver safe and quality supports — a role that the QSC is best placed to undertake, rather than the NDIA. The benefit of having an independent price regulator is that it would provide a credible, independent and transparent evidence base upon which pricing decisions could be made. The QSC would consult with, and accept submissions from all interested parties on its pricing decisions, including the NDIA.

Figure 8.2 **The PC's recommended path for NDIS price deregulation**



Box 8.7 The NDIS Quality and Safeguards Commission

The Australian Government announced that it will establish the National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission (QSC) to oversee quality and safeguards for all scheme participants, and set standards for NDIS providers. It is expected to commence operations in July 2018, with its enabling legislation currently before Parliament.

The Productivity Commission considers that the QSC is best placed to act as a price monitor in the short term, and to act as a price regulator for NDIS supports over the longer term, because its functions are consistent with the Commission's proposed pricing principles.

The QSC is to be evidence-based and transparent

The QSC is to be evidence-based in its legislated role and use its best endeavours to support and maintain a diverse and sustainable NDIS market. By law, the Commissioner will be required to:

- contribute to the National Disability Insurance Scheme Agency's provider benchmarking and to provider quality ratings, as well as monitor, review and report on the effectiveness of the NDIS, including market trends and the quality of outcomes achieved
- actively monitor those providers who would be 'hard to replace' if they ceased trading, including prudential oversight of financial viability
- form a national perspective on markets, using data and information generated by consumers and providers to identify trends in provider practice and wider market responses that may require action
- engage in, promote and coordinate the sharing of information to achieve the objectives of the NDIS Act.

The QSC is also to be transparent in its dealings with the community. The Commissioner is to have powers to initiate inquiries into systemic issues connected with supports or services provided under the NDIS. The Bill also makes clear that the Commissioner may consult and co-operate with a broad range of people, organisations and governments, including people with disability. Further, one of the Commissioner's core functions is to provide advice or recommendations to the National Disability Insurance Agency (or its Board) in relation to the performance of the Agency's functions — a function consistent with a price monitoring role.

The QSC is to be independent and well resourced

The QSC is to be an independent statutory body, with the Commissioner to hold broad-ranging powers in the exercise of his or her functions, and be accountable to the Australian Parliament. While the Minister for Social Services may give the Commissioner general directions in the exercise of their functions, the Minister is prevented from giving specific directions about particular providers, groups or individuals. The Australian Government has allocated $209 million between 2017-18 to 2020-21 to establish the QSC with about 300 staff. To support the Commissioner, the QSC is envisioned to have subordinate members including the NDIS Registrar (responsible for registering NDIS providers) and a Complaints Commissioner (responsible for complaints and reportable incidents). Adding a Pricing Adviser to assist the Commissioner in price regulation roles could be a sound approach to transfer pricing responsibilities from the National Disability Insurance Agency to the QSC.

Sources: Australian Treasury (2017b, p. 154); DSS (2016d, 2017f); National Disability Insurance Scheme Amendment (Quality and Safeguards Commission and Other Measures) Bill 2017 (Cwlth); Porter (2017); and Porter et al. (2017).

Across both stages, the body tasked with price regulation for scheme supports should have relevant capability and necessary resources[72] to perform its functions, including to:

- collect and publicly report data on providers' characteristics and costs — public reporting of this data would provide a benchmark for providers, inform public debate about prices, and facilitate relevant research by external parties
- communicate with disability support providers, participants and the NDIA to transparently set prices at regular intervals, with sufficient time for providers to phase in price changes. Providers (and participants) should be given at least 60 days' notice of price changes before they are to take effect
- periodically review and publish its price model for transitional and efficient prices in a transparent and comprehensive manner
- send granular and targeted price signals — that is, provide prices at the state and territory level, with an expectation that prices could be set at a more disaggregated regional level where possible. This would include the timely provision of supporting market information on all States and Territories (to date, the NDIA has not produced a market position statement for Western Australia (NDIA 2017p)), as well as more disaggregated data on committed supports where possible
- determine — on the basis of transparent consultation and evidence — when prices for particular NDIS supports in each region should be deregulated, and evaluate whether there is a need for price controls. To enable efficiencies to be driven by the market wherever possible, the price regulator should presume that it is appropriate for prices to be deregulated — that is, to only have price controls when there is clear evidence that unregulated prices are likely to lead to inflation that would harm participants. The review of the NDIS costs in 2023 should consider the state of market development, including progress towards price deregulation.

The third stage of deregulation will occur when the price of a given disability support is deregulated, but is still subject to subsequent monitoring. The QSC would maintain an ongoing watch on pricing, collect data, and publicly report on emerging market issues that affect the purchasing power of scheme participants. The QSC's pricing role would gradually diminish (and revert to a price monitoring role) as the market develops over time.

[72] For example, as at 30 June 2016, the Independent Pricing and Regulatory Tribunal NSW had 133 full-time equivalent employees (IPART 2016, p. 7) and the Independent Hospital Pricing Authority had 51 employees (IHPA 2016, p. 37). The NDIA had a total of 1505 employees (NDIA 2016b, p. 85), but data on how many employees were in the Markets and Pricing division are not publicly available.

RECOMMENDATION 8.1

The body responsible for regulating the price of supports under the National Disability Insurance Scheme should have relevant capabilities and the necessary resources to set price caps in a manner that is:

- transparent, with wide public consultation and publicly available information, including all assumptions used in any pricing models
- evidence-based
- supported by clear and limited legislative authority
- independent
- timely, particularly in giving providers sufficient time to phase in changes and be responsive to market conditions.

RECOMMENDATION 8.2

The Australian Government should amend the *National Disability Insurance Scheme Act 2013* (Cwlth) to require the National Disability Insurance Scheme Quality and Safeguards Commission (QSC), upon its commencement in 2018, to monitor, review and report on the price caps for scheme supports set by the National Disability Insurance Agency (NDIA). This should include appropriate funding for the QSC to undertake price monitoring of scheme supports, and to continue the business characteristics and benchmarking study currently undertaken by National Disability Services and the University of Western Australia.

The Act should require the NDIA to provide any relevant data and information that is required by the QSC in its price monitoring functions. The NDIA should make public a summary of the report of the 2017 McKinsey & Company price review upon completion, and provide the full report to the QSC.

RECOMMENDATION 8.3

The Australian Government should amend the *National Disability Insurance Scheme Act 2013* (Cwlth) to transfer the National Disability Insurance Agency's (NDIA) power to set price caps for scheme supports to the National Disability Insurance Scheme Quality and Safeguards Commission (QSC) by no later than 1 July 2020. The Act should require the NDIA to provide any relevant data and information that is required by the QSC in its price regulation functions.

Prices should only be regulated as narrowly and for as short a time as possible. As part of its price regulation functions, the QSC should:

- collect, de-identify and publicly release data on providers' characteristics, including the price, profits, costs and quality of services
- set price caps for supports at least at a state and territory level, which should be made public no less than 60 days before prices take effect
- comprehensively review and make public its price model on at least an annual basis. This review should be transparent, have wide public consultation, be evidence-based and evaluate the effectiveness of prices in meeting clearly defined objectives
- determine when to deregulate prices for supports, with particular regard to the type of support and region.

Progress towards price deregulation should be considered by the independent review of scheme costs in 2023.

9 Workforce readiness

Key points

- The disability care workforce will need to roughly double from its 2014-15 level to meet the increased demand for National Disability Insurance Scheme (NDIS) supports. This will mean that about 1 in 5 new jobs (net) forecast to be created in Australia over the transition period will need to be in disability care. While the disability care workforce has already grown considerably, it is unlikely to meet this target under current policy settings.
- There are a number of challenges to growing the disability care workforce. These include: the effect of price caps for NDIS supports on wage growth; finding carers to meet high participant demand at particular times of the day; ensuring that there are enough qualified carers to provide a reasonable quality of care (including allied health professionals); and increasing rates of retirement of workers from the sector as they age. There are also regional challenges — the workforce will need to triple or even more to meet demand in some areas.
- Policy changes that would help to address some of the workforce shortages over the transition period include:
  - taking advantage of the preference of many workers in the disability care sector to work more hours
  - using a targeted approach to immigration to address persistent skill shortages
  - trialling different approaches to help fund volunteer organisations to provide participant supports.
- Over the longer term, there needs to be a clearer delineation of roles and responsibilities for developing workforce policy for a more coordinated response to meeting the workforce needs of the NDIS. Building the evidence base on the number of workers in the sector, and their conditions and working arrangements, would be a sound investment to develop more effective workforce policies in the future.
- The way respite services are provided under the NDIS — participants are required to include it in their plans, and there are caps on the amount of respite — could be creating a disincentive for providers to supply these services. This may reduce the ability of participants' family members and friends to provide informal care. A lack of respite and informal care will increase demand for formal carers and scheme costs.

The state of the disability care market's readiness to deliver National Disability Insurance Scheme (NDIS) supports will affect scheme costs. Market readiness depends on, among other things, whether there are enough workers to provide NDIS supports.

As recognised by the National Disability Insurance Agency (NDIA), any workforce shortages are a risk to the scheme.

> A major concern for the NDIA is that the speed in growth of demand cannot be met by a commensurate speed in growth of supply. The availability of workforce is a significant factor in the ability of the market to supply the needs of people with disability. (sub. 161, p. 95)

While workforce shortages will have a direct effect on scheme costs, the NDIA's pricing policies will also affect workforce growth and scheme costs. For example, without price regulation (in the short term), increased competition for care workers could bid up wages and increase scheme costs. However, with price regulation, the workforce may not grow quickly enough. This could lead to unmet demand for participants, which will put a brake on scheme costs, but could also undermine the objectives of the scheme by restricting access to reasonable and necessary supports.

This chapter examines the question — can the disability care workforce grow quickly enough to supply the increasing demand for services under the NDIS?

Section 9.1 looks at the current state and characteristics of the disability care workforce. Section 9.2 discusses the size and scope of the workforce that will be needed when the NDIS is fully rolled out. Section 9.3 examines policy options for developing the workforce, and ways to reduce the number of workers required to provide NDIS supports. Section 9.4 examines policies for informal carers that may reduce calls on the formal care workforce.

9.1 The disability care workforce

The disability care and support workforce is diverse. It includes disability support workers that provide daily care and allied health professionals that provide specialised care. As the NDIS is rolled out, the size and scope of the workforce will increase — both to cater for more participants, and to embrace new roles driven by the market-based system as participants exercise greater choice over their supports.

To understand how the workforce will need to change requires an understanding of what it looks like now. It is difficult to measure the disability care workforce as it is usually classified in the same category with aged care workers in regularly published statistics (box 9.1). With this in mind, a number of broad conclusions about the disability (and aged care) workforce can be drawn.

- Disability care workers are older than the workforce in general (figure 9.1) — about 22 per cent of workers are aged 55 years and older (NDS, sub. 51, p. 9).
- About 80 per cent of employees in the disability care sector are women (compared with about 46 per cent of employees for all occupations).[73]

[73] Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2016).

- About 60 per cent of employees in the disability care sector work part time (compared with about 30 per cent of employees for all occupations).[74]
- The majority of workers in the disability care sector hold a certificate-level qualification (figure 9.2).

Box 9.1 Measurement issues: the disability care workforce

Data on workers in Australia are collected regularly by the Australian Bureau of Statistics based on the industry of employment (the Australia-New Zealand Standard Industry Classification (ANZSIC)) and the occupation of the worker (using the Australia-New Zealand Standard Classification of Occupations (ANZSCO)) (ABS 2006, 2013). However, neither of these classifications are well suited to identifying those working in the disability care sector, or those working in disability care roles.

For example, the most disaggregated — that is, the level of finest detail — ANZSIC classification that includes disability carers is '8790 Other Social Assistance Services', which also includes aged care assistance services, marriage guidance services, and the operation of soup kitchens. In ANZSCO it is '4231 Aged or Disabled Carer', which again combines aged and disability carers together. Neither of these are ideal for analysing the state of the disability care workforce.

Allied health professionals who work in the disability support sector are similarly hard to identify, as it is difficult to distinguish between those that may provide services occasionally or those that provide them full time to people with disability. The classification of allied health professionals is also contentious and subject to revision.

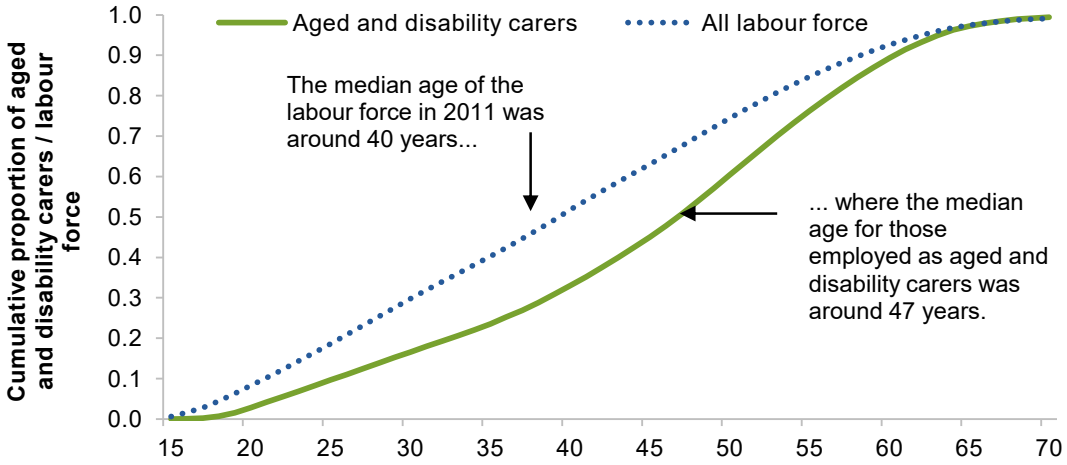
> There is no one definition which prescribes the disciplines considered as allied health. At the meeting of the Council of Australian Governments in July 2006, agreement was reached to establish NRAS [the National Registration and Accreditation Scheme] for health professionals, beginning with the ten professional groups registered in all jurisdictions, of which seven fall under the allied health banner: chiropractic care, optometry, osteopathy, pharmacy, physiotherapy, podiatry, and psychology. … A further four allied health professions joined NRAS on 1 July 2012: Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists. … Other allied health professions that are not included under NRAS, but are considered in the Commonwealth's health workforce policy planning, include: Audiologists, Counsellors, Dieticians, Exercise physiologists, Music therapists, Nutritionists, Pathologists, Social workers, Sonographers, Speech pathologists. (Department of Health and Ageing 2013)

Other studies, including the Commission's inquiry into *Disability Care and Support* (PC 2011), relied on 'one-off' surveys and alternative data sources to better understand the disability care workforce. This included a detailed survey by Martin and Healy (2010). This survey remains the most specialised data source for the disability care sector workforce, though is now becoming dated. A more recent survey on the disability care workforce (Cortis 2017) provides an update to some of the matters examined by Martin and Healy.

[74] Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2016).

Figure 9.1 **People working in the aged and disability care sector are older than the labour force in general[a]**

2011

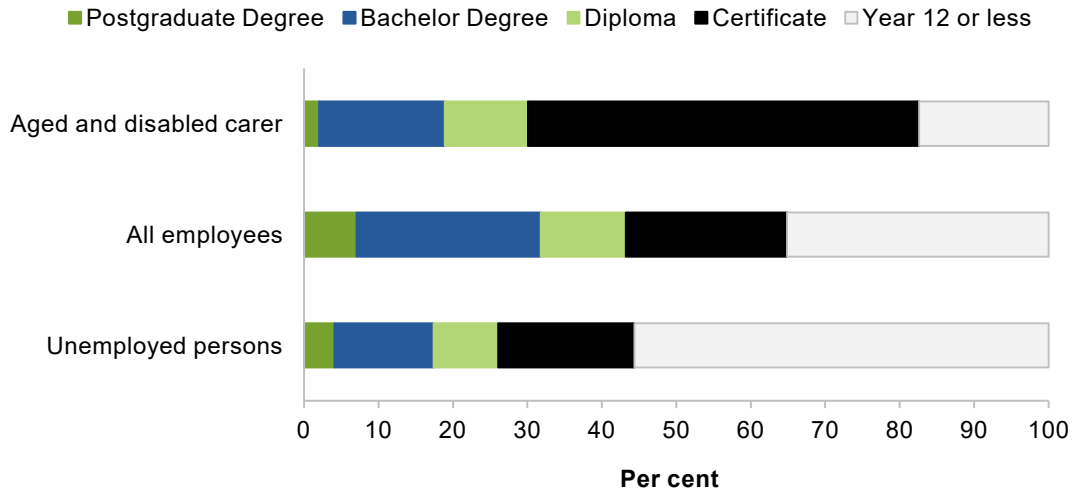


[a] Based on ANZSCO code 4231 'Aged or Disabled Carer'.

Source: Commission estimates based on ABS (*TableBuilder Basic,* 2011 Census).

Figure 9.2 **People employed in aged and disability care roles are more likely to hold certificate-level qualifications[a]**

Highest level of educational attainment, 2016



[a] Aged and disability care roles based on ANZSCO code 4231 'Aged or Disabled Carer'. The Bachelor Degree category includes postgraduate certificate and diploma qualifications.

Source: Commission estimates based on ABS (*TableBuilder,* Education and Work, May 2016).

9.2 What workforce will be needed?

While estimates of the number of workers required to deliver supports allocated through the NDIS vary, the consensus is that the workforce will need to increase by between 60 000-90 000 full-time equivalent employees (FTE) — or roughly double in size.

> The workforce will need to increase from approximately 73 600 full-time equivalent (FTE) workers, to an estimated 162 000 FTE workers. (DRC 2015a, p. 19).
>
> The workforce opportunities and challenges as a result of the introduction of the NDIS are very significant. It is expected that the NDIS will generate between 60 000 and 70 000 new jobs on a full-time equivalent basis over the next three years. This represents about 20 per cent of the total number of new jobs forecast to be created in Australia over this period. (Bonyhady 2016, p. 5)

The NDIA's market position statements suggest that about an additional 70 000 FTE workers will be needed from 2015-16 to 2019-20 (NDIA 2016c, 2016l, 2016s, 2016u, 2016w, 2016x, 2017v).

The evidence to date — at the early stage of transition — is that the workforce is growing quickly, but not fast enough to meet the overall growth target. About 18 per cent growth in FTE employees is required to meet the expected workforce needed for the scheme.[75] Data collected on the workforce by National Disability Services (NDS), a peak body for disability care providers, indicate that the number of FTE workers in the sector is growing at a rate of about 6 per cent each year (Alcorso 2017, p. 3). Data from the NDS's Financial Benchmarking Project (in partnership with the University of Western Australia) indicate annual growth of FTE workers of about 12 per cent (Gilchrist and Knight 2017b, p. 47). The ABS Labour Force data indicate growth of about 13 per cent for the most recent year.[76] Each of these indicate that workforce growth is less than what is needed.

Data on allied health professionals, albeit patchy and reported in a period early in the trial phase, also indicate that growth rates in FTE employees are slow (table 9.1). Clearly, there are considerable challenges emerging in scaling up the workforce to meet the needs of NDIS participants.

[75] Commission estimates based on NDIA (2016c, 2016l, 2016s, 2016u, 2016w, 2016x, 2017v).

[76] Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2015 and May 2016) indicate the number of people employed in aged and disability care occupations increased by about 27 per cent between 2015 and 2016 according to ABS Labour Force data. Based on the proportion of part-time to full-time positions, halving the rates of reported 'headcount' growth allows for a rough approximation of the FTE growth targets.

Table 9.1 **The number of registered allied health professionals[a]**
2014

Allied Health Category	*Number registered*	*Average hours worked per week*	*FTE equivalent per 100 000 population*	*Average annual growth rate in FTE per 100 000 population (%)*
Psychologists	31 489	32.7	87.4	1.3[b]
Physiotherapists	27 011	34.7	83.3	2.1[b]
Occupational therapists	16 757	33.1	52.2	3.2[c]
Chiropractors	4 902	32.8	15.8	1.3[b]
Podiatrists	4 314	36.2	16.1	4.0[b]
Dental prosthetists	1 223	38.8	4.9	-2.6[b]
Aboriginal and Torres Strait Islander health practitioners	322	40.7	1.2[d]	4-5[e]

[a] Only selected allied health professions shown from National Registration and Accreditation Scheme data (box 9.1). No data are available for speech therapists and dieticians. The data for 2015 were recently released (Department of Health 2017c), but are not reported in a form that can be easily compared with the above. [b] 2011 to 2014. [c] 2013 to 2014. [d] 76.4 based on Aboriginal and Torres Strait Islander population. [e] 2012 to 2014. A range is presented given the low precision in which the data are reported.

Sources: Commission estimates based on ABS (*Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, 2001 to 2026, Cat. no. 3238.0, series B); AIHW (2014a, 2014b, 2014c, 2014d, 2014e, 2014f, 2014g).

Challenges to reaching the workforce target

While estimates of FTE employees are helpful for providing an overview of the growth required, they mask a wider variation in supply and demand at a more disaggregated level. There are many different workforces that will provide services for NDIS participants, and the challenges and policy responses to each will vary. A better way is to consider the disability care workforce across 'role and region'.

- Role covers the types of workers needed to fulfil a NDIS participant's needs, which in turn will depend on individual choice, disability and other family circumstances. This translates to the skill mix of workers needed, and in turn, the mix of general carers, allied health professionals, and other workers required.
- Region covers the different number and growth in workers required in different locations.

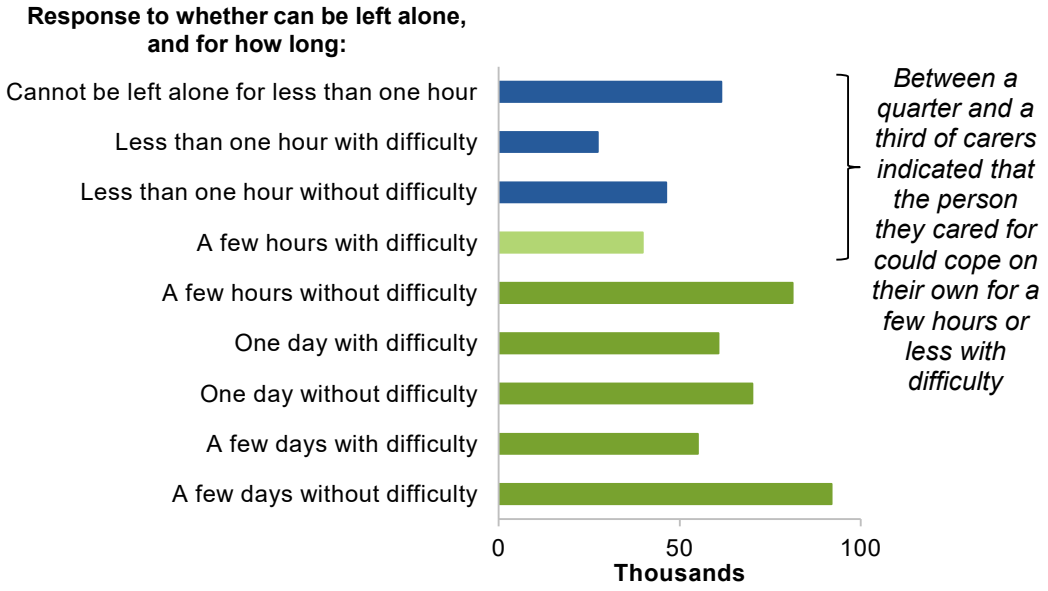
Role challenges

Peak hours

Disability carers are often required for only a few hours each day at 'peak times' — there is high demand for carers in early mornings and evenings to help people with disability get in

or out of bed, showered and fed (Physical Disability Australia, sub. 38, p. 11). This is reflected in the Survey of Disability, Ageing and Carers, which indicates that about three-quarters of people with severe or profound disability require attendant care for a few hours a day before encountering difficulties (figure 9.3).

Figure 9.3 **Amount of care required before recipient has difficulties[a]**
2015



[a] Based on the response by the carer for those with severe or profound disability aged 15 years or more.

Sources: Commission estimates based on ABS (*Disability, Ageing and Carers Australia: Summary of Findings, 2015,* Cat. no. 4430.0, table 42).

This means that there are times of the day when more carers are needed than the average would suggest, which would require a greater headcount than the FTE figures suggest. This has implications for how 'flexible' the workforce needs to be. As the NDIA said:

> Participant demand for care often occurs at 'peak times' or high demand periods which may include 7-9am (breakfast) and 4-8pm (bathing and mealtime) with less demand at late morning or mid-afternoon. This poses challenges for the sector to develop more mature rostering and staff management practices which are emerging in some areas. (sub. 161, p. 98)

Making greater use of a more casualised workforce could provide the labour needed in those hours of greatest demand. However, there are also some impediments, including:

- minimum shift requirements under the Social, Community, Home Care and Disability Services Industry Award, and the cost of casual loadings and penalty rates for working less desirable hours (such as those outside ordinary hours of work)
- quality concerns, such as whether NDIS participants want a different carer for each instance of care, and issues of reliability of casual labour (Cortis 2017, p. 6)

- whether there is the supply of casual labour to allow such an approach.
  - This includes the attractiveness to work on a casual basis for prospective workers, and the risk that more experienced and better qualified workers may seek permanent jobs elsewhere given the disincentives associated with less secure work (AAWA, sub. PP219, p. 8; Independent Inquiry into Insecure Work in Australia 2012, pp. 55-58).
  - Potential changes to casual employment in modern awards may also affect the supply of casual workers (box 9.2).

Box 9.2 Changes that may affect casual employment in the future

The Fair Work Commission (FWC) completed its four-yearly review of modern awards in July 2017. One of the matters it examined was the growing trend of casual employment, and the possibility that more casual workers were employed in patterns of work consistent with permanent employees. Some participants in the FWC review raised concerns that such employees were denied the benefits of being permanent employees, such as some entitlements under the National Employment Standards. The FWC noted:

> Although the casual loading for which modern awards provide notionally compensates for the financial benefits of those [National Employment Standards] entitlements which are not applicable to casuals, this does not take into account the detriments which the evidence has demonstrated may attach to the absence of such benefits, particularly for adult long-term casuals who are financially dependent on their casual employment. These include attending work while sick, not taking recreational leave because of concerns about whether any absence from work will endanger future employment, the incapacity to properly balance work and attending to personal and caring responsibilities and commitments, changes in working hours without notice, and potential for the sudden loss of what had been regular work without any proper notice or adjustment payment. Additionally there are other detriments associated with casual employment of this nature, including the lack of a career path, diminished access to training and workplace participation, poorer health and safety outcomes and the inability to obtain loans from financial institutions. (2017, para. 7)

In response, the FWC developed a draft model 'casual conversion' clause that provides a mechanism to allow those employed as casuals on a 'permanent' basis to achieve permanent employment. The draft clause allows:

- casual employees that have been working for a period of 12 months or longer in a pattern of hours on an ongoing basis consistent with the full-time or part-time provisions of the relevant award to request for conversion to a permanent position
- employers to only refuse the request for reasons including that:
  - to do so would require a significant adjustment to the casual employee's hours of work
  - it is reasonably foreseeable that the casual employee's position will cease to exist.

(continued next page)

Box 9.2 (continued)

The draft model clause is yet to be implemented, and subject to further consultation by the FWC.

A casual conversion clause as presently drafted by the FWC could have ramifications for the National Disability Insurance Scheme (NDIS) workforce and scheme sustainability. Much of the scheme's settings rely on a significant increase in casual employees who would work fairly consistent and predictable hours. If these workers took up the option to convert to permanency, then this could reduce the flexibility of employers to respond to demand from scheme participants (and could require adjustment to the assumptions used in the National Disability Insurance Agency's pricing approach). What is unclear is how many employees might opt to use a casual conversion clause. While some employees may be attracted to more secure employment, it would come at the cost of loading attached to casual employment.

One incentive such a clause could create is for employers to keep the number of hours worked by employees low to avoid the risk of a casual conversion occurring. This would, all else being equal, increase the number of workers required to provide NDIS supports, as the same number of hours would be spread across a larger number of shorter shifts. More data on the work patterns of those working in disability care and support roles in the NDIS is needed to understand how the introduction of the clause may affect providers, employees and the sustainability of the scheme.

Sources: FWC (2017) and Pallot et al. (2017).

Qualified staff in general

The quality of care provided to NDIS participants will depend in large part on the quality and skills of the workers providing disability supports. For many roles, formal qualifications are important, if not mandatory, to provide supports. For other roles, formal qualifications are less important. The available evidence suggests that the 'average' level of formal skills in the disability care workforce will decline over the transition period of the NDIS (box 9.3).

This raises the question — is a formal qualification the most important or necessary characteristic to secure employment as a disability support carer?

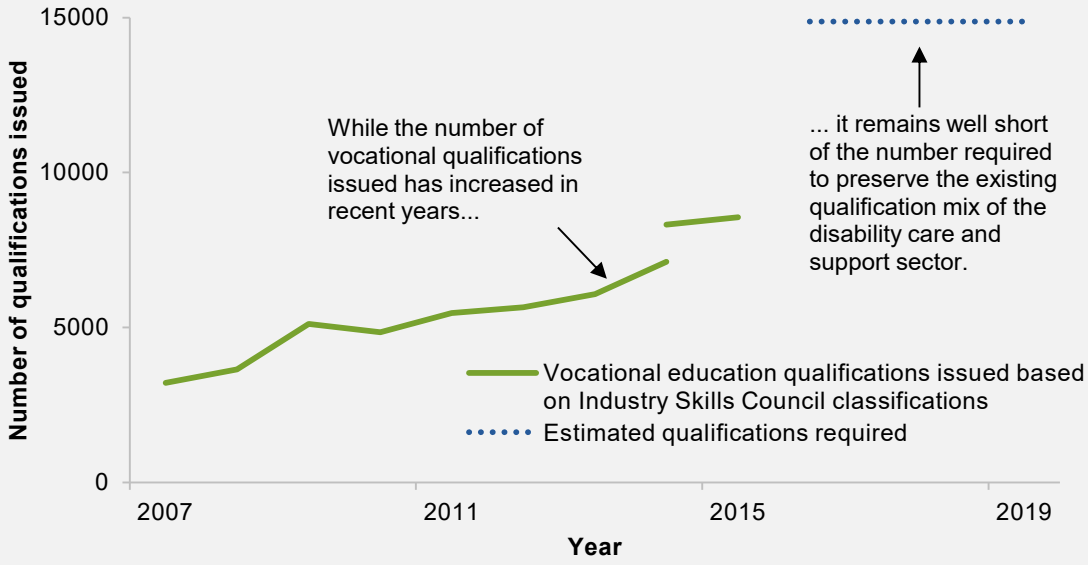
A survey of firms specialising in disability support by the Department of Employment (2014, pp. 2, 5) found the evidence to be mixed.

- 89 per cent of providers said that 'personal qualities' were 'important or very important' in terms of the characteristics sought, compared to 70 per cent for 'relevant experience' and 47 per cent for 'relevant qualifications'.
- 89 per cent of firms said that their minimum requirement for employment was a certificate-level qualification. However, 26 per cent of firms indicated that they regularly employed unqualified workers, suggesting this requirement was not a binding constraint for some firms.

Box 9.3 Not enough new trainees to maintain formal qualifications[a]

People employed in aged and disability care roles are more likely to hold a formal qualification than the workforce in general. The most common level of qualification for disability and aged care workers is a certificate III or IV. The number of people completing a qualification against expected workforce targets provides a measure of how the qualification mix of the workforce may look by the end of the National Disability Insurance Scheme transition.

The National Centre for Vocational Education Research dataset on vocational education outcomes (VOCSTATS) indicates that, if workforce targets are met, there will be a smaller proportion (than currently) of workers holding a certificate-level qualification. The figure below shows that about 50 000 certificate or diploma level qualifications were issued in the nine years between 2007 and 2015, while about another 60 000 qualifications would be necessary in the four years between 2016 and 2019 to preserve the same distribution of qualifications observed in the 2011 census.



This indicates that the proportion of workers holding certificate-level qualifications in disability care related studies will fall over the transition period. However, it is not clear what mix of qualifications will be necessary for all National Disability Insurance Scheme participants.

[a] Estimate is derived by subtracting the expected and current midpoint estimates of FTE disability care and support workers from the NDIA's market position statements and multiplying by a scaling factor of 0.85 to apply the proportion of full-time equivalent workers with a certificate or diploma qualification. This yields a result of 59 500 additional qualified workers, which when apportioned over 4 years requires 14 875 new qualified workers per year. Vocational qualifications are identified using Industry Skills Council classifications that include the term 'disability' in their title (specifically, codes CHC20599, CHC30302, CHC30408, CHC30799, CHC40202, CHC40302, CHC40308, CHC40312, CHC40799, CHC50102, CHC50108, CHC50799, CHC60102, CHC60108, CHC60112, CHC60799). The HSU (sub. PP316, p. 8) suggested that 'Certificate III in Individual Support' (CHC33015) be included — it is not included because the qualification can be aged care specific, and that there are concerns about the relevance of the qualification to disability care in general (ACT Government, sub. PP312, p. 13). Note that these data are presented in terms of qualifications awarded rather than qualifications used on a FTE basis. The break in series reflects changes in concordance between previously offered qualifications and current qualifications.

Sources: Commission estimates based on ABS (*TableBuilder,* Education and Work, May 2016) and NCVER (*VOCSTATS*, March 2017).

This inconsistent story was also reflected in evidence provided to the Commission's 2011 inquiry into *Disability Care and Support*. While some providers argued that a minimum standard or qualification should be mandated for disability support staff, others said that formal qualifications sometimes fell short of providing 'work ready' employees, and that on-the-job training was far more important (PC 2011, p. 740).

In practice, the benefits of a formal qualification depend on the role that a disability care worker is employed in, and the client's needs. The NDIS will also mean that many workers will need to learn additional skills in the market-based environment for disability supports.

> The NDIS differs considerably from previous reforms as it moves away from 'block funding' programs to a 'fee for service' model. Earlier reforms had little effect on frontline workers. But now workforce models are changing. Frontline workers need to have an understanding of sales, customer service and the ability to work within financial constraints as well [as] being able to adapt and customise service delivery in a person centred model.
>
> Conversations are being held in the sector regarding formal qualifications and whether they are necessary. Some organisations are recruiting workers with no experience and no formal qualifications, with new staff undergoing customised organisational training only. For other organisations, formal qualifications are a pre-requisite. This brings opportunities for a diverse workforce. (Queensland Alliance for Mental Health, in VICSERV & CMHA 2017, p. 46)

It seems reasonable to conclude that the lack of certificate-qualified workers will affect some firms and present a challenge to meeting the workforce target of the NDIS, but the evidence is too limited to say which areas will be most disadvantaged. Also, participants may prioritise attitude and aptitude, and choose to employ less qualified staff who better suit their needs.

Qualified allied health professionals

Allied health roles are very different to attendant care roles. Allied health professionals specialise in a range of different areas, and hold higher level qualifications relative to the disability support workforce in general.

> Allied health professionals are generally educated in the university sector with bachelor degrees, usually three to four years duration. However, in a development common to other health professions, there is an increasing move to postgraduate degrees, for example an initial generic undergraduate science degree followed by a Masters in an individual discipline. (Department of Health and Ageing 2013)

Formal qualifications are almost always a requirement for allied health professionals to practice, which means building up qualified staff can take much longer than for other roles. Constraints in this regard were recognised as part of the *Integrated Market, Sector and Workforce Strategy*.

> It is estimated that the highest rate of increase in the demand for disability workers will be for allied health professionals. The disability sector will need to work closely with related community service sectors, particularly health and aged care, to ensure the demand for allied health professionals is met.

> To support the sector and enhance the supply of allied health professionals to the disability sector, the Commonwealth and jurisdictions will work with the sector, education authorities, and professional bodies to ensure that professional education prepares graduates adequately to work in the NDIS. At the same time, to encourage allied health professionals to choose the disability sector, the Commonwealth will work with these same stakeholders to strengthen the sector's capacity to provide high-quality placements and support continuing professional development for allied health workers. (DRC 2015a, p. 20)

If the allied health professional workforce does not build quickly enough, this could lead to unmet demand for participants and a substitution away from using professional carers to using more general workers instead. There is some evidence that this is already occurring.

> A perception was expressed in the wave 1 interviews that the pricing structure of the NDIS would bring change to the role of allied health professionals through encouraging the increased use of non-professional staff. By wave 2 a de-professionalisation of the disability workforce was more commonly being reported, with increasing numbers of allied health assistants in the sector. Concerns were raised about the ability and skills of these workers to provide more complex supports and the impact this could have on the quality of care and outcomes for participants. (Mavromaras, Moskos and Mahuteau 2016, p. 48)

And one of the providers interviewed in the evaluation said:

> We have employed a number of inexperienced people, but I believe that's starting to backfire … Just the inexperience and the lack of knowledge on how to work with behaviours or understand confidentiality, or things like professional distance and all those types of things. And we're sending inexperienced people out to work individually with people with disabilities. (Mavromaras, Moskos and Mahuteau 2016, p. 48)

Evidence presented to the Commission provides another inconsistent story about supply and demand for allied health workers in the NDIS. On the one hand, the number of providers registered to deliver allied health services to NDIS participants has grown strongly (NDIA 2016r, p. 43), and in line with the expected number needed by the end of the transition period. However, many who have registered are not yet providing services to scheme participants. This makes it difficult to determine if they are registering in advance of the NDIS rollout or have changed their mind about delivering services.

Many disability service providers pointed to a number of allied health roles that are moderately or extremely difficult to fill. For example, more than half of the firms surveyed by National Disability Services said that they had experienced difficulties recruiting speech therapists and occupational therapists (NDS 2016, p. 38). The *Intermediate Review of the NDIS* also identified persistent shortages in the areas of speech pathology, occupational therapy and psychology supports (Mavromaras, Moskos and Mahuteau 2016, p. 32), although supply to those who needed such services had increased.

As one staff member of the NDIA in the Intermediate Review put it:

> The NDIS has worked twofold. It's increased the amount of service available so people can see other OTs [Occupational Therapists] outside of what they would have been able to. But there's

> an increased demand. The increased demand is way above the increase of services. (Mavromaras, Moskos and Mahuteau 2016, p. 54)

Some service providers and peak bodies expressed concerns about whether there will be enough allied health providers for NDIS participants, and the consequences for sectors (box 9.4).

A lack of allied health professionals represents a risk that supports of appropriate (and necessary) quality may not be available to some NDIS participants. The time it takes to train an allied health worker — both in terms of formal qualifications and on-the-job training — means that it may be too late to prepare the necessary allied health workforce without either diverting them from other caring sectors, or to seek skilled migrants to fill the workforce gap in the short term. Both approaches involve costs.

Box 9.4 Finding allied health workers can be difficult

Matt Burrows:

> The workforce is a wicked problem. … To think that we, as service providers, can just advertise for and employ that many qualified staff (eg therapists) in such a short time is just misguided. Let alone the considerations of balancing a commercial and compassionate culture during this transition time.
>
> At entry to the NDIS in 2012-13 the employment market for therapists relied heavily on internationals supported to work domestically on 457 visas. By 2016-17 the training institutions had geared up and graduates now make up a steady portion of the new recruits. But there remains a gap and that gap is being filled from the full employment market being accessed elsewhere. Australia only has so many therapists and their entry into the NDIS employment field means they are exiting elsewhere. (sub. 7, pp. 3–4)

Disability Services Australia:

> Professional staff, in particular Psychologists and Speech Pathologists are generally difficult to attract (especially in Regional areas) in a very competitive marketplace. This has driven the need to implement creative sourcing strategies such as the hiring of interns for a short term solution. We have also seen significant wages growth in the allied health professions due to labour shortages. (sub. 9, p. 9)

Australian Physiotherapy Association:

> Our members have suggested that increasing the NDIS workforce to that which is projected as being required will not be possible in the current policy settings. They have advised us that demand for services has already stripped supply of providers. (sub. 93, p. 16)

Allied Health Professions Australia:

> Current demand for services is already exceeding the available supply of allied health providers and there is no evidence of short term changes to this workforce shortage. (sub. 37, p. 16)

An ageing workforce and population presents a greater challenge

Australia has an ageing population, and this is reflected in the increasing average age of:

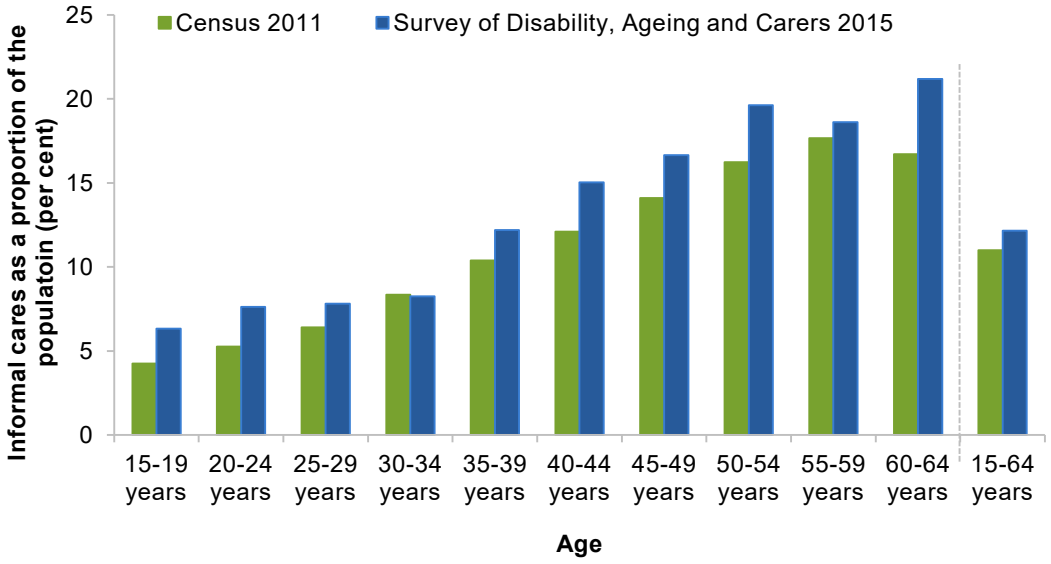
- formal carers employed to look after people with disability (figure 9.4)
- informal carers who look after friends and family with disability

- the general population, which will affect the on demand for carers more broadly.

As noted above, the average age of carers employed in the aged and disability care workforce is higher than for the general workforce. The average age of people employed in aged and disability care is about 47 years, and about a quarter are above the age of 55 years (figure 9.4).[77] An increasing proportion of the care workforce is likely to retire in the coming years, with the average retirement age of those employed in the personal care and assistance occupations about 55 years in 2014-15.[78] Only about half of those working in disability care intend to still be working in the sector in five years' time, with a further third unsure (Cortis 2017, p. 24).

Informal carers are also ageing. The trend since the 2011 Census is an increasing proportion of people aged 50-64 years providing care for others (figure 9.4). The ability of informal carers to continue providing this care as they age is likely to diminish. As the degree of informal care a NDIS participant receives affects the amount of formal care supports that they are allocated, this suggests that as informal carers age, there will be greater calls on the NDIS to provide more supports and this will require a larger formal workforce.

Figure 9.4 **Informal carers are growing older**



Sources: Commission estimates based on ABS (*TableBuilder Basic,* 2011 Census; *TableBuilder,* Survey of Disability, Ageing and Carers 2015, Cat. no. 4430.0).

The ageing population also means there will be more intensive demand for carers. While aged care workers are not perfect substitutes for disability care workers, there are some roles

77 Commission estimates based on ABS (*TableBuilder Basic,* 2011 Census).

78 Commission estimates based on ABS (*Retirement and Retirement Intentions, Australia, July 2014 to June 2015,* Cat. no. 6238.0, unpublished data).

that cross over, and about one-fifth of disability care providers are intending to enter the aged care sector (NDS 2016, p. 13). This means that even if new carers are trained, they may not be attracted to the disability care sector as the aged care sector expands. As Disability Services Australia said:

> There is no doubt that as Baby Boomers retire from full time work there will be an overall impact on a range of employment sectors. Whilst there may be some potential for retirees to take on casual disability support or mentoring roles, the ageing population will also create an increase in demand for aged care workers, in direct competition with the recruitment for workers in to disability roles. (sub. 9, p. 9)

And even if the disability sector can attract workers from the aged care sector, there could still be implications for scheme costs. For example, if the quality of aged care services falls because of workforce shortages, there could be a stronger incentive for NDIS participants to remain in the scheme past the age of 65 years.

The role of wages in growing the workforce

Most of the payments from the NDIS will be spent on wages, given the labour-intensive nature of disability care. While price caps will have an impact (chapter 8), this is likely to mean more money will be available for workers. From a policy perspective, the question is whether this money will be sufficient to induce more workers to provide disability supports. This depends on how competitive the disability care market is, how responsive care workers are to wages, and in turn, why people work in the disability care sector.

Analysis conducted prior to the introduction of the NDIS suggests that pay is one of many motivations to work in disability care. For example, a study of community service employees undertaken in 2009 found that only 16 per cent of employees were attracted to work in the disability services sector primarily for the pay (Martin and Healy 2010, p. 135). A desire to help others and a desire to do something worthwhile were far more important motivations (nominated by 76 and 68 per cent of workers, respectively) (Martin and Healy 2010, p. 135). As one disability support worker said:

> I love this industry. It's not about coming into work, doing an 8 hour shift and leaving. It's so much more than that. For some people we can be their eyes, their ears or their hands. (United Voice, sub. 118, p. 2)

However, there is also evidence that higher rates of pay can help retain workers in disability care roles and attract new workers to the sector. Just over half of employees who left a disability support provider surveyed by the Department of Employment (2014, p. 17) said that they left for a position that had 'better pay and conditions', and about 60 per cent of firms used increased remuneration as a means to improve retention. Given the ageing workforce, higher wages could be used to keep workers from retiring, to the extent that wages can increase under the NDIA's price caps.

Overcoming the perception that caring jobs do not lead to fulfilling careers may be necessary to have enough workers to provide NDIS supports. As noted in the Integrated Market, Sector and Workforce Strategy:

> To meet the increased demand for disability workers, including allied health professionals, it will be necessary to assist suppliers to promote the disability sector nationally as a career. (DRC 2015a, p. 20)

A number of study participants noted that caring roles are seen as unattractive due to the nature and remuneration of the work.

> The nature of the work of disability support staff may not in itself be attractive enough to appeal to many school leavers and those looking for a career change in later life. The work itself can be highly complex and carry significant risk, especially when supporting people with severe challenging behaviours or people with complex medical support needs. Greater provision for training support staff is vitally important at present, providers are limited in the amount of training that can be provided due to cost pressures. (Macarthur Disability Services, sub. 57, p. 8)

> The NDIA has observed over the course of trial and transition that caring jobs are often poorly valued. Common reasons cited for a lack of retention (Department of Employment survey of Personal Care Workers 2014, National Aged Care Workforce Census and Survey) include the low conditions of work and physical and emotional toll of the job. This is regrettable. (NDIA, sub. 161, p. 97)

> That caring roles are poorly [valued] is not perception, it is reality. Caring jobs are poorly valued. Pay rates are mostly minimal. Good or exceptional performance of the role is rarely valued financially. (Autism Aspergers Advocacy Australia, sub. 178, p. 26)

> Low prices also militate against the sector creating additional jobs that would be useful in alleviating professional shortages, such as allied health assistants and peer workers. (NDS, sub. 51, p. 9)

How labour will respond to conditions under the NDIS over the longer term is hard to assess. The data make it difficult to understand the number and hours worked by employees of disability care providers. The unprecedented scale of workforce growth required, combined with a new market-based approach, also mean that historical data on wages and work patterns are less useful to estimate the future. The interaction with other care sectors — especially aged care — will also be important. More data will need to be collected to make meaningful wage policy when it comes to NDIS workers.

Regional challenges

The disability care workforce needs to double in aggregate, but the scale of growth required in individual regions varies between as little as 5 to over 300 per cent (figure 9.5).[79] Most regions will need to grow their disability care workforce between 50 and 150 per cent. While some of the percentage increases are large, many are based on a very low number of workers

[79] Regions are groups of local government areas, which are the geographical basis for the NDIA's market position statements.

to start with. This is especially the case in rural or remote areas where a few workers can represent a doubling of the disability care workforce.

Some of the challenges with thin markets in remote areas are discussed in chapter 7, but it is worth noting that there are several regions within metropolitan areas where the required growth is about 200 per cent:

- South Western Sydney, where about an additional 5800 FTE workers are needed (growth of 215 per cent)
- Southern Melbourne, where about an additional 2500 FTE workers are needed (growth of 211 per cent)
- Beenleigh, where about an additional 2300 FTE workers are needed (growth of 190 per cent)
- Brimbank Melton, where about an additional 1700 FTE workers are needed (growth of 197 per cent).

Figure 9.5 **Variation in growth required in different regions**[a]

Each dot represents the growth in the amount of FTE employees needed relative to the current situation, both in terms of the number and proportion, between 2015-16 and 2019-20.

[a] The NDIA's market position statements provide a range of estimates for the number of FTE disability workers at present and what will be needed in the future. To derive these estimates for growth, the midpoints of each range are used. No data are available for Western Australia. Regions are groups of local government areas.

Sources: Commission estimates based on NDIA (2016c, 2016l, 2016s, 2016u, 2016w, 2016x, 2017v).

These data, as published, do not capture the mix of roles within the FTE positions. For example, they do not distinguish between the hours of care provided by an in-home carer as opposed to those provided by an allied health professional. All of this emphasises the need for policies that seek to mitigate workforce shortages to have a focus at a regional level, where different policy responses may be more appropriate across different regions and roles.

The bottom line?

The scale of workforce growth required, combined with challenges of worker roles and regional variation, means that the NDIS workforce targets are unlikely to be met by 2020. As both the Intermediate Review of the NDIS and the former Chair of the NDIA noted:

> While the NDIS had led to an increase in the supply of disability supports, the Scheme had also led to an increase in a demand for services (and particularly therapy services); NDIA staff concluded that overall, demand now exceeded supply. (Mavromaras, Moskos and Mahuteau 2016, p. 54)

> The Bilateral Agreements imply that in the current fiscal year of 2017-18 demand for disability services will increase by 40 per cent. The lack of progress on workforce readiness for the NDIS means that shortages and, potentially, significant shortages will appear in many areas within the next 12 months. This means that the transition to the full NDIS by mid-2019 is not achievable. (Bruce Bonyhady, sub. PP333, p. 17)

The trends to date show that providers are already responding to workforce shortages by using less skilled labour. In some cases, this may compromise the quality of care received by participants and could become more widespread as the NDIS is fully rolled out. This, in turn, will reduce the effectiveness of the NDIS, compromise its insurance principles (and increase long-term costs), and in some cases, be a risk to participants' wellbeing.

It is more difficult to make an assessment about how far the workforce will develop beyond the transition given the uncertainties about how yet-to-be implemented policies will affect the supply and demand for workers (such as the implementation of the NDIS Quality and Safeguarding Framework, outcomes of future price reviews, and the implications of the NDIA's Market Intervention Framework).

FINDING 9.1

The disability care workforce will not be sufficient to deliver the supports expected to be allocated by the National Disability Insurance Agency by 2020.

9.3 What can be done to improve workforce readiness?

The challenges confronting the readiness of the workforce, if left unaddressed, could create short-term and long-term risks to the sustainability of the scheme and the wellbeing of participants. In the short term, a lack of qualified workers may mean that less qualified staff are used to deliver supports, or there will be unmet demand. This, in turn, erodes the benefits of the insurance approach over the longer term, meaning that the costs to support participants will be higher than necessary. However, some of these challenges can be addressed relatively quickly, or alternative arrangements employed to mitigate their effects.

Getting the right balance between strategy and action

The responsibility for funding sector and workforce development was allocated to the Australian Government as part of the 2012 Intergovernmental Agreement for the National Disability Insurance Scheme Launch (ANAO 2016, p. 16). The Department of Social Services (DSS) is responsible for many of the roles developing the disability care workforce to meet the needs of the NDIS, including: coordinating and facilitating responses to workforce shortages; coordinating with other Australian Government agencies to build workforce supply; and developing a coordinated response in particularly challenging areas — such as the demand for allied health professionals (Kruk 2016).

Australian Government initiatives to foster disability care workforce readiness are focused primarily on frameworks and principles developed in consultation with the NDIA (table 9.2). These are designed to provide guidance on how the workforce is to develop.

Such a strategic approach to developing a market — especially one so ground-breaking as the NDIS — was appropriate for the trial period. However, as the scheme begins to build up over the transition period, practical implementation of the strategic objectives is required, particularly to develop the workforce. Relying on strategic policies alone is leading to uncertainty among providers.

> Several strategies have been published (Assistive Technology, Rural and Remote, Market and Workforce). They provide directions but are light on implementation detail. For these strategies to inform the planning and investment decisions of service providers, they need to be underpinned by clear publicly-available plans. (NDS in ANAO 2016, p. 32)

Table 9.2 **Many strategies affect workforce development**

Entity	*Strategy*
NDIA (2013, 2017e)	2013–16 Strategic Plan and 2017–21 Corporate Plan
NDIA (2015c)	Assistive Technology Strategy
NDIA (2016i)	NDIA Market Approach — Statement of Opportunity and Intent
NDIA (2016t)	Rural and Remote Strategy
NDIA (2017b)	Aboriginal and Torres Strait Islander Strategy
NDIA (forthcoming)	Provider of Last Resort Strategy
NDIA (forthcoming)	Market Intervention Framework
DRC (DSS 2016d)	Quality and Safeguards Framework
DRC (2015a)	Integrated Market, Sector and Workforce Strategy
DRC (DSS 2017d)	National Disability Strategy 2010-2020
DSS (2015c)	Sector Development Fund Strategy and Operational Guidelines
DSS (2017b)	Integrated Plan for Carer Support Services

The Australian National Audit Office (ANAO), looking at the market transition under the NDIS, found that the Integrated Market, Sector and Workforce Strategy lacked the details necessary for the transition.

> While establishing a national approach to the market transition, the Strategy does not provide a clear basis for coordinated actions, as it does not commit jurisdictions to specific deliverables, with agreed timeframes, accountabilities and milestones. DSS advised the ANAO that 'detailed timeframes and accountabilities will likely be captured in a bilateral context going forward, recognising the unique characteristics in each jurisdiction in terms of the market and workforce.'
> …
>
> Further detail about how the Strategy is to be operationalised, including specific actions and timeframes, would assist stakeholders, particularly service providers who need to make investment decisions. In July 2016, DSS advised the ANAO that it intends to develop a Strategy 'action plan' for 2016-17 and into the future. Publishing this action plan, including key priorities and initiatives, timeframes and milestones, may help to address stakeholder concerns. (ANAO 2016, p. 32)

The Sector Development Fund (SDF), which is funded by the Australian Government with $146 million to support the NDIS market transition between 2012-13 and 2017-18, includes workforce development as one of its objectives. The DSS administers the SDF by allocating grants to organisations and governments to address areas of identified need. However, in its evaluation of the SDF, the ANAO (2016, p. 34) found that there was limited evidence of the Commonwealth adopting a strategic approach to grant-making, and that a more strategic approach is warranted, informed by evaluation of funded projects.

More recently, most Australian Governments have taken action in response to concerns about workforce shortages (table 9.3), but have done so with different approaches and priorities. There is a risk that fragmented workforce policies will lead to duplication or

unnecessary programs at a time when the scheme can least afford it. As a union that represents many disability carers said:

> Unclear delineation of market development and stewardship responsibilities between the National Disability Insurance Agency (NDIA), the Commonwealth Department of Social Services (DSS) and the States and Territories has resulted in no substantive progress on a workforce development strategy focusing on attraction, retention, skills or quality. (Health Services Union, sub. 132, p. 4)

More recently, the DSS has made efforts to lead workforce developments among NDIS stakeholders, though this is still a work in progress.

> Significant workforce growth is needed to meet demand at full Scheme. DSS has been working with state governments, the NDIA, and the sector to support disability workforce development. This includes working directly with jurisdictions to leverage their expertise in the delivery of disability services to identify and address workforce gaps and to develop workforce plans. (DSS 2017h, p. 12)

While the COAG Disability Reform Council and the DSS have taken steps to clarify responsibilities, further refinement — and speed — is necessary. The 'big tent' approach to workforce development remains appropriate, but the responsibilities of different parties should be made public — a point agreed by the DSS (sub. PP318, p. 16).

- State and Territory Governments should have more responsibility for workforce development issues over the transition period. They know the history of unmet need and the best approaches for solving workforce issues in particular jurisdictions.
- The Australian Government should retain oversight of the scheme, and focus on areas that affect the supply and demand of care workers from an economy-wide perspective, including the interaction of the NDIS with other care sectors, including aged care and monitoring trends in the supply of skilled workers through tertiary and vocational education.
  - The Australian Government should use immigration to address workforce shortages (discussed below).
- The NDIA is best placed to provide more information to governments in the form of actuarial and scheme data collected to provide more granular detail on where supply gaps are emerging, or likely to emerge.
- Providers should also be regularly consulted by governments about emerging workforce policy issues, such as where the incentives of the scheme may be affected by other laws and regulations, like minimum standards, conditions of State, Territory and Australian Government awards, and training and development.

Table 9.3 **Some of the initiatives to build the NDIS workforce undertaken by Australian governments**

Jurisdiction	*Initiatives*
New South Wales	The New South Wales Government spent $5 million to supplement its 'industry development fund', which provides a range of resources for firms to transition to the NDIS and includes materials regarding workforce development (Nucleus Group 2015, pp. 2–3). The New South Wales Government is 'also investing in vocational education and training to create a workforce pipeline of specialist capabilities to meet the needs of the NDIS' (sub. PP230, p. 7).
Victoria	The Victorian Government (sub. 174, p. 18) spent about $26 million (supplemented in part by the Sector Development Fund (SDF)) on its Keeping Our Sector Strong policy, which has the goal of 'developing and growing the disability workforce over the transition to full scheme'.
Queensland	The Queensland Government has committed $2.8 million to establish the WorkAbility program, which is a consortium of four Queensland industry peak bodies aimed at driving 'expansion and diversification of the Queensland workforce over the transition years, engaging, attracting and connecting people to jobs in the sector' (sub. PP345, p. 16).
Western Australia	The Western Australian Government is considering a workforce development plan for the state to ensure that 'the 9 000 to 10 000 additional jobs over the next decade can be filled with properly qualified workers' (WA CCI 2017).
South Australia	The South Australian Government has sought independent advice about likely workforce needs at a more detailed level, and has provided grants as part of its Provider Readiness Program (SA DCSI 2017). It has also provided $4 million to fund 'Disability Workforce Hubs' that aim to 'connect job seekers with local employers, training providers and employment agencies to help fill local job opportunities in the growing disability sector' (SA DCSI 2016; South Australian Government 2017).
Tasmania	The Tasmanian Government 'is investing more than $8 million over six years in skills development to increase the disability workforce in Tasmania' (sub. PP247, p. 9), and has also funded a workforce development plan for the state (Petrusma 2016).
Australian Capital Territory	The ACT Government has invested in market development, and made a number of direct grants to provider organisations, including some using SDF monies (ACT Government 2016, pp. 33–35) .
Australian Government	In addition to the SDF, the Australian Government committed an additional $33 million over three years in the 2017-18 Budget to 'assist service providers in rural, regional and outer suburban areas to provide the workforce required to meet the expected growth in the disability and aged care sectors arising from the introduction of the National Disability Insurance Scheme and an ageing population' (Australian Treasury 2017b, p. 145).The Department of Education and Training has previously provided about $3.5 million in funding to help providers be NDIS ready by helping them plan workforce needs and identify the skills they will require (Department of Education and Training 2017a, p. 13).

The workforce development responsibilities of State and Territory Governments should reduce as the NDIS fully rolls out and replaces their existing disability support programs. However, State and Territory Governments should remain 'in the tent' when it comes to workforce policymaking given the interaction between the NDIS and other mainstream services.

RECOMMENDATION 9.1

The roles and responsibilities of different parties to develop the National Disability Insurance Scheme (NDIS) workforce should be clarified and made public by the beginning of 2018.

- State and Territory Governments should rely on their previous experience in administering disability care and support services to play a greater role in identifying workforce gaps and remedies tailored to their jurisdiction.
- The Australian Government should retain oversight of workforce development, including how tertiary education and aged care policy interact and affect the development of the workforce.
- The National Disability Insurance Agency should provide State and Territory Governments with data and analyses held by the Agency to enable those jurisdictions to make effective workforce development policy.
- Providers of disability supports should have access to a clear and consistent mechanism to alert the National Disability Insurance Agency, the NDIS Quality and Safeguards Commission, and the Australian, State and Territory Governments about emerging and persistent workforce gaps.

An evidence-based approach to workforce policy is needed

A lack of data makes it difficult for policymakers and market stewards to properly exercise direction and support to the sector for it to develop sustainably. The existing data do not allow for measurements of specialisation, or differentiation of caring roles (such as between aged and disability care). Nor is it straightforward to examine labour supply and wage outcomes. This means that tasks that are simple for other industries — like identifying the response in labour supply to an increase in wages — are impossible to undertake with any degree of certainty. As the DSS said:

> A significant limitation to assessing the NDIS market readiness is the availability of market and workforce data. DRC has agreed Market Key Performance Indicators to monitor NDIS market performance and identify emerging market risks and, as the Scheme matures, will assist the NDIA with identifying risk requiring intervention. (sub. 146, p. 34)

These key performance indicators will be drawn from scheme data, which will provide a richer dataset on providers and participants. However, the nature of the data means that it will be less suited for measuring workforce growth and gaps over the transition period and over the longer term. The evidence base on the NDIS workforce needs to be commensurate

with the importance of the scheme itself, and shared broadly among stakeholders. As the Victorian Government said:

> Victoria considers that greater sharing of data and information between the NDIA, the Commonwealth and providers is needed to ensure that workforce development strategies are aligned. (2017b, p. 19)

More data need to be collected on the supply and demand of disability care workers. On the demand side, the NDIA's market position statements provide the necessary information on when and where workers will be needed, and should be updated regularly. On the supply side, the Australian Bureau of Statistics should be funded to collect policy-relevant data on the disability care workforce.

RECOMMENDATION 9.2

The National Disability Insurance Agency should publish more detailed market position statements on an annual basis. These should include information on the number of participants, committed supports (disaggregated at a level of detail consistent with the guides used to set price caps), existing providers and previous actual expenditure by local government area.

The Australian Government should provide funding to the Australian Bureau of Statistics to regularly collect and publish information on the qualifications, age, hours of work and incomes of those working in disability care roles, including allied health professionals.

There is some scope to expand the supply of carers in the short term

One short-term policy to bolster the workforce is to make better use of existing disability carers. About 20 per cent of current aged and disability care workers express a desire to work more hours, and half of these want to work fulltime (figure 9.6). This confirms what Martin and Healy (2010, p. 146) observed — that frontline disability care workers 'generally wanted a substantial increase of 10 or more hours' on their weekly workload.

However, workers' desire to work more hours cannot be realised if policy settings and workers' preferences do not align. As the South Australian Government said:

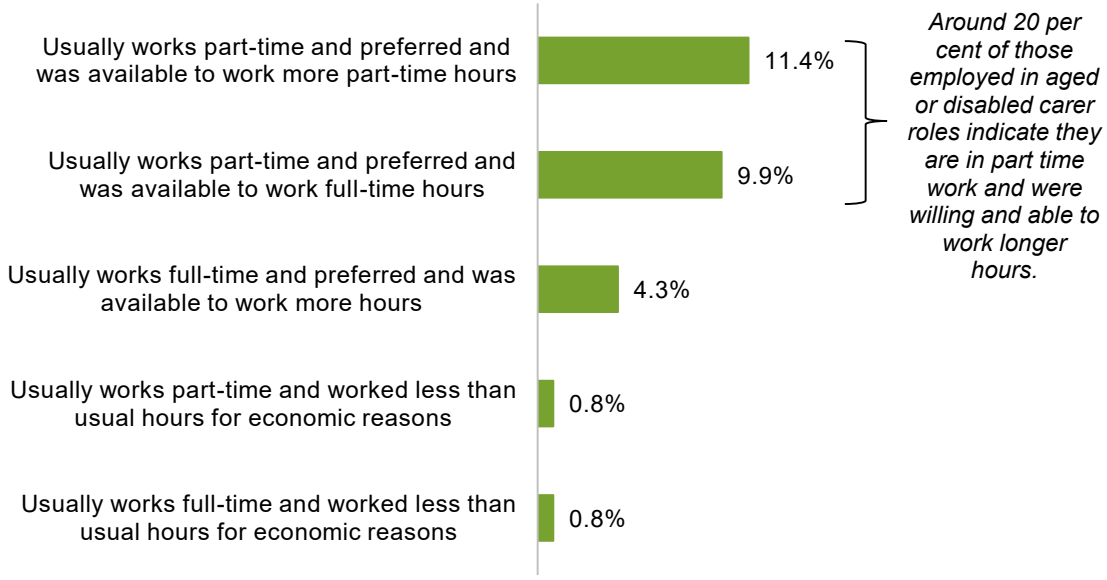
> Offering additional hours and more full time positions is an effective strategy to increase the size of the workforce, capitalising on the use of existing skilled workers and potentially offering greater security for some, particularly in the short term. However, this should also be balanced with being an employer of choice and offering flexible work arrangements to retain skilled workers in the sector. SA would therefore be interested in analysis being conducted on what level of inducement is provided by the flexibility of work arrangements that part time employment provides. (sub. 203, p. 14)

The Commission agrees, and considers that building the evidence base is key to identifying and addressing further impediments to making the most of the existing workforce. There

may also be impediments to working additional hours arising from the price caps set by the NDIA. This is an issue that the independent pricing monitor and pricing regulator should assess and respond to, if necessary (chapter 8).

Figure 9.6 **Aged and disability carers express a desire to work longer hours[a]**

Per cent of aged and disability carers, based on ANZSCO definitions, 2016



[a] Residual are those who are not underemployed (about 72 per cent of aged and disabled carers). 'Economic reasons' include being stood down or there not being enough work available.

Source: Commission estimates based on ABS (*TableBuilder,* Education and Work, May 2016).

Greater use of skilled migration should be used to address shortages

While reducing underemployment for general care workers may bolster supply of some workers, there is almost no underemployment in allied health professions.[80] The long lead time to train these workers also means that shortages could persist over the shorter term, and potentially beyond the end of the NDIS transition period.

An option to meet a shortfall in the short term is to make greater use of skilled migrants. This was proposed by the Commission in its 2011 *Disability Care and Support* inquiry (2011, pp. 720–721). The Commission considers that the existing policies and regulations for using skilled migrants are appropriate to meet the needs of the NDIS over the transition

[80] Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2016).

period, if required.[81] The flexibility of using staff employed on visas over a few years is also of value to the scheme, as participants may have changing preferences over a similar time period.

That said, using skilled migrants is not an immediate solution. Like any new worker, there is a period of on-the-job training required to become proficient in providing services, and in the case of allied health, it will still be necessary for sufficient mentoring to occur. These issues touch directly on setting the appropriate prices for supports over the transition period to enable a sufficient margin for such training to occur — an issue for the independent price regulator discussed in chapter 8.

Some participants to this study disagreed that greater reliance on skilled migration is an appropriate approach to workforce shortages. For example, Allied Health Professions Australia, while agreeing that skilled migration is one way to increase the number of qualified allied health professionals, said that the time spent to acclimatise skilled migrants to Australian conditions was as intensive as training someone locally.

> … skilled migrants are unlikely to be familiar with local health and social systems and services and may not have specialised skills as required to provide appropriate support to many participants. As a result these skilled migrants are likely to have skills and knowledge at a level that is closer to entry level allied health professionals and requiring mentoring and support. Experience suggests that significant time is required for overseas-trained graduates to learn to navigate the complex interaction of systems and understand the various parties involved in providing support. These factors mean that there will need to be significant investment to ensure that skill[ed] migrants can provide services of equivalent quality and AHPA [Allied Health Professions Australia] submits that it may be more effective to pursue alternatives such as incentivisation of Australian graduates and other workers. (sub. 37, p. 18)

However, the time to train someone to understand Australian conditions should be shorter than the time to achieve the formal qualifications to practice.

The precarious nature of skilled migration visas was also raised by study participants, with some stating that 457 visas should not be viewed as a substitute for training local workers.

As the Australian Services Union and the Disabled People's Organisations Australia said:

> Any migrant worker scheme for the NDIS should provide permanent migration and only be considered after there has been local labour market testing. The NDIS provides a significant opportunity to address high levels of unemployment for many people, including people with

[81] Commission estimates based on ABS Census data from 2011 indicate that about 10 per cent of those working in a group of allied health professional occupations (based on the ANZSCO classes relating to dieticians, optometrists and orthoptists, health therapy professionals (not further defined), occupational therapists, physiotherapists, podiatrists, speech professionals and audiologists) were born overseas and arrived in Australia after 2000, suggesting that avenues for skilled migration are possible. Analysis by the ABS found that the second most commonly reported industries of Skilled Program migrants' employment was in the Health Care and Social Assistance industry division, which includes carers and some allied health professionals (ABS 2010). It is too early to tell if recently announced changes to skilled migration visas (Dutton and Turnbull 2017) will impact on this flexibility.

> disability. While we do not support a precarious, exploitative 457-style visa scheme for NDIS workers, we do support the development of a comprehensive workforce plan to retain and attract new workers locally. (sub. 198, p. 2)

Skilled migration is a policy response that should focus on meeting the shortfall in specific roles (rather than as a general measure to address all shortages), and more clearly delineating workforce development responsibilities among governments will provide a better platform to train and develop local workers. However, given the risk of shortages in the transition period, greater use of skilled migration is likely to have more benefits than costs in this period. As previously put by the Commission:

> Overall, the role of immigration as a source of labour must balance the impacts on wages and other strategies for eliciting domestic supply of workers, and the reality that significant labour shortages are still likely, especially during the rapid growth in disability supports during the establishment phase of the NDIS. In that vein, immigration should mainly address acute and persistent shortages. (2011, p. 720)

And by the DSS:

> Migration programs, such as labour agreements, have been used in the aged care sector to meet workforce demand. A similar program could be considered for the disability sector if actions to grow the domestic workforce do not meet demand. (sub. PP318, pp. 17–18)

What remains to be seen is whether the shortfalls persist over the longer term, which is when further review and consideration should be given to changes to workforce development and immigration policies. This could be facilitated as part of the expected future reviews of the NDIS, including the regular reviews by the Joint Standing Committee on the NDIS.

RECOMMENDATION 9.3

The Australian Government should adjust immigration policies where necessary to address National Disability Insurance Scheme workforce shortages.

New technology may reduce demand for workers

Greater use of technology could reduce the need for some disability care workers, and mitigate a potential workforce shortfall. Understanding the extent that technology could be 'labour-saving' is difficult: the market for disability supports is undergoing major change, and what NDIS participants will demand is still unclear. That said, there is a range of emerging technologies that could reduce the need for workers. Some examples highlighted by the NDIA (sub. 161, pp. 98–99) as promising include:

- 'smart' alert and monitoring systems that reduce reliance on person-to-person supports in specialist disability accommodation and for participants with at-risk behaviours
- innovative transport services, such as accessible car-sharing

- telepresence technologies that allow informal carers to maintain and develop their care, and to seek readier access to assistance when needed. Telepresence can also allow for some therapy services to be provided over a distance, which can alleviate the need for providers in rural and remote areas. Such an approach was also endorsed by Allied Health Professions Australia (sub. 37, p. 17), The Shepherd Centre (sub. 107, pp. 14–15) and Speech Pathology Australia (sub. 136, pp. 47–48).

Given the scheme is in the early period of transition, it is difficult to tell what technologies will emerge, what effects they will have on the need for workers, and what the implications for scheme costs may be. The impact of technological advances are not taken into account in the NDIA's long-run costs modelling. Given the uncertainties involved, this is appropriate, and removes any risk of overstating cost savings.

Using volunteers

The number of volunteers, and the amount of volunteering they undertake, affects the workforce needed for the NDIS. Inclusion Melbourne (sub. PP207) and Volunteering Australia (sub. PP274) highlighted the cost savings and beneficial impact on workforce pressures, as well as other benefits of volunteers. These benefits stem from the strength and inclusion of genuine relationships that form between people with disability and volunteers that want to spend time with them (as opposed to being there as part of a paid relationship). As the NDIA said:

> Using services designed to match volunteers with participants can help to build informal networks and facilitate greater independence and social inclusion. Over time, this can reduce the reliance on or preference for paid supports among some participants. These programs involve rigorous on-boarding and carefully match participants and volunteers to increase the likelihood of a relationship forming. There are a number of existing services that connect volunteers with participants, such as Volunteering and Contact ACT, and Inclusion Melbourne. (sub. PP327, p. 47)

While volunteers supply their time for free, the use of volunteer-staffed supports is not costless. There are 'fixed' or up-front costs (including legally required checks and screening) and ongoing costs incurred by volunteers in meeting their volunteer role. Organisations that match volunteers with people with disability also have ongoing costs such as insurance, overheads and the administrative costs of managing volunteers.

The sources of funding for volunteer organisations are changing under the NDIS. Volunteer organisations use private fundraising and philanthropy, as well as government grants to meet the costs of providing volunteers. But as governments shift disability funding into the NDIS (chapter 12), direct grants to volunteer organisations are diminishing. Other sources of funding are available for volunteer organisations to use, such as Information, Linkage and Capacity Building (ILC) grants, but these grants target activities more broadly compared with the previous grants (chapter 6). There is also a capacity–building support that

participants could have included in their plans to initiate a connection with volunteer organisations (NDIA 2017q, p. 57).

The cost of providing volunteer supports under the NDIS have changed too, with the person-centred approach meaning that volunteer organisations need to better match volunteers with the characteristics, goals and other supports of participants. Greater coordination between volunteer and participant is necessary to ensure that the supports provided by volunteers align with others from the NDIS and mainstream services.

Within this context, some volunteer organisations are struggling to adapt to the scheme. This is putting the benefits they provide at risk. As Inclusion Melbourne said:

> It is unclear how and if volunteer based services […] are to be funded under the NDIS. The lack of inclusion of volunteering in the foundational philosophy of the NDIS and the exclusion of line items for volunteer management in the NDIS Price Guide are very concerning and represent a real danger for loss of social capital. … There is a danger of losing thousands of volunteers and hundreds of thousands of hours of support to people with disabilities unless this situation is resolved. (sub. PP207, p. 8)

A recent analysis by Extended Families Australia, Interchange Incorporated, People Outdoors and Inclusion Melbourne found that many volunteer organisations want to provide services to NDIS participants, but are not preparing to do so. Some consider this a risk to participants, their families and the broader community.

> This statistic is very concerning and represents a real danger for loss of social capital. It undoubtedly reflects the lack of information and government policy regarding how volunteering programs will fit and be funded under the NDIS. With no clear pathways for transition, this leaves organisations floundering and without clear messages to give people with a disability and their families currently supported by volunteers. There is a widespread concern from organisations about the impact of failure or delayed transition of programs into the NDIS where volunteers directly support people with a disability into the NDIS. (Inclusion Melbourne 2016, p. 14)

How should funding of volunteer organisations be considered?

Funding for volunteer organisations needs to strike a balance between several objectives. For volunteering to provide the greatest benefit, government funding of volunteer organisations should not crowd out the fundraising or support that people would provide anyway. Nor should funding be structured in a way that means volunteers are, or are perceived to be, 'paid supports' rather than people who want to offer their time to make a genuine connection and difference to people with disability. At the same time, funding and support to volunteer groups should reflect the broader social benefits they enable, and the cost and labour savings that they may allow.

The Commission's 2011 *Disability Care and Support* inquiry suggested that as formal supports were rolled out to participants in the NDIS, volunteers would focus on providing supports outside the scheme, and to all people with disability — largely funded through ILC (PC 2011, pp. 218–224). However, as the ILC program becomes more clearly defined, it

does not seem to be a good fit for all volunteer activity. As a result, the Commission considers it may be worth the NDIA trialling some new funding arrangements for volunteer organisations, particularly in this period where the workforce is not developing quickly enough.

RECOMMENDATION 9.4

Some volunteer organisations are finding it difficult to provide supports to eligible scheme participants. There is merit in the National Disability Insurance Agency:

- considering whether volunteer organisations should be funded to cover both the initial costs of connecting participants with volunteers and ongoing costs of volunteer management. The Agency should consider whether this is best done through line items for scheme participants or through a more direct funding arrangement with volunteer organisations
- trialling different funding arrangements to cover ongoing costs of volunteer management and collecting data on the outcomes of participants that use such services to better evaluate the costs and benefits of volunteer organisations providing scheme supports over the longer term.

9.4 How does informal care affect the workforce?

Unpaid informal care by family members, friends and community groups remains a critical part of the NDIS. Under the current payment system, the funding a participant receives takes into account the level of reasonable and sustainable informal support received, but as noted by the NDIA, 'the maintenance of ordinary family relationships, and the increased independence this entails for the participant, is central to the purpose of the Scheme' (NDIA, sub. PP327, p. 49).

To the extent that participants have natural and informal supports in their lives, this reduces the amount of formal care considered necessary. However, a lack of informal care could increase the need for formal carers, and require an even faster build-up of the disability care workforce.

Workforce shortages will mean that some people with disability will have to continue for some time yet to rely on their informal carers. But there are two constraints on informal carers providing additional hours of care. One is the declining ability to care (especially in the case of ageing informal carers) and other commitments (such as paid employment, or the need to engage in paid work). The other is a lack of respite services.

The ageing of informal carers means that many carers will be unable to provide additional care in the future. The most striking example are ageing parents of adult children with disabilities. Many ageing parents contributed to this study (box 9.5) and it is clear that their capacity to offer additional care is extremely limited, and should not be relied upon.

Box 9.5 **Many parents are currently the 'provider of last resort'**

Rosa Miot:

> The NDIS is crucial to my future. I have a 40 year old daughter with an intellectual disability. I have been her full time carer all of her life. … However, I am now 70 years old and I will need the NDIS to provide her with the ongoing supports she will need to be able to remain living in the community as she has done all her life. I would like to be able to concentrate on my own life and health needs and not be overburdened with the caring role. (brief sub. 134)

Evelyn Ware:

> My husband and I are 89 and 82 years old respectively and have a daughter aged 55 with autism and intellectual disability. Although living in the community she requires a considerable amount of support with budgeting, health matters, cooking and general management of her life. … once we are unable to provide the assistance we are now providing she will need to have more support from NDIS, or go into supported accommodation as her disability prevents her from living independently in the community. (brief sub. 137)

Pat van der Beek:

> Our intellectually disabled son is 41 years old this year and my husband and I are 73 and 72 respectively. When the NDIS rolls out in our area in July, we are hopeful that we will have additional resources to enhance his life. His siblings are busy with their own families, careers and lives in general and there is no certainty that they will be able (or willing) to provide the necessary support for their brother when we no longer can. … While we are currently both in reasonable health, there is obviously no guarantee this will continue; inevitably, our son will be without our support in the later years of his life. … We have genuinely done our utmost to give him the best possible life to this point and welcome the introduction of the NDIS which we hope will enhance his future while also lifting some of the responsibility from our shoulders. (brief sub. 70)

However, for others, the constraint is less to do with ability and more to do with the forgone wages that caring entails. Alleviating these constraints may allow informal carers to support family members with disability for longer and more intensively. One way to do this is to pay informal carers.

Is paying informal carers appropriate to reduce calls on the workforce?

Paying informal carers to provide attendant care judged to be reasonable and necessary under the NDIS has potential benefits, definite costs, and considerable risks. In the position paper, the Commission included a draft recommendation suggesting that the guidelines on paying informal carers should be relaxed for the period of transition, as a way to reduce workforce shortages.

The benefits of paying informal carers are that such payments can enable informal carers to provide a greater quantum of care, which reduces the calls on the formal carer workforce. Depending on a participant's circumstances — such as those in thin markets — payments to informal carers may be the only way that some will receive funded attendant care under the NDIS. If this care is not judged as reasonable and necessary, there could be greater calls on

other mainstream services, or on the scheme itself, over the longer term.[82] But while this could be beneficial to participants and reduce long-term costs, it is difficult to know what the scale or scope of these benefits might be.

Much clearer are the additional costs to the NDIS of paying informal carers, which would depend on the eligibility for such payments and the rate of payment. Currently, the NDIA's (ndd) operational guidelines 'will not fund a family member to provide personal care or community access supports unless all other options to identify a suitable provider of supports have been exhausted'. (In practice, this has sometimes been interpreted to mean that family members who are paid to provide supports do not reside at the same location as the participant (NDIA 2014b, p. 5), or that this is a rule disallowing the employment of a participant's relative to provide supports (QAI, sub. 115, p. 15)). While the NDIA does not currently collect data on how often these exceptional circumstances occur, the Commission understands that NDIS payments to family carers are very rare. Accordingly, increasing the scope of paying informal carers means that there will be greater costs to the scheme.

There are also risks to paying informal carers, which have their own potential costs and benefits that need to be considered. Participants in this study highlighted several of these risks, which fall into three broad groups: the risks to participants, risks to informal carers, and risks to the sustainability of the scheme (table 9.4).

It is difficult to quantify the likelihood and costs associated with these risks, but each points to higher potential costs or poorer potential outcomes for scheme participants. Participants have experienced safer outcomes, less unmet need and greater satisfaction under some schemes that provide paid family care (PC 2011, appendix G). But in other schemes, experience suggests that the risks and costs of paying family carers can be substantial.

One example is the experience of the NSW Lifetime Care and Support scheme (now part of icare) in paying family carers. The scheme only allows payment to family members in exceptional circumstances, including instances of geographical isolation and culturally-sensitive situations. Where such payments have been made, the dependence on the income has sometimes disrupted family relationships, including the payments for care becoming a key source of income for the extended family. It has also led to some difficulties where the needs and aspirations of the participant and their family carers change, such as when family carers become too old and frail to provide the proper attendant care they are paid to supply (icare, pers. comm., 19 September 2017).

[82] The benefits from paying informal carers are reflected in the policy decisions of many OECD countries Most OECD countries have some paid benefits program designed to support the providers of informal care. Typically, these fall into two sorts of programs: a paid allowance to the informal care giver and a payment to a person with disability that can be used to pay family carers. Austria, Belgium, the Czech Republic, France, Italy, Luxembourg, the Netherlands, New Zealand, Norway, Poland, the Slovak Republic, Spain, Sweden, the United Kingdom, and the United States all have some variant of the latter that allows for payments to pay for family members to provide disability care, though the rate and eligibility criteria vary considerably (OECD 2011, p. 139). However international comparisons are difficult to make, especially as different jurisdictions often use a range of eligibility and means test criteria in relation to such payments.

Table 9.4 **The risks from paying informal carers could be considerable**

Risk faced by	*Potential outcome*
Scheme participants	• Informal carers may provide a lower quality of care than professional carers. This could undermine participant wellbeing, and in some cases, recovery. • Participants may suffer harm or exploitation without appropriate institutional safeguards. • Payments can undermine family relationships by introducing a payment for care that was previously being provided out of love. When such payment arrangements are put in place, they can be very difficult to unwind, especially where a degree of dependence on the funding occurs.
Paid family carers	• Payments to family carers would not be costless to the economy more broadly, as they may reduce the incentives of carers to find other paid employment. • While payments may be provided to carers, these could be offset by an increased administrative burden and other costs. For example, paid family carers may need to register as a provider. • The value of the payments may be offset through the withdrawal of other (means-tested) government programs.
The scheme overall	• Additional administrative costs to the scheme. This includes the difficulty of determining that paid time to informal carers is used for the reasonable and necessary supports provided under the scheme, rather than for hours of informal care that were expected to be provided anyway. • Payments to family members to provide care may inhibit a market-driven solution that would otherwise respond to the shortfall. • Such payments could affect the interpretation of what amount of informal care may be expected of participants without payment. If payments to family members were to become the norm, then this could affect the amount of paid supports expected as part of reasonable and necessary criteria of the NDIS. This could substantially increase scheme costs.

Sources: Based on Carers Australia (sub. PP224, pp. 11–13); icare (pers. comm., 19 September 2017); NDIA (sub. PP327, pp. 49–50); Prader-Willi Syndrome Association of Australia (sub. PP228, p. 6).

Another example is the difficulties faced by the New Zealand Ministry of Health in keeping payments to family members financially sustainable. Legal challenges that broadened the extent of family carer payments increased their cost substantially in 2012, requiring a legislative change to constrain the cost (NZ HRC nd). These experiences show that paying informal carers can, in some cases, lead to undesirable outcomes from a financial, legal and scheme sustainability perspective.

The key policy question is whether taking such risks by paying informal carers is worthwhile to address the potential shortage of formal carers being faced by the NDIS. For such an approach to be effective, participants would have to *want* to use paid informal care, and informal carers would have to be prepared to supply paid care.

Study participants' views were mixed on the effectiveness and desirability of paying family members to provide care (box 9.6), with the strongest support coming from participants who see thin markets as presenting the greatest risk of a lack of supply of paid, formal carers.

Box 9.6 Some of the views on paying family members to provide care

National Disability Insurance Agency:

> The NDIA considers that the unintended side effects of such a change will cause social and financial problems that outweigh the workforce supply benefits. … Paid informal care by family members has the potential to negatively affect the social bonds between participants and families … Paid Informal care is likely to compromise the sustainability of the NDIS. (sub. PP327, pp. 49–50)

Physical Disability Australia:

> If participants are able to utilise some of their support packages to supplement the income of parents, partners, siblings and other extended family members then they will be less of a burden to them, they will be actively contributing to the economic well-being of the family and they will have the benefit of privacy at those times when they don't want workers in their homes but still need support with particular tasks. (sub. PP306, p. 4)

Australian Federation of Disability Organisations:

> Half the membership supported the relaxation of the operational guidelines to allow for the payment of informal carers citing it as an expression of the principle of choice and control. Member organisations from this group stated that in rural and regional areas informal carers may already be providing disability support in the absence of available disability support providers. This option would acknowledge that relationship, resource it and may allow for the person with a disability to continue to live at home with family rather than having to move away from all that they know and trust in order to receive disability support. (sub. PP325, p. 19)

Carers Australia:

> Many family and friend carers would regard being paid to care for a loved one as anathema and possibly an extra source of relationship strain within the family. Among those who are anxious about the consequences of family carer employment, the possibility that carers will become even more entrenched in their caring role is often raised. Further, paying informal carers can create extra burdens, particularly if it assumes that it will be in addition to the care already provided, or carers feel that receiving payment means they should be doing more than they are already.
>
> However, we know from consultations around the NDIS, that other carers and those they care for regard the option to choose to pay family or friend carers, in preference to a worker who they believe would not provide the same standard and quality of highly personal holistic care, is a key element of choice and control. Having noted the lack of consensus around the merits of paying family and friend carers, we are of the view that [payments to informal carers] bear consideration, especially in cases where replacement care is not readily available and where, as a consequence, carers are not benefiting from NDIS supports in the way intended. (sub. PP224, p. 10)

Northern Territory Government:

> The Position Paper's Draft recommendation … suggesting the relaxation of paying informal carers living in the same residence as the participant is supported, particularly for Aboriginal and remote communities. However, the NDIA will need to ensure access to such payments is simple and clearly understood by Aboriginal Australians, and that appropriate protections are in place for participants. (sub. PP359, p. 5)

The lack of data collected on where participants have been allowed to use paid family carers under the scheme, and the lack of clarity on when such circumstances occur, means that it is difficult to assess the level of workforce savings they could enable from past practice. Nor is it clear how such arrangements would interact with other NDIA policies, such as the Market Intervention Framework and Provider of Last Resort Policy (chapter 7).

Given the uncertainties about costs and risks, it would be premature to recommend any changes to paying family carers before a better evidence base is collected. At any rate, given the risks highlighted by the NDIA on payments to informal carers, it seems necessary for the good governance of the scheme that the Agency collect better data on its current arrangements in this area.

RECOMMENDATION 9.5

The National Disability Insurance Agency should collect data on the number of participants who make use of paid informal carers to deliver scheme supports, including the costs associated with such payments and their length of use.

Respite

Respite[83] services can help informal carers care for longer. A lack of respite may mean that informal carers are unable to support family members and friends who are NDIS participants. This will require more formal and costly supports in their place. It was for this reason that the Commission in its 2011 *Disability Care and Support* inquiry recommended that the needs of carers be considered as part of a participant's individualised supports (PC 2011, p. 340).

A number of respite options (such as the *Mental Health Respite Carer Support Program*) have been wound up, with the funding provided to the NDIS (Mental Health Australia, sub. PP321, p. 13). Replacement support for carers outside the scheme, including information and linkage about respite, is to be provided under the DSS' *Integrated Plan for Carer Support Services*, but this service is still to be fully implemented. A gap is emerging for respite services both within and outside the NDIS as the scheme transition occurs.

In this context, a number of study participants argued that respite services are not well catered for under the NDIS. Concerns raised included that there is a lack of respite supports in plans, or insufficient quantities of respite options for family members (Carers Australia Victoria, sub. 131, pp. 37–38; Carers ACT 2015, pp. 1–3).

It can also be difficult for some participants and their families to identify available respite options under the NDIS support list, as it is not clearly labelled as 'respite' (Anglicare Australia, sub. PP339, p. 11).

[83] Some participants in this study said the term 'respite' is pejorative and prefer the term 'family care'. The Commission is sensitive to this issue, but has used the term 'respite' for clarity — both because it is included in the NDIA's Price Guide (NDIA 2017q, p. 28) and most study participants, including people with disability, used the term in their submissions.

As the Intermediate Review into the NDIS said:

> … both the quantitative and qualitative data indicate that many family members and/or carers of NDIS participants are unable to take adequate breaks from providing support and they cannot access carer support in a consistent manner. (Mavromaras, Moskos and Mahuteau 2016, p. xiv)

Respite can be accessed under the NDIS in two ways:

- A line item in participants' plans that provides for short-term accommodation (often there is a cap on the number of days provided each year).
- A core support can be used to fund additional in-home care or support in shared facilities (NDIA, sub. PP327, p. 51).

While placing the options for respite in plans maximises choice and control for the participant, it can lead to inappropriate levels of support for informal carers (Inclusion Australia, sub. PP357, p. 23; National Mental Health Commission, sub. 153, p. 4) — especially as some block-funded supports for carers are withdrawn. As Anglicare Sydney said:

> … carer needs and supports are not formally recognised as part of NDIS packages. There is no formal assessment of the needs of the carer, no funding package for the carer and no guarantee of involvement in the assessment of the care recipient's needs. … With the closure of carer-specific support services, Anglicare is concerned that carers will no longer receive the same amount of support, let alone improved levels of support, under the new system. (Kemp et al. 2016, p. 10)

Such an approach is at odds with practices in other jurisdictions.

> Although carers' goals and aspirations are recognised in the guidelines for carer support under the NDIS, there is no formal assessment process for their needs. In the UK, carers' needs are assessed independently of the needs of service users. In the US, needs of all members of the family are assessed at once. (Hamilton et al. 2016, p. 1)

The NDIA noted that alternatives to respite, including 'community-based activities such as camps and innovative daytime opportunities that connect a person to their community' were becoming apparent under the scheme. Also, the choice not to call respite 'respite' was a deliberate choice made by the Agency in the interests of participants and families.

> On the advice of the NDIS Independent Advisory Council (IAC), 'respite' is not a distinct service listed on participant plans. The IAC notes that the 'respite' paradigm sets up an unhelpful dynamic portraying people with disability as 'burdens of care'. Parents and other carers do not need 'respite', but may need 'rest, recovery, re-energising and inspiration'. The IAC favours reframing the question to 'What would it take to enable the family and the person with disability to get a life?' Participant plans under the NDIS list specific services instead (such as short-stay supported accommodation). (sub. PP327, p. 51)

The Commission considers that the use of alternative arrangements that better connect people with disability to the community and provide respite to informal carers is an excellent example of the benefits of the scheme. However, it should also be noted that day programs

and occasional camps may not be sufficient respite in some circumstances, especially where the supply of such alternatives does not keep pace with demand. Also, not labelling short-term accommodation as respite is inadvertently causing confusion and leading to poorer outcomes for some informal carers.

This is concerning from both a wellbeing and a financial sustainability point of view, as the benefits of respite usually exceed the cost of providing them. For example, research and analysis conducted by the Victorian Ombudsman and Victorian Equal Opportunity and Human Rights Commission found that it costs far less to provide 'intensive' respite for children with disability compared with placement in out of home residential care (VEOHRC 2012, p. 54). Respite services provided to young carers have contributed to improved emotional and physical wellbeing, as well as better opportunities to complete schooling (ARTD Consultants 2008, p. vi). Internationally, respite services are recognised as both improving the wellbeing of carers, improving the quality of care to people with disability, and reducing costs to governments (OECD 2011, pp. 127–129).

Informal care, and the ability to call upon informal carers, is a vital part of the supports provided by the NDIS. Without respite services, the sustainability and success of the scheme are imperilled. It is the Commission's view that it is appropriate for respite supports to be allocated to participants on the basis of the amount of informal supports expected of informal carers, that respite should be more clearly labelled, and that the options available to participants to use their core supports for respite are clearly set out.

RECOMMENDATION 9.6

The National Disability Insurance Agency should:

- ensure planners take into account the amount of respite care that is reasonable and necessary under an individualised support package, based on the amount of informal care that is expected to be provided by informal carers
- label short-term accommodation supports provided in participants' plans in a way that makes it clear that these supports can be used for respite
- better inform participants and their informal carers that core supports provided in individualised support packages can be used to fund additional in-home care or support in shared facilities to provide respite
- include specific measures to ensure a supply of respite services in its provider of last resort policies.

Another issue raised repeatedly to this study was that price caps offered for short-term accommodation under the NDIS (which is used for respite), are too low to be sustainable, especially for participants with complex needs or challenging behaviours (Cerebral Palsy Alliance, sub. 163, att. 1, p. 4; HSU, sub. PP316, p. 8; Nardy House, sub. PP216).

In turn, the NDIA (sub. PP327, p. 50) noted that '[i]t is too early in the Transition to provide a view on whether the NDIS has affected supply and demand for respite services', and that:

> … as part of the independent pricing review, the NDIA has asked for advice on improving pricing effectiveness for the pricing of short-stay support, and for emergency and crisis supports. This will inform the NDIA's position on whether respite services can be more effectively provided. (sub. PP327, p. 51)

The Commission's recommendations on price monitoring and regulation are aimed at addressing concerns about the adequacy of pricing (chapter 8). Concerns that existing providers may be struggling to transition across to the NDIS, and that a lack of respite services may result, mean it is prudent for the NDIA to explicitly consider respite supports in its provider of last resort policies (chapter 7).

10 Participant readiness and market stewardship

Key points

- The National Disability Insurance Scheme (NDIS) relies heavily on well-informed participants making decisions in their best interests. Participant readiness depends on a number of factors, including: an individual's capacity; their network, carers and peers; assistance provided by the NDIS; assistance available in the community; how ready the market is to provide supports; and the complexity of the scheme.
- Some participants (and their families) are finding it difficult to understand and interact with the NDIS. This is in part because the scheme is a new way to allocate and supply disability supports. Some transitional issues are also contributing to these difficulties.
  - If participants are unable to interact well with the NDIS, the benefits of the scheme will not be fully realised. This has consequences for participants and their families, the financial sustainability of the scheme, and the broader community.
- Some participants receive NDIS supports to help them implement their plans, including support coordination, which makes up about 4 per cent of committed supports. The National Disability Insurance Agency (NDIA) needs to clarify the role of support coordination and allocate it based on need (rather than for a fixed time period).
- The NDIA is currently responding to participants' concerns about the online portal (which is used to manage plans) and developing the eMarketPlace. Providing timely and useful information to help participants find providers should be a matter of priority.
- Intermediary services, which can help participants manage their plans, can also reduce transaction costs and the complexity of the scheme for participants. More should be done to encourage the use of intermediaries, particularly to unlock the benefits of self-management. In a mature scheme, intermediaries could also help streamline administration and compliance costs, as well as protect participants by helping them to understand their consumer rights and protections under the scheme. However, the safeguards that apply to intermediaries to protect providers and participants need to be monitored closely so they can be adjusted to changing need as the scheme evolves.
- Disability advocacy is critical to helping participants engage with the NDIS, and for all people with disability. These services need to be appropriately funded by governments, with data collected to evaluate future funding arrangements at full scheme.
- Market stewardship would be improved by increased clarity of roles and responsibilities, data collection and greater collaboration between governments.

The new model of disability support envisioned by the National Disability Insurance Scheme (NDIS) relies heavily on well-informed participants making decisions in their own best interests. As a result, participant readiness is central to the success of the scheme. The

outcomes of the scheme are directly linked to how ready participants are to enter the NDIS; to get the plans that they need; to find their supports; and to self-manage their own affairs (if they want to).

Participant readiness also affects scheme costs. If people with disability are unable to navigate the scheme, this will lead to lower participation in the scheme, underutilisation of supports, and mean that the intended benefits of the scheme are not fully realised. While this will reduce scheme costs in the short term, it may lead to higher costs (both inside and outside of the NDIS) in the long term.

This chapter looks at participant readiness and the supports available to assist participants use the scheme (section 10.1). It then discusses options for improving participant readiness (section 10.2). (Participant engagement in the planning process is discussed in chapter 5.) The chapter concludes (section 10.3) with a wider perspective on market readiness issues, focussing on what governments need to consider to help participants, providers and workers deliver NDIS supports efficiently and effectively.

10.1 What is participant readiness?

Participant readiness should be considered in the context of the changes that the NDIS is driving for people with disability. Participants are moving from a scheme where they had little choice and control over their supports to a new system, where they have more opportunities to exercise choice and control. This change brings with it new challenges, including:

- thinking about the best way to achieve their goals
- shopping around for providers
- managing administrative and financial tasks.

And participants are tackling these new challenges while the scheme is still rolling out and as the disability support market is changing. As one study participant said:

> Telling people they have choice and control, does not give them the skills to find appropriate service providers, which are much harder to find when they are full and simply tell people to go somewhere else if they are not happy with something. There is no information anywhere on how people can choose providers, what to look for in them, the sorts of questions to ask and what sorts of things you might want to consider. Equally when providers are all full, then what options are there. (Belinda Jane, sub. 80, p. 10)

There will be some degree of 'learning-by-doing' as participants spend more time in the NDIS and become more familiar with the scheme. But the experience to date is that participants need help to become well-informed consumers who are able to make decisions that result in cost-effective outcomes.

This was recognised by the COAG Disability Reform Council.

> … many people with disability will not have had the opportunity to exercise choice. Some people with disability may require additional support to effectively exercise informed choice, especially those with high and complex needs. (2015a, pp. 14–15)

Similarly, the Victorian Ombudsman noted that:

> The NDIS is a market driven model, rooted in the belief that people with disability are best placed to decide how their money should be spent on services to support them. For many people with disability, this is a long awaited improvement, however for people with severe cognitive impairment and/or limited communication, it can present new barriers. For the most vulnerable, capacity will never improve; it is not a developmental challenge that will be rectified as people 'become more confident and skilled consumers in the market'. This fact must be acknowledged and provided for within the NDIS. (2015, p. 90)

There are two main aspects to participant readiness to exercise choice and control:

- the capacity of participants (and their families) to navigate the NDIS — including their ability, willingness, disability type, experience, skills and resources
- the complexity of the NDIS — including interactions with the National Disability Insurance Agency (NDIA), Local Area Coordinators (LACs) and providers to access and purchase supports. Participants also need to navigate the interfaces with mainstream services like health, education and transport (chapter 6). The more complex the scheme, the more skills participants will need to engage with it.

The two levers available to improve participant readiness are therefore: developing the skills (and capacity) of participants, and reducing the complexity of the scheme. While both levers have costs and benefits, they are not mutually exclusive, but interdependent and complementary.

What help is there for participants?

Scheme participants have access to resources to help them navigate the scheme, and to exercise choice and control over their supports. They range from general assistance available to all participants to more specialised services to address particular needs.

Participants also have options around how they manage their plans (box 10.1).

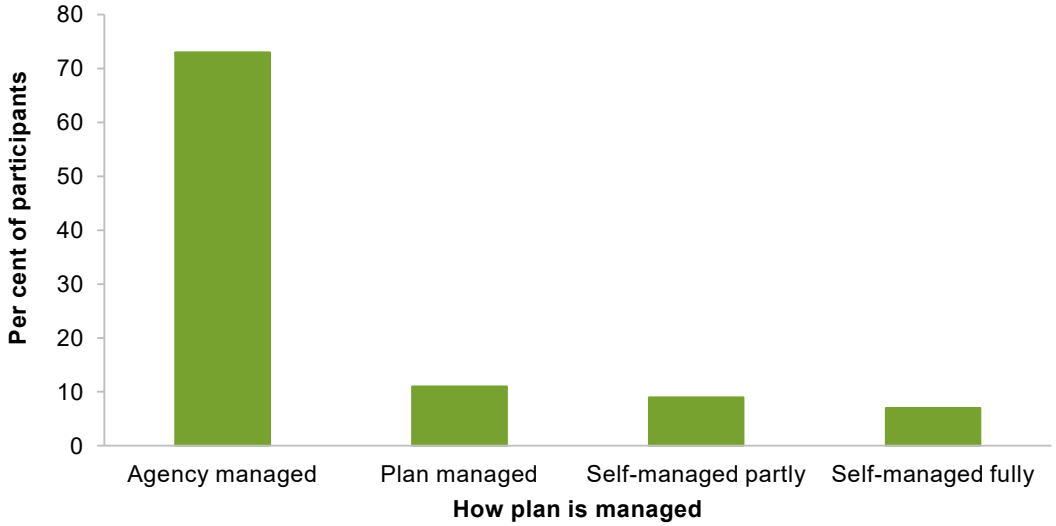
- Participants can use a NDIA-managed ('Agency-managed') plan. Under this option, participants are required to find supports from providers that are registered with the Agency. The NDIA then directly reimburses providers after they deliver supports to the participant.
- Participants can self-manage part or all of their supports. Under this option, the participant finds supports from, and manages payment to, providers. Participants can pay providers and then seek reimbursement from the NDIA, or pay providers once the participant receives funds from the NDIA (NDIA 2017x).

- Participants can use a 'plan manager'. The plan manager can either manage the payments, or provide assistance in terms of finding, hiring and firing providers on behalf of the participant. Plan managers are often referred to as financial and service intermediaries (these are the line items in approved NDIS plans to fund such supports) (NDIA 2016j, p. 48, 2016k, p. 48).
  - Financial intermediaries hold funds and manage risk on behalf of participants.
  - Service intermediaries provide broader technical assistance, including: assisting participants develop skills with plan management; negotiating and coordinating supports; sourcing providers; negotiating the method and timing of the delivery of supports; negotiating individual requirements as part of support management; recruitment, training, support and employment of staff (NDIS IAC nd). (However, the distinction between financial and service intermediaries is somewhat blurred in practice, as the service intermediary role can only be undertaken in conjunction with the financial intermediary role (NDIS IAC nd).)
- Participants can also use a combination of the above three options to meet their needs (NDIA 2017x).

Most participants to date have chosen an Agency-managed plan, rather than using a plan manager or managing their plans themselves (figure 10.1).

Figure 10.1 **How NDIS participants are managing their plans**

For participants who entered the scheme between 1 July 2016 and 30 June 2017



Source: NDIA (2017y, p. 21).

Box 10.1 Managing the funding for supports under a participant's plan

The *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act) allows a participant to choose how to manage their funding for supports. Management of funds is defined as:

- purchasing the supports identified in the plan (including paying any applicable indirect costs, such as taxes, associated with the supports)
- receiving and managing any funding provided by the National Disability Insurance Agency (NDIA)
- acquitting any funding provided by the NDIA (s. 42(1)).

A participant with an approved plan (or one that is being prepared) may make a request that funding be managed wholly, or to a specific extent, by one of the following:

- the participant — this is known as 'self-management'
- a registered plan management provider nominated by the participant
- the NDIA
- the plan nominee nominated by the participant or the CEO of the NDIA (ss. 42(2), 43).

The NDIS Act does not permit self-management of funds in some circumstances, including when:

- the participant or the plan nominee is an insolvent under administration (ss. 44(1), 44(1A))
- self-management would present an 'unreasonable risk to the participant' (s. 44(2)(a)). This is prescribed by the *National Disability Insurance Scheme (Plan Management) Rules 2013* (Cwlth), which includes a range of factors relating to the participant's legal capacity and decision-making ability that the CEO of the NDIA must consider in making this determination (NDIS Act s. 44(3)(a), *National Disability Insurance Scheme (Plan Management) Rules 2013* (Cwlth) rr. 3.7 and 3.8)
- the NDIS Rules have prescribed matters that must not be managed by a participant (s. 44(2)(b)).

If a participant does not make a plan management request, the plan is to be managed by the registered plan management provider specified by the NDIA, or by the NDIA itself (s. 43(4)). If this occurs, the CEO of the NDIA 'must, so far as reasonably practicable, have regard to the wishes of the participant in specifying who is to manage the funding for supports under the plan' (s. 43(5)).

General assistance is available for all participants

Assistance to implement and manage a plan is available for all scheme participants, including via LACs, Early Childhood Partners, Information, Linkages and Capacity Building (ILC), and plan managers (sometimes referred to as intermediaries).

LACs link participants to the NDIS, and to information and support in the community. They work with the local community to make it more inclusive for people with disability. LACs can also help participants understand the NDIS and implement their plan. Participants can receive help to:

- find and start receiving the supports that they need

- self-direct or self-manage their plan
- find mainstream and community services (NDIA 2017n).

However, LACs are still being rolled out. The nature of their services also means that they assist participants with less complex needs (NDIA, sub. 161, p. 107).

ILC-funded projects focus on community inclusion, and making sure that the community becomes more accessible and inclusive for people with disability. This includes:

- personal capacity building — making sure that people with disability and their families have the skills, resources and confidence that they need to participate in the community, or access the same kind of opportunities or services as others
- community capacity building — making sure that mainstream services or community organisations become more inclusive of people with disability (NDIA 2017k).

ILC was not part of the NDIS trial period, but is being progressively rolled out during transition (chapter 6). The NDIA has provided grants to organisations to carry out activities in the community, with further funding rounds open in the second half of 2017 (NDIA 2017k; Prentice 2017).

Participants can also use a plan manager (registered with the Agency) for some or all of their supports. A plan manager can take on a range of different tasks for the participant, allowing the participant to effectively 'outsource' the tasks that they feel least comfortable with managing, and in turn, reduce their administrative burden. For example, plan managers can coordinate payments between the participant, provider and the NDIA, but participants retain choice and control over their supports. Plan managers can also take a larger role, such as searching and securing providers to meet a participant's needs — effectively acting as an agent for the participant.

Support coordination is available for some participants

Some participants who may have less capacity to actively manage their affairs, including those with complex or high support needs, can have 'support coordination' items as part of their plan. These items include: support connection; coordination of supports; participant training in planning and plan management; and specialist support coordination (NDIA 2017q, p. 55, 2017r, p. 56, 2017s, p. 56, 2017t, p. 56).

Whether support coordination is allocated to a participant is determined in the same way as other supports — based on what is reasonable and necessary for the NDIS to provide in meeting a participant's needs or goals. About 54 per cent of scheme participants had funding for support coordination included in their plans between July 2016 and March 2017, although only 37 per cent of participants had support coordination allocated in the June 2017 quarter (NDIA 2017y, p. 21). About 4 per cent of committed supports in participant plans after 30 June 2016 were allocated to support coordination (figure 2.9).

The NDIA said the participants most likely to benefit from support coordination include people:

- with severe and multifaceted disability requiring multiple supports
- who are young and in nursing care
- with conditions of a degenerative nature, and supports requiring regular active management and ongoing adjustment due to the participant's changing needs
- with episodic mental or ill health support needs
- requiring regular crisis management
- with poorly resourced families or limited or no informal support networks
- requiring child protection or criminal justice involvement
- with a history of changing and challenging support provision (sub. PP327, pp. 53–54).

The NSW Government also nominated other groups.

> There is likely benefit in specialist support co-ordinators identified for particular groups of participants, such as children and young people, people with psychosocial disability, and Aboriginal participants. (sub. PP230, p. 9)

Support coordinators provide more intensive assistance to help a participant understand their plan, and to choose and connect with providers — effectively a more personalised and in-depth service than what LACs would provide (NDIA ndc, nde). Support coordination also aims to build and strengthen the participant's capacity to connect to and coordinate informal, mainstream and funded supports to reduce the reliance on support coordinators and others in the future. This includes resolving points of crisis, developing capacity and resilience in a participant's network, and coordinating supports from a range of sources (NDIA, sub. PP327, p. 53).

Other groups can also provide assistance to participants

While LACs, ILC, plan management and support coordination are all provided under the NDIS, there are other groups and representatives — including Disability Support Organisations (DSOs), peer support groups, advocacy organisations and trustees — who also play an important role assisting participants and their families to engage with the NDIS.

Peer support groups allow scheme participants and their families to share their experience, information and knowledge with others about issues associated with disability and the scheme (including helping people think about their goals, supports they might need and support options). Peer support groups can also provide information on how best to find and arrange supports, and connect with community activities. Some peer support groups are forming as the NDIS rolls out (for example, the Mental Health and NDIS Facebook Support Group (sub. 8), and the NDIS Grassroots Discussion Facebook Group).

Trustees can also help participants manage their affairs. For example, public trustees, established by State and Territory Governments, aim to ensure that all members of the community (including people with disability) have access to financial management services in the event that their capacity to make decisions is affected. Public trustees can make decisions on behalf of a person with disability in the best interests of that person (known as 'substitute decision making'), taking into account their needs and views. The *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act) also allows the CEO of the NDIA to appoint a public trustee as a participant's nominee in order to make decisions on planning and actioning supports.[84] These arrangements are still to be tested, and need to be carefully monitored to ensure that they are fit-for-purpose.

Navigating the NDIS is proving difficult for some participants

While there is assistance to navigate the scheme, some scheme participants are finding it difficult to understand and interact with the scheme, and to exercise choice and control over their supports. Some participants said they are finding it difficult to understand their plans (chapter 5); to find, negotiate, purchase and coordinate supports with providers in a timely manner (for example, ADACAS, sub. PP260, p. 6); and to seek assistance from the NDIA when problems occur (JSCNDIS 2017a, pp. 62–63).

A number of study participants mentioned problems with clear communication of the participant pathway. This partly reflects the changing nature of the disability support landscape. Under the previous system, scheme participants who had access to support programs (typically block-funded) often relied on advocates and providers to be the 'first port of call' to seek remedies, information or changes to services. Under the NDIS, participants now have a range of options when seeking information or clarity — including approaching a LAC or the NDIA itself. A lack of fit-for-purpose information means participants can be confused, and providers are continuing to help them navigate the system. As one study participant said:

> There needs to be much more focus on communicating clearly and simply with clients. For instance, at the moment, plans are vague and written in 'government speak'. If the government is concerned about clients overspending, the NDIS needs to give clients clear information on what their funding is for and clear conditions under which it can be spent. (Angela Blakston, brief sub. 168)

[84] To the best of the NDIA's knowledge, there have been no instances of the CEO (or their delegate) appointing a nominee for a participant under Chapter 4, Part 5, Division 2 of the NDIS Act (NDIA, pers. comm., 7 September 2017). However, there are some concerns that nominees may have a narrower ability and responsibility compared with what a public trustee would ordinarily be able to do in the interests of the beneficiary. The Australian Law Reform Commission and participants in this study also noted that there may be a conflict in the duties required of a nominee as defined in the NDIS Act, and relevant State and Territory legislation (ALRC 2014, pp. 151–152; Financial Services Council, sub. 98, pp. 4–5), but this is yet to be tested in court.

Carers Australia also said that:

> If anything has characterised the NDIS to date it is poor communications performance. It has failed to communicate changes in the Scheme as it has been rolled out to potential participants. Its communications have frequently been heavily jargonised and pitched at a very high level. Even people whose job it is to understand NDIS developments and operations often struggle with exactly what is being communicated. In some cases the NDIA has been successful in making elements of the Scheme intelligible to consumers; for example, in a number of their plain English guidelines to supports available under the NDIS. This approach needs to be incorporated into all communications with participants, their carers and providers. (sub. 195, p. 22)

Providing information about the scheme in plain English is one relatively low cost way the NDIA can make the scheme less complicated for participants and their families.

The time spent by providers assisting participants and their carers to navigate the complex system can be significant, and often are 'unbillable hours' of support (JSCNDIS 2017a, p. 64). Participants and their carers said that often they are unable to obtain helpful advice from the Agency or LACs (JSCNDIS 2017a, pp. 61–63; Macarthur Disability Services, sub. 57, p. 9). The NDIA acknowledged that:

> People with disability and their families and carers have reported that there is continued difficulty in understanding the NDIS and the process of moving through the [participant] pathway. (sub. 161, p. 107)

Vision Australia said that some information provided by the NDIA (particularly for the purpose of pre-planning) was not in a format that was accessible by participants, especially for those who are blind or have low vision.

> … much information produced by the NDIA is inaccessible — either not electronically accessible, or the print versions are not produced in either braille or large print, or information is provided in image or tables that cannot be read by text to speech software or is difficult to navigate with magnification. Informed choice and decision making requires information: the current situation forces many people who are blind or have low vision to rely on supports of others, despite preferences for independence. (sub. PP252, p. 2)

Reflecting the complexity and variation of needs and circumstances among participants, some participants will be more ready than others. This, in turn, partly reflects the extent of help that they received under previous disability support arrangements. For example, one study participant said that:

> I don't think I will have trouble utilising my plan, because I am overdue some support and will fully appreciate the value of NDIS funding. I've done my research and I know what's available in my area; however, I appreciate that I live in a city area where there is choice of providers and my needs will not be difficult for me to articulate and negotiate around. (Name Withheld, sub. 5, p. 1)

However, another study participant commented that:

> As a now plan-managed NDIS participant I find it even harder, if anything, to manage that additional layer of administrative burden and all I really want to do is to go back to the good old

> days when the MS [Multiple Sclerosis] Society told me what I want and needed and provided it at a reasonable cost. … there are many benefits to it, including being able to shrug off the burden of managing your costs and choices with a reasonably low level of bureaucratic rigidity. In the meantime … I am an 'under-utilisation' risk to the NDIS, with the immediate threat of having my unused funding cut back — not because I don't want and need the features these choices provide, but because I can't get organised to utilise the promised benefits and it's easier to blow my budget RIGHT OUT than navigate the NDIS' portal … (Kirsty Magarey, sub. 150, p. 4)

Others are also unclear about who is ultimately responsible for helping participants navigate the system, including when supports are being replaced by the NDIS.

As one study participant said:

> In a recent conversation with my mother where we discussed the upcoming pre-planning meeting, my mother was under the impression that Minda Inc. would be acting as an agent for N in the actual planning meeting with the NDIA. From her perspective, she had assumed that as Minda Inc. would be acting as an agent that that would mean that neither she nor N would not need to have to go through meeting. But I'm not sure that's the correct assumption. Nonetheless, the pre-planning meeting with Minda Inc. still requires my mother to complete some paper work on behalf of my brother and to spend time continuing to cajole N to attend that meeting. (Name Withheld, sub. PP365, pp. 1–2)

10.2 How can participant readiness be improved?

Making clearer the role of support coordination and other assistance

It was recognised before the NDIS was implemented that it would be necessary to build the capacity of participants to interact with the scheme. The NDIA's 'participant pathway' reflects this, and includes funding for participants with limited capacity to navigate the scheme.

> The NDIA has designed the participant pathway to include support for participants during the planning and implementation phases … In the implementation phase, the NDIA provides LACs for those with less complex needs and funding for support coordination for the intensive participant groups. … The NDIA has also identified that there is a need for work in the support coordination sector, particularly in some cohorts such as where participants have challenging behaviours, rural and remote areas and where there are gaps in mainstream services that the NDIS cannot fill. Work continues to educate support coordinators on the capacity building role expected of their function which is designed to build the skills of individuals over time to make support decisions themselves. (NDIA, sub. 161, p. 107)

Support coordination is the key means to bolster the readiness of participants with complex needs. For example, Mental Illness Fellowship of WA said that support coordination is particularly important for participants with multiple levels of disadvantage and/or psychosocial disability.

> Where people live in quite complex situations, are impacted by poor physical health, poverty and social isolation support coordination is a critical component keeping people well and managing

> their day to day living. At times support coordination is also a critical link between people's physical and mental health providers. (sub. PP221, p. 4)

However, there is some confusion about the role of support coordinators. It is also not clear whether support coordinators are effective in helping scheme participants find providers, or whether participants who most need these supports have access to them (box 10.2).

Box 10.2 Confusion about the role of support coordinators

Cheryl McDonnell:

> We need a step by step guide. A clear list of who is who and who does what. What the heck is a support coordinator and what exactly can they achieve in an hour a week? … Especially at the start of a plan, [a] support coordinator needs to be much more active. (sub. 79, p. 3)

Early Childhood Intervention Australia Victoria/Tasmania:

> There has been a lack of clarity and guidance around the function, allocation and use of support coordination funding … Providers also report a wide variation in the quality of the support provided. (sub. 129, p. 11)

Summer Foundation:

> In addition to the set up administration, many Support Coordinators are reporting significant time being spent in rectifying poor plans that do not represent the Participants' requirements. The NDIA states that Support Coordinators 'do not make a judgment about the adequacy of the plan and do not make requests for an unscheduled plan review on behalf of Participants'. Nevertheless Support Co-ordinators report on the amount of time overall that is being spent on rectifying inadequate planning at the Agency level, and this impacts on their work in reaching Participant outcomes. (sub. PP293, p. 4)

National Disability Insurance Agency:

> The NDIA agrees … that more clarity is needed around the role of support coordination, the effectiveness of support coordination, and the allocation of support coordination to the participants who most need it. (sub. PP327, p. 52)

The limited availability of quality and skilled support coordinators in some areas was noted by study participants, as well as delays in participants receiving support, and waiting lists for support coordination (NSWCID, sub. PP234, p. 6; Victorian OPA, sub. PP241, p. 3; Royal Institute for Deaf and Blind Children, sub. PP259, p. 7; Summer Foundation, sub. 113, p. 13).

The Victorian Government (sub. PP298, pp. 28–29) observed that some support coordinators were not equipped to assist participants with complex needs, particularly in crisis management and care coordination — resulting in State (and Territory) Government departments being re-engaged to cover the capability gap, potentially poorer participant outcomes and higher costs for governments.

These concerns reflect, in part, the current problems around developing the supply of supports and the workforce to meet the needs of participants (discussed in chapters 7 and 9 respectively). The MJD Foundation (sub. PP233, pp. 8–9) said that the NDIA did not have a clear picture about the actual support coordination options available in communities, and that support coordinators who wished to make service bookings were hampered by their

inability to view participant plans in the portal. The New South Wales Government argued that:

> … better targeting and development of the support co-ordination market is required prior to the conclusion of transition. The NDIA should implement mechanisms to communicate the purpose of the function. It should engage with the sector to co-design and commission a sustainable and well-networked support co-ordination market. (sub. PP230, p. 9)

Study participants (including the MJD Foundation, sub. PP233, p. 8; MHCSA, sub. 308, p. 6) also said that support coordination that is time-limited and focused on capacity-building is not always appropriate for people with permanent and significant disability. In the ACT — the jurisdiction that is already at full scheme — there is some suggestion that the NDIA intends to withdraw support coordination altogether and that LACs will take over this role.

> Support coordination in the ACT has been through various stages. Initial plans did not include it and many plans were not implemented as a result. Now that the LACs have commenced in the ACT the NDIA has made it clear that support coordination will be withdrawn for the majority of participants as the LACs should be doing this role in addition to their many other functions. The NDIA's understanding of support coordination is that over time all participants will develop skills so that it is no longer required. This is a simplistic understanding that does not take into account that many people will want and need support coordination on an ongoing basis … The NDIA needs to take a more realistic approach to support coordination recognising that it can play a role in ensuring sustainability of supports and outcomes for the person with disabilities. (ADACAS, sub. PP260, p. 6)

However, it is not clear whether the shift from support coordination to LAC services is because initially LAC services were not in some regions, and support coordination was funded until LAC services were in place (NDIA 2017x).

Support coordination may be required on an ongoing basis in some cases, including in cases where a participant has elderly informal carers with declining capacity to undertake support coordination (ADACAS, sub. PP260, p. 6; David Parkin, sub. PP362, p. 19).

Summer Foundation, a major provider of support coordination, echoed concerns about the subsequent withdrawal of support coordination based on time rather than participant outcomes, as well as the inconsistent allocation of support coordination in the first place.

> The allocation of Support Coordination in a participant's plan is reported as both incredibly varied with a lack of transparency about how allocation principles are applied. This generates a feeling that there is inequity. Some report also seeing huge reductions in allocation in subsequent plans despite a continuing and genuine need for support. (sub. PP293, pp. 3–4)

Although it is too early to properly evaluate the efficacy and efficiency of support coordination, it is clear that participants, their families and carers, and governments value support coordination, and that it helps many people who receive and use it. Participants who are allocated and use support coordination have higher rates of utilisation (the ratio of used to committed supports in a plan) on average than those who are allocated, but do not use, support coordination. At face value, this suggests that support coordination can help build a participant's capacity.

Because effective support coordination is important for both participant outcomes and containing scheme costs, the NDIA should clarify the roles and responsibilities of support coordinators, and how they interact with the other groups who assist participants and their families navigate the NDIS (including LACs). The NDIA (sub. PP327, p. 55) said that it is seeking to make clearer the roles of intermediaries, but whether this includes support coordinators is unclear.

The allocation of support coordination in plans should also be made transparent, and be more explicitly linked to participants' needs, circumstances and outcomes (informed by supporting data where possible), rather than be time-limited. This approach is consistent with the legislative requirement that NDIS fund reasonable and necessary supports (NDIS Act, s. 34).

RECOMMENDATION 10.1

The National Disability Insurance Agency should:

- clarify to scheme participants and the community the role of support coordinators in relation to Local Area Coordinators, plan managers, mainstream services and advocates
- allocate support coordination to participants in their plans on the basis of need (and not for a fixed time period) in determining whether it is a reasonable and necessary support, pursuant to section 34 of the *National Disability Insurance Scheme Act 2013* (Cwlth).

How can scheme complexity be reduced?

The objectives of the NDIS mean that some parts of the scheme will be complex by design. Putting in place a framework to identify, assess, plan and provide supports for people with disability is no simple task. Guidelines and processes can introduce complexity in the pathway that participants need to navigate to meet their goals. However, unnecessary complexity can lead to miscommunication or a breakdown in continuity of care (Warr et al. 2017, p. 33), and ultimately reduced participant wellbeing. Complexity can also add to scheme costs and reduce efficiency. The challenge is to simplify the scheme as much as possible, while maintaining the integrity of the scheme.

The Commission heard that the NDIS is complex. The two main areas of concern were:

- participants finding providers
- participants (and providers) understanding and using the online portal where plans and payments are managed (box 10.3).

The rapid rollout of the NDIS has led to a number of transitional issues, including with the online portal. A review of the portal found many shortcomings in its implementation, mainly

stemming from the speed of the rollout (PwC 2016). The NDIA said it accepted the recommendations of the review and is addressing the portal issues.

> Significant difficulties with the implementation of the new ICT system in July 2016 adversely impacted on both participants and providers and caused a loss of community confidence in the NDIA's administration. An assessment of the failures from July 2016 have been documented in the PricewaterhouseCoopers *NDIS MyPlace Portal Implementation Review*. The NDIA accepts the broad thrust of those findings and has now implemented, or is the process of implementing, all of the recommendations from that report. (sub. 161, p. 15)

Box 10.3 The NDIS online portal is not easy to use

Syndromes Without A Name Australia:

> The portal has a number of plans on it if the plan has been reviewed, causing confusions for clients. The headings are not the same as what is written in the plan, leading to interpretation errors. The portal crashes a number of times and the dates need to be entered a certain way. Some days the portal works better than others. There is no form on the MyGov tab or NDIS website to ask for a correction if you accidently upload a payment request to the wrong category. One family is still waiting 6 weeks later to hear from NDIS re: this issue, after submitting an enquiry regarding this. As there is no way to upload receipts, the portal uploads are open to exploitation. (sub. 86, p. 2)

Mental Health Community Coalition of the ACT:

> Service Providers are often placed in the unenviable position of having to help participants use the My Gov website in order to use their NDIS plans, including by entering passwords – technically this is breaking the guidelines of use, possibly the law. (sub. 135, p. 28)

Summer Foundation:

> The current administration of the NDIS creates a high barrier for participation by individuals with complex needs. Young people in RAC [residential aged care] typically have few informal supports and many have cognitive impairment. Most don't have ready access to a computer and/or are not able to navigate the Internet, both of which are required to activate plans and to find and negotiate supports with providers … More accessible and flexible approaches to delivering information and building the capacity of people with disabilities and their families are desperately needed. (sub. 113, p. 25)

Vision Australia:

> … the Participant Portal is completely inaccessible for a participant who is blind or has low vision and relies on JAWS [Job Access With Speech, the screen reading software]. (sub. PP252, p. 12)

More recently, the NDIA (sub. PP327, pp. 26, 52) said that, as part of its current participant and provider pathway reviews, it is committed to providing an improved online portal.

On the basis of the NDIA's commitment to address portal issues, the Commission has not made any finding or recommendation on the online portal. However, as participants (and providers) rely heavily on the portal to manage supports and payments, any issues with the portal should be closely monitored to improve accessibility for scheme participants. The online portal should also be revisited in future reviews of the NDIS.

Timely and useful information can minimise transaction costs for participants

Participants need information about providers. As the Prader-Willi Syndrome Association of Australia said:

> NDIS participants must have access to information about the performance of providers (e.g. number of complaints against them, participant's budgets running out too early, etc.). (sub. 112, p. 6)

The Minister for Social Services said that information for participants (and providers) is critical to support an effective NDIS market.

> The NDIS market is the arrangements through which participants use NDIS funding to obtain goods and services from providers. Mechanisms to provide information to people with disability about providers and to develop participants' skills as consumers are part of the NDIS market. NDIS market risks include anything that might reduce choice and control by people with disability to access goods or services that support them to live an ordinary life. An effective NDIS market is dependent upon people with disability being empowered to make informed decisions about high quality and safe supports and providers being informed about and able to meet the needs of people with disability. (Commonwealth of Australia 2017, p. 53, [310])

Information can emerge naturally from private sources, such as peer-to-peer online comparison sites (Better Caring, sub. PP296), connecting services (Ubercare, sub. PP227) and peer support groups for disability supports (Mental Health and NDIS Facebook Support Group, sub. 8). And while this is already occurring, the extent of it is unclear. The NDIA said that it:

> … is already aware of a range of small e-markets emerging around the country. For example, app-based plan management and financial management platforms are emerging to enable payments to be made to providers from participant plans, alleviating the burden on participants and providers. Another emerging e-market provides the ability to match available housing with people who are looking for specialist disability housing. (sub. PP327, p. 55)

Some providers said they are providing information to participants to help them make choices (AOPA, sub. 123, p. 8). However, as the Tasmanian Government (sub. PP247, pp. 9–10) pointed out, private sources of consumer information can lack transparency, increase the fragmentation of information, and be driven by service providers rather than consumers. And information provided by peers may not necessarily be accurate either. The effectiveness of private platforms will be limited if the NDIA holds all the relevant information necessary for participants to make decisions (such as the availability of registered providers in a particular area) and if they cannot be easily integrated with the Agency's payment system. And private payment platforms, while increasing the ease of making payments and facilitating transactions, do not by themselves help participants find providers.

The NDIA, as a market steward (section 10.3), is responsible for providing information about providers to reduce participant search costs, to increase competition, to monitor the market, and to reduce information asymmetry (NDIA 2016i, pp. 24–25). This role will

become increasingly important as the number of participants and the disability support market expands during transition. This role also reflects a key area for action under the Integrated Market Sector and Workforce Strategy (DRC 2015a, p. 15) to enhance the amount of information available to consumers. It also embodies the NDIA's (2016i, p. 24) desire for participants to have easy access to information 'about all possible service providers from which they can choose'.

According to the NDIA (sub. 161, p. 65), the NDIS 'eMarketPlace' will support information discovery, encourage industry innovation, build local community capacity, and provide timely data and analytics to assist with the scheme's sustainability (box 10.4). The eMarketPlace is broadly consistent with the Commission's 2011 recommendation that the NDIA should provide a centralised internet database of service providers with information on the range of products and services, price, availability and links to measures of performance and quality (PC 2011, pp. 486–7).

Box 10.4 The eMarketPlace aims to help participants and providers

The eMarketPlace is a project of the National Disability Insurance Agency (NDIA) to 'support information discovery, encourage industry innovation, and build local community capacity' and to 'provide timely data and analytics to assist with Scheme sustainability' (NDIA, sub. 161, p. 65). This includes the introduction of 'cognitive intelligence capabilities' — a form of artificial intelligence that will allow for easier interaction between participants, providers and the NDIA. For example, participants will be able to ask general and personalised questions about the eMarketPlace and the National Disability Insurance Scheme, rather than contacting the scheme's call centre or shopfronts. The eMarketPlace is to be co-designed by the NDIA and people with disability.

The aim of the eMarketPlace is to maximise the benefits of the scheme by making it easier and more efficient for participants to find and access the supports that they need. It will also allow providers, businesses and community organisations to market their products and services. In turn, it should improve the responsiveness of providers to participant demand, encourage the supply of supports and innovation.

The eMarketPlace is expected to reduce transaction costs for participants, providers and the NDIA. According to the NDIA:

> By introducing an eMarketPlace and eventually automating much of the payments and processing function, the NDIA will reduce the time spent on these activities and consequently the potential costs.
>
> In general contexts, eMarket platforms may be able to reduce unit costs by between 15-30%. In the NDIA context, these cost savings may flow through to participants in some scenarios. Where the NDIS is incentivising participants to shop around, the eMarketPlace will likely result in the best price for support services, in particular homogenous supports, being achieved more often. As well as open price comparison and price competition, the eMarketPlace also adds an additional commissioning channel for the participant. Cost savings realised from eMarketPlace price competition will serve to promote the effectiveness of the eMarketPlace, incentivising eMarketPlace participation, improving the scale of use and the sustainability of the NDIS. (sub. 161, p. 66)

Sources: Adapted from NDIA (sub. 161, pp. 65–66, sub. PP327, pp. 54–55).

The NDIA (2016i, pp. 29–31) initially planned to introduce the eMarketPlace by the end of June 2018, but it is unclear how long this will take in practice (there are a number of market stewardship activities and projects that are to take place during this period, including end-to-end improvements from the participant and provider pathway reviews (NDIA, sub. PP327, p. 54)). The Agency recently indicated that the eMarketPlace will not be delivered by June 2018, but rather it will be launched 'at the appropriate time once developed', while also stating that there were 'no known blockages or barriers' (apart from technological requirements) (NDIA 2017c, 2017d).

Some progress has been made on the eMarketPlace. In 2016-17, the NDIA spent about $640 000 on the eMarketPlace, and has undertaken work, in collaboration with the Department of Human Services, on the architectural models and high level requirements of the capabilities that are needed for the eMarketPlace (NDIA 2017d). The NDIA (sub. PP327, p. 54) is in the process of confirming the requirements of an effective eMarketPlace with the DSS, with functional requirements likely to include the ability to find providers and connect them to participants, trade, make payments, rate services and collect data.

The next stage of development is to determine what infrastructure changes may be required (NDIA, sub. PP327, pp. 54–5). The NDIA (sub. PP327, pp. 54–5) intends to conduct a Request for Information to gather advice from industry stakeholders about innovative solutions and commercial models that could deliver the eMarketPlace. The Agency is working with the Department of Human Services (the NDIA's shared services partner) to confirm the utility and timing of a Request for Information.

The eMarketPlace, if implemented as described, will go a long way to ensure that participants have the information they need about providers. The NDIA (whether through the eMarketPlace or directly providing information) must address existing information gaps — such as the slow updates to existing provider lists (every three months), inaccessible provider lists, and lack of consumer satisfaction indicators about providers (particularly on service quality and performance) — and make the information publicly available as soon as possible.

The eMarketPlace will supplement other work by the NDIA to develop consumer guides on best practice in areas such as therapeutic supports and equipment (DRC 2015a, p. 15), which are currently being refined. Metrics are being developed to better understand purchasing patterns and timing of participants' decision-making (NDIA, sub. 161, p. 107).

Participants must have access to information about options for supports and providers that is timely, accurate, relevant, clear and accessible, if they are to exercise choice and control. For example, ADACAS said that:

> An e-market place, appropriately set up and run would be welcome however as it is very difficult currently for people to find supports and to make informed choices about service providers. (sub. PP260, p. 6)

The New South Wales Government (sub. 60, p. 4) pointed out that 'participants are particularly vulnerable to information asymmetries and/or a differential in bargaining power

between themselves and providers'. This is particularly the case for people with disability where quality of service is highly valued (as poor service can have significant negative consequences for participants' lives) and switching costs can be high.

Accessible information to participants about providers must be made available as soon as possible. The Agency should consider outsourcing delivery of the eMarketPlace to private providers if necessary.

RECOMMENDATION 10.2

The National Disability Insurance Agency should provide accessible information to participants and the public about the providers available in the market and indicators of participant satisfaction with those providers. This information should be updated in as close to real-time as possible, and be consistent with the stated objectives of the eMarketPlace discussed in the *Integrated Market, Sector and Workforce Strategy*. It should be provided no later than 1 July 2018.

Intermediaries could play a bigger role

For some participants, the most cost-effective (and preferable) option will be to delegate some or all of the administration of their plans to an intermediary.

Intermediaries can assist participants who struggle to self-manage their affairs. They can also reduce scheme costs by aggregating participants' purchasing power for common supports. But there is some evidence that the administrative burden of self-managing a plan is a disincentive for some participants to take full control of their supports. The Intermediate Evaluation of the NDIS observed that:

> At wave 1 the option of self-managed funding was not always fully understood by NDIS participants; nor was it always discussed in the planning meetings. By wave 2 it was evident that while NDIS participants had a greater understanding of what self-management was there remained very few self-managers. The main reason for this appeared to be a reluctance to take on additional administrative activities. (Mavromaras, Moskos and Mahuteau 2016, p. 72)

Similarly, a report by the Melbourne Social Equity Institute noted that some participants are deterred by self-management because it is perceived to be too complicated and burdensome.

> … some participants had not developed an integrated package of services to meet their individual objectives and needs. Rather, they had opted for a care package which served to reduce the burdens of self-management. … One participant, caring for two children with disabilities, brought two large folders of letters, forms, reports and notes to the interview to show us the enormous amount of paperwork involved in self-managing her children's plans. (Warr et al. 2017, pp. 32–34)

Because participants who want to and can self-manage their NDIS funds are more likely to have positive outcomes (box 10.5) it is important that there are incentives to self-manage. As the NDIS Independent Advisory Council said:

> … the IAC [Independent Advisory Council] has drawn on the many evaluations of approaches to service provision to argue that when participants self-direct their support and self-manage their funds they are more likely to be able to achieve positive outcomes because they have control over the 'what, when, where and by whom' of support, making it more likely that the paid support facilitates the desired lifestyle and compliments rather than drive out freely given support by family and friends (informal support). (sub. 149, p. 6)

Increased use of self-management (where appropriate and over the long term), could benefit participants and carers. If intermediaries can build the capacity of participants to self-manage, then they should be encouraged. Intermediaries can undertake a range of tasks that participants may need for them to better self-manage. For example, intermediaries can:

- develop a participant's capacity in understanding their plan, budget and the choices available to them (increase capacity / reduce complexity)
- collaboratively develop a plan for initial plan activation / implementation
- collaborate and coordinate with the NDIA, support coordinators and LACs
- [support] the participant in sourcing services and items (as needed)
- work with the participant and providers on establishing service agreements and supporting a participant in negotiating rates and schedules as needed
- work with providers on service bookings / agreements / invoicing / payment processes
- [provide] the participant tools and personal support to effectively manage their NDIS budget
- conduct invoice processing (participant approvals required), NDIS billing and provider payment processes
- [continue] plan and budget monitoring and capacity building and planning. (Integra, sub. PP268, p. 2)

By coordinating these activities, intermediaries can act as a 'one-stop shop' for scheme participants, reducing the complexity faced by participants. In short, they mitigate the complexity of the NDIS that may be unavoidable, and which can have real costs for participants. Mind Australia said that:

> … when processes are overwhelming or negotiations are difficult, the impact on an individual's mental health can be devastating. One participant in the choice project said that when she was accepted into the NDIS, she thought that getting good support would mean fewer stays in hospital. In fact, she was admitted to hospital eight times in her first year in the scheme, which she put down [to] the stress of dealing with the NDIS and NDIS processes. Ongoing navigational support is one means to address this situation. (sub. 144, pp. 11–12)

Box 10.5 The benefits of self-directed funding

Self-management is a means through which participants can exercise self-direction over their supports and their lives. As the NDIS Independent Advisory Council explained:

> The term 'self-direction' is a generic term for an approach that gives people with disability greater control over their support and their lives. The concept is often broken into component parts of self-directed planning, self-directed funding and self-directed support. Self-directed support can be managed through a service provider, a financial intermediary or via a direct payment (self-management). (sub. 149, p. 7)

There is a strong body of evidence to suggest that self-management — including the self-direction of funding and disability supports — results in better outcomes for people with disability and their families. For example:

- The UK Individual Budget pilot found that participants who were given the opportunity to self-direct their funding were more satisfied with the scheme, had greater aspirations, and more likely to report that they felt in control of their daily lives for a given level of expenditure (Glendinning et al. 2008).
- An assessment of the US Cash and Counselling program found that those who self-managed their funds were more likely to have their needs met and be more satisfied with their care. Further, there was no evidence that self-management led to greater care-related health problems, and a significant proportion of those who self-managed had a lower incidence rate of adverse events (Carlson et al. 2007).
- A study of the Victorian scheme that examined the use of individual support packages found that those who used them reported improved choice, control, independence and self-determination in their lives — positive outcomes that they attributed to the better control they had over the way they could organise their disability supports (Fisher et al. 2010, p. viii).
- Where self-management has been used in Australia and overseas, the risks of improper use of funds (such as fraud) appear to be limited. Auditing and close observation of payments have been found to effectively mitigate the risks of abuse of self-managed funding (Fisher et al. 2010, p. 47). The incentives faced by those who self-direct also play a role in reducing fraud: to misuse support funds does not result in a net gain to participants as it is their own budget as part of an individualised support package.

Ultimately, the broader benefits of self-management are reflected in the goal of better participant outcomes and more efficient use of disability supports.

> They move from dependent clients toward active citizens who have increased independence, self-management and inclusion and as a result require less support over their lifetime. (NDIS Independent Advisory Council, sub. 149, p. 9)

Intermediaries can also have broader, scheme-wide benefits. For example, intermediaries can:

- provide systemic feedback to the NDIA on any common and recurring issues, which in turn can reinforce the scheme's insurance approach
- enable participants to exercise choice and control by providing a wider selection of providers to choose from, and empowering them to make decisions
- help enforce quality and safeguards regulations, as they may have greater visibility and knowledge of the provider landscape that allows them to detect, monitor and screen poor quality or unsafe providers, and warn against 'sharp practices'

- reduce costs to participants and to the scheme, by purchasing services on behalf of participants in bulk that can reduce unit costs ('economies of scale'). This may also provide greater certainty to providers about longer-term demand and better spread the risk of providing disability supports
- minimise the burden on the NDIA and LACs — especially given the heavy workloads to bring people with disability into the scheme — by providing an alternative avenue for troubleshooting (Integra, sub. PP268; Plan Management Partners, sub. PP324).

Reducing barriers to participants using intermediaries

Many scheme participants are unaware that intermediaries are an option to help manage their plans. The Commission heard that LACs and the NDIA provide little information about intermediaries and the option of using them (Integra, sub. PP268, pp. 3–4; Plan Management Partners, sub. PP324, pp. 3, 6). For example, Family Advocacy said that:

> LACs do not seem to fully understand what self-management means. There appears to be superficial knowledge of what options are available to the participant. One family member reported that in their 'first plan' meeting, the LAC simply said they could agency plan or self manage but did not explain what this really means or provide any options of how that could work. Another LAC told a family that she could either have support coordination or plan management but not both. This is completely incorrect and makes no sense. The first refers to support in coordinating the Plan and the second relates to how the Plan will be managed by the participant. One does not depend on the other. (sub. PP346, p. 22)

The NDIA (sub. PP327, pp. 55–6) recognised that there are barriers to participants using intermediaries that are not in the interests of the participants and the scheme, and is currently addressing these issues as part of its participant and provider pathway reviews.

The Agency also proposed that the use of intermediaries could be encouraged by:

- providing greater clarity on the roles of intermediaries — to improve consistency in planning decisions (in providing funding to intermediaries), and reduce confusion in the sector and the NDIA
- reducing barriers to entry — including administrative barriers (for example, tight definitions of intermediary supports, fungibility in rules and price controls); improvements to the NDIA's processes and policies as part of the provider pathway; and harmonisation of processes across jurisdictions (for example, regulatory, registration and compliance requirements that are proportionate and risk-based) (NDIA, sub, PP327, pp. 55–6; Neville 2017, p. 10).

The administrative rules and prices that apply to intermediaries are best left to the NDIA and the body responsible for NDIS pricing, respectively. The NDIA's pathway reviews are intended to lead to better engagement and encouragement of intermediaries. For example, the NDIA said that it wants to improve data sharing with intermediaries to enable scalability and better participant supports (Neville 2017, p. 10). However, the first step is for the Agency to provide more information to participants and planners about the roles and use of

intermediary services as an option, particularly when participants are considering self-management.

Some safeguarding issues still need addressing

While intermediaries can unlock the broader benefits of self-management to scheme participants, there are some outstanding safeguarding and consumer protection issues.

Participants should not be 'hurried' or unduly pressured into self-management. Some participants will need to build capacity first in a number of areas before being ready to self-manage (even with the assistance of intermediaries, support coordinators and other capacity-building supports). This will take time. Self-management should therefore be considered a long-term goal for many participants, and should be assessed on a case-by-case basis.

It is not clear whether the NDIS Quality and Safeguarding Framework is appropriate for intermediaries. While the Framework and proposed Code of Conduct for workers and providers (which also applies to intermediaries) give participants protections (chapter 11), the role that intermediaries play is different to direct support providers. There is a risk that participants may come to depend on intermediaries to an extent where they may find themselves unable to switch between them, to determine if they are getting a good deal (such as whether participants are given sufficient choice over their provider), or whether intermediaries are acting in their best interests more generally.

Intermediaries (like any other registered provider) will need to be closely monitored over transition, particularly in the first few years of scheme rollout, in order to implement and adjust any specific safeguarding measures as necessary. General consumer protections and guarantees under the Australian Consumer Law, or other regulations (such as Australian Securities and Investments Commission licensing and professional requirements for financial service businesses) are not necessarily fit-for-purpose for NDIS participants (who may be less likely than other consumers to complain).

While there are protections for participants, there is relatively little in the way of protections for providers who must deal with intermediaries when problems arise. For example, beyond costly litigation pursuant to service agreements, there appears to be little recourse for providers who are paid late, in part or not at all, by intermediaries. This needs to be remedied immediately by adjusting the conditions of registration for intermediaries with the NDIA (and subsequently with the NDIS Quality and Safeguards Commission) to require the timely payment to providers. Intermediaries should be held to the same account as the NDIA when they manage a participant's plan.

There is also a question about whether intermediaries should also be allowed to be service providers. The Commission's view is that plan management services should be separate from service provision. This was noted as a positive way to avoid conflict of interest by some intermediary providers and to ensure that participants' needs are met (Integra, sub. PP268,

p. 4; Plan Management Partners, sub. PP324, p. 7). The NDIA has also proposed an ongoing review of independence and conflict of interest requirements, and how best to manage this for intermediary functions (Neville 2017, p. 10).

That said, it is important to note that the intermediary market remains underdeveloped, underused and uncertain. This makes it difficult to put in place safeguards at present, except to ensure that any regulations are risk-based. The Victorian Government said that:

> It is too early to say how well equipped and how well supported NDIS participants will be to exercise informed choice in this new marketplace. As the disability service market matures, it can be anticipated that intermediaries will emerge to facilitate mutually satisfactory transactions between providers and consumers, often aided by new information and communication technologies and tools.
>
> Appropriate regulatory responses for intermediaries will also need to be determined. In the interim, the readiness of participants to exercise choice is likely to rely heavily on NDIA funded initiatives and programs designed to assist participants navigate the disability support sector. Much of this support infrastructure is yet to be fully rolled out. (sub. 174, p. 19)

Intermediaries should be closely monitored over the next few years to ensure that there are no unnecessary barriers to their operation, but also as a means to better identify areas of complexity that participants are seeking paid assistance to overcome, which may be useful for ongoing scheme reform. The activities of intermediaries should also be monitored with an eye to developing any necessary safeguards that may be needed beyond the NDIS Quality and Safeguarding Framework (which will come into effect as each state and territory reaches full scheme (DSS 2017f)).

RECOMMENDATION 10.3

The National Disability Insurance Scheme Quality and Safeguards Commission, upon commencement, should closely monitor the operation of intermediary services under the National Disability Insurance Scheme, and make changes to safeguarding rules and codes of conduct as necessary to ensure that intermediaries act in the best interests of participants.

The National Disability Insurance Agency should provide clear and timely information about the option for participants to self-manage their plans, and the role that intermediaries can play to assist them to undertake different tasks on their behalf. The Agency should continue to assess the capacity of participants to self-manage on a case-by-case basis, consistent with the provisions of the *National Disability Insurance Scheme Act 2013* (Cwlth).

Advocates provide vital assistance to people with disability

Advocates for people with disability (including scheme participants) are independent people or organisations (without a conflict of interest) who directly speak, act or write on behalf of

the interests of an individual or group. This may extend to helping people with disability find and secure supports.

There are a number of different models of disability advocacy, including:

- systemic advocacy — aimed at bringing about systematic improvement in policy and practice, and removing discriminatory barriers for people with disability
- individual advocacy (also known as 'independent advocacy') — upholding the rights of individuals with disability by working on discrimination, abuse and neglect
- self-advocacy — supporting people with disability to advocate for themselves, or as a group (DSS 2017c, p. 2).

Advocacy has always been, and continues to be, important to people with disability, and particularly so for some groups.[85] COAG's (2011, pp. 17, 41) *National Disability Strategy* noted the role of advocacy in protecting and advancing the human rights of people with disability, their wellbeing and interests, as it enables them to participate in making decisions that affect their lives. As the Victorian Government said:

> The role of advocacy and self-advocacy will continue to be important in building participants' capacity to meaningfully exercise choice. Particularly during transition, some participants may need additional assistance to navigate the planning and plan implementation processes. (sub. 174, p. 19)

While many of the arguments for intermediaries are also applicable to advocates, advocates have a broader role supporting people with disability. Indeed, this is expressly reflected in the general principles of the NDIS Act in section 4(13).

> The role of advocacy in representing the interests of people with disability is to be acknowledged and respected, recognising that advocacy supports people with disability by:
>
> (a) promoting their independence and social and economic participation; and
>
> (b) promoting choice and control in the pursuit of their goals and the planning and delivery of their supports; and
>
> (c) maximising independent lifestyles of people with disability and their full inclusion in the community.

Advocates help participants in a way that NDIS supports cannot

The NDIS affects the need for advocacy services by participants and their families. The need for advocacy may diminish as the support and assistance provided by the NDIS increases — for example, ILC, LACs, the NDIS Quality and Safeguarding Framework, intermediary and support coordination services may fulfil some of the roles previously undertaken by

85 For example, the DSS identified that people who are Aboriginal and Torres Strait Islander Australians; who are from culturally and linguistically diverse backgrounds; who live in rural, regional and remote locations; and who are very socially isolated (including those with communication difficulties and those in institutional care) are most likely to benefit from advocacy (DSS 2017g, p. 18).

advocates. That said, many of these supports are in transition, and still to be fully clarified or established. These NDIS supports reflect the DRC's agreement that the NDIS would fund decision supports, safeguard supports and capacity-building for participants, including support to approach and interact with disability supports and access mainstream services (DSS 2015b, p. 3). The DRC also agreed that systemic advocacy, legal review and representation would be funded outside the NDIS — in line with the Commission's 2011 recommendations (DSS 2015b, p. 3).

However, some study participants argued that there is an ongoing need for advocacy *because* of the NDIS, and that the need for advocacy by participants cannot — and in many cases, should not — be met by NDIS supports.

- There are limits to what information and peer support organisations can do for participants via ILC, particularly those with high support or complex needs, or who are unable to navigate the NDIS more generally.
- LACs, to date, have focused more on developing participant plans and less on linking participants to services and building participant capacity (as part of their ILC functions, chapter 6).
  - Advocates can help fill the gap *before* a plan is made and provide valuable pre-planning assistance — this is important because participants may not have access to support coordination, plan managers, intermediaries or other assistance.
  - Advocates can help ensure better quality plans for participants *during* the planning process (chapter 5) and in any *subsequent* plan reviews (including NDIS appeals).
- Despite the introduction of the NDIS Quality and Safeguarding Framework, some participants may have a lower propensity or ability to make complaints, and to seek redress on quality and safeguarding issues (ADACAS, sub. 87, pp. 22–23). Advocates can help participants prevent, identify, raise and resolve such issues — they are an important safeguard for participants. For example, Children and Young People with Disability Australia (sub. 188, p. 25) said that people are often unaware of the rights of children and young people with disability, the relevant legislation and protections, and require support to resolve specific issues. Survey data also indicate that people with disability are more likely than the population on average to experience multiple legal problems and unmet legal need (Coumarelos et al. 2012; PC 2014, p. 95).
- How effective support coordination and intermediary services are at helping participants and building their capacity is still unclear. This is partly due to a lack of clarity on their allocation to participant plans, expected roles and safeguarding issues. Even if these issues are resolved, advocates may continue to have an ongoing role in monitoring the *quality* of these services, and intervening in any safeguarding issues, particularly with respect to identifying and reporting violence, abuse and neglect against people with disability in institutional and residential settings (SCARC 2015, p. 213).

In its review of the National Disability Advocacy Program (NDAP), the DSS acknowledged the role of advocates compared with other supports (including the Commonwealth

Ombudsman for Disability), particularly their independence and the broad scope of matters within their purview.

> It is important to recognise the unique role of advocacy and understand the limitations and restrictions of other roles. For example, NDAP advocates are independent and can act solely on the side of the person with disability. This differs from NDIS LACs (who have conflicts of interest due to their direct or indirect employment by the NDIA) and NDIS Support Coordinators (who have an interest in maintaining the funding relationship). (2017g, p. 12)

Advocates assist with broader issues and access to mainstream services or the community more broadly (which NDIS supports are not designed for), particularly when there are failures and gaps in mainstream service systems (DPOA, sub. 165, pp. 12-13), and when people with disability have complex needs and multiple levels of disadvantage (Australians for Disability Justice, sub. PP342). For example, Leadership Plus, a Victorian advocacy organisation, reported that the top three issues in recent years related to:

- Services — service delivery and quality including disability specific agencies and others,
- Finances — including financial management issues with appointed Administrators, capacity to manage personal income, loss (or risk of loss) of funds due to theft or mismanagement by friends or family, and
- Accommodation — for example, having appropriate housing, maintaining tenancy in public and community housing, risk of homelessness, addressing safety concerns. (sub. 128, p. 1)

In short, advocates help participants navigate NDIS processes, manage interactions with other disability services, and ultimately exercise choice and control over their supports and lives.

> The role of independent advocacy should not be underestimated in assisting people through the pre-planning process, understanding what supports and service options that are available to them, what supports are considered reasonable and necessary, feeling confident to ask for a review of their plan if they are not happy and ensuring their plans do not simply replicate their current inadequate supports. Rather than reducing the need for independent advocacy, the processes used in delivering the NDIS have highlighted the need for strong independent relationships and support through advocacy that will ensure that people with disability do exercise choice and control and have their needs met. (SUFU, sub. PP242, p. 5)

> The evidence of this investigation [of the effectiveness of statutory oversight mechanisms in the reporting and investigating of allegations of abuse in the disability sector in Victoria] strongly suggests that the role of advocacy will need to be strengthened further with the introduction of the NDIS … Without a strategy to embed the role of advocacy, a market-based model appears inaccessible for a large sector of people with diminished capacity to make informed decisions. It is not viable for advocacy to take a secondary position in the safeguards framework. I consider advocacy to be key in a framework for Victorian people with disability who have no prospect of becoming empowered consumers and have no family or friends to voice their best interests. (Victorian Ombudsman 2015, pp. 89–90)

> Advocacy is one of the most important safeguards in protecting and upholding the rights of people with a disability … For the NDIS to deliver on the promise we made to people with a

> disability — greater choice and control, we need to make sure they have the tools to enforce their rights. (Foley 2017)

All governments should continue funding disability advocacy …

Funding for most advocacy activities is shared between the Australian[86] and State and Territory Governments (except for South Australia) (DSS 2016e, p. 2). While the Commission recommended that State and Territory Governments should continue funding disability advocacy groups (PC 2011, pp. 523–5), most State and Territory Governments will reduce or cease funding advocacy services in accordance with Bilateral Agreements on the transition of the scheme (as it is considered to be a State specialist disability service (NSWFACS 2016)). The exception is the Victorian Government (2017a, pp. 263–4), which has committed funding for disability advocacy for 2017-18, and stated that it is 'committed to strengthening the disability advocacy sector' (Foley 2016, p. 2).

Although some jurisdictions intend to withdraw funding, there is still some uncertainty about what advocacy funding should be, and who should pay for it. This is reflected in recent amendments to the DRC's terms of reference to include a review of advocacy arrangements, including roles and responsibilities, by 31 October 2017 (DRC 2017c, p. 3).

In August 2017, the DSS completed its review of the NDAP (DSS 2017g), which considered what an updated NDAP should look like, and how it should work (including funding) in a NDIS environment (DSS 2016e, p. 2). The Australian Government announced that it will provide disability advocacy funding of $60 million over the three years to 30 June 2020 for:

- disability advocacy services under the NDAP
- NDIS Appeals providers
- disability representative organisations (disability peak bodies) (Porter and Prentice 2017).

As disability advocacy funding will be reduced by most States and Territories, disability advocacy organisations will need to rely more heavily on other sources of funding to continue their operations. These include public contributions (such as volunteering and donations), Australian Government funding, ILC funding or a combination of these sources.

For people with disability inside the NDIS, this outcome is at odds with the DRC's agreement and the Commission's 2011 recommendation. For people with disability outside the scheme — including those seeking to enter the NDIS as new participants — an unintended consequence will be service gaps and potentially poorer user outcomes. While there are intangible benefits from disability advocacy, the reduction or absence of advocacy

[86] NDAP agencies based in the NDIS sites may have additional roles, such as assisting people through the planning and internal review processes with the NDIA. Australian Government funding has been provided via the NDIS Appeals program to support people with disability who seek an external review of the NDIA's decisions through the Administrative Appeals Tribunal (DSS 2017c).

can impose real costs on the wellbeing of people with disability, their families and the broader community.

Although it is appropriate for disability advocacy funding to be withdrawn for *some* participants (to avoid overlap with NDIS supports), it remains the case that many participants and people with disability who are ineligible for the scheme need and would benefit from advocacy services (Daly, Barrett and Williams 2017, pp. 11–2; DARU 2017b, pp. 14–5; Porter and Prentice 2017). Funding for advocacy services for people with disability should continue both during and after the transition to the NDIS, just like funding for most other mainstream services (chapter 6). As noted by the Disability Advocacy Resource Unit (2017b, p. 7), while there is likely to be an increase in demand for advocacy in the short term, there will be continued demand for advocacy in the long term.

… but disability advocacy should still be funded outside of the NDIS

Just as NDIS funding arrangements reflect the different incentives faced by the Australian, State and Territory Governments (chapter 12), care must also be exercised in deciding how disability advocacy should be funded to avoid cost-shifting. If advocacy is funded solely by the Australian Government, then there may be pressure to help participants access services that are funded by the States and Territories. But if advocacy is funded solely by the States and Territories, there may be pressure to help participants to enter the NDIS and use services funded by the Australian Government.

The previous practice — where the Australian, State and Territory Governments all contributed to disability advocacy funding — is appropriate to address this concern. It also reflects the fact that advocates help people with disability to prevent and resolve issues in all government services, and the interface between these services. This approach is also consistent with the joint commitment made by all governments to the National Disability Strategy, and by extension, to all people with disability.

It is appropriate that disability advocacy funding remains separate from the NDIS for a number of reasons.

- All scheme participants initially come from outside of the scheme, and some participants will need advocates after they enter or exit the scheme.
- People with disability outside the scheme need and are major users of advocacy services.
- All people with disability benefit from advocates who advance systematic issues on their behalf and seek to improve the system.
- There is a conflict of interest if the NDIS funds the same organisations whose role it is to challenge the system. Separating funding from the NDIS would ensure the independence of advocates, which is central to their effectiveness in helping people with disability.

What should funding for disability advocacy be?

Limited evidence on the benefits and costs of disability advocacy makes it difficult to determine the appropriate level of funding for advocacy (box 10.6). The benefits of disability advocacy are difficult to quantify — although there are many examples and anecdotes that it leads to better outcomes for people with disability. The costs of disability advocacy funding by governments are also often reported in an aggregated manner that makes it difficult to separate specific funding from other services.

Without good cost-benefit analysis, but recognising that disability advocacy funding needs to continue in the short term, the Commission examined the advocacy funding arrangements in two different jurisdictions, and applied them nationally on a per capita basis (table 10.1). The approaches considered were:

- the Victorian Government's funding of disability advocacy under the Victorian Disability Advocacy Program. This program receives about $3 million each year for 24 disability advocacy organisations and has an annual target of 1700 users (Victorian Government 2017a, pp. 263–264; sub. PP298, p. 7). In 2016-17, the program was supplemented with the $1.5 million Victorian Disability Advocacy Innovation Fund, which was allocated to 15 disability advocacy organisations and designed to help people with disability access an advocate when they need it (Foley 2017; VDHS 2017)
- the Australian Government's commitment to fund disability advocacy by about $20 million per year on average until 2020. In 2016-17, about $17.7 million was provided under the NDAP to 58 advocacy agencies across Australia, with about 12 000 people with disability receiving individual support (DSS 2017g, p. 3).

Based on funding in these jurisdictions, total disability advocacy funding would be between $31.7 million and $40.0 million per year between 2017-18 to 2019-20.

The Commission considers that, at this stage, State and Territory Government funding should at least match the per capita contribution of the Australian Government. This would mean total funding of about $40 million each year between 2017-18 and 2019-20, and ensure continuity of advocacy services for people with disability, including scheme participants.

Over the next few years, policy-relevant data on disability advocacy will need to be collected to inform how future funding arrangements should be determined. The Commission recommends that in particular, services provided by advocates funded under the NDAP or by State and Territory Governments to people with disability should be recorded, and where possible, linked with other NDIA data to build an appropriate evidence base. The DSS should then use this evidence for future reviews of disability advocacy funding to ensure that funding levels reflect the costs and benefits of such services. Governments also need to clarify future funding arrangements in a timely manner to reduce uncertainty for both users and advocacy organisations.

Box 10.6 Quantifying the costs and benefits of disability advocacy

While many study participants provided useful anecdotes about the benefits of disability advocacy, more rigorous and systematic analysis of the costs *and* benefits of disability advocacy is needed to better determine the appropriate amount of advocacy funding by governments, and how funding should be used to maximise its efficiency and effectiveness. Cost-benefit analysis may also help to identify potential areas for improvement and reform in the disability system.

However, there is a lack of cost-benefit analysis on disability advocacy. A 2009 report prepared for the Department of Families, Housing, Community Services and Indigenous Affairs on the models of advocacy funded under the NDAP lamented about the lack of accurate and comparable cost and outcome data (particularly for individual advocacy), and in turn, the lack of evaluation of advocacy programs (Jenny Pearson and Associates 2009, p. vii). This is still true today.

- The DSS, in their review of the NDAP, noted that systemic advocacy is funded inconsistently across jurisdictions by NDAP because of a lack of data and reporting. Many stakeholders to that review recommended greater data collection and reporting to improve the advocacy evidence base and coordination on systemic issues (DSS 2017g, p. 22).
- The Victorian Government Office for Disability Advocacy Program also collects quarterly data on disability advocacy (DARU 2017a, 2017b, p. 4). However, the Disability Advocacy Resource Unit (2017a) noted that this data may have some measurement issues (including under-reporting, misreporting, data gaps and difficulties in interpretation), and made a number of recommendations to improve the integrity of the data.
- There are a lack of publicly available, disaggregated data on expenditure on disability advocacy. For example, expenditure data on advocacy is in the same category as information and print disability services, even though they are different to advocacy services (SCRGSP 2016b, tables 15A.7 and 15A.8)).

A recent cost-benefit analysis on advocacy has helped to shed some light on its value to the community. In a study commissioned by the Disability Advocacy Network of Australia, Daly, Barrett and Williams (2017) estimated that disability advocacy funding of $232 million would provide net benefits of about $600 million to Australia (in net present value) for the ten years from 2017 to 2026 (or about $60 million per year). (While the analysis made some generous assumptions, including large cost reductions in the justice system and creation of employment due to advocacy, the overall conclusion that disability advocacy provides a net benefit to the community is still valid.)

Table 10.1 **Benchmark estimates of proposed disability advocacy funding ($ million)[a]**

Annual funding for the period 2017-18 to 2019-20

	NSW	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*NT*	*ACT*	*Aus Gov*[b]	***Total***
Benchmarked to the Victorian Government's funding of $3m per year	3.7	3.0	2.4	0.8	1.3	0.2	0.1	0.2	20.0	**31.7**
Benchmarked to the Australian Government's funding of $20m per year	6.4	5.1	4.0	1.4	2.2	0.4	0.2	0.3	20.0	**40.0**

[a] These estimates are based on taking the contribution made by a particular jurisdiction to disability advocacy funding and applying it on a per capita basis to all other jurisdictions. It assumes an equal split of disability advocacy funding between the Australian and State and Territory Governments — a proportion that is consistent with the split of historical advocacy, information and print disability funding under the National Disability Agreement (SCRGSP 2016b, table 15A.8). [b] This assumes that the Australian Government's contribution is fixed at $20m per year, reflecting the recent funding announcement.

Sources: Commission estimates based on ABS (*Demographic Statistics*, Australia, December 2016, Cat. No. 3101; *Population Projections*, Australia, November 2013, Cat. No. 3222); DSS (2017g, p. 3); Victorian Government (sub. PP298, p. 7); and Porter and Prentice (2017).

RECOMMENDATION 10.4

The Australian, State and Territory Governments should continue to fund disability advocacy organisations. State and Territory Governments should fund disability advocacy to 2019-20 by an amount that at least matches the per capita contribution of disability advocacy funding announced by the Australian Government.

The Australian, State and Territory Governments should also collect data from funded disability advocacy organisations about people with disability who use their services, and their outcomes. This data should be in a format that can be linked with data held by the National Disability Insurance Agency, and be made publicly available. The Department of Social Services should undertake an independent evaluation of advocacy funding at the beginning of 2020 to inform future funding arrangements, and thereafter periodically evaluate disability advocacy. These reports should be made public.

Supporting the outcomes from disability support organisations

Other organisations, which identify themselves as disability support organisations (DSOs), assist scheme participants to engage with the scheme and the community. In 2011, the Commission used the term to describe the support that these organisations provided to people using NDIS services — including brokering, managing administration, mentoring and planning — and to distinguish their role from that of traditional specialist service providers (PC 2011, pp. 101, 414–22).

As the scheme has evolved, so too has the definition of DSOs. It is now used in a range of different contexts, including:

- peer connection — in 2014, the Australian Government's Sector Development Fund funded 18 DSOs to facilitate up to 20 peer support groups over the life of the project (NDIA 2015b, p. 80)
- advocacy and helping prospective participants
- information sharing and community connection
- intermediary roles (for example, Plan Management Partners, sub. PP324)
- participant capacity building roles.

The term DSO is less relevant than the *supports* they provide to people with disability and the outcomes they achieve. The Commission's recommendations in this report — if implemented — should provide adequate resources for the roles of DSOs and reduce the burden on them.

- Improvements to the planning process (including LACs engaging in pre-planning) (recommendations 5.2 and 5.3) will enable participants to receive their reasonable and necessary supports.
- Properly resourced ILC is an avenue for DSOs to connect people with disability to the community (recommendation 6.1).
- Properly funded disability advocacy will provide additional support for participants to navigate the NDIS (recommendation 10.4).
- Allocating support coordination in plans based on need will help participants to build the skills they need to exercise choice and control, and ensure that they get the NDIS-funded supports they are entitled to (recommendation 10.1).
- Making available accessible information to participants about providers, reflecting the objectives of the eMarketPlace, will help participants access the supports that they need (recommendation 10.2).
- Trialling volunteer organisations to provide supports creates a means to preserve social capital and allow greater choice for participants (recommendation 9.4).
- Clarifying the role of intermediaries (and therefore making them easier to access) will help reduce the administrative and search costs faced by participants (recommendation 10.3).

These recommendations are, in the Commission's view, sufficient to enable DSOs to do their important work supporting people with disability, including scheme participants. Should the Commission's recommendations not be implemented, then Governments and the NDIA will need to consider increasing funding via other channels to ensure that participants — both actual and potential — are appropriately supported.

10.3 Market stewardship

Market readiness issues reflect poor market stewardship

As discussed in chapters 7–9, and in this chapter, there are substantial challenges developing the market supply of disability supports. While some progress is being made, there are still difficulties growing the significant number of providers and the disability care workforce required, as well as helping participants to become informed and effective consumers (figure 10.2). This is occurring at a time when the rapid pace of the rollout — and growth in demand for supports — is at its greatest. Based on experience to date, there will be a shortage of disability supports under the scheme in the short to medium term.

Many of these challenges could have been — and should have been — anticipated and acted upon earlier. This highlights the need for more effective market stewardship by governments (including the NDIA). As the Agency said:

> Market stewardship recognises that when governments implement policies to increase consumer choice and adopt market-based delivery, they must also oversee how the marketplace develops. (2017e, p. 8)

And just as providers, workers and participants need to change their approach to disability supports, so too must governments.

FINDING 10.1

The supply of disability supports in the short to medium term will not be able to meet participant demand resulting from the National Disability Insurance Scheme. This is due to a combination of factors, including rapid intake of the scheme, difficulties faced by participants to navigate the new markets for disability supports, difficulties by providers to adjust quickly to a new market-based model of service delivery, and underdeveloped market stewardship.

Figure 10.2 **The challenges confronting NDIS markets are symptoms of a greater need for better market stewardship**

Key issue	Provider readiness: Price Signals	Provider readiness: Non-Price Signals	Workforce readiness	Participant readiness
Responsible stakeholders	Price regulator (currently NDIA)	Provision of market information (NDIA)	Coordination of workforce development activities by Governments, DSS and NDIA	Assistance in plans (NDIA)
Main current actions	McKinsey & Company price review initiated by the NDIA	Changes arising from the NDIA provider pathway review	Sector Development Fund Workforce action plan developed by DSS	Changes arising from the NDIA participant pathway review
Commission recommends	Principles-based pricing Independent price monitor and regulator (NDIS Quality and Safeguards Commission)	NDIA to release more frequent and granular data on participant demand NDIA to make public its Provider of Last Resort policy and Market Intervention Framework	Better coordination between governments, providers and the NDIA to develop the workforce Appropriate data collection Trialling use of volunteers	Implement objectives of the eMarketPlace Clarifying the supports that help participants Encouraging use of intermediaries Continue funding disability advocacy

All of the market readiness issues suggest that market stewardship needs improvement

Clarify and make public the roles and responsibilities for each party
Require transparent and regular reporting against outcomes
Collect and make public disaggregated, tailored and forward-looking market data
Coordinate market stewardship actions across all sectors

What is market stewardship and the role of governments?

To facilitate the significant market growth required, governments need to change their approach to the design, oversight, management and regulation of the market for disability supports. More effective government stewardship of the market is required than previously to create and manage the NDIS market.

Government stewardship involves governments taking steps in the design, delivery and improvement of services to ensure that services meet objectives (PC 2017b). The aim of stewardship is usually to protect equity — to ensure the individual wellbeing of users and to maximise community welfare. In the NDIS, the objective of government stewardship is to ensure that participants can access reasonable and necessary supports from the market, and ultimately have greater choice and control over their lives.

To date, many of the challenges of government stewardship are in the design of the scheme — such as planning (chapter 5), funding arrangements (chapter 12), and the interface between the NDIS and mainstream services (chapter 6) — which often need coordination and cooperation by multiple governments. As a result, the Australian, State and Territory Governments are NDIS government stewards.

An additional and unique challenge for the NDIS is the need for market stewardship — a specific form of government stewardship. Aimed at facilitating the creation and development of a market, it is often required as part of structural reforms, particularly when governments have previously been large service providers (such as in the disability support sector). Market stewardship can require active intervention to not only protect participants, but also to support the functioning and sustainability of markets so that it benefits all participants (Carey et al. 2017, p. 3). This includes promoting innovation, the diffusion of best practice and higher standards of services to people with disability.

In the NDIS, market stewardship means facilitating the timely creation and development of the disability support market, and ensuring that it develops in a way that meets the objectives of the scheme. As discussed in chapters 7–10, the challenge is to facilitate a substantial increase in the number of disability support providers and workers to meet participant demand, and to ensure that participants have the skills and supports they need to navigate the market. The NDIA has the designated role of market steward. The Agency described its goals as being:

> … to create an efficient and sustainable marketplace through a diverse and competitive range of suppliers who are able to meet the structural changes created by a consumer driven market. More specifically this involves:
>
> - enabling existing and emerging suppliers to mature at an appropriate and sustainable rate;
> - providing an environment for innovation in planning and delivery of supports; and,
> - building strong business integrity systems and processes and capability. (2016i, p. 4)

To achieve these goals over the transition period, the NDIA's market stewardship activities have focused on the delivery of disability services, which include:

- regulation — such as price setting and provider registration (chapter 8)
- models of service provision — including government commissioning or provision of services in thin markets, and under provider of last resort arrangements (chapter 7)
- information provision to the market — particularly to participants and providers
- managing transitions and implementation — including the withdrawal of government service provision (chapter 7).

This reflects the continuum of NDIS market intervention options available to the NDIA to develop and correct the NDIS marketplace, which range from 'light touch' to highly interventionist actions (NDIA 2016i, p. 23).

Market oversight is also needed to protect participants

Market stewardship also requires complementary market oversight. Market oversight is a forward-looking task which involves prudential supervision of the system (including the practices and financial performance of providers), identifying systemic risks and, where possible, taking mitigating action. This may require mandatory performance reporting from providers, the acceptance of complaints, and investigation powers. Doing so would enable monitoring and evaluation of any trends in the quality or cost of services, although this may be difficult given the decentralisation of services in the NDIS. It would also ensure that market stewardship responses are proportionate to the risks.

In the NDIS, market oversight is particularly important to regulate the quality of services and to safeguard the rights of people with disability. The Senate Community Affairs References Committee (2015) found that violence, abuse and neglect of people with disability is widespread, and recommended stronger independent oversight mechanisms. Currently, the DSS (sub. 146, p. 34) is responsible for market oversight, and reports on the effectiveness of the NDIS market, including market trends and outcome quality. Under proposed legislation, the core functions of the NDIS Quality and Safeguards Commissioner will include NDIS market oversight and consumer protection. This will include monitoring changes in the NDIS market which may indicate emerging risk, as well as monitoring and mitigating the risks of provider failure and unplanned service withdrawal (s. 181E(i), National Disability Insurance Scheme Amendment (Quality and Safeguards Commission and Other Measures) Bill 2017 (Cwlth)).

Under the NDIS, particularly during the transition phase, governments need to help participants exercise choice and control over their supports and lives, and to improve their wellbeing. This is an ongoing responsibility. They can do this by not only directly helping participants navigate the NDIS and the market, but also by actively facilitating the market supply of disability supports — to ensure that there are diverse and competitive markets for participants. Regardless of the approach taken, the ultimate focus of market stewardship

should be consistent with the person-centred approach of the scheme — to enable people with disability to achieve their goals and live better lives.

How can market stewardship be improved?

The market readiness issues to date highlight the need for more effective and holistic market stewardship than at present. As noted by the UK Institute for Government, effective market stewardship requires governments to:

- clarify roles, responsibilities and accountability arrangements
- be more considered, open and flexible in design
- focus on competition, market structure and market dynamics
- increase transparency (Gash et al. 2013, p. 6).

Clarify responsibilities and coordinate responses

Clearly defined market stewardship roles and responsibilities promote transparency and accountability of market development responsibilities.

Although the NDIA is designated as the market steward, *all* governments take actions that affect market outcomes, and so have some responsibility for market stewardship. All governments have a duty to participants to actively facilitate the supply of disability supports, particularly as there are multiple and diverse local markets that differ by jurisdiction. Without the cooperation of other market stewards, the NDIA's efforts to develop the market are unlikely to be effective or efficient.

To date, responses from jurisdictions have varied and their effectiveness is unclear. Some are spending additional money to support participants (and providers), while others are relying more heavily on the market to provide services. While some of the variation in responses reflect specific jurisdictional differences (including the rollout timetable), some of this variation also highlights the uncertainties around the roles and responsibilities of governments under the NDIS. In practice, this has led to gaps, duplication and shifting of responsibilities, and lack of accountability. This poses a risk to the scheme and to the wellbeing of participants and their families.

It is possible for governments to work together in the interests of participants. Host jurisdictions are likely to provide services in monitoring the overall integrity and effectiveness of the national NDIS Quality and Safeguarding Framework. For example, worker screening and approval of restrictive practices[87] by providers will continue to be managed through current State and Territory government processes (DSS 2016d, p. 17).

87 Restrictive practices are any intervention that has the effect of restricting the rights or freedom of movement of a person with disability, with the primary purpose of protecting the person or others from harm. They include the use of seclusion and consequence driven practices, as well as chemical, mechanical, physical, psycho-social and environmental restraints (DSS 2016d, pp. 66–67).

The DRC should set a clearer, more specific and practical delineation of market stewardship roles, individual and joint responsibilities, as well as accountability arrangements of the Australian, State and Territory Governments ('accountability maps'). Where Governments, their agencies and/or the NDIA are responsible for a market stewardship task, there should be clear and transparent reporting about specific actions and outcomes (including the costs, benefits and risks of any actions), timeframes and progress towards goals.

While clarifying responsibilities is important, there should also be more effective cooperation and coordination between the Australian and State and Territory Governments, particularly with other care sectors (such as aged care and health) and mainstream services (such as employment, education and transport). This is important as participants need to access both NDIS and mainstream services. Collaboration may also allow NDIS market stewards to draw on the lessons from other sectors with similar market development issues and/or consumer-directed reforms (such as aged care).

Evidence and risk-based market intervention

A strong risk-based focus on the market supply of disability supports is essential (balanced against the costs and benefits of any proposed market intervention). Under the previous arrangements, governments that provided or commissioned services faced the risk of non-delivery of services by providers — with little or no risks borne by providers and people with disability. The NDIS market-based approach to services means that there are now new and emerging risks to participants and providers, not just governments. Risk-based market stewardship is needed to maximise the net benefits of the NDIS market-based approach, while minimising the associated risks to participants, providers and the broader community. For example, risk-based regulation requires the identification, analysis and treatment of risks; development of contingency plans; and monitoring and evaluation of outcomes (VCEC 2015).

However, to date, market stewards have not given market supply issues sufficient and timely attention. This may be partly due to ambiguity about who is responsible for market development, what market stewardship entails, why it is needed, and lack of capacity or impartiality of governments to undertake market stewardship functions. As such, 'the system for identifying and addressing emerging issues is currently informal and unfixed in the NDIS implementation' (Carey et al. 2017, p. 14).

Effective market stewardship needs to be forward-looking, transparent and evidence-based. In practice, market stewardship efforts in the NDIS are hampered by limited and fragmented information and data on the disability support market. Interventions should be subject to rigorous evaluation and be sufficiently flexible to help stewards to adapt to unpredictable market developments. The Tasmanian Government remarked that:

> … better NDIA market data would assist providers to respond on likely participant demand. The Tasmanian Government has been calling for greater market analysis for some time …

> Performance indicators for the NDIS market will be critical tools for monitoring readiness and anticipating supply shortages and provider failure. (sub. PP247, p. 8)

At the same time, market stewards need to engage in open and iterative engagement with providers, workers, participants and the broader community. For example, provider engagement could inform:

- system, program and service design (effectiveness and efficiency)
- market intelligence (current and emerging activity, trends, forecasts etc)
- market sustainability (organisational trends etc)
- participant needs (assessment and planning, person centred practices)
- innovation (new ideas, new ways of doing things) (Community Services Industry Alliance, sub. PP251, p. 4).

This information would also inform research, benchmarking, monitoring, evaluation and quality assurance. A more bottom-up approach (as opposed to the current top-down approach) would facilitate local responsiveness and flexibility.

The Commission recommends the collection and publication of more timely, disaggregated, tailored and forward-looking market data by the Australian, State and Territory Governments, in conjunction with the NDIA and the NDIS Quality and Safeguards Commission, to support market oversight and stewardship. This includes qualitative information and feedback from liaison with market participants. Better information would enable greater flexibility, evaluation and refinement of risk-based market stewardship responses.

The way forward

In the transition period, market stewardship is critical to the wellbeing of participants and their families. Now, more than ever, there must be more investment in market stewardship. The Commission has made a range of recommendations (relating to pricing, providers, workers and participants) in this regard. However, these specific recommendations are a symptom of, and do not exhaustively define, the structural problems in current market stewardship arrangements. Market stewardship more generally could be improved by clarifying responsibilities for market stewardship, collection of more specific market data, and more effective government collaboration.

Market stewardship is a dynamic role that will evolve over time as the scheme is rolled out. While it is difficult to be certain about the future pathway of market stewardship, what *is* certain is that *ongoing* market stewardship will be needed. Market stewardship must receive ongoing and consistent priority by governments and their agencies, be forward-looking, flexible and adaptive to changing circumstances. This is essential to support an effective NDIS market, the scheme's sustainability, and the lives of participants and their families.

RECOMMENDATION 10.5

The COAG Disability Reform Council should immediately clarify and make public the roles and responsibilities of the Australian, State and Territory Governments with respect to market stewardship (those actions required to define and support the effective functioning of sustainable and enduring markets for participants and providers). This should include clear and transparent reporting of the specific actions and outcomes they are to achieve (including costs, benefits and risks), timeframes and progress towards goals.

The Australian, State and Territory Governments should:

- with the National Disability Insurance Agency and the National Disability Insurance Scheme Quality and Safeguards Commission, collect and make publicly available disaggregated, tailored and forward-looking market data, including provider and workforce data on supply gaps
- coordinate their market stewardship actions across all sectors, particularly with other care sectors and mainstream services.

11 Governance

Key points

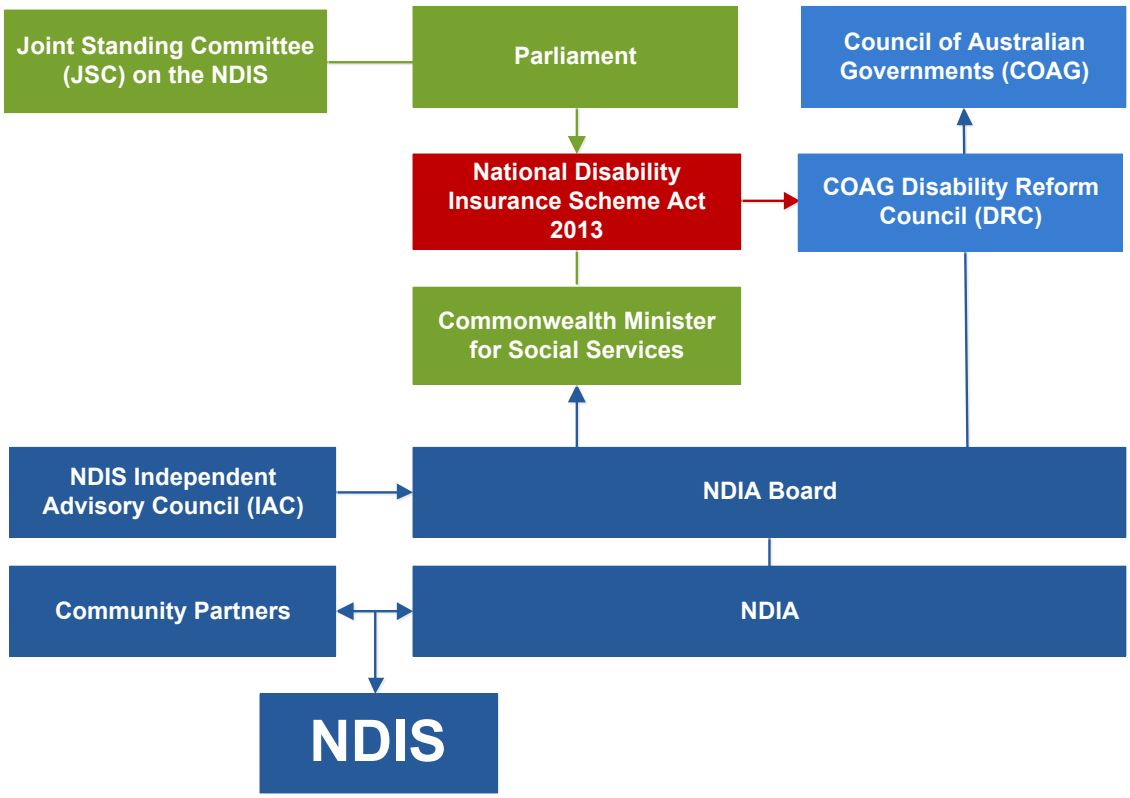
- The governance arrangements for the National Disability Insurance Scheme (NDIS) provide a good foundation for delivering the scheme. However, improvements can be made.
- More clarity should be provided around some roles and responsibilities, including Local Area Coordinators, mainstream services and market stewardship.
- The process for agreeing to Category A NDIS Rules should continue to require unanimous agreement from all jurisdictions, but changes are needed to allow for faster response times where emerging issues threaten the scheme's financial sustainability.
- The National Disability Insurance Agency (NDIA) should be given autonomy to independently manage the NDIS as an insurance scheme. The NDIA's operating cost target should be changed and the Australian Government should remove the cap on staff directly employed by the NDIA.
- Internal review processes have the potential to increase scheme costs and poor planning processes can increase the number of reviews. External review outcomes could also significantly affect scheme costs. The NDIA should publicly report on internal and external review processes.
- The timeframe to implement the NDIS Quality and Safeguarding Framework is ambitious. However, it needs to be met to ensure quality and safety for scheme participants, and to provide clarity and reduce the regulatory burden on providers. Regulation and quality assurance arrangements should be continually monitored and refined as needed.
- While the Western Australian NDIS is meant to mirror the national scheme in many respects, there is a risk that the governance arrangements could lead to a divergence in participant outcomes. There are also costs associated with setting up parallel schemes. Western Australia should be part of the national scheme.
- Current NDIS performance reporting does not have a sufficient focus on plan quality. Reporting on quality needs to be developed as a priority. Reporting on scheme participants' outcomes and attainment of participants' goals also requires further development.
- The focus of governments and the NDIA on participant intake, at the expense of quality and participant outcomes, has compromised the success of the scheme. The NDIA should better balance participant intake, the quality of plans and participant outcomes.
- The Australian, State and Territory Governments should immediately start planning for a changed participant intake timetable for the rollout of the NDIS. In doing so, they need to ensure that continuity of support arrangements are in place and assess whether additional resources are required for the scheme to meet its objectives.

This chapter examines the National Disability Insurance Scheme (NDIS) governance arrangements in the context of scheme costs and financial sustainability. Section 11.1 provides an overview of the governance arrangements. Sections 11.2 to 11.8 discuss issues with the current governance arrangements including: clarity and transparency around roles, responsibilities and processes; the NDIS Rules; the National Disability Insurance Agency's (NDIA's) structure and governance; the Western Australian NDIS; review processes; regulation; and performance reporting arrangements. Section 11.9 discusses the timetable for the scheme rollout.

11.1 Overview of governance arrangements

The NDIS is established under the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act) (figure 11.1). The NDIS Act sets out (among other things) the objectives of the NDIS, eligibility, how plans are prepared and reviewed, the governance arrangements for the NDIA, and internal and external review processes. The Act is supported by the NDIS Rules, which are legislative instruments that provide more detail on the operation of the NDIS.

Figure 11.1 **Summary of the NDIS governance arrangements**



Source: Adapted from NDIA (2016b, p. 127).

The Australian, State and Territory Governments share governance responsibility for the NDIS. The COAG Disability Reform Council (DRC) is responsible for NDIS policy and broader disability policy. Its members include the Ministers responsible for disability policy, the Treasury portfolio from each Australian, State and Territory Government, and a representative from the Australian Local Government Association (DSS 2017a).

The Australian Government Minister for Social Services is responsible for administering the NDIS Act. However, many of the Minister's responsibilities require agreement from, or consultation with, State and Territory Governments prior to being undertaken. The Minister's functions include making NDIS Rules and appointing Board and Independent Advisory Council members. The Minister can also issue directions to the NDIA about the performance of its functions (NDIA 2016b, 2017i; NDIS Act).

In addition to their governance role through the DRC, State and Territory Governments are responsible for regulating providers until the *NDIS Quality and Safeguarding Framework* is implemented (DSS 2016d, p. 17).

The NDIA is responsible for managing and delivering the NDIS. It is an Australian Government agency established under the NDIS Act and the *Public Governance, Performance and Accountability Act 2013* (Cwlth) (PGPA Act) (NDIA 2017i; NDIS Act, s. 117). Its main functions include:

- delivering the NDIS to support the independence and social and economic participation of people with disability, and enabling them to exercise choice and control in the pursuit of their goals
- managing, advising and reporting on the financial sustainability of the NDIS
- facilitating innovation, research and best practice in the disability sector
- building community awareness of disabilities
- collecting, analysing and exchanging data on people with disability, and the supports provided to them
- undertaking research relating to disabilities (NDIA 2017ab; NDIS Act, s. 118).

The NDIA is governed by a Board, which is responsible for setting the strategic direction of the NDIA, managing risks and monitoring and reporting on the Agency's performance (NDIA 2017w). The Board is advised by the Independent Advisory Council (IAC). The IAC is a panel of experts including people with disability, carers of people with disability, at least one person with expertise on disability in rural or remote areas, and at least one person with expertise in the supply of equipment or provision of disability services. The IAC can provide advice to the Board about the way in which the Agency administers the NDIS and helps to meet the objectives of the NDIS Act. The IAC can provide advice either on its own initiative or at the written request of the Board (NDIA 2017j).

A Parliamentary Joint Standing Committee on the National Disability Insurance Scheme was established in 2013 to review the implementation, administration, performance, governance

and expenditure of the NDIS, and other NDIS-related matters referred to it by parliament (JSCNDIS 2017b; NDIA 2016b, p. 131). To date, the Committee has provided two progress reports on the implementation and administration of the NDIS, a progress report on general issues around implementation and performance, an interim report on the provision of hearing services under the NDIS and completed an inquiry into services for people with psychosocial disabilities related to a mental health condition.

Different arrangements for Western Australia

Western Australia has different governance arrangements for the NDIS to the rest of Australia. While it is intended to provide similar supports to the national scheme, the Western Australian NDIS (WA NDIS) is:

- administered by the Western Australian Government, not the NDIA
- funded differently (chapter 12)
- being rolled out one year later than the national scheme (2017-18) (box 11.1).

Box 11.1 The NDIS in Western Australia

In January 2017, the Western Australian and Australian Governments signed a Bilateral Agreement for the implementation of the WA NDIS. Under this agreement, Western Australia will have a locally administered scheme, but the scheme is to be consistent with the national NDIS. The WA NDIS began rollout on 1 July 2017 (one year later than the national scheme).

Unlike the national scheme, the WA NDIS will be managed by the State Government under State legislation. A WA NDIS authority will be established to manage the scheme which, similar to the NDIA, will have a Board and Independent Advisory Committee.

The intention is that the WA NDIS will be consistent with the national scheme in a number of areas, including:

- eligibility requirements
- the core principles, including access to reasonable and necessary supports, choice and control and guaranteed portability
- the application of the National Quality and Safeguarding Framework
- the complaints and appeals process, which will mirror the national process including access to the Administrative Appeals Tribunal
- reporting requirements, including the requirement to report quarterly to the DRC
- other governance arrangements, including relevant Rules under the NDIS Act
- contributions to policy at the national level by the Western Australian Government.

Sources: Australian Government and Western Australian Government (2017); WADSC (2017).

Are the current governance arrangements effective?

The high-level governance arrangements for the NDIS mostly reflect those recommended by the Commission in its 2011 inquiry on *Disability Care and Support*, and provide a solid foundation for delivering the scheme and managing financial sustainability.

One difference is the Australian Government minister responsible for the NDIS. In 2011, the Commission recommended that the Australian Government Treasurer be the responsible Minister for the NDIS because of the proposed commercial focus of the NDIA, and the need to ensure strong cost controls, insurance characteristics, long-run sustainability and appropriate management of funds (PC 2011, p. 432). The Commission envisaged other ministers, such as the Minister for Social Services, playing a prominent role in disability policy.

However, instead, the Australian Government Minister for Social Services has primary responsibility for the NDIS. There is a risk that the intention that the scheme be firmly based on insurance principles will be less evident by placing it in a department that deals with welfare programs.

The following sections discuss areas of concern about the governance arrangements.

11.2 Lack of clarity around roles and responsibilities

While the high-level governance arrangements for the scheme are clearly set out in the NDIS Act, the Heads of Agreements, the Bilateral Agreements and other policy documents, there is a lack of clarity in practice around roles and responsibilities. For example, there is a lot of confusion about the role of Local Area Coordinators (LACs). DARE Disability Support said:

> DARE's understanding of the role initially envisaged for the LACs, namely frontline problem solving and assistance with plan implementation, appeared to change shortly before transition to planning and the Coordination of Supports for non-complex participants, surely a foreseeable gap in NDIS planning resources. (sub. 182, p. 7)

The confusion is probably, in part, because the NDIA experimented with different delivery models for LACs before settling on the current outsourced model (NDIA, sub. 161, p. 4), and because LACs were diverted away from their intended activities towards planning-related tasks. As the NDIA said:

> The need to meet bilateral estimates has also meant that for the first period of transition the NDIA has asked LAC partners to divert their resources into information gathering to facilitate the approval of plans and implementation of plans. (sub. 161, p. 56)

There is also a lack of clarity around the responsibilities of the NDIS and mainstream services, and how governments are approaching continuity of support (chapter 6). As noted by the Department of Social Services (DSS):

> The Council of Australian Governments (COAG) agreed principles to determine the responsibilities of the NDIS and mainstream service systems, which are generally sound, but need clarifying at an operational level. (sub. 146, p. 4)

The Commission is recommending that the Australian, State and Territory Governments make their approach to continuity of care, and the services they intend to provide, public and that a standing agenda item be added to the agenda of the relevant COAG Councils to address how mainstream services interface with the NDIS (chapter 6).

Other areas in need of greater clarity include supply side arrangements, including the roles and responsibilities of Australian, State and Territory Governments around market stewardship (recommendation 10.5).

Given the scale and complexity of the scheme, and the focus on insurance principles — which involves ongoing monitoring and refining of the scheme — some uncertainty and changes to roles, responsibilities and processes is inevitable, especially while the scheme is in transition. However, it is crucial that governments and the NDIA continue to work to ensure clarity and transparency in the governance arrangements so they do not undermine accountability and put the success of the scheme at risk.

11.3 NDIS Rules

The NDIS Rules are legislative instruments that provide more detail than the NDIS Act on the operation of the NDIS (NDIA 2017m). The Australian, State and Territory Governments are jointly responsible for the NDIS Rules. There are four categories of NDIS Rules (box 11.2). The Minister for Social Services has overarching responsibility for making Rules, and each Category requires a different level of involvement or agreement from State and Territory Governments. The Minister can also delegate the power to make Rules to the CEO of the NDIA, with the agreement of State and Territory Governments (NDIS Act, s. 201). NDIS Rules are disallowable instruments which means they are tabled in Parliament and open to Parliamentary veto or disallowance for fifteen sitting days. If a motion is brought to disallow an instrument, Parliament has an additional fifteen sitting days to vote on or withdraw the motion (Parliament of Australia 2017).

Most of the Rules currently in force are either Category A or Category B Rules. Category A Rules cover most of the sections of the NDIS Act, including (but not limited to) extra guidelines and information on disability and early intervention requirements, what must be included in plans, and the statement of participants' supports. Category A Rules require unanimous agreement from the Australian Government and each State and Territory Government (NDIS Act, s. 209).

Box 11.2 Categories of NDIS Rules

There are four main categories of NDIS Rules.

- Category A — The Australian Government and each host jurisdiction must agree to the Rule.
- Category B — The Australian Government and the specific host jurisdiction that the Rule relates to must agree to the Rule.
- Category C — The Australian Government and a majority of host jurisdictions must agree to the Rule.
- Category D — Each host jurisdiction must be consulted on the Rule (NDIS Act, s. 209).

In addition, under sections 125B and 180C of the NDIS Act, the Minister responsible for the *Insurance Act 1973* (Cwlth) can make Rules related to the management of risk and the Scheme Actuary's duties.

Most of the current NDIS Rules are either Category A Rules (requiring unanimous agreement) or Category B Rules (requiring agreement between the Australian Government and the relevant host jurisdiction).

Category A Rules

The current Category A Rules cover areas such as:

- rules to assist in determining who can become a participant, including extra details about age, residence and early intervention requirements (*National Disability Insurance Scheme (Becoming a Participant) Rules 2016* (Cwlth))
- requirements in determining representatives for children, and what that child's representative must comply with (*National Disability Insurance Scheme (Children) Rules 2013* (Cwlth))
- nominees, including their appointment, duties and cancellation and suspension (*National Disability Insurance Scheme (Nominees) Rules 2013* (Cwlth))
- how supports in a participant's plan should be specified and how to assess whether it would pose an unreasonable risk for a participant to manage their own plan (*National Disability Insurance Scheme (Plan Management) Rules 2013* (Cwlth))
- criteria for approving registered providers of supports and requirements registered providers of supports must comply with (*National Disability Insurance Scheme (Registered Providers of Supports) Rules 2013* (Cwlth))
- funding of Specialist Disability Accommodation (*National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* (Cwlth)).

Category B Rules

Category B Rules are jurisdiction-specific Rules. They generally relate to the schedules for phasing participants into the scheme (such as the Rules regarding the preparation of participant plans), or the specific State and Territory laws that prevent a person providing certain information to the NDIA (*National Disability Insurance Scheme (Protection and Disclosure of Information) Rules 2013* (Cwlth)).

Are the arrangements for NDIS Rules affecting scheme costs?

Some concerns were raised by study participants about the governance arrangements for Rule changes. Both the NDIA and the DSS pointed to the length of time it can take to introduce or amend NDIS Rules.

> The process for amendment of the NDIS Rules requires agreement from a majority or all (depending on the rules) of the States and Territories. Recent experience of seeking amendments to rules is that the process takes considerable time. (NDIA, sub. 161, pp. 48–49)

> This has proved cumbersome and complicated for most rules and other actions, such as making appointments and issuing directions, requiring unanimous agreement by the Commonwealth and the States. This can delay the timely sign-off of amendments, and can potentially impact timely direction being provided to the NDIA. (DSS, sub. 146, p. 32)

The NDIA and the DSS both raised the example of the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* (Cwlth) (Category A Rules), which required unanimous agreement from the Australian, State and Territory Governments. According to the DSS (sub. 146, p. 32), it took about 10 months to implement these Rules. The NDIA (sub. PP327, p. 58) also argued it 'experienced similar implementation times with the Registered Providers of Support Amendment Rules and the NSW Prescribed Program Rules'. In a transition period of three years, such timeframes could pose significant operational difficulties for the NDIA.

That said, the South Australian Government (sub. PP354, p. 12) argued that 'while agreement of the [Specialist Disability Accommodation] Rules took time, the final product much better addresses critical issues for states and territories'. The Tasmanian Government also said that, to date, the majority of Category A Rules have been agreed to in a timely manner.

> Despite the one example cited in the PC's position paper, the majority of Category A Rules, covering complex, detailed and technical matters, including how the scheme interacts with state and territory systems, have been developed and agreed by jurisdictions in a highly collaborative and timely manner. (sub. PP247, p. 10)

Can the arrangements be improved?

Some study participants called for changes to the way Rules are made, to make implementation and amendments more responsive and timely. One option supported by some study participants was to relax the requirement that Category A Rules have unanimous agreement from the Australian, State and Territory Governments (for example, AFDO, sub. PP325, p. 10; New South Wales Government, sub. PP230, p. 9). The Victorian Government noted:

> Victoria supports governance arrangements that are as responsive and streamlined as possible. Victoria supports relaxing the requirement of unanimous agreement of all jurisdictions to change some Category A NDIS Rules … to either require majority agreement or, in some cases, consultation. (sub. PP298, p. 21)

However, not all study participants were supportive of this approach. For example, the Tasmanian Government argued that the requirement for unanimous agreement reflects the fact that Category A Rules influence the boundaries of the scheme and, therefore, state and territories' non-NDIS disability and mainstream service provision.

> … NDIS design features such as eligibility and scope of supports have direct and indirect consequences for, and costs to, state systems. It is therefore appropriate that these features, established through the NDIS Category A Rules under the NDIS Act, remain subject to the agreement of all host jurisdictions. The Tasmanian Government does not support any changes to the current Rule-making arrangements with respect to Category A Rules concerning access and reasonable and necessary supports. (sub. PP247, p. 10)

Similarly, the Northern Territory Government said:

> The NT Government recognises the Commonwealth and NDIA's frustration regarding the delay in gaining authorisation from all jurisdictions to make amendments or introduce rule changes to the NDIS. However there is an inherent risk to states and territories relaxing unanimous agreement around rule changes. (sub. PP359, p. 6)

Some non-government study participants also argued against change. For example, Legal Aid NSW said it:

> … acknowledges concerns around delay in changes to the NDIS Rules, but is not supportive of relaxing the requirement for unanimous agreement from the Australian Government and all host jurisdictions. We see this requirement as an important safeguard. If all host jurisdictions were not required to agree to changes, we see a risk that the Commonwealth would make changes to the Rules to contain costs. (sub. PP245, p. 14)

Victoria Legal Aid also cautioned against providing any person (including the NDIA CEO) the power to bypass the usual process for implementing or amending Rules.

> We urge caution in giving the NDIA CEO, or any other person, the power to alter or bypass the process for amending Rules made under section 209 of the NDIS Act. The Rules are the key tool for decision making under the scheme and the process for their amendments reflect the significant impact any changes will have for participants, State Governments and service providers. … In our view it is a key priority to ensure consultation and proper consideration of the impact of changes with potentially wide ramifications for participants of the scheme before they are implemented. (sub. PP367, pp. 3–4)

Another option is to change the process for agreeing to NDIS Rules without relaxing the requirement for unanimous agreement. Some States and Territories were supportive of changing the process to improve its speed. The South Australian Government (sub. PP354, p. 12) stated it is 'open to considering changes that enhance the agility of Scheme governance'. The Northern Territory Government also said:

> … an alternative may be to develop nationally agreed key principles to provide overarching guidance to the consideration of rule changes when they occur. For example, one of the principles could include minimum timeframes for jurisdictions to respond to proposed new rules or changes. (sub. PP359, p. 6)

Risks could be reduced by more timely agreement on Rules

Governance arrangements need to be sufficiently flexible so that the NDIA and governments can respond quickly when circumstances arise that could threaten the financial sustainability of the scheme. Implementing or changing Rules can be a lengthy process, especially as they are subject to the disallowance process. However, changes to the process for agreeing to Category A Rules can be made to help ensure they are implemented in a timely manner.

While relaxing the requirement for unanimous agreement, such as to majority agreement, could decrease the time it takes to implement Rules, there are problems with this approach. Category A Rules cover much of the Act, and the current Category A Rules influence the boundaries of the scheme. For example, the National Disability Insurance Scheme (Becoming a Participant) Rules 2016 (Cwlth) include detail on the processes used to determine eligibility. As the NDIS Rules can influence who becomes a scheme participant, they can also influence who does not become a participant and therefore may need to rely on mainstream or specialist disability support services provided by State and Territory Governments. Many scheme participants will also need to access mainstream and disability service support provided by State and Territory Governments.

The involvement of State and Territory Governments in disability and mainstream service support exposes them to considerable risk and they should therefore continue to have a say over the design and boundaries of the NDIS. Given the State and Territory Governments' considerable experience in disability service provision, they are also likely to have valuable knowledge and expertise for designing and refining the scheme.

The Commission does not recommend that the requirement for agreeing to Category A NDIS Rules be changed from unanimous agreement. Instead, the process should be changed to encourage timely agreement to Rules without diluting the control of States and Territories. This could be done, for example, by requiring governments to state whether they agree or disagree to a proposed rule introduction or change within a certain amount of time. No response could be taken as agreement to the proposal.

RECOMMENDATION 11.1

The *National Disability Insurance Scheme Act 2013* (Cwlth) should be amended to change the process for agreeing to Category A Rules to reduce the time it takes to implement or amend those rules.

The amendment should not change the requirement that there be unanimous agreement among the Australian Government and the host jurisdictions for implementing or amending Category A Rules.

11.4 Structure and governance of the NDIA

It is essential that the NDIA has the correct governance model and appropriate level of independence so that is can effectively manage the NDIS in line with insurance principles.

In 2011, the Commission assessed different options for the NDIA's governance model (PC 2011) and found that the most appropriate model was a corporate governance model, independent from day-to-day government operations with clear accountability and reporting requirements. To achieve this model, the Commission recommended that:

- the NDIA be established as an independent Commonwealth statutory agency (now called a corporate Commonwealth entity) under the *Commonwealth Authorities and Companies Act 1997* (Cwlth) (no longer in force but now covered by the PGPA Act)
- the NDIA be overseen by a skills-based board, chosen by an appointment panel established jointly by the Australian, State and Territory Governments. The Board would have the sole power to appoint and dismiss the CEO
- the Australian, State and Territory Governments establish an advisory council to advise the Board
- the NDIA be provided with its own legislation that specifies its objectives, functions and governance arrangements, and future changes to key features of the scheme should be undertaken only by explicit changes to the Act, in consultation with all State and Territory Governments
- the arrangements between the NDIA and governments be at arm's length, and subject to strict transparency requirements (PC 2011).

The current governance arrangements of the NDIA (as outlined in section 11.1) largely reflect what was recommended in 2011. The NDIA is a corporate Commonwealth entity (box 11.3) under the PGPA Act. And while, under the NDIS Act, the Minister was responsible for appointing the first CEO (in consultation with State and Territory Governments), the NDIA Board is responsible for appointing or dismissing all subsequent CEOs (NDIS Act, s. 160).

The NDIA's high-level structure and level of independence is similar to the corporate structures of the Transport Accident Commission in Victoria and Insurance and Care New South Wales (*State Insurance and Care Governance Act 2015* (NSW); *Transport Accident Act 1986* (Vic)).[88]

There is, however, one key difference in the structure of the NDIA compared with what was envisioned by the Commission in 2011. When discussing the need for the NDIA to be a Commonwealth statutory authority (corporate Commonwealth entity), in 2011, the Commission noted that this type of agency 'would generally not engage staff under the

[88] Insurance and Care New South Wales was established in 2015 to administer the New South Wales Government compensation, insurance and care schemes. It includes the Lifetime Care and Support Scheme (icare 2017).

Public Service Act unless there were good reasons to do so' (PC 2011, p. 423). The NDIA engages its staff under the *Public Service Act 1999* (Cwlth) (NDIS Act, s. 169).

Box 11.3 Governance structures for Commonwealth bodies

The three main types of Commonwealth bodies are non-corporate Commonwealth entities, Corporate Commonwealth entities and Commonwealth companies. The financial and governance arrangements of these different bodies are set out in the PGPA Act and PGPA Rules, the *Corporations Act 2001* (Cwlth), entity-specific legislation or administrative arrangements.

Non-corporate Commonwealth entities

Non-corporate Commonwealth entities are legally and financially part of the Commonwealth. Entities are usually established as a non-corporate Commonwealth entity if they need direct accountability to the Parliament, will be primarily budget funded, need to be subject to Australian Government policies, will raise money or perform regulatory activities under Commonwealth law, or if they need to be classified as part of the general government sector. Government departments are an example of non-corporate Commonwealth entities.

Corporate Commonwealth entities

Corporate Commonwealth entities are separate legal entities from the Commonwealth. They can exercise certain legal rights such as entering into contracts and owning property. Entities might be established as corporate Commonwealth entities if:

- they will operate commercially or entrepreneurially;
- a multi-member accountable authority (such as a board of directors) is needed;
- it would be best that its assets are not owned or controlled by the Commonwealth directly;
- it requires a degree of independence from general Australian Government policies and executive government direction.

Corporate and non-corporate Commonwealth entities are generally subject to the same planning, performance and accountability requirements under the PGPA Act. However, corporate Commonwealth entities may have different provisions, such as those relating to banking, borrowing, and investments. Corporate Commonwealth entities also often have their own legislation that sets out its powers and can impose additional governance, reporting and accountability requirements. Examples of corporate Commonwealth entities include the Reserve Bank of Australia and the CSIRO.

Commonwealth companies

Commonwealth companies are bodies established under the Corporations Act that are controlled by the Commonwealth. An entity will generally be established as a Commonwealth company if two or more of the following apply: it will primarily conduct commercial or entrepreneurial activities and will generate profits for distribution to its members; it will operate in a commercial or competitive environment; or it is likely to be sold off by the Commonwealth in the short to medium term. Examples of Commonwealth companies include the NBN Co and the Australian Rail Track Corporation.

Sources: Department of Finance (2017a, 2017b, 2017c); PGPA Act.

Retention of the NDIA's independence is critical

While governments are responsible for determining the scope of the NDIS and its high-level funding, the NDIA should be given the independence to operate the scheme on a day-to-day basis. Some study participants highlighted the importance of, and raised some concerns about, the NDIA's level of independence (CYDA, sub. 188; National Disability and Carer Alliance, sub. PP344). For example:

> Victoria supports clarifying governance and accountability arrangements so as to provide the NDIA with the operational autonomy that was originally envisaged … The NDIA needs to be properly resourced and operate with sufficient authority so that it can implement the NDIS on the basis of robust insurance principles. (Victorian Government, sub. PP298, p. 21)

> It is also important that NDIA retain its status as an independent statutory authority. The independence of the agency responsible for administering the scheme was one of the key issues during the campaign for the introduction of the NDIS. An independent agency with its own board (including board members with disability) helps to ensure the vision of the scheme is realised and it is not subject to the changing priorities of successive governments. It is also important that the independence of the agency's decision making is not compromised or undermined by interference in day to day operational issues. Structural and systemic issues lie with the governments who work in partnership to deliver the scheme — day to day operational issues should lie with the NDIA. And the NDIA should be held to account by its own board and COAG should they fail to administer the scheme efficiently and effectively. (AFDO, sub. PP325, p. 24)

In addition, Bruce Bonyhady (sub. PP333, p. 20) raised concerns about the Australian Government's control over the NDIA, and the NDIA (sub. 161, p. 108) argued for some changes to the administrative and governance arrangements including greater flexibility to use funding allocated to package costs and greater protection for the role of the NDIA's Operational Guidelines in managing scheme costs.

The Commission identified two aspects of the governance arrangements that could hinder the NDIA's ability to effectively and independently operate the scheme — the cap on its operating costs and staffing-related concerns. (The level of independence regarding funding arrangements is discussed in chapter 12.)

Beyond these, the Commission received insufficient evidence to conclude that any significant changes to governance arrangements are required to ensure the NDIA has enough independence to undertake its functions. The high-level governance structure appears to provide the NDIA with sufficient independence from day-to-day government control. It is nevertheless important that, as the scheme develops, there are no structural barriers to the NDIA exerting an appropriate level of independence and developing a culture conducive to running the scheme in line with insurance principles. The governance of the NDIA and NDIS should be considered as part of the five-yearly reviews into NDIS costs.

The NDIA's capped operating costs

At full scheme, the NDIA's operating costs will be capped at 7 per cent of package costs each year (NDIA, sub. 161, p. 110). The 7 per cent operating cost target is similar to that estimated by the Commission in 2011 (PC 2011, pp. 776–7).

The rationale for capping the operating expenses of the NDIA appears to be to encourage administrative efficiencies. The DSS (sub. 146, p. 24) commented that the 7 per cent cap was 'an aspirational approach designed to encourage best practice and efficient operations'.

However, capping operating expenses could have perverse outcomes in practice. As noted in the NDIA's Annual Financial Sustainability Report, the risks to the scheme's financial sustainability from the setting of operating expense budgets are asymmetric:

> It is worth noting that a 10% increase in the operating budget may result in additional expenditure of approximately $150 million at full scheme, however an increase in package costs of 10% could result in an additional $2 billion at full scheme. (NDIA 2016a, p. 56)

In addition, if the NDIA's operating budget is set too tightly, this could hinder its ability to implement upfront investments, such as in LACs, assessors and planners, which could in turn have a significant effect on package costs and scheme sustainability.

Operating costs made up about 33 per cent of scheme costs in June 2016 (NDIA 2016b, p. 109). To achieve a 7 per cent target by full scheme, the NDIA will need to cut operating expenditure by about 18 per cent ($250 million) between 2018-19 and 2019-20 (box 11.4).

While similar types of schemes operate close to a 7 per cent average when they are close to maturity, they still have significant fluctuations in their annual operating expenses as a proportion of their overall expenses (box 11.4).

A number of study participants argued that the 7 per cent cap at full scheme is too low (for example, AFDO, sub. PP325, p. 24; ABF, sub. 48, p. 15; PDCN, sub. 29, p. 4; Sotica, sub. 67, p. 9). The Victorian Government also said that there are risks to holding the NDIA to a specific operating cost target:

> The NDIA has been set an operating cost target of 7 per cent of total scheme costs at full scheme. Given that the major risk to total scheme costs is package costs, which comprise around 90 per cent of total costs, it would be a mistake to hold the NDIA to an operating cost target if capping administrative costs threatened increases in package costs due to inadequate quality control or oversight. (sub. PP298, p. 10)

While the Commission understands the need to create incentives for administrative efficiencies, a hard cap for operating expenses enforced year in, year out does not align with the way an insurance scheme operates. Greater flexibility (including setting an operating budget that sits within a funding range) would allow investments in administrative functions to be made that reduce lifetime costs (for instance, investing in LACs early to increase participant capacity and readiness which could lower costs in the long term).

Box 11.4 Operating expenses of the NDIA and comparable schemes

The NDIA's operating expense ratio is projected to decrease to less than 7 per cent at full scheme.

NDIS expenses by category ($ millions)[a]

	2015-16 (actual)	*2016-17 (actual)*	*2017-18 (projections)*	*2018-19 (projections)*	*2019-20 (projections)*	*2020-21 (projections)*
Package costs	859.9	2 973.0	8 045.1	14 267.1	17 855.8	19 165.5
Information, Linkages and Capacity Building program	10.7	33.3	68.9	105.3	119.3	118.6
Operating expenses	301.2	704.9	1 033.0	1 393.9	1 143.9	1 096.2
Total scheme costs	1 171.7	3 711.2	9 147.0	15 766.2	19 119.1	20 380.3
Operating expense ratio (%)[b]	35.0	23.7	12.8	9.8	6.4	5.7

[a] Excludes Western Australia. [b] The expense ratios differ from NDIA targets and estimates because the NDIA and the DSS use different projections of scheme costs.

Comparable schemes, such as the New Zealand Accident Compensation Commission and the Victorian Transport Accident Commission have operating expense ratios close to a 7 per cent average, but they have significant fluctuations in their annual operating expense ratios.

Operating expense ratios of comparable schemes (per cent)[a]

	2010-11	*2011-12*	*2012-13*	*2013-14*	*2014-15*	*2015-16*	*Average*[b]
NZ Accident Compensation Corporation	14.34	6.0	22.9	11.2	7.4	4.9	8.3
NSW Lifetime Care and Support[c]	2.7	3.6	3.6	3.7	4.0	8.4	3.3
VIC Transport Accident Commission	8.5	4.6	11.7	7.4	6.0	4.8	6.4
Disability services nationwide[d]	7.6	7.4	6.6	6.5	6.2	6.4	6.8

[a] The ratio of average operating expenses between 2010-11 to 2015-16 to the average total expenses over the same period. [b] The average is calculated as the ratio of the average of operating and total expenses over time. [c] New South Wales Lifetime Care and Support changed its reporting methodology in 2015-16, and therefore, this number may not be comparable with previous years and has been excluded from the calculation of the average operating expense ratio. [d] Data for 2013-14 to 2015-16 are affected by the introduction of the NDIS.

Sources: ACC (2012, 2013, 2014, 2015, 2016); Australian Treasury (2016, 2017d); icare (2016a); LCAS (2012, 2013, 2014, 2015); SCRGSP (2017); TAC (2012, 2013, 2014, 2015, 2016).

One way to balance flexibility with accountability would be to allow a target range for operating expenses, with the expectation that the NDIA would sit at the bottom of this target on average. This would allow the NDIA some flexibility to smooth out year-to-year fluctuations in spending while also placing some limits on administrative spending. A number of study participants were supportive of this approach (for example, AFDO, sub. PP325, p. 11; PDA, sub. PP306, p. 5; Tasmanian Government, sub. PP247, p. 11; VALID, sub. PP332, p. 11; Victorian Government, sub. PP298, p. 10).

Based on similar types of schemes, a target of 7 to 10 per cent appears to be reasonable. The NDIA agreed:

> Providing expenditure flexibility at Full Scheme, within a range of 7 percent to 10 percent of package costs would allow the NDIA to make appropriate upfront investments, consistent with insurance principles. The investments would seek to optimise overall Scheme experience and participant outcomes, while reducing future Scheme outlays. (sub. PP327, p. 65)

Should the NDIA exceed the funding target in a particular year, it should be required to publicly report the reasons why. The NDIA (sub. PP327, p. 65) regarded a requirement to report on why the target had not been met as appropriate.

RECOMMENDATION 11.2

At full scheme, the annual operating budget for the National Disability Insurance Agency should be set within a funding target of 7–10 per cent of package costs with the expectation that, on average, it would sit at the lower end of the band.

The National Disability Insurance Agency should be required, in its annual report, to state the reasons why it has not met this target in any given year.

NDIA staff cap

The NDIA, like most Australian Government agencies, is currently subject to a staff cap, which sat at 1749 in 2016-17 (NDIA, sub. PP327, p. 65). At full scheme it will have a cap of 3000 directly employed staff (DSS, sub. 146, p. 24). It is expected that the NDIA will require a workforce of about 10 000 people to deliver the NDIS at full scheme, which means that about 7000 people will be outsourced to partner organisations (DSS, sub. 146, p. 24; NDIA, sub. 161, p. 63).

The rationale for the cap on directly employed staff appears to be to encourage the NDIA to enter into community partnerships. While it is important that the NDIA works collaboratively with the community to deliver the scheme, it could also lead to poorer outcomes. For example, the NDIA outsourcing a lot of its work can present a particular risk when the agency is so new and needs to build institutional expertise and capability (NDIA, sub. PP327, p. 66). This is especially the case in light of the problems with the planning process (chapter 5).

Independent agencies, such as corporate Commonwealth entities (and state-based equivalents), are usually given the autonomy to independently run their organisations. Similar non-Commonwealth organisations, such as the Transport Accident Commission, also generally do not have staff caps.

The Commission recommends that the Australian Government remove the cap on directly employed staff. This is on the basis that the NDIA is best placed to determine the most

effective and efficient staff mix to deliver the scheme, within the constraints of its capped operating budget.

Reconsidering the staff cap on directly employed staff was supported by some study participants (for example, ABF, sub. PP263; CPSU, sub. PP310, p. 5; PWSAA, sub. PP228, p. 9; Queensland Government, sub. PP345, p. 26; South Australian Government, sub. PP354, p. 13; Tasmanian Government, sub. PP247, p. 11; Victorian Healthcare Association, sub. PP337, p. 4). The Victorian Government said:

> The NDIA should also have more flexibility over its staffing arrangements … This would enable it to rely less on secondments from the Commonwealth Department of Social Services, which risk compromising the NDIA's operational autonomy and may lead it to take an overly welfare-based approach. (sub. PP298, p. 2)

The NDIA (sub. PP327, pp. 65–66) also said that the staff cap might constrain its ability to adopt new service delivery models that could arise from the participant and provider pathway reviews.

In contrast, JFA Purple Orange (sub. PP350, p. 27) did not support reconsidering the staff cap, arguing instead that the NDIA should make greater use of the community sector. The Commission considers there is scope for the NDIA to make greater use of the community sector's expertise, but this can be achieved through other means.

RECOMMENDATION 11.3

The Australian Government should remove the cap on staff employed directly by the National Disability Insurance Agency.

Employment of NDIA staff

As discussed above, the NDIA employs staff under the Public Service Act. This reduces the NDIA's independence in making staffing decisions, particularly around salary and conditions. It could also affect the 'cultural independence' of the Agency and contribute to a perception that it is more of a government agency rather than an independent insurance scheme. As of 1 July 2017, about 65 per cent of corporate Commonwealth entities did not employ staff under the Public Service Act (Department of Finance 2017b).

However, the Commission did not receive any evidence that this staffing arrangement has affected, or is affecting, the NDIA's independence or culture (or scheme costs or participant outcomes). But, as the scheme and the NDIA develop over time, the appropriateness of employing NDIA staff under the Public Service Act should be reassessed.

11.5 Western Australian NDIS

As noted above, Western Australia has not signed up to the national scheme. This section looks at whether the governance arrangements for the WA NDIS will affect financial sustainability. The funding arrangements are discussed in more detail in chapter 12.

Will two schemes affect financial sustainability?

In 2011, the Commission recommended a single national scheme, and a single national agency, to provide disability care and support across the country (PC 2011, pp. 424, 448). There are costs involved in implementing two systems. There is the cost of two sets of legislation — the NDIS Act and the proposed Western Australian legislation. There are also additional costs associated with setting up a separate agency in Western Australia to administer the WA NDIS (in addition to setting up the NDIA), and any associated loss of economies of scale that could ensue from having a single agency. Having two agencies could also mean that it takes longer for lessons learned from the national scheme to be adopted in Western Australia and vice versa.

There could, however, be benefits to Western Australia having its own scheme. For example, a WA NDIS could allow increased flexibility and an ability to quickly adapt to changing Western Australian conditions. While the scheme is intended to mirror the national scheme in many aspects, including most parts of the NDIS Act and the NDIS Rules, the fact that the NDIA has its own detailed operational guidelines for its functions suggests that mirroring the legislation allows for significant flexibility. This flexibility could lead to a divergence in the supports provided to scheme participants and participant outcomes between Western Australia and the rest of Australia.

There were two trials of the NDIS in Western Australia — one managed by the NDIA and the other by the Western Australian Government. There are two reviews that compared the trials in Western Australia.

- One review identified key features for an effective disability support model for Western Australia, and made a number of recommendations to address gaps in processes. It found that the Western Australian-managed trial required fewer changes in policy and processes to achieve an effective model than the NDIA-managed trial (Stantons International 2016).[89]
- The WA NDIS and the NDIS Actuaries also undertook an assessment of the two Western Australian trials. The results of the evaluation are not public.

[89] The limitations of this review should be noted. It compared and contrasted the processes related to plan preparation, activation, operation and review. It did not compare actual outcomes of participants in the two trials — this was not feasible due to the timing of the review — nor did it compare the costs of the different approaches (Stantons International 2016).

Many study participants supported Western Australia joining the national scheme, with their key concern being that inequities in disability support across jurisdictions could emerge if they remain outside the scheme (box 11.5).

Box 11.5 Many study participants supported WA joining the national scheme

Down Syndrome Australia:

> Down Syndrome Australia, as a federation of state and territory Down syndrome organisations, has advocated strongly for WA to be part of the national scheme. DSA is very concerned that people with Down syndrome in WA will not get an equitable level of support, nor the choice and control nor long-term certainty of the national scheme. (sub. 121, p. 20)

Disabled People's Organisations Australia:

> DPO Australia is very concerned about the decision by the previous Western Australian Government to establish its own NDIS. Despite a number of nationally consistent provisions in the bilateral agreement, it is concerning that the WA NDIS will have different funding arrangements and accountabilities and a greater focus on service provider control. This is highly likely to prevent market growth and innovation for people with disability in WA and create inequities in the provision of specialist disability support in WA. (sub. 165, p. 10)

Matt Burrows:

> Without WA signed up to a national Scheme, the entire Scheme is at risk. The entire Scheme is not sustainable as a *national* reform unless all States and Territories are signed up to it. (sub. 7, p. 4)

Community Mental Health Australia:

> The announcement that Western Australia (WA) would be implementing its own state-based system has immediately created a situation where there will not be a nationally consistent scheme … (sub. 11, pp. 1–2)

Queensland Advocacy Incorporated:

> [Western Australia's agreement with the Australian Government] undermines that nationally consistent approach and increases state and territory variation. (sub. 115, p. 18)

Department of Social Services:

> DSS agrees with the Commission's recommendation that WA should join the NDIA-delivered NDIS to ensure national consistency and sustainability … DSS is providing all information requested to support the WA government to make a decision about the NDIS, and is committed to working with WA to ensure that Western Australians have influence over how the NDIS is delivered in their State. (sub. PP318, p. 20)

However, some study participants said there would be benefits in Western Australia having its own scheme. For example, National Disability Services said:

> NDS supports disability service providers in WA who want a nationally consistent NDIS that provides local accountability and that recognises and respects local needs and conditions and the complexities of delivering services in regional, rural and remote areas. WA providers have little confidence that an Agency based in Geelong will be sufficiently responsive to local issues in WA. They would prefer a well-resourced and skilled agency based in WA believing that it would be best-placed to deliver and oversee the transition to the NDIS in that State. (sub. PP295, p. 10)

In April 2017, it was reported that the Western Australian Government was undertaking a review of the decision to implement the WA NDIS and that joining the national scheme was still an option (Emerson, Wearne and Carporn 2017). The outcome of this review had not been reported publicly at the time this report was finalised. Study participants were concerned about the uncertainty this situation created, and highlighted the importance of this decision being publicly communicated as soon as possible.

> WALGA supports that a decision should be made soon as this additional layer of uncertainty further complicates Local Government's current position and stalls any decision making process. Without a decision, clarity around government's roles and responsibilities makes planning difficult and moving forward to serve communities and individuals very limited. (WALGA, sub. PP320, p. 8)

> We agree that any decision on the future scheme to be embedded in Western Australia should be made public as soon as possible. (Activ, sub. PP302, p. 12)

> The ongoing arrangements for the NDIS in Western Australian should be finalised as soon as possible to remove uncertainty for people with disability, their families and carers and providers. (NDS, sub. PP295, p. 10)

Under the Bilateral Agreement between the Western Australian and Australian Governments, there are to be regular reviews of the state legislation, the first occurring two years after the commencement of the WA NDIS (Australian Government and Western Australian Government 2017). While the terms of reference for these reviews are yet to be agreed, they will include the extent to which the WA NDIS is achieving consistency with the agreed provisions in the NDIS Act. If the WA NDIS is to proceed as agreed under the Bilateral Agreement, these reviews will be important for ensuring consistency between the two schemes, and that people with disability in Western Australia are not disadvantaged by not being part of the national scheme.

It is still the Commission's view that there should be a national scheme and Western Australia should be in the NDIS. There are benefits of having a national scheme (as identified in the Commission's 2011 inquiry) and there are additional costs with two schemes. Where there is evidence that different processes in the Western Australian-managed trial have resulted in better outcomes for participants than under the national scheme, these processes should be considered for the national scheme. Regardless of whether Western Australia joins the national scheme or not, it is essential that the outcome of the review and any decisions be made public as soon as possible, to minimise uncertainty for scheme participants, providers and other governments.

RECOMMENDATION 11.4

The Western Australian Government and Australian Government should put in place arrangements for Western Australia to transition to the National Disability Insurance Scheme. Any decision to join the national scheme should be made public as soon as possible.

11.6 Review processes

Processes for resolving disputes are essential to achieving good outcomes and promoting confidence in the scheme. There are two types of *internal review* processes that can be accessed by those dissatisfied with an NDIA decision.

- *An unscheduled plan review* — a scheme participant can request that the NDIA conduct a review of their plan. The NDIA must decide within 14 days whether or not to conduct the review, begin the review within 14 days of that decision, and complete the review as soon as reasonably practicable (NDIS Act, s. 48). (This process is distinct from the periodic plan review discussed in chapter 5.)
- *A review of a decision* — a number of reviewable decisions relating to the NDIA are set out under s. 99 of the NDIS Act, including decisions regarding eligibility, supports provided and registration of providers. When the NDIA makes a reviewable decision, it must give written notice to each person directly affected informing them of the option for review. The person then has three months to request a review and the review must be completed as soon as reasonably practicable (NDIS Act, s. 100).

There are also *external review* processes for resolving disputes. If a person is dissatisfied with the outcome from a review of a decision (not an unscheduled plan review), they can apply to the Administrative Appeals Tribunal (AAT) to undertake a merit review within 28 days of the review decision (or apply for an extension of time). If the entity is dissatisfied with the outcome of the AAT review, they can appeal the decision in the Federal Court, but only if it is a question of law (NDIA 2017aa).[90]

Are the review processes appropriate and effective?

Some study participants argued the review processes are not as appropriate and effective as they could be. First, there is confusion about the two types of internal NDIA reviews. The NDIA said it:

> … is aware that there has been confusion around avenues for reviews of decision[s] (especially given the word 'review' is used in the legislation to refer to two different [processes] in relation to planning). (sub. 161, p. 94)

The Commonwealth Ombudsman also commented:

> … the distinction between an 'internal review' [a review of a decision by the NDIA] and a 'plan review' often seems to be lost on participants and their representatives. This situation was demonstrated in a recent AAT decision, *Bridgland and National Disability Insurance Agency*, where the applicant had sought an internal review and then, remaining dissatisfied, lodged an appeal with the AAT. The Tribunal found that it did not have jurisdiction to review the matter

[90] A question of law can include, for example, whether the AAT denied a person procedural fairness, correctly interpreted or applied the NDIS Act, or applied or identified the correct test. This is also known as a judicial review.

> because the NDIA reviewer had initiated a plan review, resulting in a new plan which attracted internal review rights the applicant had not yet exercised. (sub. 137, p. 12)

This confusion was also noted by EY (2015, p. 70) in its review of the NDIS Act, which recommended that the terminology in the Act be amended to make the distinction between the two types of reviews clearer. The *National Disability Insurance Scheme Amendment (Quality and Safeguards Commission and Other Measures) Bill 2017* (Cwlth), which is currently being considered by the Senate Community Affairs Legislation Committee, if passed, would rename plan reviews 'plan reassessments'.

Second, there are concerns about the adequacy of information provided about review options. Down Syndrome Australia (sub. 121, p. 15) said 'it appears that people are not well enough informed about their rights to ask for an internal review within the timeframe'. Scope Australia argued the process is not clear and that the amount of information provided is insufficient:

> … the process for resolving disputes or disagreements is not clear. The Agency rarely provides a contact name for appeals or provides a process by which participants can escalate their concerns. There is only one email address where the information and requests for review can be lodged. This is not customer friendly nor does it encourage participants to best advocate for their rights. (sub. 72, p. 19)

Similarly, Brain Injury SA commented:

> … the information provided to participants about review is unclear and inadequate. There is minimal information about the process and no information about how or where participants can get help with a review. Brain Injury SA delivers presentations to client communities about the support it can provide to participants wanting a review of an NDIA decision and further appeal rights and support. However, NDIA should provide this sort of information to all participants and be consistent about this approach.
>
> Further, Brain Injury SA has received anecdotal evidence from parents and guardians that NDIA has not been informing participants of their right to an internal review or external merits review through the AAT. (sub. 116, p. 10)

Legal Aid NSW also said:

> We have also observed that the right of participants to internal review is not adequately publicised. For instance, in our experience it can be difficult to find information about internal reviews and appeals to the AAT on the NDIA website. It is important that participants are aware of these review and appeal rights so that they can exercise them when necessary. (sub. PP245, p. 9)

Third, study participants expressed frustration about both the overall length and variability of time that reviews take. For example, Brain Injury SA (sub. 116, p. 6) said 'reviews can take between 1 and 8 months'. Others also commented on the delays.

> If people are not satisfied with their plan, they can apply for an internal review of a decision, and if necessary escalate this to the Administrative Appeals Tribunal. However, VCOSS members

> report this process can be confusing and time-consuming, taking months to resolve. (VCOSS, sub. 176, p. 12)
>
> The review process itself is complex and bureaucratic and we have heard of cases where it can take up to 18 months to be completed. Participants who are implementing their second plan are sometimes still waiting for the review of their first plan to be finalized. (Leadership Plus, sub. 128, p. 2)
>
> Although operational guidelines suggest NDIA has 14 days to decide to review a plan, Anglicare Tasmania have examples of cases where reviews have not been resolved for up to seven months. In all cases we have been involved with, timeframes have been very lengthy and involved a huge amount of follow up from families or workers. (Anglicare Tasmania, sub. 145, p. 33)
>
> We are concerned in particular about the length of time that it takes for the NDIA to conduct an internal review. We have clients who have waited five months for an internal review of a 12 month plan. (Legal Aid NSW, sub. PP245, p. 14)

Governments and the NDIA are working to address concerns about review processes. COAG has agreed to implement the recommendation from EY's review of the NDIS Act to review the terminology in the Act to make the distinction between the types of reviews clearer, and to amend the legislation to provide more guidance on the rights of scheme participants to request a review of their plan (COAG 2016, pp. 4–5). The NDIA (sub. 161, p. 94) also said it is working to improve its review processes, including working with the Commonwealth Ombudsman to develop service and process improvements.

It is important that the NDIA continues to improve the transparency, clarity and adequacy of the information it provides about reviews and on the timeliness of its reviews.

Are review processes affecting scheme costs?

Review processes can affect scheme costs in two ways.

- Internal reviews can affect the amount of supports provided or the number of people eligible for the scheme, and thereby affect scheme costs.
- Decisions resulting from external review processes will clarify the eligibility requirements and reasonable and necessary supports, which can impact scheme costs.

In addition, poor planning processes can lead to an increase in the number of reviews being requested (chapter 5). This can be costly for the NDIA and scheme participants, and can divert resources away from other, more valuable activities.

However, while review processes can increase scheme costs, they can also provide benefits when they lead to the reversal of an incorrect decision. Therefore, it does not necessarily follow that reviews that increase scheme costs will also negatively impact financial sustainability and scheme outcomes — they could result in a net benefit.

Some study participants said that a high number of unscheduled plan reviews are being undertaken for certain types of disability. For example, MND Australia stated:

> From June 2016 until January 2017 100% of all Plans for people with MND in NSW and the ACT required review. (sub. 45, p. 7)

The NDIA (2017y, p. 29) reported that, in 2016-17, it conducted 37 020 plan reviews that lasted for 30 days or more. Of these, about 15 per cent were unscheduled. The outcomes of these reviews were not reported, making it difficult to determine whether reviews are increasing costs through changes to plans. That said, the large number of unscheduled plan reviews in a year is a large direct cost itself, and suggests significant scope to improve processes and, therefore, reduce the resources the NDIA dedicates to unscheduled plan reviews.

For internal reviews of decisions, the most recent publicly available data are included in the NDIA's June 2016 quarterly report to the DRC (NDIA 2016p, p. 46). At the end of June 2016, the NDIA had conducted 772 reviews of decisions. Of these:

- 262 related to access decisions and 510 to plan decisions
- about 66 per cent of completed reviews where an outcome was recorded (384 reviews) resulted in the original decision being overturned.

While there is data on the number of internal reviews of decisions and their type, there is no publicly available data on the impact that internal reviews of decisions have had on scheme costs, such as whether they have led to more participants entering the scheme or additional supports included in plans.

There is some publicly available data on external reviews. As at 30 June 2017, there had been 268 external appeals to the AAT, up from 161 as at 31 March 2017 (NDIA 2017y, p. 29). Of the 130 appeals that were resolved by 30 June 2017, 58 per cent confirmed the NDIA's decision, 41 per cent did not confirm the NDIA's decision and 1 per cent were pending. As with the internal reviews of decisions, while participants have successfully appealed many external reviews, it is not clear whether this has led to increased scheme costs.

Two decisions by the AAT were appealed to the Federal Court. The first case, *Mulligan v National Disability Insurance Agency* [2015] FCA 544, was an appeal of an AAT ruling to affirm the NDIA's decision to decline access to the scheme. The Federal Court set aside the AAT's decision and remitted it for another decision by the AAT (NDIA 2017g).

The second case, *McGarrigle v National Disability Insurance Agency* [2017] FCA 308, was an appeal of an AAT decision to affirm the NDIA's decision to partially fund transport to access daily activities (chapter 5). The Federal Court set aside the AAT decision and remitted it for another decision by the AAT. The NDIA appealed this decision (*National Disability Insurance Agency v McGarrigle* [2017] FCAFC 132), but this appeal was dismissed on 21 August 2017.

There is the potential for external review processes to significantly increase costs in the future by expanding eligibility requirements and the scope of supports provided. As the NDIA said:

> Decisions by the AAT (and/or an appeal to the Federal Court) have the potential to vastly increase the scope of both access and reasonable and necessary supports and must be adhered to while in effect, even if the NDIA challenges the decision. (sub. 161, p. 49)

That said, scheme participants need to have access to effective external review processes to ensure that participants have access to the scheme where appropriate and are receiving the right level of support, participant outcomes are being fully realised, and there is trust in the scheme. As noted by Carers Australia Victoria:

> Internal and external reviews are a vital quality safeguard for participants and carers, enabling them to test the lawfulness and merits of NDIA decisions affecting them. Importantly, they also promote transparency in NDIA decision-making. (sub. 131, p. 14)

The NDIA has committed to improving review processes. In addition, the Commission has recommended that a process be implemented for allowing minor amendments or adjustments to plans without triggering a full plan review (recommendation 5.1).

More clarity and transparency around the effectiveness of the review processes and their effect on financial sustainability and outcomes is also required. The NDIA should undertake more detailed public performance reporting on review processes (including on the number of reviews, review timeframes, outcomes of reviews, and participant satisfaction with the review process). This will improve:

- clarity and transparency
- the NDIA's incentive to improve processes
- accountability, making it easier for governments, scheme participants and the community to assess the NDIA's performance in this area.

As argued by Legal Aid NSW:

> Reporting requirements in this area may highlight performance … increase accountability, and prompt system and process improvements at the NDIA. (sub. PP245, p. 14)

Study participants strongly supported the NDIA publicly reporting on review processes.[91] For example, Community Mental Health Australia said:

> CMHA also supports the recommendation that the NDIA publicly report on reviews, including the number of reviews, review timeframes, outcomes of reviews and participant satisfaction with

[91] Study participants who supported the NDIA publicly reporting on review processes included: the ABF (sub. PP263); AEIOU Foundation (sub. PP277); AFDO (sub. PP325); Amaze (sub. PP281); Bruce Bonyhady (sub. PP333); CSSA (sub. PP278); CYDA (sub. PP358); Legal Aid NSW (sub. PP245); Macular Disease Foundation Australia (sub. PP243); Mental Health Australia (sub. PP321); MIFA (sub. PP338); Name withheld (sub. PP237); NDS (sub. PP295); PWSAA (sub. PP228); Queensland Government (sub. PP345); Summer Foundation (sub. PP293); Tasmanian Government (sub. PP247); The Benevolent

> reviews. This has been an issue CMHA has raised significant concerns with … the number of full reviews being triggered and the time being taken for these reviews. CMHA has also raised the need for … indicators other than the number of people receiving plans, including those noted as being suggested by the Commission. (sub. PP270, p. 14)

The NDIA, in its submission to the position paper, said it is working to improve its reporting on reviews:

> The NDIA agrees that it can improve its reporting in this area and has already made progress towards better availability and reporting of the number of unexpected plan reviews. This is being further addressed through the work that is currently underway on improving participant and provider pathways … (sub. PP327, pp. 58–9).

RECOMMENDATION 11.5

The National Disability Insurance Agency should publicly report on the number of unscheduled plan reviews and reviews of decisions, review timeframes, outcomes of reviews and stakeholder satisfaction with the review process.

11.7 Regulation and quality assurance

Regulation and quality assurance arrangements are important for ensuring the quality of the scheme and good outcomes for scheme participants. Currently, the Australian, State and Territory Governments are responsible for regulation and quality assurance in their jurisdictions, and for the programs they fund (Bilateral agreements for the Transition to a National Disability Insurance Scheme, sch. F; DSS 2016d, p. 17). The NDIA also undertakes some regulatory-related responsibilities such as setting NDIS prices and detecting fraud (DSS 2016d; chapter 8).

In December 2016, the DRC endorsed the NDIS Quality and Safeguarding Framework (PMC 2017). Under this framework, nationally consistent regulation and quality assurance processes will be implemented from 1 January 2018 (Australian Treasury 2017b, p. 154). The focus of the framework is on helping scheme participants to exercise choice and control, while ensuring appropriate safeguards are in place.

The Australian Government will be responsible for most of the regulatory functions under the framework, including provider registration, the complaints handling system, serious incident notification, restrictive practice oversight,[92] and investigation and enforcement

Society (sub. PP334); VCOSS (sub. PP264); Victorian Government (sub. PP298); and Women with Disabilities Victoria (sub. PP282).

92 Restrictive practices are 'any intervention that has the effect of restricting the rights or freedom of movement of a person with disability, with the primary purpose of protecting the person or others from harm. They include the use of seclusion, as well as chemical, mechanical and physical restraint' (DSS 2016d, p. 66).

(box 11.6). A number of entities will be established to oversee the Australian Government's regulatory functions including the:

- NDIS Complaints Commissioner, who will be responsible for handling complaints, investigating serious incident notifications and investigating potential breaches of the NDIS code of conduct. The Commissioner will refer complaints to the relevant entity where appropriate, including those about provider standards to the NDIS Registrar
- NDIS Registrar, which will be responsible for registering providers, managing the NDIS practice standards and certification scheme, leading the design and broad policy settings for worker screening, monitoring provider compliance, and monitoring, reviewing and reporting on the effectiveness of the market for supports
- Senior Practitioner, who will be responsible for overseeing approved behaviour support practitioners and providers, providing best practice advice, receiving, reviewing and reporting on providers using restrictive practices, and following up on serious incidents that suggest unmet support needs (DSS 2016d, pp. 16–17).

The State and Territory Governments will be responsible for worker screening and for the authorisation of restrictive practices in their jurisdiction (box 11.6).

The Australian Government also announced that it will establish an NDIS Quality and Safeguards Commission to implement the framework and to undertake some of the Australian Government's regulatory functions listed above, including provider registration and regulation, complaints, reportable incidents, and behaviour support practices (Australian Treasury 2017b, p. 154; DSS, sub. 146, pp. 6–7). The *National Disability Insurance Scheme Amendment (Quality and Safeguards Commission and Other Measures) Bill 2017* (Cwlth), which is currently being considered by the Senate Community Affairs Legislation Committee, if passed, will establish the Commission. However, there is still a lot of work to be done in terms of implementation design and roll out of the arrangements (DSS 2016d).

Do current arrangements pose a risk to the scheme?

Developing an NDIS Quality and Safeguarding Framework is an acknowledgment that the current arrangements will not be satisfactory for full scheme. Study participants raised a number of concerns with the current arrangements, including the:

- requirement for providers to register in each jurisdiction in which it will provide services and the different registration requirements across jurisdictions (ARPA, sub. 28, p. 1; Plan Management Partners, sub. 126, p. 13)
- burden of the registration process on providers (AHPA, sub. 37, p. 5; OTA, sub. 15, p. 6; QAI, sub. 115, p. 16)
- third party verification requirements (APS, sub. 19, p. 2; ARPA, sub. 28, p. 1).

Box 11.6 NDIS Quality and Safeguarding Framework

The NDIS Quality and Safeguarding Framework outlines the national approach to regulation and quality assurance for the NDIS. The DRC endorsed the framework in December 2016. The aim of the framework is to 'help empower and support NDIS participants to exercise choice and control, while ensuring appropriate safeguards are in place, and establishes expectations for providers and their staff to deliver high quality supports' (DSS 2017e, p. 1).

The framework embodies a number of principles.

- Measures within the framework are designed to uphold and respect the human rights of people with disability.
- Developmental measures (measures intended to build capacity) are designed to empower and support people with disability to make informed decisions about providers and supports.
- The framework is designed to ensure that people with disability have the same protection, regardless of where they live in Australia.
- The regulatory requirements for workers and providers are tiered to ensure regulation is proportionate to the level of risk associated with the type of support offered and the needs of the participants supported.
- The framework starts from the presumption that all people with disability have the capacity to make decisions and exercise choice and control.
- The framework streamlines requirements so the system is easier for people with disability to navigate, and red tape is reduced for providers.
- The framework is designed to support the development of an efficient and effective market.

The framework includes a range of measures targeted at individuals, the workforce and providers in three domains — developmental, preventative and corrective.

The Australian, State and Territory Governments will share responsibilities under the framework. The Australian Government will be responsible for provider registration, the complaints handling system, serious incident notification, restrictive practice oversight, and investigation and enforcement. State and Territory Governments will be responsible for worker screening and for the authorisation of restrictive practices in their jurisdiction.

The framework also encompasses a range of other functions including:

- advocacy services, which are funded outside of the NDIS
- systems for detecting fraud and related issues associated with the responsibility for paying providers and verifying that supports have been delivered. These will remain the responsibility of the NDIA
- complaints about the NDIA and Local Area Coordinators, which will be addressed through existing measures
- universal complaints and redress mechanisms, including Fair Trading and professional and industry bodies, which will continue to be available to participants
- anti-discrimination and human rights legislation overseen by the Disability Discrimination and Human Rights Commissioners, which will provide additional avenues for raising a complaint.

The Australian Government has committed $209 million to establish the NDIS Quality and Safeguards Commission to implement the framework.

Sources: Australian Treasury (2017b, p. 154); DSS (2016d, 2017e).

The concerns with the current arrangements highlight the need to implement the new arrangements as soon as possible. It is also important that governments working on the new arrangements take into account current arrangements that could be imposing unnecessary regulatory burdens on providers.

The new framework

There is still a lot of work to be done on the implementation and rollout of the new framework. As a result, the Commission is not in a position to provide detailed commentary on the arrangements. It is also difficult to predict in advance what negative outcomes will arise if the arrangements are not sufficiently robust. That said, the underlying principles used to guide the design of the framework, including the focus on proportionality and the level of risk, are appropriate. Consultation on the framework has also been extensive (DSS 2016d).

But even if the high-level framework and the detailed processes are well-designed, it may not be enough to ensure it is effective. The regulator needs to be sufficiently resourced to undertake its functions. In the 2017-18 Australian Government Budget, $209 million over four years was allocated to establish the NDIS Quality and Safeguards Commission (Australian Treasury 2017b, p. 154).

The NDIS Quality and Safeguarding Framework was only endorsed by the DRC at the end of 2016 which means that the timeframe (like other NDIS timeframes) is ambitious. However, it is imperative that this timeframe be met to ensure quality and safety for scheme participants, and to provide clarity and reduce the regulatory burden for providers. Physical Disability Australia (sub. 38, p. 14) said it is important 'the NDIA develops and implements its national quality framework as a matter of some urgency'.

A timely and robust NDIS Quality and Safeguarding Framework is particularly important given the relative vulnerability of people with disability. As noted in the Framework document (DSS 2016d, p. 7), recent inquiries into abuse of people with disability in institutional settings have found that particular people with disability are at increased risk of violence, abuse and neglect. They include women, people with intellectual or cognitive disability, Aboriginal or Torres Strait Islanders and people from culturally and linguistically diverse backgrounds.

It is also important for safeguarding against less reputable providers entering the new market. In this respect, there may be lessons to be learnt from other reforms that have had significant issues, such as the Vocational Education and Training (VET) reforms (HSU, sub. PP316, p. 4) (box 11.7).

It is also essential that there are safeguards in place to ensure that scheme participants do not engage in fraudulent activity. While the incidence of fraud related to self-managed payments in the United Kingdom and some States and Territories is low, prevention, early detection and control strategies are still critical to maintaining the integrity of self-managed payments (NDIS IAC, sub. 149).

Box 11.7 Vocational Education and Training reforms

In 2009, the Australian Government introduced the VET FEE-HELP scheme. The scheme initially provided income-contingent loans to students undertaking VET courses at institutions that had a credit transfer arrangement with a higher education institution. In 2012, the scheme was expanded and became available to students undertaking courses at other VET providers.

The number of approved providers doubled between 2012 and 2014 and the number of students accessing VET FEE-HELP increased almost fivefold between 2012 and 2015. The increase in the number of students was mainly made up of full-fee paying students enrolled in private training providers and accessing the loans.

While there was more choice for students and more people enrolled in VET, the regulations and safeguards put in place were insufficient and significant quality problems arose. For example, there was no requirement on providers to demonstrate that they were delivering high-quality education. There was also a lack of information on the quality of providers available to students, and some private providers engaged in high-pressure marketing tactics.

Many students signed up for courses that they had little prospect of completing, and if they did, were unlikely to improve their employment outcomes due to their poor quality. Students were also left with large loan debts, and the Australian Government incurred a large fiscal liability.

The criteria for education providers are now tighter and in January 2017, the VET FEE-HELP scheme was replaced with the VET Student Loans scheme. This scheme introduced more stringent access requirements on providers, courses and students, increased monitoring of providers and strengthened compliance and payment conditions.

Sources: Birmingham (2016); Department of Education and Training (2017b); PC (2016).

The Australian National Audit Office and NDIA staff expressed concerns that the scheme lacks sufficient safeguards in the area of self-managed participants (ANAO 2017; Mavromaras, Moskos and Mahuteau 2016, p. 59). There are also questions about whether the NDIS Quality and Safeguarding Framework is appropriate for intermediaries (chapter 10).

Given the significant potential for adverse outcomes for participants, regular monitoring and review of regulation and quality assurance arrangements will be essential to ensure that problems are identified and addressed early. The arrangements should also be independently reviewed periodically once the framework is in place and operating long enough for issues to be identified. There will need to be sufficient systemic data collection so that problems can be identified.

RECOMMENDATION 11.6

The *NDIS Quality and Safeguarding Framework* and associated regulatory arrangements should be examined as part of the first five-yearly review into National Disability Insurance Scheme costs in 2023.

11.8 Performance reporting and monitoring

Performance reporting requirements can influence scheme costs by improving transparency and accountability, and providing the NDIA and governments with additional incentive to effectively manage the scheme. It is especially important that governments and the community have sufficient oversight through an effective performance monitoring mechanism given that the NDIS is projected to cost $22 billion at full scheme (chapter 12), and the NDIA's level of independence from day-to-day government control.

What are the performance reporting requirements?

The NDIA is subject to a number of performance reporting and monitoring mechanisms under both the PGPA Act and the NDIS Act, including the:

- Quarterly Report to the DRC
- Scheme Actuary's monitoring and reporting on the financial sustainability of the scheme, mainly through the Annual Financial Sustainability Report
- Annual Report and Corporate Plan.

The Annual Report and Corporate Plan are standard reporting practices for Commonwealth entities. The Quarterly Report and the Annual Financial Sustainability Report are requirements under the NDIS Act. The scope and effectiveness of the Quarterly Report, and the financial sustainability monitoring and reporting are discussed in more detail below.

Quarterly report

The Bilateral Agreements for the transition, agreed to by the Australian, State and Territory Governments, set out the framework for the NDIA's quarterly report (table 11.1).

The NDIA is not yet reporting against all of the performance measures or indicators in the reporting framework, as it has not yet built into its systems the capability to measure some of the indicators. For example, the NDIA is not reporting detailed data on the proportion of participants who attain the goals outlined in their plans, the time between requesting access and receiving support, and the number of participants and other people with disability supported by LACs (NDIA 2016r, 2017y).

Also, only limited baseline (not longitudinal) data are presented for some indicators, such as the proportion of participants, and their families and carers, who report improved economic and social outcomes (NDIA 2016r, 2017y).

As the NDIA is still developing its performance reporting against the integrated framework, it is too early to judge whether the performance reporting will be sufficient to shed light on whether the scheme is meeting its objectives. That said, the Commission has identified some gaps in the framework and the current performance reporting against that framework.

Table 11.1 **NDIA operational performance outcomes, measures and indicators**

Outcome	*Measures*	*Indicators*
1. People with disability lead lives of their choice	1.1. Outcomes for participants and their families	1.1.1. Proportion of participants, and their families and carers who report improved economic and social outcomes (as measured by the NDIS Outcomes Framework)
		1.1.2. Proportion of participants who attain the goals outlined in their plans (as measured by the NDIA's Goal Attainment Scale)
		1.1.3. Participant satisfaction
	1.2. Provision of support in response to assessed need	1.2.1. Number of registered service providers by characteristics and market profile
		1.2.2. Access request to receiving support within different timeframes
2. NDIS is a financially sustainable and insurance-based	2.1. Participant characteristics and their families	2.1.1. Access requests made by outcome
		2.1.2. Eligible participants against bilateral targets, including key characteristics
		2.1.3. Participants with approved plans against bilateral targets
		2.1.4. Trends in plan approvals
		2.1.5. Access request to plan approval within different timeframes
		2.1.6. Ineligible participant numbers and key characteristics
	2.2. Support packages	2.2.1. Committed support
		2.2.2. Actual payments
		2.2.3. Average and median package costs by sub-groups of the population and for all participants compared with the expected averages and medians, including trends
		2.2.4. Details of participants with second plans, including length and value of supports
		2.2.5. Distribution of package costs
	2.3. Projections	2.3.1. Cost of the NDIS in dollar terms and as a percentage of GDP (split by participants aged under 65 years and over 65 years). This measure will include NDIS operating costs
3. Greater community inclusion of people with disability	3.1. Mainstream services	3.1.1. Number of participants accessing mainstream services by service type
	3.2. Local Area Coordination	3.2.1. Number of participants and other people with disability supported by LACs by participant characteristics
		3.2.2. Description of activities undertaken on ILC including dollars spent by regions and activities
	3.3. Information, Linkages and Capacity Building (ILC)	3.3.1. Number of participants and other people with disability supported by ILC activities by participant characteristics
		3.3.2. Description of activities undertaken on ILC including dollars spent by regions and activities.

Sources: Bilateral Agreements for the Transition to a National Disability Insurance Scheme, sch. G.; NDIA (2016r).

There are also limited indicators on mainstream services, Information, Linkages and Capacity Building (ILC) and LACs, and for the indicators that do exist, the NDIA is not yet reporting against some of them (NDIA 2016r, 2017z). Given the importance of understanding the interaction between the NDIS and mainstream services, and the critical role that ILC and LACs play in the scheme (chapters 6 and 10), data on these activities should be an important component of reporting on scheme performance.

There is also not a strong enough focus on quality in the framework, including the quality of plans and review processes (recommendation 11.5). Over time, the NDIA intends to develop its monitoring of, and reporting on, outcomes. Evidence of good outcomes will be evidence of good performance and good plans. However, it could be some time until this reporting is of a sufficient standard. Until then, reporting on quality is needed. Given the problems with the planning process (chapter 5), and the fact that many are exacerbated by the rollout schedule (chapter 2 and section 11.9), the NDIA should begin reporting indicators and measures of quality by June 2018. This could include indicators such as participant satisfaction with their plans and their planning experience, the number of plans completed by phone and face-to-face, and the number and nature of plan reviews.

Many study participants supported the NDIA continuing to develop and expand its performance reporting.[93] For example, the South Australian Government said:

> SA supports the NDIA strengthening its reporting on Scheme outcomes, in particular in relation to plan quality, the timeliness of plan development and review, and LAC and ILC activities. (sub. PP354, p. 12)

The NDIA (sub. PP327, p. 60) said it is already taking steps to develop its reporting in these areas.

The performance reporting framework should be regularly reviewed and refined over time. The current Bilateral Agreements state that the framework is to be reviewed annually (Australian Government and Queensland Government 2015, sch. G, p. 2). Improvements could also be introduced under the next performance reporting framework to be detailed in the Bilateral Agreements for full scheme. The framework should be assessed in terms of both whether additional indicators and data are required, and whether the data collected passes a cost-benefit test.

[93] Study participants who supported the NDIA continuing to develop and expand its performance reporting included: ADACAS (sub. PP260); ABF (sub. PP263); AFDO (sub. PP325); Amaze (sub. PP281); CMHA (sub. PP270); Macular Disease Foundation Australia (sub. PP243); Mental Health Australia (sub. PP321); MIFA (sub. PP338); Name Withheld (sub. PP237); NDS (sub. PP295); NMHC (sub. PP319); OTA (sub. PP285); PWSAA (sub. PP228); Queensland Government (sub. PP345); Richard Madden (sub. PP307); Summer Foundation (sub. PP293); Tandem (sub. PP212); Tasmanian Government (sub. PP247); VCOSS (sub. PP264); and Women with Disabilities Victoria (sub. PP282).

RECOMMENDATION 11.7

The National Disability Insurance Agency (NDIA) should continue to develop and expand the performance reporting against the *Integrated NDIS Performance Reporting Framework*, including on outcomes, and Local Area Coordination and Information, Linkages and Capacity Building activities.

The NDIA should also fill gaps in its performance reporting, including reporting on plan quality (such as participant satisfaction with their plans and their planning experience, plans completed by phone versus face-to-face, and plan reviews). This work should be made a priority. The NDIA should begin reporting on measures and indicators of quality by June 2018.

The *Integrated NDIS Performance Reporting Framework*, and any additional reporting outside this framework included in the Quarterly report to the COAG Disability Reform Council (DRC), should be regularly reviewed by the DRC and refined as needed.

Monitoring and reporting on financial sustainability

Under the NDIS Act, each time an annual report is prepared, the Scheme Actuary is to:

- assess financial sustainability and identify risks to financial sustainability, and any trends in the provision of supports to people with disability
- consider the causes of those risks and trends
- estimate the future expenditure of the NDIS
- prepare a report of that assessment, consideration and estimation
- prepare a summary of that report that includes the estimates of future expenditure (NDIS, sub. 161, p. 115).

The Scheme Actuary prepares an annual financial sustainability report, which includes detailed data and information on the financial sustainability of the scheme. This report is not released publicly, although a summary is included in the NDIA's annual report (NDIS Act, s. 172). The Annual Financial Sustainability Report is also reviewed annually by an actuary independent of the NDIA and the scheme actuary (NDIS Act, s. 180E). As discussed above, performance reporting, and independent and robust review of performance reporting, is important for transparency and accountability and providing incentives to improve performance. As much data and analysis on financial sustainability as possible should be made public.

11.9 The rollout

As discussed in chapter 2, the rollout schedule for bringing participants into the scheme is already falling behind the expected pace, and if the current trend continues, the timetable will not be met. This means that 'full scheme' (the time when everyone eligible to enter the NDIS will be able to do so and have an approved plan) will be delayed beyond 2019-20 — that is, beyond the date anticipated in the Bilateral Agreements.

A refocus is needed, making the timetable even more unrealistic

This report highlights many areas where the participant intake schedule is compromising the NDIA's ability to implement the NDIS as intended. Governments need to move the focus of the rollout away from participant intake towards the quality of plans and participant outcomes. A change in focus was supported by many study participants (for example, Amaze, sub. PP281, p. 5; CSSA, sub. PP278, p. 7; NDS, sub. PP295, p. 10; NDIA, sub. PP327, p. 60; OTA, sub. PP285, p. 9).

There is some evidence that the NDIA is already shifting focus. The NDIA recently reviewed its participant and provider pathways and is currently testing 'options for improved service delivery' (sub. PP327, p. 2). The NDIA's new approach is expected to have a greater focus on outcomes, more active involvement with communities, more face-to-face communications, and improved interaction with providers and disability organisations. The NDIA also plans to make improvements to its call centre, and portal to make the portal easier to navigate (NDIA, pers. comm., 22 May 2017).

The NDIA said it is 'working actively to deliver on the bilateral estimates, while providing participants with a quality experience' (sub. PP327, p. 2) and is:

> … unequivocally committed to delivering a quality experience for participants and providers centred on an outcomes-focused approach. This is the overarching objective of the NDIS, which must guide the NDIA's decision-making and the speed of roll-out, while recognising the undoubted benefits that participants gain from entering the Scheme. (sub. PP327, p. 6)

The latest Statement of Strategic Guidance,[94] issued in March 2017, includes participant and community outcomes as one of the six areas the DRC expects the NDIA Board to focus on.[95] The DRC also notes that it has requested 'additional work on indicators to understand and monitor the experience of participants and providers that include measures of participant satisfaction and the quality of planning' (DRC 2017b, p. 2).

[94] Under section 125 of the NDIS Act, the Minister for Social Services, with agreement from the Australian, State and Territory Governments, may give the NDIA Board a statement setting out strategic guidance for the agency. The Board must have regard to this statement when performing its functions.

[95] The other areas include: building and maintaining stakeholder confidence; identifying strategic risks early and managing risks well; supporting market development; safeguarding the sustainability of the NDIS; and developing a high performing NDIA (DRC 2017b).

Without a refocus away from participant intake, the objectives of the scheme will not be achieved. The rebalancing should be explicitly tied to quality indicators that are publicly reported on (recommendation 11.7), so that the expectations set for the NDIA are clear, and the NDIA is held accountable.

RECOMMENDATION 11.8

The National Disability Insurance Agency should better balance participant intake, the quality of plans and participant outcomes. This rebalancing should be explicitly tied to quality indicators that are publicly reported on (as per recommendation 11.7).

The required rebalancing will make it more difficult to meet the bilateral estimates for the transition. In addition, the Commission has made a number of recommendations in this report aimed at improving the quality of planning and participant outcomes. Implementing the Commission's recommendations and the NDIA's new approach will increase the NDIA's workload over and above the 'businesses as usual' case of bringing new participants into the scheme and reviewing existing plans.

All of the above factors make the existing timetable for participant intake unrealistic, and full scheme will be delayed. The changed timetable must be planned for now.

Study participants' views on the implications of a slowdown

While it is now apparent that a slowdown in the participant intake is inevitable, in the position paper, the Commission sought feedback on the most effective way to operationalise a slowdown and the implications of slowing the timetable. The Commission received strong, but mixed, feedback from study participants on whether a formal slowdown was needed.

Many study participants argued a slowdown was necessary (box 11.8). For example, One Door Mental Health pointed to the extra time it would give the NDIA to implement positive changes and potential participants to apply:

> The implications of [a slowdown] are positive. From a planning perspective, NDIA planners and LACs struggling with capacity … have time to catch up, the NDIA has time to implement positive changes to emerging issues, governments have the opportunity to ensure that alternative supports are in place for those who do not qualify and service providers are given extra time to implement changes and encourage clients to apply. From a participant point of view, a slow-down will result in better quality plans and services. For those who do not qualify for a plan, there will be an extension of time in which they can access alternative supports to replace those that will no longer exist following transition. (sub. PP266, p. 16)

However, many other study participants were opposed to formally slowing down the rollout (box 11.9). For example, the Australian Federation of Disability Organisations said:

> Some in the sector have responded by arguing for a slow down of the roll out and to lengthen the transition period. To AFDO and its members, this would be completely unacceptable. For many

people with disability, the wait has already been too long. For people who have had little or no support for many years, the NDIS cannot come quickly enough. Slowing down the roll out is therefore not an option. (sub. PP325, p. 7)

Box 11.8 Some study participants highlighted the benefits of slowing the rollout …

Australian Psychological Society:

> Given the current issues with the NDIS, the APS is of the view that the ambitious timetable for the rollout presents a risk to consumers, and ultimately to the success and financial sustainability of the scheme. Slowdown would also allow more time for cross-sectorial planning and systems review in relation to the transfer of psychosocial supports for people with mental illness to the NDIS. … the APS has serious concerns about the capacity of the NDIS to provide sufficient, appropriate and effective services for people with a psychosocial disability. A slowdown would enable the necessary planning to take place to ensure consumer needs are appropriately met. (sub. PP229, p. 3)

David Parkin:

> The rollout to new areas needs to be slowed. Get the current system as right as it can be. There are enough participants now … who are actually using the system to understand where the effort needs to be applied. The NDIS has to listen to people and Providers. (sub. 177, p. 10)

Macular Disease Foundation Australia:

> The Foundation supports a slow-down in the NDIS rollout in order to assist the National Disability Insurance Agency in finding a better balance between participant intake, the quality of plans, participant outcomes and financial sustainability. … there are currently issues with the NDIS that have resulted in poor participant outcomes. Priority should be placed on addressing and resolving these issues to improve participant outcomes. Delaying the rollout may be the best option to prevent further uptake of sub-optimal plans, which not only negatively impact participants' lives, but also waste taxpayers' money and erode public trust in the NDIS. (sub. PP243, p. 5)

Royal Australasian College of Physicians:

> The rollout should be slowed as necessary to ensure that each new and existing participant can undergo effective and comprehensive planning, and receive necessary interventions throughout this process. (sub. PP299, p. 2)

JFA Purple Orange:

> Given the current difficulties in scheme design and implementation, especially those brought about by the contents of the bilateral agreements, we think there is merit in NDIS implementation slowing down. This is because we are concerned that the Scheme may develop less helpful features that are out of step with the Scheme's values and which, once 460,000 participants are enrolled will be very hard to change. This crystallisation will profoundly compromise the hoped-for benefits of the NDIS. (sub. PP350, p. 25)

There was also very little appetite from governments to delay the rollout — of the governments that provided submissions in response to the position paper, the only one to support it was the Northern Territory Government (sub. PP359, pp. 6–7). The Victorian Government (sub. PP298, p. 1) said 'there are challenges with the transition that can and should be addressed without the need to delay scheme rollout'. And the Queensland Government said:

> The Queensland Government's bilateral agreement with the Commonwealth provides for Queensland to transition in three years. Queensland does not resile from its commitment,

particularly to transition all its existing clients within the three year timeframe. Queensland would consider any extension to its transition timeframe to be a dis-benefit to Queenslanders given Queensland's transition phasing, funding decisions, contractual arrangements with funded providers and its workforce arrangements. Queensland would also prefer to avoid undue anxiety for existing service users and potential providers, and to avoid continuing to operate duplicate systems past June 2019. (sub. PP345, p. 23)

Box 11.9 … while others highlighted the costs

Name Withheld:

> … I request you recommend limiting as much as possible any slowdown in the rollout of NDIS. Many families have suffered severe hardship under inadequate state disability services and have been waiting patiently for the NDIS over the seven years since your inquiry began the NDIS process. (Name Withheld, sub. PP237, p. 5)

Victorian Advocacy League for Individuals with Disability:

> VALID does not agree that slowing down the roll out is the only response to the current implementation issues. VALID's preferred response would be to identify the issues that require resolution, prioritise their resolution, look at proposed solutions and then decide if [a] slow down is the only way to [an] appropriate resolution and the only way to achieve agreed goals. (sub. PP332, p. 10)

Queenslanders with Disability Network:

> QDN also firmly believes that the full implementation of the scheme needs to be consistent with the original principles and intent of the NDIS and supports actions that deliver on this, however QDN does not support actions to slow down the roll out of the NDIS. QDN does not support actions that compromise the long awaited access to supports that many people with disability have been waiting decades for, particularly in Queensland. (sub. PP335, p. 3)

EACH:

> The consideration of slowing the rollout of the NDIS due to both government and non-government conformance or adaptability to the Scheme should not be seen as a viable option to address these areas of concern. The rollout is based on a progressive schedule across the country, which was informed by evaluation of need and the individual requirements of potential participants. It would be unreasonable to expect potential participants to continue to wait for services purely because 'scheme design' and 'scheme roll out' has not been effectively managed or achieved. (sub. PP276, p. 16)

Richard Madden:

> The vital issue is that all Australians who are eligible have the right to enter the NDIS in accordance with the current rollout schedule. Any delay in the rollout removes entitlement from some who will be forced to wait with no supports or inadequate supports. This is wrong as a matter of social justice. (sub. PP307, p. 5)

The Department of Social Services (sub. PP318, pp. 5–6) argued that a slowdown is not required, but rather, existing flexibility within the current arrangements could ease implementation pressures while preserving the rollout schedules. It raised the examples of:

- South Australia — where the Bilateral Agreement estimates were adjusted to allow more new participants to enter the scheme
- Queensland — where it was agreed that three regions could commence transition earlier than originally planned.

There were a number of concerns raised about a slowdown, by both those who did and did not see the need for a slowdown. The main concern was potential participants waiting longer for NDIS support (Parkinson's Australia, sub. PP232, p. 6; YDAS, sub. PP262, p. 2), which would affect some people with disability more than others, including:

- those with urgent and complex needs (NDS, sub. PP295, p. 10; PWSAA, sub. PP228, p. 8)
- those not currently receiving support, or receiving inadequate support, outside the NDIS (JFA Purple Orange, sub. PP350, p. 25; PWSAA, sub. PP228, p. 8; Richard Madden, sub. PP307, p. 5)
- children (ECIA Victoria/Tasmania, sub. PP301, p. 7; NDS, sub. PP295, p. 10)
- those who turn 65 years while waiting and, unless eligibility criteria change, will not be eligible for the scheme when they otherwise would have been (ABF, sub. PP263, p. 14; BCA, sub. PP351, p. 5; Macular Disease Foundation Australia, sub. PP243, p. 5).

Another concern was that some Australian, State and Territory Government programs are already being withdrawn and a slowdown could leave some potential scheme participants without support at all (Anglicare Australia, sub. PP339, p. 11). The Australian Psychological Society said:

> A slowdown would need to be managed carefully as consumers in several jurisdictions are already experiencing a close down/transfer of all state-funded disability services. This is particularly the case in NSW, but also in Victoria with regard to the closure of mental health community-based services. A slowdown must not leave consumers without access to services. (sub. PP229, pp. 3–4)

To address these issues, study participants emphasised the importance of continuity of support arrangements (chapter 6) (The Benevolent Society, sub. PP334, p. 3; MIFWA, sub. PP221, p. 5; One Door Mental Health, sub. PP266, p. 16; Legal Aid NSW, sub. PP245, p. 15). For example, Occupational Therapy Australia said:

> … if a decision is made to delay the transition to the NDIS in some areas, slow down the scheme's rollout across the board, or prioritise some participants over others, any such decision must not adversely impact would-be participants. Once again, it falls to state and territory governments — who would presumably be party to any such decision — to ensure they have the necessary supports and services in place for those people put at risk by any changes to the scheduled rollout of the NDIS. (sub. PP285, p. 9)

Others argued that a slowdown could hinder market development (Victorian Government, sub. PP298, p. 1) due to a slowdown in the rate at which suppliers respond and enter the market. The ACT Government, for example, said:

> Proposals to slow the pace of the NDIS rollout to full scheme could further inhibit provider sustainability, and consequently market supply, where access to a regional or national market may enable providers to develop stronger ongoing business models. (sub. PP312, p. 8)

Study participants also discussed the potential impacts on public support for the scheme. On the one hand, Legal Aid NSW (sub. PP245, p. 15) and the Health Services Union (sub. PP316, p. 4) argued that public support could decline if the rollout is *not* slowed. However, the Victorian Government (sub. PP298, p. 8) said 'delaying scheme roll out could also reduce public confidence in the NDIS'.

Study participants agreed that there should not be an across the board slowdown, and instead certain groups should be prioritised, such as those with urgent and complex needs (Activ, sub. PP302, p. 12; Bruce Bonyhady, sub. PP333, p. 5; Inclusion Australia. sub. PP357, p. 26; Quality Living Options Bendigo, sub. PP220, p. 2; Speech Pathology Australia, sub. PP303, p. 10). For example, one study participant said:

> If slowdown must occur it should only be targeted to apply to people with low support needs. People with complex or higher support needs, or needing early intervention, would be at greatest risk from slowdown. I know from experience how desperate some families can feel under inadequate state disability services. Even a delay of one year could precipitate a significant tipping point for some people. A delay in transition to the NDIS may cause a spike in families relinquishing the care of people with high support needs.
>
> Slowdown should not be applied across the board nor to particular geographical areas. (Name Withheld, sub. PP237, pp. 5–6)

It is time to start planning now for a changed timetable

As noted above, a slowdown to the participant intake timetable is inevitable — the reality is that a slowdown is already taking place, and the work needed to better balance participant intake, the quality of plans and participant outcomes will only slow this down further.

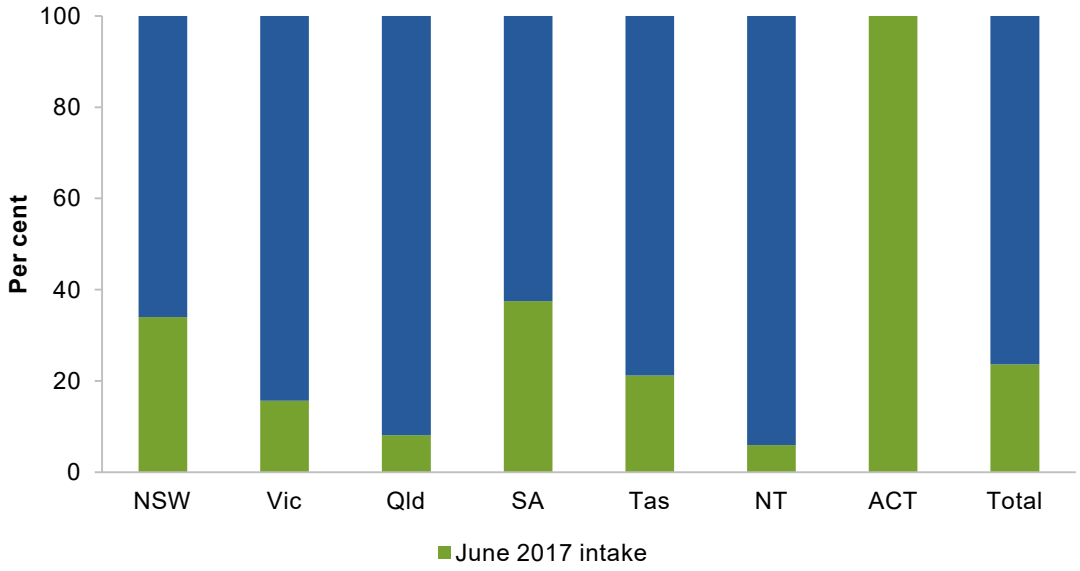
The NDIA and the Australian, State and Territory Governments need to recognise that the current timetable for participant intake will not be met. Action needs to be taken now to implement what is required to ensure the scheme meets its objectives, especially in light of the ramp up in participant numbers expected over the next two years in a number of jurisdictions. Any adjustments to the intake schedules will need to be made on a state-by-state basis, as jurisdictions are at different stages of the rollout (figure 11.2).

Any change in the timetable will have implications for scheme participants, providers, governments and the NDIA, as well as other parts of the scheme, including the impacts on market stewardship, non-NDIS service provision (mainstream services and disability services) and funding arrangements. For example, if the slowdown is not managed well, it could leave some potential scheme participants without adequate support. Governments are currently winding back some services as people with disability transition to the NDIS. Governments will need to alter their withdrawal plans and ensure that adequate continuity of support arrangements are in place.

A slowdown could also have implications for the development of the market and the supply of disability supports. The Commission has made a number of recommendations on market

development and participant readiness (chapters 7–10). But a slowdown could have additional effects on market, provider and participant readiness that will need to be managed.

Figure 11.2 **Scheme intake as a proportion of the total bilateral estimate by state, as at June 2017[a,b]**



[a] Excludes Western Australia. [b] ACT is at full scheme. Its current intake of 6047 participants has exceeded the bilateral estimate of 5075 participants.

Sources: Bilateral Agreements for the Transition to a National Disability Insurance Scheme; NDIA (2017y).

The way that funding arrangements are tied to participant phasing schedules, and whether changes to the full scheme funding arrangements are required given the slowdown, will also need to be considered.

The NDIA and governments also need to assess whether additional resources are required to implement the scheme successfully. Some study participants raised providing additional resources as another option to help deal with the current problems, and in some cases an alternative to slowing down the rollout.[96] But simply providing more money will not solve many of the immediate problems, as any additional staff will need training and experience, making this untenable as a quick fix.

[96] Study participants who raised the option of providing additional resources included: MIFA (sub. PP338); National Disability and Carers Alliance (sub. PP344); Parkinson's Australia (sub. PP232); Richard Madden (sub. PP307); Summer Foundation (sub. PP293); Victorian Government (sub. PP298); and YPINH (sub. PP326).

Decisions need to be communicated

It is critical that any decision made to change the participant intake schedule, together with any changes made to the scheme in response to this report's recommendations, are clearly and publicly communicated (Mental Health Coalition of South Australia, sub. PP308, p. 6; Vision Australia, sub. PP252, p. 13).

RECOMMENDATION 11.9

The Australian, State and Territory Governments should immediately start planning for a changed timetable for participant intake for the National Disability Insurance Scheme.

In doing so, the Australian, State and Territory Governments should ensure that adequate continuity of support arrangements are in place and assess whether additional resources are required to ensure the scheme meets its objectives. The issue of resourcing disability services under the changed timetable should be dealt with by the Treasurers and Ministers responsible for the disability portfolio in each jurisdiction, at the next COAG Disability Reform Council meeting.

12 NDIS funding arrangements

Key points

- Responsibility for funding the National Disability Insurance Scheme (NDIS) is shared between the Australian, State and Territory Governments. There are different funding arrangements for transition and full scheme.
  - During transition, the Australian, State and Territory Governments each contribute an agreed amount per participant based on the intake of participants in each state and territory. The package cost contributions equate to about a 40-60 split respectively. All cost overruns are to be funded by the Australian Government.
  - In the first year of full scheme, State and Territory Governments will contribute $10.3 billion to the NDIS. This amount will be escalated at 3.5 per cent each year. The Australian Government will fund the remainder (estimated to be $11.1 billion in 2019-20) and will have primary responsibility for cost overruns (covering at least 75 per cent).
- The funding arrangements for the NDIS need to provide funding certainty and allow the scheme to operate in line with insurance principles. This requires: sufficient funding for the National Disability Insurance Agency (NDIA) to take a lifetime approach to participant needs and support requirements; predictable funding that gives people with disability (and their families), and those who may acquire disability, certainty that they will receive reasonable and necessary supports over their lifetime; incentives for the NDIA to efficiently and effectively operate the scheme; and incentives for governments to take a collaborative approach to mainstream interfaces.
- Funds from the first 0.5 percentage point Medicare levy increase for the NDIS are credited to the DisabilityCare Australia Fund (DCAF). The DCAF is an investment account managed by the Future Fund and subject to management fees. State and Territory Governments can receive some funds from this account to put towards their NDIS contributions.
  - The DCAF should not be continued past 2023-24, as it is unlikely to be efficient to hold these funds in an account subject to management fees when 'churn' (from State and Territory Governments withdrawing a substantial proportion of the funds) is high.
  - Money from this Fund should instead be paid into the NDIS Savings Fund when it is established (along with funds from the proposed second 0.5 percentage point Medicare levy increase for the NDIS). The NDIS Savings Fund is ring-fenced within consolidated revenue and not subject to management fees (making it more suitable when churn is high).
- Given the limited and less efficient taxes available to State and Territory Governments (compared to the Australian Government), escalation parameters should be set on the basis of population growth and inflation. This will maintain constant real per capita contributions from State and Territory Governments over time. This means the Australian Government will bear a greater proportion of the total scheme costs over time.
- To give the NDIA greater capacity to operate the NDIS more in line with insurance principles, a commitment should be made now to build a pool of reserves over the medium to long term.

The National Disability Insurance Scheme (NDIS) involves a significant increase in funding provided to people with disability. When the NDIS is fully rolled out in 2019-20, it is expected to cost about $22 billion per year. This is an increase in total government spending on disability supports from $8.4 billion in 2015-16 (or just over 150 per cent) (SCRGSP 2017, p. 15.4).

This chapter examines the NDIS funding arrangements with a focus on reforming full scheme funding arrangements. Section 12.1 looks at how the NDIS is currently funded. Section 12.2 sets out a framework for evaluating funding arrangements. This framework is used to assess the way that funds are currently raised to pay for the NDIS (section 12.3), the setting of escalation parameters (section 12.4), and cost overrun and reserve arrangements (section 12.5).

12.1 How is the NDIS funded?

The complex funding arrangements for the NDIS are set out in a range of intergovernmental agreements between the Australian and State and Territory Governments. These agreements outline, among other things:

- the funding responsibilities of the Australian and State and Territory Governments in transition
- how these arrangements will change at full scheme — although full scheme arrangements are yet to be finalised and are subject to negotiation between the Australian and State and Territory Governments
- the arrangements for ongoing review of the funding agreements.

Transition funding arrangements (2016-17 to 2018-19)

During transition, package costs are shared between the Australian and State and Territory Governments. The Australian Government covers about 40.6 per cent of the 'agreed package costs'[97] for participants under 65 years, and the State and Territory Governments fund the remainder (about 59.4 per cent of the agreed cost) (table 12.1).

The Australian Government pays 100 per cent for non-Indigenous participants aged 65 years and over, and Indigenous participants aged over 50 years, in the scheme. It also funds the Information, Linkages and Capacity Building (ILC) activities and the National Disability Insurance Agency's (NDIA) operating expenses.

All cost overruns in the transition period — including those from average package costs consistently exceeding agreed amounts, or consistently higher than expected numbers of

[97] These agreed package amounts are the midpoint of Commission estimates from 2011. The Australian Government contribution is paid upfront monthly, while State and Territory Government contributions are paid monthly in arrears.

participants — are to be funded by the Australian Government (as per the Heads of Agreement).

Table 12.1 **Agreed average package costs and intake during transition**

	2016-17	*2017-18*	*2018-19*
Agreed average cost per participant ($)	39 667	41 383	43 163
Agreed (capped) participant intake[a]	78 642	123 681	153 443

[a] Excluding Western Australia and those aged over 65 years.

Sources: The Bilateral Agreements between the Australian, State and Territory Governments on the transition to the National Disability Insurance Scheme.

During transition, the NDIA is subject to a jurisdiction-by-jurisdiction cash ceiling equal to three months of agreed annual funding contributions for scheme participants in each state and territory. When the NDIA reaches this ceiling, contributions from the relevant jurisdiction and the Australian Government are reduced to ensure that the ceiling is not exceeded.

The NDIA is also subject to a jurisdiction-by-jurisdiction cash floor equal to the previous month's agreed contribution for that jurisdiction. Once this floor is breached, the Australian Government is expected to make a cash contribution to the Agency to ensure the cash holdings do not go below the nominated floor.

Funding arrangements at full scheme

At full scheme, State and Territory Government contributions to the NDIS are calculated as predetermined fixed dollar amounts, rather than shares of agreed costs for each participant. In 2019-20, State and Territory Governments, excluding Western Australia, will contribute about $9 billion (table 12.2).[98] The Australian Government will contribute the remainder of the budgeted amount. The Australian and New South Wales Governments have agreed to a fixed contribution from New South Wales of $3133 million in 2018-19. The fixed funding contributions of the other states and territories were calculated to equal the per capita contribution of New South Wales (table 12.2) (Australian Government and New South Wales Government 2012, p. 3).

[98] Estimated to be $10.3 billion should agreement with Western Australia be reached (DSS, sub. 146, p. 17).

Table 12.2 **State and Territory Government funding commitments in 2019-20**

State or Territory	*Contribution ($ million)*
NSW[a]	3 243
Vic	2 510
Qld	2 030
SA[a]	748
Tas	232
NT	99
ACT	167
Total[b]	9 029

[a] Not stated directly in the Heads of Agreement. Instead a figure of $3133 million is given for 2018-19, which was escalated at 3.5 per cent for the 2019-20 figure. The same calculation was performed for South Australia based on $723 million for their contribution in 2018-19. [b] The total excludes what Western Australia's contribution would be if it joined the national scheme.

Sources: Heads of Agreement with each State and Territory Government (except Western Australia).

State and Territory Government contributions can include in-kind services. These sometimes take the form of large capital investments made (like large residential centres or group homes) or contracts entered into prior to the NDIS. State and Territory Governments usually retain policy and administrative control over these in-kind services, including any decision to replace them with a financial contribution. Over time, and as these assets age, it is expected that they will be phased out. In-kind services are discussed in more detail in chapter 7.

The Heads of Agreement state that, at full scheme, State and Territory Government contributions will increase by 3.5 per cent per year (subject to the response to the recommendations of this study). These escalation parameters are calculated based on assumed net population growth of 1 per cent per year and the midpoint of the Reserve Bank of Australia's consumer price index medium-term inflation target of 2–3 per cent (Australian Government and New South Wales Government 2012, pp. 2–3).

Over the medium term, scheme costs are expected to increase above long-term inflation and population growth trends due to the impact of people aged over 65 years in the scheme (DSS, sub. 146, p. 17). The cost of the NDIS is expected to increase to just over $32 billion by 2029, with the Australian Government share of funding increasing from 52 per cent in 2019-20 to 56 per cent in 2028-29 (table 12.3).

Table 12.3 **Projections of the funding split over time**
$billion

	2019-20	*2020-21*	*2021-22*	*2022-23*	*2028-29*
Estimated total scheme costs[a]	21.5	22.8	24.0	25.1	32.1
Participant package costs	20.0	21.5	22.6	23.7	30.6
ILC block grants	0.1	0.1	0.1	0.1	0.1
Admin and other	1.3	1.3	1.3	1.3	1.4
Commonwealth contributions	**11.1 (52%)**	**12.0 (52%)**	**12.7 (53%)**	**13.5 (54%)**	**17.9 (56%)**
State and Territory contributions	**10.3 (48%)**	**10.9 (48%)**	**11.2 (47%)**	**11.6 (46%)**	**14.3 (44%)**

[a] These are gross figures based on the DSS model.

Source: DSS (sub. 146, p. 17).

While arrangements for cost overruns at full scheme are still to be finalised, the Heads of Agreement for each State and Territory (excluding Western Australia), note that the Australian Government will:

> … assume 100 per cent of the risk for full scheme … subject to the review [of scheme costs by the Productivity Commission] noting the Commonwealth is committed to always assuming a minimum of 75 per cent of risk … for client support costs … (Australian Government and New South Wales Government 2012, p. 4)

As discussed in chapter 11, Western Australia has opted for a locally administered scheme and has different funding arrangements to the other states and territories (box 12.1).

Sources of NDIS funding

Australian Government funding for the NDIS comes from a number of sources (figure 12.1).

- Funds redirected from previous Australian Government disability service programs to the NDIS (DSS 2016f, p. 2).
- Funds previously provided to State and Territory Governments under the National Disability Agreement and the 2011 National Health Reform Agreement (DSS 2016f, p. 2).
- A 0.5 percentage point increase in the Medicare levy on personal taxable income (estimated to raise about $4 billion per year in 2018-19) which provides funding via the DisabilityCare Australia Fund (DCAF) (box 12.2) (Australian Treasury 2017a, p. 130).
  - A maximum of $9.7 billion over 10 years will be allocated to the States and Territories, with the remainder available to the Australian Government (*DisabilityCare Australia Fund Act 2013* (Cwlth), s. 13).

- Debits from the yet-to-be-established NDIS Savings Fund (box 12.2), which will source funding from:
  - an additional 0.5 percentage point increase in the Medicare levy on taxable income (subject to legislative passage) (estimated to raise about $4 billion per year in 2019-20) (Australian Treasury 2017a, p. 130)
  - underspends and realised savings from the NDIS (through, for example, changes to budget forecasts reflecting cost saving measures by the NDIA)
  - uncommitted funds from the Building Australia Fund and Education Investment Fund (to be legislated)
  - other redirected savings at the discretion of the Australian Government
- consolidated general government revenue.

Box 12.1 Funding arrangements in Western Australia are different

Western Australia has so far opted not to join the national scheme, but rather to have a separate Western Australian National Disability Insurance Scheme (WA NDIS) (chapter 11).

WA NDIS during transition

During the transition period, as in other jurisdictions, the WA Government will contribute about 59.4 per cent of care and support package costs for an agreed number of eligible participants each year.

The Western Australian Government will cover a larger proportion of cost overruns than other State and Territory Governments.

- The Australian Government will bear a maximum of 25 per cent of any cost overruns for the WA NDIS when those overruns are due to a higher than expected number of participants or higher package costs.
- Cost overruns due to any other reasons will be funded by the WA Government.
- If there are lower than expected package costs or participant numbers, the remaining funds will be split according to the contributions of each government.

The WA Government and Australian Government will share equally in the cost of Information, Linkages and Capacity Building grants and Local Area Coordinators in that state. The WA Government will fund the administrative costs of the WA NDIS. And, as in the other states and territories, the Australian Government will fund supports for participants aged over 65 years who choose to remain in the scheme, and Indigenous participants aged over 50 years old.

WA NDIS at full scheme

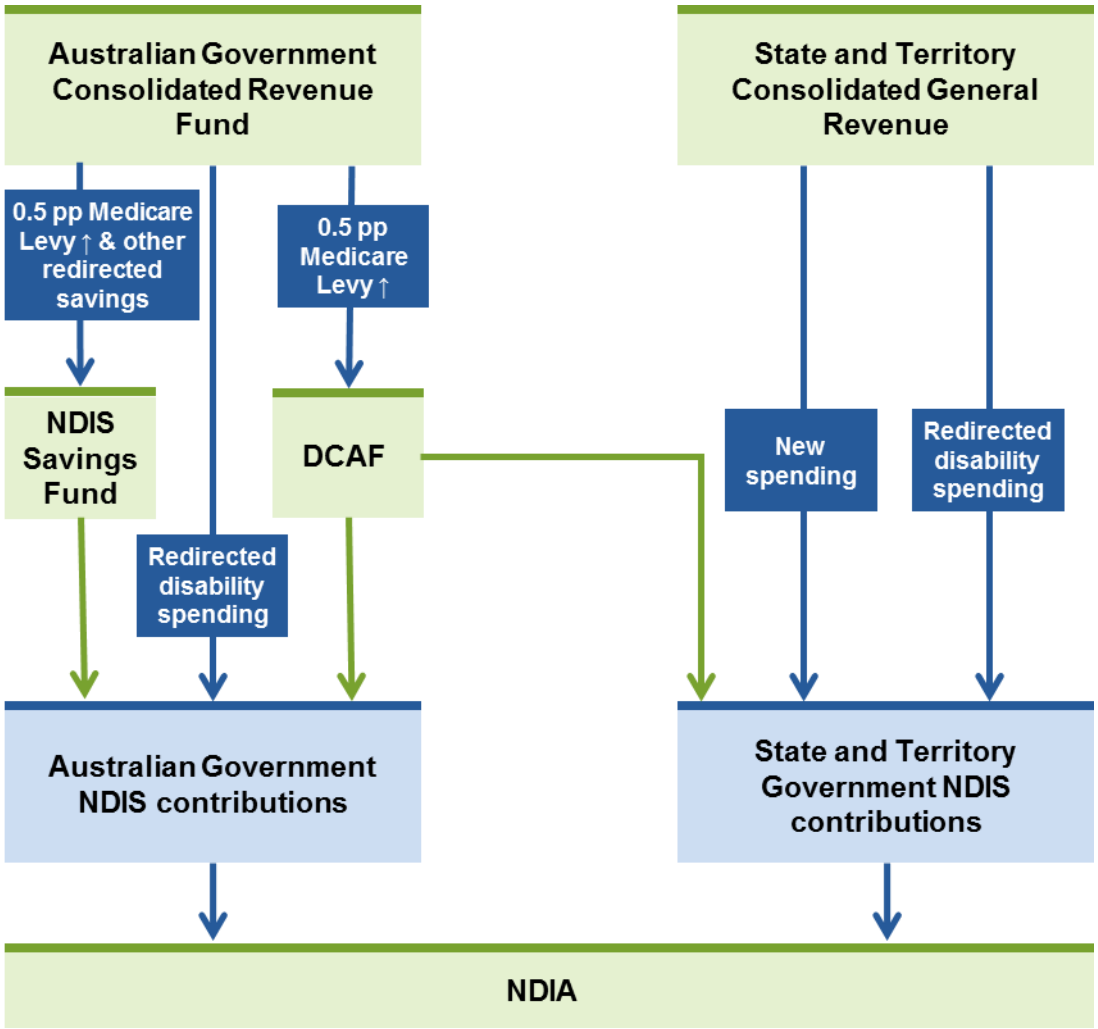
Limited details about the WA NDIS at full scheme are available, but the Bilateral Agreement does state that if the WA Government maintains a separate scheme after transition, the Australian Government will make a fixed per person contribution towards the cost of the scheme in Western Australia and this amount will escalate at 3.5 per cent per year.

Source: Australian and Western Australian Governments (2017, p. 14).

State and Territory Government contributions are funded through (figure 12.1):

- redirected funding previously used for legacy specialist disability services
- funds allocated to the States and Territories from the DCAF — the maximum amount of credits for the States and Territories is $9.7 billion over 10 years (*DisabilityCare Australia Fund Act 2013* (Cwlth), s. 13)
- consolidated State and Territory Government general government revenue.

Figure 12.1 **Proposed NDIS funding model in 2019-20[a,b]**



[a] The NDIS Savings Fund and the increase in the Medicare Levy to be put into the NDIS Savings Fund are subject to legislative passage. The abbreviation 'pp' stands for percentage point. [b] State and Territory Government consolidated general revenue is referred to by different names in different jurisdictions' constitutions.

Sources: Australian Treasury (2017b), Heads of Agreement with each State and Territory Government (except Western Australia).

Box 12.2 The DisabilityCare Australia Fund and the NDIS Savings Fund

The Australian Government increased the Medicare levy by 0.5 percentage points from July 2014-15 to provide funding for the NDIS. The funds from this increase to the Medicare levy are credited to the DisabilityCare Australia Fund (DCAF) to partially reimburse the Australian and State and Territory Governments for their contributions to the NDIS.

As set out in the *DisabilityCare Australia Fund Act 2013* (Cwlth) (DCAF Act), from 2014-15, the maximum amount of credits available for State and Territory Governments from the DCAF is $825 million per year in 2014-15. This amount will increase at 3.5 per cent each year until 2023-24. Over 10 years (ending 2023-24), the maximum amount of credits available for the State and Territory Governments is a total of $9.7 billion between them, to partially reimburse their NDIS contributions.

Governments have not yet negotiated whether the States and Territories will continue to receive these payments after 2023-24, but the operation of the DCAF Act is due to be reviewed before June 2024 (DCAF Act, s. 55).

State and Territory Governments can be paid an amount from DCAF in order to reimburse them for expenditure incurred in relation to the *National Disability Insurance Scheme Act 2013* (Cwlth). Funds not allocated to State and Territory Governments can be used by the Australian Government to reimburse it for expenditure incurred in relation to the National Disability Insurance Scheme Act.

As at 31 March 2017, the DCAF had $6.2 billion in assets.

The Australian Government's 2017-18 Budget includes plans to increase the Medicare levy by (a further) 0.5 percentage points. Revenue generated from this increase will be credited to the yet to be established NDIS Savings Fund, alongside other redirected savings, contributions from NDIS underspends, and recommitting funds from the Building Australia Fund and Education Investment Fund (subject to legislation). The NDIS Savings Fund and the increased Medicare levy are also subject to legislation passing through Parliament. The NDIS Savings Fund will ring-fence — or hypothecate — funding specifically for the NDIS.

Sources: Australian Treasury (2017b, 2017e), Australian Government (2013a), Australian Government and New South Wales Government (2012), the *National Disability Insurance Scheme Act 2013* (Cwlth), the *DisabilityCare Australia Fund Act 2013* (Cwth), and Porter and Cormann (2016)

Most funds are for individualised supports

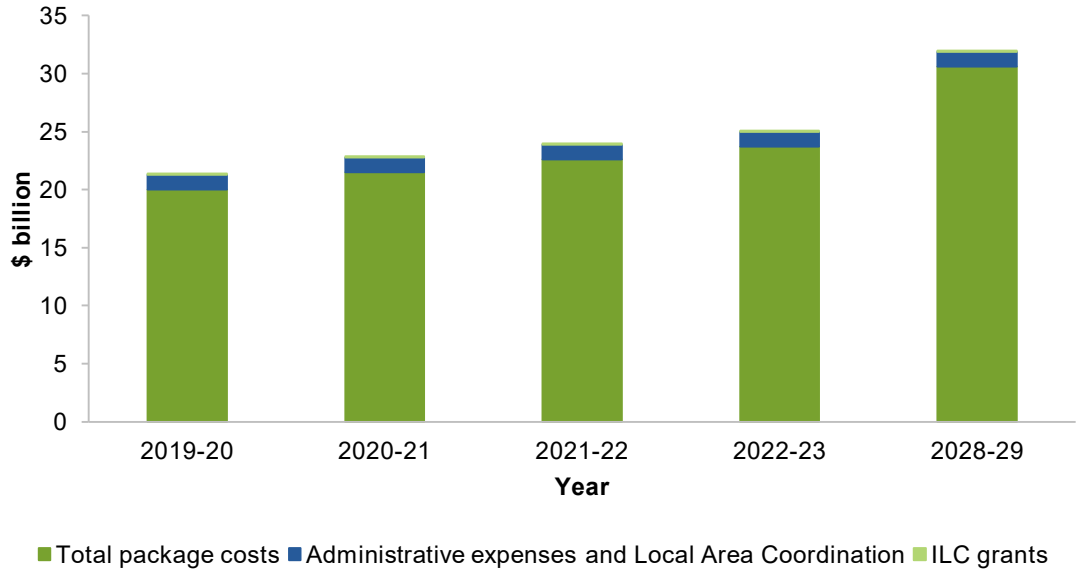
The Australian and State and Territory Governments' funding contributions to the NDIS are used for three categories of expenditure:

- individualised support costs (participant packages) — these are expected to be more than 93 per cent of the NDIS expenditure at full scheme
- operational expenses of the NDIA, including funding for assessment, planning and Local Area Coordination (LAC) — these are expected to account for less than 7 per cent of the budget at full scheme

- the Information, Linkages and Capacity Building (ILC) grants (chapter 6) — these make up the remainder of the budget, at less than 1 per cent at full scheme (table 12.3, figure 12.2).

During transition, the NDIA's operating expenses and ILC are funded by the Australian Government (Australian Treasury 2017d, p. 140). However, at full scheme, the Heads of Agreement indicate that State and Territory Governments may contribute towards ILC and LAC funding.

Figure 12.2 **The allocation of full scheme funding over time**[a]



[a] While most chapters in this report use modelling based on the NDIA's models and data, this chapter uses a funding and costs model provided by the Department of Social Services.

Source: Estimates provided by the DSS (sub. 146, p. 17) based on MYEFO 2016-17 data.

12.2 A framework for evaluating funding arrangements

As an insurance-based scheme, the NDIS should be designed to take a lifetime approach to disability care and support. As discussed in chapter 1, the NDIS is intended to provide assurance to both those with permanent and significant disability, and those who may acquire such disability in the future, that they will receive the support they require for as long as they need it. This is only possible if the funding source is both sufficient and predictable. It should also take a lifetime view of participants' needs by, for instance, seeking early investment and intervention for people in order to maximise their independence and social and economic

participation, and reduce their support requirements in the future. As the Commission's 2011 *Disability Care and Support* report said:

> Whatever its exact form, the financing mechanism must give people with a disability certainty about getting reasonable supports over their lifetime. Moreover, a stable revenue stream is needed to underpin a proper governance arrangement for the NDIS … Accordingly, funding for disability must move away from the uncertainty underlying the annual determination of government budgets for disability support. (PC 2011, p. 33)

The funding arrangements for the NDIS also need to be efficient, transparent and create the right incentives for effective management of the scheme over time.

Funding needs to be sufficient

The consequences of an insufficient source of future funding for the NDIS are considerable. As the Commission said in 2011:

> … the consequences of insufficient future benefits are worse than in many other cases where people seek assurance — uncertainty about the timely replacement of an ageing and increasingly worn-out wheelchair; unmanageable carer pressures; and the fear of inadequate or low quality care without respect or dignity for a partner or a child. Accordingly, while people value the supports they might get today, they value highly the guarantee that they will get adequate supports tomorrow too. This implies that a properly designed NDIS must reflect those preferences. (PC 2011, p. 647)

The objective of the NDIS is to fund the reasonable and necessary supports for people with disability. The scheme was designed to be uncapped in order to achieve this (noting, as discussed in chapter 1, that the ultimate cap is taxpayers' willingness to continue to pay for the scheme). This means that allocated funding needs to be sufficient to meet the cost of reasonable and necessary supports for all scheme participants. Sufficient funding is essential if the chronic underfunding and unmet demand of the previous disability support system is to be avoided.

Sufficient funding also suggests the need for access to extra funds for investments that will reduce the long-term costs of the scheme, and for managing risk in times of volatility and uncertainty.

Funding needs to be predictable

Funding predictability relates to certainty about the ongoing availability of funds. Under the previous disability support system, people with disability were typically uncertain about whether they would get the support they needed over their lifetime:

> People with disabilities and their carers do not get the certainty of lifelong support needed for proper life planning and cannot avoid the extreme anxiety about the adequacy of future funded support when informal care is no longer reasonable or feasible. Current funding for disability comes from two levels of government, which are subject to annual budget cycles — making it

> hard to give people with disabilities any certainty that they will get reasonable care and support over the long run. (PC 2011, p. 6)

A lack of funding certainty imposes costs on people with disability and their carers and families — not just the costs of inadequate care, but also the psychological costs of uncertainty (such as fear of inadequate or low quality care for a partner or child, which can create incentives for exaggerating problems when funds are severely rationed and allocated mainly to crisis support).

A predictable revenue stream is also essential if the NDIA is to take a forward-looking approach to systematically manage demand and price pressures to minimise the long-term costs of the scheme. Making long-term decisions is not feasible when future revenue sources are subject to the unpredictable processes of annual budgets (PC 2011, pp. 647–648). As the Governments of Victoria, Queensland, South Australia and the ACT said:

> To deliver on its objectives of improved social and economic participation, and to ensure equity in application and integrity of the Scheme, the NDIS must be free from the influences of evolving budget pressures. The Scheme is an insurance-based model and participants require confidence that their supports will be provided for as long as required. Decisions about eligibility and reasonable and necessary supports should not be subject to ongoing revisions to align costs with a targeted funding level. (sub. 201, p. 3)

'Predictability' requires binding commitments from governments for funds allocated to the NDIS. This suggests either an agreed amount of revenue or a specific tax dedicated to the NDIS (hypothecation is discussed further below).

Funding arrangements need to create the right incentives

Incentives to effectively and efficiently operate the scheme

Funding arrangements should allow the NDIA to operate the NDIS as an insurance-based scheme (chapter 1). For example, they should provide incentives to make investments that reduce future claims on the scheme, and be able to meet unexpected cost fluctuations.

The arrangements also need to provide incentives for the Agency to operate the scheme efficiently. For example, allowing the NDIA some flexibility to make decisions about the efficient operation of the NDIS may help to minimise costs.

And while the NDIS is funded by an annual appropriation, governments (and taxpayers) will not commit to just any level of funding. As the Commission said in 2011:

> That would provide an excuse for lax cost control and permissive benefit levels by the scheme. Any scheme that did not control premium [funding] pressures would not be sustainable or acceptable to governments and taxpayers. (PC 2011, p. 573)

Incentives for federal-state collaboration

The NDIS is funded in part by redirecting existing disability funding. However, the NDIS is not designed to cover all Australians with disability (chapter 1). The scheme is also designed to operate in conjunction with, not replace, mainstream services.

Ideally, the NDIS would operate as part of a seamless system of mainstream and disability services that takes a lifetime, insurance-based approach. That is, early interventions and well-targeted preventative care would occur in a coordinated way to minimise the overall costs of mainstream and disability services, and maximise the wellbeing of participants in those systems. However, as discussed in chapter 6, these interactions are not always seamless. Gaps in the NDIS can impose costs on mainstream services, and vice versa.

The design of funding arrangements for the NDIS can affect how these interactions play out. Arrangements need to ensure that the amount of funds available for mainstream services and continuity of support obligations is adequate.

Revenue raising needs to be efficient

Government funds for the NDIS can be sourced either from reducing expenditure on other programs, or from an increase in tax revenue (borrowing is not considered a feasible long-term option). Reducing government spending on other programs has its attractions, and it is likely that spending on disability services will have a high net benefit compared to some other government expenditure (PC 2011, p. 643).

Where tax increases are required, tax revenue should be raised in the most efficient way possible.

Transparency is important

Transparent funding arrangements are also important, particularly in the context of holding the NDIA and the Australian, State and Territory Governments accountable for decisions they make. Transparency provides the NDIA and the community with certainty that the NDIS will have access to sufficient revenue in the future by making it more difficult for governments to renege on their funding commitments.

12.3 Raising funds to pay for the NDIS

A shared funding arrangement was agreed

In 2011, the Commission's preferred funding option was for the Australian Government to be the single funder of the NDIS. This option was preferred because it would:

- provide certainty and clear lines of funding responsibility
- avoid the inefficiencies of the Commonwealth-State 'blame game' that afflicts some other shared funding arrangements
- reflect the Australian Government's capacity to raise efficient and sustainable taxes of the magnitude required (PC 2011, pp. 673–8).

This option was subject to State and Territory Governments reducing their taxes to avoid increasing the tax burden on Australians beyond what is necessary to provide additional funding to the NDIS.

The Commission also recommended that the Australian Government direct payments from consolidated revenue into a National Disability Insurance Premium Fund, using a legislated formula that provided stable revenue to meet the actuarially assessed reasonable needs of the NDIS and included funding for adequate reserves (PC 2011, p. 659).

However, the Australian, State and Territory Governments agreed on a pooled funding approach for the NDIS, with contributions from State and Territory Governments agreed in bilateral agreements (chapter 1). And there is no pool of reserves.

Concerns raised about the shared funding arrangements

The shared funding arrangements for the NDIS were raised as a concern in the context of ensuring secure funding for the NDIS. For example, Physical Disabilities Australia, said:

> PDA does not believe the current funding arrangements between the Commonwealth and the States and Territories secure the NDIS' future. Instead, we believe they will threaten the Scheme's viability. Whilst the funding commitments are shared in this way, politicians at all levels will continue to threaten the Scheme's future by claiming the other entities 'aren't paying their fair share' or are 'exploiting [their jurisdiction's] better run economy'. (sub. 38, p. 17)

However, any potential instability from shared federal-state funding is expected to be counteracted by the extraordinary commitment to the success of the NDIS by the State and Territory Governments and the support for a shared funding approach. The Victorian Government, for example, said:

> Victoria supports the continuation of a joint approach to funding the NDIS that involves Commonwealth funding of the scheme, supported by contributions from the states and territories agreed bilaterally. This approach is most likely to ensure a sustainable source of funds and offers the best prospect of delivering NDIS objectives effectively and equitably. (sub. 174, p. 23)

The South Australian Government also said:

> SA remains strongly committed to the NDIS. The issues that SA has raised in response to the Commission's Position Paper are to ensure that the Scheme is successfully implemented and sustainable in the long term for both Commonwealth and state and territory governments. This will provide people with disability the confidence that the NDIS will deliver the benefits for which it was designed. (sub. PP354, p. 15)

Others pointed to the benefits of having State and Territory Governments involved in the scheme. Bruce Bonyhady, for example, said:

> The preferred method of funding in the Productivity Commission Report in 2011 was for the Commonwealth and States to engage in a tax-swap and for the Commonwealth to fully fund the NDIS from general revenues. … However, acceptance of this recommendation would have meant that once the NDIS was fully implemented, the States and territories would not have had any 'skin in the game' and so risked the States not having an interest in the NDIS or engagement with people with disability. This would have been a mistake. … It is clear from the implementation of the NDIS to date that the shared funding model has contributed very positively and significantly to the national governance arrangements and ensured that all governments have maintained their strong commitments to the NDIS. (sub. 100, pp. 11–12)

Hypothecation

Highly volatile and inadequate disability spending was a feature of the previous disability system. In light of this, the Commission in 2011 argued that such a tax could provide greater certainty for funding the NDIS (while noting that economists and Treasury departments, often question the appropriateness of hypothecated taxes):

> A genuinely hypothecated tax can be a way of increasing certainty that government would provide adequate funding in the future … Just identifying the tax as something like a 'National Disability Insurance Premium' would make it hard to eliminate the tax or to divert it to other purposes, since most would accept the legitimacy of dedicated public funding in this area. (PC 2011, p. 659)

The Commission also noted that an alternative to a hypothecated *tax* is hypothecated or 'earmarked' *funding* — rather than specifying the tax base to be hypothecated, the Australian Government diverts a specific funding amount from consolidated revenue into a hypothecated, or earmarked, fund for the NDIS specified in legislation.

Having hypothecated funding, rather than a hypothecated tax, has two main benefits. It:

- does not lock in a particular tax base as the source of revenue for the NDIS
- minimises the need for tax increases by leaving open the option of reducing wasteful or unnecessary expenditure.

But the amount earmarked for the fund would need to include an escalation factor to reflect the anticipated growth in scheme costs over time, rather than an absolute dollar amount which falls relative to NDIS costs over time.

Hypothecation of funds — whether through a hypothecated tax or earmarked fund — can make it more difficult for governments to renege on their commitments by providing an upfront transparent commitment to the way that a pool of money will be used.

Earmarked Medicare levy increases will be used to partially fund the NDIS. There are a number of benefits from hypothecating funds from the Medicare levy for the NDIS, including:

- increasing certainty that funds are available for the NDIS by providing a transparent allocation of funds to be used for a particular purpose
- reducing reliance on State and Territory Governments to raise their own funds (displacing inefficient State and Territory Government taxes with more efficient Australian Government taxes).

As discussed above, the money raised for the NDIS from the first Medicare levy increase is currently credited to the DCAF and the proposed (second) Medicare levy increase will be credited to the proposed NDIS Savings Fund. The DCAF is an investment account managed by the Future Fund and subject to management fees. The NDIS Savings Fund is ring-fenced within consolidated revenue.

While the DCAF is an earmarked fund with transparency around what goes into the fund, it is not without its problems.

- It is subject to management fees (Future Fund Board of Guardians 2016, p. 66). At full scheme, when there is expected to be a lot of 'churn' in the funds under management from the Australian, State and Territory Government withdrawals. These management fees may erode the returns on the fund because being able to make funds readily available for withdrawals means they have to be invested in liquid assets.
- There is little transparency around how the funds are used, and how they are allocated to State and Territory Governments — the DCAF Act does not provide any certainty around when State and Territory Governments can access funds.
- It is a complex arrangement — the Medicare levy increases are to be put into two separate hypothecated funds and other Australian Government contributions come directly from consolidated revenue (not hypothecated).

These features may not be an issue in transition where the funding requirements of the NDIS are lower, and funds are building in the DCAF (reducing the impact of management fees). However, it will be difficult to justify renewing the DCAF arrangements after State and Territory Governments have made withdrawals from the DCAF, because of the increased 'churn' in funds and erosion on the fund returns. For this reason, the Commission is of the view that in 2023-24, when the DCAF arrangements are reviewed, the money raised by the Medicare levy increases intended for the NDIS should instead be put into the NDIS Savings Fund until the Australian Government needs to contribute it to the NDIS.

The benefit of the NDIS Savings Fund is that it is not subject to management fees (unlike the DCAF). And while it is not truly hypothecated (in that it remains part of consolidated

revenue), the transparency of the NDIS Savings Fund makes it a commitment that is difficult for governments to renege on. Other Australian Government contributions could also be put into the NDIS Savings Fund before they are provided to the NDIA to ensure transparency and certainty over funds committed to the NDIS.

If the Australian Government wishes to partially pay for the contributions of the State and Territory Governments — and it might be efficient to do so if it avoids some State and Territory Governments raising additional funds through inefficient state and territory taxes — it should do so by reducing the State and Territory contributions directly. This would be simpler than the DCAF, improve transparency and predictability of the funding arrangements, while also realising the benefits of hypothecation.

State and Territory Governments are likely to continue to provide funds to the NDIA directly, rather than putting them in a pool with Australian Government funds.

RECOMMENDATION 12.1

The DisabilityCare Australia Fund (DCAF) should be discontinued after 2023-24. All the Medicare levy funds hypothecated for the National Disability Insurance Scheme (NDIS) should be put in the proposed NDIS Savings Fund.

The reimbursement arrangements that currently apply under the DCAF should not be continued after 2023-24. If necessary, the impact of such reimbursements should be reflected directly in reduced contributions from the State and Territory Governments.

12.4 Escalation parameters

The NDIS is designed to be a no-fault scheme that covers the entire population, and the funding contributions of governments to the NDIS can be thought of as 'insurance premiums' paid by individuals through their taxes (PC 2011, p. 976). At full scheme, these insurance premiums will be made up of contributions from the Australian Government, and the agreed fixed funding contributions of State and Territory Governments which are escalated at 3.5 per cent per year.

The Heads of Agreement state that the DRC may agree to revise the escalation parameters based on the advice of this study. The Agreements also state that the calculations of per capita funding will be updated every five years to take into account each new Census. The first re-basing is expected to occur from 2023, based on 2021 Census figures.

The terms of reference for this study ask the Commission to look at changes in the agreed escalation parameters.

What are the objectives of the escalation parameters?

There were different views put to the Commission about what the escalation parameters are designed to achieve.

The New South Wales Government, for example, argued that the parameters should remain unchanged:

> … escalation was intended to represent a fair and fixed rate of growth to NSW's contribution. Again, it was not intended to maintain a specified cost share basis, nor meet actual cost or activity growth, nor necessarily maintain a real per capita contribution. Rather it was an agreed growth rate based on a fixed population growth factor (1.0%) and a fixed cost escalation factor (2.5% - equal to the RBA long term inflation target). (sub. PP230, p. 11)

The Tasmanian Government (sub. 247, p. 11) and South Australian Government (sub. PP354, p. 14) were also opposed to any changes to the escalation parameters.

The Victorian Government argued that escalation parameters should be used to maintain their current per capita contributions to the NDIS in real terms:

> Victoria considers it is clear from the wording of the bilateral agreements that the objective of the escalation factor to be applied to state contributions to NDIS costs was to maintain the real value of those contributions over time against growth in population and economy-wide movements in prices and wages.
>
> The states clearly did not agree to meet increased costs arising from a higher than expected participant numbers and/or higher average per person care and support costs. Under the bilateral agreements, 100 per cent of the risk of scheme cost overruns due to such factors was clearly apportioned to the Commonwealth. (sub. PP298, p. 33)

The ACT Government was also open to the parameters being explicitly defined to maintain constant real per capita contributions:

> If there is a departure from the current indexation rate of 3.5 per cent, the ACT suggests that [the] most appropriate alternative would be to set rates on the basis of maintaining a real per capita contribution to the NDIS as this is in line with the design of the scheme and the original agreement. (sub. PP312, p. 13)

Both the Queensland Government and the Victorian Government highlighted the importance of escalation parameters being certain once agreed on:

> The agreed fixed rate provides certainty for states and territories which is important in the context of smaller state budgets. Introduction of variable escalation rates may require states to set aside funds in contingencies in case of higher than expected cost pressures. Such funds could be better utilised for mainstream services or elsewhere in the economy. (Queensland Government, sub. PP345, p. 24)
>
> States' NDIS contributions have been carefully formulated and agreed. The Commonwealth cannot keep shifting the goalposts. (Victorian Government, sub. PP298, p. 33)

Others, such as the DSS, argued that the parameters should be used to increase State and Territory contributions in line with changes in scheme costs:

> … contribution levels should be linked to underlying growth in NDIS costs, including short to medium term financial implications such as expanding market and wage increases for the Social and Community Services sector. In addition, should there be an adverse impact on the pricing of supports, escalation rates should be adjusted to reflect those changes. Escalation rates should therefore be based on an economic projection of cost escalation, with any costs incurred outside of these settings considered in the context of risk sharing arrangements. (sub. PP318, p. 21)

This would require the escalation parameters to reflect the increase in NDIS costs over time. However, existing escalation parameters are unlikely to do this, as NDIS costs are expected to grow at a faster rate than inflation and population (DSS, sub. 146, p. 17). As the NDIA said, it:

> … can observe that wage inflation and the Equal Remuneration Order (ERO) are likely to result in an increase above 3.5 per cent in the short-term, which will result in a skewing of the contributions. Longer-term assumptions should be set considering wage inflation levels, population growth rates, and efficient prices. (sub. 161, p. 114)

If escalation parameters do not reflect cost increases over time, the Australian Government will, over time, bear a higher share of NDIS costs for participants aged under 65 years. The Queensland Government (sub. PP345, p. 24) argued that it was 'reasonable for the Australian Government to gradually assume a greater share of scheme costs over time, considering its greater revenue base', noting that 'this would be a move closer to the funding arrangements originally proposed by the PC in 2011'.

The DSS also suggested that the escalation parameters should be adjusted to take account of the State and Territory Governments' roles and responsibilities, including the extent to which these governments support and fund mainstream services:

> Under first principles, financial contributions from all parties should reflect, where possible, the roles and responsibilities of those parties. The architecture of the NDIS is a unique arrangement in the relationship between the Commonwealth and State governments, with current governance arrangements providing States with a significant and ongoing funding and stewardship role in the NDIS, the effective implementation of the interface of the NDIS with mainstream service systems and stimulating the appropriate workforce to deliver disability services. (sub. PP318, p. 21)

The threshold issue for determining the objective of escalation parameters is whether or not State and Territory Government contributions at full scheme and beyond should keep pace with scheme costs, or maintain existing real per capita contributions.

The argued benefit for State and Territory Government contributions to track scheme costs is to give them some 'skin in the game' to control costs, for example, by giving them additional incentives to agree to cost-saving changes in the rules. However, there are a number of factors that contribute to increasing scheme costs, and most of these are not within the control of State and Territory Governments. It is also unclear how State and Territory

Government decisions could impact many of the cost drivers that would be used to set escalation parameters, including equipment costs and social and community workers' award wages.

But, as noted by some State and Territory Governments, higher escalation parameters could impose a greater cost on taxpayers if State and Territory Governments are required to raise additional funds (because they have access to narrower and less efficient tax bases than the Australian Government) and/or affect the delivery and quality of mainstream services which are necessary for the sustainability of the NDIS (box 12.3). And limited State and Territory Government tax bases mean that guaranteeing the sufficiency of funds may be difficult when State and Territory Governments have to raise significant amounts of additional revenue.

Box 12.3 State and Territory Governments point to their access to less efficient taxes and more limited revenue bases

Victorian Government:

> … increasing the proportion of state funding or the indexation of the state contribution would increase budgetary pressures on states and may affect the delivery, quality and access to mainstream services, which are also necessary for the sustainability of the NDIS.
>
> … Increasing the NDIS' dependence on smaller state budgets that rely on Commonwealth grants and less efficient taxes may result in a backwards step — towards an NDIS that is not fully funded. (sub. PP298, p. 34)

Tasmanian Government:

> State funding contributions to the NDIS during transition and at full scheme are fixed and capped, in recognition of states' need for budget certainty and their limited capacity to raise additional funds. As pointed out in the New South Wales submission to the PC's earlier Issues Paper, state contributions were never intended to cover the costs of the scheme. (sub. PP247, p. 10)

Governments of Victoria, Queensland, South Australia and the ACT:

> Increasing the proportion of state funding or the indexation of the state contribution would add to the revenue burden on states, and may result in a reversion to the previous rationed and waitlisted disability system that was 'underfunded and inefficient', with disability funding once again competing with other state service delivery obligations. It is worth remembering that, in part, it is this concerted attempt to move away from uncertainty of supports that has driven the design of the NDIS to be one that provides participants with confidence about the services that will be available in the future. (sub. 201. p. 3)

Governments have agreed to fixed funding contributions from States and Territories at full scheme, and the Commission recommends keeping those agreed contributions constant on a real per capita basis over time. This requires calculating escalation parameters with reference to inflation and population growth.[99] In broad terms, this should mean that State and Territory Governments are unlikely to need to increase tax rates as inflation and population growth are expected to increase State and Territory Governments' nominal tax revenues.

[99] A broad measure of inflation is more appropriate than services sector inflation, or other measures of cost growth in the disability services sector, given that the objective of escalation parameters is not related to tracking scheme costs.

That said, funding splits are ultimately a reflection of what governments can afford and are prepared to contribute to the NDIS at a given time. Securing agreement is an important part of ensuring that funding is predictable. And making these agreements transparent also helps to prevent governments from reneging on their commitments.

How should the escalation parameters be set?

On the basis that escalation parameters should be set using inflation and population growth, the agreed 3.5 per cent per year would seem to be at the lower end of the likely range for these combined factors using reasonable assumptions. Using the last few years of low inflation as a short-term estimate, the agreed escalation parameters seem a little high, but it is questionable whether this low inflation will continue post 2019-20 (table 12.4). The assumed population growth of 1 per cent per year is significantly below projected and historical rates.

If population growth falls within the bounds of projections from the Australian Bureau of Statistics, and inflation falls within the Reserve Bank of Australia's medium-term target, then an escalation parameter of about 4 per cent per year (approximate midpoint of the 3.3-4.8 per cent range) would seem more appropriate for the period to 2023. This is the period over which the escalation parameters are to be set in the forthcoming bilateral agreements, with a review to be undertaken to reassess the parameters post 2023. This review should revise estimates of population and inflation for the next five-year period.

Table 12.4 **Possible population growth and inflation assumptions**
Different assumptions produce very different parameters (per cent)

	Population growth	*Inflation*	*Implied escalation parameter*[a]
Historical 3 year average annual growth (2014–2016)	1.5	1.6	3.1
Medium-term projections (2020–2023)	1.3–1.8[b]	2–3	3.3–4.8 (midpoint of 4.05)
Long-term projections (post-2050)	0.2–1.3	2–3	2.2–4.3

[a] Sum of population growth and inflation. [b] The Australian Bureau of Statistics projections have three different scenarios to project population growth. The numbers presented here are the range implied by their estimates.

Sources: ABS (*Australian Demographic Statistics, Dec 2016*, Cat. no. 3101.0; *Consumer price index Australia, June 2017*, Cat. no. 6401.0; *Population projections, Australia, 2012 (base) to 2101*, Cat. no. 3222.0).

Should escalation parameters vary by jurisdiction?

A potential issue with setting the escalation parameters on a national basis is that some states and territories can be expected to have faster population growth rates than others or differing

levels of economic growth. This could lead to different effective burdens upon some State and Territory Governments in funding their NDIS contributions. As the Northern Territory Government said:

> … for the NT the equivalent long term annual population growth is estimated at 1.5% and the average forecast CPI over the next five years is estimated at 1.2% per cent. Therefore, the 3.5% that the Territory has agreed to is higher than the growth expected in the NT. (sub. PP358, p. 7)

However, as mentioned above, the base funding allocation between State and Territory Governments will be adjusted to reflect Census population data in 2023.

RECOMMENDATION 12.2

From full scheme, the escalation parameters that determine the growth of State and Territory Government financial contributions to the costs of the National Disability Insurance Scheme should be set on the basis of population growth and inflation. This will maintain constant real per person contributions from the State and Territory Governments.

The Commission's assessment of projections of population and inflation over the period 2019-20 to 2023-24 suggests the escalation parameters should be set at 4 per cent, rather than the currently agreed 3.5 per cent.

The escalation parameters should be reassessed for the period beyond 2023-24, at 5 yearly intervals, based on the most contemporary projections of population and inflation at that time. The funding shares among the States and Territories should also be rebased according to the most contemporary census population data available at that time.

12.5 Funding an insurance-based scheme

When someone enters into an insurance contract, there is generally a guarantee that any valid claim will be honoured by the insurance company. Insurers therefore face significant risks that need to be managed — they need to satisfy all valid claims, but they do not know the actual costs of the claims that they will have to pay in any given year. They can also face very long-term liabilities when claims are granted.

Insurance schemes typically prepare actuarial forward estimates of costs over a period of time and adjust their insurance premiums in line with these estimates.

Insurers carry reserves to set aside money for future claims (box 12.4). These reserves can be used to respond to cost fluctuations, including in instances where those fluctuations may be temporary due to one-off events, or where actions need to be taken to ameliorate emerging cost pressures. This means that insurance premiums only need to be adjusted when it is clear that the cost fluctuations are sustained over the long term.

For public insurance schemes, having a funding buffer gives flexibility to respond to the inevitable annual fluctuations of costs, and so avoid governments needing to inject funds from general revenue or ration supports. A reserve also allows insurers to make upfront investments to reduce scheme costs over the longer term. However, it is important that any funds allocated to a reserve are raised efficiently, and there is transparency around access to and use of the funds.

Box 12.4 Reserves are built up through adjusting premiums

A key principle of insurance is that the liabilities created by claims should be backed by sufficient financial assets. Holding a pool of reserves is the typical way to achieve this.

In private insurance schemes, premiums are set to cover the expected cost of claims (often with a buffer to limit potential losses), administrative costs and a profit margin. For insurance where a claim has a life longer than a year, premium revenue is typically designed to exceed the annual cost of claims so that the insurance company can build up reserves. Provided the reserve assets are as large as the liabilities from outstanding claims, the insurance firm will remain solvent.

This principle is also applied in public insurance schemes, such as Victoria's Transport Accident Commission (TAC), New South Wales' Lifetime Care and Support (LCAS) (now part of icare), the Australian Government's ComCare, and New Zealand's Accident Compensation Corporation (ACC). In these schemes, levies or charges are used to collect enough revenue to cover a proportion of the full (lifetime) cost of current and expected new claims in the following year. The reserves are usually invested in financial markets by professional managers outside of the scheme.

The level of reserves held varies among schemes. For example, LCAS has financial assets approximately one and half times as large as their lifetime claim liabilities, while ComCare's financial assets are only about 80 per cent of its lifetime claim liabilities. These differences reflect a range of factors including differing: policies regarding the size of the asset base, assumptions regarding the size of liabilities and returns on investment, and performance of invested funds.

Reserve ratios of other public insurers in 2016

	Total financial assets	*Participant lifetime cost*	*Ratio*
	$ m	$ m	%
LCAS	4 371	2 939	149
TAC	11 973	13 901	86
ComCare	2 307	2 757	84
ACC[a]	37 859	36 663	103

[a] In New Zealand Dollars.

Sources: ACC (2016), ComCare (2016), icare (2016b) and TAC (2016).

But unlike other insurance schemes, the NDIA does not set its own premiums. As discussed earlier, it relies on funding contributions by the Australian and State and Territory Governments. And the financial risk associated with satisfying all valid claims for

reasonable and necessary support needs to be managed (without knowing exactly how much that will be in any given year, chapter 1).

Allowing the NDIA to manage discrepancies between actual and estimated costs in any given year is necessary to ensure that the NDIA and the public have confidence in the sufficiency and predictability of funding.

Current NDIS funding arrangements have two in-built mechanisms for managing fluctuations in expenses — cost overrun and cash ceiling arrangements.

Cost overrun arrangements

Under the current funding arrangements, any 'cost overruns' are to be funded by the Australian Government. However, what defines a cost overrun (or the circumstances when it occurs) is not clear. The Heads of Agreement state that:

> The Commonwealth will fund 100 per cent of the risk of any increase in costs associated with higher participant numbers and/or higher average per person care and support costs, and 100 per cent of DisabilityCare Australia's cash flow risk, during the launch and transition period.

Full scheme arrangements for cost overruns are not yet finalised.

Are the current arrangements appropriate?

Good risk management requires that those who are best placed to manage the risk of fluctuations in expenses should have responsibility for doing so.

Under current funding arrangements, the Australian Government has responsibility for the risk of fluctuations — State and Territory Government contributions to the NDIS are fixed contributions (effectively capped), and the Australian Government has committed to contributing the 'remainder'. However, the Bilateral Agreements do not spell out how the remainder is calculated, nor is it publicly stated whether the calculation of 'the remainder' is based on the NDIA's projections of lifetime scheme costs, or adjusted as actual scheme costs evolve.

There are a number of factors that can contribute to cost overruns, including:

- changes to the boundaries of the NDIS (defined in the NDIS Rules and interpreted by the Federal Court)
- inaccurate or outdated actuarial estimates of total scheme costs
- underestimates of the number of participants in bilateral agreements
- higher average package costs than estimated
- how efficiently the NDIA administers the scheme

- cost shifting from State and Territory Governments to the NDIS that increases scheme costs.

Many of these factors are not in the control of the Australian Government.

While no single entity has control over all of these factors, the NDIA has access to the best information about the factors driving fluctuations in expenses, not the Australian Government. If this information was used to calculate increases to funding contributions to the NDIS, and there was a buffer to account for the risk that actual costs might deviate from expected costs, then cost overruns should not occur, or only when cost increases are sudden and difficult to predict.

FINDING 12.1

If funding contributions to the National Disability Insurance Scheme increase in line with projected scheme costs and there is an actuarially-assessed buffer for risk, then cost overruns in a mature scheme will only occur where cost increases are sudden and difficult to predict.

The contributions of the Australian Government should be explicitly tied to the long-term projections of scheme costs based on the provision of reasonable and necessary supports, rather than committing to 'the remainder'. Calculating funding contributions in this way will provide the NDIA with sufficient certainty and flexibility to efficiently manage the costs of the scheme over the long term, rather than relying on injections of cash from the Australian Government under the current cost overrun arrangements. Such arrangements would put it on a much firmer insurance-based footing, and clearly differentiate it from a welfare program.

That is not to say that any government should commit to unconditionally increasing funding for the scheme — as noted in chapter 1, the scheme is only uncapped to the extent that taxpayers are willing to pay for it. Transparency and independent oversight are necessary to provide a check and balance on required scheme funding. Performance reporting is further discussed in chapter 11.

Projections of long-term costs should be generated by the NDIA. This information, along with details of the underlying assumptions, should be shared with the DSS, who would continue to generate the information provided to the Department of Finance in preparing the budget forward estimates. The independent review of the Annual Financial Sustainability Report (which includes the NDIA's projections) required under the NDIS Act should continue (chapter 11).

In the case of a sudden, unforeseeable increase in scheme costs that was not factored into government funding contributions, the Australian Government is the appropriate government to make any required cash injection given its access to a more efficient tax base than State and Territory Governments. As such, the current transition arrangements where

the Australian Government funds 100 per cent of cost overruns should continue for the full scheme.

RECOMMENDATION 12.3

From full scheme, the Australian Government should explicitly factor projected increases in scheme costs, based on the provision of reasonable and necessary supports, into the calculation of its contributions to the National Disability Insurance Scheme.

If cost overruns occur from full scheme, they should be funded by the Australian Government.

Reserve arrangements

Reserves act as a way of increasing funding certainty and providing a buffer for the risk that costs exceed available funds in a given year. As the Commission said in 2011, there should be a long-term link between costs and available funds, with a sufficient buffer provided for risk:

> In effect, the process of managing costs and revenues is like a dance of a pair of ballroom dancers — they are not always in the same position, but the pattern of their movements are orderly and they always remain linked. (PC 2011, p. 647)

In 2011, the Commission recommended the NDIS be structured as a 'pay-as-you-go' scheme and be established with a large enough reserve fund to smooth out fluctuations and reduce uncertainty. The Commission noted that a reserve would act as a buffer against unpredictability, and avoid the Australian Government needing to inject additional funds from general revenue when claim costs were higher than expected in a given year (PC 2011, p. 449).

The Tasmanian Government pointed out that the transition funding arrangements provide the NDIA with a buffer:

> The ability for the NDIA to retain up to three months of reserves was agreed by governments as part of the funding mechanism for transition in recognition of the NDIA's need to have access to a buffer to fund a surge in claims during the rollout. (sub. PP247, p. 11)

As outlined above, during transition, the NDIA can access between one and three months' worth of contributions from package cost underspends. However, any cash reserves above this need to be returned to contributing governments in proportion to their contribution.

Participants generally supported giving the NDIA a pool of reserves

The NDIA supported establishing a reserve, but was cautious about losing access to its current cash buffer:

> Insurance companies and most other existing injury support schemes typically hold significant reserves on their balance sheet. The NDIA notes that any future contingency reserve could only be built from Full Scheme. This is in comparison to the Transition, where States and Territories pay the NDIA in arrears. The appropriate level of any future contingency reserve depends on the specific purposes identified for the reserve (related to operating 'like an insurance scheme').
>
> At the same time, the NDIA notes that it would be undesirable during the Transition to fund the creation of a contingency reserve through removal of the NDIA's current cash buffer because this would reduce operating flexibility, particularly as the NDIA strives to review the appropriateness of the NDIA participant and provider pathways. (sub. PP327, p. 66)

Bruce Bonyhady said:

> Currently, the NDIA has no capacity to deal with unexpected contingencies, other than seek government top-ups, and this is a weakness in the current governance and funding arrangements. (sub. 100, p. 10)

Other participants pointed to the potential benefits from the use of reserves:

> Victoria supports establishing a future contingency reserve to allow the NDIA to manage fluctuations in expenditure and access a level of reserves that better reflect the level of risk it needs to manage. (Victorian Government, sub. PP298, p. 10)
>
> It would seem appropriate that a reserve fund should be established as any enterprise seeks to do where future demands are uncertain. (Quality Living Options Bendigo Inc, sub. PP220, p. 3)

However, others were sceptical of the need for a reserve:

> Such a scheme should be funded like any other government program, through the budget process. Government budget processes are well developed to deal with unexpected expenditure demands, including any necessary decisions to limit future expenditures. (Richard Madden, sub. PP307, p. 8)
>
> Government funding is fungible, and given the NDIA has the financial backing of the Australian, State and Territory Governments, an alternative arrangement should be considered to make funding available for use in a manner consistent with the use of a contingency reserve, but without the need for a large pool of cash to be quarantined for that purpose. (ACT, sub. PP312, p. 14)

There are benefits from establishing a pool of reserves

Providing the NDIA with a pool of reserves has the advantage of providing certainty to participants and providers that the scheme will be enduring. This is an important departure from previous highly uncertain and heavily rationed disability arrangements:

> The need for a stable revenue source also suggests that a funding buffer is required, since there will be annual fluctuations on the cost side. In those periods, the NDIS would need to run down a funding 'buffer' to meet those needs, while it would need to build up the reserve level at other times. (PC 2011, p. 650)

A pool of reserves will also allow the NDIA the funding flexibility to take a long-term approach to participants needs to reduce their support requirements in the long term (including upfront investments to reduce future outlays and ultimately reduce scheme costs). While the NDIA could bring forward its existing allocation of funding to make these investments or manage fluctuations in expenses (either as part of the cost overrun arrangements or seeking additional money from the Australian Government) like any other government expenditure program, these arrangements do not provide the NDIA with certainty over access to those funds, even though this is critical to the application of insurance principles.

The need for a pool of reserves is not negated by the Australian Government being the 'funder of last resort'. Having reserves available provides transparent and tangible evidence of the commitment to fund disability services, now and into the future. It is a bulwark against the vagaries of annual budget cycles, and avoids potential shortfalls and rationing.

It is worth noting that providing the NDIA with a pool of reserves does not mean that the NDIA should be responsible for the day-to-day management and investment of those funds (PC 2011, p. 35). Other public insurance schemes, such as the Transport Accident Commission and NSW Lifetime Care and Support, outsource this function.

Reserves should be gradually built up over time

The NDIA's current cash ceiling arrangements, with access to three months of underspends, does not give the NDIA a means for building up a reserve fund, as there is a cap on accumulations. Other public insurance schemes, such as the TAC and NSW Lifetime Care and Support (now part of icare), gradually built up reserves over time (box 12.5).

The Commission considers contributions to the NDIS should similarly provide enough leeway for the NDIA to manage long-term costs (including making early investments). Insurance schemes typically adjust the premiums that they charge to reflect changes in cost forecasts over a set period of time, and the Commission recommended earlier that the calculation of Australian Government contributions should take into account changes in costs over the long term. Allowing some future funding to be brought forward into current years with reference to these projected long-term costs to create a buffer for risk is consistent with this recommendation, and consistent with the approach of other comparable insurance schemes.

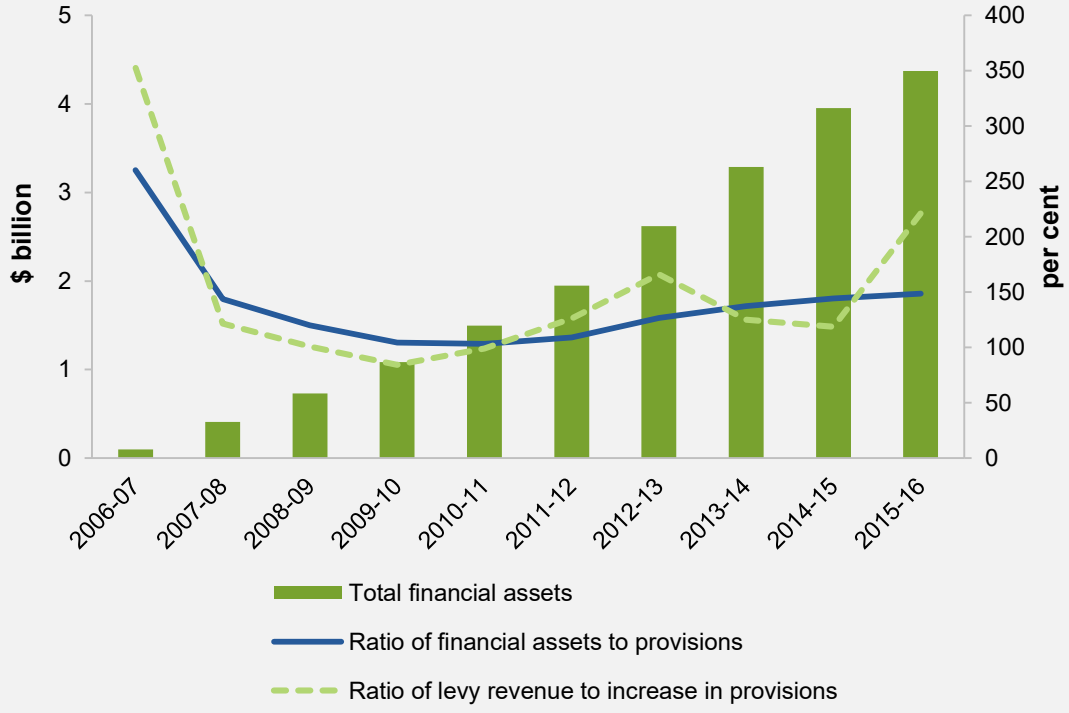
One way this could be achieved would be to create a buffer for risk by including a small margin in the contributions of the Australian Government that allows some future contributions to be brought forward to the current year. In 2011, the Commission recommended that the NDIS be funded by a formula that had a margin over and above yearly expenses to buffer against fluctuations in expenses to create a partial reserve fund (PC 2011, p. 35).

Box 12.5 **NSW Lifetime Care and Support built reserves up gradually**

The NSW Lifetime Care and Support Scheme (now part of icare) was established in 2006 by the NSW Government to provide individuals with no-fault insurance for catastrophic motor vehicle accidents in New South Wales.

NSW Lifetime Care and Support is funded through the Medical Care and Services Levy on Compulsory Third Party insurance which has funded annual claims and also built up a pool of reserves. The reserves held by NSW Lifetime Care and Support were not established by an initial capital injection, but have built up gradually over time through this levy. Reserves (after returns on investment) are now more than sufficient to cover the lifetime cost of all existing and new participants and the scheme's operating expenses in that year, plus a profit and risk margin.

Build-up of Lifetime Care and Support Reserves



Source: icare (2016) and LCAS (2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015).

A gradual accumulation of funds is a more fiscally sustainable way of building up reserves than a large initial capital injection, and this is consistent with the approach used by the TAC and NSW Lifetime Care and Support. Further, when the NDIS is in a steady state, it is likely that entry of participants into the Scheme will be fairly constant. Hence a fairly constant trickle of reserve funds to meet participants' early investment needs is likely to be appropriate for a mature scheme.

While the Commission does not consider that there should be a hard cap on the level of reserves held by the NDIA, a target amount is appropriate. As the Commission recommended in 2011, the level of reserves should be determined by an actuarial and economic determination of optimal reserves (PC 2011, pp. 671–672). There is no urgency

to build substantial reserves now. But there is an imperative for governments to make an immediate commitment to establishing a pool of reserves. It is an essential feature of an insurance-based scheme.

RECOMMENDATION 12.4

Governments should commit now to providing a pool of reserves for the National Disability Insurance Agency. The pool should build up gradually over time, with the target amount based on an actuarial and economic analysis of the optimal level of reserves.

13 Data and evidence

Key points

- The National Disability Insurance Scheme (NDIS) requires good quality data and evidence to inform an insurance based approach to disability support, and to understand any emerging risks to the financial sustainability of the scheme. Providing funding for comprehensive, accessible data is a sound investment when considered in the light of its importance in informing policy for the $22 billion scheme.
- A process of continuous improvement is embedded into the National Disability Insurance Agency's (NDIA) data collection approach — the NDIA's framework for monitoring financial sustainability involves continuous monitoring and evaluation of participant outcomes and costs.
- The NDIA collects data on participants when they access the scheme, when plans are developed, at plan implementation and plan review. At full scheme, there will be data on about 475 000 scheme participants (and progressively data will be collected for many participants over their lifetime).
- A comprehensive data warehouse and reporting capability (including for tracking longitudinal outcomes) are required to support the actuarial and research functions of the NDIA. Currently, the NDIA do not have the required capability to collect all the necessary data for the scheme. It is important that capability constraints are effectively addressed and the data warehouse capability developed.
- Ideally the NDIS will fit seamlessly within the landscape of services delivered to all people with disability. Data on services provided to people with disability outside the NDIS will be critical for assessing the performance of the scheme, and for identifying potential service gaps.
- Data collected on services provided outside the NDIS are being scaled back at a time when it is most needed. Governments should commit to the ongoing funding of the Survey of Disability, Ageing and Carers, and an expanded Disability Services National Minimum Data Set to include supports to people with disability not in the NDIS.
- Linking NDIS data with other datasets has the potential to provide a more complete picture on people with disability. The use of 'flags' in data collections for NDIS participants and people with disability can help shed light on differences in how people with disability interact with mainstream services and on outcomes. Better linking of datasets can also improve data collection efficiency.
- It is imperative that wider access to the NDIA's longitudinal database is permitted to allow research to be undertaken (with appropriate safeguards and policies to protect privacy).
- The NDIA should make public the details of the data it holds, and consult with stakeholders on how best to provide access to this data.

The National Disability Insurance Scheme (NDIS) requires good quality data and evidence to inform an insurance based approach to disability support, and to understand emerging risks to the financial sustainability of the scheme. Providing funding for comprehensive, accessible data is a sound investment when considered in the light of its importance in informing policy for the $22 billion NDIS.

This chapter examines the role of data for the NDIS (section 13.1), and the importance of data collection in relation to disability services provided outside the NDIS (section 13.2). Sections 13.3 and 13.4 look at linking and sharing data and section 13.5 discusses best practice principles for handling data and proposes a way forward.

13.1 The pivotal role of data for the NDIS

Data and evidence are pivotal to any insurance scheme. The financial performance of insurers depends on the quality of their data and how well the data are integrated into day-to-day decision making.

Like other insurance schemes, the NDIS relies on data and analysis systems to monitor (in real time) cost pressures and identify and manage emerging risks to the financial sustainability of the scheme.

Practices of continuous improvement are integrated into the NDIS (figure 13.1). As the NDIA said:

> The first insurance principle is about embedding practices of continuous improvement into the NDIS. It involves comparing actuarial forecasts of cost and participant outcomes with the actual experience of individuals, in order to maximise lifetime opportunities and minimise the lifetime costs of those who are insured. (sub. 161, p. 24)

The NDIS Prudential governance framework also states that:

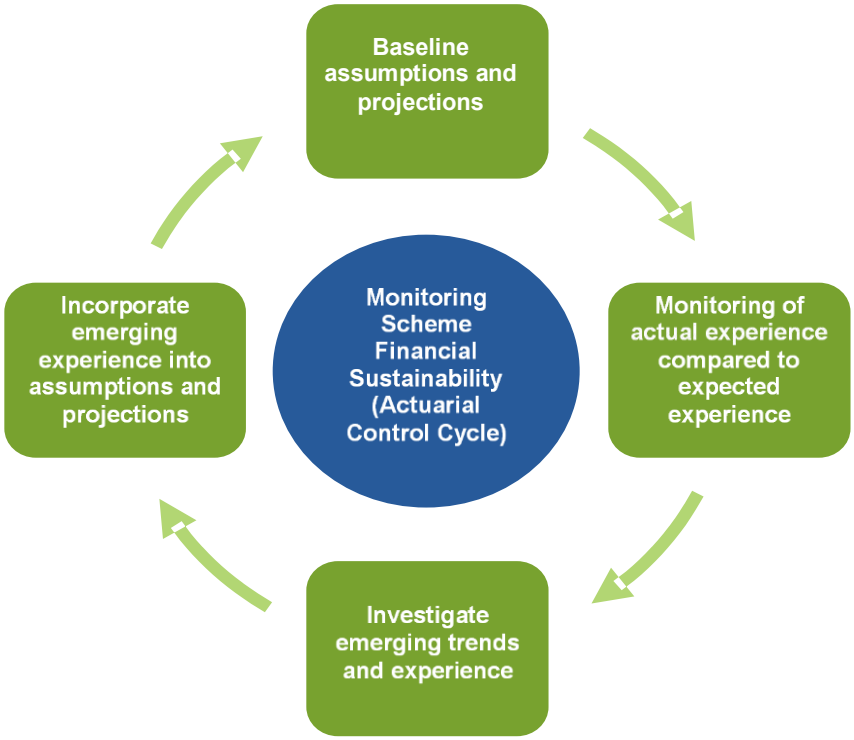
> The NDIA will have access to a person centred longitudinal database of all NDIS participants, and where necessary supplementary linked data sources, containing sufficient information to:
>
> - provide the NDIA operational staff with real-time comprehensive data and information on participant utilisation, cost of supports and participants outcomes; and
> - provide the necessary information for the Scheme Actuary to develop reports on quarterly experience, future expenditure and financial sustainability (NDIA 2016h, p. 23).

The NDIA's framework for monitoring financial sustainability (used by the Scheme Actuaries) includes an evaluation of participant outcomes and costs and involves collecting data on:

- the number of participants
- the characteristics of participants (to allow analysis of reference groups)
- the outcomes of participants

- the cost of supports of participants (sub. 161, p. 115).

Figure 13.1 **Financial sustainability monitoring framework**
Continuous monitoring and evaluation of outcomes and costs



Source: NDIA (sub. 161, p. 115).

This information is used by the NDIA to implement any changes that might be required to ensure that the scheme remains financially sustainable (figure 13.1). And, as discussed in chapter 11, it is also used for the NDIA performance reporting requirements, including the quarterly monitoring report and the Annual Financial Sustainability Report.

The NDIA collects data on participants when they access the scheme, when plans are developed, at plan implementation and plan review (figure 13.2). At full scheme, there will be data on about 475 000 scheme participants, including data on outcomes across eight key domains:

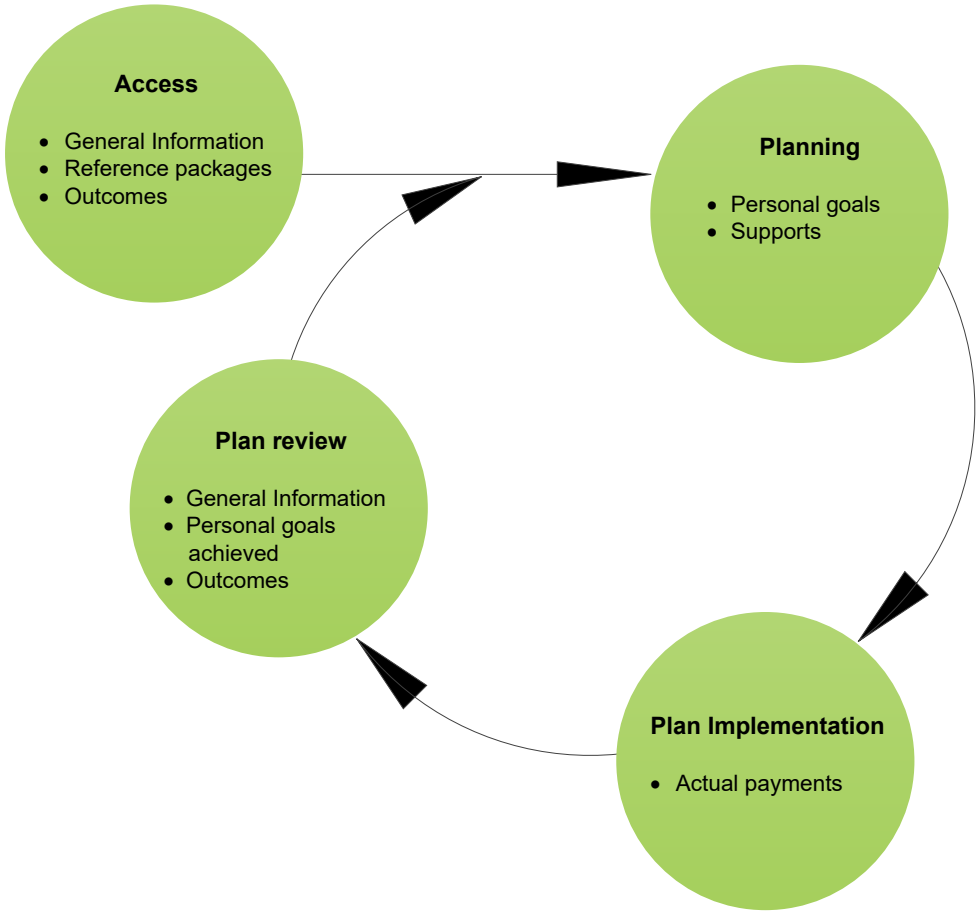
- choice and control
- daily activities
- relationships
- home
- health and wellbeing

- lifelong learning
- work
- social, community and civic participation (chapter 3, box 3.1).

A key advantage of a longitudinal database is that it can measure change over time. As most participants will receive individualised packages under the scheme over their lifetime, with time, NDIS data will be available for participants over their lifetime. Commenting on the NDIA's longitudinal dataset to support actuarial analysis of the scheme, Bruce Bonyhady said 'the NDIA is building the most comprehensive population-based longitudinal database on disability in the world' (sub. 100, p. 15).

The NDIS longitudinal dataset will take some time to build, but the NDIA are already using data from the trials and transition to track scheme performance (including participant outcomes) and identify emerging cost pressures to the scheme (chapter 2).

Figure 13.2 **Collecting data on participants**



Source: Based on NDIA (2016b, p. 10).

The critical role of data for the NDIS and the actuarial approach for measuring performance was commented on by a number of study participants. The Northern Territory Government, for example, said:

> Performance monitoring and reporting arrangements have the potential to affect the delivery and financial sustainability of the NDIS. Without robust and timely data (both qualitative and quantitative) the transition and outcomes of the Scheme are at risk. (sub. 205, p. 3)

The New South Wales Government said:

> A robust actuarial approach is required to measure scheme performance, including against agreed indicators and broader factors impacting on scheme outcomes. This will provide longitudinal data to refine reference packages as the scheme matures, and support market facilitation in areas where the supply of supports is limited. (sub. 60, p. 10)

And the Australian Institute of Health and Welfare commented on the potential benefits of the NDIS dataset:

> The establishment of the NDIS brings with it the opportunity to capture more comprehensive data, as well as opportunities to enhance data access in line with the Australian Government's public data agenda. Indeed, for the first time in Australia, data on scheme participants will enable a joined-up view of their disability support needs, the services provided in response to those needs, and the social and economic outcomes of those services. (sub. PP349, p. 5)

Building the evidence about what works and why

Building the evidence base about what works and does not work for different groups (or what yields the best outcomes at the lowest cost) is also critical. This information is important not only for the NDIA (to maximise the benefits and minimise the costs of the scheme), but also for people with disability and their carers and providers of disability services. Mind Australia, for example, said:

> At present, a lack of evidence on what works for whom and in what circumstances is lacking and needs to be developed as part of ensuring that planners can assist people to make purchasing decisions that are in their best interests, and which deliver sustainable outcomes desired by the scheme. (sub. 144, p. 8)

The Centre of Research Excellence in Disability Health also said:

> As the National Disability Insurance Scheme moves to full rollout there will be a comprehensive data base on all components of the scheme and user experiences such as service provision, service use, costs, and social, economic and health outcomes of the people with disabilities. It is critical to use this data to evaluate the outcomes of the Scheme and to identify how it can be improved.
>
> Importantly the NDIA data will be longitudinal and will enable the tracking of outcomes within and between individuals over time. (sub. 69, p. 2)

And the Victorian Government pointed to the importance of linking support plans with outcomes:

> Ensuring the sustainability of scheme costs will not only require careful management of access and scheme boundaries, consistent with the core NDIS objectives, but will also depend critically on the effectiveness of NDIA planning and assessment processes in delivering an insurance-based approach to investment to support people with disabilities.
>
> This requires an evidence base derived from longitudinal data that links individual support plans with client outcomes, and this will take time. (sub. 174, p. 4)

Facilitating innovation and undertaking research (such as controlled experiments) can help identify low cost choices among effective disability supports and interventions and shed light on what processes used by the NDIS are most effective (for example, planning approaches). One of the NDIA's insurance principles is investment in research and innovation — that is, to encourage and build the capacity and capability for innovation, outcomes analysis and evidence-based decisions on early interventions (chapter 1, box 1.1). The NDIA said it:

> … invests in research and innovation to support the long-term approach of the insurance approach. Investment in research is focused on supporting the NDIS make evidence-based decisions on early interventions to maximise lifetime value for participants. (sub. 161, p. 25)

The NDIA is currently focusing on identifying key transition points for specific cohorts and designing early interventions. The areas of focus include:

- the Early Childhood Early Intervention
- School Leaver Employment Supports
- an intervention initiative for the 7–14 years cohort (sub. 161, pp. 25–6).

The NDIA has also commissioned research on hearing, Autism Spectrum Disorder interventions, Foetal Alcohol Spectrum Disorder interventions and Assistance Animals as supports for people with disability (sub. 161, p. 26).

But it is still very early days in terms of building the evidence base. As the Department of Social Services (DSS) said:

> The insurance-basis of the NDIS is still maturing and it is too early to assess its long-term effectiveness in improving wellbeing for people with disabilities and managing costs in the Scheme. The evidence-base for lifetime cost estimation is increasing, and will need investment to be sufficiently robust and broad-based to inform individualised supports. The impact and use of technology by participants is also important to consider and incorporate into the evidence-base. While this will take time, the early and effective implementation of insurance-based principles is necessary to avoid unsustainable cost escalation. (sub. 146, p. 25)

Data gaps within the NDIS data collection

In this report, the Commission has identified a number of data gaps within the NDIS collection and made recommendations accordingly. For example, the NDIA does not collect

information on which participants have employment restrictions (chapter 3) or on which activity domains are relevant for individuals when they enter the scheme (chapter 4). The evidence base on the effectiveness of Information, Linkages and Capacity Building activities is also very thin (chapter 6), and there are gaps in the NDIA's performance reporting (chapter 11).

While more data would provide the benefit of a stronger evidence base, the benefit must be weighed against the costs of gathering the extra data.

- The collection of data imposes a burden on participants, providers and NDIA staff. A balance needs to be struck between the impost on people (and the possibility of a decline in data quality if too much is asked) and the potential benefit from the additional data.
- There are costs associated with establishing and supporting adequate information, communication and technology (ICT) and administrative systems.
- While the cost of storing data has fallen substantially in recent years, there is a cost to modifying programs to enable information to be recorded.

When deciding what data to collect, the scope to leverage off other data collections to lower the impost on participants, providers and NDIA staff must also be taken into account.

Does the NDIA have the capability to collect the required data?

The NDIS is a new scheme, and the capability to collect data is evolving. The NDIA identified the collection of data on participants as a 'major challenge'.

> Another major challenge is ensuring appropriate collection and access to quality data on participant needs, supports and outcomes. A comprehensive data warehouse and reporting capability, including for tracking longitudinal outcomes is required. Currently, the NDIA does not have the required capability and continued development in this area is critical. (sub. 161, p. 118)

Some examples of problems with the ICT system for the NDIS include that it:

- cannot transfer free text to the data warehouse, so details on individual circumstances that could impact on reasonable and necessary supports are not readily available
- does not transfer all required information on participant assessments to the data warehouse
  - for example, when assessing participants' level of function, the data warehouse is provided a standardised functionality score, but information on the screening tool used for the assessment is not transferred to the data warehouse. This compromises the ability of the NDIA to assess the appropriateness of screening tools being used or to assess how consistently a screening tool is operating in practice.

The plan was always for a staged development of ICT capacity for the NDIS. The Australian Government allocated $143 million over four years for the implementation of the system

(with the appropriation split between the NDIA, the DSS and the Department of Human Services) (DSS 2015a, p. 1 NDIA, sub 161, p. 14), with capacity building to focus on the following.

- In the first year: the ability to accept participants into the scheme, register providers and enable participants and providers to make claims.
- In the second year: improving participant and provider functionality, workflow management, business assurance and fraud prevention.
- In the third and fourth years: the e-MarketPlace and broadening communication options.
- The need for work supporting longitudinal data analysis, monitoring and facilitating an insurance approach was noted, but no time frame was specified (NDIA, sub. 161, pp. 14–15).

The NDIA has recognised that the remedial actions to address ICT failures 'have also put the development of other ICT initiatives under pressure' (sub. 161, p. 15). For example, the development of the e-MarketPlace was scheduled for 2017-18 (NDIA 2016i, pp. 31–32), but the NDIA recently indicated that the e-market program is in the design phase and that there is now no fixed time period for the launch (NDIA 2017d).

The Commission is concerned that, without ongoing improvements in this area, there is a risk that the necessary changes to the ICT system (to have a fully operational data warehouse that can support the actuarial and research functions of the Agency) will not be implemented fast enough.

While the scheme is still in the early stages of operation, it is important that the NDIA closely monitor the progress of resolving the system interface issues and the development of the data warehouse capability. In particular, ensuring that the actions are sufficiently resourced and prioritised, and where necessary, that remedial action is taken. The NDIA's annual report should include an item on the progress of the ICT system and if there are any problems that could disrupt the operation of the scheme or affect the assessment of scheme progress or financial sustainability.

Constraints on data collection

Because the NDIA needs to draw on evidence from outside the scheme, it faces the potential risk that external data collections may change. The NDIA will need to monitor the data being collected outside the scheme. Over time, it may be appropriate to revise the collection of data within the scheme if key external comparators cannot be identified.

13.2 Data on disability services outside the NDIS

Disability data collected outside the scheme should continue

Not all data relevant for assessing the effectiveness of the NDIS can, or should be, collected within the scheme. And, as a number of study participants noted, it is important to understand the wider environment in which the NDIS operates. The Australian Institute of Health and Welfare (AIHW), for example, said:

> … about 89% of all people with disability in Australia, and 36% of people with severe or profound disability aged under 65, won't be supported by the NDIS … As such, truly understanding the costs of, and pressures on, the NDIS, as well as the experiences of people with disability more broadly, will require understanding the wider environment in which the NDIS operates. (sub. PP349, p. 1)

Also:

> The ability to articulate a broader story — with the NDIS included in the context of the wider suite of supports and payments for people with disability — will be critical to governments' understanding, not only of the costs of, and pressure on, the NDIS, but also of the broader experiences of, and outcomes for, people with disability. (sub. PP349, p. i)

The two main existing datasets that collect information on supports for people with disability are:

- the Australian Bureau of Statistics Survey of Disability, Ageing and Carers (SDAC)
- the Disability Service National Minimum Data Set (NMDS) — the main source of information on government provided or funded services for people with disability outside the NDIS (box 13.1).

The SDAC collects information on the level of support needs of people with disability and the level of natural supports available to them. Because the SDAC covers both NDIS and non-NDIS participants, it will continue to be a valuable data source post-NDIS rollout — it can also provide valuable information on the needs and level of ability of future NDIS participants.

Some of the benefits of the NDIS are expected to result from reduced demands on other government supports (chapter 3). As Anglicare Australia said, the impacts of the scheme will include the cost implications on other government programs.

> … it is incumbent on the Commission to recommend evaluation measures regarding the scheme's financial sustainability that take into account the costs avoided or passed on to other areas of government if the NDIS is not properly supported. (sub. 157, p. 21)

And the DSS said:

> Better cross-system reporting on disability could make system boundaries and responsibilities more transparent, as well as give a more coherent picture of improvements in services to people with disability. (sub. 146, p. 5)

Box 13.1 Two important data collections outside the NDIS

Survey of Disability, Ageing and Carers

The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC) provides a comprehensive snapshot of the social and economic participation, circumstances and limitations of people with disability and people over 65 years, and (informal) carers of these two groups.

The latest (2015) SDAC surveyed about 25 750 households (private dwellings and self-care retirement villages) and 1000 cared-accommodation establishments. The survey was the eighth iteration of a series of similar surveys that began in 1981.

Groups covered

The three groups of interest in SDAC are:

- people with disability: disability is defined as any limitation, restriction or impairment that restricts everyday activity and has lasted (or is likely to last) at least 6 months. Both NDIS and non-NDIS participants are included
- people over 65 years old: also recorded whether they have a disease or disorder likely to last longer than six months
- carers: classified as primary carer (those over 15 years old that provide the most support) or other carers (those that provide care, but not the most care, or are under 15 years old).

Goals

SDAC's main objectives are to:

- measure the prevalence of disability in Australia
- measure the need for support of older people and those with disability
- provide a demographic and socio-economic profile of people with disability, older people and carers compared with the general population
- information on carers and those cared for.

NDIS relevant information

SDAC allows valuable insights on the NDIS market by indicating the:

- level of unmet demand for disability services
- level and sustainability of informal caring arrangements
- social and economic circumstances and participation of people with disabilities and their carers.

(continued next page)

Box 13.1 (continued)

Disability Services National Minimum Data Set

The Disability Services National Minimum Data Set (NMDS) is an annual collection and collation of a standard set of data items on disability support services provided under the National Disability Agreement. The data are collected from service users by funded agencies, and is provided to jurisdictions, which in turn provide the data to the Australian Institute of Health and Welfare (AIHW) for national collation and reporting.

The services currently covered by the NMDS include:

- *accommodation support*: services that provide accommodation to people with disability, and services that provide support to enable a person with disability to remain in their existing accommodation or to move to more suitable or appropriate accommodation
- *community support*: services that provide the support needed for a person with disability to live in a non-institutional setting
- *community access*: services designed to provide opportunities for people with disability to gain and use their abilities to enjoy their full potential for social independence
- *respite*: services that provide a short-term and time-limited break for families and other voluntary caregivers of people with disability to help support and maintain the primary caregiving relationship, while providing a positive experience for the person with disability
- *open employment*: services that provide employment assistance to people with disability in obtaining and/or retaining paid employment in the open labour market
- *supported employment*: services that provide employment opportunities and assistance to people with disability to work in specialised and supported work environments
- *advocacy, information, alternative forms of communication*: advocacy; information/referral; combined information/advocacy; mutual support/self-help groups; and alternative formats of communication
- *other support*: research and evaluation; training and development; peak bodies; and 'other support services'.

Sources: ABS (2016a), AIHW (2017a, 2017b).

The AIHW identified a number of data gaps.

> While there is some information about the use of specialist services by people with disability (for example, those provided under the National Disability Agreement, now in transition to the NDIS), we know little about their access to, and use of, mainstream and other services. We also lack a strong evidence base supporting our understanding of the interactions between sectors. (sub. PP349, p. 2)

The AIHW also highlighted the importance of understanding the interaction with, and role of, other services in meeting the needs of people with disability, including:

- mainstream services, such as health, aged care and housing
- specialist supports provided outside the NDIS, such as mental health services

- other supports, such as those provided by informal carers and the community more generally (sub. PP349, p. 2).

Concerns raised about current disability data collections

A number of stakeholders raised concerns about the ongoing funding arrangements for SDAC. Richard Madden said:

> SDAC funding is not secure. The ABS conducts the survey each three years, but must rely on funding from stakeholders (Commonwealth Departments of Social Services and Health, and States and Territories). Funding also determines the sample size. (sub. 101, pp. 11)

The DSS also said that it:

> … notes that not all jurisdictions are contributing funding towards the 2018 Survey of Disability, Ageing and Carers (SDAC). (sub. PP318, p. 11)

Currently, the ABS conducts the SDAC every six years, with an additional survey every three years if funding is provided. In recent years, the survey has been conducted every three years, with half the cost of this second survey funded by the Australian Government Departments of Social Services and Health and the remaining funds provided by the States and Territories (with contributions based on population levels).

The Commission understands that the cost of the 2018 survey is about $19 million. While most jurisdictions have agreed to contribute funding, some are yet to commit. Without ongoing commitment of funds, there is uncertainty about the frequency of the survey and/or how representative the survey will be (as the sample size may be reduced).

The SDAC is important because it provides outcomes data on people with disability both inside and outside the NDIS (as well as for carers) and the extent of unmet need. The AIHW noted that 'the planned 2018 iteration will be well timed to capture relevant information towards the end of the NDIS roll-out period' (sub. PP349, p. 5).

Less frequent (every six years instead of every three) and/or less reliable data will mean less up-to-date data to inform the outcomes during the critical early years of the NDIS. As the AIHW put it:

> … there is a risk that the vital SDAC information may only be available each 6 years, which is too infrequent to inform the experiences and outcomes associated with such a major policy reform as the NDIS. (sub. PP349, p. 5)

RECOMMENDATION 13.1

Australian, State and Territory Governments should commit, by June 2018, to fund (on an ongoing basis) the Australian Bureau of Statistics Survey of Disability, Ageing and Carers, so it can be conducted every three years.

Concerns were also raised about other datasets being discontinued as supports are transitioned to the NDIS. The DSS, for example, said:

> One way to better understand how mainstream services and the NDIS are supporting people with disability is to ensure adequate data collection and reporting. As States wind down the provision of specialist disability services, there is a risk State provided data may decrease. The NDIS will provide a rich source of new data, but only for around one tenth of the total population of people with a disability. DSS considers that all governments need to commit to sustaining and enhancing data collection and reporting on people with disability access to services in cost effective ways. (sub. PP318, p. 11)

Addressing interface issues and data gaps

With the transition to the NDIS, many programs that provide support to people with disability are being changed or discontinued (chapter 6). In addition, some supports previously provided through specialist disability programs will be provided by other systems (for example, some supports for people with psychosocial conditions may be provided through health systems).

While there may be reporting on services provided for each of these programs, it is unlikely that a comprehensive picture of supports provided to people with disability will be available unless a unified reporting system is agreed to. To date, reporting on specialist disability programs has occurred under the National Disability Strategy and data collected through the NMDS.

Where governments provide or fund supports to people with disability, they are likely to collect information on the programs and the characteristics of clients. There would be a small additional cost for governments to collect information on disability and NDIS participation status as part of these data collections — and in many cases, disability status is already collected.

One of the main impediments to expanding the NMDS to collect information on a wider set of services provided to people with disability will be identifying the additional information to collect. This will take time, but should begin as soon as possible.

There are relevant working groups operating under the National Disability Agreement with the expertise to identify the range of services provided to people with disability (the Senior Officers Working Group) and the technical knowledge of the data (the Research and Data Working Group). Each working group comprises of subject matter experts from State, Territory and the Australian Governments. These groups should be authorised to begin planning changes to the NMDS.

Broadening the data collection under the NMDS will not only provide the NDIA with better information to manage scheme costs and outcomes, but also an evidence base for monitoring services provided to people with disability who are not eligible for the NDIS. This

information could also provide insights on any cost shifting from the NDIS onto State and Territory provided services.

RECOMMENDATION 13.2

The Australian, State and Territory Governments should agree to expand the data collection for the Disability Services National Minimum Data Set to include supports to people with disability that are provided or funded by governments outside the National Disability Insurance Scheme (NDIS).

The data collected should include services provided to NDIS participants, but not provided by the NDIS.

A decision on the data to be collected should be made by June 2018, with the broader data to be included in the 2018-19 Disability Services National Minimum Data Set.

13.3 Linking data

Linking datasets for improved collection efficiency and more insights

Data linkage is a process that allows information from datasets to be combined (while also allowing privacy to be preserved). Data linkage has the potential to fill current gaps in what we know about people with disability. As the AIHW said:

> … integrating data in this way can tell a much more powerful, person-centred story than is possible from individual datasets in isolation, and can help policy makers to improve their understanding of a range of issues. … Linkage can also be used to assess outcomes at different 'levels' or for different cohorts (for example, for Indigenous Australians). (sub. PP349, p. 2)

Examples include linking specialist disability services or payments data to national hospital, Medicare Benefits Schedule or Pharmaceutical Benefits Scheme and aged care data to shed light on how people with disability interact with health services.

Linked data will also be important for tracking outcomes for people who leave the scheme in the future. This would be most relevant for people who join the scheme through early intervention pathways and people who will exit to use the aged care system.

But there are also practical challenges with linking datasets, including gaining approval to link data so that researchers can analyse data and release results in a timely way (AIHW, sub. PP349, p. 3).

Current Australian Government policy is to optimise the social value from administrative data collections.

> The data held by the Australian Government is a strategic national resource that holds considerable value for growing the economy, improving service delivery and transforming policy outcomes for the Nation. … The Australian Government commits to optimise the use and reuse

> of public data; to release non sensitive data as open by default; and to collaborate with the private and research sectors to extend the value of public data for the benefit of the Australian public. (Turnbull 2015, p. 1)

But as the Commission's recent *Data Availability and Use* inquiry (PC 2017a, pp. 114–116) highlighted, there is considerable scope to use linked datasets better and more often in policy design and analysis. If the recommendations of that inquiry are adopted (the Australian Government is currently considering a response), the scope for linking administrative datasets will be enhanced.

Data linkage keys

A data linkage key is a way of identifying records from multiple datasets that relate to the same person or organisation. If a common unique identifier is used (such as a Medicare number or Australian Business Number), datasets can be linked using the identifier. In the absence of a common identifier, it will be necessary to create a linkage key from a range of identifying information (such as name, date of birth and address).

While the initial linkage will require access to identifying information, once the match is made, a key can be developed that matches the unique identifiers for the same individual across the datasets. That data linkage key can then be used to link datasets that do not contain identifying information (thus assisting in protecting privacy).

The Commission's *Data Availability and Use* inquiry recommended the retention of linkage keys (PC 2017a, p. 44). The retention of linkage keys will be critical for the NDIA obtaining information in a timely and cost effective manner.

The NDIA will need to regularly update information to assess the lifelong impacts of the scheme. Retaining data linkage keys will reduce the cost and effort that is required to link administrative datasets. It should also reduce the rate of failed matches between the datasets.

Retention of data linkage keys should also reduce the need to duplicate efforts to 'clean' datasets. Administrative datasets often have issues with data quality (such as misspelt entries, inconsistent dates or data recorded in the wrong units of measurement) and retaining data linkage keys can overcome the need to replicate data cleaning.

Linking to surveys

There are some recent examples of survey information being linked with administrative datasets (ABS 2011a, 2011b, 2017b) that could provide a template for linking NDIS data with relevant surveys (such as the SDAC and the General Social Survey).

The ability to link NDIS data with these surveys would be enhanced if the surveys included a 'flag' indicating if the respondent was a NDIS participant. The SDAC included a flag for NDIS participants in the 2015 version of the survey.

The AIHW is also working on including a NDIS participant flag in some of the Institute's surveys, including by States and Territories, for future implementation in the AIHW's Specialist Homelessness Services Collection (sub. PP349, p. 4). Commenting on a NDIS flag, the AIHW said:

> The AIHW is developing a flag for use in data collections to indicate whether a person is receiving support through the NDIS. This flag could be used to look at the use of mainstream and other services by NDIS participants. If used together with the standardised disability flag, it could potentially also be used to examine participation in the NDIS as well as to look at if there are differences in the use of mainstream services between NDIS participants and other people with disability. (sub. PP349, p. 4)

13.4 Sharing data

Access to the longitudinal dataset

A number of stakeholders argued that it is critical that researchers are able to access the NDIA's longitudinal dataset (box 13.2). As the Centre of Research Excellence in Disability and Health noted, the NDIA has limited capacity to conduct research, and:

> … it is important that this rich data is made available to external researchers from a broad range of disciplines (e.g. business and economics, epidemiology, statistics, social sciences, public policy) who can provide independent evaluation of outcomes. … The Agency has relatively limited internal capacity to conduct the broad range of research questions that need to be answered. This recommendation is in line with the Productivity Commission's recent Inquiry into Data Availability and Use. (sub. 69, p. 3)

The longitudinal dataset should allow researchers to assess the effectiveness of particular supports by linking information about supports with participant characteristics and outcomes.

Box 13.2 Participants support researchers having access to NDIA's data

Richard Madden:

> The NDIA currently receives information on each service for which it is billed by service providers, and has full information on the NDIS participant who has received the service. NDIA should work with stakeholders and the AIHW and ABS to design an appropriate minimum data set for participants and supports received, which can be extracted from its data holdings. … A de-identified data set on participants and supports received should be provided without charge to the AIHW in a timely fashion for statistical reporting. (sub. 101, pp. 12–13)

Bruce Bonyhady:

> The disability data that is being collected … should be made available for research, as a matter of high priority, subject to appropriate safeguards. As the Productivity Commission is currently conducting an Inquiry into Data Availability and Use which will report shortly, this Review should include recommendations on how best to ensure that the NDIA data will be made available for research to improve the lives of people with disability, their families and carers. (sub. 100, p. 15)

Australian Institute of Health and Welfare:

> … while it is entirely appropriate for the NDIA to monitor the progress and sustainability of the scheme, an independent agency (such as the AIHW) should be engaged to undertake reporting more broadly, perhaps against a disability reporting framework similar to that used in the health sector.
>
> … There is great potential benefit in making non-sensitive data 'open by default' by not restricting its use or redistribution; but how to make optimal use of this huge and increasingly unstructured source of information is a major challenge. While the need to manage 'big data' is clearly evident, the key issue for all data users is to ensure these data are used in the most effective manner; that is, 'smart data'. It also presents an opportunity to develop better ways to analyse and present data, and to partner with a wider range of collaborators. (sub. PP349, p. 6)

Benefits from data sharing

A key reason for allowing approved external researchers access to the longitudinal data is that it increases the opportunities for identifying best practice models and ways to improve the scheme. Such solutions are more likely to evolve if a community of researchers develops who are actively engaged in discussions about the merits and potential unintended impacts of alternative approaches. The size and capability of the research community interested in examining NDIS related issues is likely to be substantially larger if researchers have timely access to quality data.

The gold standard for evidence based policy are systematic reviews with decisions based on a literature that has built up on an issue, particularly with academic researchers reviewing their peer's research, and re-evaluating the issue from a slightly different perspective.

This dialectic approach has the scope to develop robust findings on an issue. Such an approach is common in medical research (and especially epidemiology). The NDIA does not have the resources to replicate such a process in house.

Existing legal and policy basis for the NDIA to share data

The NDIA is sharing data with other organisations. The NDIA provided the Commission with a set of de-identified unit record data to assist with this review. The State and Territory Governments are routinely given access to similar data (NDIS Act, s. 174). The Australian Government Actuary has also had access to the NDIA's data to undertake the role of reviewing actuary (as set out in the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act)).

However, the NDIA does not currently have a public policy outlining when and how data can be shared. For the NDIA to share data, it needs:

- no legislative barrier to sharing data
  - there is no need for legislation to permit data sharing but where legislation does prescribe data protections (as is the case of the NDIS Act), there needs to be a clear legislative basis for doing so (box 13.3)
- established rules on data sharing
- the technical capacity to share data.

The Commission's recent *Data Availability and Use* (2017a) inquiry identified two other critical factors that can hamper the level of data sharing — organisation culture and agency practice.

FINDING 13.1

There are benefits from allowing researchers to have access to National Disability Insurance Scheme unit record data. Access could be provided by creating a de-identified longitudinal dataset and by allowing approved researchers access to bespoke and more detailed data sets on a case-by-case basis.

Box 13.3 The NDIA has legal permission to share data

The NDIS Act provides scope for unit record data to be shared with Australian, State and Territory government agencies, academic researchers, peak bodies and disability service providers.

Disclosure of protected information for research, actuarial analysis or policy development is permitted if the CEO of the Agency believes the information is reasonably necessary (s. 60).

The CEO can certify that information be disclosed for public interest reasons (s. 66).

The CEO may disclose information to the heads of a range of Australian, State and Territory government agencies for the purposes of the department or agency (s. 66).

Such disclosure of information needs to be consistent with rules established for the running of the Agency.

The Act also specifies that the NDIA should 'develop and enhance the disability sector, including by facilitating innovation, research and contemporary best practice in the sector' (s. 118).

Does the NDIA have rules and policies that permit data sharing?

Scheme Rules do not limit the ability to share data with other government agencies, peak bodies, providers or researchers who are interested in using the information to improve the scheme.

The *National Disability Insurance Scheme (Protection and Disclosure of Information) Rules 2013* (Cwlth) provide guidance to the CEO when considering disclosure of information for public interest purposes (Part 4) and sets out matters relating to the CEO's power to disclose information to Secretaries, chief executives and heads of Australian, State and Territory Government agencies (Part 5).

The two main areas of guidance for the CEO in considering public interest access is that those seeking access to the data have 'sufficient interest in the information' and that 'the information cannot reasonably be obtained from a source other than the agency' (*National Disability Insurance Scheme (Protection and Disclosure of Information) Rules 2013* (Cwlth), r. 4.3).

When releasing information to the heads of government agencies, the main guidance the Rules provide for the CEO is that a record should be kept of what data was supplied, who the data was supplied to and the requested purpose of the data (*National Disability Insurance Scheme (Protection and Disclosure of Information) Rules 2013* (Cwlth), r. 5.5).

The Commission understands that the NDIA does not have a policy on the release of public information, although progress on preparing such a policy is well advanced.

Does the NDIA have the technical capacity to share data?

There are two elements to the technical capacity of the NDIA to share data — the technical ability of the Agency staff and the technical capacity of the Agency's information and communication technology.

The NDIA has staff that are qualified and capable of warehousing, curating and transforming data. However, there are currently deficiencies in the NDIA's technical capacity to collect data.

13.5 A way forward

The Commission's recent inquiry on *Data Availability and Use* found that comprehensive reform of Australia's data infrastructure is needed to signal that permission is granted for active data sharing and release, and that data infrastructure and assets are a priority. To be effective, these reforms should be underpinned by:

- clear and consistent leadership to effect cultural change
- transparency and accountability for release and risk management
- reformed policies and legislation
- institutional change (PC 2017a, p. 35).

A culture of data availability and use

Leadership is important for establishing a data sharing culture. As the Commission's *Data Availability and Use* inquiry put it:

> New arrangements for data access will require, within Governments, strong and consistent leadership, from the Ministerial level as well as the upper echelons of the bureaucracy. (PC 2017a, p. 28)

The Tasmanian Government also noted:

> It takes clear, high-level direction and authorisation in order to get data-sharing initiatives up and running. (2016, p. 14)

Without a culture that grants active permission for the sharing and release of data, the benefits of data sharing and use will not be realised (and as noted above, the benefits of greater sharing and use of data about people with disability are likely to be significant). It is therefore critical that the NDIA has a data sharing culture if the benefits of the data held by the NDIA are to be realised.

The NDIA should actively promote data sharing within the Agency and with external bodies and researchers. Publishing data holdings, policies and processes (discussed later) can help signal that the NDIA is 'open for business' when it comes to data sharing and release. There are also a range of data communities of practice that the NDIA could participate in to develop expertise in data availability and use, including, for example, the Australian Government's Data Champions Network.

Data about people with disability can be highly sensitive, and there is likely to be community concern about how this data is used. Policies, processes and systems implemented to enable data sharing and release need to be designed to maintain trust, including via developing robust risk-management procedures.

One means of engendering trust is to have an independent process to review how data will be used. A standard means of reviewing the appropriateness of research on or about people

are ethics committees. Ethics committees are intended to ensure respect and protection of participants of the study, and to encourage ethical practices amongst researchers (NHMRC 2015, p. 6). Depending on the nature of the intended research using NDIS data, it may be appropriate for ethics committee approval to be obtained before data is accessed.

A comprehensive, longitudinal dataset

Data that is fit for purpose

As outlined above, the NDIA collects data for two purposes — to monitor and evaluate performance of the scheme and to inform policy.

Timely, standardised data collected at a sufficient level of disaggregation is also critical to enable broader use. The Commission's *Data Availability and Use* inquiry (PC 2017a, p. 345), set out four preconditions for releasing unit record level data. The data should be:

- machine readable
- readily linkable to other datasets
- understandable
- de-identified (unless the data is already publicly available).

One study participant, Richard Madden, suggested that the NDIA should provide the AIHW with data on participants:

> A de-identified data set on participants and supports received should be provided without charge to the AIHW in a timely fashion for statistical reporting (sub. 101, p. 13).

One benefit of providing the AIHW with data on disability is that it could be linked with other related data collections that the AIHW holds, particularly health data.

While linking disability and health data would not remove the need for the NDIA to collect outcomes information, it could significantly reduce the amount of information that it needs to collect, thus promoting cost savings to the NDIA and efficiencies across the health and disability systems.

Given that the AIHW already has expertise collecting, linking and reporting on health and disability data, and it has established and effective ICT systems, there are likely to be cost savings and efficiency benefits from the NDIA regularly providing such unit record data to the AIHW.

Managing the risk of sharing and releasing data

The Commission's *Data Availability and Use* inquiry found significant deficiencies in the way the public sector manages the risk of sharing and releasing data — including that data

is locked up and unable to be used due to concerns about the risk and sensitivity of that data, or it is shared (for genuine public interest purposes) but with poor controls on its use (PC 2017a, pp. 94–95).

The Commission proposed that data use should require rigorous assessment of *genuine* risk to inform the development of effective risk management strategies and controls by institutions that have the capability and resourcing to carry out this role effectively (PC 2017a, p. 181). A risk-based approach to data sharing and release allows the benefits of data use to be maximised, while the harms are minimised.

The five safes model is a best-practice framework for managing the risk of sharing and releasing data (box 13.4).

For the NDIA, a risk-based approach to sharing and releasing data means scaling releases of data depending on the risk of the release:

- public, or open data, should be sufficiently aggregated and confidentialised such that the data released is non-sensitive (that is, non-identifiable)
- a synthetic dataset is one way of making more disaggregated but non-sensitive data readily available to researchers
- data provided to trusted researchers in a secure environment can be more lightly de-identified
- data shared within the NDIA or with other government departments (chapter 11) may include identifiable details (if the purpose of use requires it — for instance, service delivery purposes) but secure access and storage procedures should be in place.

These initiatives require a certain amount of capability to be effectively undertaken. And the NDIA is a relatively new agency whose capability is still developing. While there will be benefits from the NDIA developing some in-house capability, there is also likely to be scope for the NDIA, particularly in the early years of its operation, to draw heavily on outside expertise from more mature organisations such as the AIHW and Data61.

Box 13.4 Five safes model

The traditional approach for managing risk of data sharing was to only release data that could not be used to identify people. This approach limits the type of analysis that can be undertaken (such as excluding analysis of disabilities where there are few sufferers, or not permitting analysis of exits from the NDIS). However, more recent approaches have been developed to allow researchers access to more identifying information, but which maintain the same level of privacy and data security, by using other levers. For example, in the NDIS context, virtual data laboratories could be used to ensure researchers can only extract results of their analysis when the data custodian considers that the results will not identify individual NDIS participants.

The five safes model focuses on five risk axes:

- *Safe people*: Can the researchers be trusted?
- *Safe projects*: Is the use of data appropriate? Does the researcher have ethics committee approval (where appropriate)?
- *Safe settings*: Does the access environment prevent unauthorised use?
- *Safe data*: Can the data disclose identity?
- *Safe outputs*: Are the statistical results non-disclosive?

In practice, the five safes model has been implemented using virtual laboratories or trusted access models which provide more risky data in a safer environment. Such facilities can be expensive to develop and require technical expertise and specialised information, communication and technology systems. While the NDIS may choose to develop its own capability, there is already an example that has been extensively used for health research in Australia — the Secure Unified Research Environment, provided through the Sax Institute (PC 2017a, p. 419). It provides a high security environment that facilitates the use of data from different custodians and also allows the collaboration of researchers working across multiple institutions, including overseas-based researchers.

Source: Adapted from Desai et al. (2016, pp. 3–5).

FINDING 13.2

The National Disability Insurance Agency should adopt a risk-based approach to sharing and release of data. A risk-based approach could include:

- open data that are able to be publicly released because they are non-sensitive
- a synthetic dataset that is more disaggregated but also non-sensitive, that is readily provided to researchers
- secure sharing of more sensitive data to researchers in an environment such as SURE
- better sharing of data with other relevant agencies such as the Australian, State and Territory Governments, with secure access and storage procedures put in place.

There are likely to be benefits, particularly in the early years of its operation, from drawing on the capability and expertise of more mature organisations such as the Australian Institute of Health and Welfare and Data61.

Best-practice policies, processes and systems

There is value in the NDIA making public details of the data it holds and how to access it. When developing policies and processes for seeking access to such data, the NDIA should consult with researchers, other data users, and relevant organisations that have expertise in data sharing (such as the DSS and the AIHW) and cover issues such as:

- what data will be of most value to researchers, including how to design a generic unit record file to reduce the cost to the NDIA of addressing bespoke data requests
- impediments researchers experience when trying to access administrative data, and practical ways to avoid them
- processes for seeking access to the data.

RECOMMENDATION 13.3

The National Disability Insurance Agency (NDIA) should engage with stakeholders on how data access will be operationalised. By July 2018, the NDIA should issue a statement outlining the organisation's goals for data sharing and an intended timeline for operationalising data sharing by the NDIA.

A Conduct of the study

The Commission received the terms of reference for this study on 20 January 2017. It subsequently released an issues paper on 22 February 2017 that invited public submissions and highlighted particular matters on which it sought information. A position paper was released on 14 June 2017, which sought further information and feedback.

An extension to the date for the final report from 20 September 2017 to 11 October 2017 was granted by the Treasurer. A copy of the extension letter is included with the terms of reference at the front of this report.

In total, the study received 372 submissions (table A.1). The study also received 185 brief submissions online, including those collected by the organisation Every Australian Counts. All public submissions are available on the study's website.

During the study, the Commission held consultations with people with disability, advocacy groups, peak bodies, service providers, disability care and support workers, and government departments and agencies (table A.2).

The Commission would like to thank all those who contributed to this study.

Data and information

The Commission would like to thank the National Disability Insurance Agency (NDIA) for providing unpublished data and information to the study, and for allocating a staff member to spend several days in the Commission's Canberra office to provide feedback on analysis conducted by the Commission. Any errors in the analysis of these data and information in this paper are attributable to the Commission.

There are two areas the Commission did not examine.

1. The construction of the NDIA's reference packages and how they are used to derive typical support packages. The Commission requested data on the nature of reference packages, which the Agency declined to provide on the grounds of the sensitive nature of the material. The NDIA instead provided a member of the actuarial team to discuss the mechanics of the reference packages with Commission staff.
2. The updates to the NDIA's Hourly Rate Model (formerly known as the 'Reasonable Cost Model' and 'Hourly Cost Model'). The model was requested by the Commission in August 2017, but was not provided the model until 11 September 2017. This was too late for the Commission to study the model and its assumptions in detail.

The Commission would also like to thank the Department of Social Services for providing unpublished data and information to the study.

This paper uses the National Centre for Vocational Education Research's data on vocational education outcomes (VOCSTATS). These data are collected by registered training organisations and state training authorities around Australia. The National Centre for Vocational Education Research is not responsible for errors in the extraction, analysis or interpretation of the data presented in this study.

Table A.1 **Public Submissions[a]**

Participants	*Submission number(s)*	
Ability First Australia	62	
Aboriginal Medical Services Alliance NT (AMSANT)	PP336	#
ACT Council of Social Service (ACTCOSS)	138	
ACT Disability, Aged and Carer Advocacy Service (ADACAS)	87, PP260	
ACT Government	156, PP312	#
Activ	PP302	
AEIOU Foundation	32, PP277	#
Aftercare	PP348	
Allianz Australia Insurance	42, PP265	
Allied Health Professions Australia (AHPA)	37	
Alzheimer's Australia	10, PP313	
Amaze	160, PP281	
Anglicare Australia	157, PP339	#
Anglicare NT	PP340	#
Anglicare Tasmania	145	#
Annecto	34	
APC Prosthetics	PP244	
Arts Access Australia	PP366	
Assistive Technology Suppliers Australasia (ATSA)	33	
Attendant Care Industry Association (ACIA)	141	
Australasian Podiatry Council (APodC)	52	
Australasian Sleep Association	PP214	
Australian Association of Social Workers (AASW)	124	
Australian Blindness Forum (ABF)	48, PP263	
Australian Federation of Disability Organisations (AFDO)	180, PP325	
Australian Institute of Health and Welfare (AIHW)	PP349	
Australian Lawyers Alliance (ALA)	54, PP257	
Australian Medical Association (AMA)	120	
Australian Orthotic Prosthetic Association (AOPA)	123, PP294	
Australian Physiotherapy Association (APA)	93	
Australian Psychological Society (APS)	19, PP229	
Australian Red Cross	PP258	
Australian Rehabilitation Providers Association (ARPA)	28	
Australian Services Union (ASU)	154	
Australian Services Union (ASU) and Disabled People's Organisations Australia (DPOA)	198	
Australian Unity	173, PP273	
Australians for Disability Justice (ADJ)	PP342	#
Autism Advisory and Support Service (AASS)	PP330	
Autism Aspergers Advocacy Australia	178	
Autism Association of Western Australia	PP219	

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Table A.1 (continued)

Participants	*Submission number(s)*	
Barnardos Australia	85	
Batt, Heather	PP368	
Becker, Bruce	PP353	*
Belconnen Community Service Board	39	
Better Caring	184, PP296	
Blind Citizens Australia (BCA)	130, PP351	
Bonyhady, Bruce	100, PP333	
Boyle, Michael	27	
Brain Injury SA	116	
Bravo Ability Service	96	#
Broken Rites	204	
Brotherhood of St Laurence	189	*
Burns, Kylie	PP315	#
Burrows, Matt	7	
Bus Association Victoria	1	
Business Council of Co-operatives and Mutuals (BCCM)	91, PP329	
Butterfly Foundation	78	#
Calvary Health Care Bethlehem	64	
Capricorn Community Development Association (CCDA)	142, PP300	
Carers Australia	195, PP224	
Carers Australia Victoria	131	
Catholic Social Services Australia (CSSA)	166, PP278	
Centacare Brisbane	44	
Centre for Disability Studies (CDS)	43, 49	#
Centre of Research Excellence in Disability and Health (CREDH)	69	
Cerebral Palsy Alliance	163	#
Cheesman, Bernadette	PP248	
Children and Young People with Disability Australia (CYDA)	188, PP358	
Cohealth	50, PP261	
Commonwealth Ombudsman	137	#
Communication Rights Australia, Disability Discrimination Legal Service and Villamanta Disability Rights Legal Service	88	
Community and Public Sector Union and Civil Services Association of WA (CPSU/CSA)	PP305	
Community and Public Sector Union (CPSU)	76, PP310	
Community Mental Health Australia (CMHA)	11, PP270	#
Community Services Industry Alliance (CSIA)	77, PP251	
Community Transport Organisation (CTO)	PP280	
Companion House	84	
Condren, James	66, PP208*	
Curley, Tricia	140	
Curlewis, Carmel	PP372	
DARE Disability Support	182	

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Table A.1 (continued)

Participants	*Submission number(s)*	
Deaf Australia	183	
Deafness Forum of Australia	127	
Department of Health (DoH)	175, PP360	
Department of Social Services (DSS)	146, PP318	
Dietitians Association of Australia (DAA)	119, PP292	
Diggins, Deb	PP364	
Disability Advocacy Network Australia (DANA)	PP371	
Disability Services Australia (DSA)	9, PP256	#*
Disability Services Commissioner	35	
Disabled People's Organisations Australia (DPOA)	165	
Down Syndrome Australia	121	
Dowse, Leanne; Paterson, Melinda; and Sprange, Mike	114	
DUO Services Australia	196	
EACH	PP276	
Early Childhood Intervention Australia (ECIA)	PP249	
Early Childhood Intervention Australia (ECIA) NSW/ACT	190	
Early Childhood Intervention Australia (ECIA) Victoria/Tasmania	129, PP301	
EarlyEd	PP290	
Ella Centre	PP250	#
Endeavour Foundation	202	
Epic Employment Service	70	
Espyconnect	PP267	*
Ethnic Communities' Council of Victoria (ECCV)	31	
Every Australian Counts	92	
Everyday Independence	133	
Family Advocacy	PP346	
Fanning, Vanessa	21	
Fear, Ross	103	
Financial Services Council (FSC)	98	#
First Peoples Disability Network	PP355	
Flourish Australia	74, PP246	
Freedom Key	125	#
Goldfields Individual and Family Support Association (GIFSA)	13	
Governments of Victoria, Queensland, South Australia, and the ACT	201	
Harrison, Jenny	PP236	
Health Services Union (HSU)	132, PP316	
Health Services Union (HSU), Australian Services Union (ASU) and United Voice	PP272	#
Homelife Association	59	
Hopkins Centre: Research for Rehabilitation and Resilience	105	
House with No Steps	104	
Inclusion Australia	185, PP357	
Inclusion Melbourne	PP207	

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Table A.1 (continued)

Participants	*Submission number(s)*	
Independent Schools Council of Australia (ISCA)	83	
Integra	99, PP268	#
Interaction Disability Services	PP213	
Interchange Inner East	PP271	
Jacqueline Pierce and Associates	147	
Jane, Belinda	80	
Jesuit Social Services	117	
JFA Purple Orange	186, PP350	
Jobsupport	191	
Kennedy, Richard	2	
Launch Housing	PP275	
Leadership Plus	128	
Legacy Australia	168, PP238	
Legal Aid NSW	PP245	
Lifestart Co-operative	97, PP322	
Lifestyle in Supported Accommodation (LISA)	3	
LINK Community Transport	194	
Livecare Australia	PP217	
Llewellyn, Gwynnyth	40	
Lutheran Community Care Queensland	197	
Macarthur Disability Services	57, PP288*	
Macular Disease Foundation Australia	75, PP243	
Madden, Richard	101, PP307	
Magarey, Kirsty	150	
Mallee Track Health and Community Service (MTHCS)	6, PP222	
Maloney, Liza	68	
Mamre Association	47	
Manning, Penny	36	
Martin, Sarah	41	*
Maurice Blackburn Lawyers	58, PP309	
McAuley Community Services for Women	PP211	
McDonnell, Cheryl	79	
Mental Health and NDIS Facebook Support Group	8	
Mental Health Australia	155, PP321	#
Mental Health Carers ARAFMI Illawarra	PP317	#
Mental Health Carers Australia	181, PP341	
Mental Health Coalition of South Australia (MHCSA)	PP308	
Mental Health Community Coalition of the ACT	135, PP286	
Mental Health Complaints Commissioner	164	
Mental Health of Young People with Developmental Disabilities	PP269	
Mental Illness Fellowship of Australia (MIFA)	122, PP338	
Mental Illness Fellowship of WA (MIFWA)	PP221	

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Table A.1 (continued)

Participants	*Submission number(s)*	
Menzel, Melisa	PP209	
Milner & Clyde	94	
Mind Australia	144	
MJD Foundation	PP233	
MND Australia	45, PP255	
Morton, James	110	
Multiple Sclerosis (MS) Australia	PP283	
Multiple Sclerosis Network of Care Australia	PP218	
Municipal Association of Victoria (MAV)	152, PP343	
Name withheld	4	
Name withheld	5	*
Name withheld	199	
Name withheld	PP215	
Name withheld	PP237	
Name withheld	PP287	
Name withheld	PP289	
Name withheld	PP365	
Nardy House	PP216	
National Disability and Carer Alliance	PP344	
National Disability Insurance Agency (NDIA)	161, PP32, PP367*, PP369*	
National Disability Services (NDS)	51, PP295	
National Mental Health Commission (NMHC)	153, PP319	
National Disability Insurance Scheme Independent Advisory Council (NDIS IAC)	149	
Neami National	63, PP347	
Nelson, Fergus	17	
Neurological Alliance Australia (NAA)	30	
New South Wales Government	60, PP230	
Noah’s Ark	108, PP328	
Northern Territory Government	205, PP359	
NSW Council for Intellectual Disability (NSWCID)	193, PP234	
NSW Disability Network Forum	18	
NSW Disability Support Organisations	90	#
NSW Nurses and Midwives' Association	PP323	
Nulsen Disability Services	PP225	*
Occupational Therapy Australia (OTA)	15, PP285	
Office of the Public Advocate (OPA)	46, PP241	
Office of the Public Guardian (OPG)	143	
One Door Mental Health	179, PP266	
O'Rourke, Hon. Coralee	106	
Orygen	PP254	
Paraplegic and Quadriplegic Association of NSW (ParaQuad NSW)	PP239	

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Table A.1 (continued)

Participants	*Submission number(s)*	
Parkin, David	177, PP362	
Parkinson's Australia	PP232	
Peterson, Frank Lawrence	148	
Physical Disability Australia (PDA)	38, PP306	
Physical Disability Council of NSW (PDCN)	29	
Psychiatric Disability Services of Victoria (VICSERV)	169, PP284	
Plan Management Partners	126, PP324	
Positive Life NSW	PP356	
Potapczyk, Hannah	26	
Power Housing Australia	139	
Prader-Willi Syndrome Association of Australia (PWSAA)	112, PP228	
Public Health Association of Australia (PHAA)	134	
Public Service Research Group	56	
Quality Living Options Bendigo	PP220	
Queensland Advocacy Incorporated (QAI)	115, PP311	
Queensland Association of Special Education	PP297	
Queensland Government	PP345	
Queensland Nurses and Midwives' Union (QNMU)	PP240	
Queenslanders with Disability Network (QDN)	PP335	
Read, Suzanne	24	
Regional Development Australia Murraylands and Riverland (RDAMR)	12, PP231	
RehabCo	23	
Ross, Francis	PP331, PP363	*
Roundsquared	170	
Royal Australasian College of Physicians (RACP)	PP299	
Royal Australian College of General Practitioners (RACGP)	200, PP361	
The Royal Australian and New Zealand College of Psychiatrists (RANZCP)	158	
Royal Institute for Deaf and Blind Children (RIDBC)	95, PP259	
Royal Society for the Blind (RSB)	82	#
Ryan, Margaret	PP226	
SAL Consulting	PP304	
Scope Australia	72	
SDN Children's Services	73	
Self Advocacy Resource Unit (SARU)	PP279	
Sharing Places	53, PP291	
Sisters Inside Inc	16	
Smith-Merry, Jennifer	55	
Social Support & Precarious Workforce Research Discussion Group	71	
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South Australian Government	203, PP354	
Speaking Up For You (SUFY)	PP242	
Speech Pathology Australia	136, PP303	
Spinal Cord Injuries Australia (SCIA)	61	
Summer Foundation	113, PP293	
Sylvanvale	192	
Syndromes Without A Name (SWAN) Australia	86, PP235	
Taggart, Michael	89	
Tandem	PP212	
Tasmanian Government	PP247	
The Able Movement	109	
The Australian Centre for Social Innovation (TACSI)	65	#
The Benevolent Society	PP334	
The Shepherd Centre	107	
Top End Association for Mental Health (TEAMhealth)	102	
Travellers Aid Australia (TAA)	20	
Ubercare Services	PP227	
United Voice	118	
VICSERV (Psychiatric Disability Services of Victoria)	169, PP284	
Victoria Legal Aid	PP314, PP367	
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)	162, PP223	
Victorian Advocacy League for Individuals with Disability (VALID)	PP332	
Victorian Council of Social Service (VCOSS)	176, PP264	
Victorian Government	174, PP298	#
Victorian Healthcare Association	172, PP337	
Victorian Mental Illness Awareness Council (VMIAC)	167	
Vision Australia	PP210, PP252	
Volunteering Australia	PP274	
Wall, Elizabeth	PP352	
Western Australia Local Government Association (WALGA)	151, PP320	
Westhaven Association	81	
Wilson, Tony	14	
Windsor & Associates	171	
Woden Community Service	159	
Women with Disabilities Victoria	111, PP282	
Yanga, Anna	22	
YFS	25	*
Young People In Nursing Homes National Alliance (YPINH)	187, PP326	
Youngcare	PP253	
Youth Disability Advocacy Service (YDAS)	PP262	
Zemanek, Elizabeth	206	

a An asterisk (*) indicates that the submission contains confidential material NOT available to the public. A hash (#) indicates that the submission includes attachments.

Table A.2 **Stakeholder consultations**

Participants
ACL Disability Services & Gig Buddies Sydney
ACT Disability Aged and Carer Advocacy Service
Anglicare Australia
Anglicare NT
Anglicare SA
Anglicare Southern Queensland
APM (Advanced Personnel Management)
Australian Bureau of Statistics
Australian Council of Social Service
Australian National Audit Office
Australian Services Union and United Voice workers and organisers
Bonyhady, Bruce
CatholicCare Social Services
Catholic Social Services Australia
Centre for Disability Studies
Cerebral Palsy Alliance
Children and Young People with Disability Australia
Cohen, Dr Martin
Community Services Industry Alliance with NDS Queensland and local disability providers
Department of Employment
Department of Finance
Department of Health (Aged Care)
Department of Social Services
Disability Advocacy Network Australia
Disability Discrimination Commissioner (Alastair McEwin)
Disabled People's Organisations Australia
EPIC Assist
Fenton, Dr Marc
Firstchance
First Peoples Disability Network
Health and Community Services Union workers and organisers
House With No Steps
Integra
JFA Purple Orange
Karingal
Kevin Stone from Victorian Advocacy League for Individuals with Disability and five parents of participants
LeapFrog Ability
Lifestart
Marymead
McKinsey and Company
Mental Health Australia
Mental Health Coordinating Council of New South Wales

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Participants
National Disability Insurance Agency
National Disability Insurance Agency Actuaries
National Disability Services
National Disability Services Queensland and the Community Services Industry Alliance
National Disability Services Western Australia
Neami National
New South Wales Government
Pegasus, Riding for the Disabled
People with Disability Australia
Physical Disability Council of New South Wales
Plan Management Partners
Queensland Alliance for Mental Health
Queensland Government
SalvoConnect
Samaritans New South Wales
The Treasury
Victorian Council of Social Service
Victorian Disability Forum
Victorian Government agencies
Victorian Government departments
Western Australian Association for Mental Health
Western Australian Government
Teleconference
ACT Community Services Directorate
ACT Chief Minister, Treasury and Economic Development Directorate
Australian Competition and Consumer Commission
Australian Federation of Disability Organisations
Australian Government Actuary
Australian Services Union
Carers Australia
Children and Young People with Disability Australia
Cross, Rebecca
Department of Health
Department of Prime Minister and Cabinet
Dyson, Maree
Gilchrist, David (University of Western Australia)
Hogan, Catherine
icare
Inclusion Melbourne
Jobsupport (Phil Tuckerman)

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Teleconference
Knight, Penny (Curtin University)
Lifetime Care and Support Authority
Mental Health Australia
National Institute of Labour Studies, Flinders University
National Mental Health Commission
New South Wales Department of Family and Community Services
New Zealand Accident Compensation Corporation
Northern Territory Department of the Chief Minister
Northern Territory Department of Treasury and Finance
Northern Territory Department of Health
Queensland Department of Communities, Child Safety and Disability Services
South Australian Department for Communities and Social Inclusion
Tasmanian Department of Education
Tasmanian Department of Health and Human Services
Tasmanian Department of Premier and Cabinet
Tasmanian Department of Treasury and Finance
TelstraHealth
United Voice
Victorian Department of Health and Human Services
Victorian Department of Premier and Cabinet
Victorian Transport Accident Commission
Victorian Treasury
Western Australia Disability Services Commission
Young People in Nursing Homes

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THE AGED CARE WORKFORCE, 2016

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Glossary

ABS	Australian Bureau of Statistics
AHA	Allied Health Assistant
AH	Allied Health
AHP	Allied Health Professional
CALD	Culturally and Linguistically Diverse
CCW	Community Care Worker
CDC	Consumer Directed Care
CHSP	Commonwealth Home Support Program
CPD	Continuing and Professional Development
Direct Care	Direct Care employees provide care directly to care recipients as a core component of their work, includes occupations Nurse Practitioner, Registered Nurse, Enrolled Nurse, Community Care Workers, Allied Health Professionals, Allied Health Assistants.
DVA	Department of Veterans' Affairs programs
EN	Enrolled Nurse
HACC	Home and Community Care
HCHS	Home Care and Home Support
HCP	Home Care Packages program
IP	Innovative Pool program
LOTE	Language Other Than English
MPS	Multi-Purpose Service program
PCA	Personal Care Attendant
NACWCS	National Aged Care Workforce Census and Survey
NATSIFACP	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
NDIS	National Disability Insurance Scheme
NP	Nurse Practitioner
PAYG	Employees for whom Pay As You Go (PAYG) tax is deducted by the organisation including for those on paid leave.
RN	Registered Nurse
TCP	Transition Care Program

Executive Summary

Background

This is a report on the findings of the 2016 National Aged Care Workforce Census and Survey (NACWCS) conducted by the National Institute of Labour Studies, on behalf of the Australian Department of Health. It is the fourth report in the series (previous reports were in 2003, 2007, and 2012).

Methodology

All provider organisations with aged care funding for residential facilities and home care/home support outlets, were invited to participate in the 2016 NACWCS. Over 4,500 facilities and outlets and more than 15,000 aged care workers responded.

Additional qualitative data focusing on newly-hired and mature-aged workers was obtained through in-depth interviews with a sample of 100 direct care workers.

Introduction

The aged care workforce can be viewed in a number of ways:

- PAYG/non-PAYG
- Direct care/non-direct care
- Employed/volunteer
- Residential/Home care and home support

This report focuses primarily on direct care[1], PAYG employees in both residential facilities and home care and home support outlets, although there is also limited information on PAYG non-direct care workers, and non-PAYG workers.

It also provides information on the residential facilities and home care and home support outlets as employers and businesses. Detailed information was collected on the presence, causes and consequences of skill shortages, job vacancies, the composition of the workforce including the use of agency workers and volunteers, the types of employment contracts used, prevailing industrial relations and other matters.

Where relevant, comparisons are made with the 2012 results. However, a caveat is that this report should be read in the context that since then, there have been significant changes in the aged care landscape and some reforms are continuing, with the full impact on workforce issues not yet clear.

Key quantitative findings of the 2016 NACWCS

Estimated number of PAYG aged care workers

- **366,027** (4 per cent increase since 2012)
  - 235,764 in residential facilities
  - 130,263 in home care and home support outlets

[1] Workers who provide care services to older Australians as a key part of their work.

Estimated number of PAYG aged care workers in direct care roles

- **240,317**
  - 153,854 in residential facilities (**5 per cent increase** since 2012 – converts to 3 per cent on a FTE basis)
  - 86,463 in home care and home support outlets (**7 per cent decrease** since 2012 – converts to 19 per cent on a FTE basis)

Characteristics of PAYG residential direct care workforce

- 87 per cent female
- Median age 46 years
- 70 per cent are Personal Care Attendants (PCA)
- 32 per cent born overseas
- 78 per cent employed on a permanent and part time basis
- 10 per cent of the workforce are casual or contract employees (down from 19 per cent in 2012)
- 80 per cent of workers engaged in work-related training (mostly mandatory) in the previous 12 months
- 58 per cent of workers undertook Continuing and Professional Development (CPD)

Characteristics of PAYG home care and home support direct care workforce

- 89 per cent female
- Median age 52 years
- 84 per cent are Community Care Workers (CCW)
- 23 per cent born overseas
- 75 per cent employed on a permanent and part time basis
- 14 per cent are casual or contract employees (down from 27 per cent in 2012)
- 75 per cent of workers engaged in work-related training (mostly mandatory) in the previous 12 months
- 48 per cent of workers undertook continuing and professional development (CPD)

Residential aged care facilities

- The average size of facilities has remained constant since 2012
- 52 per cent have more than 60 places
- 80 per cent belong to a larger provider group
- 53 per cent report skill shortages, most commonly for Registered Nurses (RN) (down from 76 per cent in 2012)
- An estimated 23,537 volunteers worked in residential aged care in the designated fortnight

Home Care and Home Support outlets

- Increase in size of outlets since 2012
- 28 per cent employ more than 40 PAYG workers
- 61 per cent belong to a larger provider group

- 42 per cent report skill shortages, most commonly for CCWs (down from 49 per cent in 2012)
- An estimated 44,879 volunteers worked in home care and home support in the designated fortnight

Profile of the 2016 Aged Care Workforce

General

- The aged care workforce is older than the national average, generally in good health and has high levels of post-school education and training
- Overall the direct care workforce is relatively stable, with only a small minority indicating an intention to leave the sector within 12 months
- The residential workforce is getting younger and the home care and home support workforce is getting older
- There are indications of modest under-utilisation of the workforce as a whole

Training

- A much smaller proportion of CCWs than other occupations in home care and home support undertook training or CPD, suggesting a training gap
- There is a lower level of work related training than in 2012
- Priority areas identified for future training included dementia, palliative care and (in home care and home support) mental health
- A lack of access to training for workers in regional and rural areas is evident

Skill shortages

- The incidence of skill shortages has declined considerably since 2012, particularly in residential facilities
- Shortages are more prevalent outside major cities, and vacancies are harder to fill in remote and very remote areas, especially for RNs in residential facilities

Job satisfaction

- Job satisfaction is high across all work aspects except for pay
- Home care and home support workers reported greater job satisfaction for time available to care for clients and having freedom in their work and less stress and pressure than their residential care counterparts
- In both sectors, workers reported that the most stressful aspect of their jobs was the unanticipated changes in work patterns including working longer than scheduled and variations being made to hours or location of work at short notice

Facilities and outlets

- The share of facilities and outlets offering both residential and home care and home support care has fallen since 2012 indicating that facilities/outlets are becoming increasingly specialised within their respective sectors
- The majority of residential aged care facilities are large, and outlets within the home care and home support sector appear to be getting larger

- Service provision which accounts for the diverse needs of older Australians from different ethnic and cultural groups is becoming more mainstream

Conclusion

The aged care workforce remains predominantly female, older, and in good health. It is a well-qualified and trained workforce, with good access to further work-related training. However access to this training was lower than in 2012. The direct care residential workforce is getting younger and the home care and home support one is getting older.

A considerable shift away from casual or contract employment arrangements has been seen since 2012, particularly within the home care and home support sector.

The general picture that emerges regarding working arrangements and conditions is one of improving working conditions without any major imbalances. Although there are indications of continuing modest under-utilisation of the workforce as a whole, this is not to the point of being a driving force for the deterioration of working conditions in the sector.

Negative perceptions of aged care work as an occupation of low pay and status remain. Given the need for the expansion of the aged care workforce, this issue must be addressed.

In summary, the 2016 NACWCS showed that the aged care workforce is both stable and committed. Its workers report relatively high levels of job satisfaction and a large majority wish to stay working in the sector. The overall picture that emerges is that both the retention of current workers and the attraction of new workers to the sector seem to be working well with no major bottlenecks or hurdles that the labour market could not sort out by itself and without intervention.

Emerging issues

The Productivity Commission has estimated that by 2050 the aged care workforce will need to have grown to around 980,000 workers. It is vital that the sector and its workforces are monitored in order to keep all stakeholders informed and help the design and implementation of new policies to meet this growth.

The reduction in the estimated size of the direct care workforce in the home care and home support sector, combined with the likely increase in future demand for care provided in this setting may cause concern.

The 2016 NACWCS sought to identify potential workforce competition with the disability sector. At present there appears to be very little interaction at the workforce level between the aged care and disability care sectors. However, given the full National Disability Insurance Scheme (NDIS) roll out over the next two to three years, this could have substantial impacts on the aged care workforce.

There is some concern in the home care and home support sector about the impacts of aged care reforms (particularly Consumer Directed Care) on working conditions and employment. The impact of these reforms should be closely monitored particularly in light of the unexpected decline in the estimated size of this workforce.

Responding to change, a majority of residential facilities continue to be large in scale but utilising a smaller proportion of direct care workers, while home care and home support outlets are growing in size, with the larger ones expanding their workforces at a faster rate than the smaller ones.

1. Introduction

Since the last report on the Australian aged care workforce in 2012 (King et al, 2012) and through the implementation of new government policies (Department of Health, 2017), the aged care sector has experienced considerable changes in both the demand for and the supply of its services. These changes are set to continue apace over the coming decades.

The Australian population as a whole has been getting older. About a quarter of all Australians are expected to be 65 years and older by the middle of the 21st Century (Productivity Commission 2013). The ageing of the population will be fuelled in part by a rapid expansion of the oldest-old (those aged 85 years and older and who typically have higher care needs) from less than two per cent today to between five and seven per cent. The number of people who will be requiring aged care services is therefore set to increase substantially in the decades to come. Through significant general advances in medicine and health care we are managing to keep the younger part of the retired population both healthier and more active than their parents' generation was at the same age. However, through improved longevity we are also seeing an increased incidence of age-related conditions such as dementia and Alzheimer's disease. Thus, not only is the overall number of elderly people set to rise, but the composition of the demand for aged care services, and its methods of delivery are all set to change further.

Over and above these unprecedented changes in the demography and the health of the nation, in the last decades Australians on the whole have been getting substantially richer. According to figures from the Organisation of Economic Cooperation and Development (OECD) which have been adjusted to constant 2010 prices, Australian Gross Domestic Product (GDP) per capita has risen from US$26,433 in 1985 to US$44,774 in 2015 (OECD 2017). Thus, we should not only be expecting to see a higher proportion of life spent in retirement, but also, for many Australians, a larger proportion of their lifetime income and wealth accumulated for and spent during retirement. Along with this financial empowerment, many older Australians are becoming clearer and better articulated about their future care needs and requirements. This includes expressing a stronger desire and ability to remain living in their own home and pursue an active lifestyle. Our expectation is that over time the demand for quality care services that are tailored and timed to suit these individual and family needs is set to increase to levels never exercised by past cohorts.

A new national picture of demand for aged care services is therefore emerging. This changing demand is being driven by greater absolute numbers of older people within the population, and also an increased preference to continue to live and receive supports within the home. Critically for the aged care sector, an increasing proportion of older Australians strongly feel willing, able, and empowered to make effective demands for a better and broader range of high quality care services and a fundamentally different consumer-driven method of provision.

The aged care sector has been listening, anticipating and responding to these changes in the types of services that are demanded and how they should be best be provided. Moreover, the sector is currently undergoing intense transformation as a consequence of the structural changes brought about by the recent aged care reforms. Since 2012, these reforms have reshaped the way aged care services are provided in Australia across both residential and community settings with further changes set to occur. By 2050, more than 3.5 million Australians are expected be using aged care services each year (Productivity Commission, 2011). In order to adequately provide services for these individuals, the Productivity Commission (2011) has estimated that the aged care workforce will need to quadruple in size over this time and employ around 980,000 workers. In this period of change it is of key importance that the sector and its workforces are monitored in order to keep all stakeholders informed and help the design and implementation of new policies to manage change.

The National Aged Care Workforce Census and Survey (NACWCS) is designed to provide continual and consistent information to monitor the sector and its workforces. The information in the NACWCS has been used by government and by providers of aged care services alike, the former in its efforts to design and provide a coordinated strategic approach to the sector and the latter in assisting to manage both present and future aged care workforce requirements.

The 2016 NACWCS is the fourth data collection and report commissioned by the Department of Health (DoH) and conducted by the National Institute of Labour Studies (NILS). The previous NACWCS reports were delivered in 2003, 2007 and 2012. Across this time the aged care sector has grown in size and changed in nature rapidly. The capacity of the sector and relevant stakeholders to respond appropriately to these developments, has been facilitated and enhanced through the independently generated statistical evidence about the sector itself and its workforces in the NACWCS. It is critical that both employers and employees can juxtapose evidence reflecting their own and one another's responses to change that affects both, in the knowledge that this evidence has been generated consistently over time within a broader nationally representative context. It is also critical for government to be able to rely on evidence that is manifestly both well-informed and independently produced.

This report describes the NACWCS 2016 data collection and findings in the following chapters. Chapter 2 sets the scene and offers an overview of the workings of the data collection and the reporting. It also outlines the research content and its design and implementation. The chapter firstly describes the sources of information used within the report, including the instruments and processes used to collect this data within residential facilities and home care and home support outlets - namely the *census* of employers/business units and the *survey* of a sample of their workforces. It then goes on to describe the response rates and the population weights of the data, the latter being explained in further detail in Appendix 1. Chapter 2 concludes with an outline of the qualitative module of NACWCS 2016 which focuses on recently hired and mature-aged workers in the direct care workforce.

Chapters 3 to 7 describe the data in detail and each section is preceded by a condensed list of its key findings for ease of future reference. Throughout the text we make comparisons between residential facilities and home care and home support outlets and their workforces. Where appropriate and feasible we also make comparisons across time, contrasting the new evidence found in the 2016 NACWCS with the findings previously outlined in the 2012, 2007 and 2003 reports.

Chapter 3 provides detailed information on the residential aged care workforce using responses primarily from the residential workforce survey and on occasion from the residential facilities census as well. It presents and discusses total employment within the sector and the key characteristics of the workforce. The main characteristics of aged care work itself are also discussed, including employment arrangements and wages, education and training, and the pathways that lead into and out of aged care. Chapter 3 continues by examining experiences of working in the sector (including satisfaction with the various aspects of the work) and the extent of work-related injury and illness. The chapter concludes with findings on cultural and linguistic diversity in the residential aged care sector.

Chapter 4 predominantly uses evidence from the residential aged care census to provide an overview of the key characteristics of the residential facilities themselves. It begins with a profile of facilities and examines their relationship with broader aged care services and the extent of ethnic specialisation. The chapter continues with evidence on skill shortages and vacancies, in the context of the sector's capacity to attract and retain staff in a competitive labour market. The employment arrangements of PAYG workers and the use of non-PAYG employees and volunteers are then explored. Chapter 4 concludes with a discussion of how quality is measured by employers in the residential aged care sector.

Chapters 5 and 6 essentially repeat the structure of Chapters 3 and 4, only now the information relates to the home care and home support workforces (Chapter 5) and outlets (Chapter 6).

These chapters take the opportunity to compare their findings with the corresponding results for the residential workforce and facilities.

Chapter 7 presents the findings of the in-depth interviews conducted with 100 newly hired, mature-aged and general direct care workers. A key question addressed by Chapter 7 relates to the capacity of the sector to attract and retain its workforce in the context of rapid change in the sector. This chapter offers a deeper and complementary understanding of the factors that matter for these specific sub-groups of aged care workers, including their working environment, wages, education and training, skills development and career paths. It offers invaluable deep insights of their experiences of working in aged care and on those factors that may ultimately influence their recruitment and retention outcomes.

Chapter 8 summarises and discusses the findings of the report and also identifies several emerging issues that warrant further investigation. The main text of this research is supported by a technical Appendix on the population weights that have been constructed and used in order to estimate the broader population numbers presented in the report.

2. Finding out About the Aged Care Workforce

In this chapter we describe the types of information used for this 2016 report on the aged care sector and its workforce. The information contained in this report comes from three sources.

The first and main source is the 2016 National Aged Care Workforce Census and Survey (NACWCS). The 2016 NACWCS packages of forms were sent to all provider organisations with aged care funding for residential facilities and home care/home support outlets providing specific aged care services as defined by the Australian Government Department of Health. Each package contained a census form, to be completed by the manager at the facility/outlet level, and several worker survey questionnaires, to be completed by a sample of direct care workers employed at that facility/outlet.

The second source of information comes from aged care administrative data supplied by the Department of Health with the lists of provider organisations and services which formed the basis for the census and survey sampling.

The third source of information comes from interviews with a small sample of direct care workers who in their worker survey had offered to be further contacted about their work. The overall design of the project, including census and survey design and research were conducted by the National Institute of Labour Studies (NILS) research team.

2.1 Overview of the 2016 National Aged Care Workforce Census and Survey

The census and survey packages were mailed out on 17 June 2016 with respondent completions accepted until 11 October for online completions and 27 October for hardcopy completions. Participants were asked to complete a questionnaire which was available in hard copy and online versions. I-view conducted the fieldwork and administered the process for disseminating the survey packages, collected and collated the data, and delivered the raw data files to NILS. Support to respondents for completing the questionnaires was provided by I-view via a free 1800 number. Additional support was provided by NILS and the Department where necessary and appropriate. Detailed information and guidance were also available online. NILS carried out the work necessary to prepare the data for statistical analysis and conducted that analysis. Where this was required, the surveys and the research process received approval from the ABS Statistical Clearing House and the Flinders University Ethics Committee in full compliance with the National Privacy Guidelines for survey research.

2.1.1 The Aged Care Workforce Research

The census of facilities/outlets and survey of a sample of their workforce sought information that is in its majority directly comparable with the information collected through the research conducted in 2012 and earlier in 2007 and 2003. The primary aim was to create a comprehensive profile of the direct aged care workforce in residential and community aged care settings. A further aim was to cover a broad range of sociodemographic and economic factors such as age, gender, qualification, and employment status, in a way that is directly comparable with the previous data collections. The information needed to be sufficiently detailed in order to inform strategies to further develop and build a skilled and flexible workforce. It also needed to include information about the skills and qualifications of aged care staff to reflect their readiness to meet the care needs of the rapidly growing number of consumers of the Australian aged care system.

The report therefore discusses how aspects of the workforce in residential facilities and home care and home support outlets have changed over time; how the direct care workforces in the two sectors compare with one another; and how new knowledge about the workforce might inform the direction and types of changes needed to recruit and retain direct care workers into

the future. To this purpose the NILS team strived to generate data that is comparable over time, as much as the various program changes that have been taking place will allow.

Four discrete questionnaire forms were produced to collect the data:

- Residential Census
- Home Care and Home Support Census
- Residential Worker Survey
- Home Care and Home Support Worker Survey

In line with the 2012 census of facilities/outlets, the 2016 data collection sought information about the characteristics of their PAYG direct care workforces[2], the conditions under which they are employed, their vacancy rates, and other characteristics of the organisation; management, administration and ancillary staff; their use of agency, brokered and self-employed (non-PAYG) staff; volunteers and volunteer hours; nurse practitioners; allied health assistants; the Aboriginal and Torres Strait Islander workforce; the culturally and linguistically diverse workforce; skill shortages; training; and work-related injuries and illnesses.

Information from the census was supplemented with administrative data provided by the Department of Health records, and primarily used to identify and contact the relevant organisations and their workers. For residential facilities, this administrative data included postcode, remoteness of geographical location, ownership type and the number of operational places (residential). To avoid duplication, these questions were not asked of the facilities. For the Home Care and Home Support census, only some of this information on outlets was available, so that postcode and remoteness of geographical location were additionally collected.

As in 2012, the survey of employees sought information about the characteristics of people who work in direct care roles, their career paths, their experiences of working in aged care and their intentions to stay in the sector. Specifically the worker surveys collected data on the role of the worker, working conditions (hours, form of employment, pay), career path (prior work, recruitment, intention to stay/leave), job satisfaction, demographic characteristics, training and qualifications, what workers like/dislike about their job; the balance between work and non-work responsibilities; migrant status; and proficiency in English. In 2016, as in 2012, Nurse Practitioners and Allied Health Assistants were included in the direct care workforce.

An important aspect of the NACWCS data collections is their linked employer-employee nature. The appeal of such data is that it links employer characteristics directly with employee characteristics at the micro (individual) level. Taking the potential problem of skill shortages as an example, by linking the data, we are able to know who the employers that may report skill shortages may be (that is, how they compare with other employers), and also who their employees are (that is how their employees compare with the employees of other employers). This attribute adds considerable granularity to the dataset and can be very useful for the microeconomic analysis of the labour market of the aged care sector.

In 2016, a small number of additional questions were asked of both employers and employees to capture information about new topics relevant to aged care workforce planning and development. Furthermore, in some existing questions, additional categories were added for similar reasons. The changes also reflected some updating needed for accommodating the new aged care funding packages and other changes to the aged care system within the questionnaires, and these new topic areas. Since the 2012 report, there has been significant reform to the way aged care is delivered to consumers, such as the migration to the Consumer Directed Care (CDC) model, the removal of the distinction between high-level and low-level residential care, and the introduction of the new Home Care Packages Program and the

[2] A key period for this information collected in the census is the last pay period (fortnight) in November 2015.

Commonwealth Home Support Program (CHSP). Additionally, these changes are taking place against a backdrop of an ageing population, changing client preferences including an increasing demand for formal aged care services delivered in a community setting, demand from competing sectors for the skills required in the aged care workforce, and a forecast reduction in the availability of informal (i.e. family) care. To the aged care workforce these factors and others represent significant pressures for change in the coming decades and imply the need to either expand the size of the workforce or improve its productivity, or both, whilst maintaining appropriate standards of quality. The additional questions asked reflect these factors and explored:

1. Potential competition with the disability sector: The workers surveys aimed to elicit the extent to which aged care skills are interchangeable with those used in disability support. The worker surveys asked whether aged care workers have worked in the past, are currently working alongside their aged care job, or expect to work in disability care in the future. The surveys also asked workers whether they have had any training in the area of disability support with new response categories added relating to disability skills and qualifications. These disability workforce questions were motivated by the impending expansion of the disability sector through the National Disability Insurance Scheme (NDIS), which may use people with similar qualifications and demographics as the aged care sector and result in skill shortages shared by the two sectors. In this context of judging the incidence of skill shortages, both the 2012 and 2016 NACWCS data included a suite of questions on skill shortages (their incidence, causes and responses to) similar to the ABS Business Longitudinal Database suite of questions developed by the ABS. This combination allows linking between the aged care and disability support sectors while also enabling national benchmarking through the ABS national data collections.
2. The role of non-PAYG workers: In addition to existing questions, the 2016 census also asked facilities and outlets to state their reasons for employing non-PAYG workers. Moreover, the 2016 census elicited additional information regarding volunteers about the roles they perform.
3. Quality of services: New questions were added about the quality monitoring undertaken by employers to give a measure of how the quality of the aged care provision is checked by management.
4. Paid travel time: A new question was added on the availability of paid travel time for the home care/home support workforces in order to obtain an overview of this practice.

In some cases of policy interest, the same or similar questions were asked of both employees and employers, on the expectation that they will be answered through a different lens. In several instances the report compares and discusses both perspectives.

2.1.2 Research Design and Implementation

Research design

The initial potential respondent lists were constructed from a set of Australian Government Department of Health lists of residential and home care and home support service providers within Australia. The lists comprised 2,952 residential services (Residential services, National Aboriginal and Torres Strait Islander Flexible Aged Care and Transition Care Program with residential places) and 5,442 home care/home support services (Home Care Packages program, the new Commonwealth Home Support Program (CHSP), HACC in Victoria and Western Australia, Multi-Purpose Services (MPS), National Aboriginal and Torres Strait Islander Flexible Aged care and Transition Care Program with home care/home support places)[3].

[3]Outlets providing DVA Community Nursing, Veteran's Home Care or other DVA administered programs were not part of the original service lists but it was recognised that some 'in-scope' outlets

NILS conducted analysis to determine the number of workforce surveys that were to accompany each census form. This was determined by the size of the service facility/outlet. Each dispatched residential census form was accompanied by either 4, 6 or 8 workforce surveys. For each Home Care and Home Support census form, the number of workforce surveys was 3, 5 or 7. Stratifying the sample of workers improved the likelihood of employees being given an equal chance to participate in the survey. The stratification was implemented so that the number of surveys sent to each organisation differed according to the size of the service as per operational places/funding/services provided in the administrative list. Small residential outlets were sent 4 worker surveys, medium sized were sent 6 and large were sent 8. Overall, an average of 6 surveys was sent to each residential facility. Small home care/ home support outlets were sent 3 worker surveys, medium sized were sent 5 and large were sent 7. Overall, an average of 5 surveys was sent to each home care/home support outlet. Where insufficient service information was available in the administrative data, the average number of surveys was sent (extra population cases that arose during fieldwork were also supplied the average number of worker surveys). The resulting total number of workers selected to receive a survey was 17,717 for the Residential Worker Survey and 27,206 for the Home Care and Home Support Worker Survey.

Fieldwork

The census and survey mail out commenced distribution on 17 June 2016. The original date for survey closure was 23 September. However, the response was slower than anticipated, but steady. In order to ensure an optimal response rate, fieldwork was extended until 11 October for online survey responses and 27 October for hardcopy completions.

At the outset of the census and survey, an interactive webcast presentation (webinar) was hosted by the Department with invitations sent to all organisations on the lists. The webinar was designed and delivered by NILS researchers, and included a set of frequently asked questions. To further support the provider organisations, their facilities and outlet managers and workers to complete the forms, I-view hosted a free 1800 Helpline from 20 June through to 28 September. In all, 2,247 inbound calls were made to the 1800 Helpline. The most common known reason for calling was to confirm distribution requirements from the provider organisation postal address to their facility/outlet service address, often associated with co-location issues where there were multiple services at the same physical facility/outlet address with a combined workforce. Further information and answers to ‘frequently asked questions’ were also made available on a dedicated website. In addition, emails were sent to residential facilities and home care and home support outlets to stimulate participation: an introductory email, two reminder emails and a final thank you/last chance email were sent to facilities/outlets. The Department supplemented these reminders with communications sent to all providers of aged care services and by directly approaching providers who had not completed their forms close to the end of the fieldwork period. The census and surveys were also advertised through professional and peak body organisations and aged care publications.

Further adjustments were required to the original contact lists to accommodate facilities that had opened or closed during the defined period, or which were discovered to be co-located after the packages were sent out. Extra cases arose that were not in the original contact lists, and they were provided with online forms when requested via the 1800 helpline (684 cases, made up of 9 Residential census with 72 related residential worker forms, 67 Home care/home support census with 536 related worker forms).

The census and survey packages, distribution of forms and completion instructions

It was established by the Department of Health that providers would be identified for the dispatch of the mailed forms by the provider organisation administrative postal address. This

also provided services under these programs and so they were included in the home care and home support lists.

was critical where a service outlet provided more than one type of aged care service with the same provider organisation administrative postal address. Of all services in the sample (8,394), 1,030 were identified as providers with more than one service at the provider administrative postal address. This corresponded to 6,426 Census and survey packages which were sent to these (administrative postal) addresses, with their associated worker surveys numbering 34,862. To these providers, bundles of the relevant number of census and survey packages corresponding to their services were sent together in satchel/s to the provider organisation administrative postal address. Each provider received a cover letter with their relevant number of census and survey packages. The cover letter asked providers to distribute the contents of their survey package to their service facility/outlets for completion of the census by the manager and distribution of the surveys to their workers. The letter introduced the project, explained the contents of the census packages, how many questionnaires they should be expecting to receive overall, the benefits of completion, how to participate in the census and how to distribute the census and survey packages out to the service levels.

Following this distribution, each facility/outlet then received a survey package which contained the census and relevant number of worker surveys. A letter inviting the outlet manager recipients to participate in the census and instructions to workers for completing the surveys was incorporated into each questionnaire. Each census and survey package also contained a separate cover letter addressed to the manager with information about how to distribute the surveys and how to complete the census. The covering letter also nominated the 1800 Helpline that the recipient could call if they had any queries regarding the study. The cover letter requested that facility/outlet managers distribute the surveys by selecting staff who were (a) on the payroll as PAYG employees; (b) providing direct care to older Australians (i.e. to those 65 years and older, or 50 years and older if Indigenous); and (c) who had their birthday nearest to the day the package was received. The latter criterion was added to provide a random element to the selection of workers by their management.

For each census and survey, instructions were also provided for participating online, including unique usernames and passwords. Overall, 53 per cent of responses were received online from residential facilities, 52 per cent of home care and home support outlets, 17 per cent of workers in residential facilities and 20 per cent of workers in home care and home support outlets.

2.2 Responses and Weighting used in this Report

2.2.1 Residential Census and Residential Worker Survey Response Rates

Out of the final population of 2,952 residential facilities, 2,240 provided valid responses. This is a 76 per cent response rate for the residential census. Of the 17,717 surveys circulated to workers in residential aged care who were invited to participate, 8,885 provided valid responses. This represents a response rate of 50 per cent for the residential worker survey. Extra cases arose during fieldwork that were not in the original contact lists, made up of 9 residential census with 72 related residential worker forms with their respective response rates at 90 per cent and 22 per cent. The analysis and discussion of the residential aged care workforce and facilities can be found in Chapters 3 and 4.

2.2.2 Home Care and Home Support Census and Home Care and Home Support Worker Survey Response Rates

As with the 2012 community census and survey, for the 2016 census and survey of home care and home support outlets, it was evident from calls to the 1800 helpline and feedback from motivational calls that a number of home care and home support services on the list were out of scope for a variety of reasons. Using a similar process to calculate the responses to that used for residential aged care, then out of the final population of 5,442 home care and home support outlets a total of 2,307 valid responses were received. This is a 42 per cent response rate for the Home Care and Home Support outlet census. Of the 27,206 surveys circulated to

workers in home care and home support aged care who were invited to participate, 7,024 provided valid responses. This is a 26 per cent response rate for the home care and home support worker survey. Extra cases arose during fieldwork that were not in the original contact lists, made up of 67 home care/home support census with 536 related worker forms. Their respective response rates were 67 per cent and 10 per cent. The analysis and discussion of the home care and home support aged care workforce and outlets can be found in Chapters 5 and 6.

2.2.3 Weighting for Response used in the Report

In order to extrapolate the responses received and make them relevant to the entire workforce that provides direct care services for older Australians, response information from both residential facilities and home care and home support outlets and their worker surveys were weighted to reflect the lists. Appendix 1 contains an explanation of how these weights were formed. Weighted results from the census and surveys are used throughout the report.

2.3 Interviews with Direct Care Workers

Interviews with direct care workers were undertaken to provide a qualitative account of working in aged care and enable better understanding of some of the information obtained from the census and surveys. Upon completion of the workforce survey, direct care workers were given an opportunity to nominate themselves to take part in a qualitative interview about their experiences of working in the aged care sector. Following the 2016 research design, a sample of 100 direct care employees were interviewed, 48 from home care and home support outlets and 52 from residential facilities. The interviews were conducted from August to October 2016 and lasted for approximately 30 minutes each. A copy of the interview schedule is provided in Appendix 2. The focus of the 2016 qualitative research was on newly hired and mature-aged workers in order to understand more about their specific experiences of working within aged care (the 2012 qualitative focus was on the migrant and male workforces). Investigation was undertaken of issues relating to recruitment and retention for these workers; this is of particular importance if the sector is to attract new workers as well as retain its existing ones. The interviews also aimed to identify and explore broader emerging issues for the aged care workforce. The results of the qualitative research are presented in Chapter 7.

3. The Residential Aged Care Workforce

Key Findings

- The total residential PAYG aged care workforce has grown by 17 per cent since 2012 to an estimated 235,764. During the same time period the residential direct care workforce increased by 5 per cent and the FTE workforce by 3 per cent.

- PCAs were the largest occupational group (70 per cent), followed by RNs (15 per cent) and ENs (10 per cent).

- The median age of the residential direct care workforce was 46 years.

- While 32 per cent of the total residential care workforce was born overseas, 40 per cent of recent hires were migrant workers.

- Aboriginal and Torres Strait Islander people accounted for 1 per cent of the residential direct care workforce.

- Over 60 per cent of workers reported being in either very good or excellent health.

- Ninety per cent of workers held post-secondary qualifications. Two-thirds (66 per cent) of facilities reported that more than 75 per cent of their PCAs hold a Certificate III in Aged Care.

- There is a drop in casual employment. Over three-quarters of all residential direct care workers were employed in 2016 on permanent part-time contracts (78 per cent), with approximately 12 per cent on full time permanent and 10 per cent on a casual/contract arrangement. The corresponding percentages for 2012 were 72, 10 and 19, suggesting a considerable shift away from casual/contract arrangement in favour of permanent employment.

- A regular daytime shift was the most common work schedule for all direct care occupations. Rotating shift patterns were the norm for a fifth of nurses and PCAs.

- There are indications of potentially underutilised labour supply as there are more workers who want to work more hours than workers who want to work fewer hours. Although 56 per cent of the residential workforce are happy with their current hours of work, 14 per cent want to reduce their hours, and 30 per cent want to increase them.

- Around a tenth of the residential workforce reported more than one current job.

- Eighty per cent of workers had undertaken training over the previous 12 months, with mandatory training the most common form of training. Dementia and palliative care were seen as priority areas for future training.

- Aged care work was a first occupation for only a small minority of workers. Apart from nursing, there were no clear pathways into aged care for other occupational groups. The aged care sector draws its workers from the broader labour market.

- Attachment to the sector measured by previous paid work in aged care was at its highest for RNs (70 per cent) above half for ENs and AHs (both at 55 per cent) and at its lowest for PCAs (35 per cent). The primary reasons provided for changing aged care employer included personal circumstances and working conditions.

- A tenth of the residential workforce was currently seeking alternative work. Most residential workers (82 per cent) expected to still be with their current employer after 12 months. Only 4 per cent of employees reported intentions to leave the aged care sector altogether.

- Relatively high levels of overall job satisfaction were reported by workers. However, when looking at satisfaction with specific aspects of their job, aged care workers were least satisfied with their total pay and with the time available to them to care for residents.

- The most prevalent unusual job demands made of workers were related to changes in work patterns (due to unanticipated needs of residents, or variations on hours, or location).

- Fourteen per cent of workers reported sustaining a work-related injury or illness over the previous 12 months, most commonly sprains/strains and chronic joint/muscle conditions.

- Most residential facilities (91 per cent) employed at least one PCA from a CALD background, most commonly from India and the Philippines.

- The employment of CALD PCAs was widely seen as offering benefits to a facility – these benefits included enhanced cross-cultural understandings and activities. About a third of facilities reported difficulties in employing CALD PCAs, with communication issues the most commonly stated difficulty.

3.1 Introduction

This chapter provides detailed information about the residential aged care workforce using responses from both workers (N=8,885) and facilities (N=2,240). The census and survey captured information on the main occupational groups within aged care. In selected tables we provide details on each of these occupations (including, as in 2012, Nurse Practitioners and Allied Health Assistants). However, given the relatively low proportion of these latter occupations, most tables in the report combine Nurse Practitioners with Registered Nurses, and Allied Health Assistants with Allied Health Professionals.

We begin the chapter by providing an overview of the residential workforce and the socio-demographic characteristics of the workers themselves. The main characteristics of aged care work are then discussed including employment arrangements, wages, multiple job holding and training. The next sections of the chapter explore career pathways into and out of aged care, the experiences of residential aged care work (job satisfaction and job demands), and the extent of work-related injuries and illness in the sector. The chapter finishes with a focus on workers from culturally and linguistically diverse backgrounds.

3.2 Total Employment and Main Workforce Characteristics

In this section we provide an overview of the residential aged care workforce including the overall size of the PAYG workforce and the different occupational groupings. We then examine the main socio-demographic characteristics of the residential workers themselves – their age, gender, ethnicity, cultural background, health and education.

3.2.1 Total Employment

In order to undertake workforce planning and development effectively it is important to understand the size and composition of the existing workforce. Our estimates of the residential aged care workforce are based on information obtained from the census of residential facilities.

Total PAYG employment in residential aged care in 2016 is estimated to be 235,764 workers, of which 153,854 are in direct care roles. Table 3.1 indicates that the whole residential aged care PAYG workforce is estimated to have grown by 17 per cent since 2012 (from 202,344 to

235,764), and by about 50 per cent since 2003. The growth in residential direct care employment is estimated to have been lower, at 5 per cent between 2012 and 2016, falling from 10 per cent between 2007 and 2012, and 15 per cent between 2003 and 2007. In total, residential direct care employment grew 33 per cent from 2003 to 2016.

The estimated proportion of the residential aged care workforce working in direct care roles continues to fall. In 2016, 65 per cent of residential aged care employees work in direct care roles, compared with 73 per cent in 2012, 76 per cent in 2007 and 74 per cent in 2003.

Table 3.1: Size of the residential aged care workforce, all PAYG employees and direct care workers: 2003, 2007, 2012 and 2016 (estimated headcount)

Occupation	2003	2007	2012	2016
All PAYG employees	156,823	174,866	202,344	235,764
Direct care employees	115,660	133,314	147,086	153,854

Source: Census of residential aged care facilities (weighted estimates).

3.2.2 Occupation

The occupational composition of the headcount of residential direct care employees is presented in Table 3.2. Personal Care Attendants (PCAs) are the largest occupational group in residential aged care (70 per cent) and they continue to grow both numerically and as a proportion of the residential aged care workforce. The number of residential aged care PCAs has grown by 7,814 since 2012.

The number of Registered Nurses (RNs) also rose by 539 between 2012 and 2016, reversing some of the decline in numbers observed between 2003 and 2012. Their share of direct care employment was 15 per cent (unchanged from 15 per cent in 2012). The number of Nurse Practitioners rose since 2012, from 294 to 386, however they still only make up a very small proportion of the workforce (0.3 per cent). The estimated number of Nurse Practitioners (NPs) will be imprecise as it is based on a very small number of observations, so strong conclusions about growth in this occupation cannot be drawn.

The number of Enrolled Nurses (ENs) has fallen by 1,218; as a proportion of the workforce, they have decreased from 12 per cent to 10 per cent. The Allied Health (AH) employment categories also experienced a decline, but most of this was for Allied Health Professionals which fell by 438 workers (falling from 2 per cent to 1 per cent share of the direct care workforce).

The overall picture in Table 3.2 suggests that residential facilities continue to rely increasingly on PCAs to provide direct care to residents. There has been some increase in the number of RNs, but there has been a corresponding and larger fall in the number of EN. PCAs are the only residential direct care occupational category to substantively raise its share of employment since 2012, with the PCA share rising by 2 per cent.

Table 3.2: Direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated headcount and per cent)

Occupation	2003	2007	2012	2016
Nurse Practitioner (NP)	n/a	n/a	294	386
			(0.2)	(0.3)
Registered Nurse (RN)	24,019	22,399	21,916	22,455
	(21.0)	(16.8)	(14.9)	(14.6)
Enrolled Nurse (EN)	15,604	16,293	16,915	15,697
	(13.1)	(12.2)	(11.5)	(10.2)
Personal Care Attendant (PCA)	67,143	84,746	100,312	108,126
	(58.5)	(63.6)	(68.2)	(70.3)
Allied Health Professional (AHP)*			2,648	2,210
	8,895*	9,875*	(1.8)	(1.4)
Allied Health Assistant (AHA)*	(7.4)	(7.4)	5,001	4,979
			(3.4)	(3.2)
Total number of employees (headcount)	**115,660**	**133,314**	**147,086**	**153,854**
(%)	**(100)**	**(100)**	**(100)**	**(100)**

Source: Census of residential aged care facilities (weighted estimates).
**In 2003 and 2007 both of these categories were combined under 'Allied Health'.*

Table 3.3 shows the estimated full-time-equivalent (FTE) direct care workforce. There has been a modest increase in the estimated number of FTE employees in direct care roles since 2012. The increase in direct care employment of 3,097 between 2012 and 2016 is comparable to the increase between 2003 and 2007 of 2,843.

Comparing the percentages in Tables 3.2 and 3.3 suggests that the distribution of residential FTE direct care workforce (presented in Table 3.3) is very similar to that of the headcount of the direct care workforce (Table 3.2). The rate of increase in the residential FTE direct care employees was 3.3 per cent, smaller than the corresponding 4.6 per cent headcount increase. This suggests that there has been growth in part-time employment during this period, or more conservatively, an increase in the proportion of workers employed for fewer hours.

Table 3.3: Full-time equivalent direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated FTE and per cent)

Occupation	2003	2007	2012	2016
Nurse Practitioner	n/a	n/a	190	293
			(0.2)	(0.3)
Registered Nurse	16,265	13,247	13,939	14,564
	(21.4)	(16.8)	(14.7)	(14.9)
Enrolled Nurse	10,945	9,856	10,999	9,126
	(14.4)	(12.5)	(11.6)	(9.3)
Personal Care Attendant	42,943	50,542	64,669	69,983
	(56.5)	(64.1)	(68.2)	(71.5)
Allied Health Professional*	5,776*	5,204*	1,612	1,092
	(7.6)	(6.6)	(1.7)	(1.1)
Allied Health Assistant*			3,414	2,862
			(3.6)	(2.9)
Total number of employees (FTE)	**76,006**	**78,849**	**94,823**	**97,920**
(%)	**(100)**	**(100)**	**(100)**	**(100)**

Source: Census of residential aged care facilities.
**In 2003 and 2007 these categories were combined under 'Allied Health'.*

Figure 3.1: Share of the occupations for the residential direct care employees (headcount and FTE, per cent)

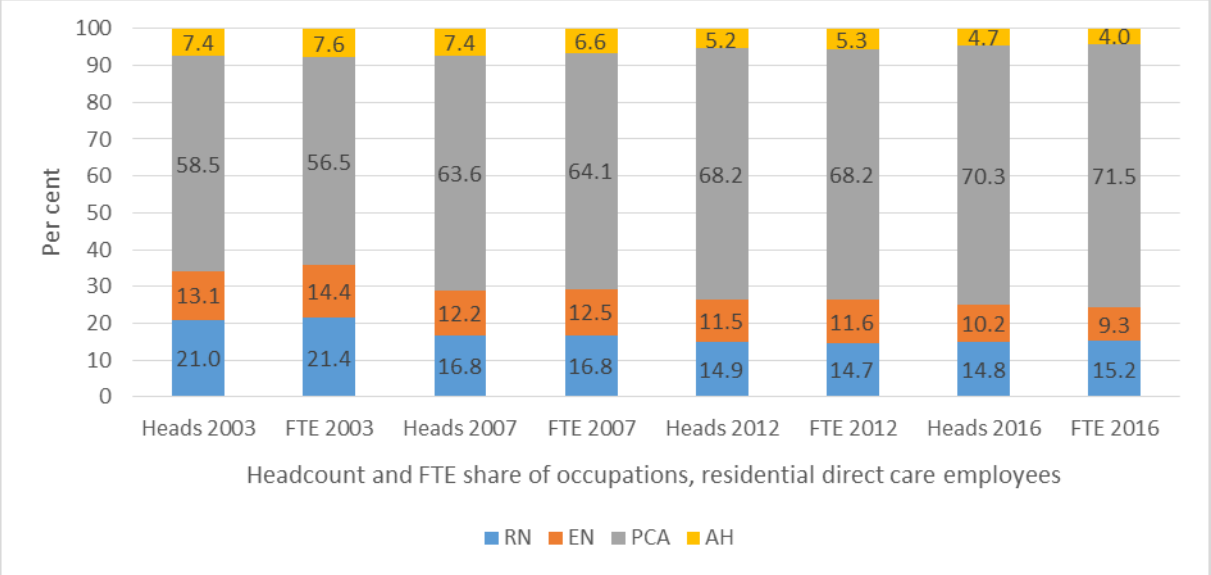
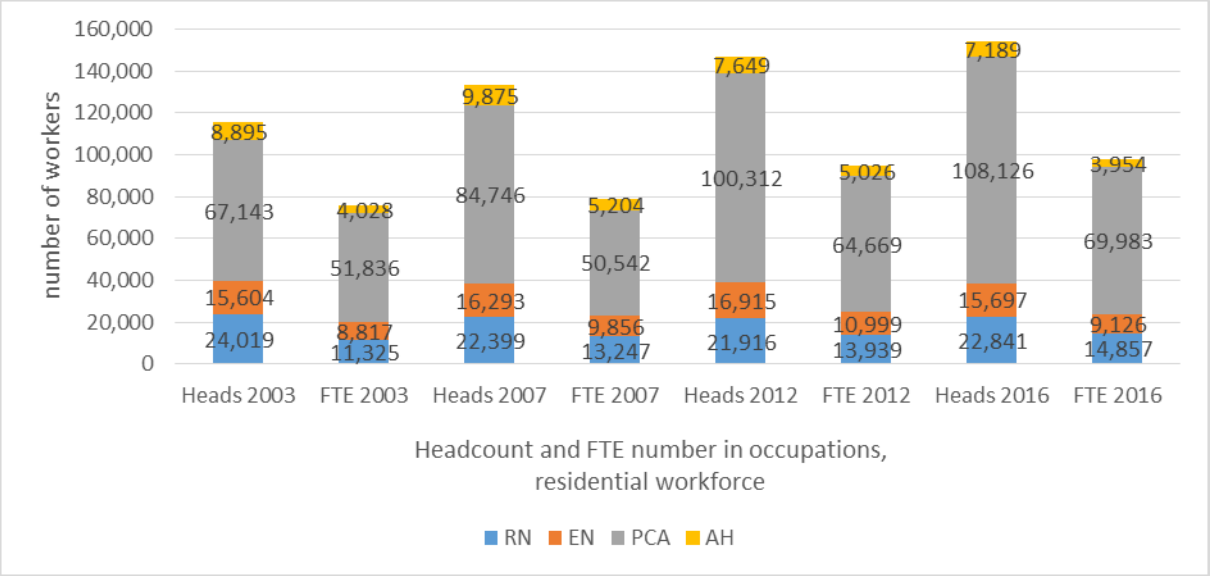


Figure 3.2: Number of the occupations for the residential direct care employees (headcount and FTE)



Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2016 in Figure 3.1 and Figure 3.2. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in 2003, 2007, 2012 and 2016 in Figure 3.1 and Figure 3.2.

The shares of non-direct care occupations are shown in Table 3.4 and are mostly unchanged compared with 2012. The majority of employees working in non-direct care occupations are ancillary workers, and they make up 69 per cent of the non-direct care workforce. There has been a very small increase in the share of care manager/coordinators and management (by 0.7 and 0.5 per cent respectively) and a corresponding small decrease in the share of ancillary workers (from 70 per cent to 69 per cent) and spiritual/pastoral care workers (from 2 per cent to 1 per cent).

Table 3.4: Employees not providing direct care in the residential aged care workforce, by occupation: 2012 and 2016 (per cent)

Occupation	2012	2016
Care Manager/Co-ordinator	6.6	7.3
Management	8.8	9.3
Administration	12.6	12.8
Spiritual/pastoral care	1.7	1.2
Ancillary care	70.4	69.3
Total (weighted)	**100**	**100**

Source: Census of residential aged care facilities.

3.2.3 Age and Gender

Previous iterations of the NACWCS conducted in 2003, 2007 and 2012 indicated that the residential aged care workforce was ageing and was, on average, older than the Australian workforce as a whole. In 2016, however, the age of the residential direct care workforce is slightly younger than in previous years.

Table 3.5 and Figure 3.3 show that in 2016 27 per cent of the direct care workforce was aged 55 years or over as in 2012. However, in contrast, the proportion of the workforce under the age of 35 years has risen to 25 per cent in 2016 (up from 19 per cent in 2012) exclusively due to an increase among those aged 25-34 years (from 12 per cent in 2012 to 19 per cent in 2016). The main loss these younger workers are replacing is in the 45–54 year age range which has fallen from 33 per cent (column 3) in 2012 to 28 per cent (column 4) in 2016.

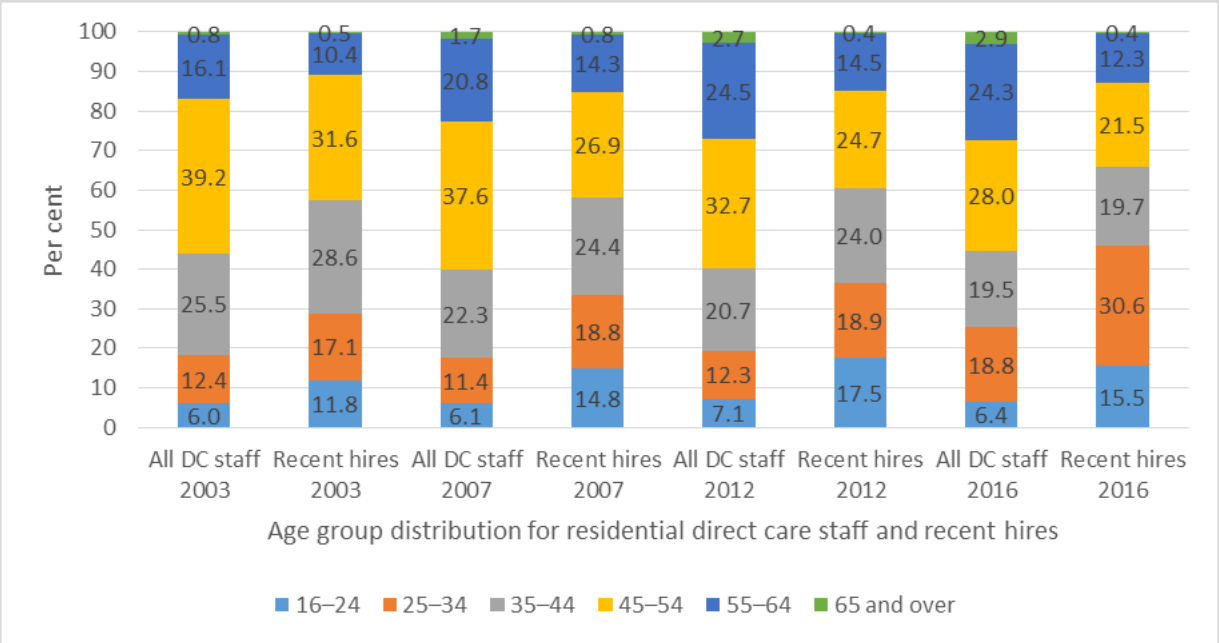
The age distribution of the workforce who have been recently hired (in employment for 12 months or less), presented in columns 5-8 of Table 3.5, emphasises that new hires are a key source of the observed change in the age structure of the workforce. Table 3.5 clearly shows the increased hiring of younger workers within the sector (particularly those aged 25-34 years). Given the strong retention record of the sector, this is an important development, also because younger workers are typically more amenable to up-skilling and to more specialised training. The age group of workers aged 34 years or younger (adding the first two rows) constitutes 46 per cent of all recent hires (column 8), an increase in this share from 36 per cent in 2012 (column 7). This 10 per cent share increase can be decomposed into a rise from 19 to 31 per cent for recent hires aged 25-34 years and a drop from 18 to 16 per cent for recent hires aged 16-24. In contrast the proportion of recent hires aged 55 years and over remained unchanged between 2007 (column 6) and 2012 (column 7) at around 15 per cent and fell slightly to 13 per cent in 2016 (column 8). The share of recent hires in the 45–54 year age group also fell from 25 per cent in 2012 to 22 per cent in 2016. Figure 3.3 also reflects these changes in the share of each age group over time.

Table 3.5: Age distribution of the residential direct care workforce, all direct care employees and recent hires: 2003, 2007, 2012 and 2016 (per cent)

Age (years)	All direct care employees				Recent hires*			
	2003 (Col 1)	2007 (Col 2)	2012 (Col 3)	2016 (Col 4)	2003 (Col 5)	2007 (Col 6)	2012 (Col 7)	2016 (Col 8)
16–24	6.0	6.1	7.1	6.4	11.8	14.8	17.5	15.5
25–34	12.4	11.4	12.3	18.8	17.1	18.8	18.9	30.6
35–44	25.5	22.3	20.7	19.5	28.6	24.4	24.0	19.7
45–54	39.2	37.6	32.7	28.0	31.6	26.9	24.7	21.5
55–64	16.1	20.8	24.5	24.3	10.4	14.3	14.5	12.3
65 and over	0.8	1.7	2.7	2.9	0.5	0.8	0.4	0.4
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.
**Recent hires have been employed for 12 months or less.*

Figure 3.3: Age distribution of the residential aged care workforce: 2003, 2007, 2012 and 2016 (per cent)



The median age (the mid-point where half of the sample are younger and the other half are older) of the residential workforce for each of the occupations, is shown in Table 3.6. This confirms that the workforce is becoming younger. Compared to 2012, the median age of the residential direct care workforce has decreased from 48 years to 46 years. Looking at column 1, with a median age of 46 years in 2016, PCAs are the youngest of the occupational groups (one year less than the median age of PCAs in 2012); RNs are similar with a median age of 47 in 2016 (lower than their median age of 51 in 2012). Workers in the other occupations have a median age of 50 years in 2016 (unchanged since 2012 for AH but slightly higher for ENs). However, Table 3.6 (columns 2 and 3) clearly demonstrates that workers recently recruited into residential aged care are younger than the direct care workforce overall (36 years compared to 46 years); the extent of this differs by occupation. RNs have the oldest median age across occupations for recent hire workers (42 years). This is in contrast to the relatively youthful median age of recently hired PCAs (35 years) and AH workers (33 years).

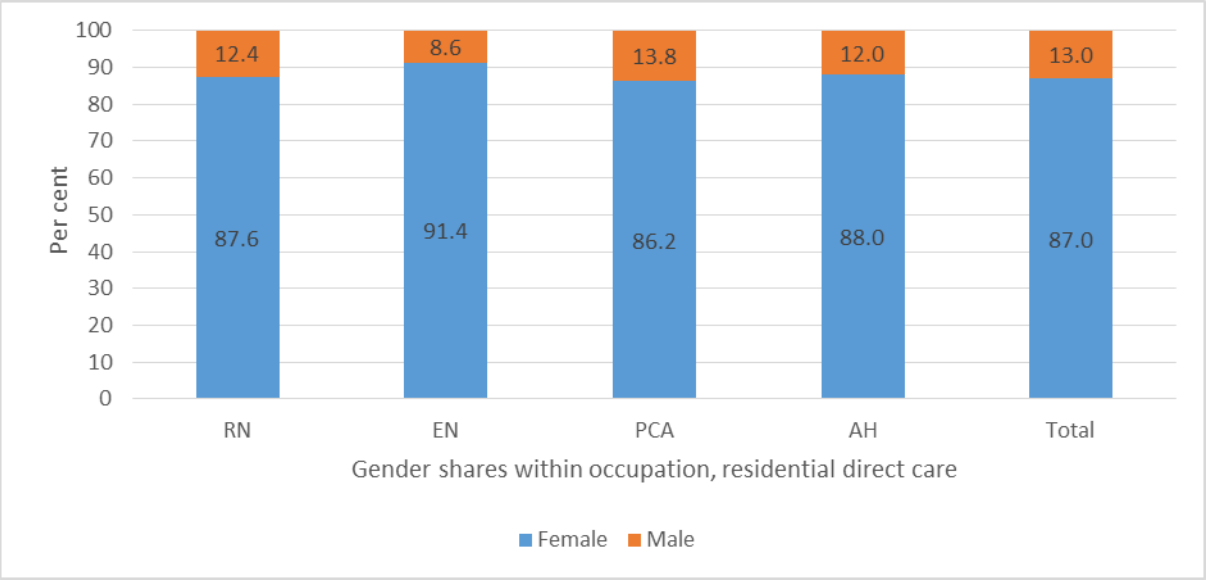
Table 3.6: Median age of the residential direct care workforce (number of years), by occupation, all direct care employees and recent hires: 2012 and 2016

	All direct care employees (Column 1)	Recent hires* (Column 2)	Difference in years in median age recent hires relative to all direct care employees (Column 3)
2016			
Registered Nurse	47	42	-5
Enrolled Nurse	50	37	-13
Personal Care Attendant	46	35	-11
Allied Health	50	33	-17
All occupations	46	36	-10
2012			
Registered Nurse	51	47	-4
Enrolled Nurse	49	44	-5
Personal Care Attendant	47	38	-9
Allied Health	50	41	-9
All occupations	48	40	-8

Source: Survey of residential care workers.
**Recent hires have been employed for 12 months or less.*

While the share of the male workers within the aged care sector has been increasing slowly over time, Figure 3.4 shows that the residential direct care workforce in 2016 remains predominantly female, (with 87 per cent female direct care workers). Among the different occupational groups, ENs have the smallest proportion of male workers at 9 per cent.

Figure 3.4: Gender distribution of the residential aged care workforce: 2016 (per cent)



3.2.4 Country of Birth

Between 2007 and 2012 there was a slight rise in the proportion of the residential direct care workforce that was overseas born (from 33 to 35 per cent). This rise has not continued; the proportion of the residential workforce born overseas has fallen slightly from 35 per cent in 2012 to 32 per cent in 2016 (see row 'other' in Table 3.7). This suggests perhaps that the retention of Australian born direct care workers has improved compared to that of the overseas born workers. However, a different picture emerges when examining the country of birth of

recently hired workers. The proportion of overseas born new hire workers has shown a continual rise from 34 per cent in 2007, to 37 per cent in 2012 and 40 per cent in 2016.

Table 3.7: Country of birth of the residential direct care workforce, all direct care employees and recent hires: 2007, 2012 and 2016 (per cent)

Country of birth	All direct care employees			Recent hires*		
	2007	2012	2016	2007	2012	2016
Australia	67.5	65.4	67.7	66.4	63.4	60.0
Other	32.5	34.6	32.3	33.6	36.6	39.9
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.
**Recent hires have been employed for 12 months or less.*

The distribution of the residential aged care workforce born overseas, by occupation, is explored in Table 3.8. The census form asked facilities to provide the numbers of workers from a culturally and linguistically diverse background (CALD) for each occupation. The worker survey also asked workers to state where they were born and whether they spoke a language other than English. Although not directly comparable, these questions provide different perspectives on the level and distribution of the residential direct care workforce that were born overseas.

Table 3.8 shows that 29 per cent of all workers are migrants (column 1) and that their occupational distribution is broadly similar to that of the overall direct care workforce as reported in Table 3.2, although a slightly higher proportion of the migrant workers are RNs (20 per cent against 15 per cent in the general direct care workforce).

There is a difference in the overall proportion of CALD employees in the residential workforce (column 3), with facilities indicating that 26 per cent of their workers were in the CALD category, while worker responses (column 2) indicated that 22 per cent were both migrant and spoke a language other than English. Care needs to be taken in making direct comparisons of these proportions because they measure slightly different things (but the difference, while noted, is relatively small).

Table 3.8: The CALD residential direct care workforce, by occupation, comparing responses from all workers and all facilities: 2016 (per cent)

Occupation	Worker (migrant)[1] (Column 1)	Worker (migrant + LOTE)[2] (Column 2)	Facility (CALD)[3] (Column 3)
% of direct care employees	28.7	22.2	26.2
Distribution:			
Registered Nurse	19.8	19.8	18.1
Enrolled Nurse	6.0	4.8	5.2
Personal Care Attendant	70.3	72.1	74.0
Allied Health	3.9	3.3	2.7
Total	**100**	**100**	**100**

Source: Survey of residential care workers, Census of residential aged care facilities.
1. Workers who report having migrated to Australia.
2. Workers who report being both migrant and speaking a language other than English.
3. Facilities that report employees from culturally and linguistically diverse backgrounds.

In 2016 (as in 2012) the worker survey asked migrant workers who spoke a language other than English how long they had been living in Australia. Although not precise, this allows exploration of the extent to which workers are likely to be familiar with English as a language

and with Australian customs and norms. Table 3.9 shows that in 2016 39 per cent (a lower share compared to the 52 per cent in 2012) of all migrant workers speaking a language other than English have been in Australia for over 10 years. In contrast, in 2016 a total of 31 per cent (lower than the 35 per cent in 2012) have been here for 5 years or less. Of the occupational groups, more PCAs have been in Australia for 5 years or less (34 per cent in 2016, slightly fewer than the 39 per cent in 2012), while similarly in 2016 to 2012, a higher share of nurses and AH workers have been in Australia for more than 10 years.

Table 3.9: Time spent in Australia for migrant residential direct care workers who speak a language other than English, by occupation: 2012 and 2016 (per cent)

	0–2 years	3–5 years	6–10 years	>10 years	Total
2016					
Registered Nurse	3.1	21.5	41.9	33.5	**100**
Enrolled Nurse	0.8	10.0	23.3	65.8	**100**
Personal Care Attendant	13.7	20.5	27.9	37.9	**100**
Allied Health	2.0	18.7	27.8	51.5	**100**
All occupations	10.6	20.1	30.4	38.8	**100**
2012					
Registered Nurse	10.7	16.9	20.0	52.4	**100**
Enrolled Nurse	4.0	9.0	12.0	75.0	**100**
Personal Care Attendant	15.1	23.7	11.7	49.5	**100**
Allied Health	11.1	18.1	13.9	56.9	**100**
All occupations	13.5	21.4	13.2	51.9	**100**

Source: Survey of residential care workers.

3.2.5 Aboriginal and Torres Strait Islander Workforce

Table 3.10 compares responses from the workers survey (column 1) and the facilities census (column 2) regarding the distribution of Aboriginal and Torres Strait Islander people in the residential direct care workforce. The proportion of Aboriginal and Torres Strait Islander people in the residential direct care workforce is low, representing 1 per cent of the workforce and 2 per cent of surveyed workers. This is similar to the corresponding figure in 2012. We note that the small sample size makes these estimates rather imprecise. With this caveat in full view we discuss the relevant parts of Table 3.10. Residential facilities report in 2016 that 1 per cent of the residential direct care workforce (approximately 1,848 workers) are of Aboriginal and Torres Strait Islander descent (Table 3.10 Facility, column 2). Amongst the Aboriginal and Torres Strait Islander workforce, around 10 per cent are RNs, 7 per cent ENs, 81 per cent PCAs, and 2 per cent AH workers.

Compared to the overall residential direct care workforce (Table 3.2), Aboriginal and Torres Strait Islander workers are more likely to be employed as PCAs and are consequently less likely to be in a nursing or allied health role. It is not clear whether this is a result of a shortage of Aboriginal and Torres Strait Islander people with the appropriate qualifications or that those who have the qualifications choose not to work in aged care. However, this imbalance in occupational distribution has improved since 2012. Now a higher proportion of Aboriginal and Torres Strait Islander workers are nurses (17 per cent from 12 per cent) and a lower proportion are PCAs (81 per cent from 85 per cent).

Table 3.10: The Aboriginal and Torres Strait Islander residential direct care workforce, by occupation, comparing facility and worker responses: 2012 and 2016 (per cent)

	Worker survey (Column 1) Workforce	Facility census (Column 2) Workforce
2016		
% of direct care employees	2.0	1.2
Of these, distribution in direct care roles		
Registered Nurse	3.6	9.6
Enrolled Nurse	5.5	7.4
Personal Care Attendant	89.0	80.9
Allied Health	1.9	2.1
Total	**100**	**100**
2012		
% of direct care employees	1.9	1.0
Of these, distribution in direct care roles		
Registered Nurse	4.3	5.2
Enrolled Nurse	6.4	6.4
Personal Care Attendant	87.1	85.4
Allied Health	2.1	3.0
Total	**100**	**100**

Source: Survey of residential care workers, Census of residential aged care facilities.
**Because the numbers of Nurse Practitioners are small, Nurse Practitioners are included with RNs.*

3.2.6 Health

Health status impacts upon an employee's capacity to undertake work tasks and, ultimately, their job retention. As in previous years, a standard measure of self-assessed health drawn from the ABS is used (rating health as excellent, very good, good, fair or poor). The proportion of employees indicating in 2016 that they are in either 'very good' or 'excellent' health is always greater than 60 per cent, but for recently hired PCAs it is much higher at 73 per cent (Table 3.11). As recently hired PCAs had a median age of 35 years (Table 3.6), the better reported health of PCAs likely reflects their younger age. Very few direct care workers have fair or poor health (fewer than 10 per cent, except for recently hired AH workers at 11 per cent) which may also be indicative of the health requirements for working in aged care.

Table 3.11: Self-assessed health of the residential direct care workforce, all direct care employees and recent hires, by occupation: 2016 (per cent)

Self-assessed health	All direct care employees			Recent hires*		
	Nurse	PCA	AH	Nurse	PCA	AH
Excellent	17.4	19.8	16.9	20.7	26.9	18.2
Very good	44.0	41.3	47.7	42.9	46.5	50.7
Good	32.7	31.1	26.4	31.4	21.8	19.6
Fair	5.6	7.2	8.1	4.8	4.4	11.4
Poor	0.3	0.5	1.0	0.1	0.4	0.0
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.
**Recent hires have been employed for 12 months or less.*

3.2.7 Education

This section focuses on the formal education of the workforce in 2016. The expanded number of questions asked about education and training which started in 2012 has been continued in 2016; this includes the collection of information about the qualifications of care managers and care leaders. Additional categories of qualifications related to disability care were added to the education questions in 2016 for the first time.

As shown in Table 3.12, the worker survey asked respondents about the qualifications they had completed post-school (with multiple responses permitted, hence there can be overlap between the shares of each type of qualification held). Looking firstly at the qualifications held by care managers and leaders, different educational pathways were found for these leadership roles. In 2016, the majority of care managers (64 per cent, against 54 per cent in 2012) have at least a degree in nursing, with 18 per cent (similar to the 19 per cent in 2012) holding a Certificate III or IV in management. In comparison, the most common qualification for care leaders in 2016 is a Certificate III (41 per cent, similar to the 42 per cent in 2012) or Certificate IV in aged care (25 per cent, slightly more than the 22 per cent in 2012), yet a substantial minority hold nursing qualifications, and a relatively low proportion hold a qualification in management. This suggests that while residential facility care managers are drawn primarily from nursing (and especially RNs), in contrast residential care leaders are drawn from a wider cross-section of the workforce.

Focusing now on the educational qualifications held by the direct care workforce as a whole, Table 3.12 shows that 90 per cent of these workers hold post-secondary qualifications, indicating widespread engagement in further education. This is a slight increase from 2012 when 86 per cent of workers had post-secondary qualifications (following an earlier increase from 2007 when 79 per cent had these). As might be expected, there is variation between occupations. For example, in 2016 the share of PCAs who had not undertaken further education (13 per cent compared to 16 per cent in 2012) is much higher than that of RNs (3 per cent, the same as in 2012).

The types of qualifications undertaken by direct care workers show there is a quite close correspondence between qualifications and occupations, which is a strong sign for a well-matched and efficient workforce. A high proportion of nurses have qualifications in health-related areas, with RNs having mostly degree-level qualifications, while ENs are more likely to hold a Certificate IV or diploma. A high proportion of PCAs and AH workers hold Certificate level qualifications in Aged Care.

Examining the educational attainments of PCAs further, we see that around two-thirds have a Certificate III in Aged Care (67 per cent in 2016), which is considered to be the standard qualification for working in this occupation. This proportion has stayed constant since 2012, and going back since 2003. In contrast, the proportion of PCAs with a Certificate IV in Aged Care has steadily increased from 8 per cent in 2003 to 20 per cent in 2012 and 23 per cent in 2016.

Residential aged care direct care workers with a disability related qualification (this question was asked for the first time in 2016) are mainly PCAs and AH workers. For PCAs, this qualification is most typically a Certificate III in Disability. AH workers show no concentration in any specific type of disability related qualification. Note that workers can hold more than one qualification type and there can be overlap where Certificate IV holders also have a Certificate III.

Table 3.12: Post-school qualifications completed by the residential direct care workforce, by occupation: 2016 (per cent)

Qualification	Care Manager	Care Leader	RN	EN	PCA	AH	All DCW*
No Post-school							
Year 10 or below	0.4	2.9	0.6	1.1	6.1	2.8	4.7
Year 11/12	2.0	3.3	2.2	2.1	6.5	2.6	5.3
Health							
Certificate IV/Diploma in Enrolled Nursing	8.6	27.3	7.2	82.0	4.5	4.1	12.6
Other basic nursing qualification	16.1	8.2	13.2	8.4	4.3	2.9	5.9
Post-basic nursing qualification	10.3	3.9	10.1	2.7	0.9	0.2	2.3
Bachelor Degree in Nursing	64.2	23.9	75.4	3.4	3.3	1.7	13.6
Bachelor Degree in Allied Health Profession	0.5	1.3	0.8	0.1	0.3	19.6	1.2
Postgraduate allied health qualification	2.3	0.8	2.2	0.2	0.3	6.2	0.8
Other health related	11.0	5.4	8.3	5.1	4.5	12.3	5.5
Aged Care							
Certificate III in Aged Care	11.1	41.2	13.0	32.5	67.4	35.8	54.6
Certificate III in Home and Community Care	2.1	5.9	1.3	4.2	12.0	8.2	9.5
Certificate IV in Aged Care	6.6	24.5	3.7	10.4	22.9	17.6	18.6
Certificate IV in Service Coordination	0.4	1.7	0.3	1.1	1.5	3.5	1.4
Other Certificate in Care Work	2.6	6.0	1.5	3.9	5.8	11.8	5.2
Post basic nursing qualification in aged care	7.0	1.5	5.5	1.5	0.6	0.0	1.4
Other aged care related	8.5	5.2	5.9	3.3	4.1	17.2	4.9
Disability							
Certificate III in Disability	0.5	2.4	0.6	1.4	5.2	2.9	4.0
Certificate IV in Disability	0.2	1.1	0.3	1.1	2.2	2.4	1.8
Diploma in Disability	0.3	0.2	0.2	0.2	0.2	0.5	0.2
Diploma Community Service	0.4	0.3	0.4	0.5	0.4	2.4	0.5
Other (Disability related)	0.5	0.6	0.7	0.7	0.7	1.8	0.7
Management							
Certificate III or IV (Management)	17.6	8.0	11.5	6.4	3.6	5.8	5.1
Diploma (Management)	16.9	3.0	9.3	3.6	2.2	4.6	3.5
Bachelor or Postgraduate Degree (Management)	8.6	2.1	7.4	0.5	1.7	1.5	2.4
Other							
Certificate III or IV (Other)	12.9	12.7	10.1	11.4	12.4	24.8	12.5
Diploma (Other)	5.4	4.9	5.3	7.2	4.6	11.4	5.3
Bachelor or Postgraduate Degree (Other)	10.7	3.5	8.9	2.2	5.5	5.3	5.7

Source: Survey of residential care workers.
**All DCW (direct care workers), does not include care managers or care leaders.*
Note: Because staff can have more than one qualification, the columns do not sum to 100.

The residential facility census also asked facility managers to provide information about the extent to which PCAs working in their facility had completed a Certificate III or IV in Aged Care (Table 3.13). Their responses reinforce the picture of a highly qualified PCA workforce. The proportion of facilities with no PCAs with Certificate III qualifications was 2 per cent, the same as in 2012, but less than half what it was in 2007 (5 per cent). The proportion of facilities with more than three-quarters of PCAs holding a Certificate III rose from 47 per cent in 2007 to 62 per cent in 2012 and rose slightly more to 66 per cent in 2016. While in the past there was a marked decrease in the number of facilities with no PCAs holding a Certificate IV in Aged Care, dropping from 42 per cent in 2007 to 22 per cent in 2012, there was a slight rise to 24

per cent in 2016. The majority of facilities (56 per cent in 2016, slightly fewer than the 58 per cent in 2012) had 1-24 per cent of their PCAs with a Certificate IV.

Table 3.13: Distribution of residential facilities by proportion of Personal Care Attendants (PCAs) with Certificate-level qualifications: 2007, 2012 and 2016 (per cent)

Proportion of PCAs with each type of qualification	Certificate III in Aged Care			Certificate IV in Aged Care		
	2007	2012	2016	2007	2012	2016
Zero	5.2	1.8	2.2	42.2	21.8	23.5
1–24	5.5	4.1	4.5	44.8	57.6	55.6
25–49	14.9	9.3	8.7	8.9	13.4	12.8
50–74	27.0	23.1	18.4	2.5	3.8	4.4
75–99	47.4*	43.9	42.6	1.5*	1.7	2.2
100		17.6	23.6		1.8	1.4
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Census of residential aged care facilities.
**In 2007, the categories were for 75-100%.*

The survey of residential care workers specifically collected information regarding the undertaking of specialised qualifications in ageing or aged care. Table 3.14 shows that in residential aged care 71 per cent of RNs, 79 per cent of Care Leaders and 63 per cent of Care Managers do not have specialised qualifications in ageing or aged care. As these are the occupations that provide leadership in the provision of care within a residential aged care facility, the extent to which they understand the specific physical and mental health issues facing older Australians is important and relevant. These proportions are very similar or mostly unchanged since 2012. Of those with the specialised aging or aged care qualifications in 2016, palliative care and gerontology are the most prevalent.

Table 3.14: Specialised qualifications in ageing or aged care of the residential direct care workforce, by occupation: 2012 and 2016 (per cent)

	Care Manager	Care Leader	RN	EN	PCA	AH
2016						
None	63.4	78.9	71.0	82.5	85.2	77.7
Specialisation in:						
Gerontology	13.8	2.7	10.2	1.9	0.3	3.3
Palliative care	13.3	11.2	10.8	9.0	7.4	4.0
Psychogeriatrics	1.3	0.2	1.0	0.6	0.2	0.3
Other	12.1	6.6	8.3	7.0	7.1	14.1
2012						
None	63.0	75.8	69.0	80.2	84.0	74.1
Specialisation in:						
Gerontology	14.0	2.5	10.4	1.3	0.1	1.4
Palliative care	12.0	11.5	11.0	8.4	6.8	6.3
Psychogeriatrics	2.4	0.8	2.1	1.0	0.2	0.3
Other	8.6	9.4	7.5	9.1	8.9	17.9

Source: Survey of residential care workers.

The level of study currently being undertaken by the direct care workforce is shown in Table 3.15. Across all occupations fewer residential aged care workers were found to be studying in 2016 compared to 2012 (16 per cent and 22 per cent respectively). In 2016 17 per cent of

PCAs, 12 per cent of RNs, 15 per cent of ENs and 11 per cent of AH workers were engaged in study (in contrast, in 2012, 25 per cent of PCAs, 13 per cent of RNs, 19 per cent of ENs and 21 per cent of AH workers were engaged in study).

Table 3.15: Current study of the residential direct care workforce, by occupation: 2012 and 2016 (per cent)

	RN	EN	PCA	AH	All occupations
2016					
Not currently studying	88.4	85.3	82.9	89.1	84.2
Currently studying	11.6	14.7	17.1	10.9	15.8
Total	**100**	**100**	**100**	**100**	**100**
2012					
Not currently studying	87.0	81.1	75.1	78.6	77.9
Currently studying	13.0	18.9	24.9	21.4	22.1
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.

3.3 The Main Characteristics of the Work

The experience of aged care work is strongly impacted upon by the context within which the work takes place. In this section the focus is on aspects of work that are primarily shaped by the employer, comprising the forms of employment offered, the shifts and hours worked, and the extent of training provided. The proportion of workers who hold multiple jobs is also included because this is an indicator of whether their current job is meeting their needs.

3.3.1 Employment Arrangements and Hours Worked

The employment arrangements and working hours available in aged care are important factors affecting the attractiveness of work in the sector. In 2016, as was the pattern since 2003, the majority of workers in all residential aged care direct care occupations are employed on permanent part-time contracts (Table 3.16), with these now forming 78 per cent of the workforce employment arrangements, compared with 72 per cent in 2012, and 69 per cent in 2007. We also note a further shift away from casual/contract arrangements. In 2016 these arrangements represented 10 per cent of all workforce employment arrangements (substantially less than the 19 per cent in 2012 and the 22 per cent in 2007). Staffing within residential aged care is therefore derived from an overwhelmingly part-time direct care workforce.

There also continue to be occupational differences relating to the form of employment in 2016 as in 2012, with a higher proportion of RNs than other occupations employed on a permanent full-time basis (22 per cent in 2016, up from 19 per cent in 2012). The proportion of casual or contract employment was halved between 2012 and 2016 for all occupations, with the exception of AHs where it was reduced to a third (from 15 per cent to 5 per cent). These jobs appear to have shifted to permanent part-time employment.

Table 3.16: Form of employment of the residential direct care workforce, by occupation: 2012 and 2016 (per cent)

	Permanent full-time	Permanent part-time	Casual or contract	Total
2016				
Registered Nurse	22.4	67.7	9.8	**100**
Enrolled Nurse	13.4	78.9	7.8	**100**
Personal Care Attendant	8.9	80.3	10.8	**100**
Allied Health	19.9	75.3	4.8	**100**
All occupations	11.9	78.1	10.1	**100**
2012				
Registered Nurse	19.3	61.3	19.4	**100**
Enrolled Nurse	10.5	74.7	14.8	**100**
Personal Care Attendant	6.9	73.6	19.5	**100**
Allied Health	12.0	72.9	15.1	**100**
All occupations	9.5	71.8	18.7	**100**

Source: Census of residential aged care facilities.
Row percentages shown.

Table 3.17 presents work schedules by occupation. Between 2007 and 2012 there was a marked change in the types of shifts worked, with a move towards employing more nurses on regular shifts rather than rotating ones (a change that was also observed in previous years between 2003 and 2007). This long-standing trend appears to have been reversed in 2016, with the proportion of nurses working a regular daytime shift having fallen to 61 per cent, accompanied by a corresponding rise in the proportion working a rotating shift (19 per cent in 2016 up from 15 per cent in 2012). The work schedules of PCAs and AH workers do not seem to be changing over time with most of the shifts that are not regular daytime shifts being worked by PCAs and with close to all AH workers working regular daytime shifts.

Table 3.17: Work schedule of the residential direct care workforce, by occupation: 2007, 2012 and 2016 (per cent)

Work schedule	Nurse			PCA			Allied Health		
	2007	2012	2016	2007	2012	2016	2007	2012	2016
A regular daytime shift	57.1	64.9	61.2	50.6	50.8	50.6	95.6	92.0	93.8
A regular evening shift	12.5	8.3	8.8	14.0	14.3	15.0	0.4	2.2	0.7
A regular night shift	5.8	3.9	3.8	5.3	5.1	5.0	0.2	0.0	0.0
A rotating shift	16.2	14.5	19.0	19.7	19.5	19.5	1.7	2.2	1.4
Spilt shift	0.5	0.5	0.3	0.6	1.1	0.8	0.2	0.5	0.1
On call	0.6	1.0	0.6	1.3	1.5	1.5	0.4	0.7	0.3
Irregular schedule	5.1	5.2	5.3	6.7	6.4	6.5	1.1	1.2	2.1
Other	2.1	1.6	0.9	1.8	1.3	1.1	0.4	1.0	1.5
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.
Table 3.19 below show the hours worked by employees in residential facilities.

The left side panel of Table 3.18, shows the actual hours worked per week. Over all direct care occupations, 44 per cent of the residential aged care workforce is working for 35 hours or more per week, which falls within the ABS definition of full-time work (this is slightly less than the 46 per cent in 2012). The difference between the proportions reporting to be working

less than 35 hours (35 per cent for RNs, 51 per cent for ENs, 62 per cent for PCAs and 45 per cent for AH workers) in Table 3.18 and those reporting a permanent part-time employment arrangement (68 per cent for RNs, 79 per cent for ENs, 80 per cent for PCAs and 75 per cent for AH workers in Table 3.16). The difference indicates that many people are putting in full-time working hours (i.e. more than 35 hours) while employed on a permanent but part-time contract.

There is some variation in the hours worked across occupational groups. RNs form the occupation with the highest proportion of workers working long hours (>40 hours per week, 23 per cent), while PCAs are most likely to be working for 16–34 hours per week (57 per cent). This suggests a possible skills shortage in RNs and excess capacity among PCAs. This overall picture is similar to 2012.

The columns in the right side panel of Table 3.18, show the hours that employees would prefer to work by the same groups and occupations. As similar to 2012, the hours preferred by the largest proportion of workers are 35–40 hours per week (47 per cent of workers). Table 3.18 highlights some discrepancies between the hours actually worked by aged care workers and the number of hours they would rather work. While only 5 per cent of the RNs express a preference for working more than 40 hours a week, 23 per cent of them report working in excess of 40 hours. A large discrepancy is also seen for AH workers (with 5 per cent preferring to work more than 40 hours per week compared to 5 per cent who actually do). These figures potentially indicate that there is a situation of over-utilisation of some types of aged care workers such as RNs and AHs which may reflect tensions on the labour market, such as skill shortages or other demand-related factors such as rigidities of employment contracts. This is not a new picture and it suggests either the presence of managerial constraints to address these issues or that the training and attraction strategies of the aged care sector have not worked as well as desired.

Table 3.18: Actual working hours and preferred working hours of direct care workers in the residential aged care workforce, by occupation: 2016 (per cent)

Occupation	Actual hours per week				Preferred hours per week			
	1–15	16–34	35–40	>40	1–15	16–34	35–40	>40
Registered Nurse	3.0	32.2	41.8	23.0	2.3	36.6	55.8	5.3
Enrolled Nurse	3.4	47.6	38.2	10.8	3.3	47.0	42.7	7.1
Personal Care Attendant	4.6	57.2	31.8	6.4	2.3	44.7	45.1	7.9
Allied Health	4.7	40.3	43.5	11.6	3.5	36.8	54.3	5.4
All occupations	4.3	51.8	34.4	9.5	2.4	43.4	46.8	7.3

Source: Survey of residential care workers.
Row percentages shown).

In examining the hours worked mismatch shown by the difference between actual and preferred hours worked, Table 3.19 shows the extent of the mismatch in terms of the preferred change in the number of hours (both positive and negative) and how these compare to previous years. Over all, the picture has been stable over time, with between 45-50 per cent wanting different hours. Of these just under two thirds want to increase their hours and just below one third want to decrease them.

The information in Table 3.19 indicates that, similar to 2012, 56 per cent of the workforce are happy with their current hours. Among the 44 per cent of the direct care workforce who reported in 2016 that they would like to change their hours, 14 per cent want to work fewer hours against 30 per cent who would prefer to work longer hours. The proportion of workers wanting to increase their hours has increased slightly since 2012 (from 30 per cent to 27 per cent). Residential direct care workers preferring an increase in hours are most likely to want a relatively small increase per week of 1–5 hours. The reasons for hours worked not being perfectly matched may stem from the inflexibility of employment contracts and the needs of

the employer (the labour demand side), but they may also stem from the specific personal and family circumstances of the workers (the labour supply side). Table 3.19 presents the net mismatch, reflecting all demand and supply pressures. Further investigation would be needed in order to understand what the best policy would be to alleviate the mismatch.

Table 3.19: Preferred change in working hours of the residential direct care workforce: 2003, 2007, 2012 and 2016 (per cent)

Desired change in hours	2003	2007	2012	2016
10+ hours less	5.5	4.0	6.2	4.9
1–9 hours less	8.5	7.5	11.0	9.1
No change in hours	57.6	60.4	55.6	55.8
1–5 hours more	13.2	12.2	12.3	13.0
6–10 hours more	10.5	10.7	9.3	10.5
11+ hours more	4.6	5.1	5.6	6.7
Total	**100**	**100**	**100**	**100**

Source: Survey of residential care workers.

3.3.2 Wages

At the time of the 2012 NACWCS, the Australian Productivity Commission Report (2011) highlighted the need for improved wage rates within aged care in order to improve the attractiveness of the sector to current and future workers. The wages paid to direct care workers in aged care continues to be a pertinent issue and the 2016 survey again collected information on earnings within the sector. Table 3.20 presents the reported gross median weekly earnings[4] for each occupation participating in the residential aged care workers survey by four groupings of number of hours worked per week (1-15, 16-34, 35-40, and more than 40).

In 2016, the gross median weekly wage reported by RNs is $1,352 per week. As discussed above, a high proportion of RNs work more than 35 hours per week and we expect this to be reflected in their median weekly wage. However, even when working part-time, RNs report a higher median weekly wage than other occupations. This was also the case in 2012.

More than half (57 per cent) of residential PCAs work 16–34 hours per week (Table 3.18), and they receive a median weekly wage of $689 (Table 3.20). In contrast, 49 per cent of all ENs work 35 hours or more (Table 3.18), with a median weekly wage of between $1,000 and $1,050 (Table 3.20). While AH Professionals ($820) have a higher median wage than AH Assistants ($750), the difference is relatively small. This is somewhat surprising given the higher qualifications required of AH Professionals. Except for those AH Professionals working more than 40 hours, their median wage is similar to that of PCAs than of ENs or RNs. This is unchanged from 2012. The median wage for AH Assistants is lower than that of any other occupation across all hours worked except for those working more than 40 hours per week, and this is also unchanged from 2012. Part of the reason for AH workers having lower median wages than other occupations may be due to the fact that most work a regular daytime shift (94 per cent, Table 3.17) and would not receive any financial benefits of working evenings, nights or being on call.

[4] As in 2012, the calculation is undertaken within each occupation group. Workers are asked in the survey about the dollar amount of their most recent pay (before tax and other deductions), and over what period those wages were for (week, fortnight, month). The amount is divided by the relevant number to calculate a weekly wage variable (divide by 2 for fortnightly pay, by 4 for monthly).

Table 3.20: Median weekly earnings (gross) of the residential direct care workforce, by occupation and working hours: 2016 ($ per week)**

Occupation	Hours per week				All hours
	1–15	16–34	35–40	>40	
Nurse Practitioner	*	*	*	*	1,000
Registered Nurse	525	1,050	1,493	1,600	1,352
Enrolled Nurse	355	800	1,050	1,000	946
Personal Care Attendant	389	689	860	850	750
Allied Health Professional	340	692	969	942	820
Allied Health Assistant	310	627	855	868	750
All occupations	400	709	940	1,000	800

Source: Survey of residential aged care workers.
**Because the numbers of Nurse Practitioners are small, the wages earned have not been reported for individual categories.*
***As in 2012, the calculation is undertaken within each occupation group. Workers are asked in the survey about the dollar amount of their most recent pay (before tax and other deductions), and over what period those wages were for (week, fortnight, month). The amount is divided by the relevant number to calculate a weekly wage variable (divide by 2 for fortnightly pay, by 4 for monthly).*

3.3.3 Multiple Job Holding

The extent to which employees hold multiple jobs is also an indicator of spare capacity within the existing workforce. In 2016, approximately 9 per cent of residential direct care employees have more than one job (Table 3.21). The figure is roughly the same as in 2012. For those concerned, most of the 'other' jobs held by RNs, PCAs, ENs and AH workers are also in residential aged care (4 out of the 9 per cent), a few were in home care and home support (1 per cent), while a further 4 per cent had another job outside of the aged and disability care sectors. Multiple job holdings within aged care reinforce the picture of a loyal sector workforce.

In the 2016 survey, an additional category was added to the question eliciting the number and nature of the jobs currently held by aged care workers. The workers could report whether they had another job in disability care. This information is particularly relevant given the roll out of the National Disability Insurance Scheme (NDIS) which has the potential to generate labour mobility from the aged care sector. The figures show no evidence that aged care workers who hold multiple jobs are now taking up jobs in the disability care sector (the categories that are in common between 2012 and 2016 do not show significant distributional shifts). Since the NDIS has not yet been fully rolled out, it is too early to make any statements about the effect of the NDIS on the mobility of the aged care workforce.

Table 3.21: Prevalence of multiple job-holding among residential direct care workers, by occupation: 2012 and 2016 (per cent)

Jobs held	RN	EN	PCA	AH	All occupations
2016					
Only have one job	88.8	91.3	91.3	89.6	90.9
Other job in residential aged care	4.7	4.6	3.4	3.0	3.7
Other job in home care and home support aged care	0.3	0.4	1.2	0.5	0.9
Other job in disability care*	0.2	0.5	0.4	0.2	0.4
Other job not in aged care or disability care*	6.0	3.2	3.7	6.7	4.1
2012					
Only have one job	88.1	89.0	89.9	88.1	89.4
Other job in residential aged care	5.5	3.5	4.4	2.5	4.4
Other job in community aged care	0.5	0.6	1.0	1.2	0.9
Other job not in aged care	6.0	7.0	4.7	8.4	5.4

Source: Survey of residential aged care workers.
Note: Multiple response allowed.
** 'Other job in disability care' and 'Other job not in aged care or disability care' only asked in 2016.*

Training

Training is an important activity which contributes to the skilling of the aged care workforce. Previously in Section 3.2.7 the extent of the post-school qualifications held by the residential direct care workforce was examined. Now in Table 3.22 we show the training undertaken 'on the job' or to maintain these qualifications, for example, continuing and professional development (CPD). The residential worker survey asked workers about their participation in different forms of training and what the purpose of this training was. It also asked them about the areas of training they thought they needed in the next 12 months, and this question was also asked of facilities with respect to the additional training they thought was required for their PCA workforce. These questions were repeated in 2016 after they were asked for the first time in 2012.

The majority of workers had engaged in CPD (58 per cent) and training (80 per cent) in the past 12 months. Mandatory training was the most common form of training undertaken, with 76 per cent of the workforce having participated in this type of training in 2016. Some differences can be observed between occupations, with participation in non-mandatory training undertaken by a higher proportion of RNs (38 per) than workers in other occupations. The level of engagement in CPD was lower for PCAs than for other occupational groups (47 per cent). Overall, the 2016 figures differ very little from the situation observed in 2012.

Table 3.22: Participation in training and/or continuing professional development (CPD) by residential aged care employees in the past 12 months, by occupation: 2012 and 2016 (per cent)

	RN	EN	PCA	AH	All occupations
2016					
CPD	91.6	85.4	46.7	63.6	57.8
Training:					
No training	12.8	15.6	21.5	21.2	19.6
Mandatory training	81.3	78.8	74.7	74.7	76.1
Non-mandatory training	37.7	31.7	18.4	24.8	22.8
2012					
CPD	88.0	79.1	49.6	63.4	60.0
Training:					
No training	15.9	19.1	19.2	18.1	18.6
Mandatory training	75.6	75.7	75.7	73.8	75.6
Non-mandatory training	40.8	32.6	21.5	32.9	26.5

Source: Survey of residential aged care workers.
Note: Multiple response allowed, columns will not sum to 100.

As Table 3.23 shows, those residential aged care workers who did participate in training stated that developing or improving their skills either for their current job or in general was the main motivation for undertaking training. Another widely nominated aim was to maintain professional/occupational standards; this was particularly important for RNs and ENs. Slightly more than half of the workers who undertook training in each occupational category indicated the need to meet accreditation requirements as their purpose for engaging in training.

A less frequently nominated reason for undertaking training was to address health and safety concerns, although this was more commonly indicated by PCAs (25 per cent) and AH workers (20 per cent) than RNs (14 per cent) and ENs (15 per cent). Smaller proportions of the workforce who undertook training viewed engaging in training as a means to help directly with career development in terms of securing a future job or promotion in residential aged care or to help get started in their aged care job. This pattern is very similar to that of 2012.

Table 3.23: Stated aims of training undertaken by the residential direct care workforce that undertook training during the last 12 months, by occupation: 2016 (per cent)

Aim of training	RN	EN	PCA	AH
Improve skills in current job	65.6	65.5	71.3	64.3
Develop skills generally	51.8	49.2	49.0	44.6
Maintain professional/occupational standards	74.9	69.5	53.2	56.8
Meet accreditation requirement	50.1	53.4	54.9	56.7
Safety/health concerns	14.0	15.4	25.2	20.3
Prepare for future job/promotion	12.2	8.2	8.8	9.0
Help get started in job	6.5	3.6	7.4	7.2
Other	7.1	4.5	4.1	3.6

Source: Survey of residential aged care workers.
Note: Multiple response allowed, columns does not sum to 100.

The types of training viewed as most needed by residential direct care workers are shown in Table 3.24. There was variation between the occupational groups. Residential workers viewed

dementia training and palliative care and, to a lesser extent, wound management, as priority areas. Half of RNs also sought training in management and leadership. The relatively high proportion of workers responding to a number of areas in which training is needed, suggests a willingness to engage in such training where it is offered. The separately gathered responses from residential workers and residential facilities about the training most needed for PCAs show that they are closely matched in terms of priorities, although the extent to which they were nominated differed. The three areas of training viewed as most needed were dementia training, palliative care and wound management. This pattern is similar to that of 2012.

Table 3.24: Areas of training identified as most needed in the next 12 months for the residential direct care workforce, by occupation, comparing facility and worker responses: 2016 (per cent)

Area of training	RN	EN	PCA		AH
	Workers	Workers	Workers	Facilities*	Workers
Dementia training	51.3	54.9	63.3	92.7	68.1
Palliative care	45.9	58.2	52.0	72.4	32.1
Management and leadership training	50.2	27.8	17.5	13.7	27.4
Wound management	38.9	57.0	29.3	44.4	4.7
Mental health	21.0	31.2	32.9	28.8	28.2
Allied health	4.3	4.9	9.0	9.1	24.8
Other	6.1	4.3	5.0	15.0	7.0

Source: Survey of residential aged care workers and Census of residential aged care facilities.
Note: Multiple responses were allowed, columns will not sum to 100.
**Facilities were only asked about their training requirements for PCAs.*

3.4 Career Paths

This section looks at the pathways into and out of aged care jobs, both within the sector and within the current roles of direct care workers. This information explores the occupational backgrounds of the workforce, when they first considered entering the direct care workforce, how long they have been in the workforce and what their intentions are in the near future. Some of the common pathways for different occupations are identified and areas that have changed or may be of interest for future planning are highlighted. Career paths can also be good indicators of the attractiveness of a sector and of the loyalty of the workforce to aged care.

3.4.1 Into Aged Care

For about 8 to 9 per cent of residential direct care workers, aged care work is their first occupation, that is, they have not had another occupation before. The proportion is greater for PCAs (14 per cent) than other workers (Table 3.25). Slightly more than one-third of PCAs (36 per cent) had a background in sales, hospitality, cleaning or clerical work, all of which are female dominated occupations that require minimal qualifications. Apart from nursing, there is no clear pathway into aged care for the other occupations. This is shown in Table 3.25 by the large share with ‘other’ occupational backgrounds (25 per cent ENs, 31 per cent for PCAs, 30 per cent for AH workers). For RNs, in total 48 per cent came from previous nursing work in acute or community care settings, showing that they come to aged care after having worked for a portion of their career in the same nursing occupation within a different setting. While about a quarter of ENs (18 per cent) share this occupational background, 59 per cent had worked in non-care occupations before entering aged care. AH workers came to aged care from a range of occupations, 12 per cent with a professional background (other than nurse) and another 20 per cent had worked in health and social care occupations.

Table 3.25: Activity prior to first job in aged care of the residential direct care workforce, by occupation: 2016 (per cent)

Last occupation before first aged care job	RN	EN	PCA	AH
No previous paid employment	8.1	9.4	14.2	7.9
Nurse, acute care	41.0	15.3	2.0	3.2
Nurse, community	7.1	2.8	0.8	1.0
Other health care	9.1	6.2	3.3	7.3
Carer in other setting	3.9	4.7	4.9	5.1
Disability care	2.1	2.9	2.6	3.7
Salesperson	2.3	10.1	7.7	6.6
Clerical worker	2.8	5.4	6.8	8.3
Hospitality worker	4.1	9.9	13.6	10.6
Cleaner	1.1	2.6	7.9	2.8
Professional (other than nurse)	2.4	3.2	2.4	11.7
Manager	4.6	1.9	2.7	2.0
Other paid employment	11.4	25.4	31.1	29.8
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Table 3.26 presents the age at which workers entered the aged care sector. As noted for Table 3.25, the majority of direct care workers have worked in other areas prior to entering aged care occupations and this may help explain the relatively high median age of the residential aged care workforce (46 years, Table 3.6). The age at which workers enter aged care also helps to explain the overall age structure of the workforce and its sustainability over time. If workers are consistently recruited from older age groups, then the overall higher median age of the workforce may not be a major issue. Table 3.26 shows that in 2016, 35 per cent of the direct care workforce had entered aged care at age 40 years or above, although there is variation between the occupational groups. For PCAs (39 per cent) and AH workers (38 per cent), slightly fewer than 40 per cent of workers had entered aged care at age 40 years or above, while for RNs (24 per cent) and ENs (24 per cent) this share was around a quarter as these occupations had more often started working in aged care when they were younger. For both nursing occupations, around 48 per cent entered aged care before they were 30 years of age. This likely reflects the educational pathway into aged care for RNs whereby they would complete their education and training within other health sectors before entering aged care on graduation (48 per cent, Table 3.25).

Table 3.26: Age at which began working in aged care of the residential direct care workforce, by occupation: 2016 (per cent)

Age (years)	RN	EN	PCA	AH	All
21 or under	15.4	26.2	14.3	16.1	15.7
22–29	33.4	22.1	20.0	24.1	22.3
30–39	27.6	27.3	26.6	21.9	26.6
40–49	16.3	20.6	27.6	26.4	25.3
50+	7.3	3.7	11.5	11.4	10.1
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

The age at which workers enter aged care (shown in Table 3.26) is partly reflected in the number of years they are able to remain in the residential aged care workforce (shown in Table 3.27). For example, a relatively high proportion of PCAs had started working in aged care at 40 years or above (39 per cent Table 3.26), and they form the lowest proportion of workers

(11 per cent in 2016 Table 3.27), who had been part of the residential aged workforce for more than 19 years. This latter proportion is far lower than the 17 per cent in 2012 (Table 3.27). In contrast, for both RNs (37 per cent) and ENs (46 per cent), a far greater share have worked in aged care for 14 years or more. The information in Table 3.27 suggests that a relatively high proportion of workers have committed many years to working in aged care, with 42 per cent of the residential aged care workforce (see all occupations in Table 3.27) having worked in the sector for more than 9 years in 2016 (but this was the case for far fewer PCAs, where the share was 35 per cent).

Compared to 2012, time spent in aged care in 2016 is shorter (Table 3.27). In 2016 42 per cent of the direct care residential aged care workforce had more than 9 years' experience in the sector compared to 58 per cent in 2012. This is partly due to the slightly younger age profile of the residential workforce in 2016. In particular PCAs are now being hired at a younger age (the median age of recent PCAs is 35 years, Table 3.6).

Table 3.27: Total time spent working in aged care of the residential direct care workforce, by occupation: 2016 (per cent)

Total time in aged care (years)	RN	EN	PCA	AH	All occupations
1 year or less	6.1	3.0	13.9	9.3	11.5
More than 1 year–4 years	15.6	9.8	23.5	18.5	20.7
More than 4 years–9 years	23.4	21.2	27.1	24.4	25.8
More than 9 years–14 years	17.7	19.7	15.9	16.2	16.5
More than 14 years–19 years	9.6	13.3	8.4	11.5	9.2
More than 19 years	27.6	33.1	11.2	20.1	16.2
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.4.2 Into their Current Job

This section focuses on mobility within the aged care sector. It explores evidence for 'churn' in the residential direct care workforce, whereby when workers leave their job they move between employers within aged care rather than leaving the aged care sector altogether.

Table 3.28 shows that in 2016 43 per cent of the residential direct care workforce had paid work in aged care prior to getting their current job (in 2012 this had been higher at 49 per cent). Nurses in particular had moved from one aged care job to another (paid or unpaid), with 71 per cent of RNs and 60 per cent of ENs having done this. A much lower proportion of PCAs (35 per cent in 2016, much lower than the 41 per cent in 2012) had paid work in aged care before, indicating that a higher proportion had been recruited from other occupations and sectors.

One route into direct care work is to acquire experience through voluntary work, which may be particularly important if a prospective employee had not held a job previously. This was not often the case in 2016 (similar to 2012), but of the occupational groups, higher proportions of PCAs and AH workers (both 5 per cent) than nurses had done unpaid work in aged care prior to getting their current job.

Table 3.28: Whether had worked in aged care prior to current job of the residential direct care workforce, by occupation: 2016 (per cent)

Whether had previous work in aged care	RN	EN	PCA	AH	All occupations
Yes, paid	69.7	55.2	34.6	54.7	42.7
Yes, unpaid	1.2	4.3	4.9	5.2	4.3
No	29.0	40.5	60.5	40.1	53.0
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

We now focus specifically on workers who started working in their current job in the last five years to provide information about recruitment patterns for the most recent cohort. Table 3.29 shows many direct care workers previously worked within their current facility prior to getting their current job. While between 13 and 20 per cent of workers had a previous relationship with their current facility, the pattern differs according to occupation. The likelihood of having previously had paid work in their current facility is strongest for RNs (16 per cent) and ENs (17 per cent). In contrast, 14 per cent of PCAs held unpaid work prior, compared to 5 per cent who had had paid work. The findings reinforce the discussion above surrounding Table 3.28, in which unpaid work was most often part of the workforce background for PCAs and AH workers. This unpaid work could be due to participation in a volunteer position or from having a placement as part of a training course or qualification.

Table 3.29: Whether had worked in current facility prior to obtaining current job of residential direct care workers employed in the last five years, by occupation: 2016 (per cent)

Whether had previous work in current facility	RN	EN	PCA	AH
Yes, paid	15.8	16.6	4.5	7.8
Yes, unpaid or volunteer	2.7	2.9	13.9	5.6
No	81.5	80.5	81.6	86.5
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.
N=4,147 (weighted).

The residential aged care worker survey asked those workers who had worked in aged care previously why they left that job. Understanding the reasons why workers leave one job and move into another within the same sector can provide insights into what may need to change in order to improve the retention of staff within a facility. Table 3.30 indicates that while some residential direct care staff turnover may be addressed at management level, there can also be other reasons, possibly related to the personal circumstances of workers.

Table 3.30 shows that in 2016, the reasons related to the personal circumstances of employees (e.g. the need to move house, find work closer to home or fulfil caring responsibilities) accounted for around 45 per cent of the main reasons given for leaving a job by PCAs, 35 per cent by ENs, 26 per cent by RNs, and 36 per cent by AH workers. These proportions have changed very little compared to the 2007 and 2012 surveys. This reflects the ways in which paid work is embedded in the broader context of family responsibilities and in the household decisions about where the family live and work (for these mostly female workers in their middle age).

Other key reasons for leaving their last aged care job were related to conditions in the workplace and hence may be addressed by residential aged care staff management. Two reasons stand out as being consistently cited across occupational groups. First is the desire to find more challenging work, which was a particular issue for nurses and AH workers (RNs 15 per cent, ENs 12 per cent, and 16 per cent for AH workers). This could be an indication of there being willingness within the current workforce to upskill themselves and to have more

variety and greater complexity in their work. The second reason for mobility is 'to get the shifts or hours desired' (strongest for PCAs with 18 per cent). As discussed previously in Table 3.19, while 56 per cent of residential aged care workers do not wish to change their working hours, the remaining 44 per cent would prefer a change. Table 3.30 indicates that the share that had changed employers in order to achieve their desired work patterns was 18 per cent for PCAs, and 15 per cent for ENs. Of the remaining reasons, some were more important for particular occupations. For example, a higher proportion of residential aged care RNs cited their reasons as not getting along with management (10 per cent), wanting to achieve higher pay (11 per cent) or because the job was too stressful (7 per cent).

Table 3.30: Main reason for leaving prior aged care job of residential direct care workers with previous experience in sector, by occupation: 2016 (per cent)

Most important reason	RN	EN	PCA	AH
Moved house/location	16.3	21.1	26.6	15.0
To find more challenging work	15.4	12.3	6.2	15.8
To get shifts or hours of work I wanted	7.7	14.8	17.5	10.0
To avoid managers/management I did not get along with or like	9.8	8.3	3.7	4.3
To achieve higher pay	11.2	6.4	4.8	9.5
To be closer to home	7.9	8.4	13.4	12.8
The job was too stressful	6.8	2.6	3.4	2.7
To fulfil care responsibilities (including having a baby)	2.2	5.3	5.5	8.0
Made redundant/retrenched	3.0	5.1	2.5	4.6
Not able to spend sufficient time with residents	0.8	1.2	3.4	2.4
To avoid workmates/colleagues I did not get along with or like	1.6	2.4	1.2	1.6
To find easier work	0.6	0.2	0.3	0.4
Other	16.8	11.9	11.4	12.9
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.
N=3,606 (weighted).

For all residential direct care workers, Table 3.31 shows the length of time that workers had been in their current jobs. Fourteen per cent of residential direct care workers had been in their jobs for 12 months or less and 26 per cent of workers had been in their jobs for more than 9 years. Slightly less than half of the workforce had worked in their current job for up to 4 years (46 per cent), but there is variation between the occupational groups as for ENs this share was lowest at 30 per cent. A higher proportion of ENs (44 per cent) and AH workers (31 per cent) had been in their current job for more than 9 years but only 24 per cent of PCAs. Compared with other occupations, a higher proportion of RNs (19 per cent) have been in their job for 1 year or less.

Table 3.31: Tenure in current job of the residential direct care workforce, by occupation: 2016 (per cent)

Tenure in current job (years)	RN	EN	PCA	AH	All occupations
12 months or less	19.4	9.0	14.1	15.6	14.4
More than 1 year–4 years	31.2	20.6	33.5	31.2	31.8
More than 4 years–9 years	25.2	25.9	28.3	22.4	27.4
More than 9 years	24.2	44.4	24.0	30.8	26.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.4.3 Into the Future

This section examines the intentions of residential aged care workers as they move into the future, including their intentions to leave their current place of employment. Understanding the intentions of the workforce has an important role in thinking about future behaviour and planning.

Table 3.32 shows the share of those actively seeking work for each direct care occupation group, with information about their current job tenure. The final row shows the overall share actively seeking work within each occupation, and the final column shows the overall share of the residential direct care workforce actively seeking work at each length of job tenure. We see that 10 per cent of the residential workforce is actively seeking work (similar to the 9 per cent in 2012). This share of workers seeking work is similar across all occupations, and the lowest proportion seeking work is found for residential aged care workers with tenure of more than 9 years (6 per cent). In contrast, a relatively higher proportion of RNs (17 per cent) and ENs (20 per cent) who have been with their current employer for 12 months or less are actively seeking work.

Table 3.32: Proportion of the residential direct care workforce actively seeking work, by occupation and tenure in current job: 2016 (per cent)

Tenure in current job (years)	RN	EN	PCA	AH	All occupations
12 months or less	17.1	20.3	15.7	12.9	16.1
More than 1 year–4 years	14.0	11.4	11.9	9.9	12.1
More than 4 years–9 years	9.9	9.6	9.8	5.4	9.6
More than 9 years	5.6	5.4	5.2	8.7	5.5
All years	11.5	9.1	10.2	9.0	10.2

Source: Survey of residential aged care workers.

Workers also indicated where they saw themselves working in 12 months from now. As reported in Table 3.33, the vast majority (82 per cent) of residential direct care workers indicated that they expect to still be with their current employer after 12 months. Of the remaining, the next highest share (10 per cent) did not have pre-existing intentions as to what they would be doing, while 4 per cent intended to leave aged care. Of all the occupational groups, a higher proportion of RNs (5 per cent) expected to leave their current aged care facility. Only 4 per cent of all employees indicated they intended to leave aged care, either to work in another sector or to retire from the paid workforce. This constitutes a relatively small proportion of the existing residential workforce that would be lost to aged care (although a further 10 per cent did not know what they would be doing). This reinforces a perspective of stability in the existing workforce, but with a degree of 'churn' between individual facilities.

Table 3.33: Expected activity in 12 months' time of the residential direct care workforce, by occupation: 2016 (per cent)

Expected activity in 12 months	RN	EN	PCA	AH	All occupations
Working in aged care, this facility	80.5	82.8	82.5	82.7	82.2
Working in aged care, different facility	4.8	1.8	2.2	1.8	2.5
Working in community aged care	0.3	0.5	0.7	0.5	0.6
Working in disability care	0.0	0.0	0.3	0.5	0.3
Working, but not in aged care	3.5	5.2	3.9	3.7	4.0
Not working for pay	1.5	0.8	0.3	0.5	0.6
Don't know	9.5	9.0	10.0	10.2	9.9
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

3.5 Experiences of Working in Residential Aged Care

Findings from the previous aged care census and surveys conducted by NILS in 2012, 2007 and 2003 indicated that aged care workers have relatively high levels of satisfaction in their work. However, this research also indicated particular areas for improvement which could have positive effects on employee retention. In this section we report on what direct care workers think about their work in 2016.

3.5.1 Job Satisfaction

In this section job satisfaction data is presented in Tables 3.34 and 3.35. These tables present responses to questions that were ordered in a scale form, whereby respondents answered on a scale from 1–7 or from 1–10. The discussion needs to be interpreted according to the ordinal nature of these questions which introduce possible limitations:

- First, many of the differences in average satisfaction levels at any point in time between different occupation groups in Tables 3.34 and 3.35 are too small to be of statistical significance and they should not be over-interpreted. Differences in averages will typically also conceal the more informative differences across the whole distribution of the reported values from 1 to 10.

- Second, comparing changes in averages over time for any occupation group (i.e. between the 2007 and 2012 data sets) will depend on the characteristics of the workforces concerned being constant over time, which we know not to be the case in all aspects of the data. This is always a problem when comparing single cross-section data sets and can only be satisfactorily handled through the use of multivariate regression.

- Finally, it should be noted that satisfaction measures are ordinal measures, that is, they can tell us if someone likes something more or less than a clear alternative, but they often lack the capacity to provide convincing information about how much more or less something is liked. This caveat naturally limits the interpretation we can give to these ordinal responses. Further, and more specifically, it means that when we observe two survey respondents, the first being satisfied enough to be ticking the box with value 4, and the second the box with value 6, this does not mean that the second person is 1.5 times more satisfied than the first person because 6 is 1.5 times higher than 4. It may mean that the second person is more satisfied than the first person, but even that may not be a universally accepted conclusion. This limitation is somewhat lessened in the case of comparing the satisfaction scores of a single person provided over time or for different aspects of their lives. The over-time comparison for individuals is not feasible through this data collection as individuals are not observed over time.

The worker survey form asked direct care workers to indicate their level of satisfaction with different aspects of their work on a scale of 1–10. These are subjective assessments about different aspects of work and, as such, they are relative to the context within which they are made. For example, such relative judgements may take into account what people may expect to achieve given their personal circumstances, or what they think they should achieve in their workplace given what they perceive their alternative work options to be. Overall, the findings indicate that workers are satisfied with what they do.

In Table 3.34, the average scores for employees' responses to each aspect of their work is shown. Overall satisfaction measured at 7.9 for all occupations shows that residential direct care workers' average overall satisfaction with direct care work has remained steady since 2012. There are slight differences between the various occupations, with AH workers somewhat more satisfied overall with their work (8.1) than PCAs (7.9) or nurses (7.8). In 2016 total pay stands out as being the area with which residential aged care workers are least satisfied (5.6), with PCAs (5.4) reporting more dissatisfaction with their pay compared to the other occupations. This was also the case in 2012. Apart from pay, residential direct care workers appear to be reasonably satisfied with all other aspects of their work.

Table 3.34: Average scores for responses from the residential direct care workforce, to statements about job satisfaction, by occupation: 2016 (range 1–10)

Satisfaction with	Nurse	PCA	AH	All occupations
Total pay	6.2	5.4	5.6	5.6
Job security	7.5	7.4	7.6	7.4
The work itself	7.8	7.7	8.2	7.8
Hours worked	7.6	7.7	7.8	7.7
Opportunities to develop abilities	7.4	7.5	7.3	7.4
Level of support from your team/service provider	7.6	7.4	7.8	7.5
Level of support from your supervisor	7.9	7.6	8.0	7.7
Flexibility to balance work and non-work commitments	7.4	7.5	7.8	7.5
Overall satisfaction	7.8	7.9	8.1	7.9

Source: Survey of residential aged care workers.
Scale used is 1(totally dissatisfied) to 10 (totally satisfied).

3.5.2 Doing the Work

Residential aged care workers were also asked to respond to a series of statements about their work on a scale of 1 (totally disagree) to 7 (totally agree). These statements refer to different aspects of their work.

Table 3.35 reports the average scores from direct care workers regarding their work and workplace. These subjective evaluations are important indicators of how confident they are in doing their work and what they view as areas that they would like changed. Overall, the highest average scores are in areas relating to skills and training (statements 2, 3 and 4 for all occupations), which receive scores of between 5.7 and 6.3. There is consistency across the occupations in the average scores for these statements. There is less consistency across occupations for the level of agreement with the statement on 'freedom to decide how to do the work' (4.4 for PCAs, 4.9 for nurses, 5.4 for AH). The relatively low average score of 3.9 for 'time to care' (statement 1) amongst residential direct care workers suggests that many workers do not think they have enough time to provide resident care (this is similar to 2012) and this persistence should be the subject of further investigations and policy discussions.

Table 3.35: Average scores for responses from the residential direct care workforce to statements about their work, by occupation: 2016 (range 1–7)

Statement	Nurse	PCA	AH	All occupations
I am able to spend enough time with each care recipient	3.9	4.0	4.1	3.9
I have the skills and abilities I need to do my job	6.2	6.3	6.3	6.3
I use many of my skills and abilities in my current job	6.0	6.2	6.1	6.1
Adequate training is available through my workplace	5.5	5.8	5.4	5.7
I have a lot of freedom to decide how to do my work	4.9	4.4	5.4	4.6
I feel under pressure to work harder in my job	4.4	4.2	4.0	4.2
My job is more stressful than I had ever imagined	4.1	3.9	3.6	4.0
Considering all my efforts and achievements I receive the respect and acknowledgement I deserve	5.0	4.9	5.1	4.9
Management and employees have good relations in my workplace	5.1	5.0	5.2	5.0

Source: Survey of residential aged care workers.
Scale used is 1(strongly disagree) to 7 (strongly agree).

In order to further examine how much time residential workers spend in direct caring, Table 3.36 reports on the time spent caring by each occupation with the final column average reflecting all residential direct care occupations. While in 2016, 65 per cent of all workers spent more than two-thirds of their shifts doing direct care tasks, this varied across occupations. Not surprisingly, PCAs spent the most time providing direct care, with slightly more than three-quarters spending the majority of their shift doing this kind of work (77 per cent). This is similar to 2012. For nurses, lower proportions (33 per cent) were providing care for more than two-thirds of their shift, but there was another 33 per cent providing care for less than one-third of their shift. This reflects the increasing managerial role that nurses are performing while PCAs are taking more responsibility for the direct care tasks. Separating RNs from ENs shows the managerial roles more clearly as 44 per cent of RNs spent less than one-third of their work time caring, but 46 per cent of ENs spent more than two-thirds of their time on direct care tasks.

Table 3.36: Responses of the residential direct care workforce to the question 'In a typical shift, how much time do you spend in direct caring?' by occupation: 2016 (per cent)

Time spent caring	RN	EN	Nurse	PCA	AH	All occupations
Less than one-third	43.5	17.4	32.8	6.4	14.0	13.3
Between one-third and two-thirds	33.0	36.2	34.3	17.1	31.4	22.0
More than two-thirds	23.5	46.4	32.9	76.5	54.6	64.7
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.
**Nurse combines RN and EN.*

The quality of relationships between the worker and management, and the worker and colleagues are shown in Tables 3.37 and 3.38. Table 3.37 suggests that most workers consider their relationship with management as good (between 80 and 88 per cent) and some consider it as neither good nor bad (between 7 and 13 per cent). Only a small minority between 4 and 7 per cent report having a bad relationship with their management (6 per cent for nurses, 7 per cent for PCAs and 4 per cent for AH workers). All in all relationships with management are reported to be satisfactory, a good message for a changing sector.

Table 3.37: Residential direct care workforce assessment of the quality of workplace relationships 'between management and yourself', by occupation: 2016 (range 1–7)

	Nurse	PCA	AH	All occupations
Bad	5.9	6.6	4.2	6.3
Neither good nor bad	8.4	12.9	7.5	11.6
Good	85.7	80.5	88.2	82.2
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers, 2016.
Scale used is 1(very bad) to 7 (very good).

Table 3.38 presents reported workplace relationships between colleagues. It suggests that workers are generally very positive with 89 per cent indicating that the relationship between themselves and their colleagues is good. This overall picture of mostly good relationships with management and a slightly higher share with good relationships with colleagues remains unchanged from 2012.

Table 3.38: Residential direct care workforce assessment of the quality of workplace relationships 'between workmates/ colleagues and yourself', by occupation: 2016 (range 1–7)

	Nurse	PCA	AH	All occupations
Bad	2.2	3.7	2.8	3.3
Neither good nor bad	5.8	8.3	7.2	7.6
Good	92.0	88.0	90.0	89.1
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers, 2016.

3.5.3 Job Demands

In 2007 and 2012 the census form asked facilities about several unusual job demands for their workforce that are viewed as stressful (King et al. 2012) in order to establish their prevalence in Australian residential aged care facilities. These demands are:

- Working longer than scheduled
- Variations in hours and location of work
- Working in unsanitary conditions
- Working with aggressive service users
- Working alone late at night.

Facilities were asked if any of these demands are made as (i) part of the normal job requirements; (ii) only in exceptional circumstances; or (iii) never. Their answers are presented in Table 3.39.

Changing work patterns: The most prevalent job demands are associated with changes in work patterns, either in response to unanticipated needs of residents (85 per cent, which is lower than the 91 per cent of facilities in 2012) or because of management needs to vary hours or location at short notice (84 per cent, roughly similar to the 86 per cent in 2012).

Unsanitary conditions: Of the five unusual job demands listed, residential facilities are least likely to ask workers to work in very unsanitary conditions, which is not surprising given that this would breach aged care accreditation standards.

Aggressive service users: Of the more prevalent unusual job demands, working with aggressive service users was a normal expectation in 28 per cent of facilities, with another 56

per cent indicating that workers were required to do this in exceptional circumstances (these are slightly different to 2012 when they were respectively more with normal expectations at 33 per cent and fewer reporting this for exceptional circumstances at 47 per cent). As in 2012, this is likely to be a consequence of the growing number of older Australians with dementia and other mental health problems who are living in residential facilities.

Alone late at night: Twelve per cent of residential facilities ask their workers to work alone at night after 10 pm, but of those that do this is often a normal requirement of the job (9 per cent).

Table 3.39: Prevalence of unusual job demands in residential facilities: 2016 (per cent)

Job demand	Under normal circumstances	In exceptional circumstances	Never	Total
Working longer than scheduled due to unanticipated needs of residents	5.0	79.6	15.5	**100**
Variations in hours or location at short notice	9.9	74.3	15.8	**100**
Working in very unsanitary conditions	0.7	3.3	96.0	**100**
Working with aggressive service users	28.0	55.9	16.1	**100**
Working alone late at night (after 10 pm)	9.2	3.1	87.7	**100**

Source: Census of residential aged care facilities 2016.
Row percentages shown. Per cent of outlets.

3.6 Work-related Injury and Illness

Previous research has suggested that workers in caring roles may be at increased risk of work-related injury and illness compared to the general workforce (Howard and Adams 2010; Kim et al 2010). In order to add to understanding of work-related injury and illness in aged care work the 2016 aged care census and survey asked questions regarding the extent, type and causes of these injuries.

Table 3.40 shows combined information from both the facilities census and the workers survey about work related injuries. There can be discrepancies between facilities and workers regarding the extent of reported work-related injuries, for a variety of reasons. Examples would include that workers and facilities may be reporting over different periods; serious work-related injuries may result in the withdrawal from the workforce of the worker, but their injury record remains; and difficulties in accurately recalling incidents over the designated period, especially minor injuries that will be recorded and reported by the facility but often forgotten by the worker. We would expect the reporting differences to be more prominent for the least prevalent injuries and illnesses. Although for these and other reasons the direct comparison between these figures is difficult, we present them together for ease of presentation and reference.

Facilities: The first two columns of Table 3.40 show that in 2016, 77 per cent of residential facilities reported at least one work-related injury/illness in the 3 months prior to the census (roughly similar to the 76 per cent in 2012). The most commonly reported injuries were sprains/strains (45 per cent of all facilities and 69 per cent of those that reported) and superficial injuries (31 per cent of all facilities and 47 per cent of those that reported). These are similar to the 2012 proportions for these same conditions.

Workers: The final two columns of Table 3.40 show work-related injuries and illnesses reported by workers in the previous 12 months. Fourteen per cent of direct care workers experienced a work-related injury or illness during this period. As with reporting by facilities, the most commonly reported injuries are sprains/strains (6 per cent of all workers and 43 per cent of those who reported), followed by chronic joint or muscle condition (4 per cent of all workers and 29 per cent of those who reported). The next most prevalent work-related injury or illness is stress or other mental condition which is reported by 3 per cent of all workers and 19 per cent of those who reported. The 2016 residential worker reports about work-related

injuries and illnesses are very similar to 2012, indicating that no overall sector improvement in health and safety has been achieved between 2012 and 2016.

Table 3.40: Types of reported work-related injuries and illnesses, comparing facilities and workers: 2016 (per cent)

Type of injury/illness	Facilities (last 3 months)		Workers (last 12 months)	
	All facilities	With any incidents	All workers	Who reported incidents
At least one injury/illness reported	76.7	n/a	14.3	n/a
None reported	23.3	n/a	85.7	n/a
Fracture	2.6	4.0	0.3	2.6
Chronic joint or muscle condition	12.3	19.0	3.7	28.5
Sprain/strain	44.9	68.9	5.6	43.1
Cut/open wound	17.4	26.6	1.3	10.0
Crushing injury/internal organ damage	0.7	1.1	0.2	1.7
Superficial injury (minor)	30.5	46.9	2.2	16.8
Stress or other mental condition	7.1	10.9	2.5	19.3
Amputation	0.2	0.3	0.0	0.1
Burns	13.1	20.2	0.3	2.2
Other	7.9	12.1	2.5	18.9

Source: Census of residential aged care facilities and Survey of residential aged care workers, 2016.
Note: Multiple response allowed, totals will not sum to 100.

Table 3.41 shows the causes attributed to reported work-related injuries and illnesses, again jointly presented for the facilities' workforce and workers.

For the 77 per cent of facilities that reported in Table 3.40 one or more incidents during the previous 3 months, there were four chief causes: 'lifting, pushing, pulling or bending'; 'hitting, being hit or cut by person, object or vehicle'; 'a fall' or 'repetitive movement'. These are roughly the same as for 2012. The pattern reported by workers in Table 3.41 is quite similar to that of the facilities. The most commonly identified cause was 'lifting, pushing, pulling, bending', followed by hitting or being hit, and falls.

Table 3.41: Causes of reported work-related injuries and illnesses, comparing facilities and workers: 2016 (per cent)

Cause of injury/illness	Facilities (last 3 months)		Workers (last 12 months)	
	All facilities	With any incidents	All workers	Who reported incidents
At least one injury/illness reported	76.7	n/a	14.3	n/a
None reported	23.3	n/a	85.7	n/a
Lifting, pushing, pulling, bending	43.5	66.8	5.6	43.2
Repetitive movement	10.0	15.3	0.6	4.4
Prolonged standing, working in cramped or unchanging positions	0.6	1.0	0.1	0.6
Vehicle accident	1.4	2.1	0.0	0.4
Hitting, being hit or cut by person, object or vehicle	26.6	40.9	1.6	12.0
Fall	16.4	25.2	0.7	5.6
Exposure to mental stress	5.2	8.0	0.4	2.9
Long-term exposure to sound	0.0	0.0	0.0	0.0
Contact with chemical or substance	5.5	8.5	0.1	0.7
Fatigue	1.6	2.5	0.3	2.6
Other	14.7	22.6	1.8	13.4

Source: Census of residential aged care facilities.
Note: Multiple response allowed, totals will not sum to 100.

The extent to which the employees are on Workcover in 2016 is shown for residential facilities in Table 3.42. Table 3.42 indicates that 44 per cent of facilities had one or more employees on Workcover during the designated fortnight in 2016 (fewer than the 54 per cent in 2012). For each of these facilities, there was an average of 1.9 employees (slightly fewer than the 2.2 in 2012) on Workcover. Although 38 per cent of facilities had PCAs on Workcover in 2016, the proportion of facilities with workers in any of the other occupational groups was much smaller, between 2 and 6 per cent.

Table 3.42: Proportion of facilities with employees on Workcover (per cent) and, of these, the mean number of employees per facility on Workcover during the designated fortnight: 2016

Occupation	Facilities Utilising Workcover (%)	Employees (average per facility)
Registered Nurse	4.7	1.1
Enrolled Nurse	5.7	1.2
Personal Care Attendant	37.8	1.8
Allied Health	2.3	1.3
All occupations	43.6	1.9

Source: Census of residential aged care facilities.

3.7 Cultural and Linguistic Diversity

In Section 3.2.4 it was shown that around a third of respondents in the survey of residential aged care workers were born overseas. This final section of the chapter presents further findings relating to the cultural and linguistic diversity of the residential workforce. In particular, we explore levels of fluency and use of a language other than English and self-assessed English literacy. Finally, this section examines the extent of the employment of PCAs from CALD backgrounds within residential facilities and the stated benefits and difficulties of hiring these workers.

Table 3.43 presents the relatively small proportion of the residential direct care workforce who completed the worker survey and reported that they speak their primary language more fluently than they do English. Of the occupational groups, a higher proportion of ENs (55 per cent) and AH workers (45 per cent) who speak a language other than English are most fluent in English. On the other hand, a higher proportion of RNs (50 per cent) and PCAs (50 per cent) speak both languages equally well. A further 18 per cent of RNs and 19 per cent of PCAs are most fluent in their primary (LOTE) language.

Table 3.43: Fluency in a language other than English (LOTE) of the residential direct care workforce, by occupation: 2016 (per cent)

Speak LOTE, most fluent in:	RN	EN	PCA	AH
English	32.1	54.9	31.8	44.7
LOTE	17.9	8.4	18.5	16.3
Both equally well	50.0	36.8	49.7	39.0
Total	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers (weighted).

A large share (39 per cent) of residential direct care workers reported they speak a language other than English in their work (Table 3.44) which is higher than the 31 per cent found in 2012. Table 3.44 shows that of the occupational groups, ENs and AH workers more often speak a language other than English in their work (58 per cent and 50 per cent respectively), however 38 per cent of PCAs and 33 per cent of RNs also use this ability in their jobs.

Table 3.44: Use of language other than English (LOTE) of the residential direct care workforce, by occupation: 2016 (per cent)

Speak LOTE and	RN	EN	PCA	AH	All occupations
Use LOTE in job	32.9	57.9	38.1	49.8	38.9
Do not use LOTE in job	67.1	42.1	61.9	50.2	61.1
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of residential aged care workers.

Workers who spoke a language other than English were asked how well they thought they could speak, read and write in English (self-assessment). As shown in Table 3.45, amongst workers who identified as being most fluent in a language other than English, nearly all (93 per cent) indicated that they could read in English 'well – very well' (this is similar to the 95 per cent reporting this in 2012). Of all three English literacy areas, writing was the area in which workers rated themselves lowest, with 14 per cent of workers indicating they could not write in English very well.

Table 3.45: Subjective assessment of English literacy for residential direct care workers most fluent in a language other than English (LOTE): 2016 (per cent)

English literacy	Not at all	Not very well	Well	Very well	Can't say	Total
Speaking	0.6	5.5	61.8	31.7	0.4	**100**
Reading	0.2	6.5	45.8	47.4	0.2	**100**
Writing	0.2	13.9	53.5	32.3	0.2	**100**

Source: Survey of residential aged care workers.

In the following tables we turn our attention to PCAs from culturally and linguistically diverse (CALD) backgrounds. Table 3.46 illustrates the extent to which facilities report how PCAs from diverse backgrounds are distributed among facilities in 2016. Very few (12 per cent, slightly fewer than the 13 per cent in 2012) residential facilities employed no PCAs from a culturally and linguistically diverse background.

Table 3.46: Distribution by proportion of personal care attendants (PCAs) from culturally and linguistically diverse backgrounds (CALD) in residential facilities: 2016 (per cent)

% of CALD PCAs per facility	Facilities
Zero	11.5
1–33	40.5
34–66	20.9
67–100	27.1
Total	**100**

Source: Census of residential aged care facilities.

The 2016 census asked facilities to identify the benefits of hiring PCAs from CALD backgrounds. As shown in Table 3.47, almost all facilities reported one or more benefits. Of the nominated benefits beyond culture and language, the opportunity to enhance cross-cultural understandings and activities was most frequently cited (84 per cent). However, 37 per cent of facilities also indicated that employing these PCAs was important for developing networks into particular communities.

Table 3.47: Stated benefits of employing personal care attendants (PCAs) from culturally and linguistically diverse backgrounds in residential facilities: 2016 (per cent)

Benefits	Facilities
No benefits	0.4
Stated benefits:	
Enhance cross-cultural understandings	83.6
Offer different cultural activities	54.7
Language (other than English) skills	56.0
Link clients to ethnic communities	36.8
Link facility to ethnic communities	33.9
Other	4.5

Source: Census of residential aged care facilities.
Note: Multiple response allowed, totals will not sum to 100.

Facilities that employ PCAs who spoke a language other than English (LOTE) were asked to nominate the most common ethnic or cultural background of those workers. Table 3.48 (column 1) shows that a higher proportion (91 per cent in 2016 against 79 per cent in 2012) of residential facilities employed PCAs from linguistically diverse backgrounds in 2016. India and the Philippines remain the most common source countries for these PCAs.

When we focus on the facilities in which PCAs who speak a language other than English are present (Table 3.48 column 2), the results confirm widespread engagement of Indian and Filipino workers. In facilities where at least one-third of PCAs are identified as LOTE speakers (Table 3.48 column 3), approximately 35 per cent of facilities identified Indian as the major background of these workers, and another 22 per cent of facilities identified their background as Filipino.

Table 3.48: Proportion of residential facilities that employ personal care attendants (PCAs) from linguistically diverse backgrounds: 2016 (per cent)

Ethnic group	All facilities	Facilities with any PCAs speaking LOTE	Facilities with at least 33% PCAs speaking LOTE
At least one PCA from linguistically diverse background	91.1	n/a	n/a
None	8.9	n/a	n/a
Indian[1]	28.3	31.2	34.5
Filipino	26.7	29.0	21.7
African	7.1	7.8	9.9
Pacific Islander	2.5	2.8	2.1
Chinese	3.0	3.4	4.5
Italian	2.3	2.5	1.3
Greek	0.5	0.6	0.7
South East Asian	7.3	8.1	6.4
Other	13.4	14.7	18.9
Total	**100**	**100**	**100**

Source: Census of residential aged care facilities.
[1]Includes Hindi and other languages spoken in India and Sri Lanka.

While we saw in Table 3.47 that facilities reported considerable benefits of hiring PCAs from CALD backgrounds, the management of a multicultural workforce can also present challenges. Facility managers were therefore asked in the census form to nominate, from a list, areas in which employing PCAs who speak a language other than English creates difficulties in providing and managing care services at the facility. About one third (32 per cent) of residential aged care facilities selected at least one area of difficulty from the list in 2016 (Table 3.49), fewer than in 2012 (40 per cent).

Table 3.49 shows that from the list of stated difficulties, communication was the chief area of concern presenting difficulties for facility managers in 2016 (88 per cent communication with residents, 72 per cent communication with the families of residents, and 67 per cent communication with management/staff).

Table 3.49: Stated difficulties of employing personal care attendants (PCAs) who speak a language other than English in residential facilities: 2016 (per cent)

Difficulties	Facilities
No difficulties	67.6
At least one difficulty	32.4
Stated difficulties (% of outlets stating difficulties)	
Occupational health and safety	26.0
Communication with management and/or other staff	66.5
Communication with residents	87.9
Communication with residents' families	72.4
Other – written communication	9.5

Source: Census of residential aged care facilities.
Note: Multiple response allowed, totals will not sum to 100.

4. The Census of Residential Facilities

Key Findings

- Almost two thirds of residential direct care workers were located in major cities, with a further third in regional areas.
- Fifty eight per cent of residential direct care workers were employed in not-for-profit facilities, 34 per cent in for-profit facilities and 7 per cent in government-owned facilities.
- Slightly more than half (52 per cent) of residential facilities were large (i.e. had more than 60 places).
- The total number of operational places available in residential aged care in 2016 was 197,046. The average ratio of residential direct care workers to places (0.78) almost unchanged from 2012. However, since 2012, the ratio of the average number of direct care to PAYG workers has fallen across residential facilities of all size indicating a reduced usage of direct care staff.
- Eighty per cent of facilities belonged to a larger provider group. About 10 per cent of residential facilities also offered community care services from the same location.
- A quarter of residential facilities catered for a specific ethnic or cultural group, most frequently of Italian, Aboriginal and Greek backgrounds.
- Almost two thirds of facilities with direct care staff (63 per cent) reported skill shortages; a shortage of RNs was most common (41 per cent) and skill shortages were more prevalent in locations outside major cities.
- Main reasons for skill shortages were lack of suitable applicants (80 per cent), slow recruitment processes (21 per cent) and specialist knowledge required (19 per cent).
- Facilities responded to skill shortages primarily by having existing staff work longer hours (62 per cent) or by making greater use of agency staff (48 per cent).
- Vacancies were most commonly reported for PCA and RN positions (by 24 per cent of facilities). These facilities had an average of 3.3 PCA and 1.8 RN vacancies.
- The average time taken to fill vacancies was 2.5 weeks for PCA positions and 4.3 weeks for RNs. Residential facilities in remote and very remote locations reported more difficulties in filling staff vacancies.
- The proportions of vacancies that were either very quick to fill (less than 1 week) or very hard to fill (more than 26 weeks) was reduced in 2016 when compared with 2012.
- The most common reasons facilities gave for staff vacancies were resignation (84 per cent), the creation of a new position (31 per cent) and retirement (27 per cent).
- Internet job advertisements (34 per cent) and a combination of internet and newspaper advertisements (23 per cent) were the most frequent recruitment strategies for PCA positions.
- For workers seeking employment in aged care, internet job advertisements and word-of-mouth were the most common strategies used. The use of recruitment agencies was also reported by around 16 per cent of nurses and AH workers.

- Over three quarters (79 per cent) of facilities used Enterprise Agreements to set employment conditions for their staff; almost a fifth (19 per cent) of facilities used award-based arrangements.

- Half of all facilities reported employing at least one non-PAYG worker (particularly RNs and PCAs) in the designated census fortnight. Agency workers (41 per cent) were most commonly used in comparison to brokered (8 per cent) and self-employed (7 per cent) workers.

- Agency staff were used to provide short-term cover for staff absences (88 per cent) and to fill vacancies (51 per cent), while brokered and self-employed staff were mainly employed to obtain specialist skills.

- Approximately 23,537 volunteers worked in residential aged care in 2016. Eighty three per cent of facilities reported one or more volunteer workers who mainly assisted with social and planned group activities and companionship/befriending.

- Methods of quality monitoring in residential facilities included monitoring by managers or supervisors (86 per cent), keeping records of service user feedback (57 per cent) and accreditation processes (56 per cent).

4.1 Introduction

This chapter provides an overview of the key characteristics of residential aged care facilities in Australia with information predominantly based on the census of residential aged care facilities (N=2,240). It should be acknowledged that there has been significant reform to the way residential aged care is delivered to consumers since the last workforce census of residential facilities in 2012. A key change has been the removal of the distinction between high-level and low-level residential aged care funding for all new and existing residents from 1 July 2014.

We begin the chapter with a profile of residential facilities showing the distribution of their employees across all states and territories, and information regarding the operational places offered. The relationship that residential facilities have with broader aged care services and whether these facilities cater for specific ethnic or cultural groups are then discussed. The next sections of the chapter provide evidence regarding skills shortages and staff vacancies within the sector, as these are reported by the employers. The industrial methods used by facilities to set employment conditions and the use of non-PAYG staff are then explored. The chapter finishes with a focus on quality monitoring in residential aged care.

4.2 A Profile of Facilities

Table 4.1 shows the distribution of the residential aged care workforce across States/Territories in 2003, 2007, 2012 and 2016. Direct comparison of the distribution of the workforce by geographical location between 2007 and 2012 is not possible because of a change in the measure used to collect this data.[5]

Although South Australia and Western Australia increased their share and Queensland and Tasmania decreased theirs, the changes are relatively small. The picture is similar whether viewing all PAYG employees or only direct care employees. In 2016, almost two-thirds (65 per

[5] In 2007, the Rural, Remote, Metropolitan Area (RRMA) classification was used, whereas in 2012 the information was categorised according to the ABS 2006 Remoteness Areas based on the 2006 Population Census. In 2016, the ABS 2011 Remoteness Areas are used, based on the more recent and updated 2011 Population Census definitions. There was no substantial change in the methodology used to define the ABS Remoteness Areas for 2012 and 2016 and in most cases comparison of the Remoteness Area is valid - ABS Statistical Geography factsheet.

cent) of direct care workers were located in major cities, one-quarter (23 per cent) in inner regional areas, 10 per cent in outer regional, with just over 1 per cent of workers located in both remote and very remote areas. There is no evidence of a significant change in the distribution of the workforce by geographical location between 2012 and 2016.

Examining the distribution of ownership type in the bottom panel of Table 4.1 shows some change. Between 2003 and 2012 there was a decline in the importance of the not-for-profit sector as an employer. This trend seems to level off as we observe a modest rise in the direct care employment proportion from 56 per cent in 2012 to 58 per cent in 2016. There was a corresponding modest decline in employment in for-profit and government facilities between 2012 and 2016.

Table 4.1: Distribution of residential direct care workforce (per cent) by State/Territory, location, ownership type and facility type: 2003, 2007, 2012 and 2016

	All PAYG employees				Direct care employees			
	2003	2007	2012	2016	2003	2007	2012	2016
State/Territory								
NSW	31.2	31.6	30.6	30.2	32.1	31.8	31.0	30.1
Victoria	30.4	27.9	27.6	27.2	29.4	28.6	27.8	27.5
Queensland	16.1	18.0	18.5	17.1	15.8	17.4	17.7	16.7
WA	7.6	7.9	8.2	8.9	7.8	8.0	8.6	8.9
SA	9.3	9.9	10.4	12.1	9.7	9.9	10.4	12.3
Tasmania	3.6	3.4	3.5	2.9	3.1	3.0	3.2	2.9
ACT	1.5	0.9	1.0	1.2	1.5	0.9	1.0	1.2
NT	0.3	0.4	0.3	0.5	0.4	0.4	0.3	0.4
Location*								
Major cities of Australia			64.0	63.4			65.6	64.6
Inner Regional Australia			24.9	23.7			23.9	23.4
Outer Regional Australia			9.9	11.0			9.3	10.3
Remote Australia			0.8	1.3			0.8	1.2
Very Remote Australia			0.4	0.6			0.4	0.5
Ownership Type								
Not-for-profit	64.5	60.0	56.8	57.8	61.6	58.4	55.7	58.3
For-profit	26.1	31.4	34.1	34.0	28.9	33.0	35.3	34.3
Government	9.4	8.6	9.0	8.2	9.5	8.6	8.9	7.4

Source: Census of residential aged care facilities.
**Direct comparison of location with previous years is not possible due to change in categories.*

When looking at the size of residential facilities (according to their total number of places), Table 4.2 shows that in 2016 over half of facilities (52 per cent) are large (61+ places). The expansion in the proportion of facilities that are large, as evident between 2007 and 2012, appears to have stopped, with the proportion in 2016 the same as that in 2012 (approximately 52 per cent). This supports the suggestion from the 2012 report (King et al. 2012) that the observed expansion between 2007 and 2012 might be explained by both changes in how the data was collected and changes in government policy. There has been a small increase in the proportion of small facilities (with 1-20 places) between 2012 and 2016 (from 6 per cent to 8 per cent), and a corresponding decline in the proportion of facilities with 41-60 places (from 25 per cent to 23 per cent).

The average size of employment in facilities with more than 60 operational places in 2016 is 113 PAYG employees, and on average 75 of these employees are direct care workers (Table A4.2, Appendix 3). These figures are fairly comparable with those obtained from the 2012 census where the largest facilities employed an average of 107 PAYG employees, with 78 of

these on average being direct care workers. Since 2012, however, the ratio of the average number of direct care to PAYG workers has decreased across residential facilities of all size indicating a decreased usage of direct care staff. This indicates a shift in workforce composition with a lower ration of direct care staff.

Table 4.2: Number of places* (per cent): 2007, 2012 and 2016

Number of places*	2007	2012	2016
1–20	7.4	5.7	7.7
21–40	26.7	17.2	17.5
41–60	30.9	24.9	23.0
61+	35.0	52.3	51.8

Source: Census of residential aged care facilities.
**Operational residential places at 3 November 2015 for in-scope aged care facilities.*

We now look at the distribution of residential aged care operational places across Australia. Table 4.3 shows that the distribution of residential care operational places across State/Territories, location and ownership type, closely mirrors the distribution of the residential care workforce in Table 4.1.

Facilities in NSW and Victoria have the largest share of total residential places, followed by Queensland, SA and WA. Two thirds of places are in facilities in major cities. Remote and very remote facilities make up only a very small share of places. Approximately 57 per cent of residential places are in not-for-profit facilities.

Table 4.3: Distribution of residential aged care operational places* (per cent): 2016

		Total
All facilities	Number of places*	197,046
State/Territory	NSW	33.2
	Victoria	26.5
	Queensland	17.0
	WA	8.5
	SA	10.6
	Tasmania	2.5
	ACT	1.4
	NT	0.4
Location	Major cities of Australia	67.2
	Inner Regional Australia	22.3
	Outer Regional Australia	8.9
	Remote Australia	1.1
	Very Remote Australia	0.5
Ownership Type	Not-for-profit	57.3
	For-profit	35.9
	Government	6.8

Source: Census of residential aged care facilities.
**Operational residential places at 3 November 2015 for in-scope aged care facilities.*

Estimated staffing ratios (obtained by dividing the total number of direct care workers by the total number of operational places) are presented in Table 4.4. In 2016 the average number of residential direct care workers to places across all facilities is 0.78; mostly unchanged from 2012 when it was 0.77.

There is minimal variation in average staffing ratios between States and Territories. There is also minimal variation in staffing ratios by location. Staffing ratios in for-profit facilities are lower than in not-for-profit facilities. Government facilities have the highest ratio, 0.85 direct care workers per residential place in 2016.

Table 4.4: Average ratio of residential direct care workers to operational places: 2012 and 2016

		2012	2016
All facilities		0.77	0.78
State/Territory	NSW	0.70	0.69
	Victoria	0.82	0.70
	Queensland	0.76	0.81
	WA	0.79	0.76
	SA	0.84	0.91
	Tasmania	0.96	0.82
	ACT	0.74	0.91
	NT	0.79	0.66
Location	Major cities of Australia	0.74	0.75
	Inner Regional Australia	0.81	0.82
	Outer Regional Australia	0.88	0.90
	Remote Australia	0.88	0.88
	Very Remote Australia	1.11	0.85
Ownership Type	Not-for-profit	0.74	0.79
	For-profit	0.77	0.74
	Government	1.03	0.85

Source: Census of residential aged care facilities.

4.3 Facilities' Relationships with Broader Aged Care Services

Many residential facilities have connections to the broader aged care sector. This is strongly highlighted in Table 4.5 which reports that approximately 80 per cent of facilities belong to a larger provider group, with the proportion highest in for-profit facilities (86 per cent). Overall, the proportion of facilities belonging to a larger group has increased with time, from 73 per cent in 2007 and 76 per cent in 2012.

In addition approximately 10 per cent of all residential facilities offer community care from the same location in 2016. The proportion also offering community care has slowly declined over time, from 13 per cent in 2007 and 12 per cent in 2012.

The proportion of residential facilities offering community care differs widely by ownership type, with approximately 21 per cent of government facilities offering community care but only 3 per cent of for-profit facilities offering these services.

Table 4.5: Proportion of residential facilities that are part of larger provider group* or provide community aged care (per cent), by ownership type: 2016

	Not-for-profit	For-profit	Government	All facilities
Part of larger provider group*	78.6	85.6	76.9	80.4
Providing community aged care	10.6	2.7	20.8	9.7

Source: Census of residential aged care facilities.
**A facility is classed as being part of a larger group if the facility is part of a larger organisation e.g. owned by a company or not-for-profit agency that owns other aged care facilities or services.*

As may be anticipated given that some residential facilities also provide community aged care services, Table 4.6 indicates that just under 17 per cent (all facilities all occupations) of all direct care workers in residential facilities also worked in community care. Allied health workers were more likely to be providing community care (21 per cent), compared to nurses (15 per cent) or PCAs (17 per cent).

Government facilities had a much higher proportion of their workforce working in both residential and community care (39 per cent). Not-for-profit facilities had the lowest proportion providing these services (11 per cent).

Table 4.6: Proportion of residential aged care employees that work in both residential and community aged care (per cent), in facilities that provide some community aged care, by ownership type: 2016

Occupation	Not-for-profit	For-profit	Government	All facilities
Nurse	7.2	25.0	31.5	15.3
Personal Care Attendant	12.8	30.4	44.1	16.8
Allied Health	7.6	26.2	64.9	21.0
All occupations	11.2	28.9	39.0	16.6

Source: Census of residential aged care facilities N=272 facilities [N=305 in 2012] providing community aged care (2016 weighted).

4.4 Ethnic Specialisation

The number of older people in Australia from CALD backgrounds is increasing. It is expected that by 2021, almost a third of those aged 65 years and older will have been born overseas (Department of Social Services, 2015). Older Australians from CALD background are not a homogenous group and this diversity needs to be acknowledged and addressed in the aged care sector. The 2016 census of residential facilities collected information regarding ethnic specialisation within aged care. Table 4.7 shows that 25 per cent of residential facilities catered for a specific ethnic or cultural group in 2016. This figure is comparable to that in 2012 (26 per cent).

Looking at facilities that did cater for a specific ethnic or cultural group, residents from an Italian background were most frequently catered for (54 per cent of these facilities), followed by Aboriginal Australians (52 per cent) and Greeks (44 per cent). Almost 44 per cent of facilities who specialise catered for gay, lesbian, bisexual, transgender and intersex residents, illustrating the increasing demand for aged care services to be inclusive of all backgrounds.

Table 4.7: Residential facilities that cater for specific ethnic or cultural groups (per cent): 2016

Ethnic group	% All facilities	% Among facilities that specialise
Catering for specific ethnic or cultural group	25.1	n/a
No catering for specific ethnic or cultural group	74.9	n/a
Polish	9.4	38.1
Italian	13.4	53.9
Aboriginal	13.0	52.4
Chinese	10.0	40.2
Greek	10.9	43.8
Dutch	9.3	37.4
German	10.1	40.7
Indian	9.0	36.2
Gay, lesbian, bisexual, transgender, intersex	10.8	43.5
Other	3.6	14.7

Source: Census of residential aged care facilities. Multiple responses allowed in 2016, percentages do not sum to 100. N=696 facilities providing specific ethnic or cultural aged care (2016, weighted).

4.5 Skill Shortages

Within the aged care system in Australia, demand for services has reached unprecedented levels and, with a rapidly ageing population, demand is expected to continue rising in the future. In such a case the sector will need to respond, either by expanding its workforce or by increasing its productivity, or, as is usually the case by a mix of the two. As demand increases, and depending on the timeliness and the type of reaction by the sector, the possibility exists that skill shortages for direct care workers may arise. It is important, for effective workforce planning and policy development, that current information is available regarding the presence of skills shortages in the aged care sector, their perceived reasons and consequences, and, finally, how they are being responded to by provider organisations and their workforces. To this purpose, the 2016 census collected information on the incidence and composition of skill shortages, the factors that caused these shortages, the consequences of these skill shortages, and how facilities are actually responding to them. This is valuable information at the individual employer level, for example, for benchmarking and similar purposes, at the level of geographical location, and at the overall national level, for example for training and related policy. Moderate and temporary skill shortages have been considered in the literature to be markers of a successfully growing and developing sector. In contrast, deep and persistent skill shortages have been associated with less well performing firms and with sectors with lower productivity, growth, profitability, and competitiveness (Healy, Mavromaras & Sloane 2015).

Table 4.8 (final column) shows that 47 per cent of residential facilities did not report having any skill shortages in 2016. Almost two-thirds of residential facilities (63 per cent) reported a shortage of workers in at least one direct care occupation. When examining skill shortages for participant occupations, a shortage of RNs was most common (reported by 41 per cent of facilities), followed by PCAs (25 per cent). Only a small proportion of facilities reported a shortage of AH workers (6 per cent). Skill shortages are more prevalent in remote and very remote areas, but we note again that the small number of respondents from remote and very remote locations may have skewed related findings.

Table: 4.8: Proportion of residential facilities reporting skill shortages in 2016 (per cent), by location and occupation affected

Whether had skill shortage	Major cities of Australia	Inner regional Australia	Outer regional Australia	Remote Australia	Very remote Australia	All facilities
Yes (of all facilities)	46.5	61.9	62.8	59.7	81.1	53.4
Yes (of all facilities with direct care staff)*	55.9	72.8	70.8	72.7	87.8	63.2
Skill shortage for occupation:						
Registered Nurse	33.9	50.3	51.5	55.2	58.5	41.2
Enrolled Nurse	15.8	27.4	31.1	29.9	22.6	21.2
Personal Care Attendant	23.6	24.6	30.6	37.3	37.7	25.4
Allied Health	6.1	6.3	4.7	11.9	3.8	6.1

*Source: Census of residential aged care facilities *This not available prior to 2016.*
Note: Multiple responses allowed for skill shortage by occupation, columns do not sum to 100.

Facilities that reported having skill shortages were asked to identify the causes of the shortages. Facilities could select more than one of the response options on the questionnaire and could also nominate other factors which were not listed. Table 4.9 (column 1) indicates that amongst facilities with skill shortages for any occupation, the highest proportion reported no suitable applicants as the cause of skill shortages in their facility (80 per cent), followed by geographical location (38 per cent), slow recruitment processes (21 per cent) and specialist knowledge required (19 per cent).

RN and PCA shortages were similar to the reasons given across all occupations. Facilities with a PCA shortage were more likely to identify 'lack of availability of adequate training' as a reason (16 per cent) than facilities with an RN shortage (12 per cent). Facilities with a PCA shortage were also more likely to report that recruitment was too slow (28 per cent) compared with facilities with an RN shortage (21 per cent).

Table 4.9: Proportion of residential facilities with skill shortages in 2016 that nominated each cause of that shortage (per cent), by occupation affected

Cause of skill shortage	Facilities that reported skill shortages		
	For any occupation	For RNs	For PCAs
Specialist knowledge required	18.9	20.8	21.3
Geographical location of facility	37.9	40.3	37.9
Wages or salary costs too high	9.9	11.2	9.3
Lack of availability of adequate training	12.0	12.3	16.2
Unsure of long term demands for service	4.6	4.8	4.9
Recruitment too slow	20.6	21.2	27.5
No suitable applicants (skills/qualifications/experience/values)	79.6	79.9	83.6
Other	6.2	6.1	6.0
Facilities (weighted)	1498	1156	712

Source: Census of residential aged care facilities.
Note: Multiple responses allowed, columns do not sum to 100.

The census also asked residential facilities to nominate the responses taken to address their skill shortages. Table 4.10 shows that the most common response to a skill shortage for any occupation is to have the existing workforce work longer hours, with 62 per cent of facilities that reported skill shortages saying they undertook this action. The next most common response was 'greater use of agency staff' (48 per cent of facilities that reported a skill shortage) followed by 'on-the-job training of staff' (36 per cent).

There are few differences when analysing responses taken by facilities with RN and PCA skill shortages compared with the overall picture. Facilities with PCA skill shortages are more likely to use student placements (19 per cent) compared with facilities with RN shortages (13 per cent). Residential facilities with PCA shortages are also a little more likely to react with on-the-job training of staff (42 per cent versus 36 per cent for RN shortages). The use of student placements and volunteers as a response to skill shortages were new categories added in 2016.

Table 4.10: Proportion of residential facilities with skill shortages in 2016 that nominated each response to that shortage (per cent), by occupation affected

Response to skill shortage	Facilities that reported skill shortages		
	For any occupation	For RNs	For PCAs
External training of staff	17.8	18.3	21.8
On-the-job training of staff	35.8	36.4	41.6
Existing workforce worked longer hours	61.9	64.2	68.4
Greater use of agency staff	48.1	49.2	51.0
Sub-contracted or outsourced services	5.7	5.4	4.9
Employed staff on short term contracts	16.8	18.1	14.5
Wages, salaries and/or conditions increased	7.3	8.7	8.6
Reduced outputs or production	2.1	1.9	2.2
Used student placements	13.2	13.0	18.8
Used volunteers	5.9	6.0	8.3
Other	9.8	9.6	8.7
Facilities (weighted)	1,498	1,156	712

Source: Census of residential aged care facilities.
Note: Multiple responses allowed, columns do not sum to 100.

4.6 Vacancies

Given the anticipated future increased demand for aged care services in Australia, the aged care workforce will need to grow considerably creating challenges for the sector and policy makers alike (CEPAR 2014). The number and types of staff vacancies are important indicators of the adequacy of the labour supply to aged care residential facilities. In the 2016 census, facilities were asked to provide information on the vacancies they had for employees across different occupational classifications. As shown in Table 4.11, the highest number of vacancies in 2016 are reported for RNs and PCAs (both 24 per cent). Vacancies are much lower for AH workers, being reported for only 4 per cent of facilities.

The proportion of residential facilities with vacancies appears lower in 2016 for all direct care occupations compared with the earlier years of 2007 and 2012, particularly for RNs and PCAs. Where facilities do have vacancies, they report a higher number of vacancies for PCAs (3.3) than for other direct care occupations. The mean number of vacancies for each occupation in 2016 was similar to that in 2012.

Table 4.11: Vacancy rate (per cent of all residential facilities) and mean number of vacancies (in facilities with vacancies), by occupation: 2003, 2007, 2012 and 2016

	Full-Time Equivalent			
	2003	2007	2012	2016
Panel 1: % of facilities with any vacancies				
Registered Nurse	25.7	31.3	32.7	23.9
Enrolled Nurse	10.8	17.7	18.7	14.9
Personal Care Attendant	23.3	31.4	36.4	23.6
Allied Health	6.3	6.7	8.8	3.6
Panel 2: Mean number of vacancies in facilities with any vacancies				
Registered Nurse	n/a	n/a	1.7	1.8
Enrolled Nurse	n/a	n/a	2.2	1.9
Personal Care Attendant	n/a	n/a	3.6	3.3
Allied Health	n/a	n/a	1.0	1.4

Source: Census of residential aged care facilities.

In order to further assess shortages for residential aged care workers, the time that facilities took to fill these vacancies is shown in Tables 4.12 and 4.13. The last column of Table 4.12 shows that across all occupations just over a quarter (26 per cent) of the most recent vacancies took less than a week to fill. The first four columns show that there is considerable variation by occupation in how quickly vacancies are filled. The first row shows that 63 per cent of facilities were able to fill their most recent AH vacancy in less than a week. The corresponding proportion was 22 per cent for RN vacancies, and 21 per cent for PCA vacancies. On the whole AH and EN vacancies appear quicker to fill than vacancies for RNs and PCAs.

The proportions of vacancies that were either very quick to fill (less than 1 week) or very hard to fill (more than 26 weeks) was reduced in 2016 when compared with 2012. Compared with 2012, RN vacancies are still sometimes more difficult for facilities to fill than PCA vacancies (for RNs, 28 per cent of vacancies take more than for 4 weeks to fill, while for PCAs this share is only 12 per cent, against 30 per cent and 14 per cent respectively in 2012). Fewer vacancies are taking longer than 8 weeks to fill in 2016 (6 per cent across all occupations in 2016, but 14 per cent in 2012).

Table 4.12: Weeks required for residential facilities to fill most recent vacancy, by occupation: 2016 (per cent)

% of facilities that took	RN	EN	PCA	AH	All occupations
Less than 1 week	22.0	39.1	20.9	62.9	26.2
1 week	7.5	6.8	17.5	4.9	10.5
2 weeks	13.9	10.3	21.4	6.9	11.3
3 to 4 weeks	28.9	24.3	28.1	15.4	30.8
5 to 8 weeks	16.9	13.1	10.0	7.9	15.1
9 to 12 weeks	5.9	3.1	1.7	0.7	3.2
13 to 26 weeks	4.0	2.3	0.3	0.7	2.7
More than 26 weeks	0.9	0.8	0.0	0.6	0.2
Facilities (weighted)	2,149	1,666	2,244	1,340	-

Source: Census of residential aged care facilities.
Facilities reporting weeks for the most recent vacancy, for that occupation.

The time taken to fill staff positions is further examined in Table 4.13 which looks at the average and the median speed at which vacancies are filled. Although there is less information in these two measures, it allows us to look at differences between State/Territories and also across location. The overall figures show that vacancies for PCAs took on average less time to fill (2.5 weeks) compared with vacancies for RNs (4.3 weeks).

There is some variation across States and Territories, with Queensland and NSW taking longer than the average (5.4 weeks and 4.9 weeks respectively) to recruit RNs, and SA and the ACT taking longer than the average to recruit PCAs (in each case 2.9 weeks).

The most pronounced observation emerging from Table 4.13 is that facilities in remote and very remote areas take considerably longer on average to fill vacancies than facilities in major cities. Vacancies for RNs in remote and very remote facilities face an even longer delay before being filled compared with vacancies for PCAs.

Table 4.13 also shows the median duration[6]. This can help give more information about the shape of the distribution of the durations. The median vacancy duration is lower than the average, particularly in cases where the average vacancy duration was high. For example, the average vacancy rates in remote areas were 7 weeks for RNs, and 11.3 weeks in very remote areas and in contrast the median is lower with the median duration for RN vacancies of 5.5 weeks in remote areas, and a median of 8 weeks in very remote areas. The median vacancy duration for all facilities is also lower than the average, at 3 weeks for RNs (the average was 4.3 weeks) and 2 weeks for PCAs (the average was 2.5 weeks). For PCAs the median and average are quite close (2 and 2.5 weeks).

[6] The median is the "middle" of a sorted list of numbers, in this case half of vacancies take longer than the median to fill and half take shorter. Hence, the median can reveal the centre of the durations the outlets reported without distortion. When the median is contrasted with the average, if the median is much lower than the average it shows that the average has been affected by cases with longer durations (and also the other way round if the median is much higher than the average then the average has been influenced by the share with shorter durations).

Link to the ABS website for further information about measures of central tendency.

Table 4.13: Average and median vacancy duration (weeks) for residential RNs and PCAs, by State/Territory and location: 2016

		RN	PCA
All Facilities	Average	4.3	2.5
State/Territory	NSW	4.9	2.6
	Victoria	3.7	2.2
	Queensland	5.4	2.5
	WA	3.3	2.4
	SA	3.8	2.9
	Tasmania	3.8	2.0
	ACT	2.5	2.9
	NT	3.9	2.0
Location	Major cities of Australia	3.2	2.2
	Inner Regional Australia	5.4	2.6
	Outer Regional Australia	5.8	2.8
	Remote Australia	7.0	3.7
	Very Remote Australia	11.3	4.8
All Facilities	Median	3.0	2.0
State/Territory	NSW	3.0	2.0
	Victoria	3.0	2.0
	Queensland	4.0	2.0
	WA	2.0	2.0
	SA	2.5	2.0
	Tasmania	4.0	2.0
	ACT	2.0	3.0
	NT	2.0	2.0
Location	Major cities of Australia	2.5	2.0
	Inner Regional Australia	4.0	2.0
	Outer Regional Australia	4.0	2.0
	Remote Australia	5.5	2.5
	Very Remote Australia	8.0	3.0

Source: Census of residential aged care facilities.

The census asked facilities about the causes of staff vacancies, with multiple responses permitted. The most common reason facilities gave for their most recent vacancy for all occupations was resignation (Table 4.14). Around 84 per cent of facilities gave this reason, and it was the most common reason when asked about RNs (52 per cent) and PCAs (73 per cent).

Other important reasons that facilities gave were the creation of a new position (31 per cent) and the retirement of staff (27 per cent). Almost 8 per cent gave injuries/illness as a reason for a vacancy arising, possibly indicating some of the physical risks and demands of residential aged care.

Table 4.14: Proportion of residential facilities giving each reason for their most recent vacancy (per cent), by occupation: 2016

% of facilities stating	RN	PCA	All occupations
New position	20.0	17.1	30.8
Retirement	20.0	20.3	26.9
Injury/illness	0.0	3.8	7.9
Resignation	52.0	72.8	84.2
End of contract	8.0	2.5	7.3
Involuntary separation	0.0	7.0	11.8
Other	14.7	13.3	33.3
Facilities (weighted)	75	158	2,439

Source: Census of residential aged care facilities.
Note: Multiple response allowed, columns will not sum to 100.

As shown in Table 4.15, the most common recruitment strategy used to hire new PCAs in 2016 was internet job advertisement (34 per cent of facilities) followed by a combination of internet and newspaper advertisements (23 per cent of facilities). These were also the predominant choices in 2012. This finding supports the view that agency services are very rarely the first option for facilities looking to hire additional PCAs (1 per cent); this was also the case in 2012.

For workers, the most common source of information for all direct care occupations was internet job advertisements followed by word of mouth. Word of mouth is particularly important for PCAs in 2016 (36 per cent), as was the case in 2012. The use of Internet job advertisements has risen for workers since 2012, becoming the most common source of information in job searching for all direct care occupations. The use of agencies is a far more common method amongst nurses and AH workers (16 per cent) compared with PCAs (7 per cent).

Table 4.15: Sources of information about recruitment opportunities used by recently hired* residential direct care workers and facilities: 2016 (per cent)

Source of job information	Nurse Worker	PCA		AH Worker
		Worker	Facility	
Walk-in	n/a	n/a	9.0	n/a
Word of mouth	28.6	35.8	7.2	21.7
Newspaper job advertisement	4.7	5.7	7.1	4.6
Internet job advertisement	40.9	37.5	33.8	51.9
Both internet and newspaper advert	n/a	n/a	23.3	n/a
Job placement program/career service	0.1	8.3	11.1	0.0
Agency	15.8	7.2	0.9	15.6
Other	9.1	5.5	7.2	5.8
Don't know	n/a	n/a	0.6	n/a
Total (weighted)	3,512	5,939	2,038	720

Source: Census of residential aged care facilities and Survey of residential aged care workers.
Note: Multiple response allowed, columns will not sum to 100.
**Recently hired workers have been employed for 12 months or less.*

4.7 Setting of Employment Conditions

The 2016 census collected information regarding the industrial methods used by residential facilities to set employment conditions for their staff. Table 4.16 reports the proportions of employees, across all residential facilities, whose employment terms and conditions are prescribed by each of several main methods. We suggest that these figures be treated with some caution, because some of the methods can operate in tandem (for example awards and agreements) and in some instances employers may not recognise clearly the distinctions between them.

Enterprise Agreements are by far the most common method of setting employment conditions. The census form defined these to include union and non-union agreements, whether certified with an industrial authority or not. Facilities reported that 79 per cent of all their employees had their employment conditions determined by Enterprise Agreements in 2016. This is higher than in 2012 when facilities reported 74 per cent of all employee conditions were set in this way. The proportion within each occupation was similar for nurses and PCAs (each 79 per cent), but lower for AH workers (72 per cent). These proportions within occupation are all higher than in 2012, but in particular facilities have reported that AH workers have raised coverage by Enterprise Agreements, rising from 66 per cent in 2012 to 72 per cent in 2016.

Award-based arrangements were the other main method of setting employee conditions in the residential aged care sector with 19 per cent of all facilities reporting this method.

Beyond Enterprise Agreements and Awards, other methods for setting employee conditions were rarely used.

Table 4.16: Industrial methods used by residential facilities to set employment conditions (per cent), by employee occupation: 2016

% of employees with conditions set by method	Nurses	PCA	AH	All occupations
Award	19.3	19.2	21.0	19.3
Enterprise Agreement	78.9	79.1	72.3	78.8
Common Law Contract	0.7	0.4	3.3	0.6
Individual Flexibility Agreement	0.7	0.7	1.9	0.8
Don't Know	0.3	0.5	1.5	0.5
Total	**100**	**100**	**100**	**100**

Source: Census of residential aged care facilities.

4.8 Agency, Brokered and Self-employed Staff

Although the 2016 census of aged care facilities predominantly collected information regarding the employment of PAYG direct care workers, providers may also hire non-PAYG staff in order to meet their employment needs. For example, non-PAYG workers may be required to allow service flexibility, cover staff absences or vacancies, or to meet the needs of specific clients on a short-term basis. Facilities were therefore asked about their use of three different types of non-PAYG workers – agency, brokered and self-employed staff. Table 4.17 presents the proportion of facilities that employed at least one non-PAYG worker (in any occupation) in the designated fortnight (last pay period in November 2015). It shows quite widespread use of non-PAYG workers by residential facilities in 2016, with half of all facilities (50 per cent) reporting some use.

Of the three types of non-PAYG workers, agency workers are the most widely used, with 41 per cent of residential facilities reporting using agency workers in 2016. The use of agency workers by facilities is lower in 2016 than that reported in 2012 (46 per cent).

Facilities most often used agency workers for RN or PCA positions. About 28 per cent reported using agency PCAs, 27 per cent agency RNs, 13 per cent agency ENs and 5 per cent agency AHs.

Table 4.17 shows that many facilities engage several agency workers in different occupations at the same time. The fact that 41 per cent of facilities in total use agency workers implies that the 27 per cent of facilities using agency RNs cannot be entirely separate from the 28 per cent using agency PCAs. Rather, these figures tell us that there is overlapping use of agency workers across different occupations within individual facilities.

Table 4.17 suggests that residential facilities use the other two types of non-PAYG workers (brokered and self-employed) mostly in order to acquire AH worker services. We note that the proportion of facilities reporting AH workers in brokered positions increased from 5 per cent in 2012 to 7 per cent in 2016, while reporting AH workers in self-employed positions decreased from 12 per cent in 2012 to 6 per cent in 2016.

Table 4.17: Proportion of residential facilities (per cent) using non-PAYG workers in the designated fortnight, by occupation and type of worker: 2016

Occupation	Agency	Brokered	Self-employed	All non-PAYG
Registered Nurse	27.0	0.9	0.7	28.3
Enrolled Nurse	13.0	0.3	0.3	13.4
Personal Care Attendant	28.0	0.9	0.2	29.1
Allied Health	5.4	7.3	6.2	17.6
All occupations	40.6	8.3	6.5	49.8

Source: Census of residential aged care facilities.

Estimates for each State/Territory of the proportions of residential facilities using non-PAYG RNs and/or PCAs across 2003 to 2016 are shown in Table 4.18.

There are quite noticeable differences in these proportions by State/Territory in 2016. Facilities located in the ACT, SA, Tasmania and the NT had much higher than the average use of non-PAYG RNs in 2016 (28 per cent).

There is evidence of change since 2012, with a strong increase in the use of non-PAYG RNs by ACT facilities (rising from 29 per cent to 38 per cent), and a small increase by NT facilities (up from 40 to 42 per cent). In contrast, with the exception of WA which remained fairly steady in their reported use of agency RNs (28 per cent), the other states recorded declines in the use of non-PAYG RNs (large declines for Queensland, SA, Tasmania).

The pattern of agency worker use to obtain PCA services was different to that of agency worker use to obtain RN services, also with noticeable differences between State/Territory in 2016. Facilities located in the ACT, SA and WA had much higher than average use of non-PAYG PCAs in 2016. Only 6 per cent of Tasmanian facilities reported using agency PCAs, which is much lower than the 29 per cent national average use.

Finally, Table 4.18 presents evidence of a strong increase in the use of non-PAYG PCAs by ACT and WA facilities since 2012. In contrast, the other states recorded reductions in the use of non-PAYG PCAs, since 2012 (with a large reduction in Victoria and a very large reduction in Queensland, SA and NT).

Table 4.18: Proportion of residential facilities (per cent) using any non-PAYG RNs or PCAs in the designated fortnight, by State/Territory: 2003, 2007, 2012 and 2016

State/Territory	RN				PCA			
	2003	2007	2012	2016	2003	2007	2012	2016
NSW	19.1	23.6	26.7	24.1	21.7	25.4	22.2	20.7
Victoria	25.9	31.9	31.2	25.3	31.6	45.7	35.9	29.9
Queensland	27.3	44.1	37.6	29.4	24.1	42.2	35.2	23.4
SA	44.6	44.8	47.3	41.0	51.2	64.1	60.8	46.6
WA	30.3	38.9	28.4	28.3	48.3	62.3	28.4	48.1
Tasmania	15.6	21.4	47.1	40.0	2.2	5.7	10.0	6.2
ACT	44.4	23.5	29.2	37.9	50.0	35.3	29.2	51.7
NT	40.0	81.8	40.0	42.1	50.0	63.6	40.0	26.3
All facilities	26.1	33.3	32.6	28.3	30.1	41.1	34.3	29.1

Source: Census of residential aged care facilities.

Table 4.19 provides a different picture of the extent to which non-PAYG workers contribute to the residential direct care workforce, indicating how many non-PAYG workers had been engaged in the designated fortnight across all residential facilities. Amongst the total number of direct care workers, the most widely used by facilities were non-PAYG PCAs, with 9,085 in residential facilities in the designated fortnight and of these, they were mainly agency PCAs (8,588). The next most widely used were non-PAYG RNs of which there were 3,323 and again the bulk of these were agency RNs (3,185). Reinforcing the findings from previous tables, almost all non-PAYG workers contributing to the residential aged care workforce are RN and PCA agency workers, but also including a sizeable number of ENs (1,708).

Table 4.19: Number of non-PAYG workers in residential facilities in the designated fortnight, by occupation: 2016

Occupation	Number of workers			
	Agency	Brokered	Self-employed	Total
Registered Nurse	3,185	69	69	**3,323**
Enrolled Nurse	1,708	62	51	**1,821**
Personal Care Attendant	8,588	176	321	**9,085**
Allied Health	890	487	369	**1,747**
All occupations	14,371	794	810	**15,976**

Source: Census of residential aged care facilities.
N=2,795 facilities (weighted).

Further questions on the reasons for non-PAYG worker use were added in the 2016 census and are shown in Table 4.20. The two most frequently cited reasons for agency workers were ‘short-term cover for staff absences’ (87 per cent), followed by being ‘unable to fill vacancies’ (51 per cent). These were followed by ‘matching staff to peaks in service user demand’ (14 per cent), ‘covering for maternity leave or annual leave’ (19 per cent) and ‘obtain specialist skills’ (4 per cent). The reasons ‘freeze on permanent staff numbers’ or ‘other reasons’ were rarely cited.

In contrast, the main reason for the much less frequent use of brokered positions and self-employed workers was to 'obtain specialist skills' (65 and 75 per cent respectively).

Table 4.20: Reasons for using non-PAYG workers in residential facilities in the designated fortnight, by type: 2016

Reason	Agency	Brokered	Self-employed
Matching staff to peaks in service user demand	14.2	9.2	6.2
Short-term cover for staff absences	87.2	10.5	9.6
Covering for maternity leave or annual leave	18.6	3.1	5.6
Unable to fill vacancies	51.1	9.2	5.6
Obtain specialist skills	4.3	64.9	75.3
Freeze on permanent staff numbers	1.9	0.9	1.7
Other reason	1.3	8.3	6.2
Facilities (weighted)	1,129	228	178

Source: Census of residential aged care facilities.
Note: Multiple response allowed, columns will not sum to 100.

4.9 Volunteers in Residential Aged Care

As in 2012, the census collected information about the extent of volunteering in residential aged care. In addition, the 2016 census also asked about the roles undertaken by volunteer staff. A high number of volunteers (23,537) provided 114,897 hours of service to residential facilities as a whole in 2016 (Table 4.21). Both the overall number of volunteers and the total hours offered by them are higher than in 2012. Responses from facilities using volunteers indicate they have an average of 10 volunteers per facility (the same as in 2012), with each volunteer contributing an average of 4.9 hours per fortnight (roughly the same as in 2012).

Table 4.21: Total number of volunteers and volunteer hours worked in residential facilities in the designated fortnight: 2012 and 2016

Year	Volunteer numbers, per fortnight	Volunteer hours, per fortnight	Average number of volunteers per facility, per fortnight	Average hours per volunteer, per fortnight
2016	23,537	114,897	10	4.9
2012	22,261	101,555	10	4.8

Source: Census of residential aged care facilities.

As shown in Table 4.22, 83 per cent of facilities have one or more volunteers. Residential facilities in inner regional locations are most likely to have volunteers, while those in remote and very remote areas have fewer volunteers than the average. The use of volunteers by residential facilities also differs by ownership type, with not-for-profit facilities more likely to use volunteers (91 per cent), than for-profit (72 per cent) or government facilities (69 per cent). Residential facility volunteering patterns in 2016 are very similar to those in 2012.

Table 4.22: Proportion of residential facilities employing volunteer workers (per cent) in the designated fortnight, by location and ownership type: 2016

		% of all facilities
All facilities		82.6
Location	Major cities of Australia	81.6
	Inner Regional Australia	88.9
	Outer Regional Australia	85.2
	Remote Australia	71.6
	Very Remote Australia	30.2
Ownership type	Not-for-profit	91.3
	For-profit	72.1
	Government	68.9

Source: Census of residential aged care facilities.

Table 4.23 presents the answers to a new question which was added in 2016 about what roles were undertaken by volunteers in aged care. Residential facilities very often used volunteers for 'social activity support assistance' (82 per cent). A high proportion of facilities also had volunteers undertaking roles such as assisting in the 'planning of group activities' (68 per cent) and to support 'companionship/befriending' (64 per cent). A smaller share of facilities had volunteers undertaking roles of 'transport assistants' (23 per cent), 'shopping/appointment assistants' (16 per cent), and 'gardening assistants' (15 per cent). Proportions of less than 10 per cent of facilities had volunteers undertake 'domestic activity assistance' (9 per cent), 'meal/preparation assistance' (6 per cent) and 'other activities' than those listed (8 per cent) with 'respite care assistance' (2 per cent) and 'home maintenance assistance' (2 per cent) rarely undertaken by volunteers.

Table 4.23: Roles undertaken by residential facility volunteer workers (per cent): 2016

	% of facilities (weighted)
Domestic activity assistance	8.9
Respite care assistance	1.8
Social activity support assistance	81.7
Planned group activity assistance	67.7
Home maintenance assistance	2.3
Gardening assistance	14.6
Transport assistance	22.9
Shopping/appointment assistance	15.7
Meal/preparation assistance	6.4
Companionship/befriending	63.8
Other	7.6
Total (facilities with volunteers, weighted)	2,319

Source: Census of residential aged care facilities.
Note: Multiple response allowed, columns will not sum to 100.

4.10 Quality Measures in Residential Aged Care

For the first time, the 2016 residential facilities census contained questions regarding the monitoring of quality in aged care. Information regarding quality in residential aged care is particularly pertinent given the establishment of the Australian Aged Care Quality Agency in 2014.

The most common form of quality monitoring undertaken by facilities/outlets was that 'managers or supervisors monitor quality' (86 per cent of facilities reported this). Keeping records of feedback or complaints from service users' was the second most common method (57 per cent), followed by 'accreditation' (56 per cent). Just over a third of residential facilities also reported that they use 'surveys of service users' (36 per cent) and/or 'inspectors from another organisation monitor quality' (32 per cent). Other less frequently used measures included 'individual employees monitor quality' (20 per cent) and 'external auditing' (16 per cent). The fact that the 'other methods' category was rarely cited (3 per cent) suggests that the list presented covered most measures used.

Table 4.24: The three most important methods for monitoring the quality of aged care services/supports in the facility (per cent): 2016

	% of all facilities
Managers or supervisors monitor quality	86.1
Inspectors from another organisation monitor quality	32.4
Individual employees monitor quality	20.3
Keep records of feedback or complaints from service users	56.9
Surveys of service users	35.6
External auditing	16.2
Accreditation	55.9
Other	2.9

Source: Census of residential aged care facilities.
Note: Multiple response allowed, columns will not sum to 100.

5. The Home Care and Home Support Aged Care Workforce

Key Findings

- The total home care and home support workforce has decreased by 13 per cent since 2012 to an estimated 130,263. During the same time period the overall direct care workforce fell by 7 per cent and the FTE workforce by 19 per cent.

- CCWs were the largest home care and home support direct care occupational group (84 per cent) followed by RNs (8 per cent) and AH professionals (5 per cent).

- The median age of the home care and home support direct care workforce was 52 years, and they were predominantly female workers (89 per cent).

- The proportion of overseas born workers in the home care and home support sector has reduced from 28 per cent in 2012 to 23 per cent in 2016.

- Aboriginal and Torres Strait Islander people accounted for 2 per cent of the home care and home support direct care workforce.

- Around 64 per cent of workers reported being in either very good or excellent health.

- Eighty eight per cent of home care and home support workers held post-secondary qualifications. Forty five per cent of outlets reported that more than three-quarters of their CCWs held a Certificate III in an aged-care related field.

- Three-quarters of all home care and home support direct care workers were employed on permanent part-time contracts. The proportion of workers on casual/contract arrangement fell from 27 per cent in 2012 to 14 per cent in 2016.

- A regular daytime shift was the most common work schedule for all direct care occupations. However, 14 per cent of CCWs reported an irregular work schedule.

- Mostly CCWs preferred to work more hours. Less than half (46 per cent) of the home care and home support workforce were happy with their hours of work, 14 per cent wanted to reduce their hours, 40 per cent wanted to increase them.

- Sixteen per cent of the home care and home support workforce reported more than one current job.

- Three quarters of workers had undertaken training over the previous 12 months, with mandatory training the most common form of training. Priority areas identified for future training included dementia, palliative care, and mental health.

- Aged care work was a first occupation for about 5-6 per cent of the home care and home support direct care workforce. No dominant career pathways into home care and home support aged care were identified for CCWs and AH workers.

- Forty two per cent of the home care and home support workforce had paid work in the sector prior to their current job. Improved working conditions, along with changing personal circumstances, were the primary reasons for moving to a different aged care employer.

- Most (81 per cent) home care and home support workers expected to still be with their current employer after 12 months and 6 per cent of the workforce was seeking alternative work.

- Slightly higher levels of job satisfaction were reported by home care and home support than residential care workers.

- The most prevalent unusual job demands made of workers were associated with changes in work patterns (working longer than scheduled, variation to hours/location).

- Twelve per cent of home care and home support direct care workers reported a work-related injury or illness over the previous 12 months, most commonly sprains/strains and chronic joint/muscle conditions.

- Seventy two per cent of outlets employed CCWs from a CALD background, most commonly from Italy and South East Asia.

- All home care and home support outlets reported benefits of employing CALD CCWs – these included enhanced cross-cultural understandings and language skills. Only a fifth of home care and home support outlets reported difficulties in employing CALD CCWs, with communication issues being most common.

5.1 Introduction

This chapter provides detailed information about the home care and home support aged care workforce using responses from both workers (N=7,024) and outlets (N=2,307). The census and survey collected information on the main occupational groups working within the sector. In selected tables we provide details on each of these occupations (including, as in 2012, Nurse Practitioners and Allied Health Assistants). Where these occupational groups are not listed separately, Nurse Practitioners are combined with Registered Nurses, and Allied Health Assistants with Allied Health Professionals under the umbrella of Allied Health worker.

The information provided in this chapter to a large extent parallels that provided for the residential workforce in Chapter 3. In some areas in this chapter direct comparisons are made between the residential and home care and home support workforces. In this chapter we examine the characteristics of the residential workforce and aged care work, career pathways into and out of aged care, the experiences of home care and home support work, the extent of work-related injuries and illness in the sector, and the cultural and linguistic diversity of the workforce.

5.2 Total Employment and Main Workforce Characteristics

The following section provides an overview of the home care and home support aged care workforce including the overall size of the PAYG workforce and how this is distributed across the different occupational classifications within the sector. We then examine key socio-demographic characteristics of the home care and home support workers themselves including age, gender, ethnicity, cultural background, health and education.

5.2.1 Total Employment

The home care and home support sector is likely to play a larger role in the provision of aged care services owing partly to an increasing preference of older Australians to continue to live and receive care in their own homes as they age. Indeed by 2050 it has been estimated that around 80 per cent of all aged care services will be community based (Productivity Commission, 2011). In order to determine how the aged care workforce can most effectively be developed to meet the future care needs of older Australians, an understanding of the size and composition of the existing workforce is necessary. Our estimates of the home care and home support aged care workforce is based on information obtained from the census of home care and home support outlets.

The 2016 census estimates that total employment in home care and home support aged care is 130,263 workers, of which 86,463 are in direct care roles. Table 5.1 compares the 2016 estimates with those from 2012 and 2007. It suggests that the whole home care and home support PAYG workforce reduced in size by 13 per cent between 2012 and 2016 (falling by 19,538 from 149,801 to 130,263). This reduction has followed an earlier rise between 2007 and 2012 (from 87,478 to 149,801).

Direct care employment also fell between 2012 and 2016. It fell by 7 per cent (an estimated fall of 6,896 from 93,359 to 86,463). There was an earlier major employment rise between 2007 and 2012 in the background (a rise of 19,292 from 74,067 to 93,359). These substantial differences indicate that the sector is undergoing considerable structural change and this is reflected in the way labour is used both in numbers but also in the differential use of direct and non-direct care employees.

The proportion of the PAYG home care and home support aged care workforce working in direct care roles continues relatively steady at 66 per cent. In 2016, 66 per cent of home care and home support aged care employees work in direct care roles, compared with 62 per cent in 2012 (85 per cent in 2007).

Table 5.1: Size of the home care and home support aged care workforce, all PAYG employees and direct care employees: 2007, 2012 and 2016 (estimated headcount)

Occupation	2007	2012	2016
All PAYG employees	87,478	149,801	130,263
Direct care employees	74,067	93,359	86,463

Source: Census of home care and home support aged care outlets.

5.2.2 Occupation

The occupational composition of the headcount of home care and home support direct care employees is presented in Table 5.2. Community Care Workers (CCWs) are the largest occupational group in the home care and home support direct care workforce (84 per cent). While their estimated headcount fell by 3,551 (5 per cent) since 2012, as a proportion of the home care and home support direct care workforce the CCW share rose from 81 per cent in 2012 to 84 per cent in 2016.

The number of home care and home support RNs also fell by 662 (9 per cent) between 2012 and 2016, but their share in the whole direct care workforce remained constant at 8 per cent. The number of nurse practitioners still only make up a very small proportion of the home care and home support direct care workforce (0.1 per cent). The number of home care and home support ENs has fallen by 1,753 since 2012 (48 per cent) and as a proportion of the direct care workforce they have fallen from 3.9 per cent to 2.2 per cent. The Allied Health employment categories had a stable share of direct care employment with 6 per cent in 2012 and in 2016.

The overall picture suggests that home care and home support outlets continue to rely on CCWs to provide direct care without much change in the occupational distribution for direct care workers. There has been a small fall in share for most occupations, with a small rise in the share of CCWs, from 81 per cent in 2012 to 84 per cent in 2016.

Table 5.2: Direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated headcount and per cent)

Occupation	2007	2012	2016
Nurse Practitioner	n/a	201	53
		(0.2)	(0.1)
Registered Nurse	7,555	7,631	6,969
	(10.2)	(8.2)	(8.1)
Enrolled Nurse	2,000	3,641	1,888
	(2.7)	(3.9)	(2.2)
Community Care Worker	60,587	76,046	72,495
	(81.8)	(81.4)	(83.8)
Allied Health Professional*		3,921	4,062
	3,925	(4.2)	(4.7)
Allied Health Assistant*	(5.3)	1,919	995
		(2.1)	(1.2)
Total number of employees (headcount)	**74,067**	**93,359**	**86,463**
(%)	**(100)**	**(100)**	**(100)**

Source: Census of home care and home support aged care outlets.
** Note: in 2007, these categories were combined under Allied Health.*

A different picture arises from the headcount measure (Table 5.2) compared to the Full Time Equivalent (FTE) employment measure (Table 5.3). These two measures when put together provide a more complete and complementary picture. Table 5.3 shows that there was a 19 per cent fall in the home care and home support FTE direct care workforce (by 10,450 workers from 54,537 in 2012 to 44,087 in 2016). In percentage terms this is a larger decline than in the headcount corresponding comparison (7 against 19 per cent), which suggests that there has been an increase in the proportion of workers employed for fewer hours.

The distribution of the home care and home support FTE direct care workforce in 2016 presented in Table 5.3 is slightly different to that of the headcount number of persons working in direct care occupations shown in Table 5.2. The share of CCWs is lower in the distribution of the home care and home support FTE direct care workforce than in the headcount distribution in Table 5.2 (79 per cent FTE against 84 per cent headcount).

Table 5.3: Full-time equivalent direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated FTE and per cent)

Occupation	2007	2012	2016
Nurse Practitioner	n/a	55	41
		(0.1)	(0.1)
Registered Nurse	6,079	6,544	4,651
	(13.2)	(12.0)	(10.5)
Enrolled Nurse	1,197	2,345	1,143
	(2.6)	(4.3)	(2.6)
Community Care Worker	35,832	41,394	34,712
	(77.8)	(75.9)	(78.7)
Allied Health Professional*		2,618	2,785
	2,948	(4.8)	(6.3)
Allied Health Assistant*	(6.4)	1,581	755
		(2.9)	(1.7)
Total number (FTE)	**46,056**	**54,537**	**44,087**
(%)	**(100)**	**(100)**	**(100)**

Source: Census of home care and home support aged care outlets.
** Note: in 2007, these categories were combined under Allied Health.*

Figures 5.1 and 5.2 can help show these changes over time with their patterns. Figure 5.1 portrays the changes over time in distributional proportions for the two measures of headcount

and FTE direct care workforce information shown in Tables 5.2 and 5.3. Figure 5.2 portrays the distribution of the numerical headcount and FTE direct care workforce information shown in Tables 5.2 and 5.3.

Figure 5.1: Share of the occupations for the home care and home support direct care employees (headcount and FTE, per cent)

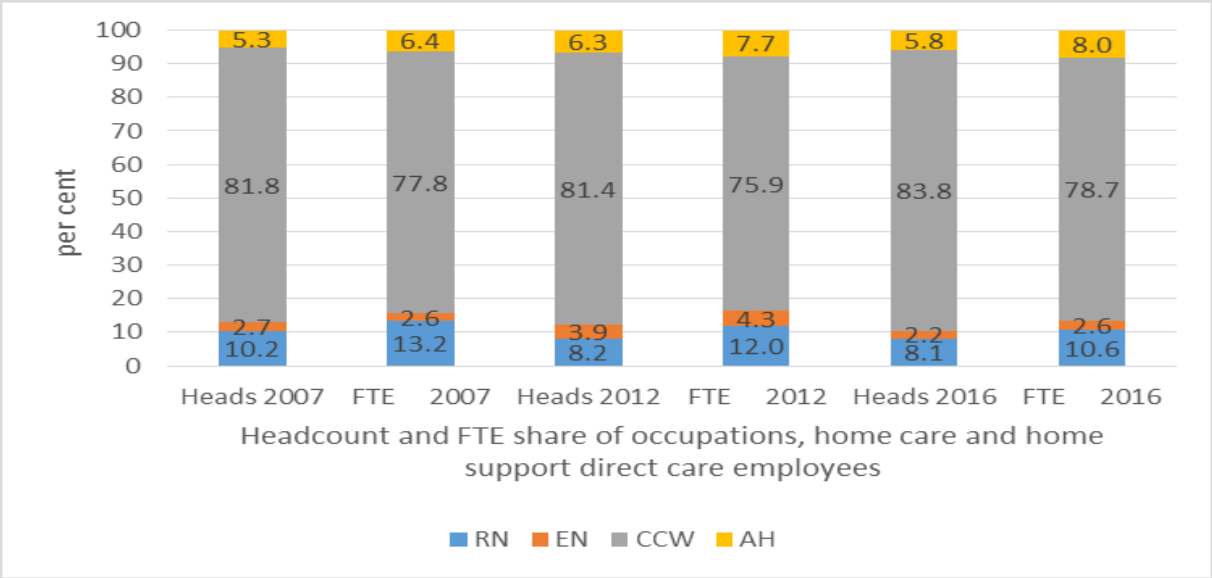
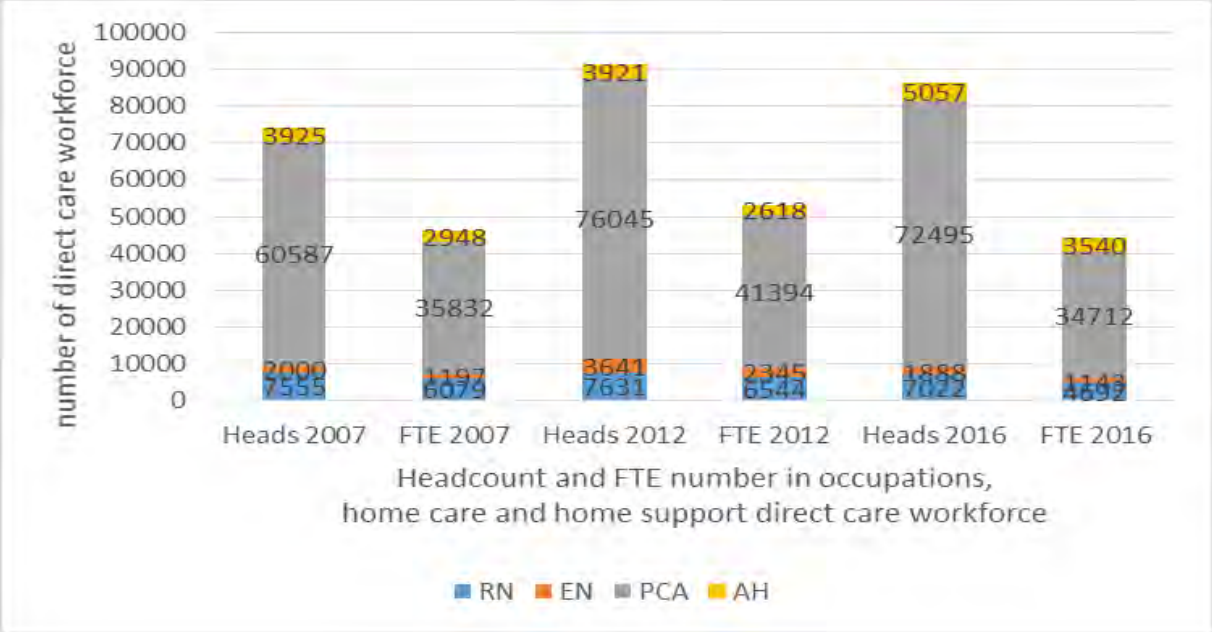


Figure 5.2: Number of the occupations for the home care and home support direct care employees (headcount and FTE)



Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2016 in Figure 5.1 and Figure 5.2. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in both 2007, 2012 and 2016 in Figure 5.1 and Figure 5.2.

Table 5.4 shows the roles of staff not providing direct care in home care and home support aged care. There is a slight change in the distribution of non-direct care staff in home care and home support aged care between 2012 and 2016. Management and administration roles have seen a small rise in their share, while other non-direct care roles have seen a drop in their share.

Table 5.4: Employees not providing direct care in the home care and home support aged care workforce, by occupation: 2016 (per cent)

Occupation	2012	2016
Care Manager/co-ordinator	33.2	29.8
Management	22.3	25.6
Administration	35.3	37.0
Spiritual/pastoral care	1.6	0.5
Ancillary care (home maintenance, modification, etc.)	7.7	7.1
Total	**100**	**100**

Source: Census of home care and home support aged care outlets.

5.2.3 Age and Gender

Understanding the age structure of employees in an industry aids future workforce planning and development. Particular workforce strategies may be required in sectors with an older worker profile, such as the implementation of measures to accommodate the needs of older workers and the addressing of staff turnover due to retirement. The aged care sector (across both residential and home care and home support) has traditionally had an older workforce compared to the Australian workforce in general. Table 5.5 and Figure 5.3 present the age distribution of home care and home support direct care workers for 2007, 2012 and 2016, and compare the direct care workforce with those recently hired (i.e. those who have been employed for 12 months or less). Looking at the whole sample, it is clear that this is an ageing workforce as the only age groups that are continually increasing in share are those above 54 years (with the exception of the 25-34 year olds who show a small increase). This pattern in the age profile of home care and home support direct care workers (Table 5.5) is in clear contrast to that of the residential direct care workforce which is getting younger (Table 3.5).

For home care and home support workers who have been hired in the last 12 months, Table 5.5 shows that 47 per cent are under the age of 45 years (compared with 28 per cent for all direct care workers). This suggests that younger people are attracted into home care and home support aged care. The age profile of recent hires in home care and home support is a little different to that in 2012, but with only slight variation in the two younger age brackets. There was a small fall in 16-24 year old new hires (from 10 per cent in 2012 to 8 per cent in 2016), a slight rise in those aged 25-34 years (from 14 per cent in 2012 to 16 per cent in 2016) and a larger fall in the share of those aged 35-44 years (from 28 per cent in 2012 to 23 per cent in 2016). These are not new hires to the sector, but to their current employers, therefore they may have been working in the aged care sector before. The new hires appear younger than the total workforce. This appears to be a trend as we see the same phenomenon in 2007 and 2012. Observing this flow of younger workers suggests that the home care and home support workforce should have been getting younger since 2007, but this is not what we actually observe. This could be happening for several reasons. It could be, that these are not new hires to the sector, but instead reflect within-sector mobility by younger workers. Alternately, it could be that these new hires may indeed be younger than the average, but those who leave the sector may also be younger than the average, because retention may be lower for the younger workers.

Another way to look at the age of the workforce is to compare the median age (mid-point) of the workforce for each of the occupations, as presented in Table 5.6. Table 5.6 shows that the median age of 52 years in 2016 is slightly higher than the 50 years in 2012. Table 5.6 also shows that the median age of 52 years in 2016 for all direct care workers is higher than that of recent hires (46 years in 2016, but it was 44 years in 2012 and so the home care and home support recent hires are older in 2016 than in 2012).

One of the key differences between the residential and home care and home support aged care workforces is in the median age of CCWs/PCAs. In 2016 residential PCAs had a younger

median age than other occupations across the workforce (46 years, Table 3.6) and for recent hires (35 years), whereas home care and home support CCWs had the highest median age at 52 years (with ENs at 51 years and RNs at 48), with recent hire CCWs (46 years) only 6 years younger. In home care and home support aged care, the youngest median age in the recent hires is for AH workers (41 years in 2016, but this is older than in 2012 when it was 36 years). Recently hired RNs in home care and home support are older by 3 years than RNs for the full direct care workforce.

Table 5.5: Age distribution of the home care and home support direct care workforce, all direct care employees and recent hires: 2007, 2012 and 2016 (per cent)

Age (years)	All direct care employees			Recent hires*		
	2007	2012	2016	2007	2012	2016
16–24	2.0	2.7	2.4	6.5	9.5	7.7
25–34	7.7	8.0	9.1	15.9	13.7	15.9
35–44	20.4	19.3	16.3	27.4	27.6	23.4
45–54	40.7	37.2	33.4	32.6	32.0	29.4
55–64	26.7	29.7	32.9	16.3	16.0	22.2
65 and over	2.5	3.1	5.9	1.4	1.2	1.3
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
**Recent hires have been employed for 12 months or less.*

Figure 5.3: Age distribution of the home care and home support aged care workforce: 2007, 2012 and 2016 (per cent)

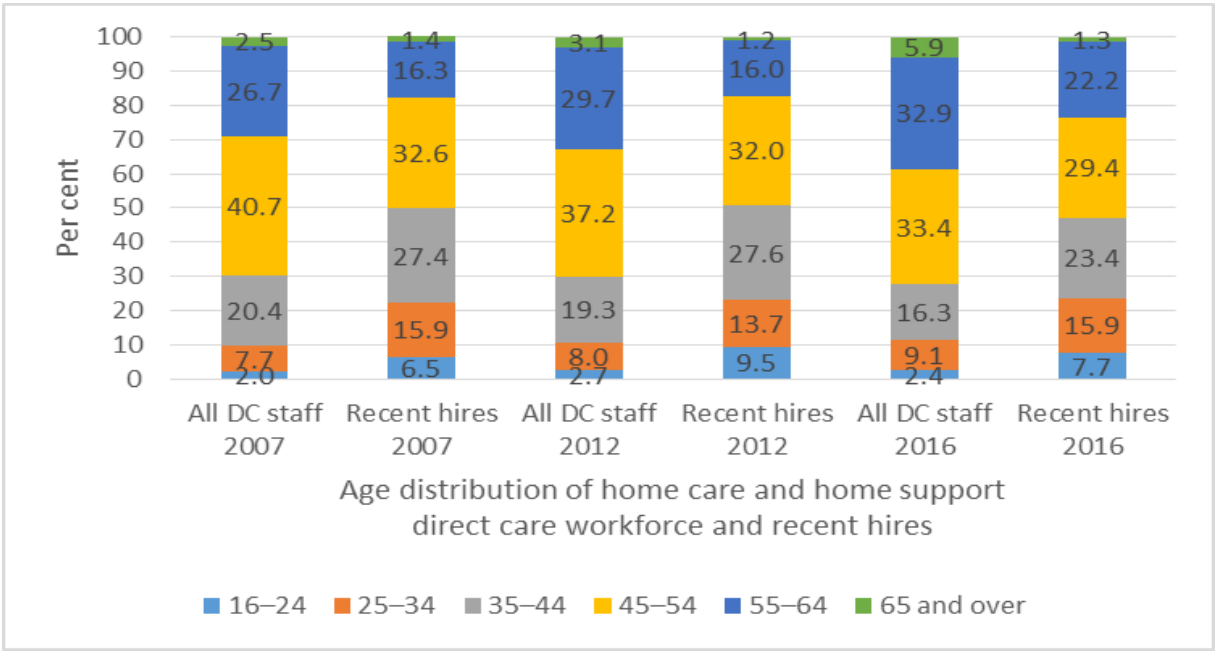


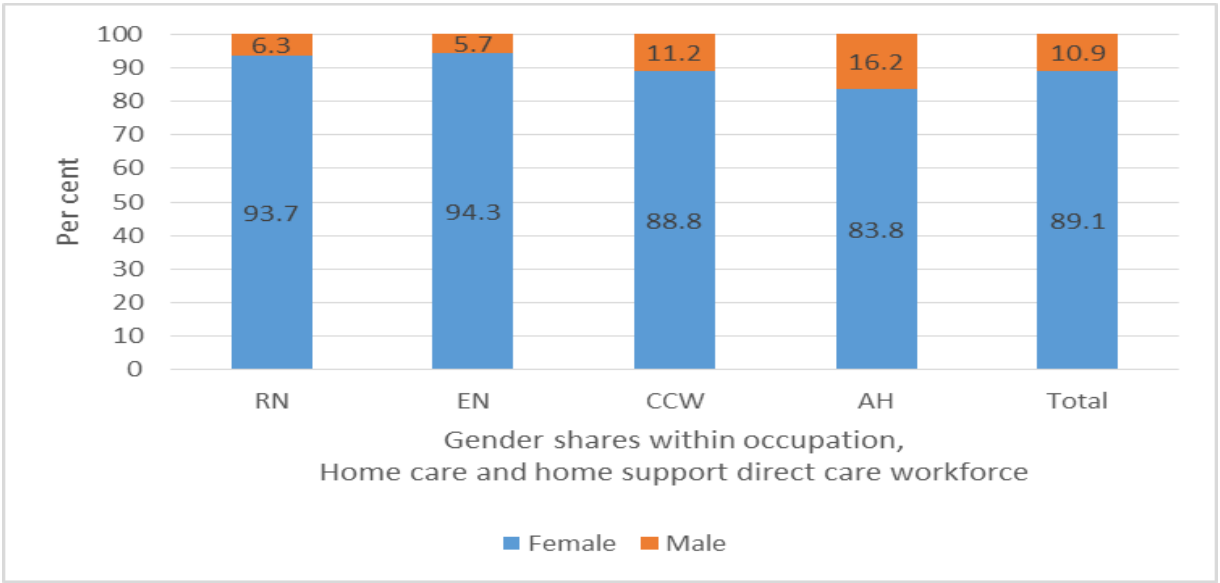
Table 5.6: Median age of the home care and home support direct care workforce, by occupation, all direct care employees and recent hires: 2012 and 2016 (number of years)

	All direct care employees	Recent hires*	Difference in years in median age for all recent hires relative to all direct care employees
2016			
Registered Nurse	48	51	3
Enrolled Nurse	51	43	-8
Community Care Worker	52	46	-6
Allied Health	47	41	-6
All occupations	52	46	-6
2012			
Registered Nurse	50	47	-3
Enrolled Nurse	49	45	-4
Community Care Worker	50	45	-5
Allied Health	48	36	-12
All occupations	50	44	-6

Source: Survey of home care and home support aged care workers.
** Recent hires have been employed for 12 months or less.*

While the proportion of male workers within aged care has slowly been increasing over time, Figure 5.4 shows the home care and home support direct care workforce in 2016 continues to be predominantly female (with 89 per cent female and 11 per cent male direct care workers). While RNs and ENs are occupations where slightly fewer men are employed within the home care and home support direct care workforce (6 per cent), more AH roles are undertaken by men (16 per cent).

Figure 5.4: Gender distribution of the home care and home support aged care workforce: 2016 (per cent)



5.2.4 Country of Birth

Table 5.7 presents the share of the home care and home support workforce born in Australia and elsewhere. The proportion of these workers born outside of Australia has fallen from 28 per cent in 2012 to 23 per cent in 2016. The profile of workers who had been hired in the last 12 months is very similar to that of all direct care workers with the share of those born overseas slightly lower at 21 per cent in 2016. A higher proportion of direct care workers in home care and home support outlets are born in Australia (77 per cent) than amongst residential aged care workers (68 per cent, Table 3.7).

Table 5.7: Country of birth of the home care and home support direct care workforce, all direct care employees and recent hires: 2007, 2012 and 2016 (per cent)

Country of birth	All direct care employees			Recent hires*		
	2007	2012	2016	2007	2012	2016
Australia	73.3	72.2	77.1	69.0	70.1	79.3
Other	26.7	27.8	22.9	31.0	29.9	20.7
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
** Recent hires have been employed for 12 months or less.*

The distribution of the overseas born workforce by occupation is explored further in Table 5.8. The census asked all facilities to provide the numbers of workers they employ from a culturally or linguistically diverse background for each occupation. The workers survey asked workers themselves to state where they were born and whether they spoke a language other than English. Although not directly comparable, these questions are complementary to each other as they provide different perspectives on the occupational level and distribution of the part of the workforce that were born overseas.

Table 5.8 shows that 23 per cent of all home care and home support direct care workers who responded to the survey are migrants (column 1). It also shows that the migrant worker occupational distribution is broadly similar to that of the overall home care and home support direct care workforce as reported in Table 5.2. Table 5.8 column 2 shows 14 per cent are both a migrant and speaking a language other than English (LOTE). This compares with the information from outlets in column 3 of Table 5.8 which indicates that 18 per cent of employees come from culturally and linguistically diverse (CALD) backgrounds. The proportions of nurses and AH workers derived from the workers' responses in the workers survey are somewhat higher than the proportions derived from the employers' responses in the census. The opposite holds for the CCW proportions.

Table 5.8: The culturally and linguistically diverse (CALD) home care and home support direct care workforce, by occupation, comparing outlet and worker responses: 2016 (per cent)

Occupation	Worker (migrant)[1]	Worker (migrant + LOTE)[2]	Outlet (CALD)[3]
% of direct care employees	22.9	13.7	18.0
Distribution			
Registered Nurse	7.5	6.0	2.8
Enrolled Nurse	1.3	1.1	0.6
Community Care Worker	84.3	86.2	92.8
Allied Health	6.9	6.7	3.8
Total	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers, Census of home care and home support aged care outlets.
1. Workers who report having migrated to Australia.
2. Workers who report being both migrant and speaking a language other than English.
3. Facilities that report employees from culturally and linguistically diverse backgrounds.

The worker survey asked migrant workers who spoke a language other than English how long they had been living in Australia. This question allows the exploration of the extent to which workers are likely to be familiar with English as a language and with Australian customs and norms. Table 5.9 presents the proportions of time spent in Australia by LOTE migrants, by occupation and for 2012 and 2016. Table 5.9 shows that in 2016 70 per cent of the migrant direct care workforce in home care and home support outlets who speak a language other than English have been in Australia for more than 10 years. There is considerable variation between occupational groups. For example, in 2016, 49 per cent of RNs had been in Australia for 10 years or more, compared to 83 per cent of AH workers.

The proportions of all migrant workers in the sample who speak a language other than English and who have been in Australia for over 10 years in Table 5.9 is 76 per cent for 2012 and 70 per cent for 2016. This is a much different profile to residential aged care workers with a higher proportion of migrants who have recently arrived in Australia, and where only 39 per cent of all residential aged care migrant workers speaking a language other than English have been in Australia for over 10 years, (Table 3.9). The difference relates mainly to workers in CCW/PCA roles, where a higher proportion of home care and home support CCWs (71 per cent, Table 5.9) than residential PCAs (38 per cent, Table 3.9) have been in Australia for longer than 10 years.

Table 5.9: Time spent in Australia of migrant home care and home support direct care workers who speak a language other than English, by occupation: 2012 and 2016 (per cent)

	0–2 years	3–5 years	6–10 years	>10 years	Total
2016					
Registered Nurse	4.4	11.7	35.4	48.6	**100**
Enrolled Nurse	0.0	27.5	0.0	72.5	**100**
Community Care Worker	1.9	7.5	20.0	70.7	**100**
Allied Health	2.2	5.8	9.2	82.8	**100**
All occupations	2.1	7.9	19.9	70.1	**100**
2012					
Registered Nurse	9.7	6.5	25.8	58.0	**100**
Enrolled Nurse	*	*	*	*	*****
Community Care Worker	4.7	8.8	9.6	76.9	**100**
Allied Health	14.0	10.0	14.0	62.0	**100**
All occupations	5.5	8.5	10.3	75.7	**100**

Source: Survey of home care and home support aged care workers.
**The proportion of ENs in these categories was too small to report.*

5.2.5 Aboriginal and Torres Strait Workforce

Home care and home support outlets provide a range of services (both culturally specific and as part of broader service options) to older Aboriginal and Torres Strait Islander people. Table 5.10 presents the distribution of the Aboriginal and Torres Strait Islander workforce in home care and home support outlets. We note that the small sample size makes these estimates rather imprecise. Home care and home support outlets report in 2016 that 2 per cent of the direct care workforce are Aboriginal and Torres Strait Islander descent (Table 5.10 Outlet, column 2). Amongst these direct care workers of Aboriginal and Torres Strait Islander origin, home care and home support outlets report in 2016 that their occupational distribution is 3 per cent RNs, 1 per cent ENs, 94 per cent CCWs, 2 per cent AH workers.

The outlet reports from the census reveal that 10 per cent of the home care and home support direct care workforce works in a nursing role (see earlier Table 5.2), three times as many compared with 3 per cent of the Aboriginal and Torres Strait Islander direct care workforce shown in Table 5.10. The vast majority of Aboriginal and Torres Strait Islander home care and home support direct care workers are employed as CCWs (94 per cent, Table 5.10, more than the 84 per cent of all home care and home support workers, Table 5.2). Correspondingly, this means that they are slightly less likely to be in a nursing or AH role.

There is no improvement in the occupational distribution of home care and home support workers for Aboriginal and Torres Strait Islander people since 2012, when also 3 per cent were nurses). The present data collection is not designed to generate information at the required depth for such a small sub-population. More extensive in depth research would be required in this area.

Table 5.10: The Aboriginal and Torres Strait Islander home care and home support direct care workforce, by occupation, comparing outlet and worker responses: 2012 and 2016 (per cent)

	Worker survey (Column 1) Workforce	Outlet census (Column 2) Workforce
2016		
% of direct care employees	2.8	2.1
Of these, distribution in direct care roles		
Registered Nurse	1.2	2.9
Enrolled Nurse	2.6	1.1
Community Care Worker	93.2	93.9
Allied Health	3.0	2.1
Total	**100**	**100**
2012		
% of direct care employees	2.7	2.3
Of these, distribution in direct care roles		
Registered Nurse	3.9	1.8
Enrolled Nurse	1.6	0.7
Community Care Worker	92.2	95.6
Allied Health	2.4	1.9
Total	**100**	**100**

Source: Survey of home care and home support aged care workers, Census of home care and home support aged care outlets.

5.2.6 Health

Given the often physical nature of aged care work, the health status of the workforce provides an indication of their capacity to undertake these work tasks. Using a standardised measure of self-assessed health drawn from the ABS (which uses a rating of health as excellent, very good, good, fair or poor), Table 5.11 presents information on the self-assessed health of the home care and home support workforce. Differences between the occupations exist, with a smaller proportion of CCWs saying they had excellent or very good health. Self-assessed health is high across each of the occupations, with around 65 per cent of nurses, 59 per cent of CCWs and 67 per cent of AH home care and home support direct care workers reporting that they are in ‘excellent’ or in ‘very good’ health. This is similar to 2012 when it was about 60 per cent for direct care workers in excellent or very good health, with variation by occupation.

Table 5.11 contrasts the health of all home care and home support direct care workers with that of the new hires. The most notable difference is that both CCW and nurse new hires report much better health than existing workers. The health of recent hires is noticeable for CCWs, where 67 per cent indicate they have excellent or very good health compared with 59 per cent of CCWs in the direct care workforce more generally; and nurses (73 per cent compared with 65 per cent in recent hires).

Table 5.11: Self-assessed health of the home care and home support direct care workforce, all direct care employees and recent hires, by occupation: 2016 (per cent)

Self-assessed health	All direct care employees			Recent hires*		
	Nurse	CCW	AH	Nurse	CCW	AH
Excellent	14.4	15.8	21.2	19.9	19.4	20.3
Very good	50.2	43.3	46.3	53.5	48.0	48.4
Good	23.4	33.2	25.1	19.9	27.5	25.8
Fair	10.0	7.2	7.0	6.3	4.6	4.7
Poor	2.0	0.6	0.4	0.5	0.5	0.8
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
**Recent hires have been employed for 12 months or less.*

5.2.7 Education

Having an appropriately qualified and skilled workforce is important for career development within the aged care sector and also for the provision of quality care to older Australians. From the point of view of the sector as a whole and the national aged care policy in the context of an increasing consumer directed home care environment, an appropriately qualified and skilled workforce is not only important, but also critical for attracting the necessary investment for the growth of the sector. In all advanced economies the presence of adequate labour supply in the form of a skilled and well qualified workforce can act like a magnet for investment. The aged care sector has such a well-qualified and skilled workforce at its disposal and our reports since 2003 suggest that it is getting better. The need to monitor regularly is met through the NACWCS data collections.

This section presents information about the formal education of the home care and home support workforce. Additional categories of qualifications related to disability care were added to the 2016 questionnaires for the first time to account for a possible linkage between aged care and disability care labour supply and demand. The questions about the qualifications of care managers and care leaders, which were first asked in 2012, have been continued, together with the further training questions.

Examining the educational qualifications held by the direct care workforce as a whole, Table 5.12 shows that in 2016 88 per cent of home care and home support direct care workers have post-school qualifications, a small rise from 86 per cent in 2012, and is now nearly as high as for residential direct care workers (90 per cent, Table 3.12). Of the occupations, a higher proportion of CCWs than others have no post-school qualification (14 per cent), although this is slightly lower than the 16 per cent recorded in 2012.

The types of qualifications held generally reflect workers' occupational roles. RNs mostly have a Bachelor Degree in Nursing (78 per cent), with many having other nursing or health related qualifications; 86 per cent of ENs have a Certificate IV/Diploma in Enrolled Nursing; and CCWs have mostly certificate level qualifications in aged care (51 per cent Certificate III, 12 per cent Certificate IV). The AH category contains both AH Professionals and AH Assistants, and so their post-school qualifications are split between health and aged care.

The proportion of CCWs with aged care or related qualifications has increased only slightly since 2012. Just over half have a Certificate III in Aged Care (51 per cent in 2016, 48 per cent in 2012) and just over a quarter have a Certificate III in Home and Community Care (27 per cent in 2016, 20 per cent in 2012). However, while in 2012, 19 per cent of CCWs held an Aged Care or Service Co-ordination Certificate IV qualification, this has fallen to 15 per cent in 2016.

For the first time in 2012 information was added about the post-secondary qualifications of care managers and care leaders.[7] The educational profile of these two leadership positions is quite similar. As in 2012, a slightly higher proportion of care leaders have Certificate III in Aged Care (42 per cent in 2016, higher than the 37 per cent in 2012), while care managers are more likely to have a Bachelor Degree in Nursing (27 per cent in 2016, also higher than the 18 per cent in 2012), or management qualifications; but the differences between them are not of the same scale as for the equivalent staff in residential facilities. One of the chief differences between care managers and leaders in residential and home care and home support aged care is that, in home care and home support outlets, a higher proportion hold qualifications in non-work related fields, suggesting that they had a different occupation before entering aged care.

Home care and home support aged care direct care workers with a disability related qualification (asked for the first time in 2016), are mostly CCWs with a Certificate III in Disability (9 per cent), with a Certificate IV in Disability held by 6 per cent (these may overlap since some may hold both). These are slightly greater shares than in residential aged care. In both types of aged care services, it is mainly CCW/PCAs holding a Certificate III in Disability.

[7] Care managers were defined as having responsibility for all direct care workers in the outlet; while care leaders were defined as having responsibility for a team of direct care workers, but reporting to a care manager.

Table 5.12: Post-school qualifications completed by the home care and home support direct care workforce, by occupation: 2016 (per cent)

Qualification	Care Manager	Care Leader	RN	EN	CCW	AH	All DCW*
No Post-school							
Yr 10 or below	2.1	1.5	0.6	0.0	6.9	1.0	5.9
Yr 11/12	2.4	4.3	1.1	0.0	7.3	1.7	6.3
Health							
Certificate IV/Diploma in Enrolled Nursing	7.8	9.1	2.8	86.4	3.5	2.6	5.2
Other basic nursing qualification	7.6	2.8	13.3	9.7	2.6	3.4	3.7
Post-basic nursing qualification	5.3	2.7	18.4	3.8	0.6	0.4	2.1
Bachelor Degree in Nursing	26.9	18.0	78.2	0.0	1.4	1.4	7.6
Bachelor Degree in Allied Health Profession	3.9	2.6	0.6	0.0	0.9	41.8	3.2
Postgraduate allied health qualification	3.0	0.7	1.2	0.4	0.4	11.4	1.1
Other health related	7.9	6.7	12.1	3.2	5.6	9.3	6.3
Aged Care							
Certificate III in Aged Care	19.3	41.9	4.4	28.0	50.9	12.5	44.4
Certificate III in Home and Community Care	8.1	14.7	0.4	3.1	26.6	6.9	22.8
Certificate IV in Aged Care	10.4	20.4	1.9	10.3	12.2	4.6	10.9
Certificate IV in Service Coordination	6.4	4.0	0.0	1.0	2.8	4.5	2.6
Other Certificate in Care Work	7.4	9.0	1.0	1.6	8.2	6.3	7.3
Post basic nursing qualification in aged care	2.6	1.8	5.8	2.7	0.5	0.1	1.0
Other aged care related	7.5	6.7	4.3	2.1	5.7	5.7	5.5
Disability							
Certificate III in Disability	3.5	4.2	0.2	4.0	8.6	3.5	7.5
Certificate IV in Disability	5.8	5.5	0.2	0.4	6.3	4.0	5.6
Diploma in Disability	1.9	0.4	0.0	0.0	0.6	0.9	0.5
Diploma Community Service	2.5	2.4	0.0	0.0	1.8	0.5	1.6
Other (Disability related)	1.5	2.3	0.2	2.3	1.6	0.6	1.4
Management							
Certificate III or IV (Management)	12.4	7.2	7.8	6.1	4.6	3.6	4.8
Diploma (Management)	14.3	4.0	4.1	5.0	3.5	7.7	3.8
Bachelor or Postgraduate Degree (Management)	6.5	2.0	9.1	0.0	1.3	3.9	2.0
Other							
Certificate III or IV (Other)	15.7	16.0	9.2	19.0	14.9	16.1	14.6
Diploma (Other)	12.2	9.2	4.9	13.1	9.7	7.7	9.3
Bachelor or Postgraduate Degree (Other)	14.1	10.7	13.4	3.4	8.2	16.6	9.0

Source: Survey of home care and home support aged care workers.
**All DCW (direct care workers), does not include care managers or care leaders.*
Note: Because staff can have more than one qualification, the columns do not sum to 100.

Table 5.13 shows the percentage of workers with aged care Certificate III and IV within home care and home support outlets for 2007, 2012, and 2016. In 2016, the proportion of outlets with more than 75 per cent of CCWs with a relevant Certificate III was 45 per cent (between 2007 and 2012 this share rose from 28 per cent to 40 per cent)). While CCWs with relevant Certificate IV qualifications are found less often, the proportion of outlets with no CCWs

holding these qualifications was steady with 30 per cent in 2016, against 30 per cent in 2012 (in a substantial earlier change this share decreased from 42 per cent in 2007 to 30 per cent in 2012).

The prevalence of CCWs with relevant Certificate III qualifications in outlets is not as high as it is for PCAs in residential facilities (11 per cent of outlets have no CCWs with Certificate III qualifications Table 5.13, whereas only 2 per cent of residential facilities have no PCAs with Certificate III qualifications Table 3.13).

The share of home care and home support outlets with no CCWs with relevant Certificate IV qualifications is now 30 per cent, against the 24 per cent of residential facilities with no PCAs with Certificate IV qualifications.

Table 5.13: Distribution of community outlets by proportion of Community Care Workers (CCWs) with relevant Certificate-level qualifications: 2007, 2012 and 2016 (per cent)

Proportion of CCWs with each type of qualification	Relevant Certificate III			Relevant Certificate IV		
	2007	2012	2016	2007	2012	2016
Zero	10.9	12.5	11.4	41.6	29.9	29.6
1–24%	14.5	8.5	8.9	35.8	41.1	42.3
25–49%	22.0	14.2	13.1	11.1	14.0	13.7
50–74%	24.7	25.1	22.1	6.7	8.0	6.9
75–99%	16.2	25.7	25.8	1.8	1.7	2.9
100%	11.8	14.0	18.8	3.0	5.3	4.6
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Census of home care and home support aged care outlets.

As older Australians increasingly choose to stay and receive care within their own homes, direct care workers in the community often provide support to people with a wider range of care needs than previously. The worker survey therefore asked workers if they had specialised qualifications that would help them deal with certain types of aged care needs. These specialisations were selected as being important for aged care, but this is not an exhaustive list.

Table 5.14 shows that in home care and home support aged care, 80 per cent of care leaders and 79 per cent of care managers do not have specialised qualifications in aging or aged care. These proportions have improved since 2012 when 92 per cent of care leaders and 89 per cent of care managers did not have specialised qualifications in ageing or aged care. Of those with the specialised ageing or aged care qualifications in 2016, palliative care and gerontology are the most prevalent, and this is similar to 2012. Across all occupations, the most common specialty was in palliative care.

Just under a quarter of home care and home support RNs (23 per cent) had one of these specialised qualifications and 20 per cent of ENs. This was higher than other occupational groups, with only 14–16 per cent of other direct care workers. More of care managers and care leaders had qualifications in any of the areas of specialty listed (21 per cent and 20 per cent respectively). This reflects a smaller proportion of the home care and home support workforce with specialised qualifications than in residential facilities (Table 3.14).

Table 5.14: Specialised qualifications in ageing or aged care of the home care and home support direct care workforce, by occupation: 2012 and 2016 (per cent)

	Care Manager	Care Leader	RN	EN	CCW	AH
2016						
None	79.2	80.2	77.0	80.3	85.2	85.9
Specialisation in:						
Gerontology	2.8	0.4	5.4	0.7	0.4	1.3
Palliative Care	5.9	12.1	9.8	9.3	6.4	2.5
Psychogeriatrics	0.6	0.3	0.6	4.2	0.1	0.5
2012						
None	88.8	91.8	77.9	93.7	96.2	96.0
Specialisation in:						
Gerontology	4.3	1.4	9.1	0.7	0.5	2.2
Palliative Care	5.1	6.0	10.1	4.2	3.0	0.9
Psychogeriatrics	1.8	0.7	2.9	1.4	0.3	0.9

Source: Surveys of home care and home support aged care workers.

The level of study currently being undertaken by the home care and home support direct care workforce is shown in Table 5.15. Far fewer home care and home support aged care workers are studying in 2016 (11 per cent) than there were in 2012 (21 per cent). Split by their occupation, in 2016 11 per cent of CCWs, 11 per cent of RNs, 16 per cent of ENs and 9 per cent of AH workers were engaged in study. The corresponding 2012 percentages were 21 per cent of CCWs, 13 per cent of RNs, 28 per cent of ENs and 17 per cent of AH workers. Furthermore, in comparison to the residential workforce, fewer home care and home support workers report that they were currently studying in 2016 (11 per cent compared to 16 per cent residential Table 3.15).

Table 5.15: Current study of the home care and home support direct care workforce, by occupation: 2016 (per cent)

	RN	EN	CCW	AH	All occupations
2016					
Not currently studying	89.2	84.3	89.4	91.0	89.4
Currently studying	10.8	15.7	10.6	9.0	10.6
Total	**100**	**100**	**100**	**100**	**100**
2012					
Not currently studying	86.6	72.1	78.6	82.8	79.2
Currently studying	13.4	27.9	21.4	17.2	20.8
Total	**100**	**100**	**100**	**100**	**100**

Source: Surveys of home care and home support aged care workers.

5.3 The Main Characteristics of the Work

The next section examines the structural features of working in aged care. These include the types of arrangements under which workers are employed, their shifts and whether they are working their preferred hours, their wages and whether they need to hold multiple jobs, and the opportunities provided by employers for additional training.

5.3.1 Employment Arrangements and Hours Worked

The employment arrangements and working hours in aged care provide an indication of the level of flexibility required by both employers and employees. These factors also reflect the current robustness of the labour market. For example, in a strong labour market employees are more likely to be able to have the form of employment contract, shifts and hours they prefer. Table 5.16 presents the different forms of employment in the home care and home support aged care in 2012 and 2016, distinguishing between permanent full-time, permanent part-time and casual or contract. The proportions have changed since 2012. In particular, the proportion of workers employed under permanent part-time arrangements has increased from 62 per cent in 2012 to 75 per cent in 2016. This increase has been principally through a reduction in casual and contract arrangements, from 27 to 14 per cent. Full time permanent employment remained unchanged at around 11 per cent.

There was an increase of CCWs in permanent part-time employment from 63 per cent in 2012 to 79 per cent in 2016. For nurses, the increase in permanent part-time is modest and the AHs show a decrease. Similarly, what appears to be a constant proportion of overall full-time permanent employment conceals a modest decrease for CCWs (7 to 6 per cent), a modest increase for RNs (33 to 35 per cent), and a sizeable increase for ENs and AHs (17 to 24 per cent and 27 to 39 per cent respectively).

In contrast to the situation in 2012 when a higher proportion of direct care workers were on casual or contract basis (27 per cent) in community aged care, compared with residential aged care (19 per cent, Table 3.16), the situation in 2016 shows a narrowing down of the gap between the two types of care. Indeed in 2016, 14 per cent of home care and home support workers are on casual contracts similar to those in residential aged care (10 per cent, Table 3.16). Also a roughly similar proportion (11–12 per cent) is employed under permanent full-time arrangements across home care and home support and residential care in 2016, but this is largely unchanged from 2012 when it was 10-11 per cent.

Table 5.16: Form of employment of the home care and home support direct care workforce, by occupation: 2012 and 2016 (per cent)

	Permanent full-time	Permanent part-time	Casual or contract	Total
2016				
Registered Nurse	34.9	59.4	5.7	**100**
Enrolled Nurse	23.8	71.5	4.7	**100**
Community Care Worker	5.7	79.0	15.3	**100**
Allied Health	39.0	55.7	5.3	**100**
All occupations	11.2	75.3	13.5	**100**
2012				
Registered Nurse	32.6	53.3	14.2	**100**
Enrolled Nurse	17.0	67.2	15.8	**100**
Community Care Worker	6.7	62.9	30.4	**100**
Allied Health	27.4	60.0	12.5	**100**
All occupations	10.6	62.1	27.3	**100**

Source: Census of home care and home support aged care outlets.

Table 5.17 presents the distribution of work schedules in the home care and home support direct care workforce. Unlike the employment arrangements in the previous Table 5.16, where considerable change was observed between 2012 and 2016, here our evidence goes further back to 2007 and finds no major change between 2007, 2012 and 2016 work schedules. The majority of home care and home support direct care workers continue to be employed on regular daytime shifts. We note some slight changes in rotating shifts and irregular shifts, among nurses and CCWs, but the numbers are too small and this finding of change is probably unreliable and should not be over-interpreted.

Table 5.17: Work schedule of the home care and home support direct care workforce, by occupation: 2007, 2012 and 2016 (per cent)

Work schedule	Nurse			CCW			AH		
	2007	2012	2016	2007	2012	2016	2007	2012	2016
A regular daytime shift	84.2	82.4	82.5	75.4	79.5	76.2	95.9	96.0	93.2
A regular evening shift	1.1	1.7	1.7	0.9	0.7	1.0	0.0	0.0	0.1
A regular night shift	1.3	0.8	0.4	0.5	0.4	0.2	0.0	0.0	0.1
A rotating shift	6.6	10.4	7.4	3.2	2.1	3.0	0.0	0.8	0.6
Spilt shift	0.5	0.6	2.2	3.4	2.5	2.9	0.0	0.0	0.0
On call	0.5	0.2	0.3	0.8	1.0	0.8	0.5	0.4	0.7
Irregular schedule	5.5	2.5	4.5	15.3	11.9	13.8	3.1	1.6	1.0
Other	0.2	1.4	1.0	0.5	1.9	2.1	0.5	1.2	4.2
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

The number of hours an employee prefers to work is often associated with the ability to achieve a required level of financial security and also to effectively undertake non-work responsibilities. Table 5.18 presents and contrasts the number of actual hours worked with number of the hours individual workers say they would prefer to work. The majority of home care and home support workers work between 16–34 hours per week (56 per cent), as was the case in 2012 (54 per cent).

There are occupational differences in the hours worked. More than half of the RNs (55 per cent) and half AH workers (50 per cent) work 35 hours or more per week, compared to only 22 per cent of CCWs. CCWs are the major occupational category working 1–15 hours (20 per cent), with the majority of CCWs working 16–34 hours per week (58 per cent). However, since 2012 there has been a fall in the proportion of CCWs working 35 hours or more or longer (from 25 per cent in 2012 to 22 per cent in 2016) and this reverses the rise in their longer hours observed from 2007 to 2012.

When we look at the reported hours that workers would prefer to work, the least preferred categories are working for 1–15 hours or for >40 hours categories, followed by the 35–40 hours per week. The most preferred category for all types of direct workers is 16-34 hours per week. The preference to work 35-40 hours per week is particularly noticeable for RNs, ENs and AH workers who had 16 per cent, 14 per cent and 11 per cent working more than 40 hours per week. The preference for longer hours relates mainly to CCWs where there is a clear preference to move away from working 1-15 or 16-34 hours and into working 35-40 hours. Table 5.18 shows that many people would like to be working different hours than they actually do, some fewer, but most, more hours.

Table 5.18: Actual working hours and preferred working hours of direct care workers in the home care and home support direct care workforce, by occupation: 2016 (per cent)

Occupation	Actual hours per week				Preferred hours per week			
	1–15	16–34	35–40	>40	1–15	16–34	35–40	>40
Registered Nurse	3.6	41.2	38.9	16.3	2.5	51.5	43.5	2.6
Enrolled Nurse	8.0	51.1	27.4	13.6	6.0	51.9	35.0	7.2
Community Care Worker	19.9	58.1	17.6	4.5	13.3	53.7	30.7	2.3
Allied Health	6.9	43.1	38.6	11.4	5.0	48.6	42.4	4.1
All occupations	17.5	55.7	20.8	6.0	11.8	53.2	32.5	2.5

Source: Survey of home care and home support aged care workers (Row totals).

To further investigate these preferences in working hours, Table 5.19 shows the direction of preferred change (more or less hours) and the extent of the preferred change in terms of the number of hours workers want to increase or decrease their hours by. The preferences are compared with those of workers in earlier years 2007 and 2012.

There has been a slight change between 2016 and 2012 in the proportion of home care and home support workers happy with the hours they currently work, falling from 49 per cent in 2012 to 46 per cent in 2016. Alongside this 40 per cent of workers are seeking more hours in 2016 compared with 36 per cent in 2012. The two extreme categories (10+ hours less and 11+ hours more) are mostly stable between 2012 and 2016 for home care and home support, in that there are still few people who would wish to work considerably fewer hours (down from 5 per cent in 2012 to 4 per cent in 2016) and more people who would wish to work considerably more hours (up from 6 per cent in 2012 to 7 per cent in 2016).

The major finding in these two tables is that throughout the period of 2007 to 2016 most of those workers who want to change their hours, are looking to increase their hours. One implication of this finding is that the demand for labour is soft. This suggests that this sector has considerable labour reserves in the form of the observed under-utilisation of its present workforce. This would mean the possibility that present or future skill shortages could be accommodated through the use of the present workforce. This is in line with the evidence presented in the skill shortages section of the report.

Table 5.19: Preferred change in working hours of the home care and home support direct care workforce: 2007, 2012 and 2016 (per cent)

Desired change in hours	2007	2012	2016
10+ hours less	3.5	4.7	3.8
1–9 hours less	7.6	10.6	10.0
No change in hours	47.3	48.7	46.4
1–5 hours more	23.1	19.9	20.3
6–10 hours more	12.6	10.4	12.4
11+ hours more	6.0	5.8	7.1
Total	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

5.3.2 Wages

The worker survey collected information on the wages earned by direct care workers in the home care and home support sector. Table 5.20 presents the reported gross median weekly earnings for each occupation participating in the residential aged care workers survey by the four groupings of number of hours worked per week (1-15, 16-34, 35-40, and more than 40).

In 2016, the gross median weekly wage reported by RNs is $1,200 per week. As discussed above, a high proportion of RNs work more than 35 hours per week (Table 5.18) and we expect this to be reflected in the overall median weekly wage for the profession. When working part-time, RNs report a higher median weekly wage than other occupations for the 16-34 hours category and a lower weekly wage for the 1-15 hours category, almost certainly reflecting the differences in the weekly hours worked between the occupations.

AH professionals, who have a similar level of qualifications to that of RNs, have a slightly lower median wage than RNs ($1,153), but this is reversed in the 1–15 hour category ($386 whereas RNs $325). AH professionals are the only occupational group with a higher median wage in home care and home support than in residential aged care across all categories. A higher proportion of workers are part-time in home care and home support aged care, especially in the 1–15 hours category. Of these workers only AH Professionals with 1-15 hours per week have a higher median wage than similar workers in residential facilities.

Table 5.20: Median weekly earnings of the home care and home support direct care workforce, by occupation and working hours: 2016 ($ per week)**

Occupation	Hours per week				All hours
	1–15	16–34	35–40	>40	
Nurse Practitioner	*	*	*	*	750
Registered Nurse	325	1,000	1,350	1,400	1,200
Enrolled Nurse	350	781	993	1,274	874
Community Care Worker	330	650	920	1,000	650
Allied Health Professional	386	945	1,311	1,318	1,153
Allied Health Assistant	270	600	982	890	660
All occupations	330	656	1,000	1,117	693

Source: Survey of home care and home support aged care workers.
**As the numbers of Nurse Practitioners are small, the wages earned have not been reported for individual categories.*
***As in 2012, the calculation is undertaken within each occupation group. Workers are asked in the survey about the dollar amount of their most recent pay (before tax and other deductions), and over what period those wages were for (week, fortnight, month). The amount is divided by the relevant number to calculate a weekly wage variable (divide by 2 for fortnightly pay, by 4 for monthly).*

5.3.3 Multiple Job Holding

Within the broader Australian workforce, approximately 5.3 per cent of employees hold more than one job (ABS, 2013). As shown in Table 5.21, multiple job holding is more common within aged care than the national average. In 2016, 16 per cent of home care and home support direct care workers reported holding multiple jobs (comparable to 14 per cent in 2012). Within this 16 per cent, 7 per cent have another job in aged care (5 per cent in home care and 2 per cent in residential care), another 7 per cent have another job not in aged care or disability care, and a final 2 per cent have another job in disability care. This fits in with the information already presented showing low working hours (1-15 hours, Table 5.18) and preference for more hours of work (Table 5.19) for home care and home support CCWs, which shows there is scope for them to hold more than one job. The overall picture of multiple job holding and its split by occupation has not changed in a pronounced way since 2012. Overall 2 per cent are also working in disability care alongside their aged care job. It is possible that as the NDIS expands more aged care sector workers may be attracted to this alternative career.

Table 5.21: Prevalence of multiple job-holding among home care and home support direct care workers, by occupation: 2012 and 2016 (per cent)

	RN	EN	CCW	AH	All occupations
2016					
Only have one job	83.7	87.0	84.3	83.0	84.3
Other job in residential aged care	3.0	3.0	1.7	2.2	1.9
Other job in home care and home support aged care	3.5	0.0	5.2	1.3	4.7
Other job in disability care*	0.8	1.0	2.2	0.6	2.0
Other job not in aged care or disability care*	9.0	8.9	6.5	12.9	7.1
2012					
Only have one job	88.4	83.2	85.9	86.2	86.0
Other job in residential aged care	2.0	5.4	2.1	1.5	2.2
Other job in community aged care	1.1	1.8	3.6	6.1	3.5
Other job not in aged care	8.5	9.6	8.5	6.1	8.4

Source: Survey of home care and home support aged care workers.
**'Other job in disability care' and 'Other job not in aged care or disability care' category added in 2016. Multiple response.*

5.3.4 Training

In Section 5.2.7 a high proportion of the home care and home support workforce were shown to hold formal post-school qualifications. This next section presents information on the training and continuing professional development (CPD) undertaken 'on the job' or to maintain these qualifications. Within aged care, training is an important element of the work. New questions about training were asked of workers in 2012 to establish their participation, the aims of the training undertaken, and the areas in which they would like further training. This last aspect of training was also asked of outlets in relation to training required for CCWs, the largest component of their workforce. These questions were repeated in 2016 and we present this comparison in Table 5.22.

Table 5.22, shows that 48 per cent of the home care and home support workforce undertook CPD in 2016, a smaller share than the 53 per cent in 2012. It also shows that 75 per cent undertook training during the previous 12 months (slightly fewer than in 2012 at 78 per cent). As with residential aged care, mandatory training was the most common type of training undertaken in home care and home support aged care, 69 per cent of the workforce participated in this type of training (however this is a lower share than the 76 per cent in residential care). A much smaller proportion of CCWs than workers in all other occupations undertook any form of training or CPD, which implies that the training gap between CCWs and the rest of the workforce is set to intensify. Comparing the 2012 and 2016 percentages supports this view. The same lower CPD/training is observed among PCAs in the residential sector (Table 3.22), but not of the same scale as in Table 5.22 among CCWs.

Similar to residential care, the more specialised occupations (nurses and AHs) in home care and home support engage in greater levels of CPD and training. Some of this training/CPD will be a compulsory requirement by their professional associations. ENs show the strongest increase in training between 2012 and 2016, especially in the increasing proportion of mandatory training from 59 per cent to 73 per cent. RNs show the same pattern, but somewhat weaker than ENs. AHs give a mixed picture of more training but less CPD in 2016, whilst CCWs show less training and less CPD. There was an overall fall in CPD from 2012 to 2016 for CCWs (47 per cent in 2012 to 41 per cent in 2016) and AHs (75 per cent in 2012 to 71 per cent in 2016). There is some change in the composition of mandatory versus non-mandatory training for CCWs (non-mandatory training fell from 19 per cent in 2012 to 14 per cent in 2016) and AHs (mandatory training rose from 68 per cent in 2012 to 70 per cent in 2016).

Table 5.22: Participation in training and/or continuing professional development (CPD) by home care and home support aged care employees in the past 12 months, by occupation: 2012 and 2016 (per cent)

	RN	EN	CCW	AH	All occupations
2016					
CPD	95.4	87.1	40.6	70.9	47.8
Training:					
No training	15.8	18.5	26.5	18.7	25.0
Mandatory training	77.4	73.2	67.4	70.1	68.5
Non-mandatory training	32.5	21.3	13.6	30.9	16.3
2012					
CPD	89.8	73.8	46.5	75.1	52.5
Training:					
No training	20.6	23.7	22.5	21.7	22.3
Mandatory training	67.9	58.9	69.6	67.7	69.0
Non-mandatory training	36.7	33.7	19.2	31.2	21.8

Source: Survey of home care and home support aged care workers.
Note: Multiple response allowed, totals will not sum to 100.

Workers engage in training with a variety of aims, as illustrated in Table 5.23. The two most commonly selected aims were 'to improve skills' and 'maintain professional/occupational standards. A high proportion of workers, particularly RNs (78 per cent), selected 'to maintain professional/occupational standards' as one of their aims, and this is similar to 2012 when this share was 76 per cent. 'Meeting accreditation requirements' was a relatively popular reason for home care and home support workers undertaking training (over 40 per cent for each occupation) however this was not as high as it was for residential workers (where it was over 50 per cent for each occupation). In line with 2012, just under a quarter of CCWs nominated 'safety/health concerns' as an aim of the training they had undertaken within the last 12 months. A relatively low proportion of workers viewed training as having direct relevance to being able 'to secure a job or promotion' or 'to help get started in their job' and again this was similar in 2012.

Table 5.23: Stated aims of training undertaken by the home care and home support direct care workforce during the last 12 months, by occupation: 2016 (per cent selecting)

Aim of training	RN	EN	CCW	AH
Improve skills in current job	56.8	70.1	66.8	57.5
Develop skills generally	45.1	49.4	43.6	42.6
Maintain professional/occupational standards	77.7	72.6	53.6	56.9
Meet accreditation requirement	45.9	41.5	47.1	48.3
Safety/health concerns	12.2	13.2	24.1	18.2
Prepare for future job/promotion	7.2	3.4	7.1	8.4
Help get started in job	2.5	0.8	6.6	7.3
Other	6.9	7.4	3.6	4.2

Source: Survey of home care and home support aged care workers.
Note: Multiple response allowed, totals will not sum to 100.

In Table 5.24 it can be seen that home care and home support workers identified numerous areas in which they thought additional training was needed for their workplace in the next 12 months. The relatively high proportions of workers that identified multiple areas suggest that they believe their skills could be improved in a range of areas. In particular, for CCWs, dementia training was viewed as needed by the largest share of workers (61 per cent). Outlets also identified dementia training as most needed for CCWs (83 per cent). When compared

with the responses from CCWs, although the proportions are different, the outlet priorities are the same. The top three areas of training are dementia training, mental health and palliative care. In home care and home support mainly it was a higher proportion of RNs (41 per cent) than workers in other occupations (proportions lower than 30 per cent) that sought training in management and leadership.

Table 5.24: Areas of training identified as most needed in the next 12 months for the home care and home support direct care workforce, by occupation, comparing outlet and worker responses: 2016 (per cent)

Area of training	RN Workers	EN Workers	CCW Workers	CCW Outlets	AH Workers
Dementia training	41.8	47.4	61.0	82.7	46.7
Palliative care	35.9	48.3	29.5	28.4	17.7
Management and leadership training	40.5	19.6	20.9	12.9	28.0
Wound management	39.2	59.8	18.3	18.2	7.0
Mental health	14.5	23.8	41.4	42.6	33.2
Allied health	2.4	4.2	11.4	5.3	33.4
Other	10.5	11.1	6.1	23.3	5.8

Source: Survey of home care and home support aged care workers and Census of home care and home support aged care outlets.
Note: Multiple responses were allowed, columns do not sum to 100.

5.4 Career Paths

In order to meet the increasing preference for community-based care by older Australians, the sector needs to attract new entrants into home care and community support roles and retain them once employed. This section looks at the pathways into and out of home care and home support aged care jobs, both within the sector and within the current roles of direct care workers. This information explores the occupational backgrounds of the community workforce, when they first considered entering the direct care workforce, how long they have been in the workforce, and what their intentions are in the near future. Some of the common pathways for different occupations are identified and areas that have changed or may be of interest for future planning are highlighted. Similar to residential care, career paths can also be good indicators of the attractiveness of a sector and of the loyalty of the workforce to aged care.

5.4.1 Into Aged Care

Very few workers start their career in aged care. Table 5.25 shows that only 5 to 7 per cent of the home care and home support direct care workforce reported that aged care is their first occupation. Most home care and home support direct care workers have worked in other jobs before aged care. This aspect of the workforce was observed in 2012 as well. Nurses have a clear pathway into aged care, as 69 per cent of RNs (a smaller share than the 77 per cent of RNs in 2012) and 38 per cent of ENs had worked in a different health or social care setting such as acute care, community or other health care (roughly the same as the 43 per cent in 2012). In comparison, a relatively high proportion of CCWs have worked in quite different occupations, as 36 per cent (similar to the 38 per cent of CCWs in 2012) had a background in sales, hospitality, cleaning or clerical work (with AH 24 per cent, 21 per cent of ENs but only 8 per cent of RNs). As noted in 2012, these are areas of work that are dominated by women and often do not require post-school qualifications. AH workers also have diverse backgrounds, 15 per cent with backgrounds of other health or social care jobs and just over a quarter (27 per cent) from professional or management jobs. For CCWs and AH workers there is no dominant pathway into aged care work, as in 2012. Attracting these workers into aged care will continue to require a variety of strategies that emphasise the benefits of this work compared with their current jobs.

In 2016, disability care was added to the list of occupations. Table 5.25 shows that disability care was rarely a prior job for home care and home support nurses and only 5-6 per cent of CCW and AH workers had a disability care background. The implication is that there has not been a shift of workers from disability into aged care due to the National Disability Insurance Scheme (NDIS), which commenced in small volumes in 2013. If there is to be such a change, this will only be discernible after at least one to two years of the NDIS implementation when NDIS volumes will have increased and the various transition agreements with pre-NDIS providers will be coming to an end.

Table 5.25: Activity prior to first job in aged care of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Last occupation before first aged care job	RN	EN	CCW	AH
No previous paid employment	5.2	5.6	6.8	5.8
Nurse, acute care	53.1	23.4	1.7	1.8
Nurse, community	11.5	5.7	1.2	0.5
Other health care	4.2	8.9	4.0	12.3
Carer in other setting	0.6	5.3	5.0	2.3
Disability care	1.5	3.2	4.5	5.8
Salesperson	2.9	7.4	9.7	6.9
Clerical worker	2.0	3.8	11.2	5.6
Hospitality worker	2.2	8.1	7.2	8.2
Cleaner	0.6	1.3	7.9	3.0
Professional (other than nurse)	0.7	0.5	4.5	19.6
Manager	2.4	1.3	4.3	6.9
Other paid employment	13.2	25.4	32.0	21.3
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

Table 5.25 shows that more than 90 per cent of all home care and home support direct care workers have worked in other jobs before aged care and they join the sector at the relatively high median age of 46 for recent hires (Table 5.6). Aged care is not, therefore, a career choice of many young people. Further details on the age profile of the home care and home support workforce is provided in Table 5.26 which shows the age distribution of the workforce on entry into the sector by occupation. In 2016 55 per cent of all direct care workers were 40 years or older when they first started working in home care and home support aged care.

When broken down by occupation, the proportion of the 40 years or older is 60 per cent for CCWs, 33 per cent for AHs, 28 per cent for RNs and 29 per cent for ENs. At the other end of the age spectrum, 40 per cent of RNs, 44 per cent of ENs, 46 per cent of AH workers and just 17 per cent of CCWs began working in aged care before the age of 30. Compared with direct care workers in residential facilities, a greater share of home care and home support direct care workers start working in the sector at a later stage in life. There are no noteworthy differences between the 2012 and the 2016 proportions.

Table 5.26: Age at which began working in aged care of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Age (years)	RN	EN	CCW	AH	All occupations
21 or under	17.4	27.5	7.4	10.5	8.8
22–29	32.1	16.6	9.5	35.9	13.0
30–39	23.0	27.4	22.7	20.5	22.7
40–49	21.2	25.6	35.3	19.4	33.0
50+	6.3	2.9	25.1	13.7	22.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

The age at which workers are first employed in aged care influences the total time they can remain in the workforce. Table 5.27 shows the total time spent working in aged care across the different occupational groups on the home care and home support workforce.

About a third of RNs (34 per cent) and ENs (34 per cent), have been in aged care for more than 19 years, which is in accordance with the younger age at which they started working in aged care, compared to other occupational groups (Table 5.26). The majority of RNs and ENs have been working in home care and home support aged care for more than 9 years, demonstrating that once people come into aged care, they often stay for a considerable length of time (64 per cent and 71 per cent respectively). The lower proportion of CCWs who have been in aged care for more than 9 years (39 per cent) can be in part attributed to their older starting age (25 per cent of CCWs started working in aged care when 50 years or older, as shown in Table 5.26). On the whole, this is a very stable workforce, which may be exposed to the risk of high levels of retirement, but which sees few leakages to other sectors. Whether this picture will persist as parts of the workforce becomes younger (as we see happening in the residential workforce) and as alternative forms of similar employment becomes available through the NDIS, is a question that this data cannot answer.

Table 5.27: Total time spent working in aged care of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Total time in aged care (years)	RN	EN	CCW	AH	All occupations
1 year or less	3.0	5.3	10.3	13.0	9.8
More than 1 year–4 years	11.3	8.7	24.0	14.5	22.1
More than 4 years–9 years	21.5	15.2	26.9	22.7	25.9
More than 9 years–14 years	18.0	21.8	18.3	17.1	18.3
More than 14 years–19 years	12.7	15.1	9.0	11.3	9.6
More than 19 years	33.5	34.0	11.5	21.4	14.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

5.4.2 Into their Current Job

Aged care providers in Australia commonly express concerns regarding difficulties recruiting and retaining skilled staff. It is important, therefore, to understand the level of turnover within the home care and home support sector and the reasons why workers choose to move to a different aged care employer. This next section examines pathways into the current job held by direct care workers and finds out the extent of, and reasons for, job mobility.

Table 5.28 shows that about half of the direct care workers had worked in aged care prior to getting their current job (48 per cent). There were occupational differences, with a lower

proportion of CCWs (45 per cent in 2016 and 44 per cent in 2012) than workers in other occupations who had worked in aged care previously. While the proportion of workers who had worked in aged care on an unpaid basis was low, it appears that unpaid work is a more important pathway for CCWs (6 per cent) and AH workers (6 per cent) than for nurses (1-2 per cent).

Table 5.28: Whether had worked in aged care prior to current job of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Whether had previous work in aged care	RN	EN	CCW	AH	All occupations
Yes, paid	70.4	74.9	38.3	50.2	42.4
Yes, unpaid	0.7	1.6	6.4	6.1	5.9
No	28.9	23.5	55.2	43.7	51.7
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

In order to examine recruitment patterns among the newer worker in aged care, Table 5.29 presents the proportion of home care and home support workers who had been in the sector for up to 5 years and whether they had worked in their current outlet previously. Table 5.29 shows that a higher proportion of nurses (RNs 26 per cent, ENs 28 per cent) than CCWs (13 per cent) have worked in the outlet previously. This pattern is similar to that for residential workers but with higher shares than in residential care (RNs 19 per cent, ENs 19 per cent, PCAs 18 per cent, Table 3.29). CCWs (5 per cent) and AH workers (6 per cent) but also ENs (4 per cent) had past unpaid or voluntary work in the outlet of their current job.

Table 5.29: Whether had worked in current outlet prior to obtaining current job of home care and home support direct care workers employed in the last five years, by occupation: 2016 (per cent)

Whether had previous work in current outlet	RN	EN	CCW	AH
Yes, paid work	25.8	23.9	8.0	18.3
Yes, unpaid or volunteer work	0.6	3.9	5.2	6.1
No	73.6	72.1	86.8	75.6
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
N=2,644 (weighted).

The home care and home support aged care worker survey asked those employees who had worked in aged care previously why they left their prior job. Understanding the reasons why workers leave one job and move into another within aged care can provide insights into what may need to change to improve the retention of staff within a facility. Table 5.30 indicates that while some of the home care and home support worker turnover may be addressed at management level, other reasons may also be responsible, often related to the personal circumstances of workers.

A third of home care and home support RN and CCW workers (33 and 34 per cent respectively) cited personal reasons for leaving their last job, such as moving house, fulfilling care responsibilities or wanting a job closer to home. These reasons reflect the gender, age and other demographic characteristics of the workforce. It is female dominated (see figure 5.4) and therefore workers are more likely to bear the majority of domestic (day-to-day) responsibilities; and it is largely part-time or casual (Table 5.16) and therefore workers are less likely to be primary wage earners. These factors provide the context within which workers have to make decisions about their aged care work.

Some of the reasons for leaving a job may have to do with work conditions and work roles and may be amenable to management intervention. After moving house, five reasons were cited by home care and home support workers for leaving their previous aged care job that have to do with work conditions and work roles, namely higher pay, challenging work, get preferred hours, avoid managers, relief from stress. Together these five reasons account for more than 40 per cent of the total of workers who left their previous job (41 per cent RNs, 50 per cent ENs, 40 per cent CCWs, 47 per cent AH).There were some differences between the occupational groups in the proportions of workers citing each of these reasons. More AHs had left for higher pay (11 per cent); more ENs and CCWs left in order to get their preferred shifts or hours (20 per cent and 13 per cent respectively), and 18 per cent of RNs and 19 per cent of AH workers left in order to find more challenging work.

Table 5.30: Main reason for leaving prior aged care job of home care and home support direct care workers with previous experience in sector, by occupation: 2016 (per cent)

Most important reason	RN	EN	CCW	AH
Moved house/location	23.6	14.4	19.8	9.8
To find more challenging work	18.3	15.7	9.7	19.1
To get shifts or hours of work I wanted	8.4	19.9	12.7	5.3
To avoid managers/management I did not get along with or like	4.3	3.9	6.3	5.4
To achieve higher pay	5.6	8.9	5.9	11.2
To be closer to home	7.4	2.1	5.1	11.1
The job was too stressful	5.0	1.5	5.1	5.6
To fulfil care responsibilities (including having a baby)	2.2	8.5	9.1	7.6
Made redundant/retrenched	2.8	3.3	5.7	6.6
Not able to spend sufficient time with residents	2.4	5.8	5.1	2.4
To avoid workmates/colleagues I did not get along with or like	1.1	0.0	0.6	0.5
To find easier work	2.9	0.9	1.0	0.7
Other	16.1	15.1	14.0	15.0
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers (weighted).

Returning now from those workers who had worked in aged care previously to all direct care workers, Table 5.31 shows the proportion of the home care and home support workforce that has worked in their current jobs for various lengths of time. For all occupations, 47 per cent of the home care and home support direct care workforce has been in their job for up to 4 years (15 per cent 12 months or less and 32 per cent for more than one year and up to 4 years), which is a smaller share than reported by residential direct care workers (46 per cent, Table 3.31).

A very slightly lower proportion of workers in home care and home support outlets have been in their jobs for longer than 9 years (24 per cent, which is higher than the 20 per cent in 2012) than direct care workers in residential facilities (26 per cent, which is slightly lower than their 24 per cent in 2012).

Table 5.31: Tenure in current job of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Tenure in current job (years)	RN	EN	CCW	AH	All occupations
12 months or less	9.8	23.1	14.3	20.7	14.5
More than 1 year–4 years	30.7	20.5	33.1	27.9	32.3
More than 4 years–9 years	30.5	24.7	28.9	26.5	28.8
More than 9 years	29.0	31.7	23.7	25.0	24.4
Total	**100**	**100**	**100**	**100**	**100**

Source: Census of home care and home support aged care workers.

5.4.3 Into the Future

In this section the focus is on the future intentions of home care and home support workers. Intentions to leave a job have been shown to have a significant impact on actual turnover in aged care (King et al., 2013). The 2016 survey therefore asked direct care workers whether they planned to stay in their current jobs and the future work plans of those seeking a change.

Table 5.32 presents those who are actively seeking alternative work by occupation and tenure. It shows that in 2016 around 9 per cent of home care and home support direct care workers were actively seeking work at the time of the survey, which is largely unchanged from 2012 (8 per cent). This varies across occupational groups, with slightly higher proportions of AH workers (11 per cent) seeking work than other occupations. Across the workforce, intentions to leave are lowest for workers who have been employed in their current job for more than 9 years. Two sub-groups appear to differ in Table 5.32 with relatively high proportions of job seeking (RNs who have been in their jobs for 4 to 9 years, at 16 per cent, and AH workers who have been in their jobs for 1 to 4 years, at 15 per cent).

Table 5.32: Proportion of the home care and home support direct care workforce actively seeking work by occupation and tenure in current job: 2016 (per cent)

Tenure in current job (years)	RN	EN	CCW	AH	All occupations
12 months or less	11.4	5.7	7.2	10.1	7.7
More than 1 year–4 years	8.5	9.1	10.9	15.3	10.9
More than 4 years–9 years	15.7	11.6	9.2	9.9	9.8
More than 9 years	3.5	4.0	5.1	9.8	5.2
All years	9.5	7.3	8.5	11.4	8.7

Source: Survey of home care and home support aged care workers.

What workers thought they would be doing in 12 months is shown in Table 5.33, which indicates that in 2016 the vast majority (81 per cent, slightly more than the 82 per cent in 2012) expect to be working for their current employer. Indeed, around 83 per cent of RNs, 81 per cent of ENs and CCWs, and 74 per cent of AH workers thought they would be staying in their current job. The next large group was those who did not know what they would be doing (between 9 and 16 per cent). A small proportion (2 per cent) of the existing workforce is intending to leave aged care completely (although there was a fairly high share of home care and home support direct care workers who did not know where they would be in 12 months, 12 per cent).

Table 5.33: Expected activity in 12 months of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Expected activity in 12 months	RN	EN	CCW	AH	All occupations
Working in aged care, this outlet	82.4	80.5	80.9	73.5	80.6
Working in aged care, different outlet	3.6	0.7	2.2	3.8	2.4
Working in residential aged care	0.1	2.1	0.7	1.1	0.7
Working in disability care	0.0	0.0	0.7	0.8	0.6
Working, but not in aged care	2.9	4.5	2.2	4.7	2.4
Not working for pay	2.5	1.6	0.9	0.8	1.0
Don't know	8.5	10.6	12.4	15.4	12.2
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

5.5 Experiences of Working in Home Care and Home Support Aged Care

Aged care employees work in the sector for a variety of reasons including enjoyment of care work, wanting to make a difference in the lives of older Australians, financial imperatives, and to enable an effective work-life balance. Findings from the previous aged care worker surveys in 2007 and 2012 indicated widespread job satisfaction amongst the home care and home support workforce. The next section of this report investigates worker experiences of home care and home support work in 2016.

As in the corresponding earlier Section 3.5 for residential care workers, this section presents job satisfaction data in two separate Tables 5.34 and 5.35. These tables show responses to questions that were ordered in a scale form, whereby respondents answered on a scale from 1–10 in Table 5.34 and from 1–7 in Table 5.35. The discussion needs to be interpreted according to the framework set out and described earlier in Section 3.5.1, including the limitations due to the use of an ordinal measure of job satisfaction.

5.5.1 Job Satisfaction

In this section we examine the range of factors that contribute to job satisfaction. The home care and home support worker survey form asked workers to rate their satisfaction with aspects of their work on a 10-point scale with the range of 1 (totally dissatisfied) and 10 (totally satisfied). Average scores from these responses are shown in Table 5.34.

The overall job satisfaction score is 8.1 in 2016, roughly equivalent to the score in 2012 of 8.2, indicating widespread job satisfaction with direct care work. CCWs are slightly more satisfied overall (8.2) than nurses or AH workers (7.8 each). Satisfaction with total pay has risen to 6.3 in 2016 from 5.6 in 2012 (this is also higher for home care and home support workers than the 5.6 for residential workers Table 3.34). Home care and home support direct care workers are slightly more satisfied with their work overall (8.1) than those in residential facilities (7.9). It is interesting that the highest scores are found for 'the work itself', the 'hours worked' and the 'flexibility to balance work and non-work commitments', all of which can be used as, at least partial, explanations for the high retention of the home care and home support sector.

Table 5.34: Average scores for responses from the home care and home support direct care workforce to statements about job satisfaction, by occupation: 2016 (range 1-10)

Satisfaction with	Nurse	CCW	AH	All occupations
Total pay	6.7	6.2	6.4	6.3
Job security	7.0	7.1	6.7	7.1
The work itself	8.0	8.2	7.8	8.1
Hours worked	7.7	7.3	8.0	7.4
Opportunities to develop abilities	7.2	7.3	6.8	7.3
Level of support from your team/service provider	7.6	8.0	7.4	7.9
Level of support from your supervisor	7.7	8.1	7.5	8.0
Flexibility to balance work and non-work commitments	7.4	8.0	7.4	7.9
Overall satisfaction	7.8	8.2	7.8	8.1

Source: Survey of home care and home support aged care workers.
Scale used is 1(totally dissatisfied) to 10 (totally satisfied).

5.5.2 Doing the Work

Home care and home support workers responded to a number of statements about 'doing' care work in the worker survey questionnaire. For each statement, they were asked the extent to which they agreed this to be the case for them, and they could give a score on a scale of 1 (totally disagree) to 7 (totally agree), with 4 being considered the midpoint. Although subjective, these assessments of their work are important indicators of what they would like changed and their confidence in performing the work.

Table 5.35 reports the average scores for each statement by occupation. Home care and home support direct care workers agree most strongly with statements about having skills (statement 2: average score of 6.3), using these skills in their current job (statement 3: 6.1) and the availability of adequate workplace training (statement 4: 5.6). Residential workers also agreed most strongly with these three statements. Average scores on pressure to work harder (statement 6: 3.3) and stress (statement 7: 3.2) were the lowest scores reported, indicating disagreement.

Overall, home care and home support direct care workers had lower average scores than residential workers for statements about pressure/stress indicating they on average disagreed with the statement (statement 6: 4.2 residential workers Table 3.35, 3.3 home care and home support workers; statement 7: 4.0 residential workers Table 3.35, 3.2 home care and home support workers). Having sufficient time to care (statement 1) was more commonly agreed with by home care and home support workers (average score 5.1) than by residential workers who on average disagreed with this statement (average score 3.9 Table 3.35). Having job freedom (statement 5: 5.0) and receiving respect (statement 8: 5.2) are slightly higher than for residential workers (4.6 and 4.9, Table 3.35).

On the whole these satisfaction statements reflect a hard-working workforce, confident in their skills and the way these skills are utilised in their workplace, willing to take on challenges, who like a lot what they are doing, but who are at the same time feeling under pressure regarding some aspects of their jobs.

Table 5.35: Average scores for responses from the home care and home support direct care workforce to statements about their work, by occupation: 2016 (range 1-7)

Statement	Nurse	CCW	AH	All occupations
I am able to spend enough time with each care recipient	4.8	5.2	4.9	5.1
I have the skills and abilities I need to do my job	6.0	6.3	6.2	6.3
I use many of my skills and abilities in my current job	5.8	6.1	5.9	6.1
Adequate training is available through my workplace	5.2	5.7	5.0	5.6
I have a lot of freedom to decide how I do my work	5.2	4.9	5.4	5.0
I feel under pressure to work harder in my job	4.3	3.2	4.1	3.3
My job is more stressful than I had ever imagined	3.8	3.1	3.6	3.2
Considering all my efforts and achievements I receive the respect and acknowledgement I deserve	4.9	5.2	4.8	5.2
Management and employees have good relations in my workplace	5.0	5.4	5.0	5.3

Source: Survey of home care and home support aged care workers.
Scale used is 1(strongly disagree) to 7 (strongly agree).

It is widely acknowledged by care workers that one of the most rewarding and, at the same time, challenging aspects of the job is the time spent actively caring for clients. Table 5.36 shows that in 2016, 61 per cent of direct care workers in home care and home support outlets spend more than two-thirds of their shift actively caring (slightly more than the 59 per cent in 2012). CCWs (68 per cent) are the dominant occupational group who spend more than two-thirds of their shift actively caring. Far fewer of nurses (35 per cent of ENs and 28 per cent of RNs) and AH workers (25 per cent) spend this much time with their clients.

The amount of time spent actively caring is lower for all occupations in home care than in residential facilities (especially CCWs at 68 per cent Table 5.36, compared to residential PCAs at 77 per cent, Table 3.36).

Table 5.36: Responses of the home care and home support direct care workforce to the question 'In a typical shift, how much time do you spend actively caring for care recipients?', by occupation: 2016 (per cent)

Time spent caring	RN	EN	Nurse*	CCW	AH	All occupations
Less than one-third	35.2	27.8	33.6	18.1	38.1	20.9
Between one-third and two-thirds	36.4	37.1	36.6	14.4	36.5	18.0
More than two-thirds	28.4	35.0	29.8	67.5	25.4	61.1
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
**Nurse combines RN and EN.*

Workers in the home care and home support aged care sector may also provide care to younger people with disability. As Table 5.37 shows, 33 per cent of nurses, 37 per cent of AH workers and 45 per cent of CCWs work solely with aged clients[8]. A further 41 per cent of workers across all occupational groups report that between 75 and 99 per cent of their clientele are aged care clients. The remaining workers have more variety in the type of clients they care for.

[8] Aged clients are non-Indigenous people aged 65 years or over and Indigenous Australians aged 50 years and older.

Table 5.37: Distribution of the proportion of aged clients cared for by home care and home support direct care workers, by occupation: 2016 (per cent)

% of aged clients* cared for	Nurse	CCW	AH	All occupations
Less than 50% aged clients	3.1	7.1	9.6	6.8
50–74	11.8	8.1	14.2	8.8
75–99	52.1	39.4	38.8	40.7
100% aged clients	33.0	45.4	37.4	43.6
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.
**Aged clients are non-Indigenous people aged 65 years or over and Indigenous Australians aged 50 years and older.*

An important aspect of the functioning of a workplace is the degree to which workers get along with their managers and colleagues. Dissatisfaction with this aspect of the workplace leads to lower job satisfaction, poorer staff retention and is generally associated with worse career progression, outcomes and lower quality of production. Information from workers about their relationships with management and colleagues were separately recorded in Tables 5.38 and 5.39. Most workers report that positive relationships with their management (an average of 85 per cent in Table 5.38) and even more believe that their relationship with colleagues is good (91 per cent in Table 5.39). Table 5.38 shows that CCWs are the most satisfied with the quality of management relationship (86 per cent) followed by nurses (82 per cent) and AH workers (81 per cent). Table 5.39 shows that AHs are the most satisfied with their colleagues (96 per cent) followed by nurses (93 per cent) and CCWs (91 per cent). The overall picture of the sector is one of very good workplace relationships, which is also shown by other related measures of the quality of the job and the workplaces.

Table 5.38: Home care and home support direct care workforce assessment of the quality of workplace relationships 'between management and yourself', by occupation: 2016 (range 1–7)

	Nurse	CCW	AH	All occupations
Bad	8.2	5.5	10.1	6.0
Neither good nor bad	10.4	8.8	9.0	9.0
Good	81.5	85.8	80.9	85.0
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers, 2016.
Scale used is 1 (very bad) to 7 (very good).

Table 5.39: Home care and home support direct care workforce assessment of the quality of workplace relationships 'between workmates/colleagues and yourself', by occupation: 2016 (range 1–7)

	Nurse	CCW	AH	All occupations
Bad	1.5	2.9	0.8	2.6
Neither good nor bad	5.5	6.5	3.4	6.3
Good	92.9	90.6	95.8	91.1
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers, 2016.
Scale used is 1 (very bad) to 7 (very good).

5.5.3 Job Demands

The home care and home support outlet census form asked questions about the prevalence of unusual job demands that may be made of their workers, shown in Table 5.40. Two types of demands are considered, those that are made under normal circumstances and those that are made only in exceptional circumstances. Such demands may be perfectly justifiable from the point of view of the aged care clients who themselves may face life uncertainties, as it will be perfectly understandable that the employers and the workers will be willing to provide the necessary support. However, they inevitably create an element of uncertainty in organising the workplace for employers and in organising working hours for employees. Especially for smaller size employers where substitutes may not be easy to find, such demands may make it difficult for employees to plan their workload and to meet their non-work responsibilities at the same time.

Of the five unusual job demands listed, the most widely made demand under normal circumstances is to vary hours or location at short notice (36 per cent of outlets). This is slightly higher than the 32 per cent reported in 2012. Working longer than scheduled due to unanticipated needs of clients occurred under normal circumstances for workers in 14 per cent of outlets.

As with residential facilities, in home care and home support outlets the most prevalent job demands are related to unanticipated changes in work patterns, working longer than scheduled or varying hours or location at short notice. While the majority of outlets who make these demands indicated that it was only done in exceptional circumstances, slightly more than a third of outlets (36 per cent) vary hours or location at short notice under normal circumstances, and 14 per cent normally ask employees to work longer than scheduled hours because of unanticipated needs of residents. These demands create an element of uncertainty in working hours for employees and may make it difficult for them to plan their workload or meet their non-work responsibilities.

There are 62 per cent of outlets which in exceptional circumstances ask their direct care employees to work with aggressive service users, with 11 per cent doing so under normal circumstances (both slightly different shares than in 2012 when they were 53 per cent and 16 per cent). Given that most home care and home support direct care workers work alone, the need to visit aggressive service users could raise concerns about safety issues.

Table 5.40: Prevalence of unusual job demands in home care and home support outlets: 2016 (per cent)

Job demand	Under normal circumstances	In exceptional circumstances	Never	Total
Working longer than scheduled because of unanticipated needs of clients	13.7	70.7	15.7	**100**
Variations in hours or location at short notice	35.9	48.0	16.2	**100**
Working in very unsanitary conditions	1.7	29.5	68.8	**100**
Working with aggressive service users	10.8	62.1	27.1	**100**
Working alone late at night (after 10 pm)	7.2	15.3	77.6	**100**

Source: Census of home care and home support aged care outlets.
Row percentages shown. Per cent of outlets.

5.6 Work-related Injury and Illness

Within home care and home support the type of work performed and the environment in which it occurs is different to the services provided in a residential aged care setting. Workers often work alone rather than in teams, they work in the private homes of service users rather than in a managed facility, and they can only influence the health and well-being of clients for short

periods of time rather than being able to have them under constant surveillance. This diversity of working environments and the lack of the explicit structure that a single physical workplace can offer, means that home care and home support workers are often exposed to work-related risks in their work that could impact on their own health and safety. The additional questions that were first introduced in 2012 about workplace injuries and illnesses in both the employer census and the workers survey, were continued in 2016. This section presents the findings from both sources.

Table 5.41 shows the types of work-related injuries and illnesses that were reported by outlets and workers separately and independently. These percentages reported by outlets and by workers are not directly comparable, as the outlet ones refer to the incidents for *all workers* in this outlet and the worker ones refer to only the *one worker* who is responding. Further, the outlets refer to the last three months while the worker refers to the last 12 months.

There were no work related incidents reported in the 3 months leading up to the census for 52 per cent of outlets. Of those outlets with incidents, the most commonly reported injuries were sprains and strains (59 per cent), superficial injuries (30 per cent), chronic joint or muscle conditions (26 per cent) and stress or other mental condition (18 per cent).

Twelve per cent of all workers reported a work-related injury or illness had occurred to them in the last 12 months. The most commonly reported incidents (by those who reported one) were similar to those reported by outlets: sprains and strains (43 per cent), chronic joint or muscle conditions (22 per cent), stress and other mental conditions (18 per cent), and superficial injuries (14 per cent). A further 2 per cent of all workers (and 19 per cent of those workers who reported an incident) indicated that they had experienced 'other' (unspecified) injuries or illnesses as a consequence of their work.

Table 5.41: Types of reported work-related injuries and illnesses, comparing outlets and workers: 2016 (per cent)

Type of injury/illness	Outlets (last 3 months)		Workers (last 12 months)	
	All outlets	With any incidents	All workers	Who reported incidents
None reported	51.6	n/a	87.6	n/a
Fracture	2.5	6.7	0.4	3.5
Chronic joint or muscle condition	9.9	26.2	2.5	21.6
Sprain/strain	22.2	58.5	5.0	43.2
Cut/open wound	4.9	12.8	1.0	8.7
Crushing injury/internal organ damage	0.2	0.4	0.1	0.7
Superficial injury (minor)	11.4	30.0	1.6	13.5
Stress or other mental condition	6.9	18.1	2.1	18.1
Amputation	0.0	0.0	0.0	0.0
Burns	2.3	6.0	0.6	5.2
Other	3.8	10.0	2.2	19.3

Source: Census of home care and home support aged care outlets.
Note: Multiple response allowed, columns will not sum to 100.

It is important to understand better the causes of reported injuries, as both employers and employees wish to see their prevalence reduced. Table 5.42 shows the causes of reported work-related injuries and illnesses for home care and home support outlets and workers. For the 48 per cent of home care and home support outlets that had any incident in the last 3 months, the four main causes are: lifting, pushing, pulling and bending (54 per cent); a fall (29 per cent); hitting or being hit or cut by a person, object or vehicle (19 per cent); and repetitive movement (19 per cent). These were similar to the causes identified by workers who reported incidents in the last 12 months: lifting, pushing, pulling and bending (39 per cent); a fall (17

per cent), repetitive movement (9 per cent). Both outlets (15 per cent) and workers (13 per cent) indicated that a substantial minority of work-related injuries and illnesses were due to 'other' causes.

Table 5.42: Causes of reported work-related injuries and illnesses, comparing outlet and worker responses: 2016 (per cent)

Cause of injury/illness	Outlets (last 3 months)		Workers (last 12 months)	
	All outlets	With any incidents	All workers	Who reported incidents
None reported	51.6	n/a	87.6	n/a
Lifting, pushing, pulling, bending	20.6	54.2	3.7	39.1
Repetitive movement	7.3	19.2	0.9	9.4
Prolonged standing, working in cramped or unchanging positions	0.8	2.1	0.1	1.0
Vehicle accident	6.3	16.7	0.3	2.9
Hitting, being hit or cut by person, object or vehicle	7.1	18.8	0.7	7.3
Fall	10.8	28.5	1.6	17.0
Exposure to mental stress	4.4	11.6	0.5	5.5
Long term exposure to sound	0.2	0.4	0.0	0.0
Contact with chemical of substance	1.0	2.7	0.1	1.6
Fatigue	1.3	3.5	0.3	3.3
Other	5.8	15.2	1.2	13.0

Source: Census of home care and home support aged care outlets.
Note: Multiple response allowed, columns will not sum to 100.

The extent to which Workcover is used by outlets and workers provides an indication of the seriousness of reported occupational injuries and illnesses. Table 5.43 shows that 26 per cent of outlets had one or more employee on Workcover in the designated fortnight, slightly more than the 24 per cent in 2012. Reflecting the relative sizes of each occupation, most outlets had Workcover cases for CCWs. The 25 per cent of outlets that had CCWs on Workcover, used it for an average of 2 CCWs; while the 1 per cent of outlets using Workcover for RNs had an average of 2.5 RNs on Workcover during the designated fortnight.

Table 5.43: Proportion of outlets with employees on Workcover (per cent) and, of these, the mean number of employees per outlet on Workcover during the designated fortnight: 2016

Occupation	Outlets using Workcover (%)	Employees (average per outlet)
Registered Nurse	1.4	2.5
Enrolled Nurse	0.9	1.5
Community Care Worker	24.5	2.0
Allied Health	1.1	1.2
All occupations	26.3	2.1

Source: Census of home care and home support aged care outlets.

5.7 Cultural and Linguistic Diversity

Cultural and linguistic diversity is an important aspect of aged care provision in Australia in terms of both the demand and the supply of aged care services. Currently around a fifth of older Australians are of culturally and linguistically diverse origin and within the next five years it is expected that more than 30 percent of this cohort will have been born overseas (Department of Social Services, 2015). On the demand for services side, service users often prefer or even require the supports that can be afforded by culturally and linguistically sensitive and well equipped service providers. On the supply of services side, some of the labour and skill shortages that are often felt in the Australian health, care, and related services sectors can be addressed by hiring recent migrants. The aged care sector is culturally and linguistically diverse in both these demand and supply perspectives. This section explores the experiences of workers from culturally and linguistically diverse backgrounds in home care and home support aged care.

The next three tables (Tables 5.44 – 5.46) relate only to those respondents to the home care and home support survey who identified that they are fluent in a language other than English. An important aspect of service provision within aged care is the ability to speak fluid English. Table 5.44 shows that a relatively high proportion of workers in home care and home support aged care are most fluent in English although this varies by occupation. Most RNs (73 per cent) and ENs (85 per cent) are most fluent in English, although a substantial minority speak both English and their primary language equally well (12 and 15 per cent respectively). About two thirds of the AH workers are most fluent in English (68 per cent), with another 21 per cent speaking both English and their primary language equally well. For CCWs, 39 per cent speak both languages equally well, with 43 per cent most fluent in English. Of all the occupational groups, CCWs have the highest proportion that is most fluent in LOTE (19 per cent).

Table 5.44: Fluency in a language other than English (LOTE) of the home care and home support direct care workforce, by occupation: 2016 (per cent)

Speak LOTE, most fluent in	RN	EN	CCW	AH
English	73.1	84.8	42.5	68.2
LOTE	14.9	0.0	18.9	10.7
Both equally well	12.0	15.2	38.6	21.1
Total	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers (weighted).

The use of a language other than English in the workplace was far more commonly reported by workers in home care and home support than in the residential sector. As shown in Table 5.45, 67 per cent of home care and home support workers who are fluent in a language other than English use it in their work. This compares to only 39 per cent of direct care workers based in residential facilities (Table 3.44). Of the occupational groups, a higher proportion of ENs (74 per cent) and AH (76 per cent) than other occupations use these language skills in their work.

Table 5.45: Use of language other than English (LOTE) by the home care and home support direct care workforce, by occupation: 2016 (per cent)

Speak LOTE and	RN	EN	CCW	AH	All occupations
Use LOTE in job	58.1	74.0	66.7	76.3	66.8
Do not use LOTE in job	41.9	26.0	33.3	23.7	33.2
Total	**100**	**100**	**100**	**100**	**100**

Source: Survey of home care and home support aged care workers.

Workers who were fluent in a language other than English were asked in the survey form to assess their skills in reading, writing and speaking English. Of the three areas of English literacy, workers are most confident in their ability to speak and read in English (Table 5.46). Slightly more than a quarter of home care and home support direct care workers who speak a language other than English assessed their fluency in writing in English as 'not very well' (26 per cent). This could be viewed as a concerning percentage of workers particularly around service provision where they are expected to undertake important medication or recording roles. As in residential aged care (Table 3.45), writing was viewed as the area in which these home care and home support workers are least fluent in English. As provision becomes more complex with time (older clients and more stringent formal education requirements) this share with low capacity in written English may not be able to continue to be part of the workforce.

Table 5.46: Subjective assessment of English literacy for home care and home support direct care workers most fluent in a language other than English (LOTE): 2016 (per cent)

English literacy	Not at all	Not very well	Well	Very well	Can't say	Total
Speaking	0.8	11.6	55.1	32.6	0.0	**100**
Reading	0.3	10.7	49.7	39.4	0.0	**100**
Writing	0.5	25.9	49.6	24.0	0.0	**100**

Source: Survey of home care and home support aged care workers.

Information provided by outlets about the CCWs they employ who come from culturally and linguistically diverse (CALD) backgrounds are shown in Tables 5.47 to 5.50. CCWs are of special interest because they are the largest occupational group in home care and home support aged care (in 2016 there are over 72, 000 CCW workers, 84 per cent of the home care and home support direct care workforce, Table 5.2).

Table 5.47 shows that 31 per cent of all outlets had no CCWs from CALD backgrounds (slightly fewer than the 35 per cent in 2012). Another 39 per cent of outlets indicated that CCWs from diverse backgrounds comprised between 1 and 33 per cent of their CCW workforce. This indicates that the employment of CCWs from CALD backgrounds is widespread and goes beyond those outlets that provide specialised services to particular groups. However, the employment of CCWs from CALD backgrounds is not as widespread as in residential facilities (where 12 per cent of residential facilities had zero, Table 3.46, compared to 31 per cent of home care and home support outlets, Table 5.47).

Table 5.47: Distribution by proportion of community care workers (CCWs) from CALD backgrounds in home care and home support outlets: 2016 (per cent)

% of CALD CCWs per outlet	Outlets
Zero	30.8
1–33	38.9
34–66	14.4
67–100	15.9
Total	**100**

Source: Census of home care and home support aged care outlets.

Home care and home support outlets were asked in the census about the benefits of employing CCWs from CALD backgrounds. As shown in Table 5.48, all outlets indicated that they received benefits from hiring these workers. Of these benefits, the opportunity to enhance cross-cultural understandings (85 per cent) and the use of language skills (other than English skills (68 per cent) were cited most frequently.

Table 5.48: Stated benefits of employing community care workers (CCWs) from CALD backgrounds in home care and home support outlets: 2016 (per cent)

Benefits	Outlets
No benefits	0
Stated benefits:	
Enhance cross-cultural understandings	84.7
Offer different cultural activities	50.0
Language (other than English) skills	67.6
Link clients to ethnic communities	49.5
Link outlet to ethnic communities	47.7
Other	5.3

Source: Census of home care and home support aged care outlets.
Note: Multiple response allowed, column will not sum to 100.

Outlets that employ CCWs from CALD backgrounds were asked to nominate the most common ethnic or cultural background of those workers. Table 5.49 shows that 72 per cent of all home care and home support outlets employed CCWs who spoke a language other than English (this is much higher than in 2012 when it was 52 per cent). Of those outlets that did employ CCWs who spoke a language other than English (column 2), the most common languages spoken were Italian (16 per cent) and South East Asian (11 per cent). For home care and home support outlets with more than a third of CCWs speaking a language other than English (column 3), Chinese, Italian and South East Asian were the three most widely spoken language groups.

Table 5.49: Proportion of home care and home support outlets that employ community care workers (CCWs) from CALD backgrounds: 2016 (per cent)

Ethnic group	All outlets	Outlets with any CCWs speaking LOTE	Outlets with >33% CCWs speaking LOTE
At least one CCW from a linguistically diverse background	72.1	n/a	n/a
None	27.9	n/a	n/a
Indian[1]	5.4	7.7	5.2
Filipino	6.5	8.8	5.2
African	4.0	5.7	3.2
Pacific Islander	2.5	3.6	0.5
Chinese	6.5	8.9	14.0
Italian	11.2	15.6	13.0
Greek	4.1	5.8	5.9
South East Asian	8.0	11.1	11.1
Other	23.8	32.9	42.0
Total	**100**	**100**	**100**

Source: Census of home care and home support aged care outlets.
[1]Includes Hindi and other languages spoken in India and Sri Lanka.

While Table 5.50 indicates that managing a multilingual workforce can in some instances present challenges, the majority (80 per cent) of home care and home support outlets indicated no difficulty in employing CCWs who speak a language other than English. Of those home care and home support outlets reporting difficulties, the main concerns focused on communication with management/staff (73 per cent) and communications with clients (63 per

cent). Other stated difficulties such as ‘occupational health and safety’ (37 per cent) and ‘communicating with client families’ (43 per cent) were identified by fewer outlets, but still a reasonably high share.This is in contrast to residential aged care, where communication with residents was the main reported area of concern (88 per cent, Table 3.49),

Table 5.50: Stated difficulties of employing community care workers (CCWs) who speak a language other than English in home care and home support outlets: 2016 (per cent)

Difficulties	Per cent of outlets
No difficulties	80.0
At least one difficulty	20.0
Stated difficulties (% of outlets stating difficulties)	
Occupational health and safety	37.4
Communication with management and/or other staff	72.9
Communication with clients	63.0
Communication with client families	42.5
Other – written communication	20.3

Source: Census of home care and home support aged care outlets.
Note: Multiple response allowed, column will not sum to 100 N=1391 outlets.

6. The Census of Home Care and Home Support Outlets

Key Findings

- Sixty per cent of home care and home support direct care workers were located in major cities, with a further 36 per cent in regional areas. Since 2012, the proportion of the total PAYG home care and home support workforce based in Victoria increased from 23 per cent to 33 per cent.

- Seventy per cent of PAYG home care and home support workers were employed in the not-for-profit sector and 20 per cent in government outlets. The proportion of workers employed in for-profit outlets has increased since 2012.

- Fourteen per cent of all PAYG employees and a quarter of direct care workers were employed in very small outlets (with 1 to 5 employees).

- Employment numbers in larger outlets (more than 40 PAYG staff) have grown since 2012, particularly for direct care employment.

- Commonwealth Home Support Program (64 per cent) and Home Care Packages Program (45 per cent) services were most commonly provided by outlets. Smaller outlets with 1-5 direct care staff commonly provided CHSP services (28 per cent), while large (21-40 direct care staff) and very large (more than 40 direct care staff) outlets often provided Home Care Packages (53 per cent).

- Sixty one per cent of home care and home support outlets belonged to a larger provider group. Thirteen per cent of outlets also offered residential aged care.

- Forty three per cent of outlets catered for a specific ethnic or cultural group, most frequently Aboriginal and Torres Strait Islander and Italian older adults.

- Almost half of outlets with direct care staff reported skill shortages; a shortage of CCWs was most common and skill shortages were more prevalent in very remote areas. The main reasons for these skill shortages were a lack of suitable applicants (72 per cent), the geographical location of the outlet (39 per cent) and slow recruitment processes (28 per cent).

- Outlets primarily responded to skill shortages by requiring existing staff to work longer hours (55 per cent), providing on-the-job training (37 per cent) and making greater use of agency staff (29 per cent).

- Vacancies were most frequently reported for CCW positions (by 25 per cent of outlets). These outlets had an average of 3.6 CCW vacancies. The average time taken to fill vacancies was 4.1 weeks for CCW positions and 4.7 weeks for RNs.

- The most common reasons for staff vacancies were resignation (63 per cent), creation of a new position (33 per cent) and retirement (21 per cent).

- Internet job advertisements (36 per cent) and a combination of internet and newspaper advertisements (30 per cent) were the most frequent recruitment strategies for CCW positions by outlets.

- For workers seeking employment in home care and home support outlets, internet job advertisements and word-of-mouth were the most common strategies used. The use of recruitment agencies was also reported by 14 per cent of nurses and 13 per cent of AH workers.

- Fifty nine per cent of home care and home support outlets used Enterprise Agreements to set employment conditions for their staff; 39 per cent of outlets used award-based arrangements.

- Seventy per cent of all outlets provided paid time for travel between care appointments; 48 per cent provided a petrol/depreciation allowance for work-related transport costs.

- Twenty seven per cent of outlets reported employing at least one non-PAYG worker (mainly CCWs, 21 per cent) in the designated census fortnight. Brokered staff (15 per cent and agency workers (12 per cent) were most commonly used.

- There were 44,879 estimated volunteers working in home care and home support outlets in 2016. About half (51 per cent) of all outlets had one or more volunteers who mainly assisted with social/group activities and transport.

- Multiple methods of quality monitoring in home care and home support outlets were reported including monitoring by managers or supervisors (78 per cent), keeping records of service user feedback (66 per cent) and undertaking client surveys (52 per cent).

6.1 Introduction

This chapter provides details of the key characteristics of home care and home support aged care outlets in Australia with information predominantly based on the census of home care and home support aged care outlets (N=2,307).

We begin the chapter with an overview of the reforms which have occurred in the sector since the last NACWCS was undertaken in 2012 and the aged care programs which are now provided by home care and home support outlets. A profile of home and community support outlets showing the distribution of their employees across all states and territories, and information regarding the programs offered is presented. The relationship that home care and home support outlets have with broader aged care services and whether these facilities cater for specific ethnic or cultural groups are then discussed. The next sections of the chapter examine the extent of, reasons for, and responses to skills shortages and staff vacancies within the sector. The industrial methods used by outlets to set employment conditions and the use of non-PAYG staff are then explored. The chapter finishes with a focus on how quality of care is monitored in community-based aged care.

6.1.1 Home Care and Home Support Aged Care Programs

Home care and home support outlets provide a range of aged care services delivered usually at the home of the aged care client. There has been significant reform to the way home care and home support aged care is delivered to consumers including the introduction of the new Home Care Packages Program, Commonwealth Home Support Program and the Consumer Directed Care model of care provision.

In this 2016 report we cover and report by these specific programs of services:

- Commonwealth Home Support Program
- Home Care Packages Program
- Home and Community Care in Victoria
- Home and Community Care in Western Australia
- Home Care places under Multi-Purpose Service Program/National Aboriginal and Torres Strait Islander Flexible Aged Care Program/Innovative Pool Program
- DVA Community Nursing, Veteran's Home Care or other DVA administered program[9]

[9] While DVA programs were not part of the in-scope lists, some in-scope outlets also provide services under the DVA programs.

- Transition Care Program

These programs are described below and where relevant, previous programs that have now been replaced are noted.

Home Support Programs

Home support programs provide entry-level support services for frail, older people aged 65 years and older (or 50 years and older for Aboriginal and Torres Strait Islander people) who need assistance to keep living independently at home and in their community. In 2015–16 these services were delivered in most states and territories through the Commonwealth Home Support Program (CHSP). Over the same time period, within Victoria and Western Australia the jointly funded and state-operated Home and Community Care (HACC) programs continued operating.

The CHSP was introduced by the Australian Government on 1 July 2015 to provide streamlined access to services through the consolidation of four former Commonwealth-funded aged care programs. These programs include the Commonwealth Home and Community Care (HACC) program[10], the National Respite for Carers Program (NRCP), the Day Therapy Centres (DTC) program and the Assistance with Care and Housing for the Aged (ACHA) program.

The CHSP provides a range of services to older Australians including:

- transport
- social support
- assistance with food preparation in the home and delivery of meals
- nursing care and personal care
- allied health services like podiatry, physiotherapy and speech pathology
- domestic assistance including help with cleaning, washing and shopping
- support for carers including respite services
- home maintenance and modifications.

Home Care Packages Program

The Australian Government recognises that many older people want to remain living independently in their own homes for as long as possible. To support this, the Government subsidises packages to provide home-based care that can improve older Australians' quality of life and help them to remain in their homes and connected to their communities. Under a home care package, a range of personal care, support services, clinical services and other services is tailored to meet the assessed needs of the consumer.

On 1 August 2013 the Home Care Packages Program replaced the former community packaged care programs – Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACH-D) packages. Subsequently, from 1 July 2015, all home care packages were required to be delivered on a consumer directed care (CDC) basis. CDC provides greater transparency to consumers about what funding is available under their package and how those funds are spent through the use of an individualised budget. CDC also aims to give a consumer more choice and flexibility about the types of care and services they access and how the care is delivered to best meet their needs.

Eligibility and the level of Home Care Package an older person can receive is determined through an assessment by an Aged Care Assessment Team (ACAT). The Home Care

[10] Except in Victoria and Western Australian where the joint Commonwealth-State HACC programs continued to operate separately to the CHSP in 2015–16.

Packages Program provides four levels of packages, each with a different associated subsidy amount:

- Home Care Level 1 – to support people with basic care needs
- Home Care Level 2 – to support people with low level care needs
- Home Care Level 3 – to support people with intermediate care needs
- Home Care Level 4 – to support people with high care needs.

Multi-Purpose Service Program

The Multi-Purpose Service Program is a joint initiative between the Australian Government and all states and territories (except the ACT). The program recognises that the delivery of some health and aged care services may not be viable in rural and remote communities if they are provided separately. Through the use of pooled funding arrangements, Multi-Purpose Services deliver a mix of aged care, health and community services in rural and remote communities. In general, these services are operated by state, territory, and local governments.

Innovative Pool Program

The Innovative Pool Program (also known as the Innovative Care Program) provides opportunities to develop and test flexible models of service delivery to provide care where mainstream aged care services may not be appropriate for a specific location or target group. This program aims to allocate aged care places to services who will work with client groups for whom current service provision is limited or to client groups which are newly-emerging.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Services funded under this program provide culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to home and community. The program allows the provision of both residential and home care services mainly in rural and remote areas.

Transition Care Program

The Transition Care Program enables older people to return home after a hospital stay, rather than prematurely entering a residential aged care home. A person can only enter transition care directly after being discharged from hospital. The program provides time-limited, goal-oriented and therapy-focused packages of services to older people after a hospital stay.

Department of Veterans' Affairs Programs

Veterans' Home Care (VHC) is a DVA-funded program designed to assist eligible veterans and war widows/widowers who need a small amount of practical help to continue living independently in their own home. Services include domestic assistance, personal care, respite care, and safety-related home and garden maintenance.

The DVA Community Nursing Program provides home community nursing services for entitled persons to meet their assessed clinical and personal care needs.

6.2 A Profile of Service Outlets

Firstly we examine the distribution of the home care and home support workforce by state and territory, location and type of outlet. As shown in Table 6.1, there is evidence of some significant change in the distribution of the workforce across States/Territories between 2012 and 2016. Victoria increased their home care and home support PAYG workforce share substantially, rising from 23 per cent in 2012 to 32 per cent in 2016, with a slightly smaller rise in their direct care workforce (from 21 per cent to 27 per cent). In contrast, NSW had a large

fall in their PAYG workforce (falling from 31 per cent in 2012 to 26 per cent in 2016; and their direct care workforce falling by slightly more than the PAYG total (from 33 per cent to 26 per cent). Further analysis indicates that this change in workforce distribution across Victoria and NSW was due to two factors. Firstly, the share of outlets located in Victoria has increased since 2012. Secondly, while the average number of workers per outlet increased in both Victoria and NSW, this increase was larger in Victoria. Although Tasmania increased their PAYG workforce share very slightly, the share for all other states and territories fell slightly compared to 2012.

The picture is not always similar when viewing PAYG employees or only direct care employees. In WA, for example, while the proportion of PAYG employees fell slightly from 2012 (from 13 per cent to 12 per cent), it rose for direct care employees (from 11 per cent to 14 per cent).

Direct comparison of the distribution of the home care and home support workforce by location category before 2016 is not possible because of a change in the reporting of this data. In 2016 information regarding the location of home care and home support outlets was based on current ABS remoteness area categories; this information was not previously available at the time of the 2012 NACWCS.

Examining ownership type, the distribution shows some change. In 2016, not-for-profit providers employ 70 per cent of the total PAYG workforce in home care and home support aged care services, a slight decline from 74 per cent in 2012 (Table 6.1). The not-for-profit share of direct care employment in home care and home support, now at 68 per cent, has experienced a more marked decline (from 76 per cent in 2012). For-profit outlets employ 9 per cent of the PAYG workforce, and 12 per cent of the direct care workforce, an increase since 2012. The for-profit share of the direct care workforce has grown by 5 per cent since 2007.

Table 6.1: Distribution of home care and home support direct care workforce Total PAYG and Direct Care (per cent) by State/ Territory, location, and ownership type: 2007, 2012 and 2016

	Total PAYG employees			Direct care employees		
	2007	2012	2016	2007	2012	2016
State/Territory						
NSW	20.5	31.2	25.7	22.7	32.9	26.4
Victoria	30.5	22.6	32.3	27.6	20.9	26.5
Queensland	20.3	16.9	15.8	22.3	19.1	17.8
WA	11.3	13.1	12.1	10.7	11.1	13.7
SA	9.0	10.7	7.4	9.4	9.5	8.1
Tasmania	6.2	2.5	4.4	4.9	3.0	5.1
ACT	1.2	2.1	1.8	1.2	2.0	1.8
NT	1.0	1.0	0.6	1.3	1.4	0.6
Location*						
Major cities of Australia			63.5			59.7
Inner Regional Australia			16.9			18.9
Outer Regional Australia			14.6			17.0
Remote Australia			4.0			3.5
Very Remote Australia			0.6			0.6
Ownership Type						
Not-for-profit	70.0	74.4	70.4	72.9	76.1	68.0
For-profit	7.6	5.2	9.3	4.7	6.7	12.1
Government	22.5	20.4	20.3	22.4	17.1	19.9

Source: Census of home care and home support outlets.
**ABS remoteness area categories.*

The home care and home support census uses the number of total PAYG and direct care employees reported by outlets as a method of estimating their size. Table 6.2 shows overall that since 2012, the proportion of smaller outlets (employing up to 10 workers) has decreased while the share of larger outlets (with more than 10 workers) has grown for both all PAYG employees and direct care workers. This suggests that the average size of outlets in the home care and home support sector has increased over time. We also see that in 2016 very small outlets employing 1 to 5 employees now account for a quarter of direct care employees and 14 per cent of all PAYG employees. In contrast large outlets (employing more than 40 people) account for 28 per cent of all PAYG staff and 21 per cent of direct care employees in 2016.

The average size of employment in outlets which employ more than 40 PAYG employees in 2016 is 116 PAYG employees (Table A6.2, Appendix 3); 75 of these are direct care workers. These employment numbers in larger outlets have grown since 2012, particularly for direct care employment (in 2012 larger outlets employed on average 111 PAYG employees of which 65 were direct care workers). This trend was not found for small to medium outlets (with 40 or fewer workers), for these outlets the average number of PAYG and direct care employees has remained stable since 2012.

Table 6.2: Distribution of home care and home support direct care workforce (per cent) by size of outlet, by number of Total PAYG and direct care employees: 2007, 2012 and 2016 (per cent)

Number of employees	Total PAYG employees			Direct care employees		
	2007	2012	2016	2007	2012	2016
1–5	22.3	19.8	14.0	24.0	26.1	24.7
6–10	21.0	21.3	16.4	22.3	19.2	17.6
11–20	20.5	16.9	22.1	20.3	16.2	19.4
21–40	16.8	18.7	19.2	16.9	20.9	17.6
More than 40	19.3	23.3	28.3	16.4	17.6	20.6
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: Census of home care and home support outlets.

The following tables focus on the distribution of home care and home support outlets that offer particular type of programs to older people living in the community. It should be noted that outlets can provide services under more than one program. Almost two thirds of outlets (64 per cent) provide services under the Commonwealth Home Support Program (CHSP), as shown in Table 6.3. HACC Victoria services are delivered by 15 per cent of outlets and HACC Western Australia by 8 per cent of outlets. There are 45 per cent of outlets providing services under the Home Care Packages Program, while just over 17 per cent of service outlets deliver services for DVA. A further 9 per cent of outlets provide services under the Transition Care Program for post-hospital aged care needs and 3 per cent of outlets deliver home care places under Flexibles Programs (the Multi-Purpose Service Program, National Aboriginal and Torres Strait Islander Flexible Aged Care Program, and Innovative Pool Program).

Table 6.3: Distribution of home care and home support outlets (per cent) between programs in the last reporting period: 2016

Program	% of outlets
Commonwealth Home Support Program*	63.9
Home Care Packages Program	45.1
Home and Community Care Victoria	14.8
Home and Community Care Western Australia	7.8
Home Care places under Multi-Purpose Service Program/National Aboriginal and Torres Strait Islander Flexible Aged Care Program/Innovative Pool Program	3.1
DVA Community Nursing, Veteran's Home Care or other DVA administered program	17.1
Transition Care Program	9.0
All outlets (weighted)	3,040

Source: Census of home care and home support outlets.
Note: Multiple responses allowed, percentages do not sum to 100.
Outlets can provide services under more than one program.
**From 1 July 2015, the Commonwealth Home Support Program brought together Commonwealth HACC Program, Planned Respite from National Respite from National Respite for Carers Program (NRCP), Day Therapy Centres Program (DTC), Assistance with Care and Housing for the Aged Program (ACHA).*

Table 6.4 shows the distribution of home care and home support outlets providing services under these programs across state, location and ownership type. Note that the final row shows the number of outlets providing services under each program type; as outlets can provide services under more than one program each outlet can be counted under one or more columns in Tables 6.4 and 6.5.

Looking first at the state distribution for each program type, we see that outlets providing services under the Commonwealth Home Support Program (Table 6.4, column 1) are chiefly within NSW (35 per cent) and Queensland (29 per cent), and with the two remaining state HACC reflected in the lower 13 per cent for CHSP in Victoria and 4 per cent in WA (HACC Victoria and HACC Western Australia are in columns 3 and 4). The remaining States and Territories in CHSP show fewer than 10 per cent of outlets are within each of these locations.

Outlets providing services for the Home Care Packages Program, which is shown in column 2, is also chiefly serviced with outlets in NSW and Queensland (27 per cent and 28 per cent respectively) with 16 per cent in Victoria, 11 per cent in WA, 8 per cent in SA, 6 per cent in Tasmania and with other States and Territories each at less than 5 per cent.

The DVA administered programs shown in column 6 have a different State and Territory distribution, with the largest share of outlets servicing this program within Queensland (35 per cent) followed by Victoria (22 per cent) and NSW (21 per cent). The remaining States and Territories have a share of less than 10 per cent.

The largest share of outlets servicing the Transition Care Program are found in Queensland (36 per cent), NSW (26 per cent) and Victoria (18 per cent), with the remaining States and Territories each at less than 10 per cent.

Outlets providing services under Flexible Program (column 5) have the highest share within NSW (31 per cent), followed by WA and NT (18 per cent respectively), with 13 per cent in Queensland and the remaining States and Territories with shares lower than 10 per cent.

Table 6.4 also shows the distribution of outlets categorised by the remoteness area classification of their outlet location. The majority of outlets delivering services under most programs are found within major cities: 41 per cent of outlets providing CHSP, 44 per cent of Home Care Packages, 54 per cent of HACC Victoria, and 60 per cent of HACC Western Australia. Exceptions to this city-based concentration are outlets servicing DVA administrated programs where a much lower 33 per cent are within metropolitan cities and a greater share are in the outer regional areas with 33 per cent; and outlets under Transition Care where 30 per cent are within major cities and a greater share are in inner and outer regional areas (32 and 30 per cent respectively). A further exception were outlets delivering home care places under Flexible Programs as only 11 per cent of these outlets were located in major cities compared to 42 per cent in outer regional areas, 16 per cent in remote areas and 20 per cent in very remote Australia.

There is variation in the concentration of outlets amongst ownership types within the programs (bottom part of Table 6.4). Not-for-profit outlets provided the majority of services under all program types (with the exception of the Flexible Programs). For-profit outlets meanwhile were the least common ownership type across all programs, accounting for less than 5 per cent of outlets providing services under the programs of CHSP, HACC Western Australia, and Flexible Programs and none under HACC Victoria. Slightly higher shares of for-profit outlets delivered home care and home support services under the Transition Care Program (9 per cent), the Home Care Packages Program (10 per cent), and DVA administered programs (13 per cent). Outlets delivering services under Flexible Programs had the highest share of government ownership at 63 per cent, reflecting their specialist role in supporting the supply of aged care services in communities mostly within rural and remote areas.

In Table 6.5 we can see that the size of an outlet impacts upon the type of aged care program services offered. For example, there is a higher share of very small outlets (with up to 5 PAYG employees) providing services under CHSP (15 per cent of all outlets), HACC Victoria (18 per cent) and Flexible Programs (17 per cent) compared to other program types such as the Home Care Packages Program (7 per cent) and DVA programs (1 per cent). In contrast very large outlets (with more than 40 PAYG staff) accounted for a greater share of services provided under DVA administered programs (52 per cent), HACC Western Australia (50 per cent), Transition Care Program (44 per cent) and the Home Care Packages Program (40 per cent).

The same trend persists when considering program service provision according to outlet size for direct care employees. Very small outlets (with up to 5 direct care employees) again accounted for a relatively greater share of services provided under CHSP (28 per cent of all outlets), HACC Victoria (27 per cent) and Flexible Programs (26 per cent) compared to other program types. Meanwhile very large outlets (with more than 40 direct care staff) accounted for a greater share of services provided under DVA administered programs (42 per cent), Transition Care Program (33 per cent), HACC Western Australia (38 per cent), and the Home Care Packages Program (31 per cent).

Table 6.4: Proportion of outlets offering services under each program in the last reporting period, by state, geographical location and ownership type: 2016 (per cent)

	Commonwealth Home Support Program*	Home Care Packages Program	Home and Community Care Victoria	Home and Community Care Western Australia	Home Care places under Flexible Programs**	DVA Community Nursing, Veteran's Home Care or other DVA administered program	Transition Care Program	Total
All outlets	63.9	45.1	14.8	7.8	3.1	17.1	9.0	n/a
State/Territory								
NSW	34.6	27.1	0.4	0.0	30.9	21.1	25.9	29.2
Victoria	13.0	15.5	98.9	0.0	9.6	21.5	17.5	22.4
Queensland	28.5	28.4	0.2	0.0	12.8	34.7	36.1	22.2
WA	4.1	11.2	0.2	100.0	18.1	8.1	3.3	10.3
SA	9.4	7.8	0.0	0.0	2.1	8.3	9.5	7.4
Tasmania	5.7	5.5	0.0	0.0	8.5	5.6	3.6	4.7
ACT	1.6	1.0	0.0	0.0	0.0	0.2	0.4	1.3
NT	3.1	3.4	0.0	0.0	18.1	0.8	4.0	2.6
Location								
Major cities of Australia	41.0	43.7	53.5	60.0	10.6	32.9	29.6	44.3
Inner Regional Australia	22.3	22.6	18.9	12.3	8.5	24.2	32.3	21.3
Outer Regional Australia	23.1	21.0	20.7	15.3	41.5	33.1	29.6	22.6
Remote Australia	9.9	8.6	6.0	9.4	16.0	8.1	8.5	8.7
Very Remote Australia	3.0	3.4	0.4	3.0	20.2	0.8	0.0	2.4
Ownership Type								
Not-for-profit	80.8	80.0	62.2	69.6	33.0	67.8	58.0	75.8
For-profit	4.9	9.9	0.0	3.0	4.3	12.5	9.1	6.0
Government	13.6	9.9	37.6	25.3	62.8	18.8	32.5	18.2
Outlets (weighted)	1,942	1,371	450	237	94	521	274	3,040***

Source: Census of home care and home support outlets; Note: Question A3.1 Programs is a multiple response question, outlets can provide services under more than one program.
**From 1 July 2015, the Commonwealth Home Support Program brought together Commonwealth HACC Program, Planned Respite from National Respite from National Respite for Carers Program (NRCP), Day Therapy Centres Program (DTC), Assistance with Care and Housing for the Aged Program (ACHA).*
***Home Care places under Multi-Purpose Service Program/National Aboriginal and Torres Strait Islander Flexible Aged Care Program/Innovative Pool Program.*
****As outlets can provide services under more than one program, the total number of outlets cannot be derived from the number of outlets offering services across the different program types.*

Table 6.5: Proportion of outlets offering services under each program in the last reporting period, (per cent) by size of outlet in number of Total PAYG and direct care employees: 2016 (per cent)

Number of employees	Commonwealth Home Support Program*	Home Care Packages Program	Home and Community Care Victoria	Home and Community Care Western Australia	Home Care places under Flexible Programs**	DVA Community Nursing, Veteran's Home Care or other DVA administered program	Transition Care Program	% of all outlets
Total PAYG								
1–5	15.4	7.1	18.4	4.7	17.4	1.2	3.0	13.9
6–10	16.9	11.3	13.5	9.5	20.7	4.6	8.5	16.5
11–20	22.5	20.2	12.6	18.5	18.5	18.9	18.1	22.0
21–40	17.1	21.8	20.6	17.7	18.5	23.3	25.9	19.3
More than 40	28.1	39.6	35.0	49.6	25.0	52.0	44.4	28.4
Outlets (weighted)	1,882	1,370	446	232	92	519	270	2,971***
All Direct Care								
1–5	27.9	15.0	27.0	11.8	25.6	3.9	9.8	24.6
6–10	17.8	13.2	14.2	8.2	20.0	8.0	10.5	17.7
11–20	17.3	18.6	16.8	20.9	17.8	21.7	20.3	19.4
21–40	16.1	22.0	19.8	20.9	23.3	24.2	26.7	17.7
More than 40	20.9	31.2	22.1	38.2	13.3	42.2	32.7	20.6
Outlets (weighted)	1,778	1,314	429	220	90	512	266	2,816***

Source: Census of home care and home support outlets Note: Question A3.1 Programs is a multiple response question, outlets can offer services in more than one program, rows do not total 100.
The number of outlets differs to that of Table 6.4 due to the combination of different non-response for employee questions and the effects of weighting.
**From 1 July 2015, the Commonwealth Home Support Program brought together Commonwealth HACC Program, Planned Respite from National Respite for Carers Program (NRCP), Day Therapy Centres Program (DTC), Assistance with Care and Housing for the Aged Program (ACHA).*
***Home Care places under Multi-Purpose Service Program/National Aboriginal and Torres Strait Islander Flexible Aged Care Program/Innovative Pool Program.*
****As outlets can provide services under more than one program, the total number of outlets cannot be derived from the number of outlets offering services across the different program types.*

6.3 Outlets' Relationships with Broader Aged Care Services

Many home care and home support outlets have connections to the broader aged care sector either as part of a larger provider organisation or through the provision of both residential and community-based aged care services. Table 6.6 shows that 61 per cent of all outlets are part of larger organisational groups, the same as in 2012. The proportion of for-profit outlets belonging to a larger group has risen from 67 per cent in 2012 to 76 per cent in 2016, a large increase that continues the consolidation from the 46 per cent of for-profit outlets that were part of a larger organisation in 2007.

There is also evidence of greater specialisation as the proportion of home care and home support outlets also providing residential aged care services has fallen since 2012, from 20 per cent to 13 per cent in 2016. The proportion of outlets providing a combination of home care and home support with residential services has markedly declined since 2012 for all ownership types.

Table 6.6: Proportion of home care and home support outlets that are part of larger provider group or provide residential aged care (per cent), by ownership type: 2012 and 2016

	Not-for-profit	For-profit	Government	All outlets
2016				
Part of larger provider group	62.9	76.1	48.2	61.0
Providing residential aged care	12.3	5.0	20.8	13.4
2012				
Part of larger provider group	65.0	66.9	40.5	60.6
Providing residential aged care	18.2	13.7	26.4	19.5

Source: Census of home care and home support outlets.

Table 6.7 concentrates on those outlets that provide both home care and home support as well as residential care. Focusing on the 13 per cent of outlets (409 outlets) that also provide residential aged care services (Table 6.6), 21 per cent of staff (18 per cent of nurses and 17 per cent of CCWs, Table 6.7) working in these outlets provide both residential and home care and home support care services. In contrast, Allied Health workers commonly provide services for both residential and home care and home support care (53 per cent, Table 6.7). No for-profit outlets reported a joint workforce for residential and home care combined services.

Table 6.7: Proportion of home care and home support aged care employees that work in both residential and home care/home support aged care (per cent), in outlets that also provide some residential aged care, by ownership type: 2016

Occupation	Not-for-profit	Government	All outlets*
Nurse	19.4	17.7	18.2
CCW	18.1	19.5	17.4
Allied Health	55.6	51.9	53.4
All occupations	20.6	23.9	21.0

Source: Census of home care and home support outlets.
**For profit not shown (2 cases weighted).*

6.4 Ethnic Specialisation

As previously discussed in Section 4.4, the number of older people from CALD backgrounds in Australia is increasing and therefore also the need for ethnically and culturally appropriate services for this cohort. The 2016 census explored the extent of ethnic specialisation in the

home care and home support aged care sector, and found that almost 43 per cent of outlets cater to a specific ethnic or cultural group (Table 6.8), compared with 41 per cent of outlets in 2012.

Amongst outlets that did cater for a specific ethnic or cultural group, Aboriginal and Torres Strait Islander clients were most frequently catered for (67 per cent of outlets), followed by clients from an Italian (41 per cent), Greek (36 per cent) and Chinese (35 per cent) backgrounds. Almost 41 per cent of outlets who specialise indicated that they cater for gay, lesbian, bisexual, transgender and intersex clients. This figure is much higher than the 1 per cent of community outlets that reported catering to residents with this background in 2012, illustrating the increasing supply of aged care services which are sensitive to and inclusive of diverse backgrounds.

Table 6.8: Home care and home support outlets catering for specific ethnic or cultural groups: 2016 (per cent)

Ethnic group	% All outlets	% among outlets that specialise
Catering for specific ethnic or cultural group	42.5	n/a
No catering for specific ethnic or cultural group	57.5	n/a
Polish	13.1	30.6
Aboriginal/Torres Strait Islander	28.9	67.4
Italian	17.4	40.6
Chinese	15.2	35.4
Dutch	11.7	27.2
Greek	15.3	35.6
Gay, lesbian, bisexual, transgender, intersex	17.4	40.6
German	13.0	30.3
Indian	12.7	29.7
Other	5.2	12.1

Source: Census of home care and home support outlets.
2016 N=1577 outlets catering for specific ethnic or cultural groups (weighted).
Note: Multiple responses were allowed, columns do not sum to 100.

6.5 Skill Shortages

The provision of quality aged care services depends considerably upon adequate numbers of workers with the required skills being employed in the workforce. In order to advance understanding of skill shortages which may exist within the sector, the 2016 census of home care and home support outlets collected information on the incidence of skill shortages, the factors that cause these shortages, and how facilities respond to them. Table 6.9 shows that skill shortages were reported by 42 per cent of all home care and home support outlets, and 49 per cent of outlets with direct care staff (final column Table 6.9). This table also shows the proportion of outlets with skill shortages for particular direct care occupations. Similar to 2012, a shortage of CCWs was the most commonly reported occupation in which there was a skills shortage (33 per cent in 2016, 37 per cent in 2012), followed by RNs (10 per cent of outlets) and AH (7 per cent) with ENs rarely reported to be in shortage (3 per cent).

Table: 6.9: Proportion of home care and home support outlets reporting skill shortages in 2016 (per cent), by location and occupation affected

Whether had skill shortage	Major cities of Australia	Inner Regional Australia	Outer Regional Australia	Remote Australia	Very Remote Australia*	All outlets
Yes (of all outlets)	40.8	43.4	43.3	43.8	51.4	42.4
Yes (of all outlets with direct care staff)	46.9	49.7	51.1	52.2	60.7	49.2
Yes, for:						
RN	7.3	12.5	12.0	16.5	12.5	10.4
EN	1.7	2.8	3.5	3.4	5.6	2.6
CCW	33.1	33.7	32.3	34.8	43.1	33.3
AH	7.1	7.8	6.2	4.1	2.8	6.6

Source: Census of home care and home support outlets.
Note: Multiple responses allowed, columns do not sum to 100.
**N=24 cases (weighted); Overall outlets with skill shortages N=1,277 outlets (weighted).*

For those 1,277 outlets reporting skill shortages (42 per cent of outlets, Table 6.9), the managers were asked to identify factors to which the shortage was attributable, shown in Table 6.10. The main skills shortage issue was a lack of suitable applicants reflecting the desired skills, qualifications, experience or values sought (72 per cent), with very little variation by occupation skill type (76 per cent of outlet managers cited this for RNs and 73 per cent for CCWs). The second most commonly reported issue was the geographic location in which the outlet services were delivered (39 per cent), however this was more commonly reported for RN shortages (54 per cent) than for CCW shortages (40 per cent). Recruitment being too slow for the outlet service needs was the third most common issue for skill shortages (28 per cent), and this was also more commonly reported for an RN shortage (35 per cent) than a CCW shortage (27 per cent). Specialist knowledge was reported by home care and home support outlets as a key source of skills shortages for RN occupations by 28 per cent of outlets (in contrast to only 19 per cent reporting this for CCWs). While these three reasons were also the most commonly reported sources of skills shortages for residential facilities, slightly more residential facilities reported no suitable applicants (80 per cent, Table 4.9) than did home care and home support outlets (72 per cent, Table 6.10).

Table 6.10: Proportion of home care and home support outlets with skill shortages in 2016 that nominated each cause of that shortage (per cent), by occupation affected

Cause of skill shortage	Outlets that reported skill shortages		
	For any occupation	For RNs	For CCWs
Specialist knowledge required	20.4	28.2	19.1
Geographical location of outlet	39.3	53.9	39.9
Wages or salary costs too high	11.7	16.1	12.1
Lack of availability of adequate training	15.9	14.6	18.4
Unsure of long term demands for service	17.0	18.6	19.2
Recruitment too slow	28.4	35.0	27.3
No suitable applicants (skills/qualifications/experience/values)	71.7	75.9	72.8
Other	7.9	5.6	7.7

Source: Census of home care and home support outlets.
Note: Multiple responses were allowed, columns do not sum to 100.
N=1,277 outlets (weighted).

For those outlets reporting skill shortages, an additional question asked outlet managers what strategies they used in response to having these shortages (shown in Table 6.11). As also found in 2012, a majority of these outlets (55 per cent) asked their existing staff to work longer hours. This was also the most frequent strategy nominated by residential facilities in 2016 (62 per cent, Table 4.10).

The second most frequent strategy for responding to skills shortages differed by the type of occupation that was in shortage. Outlets responded with greater use of agency staff for a shortage of RNs (38 per cent) but for a shortage of CCWs used on-the-job training of staff (41 per cent). In contrast, and also frequently used, the third most used strategy for an RN skills shortage was on-the-job training of staff (33 per cent) and for a shortage of CCWs was greater use of agency staff (29 per cent).

In 2016, the categories of student placement usage and volunteer usage were added to this question. For a shortage of CCWs, volunteers were reported to be used by 12 per cent of outlets and student placements were used by 7 per cent of outlets. Along with increasing wages, salaries or conditions, these were among the least common responses to skills shortages (reported by up to 10 per cent of outlets for any occupation shortage).

Table 6.11: Proportion of home care and home support outlets with skill shortages in 2016 that nominated each response to that shortage (per cent), by occupation affected

Response to skill shortage	Outlets that reported skill shortages		
	For any occupation	For RNs	For CCWs
External training of staff	20.2	18.3	23.4
On-the-job training of staff	36.8	33.4	41.0
Existing workforce worked longer hours	55.1	57.0	56.9
Greater use of agency staff	28.7	37.5	29.0
Sub-contracted or outsourced services	21.0	24.8	21.9
Employed staff on short term contracts	17.9	22.9	13.7
Wages, salaries and/or conditions increased	7.4	9.0	7.6
Reduced outputs or production	14.4	18.3	12.3
Used student placements	5.5	6.2	6.6
Used volunteers	9.5	3.1	11.7
Other	5.1	4.3	4.0

Source: Census of home care and home support outlets.
Note: Multiple responses were allowed, columns do not sum to 100.

6.6 Vacancies

The overall number and types of staff vacancies are further indicators of current conditions within the aged care labour market. Combining this information with the data collected on skills shortages, we are able to present evidence on the extent of difficulties experienced by home care and home support outlets in recruiting adequate numbers of skilled staff.

Outlet managers were asked to report in the census form on the number of vacancies they had at the time of completion, for employees in each direct care occupational classification. This information has been used in Table 6.12 to calculate the proportion of outlets with vacancies in each direct care occupation (Panel 1) and the average number of vacancies for these outlets (Panel 2). Outlets that did not report any vacancies were excluded.

Panel 1 of Table 6.12 shows that a small proportion of outlets reported FTE vacancies across the range of occupations, but similarly to 2012 (and also 2007), more outlets reported vacancies for CCWs (25 per cent in 2016) than other occupations. This is understandable given the distribution of the different occupations in home care and home support aged care,

because CCWs comprise the greatest part of the direct care workforce. Panel 2 of Table 6.12 shows that in 2016 amongst outlets with vacancies, the average number of unfilled FTE positions was 3.6 for CCWs but less than 2 for other occupations (this is very similar to 2012 when there were 3.5 for CCWs).

Table 6.12: Vacancy rate (per cent of all home care and home support outlets) and average number of vacancies (in outlets with vacancies), by occupation: 2007, 2012 and 2016

	Full-Time Equivalent		
	2007	**2012**	**2016**
Panel 1: % of outlets with any vacancies			
Registered Nurse	6.1	5.5	5.7
Enrolled Nurse	2.5	2.1	1.0
Community Care Worker	22.2	21.4	25.3
Allied Health	5.2	3.8	4.3
Panel 2: Average number of vacancies in outlets with any vacancies			
Registered Nurse	n/a	1.4	1.5
Enrolled Nurse	n/a	1.6	1.3
Community Care Worker	n/a	3.5	3.6
Allied Health	n/a	2.3	1.7

Source: Census of home care and home support outlets. Outlets that did not report any vacancies were excluded. N=2,473 outlets (weighted).

A further way of investigating vacancies in aged care is to consider the amount of time that it takes to fill positions for different occupations. Tables 6.13 and 6.14 examine vacancy duration (measured in weeks) with reference to the most recent vacancy that outlets advertised. Table 6.13 shows that in 2016, with the exception of AH, two thirds or more of vacancies lasted up to 3-4 weeks (68 per cent RN, 82 per cent EN, 76 per cent CCWs) but for AH only 61 per cent were filled within 4 weeks. Whereas for EN and CCW only 6 per cent of vacancies were reported by outlets as taking longer than 8 weeks to fill, in contrast this was reported for 13 per cent of RN vacancies and 15 per cent of AH vacancies.

Table 6.13: Weeks required by home care and home support outlets to fill most recent vacancy (in outlets with vacancies), by occupation: 2016

% of outlets that took	**RN**	**EN**	**CCW**	**AH**	**All occupations**
Less than 1 week	31.3	48.9	12.5	26.5	13.1
1 week	4.6	3.2	9.4	2.4	8.7
2 weeks	8.8	8.6	18.9	7.4	16.0
3 to 4 weeks	23.1	21.4	35.1	24.3	33.5
5 to 8 weeks	19.5	12.2	18.1	24.8	19.5
9 to 12 weeks	7.0	3.5	3.9	7.9	5.5
13 to 26 weeks	4.1	1.1	1.5	5.7	2.7
More than 26 weeks	1.5	1.1	0.6	1.0	0.9
Total	**100**	**100**	**100**	**100**	**100**

Source: Census of home care and home support outlets.
Outlets that did not report any vacancies were excluded.
N=2,473 outlets (weighted).

Table 6.14 shows that in 2016 there was mixed experience for outlets with a much higher than average vacancy duration for RNs in WA (7.5 weeks) and very slightly higher than average vacancy durations in NSW (4.9 weeks) and Queensland (4.9 weeks). For CCW vacancies, slightly higher than average vacancy durations were reported in WA (4.4 weeks), ACT (4.6

weeks) and marginally higher than average vacancy durations in Victoria (4.3 weeks) and SA (4.3 weeks).

Variation in the average vacancy duration by the outlet's remoteness area location, depending on the occupational classifications was also found. For RN vacancies, outlets in major cities, inner regional areas and also very remote locations reported durations less than the average 4.7 weeks to fill the vacancy. For CCW vacancies, major cities and inner regional located outlets reported durations less than the average 4.1 weeks.

Table 6.14 also shows the median[11] vacancy duration. Contrasting the average with the median can give more information about the distribution of the durations as the median always shows the centre of the distribution. In the case of WA, where the average vacancy duration for RNs was very high (7.5 weeks) the median is much lower at 4 weeks. This indicates that while for half of the outlets in WA the RN vacancies lasted up to 4 weeks (the median), the higher average shows the average was affected by vacancies longer than this. For CCWs, there was a higher average vacancy duration for outlets in outer regional areas (5.6 weeks), and the corresponding median is 3 weeks. This indicates that while for half of the outlets in outer regional areas the CCW vacancies lasted up to 3 weeks, the higher average reflects that it was affected by vacancies that were filled after 5 weeks and longer.

[11]The median is the "middle" of a sorted list of numbers. Hence it can reveal the centre of the durations the outlets reported without distortion. When the median is contrasted with the average if the median is much lower than the average it shows that the average has been affected by cases with longer durations (and also the other way round if the median is much higher than the average then the average has been influenced by the share with shorter durations). Link to the ABS website for further information about measures of central tendency.

Table 6.14: Average and median vacancy duration (weeks) for RNs and CCWs, by State/Territory and location: 2016

		RN	CCW
All outlets	Average	4.7	4.1
State/Territory	NSW	4.9	3.9
	Victoria	3.6	4.3
	Queensland	4.9	4.1
	WA	7.5	4.4
	SA	4.0	4.3
	Tasmania	3.0	3.3
	ACT	1.0	4.6
	NT	0.7	5.5
Location	Major cities of Australia	3.8	3.7
	Inner Regional Australia	4.1	3.2
	Outer Regional Australia	5.8	5.6
	Remote Australia	6.7	4.4
	Very Remote Australia	3.6	6.2
All outlets	Median	3.0	3.0
State/Territory	NSW	4.0	3.0
	Victoria	4.0	4.0
	Queensland	3.0	3.0
	WA	4.0	3.0
	SA	4.0	3.0
	Tasmania	1.0	2.0
	ACT	0.0	3.0
	NT	1.0	3.0
Location	Major cities of Australia	3.0	3.0
	Inner Regional Australia	4.0	3.0
	Outer Regional Australia	3.0	3.0
	Remote Australia	4.0	3.0
	Very Remote Australia	4.0	4.0

Source: Census of home care and home support outlets.
Outlets that did not report any vacancies were excluded.
N=2,473 outlets (weighted).

As vacancies can exist for a variety of reasons, the census asked outlets about the cause(s) for their most recent vacancy for each of the occupations (Table 6.15). As in 2012, the primary reason for an outlet vacancy across all direct care occupations in 2016 was resignation (63 per cent). In the case of CCW vacancies, a quarter of outlets (25 per cent) cited that it was for a new position.

Table 6.15: Proportion of home care and home support outlets giving each reason for their most recent vacancy (per cent), by occupation: 2016

% of outlets stating	RN	CCW	All occupations
New position	5.6	25.3	32.7
Retirement	11.1	18.3	20.7
Injury/illness	7.4	5.4	6.3
Resignation	59.3	54.1	62.7
End of contract	3.7	1.5	3.4
Involuntary separation	0.0	4.6	5.2
Other	20.4	17.7	21.1
Total outlets (weighted)	54	1,581	2,686

Source: Census of home care and home support outlets.
Note: Multiple response allowed, columns will not sum to 100.

The census form asked outlets what was the primary method they used when they recruited CCWs. Table 6.16 summarises their responses (see column 3). Outlets in 2016 most commonly advertised these vacancies through the internet (36 per cent), or the internet and newspaper jointly (30 per cent). Newspaper only advertising was reported by far fewer outlets (10 per cent) as well as the use of word of mouth (10 per cent). Fewer than 5 per cent of outlets reported other alternatives such as walk-ins, agency or job-placement/career service routes.

For recently hired home care and home support workers, the pattern is similar to that found for recently hired residential workers (Table 4.15). Word of mouth and internet job advertisements are the most commonly reported sources of job information for workers in Table 6.16. For nurses, word of mouth is the most common source (41 per cent), while CCWs (41 per cent) and AH workers (52 per cent) are more likely to find their jobs through internet job advertisements. Internet job advertisements have grown in importance since 2012, particularly for CCWs. The increasing use of internet job advertisements has corresponded with a decline in use of newspaper job advertisements as a source of information, and for CCWs, internet job advertisements (41 per cent) appear to have all but replaced job placements and career services (less than 1 per cent) as a source of information. While only 3 per cent of outlets use agencies to recruit CCWs, agency use is far more common among the workers themselves, with 9 per cent of CCWs, 14 per cent of RNs and 13 per cent of AH workers finding out about jobs through agencies.

Table 6.16: Sources of information about recruitment opportunities used by recently hired* home care and home support direct care workers and outlets: 2016 (per cent)

Source of job information	Nurse	CCW		AH
	Worker	Worker	Outlet	Worker
Walk-in	n/a	n/a	3.0	n/a
Word of mouth	40.8	31.4	10.2	20.6
Newspaper job advertisement	15.5	11.2	9.7	6.7
Internet job advertisement	22.5	41.4	35.8	52.0
Both internet and newspaper job advertisement	n/a	n/a	30.2	n/a
Job placement program/career service	1.9	0.3	2.7	0.4
Agency	13.8	9.3	3.1	13.0
Other	2.7	5.2	4.5	5.0
Don't know	n/a	n/a	0.9	n/a
Total cases (weighted)	856	7,096	2,220	806

Source: Census of home care and home support outlets, and Survey of home care and home support aged care workers (weighted).
Note: Multiple response allowed for workers, columns will not sum to 100.
**Recently hired workers have been employed for 12 months or less.*

6.7 Setting of Employment Conditions

The industrial method used by a home care and home support outlet when setting employment conditions for their workers provides an indication of the degree of flexibility that an organisation can have over working arrangements. Table 6.17 reports the proportions of employees across all home care and home support outlets that are bound by particularly forms of agreement for employee conditions. It should be noted that some of the methods operate in tandem (e.g. awards and agreements) and employers may not recognise the distinctions between them. However, we report the responses as provided by outlets.

Similar to residential aged care but to a lesser extent, the most common method of setting employment conditions is Enterprise Agreement (Table 6.17), with 59 per cent of home care and home support outlets using this method, compared with 79 per cent of residential facilities (Table 4.16). Alongside this, a higher share of home care and home support outlet employees are under Awards (39 per cent, Table 6.17) than in residential facilities (19 per cent, Table 4.16). This pattern has not changed since 2012.

Table 6.17: Industrial methods used by home care and home support outlets to set employment conditions (per cent), by employee occupation: 2016

% of employees with conditions set by method	Nurses	CCW	AH	All occupations
Award	35.6	39.3	43.6	39.1
Enterprise Agreement	61.5	59.1	52.8	59.0
Common Law Contract	1.1	0.7	0.3	0.8
Individual Flexibility Agreement	0.7	0.3	2.8	0.4
Don't Know	1.1	0.6	0.5	0.7
Total	**100**	**100**	**100**	**100**

Source: Census of home care and home support outlets.

Table 6.18 shows the proportions of home care and home support outlets that reported they supply allowances to their employees. This was a new question added in 2016. Seventy per cent of outlets supply an allowance to employees to account for travel between home care and support appointments. Less than half of outlets (48 per cent) supply a petrol or depreciation allowance for transport costs related to the work home care and support appointments. To offset this some organisations may supply a work car for rostered staff. Slightly less than a fifth of outlets paid allowances for time for travel between home and care/support appointments (17 per cent) and 16 per cent paid no allowances of any type.

Table 6.18: Allowances supplied by home care and home support outlets to employees (per cent): 2016

% of outlets paying allowance to their employees	All outlets
Paid time for travel between care/support appointments	70.1
Paid time for travel between home and care/support appointments	16.7
Petrol/depreciation allowance for transport costs related to care/support appointments	47.5
None of these allowances paid to employees	15.7
Outlets (weighted)	3,049

Source: Census of home care and home support outlets Question A7.
Note: Multiple response allowed, column will not sum to 100.

Table 6.19 reports the proportions of home care and home support outlets that reported they supply allowances to their employees by the remoteness area of the outlet. Differences were found depending on the location of the outlet. Overall, outlets in remote (21 per cent) and especially very remote (36 per cent) locations were less likely to pay allowances to their staff.

Table 6.19: Allowances supplied by home care and home support outlets to employees (per cent) by remoteness area: 2016

% of outlets paying allowance to their employees	Major cities of Australia	Inner Regional Australia	Outer Regional Australia	Remote Australia	Very Remote Australia	All outlets
Paid time for travel between care/support appointments	69.0	74.3	72.4	66.7	45.8	70.1
Paid time for travel between home and care/support appointments	15.4	15.0	16.2	24.7	27.8	16.6
Petrol/depreciation allowance for transport costs related to care/support appointments	53.6	49.3	41.6	37.1	19.4	47.5
None of these allowances paid to employees	15.0	12.6	16.3	20.6	36.1	15.9
Total (weighted)	**1,333**	**641**	**681**	**267**	**72**	**3,015**

Source: Census of home care and home support outlets Excludes don't know N=21.
Note: Multiple response allowed, column will not sum to 100.

6.8 Agency, Brokered and Self-employed Staff

In order to supplement an organisation's regular PAYG workforce, workers may be sourced through nursing or employment agencies, other aged care providers, or through networks of independent care workers. We refer to these 'agency', 'brokered' or 'self-employed' employees as 'non-PAYG'. The traditional use of non-PAYG workers is to fill temporary gaps when permanent or casual staff are on leave, or where there is an unexpected vacancy. Outlets may also use non-PAYG workers on a more permanent basis and view them as part of their core staff. Outlets were asked in the census form to provide information about their use of non-PAYG workers, to gain information about the extent to which these workers augment the workforce in home care and home support aged care.

Table 6.20 shows that a minority of home care and home support aged care outlets (27 per cent) used at least one non-PAYG worker in the designated fortnight. This is the same scale of non-PAYG use as in 2012. Of the three types of non-PAYG workers, outlets were most likely to engage brokered workers (15 per cent), with 12 per cent using agency workers and 5 per cent using self-employed workers. This distribution across the types of non-PAYG staff used by outlets is very similar to that of 2012. The bulk of non-PAYG workers were CCWs (21 per cent). Brokered staff are used more often in home care and home support (15 per cent, Table 6.20) than in residential care (8 per cent, Table 4.17).

Table 6.20: Proportion of home care and home support outlets (per cent) using non-PAYG workers in the designated fortnight, by occupation and type of worker: 2016

Occupation	Agency	Brokered	Self-employed	All non-PAYG
Registered Nurse	3.2	3.2	0.2	6.5
Enrolled Nurse	0.5	0.7	0.0	1.2
Community Care Worker	8.6	12.7	1.8	21.2
Allied Health	2.0	4.0	2.7	8.3
All occupations	11.8	15.4	4.5	27.1

Source: Census of home care and home support outlets.

Table 6.21 reflects the State and Territory variation in the use of non-PAYG workers by outlets in the two occupations of RN and CCW for the years 2007 to 2016. The proportion of outlets using non-PAYG RNs in 2016 is always less than 10 per cent (overall 7 per cent), whereas for CCWs the rate is strikingly higher with an overall rate of 21 per cent and only one state (NT at 5 per cent) having a low share for non-PAYG CCWs. The States and Territories with higher shares of outlets using non-PAYG RNs were NT (8 per cent), WA (9 per cent) and NSW (8 per cent). Meanwhile the locations with higher usage of non-PAYG CCWs were ACT (45 per cent), WA (26 per cent) and SA (25 per cent).

Table 6.21: Proportion of home care and home support outlets (per cent) using any non-PAYG RNs or CCWs in the designated fortnight, by State/Territory: 2007, 2012 and 2016

State/Territory	RN			CCW		
	2007	2012	2016	2007	2012	2016
NSW	7.5	6.9	7.9	14.3	21.1	23.1
Victoria	1.7	11.9	6.3	13.0	26.8	20.6
Queensland	3.0	9.9	5.8	8.8	14.4	17.6
WA	1.9	5.3	8.6	12.1	18.2	25.7
SA	3.3	1.6	4.4	13.0	27.6	25.3
Tasmania	0.0	5.0	2.8	3.4	21.3	16.1
ACT	7.7	5.3	2.6	15.4	28.1	44.7
NT	3.0	6.9	7.7	6.1	20.7	5.1
All outlets	2.2	7.9	6.6	11.6	21.0	21.3

Source: Census of home care and home support outlets.

In our examination of the non-PAYG workforce in the home care and home support aged care sector, Table 6.22 reports the number of non-PAYG workers employed by outlets in the designated fortnight. Overall 12,103 non-PAYG workers were employed during this time period. Across occupations, non-PAYG CCWs were the most widely used direct care occupation hired by outlets; there were 10,099 non-PAYG CCWs in outlets in the designated fortnight, also reflecting their role as the majority of the home care and home support workforce generally. The next most widely utilised occupation were non-PAYG AH workers of which there were 1,443. This is similar to the 2012 distribution of non-PAYG usage by outlets but a lower scale of use. As discussed above, the majority of non-PAYG workers in home care and home support were brokered. Extremely few nurses were reported to be self-employed but there was a reasonable share of CCWs and AH workers that outlets reported were self-employed.

Table 6.22: Number of non-PAYG workers in home care and home support outlets in the designated fortnight, by occupation: 2016

Occupation	Number of workers			
	Agency	Brokered	Self-employed	Total
RN	226	254	5	**484**
EN	26	49	1	**77**
CCW	2,774	6,586	739	**10,099**
AH	220	787	437	**1,443**
All occupations	3,246	7,676	1,182	**12,103**

Source: Census of home care and home support outlets.
N=3,066 outlets (weighted).

Further questions on the reasons for non-PAYG worker use were added in the 2016 census and are shown in Table 6.23. The two most frequently cited reasons for home care and home support use of agency workers were 'short-term cover for staff absences' (66 per cent), followed by being 'unable to fill vacancies' (38 per cent). For the use of brokered staff, the most common reasons were 'matching staff to peaks in service user demand' (44 per cent), and 'short-term cover for staff absences' (43 per cent). Self-employed staff, meanwhile, were most commonly hired to 'obtain specialist skills' (45 per cent) and 'matching staff to peaks in service user demand' (33 per cent). The reason 'freeze on permanent staff numbers' was rarely cited except for self-employed (7 per cent).

Table 6.23: Reasons for using non-PAYG workers in home care and home support outlets in the designated fortnight, by type: 2016

Reason	Agency	Brokered	Self-employed
Matching staff to peaks in service user demand	36.1	44.2	33.1
Short-term cover for staff absences	65.9	42.5	6.6
Covering for maternity leave or annual leave	12.3	12.9	2.2
Unable to fill vacancies	38.4	34.3	8.8
Obtain specialist skills	18.3	29.5	44.9
Freeze on permanent staff numbers	3.2	1.7	6.6
Other reason	7.2	26.1	12.5
Outlets (weighted)	349	464	136

Source: Census of home care and home support aged care facilities.
Note: Multiple response allowed, columns will not sum to 100.

6.9 Volunteers in Home Care and Home Support Aged Care

The outlet census collected information on the extent of volunteers in home care and home support aged care programs. Information about the number of volunteers and the hours they contributed in home care and home support outlets, was collected in the census for the first time in 2012. Table 6.24 shows that outlets responding to this question engaged 44,879 volunteers who provided 206,531 hours of service in the designated fortnight. This equates to an average of 29 volunteers per outlet indicating use of volunteers, with each volunteer averaging 4.6 hours for the fortnight.

Table 6.24: Total number of volunteers and volunteer hours worked in home care and home support outlets in the designated fortnight: 2012 and 2016

Year	Volunteer numbers, per fortnight	Volunteer hours, per fortnight	Average number of volunteers per outlet, per fortnight	Average hours per volunteer, per fortnight
2016	44,879	206,531	29	4.6
2012	56,729	258,373	27	4.6

Source: Census of home care and home support outlets. Outlets N=1,536 (weighted).

As shown in Table 6.25, 51 per cent of outlets reported the use of one or more volunteers (the same as in 2012). The distribution of volunteers is fairly consistent for most locations with the exception of remote and very remote areas, where their contribution is lower with 43 per cent of outlets and 11 per cent respectively reporting volunteering activity. The use of volunteers also differs by the ownership type of outlets, with for-profit outlets much less likely to engage volunteers than not-for-profit or government outlets.

Table 6.25: Proportion of home care and home support outlets employing volunteer workers (per cent) in designated fortnight, by location and ownership type: 2016

	% outlets (weighted)
All outlets	50.9
Location	
Major cities of Australia	52.7
Inner Regional Australia	48.8
Outer Regional Australia	52.1
Remote Australia	42.7
Very Remote Australia*	11.1
Ownership type	
Not-for-profit	54.5
For-profit	5.6
Government	45.9

Source: Census of home care and home support outlets.
**Very remote N=8 (weighted).*

A new question was added in the 2016 census to gain a better understanding of what roles were undertaken by volunteers in aged care (Table 6.26). As found in residential facilities, home care and home support outlets most often used volunteers for 'social activity support assistance' (55 per cent). However the use of these roles was less frequent than in residential facilities (at 82 per cent, Table 4.23). A high proportion of home care and home support outlets also had volunteers undertaking roles such as 'planned group activity assistance' (50 per cent Table 6.26, and this was also lower than for residential settings where 68 per cent of facilities used volunteers for this role, Table 4.23) and 'companionship/befriending' (34 per cent almost half of the 64 per cent in residential facilities). However for 'transport assistance', 44 per cent of outlets reported volunteer roles supporting this service, while a smaller share of residential facilities had volunteers undertaking roles of 'transport assistance' (23 per cent, Table 4.23). 'Shopping/appointment assistance' was also more often a volunteer role for home care and home support outlets (20 per cent against 16 per cent of residential facilities reporting this) as was 'meal/preparation assistance' (30 per cent against 6 per cent of residential facilities). Somewhat surprisingly, volunteer roles for 'gardening assistance' were less commonly reported by home care and home support outlets (8 per cent against 15 per cent by residential facilities). Twelve per cent of volunteers provided 'respite care assistance'. Fewer than 10 per cent of home care and home support outlets had volunteers undertake 'domestic activity assistance' (5 per cent), and 'home maintenance assistance' (3 per cent), with these last activities rarely undertaken by volunteers.

Table 6.26: Roles undertaken by volunteer workers in home care and home support outlets (per cent): 2016

	Outlets where volunteers undertaking roles
Domestic activity assistance	4.8
Respite care assistance	11.5
Social activity support assistance	55.3
Planned group activity assistance	50.1
Home maintenance assistance	2.8
Gardening assistance	7.7
Transport assistance	44.2
Shopping/appointment assistance	20.1
Meal/preparation assistance	29.8
Companionship/befriending	34.0
Other	18.8
Total (facilities with volunteers, weighted)	1,536

Source: Census of home care and home support aged care outlets.
Note: Multiple response allowed, column will not sum to 100.

6.10 Quality measures in Home Care and Home Support Aged Care

Quality monitoring questions were added within the census in 2016 to give a measure of how the quality of the aged care provision is checked (Table 6.27). The most common form of quality monitoring undertaken by home care and home support outlets was that 'managers or supervisors monitor quality' 78 per cent (86 per cent in residential facilities, Table 4.24), with 'keeping records of feedback or complaints from service users' a second key method reported by 66 per cent of home care and home support outlets (57 per cent in residential facilities). About half of home care and home support outlets (52 per cent) had 'surveys of service users to monitor quality'. This last finding about using surveys is in contrast to residential facilities where just over a third of facilities had surveys of service users (36 per cent, Table 4.24), instead reporting 'accreditation' as the third most preferred method (56 per cent of residential facilities, Table 4.24).

Some quality methods were much less commonly reported by home care and home support outlets than by residential facilities. 'Inspectors from another organisations monitor quality' was found in only 16 per cent of outlets (Table 6.27), which is only half of the 32 per cent of residential facilities who reported this method, Table 4.24). Slightly less than a quarter (22 per cent) of home care and home support outlets used 'external auditing' for monitoring quality, whereas in residential facilities 16 per cent undertook this form of quality monitoring. Similar to residential facilities, slightly less than a quarter said that 'individual employees monitor quality' (22 per cent, Table 6.27) against 20 per cent in residential facilities (Table 4.24). Similar to residential facilities, additional methods of quality monitoring were rarely cited (3 per cent).

Table 6.27: The three most important methods for monitoring the quality of aged care services/supports in the facility (per cent): 2016

	% of all facilities
Managers or supervisors monitor quality	78.3
Inspectors from another organisation monitor quality	16.2
Individual employees monitor quality	21.5
Keep records of feedback or complaints from service users	66.2
Surveys of service users	52.1
External auditing	21.6
Accreditation	43.7
Other	3.0

Source: Census of home care and home support aged care outlets N=3,049.
Note: Multiple response allowed, column will not sum to 100.

7. Interviews with Direct Care Workers

Key Findings

- In-depth interviews were conducted with 100 direct care workers – 40 mature workers, 30 new hire workers and 30 general workers.
- Most respondents had entered aged care with substantial employment histories. Some reported additional sources of paid work in order to supplement their hours or income.
- Motivations for choosing to enter aged care included a direct interest in the work, job availability, flexible working hours and the potential for future healthcare employment.
- Positive aspects of aged care work included good relationships with clients, making effective use of skills and training, and having autonomy and task diversity.
- Workers reported difficulties in their aged care work, most commonly high workloads and levels of administration. Unsatisfactory working conditions, client care issues, and challenging relationships with managers and co-workers were also reported.
- The majority of respondents wished to remain working within aged care in their current role. Some employees (primarily residential new hire and mature workers) intended to leave the sector to either move to other healthcare settings or retire.
- Effective aged care workers were described as possessing personal qualities and specific skills and qualifications. A range of workers of different ages, gender and cultural background was seen as being beneficial to the sector.
- Adequate staffing and funding, supportive management, positive organisational values and effective workplace policies were seen as contributing to quality client care.
- Respondents had good awareness and understanding of OHS policies and procedures. A quarter of workers expressed OHS concerns in their work, mainly around manual handling techniques, physical hazards and client medication.
- A majority of PCAs and CCWs felt that their Certificate Level III training had equipped them well for their work. Concerns raised about aged care training included the length of courses and placements, a lack of face-to-face training and gaps in content.
- While work-related training was widely available, access was limited in regional/ remote areas. Training in dementia and palliative care was found to be most useful.
- Most workers had extensive responsibilities outside of their aged care work, most commonly caring for children and elderly parents. Strategies used to promote work-life balance included using flexible work arrangements, maintaining boundaries between work and home, and utilising support from family and friends.
- Three emergent themes were raised in the interviews relating to aged care sector reforms and funding, staffing levels in residential facilities, and negative perceptions of aged care work.
- Concerns were raised about the recent aged care reforms including future funding for organisations, possibly leading to reduced service provision and reduced staffing levels, and about re-assessments of clients for higher packages. Home care and home support workers raised concerns about the future sustainability of their organisations and their own employment.

- Concerns were raised regarding staffing levels in residential aged care. Perceptions of insufficient staff numbers and the replacement of RNs with lesser qualified staff were considered to be negatively impacting on resident care.

- Workers were concerned that aged care work was held in low esteem by the general community and those working in other healthcare sectors. Respondents recommended that negative perceptions and working conditions be addressed to make the sector more attractive to potential workers.

Qualitative interviews with 100 direct care workers were undertaken following the aged care workforce survey. These interviews had four primary aims. Firstly, as limited previous research has focused on newly hired and mature workers within aged care, we sought to understand more about their specific experiences of working in the sector. Secondly, a key focus of the qualitative interviews was to investigate issues relating to recruitment and retention in aged care. Thirdly, we sought to explore direct care workers experiences of job satisfaction, knowledge and skills, work-life balance, occupational health and safety, and quality aged care services. Finally, the interviews identified and explored emerging issues for the aged care workforce.

7.1 The Interview Process

Upon completion of the workforce survey, direct care workers were given an opportunity to nominate themselves to take part in a qualitative interview about their experiences of working in the aged care sector. This section outlines the sampling and recruitment strategies undertaken and provides a description of the sample of direct care workers who participated in an interview.

7.1.1 Sampling and Recruitment

A purposive sampling strategy was used to identify eligible participants for the qualitative interviews. In total we aimed to interview 100 aged care workers with equal numbers based in residential and home care and home support facilities/outlets. The sample was then further stratified to oversample our two target groups: new hire workers (who had been working in aged care for a year or less) and mature workers (aged 55 years and older). A third group of general workers (who did not meet the criteria for the other two groups) was also selected. Overall, we aimed to interview 30 new hires, 40 mature workers, and 30 general workers. Within these three groups, we sought to select approximately equal numbers of workers from the two main occupations within aged care - nursing staff (RNs, ENs and nurse practitioners) and care workers (PCAs and CCWs).

The recruitment process for the qualitative component involved randomly generating a sample of workers using the purposive sampling strategy described above. The NILS research team then called potential participants to schedule telephone interviews at a time that was convenient for the participant. Three attempts were made to contact each person and if this was unsuccessful he or she was replaced in the sample. Those who expressed a desire not to take part in an interview were also replaced. This process occurred until interviews with 100 workers were completed.

The interviews were conducted from August to October 2016 and lasted for approximately 30 minutes. A copy of the interview schedule is provided in Appendix 2.

After obtaining consent from each participant, the interviews were digitally recorded and transcribed verbatim by a professional transcription service. The transcribed data were entered into NVivo 11 in order to assist with the management and analysis of the data. Following familiarisation with the data through the reading of the transcripts, a thematic framework was developed and agreed upon by the qualitative research team. This thematic framework was based around the core topics outlined in the interview schedule and included

the main sub-themes which had emerged during the interviews in relation to these topics. The interview transcripts were then coded according to this thematic framework. Key themes were developed and refined throughout the data analysis to enable further emergent categories to be identified.

In order to maintain anonymity, each interviewee was designated an identification number which reflected key attributes of their work sector, employee group and occupation. An identification number with the prefix R indicates a worker from a residential facility, while H indicates a home care and home support worker. The identification suffix identifies the sample group a worker belonged to (with N for new hire, M for mature worker and G for general worker) and their occupational group (RN for registered nurse, EN for enrolled nurse, NP for nurse practitioner, PCA for personal care attendant and CCW for community care worker). Therefore a quote by worker R14M_PCA relates to interview number 14 of the residential workers; and as the suffix is 'M_PCA', this person was a mature worker employed as a PCA.

7.1.2 The Interview Sample

Using the stratification process described above, a randomised sample of employees was selected. Overall, semi-structured interviews were conducted with 100 workers. Of these, residential workers accounted for 52 of the interviews and home care and home support workers for 48 interviews. Across occupational groups, 43 nurses (29 RNs, 11 ENs and 3 NPs) and 57 care staff (31 CCWs and 26 PCAs) were interviewed. Parity with regard to work setting and occupation was unable to be reached due to a relative lack of new hire nurses in the sample, particularly in home care and home support settings (further detail on this is provided below in Section 7.1.2.1).

As planned the total sample included 30 new hires, 40 mature workers and 30 general workers. A description of the workers interviewed in each of these groups is provided below.

7.1.2.1 New hire workers

In total 30 new hire workers were interviewed. Within this group we had aimed to interview equal numbers of nurses and care workers. At the time of recruitment for the qualitative interviews, however, fewer new hire nurses than anticipated nominated themselves to take part in a qualitative interview (in total two new hire nurses in the community and 11 residential nurses). As several of these workers were subsequently unable to be contacted or declined to participate, interviews were only able to be conducted with eight residential new hire nurses (and no nurses from the home care and home support sector). Thus in order achieve a total of 30 new hire interviews, additional CCWs and PCAs were recruited and interviewed.

Thirteen of the new hire workers interviewed were employed in home care and home support outlets (all working as CCWs) and 17 worked in residential care (9 PCAs, 7 RNs and 1 EN). All the new hire interviewees had worked within the sector for a year or less (the shortest tenure was three weeks). The age of these interviewees ranged from 20 to 62 years; including four mature workers who were aged 55 years and older. A fifth of the new hire sample were male workers.

7.1.2.2 Mature workers

Interviews with mature aged care workers were conducted with 20 home care and home support employees (10 CCWs and 10 RNs) and 20 residential workers (10 PCAs, 6 RNs, 3 ENs and 1 NP). These workers were aged from 55 to 72 years of age; 12 workers were aged 55-59 years, 16 were 60-64 years, and 12 were 65 years and older. Experience in the aged care sector ranged from two to 43 years. While several mature aged workers had spent their entire working lives in aged care, around half of the interviewees were relatively new entrants to the sector and had worked in aged care for less than 10 years. The mature worker sample included four males.

7.1.2.3 General workers

The sample of general workers interviewed included 15 home care and home support workers (8 CCWs, 4 ENs and 3 RNs) and 15 residential workers (7 PCAs, 3 RNs, 3 ENs and 2 NPs). The general worker group had between two and 28 years of experience in the sector and their ages ranged from 21 to 54 years. Six of the general worker sample were male.

7.2 Recruitment and Retention in the Aged Care Workforce

Over coming decades the aged care workforce will need to expand considerably if it is to meet the forthcoming anticipated increase in demand for aged care services. It is therefore of primary importance that new workers are attracted to enter the sector and that the retention of the existing workforce is improved. A key aim of the qualitative interviews then was to identify specific issues relating to recruitment and retention in aged care. The interviews examined pathways into aged care including previous work histories, the interviewee's current role in aged care and whether they held more than one paid job. Motivators of becoming an aged care worker were explored with respondents including the reasons for choosing a career in aged care and for selecting to work in their current organisation. In order to examine issues relating to staff retention, interviewees were asked about positive and negative aspects of their work and also about their career plans over the next three to five years.

7.2.1 Pathways into Aged Care

Only a small number of workers reported that their employment in the aged care sector was their first paid work experience. Typically the majority of respondents had entered the sector following quite substantial employment histories. For the new hire sub-sample, the working backgrounds of CCWs and PCAs was diverse, ranging from factory and cleaning work to employment in the corporate sector. Several of the new hire PCAs reported that while they had previously worked in the aged care sector, this was in non-care related roles, such as kitchen assistants.

> *My pathway is completely very, very different. I have no medical background or nursing background or anything like that, I come from completely a corporate world, and it's a huge switch to move into community services.* (H23N_CCW)
>
> *I'd actually worked in another aged care facility, but I was actually in the kitchen. So, I was kitchen staffing before I started my nursing and throughout my first year. And, then at the end of the first year I got my certificate and did my placement.* (R33N_PCA)

A majority of new hire nurses had had established long-term careers in other fields of nursing; only three nurses in the sample reported that their role in aged care was their first position as a qualified nurse.

> *I've only been in aged care for about 12 months. I've been in general practice for seven years and prior to that, nurse management - well I've been in nurse management per se for the past 20 years, but I've been in the acute sector.* (R21N_RN)

Most aged care workers held only one current paid job in aged care and were not seeking additional sources of employment.

> *No, no, this is my only job…I couldn't even work five days, I can't do anymore than - I mean it's such a physically demanding job…so my body could not do any more than I'm doing now.* (H35N_CCW)

However, reports of having additional paid work on top of their primary aged care role were not uncommon within the sample (particularly for the new hire home care and home support and general workers). Some respondents reported that they combined their direct care work with a different role for the same organisation – these secondary roles included administrative work, primary health nursing, diversional therapy and, for some home care and home support

staff, doing residential nursing or care work. Other workers reported having additional employment with different employers, predominantly casual nursing and care worker roles within aged care. However, several direct care workers were also working in non-aged care related roles in other healthcare sectors, research, retail, labouring and some were running their own businesses.

> *I take two roles under the same company. On different days and different shifts as well…in the afternoon is helping out at the aged care facility, and after 3:00, 4:00 to 6:00 PM or 7:00 PM I'll be helping out at the client's house.* (H21N_CCW)

The need to supplement their income from their primary aged care job was a primary reason given for the taking on of additional work, thus indicating the presence of underemployment in the sector. For others, diversity of work and flexibility were motivations for a second paid job.

> *I think it works for me, it gives me lifestyle. And mental stimulation I think, it prevents burnout in one particular area.* (R27N_RN)

7.2.2 Choosing to Work in Aged Care

When asked why they had chosen to work in aged care, direct care workers from across all three groups described their primary motivations. These included having a direct interest in aged care, job availability and opportunity, flexible working conditions and seeing aged care work as a stepping stone to employment in other healthcare sectors.

Around half of the workers interviewed attributed their decision to work in the sector to an active interest in aged care work. Respondents predominantly described wanting to care for the elderly or deriving enjoyment in working directly with people. For some workers, and particularly those in the community, previous experiences of caring for elderly relatives had led them to view aged care as a viable option for paid work.

> *I had been an at-home mother for 18 years, and so was looking to go back into workforce… I've always worked/enjoyed dealing with aged people, and I knew it was a growth sector.* (H29N_CCW)
>
> *Sort of the reason I went into aged care, I was taking my nan up from Sydney and taking her home and doing all her personal care and everything like that, so I had a lot of compassion there and stuff like that, so I just went into retraining myself to go into aged care.* (H22N_CCW)

For other workers, undertaking care work in other industries led to them viewing employment in the aged care sector favourably. The completion of a placement in aged care as part of a training course had also cemented a decision to work in aged care for several interviewees.

> *I was working in childcare before I went on maternity leave and instead of going back to childcare I decided to try something new.* (H24N_CCW)
>
> *When I was doing my study to get my registration back, I did a placement in an aged care facility, and I was absolutely gobsmacked by how much I enjoyed it. I wouldn't have predicted that. And, I think the other thing is that my mother at that time was in an aged care facility and I just saw how important it is.* (R04M_RN)

Half of the mature-aged and general worker sample (and a smaller proportion of new hire respondents) attributed their decision to work in the sector primarily to the presence of an available position when they were seeking work. Some nursing staff had experienced difficulties in securing work in other areas of nursing due to their location or a difficult job climate while a number of care workers described the aged care sector as *"something that I fell into"* (R48G_PCA).

> *It's going to sound awful, but I'm a new grad nurse, and in WA the job climate is just absolutely ridiculous, there's not a lot going on. We've got a freeze on all public health positions, yeah, and so…that's how we ended up in aged care. Not to say that I don't like it.* (R24N_RN)

> *It was probably by accident. I'd had a change of career and in the interim, while I was deciding what to do next, I was working for an agency, and as part of that agency employment I got sent to aged care to do some work, and just being exposed to it through the agency I ended up in this area. So I didn't seek it out, it was just where I ended up and I liked it*. (R47G_PCA)

The ability to achieve a good work-life balance was a common motivator for entering aged care particularly for respondents in home care and home support settings. Working conditions in aged care were perceived as being fairly flexible, enabling a more effective combining of work and non-work responsibilities.

> *Well, I wanted something that was through the week. Because before I'd been doing like hotel work or baking and so having a young child, could no longer do weekends or nights, so I wanted something more nine to five, Monday to Friday, and so the days were perfect. And I enjoy working out in the community and meeting new people.* (H24N_CCW)

Amongst new hire employees, and particularly those working in residential care, a further common reason for choosing to work in the sector was that it would act as a *"stepping stone"* (R23N_RN) for a career in other areas of healthcare. For most of these respondents, aged care work was seen as a first step towards achieving their ultimate goal of qualifying and/or working as a nurse in the hospital system.

> *I've always loved the idea of helping others, and my eventual goal is nursing. There was a study opportunity for me to study under a scholarship, and so I kind of grabbed it. It was to study aged care, and I thought that would be a nice gentle ease into the healthcare industry.* (H32N_CCW)

In addition to providing information about why they had chosen to enter the sector, some new hire workers described the reasons they had specifically selected to work in a home care and home support setting. Positive perceptions of community aged care (compared to residential care) which had influenced this decision-making included views that a home care and home support setting allowed workers to have more time with their clients, leading to more meaningful interactions and greater job satisfaction. Community aged care was also seen as providing more variety and, due to the lower care needs of clients in that setting, necessitating less intensive care responsibilities.

> *When I went for my placement in the nursing home, it sort of gave me a scare, like I didn't expect certain things and I was not ready for it, and I was not prepared, and I thought, oh it's not going to work with this being in high care and low care, it's not going to work out for me with the duty of care. But, the community services I came on again is different. I mean, it is attending to aged care people, but it's in their own home. That was much more easier and more fulfilling at end of the day, because you had a one-to-one interaction with the clients, and you sort of build that bonding and you get to know them better, and you can serve better to them personally…yeah that was the driving point for me.* (H23N_CCW)

When asked why they had chosen to work for their current employer, most respondents identified that this choice had been a matter of convenience rather than a definite preference. For many the availability of work at the organisation was the key factor informing their decision to work there. Others (mostly new hire workers) had secured their employment with the organisation as a result of doing a placement there as part of their studies.

> *It was circumstances, they were recruiting at the time and I wanted to get my foot in the door.* (R27N_RN)
>
> *I was offered a position. I still had to go through a formal application process, in terms of referees and a resume, but I was approached while I was training, if I would be interested in a position.* (H32N_CCW)

The location of the work setting was of particular importance to residential workers across all three groups; geographical convenience contributed to many decisions as to which organisation to work for. The location of the workplace was especially important for those who had made a lifestyle decision to move to the country or were seeking a reduced commute

time: *"I like to work in country hospitals, I don't like working the bigger ones, and I saw this position come up, so yeah. And, I needed to come closer to home for work*" (R10M_RN).

Having had personal contacts within an aged care organisation that had facilitated work opportunities was a further reason noted by several respondents in their choice of employer.

> *Well, we have limited areas available over here, being in the country, for employment…I had friends working out there as well and they said, "They're looking for more people. Put an application in and see how you go." And, yeah that's how I started, I put an application in and I'm still there today.* (R45G_PCA)

Finally a minority of workers reported that an existing positive perception of the organisation had influenced their choice of workplace. Their organisation was seen as having a good reputation and values they admired, provided good quality patient care or was perceived to give their staff job stability and diversity of work experience.

> *Because I actually liked their values, their set of beliefs. It's pride, respect, resilience, teamwork, empathy and trust. I thought, if that's true then that's the place I want to work for.* (R06M_NP)
>
> *I chose to move to [Name of organisation] because…I prefer to work… where you get a range of different clients.* (H20M_CCW)

7.2.3 Job Satisfaction

In order to inform understanding of factors which influence workforce retention in aged care, the interviews explored job satisfaction in the sector. Interviewees were asked about the elements of their work that they liked best. The interviews also examined aspects of aged care work that were perceived to be difficult or stressful, the impact these issues had on the workers themselves and their daily work, and the strategies used to deal with these difficulties.

7.2.3.1 Positive aspects

When asked what they liked best about their work, direct care workers most frequently described the close relationships and interactions they had with their clients.

> *It's the residents. I think once you start doing a job like (this) and you become involved, you recognise their individual personalities and their sense of humour and just everything.* (R14M_PCA)
>
> *Now I'm in community care, I feel I get more of that one-on-one time to socialise with people…when I became involved with people in residential care, I'd have five minutes with them before it was moving onto the next thing, and so I felt like I was being rushed in that sense...Whereas, now that I'm in home care some of my clients I'm with them for an hour, I'm with some of my clients for three hours, so I feel like I get so much time to get to know them, and spend that time with them I suppose.* (H32N_CCW)

The sense of fulfilment gained from knowing that they were making an important difference to the quality of the lives of older people was a further important aspect of job satisfaction for the workers interviewed. For respondents in the community, the understanding that they were helping their clients to remain living in their own homes was also valued.

> *You make a difference because they're able to stay at home. If those services weren't in place they wouldn't be able to stay at home.* (H47G_CCW)

Specific aspects of aged care work which led positively to job satisfaction were also discussed by many interviewees (and particularly by those working in home care and home support settings and by residential nursing staff). These workers appreciated being able to effectively use their skills and training, make autonomous care decisions, and have diversity in their day-to-day work.

> *[I like] the fact that it's different every day. The fact that you get to be autonomous in your role here, and when I say that you don't have doctors sort of over you managing the situation. You're able to use your clinical expertise which you wouldn't be able to do in a hospital system*. (R40G_NP)

Further positive aspects of working in aged care that were highlighted by interviewees included having good relationships with co-workers and valuing the teamwork which occurred within an organisation to provide quality client care. Supportive relationships with management and flexible working conditions were also noted by a small number of interviewees.

> *We've got a really lovely team and we don't let anything stress us or anything and we work as a team to, like, the best we can and to meet all the client's needs, you know.* (H22N_CCW)

> *The managers and everyone is really good, like they appreciate what we do, whereas in other places you just don't get appreciated, which is important I think to get appreciated. So especially with the job like carer, which is really hard, like physically and mentally draining. So it's very important to get appreciated for your work I think.* (R29N_PCA)

7.2.3.2 Negative aspects

While a small proportion of workers reported that there was nothing difficult or stressful about their work, the majority of interviewees identified negative aspects of working in aged care. Excessive workload and perceived time stress was a significant issue for many workers. High workloads were attributed to inadequate staffing numbers (particularly in residential settings) and excessive amounts of administrative tasks and paperwork. Levels of administration were considered by some workers (and particularly those in home care and home support outlets) to have increased with recent changes to the sector.

> *It's usually very, very busy and I think you're just constantly in a state of juggling multiple demands on your time that are often in conflict, and that can be stressful*. (R04M_RN)

> *The most difficult and stressful would be the amount of administration that's required now, from the government basically. And, the regulations and the referral pathways and systems that are being put in place without the support, because that's impacting on patient care*. (H38G_RN)

The difficulties caused by high workloads led many in the sample to undertake significant amounts of overtime and unpaid work or to be unable to take available leave. High staff workloads were also perceived to impact negatively on the care received by clients.

> *Well, you have to shortcut and that's the only honest answer I can give you, you have to shortcut. You don't have the time to do everything that you would like to do and that we should be doing for these residents.* (R12M_PCA)

Some respondents reported feeling overwhelmed and unable to address underlying work pressures: "*because nurses don't complain, we're our own worst enemies, at least a few of us*" (R08M_RN). Other direct care workers related strategies utilised for dealing with excessive work responsibilities. These included leaving the work for the next shift, getting help from or delegating tasks to other staff, prioritising activities that needed to be done, and delaying spending quality time with residents until urgent tasks had been completed. Others felt impelled to be assertive in advocating for change: *"So I am fairly vocal with things that I don't like, and I think that's a personality experience thing, and so far, it's worked"* (H17M_CCW)

Working conditions and arrangements were a further source of stress for many aged care workers. Respondents across all settings and occupations were unhappy about the rates of pay in the sector, comparing their pay rates unfavourably to those offered in different settings.

> *One of the issues that I think all of us have as care workers is the pay rates. It's not very good…For what we do I don't think we are paid enough and I'm not being greedy.* (H25N_CCW)

Further issues relating to working conditions in aged care were raised by home care and home support staff (and predominantly CCWs). Insecure employment – in the form of casual contracts, insufficient hours, being on-call, irregular rosters and split shifts – was a major source of stress for these workers. A lack of financial compensation for travel time when commuting between clients' houses was a further frustration expressed by some home care and home support workers.

> *You might have 10 hours today and next week it's only 15, and next week could be 20 and then back to zero…That would be much easier for me to know that every day I got a normal 35 hour shift, to be able to live out of that. But I understand that it's not the way it is and at the moment it makes things difficult for me, because I need to think of the future too, and eventually I might have to do some other stuff to have a budget to live on.* (H31N_CCW)
>
> *The other day…they wanted me to drive 20 kilometres to do a one-hour service and then drive back home sit around for three hours, well, be off work for three hours, and then go back to the same place 20 kilometres away and work for two hours, and then again come home and have an hour off and then go off and do two more hours work of an evening.* (H17M_CCW)

Interviewees also commonly raised specific concerns about their work with clients and their families. The deteriorating health and death of clients was perceived to be emotionally draining. Workers also reported finding the care needs or challenging behaviours of some clients difficult to deal with; this was particularly pertinent for those working in palliative and dementia care. In addition some respondents expressed concern that unreasonable expectations of clients or family members negatively impacted upon job satisfaction. In order to deal with the psychological impact of these stressors, workers reported relying upon their support networks from both inside and outside their work environment.

> *Since I've started there we've had a few pass on, so we as PCAs tend to have a bit of a chat and remember good things, bad things, funny things, strange things, whatever it is about those residents. When we're working we have a chat and when we are at lunch or dinner we'll often have a few chats, and I'm lucky I've got quite a few friends that are all nurses, so I can speak quite discretely with them about feelings I'm having and not having and go through the process. I'm quite lucky that I've got a large support system around me, at work and outside.* (R31N_PCA)

Difficulties relating to relationships with co-workers and management were a further source of stress for some direct care workers. Some co-workers were perceived as having negative attitudes to their fellow colleagues and providing poor quality care to their clients. Dissatisfaction with management was also reported by several workers. This ranged from concerns about decision-making by senior staff, the absence of supervision and frustrations about the quality of management (including not listening to, understanding or respecting the experience of care staff).

> *There are some staff which didn't attain at least a Cert III in aged care or community service. They just joined the organisation but they've been working with the company for 18 years. So they do things their way, but from my perspective, sometimes I see them carrying out the task but I feel that it's very dangerous for the client.* (H21N_CCW)
>
> *They [management] sit in the office and have a meeting and then make their decisions from that rather than actually (having) the knowledge of what goes on*. (R12M_PCA)

7.2.4 Retention in the Aged Care Workforce

When questioned about their future work plans, around three-quarters of direct care workers (and all but one of the home care and home support new hire staff) expressed a desire to remain working in the sector over the next three to five years. These workers frequently cited enjoyment in their work, positive relationships with clients, and satisfaction with their current employer as contributing to this intention to stay. Some mature-aged workers also reported wanting to stay in aged care in order to complete on-going projects or promote improvements within their organisation.

> *I can see myself still working for the same organisation. I really enjoy working here and I enjoy the people I work with. It's a good work environment. You've got a lot of support. I can't see me being anywhere else.* (H43G_CCW)

> *I'd love to achieve, what I'm chasing now for our unit, is a better practice award. I've come home from this…conference with a bit of a new module of care in my mind, which I want to implement.* (H04M_RN)

Most employees who intended to remain in aged care expected to maintain the same position with their current organisation. Other respondents hoped to pursue other roles within aged care including taking on, or extending, managerial responsibilities. Some staff also planned to undertake further education and training to enhance their skills and job opportunities. This included several CCWs and PCAs, who were either currently undertaking, or expressed a future desire to start, a nursing qualification.

> *With home care I'm not really getting anywhere further. I would like to go further in my career. I'm looking into becoming a nurse, because that's just the next step up from being an aged care carer.* (H46G_CCW)

> *Maybe doing some stints in a managerial role and especially knowing, in aged care about the budgeting and all the sort of administration that goes behind running a nursing home, the healthcare management.* (R27N_RN)

While the vast majority of mature-aged and general workers wanted to remain working with their current employer, some new hire respondents expressed a desire to move to a different aged care organisation. The reasons provided for this proposed move included finding a facility that was closer to home, working in a setting that better matched their personal values, and moving into the community aged care sector.

> *I really want to really get into palliative care in community work. I have done it as a placement, absolutely loved it. Just not quite sure how I'm getting there, but that's my focus right now.* (R25N_RN)

For a small number of new hire respondents (and particularly those working for home care and home support organisations) their future work goals in aged care included improving their working conditions through obtaining more secure employment, increasing their hours or improving rates of pay.

> *It's because I'm casual, like it's really quite simple, like at least 20 hours, but it's not constant and I sometimes get ten hours, sometimes get 15, so it's just being casual, yeah…I would really prefer to have at least 20 hours per week…Yeah, I'm keen to be a permanent part-time.* (H23N_CCW)

> *If a public facility was to offer the same sort of hours and close to home and salary packaging, and the rate of pay that my nursing federation award gives us – because the private actually pay less – I would move. Because they will give me my full awards rate and they would pay me penalties right through Sunday nights, Monday morning where my facility will only pay Sunday rates till midnight on Sunday…So I suppose, you know, for wages wise and pay I would move.* (R27N_RN)

Although several older workers (including some aged 65 years and older) were keen to remain in their roles in aged care, they acknowledged that their future capacity to manage the work was dependent on maintaining their health and fitness as they aged.

> *Providing my fitness and ability to do the job continues I would continue as long as possible in the industry…I do see that in other workers, that people don't always make it to retirement age in the aged care industry. But having said that, as basically unskilled workers they wouldn't have made it in probably any other industry that requires them to be on their feet all day. It's probably not specific to aged care*. (R47G_PCA)

> *I would like to work until the day I die. I really - as long as I'm fit, because I'm pretty fit, as long as I'm fit and well enough*. (R01M_EN)

However, not all respondents planned to remain working within aged care in the longer-term. Intentions to leave aged care were particularly prevalent for residential new hire workers and older workers. A fifth of the new hire workers (mostly residential staff) reported that they planned to leave the sector. Although most were aiming to move into hospital nursing, some were considering a return to aged care once they had expanded their skill set in an acute setting.

> *I'm a new grad that was hoping to get into a hospital…I'm learning a lot and getting to use my clinical skills. So basically just working on doing well at this position and I would still like to get into a hospital. ED is my main goal. But I'm certainly making the most of the job while I'm here. (R24N_RN)*
>
> *I'm not sure if I'll stay in this role for that long. Probably towards the next year or so I'll be staying in here but then I'll be moving over into something else. Just because I'm going into arts and business and that sort of side of things.* (H33N_CCW)

For many in the mature aged cohort retirement was foremost in their minds, with almost half of the sample reporting expectations of retiring in the next three to five years. In some cases poor health or existing workplace injuries were forcing this decision. Some had already begun to make active plans for this transition, for example reducing their hours of work.

> *I just felt really tired…I've got to that 25-year milestone and I thought…"oh no I can't do this anymore. It's been a great job, but I just can't do it anymore*. (H03M_RN)
>
> *My plan is in five years' time, I'm going to be out of here, because I'm already 56 and I've got that many injuries…a couple of whiplash injuries and got multiple fractures in my upper back and six bulging discs in my lower back. And I've got bursitis in my hips and in my shoulders…And my plan for probably next year is to try and find a part-time job, so that I can work part-time for the next five years before I retire.* (R06M_NP)

7.3 Experiences of Working in Aged Care

A further aim of the qualitative interviews was to understand the experiences of direct care workers in relation to quality in aged care, occupational health and safety, job satisfaction, knowledge and skills, and work-life balance.

7.3.1 Quality Aged Care Services

The interviews examined worker perspectives on quality within aged care. Specifically respondents were asked about the characteristics, skills and qualifications that make a good aged care worker. At an organisational level, the factors which enable an aged care outlet to provide quality care to its clients were also discussed.

7.3.1.1 Characteristics of good aged care workers

When respondents were asked about their perception of what makes a good aged care worker, overwhelmingly they spoke about particular "qualities" a person needed to have to be able to work with older people. Possessing personal qualities such as patience, understanding, compassion and empathy were seen as being more important than other characteristics such as aged care skills: "*Well, skills can be taught but a personality can't"* (R23N_RN). Qualities relating to aged care work itself - having a strong work ethic, being a team player, having a willingness to learn and a desire to work with older people – were also valued highly.

To a lesser extent, respondents discussed factors relating to skills and qualifications when describing what makes a good aged care worker. Core skills perceived to be important in aged care work included effective communication, being person rather than task-focused, literacy skills, good time management, conflict resolution skills and being organised. For nursing staff, being comfortable with autonomy and decision-making was also seen as being vital. Many respondents (and particularly those who had been working for longer in the sector) stressed

the importance of minimum requirements for workers to hold a Certificate Level III aged care qualification. However, as discussed below in Section 7.3.3, reservations were expressed regarding the quality of some certificate level courses. Consequently, respondents stressed the importance of care workers also having hands-on experience and ongoing work-related training.

> *I think you just need to be the right sort of person, so qualifications help with knowledge and when you get into situations, but it's as much to do with experience as the qualification.* (H17M_CCW)

Socio-demographic factors such as age, gender and culture were felt to play a minor role as to whether or not someone was a good aged care worker. Having both younger and older workers in the sector was thought to offer benefits to client care. Older workers were seen as contributing valuable life experience and reliability (in presenting for shifts and loyalty to the organisation). Clients were also often reported to be more comfortable working with mature workers. In contrast, younger workers were perceived to bring energy and be a *"breath of fresh air"* (R21N_RN) to the sector.

> *The young ones that work at our facility they're very good. They're very, very caring and most of them want to be nurses so they've got that nurse personality, so very caring.* (R13M_PCA)
>
> *Some of the elderly that we look after prefer to have an older carer because they might be embarrassed about their incontinence or things like that.* (R21N_RN)

Likewise, although the gender of an aged care worker was recognised to be a barrier for some older people (e.g. if they preferred to have their personal care needs undertaken by a male or female worker), on the whole respondents welcomed a mix of both male and female workers in the sector. Some respondents believed that the sector would benefit from more men entering aged care work, particularly with regard to assisting with the care needs of male clients. Male workers were seen as being as competent and skilled as female workers and were particularly valued for their perceived ability to deter threatening behaviour from clients and being able to assist with tasks which required physical strength such as client transfers.

> *Well, a lot of our residents, if they're female, they really struggle with having a male carer. We do have, there's one particular carer that's male that I work with quite a lot. He's absolutely amazing, he's brilliant, and he's very good at helping those ladies that don't really want a male person showering them, and he's very understanding with that, and if it's too much for them, he just steps back*. (H36G_EN)

> *In a lot of ways in so many situations we need the men because there are clients that only want to go out with guys. They want to go down the pub or whatever and they want to be with a guy. At our service we're in a coastal area and there are men that all used to be surfers and beach goers and they need to have a carer that's got more strength to help them down the beach and places like that*. (H44G_CCW)

While respondents reported overall that a worker's cultural background made little contribution as to whether they provided good care or not, having staff who shared a mutual language and cultural background with CALD clients was considered a favourable employee characteristic. The importance of English proficiency in an aged care worker, however, was also thought important by some respondents in order to aid communication with clients.

> *My last facility…was more of a multicultural facility, and staff as well, and certainly if we have staff on that are multicultural and actually can speak a native language to a resident who kind of reverts back to their native tongue in dementia, it's a great resource*. (R39G_NP)

7.3.1.2 Factors enabling aged care organisations to provide quality care

The factor most emphasised by respondents as enabling aged care providers to deliver quality care was the presence of adequate levels of skilled staff. In particular, organisations were seen as needing the ability to cover shifts when staff were absent rather than relying on agency

and casual staff or working short-staffed. Negative impacts of inadequate staffing on client care are discussed further in Section 7.4.2.

> *I think that's the biggest thing, if you have adequate staff and staff that are trained properly, they're able to do their job the best they can.* (H32N_CCW)

Many respondents also noted the importance of good management in contributing to the provision of high quality aged care. Many reported the need for managers to value staff skills and experience, to promote lines of communication with their staff, and to listen to and advocate for their workers. This was thought vital in supporting good teamwork and a respectful and well-functioning workplace. Other respondents suggested effective management provided good oversight and supervision to ensure quality of care, and supported flexible and innovative care options. It was also considered important that managers personally have previous direct care work experience in order to be able to make decisions that lead to quality care.

> *Excellent management. You need good managers because without a good manager, the ship just doesn't go.* (R01M_EN)
>
> *Our manager there worked on the floor for a long time before she took on a management role so she's quite sympathetic to us and she understands. She's quite good. But the higher-ups in the company…are there for the bottom line rather than for the care of the residents I think.* (R23N_RN)

Adequate funding for aged care services was seen as impacting upon an organisation's ability to provide quality care. Appropriate levels of aged care funding (as further described in Section 7.4.1) were important in enabling good staffing levels and also in improving care in residential settings through an enhanced physical environment (e.g. large rooms for residents), a broad range of resident activities and the ability to purchase and maintain specialised equipment.

> *They're quite generous with their funding, so if we feel we need a piece of equipment for a resident, we can get it. So, if I felt if someone needed a pressure mattress, we would have it, if I felt someone needed a specialised wound product we would get it. So, yes they are very accommodating from that point of view*. (R38G_RN)

Some respondents (and especially the mature workers) noted the importance of organisational values in supporting quality client care. Evidence of positive values included communicating expectations of high quality care to staff, providing access to ongoing training, and demonstrating clear accountability (e.g. being responsive when problems occurred). Several respondents highlighted the perceived differences in operational imperatives between for-profit and not-for-profit aged care providers; in order to provide quality aged care services it was seen as being important that organisations prioritised the needs of their clients rather than be driven by business practices.

> *It's always the values of the organisation. It's also the staff. It's the culture of the organisation. What they promote as good care, acceptable care, and the standards that they expect of their staff*. (H01M_RN)

Finally, effective workplace policies and procedures were thought to be core components of a good aged care organisation and assisted in the provision of quality care. Respondents recommended that these policies and procedures should follow best practice, be well-structured and clear, and easily accessible to staff members.

> *Ours (policies and guidelines) up until recently were a little bit outdated, and they've all just been reviewed, basically the whole file got turned upside down and shaken out. And they all got reviewed and rewritten and it has made a vast improvement with the procedure for a lot of the care practices, just being improved and updated, and yeah being monitored to make sure that it's the best practice.* (H36G_EN)

7.3.2 Occupational Health and Safety

The qualitative interviews explored issues relating to occupational health and safety (OHS) in aged care. Interviewees were asked about the OHS policies and procedures in their workplace, how these were communicated to staff, and how well these policies and procedures were working. Participants were also questioned about concerns relating to health and safety in their work and, if raised, the responsiveness of their employer to these issues.

7.3.2.1 OHS policies and procedures in the workplace

Awareness and understanding of OHS policies and procedures in the workplace was high amongst interviewees (including the newly hired workers). These included policies and procedures on manual handling and use of equipment, fire safety, first aid, infection control and hygiene, medication management, and chemical spills and waste disposal. For workers based in the community, policies and procedures were also reported regarding home risk assessments and travel.

Respondents advised that a range of methods were used to communicate information about OHS policies and procedures to staff. The interviews suggested that most organisations undertook initial communication of these policies and procedures at the point of employee induction, followed by annual refresher training (conducted either online or face-to-face). Concerns were raised, however, around access to, and the level and quality of, this training. Some respondents felt that face-to-face training days for staff were occurring less frequently, or not at all in some organisations, attributing this to funding constraints. Others thought that some areas of health and safety – specifically manual handling – were inadequately covered in online modules or in passive face-to-face presentations. Some respondents observed that they were either expected to complete the OHS training in their own time or struggled to attend sessions in worktime due to workload pressures.

> *I think it's something that has to be learnt on the job. You can sit in the classroom and learn something, but I think manual handling and support and all that has to be done on the floor. (*H20M_CCW)
>
> *…so we get a half an hour training during our break sometimes, which I find it a bit hard to cope with because we are trying to have a break and they want us to come for training.* (R29N_PCA)

Respondents suggested OHS policies and procedures were easily accessible in their workplaces. In some cases they were in electronic format: *"You can always go to the computer and if you're not sure what the rules and regulations are you can always access it"* (R09M_RN). Others reported that hard copies of manuals and other OHS documents were centrally placed (e.g. in staff rooms or offices), or noted that some policies were posted to office walls. Changes to OHS policies and procedures were typically communicated to staff at their regular staff meetings or through emails, communication books and message boards.

In addition to the direct reporting of OHS issues, most respondents noted their organisation had administrative procedures in place relating to the reporting of health and safety concerns. These took the form of client and personal incident reports and hazard reporting forms. Completion of these forms ensured concerns were logged and forwarded to site managers. The majority of respondents in both residential and home care and home support settings were satisfied with how well OHS policies and procedures were operating in their workplace. The value of these processes in protecting staff and clients well-being was also recognised.

> *I think some of them [the OHS policies] are a little bit overkill, but…rather be you have it than you don't, because it protects you, it protects the client, it protects your business.* (H45G_CCW)

7.3.2.2 OHS concerns in aged care

While most direct care workers felt that their workplace was a safe environment, around a quarter of those interviewed raised OHS concerns. These concerns were predominantly about co-workers not following appropriate procedures such as manual handling techniques. This was attributed to a lack of available equipment or poor room design not allowing the use of equipment, as well as workers choosing to ignore directives. Furthermore the pressure of work demands was seen as leading to workers rushing their job tasks and staff shortages meant that staff were working alone rather alongside co-workers; these were additional factors which contributed to breaches in OHS protocols. Home care and home support workers also raised specific concerns relating to physical hazards in and around client's homes, a lack of oversight of client medications, and an observation of elder abuse.

Some PCAs also acknowledged that they themselves did not follow recommended OHS protocols due to work pressures when working with residents.

> *These days more and more people are getting sick, so meaning to say we are understaffed. So, by the time that I have to call someone to help me lift one resident and then other carers are engaged with the other residents, I have to find another way to help the resident to stand up, and it's difficult, or else I have to wait for them, when they're going to finish.* (R52N_PCA)
>
> *You become tired, your attention span isn't the same, you take risks and then someone else is hurt, which (has) proved true.* (R20M_PCA)

A fifth of the mature-aged respondents (mostly, but not exclusively, CCWs and PCAs) described having health problems or injuries which were thought related to having worked in aged care for an extended time. Several noted that their conditions were in part a consequence of less stringent policies around manual handling and lifting in previous years. The cumulative stress caused by constant overwork was also reported to have taken an emotional toll for some older workers.

> *I remember all those stupid lifts that they used to make us do when we were younger…They killed our bodies by making us lift patients around. We followed all the rules, we did what they told us to do…It wasn't that we did anything wrong, but by using our body as a lifting machine for years and years, now everyone my age that's been in nursing for years, it's taken its toll. I haven't fell over at work or had a bad accident or anything like that, it's just wear and tear and general deterioration. It's just cracked from working too hard.* (R06M_NP)
>
> *I work a lot of unpaid overtime, I'm certainly stressed, everybody's stressed but yes, it takes a toll over years and years and years of doing this. Things are getting worse not better, so it takes an emotional toll*. (R03M_RN)

Respondents discussed how management in their workplace had responded to OHS concerns which had been reported by themselves, other staff or clients. On the whole satisfaction was expressed that these concerns had been responded to quickly and remedied if possible. Actions undertaken to address OHS concerns included removing hazards, providing more carer hours, organising training or making adjustments to existing policies and procedures. Staff also described the role of facility health and safety representatives in ensuring OHS practices were followed.

> *Any risks that arise are dealt with straight away, any hazards, and management's usually onto any hazards pretty quickly. If we find something that we deem as a worker as a hazard or a risk, we document it straight away, and it's pretty much followed up within a day.* (R45G_PCA)
>
> *We have health and safety representatives all around and they're actually, they're very good. We have one there…and she's actually brilliant. She's right onto it with the people especially if they're not doing anything safely or, she's jumps on them, reports them straightway. She doesn't muck around.* (R13M_PCA)

A lack of management and organisational responsiveness to health and safety concerns, however, was expressed by some workers. These interviewees reported feeling that their

concerns were not being adequately heard and a subsequent lack of action or follow-up had occurred.

> *When these people are getting injured I went to the boss at OH&S, at that time. I said, 'Look, these people are working short, you're going to have trouble. More people are going to get hurt' and he said, 'Well, look, I've got this pie here and this pie is all full. I have no more money.*' (R20M_PCA)

7.3.3 Training and Skills

The qualitative interviews examined issues relating to aged care training and skills. Interviewees were asked about any specific qualifications in aged care that they had undertaken and how well they felt this training had equipped them to work in the sector. The extent that employers supported their staff to do work-related training was also explored as well as the kinds of training direct care workers found most useful for their work.

7.3.3.1 Aged care qualifications

The majority of nurses in the sample did not report holding any aged care specific qualifications, in addition to relevant training received as part of their primary nursing qualification. A small number, however, indicated they had done further post-qualifying training including courses in dementia, mental health, gerontology, and aspects of aged care (continence and wound care).

Some nurses felt that their nursing qualification provided an appropriate basis of their work in aged care, considering their university studies gave: *"a foundation, I think, as with any training should do. You've got to go in with that theory before you apply it to the practical"* (R02M_EN). However, most nursing staff reported that university-level nurse training was too narrowly focused to prepare new entrants for the complexities of working with older people; many instead recommended that nurses in both home care and home support and residential settings have prior practical experience of working with older people before moving into the aged care sector.

> *Aged care is totally different from your normal kind of patient I suppose, because you've got different challenges, it's just not them being sick; it's them being elderly, mobility, (and) communication. And, I think that if you're not or you don't have the right training, even as far as your nurses, we find a very high turnover.* (H05M_RN)

All of the PCAs and a majority of the CCWs interviewed held certificate-level qualifications in aged care. Of the remaining CCWs, some had certificates in other fields of care work including home and community care, disability, health services and child care. The majority of care workers who held aged care qualifications (including many of the new hire group) reported that the training had equipped them well for their subsequent work in the sector. In particular, the course placement undertaken as part of a certificate-level qualification was viewed as being very important in highlighting the realities of aged work. Respondents, however, acknowledged that there were some aspects of care work (such as behaviour management and techniques for working with people with dementia) that could only be learned on the job.

> *I think with this kind of job it needs to be more hands-on training. The Certificate III gives you only the theoretical part of it whereas when you go for placement it gives you the practical part of it. You learn every day I think with this work. You can't just train a carer to be a carer in six months, that's impossible.* (R29N_PCA)

A minority of respondents raised serious concerns about the quality of some certificate-level qualifications in aged care. These included a perception of the declining quality of certificate training with reports of shorter courses and reduced placement times, ineffective online training and significant gaps in the content of courses (e.g. communication skills, behaviour management, dementia care).

I went to a school in north Melbourne. They were a kind of Mickey Mouse school. There's plenty of us. What I know about aged care I think I learned about working there, being not at school. (R34N_PCA)

The standard of training for staff to work in aged care is getting poorer. A person can virtually walk off the street, do sometimes an online course in aged care, and in they come. There's no, from what I can see, no basic standard for these people to achieve. (R02M_EN)

7.3.3.2 Work-related training

The majority of direct care workers interviewed reported that their employer supported them to do work-related training. This included induction training for new staff, mandatory training courses and professional development activities. Support provided by employers to enable their workers to undertake additional training included offering training in-house, disseminating information about training courses, paying for staff time or flexible rostering and, to a lesser extent, funding course fees. Barriers to training were reported by some interviewees including having to undertake training in their own time and a lack of access to training in regional and rural areas.

It's hard for training in regional areas…you have to travel a fair bit for proper training…that is expensive with travel and then accommodation…and expenses aren't reflected in our funding, because they don't care that we live 400 kilometres away from our nearest big centre. (H45G_CCW)

The new hire workers in the sample described the induction training they had received upon commencing their employment in aged care. Induction processes took various forms from full day intensive training, shorter periods of training held over several weeks and the use of buddy shifts with more experienced staff. Induction training commonly included the provision of information about the organisation and its workplace policies and procedures, as well as mandatory training on issues such as manual handling and fire safety. Some criticisms were made regarding induction training with several new hire workers commenting that they would have preferred to receive more initial training or buddy shifts. Furthermore some home care and home support workers felt that their induction training was modelled on a residential rather than a community care setting. Overall, however, most new hire workers found their induction training to be satisfactory.

When I started, we do what they call a buddy shift so I go out with the more experienced carers. I think I did that for about a week, all the different carers, and they explain as you go what they're doing, what you have to do. That was very good. (H25N_CCW)

With regard to work-related training beyond induction, workers reported that most of this training was typically of good quality and of direct relevance to their day-to-day work. Respondents had especially valued opportunities for training in dementia and palliative care; courses in wound management, manual handling, mental health and first aid were also thought to be useful. New hire staff identified topics for further training that would be beneficial in their work and enable them to become more effective aged care workers. This included training on aged care practices (dementia and palliative care, chronic disease management, medication and wound management, first aid) and skills (behaviour management, communication with clients and families, and time management).

I'm fairly new to aged care so there is a big gap there in my knowledge. Yeah, so anything to do with aged care and Parkinson's, dementia management, that kind of thing…I'm very lucky, I'm actually exposed to lots of experts. So they provide lots of onsite training and education. I get invited to symposiums and forums and things like that, so I'm really very lucky. (R21_RN)

7.3.4 Work-life Balance

The final area examined in the qualitative interviews related to work-life balance. Interviewees were asked about the responsibilities and activities they had outside of their work in aged care and how they managed to combine these with their work responsibilities. The most common out-of-work responsibility reported by respondents was the care of family members (primarily children and elderly parents). Other non-work responsibilities and activities undertaken by the sample included studying, business interests, community activities and volunteer work, sport and fitness, and social and recreation activities.

Many workers were able to identify strategies they employed to successfully combine their work and non-work responsibilities. Most frequently cited was taking advantage of the flexibility in working hours or rostering offered by their employer. Part-time work, and having a set shift pattern assisted caring responsibilities to be achieved. Many respondents also noted that their employers where possible adapted rosters to fit in with staff needs or allowed workers to have time off if required. Some home care and home support workers described being able to work "school hours", a major factor that had determined their choice to work in community rather than residential aged care.

> *I've negotiated to have the one Friday off a fortnight, because my parents are ageing and sometimes you've got to spend time with them or take them for appointments.* (R06M_NP)
>
> *When [my supervisors] realised that my husband and I had split up and whilst I needed a really steady income I also had limitations on my time and they customised my roster so that it was almost entirely school hours…Working in an aged care facility would be different because you've got very fixed rosters and none of them are family-friendly…home care is definitely the way to go for me with younger children at home.* (H30N_CCW)

Further strategies centred on the creation and upholding of boundaries between work and home-life including not taking work home, leaving work on time and choosing not to work on weekends. Support was also obtained from family and friends to assist with caring responsibilities and household tasks. Keeping fit and healthy for both work and non-work activities through a good diet and regular exercise was a final strategy reported by some respondents.

> *I didn't have a very healthy work life balance originally and I spent most of my days at work and nights, and that soon wore thin…I've got a very good dear friend who's my deputy here and she makes me go home on time too, and she doesn't allow me not to, and so I get to five o'clock and I'm out the door now.* (R40G_NP)
>
> *I've got a very supporting husband…(he) works permanent very early mornings, so luckily he's home in the afternoon so that I predominantly do an afternoon shift, which is a short shift, a 4 o'clock till 9 o'clock at night. He does a lot of the afterschool runnings, pickups, gets dinner ready sometimes as well, so I'm lucky that I've got someone that can do that without asking or paying for extra care…It's finding that balance which works.* (R31N_PCA)

Barriers to a successful work-life balance were also discussed by some workers. A minority of respondents reported that they had been unable to get their preferred shift pattern or that their employer was reluctant to provide paid time off to staff, instead requiring the use of annual leave days. The availability and cost of child-care was a further factor which hindered the ability of some workers to negotiate an effective work-life balance.

> *I've had my children on the waiting list at their primary school now for over a year-and-a-half. Their before school care and after school care has been fully booked, and it's usually a rollover of children from the previous year, so of course trying to get three children in is nearly impossible.* (H32N_CCW)

Respondents also described factors which, while not in place at present, would assist them to more successfully combine their work and non-work responsibilities. These included having changes to their working conditions (more flexible work arrangements, reduced hours, regular shift patterns or working from home) as well as their employer hiring additional staff to cover

excessive workloads. However, for some these changes were seen as being difficult to achieve due to the demands of current work roles or financial imperatives.

> *I think amount of staff needs to be increased to be honest because as I said I look after 13 residents at work - they have got high demands as well. So I have to prepare myself to give everyone what they want and make sure they're cared for. If I get help from someone, like if they put another staff or someone, so that wouldn't stress me out that much, so I can have, not stressing, but less stress at work. So it's working for my outside work life as well I think.* (R29N_PCA)
>
> *It would be nice to have a proper 30 hours' work that you know that you have, and then you don't worry about anything else.* (H32N_CCW)

7.4 Emergent Themes

The interviews were conducted using a semi-structured approach and respondents were encouraged to raise any issues that they felt were important regarding their experiences of working in aged care. In addition to the themes described in the preceding sections, three emergent themes relating to aged care reforms and funding, staffing in residential care facilities, and perceptions of aged care work were commonly discussed by the interview respondents.

7.4.1 Aged Care Reforms and Funding

Many respondents (and particularly mature aged workers and those working in home care and home support settings) raised concerns about the impact that the recent aged care reforms and associated changes to funding models had had on their workplaces. Within community aged care the move to a consumer-directed care model was perceived to be changing the client base of some organisations and impacting upon the caseloads of home care and home support workers. Staff in the community also raised concerns about the future funding of their organisations and the impact this had on their own job security.

> *It does worry me a bit, the stability of it, because so many services like ours are just going from year to year funding-wise. They don't know where they're going…The only alternative is to go and work for a bigger organisation, to work for a big aged care residence, a company that has a few residences, but that seems pointless to me because everyone wants to stay in the community so aged care service residences should only be for end of life. You generally die within an hour once you're there, so why is that the stable job? The stable one should be out in the community because that's where everyone wants to be.* (H44G_CCW)
>
> *(My employer's funding) contract is up soon so we don't know what work, how much work, if any work we're going to have at the end of that contract…Any organisation in the country can package any client anywhere now. It makes it a bit tougher for us…We've definitely lost clients…I lost seven hours in one hit because a client went to a package with a different company*. (H47G_CCW)

Within the community, workers also expressed concerns for their elderly clients under the new funding arrangements. A lack of general awareness of the changes which had occurred in the aged care system and specific understanding of what could be funded under the scheme was noted. The ability of clients to be re-assessed and moved to a larger package if their support needs increased was also questioned by some workers. Moreover, in both home care and home support and residential settings, examples were provided of changes to funding models leading to reduced service provision (including equipment maintenance) and threatening the future sustainability of some programs.

> *If they're on a smaller package and their needs get more over the years, sometimes it's harder to get onto a higher package.* (H22N_CCW)
>
> *We do a lot of other programs, and it's just it's evolved like that. We sort of started an exercise program…that's been going probably 15 years, of gentle exercise, tai chi and a gym, and then we get extra funding from the carer group and link people in with a music therapist…so we do*

> *some music therapy in the home, and in-home diversional activities for people that don't want to join the other diversional activity group, but eventually we try and transition them across. So, I don't know, I think those programs won't keep going.* (H03M_RN)

Within residential aged care facilities, changes to funding models were not seen as reflecting the actual care needs of residents. As described below in Section 7.4.2, these changes were perceived to have negatively impacted on the overall funding available to aged care organisations leading to reduced staffing levels and increased workloads.

> *For a resident to be classified as high care, which means more funding, it's a lot more difficult. They changed the criteria. That was really disappointing because now, it's based mainly on their cognitive functioning. So if a resident has poor cognitive functioning, e.g. mental health issue or dementia or whatever, they receive more funding. Whereas if we've got a resident who's got PEG feeds or indwelling catheter in or is on two hourly turns, they receive less funding. Which is ridiculous, because they need more or just as much care as the one with the cognitive functioning deficit. So that was pretty disappointing. (R02M_EN)*

A minority of respondents believed that the new aged care reforms had led to positive changes, particularly to service provision in the community. Service quality and flexibility was reported to have increased and clients now had greater choice over their supports.

> *Once upon a time when aged care services were given funding, they were like they said, "You can provide A, B and C. And, that's all you're funded for and you can't do any more." And, that closed our books, and that's what we could do, A, B, and C. But, now under the (new funding model), what things are different is we have a little bit more flexibility, so I think being able to provide flexible services, because every client is different. I think that's really important*. (H45G_CCW)

7.4.2 Staffing Issues in Residential Care Facilities

Concerns regarding staffing levels within residential care facilities were raised by respondents from all three groups (new hires, mature workers and general workers). Funding constraints were felt to be contributing to insufficient numbers of staff within facilities including a lack of cover when regular workers were absent or staff not being replaced when they retired. Subsequently increased staff-to-resident ratios had been experienced and led to workload pressures and poorer quality care for residents.

> *There's not enough staff, either carers and/or nurses on all shifts; that's primarily due to the reduced funding from the government although they spruik on about what they do… but of course the general population doesn't really know that, facilities are being run as a business rather than as a caring organisation…When there's not enough staff it's harder for everybody to give out how they want to and it certainly hard for the recipients or residents who get to come into an aged care facility already stressed but expecting really good end-of-life care and we do our best, everybody does their best but we all know now it's not good enough*. (R03M_RN)

In addition to general concerns regarding inadequate staffing numbers within residential care, respondents reported particular issues affecting nursing care within the sector. Increasing RN-to-resident ratios were reported alongside an emerging trend of replacing RNs with less qualified workers (Certificate IV nurses and PCAs). This trend was largely attributed to inadequate government funding and aged care organisations wanting to generate larger profit margins. In order to ensure quality care within residential facilities, several respondents recommended the need for mandatory staffing ratios and the retention of staff with nursing qualifications.

> *We're losing a lot of nursing staff and I find a lot of organisations are putting in PCAs to do nursing work. I think we just need to be careful that we're not blurring the boundaries a little bit too much…Because it's cheaper to have PCAs to do - so the PCAs can do obs and things like that, but if something goes wrong, they don't necessarily have the depth of assessment skills to really be able to deal with that…I find a lot of the big private companies now are getting rid*

of the RNs and things or only having one RN for 120 residents because it's too expensive to have an RN. (R36G_RN)

7.4.3 Perceptions of Aged Care Work

The existence of poor perceptions of aged care work by the general community was considered to be problematic by some workers. Moreover, the interviews were conducted at a time when a case of abuse within the aged care system was prominent within the media and these negative perceptions were thought to have been exacerbated as a consequence.

> *In the media those handful of bad carers give everyone a bad reputation. That's absolutely distressing for us that do a good job to think that somebody has the audacity to treat someone so badly.* (R31N_PCA)

Respondents also reported that within other areas of healthcare, aged care was seen as offering few career pathways and being a low status job which required little clinical or technical expertise. As a consequence of these factors, the aged care industry was considered to be unattractive to new workers, and students and newly qualified nurses and care workers were reported to be reluctant to join the sector.

> *If you work in aged care you have to know cardiac, you have to know renal, you have to know palliative care, you have to know dementia, because the people you're working with have such a broad range of conditions that you need to know a lot of different skills instead of being specialised…we have students here quite a bit, PCA students and EN students and I always ask them where are you thinking about going with your nursing. I will always say please consider aged care. I said, it's a great industry to work in.* (R36G_EN)

This perceived low value placed on aged care work was seen as being reflected in the relatively poor pay rates offered within the sector and a lack of workforce development by the federal government.

> *They say, "You could be doing a job that pays double this and less manual work. Why are you doing this?" and I said, "Well, apart from the fact that I enjoy the smiling faces, happy, all that type of thing, don't you know the theory of the more that you actually help people, the less you get paid? If I don't turn up for my shift, there's a lot of people that could be sitting in their own filth because they can't get to the toilet. If a CEO of a company that gets a million dollars a year doesn't turn up for a month would anyone know? The more help you have for another individual, the lower you get paid."* (R31N_PCA)

Concerns were also expressed that employment agencies were actively encouraging unemployed people to undertake aged care training without consideration as to whether they were well suited or committed to working in the sector. This was seen as contributing to poor quality care and high staff turnover. Similarly, it was understood that many students (e.g. trainee nurses who aimed to work in a hospital setting) saw aged care work as a stepping stone to other employment opportunities rather than a career in itself.

> *A lot of the time these days I don't know (how) the government sees the unemployed… 'You've been long-term unemployed. How about you do a carer's course?' They shove them out there and do a carer's course and then they get employed and consequently that's not where they ever wanted to be. Out of a group of ten you might get two really good carers, but by God, you get some crap.* (H04M_RN)
>
> *We get a lot of uni students that are filling the gaps while they're doing their uni courses, so you have to cover them when they're off at prac or resi school and things like that, and then when they get the qualifications they leave*. (R15M_PCA)

7.5 Summary

In-depth qualitative interviews were conducted with 100 direct care workers following completion of the aged care workforce survey. This sample included 40 mature workers, 30 new hire workers and 30 general workers. The qualitative interviews aimed to (1) explore the specific aged care experiences of new hire and mature-aged workers, (2) investigate issues relating to recruitment and retention in aged care, (3) explore the experience of working in aged care (with relation to quality services, OHS, training and skills, and work-life-balance) and (4) identify and explore emerging issues for the aged care workforce.

7.5.1 Recruitment and Retention in the Aged Care Workforce

Most respondents had entered aged care with substantial employment histories; care workers reported coming from a diverse range of industries while many nurses brought considerable experience from other fields of nursing. A career in aged care, therefore, was a first job for only a small minority within the sample. Although most of those interviewed held only one current paid job in aged care, some reported having additional sources of paid work (primarily to supplement hours or income from their primary job).

Key motivations for choosing to work in aged care included a direct interest in the work, job availability and opportunity, flexible working hours within the sector, and the perception that aged care work could lead to employment in other healthcare sectors. Employment within the home care and home support sector was also seen as being particularly favourable by some workers due to perceptions of greater time with clients, more work variety and less intensive care responsibilities. Most workers in the sample had not made a direct preference when choosing their aged care employer. Rather this decision was informed by the availability of work, having undertaken a placement at the organisation, the location of the workplace, and having existing personal contacts within the facility.

Direct care workers reported that they gained much job satisfaction from their work in aged care. Positive aspects of their daily work included having good relationships and interactions with clients and a feeling of making an important difference to the lives of older people. Being able to use their skills and training, having autonomy and diversity in their work, and good relationships with colleagues and management were further factors contributing to job satisfaction. These workers also, however, reported encountering stresses and difficulties in their working lives. High workloads and levels of administration were the most common concern among respondents. Unsatisfactory working conditions (in the form of pay rates and insecure employment) was a further source of dissatisfaction for some workers and especially those working for home care and home support outlets. Difficulties relating to client care and relationships with co-workers and managers were also frequently reported by respondents.

Despite these reported difficulties, the majority of interviewees wanted to remain working in the aged care sector into the future. Although many workers were satisfied with their current role and organisation, some respondents sought to undertake training which could enhance their skills and job opportunities; others were hoping to transition to roles which offered greater levels of responsibility. Additionally some workers (particularly in home care and home support outlets) aimed to improve their current working conditions while some new hire workers expressed a desire to move to a different aged care organisation. Intentions to leave the sector were noted primarily by residential new hire workers and mature-aged workers. For the former group this was typically to pursue a nursing career within an acute setting, while retirement was a forthcoming pathway from the sector for half of the mature-aged sample. However, many mature workers were keen to continue working in aged care for as long as their health permitted.

7.5.2 Experiences of Working in Aged Care

The qualitative interviews also examined quality in aged care provision, OHS, training and skills, and work-life balance. Respondents discussed worker and organisational characteristics which they believed promote quality client care. Effective aged care workers were thought to possess innate personal qualities, alongside specific skills and qualifications, which made them suitable for their role. Having a range of workers across different ages, genders and cultural backgrounds within the sector was also perceived as contributing to good client care. Adequate staffing was strongly viewed as being a key factor which enabled organisations to provide quality care to their clients and residents. Supportive management, adequate aged care funding, positive organisational values, and effective workplace policies and procedures were also considered to contribute strongly to care provision.

Awareness and understanding of OHS policies and procedures was high among respondents. Most felt that they had received adequate training in OHS issues and that workplace guidelines operated effectively. Although most direct care workers considered their workplace to be a safe environment, specific OHS concerns were raised by a quarter of workers. The pressure of work demands and staff shortages were felt to contribute to breaches in OHS protocols by respondents and their co-workers (particularly around manual handling techniques). Specific concerns relating to physical hazards, client medication and elder abuse were also raised by some home care and home support workers, while reports of work-related injuries were described primarily by mature aged workers. Overall, however, interviewees expressed satisfaction that their employers addressed any OHS concerns effectively.

The qualitative interviews also examined training and skills in the aged care workforce. All the PCAs and most of the CCWs interviewed reported having undertaken, at a minimum, Certificate Level III training in aged care. While most of these workers considered that their training had equipped them well for working in the sector, concerns were raised regarding the quality of some Level III training courses. These included misgivings about the length of courses and placements, a reliance on online rather than face-to-face training methods, and gaps in course content. Work-related training was available to most of the respondents, including induction training, mandatory training courses and professional development activities. However, barriers to training were described by some workers including a lack of access in regional and rural areas. The training received by respondents was perceived to typically be of good quality and of direct relevance to aged care work; training in dementia and palliative care was reported to be particularly useful. New hire workers also identified specific types of training (centred on aged care practices and skills) which they considered would be beneficial for their future work in the sector.

Work-life balance was a final area explored in the qualitative interviews with direct care workers. Most workers reported extensive responsibilities and activities outside of their work in aged care, most commonly caring responsibilities for children and elderly parents. Strategies used by aged care workers to effectively combine work and non-work responsibilities included taking advantage of flexible working hours or rostering, maintaining boundaries between work and home and utilising support from family and friends. Not all respondents, however, felt able to have an effective work-life balance. Difficulties were reported by some workers in obtaining flexible working conditions or paid leave from their employer; the availability and cost of childcare was a further barrier experienced by some respondents.

7.5.3 Emergent Themes

Three emergent themes were raised by respondents during the interviews relating to aged care sector reforms and funding, staffing levels in residential care facilities and negative perceptions of aged care work. Concerns were expressed regarding the impact of the recent aged care reforms on the sector across provider, worker and client levels. Home care and home support workers were particularly worried about the future funding and sustainability of

their organisations and the potential effects this could have on their own employment. A lack of client awareness and understanding of recent changes within the aged care system was also reported. In contrast, a minority of workers felt that the aged care reforms had been beneficial, enhancing service provision and client choice in the community.

Associated with concerns regarding aged care funding arrangements, were reports of staffing issues within some residential care facilities. Perceptions of insufficient staff numbers and the reported replacement of RNs with lesser qualified staff led to unease about the quality of resident care in some organisations (and particularly within the for-profit sector). A final emerging theme which arose from the interviews with direct care workers was a sense that aged care work was held in low esteem by both the general community and those working in other healthcare sectors. At a time when the aged care workforce needs to expand, respondents recommended that negative perceptions and working conditions be addressed in order to make the sector more attractive to potential workers.

8. Conclusion

8.1 Overview of the 2016 National Aged Care Workforce Census and Survey

The National Aged Care Workforce Census and Survey (NACWCS) 2016 provides information about the size and composition of the workforce, the characteristics of aged care workers and the organisations in which they work, experiences of working in the sector, and factors related to staff recruitment and retention.

The NACWCS consists of two separate data collections: one for the residential facilities and one for home care and home support outlets. Each data collection comprises of two linked parts - a census of all employers and a survey of their employees. From these we have two large employer-employee data sets representing the residential and the home care and home support sides of the aged care sector. The structure of aged care programs and services in Australia has changed considerably since the NACWCS was last conducted in 2012. These changes impacted on the responding framework for the census, which was relaxed in the 2016 data collection, necessitating a longer duration of fieldwork in order to achieve comparable response rates.

The NACWCS gains further in-depth knowledge on the sector through the addition of a qualitative research element connected with issues of specific policy importance. In the 2012 NACWCS we focused on migrant and male workers in aged care, motivated by the expectation that they will form an important source of new workers for the sector. In 2016 we focus on recently hired and mature-aged workers, again motivated in a broader way by issues of attraction and retention of the aged care workforce. We conducted 100 in-depth qualitative interviews with recently hired, mature-aged and general employees from the direct care workforce. These interviews provide further detailed information on experiences of working in the aged care sector including factors related to recruitment and retention.

Throughout the report we have compared the residential and home care and home support workforces (with a particular focus on the direct care occupations), differences between various components of the workforce (including occupational groups and recent hires) and, where appropriate, contrasted the characteristics of the aged care workforce with the broader Australian population. This concluding chapter provides a summary of findings and identifies a selection of emerging issues that may benefit from further investigation.

This was the fourth time that the National Institute of Labour Studies (NILS) has undertaken this important research – previously the NACWCS was conducted by NILS in 2003, 2007 and 2012. The accumulated evidence is remarkable in its continuity and completeness. As a consequence this research is the best available source of information for tracing the changes that have occurred in the Australian aged care workforce over this time period and guiding relevant workforce policy. In doing so however, we need to bear in mind several generally well-understood, but often under-reported or even ignored, statistical caveats.

The structure of aged care programs and services in Australia has changed considerably since the NACWCS started to be conducted in 2003. Measuring and comparing in the midst of change will always remain an imprecise undertaking. For example, a question we asked in 2003 may not have been asked of the same (type of) people as in 2016, or may have a different meaning in 2016 due to sector changes that have happened in the meantime. The answers provided in 2003 and 2016 may, therefore, not be directly or fully comparable. Although the NACWCS employs the most powerful tool for the employers' evidence, that is, a census where all employers in scope are invited to respond, and a large-scale survey for employees, with the added granularity that can be gained through the employer-employee linkage, structural change will nevertheless always have an impact but whose size and magnitude is hard to estimate. Consequently, this statistical caveat should always be kept in mind when making direct comparisons of aged care services across different parts of the

sector over time and we should be careful to not over-interpret the estimates derived from this data. With these thoughts in mind, we turn to the conclusion of this research.

8.2 The Size and Composition of the Aged Care Workforce

In 2016, the estimated total aged care workforce comprised 366,027 PAYG employees (an increase of 4 per cent from 2012). Of these, 235,764 were employed in residential facilities and 130,263 in home care and home support outlets. This report focuses primarily on direct care workers within the sector, i.e. those workers who provide care services to older Australians as a key part of their work. Our 2016 estimates suggest that 240,317 aged care workers were employed in direct care roles; this figure being very close to the corresponding estimate in 2012. There were 153,854 direct care workers in residential facilities and 86,463 in home care and home support outlets.

While both the residential and home care and home support sectors experienced a considerable increase in their direct care workforces between 2007 and 2012 (by 10 per cent and 25 per cent respectively), this increase has not been observed between 2012 and 2016. The 2016 estimates suggest that, since 2012, residential direct care employment has grown (but at the lower rate of 5 per cent and not uniformly) and home care and home support employment has shrunk (at a contraction rate of 7 per cent). When converted to full-time equivalent (FTE) employees we see a different picture. From 2012, the FTE residential direct care workforce has increased by 3 per cent and the home care and home support workforce has decreased by 19 per cent (compared to 5 per cent growth and 7 per cent contraction respectively in the headcount figures). These estimates suggest that the sector is undergoing considerable structural change and that there has been an increase in the proportion of workers employed for fewer hours.

The direct care workforce consists of six primary occupational groups: Nurse Practitioners (NP), Registered Nurses (RN), Enrolled Nurses (EN) Personal Care Attendants (PCA)/Community Care Workers (CCW), Allied Health Professionals (AHP) and Allied Health Assistants (AHA). Within residential aged care, the proportion of PCAs has continued to grow and now constitutes 70 per cent of the residential workforce. The number of RNs in this workforce has also increased since 2012, reversing a previous negative trend seen in the sector since 2003; however, we note that the proportion of RNs in residential care remained unchanged from 2012. In contrast the proportion of ENs and AHPs working in residential aged care has fallen slightly (from 12 per cent to 10 per cent; and from 2 per cent to 1 per cent respectively). The proportion of AHAs in the residential workforce has remained constant at 3 per cent.

Looking at the occupational composition of the home care and home support sector, CCWs are by far the largest group and their share of the workforce has increased from 81 per cent in 2012 to 84 per cent in 2016. While the proportion of ENs working in community-based aged care has fallen since 2012 (from 4 per cent to 2 per cent), minimal change was seen within the other occupational groups.

Almost two thirds of the aged care workforce is located in major cities, with a further third in regional areas. While little change was seen in the distribution of residential workers across the states and territories since 2012, greater changes were observed in the home care and home support workforce. In particular the proportion of the total PAYG workforce in home care and home support increased from 23 per cent to 32 per cent in Victoria, while the proportion of workers located in NSW fell from 31 per cent to 26 per cent. This appears to be due to an increase in the share of outlets located in Victoria and also in the average number of workers per outlet in that state.

The type of organisation a worker is employed in varies considerably between residential and home care. Within residential aged care 58 per cent of direct care workers were employed in not-for-profit facilities, 34 per cent in for-profit facilities and 7 per cent in facilities owned by the

government; this distribution is largely unchanged since 2012. Within home care and home support aged care in contrast, the proportion of workers in not-for-profit outlets has fallen considerably since 2012 to 68 per cent (from 76 per cent), while employment in for-profit organisations has increased to 12 per cent (from 7 per cent).

While the key focus of the 2016 NACWCS was on the direct care workforce, we also examined the use of other types of workers within aged care. Around a third of all PAYG employees across both the residential and home care and home support sectors are non-direct care staff. Since 2012, the proportion of non-direct care staff working in residential settings has increased by 8 per cent; the share found in home care and home support outlets meanwhile remains unchanged. Non-direct care workers are found predominantly in ancillary care roles in residential facilities (70 per cent). In home care and home support outlets, managers (including care managers and co-ordinators) and administrative staff account for 92 per cent of the non-direct care workforce.

During the designated fortnight (the last pay period in November 2015) 28,079 non-PAYG staff (agency, brokered and self-employed workers) were employed across the aged care sector. This constitutes a decrease of 29 per cent in the use of non-PAYG staff since 2012. The use of non-PAYG staff remains more common within residential aged care with 50 per cent of facilities reporting employing at least one non-PAYG worker compared to only 27 per cent of home care and home support outlets. Non-PAYG workers were most commonly employed to fill PCA and RN positions in residential care and CCW roles in the community. For the first time in 2016, the census included a question on the reasons for the employment of non-PAYG workers. Within both residential facilities and home care and home support outlets, agency staff were most commonly hired to provide short-term cover for staff absences and unfilled vacancies.

The use of volunteer staff is widespread within aged care, with 83 per cent of residential facilities and 51 per cent of home care and home support outlets using the services of volunteers. Our estimates suggest that during the designated fortnight, 68,416 volunteers worked in the sector. There were 23,537 volunteers in residential facilities who worked an average of 4.9 hours each per fortnight, and 44,879 volunteers in home care and home support outlets working an average of 4.6 hours each. The 2016 census contained a new question relating to the roles undertaken by volunteer workers in aged care. Volunteer staff were found to provide a variety of roles: in residential facilities they assist most commonly with providing social and planned group activities and also companionship. In home care and home support outlets volunteers most frequently assist with social and group activities and transport.

The overall picture of the size and composition of the aged care workforce is mixed and suggestive of considerable structural change taking place. The institutional changes that have occurred concurrently within the sector make the generation, the reading, and the interpretation of these estimates harder. The overall PAYG workforce is estimated to have increased by 4 per cent as a whole, with its direct workers proportion being 5 per cent higher in residential care and 7 per cent lower in home care (or a 3 per cent increase and 19 per cent decrease in FTE positions respectively). Since 2012, the relative share of both PCAs and CCWs have increased, whilst evidence suggests that non-PAYG numbers have dropped substantially. Meanwhile, the number of volunteers working has increased in residential facilities but fallen in home care and home support outlets.

8.3 Characteristics of the Direct Care Aged Care Workforce

The characteristics of the direct care aged care workforce in 2016 were largely similar to those found previously in 2012, with the exception of some differences traced in the estimated age and sex of the workforce and also in the proportion of migrant workers in the sector.

Previous iterations of the NACWCS (2003 to 2012) had indicated that the aged care workforce was ageing. While this trend has continued within the home care and home support sector (the median age is now 52 years compared to 50 years in 2012), the median age of residential direct care workers has fallen to 46 years (from 48 years in 2012). A similar pattern is seen for recently hired employees: the median age of new hires in the home and community care sector has increased to 46 years but has reduced considerably for recently hired residential workers to just 36 years (from 44 and 40 years respectively in 2012).

Although aged care remains a female dominated sector, the proportion of males in the workforce is continuing to grow, albeit slowly and from a small base. In residential aged care, 13 per cent of workers are now male, and in the home care and home support sector men represent 11 per cent of all workers.

Reversing its previous trend, the overall proportion of the workforce born overseas has decreased since 2012; 32 per cent of the residential and 23 per cent of the home care and home support workforce in 2016 are migrant workers. When looking at the country of birth of recently hired workers, however, the residential sector continues to attract an increasing proportion of overseas-born workers (40 per cent compared to 37 per cent in 2012). In contrast, the share of recently hired migrant employees in home care and home support outlets has fallen to just 21 per cent (from 30 per cent in 2012). Most residential facilities and home care outlets (91 per cent and 72 per cent respectively) reported employing at least one PCA/CCW from a CALD background. Within residential aged care these workers were most commonly from India and the Philippines, and in home care and home support from Italy and South East Asia.

Aboriginal and Torres Strait Islander people account for around 1-2 per cent of the aged care workforce reported by outlets; this share has remained similar since 2012.

The aged care workforce is in relatively good health with 60-65 per cent of workers across all occupational groups rating their health as excellent or very good. Unsurprisingly given their younger age, recently hired employees report higher self-assessed health than the aged care workforce in general.

The aged care workforce has high levels of post-school education and training. Most workers (around 90 per cent) hold a post-secondary school qualification. Around three quarters of RNs reported having a nursing degree (compared to around two-thirds in 2012) while a similar proportion of ENs hold a Certificate IV/Diploma of Enrolled Nursing. The proportion of PCAs with a Certificate III in Aged Care has remained the same since 2012 at around two-thirds of the workforce. Meanwhile, the proportion of CCWs with a relevant certificate-level qualification is growing; in 2016, 51 per cent of CCWs have a Certificate III in Aged Care and 27 per cent a Certificate III in Home and Community Care. Two-thirds of residential facilities and almost half of all home care and home support outlets reported that at least three-quarters of their PCAs/CCWs had relevant Certificate III qualifications.

The qualitative interviews explored the adequacy of Certificate-level courses in preparing workers for a career in aged care. While most PCAs and CCWs felt that their training had equipped them well, concerns were also commonly raised regarding the inadequate length of courses and placements, the use of online training methods, and gaps in course content.

A relatively small proportion of the workforce has a specialised qualification in ageing; the most common areas being palliative care and gerontology. However, the levels of specialised qualifications increased across most occupational groups in home care and home support

from 2012 and are now fairly comparable to those in residential settings. Far fewer direct care workers were currently studying for a qualification in 2016 than in 2012 (11 per cent of home care and home support workers and 16 per cent of residential workers compared to around 20 per cent across both sectors in 2012).

Access to ongoing training is common within aged care; 80 per cent of residential workers and 75 per cent of home care and home support workers had engaged in work-related training (mostly mandatory training) in the previous 12 months. Continuing and professional development was undertaken more frequently by residential than home care and home support workers (58 per cent to 48 per cent). Priority areas identified in both the worker surveys and qualitative interviews for future training included dementia, palliative care and (in home care and home support) mental health. The newly hired workers taking part in the interviews also highlighted the need for further training on aged care practices and skills. Barriers in accessing work-related training were also identified in the interviews with direct care workers; a lack of access to training for workers in regional and rural areas was particularly prevalent.

The NACWCS 2016 finds that the aged care workforce remains predominantly female, older, and in good health. It is a well-qualified and trained workforce, with good access to further work-related training. In 2016 the aged care workforce comprises of a sizeable but reducing migrant share and a very small proportion of Aboriginal and Torres Strait Islander people.

8.4 Characteristics of Aged Care Facilities and Outlets

As in 2012, slightly more than half of all residential facilities were large (i.e. had more than 60 places). Within home care and home support aged care, however, the trend towards larger outlets has continued. Twenty eight per cent of the home care and home support PAYG workforce are now employed within very large outlets (with more than 40 staff).

In 2016, the services most commonly provided by home care and home support outlets were the Commonwealth Home Support Program (by 64 per cent of outlets) and Home Care Packages Program (45 per cent). The size of an organisation strongly determined the type of program services offered. Smaller outlets (with up to 5 direct care staff) were responsible for over a quarter of all CHSP services, while very large outlets (with more than 40 staff) provided almost a third of all Home Care Package supports. Within the residential sector, the 2016 census indicated that the total number of operational places was 197,046. The average ratio of residential direct care workers to places (0.8) was unchanged from 2012.

A strong relationship to the broader age care sector was apparent in both residential and home care and home support. The proportion of residential facilities belonging to a larger provider group increased to 80 per cent in 2016 (from 76 per cent in 2012); the proportion of home care and home support outlets has remained constant (at 61 per cent). The share of providers offering both residential and home care and home support care has fallen since 2012 indicating that provider organisations are becoming increasingly specialised within their respective sectors. The proportion of home care and home support outlets also offering residential care has fallen particularly sharply since 2012, from 20 per cent to just 13 per cent.

Around a quarter of residential facilities and 43 per cent of home care and home support outlets cater for a specific ethnic or cultural group, most frequently Aboriginal and Torres Strait Islander and Italian older adults. A much higher proportion of facilities and outlets reported catering for the needs of gay, lesbian, bisexual, transgender and intersex clients in 2016. This illustrates the increasing supply of aged care services which are inclusive of older adults from diverse backgrounds.

Methods of quality monitoring in aged care were explored for the first time in the 2016 census. Multiple methods were used across both sectors, in particular monitoring by managers or supervisors and keeping records of service user feedback. Issues around quality care provision were more broadly discussed in the qualitative interviews. Factors identified as contributing to quality aged care included having adequate funding and numbers of

appropriately skilled staff, supportive management, positive organisational values, and effective workplace practices and procedures.

The overall picture that emerges of the key characteristics of aged care facilities and outlets in 2016 is somewhat mixed, due to the intense recent organisational change in the sector. A majority of residential aged care facilities are large, and business units within the home care and home support sector appear to be getting larger. The way these business units respond to change also appears to differ by the size of the unit. For example, within home care and home support, the size of an outlet appears to determine the type of program service provision. Moreover, the differentiation between residential and home care appears to be intensifying and service provision which accounts for the diverse needs of older Australians from different ethnic and cultural groups is becoming more mainstream.

8.5 Working Arrangements and Conditions in Aged Care

Working arrangements and conditions offered within aged care are important factors for attracting new workers and retaining current ones. A considerable shift away from casual or contract employment arrangements has been seen since 2012, particularly within the home care and home support sector. In 2016 only 10 per cent of the residential and 14 per cent of the home care and home support workforces were casual or contract employees (compared to 19 per cent and 27 per cent respectively in 2012). In contrast, little change over time was noted in the work schedules of the direct care workforce; the most common shift pattern remains a regular daytime shift across both sectors.

Employment conditions for residential and home care and home support staff were predominantly determined through the use of Enterprise Agreements (79 per cent and 59 per cent respectively). Award-based arrangements were more commonly used by home care and home support outlets (39 per cent compared to 21 per cent of residential facilities). Home care and home support outlets were asked about the allowances supplied to their workers for the first time in 2016. Eighty-four per cent of outlets provided some form of allowance, most commonly paid time for travel between appointments (70 per cent) and for petrol/depreciation (46 per cent).

There are indications of potentially underutilised labour supply within the aged care sector as a considerable proportion of workers (30 per cent of residential and 40 per cent of home care and home support staff) reported that they would prefer to work more hours than they do. The proportion of workers with a preference for more hours has increased slightly across both sectors since 2012, and PCAs and CCWs are the occupation most likely to prefer an increase in their working hours.

The extent of multiple job holding by aged care workers provides further evidence of spare capacity within the existing workforce. Multiple job holding is far more common within aged care than in the whole Australian workforce and rates remain similar to those found in the 2012 NACWCS. In 2016, 9 per cent of residential workers and 16 per cent of home care and home support workers had more than one job (compared to 5 per cent of the whole Australian workforce). Most of the additional jobs of multiple job holders were within the aged and disability care sectors. The need to supplement hours or income from their main aged care job was the primary reason for multiple job holding given in the qualitative interviews.

Working conditions are impacted upon by unusual job demands that an employee may perceive to be stressful. Across both sectors the most prevalent job demands were related to unanticipated changes in work patterns including working longer than scheduled and variations being made to hours or location of work at short notice. While the majority of facilities and outlets that made these demands indicated that it was done only in exceptional circumstances, more than a third of home care and home support outlets vary the hours or location of their workers at short notice routinely. Additionally the overall prevalence of unusual job demands had increased within the home care and home support sector since 2012.

A similar proportion of workers in residential care and home care and home support (14 per cent and 12 per cent respectively) reported sustaining a work-related injury or illness over the previous 12 months; this was unchanged from 2012. These injuries were most commonly sprains/strains and chronic joint/muscle conditions caused by lifting, pushing, pulling or bending. The next most prevalent issue was stress or a mental health condition, reported by around a fifth of aged care workers.

Occupational health and safety was a key topic in the qualitative interviews. While most workers felt that OHS issues were dealt with well by their employer, specific concerns were raised by a quarter of the workers interviewed. These concerns were primarily around breeches in protocols for manual handling techniques due to the pressure of work demands and staff shortages. Reports of work-related injuries were primarily described by mature-aged workers and were attributed to the years of undertaking a physically demanding role and also to following poor manual handling protocols earlier in their careers.

The general picture that emerges regarding working arrangements and conditions is one of improving working conditions without any major imbalances identified by the data. Although there are indications of continuing modest underutilisation of the workforce as a whole, (as preferred hours are longer than actual and some workers hold multiple jobs), this is not to the point of being a driving force for the deterioration of working conditions in the sector.

8.6 Recruitment and Retention

Aged care work has been their first ever occupation for only a small minority of workers. Apart from nursing, we find no clear pathways into aged care for all other occupational groups. The aged care sector typically draws its workers from the broader labour market. These findings were confirmed in the qualitative interviews. While many of the nurses interviewed had previously worked in other fields of nursing, the PCAs and CCWs had come to aged care from a diverse range of previous employment. The interviews also found that workers enter the sector for a variety of reasons including an interest in the work, job availability, and as an employment pathway into other healthcare fields.

The direct care workforce is relatively mobile with almost half of the workforce having had previous work with another employer in the sector. Across the different occupational groups, PCAs and CCWs are more likely to be new entrants to aged care. As in 2012, around a third of job mobility within aged care is due to factors relating to the personal circumstances of workers. However, work conditions and work role are further factors which considerably contribute to churn within the sector. In particular, a desire to find more challenging work, the attainment of preferred shifts or hours of work, and the achievement of higher pay were frequently cited in the worker surveys as reasons for moving to a new aged care employer.

Relatively high levels of job satisfaction were reported by workers in aged care and are similar to those found in 2012. When looking at satisfaction with specific aspects of their job, aged care workers reported most satisfaction in those areas which related to skills and training. Relationships with managers and colleagues were also seen in a positive light by a large majority of the workers. Although aged care workers continued to be least satisfied with their total pay, satisfaction in this domain has increased since 2012. Some salient differences were found across the residential and home care and home support workforces. Home care and home support workers had greater job satisfaction across several domains including time available to care for clients and having freedom in their work. These workers also reported feeling under less pressure and stress in their work than their residential counterparts.

Job satisfaction was further explored in the qualitative interviews. As found in the worker surveys, job satisfaction was high. Positive relationships with service users, colleagues and managers; being able to make effective use of skills and training; and having autonomy and diversity in their work contributed strongly to job satisfaction. However, these workers also

described issues which impacted negatively on their working lives. High workloads (including levels of administration) and unsatisfactory working conditions were commonly discussed.

Aged care has a highly committed and stable workforce that predominantly wishes to stay working in the sector. Similar to 2012, around a tenth of the aged care workforce were actively seeking alternative work. In order to examine future work intentions, we asked workers where they saw themselves working in 12 months' time. About 80 per cent of workers expected to still be with their current organisation and 3 per cent intended to move to a different aged care employer. Around a further tenth of aged care employees were unsure of their future work intentions. Only a small minority of aged care employees (2-4 per cent) reported definite intentions to leave the aged care sector altogether within the next year.

The qualitative interviews explored the longer-term career plans of the direct care workforce. Looking at work intentions over the coming three to five years most interviewees expressed a desire to remain within the sector and also with their current employer. However, some of these workers were seeking to develop their skills and take on more responsibilities in their role, while others (mainly newly hired workers) planned to move to a different aged care organisation. Intentions to leave the sector were primarily expressed by residential new hire workers (seeking nursing careers in acute settings) and mature-aged workers who were considering retirement. It should be noted, however, that many older workers planned to continue working in the sector while their health permitted.

The incidence of skill shortages in the sector has declined considerably since 2012, particularly in the residential sector. Skill shortages were reported by 53 per cent of residential facilities and 42 per cent of home care and home support outlets (compared to 76 per cent and 49 per cent respectively in 2012). Across both sectors skill shortages were more prevalent in locations outside major cities. Within residential care a shortage of RNs was most common, while an inadequate supply of CCWs was noted by home care and home support outlets. A lack of suitable applicants was the primary reason given for these skill shortages; slow recruitment processes leading to skill shortages was also common across both aged care sectors. In addition, residential facilities reported the need for specialist knowledge while the geographical location of the outlet contributed to skill shortages in home care and home support.

Common responses to address skill shortages across both aged care sectors included having existing staff work longer hours and making greater use of agency staff. Home care and home support outlets also frequently provided on-the-job training when addressing skill shortages.

The 2016 census collected information regarding current vacancy rates across the different occupational groups. FTE vacancy rates across all occupational groups have fallen within residential aged care since 2012. Around a quarter of residential facilities reported currently having vacancies for PCA and RN positions. The average number of vacancies reported by aged care organisations across the different occupations meanwhile remains relatively the same as in 2012. The highest average number of vacancies were found for PCA positions (at 3.3 positions per facility reporting a vacancy). The average time taken to fill vacancies was 2.5 weeks for PCA positions and 4.3 weeks for RNs; slightly quicker than in 2012. The pattern as to when vacancies are filled has also changed over time. The proportion of vacancies that are very quick to fill (less than one week) or very hard to fill (more than 26 weeks) has reduced and a greater number of vacancies are now taking around 3 to 4 weeks to fill. As was also found in 2012, residential facilities in remote and very remote locations reported more difficulties in filling staff vacancies.

The proportion of home care and home support outlets reporting vacancies is fairly similar to 2012. Vacancies for CCW positions continue to be most commonly reported by outlets (25 per cent), with an average of 3.6 unfilled CCW positions reported by these outlets. Similar to 2012, the average time taken to fill vacancies was 4.1 weeks for CCW positions and 4.7 weeks for RNs. Similar to the trend found in the residential sector, the proportion of vacancies across all occupational groups which are filled within a week by home care and home support outlets

has reduced and more positions are now taking between 3 to 8 weeks to fill. Also staff vacancies located in remote and very remote Australia take longer to fill, particularly for RNs.

As in the 2012 census, across both sectors the most common reasons given for staff vacancies were resignation, the creation of a new position, and retirement. The use of internet job advertisements has become more widespread since 2012 and is the most common recruitment strategy used by both facilities/outlets and recently hired workers. Word-of-mouth information about recruitment opportunities remains an important source for direct care workers. Although the use of agencies by aged care organisations to recruit PCAs and CCWs has not increased since 2012, considerably more recently hired workers are now using agencies as a method for identifying employment opportunities.

In summary, the 2016 NACWCS showed that the aged care workforce is both stable and committed. Moreover, its workers report relatively high levels of job satisfaction and a large majority wish to stay working in the sector. The overall picture that emerges from the skill shortages and vacancies evidence is that both the retention of current workers and the attraction of new workers to the sector seem to be working well with no major bottlenecks or hurdles that the labour market could not sort out by itself and without intervention.

8.7 Emerging Issues

Several emerging issues have arisen from the information collected in the 2016 NACWCS across the organisational census, worker surveys and qualitative interviews with direct care workers which may require further investigation.

First, findings from the 2016 census and survey indicate that the size of the home care and home support workforce has declined since 2012. Given that demand for home care and home support services by older Australians is expected to increase considerably over coming years, investigation appears to be necessary to examine the reasons for this decline, the impact this may have on the provision of aged care services, and the strategies which need to be implemented for the future planning and development of this workforce.

Second, our findings suggest that as an overall response to change, a majority of residential facilities continue to be large in scale, while outlets in the home care and home support sector are growing in size over time. However, preliminary further investigations suggest that this trend conceals two important differences. The first one is that large outlets within home care and home support are expanding their workforce more than smaller outlets, which raises issues of market power, especially where local monopolies may be likely to emerge for instance in rural settings. The second difference is that facilities within the residential sector are growing by opting for a workforce composition with lower use of direct care staff, which may have future implications regarding quality of provision.

Third, at present there appears to have been very little interaction at the workforce level between the aged care and disability sectors. This is not surprising as at the time of the 2016 NACWCS fieldwork, the NDIS was still in its starting phase with less than 15 per cent of its total participants with operational support plans. As the NDIS rolls out to full implementation and demand for disability supports increase, we can expect that the two sectors will end up sharing some of one another's workforces. Given the large numbers involved in the NDIS full roll out over the next two to three years, this could have substantial impacts on the aged care workforce.

Fourth, the qualitative interviews highlighted worker concerns regarding the impact of the recent aged care reforms. In particular home care and home support workers were fearful of the future sustainability of their organisations and their own working conditions and employment. The consumer-directed model of care which has been introduced into the sector was already perceived to be changing the work undertaken by home care and home support workers. As CDC is further implemented, it is important that resulting impacts on the home care and home support workforce are monitored and addressed.

Concerns regarding staffing within residential care was a further issue raised in the interviews with direct care workers. Strong perceptions were expressed that insufficient staff numbers, higher workloads and the replacement of RNs with less qualified staff were impacting negatively on resident care in some facilities (particularly within the for-profit sector). These perceptions were not strongly supported, however, by the census and survey data. The worker survey confirmed that residential care staff report greater levels of stress and pressure in their work than those in the home care and home support sector; dissatisfaction was also expressed by these workers regarding the time available to care for residents. However, the census indicated that overall staffing ratios and the proportion of RNs in the residential sector had remained constant since 2012. The discrepancies between the perceptions of residential workers and the findings from the census could benefit from further examination.

A final emerging issue which was raised in the qualitative interviews focused on perceptions of aged care work. Interviewees were concerned that aged care was considered an unattractive industry by potential employees due to perceptions that it was a low status job which offered poor pay and few career pathways. Future workforce planning and development of the aged care workforce may need to further explore and address these issues.

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Appendix 1: Weights for the National Aged Care Workforce Census and Survey

While the National Aged Care Workforce Census purports to be a complete collection, in practice there is substantial non-response.

To address this, we calculate 'weights' for each respondent such that a tabulation of respondents provides an estimate for the entire population. The general approach is to create strata and assume that within each stratum the respondents are a simple random sample of the corresponding population. By creating strata we allow for differential non-response, at least to some extent; each respondent is assumed to be representative of the strata rather than the whole population.

The strata make use of information which is available for the whole population as well as the sample. The finer the level of the strata, the smaller is the bias caused by differential non-response. On the other hand, if the stratification is too fine then the estimates will become very sensitive to the responses of a small number of respondents. Typically, 20 respondents in a stratum are considered more than adequate. To ensure robustness, the approach is to have a stratification broad enough to have a reasonable number of respondents in each stratum, and a stratification which does not result in an excessive spread of weights. The level of stratification is thus a matter of judgment.

The stratification for the residential outlet census collection is as follows, noting that the strata are mutually exclusive and comprehensive:

Table A1.1: Stratification design for residential aged care service facilities

	Notes
All very remote	All very remote facilities are in a single stratum because of small numbers
All remote	All remote facilities are in a single stratum because of small numbers
All Transition Care[12]	All facilities offering transition care are in a single stratum because of small numbers
Residential and flexibles with residential, excluding those that are remote or very remote	Residential facilities and those offering flexible care as well are combined because of the small number of the latter group. The facilities are then stratified by geography and size (nine cells)
Major cities	
Small	
Medium	
Large	
Inner regional	
Small	
Medium	
Large	
Outer regional	
Small	
Medium	
Large	

[12] All very remote, all remote, and all transition care are mutually exclusive (there are no transition care facilities in remote and very remote Australia.)

The size of the facility is taken from the number of worker forms sent to the facility (4, 6 or 8). The weights are obtained by dividing the number of the facilities in the cell by the number of responding facilities in the cell. Outlets where the questionnaire was 'returned to sender' are excluded from both the numerator and the denominator. Respondents who were 'out of scope' are included, with the idea that the respondents we know to be out of scope are representative of facilities who did not respond. The weights are also adjusted to account for a couple of coding errors (with a residential outlet mistakenly coded as a home care outlet and *vice versa*). The weights are in the table A1.2.

Table A1.2: Weights for the residential census

	N	n	Weight
Very Remote Australia	57	27	1.9655
Remote Australia	75	40	1.6667
All transition care	75	21	2.4194
Major cities			
Small	375	268	1.2931
Medium	612	474	1.2541
Large	670	532	1.243
Inner regional			
Small	246	175	1.337
Medium	243	190	1.2526
Large	185	156	1.1783
Outer regional			
Small	232	147	1.3728
Medium	109	83	1.2976
Large	69	47	1.4375
Total	**2,948**	**2,160**	

There are a number of 'respondents' for whom fundamental data on number of workers is missing in B2 (How many employees in each classification are female and how many are male?). These are treated as 'non-respondents'. There are also a number of 'respondents' for whom B2 is zero, despite evidence from other questions such as A6 (How many of the employees in each classification worked the following hours in the last fortnight pay period in November 2015?) that the facility does have direct care employees. In addition, there are facilities with zero employees recorded in B2 but where workers have returned questionnaires in the worker survey, indicating that the facility also had direct care employees. The estimates on the number of direct care employees will be underestimates to the extent that these respondents actually have direct care employees.[13]

Home Care and Home Support Census

A similar methodology for deriving weights is used, although the program is also used to define strata. The variables used as a proxy for the size of the service outlet is the number of worker

[13] There were some 46 respondents with data for A6 and zero recorded for B2. Based on B2, the estimate of the direct care workforce is of the order 150,000. If these respondents were to be treated as missing then the estimate would increase by around 3,000.

forms sent to the outlet (small is 3, medium is 5, large is 7). The size of some of the outlets was unknown in which case five worker survey forms were sent to the outlet. These are included in the 'medium' size category.

Table A1.3: Stratification design for home care and home support service outlets

	Notes
All very remote	All very remote outlets are in a single stratum because of small numbers
All remote	All remote outlets are in a single stratum because of small numbers
Outlet program types: all except CHSP, VIC_HACC, WA_HACC	
Major cities	
Small	
Medium	
Large	
Inner regional	
Small	
Medium	
Large	
Outer regional	
Small	
Medium	
Large	
CHSP	No remote classification on file
Small	
Medium	
Large	
VIC_HACC	No remote classification on file and only medium outlets
WA_HACC	No remote classification
Small	
Medium	
Large	

Note that the remoteness classification was not available for HC_CHSP, HC_VIC and HC_WA_HACC, so any remote or very remote outlets will be in the strata associated with those programs.

The weights (Table A1.4) are derived using the same rules as for the residential facility census collection.

Prior to finalisation of the data file, the Department of Health identified a number of outlets as being out of scope. These were removed from the population file with the exception of a handful who had supplied valid responses.

As for the residential care, there are a number of respondents for which the essential information on the number of direct care employees is missing for B2 (How many employees in each classification are female and how many are male?). These are treated as non-respondents if the outlet had indicated that it has some PAYG direct care employees (in question A10.3 (If your service outlet does not employ PAYG paid staff, please indicate here) and as a nil response otherwise.

Table A1.4: Weights for the home care and home support outlet census

	N	n	weight
All very remote (excluding CHSP, VIC_HACC, WA_HACC)	93	42	2.214286
All remote (excluding CHSP, VIC_HACC, WA_HACC)	58	26	2.230769
Major cities (excluding CHSP, VIC_HACC, WA_HACC)			
Small	249	196	1.270408
Medium	363	260	1.396154
Large	426	315	1.352381
Inner regional (excluding CHSP, VIC_HACC, WA_HACC)			
Small	160	117	1.367521
Medium	181	113	1.60177
Large	131	81	1.617284
Outer regional (excluding CHSP, VIC_HACC, WA_HACC)			
Small	100	61	1.639344
Medium	82	40	2.05
Large	63	35	1.8
CHSP			
Small	639	306	2.088235
Medium	723	384	1.882813
Large	626	304	2.059211
VIC_HACC	598	313	1.910543
WA_HACC			
Small	76	37	2.054054
Medium	88	54	1.62963
Large	72	54	1.333333
Total	**4,728**	**2,738**	

Residential Workforce Survey and the Home Care and Home Support Workforce Survey

These worker surveys are two stage collections with service facilities/outlets asked to distribute a specified number of survey forms to a sample of aged care workers. The service managers are asked to ensure that the selected employees work in direct care roles, are

employed as PAYG staff and are randomly selected by choosing the employees with a date of birth closest to the date the letter is received.

While the first stage of the collection is notionally a census, in practice not all service facilities/outlets participated in the workforce census, and of those that did participate in the census not all distributed the survey forms to their workers. Therefore we need to treat the worker survey as a two stage collection where:

- The first stage consists of all those service facilities/outlets who distributed worker survey forms and there is at least one responding worker. For this stage, we adopt the same stratification as for the residential care census (or home care census), and assume that those service facilities/outlets are a random sample of all service facilities/outlets (with at least one direct care employee) in a particular stratum.

- The second stage consists of the responding workers.

The standard way of proceeding is to derive weights for each stage and combine them to an overall weight for the responding worker. However, there is reason to believe that many service facilities/outlets have not followed the instructions about sample selection and therefore the sample of workers is biased. If this is the case then an estimate of say, the number of nurses, obtained from the worker survey will differ from the estimate obtained from the service facility/outlet census collection. We account for this bias by modifying the respondent worker weights so that an estimate of workforce size from the worker survey is the same as the estimate from the service facility/outlet census collection. Moreover, we apply this modification differentially so that the estimates of workforce size are consistent for four groups:

- Registered nurses combined with nurse practitioners
- Enrolled nurses
- Personal care attendants
- Allied health professionals and assistants

The question we use in the service facility/outlet census collection is B2: employee classification by sex. This is the most straight forward question involving employee classification and is considered to be the most robust measure of the total number of direct care employees.[14]

A further complication is that there are cases where worker forms were returned but there was no corresponding return for the service facility/outlet census or the census form recorded zero direct employees, and cases where the number of worker forms exceeds the number of direct care employees recorded in the census form. In the first of these, we impute the number of direct care employees for the service facility/outlet based on the average number of employees in the corresponding stratum. In the latter, we did not change the weights, implying that it is possible that the weights are less than one. This approach was adopted in order to maintain coherence between the worker and service facility/outlet collections. The approach means that the estimates of number of direct care workers for each of the four groups are consistent between the service facility/outlet and worker collections.

[14] That said, we know that there are data quality issues with this question, and the treatment of facilities/outlets without data for B2 (employee classification by sex) has an element of arbitrariness. The main issue is whether the facility/outlet is treated as a non-respondent – that is, has not provided data for B2- or a respondent with no direct care employees.

Appendix 2: Interview Schedule

1. What is your current role in aged care?
    - Do you have more than one job? *If yes - probe:*
        - *What do you do?*
        - *If in aged care, with this provider or another?*
        - *Why do you need to have more than one job?*
        - *How do you manage to combine the jobs?*

2. How long have you worked in aged care?
    - Why did you choose to work in aged care?
    - Why this organisation?

3. What do you like best about your work?

4. Is there anything about your work that you find difficult or stressful? *If yes, - probe:*
        - *What do you find difficult or stressful?*
        - *How does this impact on your work/availability for work?*
        - *What strategies do you use to deal with this issue?*
        - *Is support available at work to help you with this?*

5. What do you think makes a good aged care worker?
   Probe:
        - *Issues re age, gender, culture, language*
        - *Qualifications, skills, qualities*

6. What factors enable an aged care outlet to provide quality care?
   Probe:
        - *Staffing – ratio, skills, working conditions*
        - *Management – support, supervision*
        - *Policies and guidelines*
        - *Organisational values*

7. What health and safety policies and procedures are in place at your work? *Probe:*
        - *Communication of policies and procedures by employer*
        - *Processes for reporting concerns*
    - How well do these policies and procedures work?
    - What training have you received regarding workplace health and safety?

8. Do you have any health and safety concerns in your work?
    - Have you reported these to your employer? *If yes - probe*
        - *How has your employer responded to these?*

9. Do you hold any specific qualifications in aged care?
    - (If yes) How well do you feel this training has equipped you to work in aged care?

10. To what extent does your employer support you to do work-related training?
    - (For new hires only, i.e. less than twelve months in aged care) What induction training did you receive? When did this take place?
    - What kinds of training do you find most useful?
    - Have you done any training that hasn't been useful? If yes, what kinds?
    - Is there any training which you have not done, which you feel would be useful in your work? If yes, what kinds?

11. We are interested in knowing how your work fits into your life. What responsibilities and activities do you have outside of your work in aged care? *Probe:*

- *Caring for children/relatives, other caring responsibilities*
- *Studying*
- *Volunteer work*
- *Community activities*
- *Other main activities, e.g. social, fitness*

12. How do you manage to combine your work and non-work responsibilities and activities?
    - What has worked?
    - What hasn't worked?
    - Is there anything that might make it easier to combine your work and non-work responsibilities and activities? *Probe*
        - *Changes to job (role, hours, schedule)*
        - *Support from employer*
        - *Workplace policies*

13. What would you like to achieve in your work over the next 3-5 years?

14. Is there anything else that you would like to talk about in regards to working in aged care?

Appendix 3: Additional Tables

Table A4.2: Average number of residential direct care workforce by size of outlet (places), by number of Total PAYG and direct care employees: 2012 and 2016

Number of places	Average Total PAYG employees		Average direct care employees		Ratio of Average Direct Care/Total PAYG	
	2012	2016	2012	2016	2012	2016
1–20	31	32	20	19	0.65	0.59
21–40	40	48	29	29	0.73	0.60
41–60	56	63	41	40	0.73	0.63
61+	107	113	78	75	0.73	0.66

Source: Census of residential aged care facilities.
**Operational residential places at 3 November 2015 for in-scope aged care facilities.*

Table A6.2: Average number of home care and home support direct care workforce by size of outlet, by number of Total PAYG and direct care employees: 2012 and 2016

Number of Total PAYG employees	Average Total PAYG employees		Average direct care employees		Ratio of Average Direct Care/Total PAYG	
	2012	2016	2012	2016	2012	2016
1–5	3	3	3	2	1.00	0.67
6–10	8	8	7	5	0.88	0.63
11–20	15	15	12	11	0.80	0.73
21–40	29	29	21	22	0.72	0.76
More than 40	111	116	65	75	0.59	0.65

Source: Census of home care and home support outlets.

Appendix 4: Questionnaires

Flinders UNIVERSITY

Australian Government
Department of Health

barcode
BSP:xxx-Sequence
Provider contact position
Provider name
Provider POSTAL address line 1
Provider POSTAL address line 2
Provider POSTAL Suburb, State, Postcode

MAILING DATE

To Provider contact position, Provider name

Invitation to participate in the 2016 National Aged Care Workforce Census and Survey

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at: Survey.ipsos.com.au/NACWCAS.

The National Aged Care Workforce Census and Survey collects important information that allows the Australian Government to make more informed strategic decisions about how to provide quality care to older Australians. The research in 2003, 2007 and 2012 has informed decisions about workforce planning and addressed workforce issues.

Responsibility to complete the census

All approved providers of aged care services must ensure completed census returns, as set out in the *Accountability Principles 2014* Part 5, made under subsection 96-1 of the *Aged Care Act 1997*.

Commonwealth Home Support Programme (CHSP) grant recipients must ensure completed aged care workforce censuses are returned, as set out in Section 5.3.5 within the *CHSP Programme Manual 2015*.

How to participate and distributing the census and survey packages

Provider name has been sent X census and survey package(s) for the number of aged care services your organisation provides.

We request that you send each hardcopy census and survey package to the person best suited for completing the census (and distributing the surveys) in each of your aged care service locations. The person best suited to receive the package and complete the Census is either **the personnel manager or the person who recruits and manages staff at each of your aged care service locations**.

There are two different census and survey packages: the Census of Residential Aged Care Facilities (with a set of Residential Worker Surveys) and the Census of Home Care and Home Support Aged Care Outlets (with a set of Home Care and Home Support Worker Surveys). Please call the free helpline 1800 071 735 if you need any assistance.

Larger organisations with multiple aged care services; co-located services

If your organisation is large and provides multiple aged care services, you should provide information for each type of service (Residential and/or Home Care and Home Support – please see table on the next page), at each aged care service location, in each specific census form.

Services that are provided from one location are called co-located services. If your organisation has co-located services and the workforce for these services is coordinated, only one census and survey pack is required for the co-located services (rather than one for each of the services). Please note that where Residential and Home Care/Home Support services are co-located then both Residential and Home Care/Home Support census and survey packages should be completed.

Ethics and Privacy

All responses to the census and survey are confidential and identifying details will be removed prior to analysis. Your census and surveys will be combined with all other data and no individual site or person will be identified. At the end of the project, the Australian Government Department of Health will receive a list of services that participated in the census. This list will not be associated with any information you provide.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House number 02468 - 01) and by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

This survey has been approved by the ABS Statistical Clearing House. Approval Number *02468 - 01*

Census and Survey Packages

Census of Residential Aged Care Facilities (with a set of Residential Worker Surveys)	**Census of Home Care and Home Support Aged Care Outlets** (with a set of Home Care and Home Support Worker Surveys)
This is for services which provide care under the following programmes: • Residential aged care • Flexible programmes with residential places: National Aboriginal and Torres Strait Islander Flexible Aged Care Programme; Multi-Purpose Services Programme; Innovative Pool Programme • Transition Care (in residential setting)	This is for service outlets which provide care under the following programmes: • Home Care Packages Programme • Flexible programmes with home care places: National Aboriginal and Torres Strait Islander Flexible Aged Care Programme; Multi-Purpose Services Programme; Innovative Pool Programme • Commonwealth Home Support Programme • Home and Community Care (Victoria) • Home and Community Care (Western Australia) • Transition Care (in community setting) • DVA Community Nursing, Veteran's Home Care or other DVA administered programme

If you have any queries about the census or survey, please contact the free helpline on 1800 071 735.

Query	**Action**
More census and survey packs than service locations	Please call the helpline on 1800 071 735.
More service locations than census and survey packs	Please call the helpline on 1800 071 735 and request more census and survey packs.
The services at a single location are of only one type (Residential only or Home Care/Home Support only)	Please call the helpline on 1800 071 735 if you don't have the correct type of census and survey pack. Distribute only the correct census and survey pack (Residential or Home Care/Home Support) to the service location.
The services at a single location are of both types (Residential or Home Care/Home Support)	Please call the helpline on 1800 071 735 if you need another type of census and survey pack. Distribute one of each census and survey pack (Residential and Home Care/Home Support) to the service location.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Yours sincerely

Professor Kostas Mavromaras
Director, National Institute of Labour Studies
Flinders University, SA

Encs

This survey has been approved by the ABS Statistical Clearing House: Approval Number *02468 - 01*

Flinders UNIVERSITY

Australian Government
Department of Health

barcode
BSP:xxx-Service ID-Sequence
The Manager of the aged care service outlet
Service outlet: Service Name
Provider: Provider Name
Service Postal address1
Service Postal address2
Service Suburb, State, Postcode

MAILING DATE

To The Manager of the Home Care/Home Support aged care service outlet provided by Provider Name

Invitation to participate in the 2016 National Aged Care Workforce Census and Survey

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. The National Aged Care Workforce Census and Survey collects critical information about residential, home care and home support aged-care services and the people who work in aged care. More details can be found at Survey.ipsos.com.au/NACWCAS.

There are two different census and survey packages:
The Census of Residential Aged Care Facilities (with a set of Residential Worker Surveys); and
The Census of Home Care and Home Support Aged Care Outlets (with a set of Home Care and Home Support Worker Surveys).

As the manager of the Home Care/Home Support service outlet at this location, we are asking you to complete the *Home Care/Home Support Census* (pink) and distribute the *Home Care/Home Support worker surveys* (pink) to your employees (see over page).

The census collects information about workers at the ***service outlet location*** at which your aged care services are coordinated. When home care/home support services are co-located (i.e. where more than one service outlet operates from the same location), and the workforce is coordinated, only one Home Care and Home Support Census needs to be completed.

If your aged care service belongs to a larger organisation, the information provided in the census needs to be for the home care/home support service outlets at this location only, not for the whole organisation.

Please call the free helpline 1800 071 735 if you need any assistance.

How to participate in the census

You can participate online via a secure website or by filling in the enclosed census and returning it in the reply paid envelope. The census cover has the website, username and password needed for online participation.

Unless you have told us otherwise, complete only one Home Care/Home Support Aged Care Census about the workforce at this service outlet location.

Some questions require you to refer to your personnel/payroll records (e.g. to calculate numbers of full time equivalent staff or calculate hours worked).

The person best suited to complete the census is either **the personnel manager or the person who recruits and manages staff**.

This survey has been approved by the ABS Statistical Clearing House; Approval Number *02468 - 01*

Distributing the worker surveys

We are asking you to distribute X surveys to a sample of aged care workers.

The person best suited to distribute these surveys is either the **manager or care coordinator**. If you are not this person, please pass the surveys onto this person, along with this letter.

It is important that a broad cross-section of the aged care workforce participate in the survey. This may mean providing encouragement and support to assist employees with literacy or English language difficulties to complete the survey.

When selecting employees (including yourself) for participation, please ensure that they:

a. work in direct care roles (i.e. nurses, allied health professionals, allied health assistants, community care workers), associated with the aged (i.e. they provide care for persons 65 years and older, or 50 years and older if Indigenous); **and**

b. are employed as PAYG staff (i.e. do not include volunteers or agency/brokered/self-employed staff); **and**

c. are randomly selected by choosing employees with a date of birth closest to today's date.

If you follow these distribution guidelines, our survey will include persons who are representative of all aged care workers in all services across Australia.

Aged care workers can participate online via a secure website or by filling in the enclosed survey and returning it in the reply paid envelope. The cover of each worker survey has specific information about online participation.

Ethics and Privacy

All responses to the census and survey are confidential and identifying details will be removed prior to analysis. Your census and surveys will be combined with all other data and no individual site or person will be identified. At the end of the project, the Australian Government Department of Health will receive a list of services that participated in the census. This list will not be associated with any information you provide.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House number 02468 - 01) and by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

If you have any queries about the census or survey, please call the free helpline on 1800 071 735.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Yours sincerely

Professor Kostas Mavromaras
Director, National Institute of Labour Studies
Flinders University, SA

Encs

This survey has been approved by the ABS Statistical Clearing House. Approval Number *02468 - 01*

Flinders UNIVERSITY

Australian Government
Department of Health

barcode
BSP:xxx-Service ID-Sequence
The Manager of the aged care service
Service Name
Service Postal address1
Service Postal address2
Service Suburb, State, Postcode

MAILING DATE

To the Manager of Service Name

Invitation to participate in the 2016 National Aged Care Workforce Census and Survey

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at Survey.ipsos.com.au/NACWCAS.

There are two different census and survey packages:
The Census of Residential Aged Care Facilities (with a set of Residential Worker Surveys); and
The Census of Home Care and Home Support Aged Care Outlets (with a set of Home Care and Home Support Worker Surveys).

As the manager of the residential service at this location, we are asking you to complete the *Census of Residential Aged Care Facilities* (blue) and distribute the *Residential Worker Surveys* (blue) to your employees (see below).

The census collects information about workers at the ***service location*** at which your aged care services are coordinated. When residential services are co-located (i.e. where more than one residential service operates from the same location), and the workforce is coordinated, only one residential census needs to be completed.

If your aged care service belongs to a larger organisation, the information provided in the census needs to be for the facilities at this location only, not for the whole organisation.

Please call the free helpline 1800 071 735 if you need any assistance.

How to participate in the census

You can participate online via a secure website or by filling in the enclosed census and returning it in the reply paid envelope. The census cover has the website, username and password needed for online participation.

Unless you have told us otherwise, complete only one Census of Residential Aged Care Facilities about the workforce at this location. Some questions require you to refer to your personnel/payroll records (e.g. to calculate numbers of full time equivalent staff or to calculate hours worked).

The person best suited to complete the census is either the **personnel manager or the person who recruits and manages staff**.

This survey has been approved by the ABS Statistical Clearing House: Approval Number *02468 - 01*

Distributing the worker surveys

We are asking you to distribute X surveys to a sample of aged care workers.

The person best suited to distribute these surveys is either the **manager or director of nursing**. If you are not this person, please pass the surveys onto this person, along with this letter.

It is important that a broad cross-section of the aged care workforce participate in the survey. This may mean providing encouragement and support to help employees with literacy or English language difficulties to complete the survey.

When selecting employees (including yourself) for participation, please ensure that they:

a. work in direct care roles (i.e. nurses, allied health professionals, allied health assistants, community care workers), associated with the aged (i.e. they provide care for persons 65 years and older, or 50 years and older if Indigenous); **and**

b. are employed as PAYG staff (i.e. do not include volunteers or agency/brokered/self-employed staff); **and**

c. are randomly selected by choosing employees with a date of birth closest to today's date.

If you follow these distribution guidelines, our survey will include persons who are representative of all aged care workers in all services across Australia.

Aged-care workers can participate **online** via a secure website or by filling in the enclosed survey and returning it in the reply paid envelope. The cover of each worker survey has specific information about online participation.

Ethics and Privacy

All responses to the census and survey are confidential and identifying details will be removed prior to analysis. Your census and surveys will be combined with all other data and no individual site or person will be identified. At the end of the project, the Australian Government Department of Health will receive a list of services that participated in the census. This list will not be associated with any information you provide.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House number 02468 - 01) and by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

If you have any queries about the census or survey, please call the free helpline on 1800 071 735.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Yours sincerely

Professor Kostas Mavromaras
Director, National Institute of Labour Studies
Flinders University, SA

Encs

This survey has been approved by the ABS Statistical Clearing House. Approval Number *02468 - 01*

Flinders UNIVERSITY

Australian Government
Department of Health

MAILING DATE

Service Name: Service name, Service ID

Provider Name: Provider name

Form Type: Home Care and Home Support Census

Unique Service Identification: XX-XXXXXX-XX

Invitation to participate in the 2016 National Aged Care Workforce Census

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at Survey.ipsos.com.au/NACWCAS.

How to participate in the census

We are asking you to complete this census for the home care and home support services provided by Provider name at this location only.

You can participate online via a secure website. Go to Survey.ipsos.com.au/HC2016 and enter your username and password:

Username: XXXXXX

Password: XXXXXX

You can also fill in this form instead and use one of the reply paid envelopes to return it.

Please call the free helpline 1800 071 735 if you need any help.

Ethics and Privacy

All responses to the census are confidential and identifying details will be removed prior to analysis. Your census will be combined with all other data and no individual site or person will be identified. At the end of the project, the Australian Government Department of Health will receive a list of services that participated in the census. This list will not be associated with any information you provide.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House approval number 02468 - 01) and by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Thank you for your assistance.

Yours sincerely

Professor Kostas Mavromaras

Director, National Institute of Labour Studies

Flinders University, SA

This survey has been approved by the ABS Statistical Clearing House: Approval Number 02468 - 01

APPROVED

Additional information about the 2016 National Aged Care Workforce Census

When completing this form, please ensure that you...

1. Make sure you answer every question (unless otherwise stated)
2. Cross the appropriate box/boxes like this [X]
3. Enter numbers into individual boxes like this [1] [2] [3]
4. If the answer to a question is nil, please write '0' and go to the next question.
5. Please write clearly using a BLACK or BLUE pen.
6. Sometimes you will find the box you have marked has an instruction to go to another question.
   By following the instructions carefully you will be able to skip questions that do not apply to you
7. Don't worry if you make a mistake or wish to change a response; simply colour in the wrong box like this [■] and mark the correct box like this [X]
8. Call the toll-free helpline on 1800 071 735 if you have any queries, or visit Survey.ipsos.com.au/NACWCAS

It is important that you are as accurate as possible. Please refer to payroll or staffing records where necessary.
The pay period referred to in the census is the last pay period (i.e. fortnight) in November 2015.

Key Definitions

Throughout this questionnaire, the following definitions are used when referring to employee classifications. Please refer to these as you answer the questions.

Allied health assistants *support allied health professionals in providing personal, social and emotional care to residents. Job titles include recreational officer, occupational therapy assistant, social work assistant and others.*

Allied health professionals *include professional accredited allied health workers such as physiotherapists, diversional therapists, speech therapists, social workers and similar. Exclude employees solely engaged in a coordinator/management role.*

Ancillary care workers *have responsibility for providing services to care recipients such as home repairs, home modification, and home maintenance.*

Care manager *is responsible for all direct care staff; other job titles may be Director of Nursing, Care Co-ordinator and others.*

Community care workers *provide personal, domestic, social and other home care to care recipients as a core part of their jobs. For example: showering, medication, respite, cleaning, meals, transport, shopping. Job titles of community care worker vary widely.*

Direct care staff *provide care directly to care recipients as a core component of their work.*

Enrolled nurses *provide nursing care, working under the direction and (direct or indirect) supervision of the registered nurse.*

Nurse practitioner *is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role.*

Pastoral/spiritual care workers *include professional pastoral/spiritual care workers (eg chaplains).*

Registered nurses *provide and supervise nursing care.*

Section A: About the Service Outlet

The following questions ask for basic information about the home care and home support aged care services provided at this location. We refer to these as your 'service outlet'. The information will help us to understand how the aged care workforce is distributed across different types of service outlets.

A1.1 Where is your service outlet located? *(Please describe the actual location from which these services are delivered. ABS Remoteness Areas category)*

- Major Cities of Australia ☐ 1
- Inner Regional Australia ☐ 2
- Outer Regional Australia ☐ 3
- Remote Australia ☐ 4
- Very Remote Australia ☐ 5
- Don't Know ☐ 6

A1.2 What is the postcode for the location of this service outlet?

☐☐☐☐

A1.2a What is the name of the suburb/town/locality for the location of this service outlet?

A2 Is your service outlet:

- Not-for-Profit ☐ 1
- For Profit ☐ 2
- Government ☐ 3

A3.1 In the last reporting period, under which programmes did your service outlet provide services?

- Commonwealth Home Support Programme* ☐ 1
- Home Care Packages Programme ☐ 2
- Home and Community Care Victoria ☐ 3
- Home and Community Care Western Australia ☐ 4
- Home Care places under Multi-Purpose Service Programme ☐ 5
- Home Care places under National Aboriginal and Torres Strait Islander Flexible Aged Care Programme ☐ 6
- Home Care places under Innovative Pool Programme ☐ 7
- DVA Community Nursing, Veteran's Home Care or other DVA administered programme ☐ 8
- Transition Care Programme ☐ 9

A4 Is your service outlet part of a larger organisation, ie owned by a company or not-for-profit agency that owns other aged care facilities or services?

Yes ☐ 1 No ☐ 2

A5.1 Does your service outlet aim to cater for specific cultural or ethnic groups?

Yes ☐ 1 No ☐ 2 → **If 'no', go to A6.1**

A5.2 For which cultural or ethnic group/s does your service outlet cater? *(Cross all relevant boxes)*

- Aboriginal and/or Torres Strait Islander ☐
- Chinese ☐
- Dutch ☐
- Gay, lesbian, bisexual, transgender, intersex ☐
- Greek ☐
- Italian ☐
- Polish ☐
- German ☐
- Indian ☐
- Other *(please specify)* ☐

A5.3 Does your service outlet employ staff with particular language or other cultural knowledge in order to cater to the group/s listed in A5.2?

Yes ☐ 1 No ☐ 2

A6.1 What qualifications does the Care Manager/ Care Coordinator in your service outlet have? *(Cross one box only)*

- Nursing qualifications ☐ 1
- Managerial qualifications ☐ 2
- Nursing and managerial qualifications ☐ 3
- None of the above ☐ 4
- Don't know ☐ 5

A6.2 What specialised qualifications in ageing does the Care Manager/Care Coordinator in your service outlet have? *(cross all relevant boxes)*

- Gerontology ☐
- Palliative Care ☐
- Psychogeriatrics ☐
- Other ☐
- None of the above ☐
- Don't Know ☐

**From 1 July 2015, the Commonwealth Home Support Programme brought together Commonwealth HACC Programme, Planned Respite from National Respite for Carers Programme (NRCP), Day Therapy Centres Programme (DTC), Assistance with Care and Housing for the Aged Programme (ACHA).*

A6.3 What are the three most important methods used to monitor the quality of aged care services/supports provided by this outlet?
(Cross three boxes only)

- Managers or supervisors monitor quality ☐ 1
- Inspectors from another part of the organisation monitor quality ☐ 2
- Individual employees monitor quality ☐ 3
- Keep records of feedback or complaints from service users ☐ 4
- Surveys of service users ☐ 5
- External auditing (beyond accreditation, e.g. third party inspectors) ☐ 6
- Accreditation ☐ 7
- Other *(please specify)* ☐ 8

A7 Do employees receive?
(Cross all relevant boxes)

- Paid time for travel between care/support appointments? ☐
- Paid time for travel between home and care/support appointments? ☐
- Petrol/depreciation allowance for transport costs related to care/support appointments? ☐
- None of these ☐

A8 How many people does your service outlet employ in total, including all full-time, part-time and casual employees, excluding agency staff?
(Count all employees for whom PAYG tax is deducted by your organisation, including those on paid leave for the last fortnight pay period.)

☐☐☐☐ **PAYG Employees**

A9 How many of the employees in each classification worked the following hours in the last fortnight pay period in November 2015?
(Count all employees for whom PAYG tax is deducted by your organisation, including those on paid leave. Be sure to write '0' if no employees in a particular classification. Where an employee works in more than one classification, provide the number of hours for each classification. For example, if an employee works 40 hours per fortnight as a care manager and 20 hours per fortnight as a registered nurse, mark 1 in the care manager 31-69 hours category and 1 in the registered nurse 1-30 hours category).

Employee Classification (Definitions on Page 2)	Hours worked in a fortnight 1 – 30	31 – 69	70 – 80	81+	On leave
Management					
Administration					
Pastoral/spiritual care worker					
Direct care staff					
• Care manager/care co-ordinator					
• Nurse practitioner					
• Registered nurse					
• Enrolled nurse					
• Community care worker – personal, domestic or social care					
• Allied health professional					
• Allied health assistant					
• Ancillary care worker (e.g home repairs, modification, maintenance)					

A10.1 **Does this service outlet provide residential as well as home care/home support aged care services?**

Yes ☐ 1 No ☐ 2 → **If 'no', go to A10.3**

A10.2 **How many of your direct care PAYG employees in each classification work in your home care/ home support and/or residential services?** *(Please be sure to write '0' if no employees in a particular classification work in both services)*

Employee Classification	Number of direct care employees working in.... Residential ONLY	Home care/ home support ONLY	BOTH residential and home care/ home support
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Personal care attendant/Community care worker			
Allied health professional			
Allied health assistant			

A10.3 **If your service outlet does not employ PAYG paid staff, please indicate here and go to Section D, page 12.**

No PAYG paid staff ☐ 1

Section B: About the Direct Care Workforce

The following questions ask about the direct care workforce currently employed in your service outlet. Please note:

- *Definitions for employee classifications of direct care staff are on the inside cover, page 2.*
- *Only employees for whom PAYG tax is deducted by your organisation should be included. Agency and other non-PAYG contract staff are covered in Section D.*
- *Include staff who were on paid leave during the designated period.*
- *Only employees providing home care/home support aged care, including staff working in BOTH home care /home support and residential aged care, should be included here. Information about employees who ONLY provide residential aged care will be in the Census of Residential Aged Care Facilities.*

Unless otherwise indicated, when completing Section B please provide information based on the last pay period (ie fortnight) in November 2015.

If you have ***no employees in a category*** *please* ***write '0'*** *in the appropriate space.*

It is important to be as ***accurate*** *as possible. Please refer to your records where necessary.*

B1.1 **How many people employed in each classification work in your outlet as permanent full-time, permanent part-time or casual/fixed term contract?** *(Include staff on paid leave)*

Employee Classification	Permanent full-time*	Permanent part-time*	Casual/ contract full-time*	Casual/ contract part-time*
Nurse practitioner				
Registered nurse				
Enrolled nurse				
Community care worker				
Allied health professional				
Allied health assistant				
Total				

**The ABS definition of full-time work is 35 hours or more per week.*

B1.2 **Please record the number of full-time equivalent (FTE) employees*, in each classification in your outlet for the last pay period in November 2015.** *(Include staff on paid leave)*

**To calculate the full time equivalent (FTE) employee number for an employee classification, divide the total number of hours worked per fortnight by workers of that classification by 70 (the standard used by the Australian Bureau of Statistics for full-time work is 35 hours per week). This takes into account both the number of employees and the fraction of full-time work status of each. For example, an employee working full-time will register as 1 FTE; while an employee working a fractional load of half-time will register as 0.5 FTE. If an employee is on leave, count the number of hours they would usually have worked in the FTE calculation.*

Employee Classification	Total hours worked	Divide by 70 to calculate	Full-time equivalent employees (FTEs)*
Nurse practitioner		Divide by 70=	
Registered nurse		Divide by 70=	
Enrolled nurse		Divide by 70=	
Community care worker		Divide by 70=	
Allied health professional		Divide by 70=	
Allied health assistant		Divide by 70=	
Total			

We now ask for more detail about the employees listed in B1.1

Please ensure that:

- *You include all these employees in your answers.*
- *If you have no employees in a particular category, write '0' in your answer.*
- *The information is for the last pay period in November 2015 (unless stated otherwise in question).*

B2 **How many employees in each classification are female and how many are male?**

Employee Classification	Female	Male	Employee Classification	Female	Male
Nurse practitioner			Community care worker		
Registered nurse			Allied health professional		
Enrolled nurse			Allied health assistant		

B3 **How many of the employees in each classification fall into the following age categories?**

Employee Classification	Under 30 years	30 – 39 years	40 – 49 years	50 – 59 years	60+ years
Nurse practitioner					
Registered nurse					
Enrolled nurse					
Community care worker					
Allied health professional					
Allied health assistant					

B3a For this outlet, what was the direct care staff headcount?

Employee Classification	Care staff headcount for the last pay period in November 2014	Number of care staff who left in the 12 months to the last pay period in November 2015	Number of care staff hired in the 12 months to the last pay period in November 2015
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Community care worker			
Allied health professional			
Allied health assistant			

B4 How many employees in each classification identify as being of Aboriginal and/or Torres Strait Islander origin?

Employee Classification	Number of employees	Don't know	Employee Classification	Number of employees	Don't know
Nurse practitioner			Community care worker		
Registered nurse			Allied health professional		
Enrolled nurse			Allied health assistant		

B5 For each employee classification, how many are from culturally and linguistically diverse backgrounds*? *(not including those reported in B4)*

Employee Classification	Number of employees	Don't know	Employee Classification	Number of employees	Don't know
Nurse practitioner			Community care worker		
Registered nurse			Allied health professional		
Enrolled nurse			Allied health assistant		

**Individuals who identify as having a specific cultural or linguistic affiliation because of their place of birth, ancestry, ethnic origin, religion, preferred non-English main language or language(s) spoken at home, or because of their parents' identification on a similar basis.*

B6.1 For each employee classification, please indicate how many employees you have working under each form of employment contract.

Employee Classification	Award	Enterprise Agreement*	Common Law Contract	Individual Flexibility Agreement	Don't Know
Nurse practitioner					
Registered nurse					
Enrolled nurse					
Community care worker					
Allied health professional					
Allied health assistant					

** Enterprise Agreements include union agreements, non-union agreements and certified agreements.*

B6.2 **For each employment classification, please indicate all awards that apply to employees in your service outlet.** *(Note. all agreements will have a base condition award)*

Employee Classification	Aged Care Award 2010	Nurses Award 2010	SACH Award 2010	Other *(please specify relevant State Award)*	
Nurse practitioner	☐	☐	☐	☐	
Registered nurse	☐	☐	☐	☐	
Enrolled nurse	☐	☐	☐	☐	
Community care worker	☐	☐	☐	☐	
Allied health professional	☐	☐	☐	☐	
Allied health assistant	☐	☐	☐	☐	

B7.1 **For each employee classification, please indicate whether you had skill shortages during the last 12 months.** *(cross all relevant boxes)*

Employee Classification	Yes
Nurse practitioner	☐
Registered nurse	☐
Enrolled nurse	☐
Community care worker	☐
Allied health professional	☐
Allied health assistant	☐
No skill shortages	☐

If no skill shortages go to B8.1

B7.2 **Were these skill shortages due to any of the following?** *(cross all relevant boxes)*

- Specialist knowledge required ☐
- Geographical location of service ☐
- Wages or salary costs too high for business ☐
- Lack of availability of adequate training ☐
- Unsure of long-term demands for service ☐
- Recruitment too slow ☐
- Lack of suitable applicants (skills/ qualifications/experiences/values) ☐
- Other *(please specify)* ☐

If specialist knowledge go to B7.2a, otherwise go to B7.3

B7.2a **If specialist knowledge was required, was this ?** *(cross all relevant boxes)*

- ICT/IT ☐
- Dementia Care ☐
- Palliative Care ☐
- Clinical skills for high care ☐
- Medications ☐
- Other *(please specify)* ☐

B7.3 **How were these skill shortages addressed in the last 12 months?** *(cross all relevant boxes)*

- More use of external training of staff ☐
- More use of on-the-job training of staff ☐
- Existing workforce worked longer hours ☐
- Made greater use of agency staff ☐
- Sub-contracted or outsourced services to other businesses ☐
- Employed staff on short-term contract basis ☐
- Wages, salaries and/or conditions increased ☐
- Reduced outputs or production ☐
- Used student placements ☐
- Used volunteers ☐
- Other *(please specify)* ☐

B8.1 How many vacancies do you currently have in each classification?

Employee Classification	Total vacancies Full-time Equivalent*	How many POSITIONS are vacant? Full-time	Part-time
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Community care worker			
Allied health professional			
Allied health assistant			

**To calculate the full time equivalent (FTE) employee number for an employee classification, divide the total number of hours worked per fortnight by workers of that classification by 70 (the standard used by the Australian Bureau of Statistics for full-time work is 35 hours per week). This takes into account both the number of employees and the fraction of full-time work status of each. For example, an employee working full-time will register as 1 FTE; while an employee working a fractional load of half-time will register as 0.5 FTE.*

B8.2 Approximately how long did it take you to fill the MOST RECENT vacancy for employees in each classification?

Employee Classification	Weeks	Employee Classification	Weeks
Nurse practitioner		Community care worker	
Registered nurse		Allied health professional	
Enrolled nurse		Allied health assistant	

B8.3 What was the reason for the most recent vacancy for employees in each classification?
(cross all relevant boxes)

Reason	New position	Retirement	Injury/ illness	Resignation	End of contract	Involuntary separation	Other
Nurse practitioner							
Registered nurse							
Enrolled nurse							
Community care worker							
Allied health professional							
Allied health assistant							

B9 Are direct care workers required to do any of the following as part of their job?
(cross one box per row)

	Under normal circumstances	In exceptional circumstances	Never
Working longer than scheduled due to unanticipated needs of care recipients			
Variations in hours or location at short notice			
Working in very unsanitary conditions			
Working with aggressive service users (due to dementia etc)			
Working alone late at night (after 10 pm)			

B10.1 **In the last three months, how many instances of the following work-related injuries or illnesses were reported at your service outlet for direct care workers? Please check your records/incident reports.**
(If no work-related injuries or illnesses were reported, please write '0' and go to B11)

Reported Work-related Injury/Illness	Number	Reported Work-related Injury/Illness	Number
Fracture		Stress or other mental condition	
Chronic joint or muscle condition		Amputation	
Sprain/strain		Burns	
Cut/open wound		Other *(please specify)*	
Crushing injury/internal organ damage			
Superficial injury (minor injury)			

B10.2 **How many of these work-related injuries or illnesses reported at your service outlet were caused by:**

Cause of Reported Work-related Injury/Illness	Number	Cause of Reported Work-related Injury/Illness	Number
Lifting, pushing, pulling, bending		Fall	
Repetitive movement with low muscle loading		Exposure to mental stress	
Prolonged standing, working in cramped or unchanging positions		Long-term exposure to sound	
Vehicle accident		Contact with a chemical or substance	
Hitting, being hit or cut by person, object or vehicle		Fatigue	
		Other *(please specify)*	

B11 **How many of your PAYG direct care employees in each classification were on Workcover or other injury related leave or a graduated return to work program during the last three months?**

Employee Classification	Number of employees	Employee Classification	Number of employees
Nurse practitioner		Community care worker	
Registered nurse		Allied health professional	
Enrolled nurse		Allied health assistant	

Section C: Community Care Workers

We would like to know some further information about the community care workers (CCWs) employed in your aged care outlet. If no CCWs please go to Section D.

C1 **How many of your CCW employees have completed a Certificate III or Certificate IV in an area related to their direct care work?**

☐ **Completed** Certificate III (only) ☐ **Completed** Certificate IV

C2 **In the next 12 months, what areas of training will your CCWs most need/like to undertake:**
(cross all relevant boxes)

Dementia	☐	Allied health	☐
Mental health	☐	ICT/IT	☐
Management and leadership	☐	Other *(please specify)*	☐
Wound management	☐		
Palliative care	☐		

C3 **If you wished to employ additional CCWs, how would you be most likely to find them?** *(cross one box only)*

- Wait for walk-ins ☐ 1
- Word of mouth ☐ 2
- Place a newspaper job advertisement ☐ 3
- Place an internet job advertisement ☐ 4
- Place both newspaper and internet job advertisements ☐ 5
- Employ those already working through a job placement program ☐ 6
- Agency ☐ 7
- Other ☐ 8
- Don't know ☐ 9

C4.1 **Does your outlet employ CCWs from culturally and linguistically diverse backgrounds*?**

Yes ☐ 1 No ☐ 2 → **If 'no', go to D1**

**Individuals who identify as having a specific cultural or linguistic affiliation because of their place of birth, ancestry, ethnic origin, religion, preferred non-English main language or language(s) spoken at home, or because of their parents' identification on a similar basis.*

C4.2 **Please indicate the benefit which employing CCWs from culturally and linguistically diverse backgrounds has for your outlet** *(cross all relevant boxes)*

	Yes		Yes
Enhance cross-cultural understandings	☐	Link clients to ethnic communities	☐
Offer different cultural activities	☐	Link service to ethnic communities	☐
Language (other than English) skills	☐	Other *(please specify)*	☐
Don't know	☐		

C5.1 **What proportion of your current CCWs speak a language other than English as their first language?**

None ☐ 1 → **If 'none', go to D1** OR ☐☐☐ **Per cent (%)**

A number 1 to 100

C5.2 **What is the most common ethnic or cultural background of CCWs who speak a language other than English as their first language?** *(cross one box only)*

- African ☐ 1
- Chinese ☐ 2
- Filipino ☐ 3
- Greek ☐ 4
- Indian ☐ 5
- Italian ☐ 6
- Pacific Islands ☐ 7
- South-East Asian (other) ☐ 8
- Other *(please specify)* ☐ 9

C5.3 **Does lack of English language skills amongst your CCWs cause any difficulties in your outlet?**

Yes ☐ 1 No ☐ 2 → **If 'no', go to D1**

C5.4 **In which areas does lack of English language skills amongst your CCWs cause difficulties?** *(cross all relevant boxes)*

- Occupational Health and Safety ☐
- Communication with management and/or other staff ☐
- Communication with residents ☐
- Communication with residents' families ☐
- Other *(please specify)* ☐

Section D: Volunteers, Agency, Brokered, and Self-Employed Staff

We would now like to ask about the nursing or employment agency staff, brokered staff, self-employed staff and volunteers for whom you do not deduct PAYG tax, who worked in your service outlet during the last pay period in November 2015. If you did not have any of these staff types, please write '0' for each category.

D1 **How many people from nursing or employment agencies, brokered or self-employed staff worked at your aged care service outlet during the last pay period in November 2015?**

Employee Classification	Number of agency staff	Number of brokered staff	Number of self-employed staff
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Community care worker			
Allied health professional			
Allied health assistant			

Definitions:

Agency staff are contracted from a nursing or employment agency (i.e. labour hire agency). Your service outlet has responsibility for training and supervising these staff members.

Brokered staff are contracted from other care providers.

Self-employed staff are individuals who have their own ABN and operate as independent care workers. Your service outlet would broker directly with the individual to engage their services.

D2 **Why does this outlet choose to use agency, brokered, or self-employed staff?** *(cross all that apply)*

	Agency staff	Brokered staff	Self-employed staff
Matching staff to peaks in service user demand			
Short-term cover for staff absences			
Covering for maternity leave or annual leave			
Unable to fill vacancies			
Obtain specialist skills			
Freeze on permanent staff numbers			
Other *(please specify)*			

D3 **How many volunteers worked in your service outlet in the last two weeks?**

☐☐☐ **Volunteers** → **If '0', go to survey end**

If 'volunteers' at D3

D4 **What was the total amount of hours worked by all volunteers in the last two weeks?**

☐☐☐☐

If 'volunteers' at D3

D5 **If you have volunteers, what is the area or role that they undertake?**

Domestic activity assistance	☐ 1	Transport assistance	☐ 7
Respite care assistance	☐ 2	Shopping/appointment assistance	☐ 8
Social activity support assistance	☐ 3	Meal preparation/delivery assistance	☐ 9
Planned group activity assistance	☐ 4	Companionship/befriending	☐ 10
Home maintenance assistance	☐ 5	Other *(please specify)*	☐ 11
Gardening assistance	☐ 6		

Barcode

THANK YOU FOR YOUR HELP

For future surveys, please tell us approximately how long it took to complete this form. ☐☐☐ **Minutes**

Flinders UNIVERSITY

Australian Government
Department of Health

MAILING DATE
Service Name: Service name, Service ID
Provider Name: Provider name
Form Type: Residential Census
Unique Service Identification: XX-XXXXXX-XX

Invitation to participate in the 2016 National Aged Care Workforce Census

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at Survey.ipsos.com.au/NACWCAS.

How to participate in the census

We are asking you to complete this census for the residential services provided by Provider name at this location only.

You can participate online via a secure website. Go to Survey.ipsos.com.au/RC2016 and enter your username and password:

Username: XXXXXX

Password: XXXXXX

You can also fill in this form and use one of the reply paid envelopes to return it.

Please call the free helpline 1800 071 735 if you need any help.

Ethics and Privacy

All responses to the census are confidential and identifying details will be removed prior to analysis. Your census will be combined with all other data and no individual site or person will be identified. At the end of the project, the Australian Government Department of Health will receive a list of services that participated in the census. This list will not be associated with any information you provide.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House approval number 02468 - 01) and the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Thank you for your assistance.

Yours sincerely

Professor Kostas Mavromaras
Director, National Institute of Labour Studies
Flinders University, SA

This survey has been approved by the ABS Statistical Clearing House: Approval Number 02468 - 01

APPROVED

Additional information about the 2016 National Aged Care Workforce Census

When completing this form, please ensure that you...

1. Make sure you answer every question (unless otherwise stated)
2. Cross the appropriate box/boxes like this ☒
3. Enter numbers into individual boxes like this 1 2 3
4. If the answer to a question is nil, please write '0' and go to the next question.
5. Please write clearly using a BLACK or BLUE pen.
6. Sometimes you will find the box you have marked has an instruction to go to another question.
   By following the instructions carefully you will be able to skip questions that do not apply to you
7. Don't worry if you make a mistake or wish to change a response; simply colour in the wrong box like this ■ and mark the correct box like this ☒
8. Call the toll-free helpline on 1800 071 735 if you have any queries, or visit Survey.ipsos.com.au/NACWCAS

It is important that you are as accurate as possible. Please refer to payroll or staffing records where necessary. **The pay period for the census is the last pay period (i.e. fortnight) in November 2015.**

Key Definitions

Throughout this questionnaire, the following definitions are used when referring to employee classifications. Please refer to these as you answer the questions.

Allied health assistants *support allied health professionals in providing personal, social and emotional care to residents. Job titles include recreational officer, occupational therapy assistant, social work assistant and others.*

Allied health professionals *include professional accredited allied health workers such as physiotherapists, diversional therapists, speech therapists, social workers and similar. Exclude employees solely engaged in a coordinator/management role.*

Ancillary staff – other *have responsibility for ensuring that the buildings, property and gardens are maintained.*

Ancillary staff – resident wellbeing *have responsibility for cleaning residents rooms, providing meals and other services that support the personal care provided by direct care staff.*

Care manager *is responsible for all direct care staff; other job titles may be Director of Nursing, Care Co-ordinator and others.*

Direct care staff *provide personal care directly to residents as a core component of their work.*

Enrolled nurses *provide nursing care, working under the direction and (direct or indirect) supervision of the registered nurse.*

Nurse practitioner *is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role.*

Pastoral/spiritual care workers *include professional pastoral/spiritual care workers (e.g. chaplains).*

Personal care attendants *provide personal care to residents as a core part of their jobs (usually under direction of nursing staff). Job titles of personal care attendants vary widely. They include assistant or aide, personal care worker, assistant-in-nursing and others.*

Registered nurses *provide and supervise nursing care.*

Section A: About the Facility

The following questions ask for information about your aged care facility. This information will help us to understand how the aged care workforce is distributed across different types of homes.

A1 **Is your facility part of a larger organisation eg owned by a company or not-for-profit agency that owns other aged care facilities or services?**

Yes ☐ 1 No ☐ 2

A2.1 **Does your facility aim to cater for specific cultural or ethnic groups?**

Yes ☐ 1 No ☐ 2 → **If 'no', go to A3.1**

A2.2 **For which cultural or ethnic group/s does your facility cater?** *(cross all relevant boxes)*

- Aboriginal and/or Torres Strait Islander ☐
- Chinese ☐
- Dutch ☐
- Gay, lesbian, bisexual, transgender, intersex ☐
- Greek ☐
- Italian ☐
- Polish ☐
- German ☐
- Indian ☐
- Other *(please specify)* ☐

A2.3 **Does your facility employ staff with particular language or other cultural knowledge in order to cater to the group/s listed in A2.2?**

Yes ☐ 1 No ☐ 2

A3.1 **What qualifications does the Care Manager/ Care Coordinator in your facility have?** *(cross one box only)*

- Nursing qualifications ☐ 1
- Managerial qualifications ☐ 2
- Nursing and managerial qualifications ☐ 3
- None of the above ☐ 4
- Don't know ☐ 5

A3.2 **What specialised qualifications in ageing does the Care Manager/Care Coordinator in your facility have?** *(cross all relevant boxes)*

- Gerontology ☐
- Palliative Care ☐
- Psychogeriatrics ☐
- Other ☐
- None of the above ☐
- Don't know ☐

A3.3 **What are the three most important methods used to monitor the quality of aged care services/supports provided by this facility?** *(cross three boxes only)*

- Managers or supervisors monitor quality ☐ 1
- Inspectors from another part of the organisation monitor quality ☐ 2
- Individual employees monitor quality ☐ 3
- Keep records of feedback or complaints from service users ☐ 4
- Surveys of service users ☐ 5
- External auditing (beyond accreditation, e.g. third party inspectors) ☐ 6
- Accreditation ☐ 7
- Other *(please specify)* ☐ 8

A5 **How many people does your facility employ in total, including all full-time, part-time and casual employees, excluding agency staff?** *(Count all employees for whom PAYG tax is deducted by your facility, including staff on paid leave, for the last fortnight pay period.)*

☐☐☐☐ **PAYG Employees**

A6 **How many of the employees in each classification worked the following hours in the last fortnight pay period in November 2015?** *(Count all employees for whom PAYG tax is deducted by your organisation, including those on paid leave. Be sure to write '0' if no employees in a particular classification. Where an employee works in more than one classification, provide the number of hours for each classification. For example, if an employee works 40 hours per fortnight as a care manager and 20 hours per fortnight as a registered nurse, mark 1 in the care manager 31-69 hours category and 1 in the registered nurse 1-30 hours category).*

Employee Classification (definitions on page 2)	Hours worked in a fortnight 1 – 30	31 – 69	70 – 80	81+	On leave
Management					
Administration					
Pastoral/spiritual care work					
Direct care staff					
• Care manager/care co-ordinator					
• Nurse practitioner					
• Registered nurse					
• Enrolled nurse					
• Personal care attendant					
• Allied health professionals					
• Allied health assistants					
Ancillary staff					
• Resident wellbeing (e.g. cleaning, kitchen)					
• Other ancillary staff (e.g. gardening, maintenance)					

A7.1 **Does this facility provide home care/home support aged care services as well as residential services?**

Yes ☐ 1 No ☐ 2 → **If 'no', go to A7.3**

A7.2 **How many of your direct care PAYG employees in each classification work in your residential and home care/home support services?** *(Please include staff on paid leave. Be sure to write '0' if no employees in a particular classification work in both services)*

Employee Classification	Number of direct care employees working in…. Residential ONLY	Home care/ home support ONLY	BOTH Residential and home care/home support
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Personal care attendant/Community care worker			
Allied health professional			
Allied health assistant			

A7.3 **If your facility does not employ PAYG paid direct care staff, please indicate here and go to Section D (page 11).**

No PAYG paid staff ☐ 1

Section B: About the Direct Care Workforce

The following questions ask about the direct care workforce currently employed in your facility. Please note:

- *Definitions for employee classifications of direct care staff are on the inside cover, page 2.*
- *Only employees for whom PAYG tax is deducted by your organisation should be included. Agency and other non-PAYG contract staff are covered in Section D.*
- *Include staff who were on paid leave during the designated period.*
- *Only employees providing residential aged care, including staff working in BOTH residential and home care/home support aged care, should be included. Information about employees who ONLY provide home care/home support based aged care will be captured in the Census of Home Care and Home Support Aged Care Outlets.*

Unless otherwise indicated, when completing Section B please give information for the last pay period (i.e. fortnight) in November 2015.

*If you have **no employees in a category** please **write '0'** in the appropriate space.*

It is important to be as accurate as possible. Please refer to your records where necessary.

B1.1 How many people employed in each classification work in your facility as permanent full-time, permanent part-time or casual/fixed term contract*?
(Include staff on paid leave)

Employee Classification	Permanent full-time*	Permanent part-time*	Casual/ contract full-time*	Casual/fixed term contract part-time*
Nurse practitioner				
Registered nurse				
Enrolled nurse				
Personal care attendant				
Allied health professional				
Allied health assistant				
Total				

**The ABS definition of full-time work is 35 hours or more per week.*

B1.2 Please record the number of full-time equivalent (FTE) employees*, in each classification in your facility for the last pay period in November 2015. *(Include staff on paid leave)*

**To calculate the full time equivalent (FTE) employee number for an employee classification, divide the total number of hours worked per fortnight by workers of that classification by 70 (the standard used by the Australian Bureau of Statistics for full-time work is 35 hours per week). This takes into account both the number of employees and the fraction of full-time work status of each. For example, an employee working full-time will register as 1 FTE; while an employee working a fractional load of half-time will register as 0.5 FTE. If an employee is on leave, count the number of hours they would usually have worked in the FTE calculation.*

Employee Classification	Total hours worked	Divide by 70 to calculate	Full-time equivalent employees (FTEs)*
Nurse practitioner		Divide by 70=	
Registered nurse		Divide by 70=	
Enrolled nurse		Divide by 70=	
Personal care attendant		Divide by 70=	
Allied health professional		Divide by 70=	
Allied health assistant		Divide by 70=	
Total			

We now ask for more detail about the employees listed in B1.1

Please ensure that:

- *You include all these employees in your answers.*
- *If you have no employees in a particular category, write '0' in your answer.*
- *The information is for the last pay period in November 2015 (unless stated otherwise in question).*

B2 How many employees in each classification are female and how many are male?

Employee Classification	Female	Male	Employee Classification	Female	Male
Nurse practitioner			Personal care attendant		
Registered nurse			Allied health professional		
Enrolled nurse			Allied health assistant		

B3 How many of the employees in each classification fall into the following age categories?

Employee Classification	Under 30 years	30 – 39 years	40 – 49 years	50 – 59 years	60+ years
Nurse practitioner					
Registered nurse					
Enrolled nurse					
Personal care attendant					
Allied health professional					
Allied health assistant					

B3a For this facility, what was the direct care staff headcount?

Employee Classification	Care staff headcount for the last pay period in November 2014	Number of care staff who left in the 12 months to the last pay period in November 2015	Number of care staff hired in the 12 months to the last pay period in November 2015
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Personal care attendant			
Allied health professional			
Allied health assistant			

B4 How many employees in each classification identify as being of Aboriginal and/or Torres Strait Islander origin?

Employee Classification	Number of employees	Don't know
Nurse practitioner		
Registered nurse		
Enrolled nurse		
Personal care attendant		
Allied health professional		
Allied health assistant		

B5 For each employee classification, how many are from culturally and linguistically diverse backgrounds* *(not including those reported in B4)*?

Employee Classification	Number of employees	Don't know
Nurse practitioner		
Registered nurse		
Enrolled nurse		
Personal care attendant		
Allied health professional		
Allied health assistant		

**Individuals who identify as having a specific cultural or linguistic affiliation because of their place of birth, ancestry, ethnic origin, religion, preferred non-English main language or language(s) spoken at home, or because of their parents' identification on a similar basis.*

B6.1 For each employee classification, please indicate how many employees you have working under each form of employment contract.

Employee Classification	Award	Enterprise Agreement*	Common Law Contract	Individual Flexibility Agreement	Don't know
Nurse practitioner					
Registered nurse					
Enrolled nurse					
Personal care attendant					
Allied health professional					
Allied health assistant					

** Enterprise Agreements include union agreements, non-union agreements and certified agreements.*

B6.2 For each employment classification, please indicate all awards that apply to employees in your facility. *(Note: all agreements will have a base condition award)*

Employee Classification	Aged Care Award 2010	Nurses Award 2010	SACH Award 2010	Other *(please specify relevant State Award)*
Nurse practitioner				
Registered nurse				
Enrolled nurse				
Personal care attendant				
Allied health professional				
Allied health assistant				

B7.1 For each employee classification, please indicate whether you had skill shortages during the last 12 months.

Employee Classification	Yes
Nurse practitioner	
Registered nurse	
Enrolled nurse	
Personal care attendant	
Allied health professional	
Allied health assistant	
No skill shortages	

If no skill shortages go to B8.1

B7.2 Were these skill shortages due to any of the following? *(cross all relevant boxes)*

- Specialist knowledge required
- Geographical location of facility
- Wages or salary costs too high for business
- Lack of availability of adequate training
- Unsure of long-term demands for service
- Recruitment too slow
- Lack of suitable applicants (skills/qualifications/experience/values)
- Other *(please specify)*

If specialist knowledge go to B7.2a; otherwise go to B7.3

B7.2a If specialist knowledge was required, was this? *(cross all relevant boxes)*

- ICT/IT
- Dementia care
- Palliative care
- Clinical skills for high care
- Medications
- Other *(please specify)*

B7.3 How were these skill shortages addressed in the last 12 months? *(cross all relevant boxes)*

- More use of external training of staff
- More use of on-the-job training of staff
- Existing workforce worked longer hours
- Made greater use of agency staff
- Sub-contracted or outsourced services to other businesses
- Employed staff on short-term contract basis
- Wages, salaries and/or conditions increased
- Reduced outputs or production
- Used student placements
- Used volunteers
- Other *(please specify)*

B8.1 How many vacancies do you currently have in each classification?

Employee Classification	Total vacancies Full-time Equivalent/FTE*	How many POSITIONS are vacant? Full-time	Part-time
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Personal care attendant			
Allied health professional			
Allied health assistant			

**To calculate the full time equivalent (FTE) employee number for an employee classification, divide the total number of hours worked per fortnight by workers of that classification by 70 (the standard used by the Australian Bureau of Statistics for full-time work is 35 hours per week). This takes into account both the number of employees and the fraction of full-time work status of each. For example, an employee working full-time will register as 1 FTE, while an employee working a fractional load of half-time will register as 0.5 FTE.*

B8.2 Approximately how long did it take you to fill the MOST RECENT vacancy for employees in each classification?

Employee Classification	Weeks	Employee Classification	Weeks
Nurse practitioner		Personal care attendant	
Registered nurse		Allied health professional	
Enrolled nurse		Allied health assistant	

B8.3 What was the reason for the most recent vacancy for employees in each classification?
(cross all relevant boxes)

Reason	New position	Retirement	Injury/ illness	Resignation	End of contract	Involuntary separation	Other
Nurse practitioner	☐	☐	☐	☐	☐	☐	☐
Registered nurse	☐	☐	☐	☐	☐	☐	☐
Enrolled nurse	☐	☐	☐	☐	☐	☐	☐
Personal care attendant	☐	☐	☐	☐	☐	☐	☐
Allied health professional	☐	☐	☐	☐	☐	☐	☐
Allied health assistant	☐	☐	☐	☐	☐	☐	☐

B9 Are direct care workers required to do any of the following as part of their job?
(cross one box per row)

	Under normal circumstances	In exceptional circumstances	Never
Working longer than scheduled due to unanticipated needs of residents	☐	☐	☐
Variations in hours or location at short notice	☐	☐	☐
Working in very unsanitary conditions	☐	☐	☐
Working with aggressive service users (due to dementia etc)	☐	☐	☐
Working alone late at night (after 10 pm)	☐	☐	☐

B10.1 **In the last three months, how many instances of the following work-related injuries or illnesses were reported at your facility? Please check your records/incident reports.** *(If no work-related injuries or illnesses were reported, please write '0' and go to B11)*

Reported Work-related Injury/Illness	Number
Fracture	
Chronic joint or muscle condition	
Sprain/strain	
Cut/open wound	
Crushing injury/internal organ damage	
Superficial injury (minor injury)	
Stress or other mental condition	
Amputation	
Burns	
Other *(please specify)*	

B10.2 **How many of these work-related injuries or illnesses reported at your facility were caused by:**

Cause of Work-related Injury/Illness	Number
Lifting, pushing, pulling, bending	
Repetitive movement with low muscle loading	
Prolonged standing, working in cramped or unchanging positions	
Vehicle accident	
Hitting, being hit or cut by person, object or vehicle	
Fall	
Exposure to mental stress	
Long-term exposure to sound	
Contact with a chemical or substance	
Fatigue	
Other *(please specify)*	

B11 **How many of your PAYG employees in each classification were on Workcover or other injury related leave or a graduated return to work program during the last three months?**

Employee Classification	Number of employees
Nurse practitioner	
Registered nurse	
Enrolled nurse	
Personal care attendant	
Allied health professional	
Allied health assistant	

Section C: Personal Care Attendants

We would like to know some further information about the personal care attendants (PCAs) employed in your aged care facility. If there are no PCAs please go to Section D.

C1 **How many of your PCA employees have completed a Certificate III or Certificate IV in an area related to their direct care work?**

☐ **Completed** Certificate III (only) ☐ **Completed** Certificate IV

C2 **In the next 12 months, what areas of training will your PCAs most need/like to undertake:** *(cross all relevant boxes)*

Dementia	☐	Allied health	☐
Mental health	☐	ICT/IT	☐
Management and leadership	☐	Other *(please specify)*	☐
Wound management	☐		
Palliative care	☐		

C3 **If you wished to employ additional PCAs, how would you be most likely to find them?** *(cross one box only)*

Wait for walk-ins	☐ 1	Employ those already working through a job placement program	☐ 6
Word of mouth	☐ 2	Agency	☐ 7
Place a newspaper job advertisement	☐ 3	Other	☐ 8
Place an internet job advertisement	☐ 4	Don't know	☐ 9
Place both newspaper and internet job advertisements	☐ 5		

C4.1 **Does your facility employ PCAs from culturally and linguistically diverse backgrounds*?**

Yes ☐ 1 No ☐ 2 → **If 'no', go to D1**

**Individuals who identify as having a specific cultural or linguistic affiliation because of their place of birth, ancestry, ethnic origin, religion, preferred non-English main language or language(s) spoken at home, or because of their parents' identification on a similar basis.*

C4.2 **Please indicate the benefits which employing PCAs from culturally and linguistically diverse backgrounds has for your facility:** *(cross all relevant boxes)*

	Yes		Yes
Enhance cross-cultural understandings	☐	Link facility to ethnic communities	☐
Offer different cultural activities	☐	Don't know	☐
Language (other than English) skills	☐	Other *(please specify)*	☐
Link clients to ethnic communities	☐		

C5.1 **What proportion of your current PCAs speak a language other than English as their first language?**

None ☐ 1 → **If 'none', go to D1** OR ☐☐☐ **Percent (%)**

A number 1 to 100

C5.2 **What is the most common ethnic or cultural background of PCAs who speak a language other than English as their first language?** *(cross one box only)*

African	1	Italian	6
Chinese	2	Pacific Islands	7
Filipino	3	South-East Asian (other)	8
Greek	4	Other *(please specify)*	9
Indian	5		

C5.3 **Does lack of English language skills amongst your PCAs cause any difficulties in your facility?**

Yes 1 No 2 → **If 'no', go to D1**

C5.4 **In which areas does lack of English language skills amongst your PCAs cause difficulties?** *(cross all relevant boxes)*

Occupational Health and Safety		Communication with residents' families	
Communication with management and/ or other staff		Other *(please specify)*	
Communication with residents			

Section D: Volunteers, Agency, Brokered, and Self-Employed Staff

We would now like to ask about the nursing or employment agency staff, brokered staff, self-employed staff and volunteers, for whom you do not deduct PAYG tax who worked in your facility during the last pay period in November 2015 (fortnight). If you did not have any of these staff in your facility, please write '0' for each category.

D1 **How many people from nursing or employment agencies, brokered or self-employed staff worked in your aged care facility during the last pay period in November 2015?**

Employee Classification	Number of agency staff	Number of brokered staff	Number of self-employed staff
Nurse practitioner			
Registered nurse			
Enrolled nurse			
Personal care attendant			
Allied health professional			
Allied health assistant			

Definitions:
Agency staff are contracted from a nursing or employment agency (i.e. labour hire agency). Your facility has responsibility for training and supervising these staff members.
Brokered staff are contracted from other care providers.
Self-employed staff are individuals who have their own ABN and operate as independent care workers. Your facility would broker directly with the individual to engage their services.

D2 Why does this facility choose to use agency, brokered, or self-employed staff?
(cross all that apply)

	Agency staff	Brokered staff	Self-employed staff
Matching staff to peaks in service user demand	☐	☐	☐
Short-term cover for staff absences	☐	☐	☐
Covering for maternity leave or annual leave	☐	☐	☐
Unable to fill vacancies	☐	☐	☐
Obtain specialist skills	☐	☐	☐
Freeze on permanent staff numbers	☐	☐	☐
Other *(please specify)*			

D3 How many volunteers worked in your facility in the last two weeks?

☐☐☐ **Volunteers** → **If '0', go to survey end**

If 'volunteers' at D3

D4 What was the total amount of hours worked by all volunteers in the last two weeks?

☐☐☐☐ **Volunteer Hours**

If 'volunteers' at D3

D5 If you have volunteers, what is the area or role that they undertake?
(cross all relevant boxes)

Domestic activity assistance	☐	Transport assistance	☐
Respite care assistance	☐	Shopping/appointment assistance	☐
Social activity support assistance	☐	Meal preparation/delivery assistance	☐
Planned group activity assistance	☐	Companionship/befriending	☐
Home maintenance assistance	☐	Other *(please specify)*	☐
Gardening assistance	☐		

THANK YOU FOR YOUR HELP

FOR FUTURE SURVEYS, PLEASE TELL US APPROXIMATELY HOW LONG IT TOOK TO COMPLETE THIS FORM. ☐☐☐ **Minutes**

Barcode

Flinders UNIVERSITY

Australian Government
Department of Health

MAILING DATE

Form Type: Home Care and Home Support Workforce Survey

Unique Service Identification: XX-XXXXXX-XX

Invitation to participate in the 2016 National Aged Care Workforce Survey

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at Survey.ipsos.com.au/NACWCAS.

Workers in aged-care services across Australia are being approached to take part in this survey.

In order to provide an accurate picture of the aged care workforce it is important to include information from workers such as yourself. We are interested in your experiences of working in aged care; your characteristics (such as age and gender etc.), the conditions under which you work, and how you feel about what you do.

How to participate in the survey

We are asking you to complete this survey as an employee of the home care and home support services provided at this location. To take part online go to the secure website Survey.ipsos.com.au/HW2016 and enter your username and password:

Username: XXXXXX

Password: XXXXXX

You can also fill in this form instead and use the reply paid envelope to return it.

If you have any queries regarding the survey, please contact the free helpline on 1800 071 735.

Ethics and Privacy

All responses to the survey are confidential and identifying details will be removed prior to analysis. The information from your survey will be combined with all other data and no individual site or person will be identified.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House approval number 02468 - 01) and the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Thank you for your assistance.

Yours sincerely

Professor Kostas Mavromaras

Director, National Institute of Labour Studies

Flinders University, SA

This survey has been approved by the ABS Statistical Clearing House: Approval Number 02468 - 01

APPROVED

Additional information about the 2016 National Aged Care Workforce Survey

When completing this form, please ensure that you...

1. Make sure you answer every question (unless otherwise stated)
2. Cross the appropriate box/boxes like this [X]
3. Enter numbers into individual boxes like this [1] [2] [3]
4. If the answer to a question is nil, please write '0' and go to the next question
5. Please write clearly using a BLACK or BLUE pen
6. Sometimes you will find the box you have marked has an instruction to go to another question. By following the instructions carefully you will be able to skip questions that do not apply to you.
7. Don't worry if you make a mistake or wish to change a response, simply colour in the wrong box like this [■] and mark the correct box like this [X]
8. Call the toll-free helpline on 1800 071 735 if you have any queries
9. More detailed information about the National Aged Care Workforce Census and Survey can be found at the following website: Survey.ipsos.com.au/NACWCAS

It is important that you are as accurate as possible.

Section A: About Your Work

Please answer the questions in this section by thinking about the direct care job you do for this aged care service outlet, unless the question refers specifically to another job you may have. Please remember that this questionnaire is completely confidential. Only the independent survey company will ever see your response. Your answers will be added to those of many other people who work in aged care, to give an overall picture.

A1.1 What is your main job?

- Nurse practitioner ☐ 1
- Registered nurse ☐ 2
- Enrolled nurse ☐ 3
- Physiotherapist ☐ 4
- Occupational therapist ☐ 5
- Social worker ☐ 6
- Speech therapist ☐ 7
- Diversional therapist ☐ 8
- *Community care worker ☐ 9
- *Allied health assistant ☐ 10

If 9 'community care worker' or 10 'allied health assistant', go to A1.2. Otherwise go to A2

- Other *(please specify)* ☐ 11

Definitions:

Community care worker: provides personal, domestic, social and other home care to care recipients as a core part of their job. Job titles of community care workers vary widely.

Allied health assistant: supports allied health professionals in providing personal, social and emotional care to care recipients. Job titles include recreational officer, occupational therapy assistant, social work assistant and others.

A1.2 If you are a community care worker or allied health assistant, what is your main role?

- Personal care ☐ 1
- Home care/domestic assistance ☐ 2
- Respite care ☐ 3
- Planned activity group assistant ☐ 4
- Home maintenance/modification ☐ 5
- Gardening ☐ 6
- Transport ☐ 7
- Shopping/appointments ☐ 8
- Meal preparation/delivery ☐ 9
- Therapeutic support assistance ☐ 10
- Social activity support assistance ☐ 11
- Other *(please specify)* ☐ 12

A2 What proportion (percent) of the care recipients you work with are:

☐☐☐ **% Aged***

☐☐☐ **% Younger people with a disability**

☐☐☐ **% Other**

Definition:

Aged clients are non-Indigenous people aged 65 years or over and Indigenous Australians aged 50 years and older.

A3 Does your role involve managing or supervising direct care staff?

- Yes, I am a care manager/co-ordinator* ☐ 1
- Yes, I am a care leader* ☐ 2
- Yes, but neither of the above ☐ 3
- No ☐ 4
- Don't know ☐ 5

Definitions:

A care manager or care co-ordinator has responsibility for all direct care staff; other job titles may be Director of Nursing and others.

A care leader has responsibility for a team of direct care staff but will report to a care manager.

A4.1 Which of the following best describes your current work schedule?

- A regular daytime shift ☐ 1
- A regular evening shift ☐ 2
- A regular night shift ☐ 3
- A rotating shift (changes from days to evening to nights) ☐ 4
- Split shift (two distinct periods each day) ☐ 5
- On call ☐ 6
- Irregular schedule ☐ 7
- Other ☐ 8

A4.2 **Would you prefer to maintain your current work schedule or change it?**

- Prefer to maintain current schedule — If 'maintain', go to A5.1 → ☐ 1
- Change to a different schedule ☐ 2

A4.3 **Which describes the work schedule you would *prefer*?**

- A regular daytime shift ☐ 1
- A regular evening shift ☐ 2
- A regular night shift ☐ 3
- A rotating shift (changes from days to evening to nights) ☐ 4
- Split shift (two distinct periods each day) ☐ 5
- On call ☐ 6
- Irregular schedule ☐ 7
- Other ☐ 8

A5.1 **How many hours on average do you *usually* work each week in this job** *(include all paid and unpaid hours)*?

☐☐ **Hours per week**

A5.2 **How many hours would you *like* to work in this job?**

☐☐ **Hours per week**

A6 **How many of the hours you usually work each week are paid and unpaid?** *(If you do not work any unpaid hours write '0' in the corresponding box)*

☐☐ **Paid hours**

☐☐ **Unpaid hours**

A7 **What was the minimum number of hours in a day that you were required to work last week?** *(ie the minimum number of hours that you worked before your roster/shift ended)*

☐☐ **Hours**

A8 **Thinking about a typical shift, how much of your shift would you spend actively caring for recipients of the aged care service** *(as opposed, for example, to doing paperwork, attending meetings, or in discussions with other staff)*?

- Less than a third ☐ 1
- Between one third and two thirds ☐ 2
- More than two thirds ☐ 3

A9 **Which best describes your form of employment?**

- Casual ☐ 1
- Permanent (full or part-time) ☐ 2
- Fixed term contract ☐ 3

A10 **Are you entitled to paid sick leave?**

- Yes ☐ 1
- No ☐ 2
- Don't know ☐ 3

A11.1 **For this job, what was the total amount of your most recent pay before tax or anything else was taken out?** *(Amount to the nearest dollar)*

$ ☐,☐☐☐.~~0~~ 0

A11.2 **For what period does that cover?**

- Week ☐ 1
- Fortnight ☐ 2
- Month ☐ 3

A12 **How long have you worked for this home care / home support aged care service?**

☐☐ **Years** ☐☐ **Months**

A13 **How old were you when you first began working in aged care?**

☐☐ **Years**

A14 **Excluding any breaks from working in aged care, for how many years have you actually worked in aged care?**

☐☐ **Years**

A15 **Before you first obtained this job, had you done any work for this provider?**

- No 1
- Yes, paid work 2
- Yes, unpaid work/volunteer 3

A16.1 **When you approached this aged care provider for your job, did you know there was a job available?**

- Yes 1
- No 2 — If 'no', go to A17.1 →
- Don't know 3

A16.2 **How did you find out your job was available?** *(cross one box only)*

- Job network employment agency 1
- Other employment agency 2
- Career service at a tertiary educational institution 3
- School programs 4
- Newspaper advertisements 5
- Internet sites 6
- Centrelink job search services/ touchscreens 7
- Company or professional contacts 8
- Workplace noticeboards 9
- Word of mouth 10
- Other *(please specify)* 11

A17.1 **What was your last paid job before you FIRST worked in aged care?**

- No previous paid employment 1 — If 'no', go to A18 →
- Nurse, acute care 2
- Nurse, community care 3
- Other healthcare 4
- Carer in other setting 5
- Disability care 6
- Salesperson 7
- Clerical worker 8
- Hospitality worker (waitress, etc.) 9
- Cleaner 10
- Professional (other than nurse) 11
- Manager 12
- Other paid employment 13

A17.2 **Why did you leave that job?** *(cross one box only)*

- Family reasons 1
- Personal reasons (including health) 2
- Did not like job 3
- Contract ended 4
- Redundancy 5
- Career change 6
- Other 7

A18 **Had you worked in aged care before you began your CURRENT job?**

- Yes, paid 1
- Yes, unpaid/voluntary 2
- No 3 — If 'no', go to A20.1 →

A19 **What was the most important reason you left the last (paid) aged care job you held before your current one?** *(cross one box only)*

- To achieve higher pay 1
- To avoid workmates/colleagues I did not get along with or like 2
- To avoid managers/management I did not get along with or like 3
- The job was too stressful 4
- Not able to spend sufficient time with clients 5
- To get shifts or hours of work I wanted 6
- To be closer to home 7
- To fulfil care responsibilities (including having a baby) 8
- To find more challenging work 9
- To find easier work 10
- Made redundant/retrenched 11
- Moved house/location 12
- Other *(please specify)* 13

A20.1 **Did you have more than one job last week?**

- Yes 1
- No 2 — If 'no', go to A21 →

A20.2 **Where did you work in your other job(s) last week?** *(cross all relevant boxes)*

- A residential aged care facility
- Another home care / home support aged care service
- Disability care
- Not in aged or disability care, something else

A20.3 How many hours each week do you usually work in your other AGED CARE job(s)?

☐☐ Hours p.w. in other AGED CARE jobs

A20.4 How many hours each week do you usually work in your other job(s) OUTSIDE OF aged care?

☐☐ Hours p.w. in NON aged care jobs

A21 Are you currently actively seeking work outside of this aged care provider?

- Yes ☐ 1
- No ☐ 2

A22.1 Do you expect to be working for this aged care provider in 12 months time?

- Yes — If 'yes', go to A23 → ☐ 1
- No ☐ 2
- It depends ☐ 3
- Don't know ☐ 4

A22.2 Where do you see yourself working 12 months from now?

- Working in aged care, different provider ☐ 1
- Working in residential aged care ☐ 2
- Working in disability care ☐ 3
- Working, not in aged or disability care ☐ 4
- Not working for pay ☐ 5
- Don't know ☐ 6

A22.3 What is the main reason you may finish work for this aged care provider in the next 12 months? *(cross one box only)*

- Family reasons ☐ 1
- Financial reasons ☐ 2
- Employment conditions ☐ 3
- Nature of care work ☐ 4
- Stress/burnout ☐ 5
- Other health related reasons ☐ 6
- Returning to study ☐ 7
- Travel ☐ 8
- Retiring ☐ 9
- End of contract ☐ 10
- Retrenchment/redundancy ☐ 11
- Falling quality of care ☐ 12
- Other *(please specify)* ☐ 13

A23 Where do you see yourself working 3 years from now? *(cross one box only)*

- Working in aged care, this provider ☐ 1
- Working in aged care, different provider ☐ 2
- Working in residential aged care ☐ 3
- Working in disability care ☐ 4
- Working, not in aged care or disability care ☐ 5
- Not working for pay ☐ 6
- Don't know ☐ 7
- Other ☐ 8

A24 The following statements are about your current job for this home care / home support aged care provider.

(Please indicate, by putting a cross in one box on each line, how strongly you agree or disagree with each. The more you agree the higher the number you should choose. The more you disagree, the lower the number you should choose.)

	Strongly disagree						Strongly agree
a) I am able to spend enough time with each care recipient	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
b) I have the skills and abilities I need to do my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
c) I use many of my skills and abilities in my current job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
d) I have a lot of freedom to decide how I do my work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
e) I feel under pressure to work harder in my job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
f) My job is more stressful than I had ever imagined	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
g) Considering all my efforts and achievements, I receive the respect and acknowledgement I deserve	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
h) Management and employees have good relations in my workplace	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
i) Adequate training is available through my workplace	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

A25 **In general, how would you describe relations at your workplace?**
(Using a scale from 1 to 7, where 1 is when workplace relations are very bad and 7 is when workplace relations are very good, please put a cross in one box on each line)

	Very bad						Very good
Between management and yourself	1	2	3	4	5	6	7
Between workmates/colleagues and yourself	1	2	3	4	5	6	7

A26 **The following questions ask about how satisfied or dissatisfied you are with different aspects of your job.**
(Using a scale from 1 to 10, where 1 is 'totally dissatisfied' and 10 is 'totally satisfied', please put a cross in one box on each line to indicate how satisfied or dissatisfied you are with the following aspects of your aged care job. The more satisfied you are, the higher the number you should pick. The less satisfied you are, the lower the number)

	Totally dissatisfied									Totally satisfied
a) Your total pay	1	2	3	4	5	6	7	8	9	10
b) Your job security	1	2	3	4	5	6	7	8	9	10
c) The work itself (what you do)	1	2	3	4	5	6	7	8	9	10
d) The hours you work	1	2	3	4	5	6	7	8	9	10
e) The opportunity to develop your abilities	1	2	3	4	5	6	7	8	9	10
f) The level of support from your team/ service provider	1	2	3	4	5	6	7	8	9	10
f2) The level of support from your supervisor	1	2	3	4	5	6	7	8	9	10
g) The flexibility available to balance work and non-work commitments	1	2	3	4	5	6	7	8	9	10
h) All things considered, how satisfied are you with your job	1	2	3	4	5	6	7	8	9	10

A27.1 **In relation to the balance between your work and the rest of your life, please put a cross in one box on each line on the scale from 1-6** *(where 1 = never, 5 = almost always and 6=don't know)*, **for how often your WORK:**

	Never	Rarely	Some-times	Often	Almost always	Don't know
a) Interferes with your responsibilities or activities outside of work.	1	2	3	4	5	6
b) Keeps you from spending the amount of time you would like with family or friends.	1	2	3	4	5	6
c) Interferes with your ability to develop or maintain connections and friendships in your community.	1	2	3	4	5	6

A27.2 Thinking about your life in general, how often do you feel rushed or pressed for time?

Never	Rarely	Some-times	Often	Almost always	Don't know
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

A27.3 Thinking about your life right now, how satisfied are you with the balance between your work and the rest of your life?

Not at all satisfied	Not very satisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very satisfied	Don't know
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

A28.1 In the last 12 months have you sustained a work- related injury or illness at work (in this job)

- Yes ☐ 1
- No ☐ 2 — If "no", go to A28.6 →

A28.2 What kind(s) of work-related injury or illness did you sustain in the last 12 months?
(cross all relevant boxes)

- Fracture ☐
- Chronic joint or muscle condition ☐
- Sprain/strain ☐
- Cut/open wound ☐
- Crushing injury/internal organ damage ☐
- Superficial injury (minor injury) ☐
- Stress or other mental condition ☐
- Amputation ☐
- Burns ☐
- Other ☐

A28.3 Did the <u>most recent</u> work-related injury or illness sustained in the last 12 months result in you taking time off work?

- Yes ☐ 1
- No ☐ 2 — If "no", go to A28.5 →

A28.4 How long did you take off work?

- Part of 1 day ☐ 1
- 1 whole day ☐ 2
- 2-5 days ☐ 3
- 6-15 days ☐ 4
- More than 15 days ☐ 5

A28.5 What was the cause of your <u>most recent</u> work-related injury or illness you sustained in the last 12 months?
(cross one box only)

- Lifting, pushing, pulling, bending ☐ 1
- Repetitive movement with low muscle loading ☐ 2
- Prolonged standing, working in cramped or unchanging positions ☐ 3
- Vehicle accident ☐ 4
- Hitting, being hit or cut by person, object or vehicle ☐ 5
- Fall ☐ 6
- Exposure to mental stress ☐ 7
- Long term exposure to sound ☐ 8
- Contact with chemical or substance ☐ 9
- Fatigue ☐ 10
- Other *(please specify)* ☐ 11

A28.6 For your daily work, do you receive?
(cross all relevant boxes)

- Paid time for travel between care/support appointments? ☐
- Paid time for travel between home and care/support appointments? ☐
- Petrol/depreciation allowance for transport costs related to care/support appointments? ☐
- None of these ☐

Section B: About You

Please remember that this questionnaire is completely confidential. We do not even ask your name. No-one but the independent survey company will ever see your response. Your answers will be added to those of many other people who work in aged care, to give an overall picture.

B1 Are you male or female?

- Male ☐ 1
- Female ☐ 2

B2 How old were you on your last birthday?

☐☐ **Years**

B3.1 In what country were you born?

- Australia — If 'Australia', go to B4 → ☐ 1
- Other (please specify) ☐ 2

☐

B3.2 In what year did you first arrive in Australia to live for six months or more (even if you have spent time abroad since)?

☐☐☐☐

B3.3 Are you an Australian citizen?

- Yes — If 'yes', go to B3.5 → ☐ 1
- No ☐ 2

B3.4 Are you a permanent resident of Australia?

- Yes ☐ 1
- No ☐ 2

B3.5 Which of the following categories best describes your migration category when you or your family first arrived in Australia to stay? *(cross one box only)*

- Skilled migrant ☐ 1
- Business migrant ☐ 2
- Family migrant ☐ 3
- Refugee or special humanitarian migrant ☐ 4
- New Zealand citizen ☐ 5
- None of the above ☐ 6
- Don't know ☐ 7

B4 Are you of Aboriginal or Torres Strait Islander origin? *(cross one box only)*

- No ☐ 1
- Yes, Aboriginal ☐ 2
- Yes, Torres Strait Islander ☐ 3
- Yes, both ☐ 4

B5.1 Are you fluent in a language other than English?

- Yes ☐ 1
- No — If 'no', go to B6.1 → ☐ 2

B5.2 Do you use this language in your job?

- Yes ☐ 1
- No ☐ 2

B5.3 Which language are you most fluent in?

- English — If 'English', go to B6.1 → ☐ 1
- Language other than English ☐ 2
- Both equally well ☐ 3

B5.4 How well would you say you: *(cross one box on each row)*

	Not at all	Not very well	Well	Very well	Can't say
Speak English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Read English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Write English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

B6.1 **Do you have financial dependents?**

- No — If 'no', go to B7 → ☐ 1
- Yes, spouse/partner only — If 'spouse/partner only', go to B7 → ☐ 2
- Yes, children only ☐ 3
- Yes, spouse/partner and children ☐ 4
- Yes, other ☐ 5

B6.2 **How many financially dependent children do you have in each of the following age groups?**

☐ **0 – 5 years**

☐ **6 – 15 years**

☐ **16 – 24 years**

B7 **In a normal week, about how many unpaid hours would you spend caring for family members (eg children or disabled or elderly relatives)?**
(if you have no care responsibilities write '0')

☐☐ **Hours**

B8 **In general, would you say your health is:**

- Excellent ☐ 1
- Very good ☐ 2
- Good ☐ 3
- Fair ☐ 4
- Poor ☐ 5

B9.1 **What is the highest level of primary or secondary school you have completed?**

- Did not go to school ☐ 1
- Year 8 or below ☐ 2
- Year 9 or equivalent ☐ 3
- Year 10 or equivalent ☐ 4
- Year 11 or equivalent ☐ 5
- Year 12 or equivalent ☐ 6

B9.2 **Have you completed any post-school qualifications?**

- Yes ☐ 1
- No — If 'no', go to B11.1 → ☐ 2

B9.3 **What qualifications have you completed?**
(cross all relevant boxes)

Health
- Bachelor Degree in Nursing ☐
- Bachelor Degree in Allied Health Profession ☐
- Certificate IV/Diploma in Enrolled Nursing ☐
- Other basic nursing qualification ☐
- Post-basic nursing qualification (not in aged care) ☐
- Post-graduate allied health qualification ☐
- Other (health related) ☐

Aged Care
- Certificate III in Aged Care ☐
- Certificate III in Home and Community Care ☐
- Certificate IV in Aged Care ☐
- Certificate IV in Service Coordination (Ageing and Disability) ☐
- Other Certificate in Care Work ☐
- Post basic nursing qualification in aged care ☐
- Other (aged care related) ☐

Disability
- Certificate III Disability/Disability work ☐
- Certificate IV Disability/Disability work ☐
- Diploma Disability/Disability work ☐
- Diploma Community Service (Disability work) ☐
- Other (Disability related) ☐

Management
- Certificate III or IV ☐
- Diploma ☐
- Bachelor or Postgraduate Degree ☐

Other
- Certificate III or IV ☐
- Diploma ☐
- Bachelor or Postgraduate Degree ☐

B9.4 **Where did you complete your highest level of qualification?**

- Australia ☐ 1
- Overseas ☐ 2
- Overseas, with recognition obtained in Australia ☐ 3
- Overseas, not recognised ☐ 4

B9.5 **Do you have other relevant specialised qualifications in ageing or aged care?** *(cross all relevant boxes)*

- No ☐
- Yes, in gerontology ☐
- Yes, in palliative care ☐
- Yes, in psychogeriatrics ☐
- Yes, other ☐

B9.6 **How satisfied or dissatisfied are you with the match between your work and your qualifications?** *(Using a scale from 1 to 10, where 1 is 'totally dissatisfied' (ie a bad match) and 10 is 'totally satisfied' (ie a good match), please cross one box)*

Totally dissatisfied										Totally satisfied
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	

If at B9.3 your qualification is 3 'Certificate IV/Diploma in Enrolled Nursing' (box 3)

B10 **Did you study for a Certificate IV/Diploma in Enrolled Nursing while working as a community care worker (CCW)?**

- Yes ☐ 1
- No ☐ 2
- Never worked as a CCW ☐ 3
- Do not have a Cert IV/diploma in enrolled nursing ☐ 4

B11.1 **Are you currently studying for any qualifications?**

- Yes ☐ 1
- No — If 'no', go to B12 → ☐ 2

B11.2 **What qualification are you currently studying for?** *(eg Certificate III in Aged Care)*

B12 **During the last 12 months have you undertaken any continuing professional development / education?**

- Yes ☐ 1
- No ☐ 2

B13.1 **During the last 12 months have you undertaken any training (not including professional development), as part of your employment?** *(cross all relevant boxes)*

- No — If 'no', go to B14 → ☐
- Yes, mandatory training ☐
- Yes, non-mandatory training ☐

B13.2 **What were the aims of this training?** *(cross all relevant boxes)*

- To help you get started in your job ☐
- To improve your skills in your current job ☐
- To maintain professional status and/or meet occupational standards ☐
- To prepare you for a future job or facilitate promotion ☐
- To develop your skills generally ☐
- Because of safety/health concerns ☐
- To meet the provider's accreditation requirement ☐
- Other aims ☐

B13.3 **Have you contributed towards the cost of any of this training?**

- No ☐ 1
- Yes, contributed to some of the cost ☐ 2
- Yes, paid for all of it ☐ 3

B13.4 **To what extent do you think you can use the new skills you have acquired from any of this training in your current job?** *(cross one box only)*

- Not at all ☐ 1
- Only to a limited extent ☐ 2
- To a moderate extent ☐ 3
- To a great extent ☐ 4
- To a very great extent ☐ 5
- Did not learn any new skills ☐ 6

B14 **In the next 12 months, what is the area of training you think you will most need / you would most like to undertake:** *(cross all relevant boxes)*

- Dementia ☐
- Mental health ☐
- Management and leadership ☐
- Wound management ☐
- Palliative care ☐
- Allied health ☐
- ICT/IT ☐
- Other (please specify) ☐

B15 What are the best things about your job at the moment?

B16 What are the worst things about your job at the moment?

Thank you for sharing your experiences of working in aged care.

PLEASE TELL US HOW LONG IT TOOK YOU TO COMPLETE THIS SURVEY ☐☐☐ Minutes

Do you have more to say about your work?

We invite you to tell us more about your work. We would like to add to our understanding of your experiences of working in aged care by interviewing 100 direct care workers like yourself. These interviews will be by phone and will take approximately 30 minutes of your time.

If you would like to participate please provide your name and phone number:

Name: **Telephone Number:**

Please be assured that these details will be removed from the survey form and will not be associated with your responses in the questionnaire.

If you are selected to be interviewed, you will be contacted by researchers from the National Institute of Labour Studies, Flinders University in August/September 2016.

Barcode

Flinders UNIVERSITY

Australian Government
Department of Health

MAILING DATE

Form Type: Residential Workforce Survey

Unique Service Identification: XX-XXXXXX-XX

Invitation to participate in the 2016 National Aged Care Workforce Survey

The Australian Government Department of Health has commissioned the National Institute of Labour Studies to conduct the fourth National Aged Care Workforce Census and Survey. More details can be found at Survey.ipsos.com.au/NACWCAS.

Workers in aged-care services across Australia are being approached to participate in this survey.

In order to provide an accurate picture of the aged care workforce it is important to include information from workers such as yourself. We are interested in your experiences of working in aged care; your characteristics (such as age and gender etc.), the conditions under which you work, and how you feel about what you do.

How to participate in the survey

We are asking you to complete this survey as an employee of the residential aged care services provided at this location.

To take part online go to Survey.ipsos.com.au/RW2016 and enter your username and password:

Username: XXXXXX

Password: XXXXXX

You can also fill in this form instead and use the reply paid envelope to return it.

If you have any queries regarding the survey, please contact the free helpline on 1800 071 735.

Ethics and Privacy

All responses to the survey are confidential and identifying details will be removed prior to analysis. The information from your survey will be combined with all other data and no individual site or person will be identified.

The research has been approved by the Australian Bureau of Statistics (Statistical Clearing House approval number 02468 - 01) and the Flinders University Social and Behavioural Research Ethics Committee (Project Number 7069). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035 or by email human.researchethics@flinders.edu.au. It also complies with the National Privacy Guidelines for all data collection processes undertaken for survey research.

The National Aged Care Workforce Census and Survey closes on **23 September 2016**.

Thank you for your assistance.

Yours sincerely

Professor Kostas Mavromaras
Director, National Institute of Labour Studies
Flinders University, SA

APPROVED

This survey has been approved by the ABS Statistical Clearing House. Approval Number 02468 - 01

Additional information about the 2016 National Aged Care Workforce Survey

When completing this form, please ensure that you...

1. Make sure you answer every question (unless otherwise stated)
2. Cross the appropriate box/boxes like this [X]
3. Enter numbers into individual boxes like this [1][2][3]
4. If the answer to a question is nil, please write '0' and go to the next question
5. Please write clearly using a BLACK or BLUE pen
6. Sometimes you will find the box you have marked has an instruction to go to another question. By following the instructions carefully you will be able to skip questions that do not apply to you
7. Don't worry if you make a mistake or wish to change a response; simply colour in the wrong box like this [■] and mark the correct box like this [X]
8. Call the toll-free helpline on 1800 071 735 if you have any queries
9. More detailed information about the National Aged Care Workforce Census and Survey can be found at the following website: Survey.ipsos.com.au/NACWCAS

It is important that you are as accurate as possible.

Section A: About Your Work

Please answer the questions in this section by thinking about the direct care job you do in this aged care facility, unless the question refers specifically to another job you may have. Please remember that this questionnaire is completely confidential. Only the independent survey company will ever see your response. Your answers will be added to those of many other people who work in aged care, to give an overall picture.

A1 What is your main job?

- Nurse practitioner ☐ 1
- Registered nurse ☐ 2
- Enrolled nurse ☐ 3
- Physiotherapist ☐ 4
- Occupational therapist ☐ 5
- Social worker ☐ 6
- Speech therapist ☐ 7
- Diversional therapist ☐ 8
- *Personal care attendant ☐ 9
- *Allied health assistant ☐ 10
- Other *(please specify)* ☐ 11

Definitions:
Personal care attendant: provides personal care to residents as a core part of their jobs (usually under direction of nursing staff). Job titles of personal care attendants vary widely. They include, for example: personal care attendant, assistant or aide, personal care worker, assistant-in-nursing and others
Allied health assistant: supports allied health professionals in providing personal, social and emotional care to residents. Job titles include recreational officer, occupational therapy assistant, social work assistant and others.

A2 Does your role involve managing or supervising direct care staff?

- Yes, I am a care manager ☐ 1
- Yes, I am a care leader ☐ 2
- Yes, but neither of the above ☐ 3
- No ☐ 4
- Don't know ☐ 5

Definitions:
A care manager has responsibility for all direct care staff in the facility; other job titles may be Director of Nursing and others.
A care leader has responsibility for a team of direct care staff but will report to a care manager.

A3.1 Which of the following best describes your current work schedule?

- A regular daytime shift ☐ 1
- A regular evening shift ☐ 2
- A regular night shift ☐ 3
- A rotating shift (changes from days to evening to nights) ☐ 4
- Split shift (two distinct periods each day) ☐ 5
- On call ☐ 6
- Irregular schedule ☐ 7
- Other ☐ 8

A3.2 Would you prefer to maintain your current work schedule or change it?

- Prefer to maintain current schedule **If 'maintain', go to A4.1→** ☐ 1
- Change to a different schedule ☐ 2

A3.3 Which describes the work schedule you would *prefer*?

- A regular daytime shift ☐ 1
- A regular evening shift ☐ 2
- A regular night shift ☐ 3
- A rotating shift (changes from days to evening to nights) ☐ 4
- Split shift (two distinct periods each day) ☐ 5
- On call ☐ 6
- Irregular schedule ☐ 7
- Other ☐ 8

A4.1 How many hours on average do you *usually* work each week in this job *(include all paid and unpaid hours)*?

☐☐ **Hours per week**

A4.2 How many hours would you *like* to work in this job?

☐☐ **Hours per week**

A4.3 How many of the hours you usually work each week are paid and unpaid? *(If you do not work any unpaid hours write '0' in the corresponding box)*

☐☐ **Paid hours**

☐☐ **Unpaid hours**

A5 **Thinking about a typical shift, how much of your shift would you spend actively caring for residents of the aged care facility** *(as opposed, for example, to doing paperwork, attending meetings, or in discussions with other staff)*?

- Less than a third ☐ 1
- Between one third and two thirds ☐ 2
- More than two thirds ☐ 3

A6 **Which best describes your form of employment?**

- Casual ☐ 1
- Permanent (full or part-time) ☐ 2
- Fixed term contract ☐ 3

A7 **Are you entitled to paid sick leave?**

- Yes ☐ 1
- No ☐ 2
- Don't know ☐ 3

A8.1 **For this job, what was the total amount of your most recent pay before tax or anything else was taken out?** *(Amount to the nearest dollar)*

$ ☐,☐☐☐.~~0~~0

A8.2 **For what period does that cover?**

- Week ☐ 1
- Fortnight ☐ 2
- Month ☐ 3

A9 **How long have you worked in this aged care facility?**

☐☐ **Years** ☐☐ **Months**

A10 **How old were you when you first began working in aged care?**

☐☐ **Years**

A11 **Excluding any breaks from working in aged care, for how many years have you actually worked in aged care?**

☐☐ **Years**

A12 **Before you first obtained this job, had you done any work for this facility?**

- No ☐ 1
- Yes, paid work ☐ 2
- Yes, unpaid work/volunteer ☐ 3

A13.1 **When you approached this aged care facility for your job, did you know there was a job available?**

- Yes ☐ 1
- No **If 'no', go to A14.1** → ☐ 2
- Don't know ☐ 3

A13.2 **How did you find out your job was available?** *(cross one box only)*

- Job network employment agency ☐ 1
- Other employment agency ☐ 2
- Career service at a tertiary educational institution ☐ 3
- School programs ☐ 4
- Newspaper advertisements ☐ 5
- Internet sites ☐ 6
- Centrelink job search services/ touchscreens ☐ 7
- Company or professional contacts ☐ 8
- Workplace noticeboards ☐ 9
- Word of mouth ☐ 10
- Other *(please specify)* ☐ 11

A14.1 **What was your last paid job before you FIRST worked in aged care?**

- No previous paid employment **If 'no', go to A15** → ☐ 1
- Nurse, acute care ☐ 2
- Nurse, community care ☐ 3
- Other healthcare ☐ 4
- Carer in other setting ☐ 5
- Disability care ☐ 6
- Salesperson ☐ 7
- Clerical worker ☐ 8
- Hospitality worker (waitress, etc.) ☐ 9
- Cleaner ☐ 10
- Professional (other than nurse) ☐ 11
- Manager ☐ 12
- Other paid employment ☐ 13

A14.2 Why did you leave that job? *(cross one box only)*

- Family reasons 1
- Personal reasons (including health) 2
- Did not like job 3
- Contract ended 4
- Redundancy 5
- Career change 6
- Other *(please specify)* 7

A15 Had you worked in aged care before you began your CURRENT job?

- Yes, paid 1
- Yes, unpaid/voluntary 2
- No — If 'no', go to A17.1 → 3

A16 What was the most important reason you left the last (paid) aged care job you held before your current one? *(cross one box only)*

- To achieve higher pay 1
- To avoid workmates/colleagues I did not get along with or like 2
- To avoid managers/management I did not get along with or like 3
- The job was too stressful 4
- Not able to spend sufficient time with residents 5
- To get shifts or hours of work I wanted 6
- To be closer to home 7
- To fulfil care responsibilities (including having a baby) 8
- To find more challenging work 9
- To find easier work 10
- Made redundant/retrenched 11
- Moved house/location 12
- Other *(please specify)* 13

A17.1 Did you have more than one job last week?

- Yes 1
- No — If 'no', go to A18 → 2

A17.2 Where did you work in your other job(s) last week? *(cross all relevant boxes)*

- Another residential aged care facility
- Home care/home support aged care service
- Disability care
- Not in aged or disability care, something else

A17.3 How many hours each week do you usually work in your other AGED CARE job(s)?

☐☐ **Hours p.w. in other AGED CARE jobs**

A17.4 How many hours each week do you usually work in your other job(s) OUTSIDE OF aged care?

☐☐ **Hours p.w. in NON aged care jobs**

A18 Are you currently actively seeking work outside of this aged care facility?

- Yes 1
- No 2

A19.1 Do you expect to be working for this aged care facility in 12 months time?

- Yes — If 'yes', go to A20 → 1
- No 2
- It depends 3
- Don't know 4

A19.2 Where do you see yourself working 12 months from now?

- Working in aged care, different facility 1
- Working in home care/home support aged care 2
- Working in disability care 3
- Working, but not in aged or disability care 4
- Not working for pay 5
- Don't know 6

A19.3 **What is the main reason you may finish work for this aged care facility in the next 12 months?** *(cross one box only)*

- Family reasons 1
- Financial reasons 2
- Employment conditions 3
- Nature of care work 4
- Stress/burnout 5
- Other health related reasons 6
- Returning to study 7
- Travel 8
- Retiring 9
- End of contract 10
- Retrenchment/redundancy 11
- Falling quality of care 12
- Other *(please specify)* 13

A20 **Where do you see yourself working 3 years from now?** *(cross one box only)*

- Working in aged care, this facility 1
- Working in aged care, different facility 2
- Working in home care/home support aged care 3
- Working in disability care 4
- Working, not in aged care or disability care 5
- Not working for pay 6
- Don't know 7
- Other 8

A21 **The following statements are about your current job in this aged care facility.** *Please indicate, by putting a cross in one box on each line, how strongly you agree or disagree with each. The more you agree the higher the number you should choose. The more you disagree, the lower the number you should choose.*

	Strongly disagree						Strongly agree
a) I am able to spend enough time with each care recipient	1	2	3	4	5	6	7
b) I have the skills and abilities I need to do my job	1	2	3	4	5	6	7
c) I use many of my skills and abilities in my current job	1	2	3	4	5	6	7
d) I have a lot of freedom to decide how I do my work	1	2	3	4	5	6	7
e) I feel under pressure to work harder in my job	1	2	3	4	5	6	7
f) My job is more stressful than I had ever imagined	1	2	3	4	5	6	7
g) Considering all my efforts and achievements, I receive the respect and acknowledgement I deserve	1	2	3	4	5	6	7
h) Management and employees have good relations in my workplace	1	2	3	4	5	6	7
i) Adequate training is available through my workplace	1	2	3	4	5	6	7

A22 **In general, how would you describe relations at your workplace?**
(Using a scale from 1 to 7, where 1 is when workplace relations are very bad and 7 is when workplace relations are very good, please put a cross in one box on each line.)

	Very bad						Very good
Between management and yourself	1	2	3	4	5	6	7
Between workmates/colleagues and yourself	1	2	3	4	5	6	7

A23 **The following questions are about how satisfied or dissatisfied you are with different aspects of your job.**
(Using a scale from 1 to 10, where 1 is 'totally dissatisfied' and 10 is 'totally satisfied', please put a cross in one box on each line to indicate how satisfied or dissatisfied you are with the following aspects of your aged care job. The more satisfied you are, the higher the number you should pick. The less satisfied you are, the lower the number)

	Totally dissatisfied									Totally satisfied
a) Your total pay	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
b) Your job security	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
c) The work itself (what you do)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
d) The hours you work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
e) The opportunity to develop your abilities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
f) The level of support from your team /service provider	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
f2) The level of support from your supervisor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
g) The flexibility available to balance work and non-work commitments	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
h) All things considered, how satisfied are you with your job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

A24.1 **In relation to the balance between your work and the rest of your life, please put a cross in one box on each line on the scale from 1 – 6** *(where 1 = never, 5= almost always and 6=Don't know)*, **for how often your WORK:**

	Never	Rarely	Some-times	Often	Almost always	Don't know
a) Interferes with your responsibilities or activities outside of work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b) Keeps you from spending the amount of time you would like with family or friends.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c) Interferes with your ability to develop or maintain connections and friendships in your community.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

A24.2 **Thinking about your life in general, how often do you feel rushed or pressed for time?**

Never	Rarely	Some-times	Often	Almost always	Don't know
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

A24.3 **Thinking about your life right now, how satisfied are you with the balance between your work and the rest of your life?**

Not at all satisfied	Not very satisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very satisfied	Don't know
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

A25.1 **In the last 12 months have you sustained a work- related injury or illness at work (in this job)**

- Yes ☐ 1
- No — **If 'no', go to Section B →** ☐ 2

A25.2 **What kind(s) of work-related injury or illness did you sustain in the last 12 months?** *(cross all relevant boxes)*

- Fracture ☐
- Chronic joint or muscle condition ☐
- Sprain/strain ☐
- Cut/open wound ☐
- Crushing injury/internal organ damage ☐
- Superficial injury (minor injury) ☐
- Stress or other mental condition ☐
- Amputation ☐
- Burns ☐
- Other ☐

A25.3 **Did the <u>most recent</u> work-related injury or illness sustained in the last 12 months result in you taking time off work?**

- Yes ☐ 1
- No — **If 'no', go to A25.5 →** ☐ 2

A25.4 **How long did you take off work?**

- Part of 1 day ☐ 1
- 1 whole day ☐ 2
- 2-5 days ☐ 3
- 6-15 days ☐ 4
- More than 15 days ☐ 5

A25.5 **What was the cause of the most recent work-related injury or illness you sustained in the last 12 months?** *(cross one box only)*

- Lifting, pushing, pulling, bending ☐ 1
- Repetitive movement with low muscle loading ☐ 2
- Prolonged standing, working in cramped or unchanging positions ☐ 3
- Vehicle accident ☐ 4
- Hitting, being hit or cut by person, object or vehicle ☐ 5
- Fall ☐ 6
- Exposure to mental stress ☐ 7
- Long term exposure to sound ☐ 8
- Contact with a chemical or substance ☐ 9
- Fatigue ☐ 10
- Other *(please specify)* ☐ 11

Section B: About You

Please remember that this questionnaire is completely confidential. We do not even ask your name. No-one but the independent survey company will ever see your response. Your answers will be added to those of many other people who work in aged care, to give an overall picture.

B1 Are you male or female?

- Male ☐ 1
- Female ☐ 2

B2 How old were you on your last birthday?

☐☐ **Years**

B3.1 In what country were you born?

- Australia — **If 'Australia', go to B4** → ☐ 1
- Other *(please specify)* ☐ 2

☐

B3.2 In what year did you first arrive in Australia to live for six months or more (even if you have spent time abroad since)?

☐☐☐☐

B3.3 Are you an Australian citizen?

- Yes — **If 'yes', go to B3.5** → ☐ 1
- No ☐ 2

B3.4 Are you a permanent resident of Australia?

- Yes ☐ 1
- No ☐ 2

B3.5 Which of the following categories best describes your migration category when you or your family first arrived in Australia to stay? *(cross one box only)*

- Skilled migrant ☐ 1
- Business migrant ☐ 2
- Family migrant ☐ 3
- Refugee or special humanitarian migrant ☐ 4
- New Zealand citizen ☐ 5
- None of the above ☐ 6
- Don't know ☐ 7

B4 Are you of Aboriginal or Torres Strait Islander origin? *(cross one box only)*

- No ☐ 1
- Yes, Aboriginal ☐ 2
- Yes, Torres Strait Islander ☐ 3
- Yes, both ☐ 4

B5.1 Are you fluent in a language other than English?

- Yes ☐ 1
- No — **If 'no', go to B6.1** → ☐ 2

B5.2 Do you use this language in your job?

- Yes ☐ 1
- No ☐ 2

B5.3 Which language are you most fluent in?

- English — **If 'English', go to B6.1** → ☐ 1
- Language other than English ☐ 2
- Both equally well ☐ 3

B5.4 How well would you say you: *(cross one box on each row)*

	Not at all	Not very well	Well	Very well	Can't say
Speak English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Read English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Write English	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

B6.1 Do you have financial dependents?

- No — If 'no', go to B7 → ☐ 1
- Yes, spouse/partner only — If 'yes', go to B7 → ☐ 2
- Yes, children only ☐ 3
- Yes, spouse/partner and children ☐ 4
- Yes, other ☐ 5

B6.2 How many financially dependent children do you have in each of the following age groups?

- ☐ 0 – 5 years
- ☐ 6 – 15 years
- ☐ 16 – 24 years

B7 In a normal week, about how many unpaid hours would you spend caring for family members (eg children or disabled or elderly relatives)?
(if you have no care responsibilities write '0')

☐☐ Hours

B8 In general, would you say your health is:

- Excellent ☐ 1
- Very good ☐ 2
- Good ☐ 3
- Fair ☐ 4
- Poor ☐ 5

B9.1 What is the highest level of primary or secondary school you have completed?

- Did not go to school ☐ 1
- Year 8 or below ☐ 2
- Year 9 or equivalent ☐ 3
- Year 10 or equivalent ☐ 4
- Year 11 or equivalent ☐ 5
- Year 12 or equivalent ☐ 6

B9.2 Have you completed any post-school qualifications?

- Yes ☐ 1
- No — If 'no', go to B11.1 → ☐ 2

B9.3 What qualifications have you completed?
(cross all relevant boxes)

Health
- Bachelor Degree in Nursing ☐
- Bachelor Degree in Allied Health Profession ☐
- Certificate IV/Diploma in Enrolled Nursing ☐
- Other basic nursing qualification ☐
- Post-basic nursing qualification (not in aged care) ☐
- Post-graduate allied health qualification ☐
- Other (health related) ☐

Aged Care
- Certificate III in Aged Care ☐
- Certificate III in Home and Community Care ☐
- Certificate IV in Aged Care ☐
- Certificate IV in Service Coordination (Ageing and Disability) ☐
- Other Certificate in Care Work ☐
- Post basic nursing qualification in aged care ☐
- Other (aged care related) ☐

Disability
- Certificate III Disability/Disability work ☐
- Certificate IV Disability/Disability work ☐
- Diploma Disability/Disability work ☐
- Diploma Community Service (Disability work) ☐
- Other (Disability related) ☐

Management
- Certificate III or IV ☐
- Diploma ☐
- Bachelor or Post-graduate Degree ☐

Other
- Certificate III or IV ☐
- Diploma ☐
- Bachelor or Post-graduate Degree ☐

B9.4 Where did you complete your highest level of qualification?

- Australia ☐ 1
- Overseas ☐ 2
- Overseas, Australian recognised ☐ 3
- Overseas, not recognised ☐ 4

B9.5 **Do you have other relevant specialised qualifications in ageing or aged care?** *(cross all relevant boxes)*

- No ☐
- Yes, in gerontology ☐
- Yes, in palliative care ☐
- Yes, in psychogeriatrics ☐
- Yes, other ☐

B9.6 **How satisfied or dissatisfied are you with the match between your work and your qualifications?** *(Using a scale from 1 to 10, where 1 is 'totally dissatisfied' (ie a bad match) and 10 is 'totally satisfied' (ie a good match), please cross one box)*

Totally dissatisfied ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Totally satisfied

If at B9.3 your qualification is 'Certificate IV/Diploma in Enrolled Nursing' (box 3)

B10 **Did you study for a Certificate IV/Diploma in Enrolled Nursing while working as a Personal care attendant (PCA)?**

- Yes ☐1
- No ☐2
- Never worked as a PCA ☐3
- Do not have a Cert IV/diploma in enrolled nursing ☐4

B11.1 **Are you currently studying for any qualifications?**

- Yes ☐1
- No **If 'no', go to B12** → ☐2

B11.2 **What qualification are you currently studying for?** *(eg Certificate III in Aged Care)*

B12 **During the last 12 months have you undertaken any continuing professional development/education?**

- Yes ☐1
- No ☐2

B13.1 **During the last 12 months have you undertaken any training (not including professional development), as part of your employment?** *(cross all relevant boxes)*

- No **If 'no; go to B14** → ☐
- Yes, mandatory training ☐
- Yes, non-mandatory training ☐

B13.2 **What were the aims of this training?** *(cross all relevant boxes)*

- To help you get started in your job ☐
- To improve your skills in your current job ☐
- To maintain professional status and/or meet occupational standards ☐
- To prepare you for a future job or facilitate promotion ☐
- To develop your skills generally ☐
- Because of safety/health concerns ☐
- To meet the facility's accreditation requirement ☐
- Other aims ☐

B13.3 **Have you contributed towards the cost of any of this training?**

- No ☐1
- Yes, contributed to some of the cost ☐2
- Yes, paid for all of it ☐3

B13.4 **To what extent do you think you can use the new skills you have acquired from any of this training in your current job?** *(cross one box only)*

- Not at all ☐1
- Only to a limited extent ☐2
- To a moderate extent ☐3
- To a great extent ☐4
- To a very great extent ☐5
- Did not learn any new skills ☐6

B14 **In the next 12 months, what is the area of training you think you will most need / you would most like to undertake:** *(cross all relevant boxes)*

- Dementia ☐
- Mental health ☐
- Management and leadership ☐
- Wound management ☐
- Palliative care ☐
- Allied health ☐
- ICT/IT ☐
- Other *(please specify)* ☐

B15 What are the best things about your job at the moment?

B16 What are the worst things about your job at the moment?

Thank you for sharing your experiences of working in aged care.

PLEASE TELL US HOW LONG IT TOOK YOU TO COMPLETE THIS SURVEY ☐☐☐ Minutes

Do you have more to say about your work?

We invite you to tell us more about your work. We would like to add to our understanding of your experiences of working in aged care by interviewing 100 direct care workers like yourself. These interviews will be by phone and will take approximately 30 minutes of your time.

If you would like to participate please provide your name and phone number:

Name: **Telephone Number:**

Please be assured that these details will be removed from the survey form and will not be associated with your responses in the questionnaire.

If you are selected to be interviewed, you will be contacted by researchers from the National Institute of Labour Studies, Flinders University in August/September 2016.

Barcode

NDIS Price Guide

Victoria, New South Wales, Queensland, Tasmania

Valid from: 1 July 2018

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Table of Contents

2018/19 National Disability Insurance Scheme (NDIS) Price Guide

This Price Guide (Guide) is a summary of NDIS price limits and associated arrangements (price controls) that will apply from 1 July 2018 as set by the National Disability Insurance Agency (NDIA). It is designed to assist participants and disability support providers, both current and prospective, to understand the way that price controls for supports and services work in the NDIS.

The NDIA sets price controls for certain NDIS supports to ensure NDIS participants obtain reasonable value from their support packages. The price limits in this Guide are the **maximum prices** that Registered Providers can charge NDIS participants for specific supports. There is *no requirement* for providers to charge at the maximum price for a given support or service. Participants and providers are free to negotiate lower prices.

Price controls must be sustainable, which means that efficient providers must be able to recover the cost of delivering high quality disability supports. The NDIA takes into account market risks, when setting price controls to protect against supply gaps and ensure participants receive critical supports. This is important especially in markets that are immature or where there is limited choice for participants. Over time, the need for price controls will reduce, as disability support markets develop and competitive tension increasingly keeps support prices at reasonable levels.

Not all NDIS support items have price limits, and this NDIS Price Guide is not a comprehensive list of all supports that are available to NDIS participants. Instead, this Guide lists the specific supports that have maximum prices, and also sets out other rules and support definitions that are part of NDIA' market intervention approach. A complete list of disability supports recognised by the NDIS (Support Catalogue) is maintained on the NDIS website (https://www.ndis.gov.au/providers/pricing-and-payment).

Application of Price Controls

This Guide should be read in conjunction with the NDIS Terms of Business for Registered Support Providers[1].

The price limits and other arrangements in this Guide must be followed when supports are delivered to NDIS participants who have either an agency-managed plan or a plan manager:

- Providers of supports to participants with agency-managed plans must be a 'Registered Provider' with the NDIS , and are subject to the NDIS *Terms of Business for Registered Support Providers* (the NDIS Terms of Business), which states that "Registered Providers must adhere to the NDIS Price Guide" (p. 4).
- Plan managers can purchase supports on behalf of participants from either registered or unregistered providers, but they are Registered Providers themselves, and therefore **responsible for ensuring that prices paid for supports on behalf of their participant clients adhere to the arrangements in the NDIS Price Guide, including price limits**.

Self-Managing participants can use registered or unregistered providers and are ***not*** subject to the pricing arrangements in the NDIS Price Guide.

[1] https://providertoolkit.ndis.gov.au/sites/g/files/net3066/f/ndis_terms_of_business.pdf

NDIS Supports Overview – Purpose, Categories and Line Items

This section describes the way that the NDIS categorises disability supports. These categories can be relevant to rules for participants about how they can spend their support budgets, and for providers when seeking payment for delivered supports.

Support Purpose Types

NDIS participant budgets can be allocated to three separate types of support purpose:

1. CORE – Supports that enable participants to complete activities of daily living. Participant budgets often have a lot of flexibility to choose specific supports with their core support budgets, but cannot reallocate this funding for other support purposes (i.e. capital or capacity building supports).

2. CAPITAL – An investment, such as assistive technologies - equipment, home or vehicle modifications, or for Specialist Disability Accommodation (SDA). Participant budgets for this support purpose are restricted to specific items identified in the participant's plan. The NDIS publishes separate price guides for Assistive Technology[2] and Specialist Disability Accommodation[3].

3. CAPACITY BUILDING - A support that enables a participant to build their independence and skills. Participant budgets are allocated at a support category level (see next section) and must be used to achieve the goals set out in the participant's plan.

[2] https://www.ndis.gov.au/providers/at/supplying-at.html
[3] https://www.ndis.gov.au/specialist-disability-accommodation.html

Support Categories: aligned to the NDIS Outcomes Framework

Support purpose categories are aligned with the NDIS Outcomes Framework, which has been developed to measure goal attainment for individual participants and overall performance of the Scheme. There are 8 Outcome Domains (‘Domains’) in the Framework, which help participants think about goals in different areas of their life and assist planners explore where supports in these areas already exist and where further supports are required. These Domains are:

1. Daily Living
2. Home
3. Health and Well-being
4. Lifelong Learning
5. Work
6. Social and Community Participation
7. Relationships
8. Choice and Control

The Outcomes Framework directly relates to the 15 support categories outlined in the next section. NDIS service providers should be aware that all supports and services for NDIS participants must contribute to the achievement of their individual goals as outlined in the participant’s plan.

Support purpose categories are designed to align with the Outcomes Framework and the 15 support categories. This helps participants choose supports that help them in achieving their goals, and providers to understand how the supports they provide contribute to the participant’s goals. The following table shows the links between support purpose types, domains in the Outcomes Framework, and support categories.

SUPPORT PURPOSE	OUTCOMES FRAMEWORK DOMAIN	SUPPORT CATEGORY (Allocated to plans)
CORE	Daily Living	Assistance with Daily Life (1.01)
	Daily Living	Transport (1.02)
	Daily Living	Consumables (1.03)
	Social & Community Participation	Assistance with Social & Community Participation (1.04)
CAPITAL	Daily Living	Assistive Technology (2.05)
	Home	Home Modifications and Specialised Disability Accommodation (SDA) (2.06)
CAPACITY BUILDING	Choice & Control	Support Coordination (3.07)
	Home	Improved Living Arrangements (3.08)
	Social and Community Participation	Increased Social and Community Participation (3.09)
	Work	Finding and Keeping a Job (3.10)
	Relationships	Improved Relationships (3.11)
	Health & Wellbeing	Improved Health and Wellbeing (3.12)
	Lifelong Learning	Improved Learning (3.13)
	Choice and Control	Improved Life Choices (3.14)
	Daily Living	Improved Daily Living Skills (3.15)

Support Line Items

Although most are not all listed in this document, each support category has many specific supports and services that are recognised in the NDIS payment system. These are referred to as ‘line items’ and are in most cases are not prescribed in participant plans. A comprehensive listing of support line items is kept up to date as a separate file (csv format) on the NDIS website[4]. This file includes item descriptors to assist providers to claim payments using a “best-fit” approach, and to assist participants in engaging and negotiating with service providers.

Providers should claim payments against a support line item that most closely aligns to the service they have delivered.

Each support line item has a unique reference number, which is explained in the next section.

[4] https://www.ndis.gov.au/providers/pricing-and-payment

Claiming for 2018/19 NDIS supports and services using this Guide

This Price Guide applies for services delivered from 1 July 2018 onwards. Providers and participants can make service agreements under or at the 2018/19 price limits as long as the service is delivered on or after 1 July 2018.

Registered Providers can make a claim for payment once that support has been delivered or provided. Prepayment is not permitted unless the NDIA has given prior approval in writing to the Registered Provider. This will only occur in exceptional circumstances such as home modifications and remote area servicing.

Where price limits apply, prices charged to participants must not exceed the price limit prescribed for that support in this Guide. No other charges are to be added to the cost of the support, including credit card surcharges, or any additional fees including any 'gap' fees, late payment fees or cancellation fees unless otherwise stated in this Guide. Providers should refer to the NDIS Terms of Business for further details or the *Other Considerations* section within this Guide.

When claiming, it is the responsibility of the provider to ensure that the claim accurately reflects the supports delivered, including the frequency and volume of supports. Falsifying claims for any aspect of supports delivered, is a serious compliance issue and may result in action against the provider. Providers are also required to keep accurate records of claims, which are subject to audit at any time.

Service Bookings

2018/19 NDIS payment system allows Service Bookings to be created between the participant and their provider. This ensures that both parties are aware of the requirements for service, the length of time the service is required for, and that the participant will be able to pay for the service. For more information please refer to Section 5.2 of the Provider Toolkit[5].

To help participants keep track of their Service Bookings and budget, a Monthly Payment Statement will be available on the NDIS participant portal. Payment Statements will be available to the participant (and/or their nominee) on the first business day of each month, containing a summary of the previous month's payments, available budget remaining, committed budget and spent budget. It will list which participant and provider claims have been received, which Service Bookings they relate to, which Support Categories the money was deducted from and on which dates the deductions were made. The Payment Summary will be available in their preferred document format, either pdf or word. The participant (and/or their nominee) will be sent an email or SMS notification when their statements are available online.

[5] https://providertoolkit.ndis.gov.au/52-service-bookings

Support Item Reference Numbers

NDIS payments system applies unique numbers for each support line item, according to the following structure:

For example:

Assistance With Self-Care - Active Overnight - Complex line item number is: 01_018_0104_1_1

Support Category	Line Item	Reg Group	Domain	Funding Type
1	018	0104	1	1

Support Connection line item number is: 07_001_0106_8_3

Support Category	Line Item	Reg Group	Domain	Funding Type
7	001	0106	8	3

Units of Measure

The NDIS payment system for 2018/19 includes units of measure to suit each support line item as follows:

- Each
- Hour
- Daily
- Week
- Month
- Annual

Special NDIS Pricing Arrangements

In certain circumstances, providers may be entitled to charge for expenses incurred in the provision of supports. These may include certain transport and travel costs, or servicing remote or very remote areas, which are outlined below.

Supports for participants with high intensity or complex needs

The delivery of supports to a participant with higher intensity or complex needs can require specialised or more skilled support worker/s, and other arrangements that increase the cost of support delivery for providers.

To allow for these additional costs, this Price Guide defines both ‘standard needs’ and ‘high intensity’ line items for some supports, such as assistance with self-care activities and group-based community participation supports. High intensity line items will have price limits that are set at higher price levels than the equivalent ‘standard needs’ support.

Regional, Remote and Very Remote Areas

Supports delivered in remote and very remote areas may have higher additional service delivery costs, and may require higher price limits in place to accommodate for this. The Modified Monash Model (MMM) is used to determine regional, remote and very remote areas using a scale from 1-7 based on population size and locality. Participants located in MMM4 and MMM5 areas are classified as ‘Regional’, MMM6 as ‘Remote’, and MMM7 as ‘Very Remote’. Further details on the MMM can be found on the

Department of Health's DoctorConnect website[6]. This website also contains a resource to look up the MMM area for particular locations[7].

There are separate Price Guides for Remote and Very Remote areas. Prices are 20% higher in remote areas and 25% higher in very remote areas for some supports. There is no additional loading applied for delivery of supports in regional areas.

Providers should refer to support price limits based on where the support is delivered, which is not necessarily where the participant lives. For example, if a participant living in a Remote location visits a therapist in their capital city, the therapist should not attempt to claim a price that is higher than the price limit for the support in that city. On the other hand, if the therapist was to visit the participant in their local area to deliver the support, then the therapist could claim a price that is within the limit set by the 'Remote' Price Guide (i.e. 20% higher).

If local providers are not available, the NDIA may enter into arrangements (and at times contracts) with specific providers for provision of services to more remote regions. The contract with a service provider will specify the cost of travel and any other associated expenses in these areas.

[6] http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/about-DoctorConnect

[7] http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/MMM_locator

Provider Travel and Participant Transport

Provider travel and participant transport are different concepts. This section explains the differences and notes specific rules and arrangements for both travel and transport in the NDIS payments system.

Provider Travel

Providers who intend to claim travel costs from a participant must have the **agreement of the participant in advance** (i.e. the service agreement between the participant and provider should specify the travel costs that can be claimed).

Travel to provide personal care and community access

Providers may not claim travel costs for the time that a support worker spends travelling from home to the workplace (or first participant) and from the workplace (or last participant).

Where a support worker travels from one participant appointment to another, up to 20 minutes of time can be claimed against the next appointment at the hourly rate for the relevant support item.

Where a worker travels from one participant appointment to another in an MMM4 or MMM5 area, up to 45 minutes of time can be claimed against the next appointment at the hourly rate for the relevant support item.

Travel to provide therapy supports

Therapy providers may claim travel costs when travelling to and from appointments:

- For travel to a first participant appointment each day, or for travel from one participant appointment to another, therapy providers can claim up to 20 minutes of time against the appointment they are travelling to, at the hourly rate for the relevant support item. If the appointment is in a MMM4 or MMM5 area, therapy providers can claim up to 45 minutes of travel time against the appointment they are travelling to, at the hourly rate for the relevant support item.
- Therapy providers can also claim for return travel from the final appointment in a day.

In remote areas, therapy providers may enter specific arrangements with participants to cover travel costs, up to the relevant hourly rate for the support item. Providers should assist participants to minimise the travel costs that they need to pay (e.g. co-ordinating appointments with other participants in an area, so that travel costs can be shared between participants).

Participant Transport: Accompanying participants for community access

Providing community access supports may, at the request of a participant, involve a worker accompanying a participant on a community outing and/or transporting a participant from their home to the community. In these situations, the worker's time can be claimed at the hourly rate for the relevant support item for the total time the worker provides support to one or more participants, including time spent accompanying and/or transporting the participant. Where a provider is transporting two or more participants on the same trip, the worker's time should be claimed at the appropriate group rate for the relevant support.

Participant Transport: Contribution towards costs of transport itself

If a provider incurs costs, in addition to the cost of a worker's time, when accompanying and/or transporting participants in the community (such as cost of ticket for public transport), they may negotiate with the participant for them to make a reasonable contribution towards these costs. A participant's support budget may include funding for transport, and this funding can be used for these types of contributions, which should be clearly specified in the service agreement.

Cancellations and “no shows” for scheduled supports

Providers should have business arrangements in place to minimise the risk of cancellations, "no shows” or late changes to the delivery of a scheduled support. Service agreements between participants and providers need to include details of these arrangements including: rescheduling the appointment; notice periods for cancellations and the cancellation fee that can apply; and changes to agreed appointments.

If a participant makes a short-notice cancellation, which is after 3pm the day before the service, the provider may charge up to 90% of the agreed price for the cancelled appointment. A fee may be charged against a participant plan up to 12 times per year for personal care and community access supports. Beyond this threshold, the NDIA will require the provider to demonstrate they are taking steps to actively manage cancellations.

For other cancellations, where the participant has provided notice of cancellation prior to 3pm the day before the scheduled service, providers may not charge a cancellation fee.

Where participants make short-notice cancellations for therapy services, the therapist can charge a cancellation fee up to 90% of the agreed price for the cancelled appointment. Within the period of any Service Booking between a provider and participant, the total of cancelled appointments charged by the provider must not exceed six hours.

Where a participant fails, at short-notice or without notice, to keep the scheduled arrangement for the support, the provider must make every effort to contact the participant to determine if there is an additional problem (e.g. the person has fallen out of bed and cannot raise an alarm, or there is a sudden breakdown in the informal supports and additional support is likely to be required).

Where there is a specific risk that a participant will frequently make short-notice cancellations for a support due to the nature of a person's disability or the nature of the support (e.g. behaviour intervention supports), the provider should make individual arrangements to minimise the number of cancellations.

No fee is payable by the NDIA or the participant, for cancellation by a provider or due to the provider's failure to deliver the agreed supports, unless previously agreed to and documented in the Service Agreement with the participant.

NDIA does not permit collection of deposits, or money as a bond from participants that a provider would retain in the event of cancellation of a support per the NDIS Terms of Business.

Other Payment Considerations

This section outlines various other considerations that may be relevant to participants and providers. These should be reviewed when entering into a new Service Agreement or if there is a significant change in the participant's circumstances.

Medicare and insurance

Some elements of a participant's care may be covered by funds outside the NDIS. These expenses are commonly medical, including those covered by private health insurance or Medicare. These medical expenses are not funded under the NDIS, even if they are related to, or a symptom of the disability. These expenses should be claimed under the relevant health care scheme or insurance policy. Some providers (e.g. therapists) may need to distinguish between the health services and disability supports that they provide to a single client, and make separate payment claims (e.g. claim payments from Medicare for health services, and the NDIS for disability supports).

Prepayments

Prepayments are generally not required under the NDIS, unless the NDIA has given prior approval to the Registered Provider. Providers should make claims only for supports that have been delivered. Approval for prepayment may be given for certain assistive technologies where this has been agreed to by the participant.

Co-Payments for Capital items, including assistive technology

Co-Payments by the participant are not required; however, where the participant would like a customisation to a support or assistive technology that is not considered reasonable or necessary, they are required to pay for this themselves. These may

include an aesthetic customisation to an assistive technology or modifications to a vehicle that are additional to the assistive components.

Goods and Services Tax (GST)

Most items are GST exempt, as per Australian Tax Office information about GST and NDIS and the application of section 38-38 of the GST Act[8]. For a small number of items where GST is applicable (for example, delivery fees and building materials), the price is inclusive of GST.

Other fees (Commissions and exit fees)

Participants are generally not required to pay exit fees, even when changing providers part way through a plan. A core principle of the NDIS is choice and control for participants, allowing them to change providers without expense. Further information on establishment fees claimable by the incoming provider can be found below under *Establishment fee for personal care/community access*.

[8] http://www8.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/antsasta1999402/s38.38.html

CORE SUPPORTS

This section describes the rules and arrangements that apply to core supports. It also notes price limits that apply to specific line items.

Assistance with Daily Living (Support Category 1.01)

Assistance with daily personal activities

This support category relates to assisting with and/or supervising personal tasks of daily life to enable the participant to live as autonomously as possible. These supports are provided individually to participants and can be provided in a range of environments, including but not limited to, the participant's own home.

A hierarchy of price controls apply to the category of support, based on:

A. The **level of support** required: a higher intensity support may be paid where a participant requires assistance from a support worker with additional qualifications and experience relevant to the participant's complex needs. The **high intensity rate** may be considered when:

- Frequent (at least 1 instance per shift) assistance is required to manage challenging behaviours that require intensive positive behaviour support and/or
- Continual active support is required due to high medical support needs (such as unstable seizure activity or respiratory support)

B. The time of day that the support is provided:

- Daytime starts at 6am and finishes at 8pm
- Evening is where the support finishes after 8pm and before 12 midnight, where the evening rate applies to the entire shift
- Overnight is where the support finishes after 12 midnight and before 6am.

C. The day of the week that the support is provided:

- A weekday is Monday to Friday;
- The extra rates paid for Saturday, Sunday and Public holidays are in substitution for, and not cumulative upon, the shift premiums payable for evening and overnight supports.
- The extra rates for Saturday/Sunday/Public holidays do not increase further when the support finishes after 8pm.

Provisions for 'shadow shifts'

Shadow shifts may be considered where the participant has complex individual support needs that are best met by introducing a new worker to the participant before it is reasonable that they commence providing the support independently. These are considered where the specific individual support needs include:

- Very limited communication;
- Behaviour support needs; and/or

- Medical needs/procedures such as ventilation or home enteral nutrition.

Where the individual would require shadow shifts to assist with the introduction of new workers, and this is the desired method by the participant or their family, the provider may claim for up to 6 hours of weekday support per year.

Introducing new workers is not designed to replace formal, recognised training that will be provided by an employer to their workforce, such as Shadowing (or “Buddying”) less experienced staff or new staff with experienced workers or informal carers to help build knowledge and social capital (worker retention), which is not claimable under the NDIS.

Establishment fee for personal care/community access

This fee applies to all new NDIS participants in their first plan where they receive at least 20 hours of personal care/community access support per month. This payment is to cover non-ongoing costs for providers establishing arrangements and assisting participants in implementing their plan. The establishment fee is claimable by the provider who assists the participant with the implementation of their NDIS Plan, delivers a minimum of 20 hours per month of personal care/community access support and has made an agreement with the participant to supply these services.

The establishment fee will operate as follows:

- Providers can charge $500 against a plan if assisting a new participant, who is new to NDIS and new to the provider.
- A provider can charge $250 when they are maintaining an existing client of theirs who is commencing as a participant of the NDIS.
- Should a participant wish to change providers on commencing their first NDIS plan, $250 is available to the new provider. This is to assist the participant in changing providers.

- A budget of $750 is included in the first plan for NDIS participants, in case they need to this type of assistance from providers to design and implement support arrangements.

Assistance with household tasks

Assistance with household tasks enables participants to maintain their home environment. This may involve undertaking essential household tasks that the participant is not able to undertake.

Preparation and delivery of meals

This support item is for the preparation and delivery of food to participants who are unable to do this themselves, and are not in receipt of other supports that would meet the same need. The cost of the food itself is not covered by the NDIS. The cost of this support will vary based on the number of meals prepared and the deliveries required.

Assistance in Shared Living Arrangements – Supported Independent Living (SIL)

SIL is the assistance with and/or supervising tasks of daily life in a shared living environment, with a focus on developing the skills of each individual to live as autonomously as possible. The support is provided to each person living in the shared arrangement in accordance with their need.

SIL does not include rent, board and lodging or other day to day usual living expenses such as food and activities. It also does not include the capital costs associated with a participant’s accommodation.

SIL does not have fixed price limits, and providers can quote for the specific SIL service that they offer to each participant. To assist providers with quoting, the NDIA has developed a Provider SIL Pack[9]. The Provider SIL Pack contains templates that assist providers in developing an individualised quote. The purpose of this quote is to identify:

- The individual supports that will be available for the person, focused on maximising the person's capacity to be as independent as possible with household decision making, personal care and domestic tasks,
- The typical roster of supports that is shared between participants to maximise the efficient use of resources, and
- What supports are available to all residents to ensure the smooth operation and running of the household.

Once a quote is received, the NDIA uses a 'SIL Tool' to analyse provider quotes and to make sure that they represent value for money. In some cases, negotiation between the NDIA and providers will be necessary to agree appropriate prices for SIL.

For those providers who wish to continue to use the previous version of the quoting templates they may do so as these will continue to be accepted by the Agency.

Note on removal of 'benchmark' prices: Previous NDIS Price Guides have included benchmark prices for SIL. These benchmarks do not have any function in the SIL tool process, which recognises the individual support needs of participants. For this reason, the NDIA has removed the benchmarks from this Price Guide.

[9] https://www.ndis.gov.au/providers/sil

Short Term Accommodation and Assistance

From time to time, participants may require temporary supports that are different from their usual arrangements. These are non-typical days and may include short stays in a group-based facility (short term accommodation), or the purchase of additional in-home support.

For the purposes of this Price Guide, the 'short term accommodation' price limit includes all expenses in a 24 hour period including assistance with daily personal activities, accommodation, food and negotiated activities. Typically, this type of support would be used for short periods of up to 14 days at a time. For longer term arrangements, other options are likely to be more appropriate (e.g. Supported Independent Living).

In cases where a participant will receive substantially less than 24 hours of assistance with daily personal activities, it may be appropriate for the participant and provider to negotiate a lower price than the maximum price specified in this Guide, based on the actual support provided. This situation might arise, for example, if a participant enters a short term accommodation facility in the evening, and exits again early the following morning. Also, where a participant enters accommodation late in the day, it may be appropriate to claim the daily rate for the day of the week that the majority of the support is provided. In each case, support arrangements, including price, should be **agreed with participants in advance**.

Short term accommodation price limits vary according to the support needs of the participant and the day of the week the support is provided. Providers claiming at the rates for high intensity (i.e. ratio of 1 support worker for 2 participants) or 1:1 support must deliver assistance with daily personal activities at those support ratios for the duration of the participant's stay.

Transport Support (Support Category 1.02)

Transport enables participants to access disability supports outside their home, and to pay for transport that helps them to achieve the goals in their plan. Transport supports generally do not have price controls; however, participants should use the least expensive transport that meets their needs. Transport funding is paid fortnightly in advance to self-managed participants. Funding transport assistance is limited to those who cannot use public transport due to their disability. If the participant has questions about their transport support, providers may direct them to the NDIS factsheet available on the NDIS Website[10].

Consumables (Support Category 1.03)

Consumables are a support category available to assist participants with purchasing everyday use items. Supports such as continence and home enteral nutrition (HEN) products are included in this category. More information on these supports can be found in the *Assistive Technology and Consumables Code Guide*[11].

[10] https://www.ndis.gov.au/document/participant-transport-funding-informati

[11] https://www.ndis.gov.au/medias/documents/hf5/hae/8800885211166/AT-and-consumables-guide.pdf

Assistance with Social and Community Participation (Support Category 1.04)

These supports enable a participant to engage in community, social or recreational activities. They may be provided in a centre or in community settings at standard or higher intensity rates. If arranged in advance with participants, providers may charge up to 4 hours for each plan period to document proposed supports and expected outcomes. Price limits vary according to the support needs of the participant and the day of the week the support is provided.

Providers should not claim payment for:

- Expenses related to recreational pursuits, such as event tickets for the participant, as they are not covered by the NDIS.
- The cost of travel or entry for a paid support worker to attend a social or recreational event

Community and social activity costs

This support is included in a participant's plan to enable them to pursue recreational activities and engage in the community when associated with a participant's disability and goals. Participants may use this funding for activities such as camps, vacation and outside school hours' care, course or membership fees. More information can be found in the Operational Guidelines[12]

[12] https://www.ndis.gov.au/Operational-Guideline/including-10.html

Where appropriate, funded hours in a Community Access budget may be converted to a fee and claimed by a provider for these purposes.

New structure for group-based supports

Assistance to access community, social and recreational activities is often provided in a group setting.

This Price Guide introduces a new, consistent price limit structure for this support category. These new price limits allow for per-person costs within each group, and for capital costs for centre-based group care to support providers meeting increased costs associated with delivering care in a facility. The allowance will be charged at $2 per participant, per hour, and has been reflected in the relevant price tables below.

For support ratios that are not stated in this Guide (e.g. two workers for three participants), participants and providers should discuss and agree the most appropriate line item to be used for payments, and the appropriate price to be paid (which might be lower than the price limit for that line item).

Price Controls for Core Supports

This section lists Support Item price limits and benchmarks for Core supports.

Assistance with self-care activities

Standard needs: Assistance with self-care activities

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Assistance With Self-Care Activities - Standard - Weekday Daytime	01_011_0107_1_1	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	Hour	$48.14
Assistance With Self-Care Activities - Standard - Weekday Evening	01_015_0107_1_1	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	Hour	$52.79
Assistance With Self-Care Activities - Standard - Saturday	01_013_0107_1_1	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	Hour	$66.77
Assistance With Self-Care Activities - Standard - Sunday	01_014_0107_1_1	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	Hour	$85.45
Assistance With Self-Care Activities - Standard – Public Holiday	01_012_0107_1_1	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	Hour	$104.08

Complex needs: Assistance with self-care activities

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Assistance With Self-Care Activities - Complex - Weekday Daytime	01_008_0104_1_1	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	Hour	$49.63
Assistance With Self-Care Activities - Complex - Weekday Evening	01_009_0104_1_1	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	Hour	$54.42
Assistance With Self-Care Activities - Complex - Saturday	01_006_0104_1_1	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	Hour	$68.85
Assistance With Self-Care Activities - Complex - Sunday	01_007_0104_1_1	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	Hour	$88.09
Assistance With Self-Care Activities - Complex – Public Holiday	01_005_0104_1_1	Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible.	Hour	$107.33

Assistance with self-care activities: Overnight

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Assistance With Self-Care - Night-Time Sleepover	01_010_0107_1_1	Assistance with, or supervision of, personal tasks of daily living where overnight support is needed, but the care giver can sleep when not required to provide support.	Each	$204.81
Assistance With Self-Care - Active Overnight - Standard	01_002_0107_1_1	Assistance with, or supervision of, personal tasks of daily living where overnight support is needed and the care giver will not have the option to sleep.	Hour	$53.71
Assistance With Self-Care - Active Overnight - Complex	01_018_0104_1_1	Assistance with, or supervision of, personal tasks of daily living where intensive overnight support is needed and the care giver will not have the option to sleep.	Hour	$55.40

Assistance with daily life

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Assistance With Personal Domestic Activities	01_004_0107_1_1	Assist participant to undertake and/or develop skills to maintain their home environment where the participant owns their own home and/or has sole or substantial responsibility for its maintenance. Includes assisting participant to do basic house and yard work.	Hour	$44.61
Specialised Home Based Assistance For A Child	01_016_0104_1_1	Specialist assistance in the home required due to additional requirements of a child's disability; may be provided to strengthen the sustainability of informal supports.	Hour	$47.02
House And/Or Yard Maintenance	01_019_0120_1_1	Performing essential house and/or yard activities that the participant is not able to undertake.	Hour	$46.20
House Cleaning And Other Household Activities	01_020_0120_1_1	Performing essential house cleaning activities that the participant is not able to undertake.	Hour	$41.43

Short Term Accommodation

The cells in the table contain the price limits for each support and the support item reference number in the following format:

Price Limit	**$522.80**
Support Item Reference Number	*01_045_0115_1_1*

Support ratio	Weekday (per 24 hour day)	Saturday (per 24 hour day)	Sunday (per 24 hour day)	Public Holiday (per 24 hour day)
1:1	**$1,479.80** *01_058_0115_1_1*	**$1,855.80** *01_059_0115_1_1*	**$2,317.80** *01_060_0115_1_1*	**$2,779.80** *01_061_0115_1_1*
1:2	**$841.80** *01_054_0115_1_1*	**$1,029.80** *01_055_0115_1_1*	**$1,260.80** *01_056_0115_1_1*	**$1,491.80** *01_057_0115_1_1*
1:3	**$628.80** *01_062_0115_1_1*	**$754.80** *01_063_0115_1_1*	**$908.80** *01_064_0115_1_1*	**$1,062.80** *01_065_0115_1_1*
1:4	**$522.80** *01_045_0115_1_1*	**$616.80** *01_051_0115_1_1*	**$732.80** *01_052_0115_1_1*	**$847.80** *01_053_0115_1_1*

Assistance to access community, social and recreational activities

The tables below contain price limits for assistance to access community, social and recreational activities, taking account of whether the support is:

- Delivered in a centre ('centre-based') or in a general community setting ('community-based'), and
- A 'standard needs' support or a higher intensity support ('complex needs').

The cells in these tables contain the price limit for each support and the support item reference number in the following format:

Price Limit	**$52.79**
Support Item Reference Number	*04_103_0125_6_1*

Assistance to access <u>community-based</u> social and recreational activities - Standard needs

Support ratio	Weekday (max per hour)	Weekday evening (max per hour)	Saturday (max per hour)	Sunday (max per hour)	Public Holiday (max per hour)
1:1	**$48.14** *04_104_0125_6_1*	**$52.79** *04_103_0125_6_1*	**$66.77** *04_105_0125_6_1*	**$85.45** *04_106_0125_6_1*	**$104.08** *04_102_0125_6_1*
1:2	**$26.96** *04_111_0136_6_1*	**$29.56** *04_114_0136_6_1*	**$37.39** *04_112_0136_6_1*	**$47.85** *04_113_0136_6_1*	**$58.28** *04_128_0136_6_1*
1:3	**$19.90** *04_120_0136_6_1*	**$21.82** *04_123_0136_6_1*	**$27.60** *04_121_0136_6_1*	**$35.31** *04_122_0136_6_1*	**$43.02** *04_129_0136_6_1*
1:4	**$16.36** *04_136_0136_6_1*	**$17.95** *04_137_0136_6_1*	**$22.70** *04_138_0136_6_1*	**$29.05** *04_139_0136_6_1*	**$35.38** *04_140_0136_6_1*
1:5	**$14.25** *04_141_0136_6_1*	**$15.62** *04_142_0136_6_1*	**$19.76** *04_143_0136_6_1*	**$25.29** *04_144_0136_6_1*	**$30.80** *04_145_0136_6_1*

Assistance to access community-based social and recreational activities - Complex needs

Support ratio	Weekday (max per hour)	Weekday evening (max per hour)	Saturday (max per hour)	Sunday (max per hour)	Public Holiday (max per hour)
1:1	**$49.63** *04_101_0104_6_1*	**$54.42** *04_098_0104_6_1*	**$68.85** *04_099_0104_6_1*	**$88.09** *04_100_0104_6_1*	**$107.33** *04_097_0104_6_1*
1:2	**$29.75** *04_116_0104_6_1*	**$32.65** *04_119_0104_6_1*	**$41.29** *04_117_0104_6_1*	**$52.84** *04_118_0104_6_1*	**$64.32** *04_130_0104_6_1*
1:3	**$21.96** *04_124_0104_6_1*	**$24.08** *04_127_0104_6_1*	**$30.46** *04_125_0104_6_1*	**$38.98** *04_126_0104_6_1*	**$47.48** *04_131_0104_6_1*
1:4	**$18.06** *04_146_0104_6_1*	**$19.81** *04_147_0104_6_1*	**$25.05** *04_148_0104_6_1*	**$32.06** *04_149_0104_6_1*	**$39.05** *04_150_0104_6_1*
1:5	**$15.72** *04_151_0104_6_1*	**$17.24** *04_152_0104_6_1*	**$21.81** *04_153_0104_6_1*	**$27.91** *04_154_0104_6_1*	**$34.00** *04_155_0104_6_1*

Assistance to access centre-based social and recreational activities - Standard needs

Support ratio	Weekday (max per hour)	Weekday evening (max per hour)	Saturday (max per hour)	Sunday (max per hour)	Public Holiday (max per hour)
1:1	**$50.29** *04_160_0136_6_1*	**$54.94** *04_161_0136_6_1*	**$68.92** *04_162_0136_6_1*	**$87.60** *04_163_0136_6_1*	**$106.23** *04_164_0136_6_1*
1:2	**$29.11** *04_165_0136_6_1*	**$31.71** *04_166_0136_6_1*	**$39.54** *04_167_0136_6_1*	**$50.00** *04_168_0136_6_1*	**$60.43** *04_169_0136_6_1*
1:3	**$22.05** *04_170_0136_6_1*	**$23.97** *04_171_0136_6_1*	**$29.75** *04_172_0136_6_1*	**$37.47** *04_173_0136_6_1*	**$45.17** *04_174_0136_6_1*
1:4	**$18.52** *04_175_0136_6_1*	**$20.10** *04_176_0136_6_1*	**$24.85** *04_177_0136_6_1*	**$31.20** *04_178_0136_6_1*	**$37.54** *04_179_0136_6_1*
1:5	**$16.40** *04_180_0136_6_1*	**$17.78** *04_181_0136_6_1*	**$21.91** *04_182_0136_6_1*	**$27.44** *04_183_0136_6_1*	**$32.96** *04_184_0136_6_1*

Assistance to access centre-based social and recreational activities – Complex needs

Support ratio	Weekday (max per hour)	Weekday evening (max per hour)	Saturday (max per hour)	Sunday (max per hour)	Public Holiday (max per hour)
1:1	**$51.73** *04_185_0104_6_1*	**$56.52** *04_186_0104_6_1*	**$70.95** *04_187_0104_6_1*	**$90.19** *04_188_0104_6_1*	**$109.43** *04_189_0104_6_1*
1:2	**$31.85** *04_190_0104_6_1*	**$34.73** *04_191_0104_6_1*	**$43.37** *04_192_0104_6_1*	**$54.91** *04_193_0104_6_1*	**$66.43** *04_194_0104_6_1*
1:3	**$24.06** *04_195_0104_6_1*	**$26.18** *04_196_0104_6_1*	**$32.56** *04_197_0104_6_1*	**$41.08** *04_198_0104_6_1*	**$49.58** *04_199_0104_6_1*
1:4	**$20.16** *04_200_0104_6_1*	**$21.91** *04_201_0104_6_1*	**$27.16** *04_202_0104_6_1*	**$34.16** *04_203_0104_6_1*	**$41.15** *04_204_0104_6_1*
1:5	**$17.83** *04_205_0104_6_1*	**$19.35** *04_206_0104_6_1*	**$23.91** *04_207_0104_6_1*	**$30.01** *04_208_0104_6_1*	**$36.10** *04_209_0104_6_1*

CAPITAL SUPPORTS

This section describes the rules and arrangements that apply to capital supports.

Assistive Technology (Support Category 2.05)

This category includes all aids or equipment supports that assist participants to live independently or assist a carer to support the participant. It also includes related delivery, set-up and some training support items. Usually providing independent advice, guidance, trials, set-up and training (not bundled with sale of an item) is funded through **Capacity Building (Support Category 2.15)**. More detailed information on assistive technologies and consumables codes can be found in the *Assistive Technologies and Consumables Guide*[13].

Vehicle Modifications

Vehicle modifications include the installation of, or changes to, equipment in a vehicle to enable a participant to travel safely as a passenger or to drive.

A participant is free to choose a more expensive option at their own expense, where the more expensive option is not considered to be reasonable and necessary. An example of this situation would be where a vehicle modification has been approved for a

[13] https://www.ndis.gov.au/medias/documents/hf5/hae/8800885211166/AT-and-consumables-guide.pdf

participant, but the participant would like cosmetic or personalised fittings that are not related to their disability or are more expensive than others that have an equivalent function. In this situation, the NDIA will cover the reasonable and necessary component of the modification, and the participant will pay the additional cost.

Home (Support Category 2.06)

This category includes home modifications and Specialist Disability Accommodation (SDA) supports.

Home Modifications

Home modifications include design, construction, installation of or changes to equipment or non-structural components of the building, and installation of fixtures or fittings, to enable participants to live as independently as possible or to live safely at home. All home modifications in excess of $1,500 are quotable.

A participant is free to choose a more expensive option or modification that achieves the same outcome at their own expense, where the more expensive option is not reasonable and necessary. For example, where a home modification has been approved for a participant, but the participant would like cosmetic or personalised fittings that are not reasonable and necessary, the NDIA will provide funding for the reasonable and necessary component of the modification, and the participant will pay any extra costs.

Specialist Disability Accommodation (SDA)

SDA funding is intended for participants who require a specialist dwelling that reduces their need for person-to-person supports, or improves the efficiency of the delivery of person-to-person supports. SDA funding will only be provided for participants who meet the eligibility criteria. Participants who meet the eligibility criteria will have an extreme functional impairment and/or very high support needs.

SDA does not refer to the support services, but the homes in which these are delivered. SDA may include special designs for people with very high needs or may have a location or features that make it feasible to provide complex or costly supports for independent living.

SDA payments are an adjusted contribution to the cost of capital required for the land and physical building required for SDA needs. Importantly, SDA funding is not intended to cover personal support costs, which are assessed and funded separately by the NDIS. SDA also does not cover accommodation costs where these are not linked to a person's disability or where specialist accommodation with integrated supports is not required. SDA is a separate support category and does not replace Supported Independent Living (SIL) or any other support. Participants receiving SDA could also be eligible for SIL supports in their package.

All providers who are registered with the NDIA for the Registration Group 'Specialist Disability Accommodation' will also be required to declare and ensure that the infrastructure meets the NDIA's specialist built form requirements and the relevant legislation and standards applicable to the state in which the accommodation is situated. These individual sites/locations must also be enrolled with the NDIA.

Due to the nature of the support, the identification of maximum SDA prices and the process by which providers can claim for SDA are more complex than for most other supports. Providers should refer to the Specialist Disability Accommodation section of the

NDIS website for detailed information about maximum prices that can be charged, dwelling enrolment and participant assessments[14].

SDA has two support line items: Specialist Disability Accommodation and SDA person-specific adjustments.

Specialist Disability Accommodation

Each SDA dwelling has a unique maximum price, based on a standard set of factors. There are also limits on the amount that providers of SDA can charge participants in addition to the SDA price, for rent and other board-like services provided. Providers should refer to the SDA section of the NDIS website for detailed guidance on maximum prices[15]. Participants are able to choose to move between SDA dwellings, as long as the SDA dwelling is commensurate with their SDA budget.

SDA person specific adjustments

In certain limited circumstances, the NDIA will continue to make SDA payments on behalf of a participant who has moved out of an enrolled SDA dwelling. Provided all conditions are met in section 6.3 of the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016, vacancy payments may continue to be made for a period of up to 90 days if the dwelling is enrolled to house four or five residents, or up to 60 days if the dwelling is enrolled to house two or three residents[16]. Vacancy

[14] https://www.ndis.gov.au/specialist-disability-accommodation.html

[15] https://www.ndis.gov.au/SDA-pricing-payments.html

[16] https://www.legislation.gov.au/Details/F2017L00209

payments will not be made where a dwelling is only enrolled to house one resident. Vacancy payments will only be payable if the vacancy is available to another NDIS participant and the NDIA has been notified.

CAPACITY BUILDING SUPPORTS

This section describes the rules and arrangements that apply to capacity-building supports. It also notes price limits that apply to specific line items.

Support Coordination (Support Category 3.07)

There are three items in the NDIS Price Guide that describe different layers of support coordination activity:

Support Connection

Assistance for participants to implement their plan by strengthening the ability to connect with the broader systems of supports and understand the purpose of the funded supports and participant in the community. Support Connection will assist a participant to understand the aspects of the plan, assisting in ongoing management of supports, and answer questions as they arise. Support Connection will increase a participant's capacity to maintain support relationships, resolve service delivery issues, and to participate independently in NDIA processes.

The intended outcomes of support connection is for participant's to have the confidence and capacity to lead their plan, with the ongoing need for connection based supports reduced as a participant builds their capacity including, but not limited to:

- Understand the plan: assist the participant to understand their plan, the role of the broader systems of support, and the purpose of funded supports.

- Connection to broader system of support: assist the participant by linking to the broader systems of supports.
- Establish Supports: assist the participant to identify and consider support options.
- Coach, Refine, Reflect: Assist the participant through challenges that come up. Helps participant prepare for review and report on achieved participant outcomes.

Where a participant aged 0-6 years is receiving assistance from Partners in the Community (PITC) delivering Early Childhood Early Intervention (ECEI) services, linking the family to a service provider/s (under ECEI best practice principles a service provider operating under the key worker approach) and support through changes in circumstance will be delivered through Partner arrangements.

Where a participant aged 7 and over is receiving assistance from Partners in the Community (PITC) delivering Local Area Coordination (LAC) services, plan implementation and monitoring support will be delivered by a Participant's Local Area Coordinator.

Support Coordination: Coordination of Supports

The delivery of Coordination of Supports is to assist strengthening a participant's ability to design and the build their supports with an emphasis on linking the broader systems of support across a complex service delivery environment. Coordination of Supports is to focus on supporting participants to direct their lives, not just their services. This involves working together to understand the funding, identify what participants expect from services, and how participants want this designed. Coordination of Supports also includes coaching participants, and working with participants to develop capacity and resilience in their network.

The intended outcomes of providing Coordination of Supports is that a participant's capacity and ability to design, develop and implement their supports is sustained and includes, but is not limited to:

- Connection: assist the participant to develop knowledge, experience and connections with the community and broader systems of support.
- Support Design: works together with participant to understand plan funding and its purpose. Support Coordinator will understand the participant's confidence and skills, and helps participant identify what they want from services. Will develop and design support solutions to meet participant outcomes.
- Establish Supports: assist the participant to identify and consider support options, and link the participant to the broader systems of supports. Where practical creates a supports and action plan to facilitate the participant to implement their plan.
- Crisis: Assistance to resolve points of crisis and developing capacity and resilience in the participant's network.
- Coach, Refine, Reflect: Coach the participant through challenges that come up. Helps participant prepare for review and report on achieved participant outcomes.

Over time as a participants capacity is strengthened this support may be replaced by Support Connection or the introduction of a Local Area Coordinator or Early Childhood Early Intervention Partner in subsequent plans.

Specialist Support Coordination

Specialist Support Coordination is delivered utilising an expert or specialist approach, necessitated by specific high complex needs or high level risks in a participant's situation. Specialist Support Coordination is generally delivered in a time limited, outcomes focused manner and by an appropriately qualified and experienced practitioner to meet the individual needs of the participant's circumstances such as a Psychologist, Occupational Therapist, Social Worker, or Mental Health Nurse. Specialist Support Coordination will address highly complex barriers impacting on the ability to implement their plan.

Specialist Support Coordination should reduce complexity in the participant's support environment in the context of broader systems of support, whilst also assisting the participant to connect with NDIS supports, negotiate solutions with multiple stakeholders and build capacity and resilience. Specialist Support Coordination may also involve assisting in resolving points of crisis for participants, and ensuring a consistent delivery of service during crisis situations.

The intended outcome of specialist support coordination is that complexities and barriers affecting a participant's capacity and ability to implement their plan is reduced, and may be replaced by support coordination in subsequent plans. Specialist Support Coordination may also involve development of an intervention plan which will be put in place by disability support workers.

Improved Living Arrangements (Support Category 3.08)

Support is provided to guide, prompt, or undertake activities to ensure the participant obtains and/or retains appropriate accommodation. This may include assisting to apply for a rental tenancy or to undertake tenancy obligations in line with the participant's tenancy agreement.

Increased Social and Community Participation (Support Category 3.09)

This category involves supports for participation in skills-based learning to develop independence in accessing the community.

Innovative Community Participation

This support item is designed to allow providers to offer new and innovative services to NDIS participants. Any standards applicable to the industry in which the provider operates would need to be met.

Community Participation Activities

This item will enable providers to claim for tuition fees, art classes, sports coaching and similar activities that build skills and independence. Camps, classes and vacation activities that have capacity building components. These may include assistance to establish volunteer arrangements in the community, mentoring, peer support or individual skill development.

The group rates are based on a staff/participant ratio of 1:3. If the group size differs, providers should claim at the rate applicable for the group size. A higher staff ratio for groups may indicate when a participant has challenging behaviour or high medical support needs which require additional assistance from another worker and this is referred to as a higher intensity support.

All supports funded under this item need to be determined as reasonable and necessary given the participant's plan goals and could include, but are not limited to:

- Universal recreational activities: A limited number of lessons could be funded to enable a participant to try out an activity and test their capability and interest in pursuing this activity further – such as horse riding, art, dance or singing classes
- Funding to attend a "camp" or groups that build a person's relationship skills and offer a range of activities and opportunities to explore wider interests.

Other items or adjustments such as customised tools required because of the person's disability, could also be funded.

Finding and Keeping a Job (Support Category 3.10)

Workplace assistance that enables a participant to successfully obtain and/or retain employment in the open or supported labour market. Australian Disability Enterprise's (ADEs) provide supported employment for people with disability who require ongoing support to find and maintain employment.

School Leaver Employment Supports (SLES) (Support Category 3.10)

School Leaver Employment Supports (SLES) is support for Year 12 school leavers to assist them transition from school into employment if they have a goal or aspiration to be employed.

Supports may include work experience generally in open employment, job site training, travel training and activities that contribute to achieving an employment outcome and linkages to ongoing employment support.

This support is now offered nationwide and providers from all states providing this service may be able to claim for this if the participant is funded for SLES.

Improved Relationships (Support Category 3.11)

This category is the provision of specialised assessment where the participant may have complex or unclear needs, requiring long term and/or intensive supports to address behaviours of concern.

Behaviour Support

Behaviour support requires a behaviour support plan to be developed that aims to limit the likelihood of behaviours of concern developing or increasing once identified. This plan outlines the specifically designed positive behavioural support strategies for a participant, their family and support persons that will achieve the intended outcome of eliminating or reducing behaviours of concern. This support category includes specialist behavioural intervention support, which is an intensive support for a participant, intending to address significantly harmful or persistent behaviours of concern.

Improved Health & Wellbeing (Support Category 3.12)

Physical Wellbeing Activities

All activities to support, maintain or increase physical mobility or well-being such as personal training or exercise physiology. Physical well-being activities promote and encourage improved physical capacity and health.

These supports can be funded by NDIS where the physical and wellbeing difficulties are directly attributable to their disability and can assist them to participate in the community.

Dietetics

Individual advice to a participant on managing diet for health and wellbeing due to the impact of their disability.

Improved Learning (Support Category 3.13)

This category is for provision of skills training, advice, assistance with arrangements and orientation to assist a participant moving from school to further education.

Improved Life Choices (Support Category 3.14)

Plan and Financial Capacity Building

This reasonable and necessary support focuses on strengthening the participant's ability to undertake tasks associated with the management of their supports. This includes:

- Building financial skills
- Organisational skills
- Enhancing the participant's ability to direct their supports
- Develop self-management capabilities

Plan and Financial Capacity Building providers are expected to assist the participant to develop their skills for self-management in future plans, where this is possible. As a part of this capacity building support, providers are to assist the participant with the overall management of the plan including assisting the participant to engage providers, develop service agreements, paying providers and claiming payment from the NDIA and assisting the participant to maintain records.

Funding for plan management includes an establishment fee and payments at an hourly rate for completing this work.

Plan Management – Financial Administration *(previously referred to as Financial Intermediary)*

Plan Management – Financial Administration funding applies to registered providers who undertake financial administration of a plan on behalf of a participant.

Plan Management – Financial Administration funding includes a setup fee to establish the payment arrangements with providers and a monthly processing fee. This support assists a participant by:

- Giving increased control over plan implementation and utilisation with plan financial assistance
- Managing and monitoring budgets over the course of the plan
- Managing NDIS claims and paying providers for delivered service
- Maintaining records and producing regular statements showing the financial position of the plan
- Providing advice on commercial terms within service agreements
- Providing access to a wider range of service providers, including non-registered providers whilst remaining in line with the price limits contained within this Guide.

A Plan Management – Financial Administration provider will typically possess bookkeeping/accounting skills and have systems in place for efficiently processing payments on behalf of a participant.

Improved Daily Living (Support Category 3.15)

This category includes the assessment, training, development and/or therapy to assist in the development or increase in skills for independence and community participation. Supports can be delivered in groups or individually.

Therapy Services

In the NDIS, therapy supports are for participants with an established disability, where maximum medical improvement has been reached, to facilitate functional improvement.

For people who access the Scheme as ‘early intervention’ NDIS participants, reasonable and necessary supports are likely to be a blend of medical and disability therapies, but should be predominantly disability therapy supports. Therapy in this context must be aimed at adjustment, adaption and building capacity for community participation.

For NDIS participants whose medical condition, illness or disease requires a particular treatment to maintain the functioning of a body part, or slow/prevent the deterioration, the NDIS may fund reasonable and necessary training for non-skilled personnel to undertake this intervention as part of the usual daily personal care. For participants where such treatment can only be met through skilled rather than non-skilled care, this treatment is to be funded through medical funds, not the NDIS.

Ongoing funding for therapy is subject to a detailed support plan that is designed to deliver progress or change for the participant. Providers develop this plan with the participant and it should clearly state the expected therapy outcomes and demonstrate a link to the participant’s goals, objectives and aspirations.

Therapists often spend time making notes at the end of appointments as part of the delivery of support to participants. This is standard practice, and part of individual support for participants, even when this activity is not during face-to face time. Therapists may charge for a portion of this time, as long as this is agreed with the participant in advance.

Maintenance Therapy

Where maintenance therapy is reasonable and necessary, it is funded as part of ongoing direct support hours (delivered by carers who are or can be trained in this if required), and is not funded as ongoing therapy.

For participants whose medical condition or disability requires a particular regime to maintain functioning of a body part, or to slow the deterioration of a medical condition or body part, the NDIS will fund reasonable and necessary training for non-qualified personnel to assist the individual as part of usual daily care.

Where a skilled therapist is involved in establishing a therapy program for a participant, funding can include the development of a plan and training for a therapy assistant, informal or funded carers, as part of usual care. Building capacity with family and carers to undertake therapy or exercises under the supervision of a skilled therapist can deliver ongoing benefit to NDIS participants.

Massage Therapy

Massage, delivered directly to impact a body part or body system, is more appropriately provided by the health system and is therefore not funded by the NDIS.

Multidisciplinary Team Intervention

This support item enables a coordinated multidisciplinary approach to be delivered to participants beyond the age covered by the Early Childhood Early Intervention approach. All team members will claim against a single support item, thereby increasing flexibility in service delivery to reflect the changing needs of a participant.

Therapy reports

Therapists will be expected to provide progress reports to the participant and NDIS at agreed times. A provider may charge for the time taken to write a therapy report that is requested by the NDIA, and claim this against the appointment at the hourly rate for the relevant support item. A report requested by the NDIA is considered a report that is required at the commencement of a plan which outlines plan objectives and goals, and at plan review which measures against the originally stipulated goals. Providers may also charge for any other NDIA-requested therapy report that is stipulated as being required in a participant's plan.

Early Childhood Intervention Supports

Early Childhood Early Intervention (ECEI) is a nationally consistent, best practice support approach for children 0-6 years old who have a developmental delay or disability, which provides individualised support for each child based on their needs.

The NDIS ECEI approach has been designed to support all children and their families to achieve better long-term outcomes, regardless of diagnosis. All children and families will be treated as individuals to ensure that they receive the right support to meet their goals and aspirations. The type of supports will be different for every child and their family according to their needs.

Eligible participants will have budgets built by ECEI Partners to reflect the child and family individual needs, applying the reasonable and necessary criteria. Budgets will allow flexibility in service delivery by ECEI providers to reflect the changing needs of the participant.

The provision of supports under early childhood intervention are expected to deliver outcomes for the child that will enable participation in mainstream or education from commencement of school. Each child's NDIS plan will summarise the outcomes expected from early intervention and will be reviewed at least annually.

Providers of these supports can use the same claiming rules for travel, cancellation and report writing as those providing therapy supports.

Group Supports for Therapy

The NDIA prefers to allow participants and providers flexibility in negotiating arrangements, so there may not be price controls or support items for specific group ratios beyond what is currently in place. For support ratios that are not stated in this Guide (such as one therapist to two participants, or one therapist to four participants), the NDIA encourages participants and providers to discuss arrangements both parties agree to, including price. Therapy delivered in a group may be claimed using the relevant therapy support line item but with lower prices than the price limit as agreed between provider and participant. This arrangement for support ratios is intended to allow providers to offer a range of services and discuss with participants about more flexible arrangements which both parties prefer.

Support Coordination

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Support Connection	07_001_0106_8_3	Assistance for participants to implement their plan by strengthening the ability to connect with the broader systems of supports and understand the purpose of the funded supports and participant in the community. Support Connection will assist a participant to understand the aspects of the plan, assisting in ongoing management of supports, and answer questions as they arise.	Hour	$58.92
Coordination Of Supports	07_002_0106_8_3	Further qualifications/experience required to strengthen a participant's ability to design and the build their supports with an emphasis on linking the broader systems of support across a complex service delivery environment. Coordination of Supports is to focus on supporting participants to direct their lives, not just their services. This may include resolving points of crisis, and developing resilience in the participant's network.	Hour	$96.04
Training In Planning And Plan Management	07_003_0117_8_3	Capacity building and training in plan administration and management for participants unable to do this independently but who could do all or part of the task with training.	Hour	$57.32
Specialist Support Coordination	07_004_0132_8_3	Generally delivered in a time limited, outcomes focused manner and by an appropriately qualified and experienced practitioner to meet the individual needs of the participant's circumstances. Necessitated by specific high complex needs or high level risks in a participant's situation, to reduce complexity in the participant's support environment in the context of broader systems of support, whilst also assisting the participant to connect with NDIS supports, negotiate solutions with multiple stakeholders and build capacity and resilience.	Hour	$182.74

Improved Living Arrangements

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Assistance With Accommodation And Tenancy Obligations	08_005_0106_2_3	Support is provided to guide, prompt or undertake activities to ensure the participant obtains and/or retains appropriate accommodation. May include assisting to apply for a rental tenancy or to undertake tenancy obligations.	Hour	$58.92

Increased Social and Community Participation

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Life Transition Planning Including Mentoring, Peer-Support And Individual Skill Development	09_006_0106_6_3	Establishing volunteer assistance within the participant's home or community to develop skills. For instance, assistance in attending appointments, shopping, bill paying, taking part in social activities and maintaining contact with others.	Hour	$58.92
Skills Development In A Group	09_007_0117_6_3	Training for the participant in a group of 2 or more to increase their independence in daily personal activities.	Hour	$28.66
Individual Skills Development And Training	09_009_0117_6_3	Individual life skills development and training including public transport training and support, developing skills for community, social and recreational participation.	Hour	$57.32

Finding and Keeping a Job

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Employment Related Assessment And Counselling	10_011_0128_5_3	Workplace assessment conducted by a workplace rehabilitation provider to determine adjustments or modifications to the workplace or work processes to ensure employment is maintained and matches the employee's capabilities.	Hour	$182.74
Individual Employment Support	10_016_0102_5_3	Time limited, on-the-job training including post placement support related to the participant's disability that enables them to adjust and manage demands of the job in the workplace environment, and to assist employers to successfully manage the participant's placement.	Hour	$57.82

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Employment Preparation And Support In A Group - Group Of 3	10_017_0102_5_3	In a group setting, building capacity by providing skills training such as transport, time/financial management and self-care to support a participant to get a job post school. This assumes a group of 3.	Hour	$19.28

Improved Relationships

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Specialist Behavioural Intervention Support	11_022_0110_7_3	Highly specialised intensive support interventions to address significantly harmful or persistent behaviours of concern. Development of behaviour support plans that temporarily use restrictive practices, with intention to minimise use of these practices.	Hour	$200.58
Behaviour Management Plan Including Training In Behaviour Management Strategies	11_023_0110_7_3	Training for carers and others in behaviour management strategies required due the participant's disability.	Hour	$182.74
Individual Social Skills Development	11_024_0117_7_3	Social skills development with an individual, for participation in community and social activities.	Hour	$57.32

Improved Health and Wellbeing

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Dietician Consultation And Diet Plan Development	12_025_0128_3_3	Individual advice to a participant on managing diet for health and well-being due to the impact of their disability.	Hour	$182.74
Dietitian Group Session – Group of 3	12_026_0128_3_3	Group based specialist dietary advice on managing diet for well-being due to the impact of their disability. This assumes a group of 3.	Hour	$60.92
Exercise Physiology	12_027_0126_3_3	Individual advice to a participant regarding exercise required due to the impact of their disability.	Hour	$148.69

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Exercise Physiology In A Group - Group of 3	12_028_0126_3_3	Advice to a participant regarding exercise required due to the impact of their disability, provided in group setting, assuming a group of 3.	Hour	$49.56
Personal Training	12_029_0126_3_3	Personal training provided to a participant due to the impact of their disability.	Hour	$55.72

Improved Learning

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Transition Through School And To Further Education	13_030_0102_4_3	Provision of skills training, advice, assistance with arrangements and orientation to assist a person with disability moving from school to further education.	Hour	$58.92

Improved Life Choices

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Plan and Financial Capacity Building	14_031_0127_8_3	Undertaking regular liaison with a participant to strengthening their ability to undertake tasks associated with the management of their supports. Providers of this support are to assist the participant with the overall management of the plan including assisting the participant to engage providers, develop service agreements, paying providers and claiming payment from the NDIA and assisting the participant to maintain records.	Hour	$55.27
Plan Management And Financial Capacity Building - Set Up Costs	14_033_0127_8_3	A one-off (per plan) establishment fee for setting up of the financial management arrangements for managing of funding of supports.	Each	$222.85
Plan Management – Financial Administration	14_034_0127_8_3	A monthly fee for the ongoing maintenance of the financial management arrangements for managing of funding of supports.	Monthly	$100.18

Improved Daily Living Skills

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Assistance With Decision Making, Daily Planning and Budgeting	15_035_0106_1_3	Provision of time limited support to assist a person to develop and maintain daily budget, including assisting in planning purchases.	Hour	$44.54
Individual Assessment And Support By A Nurse	15_036_0114_1_3	Provision of care, training and supervision of a delegated worker to respond to the complex care needs of a participant where that care is not the usual responsibility of the health system.	Hour	$97.78
Individual Skill Development And Training Including Public Transport Training	15_037_0117_1_3	Individual training provided in the home for general life skills to increase independence.	Hour	$44.54
Training For Carers/Parents	15_038_0117_1_3	Training for carers in matters related to caring for a person with disability.	Hour	$57.32
Specialised Group Early Childhood Interventions - Max Group Of 4	15_039_0118_1_3	Group based specialist interventions to assist a child with disability or developmental delay and their family in home, care, community and education settings. Maximum group of 4.	Hour	$60.92
Capacity Building Supports For Early Childhood	15_040_0118_1_3	Individual specialist interventions to assist a child with disability or developmental delay and their family in home, care, community and education settings.	Hour	$182.74
Counselling Group - Group Of 3	15_042_0128_1_3	Facilitating self-knowledge, emotional acceptance and growth and the optimal development of personal resources through a group session. Assisting participants to gain their personal goals and gain greater insight into their lives. Group of 3.	Hour	$50.98
Individual Counselling	15_043_0128_1_3	Facilitating self-knowledge, emotional acceptance and growth and the optimal development of personal resources on a one to one basis. Assist participants to work towards their personal goals and gain greater insight into their lives.	Hour	$152.95
Group Therapy – Group Of 3	15_044_0128_1_3	Provision of interventions by more than one professional in a group session towards the participants agreed goals. Group of 3.	Hour	$59.76

Support Item	Support Item Ref No.	Description	UOM	Price Limit
Community Engagement Assistance	15_045_0128_1_3	Program to empower participants and improve interactions between participants and their social networks. Assistance to engage effectively in the community through a group approach to help achieve goals, gain insight into their lives and make informed decisions.	Hour	$42.59
Therapy Assistants (Level 1)	15_052_0128_1_3	Support role for an allied health assistant working under the supervision of a therapist.	Hour	$45.66
Selection And/Or Manufacture Of Customised Or Wearable Technology	15_047_0135_1_3	Selection and/or manufacturing of customised or wearable technology.	Hour	$164.91
Individual Assessment, Therapy And/Or Training (Includes Assistive Technology)	15_048_0128_1_3	Assessment, therapy, training, fitting and any approved travel to deliver support.	Hour	$179.26
Community Nursing Care For Continence Aid	15_051_0114_1_3	Continence aids: assessment, recommendation, and training delivered by a nurse.	Hour	$97.78

Dear Providers

This letter provides an update on the Independent Pricing Review (IPR).

In response to market feedback that, in some areas, price limits set by the NDIA required more detailed consideration, the National Disability Insurance Agency (NDIA) Board engaged McKinsey & Company in June 2017 to undertake an Independent Pricing Review for the National Disability Insurance Scheme (NDIS). As the NDIS is rolled out across Australia, the establishment of the IPR reflected the NDIA's commitment to developing a vibrant provider sector that can provide reasonable and necessary supports to NDIS participants to help them live a better life.

As part of this independent process, McKinsey & Company consulted with over 1000 individuals, held ten open forums, nine webinars, and 45 one-on-one meetings in the second half of 2017.

The IPR was commissioned recognising the important role that price plays as a key driver of value for participants, particularly during transition. In commissioning the review, it was acknowledged that prices paid to providers must be sufficient to create adequate supply to meet the short and longer term needs of participants. To that end, the IPR undertook detailed analysis of provider economics, market development, and Scheme and sector data, resulting in a deeper understanding of the complex environment in which providers operate.

In March 2018, the full IPR and the NDIA Response were published, including in principle endorsement of the report's 25 recommendations. The NDIA response also outlined that additional work was required prior to implementation for some of the more complex recommendations.

The disability sector has welcomed the IPR's message that close attention must be paid to price, and in particular that action was needed to support providers during their transition to the participant centred funding approach that is integral to the NDIS . The NDIA has continued to engage and consult with providers about the impact of the IPR's recommendations, and has committed to communicate with providers and implement the IPR recommendations in a thorough and timely way. Following those initial soundings, the NDIA provided an update to the market in April, 2018 revising those recommendations that would be progressed immediately and those where further work was required.

The NDIA now confirms the specific IPR recommendations that will be implemented for 2018/19 from 1 July 2018. These changes will give providers immediate support to meet the challenges of transitioning to the participant centred NDIS funding approach.

Price limits for most supports will increase. For standard intensity attendant care supports, price limits will include a new 2.5% loading, following the IPR recommendation to give providers temporary support for their overhead costs (TSO). 'Attendant care' refers both to assistance with daily personal activities and assistance with community participation.

The initial IPR recommendation was that this should be put in place for one year. However, the NDIA Board has decided that this TSO measure will remain partially in place (at 1.25%) in 2019/20, rather than be removed after 12 months as originally recommended. While this

TSO loading is in place, the NDIA will continue to work to deliver initiatives which will reduce provider administrative costs and deliver a better NDIS provider experience. Significant progress has been made, with the NDIA delivering provider portal enhancements, payments process improvements, and continuous development of helpful tools such as the provider finder. The NDIA has clear initiatives for delivery over the coming financial year, which will build on this work, and will also work with providers to help improve their efficiency.

New price limits will also take full account of growth in wage costs under the Social, Community, Home Care and Disability Services Industry Award and the Equal Remuneration Order. The cumulative impact of both is 5.14%. When combined with the TSO of 2.5% for the year, this means that the price limit for standard attendant care supports will increase by 7.6% from 1 July 2018.

Group community participation supports will be converted to a new, consistent structure in the NDIS support catalogue, to give providers and participants more clarity and flexibility. Providers will also benefit from new price limits that recognise per-person costs when delivering group supports, and include an allowance for capital costs when these supports are delivered in a specialist centre.

New, more flexible arrangements for provider travel and appointment cancellations will also be introduced from 1 July 2018.

To ensure that participants are not adversely impacted by this price increase and that they can purchase their reasonable and necessary supports, the 1 July 2018 price limit changes will be accompanied by automatic updates to participant budgets and service bookings. These adjustments will reflect the additional costs that each individual participant will face as a result of the increases in price limits. Other changes, such as for cancellation and travel cannot readily be adjusted, but will be monitored closely for individual participants to ensure they are not adversely affected.

Full details of all price limit changes are being published at the same time as this advice is provided.

As advised in April, some other changes—originally envisaged to be implemented on July 1—will be delayed pending further consultation.

Specifically, this applies to therapy support. Therapy support is crucial for many participants, and providers are responding to the opportunity that the roll-out of the NDIS provides. For instance, while variations in growth rates occur among states and territories, in the year to 30 March 2018, the number of registered providers across Australia offering therapeutic supports more than doubled from 3560 to 7161. Therapy providers are the single largest group of registered providers in all states, other than Western Australia where many are expected to register now that the NDIS is fully national.

However, based on therapy provider feedback since the IPR; the interrelationship of therapy prices with the IPR's recommendations in relation to pricing for complexity; and Western Australia's decision to join the NDIS, the NDIA has asked McKinsey & Company to ensure the appropriateness of its therapy price control recommendations. The NDIA was particularly eager to ensure that initial IPR recommendations captured differences among states, including those with a substantial number of participants in remote areas, along with differentiation by therapy types. For this reason, adjustments to therapy prices will only be implemented after this work is complete and fully considered.

This approach reflects the NDIA's commitment to working collaboratively with the sector to deliver a strong, vibrant and innovative market for quality disability supports.

Following implementation of the first set of IPR recommendations, the NDIA will move immediately to finalise the next set of recommendations, including therapy price limits and complexity. Consultation with provider groups and experts from the sector in relation to these recommendations will occur before implementation. We expect the outcomes of the important work on therapy and complexity to be implemented in late 2018.

You can find more information relating to the implementation of IPR recommendations on the NDIS website: https://www.ndis.gov.au/providers/independent-pricing-review.html.

Regards

Robert De Luca
Chief Executive Officer
National Disability Insurance Agency

IPR Implementation

The NDIA confirms that the Independent Pricing Review (IPR) recommendations that will be implemented for 2018/19, taking effect on 1 July 2018 are as follows:

- 4 - Regional Travel
- 9 – High intensity loading for centre-based activities
- 10 - Short Term Accommodation
- 14 - Temporary Support for Overheads (TSO)
- 15 - Cancellation policy for core supports
- 16 - Group supports
- 18 - Therapy Assistants (phase one)
- 19 - Therapy travel (phase one)
- 20 – Cancellation policy for therapy
- 21 – Reports requested by the NDIA

Full details of these changes are available in the link to the 2018-19 NDIS Price Guide. Key changes, to take effect on 1 July 2018, include the following:

- A TSO loading of 2.5 per cent will be applied to all standard intensity attendant care price limits in the 2018-19 Price Guide.
  - This measure will provide temporary financial relief for providers as they transition to the NDIS funding approach of individualised participant packages.
  - Half of this loading (1.25%) will remain in place during 2019-20.
  - The loading will be removed in 2020-21, as an adjustment to the annual price review.
  - While the TSO loading is in place, the NDIA will continue to work on pathway initiatives that will provide ongoing cost reductions and an improved and easier experience for disability support providers.. Initiatives already underway or completed include improvements to the provider portal, provider payments systems, and helpful tools such as the provider finder.

Standard needs attendant care price limit per hour	Without TSO	TSO for 12 months	Decision - extended TSO
2017/18	$44.72	$44.72	$44.72
2018/19	$47.02	$48.14	$48.14
2019/20*	$49.44	$49.44	$50.02

*The 2019/20 figures are projections only, assuming a 3.5% growth in Modern Award wage levels on 1 July 2019.

- As in previous years, price limit increases for attendant care take full account of growth in wages under the *Social, Community, Home Care and Disability Services Industry (SCHADS) Award* as well as the Equal Remuneration Order (ERO) by Fair Work Australia. This results in the following adjustments.

	Component	Cumulative
ERO 1 December 2017	2.27%	
SCHADS wage growth 1 July 2018	3.50%	5.14%*
TSO (applies to standard intensity supports)	2.50%	7.64%

* See Appendix A for further detail.

- Combined with annual 'indexation' adjustments to account for growth in provider costs, this means that price limits will increase in 2018/19 by:
  - 7.64% for standard intensity attendant care supports (including TSO),
  - 5.14% for high intensity attendant care supports (TSO does not apply – see Appendix A), and
  - 2.1% for capacity-building supports, including therapy, based on growth in the national Wage Price Index (these supports are delivered by highly skilled workers, for whom the SCHADS award is not an appropriate reference).
- Based on provider feedback, a new price limit will be added for Short Term Accommodation (STA) to allow for a 1:3 support worker to participant ratio. The new limit will be consistent with existing STA price limits, and will provide more flexibility to providers and participants in making support arrangements.
- Providers will be able to charge 90 per cent of the service booking price for short notice cancellations, up to a maximum of 12 cancellations per year for core supports and 6 hours per year for therapy.
- New price limits will be introduced for both standard and high intensity community-based group supports, to allow for support ratios of 1:4 and 1:5 (i.e. worker:participant ratio).
- A capital allowance will be included in the price limits for centre-based group care.
- Therapy travel recommendations that will benefit providers will also be introduced from 1 July 2018 (i.e. allowing providers to charge up to 45 minutes of travel time in rural areas). More specific travel claiming arrangements for remote areas that were flagged in the IPR (allowing travel costs on a quote basis) will be implemented as soon as possible. In the meantime, travel cost arrangements for remote areas can still be claimed, subject to explicit agreement by the participant in advance.

The implementation schedule for the remaining IPR recommendations remains as outlined in the 24 April update (https://www.ndis.gov.au/news/ipr-implementation-update.html).

The NDIA is committed to ensuring that providers are supported as they transition from block funding to the participant-led NDIS, and the eventual creation of a deregulated market for services.

Participant Plans will be adjusted to match the indexation increases in price limits for disability supports, ensuring participants will maintain their purchasing power for reasonable

and necessary supports. The specific impact on each participant's budget will vary, according to the mix of supports that are reasonable and necessary for each individual.

Changes to the group support price limit tiers and cancellation and travel policies will not be adjusted in participant plan budgets. While these changes will have a positive impact on individual participants through increased flexibility, changes to support arrangements between providers and participants will only come into effect through an individual participant's choice, making it difficult to make broader adjustments. The NDIA will monitor cancellation practices, particularly in areas with high risk of cancellations and heavy reliance on provider travel (e.g. participants living in regional areas). The NDIA will consider targeted action if there is a risk to the delivery of reasonable and necessary supports, without the need for a plan review.

The 'Supported Independent Living (SIL) tool', used to determine reasonable and necessary support budgets for participants in shared accommodation arrangements, will be updated before 1 July 2018. The new version, for use in 2018/19, will include specific changes to provide for an 'indexation' adjustment of 5.14% to account for growth in wages. Consistent with the IPR recommendation, the TSO will not apply to SIL calculations. Because the SIL tool will be in use from July 1, there is no requirement for SIL benchmarks, and they will be removed from the NDIS Price Guide.

Nonetheless, existing service bookings between providers and participants for SIL will be updated as appropriate in the following ways:

- The NDIA understands that SIL providers will experience the same wage cost growth on 1 July 2018 as other providers of attendant care supports, but may not have factored this growth into their original quotes. For this reason, the NDIA is taking steps to make sure that any SIL service bookings (and participant budgets) that continue into the 2018/19 financial year are adjusted appropriately.
- In future years, SIL service bookings will not be subject to automatic updates to account for inflation. Instead, the NDIA expects that SIL providers will use the updated SIL tool to anticipate wage growth during the course of their service bookings and factor in indexation as part of their quote.

APPENDIX A

Price limits increase in the NDIS line with the increase in costs that providers face in delivering different supports. For attendant care, most of the cost is driven by wages of support workers, who are employed under the *Social, Community, Home Care and Disability Services Industry* (SCHADS) Award. Their wages increase in line with national minimum wage decisions and the Equal Remuneration Order (ERO). Some other costs that providers face, such as overheads, increase at a different rate, typically in line with general measures of inflation such as CPI. Combining these increases for different costs results in an indexation adjustment to attendant care price limits of 5.14% in 2018-19. The following table explains this calculation in detail.

<table>
<tr><th colspan="3">Components of cost growth</th><th>Cost growth</th><th>Estimated proportion of costs</th><th>Weighted average cost growth</th></tr>
<tr><td rowspan="2">Labour cost</td><td>ERO 1 December 2017</td><td>2.27%</td><td rowspan="2">A. 5.8%</td><td rowspan="2">C. 82%</td><td rowspan="3">5.14%
A * C + B * D</td></tr>
<tr><td>SCHADS wage growth 1 July 2018</td><td>3.5%</td></tr>
<tr><td>Other Cost</td><td>CPI</td><td>1.9%</td><td>B. 1.9%</td><td>D. 18%</td></tr>
</table>

Combined with annual ‘indexation’ adjustments to account for growth in provider costs, this means that price limits will increase in 2018/19 by:

- 7.64% for standard intensity attendant care supports (including TSO),
- 5.14% for high intensity attendant care supports (high intensity supports will be addressed by more specific IPR recommendations, so the IPR recommended that the TSO apply to standard intensity supports only), and
- 2.1% for capacity-building supports, including therapy, based on growth in the national Wage Price Index (these supports are delivered by highly skilled workers, for whom the SCHADS award is not an appropriate reference).

National Disability Services

Australian Disability Workforce Report

3rd edition - July 2018

WORKFORCE WIZARD

care careers

Findings from Workforce Wizard and carecareers – the best sources of disability workforce data in Australia

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This data for this report was collected in part through the NDS Disability Workforce Innovation Network project 2014-16 which took place with the assistance of funding provided by the Australian Government. NDS also recognises the significant contribution of the industry in embracing Workforce Wizard, helping shape it and making it the successful tool it is today.

About this report

This is the third edition of a twice yearly publication. It was prepared by Adrian Lui and Caroline Alcorso, NDS. The next edition will be published in February 2019.

About National Disability Services

National Disability Services ('NDS') is the peak body for non-government disability services. Its purpose is to promote quality service provision and life opportunities for people with disability. NDS's Australia-wide membership includes more than 1000 non-government organisations, which support people with all forms of disability. NDS provides information and networking opportunities to its members and policy advice to state, territory and federal governments.

National Disability Services

Contents

Introduction

This midyear update is part of NDS's on-going tracking of disability workforce trends using data from Workforce Wizard, the sector's quarterly workforce data collection. Eleven quarters of Workforce Wizard data, now covering some 45,000 workers nationally, are presented.

The update examines whether the patterns comprehensively analysed in our February 2018 Australian Disability Workforce Report (available through the NDS website) are continuing, stalling or reversing.

In addition, it discusses state-level features which highlight the challenges faced by the sector in different parts of the country. Finally, the results of the two latest 'spotlight topics' are included, providing new information about topics providers report on a one-off basis.

This report does not give a detailed account of our methodology, nor does it present all the data behind trends. For methodology, please read the February 2018 Australian Disability Workforce Report available at the NDS Workforce Hub, on the Knowing Your Workforce page. If you would like to receive tables with the data behind the trends presented here, please contact Adrian Lui (email: adrian.lui@nds.org.au).

As always, we are keen to hear your suggestions about reports, and what you would like Workforce Wizard to tackle next. Workforce Wizard is your workforce data tool, built for convenience, rigour and maximum usefulness for the sector.

Chapter 1: The latest trends in the disability support workforce

Workforce Wizard data over the last two years has shown that the majority of disability support workers in Australia are employed either as permanent or casual employees, with very few people on short-term contracts. Permanent employment has been more common, but a gradual trend towards increased casual employment has been emerging. Has this trend continued during 2018?

Employment type

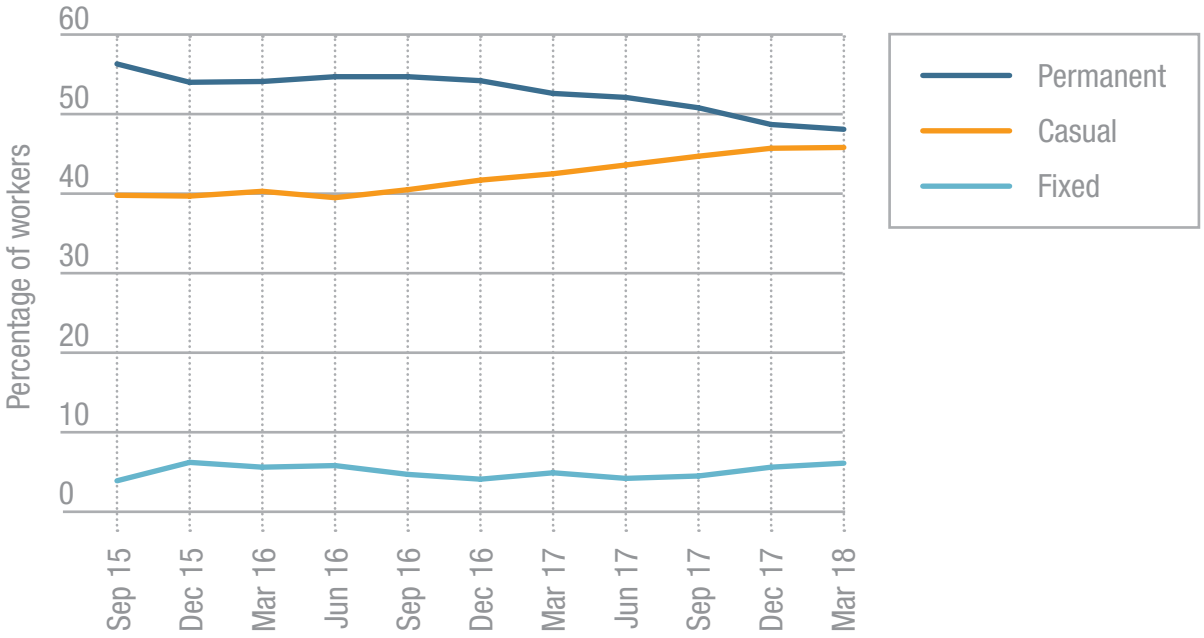
The latest data shows that most (48%) disability support workers are still employed on a permanent basis, whether part-time or full-time. However, the proportion continues to fall. Casual employment, alternatively, is rising and in March 2018 accounted for nearly half of the total workforce (see Figure 1).

Key points

- In September 2015, permanent workers made up 56% of the disability support workforce
- In March 2018, permanent workers made up 48% of the disability support workforce
- Casual employment as a proportion of the total increased from 40% in September 2015 to 46% in March 2018

Increased use of casual workers has been particularly notable in the last four quarters.

Figure 1: *Forms of employment*

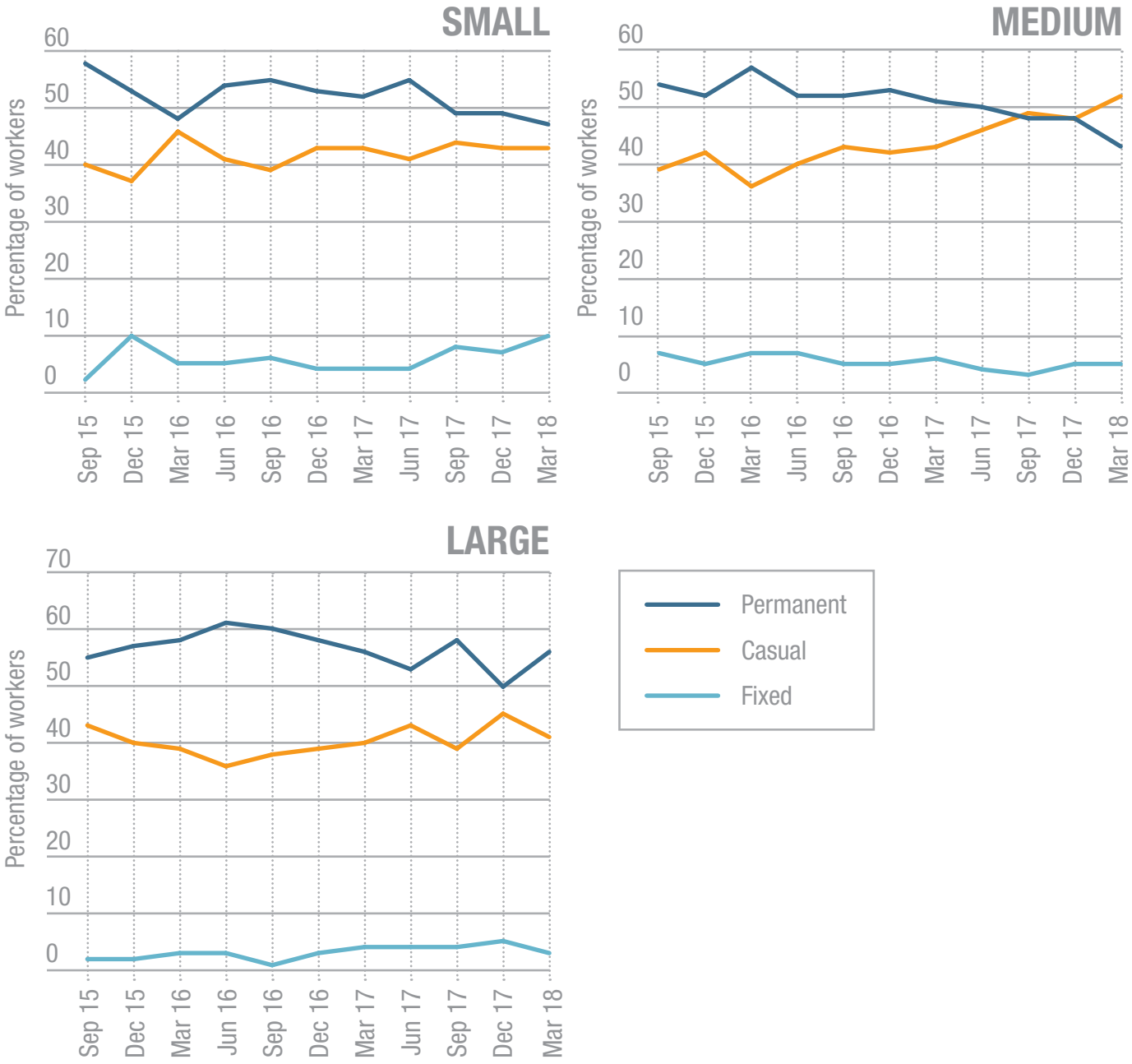


Small and medium organisations[1] — where casualisation takes place

The casualisation trend, however, is not universal. In the February 2018 Australian Disability Workforce Report (available at www.nds.workforce-hub/knowing-your-workforce), we observed that casualisation is more prevalent in small and medium organisations, with the trend absent in large organisations. This pattern has held.

In small organisations, the gap between permanent and casual employment shares has been closing since September 2017. In medium organisations, casual employment has already become the most common form of employment. Only in large organisations does a notable preference for permanent workers remain (see Figure 2).

Figure 2: *Forms of employment by organisation size*



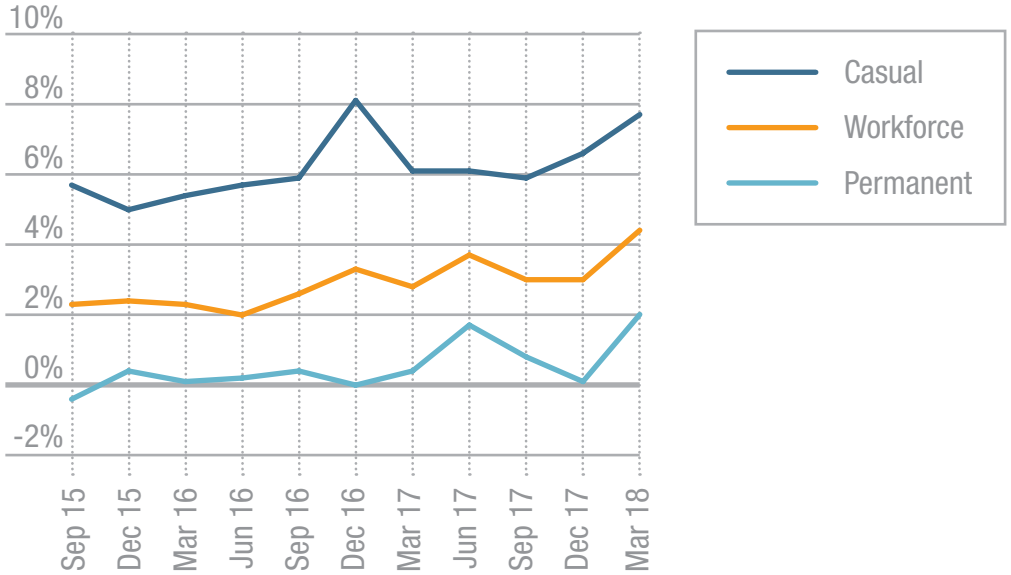
1 Organisational size is classified on the basis of the number of disability support workers in the organisation, as follows: Small = less than 50 workers; Medium = 50 to 199 workers; and Large = 200 or more workers.

Employment growth

The disability workforce has been growing strongly. According to NDS's February 2018 report, the disability support workforce growth rate was 11.1% per year (averaged over a two-year period between September 2015 and 2017). This compares with growth of just 1.6% for the Australian workforce as a whole at the time.

This remarkable growth rate came overwhelmingly from the recruitment of casual workers. The average permanent workforce growth rate was just 1.3% per year, while the casual growth rate was 26% per year.

Figure 3: *Quarterly workforce growth rate by form of employment*



During the December 2017 and March 2018 quarters, net workforce growth continued to be strong. Both the permanent and casual workforces grew at a stronger pace than in the earlier periods.

This is consistent with faster employment growth across the Australian economy, albeit not as fast as in disability. National employment growth (trend) was 2.6% between May 2017 to May 2018.[2]

Key points

- Overall, the disability support workforce grew by 13.8% in the 2017-18 financial year
- This reflected an average growth rate of 3.8% for the permanent component and 26.8% for the casual component.

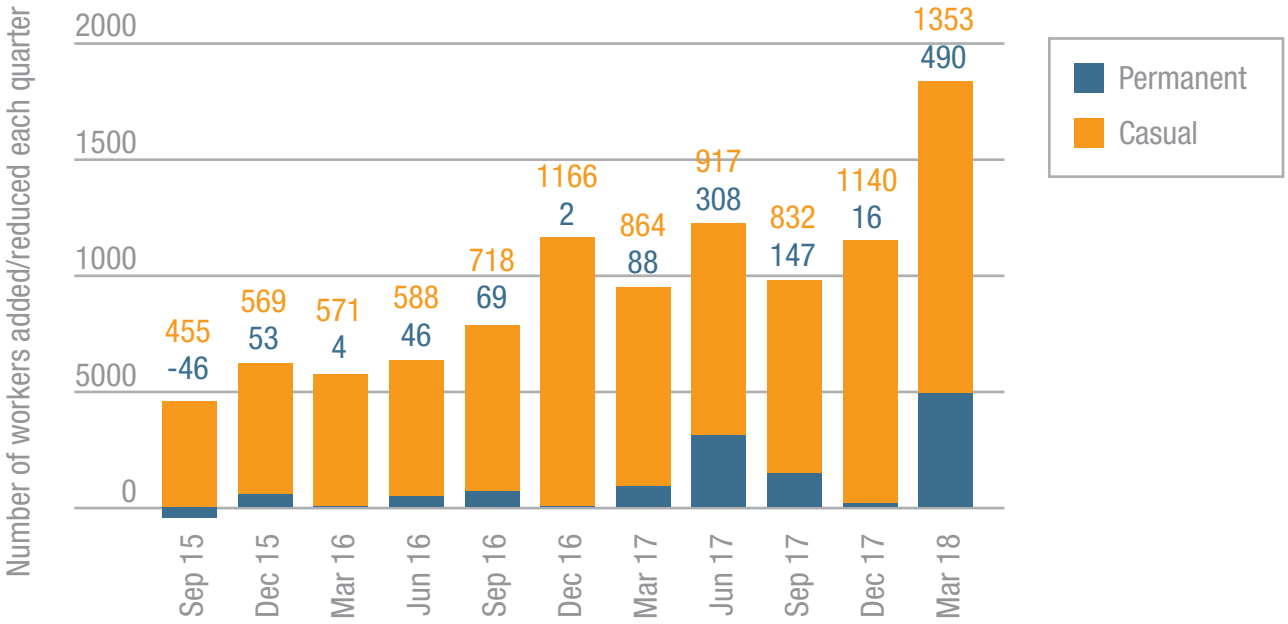
Employment gains and losses by organisational size

Of note is that in March 2018, Workforce Wizard data indicated a large net increase in permanent employment. This was due to one large organisation acquiring services previously provided by a public sector agency, as part of the NSW Government's divestment program.

Figure 4 shows the 'net component change' in the disability workforce. Employment losses in the sector tend to come from permanent workers departing while most of the gains are from increased recruitment of casuals.

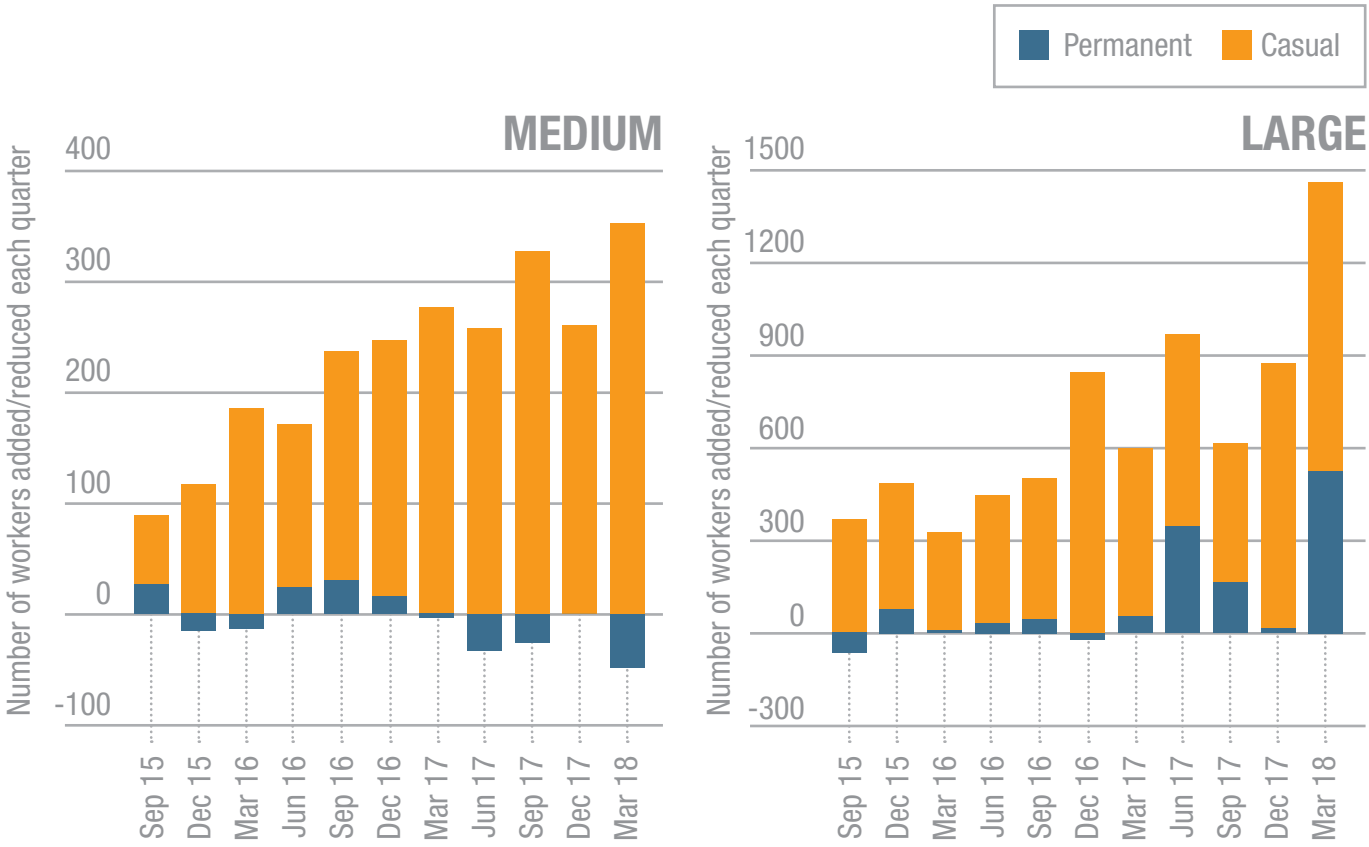
2 ABS, Labour Force Australia, Cat no. 6202.0, May 2018.

Figure 4: *Net change in permanent and casual staff*



The gain in permanent employment in March 2018 came mainly from large organisations, continuing the pattern described earlier. In medium size organisations, the proportion of casual workers also grew, sometimes at the expense of permanent employment, while in large organisations, both workforces grew, albeit at different speeds (see Figure 5).

Figure 5: *Net change in permanent and casual workers, by organisational size*



Workforce turnover

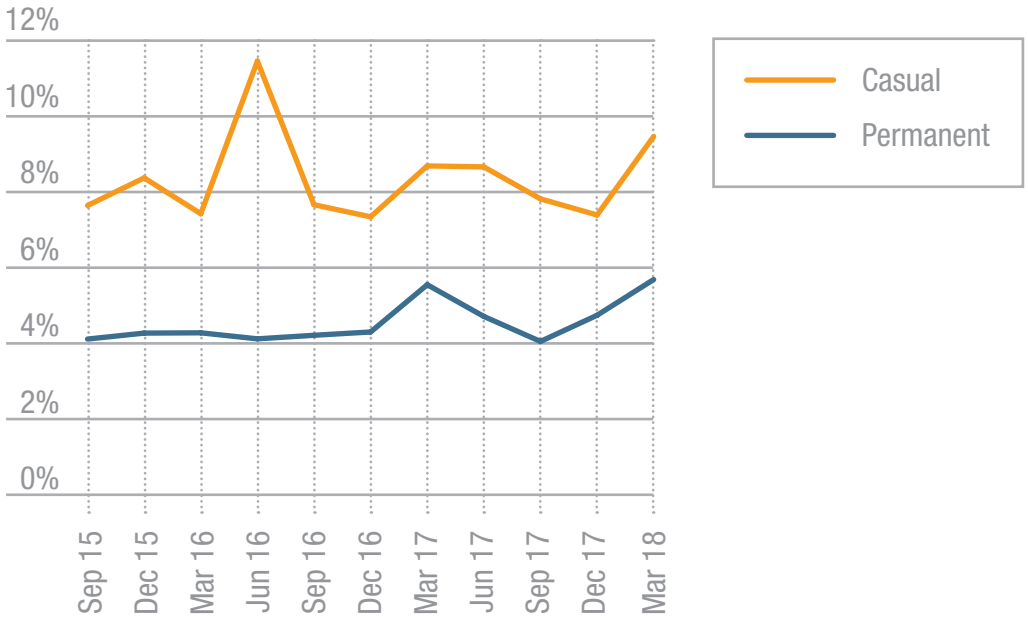
Workforce turnover[3] is inevitable as the personal circumstances of workers alter, and also organisations need different staff to adapt to changing environments.

However, high workforce turnover can reflect lower employee engagement, and also disrupt continuity of care, leaving clients less satisfied with the quality of service. Rapid turnover means more expenditure on recruitment and training.

Workforce Wizard has consistently shown casual workers to have considerably higher turnover rates than permanent workers. Historically, this has been a difference of four percentage points/quarter, or 16 percentage points/year.

In the last two quarters, both casual and permanent workforce turnover are trending upwards, as shown in Figure 6 below. This could be related to the more buoyant labour market and the accelerating NDIS rollout.

Figure 6: *Quarterly turnover rates by form of employment*



Key points

- In the two most recent quarters workforce turnover for permanent disability support workforce has averaged 5.2% per quarter
- Casual workforce turnover in the same period has been 8.5% per quarter

3 We measure workforce turnover as follows: the number of workers who leave an organisation during a quarter, as a percentage of the total number of workers, averaged over two recent quarters.

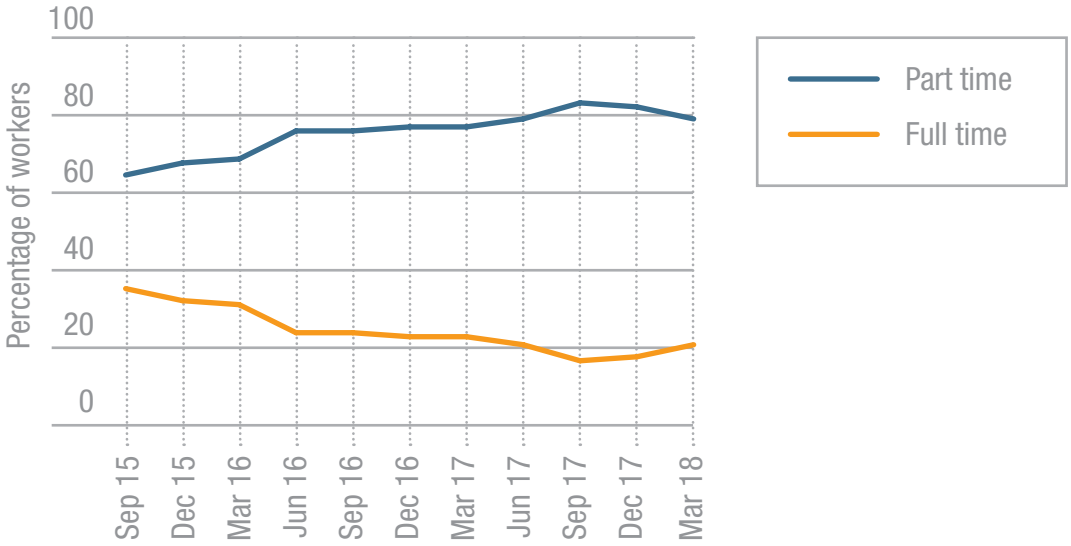
Working hours

In the February 2018 Australian Disability Workforce Report, we observed that the disability sector displays an intensified version of the part-time employment profile characteristic of the health care and social assistance sector.[4]

In the past two years, the proportion of permanent workers who worked part-time increased from 65% in September 2015 to 83% in September 2017.

In the most recent two quarters this trend reversed (see Figure 7) with part-time employment falling back to 79%.

Figure 7: *Full-time and part-time work: employment shares (%)*



In addition, the average hours worked by a disability support worker increased for the March 2018 quarter to 22 hours/week. This compares to 21 hours/week in the preceding two quarters. It remains to be seen whether this is a reversal of the previous falling hours trend, or simply a one-off variation.

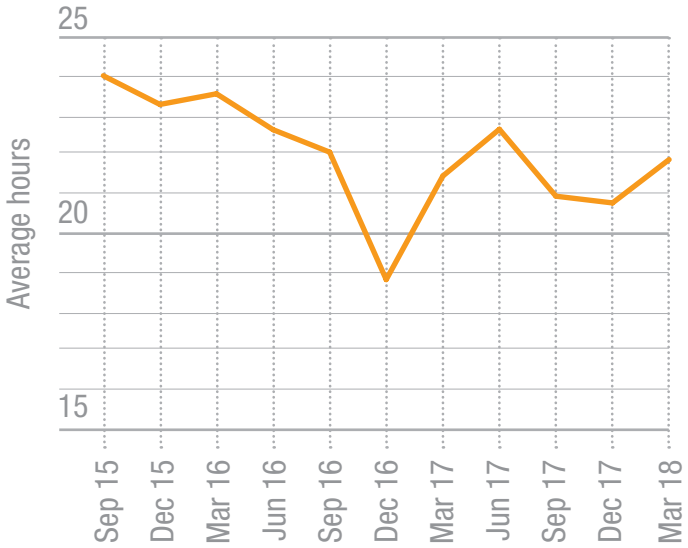
Previously, average hours have trended downwards from 24 hours per week in September 2015 to 21 hours per week at the end of 2017. The data shows some volatility which is likely due to the changing nature of the sample, and seasonal factors.

Recent ABS data indicates that while employment growth has been relatively strong, utilisation rates have changed little. In the health care and social assistance industry, average hours per job remained lower at the end of 2017 than in 2010. This industry had the second lowest hours per job of the 19 ABS industry categories.[5]

4 Part-time workers refer to workers who work less than 38 hours, while full-time workers refer to workers who work 38 hours or more.

5 ABS, Labour Account Australia, Quarterly Experimental Estimates, Cat no. 6150.0.55.003, Sept 2018.

Figure 8: *Average hours of work per week per worker*



Key points

- Full-time work, which has been falling in the disability support workforce has recovered slightly in the March 2018 quarter
- Average working hours also rose slightly, to 22 hours/week.

Summary

In this mid-year analysis, trends observed in previous reports are again evident. The casual workforce has grown strongly. Casual workers continue to have a higher turnover than permanent workers. The different strategies employed by organisations of different sizes to cope with flexible demands appear to persist.

The March 2018 quarter has however been a period of strong sustained growth, more rapid even than in the past. Perhaps as a result, we see two new trends:

- a substantial net increase in the permanent workforce; and
- a minor reversal of the trend of increasing part-time work, coupled with declining working hours

It is not yet clear if the longer term trajectory of the disability workforce is shifting or if these are one-off reversals. However, it is undoubtedly the case that disability providers are experimenting with their workforce strategy, switching between forms of employment and approaches to employee engagement to obtain the best balance between client, worker and financial imperatives.

In the following chapter, we will examine the patterns of disability workforce in the states and territories.

Chapter 2: The disability workforce in the states and territories

Workforce casualisation — a converging trend

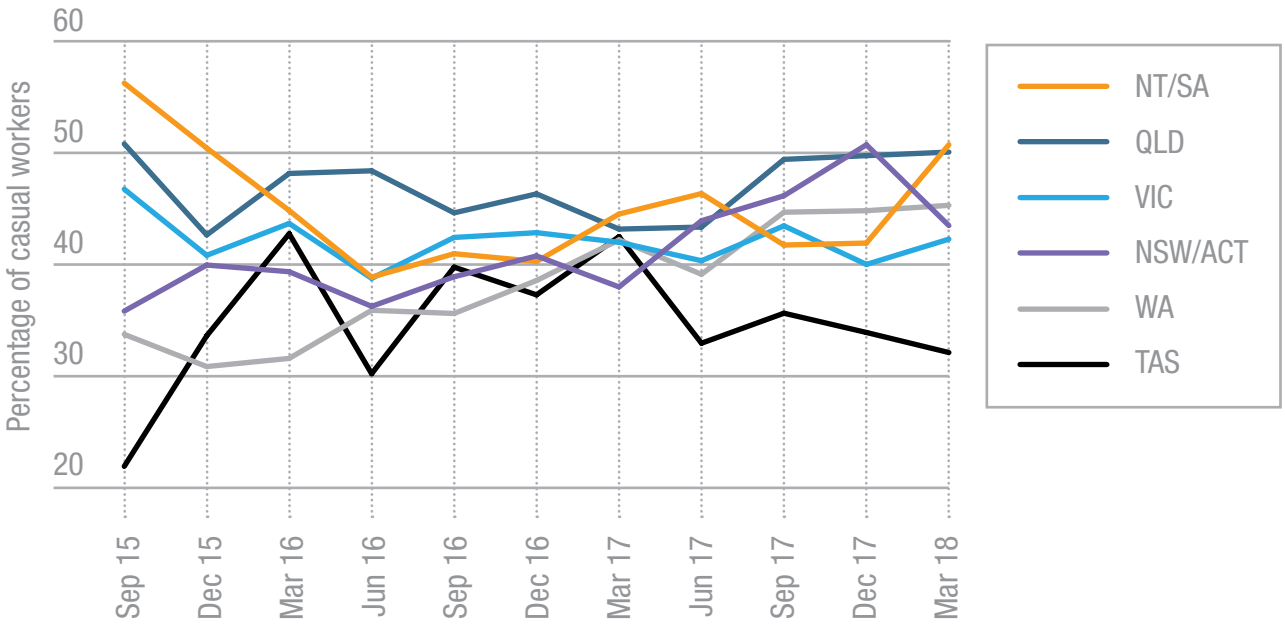
The analysis in Chapter 1 shows that there is a slow but steady trend towards casualisation in Australia. Is this trend universal in each state and territory?

In fact casualisation has risen substantially in most states, including Western Australia and NSW/ACT, which employed fewer casual workers in the beginning of the period. Casual employment growth tended to be lower in states where the employment of casuals was already high, such as Victoria. Note that Tasmania shows fluctuations which are probably due to the small sample size.

Key point

- Casualisation appears to be a converging trend; states where fewer casuals were employed have been catching up with states which had higher rates of casual employment in the first place.

Figure 9: *The proportion of casual workers by state*

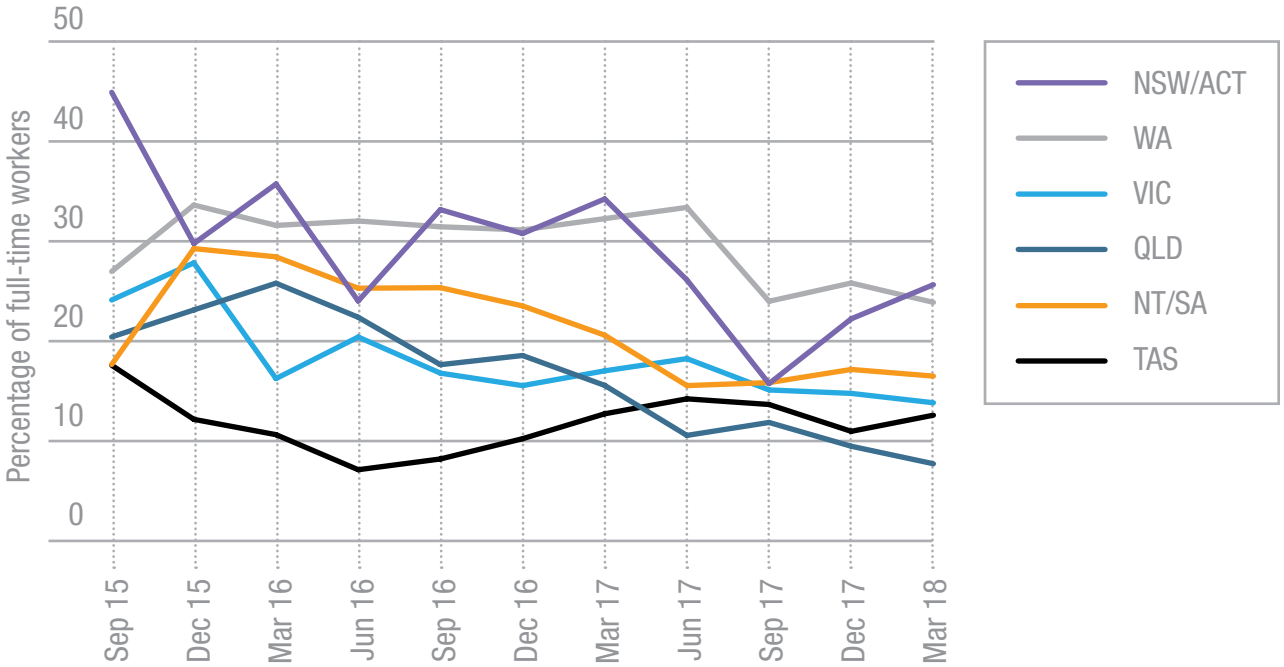


Western Australia charts a different course on forms of employment

The changing share of full-time and part-time employment work however is not standard across the states and territories.

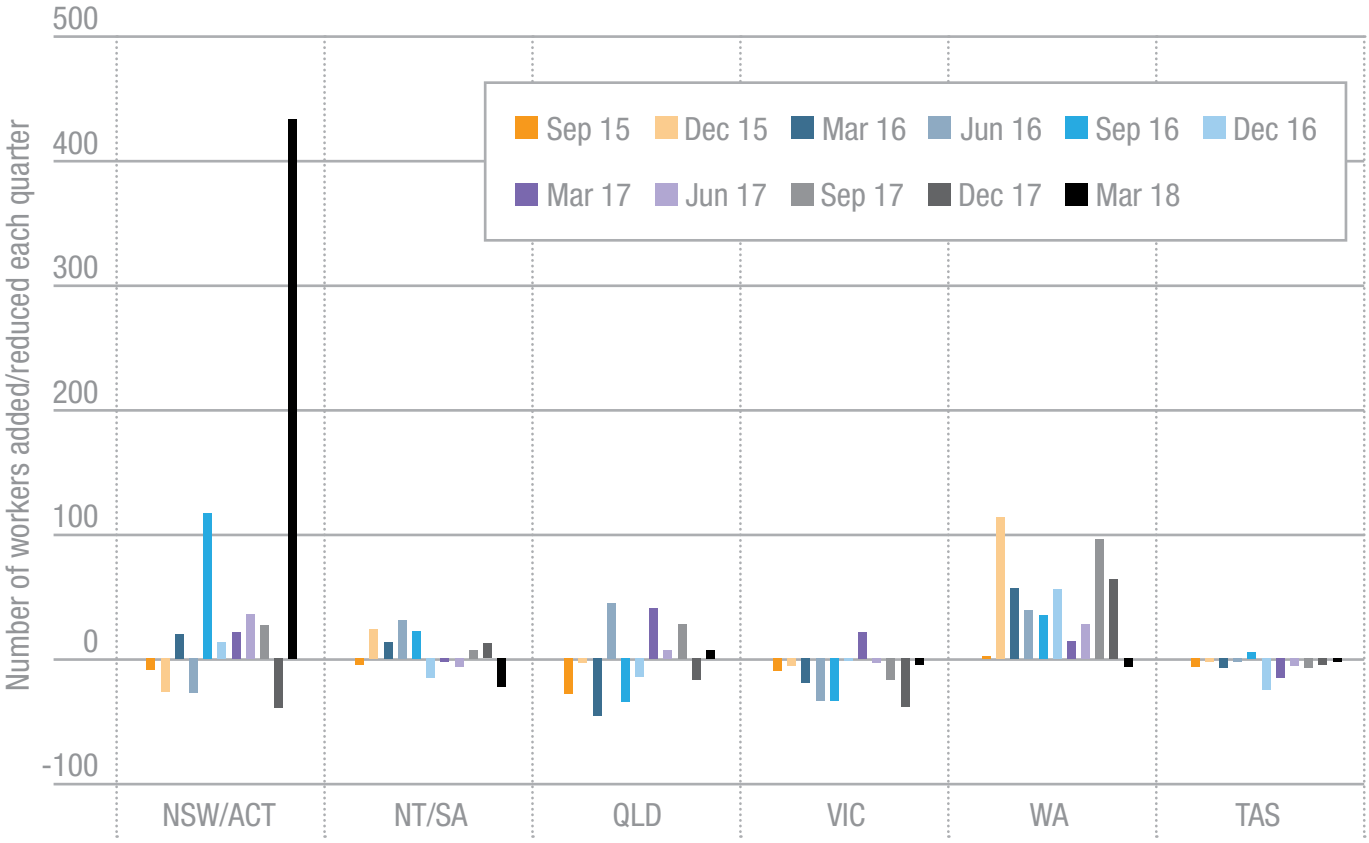
The decline in full-time work is only marked in Queensland, NT/SA and to a certain extent, Victoria. Western Australia has maintained a relatively high proportion of full-time workers, compared to the rest of the country. Tasmania, on the other hand, has a much lower proportion of full-time workers throughout the period. Recently, Queensland overtook Tasmania as the state with the lowest proportion of full-time workers in the permanent disability workforce (See Figure 10).

Figure 10: *The proportion of full-time employment in the permanent disability workforce*



In Figure 11, the net change in permanent workers shifts between positive and negative growth in all states, with the exception of Western Australia. In Western Australia, the permanent workforce has grown in all quarters except March 2018. Tasmania, on the contrary, has negative growth of permanent workers in all but one quarter.

Figure 11: *Net change in permanent workers, by state*



Workforce turnover

The 11-quarter average turnover rate for permanent workers in Australia is about 4.6% per quarter. This rate remains reasonably stable across states and quarters. Casual turnover at nearly 8.5% per quarter, on average, which is higher and more volatile. Western Australia has the highest casual workforce turnover rate, with double digit rates in seven of the last 11 quarters. This could be linked to Western Australia's lower reliance on casual workers than other states.

Figure 12: *Quarterly turnover rates of permanent workers, by state*

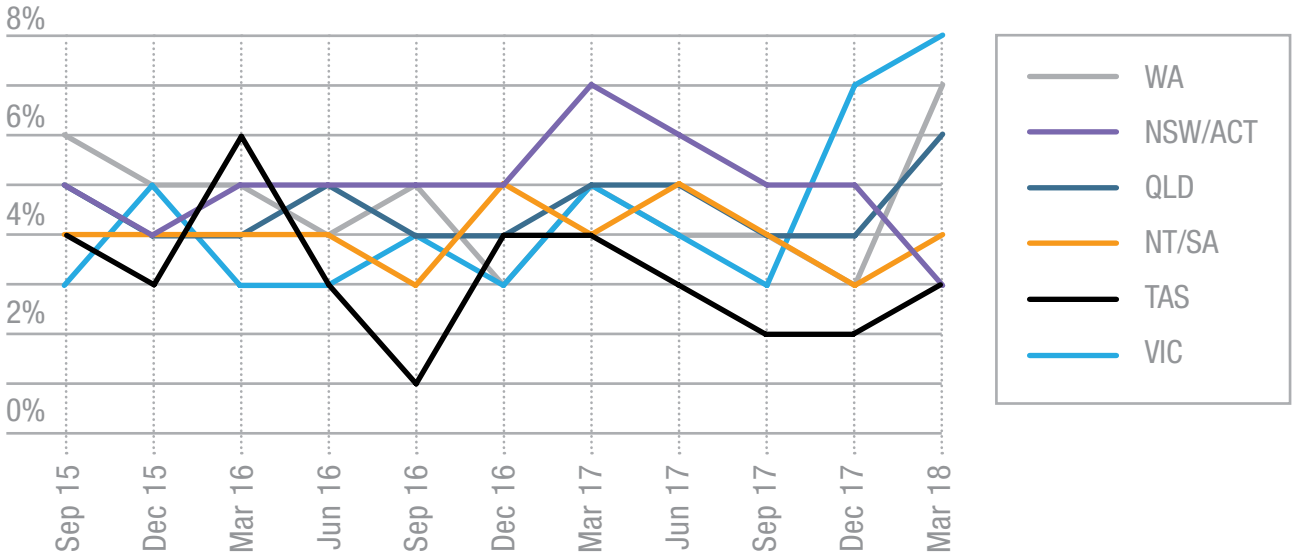
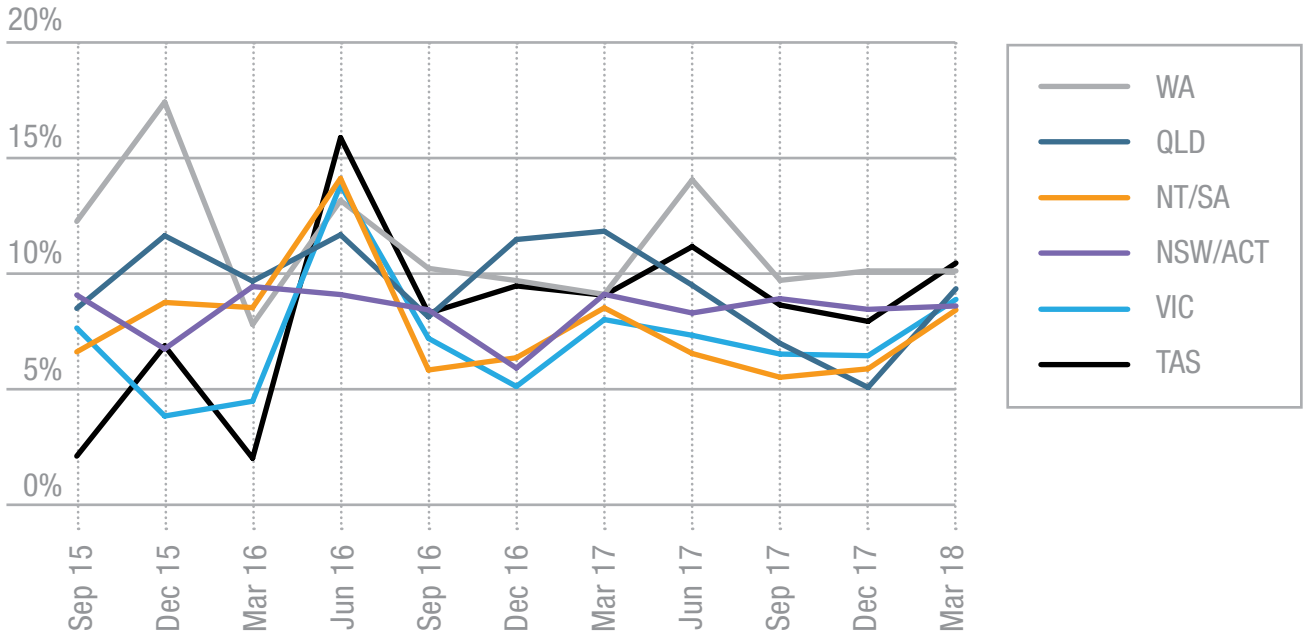


Figure 13: *Quarterly turnover rates of casual workers, by state*



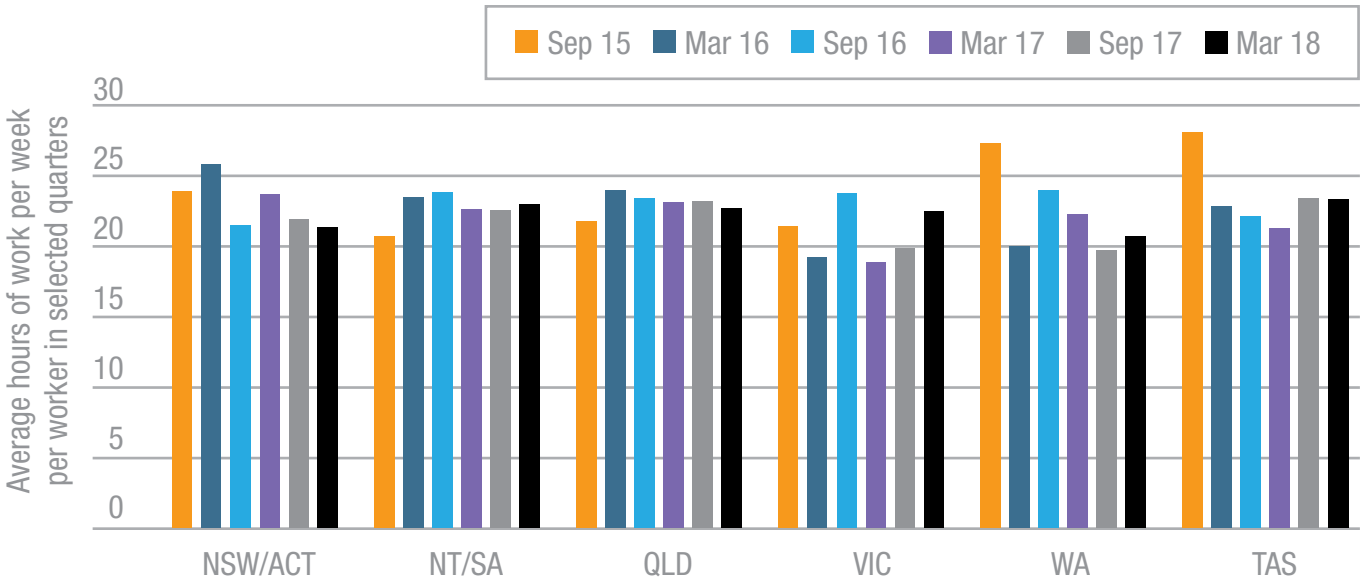
Working hours variability

The average permanent disability worker works 22 hours per week. As Figure 14 shows, there is some variation between states and considerable volatility.

Key points

- Victoria has the lowest working hours, with average hours dropping to 21 hours or below in seven out of the past eleven quarters
- In contrast, workers in NT/SA and Queensland, on average, worked 22 hours or more in all quarters except December 2016
- There appears to be a declining trend in working hours in NSW/ACT and Western Australia, but this trend is not clear in other states.

Figure 14: *Average hours of work per week per worker in selected quarters*



Consistent gender and age disparities

The female-to-male ratio in the disability support workforce is 7:3.

Key point

- The gender ratio is roughly the same in all states and has been stable for the past eleven quarters.

Similarly, the disability support workforce is older than the Australian workforce as a whole across the country.

Key points

Australian workers over 45 years old make up around 34% of the total workforce[6]. By comparison,

- the 'youngest' state is Western Australia where disability workers over 45 years old made up 40% of the workforce in March 2018
- in Queensland, which has the oldest disability workforce, workers of this age group made up of nearly half of the workforce (49%) in March 2018.

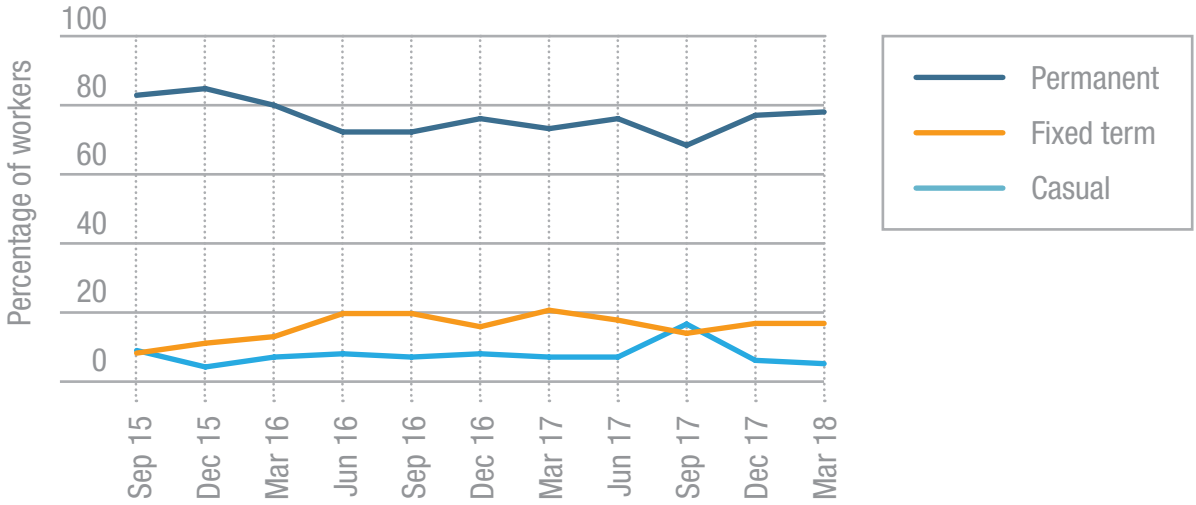
6 ABS, Labour Force, Australia, Detailed, Quarterly, May 2018. Cat. No. 6291.0.55.003.

Chapter 3: The profile of the allied health professionals

Forms of employment

Unlike disability support workers, casual employment is uncommon among allied health workers. Fixed-term employment has risen in recent years - from 8% in September 2015 to 17% in March 2018. However, permanent employment remains the dominant form of employment for allied health workers.

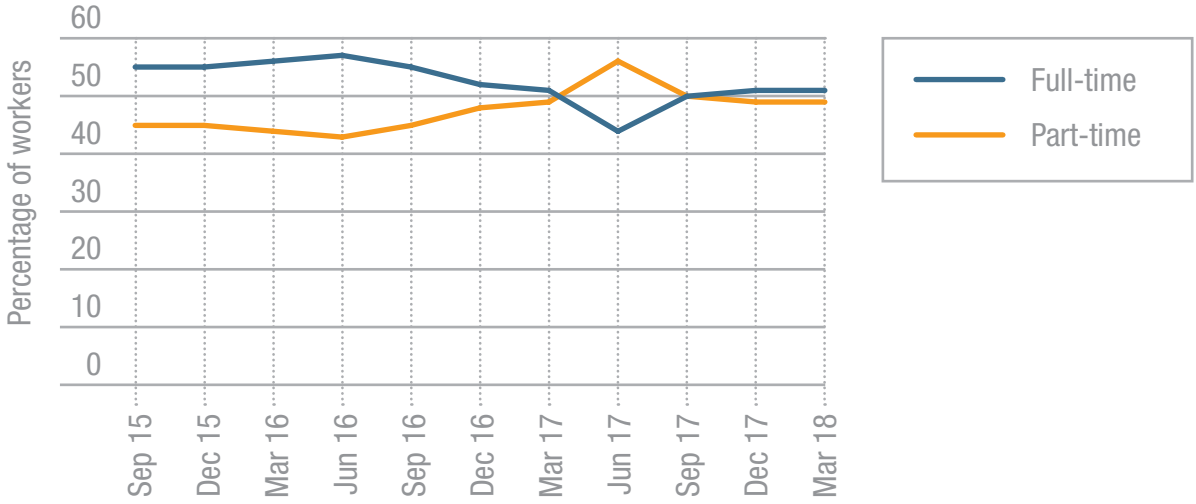
Figure 15: *Forms of employment*



Part-time work has been increasing among allied health professionals as in the support workforce, although the rate of increase has been much less.

In September 2015, full-time employment was a little more common than part-time, making up 55% of the permanent workforce. More recently, the shares of full-time and part-time employment have equalised (see Figure 16).

Figure 16: *Full-time and part-time allied health professionals: employment shares (%)*

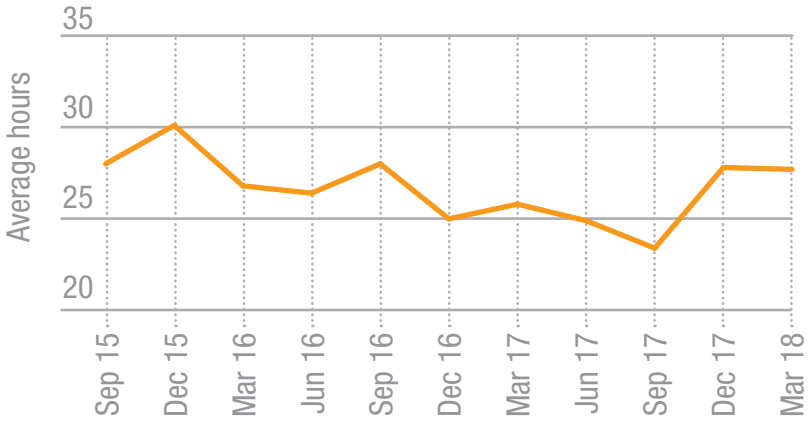


More positively, Figure 17 indicates that the long-term downward trend in working hours among allied health workers has reversed in the last two quarters.

Key point

- In March 2018, allied health professionals worked on average 28 hours per worker per week – the same amount as in September 2015.

Figure 17: *Average hours of work per week per worker*

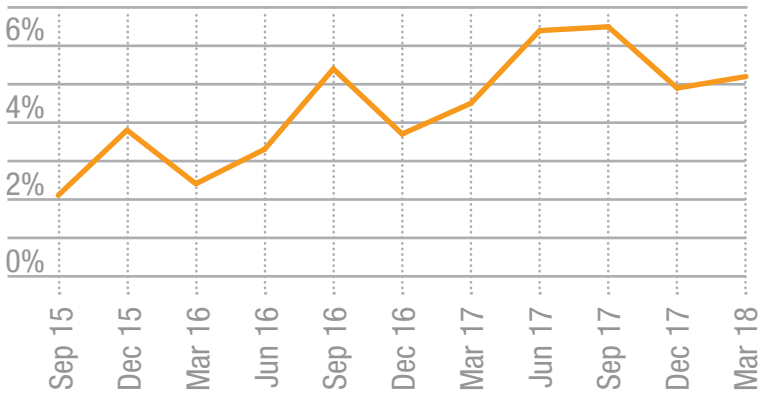


Workforce turnover

The turnover rate[7] of the permanent allied health workforce is lower than that of the direct support workforce in the period between September 2015 and June 2016. However, workforce turnover trends upwards after June 2016, as shown in Figure 18. Allied health professionals appear to be changing jobs more frequently as the NDIS rolls out.

Since they are an expensive workforce to recruit, on-board and induct, and may take clients with them when they move, workforce instability can have a negative impact on providers.

Figure 18: *Quarterly turnover rate of permanent allied health workforce*



7 Due to the small sample size of allied health workforces, the quarterly workforce turnover rates of permanent allied health workforces using the organisational average tend to be volatile. Hence, a different measure is used. The turnover rates presented here are measured by the aggregate number of permanent workers who left the workforce as a proportion of all permanent workers in a quarter. The trend of increasing turnover rates is notable in both measurements of workforce turnover.

The age and gender profile of allied health professionals

The allied health workforce is overwhelmingly female. In March 2018, 93% of allied health professionals were women.

It is also a remarkably young workforce. In March 2018, 70% of allied health workers were in the middle years of 25 to 44. Only 21% of the workers were older than 45 years, relatively fewer than the Australian workforce generally[8] (34%) and the disability support workforce (45%).

8 ABS, Labour Force, Australia, Detailed, Quarterly, May 2018, Cat. No. 6291.0.55.003.

Chapter 4: Spotlight topics

Introduction

Each quarter the Workforce Wizard 'Spotlight Topic' shines a light on an issue of importance to the sector but not suitable for quarterly tracking. Some of these topics are repeated every one or two years to provide the sector a long-term perspective on them. NDS is particularly grateful to disability organisations for providing answers to these occasional questions, as they require extra effort to complete.

In December 2017, the qualifications of new recruits was the Spotlight Topic, while in the March 2018 quarter it was recruitment difficulty. The results are summarised below (reporting is also provided to Workforce Wizard users on closure of the data entry period).

Spotlight Topic 1: The qualifications of newly recruited disability workers

Nearly two-thirds of all users (65%) responded to the December 2017 questions asked about the qualifications of newly recruited disability support workers.

How many new recruits are formally qualified?

Providers reported that approximately one in five new recruits had a disability-related qualification (Certificate III and above). Among 3,246 newly recruited disability support workers, around 660 people had a disability-related qualification.

This appeared to be at least in part a matter of employer policy. In a sizable portion of workforces all new recruits had a disability-related qualification (24%). On the other hand, an equally substantial portion (20%) did not recruit any new workers with formal qualifications. See Table 1.

Table 1: *Disability workforces by new recruits with a disability-related qualification*

New workers who had a disability related qualification	Disability workforces (%)
All new recruits	24
75% - 99% of new recruits	4
50% - 74% of new recruits	18
25% - 49% of new recruits	18
1% - 24% of new recruits	15
No new recruits	20

Small organisations[9] were more likely to recruit people with a disability-related certificate qualification. A third of workforces in small organisations (33%) had all new recruits with a disability-related qualification, while only 14 per cent of medium to large organisations and none of the large organisations had this level of formally qualified new recruits.[10]

How states vary in the level of qualified new recruits

Most states and territories are in line with the national average, 21%. Victoria has the highest level of formally qualified workers (30%), while Queensland has the lowest (15%).

Table 2: *Newly recruited workers with a disability-related qualification, by state and territory*

State or territory	Formally qualified new workers (%)
Victoria	30
Northern Territory	24
NSW/ACT	23
South Australia	22
Tasmania	21
Western Australia	20
Queensland	15
Multi-state	14
Total	**21**

Spotlight Topic 2: Recruitment difficulty

The same three recruitment difficulty questions were asked as Spotlight Topics in the March 2017 and March 2018 quarters. Over 90 per cent of users who entered data on their disability support workforce also responded to these questions. In 2018 there were 176 valid responses.

Level of recruitment activity

Nearly fourth-fifths of organisations (79 per cent) indicated that they advertised to fill at least one disability support worker position in the March 2018 quarter, a little higher than 12 months before (76 per cent).

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9 Small organisations are those with less than 50 disability support workers. Medium organisations are those with 50 to 199 disability support workers. Large organisations are those with more than 200 disability support workers.

10 The figures for large organisations need to be used with caution. Only 6 workforces from large organisations provided data on this question. The numbers of workforces in small, small-to medium, medium to large organisations which provided data are 42, 46 and 43 respectively.

Organisations in every state except NSW had become more active in recruitment in the March 2018 quarter. In 2017, NSW was the most active state in recruiting direct support workers (88% of organisations advertised to recruit in the March 2017 quarter). However, NSW was the least active state in the March 2018 quarter (71% of organisations advertised to recruit). Not surprisingly, multi-state organisations were most active in recruitment, with almost all organisations advertising to fill a position (94%).

Table 3: *Recruiting organisations, by state, March 2018 & 2017 quarters*

State	Yes, we recruited to fill DSW roles (%)		Number of organisations responding	
	March 18	March 17	March 18	March 17
Multi-state	94	75	16	12
South Australia	89	75	18	20
Western Australia	86	82	29	33
Queensland	82	70	28	33
Victoria	74	68	35	44
New South Wales	71	88	35	33
Other states & territories	N/A	N/A	15	17
Total	**79**	**76**	**176**	**192**

Were employers successful in filling their vacancies?

Seven out of ten organisations (70 per cent) were able to fill all disability support positions advertised in the March 2018 quarter. Recruitment has become a little easier than a year before when 65 percent of organisations were able to fill all advertised positions.

The level of difficulty varied across the states. For example, Western Australia, which had the lowest rate of filled vacancies (56%) in the March 2017 quarter, became the state with the highest rate (75%) this quarter. Queensland, alternatively, had the highest rate (79%) in the March 2017 quarter but dropped to below the national average (67%) in 2018. South Australia had the lowest rate of filled vacancies in the March 2018 quarter, with only 53% of organisations saying they had filled all advertised positions.

A handful of organisations (3.6%) indicated that direct support worker positions are advertised all year around and that they have no recruitment limit, rather taking all suitable candidates.

Table 4: *Organisations with advertised positions filled/unfilled, March 2018 and 2017 quarters, by state (%)*

State	Filled (%)		Unfilled (%)		n	
	March 18	March 17	March 18	March 17	March 18	March 17
Multi-state	80	N/A	20	N/A	10	N/A
Western Australia	75	56	25	44	24	25
Victoria	73	62	27	38	26	29
Queensland	67	79	33	21	21	19
New South Wales	65	67	35	33	23	27
South Australia	53	64	47	36	15	14
Other states & territories	N/A	N/A	N/A	N/A	9	19
Total	**70**	**65**	**30**	**35**	**128**	**133**

Note: n is the number of organisations in the sample. A small proportion (7 per cent) of users did not answer whether or not their advertised positions were filled.

The ratio of filled positions to unfilled vacancies in the March 2018 quarter was 12.3. This was higher than March 2017 quarter (11.4), consistent with earlier results, suggesting organisations are now more able to fill their advertised positions than a year ago. Since there has not been a significant change in unemployment or underemployment rates, this result may reflect improved recruitment techniques learned through experience.

Reasons for unfilled vacancies

The reasons given for unfilled vacancies are similar in the March 2018 and the March 2017 quarters:

- the lack of suitable or qualified candidates was the most cited reason (43%), followed by
- candidates being unable or unwilling to meet specific job requirements (29%)
- geographical factors (13%)
- poor employment conditions and/or job prospects (9%).

Similar to the results a year ago, a number of responses advised that the advertised roles required one or more of the following:

- specific job skills or experiences (e.g. behaviour support for clients with complex needs)
- personality or demographic characteristics that match customer preferences
- ability to work flexible hours in order to fit shifts that align with client needs.

Some organisations (13% in 2017 and 9% in 2018) mentioned poor employment conditions, especially the lack of permanent full-time roles, short working hours and low rates of pay as possible reasons for unfilled vacancies.

Table 5: *Reasons positions were unfilled at the end of the recruitment round*

Reason given	%		n	
	March 18	March 17	March 18	March 17
Lack of suitable/qualified candidates	43	29	24	20
Candidates unable/unwilling to meet job requirements	29	22	16	15
Geographical factors	13	13	7	9
Poor employment conditions and/or job prospects	9	13	5	9
Organisational factors	2	9	1	6
Limited labour supply for the expanding vacancies	2	7	1	5
Seasonal factors	0	3	0	2
Total (including other)	**100**	**100**	**57**	**69**

Notes: n is the number of times the reason was cited. This was an open-ended question so a respondent could mention more than one factor.

It is important to note that the success rate of filled vacancies is only one way of measuring recruitment difficulty. Indeed, a number of organisations remarked that even though they were successful in filling all advertised positions, they did so reluctantly by recruiting unqualified staff just to meet the growing demand. In other words, there are 'hidden recruitment difficulties' not picked up through this data.

Recruiting allied health professionals

Twenty five out of 26 organisations which entered data on allied health professionals responded to the Spotlight Topics on recruitment difficulty (96 per cent). Of these, 20 respondents indicated that they advertised to fill an allied health professional position in the March 2018 quarter (80%). This was more than in the March 2017 quarter, when only 62 per cent of organisations did so.

While more organisations advertised, a smaller proportion of them were successful in filling all the vacancies. Only eight out of eighteen organisations (44%) were able to fill all advertised positions, compared to 64% in the March 2017 quarter.

An estimated 27 allied health professional positions were unfilled (from 9 organisations reporting unfilled vacancies) in the March 2018 quarter, while 88 permanent and casual allied health positions were filled. In the March 2017, an estimated 10 positions were unfilled (from 4 organisations reporting unfilled vacancies), while 64 permanent and casual positions were filled. Note the sample size of allied health workforces is small in both quarters, hence, a direct comparison on the number of filled and unfilled positions between these the quarters is not recommended.

Some of the challenges in recruiting allied health professionals are similar to those faced by organisations recruiting disability support workers. They include the lack of suitable/qualified candidates, poor pay and rural and

remote locations. A number of responses mentioned that the salary they can offer is unattractive when compared with the private sector or the adjacent aged care sector.

Unlike disability support workers, increasing specificity in job requirements was not mentioned as a problem for organisations employing allied health professionals. A number of organisations did look for allied health professionals with specific professional skills which were an ongoing problem for them to locate.

Summary

The results indicate the difficulty experienced by organisations in the disability sector in employing allied health professionals.

This result echoes the NDS Market Survey 2017, which found that organisations ranked allied health employees as the most difficult group to recruit.[11] Providers reported 'extreme difficulty' in recruiting specific allied health professions, with the following percentages saying this about:

- psychologists (41%)
- physiotherapists (36%)
- occupational therapists (27%)
- speech therapists (25%)

The NDIS rollout and state government divestment of services previously provided by public sector agencies means the disability sector is an industry growing quickly, rich with new jobs. It is not surprising that recruitment is a key focus for most services, with many experimenting with new ways to creatively source and attract workers.

Workforce Wizard Spotlight Topic data highlights the volume of recruitment activity occurring, and the relative success providers are having with front line workers. Attracting allied health professionals to the sector is a different story, despite the fact that the number of registered professionals in Australia has been growing at a healthy rate in recent years.

As disability providers become more used to the NDIS and the pace of change eases, it will be important for them to focus as strongly on techniques to keep workers as to recruit them. Recently turnover rates have been increasing in both the disability support and allied health workforces. The next Australian Disability Workforce Report will address this issue in more depth.

11 NDS State of the Disability Sector 2017, Figure 20, page 49.

Appendix

Sample size, Workforce Wizard users each quarter

Table A: *Number of organisations (direct support workforce), by state*

	NSW/ACT	NT/SA	QLD	VIC	WA	TAS	**Total**
Sep 15	47	10	16	20	9	8	**110**
Dec 15	39	16	26	21	15	5	**122**
Mar 16	47	14	28	26	24	5	**144**
Jun 16	52	22	35	30	16	10	**165**
Sep 16	49	23	37	38	21	7	**175**
Dec 16	40	26	36	38	28	10	**178**
Mar 17	34	26	34	46	31	8	**179**
Jun 17	37	30	32	41	33	11	**184**
Sep 17	33	23	29	40	29	9	**163**
Dec 17	37	25	35	39	29	8	**173**
Mar 18	43	24	28	41	32	8	**176**

Table B: *Number of organisations (allied health workforce)*

	Australia
Sep 15	10
Dec 15	9
Mar 16	11
Jun 16	9
Sep 16	10
Dec 16	10
Mar 17	11
Jun 17	14
Sep 17	8
Dec 17	8
Mar 18	11

National Disability Services

NDIS Price Guide 2019-20

Valid from: 1 October 2019

(Version 1.3 – Publication Date: 1/10/2019)

Delivered by the National Disability Insurance Agency

Version Control

The NDIS Price Guide is subject to change. The latest version of the NDIS Price Guide is available on the NDIS website.

Version	Page.	Details of Amendment	Date
1.0			25 June 2019
1.1	6	• Text added to clarify the link between the Price Guide and the Support Catalogue	28 June 2019
	12	• Text added to clarify that non-registered providers are not eligible for the TTP.	
	13	• Text added to better distinguish between Core travel and Capacity Building travel • Added 4 examples of the application of the travel rules	
	18	• Text added to clarify that “no shows” are treated as short notice cancellations. • Added an example of the application of the cancellation rules;	
	29	• Price limits in the Support Catalogue for group-based supports have been substantially revised. • Text added to clarify that providers of group-based supports are not permitted to bill for non-face-to-face services as the hourly price limits for these supports include an allowance for non-face-to-face services.	
	39	• Further text added on Employment Related Assessment and Counselling supports.	
	39	• Further text added on Workplace Assistance supports.	
1.2	10	• Update reference and link to the MMM website.	23 Sep 2019
	11	• Added definition and list of isolated towns that were reclassified as Remote locations	
	15	• Inclusion of Participant Transport examples for claiming purposes.	
	20	• Included information on Disability Related Health Supports	
	25	• Content update for Supported Independent Living (SIL) providers using the latest SIL Tool template.	
	46	• Content updates for Early Childhood Early Intervention (ECEI).	
	47	• Included information on nursing support items	
1.3	23	• Terminology change from Weekday Evening to Weekday Afternoon.	1 Oct 2019
	38	• Clarification on claim types applicable to these supports.	

Contents

Scope of the NDIS Price Guide

Where possible, the National Disability Insurance Agency (NDIA) utilises market mechanisms to deliver the level of supply required by the he National Disability Insurance Scheme (NDIS) to meet participant demand and deliver the correct mix of goods/services, produced at market clearing (efficient) prices. However, in underdeveloped or non-existent markets, reliance on a deregulated market mechanism may not meet participant demands; may not deliver adequate supply; may not deliver the correct mix of disability supports and may not produce efficient prices. To address these issues, the NDIA has a role, as market steward, to create an efficient and sustainable marketplace through a diverse and competitive range of suppliers who are able to meet the needs of a consumer driven market.

As part of its market stewardship role, the NDIA imposes price controls on some supports by limiting the prices that registered providers can charge for those supports and by specifying the circumstances in which registered providers can charge participants for supports. Price controls are in place to ensure that participants receive value for money in the supports that they receive. In the short to medium term, price controls are required for some disability supports because the markets for disability goods and services is not yet fully developed. The longer-term goal of the NDIA is to remove regulatory mechanisms from the markets for disability supports.

This Price Guide is a summary of NDIS price limits and the associated pricing arrangements that will apply from 1 July 2019 as set by the NDIA. It is designed to assist participants and disability support providers, both current and prospective, to understand the way that price controls for supports and services work in the NDIS. The price limits within this Price Guide are the maximum prices that Registered Providers can charge NDIS participants for specific supports. There is no requirement for providers to charge at the maximum price for a given support or service. Participants and providers are free to negotiate lower prices.

Currently, the NDIA varies its approach to the regulation of prices, depending on market conditions, between:

- **No regulation** (deregulated markets): this is typically used in cases where markets are highly competitive – for example, transport.
- **The imposition of price limits**: these represent a maximum allowable price payable by participants for types of supports. This approach is used in a significant number of markets, which are still developing and growing, such as those for attendant care.
- **Quotable supports**: in which participants are expected to obtain quotations from suppliers to provide to the NDIA, which will verify that the prices are fair and reasonable. This approach is typically used in the case of highly specialised, differentiated supports that may not have a high level of competition – for example, assistive technology. They are also used in cases, such as supported independent living, where a bundle of supports is being purchased.

This Price Guide is principally concerned with the rules that apply to NDIS supports that are subject to price limits.

A comprehensive list of all NDIS supports (“the Support Catalogue”) is at https://www.ndis.gov.au/providers/price-guides-and-information.

The Support Catalogue:

- **includes item descriptors to assist providers to claim payments using a "best-fit" approach, and to assist participants in engaging and negotiating with service providers; and**
- **lists the price limits of those support items that are subject to price limits.**

In general, support items subject to price controls have a single national price limit. However, some Capacity Building supports have two price limits: one for New South Wales, Victoria, Queensland and the Australian Capital Territory; and a different price limit for South Australia, Western Australia, Tasmania and the Northern Territory.

The NDIA publishes separate price guides for:

- Assistive Technology at https://www.ndis.gov.au/providers/essentials-providers-working-ndia/providing-assistive-technologies-and-home-modifications
- Specialist Disability Accommodation at https://www.ndis.gov.au/providers/essentials-providers-working-ndia/specialist-disability-accommodation

Application of this Price Guide

The price limits and other arrangements in this Guide must be followed when supports are delivered to NDIS participants who have either an agency-managed plan or a plan manager.

A provider of supports to a participant with an agency-managed plan (or of a support that is agency managed):

- must be a registered provider with the NDIS;
- must declare relevant prices to participants before delivering a service, including any notice periods or cancellation terms;
- must adhere to the arrangements in the Price Guide, including ensuring that their prices do not exceed the price limits prescribed in the Pricing Guide

Plan managers can purchase supports on behalf of participants from either registered or unregistered providers, but they are registered providers themselves, and therefore responsible for ensuring that prices paid for supports on behalf of their participants adhere to the arrangements in the Price Guide, including price limits.

Self-managing participants can use registered or unregistered providers and are not subject to the pricing arrangements in the Price Guide.

In addition, all registered providers, regardless of whether funding for the support is managed by the participant, by a registered provider, or by the NDIA, must not add any other charge to the cost of the supports they provide, including credit card surcharges, or any additional fees including any 'gap' fees, late payment fees or cancellation fees.

Support Purposes, Categories and Line Items

This section describes the way that the NDIS categorises disability supports. These categories can be relevant to rules for participants about how they can spend their support budgets, and for providers when seeking payment for delivered supports.

Support Purpose Types

NDIS participant budgets can be allocated to three separate types of support purpose:

1. CORE – Supports that enable participants to complete activities of daily living. Participant budgets often have a lot of flexibility to choose specific supports with their core support budgets, but cannot reallocate this funding for other support purposes (i.e. capital or capacity building supports).
2. CAPITAL – Investments, such as assistive technologies - equipment, home or vehicle modifications, or for Specialist Disability Accommodation (SDA). Participant budgets for this support purpose are restricted to specific items identified in the participant's plan.
3. CAPACITY BUILDING - Supports that enable a participant to build their independence and skills.

Support Categories aligned to the NDIS Outcomes Framework

Participant budgets are allocated at a support category level and must be used to achieve the goals set out in the participant's plan.

Support categories are aligned with the NDIS Outcomes Framework, which has been developed to measure goal attainment for individual participants and overall performance of the Scheme. There are eight outcome domains in the Framework, which help participants think about goals in different areas of their life and assist planners explore where supports in these areas already exist and where further supports are required. These domains are:

1. Daily Living	5. Work
2. Home	6. Social and Community Participation
3. Health and Wellbeing	7. Relationships
4. Lifelong Learning	8. Choice and Control

NDIS service providers should be aware that all supports and services for NDIS participants must contribute to the achievement of their individual goals as outlined in the participant's plan. Support purpose categories are designed to align with the Outcomes Framework and the 15 support categories (listed below). This helps participants choose supports that help them achieve their goals, and providers to understand how the supports they provide contribute to the participant's goals. The following table shows the links between support purpose types, domains in the Outcomes Framework and support categories.

SUPPORT PURPOSE	OUTCOME DOMAINS in FRAMEWORK	SUPPORT CATEGORY
CORE	Daily Living Daily Living Daily Living Social & Community Participation	Assistance with Daily Life Transport Consumables Assistance with Social & Community Participation
CAPITAL	Daily Living Home	Assistive Technology Home Modifications and Specialised Disability Accommodation (SDA)
CAPACITY BUILDING	Choice & Control Home Social and Community Participation Work Relationships Health & Wellbeing Lifelong Learning Choice and Control Daily Living	Support Coordination Improved Living Arrangements Increased Social and Community Participation Finding and Keeping a Job Improved Relationships Improved Health and Wellbeing Improved Learning Improved Life Choices Improved Daily Living Skills

Support items

Each support category has many specific supports and services that are recognised in the NDIS payment system. These are referred to as ‘support items’ and are, in most cases, not prescribed in participant plans.

Providers should claim payments against a support item that most closely aligns to the service they have delivered.

Each support item has a unique reference number, according to the following structure:

For example:

01_013_0107_1_1 - Assistance with Self-Care Activities - Standard - Saturday

Support Category	Sequence Number	Registration Group	Outcome Domain	Support Purpose
01	013	0107	1	1

Units of Measure

The NDIS payment system includes units of measure to suit each support item as follows:

• Each	• Hour	• Daily
• Week	• Month	• Annual

Claiming supports and services

Registered Providers can make a claim for payment for a support once that support has been delivered or provided. Where price limits apply, prices charged to participants must not exceed the price limit prescribed for that support in this Guide. Providers cannot add any other charges to the cost of the support, including credit card surcharges, or any additional fees including any 'gap' fees, late payment fees or cancellation fees unless otherwise stated in this Price Guide.

When claiming, it is the responsibility of the provider to ensure that the claim accurately reflects the supports delivered, including the frequency and volume of supports. Falsifying claims for any aspect of supports delivered is a serious compliance issue and may result in action against the provider. Providers are also required to keep accurate records of claims, which are subject to audit at any time.

Providers should claim payments against a support item that most closely aligns to the service they have delivered.

Service Agreements

A Service Agreement is a formal agreement between a participant and provider. They help to ensure there is a shared understanding of:

- expectations of what supports will be delivered and how they will be delivered; and
- the respective responsibilities and obligations of the provider and the participant and how to resolve any problems that may arise.

Service Bookings

Service bookings are used to set aside funding for an NDIS registered provider for a support or service they will deliver. Each service booking sets out the specific supports or support domains agreed to be provided and the length of time that agreement is applicable within the current participant plan dates. Service bookings are not the same as 'service agreements', which set out the terms and conditions negotiated with the participant.

The Agency recommends that service bookings should be created at the category level, where possible. This allows providers and participants to negotiate or access supports on a more flexible basis, especially for on-the-spot assessments or less predictable support needs. This is preferable to having to edit existing service bookings or create another service booking for that item at a later date or have funds locked into a support item that may not eventuate, which restricts funding for alternate services. **A provider must have a service booking in place to make a payment claim in the Portal.**

See the 'NDIS Myplace Provider Portal Step-by-step guide' on the Provider Toolkit for further information.

Special NDIS Pricing Arrangements

Regional, Remote and Very Remote Areas

The NDIA uses the Modified Monash Model (MMM) to determine regional, remote and very remote areas using a scale based on population size and locality (see Table below).

Description	Zones	MMM	Inclusion
Metropolitan	MMM 1-3	1	All areas categorised as Major Cities of Australia.
Regional Centres		2	Areas categorised as Inner Regional Australia or Outer Regional Australia that are in, or within 20km road distance, of a town with population >50,000.
		3	Areas categorised as Inner Regional Australia or Outer Regional Australia that are not in MM 2 and are in, or within 15km road distance, of a town with population between 15,000 and 50,000.
Regional Areas	MMM 4-5	4	Areas categorised as Inner Regional Australia or Outer Regional Australia that are not in MM 2 or MM 3, and are in, or within 10km road distance, of a town with population between 5,000 and 15,000.
		5	All other areas in Inner Regional Australia or Outer Regional Australia.
Remote	MMM 6	6	All areas categorised Remote Australia that are not on a populated island that is separated from the mainland and is more than 5km offshore.
Very Remote	MMM 7	7	All other areas – that being Very Remote Australia and areas on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.

Providers and participants can determine the MMM rating of a location using the Health Workforce Locator tool on the Department of Health's website.[1] NDIS geographic locations are based on the 2015 MMM (not the 2019 MMM).

In general, price limits are 40% higher in remote areas and 50% higher in very remote areas. There is no additional loading applied for supports in Metropolitan areas, regional centres or regional areas.

Providers should refer to support price limits based on where the support is delivered, which is not necessarily where the participant lives. For example, if a participant living in a Remote location visits a therapist in their capital city, the therapist should not attempt to claim a price that is higher than the price limit for the support in that city. On the other hand, if the therapist was to visit the participant in their local area to deliver the support, then the therapist could claim a price that is within the limit set by the 'Remote' Price Guide.

If local providers are not available, the NDIA may enter into arrangements (and at times contracts) with specific providers for provision of services to more remote regions. The contract with a service provider will specify the cost of travel and any other associated expenses in these areas.

[1] https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator/health-workforce-locator#hwc-map

Isolated Towns

From 1 August 2019, the NDIA has amended its geographic arrangements so that areas classified as ‘regional’ that are completely surrounded by ‘remote’ or ‘very remote’ areas are classified as ‘remote’ for planning and pricing purposes.

Postcode	Location Name	State	MMM Rating	Reclassified MMM Rating
2711	Hay	NSW	5	6
2715	Balranald	NSW	5	6
2880	Broken Hill	NSW	3	6
4455	Roma	QLD	4	6
4455	Blythdale	QLD	5	6
4455	Euthulla	QLD	5	6
4455	Orange Hill	QLD	5	6
4717	Blackwater	QLD	5	6
4720	Emerald	QLD	4	6
4741	Coppabella	QLD	5	6
4744	Moranbah	QLD	4	6
4745	Dysart	QLD	5	6
4820	Queenton	QLD	4	6
4820	Charters Towners	QLD	4	6
4820	Alabama Hill	QLD	4	6
4820	Breddan	QLD	4	6
4820	Broughton	QLD	4	6
4820	Grand Secret	QLD	4	6
4820	Millchester	QLD	4	6
4820	Mosman Park	QLD	4	6
4820	Richmond Hill	QLD	4	6
4820	Southern Cross	QLD	4	6
4820	Toll	QLD	4	6
4820	Towers Hill	QLD	4	6
6430	Kalgoorlie	WA	3	6
6430	Broadwood	WA	3	6
6430	Hannans	WA	3	6
6430	Karlkurla	WA	3	6
6430	Lamington	WA	3	6
6430	Mullingar	WA	3	6
6430	Piccadilly	WA	3	6
6430	Somerville	WA	3	6
6430	South Kalgoorlie	WA	3	6
6430	West Kalgoorlie	WA	3	6
6430	West Lamington	WA	3	6
6430	Williamstown	WA	3	6
6442	Kambalda West	WA	5	6
6442	Kambalda East	WA	5	6

Temporary Transformation Payment (TTP)

Providers of attendant care and community participation supports who meet the eligibility criteria set out below will have access to a higher price limit through a Temporary Transformation Payment (TTP). This conditional loading will assist providers to continue transforming their businesses in the move towards a more competitive marketplace. This replaces the Temporary Support for Overheads. In order to access the higher TTP price limits, providers will have to:

- publish their service prices;
- list their business contact details in the Provider Finder and ensure those details are kept up-to-date; and
- participate annually in an Agency-approved market benchmarking survey.

TTP Providers will have to until 31 December 2019 to meet these requirements, and to include in their contractual arrangements with their participants that they are entitled to use the TTP support items (and price limits) because they are compliant with the TTP terms.

That is, in the first year, providers can commence making claims using the TTP items from 1 July 2019, and will have until 31 December 2019 to meet the three compliance requirements. In later years, providers will need to be compliant by the start of the financial year, noting that the Benchmarking Requirement is met up until 31 December of any year by the provider's intention to take part in the next Benchmarking Survey, and after that date by actual participation in the most recent Benchmarking Survey.

Providers who become non-compliant during a financial year should not claim for TTP items while they are non-compliant.

Every support item in scope of the TTP has two support items and two price limits. The non-TTP items should be used by providers who are not compliant with the TTP conditions. The TTP items should be used by providers who are compliant with the TTP conditions, an example is given in the following Table.

01_011_0107_1_1	Assistance With Self-Care Activities - Standard - Weekday Daytime
01_011_0107_1_1_T	Assistance With Self-Care Activities - Standard - Weekday Daytime - TTP

There will be no formal registration process for TTP providers. Providers indicate that they intend to fulfil the TTP conditions by making a claim for a TTP support item through the payment system. They will be required to acknowledge compliance to the Price Guide terms, including the TTP terms if applicable, when submitting a payment request through the Myplace Provider Portal. By claiming TTP items through the NDIA payment system, or from a plan manager, providers are warranting that they have complied with the TTP conditions, or intend to comply with the TTP conditions by the relevant time.

Plan managers will not be responsible for ensuring providers are TTP compliant. They can accept the claim for a TTP support item by a registered provider as proof of TTP compliance. However, non-registered providers are not eligible for the TTP and plan managers should not use TTP line items to claim for services delivered by non-registered providers.

Claims for the new TTP support items can be made against existing service bookings that were made at the support category level.

Billing for non-direct services

Provider Travel

Providers can only claim travel costs from a participant in respect of the delivery of a support item if:

- the Support Catalogue indicates that providers can claim for Provider Travel in respect of that support item;
- the provider has the agreement of the participant in advance (i.e. the service agreement between the participant and provider should specify the travel costs that can be claimed); and
- the provider is required to pay the worker delivering the support for the time they spent travelling as a result of the agreement under which the worker is employed; or the provider is a sole trader and is travelling from their usual place of work to or from the participant, or between participants.

Where a provider claims for travel time in respect of a support then the maximum amount of travel time that they can claim for the time spent travelling to each participant (for each eligible worker) is 30 minutes in MMM1-3 areas and 60 minutes in MMM4-5 areas. (Note the relevant MMM classification is the classification of the area where the support is delivered.)

In addition to the above travel, capacity-building providers who are permitted to claim for provider travel can also claim for the time spent travelling from the last participant to their usual place of work. The maximum amount of travel time that they can claim for the time spent on return travel (for each eligible worker) is 30 minutes in MMM1-3 areas and 60 minutes in MMM4-5 areas. (Note the relevant MMM classification is the classification of the area where the support is delivered.)

Where a worker is travelling to provide services to more than one participant in a ‘region’ then the provider can apportion that travel time (including the return journey where applicable) between the participants, with the agreement of each participant in advance.

Claims for travel in respect of a support must be made separately to the claim for the primary support (the support for which the travel is necessary) using the same line item as the primary support and the “Provider Travel” option in the Myplace portal. When claiming for travel in respect of a support, a provider should use the same hourly rate as they have agreed with the participant for the primary support (or a lower hourly rate for the travel if that is what they have agreed with the participant) in calculating the claimable travel cost.

Remote and very remote travel

In remote areas, capacity-building providers may enter specific arrangements with participants to cover travel costs, up to the relevant hourly rate for the support item. Providers should assist participants to minimise the travel costs that they need to pay (e.g. co-ordinating appointments with other participants in an area, so that travel costs can be shared between participants).

Provider Travel Example 1 – Core support – Single Participant – MMM 1-3
(In this example, the support is 01_301_0104_1_1, which has a price limit of $58.31 per hour)

A Provider travels for 25 minutes to a participant who is located in zone 3 of the Modified Monash Model. They provide two hours of support to the participant They then spend 25 minutes returning to their usual place of business.

The provider and participant have agreed an hourly rate of $50.00, which is below the price limit for this item. **They have also agreed that the provider can claim for travel time.**

The provider is entitled to apply the 30-minute time-cap against the 25 minutes of travel to the participant. They are not entitled to claim for the time spent travelling back to their usual place of business, even though some of that time is could fit within the 30-minute time-cap. In total, 25 minutes of travel can be claimed.

The provider's claim for this support is in two parts, which should be shown separately on their invoice to the participant and claimed for separately in the system.

- $100.00 for the two hours of support
- $20.83 for the 25 minutes travel to the participant.
  $\left(\frac{25}{60}\right) \times \$50\ agreed\ price = \$20.83\ travel\ claim$

Provider Travel Example 2 – Capacity building support – Multiple Participants – MMM 1-3
(In this example, the support is 15_056_0128_1_3, which has a price limit of $193.99 per hour)

A Provider travels for 35 minutes to a participant who is located in zone 3 of the Modified Monash Model. They provide two hours of support to the participant They then spend 25 minutes returning to their usual place of business.

The provider and participant have agreed an hourly rate of $190.00. **They have also agreed that the provider can charge for their travel time.**

The provider is entitled to apply the 30-minute time-cap against the 35 minutes of travel to the participant. They are also entitled to claim for the time spent travelling back to their usual place of business by applying the 30-minute time-cap against the 25 minutes of return travel. In total, 55 minutes of travel can be claimed.

The provider's claim for these supports is in two parts, which should be shown separately on their invoice to the participant and claimed for separately in the system.

- $380.00 for the two hours of support
- $174.17 for the 55 minutes travel to the participant.
  $\left(\frac{55}{60}\right) \times \$190\ agreed\ price = \$174.17\ travel\ claim$

Provider Travel Example 3 – Core support – Multiple Participants – MMM 4-5
(In this example, the support is 01_301_0104_1_1, which has a price limit of $58.31 per hour)

A Provider travels for 65 minutes to Participant A who is located in zone 4 of the Modified Monash Model. They then provide two hours of the support to participant A. The provider then travels 25 minutes to Participant B, who is also located in zone 4. They deliver one hour of support to participant B. They then spend 45 minutes returning to their usual place of business.

The provider and participants have agreed an hourly rate of $50.00. **They have also agreed that the provider can charge for their travel time and that the provider can apportion the costs of the travel between the participants.**

The provider is entitled to apply the 2x60 minute time-cap against the 65 minutes of travel to participant A and the 25 minutes of travel to participant B. They are not entitled to claim for the time spent travelling back to their usual place of business, even though some of that time is could fit under the 2x60 minute time-cap. In total, 90 minutes of travel can be claimed.

The provider's claim for these supports is in two parts for each participant, which should be shown separately on their invoice to the participant and claimed for separately in the system.

Participant A
- $100.00 for the two hours of support to the participant
- $37.50 for the 45 minutes travel to and between participants

Participant B
- $50.00 for the two hours of support to the participant
- $37.50 for the 45 minutes travel to and between participants

Provider Travel Example 4 – Core support – Multiple Participants – MMM 1-3
(In this example, the support is 01_301_0104_1_1, which has a price limit of $58.31 per hour)

A Provider travels for 35 minutes to Participant A who is located in zone 3 of the Modified Monash Model. They then provide two hours of the support to participant A. The provider then travels 10 minutes to Participant B who is also located in zone 3. They deliver one hour of support to participant B. They then spend 25 minutes returning to their usual place of business.

The provider and participants have agreed an hourly rate of $50.00. **They have also agreed that the provider can charge for their travel time. They have not agreed that the provider can apportion the costs of the travel between the participants.**

The provider is entitled to apply the 30-minute time-cap against the 35 minutes of travel to participant A. They are also entitled to apply the 30-minute time-cap against the 10 minutes of travel to participant B. They are not entitled to claim for the time spent travelling back to their usual place of business, even though some of that time is could fit under the 30-minute time-cap. In total, 40 minutes of travel can be claimed.

The provider's claim for these supports is in two parts for each participant, which should be shown separately on their invoice to the participant and claimed for separately in the system.

Participant A
- $100.00 for the two hours of support to the participant
- $25.00 for the 30 minutes travel to the participant

Participant B
- $50.00 for the two hours of support to the participant
- $8.33 for the 10 minutes travel to the participant

Participant Transport

Participant transport as part of a community participation support

Providing community participation supports may, at the request of a participant, involve a worker accompanying a participant on a community outing and/or transporting a participant from their home to the community. In these situations, the worker's time can be claimed at the agreed hourly rate for the relevant support item for the total time the worker provides support to one or more participants, including time spent accompanying and/or transporting the participant. Where a provider is transporting two or more participants on the same trip, the worker's time should be claimed at the appropriate group rate for the relevant support.

This claim should be made using the relevant community participation support item and against the participant's core budget. In essence, the participant transport is a part of the community participation activity and should be billed accordingly.

Contribution towards costs of transport itself

If a provider incurs costs, in addition to the cost of a worker's time, when accompanying and/or transporting participants in the community (such as cost of ticket for public transport, road tolls, parking fees and the running costs of the vehicle), they may negotiate with the participant for them to make a reasonable contribution towards these costs.

A participant's support budget may include funding for transport, and this funding can be used for these types of contributions, which should be clearly specified in the service agreement. If the participant's support budget does not include funding for transport, then these costs should not be met from the participant's plan, but can be charged as an out of pocket expense to the participant.

Participant Transport Example 1:

- the support being delivered is 04_104_0125_6_1 with a price limit of $52.85 per hour
- the participant receives a **fortnightly instalment/periodic payment** towards transport costs.*

A Provider is delivering Assistance with Social and Community Participation services and is required to transport a participant from their home to a local swimming pool and back again, as part of that service.

The transport by taxi takes 25 minutes to arrive at the swimming pool, including the time to assist the participant to and from the vehicle and getting them set up to participate in the activity. They then provide 40 minutes of support to that participant. Afterwards, they spend 20 minutes returning the participant to their home by taxi.

The provider and participant have agreed an hourly rate of $50.00, which is below the price limit for this item. This amount also applies to the **support worker's time when transporting participants**.

The provider's claim for the **support worker's time** will be claimed in the portal as:

- 40 minutes of direct service at the agreed price of $50.00 per hour – that is, $30.00 against line item 04_104_0125_6_1; and
- 45 minutes of transport time at the agreed price of $50.00 per hour – that is, $37.50 against line item 04_104_0125_6_1.

In addition, the participant pays for the taxi fares as an out-of-pocket expense in accordance with **the Service Agreement in place with the provider**—participants can use their fortnightly instalment/periodic payment or their own funds to pay the taxi fare directly or to reimburse the provider for the cost of the taxi fare.

*While a fortnightly instalment/periodic payment is displayed as transport in the participant's Core Support budget, providers cannot claim against this item because it is paid in fortnightly/periodic instalments to the participant.

Participant Transport Example 2:

- the support being delivered is 04_104_0125_6_1, which has a price limit of $52.85 per hour
- the participant has a **budget** allocated under **Transport as a core support** in their plan and is not receiving a fortnightly instalment/periodic payment.

A Provider is delivering Assistance with Social and Community Participation services and is required to transport a participant from their home to the shops and back again, as part of that service.

The transportation involves the provider's time to accompany the participant and the non-labour transportation costs associated with using the provider's/support worker's car, which takes a total of 40 minutes. The service delivery (time spent at the shops) takes 60 minutes.

The provider and participant have agreed on using the price limit, when claiming for the **support worker's time**. The participant has a **transport budget** and has agreed for the provider to claim for **the non-labour transport costs**, which in this case are the support worker's car park fee ($5) and vehicle running costs at a rate as agreed with the participant of $0.78* a kilometre (20 km) against support line 02_051_0108_1_1.

The provider's claim for the **support worker's time** will be shown separately to the **claim for the agreed non-labour transport costs** on the payment claim in the portal:

- 60 minutes of direct service at $52.85 per hour – that is, $52.85 against line item 04_104_0125_6_1;
- 40 minutes of transport time at $52.85 per hour – that is, $35.23 against line item 04_104_0125_6_1; and
- The non-labour transport costs for the provider's car park fee and vehicle running costs of $20.60 against line item 02_051_0108_1_1.

*This is an example only and an agreed rate is negotiated between the provider and participant in the Service Agreement.

If the participant receives a **fortnightly instalment/periodic payment** towards transport costs rather than having a **budget** allocated under **Transport as a core support** in their plan, then they would pay for the non-labour transport costs as an out-of-pocket expense in accordance with **the Service Agreement in place with the provider.** Participants can use their fortnightly instalment/periodic payment or their own funds to pay this out-of-pocket expense directly or by reimbursing the provider.

Participant Transport Example 3:

- the support being delivered is 04_104_0125_6_1, which has a price limit of $52.85 per hour
- participant A has a **budget** allocated under **Transport as a core support** in their plan and is not receiving a fortnightly instalment/periodic payment
- participant B shares a house with participant A and receives a **fortnightly instalment/periodic payment** towards transport costs.

A Provider is delivering Assistance with Social and Community Participation services to the two participants and is required to transport them from their home to the library and back again, as part of that service.

The transportation involves the provider's time to accompany the participants and the non-labour transportation costs associated with using the provider's/support worker's car, which takes a total of 40 minutes. The service delivery (time spent at the library) takes 60 minutes.

The provider and participants have agreed on using the price limit, when claiming for the **support worker's time**. Participant A has a **transport budget** and has agreed for the provider to claim for their share of **the total non-labour transport costs**, which in this case includes the support worker's car park fee (total $5) and vehicle running costs at a rate as agreed with the participants of $0.78* a kilometre in total (20 km) against support line 02_051_0108_1_1. Participant B has also agreed to pay their share of the total non-labour transport costs.

The provider's claim for the **support worker's time** will be shown separately to the **claim for the agreed non-labour transport costs** on the payment claim in the portal, and will apportion the costs between the participants:

- 30 minutes of direct service at $52.85 per hour to participant A – that is, $26.42 against line item 04_104_0125_6_1;
- 30 minutes of direct service at $52.85 per hour to participant B – that is, $26.42 against line item 04_104_0125_6_1;
- 20 minutes of transport time at $52.85 per hour to participant A – that is, $17.62 against line item 04_104_0125_6_1;
- 20 minutes of transport time at $52.85 per hour to participant B – that is, $17.62 against line item 04_104_0125_6_1; and
- **Half** the transport costs for the provider's car park fee and vehicle running costs to participant A – that is $10.30 against line item 02_051_0108_1_1.

In addition, Participant B pays the provider for half the transport costs for the provider's car park fee and vehicle running costs ($10.30) as an out-of-pocket expense.

*This is an example only and an agreed rate is negotiated between the provider and participant in the Service Agreement.

Cancellations

Where a provider has a short notice cancellation (or no show) they are able to recover 90% of the fee associated with the activity, subject to the terms of the service agreement with the participant. Providers are only permitted to charge for a short notice cancellation (or no show) if they have not found alternative billable work for the relevant worker and are required to pay the worker for the time that would have been spent providing the support.

A cancellation is a short notice cancellation if the participant:

- does not show up for a scheduled support within a reasonable time, or is not present at the agreed place and within a reasonable time when the provider is travelling to deliver the support; or
- has given less than two (2) clear business days' notice for a support that meets both of the following conditions:
    - the support is less than 8 hours continuous duration; AND
    - the agreed total price for the support is less than $1000; or
- has given less than five (5) clear business days' notice for any other support.

Claims for a short notice cancellation should made using the same support item as would have been used if the support had been delivered, using the "Cancellation" option in the Myplace portal. When making a claim for a cancelled support the provider should claim for the full-agreed price of the support and indicate in the payment system that the claim is for a cancellation. The payment system will reduce the claim to 90% of the full-agreed price.

Cancellation Example 1:
(In this example, the support is 01_301_0104_1_1, which has a price limit of $58.31 per hour)

A one-hour support is scheduled for 10 am on a Tuesday following a Public Holiday Monday.

The provider and participant have agreed an hourly rate of $50.00 and have agreed that the provider can charge for short notice cancellations and no shows.

The participant cancels the support after 10 am on the preceding Thursday and the provider is not able to find alternative billable work for the relevant worker and is required to pay the worker for the time that would have bene spent providing the support.

The provider's claim for this support should be made at the agreed rate for the service and indicate that the support was cancelled at short notice. The system will reduce the claimed amount by 10%.

There is no limit on the number of short notice cancellations (or no shows) that a provider can claim in respect of a participant. However, providers have a duty of care to their participants and if a participant has an unusual number of cancellations then the provider should seek to understand why they are occurring.

The NDIA will monitor claims for cancellations and may contact providers who have a participant with an unusual number of cancellations.

NDIA Reporting

Providers will be expected to provide progress reports to the participant and NDIS at agreed times. A provider may charge for the time taken to write a therapy report (including functional assessment) that is requested by the NDIA, and claim this against the appointment at the hourly rate for the relevant support item. A report requested by the NDIA is considered a report that is required at the commencement of a plan that outlines plan objectives and goals, and at plan review, which measures functional outcomes against the originally stipulated goals. Providers are also expected to make recommendations for ongoing identified needs (informal/community/mainstream and/or funded supports). Providers may charge for any other NDIA-requested therapy report that is stipulated as being required in a participant's plan.

Claims for a NDIS requested reports are made using the relevant support item, using the "NDIA Report" option in the Myplace portal.

Non-Face-to-Face Supports

Non face-to-face activities are billable as a support if:

- the activities are part of delivering a specific disability support item to that participant (rather than a general activity such as enrolment, administration or staff rostering); and
- the provider explains the activities to the participant, including why they represent the best use of the participant's funds (i.e. explains the value of these activities to the participant); and
- the proposed charges for the activities comply with the NDIS Price Guide, and
- the participant agrees to pay for the activities (preferably in a service agreement).

For example, the Assistance with Self Care support items are described as covering activities "Assisting with, and/or supervising, personal tasks of daily life to develop skills of the participant to live as autonomously as possible". Therefore, time spent on non-face to face activities that assist the participant - for example, writing reports for co-workers and other providers about the client's progress with skill development – could be charged against this support item. The costs of training and upskilling staff, and of supervision, are also included in the base price limits for supports and are not considered billable non-face-to-face supports. However, research undertaken by a capacity-building provider specifically linked to the needs of a participant and to the achievement of the participant's goals may be billable as a non-face-to-face support with the participant's prior agreement.

Service agreements with each client can 'pre-authorise' these activities, but providers should only charge a participant for delivering a support item if they have completed activities that are part of the support for that participant. Charging a fee that is not linked to completed activities would not be appropriate.

Time spent on administration, such as the processing of NDIS payment claims for all clients, is outside the description of the support item and should not be claimed from a participant's budget as a non-face-to-face support. The NDIS price limits include an allowance for overheads, so that providers can fully recover the efficient costs, including the costs of administration tasks. Examples of administrative activities that are covered by the overhead component of the primary support price limits and that should not be billed as non-face-to-face supports include:

- Pre-engagement visits
- Developing and agreeing Service Agreements
- Entering or amending participant details into system
- Making participant service time changes
- Staff / participant travel monitoring and adjustment
- Ongoing NDIS plan monitoring
- Completing the Quoting tool
- Making service bookings and payment claims

In working out the cost of non-face-to-face supports, it is not appropriate to charge all participants an average additional fee. The additional fee must be worked out in each case and related specifically to the non-face-to-face supports delivered to the particular participant. This is not to say that the same additional fee might end up being charged to a number of participants, but it must be worked out separately.

Claims for a non-face-to-face supports are made using the relevant support item, using the “Non-face-to-face” option in the Myplace portal.

Disability-Related Health Supports

From 1 October 2019, the NDIS will fund disability-related health supports where these supports directly relate to a participant’s significant and permanent functional impairment and assist them to undertake activities of daily living. These supports are provided individually to participants and can be provided in a range of environments, including, but not limited to, the participant’s own home.

Participants are not permitted to claim for health supports from their plans when those health supports do not relate to their disability and when they do not require health supports on a regular basis. Those health supports will continue to be provided by the health system. Additionally, if a participant’s support needs become acute, that support should be provided in a hospital or another health setting by the relevant state/territory health care system or private health system and not be claimed from the participant’s plan.

The list below provides an indication of the majority of disability-related health supports that may be required by NDIS participants; however, it is not an exhaustive list. Disability-related health supports are expected to assist in areas such as:

- **Dysphagia**: for participants who have trouble eating, drinking or swallowing on a daily basis.
- **Respiratory**: for participants requiring help with their breathing and maintenance of their respiratory health, including any associated care, comfort, planning or supports
- **Nutrition**: for participants requiring help with the way they eat or understanding the food they need.
- **Diabetes**: for participants who have daily problems with how much sugar is in their blood.
- **Continence**: for participants who need daily assistance with toileting (bladder and bowel).
- **Wound & Pressure Care**: for participants who need daily wound and pressure care (resulting from pressure wounds or swollen limbs).
- **Podiatry**: for participants who require help looking after their feet, ankles and lower limbs.

- **Epilepsy**: for participants who need daily help managing the way epilepsy affects the way their brain and nerves work.
- **Botox and Splinting**: It is unlikely Botox and splinting supports will be reasonable and necessary to include in a plan, as these are generally provided in a clinical setting.

Five types of disability-related health supports have been identified in the *NDIS Support Catalogue*:

a) Provision of Disability-Related Health Supports by Disability Support Workers – these supports should be claimed using the standard Daily Personal Activities and High Intensity Daily Personal Activities support items;
b) Assessment, planning and the provision of Disability-Related Health Supports by therapists these supports should be claimed using the standard ECEI and Therapy support items;
c) Assessment, planning and the provision of Disability-Related Health Supports by nurses – these supports should be claimed using the new nursing support items;
d) Consumables related to Disability Related Health Supports – these supports should be claimed using the new Low-Cost or High-Cost Disability Related Health Consumables support line items; and
e) Assistive Technology related to Disability Related Health Supports – these supports should be claimed using the new Disability Related Health Assistive Technology support line items.

Other Payment Considerations

This section outlines various other considerations that may be relevant to participants and providers. These should be reviewed when entering into a new Service Agreement or if there is a significant change in the participant's circumstances.

Medicare and insurance

Some elements of a participant's care may be covered by funds outside the NDIS. These expenses are commonly medical, including those covered by private health insurance or Medicare. These medical expenses are not funded under the NDIS, even if they are related to, or a symptom of the disability. These expenses should be claimed under the relevant health care scheme or insurance policy. Some providers (e.g. therapists) may need to distinguish between the health services and disability supports that they provide to a single client, and make separate payment claims (e.g. claim payments from Medicare for health services, and the NDIS for disability supports).

Prepayments

Registered Providers can make a claim for payment once a service booking has been created and the support has been delivered or provided. Prepayment is not permitted unless the NDIA has given prior approval in writing to the Registered Provider. This will only occur in exceptional circumstances such as for certain assistive technologies, home modifications and remote area servicing where this has been agreed to by the participant.

Co-Payments for Capital items, including assistive technology

Co-Payments by the participant are not required; however, where the participant would like a customisation to a support or assistive technology that is not considered reasonable or necessary, they are required to pay for these themselves. These may include an aesthetic customisation to an assistive technology or modifications to a vehicle that are additional to the assistive components.

Goods and Services Tax (GST)

Many, but not all, NDIA supports provided to NDIS participants are GST-free. Further information about the NDIS and GST can be accessed on the Australian Taxation Office website[2]. Providers should seek independent legal or financial advice if they require assistance with tax law compliance. If GST is applicable to a support, the price limit is inclusive of GST.

Other fees (Commissions and exit fees)

Participants are generally not required to pay exit fees, even when changing provider's part way through a plan. A core principle of the NDIS is choice and control for participants, allowing them to change providers without expense. Further information on establishment fees claimable by the incoming provider can be found below under *Establishment fee for personal care/community access*.

[2] https://www.ato.gov.au/business/gst/in-detail/your-industry/gst-and-health/?page=6#National_Disability_Insurance_Scheme

Core – Assistance with Daily Life (includes Supported Independent Living)

This support category relates to assisting with and/or supervising personal tasks of daily life to enable the participant to live as autonomously as possible. These supports are provided individually to participants and can be provided in a range of environments, including but not limited to, the participant's own home.

Daily Personal Activities, including High Intensity Daily Personal Activities

A hierarchy of price limits applies to this group of supports, based on:

A) the time of day that the support is delivered;

B) the day of week that the support is delivered;

C) whether the support is Standard Intensity or High Intensity;

D) if the support is High Intensity then whether it is a Level 1 (Standard), Level 2 (High Intensity) or Level 3 (Very High Intensity) support; and

E) whether the provider is eligible for the Temporary Transformation Payment.

Time of day

In determining which price limit is applicable to a support, providers should note that a support is considered to be:

- a Daytime Support is it is delivered between 6 am and 8 pm;
- an Afternoon (formerly Evening) Support if it is delivered after 8 pm and before 12 midnight; and
- an Overnight Support is it is delivered between 12 midnight and 6 am.

Day of week

In determining which price limit is applicable to a support, providers should note:

- a weekday is Monday to Friday;
- the extra rates paid for Saturday, Sunday and Public holidays are in substitution for, and not cumulative upon, the shift premiums payable for afternoon and overnight supports; and
- the extra rates for Saturday/Sunday/Public holidays do not increase further when the support finishes after 8pm.

High intensity supports

A support is considered a high intensity support if the participant requires assistance from a support worker with additional qualifications and experience relevant to the participant's complex needs. The high intensity price limits may be considered when:

- frequent (at least 1 instance per shift) assistance is required to manage challenging behaviours that require intensive positive behaviour support; and/or

- continual active support is required due to high medical support needs (such as unstable seizure activity or respiratory support)

In determining which price limit for High Intensity Supports should apply to a given support, the provider should consider the skills and experience of the worker delivering the support. In general, the Level 2 price limit applies to most high intensity supports. However, if the particular instance of support is delivered by a worker who does not have the skills and experience to deliver a high intensity support then the Level 1 price limit should be applied. If the particular instance of the support is delivered by a more highly skilled or experienced worker then the provider can consider applying the Level 3 price cap, with the participant's prior agreement.

Other matters

Provisions for 'shadow shifts'

Shadow shifts may be considered where the participant has complex individual support needs that are best met by introducing a new worker to the participant before it is reasonable that they commence providing the support independently. These are considered where the specific individual support needs include:

- Very limited communication;
- Behaviour support needs; and/or
- Medical needs/procedures such as ventilation or Home Enteral Nutrition (HEN).

Where the individual would require shadow shifts to assist with the introduction of new workers, and this is the desired method by the participant or their family, the provider may claim for up to 6 hours of weekday support per year.

Introducing new workers is not designed to replace formal, recognised training that will be provided by an employer to their workforce, such as Shadowing (or "Buddying") less experienced staff or new staff with experienced workers or informal carers to help build knowledge and social capital (worker retention), which is not claimable under the NDIS.

Establishment fee for personal care/community access

This fee applies to all new NDIS participants in their first plan where they receive at least 20 hours of personal care/community access support per month. This payment is to cover non-ongoing costs for providers establishing arrangements and assisting participants in implementing their plan.

An establishment fee is claimable by the provider who assists the participant with the implementation of their NDIS Plan, delivers a minimum of 20 hours per month of personal care/community access support and has made an agreement with the participant to supply these services.

A budget of $750 is included in the first plan for NDIS participants, in case they need this type of assistance from providers to design and implement support arrangements. Providers can draw against this budget as follows:

- If the participant is new to the NDIS and new to the provider, then the provider can charge a maximum of $500 against the participant's plan;
- If the participant is new to the NDIS but is an existing client of the provider, then the provider can charge a maximum of $250 against the participant's plan; and

- If the participant is choosing to change providers, then the new provider can charge a maximum of $250 against the participant's plan to assist the participant in changing providers.

Assistance with household tasks

These support items enable participants to maintain their home environment. This may involve undertaking essential household tasks that the participant is not able to undertake.

Preparation and delivery of meals

This support item is for the preparation and delivery of food to participants who are unable to do this themselves, and are not in receipt of other supports that would meet the same need. The cost of the food itself is not covered by the NDIS. The cost of this support will vary based on the number of meals prepared and the deliveries required.

Assistance in Shared Living Arrangements – Supported Independent Living

Supported Independent Living (SIL) is the assistance with and/or supervising tasks of daily life in a shared living environment, with a focus on developing the skills of each individual to live as autonomously as possible. The support is provided to each person living in the shared arrangement in accordance with their need.

SIL does not include rent, board and lodging or other day-to-day usual living expenses such as food and activities. It also does not include the capital costs associated with a participant's accommodation.

SIL does not have fixed price limits, and providers can quote for the specific SIL service that they offer to each participant. To assist providers with quoting, the NDIA has developed a Provider SIL Pack[3]. The Provider SIL Pack contains templates that assist providers in developing an individualised quote. The purpose of this quote is to identify:

- The individual supports that will be available for the person, focussed on maximising the person's capacity to be as independent as possible with household decision making, personal care and domestic tasks;
- The typical roster of supports that is shared between participants to maximise the efficient use of resources; and
- What supports are available to all residents to ensure the smooth operation and running of the household.

Once a quote is received, the NDIA uses a 'SIL Tool' to analyse provider quotes and to make sure that they represent value for money. In some cases, negotiation between the NDIA and providers will be necessary to agree appropriate prices for SIL.

The Agency will only accept SIL quotes in the current templates, which can be downloaded as part of the Provider SIL pack from the NDIS internet page 'Supported Independent Living'.[4] This means that quotes can be processed in a much timelier, consistent and effective manner and the duplication of work is also reduced through simple automation. The new Provider SIL Pack allows for much more flexibility – among other things, providers are now able to specify overnight

[3] https://www.ndis.gov.au/providers/essentials-providers-working-ndia/supported-independent-living
[4] https://www.ndis.gov.au/providers/essentials-providers-working-ndia/supported-independent-living

information, cross-over shift information, and choose their own ratios of support. This means that providers should experience fewer delays in getting their SIL quotes approved.

Queries about the Provider SIL Pack should be made to sil@ndis.gov.au.

Short Term Accommodation and Assistance

From time to time, participants may require temporary supports that are different from their usual arrangements. These are non-typical days and may include short stays in a group-based facility (short term accommodation), or the purchase of additional in-home support.

For the purposes of this Price Guide, the 'short term accommodation' price limit includes all expenses in a 24-hour period including assistance with daily personal activities, accommodation, food and negotiated activities. Typically, this type of support would be used for short periods of up to 14 days at a time. For longer-term arrangements, other options are likely to be more appropriate (e.g. Supported Independent Living).

In cases where a participant will receive substantially less than 24 hours of assistance with daily personal activities, it may be appropriate for the participant and provider to negotiate a lower price than the maximum price specified in this Guide, based on the actual support provided. This situation might arise, for example, if a participant enters a short term accommodation facility in the evening, and exits again early the following morning. In addition, where a participant enters accommodation late in the day, it may be appropriate to claim the daily rate for the day of the week that the majority of the support is provided. In each case, support arrangements, including price, should be agreed with participants in advance.

Short term accommodation price limits vary according to the support needs of the participant and the day of the week the support is provided. Providers claiming at the rates for high intensity (i.e. ratio of 1 support worker for 2 participants) or 1:1 support must deliver assistance with daily personal activities at those support ratios for the duration of the participant's stay.

Core - Transport

Transport enables participants to access disability supports outside their home, and to pay for transport that helps them to achieve the goals in their plan. Transport supports generally do not have price limits; however, participants should use the least expensive transport that meets their needs. Transport funding is paid fortnightly in advance to self-managed participants. Funding transport assistance is limited to those who cannot use public transport due to their disability. If the participant has questions about their transport support, providers may direct them to the NDIS factsheet available on the NDIS Website[5].

Accompanying participants for community access

Providing community access supports may, at the request of a participant, involve a worker accompanying a participant on a community outing and/or transporting a participant from their home to the community. In these situations, the worker's time can be claimed at the agreed hourly rate for the relevant support item for the total time the worker provides support to one or more participants, including time spent accompanying and/or transporting the participant. Where a provider is transporting two or more participants on the same trip, the worker's time should be claimed at the appropriate group rate for the relevant support.

This claim should be made using the relevant community participation support item and against the participant's core budget. In essence, the participant transport is a part of the community participation activity and should be billed accordingly.

Contribution towards costs of transport itself

If a provider incurs costs, in addition to the cost of a worker's time, when accompanying and/or transporting participants in the community (such as cost of ticket for public transport, road tolls, parking fees and the running costs of the vehicle), they may negotiate with the participant for them to make a reasonable contribution towards these costs.

Further details can be found at page 3.

[5] https://www.ndis.gov.au/participants/creating-your-plan/plan-budget-and-rules/transport-funding

Core - Consumables

Consumables are a support category available to assist participants with purchasing everyday use items. Supports such as Continence and Home Enteral Nutrition (HEN) products are included in this category. More information on these supports can be found in the *Assistive Technology and Consumables Code Guide* on the Assistive Technology webpage.[6]

[6] https://www.ndis.gov.au/providers/essentials-providers-working-ndia/providing-assistive-technologies-and-home-modifications

Core - Assistance with Social and Community Participation

These supports enable a participant to engage in community, social or recreational activities. They may be provided in a centre or in community settings at standard or higher intensity rates. If arranged in advance with participants, providers may charge up to four hours for each plan period to document proposed supports and expected outcomes. Price limits vary according to the support needs of the participant and the day of the week the support is provided.

Providers should not claim payment for:

- expenses related to recreational pursuits, such as event tickets for the participant, as they are not covered by the NDIS; and
- the cost of entry for a paid support worker to attend a social or recreational event.

A hierarchy of price limits also applies to this group of supports, based on:

A) the time of day that the support is delivered;

B) the day of week that the support is delivered;

C) whether the support is Standard Intensity or High Intensity;

D) if the support is High Intensity then whether it is a Level 1 (Standard), Level 2 (High Intensity) or Level 3 (Very High Intensity) support; and

E) whether the provider is eligible for the Temporary Transformation Payment.

(See the definitions and notes in the Assistance with Daily Living Support Category.)

Community and social activity costs

This support is included in a participant's plan to enable them to pursue recreational activities and engage in the community when associated with a participant's disability and goals. Participants may use this funding for activities such as camps, vacation and outside school hours' care, course or membership fees. More information can be found in the Operational Guidelines[7]

Where appropriate, funded hours in a Community Access budget may be converted to a fee and claimed by a provider for these purposes.

Group based supports

Assistance to access community, social and recreational activities is often provided in a group setting, either in the community or in a centre.

A hierarchy of price limits applies to group based supports, based on:

A) the time of day that the support is delivered;

B) the day of week that the support is delivered;

C) whether the support is Standard Intensity or High Intensity (complex);

D) whether the provider is eligible for the Temporary Transformation Payment;

[7] https://www.ndis.gov.au/about-us/operational-guidelines/planning-operational-guideline/planning-operational-guideline-deciding-include-supports-participants-plan

E) the size of the group and ratio of staff to participants; and

F) whether the support is provided in a Centre or in the community.

(See the definitions and notes in the Assistance with Daily Living Support Category.)

For support ratios that are not stated in this Guide (e.g. two workers for three participants), participants and providers should discuss and agree the most appropriate line item to be used for payments, and the appropriate price to be paid (which might be lower than the price limit for that line item).

Providers of group-based supports are not permitted to bill for non-face-to-face services as the hourly price limits for these supports include an allowance for non-face-to-face services.

Capital – Assistive Technology

This support category includes all aids or equipment supports that assist participants to live independently or assist a carer to support the participant. It also includes related delivery, set-up and some training support items. Usually, providing independent advice, guidance, trials, set-up and training (not bundled with the sale of an item) is funded through a capacity building support.

More detailed information on assistive technologies and consumables codes can be found in the *Assistive Technology and Consumables Guide* on the Assistive Technology webpage[8].

Vehicle Modifications

Vehicle modifications include the installation of, or changes to, equipment in a vehicle to enable a participant to travel safely as a passenger or to drive.

A participant is free to choose a more expensive option at their own expense, where the more expensive option is not considered to be reasonable and necessary. An example of this situation would be where a vehicle modification has been approved for a participant, but the participant would like cosmetic or personalised fittings that are not related to their disability or are more expensive than others that have an equivalent function. In this situation, the NDIA will cover the reasonable and necessary component of the modification, and the participant will pay the additional cost.

[8] https://www.ndis.gov.au/providers/at/supplying-at.html

Capital – Home Modifications and Specialist Disability Accommodation

This support category includes home modifications and Specialist Disability Accommodation (SDA) supports.

Home Modifications

Home modifications include design, construction, installation of or changes to equipment or non-structural components of the building, and installation of fixtures or fittings, to enable participants to live as independently as possible or to live safely at home. All home modifications in excess of $1,500 are quotable.

A participant is free to choose a more expensive option or modification that achieves the same outcome at their own expense, where the more expensive option is not reasonable and necessary. For example, where a home modification has been approved for a participant, but the participant would like cosmetic or personalised fittings that are not reasonable and necessary, the NDIA will provide funding for the reasonable and necessary component of the modification, and the participant will pay any extra costs.

Specialist Disability Accommodation (SDA)

SDA funding is intended for participants who require a specialist dwelling that reduces their need for person-to-person supports, or improves the efficiency of the delivery of person-to-person supports. SDA funding will only be provided for participants who meet the eligibility criteria. Participants who meet the eligibility criteria will have an extreme functional impairment and/or very high support needs.

SDA does not refer to the support services, but the homes in which these are delivered. SDA may include special designs for people with very high needs or may have a location or features that make it feasible to provide complex or costly supports for independent living.

SDA payments are an adjusted contribution to the cost of capital required for the land and physical building required for SDA needs. Importantly, SDA funding is not intended to cover personal support costs, which are assessed and funded separately by the NDIS. Additionally, SDA does not cover accommodation costs where these are not linked to a person's disability or where specialist accommodation with integrated supports is not required. SDA is a separate support category and does not replace Supported Independent Living (SIL) or any other support. Participants receiving SDA could also be eligible for SIL supports in their package.

All providers who are registered with the NDIA for the Registration Group 'Specialist Disability Accommodation' will also be required to declare and ensure that the infrastructure meets the NDIA's specialist built form requirements and the relevant legislation and standards applicable to the state in which the accommodation is situated. These individual sites/locations must also be enrolled with the NDIA.

Due to the nature of the support, the identification of maximum SDA prices and the process by which providers can claim for SDA are more complex than for most other supports. Providers should refer to the Specialist Disability Accommodation section of the NDIS website for detailed

information about maximum prices that can be charged, dwelling enrolment and participant assessments[9].

SDA has two support items: Specialist Disability Accommodation and SDA person-specific adjustments.

Each SDA dwelling has a unique maximum price, based on a standard set of factors. There are also limits on the amount that providers of SDA can charge participants in addition to the SDA price, for rent and other board-like services provided. Providers should refer to the SDA section of the NDIS website for detailed guidance on maximum prices[10]. Participants are able to choose to move between SDA dwellings, as long as the SDA dwelling is commensurate with their SDA budget.

SDA person specific adjustments

In certain limited circumstances, the NDIA will continue to make SDA payments on behalf of a participant who has moved out of an enrolled SDA dwelling. Provided all conditions are met in section 6.3 of the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016*, vacancy payments may continue to be made for a period of up to 90 days if the dwelling is enrolled to house four or five residents, or up to 60 days if the dwelling is enrolled to house two or three residents[11]. Vacancy payments will not be made where a dwelling is only enrolled to house one resident. Vacancy payments will only be payable if the vacancy is available to another NDIS participant and the NDIA has been notified.

[9] https://www.ndis.gov.au/providers/essentials-providers-working-ndia/specialist-disability-accommodation
[10] https://www.ndis.gov.au/providers/price-guides-and-information/sda-pricing-and-payments
[11] https://www.legislation.gov.au/Details/F2017L00209

Capacity Building - Support Coordination

Support Coordination (if required) is included in the Capacity Building budget. This is a fixed amount for strengthening participant's abilities to coordinate and implement supports in their plans and to participate more fully in the community.

Three items in the NDIS Price Guide describe different layers of support coordination activity.

Level 1: Support Connection

Assistance for participants to implement their plan by strengthening the ability to connect with the broader systems of supports and understand the purpose of the funded supports and participant in the community Support Connection will assist a participant to understand their NDIS plan, connect participants with broader systems of supports, and provide assistance to connect with providers. Support Connection will assist participants to achieve effective utilisation of their NDIS plan.

Support Connection will increase a participant's capacity to maintain (or in some cases change) support relationships, resolve service delivery issues, and participate independently in NDIA processes. Support Connection includes, but not limited to:

- Understand the Plan;
- Connect with Supports and Services;
- Establish Supports;
- Coach, Refine, Reflect; and
- Report to the NDIA.

Where a participant aged 0-6 years is receiving assistance from Partners in the Community (PITC) delivering Early Childhood Early Intervention (ECEI) services, linking the family to a service provider/s (under ECEI best practice principles, a service provider operating under the key worker approach) and support through changes in circumstance will be delivered through Partner arrangements.

Where a participant aged seven (7) and over is receiving assistance from Partners in the Community (PITC) delivering Local Area Coordination (LAC) services, plan implementation and monitoring support will be delivered by a Participant's Local Area Coordinator.

Level 2: Coordination of Supports

The delivery of Coordination of Supports is to assist strengthening a participant's ability to design and then build their supports with an emphasis on linking the broader systems of support across a complex service delivery environment. Coordination of Supports is to focus on supporting participants to direct their lives, not just their services. This involves working together to understand the funding, identify what participants expect from services, and how participants want this designed. Coordination of Supports also includes coaching participants, and working with participants to develop capacity and resilience in their network.

Support coordinators are focussed on assisting participants to build and maintain a resilient network of formal and informal supports.

It is generally expected that participants will develop their capacity to implement and manage their supports and network more independently over time. Some participants however will require Coordination of Supports funding in subsequent plans to support ongoing capacity building or

manage the complexity within the participants support environment and/or circumstances. This is to be identified in the plan review process. Coordination of Supports includes, but is not limited to:

- Understand the Plan;
- Connect with Supports and Services;
- Design Support Approaches;
- Establish Supports;
- Coach, Refine, Reflect;
- Targeted Support Coordination;
- Crisis: Planning, Prevention, Mitigation and Action;
- Build Capacity and Resilience; and
- Report to the NDIA.

Over time as a participant's capacity is strengthened, this support may be replaced by Support Connection or the introduction of a Local Area Coordinator (LAC) or Early Childhood Early Intervention (ECEI) Partner in subsequent plans.

Level 3: Specialist Support Coordination

Specialist Support Coordination is delivered utilising an expert or specialist approach, necessitated by specific high complex needs or high level risks in a participant's situation. Specialist Support Coordination is delivered by an appropriately qualified and experienced practitioner to meet the individual needs of the participant's circumstances such as a Psychologist, Occupational Therapist, Social Worker, or Mental Health Nurse. Specialist Support Coordination will address highly complex barriers impacting on the ability to implement their plan.

Specialist support coordination is expected to address complex barriers impacting a participant's ability to implement their plan and access appropriate supports. Specialist support coordinators assist participants to reduce complexity in their support environment, and overcome barriers to connecting with broader systems of supports as well as funded supports.

Specialist support coordinators are expected to negotiate appropriate support solutions with multiple stakeholders and seek to achieve well-coordinated plan implementation. Specialist support coordinators will assist stakeholders with resolving points of crisis for participants, assist to ensure a consistent delivery of service and access to relevant supports during crisis situations.

Specialist support coordination is generally delivered through an intensive and time limited period necessitated by the participant's immediate and significant barriers to plan implementation. Depending on individual circumstances, a specialist support coordinator may also design a complex service plan that focusses on how all the stakeholders in a participant's life will interact to resolve barriers and promote appropriate plan implementation. Once developed, a specialist support coordinator will continue to monitor the plan, but it may be maintained by one of the participant's support workers or other care supports.

In some instances depending on the individual circumstances, a participant may have specialist support coordination as well as Coordination of Supports funded in the same plan. For instance, when immediate complex barriers have been addressed and the participant still requires more general coordination of supports for the remainder of their plan period. For others, they may have specialist support coordination in one plan and Coordination of Supports in subsequent plans. Specialist Support Coordination includes, but is not limited to:

- Understand the Plan;
- Connect with Supports and Services;
- Design Support Approaches;
- Establish Supports;
- Coach, Refine, Reflect;
- Targeted Support Coordination;
- Crisis: Planning, Prevention, Mitigation and Action;
- Address Complex Barriers;
- Design Complex Service Plan;
- Build Capacity and Resilience; and
- Report to the NDIA.

Capacity Building and Training in Plan and Financial Management by a Support Coordinator

This reasonable and necessary support focusses on strengthening the participant's ability to undertake tasks associated with the management of their supports. This includes:

- Building financial skills
- Organisational skills
- Enhancing the participant's ability to direct their supports
- Develop self-management capabilities

Plan and Financial Capacity Building providers are expected to assist the participant to develop their skills for self-management in future plans, where this is possible. As a part of this capacity building support, providers are to assist the participant to build capacity in the overall management of the plan including engaging providers, developing service agreements, paying providers and claiming payment from the NDIA and maintain records.

Capacity Building - Improved Living Arrangements

Support is provided to guide, prompt, or undertake activities to ensure the participant obtains and/or retains appropriate accommodation. This may include assisting to apply for a rental tenancy or to undertake tenancy obligations in line with the participant’s tenancy agreement.

Capacity Building - Increased Social and Community Participation

This support category involves supports for participation in skills-based learning to develop independence in accessing the community.

Skills Development and Training

These support items are price controlled. Providers of these supports can also claim for: Provider Travel and Cancellations.

The group rate is based on a staff/participant ratio of 1:3. If the group size differs, providers should claim at the rate applicable for the group size. A higher staff ratio for groups may be indicated when a participant has challenging behaviour or high medical support needs, which require additional assistance from another worker and this is referred to as a higher intensity support.

Innovative Community Participation

This support item is not price controlled. It is designed to allow providers to offer new and innovative services to NDIS participants. Any standards applicable to the industry in which the provider operates would need to be met.

Community Participation Activities

These support items are not price controlled. They are designed to enable providers to claim for tuition fees, art classes, sports coaching and similar activities that build skills and independence. Camps, classes and vacation activities that have capacity building components. These may include assistance to establish volunteer arrangements in the community, mentoring, peer support or individual skill development.

All supports funded under these items need to be determined as reasonable and necessary given the participant's plan goals and could include, but are not limited to:

- Universal recreational activities: A limited number of lessons could be funded to enable a participant to try out an activity and test their capability and interest in further pursuing this activity – such as horse riding, art, dance or singing classes
- Funding to attend a "camp" or groups that build a person's relationship skills and offer a range of activities and opportunities to explore wider interests.
- Other items or adjustments such as customised tools required because of the person's disability could also be funded.

Capacity Building - Finding and Keeping a Job

Employment Related Assessment and Counselling

This support is designed to provide workplace assessment and/or counselling to assist participants successfully engage in employment. For workplace assessments - if a participant is employed and on award wages, then in most instances a work place assessment is available through the Employment Assistance Fund administered by JobAccess and is a free service to employers. For employment related counselling, this service may benefit participants who have, for example, experienced traumatic injury and need significant support (over and above a mainstream employment related service) to develop a new work pathway.

Please note that this support item falls under a different registration group, therapeutic supports, and as such, a provider needs to have registration for this group to deliver this supports.

Workplace assistance

These supports provide workplace assistance that enables a participant to successfully obtain and/or retain employment in the open or supported labour market.

These supports can be applied to any working age participant (including students reaching working age) with an employment goal. This may include supports to:

- explore what work would mean for them (discovery);
- build essential foundation skills for work;
- managing complex barriers to obtaining and sustaining employment;
- specialised job customisation;
- supports to transition from an Australian Disability Enterprise (ADE) to open employment;
- develop a career plan; and
- other capacity building supports that are likely to lead to successful engagement in a Disability Employment Service (DES).

School Leaver Employment Supports (SLES)

School Leaver Employment Supports (SLES) is a support for school leavers to assist them to transition from school into employment. Some students may already be engaged with the mainstream DES Eligible School Leaver (ESL) program during Year 12 and therefore not require SLES.

These supports are designed to plan and implement a pathway to inclusive employment, focussing on capacity building for goal achievement. With appropriate supports, it is expected that the majority of SLES participants will transition to DES to undertake the job seeking, placement and post placement support phases of their pathway.

Supports will have an individualised approach, with a strong emphasis on “try and test” work experience opportunities, (generally in work places that would pay award wages). Capacity building should focus on hard and soft skill development.

Supports, more generally, should facilitate positive experiences that contribute to developing an understanding of work capability and confidence to step into employment. SLES should also help inform the level and nature of future supports needed to obtain and sustain employment.

Capacity Building - Improved Relationships

This support category is the provision of specialised assessment where the participant may have complex or unclear needs, requiring long term and/or intensive supports to address behaviours of concern.

Behaviour support requires a behaviour support plan to be developed that aims to limit the likelihood of behaviours of concern developing or increasing once identified. This plan outlines the specifically designed positive behavioural support strategies for a participant, their family and support persons that will achieve the intended outcome of eliminating or reducing behaviours of concern.

This support category includes specialist behavioural intervention support, which is an intensive support for a participant, intending to address significantly harmful or persistent behaviours of concern.

Capacity Building - Improved Health and Wellbeing

Physical Wellbeing Activities

These activities support, maintain or increase physical mobility or well-being through personal training or exercise physiology. Physical well-being activities promote and encourage improved physical capacity and health.

Dietetics

These supports provide individual advice to a participant on managing diet for health and wellbeing due to the impact of their disability.

Capacity Building - Improved Learning

This support is for provision of skills training, advice, assistance with arrangements and orientation to assist a participant moving from school to further education.

Capacity Building - Improved Life Choices

Plan Management – Financial Administration

Plan Management – Financial Administration funding applies to registered providers who undertake financial administration of a plan on behalf of a participant.

Plan Management – Financial Administration funding includes a setup fee to establish the payment arrangements with providers and a monthly processing fee. This support assists a participant by:

- Giving increased control over plan implementation and utilisation with plan financial assistance
- Managing and monitoring budgets over the course of the plan
- Managing NDIS claims and paying providers for delivered service
- Maintaining records and producing regular (at least monthly) statements showing the financial position of the plan
- Providing access to a wider range of service providers, including non-registered providers whilst remaining in line with the price limits contained within this Guide.

A Plan Management – Financial Administration provider will possess bookkeeping / accounting skills and qualifications. They will have systems in place for efficiently processing payments on behalf of a participant.

Capacity Building and Training in Plan and Financial Management by a Plan Manager

This reasonable and necessary support focusses on strengthening the participant's ability to undertake tasks associated with the management of their supports. This includes:

- Building financial skills
- Organisational skills
- Enhancing the participant's ability to direct their supports
- Develop self-management capabilities

Plan and Financial Capacity Building providers are expected to assist the participant to develop their skills for self-management in future plans, where this is possible. As a part of this capacity building support, providers are to assist the participant to build capacity in the overall management of the plan including engaging providers, developing service agreements, paying providers and claiming payment from the NDIA and maintain records.

Capacity Building - Improved Daily Living

This support category includes assessment, training, strategy development and/or therapy (including Early Childhood Intervention) supports to assist the development or increase a participant's skills and/or capacity for independence and community participation. Supports can be delivered to individuals or groups.

Therapy Supports (over 7 years)

In the NDIS, therapy supports are for participants with an established disability, where maximum medical improvement has been reached, to facilitate functional improvement. For people who access the Scheme as 'early intervention' NDIS participants, reasonable and necessary supports are likely to be a blend of medical and disability therapies, but should be predominantly disability therapy supports. Therapy in this context must be aimed at adjustment, adaption and building capacity for community participation.

For NDIS participants whose medical condition, illness or disease requires a particular treatment to maintain the functioning of a body part, or slow/prevent the deterioration, the NDIS may fund reasonable and necessary training for non-skilled personnel to undertake this intervention as part of the usual daily personal care. For participants where such treatment can only be met through skilled rather than non-skilled care, this treatment is to be funded through medical funds, not the NDIS.

Ongoing funding for therapy is subject to a detailed support plan that is designed to deliver progress or change for the participant. Providers develop this plan with the participant and it should clearly state the expected therapy outcomes and demonstrate a link to the participant's goals, objectives and aspirations.

Massage Therapy (over 7 years)

Massage, delivered directly to impact a body part or body system, is more appropriately provided by the health system and is therefore not funded by the NDIS.

Maintenance Therapy (over 7 years)

Where maintenance therapy is reasonable and necessary, it is funded as part of ongoing direct support hours (delivered by carers who are or can be trained in this if required), and is not funded as ongoing therapy.

For participants whose medical condition or disability requires a particular regime to maintain functioning of a body part, or to slow the deterioration of a medical condition or body part, the NDIS will fund reasonable and necessary training for non-qualified personnel to assist the individual as part of usual daily care.

Where a skilled therapist is involved in establishing a therapy program for a participant, funding can include the development of a plan and training for a therapy assistant, informal or funded carers, as part of usual care. Building capacity with family and carers to undertake therapy or exercises under the supervision of a skilled therapist can deliver ongoing benefit to NDIS participants.

Group Supports for Therapy (over 7 years)

The NDIA prefers to allow participants and providers flexibility in negotiating arrangements, so there may not be price limits or support items for specific group ratios beyond what is currently in place.

For support ratios that are not stated in this Guide (such as one therapist to two participants, or one therapist to four participants), the NDIA encourages participants and providers to discuss arrangements both parties agree to, including price. Therapy delivered in a group may be claimed using the relevant therapy support line item, but with lower prices than the price limit, as agreed between provider and participant. This arrangement for support ratios is intended to allow providers to offer a range of services and discuss with participants about more flexible arrangements that both parties prefer.

Early Childhood Intervention Supports (under 7 years)

Early Childhood Intervention (ECI) provides specialised support and services for infants and young children with development delay and/or disability and their family/carers, to work towards increased functional independence and social participation. Children learn best in everyday situations with familiar people and ECI builds on opportunities for learning and development in the activities and daily routines of their everyday life.

This category includes supports provided in small groups or to individually to children and their family/carers. An ECI provider will usually offer supports via the key worker model, where the key worker has expertise in child development, learning and wellbeing more generally as well as professional qualifications, including special/early childhood education, speech pathology, occupational therapy, psychology, social work and physiotherapy. Following best practice, a key worker should take a lead role in ensuring that the professionals work in collaboration with the family/carer to provide a ‘team around the child’. Supports under this category can also be provided by an allied health assistant working under the supervision of a suitably qualified allied health professional and/or any other combination of ECI supports.

Participants under 7 years will have budgets built by Early Childhood (EC) Partners to reflect the child and family individual needs, applying the reasonable and necessary criteria as per the Early Childhood Early Intervention (ECEI) approach. Budgets will allow flexibility in service delivery by ECI providers (under the key worker model) to reflect the changing needs of the participant.

The provision of supports under ‘capacity building supports for early childhood’ are expected to deliver outcomes for the child that will enable them to participate meaningfully in everyday life. Each child’s NDIS plan will focus on functional, participation based goals and will be reviewed by the EC partner at regular intervals.

Group ratios stated in this Guide are intended to be flexible and the NDIA encourages participants and providers to discuss arrangements that both parties agree to, including price. Capacity building group programs for early childhood should be delivered by an appropriately qualified allied health professional or early childhood educator who could co-facilitate with an allied health assistant or another allied health professional or early childhood educator from the team.

ECI Providers of these supports can also claim for: Provider Travel, Cancellations, NDIA Report Writing and Non Face to Face supports.

Multidisciplinary Team Intervention (over 7 years)

This support item enables a coordinated multidisciplinary approach to be delivered to participants beyond the age covered by the Early Childhood Early Intervention approach. All team members will claim against a single support item, thereby increasing flexibility in service delivery to reflect the changing needs of a participant. This support item is not price controlled.

Delivery of Health Supports by a Nurse

A hierarchy of price limits applies to this group of supports, based on:

A) the time of day that the support is delivered;
B) the day of week that the support is delivered; and
C) who the support is delivered by:
    - Enrolled Nurses (EN)
    - Registered Nurses (RN)
    - Clinical Nurses (CN)
    - Clinical Nurse Consultant (CNC)
    - Nurse Practitioner (NP)

(See the definitions for time of day and day of week in the Assistance with Daily Living Support Category.)

Definitions

An **enrolled nurse** is a person who provides nursing care under the direct or indirect supervision of a RN. They have completed the prescribed education preparation, and demonstrate competence to practise under the Health Practitioner Regulation National Law as an EN in Australia. Enrolled nurses are accountable for their own practice and remain responsible to an RN for the delegated care.

A **registered nurse** is a person who has completed the prescribed education preparation, demonstrates competence to practise and is registered under the Health Practitioner Regulation National Law as a RN in Australia.

A **clinical nurse** is a more experienced and skilled RN. Duties of a CN will substantially include, but are not confined to:

- delivering direct and comprehensive nursing care and individual case management to a specific group of patients or clients in a particular area of nursing practice within the practice setting;
- providing support, direction, orientation and education to RNs, ENs, student nurses and student ENs;
- being responsible for planning and coordinating services relating to a particular group of clients or patients in the practice setting, as delegated by the CNC;
- acting as a role model in the provision of holistic care to patients or clients in the practice setting; and
- assisting in the management of action research projects, and participating in quality assurance programs and policy development within the practice setting.

A **clinical nurse consultant** (also known as an advanced practice nurse) is a nurse practising in the advanced practice role. Advanced practice nursing is a qualitatively different level of advanced nursing practice to that of the registered nurse due to the additional legislative functions and the

regulatory requirements. The requirements include a prescribed educational level, a specified advanced nursing practice experience, and continuing professional development. Nurses practising at an advanced level incorporate professional leadership, education and research into their clinically based practice. Their practice is effective and safe. They work within a generalist or specialist context and they are responsible and accountable in managing people who have complex health care requirements.

Duties of a clinical nurse consultant will substantially include, but are not confined to:

- providing leadership and role modelling, in collaboration with others including the Nurse manager and the Nurse educator, particularly in the areas of action research and quality assurance programs;
- staff and patient/client education;
- staff selection, management, development and appraisal;
- participating in policy development and implementation;
- acting as a consultant on request in the employee's own area of proficiency; for the purpose of facilitating the provision of quality nursing care;
- delivering direct and comprehensive nursing care to a specific group of patients or clients with complex nursing care needs, in a particular area of nursing practice within a practice setting;
- coordinating, and ensuring the maintenance of standards of the nursing care of a specific group or population of patients or clients within a practice setting; and
- coordinating or managing nursing or multidisciplinary service teams providing acute nursing and community services.

A **nurse practitioner** is an advanced practice nurse endorsed by the Nursing and Midwifery Board of Australia who has direct clinical contact and practises within their scope under the legislatively protected title 'nurse practitioner' under the Health Practitioner Regulation National Law.

IN THE FAIR WORK COMMISSION

4 Yearly Review of Modern Awards

National Disability Services

Submission – AM2018/26

Substantive Issues

1. NDS makes the following submission pursuant to the Directions made on 1 May 2019.

A. Modern awards containing reference to translators and interpreters

2. FWC has published a Background Document which sets out existing award provisions regarding community language allowances and similar provisions for employees required to perform occasional interpreting duties.

3. A number of these awards list unqualified and qualified interpreters as indicative duties for particular classification levels. The minimum rates of pay for these levels can be compared with the minimum rates of pay for SACS employees as set out in the following table.

Award	**Classification**	**Pay rate**	**SCHADS – nearest equivalent SACS classification and paypoint**	**Pay rate**
Aged Care Award 2010	Level 5 (Secretary interpreter unqualified)	$865.70	Level 2.2	$863.60
	Level 7 Interpreter (qualified)	$928.80	Level 3.1	$913.70
Amusement, Events & Recreation Award 2010	Grade 3 International host required to speak a second language	$794.70	Level 1.1	$782.00
	Grade 4 Interpreter	$837.40	Level 2.1	$837.40
Health Professionals and Support Services Award 2010	Level 5 Interpreter (unqualified)	$865.70	Level 2.2	$863.60

	Level 7 Interpreter (qualified)	$928.80	Level 3.1	$913.70

4. The SACS rates shown in the above table do not include the equal remuneration component. This means that the rates reflect the skill based relativities applied to award rates without the addition of a component that applies uniquely to the SCHADS award to remedy historic undervaluation due to gender. In other words, this enables a comparison of "apples with apples".

5. Where awards have classified the duties of interpreters they are generally at skill levels equivalent to SACS level 2 for unqualified interpreters, and SACS level 3 for qualified interpreters.

6. The *Aged Care Award* and the *Health Professionals and Support Services Award* are awards that apply to similar types of workers and workplaces as the SCHADS Award.

7. The SACS classification definitions contemplate a far wider and non-exhaustive range of skills than the classification definitions for most of the awards identified as having community language allowances and similar provisions. In those awards, the definitions are typically restricted to a short and narrow list of duties and skills at each level.

8. The relevance of the SACS classification definitions is dealt with further in the section of this submission regarding community language skills and the classification structure.

D. Industry data and the Equal Remuneration Order

9. The operation of the Equal Remuneration Order (ERO) will be the subject of a separate submission to be filed jointly by NDS, AFEI and ASU.

10. The Industry Profile published by FWC on 12 April 2019 draws on 2016 census data for employees working in the "other residential care services" and "other social assistance services" industry classes. Total employment is shown as being 167,793 in 2016.

11. The use of these industry classes is consistent with the approach of the Commonwealth Government in its submission of 18 November 2010 in the equal remuneration case for social and community services workers (C2010/3131)[1]. The Commonwealth's submission also pointed to a number of limitations to this approach[2], but concluded that nevertheless it provided a reasonable basis for estimating the size and characteristics of the sector.

12. No party disputed the approach taken by the Commonwealth in their submission regarding the size and characteristics of the sector.

13. In that submission, the Commonwealth provided an overview of the industry that would be covered by the proposed ERO. They estimated that in 2007 there would have been 6,093

[1] Australian Government submission in the matter of C2010/3131, 18 November 2010 https://www.fwc.gov.au/documents/sites/remuneration/submissions/austgovt_submission.pdf
[2] *ibid*, footnote 41 at page 64

organisations that could be subject to the ERO. Of these, it was estimated that 2,607 were employing businesses.

14. The Commonwealth Government's submission also reported that by 2009, the ABS Community Services survey estimated there were 4,033 businesses in the SACS sector subject to the equal remuneration case. These employed around 153,322 employees (90,271 fulltime equivalent). Some 90% of these employees were employed by not for profit organisations.

15. Data presented by the NSW Government in the equal remuneration case also points to a similar order of magnitude for the size of the sector. That submission drew on a report[3] of survey of state government funded organisations in NSW and indicated about 1500 such employers in NSW in 2010.

16. The estimate of employment in the current Industry Profile published by FWC is a similar order of magnitude to that of estimates provided by the Commonwealth government in the equal remuneration case.

17. By using data for the same industry classes as was used in submissions for the equal remuneration case, the same limitations of precisely defining the sector identified by the Commonwealth will also apply.

18. NDS concludes that the approach taken in the Industry Profile results in a reasonable estimate of the likely size of the sector.

E. **Community language skills and the classification structure**

19. The classification definitions for SACS employees are set out at Schedule B of the SCHADS award.

20. The classification definitions set out

    a) generic characteristics of work at each classification level, together with

    b) a non-exhaustive list of indicative duties and responsibilities that would sit at each classification level, and

    c) Skills and experience required, and

    d) Organisational relationships and extent of authority at each level.

21. NDS submits that while "community language skills" are not explicitly named in the classification definitions, they can be considered to be contemplated by the reference to generic related skills.

22. SACS Level 2 specifies (at B.2.3 (a) (i)) that skills needed to perform work at that level include *"…basic skills in oral and written communication with clients and other members of the public…"*

23. The reference to skills in communication does not specify any particular language. Ordinarily it would be presumed that the relevant language is English. However in services where

[3] Social Policy Research Centre, UNSW (2010) *Profiling non-government community services organisations in New South Wales*. Report prepared for Department of Human Services NSW. https://www.fwc.gov.au/documents/sites/remuneration/submissions/austgovt_submission.pdf

workers are required to use their native non-english language in working within the community, the level of skill required will be equivalent to "basic skills in oral and written communication".

24. SACS Level 2 is the entry level for Certificate qualified workers and equivalent to the classification levels used for unqualified interpreters in the modern awards tabulated at paragraph 3 of this submission.

25. Work at SACS Level 2 may be quite highly skilled and can cover work performed by certificate 4 qualified workers with significant experience.

26. One of the general characteristics of SACS level 2 is that a worker "…*may contribute specific knowledge and/or specific skills to the work of the organisation*…" (B.2.1 (b)).

27. Knowledge of a second language can be considered to be a "specific knowledge or skill".

28. SACS Level 3 specifies

    a) At B.3.2 (j), that responsibilities may include *"……scope for exercising initiative in the application of established work procedures…"* and

    b) At B.3.2 (n), that "…*where prime responsibility lies in a specialised field, employees at this level would undertake at least some of the following:*

        a. ……;

        b. perform duties of a specialised nature;

        c. *provide a range of information services;…*"

    c) At B.3.3 (a) (iii) that in relation to skills and knowledge needed for work at this level, the employee "…*may utilise limited professional or specialised knowledge*…"

29. SACS level 3 is the entry level for degree qualified workers and equivalent to the classification levels used for qualified interpreters in the modern awards tabulated at para 3 of this submission.

30. Work at SACS Level 3 covers graduates as well as experienced workers without formal qualifications. One of the general characteristics of the level is that the work may "…*involve solving problems of limited difficulty using knowledge, judgment and work organisational skills acquired through qualifications and/or previous work experience*…" (at B.3.1 (b)).

31. The definitions at both SACS levels 2 and 3 are not a narrow list of tasks or occupations. Rather they describe a range of generic skills and indicative tasks. Where a job role has duties not specifically mentioned in the classification definitions, the generic descriptors enable an assessment of the classification to be made by referring to equivalent types of skills and responsibilities.

F. Part-time employment and casual employment Full Bench (AM 2014/196 and AM 2014/197)

32. The operation of the NDIS is described by the Full Bench in the Part-time and casual employment decision.[4]

33. NDS submits that the observations of the Full Bench were accurate at the time and remain broadly relevant in 2019.

34. However, since that decision in 2017 the NDIS has continued to grow and has undergone some changes in the detail of its operation.

35. NDIS participant numbers are behind the original NDIS Bilateral agreements participant estimates (i.e. by about 100,000). This means the current rate of rollout of NDIS is at about 75% of the level originally planned in 2011[5]. Consequently the rollout will be extended well into 2019-20 and is unlikely to be completed before then.

36. At paragraph [631] of the Full Bench decision, reference is made to cancellations of supports by clients. Since that time, the approach of NDIA to cancellations has been modified. The current NDIS Price Guide allows for 90% of the fee to be charged if a participant cancels later than 3pm the day before the appointment. The participant can be charged up to 12 times in a year, after which NDIA may review the situation.

37. If a participant provides notice prior to 3pm the previous day, the provider cannot charge the participant.

38. The workforce has also undergone changes since the 2017 decision. At paragraph [633] of the Full Bench decision there is discussion of the characteristics of the disability workforce. That discussion referred to workforce reports published by NDS using 2016 data.

39. NDS has developed a Data Metrics Tool called Workforce Wizard designed to assist disability organisations track workforce trends. This was the source of the data referred to by the Full Bench in its decision at [633].

40. NDS have published a comprehensive report with data to July 2018[6]. Since then Workforce Wizard for the December 2018-19 quarter have been obtained, and this included data from 187 organisations, comprising of 41,119 workers in the disability and allied health sectors.

41. The average proportion of casual employment increased from 40.9% in September 2015 to 45.2% in December 2018. However, it has remained at around 45% since September 2017, with the exception of the September 2018 quarter (47.3%). While disability service providers are hiring more casual workers, the trend towards increased casual employment since 2015 appears to have stabilised.

42. It is important to note that the rate of casual employment has increased to 45.2% from a low of 39.2% in the June 2016 quarter.

National Disability Services

17 May 2019

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[4] [2017] FWCFB 3541 at [554] and [630]-[633].

[5] NDIS (2019), *Report to the COAG Disability Reform Council for Q3 of Y6 Summary Part A* , page 6, section 1.4, https://www.ndis.gov.au/about-us/publications/quarterly-reports

[6] NDS (2018), *Australian Disability Workforce Report July 2018*. https://www.nds.org.au/images/workforce/ADWR_Third_Edition_July_2018.pdf

Operation of the Equal Remuneration Order

1. The Equal Remuneration Order commenced on 1 July 2012, and provides for equal remuneration payments in addition to the *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award) minimum rates for SACS classifications 2-8 and Crisis Accommodation classifications 1- 4.
2. The Order provides for rates of pay which will be between 23-45% above the SCHADS Award minimum rates, depending on the classification level once fully phased in (the 'final ER rates'). These are inclusive of a 4% loading to compensate for obstacles to bargaining in the sector.
3. The final ER rates are being phased in between 2012 and 2020 via nine equal instalments[1], as outlined in 5.5 of the Order.
4. Table 1 shows the percentage difference between the SCHADS Award rates, and the final ER rates, for each SACS classification level. As the final ER rates are being phased in via nine equal instalments, the table also shows the approximate percentage difference per annum.

SACS Level	Final ER rates by 2020 (% above Award rates)	1/9 instalment per annum (%)*
2	23	2.6
3	26	2.9
4	32	3.6
5	37	4.1
6	40	4.4
7	42	4.7
8	45	5
*The exact percentage varies slightly in the years after 2012 due to the effects of compounding, incorporation of national wage increases and rounding. Note: The payments for Crisis Accommodation are identical, with CA levels 1-4 aligning with SACS levels 3-6.		

Table 1 Final ER rates, as a percentage above the SCHADS Award rate at each SACS classification level

[1] [2012] FWAFB 5184 at [73]

5. The ERO case ran during the first 2 years of implementing the modern award system, and the transition from pre-reform award and NAPSA classifications and pay rates to the modern award was put on hold pending the outcome of the ERO case.
6. A Fair Work Commission audit of awards for award modernisation indicated 39 pre-reform awards and NAPSAs that would transition to the SCHADS Award. These instruments had different classification and pay structures, with some classification and pay points having rates lower than the SCHADS rate for the equivalent classification (as set out in clauses 15 and 16 of the Award), and some above.
    a) Where a pre-reform award or NAPSA pay rate was below the equivalent SCHADS Award rate (cl 15 & 16 of the award), from July 2012 the rate transitioned fully to the SCHADS Award rate, without the phasing in process that applied to other modern awards.
    b) Where a pre-reform award or NAPSA pay rate was above the equivalent SCHADS Award rate, that rate was preserved as a transitional minimum rate of pay by Clause A.3.9 of the SCHADS Award. Although A.3.9 ceased effect on 1 July 2014, it is preserved in 5.3 of the ERO, for the duration of the phasing in of the final ERO rates.
7. In order to determine whether a transitional minimum rate applies to a particular position, it is necessary to:
    a) Classify the position under the SCHADS Award;
    b) Classify the position under the relevant pre-reform award or NAPSA, as if it still applied;
    c) Compare the pay rates for the classification for each of the two instruments at 1 January 2010;
    d) If the relevant pre-reform award or NAPSA rate is higher, then a transitional rate applies and is used as the basis for the calculation of ERO payments.
8. Each December from 2012-2020 an ERO instalment is payable. This is 1/9 of the difference between the applicable SCHADS or transitional minimum rate, and the final full ER amount calculated on the SCHADS rate.
9. The effect is that if a transitional minimum rate applies that is above the SCHADS Award rate, a smaller increase is payable.
10. Figures 1 and 2 illustrate how this works.

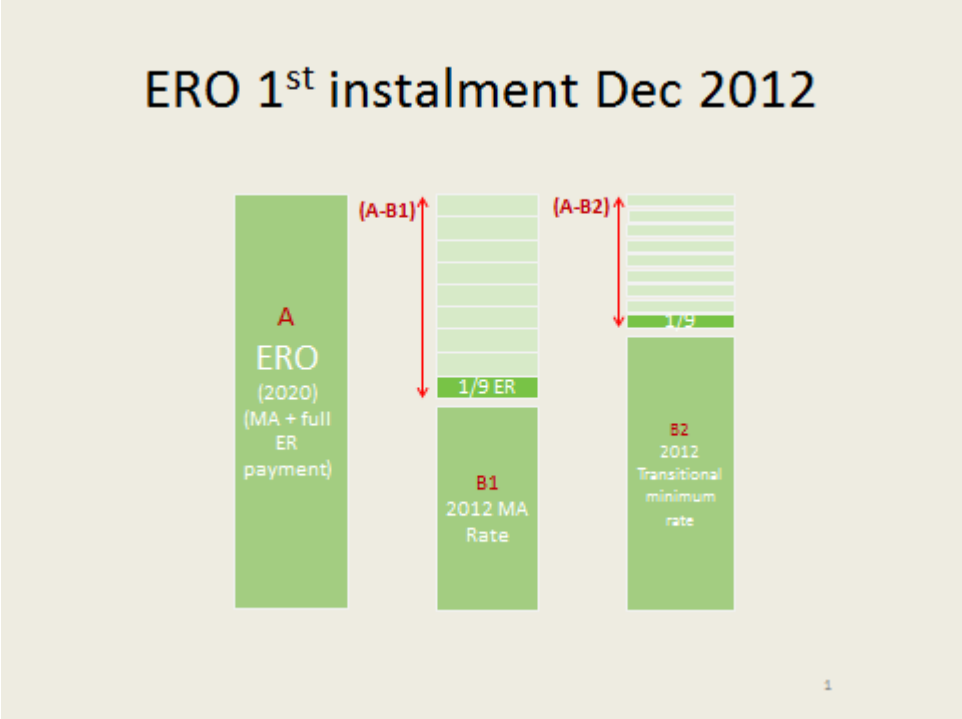


Figure 1 The application of the first ERO instalment in 2012. Column A represents the full ER payment calculated on the relevant SCHADS rate of pay (MA) for a classification level. Column B1 shows the payment of the first instalment of 1/9 of the ER payment on the SCHADS rate (MA). Column B2 shows the payment of the first instalment where a transitional minimum rate applies.

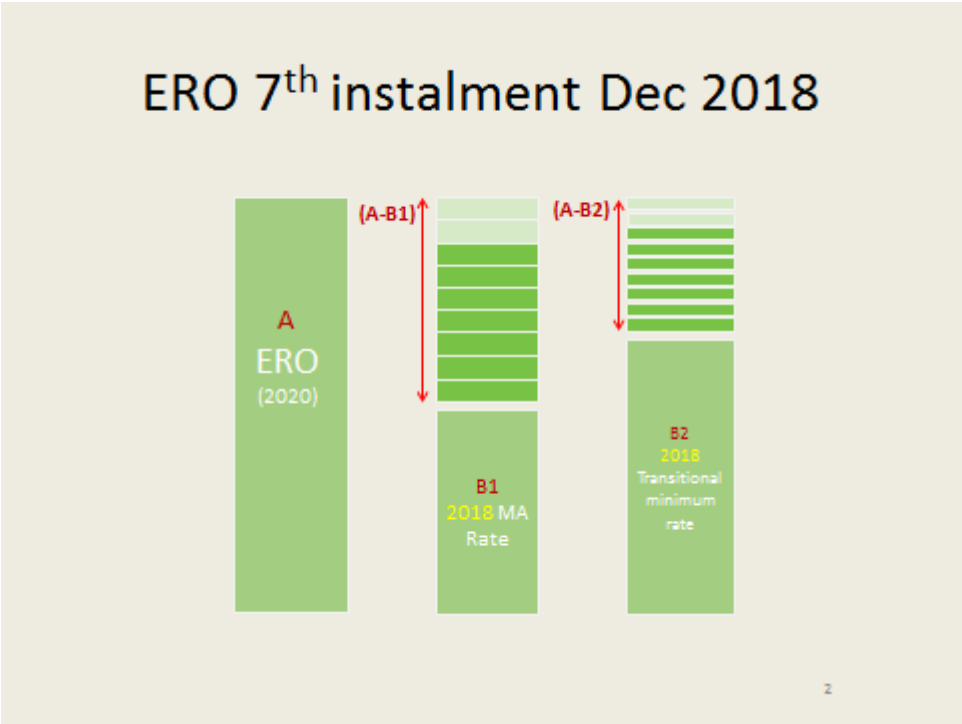


Figure 2 The application of the most recent, 7th, instalment in December 2018.

11. Figures 1 and 2 show how at any point in time, the actual rate paid will be different for different transitional pay rates derived from pre-reform awards or NAPSAs.

12. Figure 3 illustrates how the gap between a transitional rate plus ER and the SCHADS rate plus ER closes over time, and disappears by December 2020.

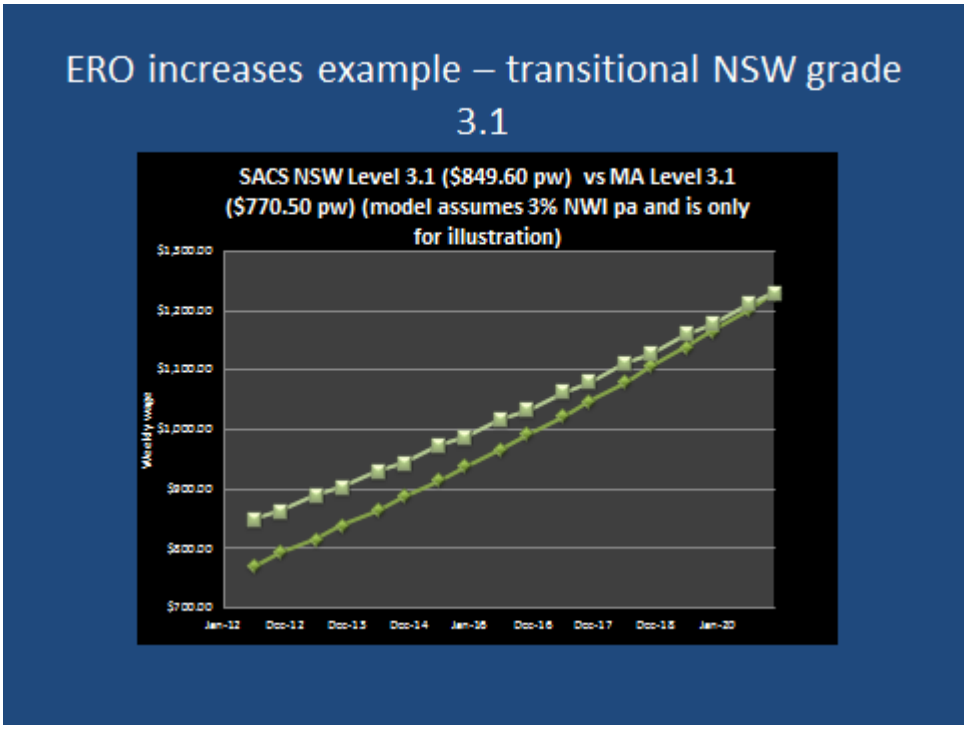


Figure 3 Example of how the gap between SCHADS plus ER pay rates and transitional award + ER pay rates closes over the period 2012-2020. The example is based on ERO payments for the transitional rate for SACS Level 3.1 (derived from Grade 3.1 of the SACS NSW NAPSA), compared with ERO payments for the SCHADS rate for SACS Level 3.1 set by clause 15.

13. Payments under the ERO count as part of the ordinary rate of pay for all purposes. The Standard Rate of the award that is used for the calculation of allowances does not however incorporate the ER payment.

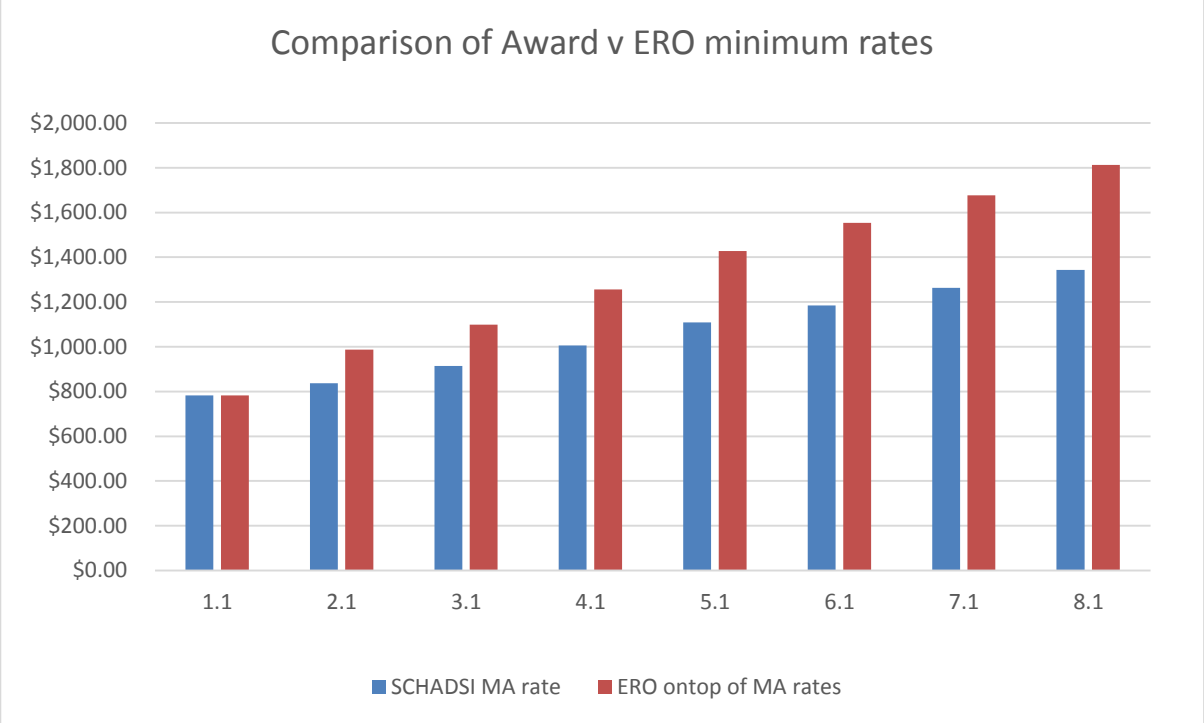
14. From December 2020, the final ER rates will be fully phased in, and forms part of the ordinary rate of pay for all purposes. The transitional rates will no longer apply from this date, and will no longer be relevant because the final ER rate is the same irrespective of pre-modern award coverage.

15. One consequence of the ERO is that the rates set out in clauses 15 and 16 of the SCHADS Award do not represent the minimum rates actually paid.

16. Table 2 below compares the clause 15 rates for SACS classifications in the SCHADS Award (used in the Information Note published by FWC on 9 April 2019), with the actual rates payable for the current instalment under the ERO, where the pre-modern award instrument was not higher than the SCHADS award at 1 January 2010. In these circumstances, calculation of the current ER instalment is based on the SCHADS Award rate in Cl. 15 only.

SACS Level	SCHADS Cl 15 rate	ERO rate	% difference after the December 2018 increase
1.1	$782.00	n/a	0
2.1	$837.40	$987.20	17.9
3.1	$913.70	$1098.47	20.2
4.1	$1005.90	$1256.26	24.9
5.1	$1108.70	$1427.76	28.8
6.1	$1185.30	$1554.06	31.1
7.1	$1264.00	$1676.91	32.7
8.1	$1343.00	$1813.05	35

Table 2 Rates payable under the ERO where the pre-modern award instrument was not higher than the SCHADS Award rate at 1 January 2010.



Graph 1: gives a visual representation of Table 2

17. There are thousands of potential paypoints that could apply for the various possible classification translations and transitional pay rates from about 39 pre-reform awards and NAPSAs. Table 3 uses one SCHADS Award paypoint - the 4 year degree entry point (SACS 3.4) - to illustrate the different transitional rates that apply for some of the more commonly used pre-reform awards and NAPSAs that specified a 4 year degree entry point.

Pre-reform award or NAPSA	Current ER rate (Dec 2018)	Difference compared to current ER rate calculated on SCHADS CL.15 rate only	% Difference
SACS awards from ACT, Qld, SA, & WA Community Services Award Tas	$1177.72* (pre-modern awards not higher than SCHADS Award rate)	-	-
SACS Vic - Social worker classification	$1184.54*	$6.87	0.6%
SACS NT	$1185.99*	$8.27	0.7%
Disability Services Vic	$1202.61**	$24.89	2.1%
SACS NSW	$1207.78	$30.02	2.6%
Qld TPEO^	$1257.70*	$79.98*	6.8%*

*The Fair Work Ombudsman Pay Guide Rates

** Rates may vary depending on rounding

Table 3 Comparison of current ER rates where pre-modern award was higher than the SCHADS Award at 1 January 2010, with ER rates where pre-modern award was not higher than SCHADS Award, for Level 3.4 (calculated on the SCHADS Award rate only).

18. ^The final example in Table 3 is the rate from the Queensland Transitional Pay Equity Order which applies to a small number of organisations in Queensland. The TPEO preserves the effect of the 2009 Queensland pay equity order of the QIRC which delivered payments similar to the national ERO. Those equal remuneration payments were delivered in full by 2015. The December ER payments do not apply to those rates. National wage increases do apply to the TPEO, and the TPEO rates will align with the equal remuneration order rates based on the modern award by December 2020.

National Disability Services

Australian Federation of Employers and Industries

Australian Services Union

16 May 2019

IN THE FAIR WORK COMMISSION

4 Yearly Review of Modern Awards

National Disability Services

Submission – AM2018/26

Social, Community, Home Care and Disability Services Industry Award 2010

Substantive Issues Tranche 2 – Claims advanced by ABI and others

Introduction

1. National Disability Services (NDS) makes the following submission pursuant to the Directions made on 13 May 2019 and amended on 28 June 2019.

2. This submission is in support of the variations proposed by Australian Business Industrial, the NSW Business Chamber, Aged & Community Services Australia and Leading Age Services Australia (ABI & others).

3. ABI & others filed a draft determination on 2 April 2019. The draft determination provided for substantive changes in relation to provisions of the *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS, or the Award) regarding:

    a) Ordinary hours of work;

    b) Client cancellation; and

    c) Remote response work and consequential amendments to the clause relating to on call allowance and also to the clause for recall to work overtime.

A. Ordinary hours of work

Variation to Clause 25.1 – ordinary hours of work

4. Clause 25.1 of the Award currently prescribes three ways in which fulltime hours may be worked.

> **(a)** *The ordinary hours of work will be 38 hours per week or an average of 38 hours per week and will be worked either:*
>
> > **(i)** *in a week of five days in shifts not exceeding eight hours each;*
> >
> > **(ii)** *in a fortnight of 76 hours in 10 shifts not exceeding eight hours each; or*
> >
> > **(iii)** *in a four week period of 152 hours to be worked as 19 shifts of eight hours each, subject to practicality.*
>
> **(b)** *By agreement, the ordinary hours in clause 1.1(a) may be worked up to 10 hours per shift.*

5. The list is exhaustive and on the face of it does not permit alternative arrangements for fulltime work.

6. The effect of the current clause is that it prevents other arrangements from being mutually agreed. For example, it does not permit an employee to work a compressed 4 day working week of shifts of 9 hours 30 minutes each, and having the benefit of three consecutive days off as a long weekend.

7. The draft determination retains the current protections for employees in relation to a default maximum shift of 8 hours which can only be increased, to a maximum of 10 hours, by mutual agreement between the employer and employee.

8. The effect of the changes to clause 25.1 would simply be that the ordinary hours of work for a fulltime employee are subject to the same constraints as currently apply in relation to shift length, span of hours and rest breaks, but allows an employer and employee to agree on a wider range of mutually agreeable arrangements within those constraints.

9. The draft determination has no effect on other key hours of work provisions such as the span of hours (clause 25.2) or rest breaks between shifts (clause 25.3).

10. NDS submits that the restriction of fulltime hours of work to the three formulations allowed by the current clause 25.1 (a) is unnecessary and limits flexibility and options for work life balance for the employee.

Variation to clause 25.4 – Rest breaks between rostered work

11. It is proposed by ABI & others that clause 25.4 (a) be varied by the deletion of the phrase "or period of work". The phrase in question does not seem to serve any particular purpose that is not already covered by the term "shift" in the same clause. The phrase "period of work" is not used anywhere else in the award in relation to hours of work and so its deletion simply helps with clarity.

Variation to clause 25.5(d) - Rosters

12. It is also proposed that clause 25.5(d)(ii) be varied to allow a roster to be varied at any time by mutual agreement, or where the employee is absent on specified types of paid leave.

13. The ability to change the roster by mutual agreement facilitates reasonable flexibility without restricting the rights of employees. An example might be if two employees approach their employer to swap shifts at short notice for non-urgent reasons. The current provision appears to mean that if an employee and employer genuinely agree to such a change with less than 7 days' notice, they may be in breach of the award.

14. The specification of the types of paid leave relevant to the ability to change the roster at short notice serves to update the provision in relation to the range of leave entitlements that are available for use in situations that can occur at short notice, such as family and domestic violence.

15. The proposed variation does not confer on the employer any new expanded right to roster at short notice without the agreement of the employee.

Conclusion

16. The variations in the terms sought for the ordinary hours of work and rostering provisions would be consistent with the modern awards objective, in particular the need to promote

flexible modern work practices and efficient and productive performance of work (s136 (d) of the Act).

B. Client cancellation

17. Clause 25.5 (f) currently prescribes arrangements for when a client cancels a rostered home care service. The clause only applies to home care services and so appears to only apply to workers classified in accordance with Schedule E of the Award as Home Care Employees.

18. The current clause allows an employer to withhold payment to the employee provided notice of the cancellation is given by 5pm of the day prior to the rostered shift. It also enables the employer to direct the employee to work make up time in exchange for payment, as set out below.

> *(f)* ***Client cancellation***
>
> *(i) Where a client cancels or changes the rostered home care service, an employee will be provided with notice of a change in roster by 5.00 pm the day prior and in such circumstances no payment will be made to the employee. If a full-time or part-time employee does not receive such notice, the employee will be entitled to receive payment for their minimum specified hours on that day.*
>
> *(ii) The employer may direct the employee to make-up time equivalent to the cancelled time, in that or the subsequent fortnightly period. This time may be made up working with other clients or in other areas of the employer's business providing the employee has the skill and competence to perform the work.*

19. The proposed variation does three things:

    a) It removes the option of withholding payment from a worker in the event of a cancellation;

    b) It extends the operation of the clause to disability support work; and

    c) It provides more flexibility around the timetabling of make up time.

Payment in the event of client cancellation

20. The proposal from ABI & others removes the ability of the employer to withhold payment to an employee in the event of a client cancellation where notice has been provided by 5pm the previous day.

21. Instead, it is proposed that a more flexible approach to make up time is a more appropriate way to deal with the operational difficulties that arise from client cancellations.

22. NDS supports this approach as the current provision for home care employees would appear onerous, while at the same time, employers face genuine operational difficulties in relation to client cancellations.

Application of client cancellation provisions to disability services

23. NDS submits that the implementation of the National Disability Insurance Scheme (NDIS) has resulted in a major expansion in the amount of disability support work being performed for individual clients in private residences and community settings. Client cancellations are an

increasingly common occurrence in disability services, usually for perfectly legitimate reasons such as illness of the client.

24. The NDIS commenced in 2013 and previous submissions and evidence in these proceedings, including from the union parties, have attested to the fundamental changes occurring in the organisation of work under the NDIS.

25. A result of the changes under NDIS is that client cancellation in disability services is a much greater operational issue than was the case at the time of the making of the modern award in 2010. It is therefore appropriate to revisit the issue in the context of this four yearly review.

26. NDS also refers to the witness statement of Steven Miller, from Endeavour Foundation, filed in these proceedings as evidence in relation to this matter.

27. Mr Miller reports that cancellations are a frequent occurrence in his organisation with around 50 cancellations per month across the services of Endeavour Foundation.[1]

Flexibility and make up time

28. As a practical reality, it is not always possible to simply allocate a support worker to another customer when there has been a cancellation. In the example of Endeavour Foundation, the practice (consistent with the award rostering requirements) is to ensure rosters are set 2 weeks in advance which means that support workers are already allocated to customers by the time a cancellation occurs. Mr Miller reports that even where another service becomes available to be filled at short notice, a particular support worker might not be able to cater to the specific needs of the client if they have not undergone specific training or orientation[2].

29. NDS submits that additional considerations include the personal preference of clients regarding which worker is assigned to provide their support. This is a fundamental aspect of choice and control for people with disabilities under the NDIS and reflected in care plans negotiated with clients. The personal preference of clients regarding the identity of their workers is an additional constraint on the ability to reallocate work.

30. The NDIS Price Guide for 2019-2020 has modified funding arrangements in the event of client cancellation. Specifically, providers can claim 90% of the charge for the cancelled appointment where the client provides up to 2 days' notice, and there is no cap on the number of times this can be done. The Guide states[3]:

> *Where a provider has a short notice cancellation (or no show) they are able to recover 90% of the fee associated with the activity, subject to the terms of the service agreement with the participant.*
>
> *A cancellation is a short notice cancellation (or no show) if the participant has given*
>
> - *less than 2 clear business days' notice for a support that is less than 8 hours continuous duration and worth less than $1000; and*

[1] Statement of Steven Miller [40-41]
[2] Miller [43-46]
[3] NDIS Price Guide 2019-2020, (1 July 2019), pages 12-13

- *less than 5 clear business days' notice for any other support.*

There is no limit on the number of short notice cancellations (or no shows) that a provider can claim in respect of a participant.

However, providers have a duty of care to their participants and if a participant has an unusual number of cancellations then the provider should seek to understand why they are occurring.

The NDIA will monitor claims for cancellations and may contact providers who have a participant with an unusual number of cancellations.

31. The changes for 2019-2020 mean that the financial impact on the employer of a cancellation made with 2 days' notice is slightly reduced compared to previous years, because the previous cap of payment for a maximum of 8 occasions per year has been removed.

32. Nevertheless, client cancellation remains a problem. An employer still needs to be able to reallocate work in the event of a cancellation, if other work is available. An example where this is important for reasons of efficiency and productivity, is if the worker can be redeployed to backfill for another worker on unplanned personal leave.

33. Notwithstanding the changes to the arrangements for cancellations under the NDIS Price Guide, the employer still has a problem in relation to cancellations made with more than 2 days' notice but less than 7 days. If no other work is available to be allocated to the worker, then the worker is paid without having to perform work, and the employer is unable to charge the customer for this. Furthermore, clause 25.5 (d) limits the ability of an employer to change a roster with less than 7 days' notice to situations of illness or emergency.

34. The current clause 25.5(f) deals with this situation for home care workers by providing the option using make up time by the end of the following fortnightly period.

35. The proposed new clause 25.5(f) extends this option to disability support workers, but also extends the time available for the employer to find suitable work to 3 months.

36. NDS submits that an extended period is needed to enable suitable work to be found for the working of make-up time because of the difficulty of matching appropriate workers to individual clients[4].

37. Client choice and control in the operation of the NDIS is also a factor in the need for an extended period to organise make up time, because the individual client has enhanced negotiating power with providers in relation to the timetabling of supports, as well as the identity of the worker as previously mentioned. The provider cannot unilaterally schedule work for their own administrative convenience without reference to the client.

38. The proposed variation provides that the employee must be consulted in accordance with clause 8A about rostering the make-up time.

39. If make up time is to be performed it must be rostered, in accordance with the relevant award clause (25.5(a)), which means the onus is on the employer to use the provision. It cannot be delayed indefinitely but must be arranged by the employer within 3 months. This

[4] Miller, [43-46]

provides reasonable certainty for the employee about the expectations around future make up time that may be required of them.

40. NDS supports the proposed variation to the client cancellation provisions. The variations would be consistent with the modern awards objective, in particular the need to promote flexible modern work practices and efficient and productive performance of work (s136 (d) of the Act).

E. **Remote response**

41. The award is currently silent on how to deal with work performed outside ordinary rostered hours that does not require travel to a physical workplace. This has the potential to create confusion and disputation around the application of clause 28.4 which deals with recall to work overtime.

42. Since the making of this modern award in 2010 there has been a rapid growth in the use of technology to enable remote working arrangements.

43. NDS is aware that on call arrangements are widely used throughout the social and community services sector, not just in disability services. The purpose of on call varies but includes availability for dealing with client emergencies, ensuring frontline workers can access advice from senior employees for non-routine circumstances, and in the context of the NDIS, handling short term rostering issues such as client cancellation or employee absences.

44. The draft determination filed by ABI & others seeks to do a number of things that clarify the operation of the Award, while ensuring reasonable protections for employees.

45. The first proposal is to vary clause 20.9 to the effect that the on call allowance applies to workers who are required to be on call, with on call defined to include availability for remote response duties in addition to the existing requirement of "*available for recall to duty*".

46. The second proposal is to insert a new clause 20.10 which deals with the category of work called remote response. It defines such work as the type of work that is very common in the twenty first century, including using email and phones to respond to work requirements.

47. The key difference between remote response duties and recall to duty, is that recall to duty requires physical travel to a workplace from the employee's private out of hours location.

48. The current clause 28.4 deals with recall to work overtime after the employee has left the employers' premises and provides for payment for a minimum of two hours of work. The purpose of the two hours' minimum payment is to compensate the employee for the time, inconvenience and costs associated with travel to the workplace. In this respect it is analogous to a minimum engagement payment. The work performed is overtime because it is not rostered ordinary hours, and is paid at the appropriate rate for the employee.

49. NDS submits that clause 28.4 as it stands does not apply to an employee who responds to a phone call or email while on call but who does not need to travel to a workplace. However, we are aware of the potential for confusion in relation to this and support the need for the Award to be amended to remove any ambiguity.

50. The effect of the draft determinations for variations to clauses 20.8 and 28.4, and a new clause 20.9 would be to remove any ambiguity and also to set reasonable minimum entitlements for employees who perform remote response duties.

51. NDS submits that when an employee performs remote response duties while on call, the work does not meet the definition of ordinary hours or a rostered shift because the work itself is not timetabled or rostered. The employee is rostered and paid an on call allowance as compensation for keeping themselves available to work. There is no certainty as to whether they will be required to perform any work at all.

52. In the event that remote response duties need to be performed, the work will therefore be overtime. If the matter was left there, the employer would simply be required to pay overtime for the exact amount of time worked. NDS submits that this leads to some practical administrative difficulties with tracking short duration tasks. It also potentially does not adequately compensate for the disruption associated with short tasks at unpredictable intervals. The draft variation addresses this by proposing a minimum payment of 15 minutes.

53. In addition, by its nature, on call is usually used for out of normal office hours availability. This includes overnight and raises the prospect of employees having their sleep disturbed by late night calls. The proposal from ABI & others recognises the need to compensate employees for the disruption associated with calls during the night by providing for a one hour minimum payment for remote response duties performed between the hours of 10pm to 6am.

54. The draft variation then sets out administrative requirements for ensuring accurate record keeping and facilitating the operation of the clause.

55. NDS submits that this proposal removes ambiguity about the operation of the Award in relation to on call and recall.

56. The draft determination also fill a gap in the safety net for employees who are required to perform remote response duties, by specifying reasonable minimum payments for such work in compensation for the interruptions and inconvenience imposed, while not requiring the employer to match the compensation required for a physical recall to a different location.

57. NDS supports the proposed variations to establish entitlements in relation to remote response duties and the consequential amendments to the on call and recall provisions of the Award.

Michael Pegg

on behalf of National Disability Services

2 July 2019

IN THE FAIR WORK COMMISSION

4 Yearly Review of Modern Awards

National Disability Services

Submission in Reply – AM2018/26

Social, Community, Home Care and Disability Services Industry Award 2010

Substantive Issues Tranche 2 – Claims advanced by Unions (Attachment C)

Introduction

1. National Disability Services (NDS) makes the following submission in reply, pursuant to the Directions made on 13 May 2019 and amended on 11 July 2019.
2. This submission is in response to variations proposed by the Australian Services Union (ASU), United Voice (UV), and Health Services Union (HSU) as summarised in Attachment C of the Directions.

Industry Context

3. National Disability Services (NDS) is the peak organisation for non-government disability providers with about 1,000 members across Australia.
4. NDS members operate several thousand services for Australians with all types of disability. Members range in size from small support groups to large multi-service organisations. They provide person-centred support for people with a disability – through personal one-to-one care in homes and in group settings, professional therapy, education, training and life-skills development, employment, accommodation support, respite and recreation.
5. The disability sector is undergoing profound change as a consequence of the implementation of the National Disability Insurance Scheme (NDIS). The NDIS is a major social program that, when fully implemented, will deliver supports to an estimated 460,000 people with disability.
6. Our submission of 5 April 2019 in these proceedings made brief reference to earlier submissions and evidence about the impact of the NDIS on this industry. We now also refer to the witness statement of David Moody[1], acting CEO of NDS, which provides an updated summary of the implementation of the NDIS, how it is affecting the operations of providers and the delivery of care by workers, and the relevance of NDIS to consideration of proposed changes to the Award.
7. In short, the NDIS is more than just another funding program. It represents a complete overhaul of the delivery of disability services, requiring an investment when fully

[1] Witness Statement of David Moody.

implemented of about 1% of GDP[2]. The scheme has bipartisan political support and can be expected to underpin disability service delivery for a long time to come.

8. The NDIS has similarities to the introduction of consumer directed care in aged care, which applies in the home care sector covered by the *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS award). The arrangements deliberately place more power in the hands of the individual being supported (the participant) in determining how, when and by whom their supports will be provided. There is a corresponding reduction in the power of the provider to dictate these things to participants.

9. The relevance of the NDIS is apparent in relation to the raft of claims made by the unions in both tranches 1 and 2 of the present review of the SCHADS award. Most of the claims respond directly to issues that arise as a consequence of the NDIS.

10. The introduction of the NDIS post-dates the making of this modern award, and so we submit that it is appropriate that the review take account of these changes. Our submission of 2 July 2019 in support of proposals made by other employer parties, was made in recognition of the need for change in some aspects of the award.

11. Nevertheless, NDS submits that a balanced approach is needed to considering claims to vary the award. The tight pricing approach of the NDIS, together with the choice and control available to participants, places employers under very real pressure to be able to be flexible in the delivery of services. At the same time, NDS is aware of the risks of unfettered flexibility that might be expected to drive casualisation, high turnover and de-skilling of the workforce[3].

Minimum Engagement

12. The HSU proposal seeks to impose a minimum engagement of 3 hours for all part-time and casual employees subject to this award.

13. The two key aspects of the draft variation are

    a) an increase in the minimum engagement for disability and home care workers to 3 hours, and

    b) the extension of the minimum engagement provision to fulltime and part-time employees.

14. The minimum engagement provided by the SCHADS award for casual employees in disability services of 2 hours reflect the realities of work in the context of the NDIS. Disability support work often involves catering to personal care needs of disabled clients who only require 45 minutes to 2 hours of assistance at a time. As an example, evidence from Steven Miller describes the high level of demand for short periods of support experienced by a major

[2] David Moody, [14]
[3] David Moody, [23-40]

disability service provider that provides a range of supports[4]. This evidence is consistent with the observations of NDS across the sector[5]

15. The award already provides an incentive for the employer to attempt to create longer shifts by arranging for workers to visit a number of clients sequentially, in order to avoid the cost of paying, for example, 2 hours wage when only one hour of work is needed. Despite this, outside densely populated metropolitan areas, there may not be sufficient clients to allow this type of bundling of work to occur.

16. Under NDIS, there is no payment to the provider for topping up to the minimum engagement if only a shorter period of work is required.

17. We note that the issue of minimum engagement was dealt with in depth by a Full Bench in the *Casual and Part Time Employment Decision*[6]. That decision took account of a wide range of factors to be considered in general in relation to the establishment of minimum engagements, including the need to consider industry-specific circumstances and the potential downsides for employees of unduly long minimum engagements.

18. Factors that are relevant in the context of the SCHADS award include the provisions of clause 10.3 which require employers to provide part-time employees with guarantees regarding their hours of work on a weekly and daily basis. These requirements provide a degree of stability for part-time employees compared to the situation for casuals.

19. The effect of the HSU claim for a 3 hour minimum engagement will simply be to increase the cost of the minimum engagement for disability support workers, with there being no mechanism available for the employer to recover that cost. Where short shifts are currently used, it is because there is no other work available. A 3 hour minimum will not result in 3 hours work appearing where it currently does not exist.

20. The proposal to increase the minimum engagement clashes with the public policy objective of giving people with disability a long needed capacity to tailor the delivery of services to meet their individual needs, including the timetabling of supports that do not require anywhere near 3 hours of work.

21. The claim to apply a minimum engagement provision to fulltime and part-time employees interacts with a number of other parts of the award, including provisions relating to types of employment, and ordinary hours of work and rostering.

22. NDS submits a minimum engagement is unnecessary in the case of fulltime employees because the setting of fulltime ordinary working hours in accordance with clause 25.1 already imposes significant constraints on how engagements can be set.

23. The claim to extend minimum engagements to part-time employees is also relevant to the claims relating to broken shift. We deal with broken shift in more detail elsewhere in this submission.

24. The HSU in their submission are critical of how clause 10.3 (c) of the award operates in relation to part-time employees and also point to evidence of the use of short shifts in the

[4] Witness statement of Steven Miller, [21-39]
[5] David Moody, [51-54]
[6] [2017] FWCFB 3541

industry[7]. This reflects the emerging reality about the organisation of work in the NDIS environment. NDS is concerned that the increasing pressure to arrange for short shifts that change from time to time, in response to the legitimate needs of clients, has the potential to drive unnecessary casualisation if the requirements of clause 10.3 (c) make part-time employment too difficult.

25. NDS is not opposed to consideration of a minimum engagement for part-time disability services employees limited to work performed for the purpose of delivering client services, provided such a minimum reflects the 2 hours that currently applies with regard to casual employees. This is part of the balance that we submit needs to be struck in reviewing this award. However any such consideration needs to be in the context of also considering how clause 10.3 operates together with the rostering provisions of clause 25.5, to enable some reasonable degree of flexibility in the rostering of part-time employees.

26. The HSU claim does not take sufficient account of the modern award objectives in relation to the needs of business, particularly at ss 134 (d) and (f).

27. In the case of the provision of disability services, it is not just employers who require the modern award safety net to promote flexibility and efficiency, but also the users of those services, people with disability who rely on NDIS to improve the quality of their lives.

Broken Shift

28. The three unions have each made different claims in relation to broken shift.

29. The evidence in this review, including the witness statements of Steven Miller and David Moody, shows that the use of broken shift is driven by the needs of clients. NDS supports the NDIS objective that people with disability should be able to exercise choice and control over how they live their lives and how supports are provided. The consequence of that objective is that broken shift will often be the only practicable way of meeting those needs.

30. NDS opposes the detail of most of the union claims relating to broken shift. However, as indicated above, we accept that an appropriate balance has to be struck between flexibility needed in order to deliver services in the context of tight pricing, and the need for employees to have some level of stability in their employment.

31. We also note that some of the union proposals interact with concerns regarding travel time, and we will make further submissions in relation to travel time, pursuant to the amended directions of 11 July 2019.

<u>United Voice claims – Broken Shift</u>

32. United Voice seek to

    a) Restrict broken shift to just 2 sessions, and

    b) provide that any shift penalty be determined by the starting or finishing time of the broken shift, whichever is highest.

[7] HSU submission 15 February 2019, at [26] and [29]

33. The proposal to restrict broken shift to just 2 parts is an unnecessary restriction that would impact on the ability of participants to schedule supports for when they actually need them throughout the day.

34. The evidence of Steven Miller points to a pattern of peaks and troughs in the times that clients require supports[8]. But while there are clear peaks at the beginning and of day, there are also varying amounts of service delivery required throughout the day. The operational need is to be able to cover a variety of different individual patterns of supports through the day, and this might reasonably require a worker to work a broken shift with more than one break.

35. The concentration of supports around a few hours at each end of the day means broken shift arrangements are often the only way to offer some workers enough hours for a living wage, especially if the worker is engaged on a casual basis. It is likely that the restriction sought by United Voice would also affect the ability of part-time and casual employees to obtain additional hours where they seek them. NDS opposes that part of the United Voice claim.

36. We accept that in relation to shift penalties that apply, the current award provision results in an employee working broken shift not receiving a shift penalty in some circumstances where such a shift penalty would apply to a continuous shift. This is the case for work that commences before 6am Monday to Friday (clause 29.2 (b) of the award). The example provided by United Voice of a broken shift commencing at 5am but receiving no shift penalty is a valid example of this scenario.

37. The relevant clause (clause 25.6 (b)) was varied in the two-yearly review[9] to provide that the finishing time of the shift would determine any shift penalty. This aligned the broken shift clause with the provision of clause 29 which deals with shiftwork. NDS submits that the problem identified by United Voice is an unintended consequence of that variation.

38. NDS does not oppose the United Voice proposal to provide that any shift penalty be determined by the starting or finishing time of the broken shift, whichever is highest.

<u>HSU Claims – Broken Shift</u>

39. HSU propose that

    a) Broken shift should only be worked by agreement between the employer and employee;

    b) There be a limit of one break in a broken shift;

    c) The minimum engagement apply to each period of work in a broken shift; and

    d) That travel time be paid for travel between clients including during any break.

40. NDS will address the travel time proposal in a further submission pursuant to the amended directions of 11 July 2019.

41. NDS opposes the claim for a limit of one break per broken shift, for the reasons set out above at paras 33-35.

[8] Steven Miller, [21-39]
[9] PR531544

42. The draft variation from HSU includes a requirement that broken shift only be worked by mutual agreement between the employee and employer. NDS does not consider this part of the draft variation to be necessary given the requirements clause 10.3 in relation to part-time employment, and the provisions of clause 25.5 in relation to rosters. However, NDS does not oppose that aspect of the claim.

43. The HSU claim for a minimum engagement to be applied to each period of work is unworkable in the context of NDIS because it does not reflect the reality of participant requirements, as we discuss above in relation to the general claim regarding minimum engagements.

44. As outlined at para 25 above, NDS is not opposed to considering a minimum engagement of 2 hours for part-time disability services employees, limited to work performed when delivering client services, as a way of providing some amelioration of the concerns raised by HSU.

ASU claims – Broken Shift

45. The ASU have proposed a 15% loading to apply to a broken shift, including during breaks.

46. NDS opposes this claim, particularly in the context of the tight pricing arrangements that affect provision of disability services.

47. The quantum of the loading is out of kilter with the provisions of other awards that deal with broken shift.

48. The current award clause regulates the length of a broken shift and also provides for shift penalties as appropriate.

49. NDS submits that the restrictions imposed by clause 10.3 (c) in the setting of hours in part-time contracts provides significant protection for part-time employees in relation to the predictability of their hours of work, while casual employees receive a casual loading in compensation for irregular hours of work.

Rosters

50. United Voice have proposed that overtime penalty rates should apply where less than 7 days' notice of a change in roster is provided to an employee.

51. NDS opposes this claim as it is unnecessary. A failure to provide such notice is a breach of the award and the employer can be prosecuted and exposed to fines as a result.

52. We also refer to the protection afforded to part-time employees by the requirements of clause 10.3 (c), while fulltime employees have the protections of the ordinary hours provisions of clauses 25.1-25.4.

Recall to work

53. HSU have made a claim in relation to the performance of work by phone or email after leaving the employer's or client's premises. The draft variation provides for a one hour minimum payment.

54. NDS accepts that remote response work of this type should be paid. However, there is no reasonable basis for the payment of a minimum of one hour for a task that might require only a few minutes.

55. The HSU proposal requires that all such work be paid at "the overtime rate". NDS accepts that in may circumstances, such work will be overtime – for example work that arises during a period of on-call and that has not been rostered. But t is not necessarily the case that all work performed from home will be overtime. Some employees perform their rostered ordinary hours by working from home as part of a flexible working arrangement, for example.

56. The drafting of the HSU variation in relation to payment at "the overtime rate" is also problematic because the relevant overtime rate will depend on whether the employee is fulltime, part-time or casual.

57. The HSU claim is an alternative to the draft variation proposed by Australian Business Industrial, the NSW Business Chamber, Aged & Community Services Australia and Leading Age Services Australia (ABI & others) and which was the subject of a submission in support from NDS on 2 July 2019.

58. The alternative variation from ABI & others avoids the problems associated with the HSU proposal, in particular by limiting the provision to situations of on-call or other work that has not been rostered as ordinary hours.

59. We reiterate our support for the alternative proposal from ABI & others.

60. NDS opposes the HSU claim.

Client Cancellation

61. The HSU claim in relation to client cancellation is limited to the home care sector and seeks to increase the notice period required.

62. NDS notes the alternative draft determination filed by ABI & others in April 2019, their submission of 2 July 2019, and we rely on our submission in support of that proposal also filed on 2 July 2019.

63. NDS reiterates its support for the proposal from ABI & others.

64. NDS opposes the HSU claim as it does not provide for any flexibility for dealing with client cancellation in the disability sector.

Michael Pegg

on behalf of National Disability Services

16 July 2019

IN THE FAIR WORK COMMISSION

4 Yearly Review of Modern Awards

National Disability Services

Submission in Reply – AM2018/26

Social, Community, Home Care and Disability Services Industry Award 2010

Substantive Issues Tranche 2 – Travel Time Claims

Introduction

1. National Disability Services (NDS) makes the following submission in reply pursuant to the Directions made on 13 May 2019 and as amended on 2 September 2019.
2. NDS is the peak organisation for non-government disability providers with about 1,000 members across Australia.
3. NDS members operate several thousand services for Australians with all types of disability. Members range in size from small support groups to large multi-service organisations. They provide person-centred support for people with a disability – through personal one-to-one care in homes and in group settings, professional therapy, education, training and life-skills development, employment, accommodation support, respite and recreation.
4. The implementation of the National Disability Insurance Scheme (NDIS) is driving a growth in the amount of work performed for participants in their private homes, and a consequent growth in the use of broken shift arrangements in order to accommodate participant preferences regarding the time of delivery of supports[1,2].
5. In particular, a core aim of the NDIS is to provide participants with more choice and control in their daily lives. This is an important public policy objective informed by a human rights approach to disability.
6. A corollary is that employers who are engaged by clients to provide supports have less power than in the past to dictate timetabling to meet their administrative convenience.
7. NDS makes the point that the use of broken shift is not something that is done at the whim of the employer. Broken shift is a necessary way of organising certain types of work in a manner that meets the legitimate needs and preferences of people with disabilities.
8. Similarly, the way in which an employer arranges the work of employees who are required to travel between clients at different locations is constrained by the requirements of the clients, as well as by the pricing arrangements which limit the amount that the employer can claim to cover the costs of employee travel.

[1] Witness statement of David Moody [51-63]
[2] Witness statement of Steven Miller [19], [21-39]

9. At the same time, NDS is aware of international evidence of the risks of a market-based system such as NDIS leading to employment practices that undermine reasonable minimum employment standards, resulting in high levels of employee turnover and deskilling of the workforce, resulting in a higher risk of abuse and neglect of clients[3].

10. NDS acknowledges that there are potential ambiguities and problems with the way in which travel time connected with broken shifts is currently treated by the award. If the Commission determines that the award needs to be varied with respect to travel time, and in light of the foregoing discussion, this submission outlines some possible approaches.

11. NDS opposes the union claims as currently drafted because they go further than is necessary to resolve the potential problems that we identify.

The travel time claims

12. There are three claims made by unions to vary the award with respect to travel time:

    a) United Voice travel time claim. United Voice propose a variation to the effect that time required to travel between clients shall be treated as time worked, but excluding commuting the beginning and end of the shift;

    b) HSU travel time claim. HSU propose that where a broken shift is worked an employee will be paid for the reasonable time of travel from the location of the last client before a break to the next client at the end of that break; and

    c) HSU travel allowance claim. HSU also propose that the current travel allowance for an employee's use of their private vehicle be varied to specifically require payment for commuting to and from their residence and any client, as well as requiring payment when travelling between clients.

13. The claims are related to a number of other claims made by the unions regarding broken shift and minimum engagements. They reflect union concerns that the growth in non-standard working arrangements together with pricing and other commercial pressures, are leading some employers to arrange work in such a way as to avoid paying workers for significant periods of time during their working day.

Terminology

14. In this submission, NDS will use the following terminology.

15. A "**shift**" is taken to be the rostered day's work for an employee. If a shift is rostered outside the span of hours a shift penalty may apply in accordance with clause 29 of the award. Clause 29.4 then also states that

    "*Shifts are to be worked in one continuous block of hours that may include meal breaks and sleepover*".

[3] See for example, Moody [36] and reference therein

16. For home care and disability workers, clause 25.6 provides that the shift may be broken by one or more breaks which are not meal breaks and prescribes certain requirements to be met. In effect, this clause provides an exception to the requirement of clause 29.4 that shifts be continuous.

17. For the purpose of this submission, the parts of the shift that are worked before and after a break will be referred to as "**portions**". We make this point because in common usage, the separate periods of work in a broken shift are sometimes also referred to as shifts, which is potentially confusing in the context of responding to the present union claims regarding travel and broken shift.

General concepts about travel

18. NDS submits that conceptually there are three types of travel that the union claims seek to deal with.

    a) Direct travel between clients. Travel directly between clients during a continuous shift or within a portion of a broken shift.

    b) Travel during breaks. Travel between the last client of a portion of a broken shift and the first client of the next portion, which occurs during a break in the shift; and

    c) Commute. Travel between the employee's residence and a client;

19. The first and second types of travel are covered by both the United Voice and HSU travel time claims.

20. The third of these types of travel is covered in the HSU travel allowance claim.

21. NDS submits that it is useful to distinguish between the different types of travel as each requires different considerations in responding to the union claims.

Response to the union claims

Direct travel between clients

22. NDS accepts that where an employee is required to travel directly from one client to the next as directed by their employer in order to perform their duties (11 (a) above), without any break, then the employee should be compensated for that time.

23. Under this award, where employees other than home care or disability workers are required to travel between different locations or clients in the course of their duties that time would form part of their shift for the day and would be paid at the appropriate rate for hours worked.

24. NDS submits that the same logic would apply to direct travel required within a portion of a broken shift.

25. The United Voice travel time claim would capture travel associated with breaks, but it would also apply to direct travel between clients as part of a continuous shift or within a portion of

a broken shift. In our view that aspect of the United Voice claim reflects the current position and so is not necessary.

26. However, to the extent that there is any doubt about payment for such travel under the current provisions of the award, NDS does not oppose a variation to clarify the situation.

27. Where such travel requires the employee to use their private vehicle "*in the course of their duties*", clause 20.5 (a) requires the payment of an allowance of $0.78 per kilometre. This allowance is compensation for the cost of running and maintaining the vehicle and is separate to payment for time.

28. Our understanding is that generally employers pay the travel allowance for such travel, and may also pay travel time. The union witnesses also provide evidence that at least some employers also pay travel time, or have done until recently.[4]

Travel during breaks

29. The more difficult issue is the question of how to deal with travel that is undertaken during the unpaid break between portions of a broken shift.

30. A break, other than a meal break, in a broken shift can total several hours. During that time the employee is at least notionally free to do as they please, provided they arrive in time to attend at their next location of work for the next portion of the broken shift.

31. The component of travel that is necessarily required to get from the last client of the earlier portion to the first client of the next portion of the shift has the appearance of being a commute.

32. The unions object that, in fact, this is travel that is required by the employer and is undertaken in the course of their duties. It is not travel for private or recreational purposes.

33. When an employee is on a break, they are not on duty and their movements are not controlled by the employer. NDS considers there are practical difficulties in quantifying the travel required when undertaken during a break. It is different to the situation of direct travel between clients where the employer has some control over the timetabling of appointments within a portion of a broken shift.

34. Alternatively, if travel during breaks were to be considered as akin to the commute at the start and finish of the working day, then on the face of it there should not be any separate compensation.

35. However, NDS accepts that there is the potential for this to be onerous on the employee where there are a number of such periods of travel and in particular where the portions of the shift are of short duration.

36. To the extent that the modern award system acknowledges the cost and disruption of a commute, it is in the concept of a minimum engagement which is taken to ensure that each engagement to attend the workplace provides sufficient compensation for the employment to be economically viable for the employee.

[4] United Voice supplementary witness statements of Dion Fleming and Trish Stewart, 1 April 2019

37. The SCHADS award sets minimum engagements for casual home care employees of one hour, and for casual SACS employees engaged in disability work, two hours (clause 10.4 (c)). There is no minimum engagement for part-time or fulltime employees.

38. NDS notes the reasoning of the Full Bench in the review of the *Aged Care Award 2010*, in relation to broken shifts[5]. The SCHADS award does not specify whether the casual minimum engagement applies to each portion of a broken shift, or only to the sum of the hours worked across a broken shift.

39. If the Commission were to determine that there is ambiguity in relation to the application of minimum engagements in broken shifts, then consistent with our earlier submission in relation to union claims regarding broken shifts[6], NDS submits that resolving that ambiguity by specifying a minimum engagement for each portion of a broken shift could provide a basis for ensuring reasonable compensation for associated travel during the break.

40. NDS is aware of the submission filed on behalf of ABI, NSWBC, ACSA and LASA (ABI & others) and their alternative formulation for an allowance to deal with this issue.

41. If the Commission is not persuaded that the issue can be adequately resolved by setting a minimum engagement for each portion of a broken shift, NDS does not oppose the alternative formulation for an allowance instead, as proposed by ABI & others.

42. Finally, the United Voice claim applies to all employees covered by this award and is not limited to home care or disability employees engaged to work broken shifts. As submitted above at [22-25], the claim is not necessary for workers who do not work a broken shift.

<u>Commute</u>

43. There is a longstanding presumption that employees are not entitled to payment for the daily commute to and from their place of work.

44. NDS opposes the HSU travel allowance claim that would impose an allowance to be paid for the daily commute.

45. Modern awards are required to provide minimum entitlements and the payment of an allowance for an employee's commute goes beyond the terms allowed by s139 of the Act. Commuting is not carried out in the course of an employee's duties, the extent of commute is unique to each employee and is outside the control of the employer.

46. The HSU travel allowance claim should be refused.

Michael Pegg
on behalf of National Disability Services
16 September 2019

[5] [2019] FWCFB 5078, 26 August 2019
[6] NDS submission in reply, 16 July 2016 [28-49]

BEFORE THE FAIR WORK COMMISSION

MATTER NO. AM2018/26

S.156 – FOUR YEARLY REVIEW OF MODERN AWARDS – SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

Statement of David Moody

I, David Moody, of Level 6, 369 Royal Parade, Parkville in the State of Victoria say:

1. I am the acting Chief Executive Officer of National Disability Services (NDS).
2. I commenced with NDS in July 2015 in the role of Victorian State Manager.
3. Before working at NDS I was employed in a number of different roles, including as a private lawyer, practising in workers' compensation and OHS; and as an executive at WorkSafe Victoria and in the Victorian Public Service, including as Assistant Director, NDIS Secretariat at the Department of Premier and Cabinet, from January 2011 until August 2013.
4. I hold a BA and LLB from Monash University.
5. In my role as acting CEO of NDS, I provide information, representation and policy advice to government on disability and related issues.
6. I make this statement on the basis of my own knowledge and inquiries, save where otherwise stated. Where I make statements based on information provided to me by others, I believe such information to be true.

About NDS

7. NDS has more than 1,000 members across Australia. Collectively, NDS members operate several thousand services for Australians with all types of disability.
8. NDS is the only organisation that represents the full spectrum of disability service providers. Members range in size from small support groups to large multi-service organisations and are located in every region of Australia.
9. NDS traces its roots back to 1945. It was founded by charitable organisations – many of them founded by the families of people with disability – that recognised the value of national representation. From an initial advisory council, the Australian Council for the Rehabilitation of the Disabled was established which evolved into National Disability Services.

10. In 2008 NDS, Carers Australia and the Australian Federation of Disability Organisations formed an alliance and in 2011 founded the Every Australian Counts Campaign to promote a national disability insurance scheme. The strong campaigning of Every Australian Counts highlighted to politicians and the general community the chronic under-funding and disrepair of the existing system and the need for a new, well-funded system responsive to the needs and choices of people with disability and their families.

The National Disability Insurance Scheme (NDIS)

11. Having campaigned hard for its introduction, NDS is a strong supporter of the NDIS. We are convinced that a service system that is responsive to the individual goals, needs and preferences of people with disability will boost their quality of life and their opportunities to participate in social and economic life.
12. The NDIS represents a major transformation of the role of disability service organisations, with implications for every aspect of their operations, including their model of service provision, financial management, marketing, the way they engage with their service users and their workforce.
13. From 2013 to end June 2016, the NDIS was the subject of 'trials' in various sites around Australia. Roll-out of the full scheme commenced progressively from July 2016.
14. When the NDIS is fully implemented across Australia, 460,000 Australians with severe disability will benefit. Government expenditure on disability services will double from 0.5 to 1 per cent of GDP ($22 billion in 2019-20). The Scheme was scheduled to be rolled-out fully in all states and territories, other than WA, by July 2019, and in WA by July 2020.
15. At present, however, the pace of roll-out is such that this schedule will not be met and will require at least another year, with full roll-out not expected to be complete until mid-2020 (a year later in WA).
16. As of 31 March 2019, 277,155 people with disabilities had become NDIS participants. This contrasts with the original bilateral estimates for the states and territories during NDIS transition of approximately 377,000 people accessing the scheme by 30 June 2019.
17. The disability services market is growing. As of 31 March 2019, 20,208 organisations are now registered as providers with the NDIS. However, of those providers, only 57% (or 11,418) were active at 31 March 2019.
18. Most State and Territory Governments have already or are planning to withdraw partially or fully from direct service delivery and to transfer services to the non-government sector, adding another dimension to disability industry restructuring.

19. NDS has provided support to the sector during the roll-out and in every state has a direct role in assisting organisations to understand the impact of the Scheme and assist in their transition to the NDIS.
20. In 2013-4, NDS led a national consortium that provided the Australian Government with an analysis of workforce supply, demand and utilisation in the NDIS trial sites; it included several reports that outlined policy and program responses to increase workforce sustainability under the NDIS[1].
21. NDS has also managed multiple workforce readiness projects funded to support NDIS roll-out. As a result of its research program, practical support to providers and ongoing direct engagement with the sector, NDS is acutely aware that service providers have found and find it difficult to deploy workers flexibly within the current award settings, which is exacerbated by tight NDIS pricing.
22. More recently, NDS administered the Innovative Workforce Fund on behalf of the Commonwealth Department of Social Services. The Fund supported 30 projects, some of which focussed specifically on issues associated with managing workforce under award conditions in the NDIS environment. One of the key findings was that service providers find it increasingly difficult to support training, professional development and practice leadership under NDIS pricing. This finding is consistent with other research which found that time for training and professional development has diminished under NDIS operating environment[2].

Workforce management

23. NDS regularly surveys its members regarding workforce issues, particularly through its Workforce Wizard Tool. Workforce Wizard data forms the basis of NDS's Australian Disability Workforce Report (most recent editions in February and July 2018).
24. The July report was informed by data from 45,000 workers around Australia, collected over 11 quarters from service providers through Workforce Wizard.
25. Workforce Wizard is intended to monitor how the workforce is changing during the rollout of the NDIS. It was also intended to support NDS's advocacy work on behalf of the sector.

[1] Roadmap to a Sustainable Workforce, A National Disability Services Report prepared for the Australian Government Department of Social Services. K Windsor and C Alcorso, 2014

[2] Building an Industry of Choice: Service Quality, Workforce Capacity and Consumer-Centred Funding in Disability Care Final Report for United Voice, Australian Services Union, and Health and Community Services Union Natasha Cortis, Gabrielle Meagher, Sharni Chan, Bob Davidson & Toby Fattore March 2013 SPRC Report 02/13

26. Workforce Wizard tracks if more people are being employed as casual rather than permanent workers, changes in the mix of skills and demographics and what is happening to hours of work, working conditions and training. Previously, there was no reliable, high quality, up-to-date data on those matters. As more services have used Workforce Wizard, data on key trends is emerging and is providing useful evidence on issues such as workplace relations, NDIS pricing and market development.
27. Workforce Wizard allows providers to benchmark their data with other providers in the sector who have entered the same information and other national data sources such as the ABS.
28. The last set of Workforce Wizard figures were collected for the December 2018-19 quarter, but not publicly released. This included data from 187 organisations, comprising of 41,119 workers in the disability and allied health sectors. While disability service providers are hiring more casual workers, the trend towards increased casual employment since 2015 appears to have stabilised.
29. The average proportion of casual employment increased from 40.9 per cent in September 2015 to 45.2 per cent in December 2018. However, it has remained at around 45 per cent since September 2017, with the exception of the September 2018 quarter (47.3 per cent). It is important to note that the rate of casual employment has increased to 45.2% from a low of 39.2% in the June 2016 quarter.
30. This casualisation trend is not universal and is more prevalent in small and medium organisations, with the trend absent in large organisations. This pattern has held since September 2015.
31. I am aware that the recent 'Survey - Social, Community, Home Care and Disability Services Industry Award 2010' conducted by the Fair Work Commission contained a question on category of worker employment. Over 40% of the employees of the 854 respondent enterprises were engaged on a casual basis, while 63% of the respondent enterprises were engaged in the provision of disability services.
32. The disability workforce has been growing strongly. According to NDS's February 2018 report, the disability support workforce growth rate was 11.1% per year (averaged over a two-year period between September 2015 and 2017). This compares with growth of just 1.6% for the Australian workforce as a whole at the time.
33. This remarkable growth rate came overwhelmingly from the recruitment of casual workers. The average permanent workforce growth rate was just 1.3% per year, while the casual growth rate was 26% per year.

34. NDS has previously expressed concerns about the possible consequences of rapid growth in the casualisation of the disability workforce. Firstly, there is a very high turnover rate of casual workers – a two-year average of nearly 9% per quarter (equal to 35% per annum).
35. This is a significant cost and administrative burden for providers and also presents challenges to providers wishing to offer continuity of support and care to NDIS participants. Secondly, detailed investigation of NDS carecareers job board data shows job applicants have a clear preference for permanent over casual roles. In the competition for talented people, employers that predominantly offer casual jobs will be at a disadvantage.
36. In addition, as evidence from overseas suggests, heavy concentrations of casual and part-time work within the sector is very likely to result in high turnover, low morale and inconsistent standards of service provision[3], including instances of participant abuse and neglect.
37. The projected growth of the workforce required to meet the needs of the remaining 183,000 people with disability still to access the NDIS (and within the next 12 months) presents a huge challenge for the sector.
38. For this growth to be achieved, the sector must, amongst other things, be seen as providing competitive and reasonable employment conditions as well as longer term career options.
39. Should the impending Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability reveal a pattern of unacceptable outcomes driven by a lack of stable and attractive employment options for disability support workers, then the need to address this situation will become critical.
40. Consequently, NDS regards it as imperative that the SCHADS Award review does not result in variations to the Award that would accelerate the casualisation of employment in the Disability Support Sector. Our research indicates that a balance needs to be struck between flexibility that is needed to meet the requirements of NDIS participants, while still enabling reasonable stability and security in employment for the support workforce.

Pricing

41. Following on the Independent Pricing Review conducted in 2017 as well as further advocacy from NDS and other sector stakeholders, there have been a significant raft of recent changes to NDIS pricing for supports, many of which are both substantial and

[3] Do personal budgets increase the risk of abuse? Evidence from English national data.
Ismail, M., Hussein, S., Stevens, M. Woolham, J, Manthorpe, J., Baxter, K., Samsi, K. and Aspinal, F. (2017) Journal of Social Policy 46 2 291-311

welcome. Pricing for NDIS supports is now largely standardised across the country, with adjustments for some locations.

42. Maximum prices are still set by the Agency. The most common supports are specified in Plans and purchased on an hourly basis, though some allied health services, equipment purchases and other services are allocated a maximum amount or require the participant to tender quotations.
43. There are a number of business consequences. A service only receives payment after the successfully delivery of a funded support/service. There is minimal support for vacancy rates, inquiries and referrals and no-shows or cancellations.
44. These tighter funding arrangements require far greater financial vigilance from services. Under previous state and territory programs, governments often recognised the need to at least partly underwrite the financial viability of funded service providers. Under the NDIS, any such risk sits squarely with the service provider.
45. It should also be understood that client plans change, and can change considerably at short notice. At the end of 2015, 30 months into the Scheme, of the approximately 22,300 participants to that point in time, the NDIA reported there were 15,134 second plans, 8,613 third plans, 444 fourth plans, and 20 fifth plans among their participants.
46. In March, the NDIA announced indicative increases in the base prices for attendant care and community participation and the introduction of a Temporary Transformation Payment (TTP) for services that comply with certain criteria. These base prices have been indexed in line with ABS Wage and Consumer Price Indexes and the national minimum wage order of the Fair Work Commission.
47. Other price announcements, made in late June, reflect increased loadings for remote and very remote areas (40 and 50 per cent respectively, up from 20 and 25 per cent).
48. There is now more clarity around non-face-to-face billing arrangements. Non-face-to-face activities are billable if:
    - provided as part of mutually agreed one to one support arrangements
    - the activities are part of delivering a disability support such as report writing
    - the provider has explained all activities to be billed to the participant
    - the charges for the activities comply with the NDIS Price Guide
49. One of the key features of the NDIS is that the stated needs of the individual are the focus for funding and service delivery. Previously, many services adopted person-centred service planning within the programs they were funded to deliver. However, under the

NDIS only those activities listed on a person's individual plan are funded. This plan is not developed by the service provider, but by the person with disability, their family and carers and the National Disability Insurance Agency (NDIA) planner. The plan-holder then chooses the services they want to provide the various elements of the Plan. The power to purchase rests with the participant and their family.

50. Consequently, these arrangements differ significantly from the provision of home care services and require far more flexibility from disability service providers and support workers.

Broken Shift

51. I am aware that one of the variations sought to the Award (by the HSU in its draft determination of 19 February 2019) seeks to define a broken shift as: "For the purposes of this clause, broken shift means a shift worked by a casual or part-time employee that includes **no more than one break** (other than a meal break) and where the span of hours is not more than 12 hours."
52. The variation sought above does not align with the reality of operational need being driven by the NDIS and reported to NDS by its members, particularly the flexibility required of disability services and workers in order to meet the widely differing support needs of NDIS participants in an increasingly competitive market.
53. In the area of assistance with daily living (in home and community), individualisation and choice and control means many NDIS participants have no need for continuous shifts associated with their supports. Their time of most intense needs will be concentrated at the beginning and end of each day and will tend to be of a short duration (e.g. 2-3 hours).
54. This support usage pattern has been borne out repeatedly in evidence provided to the FWC by NDS members. These regular supports are likely to be supplemented by different types of supports provided during the day. These supports will be provided by disability support workers that possess the relevant skills and in a large number of instances will not be provided by one support worker for a period of, for example, eight hours.
55. Service mix is important. Service providers that offer a mix of services (or that use staff sharing arrangements) that enable them to deploy workers over home care and SIL/day care services will be better placed to avoid the use of broken shifts.
56. In addition, there is no way for employers to determine if workers are engaged by other employers or as casuals through various platforms. These workers could consequently be working long hours, potentially placing NDIS participants at risk.

57. Our research indicates that there is underemployment in the sector with many workers seeking additional hours.
58. The concentration of supports around a few hours at each end of the day means broken shift arrangements are often the only way to offer some workers enough hours for a living wage, especially if the worker is engaged on a casual basis.

Travel

59. I am aware of recent changes in the NDIS Price Guide in relation to travel. The length of time providers can claim for travel has changed from 1 July 2019.
60. If agreed by participants, providers can now claim for travel up to 30 minutes per participant per day between appointments within city areas and up to 60 minutes per participant per day in regional areas. This is an increase from 20 and 45 minutes, respectively.
61. Providers delivering capacity-building supports are also able to claim time spent travelling from the last participant to their usual place of work. The maximum amount that can be claimed for return travel is 30 minutes within city areas and 60 minutes in regional areas.
62. Before providers can charge for travel, they must obtain agreement from the participant.
63. Clause 20.5 (a) in the Award mandates a vehicle travel allowance for employees of $0.78 per kilometre. The Agency has not made provision for covering the cost of a vehicle used by a worker as they travel from appointment to appointment. These costs are substantial, cannot be avoided, and are not covered by the current price limits.

Client Cancellation

64. From NDS's work with providers throughout implementation of NDIS, I am aware that a direct result of the implementation of the NDIS is that providers have carried substantial costs associated with cancellations. New arrangements for client cancellations have recently been announced by the NDIA and incorporate amendments designed to alleviate some key service provider concerns.
65. A short notice cancellation is now defined as being when there is a failure to provide two clear business days' notice for a support or service which is eight hours or less in duration and less than $1,000, or five clear business days' notice, in all other cases.
66. As of 1 July 2019 there is no limit on the number of short notice cancellations (or no shows) that a provider can claim, however these will only be paid at 90% of the full fee. If a participant has an unusual number of cancellations then the provider should seek to understand why these are occurring, as for higher rates of short notice cancellations, the

Agency “will require the provider to demonstrate they are taking steps to actively manage cancellations”.

David Moody

Acting Chief Executive Officer

National Disability Services

12 July 2019

BEFORE THE FAIR WORK COMMISSION

MATTER NO. AM2018/26

S.156 – FOUR YEARLY REVIEW OF MODERN AWARDS – SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

Statement of Steven Miller

I, Steven Miller, of 225 California Creek Road, Cornubia, say:

1. I am employed by Endeavour Foundation as the Head of Operations, Service Delivery.
2. I commenced with Endeavour Foundation on 19th November 2018. My role involves the leadership of Endeavours Support Services including billing, rostering and the NDIS support function (policy, process, customer onboarding and funding management).
3. Prior to my current role I have held numerous leadership roles in the community services sector encompassing Aged Care, Carer Support and NDIS services. These roles included NDIS Lead for Vision Australia, Customer Service Manager for Uniting Vic Tas and Customer Service Manager for Uniting LifeAssist.
4. I hold a Graduate Diploma in Business and a Masters of Business Administration.
5. I make this statement on the basis of my own knowledge and inquiries, save where otherwise stated. Where I make statements based on information provided to me by others, I believe such information to be true.

Endeavour Foundation

6. Endeavour Foundation was established in 1951 by a group of parents of children with an intellectual disability. The purpose was to provide more educational options and opportunities in life for children with intellectual disabilities.
7. Today Endeavour Foundation exists to make possibilities a reality for people living with disability and achieves this by collaborating with our customers to imagine the possibilities and then work together to make them happen.
8. In the 68 years since being established, Endeavour Foundation has grown to a major provider of a range of disability services. Under the NDIS Endeavour provides services to over 800 customers in accommodation (Supported Independent Living), over 2000 supported employees in supported employment services (Assisted Disability Employment Facilities) and over 500 customers in home and community participation supports (Learning and Lifestyle Centres).

9. Endeavour Foundation operates across Queensland, New South Wales and Victoria.

Workforce of Endeavour Foundation

10. Endeavour Foundation employs 4684 people including 1260 Support Workers and 2106 Supported Employees.

11. The Support Worker workforce includes 236 full time, 901 part time and 123 casual employees.

12. Most of the support workforce in Queensland is covered by the Endeavour Foundation Union Collective Agreement 2009, but as a result of mergers, some staff in NSW and Victoria are employed under the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS).

NDIS

13. The National Disability Insurance Scheme (NDIS) launched in July 2013, and has gradually rolled out across all Endeavour operations. Transition to the NDIS for all Endeavour customers will be complete in July 2019.

14. The NDIS is a transformational change in service approach for people with severe and profound physical and psychological disabilities. As a result, the rollout of the National Disability Insurance Scheme (NDIS) has required significant changes in the ways in which Endeavour Foundation organises its work.

15. A key purpose of NDIS is to provide participants with more choice and control over how they live their lives. This includes giving participants more control over the timing of when supports are delivered by their provider.

16. As a result of the introduction of the NDIS, Endeavours organisational systems and processes have been required to adapt to accommodate:
    a. Enhanced Customer control of their service options and usage of services
    b. A significantly expanded and competitive market model
    c. Payment and pricing systems tightly defined and controlled by NDIA

17. For Supported Independent Living (accommodation) services the NDIA undertakes the service provision planning with the customer directly, this customer plan then tightly defines the services and support ratios that the customer will receive. The NDIA will also approve a SIL quote per accommodation facility which defines the exact income that Endeavour can claim to deliver these services to all customers.

18. If Endeavour delivers services in these Supported Independent Living facilities over and above the customers plan or the SIL quote there is no mechanism to receive additional income and the services will be unfunded.

19. For in home supports the same restrictions apply. Customers services will be outlined in the customers plan and services pricing is capped. Customers also have the ability to choose what times they want to receive services.

20. The NDIS pricing structure incorporates tight assumptions in pricing. These pricing models are designed to provide value for both the customer and the NDIS and will only benefit "efficient" providers (NDIS Price Guide 2018/19). Registered Providers cannot charge over prices defined in the NDIS price guide.

Broken Shift

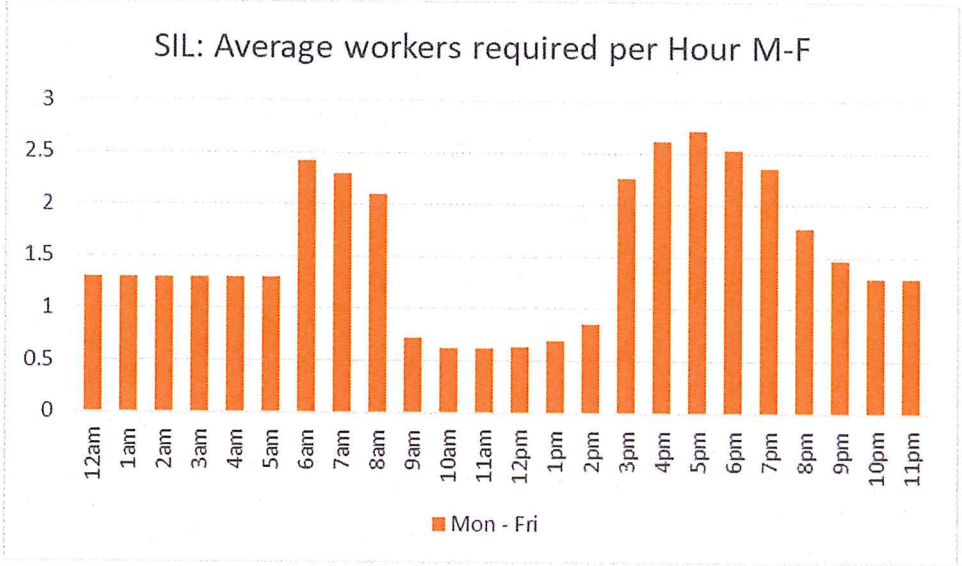
21. Our experience is that participants are asserting their preferences regarding the timing of supports. The result is that there are peaks and troughs of demand during the day.

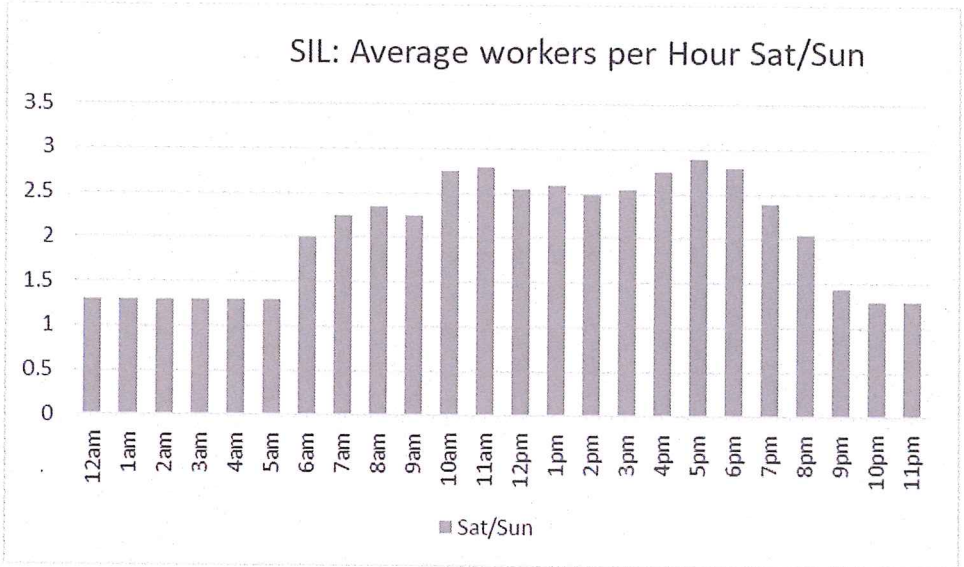
22. The NDIS approves appointments for customers for Accommodation and In-Home services with a minimum appointment length of one hour in many cases.

23. Customers can choose when they receive services, most customers choose to have these services during peak times, these include morning from 6am to 9am and Evening for 3pm to 7pm.

24. In the data that is presented below, an appointment for a client is not necessarily the whole shift for an employee, as they may have other appointments, although sometimes it may be. The data is intended to show customer demand.

25. Below is a breakdown across 10 Endeavour Accommodation facilities (Approx. 40 customers) and the spread of hours approved in the relevant SIL quotes from the NDIS.





26. We can see that in accommodation services customers require supports primarily only during peak hours with an average appointment length of two hours in the morning (6-8) to get up and ready for work or recreation activities and an average of 4 hours in the evening to arrive home from work or recreational activities and prepare for bed.
27. This is mitigated somewhat on weekends when customers spend more time in the accommodation facilities.
28. In this way we are seeing customers exercise choice and control over the provision of services that would align with the preferences of people without disabilities.
29. Note that the hours indicated in the above data are the hours approved by the NDIA for these facilities and the only hours of service which Endeavour can claim revenue to deliver.
30. For In-Home Supports an analysis is also provided of 6 Endeavour Customers over a two-week roster period, results of appointment start times and average requested durations

are below. The term "shift" in these tables relates to individual customer supports, not necessarily an individual employee's total shift.

Start Time	# Shifts	%	Average Shift Duration
5 AM	11	6%	2.5
6 AM	26	14%	2.4
7 AM	19	10%	1.8
8 AM	22	12%	4.0
9 AM	11	6%	4.5
10 AM	8	4%	3.9
12 PM	4	2%	1.0
1 PM	6	3%	1.7
2 PM	1	1%	2.0
3 PM	16	9%	2.0
4 PM	29	16%	1.9
5 PM	6	3%	1.5
6 PM	8	4%	1.0
7 PM	2	1%	1.0
8 PM	2	1%	1.5
9 PM	14	8%	2.5

Shift Length	# Shifts	%
1	31	17%
1.5	2	1%
2	83	45%
2.5	37	20%
3	3	2%
4	9	5%
5	4	2%
6	6	3%
6.25	10	5%

31. For In-Home Care 42% of all appointments have a start time between 5am and 9am with an average length of 2.7 hours. An additional 24% of appointments have a start time between 3pm and 4pm with an average length of 2 hours.

32. Overall for In-Home Care, 83% of appointments have a length between 1-2.5 hours with only 8% of requested appointments being in excess of 6 hours.

33. As additional information, below are some example rosters (employees and customer details redacted) to demonstrate the type of In-Home services approved by the NDIS and requested by customers.

Roster Calendar

Client [redacted]

Saturday, 15 June, 2019		
07:00 AM - 09:00 AM	15/06/2019	Employee: activities -
04:30 PM - 06:30 PM	15/06/2019	Employee: care activi
Sunday, 16 June, 2019		
07:00 AM - 09:00 AM	16/06/2019	Employee: activities -
04:30 PM - 06:30 PM	16/06/2019	Employee: care activi
Monday, 17 June, 2019		
06:30 AM - 08:30 AM	17/06/2019	Employee: activities -
04:30 PM - 06:30 PM	17/06/2019	Employee: activities -
Tuesday, 18 June, 2019		
07:00 AM - 09:00 AM	18/06/2019	Employee: care activi
04:30 PM - 06:30 PM	18/06/2019	Employee: activities -
Wednesday, 19 June, 2019		
06:30 AM - 08:30 AM	19/06/2019	Employee: activities -
02:00 PM - 04:00 PM	19/06/2019	Employee: & rec activ
04:30 PM - 06:30 PM	19/06/2019	Employee: activities -
Thursday, 20 June, 2019		
07:00 AM - 09:00 AM	20/06/2019	Employee: activities -
09:00 AM - 01:00 PM	20/06/2019	Employee: & rec activ
04:30 PM - 06:30 PM	20/06/2019	Employee: activities -
Friday, 21 June, 2019		
06:30 AM - 08:30 AM	21/06/2019	Employee: activities -
04:30 PM - 06:30 PM	21/06/2019	Employee: activities -
Saturday, 22 June, 2019		
07:00 AM - 09:00 AM	22/06/2019	Employee: activities -
04:30 PM - 06:30 PM	22/06/2019	Employee: activities -
Sunday, 23 June, 2019		
07:00 AM - 09:00 AM	23/06/2019	Employee: activities -
04:30 PM - 06:30 PM	23/06/2019	Employee:

Monday, 17 June, 2019		
06:00 AM - 08:00 AM	17/06/2019	Employee: [redacted] Assist with self care activities - Std
08:30 AM - 02:45 PM	17/06/2019	Employee: [redacted] Group based in a centre 1:3 - Weekday - Std
03:00 PM - 05:00 PM	17/06/2019	Employee: [redacted] Assist with self care activities - Std
Tuesday, 18 June, 2019		
06:00 AM - 08:00 AM	18/06/2019	Employee: [redacted] Assist with self care activities - Std
08:30 AM - 02:45 PM	18/06/2019	Employee [redacted] Group based in a centre 1:3 - Weekday - Std
03:00 PM - 05:00 PM	18/06/2019	Employee: [redacted] Assist with self care activities - Std
05:00 PM - 06:00 PM	18/06/2019	Employee: [redacted] House cleaning and other household activities

34. In example one we see a standard weekly in-home support service profile for a NDIS customer with shifts occurring at consistent peak times during the morning and afternoon.

35. In example two we see a customer moving between 1:1 services at peak times in-home and 1:3 services in a group based environment during the day.

36. Shorter support durations at peak morning and afternoon times are a requirement in the NDIS market. Customers are exercising their choice to have supports at these peak times.

37. Supports are required for short durations in the peak hours during the morning and afternoon to allow customers to attend employment and day programs, and allow them to live a normal lifestyle

38. The inability to roster broken shifts would severely restrict the capability of Endeavours workforce to cover the services required.

39. The inability to allocate staff broken shifts would require Endeavour to engage a higher number of support workers working contracts with less hours to cover peak customer periods in both the morning and afternoon.

Customer Cancellation

40. From time to time participants need to cancel their appointments. This can be for a variety of circumstances and is often last minute.

41. Our data shows, that for Endeavours 1:1 support and Group Based Services we average over 50 cancellations per month.

42. For affected support workers it is not always possible to find alternative work immediately.

43. To meet customer requirements and to ensure safety of customers Endeavour aims to have all support shifts covered two weeks out from the service delivery date.

44. As a result, if a service is cancelled by the customer at the last minute there is not always an available support shift for the support worker to be allocated to.

45. Support workers who have their shifts cancelled will be allocated shifts should another staff member call in sick.

46. This may not be an available option if it is not a service the support worker normally undertakes as due to the specific care needs of customers support workers need to have been orientated and signed off to work in specific Endeavour services.

47. The NDIS price guide outlines that Endeavour can claim for up to 90% of the cost of a customer cancelled shift. This is only available if the customer cancels with less than 2 clear business days' notice.

48. There is not ability or recourse to funding if the client cancels before with more than two clear business days' notice.

49. If there is more than 2 day's notice, but less than 7 days, then for employees covered by the Award, our ability to change the employee's roster is restricted, and no payment can be claimed from the NDIS to cover the cancelled hours of work.

50. Only customer service shifts are funded under the NDIS. Moving staff to other types of work such as administration shifts would not be sustainable as these are not funded under customer plans.

28/6/2019.

Steven Miller

Head of Operations – Service Delivery

Endeavour Foundation

UNITED VOICE TRANCHE 2 DRAFT DETERMINATIONS

Fair Work Act 2009
s.156–4 yearly review of modern awards

4 yearly review of modern awards
[AM2018/26]

Social, Community, Home Care and Disability Services Industry Award 2010
[MA0000100]

Social, community, home care and disability

ROSS, PRESIDENT SYDNEY, XX YYY 2019

4 yearly review of modern awards

A. Further to the Full Bench decision issued by the Fair Work Commission on XX XXX 2019[1], the above award is varied as follows:

1. By inserting new clause 20.2(b) at clause 20.2 as follows:

20.2(b) An adequate number of uniforms should allow an employee to work their agreed hours of work in a clean uniform without having to launder work uniforms more than once a week.

2. By renumbering clauses 20.2 (b) to (d) as clauses 20.2 (c) to (e) respectively.

3. By amending clause 20.6 as follows:

20.6 Telephone allowance

(a) Where the employer requires an employee to install and/or maintain a telephone for the purpose of being on call, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts.

(b) Where the employer requires an employee to use a mobile phone for the purpose of being on call, for the performance of work duties or to access work related information, the employer will either:

(i) provide a mobile phone fit for purpose and cover the cost of any subsequent charges; or

(ii) provide a mobile phone and reimburse subsequent costs on the production of receipts, or

[1] [Insert decision reference]

(iii) reimburse the employee for the cost of the phone and its use according to clause (c).

(c) Where the employer requires the employee to use the employee's own mobile phone in the course of employment:

(i) where the mobile telephone is provided under a mobile phone plan from a telecommunications provider, the employer and employee must agree in writing on the amount of reasonable reimbursement payable by the employer to the employee for the use of the employee's mobile phone in the course of employment provided that such reimbursement must not be less than 50% of the cost of the employee's monthly mobile phone plan, up to a maximum monthly phone plan of $100; or

(ii) where the mobile phone is a pre-paid mobile phone, the employer and employee must agree in writing on the amount of reasonable reimbursement payable by the employer to the employee for the use of the employee's pre-paid mobile phone.

(d) If requested, the employee must provide the employer with a copy of the mobile phone plan associated with the mobile telephone to be used by the employee in the course of employment.

(e) If the employee enters into a new mobile phone plan or arrangement with a telecommunications provider entitling the employee to a different allowance under this sub-clause, the new allowance will become payable from the first full pay period after the date the employee provides the employer with a true copy of the new mobile phone plan.

4. By amending clause 25.5(d)(i) as follows:

(i) Seven days' notice will be given of a change in a roster. Full time and part time employees will be entitled to the payment of overtime for roster changes where seven days' notice is not provided.

5. By deleting clause 25.6(b) and inserting the following:

25.6(b) Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the starting or finishing time of the broken shift, whichever is the greatest.

6. By amending clause 25.6(a) as follows:

This clause only applies to social and community services employees when undertaking disability services work and home care employees.

(a) For the purposes of this award a broken shift is a shift where an employee works in two separate periods of duty on any day within a maximum spread of twelve (12) hours and where the break between periods exceeds one hour.

7. By inserting new clause 25.7 Travel time as follows:

Clause 25.7 Travel time

(a) Where an employee is required to work at different locations they shall be paid at the appropriate rate for reasonable time of travel from the location of the preceding client to the location of the next client, and such time shall be treated as time worked. The travel allowance in clause 20.5 also applies.

(b) This clause does not apply to travel from the employee's home to the location of the first client nor does it apply to travel from the location of the last client to the employee's home.

8. By renumbering clause 25.7 as 25.8.

B. This determination will come into operation from XX YYY 2019. In accordance with s.165(3) of the *Fair Work Act 2009* (Cth) these items do not take effect until the start of the first full pay period that starts on or after XXX XXXX 2019.

PRESIDENT

IN THE FAIR WORK COMMISSION

Matter No: 2018/26

Section 156 - Four Yearly Review of Modern Awards – *Social, Community, Home Care and Disability Services Industry Award 2010*

SUBMISSION OF UNITED VOICE

1. This submission is made pursuant to the amended directions of the Fair Work Commission ('the Commission') made on 4 February 2019 requiring any '*interested party*' to file evidence and submissions in support of '*their claims*' in the 4 yearly review of the *Social, Community, Home Care and Disability Services Industry Award* 2010 ('the Award').
2. The directions had as their point of reference a report of the Commission published on 30 October 2018 in which outstanding claims of parties were listed together with the report of a conciliation.
3. From 3 June 2016 to 28 February 2017, conciliation was conducted by Deputy President Booth ('the conciliation') concerning substantive claims made by both union and employer participants in the review of the Award. The conciliation ran in parallel with conferences conducted by Commissioner Lee concerning technical and drafting issues in the review of the Award.
4. United Voice was a participant in the conciliation.
5. On 8 May 2017, a document titled '*Joint Report of the interested parties to the Social, Community, Homecare and Disability Services Award 2010'* ('the Joint Report') was agreed by the union and employer parties that participated in the conciliation. The Joint Report annexed draft determinations which represented the participants' agreement concerning a number of matters. The Joint Report included a summary of claims that had been withdrawn. The Australian Industry Group ('AiG') did not participate in the conciliation but did participate in the conferences on technical and drafting matters.
6. On 22 October 2018, a directions hearing took place conducted by the President. The President noted that a consolidated list of claims and the Joint Report would be published and any party who opposed the Joint Report was invited to indicate their concerns.
7. On 30 October 2018, a report of the Commission containing draft directions for the further review of the Award was published. This report contemplated an arbitration taking place concerning the remaining claims on the basis that some claims were resolved by the Joint Report.
8. On 9 November 2018, a further directions hearing took place conducted by the President. At this hearing the AiG expressed opposition to the Joint Report on behalf of unnamed employers.
9. On 13 November 2018, directions were made in relation to the remaining substantive issues in the review of the Award. These directions were amended but are essentially the directions pursuant to which our materials here are being filed. We have prepared our materials on the basis of the claims we

are listed as seeking to progress in the report of 30 October 2018. These claims are the '*claims'* that were not resolved by the conciliation.

10. On 31 January and 8 February 2019, Commissioner Lee conducted conciliation conferences concerning the draft determinations that formed the substance of the Joint Report. Confidential discussions took place with some matters noted on the record.

11. The AiG has never clearly particularised its concerns or said who it represents. The status of the Joint Report is not clear and there are now further draft clauses from the conferences conducted by Commissioner Lee which appear to supersede the Joint Report. There is no unanimity concerning these most recent draft clauses. Accordingly, we have been unable to identify which additional substantive claims we should pursue as a consequence of the possible obsolescence of the Joint Report and related draft clauses. Timing has also made it practically impossible to make appropriate new claims and present evidence concerning matters that may or may not be resolved by the Joint Report or a related process.

12. We reserve our position concerning the Joint Report and our capacity to make appropriate substantive claims in the event that in whole or part the Joint Report is not given effect to.

13. We remain committed to a timely, efficient and fair review of this Award by the Commission.

Introduction

1. United Voice has 10 outstanding claims in the review of the Award. These claims can be identified as the following items on the '*Revised Summary of Proposed Substantive Variations*' ('the Revised Summary') dated 22 November 2017:

- *S2A -Variation to Clothing and equipment allowance (Uniforms)*
- *S3A -Variation to Rosters clause*
- *S21 –Variation to Telephone allowance*
- *S37 –Variation to Broken shifts clause*
- *S40 –Variation to Sleepover clause*
- *S44A –Deletion or variation to 24 Hour care clause*
- *S47 –Variation to Excursions clause*
- *S49 –Variation to Meal breaks clause*
- *S51 –Variation to Overtime clause*
- *S57 –Variation to Public Holiday clause*

2. We seek to pursue the above claims with the exception of *S49 –Variation to Meal breaks clause*. This claim is withdrawn.

3. Claim *S51 –Variation to Overtime clause* is pursued in part.

4. We also have 3 other claims that were withdrawn as a result of the Joint Report, dated 8 May 2017 ('Joint Report').

5. As stated previously, if the Joint Report is not endorsed by the Commission United Voice reserves our right to pursue the withdrawn claims. The withdrawn claims we withdrew pursuant to the conciliation which lead to the Joint Report are:

- *S2 – Travel time*
- *S3 – Variations to Rosters clause*
- *S30 –Client cancellation*

S44A –Deletion or variation to 24 Hour care clause and S47 –Variation to Excursions clause, S40 –Variation to Sleepover clause

S44A –Deletion or variation to 24 Hour care clause

6. Clause 25.8 '*24 hour care*' is problematic. Whilst this clause is part of the industrial '*landscape'* of the care sector, it requires more than cursory review.

7. Clause 25.8 states:

> '*This clause only applies to home care employees.*
>
> *(a) A 24 hour care shift requires an employee to be available for duty in a client's home for a 24 hour period. During this period, the employee is required to provide the client with the services specified in the care plan. The employee is required to provide a total of no more than eight hours of care during this period.*
>
> *(b) The employee will normally have the opportunity to sleep during a 24 hour care shift and, where appropriate, a bed in a private room will be provided for the employee.*
>
> *(c) The employee engaged will be paid eight hours work at 155% of their appropriate rate for each 24 hour period*.'

8. The clause permits an employer to require an employee to work for 24 hours whilst only paying the employee for 8 hours.

Legislative context

9. The only legislative assumption, made through the deeming provision in item 4 of the Schedule 5 to the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* ('Transitional Act'), was that a modern award made pursuant to the award modernisation process was a modern award for the purposes of the Act and there is no absolute acceptance that such an award made was meeting the modern awards objective. In the context of the 2 yearly transitional review the Full Bench observed that awards made as a result of award modernisation demonstrated a legislative acceptance that the terms of the existing modern award are consistent with the modern awards objective.[1] The Full Bench in the 2014 Jurisdictional Issues Decision clearly indicated that the 4 yearly review '*will proceed on the basis that* ***prima facie*** (emphasis added) *the modern award being reviewed achieved*

[1] *Re Modern Awards* [2012] FWAFB 5600; 223 IR 49, at 69.

the modern award objective at the time it was made'.[2] The Full Federal Court *Shop, Distributive and Allied Employees Association and another v The Australian Industry Groups and others*[3] ('the Federal Court Penalty Rates case') also observed item 4 in the Transitional Act appeared with items 6 which mandated a transitional review.[4]

10. As the Full Federal Court in *Construction, Forestry, Mining and Energy Union v Anglo American Metallurgical Coal Pty Ltd*[5] recently observed:

> *It is of the essence to appreciate that a modern award is not an instrument the product of agreement, or conciliation and arbitration as representing all the terms and conditions of employment of identified employees. Rather, together with the National Employment Standards its purpose is to provide* ***a fair and relevant minimum safety net*** *of terms and conditions.*[6]

11. The Commission in conducting its function under section 156 of the Act and is not bound by the claims of participants. The Award must be reviewed '*in its own right*' and the Commission can and should act independently and where appropriate disregard claims made by participants in the review process subject to the *Fair Work Act* 2009 and the rules of natural justice.

12. Recently, the Full Federal Court in *Shop, Distributive and Allied Employees Association and another v The Australian Industry Groups and others* [2017] FCAFC 161 ('the Federal Court Penalty Rates case') observed at paragraph 38:

> *The meaning of s 156(2) is clear. The FWC must review all modern awards under s 156(2) (a). In that context "review" takes its ordinary and natural meaning of "survey, inspect, re-examine or look back upon". Consequential upon a review the FWC may exercise the powers in s 156(2) (b). In performing both functions the FWC must apply the modern awards objective as provided for in s 134(2) (a).*

13. The Full Court observation of the meaning of '*review'* noted above was made in the context of the Court dismissing a point of appeal made by United Voice and another union that a material change in circumstances was required for alteration in the modern award safety net. No material change in circumstances is required to enliven the Commission's capacity to review these clauses but as noted below, it is apparent that there has likely been a material change in circumstances in the sector covered by the Award.

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2 *Four Yearly Review of Modern Awards–Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at para. 24.
3 [2017] FCAFC 161.
4 At [26].
5 [2017] FCAFC 123.
6 As above at paragraph 18.

14. In *Re Four Yearly Review of Modern Awards –Preliminary Jurisdictional Issues* [2014] FWCFB 1788, (2014) 241 IR 189 ('Jurisdictional Issues Decision') the Full Bench identified that in addition to section 156 a range of other provisions in the Act are relevant to the review. Those provisions included the objects of the Act (s. 3), the interaction with the NES (s. 55) and those provisions providing for the performance of functions and exercise of powers by the Commission (ss. 577 and 578).[7]

Focus of review

The sector has changed

15. First, the sector covered by the Award has under gone significant change since award modernisation notably the introduction of the National Disability Insurance Scheme and a greater focus on consumer directed care as the funding model. The sector can be described as more deregulated, diffuse and subject to greater competitive pressures in relation to labour costs.
16. Further the sector is expanding with greater focus on homecare and competition between providers. While these clauses are problematic in themselves, they become more awkward as part of the modern award safety net when contextualised with recent changes in the sector.

Legal issues

17. It is questionable whether clause 25.8 is compliant with the Act. There are a number of issues and these are distinct from the merit consideration as to whether it is appropriate to have such a clause in a safety-net instrument. Merit considerations are principally whether the clause complies with the modern awards objective.

18. Clause 25.8 provides no certainty concerning the hours or work of an employee. Subsection 62(1) reads:

> *(1) An employer must not request or require an employee to work more than the following number of hours in a week unless the additional hours are reasonable:*
>
> *(a) for a full-time employee--38 hours; or*
>
> *(b) for an employee who is not a full-time employee--the lesser of:*
>
> *(i) 38 hours; and*
>
> *(ii) the employee's ordinary hours of work in a week.*

[7] *Four Yearly Review of Modern Awards–Preliminary Jurisdictional Issues* [2014] FWCFB 1788 at paragraph 10.

Employee may refuse to work unreasonable additional hours

19. Subsection 62(2) further provides '*the employee may refuse to work additional hours (beyond those referred to in paragraph (1) (a) or (b)) if they are unreasonable.*' Subsection 62(3) of the Act sets out some considerations to determine whether a request or direction to work additional hours is reasonable. One consideration as to whether a direction to work additional hours is reasonable is:

> *(d) whether the employee is entitled to receive overtime payments, penalty rates or other compensation for, or a level of remuneration that reflects an expectation of, working additional hours;*

20. The 24 hour care shift clause creates situations where an employee is effectively liable to work in excess of the notional hours attributed to the engagement. Whilst the clause states the employee will be required to provide a total of no more than eight hours of care during a 24 hour care shift, in reality the hours that such engagements will '*require'* the employee to work are not foreseeable. At best when an employer directs an employee to undertake a 24 hour care shift there is a contingent request by the employer, if necessary, for the employee to work additional hours in relation to emergencies and unforeseen care needs of clients. These hours may be additional hours in terms of section 62. While section 62 does not deal with intra-day durations of work, there is the merit consideration that the clause allows unreasonable intraday durations of work, and here the issue of the employee working the additional hours is in a practical sense non-negotiable.

21. At least in terms of subsection 62(1), the Act clearly contemplates the employer requesting or requiring an employee to work their hours. A provision in a modern award that effectively places on an employee the responsibility to perform what could be considerable additional hours of work is problematic.

22. Subsection 62(2) provides a right for employees to refuse additional work beyond 38 hours a week. Where a 24 hour care shift falls late in the weekly roster cycle, it is not inconceivable that an employee will be effectively compelled to work greater than 38 hours. This clause provides no facility for the employee to refuse additional hours that may be required during the engagement. The employee will literally be '*stuck'* overnight at '*premises'* or a '*client's home.*' If something happens the employee has to respond and '*work'*.

23. The 24 hour care clause is not an '*on call*' provision but an engagement at a work site with a start and finish time. The employee is required to attend and remain at '*premises'* or a '*client's home'* by the terms of the engagement and cannot leave although it is contemplated that the employee can sleep. Sleep is not antithetical to the work. As work is contractual in origin. If an employer wants to contract

with an employee on the basis that for some part of a work engagement, the employee is asleep, this is still work.

24. A more fundamental concern with this clause is that the entire engagement is work and should be remunerated as such. Notionally attributing a certain number of hours as work to what could be a significantly longer duration of work is problematic.

25. If an employer and employee are unencumbered by legislative restrictions what payment (or even lack of payment) that can be made for '*work'* is a matter for the parties.[8] This is not the case here and particularly not so as the Commission is concerned with a safety-net provision.

26. The so called English Truck Acts of 1831[9] sought to restrict the faux contractual freedom of the parties (but in reality employers' prerogative) to pay for work other than in money. The Truck[10] Acts required payment in '*current coin of the realm'* and these Acts were principally designed to prevent employees being paid by way of tokens that had to be spent in the employer's shop and to prevent unreasonable and excessive deductions from wages.

27. Division 2, Part 2-9 of the Act which contains sections 322 to 327 are in some ways the modern successor of the English Truck Acts with some qualifications and innovations. A possible innovative aspect of the Part is that may contain a guarantee that an employer must generally '*pay'* an employee for work in codifying how work is paid for and when.

28. Mark Irving notes:

> *Section 323 (1) in part states 'an employer must pay an employee amounts payable to the employee in relation to the performance of work …in full… in money…at least monthly.' … It creates a statutory obligation to pay amounts that are payable for the performance of work. This is not a traditional part of Truck Act schemes, though it is clearly part of the scheme established by s 323. The obligation is imposed on all national system employers for their national system employees. It is not limited to employees covered by awards or industrial instruments. Section 323 is a civil penalty provision. A contravention carries a significant pecuniary penalty.*[11]

29. Justice Buchanan note in *APESMA v Wollongong Coal Ltd* [2014] FCA 878 at [28]–[30]:

> *It is certainly apparent, as the respondents contend, that ss 323 and 324 of the FW Act are intended to provide for matters dealt with in the Truck Acts – i.e. payment in money*

8 *Smith & Wood's Employment Law*, Oxford, 12th edition, 2015, p. 201.
9 As above, p. 226.
10 '*Truck'* in this sense means barter.
11 M Irving, *The Contract of Employment*, 2nd ed (forthcoming).

(not in kind), without unauthorized deductions, and with specific and reasonable periodicity.

However, that conclusion does not suffice to exclude the possibility that s 323 of the FW Act has an additional role to play.

The ordinary language of s 323 is apt to identify, and provide for the enforcement of, an obligation to pay amounts which have become payable, as well as the more specific obligation to pay such amounts in full, in money and at least monthly (subject to the statutory exemptions which accompany the obligation). It does so by permitting the imposition of a civil penalty for contravention of the obligation.

30. Clause 25.8 may breach s 323 of the Act in that it permits an employer to require an employee to work for a 24 hour period but does not require the employer to pay the employee in full for the performance of the work. Under clause 25.8, in each 24 hour care shift, an employee is performing 16 hours of unpaid work.

Merit consideration

31. These clauses are not appropriate parts of a safety net instrument. They do not comply with the modern awards objective. It is hard to characterise a provision that demands an employee is required to attend and remain at '*premises'* or a 'c*lient's home'* for durations of up to 24 hours where the employee's remuneration for the work has a rigid ceiling as consistent with a fair and relevant minimum safety net of terms and conditions.

32. The remuneration provided for the unsocial nature of the work is too low. On 1 January 2014, section 134(1) (da) became part of the modern awards objective and is relevant.

33. Presumably the employee has to make some arrangements for his or her children to be cared for by someone else when engaged on a 24 hour care shift.

34. The terms would appear to not be apt to promote '*social inclusion though increased workforce participation'*[12]. The employee for an extended period cannot do any other work effectively. The practices further are also arguably inflexible, inefficient and not conducive to productivity[13]. Leaving one employee for lengthy periods on duty dealing with complex interpersonal matters is problematic.

35. Whilst the clause contemplates that the employee will not be required to provide a total of no more than 8 hours of care during the 24 hour period, this has no practical application. A home care worker in a client's home cannot realistically turn aside from assisting a client with their needs even when 8 hours of care have already been provided. This is especially so given clients who require 24 hour care are likely to be clients who require a high level of care. Yet there is no provision within the

[12] 134(1)(c).
[13] 134(1)(d).

clause for overtime rates beyond the 8 hours of care or even for the home care worker to be paid at all beyond the 8 hours.

36. Further, that the home care worker is required to be at the client's home for 24 hours by the employer is by necessity, *work*. The home care worker is not free to leave and should appropriately be paid for all hours they are required to be present at a client's home.

37. It is our position that clause 25.8 should be deleted.

38. It is our position that the existence of clause 25.7, the 'Sleepover' clause, negates the requirement for clause 25.8.

39. The sleepover clause at least assumes the employee will sleep and requires payment for work performed prior to or following the sleepover shift. The 24 hour clause permits an employee being left alone in a client's home where there may be a number of persons living and 'normally' the employee will have the opportunity to sleep. The current phrasing of the clause is ambiguous as to whether the employee will be provided with a safe and clean space to sleep during the 24 hour care shift.

40. The sleepover clause also provides that employees will receive an allowance and payment for time worked during a sleepover. This is far more appropriate than the 24 hour care clause, which provides no payment for the sleepover portion of the shift.

41. Clause 25.8 does not meet the modern award objectives and should be deleted from the Award.

42. Clause 25.7(a) should be amended to remove the words '*and is not a 24 hour care shift pursuant to clause 25.8*' to ensure that employees previously undertaking 24 hour care shifts will be covered by the provisions of the sleepovers clause.

S47 –Variation to Excursions clause

43. Clause 25.9 (ii) of the award provides that where an employee agrees to supervise clients on excursion activities that may involve overnight stays, then '*the employer and employee may agree to accrual of time instead of overtime payment for all other hours*'.

44. This clause is ambiguous as to whether the accrual of time would be equivalent to the normal hourly rate or overtime. Therefore we seek to vary the existing clause to read:

> '*The employer and employee may agree to accrual of time instead of overtime payment. The time accrued will be calculated at the overtime rate*.'

45. The modern award objective s134 (1) (da) should be taken into consideration when reviewing clause 25.9(ii). The clause is currently in contravention of this objective because it is ambiguous as to whether employees will be compensated for working overtime. Amending clause 25.9(ii) as proposed would satisfy this objective by ensuring that workers who are required to undertake excursion shifts at unsocial hours are compensated appropriately.

46. United Voice does not consider it to be fair to employees to be provided with the accrual of time at an hour for hour rate rather than to be paid overtime. Such an arrangement clearly benefits employers and does not reflect the true value of the work undertaken by the employee. We submit that

the clause in its current form allows employers to apply pressure to employees to accept accrual of time at an hour for hour rate instead of paying overtime or accrual of time at the overtime rate for the hours worked during an excursion in which they would ordinarily be entitled to overtime rates. The power imbalance that exists between employer and employee should not be underestimated in circumstances regarding wages. If an employee works hours that are unsocial or outside of their normal hours of work, then they should be entitled to overtime rates. Amending clause 25.9(ii) as proposed ensures that employees are compensated appropriately if they are to work unsocial or unusual hours.

S40 –Variation to Sleepover clause

47. We seek the deletion of the words '*and is not a 24 hour care shift pursuant to clause 25.8'*. The claim that these words be deleted is a consequence of the claim concerning the deletion of clause 25.8 concerning 24 hour shifts.

S2A -Variation to Clothing and equipment allowance (Uniforms)

48. Clause 20.2(a) states:

> *'Employees required by the employer to wear uniforms will be supplied with an adequate number of uniforms appropriate to the occupation free of cost to employees. Such items are to remain the property of the employer and be laundered and maintained by the employer free of cost to the employee.'*

49. Clause 20.2 (a) of the Award provides that where an employee is required to wear a uniform by the employer, then the employer must provide the employee with '*an adequate number of uniforms*' free of cost to the employee.

50. The Award does not define '*adequate*' and as a result, the decision as to what constitutes an '*adequate*' number of uniforms is often made solely by the employer. When this decision is solely made by the employer, the cost of providing uniforms can carry greater weight than other relevant considerations, and employees are often not provided with a genuinely adequate number of uniforms.

51. Many of the employees covered by the Award carry out work which can easily result in uniforms becoming stained or dirty quickly. For example, home care workers carry out tasks such as cooking, doing laundry, cleaning, helping clients shower and assisting clients with personal hygiene tasks. One home care worker may assist several different clients with these tasks in the course of one day.

52. Where employees are not provided with a genuinely adequate number of uniforms, the burden of ensuring they have a clean uniform for work falls on individual employees, and can result in employees having to wash their uniform multiple times a week.

53. Having to wash uniforms several times a week can be onerous.

54. Employees covered by the Award should be provided with enough uniforms to ensure that they are able to attend work in a clean uniform, without having to wash their uniforms more than once a week.

55. The evidence indicates that there are employees in this sector who are not provided with an adequate number of uniforms.

56. Our witness, Belinda Sinclair, indicates that she was not provided with enough uniforms to attend work in a clean uniform without having to wash her uniforms more than once a week.[14] As she states: '*When I only had 2 shirts, I had to wash them every day of employment, so one was ready to wear the next day. Working five days in a row meant I had to wash them at least three times per week.*'[15]

57. It was only after Belinda Sinclair advocated for herself on several occasions that she was provided with an adequate number of shirts, one and a half years after she had commenced work with this employer.[16]

58. We seek to vary clause 20.2 of the Award to ensure that the employee will be given a sufficient number of uniforms that they will not need to launder their work wear more than once a week. The variation we seek is the insertion of a new clause 20.2(b) (with the subsequent clauses renumbered):

> *'20.2(b) An adequate number of uniforms should allow an employee to work their agreed hours of work in a clean uniform without having to launder work uniforms more than once a week.'*

59. This variation is in line with the modern awards objective, specifically:

- s 134(1)(a) – '*relative living standards and the needs of the low paid*' -this variation would assist provide for the needs of the low paid. Employees covered under the SCHDS Award can generally be considered low paid. This is further exacerbated by the fact that the majority of work in the sector is part-time.
- s 134(1)(c) – '*the need to promote social inclusion through increased workforce participation'* – participation in the workplace is facilitated by the dignity in having a clean uniform.

S3A -Variation to Rosters clause

60. Clause 25.5(d)(i) states:

> *'(d) Change in roster*
>
> *(i) Seven days' notice will be given of a change in a roster.*
>
> *(ii) However, a roster may be altered at any time to enable the service of the organisation to be carried on where another employee is absent from duty on account of illness, or in an emergency.*

[14] Statement of Belinda Sinclair at [18]-[19].
[15] Sinclair at [19].
[16] Sinclair at [20].

(iii) This clause will not apply where the only change to the roster of a part-time employee is the mutually agreed addition of extra hours to be worked such that the part-time employee still has four rostered days off in that fortnight or eight rostered days off in a 28 day roster cycle, as the case may be.'

61. Clause 25.5(d) (i) provides that seven days' notice will be given of a change in roster. There are two exceptions to this, which are listed in clause 25.5(d) (ii) and (iii).

62. Clause 25.5(d) (ii) provides that rosters may be altered without seven days' notice where another employee is absent due to illness or emergency and the service of the organisation must still be carried out, and clause 25.5(d) (iii) provides that rosters may be altered with agreement for part time employees, provided they still have the required number of days off within that work period.

63. We note that the Joint Report contains an agreed position in respect of clause 14.3(f)(ii) of the Exposure Draft of the Award dated 6 January 2017, which corresponds clause to clauses 25.5(d)(ii) and (iii) of the Award.

64. Our submission here does not seek to disrupt that position.

65. Our submission is made only in respect of clause 25.5(d) (i) of the Award (which corresponds with clause 13.5(f) (i) of the Exposure Draft of the Award, dated 26 March 2018).

66. Clause 25.5(d) (i) of the Award provides that seven days' notice will be given of a change in roster.

67. The Award does not explicitly identify what the consequence is for the employer for failing to providing seven days' notice of a roster change in a situation where the exceptions in clause 25.5(d) (ii) and (iii) do not apply.

68. The logical interpretation is that any roster changes where seven days' notice has not been provided must be paid as overtime. This is also the stand industrially generally.

69. However, many employers in the sector do not heed this, and regularly make changes to employee rosters without the required notice and without the payment of overtime.

70. Our witness, Belinda Sinclair, provides evidence that her employer frequently makes late roster changes, sometimes without her agreement.[17] She states that the roster changes '*make it difficult for me to plan things for when I am not rostered or to make a weekly budget, despite that I am a permanent employee, not a casual.*'[18]

71. This needs to be considered in the context of a sector in which there are constant and unpredictable shift changes. Our witnesses all indicate that there are frequent changes to their rosters and a significant variability in hours from week to week[19]. This creates financial uncertainty.[20]

72. United Voice proposes that clause 25.5(d)(i) is amended as follows:

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17 Sinclair at [23] and [25].
18 Sinclair at [25].
19 Statement of Deon Fleming at [13], [15] and [16]; statement of Trish Stewart at [9], Sinclair at [25].
20 Fleming at [16], Stewart at [10], Sinclair at [25].

'*Seven days' notice will be given of a change in a roster. Full time and part time employees will be entitled to the payment of overtime for roster changes where seven days' notice is not provided*'.

73. The proposed amendment will remove any ambiguity about what occurs when seven days' notice is not provided.

74. Roster changes without adequate notice can be disruptive and can have a significant impact on the ability of members to attend to their family and caring responsibilities.

75. For example, employees who are parents generally need to make arrangements for children in advance – whether that is for pick up/drop off, attending after school activities or care at home. Late changes to a roster can disrupt arrangements that have been made in advance.

76. Employees who have caring responsibilities for parents, spouses or others may have made arrangements for hospital and other appointments in advance. Again, late changes to a roster can disrupt these arrangements.

77. The Award currently offers employers a significant level of flexibility in rostering. As noted above, clause 25.5(d) (ii) and (iii) provide two exceptions to the requirement to provide seven days' notice. In addition, clause 25.5(f) provides the employer with flexibility in rostering when a client cancels.

78. Whilst the roster change clause would ideally provide for a greater period of notice for roster changes, the seven days' notice required for change of roster under clause 25.5(d)(i) at least provides some measure of security for employees in planning out their outside of work commitments.

79. However, clause 25.5(d) (i) is not currently having the intended effect, as the clause does not explicitly identify the penalty for failing to provide 7 days' notice of a roster change. United Voice's proposed amendment will ensure that the clause has the intended effect.

80. This variation is in line with the modern awards objective, specifically section 134 (1) (da) (ii) '*the need to provide additional remuneration for employees working unsocial, irregular or unpredictable hours*'. There should be proper compensation for employees who are required to work unpredictable hours as a result of late roster changes.

S21 –Variation to Telephone allowance

81. Clause 20.6 of the Award reads:

> ***20.6 Telephone allowance***
>
> *Where the employer requires an employee to install and/or maintain a telephone for the purpose of being on call, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts.*

82. Currently, the Award contains no clear allowance or mechanism for an employee who is required to purchase and maintain a mobile phone for work purposes to receive any reimbursement of costs

associated with the worked related use of the device. Notionally, the entire cost of a work related mobile phone use is '*shifted'* onto the employee unless the employer has some policy which provides for work related phone use.

83. The Award contains a number of classifications where the work takes place outside of a conventional workplace office, individually and in some cases in the recipient of the care's home. For example, all classifications of home care workers except level 5 supervisors will spend a substantial proportion of their work hours outside of the workplace providing services in a person's home.

84. Our draft determination seeks the insertion of a new clause 20.6:

> *Where the employer requires an employee to install and/or maintain a telephone **or mobile phone** for the purpose of being on call, **for the performance of work duties or to access work related information**, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts.*

85. The Health Service Union has a similar claim.

86. United Voice has a similar claim for an allowance where an employee is directed to possess a mobile phone for work related purposes in the review of the *Aged Care Award 2010.*

87. For this award, the addition of an appropriate allowance that reflects current technology and workplace practise is an appropriate object of review.

88. As the Full Federal Court observed in *Shop, Distributive and Allied Employees Association v The Australian Industry Group*[21] at [38]

> *In that context "review" takes its ordinary and natural meaning of "survey, inspect, re-examine or look back upon". Consequential upon a review the FWC may exercise the powers in s 156(2) (b). In performing both functions the FWC must apply the modern awards objective as provided for in s 134(2) (a).*

89. More relevantly, the *Telecommunications Award* 2010 contains a telephone allowance that at clause 17(c):

> ***(c) Telephone allowance***
>
> ***(i)** Where an employee does not have a telephone, modem or broadband connection and, at the written request of the employer, the employee is required to have such equipment, the employer must reimburse the cost of purchase, installation and rental.*
>
> ***(ii)** Where an employee makes telephone calls in connection with the business on their private telephone at the direction of the employer, the employer must reimburse the cost*

[21] [2017] FCAFC 161 (11 October 2017).

> *of such calls. Provided that the employer may request details of all such calls claimed by the employee.*

90. The principle that an employee should be reimbursed where an employer requires that the employee have access to a mobile telephone for work is of continuing relevance and should form part of the modern award safety net where mobile phones have become tools of trade and an employee is directed to use one for work. More generally, the established principle that the modern award system generally provides some compensation to an employee when the employer directs that a particular tool of trade is used is relevant.

91. In recent decision[22] which dealt with the tool allowances in the *Restaurant Industry Award* 2010 and *Hospitality Industry (General) Award* 2010, the Full Bench noted in the context of increasing the allowance in the Hospitality Award and expanding the scope of the allowances in both awards:

[242] *The variations we propose to make to the tool allowance provisions in these awards will assist the low paid to meet their needs (s 134(1)(a)) and will have an adverse impact on employment costs (s 134(1)(f)), albeit the impact is not likely to be significant ... Taking into account the s 134 considerations (insofar as they are relevant) we are satisfied that the variations proposed are necessary to ensure that the Hospitality Award and the Restaurant Award achieve the modern awards objective.*

92. On 30 November 2018, the Australian Communications and Media Authority released data indicating that 5.78 million Australians, about 31 % of the population, have no fixed landline at home.[23]

93. *'Digital disruption'* has been a matter of comment by many workplace experts and the subject of a 2016 research report by the Productivity Commission[24]. Associate Professor Sarah Kaine has summarised some of the consequences of '*disruption'*:

> *In the traditional economy businesses provide capital and employees provide labour. This is being challenged by the disruption wrought by technology, specifically the multitude of digital matching platforms.*
>
> *There are now a vast array of organisations providing very different goods and services using digital platforms to match consumers and service providers in the sharing economy (also known as the collaborative economy, access economy or peer economy).*

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[22] *4 Yearly review of modern awards- Restaurant Industry Award* 2010 – *Hospitality industry (General) Award* 2010 [2018] FWCFB 7263.

[23] Marcus Strom, *The long inexorable decline of the landline in Australia*, 6 January 2017, Sydney Morning Herald, https://www.smh.com.au/technology/the-long-inexorable-decline-of-the-landline-in-australia-20161221-gtfjsp.html.

[24] Productivity Commission, *Digital Disruption: What do governments need to do*? Australian Government, June 2016.

> *In this type of economy many organisations are "asset light". This means businesses make money through providing access to goods and services and making connections between smaller providers and consumers. In doing so, the risk shifts from business to individual gig workers.*[25]

94. The Productivity Commission in its 2016 report explicitly drew a link between the greater use of technology and improved productivity[26] and workplace participation.[27]

Witness evidence

95. Our witnesses, Trish Stewart, Deon Fleming and Belinda Sinclair, all indicate that possession of a mobile phone is necessary to perform their duties as home care workers.[28] The work takes place almost exclusively outside of a conventional office environment remotely and rosters and other important work related materials are provided by the employer to the employee via their own mobile phone.[29] The evidence indicates that the employers do not routinely provide to home care workers with a phone or reimbursement for costs when the employees' personal mobile phone is used for work related purposes during rostered hours.[30]

96. A number of the witnesses indicate that the possession of a personal mobile phone was '*presumed'* by the employer, their mobile numbers were asked for and the employer commenced communicating and incorporating the employee's personal mobile into its work.[31] Trish Stewart notes:

> *One of my duties involves making phone calls to clients to check that they have taken their medications. I am directed to do this as part of my job. I normally make 2-3 of these phone calls per working day. I am also required to call clients if I am running late to meet them for an appointment. This can happen frequently due to traffic.*

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25 Sarah Kaine, *Workers are taking on more risk in the gig Economy*, 6 July 2016, the Conversation, https://theconversation.com/workers-are-taking-on-more-risk-in-the-gig-economy-61797.

26 As above, Part 1.4, *The economic impact of new technologies*, pages 27 to 30.

27 As above, part 3.6, Technology can enable participation in the workforce, pages 94 to 95.

28 Stewart at [20] to [22]; Fleming at [18] to [20]; and Sinclair at [14] to [16].

29 Stewart at [22]; Fleming at [28]; and Sinclair at [17].

30 Stewart at [21]; Fleming at [30]; and Sinclair at [16].

31 Stewart at [21]; Fleming at [28]; and Sinclair at [16].

I make these phone calls from my personal mobile phone. I am not provided with a phone by my employer to make these phone calls. My employer asked me for my mobile and made it clear this was because I would be contacted by my employer on my own mobile for work related matters. I have never been provided with a work mobile and the only device I can use for work related calls is my own mobile. I am not reimbursed for the cost of making these phone calls or the cost required to maintain my personal phone to ensure I can make these phone calls. My phone bill costs approximately $170 per month. If I was not required to make as many work calls, I could consider dropping to a cheaper mobile phone plan.

Since August 2018, my employer has been emailing our rosters to us, so I am required to have access to an email account and the internet in order to check my roster. I also scan and email timesheets to my employer at the end of each week, which also requires access to the internet. I am also reliant upon the internet at home if I am asked to pick up a shift with a client I am not familiar with. I will have the care plan emailed to me and I will read it from home prior to attending the appointment so that I am aware of their history and requirements.[32]

97. The evidence of Belinda Sinclair clearly indicates the utility and need for a home care worker to possess a mobile phone and lists a range of common work events for which it is necessary to possess a mobile phone:

a. *if the client doesn't open the door when I visit them,*

b. *if there is traffic that is going to make me late,*

c.*if the clients home phone/call alarm is not working,*

d. *if the work email or tablet system is not working properly, and*

e.*report a hazard/incident in line with Wesley Mission's policy and procedures*.[33]

98. All three witnesses can be described as low paid workers and the practical necessity to maintain a mobile phone is a significant expense. The witnesses also all indicate a level of vulnerability in wanting to maintain their hours.[34]

99. The employers further have not adopted policies or processes to reimburse their employees for work related mobile phone use or a practical reality do not.[35]

100. This claim reflects recent changes in technology and patterns of work that have occurred after award modernisation in 2009. The rise of the so called '*smart phone'* as a workplace tool has occurred after 2009.[36] Accordingly, award histories and the *status quo* are of limited utility as the need for

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32 Stewart at [20] to [22]

33 Sinclair at [14].

34 Stewart at [11]; Fleming at [16] to [17]; and Sinclair at [26].

35 Stewart at [21]; Fleming at [30]; and Sinclair at [16].

36 Charles Arthur, *The History of Smartphones: timelines*, 25 January 2012, the Guardian: https://www.theguardian.com/technology/2012/jan/24/smartphones-timeline.

review stems from a recent change that has not been reflected industrially in the modern award system.

101. The telephone allowance in the Award is anachronistic, does not reflect the current ubiquity of mobile '*smart'* phone use and their status as work tools. So far as one is necessary, a significant change of circumstances has taken place since this Award was made which requires the Commission to conduct a substantive review of this matter.

102. Australia's social safety net needs to reflect changes in technology and the greater use of such technologies. Costs associated with the use of new technology should not be shifted onto low income workers. The Productivity Commission noted:

> *There will be adjustments that come with digital disruption. Some workers will struggle to adjust to changes in demand for their skills and new, more flexible but less reliable, work options. Australia's social safety net will remain important in mitigating risks for workers and lessening the effects of a widening distribution in incomes.*[37]

103. Award reliant home care workers are not part of the '*gig'* economy but their evolving patterns of work demands greater reliance of mobile phone technology which make some of the general findings of the Productivity Commission apposite.

104. The witness evidence clearly indicates that much of the work covered by the Award takes place in the community where possession of a mobile phone is a practical necessity. The evidence further supports the thesis of Dr Kaine and others concerning technology having the practical effect of allowing employers to shift costs onto workers. A fair characterisation of the evidence is that the employers here appear to be '*free riding*' and shifting an expense that in whole or in part should be attributed to the employer. This behaviour is driven by the ubiquity of possession of a mobile phone. Award reliance which often equates with being low paid and some precariousness also does not place the employee in a position to demand reimbursement of all work related expenses. This is especially the case in relation to work expenses associate with technological change where there is not a clear industrial custom concerning the attribution of the cost.

105. As noted, the evidence indicates the employers are not adopting policies or practices to reimburse their employees for work related mobile phone use. This indicates a clear need for a safety-net instrument such as the Award to deal with the issue.

106. In circumstances where the employee does not possess an appropriate device and the employer directs the employee to possess one for the purpose of their employment, it is appropriate that the employee is reimbursed for the associated costs. Where an employer provides a work phone for the employee, the allowance would have no application.

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[37] As above at page 2.

107. The proposed allowance covers the quite specific circumstance where an employer requires an award covered employee as a condition of their employment to possess a mobile phone and use it. Currently, the award provides no clarity concerning the attribution of the cost of the purchase and use of such technology.

108. The Award is a safety net instrument and intended to provide '*a fair and relevant minimum safety net of terms and conditions taking into account relative living standards and the needs of the low paid*.' In light of the expense of purchasing and maintaining a mobile phone and its status as a tool of trade; it is appropriate that a reimbursement allowance as proposed is part of the safety net of this modern award.

109. Much of the work covered by the Award can be classified as low paid and the cost of purchasing and maintaining a mobile phone because the employer demands its employees use this technology is a significant imposition and a cost which the employer should properly make some contribution towards. The allowance as proposed would also provide certainty to employers that any direction to possess and use a mobile phone as a tool of work is a lawful and reasonable direction. It is unarguable that any work direction to use a personal mobile phone without some reimbursement provision for expenses is not '*reasonable'*.

110. Further, such an allowance can be characterised apt to '*promote flexible modern work practices and the efficient and productive performance of work,*'[38]and greater workforce participation.[39]

S37 –Variation to Broken shifts clause

111. There are two parts to our claim to vary clause 25.6(a) broken shifts. The first is that the clause should be varied to explicitly state that a broken shift can only be worked in 2 parts. The second is that the higher of the shift loadings should apply. Each part of our claim is addressed separately.

Number of broken shifts per day

112. Clause 25.6(a) of the Award states:

> *'This clause only applies to social and community services employees when undertaking disability services work and home care employees.*
>
> *(a) A broken shift means a shift worked by an employee that includes one or more breaks (other than a meal break) and where the span of hours is not more than 12 hours.'*

113. A significant number of employers in the sector are interpreting this clause as if it allows for an unlimited number of broken shifts per day.

[38] Paragraph 134(1) (d).
[39] Paragraph 134(1) (c).

114. It is common for employers to only provide employees with a few paid hours of work in several broken shifts over a long span of hours. For example, a home care employee could have 4 hours of work across a span of 10 hours, and these 4 hours of work could be split into 6 different broken shifts.
115. The impact of the Award being read by employers as providing for an unlimited number of broken shifts is compounded by several other issues within the Award.

Travel time

116. The time spent by an employee travelling from one client to another is rightfully time worked and should be paid as such. However, a significant number of employers in this sector '*de-roster*' employees for travel time between shifts to avoid paying the employee their rightful wages. This type of '*de-rostering*' is facilitated by an interpretation of clause 25.6(a) that allows for an unlimited number of broken shifts.
117. For example, a home care worker may commence work at the first client's home at 7am for 30 minutes to undertake a medication check. The worker will then drive 30 minutes to the next client's home. The worker will attend the second client's home for 1 hour from 8am to 9am for meal preparation duties and then travel 40 minutes to the third client's house, where they will undertake cleaning duties for 1 hour.
118. Many employers will characterise this period of work as consisting of 3 separate broken shifts, and only pay the worker for 2 hours and 30 minutes of work. The 1 hour and 10 minutes spent travelling by the worker at the direction of the employer would be unpaid.
119. United Voice has a separate claim in this review in relation to payment of travel time (*S2 – Travel time).* This claim was withdrawn subject to the endorsement of the Joint Report, which is yet to be confirmed. We do not re-agitate it here but highlight this issue to draw attention to how employers improperly utilise broken shifts to avoid paying employees for time worked.

Minimum engagement

120. Employment within this sector is predominately part-time and casual.
121. There is no minimum engagement period for part-time employees under this Award.
122. The minimum engagement period for casual employees varies depending on type of work. The broken shifts clause only applies to home care employees and disability services workers, and the minimum engagement for each is 1 hour and 2 hours respectively.
123. Employees working broken shifts are commonly working shifts of short duration. One to 2 hours shifts are common. Employers frequently roster employees on shifts as short as 15 minutes (for tasks such as 'medication checks'). Employees are also commonly rostered on for telephone shifts of 5 minutes duration.

124. The lack of minimum engagement provisions for part-time employees within this Award (and the short minimum engagement periods for casual employees) exacerbates the impact of multiple broken shifts. This is explored further in the next section.
125. We note the HSU has a claim for a 3 hour minimum engagement period for all employees under this Award. We support this claim.

The disruptive effect of broken shifts

126. The interpretation by employers that clause 25.6(a) allows an unlimited number of broken shifts is disruptive to the lives of employees.
127. It provides employers with an extreme and unjustifiable degree of flexibility in rostering at the expense of the employee.
128. Witness evidence from Trish Stewart, Deon Fleming and Belinda Sinclair indicates that broken shifts are common within the sector. Stewart and Fleming commonly work broken shifts, whilst Sinclair sometimes worked broken shifts until around mid-2018.[40]
129. Employees are expected to be available for a long span of hours across the day if they want a reasonable number of hours of work. Our witness Trish Stewart states: '*The way that these appointments are broken up across my day requires me to be available for 12-13 hours during the day, but I will only be paid for 4-5 hours of work.*'[41]
130. This is also an issue for Deon Fleming, who states '*The broken shifts which spread across the day mean I am effectively working the entire day. I may only be paid for 4-5 hours.*'[42]
131. This creates difficulties for employees who have caring responsibilities, who may struggle to find appropriate care arrangements for intermittent work over a long span of hours.
132. This also requires employees to forego making other plans. This may include foregoing spending time with and caring for children or grandchildren, foregoing time with friends and family and foregoing time spent on personal interests. The evidence of Trish Stewart indicates that she foregoes time that could be spent with grandchildren in order to be available for lengthy broken shifts.[43]
133. This may also include foregoing other work opportunities –which can be critical to earning enough income, given the low wages and levels of underemployment within this sector. Both Stewart and Fleming both give evidence that obtaining secondary employment is difficult, given that they are required to be available upwards of 12 hours per day.[44]
134. For some employees working broken shifts, the cost of being available for work can sometimes be greater than the income derived from the work.

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40 Stewart at [13], Fleming at [18]-[20], Sinclair at [12].
41 Stewart at [16].
42 Fleming at [23].
43 Stewart at [19].
44 Stewart at [18] and Fleming at [24].

135. The importance of minimum engagement provisions in ensuring that employees are provided with an adequate amount of compensation for the cost of each attendance in the workplace was considered in the Decision on Casual employment and Part-time employment dated 5 July 2017[45] ('the July Decision'):

> *[399] Minimum engagement periods in awards have developed in an ad hoc fashion rather than having any clear founding in a set of general principles. However their fundamental rationale has essentially been to ensure that the employee receives a sufficient amount of work, and income, for each attendance at the workplace to justify the expense and inconvenience associated with that attendance by way of transport time and cost, work clothing expenses, childcare expenses and the like. An employment arrangement may become exploitative if the income provided for the employee's labour is, because of very short engagement periods, rendered negligible by the time and cost required to attend the employment. Minimum engagement periods are also important in respect of the incentives for persons to enter the labour market to take advantage of casual and part-time employment opportunities (and thus engage the consideration in paragraph (c) of the modern awards objective in s.134).*

136. The manner in which broken shifts are rostered within this sector, alongside the lack of minimum engagement provisions for part-time employees (and the short minimum engagement periods for casual employees), result in what can be properly classified as an exploitative employment arrangement.

137. This is particularly so when considering that employees in home care and disability support are predominately women on low wages.

138. The number of broken shifts that can be worked within any one day should be limited.

139. Traditionally, broken shifts have consisted of a shift that is split into two parts. This is explicitly stated in some awards:

Modern Award	**Clause**
Security Services Industry Award 2010	***15.6 Broken shift allowance*** A broken shift allowance is payable to an employee who is required to work a rostered shift in two periods of duty (excluding crib breaks).
Children's Services Award 2010	***15.1 Broken shift allowance*** Where an employee works two separate shifts in a day, they will be paid an allowance of 1.91% of the standard rate per day for each day on which a broken

[45] [2017] FWCFB 3541.

	shift is worked.
Cleaning Services Award 2010	***17.1 Broken shift allowance*** An employee who works a broken shift will be paid an allowance of 0.458% of the standard rate per day up to a maximum of 2.29% of the standard rate per week. For the purposes of this award a broken shift is a shift where an employee works in two separate periods of duty on any day within a maximum spread of thirteen 13 hours and where the break between periods exceeds one hour.

140. The wording of clause 25.6(a) of this Award requires variation so that it is explicit that a broken shift can only be worked in two parts. United Voice proposes the following wording:

> '*For the purposes of this award a broken shift is a shift where an employee works in two separate periods of duty on any day within a maximum spread of twelve (12) hours and where the break between periods exceeds one hour*.'

141. This variation is in line with the modern awards objective, specifically:

- s 134(1)(a) – '*relative living standards and the needs of the low paid*' – Amending the Award to provide that a broken shift can only be worked in two parts would improve the living standards of low paid workers covered by this Award. Employers would have to properly roster shifts so that there would only be one break (excluding meal and rest breaks) at a maximum. This would reduce the ability of employers to avoid paying travel time and would reduce the occurrence of intermittent work in this sector. This variation would also likely reduce the need for employees to seek secondary employment, as more regular steady work would be available.
- s 134(1)(c) – '*the need to promote social inclusion through increased workforce participation'* – This amendment would result in improved conditions for part-time and casual employees under this Award, and would encourage employees staying in employment in this sector.

Broken shift allowance

142. Clause 25.6(b) of the Award states:

> *(b) Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 29—Shift work, with shift allowances being determined by the finishing time of the broken shift.*

143. Under the Award, the shift allowance applicable to a broken shift is determined by the finishing time of the broken shift.

144. Clause 29.2 contains the shift definitions under this award and clause 29.3 contains the penalties.

145. Clause 29.2 Definitions states:

> *(a)* ***Afternoon shift*** *means any shift which finishes after 8.00 pm and at or before 12 midnight Monday to Friday.*
>
> *(b)* ***Night shift*** *means any shift which finishes after 12 midnight or commences before 6.00 am Monday to Friday.*
>
> *(c) A* ***public holiday shift*** *means any time worked between midnight on the night prior to the public holiday and midnight of the public holiday.*

146. Clause 29.3 Shift allowances and penalty rates states:

> *(a) An employee who works an afternoon shift will be paid a loading of 12.5% of their ordinary rate of pay for the whole of such shift.*
>
> *(b) An employee who works a night shift will be paid a loading of 15% of their ordinary rate of pay for the whole of such shift.*
>
> *(c) An employee who works a public holiday shift will be paid a loading of 150% of their ordinary rate of pay for that part of such shift which is on the public holiday.*

147. Under the Award, an employee who commenced a broken shift at 5am and finished at 3pm would not receive any shift loadings.

148. This creates an anomaly, in that whilst an employee who was working a continuous shift would rightfully receive the night shift penalty of 15% of their ordinary rate of pay for the whole of the shift, an employee working a broken shift receives no shift loading for the whole of the shift.

149. The Award in this respect is inconsistent with the modern award objectives in that for employees working broken shifts, the Award does not provide adequate '*additional remuneration for employees working shifts*' (s134 (1)(da)(iv) of the Act).

150. United Voice has proposed the following variation:

> *25.6(b) Payment for a broken shift will be at ordinary pay with penalty rates and shift allowances in accordance with clause 29—Shiftwork, with shift allowances being determined by the starting or finishing time of the broken shift, whichever is the greatest.*

151. This is an appropriate variation that will ensure that employees who undertake shift work are appropriately remunerated for the disutility of working early or late hours.

S51 –Variation to Overtime clause

152. We support the HSU in their claim to vary clause 28 to ensure all time worked beyond rostered hours is paid at overtime rates. Otherwise we do not make further submissions on that matter.
153. We withdraw our claim to amend clause 28.1(b) (iii) to make overtime payable after 8 hours instead of 10 hours.
154. We maintain our claim to amend clause 28.1(b) (iv) to ensure casual employees are paid the casual loading when working overtime.
155. Clause 28.1(b)(iv) of the Award states:

> *(iv) Overtime rates payable under this clause will be in substitution for and not cumulative upon:*
> *(A) the shift premiums prescribed in clause 29—Shiftwork; and*
> *(B) the casual loading prescribed in clause 10.4(b),*
> *and are not applicable to ordinary hours worked on a Saturday or a Sunday.*

156. Our proposed amendment is as follows:

> *(iv) Overtime rates payable under this clause will be in substitution for and not cumulative upon the shift premiums prescribed in clause 29—Shiftwork and are not applicable to ordinary hours worked on a Saturday or a Sunday.*

157. In the decision of 23 February 2017, *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 ('the Penalty Rates Decision'), the Commission made repeated reference to the views of the Productivity Commission concerning the interaction of penalty rates and the casual loading. At paragraph 333 of the Penalty Rates Decision, the Commission noted that the Productivity Commission in its Final Report observed:

> *In some awards, penalty rates for casual employees fail to take into account the casual loading, which distorts the relative wage cost of casuals over permanent employees on weekends (and particularly Sundays). The wage regulator should reassess casual penalty rates on weekends, with the goal of delivering full cost neutrality between permanent and casual rates on weekends, unless clearly adverse outcomes can be demonstrated. This would imply that casual penalty rates on weekends would be the sum of the casual loading and the penalty rates applying to permanent employees.*

158. The Productivity Commission described a '*default approach*' where:

> *… the casual loading is always set as a percentage of the ordinary/base wage (and not the ordinary wage plus the penalty rate). The rate of pay for a casual employee is therefore always 25 percentage points above the rate of pay for non-casual employees.*[46]

[46] The Decision, paragragh [335].

159. At paragraph 337 of the Penalty Rates Decision, the Commission indicated a preference for the default approach as:

> *… the casual loading is paid to compensate casual employees for the nature of their employment and the fact that they do not receive the range of entitlements provided to full-time and part-time employees, such as annual leave, personal/carer's leave, notice of termination and redundancy benefits.*

160. The Commission further observed that the default approach is consistent with consideration 134(1) (g) of the modern award objective which requires that modern awards are '*simple, easy to understand, stable and* [provide a] *sustainable system for Australia that avoids unnecessary overlap of modern awards'*.[47] This consideration most clearly identifies consistency in the treatment of terms and conditions across all modern awards as *prima facie* an element of the modern award objective.

161. While the Commission did not make any specific reference to consideration 134(1) (da) (iii) which deals with the need to provide additional remuneration for employees working unsocial hours, United Voice contends that the insertion of this consideration into the modern award objective in January 2013 also provides support for the casual loading being an additional amount paid when any penalty or loading applies to work at an unsocial time. Subsuming the casual loading into other penalties and loadings also means that a casual employee is not compensated for disutility determined to apply for the hours worked.

162. The Commission in the Penalty Rates Decision stated a preference for the default approach generally whenever it reduced or altered rates in relation to the modern awards the subject to the review. Examples of specific applications of this approach are found in the general consideration of weekend penalty rates for casuals;[48] in the Commission's proposed reductions in the Sunday rate in the *Hospitality Industry (General) Award* 2010 ('Hospitality Award'), [49] in the Commission's proposed reductions in the public holiday rate in the Hospitality Award, *Restaurant Industry Award* 2010, *General Retail Industry Award* 2010 ('Retail Award'), *Fast Food Industry Award* 2010 ('Fast Food Award) and *Pharmacy Industry Award* 2010 ('Pharmacy Award') (it was not applied to the Registered and Licensed Clubs Awards 2010 as the rates in this award were not altered);[50] in effect in the proposed reductions in the Saturday and Sunday rate for casuals under the Fast Food Award;[51] in the Commission's proposed reductions in the Sunday rate in the Retail Award;[52] and for the proposed reductions in the Sunday rate in the Pharmacy Award.[53] The principle can be said to be one of general

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47 As above, [338].
48 As above, [333] to [338].
49 As above, [888] to [898].
50 As above, [1962] to [1979].
51 As above, [1403] to [1406].
52 As above, [1715].
53 As above [1878] to [1884].

application within the modern award system unless there is some cogent industry or sector specific reason for it not to be applied here. The reliance by the Commission on consideration 134(1) (g) of the modern award objective as justification for its adoption is significant.

163. Accordingly, the preferred position in relation to the treatment of the casual loading is that it should be disaggregated from penalties and loadings generally. This is not the case in the Award and United Voice urges the Commission to ensure that the Award is consistent with current preferred practice in relation to the treatment of the casual loading.

S57 –Variation to Public Holiday clause

164. Section 114 of the *Fair Work Act 2009* ('the Act') provides that an employee is entitled to be absent from their employment on a public holiday.

165. Section 116 of the Act states that an employee absent from their employment on a public holiday must be paid their base rate of pay for the employee's ordinary hours of work.

166. There are some employers who are altering the rosters of part-time employees to avoid the payment of public holiday rates.

167. Clause 34.2 of the Award should be amended with the addition of clause 34.2(c) as follows:

34.2(c) Rosters must not be altered for the purpose of avoiding public holiday entitlements under this Award and the NES.

168. This amendment will assist in ensuring that employees do not have their rosters altered by the employer to avoid the payment of public holiday entitlements.

169. This variation is in line with the modern awards objective, primarily in ensuring that the Award is '*fair and relevant*' and provides that part-time employees do not receive less pay than they are entitled to.

United Voice

4 February 2019

IN THE FAIR WORK COMMISSION

Matter No: 2018/26

Section 156 - Four Yearly Review of Modern Awards – *Social, Community, Home Care and Disability Services Industry Award 2010*

SUPPLEMENTARY SUBMISSION OF UNITED VOICE

1. This submission supplements our submission filed on 15 February 2019 ('*the submission'*) in the review of the *Social, Community, Home Care and Disability Services Industry Award 2010* ('*the SCHDS Award'*). In the submission, we reserved our right to pursue withdrawn claims if the document referred to as '*the Joint Report'* was not endorsed by the Commission.
2. It is apparent that the Joint Report no longer has the support of significant interested parties and as such we intend to pursue our claim for travel time, which is identified as *Item 2 – Travel time* in the revised summary of proposed substantive variations republished on 22 November 2017.
3. We file the following statements in support of our claim:
    - Supplementary statement of Deon Fleming dated 28 March 2019.
    - Supplementary statement of Trish Stewart dated 1 April 2019 (collectively including earlier statement evidence filed: 'the evidence').
4. It is apparent from the evidence of our witnesses that the non-payment of travel time is a significant issue for employees within the sector covered by the Award. Home care workers and some disability services workers spend the majority of their working time at the homes of different persons in need of care and assistance. These workers do not have a '*workplace*' in the traditional sense of an office or a depot in which they commence and finish duties. It is rare that these workers would work in their employer's head office for any length of time, although they may attend on occasion for induction, training and related purposes. Rather, these workers commonly travel from their own home to the home of their first client, and then to the next client, and so on throughout the working day. This time spent travelling between the homes of clients is essential to perform the duties of the job, and should be paid and considered as time worked.

5. Our witnesses Trish Stewart and Deon Fleming provide evidence that travel between client homes is an essential part of their jobs as home care workers.[1] Both travel by car between shifts, are required to have a driver's licence as a requirement of their role.[2]
6. Both witnesses were previously paid travel time when employed by Excelcare. However, once Excelcare was taken over by LiveBetter in around July 2017, they no longer received travel time.[3]
7. The non-payment of travel time is significant. Witness Trish Stewart states that she '*can spend up to 1-2 hours accumulatively during a working day travelling between appointments. This is time that I used to be paid for and now I miss out on that pay. It has been a significant paycut for me*.'[4] Witness Deon Fleming states '*I have lost roughly up to 4-5 hours of pay per week.*'[5]
8. Our claim for travel time is interrelated to our claim *S37 –Variation to Broken shifts clause*, which is intended to address the use of unlimited broken shifts within this sector. We refer to and rely upon paragraphs 111 to 141 of the submission.
9. The combination of the non-payment of travel time, the unrestricted use of broken shifts, and the lack of minimum engagement provisions do not provide a fair and relevant minimum safety net of terms and conditions. The current terms and conditions of the Award lend themselves to inappropriate and unsustainable work patterns. There is little or no incentive for employers in what is an increasingly competitive and diverse sector to structure work efficiently. The cost of poor rostering decisions and the taking on work which is geographically remote or at different times of the day are able to be shifted onto employees. This is inappropriate and inefficient.
10. We seek that the Award is varied in the terms of the attached draft determination.
11. This variation is in line with the modern awards objectives, specifically:
    - s 134(1)(a) – '*relative living standards and the needs of the low paid*' – The SCHDS Award cannot be said to be '*fair and relevant*' when low paid award reliant employees are not paid for time that they are required to travel in the course of their duties. Varying the SCHDS Award to clarify that travel time must be paid will address this and ensure that employees are paid for all time worked.
    - s 134(1)(c) – '*the need to promote social inclusion through increased workforce participation*' – Intermittent broken shifts, unpaid travel time and no minimum engagement have created a situation in which part time employees covered by the

[1] Supplementary Statement of Trish Stewart dated 1 April 2019, paragraph 4, supplementary statement of Deon Fleming dated 28 March 2019, paragraph 7.
[2] Supplementary Statement of Trish Stewart, paragraph 5, supplementary statement of Fleming, paragraph 8.
[3] Supplementary Statement of Trish Stewart, paragraph 6-7, supplementary statement of Fleming, paragraph 6.
[4] Supplementary Statement of Trish Stewart, paragraph 9.
[5] Supplementary statement of Deon Fleming, paragraph 6.

SCHDS Award are required to be available to work across long periods of the day to undertake paid work. Part time workers covered by the Award will have '*dead time*' during the day will precludes them from undertaking other work or participating in family or social activities. There are also negative impacts on the ability of employees to manage their caring responsibilities and outside of work commitments. The current terms and conditions of the Award promote social exclusion rather than social inclusion.

United Voice
1 April 2019

IN THE FAIR WORK COMMISSION

Matter No: 2018/26

Section 156 - Four Yearly Review of Modern Awards – *Social, Community, Home Care and Disability Services Industry Award 2010* – Substantive review

SUBMISSION IN REPLY OF UNITED VOICE

1. This submission is made in accordance with the amended directions of the Fair Work Commission ('the Commission') dated 11 July 2019, and is made in reply to the claims made by Australian Business Industrial ('ABI'), the NSW Business Chamber, Aged & Community Services Australia and Leading Age Services Australia to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* ('the Award') as set out in their draft determination filed on 2 April 2019. ABI, the NSW Business Chamber, Aged & Community Services Australia and Leading Age Services Australia will be collectively referred to as the '*ABI and others*' within this submission.

Ordinary hours of work claim

2. ABI and others seek to vary clause 25.1 to amend the manner in which ordinary hours can be worked. In their submission, dated 2 July 2019, ABI and others claim this is a minor technical change rather than a substantive one.[1] We oppose this variation as it will have a substantive detrimental effect on employees covered by the Award.
3. The Award currently permits ordinary hours to be worked in one of three distinct ways:
   (i) in a week of five days in shifts not exceeding eight hours each;
   (ii) in a fortnight of 76 hours in 10 shifts not exceeding eight hours each; or
   (iii) in a four week period of 152 hours to be worked as 19 shifts of eight hours each, subject to practicality.
4. The variation sought by ABI and others removes these restrictions and provides employers with greater discretion to allocate ordinary hours provided there is an average of 38 hours ordinary hours across a 4 week period.
5. This will be detrimental for full time employees covered by this Award, especially if the averaging facility is used. Under the current Award, an employer may only roster an employee across a 4 week period where the employee receives a rostered day off ('RDO') as the '*benefit*' for having a 4 week roster. If the variation sought by the employer parties was

[1] Submission of ABI and others dated 2 July 2019, paragraph 4.9.

made, employees could be required to have hours averaged over 4 weeks without receiving a RDO.

6. National Disability Services ('NDS') submit that the current Award clause prevents other arrangements from being mutually agreed.[2] The Award already permits an employer and an employee to mutually agree to specific arrangements for when work is performed under clause 7.1(a) which deals with individual flexibility agreements. Such agreements can only be made on the basis that agreement results in the employee being better off overall at the time the agreement is made than if the agreement had not been made.[3]
7. No evidence has been filed by ABI and others in support of this variation. There is no evidence that the current clause is ineffective or unworkable.
8. The variation sought is unnecessary, contrary to the modern awards objective and should be rejected.

'*Period of work'*

9. Clause 25.4(a) specifies that an employee must be provided with a break of not less than 10 hours between the end of one shift or period of work and the start of another. ABI and others seek to vary clause 25.4(a) to delete the words '*period of work*'. We oppose this variation.
10. ABI and others claim that this is a minor technical change, and will not have any substantive effect.[4] United Voice has concerns that deleting the words '*period of work*' may have unintended consequences.
11. The term '*period of work*' has relevance within this Award, as there are several circumstances in which an employee may be engaged in a '*period of work*' that may not be recognised as part of a shift. These periods of work are:
    (a) team meeting;
    (b) 24 hour care engagements; and
    (c) excursions.
12. For example, clause 25.8 which deals with 24 hour care requires an employee to be at a client's home for a 24 hour period, but states that the employee is required to provide a total of no more than 8 hours of care during this period. United Voice has previously made submissions as to why the whole period is properly considered work, and why this clause should be deleted, but as it currently stands, there is a possibility that some part of the shift may not be considered '*work*'. The removal of the term '*period of work*' from clause 25.4(a) could result in some employees under the Award not receiving sufficient breaks in between such shifts.

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2 NDS Submission dated 2 July 2019, paragraph 6.
3 Clause 7.5.
4 Submission of ABI and others dated 2 July 2019, paragraph 4.10.

Change of roster

13. Clause 25.5(d)(i) of the Award requires an employer to give seven days' notice of a roster change, however subclause (ii) provides that the roster may be altered at any time to enable the service of the organisation to be carried on where another employee is absent from duty on account of illness, or in an emergency. ABI and others seek to vary clause 25.5(d)(ii) to extend the circumstances in which an exception to the 7 days' notice of roster applies, to include when another employee is absent due to '*compassionate leave, community service leave, ceremonial leave, leave to deal with family and domestic violence.'*
14. United Voice opposes this variation.
15. The current exception in the Award is limited, and only applies where another employee is absent due to '*illness, or in an emergency'*. Despite this limitation, employees covered by the Award experience a high level of change in their rosters without the payment of any overtime
16. United Voice witness Ms Belinda Sinclair, a home care worker with Wesley Mission states: '*My employer is constantly making changes to my roster and these changes make it difficult for me to plan things for when I am not rostered or to make a weekly budget, despite that I am a permanent employee, not a casual*.'[5] Similarly, witness Trish Stewart states: '*At least once per week, my roster will be altered as a result of either another support worker who has called in sick or a client cancelling their appointment. If a client cancels their appointment before 5pm the day before their scheduled appointment then I do not get paid for the shift. If they cancel after 5pm the day before, then I will get paid. This means that I can never be certain of the amount of hours I am going to receive and how much I will be paid each week.'*[6]
17. Increasing the circumstances in which rosters can be changed without notice will increase the level of uncertainty and unpredictability for employees in this sector.
18. There is no evidence that this change is necessary. Clause 25.5(d)(ii) is not the only exception to the requirement that seven days' notice of a change of roster be given. Subclause (iii) also provides that the seven days' notice does not apply '*where the only change to the roster of a part-time employee is the mutually agreed addition of extra hours to be worked such that the part-time employee still has four rostered days off in that fortnight or eight rostered days off in a 28 day roster cycle, as the case may be*.'
19. There is evidence that indicates that there is a high level of under-employment in this sector, and that employees willingly agree to work additional hours. Ms Sinclair gives evidence that: '*I agree to changes in my roster because I need the hours and am concerned that if I*

5 Witness statement of Belinda Sinclair dated 16 January 2019, paragraph 25.
6 Witness statement of Trish Stewart dated 17 January 2019, paragraph 10.

complain or don't accept additional hours, I will be rostered less. This is not an accusation against my employer but my concern. I have a tight budget and cannot afford to lose hours.'[7]

20. Ms Stewart states: '*Most weeks I would like to pick up more hours because I do not receive enough hours to cover my weekly expenses. My managers normally ask me to cover a shift at short notice if a colleague has taken sick leave. I will normally accept these hours if I am available because I need to accept all of the hours I am offered to make enough money.'*[8]
21. In a similar manner, Ms Deon Fleming states: *'At least once per fortnight my manager will ask me if I can take on extra work because a colleague has called in sick. If I am available, I will take these extra shifts because I want to work more hours.'* [9]
22. Research also supports the existence of underemployment within the sectors covered by this Award. The NDS State of the Disability Sector Report 2017 stated that '*Underemployment in health care and social assistance is among the highest of any industry at nearly 11 per cent. Average hours worked for disability support workers is 21 hours per week and 24 hours per week for allied health professionals*.'[10]
23. The Joint Standing Committee on the National Disability Insurance Scheme Report on '*Market readiness for provision of services under the NDIS'* released in September 2018 expressed concerns about the lack of incentives to choose a career in the disability support sector, finding:

> '*Submitters who have worked for a very long time in the sector described how working conditions have dramatically deteriorated under the NDIS. In short, they reported a rise in underemployment and insecure work arrangements, inadequate wages and no prospect of professional development opportunities. Under these conditions, it is hard to imagine how to retain highly experienced and qualified workers and attract new workers, including young people entering the workforce*.'[11]

24. With respect to home care, the Department of Health Aged Care Workforce, 2016 report found that 40% of home care and home support workers were seeking more hours.[12]
25. Similarly, the Future of Employment and Skills research centre report titled 'Attraction, Retention and Utilisation of the Aged Care Workforce' released in April 2018 identified that

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7 Witness statement of Belinda Sinclair, paragraph 26.

8 Witness statement of Trish Stewart, paragraph 11.

9 Witness statement of Deon Fleming, dated 16 January 2019, paragraph 17.

10 National Disability Services, 'State of the disability sector report 2017', December 2017, p. 49 available at https://www.nds.org.au/pdf-file/db83601f-42d6-e711-91e7-0050568e2189

11 Joint Standing Committee on the National Disability Insurance Scheme, 'Market readiness for provision of services under the NDIS', September 2018, paragraph 3.96 available at https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/MarketReadiness/~/media/Committees/ndis_ctte/MarketReadiness/report.pdf

12 Department of Health, 'The Aged Care Workforce 2016 report', released March 2017, page 86, available at https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Workforce/The-Aged-Care-Workforce-2016.pdf

whilst low pay was the dominant concern for workers, in addition: '*concerns were raised regarding irregular and split shift patterns, insufficient and variable working hours, and casual employment contracts*.'[13]

26. Given the high levels of underemployment, and the evidence that employees are regularly agreeing to additional shifts, there is no justification for further exceptions to the requirement to provide 7 days' notice of a roster change.
27. The following modern awards objectives are relevant:
    - s134(1)(a) *relative living standards and the needs of the low paid* – a significant number of employees covered under this Award are low paid. The proposed variation would increase the insecurity of working hours, with a corresponding increase in stress and uncertainty for employees. This would be detrimental to the living standards of the low paid employees covered by this Award.
    - s134(1)(da)(ii) *the need to provide additional remuneration for employees working unsocial, irregular or unpredictable hours* – Enabling a roster to be altered at any time in certain circumstances results in employees working unpredictable hours. The current clause 25.5(d)(ii) already permits an employer to vary the roster at any time in certain circumstances without any corresponding penalty or benefit. Expanding the circumstances in which the roster can be varied at any time will increase the incidence of employees under this Award working unpredictable hours without any additional remuneration.
28. The variation sought by ABI and others should be rejected.

Client cancellation

29. Clause 25.5(f) of the Award currently only applies to home care workers. The clause permits an employer to withhold payment of rostered work for an employee where the client cancels or changes the rostered shift, and the employee is provided with notice or a change in roster occurs, by 5pm the day prior. As an alternative to withholding payment, the employer may direct the employee to make-up time equivalent to the cancelled time, in the current roster or the subsequent fortnightly period.
30. ABI and others seek to extend the client cancellation clause to disability support workers. ABI and others also seek to amend the client cancellation clause to delete the provision enabling an employer to withhold payment, but enable make up time to be worked within 3 months

[13] Future of Employment and Skills research centre, 'Attraction, Retention and Utilisation of the Aged Care Workforce', April 2018, page 15 available at https://agedcare.health.gov.au/sites/default/files/documents/09_2018/retention_and_utilisation_of_the_aged_care_workforce_uni.of_adelaide_-_20.4.18.pdf

rather than within the next fortnightly period. Unlike the current clause, the proposed variation does not require that the employee is notified by any particular time.

Home care workers

31. For home care workers, the current client cancellation clause creates instability and uncertainty. Employees can lose a shift provided they are notified by 5pm the day before. The weekly income of the employee can be quite different to what was expected, and this creates difficulties in planning and managing income.
32. All three United Voice member witnesses identify that the uncertainty caused by client cancellation has a significant impact on their weekly income.[14] Ms Fleming's evidence is indicative:

> '*If clients cancel on the same day of their appointment, then I am paid for the shift. But if a client cancels a home care visit before 5pm the day before the scheduled appointment, then I am not paid for that appointment and these are hours I miss out on. At least once per week, I will have a client cancel their appointment with the required notice. This creates a lot of uncertainty for me in being able to anticipate how much I will get paid in the week*.' [15]

33. The current client cancellation clause unjustly shifts the burden of client cancellation from the provider to the employee. This cost properly should be principally borne by the employer rather than their low paid employees. Providers have greater capacity to absorb the risks and costs of variable client demand and mitigate those risks and costs. The employer as the provider of the service has some control over the terms and conditions of service provision and the organisation of the work. It is dysfunctional to perpetuate a term within a modern award that in effect shifts the cost of events that can be in part characterised as the product of poor management onto low income employees.
34. Our primary position is that there should be no client cancellation clause in the Award.
35. If there is to be a client cancellation clause for home care workers in the Award, ABI and others' proposal to extend the period in which make-up time may be worked to three months could create logistical difficulties. Given that roster variation occurs with some frequency in the home care sector, it may be difficult for employees to keep track of make-up hours over three monthly periods and to identify if they have been correctly paid.
36. ABI and others' proposed clause also does not provide a '*cut off*' time at which the employee must be notified. Home care is generally provided under the terms of a Home Care Agreement, with the terms of service set out and negotiated between the home care provider

[14] See witness statement of Trish Stewart, paragraph 10, witness statement of Belinda Sinclair, paragraph 25 and witness statement of Deon Fleming, paragraph 16.
[15] Witness statement of Deon Fleming, paragraph 16.

and the consumer. In general, a consumer must provide a set amount of notice of a cancelled service in accordance with the terms of their Home Care Agreement; otherwise they must pay a cancellation fee. Any client cancellation clause should retain a cut-off point by which the employee must be notified. Without a time frame for cancellations, an employee's shift could be '*cancelled'* as he or she completes travel at their own expense to the client's home and is just about to knock on the client's door.

37. The proposed clause does have a beneficial effect in that it would provide employees with a more stable and secure income as the employer would either have to pay the employee for the shift or may '*deploy*' the employee to another shift rather than withhold payment altogether. In this respect, this clause is an improvement on the current client cancellation clause.
38. United Voice supports the variation ABI and others seek in respect of home care workers *provided* that:
    - There is a set time by which the employee must be notified of the cancelled shift. If the employee is notified by that timeframe, then the employer could require the employee to work make up time. If the employee is not notified by that timeframe, then the employee should be paid for the shift as rostered (and cannot be required to work make up time). The current standard of 5pm the day prior should be the starting point.
    - Clause 25.5(f)(v) is amended to reference clause 25.5(f)(iv)(A) instead of (B). It is unclear if this is a drafting error. As currently drafted clause 25.5(f)(v) states that the make-up time arrangement *cannot* be utilised where the employee is notified of a cancelled shift after arriving at the relevant place of work to perform the shift, and states that clause 25.5(f)(iv)(B) applies instead, which itself refers back to the make-up time arrangement.
    - There is greater clarity around when the '*make-up time'* must be paid. Where an employee is required to work make-up time, they should be paid for as if the shift was not cancelled. We would support a form of words as follows:

      (vii) Where 25.5(f)(iv)(B) applies the employee will receive payment for the cancelled service as if they had worked it (including any applicable penalties or loadings).

      (viii) Where the applicable rate of pay for working the make-up time is higher than the rate of pay the employee received for the cancelled service under 25.5(f)(vii) the employee will be paid the difference between the two rates of pay.
    - The time within which make-up may be worked should not be three months. Three months is an excessive length of time. The three month time frame will allow larger balances of make-up time to accrue and also greater deficits in remuneration for work

performed when make-up time is worked. The current Award clause requires that make-up time must be worked in '*that, or the subsequent fortnightly period*'. We propose that the time in which make up can be worked is extended to only the next *two* fortnightly periods *i.e*. a month. This extension should enable employers to find an appropriate make-up shift for the employee, whilst not being so long to lose the nexus between the paid shift and the make-up time shift.

- Under the current award provision concerning make-up time, it is likely that if the employer does not direct the employee to work any balance within the fortnight, the right of the employer to direct the employee to perform work as make up time lapses. A clear provisions that this is in fact the case, is necessary and particularly if the Commission is considering longer durations for the accumulation of make-up time.

39. United Voice would not support extending the period in which make up time can be worked where the employer retains the ability to withhold payment of wages to an employee when a client cancels. Such a clause would extend the detriment suffered by employees under the current client cancellation clause without any corresponding benefit. In this respect, it is notable that whilst a significant number of employees covered under this Award are low paid, home care workers have the lowest rates of pay under this Award, and s134(1)(a) '*the relative living standards and the needs of the low paid*' is a relevant consideration. The current combination of low pay and insecure working conditions creates significant uncertainty for low paid employees in home care. Extending the period for client cancellation make up time, without any benefit, would increase the level of insecurity experienced by such employees.

Disability support workers

40. United Voice does not support extending the client cancellation clause to disability support workers. Extending this to disability support workers will create greater instability for the disability workforce. As referred to above, there is already increasing levels of '*insecure work arrangements'* in the disability sector[16], and award changes that increase further insecurity are not warranted.
41. There is no cogent reason to extend the client cancellation clause to disability sector workers. Disability sector work is now primarily funded via the National Disability Insurance Scheme (NDIS). The NDIS Price Guide sets out the amount that can be charged for a client cancellation, and the timeframe in which the cancellation must be made. Previous price guides contained restrictions on the amount of cancellations that could be claimed against a participant. The 2018-19 price guide (NSW/Vic/Qld/Tas) stated that if a participant made a short-notice cancellation (after 3pm the day before the service), then the provider could

[16] Joint Standing Committee on the National Disability Insurance Scheme, 'Market readiness for provision of services under the NDIS', paragraph 3.96.

charge up to 90% of the agreed price for the cancelled appointment.[17] The fee could be charged against the participant's plan up to 12 times per year for personal care and community access supports. For other cancellations, where the participant provided notice prior to 3pm the day before, providers were not able to charge a cancellation fee. The 2018-19 price guide for WA/SA/ACT/NT contained the same cancellation scheme.[18]

42. That cancellation scheme has been significantly altered in the 2019-20 Price Guide. Under the latest guide, where a provider has a short notice cancellation (or there is a '*no show'* on the part of the client) a provider is able to recover 90% of the fee, subject to the terms of the service agreement with the participant. There is no limit on the number of cancellations a provider can claim for.[19]
43. The definition of what is considered a short notice cancellation has also changed. Under the current NDIS Price Guide 2018-19, a short notice cancellation was defined as one that occurred after 3pm the day before the service.
44. Under the NDIS Price Guide 2019-20, a short notice cancellation is where the participant has given less than two clear business days' notice for a support where the support is for less than 8 hours duration and the cost of the service is less than $1000. Where the support is for a longer period or of a higher cost, a short notice cancellation is where the participant has given less than 5 clear business days' notice.
45. Under the NDIS Price Guide 2019-20 providers have greater ability to manage and claim for short notice cancellations than under previous guides.
46. Further, as is demonstrated by recent changes to the NDIS Price Guide, funding arrangements change and sometimes within short time frames.
47. The Commission should be principally guided by the extent to which any proposed variation is necessary to ensure a fair and relevant safety-net in accordance with the modern awards objectives and not by the funding scheme. Extending the client cancellation clause to disability support workers would not provide such workers with a '*fair and relevant*' safety net.
48. As stated above in paragraph [33], the client cancellation clause in home care unjustly shifts the burden of client cancellation from the provider to the employee. There is no reason to extend this unjust practice to disability support workers. Part time employment should be reasonably regular and consistent, and part time employees should be able to rely on a certain amount of hours of work, as agreed upon, and as notified on their roster. An Award clause

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[17] The NDIS 2018-19 price guide (NSW/Vic/Qld/Tas), page 18 available at https://www.ndis.gov.au/media/1154/download

[18] The NDIS 2018-19 price guide (WA/SA/ACT/NT), page 18, available at https://www.ndis.gov.au/media/1156/download

[19] The NDIS 2019-20 Price guide, pages 18-19, available at https://www.ndis.gov.au/media/1455/download

enabling an employer to withhold payment for a rostered shift with minimal (or no) notice undermines the security of part time employment, and should not properly be part of a '*fair and relevant*' minimum set of employment conditions. Even if, as per ABI and others' proposed determination, the employer could not withhold the payment but rather require the employee to '*make up*' the hours within a three month period, this would still have the effect of increasing employment insecurity for disability support workers, and such a clause should not be inserted to a modern award that must provide a fair and relevant minimum safety net of terms and conditions.

Remote response

49. ABI and others have filed a draft determination to insert a clause addressing remote response duties. We do not oppose the insertion of a remote response clause, however we do not support the terms as proposed by ABI and others.
50. The variation proposed by ABI and others does not adequately distinguish between remote response work performed whilst on call, and remote response work performed ad hoc, and only requires payment at the applicable rate of pay for remote response work performed.
51. A distinction between remote response duties performed whilst on call, and not, is necessary. When an employee is not on call, an employee should be able to expect that they are free to go about their life without any intrusion from the workplace. This is particularly so when employees are award-reliant. Any remote response duties that the employer requires the employee to perform when they are not on call should be costed at a higher rate. This would encourage an employer to roster effectively, and ensure that an appropriate employee is available '*on call*' to address issues that may arise. Placing a higher cost on remote response work performed by employees not on call also provides some compensation for the greater disutility associated with the work.
52. Remote response duties are performed outside of rostered hours, and should be paid at overtime rates. If remote response duties are not costed effectively, this could result in some employers requiring employees to work multiple instances of remote response across a long period of time, effectively disrupting any rest break the employee is entitled to between shifts.
53. ABI and others' proposed variation also explicitly excludes '*administrative duties*' from the ambit of remote response. We oppose this exclusion. If the employer directs or authorises an employee to perform administrative duties outside of ordinary hours, then there is no reason why such duties should not be paid for under this clause.
54. The variations ABI and others propose to the on call allowance (clause 20.9) and the recall to work overtime clause (clause 28.4) are consequential to the insertion of their remote response clause. If an appropriate remote response clause was to be inserted into the Award, that upheld a distinction between remote response duties performed whilst on call and not, and

provided for overtime rates for remote response work, we would not oppose the relevant consequential amendments.

United Voice
13 September 2019

IN THE FAIR WORK COMMISSION

Matter No: 2018/26

Section 156 - Four Yearly Review of Modern Awards – *Social, Community, Home Care and Disability Services Industry Award 2010*

SUBMISSION OF UNITED VOICE

1. This submission is made pursuant to the Directions of the Fair Work Commission ('the Commission') made on 1 May 2017 requiring any '*interested party*' to provide their comments in respect of several matters in the 4 yearly review of the *Social, Community, Home Care and Disability Services Industry Award* 2010 ('the Award').
2. United Voice makes this submission in respect of matter F. *'Part-time employment and casual employment Full Bench (AM2014/196 and AM2014/197)*'.
3. In the Directions, the Commission stated '*in the Part-time employment and casual employment decision the Full Bench described the operation of the NDIS at paragraphs [554] and [630] – [633]. Do the parties take issue with any of the observations made at those paragraphs? Is there any more up to date information?*'
4. The relevant paragraphs of the Part-time employment and casual employment decision[1] ('the Decision') are reproduced below:

> ***[554]*** *The NDIS, broadly speaking, funds persons with disability directly, rather than via disability services organisations, and thereby allows persons with disability and their carers to purchase the support services they need in accordance with individualised NDIS plans. This has meant that persons with disability are able to exercise a far greater level of choice and control over how, when, where and by whom their disability support services are delivered. ABI contends that the NDIS is radically changing the disability support services sector, in that employers have lost a large degree of control over when work is required to be performed, and accordingly require much greater flexibility in the allocation of working hours to part-time employees so that they can operate in a way which is responsive to client demand. Absent such flexibility, ABI contends that there is a substantial risk that the workforce in the sector, which will need to expand significantly in order to meet the demand for individualised services generated by the NDIS, will become casualised. The ABI claim was supported by Jobs Australia,*

[1] [2017] FWCFB 3541.

which is a national peak body of non-profit organisations that assist disadvantaged people into work.

5.14 Consideration – the ABI/NSWBC claim

Findings re the operation of the NDIS

[630] *We have earlier briefly described the concept of the NDIS. Participants in the scheme (and their carers) are required to prepare a NDIS plan in conjunction with the National Disability Insurance Agency (NDIA) which, in an itemised way, sets out their support needs and the way in which these support needs are to be met. Supports may be fixed – that is, regularly required at a fixed time each day or week – or be flexible, which means the participant has scope to rearrange the supports to suit themselves within the overall budget. In the early trial phase, these plans were prepared in a highly prescriptive format, but by the time of hearing they had become far less so. An example plan that was provided to us 466 set out the basic details of the participant and his/her immediate support persons and lifestyle, the participant's goals for the plan, and the supports to be provided. The supports were identified under the headings of transport to access daily activities; assistance with daily life at home and in the community, education and at work; supported independent living; improved daily skills; assistive technology; improved living arrangements; and improved life funding. Specific supports were identified in the example plan under each heading, and an annual budget (for the period 15 June 2016 to 14 June 2017) set out for each support item. For some items, a maximum number of hours of a particular service per week or per year were specified. The example plan required each identified support to be purchased as described, and prohibited swaps from one item to another. The items in the plans are budgeted for in accordance with a "NDIS Price Guide" issued by the NDIA. In pricing items, the NDIA has been aggressive in trying to set the absolute minimal cost so as to control the cost to government of the NDIS as a whole. Labour costs are calculated by reference to the SCHCDSI Award.*

[631] *Once the plan is prepared, the majority of participants who are self-managed (as distinct from having their plans managed by a support agency) may then "buy" the services budgeted for in the plan from providers which are registered with the NDIA (although the actual payment is made by the NDIA to the provider in accordance with the plan and the NDIS Price Guide). There is no obligation to obtain all the services in a plan from a single provider, so a participant may have*

multiple service providers. The participant, once he or she has chosen the provider of a specific service, will then enter into a service agreement with the provider. We were provided with an example of a service agreement [467], which included the following provisions of significance:

- *the provider was required to "Work with you the Participant to provide supports that suit your needs and at the times preferred by you" (underline added) and to "Consult with you regarding decisions about how your supports are provided";*
- *the participant was required to keep the provider "informed of any changes to my support need which may impact on the supports they provide";*
- *in relation to payment for the services provided, "The NDIA sets the prices to be claimed for each support item and [the provider] may choose to accept or decline the provision of certain support items if the price set does not cover business operating costs";*
- *in relation to variations to the participant's plan, "The Participant and/or their Plan nominee is responsible for informing [the provider] when their NDIA Plan has been reviewed and/or modified in any way ... [the provider] requires this information so your Service Agreement can be reviewed and modified to ensure it reflects the most current supports you require [the provider]to provide";*
- *the participant was requested to inform the provider at the time of developing or reviewing the Service Agreement if they intended using multiple service providers "to ensure that sufficient support hours and funds are available as per the Service Agreement" and "Failure to provide this information may result in over-use of certain supports and impact on [the provider's] ability to claim for supports provided";*
- *in relation to cancellations of supports by the participant, "We understand that situations may occur that mean participants need to change or cancel support. When this happens, it is appreciated if participants provide at least 24 hours notice to reduce any impact on business... Should the Participant not provide 48 hours notice of his or her inability to participate in the service, [the provider] will be entitled to claim from NDIA for payment of such Service... When cancellations or 'no shows' exceed 8 times per year, [the provider] must notify the NDIA so that consideration can be made to review the plan"; and*
- *in relation to termination of the service agreement by either party, a minimum of 4 weeks' notice was required, and "If the participant chooses to cease services or engages the services of another provider without giving the agreed notice, an early exit payment will be charged of up to 4 weeks"*

[632] *Until mid-2016, the NDIS was implemented in various trial areas throughout the country. The full implementation rollout began in July 2016, but it is not expected to be completed until 2019. It is expected that the total number of participants in the NDIS will increase to about 460,000 by 2019, about 20 times the number of participants in 2016. Many of the new participants will not be living in institutionalised care or group homes with regimented support demands, but will require supports that are shorter in duration and more flexible in order to undertake work, education and social activities. The number of registered providers is also expected to increase significantly. In 2016 there were over 2,000 registered providers, the large majority of which had not been disability support providers prior to the advent of the NDIS.*

[633] *At the time of hearing, according to data collected and benchmarked by NDS, there were about 26,000 disability support workers in Australia, of which 23% were full-time, 35% were part-time, 37% were casual, and 6% were on fixed-term contracts. This workforce is predominantly female. It was estimated in 2011 that the workforce would have to double by the time of full implementation of the NDIS. There was some evidence that some employers had increased the usage of casuals in order to meet the work demands of the NDIS, against their preference to employ mainly permanent part-time employees, mainly because of the variability associated with the one-on-one attendances which are a new industry feature introduced as part of the NDIS.*

5. United Voice takes issue with some of the observations made in paragraphs [554], [631] and [633] of the Decision.
6. In respect of paragraph [554] we make the following submissions.
7. The introduction of the NDIS has created a change in the sector with a greater focus on consumer directed care. We generally agree with the statement in [554] that '*the NDIS, broadly speaking, funds persons with disability directly, rather than via disability services organisations, and thereby allows persons with disability and their carers to purchase the support services they need in accordance with individualised NDIS plans. This has meant that persons with disability are able to exercise a far greater level of choice and control over how, when, where and by whom their disability support services are delivered*.'

8. However, we disagree with the next statement, insofar as it is taken as a general observation (as opposed to a statement of ABI's position): '*ABI contends that the NDIS is radically changing the disability support services sector, in that employers have lost a large degree of control over when work is required to be performed, and accordingly require much greater flexibility in the allocation of working hours to part-time employees so that they can operate in a way which is responsive to client demand. Absent such flexibility, ABI contends that there is a substantial risk that the workforce in the sector, which will need to expand significantly in order to meet the demand for individualised services generated by the NDIS, will become casualised*.'
9. In the part-time and casual proceedings, ABI sought to vary the Award to create an exception to the requirement that on commencement, an employer and a part-time employee will agree in writing on a regular pattern of work including the number of hours to be worked each week, the days of the week the employee would work, and the starting and finishing times each day (clause 10.3(c)). The exception sought by ABI was that '*if the employee is engaged to provide supports to clients in circumstances where the client has discretion to vary when the support is provided*' the employer and employee would agree in writing only on the number of hours to be worked each week (or the average number of hours) and the days and/or times of the week that the employee was not available to work.[2]
10. Such a variation would have increased unpredictability and instability for employees covered by the Award. The variation that was sought by ABI, and the argument made in favour of it, was based on the premise of shifting the risk onto the employee rather than the employer. We say this is an inappropriate and unfair way to manage risk.
11. The NDIS has changed the disability support services sector; however employers still control when work is required to be performed. A service provider determines which type of services it will provide and when those services will be provided. People with a disability who are participants in the NDIS will determine which service provider best suits their needs.
12. The NDIS represents a move from a block-funded welfare model of support to a fee-for-service market-based approach.[3] This necessitates that services will compete in the market place for consumers. There is an inherent level of risk when competing in such a market.

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[2] See paragraph [558] of the Decision.

[3] Productivity Commission Study Report, *National Disability Insurance Scheme (NDIS) Costs*, October 2017, page 8, available at https://www.fwc.gov.au/documents/sites/awardsmodernfouryr/13f-am201826-productivitycommission-ndis-costs-hsu-150219.pdf

13. Providers have a choice when faced with increased demand for flexibility in service provision; absorb the risks and potential costs as organisational costs, or pass them on to the workforce in the form of reduced security and consistency in shifts and hours worked, with flow on effects including reduced pay. It is not inevitable that increased flexibility for NDIS participants must be borne as a cost by individual workers. The allocation of risk occasioned by the funding model is properly a choice which resides with employers. As the choice is one of employers, the attendant risk should be managed and if necessary absorbed by employers.
14. The industrial arrangements for the sector should not assist or facilitate employers passing on these risks to employees by a reduction in their terms and conditions.
15. The Award covers a service based sector[4] with clearly identified issues associated with skills shortages and retention.[5]The sector is also predominately funded by the Commonwealth Government applying uniform criteria albeit with greater autonomy given to the recipient of services about the provider accessed. Community and personal care workers comprise more award reliant employees that most other industries.[6] These workers are not in a position to absorb risks irrespective of the question of the appropriateness of attributing risk to them.
16. Reasonable core minimum employment standards provide a critical mechanism that informs providers' decision making. Employment standards are one of the mechanisms available to governments to demonstrate '*stewardship'* to mitigate risk and regulate the sector.[7] The marketization of employment terms and conditions which is implicit in the flexibility sought by the ABL is not inevitable and will in the long term be destructive of high quality and sustainable service provision.
17. David and West[8] note:

> *Given the established relationship between quality support workers and quality services, it is important that mechanisms which promote and protect quality are not simply left to the private interaction between service user and support worker in a market context.*

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[4] See the definition of '*social and community services sector'* at clause 3.1 of the Award.

[5] National Disability Insurance Agency, *Integrated Market, Sector and Workforce Strategy*, (2015), Canberra, NDIA, at page 9.

[6] Research Report 1/2017, Jimenez and Rosenbes, *Award-reliant workers in the household income distribution*, February 2017, FWC, at page 16, the authors note '*the most common occupation for award-reliant employees are Community and personal service workers, labours and Sales workers*.'

[7] David and West, *NDIS Self-Management Approaches: Opportunities for choice and control or an Uber-style wild west?* Australian Journal of Social Issues, 2017, **52**, 331 at 342.

[8] As above.

The maintenance of a fair and relevant minimum safety net of terms and conditions for the employees engaged in the sector is a critical mechanism available to promote and protect quality.

18. Further, providers have more capacity to absorb the risks and costs of higher flexibility than low-paid workers. Providers are better positioned to mitigate those risks and costs, given that they have control of rostering and work organisation. The allocation of these risks as the principal responsibility of providers also places the risk where it is likely to provide the greatest overall utilitarian benefit.
19. Given that many NDIS workers already undertake unpaid work due to unpaid travel time and a desire to provide quality care, further shifting the burden of absorbing client flexibility onto workers will likely serve to increase workforce turnover and intention to leave.[9]
20. Further, there is already significant flexibility in respect of the rostering of part time employees under the Award. Part time employees have no minimum engagement period, and can work up to 10 hours a day or 38 hours a week or 76 hours per fortnight without payment of an overtime rates (clause 28.1(b) (iii)). Further, there are already mechanisms in the Award providing flexibility for employers in the circumstances of client cancellation (clause 25.5(f)).
21. In the part time and casual employment decision, the Commission found that the variation sought by ABI was not necessary, and the reasoning behind this decision, found in paragraphs [636] to [640], remains accurate today.
22. In respect of paragraph [631], it is important to note that the majority of participants in the NDIS are not self-managed. In June 2018, only 24% of participants were either partly or fully self-managed.[10]
23. In respect of paragraph [633], there has been some change in rates of permanent and casual employment in the sector. According to the National Disability Services (NDS) Australian Disability Workforce Report of July 2018, 48% of disability support workers were permanent (full-time or part-time) and 46% were casual.[11]
24. The NDS Workforce Report also stated that the trend towards casualisation was not universal across the sector, was more prevalent in small and medium organisations, and

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[9] See Macdonald, F., Bentham, E. & Malone, J. (2018), *Wage Theft, Underpayment and Unpaid Work in Marketised Social Care*, *The Economic and Labour Relations Review*, 29:1, 80-96.

[10] NDIS, *Annual report 2017-2018*, page 66, downloaded at: https://www.ndis.gov.au/media/431/download

[11] National Disability Services (NDS), *Australian Disability Workforce Report of July 2018*, downloaded at https://www.nds.org.au/pdf-file/cd6e735a-0e8f-e811-80c8-005056ac7853

was absent in large organisations.[12] This suggests that large organisations may better be able to manage the risks associated with increased market competition under the NDIS.

25. Most employers welcomed the marketisation of disability support services, which entails more competition between providers who need to offer high quality services. If providers are unable to compete in this market without eroding workers' pay and conditions through unreasonable demands for flexibility, they may need to revaluate their business models.
26. A secure and stable workforce is a precondition for the delivery of sustainable quality services and also the long term viability of providers. A fair and relevant minimum safety net of terms and conditions should not encourage providers to shift on to employees risks associated with increased demand for flexibility in service provision.

United Voice

17 May 2019

[12] NDS, *Australian Disability Workforce Report*, page 6.

IN THE FAIR WORK COMMISSION

Matter No: 2018/26

Section 156 - Four Yearly Review of Modern Awards – *Social, Community, Home Care and Disability Services Industry Award 2010* – Substantive review

OUTLINE OF FURTHER SUBMISSIONS IN REPLY OF UNITED VOICE

1. This submission is made in accordance with the amended directions of the Fair Work Commission ('the Commission') dated 13 September 2019, and is made in reply to the submissions made by Australian Business Industrial ('ABI'), the NSW Business Chamber, Aged & Community Services Australia and Leading Age Services Australia, AFEI, and Business SA in response to union claims to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* ('the Award'). ABI, the NSW Business Chamber, Aged & Community Services Australia and Leading Age Services Australia will be collectively referred to as '*ABI and others*' within this submission.
2. In this submission, we respond to key issues raised within the various employers' submissions. Otherwise we rely on our submission filed on 15 February 2019.

S2 - Travel time claim

Queensland proceedings

3. United Voice is assisting members employed as a home care workers, Margaret Blackhurst, Deon Fleming, Trish Stewart and Tanya McKenzie, in the Queensland Magistrates Court ('the Queensland proceedings') for unpaid work related to travel.[1] These proceedings were filed with the Court in June 2019 following an attempt to resolve the matter through an industrial dispute lodged with the Commission. The employer refused to consent to the arbitration of the dispute and this necessitated the commencement of the Queensland proceedings. The Queensland proceedings have not yet been determined and the employer is seeking a stay of the proceedings on the basis that this review of the Award is incomplete.[2]
4. The basis of our claim in the Queensland proceedings is that where an employer directs an employee to travel between different locations, then that time spent travelling is time worked and should be paid at the applicable rate of pay. This is especially the case with home care workers under the Award as their work is '*domestic assistance'* of clients in their residences

[1] Matter numbers MEC/2019/24, MEC/2019/27, MEC/2019/28 and MEC/2019/29.
[2] See witness statement of United Voice Industrial Officer Jared Marks signed 3 October 2019.

and this necessarily means travel to and between clients' residences. When a home care worker undertakes travel it is done at the direction of the employer and is part of the '*job'*. We regard this as the proper legal state of the employment relationship between an employer and an award reliant home care worker.

5. However, as is apparent many employers do not share this view. The Queensland proceedings clearly demonstrate this. United Voice is seeking to address this by prosecuting one employer in the Queensland Magistrates Court *and* by seeking a variation to the Award to clarify the position of home care workers and other employees under the Award directed by their employer to undertake travel as part of their duties. Our claim concerning travel time in this review is not a concession that travel time is not currently payable. The variation is necessary due to the apparent uncertainty concerning the Award travel time provisions. The Award should clearly identify that work related travel for home care workers is work.

Response to employer submissions

6. The employer submissions in reply to our travel time claim vary. ABI and others state in their submission, dated 13 September 2019, that to the extent the Commission finds the existing broken shifts clause does not meet the modern awards objective; then the appropriate manner in which to deal with the travel time issue is to introduce an allowance.[3] United Voice opposes travel time being compensated by way of an allowance.
7. When an employer directs an employee to undertake work at different locations, the employee is in service to the employer, and the time spent travelling between those locations is properly regarded as time *worked*. The proper approach for time worked is payment at the applicable rate of pay, in accordance with the employee's classification under the Award. An allowance should not be paid for what are hours of work. Allowances deal with some additional duty, out of pocket expense or disutility experienced in addition to the employee performing work. The Award currently contains an allowance for out of pocket travel expenses.[4] The current extraordinary practise of some employers in the sector is that the entire cost of travel is shifted on to low income home care workers. This includes travel which in a traditional employment law analysis would be considered part of work.
8. ABI and others argue that there are difficulties with considering travel time as time worked. Australian Industry Group (AiG) also raises similar issues in their submission, dated 16 September 2019.[5] This submission is inconsistent with the wide spread current and ostensibly successful recognition of travel time within other modern awards and other instruments. It is commonplace to treat travel time as time worked.

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3 Submission in reply of ABI and others re: travel time dated 13 September 2019, paragraph 9.2.

4 Clause 20.5.

5 Submission in reply of AiG re: travel time dated 16 September 2019, part 6.

9. The pre-award modernisation *Community Services (Home Care Service of New South Wales) Care Workers Award 2002* recognised travel time as '*work'* for all purposes. Clause 25.4 of this award noted:

> '*All travel time between clients during an engagement shall be regarded as time worked for all purposes of the award*.'

10. Numerous other modern awards recognise that travel time as time worked. **Attachment A – '*Table of travel time clauses'*** provides many examples of travel being treated as work. Annexure A is not a comprehensive list. Whilst the circumstances of work related travel under different modern awards vary, the various clauses demonstrate that it is practical to recognise travel time as time worked and is *prima facie* part of a fair and relevant safety-net of conditions
11. ABI and others have raised a concern about whether United Voice's travel time claim is intended to regard '*reasonable time of travel*' as '*time worked*' for all purposes.[6] The United Voice travel time draft determination states that such time will be treated as '*time worked*' and no exclusions are listed. Our proposed clause is intended to ensure that it is clear that travel time is time worked for *all* purposes including the calculation of ordinary time hours worked, the accumulation of leave and in respect of any work, health and safety obligations.
12. For clarity, we confirm that our travel time clause is intended to apply to social and community services employees when undertaking disability services work and home care employees.
13. NDS in their submission, dated 16 September 2019, state that a minimum engagement period or a travel allowance could compensate for travel in between breaks.[7] Minimum engagement periods are important in providing employees with fair periods of work, and United Voice supports the HSU claim for minimum engagement periods. However, minimum engagement periods cannot solely resolve the issue of unpaid travel time. United Voice opposes an allowance to compensate for travel time for the reasons discussed above in response to the submissions of ABI and others.
14. AFEI argue in their submission, dated 17 September 2019, that if the travel time claim was accepted, the proposed variation would mean that service providers would be delivering less direct care services for the same number of employee hours.[8] We would note that some employers do already pay for travel time, and where it is not paid, the employee is effectively subsidising the cost of service provision. It is not in any way '*fair*' for an employee, particularly a low paid employee, to subsidise the cost of service provision.

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6 Submission in reply of ABI and others re: travel time, paragraph 8.32.

7 Submission in reply of NDS dated 16 September 2019 re: travel time, paragraphs 39-40.

8 Submission in reply of AFEI re: travel time dated 17 September 2019, paragraph 16.

15. The AiG raises the issue of funding and the payment of travel time.[9] As indicated in the AiG's own submission, a NDIS service provider does have the capacity to claim for travel time (within certain time limits) as part of revenue received.[10] In the home care sector, providers and the client must enter into a Home Care Agreement prior to service provision.[11] The Home Care Agreement is a legal agreement that sets out how services will be provided, who will provide the service, the cost of the service and what comprises the cost of the service. Service providers can and it is intended that they should negotiate appropriate terms and conditions within Home Care Agreement to '*price in*' travel as part of the work for the service that will be provided.

16. In the Decision[12] on the Tranche 1 issues within the Award, the Commission stated that:

> *'[137] In the context of the provision of social services where employers are largely dependent on government funding, or, in the case of the NDIS, a fixed price, we are cognisant of the fact that significant unfunded employment cost increases may result in a reduction in services to vulnerable members of the community – a point made by the NDS. But such outcomes are a consequence of current funding arrangements, which are a matter for Government. Further, as we have mentioned earlier (at [75] above) the evidence as to the impact of the recent budgetary increase to the NDIS is somewhat unsatisfactory. Nor was there much consideration given to the extent to which the impact of an increase in casual overtime work and work on weekends and public holidays may be ameliorated by the utilisation of part time and full time employees.*
>
> *[138] The Commission's statutory function is to ensure that modern awards, together with the NES, provide a fair and relevant minimum safety net. It is not the Commission's function to make any determination as to the adequacy (or otherwise) of the funding models operating in the sectors covered by the SCHADS Award. The level of funding provided and any consequent impact on service delivery is a product of the political process; not the arbitral task upon which we are engaged.*
>
> *[139] We recognise that it may take time for a funding arrangement to adapt to a change in circumstances, such as an increase in employment costs occasioned by a variation to the award safety net. Such matters can be addressed by appropriate transitional arrangements.'*

17. We trust a similar approach will be adopted in respect of the Tranche 2 matters and agree with the Commission's insightful analysis. The main issue is whether this Award provides a '*fair and relevant*' minimum safety net of terms and conditions. It is '*fair and relevant*' for a modern award covering a significant number of low paid employees in an industry in which travel between clients is a core part of the role, to clearly ensure that employees are paid for time spent travelling between those locations as time worked.

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9 Submission in reply of AiG re: travel time, part 5.

10 Submission in reply of AiG re: travel time, paragraph 46.

11 https://www.myagedcare.gov.au/agreeing-home-care-package

12 [2019] FWCFB 6067.

18. As the funding model assumes that travel time will be incorporated into the cost of the service when agreements are negotiated between clients and providers, there is clear scope for the current funding arrangements to accommodate work travel. If service providers underestimate or fail to account for travel when negotiating client service agreements this is not a cost that should then be borne by the employee. Alternatively, if providers are pricing travel within its provision of services to clients and being paid for travel undertaken by its employees but not paying the employee for travel this is entirely inappropriate.
19. The absence of clear provisions within the Award concerning travel time allows for such possibilities and the evidence indicates that very clear *'sign posts'* are necessary concerning the obligation of employers to treat employer directed travel as work.

S37 - Broken shifts claim

20. United Voice has a claim in these proceedings to limit the number of breaks between broken shifts to one (*i.e.* a maximum of two portions within any broken shift). ABI and others in their submission dated 12 July 2019 have indicated that they would not oppose a variation to the Award that would permit a broken shift of more than two portions of work to be worked only by agreement with an individual employee.[13]
21. Such a variation would not genuinely address the disadvantage caused under the broken shifts clause in respect of this Award. As indicated in the evidence, there is a high level of under-employment in this sector, and employees who are in need of work are likely to agree to lower conditions in order to obtain that work. The evidence of United Voice witness, Ms Stewart, demonstrates the effect of underemployment: '*My managers normally ask me to cover a shift at short notice if a colleague has taken sick leave. I will normally accept these hours if I am available because I need to accept all of the hours I am offered to make enough money*.'[14]
22. An appropriate variation to the broken shifts clause should operate in a manner that facilitates effective rostering by employers so that work can be performed in two portions of a broken shift (if not in one continuous shift). The evidence filed by the employer parties generally indicates that there are typically '*peak*' demand periods that occur during the morning, afternoon and/or evening.[15] Given this, an employer should have the capacity to roster in a manner that limits the broken shift portions worked by employee to no more than two.

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[13] Submission in reply of ABI and others re: outstanding union claims dated 12 July 2019, paragraph 7.27.

[14] Witness statement of Trish Stewart dated 17 January 2019, paragraph 11. See also witness statement of Deon Fleming dated 16 January 2019, paragraph 17 and witness statement of Belinda Sinclair dated 16 January, paragraph 26.

[15] Witness statement of Therese Adami dated 12 July 2019, paragraph 42, witness statement of Jeffrey Wright dated 12 July 2019, paragraph 41, witness statement of Wendy Mason, dated July 2019, paragraph 66.

23. As noted by ABI and others, we do acknowledge the connection between broken shifts, travel time and minimum engagements; however we do not accept that the issues can be addressed by the '*modest*' adjustments that ABI and others have proposed.[16] There is a pressing need for significant reform of the broken shifts, travel time and minimum engagement provisions to ensure this Award provides a '*fair and relevant*' safety net of terms and conditions.
24. NDS submits that the concentration of supports around a few hours at each end of the day means broken shift arrangements are often the only way to offer some workers enough hours for a living wage.[17] In contrast, we would submit that if there were minimum engagements for each portion of a broken shift, and a limit on the number of breaks within a broken shift, then the Award would facilitate the provision of decent hours of work for employees in this sector. For example, under such provisions, an employee could be rostered to work 6am to 9am in the morning, have one break and then be rostered to work 12pm to 3pm. This would provide the employee with 6 hours of paid work during the day, and would reduce periods of (potentially) unpaid travel time in between portions of broken shifts. It would also reduce periods in which the employee was '*waiting around*' in between shifts.
25. Such a rostering method is patently '*fairer*' than what occurs under the current Award, as evidenced by Ms Stewart:

    '*A typical day for me can consist of my shift being broken up in the following manner (the start and end times for each appointment can vary by about 30 minutes day to day):*

    a. *6am – 90 minute appointment*
    b. *7.50am – 10 minute medication check phone call (which I usually make from my home)*
    c. *8am – 45 minute appointment*
    d. *9.30am – 60 minute appointment*
    e. *12 pm - 10 minute medication check phone call*
    f. *Break at 12.10pm until around 4 pm*
    g. *4pm – 30 minute appointment*
    h. *6pm – 10 minute medication check phone call (which I usually make from my home).*'[18]

26. AiG in their submission dated 15 July 2019 states that '*the case advanced by the unions assumes that employers are implementing broken shift arrangements in a deliberate and*

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16 Submission in reply of ABI and others re: outstanding union claims, paragraph 7.23.
17 Submission in reply of NDS re: outstanding union claims filed 16 July 2019, paragraph 35.
18 Witness statement of Trish Stewart signed 17 January 2019, paragraph 15.

improper attempt to reduce their costs. Moreover, it rests on the startingly simplistic and erroneous assumption that employers in this sector will have the capacity to, and will as a matter of fact, offer hours of work on a continuous basis if access to broken shifts is limited and that they will respond to the proposed changes by restructuring the engagement of their employees in such a manner.'[19]

27. It is not simplistic or erroneous to acknowledge that service providers have choices and the capacity to decide how to absorb the risks and potential costs associated with funding models. This was addressed in paragraphs [13] to [19] of our submission dated 17 May 2019. A feature of a fair and relevant safety-net is that it informs good choices both from the perspective of the employer and the employee.
28. In response to the United Voice claim that the shift allowances be determined by either the starting time or the finishing time of the broken shift, whichever is greater, ABI and others have indicated that they do not oppose this variation.[20] NDS has also indicated that they do no oppose this variation.[21]
29. AiG opposes this claim and states that the most obvious difficult with the claim is that the Award definitions for night shift and afternoon shift only relate to finishing times.[22] This is incorrect. The definition for night shift in clause 29.2(b) of the Award states: '*night shift means any shift which finishes after 12 midnight* ***or commences before 6.00 am*** *Monday to Friday*.'
30. AiG also states that the United Voice claim would operate unfairly to the employer.[23] Under the current award, an employee who works a continuous shift that attracts a shift penalty is entitled to be paid the shift loading for the whole of their shift. An employee working a broken shift who would be entitled to a shift penalty at the start of their shift, but not the end, would not currently be entitled to a shift penalty. The current operation of the clause is unfair to the *employee* working a broken shift. AiG have not properly articulated any unfairness is to the employer in this claim.

S3A -Variation to Rosters clause

31. In response to our claim to vary clause 25.5 to ensure that overtime is paid where a roster variation occurs (outside the listed exceptions in clause 25.5(d)(ii) and (iii)), ABI and others have submitted that there are already limitations on roster variations in clause 8A and clause 10.3(c).[24] The limitation in clause 8A only applies in specific circumstances: '*8A.1 Clause 8A*

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19 Submission in reply of AiG re: outstanding union claims filed 15 July 2019, paragraph 268.
20 Submission in reply of ABI and others re: outstanding union claims) paragraph 7.32.
21 Submission in reply of NDS re: outstanding union claims, paragraph 38.
22 Submission in reply of AiG re: outstanding union claims, paragraph 283.
23 Submission in reply of AiG re: outstanding union claims, paragraph 284.
24 Submission in reply of ABI and others re: outstanding union claims, paragraph 14.10.

applies if an employer proposes to change the regular roster or ordinary hours of work of an employee, other than an employee whose working hours are irregular, sporadic or unpredictable.' We acknowledge that clause 10.3(c) and (e) are intended to have a protective effect, and would apply, in many cases consistent with clause 25.5(d) (iii). However, this clause does not provide sufficient protection and it is necessary to ensure that where an employer seeks to change a roster without 7 days' notice, overtime should apply.

32. AiG opposes the variation sought on the basis any change in roster without 7 days' notice is not permitted by the Award (save for the exceptions in clause 25. (d)(ii) and (iii)) and would constitute a breach of the Award.[25] NDS make a similar argument.[26] In reply, we say that roster changes without proper notice do occur in this sector, and that for an employee subject to these late roster changes, there is value in having a clause within the Award that provides for payment of overtime. It is appropriate that the employee has an entitlement to overtime rather than a right to allege a breach of the Award.

S21 - Telephone allowance claim

33. ABI and others have opposed our telephone allowance claim and state that it should be dismissed.[27] ABI and others have raised concerns about the drafting of our claim and concerns that employers will be required to reimburse all personal use by the employee.[28] Business SA and AFEI raise similar concerns, although Business SA does acknowledge that employees are, at times, required to use personal mobile phones in the course of their employment.[29]
34. To address some of drafting concerns raised by the employer parties, we file a revised draft determination with this submission. The revised draft determination provides the employer with several options in respect to reimbursing an employee for the cost of a mobile phone. The employer can provide a mobile phone, or alternatively, the employer can reimburse costs associated with use of the employee's own mobile phone. The reimbursement is of '*reasonable*' costs incurred in the course of employment.
35. For avoidance of doubt, our clause does not require an employer to purchase a phone for an employee to continue to use if the employment *ends*. An employer can purchase a phone, provide it to the employee to use during the period of their employment and then require the return of the phone once the employment of that employee is terminated. This method may be attractive to employers as they are able to determine the type of device purchased and any

[25] Submission in reply of AiG re: outstanding union claims, paragraph 398.
[26] Submission in reply of NDS re: outstanding union claims, paragraph 51.
[27] Submission in reply of ABI and others re: outstanding union claims, paragraph 9.37.
[28] Submission in reply of ABI and others re: outstanding union claims, paragraphs 9.25 to 9.27.
[29] Submission in reply of Business SA re: outstanding union claims dated 12 July 2019, paragraphs 24 and 25 -27, submission in reply of AFEI in reply re: outstanding union claims, paragraph 144.

service arrangement entered into. The employer is also able to ensure that the device purchased is one that can properly display any apps the employer requires the employee to use in the course of duties.

36. ABI and others argue that it is difficult to understand how an employer can reasonably be expected to reimburse an employee for mobile phone costs where an employee primarily uses it for personal use.[30] In response, we say it is difficult to understand how an employer can reasonably expect an employee to use their own mobile phone in the course of their employment without providing any reimbursement for that expenditure. The notion that an employee '*primarily*' uses the mobile phone for personal use is misleading. An employee may or may not use their mobile phone primarily for personal use, but the key issue is whether the employee is *required* to use their mobile phone for work purposes and how the employee should be reimbursed for that work-related use.
37. AiG have noted a Deloitte report from 2018, in which a survey of 2,000 Australian consumers found that 89% of those surveyed own a smart phone.[31] We acknowledge that most employees will own a phone. This does not negate the need for a mobile phone allowance. There are costs associated with using a mobile phone for work, whether that is direct charges for work-related use, having to pay for a higher plan to ensure work-related use is covered, or increased wear and tear on the device. For example, United Voice witness Ms Stewart gives evidence that '*my phone bill costs approximately $170 per month. If I was not required to make as many work calls, I could consider dropping to a cheaper mobile phone plan*.'[32] It cannot be considered '*fair*' for the cost of work-related mobile phone use to be shifted onto employees and it is appropriate that there be an Award clause that provides for compensation for work-related mobile phone usage.

S2A –Variation to Clothing and equipment allowance (uniforms)

38. With respect to this claim, we rely on our submissions filed on 15 February 2019.

United Voice
3 October 2019

30 Submission of ABI and others re: outstanding union claims, paragraph 9.31.
31 Submission in reply of AiG re: outstanding union claims, paragraph 548.
32 Witness statement of Trish Stewart signed 17 January 2019, paragraph 21.

Attachment A –Travel time clauses

Note: This is not a comprehensive list.

Modern Award	Clause
Aboriginal Community Controlled Health Services Award 2010	15.5(d) Where an employee is required to work at a place away from their normal place of work, all time reasonably spent travelling to and from the place of work will be credited at their ordinary rate of pay.
Animal Care and Veterinary Services Award 2010	22.3 Veterinary surgeons The following provisions apply to veterinary surgeons: (a) Time taken for travel required in the performance of duties, except for active on call duty, will contribute to hours of work. Required in the performance of duties includes travel additional to one return trip between the associate's place of residence and the place of work in any one day and travel between different locations of a practice.
Aquaculture Industry Award 2010	15.4 Travel time and allowance (a) An employee who on any day or from day to day is required to work at a workplace away from the usual workplace will, at the direction of the employer, present for work at such workplace at the usual starting time; but all time reasonably spent in reaching and returning from such workplace (in excess of the time normally spent in travelling from the employee's home to their usual workplace and returning) will be paid at ordinary rates of pay.
Architects Award 2010	16.2(c) Where an employee is directed to work at a place other than their usual place of employment, all time occupied by them on any day in travelling which is in excess of the time normally occupied by them in travelling when working at their usual place of employment will be deemed to be working time and must be paid for at the appropriate rate prescribed by this award. Provided that where the excess travelling time is in excess of one hour each way, the employer will have the option of providing reasonable living away from home expense reimbursement for any period in excess of four weeks.

Broadcasting, Recorded Entertainment and Cinemas Award 2010	33.4 Other duties counted as time worked (c) Time spent in servicing of a client advertiser of the employer by an employee at the direction of the employer must be paid for at ordinary rates of pay. Any travelling time incurred by an employee in carrying out such servicing must be paid for at ordinary rates of pay. (d) Should an employee be directed to travel away from the usual studios to broadcast, or record or perform any other duties, the time involved in travelling to and from such location will be counted as time worked, provided the maximum travelling time to be paid for will be eight hours on any one day. 80.1 All travel required between the daily commencement of work and the daily conclusion of work including all travel to and from location will be the responsibility of the employer, subject to the provisions of this clause. 80.2 All time spent in travelling will be counted as time worked, subject to the provisions of the award. 80.3 Where an employee elects, with the written agreement of the employer, to provide their own transport to a location which is at a distance of more than 25 km from the capital city in which the employer's usual place of business is located, time spent in travel will be regarded as time worked and will be calculated as between a radius of 25 km from the GPO and the place of location, such distance to be measured on the basis of the shortest practicable route by road between the employer's usual place of business and the location, and the time taken will be calculated on the basis of two minutes for each kilometre of distance between the 25 km radius and the location. If the location is within the 25 km radius the location may be considered the place of call and the employee's time worked may be calculated from their call time at such location.
Business Equipment Award 2010	22.2 Commercial travelers stream (c)(iii) Employees whilst travelling on their employer's business will be regarded as being "on duty" for all purposes of this award and for the purposes of all relevant State workers compensation legislation.
Car Parking Award 2010	15.4 Transfer from job-to-job allowance An employee transferred by the employer from one job to another job on the same day will be paid for the time spent in travelling as for time worked. An employee will be reimbursed all reasonably incurred travel costs.

Concrete Products Award 2010	16.2 Transfer from job to job An employee transferred by the employer from one job to another job on the same day will be paid for the time spent in travelling as for time worked.
Fitness Industry Award 2010	18.7 Travelling time and fares An employee who is required by the employer to travel from one place of work to another must be reimbursed by the employer all fares necessarily incurred by the employee. All time occupied in such travel is deemed to be working time and the employee must be paid at the appropriate rate.
Live Performance Award 2010	26.2(c) Travel time to be counted as time worked Should the employer during the course of a normal day's work require the employee to travel, the travelling time inclusive of regular stops for comfort and refreshment will be counted as time worked.
Local Government Industry Award 2010	15.4(b)(ii) Where a community services employee providing home care is required by the employer to travel between two or more work locations in any one day the employee will be reimbursed for travel expenses incurred for travel between the first and successive service points and will be paid at the appropriate rate of pay during travel time between the first and successive service points.
Wine Industry Award 2010	24.1 Travel and expenses (a) Where an employee is required by the employer to travel from one place of work to another: (i) the time occupied in such travel must be counted as time worked and paid for as such; and (ii) the transport and fares for such travel must be provided by the employer or the expense incurred by the employee for such travel must be reimbursed by the employer.

BEFORE THE FAIR WORK COMMISSION

FOUR YEARLY REVIEW OF THE MODERN AWARDS

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

MATTER NO. 2018/26

Statement of Deon Fleming

I, Deon Fleming, [redacted] say:

1. I am a member of United Voice and have been a member of my union since about 2016.

2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. My date of birth is 31 July 1968.

4. I live by myself. I own my own home.

Work History

5. I am a qualified hairdresser and worked in the hairdressing industry until about 2014.

6. Between about 2014 and mid-2016, I worked as a cleaner at Friendly Society Hospital in Bundaberg.

7. I received my Certificate III in Aged Care in about 2016. I began working as a support worker at Comlink in mid-2016. My duties included attending home visits for clients to perform medication checks, showering and dressing clients and transporting clients to and from appointments.

Current Work

8. In June 2017, I stopped working at Comlink and took up a role as a support worker at Excelcare. Around August 2018, Excelcare merged with Live Better. Live Better is my current employer.

9. My main duties at Live Better as a support worker include but are not limited to, client transport to and from appointments, showering and dressing clients, medication checks for clients and assistance with general self-care such as meal preparation. I also offer social support to clients by taking them shopping, to the hairdressers or out for coffee.

10. I am employed under the *Social, Community, Home Care and Disability Services Award* 2010 ('the Award'). I am a classified under the Award as a home care worker at level 2.

11. I am employed as a permanent part time employee and I work 5 days per week.

12. Attached to this statement and marked **Annexure 'A'** is a copy of my terms and conditions of employment with Live Better.

Roster changes

13. I am rostered, on average, to work approximately 20-25 hours per week. However, the amount of hours can decrease if there are cancellations of client appointments. Some weeks I have worked as much as 32 hours in the week.

14. I produce at attachment marked **Annexure 'B'** copies of my rosters for the period 4 May 2018 to 21 September 2018.

15. My roster is frequently changed. Most weeks the roster that is released at the beginning of the week is varied due to client cancellations and my colleagues taking sick leave.

16. If clients cancel on the same day of their appointment, then I am paid for the shift. But if a client cancels a home care visit before 5pm the day before the scheduled appointment, then I am not paid for that appointment and these are hours I miss out on. At least once per week, I will have a client cancel their appointment with the

required notice. This creates a lot of uncertainty for me in being able to anticipate how much I will get paid in the week.

17. At least once per fortnight my manager will ask me if I can take on extra work because a colleague has called in sick. If I am available, I will take these extra shifts because I want to work more hours.

The Impact of Broken Shifts

18. The structure of my roster as a support worker is varied and can be broken up into numerous short shifts over an 8-10 hour period.

19. My working day is structured by the appointments that have been booked by clients. An appointment can last from 15 minutes up to 1.5 hours or longer.

20. My first shift will usually begin somewhere between 6am to 7.30am. I will then normally attend 2-3 appointments during the day and finish at 4.30 - 5pm.

21. When I began working as a support worker with Live Better, it was common that I would be rostered on for appointments during the late afternoon or evening for 15 minutes to do medication checks. This meant that I may work from 7.30am until 2pm or 3pm with short breaks in between shifts then have a 2 hour break and then work a 15 minute shift at the end of the day.

22. These '*broken shifts*' are very disruptive to my day because it means that I will need to sit around for 2-3 hours waiting for a shift to start that only lasts for 15 minutes. I usually need to drive around 10 minutes to reach the location of the appointment. Some appointments can be a 40 minute drive away. I am not paid for the time it takes me to travel to and from these appointments.

23. The broken shifts which spread across the day mean I am effectively working the entire day. I may only be paid for 4-5 hours. These shifts prevent me from using my time off to take part in social activities with friends or family.

24. Because of these shifts, I am also not able to seek secondary employment because in order to maximize the amount of hours I will be paid for as a support worker, I have to be available for a minimum 12 hours per day.

Mobile Phone Allowance

25. When I was employed by Excelcare, they provided me and other employees with a tablet computer at no cost to us. I used the tablet to check my roster and check and respond to work emails from colleagues and my supervisor. At the time, I did not own a smart phone. The tablet was my only way of checking my roster and work emails.

26. When Excelcare merged with Live Better, these tablets were taken away from homecare workers.

27. Because I no longer had access to the tablet, I was forced to upgrade my '*flip*' style phone to a smart phone so that I could access the Internet to check my roster and my work emails. I have not been reimbursed for this expense. If I did not buy a smart phone, then I would not have been able to access my work roster or work emails. I pay approximately $65 per month for this mobile phone. Attached to this statement and marked **Annexure 'C'** is a copy of the receipt and the monthly bill.

28. My current employer asked for my mobile number and informed me that it would use it to contact me for work purposes, send my rosters via my device and other work related materials.

29. I use my phone for work related reasons regularly and would make approximately 10 calls per week on my mobile. The reasons why I have to use my own mobile are: making calls to clients for medication checks, calling clients if I am running late for an appointment, checking my roster and work emails.

30. I am not reimbursed for use of my own mobile for work related purposes.

Income and expenses

31. I am paid an hourly rate.

32. On average I earn a gross weekly amount of $250 - $500 for work, dependent on the hours I work. Attached to this statement and marked **Annexure 'D'** are copies of my pay slips for the period 24 May 2018 to 13 December 2018.

33. My average weekly expenses (excluding entertainment and savings) are approximately $457.00, comprised of:

Rates, household bills and groceries	$248.00
Car expenses, including registration and petrol:	$104.00
Other expenses: mobile phone bill, health insurance.	$105.00
Total:	**$457.00**

[redacted]

Witness Signature

DEON FLEMING 16-1-2019

Witness Name (printed) Date:

'A'

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27 June 2018

Deon Fleming
23 Letinic Street
BUNDABERG QLD 4670

Dear Deon,

I am pleased to offer you employment with LiveBetter Services Limited (LiveBetter) on the terms set out in this Letter of Employment. Please read these terms carefully and, if you wish to accept this offer, sign and return the attached copy to the Human Resources Department.

TERMS AND CONDITIONS OF EMPLOYMENT

1. Commencement date

This Letter of Employment will be effective from the 1 July 2018.

2. Term of employment

Your employment with LiveBetter will continue for an indefinite period, subject to successful relevant background checks including a review of your national police record, and working with children check. You will also be required to successfully complete a health & wellness check. If you do not consent to these background checks and health & wellness check or, if your background checks reveals past behaviours that are inconsistent with the expectations of you in this role and this Letter of Employment, then this offer of employment will be revoked immediately.

3. Role, duties and performance

You are engaged as Support Worker on a permanent, part time basis of 20 nominal hours per fortnight plus any reasonable additional hours. You will be working in the Bundaberg / Wide Bay area, in the Aged Care Services and reporting to Jennifer Bruce, Coordinator.

During your employment with LiveBetter, in addition to those duties outlined in your position description, you are required to:

- comply with all policies and procedures (as amended from time to time) that pertain to your employment and the performance of your duties, which are published by e-mail and/or located on the LiveBetter Intranet;
- perform the duties assigned to you from time to time and comply with all lawful and reasonable directions given to you by your Manager;
- perform your duties and responsibilities in a proper and efficient manner;
- except in the case of absence by reason of illness or incapacity or leave in accordance with this contract of employment, devote your time, attention and abilities during normal business hours exclusively to the business of LiveBetter;
- use your best endeavours to promote and enhance the interests, welfare, business, growth and reputation of LiveBetter; and

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- not intentionally do anything which is or may be harmful to LiveBetter.

Your duties, responsibilities, team and location may be revised from time to time in consultation with you to meet the changing needs of the organisation. Any changes will be discussed with you in advance and confirmed in writing.

4. Remuneration

Classification
Your conditions of employment will be governed by the applicable provisions of the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHCDSI).

Due to the nature and scope of your role, your position has been classified as SCHCDSI Level 2 Pay Point 2 Schedule (E) Home Care Employee on the basis of the nature and scope of the role and your qualifications and experience.

Rate of Pay
Your rate of pay upon commencement will be $22.24 per hour which represents an above Award payment. This rate is subject to change as per LiveBetter's obligations under the *Social, Community, Home Care and Disability Services Industry Award 2010*. LiveBetter will also make superannuation contributions on your behalf in accordance with the Superannuation Guarantee legislation.

Payment of Salary
Payment of your salary will be made on a fortnightly basis, in arrears, by electronic deposit to an account nominated by you. Your manager will confirm if you are required to complete a timesheet.

Superannuation contributions
You are free to direct your superannuation contributions to a regulated complying superannuation fund of your choice. If you do not advise us of your choice of a regulated complying fund, your contributions will be made to the superannuation fund chosen by LiveBetter as the default fund, currently HESTA. If you choose your own fund and do not become a member of the LiveBetter default fund, you are required to provide the information about your chosen fund as listed in the Choice of Superannuation Fund form.

Additional contributions to superannuation
In addition to the legislated employer superannuation contributions, you may direct an additional amount to the fund by means of automatic deduction from your pay. For further information please contact the Payroll Officer.

Salary packaging
You may be entitled to participate in LiveBetter's salary packaging scheme, which at present is administered by AccessPay.

Remuneration reviews
Salaries are reviewed annually in conjunction with the annual performance review process, the relevant industrial Award and the LiveBetter remuneration framework.

5. Hours of work

You are engaged on a permanent part time basis of 20 hours per fortnight. Your usual days and times of work are variable and dependant on a roster system which is published and communicated fortnightly. The

roster is based on the needs of the service and will potentially include some stand up shifts, sleep over shifts, afternoon shifts, evening shifts and potentially weekend work. Any variation of hours will be published in the roster.

6. Overtime

All overtime worked must be approved by your manager in advance and, providing approval is obtained, you will be paid in accordance with the overtime provisions of the appropriate Award. Alternatively, you may like to make use of time in lieu provisions, if mutually agreed between yourself and your supervisor and in accordance with the relevant Modern Award.

7. Leave entitlements

Annual leave
You will be entitled to accrue entitlements to paid annual leave at the rate of 20 days for each year of continuous service (or, if part-time, pro-rated) in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time and the appropriate Award.

Annual leave loading of 17.5% will be paid on accrued leave when it is taken.

Unused annual leave will be paid out on termination of employment.

Personal/carer's leave
You will be entitled to ten days paid personal/carer's leave for each year of continuous service (or, if part-time, pro-rated) in accordance with the LiveBetter Leave Entitlements Policy as amended from time to time.

You are not entitled to any payment in lieu of accrued personal leave on termination of your employment.

Compassionate leave
You will be entitled to up to two days paid compassionate leave per permissible occasion in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time.
Parental leave
You will be entitled to parental leave in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time and relevant industrial instruments, such as the Fair Work Act.

Long Service Leave
You will be entitled to long service leave in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time.

Public holidays
You will be entitled to public holidays as proclaimed in your relevant state or territory without loss of pay. Payment will be made in accordance with the National Employment Standards.

Other leave
For information regarding all other leave such as community service leave, religious holidays, study leave and leave without pay, refer to LiveBetter's Leave Entitlements Policy or contact the HR team.

Service Date
For the purpose of calculating service and leave accruals, your original start date with Excelcare Australia Limited will be used.

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Transfer of leave entitlements
As part of your transition from Excelcare Australia Limited, LiveBetter will be transferring your statutory entitlement accruals. This transfer is conditional upon LiveBetter receiving sufficient funds from Excelcare Australia Limited to cover these entitlements prior to commencement.

8. Workers' compensation

LiveBetter has workers' compensation insurance in accordance with the relevant state or territory legislation. In the event of any injury occurring during working hours you should immediately notify your manager.

9. Code of Conduct

LiveBetter is committed to ensuring that all individuals are treated with dignity and respect. The LiveBetter Code of Conduct explains what is meant by equal employment opportunity, discrimination, harassment, victimisation and bullying. It is essential that you understand and comply with the Code of Conduct as amended from time to time. A copy of the Code of Conduct is included in your employee handbook which is issued at induction and is also available on the intranet.

10. Conduct and attire

You will be expected to conduct yourself in a manner that enhances the professional standing of LiveBetter, whether in the office, at third party locations, or any forum in which you may be seen as representing LiveBetter.

11. Driver's Licence

Given the nature of the role, a condition of employment is that you must possess and maintain a valid unrestricted Australian driver's licence. You must provide LiveBetter with a copy of your valid driver's licence and must notify LiveBetter immediately if you are disqualified from driving.

12. Confidentiality

You must not disclose, or allow access to, any confidential information, to any person except in the proper course of your duties, or as permitted by LiveBetter, either during or after the course of your employment. Confidential information is defined as any information relating to LiveBetter employees and clients, which is not lawfully available to the general public.

Further, as an employee of LiveBetter you will have access to "Know-How", and have a detailed knowledge of LiveBetter's clients and business' clients. You will have the opportunity to build professional relationships with those clients, employees and others engaged in LiveBetter's Business (goodwill). It is reasonable for LiveBetter to protect the goodwill of the business and as such, you must not during or post employment with LiveBetter, induce, solicit, canvas or approach any customers of LiveBetter on behalf of any other business. This includes, but is not limited to soliciting or approaching LiveBetter clients/and or families to move providers, or encouraging LiveBetter client/ and or families to select another service provider on the basis of your employment with that provider.

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In addition, you must not during or post employment with LiveBetter, do or say anything that may be harmful to the reputation of LiveBetter in any forum, or that may lead a person to cease, curtail or alter their dealings with LiveBetter.

13. Medical Examinations and Considerations

Where a specific medical examination is not required for your position, LiveBetter assumes that you are medically fit to undertake employment with LiveBetter unless you notify it otherwise. If you have a medical condition that may have an impact upon your ability to carry out your duties or may require LiveBetter to provide you with assistance to undertake your duties then it is important to disclose the extent of the medical condition to LiveBetter so that it may fulfil any requirements it has to assist you.

Where during the course of your employment with LiveBetter the CEO forms the opinion that there are reasonable concerns that you are not fit to undertake your normal duties you may be required to attend a medical examination.

14. Termination of employment

Either you or LiveBetter may terminate your employment with LiveBetter at any time by giving written notice in accordance with the National Employment Standards as outlined below.

Period of continuous service at the end of the day the notice is given	Notice period
Not more than 1 year	1 week
More than 1 year but not more than 3 years	2 weeks
More than 3 years but not more than 5 years	3 weeks
More than 5 years	4 weeks

Notwithstanding any other provision contained in the Letter of Employment, LiveBetter may terminate your employment at any time without prior notice if you commit an act of serious misconduct. Serious misconduct includes both of the following:

- wilful or deliberate behaviour that is inconsistent with the continuation of this Letter of Employment;
- conduct that causes imminent and serious risk to the health and safety of a person, or the reputation or viability of LiveBetter.

Examples of serious misconduct include but are not limited to:

- theft, fraud, assault, intoxication, or refusing to carry out a lawful and reasonable instruction consistent with this Letter of Employment;
- the commission of a crime in the course of your employment;
- the commission of a crime outside your employment with LiveBetter (eg criminal dishonesty, where your duties require good faith and honesty);
- neglect of duties; and/or
- the use of objectionable or obscene language in certain circumstances (eg if such language is directed towards managers, employees or clients of LiveBetter).

LiveBetter may suspend you on full pay from part or all of your duties at any time, including during any period of notice of termination of your employment.

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15. Security of equipment and documentation

Whilst working at LiveBetter you are required to take care to secure your personal belongings. LiveBetter will not reimburse an individual who suffers a loss due to theft of cash or personal possessions. You are also responsible for all equipment issued to you and documentation in your custody. This includes computers, mobile phones and confidential documentation. Any losses must be reported to your manager immediately.

16. Variation and entire agreement

This Letter of Employment may only be varied, replaced or terminated by agreement in writing signed by you and an authorised representative of LiveBetter. This Letter of Employment embodies the entire understanding of the parties in relation to your employment by LiveBetter and supersedes all previous negotiations, representations or agreements. This offer of employment is valid for strictly two weeks from the date of issue unless otherwise agreed.

Please indicate your written acceptance of this offer by signing, dating and returning the copy of this Letter of Employment to the Human Resources Department.

Yours sincerely,

Nerissa Marat
General Manager People & Culture

I have read and accept the terms and conditions of employment as set out in this Letter of Employment.

Deon Fleming	D. Fleming	13-7-18
Employee Name	Signature	Date

**** LIVEBETTER ****

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD FLEMD Period Ending :13/05/2018 Printed : 22/09/2018 12:08 pm Page Number : 3

				Activity	Program	In	Out	Dur'n	T/Tm	Kms	Signature
12:30	- 14:30	02:00	[redacted]	C-DA.CLEAN	CHSP-DA.WB						
14:50	- 15:20	00:30	[redacted]		HCP-L3-NOAK6						

Client has Disability Parking Permit

Daily Hours 5.50 hh:mm 05:30

Friday 04-May-2018

07:15	- 08:00	00:45	TRAVEL		CHSP-SS.WB						
07:15	- 11:45	04:30	25-713-TLB BBERG	BOOKING CAR STAFF	CHSP-SS.WB						
08:00	- 11:00	03:00	[redacted]		HCP-L2-COOPP						
11:00	- 11:45	00:45	TRAVEL		CHSP-SS.WB						
11:45	- 12:15	00:30	MEAL BREAK		KHOLD2						
12:30	- 15:30	03:00	[redacted]		HCP-L3-JENSB						

Daily Hours 7.50 hh:mm 07:30

Saturday 05-May-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF		KHOLD2						

Daily Hours 0.00 hh:mm 00:00

Sunday 06-May-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF		KHOLD2						

Daily Hours 0.00 hh:mm 00:00

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending : 13/05/2018 | Printed : 22/09/2018 12:08 pm | Page Number : 4

		Activity	Program	In	Out	Dur'n	T/Tm	Kms	Signature

Monday 07-May-2018

07:15	- 08:00	00:45	PUBLIC HOLIDAY NOT WORKED	HCP-L2 COOPP						
08:00	- 11:00	03:00	PUBLIC HOLIDAY NOT WORKED	HCP-L2-COOPP						
11:00	- 11:45	00:45	PUBLIC HOLIDAY NOT WORKED	HCP-L2 COOPP						
13:00	- 15:00	02:00	PUBLIC HOLIDAY NOT WORKED	KHOLD2						

Daily Hours 6.50 hh:mm 06:30

Tuesday 08-May-2018

07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTM A						
			Medication check and put in hearing aids							
09:00	- 10:30	01:30	[redacted]							
10:50	- 11:50	01:00	[redacted]	HCP-L3-BERTM A						
11:50	- 12:50	01:00	[redacted]	HCP-L3-BERTM A						
			• Meal Prep							
12:50	- 13:20	00:30	MEAL BREAK	KHOLD2						
13:30	- 15:30	02:00	[redacted]	CHSP-RESP.WB						

Daily Hours 5.75 hh:mm 05:45

**** LIVEBETTER ****

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :13/05/2018 | Printed : 22/09/2018 12:08 pm | Page Number : 5

			Activity	Program	In	Out	Dur'n	T/Tim	Kms	Signature
Wednesday 09-May-2018										
07:30	- 08:30	01:00	[redacted]	HCP-L4-WHITG R						
09:15	- 12:15	03:00	[redacted] 3	HCP-L3-JENSB						
12:30	- 13:00	00:30	MEAL BREAK	KHOLD2						
13:15	- 14:45	01:30	[redacted]	HCP-L2-GUPPS						
Daily Hours	5.50	hh:mm	05:30							
Thursday 10-May-2018										
08:20	- 08:50	00:30	[redacted]	HCP-L3-ODON BE						
			Medication							
10:00	- 12:30	02:30	[redacted]	HCP-L3-BRANN						
			Pick up from clients home. Take to 10.30am eye appointment with Wilson Eye Centre, 312 Bourbong Street, Bundaberg West Ph: 41528772							
13:30	- 14:30	01:00	[redacted]	HCP-L2-BORCA						
			• Hoouse DA							
Daily Hours	4.00	hh:mm	04:00							
Friday 11-May-2018										

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD **FLEMD** Period Ending :13/05/2018 Printed : 22/09/2018 12:08 pm Page Number : 6

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
07:30	- 08:00	00:30	[redacted] Medication	HCP-L3-ODONBE						
09:00	- 09:30	00:30	[redacted]							
09:45	- 11:45	02:00	[redacted]	HCP-L2-GARDDO						
11:45	- 12:15	00:30	MEAL BREAK	KHOLD2						
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						
Daily Hours	6.00	hh:mm	06:00							
Saturday	**12-May-2018**									
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Sunday	**13-May-2018**									
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							

Hours Total : 54.67
Kms Total :

Staff Signature : _____ **Approved By :** _____ **Data Entry :** _____

Notifications :

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD Period Ending :27/05/2018 | Printed : 22/09/2018 12:09 pm | Page Number : 1

			Activity	Program	In	Out	Dur'n	T/Tim	Kms	Signature
Monday	**14-May-2018**									
07:15	- 07:30	00:15	[redacted]	HCP-L3-BERTM A						
			• Medication check and put in hearing aids							
07:45	- 08:15	00:30	[redacted]	HCP-L3-ODON BE						
			Medication							
08:30	- 10:30	02:00	[redacted]	CHSP-DA.WB						
10:45	- 11:45	01:00	[redacted]	HCP-L3-JENSB						
12:30	- 14:00	01:30	[redacted]	HCP-L2-GUPPS						
Daily Hours	5.25	hh:mm	05:15							
Tuesday	**15-May-2018**									
07:30	- 08:00	00:30	[redacted]	HCP-L3-ODON-BE						
			Medication							
08:40	- 10:10	01:30	[redacted]	HCP-L2-WITTR						
10:30	- 11:30	01:00	[redacted]	HCP-L3-BERTM A						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD FLEMD Period Ending :27/05/2018 Printed : 22/09/2018 12:09 pm Page Number : 2

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
11:30	- 12:30	01:00	[redacted]	HCP-L3-BERTM A						
			• Food Prep							
12:45	- 13:45	01:00	[redacted]	CHSP-DA.WB						

Daily Hours 5.00 hh:mm 05:00

Wednesday 16-May-2018

07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTM A						
			Medication check and put in hearing aids							
10:45	- 13:45	03:00	[redacted]	HCP-L3-JENSB						
17:00	- 17:15	00:15	[redacted]	HCP-L3-BERTM A						
			Medication Check							

Daily Hours 3.50 hh:mm 03:30

Thursday 17-May-2018

07:45	- 08:00	00:15	[redacted]	HCP-L2-WATSA UD						
			Pick up from Argle office, Twyford Street - Take client from home to Cancer/ Dental Clinic in Hope Street for a 8am appointment.							
09:45	- 11:45	02:00	[redacted]	CHSP-DA.WB						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :27/05/2018 | Printed : 22/09/2018 12:09 pm | Page Number : 3

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
12:30	- 14:30	02:00	[redacted]	CHSP-DA.WB						
15:45	- 16:15	00:30		HCP-L3-BRUNA						

• Pick up from Dr Isobel Mclean, 302 Bourbong St BUNDABERG and transport home

Daily Hours 4.75 hh:mm 04:45

Friday 18-May-2018

07:15	- 08:00	00:45	TRAVEL	KSTTNG						
07:15	- 11:45	04:30	25-713-TLB BBERG BOOKING CAR STAFF	CHSP-SS.WB						
08:00	- 10:30	02:30	[redacted]	HCP-L2-COOPP						
10:30	- 11:00	00:30		HCP-L2-COOPP						
11:00	- 11:45	00:45	TRAVEL	KSTTNG						
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						

Daily Hours 7.50 hh:mm 07:30

Saturday 19-May-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						

Daily Hours 0.00 hh:mm 00:00

Sunday 20-May-2018

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD Period Ending :27/05/2018 | Printed :22/09/2018 12:09 pm | Page Number : 4

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Monday	**21-May-2018**									
07:15	- 08:00	00:45	TRAVEL	KSTTNG						
07:15	- 11:45	04:30	25-713-TLB BBERG BOOKING CAR STAFF	CHSP-SS.WB						
08:00	- 10:30	02:30	[redacted]	HCP-L2-COOPP						
10:30	- 11:00	00:30		HCP-L2-COOPP						
11:00	- 11:45	00:45	TRAVEL	KSTTNG						
13:00	- 15:00	02:00	[redacted]	HCP-L3-JENSB						
Daily Hours	6.50	hh:mm	06:30							
Tuesday	**22-May-2018**									
07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTM A						
			Medication check and put in hearing aids							
09:00	- 10:30	01:30	[redacted]							
10:50	- 11:50	01:00	[redacted]	HCP-L3-BERTM A						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :27/05/2018 | Printed :22/09/2018 12:09 pm | Page Number : 5

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
11:50	- 12:50	01:00	[redacted]	HCP-L3-BERTM A						
			• Meal Prep							
12:50	- 13:20	00:30	MEAL BREAK	KHOLD2						
13:30	- 15:30	02:00	[redacted]	CHSP-RESP.WB						

Daily Hours 5.75 hh:mm 05:45

Wednesday 23-May-2018

07:30	- 08:30	01:00	[redacted]	L4-WHITG						
09:15	- 12:15	03:00		HCP-L3-JENSB						
12:30	- 13:00	00:30	MEAL BREAK	KHOLD2						
13:15	- 14:45	01:30	[redacted]	L2-GUPPS						

Daily Hours 5.50 hh:mm 05:30

Thursday 24-May-2018

08:20	- 08:50	00:30	[redacted]	HCP-L3-ODON BE						
			Medication							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :27/05/2018 | Printed : 22/09/2018 12:09 pm | Page Number : 6

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
09:15	- 11:15	02:00	[redacted]	HCP-L2-GARDDO						
13:30	- 14:30	01:00		HCP-L2-BORCA						
			• Hoouse DA							
Daily Hours	3.50	hh:mm	03:30							
Friday	**25-May-2018**									
07:30	- 08:00	00:30	[redacted]	HCP-L3-ODONBE						
			Medication							
09:00	- 09:30	00:30	[redacted]							
11:45	- 12:15	00:30	MEAL BREAK	KHOLD2						
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						
Daily Hours	4.00	hh:mm	04:00							
Saturday	**26-May-2018**									
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Sunday	**27-May-2018**									
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD **FLEMD** **Period Ending :27/05/2018** **Printed : 22/09/2018 12:09 pm** **Page Number : 7**

			Activity	Program	In	Out	Dur'n	T/Time	Kms	Signature
07:35	- 08:05	00:30	[redacted]	CP-L4-WHITG						
08:05	- 08:15	00:10		HCP-L3-BRANN						
08:35	- 09:05	00:30		HCP-L3-ODONBE						
			Medication							
11:55	- 12:05	00:10	[redacted]	HCP-L3-BRANN						
16:00	- 16:30	00:30		HCP-L4-WHITG						
17:00	- 17:30	00:30	ABORTED VISIT	HCP-L3-GARDG						
17:45	- 17:55	00:10	[redacted]	HCP-L3-BRANN						

Daily Hours **2.50** hh:mm **02:30**

Hours Total : 53.75

Kms Total :

Staff Signature : _____ **Approved By :** _____ **Data Entry :** _____

Notifications :

**** LIVEBETTER ****

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :10/06/2018 | Printed : 22/09/2018 12:14 pm | Page Number : 1

			Activity	Program	In	Out	Durn	T/Tm	Kms	Signature
Monday	**28-May-2018**									
07:15	- 07:30	00:15	[redacted]	HCP-L3-BERTM A						
			• Medication check and put in hearing aids							
07:45	- 08:15	00:30	[redacted]	HCP-L3-ODON BE						
			Medication							
08:30	- 10:30	02:00	[redacted]	CHSP-DA.WB						
10:45	- 11:45	01:00	[redacted]	HCP-L3-JENSB						
11:45	- 11:55	00:10	ADMINISTRATION	KCOORD						
12:30	- 14:30	02:00	[redacted]	CHSP-DA.WB						
14:30	- 15:00	00:30	ADMINISTRATION	KCOORD						
Daily Hours	6.42	hh:mm	06:25							
Tuesday	**29-May-2018**									
07:30	- 08:00	00:30	[redacted]	HCP-L3-ODON BE						
			Medication							
08:40	- 10:10	01:30	[redacted]	HCP-L2-WITTR						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD : **FLEMD** Period Ending :10/06/2018 Printed : 22/09/2018 12:14 pm Page Number : 2

			Activity	Program	In	Out	Dur'n	T/Tim	Kms	Signature
10:30	- 11:30	01:00	[redacted]	HCP-L3-BERTM A						
11:30	- 12:30	01:00		HCP-L3-BERTM A						
			• Food Prep							
12:45	- 13:45	01:00	[redacted]	CHSP-DA.WB						
13:45	- 14:15	00:30	**ADMINISTRATION**	KCOORD						
Daily Hours	5.50	hh:mm	05:30							

Wednesday 30-May-2018

07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTM A						
			Medication check and put in hearing aids							
09:00	- 12:00	03:00	[redacted]	HCP-L3-JENSB						
13:15	- 14:45	01:30	[redacted]	HCP-L2-GUPPS						
15:00	- 17:00	02:00	[redacted]	CHSP-DA.WB						
18:10	- 18:20	00:10	**ADMINISTRATION**	KCOORD						
Daily Hours	6.92	hh:mm	06:55							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD **FLEMD** Period Ending :10/06/2018 Printed : 22/09/2018 12:14 pm Page Number : 3

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
Thursday 31-May-2018										
09:45	- 11:45	02:00	PUBLIC HOLIDAY NOT WORKED	KHOLD2						
12:30	- 14:30	02:00	PUBLIC HOLIDAY NOT WORKED	KHOLD2						
15:00	- 15:15	00:15	PUBLIC HOLIDAY NOT WORKED	KHOLD2						
Daily Hours	4.25	hh:mm	04:15							
Friday 01-Jun-2018										
09:00	- 09:30	00:30	[redacted]	HCP-L2-GARDDO						
			• make bed, wipe kitchen benches etc. This is an extra while Gwyn in hospital.							
09:35	- 10:35	01:00	ADMINISTRATION	KCOORD						
			• Admin duties							
11:15	- 13:15	02:00	[redacted]	HCP-L2-WHITW						
13:30	- 14:00	00:30	ADMINISTRATION	KCOORD						
Daily Hours	4.00	hh:mm	04:00							
Saturday 02-Jun-2018										
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Sunday 03-Jun-2018										
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD **FLEMD** Period Ending :10/06/2018 Printed : 22/09/2018 12:14 pm Page Number : 4

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
Monday 04-Jun-2018										
13:00	- 15:00	02:00	[redacted]	HCP-L3-JENSB						
Daily Hours	2.00	hh:mm	02:00							
Tuesday 05-Jun-2018										
07:30	- 07:45	00:15	[redacted] Medication check and put in hearing aids	HCP-L3-BERTM A						
09:00	- 10:30	01:30	[redacted]							
10:50	- 11:50	01:00	[redacted]	HCP-L3-BERTM A						
11:50	- 12:50	01:00	[redacted] • Meal Prep	HCP-L3-BERTM A						
12:50	- 13:20	00:30	MEAL BREAK	KHOLD2						
13:30	- 15:30	02:00	[redacted]	CHSP-RESP.WB						
Daily Hours	5.75	hh:mm	05:45							
Wednesday 06-Jun-2018										

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD FLEMD Period Ending :10/06/2018 Printed : 22/09/2018 12:14 pm Page Number : 5

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
07:30	- 08:30	01:00	[redacted]	HCP-L4-WHITG R						
09:15	- 12:15	03:00	[redacted]	HCP-L3-JENSB						
12:30	- 13:00	00:30	MEAL BREAK	KHOLD2						
13:15	- 14:45	01:30	[redacted]	HCP-L2-GUPPS						

Daily Hours 5.50 hh:mm 05:30

Thursday 07-Jun-2018

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
08:20	- 08:50	00:30	[redacted] Medication	HCP-L3-ODON BE						
09:15	- 11:15	02:00	[redacted]	HCP-L2-GARDD O						
11:40	- 12:40	01:00	[redacted]	CHSP-DA.WB						
13:30	- 14:30	01:00	[redacted] • Hoouse DA	HCP-L2-BORCA						

Daily Hours 4.50 hh:mm 04:30

Friday 08-Jun-2018

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD **FLEMD** Period Ending :10/06/2018 Printed : 22/09/2018 12:14 pm Page Number : 6

			Activity	Program	In	Out	Dur'n	T/Time	Kms	Signature
07:30	- 08:00	00:30	[redacted]	HCP-L3-ODONBE						
			Medication							
09:15	- 10:45	01:30	[redacted]	CHSP-DA.WB						
11:45	- 12:15	00:30	MEAL BREAK	KHOLD2						
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						

Daily Hours 5.00 hh:mm 05:00

Saturday 09-Jun-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						

Daily Hours 0.00 hh:mm 00:00

Sunday 10-Jun-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						

Daily Hours 0.00 hh:mm 00:00

Hours Total : 49.83 **Staff Signature :** _____ **Approved By :** _____ **Data Entry :** _____

Kms Total :

Notifications :

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :24/06/2018 | Printed : 22/09/2018 12:15 pm | Page Number : 1

Activity	Program	In	Out	Dur'n	T/Tim A	Kms	Signature

Monday 11-Jun-2018

07:15	- 07:30	00:15	[redacted]	HCP-L3-BERTM A							
			• Medication check and put in hearing aids								
07:45	- 08:15	00:30	[redacted]	HCP-L3-ODON BE							
			Medication								
08:30	- 10:30	02:00	[redacted]	CHSP-DA,WB							
10:45	- 11:45	01:00	[redacted]	HCP-L3-JENSB							

Daily Hours 3.75 hh:mm 03:45

Tuesday 12-Jun-2018

07:30	- 08:00	00:30	[redacted]	HCP-L3-ODON BE							
			Medication								
08:40	- 10:10	01:30	[redacted]	HCP-L2-WITTR							
10:30	- 11:30	01:00	[redacted]	HCP-L3-BERTM A							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD **FLEMD** Period Ending :24/06/2018 Printed : 22/09/2018 12:15 pm Page Number : 2

			Activity	Program	In	Out	Dur'n	T/Tm	Kms	Signature
11:30	- 12:30	01:00	[redacted]	HCP-L3-BERTM A						
			• Food Prep							
12:45	- 13:45	01:00	[redacted]	CHSP-DA.WB						
Daily Hours	5.00	hh:mm	05:00							
Wednesday 13-Jun-2018										
07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTM A						
			Medication check and put in hearing aids							
09:00	- 12:00	03:00	[redacted]	HCP-L3-JENSB						
13:15	- 14:45	01:30	[redacted]	HCP-L2-GUPPS						
17:00	- 17:15	00:15	[redacted]	HCP-L3-BERTM A						
			Medication Check							
Daily Hours	5.00	hh:mm	05:00							
Thursday 14-Jun-2018										
07:45	- 08:00	00:15	SICK LEAVE	KHOLD2						
09:45	- 11:45	02:00	SICK LEAVE	KHOLD2						
12:30	- 14:30	02:00	SICK LEAVE	KHOLD2						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD — FLEMD Period Ending :24/06/2018 — Printed : 22/09/2018 12:15 pm — Page Number : 3

			Activity	Program	In	Out	Dur'n	T/Tim	Kms	Signature
15:00	- 15:15	00:15	SICK LEAVE	KHOLD2						
Daily Hours	4.50	hh:mm	04:30							
Friday	**15-Jun-2018**									
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						
Daily Hours	3.00	hh:mm	03:00							
Saturday	**16-Jun-2018**									
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Sunday	**17-Jun-2018**									
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Monday	**18-Jun-2018**									
07:10	- 07:25	00:15	[redacted]	HCP-L3-BERTMA						
			• Medication check and put in hearing aids							
07:30	- 07:50	00:20	[redacted]	HCP-L3-GARDG						
			From 15 May Street to Cancer and Dental Clinic in Hope Street							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :24/06/2018 | Printed :22/09/2018 12:15 pm | Page Number : 4

			Activity	Program	In	Out	Dur'n	T/Tim	Kms	Signature
07:45	- 08:00	00:15	[redacted]	HCP-L2-WATSAUD						
			Pick up from Argle office, Twyford Street - Take client from home to Cancer/ Dental Clinic in Hope Street for a 8am appointment.							
09:30	- 11:30	02:00	[redacted]	CHSP-RESP.WB						
13:00	- 15:00	02:00	[redacted]	HCP-L3-JENSB						
Daily Hours	4.83	hh:mm	04:50							
Tuesday	19-Jun-2018									
07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTHA						
			Medication check and put in hearing aids							
10:50	- 11:50	01:00	[redacted]	HCP-L3-BERTHA						
11:50	- 12:50	01:00	[redacted]	HCP-L3-BERTHA						
			• Meal Prep							
12:50	- 13:20	00:30	MEAL BREAK	KHOLD2						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :24/06/2018 | Printed : 22/09/2018 12:15 pm | Page Number : 5

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
14:30	- 14:55	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						

- CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS

- Group 1
- 1420-1430 Pick up from Gracie Dixon Respite Centre and drop home
- DEZOM

- Group 2
- Pick up group from Gracie Dixon Respite Centre and drop home in sequence
- 1440-1500 DARCL
- 1440-1510 THOMTH

Daily Hours 2.67 hh:mm 02:40

Wednesday 20-Jun-2018

07:30	- 08:30	01:00	[redacted]	HCP-L4-WHITG R						
09:15	- 12:15	03:00	[redacted]	HCP-L3-JENSB						
12:30	- 13:00	00:30	MEAL BREAK	KHOLD2						
13:15	- 14:45	01:30	[redacted]	HCP-L2-GUPPS						
15:00	- 17:00	02:00	[redacted]	CHSP-DA.WB						

Daily Hours 7.50 hh:mm 07:30

Thursday 21-Jun-2018

07:00	- 08:00	01:00	ABORTED VISIT	HCP-L2-BORCA						

**** LIVEBETTER ****

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD Period Ending :24/06/2018 | Printed : 22/09/2018 12:15 pm | Page Number : 6

			Activity	Program	In	Out	Dur'n	T/Tim	Kms	Signature
08:20	- 08:50	00:30	[redacted]	HCP-L3-ODONBE						
			Medication							
09:15	- 11:15	02:00	[redacted]	HCP-L2-GARDDO						
12:00	- 12:10	00:10	[redacted]	HCP-L3-BRANN						
12:20	- 12:30	00:10	**ADMINISTRATION**	KCOORD						
13:30	- 15:00	01:30	[redacted]	HCP-L2-CHARCE						
			Access to clients unit attached to grandsons home is from Moray Court							
15:00	- 16:30	01:30	[redacted]	HCP-L2-CHARCE						
			Access to clients unit attached to grandsons home is from Moray Court							
Daily Hours	6.83	hh:mm	06:50							

Friday 22-Jun-2018

07:30	- 08:00	00:30	[redacted]	HCP-L3-ODONBE						
			Medication							
08:40	- 08:50	00:10	**ADMINISTRATION**	KCOORD						
09:15	- 11:15	02:00	[redacted]	HCP-L3-NOAKB						
			Client has Disability Parking Permit							
11:45	- 12:15	00:30	**MEAL BREAK**	KHOLD2						
Daily Hours	2.67	hh:mm	02:40							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD **FLEMD** Period Ending :24/06/2018 Printed : 22/09/2018 12:15 pm Page Number : 7

	Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
Saturday 23-Jun-2018								
06:00 - 20:00 14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours 0.00 hh:mm 00:00								
Sunday 24-Jun-2018								
06:00 - 20:00 14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours 0.00 hh:mm 00:00								

Hours Total : 45.75 **Staff Signature :** _____ **Approved By :** _____ **Data Entry :** _____

Kms Total :

Notifications :

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :08/07/2018 | Printed : 22/09/2018 12:15 pm | Page Number : 1

		Activity	Program	In	Out	Dur'n	T/Tim	Kms	Signature
Monday	**25-Jun-2018**								
07:15	- 07:30	00:15 [redacted]	HCP-L3-BERTM A						
		• Medication check and put in hearing aids							
07:45	- 08:15	00:30 [redacted]	HCP-L3-ODON BE						
		Medication							
08:30	- 10:30	02:00 [redacted]	CHSP-DA.WB						
10:40	- 10:50	00:10 ADMINISTRATION	KCOORD						
10:45	- 11:45	01:00 [redacted]	HCP-L3-JENSB						
Daily Hours	3.92	hh:mm 03:55							
Tuesday	**26-Jun-2018**								
07:00	- 07:30	00:30 [redacted]	HCP-L4-WHITG R						
07:50	- 08:20	00:30 [redacted]	HCP-L3-ODON BE						
		• Medication							
08:40	- 10:10	01:30 [redacted]	HCP-L2-WITTR						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :19/08/2018 | Printed :22/09/2018 12:19 pm | Page Number :1

Activity	Program	In	Out	Dur'n	T/Tm	Kms	Signature
Monday 06-Aug-2018							
07:15 - 07:30 00:15 [redacted]	HCP-L3-BERTM A						
• Medication check and put in hearing aids							
07:45 - 08:15 00:30 [redacted]	HCP-L3-ODON BE						
Medication							
08:30 - 10:30 02:00 [redacted]	CHSP-DA.WB						
10:45 - 11:45 01:00 ABORTED VISIT	HCP-L3-JENSB						
10:45 - 12:45 02:00 [redacted]	CHSP-DA.WB						
11:45 - 12:15 00:30 MEAL BREAK	KHOLD2						
Daily Hours 5.75 hh:mm 05:45							
Tuesday 07-Aug-2018							
07:30 - 08:00 00:30 [redacted]	HCP-L3-ODON BE						
Medication							
08:40 - 10:10 01:30 [redacted]	HCP-L2-WITTR						
10:30 - 11:30 01:00 [redacted]	HCP-L3-BERTM A						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :19/08/2018 | Printed : 22/09/2018 12:19 pm | Page Number : 2

			Activity	Program	In	Out	Dur'n	T/Tim	kms	Signature
11:30	- 12:30	01:00	[redacted]	HCP-L3-BERTM A						
			• Food Prep							
13:30	- 15:30	02:00	[redacted]							
Daily Hours	6.00	hh:mm	06:00							
Wednesday 08-Aug-2018										
07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTM A						
			Medication check and put in hearing aids							
09:00	- 12:00	03:00	[redacted]	HCP-L3-JENSB						
13:15	- 14:45	01:30	[redacted]	CP-L2-GUPPS						
Daily Hours	4.75	hh:mm	04:45							
Thursday 09-Aug-2018										
07:45	- 08:00	00:15	[redacted]	CP-L2-WATSA ID						
			Pick up from Argle office, Twyford Street - Take client from home to Cancer/ Dental Clinic in Hope Street for a 8am appointment.							
09:45	- 11:45	02:00	[redacted]	CHSP-DA.WB						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD FLEMD Period Ending 19/08/2018 Printed : 22/09/2018 12:19 pm Page Number : 3

			Activity	Program	In	Out	Dur'n	T/Tm A	Kms	Signature
11:45	- 12:15	00:30	MEAL BREAK	KHOLD2						
12:30	- 13:00	00:30	[redacted]	HCP-L3-NOAKB						
			Client has Disability Parking Permit							
Daily Hours	2.75	hh:mm	02:45							

Friday 10-Aug-2018

08:00	- 08:25	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
			• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS							
09:00	- 09:30	00:30	[redacted]	HCP-L2-GARDD O						
09:45	- 11:45	02:00	[redacted]	HCP-L3-NOAKB						
			Client has Disability Parking Permit							
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						
Daily Hours	5.92	hh:mm	05:55							

Saturday 11-Aug-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							

Sunday 12-Aug-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD FLEMD Period Ending :19/08/2018 Printed : 22/09/2018 12:19 pm Page Number : 4

			Activity	Program	In	Out	Dur'n	T/Tm	Kms	Signature
Monday	**13-Aug-2018**									
07:15	- 07:45	00:30	[redacted]	HCP-L3-ODONBE						
			• Medication							
07:45	- 07:55	00:10	ADMINISTRATION	KCOORD						
08:00	- 08:25	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
			• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS							
09:15	- 09:45	00:30	[redacted]	HCP-L2-GARDDO						
10:00	- 12:00	02:00	[redacted]	CHSP-DA.WB						
13:00	- 15:00	02:00	[redacted]	HCP-L3-JEWSB						
Daily Hours	5.58	hh:mm	05:35							
Tuesday	**14-Aug-2018**									
07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTMA						
			Medication check and put in hearing aids							
09:00	- 10:30	01:30	[redacted]							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD FLEMD Period Ending :19/08/2018 Printed : 22/09/2018 12:19 pm Page Number : 5

			Activity	Program	In	Out	Dur'n	T/Tim	Kms	Signature
10:50	- 11:50	01:00	[redacted]	HCP-L3-BERTM A						
11:50	- 12:50	01:00	[redacted]	HCP-L3-BERTM A						
			• Meal Prep							
12:50	- 13:20	00:30	MEAL BREAK	KHOLD2						
13:30	- 15:30	02:00	[redacted]	CHSP-RESP.WB						
Daily Hours	5.75	hh:mm	05:45							

Wednesday 15-Aug-2018

07:30	- 08:30	01:00	[redacted]	HCP-L4-WHITG R						
09:15	- 12:15	03:00	[redacted]	HCP-L3-JENSB						
12:30	- 13:00	00:30	MEAL BREAK	KHOLD2						
13:15	- 14:45	01:30	[redacted]	HCP-L2-GUPPS						
15:00	- 15:30	00:30	ADMINISTRATION	KCOORD						
15:45	- 15:55	00:10	ADMINISTRATION	KCOORD						
Daily Hours	6.17	hh:mm	06:10							

Thursday 16-Aug-2018

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD FLEMD Period Ending :19/08/2018 Printed : 22/09/2018 12:19 pm Page Number : 6

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
08:00	- 08:25	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
			• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS							
08:30	- 09:00	00:30	[redacted]	HCP-L3-ODON BE						
			• Medication							
09:15	- 11:15	02:00	[redacted]	HCP-L2-GARDD D						
11:25	- 11:45	00:20	[redacted]	HCP-L3-GARDG						
			• To Friendlies hospital Radiology for 12 pm appt. Need to be ther by 11.45am.							
12:40	- 13:10	00:30	[redacted]	HCP-L3-NOAKB						
			Client has Disability Parking Permit							
13:30	- 14:30	01:00	[redacted]	HCP-L2-BORCA						
			• Hoouse DA							
15:00	- 17:00	02:00	ADMINISTRATION	KCOORD						
17:00	- 17:10	00:10	ADMINISTRATION	KCOORD						
Daily Hours		6.92 hh:mm	06:55							
Friday		17-Aug-2018								
07:30	- 08:00	00:30	[redacted]	HCP-L3-ODON BE						
			Medication							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD **FLEMD** Period Ending :19/08/2018 Printed : 22/09/2018 12:19 pm Page Number : 7

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
09:45	- 11:45	02:00	[redacted]	DA.WB						
11:45	- 12:15	00:30	MEAL BREAK	KHOLD2						
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						

Daily Hours 5.50 hh:mm 05:30

Saturday 18-Aug-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						

Daily Hours 0.00 hh:mm 00:00

Sunday 19-Aug-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						

Daily Hours 0.00 hh:mm 00:00

Hours Total : 55.08 **Staff Signature :** _____ **Approved By :** _____ **Data Entry :** _____

Kms Total :

Notifications :

**** LIVEBETTER ****

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD FLEMD Period Ending :30/09/2018 Printed : 22/09/2018 12:22 pm Page Number : 5

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
Daily Hours	4.92	hh:mm	04:55							
Tuesday 25-Sep-2018										
07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTM A						
			Medication check and put in hearing aids							
09:00	- 10:30	01:30	[redacted]							
10:50	- 11:50	01:00	[redacted]	HCP-L3-BERTM A						
11:50	- 12:50	01:00	[redacted]	HCP-L3-BERTM A						
			• Meal Prep							
12:50	- 13:20	00:30	MEAL BREAK	KHOLD2						
13:30	- 15:30	02:00	[redacted]	CHSP-RESP.WB						
Daily Hours	5.75	hh:mm	05:45							
Wednesday 26-Sep-2018										
07:30	- 08:30	01:00	[redacted]	[redacted]-WHITG						
09:15	- 12:15	03:00	[redacted]	HCP-L3-JENSB						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :30/09/2018 | Printed :22/09/2018 12:22 pm | Page Number : 6

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
12:30	- 13:00	00:30	MEAL BREAK	KHOLD2						
13:15	- 14:45	01:30	[redacted]	-GUPPS						

Daily Hours 5.50 hh:mm 05:30

Thursday 27-Sep-2018

08:00	- 08:25	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
			• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS							
08:30	- 09:00	00:30	[redacted]	HCP-L3-ODON BE						
			• Medication							
09:15	- 11:15	02:00	[redacted]	HCP-L2-GARDD O						
12:40	- 13:10	00:30	[redacted]	HCP-L3-ROAKB						
			Client has Disability Parking Permit							
13:30	- 14:30	01:00	[redacted]	HCP-L2-BORCA						
			• Hoouse DA							

Daily Hours 4.42 hh:mm 04:25

Friday 28-Sep-2018

07:30	- 08:00	00:30	[redacted]	HCP-L3-ODON BE						
			Medication							

**** LIVEBETTER ****

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD FLEMD Period Ending :30/09/2018 Printed : 22/09/2018 12:22 pm Page Number : 7

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
09:45	- 11:45	02:00	[redacted]	DA WB						
11:45	- 12:15	00:30	MEAL BREAK	KHOLD2						
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						

Daily Hours 5.50 hh:mm 05:30

Saturday 29-Sep-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						

Daily Hours 0.00 hh:mm 00:00

Sunday 30-Sep-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						

Daily Hours 0.00 hh:mm 00:00

Hours Total : 54.17 **Staff Signature :** _____ **Approved By :** _____ **Data Entry :** _____

Kms Total :

Notifications :

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager – JENNI BRUCE

FLEMD | FLEMD | Period Ending :02/09/2018 | Printed : 22/09/2018 12:20 pm | Page Number : 1

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
Monday	**20-Aug-2018**									
07:15	- 07:30	00:15	[redacted]	HCP-L3-BERTM A						
			• Medication check and put in hearing aids							
07:45	- 08:15	00:30	[redacted]	HCP-L3-ODON BE						
			Medication							
08:30	- 10:30	02:00	[redacted]	CHSP-DA:WB						
10:45	- 11:45	01:00	[redacted]	HCP-L3-JENSB						
11:45	- 12:15	00:30	MEAL BREAK	KHOLD2						
12:30	- 14:30	02:00	[redacted]	CHSP-DA:WB						
Daily Hours		5.75	hh:mm	05:45						
Tuesday	**21-Aug-2018**									
08:00	- 08:30	00:30	[redacted]	HCP-L3-BRUNA						
08:40	- 10:10	01:30	[redacted]	HCP-L2-WITTR						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD Period Ending :02/09/2018 | Printed : 22/09/2018 12:20 pm | Page Number : 2

			Activity	Program	In	Out	Dur'n	T/Tm A	Kms	Signature
10:30	- 11:30	01:00	[redacted]	HCP-L3-BERTM A						
11:30	- 12:30	01:00	[redacted]	HCP-L3-BERTM A						
			• Food Prep							
12:45	- 13:45	01:00	[redacted]	CHSP-DA.WB						

Daily Hours 5.00 hh:mm 05:00

Wednesday 22-Aug-2018

07:50	- 08:05	00:15	[redacted]	HCP-L3-BRUNA						
08:05	- 08:35	00:30	[redacted]	HCP-L3-BRUNA						
09:00	- 12:00	03:00	[redacted]	HCP-L3-JENSB						
13:15	- 14:45	01:30	[redacted]	HCP-L2-GUPPS						

Daily Hours 5.25 hh:mm 05:15

Thursday 23-Aug-2018

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :02/09/2018 | Printed : 22/09/2018 12:20 pm | Page Number : 3

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
07:45	- 08:00	00:15	[redacted]	HCP-L2-WATSAUD						
			Pick up from Argle office, Twyford Street - Take client from home to Cancer/ Dental Clinic in Hope Street for a 8am appointment.							
08:05	- 08:30	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
			• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS							
08:45	- 09:45	01:00	[redacted]	HCP-L4-WHITGR						
10:00	- 12:00	02:00	[redacted]	CHSP-DA.WB						
12:30	- 14:30	02:00	[redacted]	CHSP-DA.WB						
14:50	- 15:20	00:30	[redacted] Client has Disability Parking Permit	HCP-L3-NOAKB						
Daily Hours		6.17	hh:mm 06:10							
Friday		24-Aug-2018								
08:00	- 08:25	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
			• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS							
09:00	- 09:30	00:30	[redacted]	HCP-L2-GARDDO						
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD FLEMD Period Ending :02/09/2018 Printed : 22/09/2018 12:20 pm Page Number : 4

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
Daily Hours	3.92	hh:mm	03:55							
Saturday 25-Aug-2018										
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Sunday 26-Aug-2018										
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Monday 27-Aug-2018										
08:00	- 08:25	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
			• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS							
09:15	- 09:45	00:30	[redacted]	HCP-L2-GARDDO						
10:00	- 12:00	02:00	[redacted]	CHSP-DA.WB						
13:00	- 15:00	02:00	[redacted]	HCP-L3-JENSB						
Daily Hours	4.92	hh:mm	04:55							
Tuesday 28-Aug-2018										
07:30	- 07:45	00:15	SICK LEAVE	HCP-L3-BERTMA						
09:00	- 10:30	01:30	SICK LEAVE	CHSP-DA.WB						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD Period Ending :02/09/2018 | Printed : 22/09/2018 12:20 pm | Page Number : 5

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
10:50	- 11:50	01:00	SICK LEAVE	HCP-L3-BERTM A						
11:50	- 12:50	01:00	SICK LEAVE	HCP-L3-BERTM A						
12:50	- 13:20	00:30	SICK LEAVE	KHOLD2						
13:30	- 15:30	02:00	SICK LEAVE	CHSP-RESP.WB						
Daily Hours	6.25	hh:mm	06:15							
Wednesday 29-Aug-2018										
07:30	- 08:30	01:00	[redacted]	HCP-L4-WHITG R						
09:15	- 12:15	03:00	[redacted]	HCP-L3-JENSB						
12:30	- 13:00	00:30	MEAL BREAK	KHOLD2						
13:15	- 14:45	01:30	[redacted]	HCP-L2-GUPPS						
Daily Hours	5.50	hh:mm	05:30							
Thursday 30-Aug-2018										
08:00	- 08:25	00:25	SICK LEAVE	CHSP-TR.WB						
08:30	- 09:00	00:30	SICK LEAVE	HCP-L3-ODON BE						
09:15	- 11:15	02:00	SICK LEAVE	HCP-L2-GARDD O						
12:40	- 13:10	00:30	SICK LEAVE	HCP-L3-NOAKB						
13:30	- 14:30	01:00	SICK LEAVE	HCP-L2-BORCA						
Daily Hours	4.42	hh:mm	04:25							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD **FLEMD** Period Ending :02/09/2018 Printed : 22/09/2018 12:20 pm Page Number : 6

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
Friday	**31-Aug-2018**									
07:30	- 08:00	00:30	[redacted]	HCP-L3-ODONBE						
			Medication							
09:45	- 11:45	02:00	[redacted]	CHSP-DA.WB						
11:45	- 12:15	00:30	MEAL BREAK	KHOLD2						
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						
Daily Hours	5.50	hh:mm	05:30							
Saturday	**01-Sep-2018**									
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Sunday	**02-Sep-2018**									
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							

Hours Total : 52.67 **Staff Signature :** _____ **Approved By :** _____ **Data Entry :** _____

Kms Total :

Notifications :

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD - Period Ending :16/09/2018 | Printed : 22/09/2018 12:21 pm | Page Number : 1

		Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
Monday	**03-Sep-2018**								
07:15	- 07:30	00:15 [redacted]	HCP-L3-BERTH A						
		• Medication check and put in hearing aids							
07:45	- 08:15	00:30 [redacted]	HCP-L3-ODON BE						
		Medication							
08:30	- 10:30	02:00 [redacted]	CHSP-DA,WB						
10:45	- 11:45	01:00 [redacted]	HCP-L3-JENSB						
11:45	- 12:15	00:30 MEAL BREAK	KHOLD2						
12:30	- 14:30	02:00 [redacted]	CHSP-DA,WB						
15:00	- 15:15	00:15 [redacted]	HCP-L2-WATSA UD						
		Pick up from Cancer/Dental Clinic in Hope street and return home							
Daily Hours	6.00	hh:mm 06:00							
Tuesday	**04-Sep-2018**								
07:30	- 08:00	00:30 [redacted]	HCP-L3-ODON BE						
		Medication							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD FLEMD Period Ending :16/09/2018 Printed : 22/09/2018 12:21 pm Page Number : 2

			Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
08:40	- 10:10	01:30	[redacted]	HCP-L2-WITTR						
10:30	- 11:30	01:00	[redacted]	HCP-L3-BERTM A						
11:30	- 12:30	01:00	[redacted]	HCP-L3-BERTM A						
			• Food Prep							
12:45	- 13:45	01:00	[redacted]	CHSP-DA.WB						

Daily Hours 5.00 hh:mm 05:00

Wednesday 05-Sep-2018

07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTM A						
			Medication check and put in hearing aids							
09:00	- 12:00	03:00	[redacted]	HCP-L3-JENSB						
13:15	- 14:45	01:30	[redacted]	HCP-L2-GUPPS						
15:00	- 15:30	00:30	[redacted]							

Daily Hours 5.25 hh:mm 05:15

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :16/09/2018 | Printed : 22/09/2018 12:21 pm | Page Number : 3

Activity				Program	In	Out	Dur'n	T/Tim e	Kms	Signature
Thursday 06-Sep-2018										
07:45	- 08:00	00:15	[redacted]	HCP-L2-WATSAUD						
Pick up from Argle office, Twyford Street - Take client from home to Cancer/ Dental Clinic in Hope Street for a 8am appointment.										
09:45	- 11:45	02:00	[redacted]	CHSP-DA.WB						
12:30	- 14:30	02:00	[redacted]	CHSP-DA.WB						
14:50	- 15:20	00:30	[redacted]	HCP-L3-NOAKB						
Client has Disability Parking Permit										
Daily Hours	4.75	hh:mm	04:45							
Friday 07-Sep-2018										
08:00	- 08:25	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS										
09:00	- 09:30	00:30	[redacted]	HCP-L2-GARDDO						
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						
Daily Hours	3.92	hh:mm	03:55							
Saturday 08-Sep-2018										

**** LIVEBETTER ****

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :16/09/2018 | Printed :22/09/2018 12:21 pm | Page Number : 4

			Activity	Program	In	Out	Dur'n	T/Dm	Kms	Signature
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Sunday	**09-Sep-2018**									
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Monday	**10-Sep-2018**									
08:00	- 08:25	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
			• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS							
09:15	- 09:45	00:30	ABORTED VISIT	HCP-L2-GARDDO						
10:00	- 12:00	02:00	[redacted]	CHSP-DA.WB						
13:00	- 15:00	02:00	[redacted]	HCP-L3-JENSB						
15:15	- 17:15	02:00	ADMINISTRATION	KCOORD						
Daily Hours	6.92	hh:mm	06:55							
Tuesday	**11-Sep-2018**									
07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTMA						
			Medication check and put in hearing aids							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :16/09/2018 | Printed :22/09/2018 12:21 pm | Page Number : 5

			Activity	Program	In	Out	Dur'n	T/Tm	Kms	Signature
09:00	- 10:30	01:30	[redacted]							
10:50	- 11:50	01:00	[redacted]	HCP-L3-BERTM A						
11:50	- 12:50	01:00	[redacted]	HCP-L3-BERTM A						
			• Meal Prep							
12:50	- 13:20	00:30	MEAL BREAK	KHOLD2						
13:30	- 15:30	02:00	[redacted]	CHSP-RESP.WB						

Daily Hours 5.75 hh:mm 05:45

Wednesday 12-Sep-2018

			Activity	Program	In	Out	Dur'n	T/Tm	Kms	Signature
07:30	- 08:30	01:00	[redacted]	CP-L4-WHITG						
09:15	- 12:15	03:00	ABORTED VISIT	HCP-L3-JENSB						
12:30	- 13:00	00:30	MEAL BREAK	KHOLD2						
13:15	- 14:45	01:30	[redacted]	CP-L2-GUPPS						
15:45	- 16:15	00:30	[redacted]	HCP-L3-GARDG						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending 16/09/2018 | Printed : 22/09/2018 12:21 pm | Page Number : 6

			Activity	Program	In	Out	Dur'n	T/Dm	Kms	Signature
16:15	- 16:45	00:30	[redacted]	HCP-L2-GARDDO						
16:55	- 17:25	00:30	[redacted]	HCP-L3-ODONBE						

Daily Hours 7.00 hh:mm 07:00

Thursday 13-Sep-2018

			Activity	Program	In	Out	Dur'n	T/Dm	Kms	Signature
08:00	- 08:25	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
			• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS							
08:30	- 09:00	00:30	[redacted]	HCP-L3-ODONBE						
			• Medication							
09:15	- 11:15	02:00	[redacted]	HCP-L2-GARDDO						
12:40	- 13:10	00:30	[redacted]	HCP-L3-NOAKB						
			Client has Disability Parking Permit							
13:30	- 14:30	01:00	[redacted]	HCP-L2-BORCA						
			• Hoouse DA							

Daily Hours 4.42 hh:mm 04:25

Friday 14-Sep-2018

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :16/09/2018 | Printed : 22/09/2018 12:21 pm | Page Number : 7

			Activity	Program	In	Out	Dur'n	T/Tim	Kms	Signature
07:30	- 08:00	00:30	[redacted]	HCP-L3-ODON BE						
			Medication							
09:45	- 11:45	02:00	[redacted]	-DA.WB						
11:45	- 12:15	00:30	MEAL BREAK	KHOLD2						
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						
16:00	- 16:30	00:30	[redacted]	-WHITG						

Daily Hours 6.00 hh:mm 06:00

Saturday - 15-Sep-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
07:35	- 08:05	00:30	[redacted]	-WHITG						
08:05	- 08:15	00:10	[redacted]	HCP-L4-BRANN						
08:35	- 09:05	00:30	[redacted]	HCP-L3-ODON BE						
			Medication							
12:05	- 12:15	00:10	[redacted]	HCP-L4-BRANN						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD **FLEMD** **Period Ending :16/09/2018** **Printed : 22/09/2018 12:21 pm** **Page Number : 8**

			Activity	Program	In	Out	Dur'n	T/Time	Kms	Signature
16:00	- 16:30	00:30	[redacted]	[redacted]-WHITG						
17:00	- 17:30	00:30	[redacted]	HCP-L3-GARDG						
17:45	- 17:55	00:10	[redacted]	HCP-L4-BRANN						

Daily Hours **2.50** hh:mm **02:30**

Sunday 16-Sep-2018

06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						

Daily Hours **0.00** hh:mm **00:00**

Hours Total : 57.50 **Staff Signature :** _____ **Approved By :** _____ **Data Entry :** _____

Kms Total :

Notifications :

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEND | Period Ending :30/09/2018 | Printed : 22/09/2018 12:22 pm | Page Number : 1

Activity	Program	In	Out	Dur'n	T/Tim e	Kms	Signature
Monday 17-Sep-2018							
07:15 - 07:30 00:15 [redacted]	HCP-L3-BERTN A						
• Medication check and put in hearing aids							
07:45 - 08:15 00:30 [redacted]	HCP-L3-ODON BE						
Medication							
08:30 - 10:30 02:00 [redacted]	CHSP-DA.WB						
10:45 - 11:45 01:00 [redacted]	HCP-L3-JENSB						
11:45 - 12:15 00:30 **MEAL BREAK**	KHOLD2						
12:30 - 14:30 02:00 [redacted]	CHSP-DA.WB						
15:00 - 15:15 00:15 [redacted]	HCP-L2-WATSA UD						
Pick up from Cancer/Dental Clinic in Hope street and return home							
Daily Hours 6.00 hh:mm 06:00							
Tuesday 18-Sep-2018							
07:30 - 08:00 00:30 [redacted]	HCP-L3-ODON BE						
Medication							

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD Period Ending :30/09/2018 | Printed :22/09/2018 12:22 pm | Page Number : 2

			Activity	Program	In	Out	Dur'n	T/Jnr P	Kms	Signature
08:40	- 10:10	01:30	[redacted]	HCP-L2-WITTR						
10:30	- 11:30	01:00	[redacted]	HCP-L3-BERTM A						
11:30	- 12:30	01:00	[redacted]	HCP-L3-BERTM A						
			• Food Prep							
12:45	- 13:45	01:00	[redacted]	-DA.WB						
14:30	- 16:30	02:00	[redacted]	CHSP-DA.WB						
Daily Hours	7.00	hh:mm	07:00							
Wednesday 19-Sep-2018										
07:30	- 07:45	00:15	[redacted]	HCP-L3-BERTM A						
			Medication check and put in hearing aids							
09:00	- 12:00	03:00	[redacted]	HCP-L3-JENSB						
12:00	- 12:30	00:30	MEAL BREAK	KHOLD2						
13:15	- 14:45	01:30	[redacted]	-GUPPS						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :30/09/2018 | Printed : 22/09/2018 12:22 pm | Page Number : 3

			Activity	Program	In	Out	Dur'n	T/Tm	Kms	Signature
15:00	- 15:30	00:30	[redacted]							

Daily Hours 5.25 hh:mm 05:15

Thursday 20-Sep-2018

07:45	- 08:00	00:15	[redacted]	HCP-L2-WATSAUD						
			Pick up from Argle office, Twyford Street - Take client from home to Cancer/ Dental Clinic in Hope Street for a 8am appointment.							
08:15	- 08:45	00:30	[redacted]	HCP-L3-ROAKB						
			Client has Disability Parking Permit							
09:00	- 11:30	02:30	[redacted]	HCP-L3-GARDG						
12:30	- 14:30	02:00	[redacted]	CHSP-DA.WB						

Daily Hours 5.25 hh:mm 05:15

Friday 21-Sep-2018

08:00	- 08:25	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
			• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS							
09:00	- 09:30	00:30	[redacted]	HCP-L2-GARDDO						
12:30	- 15:30	03:00	[redacted]	HCP-L3-JENSB						

****** LIVEBETTER ******

Staff Roster

For all roster queries please contact your manager - JENNI BRUCE

FLEMD | FLEMD | Period Ending :30/09/2018 | Printed : 22/09/2018 12:22 pm | Page Number : 4

			Activity	Program	In	Out	Dur'n	T/Tm	Kms	Signature
17:35	- 18:05	00:30	[redacted]	HCP-L3-ODONBE						
18:05	- 18:15	00:10	[redacted]	HCP-L4-BRANN						
Daily Hours	4.58	hh:mm	04:35							
Saturday	**22-Sep-2018**									
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Sunday	**23-Sep-2018**									
06:00	- 20:00	14:00	ROSTERED DAY OFF	KHOLD2						
Daily Hours	0.00	hh:mm	00:00							
Monday	**24-Sep-2018**									
08:00	- 08:25	00:25	25-713-TLB BBERG C-TR.DIR.>20KM	CHSP-TR.WB						
			• CHECK TRANSPORT RUNSHEET FOR CANCELLATIONS							
09:15	- 09:45	00:30	[redacted]	HCP-L2-GARDDO						
10:00	- 12:00	02:00	[redacted]	CHSP-DA.WB						
13:00	- 15:00	02:00	[redacted]	HCP-L3-JENSB						

'C'

GREBAVIT PTY LTD A.C.N. 619 277 575 / A.B.N. 61 833 426 471
as Trustee of the GREBAVIT No. 2 Trust
trading as

Harvey Norman AV/IT Superstore Bundaberg
125 Takalvan Street
Bundaberg QLD 4670
Phone: 07 41 545 000 Fax: 07 41545099

==========

TAX INVOICE
INVOICE 1323405 **28/09/18 17:05:44 70 3525833**
MISS DEON FLEMING Assist: 58 DRANN
23 LETINIC ST Cust #: 422949532
BUNDABERG SType : MOBILE PHONE PROMO
QLD 4670 Oper : 58 Drann

Product	Qty	Price	Total
1091004100	1	$0.00	0.00
SAMSUNG GALAXY S9 64GB BLU		Batch: 251820710	
IMEI No.:	352802093356163		
PLAN:	MY PLAN PLUS $65 - 24		
Contract#:	27150258A		
SIM:	8961025718008389333		
PH#:	0422949532		
User:	MISS DEON FLEMING 23 LETINIC BUNDABERG 4670 QLD		
Disclaimer:	30 DAYS FROM DATE OF PURCHASE FROM OPTUS		
Manufacturer Warranty of 24 Months			
See Manufacturers documentation for Warranty Details.			
EXCLUDEPRODCARE	1	$0.00	0.00
1091004100 SAMSUNG GALAXY S9 64GB BLU			
EXCLUDING PRODUCT CARE			
USIMCONMULTI	1	$0.00	0.00
OPTUS POSTPAID TRIPLE SIM		Batch: 002516158	

Invoice Notes:
VR - 0827100389
Source document
Customer invoice:

INV PENDING	$0.00
BALANCE OWING	$0.00

THANK YOU PLEASE CALL AGAIN

Customer Signature: _____ No of Pieces: _____

For consumer enquiries please contact
1300 GO HARVEY (1300 464 278) or the
store phone number listed on this invoice.

E&OE.
V2018.7

TUS

Services Pty. Ltd
1 536

Mr Deon Fleming
23 Letinic Street
MILLBANK QLD 4670

Tax Invoice

Invoice No:	000028911491
Issue Date:	29 Oct 18
Invoice Period:	28 Sep 18 to 27 Oct 18

ACCOUNT NUMBER	6230 5116 352
TOTAL AMOUNT DUE	$8.27
THIS BILL DUE DATE	12 Nov 2018

Recent Charges

29 Oct		$76.77
22 Oct		$68.50
		$0.00

Your Last Bill Summary

Last Bill	$68.50
Payments and Adjustments	$137.00 CR
Balance of last bill	**$68.50 CR**

This Bill

Account Charges	$1.75
Service Charges	
0422949532 on $65 My Plan Plus	$75.02
Total for this bill (which includes GST of $6.98)	$76.77

Total Amount Due $8.27

Paying by Credit or Debit Card?

From 1 January 2018, the card payment processing fee will be increasing to 0.427% (incl GST). To avoid this fee set up direct debit today.

Please see "How To Pay" on your bill or optus.com.au/payments for more info.

Need help? Visit Yes Crowd

For questions about your bill or Optus products and services, join the discussion at **Yescrowd.optus.com.au**

@ optus.com.au/customerhelp

Other enquiries call 133 937
Mon - Fri 8am to 8pm (AEST)

Manage your service 24/7 with My Optus app

How to Pay

Please pay by the due date to avoid late payments fees. For details, visit www.optus.com.au/latefees.
* Pay with Direct Debit - the fee free way to go. From 01 Jan 2018, for all other payments made via credit, debit or charge cards, the payment processing fee will increase to 0.427% (incl. GST).

BPAY ®

Pay from your savings account via Internet or phone banking. More info: **www.bpay.com.au**

Biller Code: 959197

Direct Debit

Set-up Direct Debit to have the total amount due deducted from your nominated savings, or credit/debit card on the due date. To apply or for more details go to **www.optus.com.au/directdebit**

Credit Card *

Pay using **My Optus App** or the options below.
Online: **www.optus.com.au/paymybill**
Phone: **1300 309 309**
Please note transaction limits apply.

POST Billpay ®

Pay in-store at Australia Post. A transaction fee of $1.75 will apply for these payments.

*2289 62305116352

Pay Date
24/05/18

Company EXCELCARE AUSTRALIA INC
ABN 54573662320

Employee Deon Lee Fleming 51231 *
Location BDB Employee Code FLEMD Pay Point OFFICE

Pay Date
24/05/18

Company EXCELCARE AUSTRALIA INC ABN 54573662320
Employee Deon Lee Fleming 51231 *

Pay Details		Rate	$
Deon Lee Fleming	$1281.70		
Superannuation	$108.62	9.50 %	
QSuper			
194824435			
Normal	53.7500	$21.2700/H	1143.34
Km Allowance Before Tax	5.1000	$0.7800/U	3.98
Km Allowance Before Tax	12.0000	$0.7800/U	9.36
Km Allowance Before Tax	6.7000	$0.7800/U	5.23
Km Allowance Before Tax	32.0000	$0.7800/U	24.96
Km Allowance Before Tax	58.0000	$0.7800/U	45.24
Km Allowance Before Tax	32.0000	$0.7800/U	24.96
Km Allowance Before Tax	4.4000	$0.7800/U	3.43
Km Allowance Before Tax	6.1000	$0.7800/U	4.76
Km Allowance Before Tax	5.4000	$0.7800/U	4.21
Km Allowance Before Tax	12.7000	$0.7800/U	9.91
Km Allowance Before Tax	45.0000	$0.7800/U	35.10
Km Allowance Before Tax	1.0000	$0.7800/U	0.78
Km Allowance Before Tax	5.8000	$0.7800/U	4.52
Km Allowance Before Tax	7.7000	$0.7800/U	6.01
Km Allowance Before Tax	8.2000	$0.7800/U	6.40
Km Allowance Before Tax	4.6000	$0.7800/U	3.59
Km Allowance Before Tax	5.2000	$0.7800/U	4.06
Km Allowance Before Tax	2.6000	$0.7800/U	2.03
Km Allowance Before Tax	2.6000	$0.7800/U	2.03
Km Allowance Before Tax	8.0000	$0.7800/U	6.24
Km Allowance Before Tax	36.0000	$0.7800/U	28.08
Km Allowance Before Tax	5.1000	$0.7800/U	3.98
Km Allowance Before Tax	2.5000	$0.7800/U	1.95
Km Allowance Before Tax	11.0000	$0.7800/U	8.58
Km Allowance Before Tax	11.0000	$0.7800/U	8.58
Km Allowance Before Tax	16.0000	$0.7800/U	12.48
Km Allowance Before Tax	20.0000	$0.7800/U	15.60
Km Allowance Before Tax	4.8000	$0.7800/U	3.74
Km Allowance Before Tax	4.8000	$0.7800/U	3.74
Km Allowance Before Tax	7.5000	$0.7800/U	5.85

Period 09/05/18 22/05/18

This Year		This Pay			
Gross	31558.43	Gross	1457.70	Net	1281.70
Tax	3466.00	Tax	176.00	Bank	1281.70
Net	28092.43	Net	1281.70		

Company EXCELCARE AUSTRALIA INC
ABN54379682220

Pay Date
24/05/18

Employee Deon Lee Fleming 51231 *
Location BDB Employee Code FLEMD Pay Point OFFICE FLEMD

Company EXCELCARE AUSTRALIA INC ABN54379682220
Employee Deon Lee Fleming

Pay Date
24/05/18
51231 *

Pay Details			Rate	$
Km Allowance Before Tax		7.5000	$0.7800/U	5.85
Km Allowance Before Tax		4.5000	$0.7800/U	3.51
Km Allowance Before Tax		7.2000	$0.7800/U	5.62
Personal Leave	Ent:	42.9615 Hours		
Annual Leave	Ent:	91.9194 Hours		

Period 09/05/18 22/05/18 Total hours this pay 53.7500

This Year		This Pay			
Gross	31558.43	Gross	1457.70	Net	1281.70
Tax	3466.00	Tax	176.00	Bank	1281.70
Net	28092.43	Net	1281.70		

Company EXCELCARE AUSTRALIA INC
ABN 84373882320

Pay Date 21/06/18

Employee Deon Lee Fleming 51562 *
Location BDB Employee Code FLEMD Pay Point OFFICE FLEMD

Company EXCELCARE AUSTRALIA INC ABN 84373882320
Employee Deon Lee Fleming

Pay Date 21/06/18
51562 *

Pay Details		Rate	$
Deon Lee Fleming	$241.97		
Superannuation	$88.41	9.50 %	
QSuper			
194824435			
Sal Sac - Meals & Ent $			-120.45
Credit to Sal Sac Acct			-735.62
Normal	39.2500	$21.2700/H	834.90
Km Allowance Before Tax	12.0000	$0.7800/U	9.36
Km Allowance Before Tax	8.2000	$0.7800/U	6.40
Km Allowance Before Tax	5.7000	$0.7800/U	4.45
Km Allowance Before Tax	1.8000	$0.7800/U	1.40
Km Allowance Before Tax	1.0000	$0.7800/U	0.78
Km Allowance Before Tax	9.2000	$0.7800/U	7.18
Km Allowance Before Tax	1.4000	$0.7800/U	1.09
Km Allowance Before Tax	3.6000	$0.7800/U	2.81
Km Allowance Before Tax	50.0000	$0.7800/U	39.00
Km Allowance Before Tax	1.4000	$0.7800/U	1.09
Km Allowance Before Tax	5.8000	$0.7800/U	4.52
Km Allowance Before Tax	7.7000	$0.7800/U	6.01
Km Allowance Before Tax	8.0000	$0.7800/U	6.24
Km Allowance Before Tax	4.6000	$0.7800/U	3.59
Km Allowance Before Tax	5.2000	$0.7800/U	4.06
Km Allowance Before Tax	4.5000	$0.7800/U	3.51
Km Allowance Before Tax	5.2000	$0.7800/U	4.06
Km Allowance Before Tax	6.7000	$0.7800/U	5.23
Km Allowance Before Tax	6.2000	$0.7800/U	4.84
Km Allowance Before Tax	5.1000	$0.7800/U	3.98
Sick Leave	4.5000	$21.2700/H	95.72
19/06/18			
Km Allowance Before Tax	42.0000	$0.7800/U	32.76
Km Allowance Before Tax	4.1000	$0.7800/U	3.20
Km Allowance Before Tax	2.5000	$0.7800/U	1.95
Km Allowance Before Tax	4.7000	$0.7800/U	3.67
Km Allowance Before Tax	8.0000	$0.7800/U	6.24
Personal Leave Ent:	42.0769 Hours		

Period 06/06/18 19/06/18

This Year		This Pay			
Gross	34223.58	Gross	1098.04	Net	241.97
Tax	3468.00	Tax	0.00	Bank	241.97
Net	29045.44	Net	241.97		

Company EXCELCARE AUSTRALIA INC
ABN 64573662320

Pay Date 21/06/18

Employee Deon Lee Fleming 51562 *
Location BDB Employee Code FLEMD Pay Point OFFICE FLEMD

Company EXCELCARE AUSTRALIA INC ABN 64573662320 Pay Date 21/06/18
Employee Deon Lee Fleming 51562 *

Pay Details		Rate	$
Annual Leave	Ent: 99.1499 Hours		

Period 06/06/18 19/06/18 Total hours this pay 43.7500

This Year		This Pay			
Gross	34223.58	Gross	1098.04	Net	241.97
Tax	3466.00	Tax	0.00	Bank	241.97
Net	29045.44	Net	241.97		

Company Livebetter Community Services
ABN 19160285612

Pay Date 05/07/18

Employee Deon Lee Fleming 51725 *
Location BDB Employee Code FLEMD Pay Point OFFICE FLEMD

Company Livebetter Community Services ABN 19160285612
Employee Deon Lee Fleming

Pay Date 05/07/18
51725 *

Pay Details		Rate	$
Normal	52.6701	$22.2400/H	1171.39
Km Allowance Before Tax	12.0000	$0.7800/U	9.36
Km Allowance Before Tax	8.2000	$0.7800/U	6.40
Km Allowance Before Tax	20.0000	$0.7800/U	15.60
Km Allowance Before Tax	50.0000	$0.7800/U	39.00
Km Allowance Before Tax	1.8000	$0.7800/U	1.40
Km Allowance Before Tax	11.0000	$0.7800/U	8.58
Km Allowance Before Tax	14.0000	$0.7800/U	10.92
Km Allowance Before Tax	5.7000	$0.7800/U	4.45
Km Allowance Before Tax	7.0000	$0.7800/U	5.46
Km Allowance Before Tax	2.6000	$0.7800/U	2.03
Km Allowance Before Tax	2.6000	$0.7800/U	2.03
Km Allowance Before Tax	12.0000	$0.7800/U	9.36
Km Allowance Before Tax	4.6000	$0.7800/U	3.59
Km Allowance Before Tax	4.6000	$0.7800/U	3.59
Km Allowance Before Tax	5.5000	$0.7800/U	4.29
Km Allowance Before Tax	8.0000	$0.7800/U	6.24
Km Allowance Before Tax	5.2000	$0.7800/U	4.06
Km Allowance Before Tax	8.2000	$0.7800/U	6.40
Km Allowance Before Tax	6.3000	$0.7800/U	4.91
Km Allowance Before Tax	20.0000	$0.7800/U	15.60
Km Allowance Before Tax	17.0000	$0.7800/U	13.26
Km Allowance Before Tax	44.0000	$0.7800/U	34.32
Km Allowance Before Tax	2.5000	$0.7800/U	1.95
Km Allowance Before Tax	2.5000	$0.7800/U	1.95
Km Allowance Before Tax	11.0000	$0.7800/U	8.58
Km Allowance Before Tax	19.0000	$0.7800/U	14.82
Km Allowance Before Tax	17.0000	$0.7800/U	13.26
Km Allowance Before Tax	12.0000	$0.7800/U	9.36
Km Allowance Before Tax	6.5000	$0.7800/U	5.07
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	5.4000	$0.7800/U	4.21
Km Allowance Before Tax	4.1000	$0.7800/U	3.20
Km Allowance Before Tax	62.0000	$0.7800/U	48.36
Km Allowance Before Tax	5.4000	$0.7800/U	4.21

Period 20/06/18 03/07/18

This Year		This Pay			
Gross	1528.88	Gross	1528.88	Net	672.81
Tax	0.00	Tax	0.00	Bank	672.81
Net	672.81	Net	672.81		

Company	Livebetter Community Services		Pay Date 05/07/18
	ABN 13160256512		
Employee	Deon Lee Fleming		51725 *
Location	BDB Employee Code FLEMD	Pay Point OFFICE	FLEMD

Company	Livebetter Community Services	ABN 13160256512	Pay Date 05/07/18
Employee	Deon Lee Fleming		51725 *

Pay Details			Rate	$
Km Allowance Before Tax		5.2000	$0.7800/U	4.06
Km Allowance Before Tax		7.5000	$0.7800/U	5.85
Km Allowance Before Tax		7.5000	$0.7800/U	5.85
Km Allowance Before Tax		4.5000	$0.7800/U	3.51
Km Allowance Before Tax		4.5000	$0.7800/U	3.51
Km Allowance Before Tax		1.0000	$0.7800/U	0.78
Km Allowance Before Tax		8.0000	$0.7800/U	6.24
Deon Lee Fleming		$672.81		
Superannuation		$111.28	9.50 %	
QSuper				
194824435				
Sal Sac - Meals & Ent $				-120.45
Credit to Sal Sac Acct				-735.62
Personal Leave	Ent:	44.0769 Hours		
Annual Leave	Ent:	103.1497 Hours		

Period	20/06/18	03/07/18		Total hours this pay	52.8701
This Year			This Pay		
Gross	1528.88		Gross	1528.88	Net 672.81
Tax	0.00		Tax	0.00	Bank 672.81
Net	672.81		Net	672.81	

Company Livebetter Community Services
ABN 13180259512

Pay Date 25/07/18

Employee Deon Lee Fleming 51938 *
Location BDB Employee Code FLEMD Pay Point OFFICE FLEMD

Company Livebetter Community Services ABN 13180259512 Pay Date 25/07/18
Employee Deon Lee Fleming 51938 *

Pay Details		Rate	$
Normal	44.5100	$22.2400/H	989.90
Km Allowance Before Tax	5.8000	$0.7800/U	4.52
Km Allowance Before Tax	5.4000	$0.7800/U	4.21
Km Allowance Before Tax	3.9000	$0.7800/U	3.04
Km Allowance Before Tax	2.3000	$0.7800/U	1.79
Km Allowance Before Tax	6.7000	$0.7800/U	5.23
Km Allowance Before Tax	5.1000	$0.7800/U	3.98
Km Allowance Before Tax	2.5000	$0.7800/U	1.95
Km Allowance Before Tax	2.5000	$0.7800/U	1.95
Km Allowance Before Tax	5.6000	$0.7800/U	4.37
Km Allowance Before Tax	5.6000	$0.7800/U	4.37
Km Allowance Before Tax	5.4000	$0.7800/U	4.21
Km Allowance Before Tax	37.0000	$0.7800/U	28.86
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	1.8000	$0.7800/U	1.40
Km Allowance Before Tax	7.2000	$0.7800/U	5.62
Km Allowance Before Tax	7.5000	$0.7800/U	5.85
Km Allowance Before Tax	7.5000	$0.7800/U	5.85
Km Allowance Before Tax	4.5000	$0.7800/U	3.51
Km Allowance Before Tax	8.0000	$0.7800/U	6.24
Km Allowance Before Tax	62.0000	$0.7800/U	48.36
Km Allowance Before Tax	12.0000	$0.7800/U	9.36
Km Allowance Before Tax	8.2000	$0.7800/U	6.40
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	2.7000	$0.7800/U	2.11
Km Allowance Before Tax	1.8000	$0.7800/U	1.40
Km Allowance Before Tax	3.9000	$0.7800/U	3.04
Km Allowance Before Tax	9.2000	$0.7800/U	7.18
Km Allowance Before Tax	10.6000	$0.7800/U	8.27
Km Allowance Before Tax	4.0000	$0.7800/U	3.12
Km Allowance Before Tax	2.1000	$0.7800/U	1.64
Km Allowance Before Tax	5.2000	$0.7800/U	4.06

Period 09/07/18 22/07/18

This Year

Gross	3043.38
Tax	0.00
Net	1015.62

This Pay

Gross	1197.48	Net	342.81
Tax	0.00	Bank	342.81
Net	342.81		

Company	Livebetter Community Services		Pay Date 25/07/18
	ABN 13160259612		
Employee	Deon Lee Fleming		51938
Location	BDB Employee Code FLEMD	Pay Point OFFICE	FLEMD

Company	Livebetter Community Services	ABN 13160259612	Pay Date 25/07/18
Employee	Deon Lee Fleming		51938

Pay Details			Rate	$
Backpay		1.0000	$6.3400/H	6.34
Back pay - rate change 01.07.18				
Deon Lee Fleming		$342.81		
Superannuation		$94.64	9.50 %	
QSuper				
194824435				
Sal Sac - Meals & Ent $				-120.45
Credit to Sal Sac Acct				-734.22
Personal Leave	Ent:	46.3481 Hours		
Annual Leave	Ent:	107.6880 Hours		

Period	09/07/18	22/07/18	Total hours this pay	45.5100

This Year		This Pay			
Gross	3043.38	Gross	1197.48	Net	342.81
Tax	0.00	Tax	0.00	Bank	342.81
Net	1015.62	Net	342.81		

Company Livebetter Community Services
ABN 13160259612

Pay Date 08/08/18

Employee Deon Lee Fleming
Location BDB Employee Code FLEMD Pay Point OFFICE

52062
FLEMD

Company Livebetter Community Services ABN 13160259612
Employee Deon Lee Fleming

Pay Date 08/08/18
52062

Pay Details		Rate	$
Normal	54.4299	$22.2400/H	1210.51
Km Allowance Before Tax	85.8000	$0.7800/U	66.92
Km Allowance Before Tax	5.8000	$0.7800/U	4.52
Km Allowance Before Tax	7.7000	$0.7800/U	6.01
Km Allowance Before Tax	7.2000	$0.7800/U	5.62
Km Allowance Before Tax	4.6000	$0.7800/U	3.59
Km Allowance Before Tax	2.6000	$0.7800/U	2.03
Km Allowance Before Tax	20.2000	$0.7800/U	15.76
Km Allowance Before Tax	5.1000	$0.7800/U	3.98
Km Allowance Before Tax	5.2000	$0.7800/U	4.06
Km Allowance Before Tax	2.5000	$0.7800/U	1.95
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	1.8000	$0.7800/U	1.40
Km Allowance Before Tax	7.2000	$0.7800/U	5.62
Km Allowance Before Tax	7.5000	$0.7800/U	5.85
Km Allowance Before Tax	7.5000	$0.7800/U	5.85
Km Allowance Before Tax	4.5000	$0.7800/U	3.51
Km Allowance Before Tax	8.0000	$0.7800/U	6.24
Km Allowance Before Tax	4.7000	$0.7800/U	3.67
Km Allowance Before Tax	8.2000	$0.7800/U	6.40
Km Allowance Before Tax	50.0000	$0.7800/U	39.00
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	4.2000	$0.7800/U	3.28
Km Allowance Before Tax	4.2000	$0.7800/U	3.28
Km Allowance Before Tax	2.7000	$0.7800/U	2.11
Km Allowance Before Tax	9.2000	$0.7800/U	7.18
Km Allowance Before Tax	4.0000	$0.7800/U	3.12
Km Allowance Before Tax	2.1000	$0.7800/U	1.64
Km Allowance Before Tax	40.0000	$0.7800/U	31.20
Saturday Rate	2.5001	$33.3600/H	83.40
Km Allowance Before Tax	13.0000	$0.7800/U	10.14
Km Allowance Before Tax	13.0000	$0.7800/U	10.14
Km Allowance Before Tax	13.0000	$0.7800/U	10.14

Period 23/07/18 05/08/18

This Year

Gross	4618.98
Tax	2.00
Net	1734.55

This Pay

Gross	1575.60	Net	718.93
Tax	2.00	Bank	718.93
Net	718.93		

Company	Livebetter Community Services ABN 13160259512		Pay Date 08/08/18
Employee	Deon Lee Fleming		52062 *
Location	BDB Employee Code FLEMD	Pay Point OFFICE	FLEMD

Company	Livebetter Community Services	ABN 13160259512	Pay Date 08/08/18
Employee	Deon Lee Fleming		52062 *

Pay Details			Rate	$
Deon Lee Fleming		$718.93		
Superannuation		$122.92	9.50 %	
QSuper 194824435				
Sal Sac - Meals & Ent $				-120.45
Credit to Sal Sac Acct				-734.22
Personal Leave	Ent:	48.5384 Hours		
Annual Leave	Ent:	112.0724 Hours		

Period	23/07/18	05/08/18	Total hours this pay	56.8300

This Year		This Pay			
Gross	4618.98	Gross	1575.60	Net	718.93
Tax	2.00	Tax	2.00	Bank	718.93
Net	1734.55	Net	718.93		

Company Livebetter Community Services
ABN 13160259512

Pay Date 11/07/18

Employee Deon Lee Fleming 51772
Location BDB Employee Code FLEMD Pay Point OFFICE FLEMD

Company Livebetter Community Services ABN 13160259512 Pay Date 11/07/18
Employee Deon Lee Fleming 51772

Pay Details			Rate	$
Normal		12.6700	$21.7400/H	275.45
Km Allowance Before Tax		13.0000	$0.7800/U	10.14
Km Allowance Before Tax		2.4000	$0.7800/U	1.87
Km Allowance Before Tax		2.7000	$0.7800/U	2.11
Km Allowance Before Tax		1.8000	$0.7800/U	1.40
Km Allowance Before Tax		12.5000	$0.7800/U	9.75
Km Allowance Before Tax		3.9000	$0.7800/U	3.04
Km Allowance Before Tax		9.2000	$0.7800/U	7.18
Km Allowance Before Tax		4.0000	$0.7800/U	3.12
Km Allowance Before Tax		3.8000	$0.7800/U	2.96
Superannuation		$26.17	9.50 %	
QSuper				
194824435				
Credit to Sal Sac Acct				-317.02
Personal Leave	Ent:	44.5769 Hours		
Annual Leave	Ent:	104.1497 Hours		

Period 26/06/18 08/07/18 **Total hours this pay** 12.6700

This Year		This Pay			
Gross	1845.90	Gross	317.02	Net	0.00
Tax	0.00	Tax	0.00		
Net	672.81	Net	0.00		

Company Livebetter Community Services
ABN 13160259612

Pay Date 22/08/18

Employee Deon Lee Fleming 52202 *
Location BDB Employee Code FLEMD Pay Point OFFICE FLEMD

Company Livebetter Community Services ABN 13160259612
Employee Deon Lee Fleming

Pay Date 22/08/18
52202 *

Pay Details		Rate	$
Normal	55.0901	$22.2400/H	1225.21
Km Allowance Before Tax	1.0000	$0.7800/U	0.78
Km Allowance Before Tax	5.8000	$0.7800/U	4.52
Km Allowance Before Tax	5.1000	$0.7800/U	3.98
Km Allowance Before Tax	4.6000	$0.7800/U	3.59
Km Allowance Before Tax	5.2000	$0.7800/U	4.06
Km Allowance Before Tax	4.1000	$0.7800/U	3.20
Km Allowance Before Tax	8.0000	$0.7800/U	6.24
Km Allowance Before Tax	5.2000	$0.7800/U	4.06
Km Allowance Before Tax	6.4000	$0.7800/U	4.99
Km Allowance Before Tax	5.1000	$0.7800/U	3.98
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	11.0000	$0.7800/U	8.58
Km Allowance Before Tax	20.0000	$0.7800/U	15.60
Km Allowance Before Tax	51.4000	$0.7800/U	40.09
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	3.9000	$0.7800/U	3.04
Km Allowance Before Tax	21.0000	$0.7800/U	16.38
Km Allowance Before Tax	7.8000	$0.7800/U	6.08
Km Allowance Before Tax	1.0000	$0.7800/U	0.78
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	1.8000	$0.7800/U	1.40
Km Allowance Before Tax	7.2000	$0.7800/U	5.62
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	7.5000	$0.7800/U	5.85
Km Allowance Before Tax	7.5000	$0.7800/U	5.85
Km Allowance Before Tax	4.5000	$0.7800/U	3.51
Km Allowance Before Tax	8.0000	$0.7800/U	6.24
Km Allowance Before Tax	8.9000	$0.7800/U	6.94
Km Allowance Before Tax	14.0000	$0.7800/U	10.92
Km Allowance Before Tax	50.0000	$0.7800/U	39.00
Km Allowance Before Tax	45.0000	$0.7800/U	35.10
Km Allowance Before Tax	3.0000	$0.7800/U	2.34
Km Allowance Before Tax	2.4000	$0.7800/U	1.87
Km Allowance Before Tax	2.7000	$0.7800/U	2.11

Period 06/08/18 19/08/18

This Year	
Gross	6162.11
Tax	2.00
Net	2423.01

This Pay			
Gross	1543.13	Net	688.46
Tax	0.00	Bank	688.46
Net	688.46		

Company Livebetter Community Services
ABN 13160269512

Pay Date
22/08/18

[redacted] 52202 *

Location BDB Employee Code FLEMD Pay Point OFFICE FLEMD

Company Livebetter Community Services ABN 13160269512
Employee Deon Lee Fleming

Pay Date
22/08/18
52202 *

Pay Details			Rate	$
Km Allowance Before Tax		1.8000	$0.7800/U	1.40
Km Allowance Before Tax		4.8000	$0.7800/U	3.74
Km Allowance Before Tax		9.2000	$0.7800/U	7.18
Km Allowance Before Tax		4.0000	$0.7800/U	3.12
Km Allowance Before Tax		2.1000	$0.7800/U	1.64
Km Allowance Before Tax		47.0000	$0.7800/U	36.66
Deon Lee Fleming		$688.46		
Superannuation		$116.39	9.50 %	
QSuper 194824435				
Sal Sac - Meals & Ent $				-120.45
Credit to Sal Sac Acct				-734.22
Personal Leave	Ent:	50.6538 Hours		
Annual Leave	Ent:	116.3030 Hours		

Period	06/08/18	19/08/18	Total hours this pay	55.0901

This Year		This Pay			
Gross	6162.11	Gross	1543.13	Net	688.46
Tax	2.00	Tax	0.00	Bank	688.46
Net	2423.01	Net	688.46		

Payment Advice

liveBetter

Fleming Deon Lee	**LiveBetter Services Ltd**
23 Latinic St	ABN No : 13160256512 Pers ID : 0812467
Bundaberg - 4670	PP Ending : 02.09.2018 Pay Date : 06.09.2018
	Working Hrs : 80.00

Payments	Retro	Number	Rate	Amount
Ordinary hours		41.92	22.84	932.80
Sick Leave		0.15	22.84	3.34
Travel MV perkm Allowance		182.12	0.78	142.06
Total Payments :				1,077.70

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	854.67
Total Deductions :				854.67

Contributions	Account Name	Account Number	Retro	Amount
Total Contributions :				

Net Pay : 223.03

Bank Number	Account Number	Payee	Amount
734-122	574997	D Fleming	223.03

Leave Quota	Remaining Balance	Time Units
Annual Leave	120.79	Hours
Sick Leave	52.75	Hours

Year-to-date Details	Amount
Total gross	1,077.70
Full Taxable Gross	80.97
Net payments/Deductions	- 854.67
Amount paid	223.03

Messages :

Payment Advice

live etter

Fleming Deon Lee	**LiveBetter Services Ltd**
23 Letinic St	ABN No : 13180258512 Pers ID : 0012467
Bundaberg - 4670	PP Ending : 30.09.2018 Pay Date : 04.10.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours		69.48	22.24	1,189.82
Travel MV perkm Allowance	X	259.2	0.78	202.18
Travel MV perkm Allowance		185.64	0.78	144.80
Total Payments :				1,536.60

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	854.67
Total Deductions :				- 854.67

Contributions	Account Name	Account Number	Retro	Amount
Total Contributions :				

Net Pay :

Net Pay : 681.93

Bank Number	Account Number	Payee	Amount
734-122	574697	D Fleming	681.93

Leave Quota	Remaining Balance	Time Units
Annual Leave	150.27	Hours
Sick Leave	47.04	Hours

Year-to-date Details	Amount
Total gross	4,461.10
Full Taxable Gross	1,142.98
Net payments/Deductions	- 2,564.01
Amount paid	1,917.09

Messages :

Payment Advice

liveBetter

Fleming Deon Lee	**LiveBetter Services Ltd**
23 Lelnic St	ABN No : 13160259512 Pers ID : 0012467
Bundaberg - 4670	PP Ending : 16.09.2018 Pay Date : 20.09.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Sick Leave	X	10.46	22.24	232.41
Ordinary hours		59.42	22.24	1,321.50
Travel MV perkm Allowance	X	133.48	0.78	104.11
Shift Penalty 50%		2.5	11.12	27.80
Travel MV perkm Allowance		232.02	0.78	180.98
Total Payments :				1,866.80

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	854.67
Total Deductions :				- 854.67

Contributions	Account Name	Account Number	Retro	Amount
Super - COF ER	QSUPER	.194824435		239.15
Total Contributions :				239.15

Net Pay :

Net Pay : **1,012.13**

Bank Number	Account Number	Payee	Amount
734-122	574697	D Fleming	1,012.13

Leave Quota	Remaining Balance	Time Units
Annual Leave	128.16	Hours
Sick Leave	44.98	Hours

Year-to-date Details	Amount
Total gross	2,944.50
Full Taxable Gross	809.01
Net payments/Deductions	- 1,709.34
Amount paid	1,235.16

Messages :

Payment Advice

live better

Fleming Deon Lee	**LiveBetter Services Ltd**
23 Letinic St	ABN No : 13160259512 Pers ID : 0012467
Bundaberg - 4670	PP Ending : 14.10.2016 Pay Date : 18.10.2016
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours		47.52	22.24	1,052.40
Travel MV perkm Allowance	X	258.94	0.78	201.97
Travel MV perkm Allowance		150.9	0.78	117.70
Total Payments :				1,372.07

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt				- 854.67
Total Deductions :				- 854.67

Contributions	Account Name	Account Number	Retro	Amount
Super - COF ER	QSUPER	194824435		212.99
Total Contributions :				212.99

Net Pay :

Net Pay : 517.40

Bank Number	Account Number	Payee	Amount
734-122	574697	D Fleming	517.40

Leave Quota	Remaining Balance	Time Units
Annual Leave	133.89	Hours
Sick Leave	48.86	Hours

Year-to-date Details	Amount
Total gross	5,853.17
Full Taxable Gross	1,340.69
Net payments/Deductions	- 3,418.68
Amount paid	2,434.49

Messages :

Payment Advice

liveBetter

Fleming Deon Lee	**LiveBetter Services Ltd**
23 Letinic St	ABN No : 13160259512 Pers ID : 0012467
Bundaberg - 4670	PP Ending : 28.10.2018 Pay Date : 01.11.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours		46.66	22.24	1,082.20
Travel MV perkm Allowance	X	167	0.78	130.26
Travel MV perkm Allowance		148.36	0.78	115.72
Total Payments :				1,328.18

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt				854.67
Total Deductions :				854.67

Contributions	Account Name	Account Number	Retro	Amount
Total Contributions :				

Net Pay :

Net Pay : 473.51

Bank Number	Account Number	Payee	Amount
734-122	574697	D Fleming	473.51

Leave Quota	Remaining Balance	Time Units
Annual Leave	137.63	Hours
Sick Leave	50.72	Hours

Year-to-date Details	Amount
Total gross	7,181.35
Full Taxable Gross	1,569.22
Net payments/Deductions	4,273.35
Amount paid	2,908.00

Messages :

Payment Advice

liveBetter

Fleming Deon Lee	**LiveBetter Services Ltd**
23 Letinic St	ABN No : 13160259512 Pers ID : 0012467
Bundaberg - 4670	PP Ending : 11.11.2018 Pay Date : 15.11.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Public Holiday Not Worked	X	8	22.24	183.44
Ordinary hours		57.49	22.24	1,278.58
Travel MV perkm Allowance	X	217.04	0.78	169.29
Shift Penalty 50%		2	11.12	22.24
Travel MV perkm Allowance		211.42	0.78	164.90
Total Payments :				1,768.45

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt				- 854.67
Total Deductions :				- 854.67

Contributions	Account Name	Account Number	Retro	Amount
Total Contributions :				

Net Pay :

Net Pay : 913.78

Bank Number	Account Number	Payee	Amount
734-122	574697	D Fleming	913.78

Leave Quota	Remaining Balance	Time Units
Annual Leave	142.51	Hours
Sick Leave	53.16	Hours

Year-to-date Details	Amount
Total gross	8,949.80
Full Taxable Gross	2,147.51
Net payments/Deductions	- 5,128.02
Amount paid	3,821.78

Messages :

Payment Advice

liveBetter

Fleming Deon Lee	**LiveBetter Services Ltd**
23 Letinic St	ABN No : 13160259512 Pers ID : 0012467
Bundaberg - 4670	PP Ending : 25.11.2018 Pay Date : 26.11.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours		49.91	22.24	1,110.00
Travel MV perkm Allowance	X	218.58	0.78	170.49
Travel MV perkm Allowance		152.96	0.78	119.31
Total Payments :				1,399.80

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	854.67
Ad Hoc Advance Payment			-	170.49
Total Deductions :				- 1,025.16

Contributions	Account Name	Account Number	Retro	Amount
Super - COF ER	QSUPER	194824435		344.51
Total Contributions :				344.51

Net Pay :

Net Pay : 374.64

Bank Number	Account Number	Payee	Amount
734-122	574697	D Fleming	374.64

Leave Quota	Remaining Balance	Time Units
Annual Leave	146.34	Hours
Sick Leave	55.07	Hours

Year-to-date Details	Amount
Total gross	10,349.89
Full Taxable Gross	2,403.14
Net payments/Deductions	- 6,153.18
Amount paid	4,196.42

Messages :

Payment Advice

live better

Fleming Deon Lee	**LiveBetter Services Ltd**
23 Lelinic St	ABN No : 13160259512 Pers ID : 0012467
Bundaberg - 4670	PP Ending : 09.12.2018 Pay Date : 13.12.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours		35.75	22.24	795.08
Annual Leave		3.32	22.24	73.84
Leave Loading		3.32	3.89	12.92
Compassionate Leave		4.5	22.24	100.08
Travel MV perkm Allowance	X	162.54	0.78	126.78
Travel MV perkm Allowance		114	0.78	88.92

Total Payments : 1,197.62

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	864.67
Ad Hoc Advance Payment			-	126.78

otal Deductions : 981.45

ontributions	Account Name	Account Number	Retro	Amount

tal Contributions :

t Pay :

t Pay : 216.17

k Number	Account Number	Payee	Amount
-122	574697	D Fleming	216.17

e Quota	Remaining Balance	Time Units
al Leave	148.38	Hours
Leave	56.74	Hours

o-date Details	Amount
gross	11,547.22
xable Gross	2,530.39
yments/Deductions	- 7,134.63
t paid	4,412.59

s :

BEFORE THE FAIR WORK COMMISSION

FOUR YEARLY REVIEW OF THE MODERN AWARDS

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

MATTER NO. 2018/26

Supplementary statement of Deon Fleming

I, Deon Fleming, of [redacted] in the state of Queensland say:

1. I am a member of United Voice and have been a member of my union since about 2016.

2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

3. I have previously provided a statement in relation to these proceedings, dated 16 January 2019.

4. My date of birth is [redacted].

Travel Time

5. I began working at Excelcare in around June 2017. For a short time while I worked at Excelcare, the time that it took me to travel between appointments with clients was considered time worked and I was paid for it. I was paid my normal hourly rate for this time. I am unsure how this time was calculated by the rostering team.

6. In or around July 2017, Excelcare became Livebetter and I stopped getting paid for the travel time. This means that I have lost roughly up to 4-5 hours of pay per week. It was noticeable to me when it stopped.

7. The travel that I do as part of my job is necessary in order to provide the services my clients require. I have no option whether I do this travel or not.

8. My position description, provided with my 16 January 2019 statement, states that it is a requirement of my role that I have a driver's licence. I use my own car to travel between the appointments.

[redacted]

Witness Signature

DEON FLEMING 28-3-19.

Witness Name (printed) Date:

BEFORE THE FAIR WORK COMMISSION

FOUR YEARLY REVIEW OF THE MODERN AWARDS

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

MATTER NO. 2018/26

Statement of Belinda Sinclair

I, Belinda Sinclair, [redacted], in the state of New South Wales say:

1. I am a member of United Voice and have been a member of my union since 2 May 2016.

2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. My date of birth is 11 March 1981.

4. I live in a share house with 3 unrelated adults.

Work History

5. I worked for three years as an environmental engineer for Jeffery and Katuakas, located in North Ryde.

6. I began working in home care in 2011. I initially worked with the Sister of St Joseph's Community Care, which became Catholic Community Care.

7. I started with Wesley Mission on 20th March 2017.

8. I hold a CHC30208 certificate 3 in aged care, which I have held since June 2013.

Current Work

9. I am employed by Wesley Mission as a part time home care worker. The *Social, Community, Home Care and Disability Services Industry Award 2010* ('the Award') applies to my work. I am a level 3 home care worker under the Award.

10. My contract guarantees me a minimum of 30 hours per fortnight. My duties predominantly involve home visits to assist elderly and disabled clients with cleaning, showering, dressing, medication prompting, transporting them to and from appointments and shopping for clients. Annexed and marked '**A**' is a copy of the written agreement with my current employer concerning my hours of work.

11. The hours that I am rostered for can vary greatly. Some weeks, I may be rostered for as little as 13 hours across the week and then other weeks I may be rostered for 21 hours per week. I work five days per week, Monday through to Friday.

The Impact of Broken Shifts

12. In my work, I am sometimes required to work a broken shift. On 9 February 2018, I sent an email to my supervisor about why we don't get paid travel time and kilometres travelled payment for broken shifts. I was informed that I am not undertaking duties during a broken shift and therefore I am not entitled to these allowances.

13. Since the middle of 2018, I have had only 1 broken shift scheduled. The rostering officer of my employer told me that they don't like putting broken shifts on our rosters. My workload is low some days with only 1 hour in the morning.

14. I produce at annexure marked '**B**' copies of my rosters for the period 3 December 2018 to 20 January 2019.

Mobile Phone Allowance

15. There are a number of different times or situations where I need to make phone calls on my mobile phone. I normally make two to eight calls each working week. This includes:

    - if the client doesn't open the door when I visit them,

- if there is traffic that is going to make me late,
- if the clients home phone/call alarm is not working,
- if the work email or tablet system is not working properly, and
- report a hazard/incident in line with Wesley Mission's policy and procedures.

16. I make these phone calls from my personal mobile phone. I am not provided with a phone by my employer to make these phone calls. My managers asked for my mobile phone number and routinely contact me and send work related material to my mobile phone. There appeared to be a presumption that I had a mobile phone and that I will make these work related phone calls from my personal phone. I am not reimbursed for the cost of making these phone calls or the cost required to maintain my personal phone to ensure I can make these phone calls. Wesley Mission also contacts me about roster changes and other workplace issues by sms on my mobile and I am required to reply and use my own device.

17. If the work tablet computer is not working, my employer will email my roster to me directly, so I am required to have access to a personal email account and the internet in order to check my roster. I rely on my mobile phone to check rostering when this happen. I am having problems about every month with the work tablet.

Uniforms

18. When I began with Wesley Mission, I was given two shirts to wear, identifying me as a Wesley Mission care worker. I am required to wear these shirts when I am working so as to be clearly identified as a Wesley Mission care worker by the clients. Some of the clients are elderly and have issues with dementia. My employer has a uniform policy that states we must wear the shirts when attending on clients.

19. When I only had 2 shirts, I had to wash them every day of employment, so one was ready to wear the next day. Working five days in a row meant I had to wash them at least three times per week. I asked one of the rostering staff and after six weeks of work and was given one more shirt.

20. I attempted to get more uniforms from my employer, but they didn't provide any initially. It took two emails and approximately two weeks for me to get an additional three shirts, a year and a half after I started.

21. An adequate number of uniforms would be a uniform for each day I work each week and a spare. This would allow me to wash my uniforms with my usual load of weekly washing each week and avoid daily or *ad hoc* washing.

Roster Changes

22. My roster can change without notice when another employee falls ill or is unable to work. I understand that Wesley Mission North at Macquarie Park uses a large number of external staff to meet the workload. If an external company can't meet the service, it is called a "push back" and my roster might change. If Wesley Mission cannot find a casual then they change the roster so that the client will not miss out on service by adding the service onto a permanent employee's roster.

23. My roster changed late in the afternoon on Friday 7 December 2018 afternoon. I don't know why. Two other care worker's clients were on my roster. I wasn't asked if I was able to or would like to do these shifts. I did not agree to the roster changes. I was required to make the following changes to my roster:

Day	Before roster change	After roster change
Monday	8.00 am – 2.10 pm	8.50 am – 2.10 pm
Tuesday	8.00 am - 10.30 am	8.00 am – 1.00 pm
Wednesday	8.00 am – 10.20 am	8.00 am – 1.00 pm
Thursday	10.00 am – 3.15 pm	8.25 am – 3.15 pm
Friday	8.00 am – 10:40 am	8.00 am – 12:10 pm

24. On, Wednesday 12 December 2018, I was asked if I could move my Health Safety Representative hour in the office to that day so I could do an additional shift on Friday, going shopping with a client. This meant I would finish my day ten minutes after my agreed availability, so I was able to decline the request. I had another commitment at 3.00 pm. I suggested that I might be able to help provided the shift finished by 2.45 pm. My Friday then changed to 7.50 am to 2.45 pm.

25. My employer is constantly making changes to my roster and these changes make it difficult for me to plan things for when I am not rostered or to make a weekly budget, despite that I am a permanent employee, not a casual.

26. I agree to changes in my roster because I need the hours and am concerned that if I complain or don't accept additional hours, I will be rostered less. This is not an accusation against my employer but my concern. I have a tight budget and cannot afford to lose hours.

Income and expenses

27. I am paid an hourly rate.

28. On average I earn a gross weekly amount of $600 for work. Attached to this statement and marked **Annexure 'C'** are copies of my pay slips for the period 2 July 2018 to 30 December 2018.

29. My average weekly expenses (excluding entertainment and savings) are approximately $533.00, comprised of:

Rent, household bills, course fees for Certificate IV in Work Health and Safety and groceries	$385.00
Car expenses, including registration and petrol:	$100.00
Other expenses: mobile phone bill, health insurance.	$48.00
Total:	**$533.00**

Witness Signature

[redacted]

Witness Name (printed) Date:

Belinda Sinclair 16/1/19

'A'

Wesley Dalmar Centre
3 Dalmar Place
Carlingford NSW 2118
PO Box 2446
Carlingford NSW 2118

PH. (02) 9857 2500
FAX. (02) 9857 2667
WEB. WWW.WESLEYMISSION.ORG.AU

TO Belinda Sinclair

FROM Samip Patel, Service Team Leader, Wesley Home & Residential Care

DATE 24/09/2018

REF Hours of work update

Dear Belinda,

As discussed, this memo is to confirm an update in the hours of work in your position of Support Worker, Wesley Home & Residential Care, effective from 24/09/2018.

Hours of work

Your ordinary hours of work each fortnight shall be 80 hours

Your work schedule shall be as follows:

Monday:	6:00 am – 2:30 pm
Tuesday:	6:00 am – 3:00 pm
Wednesday:	6:00 am – 2:30 pm
Thursday:	6:00 am – 6:00 pm
Friday:	6:00 am – 2:30 pm

In your position, you may be required to work in addition to your ordinary hours from time to time. Changes in hours may be made by agreement in writing between the employer and employee.

All other conditions remain unchanged in accordance with your most recent letter of offer/transfer.

Would you please signify your acceptance of this offer by signing where indicated below and returning the original to me.

You acknowledge that, prior to entering into this agreement, you:

- Have had sufficient time to review the contents of this agreement and understand its effect, and
- Have not been placed under any undue pressure to enter into this agreement.

Yours sincerely,

Samip Patel
Service Team Leader

Acceptance of Memo

I have read, understood and accept the terms and conditions of employment contained in this memo.

Signed: B Sinclair Date: 21/9/18

'B'

Belinda Sinclair
5 Angophora Crescent
FORESTVILLE, NSW, 2087

Pay Period : 02/07/2018 To 15/07/2018
Payment Date : 18/07/2018

Employee : 0035254
Pay Entity : Wesley Community Services
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	54.75	22.71316	1,243.56
Personal Leave	2.67	22.71316	60.64
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	265.70	0.78000	207.25
Laundry Allowance	9.00	0.32000	2.88
Laundry Allowance			0.10
RET Ordinary Hours	0.50		10.98

TOTALS	PERIOD	YTD
Gross pay (A):	1,537.71	2,864.12
BTAX Deductions	**Period**	**YTD**
SP Admin Fee	3.84	7.68
SP Advantage	611.50	1,223.00
SP Fee for Advantage	7.70	15.40
Total (B):	623.04	
All Taxes	**Period**	**YTD**
Marginal Tax	42.00	42.00
HELP Amount	86.00	172.00
RET Marginal Tax	2.00	2.00
Total (C):	130.00	
All Employer-Paid Benefits	**Period**	**YTD**
CBUS	127.43	239.29
Net Pay (A-(B+C)):	784.67	

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	74.93	ADO	0.00	PER	22.34

Net Pay Distribution

Bank Account Number	Amount
CBA 10008179	784.67
Total:	784.67

Belinda Sinclair
5 Angophora Crecent
FORESTVILLE, NSW, 2087

Pay Period : 16/07/2018 To 29/07/2018
Payment Date : 01/08/2018

Employee : 0035254
Pay Entity : Wesley Community Services
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	51.08	22.71316	1,160.27
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	254.00	0.78000	198.12
Laundry Allowance	8.00	0.32000	2.56
Laundry Allowance			0.42

TOTALS	PERIOD	YTD
Gross pay (A):	1,373.67	4,245.35

BTAX Deductions	Period	YTD
SP Admin Fee	3.84	11.52
SP Advantage	611.50	1,834.50
SP Fee for Advantage	7.70	23.10
Total (B):	623.04	

All Taxes	Period	YTD
Marginal Tax	8.00	50.00
RET Marginal Tax		2.00
HELP Amount	86.00	258.00
Total (C):	94.00	

All Employer-Paid Benefits	Period	YTD
CBUS	111.68	350.97

Net Pay (A-(B+C)): 656.63

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	78.86	ADO	0.00	PER	24.31

Net Pay Distribution

Bank Account Number		Amount
CBA 10008179		656.63
	Total:	656.63

Belinda Sinclair
5 Angophora Crecent
FORESTVILLE, NSW, 2087

Pay Period : 30/07/2018 To 12/08/2018
Payment Date : 15/08/2018

Employee : 0035254
Pay Entity : Wesley Community Services
Department : ECP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	54.67	22.71316	1,241.66
Overtime 0.5	1.00	22.71316	11.36
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	304.00	0.78000	237.12
Laundry Allowance			2.98
RET Ordinary Hours	0.50		10.97
RET Kilometre Reimbursement	30.30		23.63
RET PH Work 150%	0.50		16.46

TOTALS	PERIOD	YTD
Gross pay (A):	1,556.48	5,794.27

BTAX Deductions	Period	YTD
SP Admin Fee	3.84	15.36
SP Advantage	611.50	2,446.00
SP Fee for Advantage	7.70	30.80
Total (B):	623.04	

All Taxes	Period	YTD
Marginal Tax	36.00	86.00
HELP Amount	86.00	344.00
RET Marginal Tax	16.00	18.00
Total (C):	138.00	

All Employer-Paid Benefits	Period	YTD
CBUS	124.62	475.59

Net Pay (A-(B+C)): 795.44

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	83.10	ADO	0.00	PER	26.43

Net Pay Distribution

Bank Account Number		Amount
CBA 10008179		795.44
	Total:	795.44

Belinda Sinclair
5 Angophora Crecent
FORESTVILLE, NSW, 2087

Pay Period : 13/08/2018 To 26/08/2018
Payment Date : 29/08/2018

Employee : 0035254
Pay Entity : Wesley Community Services Ltd
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	37.68	22.71316	855.91
Personal Leave	6.50	22.71316	147.64
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	144.00	0.78000	112.32
Laundry Allowance	9.00	0.32000	2.88

TOTALS	PERIOD	YTD
Gross pay (A):	1,131.05	6,925.32

BTAX Deductions	Period	YTD
SP Admin Fee	3.84	19.20
SP Advantage	611.50	3,057.50
SP Fee for Advantage	7.70	38.50
Total (B):	623.04	

All Taxes	Period	YTD
Marginal Tax		86.00
HELP Amount	86.00	430.00
RET Marginal Tax		18.00
Total (C):	86.00	

All Employer-Paid Benefits	Period	YTD
CBUS	96.78	572.37

Net Pay (A-(B+C)): 422.01

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	86.50	ADO	0.00	PER	21.63

Net Pay Distribution

Bank Account Number		Amount
CBA 10008179		422.01
	Total:	422.01

Belinda Sinclair
5 Angophora Crecent
FORESTVILLE, NSW, 2087

Pay Period : 27/08/2018 To 09/09/2018
Payment Date : 12/09/2018

Employee : 0035254
Pay Entity : Wesley Community Services Ltd
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	44.42	22.71316	1,008.85
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	181.00	0.78000	141.18
Laundry Allowance	8.00	0.32000	2.56
Laundry Allowance			0.42

TOTALS	PERIOD	YTD
Gross pay (A):	1,165.31	8,090.63

BTAX Deductions	Period	YTD
SP Admin Fee	3.84	23.04
SP Advantage	611.50	3,669.00
SP Fee for Advantage	7.70	46.20
Total (B):	623.04	

All Taxes	Period	YTD
Marginal Tax		86.00
HELP Amount	86.00	516.00
RET Marginal Tax		18.00
Total (C):	86.00	

All Employer-Paid Benefits	Period	YTD
CBUS	97.29	669.66

Net Pay (A-(B+C)): 456.27

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	89.92	ADO	0.00	PER	23.34

Net Pay Distribution

Bank Account Number	Amount
CBA 10008179	456.27
Total:	456.27

Belinda Sinclair
5 Angophora Crecent
FORESTVILLE, NSW, 2087

Pay Period : 10/09/2018 To 23/09/2018
Payment Date : 26/09/2018

Employee : 0035254
Pay Entity : Wesley Community Services Ltd
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	50.33	22.71316	1,143.23
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	225.50	0.78000	175.89
Laundry Allowance	8.00	0.32000	2.56
Laundry Allowance			0.42

TOTALS	PERIOD	YTD
Gross pay (A):	1,334.40	9,425.03

BTAX Deductions	Period	YTD
SP Admin Fee	3.84	26.88
SP Advantage	611.50	4,280.50
SP Fee for Advantage	7.70	53.90
Total (B):	623.04	

All Taxes	Period	YTD
Marginal Tax		86.00
HELP Amount	86.00	602.00
RET Marginal Tax		18.00
Total (C):	86.00	

All Employer-Paid Benefits	Period	YTD
CBUS	110.06	779.72

Net Pay (A-(B+C)): 625.36

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	93.79	ADO	0.00	PER	25.27

Net Pay Distribution

Bank Account Number		Amount
CBA 10008179		625.36
	Total:	625.36

Belinda Sinclair
5 Angophora Crescent
FORESTVILLE, NSW, 2087

Pay Period : 24/09/2018 To 07/10/2018
Payment Date : 10/10/2018

Employee : 0035254
Pay Entity : Wesley Community Services Ltd
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	30.58	22.71316	694.65
PH Worked 150%	3.75	22.71316	127.76
Annual Leave	4.17	22.71316	94.64
Leave Loading	4.17	22.71316	16.56
Personal Leave	6.50	22.71316	147.64
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	166.00	0.78000	129.48
Laundry Allowance	8.00	0.32000	2.56

TOTALS	PERIOD	YTD
Gross pay (A):	1,225.59	10,650.62

BTAX Deductions	Period	YTD
SP Admin Fee	3.84	30.72
SP Advantage	611.50	4,892.00
SP Fee for Advantage	7.70	61.60
Total (B):	623.04	

All Taxes	Period	YTD
Marginal Tax		86.00
HELP Amount	86.00	688.00
RET Marginal Tax		18.00
Total (C):	86.00	

All Employer-Paid Benefits	Period	YTD
CBUS	104.13	883.85

Net Pay (A-(B+C)): 516.55

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	92.80	ADO	0.00	PER	20.36

Net Pay Distribution

Bank Account Number	Amount
CBA 10008179	516.55
Total:	516.55

Belinda Sinclair
5 Angophora Crecent
FORESTVILLE, NSW, 2087

Pay Period : 08/10/2018 To 21/10/2018
Payment Date : 24/10/2018

Employee : 0035254
Pay Entity : Wesley Community Services Ltd
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	52.25	22.71316	1,186.76
Overtime 0.5	1.50	22.71316	17.03
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	312.20	0.78000	243.52
Laundry Allowance			2.98

TOTALS	PERIOD	YTD
Gross pay (A):	1,462.59	12,113.21

BTAX Deductions	Period	YTD
SP Admin Fee	3.84	34.56
SP Advantage	611.50	5,503.50
SP Fee for Advantage	7.70	69.30
Total (B):	623.04	

All Taxes	Period	YTD
Marginal Tax	24.00	110.00
RET Marginal Tax		18.00
HELP Amount	86.00	774.00
Total (C):	110.00	

All Employer-Paid Benefits	Period	YTD
CBUS	114.19	998.04

Net Pay (A-(B+C)): 729.55

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	96.82	ADO	0.00	PER	22.37

Net Pay Distribution

Bank Account Number	Amount
CBA 10008179	729.55
Total:	729.55

Belinda Sinclair
5 Angophora Crescent
FORESTVILLE, NSW, 2087

Pay Period : 22/10/2018 To 04/11/2018
Payment Date : 07/11/2018

Employee : 0035254
Pay Entity : Wesley Community Services Ltd
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	39.42	22.71316	895.28
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	167.00	0.78000	130.26
Laundry Allowance	8.00	0.32000	2.56
Laundry Allowance			0.42

TOTALS	PERIOD	YTD
Gross pay (A):	1,040.82	13,154.03

BTAX Deductions	Period	YTD
SP Admin Fee	3.84	38.40
SP Advantage	611.50	6,115.00
SP Fee for Advantage	7.70	77.00
Total (B):	623.04	

All Taxes	Period	YTD
Marginal Tax		110.00
HELP Amount	86.00	860.00
RET Marginal Tax		18.00
Total (C):	86.00	

All Employer-Paid Benefits	Period	YTD
CBUS	86.50	1,084.54

Net Pay (A-(B+C)): 331.78

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	99.85	ADO	0.00	PER	23.89

Net Pay Distribution

Bank Account Number		Amount
CBA 10008179		331.78
	Total:	331.78

Belinda Sinclair
5 Angophora Crecent
FORESTVILLE, NSW, 2087

Pay Period : 05/11/2018 To 18/11/2018
Payment Date : 21/11/2018

Employee : 0035254
Pay Entity : Wesley Community Services Ltd
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	35.67	22.71316	810.10
Personal Leave	1.50	22.71316	34.07
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	134.00	0.78000	104.52
Laundry Allowance	9.00	0.32000	2.88
Laundry Allowance			0.10

TOTALS	PERIOD	YTD
Gross pay (A):	963.97	14,118.00

BTAX Deductions	Period	YTD
SP Admin Fee	3.84	42.24
SP Advantage	611.50	6,726.50
SP Fee for Advantage	7.70	84.70
Total (B):	623.04	

All Taxes	Period	YTD
Marginal Tax		110.00
HELP Amount	86.00	946.00
RET Marginal Tax		18.00
Total (C):	86.00	

All Employer-Paid Benefits	Period	YTD
CBUS	81.65	1,166.19

Net Pay (A-(B+C)): 254.93

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	102.75	ADO	0.00	PER	23.83

Net Pay Distribution

Bank Account Number	Amount
CBA 10008179	254.93
Total:	254.93

Belinda Sinclair
5 Angophora Crescent
FORESTVILLE, NSW, 2087

Pay Period : 19/11/2018 To 02/12/2018
Payment Date : 05/12/2018

Employee : 0035254
Pay Entity : Wesley Community Services Ltd
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	30.33	22.71316	688.97
Personal Leave	10.42	22.71316	236.60
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	149.00	0.78000	116.22
Laundry Allowance	8.00	0.32000	2.56

TOTALS	PERIOD	YTD
Gross pay (A):	1,056.65	15,174.65
BTAX Deductions	**Period**	**YTD**
SP Admin Fee	3.84	46.08
SP Advantage	611.50	7,338.00
SP Fee for Advantage	7.70	92.40
Total (B):	623.04	
All Taxes	**Period**	**YTD**
Marginal Tax		110.00
HELP Amount	86.00	1,032.00
RET Marginal Tax		18.00
Total (C):	86.00	
All Employer-Paid Benefits	**Period**	**YTD**
CBUS	89.34	1,255.53
Net Pay (A-(B+C)):	347.61	

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	105.88	ADO	0.00	PER	14.98

Net Pay Distribution

Bank Account Number		Amount
CBA 10008179		347.61
	Total:	347.61

Belinda Sinclair
5 Angophora Crecent
FORESTVILLE, NSW, 2087

Pay Period : 03/12/2018 To 16/12/2018
Payment Date : 19/12/2018

Employee : 0035254
Pay Entity : Wesley Community Services Ltd
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	51.42	22.71316	1,167.83
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	344.00	0.78000	268.32
Laundry Allowance			2.98

TOTALS	PERIOD	YTD
Gross pay (A):	1,451.43	16,626.08

BTAX Deductions	Period	YTD
SP Admin Fee	3.84	49.92
SP Advantage	611.50	7,949.50
SP Fee for Advantage	7.70	100.10
Total (B):	623.04	

All Taxes	Period	YTD
Marginal Tax	22.00	132.00
RET Marginal Tax		18.00
HELP Amount	86.00	1,118.00
Total (C):	108.00	

All Employer-Paid Benefits	Period	YTD
CBUS	112.40	1,367.93

Net Pay (A-(B+C)): 720.39

LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	109.84	ADO	0.00	PER	16.96

Net Pay Distribution

Bank Account Number		Amount
CBA 10008179		720.39
	Total:	720.39

Belinda Sinclair
5 Angophora Crescent
FORESTVILLE, NSW, 2087

Pay Period : 17/12/2018 To 30/12/2018
Payment Date : 02/01/2019

Employee : 0035254
Pay Entity : Wesley Community Services Ltd
Department : HCP - Northern Sydney
Location : MACQUARIE PARK 64 Talavera Rd
Pay Rate : 681.39 (Biweekly)
Job Description : Support Worker
Company : Wesley Community Services
ABN : 42164655145

EARNINGS

Description	Units/Hrs	Rate	Amount
Ordinary Hours	46.75	22.71316	1,061.83
PH Worked 150%	2.50	22.71316	85.17
PH Not Worked	2.33	22.71316	53.00
Uniform Allowance	10.00	1.23000	12.30
Kilometre Reimbursement	268.10	0.78000	209.12
Laundry Allowance	9.00	0.32000	2.88

TOTALS	PERIOD	YTD
Gross pay (A):	1,424.30	18,050.38

BTAX Deductions	Period	YTD
SP Admin Fee	3.84	53.76
SP Advantage	611.50	8,561.00
SP Fee for Advantage	7.70	107.80
Total (B):	623.04	

All Taxes	Period	YTD
Marginal Tax	18.00	150.00
RET Marginal Tax		18.00
HELP Amount	86.00	1,204.00
Total (C):	104.00	

All Employer-Paid Benefits	Period	YTD
CEUS	115.44	1,483.37

Net Pay (A-(B+C)): 697.26

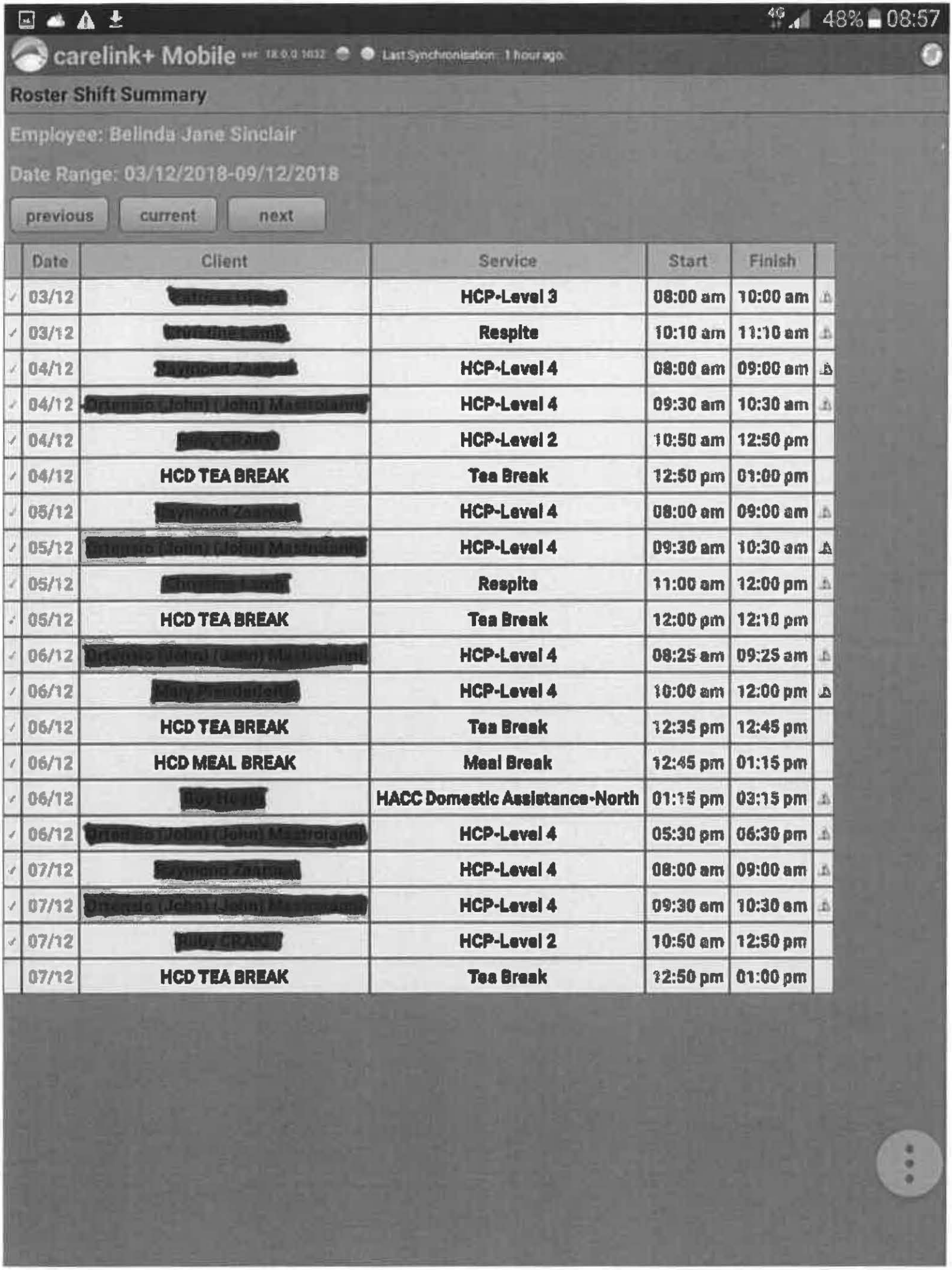
LEAVE BALANCES

	Hrs		Hrs		Hrs
ANN	113.61	ADO	0.00	PER	18.85

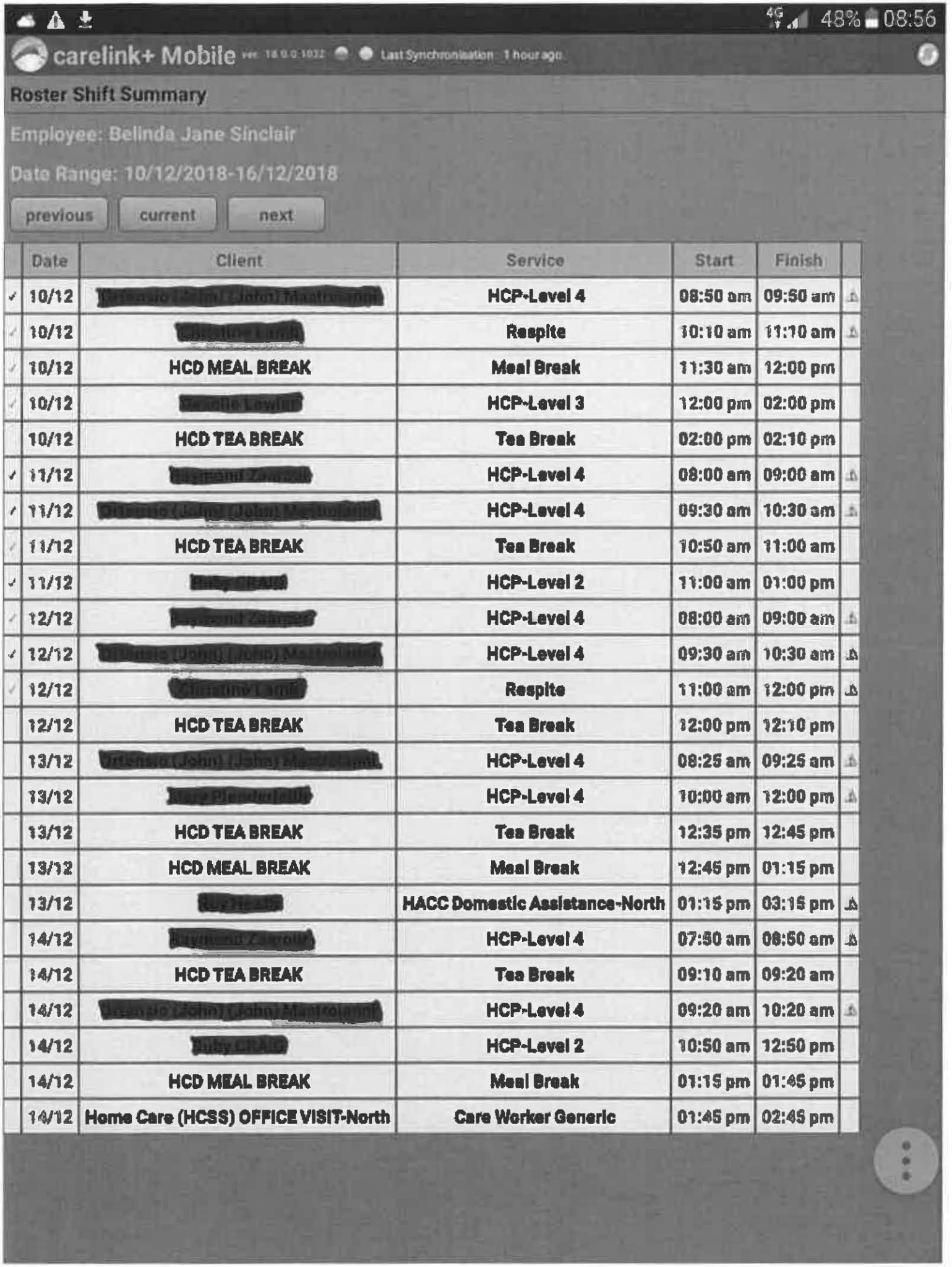
Net Pay Distribution

Bank	Account Number	Amount
CBA	10008179	697.26
	Total:	697.26

'C'



	Date	Client	Service	Start	Finish	
✓	03/12	[redacted]	HCP-Level 3	08:00 am	10:00 am	⚠
✓	03/12	[redacted]	Respite	10:10 am	11:10 am	⚠
✓	04/12	[redacted]	HCP-Level 4	08:00 am	09:00 am	⚠
✓	04/12	[redacted]	HCP-Level 4	09:30 am	10:30 am	⚠
✓	04/12	[redacted]	HCP-Level 2	10:50 am	12:50 pm	
✓	04/12	HCD TEA BREAK	Tea Break	12:50 pm	01:00 pm	
✓	05/12	[redacted]	HCP-Level 4	08:00 am	09:00 am	⚠
✓	05/12	[redacted]	HCP-Level 4	09:30 am	10:30 am	⚠
✓	05/12	[redacted]	Respite	11:00 am	12:00 pm	⚠
✓	05/12	HCD TEA BREAK	Tea Break	12:00 pm	12:10 pm	
✓	06/12	[redacted]	HCP-Level 4	08:25 am	09:25 am	⚠
✓	06/12	[redacted]	HCP-Level 4	10:00 am	12:00 pm	⚠
✓	06/12	HCD TEA BREAK	Tea Break	12:35 pm	12:45 pm	
✓	06/12	HCD MEAL BREAK	Meal Break	12:45 pm	01:15 pm	
✓	06/12	[redacted]	HACC Domestic Assistance-North	01:15 pm	03:15 pm	⚠
✓	06/12	[redacted]	HCP-Level 4	05:30 pm	06:30 pm	⚠
✓	07/12	[redacted]	HCP-Level 4	08:00 am	09:00 am	⚠
✓	07/12	[redacted]	HCP-Level 4	09:30 am	10:30 am	⚠
✓	07/12	[redacted]	HCP-Level 2	10:50 am	12:50 pm	
	07/12	HCD TEA BREAK	Tea Break	12:50 pm	01:00 pm	



	Date	Client	Service	Start	Finish	
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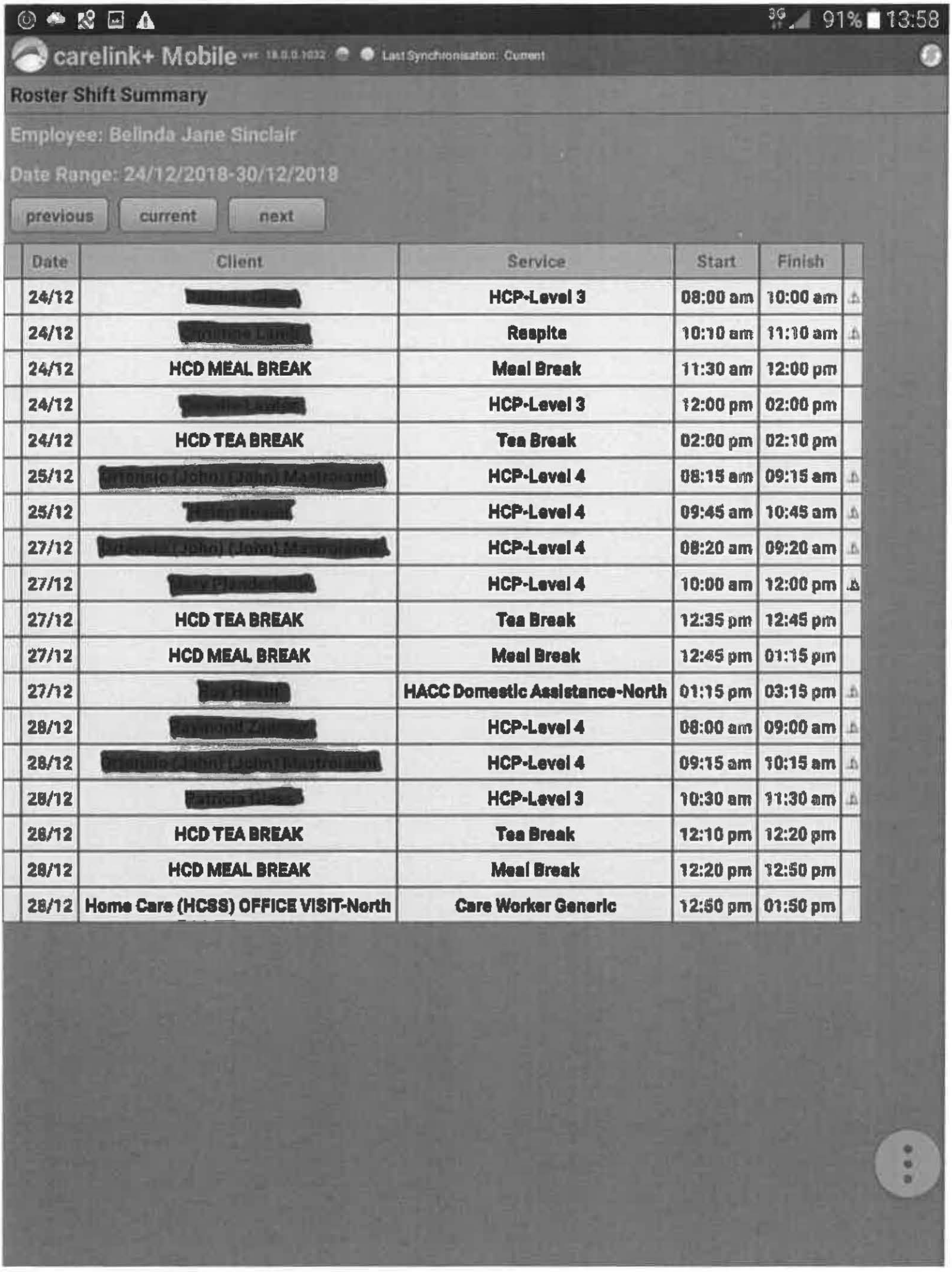
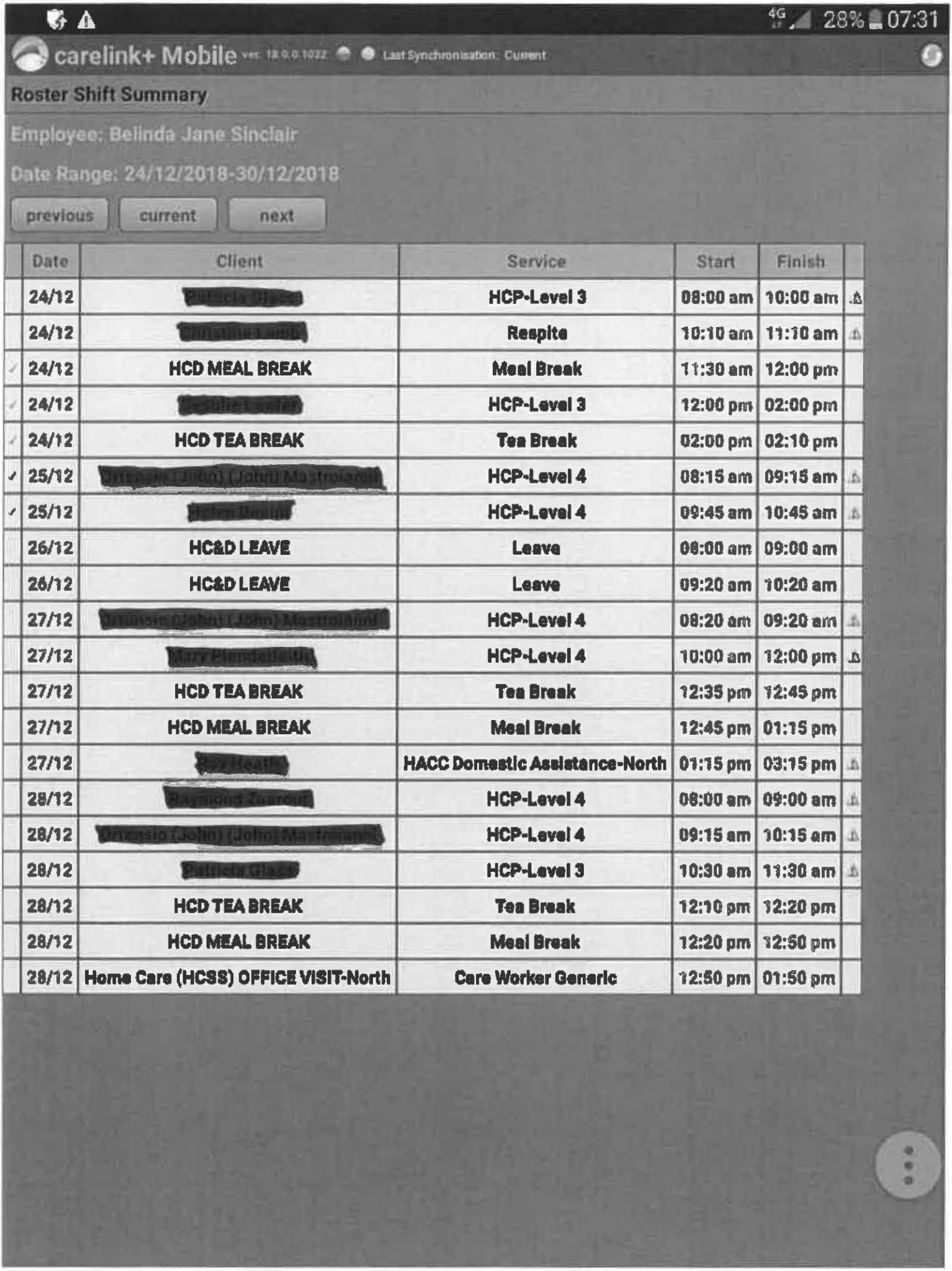
✓	10/12	[redacted]	Respite	10:10 am	11:10 am	⚠
✓	10/12	HCD MEAL BREAK	Meal Break	11:30 am	12:00 pm	
✓	10/12	[redacted]	HCP-Level 3	12:00 pm	02:00 pm	
	10/12	HCD TEA BREAK	Tea Break	02:00 pm	02:10 pm	
✓	11/12	[redacted]	HCP-Level 4	08:00 am	09:00 am	⚠
✓	11/12	[redacted]	HCP-Level 4	09:30 am	10:30 am	⚠
✓	11/12	HCD TEA BREAK	Tea Break	10:50 am	11:00 am	
✓	11/12	[redacted]	HCP-Level 2	11:00 am	01:00 pm	
✓	12/12	[redacted]	HCP-Level 4	08:00 am	09:00 am	⚠
✓	12/12	[redacted]	HCP-Level 4	09:30 am	10:30 am	⚠
✓	12/12	[redacted]	Respite	11:00 am	12:00 pm	⚠
	12/12	HCD TEA BREAK	Tea Break	12:00 pm	12:10 pm	
	13/12	[redacted]	HCP-Level 4	08:25 am	09:25 am	⚠
	13/12	[redacted]	HCP-Level 4	10:00 am	12:00 pm	⚠
	13/12	HCD TEA BREAK	Tea Break	12:35 pm	12:45 pm	
	13/12	HCD MEAL BREAK	Meal Break	12:45 pm	01:15 pm	
	13/12	[redacted]	HACC Domestic Assistance-North	01:15 pm	03:15 pm	⚠
	14/12	[redacted]	HCP-Level 4	07:50 am	08:50 am	⚠
	14/12	HCD TEA BREAK	Tea Break	09:10 am	09:20 am	
	14/12	[redacted]	HCP-Level 4	09:20 am	10:20 am	⚠
	14/12	[redacted]	HCP-Level 2	10:50 am	12:50 pm	
	14/12	HCD MEAL BREAK	Meal Break	01:15 pm	01:45 pm	
	14/12	Home Care (HCSS) OFFICE VISIT-North	Care Worker Generic	01:45 pm	02:45 pm	

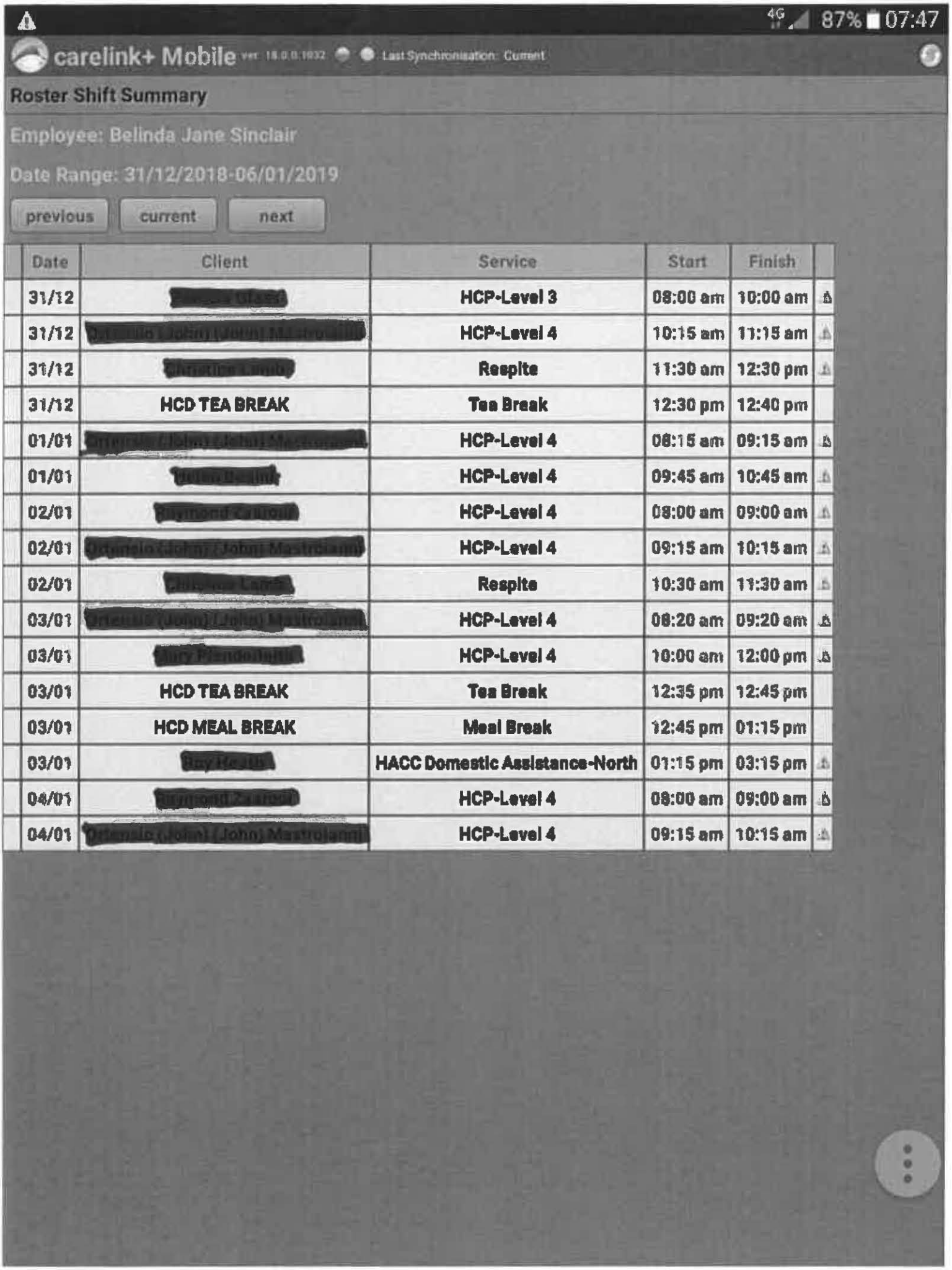
	Date	Client	Service	Start	Finish	
✓	17/12	[redacted]	HCP-Level 3	08:00 am	10:00 am	⚠
✓	17/12	[redacted]	HCP-Level 4	10:10 am	11:10 am	⚠
✓	17/12	[redacted]	HCP-Level 2	11:30 am	01:00 pm	⚠
✓	17/12	HCD TEA BREAK	Tea Break	01:00 pm	01:10 pm	
✓	18/12	[redacted]	HCP-Level 4	08:00 am	09:00 am	⚠
✓	18/12	[redacted]	HCP-Level 4	09:20 am	10:20 am	⚠
✓	18/12	HCD TEA BREAK	Tea Break	10:40 am	10:50 am	
✓	18/12	[redacted]	HCP-Level 2	10:50 am	12:50 pm	
	19/12	[redacted]	HCP-Level 4	08:00 am	09:00 am	⚠
	19/12	[redacted]	HCP-Level 4	09:20 am	10:20 am	⚠
	19/12	HCD TEA BREAK	Tea Break	10:35 am	10:45 am	
	19/12	[redacted]	Respite	10:45 am	11:45 am	⚠
	19/12	Home Care (HCSS) OFFICE VISIT-North	Care Worker Generic	02:30 pm	04:00 pm	
	20/12	[redacted]	HCP-Level 4	08:25 am	09:25 am	⚠
	20/12	[redacted]	HCP-Level 4	10:00 am	12:00 pm	⚠
	20/12	HCD TEA BREAK	Tea Break	12:35 pm	12:45 pm	
	20/12	HCD MEAL BREAK	Meal Break	12:45 pm	01:15 pm	
	20/12	[redacted]	HACC Domestic Assistance-North	01:15 pm	03:15 pm	⚠
	21/12	[redacted]	HCP-Level 4	08:00 am	09:00 am	⚠
	21/12	[redacted]	HCP-Level 4	09:15 am	10:15 am	⚠



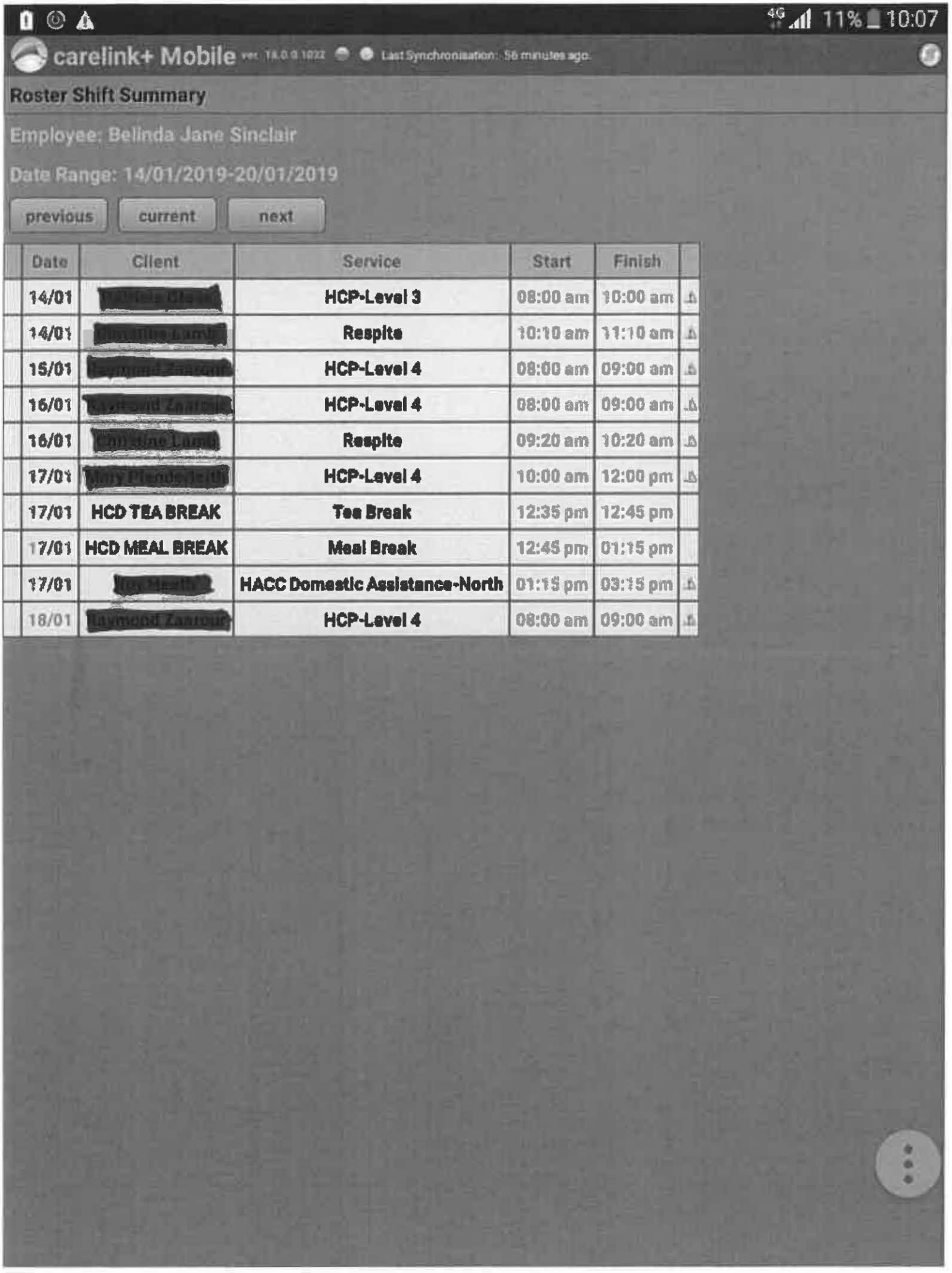
Date	Client	Service	Start	Finish	
24/12	[redacted]	HCP-Level 3	08:00 am	10:00 am	⚠
24/12	[redacted]	Respite	10:10 am	11:10 am	⚠
24/12	HCD MEAL BREAK	Meal Break	11:30 am	12:00 pm	
24/12	[redacted]	HCP-Level 3	12:00 pm	02:00 pm	
24/12	HCD TEA BREAK	Tea Break	02:00 pm	02:10 pm	
25/12	[redacted]	HCP-Level 4	08:15 am	09:15 am	⚠
25/12	[redacted]	HCP-Level 4	09:45 am	10:45 am	⚠
27/12	[redacted]	HCP-Level 4	08:20 am	09:20 am	⚠
27/12	[redacted]	HCP-Level 4	10:00 am	12:00 pm	⚠
27/12	HCD TEA BREAK	Tea Break	12:35 pm	12:45 pm	
27/12	HCD MEAL BREAK	Meal Break	12:45 pm	01:15 pm	
27/12	[redacted]	HACC Domestic Assistance-North	01:15 pm	03:15 pm	⚠
28/12	[redacted]	HCP-Level 4	08:00 am	09:00 am	⚠
28/12	[redacted]	HCP-Level 4	09:15 am	10:15 am	⚠
28/12	[redacted]	HCP-Level 3	10:30 am	11:30 am	⚠
28/12	HCD TEA BREAK	Tea Break	12:10 pm	12:20 pm	
28/12	HCD MEAL BREAK	Meal Break	12:20 pm	12:50 pm	
28/12	Home Care (HCSS) OFFICE VISIT-North	Care Worker Generic	12:50 pm	01:50 pm	



	Date	Client	Service	Start	Finish	
	24/12	[redacted]	HCP-Level 3	08:00 am	10:00 am	⚠
	24/12	[redacted]	Respite	10:10 am	11:10 am	⚠
✓	24/12	HCD MEAL BREAK	Meal Break	11:30 am	12:00 pm	
✓	24/12	[redacted]	HCP-Level 3	12:00 pm	02:00 pm	
✓	24/12	HCD TEA BREAK	Tea Break	02:00 pm	02:10 pm	
✓	25/12	[redacted]	HCP-Level 4	08:15 am	09:15 am	⚠
✓	25/12	[redacted]	HCP-Level 4	09:45 am	10:45 am	⚠
	26/12	HC&D LEAVE	Leave	08:00 am	09:00 am	
	26/12	HC&D LEAVE	Leave	09:20 am	10:20 am	
	27/12	[redacted]	HCP-Level 4	08:20 am	09:20 am	⚠
	27/12	[redacted]	HCP-Level 4	10:00 am	12:00 pm	⚠
	27/12	HCD TEA BREAK	Tea Break	12:35 pm	12:45 pm	
	27/12	HCD MEAL BREAK	Meal Break	12:45 pm	01:15 pm	
	27/12	[redacted]	HACC Domestic Assistance-North	01:15 pm	03:15 pm	⚠
	28/12	[redacted]	HCP-Level 4	08:00 am	09:00 am	⚠
	28/12	[redacted]	HCP-Level 4	09:15 am	10:15 am	⚠
	28/12	[redacted]	HCP-Level 3	10:30 am	11:30 am	⚠
	28/12	HCD TEA BREAK	Tea Break	12:10 pm	12:20 pm	
	28/12	HCD MEAL BREAK	Meal Break	12:20 pm	12:50 pm	
	28/12	Home Care (HCSS) OFFICE VISIT-North	Care Worker Generic	12:50 pm	01:50 pm	



Date	Client	Service	Start	Finish	
31/12	[redacted]	HCP-Level 3	08:00 am	10:00 am	
31/12	[redacted]	HCP-Level 4	10:15 am	11:15 am	
31/12	[redacted]	Respite	11:30 am	12:30 pm	
31/12	HCD TEA BREAK	Tea Break	12:30 pm	12:40 pm	
01/01	[redacted]	HCP-Level 4	08:15 am	09:15 am	
01/01	[redacted]	HCP-Level 4	09:45 am	10:45 am	
02/01	[redacted]	HCP-Level 4	08:00 am	09:00 am	
02/01	[redacted]	HCP-Level 4	09:15 am	10:15 am	
02/01	[redacted]	Respite	10:30 am	11:30 am	
03/01	[redacted]	HCP-Level 4	08:20 am	09:20 am	
03/01	[redacted]	HCP-Level 4	10:00 am	12:00 pm	
03/01	HCD TEA BREAK	Tea Break	12:35 pm	12:45 pm	
03/01	HCD MEAL BREAK	Meal Break	12:45 pm	01:15 pm	
03/01	[redacted]	HACC Domestic Assistance-North	01:15 pm	03:15 pm	
04/01	[redacted]	HCP-Level 4	08:00 am	09:00 am	
04/01	[redacted]	HCP-Level 4	09:15 am	10:15 am	


11% 10:07
carelink+ Mobile ver. 18.0.0.1022 Last Synchronisation: 56 minutes ago.
Roster Shift Summary
Employee: Belinda Jane Sinclair
Date Range: 14/01/2019-20/01/2019
previous
current
next
Date
Client
Service
Start
Finish
14/01
HCP-Level 3
08:00 am
10:00 am
14/01
Respite
10:10 am
11:10 am
15/01
HCP-Level 4
08:00 am
09:00 am
16/01
HCP-Level 4
08:00 am
09:00 am
16/01
Respite
09:20 am
10:20 am
17/01
HCP-Level 4
10:00 am
12:00 pm
17/01
HCD TEA BREAK
Tea Break
12:35 pm
12:45 pm
17/01
HCD MEAL BREAK
Meal Break
12:45 pm
01:15 pm
17/01
HACC Domestic Assistance-North
01:15 pm
03:15 pm
18/01
HCP-Level 4
08:00 am
09:00 am

Employee - Weekly Roster & Timesheet

Payroll Period: 17/12/2018 to 23/12/2018
Employee **Sinclair, Belinda**

Monday, 17 December, 2018

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted] **Address** **Suburb** FRENCHS FOREST	HCP-Level 3	08:00	10:00	2.00	10	4.00		
		Notes **Assist client with her shower as per care plan.** Have a chat and a cuppa with [redacted] **for some social contact.**						

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted] **Address** **Suburb** BEACON HILL	HCP-Level 4	10:10	11:10	1.00	10	8.00		
		Notes Personal care - full shower assist, apply cream to body after drying.						

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted] **Address** **Suburb** COLLAROY	HCP-Level 2	11:20	12:50	1.50	30	15.00		
		Notes **DA and SS. Please assist [redacted] with wiping up spills in the kitchen and assisting with small tasks around the home. He will let you know what to do in the home.** DA and SS. Please assist [redacted] with wiping up spills in the kitchen and assisting with small tasks around the home. He will let you know what to do in the home.						

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name TEA BREAK, HCD **Address** 220 Pitt Street **Suburb** SYDNEY	Tea Break	12:50	13:00	0.17	0	0.00		
		Notes						

Tuesday, 18 December, 2018

Employee - Weekly Roster & Timesheet

Payroll Period: 17/12/2018 to 23/12/2018
Employee Sinclair, Belinda

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted]	HCP-Level 4	08:00	09:00	1.00	15	8.00		
Address		Notes						
Suburb BELROSE		for 1 hour in AM for meal prep, social, get dressed for the day if he isn't already dressed and go for a walk.						

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted]	HCP-Level 4	09:15	10:15	1.00	20	14.00		
Address		Notes						
Suburb BEACON HILL								

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name TEA BREAK, HCD	Tea Break	10:25	10:35	0.17	0	0.00		
Address 220 Pitt Street		Notes						
Suburb SYDNEY								

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted]	HCP-Level 2	10:35	12:35	2.00	0	0.00	2.00	
Address	Socialisation	Notes						
Suburb EAST LINDFIELD		meds, shopping , social and sometimes appointments						

Wednesday, 19 December, 2018

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted]	HCP-Level 4	08:00	09:00	1.00	30	18.00		
Address		Notes						
Suburb BELROSE		Full shower assistance, assist with drying and dressing. Change bed linen if requested. Wipe down shower after use and hang up towel. Take client on a walk.						

Employee - Weekly Roster & Timesheet

Payroll Period: 17/12/2018 to 23/12/2018
Employee Sinclair, Belinda

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted]	HCP-Level 4	09:30	10:30	1.00	30	22.00		
Address		**Notes**						
Suburb BEACON HILL								

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted]	Respite	11:00	12:00	1.00	0	0.00		
Address		**Notes**						
Suburb FRENCHS FOREST								

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name OFFICE VISIT-North, Home Car	Care Worker Generic	14:30	16:00	1.50	0	0.00		
Address G2 - 64 Talavera Road		**Notes**						
Suburb MACQUARIE PARK								

Thursday, 20 December, 2018

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted]	HCP-Level 4	08:25	09:25	1.00	35	18.00		
Address		**Notes** Full shower, dry, dress and apply cream to body.						
Suburb BEACON HILL								

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted]	HCP-Level 4	10:00	12:00	2.00	35	19.00		
Address		**Notes** Shower prompt, IMPORTANT- Med prompt. Prompt [redacted] let the dog out of the garage. Wash and change bed sheets as required, do a load of washing and hang out washing or put in the drier. General tidy up - ens [redacted] eats her lunch. Make a sandwich for her to eat for dinner.						
Suburb EAST RYDE								

Employee - Weekly Roster & Timesheet

Payroll Period: 17/12/2018 to 23/12/2018
Employee Sinclair, Belinda

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name TEA BREAK, HCD **Address** 220 Pitt Street **Suburb** SYDNEY	Tea Break	12:35	12:45	0.17	0	0.00		
		Notes						

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name MEAL BREAK, HCD **Address** 220 Pitt Street **Suburb** SYDNEY	Meal Break	12:45	13:15	0.50	0	0.00		
		Notes						

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted] **Address** **Suburb** DAVIDSON	HACC Domestic Assistance-North	13:15	15:15	2.00	0	0.00		
		Notes						

Friday, 21 December, 2018

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted] **Address** **Suburb** BELROSE	HCP-Level 4	08:00	09:00	1.00	15	18.00		
		Notes						

Client Details	Service / Task	Start Time	Finish Time	Duration	Travel Time	Internal Distance Travelled	Km travelled with the client	Signature
Name [redacted] **Address** **Suburb** BEACON HILL	HCP-Level 4	09:15	10:15	1.00	0	0.00		
		Notes						

BEFORE THE FAIR WORK COMMISSION

FOUR YEARLY REVIEW OF THE MODERN AWARDS

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

MATTER NO. 2018/26

Statement of Trish Stewart

I, Trish Stewart, [redacted] in the state of Queensland say:

1. I am a member of United Voice and have been a member of my union since about 2016.

Personal Details

2. My date of birth is 19 February 1967.

3. I live by myself in a rental property. I have two grandchildren that live close by with my daughter.

Work History

4. For the majority of my working life, I have worked as a commercial cleaner with various cleaning services.

5. In February 2014, I received my certificate III in aged care. I also received my certificate III in disability services in October 2015.

Current Work

6. In or around April 2014, I began working at Excelcare. In August 2018, Excelcare was taken over by Livebetter, who are now my current employer.

7. I am currently employed as a permanent part time support worker at level 2 under the Social, Community, Home Care Worker and Disability Services Award. My

contract guarantees a minimum of 10 hours per week. Attached and marked 'Annexure A' is a copy of my terms and conditions of employment from LiveBetter.

8. My duties predominantly involve home visits to assist elderly and disabled clients with cleaning, showering, dressing, transporting them to and from appointments, meal preparation and making phone calls to clients to perform medication checks. I also undertake social support appointments with clients, which involves taking them out for a walk or a coffee or doing their groceries with them.

Rostering

9. The hours that I am rostered for can vary greatly. Some weeks, I may be rostered for as little as 10 hours across the week and then other weeks I may be rostered for 30 hours per week. I work 5 days per week.

10. At least once per week, my roster will be altered as a result of either another support worker who has called in sick or a client cancelling their appointment. If a client cancels their appointment before 5pm the day before their scheduled appointment then I do not get paid for the shift. If they cancel after 5pm the day before, then I will get paid. This means that I can never be certain of the amount of hours I am going to receive and how much I will be paid each week.

11. Most weeks I would like to pick up more hours because I do not receive enough hours to cover my weekly expenses. My managers normally ask me to cover a shift at short notice if a colleague has taken sick leave. I will normally accept these hours if I am available because I need to accept all of the hours I am offered to make enough money.

12. I have not agreed to a normal pattern of shifts with my employer. At least once per day I am rostered on for a 15 minute shift which is interspersed with longer shifts of 1-3 hours. If I had a choice in the way my roster was structured, I would not do these 15 minute shifts but I feel that I have to accept whatever hours I am given.

The Impact of Broken Shifts

13. Each daily shift that I work is broken up by significant breaks.

14. My rostered days can vary in length and how these breaks are spread out through the day can also vary.

15. A typical day for me can consist of my shift being broken up in the following manner (the start and end times for each appointment can vary by about 30 minutes day to day):

- 6am – 90 minute appointment
- 7.50am – 10 minute medication check phone call (which I usually make from my home)
- 8am – 45 minute appointment
- 9.30am – 60 minute appointment
- 12 pm - 10 minute medication check phone call
- Break at 12.10pm until around 4 pm
- 4pm – 30 minute appointment
- 6pm – 10 minute medication check phone call (which I usually make from my home).

16. The way that these appointments are broken up across my day requires me to be available for 12-13 hours during the day, but I will only be paid for 4-5 hours of work. I am not paid for the time it takes me to travel between each appointment. Attached and marked '**Annexure B**' are copies of my rosters for the period 24 September 2018 to 14 December 2018.

17. These broken shifts impact me greatly in that I am prevented from seeking a second job because of the demands these shifts place on my availability. I am barely provided with enough hours to cover my living expenses and rent in my current job. I frequently feel that I need to supplement my current income by getting a second job. The fact I need to be effectively on call to maximize my hours makes getting a second job almost impossible.

18. I have friends who work in commercial cleaning and they have previously offered to assist me with finding casual shifts as a cleaner. However, I am rarely able to take

these shifts because my shifts with Livebetter require me to be available across 12-13 hours of the day. When I have spoken about this with my manager, I have been told that I should not be taking a second job as a cleaner because my priority is to Livebetter.

19. I have two grandchildren that live close by and I would like to spend more time with them. If my broken shifts at Livebetter were not as long, I would be able to assist my daughter with babysitting them so that my granddaughter does not have to be in daycare as frequently and I could look after my grandson after school.

Mobile Phone Allowance

20. One of my duties involves making phone calls to clients to check that they have taken their medications. I am directed to do this as part of my job. I normally make 2-3 of these phone calls per working day. I am also required to call clients if I am running late to meet them for an appointment. This can happen frequently due to traffic.

21. I make these phone calls from my personal mobile phone. I am not provided with a phone by my employer to make these phone calls. My employer asked me for my mobile number and made it clear this was because I would be contacted by my employer on my own mobile for work related matters. I have never been provided with a work mobile and the only device I can use for work related calls is my own mobile. I am not reimbursed for the cost of making these phone calls or the cost required to maintain my personal phone to ensure I can make these phone calls. My phone bill costs approximately $170 per month. If I was not required to make as many work calls, I could consider dropping to a cheaper mobile phone plan.

22. Since August 2018, my employer has been emailing our rosters to us, so I am required to have access to an email account and the internet in order to check my roster. I also scan and email timesheets to my employer at the end of each week, which also requires access to the internet. I am also reliant upon the internet at home if I am asked to pick up a shift with a client I am not familiar with. I will have the care plan emailed to me and I will read it from home prior to attending the appointment so that I am aware of their history and requirements.

Income and expenses

23. I am paid an hourly rate.

24. On average I earn a gross weekly amount between $500 and $1000 for work, depending upon the hours worked. Attached to this statement and marked **'Annexure C'** are copies of my pay slips for the period 15 February 2018 to 9 December 2018.

25. My average weekly expenses (excluding entertainment and savings) are approximately $873.00, comprised of:

Rent, household bills and groceries	$500.00
Car expenses, including registration and petrol:	$330.00
Other expenses: mobile phone bill etc.	$43.00
Total:	**$873.00**

[redacted]

Witness Signature

Trish Stewart. 17-1-19

Witness Name (printed) Date:

'A'

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27 June 2018

Trish Stewart
4 Comber Street
SVENSSON HEIGHTS QLD 4670

Dear Trish,

I am pleased to offer you employment with LiveBetter Services Limited (LiveBetter) on the terms set out in this Letter of Employment. Please read these terms carefully and, if you wish to accept this offer, sign and return the attached copy to the Human Resources Department.

TERMS AND CONDITIONS OF EMPLOYMENT

1. Commencement date

This Letter of Employment will be effective from the 1 July 2018.

2. Term of employment

Your employment with LiveBetter will continue for an indefinite period, subject to successful relevant background checks including a review of your national police record, and working with children check. You will also be required to successfully complete a health & wellness check. If you do not consent to these background checks and health & wellness check or, if your background checks reveals past behaviours that are inconsistent with the expectations of you in this role and this Letter of Employment, then this offer of employment will be revoked immediately.

3. Role, duties and performance

You are engaged as Support Worker on a permanent, part time basis of 20 nominal hours per fortnight plus any reasonable additional hours. You will be working in the Bundaberg / Wide Bay area, in the Aged Care Services and reporting to Sharon Walker, Coordinator.

During your employment with LiveBetter, in addition to those duties outlined in your position description, you are required to:

- comply with all policies and procedures (as amended from time to time) that pertain to your employment and the performance of your duties, which are published by e-mail and/or located on the LiveBetter Intranet;
- perform the duties assigned to you from time to time and comply with all lawful and reasonable directions given to you by your Manager;
- perform your duties and responsibilities in a proper and efficient manner;
- except in the case of absence by reason of illness or incapacity or leave in accordance with this contract of employment, devote your time, attention and abilities during normal business hours exclusively to the business of LiveBetter;
- use your best endeavours to promote and enhance the interests, welfare, business, growth and reputation of LiveBetter; and

- not intentionally do anything which is or may be harmful to LiveBetter.

Your duties, responsibilities, team and location may be revised from time to time in consultation with you to meet the changing needs of the organisation. Any changes will be discussed with you in advance and confirmed in writing.

4. Remuneration

Classification
Your conditions of employment will be governed by the applicable provisions of the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHCDSI).

Due to the nature and scope of your role, your position has been classified as SCHCDSI Level 2 Pay Point 2 Schedule (E) Home Care Employee on the basis of the nature and scope of the role and your qualifications and experience.

Rate of Pay
Your rate of pay upon commencement will be $22.24 per hour which represents an above Award payment. This rate is subject to change as per LiveBetter's obligations under the *Social, Community, Home Care and Disability Services Industry Award 2010*. LiveBetter will also make superannuation contributions on your behalf in accordance with the Superannuation Guarantee legislation.

Payment of Salary
Payment of your salary will be made on a fortnightly basis, in arrears, by electronic deposit to an account nominated by you. Your manager will confirm if you are required to complete a timesheet.

Superannuation contributions
You are free to direct your superannuation contributions to a regulated complying superannuation fund of your choice. If you do not advise us of your choice of a regulated complying fund, your contributions will be made to the superannuation fund chosen by LiveBetter as the default fund, currently HESTA. If you choose your own fund and do not become a member of the LiveBetter default fund, you are required to provide the information about your chosen fund as listed in the Choice of Superannuation Fund form.

Additional contributions to superannuation
In addition to the legislated employer superannuation contributions, you may direct an additional amount to the fund by means of automatic deduction from your pay. For further information please contact the Payroll Officer.

Salary packaging
You may be entitled to participate in LiveBetter's salary packaging scheme, which at present is administered by AccessPay.

Remuneration reviews
Salaries are reviewed annually in conjunction with the annual performance review process, the relevant industrial Award and the LiveBetter remuneration framework.

5. Hours of work

You are engaged on a permanent part time basis of 20 hours per fortnight. Your usual days and times of work are variable and dependant on a roster system which is published and communicated fortnightly. The

roster is based on the needs of the service and will potentially include some stand up shifts, sleep over shifts, afternoon shifts, evening shifts and potentially weekend work. Any variation of hours will be published in the roster.

6. Overtime

All overtime worked must be approved by your manager in advance and, providing approval is obtained, you will be paid in accordance with the overtime provisions of the appropriate Award. Alternatively, you may like to make use of time in lieu provisions, if mutually agreed between yourself and your supervisor and in accordance with the relevant Modern Award.

7. Leave entitlements

Annual leave
You will be entitled to accrue entitlements to paid annual leave at the rate of 20 days for each year of continuous service (or, if part-time, pro-rated) in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time and the appropriate Award.

Annual leave loading of 17.5% will be paid on accrued leave when it is taken.

Unused annual leave will be paid out on termination of employment.

Personal/carer's leave
You will be entitled to ten days paid personal/carer's leave for each year of continuous service (or, if part-time, pro-rated) in accordance with the LiveBetter Leave Entitlements Policy as amended from time to time.

You are not entitled to any payment in lieu of accrued personal leave on termination of your employment.

Compassionate leave
You will be entitled to up to two days paid compassionate leave per permissible occasion in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time.
Parental leave
You will be entitled to parental leave in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time and relevant industrial instruments, such as the Fair Work Act.

Long Service Leave
You will be entitled to long service leave in accordance with LiveBetter's Leave Entitlements Policy as amended from time to time.

Public holidays
You will be entitled to public holidays as proclaimed in your relevant state or territory without loss of pay. Payment will be made in accordance with the National Employment Standards.

Other leave
For information regarding all other leave such as community service leave, religious holidays, study leave and leave without pay, refer to LiveBetter's Leave Entitlements Policy or contact the HR team.

Service Date
For the purpose of calculating service and leave accruals, your original start date with Excelcare Australia Limited will be used.

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Transfer of leave entitlements
As part of your transition from Excelcare Australia Limited, LiveBetter will be transferring your statutory entitlement accruals. This transfer is conditional upon LiveBetter receiving sufficient funds from Excelcare Australia Limited to cover these entitlements prior to commencement.

8. Workers' compensation

LiveBetter has workers' compensation insurance in accordance with the relevant state or territory legislation. In the event of any injury occurring during working hours you should immediately notify your manager.

9. Code of Conduct

LiveBetter is committed to ensuring that all individuals are treated with dignity and respect. The LiveBetter Code of Conduct explains what is meant by equal employment opportunity, discrimination, harassment, victimisation and bullying. It is essential that you understand and comply with the Code of Conduct as amended from time to time. A copy of the Code of Conduct is included in your employee handbook which is issued at induction and is also available on the Intranet.

10. Conduct and attire

You will be expected to conduct yourself in a manner that enhances the professional standing of LiveBetter, whether in the office, at third party locations, or any forum in which you may be seen as representing LiveBetter.

11. Driver's Licence

Given the nature of the role, a condition of employment is that you must possess and maintain a valid unrestricted Australian driver's licence. You must provide LiveBetter with a copy of your valid driver's licence and must notify LiveBetter immediately if you are disqualified from driving.

12. Confidentiality

You must not disclose, or allow access to, any confidential information, to any person except in the proper course of your duties, or as permitted by LiveBetter, either during or after the course of your employment. Confidential information is defined as any information relating to LiveBetter employees and clients, which is not lawfully available to the general public.

Further, as an employee of LiveBetter you will have access to "Know-How", and have a detailed knowledge of LiveBetter's clients and business' clients. You will have the opportunity to build professional relationships with those clients, employees and others engaged in LiveBetter's Business (goodwill). It is reasonable for LiveBetter to protect the goodwill of the business and as such, you must not during or post employment with LiveBetter, induce, solicit, canvas or approach any customers of LiveBetter on behalf of any other business. This includes, but is not limited to soliciting or approaching LiveBetter clients/and or families to move providers, or encouraging LiveBetter client/ and or families to select another service provider on the basis of your employment with that provider.

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community services

In addition, you must not during or post employment with LiveBetter, do or say anything that may be harmful to the reputation of LiveBetter in any forum, or that may lead a person to cease, curtail or alter their dealings with LiveBetter.

13. Medical Examinations and Considerations

Where a specific medical examination is not required for your position, LiveBetter assumes that you are medically fit to undertake employment with LiveBetter unless you notify it otherwise. If you have a medical condition that may have an impact upon your ability to carry out your duties or may require LiveBetter to provide you with assistance to undertake your duties then it is important to disclose the extent of the medical condition to LiveBetter so that it may fulfil any requirements it has to assist you.

Where during the course of your employment with LiveBetter the CEO forms the opinion that there are reasonable concerns that you are not fit to undertake your normal duties you may be required to attend a medical examination.

14. Termination of employment

Either you or LiveBetter may terminate your employment with LiveBetter at any time by giving written notice in accordance with the National Employment Standards as outlined below.

Period of continuous service at the end of the day the notice is given	Notice period
Not more than 1 year	1 week
More than 1 year but not more than 3 years	2 weeks
More than 3 years but not more than 5 years	3 weeks
More than 5 years	4 weeks

Notwithstanding any other provision contained in the Letter of Employment, LiveBetter may terminate your employment at any time without prior notice if you commit an act of serious misconduct. Serious misconduct includes both of the following:

- wilful or deliberate behaviour that is inconsistent with the continuation of this Letter of Employment;
- conduct that causes imminent and serious risk to the health and safety of a person, or the reputation or viability of LiveBetter.

Examples of serious misconduct include but are not limited to:

- theft, fraud, assault, intoxication, or refusing to carry out a lawful and reasonable instruction consistent with this Letter of Employment;
- the commission of a crime in the course of your employment;
- the commission of a crime outside your employment with LiveBetter (eg criminal dishonesty, where your duties require good faith and honesty);
- neglect of duties; and/or
- the use of objectionable or obscene language in certain circumstances (eg if such language is directed towards managers, employees or clients of LiveBetter).

LiveBetter may suspend you on full pay from part or all of your duties at any time, including during any period of notice of termination of your employment.

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15. Security of equipment and documentation

Whilst working at LiveBetter you are required to take care to secure your personal belongings. LiveBetter will not reimburse an individual who suffers a loss due to theft of cash or personal possessions. You are also responsible for all equipment issued to you and documentation in your custody. This includes computers, mobile phones and confidential documentation. Any losses must be reported to your manager immediately.

16. Variation and entire agreement

This Letter of Employment may only be varied, replaced or terminated by agreement in writing signed by you and an authorised representative of LiveBetter. This Letter of Employment embodies the entire understanding of the parties in relation to your employment by LiveBetter and supersedes all previous negotiations, representations or agreements. This offer of employment is valid for strictly two weeks from the date of issue unless otherwise agreed.

Please indicate your written acceptance of this offer by signing, dating and returning the copy of this Letter of Employment to the Human Resources Department.

Yours sincerely,

Nerissa Marat
General Manager People & Culture

I have read and accept the terms and conditions of employment as set out in this Letter of Employment.

Trish Stewart _____ [redacted] 13-7-18
Employee Name Signature Date

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Direct Service Staff schedule

Direct Service Staff Name: Trish Stewart

W/I B/W

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Monday 24/09	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Monday 24/09	[redacted]	[redacted]	08:15	08:46	0.52	41592472	IHS : Personal Care		Assigned	
Monday 24/09	[redacted]	[redacted]	09:00	11:00	2	41591324	CHS: Domestic Assistance		Assigned	4.4
Monday 24/09	[redacted]	[redacted]	11:55	12:05	0.17	41608927	IHS : Personal Care		Assigned	
Monday 24/09	[redacted]	[redacted]	12:30	13:30	1	41594204	CHS: Domestic Assistance		Assigned	12
Monday 24/09	[redacted]	[redacted]	13:45	15:45	2	41556426	CHS: Domestic Assistance		Assigned	8.1
Monday 24/09	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 25/09	[redacted]	[redacted] Sick leave	07:45	07:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 25/09	[redacted]	[redacted] Sick leave	08:00	08:30	0.5	41592472	IHS : Personal Care		Assigned	
Tuesday 25/09	[redacted]	[redacted] Sick leave	09:00	10:30	1.5	41514704	CHS: Domestic Assistance		Assigned	
Tuesday 25/09	[redacted]	[redacted] Sick leave	10:40	11:40	1	41529685	CHS: Domestic Assistance		Assigned	
Tuesday 25/09	[redacted]	[redacted] Sick leave	11:25	11:35	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 25/09	[redacted]	[redacted] Sick leave	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM		Assigned	
Tuesday 25/09	[redacted]	[redacted] Sick leave	15:45	16:15	0.5	41599881	IHS : Personal Care		Assigned	
Tuesday 25/09	[redacted]	[redacted] Sick leave	16:35	17:05	0.5		IHS : Personal Care		Assigned	
Tuesday 25/09	[redacted]	[redacted] Sick leave	18:05	18:15	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 26/09	[redacted]	[redacted]	06:00	07:30	1.5	41542107	CHS: Domestic Assistance		Assigned	
Wednesday 26/09	[redacted]	[redacted]	07:30	07:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 26/09	[redacted]	[redacted]	08:00	08:15	0.25	41592472	IHS : Domestic Assistance		Assigned	
Wednesday 26/09	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Wednesday 26/09	[redacted]	[redacted]	09:00	10:00	1	41590691	CHS: Domestic Assistance		Assigned	4.4
Wednesday 26/09	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 26/09	[redacted]	[redacted]	14:15	15:15	1	41592472	IHS : Domestic Assistance		Assigned	14

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer ID & PIN	Status	
Wednesday 26/09	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 27/09	[redacted]	[redacted]	07:30	07:45	0.25	41531092	IHS : Personal Care		Assigned	
Thursday 27/09	[redacted]	[redacted]	07:45	07:55	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 27/09	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	16
Thursday 27/09	[redacted]	[redacted]	11:30	12:30	1	41531092	IHS : Domestic Assistance		Assigned	16
Thursday 27/09	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 27/09	[redacted]	[redacted]	14:30	16:00	1.5	41823707	CHS: Domestic Assistance		Assigned	2.7
Thursday 27/09	[redacted]	[redacted]	16:20	16:50	0.5	41599881	IHS : Personal Care		Assigned	14
Thursday 27/09	[redacted]	[redacted]	17:10	17:40	0.5		IHS : Personal Care		Assigned	13
Thursday 27/09	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Friday 28/09	[redacted]	[redacted]	07:15	07:30	0.25	41531092	IHS : Personal Care		Assigned	
Friday 28/09	[redacted]	[redacted]	07:40	07:50	0.17	41608927	IHS : Personal Care		Assigned	
Friday 28/09	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	16
Friday 28/09	[redacted]	[redacted]	09:00	11:00	2	41547071	CHS: Domestic Assistance		Assigned	5.6
Friday 28/09	[redacted]	[redacted]	11:35	11:45	0.17	41608927	IHS : Personal Care		Assigned	
Friday 28/09	[redacted]	[redacted]	22:00	23:59	1.98	41536361	01_002_0107_1_1 Assistance with self-care activities - active overnight		Assigned	
Saturday 29/09	[redacted]	[redacted]	00:00	06:00	6	41536361	01_013_0107_1_1 Assistance with self-care activities on Saturdays		Assigned	
Total Hours					31.42					

Total kg 164.2

Direct Service Staff schedule

Direct Service Staff Name: Trish Stewart

W/I B/T

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Tuesday 02/10	[redacted]	[redacted]	06:00	08:00	2		CHS: Domestic Assistance		Assigned	
Tuesday 02/10	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care	[redacted]	Assigned	4·4
Tuesday 02/10	[redacted]	[redacted]	11:25	11:35	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 02/10	[redacted]	[redacted]	14:00	14:20	0.33	41515435	CA : Transport	4·1	Assigned	16
Tuesday 02/10	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2·6	Assigned	2·6
Tuesday 02/10	[redacted]	[redacted]	16:00	16:30	0.5	41599681	IHS : Personal Care		Assigned	12
Tuesday 02/10	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 03/10	[redacted]	[redacted]	06:30	07:30	1	41542107	CHS: Domestic Assistance		Assigned	R
Wednesday 03/10	[redacted]	[redacted]	07:30	07:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 03/10	[redacted]	[redacted]	08:00	08:15	0.25	41592472	IHS : Domestic Assistance		Assigned	18
Wednesday 03/10	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Wednesday 03/10	[redacted]	[redacted]	09:00	10:00	1	41590691	CHS: Domestic Assistance		Assigned	4·4
Wednesday 03/10	[redacted]	[redacted]	11:00	11:15	0.25	41597481	CA : Transport	Cancelled	Assigned	
Wednesday 03/10	[redacted]	[redacted]	12:15	12:25	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 03/10	[redacted]	[redacted]	16:45	17:15	0.5		IHS : Personal Care	Cancelled	Assigned	
Wednesday 03/10	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 04/10	[redacted]	[redacted]	07:30	07:45	0.25	41531092	IHS : Personal Care		Assigned	
Thursday 04/10	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	16
Thursday 04/10	[redacted]	[redacted]	09:30	11:30	2	41531092	IHS : Domestic Assistance	51	Assigned	16
Thursday 04/10	[redacted]	[redacted]	11:30	12:30	1	41531092	IHS : Domestic Assistance		Assigned	
Thursday 04/10	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 04/10	[redacted]	[redacted]	13:50	15:20	1.5	41523707	CHS: Domestic Assistance		Assigned	2·9
Thursday 04/10	[redacted]	[redacted]	16:00	16:30	0.5	41599681	IHS : Personal Care		Assigned	12

B/T

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status
Thursday 04/10	[redacted]	[redacted]	17:50	18:00	0.17	41608927	IHS : Personal Care		Assigned
Friday 05/10	[redacted]	[redacted]	07:15	07:30	0.25	41531092	IHS : Personal Care		Assigned
Friday 05/10	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned
Friday 05/10	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned
Friday 05/10	[redacted]	[redacted]	09:30	11:30	2	41547071	CHS: Domestic Assistance		Assigned
Friday 05/10	[redacted]	[redacted]	11:50	12:00	0.17	41608927	IHS : Personal Care		Assigned
Friday 05/10	[redacted]	[redacted]	16:40	17:25	0.75	41515435	IHS : Personal Care		Assigned
Friday 05/10	[redacted]	[redacted]	17:25	17:55	0.5	41515435	IHS : Personal Care		Assigned
Friday 05/10	[redacted]	[redacted]	17:55	18:05	0.17	41608927	IHS : Personal Care		Assigned
Total Hours					18.58				

16

4.3

201.9 km

Plus Public Holiday Monday.

Direct Service Staff schedule

Direct Service Staff Name : **Trish Stewart**

T/B

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Monday 08/10	[redacted]	[redacted]	06:50	07:00	0.17	41608927	IHS : Personal Care		Assigned	
Monday 08/10	[redacted]	[redacted]	07:15	07:46	0.52	41592472	IHS : Personal Care		Assigned	
Monday 08/10	[redacted]	[redacted]	08:00	10:00	2	41591324	CHS: Domestic Assistance		Assigned	4.4
Monday 08/10	[redacted]	[redacted]	10:55	11:05	0.17	41608927	IHS : Personal Care		Assigned	
Monday 08/10	[redacted]	[redacted]	11:30	12:30	1	41594204	CHS: Domestic Assistance		Assigned	12
Monday 08/10	[redacted]	[redacted]	12:45	14:45	2	41556426	CHS: Domestic Assistance		Assigned	8.1
Monday 08/10	[redacted]	[redacted]	16:45	16:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 09/10	[redacted]	[redacted]	06:45	06:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 09/10	[redacted]	[redacted]	07:00	07:30	0.5	41592472	IHS : Personal Care		Assigned	
Tuesday 09/10	[redacted]	[redacted]	08:00	09:30	1.5	41514704	CHS: Domestic Assistance		Assigned	14
Tuesday 09/10	[redacted]	[redacted]	09:40	10:40	1	41529685	CHS: Domestic Assistance		Assigned	7
Tuesday 09/10	[redacted]	[redacted]	10:25	10:35	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 09/10	[redacted]	[redacted] went to office	13:40	14:00	0.33	41533002	CHS: Transport - 0-6KM	Aborted	Assigned	6.6
Tuesday 09/10	[redacted]	[redacted]	14:45	15:15	0.5	41599881	IHS : Personal Care		Assigned	12
Tuesday 09/10	[redacted]	[redacted]	15:00	15:30	0.5	41599881	IHS : Personal Care	Cancelled	Assigned	
Tuesday 09/10	[redacted]	[redacted]	15:35	16:05	0.5		IHS : Personal Care	Cancelled	Assigned	
Tuesday 09/10	[redacted]	[redacted]	16:45	16:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 09/10	[redacted]	[redacted]	17:05	17:15	0.17	41608927	IHS : Personal Care	Cancelled	Assigned	
Wednesday 10/10	[redacted]	[redacted]	05:00	06:30	1.5	41542107	CHS: Domestic Assistance		Assigned	
Wednesday 10/10	[redacted]	[redacted]	06:30	06:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 10/10	[redacted]	[redacted]	07:00	07:15	0.25	41592472	IHS : Domestic Assistance		Assigned	18
Wednesday 10/10	[redacted]	[redacted]	07:15	07:45	0.5	41592472	IHS : Personal Care		Assigned	
Wednesday 10/10	[redacted]	[redacted]	08:00	09:00	1	41590691	CHS: Domestic Assistance		Assigned	4.4

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status
Wednesday 10/10	[redacted]	[redacted]	11:30	11:40	0.17	41608927	IHS : Personal Care		Assigned
Wednesday 10/10	[redacted]	[redacted]	12:00	13:00	1	41592472	IHS : Domestic Assistance		Assigned
Wednesday 10/10	[redacted]	[redacted]	16:45	16:55	0.17	41608927	IHS : Personal Care		Assigned
Thursday 11/10	[redacted]	[redacted]	06:30	06:45	0.25	41531092	IHS : Personal Care		Assigned
Thursday 11/10	[redacted]	[redacted]	06:45	06:55	0.17	41608927	IHS : Personal Care		Assigned
Thursday 11/10	[redacted]	[redacted]	07:15	07:45	0.5	41592472	IHS : Personal Care		Assigned
Thursday 11/10	[redacted]	[redacted]	10:30	11:30	1	41531092	IHS : Domestic Assistance		Assigned
Thursday 11/10	[redacted]	[redacted]	11:30	11:40	0.17	41608927	IHS : Personal Care		Assigned
Thursday 11/10	[redacted]	[redacted]	13:30	15:00	1.5	41523707	CHS: Domestic Assistance		Assigned
Thursday 11/10	[redacted]	[redacted]	15:20	15:50	0.5	41599881	IHS : Personal Care		Assigned
Thursday 11/10	[redacted]	[redacted]	16:10	16:40	0.5		IHS : Personal Care	Cancelled	Assigned
Thursday 11/10	[redacted]	[redacted]	16:45	16:55	0.17	41608927	IHS : Personal Care		Assigned
Friday 12/10	[redacted]	[redacted]	06:15	06:30	0.25	41531092	IHS : Personal Care		Assigned
Friday 12/10	[redacted]	[redacted]	06:40	06:50	0.17	41608927	IHS : Personal Care		Assigned
Friday 12/10	[redacted]	[redacted]	07:15	07:45	0.5	41592472	IHS : Personal Care		Assigned
Friday 12/10	[redacted]	[redacted]	08:00	10:00	2	41547071	CHS: Domestic Assistance	Cancelled	Assigned
Friday 12/10	[redacted]	[redacted]	10:35	10:45	0.17	41608927	IHS : Personal Care		Assigned
Friday 12/10	[redacted]	[redacted]	21:00	22:59	1.98	41536361	01_002_0107_1_1 Assistance with self-care activities - active overnight		Assigned
Saturday 13/10	[redacted]	[redacted]	23:00	05:00	6	41536361	01_013_0107_1_1 Assistance with self-care activities on Saturdays		Assigned
Total Hours					32.08				

TIB

4.4

.16

16

2.9

13

16

~~[redacted]~~ Travel 154.8

Direct Service Staff schedule

Direct Service Staff Name : **Trish Stewart**

W/R T/B

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Monday 15/10	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Monday 15/10	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Monday 15/10	[redacted]	[redacted]	09:15	10:15	1	41527422	CHS: Domestic Assistance		Assigned	19
Monday 15/10	[redacted]	[redacted]	11:00	12:00	1		CHS: Domestic Assistance		Assigned	26
Monday 15/10	[redacted]	[redacted]	11:40	11:50	0.17	41608927	IHS : Personal Care		Assigned	
Monday 15/10	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2-4	Assigned	22
Tuesday 16/10	[redacted]	[redacted]	08:00	08:30	0.5	41592472	IHS : Personal Care		Assigned	
Tuesday 16/10	[redacted]	[redacted]	11:25	11:35	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 16/10	[redacted]	[redacted]	13:00	13:20	0.33	41515435	CA : Transport	To office	Assigned	6A
Tuesday 16/10	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2-4	Assigned	1-4
Tuesday 16/10	[redacted]	[redacted]	16:00	16:30	0.5	41599681	IHS : Personal Care		Assigned	13
Wednesday 17/10	[redacted]	[redacted]	06:30	07:30	1	41542107	CHS: Domestic Assistance		Assigned	
Wednesday 17/10	[redacted]	[redacted]	07:30	07:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 17/10	[redacted]	[redacted]	08:00	08:15	0.25	41592472	IHS : Domestic Assistance		Assigned	18
Wednesday 17/10	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Wednesday 17/10	[redacted]	[redacted]	09:00	10:00	1	41590591	CHS: Domestic Assistance		Assigned	4-6
Wednesday 17/10	[redacted]	[redacted]	11:00	11:15	0.25	41597481	CA : Transport	To office	Assigned	15
Wednesday 17/10	[redacted]	[redacted]	12:15	12:25	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 17/10	[redacted]	[redacted]	16:45	17:15	0.5		IHS : Personal Care	Cancelled	Assigned	
Wednesday 17/10	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Total Hours					9					

Travel 137.6

Direct Service Staff schedule

Direct Service Staff Names: **Trish Stewart**

B/T

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Thursday 25/10	[redacted]	[redacted]	07:45	07:55	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 25/10	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Thursday 25/10	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 25/10	[redacted]	[redacted]	14:30	16:00	1.5	41523707	CHS: Domestic Assistance		Assigned	13
Thursday 25/10	[redacted]	[redacted]	16:20	16:50	0.5	41599881	IHS : Personal Care		Assigned	12
Thursday 25/10	[redacted]	[redacted]	17:10	17:40	0.5		IHS : Personal Care	Cancelled	Assigned	
Thursday 25/10	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Friday 26/10	[redacted]	[redacted]	07:40	07:50	0.17	41608927	IHS : Personal Care		Assigned	
Friday 26/10	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Friday 26/10	[redacted]	[redacted]	09:00	11:00	2	41547071	CHS: Domestic Assistance		Assigned	5.6
Friday 26/10	[redacted]	[redacted]	11:35	11:45	0.17	41608927	IHS : Personal Care		Assigned	
Friday 26/10	[redacted]	[redacted]	22:00	23:59	1.98	41536361	01_002_0107_1_1 Assistance with self-care activities - active overnight		Assigned	
Saturday 27/10	[redacted]	[redacted]	00:00	06:00	6	41536361	01_013_0107_1_1 Assistance with self-care activities on Saturdays		Assigned	
Total Hours					**14.32**					

Travel 30.6 km

Direct Service Staff schedule

Direct Service Staff Name : **Trish Stewart**

W/I T/B

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Monday 29/10	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Monday 29/10	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Monday 29/10	[redacted]	[redacted]	09:15	10:15	1	41527422	CHS: Domestic Assistance		Assigned	.19
Monday 29/10	[redacted]	[redacted]	11:00	12:00	1		CHS: Domestic Assistance		Assigned	26
Monday 29/10	[redacted]	[redacted]	11:40	11:50	0.17	41608927	IHS : Personal Care		Assigned	
Monday 29/10	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2·4	Assigned	22
Tuesday 30/10	[redacted]	[redacted]	08:00	08:30	0.5	41592472	IHS : Personal Care		Assigned	
Tuesday 30/10	[redacted]	[redacted]	08:45	10:45	2		CHS: Domestic Assistance		Assigned	4·4
Tuesday 30/10	[redacted]	[redacted]	11:25	11:35	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 30/10	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2·4	Assigned	16
Tuesday 30/10	[redacted]	[redacted]	16:00	16:30	0.5	41599881	IHS : Personal Care		Assigned	13
Wednesday 31/10	[redacted]	[redacted]	06:30	07:30	1	41542107	CHS: Domestic Assistance		Assigned	
Wednesday 31/10	[redacted]	[redacted]	07:30	07:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 31/10	[redacted]	[redacted]	08:00	08:15	0.25	41592472	IHS : Domestic Assistance		Assigned	18
Wednesday 31/10	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Wednesday 31/10	[redacted]	[redacted]	09:00	10:00	1	41590691	CHS: Domestic Assistance		Assigned	4.4
Wednesday 31/10	[redacted]	[redacted]	11:00	11:15	0.25	41597481	CA : Transport	Pride of Cas	Assigned	15
Wednesday 31/10	[redacted]	[redacted]	12:15	12:25	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 31/10	[redacted]	[redacted]	14:00	14:30	0.5	41591839	CHS: Transport - 7-20KM		Assigned	
Wednesday 31/10	[redacted]	[redacted]	16:45	17:15	0.5		IHS : Personal Care	Cancelled.	Assigned	
Wednesday 31/10	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 01/11	[redacted]	[redacted]	07:30	07:45	0.25	41531092	IHS : Personal Care		Assigned	
Thursday 01/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	16

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Thursday 01/11	[redacted]	[redacted]	09:30	11:30	2	41531092	IHS : Domestic Assistance		Assigned	16
Thursday 01/11	[redacted]	[redacted]	11:30	12:30	1	41531092	IHS : Domestic Assistance		Assigned	
Thursday 01/11	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 01/11	[redacted]	[redacted]	13:50	15:20	1.5	41523707	CHS: Domestic Assistance	Cancelled	Assigned	
Thursday 01/11	[redacted]	[redacted]	16:00	16:30	0.5	41599881	IHS : Personal Care		Assigned	13
Thursday 01/11	[redacted]	[redacted]	17:50	18:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 02/11	[redacted]	[redacted]	07:15	07:30	0.25	41531092	IHS : Personal Care		Assigned	
Friday 02/11	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 02/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	16
Friday 02/11	[redacted]	[redacted]	09:30	11:30	2	41547071	CHS: Domestic Assistance		Assigned	5·6
Friday 02/11	[redacted]	[redacted]	11:50	12:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 02/11	[redacted]	[redacted]	12:45	13:30	0.75	41515435	IHS : Personal Care		Assigned	1·7
Friday 02/11	[redacted]	[redacted]	16:30	17:00	0.5	41515435	IHS : Personal Care		Assigned	
Friday 02/11	[redacted]	[redacted]	17:30	17:40	0.17	41608927	IHS : Personal Care		Assigned	
Total Hours					21.75					

Total km 236·9

Direct Service Staff schedule

Direct Service Staff Name: **Trish Stewart**

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Monday 05/11	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Monday 05/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Monday 05/11	[redacted]	[redacted]	09:00	11:00	2	41591324	CHS: Domestic Assistance		Assigned	4.4
Monday 05/11	[redacted]	[redacted]	11:55	12:05	0.17	41608927	IHS : Personal Care		Assigned	
Monday 05/11	[redacted]	[redacted]	12:30	13:30	1	41594204	CHS: Domestic Assistance		Assigned	12
Monday 05/11	[redacted]	[redacted]	13:45	15:45	2	41556426	CHS: Domestic Assistance		Assigned	8.1
Monday 05/11	[redacted]	[redacted]	16:05	17:05	1	41599881	IHS : Personal Care		Assigned	24
Monday 05/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 06/11	[redacted]	[redacted]	07:45	07:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 06/11	[redacted]	[redacted]	08:00	08:30	0.5	41592472	IHS : Personal Care		Assigned	
Tuesday 06/11	[redacted]	[redacted]	09:00	10:30	1.5	41514704	CHS: Domestic Assistance		Assigned	13
Tuesday 06/11	[redacted]	[redacted]	10:40	11:40	1	41529685	CHS: Domestic Assistance		Assigned	7
Tuesday 06/11	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2.4	Assigned	5
Tuesday 06/11	[redacted]	[redacted]	15:45	16:15	0.5	41599881	IHS : Personal Care		Assigned	12
Tuesday 06/11	[redacted]	[redacted]	18:05	18:15	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 07/11	[redacted]	[redacted]	06:00	07:30	1.5	41542107	CHS: Domestic Assistance		Assigned	
Wednesday 07/11	[redacted]	[redacted]	07:30	07:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 07/11	[redacted]	[redacted]	08:00	08:15	0.25	41592472	IHS : Domestic Assistance		Assigned	8
Wednesday 07/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	4.4
Wednesday 07/11	[redacted]	[redacted]	09:00	10:00	1	41590691	CHS: Domestic Assistance		Assigned	
Wednesday 07/11	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 07/11	[redacted]	[redacted]	13:00	14:00	1	41592472	IHS : Domestic Assistance		Assigned	14
Wednesday 07/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Thursday 08/11	[redacted]	[redacted]	07:30	07:45	0.25	41531092	IHS : Personal Care		Assigned	
Thursday 08/11	[redacted]	[redacted]	07:45	07:55	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 08/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	16
Thursday 08/11	[redacted]	[redacted]	11:30	12:30	1	41531092	IHS : Domestic Assistance		Assigned	16
Thursday 08/11	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 08/11	[redacted]	[redacted]	14:30	16:00	1.5	41523707	CHS: Domestic Assistance	Cancelled	Assigned	
Thursday 08/11	[redacted]	[redacted]	16:00	16:30	0.5	41599881	IHS : Personal Care		Assigned	13
Thursday 08/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Friday 09/11	[redacted]	[redacted]	07:15	07:30	0.25	41531092	IHS : Personal Care		Assigned	
Friday 09/11	[redacted]	[redacted]	07:40	07:50	0.17	41608927	IHS : Personal Care		Assigned	
Friday 09/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	16
Friday 09/11	[redacted]	[redacted]	09:00	11:00	2	41547071	CHS: Domestic Assistance	✓	Assigned	5.6
Friday 09/11	[redacted]	[redacted]	11:35	11:45	0.17	41608927	IHS : Personal Care		Assigned	
Friday 09/11	[redacted]	[redacted]	22:00	23:59	1.98	41536361	01_002_0107_1_1 Assistance with self-care activities - active overnight		Assigned	
Saturday 10/11	[redacted]	[redacted]	00:00	06:00	6	41536361	01_013_0107_1_1 Assistance with self-care activities on Saturdays		Assigned	
Total Hours					31.23					

Total Km's 206.9

Direct Service Staff schedule

Direct Service Staff Name: Trish Stewart

W/T Q/T

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status
Monday 12/11	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned
Monday 12/11	[redacted]	[redacted]	11:00	12:00	1		CHS: Domestic Assistance		Assigned
Monday 12/11	[redacted]	[redacted]	11:40	11:50	0.17	41608927	IHS : Personal Care		Assigned
Monday 12/11	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2·4	Assigned
Monday 12/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned
Tuesday 13/11	[redacted]	[redacted]	08:00	08:30	0.5	41592472	IHS : Personal Care		Assigned
Tuesday 13/11	[redacted]	[redacted]	08:45	10:45	2		CHS: Domestic Assistance		Assigned
Tuesday 13/11	[redacted]	[redacted]	11:00	13:00	2	49424253	IHS : Domestic Assistance	988581	Assigned
Tuesday 13/11	[redacted]	[redacted]	13:00	13:10	0.17	41608927	IHS : Personal Care		Assigned
Tuesday 13/11	[redacted]	[redacted]	13:30	14:00	0.5	41591839	CHS: Transport - 7-20KM		Assigned
Tuesday 13/11	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2·4	Assigned
Tuesday 13/11	[redacted]	[redacted]	15:15	16:15	1	41527422	CHS: Domestic Assistance		Assigned
Tuesday 13/11	[redacted]	[redacted]	16:40	17:10	0.5	41599881	IHS : Personal Care		Assigned
Tuesday 13/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned
Wednesday 14/11	[redacted]	[redacted]	06:30	07:30	1	41542167	CHS: Domestic Assistance		Assigned
Wednesday 14/11	[redacted]	[redacted]	07:30	07:40	0.17	41608927	IHS : Personal Care		Assigned
Wednesday 14/11	[redacted]	[redacted]	08:00	08:15	0.25	41592472	IHS : Domestic Assistance		Assigned
Wednesday 14/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned
Wednesday 14/11	[redacted]	[redacted]	09:00	10:00	1	41590691	CHS: Domestic Assistance		Assigned
Wednesday 14/11	[redacted]	[redacted]	11:00	11:15	0.25	41597481	CA: Transport	To office	Assigned
Wednesday 14/11	[redacted]	[redacted]	12:15	12:25	0.17	41608927	IHS : Personal Care		Assigned
Wednesday 14/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned
Thursday 15/11	[redacted]	[redacted]	07:30	07:45	0.25	41531092	IHS : Personal Care		Assigned

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14

18

4·4

15

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Thursday 15/11	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 15/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	16
Thursday 15/11	[redacted]	[redacted]	09:30	11:30	2	41531092	IHS : Domestic Assistance		Assigned	16
Thursday 15/11	[redacted]	[redacted]	11:30	12:30	1	41531092	IHS : Domestic Assistance		Assigned	
Thursday 15/11	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 15/11	[redacted]	[redacted]	13:50	15:20	1.5	41523707	CHS: Domestic Assistance		Assigned	2·9
Thursday 15/11	[redacted]	[redacted]	16:00	16:30	0.5	41599881	IHS : Personal Care		Assigned	12
Thursday 15/11	[redacted]	[redacted]	17:50	18:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 16/11	[redacted]	[redacted]	07:15	07:30	0.25	41531092	IHS : Personal Care		Assigned	
Friday 16/11	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 16/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	16
Friday 16/11	[redacted]	[redacted]	09:30	11:30	2	41547071	CHS: Domestic Assistance		Assigned	5·6
Friday 16/11	[redacted]	[redacted]	11:50	12:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 16/11	[redacted]	[redacted]	[redacted]	[redacted]	0.75	41515435	IHS : Personal Care		Assigned	13
Friday 16/11	[redacted]	[redacted]	17:25	17:55	0.5	41515435	IHS : Personal Care	Cancelled	Assigned	
Friday 16/11	[redacted]	[redacted]	17:55	18:05	0.17	41608927	IHS : Personal Care		Assigned	
Total Hours					23.25					

Total km's ~~[redacted]~~
169.4

Direct Service Staff schedule

Direct Service Staff Name: **Trish Stewart**

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Monday 19/11	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Monday 19/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care	Cancelled	Assigned	
Monday 19/11	[redacted]	[redacted]	09:00	11:00	2	41591324	CHS: Domestic Assistance		Assigned	
Monday 19/11	[redacted]	[redacted]	11:55	12:05	0.17	41608927	IHS : Personal Care		Assigned	
Monday 19/11	[redacted]	[redacted]	12:30	13:30	1	41594204	CHS: Domestic Assistance		Assigned	12
Monday 19/11	[redacted]	[redacted]	13:45	15:45	2	41556426	CHS: Domestic Assistance		Assigned	8-1
Monday 19/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 20/11	[redacted]	[redacted]	07:45	07:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 20/11	[redacted]	[redacted]	08:00	08:30	0.5	41592472	IHS : Personal Care		Assigned	
Tuesday 20/11	[redacted]	[redacted]	11:30	13:00	1.5	41514704	CHS: Domestic Assistance		Assigned	7-1
Tuesday 20/11	[redacted]	[redacted]	9:30	10:30	1	41529685	CHS: Domestic Assistance		Assigned	8-4
Tuesday 20/11	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-60M	2-4	Assigned	2-2
Tuesday 20/11	[redacted]	[redacted]	15:45	16:15	0.5	41590681	IHS : Personal Care		Assigned	12
Tuesday 20/11	[redacted]	[redacted]	18:05	18:15	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 21/11	[redacted]	[redacted]	06:00	07:30	1.5	41542107	CHS: Domestic Assistance		Assigned	
Wednesday 21/11	[redacted]	[redacted]	07:30	07:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 21/11	[redacted]	[redacted]	08:00	08:15	0.25	41592472	IHS : Domestic Assistance		Assigned	18
Wednesday 21/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Wednesday 21/11	[redacted]	[redacted]	09:00	10:00	1	41590691	CHS: Domestic Assistance		Assigned	4-4
Wednesday 21/11	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 21/11	[redacted]	[redacted]	13:00	14:00	1	41592472	IHS : Domestic Assistance		Assigned	4-4
Wednesday 21/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 22/11	[redacted]	[redacted]	07:30	07:45	0.25	41531092	IHS : Personal Care	Cancelled	Assigned	

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer TVA PIN	Status	
Thursday 22/11	[redacted]	[redacted]	07:45	07:55	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 22/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Thursday 22/11	[redacted]	[redacted]	11:30	12:30	1	41531092	IHS : Domestic Assistance	Cancelled	Assigned	
Thursday 22/11	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 22/11	[redacted]	[redacted]	14:30	16:00	1.5	41523707	CHS: Domestic Assistance	Cancelled	Assigned	
Thursday 22/11	[redacted]	[redacted]	16:20	16:50	0.5	41599881	IHS : Personal Care		Assigned	22
Thursday 22/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Friday 23/11	[redacted]	[redacted]	07:15	07:30	0.25	41531092	IHS : Personal Care		Assigned	
Friday 23/11	[redacted]	[redacted]	07:40	07:50	0.17	41608927	IHS : Personal Care		Assigned	
Friday 23/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Friday 23/11	[redacted]	[redacted]	09:00	11:00	2	41542071	CHS: Domestic Assistance		Assigned	5.6
Friday 23/11	[redacted]	[redacted]	11:35	11:45	0.17	41608927	IHS : Personal Care		Assigned	
Friday 23/11	[redacted]	[redacted]	22:00	23:59	1.98	41536361	01_002_0107_1_1 Assistance with self-care activities - active overnight		Assigned	
Saturday 24/11	[redacted]	[redacted]	00:00	06:00	6	41536361	01_013_0107_1_1 Assistance with self-care activities on Saturdays		Assigned	
Total Hours					30.23					

Total km 106.6

Direct Service Staff schedule

Direct Service Staff Name : **Trish Stewart**

T/W

BT/B

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Monday 26/11	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Monday 26/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Monday 26/11	[redacted]	[redacted]	09:15	10:15	1	41527422	CHS: Domestic Assistance		Assigned	19
Monday 26/11	[redacted]	[redacted]	11:00	12:00	1		CHS: Domestic Assistance		Assigned	26
Monday 26/11	[redacted]	[redacted]	11:40	11:50	0.17	41608927	IHS : Personal Care		Assigned	
Monday 26/11	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2.4	Assigned	22
Monday 26/11	[redacted]	[redacted]	15:05	15:20	0.25		CA : Transport	3	Assigned	4.5
Monday 26/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 27/11	[redacted]	[redacted]	08:00	08:30	0.5	41592472	IHS : Personal Care		Assigned	
Tuesday 27/11	[redacted]	[redacted]	08:45	10:45	2		CHS: Domestic Assistance		Assigned	4.4
Tuesday 27/11	[redacted]	[redacted]	11:00	13:00	2	49424253	IHS : Domestic Assistance	988581	Assigned	4.3
Tuesday 27/11	[redacted]	[redacted]	11:25	11:35	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 27/11	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2.4	Assigned	13
Tuesday 27/11	[redacted]	[redacted]	16:00	16:30	0.5	41599881	IHS : Personal Care		Assigned	12
Tuesday 27/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 28/11	[redacted]	[redacted]	06:30	07:30	1	41542107	CHS: Domestic Assistance		Assigned	
Wednesday 28/11	[redacted]	[redacted]	07:30	07:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 28/11	[redacted]	[redacted]	08:00	08:15	0.25	41592472	IHS : Domestic Assistance		Assigned	19
Wednesday 28/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Wednesday 28/11	[redacted]	[redacted]	09:00	10:00	1	41590691	CHS: Domestic Assistance		Assigned	4.4
Wednesday 28/11	[redacted]	[redacted]	11:00	11:15	0.25	41597481	CA : Transport	office	Assigned	15
Wednesday 28/11	[redacted]	[redacted]	12:15	12:25	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 28/11	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Thursday 29/11	[redacted]	[redacted]	07:30	07:45	0.25	41531092	IHS : Personal Care	Cancelled	Assigned	
Thursday 29/11	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 29/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Thursday 29/11	[redacted]	[redacted]	09:30	11:30	2	41531092	IHS : Domestic Assistance		Assigned	16
Thursday 29/11	[redacted]	[redacted]	11:30	12:30	1	41531092	IHS : Domestic Assistance		Assigned	
Thursday 29/11	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 29/11	[redacted]	[redacted]	16:00	16:30	0.5	41599881	IHS : Personal Care		Assigned	11
Thursday 29/11	[redacted]	[redacted]	17:50	18:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 30/11	[redacted]	[redacted]	07:15	07:30	0.25	41531092	IHS : Personal Care	Cancelled	Assigned	
Friday 30/11	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 30/11	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Friday 30/11	[redacted]	[redacted]	09:30	11:30	2	41547071	CHS: Domestic Assistance		Assigned	5.6
Friday 30/11	[redacted]	[redacted]	11:50	12:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 30/11	[redacted]	[redacted]	16:40	17:25	0.75	41515435	IHS : Personal Care	Cancelled	Assigned	
Friday 30/11	[redacted]	[redacted]	17:25	17:55	0.5	41515435	IHS : Personal Care	Cancelled.	Assigned	
Friday 30/11	[redacted]	[redacted]	17:55	18:05	0.17	41608927	IHS : Personal Care		Assigned	
Total Hours					22					

Total km 186.8

Direct Service Staff schedule

Direct Service Staff Name : Trish Stewart

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Monday 03/12	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Monday 03/12	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Monday 03/12	[redacted]	[redacted]	09:00	11:00	2	41591324	CHS: Domestic Assistance		Assigned	4.4
Monday 03/12	[redacted]	[redacted]	11:55	12:05	0.17	41608927	IHS : Personal Care		Assigned	
Monday 03/12	[redacted]	[redacted]	12:30	13:30	1	41594204	CHS: Domestic Assistance		Assigned	12
Monday 03/12	[redacted]	[redacted]	13:45	15:45	2	41556426	CHS: Domestic Assistance		Assigned	8.1
Monday 03/12	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 04/12	[redacted]	[redacted]	07:45	07:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 04/12	[redacted]	[redacted]	08:00	08:30	0.5	41592472	IHS : Personal Care		Assigned	
Tuesday 04/12	[redacted]	[redacted]	09:00	10:30	1.5	41514704	CHS: Domestic Assistance		Assigned	14
Tuesday 04/12	[redacted]	[redacted]	10:40	11:40	1	41529685	CHS: Domestic Assistance		Assigned	7
Tuesday 04/12	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2-4	Assigned	5
Tuesday 04/12	[redacted]	[redacted]	15:45	16:15	0.5	41599881	IHS : Personal Care		Assigned	12
Tuesday 04/12	[redacted]	[redacted]	18:05	18:15	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 05/12	[redacted]	[redacted]	06:00	07:30	1.5	41542107	CHS: Domestic Assistance		Assigned	
Wednesday 05/12	[redacted]	[redacted]	07:30	07:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 05/12	[redacted]	[redacted]	08:00	08:15	0.25	41592472	IHS : Domestic Assistance		Assigned	
Wednesday 05/12	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Wednesday 05/12	[redacted]	[redacted]	09:00	10:00	1	41590691	CHS: Domestic Assistance		Assigned	
Wednesday 05/12	[redacted]	[redacted]	12:00	12:10	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 05/12	[redacted]	[redacted]	13:05	14:05	1	41592472	IHS : Domestic Assistance		Assigned	
Wednesday 05/12	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 06/12	[redacted]	[redacted]	07:30	07:45	0.25	41531092	IHS : Personal Care	Stele	Assigned	

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer EVR PIN	Status
Thursday 06/12	[redacted]	[redacted]	07:45	07:55	0.17	41608927	IHS : Personal Care	Sick	Assigned
Thursday 06/12	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care	Sick	Assigned
Thursday 06/12	[redacted]	[redacted]	09:45	10:15	0.5	41591839	CHS: Transport - 7-20KM	Sick	Assigned
Thursday 06/12	[redacted]	[redacted]	11:00	12:00	1	41531092	IHS : Domestic Assistance	Sick	Assigned
Thursday 06/12	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care	Sick	Assigned
Thursday 06/12	[redacted]	[redacted]	16:20	16:50	0.5	41599881	IHS : Personal Care	Sick	Assigned
Thursday 06/12	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care	Sick	Assigned
Friday 07/12	[redacted]	[redacted]	07:15	07:30	0.25	41531092	IHS : Personal Care	Cancelled	Assigned
Friday 07/12	[redacted]	[redacted]	07:40	07:50	0.17	41608927	IHS : Personal Care		Assigned
Friday 07/12	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned
Friday 07/12	[redacted]	[redacted]	09:00	11:00	2	41547071	CHS: Domestic Assistance		Assigned
Friday 07/12	[redacted]	[redacted]	11:35	11:45	0.17	41608927	IHS : Personal Care		Assigned
Friday 07/12	[redacted]	[redacted]	22:00	23:59	1.98	41536361	01_002_0107_1_1 Assistance with self-care activities - active overnight		Assigned
Saturday 08/12	[redacted]	[redacted]	00:00	06:00	6	41536361	01_013_0107_1_1 Assistance with self-care activities on Saturdays		Assigned
Total Hours					29.23				

5.6

Total km's 70.5

Direct Service Staff schedule

Direct Service Staff Name : **Trish Stewart**

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Monday 10/12	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Monday 10/12	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Monday 10/12	[redacted]	[redacted]	09:15	10:15	1	41527422	CHS: Domestic Assistance		Assigned	19
Monday 10/12	[redacted]	[redacted]	11:00	12:00	1		CHS: Domestic Assistance		Assigned	26
Monday 10/12	[redacted]	[redacted]	11:40	11:50	0.17	41608927	IHS : Personal Care		Assigned	
Monday 10/12	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2·4	Assigned	22
Monday 10/12	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 11/12	[redacted]	[redacted]	08:00	08:30	0.5	41592472	IHS : Personal Care		Assigned	
Tuesday 11/12	[redacted]	[redacted]	08:45	10:45	2		CHS: Domestic Assistance		Assigned	4-4 office 15
Tuesday 11/12	[redacted]	[redacted] Aborted	11:00	13:00	2	49424253	IHS : Domestic Assistance	988581	Assigned	
Tuesday 11/12	[redacted]	[redacted]	11:25	11:35	0.17	41608927	IHS : Personal Care		Assigned	
Tuesday 11/12	[redacted]	[redacted]	14:40	15:00	0.33	41533002	CHS: Transport - 0-6KM	2-4	Assigned	1-4
Tuesday 11/12	[redacted]	[redacted]	16:00	16:30	0.5	41599881	IHS : Personal Care		Assigned	12
Tuesday 11/12	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 12/12	[redacted]	[redacted]	06:30	07:30	1	41542107	CHS: Domestic Assistance		Assigned	
Wednesday 12/12	[redacted]	[redacted]	07:30	07:40	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 12/12	[redacted]	[redacted]	08:00	08:15	0.25	41592472	IHS : Domestic Assistance		Assigned	19
Wednesday 12/12	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Wednesday 12/12	[redacted]	[redacted]	09:00	10:00	1	41590691	CHS: Domestic Assistance		Assigned	4-4 office 1-7
Wednesday 12/12	[redacted]	[redacted] Cancelled?	11:00	11:15	0.25	41597481	CA : Transport		Assigned	
Wednesday 12/12	[redacted]	[redacted]	12:15	12:25	0.17	41608927	IHS : Personal Care		Assigned	
Wednesday 12/12	[redacted]	[redacted]	17:45	17:55	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 13/12	[redacted]	[redacted] Cancelled	07:30	07:45	0.25	41531092	IHS : Personal Care		Assigned	

Service Day	Customer Name	Customer Address	Time From	Time To	Total Hours	Phone No	Service	Customer IVR PIN	Status	
Thursday 13/12	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 13/12	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Thursday 13/12	[redacted]	[redacted] Cancelled	09:30	11:30	2	41531092	IHS : Domestic Assistance		Assigned	
Thursday 13/12	[redacted]	[redacted] cancelled.	11:30	12:30	1	41531092	IHS : Domestic Assistance		Assigned	
Thursday 13/12	[redacted]	[redacted]	12:30	12:40	0.17	41608927	IHS : Personal Care		Assigned	
Thursday 13/12	[redacted]	[redacted]	16:00	16:30	0.5	41599881	IHS : Personal Care		Assigned	22
Thursday 13/12	[redacted]	[redacted]	17:50	18:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 14/12	[redacted]	[redacted] Cancelled.	07:15	07:30	0.25	41531092	IHS : Personal Care		Assigned	
Friday 14/12	[redacted]	[redacted]	07:50	08:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 14/12	[redacted]	[redacted]	08:15	08:45	0.5	41592472	IHS : Personal Care		Assigned	
Friday 14/12	[redacted]	[redacted]	09:30	11:30	2	41547071	CHS: Domestic Assistance		Assigned	5-6
Friday 14/12	[redacted]	[redacted]	11:50	12:00	0.17	41608927	IHS : Personal Care		Assigned	
Friday 14/12	[redacted]	[redacted]	16:40	17:25	0.75	41515435	IHS : Personal Care		Assigned	13
Friday 14/12	[redacted]	[redacted]	17:25	17:55	0.5	41515435	IHS : Personal Care		Assigned	
Friday 14/12	[redacted]	[redacted]	17:55	18:05	0.17	41608927	IHS : Personal Care		Assigned	
Total Hours					21.75					

Total kms 189

'C'

Pay Date
15/02/18

Company EXCELCARE AUSTRALIA INC
ABN 84973882320

Employee Trish Anne Stewart 50086
Location BDB Employee Code STEWT Pay Point NBT STEWT

Pay Date
15/02/18

Company EXCELCARE AUSTRALIA INC ABN 84973882320
Employee Trish Anne Stewart 50086

Pay Details			Rate	$
Trish Stewart		$1037.63		
Superannuation		$126.03	9.50 %	
Australian Super				
38185651				
Credit to Sal Sac Acct				-622.24
Normal		59.6100	$22.1600/H	1326.68
Km Allowance Before Tax		560.5000	$0.7800/U	437.19
Personal Leave	Ent:	61.9996 Hours		
Annual Leave	Ent:	52.6258 Hours		

Period 31/01/18 13/02/18 Total hours this pay 59.6100

This Year		This Pay			
Gross	28998.47	Gross	1763.87	Net	1037.63
Tax	1516.00	Tax	104.00	Bank	1037.63
Net	18904.39	Net	1037.63		

Company	EXCELCARE AUSTRALIA INC			Pay Date 01/03/18
	ABN 64373882330			
Employee	Trish Anne Stewart			50246 *
Location	BDB	Employee Code STEWT	Pay Point NBT	STEWT

Company	EXCELCARE AUSTRALIA INC	ABN 64373882330	Pay Date 01/03/18
Employee	Trish Anne Stewart		50246 *

Pay Details			Rate	$
Trish Stewart		$871.24		
Superannuation		$112.38	9.50 %	
Australian Super 36185851				
Credit to Sal Sac Acct				-822.24
Normal		53.3300	$22.1800/H	1182.91
Km Allowance Before Tax		459.7000	$0.7800/U	358.57
Personal Leave	Ent:	84.0380 Hours		
Annual Leave	Ent:	56.7026 Hours		

Period	14/02/18	27/02/18		Total hours this pay	53.3300
This Year			**This Pay**		
Gross	30539.95		Gross	1541.48	Net 871.24
Tax	1564.00		Tax	48.00	Bank 871.24
Net	17775.63		Net	871.24	

Company	EXCELCARE AUSTRALIA INC		Pay Date 16/03/18
	ABN 64378852820		
Employee	Trish Anne Stewart		50401
Location	BDB Employee Code STEWT	Pay Point NBT	STEWT

Company	EXCELCARE AUSTRALIA INC	ABN64378852820	Pay Date 15/03/18
Employee	Trish Anne Stewart		50401

Pay Details			Rate	$
Trish Stewart		$977.49		
Superannuation		$121.93	9.50 %	
Australian Super 36185851				
Credit to Sal Sac Acct				-622.24
Normal		54.0967	$22.1800/H	1199.92
Saturday Rate		2.5100	$33.2700/H	83.54
Km Allowance Before Tax		518.3000	$0.7800/U	404.27
Personal Leave	Ent:	86.2303 Hours		
Annual Leave	Ent:	61.0870 Hours		

Period	28/02/18	13/03/18	Total hours this pay	56.6067

This Year		This Pay			
Gross	32227.68	Gross	1687.73	Net	977.49
Tax	1652.00	Tax	88.00	Bank	977.49
Net	18753.12	Net	977.49		

Company	EXCELCARE AUSTRALIA INC			Pay Date 28/03/18
	ABN 84678652320			
Employee	Trish Anne Stewart			50561 *
Location	BDB	Employee Code STEWT	Pay Point NBT	STEWT

Company	EXCELCARE AUSTRALIA INC	ABN 84678652320		Pay Date 28/03/18
Employee	Trish Anne Stewart			50561 *

Pay Details			Rate	$
Trish Stewart		$728.42		
Superannuation		$105.71	9.50 %	
Australian Super				
36185651				
Credit to Sal Sac Acct				-622.24
Normal		45.4100	$22.1600/H	1007.20
Sick Leave		4.7600	$22.1600/H	105.56
26/03/18				
Km Allowance Before Tax		310.1000	$0.7800/U	241.88
Personal Leave	Ent:	83.3934 Hours		
Annual Leave	Ent:	64.9930 Hours		

Period	13/03/18	26/03/18	Total hours this pay	50.1700

This Year		This Pay			
Gross	33582.34	Gross	1354.66	Net	728.42
Tax	1656.00	Tax	4.00	Bank	728.42
Net	19481.54	Net	728.42		

Company	EXCELCARE AUSTRALIA INC			Pay Date 12/04/18
	ABN[redacted]			
Employee	Trish Anne Stewart			50728 *
Location	BDB	Employee Code STEWT	Pay Point NBT	STEWT

				Pay Date
Company	EXCELCARE AUSTRALIA INC	ABN[redacted]		12/04/18
Employee	Trish Anne Stewart			50728 *

Pay Details			Rate	$
Trish Stewart		$934.60		
Superannuation		$131.57	9.50 %	
Australian Super 36185651				
Credit to Sal Sac Acct				-622.24
Saturday Rate		0.5000	$33.2700/H	16.64
Normal		47.4900	$22.1800/H	1053.37
Public Holiday No Work		8.4400	$22.1800/H	187.21
Km Allowance Before Tax		315.2000	$0.7800/U	245.86
Sick Leave		5.7600	$22.1800/H	127.76
10/04/18				
Personal Leave	Ent:	80.0180 Hours		
Annual Leave	Ent:	69.7020 Hours		

Period	28/03/18	10/04/18	Total hours this pay	62.1900

This Year		This Pay			
Gross	35213.18	Gross	1630.84	Net	934.60
Tax	1730.00	Tax	74.00	Bank	934.60
Net	20416.14	Net	934.60		

Company	EXCELCARE AUSTRALIA INC		Pay Date 26/04/18
	ABN 54373882320		
Employee	Trish Anne Stewart		50897 *
Location	BDB Employee Code STEWT	Pay Point NBT	STEWT

Company	EXCELCARE AUSTRALIA INC	ABN 54373882320	Pay Date 26/04/18
Employee	Trish Anne Stewart		50897 *

Pay Details			Rate	$
Trish Stewart		$837.50		
Superannuation		$106.62	9.50 %	
Australian Super 36185651				
Credit to Sal Sac Acct				-622.24
Normal		50.6900	$22.1800/H	1124.38
Km Allowance Before Tax		476.1000	$0.7800/U	371.36
Personal Leave	Ent:	81.9795 Hours		
Annual Leave	Ent:	73.6250 Hours		

Period	11/04/18	24/04/18	Total hours this pay	50.6900

This Year		This Pay			
Gross	36708.92	Gross	1495.74	Net	837.50
Tax	1766.00	Tax	36.00	Bank	837.50
Net	21253.64	Net	837.50		

Company EXCELCARE AUSTRALIA INC
ABN 84373662320

Pay Date 10/05/18

Employee Trish Anne Stewart 51069
Location BDB Employee Code STEWT Pay Point NBT STEWT

Company EXCELCARE AUSTRALIA INC ABN 84373662320
Employee Trish Anne Stewart

Pay Date 10/05/18
51069

Pay Details			Rate	$
Trish Stewart		$991.71		
Superannuation		$129.49	9.50 %	
Australian Super 36185651				
Credit to Sal Sac Acct				-622.24
Public Holiday No Work		12.0200	$22.1800/H	266.62
Normal		44.4100	$22.1800/H	985.07
Sunday Rate		2.5100	$44.3600/H	111.34
Km Allowance Before Tax		442.2000	$0.7800/U	344.92
Personal Leave	Ent:	84.2488 Hours		
Annual Leave	Ent:	76.1632 Hours		

Period	25/04/18	08/05/18	Total hours this pay	58.9400

This Year		This Pay			
Gross	38416.87	Gross	1707.95	Net	991.71
Tax	1860.00	Tax	94.00	Bank	991.71
Net	22245.35	Net	991.71		

Company	EXCELCARE AUSTRALIA INC ABN 64975682320		Pay Date 24/05/18
Employee	Trish Anne Stewart		51240 *
Location	BDB Employee Code STEWT	Pay Point NBT	STEWT

Company	EXCELCARE AUSTRALIA INC	ABN 64975682320	Pay Date 24/05/18
Employee	Trish Anne Stewart		51240 *

Pay Details			Rate	$
Trish Stewart		$962.45		
Superannuation		$122.11	9.50 %	
Australian Super 36185651				
Credit to Sal Sac Acct				-622.24
Normal		54.1800	$22.1800/H	1201.78
Double Time O/T		0.1700	$44.3600/H	7.54
Km Allowance Before Tax		246.1000	$0.7800/U	191.96
Saturday Rate		2.5100	$33.2700/H	83.54
Km Allowance Before Tax		238.3000	$0.7800/U	185.87
Personal Leave	Ent:	86.4026 Hours		
Annual Leave	Ent:	82.4708 Hours		

Period	09/05/18 22/05/18		Total hours this pay	56.8600
This Year		**This Pay**		
Gross	40087.56	Gross	1670.69	Net 962.45
Tax	1946.00	Tax	86.00	Bank 962.45
Net	23207.80	Net	962.45	

Company EXCELCARE AUSTRALIA INC
ABN 54372662320

Pay Date 07/06/18

Employee Trish Anne Stewart 51409 *
Location BDB Employee Code STEWT Pay Point NBT STEWT

Company EXCELCARE AUSTRALIA INC ABN 54372662320 Pay Date 07/06/18
Employee Trish Anne Stewart 51409 *

Pay Details			Rate	$
Trish Stewart		$895.04		
Superannuation		$117.52	9.50 %	
Australian Super 36185651				
Credit to Sal Sac Acct				-622.24
Normal		49.6800	$22.1800/H	1101.96
Km Allowance Before Tax		272.5000	$0.7800/U	212.55
Public Holiday No Work		6.0900	$22.1600/H	135.08
Km Allowance Before Tax		163.7000	$0.7800/U	127.69
Personal Leave	Ent:	88.5565 Hours		
Annual Leave	Ent:	86.7763 Hours		

Period 23/05/18 05/06/18 Total hours this pay 55.7700

This Year		This Pay			
Gross	41664.84	Gross	1577.28	Net	895.04
Tax	2006.00	Tax	60.00	Bank	895.04
Net	24102.84	Net	895.04		

Company EXCELCARE AUSTRALIA INC
ABN 64373892320

Pay Date 21/06/18

Employee Trish Anne Stewart 51571
Location BDB Employee Code STEWT Pay Point NBT STEWT

Company EXCELCARE AUSTRALIA INC ABN 64373892320
Employee Trish Anne Stewart

Pay Date 21/06/18
51571

Pay Details			Rate	$
Trish Stewart		$1149.48		
Superannuation		$133.17	9.50 %	
Australian Super				
38185651				
Credit to Sal Sac Acct				-622.24
Normal		58.1800	$22.1800/H	1290.50
Sunday Rate		2.5100	$44.3600/H	111.34
Km Allowance Before Tax		377.9000	$0.7800/U	294.76
Km Allowance Before Tax		268.1000	$0.7800/U	209.12
Personal Leave	Ent:	90.9026 Hours		
Annual Leave	Ent:	91.4704 Hours		

Period	06/06/18	19/06/18	Total hours this pay	60.5900

This Year		This Pay			
Gross	43570.56	Gross	1905.72	Net	1149.48
Tax	2140.00	Tax	134.00	Bank	1149.48
Net	25252.32	Net	1149.48		

Company Livebetter Community Services
ABN 13160258512

Pay Date 11/07/18

Employee Trish Anne Stewart 51781 *
Location BDE Employee Code STEWT Pay Point NBT STEWT

Company Livebetter Community Services ABN 13160258512
Employee Trish Anne Stewart

Pay Date 11/07/18
51781 *

Pay Details			Rate	$
Normal		13.2800	$22.1800/H	294.56
Km Allowance Before Tax		142.3000	$0.7800/U	110.99
Superannuation		$27.98	9.50 %	
Australian Super				
36165651				
Credit to Sal Sac Acct				-405.55
Personal Leave	Ent:	89.9665 Hours		
Annual Leave	Ent:	96.7779 Hours		

Period 25/06/18 08/07/18 Total hours this pay 13.2800

This Year		This Pay			
Gross	2092.27	Gross	405.55	Net	0.00
Tax	88.00	Tax	0.00		
Net	976.48	Net	0.00		

Company	Livebetter Community Services		Pay Date 25/07/18
	ABN 13180258512		
Employee	Trish Anne Stewart		51947
Location	BDB Employee Code STEWT	Pay Point NBT	STEWT

Company	Livebetter Community Services	ABN 13180258512	Pay Date 25/07/18
Employee	Trish Anne Stewart		51947

Pay Details			Rate	$
Normal		47.4267	$22.2400/H	1054.75
Km Allowance Before Tax		384.9000	$0.7800/U	300.22
Night Shift		2.0000	$25.5760/H	51.15
Saturday Rate		6.0000	$33.3600/H	200.16
Backpay		1.0000	$0.8000/H	0.80
Back pay - rate change 01.07.18				
Trish Stewart		$918.24		
Superannuation		$124.15	9.50 %	
Australian Super				
36185651				
Credit to Sal Sac Acct				-620.84
Personal Leave	Ent:	92.1203 Hours		
Annual Leave	Ent:	101.0854 Hours		

Period	09/07/18	22/07/18	Total hours this pay	56.4267

This Year		This Pay			
Gross	3699.35	Gross	1607.08	Net	918.24
Tax	156.00	Tax	68.00	Bank	918.24
Net	1894.72	Net	918.24		

Company	EXCELCARE AUSTRALIA INC		Pay Date 20/07/17
	ABN 64378882320		
Employee	Trish Anne Stewart		47733
Location	BDB Employee Code STEWT	Pay Point NBT	STEWT

Company	EXCELCARE AUSTRALIA INC	ABN 64378882320	Pay Date 20/07/17
Employee	Trish Anne Stewart		47733

Pay Details			Rate	$
Trish Stewart		$1024.37		
Superannuation		$134.87	9.50 %	
Australian Super 36185651				
Credit to Sal Sac Acct				-822.24
Normal		69.8632	$22.1800/H	1416.48
Km Allowance Before Tax		288.7000	$0.7800/U	225.19
Km Allowance Before Tax		137.1000	$0.7800/U	106.94
Personal Leave	Ent:	71.6847 Hours		
Annual Leave	Ent:	82.3592 Hours		

Period	05/07/17	18/07/17	Total hours this pay	69.8632

This Year		This Pay			
Gross	3618.80	Gross	1748.61	Net	1024.37
Tax	230.00	Tax	102.00	Bank	1024.37
Net	2144.32	Net	1024.37		

Payment Advice

liveBetter

Stewart Trish	**LiveBetter Services Ltd**
4 Coomber St	ABN No : 13160259812 Pers ID : 0012510
Bundaberg - 4670	PP Ending : 02.06.2018 Pay Date : 08.06.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Total Payments :				

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Total Deductions :				

Contributions	Account Name	Account Number	Retro	Amount
Total Contributions :				

Bank Number	Account Number	Payee	Amount

Leave Quota	Remaining Balance	Time Units
Annual Leave	111.07	Hours
Sick Leave	96.36	Hours

Year-to-date Details	Amount
Messages :	

Payment Advice

liveBetter

Stewart Trish 4 Coomber St Bundaberg - 4670	**LiveBetter Services Ltd** ABN No : 18160259512 Pers ID : 0012510 PP Ending : 16.09.2018 Pay Date : 20.09.2018 Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours	X	24.68	22.94	566.66
Overtime @ 1.5	X	2.95	33.36	99.41
Overtime @ 2.0	X	1.67	44.49	74.28
Annual Leave	X	35.75	22.94	795.07
Leave Loading	X	35.75	3.89	139.07
Ordinary hours		51.31	22.94	1,141.14
Overtime @ 1.5		2.98	33.36	99.41
Shift Penalty 50%	X	5	11.12	55.60
Meal Allowance	X	1	12.88	12.88
Travel MV perkm Allowance	X	278.46	0.78	217.21
Shift Penalty 50%		5	11.12	55.60
Travel MV perkm Allowance		626.9	0.78	488.97
Total Payments :				3,725.30

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	1,241.66
Ad Hoc Advance Payment			-	373.20
Full Income tax			-	264.00
Total Deductions :				1,878.86

Contributions	Account Name	Account Number	Retro	Amount
Super - CCF ER	AUSTRALIANSUPER SBC	3618551		246.44
Total Contributions :				246.44

Net Pay : 1,846.42

Bank Number	Account Number	Payee	Amount
062-693	10823621	T Stewart	1,846.42

Leave Quota	Remaining Balance	Time Units
Annual Leave	83.89	Hours
Sick Leave	99.55	Hours

Payment Advice

Year-to-date Details	Amount
Total gross	9,728.30
Full Taxable Gross	1,764.86
Net payments/Deductions	1,814.88
Full income tax	264.00
Amount paid	1,844.42

Messages

Payment Advice

live etter

Stewart Trish	**LiveBetter Services Ltd**
4 Coomber St	ABN No : 13160259512 Pare ID : 0012510
Bundaberg - 4670	PP Ending : 16.09.2018 Pay Date : 20.09.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours	X	24.58	22.24	546.69
Overtime @ 1.5	X	2.98	33.30	99.41
Overtime @ 2.0	X	1.67	44.48	74.28
Shift Penalty 50%	X	5	11.12	55.60
Meal Allowance	X	1	12.88	12.88
Travel MV parkin Allowance	X	278.45	0.78	217.21
Total Payments :				1,006.04

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt				- (620.84)
Full Income tax				12.00
Total Deductions :				632.84

Contributions	Account Name	Account Number	Retro	Amount
Super - COF ER	AUSTRALIANSUPER SGC	36165661		57.21
Total Contributions :				57.21

Net Pay : 373.20

Bank Number	Account Number	Payee	Amount
082-683	10823821	T Stewart	373.20

Leave Quota	Remaining Balance	Time Units
Annual Leave	112.86	Hours
Sick Leave	96.8	Hours

Year-to-date Details	Amount
Total gross	1,006.04
Full Taxable Gross	156.11
Net payments/Deductions	- 620.84
Full Income tax	- 12.00
Amount paid	373.20

Messages :

Payment Advice

liveBetter

Stewart Trish	**LiveBetter Services Ltd**
4 Coomber St	ABN No : 13166259512 Pers ID : 0012510
Bundaberg - 4670	PP Ending : 30.09.2018 Pay Date : 04.10.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours		49.59	22.24	1,102.89
Overtime @ 1.5		2.66	33.36	88.41
Sick Leave		1.67	22.24	37.14
Shift Penalty 50%		5	11.12	55.60
Travel MV perkm Allowance		391.48	0.78	305.34
Total Payments :				1,600.37

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	620.84
Total Deductions :				620.84

Contributions	Account Name	Account Number	Retro	Amount
Total Contributions :				

Net Pay : 979.53

Bank Number	Account Number	Payee	Amount
082-693	10023821	T Stewart	979.53

Leave Quota	Remaining Balance	Time Units
Annual Leave	87.84	Hours
Sick Leave	99.95	Hours

Year-to-date Details	Amount
Total gross	5,325.87
Full Taxable Gross	2,438.75
Net payments/Deductions	- 2,295.72
Full Income tax	- 284.00
Amount paid	2,825.95

Messages :

Payment Advice

liveBetter

Stewart Trish	**LiveBetter Services Ltd**
4 Coomber St	ABN No : 13160259512 Pers ID : 0012510
Bundaberg - 4670	PP Ending : 14.10.2018 Pay Date : 18.10.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours		44.57	22.24	991.24
Overtime @ 1.5		2.66	33.36	88.41
Shift Penalty 50%		5	11.12	55.60
Travel MV perkm Allowance		270.74	0.78	211.18
Total Payments :				1,357.43

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	620.84
Total Deductions :				- 620.84

Contributions	Account Name	Account Number	Retro	Amount
Super - COF ER	AUSTRALIANSUPER SGC	36185851		213.03
Total Contributions :				213.03

Net Pay : 736.59

Bank Number	Account Number	Payee	Amount
082-693	10329821	T Stewart	736.59

Leave Quota	Remaining Balance	Time Units
Annual Leave	91.28	Hours
Sick Leave	101.66	Hours

Year-to-date Details	Amount
Total gross	6,883.19
Full Taxable Gross	2,994.16
Net payments/Deductions	- 2,856.58
Full income tax	- 284.00
Amount paid	3,582.84

Messages :

Payment Advice

liveBetter

Stewart Trish 4 Coomber St Bundaberg - 4670	**LiveBetter Services Ltd** ABN No : 13160289812 Pers ID : 0012610 PP Ending : 26.10.2018 Pay Date : 26.10.2018 Working Hrs : 0.00

Payments	Retro	Number	Rate	Amount

Total Payments :

Deductions/Taxes	Account Name	Account Number	Retro	Amount

Total Deductions :

Contributions	Account Name	Account Number	Retro	Amount

Total Contributions :

Bank Number	Account Number	Payee	Amount

Leave Quota	Remaining Balance	Time Units

Year-to-date Details	Amount
Total gross	6,959.10
Full Taxable Gross	2,994.16
Net payments/Deductions	- 2,856.66
Full income tax	- 284.00
Amount paid	3,852.54

Messages :

Payment Advice

liveBetter

Stewart Trish	**LiveBetter Services Ltd**
4 Coomber St	ABN No : 13160259512 Pers ID : 0012510
Bundaberg - 4670	PP Ending : 28.10.2018 Pay Date : 01.11.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours		19.33	22.24	429.90
Overtime @ 1.5		2.99	33.36	99.41
Annual Leave		16.42	22.24	365.18
Leave Loading		16.42	3.89	63.89
Shift Penalty 50%		5	11.12	55.60
Travel MV parkm Allowance		171.2	0.78	133.53
Total Payments :				1,147.50

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	620.84
Total Deductions :			-	620.84

Contributions	Account Name	Account Number	Retro	Amount
Total Contributions :				

Net Pay : 526.66

Bank Number	Account Number	Payee	Amount
082-093	10923821	T Stewart	526.66

Leave Quota	Remaining Balance	Time Units
Annual Leave	77.58	Hours
Sick Leave	103.03	Hours

Year-to-date Details	Amount
Total gross	7,830.60
Full Taxable Gross	3,367.29
Net payments/Deductions	- 3,477.40
Full Income tax	- 264.00
Amount paid	4,089.20

Messages :

Payment Advice

liveBetter

Stewart Trish	**LiveBetter Services Ltd**
4 Coomber St	ABN No : 13160258512 — Pers ID : 0012610
Bundaberg - 4670	PP Ending : 11.11.2018 — Pay Date : 15.11.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Annual Leave	X	10.68	22.24	235.30
Leave Loading	X	10.68	3.89	41.16
Public Holiday Not Worked	X	4.1	22.24	91.18
Ordinary Hours		52.98	22.24	1,178.28
Overtime @ 1.5		2.66	33.36	88.41
Shift Penalty 50%		7	11.12	77.84
Travel MV perkm Allotments		417.2	0.78	325.42
Total Payments :				2,048.59

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	620.84
Full Income tax			-	4.00
Total Deductions :				- 624.84

Contributions	Account Name	Account Number	Retro	Amount
Total Contributions :				

Net Pay :

Net Pay : 1,423.75

Bank Number	Account Number	Payee	Amount
082-503	10823821	T Stewart	1,423.75

Leave Quota	Remaining Balance	Time Units
Annual Leave	72.2	Hours
Sick Leave	105.63	Hours

Year-to-date Details	Amount
Total gross	6,679.19
Full Taxable Gross	4,469.62
Net payments/Deductions	- 4,098.24
Full Income tax	- 269.00
Amount paid	5,512.95

Messages :

Payment Advice

liveBetter

Stewart Trish	**LiveBetter Services Ltd**
4 Coomber St	ABN No : 13160259512 Pers ID : 0012510
Bundaberg - 4670	PP Ending : 25.11.2018 Pay Date : 29.11.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours		47.48	22.24	1,055.96
Overtime @ 1.5		2.98	33.36	99.41
Shift Penalty 50%		5	11.12	55.60
Travel MV perkm Allowance		265	0.78	206.70
Total Payments :				1,417.67

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	620.84
Total Deductions :			-	620.84

Contributions	Account Name	Account Number	Retro	Amount
Super - CGF ER	AUSTRALIANSUPER SGC	36185681		336.76
Total Contributions :				336.76

Net Pay : 796.83

Bank Number	Account Number	Payee	Amount
082-693	10823821	T Stewart	796.83

Leave Quota	Remaining Balance	Time Units
Annual Leave	75.84	Hours
Sick Leave	107.45	Hours

Year-to-date Details	Amount
Total gross	11,295.86
Full Taxable Gross	5,049.75
Net payments/Deductions	- 4,719.08
Full income tax	- 268.00
Amount paid	6,309.78

Messages :

Payment Advice

liveBetter

Stewart Trish	**LiveBetter Services Ltd**
4 Coomber St	ABN No : 13160259512 Pers ID : 0012513
Bundaberg - 4670	PP Ending : 09.12.2018 Pay Date : 13.12.2018
	Working Hrs : 20.00

Payments	Retro	Number	Rate	Amount
Ordinary hours		45.98	22.24	1,022.60
Overtime @ 1.5		2.98	33.36	99.41
Sick Leave		2.75	22.24	61.16
Shift Penalty 50%		5	11.12	55.60
Travel MV perkm Allowance		252.66	0.78	197.08
Total Payments :				1,435.85

Deductions/Taxes	Account Name	Account Number	Retro	Amount
Salary Sacrifice Amt			-	820.84
Total Deductions :				820.84

Contributions	Account Name	Account Number	Retro	Amount
Total Contributions :				

Net Pay : $615.01

Bank Number	Account Number	Payee	Amount
082-693	10823821	T Stewart	615.01

Leave Quota	Remaining Balance	Time Units
Annual Leave	79.58	Hours
Sick Leave	106.57	Hours

Year-to-date Details	Amount
Total gross	12,782.71
Full Taxable Gross	5,667.68
Net payments/Deductions	5,339.92
Full Income tax	268.00
Amount paid	7,124.79

Messages :

BEFORE THE FAIR WORK COMMISSION

FOUR YEARLY REVIEW OF THE MODERN AWARDS

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

MATTER NO. 2018/26

Supplementary Statement of Trish Stewart

I, Trish Stewart, of [redacted] in the state of Queensland say:

1. I have previously provided a statement dated 17 January 2019 in these proceedings.

2. My date of birth is [redacted].

Travel Time

3. My work in home care requires a significant amount of travelling between client's homes for their appointments. This travel is an essential part of the job and is a requirement in order for the services to be delivered.

4. I use my own car to travel to and from the appointments. The position description provided to me by Livebetter states that it is a requirement of my position that I have a driver's licence.

5. Prior to July 2017, I received pay for the travel time between appointments. The amount we were paid depended on the time that it took for us to travel between appointments. We were paid our normal hourly rate for that time and it was counted as time worked. I understand the rostering staff used Google maps to get an estimate for how long the travel should take and this was how our pay was calculated.

6. In July 2017, Excelcare, the company I worked for, became Livebetter, who are my current employer. This change, I believe, is the reason that we are no longer paid our travel time. I do not know why Livebetter chose to stop paying for travel time.

7. Attached to this statement and marked 'A' is a spreadsheet showing an estimate of my time spent travelling between appointments for the period 26 July 2017 to 8 February 2019.I used a website called Openstreet map to calculate the estimates and it includes traffic.

8. As the spreadsheet shows, I can spend up to 1-2 hours accumulatively during a working day travelling between appointments. This is time that I used to be paid for and now I miss out on that pay. It has been a significant paycut for me.

[redacted]

Witness Signature

Trish Stewart

Witness Name (printed) Date: 1-4-19

Annexure A

date	client {travel from}	location	Client (travel to)	location	travel time {minu
wed 26 july 2017	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	20
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	7
"	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	20
"	DAYCO	Coonarr Beach Rd Coonarr Beach	BRUNA	Howard st Bargara	47
"	BYNOP	Mist Court Bargar	BRUNA	Howard st Bargara	9
thur 27 july 2017	BRUNA	Howard st Bargara	BYNOP	Mist Court Bargara	9
"	BYNOP	Mist Court Bargara	DUNNEL	Tummon Street Walkervale	22
"	DUNNEL	Tummon St Walkervale	BRANN	Blackall st Avondale	38
"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	31
fri 28 july 2017	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	2
"	FOWLV	Burkitt st Bargara	BYNOP	Mist Court Bargara	8
"	BYNOP	Mist Court Bargara	DAVISU	Shoreline Crescent Bargara	4
Mon 31 july 2017	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	7
"	SIMPV	Carlyle gardens Bargara	BYNOP	Mist Court Bargara	4
"	BYNOP	Mist Court Bargara	SANDV	Burnett Heads Rd Burnett Heads	14
"	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	10
tue 1 august 2017	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	16
	STEHJ	Boston st Walkervale	BYNOP	Mist Court Bargara	22
	BYNOP	Mist Court Bargara	transport	office Barolin st Pick up car	23
wed 2 August 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	20
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	7
"	KIRBW	Carlyle gardens Bargara	BYNOP	Mist Court Bargara	4
"	BYNOP	Mist Court Bargara	BRUNA	Howard st Bargara	9
"	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	28
thur 3 August 17	BRUNA	Howard st Bargara	BYNOP	Mist Court Bargara	9
"	BYNOP	Mist Court Bargara	DUNNEL	Tummon Street Walkervale	22
"	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	19
"	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	18
Fri 4 August 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	8
"	DAVISU	Shoreline Crescent Bargara	BYNOP	Mist Court Bargara	4
"	BYNOP	Mist Court Bargara	ODONJ	Egret Lane Moore park beach	52
"	ODONJ	Egret Lane Moore Park Beach	BRANN	Blackall st Avondale	48

"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
mon 7 August 17	BRUNA	Howard st Bargara	BYNOP	Mist Court Bargara	**9**
"	BYNOP	mist court Bargara	transport	office Barolin st pick up car	**23**
"	drop car at office	Barolin st South Bundy	GRAHMA	Riedy st Thabeban	**8**
"	GRAHMA	Riedy stThabeban	ODONBE	Grange St Norville	**8**
Tue 8 Auguat 17	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
"	KROPRH	Carlyle gardens Bargara	BYNOP	Mist Court Bargara	**4**
"	BYNOP	Mist Court Bargara	transport	office Barolin st pick up car	**23**
"	drop car at office	Barolin st South Bundy	WHITGR	Whites Rd Gooburrum	**15**
"	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Wed 9 Aug 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	Aborted shift Office	Barolin st South Bundy	**22**
"	Aborted shift Office	Barolin st South Bundy	BYNOP	Mist Court Bargara	**23**
"	BYNOP	Mist Court Bargara	BRUNA	Howard st Bargara	**9**
thur 10 Aug 17	BRUNA	Howard st Bargara	BYNOP	Mist Court Bargara	**9**
"	BYNOP	Mist Court Bargara	DUNNEL	Tummon Street Walkervale	**22**
"	DUNNEL	Tummon St Walkervale	BRANN	Blackall st Avondale	**38**
"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
fri 11 aug 17	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
"	FOWLV	Burkitt st Bargara	BYNOP	Mist Court Bargara	**8**
"	BYNOP	Mist Court Bargara	DAVISU	Shoreline Crescent Bargara	**4**
"	DAVISU	Shoreline Crescent Bargara	GRAHMA	Riedy st Thabeban	**22**
Mon 14 Aug 17	WATSAUD	Argyle Gargens Twyford st Avoca	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	BYNOP	Mist Court Bargara	**4**
	BYNOP	Mist court Bargara	SANDV	Burnett Heads Rd Burnett Heads	**14**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 15 Aug 17	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
"	STEHJ	Boston st Walkervale	BYNOP	Mist Court Bargara	**22**
"	BYNOP	Mist Court Bargara	Transport Pick up car	office Barolin st South Bundy	**23**
Wed 16 Aug 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	BYNOP	Mist Court Bargara	**4**

"	BYNOP	mist court Bargara	BRUNA	Howard st Bargara	**9**
"	BRUNA	Howard st Bargara	Transport Pick up Car	office Barolin st South Bundy	**16**
"	Office drop car back	office Barolin South Bundy	GRAHMA	Riedy st Thabeban	**8**
"	GRAHMA	Riedy st WThabeban	WHITGR	Whites Rd Gooburrum	**22**
Thur 17 Aug 17	BRUNA	Howard st Bargara	BYNOP	Mist Court Bargara	**9**
"	BYNOP	Mist Court Bargara	DUNNEL	Tummon Street Walkervale	**22**
"	WHITGR	Whites Rd Gooburrum	Team Meeting	Office Barolin st South Bundy	**16**
Fri 18 Aug 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	BYNOP	Mist Court Bargara	**4**
"	BYNOP	Mist Court Bargara	ODONJ	Egret Lane Moore park beach	**52**
"	ODONJ	Egret Lane Moore Park Beach	BRANN	Blackall st Avondale	**48**
"	BRUNN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
Mon 21 Aug 17	Holidays				**0**
mon 28 Aug 17	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
"	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
"	SANDV	Burnett Head Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
"	MOOREL	Burnett Heads Rd Rubyanna	STEHJ	Boston st walkervale	**10**
Tue 29 Aug 17	BRUNA	howard st Bargara	MORRLO	hilltop Parade avoca	**23**
"	MORRLO	Hilltop Parade Avoca	KIRBW	Carlyle Gardens Bargara	**28**
"	KIRBW	Carlyle gardens Bargara	FOWLV	Burkitt St Bargara	**5**
"	FOWLV	Burkitt st Bargara	Transport Pick up car	office Barolin st South Bundy	**17**
Wed 30 Aug 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
Thur 31 Aug 17	BRUNA	Howard st Bargara	DUNNEL	Tummon Street Walkervale	**16**
"	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
"	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 1 Sep 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
"	ODONJ	Egret Lane Moore Park Beach	BRANN	Blackall st Avondale	**48**
"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
Mon 4 Sep 17	BRUNA	Howard st Bargara	Aborted shift	Office Barolin St south Bundy	**16**
"	Transport	Droped car at Office	GRAHMA	Riedy st Thabeban	**8**
Tue 5 Sep 17	BRUNA	Howard st Bargara	Transport Pick up car	office Barolin st South Bundy	**16**
"	Transport drop car off	office Barolin South Bundy	WHITGR	Whites Rd Gooburrum	**15**

"	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Wed 6 Sep 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	Aborted shift	Office Barolin st south Bundy	**22**
"	Aborted shift	office Barolin st South Bundy	BRUNA	Howard st Bargara	**16**
Thur 7 sep 17	BRUNA	Howard st Bargara	STREN	Argyle Gardens Twyford st Bundy	**20**
"	STREN	Argyle Gargens Twyford st Avoca	SUPERVISION	Office Barolin st south Bundy	**7**
"	SUPERVISION	Office Barolin st South Bundy	DUNNEL	Tummon Street Walkervale	**5**
"	DUNNEL	Tummon St Walkervale	BRANN	Blackall st Avondale	**38**
"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
FRI 8 Sep 17	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
"	FOWLV	Burkitt st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	GARDG	May St Walkervale	**20**
Mon 11 Sep 17	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
"	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
"	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
"	MOOREL	Burnett Heads Rd Rubyanna	GRAHMA	Riedy st Thabeban	**13**
"	GRAHMA	Riedy St Thabeban	GARDG	May St Walkervale	**7**
Tue 12 Sep 17	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
"	STEHJ	Boston st Walkervale	Transport Pick up car	Office Barolin st South Bundy	**2**
"	Transport drop car off	office Barolin st South Bundy	GREEI	mimnagh walkervale	**3**
"	GREEI	Mimnagh st Walkervale	ABORTED SHIFT	Office Barolin st south Bundy	**3**
"	ABORTED SHIFT	Office Barolin st South Bundy	DARCL	Polo pl Branyan	**13**
"	DARCL	Polo pl Branyan	ODONBE	Grange St Norville	**13**
Wed 13 Sep 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
"	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
Thur 14 Sep 17	Sick leave				**0**
Fri 15 Sep 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
"	ODONJ	Egret Lane Moore Park Beach	BRANN	Blackall st Avondale	**48**
"	BRANN	Blackall st Avondale	ODONBE	Grange St Norville	**37**
"	ODONBE	Grange st Norville	GARDG	May St Walkervale	**4**

"	GARDG	May st Walkervale	DARCL	Polo pl Branyan	**13**
Mon 18 Sep 17	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
"	MORRLO	Hilltop Parade Avoca	Transport Pick up car	office Barolin st South Bundy	**9**
"	Transport drop car off	Office Barolin st South Bundy	ODONBE	Grange St Norville	**3**
"	ODONBE	Grange st Norville	GRAHMA	Riedy st Thabeban	**8**
"	GRAHMA	Riedy St Thabeban	DARCL	Polo pl Branyan	**14**
Tue 19 Sep 17	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
"	KROPRH	Carlyle gardens Bargara	Transport Pick up car	Office Barolin St south Bundy	**22**
"	Transport drop car off	office Barolin st South Bundy	WHITGR	Whites Rd Gooburrum	**15**
"	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
"	ODONBE	Grange st Norville	DARCL	Polo pl Branyan	**13**
Wed 20 Sep 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
"	DAYCO	Coonarr Beach Road	BYNOP	Mist Court Bargara	**48**
"	BRUNA	Howard st Bargara	GARDDO	May St Walkervale	**16**
"	GARDDO	May st Walkervale	TUCKR	Clearview Ave Thabeban	**7**
Thur 21 Sep 17	BRUNA	Howard st Bargara	BRANN	Blackall st Avondale	**47**
"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
Fri 22 Sep 17	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
"	FOWLV	Burkitt st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GRAHMA	Riedy st Thabeban	**22**
"	GRAHMA	Riedy St Thabeban	GARDG	May St Walkervale	**7**
Sat 23 Sep 17	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
"	ODONBE	Grange st Norville	GARDG	May St Walkervale	**4**
"	GARDG	May st Walkervale	WHITGR	Whites Rd Gooburrum	**18**
Mon 25 Sep 17	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
"	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
"	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
"	MOOREL	Burnett Heads Rd Rubyanna	GRAHMA	Riedy st Thabeban	**13**
"	GRAHMA	Riedy St Thabeban	ODONBE	Grange St Norville	**8**
"	ODONBE	Grange st Norville	TUCKR	Clearview Ave Thabeban	**8**
Tue 26 Sep 17	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
"	STEHJ	Boston st Walkervale	CHARCE	Carlyle Gardens Bargara	**21**

"	CHARCE	Carlyle gardens Bargara	Transport Pick up car	Office Barolin st south Bundy	**22**
"	Transport drop car off	office Barolin st South Bundy	ODONBE	Grange St Norville	**3**
Wed 27 Sep 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
"	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
Thur 28 Sep 17	BRUNA	Howard st Bargara	CAMPWE	Shoreline Crescent Bargara	**8**
"	CAMPWE	Shoreline Crescent Bargara	DUNNEL	Tummon Street Walkervale	**20**
"	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
"	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 29 Sep 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
"	ODONJ	Egret Lane Moore Park Beach	GREEI	mimnagh st walkervale	**35**
"	GREEI	Mimnagh st Walkervale	GARDG	May St Walkervale	**2**
"	GARDG	May st Walkervale	WHITGR	Whites Rd Gooburrum	**18**
"	WHITGR	Whites Rd Gooburrum	TUCKR	Clearview Ave Thabeban	**23**
Mon 2 Oct 17	Public Holiday				**0**
Tue 3 Oct 17	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
"	KROPRH	Carlyle gardens Bargara	BRANN	Blackall st Avondale	**52**
"	BRANN	Blackall st Avondale	Transport Pick up car	Office Barolin St south Bundy	**35**
"	Transport drop car off	office Barolin st South Bundy	WHITGR	Whites Rd Gooburrum	**15**
Wed 4 Oct 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	ABORTED SHIFT	Office Barolin st South Bundy	**22**
"	ABORTED SHIFT	Office Baroin st South Bundy	BRUNA	Howard st Bargara	**16**
"	BRUNA	Howard st Bargara	ABORTED SHIFT	Office Barolin st south Bundy	**16**
"	ABORTED SHIFT	Office Barolin st South Bundy	TUCKR	Clearview Ave Thabeban	**8**
Thur 5 Oct 17	BRUNA	Howard st Bargara	DUNNEL	Tummon Street Walkervale	**16**
"	DUNNEL	Tummon St Walkervale	BRANN	Blackall st Avondale	**38**
"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
FRI 6 Oct 17	WHITGR	Whites Rd Gooburrum	BRUNA	Howard st Bargara	**28**
"	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
"	FOWLV	Burkitt st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	BERTMA	Horton st Norville	**23**

"	BERTMA	Horton st Norville	GARDG	May St Walkervale	**4**
Mon 9 Oct 17	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
"	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
"	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
"	MOOREL	Burnett Heads Rd Rubyanna	GRAHMA	Riedy st Thabeban	**13**
"	GRAHMA	Riedy St Thabeban	TUCKR	Clearview Ave Thabeban	**1**
Tue 10 Oct 17	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
"	STEHJ	Boston st Walkervale	Transport Pick up car	Office Barolin st south Bundy	**2**
"	Transport drop car off	office Barolin st South Bundy	ODONBE	Grange St Norville	**3**
"	ODONBE	Grange st Norville	DARCL	Polo pl Branyan	**13**
Wed 11 Oct 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
Thur 12 Oct 17	BRUNA	Howard st Bargara	BRANN	Blackall st Avondale	**47**
"	BRANN	Blackall st Avondale	DUNNEL	Tummon Street Walkervale	**38**
"	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
"	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 13 Oct 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
Mon 16 Oct 17	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
"	MORRLO	Hilltop Parade Avoca	MORGAR	Clive Cresent Kepnock	**15**
"	MORGAR	Transport	Transport Pick up car	Office	**0**
"	Transport	Droped car at Office	GRAHMA	Riedy st Thabeban	**8**
Tue 17 Oct 17	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
"	KROPRH	Carlyle gardens Bargara	Transport Pick up car	Office Barolin St south Bundy	**22**
"	Transport	Droped car at Office	WHITGR	Whites Rd Gooburrum	**15**
Wed 18 Oct 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	ABORTED SHIFT	Office Barolin st South Bundy	**22**
Thur 19 Occt 17	BRUNA	Howard st Bargara	GARDG	May St Walkervale	**16**
"	GARDG	May st Walkervale	DUNNEL	Tummon Street Walkervale	**3**
"	DUNNEL	Tummon St Walkervale	BRANN	Blackall st Avondale	**38**
"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**

"	WHITGR	Whites Rd Gooburrum	Team Meeting	Office Barolin st South Bundy	**16**
Fri 20 Oct 17	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
"	FOWLV	Burkitt st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	GRAHMA	Riedy st Thabeban	**22**
"	GRAHMA	Riedy St Thabeban	GARDG	May St Walkervale	**7**
Sat 21 Oct 17	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
"	ODONBE	Grange st Norville	WHITGR	Whites Rd Gooburrum	**18**
"	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Mon 23 Oct 17	Sick leave				**0**
Tue 24 Oct 17	Sick leave				**0**
Wed 25 Oct 17	Sick leave				**0**
Thur 26 Oct 17	BRUNA	Howard st Bargara	DUNNEL	Tummon Street Walkervale	**16**
"	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
"	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
FRI 27 Oct 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
"	ODONJ	Egret Lane Moore Park Beach	BRANN	Blackall st Avondale	**48**
"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
Mon 30 Oct 17	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
"	MORRLO	Hilltop Parade Avoca	Transport	Picked up car Office	**9**
"	Transport	Droped car at Office	GRAHMA	Riedy st Thabeban	**8**
"	GRAHMA	Riedy St Thabeban	TUCKR	Clearview Ave Thabeban	**1**
Tue 31 Oct 17	BRUNA	Howard st Bargara	Transport	Picked up car Office	**16**
"	Transport	Droped car at Office	WHITGR	Whites Rd Gooburrum	**15**
Wed 1 Nov 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
"	DAYCO Drop home	Coonarr Beach Rd Coonarr Beach	BRUNA	Howard st Bargara	**47**
"	BRUNA	Howard st Bargara	TUCKR	Clearview Ave Thabeban	**20**
Thur 2 Nov 17	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
"	BRUNA	Howard st Bargara	MORGAR	Clive Cresent Kepnock pick up	**15**
"	MORGAR drop of	Hope st Millbank	KROPRH	Carlyle Gardens Bargara	**22**
"	KROPRH	Carlyle gardens Bargara	DUNNEL	Tummon Street Walkervale	**21**
"	DUNNEL	Tummon St Walkervale	BRANN	Blackall st Avondale	**38**

"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
Fri 3 Nov !7	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
"	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
"	FOWLV	Burkitt st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	GRAHMA	Riedy st Thabeban	**22**
"	GRAHMA	Riedy St Thabeban	GARDG	May St Walkervale	**7**
Mon 6 Nov 17	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
"	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
"	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
"	MOOREL	Burnett Heads Rd Rubyanna	GRAHMA	Riedy st Thabeban	**13**
"	GRAHMA	Riedy St Thabeban	GARDG	May St Walkervale	**7**
Tue 7 Nov 17	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
"	STEHJ	Boston st Walkervale	Transport	Picked up car Office	**2**
"	Transport	Droped car at Office	GARDG	May St Walkervale	**3**
"	GARDG	May st Walkervale	ODONBE	Grange St Norville	**4**
Wed 8 Nov 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	RODGR	Regal Court Millbank	**26**
"	RODGR	Regal Court Millbank	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
"	WHITGR	Whites Rd Gooburrum	ABORTED SHIFT	Office Barolin st Bundy	**16**
"	ABORTED SHIFT	office Barolin st South Bundy	ODONBE	Grange St Norville	**3**
Thur 9 Nov 17	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
"	BRUNA	Howard st Bargara	POTTMA	Schulte st East Bundy	**12**
"	POTTMA	Schulte st East Bundy	DUNNEL	Tummon Street Walkervale	**8**
"	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
"	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 10 Nov 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
"	ODONJ	Egret Lane Moore Park Beach	BRANN	Blackall st Avondale	**48**
"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
"	WHITGR	Whites Rd Gooburrum	ODONBE	May St Walkervale	**18**
Sat 11 Nov 17	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
"	ODONBE	Grange st Norville	WHITGR	Whites Rd Gooburrum	**18**

"	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Sun 12 Nov 17	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
"	ODONBE	Grange st Norville	WHITGR	Whites Rd Gooburrum	**18**
"	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Mon 13 Nov 17	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
"	MORRLO	Hilltop Parade Avoca	Transport	Picked up car Office	**9**
"	TRANSPORT	Droped car at Office	GRAHMA	Riedy st Thabeban	**8**
"	GRAHMA	Riedy St Thabeban	BERTMA	Horton st Norville	**8**
Tue 14 Nov 17	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
"	KROPRH	Carlyle gardens Bargara	Transport	Picked up car Office	**22**
"	Transport	Droped car at Office	WHITGR	Whites Rd Gooburrum	**15**
"	WHITGR	Whites Rd Gooburrum	DARCL	Polo pl Branyan	**24**
"	DARCL	Polo pl Branyan	ODONBE	May St Walkervale	**13**
Wed 15 Nov 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
"	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
"	BRUNA	Howard st Bargara	DARCL	Polo pl Branyan	**26**
Thur 16 Nov 17	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
"	BRUNA	Howard st Bargara	WITTR	clive cre Kepnock	**15**
"	WITTR	Clive Cre Kepnock	DUNNEL	Tummon Street Walkervale	**19**
"	DUNNEL	Tummon St Walkervale	BRANN	Blackall st Avondale	**38**
"	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
FRI 17 Nov 17	Annual Leave				**0**
Mon 20 Nov 17	Annual Leave				**0**
Tue 21 Nov 17	Annual Leave				**0**
Wed 22 Nov 17	Annual Leave				**0**
Thu 23 Nov 17	Annual Leave				**0**
Fri 24 Nov 17	Annual Leave				**0**
Mon 27 Nov 17	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
"	MORRLO	Hilltop Parade Avoca	Transport	office pick up car	**9**
"	Transport	Droped car at Office	GRAHMA	Riedy st Thabeban	**8**
"	GRAHMA	Riedy St Thabeban	DENCE	Liberty Villas East Bundy	**13**
Tue 28 Nov 17	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
"	KROPRH	Carlyle gardens Bargara	Transport	office pick up car	**22**

"	Transport	Droped car at Office	WHITGR	Whites Rd Gooburrum	**15**
"	WHITGR	Whites Rd Gooburrum	DARCL	Polo pl Branyan	**24**
Wed 29 Nov 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	ABORTED SHIFT	Office Barolin st South Bundy	**16**
"	ABORTED SHIFT	office Barolin st South Bundy	BRUNA	Howard st Bargara	**16**
"	BRUNA	Howard st Bargara	DARCL	Polo pl Branyan	**26**
"	DARCL	Polo pl Branyan	BERTMA	Horton st Norville	**13**
Thu 30 Nov 17	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
"	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
"	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
"	DUNNEL	Tummon St Walkervale	BRANN	Blackall st Avondale	**38**
Fri 1 Dec 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
"	DAVISU	Shoreline Crescent Bargara	KIRBW	Carlyle Gardens Bargara	**5**
"	KIRBW	Carlyle gardens Bargara	GRAHMA	Riedy st Thabeban	**25**
"	GRAHMA	Riedy St Thabeban	DENCE	Liberty Villas East Bundy	**13**
"	DENCE	Liberty Villas East Bundy	GARDG	May St Walkervale	**7**
"	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 4 Dec 17	MARAP	Baldwin Cres Avoca	ODONBE	Grange St Norville	**8**
"	ODONBE	Grange st Norville	BRUNA	Howard st Bargara	**18**
"	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
"	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
"	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
"	MOOREL	Burnett Heads Rd Rubyanna	GRAHMA	Riedy st Thabeban	**13**
"	GRAHMA	Riedy St Thabeban	BERTMA	Horton st Norville	**8**
"	BERTMA	Horton st Norville	DENCE	Liberty Villas East Bundy	**10**
Tue 5 Dec 17	MARAP	Baldwin Cres Avoca	BRUNA	Howard st Bargara	**21**
"	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
"	STEHJ	Boston st Walkervale	FOWLV	Burkitt St Bargara	**17**
"	FOWLV	Burkitt st Bargara	Transport Pick up car	Office Barolin street	**17**
"	Transport		DARCL	Polo pl Branyan	**13**
"	DARCL	Droped car at Office	BERTMA	Horton st Norville	**13**
"	BERTMA	Horton st Norville	ODONBE	Grange St Norville	**1**
Wed 6 Dec 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
"	BRUNA	Howard st Bargara	RADBC	Argyle Gardens Twyford st Bundy	**20**

	RADBC	Argyle Gargens Twyford st Bundy	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	POULE pick up drop off	Base Hospital	**18**
	POULE	Kentunky Blue Grass Branyan	GRAHMA	Riedy st Thabeban	**11**
	GRAHMA	Riedy St Thabeban	DENCE	Liberty Villas East Bundy	**13**
	DENCE	Liberty Villas East Bundy	BERTMA	Horton st Norville	**10**
	BERTMA	Horton st Norville	DARCL	Polo pl Branyan	**13**
Thu 7 Dec 17	MARAP	Baldwin Cres Avoca	BRUNA	Howard st Bargara	**21**
	BRUNA	Howard st Bargara	WITTR	clive cre Kepnock	**15**
	WITTR	Clive Cre Kepnock	MORGAR pick up	Aberdovy Clinic crofton st bundy	**15**
	MORGAR	Clive Cre Kepnock	BERTMA	Horton st Norville	**9**
	BERTMA	Horton st Norville	ABORTED SHIFT	Office Barolin st	**5**
	AbORTED SHIFT	office Barolin st	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
fri 8 dec 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	BRANN	Blackall st Avondale	**48**
	BRANN	Blackall st Avondale	DENCE	Liberty Villas East Bundy	**37**
	DENCE	Liberty Villas East Bundy	BERTMA	Horton st Norville	**10**
Mon 11 Dec 17	JONERH pick up	Carlyle gardens Bargara	Mater Hospital	Bourbong St Millbank	**23**
	Mater Hospital	Bourbong St Millbank	BRUNA	Howard st Bargara	**18**
	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	MARTGL	Wainwright St	**7**
	MARTGL	Wainwright st	Transport pick up	Gracie Dixon Respite centre	**5**
	TRANSPORT	Polo pl Branyan	GRAHMA	Riedy st Thabeban	**8**
	GRAHMA	Riedy St Thabeban	BERTMA	Horton st Norville	**8**
	BERTMA	Horton st Norville	DENCE	Liberty Villas East Bundy	**10**
Tue 12 Dec 17	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	RATTV	Tropicana Dr Avoca	**29**
	RATTV	Tropicana Dr Avoca	Transport pick up car	Office Barolin st South Bundy	**10**
	DARCL Drop off car	Office Barolin st	WHITGR	Whites Rd Gooburrum	**15**
Wed 13 Dec 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	WITTR	clive cre Kepnock	**20**

	WITTR	Clive Cre Kepnock	DAYCO pick up	Ozcare Woongarra st Bundy	**15**
	DAYCO Drop home	Coonarr Beach Rd Coonarr Beach	BRUNA	Howard st Bargara	**47**
	BRUNA	Howard st Bargara	DARCL	Polo pl Branyan	**26**
Thu 14 Dec 17	BRUNA	Howard st Bargara	DUNNEL	Tummon Street Walkervale	**16**
	DUNNEL	Tummon St Walkervale	BRANN	Blackall st Avondale	**38**
	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
Fri 15 Dec 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	FOWLV	Burkitt St Bargara	**8**
	FOWLV	Burkitt st Bargara	DENCE	Liberty Villas East Bundy	**13**
	DENCE	Liberty Villas East Bundy	GRAHMA	Riedy st Thabeban	**13**
	GRAHMA	Riedy St Thabeban	GARDG	May St Walkervale	**7**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 18 Dec 17	ODONBE	Grange st Norville	BRUNA	Howard st Bargara	**18**
	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
	MOOREL	Burnett Heads Rd Rubyanna	GRAHMA	Riedy st Thabeban	**13**
	GRAHMA	Riedy St Thabeban	DARCL	Polo pl Branyan	**14**
Tue 19 Dec 17	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	GREEI	mimnagh st walkervale	**3**
	GREEI	Mimnagh st Walkervale	Transport pick car up	Office Barolin st South Bundy	**3**
	Transport drop car off	office Barolin st South Bundy	WHITGR	Whites Rd Gooburrum	**15**
	WHITGR	Whites Rd Gooburrum	DARCL	Polo pl Branyan	**24**
	DARCL	Polo pl Branyan	ODONBE	Grange St Norville	**13**
Wed 20 Dec 17	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	GREEI	mimnagh st walkervale	**17**
	GREEI	Mimnagh st Walkervale	GRAHMA	Riedy st Thabeban	**6**
	GRAHMA	Riedy St Thabeban	DENCE	Liberty Villas East Bundy	**13**
Thu 21 Dec 17	BRUNA	Howard st Bargara	SHARK	Taylor st Kepnock	**15**
	SHARK	Taylor st Kepnock	BRUNA	Howard st Bargara	**15**
	BRUNA	Howard st Bargara	DUNNEL	Tummon Street Walkervale	**16**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**

	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 22 Dec 17	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	BRANN	Blackall st Avondale	**48**
	BRANN	Blackall st Avondale	WHITGR	Whites Rd Gooburrum	**31**
Sat 23 Dec 17	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	GREEI	mimnagh st walkervale	**2**
	GREEI	Mimnagh st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Sun 24 Dec 17	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	WHITGR	Whites Rd Gooburrum	**18**
Mon 25 Dec 17	XMAS				**0**
Tue 26 Dec 17	Hoilday				**0**
Wed 27 Dec 17	Annual Leave				**0**
Thu 28 Dec 17	Annual Leave				**0**
Fri 29 Dec 17	MARAP	Baldwin Cres Avoca	WATSAUD	Argyle Gardens Twyford st Bundy	**2**
	WATSAUD	Argyle Gargens Twyford st Bundy	Transport	Hope st Millbank	**5**
	Transport	Hope st Millbank	WHITGR	Whites Rd Gooburrum	**15**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	BRUNA	Howard st Bargara	**18**
	BRUNA	Howard st Bargara	SEMPA	Argyle Gardens Twyford st Bundy	**20**
	SEMPA	Argyle Gargens Twyford st Bundy	GREEI	mimnagh st walkervale	**6**
	GREEI	Mimnagh st Walkervale	WATSAUD pick up	Hope st Millbank	**6**
	WATSAUD	Argyle Gargens Twyford st Bundy	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Mon 1 jan 18	Public Holiday				**0**
Tue 2 jan 18	STEHJ	Boston st Walkervale	BRUNA	Howard st Bargara	**16**
	BRUNA	Howard st Bargara	Administation	Office Barolin st	**16**
	Administation	Office Baroin st South Bundy	WhITGR	Whites Rd Gooburrum	**15**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	BERTMA	Horton st Norville	**1**
Wed 3 Jan 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**

	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
Thu 4 Jan 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
FRI 5 Jan 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	WHITGR	Whites Rd Gooburrum	**25**
	WHITGR	Whites Rd Gooburrum	BERTMA	Horton st Norville	**20**
Mon 8 Jan 18	WHITGR	Whites Rd Gooburrum	BRUNA	Howard st Bargara	**28**
	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	READBE	Argyle Gardens Twyford st Bundy	**5**
	READBE	Argyle Gargens Twyford st Bundy	Transport pick up car	Office Barolin st	**6**
	Transport drop car off	Office Barolin st	GRAHMA	Riedy st Thabeban	**8**
	GRAHMA	Riedy St Thabeban	DARCL	Polo pl Branyan	**14**
Tue 9 Jun 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	RATTV	Tropicana Dr Avoca	**29**
	RATTV	Tropicana Dr Avoca	Transport pick up car	Office Barolin st	**10**
	Transport drop car off	office Barolin st	WHITGR	Whites Rd Gooburrum	**15**
	WHITGR	Whites Rd Gooburrum	DARCL	Polo pl Branyan	**24**
Wed 10 jan 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	READBE	Argyle Gardens Twyford st Bundy	**26**
	READBE	Argyle Gargens Twyford st Bundy	ABORTED SHIFT	Office Barolin st	**6**
	ABORTED SHIFT	Office Barolin st	BRUNA	Howard st Bargara	**16**
	BRUNA	Howard st Bargara	DARCL	Polo pl Branyan	**26**
Thu 11 Jan 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	DARCL	Polo pl Branyan	**24**
Fri 12 Jan 18	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**

	FOWLV	Burkitt st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GREEI	mimnagh st walkervale	**21**
	GREEI	Mimnagh st Walkervale	GRAHMA	Riedy st Thabeban	**6**
	GRAHMA	Riedy St Thabeban	GARDG	May St Walkervale	**7**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Sat 13 Jan 18	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	WHITGR	Whites Rd Gooburrum	**18**
	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Sun 14 Jan 18	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	WHITGR	Whites Rd Gooburrum	**18**
	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Mon 15 jan 18	STEHJ	Boston st Walkervale	BRUNA	Howard st Bargara	**16**
	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	went home sick				**0**
Tue 16 Jan 18	Annual Leave				**0**
Wed 17 jan 18	Annual Leave				**0**
Thu 18 jan 18	Annual Leave				**0**
Fri 19 Jan 18	Annual Leave				**0**
Mon 22 jan 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	Transport Pick up car	Office barolin st	**9**
	Transport drop car off	Office Barolin st	AbORTED SHIFT	office Barolin st	**0**
	AboRTED SHIFT	Office	DARCL	Polo pl Branyan	**13**
Tue 23 jan 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	Transport Pick up car	Office Barolin st	**22**
	Transport drop car off	Office Barolin st	WhITGR	Whites Rd Gooburrum	**15**
	WHITGR	Whites Rd Gooburrum	DARCL	Polo pl Branyan	**24**
Wed 24 Jan 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	BRUNA	Howard st Bargara	**15**
	BRUNA	Howard st Bargara	DARCL	Polo pl Branyan	**26**
Thu 25 Jan 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**

	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	DARCL	Polo pl Branyan	**24**
Fri 26 Jan 18	Public Holiday				**0**
Mon 29 jan 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
	MOOREL	Burnett Heads Rd Rubyanna	DARCL	Polo pl Branyan	**20**
Tue 30 jan 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	Transport pick up car	Office Barolin st	**2**
	Transport drop car off	office barolin st	WHITGR	Whites Rd Gooburrum	**15**
	WHITGR	Whites Rd Gooburrum	DARCL	Polo pl Branyan	**24**
	DARCL	Polo pl Branyan	ODONBE	Grange St Norville	**13**
	ODONBE	Grange st Norville	BERTMA	Horton st Norville	**1**
wed 31 Jan 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DARCL	Polo pl Branyan	**13**
Thu 1 Feb 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	SHARK	Taylor st Kepnock	**15**
	SHARK	Taylor st Kepnock	BERTMA	Horton st Norville	**6**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 2 Feb 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	WHITGR	Whites Rd Gooburrum	**25**
	WHITGR	Whites Rd Gooburrum	BERTMA	Horton st Norville	**20**
Mon 5 feb 18	WHITGR	Whites Rd Gooburrum	BRUNA	Howard st Bargara	**28**
	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	Transport pick up car	office	**9**
	DARCL	Polo pl Branyan	Drop car back	Office Barolin st	**13**
Tue 6 Feb 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	DINNM	Barolin st Walkervale	**22**

	DINNM	Barolin st Walkervale	Transport pick up car	Office	**2**
	Transport drop car off	Office	WHITGR	Whites Rd Gooburrum	**15**
	WHITGR	Whites Rd Gooburrum	DARCL	Polo pl Branyan	**24**
Wed 7 feb 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	MCGUD	Memory Boulevard Innes Park	**16**
	MCGUD	Memory Boulevard innes Park	GREEI	mimnagh st walkervale	**20**
	GREEI	Mimnagh st Walkervale	DARCL	Polo pl Branyan	**13**
	DARCL	Polo pl Branyan	GARDG	May St Walkervale	**13**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
thur 8 Feb 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	GREEI	mimnagh st walkervale	**2**
	GREEI	Mimnagh st Walkervale	DUNNEL	Tummon Street Walkervale	**4**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
	GARDG	May st Walkervale	BERTMA	Horton st Norville	**4**
	BERTMA	Horton st Norville	DARCL	Polo pl Branyan	**13**
Fri 9 Feb 18	WHITGR	Whites Rd Gooburrum	BRUNA	Howard st Bargara	**28**
	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	GREEI	mimnagh st walkervale	**18**
	GREEI	Mimnagh st Walkervale	DARCL	Polo pl Branyan	**13**
	DARCL	Polo pl Branyan	GARDG	May St Walkervale	**13**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 12 Feb 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
	MOOREL	Burnett Heads Rd Rubyanna	BERTMA	Horton st Norville	**12**
	BERTMA	Horton st Norville	DARCL	Polo pl Branyan	**13**
Tue 13 Feb 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	GREEI	mimnagh st walkervale	**3**
	GREEI	Mimnagh st Walkervale	Transport Pick up car	Office	**3**
	Transport drop car off	office	WHITGR	Whites Rd Gooburrum	**15**

	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	BERTMA	Horton st Norville	**1**
Wed 14 feb 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	GREEI	mimnagh st walkervale	**17**
	GREEI	Mimnagh st Walkervale	DARCL	Polo pl Branyan	**13**
	DARCL	Polo pl Branyan	BERTMA	Horton st Norville	**13**
Thu 15 feb 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	SHARK	Taylor st Kepnock	**15**
	SHARK	Taylor st Kepnock	BERTMA	Horton st Norville	**6**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 16 feb 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	Transport Pick up car	Office Barolin st	**33**
	Transport drop car off	Office	WHITGR	Whites Rd Gooburrum	**15**
	WHITGR	Whites Rd Gooburrum	BERTMA	Horton st Norville	**20**
Mon 19 Feb 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	Transport Pick up car	Office	**9**
	DARCL	Polo pl Branyan	Drop car back	Office Barolin st	**13**
Tue 20 feb 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	Transport pick up car	Office Barolin st	**22**
	DARCL	Polo pl Branyan	Drop car back	office	**13**
	drop car at office	Barolin st	WHITGR	Whites Rd Gooburrum	**14**
Wed 21 Feb 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	DARCL	Polo pl Branyan	**14**
Thu 22 feb 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**

	DUNNEL	Tummon St Walkervale	GREEI	mimnagh st walkervale	**5**
	GREEI	Mimnagh st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
FRI 23 feb 18	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	Transport	Gracie Dixon Respite centre	**15**
	Transport	Barolin st Walkervale	GARDG	May St Walkervale	**3**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 26 feb 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
	MOOREL	Burnett Heads Rd Rubyanna	BERTMA	Horton st Norville	**12**
	BERTMA	Horton st Norville	DARCL	Polo pl Branyan	**13**
Tue 27 Feb 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	Transport pick up car	Office	**2**
	DARCL	Polo pl Branyan	WHITGR	Whites Rd Gooburrum	**24**
	WHITGR	Whites Rd Gooburrum	Drop car back	Office	**16**
	Office	Barolin st	ODONBE	Grange St Norville	**3**
Wed 28 Feb 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	SCOTMAY	Collins St East Bundy	**18**
	SCOTMAY	Collins St East Bundy	BRUNA	Howard st Bargara	**13**
	BRUNA	Howard st Bargara	DARCL	Polo pl Branyan	**26**
	DARCL	Polo pl Branyan	BERTMA	Horton st Norville	**13**
Thu 1 Mar 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 2 Mar18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	ODONJ	Egret Lane Moore park beach	**45**
	ODONJ	Egret Lane Moore Park Beach	WHITGR	Whites Rd Gooburrum	**25**
	WHITGR	Whites Rd Gooburrum	BERTMA	Horton st Norville	**20**
Sat 3 Mar 18	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	WHITGR	Whites Rd Gooburrum	**18**
	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Mon 5 Mar 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**

	MORRLO	Hilltop Parade Avoca	Transport Pick up car	Office	9
	DARCL	Polo pl Branyan	Drop car back	Office	13
Tue 6 Mar 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	7
	KROPRH	Carlyle gardens Bargara	SUPERVISION	Office Barolin st	22
	SUPERVISION	Office Barolin st	Transport		0
	Transport Take car	From office	DARCL	Polo pl Branyan	13
	DARCL	Polo pl Branyan	WHITGR	Whites Rd Gooburrum	24
	WHITGR	Whites Rd Gooburrum	Drop car back	Office	16
Wed 7 Mar 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	20
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	7
	KIRBW	Carlyle gardens Bargara	ABORTED SHIFT	Office Barolin st	22
	ABORTED SHIFT	Office	DARCL	Polo pl Branyan	13
Thu 8 Mar 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	19
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	19
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	5
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	19
Fri 9 Mar 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	19
	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	2
	FOWLV	Burkitt st Bargara	GARDG	May St Walkervale	17
	GARDG	May st Walkervale	GARDDO	May St Walkervale	0
Mon 12 Mar 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	7
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	18
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	10
	MOOREL	Burnett Heads Rd Rubyanna	DARCL	Polo pl Branyan	20
Tue 13 Mar 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	16
	STEHJ	Boston st Walkervale	Transport	Gracie Dixon Respite centre	3
	Transport	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	15
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	18
	ODONBE	Grange st Norville	Team Meeting	Office Barolin st	3
Wed 14 Mar 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	20
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	7
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	7
	BRUNA	Howard st Bargara	FLETC	Row St Kepnock	15
Thu 15 Mar 18	BRUNA	Howard st Bargara	DUNNEL	Tummon Street Walkervale	16

	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 16 Mar 18	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	WHITGR	Whites Rd Gooburrum	**25**
Mon 19 Mar 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
Tue 20 Mar 18	Sick leave				**0**
Wed 21 Mar 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	ABORTED SHIFT	Office Barolin st	**22**
	ABORTED SHIFT	Office	FLETC	Row St Kepnock	**6**
Thu 22 Mar 18	BRUNA	Howard st Bargara	DUNNEL	Tummon Street Walkervale	**16**
	DUNNEL	Tummon St Walkervale	SMITMARC	Boundry st Bundy South	**3**
	SMITMARC	Boundry st Bundu South	WHITGR	Whites Rd Gooburrum	**17**
Fri 23 mar 18	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GREEI	mimnagh st walkervale	**21**
	GREEI	Mimnagh st Walkervale	GARDG	May St Walkervale	**2**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 26 Mar 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
	MOOREL	Burnett Heads Rd Rubyanna	WHITGR	Whites Rd Gooburrum	**21**
Tue 27 Mar 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	transport own car	Gracie Dixon Respite centre	**3**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Wed 28 Mar 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	FLETC	Row St Kepnock	**15**
Thu 29 Mar 18	BRUNA	Howard st Bargara	SHARK	Taylor st Kepnock	**15**
	SHARK	Taylor st Kepnock	GREEI	mimnagh st walkervale	**5**
	GREEI	Mimnagh st Walkervale	DUNNEL	Tummon Street Walkervale	**4**

	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 30 mar 18	Public Holiday				**0**
Mon 2 Apr 18	Public Holiday				**0**
Tue 3 Apr 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	transport own car	Gracie Dixon Respite centre	**22**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 4 Apr 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DUNNEL	Tummon Street Walkervale	**21**
	DUNNEL	Tummon St Walkervale	FOWLM	Liberty Villas East Bundy	**7**
	FOWLM	Branyan st Clinic	FLETC	Row St Kepnock	**7**
Thu 5 Apr 18	Sick leave				**0**
Fri 6 Apr 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDG	May St Walkervale	**20**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 9 Apr 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
	MOOREL	Burnett Heads Rd Rubyanna	BERTMA	Horton st Norville	**12**
Tue 10 Apr 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	transport own car	Gracie Dixon Respite centre	**3**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	BERTMA	Horton st Norville	**1**
Wed 11 Apr 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	GREEI	mimnagh st walkervale	**17**
	GREEI	Mimnagh st Walkervale	BERTMA	Horton st Norville	**2**
Thur 12 Apr 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**

	BERTMA	Horton st Norville	GREEI	mimnagh st walkervale	**2**
	GREEI	Mimnagh st Walkervale	transport own car	Gracie Dixon Respite centre	**4**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 13 Apr 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	WHITGR	Whites Rd Gooburrum	**25**
	WHITGR	Whites Rd Gooburrum	BERTMA	Horton st Norville	**20**
Mon 16 apr 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	GARDG pick up	Hope st Millbank	**7**
	GARDG Drop home	May st Walkervale	Transport	Gracie Dixon Respite centre	**4**
	DEZOM	Barolin st Walkervale	GARDG	May St Walkervale	**1**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Tue 17 Apr 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	Transport	Gracie Dixon Respite centre	**22**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Wed 18 Apr 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	GARDG	May St Walkervale	**3**
Thu 19 Apr 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	WHITGR	Whites Rd Gooburrum	**19**
Fri 20 Apr 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	GARDG	May St Walkervale	**17**
Mon 23 Apr 18	BRUNA	Howard st Bargara	ANDEJO pick up	Osborn st Svensson Hieghts	**20**
	ANDEJO drop off	willsons eye clinic	SANDV	Burnett Heads Rd Burnett Heads	**19**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
	MOOREL	Burnett Heads Rd Rubyanna	BERTMA	Horton st Norville	**12**
Tue 24 Apr 18	BRUNA	Howard st Bargara	STEHJ	Horton st Norville	**16**
	STEHJ	Horton st Norville	Transport pick up	Gracie Dixon Respite centre	**3**

	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	BERTMA	Horton st Norville	**1**
wed 25 apr 18	Public Holiday				**0**
Thr 26 Apr 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	TRAINING	Office Barolin st	**16**
	Training	Office	BERTMA	Horton st Norville	**5**
	BERTMA	Horton st Norville	GREEI	mimnagh st walkervale	**2**
	GREEI	Mimnagh st Walkervale	Meeting	Office Barolin st	**3**
	Meeting	Office	ODONBE	Grange St Norville	**3**
Fri 27 Apr 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	Transport pick up	Gracie Dixon Respite centre	**32**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	BERTMA	Horton st Norville	**20**
Sun 29 Apr 18	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	WHITGR	Whites Rd Gooburrum	**18**
	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Mon 30 Apr 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	SEMPA	Argyle Gardens Twyford st Bundy	**5**
	SEMPA	Argyle Gargens Twyford st Bundy	GARDG pick up	Hope st Millbank	**4**
	GARDG Drop home	May st Walkervale	Transport	Gracie Dixon Respite centre	**4**
Tue 1 May 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	RATTV	Tropicana Dr Avoca	**29**
	RATTV	Tropicana Dr Avoca	Transport	Gracie Dixon Respite centre	**10**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 2 May 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	FLETC	Row St Kepnock	**3**
Thu 3 May 18	BERTMA	Horton st Norville	BRUNA	Horton st Norville	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**

	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 4 May 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	GARDG	May St Walkervale	**17**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 7 may 18	Public Holiday				**0**
Tue 8 May 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	GARDG pick up	Hope st Millbank	**6**
	GARDG Drop home	May st Walkervale	Transport	Gracie Dixon Respite centre	**4**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Wed 9 May 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	FLETC	Row St Kepnock	**15**
Thr 10 May 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BERTMA	Horton st Norville	**24**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 11 May 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	WHITGR	Whites Rd Gooburrum	**25**
	WHITGR	Whites Rd Gooburrum	BERTMA	Horton st Norville	**20**
Mon 14 May 18	BRUNA	Howard st Bargara	SEMPA	Argyle Gardens Twyford st Bundy	**20**
	SEMPA	Argyle Gargens Twyford st Bundy	GARDG pick up	Hope st Millbank	**4**
	GARDG Drop home	May st Walkervale	Transport	Gracie Dixon Respite centre	**4**
	DEZOM	Barolin st Walkervale	GARDG	May St Walkervale	**1**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Tue 15 May 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	Transport	Gracie Dixon Respite centre	**22**
	DEZOM	Barolin st Walkervale	MORRLO	hilltop Parade avoca	**10**
	MORRLO	Hilltop Parade Avoca	WHITGR	Whites Rd Gooburrum	**20**
Wed 16 may 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**

	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	ABORTED SHIFT	office Barolin st	**22**
	ABORTED SHIFT	Office Barolin St	SMITMARC	Boundry st Bundy South	**3**
Thu 17 May 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WATSAUD pick up	Hope st Millbank	**8**
	WATSAUD	Argyle Gargens Twyford st Bundy	WHITGR	Whites Rd Gooburrum	**17**
Fri 18 May 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDG	May St Walkervale	**20**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Sat 19 May 18	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	GARDG	May St Walkervale	**4**
	GARDG	May st Walkervale	WHITGR	Whites Rd Gooburrum	**18**
Mon 21 May 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	BERTMA	Horton st Norville	**22**
Tue 22 may 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	TRANSPORT	Gracie Dixon Respite centre	**6**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	BERTMA	Horton st Norville	**1**
Wed 23 May 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	ODONBE	Grange St Norville	**23**
	ODONBE	Grange st Norville	BRUNA	Howard st Bargara	**18**
	BRUNA	Howard st Bargara	SMITMARC	Boundry st Bundy South	**14**
Thu 24 May 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	MORGAR	clive cre Kepnock	**15**
	MORGAR	Clive Cre Kepnock	BERTMA	Horton st Norville	**9**
	BERTMA	Horton st Norville	GREEI	mimnagh st walkervale	**2**

	GREEI	Mimnagh st Walkervale	DUNNEL	Tummon Street Walkervale	**4**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 25 May 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	WHITGR	Whites Rd Gooburrum	**25**
	WHITGR	Whites Rd Gooburrum	BERTMA	Horton st Norville	**20**
Mon 28 May 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	SEMPA	Argyle Gardens Twyford st Bundy	**5**
	SEMPA	Argyle Gargens Twyford st Bundy	ABORTED SHIFT	Office Barolin st	**6**
	ABORTED SHIFT	Office Barolin St	Transport	Gracie Dixon Respite centre	**3**
Tue 29 May 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	Transport	Gracie Dixon Respite centre	**22**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 30 May 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DUNNEL	Tummon Street Walkervale	**21**
	DUNNEL	Tummon St Walkervale	SMITMARC	Boundry st Bundy South	**3**
	SMITMARC	Boundry st Bundu South	BERTMA	Horton st Norville	**17**
	BERTMA	Horton st Norville	ODONBE	Grange St Norville	**1**
Thu 31 May 18	Public Holiday				**0**
Fri 1 jun 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDG	May St Walkervale	**20**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 4 Jun 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
	MOOREL	Burnett Heads Rd Rubyanna	BERTMA	Horton st Norville	**12**
Tue 5 Jun 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	Transport	Gracie Dixon Respite centre	**6**

	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	BERTMA	Horton st Norville	**1**
Wed 6 Jun 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	SMITMARC	Boundry st Bundy South	**14**
Thu 7 Jun 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
	WHITGR	Whites Rd Gooburrum	BERTMA	Horton st Norville	**20**
	BERTMA	Horton st Norville	GREEI	mimnagh st walkervale	**2**
	GREEI	Mimnagh st Walkervale	DUNNEL	Tummon Street Walkervale	**4**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 8 Jun 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	GREEI	mimnagh st walkervale	**35**
	GREEI	Mimnagh st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	BERTMA	Horton st Norville	**20**
Sun 10 Jun 18	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	WHITGR	Whites Rd Gooburrum	**18**
	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Mon 11 Jun 18	WHITGR	Whites Rd Gooburrum	BRUNA	Howard st Bargara	**28**
	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	ABORTED SHIFT	Office	**9**
	ABORTED SHIFT	office	Transport	Gracie Dixon Respite centre	**3**
	DEZOM	Barolin st Walkervale	GARDG	May St Walkervale	**1**
	GARDG	May st Walkervale	MORGAR	clive cre Kepnock	**7**
	MORGAR	Clive Cre Kepnock	WHITGR	Whites Rd Gooburrum	**22**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Tue 12 Jun 18	BRUNA	Howard st Bargara	Transport	Gracie Dixon Respite centre	**15**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 13 Jun 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**

	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	SMITMARC	Boundry st Bundy South	**2**
Thu 14 Jun 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Horton st Norville	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 15 May 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	GARDG	May St Walkervale	**17**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 18 Jun 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
	MOOREL	Burnett Heads Rd Rubyanna	BERTMA	Horton st Norville	**12**
	BERTMA	Horton st Norville	ODONBE	Grange St Norville	**1**
Tue 19 Jun 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	DAYCO pick up	Kepnock grove Kepnock	**8**
	DAYCO Drop home	Kepnock grove Kepnock	WHITGR	Whites Rd Gooburrum	**18**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	BERTMA	Horton st Norville	**1**
Wed 20 Jun 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	BRUNA	Howard st Bargara	**15**
	BRUNA	Howard st Bargara	SMITMARC	Boundry st Bundy South	**14**
Thu 21 Jun 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	went home sick				**0**
Fri 22 Jun 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
	ODONJ	Egret Lane Moore Park Beach	WHITGR	Whites Rd Gooburrum	**25**

	WHITGR	Whites Rd Gooburrum	BERTMA	Horton st Norville	**20**
Mon 25 Jun 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	GARDG pick up	Hope st Millbank	**7**
	GARDG Drop home	May st Walkervale	Transport	Gracie Dixon Respite centre	**4**
	DEZOM	Barolin st Walkervale	WATSAUD pick up	Hope st Millbank	**6**
	WATSAUD Drop home	Argyle Gargens Twyford st Bundy	BERTMA	Horton st Norville	**6**
	BERTMA	Horton st Norville	ABORTED SHIFT	Office	**6**
Tue 26 Jun 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	ABORTED SHIFT	Office Barolin st South Bundy	**16**
	ABORTED SHIFT	Office	WHITGR	Whites Rd Gooburrum	**15**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Wed 27 Jun 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	transport own car	Carlyle Gardens Bargara	**20**
	Mater Hospital	Bourbong St Millbank	SMITMARC	Boundry st Bundy South	**6**
	SMITMARC	Boundry st Bundu South	ODONBE	Grange St Norville	**4**
Thu 28 Jun 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
Fri 29 Jun 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	GARDG	May St Walkervale	**17**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Sat 30 Jun 18	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	WHITGR	Whites Rd Gooburrum	**18**
	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Mon 2 Jul 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 3 jul 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	JONETE	Carlyle Gardens Bargara	**15**

	JONETE	Carlyle gardens Bargara	transport own car	Gracie Dixon Respite centre	**20**
Wed 4 Jul 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
thu 5 Jul 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 6 Jul 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ODONJ	Egret Lane Moore park beach	**51**
Mon 9 jul 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	GARDG pick up	Hope st Millbank	**7**
	GARDG Drop home	May st Walkervale	transport own car	Gracie Dixon Respite centre	**4**
Tue 10 Jul 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	transport own car	Gracie Dixon Respite centre	**22**
	DEZOM	Barolin st Walkervale	WhITGR	Whites Rd Gooburrum	**17**
Wed 11 Jul 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	ODONBE	Grange St Norville	**5**
Thu 12 jul 18	BRUNA	Howard st Bargara	DENTW	Hillrose Court East Bundy	**10**
	DENTW	Hillrose Court East bundy	DUNNEL	Tummon Street Walkervale	**8**
	DUNNEL	Tummon St Walkervale	WhITGR	Whites Rd Gooburrum	**19**
Fri 13 Jul 18	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDG	May St Walkervale	**20**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 16 Jul 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
	MOOREL	Burnett Heads Rd Rubyanna	BERTMA	Horton st Norville	**12**
Tue 17 Jul 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**

	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	NOAKB	Leivesley St East Bundy	**2**
	NOAKB	Leivesley St East Bundy	GARDG pick up	Hope st Millbank	**8**
	GARDG Drop home	May st Walkervale	transport own car	Gracie Dixon Respite centre	**4**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
	ODONBE	Grange st Norville	BERTMA	Horton st Norville	**1**
Wed 18 Jul 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	SMITMARC	Boundry st Bundy South	**14**
Thu 19 Jul 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DENTW	Hillrose Court East Bundy	**10**
	DENTW	Hillrose Court East bundy	BRUNA	Howard st Bargara	**10**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 20 Jul 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	Nght shift				**0**
Mon 23 Jul 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	ODONJ	Egret Lane Moore park beach	**38**
	ODONJ	Egret Lane Moore Park Beach	GARDG pick up	Hope st Millbank	**32**
	GARDG Drop home	May st Walkervale	transport own car	Gracie Dixon Respite centre	**4**
Tue 24 Jul 18	Sick leave				**0**
Wed 25 Jul 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	MORGAR	clive cre Kepnock	**4**
	MORGAR	Clive Cre Kepnock	SMITMARC	Boundry st Bundy South	**5**
	SMITMARC	Boundry st Bundu South	ODONBE	Grange St Norville	**4**
Thu 26 Jul 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	WHITGR	Whites Rd Gooburrum	**19**

Fri 27 Jul 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	FOWLV	Burkitt st Bargara	GARDG pick up	Hope st Millbank	**18**
	GARDG Drop home	May st Walkervale	GARDG	May St Walkervale	**0**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 30 Jul 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 31 Jul 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	JENSK	Gaffel st Svensson Heights	**9**
	JENSK	Gaffel st Svensson Hieghts	transport own car	Gracie Dixon Respite centre	**5**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Wed 1 Aug 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	RODGR	Regal Court Millbank	**26**
	RODGR	Regal Court Millbank	ABORTED SHIFT	Office Barolin st	**7**
Thu 2 Aug 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	CAMPWE	Shoreline Crescent Bargara	**8**
	CAMPWE	Shoreline Crescent Bargara	BERTMA	Horton st Norville	**23**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 3 Aug 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	Night shift				**0**
Mon 6 Aug 18	BRUNA	Howard st Bargara	SMITPAT	Avoca rd Avoca	**22**
	SMITPAT	Avoca Rd Avoca	ODONJ	Egret Lane Moore park beach	**37**
	ODONJ	Egret Lane Moore Park Beach	GARDG pick up	Hope st Millbank	**32**
	GARDG Drop home	May st Walkervale	transport own car	Gracie Dixon Respite centre	**4**
Tue 7 Aug 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	JONERH	Carlyle Gardens Bargara	**1**
	JONERH	Carlyle gardens Bargara	transport own car	Gracie Dixon Respite centre	**20**

	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 8 Aug 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	TURNB	Wilmington st Thabeban	**24**
	TURNB	Wilmington st Thabeban	SMITMARC	Boundry st Bundy South	**5**
	SMITMARC	Boundry st Bundu South	ODONBE	Grange St Norville	**4**
Thu 9 Aug 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 10 Aug 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	FOWLV	Burkitt St Bargara	**2**
	Night Shift				**0**
Mon 13 Aug 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 14 Aug 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	MORRLO	hilltop Parade avoca	**14**
	MORRLO	Hilltop Parade Avoca	transport own car	Gracie Dixon Respite centre	**9**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Wed 15 Aug 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	Administration	Office	**22**
	Administation	Office	BRUNA	Howard st Bargara	**16**
	BRUNA	Howard st Bargara	SMITMARC	Boundry st Bundy South	**14**
Thu 16 Aug 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 17 Aug 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**

Mon 20 Aug 18	Annual Leave				**0**
Tue 21 Aug 18	Annual Leave				**0**
Wed 22 Aug 18	Annual Leave				**0**
Thu 23 Aug 18	Annual Leave				**0**
Fri 24 Aug 18	Annual Leave				**0**
Mon 27 Aug 18	Annual Leave				**0**
Tue 28 Aug 18	Annual Leave				**0**
Wed 29 Aug 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	STEHJ	Boston st walkervale	**21**
	STEHJ	Boston st Walkervale	BRUNA	Howard st Bargara	**16**
	BRUNA	Howard st Bargara	SMITMARC	Boundry st Bundy South	**14**
	SMITMARC	Boundry st Bundu South	Staff Training	Office Barolin st	**3**
Thu 30 Aug 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	GARDDO	May St Walkervale	**16**
	GARDDO	May st Walkervale	BERTMA	Horton st Norville	**4**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 31 Aug 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	Night shift				**0**
Mon 3 Sep 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	ODONJ	Egret Lane Moore park beach	**38**
	ODONJ	Egret Lane Moore Park Beach	transport own car	Gracie Dixon Respite centre	**32**
Tue 4 Sep 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	transport own car	Gracie Dixon Respite centre	**22**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 5 Sep 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	SMITMARC	Boundry st Bundy South	**20**
	SMITMARC	Boundry st Bundu South	ODONBE	Grange St Norville	**4**
Thu 6 Sep 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**

	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 7 Sep 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDG	May St Walkervale	**20**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 10 Sep 18	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
	MOOREL	Burnett Heads Rd Rubyanna	AbORTED SHIFT	Office Barolin st	**10**
Tue 11 Sep 18	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	JONERH	Carlyle Gardens Bargara	**15**
	JONERH	Carlyle gardens Bargara	ABORTED SHIFT	Office Barolin st	**22**
	ABORTED SHIFT	Office Barolin st	WHITGR	Whites Rd Gooburrum	**15**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Wed 12 Sep 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	KIRBW	Carlyle gardens Bargara	SMITMARC	Boundry st Bundy South	**20**
Thu 13 Sep 18	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
Fri 14 Sep 18	BERTMA	Horton st Norville	DAVISU	Shoreline Crescent Bargara	**23**
	Night Shift				**0**
Mon 17 Sep 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	ODONJ	Egret Lane Moore park beach	**38**
	ODONJ	Egret Lane Moore Park Beach	GARDG pick up	Hope st Millbank	**32**
	GARDG Drop home	May st Walkervale	transport own car	Gracie Dixon Respite centre	**4**
	DEZOM	Barolin st Walkervale	ODONBE	Grange St Norville	**2**
Tue 18 sep 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	transport own car	Gracie Dixon Respite centre	**15**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 19 sep 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	SMITMARC	Boundry st Bundy South	**2**

	SMITMARC	Boundry st Bundu South	ODONBE	Grange St Norville	**4**
Thu 20 Sep 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 21 Sep 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	transport own car	Gracie Dixon Respite centre	**20**
	DEZOM	Barolin st Walkervale	GARDG pick up	Hope st Millbank	**6**
	GARDG Drop home	May st Walkervale	GARDDO	May St Walkervale	**0**
	GARDDO	May st Walkervale	GARDG	May St Walkervale	**0**
Mon 24 Sep 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 25 Sep 18	Sick leave				**0**
Wed 26 sep 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	STEHJ	Boston st walkervale	**21**
	STEHJ	Boston st Walkervale	BRUNA	Howard st Bargara	**16**
	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
Thu 27 sep 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
	WHITGR	Whites Rd Gooburrum	ODONBE	Grange St Norville	**18**
FRI 28 Sep 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	Night shift				**0**
Mon 1 Oct 18	Public Holiday				**0**
Tue 2 Oct 18	KROPRH	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	GARDG	May St Walkervale	**16**
	GARDG	May st Walkervale	transport own car	Gracie Dixon Respite centre	**4**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed Oct 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**

	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	SMITMARC	Boundry st Bundy South	**20**
Thur 4 Oct 19	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 5 Oct 19	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDG	May St Walkervale	**20**
Mon 8 Oct 19	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 9 Oct 19	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	Transport DEZOM	Gracie Dixon Respite centre	**6**
	DEZOM	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 10 Oct 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	SMITMARC	Boundry st Bundy South	**14**
Thur 11 Oct 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 12 Oct 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	Night shift				**0**
Mon 15 Oct 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	ODONJ	Egret Lane Moore park beach	**38**
	ODONJ	Egret Lane Moore Park Beach	DEZOM pick up	Gracie Dixon Respite centre	**32**
Tue 16 Oct 18	BRUNA	Howard st Bargara	GARDDO	May street Walkervale	**16**
	GARDDO	May st Walkervale	DEZOM pick up	Gracie Dixon Respite centre	**4**
	DEZOM Drop home	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 17 Oct 18	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**

	DAYCO Drop home	Kepnock grove Kepnock	SMITMARC	Boundry st Bundy South	**2**
Thur 18 Oct 18	Annual Leave				**0**
Fri 19 Oct 18	Annual Leave				**0**
Mon 22 Oct 18	Annual Leave				**0**
Tue 23 Oct 18	Annual Leave				**0**
Wed 24 Oct 18	Annual Leave				**0**
Thur 25 Oct 18	BRUNA	Howard st Bargara	DUNNEL	Tummon Street Walkervale	**16**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 26 Oct 18	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	Night shift				**0**
Mon 29 Oct 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	ODONJ	Egret Lane Moore park beach	**38**
	ODONJ	Egret Lane Moore Park Beach	DEZOM pick up	Gracie Dixon Respite centre	**32**
Tue 30 Oct 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	DEZOM pick up	Gracie Dixon Respite centre	**22**
	DEZOM Drop home	Barolin st Walkervale	WhITGR	Whites Rd Gooburrum	**17**
Wed 31 Oct 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	PEATJ	South Pocket Avenell Hieghts	**5**
Thur 1 Nov 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	WHITGR	Whites Rd Gooburrum	**19**
FRI 2 Nov 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDDO	May St Walkervale	**20**
Sat 3 Nov 18	WHITGR	Whites Rd Gooburrum	GARDG	May St Walkervale	**18**
Mon 5 Nov 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	burnett heads rd burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 6 Nov 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	DEZOM pick up	Gracie Dixon Respite centre	**6**
	DEZOM Drop home	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**

Wed 7 Nov 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	Meeting	Office Barolin st Bundy	**22**
	Meeting	Office Barolin st Bundy	BRUNA	Howard st Bargara	**16**
Thur 8 Nov 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	WHITGR	Whites Rd Gooburrum	**19**
Fri 9 Nov 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	Night shift				**0**
Mon 12 Nov 18	ODONJ	Egret Lane Moore Park Beach	DEZOM pick up	Gracie Dixon Respite centre	**32**
	DEZOM Drop home	Barolin st Walkervale	BERTMA	Horton st Norville	**2**
Tue 13 Nov 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	DEZOM pick up	Ozcare Woongarra st Bundy	**22**
	DEZOM Drop home	Barolin st Walkervale	MORRLO	hilltop Parade avoca	**10**
	MORRLO	Hilltop Parade Avoca	WHITGR	Whites Rd Gooburrum	**20**
Wed 14 Nov 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock			**0**
Thur 15 Nov 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 16 Nov 18	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ABORTED SHIFT	Office Barolin st Bundy	**20**
	ABORTED SHIFT	Office Barolin st Bundy	GARDG	May St Walkervale	**3**
Mon 19 Nov 18	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 20 Nov 18	BRUNA	Howard st Bargara	MOBBE	Meilene St east bundy	**10**
	MOBBE	Meilene st east bundy	STEHJ	Boston st walkervale	**9**
	STEHJ	Boston st Walkervale	DEZOM pick up	Gracie Dixon Respite centre	**3**
	DEZOM Drop home	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**

Wed 21 Nov 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
Thur 22 Nov 18	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
Fri 23 Nov 18	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
Mon 26 Nov 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	ODONJ	Egret Lane Moore park beach	**38**
	ODONJ	Egret Lane Moore Park Beach	DEZOM pick up	Gracie Dixon Respite centre	**32**
	DEZOM Drop home	Barolin st Walkervale	WATSAUD pick up	Hope st Millbank	**6**
Tue 27 Nov 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	DEZOM pick up	Gracie Dixon Respite centre	**22**
	DEZOM Drop home	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 28 Nov 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	ABORTED SHIFT	Office Barolin st Bundy	**22**
Thur 29 Nov 18	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	JONERH	Carlyle Gardens Bargara	**24**
	JONERH	Carlyle gardens Bargara	WHITGR	Whites Rd Gooburrum	**33**
Fri 30 Nov 18	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	ABORTED SHIFT	Office Barolin st Bundy	**20**
Mon 17 Dec 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 4 Dec 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	DEZOM pick up	Gracie Dixon Respite centre	**6**
	DEZOM Drop home	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 5 Dec 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	JONERH	Carlyle Gardens Bargara	**1**
	JONERH	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
Thur 6 Dec 18	Sick leave				**0**
Fri 7 Dec 18	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	Night shift				**0**

Mon 10 Dec 18	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	ODONJ	Egret Lane Moore park beach	**38**
	ODONJ	Egret Lane Moore Park Beach	DEZOM pick up	Gracie Dixon Respite centre	**32**
	DEZOM Drop home	Barolin st Walkervale			**0**
Tue 11 Dec 18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	DEZOM pick up	Gracie Dixon Respite centre	**22**
	DEZOM Drop home	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 12 Dec 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	GARDG Pick up	May St Walkervale	**21**
	GARDG Drop off	Cancer Clinic Hope st	ABORTED SHIFT	Office Barolin st Bundy	**3**
	ABORTED SHIFT	Office Barolin st Bundy	GARDG Pick up	Cancer Clinic Hope st	**4**
	GARDG Drop home	May st Walkervale			**0**
Thur 14 Dec 18	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
FRI 14 Dec 18	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDG	May St Walkervale	**20**
Mon 31 Dec 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 18 Dec 18	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	DEZOM pick up	Gracie Dixon Respite centre	**6**
	DEZOM Drop home	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 19 Dec 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	GARDG	May St Walkervale	**21**
	GARDG	May st Walkervale	BRUNA	Howard st Bargara	**16**
Thur 20 Dec 18	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DAVIBA	Steuart st Bundy nth	**9**
	DAVIBA	Steuart st Bundy nth	WHITGR	Whites Rd Gooburrum	**14**
Fri 21 Dec 18	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	Night shift				**0**
Mon 24 Dec 18	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
	WHITGR	Whites Rd Gooburrum	ODONJ	Egret Lane Moore park beach	**25**

	ODONJ	Egret Lane Moore Park Beach	CURTP	George st Bundy	**33**
	CURTP	George st Bundy	WHITGR	Whites Rd Gooburrum	**15**
Tue 25 Dec 18	Public Holiday				**0**
Wed 26 Dec 18	Public Holiday				**0**
Thur 27 Dec 18	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	KIRBW	Carlyle Gardens Bargara	**24**
	KIRBW	Carlyle gardens Bargara	WhITGR	Whites Rd Gooburrum	**33**
Fri 28 Dec18	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	GARDG	May St Walkervale	**21**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 14 Jan 19	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 1 Jan 19	Public Holiday				**0**
Wed 2 Jan 19	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	STEHJ	Boston st walkervale	**21**
	STEHJ	Boston st Walkervale	BRUNA	Howard st Bargara	**16**
	BRUNA	Howard st Bargara	MOBBE	Meilene St east bundy	**10**
Thur 3 Jan 19	BRUNA	Howard st Bargara	GARDG	May St Walkervale	**16**
	GARDG	May st Walkervale	BERTMA	Horton st Norville	**4**
	BERTMA	Horton st Norville	WHITGR	Whites Rd Gooburrum	**19**
Fri 4 Jan 19	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	Night shift				**0**
Mon 7 Jan 19	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	ODONJ	Egret Lane Moore park beach	**38**
	ODONJ	Egret Lane Moore Park Beach	DEZOM pick up	Gracie Dixon Respite centre	**32**
	DEZOM Drop home	Barolin st Walkervale			**0**
Tue 8 Jan 19	Sick leave				**0**
Wed 9 Jan 19	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
Thur 10 Jan 19	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	GARDG	May St Walkervale	**4**

	GARDG	May st Walkervale	WHITGR	Whites Rd Gooburrum	**18**
Fri 11 Jan 19	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDG	May St Walkervale	**20**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 3 Dec 18	BRUNA	Howard st Bargara	SIMPV	Carlyle Gardens Bargara	**7**
	SIMPV	Carlyle gardens Bargara	SANDV	Burnett Heads Rd Burnett Heads	**18**
	SANDV	Burnett Heads Rd Burnett Heads	MOOREL	Burnett Heads Rd Rubyanna	**10**
Tue 15 Jan 19	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	GARDG	May St Walkervale	**9**
	GARDG	Frendlies Hospital	DEZOM pick up	Gracie Dixon Respite centre	**4**
	DEZOM Drop home	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 16 Jan 19	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
	BRUNA	Howard st Bargara	CAMPWE	Shoreline Crescent Bargara	**8**
Thur 17 Jan 19	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
Fri 18 Jan19	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	Night shift				**0**
Mon 21 Jan 19	BRUNA	Howard st Bargara	MORRLO	hilltop Parade avoca	**23**
	MORRLO	Hilltop Parade Avoca	ODONJE	Egret Lane Moore park beach	**38**
	ODONJ	Egret Lane Moore Park Beach	DEZOM pick up	Gracie Dixon Respite centre	**32**
	DEZOM Drop home	Barolin st Walkervale			**0**
Tue 22 Jan 19	KROPRH	Carlyle gardens Bargara	DEZOM pick up	Gracie Dixon Respite centre	**22**
	DEZOM Drop home	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 23 Jan 19	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock			**0**
Thur 24 Jan 19	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**
	BRUNA	Howard st Bargara	BERTMA	Horton st Norville	**19**
	BERTMA	Horton st Norville	DUNNEL	Tummon Street Walkervale	**5**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 25 Jan 19	BERTMA	Horton st Norville	BRUNA	Howard st Bargara	**19**

	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDG	May St Walkervale	**20**
	GARDG	May st Walkervale	GARDDO	May St Walkervale	**0**
Mon 28 Jan 19	Public Holiday				**0**
Tue 29 Jan 19	BRUNA	Howard st Bargara	STEHJ	Boston st walkervale	**16**
	STEHJ	Boston st Walkervale	MOBBE	Meilene St east bundy	**8**
	MOBBE	Meilene st east bundy	DEZOM pick up	Gracie Dixon Respite centre	**6**
	DEZOM Drop home	Barolin st Walkervale	WHITGR	Whites Rd Gooburrum	**17**
Wed 30 jan 19	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	BRUNA	Howard st Bargara	**7**
Thur 31Jan 19	BRUNA	Howard st Bargara	WHITGR	Whites Rd Gooburrum	**28**
Fri 1 Feb 19	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDG	May St Walkervale	**20**
	Night shift				**0**
Mon 4 Feb 19	BRUNA	Howard st Bargara	ODONJ	Egret Lane Moore park beach	**45**
	ODONJ	Egret Lane Moore Park Beach	WATSAUD pick up	Hope st Millbank	**32**
Tue 5 feb 19	BRUNA	Howard st Bargara	KROPRH	Carlyle Gardens Bargara	**7**
	KROPRH	Carlyle gardens Bargara	LAYLA	Aborted shift Office 65 Barolin st	**22**
	ABORTED SHIFT	65 Barolin st	GARDG	Pick up friendly Hospital	**3**
	GARDG	Drop home May st Walkervale	DEZOM pick up	Gracie Dixon Respite centre	**4**
	DEZOM Drop home	Barolin st Walkervale	MORRLO	hilltop Parade avoca	**10**
	MORRLO	Hilltop Parade Avoca	WHITGR	Whites Rd Gooburrum	**20**
Wed 6 Feb 19	BROUJ	Sugarland Gardens Avoca	BRUNA	Howard st Bargara	**20**
	BRUNA	Howard st Bargara	KIRBW	Carlyle Gardens Bargara	**7**
	KIRBW	Carlyle gardens Bargara	DAYCO pick up	Ozcare Woongarra st Bundy	**22**
	DAYCO Drop home	Kepnock grove Kepnock	CARRJO	Lillypilly pl Moore park	**41**
Thu 7 Feb 19	BRUNA	Howard st Bargara	DUNNEL	Tummon Street Walkervale	**16**
	DUNNEL	Tummon St Walkervale	WHITGR	Whites Rd Gooburrum	**19**
Fri 8 Feb 19	BRUNA	Howard st Bargara	DAVISU	Shoreline Crescent Bargara	**8**
	DAVISU	Shoreline Crescent Bargara	GARDDO	May St Walkervale	**20**
	GARDDO	May st Walkervale	GARDG	May St Walkervale	**0**
	GARDG	May st Walkervale	WHITGR	Whites Rd Gooburrum	**18**
Sat 9 Feb 19					

Sun 10 Feb 19			22657

BEFORE THE FAIR WORK COMMISSION

FOUR YEARLY REVIEW OF THE MODERN AWARDS

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

MATTER NO. 2018/26

Further Statement of Trish Stewart

I, Trish Stewart, of 37A Plum Tree Crescent, Moore Park Beach in the state of Queensland say:

1. I have previously provided statements dated 17 January 2019 and 1 April 2019 in these proceedings.

2. I recently resigned from my role as a home care support worker with LiveBetter. My last day of employment with LiveBetter was 16 September 2019.

3. I resigned from my role with LiveBetter for the following reasons:

4. I did not receive enough hours of work to meet my financial responsibilities. I did speak to my direct coordinators (Ms. Jenni Bruce and Ms. Sharon Walker) on several occasions about receiving more hours, but I was not provided with more hours. Towards the end of my employment with LiveBetter, there was a period of time when additional hours of work were being emailed to a group of support workers, and whoever saw the email first and was able to respond first received the additional hours, or the shifts were given to casual staff.

5. Broken shifts - In my role with LiveBetter, I was required to be available for around 12-13 hours in a day, in order to try and receive a few hours of paid broken shifts. The long availability period affected my family life and it also affected my ability to maintain a second job.

6. Unpaid travel time - I was not paid for travelling between shifts. I live about 30 minutes' drive out of town and when there were gaps between broken shifts I either had to wait around in town or drive home and then drive back to town to the next client.

7. In around April 2019, I obtained a casual job with Edmen Group as a disability support worker. I needed a second job as my income from LiveBetter was not sufficient to live on. I told my coordinator (Ms Jenni Bruce) at LiveBetter about

working for Edmen Group and she said words to the following effect: "*It is fine as long as it does not interfere with your job at LiveBetter.*"

8. However, as I was required to be available for long periods of the day with LiveBetter, I did not have much availability for shifts with Edmen Group. Edmen Group cancelled my contract and listed me as '*inactive*' in around August 2019 as I did not have good availability. In total, I think I did approximately 6-8 shifts with Edmen.

9. I am now employed as a casual Environmental Service Worker in the kitchen of a residential aged care facility (Gracehaven –Churches of Christ Care) in Bundaberg. I am employed at Level 1.1 under the *Aged and Community Care Support Staff Enterprise Agreement* and I am paid $21.21 per hour, plus a 25% casual loading.

10. I have been receiving 8 hour shifts 4 days a week.

11. I do not work any broken shifts. When I go to work, I am there for a full 8 hours and I am paid for those hours. With my new job, I am better able to meet my financial commitments.

12. As my new job has shifts in one block, I have more availability to take on additional hours of work in a second job. I now do occasional work as a contract cleaner and this allows me to supplement my income and pay for bills and other expenses.

13. I am also hoping to be able to move back into my own home now that I have a new job. Because of my income as a home care worker, I was struggling to pay my mortgage repayments in 2018. I applied for financial hardship assistance from my bank, and received a fee free period for 6 months. I tried to sell my home but was unable to.

14. In late 2018 I moved out of my home and found a town house to rent. I am still living in this town house.

15. I was able to lease out my home to a tenant by around February 2019. The mortgage is $400 per week, and the rental income I receive is $360 per week.

16. I am in arrears on my mortgage repayments but I am now able to start paying it back. I am hoping to move back into my home towards the end of the year as I should be able to make my mortgage repayments with my new job if I continue to receive the same number of shifts regularly.

17. I loved working in home care and would have liked to have continued to work in home care. I loved the clients and I felt that I made a difference in the lives of my clients. Most of my clients I had been working with for around 5 years and I had built

a rapport with my clients. It was hard for me to leave my role in home care because of the relationship I had with the clients; however I resigned because of the stress I was under from the low pay, low hours, and broken shifts and from not receiving payment for travel time.

[redacted]

Witness Signature

Trish Stewart 1-10-19

Witness Name (printed) Date:

BEFORE THE FAIR WORK COMMISSION

MATTER NO. 2018/26

Section 156 - Four Yearly Review of Modern Awards – Social, Community, Home Care and Disability Services Industry Award 2010 – Substantive review

Statement of Melissa Coad

I, Melissa Coad, union official, of [redacted] say:

1. I am employed by United Voice as the Executive Projects Coordinator.
2. I am responsible for the coordination of United Voice's activities in home care, disability care and the residential aged care industries. The role requires an in depth knowledge of the home care, disability and aged care sectors, including a detailed knowledge of:
   a. the structure and operation of the sectors, including eligibility processes for consumers, and funding mechanisms,
   b. legislative and policy reforms in both sectors, and
   c. workforce and the issues impacting the provision of quality care and support.
3. The role requires contribution to and involvement in stakeholder and government forums and engagement in the policy debate. I am or was a member of or participate in the following groups and forums: National Aged Care Alliance (NACA) including chairing the NACA workforce sub-committee, the Aged Services Industry Reference Committee, the Aged Care Workforce Industry Council, the (former) Community Services and Health Industry Skills Council, the University of South Australia Quality Jobs Quality Care Project Advisory Committee and Project Working Group, the (former) Department of Health and Ageing Strategic Workforce Advisory Group. My participation in these groups is on behalf of United Voice and its members and the main focus of my involvements is the protection and enhancement of the industrial rights and general well-being of our members.
4. I have been in this role since August 2013.
5. I previously made a statement in the 4 yearly review Part time and Casual proceedings. I have updated that statement for the purposes of these proceedings.
6. I have read the submissions of Australian Business Industrial, the NSW Business Chamber Ltd, Aged and Community Services Australia and Leading Age Services Australia dated 2 July 2019.
7. I have read the submissions of National Disability Services dated 2 July 2019.

Funding of Aged Care

8. The Commonwealth is the primary funder and regulator of aged care in Australia. At the Commonwealth level, the main regulatory instrument is the *Aged Care Act 1997* (Cth), which sets out the basis for service planning, user rights, eligibility for care, funding, quality assurance and accountability.

9. Aged care can be delivered in the home or in a residential aged care facility. There are different models of funding for each sector.

10. Home care employees covered by the *Social, Community, Home Care and Disability Services Industry Award 2010* predominantly provide aged care services in the home. Care workers in residential aged care facilities are covered by the *Aged Care Award 2010*.

11. Eligibility for residential aged care or a Home Care Package is determined by assessment. Assessments are undertaken by an Aged Care Assessment Team ('an ACAT'). Eligibility for services delivered under the Commonwealth Home Support Programme (CHSP) are assessed by a Regional Assessment Service (RAS). A person wanting to enter residential aged care or wanting assistance at home would first contact the Commonwealth Government through a contact centre called My Aged Care. Where appropriate the contact centre will refer the person to an ACAT, or RAS in their local area for assessment. The ACAT or RAS will determine if a person is eligible for residential aged care or for home care and the level of support they are able to receive.

12. Once a person is assessed and eligible they can enter residential aged care or receive a home care package or services provided through CHSP. If residential places or home care packages are not available immediately they will go on a waiting list until places or services are available.

Federal Funding of Home Care

13. Consumer Directed Care ('CDC') and individualised funding is the current model of funding for Federal Home Care Packages Programme. Home Care Packages are different to the Commonwealth Home Support Programme (CHSP).[1]

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[1] The CHSP brings together four programs: Commonwealth Home and Community Care (HACC) Program, Planned respite from the National Respite for Carers Program (NRCP), Day Therapy Centres (DTC) Program, Assistance with Care and Housing for the Aged (ACHA) Program. The CHSP is one consolidated programme that provides entry-level home support for older people who need assistance to keep living independently at home and in their community.

14. Home Care Packages were introduced on 1 August 2013, to replace the former Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) Packages and Extended Aged Care at Home Dementia ('EACHD') Packages as part of the *Living Longer, Living Better* aged care reforms. With the introduction of the Home Care Packages programme, the first tranche of home care places were required to be delivered on a CDC basis.

15. As at 30 June 2014, there were 6,833 home care packages being delivered on a CDC basis. From the 1 July, 2015 all Federal Home Care Packages are required to be delivered on a CDC basis. On 1 July 2015, approximately 59,000 existing Federal Home Care packages were converted to the CDC funding model. As at December 2018 there were 93, 331 people receiving Home Care Package.

16. The purpose of CDC is to deliver greater flexibility and choice to home care clients, who will now be able to choose the types of care and services that they want. This will include how the service is delivered. Individualised funding gives the consumer more control by clearly identifying the sum of money available to support the individual and how that money is spent.[2]

17. The introduction of CDC was a significant change in the way that home care is delivered in Australia. The most significant change that CDC presents is the introduction of individualised budgets for each consumer. Previously, funding of Home Care Packages was provided as 'block' funding to care providers, with a sum of money being provided to care providers to care for an allotted number of consumers. Although they were not entitled to move funds from one client to another, providers would move 'unused' funds from one client to another that required topping up. Some recipients with less intense packages essentially subsidised those who needed more intensive in-home care. However, this can no longer occur due to the introduction of individualised budgets. This 'cross-subsidisation' is impossible under the new system.

18. There is a substantial amount of unspent funds as clients either 'save' for a genuine high cost item or event, save due to attitude "I don't really need it now" or they just don't spend the funds – it is not known exactly why. There was about $539 million in unspent funds as at the end of the 2018 financial year.[3] This was up on the previous financial year. As of 20 June 2017, there were $329 million in unspent funds.[4]

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[2] Guidelines outlining how the Home Care Packages Programme is to be delivered can be found here:https://www.dss.gov.au/sites/default/files/documents/08_2014/home_care_packages_guidelines_2014.pdf

[3] Aged Care Financing Authority, Seventh report on the Funding and Financing of the Aged Care Industry. July 2019, pg 56, available here: https://agedcare.health.gov.au/sites/default/files/documents/08_2019/acfa-seventh-report-2019-acc.pdf

19. Home Care Packages are additionally funded through a consumer contribution of a 'basic daily fee' and dependant on income an 'income tested care fee' as well.

20. Currently, the Federal Home Care package subsidy will still be paid to the home care providers and not directly to the consumer. The Home Care subsidy is paid to the home care provider monthly in advance through the Department of Human Services aged care payment system. The subsidy is calculated on a daily basis.[5]

21. Reforms that commenced in February 2017 enabled funding to follow the consumer (although it will still be paid to the provider). This will mean packages are no longer allocated via an annual planning round to providers; instead, consumers will take their eligible package to any provider of their choice.

22. Additional reforms, which were slated for 2018 (but have yet to occur) will effectively merge the Commonwealth Home Support Programme (previously state based HACC), Home Care Packages and ultimately residential aged care into one seamless aged care system, accessed by the consumer at the appropriate level based on assessment.

23. A crucial feature of both the NDIS and Home Care Packages is an increase in the standardisation of policy and practice across Australia and also the use of a diverse and competitive array of providers. United Voice has been an advocate for workers in these sectors during recent changes to ensure our members conditions are maintained and improved.

24. Employers in aged care, home care and disability appear to be using fears about the change in the funding model for home care and the introduction of the NDIS to demand greater workforce flexibility. When in fact for many providers it may mean a more certain income stream as they are able to attract a greater number of consumers than they were allocated under the previous funding arrangements.

25. A feature of CDC is that greater choice is provided to the consumer. United Voice members are the individuals providing the care and support under this system and the face of the provider. United Voice has been working with employers and peak organisations and amongst the more progressive there is an awareness that stability and better terms and conditions for the workers delivering the actual service is critical for a provider's survival and growth when consumers have greater choice concerning where the money goes. There are a number of factors that militate against uncertainty in this sector under the CDC model of funding.

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[4] As above.

[5] https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/aged-care-subsidies-and-supplements

26. CDC provides incentives for employers to increase the predictability and consistency of service delivery. The work involves delivering personal care services to vulnerable persons who are often isolated in various ways. Continuity of service is sought and desirable. When a good relationship has developed between a carer and a recipient of care, there are incentives to maintain this relationship under CDC.

27. Demand for aged care services (both residential and in the home) is higher than what can currently be delivered due to the planning process effectively 'capping' supply. Many stakeholders in the aged care sector, providers and consumers alike have and continue to call for an uncapping of supply. Demand for aged care services is likely only to grow into the future as the population ages. As at 31 March 2019 there were 129, 038 people waiting to receive a package at their assessed level of need.[6]

28. The nature of the care and support provided by United Voice members in aged care, both in residential and in home care includes, domestic support such as cleaning, cooking and transport, personal care such as assistance with showering, dressing, eating and incontinence and medication management. The care provided is generally low acuity care and should be able to be provided in a planned manner. While our members assist persons in the community with medical emergencies and other one off needs for assistance this is not what this type of service is designed to provide.

29. Accordingly, the nature of these services is that they tend to be performed in a routine manner, *i.e.* at the same time each day, and this allows for both the recipients and providers of the care to negotiate mutually acceptable times for the service to be provided in advance. Continuity and predictability in the pattern of the provision of care is consistent with a higher quality service. An important element of this is the development of relationships between the provider of care and the recipient.

30. There will always be demands on care giver and providers to provide more services and respond to requests for additional services. Many of the recipients of care are socially isolated and have significant mental and physical illnesses. This is the case under past and current funding arrangements and it is incumbent on providers to provide the services that they are able to provide in a planned and measured manner. The majority of care recipients understand and will be able to negotiate a balance between their desired service and the capacity for that service to be provided by the person of their choice and at the time of their choice.

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[6] Department of Health. Home Care Packages Program Data report 3rd Quarter 2018-2019. ! January to 31 March. 2019. June 2019

Funding of residential aged care

31. CDC does not apply to the Residential Aged Care. The *Living Longer Living Better* reforms announced by the former Labor government in 2012 included a commitment to pilot CDC in residential care. Despite this initial interest from government, a trial is yet to commence. If CDC was to be implemented in a residential care setting it would require a very different approach to CDC in home care. The congregate care setting, shared costs and group rosters would make the application of individual budgets in a residential environment impractical. The concept of CDC in residential care is further complicated by the vulnerability and frailty of residents.[7]

32. Residential aged care places are allocated to providers in an annual Aged Care Approvals Round ('ACAR'). ACAR is an annual competitive application process in which prospective and existing approved providers of aged care can apply for Government funded residential aged care places. These places are capped and become available on the basis of planning based on demographics and geography. The ACAR also provides the opportunity to apply for financial assistance in the form of a capital grant. Applications are assessed and places allocated to those providers that demonstrate that they can provide the best care to potential residents. There is currently a review of the ACAR process underway. The consultation period ends on 13 September 2019.[8]

33. Once assessed by an ACAT, individuals can then access residential aged care based on availability.

34. Consumers contribute to the cost of their care and accommodation in residential aged care via payment of a 'basic daily fee' and possibly a 'means tested care fee'. Accommodation payments are means tested and can be paid via a refundable lump sum or as a 'daily accommodation payment'.

35. Residential aged care providers receive funding per resident based on each resident's care needs and any supplements they may be entitled to. This is paid monthly. An accommodation supplement is also paid for those residents not paying their own accommodation fees due to limited income or assets. A higher accommodation supplement is paid to facilities that are new or recently refurbished.

36. Capital grant funding for capital investment may also be available to residential providers who meet a number of criteria.

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[7] http://www.australianageingagenda.com.au/2015/08/05/special-report-putting-residents-front-and-centre/

[8] https://consultations.health.gov.au/aged-care-policy-and-regulation/alternative-allocation-models-residential-care/

[redacted]

Witness Signature

MELISSA CORP

Witness Name (printed)

Date: 16/09/2019

FAIR WORK COMMISSION

FOUR YEARLY REVIEW OF MODERN AWARDS

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

MATTER NO. 2018/26

Statement of Jared Marks

I, Jared Marks, Industrial Officer of [redacted] in the State of Queensland, state as follows:

1. I am employed by United Voice (**UV**) and have the conduct of proceedings in the Queensland Magistrates Court (matter numbers MEC/2019/24, MEC/2019/27, MEC/2019/28 and MEC/2019/29) which address the monetary loss caused by the defendant's failure to pay travel time (**related proceedings**).

2. I am aware that UV has advanced claims relating to travel time in these proceedings.

3. I make this statement to inform the Commission on the background to and current state of the related proceedings and the respective positions of the parties.

The parties in the related proceedings

4. LiveBetter Services Limited (**LiveBetter**) is a business engaged in the provision of in-home care providing domestic services to disabled and aged clients.

5. LiveBetter employs home care workers (termed 'support workers') who are classified as *'home care employees'* in accordance with the classification definitions of Schedule E to the *Social, Community, Home Care and Disability Services Industry Award 2010* (**Award**).

6. UV has coverage of home care employees.

Background to the related proceedings

7. On 3 August 2018, UV applied pursuant to s.738(a) of the *Fair Work Act 2009* (Cth) for the Fair Work Commission to deal with a dispute between UV and LiveBetter (**Dispute**).

8. I had the conduct of the Dispute.

9. At that time, the Award dispute procedure provided arbitration by consent only.

10. The Dispute was listed for two Conferences before Commissioner Simpson which occurred on 23 August 2018 and 8 October 2018.

11. The Dispute did not resolve at Conference and LiveBetter, the respondent in this matter, did not consent to the matter being arbitrated.

12. In the circumstances, UV decided to pursue the matter further in the Courts, which precipitated UV filing four employment claims in the Magistrates Court on behalf of four affected members of UV (*i.e.* the related proceedings). The employment claims were filed on 18 June 2019.

The related proceedings

13. A copy of one of the employment claims is **exhibited** hereto and marked "**JM1**".

14. All four employment claims seek orders for compensation and pecuniary penalties from the defendant, LiveBetter, for the failure to pay wages for periods of time home care workers undertook work related travel at the direction of their employer.

15. On 12 August 2019, LiveBetter filed a defence to each of the employment claims.

16. A copy of one of the defences is **exhibited** hereto and marked "**JM2**".

17. On 12 September 2019, LiveBetter filed interlocutory applications and supporting affidavits (each affidavit constituting 379 pages) applying for an order staying any further steps in the related proceedings pending the determination of these proceedings (**stay applications**).

18. A copy of one of the interlocutory applications is **exhibited** and marked "**JM3**". I do not produce a copy of the supporting affidavits however a copy can be produced upon request.

19. The stay applications have been listed for hearing on 2 December 2019.

The parties respective positions in the related proceedings

20. The principle issue in dispute is whether home care workers covered by the Award are entitled to be paid as time worked for time spent travelling between clients of LiveBetter when directed to attend clients' homes on the employer's behalf.

LiveBetter's position

21. The pattern of work (determined by LiveBetter) is for home care workers to attend the residences of clients at non-consecutive times throughout the work day.

22. LiveBetter characterises the pattern of work as a series of broken shifts and concedes that travel time is payable except for travel to and from a broken shift.[1]

23. By LiveBetter's reasoning, a broken shift commences when a support worker arrives at a client's home and ends when the home care worker departs from the client's home.

24. It appears LiveBetter intends to argue the principle that '*employees are not entitled to be paid for their commute between home and work*' should be extended to broken shifts.

UV's position

25. UV does not agree that travel time can be severed from a shift irrespective of whether the shift has been broken or not.

26. A key feature of the duties of a home care worker under the Award is the provision of domestic assistance in clients' homes at the direction of their employer. For this to occur, the home care worker must travel to and between clients at the direction of the employer. This is part of their normal work and anticipated in the Award classifications.

27. LiveBetter requires home care workers to use their own vehicles for this purpose and compensates them by paying a kilometre allowance in accordance with clause 20.5(a) of the Award. The kilometre allowance compensates support workers for some of the wear and tear on their vehicles and fuel, but it does not compensate them for their time which we say is time worked.

28. In any employment relationship it is fundamental that when an employee is directed to perform a function for the employer, usually for the benefit of the employer and/or its client, the employee is engaged in work which must attract remuneration.

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[1] Paragraph 4 of the defence.

29. In the case of home care workers, the function of work related travel is inherent to the role because the service occurs at the premises of a client.

30. For this reason, the concept of *'travelling to and from a broken shift'* is unsound, because the travel cannot be separated from the domestic assistance that takes place in the client's home from the shift. This is because when a home care worker travels to a client they are performing their duties as directed.

31. LiveBetter's position is that travel to and from a broken shift is equivalent to the commute from home to work.

32. UV's position is that the commute between home and work occurs at the start and end of a work day. Work related travel, being inherent to the role, occurs during the working day and forms part of any shift, including shifts arising out of a broken shift.

The stay application

33. LiveBetter seeks to defer the matter pending the conclusion of the award review proceedings because, in its view, the Full Bench is a specialist tribunal who are currently addressing the issues relevant to the related proceedings.

34. UV does not agree with LiveBetter's approach because the review proceedings are an *inter partes* review of the Award. Any variation that the Full Bench may make to the Award will be prospective and will not affect the employment claims which have been made by our members. Further, the Full Bench in the review is not in a position to deal with individual cases or make any kind of determination about individual cases. In light of the refusal of LiveBetter to consent to arbitration, there is no jurisdiction for a member of the Commission to sit as a private arbitrator and make a binding determination concerning the employment claims.

35. I trust this material assists the Full Bench in its review of the Award.

Jared Marks

Dated: 3 October 2019

FAIR WORK COMMISSION

FOUR YEARLY REVIEW OF MODERN AWARDS

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

MATTER NO. 2018/26

Exhibit JM1

MAGISTRATES COURT OF QUEENSLAND

REGISTRY: Brisbane
NUMBER: M 2400/19

Plaintiff: **MARGARET BLACKHURST**

AND

Defendant: **LIVEBETTER SERVICES LIMITED ACN 160 259 512**

EMPLOYMENT CLAIM

STATEMENT OF PARTICULARS OF CLAIM

The Parties

1. The plaintiff is and has been employed by the defendant in the role of Support Worker since 27 April 2017.

2. The defendant is, and was at all material times:

   (a) a body corporate duly registered and capable of being sued;

   (b) engaged, *inter alia*, in the provision of in-home domestic services to disabled and aged clients (**clients**).

The plaintiff's employment

3. Prior to 1 July 2018, the plaintiff was employed by Excelcare Australia Limited ACN 614 290 292 t/a Excelcare Australia Incorporated (**Excelcare**) on a permanent part-time basis in the role of home care worker (the **employment**).

4. On about 1 July 2018, Excelcare's business transferred to the defendant (the **transfer of business**).

14 JUN 2019

EMPLOYMENT CLAIM
Filed on Behalf of the Plaintiff

Form 2A Version 1
Uniform Civil Procedure Rules 1999
Rule 22; 522C

Name: Jared Marks, Industrial Officer
Address: United Voice, 27 Peel Street, South Brisbane 4101

Phone No: 07 3291 4654
Fax No: 07 3291 4699
Email: jared.marks@unitedvoice.org.au

5. The defendant continued to employ the plaintiff after the transfer of business and the plaintiff's service and entitlements transferred with the employment (the **transfer of employment**).

6. By virtue of the transfer of business and the transfer of employment, the defendant assumed liability for any unpaid wages and/or entitlements accrued but not paid during the period the plaintiff was employed by Excelcare.

Relevant Industrial Instruments

Agreements and Awards

7. The *Keppel Community Care Association Inc Support Workers Agreement 2008 Employee Collective Agreement* (the **Agreement**), covered and applied to the employment from 2008 until it was terminated on 19 June 2017.

8. On and from 19 June 2017, the *Social, Community, Home Care and Disability Services Industry Award 2010* (the **Award**) covered and applied to the employment.

Contracts of employment

9. On 8 October 2016, the plaintiff entered into a contract of employment with Excelcare dated 1 October 2016.

10. On 1 July 2018, the plaintiff entered into a contract of employment with the defendant dated 27 June 2018.

Particulars

Clause 4 of the contract dated 1 July 2018 states, "*Your conditions of employment will be governed by the applicable provisions of the Social, Community, Home Care and Disability Services Industry Award 2010*".

Work arrangements

11. Throughout the employment, the plaintiff has been required and authorised to use their personal motor vehicle to travel to and between client residences (**work related travel**) to provide in-home domestic services, in accordance with a fortnightly roster.

12. On and from 19 June 2017, the plaintiff has been paid a travel allowance in accordance with Clause 20.5(a) of the Award (the **travel allowance**).

Particulars

Clause 20.5(a) of the Award states, "*Where an employee is required and authorised by their employer to use their motor vehicle in the course of their duties, the employee is entitled to be reimbursed at the rate of $0.78 per kilometre.*"

13. Prior to 26 July 2017, the plaintiff was paid for work related travel.

14. On and from 26 July 2017, the plaintiff was no longer paid for work related travel.

Relevant entitlements

15. On and from 19 June 2017, the plaintiff was entitled to be paid for all hours worked in accordance with the classification levels in Clause 17 of, and the classification definitions in Schedule E to, the Award.

16. In the premises, since 19 June 2017 the plaintiff was entitled to be paid for work related travel as time worked in accordance with the Award.

Contraventions

17. By virtue of the above matters:

(a) the defendant is liable for the failure to pay the plaintiff for travel time since 19 June 2017;

(b) thereby contravened a term of the Award;

(c) thereby contravened s.45 of the FW Act.

Loss and damage

18. As a consequence of the defendant's contraventions of s.45 of the FW Act, as pleaded in paragraphs 17 herein, the plaintiff has suffered pecuniary loss in the sum of $4,494.30 particulars of which are set out in Appendix A to this claim.

Orders sought

19. The plaintiff seeks the following orders:

(a) by reason of the matters pleaded in paragraph 18 herein, the defendant pay compensation to the plaintiff in the sum of $4,494.30 pursuant to s.545 of the FW Act for loss suffered because of the contraventions of s.45 of the FW Act;

(a) the defendant pay interest on compensation in accordance with s.547 of the FW Act or, alternatively s.58(3) of the *Civil Proceedings Act 2011* (Qld);

(b) the defendant pay a pecuniary penalty pursuant to s.546 of the FW Act for its contraventions of s.45 of the FW Act;

(c) the pecuniary penalties be paid to United Voice pursuant to s.546(3) of the FW Act.

The plaintiff claims the amount set out below and elects to have this claim heard and decided in the Magistrates Court under the simplified procedures as an Employment Claim:-

Claim	$	4,494.30
Filing fee	$	62.05
Bailiff's service fee	$	50.40
Total	$	4,606.75

To the defendant[s]: TAKE NOTICE that you are being sued by the plaintiff in the Court.

If you assert that this claim is not an employment claim for the purposes of the *Magistrates Courts Act 1921* you may apply under section 42C of that Act to the court to decide the issue.

If you do not dispute that the claim is an employment claim, the Registrar will appoint a conciliator who will contact you to arrange a conciliation process and may require you to participate in a particular way.

If the employment claim is not resolved in the conciliation process and you intend to dispute the claim you must file a Notice of Intention to Defend and Defence to an Employment Claim in the registry within 28 days after the conciliator files a certificate in the registry and serve a sealed copy of it at the plaintiff's address for service shown in the claim as soon as possible.

The Notice should be in the approved form under the *Uniform Civil Procedure Rules 1999*. You do not need to do this until after the conciliation process has ended. If you do not comply with this requirement, judgment may be given against you for the amount claimed without further notice to you.

The Notice should be in the approved form under the *Uniform Civil Procedure Rules 1999*. You do not need to do this until after the conciliation process has ended. If you do not comply If you object that these proceedings have not been commenced in the correct district or that this Court does not have jurisdiction in this matter, that objection should be included in your Notice of Intention to Defend and Defence to an Employment Claim.

Address of registry: 363 George St, Brisbane City QLD 4000

PARTICULARS OF THE PLAINTIFF:

Name: Margaret Blackhurst
plaintiff's residential or business address: 397 Pine Creek Road, Pine Creek, 4670, QLD
Name of solicitor or agent: Jared Marks, Industrial Officer, United Voice
Business address of solicitor or agent: 27 Peel Street, South Brisbane, 4101, QLD
Address for service: 27 Peel Street, South Brisbane, 4101, QLD
Telephone: 07 3291 4654
Fax: 07 3291 4699
E-mail address: jared.marks@unitedvoice.org.au

Signed: 

Description: Agent for the plaintiff

Dated: 14 / 06 / 2019

This claim is to be served on: LIVEBETTER SERVICES LIMITED ACN 160 259 512

of: LEVEL 1, 127 BYNG STREET, ORANGE, NSW, 2800

ISSUED WITH THE AUTHORITY OF THE MAGISTRATES COURTS OF QUEENSLAND

And filed in the Brisbane Registry on (*date*):

Registrar: *(registrar to sign and seal)*

Note: All relevant documents must be brought with you and made available to the Court at any hearing of this proceeding.

MAGISTRATES COURT OF QUEENSLAND

REGISTRY:
NUMBER:

Plaintiff: **MARGARET BLACKHURST**

AND

Defendant: **LIVEBETTER SERVICES LIMITED ACN 160 259 512**

Appendix A

17/18 FY	$2,792.38
18/19 FY	$1,701.92
TOTAL	$4,494.30

Date	Client (travel from)	Client location	Client (travel to)	Client location	Travel Time (minutes)	Applicable Pay Rate ($/h)	Should Have Been Paid ($)
Wednesday, 26 July 2017	SICK LEAVE						
Thursday, 27 July 2017	SICK LEAVE						
Friday, 28 July 2017	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 28 July 2017	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Saturday, 29 July 2017	RDO						
Sunday, 30 July 2017	RDO						
Monday, 31 July 2017	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 31 July 2017	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 31 July 2017	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 31 July 2017	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 1 August 2017	CHARCE	Osprey St, Bargara	DAYCO	Kepnock Rd, Kepnock	20	$24.01	$8.00
Wednesday, 2 August 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 3 August 2017	OFFICE	Barolin St, Bundaberg South	BAILB	Johnston St, Avoca	7	$24.01	$2.80
Thursday, 3 August 2017	BAILB	Johnston St, Avoca	VANIE	Thomsen St, Millbank	4	$24.01	$1.60
Friday, 4 August 2017	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 4 August 2017	NOAKB	Leivesley St, Bundaberg East	FOWLM	Ovens St, Bundaberg East	2	$24.01	$0.80
Friday, 4 August 2017	FOWLM	Ovens St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	6	$24.01	$2.40
Friday, 4 August 2017	OFFICE	Barolin St, Bundaberg South	GRAHMA	Riedy St, Bundaberg South	5	$24.01	$2.00
Saturday, 5 August 2017	RDO						
Sunday, 6 August 2017	RDO						
Monday, 7 August 2017	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Monday, 7 August 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Tuesday, 8 August 2017	CHARCE	Osprey St, Bargara	EGBEP	Electra St, Bundaberg	23	$24.01	$9.20
Tuesday, 8 August 2017	EGBEP	Electra St, Bundaberg	SCOTBA	Thabeban St, Avenell Heights	6	$24.01	$2.40
Tuesday, 8 August 2017	SCOTBA	Thabeban St, Avenell Heights	OFFICE	Barolin St, Bundaberg South	3	$24.01	$1.20
Wednesday, 9 August 2017	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 9 August 2017	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 10 August 2017	STEPLYN	Griffith St, Bundaberg	STREN	Twyford St, Avoca	6	$24.01	$2.40
Friday, 11 August 2017	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 11 August 2017	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Friday, 11 August 2017	NOAKB	Leivesley St, Bundaberg East	TESSD	Gin Gin Road, South Kolan	25	$24.01	$10.00
Saturday, 12 August 2017	RDO						
Sunday, 13 August 2017	RDO						
Monday, 14 August 2017	COMPASSIONATE LEAVE						
Tuesday, 15 August 2017	COMPASSIONATE LEAVE						
Wednesday, 16 August 2017	HOBEG	Johnston St, Avoca	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 16 August 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 17 August 2017	WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 17 August 2017	OFFICE	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 17 August 2017	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 17 August 2017	BAILB	Johnston St, Avoca	TRANSPORT	Barolin St, Bundaberg South	7	$24.01	$2.80
Thursday, 17 August 2017	TRANSPORT	Barolin St, Bundaberg South	TESSD	Gin Gin Road, South Kolan	22	$24.01	$8.80
Thursday, 17 August 2017	TESSD	Gin Gin Road, South Kolan	TRANSPORT	Barolin St, Bundaberg South	22	$24.01	$8.80
Friday, 18 August 2017	TRANSPORT	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 18 August 2017	NOAKB	Leivesley St, Bundaberg East	TRANSPORT	Barolin St, Bundaberg South	8	$24.01	$3.20
Friday, 18 August 2017	TRANSPORT	Barolin St, Bundaberg South	GRAHMA	Riedy St, Bundaberg South	5	$24.01	$2.00

Friday, 18 August 2017	GRAHMA	Riedy St, Bundaberg South	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Friday, 18 August 2017	TRANSPORT	Barolin St, Bundaberg South	TESSD	Gin Gin Road, South Kolan	22	$24.01	$8.80
Friday, 18 August 2017	TESSD	Gin Gin Road, South Kolan	TRANSPORT	Barolin St, Bundaberg South	22	$24.01	$8.80
Saturday, 19 August 2017	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$36.02	$10.81
Saturday, 19 August 2017	ODONBE	Grange St, Norville	GARDG	May St, Walkervale	4	$36.02	$2.40
Saturday, 19 August 2017	GARDG	May St, Walkervale	WHITGR	Whites Rd, Gooburrum	17	$36.02	$10.21
Sunday, 20 August 2017	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$48.02	$14.41
Sunday, 20 August 2017	ODONBE	Grange St, Norville	WHITGR	Whites Rd, Gooburrum	18	$48.02	$14.41
Monday, 21 August 2017	WATSAUD	Hope St, Bundaberg West	BRUNA	Howard St, Bargara	17	$24.01	$6.80
Monday, 21 August 2017	BRUNA	Howard St, Bargara	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Monday, 21 August 2017	NOAKB	Leivesley St, Bundaberg East	BYNOP	Mist Court, Bargara	18	$24.01	$7.20
Monday, 21 August 2017	BYNOP	Mist Court, Bargara	PEATJ	South Pocket Rd, Avenell Heights	20	$24.01	$8.00
Monday, 21 August 2017	PEATJ	South Pocket Rd, Avenell Heights	GRAHMA	Riedy St, Bundaberg South	7	$24.01	$2.80
Tuesday, 22 August 2017	NO TRIPS						
Wednesday, 23 August 2017	ODONBE	Grange St, Norville	TUCKR	Clearview Ave, Thabeban	8	$24.01	$3.20
Wednesday, 23 August 2017	TUCKR	Clearview Ave, Thabeban	NOAKB	Leivesley St, Bundaberg East	13	$24.01	$5.20
Wednesday, 23 August 2017	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 24 August 2017	WHITPA	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 24 August 2017	STEPLYN	Griffith St, Bundaberg	STREN	Twyford St, Avoca	6	$24.01	$2.40
Friday, 25 August 2017	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 25 August 2017	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Saturday, 26 August 2017	RDO						
Sunday, 27 August 2017	RDO						
Monday, 28 August 2017	GARDG & WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 28 August 2017	TRANSPORT	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 28 August 2017	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 28 August 2017	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 28 August 2017	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 29 August 2017	CHARCE	Osprey St, Bargara	NOAKB	Leivesley St, Bundaberg East	18	$24.01	$7.20
Tuesday, 29 August 2017	NOAKB	Leivesley St, Bundaberg East	ODONBE	Grange St, Norville	10	$24.01	$4.00
Wednesday, 30 August 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 31 August 2017	TRANSPORT	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 31 August 2017	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Friday, 1 September 2017	ANNUAL LEAVE						
Saturday, 2 September 2017	RDO						
Sunday, 3 September 2017	RDO						
Monday, 4 September 2017	ANNUAL LEAVE						
Tuesday, 5 September 2017	ROSEPA	Sydney St, Kepnock	CHARCE	Osprey St, Bargara	18	$24.01	$7.20
Tuesday, 5 September 2017	CHARCE	Osprey St, Bargara	VANIE	Thomsen St, Millbank	26	$24.01	$10.40
Tuesday, 5 September 2017	VANIE	Thomsen St, Millbank	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 6 September 2017	ANNUAL LEAVE						
Thursday, 7 September 2017	ANNUAL LEAVE						
Friday, 8 September 2017	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 8 September 2017	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Friday, 8 September 2017	NOAKB	Leivesley St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	8	$24.01	$3.20
Saturday, 9 September 2017	RDO						
Sunday, 10 September 2017	RDO						
Monday, 11 September 2017	GARDG & WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00

Monday, 11 September 2017	TRANSPORT	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 11 September 2017	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 11 September 2017	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 11 September 2017	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 12 September 2017	OFFICE	Barolin St, Bundaberg South	FOWLM	Ovens St, Bundaberg East	6	$24.01	$2.40
Tuesday, 12 September 2017	FOWLM	Ovens St, Bundaberg East	DAYCO	Coonarr Rd, Kinkuna	24	$24.01	$9.60
Tuesday, 12 September 2017	DAYCO	Coonarr Rd, Kinkuna	OFFICE	Barolin St, Bundaberg South	18	$24.01	$7.20
Wednesday, 13 September 2017	BORRB	Bourbong St, Bundaberg	NOAKB	Leivesley St, Bundaberg East	7	$24.01	$2.80
Wednesday, 13 September 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 14 September 2017	WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 14 September 2017	TRANSPORT	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 14 September 2017	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 14 September 2017	BAILB	Johnston St, Avoca	WATSAUD	Hope St, Bundaberg West	5	$24.01	$2.00
Friday, 15 September 2017	OFFICE	Barolin St, Bundaberg South	FORDE	Pickett St, Svensson Heights	4	$24.01	$1.60
Friday, 15 September 2017	FORDE	Pickett St, Svensson Heights	TRANSPORT	Barolin St, Bundaberg South	4	$24.01	$1.60
Friday, 15 September 2017	TRANSPORT	Barolin St, Bundaberg South	GRAHMA	Riedy St, Bundaberg South	5	$24.01	$2.00
Saturday, 16 September 2017	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$36.02	$10.81
Saturday, 16 September 2017	ODONBE	Grange St, Norville	GARDG	May St, Walkervale	4	$36.02	$2.40
Saturday, 16 September 2017	GARDG	May St, Walkervale	WHITGR	Whites Rd, Gooburrum	17	$36.02	$10.21
Sunday, 17 September 2017	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$48.02	$14.41
Sunday, 17 September 2017	ODONBE	Grange St, Norville	WHITGR	Whites Rd, Gooburrum	18	$48.02	$14.41
Monday, 18 September 2017	GARDG & WATSAUD	Hope St, Bundaberg West	ODONBE	Grange St, Norville	6	$24.01	$2.40
Monday, 18 September 2017	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Monday, 18 September 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 18 September 2017	PEATJ	South Pocket Rd, Avenell Heights	WHITGR	Whites Rd, Gooburrum	23	$24.01	$9.20
Tuesday, 19 September 2017	ROSEPA	Sydney St, Kepnock	CHARCE	Osprey St, Bargara	18	$24.01	$7.20
Tuesday, 19 September 2017	CHARCE	Osprey St, Bargara	JONERH	Carlyle Court, Bargara	4	$24.01	$1.60
Tuesday, 19 September 2017	JONERH	Carlyle Court, Bargara	FOWLM	Ovens St, Bundaberg East	17	$24.01	$6.80
Wednesday, 20 September 2017	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 20 September 2017	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 21 September 2017	WHITPA	Stoutley St, Bundaberg	OFFICE	Barolin St, Bundaberg South	7	$24.01	$2.80
Thursday, 21 September 2017	OFFICE	Barolin St, Bundaberg South	STREN	Twyford St, Avoca	7	$24.01	$2.80
Thursday, 21 September 2017	STREN	Twyford St, Avoca	STEPLYN	Griffith St, Bundaberg	6	$24.01	$2.40
Friday, 22 September 2017	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 22 September 2017	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Saturday, 23 September 2017	RDO						
Sunday, 24 September 2017	RDO						
Monday, 25 September 2017	ANNUAL LEAVE						
Tuesday, 26 September 2017	ANNUAL LEAVE						
Wednesday, 27 September 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 28 September 2017	WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 28 September 2017	TRANSPORT	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 28 September 2017	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 28 September 2017	BAILB	Johnston St, Avoca	WATSAUD	Hope St, Bundaberg West	5	$24.01	$2.00
Friday, 29 September 2017	GARDG	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Friday, 29 September 2017	TRANSPORT	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 29 September 2017	NOAKB	Leivesley St, Bundaberg East	FOWLM	Ovens St, Bundaberg East	2	$24.01	$0.80
Friday, 29 September 2017	FOWLM	Ovens St, Bundaberg East	TRANSPORT	Barolin St, Bundaberg South	6	$24.01	$2.40

Friday, 29 September 2017	TRANSPORT	Barolin St, Bundaberg South	GRAHMA	Riedy St, Bundaberg South	5	$24.01	$2.00
Friday, 29 September 2017	GRAHMA	Riedy St, Bundaberg South	GARDDO	May St, Walkervale	5	$24.01	$2.00
Friday, 29 September 2017	GARDDO	May St, Walkervale	ODONBE	Grange St, Norville	4	$24.01	$1.60
Saturday, 30 September 2017	RDO						
Sunday, 1 October 2017	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$48.02	$14.41
Sunday, 1 October 2017	ODONBE	Grange St, Norville	WHITGR	Whites Rd, Gooburrum	18	$48.02	$14.41
Monday, 2 October 2017	PUBLIC HOLIDAY						
Tuesday, 3 October 2017	TRANSPORT	Bourbong St, Bundaberg	CHARCE	Osprey St, Bargara	23	$24.01	$9.20
Tuesday, 3 October 2017	CHARCE	Osprey St, Bargara	PEATJ	South Pocket Rd, Avenell Heights	19	$24.01	$7.60
Tuesday, 3 October 2017	PEATJ	South Pocket Rd, Avenell Heights	FOWLM	Ovens St, Bundaberg East	8	$24.01	$3.20
Tuesday, 3 October 2017	FOWLM	Ovens St, Bundaberg East	SEMPA	Twyford St, Avoca	9	$24.01	$3.60
Wednesday, 4 October 2017	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 4 October 2017	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Wednesday, 4 October 2017	VANIE	Thomsen St, Millbank	GRAHMA	Riedy St, Bundaberg South	11	$24.01	$4.40
Wednesday, 4 October 2017	GRAHMA	Riedy St, Bundaberg South	GARDDO	May St, Walkervale	5	$24.01	$2.00
Wednesday, 4 October 2017	GARDDO	May St, Walkervale	ODONBE	Grange St, Norville	4	$24.01	$1.60
Thursday, 5 October 2017	NOAKB	Leivesley St, Bundaberg East	STEPLYN	Griffith St, Bundaberg	8	$24.01	$3.20
Friday, 6 October 2017	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Saturday, 7 October 2017	RDO						
Sunday, 8 October 2017	RDO						
Monday, 9 October 2017	SICK LEAVE						
Tuesday, 10 October 2017	SICK LEAVE						
Wednesday, 11 October 2017	SICK LEAVE						
Thursday, 12 October 2017	SICK LEAVE						
Friday, 13 October 2017	SICK LEAVE						
Saturday, 14 October 2017	RDO						
Sunday, 15 October 2017	RDO						
Monday, 16 October 2017	GARDG & WATSAUD	Hope St, Bundaberg West	ODONBE	Grange St, Norville	6	$24.01	$2.40
Monday, 16 October 2017	ODONBE	Grange St, Norville	GROUI	Shaw St, Norville	2	$24.01	$0.80
Monday, 16 October 2017	GROUI	Shaw St, Norville	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Monday, 16 October 2017	NOAKB	Leivesley St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	8	$24.01	$3.20
Monday, 16 October 2017	OFFICE	Barolin St, Bundaberg South	MORGAR	Walker St, Bundaberg South	2	$24.01	$0.80
Monday, 16 October 2017	MORGAR	Clive Crescent, Kepnock	GARDG	May St, Walkervale	7	$24.01	$2.80
Tuesday, 17 October 2017	SICK LEAVE						
Wednesday, 18 October 2017	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 18 October 2017	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Wednesday, 18 October 2017	VANIE	Thomsen St, Millbank	ANDEJO	Osborn St, Svensson Heights	6	$24.01	$2.40
Wednesday, 18 October 2017	ANDEJO	Osborn St, Svensson Heights	SEMPA	Twyford St, Avoca	4	$24.01	$1.60
Thursday, 19 October 2017	MORGAR	Clive Crescent, Kepnock	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 19 October 2017	STEPLYN	Griffith St, Bundaberg	STREN	Twyford St, Avoca	6	$24.01	$2.40
Thursday, 19 October 2017	STREN	Twyford St, Avoca	OFFICE	Barolin St, Bundaberg South	7	$24.01	$2.80
Friday, 20 October 2017	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 20 October 2017	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Saturday, 21 October 2017	RDO						
Sunday, 22 October 2017	RDO						
Monday, 23 October 2017	GARDG & WATSAUD	Hope St, Bundaberg West	BRUNA	Howard St, Bargara	17	$24.01	$6.80
Monday, 23 October 2017	BRUNA	Howard St, Bargara	JOHNMARIO	Carlyle Court, Bargara	7	$24.01	$2.80
Monday, 23 October 2017	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40

Monday, 23 October 2017	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 23 October 2017	HAREA	Walters St, Bundaberg North	SEMPA	Twyford St, Avoca	9	$24.01	$3.60
Monday, 23 October 2017	SEMPA	Twyford St, Avoca	ODONBE	Grange St, Norville	7	$24.01	$2.80
Tuesday, 24 October 2017	CHARCE	Osprey St, Bargara	DAYCO	Coonarr Rd, Kinkuna	35	$24.01	$14.01
Tuesday, 24 October 2017	DAYCO	Coonarr Rd, Kinkuna	FOWLM	Ovens St, Bundaberg East	24	$24.01	$9.60
Wednesday, 25 October 2017	ODONBE	Grange St, Norville	BORRB	Jefferis St, Bundaberg North	9	$24.01	$3.60
Wednesday, 25 October 2017	BORRB	Bourbong St, Bundaberg	GARDG	May St, Walkervale	5	$24.01	$2.00
Wednesday, 25 October 2017	GARDG	Bingera St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Wednesday, 25 October 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Wednesday, 25 October 2017	PEATJ	South Pocket Rd, Avenell Heights	SEMPA	Twyford St, Avoca	12	$24.01	$4.80
Wednesday, 25 October 2017	SEMPA	Twyford St, Avoca	OFFICE	Barolin St, Bundaberg South	7	$24.01	$2.80
Thursday, 26 October 2017	WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 26 October 2017	TRANSPORT	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 26 October 2017	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 26 October 2017	BAILB	Schulte St, Bundaberg East	WATSAUD	Hope St, Bundaberg West	8	$24.01	$3.20
Friday, 27 October 2017	GARDG	May St, Walkervale	TRANSPORT	Barolin St, Bundaberg South	2	$24.01	$0.80
Friday, 27 October 2017	TRANSPORT	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 27 October 2017	NOAKB	Leivesley St, Bundaberg East	DODDN	Lithgow Crescent, Norville	10	$24.01	$4.00
Friday, 27 October 2017	DODDN	Lithgow Crescent, Norville	TRANSPORT	Barolin St, Bundaberg South	4	$24.01	$1.60
Friday, 27 October 2017	TRANSPORT	Barolin St, Bundaberg South	GRAHMA	Riedy St, Bundaberg South	5	$24.01	$2.00
Friday, 27 October 2017	GRAHMA	Riedy St, Bundaberg South	ODONBE	Grange St, Norville	6	$24.01	$2.40
Saturday, 28 October 2017	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$36.02	$10.81
Saturday, 28 October 2017	ODONBE	Grange St, Norville	WHITGR	Whites Rd, Gooburrum	18	$36.02	$10.81
Sunday, 29 October 2017	RDO						
Monday, 30 October 2017	GARDG & WATSAUD	Hope St, Bundaberg West	ODONBE	Grange St, Norville	6	$24.01	$2.40
Monday, 30 October 2017	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Monday, 30 October 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 30 October 2017	PEATJ	South Pocket Rd, Avenell Heights	SEMPA	Twyford St, Avoca	12	$24.01	$4.80
Tuesday, 31 October 2017	ROSEPA	Sydney St, Kepnock	CHARCE	Osprey St, Bargara	18	$24.01	$7.20
Tuesday, 31 October 2017	CHARCE	Osprey St, Bargara	FOWLM	Ovens St, Bundaberg East	18	$24.01	$7.20
Tuesday, 31 October 2017	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Wednesday, 1 November 2017	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 1 November 2017	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Wednesday, 1 November 2017	VANIE	Thomsen St, Millbank	MORGAR	Crofton St, Bundaberg	5	$24.01	$2.00
Wednesday, 1 November 2017	MORGAR	Clive Crescent, Kepnock	SEMPA	Twyford St, Avoca	12	$24.01	$4.80
Thursday, 2 November 2017	WHITPA	Stoutley St, Bundaberg	MORGAR	Hope St, Bundaberg West	6	$24.01	$2.40
Thursday, 2 November 2017	MORGAR	Clive Crescent, Kepnock	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 2 November 2017	STEPLYN	Griffith St, Bundaberg	STREN	Twyford St, Avoca	6	$24.01	$2.40
Friday, 3 November 2017	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 3 November 2017	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Friday, 3 November 2017	NOAKB	Leivesley St, Bundaberg East	SEMPA	Twyford St, Avoca	11	$24.01	$4.40
Saturday, 4 November 2017	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$36.02	$10.81
Saturday, 4 November 2017	ODONBE	Grange St, Norville	WHITGR	Whites Rd, Gooburrum	18	$36.02	$10.81
Saturday, 4 November 2017	WHITGR	Whites Rd, Gooburrum	GARDG	May St, Walkervale	17	$36.02	$10.21
Sunday, 5 November 2017	RDO						
Monday, 6 November 2017	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 6 November 2017	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 6 November 2017	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40

Monday, 6 November 2017	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 6 November 2017	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 7 November 2017	CHARCE	Osprey St, Bargara	PEATJ	South Pocket Rd, Avenell Heights	19	$24.01	$7.60
Tuesday, 7 November 2017	PEATJ	South Pocket Rd, Avenell Heights	FOWLM	Ovens St, Bundaberg East	8	$24.01	$3.20
Wednesday, 8 November 2017	SICK LEAVE						
Thursday, 9 November 2017	SICK LEAVE						
Friday, 10 November 2017	GARDG	May St, Walkervale	OFFICE	Barolin St, Bundaberg South	2	$24.01	$0.80
Friday, 10 November 2017	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 10 November 2017	NOAKB	Leivesley St, Bundaberg East	DODDN	Lithgow Crescent, Norville	10	$24.01	$4.00
Friday, 10 November 2017	DODDN	Lithgow Crescent, Norville	OFFICE	Barolin St, Bundaberg South	4	$24.01	$1.60
Friday, 10 November 2017	OFFICE	Barolin St, Bundaberg South	GRAHMA	Riedy St, Bundaberg South	5	$24.01	$2.00
Saturday, 11 November 2017	RDO						
Sunday, 12 November 2017	RDO						
Monday, 13 November 2017	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Monday, 13 November 2017	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Monday, 13 November 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 13 November 2017	PEATJ	South Pocket Rd, Avenell Heights	SEMPA	Twyford St, Avoca	12	$24.01	$4.80
Tuesday, 14 November 2017	BERTMA	Horton St, Norville	ROSEPA	Sydney St, Kepnock	7	$24.01	$2.80
Tuesday, 14 November 2017	ROSEPA	Sydney St, Kepnock	CHARCE	Osprey St, Bargara	18	$24.01	$7.20
Tuesday, 14 November 2017	CHARCE	Osprey St, Bargara	FOWLM	Ovens St, Bundaberg East	18	$24.01	$7.20
Tuesday, 14 November 2017	FOWLM	Ovens St, Bundaberg East	BERTMA	Horton St, Norville	9	$24.01	$3.60
Wednesday, 15 November 2017	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 15 November 2017	NOAKB	Leivesley St, Bundaberg East	FOWLM	Ovens St, Bundaberg East	2	$24.01	$0.80
Wednesday, 15 November 2017	FOWLM	Ovens St, Bundaberg East	SEMPA	Twyford St, Avoca	9	$24.01	$3.60
Wednesday, 15 November 2017	SEMPA	Twyford St, Avoca	WHITGR	Whites Rd, Gooburrum	18	$24.01	$7.20
Wednesday, 15 November 2017	WHITGR	Whites Rd, Gooburrum	BERTMA	Horton St, Norville	19	$24.01	$7.60
Thursday, 16 November 2017	WHITPA	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 16 November 2017	STEPLYN	Griffith St, Bundaberg	STREN	Twyford St, Avoca	6	$24.01	$2.40
Thursday, 16 November 2017	STREN	Twyford St, Avoca	BERTMA	Horton St, Norville	7	$24.01	$2.80
Friday, 17 November 2017	TURNB	Wilmington St, Thabeban	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Friday, 17 November 2017	NOAKB	Leivesley St, Bundaberg East	GRAHMA	Riedy St, Bundaberg South	11	$24.01	$4.40
Friday, 17 November 2017	GRAHMA	Riedy St, Bundaberg South	BERTMA	Horton St, Norville	6	$24.01	$2.40
Saturday, 18 November 2017	RDO						
Sunday, 19 November 2017	RDO						
Monday, 20 November 2017	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 20 November 2017	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 20 November 2017	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 20 November 2017	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Tuesday, 21 November 2017	CHARCE	Osprey St, Bargara	GRAHMA	Riedy St, Bundaberg South	10	$24.01	$4.00
Tuesday, 21 November 2017	DAYCO	Kepnock Rd, Kepnock	DAYCO	Kepnock Rd, Kepnock	20	$24.01	$8.00
Wednesday, 22 November 2017	BERTMA	Horton St, Norville	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 22 November 2017	ODONBE	Grange St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 22 November 2017	NOAKB	Leivesley St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 22 November 2017	PEATJ	South Pocket Rd, Avenell Heights	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Wednesday, 22 November 2017	SEMPA	Twyford St, Avoca	SEMPA	Twyford St, Avoca	12	$24.01	$4.80
Thursday, 23 November 2017	BERTMA	Horton St, Norville	BERTMA	Horton St, Norville	7	$24.01	$2.80
Thursday, 23 November 2017	WATSAUD	Twyford St, Avoca	WATSAUD	Twyford St, Avoca	7	$24.01	$2.80
			OFFICE	Barolin St, Bundaberg South	7	$24.01	$2.80

Thursday, 23 November 2017	OFFICE	Barolin St, Bundaberg South	MORGAR	Hope St, Bundaberg West	5	$24.01	$2.00
Thursday, 23 November 2017	MORGAR	Clive Crescent, Kepnock	POTTMA	Schulte St, Bundaberg East	6	$24.01	$2.40
Thursday, 23 November 2017	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 23 November 2017	BAILB	Johnston St, Avoca	WATSAUD	Twyford St, Avoca	2	$24.01	$0.80
Friday, 24 November 2017	WATSAUD	Twyford St, Avoca	BERTMA	Horton St, Norville	7	$24.01	$2.80
Friday, 24 November 2017	GARDG	May St, Walkervale	OFFICE	Barolin St, Bundaberg South	2	$24.01	$0.80
Friday, 24 November 2017	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 24 November 2017	NOAKB	Leivesley St, Bundaberg East	DODDN	Lithgow Crescent, Norville	10	$24.01	$4.00
Friday, 24 November 2017	OFFICE	Lithgow Crescent, Norville	GARDDO	May St, Walkervale	4	$24.01	$1.60
Friday, 24 November 2017	GARDDO	May St, Walkervale	GRAHMA	Riedy St, Bundaberg South	5	$24.01	$2.00
Friday, 24 November 2017	GRAHMA	Riedy St, Bundaberg South	ODONBE	Grange St, Norville	6	$24.01	$2.40
Saturday, 25 November 2017	RDO						
Sunday, 26 November 2017	RDO						
Monday, 27 November 2017	GARDG & WATSAUD	Hope St, Bundaberg West	BERTMA	Horton St, Norville	7	$24.01	$2.80
Monday, 27 November 2017	BERTMA	Walker St, Bundaberg	NOAKB	Leivesley St, Bundaberg East	7	$24.01	$2.80
Monday, 27 November 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 27 November 2017	PEATJ	South Pocket Rd, Avenell Heights	SEMPA	Twyford St, Avoca	12	$24.01	$4.80
Monday, 27 November 2017	SEMPA	Twyford St, Avoca	BERTMA	Horton St, Norville	7	$24.01	$2.80
Tuesday, 28 November 2017	BERTMA	Horton St, Norville	CHARCE	Osprey St, Bargara	24	$24.01	$9.60
Tuesday, 28 November 2017	CHARCE	Osprey St, Bargara	FOWLM	Ovens St, Bundaberg East	18	$24.01	$7.20
Tuesday, 28 November 2017	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Wednesday, 29 November 2017	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 29 November 2017	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 30 November 2017	WHITPA	Stoutley St, Bundaberg	ANDEJO	Osborn St, Svensson Heights	10	$24.01	$4.00
Thursday, 30 November 2017	ANDEJO	Osborn St, Svensson Heights	STEPLYN	Griffith St, Bundaberg	5	$24.01	$2.00
Thursday, 30 November 2017	STEPLYN	Griffith St, Bundaberg	STREN	Twyford St, Avoca	6	$24.01	$2.40
Thursday, 30 November 2017	STREN	Twyford St, Avoca	WHITGR	Whites Rd, Gooburrum	18	$24.01	$7.20
Friday, 1 December 2017	TURNB	Wilmington St, Thabeban	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Friday, 1 December 2017	NOAKB	Leivesley St, Bundaberg East	SEMPA	Twyford St, Avoca	11	$24.01	$4.40
Friday, 1 December 2017	SEMPA	Twyford St, Avoca	BERTMA	Horton St, Norville	7	$24.01	$2.80
Saturday, 2 December 2017	RDO						
Sunday, 3 December 2017	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$48.02	$14.41
Sunday, 3 December 2017	ODONBE	Grange St, Norville	WHITGR	Whites Rd, Gooburrum	18	$48.02	$14.41
Sunday, 3 December 2017	WHITGR	Whites Rd, Gooburrum	GARDG	May St, Walkervale	17	$48.02	$13.61
Monday, 4 December 2017	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 4 December 2017	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 4 December 2017	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 4 December 2017	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 4 December 2017	HAREA	Walters St, Bundaberg North	SEMPA	Twyford St, Avoca	9	$24.01	$3.60
Monday, 4 December 2017	SEMPA	Twyford St, Avoca	ODONBE	Grange St, Norville	7	$24.01	$2.80
Tuesday, 5 December 2017	CHARCE	Osprey St, Bargara	DAYCO	Kepnock Rd, Kepnock	20	$24.01	$8.00
Tuesday, 5 December 2017	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 6 December 2017	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 6 December 2017	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 6 December 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 7 December 2017	BERTMA	Horton St, Norville	WATSAUD	Twyford St, Avoca	7	$24.01	$2.80
Thursday, 7 December 2017	WATSAUD	Twyford St, Avoca	OFFICE	Barolin St, Bundaberg South	7	$24.01	$2.80
Thursday, 7 December 2017	OFFICE	Barolin St, Bundaberg South	MORGAR	Clive Crescent, Kepnock	7	$24.01	$2.80

Thursday, 7 December 2017	MORGAR	Crofton St, Bundaberg Central	POTTMA	Schulte St, Bundaberg East	6	$24.01	$2.40
Thursday, 7 December 2017	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 7 December 2017	BAILB	Johnston St, Avoca	WATSAUD	Twyford St, Avoca	2	$24.01	$0.80
Thursday, 7 December 2017	WATSAUD	Twyford St, Avoca	BERTMA	Horton St, Norville	7	$24.01	$2.80
Friday, 8 December 2017	GARDG	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Friday, 8 December 2017	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 8 December 2017	NOAKB	Leivesley St, Bundaberg East	DODDN	Lithgow Crescent, Norville	10	$24.01	$4.00
Friday, 8 December 2017	DODDN	Lithgow Crescent, Norville	OFFICE	Barolin St, Bundaberg South	4	$24.01	$1.60
Friday, 8 December 2017	OFFICE	Barolin St, Bundaberg South	GRAHMA	Riedy St, Bundaberg South	5	$24.01	$2.00
Friday, 8 December 2017	GRAHMA	Riedy St, Bundaberg South	WHITGR	Whites Rd, Gooburrum	20	$24.01	$8.00
Friday, 8 December 2017	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$24.01	$7.20
Saturday, 9 December 2017	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$36.02	$10.81
Saturday, 9 December 2017	ODONBE	Grange St, Norville	WHITGR	Whites Rd, Gooburrum	18	$36.02	$10.81
Saturday, 9 December 2017	WHITGR	Whites Rd, Gooburrum	GARDG	May St, Walkervale	17	$36.02	$10.21
Sunday, 10 December 2017	RDO						
Monday, 11 December 2017	GARDG & WATSAUD	Hope St, Bundaberg West	WHITGR	Whites Rd, Gooburrum	14	$24.01	$5.60
Monday, 11 December 2017	WHITGR	Whites Rd, Gooburrum	NOAKB	Leivesley St, Bundaberg East	19	$24.01	$7.60
Monday, 11 December 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 11 December 2017	PEATJ	South Pocket Rd, Avenell Heights	SEMPA	Twyford St, Avoca	12	$24.01	$4.80
Tuesday, 12 December 2017	CHARCE	Osprey St, Bargara	FOWLM	Ovens St, Bundaberg East	18	$24.01	$7.20
Tuesday, 12 December 2017	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Wednesday, 13 December 2017	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 13 December 2017	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Wednesday, 13 December 2017	VANIE	Thomsen St, Millbank	SEMPA	Twyford St, Avoca	5	$24.01	$2.00
Thursday, 14 December 2017	WHITPA	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 14 December 2017	STEPLYN	Griffith St, Bundaberg	STREN	Twyford St, Avoca	6	$24.01	$2.40
Friday, 15 December 2017	TURNB	Wilmington St, Thabeban	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Saturday, 16 December 2017	RDO						
Sunday, 17 December 2017	RDO						
Monday, 18 December 2017	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 18 December 2017	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 18 December 2017	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 18 December 2017	NOAKB	Leivesley St, Bundaberg East	ODONBE	Grange St, Norville	10	$24.01	$4.00
Tuesday, 19 December 2017	CHARCE	Osprey St, Bargara	DAYCO	Kepnock Rd, Kepnock	15	$24.01	$6.00
Wednesday, 20 December 2017	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 20 December 2017	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 21 December 2017	ANDEJO	Osborn St, Svensson Heights	POTTMA	Schulte St, Bundaberg East	12	$24.01	$4.80
Thursday, 21 December 2017	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Friday, 22 December 2017	WATSAUD	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 22 December 2017	NOAKB	Leivesley St, Bundaberg East	DODDN	Lithgow Crescent, Norville	10	$24.01	$4.00
Friday, 22 December 2017	DODDN	Lithgow Crescent, Norville	GRAHMA	Riedy St, Bundaberg South	7	$24.01	$2.80
Friday, 22 December 2017	GRAHMA	Riedy St, Bundaberg South	SEMPA	Twyford St, Avoca	11	$24.01	$4.40
Saturday, 23 December 2017	RDO						
Sunday, 24 December 2017	RDO						
Monday, 25 December 2017	PUBLIC HOLIDAY						
Tuesday, 26 December 2017	PUBLIC HOLIDAY						
Wednesday, 27 December 2017	ANNUAL LEAVE						
Thursday, 28 December 2017	ANNUAL LEAVE						

Friday, 29 December 2017	ANNUAL LEAVE						
Saturday, 30 December 2017	RDO						
Sunday, 31 December 2017	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$48.02	$14.41
Sunday, 31 December 2017	ODONBE	Grange St, Norville	WHITGR	Whites Rd, Gooburrum	18	$48.02	$14.41
Sunday, 31 December 2017	WHITGR	Whites Rd, Gooburrum	GARDG	May St, Walkervale	17	$48.02	$13.61
Monday, 1 January 2018	PUBLIC HOLIDAY						
Tuesday, 2 January 2018	GARDG	Hope St, Bundaberg West	CHARCE	Osprey St, Bargara	23	$24.01	$9.20
Tuesday, 2 January 2018	CHARCE	Osprey St, Bargara	DAYCO	Kepnock Rd, Kepnock	20	$24.01	$8.00
Tuesday, 2 January 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 3 January 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 3 January 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 3 January 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 4 January 2018	OFFICE	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 4 January 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 4 January 2018	BAILB	Johnston St, Avoca	HAREA	Walters St, Bundaberg North	8	$24.01	$3.20
Thursday, 4 January 2018	HAREA	Walters St, Bundaberg North	BERTMA	Horton St, Norville	9	$24.01	$3.60
Friday, 5 January 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Friday, 5 January 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 5 January 2018	NOAKB	Leivesley St, Bundaberg East	DODDN	Lithgow Crescent, Norville	10	$24.01	$4.00
Friday, 5 January 2018	DODDN	Lithgow Crescent, Norville	OFFICE	Barolin St, Bundaberg South	4	$24.01	$1.60
Friday, 5 January 2018	OFFICE	Barolin St, Bundaberg South	WATSAUD	Hope St, Bundaberg West	5	$24.01	$2.00
Friday, 5 January 2018	WATSAUD	Twyford St, Avoca	GRAHMA	Riedy St, Bundaberg South	11	$24.01	$4.40
Saturday, 6 January 2018	RDO						
Sunday, 7 January 2018	RDO						
Monday, 8 January 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 8 January 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 8 January 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 8 January 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Tuesday, 9 January 2018	CHARCE	Osprey St, Bargara	FOWLM	Ovens St, Bundaberg East	18	$24.01	$7.20
Tuesday, 9 January 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Wednesday, 10 January 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 10 January 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 11 January 2018	WHITPA	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 11 January 2018	STEPLYN	Griffith St, Bundaberg	STREN	Twyford St, Avoca	6	$24.01	$2.40
Friday, 12 January 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 12 January 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Saturday, 13 January 2018	RDO						
Sunday, 14 January 2018	RDO						
Monday, 15 January 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 15 January 2018	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 15 January 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 15 January 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 15 January 2018	HAREA	Walters St, Bundaberg North	GRAHMA	Riedy St, Bundaberg South	10	$24.01	$4.00
Monday, 15 January 2018	GRAHMA	Riedy St, Bundaberg South	ODONBE	Grange St, Norville	6	$24.01	$2.40
Tuesday, 16 January 2018	CHARCE	Osprey St, Bargara	DAYCO	Kepnock Rd, Kepnock	20	$24.01	$8.00
Tuesday, 16 January 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 17 January 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 17 January 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00

Wednesday, 17 January 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Wednesday, 17 January 2018	PEATJ	South Pocket Rd, Avenell Heights	BERTMA	Horton St, Norville	10	$24.01	$4.00
Thursday, 18 January 2018	WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 18 January 2018	OFFICE	Barolin St, Bundaberg South	ANDEJO	Osborn St, Svensson Heights	6	$24.01	$2.40
Thursday, 18 January 2018	ANDEJO	Osborn St, Svensson Heights	BAILB	Johnston St, Avoca	5	$24.01	$2.00
Thursday, 18 January 2018	BAILB	Johnston St, Avoca	WATSAUD	Hope St, Bundaberg West	5	$24.01	$2.00
Thursday, 18 January 2018	WATSAUD	Twyford St, Avoca	BERTMA	Horton St, Norville	7	$24.01	$2.80
Friday, 19 January 2018	BERTMA	Horton St, Norville	GARDG	May St, Walkervale	4	$24.01	$1.60
Friday, 19 January 2018	GARDG	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Friday, 19 January 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 19 January 2018	NOAKB	Leivesley St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	8	$24.01	$3.20
Friday, 19 January 2018	OFFICE	Barolin St, Bundaberg South	GRAHMA	Riedy St, Bundaberg South	5	$24.01	$2.00
Saturday, 20 January 2018	RDO						
Sunday, 21 January 2018	RDO						
Monday, 22 January 2018	GARDG & WATSAUD	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 22 January 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 22 January 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Monday, 22 January 2018	WATSAUD	Twyford St, Avoca	BERTMA	Horton St, Norville	7	$24.01	$2.80
Tuesday, 23 January 2018	BERTMA	Horton St, Norville	CHARCE	Osprey St, Bargara	24	$24.01	$9.60
Tuesday, 23 January 2018	CHARCE	Osprey St, Bargara	FOWLM	Ovens St, Bundaberg East	18	$24.01	$7.20
Tuesday, 23 January 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Tuesday, 23 January 2018	ODONBE	Grange St, Norville	BERTMA	Horton St, Norville	1	$24.01	$0.40
Wednesday, 24 January 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 24 January 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 25 January 2018	WHITPA	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 25 January 2018	STEPLYN	Griffith St, Bundaberg	TURNB	Wilmington St, Thabeban	4	$24.01	$1.60
Thursday, 25 January 2018	TURNB	Wilmington St, Thabeban	STREN	Twyford St, Avoca	9	$24.01	$3.60
Friday, 26 January 2018	PUBLIC HOLIDAY						
Saturday, 27 January 2018	RDO						
Sunday, 28 January 2018	RDO						
Monday, 29 January 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 29 January 2018	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 29 January 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 29 January 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 29 January 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 30 January 2018	CHARCE	Osprey St, Bargara	DAYCO	Kepnock Rd, Kepnock	20	$24.01	$8.00
Tuesday, 30 January 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 31 January 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 31 January 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 31 January 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 1 February 2018	WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 1 February 2018	OFFICE	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 1 February 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Friday, 2 February 2018	GARDG	May St, Walkervale	OFFICE	Barolin St, Bundaberg South	2	$24.01	$0.80
Friday, 2 February 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 2 February 2018	NOAKB	Leivesley St, Bundaberg East	SEMPA	Twyford St, Avoca	11	$24.01	$4.40
Friday, 2 February 2018	SEMPA	Twyford St, Avoca	OFFICE	Barolin St, Bundaberg South	7	$24.01	$2.80
Saturday, 3 February 2018	RDO						

Sunday, 4 February 2018	RDO						
Monday, 5 February 2018	WATSAUD	Hope St, Bundaberg West	GARDG	May St, Walkervale	6	$24.01	$2.40
Monday, 5 February 2018	GARDG	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 5 February 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 5 February 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Monday, 5 February 2018	WATSAUD	Twyford St, Avoca	BOYDV	Sinclair St, Avenell Heights	10	$24.01	$4.00
Tuesday, 6 February 2018	BOYDV	Sinclair St, Avenell Heights	BERTMA	Horton St, Norville	5	$24.01	$2.00
Tuesday, 6 February 2018	BERTMA	Horton St, Norville	CHARCE	Osprey St, Bargara	24	$24.01	$9.60
Tuesday, 6 February 2018	CHARCE	Osprey St, Bargara	FOWLM	Ovens St, Bundaberg East	18	$24.01	$7.20
Tuesday, 6 February 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Tuesday, 6 February 2018	ODONBE	Grange St, Norville	BERTMA	Horton St, Norville	1	$24.01	$0.40
Wednesday, 7 February 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 7 February 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 8 February 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 8 February 2018	STEPLYN	Griffith St, Bundaberg	STREN	Twyford St, Avoca	6	$24.01	$2.40
Thursday, 8 February 2018	STREN	Twyford St, Avoca	WATSAUD	Hope St, Bundaberg West	4	$24.01	$1.60
Friday, 9 February 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 9 February 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Friday, 9 February 2018	NOAKB	Leivesley St, Bundaberg East	BOYDV	Sinclair St, Avenell Heights	10	$24.01	$4.00
Friday, 9 February 2018	BOYDV	Sinclair St, Avenell Heights	BERTMA	Horton St, Norville	5	$24.01	$2.00
Saturday, 10 February 2018	RDO						
Sunday, 11 February 2018	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$48.02	$14.41
Sunday, 11 February 2018	ODONBE	Grange St, Norville	WHITGR	Whites Rd, Gooburrum	18	$48.02	$14.41
Sunday, 11 February 2018	WHITGR	Whites Rd, Gooburrum	GARDG	May St, Walkervale	17	$48.02	$13.61
Monday, 12 February 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 12 February 2018	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 12 February 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 12 February 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 12 February 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 13 February 2018	CHARCE	Osprey St, Bargara	DAYCO	Kepnock Rd, Kepnock	20	$24.01	$8.00
Tuesday, 13 February 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 14 February 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 14 February 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 14 February 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 15 February 2018	WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 15 February 2018	OFFICE	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 15 February 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 15 February 2018	BAILB	Johnston St, Avoca	WATSAUD	Hope St, Bundaberg West	5	$24.01	$2.00
Thursday, 15 February 2018	WATSAUD	Twyford St, Avoca	BERTMA	Horton St, Norville	7	$24.01	$2.80
Friday, 16 February 2018	ANNUAL LEAVE						
Saturday, 17 February 2018	RDO						
Sunday, 18 February 2018	RDO						
Monday, 19 February 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 19 February 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 19 February 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 19 February 2018	PEATJ	South Pocket Rd, Avenell Heights	BERTMA	Horton St, Norville	10	$24.01	$4.00
Tuesday, 20 February 2018	BERTMA	Horton St, Norville	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Tuesday, 20 February 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60

Tuesday, 20 February 2018	ODONBE	Grange St, Norville	BERTMA	Horton St, Norville	1	$24.01	$0.40
Wednesday, 21 February 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 21 February 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 22 February 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 22 February 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 23 February 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 23 February 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Saturday, 24 February 2018	RDO						
Sunday, 25 February 2018	RDO						
Monday, 26 February 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 26 February 2018	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 26 February 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 26 February 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 26 February 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 27 February 2018	NO TRIPS						
Wednesday, 28 February 2018	BERTMA	Horton St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 28 February 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 1 March 2018	WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 1 March 2018	OFFICE	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 1 March 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 1 March 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 2 March 2018	GARDG	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Friday, 2 March 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 2 March 2018	NOAKB	Leivesley St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	8	$24.01	$3.20
Friday, 2 March 2018	OFFICE	Barolin St, Bundaberg South	BOYDV	Sinclair St, Avenell Heights	5	$24.01	$2.00
Saturday, 3 March 2018	RDO						
Sunday, 4 March 2018	RDO						
Monday, 5 March 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 5 March 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 5 March 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 5 March 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Monday, 5 March 2018	WATSAUD	Twyford St, Avoca	BERTMA	Horton St, Norville	7	$24.01	$2.80
Tuesday, 6 March 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 6 March 2018	PEATJ	South Pocket Rd, Avenell Heights	FOWLM	Ovens St, Bundaberg East	8	$24.01	$3.20
Tuesday, 6 March 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Tuesday, 6 March 2018	ODONBE	Grange St, Norville	BERTMA	Horton St, Norville	1	$24.01	$0.40
Wednesday, 7 March 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 7 March 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 8 March 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Thursday, 8 March 2018	CHARCE	Osprey St, Bargara	OFFICE	Barolin St, Bundaberg South	21	$24.01	$8.40
Friday, 9 March 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 9 March 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Saturday, 10 March 2018	RDO						
Sunday, 11 March 2018	RDO						
Monday, 12 March 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 12 March 2018	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 12 March 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 12 March 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60

Monday, 12 March 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 13 March 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Tuesday, 13 March 2018	FOWLM	Ovens St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	6	$24.01	$2.40
Wednesday, 14 March 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 14 March 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 15 March 2018	WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 15 March 2018	OFFICE	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 15 March 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 15 March 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 16 March 2018	GARDG	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Friday, 16 March 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 16 March 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 16 March 2018	BARRD	Laack St, Kepnock	OFFICE	Barolin St, Bundaberg South	3	$24.01	$1.20
Friday, 16 March 2018	OFFICE	Barolin St, Bundaberg South	BOYDV	Sinclair St, Avenell Heights	5	$24.01	$2.00
Saturday, 17 March 2018	RDO						
Sunday, 18 March 2018	RDO						
Monday, 19 March 2018	ANNUAL LEAVE						
Tuesday, 20 March 2018	ANNUAL LEAVE						
Wednesday, 21 March 2018	ANNUAL LEAVE						
Thursday, 22 March 2018	ANNUAL LEAVE						
Friday, 23 March 2018	ANNUAL LEAVE						
Saturday, 24 March 2018	RDO						
Sunday, 25 March 2018	RDO						
Monday, 26 March 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 26 March 2018	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 26 March 2018	JOHNMARIO	Carlyle Court, Bargara	HAREA	Walters St, Bundaberg North	23	$24.01	$9.20
Monday, 26 March 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 27 March 2018	WHITW	Stoutley St, Bundaberg	DAYCO	Kepnock Rd, Kepnock	11	$24.01	$4.40
Tuesday, 27 March 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 28 March 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 28 March 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 29 March 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 29 March 2018	OFFICE	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 29 March 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 29 March 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 30 March 2018	PUBLIC HOLIDAY						
Saturday, 31 March 2018	RDO						
Sunday, 1 April 2018	RDO						
Monday, 2 April 2018	PUBLIC HOLIDAY						
Tuesday, 3 April 2018	BERTMA	Horton St, Norville	GARDG	May St, Walkervale	4	$24.01	$1.60
Tuesday, 3 April 2018	GARDG & WATSAUD	Hope St, Bundaberg West	PEATJ	South Pocket Rd, Avenell Heights	12	$24.01	$4.80
Tuesday, 3 April 2018	PEATJ	South Pocket Rd, Avenell Heights	NOAKB	Leivesley St, Bundaberg East	7	$24.01	$2.80
Tuesday, 3 April 2018	NOAKB	Leivesley St, Bundaberg East	GARDG	Hope St, Bundaberg West	8	$24.01	$3.20
Tuesday, 3 April 2018	GARDG	Hope St, Bundaberg West	FOWLM	Ovens St, Bundaberg East	6	$24.01	$2.40
Tuesday, 3 April 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Tuesday, 3 April 2018	ODONBE	Grange St, Norville	BERTMA	Horton St, Norville	1	$24.01	$0.40
Wednesday, 4 April 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 4 April 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00

Thursday, 5 April 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 5 April 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 6 April 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 6 April 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Saturday, 7 April 2018	RDO						
Sunday, 8 April 2018	RDO						
Monday, 9 April 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 9 April 2018	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 9 April 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 9 April 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 9 April 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 10 April 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Tuesday, 10 April 2018	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Wednesday, 11 April 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 11 April 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 11 April 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Wednesday, 11 April 2018	PEATJ	South Pocket Rd, Avenell Heights	OFFICE	Barolin St, Bundaberg South	8	$24.01	$3.20
Thursday, 12 April 2018	WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 12 April 2018	OFFICE	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 12 April 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 12 April 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 13 April 2018	GARDG	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 13 April 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 13 April 2018	BARRD	Laack St, Kepnock	OFFICE	Barolin St, Bundaberg South	3	$24.01	$1.20
Saturday, 14 April 2018	RDO						
Sunday, 15 April 2018	RDO						
Monday, 16 April 2018	GARDG & WATSAUD	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 16 April 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 16 April 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Monday, 16 April 2018	WATSAUD	Twyford St, Avoca	BERTMA	Horton St, Norville	7	$24.01	$2.80
Monday, 16 April 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Tuesday, 17 April 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 17 April 2018	PEATJ	South Pocket Rd, Avenell Heights	NOAKB	Leivesley St, Bundaberg East	7	$24.01	$2.80
Tuesday, 17 April 2018	NOAKB	Leivesley St, Bundaberg East	FOWLM	Ovens St, Bundaberg East	2	$24.01	$0.80
Tuesday, 17 April 2018	FOWLM	Ovens St, Bundaberg East	BERTMA	Horton St, Norville	9	$24.01	$3.60
Tuesday, 17 April 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 18 April 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 18 April 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 19 April 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Thursday, 19 April 2018	CHARCE	Osprey St, Bargara	PEATJ	South Pocket Rd, Avenell Heights	19	$24.01	$7.60
Friday, 20 April 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 20 April 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Saturday, 21 April 2018	RDO						
Sunday, 22 April 2018	RDO						
Monday, 23 April 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 23 April 2018	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 23 April 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 23 April 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60

Monday, 23 April 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 24 April 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Tuesday, 24 April 2018	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Tuesday, 24 April 2018	DAYCO	Kepnock Rd, Kepnock	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Wednesday, 25 April 2018	PUBLIC HOLIDAY						
Thursday, 26 April 2018	WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 26 April 2018	OFFICE	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 26 April 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 26 April 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 27 April 2018	GARDG	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Friday, 27 April 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 27 April 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 27 April 2018	BARRD	Laack St, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	6	$24.01	$2.40
Saturday, 28 April 2018	RDO						
Sunday, 29 April 2018	RDO						
Monday, 30 April 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 30 April 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 30 April 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 30 April 2018	PEATJ	South Pocket Rd, Avenell Heights	GARDG	May St, Walkervale	8	$24.01	$3.20
Monday, 30 April 2018	GARDG	Bingera St, Bundaberg West	WATSAUD	Hope St, Bundaberg West	3	$24.01	$1.20
Monday, 30 April 2018	WATSAUD	Twyford St, Avoca	GARDG	Bingera St, Bundaberg West	6	$24.01	$2.40
Monday, 30 April 2018	GARDG	May St, Walkervale	BERTMA	Horton St, Norville	4	$24.01	$1.60
Tuesday, 1 May 2018	BERTMA	Horton St, Norville	MORGAR	Clive Crescent, Kepnock	9	$24.01	$3.60
Tuesday, 1 May 2018	MORGAR	Clive Crescent, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Tuesday, 1 May 2018	PEATJ	South Pocket Rd, Avenell Heights	NOAKB	Leivesley St, Bundaberg East	7	$24.01	$2.80
Tuesday, 1 May 2018	NOAKB	Leivesley St, Bundaberg East	FOWLM	Ovens St, Bundaberg East	2	$24.01	$0.80
Tuesday, 1 May 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Tuesday, 1 May 2018	ODONBE	Grange St, Norville	BERTMA	Horton St, Norville	1	$24.01	$0.40
Wednesday, 2 May 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 2 May 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 3 May 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 3 May 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 4 May 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 4 May 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Saturday, 5 May 2018	RDO						
Sunday, 6 May 2018	RDO						
Monday, 7 May 2018	PUBLIC HOLIDAY						
Tuesday, 8 May 2018	GARDG & WATSAUD	Hope St, Bundaberg West	HAREA	Walters St, Bundaberg North	4	$24.01	$1.60
Tuesday, 8 May 2018	HAREA	Walters St, Bundaberg North	DAYCO	Kepnock Rd, Kepnock	9	$24.01	$3.60
Tuesday, 8 May 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 9 May 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 9 May 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 9 May 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 10 May 2018	WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 10 May 2018	OFFICE	Gracie Dixon, Woondooma St, Bundaberg	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 10 May 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 10 May 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 11 May 2018	GARDG	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00

Friday, 11 May 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 11 May 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 11 May 2018	BARRD	Laack St, Kepnock	OFFICE	Barolin St, Bundaberg South	3	$24.01	$1.20
Saturday, 12 May 2018	RDO						
Sunday, 13 May 2018	RDO						
Monday, 14 May 2018	GARDG & WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 14 May 2018	TRANSPORT	Gracie Dixon, Woondooma St, Bundaberg	NOAKB	Leivesley St, Bundaberg East	6	$24.01	$2.40
Monday, 14 May 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 14 May 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Monday, 14 May 2018	WATSAUD	Hope St, Bundaberg West	BERTMA	Horton St, Norville	7	$24.01	$2.80
Tuesday, 15 May 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 15 May 2018	PEATJ	South Pocket Rd, Avenell Heights	FOWLM	Ovens St, Bundaberg East	8	$24.01	$3.20
Tuesday, 15 May 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Tuesday, 15 May 2018	ODONBE	Grange St, Norville	BERTMA	Horton St, Norville	1	$24.01	$0.40
Wednesday, 16 May 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 16 May 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Wednesday, 16 May 2018	VANIE	Thomsen St, Millbank	GARDG	May St, Walkervale	7	$24.01	$2.80
Thursday, 17 May 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 17 May 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 18 May 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 18 May 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Saturday, 19 May 2018	RDO						
Sunday, 20 May 2018	RDO						
Monday, 21 May 2018	BERTMA	Horton St, Norville	GARDG & WATSAUD	May St, Walkervale	4	$24.01	$1.60
Monday, 21 May 2018	GARDG & WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 21 May 2018	TRANSPORT	Gracie Dixon, Woondooma St, Bundaberg	JOHNMARIO	Carlyle Court, Bargara	20	$24.01	$8.00
Monday, 21 May 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 21 May 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 21 May 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 22 May 2018	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Wednesday, 23 May 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 23 May 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 23 May 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 24 May 2018	WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 24 May 2018	OFFICE	Gracie Dixon, Woondooma St, Bundaberg	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 24 May 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 24 May 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 25 May 2018	GARDG	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Friday, 25 May 2018	OFFICE	Gracie Dixon, Woondooma St, Bundaberg	NOAKB	Leivesley St, Bundaberg East	6	$24.01	$2.40
Friday, 25 May 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 25 May 2018	BARRD	Laack St, Kepnock	TRANSPORT	Gracie Dixon, Woondooma St, Bundaberg	5	$24.01	$2.00
Saturday, 26 May 2018	RDO						
Sunday, 27 May 2018	RDO						
Monday, 28 May 2018	WATSAUD	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 28 May 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 28 May 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Monday, 28 May 2018	WATSAUD	Hope St, Bundaberg West	BERTMA	Horton St, Norville	7	$24.01	$2.80
Tuesday, 29 May 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00

Tuesday, 29 May 2018	PEATJ	South Pocket Rd, Avenell Heights	FOWLM	Ovens St, Bundaberg East	8	$24.01	$3.20
Tuesday, 29 May 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Tuesday, 29 May 2018	ODONBE	Grange St, Norville	BERTMA	Horton St, Norville	1	$24.01	$0.40
Wednesday, 30 May 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 30 May 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Wednesday, 30 May 2018	VANIE	Thomsen St, Millbank	OFFICE	Barolin St, Bundaberg South	6	$24.01	$2.40
Thursday, 31 May 2018	PUBLIC HOLIDAY						
Friday, 1 June 2018	SICK LEAVE						
Saturday, 2 June 2018	RDO						
Sunday, 3 June 2018	RDO						
Monday, 4 June 2018	BERTMA	Horton St, Norville	GARDG & WATSAUD	May St, Walkervale	4	$24.01	$1.60
Monday, 4 June 2018	GARDG & WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 4 June 2018	TRANSPORT	Gracie Dixon, Woondooma St, Bundaberg	JOHNMARIO	Carlyle Court, Bargara	20	$24.01	$8.00
Monday, 4 June 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 4 June 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 4 June 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 5 June 2018	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Wednesday, 6 June 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 6 June 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 6 June 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 7 June 2018	WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 7 June 2018	OFFICE	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 7 June 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 7 June 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 8 June 2018	GARDG	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Friday, 8 June 2018	TRANSPORT	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 8 June 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 8 June 2018	BARRD	Laack St, Kepnock	TRANSPORT	Gracie Dixon, Woondooma St, Bundaberg	5	$24.01	$2.00
Saturday, 9 June 2018	RDO						
Sunday, 10 June 2018	RDO						
Monday, 11 June 2018	GARDG & WATSAUD	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 11 June 2018	OFFICE	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 11 June 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 11 June 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Monday, 11 June 2018	WATSAUD	Hope St, Bundaberg West	BERTMA	Horton St, Norville	7	$24.01	$2.80
Tuesday, 12 June 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 12 June 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 12 June 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Tuesday, 12 June 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Tuesday, 12 June 2018	ODONBE	Grange St, Norville	BERTMA	Horton St, Norville	1	$24.01	$0.40
Wednesday, 13 June 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 13 June 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 14 June 2018	WATSAUD	Hope St, Bundaberg West	ADMIN	South Pocket Rd, Avenell Heights	12	$24.01	$4.80
Thursday, 14 June 2018	ADMIN	South Pocket Rd, Avenell Heights	STEPLYN	Griffith St, Bundaberg	8	$24.01	$3.20
Thursday, 14 June 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Thursday, 14 June 2018	CHARCE	Osprey St, Bargara	WATSAUD	Hope St, Bundaberg West	23	$24.01	$9.20
Friday, 15 June 2018	ABORTED VISIT	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 15 June 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80

Saturday, 16 June 2018	RDO					
Sunday, 17 June 2018	RDO					
Monday, 18 June 2018	ANNUAL LEAVE					
Tuesday, 19 June 2018	ANNUAL LEAVE					
Wednesday, 20 June 2018	ANNUAL LEAVE					
Thursday, 21 June 2018	ANNUAL LEAVE					
Friday, 22 June 2018	ANNUAL LEAVE					
Saturday, 23 June 2018	RDO					
Sunday, 24 June 2018	RDO					
Monday, 25 June 2018	ANNUAL LEAVE					
Tuesday, 26 June 2018	ANNUAL LEAVE					
Wednesday, 27 June 2018	ANNUAL LEAVE					
Thursday, 28 June 2018	ANNUAL LEAVE					
Friday, 29 June 2018	ANNUAL LEAVE					
Saturday, 30 June 2018	RDO					
						Total: $2,792.38

Date	Client (travel from)	Client location	Client (travel to)	Client location	Travel Time (minutes)	Applicable Pay Rate ($/h)	Should Have Been Paid ($)
Sunday, 1 July 2018	RDO						
Monday, 2 July 2018	BERTMA	Horton St, Norville	WATSAUD	May St, Walkervale	4	$24.01	$1.60
Monday, 2 July 2018	WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 2 July 2018	TRANSPORT	Gracie Dixon, Woondooma St, Bu	JOHNMARIO	Carlyle Court, Bargara	20	$24.01	$8.00
Monday, 2 July 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 2 July 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 2 July 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 3 July 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Tuesday, 3 July 2018	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Wednesday, 4 July 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 4 July 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 4 July 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 5 July 2018	WATSAUD	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 5 July 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 5 July 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 6 July 2018	GARDG	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 6 July 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 6 July 2018	BARRD	Laack St, Kepnock	TRANSPORT	Gracie Dixon, Woondooma St, Bundabe	5	$36.02	$3.00
Saturday, 7 July 2018	RDO						
Sunday, 8 July 2018	RDO						
Monday, 9 July 2018	GARDG & WATSAUD	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 9 July 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 9 July 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Tuesday, 10 July 2018	MORGAR	Walker St, Bundaberg	PEATJ	South Pocket Rd, Avenell Heights	8	$24.01	$3.20
Tuesday, 10 July 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 10 July 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Tuesday, 10 July 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Wednesday, 11 July 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 11 July 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 12 July 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 12 July 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 13 July 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 13 July 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$36.02	$1.20
Saturday, 14 July 2018	WHITGR	Whites Rd, Gooburrum	ODONBE	Grange St, Norville	18	$36.02	$10.81
Saturday, 14 July 2018	ODONBE	Grange St, Norville	WHITGR	Whites Rd, Gooburrum	18	$36.02	$10.81
Saturday, 14 July 2018	WHITGR	Whites Rd, Gooburrum	GARDG	May St, Walkervale	17	$48.02	$13.61
Sunday, 15 July 2018	RDO						
Monday, 16 July 2018	BERTMA	Horton St, Norville	GARDG & WATSAUD	May St, Walkervale	4	$24.01	$1.60
Monday, 16 July 2018	GARDG & WATSAUD	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 16 July 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 16 July 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 17 July 2018	FOWLM	Ovens St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	6	$24.01	$2.40

Tuesday, 17 July 2018	OFFICE	Barolin St, Bundaberg South	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Wednesday, 18 July 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 18 July 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 18 July 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 19 July 2018	WATSAUD	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 19 July 2018	POTTMA	Schulte St, Bundaberg East	ABORTED VISIT	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 19 July 2018	ABORTED VISIT	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 20 July 2018	GARDG	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 20 July 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 20 July 2018	BARRD	Laack St, Kepnock	JOHNMARIO	Carlyle Court, Bargara	20	$36.02	$12.01
Saturday, 21 July 2018	RDO						
Sunday, 22 July 2018	RDO						
Monday, 23 July 2018	GARDG & WATSAUD	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 23 July 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 23 July 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Monday, 23 July 2018	WATSAUD	Twyford St, Avoca	BERTMA	Horton St, Norville	7	$24.01	$2.80
Tuesday, 24 July 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 24 July 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 24 July 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Tuesday, 24 July 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Tuesday, 24 July 2018	ODONBE	Grange St, Norville	BERTMA	Horton St, Norville	1	$24.01	$0.40
Wednesday, 25 July 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 25 July 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 26 July 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 26 July 2018	STEPLYN	Griffith St, Bundaberg	PEATJ	South Pocket Rd, Avenell Heights	8	$24.01	$3.20
Friday, 27 July 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 27 July 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$36.02	$1.20
Saturday, 28 July 2018	RDO						
Sunday, 29 July 2018	RDO						
Monday, 30 July 2018	BERTMA	Horton St, Norville	GARDG & WATSAUD	May St, Walkervale	4	$24.01	$1.60
Monday, 30 July 2018	GARDG & WATSAUD	Hope St, Bundaberg West	YOUNPE	Bocks Rd, Branyan	8	$24.01	$3.20
Monday, 30 July 2018	YOUNPE	Bocks Rd, Branyan	JOHNMARIO	Carlyle Court, Bargara	29	$24.01	$11.60
Monday, 30 July 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 30 July 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Tuesday, 31 July 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 31 July 2018	TRANSPORT	Barolin St, Bundaberg South	FOWLM	Ovens St, Bundaberg East	6	$24.01	$2.40
Tuesday, 31 July 2018	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Wednesday, 1 August 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 1 August 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 1 August 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 2 August 2018	WATSAUD	Hope St, Bundaberg West	ADMIN	Barolin St, Bundaberg South	5	$24.01	$2.00
Thursday, 2 August 2018	ADMIN	Barolin St, Bundaberg South	POTTMA	Schulte St, Bundaberg East	7	$24.01	$2.80
Thursday, 2 August 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 2 August 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40

Friday, 3 August 2018	GARDG	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 3 August 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 3 August 2018	BARRD	Laack St, Kepnock	TRANSPORT	Gracie Dixon, Woondooma St, Bundabe	5	$24.01	$2.00
Friday, 3 August 2018	TRANSPORT	Barolin St, Bundaberg South	ODONBE	Grange St, Norville	3	$36.02	$1.80
Saturday, 4 August 2018	RDO						
Sunday, 5 August 2018	RDO						
Monday, 6 August 2018	GARDG & WATSAUD	Hope St, Bundaberg West	YOUNPE	Bocks Rd, Branyan	8	$24.01	$3.20
Monday, 6 August 2018	YOUNPE	Bocks Rd, Branyan	NOAKB	Leivesley St, Bundaberg East	15	$24.01	$6.00
Monday, 6 August 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 6 August 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Tuesday, 7 August 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 7 August 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 7 August 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Tuesday, 7 August 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Wednesday, 8 August 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 8 August 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 9 August 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 9 August 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 10 August 2018	ANNUAL LEAVE						
Saturday, 11 August 2018	RDO						
Sunday, 12 August 2018	RDO						
Monday, 13 August 2018	BERTMA	Horton St, Norville	GARDG & WATSAUD	May St, Walkervale	4	$24.01	$1.60
Monday, 13 August 2018	GARDG & WATSAUD	Hope St, Bundaberg West	JOHNMARIO	Carlyle Court, Bargara	22	$24.01	$8.80
Monday, 13 August 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 13 August 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 13 August 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 14 August 2018	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Wednesday, 15 August 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 15 August 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 15 August 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 16 August 2018	WATSAUD	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 16 August 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 16 August 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 17 August 2018	GARDG	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 17 August 2018	NOAKB	Leivesley St, Bundaberg East	ADMIN	Barolin St, Bundaberg South	8	$24.01	$3.20
Friday, 17 August 2018	ADMIN	Barolin St, Bundaberg South	TRANSPORT	Gracie Dixon, Woondooma St, Bundabe	2	$36.02	$1.20
Saturday, 18 August 2018	RDO						
Sunday, 19 August 2018	RDO						
Monday, 20 August 2018	GARDG & WATSAUD	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 20 August 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Monday, 20 August 2018	PEATJ	South Pocket Rd, Avenell Heights	WATSAUD	Hope St, Bundaberg West	12	$24.01	$4.80
Tuesday, 21 August 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Tuesday, 21 August 2018	ODONBE	Grange St, Norville	PEATJ	South Pocket Rd, Avenell Heights	9	$24.01	$3.60
Tuesday, 21 August 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20

Tuesday, 21 August 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Tuesday, 21 August 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Wednesday, 22 August 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 22 August 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 23 August 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 23 August 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Thursday, 23 August 2018	CHARCE	Osprey St, Bargara	OFFICE	Barolin St, Bundaberg South	21	$24.01	$8.40
Friday, 24 August 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 24 August 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$36.02	$1.20
Saturday, 25 August 2018	RDO						
Sunday, 26 August 2018	RDO						
Monday, 27 August 2018	BERTMA	Horton St, Norville	WATSAUD	Twyford St, Avoca	7	$24.01	$2.80
Monday, 27 August 2018	WATSAUD	Hope St, Bundaberg West	JOHNMARIO	Carlyle Court, Bargara	22	$24.01	$8.80
Monday, 27 August 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 27 August 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 27 August 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 28 August 2018	BRUNA	Howard St, Bargara	FOWLM	Ovens St, Bundaberg East	12	$24.01	$4.80
Tuesday, 28 August 2018	FOWLM	Ovens St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	8	$24.01	$3.20
Tuesday, 28 August 2018	PEATJ	South Pocket Rd, Avenell Heights	FOWLM	Ovens St, Bundaberg East	8	$24.01	$3.20
Wednesday, 29 August 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 29 August 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 29 August 2018	NOAKB	Leivesley St, Bundaberg East	FOWLM	Ovens St, Bundaberg East	2	$24.01	$0.80
Wednesday, 29 August 2018	FOWLM	Ovens St, Bundaberg East	TRAINING	Barolin St, Bundaberg South	6	$24.01	$2.40
Thursday, 30 August 2018	WATSAUD	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 30 August 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 30 August 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 31 August 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 31 August 2018	BARRD	Laack St, Kepnock	TRANSPORT	Gracie Dixon, Woondooma St, Bundabe	5	$36.02	$3.00
Saturday, 1 September 2018	RDO						
Sunday, 2 September 2018	RDO						
Monday, 3 September 2018	GARDG & WATSAUD	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 3 September 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Tuesday, 4 September 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 4 September 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 4 September 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Tuesday, 4 September 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Wednesday, 5 September 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 5 September 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 6 September 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 6 September 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 7 September 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 7 September 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$36.02	$1.20
Saturday, 8 September 2018	RDO						
Sunday, 9 September 2018	RDO						

Monday, 10 September 2018	BERTMA	Horton St, Norville	GARDG & WATSAUD	May St, Walkervale	4	$24.01	$1.60
Monday, 10 September 2018	GARDG & WATSAUD	Hope St, Bundaberg West	ANDEJO	Osborn St, Svensson Heights	5	$24.01	$2.00
Monday, 10 September 2018	ANDEJO	Osborn St, Svensson Heights	JOHNMARIO	Carlyle Court, Bargara	25	$24.01	$10.00
Monday, 10 September 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 10 September 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 10 September 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 11 September 2018	FOWLM	Ovens St, Bundaberg East	ABORTED VISIT	Kepnock Rd, Kepnock	5	$24.01	$2.00
Tuesday, 11 September 2018	ABORTED VISIT	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 12 September 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40
Wednesday, 12 September 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 12 September 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Wednesday, 12 September 2018	PEATJ	South Pocket Rd, Avenell Heights	FOWLM	Ovens St, Bundaberg East	8	$24.01	$3.20
Thursday, 13 September 2018	WATSAUD	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 13 September 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 13 September 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 14 September 2018	GARDG	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 14 September 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 14 September 2018	BARRD	Laack St, Kepnock	TRANSPORT	Gracie Dixon, Woondooma St, Bundabe	5	$36.02	$3.00
Saturday, 15 September 2018	RDO						
Sunday, 16 September 2018	RDO						
Monday, 17 September 2018	GARDO & WATSAUD	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 17 September 2018	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Monday, 17 September 2018	DAYCO	Kepnock Rd, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	5	$24.01	$2.00
Tuesday, 18 September 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 18 September 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 18 September 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Tuesday, 18 September 2018	FOWLM	Ovens St, Bundaberg East	ODONBE	Grange St, Norville	9	$24.01	$3.60
Wednesday, 19 September 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 19 September 2018	NOAKB	Leivesley St, Bundaberg East	STREN	Twyford St, Avoca	11	$24.01	$4.40
Thursday, 20 September 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 20 September 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 21 September 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 21 September 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$36.02	$1.20
Saturday, 22 September 2018	RDO						
Sunday, 23 September 2018	RDO						
Monday, 24 September 2018	BERTMA	Horton St, Norville	GARDG & WATSAUD	Hope St, Bundaberg West	7	$24.01	$2.80
Monday, 24 September 2018	GARDG & WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 24 September 2018	TRANSPORT	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 24 September 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 24 September 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 24 September 2018	HAREA	Walters St, Bundaberg North	ODONBE	Grange St, Norville	8	$24.01	$3.20
Tuesday, 25 September 2018	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Tuesday, 25 September 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 26 September 2018	BERTMA	Horton St, Norville	ODONBE	Grange St, Norville	1	$24.01	$0.40

Wednesday, 26 September 2018	ODONBE	Grange St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 26 September 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 27 September 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Thursday, 27 September 2018	TRANSPORT	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 27 September 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 27 September 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 28 September 2018	GARDG	May St, Walkervale	TRANSPORT	Hope St, Bundaberg West	6	$24.01	$2.40
Friday, 28 September 2018	TRANSPORT	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 28 September 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 28 September 2018	BARRD	Laack St, Kepnock	TRANSPORT	Barolin St, Bundaberg South	3	$36.02	$1.80
Saturday, 29 September 2018	RDO						
Sunday, 30 September 2018	RDO						
Monday, 1 October 2018	PUBLIC HOLIDAY						
Tuesday, 2 October 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 2 October 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 2 October 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Wednesday, 3 October 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 3 October 2018	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Wednesday, 3 October 2018	DAYCO	Kepnock Rd, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	5	$24.01	$2.00
Thursday, 4 October 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 4 October 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 5 October 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 5 October 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Friday, 5 October 2018	NOAKB	Leivesley St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	8	$36.02	$4.80
Saturday, 6 October 2018	RDO						
Sunday, 7 October 2018	RDO						
Monday, 8 October 2018	BERTMA	Horton St, Norville	GARDG & WATSAUD	Hope St, Bundaberg West	7	$24.01	$2.80
Monday, 8 October 2018	GARDG & WATSAUD	Hope St, Bundaberg West	TRANSPORT	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 8 October 2018	TRANSPORT	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 8 October 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 8 October 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Tuesday, 9 October 2018	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Tuesday, 9 October 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 10 October 2018	BERTMA	Horton St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 10 October 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Thursday, 11 October 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Thursday, 11 October 2018	TRANSPORT	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Friday, 12 October 2018	SICK LEAVE						
Saturday, 13 October 2018	RDO						
Sunday, 14 October 2018	RDO						
Monday, 15 October 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 15 October 2018	TRANSPORT	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 15 October 2018	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Monday, 15 October 2018	DAYCO	Kepnock Rd, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	5	$24.01	$2.00

Tuesday, 16 October 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 16 October 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Wednesday, 17 October 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Thursday, 18 October 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 18 October 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 19 October 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 19 October 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Friday, 19 October 2018	NOAKB	Leivesley St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	8	$36.02	$4.80
Saturday, 20 October 2018	RDO						
Sunday, 21 October 2018	RDO						
Monday, 22 October 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 22 October 2018	TRANSPORT	Hope St, Bundaberg West	JOHNMARIO	Carlyle Court, Bargara	22	$24.01	$8.80
Monday, 22 October 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 22 October 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Tuesday, 23 October 2018	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Tuesday, 23 October 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 24 October 2018	only one client						
Thursday, 25 October 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Thursday, 25 October 2018	TRANSPORT	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 25 October 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 25 October 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 26 October 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 26 October 2018	BARRD	Laack St, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	6	$36.02	$3.60
Saturday, 27 October 2018	RDO						
Sunday, 28 October 2018	RDO						
Monday, 29 October 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 29 October 2018	TRANSPORT	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 29 October 2018	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Monday, 29 October 2018	DAYCO	Kepnock Rd, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	5	$24.01	$2.00
Tuesday, 30 October 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 30 October 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 30 October 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Wednesday, 31 October 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 31 October 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 1 November 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 1 November 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 2 November 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 2 November 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$36.02	$1.20
Saturday, 3 November 2018	RDO						
Sunday, 4 November 2018	RDO						
Monday, 5 November 2018	ANNUAL LEAVE						
Tuesday, 6 November 2018	ANNUAL LEAVE						
Wednesday, 7 November 2018	ANNUAL LEAVE						
Thursday, 8 November 2018	ANNUAL LEAVE						

Friday, 9 November 2018	ANNUAL LEAVE						
Saturday, 10 November 2018	RDO						
Sunday, 11 November 2018	RDO						
Monday, 12 November 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 12 November 2018	TRANSPORT	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 12 November 2018	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Monday, 12 November 2018	DAYCO	Kepnock Rd, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	5	$24.01	$2.00
Tuesday, 13 November 2018	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 13 November 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 13 November 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Wednesday, 14 November 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 14 November 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 15 November 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 15 November 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 16 November 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 16 November 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$36.02	$1.20
Saturday, 17 November 2018	RDO						
Sunday, 18 November 2018	RDO						
Monday, 19 November 2018	BERTMA	Horton St, Norville	WATSAUD	Twyford St, Avoca	7	$24.01	$2.80
Monday, 19 November 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 19 November 2018	TRANSPORT	Hope St, Bundaberg West	JOHNMARIO	Carlyle Court, Bargara	22	$24.01	$8.80
Monday, 19 November 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 19 November 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Tuesday, 20 November 2018	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Tuesday, 20 November 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Tuesday, 20 November 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Wednesday, 21 November 2018	BERTMA	Horton St, Norville	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Wednesday, 21 November 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Wednesday, 21 November 2018	PEATJ	South Pocket Rd, Avenell Heights	NOAKB	Leivesley St, Bundaberg East	7	$24.01	$2.80
Thursday, 22 November 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Thursday, 22 November 2018	TRANSPORT	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 22 November 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 22 November 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Thursday, 22 November 2018	CHARCE	Osprey St, Bargara	NOAKB	Leivesley St, Bundaberg East	18	$24.01	$7.20
Friday, 23 November 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 23 November 2018	BARRD	Laack St, Kepnock	TRANSPORT	Barolin St, Bundaberg South	3	$24.01	$1.20
Friday, 23 November 2018	TRANSPORT	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$36.02	$4.80
Saturday, 24 November 2018	RDO						
Sunday, 25 November 2018	RDO						
Monday, 26 November 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 26 November 2018	TRANSPORT	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 26 November 2018	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Monday, 26 November 2018	DAYCO	Kepnock Rd, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	5	$24.01	$2.00
Monday, 26 November 2018	PEATJ	South Pocket Rd, Avenell Heights	NOAKB	Leivesley St, Bundaberg East	7	$24.01	$2.80

Tuesday, 27 November 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 27 November 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Wednesday, 28 November 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Wednesday, 28 November 2018	NOAKB	Leivesley St, Bundaberg East	VANIE	Thomsen St, Millbank	10	$24.01	$4.00
Thursday, 29 November 2018	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 29 November 2018	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Thursday, 29 November 2018	CHARCE	Osprey St, Bargara	NOAKB	Leivesley St, Bundaberg East	18	$24.01	$7.20
Friday, 30 November 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 30 November 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$36.02	$1.20
Saturday, 1 December 2018	RDO						
Sunday, 2 December 2018	RDO						
Monday, 3 December 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 3 December 2018	TRANSPORT	Hope St, Bundaberg West	JOHNMARIO	Carlyle Court, Bargara	22	$24.01	$8.80
Monday, 3 December 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 3 December 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Monday, 3 December 2018	HAREA	Walters St, Bundaberg North	OFFICE	Barolin St, Bundaberg South	6	$24.01	$2.40
Tuesday, 4 December 2018	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Tuesday, 4 December 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Tuesday, 4 December 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Wednesday, 5 December 2018	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Wednesday, 5 December 2018	PEATJ	South Pocket Rd, Avenell Heights	NOAKB	Leivesley St, Bundaberg East	7	$24.01	$2.80
Thursday, 6 December 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Thursday, 6 December 2018	TRANSPORT	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 6 December 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 6 December 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Thursday, 6 December 2018	CHARCE	Osprey St, Bargara	NOAKB	Leivesley St, Bundaberg East	18	$24.01	$7.20
Friday, 7 December 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 7 December 2018	BARRD	Laack St, Kepnock	TRANSPORT	Gracie Dixon, Woondooma St, Bundabe	5	$24.01	$2.00
Friday, 7 December 2018	TRANSPORT	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Friday, 7 December 2018	NOAKB	Leivesley St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	8	$36.02	$4.80
Saturday, 8 December 2018	RDO						
Sunday, 9 December 2018	RDO						
Monday, 10 December 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 10 December 2018	TRANSPORT	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 10 December 2018	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Monday, 10 December 2018	DAYCO	Kepnock Rd, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	5	$24.01	$2.00
Tuesday, 11 December 2018	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 11 December 2018	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Tuesday, 11 December 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80
Wednesday, 12 December 2018	ANDEJO	Osborn St, Svensson Heights	NOAKB	Leivesley St, Bundaberg East	11	$24.01	$4.40
Thursday, 13 December 2018	WHITW	Stoutley St, Bundaberg	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Thursday, 13 December 2018	CHARCE	Osprey St, Bargara	NOAKB	Leivesley St, Bundaberg East	18	$24.01	$7.20
Friday, 14 December 2018	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 14 December 2018	FOWLM	Ovens St, Bundaberg East	NOAKB	Leivesley St, Bundaberg East	2	$24.01	$0.80

Friday, 14 December 2018	NOAKB	Leivesley St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	8	$36.02	$4.80
Saturday, 15 December 2018	RDO						
Sunday, 16 December 2018	RDO						
Monday, 17 December 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 17 December 2018	TRANSPORT	Hope St, Bundaberg West	STEPLYN	Griffith St, Bundaberg	5	$24.01	$2.00
Monday, 17 December 2018	STEPLYN	Griffith St, Bundaberg	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 17 December 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 17 December 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Tuesday, 18 December 2018	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Tuesday, 18 December 2018	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 19 December 2018	NOAKB	Leivesley St, Bundaberg East	WHITW	Stoutley St, Bundaberg	10	$24.01	$4.00
Wednesday, 19 December 2018	WHITW	Stoutley St, Bundaberg	VANIE	Thomsen St, Millbank	8	$24.01	$3.20
Wednesday, 19 December 2018	VANIE	Thomsen St, Millbank	NOAKB	Leivesley St, Bundaberg East	10	$24.01	$4.00
Thursday, 20 December 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Thursday, 20 December 2018	TRANSPORT	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 20 December 2018	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 20 December 2018	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Thursday, 20 December 2018	CHARCE	Osprey St, Bargara	NOAKB	Leivesley St, Bundaberg East	18	$24.01	$7.20
Friday, 21 December 2018	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 21 December 2018	BARRD	Laack St, Kepnock	TRANSPORT	Gracie Dixon, Woondooma St, Bundabe	5	$24.01	$2.00
Friday, 21 December 2018	TRANSPORT	Gracie Dixon, Woondooma St, Bu	DEZOTTI	Barolin St, Bundaberg South	2	$24.01	$0.80
Friday, 21 December 2018	DEZOTTI	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$36.02	$4.80
Saturday, 22 December 2018	RDO						
Sunday, 23 December 2018	RDO						
Monday, 24 December 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 24 December 2018	TRANSPORT	Hope St, Bundaberg West	PEATJ	South Pocket Rd, Avenell Heights	12	$24.01	$4.80
Monday, 24 December 2018	PEATJ	South Pocket Rd, Avenell Heights	NOAKB	Leivesley St, Bundaberg East	7	$24.01	$2.80
Monday, 24 December 2018	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Monday, 24 December 2018	DAYCO	Kepnock Rd, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	5	$24.01	$2.00
Tuesday, 25 December 2018	XMAS						
Wednesday, 26 December 2018	BOXING DAY						
Thursday, 27 December 2018	ANNUAL LEAVE						
Friday, 28 December 2018	ANNUAL LEAVE						
Saturday, 29 December 2018	RDO						
Sunday, 30 December 2018	RDO						
Monday, 31 December 2018	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 31 December 2018	TRANSPORT	Hope St, Bundaberg West	OFFICE	Barolin St, Bundaberg South	5	$24.01	$2.00
Monday, 31 December 2018	OFFICE	Barolin St, Bundaberg South	JOHNMARIO	Carlyle Court, Bargara	21	$24.01	$8.40
Monday, 31 December 2018	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 31 December 2018	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Tuesday, 1 January 2019	PUBLIC HOLIDAY						
Wednesday, 2 January 2019	NOAKB	Leivesley St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	7	$24.01	$2.80
Wednesday, 2 January 2019	PEATJ	South Pocket Rd, Avenell Heights	NOAKB	Leivesley St, Bundaberg East	7	$24.01	$2.80
Thursday, 3 January 2019	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60

Thursday, 3 January 2019	TRANSPORT	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Thursday, 3 January 2019	NOAKB	Leivesley St, Bundaberg East	POTTMA	Schulte St, Bundaberg East	1	$24.01	$0.40
Thursday, 3 January 2019	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 3 January 2019	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Thursday, 3 January 2019	CHARCE	Osprey St, Bargara	NOAKB	Leivesley St, Bundaberg East	18	$24.01	$7.20
Friday, 4 January 2019	NOAKB	Leivesley St, Bundaberg East	BARRD	Laack St, Kepnock	7	$24.01	$2.80
Friday, 4 January 2019	BARRD	Laack St, Kepnock	TRANSPORT	Gracie Dixon, Woondooma St, Bundabe	5	$24.01	$2.00
Friday, 4 January 2019	TRANSPORT	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$36.02	$4.80
Saturday, 5 January 2019	RDO						
Sunday, 6 January 2019	RDO						
Monday, 7 January 2019	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 7 January 2019	TRANSPORT	Hope St, Bundaberg West	NOAKB	Leivesley St, Bundaberg East	8	$24.01	$3.20
Monday, 7 January 2019	NOAKB	Leivesley St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	6	$24.01	$2.40
Monday, 7 January 2019	DAYCO	Kepnock Rd, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	5	$24.01	$2.00
Tuesday, 8 January 2019	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 8 January 2019	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Wednesday, 9 January 2019	ANDEJO	Osborn St, Svensson Heights	LINES	George St, Bundaberg West	5	$24.01	$2.00
Wednesday, 9 January 2019	LINES	George St, Bundaberg West	NOAKB	Bourbong St, Bundaberg	2	$24.01	$0.80
Wednesday, 9 January 2019	NOAKB	Bourbong St, Bundaberg	VANIE	Thomsen St, Millbank	4	$24.01	$1.60
Thursday, 10 January 2019	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 10 January 2019	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 11 January 2019	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 11 January 2019	FOWLM	Ovens St, Bundaberg East	NOAKB	Bourbong St, Bundaberg	5	$36.02	$3.00
Saturday, 12 January 2019	RDO						
Sunday, 13 January 2019	RDO						
Monday, 14 January 2019	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 14 January 2019	TRANSPORT	Hope St, Bundaberg West	JOHNMARIO	Carlyle Court, Bargara	22	$24.01	$8.80
Monday, 14 January 2019	JOHNMARIO	Carlyle Court, Bargara	NOAKB	Leivesley St, Bundaberg East	16	$24.01	$6.40
Monday, 14 January 2019	NOAKB	Leivesley St, Bundaberg East	HAREA	Walters St, Bundaberg North	9	$24.01	$3.60
Tuesday, 15 January 2019	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Tuesday, 15 January 2019	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 16 January 2019	NOAKB	Bourbong St, Bundaberg	PEATJ	South Pocket Rd, Avenell Heights	11	$24.01	$4.40
Thursday, 17 January 2019	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Thursday, 17 January 2019	TRANSPORT	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 17 January 2019	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 17 January 2019	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 18 January 2019	FOWLM	Ovens St, Bundaberg East	LINES	George St, Bundaberg West	7	$24.01	$2.80
Friday, 18 January 2019	LINES	George St, Bundaberg West	BARRD	Laack St, Kepnock	6	$24.01	$2.40
Friday, 18 January 2019	BARRD	Laack St, Kepnock	TRANSPORT	Gracie Dixon, Woondooma St, Bundabe	5	$24.01	$2.00
Friday, 18 January 2019	TRANSPORT	Barolin St, Bundaberg South	NOAKB	Leivesley St, Bundaberg East	8	$36.02	$4.80
Saturday, 19 January 2019	RDO						
Sunday, 20 January 2019	RDO						
Monday, 21 January 2019	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 21 January 2019	TRANSPORT	Hope St, Bundaberg West	DAYCO	Kepnock Rd, Kepnock	8	$24.01	$3.20

Monday, 21 January 2019	DAYCO	Kepnock Rd, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	5	$24.01	$2.00
Tuesday, 22 January 2019	BERTMA	Horton St, Norville	PEATJ	South Pocket Rd, Avenell Heights	10	$24.01	$4.00
Tuesday, 22 January 2019	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 22 January 2019	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Wednesday, 23 January 2019	ANDEJO	Osborn St, Svensson Heights	LINES	George St, Bundaberg West	5	$24.01	$2.00
Wednesday, 23 January 2019	LINES	George St, Bundaberg West	VANIE	Thomsen St, Millbank	6	$24.01	$2.40
Thursday, 24 January 2019	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 24 January 2019	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Thursday, 24 January 2019	CHARCE	Osprey St, Bargara	OFFICE	Barolin St, Bundaberg South	21	$24.01	$8.40
Friday, 25 January 2019	TURNB	Wilmington St, Thabeban	FOWLM	Ovens St, Bundaberg East	9	$24.01	$3.60
Friday, 25 January 2019	FOWLM	Ovens St, Bundaberg East	OFFICE	Barolin St, Bundaberg South	6	$36.02	$3.60
Saturday, 26 January 2019	RDO						
Sunday, 27 January 2019	RDO						
Monday, 28 January 2019	PUBLIC HOLIDAY						
Tuesday, 29 January 2019	FOWLM	Ovens St, Bundaberg East	DAYCO	Kepnock Rd, Kepnock	5	$24.01	$2.00
Tuesday, 29 January 2019	DAYCO	Kepnock Rd, Kepnock	FOWLM	Ovens St, Bundaberg East	5	$24.01	$2.00
Wednesday, 30 January 2019	HAREA	Walters St, Bundaberg North	FOWLM	Ovens St, Bundaberg East	8	$24.01	$3.20
Wednesday, 30 January 2019	FOWLM	Ovens St, Bundaberg East	PEATJ	South Pocket Rd, Avenell Heights	8	$24.01	$3.20
Thursday, 31 January 2019	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Thursday, 31 January 2019	TRANSPORT	Hope St, Bundaberg West	POTTMA	Schulte St, Bundaberg East	8	$24.01	$3.20
Thursday, 31 January 2019	POTTMA	Schulte St, Bundaberg East	BAILB	Johnston St, Avoca	12	$24.01	$4.80
Thursday, 31 January 2019	BAILB	Johnston St, Avoca	CHARCE	Osprey St, Bargara	26	$24.01	$10.40
Friday, 1 February 2019	FOWLM	Ovens St, Bundaberg East	LINES	George St, Bundaberg West	7	$24.01	$2.80
Friday, 1 February 2019	LINES	George St, Bundaberg West	BARRD	Laack St, Kepnock	6	$24.01	$2.40
Friday, 1 February 2019	BARRD	Laack St, Kepnock	TRANSPORT	Gracie Dixon, Woondooma St, Bundabe	5	$24.01	$2.00
Friday, 1 February 2019	TRANSPORT	Gracie Dixon, Woondooma St, Bu	OFFICE	Barolin St, Bundaberg South	2	$36.02	$1.20
Saturday, 2 February 2019	RDO						
Sunday, 3 February 2019	RDO						
Monday, 4 February 2019	WATSAUD	Twyford St, Avoca	TRANSPORT	Hope St, Bundaberg West	4	$24.01	$1.60
Monday, 4 February 2019	TRANSPORT	Hope St, Bundaberg West	DAYCO	Kepnock Rd, Kepnock	8	$24.01	$3.20
Monday, 4 February 2019	DAYCO	Kepnock Rd, Kepnock	PEATJ	South Pocket Rd, Avenell Heights	5	$24.01	$2.00
Tuesday, 5 February 2019	PEATJ	South Pocket Rd, Avenell Heights	BAILB	Johnston St, Avoca	13	$24.01	$5.20
Tuesday, 5 February 2019	BAILB	Johnston St, Avoca	FOWLM	Ovens St, Bundaberg East	10	$24.01	$4.00
Wednesday, 6 February 2019	ANDEJO	Osborn St, Svensson Heights	PEATJ	South Pocket Rd, Avenell Heights	12	$24.01	$4.80
Wednesday, 6 February 2019	PEATJ	South Pocket Rd, Avenell Heights	LINES	George St, Bundaberg West	10	$24.01	$4.00
Wednesday, 6 February 2019	LINES	George St, Bundaberg West	VANIE	Thomsen St, Millbank	6	$24.01	$2.40
Thursday, 7 February 2019	WHITW	Stoutley St, Bundaberg	STEPLYN	Griffith St, Bundaberg	7	$24.01	$2.80
Thursday, 7 February 2019	STEPLYN	Griffith St, Bundaberg	CHARCE	Osprey St, Bargara	21	$24.01	$8.40
Friday, 8 February 2019	SICK LEAVE						
Saturday, 9 February 2019	RDO						
						Total	$1,701.92

FAIR WORK COMMISSION

FOUR YEARLY REVIEW OF MODERN AWARDS

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

MATTER NO. 2018/26

Exhibit JM2

MAGISTRATES COURT OF QUEENSLAND

REGISTRY: BRISBANE
NUMBER: M2400/19

Plaintiff: **MARGARET BLACKHURST**

AND

Defendant: **LIVEBETTER SERVICES LIMITED (ACN 160 259 512)**

NOTICE OF INTENTION TO DEFEND

TAKE NOTICE that the Defendant intends to defend this proceeding.

The facts relied on by the Defendant are set out in the attached defence.

Filed in the Brisbane Registry on: 12 August 2019

MAGISTRATES COURT BRISBANE

Registrar

PARTICULARS OF THE DEFENDANT:

Name: LiveBetter Services Limited (ACN 160 259 512)

Defendant's residential or business address:

Level 1, Byng Street
Orange NSW 2800

Defendant's solicitors name and firm name: Louise Nixon of Lander & Rogers as town agent for Nikki Town of Kardos Scanlan Lawyers

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NOTICE OF INTENTION TO DEFEND
Filed on Behalf of the Defendant

Form 6, Version 1
Uniform Civil Procedure Rules 1999
Rule 139

Name: Lander & Rogers
Address: Waterfront Place,
Level 11, 1 Eagle Street,
Brisbane, Qld 4000

Phone No: 07 3456 5000
Email: lnixon@landers.com.au

Solicitor's business address:	Lander & Rogers as town agent for Kardos Scanlan Lawyers at Waterfront Place, Level 11, 1 Eagle Street, Brisbane, Qld 4000
Address for service:	Lander & Rogers as town agent for Kardos Scanlan Lawyers at Waterfront Place, Level 11, 1 Eagle Street, Brisbane, Qld 4000
Telephone:	07 3456 5000
Fax:	07 3456 5001
E-mail address:	lnixon@landers.com.au

Signed: L Nixon Lander + Rogers

Description: Solicitor

Dated: 12 August 2019

LOUISE MARIE NIXON
1 Eagle Street, Brisbane 4000
An Australian Legal Practitioner
within the meaning of the
Legal Profession Act 2007 (QLD)

MAGISTRATES COURT OF QUEENSLAND

REGISTRY: BRISBANE

NUMBER: M2400/19

Plaintiff: **MARGARET BLACKHURST**

AND

Defendant: **LIVEBETTER SERVICES LIMITED (ACN 160 259 512)**

DEFENCE OF THE DEFENDANT

The defendant relies on the following facts in defence of the claim:

1. The defendant admits the allegations in paragraphs 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13 of the statement of claim.

2. The defendant denies the allegation in paragraph 14 of the statement of claim because, pursuant to the *Social, Community, Home Care and Disability Services Industry Award 2010* (the **Award**), properly construed, the Defendant did pay the plaintiff for any work related travel that the plaintiff undertook.

3. The defendant denies the allegation in paragraph 15 of the statement of claim because, when properly construed, the plaintiff was only entitled to be paid for hours worked in accordance with one classification level (or pay point) set out in clause 17 of the Award, at any one point in time.

4. The defendant denies the allegations in paragraph 16 of the statement of claim, and says that:

   (a) the plaintiff was entitled, pursuant to the Award, to be paid by the defendant for time taken for travel which is (properly construed under the Award) work related travel;

   (b) the defendant paid, pursuant to the Award, the plaintiff for any time taken for travel which was (properly construed under the Award) work related travel; and

Name: Lander & Rogers
Address: Waterfront Place,
Level 11, 1 Eagle Street,
Brisbane, Qld 4000

Phone No: 07 3456 5000
Email: lnixon@landers.com.au

(c) the plaintiff was not entitled, pursuant to the Award, to be paid for time taken travelling to and from broken shifts.

5. The defendant denies the allegations in paragraph 17 of the statement of claim because:

   (a) of the matters set out in paragraph 4 of this defence;

   (b) the defendant has no liability for "travel time since 19 June 2017";

   (c) the defendant has not contravened a term of the Award; and

   (d) the defendant has not contravened s 45 of the *Fair Work Act 2009* (Cth).

6. The defendant denies the allegations in paragraph 18 of the statement of claim because of the premises set out in paragraphs 4 and 5 of this defence.

7. The defendant does not plead to the prayer for relief (set out in paragraph 19 of the statement of claim).

Signed: 

Description: Lander & Rogers Lawyers as town agent for Kardos Scanlan

This pleading was settled by R W Haddrick of Counsel.

NOTICE AS TO REPLY

You have fourteen days within which to file and serve a reply to this defence. If you do not do so, you may be prevented from adducing evidence in relation to allegations of fact made in this defence.

FAIR WORK COMMISSION

FOUR YEARLY REVIEW OF MODERN AWARDS

SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

MATTER NO. 2018/26

Exhibit JM3

MAGISTRATES COURT OF QUEENSLAND

REGISTRY: BRISBANE
NUMBER: M2400/19

Plaintiff: **MARGARET BLACKHURST**

AND

Defendant: **LIVEBETTER SERVICES LIMITED (ACN 160 259 512)**

APPLICATION

TAKE NOTICE that the Defendant is applying to the Court for the following orders:

1. Pursuant to rule 367 of the *Uniform Civil Procedure Riles 1999*, an order staying the further steps in the proceeding pending the determination of a proceeding or matter before the Full Bench of the Fair Work Commission, in matter number AM2018/26.

2. The plaintiff pay the costs of, and incidental to, the defendant bringing this application.

This application will be heard by the Court at Brisbane
on: 2 December 2019 at 9 am.

12 September 2019

Filed in the Brisbane Registry on 12 September 2019:

Registrar:

MAGISTRATES COURT BRISBANE

MAGISTRATES COURT BRISBANE

APPLICATION

Filed on Behalf of the Defendant

Form 9, Version 1
Uniform Civil Procedure Rules 1999
Rule 31

Name: Lander & Rogers (as town agent for Kardos Scanlan Lawyers)
Address: Waterfront Place, Level 11, 1 Eagle Street, Brisbane QLD 4000

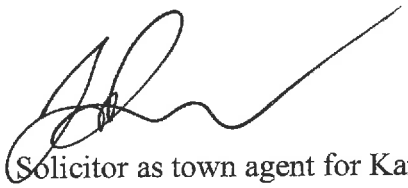
Phone No: 07 3456 5000
Fax No:NA
Email: lnixon@landers.com.au

If you wish to oppose this application or to argue that any different order should be made, you must appear before the Court in person or by your lawyer and you shall be heard. If you do not appear at the hearing the orders sought may be made without further notice to you.

On the hearing of the application the applicant intends to rely on the following affidavits:

1. Affidavit of Nicole Town, affirmed on 6 September 2019.

The applicant estimates the hearing should be allocated is 45 Minutes.

Signed:  Jamie Thomas O'Regan
Solicitor

Description: Solicitor as town agent for Kardos Scanlan Lawyers.

Dated: 12 September 2019

This application is to be served on:

Jared Marks
Industrial Officer
United Voice
27 Peel Street
South Brisbane
4101 QLD
Jared.marks@unitedvoice.org.au

Fair Work Commission
Four Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award
Matter no: AM2014/285 and AM2018/26

SUBMISSION IN REPLY – FOUR YEARLY REVIEW – SUBSTANTIVE ISSUES
Social, Community, Home Care and Disability Services Industry Award

Overview

These submissions are made by Business SA's as Submission in Reply to the substantive claims lodged by the Health Services Union (HSU) and United Voices (UV) to vary the Social, Community, Home Care and Disability Services Award 2010 (the Award). The matters listed in Attachment C of the Amended Directions issued by the Fair Work Commission on 28 June 2019. Business SA has not addressed all the issues set out in the Statement; however, this should not be taken as Business SA's agreement to the remaining Union claims set out in their applications.

Clothing and equipment allowance

1. United Voice (UV)[1] and the Health Services Union (HSU)[2] lodged substantive applications to vary Clause 20.2 – Clothing and Equipment.

2. The SCHCADS Award currently provides the following in clause 20.2 – Clothing and Equipment:

> *20.2 Clothing and equipment*
>
> *(a) Employees required by the employer to wear uniforms will be supplied with an adequate number of uniforms appropriate to the occupation free of cost to employees. Such items are to remain the property of the employer and be laundered and maintained by the employer free of cost to the employee.*
>
> *(b) Instead of the provision of such uniforms, the employer may, by agreement with the employee, pay such employee a uniform allowance at the rate of $1.23 per shift or part thereof on duty or $6.24 per week, whichever is the lesser amount. Where such employee's uniforms are not laundered by or at the expense of the employer, the employee will be paid a laundry allowance of $0.32 per shift or part thereof on duty or $1.49 per week, whichever is the lesser amount.*

1 Submission of United Voice – Four Yearly Review, 5 February 2019 para 48 - 59
2 Submission of Health Services Union – Four Yearly Review – Substantive Issues, 15 February 2019 para 61-62

(c) The uniform allowance, but not the laundry allowance, will be paid during all absences on paid leave, except absences on long service leave and absence on personal/carer's leave beyond 21 days. Where, prior to the taking of leave, an employee was paid a uniform allowance other than at the weekly rate, the rate to be paid during absence on leave will be the average of the allowance paid during the four weeks immediately preceding the taking of leave.

(d) Where an employer requires an employee to wear rubber gloves, special clothing or where safety equipment is required for the work performed by an employee, the employer must reimburse the employee for the cost of purchasing such special clothing or safety equipment, except where such clothing or equipment is provided by the employer.

3. The HSU has made an application to amend the uniform allowance to ensure that a uniform is provided, or an allowance is paid; and providing a new entitlement for the replacement of damaged clothing.

Damaged clothing allowance

(i) Where an employee, in the course of their employment suffers any damage to or soiling of clothing or other personal effects (excluding hosiery), upon provision of proof of the damage, employees shall be compensated at the reasonable replacement value of the damaged or soiled item of clothing. (ii) This clause will not apply where the damage or soiling is caused by the negligence of the employee.

4. UV has made an application to vary subclause 22.2(b) to provide:

An adequate number of uniforms should allow an employee to work their agreed hours of work in a clean uniform without having to launder work uniforms more than once a week.

The HSU Claim

5. The HSU submits the Award should include a damaged clothing allowance, to take into account that employees' clothing will frequently become damaged, soiled or worn given the nature of the work they do. Where such damage occurs, upon provision of proof of the damage, employees should be compensated at the reasonable replacement value of the damaged or soiled item of clothing.

6. Business SA acknowledges that not all workplaces provide uniforms, or the uniform provided will be a company shirt and not pants and there is a requirement for employees to wear some of their own clothing.

7. Business SA acknowledges that employees covered by the SCHCADS Award may undertake work that results in the soiling or damage of clothing, such as using harsh cleaning chemicals or from bodily fluids.

8. The HSU witness, Ms Waddell states that their uniform becomes damages or worn out very quickly and that clothing can become spoiled with bodily fluids.

9. It is not unusual for employees to wear their own clothes to work and general wear and tear of such clothing should not be the liability of the employer. Employees are expected to take all reasonable care necessary to protect their clothing.

10. The HSU has proposed the following wording:

20.3 Damaged clothing allowance

(i) Where an employee, in the course of their employment suffers any damage to or soiling of clothing or other personal effects (excluding hosiery), upon provision of proof of the damage, employees shall be compensated at the reasonable replacement value of the damaged or soiled item of clothing.

(ii) This clause will not apply where the damage or soiling is caused by the negligence of the employee

11. The standard wording for reimbursement of clothing allowance is as per the Manufacturing Award and has been used in a number of other, similar awards.

Manufacturing Award: 32.2 (d) Damage to clothing, spectacles, hearing aids and tools

(ii) Where an employee as a result of performing any duty required by the employer, and as a result of negligence of the employer, suffers any damage to or soiling of clothing or other personal equipment, including spectacles and hearing aids, the employer is liable for the replacement, repair or cleaning of such clothing or personal equipment including spectacles and hearing aids.

Food and Beverage Manufacturing 26.2 (d) Damage to clothing, spectacles and hearing aids

Where an employee as a result of performing any duty required by the employer, and as a result of negligence of the employer, suffers any damage to or soiling of clothing or other personal equipment, including spectacles and hearing aids, the employer is liable for the replacement, repair or cleaning of such clothing or personal equipment including spectacles and hearing aids.

The UV Claim

12. UV have submitted that the wording "adequate" contained in the Award allows for employer discretion resulting in the employees not receiving enough uniforms.[3] UV have also submitted that many workers covered by the Award carry out work that results in their clothing being stained, resulting in the employees washing their uniforms multiple times per week, which can be onerous.
13. UV submit that employees should be provided with enough uniforms so that they do not need to wash more than once per week.[4]

[3] Submissions of United Voice, 4 February 2019, Para 50
[4] Submissions of United Voice, 4 February 2019, Para 54

14. United Voice have proposed the following wording:

20.2(b) An adequate number of uniforms should allow an employee to work their agreed hours of work in a clean uniform without having to launder work uniforms more than once a week.

15. UV have relied on the modern award objective contained in the Fair Work Act 2009, specifically:

s 134(1)(a) – 'relative living standards and the needs of the low paid' -this variation would assist provide for the needs of the low paid. Employees covered under the SCHDS Award can generally be considered low paid.

s 134(1)(c) – 'the need to promote social inclusion through increased workforce participation' – participation in the workplace is facilitated by the dignity in having a clean uniform.

16. The UV witness, Ms Belinda Sinclair, indicates that she was not provided with enough uniforms to attend work in a clean uniform without having to wash her uniforms more than once a week. She states: '*When I only had 2 shirts, I had to wash them every day of employment, so one was ready to wear the next day. Working five days in a row meant I had to wash them at least three times per week*.'

17. While washing clothing more than once a week, may be seen as an inconvenience, the Union has not provided sufficient evidence to show that by requiring an employee to wash more than once a week results in the modern award objectives are not met. Ms Sinclair's statement does not provide evidence that participation in the workplace is facilitated by having a clean uniform or that providing additional uniform will improve the relative living standards and needs of the low paid.

18. The provision of additional uniforms to ensure an employee only washes clothing once a week is a cost on employers that is unnecessary and prohibitive. It is not possible for an employer

19. If an employee is required to wash uniforms, the employer will be in breach of the Award.

Telephone allowance

20. The SCHADS Award currently has the following provisions for telephone allowance:

20.6 Telephone allowance

Where the employer requires an employee to install and/or maintain a telephone for the purpose of being on call, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts.

21. The HSA and UV have submitted claims to increase the telephone allowance.
22. The HSU wording to be submitted is a new clause:

20.7 Telephone allowance

Where the employer requires an employee to use a mobile phone for any work related purpose, the employer will either:

(a) provide a mobile phone fit for purpose and cover the cost of any subsequent charges; or

(b) refund the cost of purchase and subsequent usage charges on production of receipts.

23. UV has submitted the following wording:

Where the employer requires an employee to install and/or maintain a telephone ***or mobile phone*** *for the purpose of being on call,* ***for the performance of work duties or to access work related information****, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts.*

24. Business SA and its members acknowledge that employees are, at times, required to use personal mobile phones in the course of their employment.
25. Business SA does not believe it is appropriate for an employer to pay for a mobile phone, which may only be used for a small amount of work, for the employee to keep. There are fringe benefit issues that need to be explored here. It is not a matter of just providing a phone.
26. Mobile phone plans vary significantly. A preliminary search of mobile phone plans shows that the availability of plans from $15 per month with all calls and text messages covered and 3 gigs of data. An employer should only be required to pay for a suitable plan or a mobile phone allowance, rather than subsidise an employee's personal phone usage. The following provides evidence of a significant number of phone plans from various providers that do not require the payment of calls.
27. The United Voice witness, Trish Stewart states she spends $170 per month on phone bills due to work commitments.[5] Business SA submits that such a high cost is an anomaly and can easily avoided if the employee is on a cost-effective plan. Most plans include all phone call and text messaging costs and any reimbursement should be a reasonable amount and not subsidise either poor phone plan choice or an employee's personal usage.
28. HSU states in para [60], Any employees required to use a phone for work int his way should receive a telephone allowance which reflects the cost of maintaining and using such phone. Business SA agrees to a degree. Businesses should only be required to reimburse the work-related cost of maintaining and using a phone, not the personal component.
29. While Business SA is not proposing a variation to the phone allowance in the current SCHCADS Award, we draw the Commission's attention to the Real Estate Industry Award's mobile phone allowance which contemplates and better reflects the nature of using a personal mobile phone for work purposes.

[5] Submission of United Voice para 95, witness statement Stewart at [20] - [22]

18.6 Mobile telephone allowance

(a) Where the employer requires the employee to use the employee's own mobile phone in the course of employment and:

(i) the mobile telephone is provided under a mobile phone plan from a telecommunications provider, the employer and employee must agree in writing on the amount of reasonable reimbursement payable by the employer to the employee for the use of the employee's mobile phone in the course of employment provided that such reimbursement must not be less than 50% of the cost of the employee's monthly mobile phone plan, up to a maximum monthly phone plan of $100; or

(ii) the mobile phone is a pre-paid mobile phone; the employer and employee must agree in writing on the amount of reasonable reimbursement payable by the employer to the employee for the use of the employee's pre-paid mobile phone.

(b) Without limiting an agreed method of payment for reimbursement, an employee's salary in excess of the minimum weekly wage may be inclusive of reimbursement providing the reimbursement component of the salary is identified in the agreement.

(c) The mobile phone allowance under cause 18.6(a) is payable during the entire period of employment, except when the employee is on any period of leave either paid or unpaid.

(d) If requested, the employee must provide the employer with a copy of the mobile phone plan associated with the mobile telephone to be used by the employee in the course of employment.

(e) If the employee enters into a new mobile phone plan or arrangement with a telecommunications provider entitling the employee to a different allowance under this sub-clause, the new allowance will become payable from the first full pay period after the date the employee provides the employer with a true copy of the new mobile phone plan.

Minimum Engagement

30. The HSU has made an application to vary the Award to allow for all employees, whether full-time, part time or casual to be entitled to a minimum engagement of three hours in all sectors covered by the award.
31. Currently the Award only contains a minimum engagement clause for casual employees.
32. The casual minimum engagement clause states:

(c) Casual employees will be paid the following minimum number of hours, at the appropriate rate, for each engagement:

(i) social and community services employees except when undertaking disability services work—3 hours;

(ii) home care employees—1 hour; or

(iii) all other employees—2 hours.

33. Business SA acknowledges that there is no minimum engagement for part-time or fulltime employees and agree with the HSU that, this is generally not an issue for full-time employees due to roster arrangements.
34. The HSU, in its application has provided cogent reasons why there should be a minimum engagement for part-time employees, has not provided any evidence or rationale on why all minimum engagements should be set at three hours.
35. HSU has not provided a reason why casual employee engagement should be increased for home care employees or all other employees to three hours. and has only focused on part-time employment and then extrapolated this to other classifications.
36. In the process of creating the SCHCADS Award Australian Industrial Relations Commission (AIRC) released an exposure draft of September 2009, which contained a minimum engagement of three hours. This was argued against by employer parties on based on the inherent requirements of the industry. On 29 December 2009 the AIRC handed down a decision that varied the minimum engagement clause to the current modern award clause. The AIRC stated:

    [83] The minimum engagement has been established to take into account the different sectors in the industry.

37. Although the funding model of the industry has changed, the requirements of clients who receive the services has not. The requirement for short shifts still exists. Larger organisations in some circumstances may be able to roster around the shorter shifts, however, this will not be possible for smaller and regional employers.
38. HSU has made its submission on the minimum engagement in isolation and has not explored how the proposed variation will affect the broken shift clause, re-call to work clause and responding to emails after hours clause.
39. Business SA submits that a minimum engagement of 3 hours across for all work types would be a significant cost impact to the industry and would not meet the modern award object of the need to promote flexible modern work practices and the efficient and productive performance of work[6]; and the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden.[7]

S.35 Broken Shifts

ASU Claim

40. The ASU is seeking a variation to Clause 25.3 to provide a 15 per cent loading to be paid to employees who work broken shifts to compensate for the disunity associated with working unusual broken shift arrangements.[8]

[6] Fair Work Act 2009 s134(d)
[7] Ibid s134(f)
[8] ASU Submission, 18 February p.7

41. Broken shift allowances in other modern awards are:

    a. Children's Services Award – 1.19% of the standard weekly rate = $10.26[9]
    b. Aged Care Award – No allowance
    c. Hospitality Industry Award:

       where the time between periods of work is two hours and up to three hours—an allowance per day equal to 0.33% of the standard weekly rate; or $2.85

       where the time between periods of work is more than three hours—an allowance per day equal to 0.5% of the standard weekly rate. $862.50 = $4.31[10]

    d. Fitness Industry Award - 1.7% of the standard rate extra and for excess fares $1.94 extra. = $13.91[11]

    e. Security Services Award - 1.62% of standard rate = $14.11[12]

42. Business SA submits the claim for a 15% loading of their ordinary rate of pay for each hour from the commencement of the shift to the conclusion of the shift is significantly higher than any other industry. If a Level 2, pay point 1 casual worker receives the minimum of $27.80 per hour and works split shifts over the maximum allowable period of 12 hours[13], they will receive a shift allowance of $50.04 per shift (12 x $27.80 = $333.59 * 15% = $50.04). This is an extraordinarily high shift allowance for an industry with low margins and limited ability to absorb increased costs. The claim by the ASU is out of line with other industries and it is Business SA's view that the evidence provided does not substantiate a shift allowance of such a high amount, especially when viewed along with the other claims to vary the broken shift provision.

United Voice Claim

43. United Voice and HSU have submitted that broken shifts should only be worked in two parts. The evidence produced by the United Voice witness, Belinda Sinclair does not address the issue of broken shifts as she states that since the middle of 2018, she has only had once such shift scheduled as her employer does not like to use them.

44. It is Business SA's submission that evidence has not been provided to limit the splitting of shifts to only two. It is common practise in the industry to have a person provide support over three distinct parts of the day in order to meet the client's needs. If shifts are limited to only two, this will reduce the continuity of service to clients in the industry, who request the same carer for all shifts. The care of a person is a very personal choice and the client will request or choose a carer who makes them comfortable. Restricting the number of parts of

[9] Children's Services Award 2010 cl.15.1
[10] Hospitality Industry Award 2010 cl.21.3
[11] Fitness Industry Award 2010 cl.18.4
[12] Security Industry Award 2010 cl.15
[13] SCHADS Award cl 25.6(a)

the broken shift to two will significantly impact the choices of the clients. As well as be a cost impact of the business due to increased scheduling.

45. In addition to limiting broken shifts to two parts, as detailed above, the HSU is also seeking to vary the broken shift clause to ensure that broken shifts can only be worked by agreement and short shifts are not broken. (Clause 25.6; ED Clause 13.6)[14]

46. It is Business SA's submission that preventing an employer from being able to direct an employee to work broken shifts will significantly impair the ability to provide services to clients. It is recognised that, in homecare services the provision of care to a client over the course of the day is a regular requirement.

Conclusion

47. Funding arrangements for the NDIS are complex and there is no guarantee from the Federal Government that the National Disability Insurance Scheme (NDIS) will make adjustments to cover all of the additional costs specific to the increases if the Award is varied. This will result in businesses absorbing the cost of the increases. The flow-on effect of such increases will be the reduction of services to clients, reduction in staffing numbers, organisations looking towards alternative businesses models to overcome the increased costs and the closure of businesses.

48. Consideration of applications to vary the Award should only occur in the context of industry specific criteria and the unusual difficulties faced by the industry.

49. Business SA asks the Fair Work Commission to be cautious in implementing increases and variations that will have counter intuitive results to the industry and its stakeholders.

12 July 2019

File on behalf of: South Australian Chamber of Commerce and Industry (T/as Business SA)
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[14] Submission of the HSU, 15 February 2019, p3

FAIR WORK COMMISSION
4 Yearly Review of Modern Awards
Social, Community, Home Care and Disability Services Industry Award 2010

Matter: AM2018/26

WITNESS STATEMENT OF JEFFREY OWEN SMITH
Filed on behalf of People with Disability Australia and Disabled People's Organisations Australia (DPO Australia).

I, Jeffrey Owen Smith, of 3 Moncur St, Marrickville, Sydney, New South Wales, affirm:

Background

1. I am the Chief Executive Officer for People with Disability Australia. I have been employed by PWDA since August 2019.

2. People with Disability Australia (PWDA) is a national cross-disability rights and advocacy organisation run by and for people with disability. Working within a human rights framework, PWDA represents the interests of people with all kinds of disability. We are a Disabled Peoples Organisation (DPO), meaning that our primary membership is people with disability and organisations primarily constituted by people with disability. We also have a large associate membership of other individuals and organisations committed to the disability rights movement. We have a vision of a socially just, accessible, and inclusive community, in which the human rights, citizenship, contribution, potential and diversity of all people with disability are recognised, respected and celebrated.

3. As a national DPO PWDA has a significant interest in the successful transition to the NDIS. We campaigned with and for people with disability for the introduction of the scheme over many years; we conducted a national engagement project with the National Disability and Carers Alliance to co-design the Scheme (2012-13) and I represent PWDA at the NDIA CEO forum. PWDA also provides a Commonwealth funded Individual Advocacy Service across NSW and locations in Queensland assisting over 2400 clients each year, many of whom will be effected by the NDIS transition.

4. PWDA is also a founding member of the Disabled People's Organisations Australia (DPO Australia), the others being First Peoples Disability Network Australia (FPDNA), Women With Disabilities Australia (WWDA), and National Ethnic Disability Alliance (NEDA). The key purpose of DPO Australia is to promote, protect and advance the human rights and freedoms of people with disability in Australia by working collaboratively on areas of shared interests, purposes and strategic priorities and opportunities. DPO Australia has been funded by the Australian Government to be the recognised coordinating point between Government/s and other stakeholders, for consultation and engagement with people with disability in Australia. In forming DPO Australia, its four founding member organisations recognise and value the strength of working together in a spirit of mutual respect and trust, to proactively pursue human rights outcomes for all people with disability in Australia.

5. In making this witness statement I am representing the views of PWDA.

6. I hold a Bachelor of Arts and Law at Macquarie University and a Masters of Law at the University of Sydney.

Choice and control for people with disability

7. The NDIS is premised on the principles of choice and control for people with disability. Choice of support provider and control over the terms of the supports being provided. In doing this people with disability are reshaping the market for disability supports by creating demand on their own terms, as opposed to accepting an inflexible, block funded supply. By funding individuals to create demand as opposed to funding services to create supply, the person centred approach of the NDIS takes the provision of disability support out of the specialised, segregated market and opens it up to operate within a free market model – like other services required by people in the community such as grocery shopping, leisure, entertainment, healthcare and transport, all of which operate outside of a traditional 9-5 office hours framework and respond to uncertain demand.

8. The NDIS is supporting people with disability to receive their disability supports in a way which will increase their social and economic participation. For example, the provision of disability support at flexible times to allow participation in social activities, employment and to make necessities such as visiting the doctor and shopping more convenient. It is the right of people with disability to undertake these activities as and when it suits them.

9. Some flexibility from the workforce will be required in order to realise this vision of the NDIS, and the ability of providers to deliver flexible, appropriate, good value, high quality, safe services must be a standard to which the success of the NDIS is held. The challenge of meeting these expectations lies with the service provider who must develop a business model that meets the needs of consumers through engagement of a workforce that is appropriately skilled, motivated, paid and valued for their work.

10. Spontaneity of needs may be addressed by existing casual support worker provisions, and it is important that these casual staff are properly remunerated for the insecure nature of their work. However, people with disability must not be characterised as unreasonable, unpredictable or irrational people who expect to have their preferred staff ‘on call’ to respond to their whims. People with disability are aware of the constraints that workers operate under and in some instances are also disability support workers themselves.

11. It is also critical to note that for the majority of people requiring disability supports their needs are regular and predictable. For example, a person requiring personal care every morning before work will be likely to require it at the same time, every working day, for every working week of the year. In our experience people with disability value continuity of support and are likely to seek to retain ‘’good’’ staff on a regular basis. They frequently express immense frustration with having to repeatedly 'train' new support workers in how to provide person-centred services to them as a result of a highly casualised and transient workforce. To our knowledge, the majority of NDIS participants want to employ staff regularly and over the long-term.

12. NDIS Support Plans are also drawn up and pre-agreed in advance, with spending justified at regular intervals. It is erroneous to characterise the NDIS as a system that provides for people with disability to change their support preferences on an ongoing and erratic basis.

The emphasis is on encouraging regimes of support that work well, when these patterns are achieved there should be little need for significant alteration to plans and service provision. Again, the key to meeting the expectations of people with disability and enabling service providers to operate with predictability and consistency is reliable, content, quality staff.

13. People with disability want to employ staff who are paid appropriately for their work, and for working anti-social hours whether they be long, short, late, early, fall on public or religious holidays, or at other times when they may prefer to be spending time with family and friends. Not only do positive working conditions mean that staff are more content in their job; their ability to build trusting, positive and productive relationships with clients is increased. Resentful and disgruntled staff are more likely to be more difficult for people with disability to work with, influence high rates of staff turnover, and ultimately can result in people with disability being put at risk of harm.

Devaluing the work of disability support workers devalues the lives of the people with disability they support

14. The proposed changes to the SCHDS Award – including to ordinary hours of work and rostered work - threaten the quality of staff and thus services on offer to people with disability.

15. The removal of overtime protections and changes to roster provisions would make disability support work an increasingly unattractive career path and lower the level of skills and commitment in the already strained workforce. This is at a time when the workforce should be expanding, diversifying, and up-skilling to adapt to the new environment and provide innovative solutions to people with disability. Disability support work is a challenging and rewarding career path, it should not be characterised as a fall back, or stop gap career for people unable to secure alternative better paid work with more standardised working conditions.

16. The proposed changes will potentially create a category of worker who is offered insecure employment with less protections *specifically* because they work with people with disability. The inference being that people with disability somehow still require something ‘different’ than others in the community, and cannot be served by mainstream style supports. The NDIS challenges this perception, and it is the service sector that must respond by changing working cultures, raising expectations, and rewarding good staff as opposed to targeting the workforce for cuts and placing the responsibility for this on people with disability who are merely seeking the choice and control experienced by others in the community.

17. Moreover, the changes will disproportionality affect women who make up the majority of the current disability support workforce. It will also create a further barrier to employment for people with disability themselves who could be using their skills and expertise to increase their economic participation and strengthen their economic security by working in the sector.

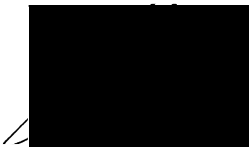
18. Creating systemic employment discrimination problems for disability support workers discriminates against people with disability too by indirectly channelling potential staff into

other industries with better working conditions. Devaluing the work of disability support workers devalues the lives of the people with disability they support.

19. Furthermore, there is considerable evidence linking underpaid, unmotivated, undervalued staff to violence, abuse, neglect and exploitation of people with disability especially those living in residential institutions or receiving personal care in their own homes. Research demonstrates that violence, abuse and neglect tend to occur where work is precarious, unstable or contingent (Mayhew and Quinlan, 2000 Both PWDA have advocated extensively on this topic, most recently in evidence to the Senate Community Affairs Inquiry into Violence, Abuse and Neglect Against People with Disability in Residential and Institutional Settings (2015). The Senate Report made specific recommendations around workplaces and worker practices with regard to addressing violence committed by staff.

20. Given the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability is just starting, it is premature to rein in employee entitlements in the manner suggested. The Royal Commission is likely to uncover many examples of violence, exploitation, abuse and neglect, and undoubtedly some of these will be due to structural issues arising out of the employment relationship, including where this spills over into unhappy and resentful staff.

21. Attractive working conditions for disability support workers are essential in order to support and maintain the paradigm shift embodied by the NDIS, encourage the development of a high quality market for disability supports which meets the needs of consumers, and to ameliorate the risk of violence towards people with disability. I urge the Fair Work Commission to look past the reactionary and short term needs of a service sector going through a period of urgent transition, and put the needs of people with disability and those who they employ to support them at the forefront of your deliberations.



Jeff Smith
CEO People with Disabilty Australia

Dated 11 September 2019